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BOARD OF COMMISSIONERS AND FINANCE & AUDIT COMMITTEE JOINT MEETING AGENDA
June 29, 2021
1515 N Flagler Drive, Suite101
West Palm Beach, FL 33401

Remote Participation Link:
https://zoom.us/j/5507895592?pwd=REZ4TWtYUXowQWNpWTBaVXRsZ1dDQT09

Via Telephone dial-in access: (646) 558-8656 / Meeting ID: 550 789 5592 / Password: 946503

1. Call to Order – Les Daniels, Chair

A. Roll Call

B. Invocation

C. Pledge of Allegiance

D. Affirmation of Mission: The mission of the Health Care District of Palm Beach County is to be the health care safety net for Palm Beach County. Our vision is meeting changes in health care to keep our community healthy.

2. Agenda Approval

A. Additions/Deletions/Substitutions

B. Motion to Approve Agenda

3. Awards, Introductions and Presentations

A. Introduction of Heather Bokor, VP & Chief Compliance and Privacy Officer (Darcy Davis)

B. Introduction of Bernabe Icaza, VP & General Counsel (Darcy Davis)

C. Introduction of Candice Abbott VP & Chief Financial Officer (Darcy Davis)

D. Introduction of Jessica Cafarelli, AVP & Controller (Candice Abbott)

E. 2021 Legislative Session Summary (Ballard Partners - Mat Forrest & Jan Gorrie)

F. Economic Update and Investment Portfolio Strategy Review (John Grady)

G. Employee Engagement Results (Steven Hurwitz)

H. EPIC Update (Patty Lavely)

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3. Awards, Introductions and Presentations (Continued)

I. Budget Version 1 (Darcy Davis)

4. Disclosure of Voting Conflict

5. Public Comment

6. Meeting Minutes

A. **Staff Recommends a MOTION TO APPROVE:**
Board Meeting Minutes of March 11, 2021 [Pages 1-6]

7. FINANCE AND AUDIT COMMITTEE

A. **Staff Recommends a MOTION TO APPROVE:**
Finance & Audit Committee Meeting Minutes of March 10, 2021 [Pages 7-10]

8. Committee Reports

8.1 Finance and Audit Committee – (No Report)

8.2 Good Health Foundation Committee – (No Report)

8.3 Quality, Patient Safety and Compliance Committee – (Commissioner Alonso)

8.4 Lakeside Health Advisory Board – (Commissioner Alonso)

8.5 Primary Care Clinics Board – (Commissioner Jackson-Moore)

9. Consent Agenda – Motion to Approve Consent Agenda Items

HEALTH CARE DISTRICT

A. **ADMINISTRATION**

9A-1 **RECEIVE AND FILE:**
June 2021 Internet Posting of District Public Meeting
https://www.hcdpbc.org/EventViewTrainingDetails.aspx?Bck=Y&EventID=344&m=0|0&DisplayType=C

9A-2 **RECEIVE AND FILE:**
Health Care District Board Attendance [Page 11]

9A-3 **RECEIVE AND FILE:**
Health Care District Financial Statements May 2021 (Darcy Davis)
[Pages 12-60]

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9. Consent Agenda (Continued)

9A-4 **Staff Recommends a MOTION TO APPROVE:**
Medical Staff Appointment(s) for Lakeside Medical Center (Belma Andric, MD) [Pages 61-63]

9A-5 **Staff Recommends a MOTION TO APPROVE:**
Re-credentialing and Privileging of Healey Center Practitioner (Belma Andric, MD) [Pages 64-65]

9A-6 **Staff Recommends a MOTION TO APPROVE:**
Proclamation Recognizing the Trauma System's 30th Year (Belma Andric) [Pages 66-68]

9A-7 **Staff Recommends a MOTION TO APPROVE:**
Proclamation Recognizing National Nurses Week (Steven Hurwitz) [Pages 69-71]

9A-8 **Staff Recommends a MOTION TO APPROVE:**
Lakeside Medical Center Confidential Public Records Request Quarterly Report (Christy Goddeau) [Pages 72-74]

9A-9 **RECEIVE AND FILE:**
Sponsored Programs Calendar Year 2020 Dashboard (Tom Cleare) [Pages 75-77]

9A-10 **Staff Recommends a MOTION TO APPROVE:**
Internal Audit Charter (Betsy Bittar) [Pages 78-83]

9A-11 **Staff Recommends a MOTION TO APPROVE:**
Revisions to Purchasing Policy (Candice Abbott) [Pages 84-92]

9A-12 **Staff Recommends a MOTION TO APPROVE:**
RFQ for Pre-Qualified Architectural and Engineering Firms (Cindy Dupont) [Pages 93-95]

10. Regular Agenda

A. **ADMINISTRATION**

10A-1 **Staff Recommends a MOTION TO APPROVE:**
Tentative Millage Rate (Darcy Davis) [Pages 96-97]

10A-2 **Staff Recommends a MOTION TO APPROVE:**
OB Service Line at Lakeside Medical Center (Karen Harris) [Pages 98-105]

10A-3 **RECEIVE AND FILE:**
Internal Audit Timeline (Betsy Bittar) [Pages 106-111]

10A-4 **Staff Recommends a MOTION TO APPROVE:**
Internal Audit Update (Betsy Bittar) [Pages 112-124]

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10. Regular Agenda (Continued)

10A-5 **Staff Recommends a MOTION TO APPROVE:**
2020 Health Care District Audit (RSM) [Pages 125-260]

B. **TRAUMA** – Public Hearing

10B-1 **Staff Recommends a MOTION TO APPROVE:**
Trauma Agency Five Year Plan. (Belma Andric) [Pages 261-387]

11. CEO Comments

12. Finance & Audit Committee Member Comments

13. HCD Board Member Comments

14. Establishment of Upcoming Board Meetings

September 16, 2021

- 4:00PM, Joint Meeting with the Finance & Audit Committee
- 5:15PM, Truth In Millage (TRIM) Meeting

September 28, 2021

- 4:00PM, Health Care District Board Annual Meeting (Officer Elections)
- 5:15PM, Truth In Millage (TRIM) Meeting

December 15, 2021

- 2:00PM, Health Care District Board Meeting

15. Motion to Adjourn

HEALTH CARE DISTRICT OF PALM BEACH COUNTY BOARD OF COMMISSIONERS MEETING SUMMARY MINUTES

March 11, 2021
1515 N Flagler Drive, Suite101
West Palm Beach, FL 33401

Remote Participation Link:
https://zoom.us/j/5507895592?pwd=REZ4TWtYUXowQWNpWTBaVXRsZ1dDQT09

Via Telephone dial-in access: (646) 558-8656 / Meeting ID: 550 789 5592 / Password: 946503

1. Call to Order

Les Daniels called the meeting to order.

A. Roll Call

Health Care District Board members present included: Les Daniels, Chair; Nancy Banner, Vice Chair; Sean O'Bannon, Secretary; Dr. Alonso; Cory Neering; Ed Sabin and Tammy Jackson-Moore.

Staff present included: Darcy Davis, Chief Executive Officer; Dr. Belma Andric, Chief Medical Officer; Valerie Shahriari, General Counsel; Dr. Tom Cleare, AVP Planning & Community Engagement; Karen Harris, VP of Field Operations; Steven Hurwitz, Chief Administrative Officer; Candice Abbott, Chief Clinical Integration Officer; Tony Colby, Interim Chief Financial Officer and Patty Lavely, Chief Information & Digital Officer.

Recording/Transcribing Secretary: Heidi Bromley

B. Invocation

Ms. Davis led the invocation.

C. Pledge of Allegiance

The Pledge of Allegiance was recited.

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D. Affirmation of Mission: The mission of the Health Care District of Palm Beach County is to be the health care safety net for Palm Beach County. Our vision is meeting changes in health care to keep our community healthy.

2. Agenda Approval

A. Additions/Deletions/Substitutions

Ms. Davis stated that we are going to delete Item 3B and move Item 3C, Epic Update under the Consent agenda 8-A12.

B. Motion to Approve Agenda

CONCLUSION/ACTION: Commissioner Jackson-Moore made a motion to approve the revised agenda. The motion was duly seconded by Commissioner Banner. There being no opposition, the motion passed unanimously.

3. Awards, Introductions and Presentations

A. Recognition of Valerie Shahriari

Ms. Davis recognized Ms. Shahriari for all of her dedicated work while at the Health Care District.

B. PCI and Data Security Risk Assessment Annual Reports

This item was deleted from the agenda.

C. Epic Update

This item was moved to the Consent agenda 8A-12.

4. Disclosure of Voting Conflict

5. Public Comment

6. Meeting Minutes

A. <u>**Staff Recommends a MOTION TO APPROVE:**</u>
Board Meeting Minutes of December 8, 2020.

CONCLUSION/ACTION: Commissioner Neering made a motion to approve the Meeting Minutes of December 8, 2020 as presented. The motion was duly

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seconded by Commissioner Alonso. There being no objection, the motion passed unanimously.

7. Committee Reports

7.1 Finance and Audit Committee Report

Commissioner Sabin stated that the Finance & Audit committee met yesterday. John Grady provided an Economic Update and Portfolio Strategy Review to the Committee. We received an update from Ms. Lavely on where we are with Epic and we reviewed the Financial Statements.

7.2 Good Health Foundation Committee Report – (No Report)

7.3 Quality, Patient Safety and Compliance Committee

Commissioner Alonso stated that we had the Quality, Patient Safety and Compliance Committee meeting yesterday. Sylvia Hall provided a presentation; Press Ganey Population and Sampling. We reviewed the Patient Relations Dashboards and the Quality & Patient Safety Reports.

7.4 Lakeside Health Advisory Board Report

Commissioner Alonso stated that the Lakeside Health Advisory Board met on March 3rd. Ms. Davis introduced Tony Colby, Interim Chief Financial Officer and Candice Abbott, Chief Clinical Integration Officer. Dr. Andric gave an update of the COVID Vaccination outreach. Ms. Moreland gave a hospital update which included MRI services, Dialysis outpatient services and new EHR – EPIC update. Dr. Cleare gave an update on Unite Us and the partnerships that are in the Glades and Ms. Shahriari did the Annual Sunshine Review.

7.5 Primary Care Clinics Board Report

Commissioner Jackson-Moore stated that meetings were held on December 16, 2020, January 27, 2021 & February 24, 2021

- *Updates on Key Management*
  Reviewed changes in clinic organizational structure.

- *Data Reporting Schedule*
  Reporting one month behind for Operations and Quality Council.

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- *COVID-19 Vaccine*
  Began administering the vaccine mid-December.
  North County COVID-19 Temporary Vaccination Site opened February 24th.

- *Uniform Data System (UDS)*
  Submitted 2/10/2021.

7. Consent Agenda – Motion to Approve Consent Agenda Items

CONCLUSION/ACTION: Commissioner Jackson-Moore made a motion to approve the Consent Agenda. The motion was duly seconded by Commissioner Neering. There being no objection, the motion passed unanimously.

HEALTH CARE DISTRICT

A. **ADMINISTRATION**

8A-1 **RECEIVE AND FILE:**
March 2021 Internet Posting of District Public Meeting
https://www.hcdpbc.org/EventViewTrainingDetails.aspx?Bck=Y&EventID=344&m=0|0&DisplayType=C

8A-2 **RECEIVE AND FILE**
Health Care District Board Attendance

8A-3 **RECEIVE AND FILE:**
Health Care District Financial Statements January 2021

8A-4 **Staff Recommends a MOTION TO APPROVE:**
Medical Staff Appointment(s) for Lakeside Medical Center

8A-5 **Staff Recommends a MOTION TO APPROVE:**
Recredentialing and Privileging of Healey Center Practitioner

8A-6 **Staff Recommends a MOTION TO APPROVE:**
Legal Settlement

8A-7 **Staff Recommends a MOTION TO APPROVE:**
Amendment to HCD Bylaws

8A-8 **Staff Recommends a MOTION TO APPROVE:**
Amendment to 1515 N. Flagler Drive Lease Agreement

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8. Consent Agenda (Continued)

8A-9 **RECEIVE AND FILE:**
Internal Audit Update

8A-10 **Staff Recommends a MOTION TO APPROVE:**
Third Amendment to Agreement between the Health Care District and District Clinic Holdings, Inc.

8A-11 **Staff Recommends a MOTION TO APPROVE:**
Second Amendment to Chief Executive Officer Employment Agreement

9. Regular Agenda

A. **ADMINISTRATION**

9A-1 **Staff Recommends a MOTION TO APPROVE:**
CEO Annual Evaluation (Chair Daniels) [Verbal]

Commissioner Daniels stated that this agenda item is to approve the annual evaluation of Darcy Davis. He asked if there were any questions. There being no questions; he asked for a motion to approve the CEO Annual Evaluation.

CONCLUSION/ACTION: Commissioner Banner made a motion to approve the CEO Annual Evaluation. The motion was duly seconded by Commissioner Alonso. There being no objection, the motion passed unanimously.

9A-2 **RECEIVE AND FILE:**
Department of Health Subsidy Budget Status Update

Dr. Cleare provided an update on the Department of Health Budget Status to the Board.

CONCLUSION/ACTION: Received and filed.

10. CEO Comments

11. HCD Board Member Comments

12. Establishment of Upcoming Board Meetings

June 9, 2021

- 2:00PM, Joint Meeting with the Finance & Audit Committee

(1st) September Meeting (Date TBD)

- 4:00PM, Joint Meeting with the Finance & Audit Committee
- 5:15PM, Truth In Millage (TRIM) Meeting

(2nd) September Meeting (Date TBD)

- 4:00PM, Health Care District Board Annual Meeting (Officer Elections)
- 5:15PM, Truth In Millage (TRIM) Meeting

December 15, 2021

- 2:00PM, Health Care District Board Meeting

13. Motion to Adjourn

There being no further business, the meeting was adjourned.

_____________________________ ____________________

Sean O'Bannon, Secretary **Date**

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FINANCE & AUDIT COMMITTEE MEETING
SUMMARY MINUTES

March 10, 2021 at 12:00 P.M.
1515 N. Flagler Drive, Suite 101
West Palm Beach, FL 33401

Remote Participation Link:
https://zoom.us/j/5507895592?pwd=REZ4TWtYUXowQWNpWTBaVXRsZ1dDQT09

Via Telephone dial-in access: (646) 558-8656 / Meeting ID: 550 789 5592 / Password: 946503

1. Call to Order – Edward Sabin, Chair

Ed Sabin called the meeting to order.

A. Roll Call

Health Care District Finance and Audit Committee members present included: Edward Sabin, Chair; Nancy Banner; Les Daniels; Michael Burke; Richard Sartory; Mark Marciano; Joe Gibbons and Sophia Eccleston.

Staff present included: Darcy Davis, Chief Executive Officer; Valerie Shahriari, General Counsel; Dr. Belma Andric, Chief Medical Officer; Karen Harris, VP of Field Operations; Dr. Thomas Cleare, AVP Planning and Community Engagement; Steven Hurwitz, VP, Chief Administrative Officer; Patricia Lavely, Vice President, Chief Information and Digital Officer; Betsy Bittar, Senior Internal Auditor; Chase Wright, Partner, Cherry Bekaert, LLP; Janet Moreland, AVP, Administrator of Lakeside Medical Center; Shelly Ann Lau, AVP, Administrator of Healey Center; and Mina Bayik, Director of Finance.

Recording/Transcribing Secretary: Tanya McCain

B. Affirmation of Mission: The mission of the Health Care District of Palm Beach County is to be the health care safety net for Palm Beach County. Our vision is meeting changes in health care to keep our community healthy.

2. Agenda Approval

A. Additions/Deletions/Substitutions

B. Motion to Approve Agenda

CONCLUSION/ACTION: Michael Burke made a motion to approve the agenda. The motion was duly seconded by Les Daniels. There being no opposition, the motion passed unanimously.

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3. Awards, Introductions and Presentations

A. Introduction: Tony Colby, Interim VP & CFO (Darcy J. Davis)

Ms. Davis introduced Tony Colby to the Finance and Audit Committee.

B. Introduction: Candice (Candie) Abbott, VP, Clinical Integration (Darcy J. Davis)

Ms. Davis introduced Candie Abbott to the Finance and Audit Committee

C. Introduction: Sophia Eccleston, HCD Finance & Audit Committee (Darcy J. Davis)

Ms. Davis introduced Sophia Eccleston as the newest member of the Finance and Audit Committee.

D. Economic Update and Portfolio Strategy Review (John Grady, Public Trust Advisors)

Mr. Grady gave the Committee the economic update and portfolio strategy for the current quarter.

E. PCI and Data Security Risk Assessment Annual Reports (Patty Lavely)

Ms. Lavely reviewed the Annual Reports for PCI and Data Security Risk Assessment for the Committee.

F. EPIC Journey Update (Patty Lavely)

Ms. Lavely provided the Committee with an overview of the upcoming EPIC implementation.

4. Disclosure of Voting Conflict

None

5. Public Comment

None

6. Meeting Minutes

A. **<u>Staff Recommends a MOTION TO APPROVE</u>:**
Finance & Audit Committee Meeting Minutes of December 8, 2020

CONCLUSION/ACTION: Les Daniels made a motion to approve the Finance & Audit Committee Meeting Minutes of December 8, 2020 as presented. The motion was duly seconded by Nancy Banner. There being no objection, the motion passed unanimously.

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7. Consent Agenda – Motion to Approve Consent Agenda Items

CONCLUSION/ACTION: Michael Burke made a motion to approve the Consent Agenda as presented. The motion was duly seconded by Joe Gibbons. There being no objection, the motion passed unanimously.

A. **ADMINISTRATION**

7A-1. **RECEIVE AND FILE:**
March 2021 Internet Posting of District Public Meeting
https://www.hcdpbc.org/EventViewTrainingDetails.aspx?Bck=Y&EventID=327&m=0|0&DisplayType=C

7A-2. **RECEIVE AND FILE:**
Finance and Audit Committee Attendance

8. Regular Agenda

A. **ADMINISTRATION**

8A-1. **RECEIVE AND FILE:**
Health Care District Financial Statements – January 2021

Mr. Colby reviewed the Health Care District Financial Statements of January 2021 for the Committee and responded to questions.

CONCLUSION/ACTION: Received and filed.

8A-2. **RECEIVE AND FILE:**
Internal Audit Update

Ms. Bittar and Mr. Chase Wright of Cherry Bekaert, LLP reported on the findings of the internal audit and responded to questions.

CONCLUSION/ACTION: Received and filed.

8A-3. **Staff Recommends a MOTION TO APPROVE:**
Amendment to 1515 N. Flagler Drive Lease Agreement

Dr. Cleare reported on the need to lease temporary office space for prep work and storage related to the District's COVID-19 vaccination efforts.

CONCLUSION/ACTION: Les Daniels made a motion to approve the Amendment to 1515 N. Flagler Drive Lease Agreement as presented. The motion was duly seconded by Nancy Banner. There being no objection, the motion passed unanimously.

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9. Comments

A. CEO Comments

Ms. Davis welcomed Sophia Eccleston to the Finance & Audit Committee.

B. CFO Comments

None

C. Committee Member Comments

None

10. Motion to Adjourn

There being no further business, the meeting was adjourned.

______________________________________ __________________________

Edward G. Sabin, Chair **Date**

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HEALTH CARE DISTRICT OF
PALM BEACH COUNTY
BOARD OF COMMISSIONERS

Board Meeting Attendance Tracking for 12/20 – 12/21

	12/8/20	3/11/21	6/9/21	September (TBD)	September (TBD)	12/15/21
Leslie Daniels	X	X				
Nancy Banner	X	X				
Sean O'Bannon	X	X				
Dr. Alonso	X	X				
Cory Neering	X	X				
Ed Sabin	X	X				
Tammy Jackson-Moore	X	X				

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Health Care District Financial Statements

2. Summary:

The YTD May 2021 financial statements for the Health Care District are presented for Board review.

3. Substantive Analysis:

Management has provided the income statements and key statistical information for the Health Care District. Additional management discussion and analysis is incorporated into the financial statement presentation.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

Darcy J. Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

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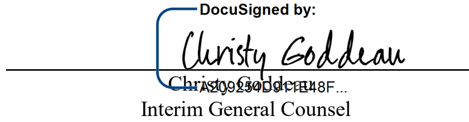
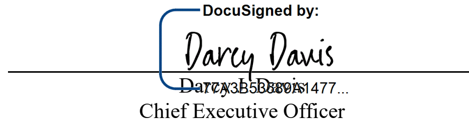
6. Recommendation:

Staff recommends the Board receive and file the YTD May 2021 Health Care District financial statements.

Approved for Legal sufficiency:



Christy Goddeau
Interim General Counsel



Darcy J. Davis
Chief Executive Officer

Health Care District of Palm Beach County

FINANCIAL STATEMENT

May 2021

Table of Contents

Management Discussion and Analysis

Combined Financial Statements

Revenues and Expenditures – Combined All Funds (Functional)…..……….. 1
Revenues and Expenses by Fund YTD…...……………………………………..2
Combined Statement of Net Position……………………………………………..3 - 4

Supplemental Information

General Fund………………………………………………………………......5 - 13
Healey Center…………………………………………………………………...14 - 16
Lakeside Medical Center…..……………………………………………………17 - 24
Primary Care Clinics…………………………………………………………......25 - 34
Medicaid Match……………………………………………………………………..35 - 36

DocuSign Envelope ID: 03200E54-4E87-4969-A60D-D1BFA61AB7F1

MEMO

To: Finance & Audit Committee

From: Darcy J. Davis, Chief Executive Officer

Date: June 10, 2021

Subject: Management Discussion and Analysis as of May 2021 Health Care District Financial Statements

The May statements represent the financial performance for the eight months of the 2021 fiscal year for the Health Care District. Total revenue year to date (YTD) of $205.3M is unfavorable to budget of $212.8M by ($7.5M) or (3.5%). Operational expenditures and expenses YTD are $22.0M favorable to budget or 13.5%. Year to date, the consolidated net margin is $62.1M, with a favorable variance to budget of $14.4M or 30.1%.

The General Fund YTD total revenue of $154.9M is above budget of $153.0M by $1.9M or 1.2%. This overall favorable variance is mainly due to revenue recognized from Cares Act, as well as timing of Ad Valorem tax revenue. Unfavorable net patient revenue of ($1.4M) is due to reduced Aeromedical transport volumes. Unrealized loss on investment variance of ($914k) represents decrease in current market value of investment portfolio held by the District, and will only be realized should the District liquidate its' portfolio.

Expenditures in the General Fund YTD after overhead allocation are favorable to budget by $20.1M or 27.2%. Significant categories of favorable YTD budget variance include salaries, wages and benefits $1.7M, purchased services $749k, medical services of $15.4M, repair and maintenance $954k, and other expenses of $1.8M. Salaries and wages is favorable to budget due primarily to vacancies in the school health program. Purchase services favorable variance are attributable to delayed implementation of transportation program, as well as reduced contracted personnel. Reduced YTD contracted personal in the Aeromed program resulted from reduced fire rescue staff due to helicopter being grounded for repairs, the helicopter has since come back online in April. Medical services claims continue to decline through better utilization management of District Cares membership and improved coordination of care. Trauma contracts cap on payments ended

DocuSign Envelope ID: 03200E54-4E87-4969-A60D-D1BFA61AB7F1

December 2020, the new contract started in January. Repair and maintenance variance relates to IT software maintenance cost after Epic implementation. Other expenses are favorable to budget due to refund of prior year medical claims paid, as well as expense timing.

The General Fund YTD has a net margin of $101.0M versus a budgeted net margin of $79.0M, for a favorable net margin variance of $22.0M or 27.8%. The General Fund has subsidized a total of $22.0M YTD to support operations of; Healey Center $2.7M, Primary Care Clinics $10.0M, Capital Project $1.7M, and Medicaid Match $7.7M.

The Healey Center total revenue YTD of $12.3M was unfavorable to budget by $42k. This unfavorable variance is due to increased charity and bad debt classification. Total YTD operating expenses before overhead allocation of $13.0M were favorable to budget by $385k or 2.9%. This favorable variance is mainly due to savings in the categories of Salaries, Wages, and Benefits $319k, as well as Purchased services $56k. Current vacant positions, and the timing of certain expenses are the primary reason for savings. The YTD net margin after overhead allocations for the Healey Center was a loss of ($3.4M) compared to budgeted loss of ($3.7M) or (10.4%).

Lakeside Medical Center total revenue YTD of $20.4M was under by ($6.2M) or (23.2%). Net patient revenue YTD of $18.9M was under budget by ($3.9M) or (17.1%). Total operating expenses YTD of $29.6M was favorable to budget by $62k or 0.2%. The YTD net margin after overhead allocations at Lakeside Medical Center was a loss of ($17.6M) compared to a budgeted loss of ($12.2M) for a variance of ($5.5M) or 45.2%.

The Primary Care Clinics total revenue YTD of $13.8M was under budget by ($3.1M) primarily due to revenue recognition timing of COVID-19 stimulus funds. Net patient revenue YTD was favorable to budget by $1.1M or 19.5%. Total operating expenses YTD for the clinics are favorable to budget by $366k or 2.0%. This favorable variance is primarily due to medical supplies $631k. Timing of medical supplies purchase are the primary reasons for savings. Total net margin YTD after overhead allocations for the Primary Care Clinics is a loss of ($10.3M), compared to budgeted loss of ($7.8M) for an unfavorable variance of ($2.5M) or 31.9%.

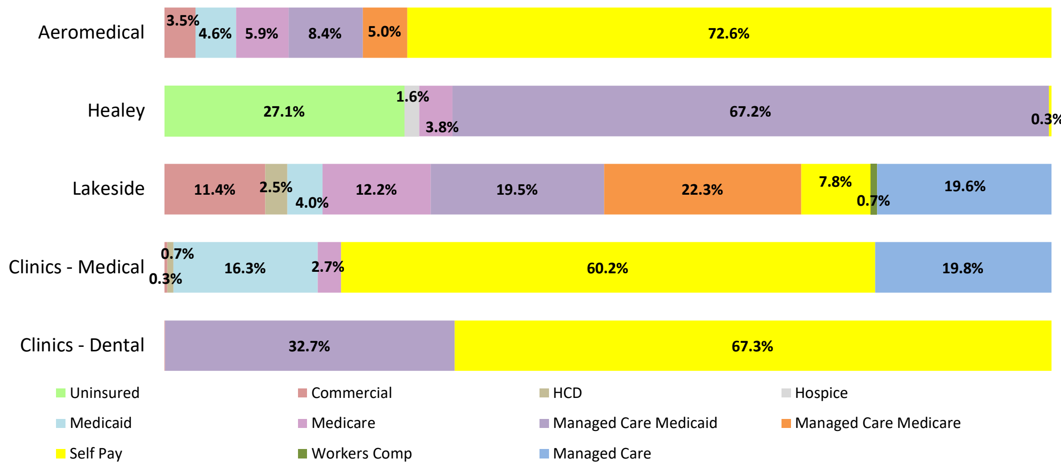
Cash and investments have a combined balance of $210.3M, of which $17.3M is restricted. Due from other governments of $15.1M reflects the tax collector receivable of $5.1M, and grants $10.0M. Total net position for all funds combined is $293.7M.

Program Dashboard - YTD May 2021

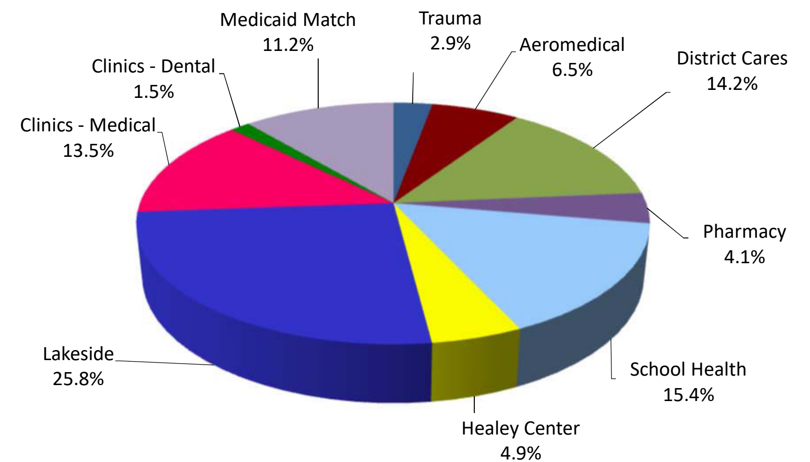
YTD Revenue and District Support by Program

	Trauma	Aeromedical	District Cares	Pharmacy	School Health	Healey Center	Lakeside	Clinics - Medical	Clinics - Dental	Medicaid Match
Patient Revenue, Net	-	980,671	-	-	-	6,032,971	18,932,954	5,396,520	1,555,910	-
Grants/Intergovernmental Payments	-	-	-	-	2,551,083	6,066,667	163,733	5,082,282	823,475	3,933,333
Other Revenue	36,771	-	-	-	-	9,048	145,426	71,310	-	23
Other Financial Assistance	-	-	-	-	-	222,045	1,171,438	746,722	74,359	-
District Support (overhead & shortfall)	1,967,751	4,447,372	9,727,602	2,786,892	10,511,079	3,360,286	17,648,769	9,232,440	1,017,897	7,663,232

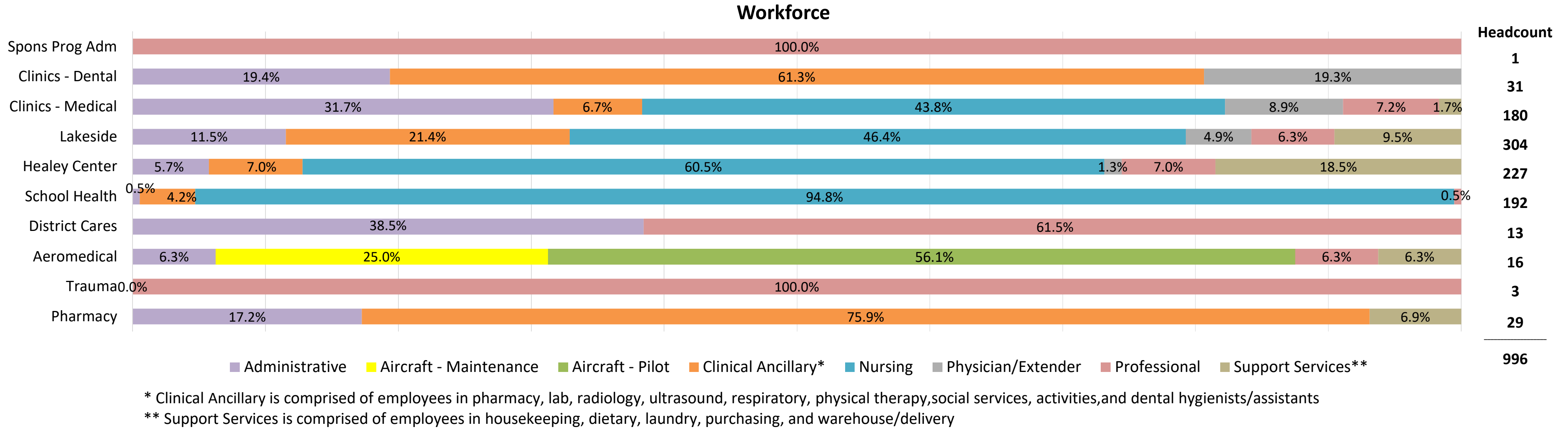
YTD Payor Mix by Volume



District Support (overhead and shortfall)

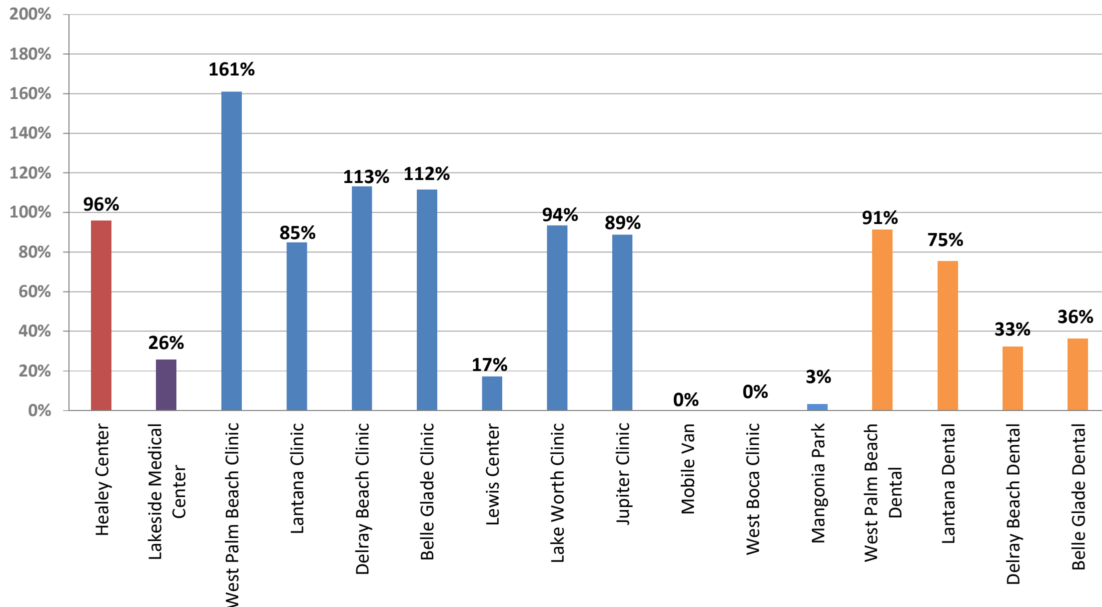


Program Dashboard - YTD May 2021

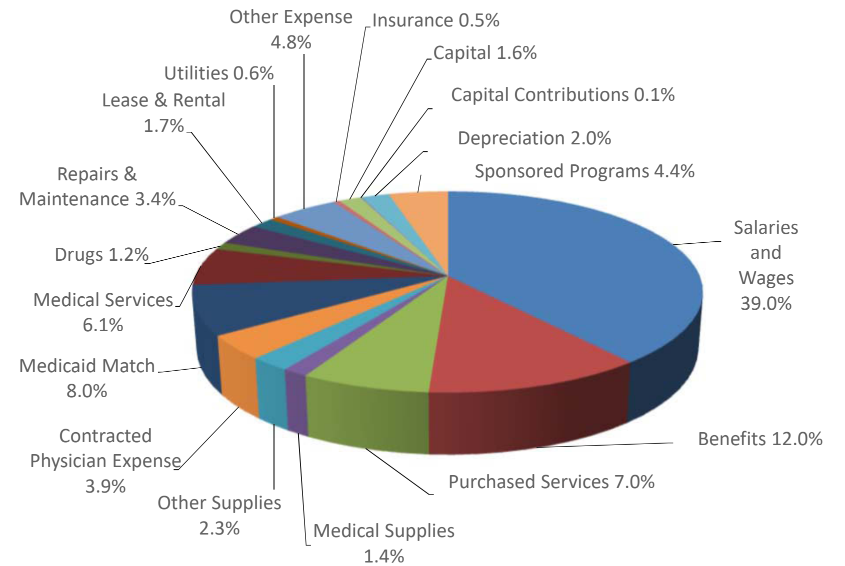


* Clinical Ancillary is comprised of employees in pharmacy, lab, radiology, ultrasound, respiratory, physical therapy,social services, activities,and dental hygienists/assistants

** Support Services is comprised of employees in housekeeping, dietary, laundry, purchasing, and warehouse/delivery



Healey Center and Lakeside Medical Center capacity percentages reflect the year-to-date average daily census.
Primary Care and Dental Clinic capacity percentages represent the number of completed visits compared to the budgeted number of visits at each location.



Revenues & Expenditures - Combined All Funds (Functional)

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
							Revenues:							
$ 1,355,359	$ 2,862,987	$ (1,507,628)	(52.7%)	$ 2,711,452	$ (1,356,093)	(50.0%)	Ad Valorem Taxes	$ 144,199,137	$ 143,193,476	$ 1,005,661	0.7%	$ 135,666,828	$ 8,532,310	6.3%
1,995,710	4,502,444	(2,506,734)	(55.7%)	3,778,235	(1,782,525)	(47.2%)	Patient Revenue, Net	32,899,026	37,355,339	(4,456,313)	(11.9%)	28,520,582	4,378,444	15.4%
1,481,917	1,481,916	1	0.0%	1,487,414	(5,497)	(0.4%)	Intergovernmental Revenue	12,551,083	11,855,328	695,755	5.9%	11,904,335	646,748	5.4%
1,488,547	1,177,202	311,345	26.4%	2,212,240	(723,693)	(32.7%)	Grants	6,069,490	6,184,705	(115,215)	(1.9%)	6,045,058	24,432	0.4%
101,242	121,339	(20,097)	(16.6%)	220,916	(119,674)	(54.2%)	Interest Earnings	1,079,330	970,712	108,618	11.2%	2,250,038	(1,170,708)	(52.0%)
13,568	-	13,568	0.0%	20,628	(7,060)	(34.2%)	Unrealized Gain/(Loss)-Investments	(913,657)	-	(913,657)	0.0%	1,518,413	(2,432,069)	(160.2%)
35,709	975,876	(940,167)	(96.3%)	3,079,396	(3,043,687)	(98.8%)	Other Financial Assistance	7,340,195	9,938,379	(2,598,184)	(26.1%)	3,079,396	4,260,799	138.4%
64,260	232,689	(168,429)	(72.4%)	74,604	(10,343)	(13.9%)	Other Revenue	2,123,270	3,304,986	(1,181,716)	(35.8%)	2,637,080	(513,810)	(19.5%)
$ 6,536,311	**$ 11,354,453**	**$ (4,818,142)**	**(42.4%)**	**$ 13,584,884**	**$ (7,048,574)**	**(51.9%)**	**Total Revenues**	**$ 205,347,876**	**$ 212,802,925**	**$ (7,455,049)**	**(3.5%)**	**$ 191,621,730**	**$ 13,726,146**	**7.2%**
							Expenditures:							
7,261,623	7,165,286	(96,337)	(1.3%)	6,260,192	(1,001,431)	(16.0%)	Salaries and Wages	56,961,275	58,741,257	1,779,982	3.0%	56,415,506	(545,769)	(1.0%)
2,313,611	2,227,771	(85,840)	(3.9%)	2,329,887	16,276	0.7%	Benefits	17,446,756	17,945,489	498,733	2.8%	17,463,650	16,894	0.1%
1,358,114	1,297,407	(60,707)	(4.7%)	1,294,395	(63,720)	(4.9%)	Purchased Services	10,259,613	10,534,215	274,602	2.6%	10,602,572	342,959	3.2%
317,964	324,830	6,866	2.1%	188,120	(129,844)	(69.0%)	Medical Supplies	2,052,275	2,474,769	422,494	17.1%	1,939,613	(112,663)	(5.8%)
433,292	406,967	(26,325)	(6.5%)	259,417	(173,875)	(67.0%)	Other Supplies	3,293,745	3,234,632	(59,113)	(1.8%)	1,662,612	(1,631,133)	(98.1%)
765,771	702,365	(63,406)	(9.0%)	690,772	(74,998)	(10.9%)	Contracted Physician Expense	5,651,132	5,618,920	(32,212)	(0.6%)	6,086,769	435,637	7.2%
1,449,573	1,449,573	(0)	(0.0%)	1,417,231	(32,343)	(2.3%)	Medicaid Match	11,596,587	11,596,584	(3)	(0.0%)	11,337,847	(258,740)	(2.3%)
1,575,653	3,805,855	2,230,202	58.6%	2,899,334	1,323,681	45.7%	Medical Services	8,837,057	24,277,242	15,440,185	63.6%	28,328,093	19,491,035	68.8%
184,570	189,675	5,105	2.7%	174,835	(9,734)	(5.6%)	Drugs	1,765,425	1,440,155	(325,270)	(22.6%)	1,711,168	(54,257)	(3.2%)
707,852	754,430	46,578	6.2%	476,821	(231,031)	(48.5%)	Repairs & Maintenance	4,946,868	6,035,440	1,088,572	18.0%	4,259,816	(687,052)	(16.1%)
328,258	362,390	34,132	9.4%	324,887	(3,371)	(1.0%)	Lease & Rental	2,493,136	2,840,499	347,363	12.2%	2,590,847	97,712	3.8%
105,800	132,590	26,790	20.2%	87,484	(18,316)	(20.9%)	Utilities	913,389	1,060,720	147,331	13.9%	913,296	(93)	(0.0%)
533,666	836,876	303,210	36.2%	532,948	(718)	(0.1%)	Other Expense	7,036,966	9,115,883	2,078,917	22.8%	6,971,691	(65,276)	(0.9%)
88,076	83,727	(4,349)	(5.2%)	115,985	27,909	24.1%	Insurance	687,978	669,816	(18,162)	(2.7%)	964,034	276,056	28.6%
820,619	836,496	15,877	1.9%	835,179	14,560	1.7%	Sponsored Programs	6,376,117	6,691,968	315,851	4.7%	6,441,327	65,211	1.0%
18,244,442	20,576,238	2,331,797	11.3%	17,887,487	(356,955)	(2.0%)	Total Operational Expenditures	140,318,321	162,277,589	21,959,269	13.5%	157,688,843	17,370,522	11.0%
$ (11,708,131)	$ (9,221,785)	$ (2,486,346)	27.0%	$ (4,302,603)	$ (7,405,528)	172.1%	Net Performance before Depreciation & Overhead Allocations	$ 65,029,555	$ 50,525,336	$ 14,504,219	28.7%	$ 33,932,887	$ 31,096,668	91.6%
372,113	354,000	(18,113)	(5.1%)	354,794	(17,319)	(4.9%)	Depreciation	2,968,100	2,832,000	(136,100)	(4.8%)	2,830,293	(137,806)	(4.9%)
18,616,555	**20,930,238**	**2,313,683**	**11.1%**	**18,242,281**	**(374,274)**	**(2.1%)**	**Total Expenses**	**143,286,420**	**165,109,589**	**21,823,169**	**13.2%**	**160,519,136**	**17,232,716**	**10.7%**
$ (12,080,244)	**$ (9,575,785)**	**$ (2,504,459)**	**26.2%**	**$ (4,657,397)**	**$ (7,422,847)**	**159.4%**	**Net Margin**	**$ 62,061,455**	**$ 47,693,336**	**$ 14,368,120**	**30.1%**	**$ 31,102,594**	**$ 30,958,862**	**99.5%**
428,993	6,400,091	5,971,098	93.3%	192,640	(236,352)	(122.7%)	**Capital**	2,380,216	20,313,377	17,933,161	88.3%	1,228,937	(1,151,279)	(93.7%)
2,022	-	(2,022)	0.0%	110,116	108,094	98.2%	**Capital Contributions**	151,407	-	(151,407)	0.0%	235,680	84,273	35.8%
$ (12,507,215)	**$ (15,975,876)**	**$ 3,468,662**	**(21.7%)**	**$ (4,739,921)**	**$ (7,767,294)**	**163.9%**	**RESERVES ADDED (USED)**	**$ 59,832,647**	**$ 27,379,959**	**$ 32,452,688**	**118.5%**	**$ 30,109,337**	**$ 29,723,310**	**98.7%**

Note: Excludes Interfund Transfers

Revenues and Expenses by Fund YTD

FOR THE EIGHT MONTH ENDED MAY 31, 2021

	General Fund	Healey Center	Lakeside Medical	Primary Care Clinics	Medicaid Match	Capital Funds	Total
Revenues:							
Ad Valorem Taxes	$ 144,199,137	$ -	$ -	$ -	$ -	$ -	$ 144,199,137
Premiums	-	-	-	-	-	-	-
Patient Revenue, Net	980,671	6,032,971	18,932,954	6,952,430	-	-	32,899,026
Intergovernmental Revenue	2,551,083	6,066,667	-	-	3,933,333	-	12,551,083
Grants	-	-	163,733	5,905,757	-	-	6,069,490
Interest Earnings	1,072,853	-	-	-	-	-	1,072,853
Unrealized Gain/(Loss)-Investments	(913,657)	-	-	-	-	-	(913,657)
Other Financial Assistance	5,125,631	222,045	1,171,438	821,081	-	-	7,340,195
Other Revenue	1,902,436	9,048	145,426	71,310	23	1,504	2,129,747
Total Revenues	**$ 154,918,156**	**$ 12,330,731**	**$ 20,413,551**	**$ 13,750,578**	**$ 3,933,356**	**$ 1,504**	**$ 205,347,876**
Expenditures:							
Salaries and Wages	24,476,199	7,814,941	13,000,872	11,669,264	-	-	56,961,275
Benefits	7,817,857	2,727,710	3,652,821	3,248,367	-	-	17,446,756
Purchased Services	6,830,974	407,132	2,219,416	802,091	-	-	10,259,613
Medical Supplies	97,524	429,552	1,217,483	307,717	-	-	2,052,275
Other Supplies	1,670,197	563,792	956,124	103,632	-	-	3,293,745
Contracted Physician Expense	12,500	9,278	5,629,354	-	-	-	5,651,132
Medicaid Match	-	-	-	-	11,596,588	-	11,596,588
Medical Services	8,206,358	135,744	-	494,954	-	-	8,837,057
Drugs	27,420	249,929	992,557	495,520	-	-	1,765,425
Repairs & Maintenance	4,256,957	200,708	438,098	51,105	-	-	4,946,868
Lease & Rental	1,236,498	10,796	404,371	841,471	-	-	2,493,136
Utilities	67,684	283,088	506,054	56,563	-	-	913,389
Other Expense	6,295,027	75,362	449,759	216,819	-	-	7,036,966
Insurance	470,728	55,495	132,763	28,992	-	-	687,978
Sponsored Programs	6,376,117	-	-	-	-	-	6,376,117
Total Operational Expenditures	67,842,039	12,963,530	29,599,671	18,316,494	11,596,588	-	140,318,321
Net Performance before Depreciation & Overhead Allocations	$ 87,076,117	$ (632,799)	$ (9,186,120)	$ (4,565,916)	$ (7,663,232)	$ 1,504	$ 65,029,555
Budget	$ 64,053,933	$ (975,008)	$ (3,069,739)	$ (1,863,434)	$ (7,662,400)	$ 41,984	$ 50,525,336
Prior Year: Net Performance before Depreciation & Overhead Allocations	$ 59,345,453	$ (482,773)	$ (12,486,188)	$ (5,086,626)	$ (7,403,548)	$ 46,569	$ 33,932,887

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Combined Governmental Funds Statement of Net Position

As of May 31, 2021

	General Fund May 2021	General Fund April 2021	Medicaid Match May 2021	Medicaid Match April 2021	Capital Projects May 2021	Capital Projects April 2021	Governmental Funds May 2021	Governmental Funds April 2021
Assets								
Cash and Cash Equivalents	$ 89,657,425	$ 85,642,436	$ 609,042	$ 609,042	$ 26,635,887	$ 25,196,093	$ 116,902,354	$ 111,447,571
Restricted Cash	-	-	-	-	-	-	-	-
Investments	97,268,252	102,859,891	-	-	-	-	97,268,252	102,859,891
Notes Receivable	-	-	-	-	-	-	-	-
Accounts Receivable, net	478,357	1,139,631	-	-	-	-	478,357	1,139,631
Due From Other Funds	-	-	-	-	-	-	-	-
Due From Other Governments	10,266,702	11,605,797	-	-	-	-	10,266,702	11,605,797
Inventory	47,382	47,382	-	-	-	-	47,382	47,382
Other Current Assets	4,066,406	5,130,943	-	-	-	-	4,066,406	5,130,943
Total Assets	$ 201,784,525	$ 206,426,079	$ 609,042	$ 609,042	$ 26,635,887	$ 25,196,093	$ 229,029,454	$ 232,231,214
Liabilites								
Accounts Payable	2,755,779	2,938,096	-	-	282,585	66,101	3,038,364	3,004,197
Medical Benefits Payable	1,141,100	1,141,100	-	-	-	-	1,141,100	1,141,100
Due To Other Funds	-	-	-	-	-	-	-	-
Due To Other Governments	-	-	-	-	-	-	-	-
Deferred Revenue	3,723,597	5,310,873	-	-	-	-	3,723,597	5,310,873
Other Current Liabilities	1,913,179	1,554,862	-	-	-	-	1,913,179	1,554,862
Noncurrent Liabilities	648,810	859,328	-	-	-	-	648,810	859,328
Total Liabilities	10,182,465	11,804,259	-	-	282,585	66,101	10,465,050	11,870,359
Fund Balances								
Nonspendable	3,503,672	4,527,122	-	-		-	3,503,672	4,527,122
Assigned to Subsequent Year's Budget	65,700,000	65,700,000	-	-	-	-	65,700,000	65,700,000
Assigned to Capital Projects	-	-	-	-	26,353,302	25,129,992	26,353,302	25,129,992
Assigned to Medicaid Match	-	-	609,042	609,042	-	-	609,042	609,042
Unassigned	122,398,387	124,394,699	-	-	-	-	122,398,387	124,394,699
Ending Fund Balance	191,602,059	194,621,821	609,042	609,042	26,353,302	25,129,992	218,564,403	220,360,855
Total Liabilities and Fund Balances	$ 201,784,524	$ 206,426,079	$ 609,042	$ 609,042	$ 26,635,887	$ 25,196,093	$ 229,029,452	$ 232,231,213

^ Excludes Interfund Transfers

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Combined Business-Type Funds Statement of Net Position

As of May 31, 2021

	Healey Center May 2021	Healey Center April 2021	Healthy Palm Beaches May 2021	Healthy Palm Beaches April 2021	Lakeside Medical Center May 2021	Lakeside Medical Center April 2021	Primary Care Clinics May 2021	Primary Care Clinics April 2021	Business-Type Funds May 2021	Business-Type Funds April 2021
Assets										
Cash and Cash Equivalents	$ 2,163,803	$ 1,780,860	$ 1,415,104	$ 1,415,104	$ (19,845,925)	$ (7,668,300)	$ (4,927,911)	$ (7,773,222)	$ (21,194,929)	$ (12,245,558)
Restricted Cash	8,855	25,124	1,500,000	1,500,000	15,555,685	15,555,685	221,426	221,426	17,285,966	17,302,236
Accounts Receivable, net	1,054,642	1,014,828	1,630	1,630	3,825,467	6,064,812	2,520,675	3,452,665	7,402,414	10,533,936
Due From Other Funds	-	-	-	-	-	-	-	-	-	-
Due From Other Governments	-	-	-	-	778,093	630,661	4,061,816	2,569,853	4,839,909	3,200,515
Inventory	-	-	-	-	450,426	542,306	-	-	450,426	542,306
Other Current Assets	110,853	24,880	45,555	45,555	736,782	576,824	125,052	74,292	1,018,241	721,551
Net Investment in Capital Assets	17,422,169	17,499,549	-	-	34,433,995	34,695,181	2,826,701	2,858,226	54,682,865	55,052,956
Total Assets	$ 20,760,322	$ 20,345,242	$ 2,962,289	$ 2,962,289	$ 35,934,524	$ 50,397,169	$ 4,827,758	$ 1,403,240	$ 64,484,893	$ 75,107,940
Deferred Outflows of Resources										
Deferred Outflows Related to Pensions	$ 112,870	$ 121,181	$ -	$ -	$ 13,243	$ 13,243	$ 20,199	$ 20,199	$ 146,312	$ 154,623
Liabilities										
Accounts Payable	256,336	136,995	-	-	640,464	729,221	175,836	200,724	1,072,636	1,066,940
Medical Benefits Payable	-	-	-	-	-	-	-	-	-	-
Due to Other Funds	-	-	-	-	-	-	-	-	-	-
Due to Other Governments	55,857	55,857	-	-	2,301,819	2,301,819	-	-	2,357,676	2,357,676
Deferred Revenue	-	16,270	-	-	15,555,685	15,555,685	859,488	1,097,816	16,415,174	16,669,771
Other Current Liabilities	1,084,013	957,788	-	-	1,927,159	1,718,653	1,210,248	1,034,533	4,221,421	3,710,975
Noncurrent Liabilities	1,327,196	1,358,207	-	-	2,123,561	2,124,605	1,414,074	1,392,996	4,864,832	4,875,808
Total Liabilities	$ 2,723,402	$ 2,525,118	$ -	$ -	$ 22,548,689	$ 22,429,983	$ 3,659,647	$ 3,726,069	$ 28,931,738	$ 28,681,170
Deferred Inflows of Resources										
Deferred Inflows	$ 102,110	$ 102,108	$ -	$ -	$ 13,627	$ 13,627	$ 474	$ 474	$ 116,211	$ 116,209
Net Position										
Net Investment in Capital Assets	17,422,169	17,499,549	-	-	34,433,995	34,695,181	2,826,701	2,858,226	54,682,865	55,052,956
Restricted	8,855	25,124	1,500,000	1,500,000	15,555,685	15,555,685	221,426	221,426	17,285,966	17,302,236
Unrestricted	616,656	314,524	1,462,289	1,462,289	(36,604,229)	(22,284,065)	(1,860,291)	(5,382,756)	(36,385,575)	(25,890,008)
Total Net Position	18,047,680	17,839,197	2,962,289	2,962,289	13,385,451	27,966,802	1,187,836	(2,303,105)	35,583,256	46,465,184
Total Net Position	$ 20,771,082	$ 20,364,315	$ 2,962,289	$ 2,962,289	$ 35,934,140	$ 50,396,785	$ 4,847,483	$ 1,422,965	$ 64,514,994	$ 75,146,354

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SUPPLEMENTAL INFORMATION

GENERAL FUND

General Fund Revenue & Expenditures

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
$ 1,355,359	$ 2,862,987	$ (1,507,628)	(52.7%)	$ 2,711,452	$ (1,356,093)	(50.0%)	Ad Valorem Taxes	$ 144,199,137	$ 143,193,476	$ 1,005,661	0.7%	$ 135,666,828	$ 8,532,310	6.3%
70,129	283,462	(213,333)	(75.3%)	53,069	17,060	32.1%	Patient Revenue, Net	980,671	2,401,704	(1,421,033)	(59.2%)	1,335,686	(355,015)	(26.6%)
231,917	231,917	(0)	(0.0%)	237,414	(5,497)	(2.3%)	Intergovernmental Revenue	2,551,083	1,855,336	695,747	37.5%	1,904,335	646,748	34.0%
-	-	-	0.0%	-	-	0.0%	Grants	-	-	-	0.0%	-	-	0.0%
101,105	114,062	(12,957)	(11.4%)	219,214	(118,109)	(53.9%)	Interest Earnings	1,072,853	912,496	160,357	17.6%	2,185,441	(1,112,587)	(50.9%)
13,568	-	13,568	0.0%	20,628	(7,060)	(34.2%)	Unrealized Gain/(Loss)-Investments	(913,657)	-	(913,657)	0.0%	1,518,413	(2,432,069)	(160.2%)
-	230,000	(230,000)	(100.0%)	-	-	0.0%	Other Financial Assistance	5,125,631	1,840,000	3,285,631	178.6%	-	5,125,631	0.0%
46,288	174,523	(128,235)	(73.5%)	54,454	(8,166)	(15.0%)	Other Revenue	1,902,436	2,839,658	(937,222)	(33.0%)	2,458,429	(555,993)	(22.6%)
$ 1,818,366	**$ 3,896,951**	**$ (2,078,585)**	**(53.3%)**	**$ 3,296,231**	**$ (1,477,865)**	**(44.8%)**	**Total Revenues**	**$ 154,918,156**	**$ 153,042,670**	**$ 1,875,486**	**1.2%**	**$ 145,069,131**	**$ 9,849,025**	**6.8%**
							Expenditures:							
3,220,980	3,086,745	(134,235)	(4.3%)	2,844,703	(376,277)	(13.2%)	Salaries and Wages	24,476,199	25,770,187	1,293,989	5.0%	24,746,327	270,129	1.1%
1,090,736	1,011,478	(79,258)	(7.8%)	1,028,134	(62,602)	(6.1%)	Benefits	7,817,857	8,178,418	360,561	4.4%	8,203,218	385,361	4.7%
844,966	931,622	86,656	9.3%	894,745	49,778	5.6%	Purchased Services	6,830,974	7,580,253	749,279	9.9%	7,140,778	309,803	4.3%
5,736	19,993	14,257	71.3%	1,286	(4,450)	(346.0%)	Medical Supplies	97,524	159,944	62,420	39.0%	41,464	(56,060)	(135.2%)
236,223	204,852	(31,371)	(15.3%)	103,349	(132,874)	(128.6%)	Other Supplies	1,670,197	1,638,816	(31,381)	(1.9%)	385,634	(1,284,563)	(333.1%)
-	4,167	4,167	100.0%	6,250	6,250	100.0%	Contracted Physician Expense	12,500	33,336	20,836	62.5%	127,083	114,583	90.2%
1,488,764	3,719,697	2,230,933	60.0%	2,824,568	1,335,804	47.3%	Medical Services	8,206,358	23,599,485	15,393,127	65.2%	27,735,266	19,528,907	70.4%
(9,094)	6,600	15,694	237.8%	(43,191)	(34,097)	78.9%	Drugs	27,420	52,800	25,380	48.1%	51,555	24,136	46.8%
645,753	651,319	5,566	0.9%	301,199	(344,554)	(114.4%)	Repairs & Maintenance	4,256,957	5,210,552	953,595	18.3%	2,590,674	(1,666,283)	(64.3%)
155,828	181,752	25,924	14.3%	146,156	(9,672)	(6.6%)	Lease & Rental	1,236,498	1,443,984	207,486	14.4%	1,208,313	(28,185)	(2.3%)
8,424	9,707	1,283	13.2%	5,953	(2,472)	(41.5%)	Utilities	67,684	77,656	9,972	12.8%	65,640	(2,044)	(3.1%)
498,028	712,062	214,034	30.1%	474,068	(23,961)	(5.1%)	Other Expense	6,295,027	8,104,586	1,809,559	22.3%	6,208,817	(86,210)	(1.4%)
59,583	55,844	(3,739)	(6.7%)	87,718	28,135	32.1%	Insurance	470,728	446,752	(23,976)	(5.4%)	777,581	306,853	39.5%
820,619	836,496	15,877	1.9%	835,179	14,560	1.7%	Sponsored Programs	6,376,117	6,691,968	315,851	4.7%	6,441,327	65,211	1.0%
9,066,546	11,432,334	2,365,788	20.7%	9,510,116	443,570	4.7%	Total Operational Expenditures	67,842,039	88,988,737	21,146,698	23.8%	85,723,678	17,881,639	20.9%
(7,248,181)	**(7,535,383)**	**287,203**	**(3.8%)**	**(6,213,885)**	**(1,034,296)**	**16.6%**	**Net Performance before Overhead Allocations**	**87,076,117**	**64,053,933**	**23,022,184**	**35.9%**	**59,345,453**	**27,730,664**	**46.7%**
(1,996,680)	(1,866,560)	(130,120)	7.0%	(1,183,810)	812,870	(68.7%)	Overhead Allocations	(13,906,457)	(14,932,478)	1,026,020	(6.9%)	(8,309,191)	5,597,266	(67.4%)
7,069,866	**9,565,774**	**2,495,908**	**26.1%**	**8,326,306**	**1,256,440**	**15.1%**	**Total Expenses**	**53,935,581**	**74,056,259**	**20,120,678**	**27.2%**	**77,414,487**	**23,478,906**	**30.3%**
$ (5,251,501)	**$ (5,668,823)**	**$ 417,323**	**(7.4%)**	**$ (5,030,075)**	**$ (221,425)**	**4.4%**	**Net Margin**	**$ 100,982,574**	**$ 78,986,411**	**$ 21,996,164**	**27.8%**	**$ 67,654,644**	**$ 33,327,930**	**49.3%**
-	-	-	0.0%	-	-	0.0%	**Capital**	-	-	-	0.0%		-	0.0%
$ (7,364,728)	**$ (4,600,300)**	**$ (2,764,428)**	**60.1%**	**$ (3,620,420)**	**$ 3,744,308**	**(103.4%)**	**General Fund Support/Transfer In(Out)**	**$ (21,977,580)**	**$ (30,811,400)**	**$ 8,833,820**	**(28.7%)**	**$ (38,980,382)**	**$ (17,002,802)**	**43.6%**

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Trauma Statement of Revenues and Expenditures

FOR THE EIGHT MONTH ENDED MAY 31, 2021

	Current Month							Fiscal Year To Date						
	Actual	Budget	Variance	%	Prior Year	Variance	%	Actual	Budget	Variance	%	Prior Year	Variance	%
Other Revenue	$ 3,652	$ 115,417	$ (111,765)	(96.8%)	$ 2,533	$ 1,119	44.2%	$ 36,771	$ 923,336	$ (886,565)	(96.0%)	$ 620,931	$ (584,160)	(94.1%)
Total Revenue	**3,652**	**115,417**	**(111,765)**	**(96.8%)**	**2,533**	**1,119**	**44.2%**	**36,771**	**923,336**	**(886,565)**	**(96.0%)**	**620,931**	**(584,160)**	**(94.1%)**
Direct Operational Expenses:														
Salaries and Wages	30,036	37,015	6,979	18.9%	36,942	6,906	18.7%	254,669	304,931	50,262	16.5%	296,741	42,072	14.2%
Benefits	8,450	11,853	3,403	28.7%	11,403	2,953	25.9%	78,584	96,527	17,943	18.6%	91,092	12,509	13.7%
Purchased Services	-	-	-	0.0%	-	-	0.0%	25,000	-	(25,000)	0.0%	-	(25,000)	0.0%
Medical Services	877,807	2,311,030	1,433,223	62.0%	2,105,416	1,227,608	58.3%	1,907,494	12,330,149	10,422,655	84.5%	15,377,198	13,469,703	87.6%
Other Supplies	73	42	(31)	(75.0%)	-	(73)	0.0%	298	336	38	11.3%	332	34	10.1%
Contracted Physician Expense	-	4,167	4,167	100.0%	6,250	6,250	100.0%	12,500	33,336	20,836	62.5%	127,083	114,583	90.2%
Repairs & Maintenance	-	-	-	0.0%	833	833	100.0%	-	-	-	0.0%	6,375	6,375	100.0%
Utilities	-	-	-	0.0%	-	-	0.0%	-	-	-	0.0%	-	-	0.0%
Other Expense	500	722	222	30.7%	139	(361)	(260.4%)	(345,856)	5,776	351,632	6,087.8%	5,025	350,881	6,982.2%
Insurance	-	-	-	0.0%	25,000	25,000	100.0%	-	-	-	0.0%	386,387	386,387	100.0%
Total Operational Expenses	**916,867**	**2,364,829**	**1,447,962**	**61.2%**	**2,185,983**	**1,269,116**	**58.1%**	**1,932,690**	**12,771,055**	**10,838,365**	**84.9%**	**16,290,234**	**14,357,544**	**88.1%**
Net Performance before Overhead Allocations	**(913,215)**	**(2,249,412)**	**1,336,197**	**(59.4%)**	**(2,183,450)**	**1,270,235**	**(58.2%)**	**(1,895,919)**	**(11,847,719)**	**9,951,800**	**(524.9%)**	**(15,669,303)**	**13,773,384**	**(87.9%)**
Overhead Allocations:														
Risk Mgt	76	66	(10)	(14.9%)	51	(25)	(48.7%)	531	530	(1)	(0.2%)	386	(145)	(37.6%)
Internal Audit	48	89	41	45.9%	33	(15)	(45.0%)	428	710	282	39.7%	956	528	55.2%
Home Office Facilities	3,143	3,302	159	4.8%	3,090	(52)	(1.7%)	23,328	26,414	3,086	11.7%	24,951	1,623	6.5%
Administration	948	766	(182)	(23.7%)	732	(215)	(29.4%)	6,942	6,127	(815)	(13.3%)	6,598	(344)	(5.2%)
Human Resources	1,220	895	(325)	(36.3%)	785	(435)	(55.4%)	7,751	7,159	(592)	(8.3%)	6,647	(1,104)	(16.6%)
Legal	253	397	144	36.2%	426	172	40.5%	3,382	3,179	(203)	(6.4%)	3,145	(237)	(7.5%)
Records	192	185	(6)	(3.5%)	137	(55)	(40.0%)	1,390	1,484	94	6.3%	1,306	(84)	(6.4%)
Compliance	244	159	(85)	(53.6%)	129	(115)	(89.7%)	989	1,270	281	22.1%	1,791	802	44.8%
Comm Engage Plan	182	161	(21)	(13.0%)	-	-	0.0%	1,247	1,292	45	3.5%	-	-	0.0%
IT Operations	1,644	1,910	267	14.0%	-	-	0.0%	13,456	15,281	1,825	11.9%	-	-	0.0%
IT Security	175	195	20	10.2%	-	-	0.0%	1,353	1,557	204	13.1%	-	-	0.0%
Finance	598	730	132	18.0%	824	226	27.4%	4,959	5,838	879	15.1%	6,439	1,480	23.0%
Public Relations	212	232	20	8.5%	233	21	9.0%	1,392	1,854	462	24.9%	1,955	563	28.8%
Information Technology	267	191	(76)	(39.5%)	2,960	2,693	91.0%	1,894	1,531	(363)	(23.7%)	17,976	16,083	89.5%
Project MGMT Office	249	259	10	3.8%	249	(1)	(0.2%)	1,705	2,071	367	17.7%	1,400	(304)	(21.7%)
Corporate Quality	113	110	(3)	(2.8%)	53	(60)	(112.6%)	1,086	878	(208)	(23.7%)	348	(739)	(212.6%)
Total Overhead Allocations	9,564	9,647	83	0.9%	9,702	2,140	22.1%	71,832	77,174	5,342	6.9%	73,898	18,122	24.5%
Total Expenses	**926,431**	**2,374,476**	**1,448,045**	**61.0%**	**2,195,686**	**1,271,256**	**57.9%**	**2,004,522**	**12,848,229**	**10,843,708**	**84.4%**	**16,364,131**	**14,375,666**	**87.8%**
Net Margin	**$ (922,779)**	**$ (2,259,059)**	**$ 1,336,280**	**(59.2%)**	**$ (2,193,152)**	**$ 1,272,375**	**(58.0%)**	**$ (1,967,751)**	**$ (11,924,893)**	**$ 9,957,143**	**(83.5%)**	**$ (15,743,200)**	**$ 13,791,505**	**87.6%**

Aeromedical Statement of Revenues and Expenditures

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
$ 1,204,364	$ 1,180,415	$ 23,949	2.0%	$ 666,846	$ 537,517	80.6%	**Gross Patient Revenue**	$ 7,949,678	$ 10,021,421	$ (2,071,743)	(20.7%)	8,894,236	$ (944,558)	(10.6%)
685,932	590,385	(95,547)	(16.2%)	517,580	(168,352)	(32.5%)	Contractual Allowances	4,171,818	5,012,221	840,403	16.8%	5,656,616	1,484,799	26.2%
116,000	178,082	62,082	34.9%	107,622	(8,378)	(7.8%)	Charity Care	127,560	1,508,250	1,380,690	91.5%	1,393,266	1,265,706	90.8%
332,302	128,486	(203,816)	(158.6%)	(11,424)	(343,727)	3,008.7%	Bad Debt	2,669,630	1,099,246	(1,570,384)	(142.9%)	508,668	(2,160,962)	(424.8%)
1,134,234	896,953	(237,281)	(26.5%)	613,777	(520,457)	(84.8%)	Total Contractuals and Bad Debt	6,969,008	7,619,717	650,709	8.5%	7,558,550	589,543	7.8%
70,129	**283,462**	**(213,333)**	**(75.3%)**	**53,069**	**17,060**	**32.1%**	**Net Patient Revenue**	**980,671**	**2,401,704**	**(1,421,033)**	**(59.2%)**	**1,335,686**	**(355,015)**	**(26.6%)**
5.82%	24.01%			7.96%			Collection %	12.34%	23.97%			15.02%		
70,129	**283,462**	**(213,333)**	**(75.3%)**	**53,069**	**17,060**	**32.1%**	**Total Revenues**	**980,671**	**2,401,704**	**(1,421,033)**	**(59.2%)**	**1,335,686**	**(355,015)**	**(26.6%)**
							Direct Operational Expenses:							
167,535	176,079	8,544	4.9%	170,431	2,895	1.7%	Salaries and Wages	1,333,904	1,450,551	116,647	8.0%	1,390,803	56,898	4.1%
50,090	54,997	4,907	8.9%	56,686	6,596	11.6%	Benefits	419,223	448,193	28,970	6.5%	452,847	33,624	7.4%
196,341	263,486	67,145	25.5%	294,202	97,861	33.3%	Purchased Services	1,637,264	2,233,542	596,278	26.7%	2,122,575	485,311	22.9%
377	1,542	1,165	75.6%	332	(45)	(13.6%)	Medical Supplies	15,529	12,336	(3,193)	(25.9%)	9,437	(6,092)	(64.6%)
9,999	9,843	(156)	(1.6%)	1,304	(8,695)	(666.9%)	Other Supplies	45,219	78,744	33,525	42.6%	63,770	18,551	29.1%
125,818	98,429	(27,389)	(27.8%)	51,060	(74,758)	(146.4%)	Repairs & Maintenance	889,232	787,432	(101,800)	(12.9%)	586,438	(302,795)	(51.6%)
4,497	4,924	427	8.7%	3,181	(1,316)	(41.4%)	Utilities	33,637	39,392	5,755	14.6%	34,342	705	2.1%
5,090	5,100	10	0.2%	5,090	-	0.0%	Lease & Rental	40,721	40,800	79	0.2%	40,721	-	0.0%
22,195	27,580	5,385	19.5%	21,291	(903)	(4.2%)	Other Expense	181,730	220,640	38,910	17.6%	170,326	(11,404)	(6.7%)
19,244	15,187	(4,057)	(26.7%)	14,048	(5,195)	(37.0%)	Insurance	152,202	121,496	(30,706)	(25.3%)	111,224	(40,978)	(36.8%)
601,185	**657,167**	**55,982**	**8.5%**	**617,625**	**16,440**	**2.7%**	**Total Operational Expenses**	**4,748,663**	**5,433,126**	**684,463**	**12.6%**	**4,982,484**	**233,821**	**4.7%**
(531,056)	**(373,705)**	**(157,351)**	**42.1%**	**(564,556)**	**33,501**	**(5.9%)**	**Net Performance before Overhead Allocations**	**(3,767,992)**	**(3,031,422)**	**(736,570)**	**24.3%**	**(3,646,798)**	**(121,194)**	**3.3%**
							Overhead Allocations:							
1,019	887	(132)	(14.9%)	624	(396)	(63.4%)	Risk Mgt	7,109	7,097	(12)	(0.2%)	4,703	(2,406)	(51.2%)
15,199	13,798	(1,401)	(10.2%)	74,655	59,456	79.6%	Rev Cycle	105,675	110,382	4,708	4.3%	383,485	277,810	72.4%
643	1,188	546	45.9%	403	(239)	(59.3%)	Internal Audit	5,735	9,508	3,773	39.7%	11,652	5,917	50.8%
12,688	10,254	(2,434)	(23.7%)	8,924	(3,765)	(42.2%)	Administration	92,949	82,035	(10,913)	(13.3%)	80,397	(12,552)	(15.6%)
4,416	3,239	(1,177)	(36.3%)	2,842	(1,574)	(55.4%)	Human Resources	28,058	25,914	(2,143)	(8.3%)	24,063	(3,995)	(16.6%)
3,393	5,320	1,927	36.2%	5,189	1,796	34.6%	Legal	45,285	42,561	(2,724)	(6.4%)	38,324	(6,961)	(18.2%)
2,570	2,483	(87)	(3.5%)	1,671	(899)	(53.8%)	Records	18,612	19,868	1,255	6.3%	15,918	(2,695)	(16.9%)
3,264	2,125	(1,140)	(53.6%)	1,566	(1,698)	(108.4%)	Compliance	13,237	16,998	3,762	22.1%	21,819	8,582	39.3%
2,443	2,162	(281)	(13.0%)	-	(2,443)	0.0%	Comm Engage Plan	16,692	17,297	605	3.5%	-	(16,692)	0.0%
22,007	25,575	3,569	14.0%	-	(22,007)	0.0%	IT Operations	180,167	204,603	24,436	11.9%	-	(180,167)	0.0%
2,341	2,606	265	10.2%	-	(2,341)	0.0%	IT Security	18,113	20,848	2,735	13.1%	-	(18,113)	0.0%
8,008	9,771	1,762	18.0%	10,045	2,037	20.3%	Finance	66,391	78,166	11,775	15.1%	78,461	12,070	15.4%
2,838	3,103	265	8.5%	2,840	2	0.1%	Public Relations	18,637	24,826	6,189	24.9%	23,817	5,180	21.7%
3,573	2,562	(1,011)	(39.5%)	36,064	32,491	90.1%	Information Technology	25,353	20,496	(4,858)	(23.7%)	219,049	193,696	88.4%
3,336	3,467	131	3.8%	3,030	(306)	(10.1%)	Project MGMT Office	22,822	27,735	4,913	17.7%	17,065	(5,757)	(33.7%)
1,510	1,469	(41)	(2.8%)	647	(864)	(133.6%)	Corporate Quality	14,545	11,753	(2,791)	(23.7%)	4,235	(10,309)	(243.4%)
89,250	90,011	761	0.8%	148,500	59,250	39.9%	Total Overhead Allocations	679,380	720,088	40,708	5.7%	922,987	243,607	26.4%
690,435	**747,178**	**56,743**	**7.6%**	**766,125**	**75,691**	**9.9%**	**Total Expenses**	**5,428,043**	**6,153,214**	**725,171**	**11.8%**	**5,905,471**	**477,428**	**8.1%**
$ (620,305)	**$ (463,716)**	**$ (156,589)**	**33.8%**	**$ (713,056)**	**$ 92,751**	**(13.0%)**	**Net Margin**	**$ (4,447,372)**	**$ (3,751,510)**	**$ (695,862)**	**18.5%**	**$ (4,569,785)**	**$ 122,413**	**2.7%**

Care Coordination Statement of Revenues and Expenditures

FOR THE EIGHT MONTH ENDED MAY 31, 2021

	Current Month							Fiscal Year To Date						
	Actual	Budget	Variance	%	Prior Year	Variance	%	Actual	Budget	Variance	%	Prior Year	Variance	%
Total Revenue	-	-	-	**0.0%**	-	-	**0.0%**	-	-	-	**0.0%**	-	-	**0.0%**
Direct Operational Expenses:														
Salaries and Wages	76,676	97,277	20,601	21.2%	164,665	87,989	53.4%	597,907	801,375	203,468	25.4%	2,442,641	1,844,735	75.5%
Benefits	25,987	36,800	10,813	29.4%	63,955	37,968	59.4%	197,781	294,400	96,619	32.8%	787,938	590,157	74.9%
Purchased Services	308,750	320,219	11,469	3.6%	282,929	(25,821)	(9.1%)	2,500,389	2,561,752	61,363	2.4%	2,288,666	(211,723)	(9.3%)
Medical Services	607,754	1,216,667	608,913	50.0%	719,153	111,399	15.5%	5,851,026	9,733,336	3,882,310	39.9%	12,358,068	6,507,042	52.7%
Other Supplies	240	1,417	1,177	83.0%	1,057	817	77.3%	11,874	11,336	(538)	(4.7%)	10,026	(1,848)	(18.4%)
Repairs & Maintenance	-	-	-	0.0%	11,159	11,159	100.0%	199	-	(199)	0.0%	172,654	172,455	99.9%
Lease & Rental	-	-	-	0.0%	-	-	0.0%	-	-	-	0.0%	47,533	47,533	100.0%
Utilities	-	-	-	0.0%	-	-	0.0%	-	-	-	0.0%	2,955	2,955	100.0%
Other Expense	893	8,096	7,203	89.0%	(52,270)	(53,163)	101.7%	(29,613)	64,768	94,381	145.7%	(167,051)	(137,438)	82.3%
Total Operational Expenses	**1,020,300**	**1,680,476**	**660,175**	**39.3%**	**1,190,648**	**170,347**	**14.3%**	**9,129,563**	**13,466,967**	**4,337,404**	**32.2%**	**17,943,431**	**8,813,868**	**49.1%**
Net Performance before Overhead Allocations	**(1,020,300)**	**(1,680,476)**	**660,175**	**(39.3%)**	**(1,190,648)**	**170,347**	**(14.3%)**	**(9,129,563)**	**(13,466,967)**	**4,337,404**	**(32.2%)**	**(17,943,431)**	**8,813,868**	**(49.1%)**
Overhead Allocations:														
Risk Mgt	717	605	(113)	(18.6%)	812	95	11.7%	5,001	4,837	(164)	(3.4%)	6,123	1,122	18.3%
Internal Audit	452	810	358	44.2%	525	73	13.9%	4,034	6,480	2,446	37.7%	15,169	11,135	73.4%
Home Office Facilities	23,223	24,397	1,174	4.8%	22,836	(387)	(1.7%)	172,374	195,174	22,800	11.7%	184,367	11,993	6.5%
Administration	8,925	6,989	(1,936)	(27.7%)	11,617	2,692	23.2%	65,381	55,911	(9,470)	(16.9%)	104,666	39,285	37.5%
Human Resources	6,587	3,758	(2,829)	(75.3%)	12,249	5,661	46.2%	41,854	30,066	(11,788)	(39.2%)	103,697	61,843	59.6%
Legal	2,387	3,626	1,239	34.2%	6,756	4,369	64.7%	31,854	29,007	(2,846)	(9.8%)	49,893	18,039	36.2%
Records	1,808	1,693	(115)	(6.8%)	2,176	368	16.9%	13,092	13,541	448	3.3%	20,723	7,631	36.8%
Compliance	2,296	1,448	(848)	(58.6%)	2,039	(257)	(12.6%)	9,311	11,585	2,274	19.6%	28,405	19,095	67.2%
Comm Engage Plan	1,718	1,474	(245)	(16.6%)	-	(1,718)	0.0%	11,741	11,789	47	0.4%	-	(11,741)	0.0%
IT Operations	15,480	17,431	1,951	11.2%	-	(15,480)	0.0%	126,730	139,446	12,716	9.1%	-	(126,730)	0.0%
IT Security	1,647	1,776	129	7.3%	-	(1,647)	0.0%	12,741	14,209	1,468	10.3%	-	(12,741)	0.0%
Finance	5,633	6,659	1,026	15.4%	13,077	7,444	56.9%	46,700	53,273	6,574	12.3%	102,146	55,447	54.3%
Public Relations	1,996	2,115	119	5.6%	3,697	1,701	46.0%	13,109	16,920	3,811	22.5%	31,006	17,897	57.7%
Information Technology	2,513	1,746	(767)	(43.9%)	46,950	44,437	94.6%	17,834	13,969	(3,865)	(27.7%)	285,174	267,340	93.7%
Project MGMT Office	2,347	2,363	16	0.7%	3,945	1,598	40.5%	16,053	18,902	2,849	15.1%	22,216	6,163	27.7%
Corporate Quality	1,062	1,001	(61)	(6.1%)	842	(221)	(26.2%)	10,231	8,010	(2,220)	(27.7%)	5,514	(4,717)	(85.6%)
Total Overhead Allocations	78,791	77,890	(902)	(1.2%)	127,521	48,730	38.2%	598,039	623,119	25,080	4.0%	959,099	361,060	37.6%
Total Expenses	**1,099,092**	**1,758,366**	**659,274**	**37.5%**	**1,318,169**	**219,077**	**16.6%**	**9,727,602**	**14,090,085**	**4,362,484**	**31.0%**	**18,902,529**	**9,174,927**	**48.5%**
Net Margin	**$ (1,099,092)**	**$ (1,758,366)**	**$ 659,274**	**(37.5%)**	**$ (1,318,169)**	**$ 219,077**	**(16.6%)**	**$ (9,727,602)**	**$ (14,090,085)**	**$ 4,362,484**	**(31.0%)**	**$ (18,902,529)**	**$ 9,174,927**	**(48.5%)**

Pharmacy Services Statement of Revenues and Expenditures

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**		**Actual**	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**
-	**-**	**-**	**0.0%**	**-**	**-**	**0.0%**	**Total Revenues**	**-**	**-**	**-**	**0.0%**	**-**	**-**	**0.0%**
							Direct Operational Expenses:							
213,248	226,278	13,030	5.8%	144,723	(68,525)	(47.3%)	Salaries and Wages	1,711,277	1,864,101	152,824	8.2%	1,848,365	137,089	7.4%
66,560	74,344	7,784	10.5%	31,796	(34,764)	(109.3%)	Benefits	531,135	603,768	72,633	12.0%	537,667	6,532	1.2%
1,049	1,900	851	44.8%	5,534	4,485	81.0%	Purchased Services	9,679	15,200	5,521	36.3%	53,666	43,987	82.0%
4,446	15,292	10,846	70.9%	8,233	3,787	46.0%	Other Supplies	35,192	122,336	87,144	71.2%	72,674	37,483	51.6%
(9,094)	6,600	15,694	237.8%	(43,191)	(34,097)	78.9%	Drugs	27,420	52,800	25,380	48.1%	51,555	24,136	46.8%
57	784	727	92.7%	15,915	15,857	99.6%	Repairs & Maintenance	2,410	6,272	3,862	61.6%	141,792	139,382	98.3%
7,799	8,973	1,174	13.1%	7,668	(131)	(1.7%)	Lease & Rental	62,195	71,784	9,589	13.4%	52,852	(9,343)	(17.7%)
-	-	-	0.0%	-	-	0.0%	Utilities	-	-	-	0.0%	-	-	0.0%
5,958	13,564	7,606	56.1%	7,968	2,011	25.2%	Other Expense	53,793	108,512	54,719	50.4%	39,864	(13,929)	(34.9%)
2,349	1,898	(451)	(23.8%)	1,898	(451)	(23.8%)	Insurance	16,194	15,184	(1,010)	(6.7%)	14,178	(2,017)	(14.2%)
292,372	**349,633**	**57,261**	**16.4%**	**180,545**	**(111,828)**	**(61.9%)**	**Total Operational Expenses**	**2,449,294**	**2,859,957**	**410,663**	**14.4%**	**2,812,614**	**363,320**	**12.9%**
(292,372)	**(349,633)**	**57,261**	**(16.4%)**	**(180,545)**	**(111,828)**	**61.9%**	**Net Performance before Overhead Allocations**	**(2,449,294)**	**(2,859,957)**	**410,663**	**(14.4%)**	**(2,812,614)**	**363,320**	**(12.9%)**
							Overhead Allocations:							
533	464	(69)	(14.9%)	345	(189)	(54.8%)	Risk Mgt	3,720	3,714	(6)	(0.2%)	2,598	(1,121)	(43.2%)
-	-	-	0.0%	-	-	0.0%	Rev Cycle	-	-	-	0.0%	-	-	0.0%
336	622	286	45.9%	223	(113)	(50.9%)	Internal Audit	3,001	4,975	1,974	39.7%	6,437	3,436	53.4%
6,639	5,366	(1,273)	(23.7%)	4,930	(1,709)	(34.7%)	Administration	48,636	42,925	(5,710)	(13.3%)	44,418	(4,218)	(9.5%)
8,198	6,013	(2,184)	(36.3%)	5,198	(3,000)	(57.7%)	Human Resources	52,085	48,106	(3,979)	(8.3%)	44,005	(8,080)	(18.4%)
1,776	2,784	1,008	36.2%	2,867	1,092	38.1%	Legal	23,696	22,270	(1,425)	(6.4%)	21,173	(2,522)	(11.9%)
1,345	1,299	(45)	(3.5%)	923	(421)	(45.6%)	Records	9,739	10,396	657	6.3%	8,794	(945)	(10.7%)
1,708	1,112	(596)	(53.6%)	865	(843)	(97.4%)	Compliance	6,926	8,894	1,968	22.1%	12,055	5,128	42.5%
1,278	1,131	(147)	(13.0%)	-	(1,278)	0.0%	Comm Engage Plan	8,734	9,051	317	3.5%	-	(8,734)	0.0%
11,515	13,382	1,867	14.0%	-	(11,515)	0.0%	IT Operations	94,273	107,059	12,786	11.9%	-	(94,273)	0.0%
1,225	1,364	139	10.2%	-	(1,225)	0.0%	IT Security	9,478	10,909	1,431	13.1%	-	(9,478)	0.0%
4,190	5,113	922	18.0%	5,550	1,359	24.5%	Finance	34,739	40,901	6,161	15.1%	43,349	8,609	19.9%
1,485	1,624	139	8.5%	1,569	84	5.3%	Public Relations	9,752	12,990	3,238	24.9%	13,158	3,406	25.9%
1,870	1,341	(529)	(39.5%)	19,925	18,055	90.6%	Information Technology	13,266	10,724	(2,542)	(23.7%)	121,021	107,755	89.0%
790	769	(21)	(2.8%)	357	(433)	(121.2%)	Corporate Quality	7,611	6,150	(1,461)	(23.7%)	2,340	(5,271)	(225.3%)
1,746	1,814	68	3.8%	1,674	(72)	(4.3%)	Project MGMT Office	11,942	14,512	2,571	17.7%	9,428	(2,514)	(26.7%)
-	-	-	0.0%	-	-	0.0%	Managed Care Contract	-	-	-	0.0%	-	-	0.0%
44,634	44,197	(437)	(1.0%)	44,426	(208)	(0.5%)	Total Overhead Allocations	337,597	353,577	15,980	4.5%	328,777	(8,820)	(2.7%)
337,007	**393,830**	**56,823**	**14.4%**	**224,971**	**(112,036)**	**(49.8%)**	**Total Expenses**	**2,786,892**	**3,213,534**	**426,643**	**13.3%**	**3,141,391**	**354,500**	**11.3%**
$ (337,007)	**$ (393,830)**	**$ 56,823**	**(14.4%)**	**$ (224,971)**	**$ (112,036)**	**49.8%**	**Net Margin**	**$ (2,786,892)**	**$ (3,213,534)**	**$ 426,643**	**(13.3%)**	**$ (3,141,391)**	**$ 354,500**	**(11.3%)**

School Health Statement of Revenues and Expenditures

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month

	Actual	Budget	Variance	%	Prior Year	Variance	%
Palm Beach County School District	$ 231,917	$ 231,917	$ (0)	(0.0%)	$ 237,414	$ (5,497)	(2.3%)
Total Revenue	**231,917**	**231,917**	**(0)**	**(0.0%)**	**237,414**	**(5,497)**	**(2.3%)**
Direct Operational Expenses:							
Salaries and Wages	1,047,744	1,053,326	5,582	0.5%	1,038,890	(8,854)	(0.9%)
Benefits	346,450	382,448	35,998	9.4%	478,938	132,488	27.7%
Purchased Services	-	-	-	0.0%	-	-	0.0%
Medical Supplies	4,812	18,201	13,389	73.6%	955	(3,857)	(404.1%)
Other Supplies	375	3,750	3,375	90.0%	(409)	(785)	191.7%
Repairs & Maintenance	-	84	84	100.0%	12,560	12,560	100.0%
Lease & Rental	280	230	(50)	(21.7%)	-	(280)	0.0%
Utilities	-	-	-	0.0%	-	-	0.0%
Other Expense	1,177	2,467	1,290	52.3%	-	(1,177)	0.0%
Total Operational Expenses	**1,400,839**	**1,460,506**	**59,667**	**4.1%**	**1,530,934**	**130,095**	**8.5%**
Net Performance before Overhead Allocations	**(1,168,922)**	**(1,228,589)**	**59,667**	**(4.9%)**	**(1,293,520)**	**124,598**	**(9.6%)**
Overhead Allocations:							
Risk Mgt	2,245	1,986	(259)	(13.0%)	1,546	(699)	(45.2%)
Internal Audit	1,415	2,661	1,246	46.8%	999	(416)	(41.6%)
Home Office Facilities	7,293	7,662	369	4.8%	7,172	(121)	(1.7%)
Administration	27,941	22,956	(4,986)	(21.7%)	22,107	(5,834)	(26.4%)
Human Resources	61,873	39,534	(22,339)	(56.5%)	37,641	(24,232)	(64.4%)
Legal	7,473	11,910	4,437	37.3%	12,857	5,384	41.9%
Records	5,660	5,560	(100)	(1.8%)	4,141	(1,519)	(36.7%)
Compliance	7,189	4,757	(2,432)	(51.1%)	3,881	(3,308)	(85.2%)
Comm Engage Plan	5,380	4,840	(540)	(11.2%)	-	(5,380)	0.0%
IT Operations	48,462	57,254	8,792	15.4%	-	(48,462)	0.0%
IT Security	5,156	5,834	678	11.6%	-	(5,156)	0.0%
Finance	17,636	21,873	4,237	19.4%	24,886	7,250	29.1%
Public Relations	6,250	6,947	697	10.0%	7,036	786	11.2%
Information Technology	7,868	5,735	(2,133)	(37.2%)	89,345	81,476	91.2%
Project MGMT Office	7,347	7,761	414	5.3%	7,506	160	2.1%
Corporate Quality	3,326	3,289	(37)	(1.1%)	1,602	(1,724)	(107.6%)
		-					
Total Overhead Allocations	222,514	210,557	(11,957)	(5.7%)	220,718	(1,796)	(0.8%)
Total Expenses	**1,623,353**	**1,671,063**	**47,711**	**2.9%**	**1,751,652**	**128,299**	**7.3%**
Net Margin	**$ (1,391,436)**	**$ (1,439,146)**	**$ 47,710**	**(3.3%)**	**$ (1,514,238)**	**$ 122,802**	**(8.1%)**

Fiscal Year To Date

	Actual	Budget	Variance	%	Prior Year	Variance	%
Palm Beach County School District	$ 2,551,083	$ 1,855,336	$ 695,747	37.5%	$ 1,904,335	$ 646,748	34.0%
Total Revenue	**2,551,083**	**1,855,336**	**695,747**	**37.5%**	**1,904,335**	**646,748**	**34.0%**
Direct Operational Expenses:							
Salaries and Wages	8,494,569	9,021,869	527,300	5.8%	9,383,485	888,916	9.5%
Benefits	2,789,553	3,126,458	336,905	10.8%	3,593,043	803,490	22.4%
Purchased Services	-	-	-	0.0%	-	-	0.0%
Medical Supplies	78,744	145,608	66,864	45.9%	32,027	(46,717)	(145.9%)
Other Supplies	41,221	30,000	(11,221)	(37.4%)	23,397	(17,824)	(76.2%)
Repairs & Maintenance	-	672	672	100.0%	100,484	100,484	100.0%
Lease & Rental	2,185	1,840	(345)	(18.8%)	-	(2,185)	0.0%
Utilities	-	-	-	0.0%	-	-	0.0%
Other Expense	7,031	19,736	12,705	64.4%	5,277	(1,753)	(33.2%)
Total Operational Expenses	**11,413,303**	**12,346,183**	**932,880**	**7.6%**	**13,137,713**	**1,724,411**	**13.1%**
Net Performance before Overhead Allocations	**(8,862,219)**	**(10,490,847)**	**1,628,628**	**(15.5%)**	**(11,233,378)**	**2,371,159**	**(21.1%)**
Overhead Allocations:							
Risk Mgt	15,656	15,887	232	1.5%	11,652	(4,004)	(34.4%)
Internal Audit	12,629	21,284	8,655	40.7%	28,866	16,237	56.2%
Home Office Facilities	54,138	61,298	7,161	11.7%	57,904	3,767	6.5%
Administration	204,689	183,647	(21,042)	(11.5%)	199,177	(5,512)	(2.8%)
Human Resources	393,118	316,269	(76,849)	(24.3%)	318,669	(74,449)	(23.4%)
Legal	99,725	95,279	(4,446)	(4.7%)	94,945	(4,781)	(5.0%)
Records	40,988	44,476	3,488	7.8%	39,436	(1,552)	(3.9%)
Compliance	29,149	38,053	8,903	23.4%	54,055	24,905	46.1%
Comm Engage Plan	36,758	38,721	1,963	5.1%	-	(36,758)	0.0%
IT Operations	396,757	458,030	61,274	13.4%	-	(396,757)	0.0%
IT Security	39,888	46,670	6,783	14.5%	-	(39,888)	0.0%
Finance	146,204	174,984	28,780	16.4%	194,382	48,178	24.8%
Public Relations	41,042	55,576	14,535	26.2%	59,004	17,962	30.4%
Information Technology	55,832	45,883	(9,950)	(21.7%)	542,679	486,847	89.7%
Project MGMT Office	50,258	62,088	11,830	19.1%	42,276	(7,981)	(18.9%)
Corporate Quality	32,029	26,311	(5,718)	(21.7%)	10,492	(21,537)	(205.3%)
Total Overhead Allocations	1,648,859	1,684,458	35,598	2.1%	1,653,536	4,677	0.3%
Total Expenses	**13,062,162**	**14,030,641**	**968,479**	**6.9%**	**14,791,249**	**1,729,088**	**11.7%**
Net Margin	**$ (10,511,079)**	**$ (12,175,305)**	**$ 1,664,226**	**(13.7%)**	**$ (12,886,915)**	**$ 2,375,836**	**(18.4%)**

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Sponsored Programs

FOR THE EIGHT MONTH ENDED MAY 31, 2021

	Current Month							Fiscal Year To Date					
	Actual	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**	**Actual**	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**
Sponsored Programs:													
DOH Uninsured/Preventive Care Svs	708,996	708,996	0	0.0%	708,996	-	0.0%	5,671,965	5,671,968	3	0.0%	5,671,965	-	0.0%
Grant Funded Programs for Uninsured	111,623	125,000	13,377	10.7%	126,183	14,560	11.5%	704,152	1,000,000	295,848	29.6%	769,363	65,211	8.5%
Community Health Planning	-	2,500	2,500	100.0%	-	-	0.0%	-	20,000	20,000	100.0%	-	-	0.0%
Total Sponsored Programs	**820,619**	**836,496**	**15,877**	**1.9%**	**835,179**	**14,560**	1.7%	**6,376,117**	**6,691,968**	**315,851**	**4.7%**	**6,441,327**	**65,211**	1.0%
Direct Operational Expenses:													
Salaries and Wages	8,793	13,480	4,687	34.8%	13,911	5,118	36.8%	74,885	111,046	36,161	32.6%	121,669	46,784	38.5%
Benefits	3,219	6,122	2,903	47.4%	5,570	2,351	42.2%	25,127	49,760	24,633	49.5%	44,562	19,435	43.6%
Other Supplies	-	50	50	100.0%	97	97	100.0%	10	400	391	97.6%	241	232	96.1%
Repairs & Maintenance	-	-	-	0.0%	-	-	0.0%	-	-	-	0.0%	36,667	36,667	100.0%
Other Expense	135	454	319	70.2%	-	(135)	0.0%	2,699	3,632	933	25.7%	5,279	2,580	48.9%
	12,147	**20,106**	**7,959**	**3**	**19,578**	**7,430**	38.0%	**102,720**	**164,838**	**62,118**	**60.5%**	**208,418**	**105,697**	50.7%
Total Expenses	**$ 832,766**	**$ 856,602**	**$ 23,836**	**2.8%**	**$ 854,756**	**$ 21,990**	**2.6%**	**$ 6,478,837**	**$ 6,856,806**	**$ 377,969**	**5.5%**	**$ 6,649,745**	**$ 170,908**	**2.6%**

General Fund Statement of Revenues and Expenditures by Month

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Year to Date
Revenues:													
Ad Valorem Taxes	$ -	$ 11,309,327	$ 113,608,685	$ 3,600,591	$ 5,167,017	$ 2,615,797	$ 6,542,362	$ 1,355,359	$ -	$ -	$ -	$ -	$ 144,199,137
Premiums													-
Patient Revenue, Net	38,235	161,158	215,563	195,556	147,541	21,119	131,370	70,129	-	-	-	-	980,671
Intergovernmental Revenue	231,917	231,917	231,917	231,917	927,667	231,917	231,917	231,917	-	-	-	-	2,551,083
Grants	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Earnings	158,408	147,222	143,533	141,543	125,590	130,224	125,229	101,105	-	-	-	-	1,072,853
Unrealized Gain/(Loss)-Investments	(206,894)	(66,642)	(51,801)	(139,529)	(266,557)	(162,231)	(33,570)	13,568	-	-	-	-	(913,657)
Other Financial Assistance	-	-	-	-	-	5,127,280	(1,649)	-	-	-	-	-	5,125,631
Other Revenue	63,590	175,729	1,393,054	23,445	68,010	31,159	101,161	46,288	-	-	-	-	1,902,436
Total Revenues	**$ 285,255**	**$ 11,958,710**	**$ 115,540,950**	**$ 4,053,523**	**$ 6,169,267**	**$ 7,995,265**	**$ 7,096,820**	**$ 1,818,366**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 154,918,156**
Expenditures:													
Salaries and Wages	3,189,482	3,111,543	2,975,420	3,029,754	2,769,394	3,114,176	3,065,449	3,220,980	-	-	-	-	24,476,199
Benefits	998,042	911,723	1,212,841	990,225	1,023,711	695,254	895,325	1,090,736	-	-	-	-	7,817,857
Purchased Services	734,073	758,271	719,752	768,563	641,679	1,107,672	1,255,997	844,966	-	-	-	-	6,830,974
Medical Supplies	13,396	16,488	4,646	2,557	20,441	22,973	11,286	5,736	-	-	-	-	97,524
Other Supplies	37,422	135,078	69,928	335,691	154,277	600,885	100,693	236,223	-	-	-	-	1,670,197
Contracted Physician Expense	4,167	4,167	4,167	-	-	-	-	-	-	-	-	-	12,500
Medical Services	819,433	877,365	1,016,722	852,671	865,740	884,162	1,401,501	1,488,764	-	-	-	-	8,206,358
Drugs	(24,554)	(23,726)	4,927	29,404	(36,791)	17,982	69,273	(9,094)	-	-	-	-	27,420
Repairs & Maintenance	312,118	525,062	547,098	488,808	366,645	571,206	800,267	645,753	-	-	-	-	4,256,957
Lease & Rental	151,518	145,084	184,407	158,915	176,441	149,002	115,304	155,828	-	-	-	-	1,236,498
Utilities	9,467	9,523	7,957	7,783	8,286	8,037	8,205	8,424	-	-	-	-	67,684
Other Expense	416,870	671,743	2,420,049	493,346	610,776	587,704	596,511	498,028	-	-	-	-	6,295,027
Insurance	52,241	64,556	59,871	58,724	58,399	58,678	58,677	59,583	-	-	-	-	470,728
Sponsored Programs	772,711	783,439	782,962	755,982	819,287	819,287	821,829	820,619	-	-	-	-	6,376,117
Total Operational Expenditures	7,486,386	7,990,316	10,010,746	7,972,421	7,478,285	8,637,020	9,200,317	9,066,546	-	-	-	-	67,842,039
Net Performance before Overhead Allocations	$ (7,201,131)	$ 3,968,394	$ 105,530,204	$ (3,918,898)	$ (1,309,019)	$ (641,755)	$ (2,103,498)	$ (7,248,181)	$ -	$ -	$ -	$ -	$ 87,076,117
Overhead Allocations	(1,321,067)	(1,530,952)	(1,808,686)	(1,789,027)	(1,549,725)	(2,231,113)	(1,679,208)	(1,996,680)	-	-	-	-	(13,906,457)
Total Expenses	**6,165,320**	**6,459,365**	**8,202,060**	**6,183,394**	**5,928,560**	**6,405,907**	**7,521,110**	**7,069,866**	**-**	**-**	**-**	**-**	**53,935,581**
Net Margin	**$ (5,880,064)**	**$ 5,499,345**	**$ 107,338,890**	**$ (2,129,871)**	**$ 240,706**	**$ 1,589,358**	**$ (424,290)**	**$ (5,251,501)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 100,982,574**
General Fund Support/ Transfer In (Out)	**$ (3,492,667)**	**$ (1,229,915)**	**$ (4,572,336)**	**$ (1,222,165)**	**$ (1,884,241)**	**$ (1,253,623)**	**$ (957,905)**	**$ (7,364,728)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ (21,977,580)**

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General Fund Program Statistics

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Current Year Total	Prior Year Total
Aeromedical														
Patients Transported - Actual	19	29	46	41	44	45	55	49					328	381
Patients Transported - Budget	50	50	50	60	53	54	50	49					416	435
Variance	**(31)**	**(21)**	**(4)**	**(19)**	**(9)**	**(9)**	**5**	**-**	**-**	**-**	**-**	**-**	**(88)**	(54)
Actual Hours Available for Service	432	718	729	741	645	722	930	1,116					6,033	8,485
Service Hours Utilized	25.0	48.0	70.0	58.0	66.0	68.0	85.0	79.0					499	550
Utilization %	5.8%	6.7%	9.6%	7.8%	10.2%	9.4%	9.1%	7.1%					8.3%	6.5%
# of Flights - Training/Public Education	-	-	-	1	-	1	9	14					25	35
# of Flights - Maintenance	7	2	5	9	8	6	8	4					49	67
Trauma														
New Trauma Patients - Actual	375	375	469	449	395	473	440	450					3,426	3,076
New Trauma Patients - Budget	399	399	399	399	399	399	399	399					3,192	3,152
Variance	**(24)**	**(24)**	**70**	**50**	**(4)**	**74**	**41**	**51**	**-**	**-**	**-**	**-**	**234**	(76)
School Health														
Medical Events	23,436	12,837	10,863	16,732	18,970	19,438	23,963	24,864					151,103	204,620
Screenings	15,444	21,308	16,728	21,545	20,858	16,294	23,951	14,492					150,620	89,100
Total Events- Actual	38,880	34,145	27,591	38,277	39,828	35,732	47,914	39,356	-	-	-	-	301,723	293,720
Total Events- Budget	44,326	35,717	35,502	43,311	42,584	45,622	52,682	51,278					351,022	463,551
Pharmacy														
Total Prescriptions Filled at In-House Pharmacies	16,335	12,569	14,010	14,035	14,344	16,178	15,404	14,681					117,556	150,966
Total Prescriptions Filled at Retail Pharmacies	48	58	57	37	14	8	2	2					226	1,612
Total Prescriptions Filled Inhouse/Retail- Actual	16,383	12,627	14,067	14,072	14,358	16,186	15,406	14,683	-	-	-	-	117,782	152,578
Total Prescriptions Filled- Budget	23,973	20,608	19,946	22,591	20,791	21,344	22,181	20,959					172,393	178,090

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SUPPLEMENTAL INFORMATION

HEALEY CENTER

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Healey Center Statement of Revenues and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
$ 1,222,137	**$ 1,243,281**	**$ (21,144)**	**(1.7%)**	**$ 1,171,785**	**$ 50,352**	**4.3%**	**Gross Patient Revenue**	**$ 9,720,455**	**$ 9,745,724**	**$ (25,269)**	**(0.3%)**	**$ 9,646,740**	**$ 73,715**	**0.8%**
109,401	91,682	(17,719)	(19.3%)	126,997	17,596	13.9%	Contractual Allowances	793,850	718,667	(75,183)	(10.5%)	989,648	195,799	19.8%
353,205	326,072	(27,133)	(8.3%)	320,785	(32,420)	(10.1%)	Charity Care	2,680,721	2,555,983	(124,738)	(4.9%)	2,518,809	(161,912)	(6.4%)
41,767	23,110	(18,657)	(80.7%)	32,943	(8,824)	(26.8%)	Bad Debt	212,913	181,151	(31,762)	(17.5%)	169,601	(43,313)	(25.5%)
504,373	440,864	(63,509)	(14.4%)	480,725	(23,648)	(4.9%)	Total Contractuals and Bad Debt	3,687,484	3,455,801	(231,683)	(6.7%)	3,678,058	(9,426)	(0.3%)
717,763	**802,417**	**(84,654)**	**(10.5%)**	**691,060**	**26,703**	**3.9%**	**Net Patient Revenue**	**6,032,971**	**6,289,923**	**(256,952)**	**(4.1%)**	**5,968,682**	**64,289**	**1.1%**
58.73%	64.54%			58.97%			Collection %	62.06%	64.54%			61.87%		
758,333	758,333	0	0.0%	758,333	-	0.0%	PBC Interlocal	6,066,667	6,066,664	3	0.0%	6,066,667	-	0.0%
16,270	-	16,270	0.0%	247,347	(231,077)	(93.4%)	Other Financial Assistance	222,045	-	222,045	0.0%	247,347	(25,302)	(10.2%)
1,003	2,062	(1,059)	(51.3%)	2,128	(1,125)	(52.9%)	Other Revenues	9,048	16,496	(7,448)	(45.2%)	27,106	(18,057)	(66.6%)
775,606	760,395	15,211	(1)	1,007,808	(232,202)	(23.0%)	Total Other Revenues	6,297,760	6,083,160	214,600	3.5%	6,341,119	(43,359)	(0.7%)
1,493,370	**1,562,812**	**(69,442)**	**(4.4%)**	**1,698,868**	**(205,499)**	**(12.1%)**	**Total Revenues**	**12,330,731**	**12,373,083**	**(42,352)**	**(0.3%)**	**12,309,801**	**20,929**	**0.2%**
							Direct Operational Expenses:							
954,670	1,007,628	52,958	5.3%	789,597	(165,073)	(20.9%)	Salaries and Wages	7,814,941	7,955,263	140,322	1.8%	7,659,945	(154,996)	(2.0%)
338,079	365,283	27,204	7.4%	375,603	37,524	10.0%	Benefits	2,727,710	2,906,164	178,454	6.1%	2,751,806	24,096	0.9%
43,278	57,952	14,674	25.3%	66,032	22,754	34.5%	Purchased Services	407,132	463,616	56,484	12.2%	588,461	181,328	30.8%
73,985	46,053	(27,932)	(60.7%)	63,200	(10,785)	(17.1%)	Medical Supplies	429,552	368,424	(61,128)	(16.6%)	363,743	(65,809)	(18.1%)
105,509	77,694	(27,815)	(35.8%)	73,561	(31,948)	(43.4%)	Other Supplies	563,792	621,552	57,760	9.3%	538,563	(25,229)	(4.7%)
1,485	1,975	490	24.8%	1,058	(426)	(40.3%)	Contracted Physician Expense	9,278	15,800	6,522	41.3%	8,268	(1,010)	(12.2%)
25,235	4,500	(20,735)	(460.8%)	3,306	(21,929)	(663.3%)	Medical Services	135,744	36,000	(99,744)	(277.1%)	32,015	(103,729)	(324.0%)
27,382	33,750	6,368	18.9%	26,957	(425)	(1.6%)	Drugs	249,929	270,000	20,071	7.4%	205,904	(44,024)	(21.4%)
14,482	25,426	10,944	43.0%	26,948	12,467	46.3%	Repairs & Maintenance	200,708	203,408	2,700	1.3%	219,615	18,907	8.6%
1,433	1,290	(143)	(11.1%)	1,248	(185)	(14.8%)	Lease & Rental	10,796	10,320	(476)	(4.6%)	8,881	(1,915)	(21.6%)
35,532	40,875	5,343	13.1%	26,454	(9,078)	(34.3%)	Utilities	283,088	327,000	43,912	13.4%	293,759	10,670	3.6%
20,981	14,429	(6,552)	(45.4%)	7,318	(13,664)	(186.7%)	Other Expense	75,362	115,432	40,070	34.7%	70,634	(4,728)	(6.7%)
7,713	6,889	(824)	(12.0%)	7,979	266	3.3%	Insurance	55,495	55,112	(383)	(0.7%)	50,979	(4,516)	(8.9%)
1,649,764	1,683,744	33,980	2.0%	1,469,261	(180,503)	(12.3%)	Total Operational Expenses	12,963,530	13,348,091	384,561	2.9%	12,792,575	(170,955)	(1.3%)
(156,394)	**(120,932)**	**(35,462)**	**29.3%**	**229,607**	**(386,001)**	**(168.1%)**	**Net Performance before Depreciation & Overhead Allocations**	**(632,799)**	**(975,008)**	**342,209**	**(35.1%)**	**(482,773)**	**(150,026)**	**31.1%**
79,402	78,333	(1,069)	(1.4%)	78,874	(528)	(0.7%)	Depreciation	633,180	626,664	(6,516)	(1.0%)	627,022	(6,157)	(1.0%)
							Overhead Allocations:							
2,481	2,159	(322)	(14.9%)	1,600	(881)	(55.1%)	Risk Mgt	17,300	17,270	(30)	(0.2%)	12,059	(5,241)	(43.5%)
1,564	2,892	1,329	45.9%	1,034	(529)	(51.2%)	Internal Audit	13,956	23,137	9,181	39.7%	29,875	15,919	53.3%
30,876	24,954	(5,922)	(23.7%)	22,880	(7,997)	(35.0%)	Administration	226,189	199,631	(26,558)	(13.3%)	206,136	(20,053)	(9.7%)
54,785	40,187	(14,599)	(36.3%)	35,576	(19,209)	(54.0%)	Human Resources	348,086	321,494	(26,592)	(8.3%)	301,187	(46,900)	(15.6%)
8,258	12,947	4,689	36.2%	13,306	5,048	37.9%	Legal	110,200	103,572	(6,628)	(6.4%)	98,262	(11,938)	(12.1%)
6,254	6,043	(211)	(3.5%)	4,285	(1,969)	(45.9%)	Records	45,293	48,347	3,054	6.3%	40,813	(4,480)	(11.0%)
7,944	5,171	(2,773)	(53.6%)	4,016	(3,928)	(97.8%)	Compliance	32,211	41,365	9,154	22.1%	55,943	23,732	42.4%
5,945	5,261	(684)	(13.0%)	-	(5,945)	0.0%	Comm Engage Plan	40,619	42,092	1,473	3.5%	-	(40,619)	0.0%
53,553	62,237	8,685	14.0%	-	(53,553)	0.0%	IT Operations	438,432	497,897	59,465	11.9%	-	(438,432)	0.0%
5,697	6,342	644	10.2%	-	(5,697)	0.0%	IT Security	44,078	50,733	6,655	13.1%	-	(44,078)	0.0%
28,682	17,617	(11,065)	(62.8%)	-	(28,682)	0.0%	IT Applications	165,454	140,939	(24,515)	(17.4%)	-	(165,454)	0.0%
34,057	33,076	(981)	(3.0%)	-	(34,057)	0.0%	Security Services	252,947	264,608	11,661	4.4%	-	(252,947)	0.0%
19,488	23,777	4,289	18.0%	25,755	6,267	24.3%	Finance	161,561	190,215	28,654	15.1%	201,174	39,612	19.7%
6,907	7,552	645	8.5%	7,282	375	5.1%	Public Relations	45,353	60,414	15,061	24.9%	61,065	15,713	25.7%
8,695	6,235	(2,460)	(39.5%)	92,467	83,772	90.6%	Information Technology	61,697	49,876	(11,821)	(23.7%)	561,640	499,943	89.0%
3,675	3,575	(100)	(2.8%)	1,658	(2,017)	(121.7%)	Corporate Quality	35,394	28,601	(6,793)	(23.7%)	10,859	(24,535)	(225.9%)
8,118	8,437	318	3.8%	7,769	(350)	(4.5%)	Project MGMT Office	55,537	67,492	11,955	17.7%	43,754	(11,783)	(26.9%)
286,980	268,461	(18,519)	(6.9%)	217,627	(69,353)	(31.9%)	Total Overhead Allocations	2,094,307	2,147,685	53,378	2.5%	1,622,766	(471,541)	(29.1%)
2,016,146	**2,030,538**	**14,392**	**0.7%**	**1,765,762**	**(250,383)**	(14.2%)	**Total Expenses**	**15,691,017**	**16,122,440**	**431,423**	**2.7%**	**15,042,363**	**(648,653)**	(4.3%)
(522,776)	**(467,726)**	**(55,051)**	**11.8%**	**(66,894)**	**(455,882)**	**681.5%**	**Net Margin**	**(3,360,286)**	**(3,749,357)**	**389,071**	**(10.4%)**	**(2,732,562)**	**(627,724)**	**23.0%**
2,022	-	2,022	0.0%	-	2,022	0.0%	**Capital Contributions**	52,058	-	52,058	0.0%	-	52,058	0.0%
$ 737,549	**$ 391,000**	**$ 346,549**	**88.6%**	**$ 235,367**	**$ (502,182)**	**(213.4%)**	**General Fund Support/Transfer In**	**$ 2,675,049**	**$ 3,134,000**	**$ (458,951)**	**(14.6%)**	**$ 2,352,887**	**$ (322,162)**	**(13.7%)**

Healey Center Statement of Revenues and Expenses by Month

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Year to Date
Gross Patient Revenue	$ 1,211,900	$ 1,196,363	$ 1,226,062	$ 1,234,757	$ 1,136,960	$ 1,266,882	$ 1,225,395	$ 1,222,137	$ -	$ -	$ -	$ -	**$ 9,720,455**
Contractual Allowances	140,804	47,683	111,948	76,057	61,142	74,804	172,011	109,401	-	-	-	-	793,850
Charity Care	329,734	348,071	317,308	373,912	336,631	408,673	213,188	353,205	-	-	-	-	2,680,721
Bad Debt	28,647	13,200	-	29,581	64,400	26,339	8,981	41,767	-	-	-	-	212,913
Total Contractuals and Bad Debt	499,185	408,953	429,256	479,549	462,173	509,815	394,180	504,373	-	-	-	-	3,687,484
Net Patient Revenue	**712,716**	**787,410**	**796,806**	**755,208**	**674,787**	**757,067**	**831,215**	**717,763**	**-**	**-**	**-**	**-**	**6,032,971**
Collections %	58.81%	65.82%	64.99%	61.16%	59.35%	59.76%	67.83%	58.73%	0.00%	0.00%	0.00%	0.00%	62.06%
PBC Interlocal	758,333	758,333	758,333	758,333	758,333	758,333	758,333	758,333	-	-	-	-	6,066,667
Other Financial Assistance	-	-	-	54,840	27,116	102,299	21,520	16,270	-	-	-	-	222,045
Other Revenues	10	1,688	822	1,683	146	1,378	2,318	1,003	-	-	-	-	9,048
Total Other Revenues	758,343	760,021	759,155	814,857	785,595	862,010	782,172	775,606	-	-	-	-	6,297,760
Total Revenues	**1,471,059**	**1,547,431**	**1,555,961**	**1,570,065**	**1,460,382**	**1,619,077**	**1,613,387**	**1,493,370**	**-**	**-**	**-**	**-**	**12,330,731**
Direct Operational Expenses:													
Salaries and Wages	1,142,186	946,754	1,023,941	867,242	895,350	950,798	1,034,001	954,670	-	-	-	-	7,814,941
Benefits	366,476	340,335	375,229	341,963	323,884	311,777	329,967	338,079	-	-	-	-	2,727,710
Purchased Services	52,581	47,198	48,968	53,954	45,209	59,546	56,398	43,278	-	-	-	-	407,132
Medical Supplies	37,009	47,907	46,804	51,803	59,416	65,985	46,644	73,985	-	-	-	-	429,552
Other Supplies	56,764	58,154	81,006	63,121	58,677	78,884	61,678	105,509	-	-	-	-	563,792
Contracted Physician Expense	1,003	1,205	512	1,214	1,220	1,050	1,590	1,485	-	-	-	-	9,278
Medical Services	2,727	39,204	7,717	16,772	9,244	13,542	21,302	25,235	-	-	-	-	135,744
Drugs	33,777	26,168	30,578	27,747	29,122	35,881	39,275	27,382	-	-	-	-	249,929
Repairs & Maintenance	19,330	26,782	24,070	39,918	20,018	21,263	34,845	14,482	-	-	-	-	200,708
Lease & Rental	1,064	1,064	1,340	1,437	1,480	1,482	1,496	1,433	-	-	-	-	10,796
Utilities	36,885	38,997	32,289	31,471	34,946	36,569	36,401	35,532	-	-	-	-	283,088
Other Expense	6,781	6,181	7,187	9,855	14,236	3,311	6,828	20,981	-	-	-	-	75,362
Insurance	6,826	6,826	6,826	6,826	6,826	6,826	6,826	7,713	-	-	-	-	55,495
Total Operational Expenses	1,763,409	1,586,775	1,686,467	1,513,322	1,499,628	1,586,916	1,677,249	1,649,764	-	-	-	-	12,963,530
Net Performance before Depreciation & Overhead Allocations	**(292,350)**	**(39,344)**	**(130,506)**	**56,743**	**(39,246)**	**32,161**	**(63,863)**	**(156,394)**	**-**	**-**	**-**	**-**	**(632,799)**
Depreciation	78,770	78,571	78,671	79,792	79,365	79,304	79,304	79,402	-	-	-	-	633,180
Overhead Allocations:													
Risk Mgt	1,499	1,303	1,426	1,414	1,276	3,288	4,613	2,481	-	-	-	-	17,300
Internal Audit	194	1,949	1,511	1,639	846	929	5,324	1,564	-	-	-	-	13,956
Administration	17,872	19,459	27,584	36,982	26,826	32,856	33,733	30,876	-	-	-	-	226,189
Human Resources	36,071	31,182	65,754	40,918	51,387	65,199	2,790	54,785	-	-	-	-	348,086
Legal	8,027	13,032	11,771	10,312	10,728	19,126	28,947	8,258	-	-	-	-	110,200
Records	5,309	5,601	6,012	5,571	4,485	6,006	6,055	6,254	-	-	-	-	45,293
Compliance	3,586	3,789	2,328	5,972	3,862	6,162	(1,432)	7,944	-	-	-	-	32,211
Comm Engage Plan	5,033	4,557	5,170	4,932	4,515	4,935	5,531	5,945	-	-	-	-	40,619
IT Operations	37,850	52,665	52,784	71,980	55,330	81,437	32,834	53,553	-	-	-	-	438,432
IT Security	5,952	3,961	6,978	5,765	4,652	5,687	5,385	5,697	-	-	-	-	44,078
IT Applications	1,674	20,112	15,865	21,973	13,177	33,610	30,361	28,682	-	-	-	-	165,454
Security Services	29,700	29,277	32,295	32,479	29,825	33,011	32,302	34,057	-	-	-	-	252,947
Finance	22,145	21,188	21,292	22,101	18,247	19,178	17,921	19,488	-	-	-	-	161,561
Public Relations	8,542	6,215	2,694	3,916	5,702	7,171	4,205	6,907	-	-	-	-	45,353
Information Technology	7,321	6,514	6,971	8,053	8,369	7,596	8,178	8,695	-	-	-	-	61,697
Corporate Quality	3,802	5,395	3,693	3,906	4,444	4,621	5,858	3,675	-	-	-	-	35,394
Project MGMT Office	5,811	6,466	6,743	6,938	6,312	7,119	8,030	8,118	-	-	-	-	55,537
Managed Care Contract	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Overhead Allocations	200,388	232,665	270,873	284,852	249,983	337,931	230,636	286,980	-	-	-	-	2,094,307
Total Expenses	**2,042,567**	**1,898,011**	**2,036,010**	**1,877,966**	**1,828,977**	**2,004,151**	**1,987,189**	**2,016,146**	**-**	**-**	**-**	**-**	15,691,017
Transfer out to Medicaid Match/ General Fund	-	-	-	-	-	-	-	-	-	-	-	-	-
Net Margin	**(571,508)**	**(350,580)**	**(480,049)**	**(307,901)**	**(368,594)**	**(385,074)**	**(373,802)**	**(522,776)**	**-**	**-**	**-**	**-**	**(3,360,286)**
Capital Contributions	-	-	-	-	-	-	-	-	-	-	-	-	-
General Fund Support/ Transfer In	**$ 492,738**	**$ 272,009**	**$ 386,429**	**$ 264,266**	**$ 226,339**	**$ 295,719**	**$ -**	**$ 737,549**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 2,675,049**

Census	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Current Year Total	Prior Year Total
Admissions	17	7	13	9	10	5	8	8					77	88
Discharges	10	6	12	9	7	6	11	8					69	102
Average Daily Census	110	115	115	115	113	117	117	115					115	117
Budget Census	118	118	118	118	118	118	118	118					118	118
Occupancy % (120 licensed beds)	92%	96%	96%	96%	94%	97%	98%	96%					96%	97%
Days By Payor Source:														
Medicaid	-	-	-	-	-	-	-	-					-	367
Managed Care Medicaid	2,381	2,314	2,386	2,375	2,181	2,399	2,386	2,378					18,800	19,983
Medicare	103	186	179	144	98	87	108	145					1,050	785
Private Pay	-		-	-	-	23	30	31					84	8
Hospice	62	60	62	62	56	62	60	36					460	450
Charity	858	898	930	987	938	1,052	929	979					7,571	6,805
Total Resident Days	**3,404**	**3,458**	**3,557**	**3,568**	**3,273**	**3,623**	**3,513**	**3,569**					**27,965**	**28,398**

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SUPPLEMENTAL INFORMATION

LAKESIDE MEDICAL CENTER

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Lakeside Medical Center Statement of Revenues and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
$ 4,344,014	$ 3,606,185	$ 737,829	20.5%	$ 7,002,242	$ (2,658,228)	(38.0%)	Inpatient Revenue	$ 35,163,652	$ 31,039,868	$ 4,123,784	13.3%	$ 34,482,476	$ 681,176	2.0%
7,708,593	7,642,228	66,365	0.9%	4,611,849	3,096,744	67.1%	Outpatient Revenue	56,521,394	65,779,696	(9,258,302)	(14.1%)	56,749,721	(228,326)	(0.4%)
-	-	-	0.0%	-	-	0.0%	Physician Clinic	-	-	-	0.0%	-	-	0.0%
12,052,607	**11,248,413**	**804,194**	**7.1%**	**11,614,092**	**438,516**	**3.8%**	**Gross Patient Revenue**	**91,685,046**	**96,819,564**	**(5,134,518)**	**(5.3%)**	**91,232,196**	**452,849**	**0.5%**
9,105,485	7,381,928	(1,723,557)	(23.3%)	7,631,599	(1,473,886)	(19.3%)	Contractual Allowances	64,402,341	63,539,197	(863,144)	(1.4%)	60,902,932	(3,499,409)	(5.7%)
625,052	295,992	(329,060)	(111.2%)	-	(625,052)	0.0%	Charity Care	1,767,319	2,547,722	780,403	30.6%	1,977,016	209,697	10.6%
2,227,125	1,049,427	(1,177,698)	(112.2%)	1,907,076	(320,050)	(16.8%)	Bad Debt	8,143,301	9,032,836	889,535	9.8%	14,910,077	6,766,776	45.4%
-	-	-	0.0%	-	-	0.0%	Physician Contractuals	-	-	-	0.0%	-	-	0.0%
$ 11,957,662	$ 8,727,347	$ (3,230,315)	(37.0%)	$ 9,538,675	$ (2,418,987)	(25.4%)	Total Contractuals and Bad Debt	$ 74,312,961	$ 75,119,755	$ 806,794	1.1%	$ 77,790,025	$ 3,477,064	4.5%
147,432	143,224	4,208	2.9%	121,724	25,708	21%	Other Patient Revenue	1,560,869	1,145,792	415,077	36.2%	973,791	587,079	60.3%
242,377	**2,664,290**	**(2,421,913)**	**(90.9%)**	**2,197,141**	**(1,954,764)**	**(89.0%)**	**Net Patient Revenue**	**18,932,954**	**22,845,601**	**(3,912,647)**	**(17.1%)**	**14,415,962**	**4,516,992**	**31.3%**
2.01%	23.69%			18.92%			Collection %	20.65%	23.60%			15.80%		
-	195	(195)	(100.0%)	1,350,000	(1,350,000)	(100.0%)	Grant Funds	163,733	1,560	162,173	10,395.7%	1,351,380	(1,187,647)	(87.9%)
-	600,000	(600,000)	(100.0%)	2,022,800	(2,022,800)	(100.0%)	Other Financial Assistance	1,171,438	3,640,419	(2,468,981)	(67.8%)	2,022,800	(851,362)	(42.1%)
15,493	12,992	2,501	19.2%	12,914	2,579	20.0%	Other Revenues	145,426	103,936	41,490	39.9%	107,915	37,512	34.8%
15,493	613,187	(597,694)	(97.5%)	3,385,714	(3,370,221)	(99.5%)	Total Other Revenues	1,480,597	3,745,915	(2,265,318)	(60.5%)	3,482,094	(2,001,497)	(57.5%)
257,870	**3,277,477**	**(3,019,607)**	**(92.1%)**	**5,582,854**	**(5,324,984)**	**(95.4%)**	**Total Revenues**	**20,413,551**	**26,591,516**	**(6,177,965)**	**(23.2%)**	**17,898,056**	**2,515,495**	**14.1%**
							Direct Operational Expenses:							
1,605,193	1,676,341	71,148	4.2%	1,391,505	(213,688)	(15.4%)	Salaries and Wages	13,000,872	13,531,722	530,850	3.9%	13,122,470	121,598	0.9%
455,307	472,275	16,968	3.6%	501,885	46,578	9.3%	Benefits	3,652,821	3,792,506	139,685	3.7%	3,604,707	(48,114)	(1.3%)
304,400	261,079	(43,321)	(16.6%)	276,757	(27,643)	(10.0%)	Purchased Services	2,219,416	2,082,151	(137,265)	(6.6%)	2,242,806	23,390	1.0%
210,739	139,242	(71,497)	(51.3%)	113,542	(97,197)	(85.6%)	Medical Supplies	1,217,483	1,007,752	(209,731)	(20.8%)	1,263,026	45,543	3.6%
65,774	97,903	32,129	32.8%	81,294	15,520	19.1%	Other Supplies	956,124	762,020	(194,104)	(25.5%)	646,360	(309,764)	(47.9%)
764,286	696,223	(68,063)	(9.8%)	683,464	(80,822)	(11.8%)	Contracted Physician Expense	5,629,354	5,569,784	(59,570)	(1.1%)	5,951,418	322,064	5.4%
114,424	90,343	(24,081)	(26.7%)	94,329	(20,096)	(21.3%)	Drugs	992,557	653,848	(338,709)	(51.8%)	775,175	(217,382)	(28.0%)
42,353	68,056	25,703	37.8%	132,008	89,655	67.9%	Repairs & Maintenance	438,098	544,448	106,351	19.5%	1,195,649	757,551	63.4%
45,580	52,239	6,659	12.7%	61,139	15,559	25.4%	Lease & Rental	404,371	417,912	13,541	3.2%	469,168	64,798	13.8%
54,911	74,667	19,756	26.5%	50,470	(4,441)	(8.8%)	Utilities	506,054	597,336	91,282	15.3%	513,516	7,461	1.5%
2,492	71,062	68,570	96.5%	38,520	36,028	93.5%	Other Expense	449,759	568,496	118,737	20.9%	483,772	34,013	7.0%
16,754	16,660	(94)	(0.6%)	16,573	(181)	(1.1%)	Insurance	132,763	133,280	517	0.4%	116,177	(16,586)	(14.3%)
3,682,213	3,716,090	33,877	0.9%	3,441,486	(240,727)	(7.0%)	Total Operational Expenses	29,599,671	29,661,255	61,584	0.2%	30,384,244	784,573	2.6%
(3,424,343)	**(438,613)**	**(2,985,730)**	**680.7%**	**2,141,368**	**(5,565,711)**	**(259.9%)**	**Net Performance before Depreciation & Overhead Allocations**	**(9,186,120)**	**(3,069,739)**	**(6,116,381)**	**199.2%**	**(12,486,188)**	**3,300,068**	**(26.4%)**

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Lakeside Medical Center Statement of Revenues and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
261,186	258,333	(2,853)	(1.1%)	256,652	(4,534)	(1.8%)	Depreciation	2,081,612	2,066,664	(14,948)	(0.7%)	2,056,889	(24,723)	(1.2%)
							Overhead Allocations:							
5,509	4,794	(715)	(14.9%)	3,571	(1,938)	(54.3%)	Risk Mgt	38,417	38,350	(66)	(0.2%)	26,917	(11,500)	(42.7%)
60,795	55,191	(5,604)	(10.2%)	-	(60,795)	0.0%	Rev Cycle	422,699	441,530	18,831	4.3%	-	(422,699)	0.0%
3,472	6,422	2,950	45.9%	2,308	(1,164)	(50.4%)	Internal Audit	30,991	51,379	20,388	39.7%	66,684	35,693	53.5%
68,565	55,413	(13,151)	(23.7%)	51,071	(17,494)	(34.3%)	Administration	502,281	443,306	(58,975)	(13.3%)	460,124	(42,157)	(9.2%)
71,230	52,249	(18,981)	(36.3%)	46,137	(25,093)	(54.4%)	Human Resources	452,566	417,993	(34,574)	(8.3%)	390,592	(61,974)	(15.9%)
18,337	28,749	10,412	36.2%	29,700	11,363	38.3%	Legal	244,714	229,994	(14,719)	(6.4%)	219,334	(25,379)	(11.6%)
13,889	13,420	(468)	(3.5%)	9,566	(4,323)	(45.2%)	Records	100,579	107,361	6,782	6.3%	91,101	(9,478)	(10.4%)
17,641	11,482	(6,158)	(53.6%)	8,965	(8,675)	(96.8%)	Compliance	71,529	91,856	20,327	22.1%	124,873	53,344	42.7%
13,202	11,684	(1,518)	(13.0%)	-	(13,202)	0.0%	Comm Engage Plan	90,200	93,470	3,270	3.5%	-	(90,200)	0.0%
118,920	138,205	19,285	14.0%	-	(118,920)	0.0%	IT Operations	973,593	1,105,643	132,050	11.9%	-	(973,593)	0.0%
12,651	14,082	1,431	10.2%	-	(12,651)	0.0%	IT Security	97,880	112,658	14,778	13.1%	-	(97,880)	0.0%
114,178	127,038	12,860	10.1%	-	(114,178)	0.0%	IT Applications	945,652	1,016,303	70,652	7.0%	-	(945,652)	0.0%
38,923	37,801	(1,122)	(3.0%)	-	(38,923)	0.0%	Security Services	289,082	302,409	13,327	4.4%	-	(289,082)	0.0%
234,401	202,669	(31,731)	(15.7%)	-	(234,401)	0.0%	IT EPIC	1,284,545	1,621,355	336,810	20.8%	-	(1,284,545)	0.0%
43,276	52,800	9,523	18.0%	57,489	14,213	24.7%	Finance	358,767	422,397	63,630	15.1%	449,048	90,281	20.1%
15,337	16,770	1,432	8.5%	16,254	916	5.6%	Public Relations	100,712	134,156	33,445	24.9%	136,306	35,595	26.1%
19,308	13,845	(5,464)	(39.5%)	206,398	187,090	90.6%	Information Technology	137,006	110,756	(26,250)	(23.7%)	1,253,658	1,116,652	89.1%
8,161	7,939	(222)	(2.8%)	3,700	(4,460)	(120.5%)	Corporate Quality	78,596	63,513	(15,084)	(23.7%)	24,239	(54,358)	(224.3%)
18,028	18,734	707	3.8%	17,341	(687)	(4.0%)	Project MGMT Office	123,326	149,875	26,548	17.7%	97,664	(25,662)	(26.3%)
-	7,848	7,848	100.0%	11,641	11,641	100.0%	Managed Care Contract	37,902	62,782	24,880	39.6%	72,255	34,353	47.5%
895,822	877,136	(18,686)	(2.1%)	464,141	(431,681)	(93.0%)	Total Overhead Allocations	6,381,036	7,017,087	636,051	9.1%	3,412,796	(2,968,240)	(87.0%)
4,839,221	**4,851,559**	**12,338**	**0.3%**	**4,162,279**	**(676,942)**	**(16.3%)**	**Total Expenses**	**38,062,320**	**38,745,006**	**682,686**	**1.8%**	**35,853,929**	**(2,208,391)**	**(6.2%)**
$ (4,581,351)	**$ (1,574,082)**	**$ (3,007,269)**	**191.0%**	**$ 1,420,575**	**$ (6,001,926)**	**(422.5%)**	**Net Margin**	**$ (17,648,769)**	**$ (12,153,490)**	**$ (5,495,278)**	**45.2%**	**$ (17,955,873)**	**$ 307,104**	**(1.7%)**
-	-	-	0.0%	110,116	(110,116)	(100.0%)	**Capital Contributions**	99,350	-	99,350	0.0%	235,680	(136,330)	(57.8%)
$ -	**$ 1,950,000**	**$ (1,950,000)**	**(100.0%)**	**$ 235,456**	**$ 235,456**	**100.0%**	**General Fund Support/ Transfer In**	**$ -**	**$ 8,807,000**	**$ (8,807,000)**	**(100.0%)**	**$ 17,686,103**	**$ 17,686,103**	**100.0%**

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Lakeside Medical Center Statement of Revenues and Expenses by Month

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Year to Date
Inpatient Revenue	$ 3,895,448	$ 3,985,552	$ 4,894,393	$ 5,375,408	$ 4,888,944	$ 3,711,527	$ 4,068,366	$ 4,344,014	$ -	$ -	$ -	$ -	$ 35,163,652
Outpatient Revenue	6,740,835	6,028,589	6,198,016	7,082,417	7,029,810	7,654,520	8,078,614	7,708,593	-	-	-	-	56,521,394
Gross Patient Revenue	**10,636,282**	**10,014,140**	**11,092,409**	**12,457,825**	**11,918,754**	**11,366,047**	**12,146,980**	**12,052,607**	**-**	**-**	**-**	**-**	**91,685,046**
Contractual Allowances	7,259,800	7,895,305	8,141,013	8,438,082	8,347,527	7,816,726	7,398,405	9,105,485	-	-	-	-	64,402,341
Charity Care	2,324,516	46,637	(2,173,316)	-	435,829	239,491	269,109	625,052	-	-	-	-	1,767,319
Bad Debt	1,255,741	(3,319,432)	2,119,861	1,479,938	534,278	4,000,320	(154,532)	2,227,125	-	-	-	-	8,143,301
Total Contractuals and Bad Debt	$ 10,840,057	$ 4,622,510	$ 8,087,558	$ 9,918,020	$ 9,317,635	$ 12,056,537	$ 7,512,982	$ 11,957,662	$ -	$ -	$ -	$ -	$ 74,312,961
Other Patient Revenue	142,009	142,009	523,423	142,009	142,009	148,119	173,857	147,432	-	-	-	-	1,560,869
Net Patient Revenue	**(61,765)**	**5,533,640**	**3,528,275**	**2,681,814**	**2,743,129**	**(542,370)**	**4,807,855**	**242,377**	**-**	**-**	**-**	**-**	**18,932,954**
Collection %	-0.58%	55.26%	31.81%	21.53%	23.02%	-4.77%	39.58%	2.01%	0.00%	0.00%	0.00%	0.00%	20.65%
Grant Funds	81,867	-	-	40,933	13,644	-	27,289	-	-	-	-	-	163,733
Other Financial Assistance	-	-	-	498,853	257,463	285,015	130,107	-	-	-	-	-	1,171,438
Other Revenue	25,133	16,319	44,660	14,514	26,237	15,021	(11,951)	15,493	-	-	-	-	145,426
Total Other Revenues	107,000	16,319	44,660	554,300	297,345	300,035	145,445	15,493	-	-	-	-	1,480,597
Total Revenues	**45,235**	**5,549,959**	**3,572,935**	**3,236,114**	**3,040,473**	**(242,335)**	**4,953,300**	**257,870**	**-**	**-**	**-**	**-**	**20,413,551**
Direct Operational Expenses:													
Salaries and Wages	1,839,260	1,564,927	1,661,704	1,533,257	1,533,530	1,564,709	1,698,291	1,605,193	-	-	-	-	13,000,872
Benefits	482,565	450,228	487,782	451,141	449,552	427,860	448,384	455,307	-	-	-	-	3,652,821
Purchased Services	289,929	232,220	257,375	236,978	323,285	333,093	242,137	304,400	-	-	-	-	2,219,416
Medical Supplies	91,738	132,622	142,210	115,484	117,523	188,985	218,183	210,739	-	-	-	-	1,217,483
Other Supplies	39,537	92,922	139,625	127,356	137,179	207,278	146,454	65,774	-	-	-	-	956,124
Contracted Physician Expense	663,185	660,448	717,386	823,931	692,946	356,973	950,197	764,286	-	-	-	-	5,629,354
Drugs	77,901	104,180	158,282	144,236	167,869	119,501	106,164	114,424	-	-	-	-	992,557
Repairs & Maintenance	46,164	49,242	47,833	67,816	54,356	55,489	74,846	42,353	-	-	-	-	438,098
Lease & Rental	52,258	50,554	68,444	58,805	32,799	44,541	51,391	45,580	-	-	-	-	404,371
Utilities	68,800	72,412	76,840	48,908	51,859	61,833	70,491	54,911	-	-	-	-	506,054
Other Expense	46,086	97,638	36,172	71,181	33,600	110,255	52,335	2,492	-	-	-	-	449,759
Insurance	16,573	16,573	16,573	16,573	16,573	16,573	16,573	16,754	-	-	-	-	132,763
Total Operational Expenses	3,713,996	3,523,966	3,810,226	3,695,666	3,611,070	3,487,089	4,075,445	3,682,213	-	-	-	-	29,599,671
Net Performance before Depreciation & Overhead Allocations	**(3,668,761)**	**2,025,993**	**(237,291)**	**(459,552)**	**(570,596)**	**(3,729,424)**	**877,855**	**(3,424,343)**	**-**	**-**	**-**	**-**	**(9,186,120)**
Depreciation	258,659	261,436	259,965	259,804	259,804	260,086	260,673	261,186	-	-	-	-	2,081,612
Overhead Allocations:													
Risk Mgt	3,328	2,893	3,167	3,141	2,834	7,301	10,244	5,509	-	-	-	-	38,417
Rev Cycle	57,418	47,266	51,614	51,149	45,293	52,592	56,572	60,795	-	-	-	-	422,699
Internal Audit	432	4,328	3,356	3,639	1,878	2,062	11,824	3,472	-	-	-	-	30,991
Administration	39,687	43,211	61,254	82,122	59,571	72,961	74,909	68,565	-	-	-	-	502,281
Human Resources	46,898	40,541	85,490	53,200	66,812	84,769	3,628	71,230	-	-	-	-	452,566
Legal	17,825	28,940	26,138	22,898	23,823	42,472	64,280	18,337	-	-	-	-	244,714
Records	11,788	12,438	13,351	12,371	9,959	13,338	13,445	13,889	-	-	-	-	100,579
Compliance	7,963	8,414	5,170	13,263	8,575	13,683	(3,179)	17,641	-	-	-	-	71,529
Comm Engage Plan	11,177	10,119	11,482	10,953	10,026	10,959	12,282	13,202	-	-	-	-	90,200
IT Operations	84,051	116,950	117,213	159,840	122,867	180,840	72,912	118,920	-	-	-	-	973,593
IT Security	13,217	8,797	15,495	12,803	10,330	12,630	11,958	12,651	-	-	-	-	97,880
IT Applications	31,724	170,938	256,322	112,810	99,879	126,396	33,403	114,178	-	-	-	-	945,652
Security Services	33,943	33,460	36,909	37,119	34,086	37,726	36,917	38,923	-	-	-	-	289,082
IT EPIC	79,716	88,644	108,508	135,518	112,323	297,967	227,468	234,401	-	-	-	-	1,284,545
Finance	49,176	47,050	47,282	49,078	40,521	42,586	39,797	43,276	-	-	-	-	358,767
Public Relations	18,969	13,802	5,983	8,697	12,663	15,924	9,338	15,337	-	-	-	-	100,712
Information Technology	16,257	14,465	15,480	17,883	18,584	16,867	18,161	19,308	-	-	-	-	137,006
Budget & Decision Support	-	-	-	-	-	-	-	-	-	-	-	-	-
Corporate Quality	8,444	11,980	8,200	8,673	9,869	10,262	13,008	8,161	-	-	-	-	78,596
Project MGMT Office	12,904	14,358	14,974	15,408	14,016	15,808	17,831	18,028	-	-	-	-	123,326
Managed Care Contract	7,116	6,835	7,346	7,112	6,476	3,001	17	-	-	-	-	-	37,902
Total Overhead Allocations	552,033	725,428	894,736	817,675	710,384	1,060,147	724,813	895,822	-	-	-	-	6,381,036
Total Expenses	**4,524,688**	**4,510,830**	**4,964,927**	**4,773,145**	**4,581,257**	**4,807,322**	**5,060,931**	**4,839,221**	**-**	**-**	**-**	**-**	**38,062,320**
Net Margin	**$ (4,479,453)**	**$ 1,039,129**	**$ (1,391,992)**	**$ (1,537,031)**	**$ (1,540,783)**	**$ (5,049,657)**	**$ (107,631)**	**$ (4,581,351)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ (17,648,769)**
Capital Contributions	-	-	-	-	17,000	28,848	53,502	-	-	-	-	-	99,350
General Fund Support/ Transfer In	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -

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Lakeside Medical Center
Statistical Information

Admissions	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Current Year Total	YTD Budget Total	% Var to Budget	Prior YTD Total
Newborn	10	9	3	5	4	4	7	10	-	-	-	-	52	106	(50.8%)	121
Pediatrics	3	2	3	2	3	3	11	6	-	-	-	-	33	48	(31.1%)	45
Adult	101	77	88	100	98	69	85	94	-	-	-	-	712	814	(12.6%)	870
Total	**114**	**88**	**94**	**107**	**105**	**76**	**103**	**110**	**-**	**-**	**-**	**-**	**797**	**968**	**(17.7%)**	**1,036**
Adjusted Admissions	**311**	**221**	**213**	**248**	**256**	**233**	**308**	**305**					**2,095**	**3,019**	**(30.6%)**	**2,842**
Patient Days																
Med Surg 2nd and 3rd Floor (14 beds)	41	39	28	84	119	30	30	30	-	-	-	-	401	637	(37.0%)	694
Pediatrics (12 beds)	17	22	30	27	11	10	34	15	-	-	-	-	166	251	(33.9%)	246
Telemetry (22 beds)	243	222	394	402	349	247	269	312	-	-	-	-	2,438	2,092	16.5%	2,051
ICU (6 beds)	126	142	163	154	157	143	147	135	-	-	-	-	1,167	1,004	16.2%	989
Obstetrics (16 beds)	29	25	13	18	11	17	18	31	-	-	-	-	162	388	(58.2%)	385
Total (70 beds)	**456**	**450**	**628**	**685**	**647**	**447**	**498**	**523**	**-**	**-**	**-**	**-**	**4,334**	**4,372**	**(0.9%)**	**4,365**
Adjusted Acute Patient Days	**1,245**	**1,131**	**1,423**	**1,588**	**1,577**	**1,369**	**1,487**	**1,451**					**11,271**	**13,637**	**(17.3%)**	**11,394**
Other Key Inpatient Statistics																
Occupancy Percentage	21%	0.2143	0.2894	0.3157	0.3301	0.2060	0.2371	0.2410	-	-	-	-	17%	26%	(34.0%)	26%
Average Daily Census (excl. newborns)	14.7	15.0	20.3	22.1	23.1	14.4	16.6	16.9					17.9	18.0	(0.4%)	17.9
Average Daily Census (incl. newborns)	15.4	15.8	20.6	22.6	23.5	14.8	17.2	17.7					18.5	19.2	(4.1%)	19.1
Average Length of Stay (excl newborns)	4.38	5.70	6.90	6.72	6.41	6.21	5.19	5.23	-	-	-	-	5.84	5.07	15.1%	4.71
Average Length of Stay (incl newborns)	4.19	5.40	6.81	6.55	6.26	6.04	5.00	4.98	-	-	-	-	5.65	4.83	17.1%	4.48
Case Mix Index- Medicare	1.9433	1.7109	1.3353	2.4190	1.5160	1.9575	1.4246	1.5021	-	-	-	-	-			1.5800
Case Mix Index- Medicaid	0.5706	2.1950	2.4349	1.7665	1.6697	0.7644	0.8969	0.6547	-	-	-	-	-			1.3770
Case Mix Index- All Payers	1.3453	1.5504	1.6374	2.0162	1.6634	1.5066	1.6564	1.2173	-	-	-	-	-			1.2357
Emergency Room and Outpatients																
ER Admissions	59	34	48	48	58	44	50	49	-	-	-	-	390	547	(28.7%)	591
ER Visits	1,367	1,269	1,292	1,502	1,396	1,629	1,707	1,647	-	-	-	-	11,809	13,133	(10.1%)	14,338
Outpatient Visits	280	235	247	213	258	213	329	313	-	-	-	-	2,088	1,702	22.7%	2,800
ER and Outpatient Visits	1,647	1,504	1,539	1,715	1,654	1,842	2,036	1,960	-	-	-	-	13,897	14,834	(6.3%)	17,138
Observation Patient Stays	219	202	169	182	206	236	245	185	-	-	-	-	1,644	2,403	(31.6%)	1,957
Surgery and Other Procedures																
Inpatient Surgeries	24	31	30	28	32	28	46	39	-	-	-	-	258	283	(8.9%)	293
Outpatient Surgeries	7	6	10	5	9	2	5	6	-	-	-	-	50	23	118.4%	29
Endoscopies	19	9	11	14	13	16	20	13	-	-	-	-	115	123	(6.5%)	102
Radiology Procedures	2,280	1,983	2,163	2,449	2,356	2,640	2,641	2,518	-	-	-	-	19,030	18,291	4.0%	18,408
Lab Charges	14,701	14,408	15,963	18,014	17,243	15,960	17,635	16,948	-	-	-	-	130,872	134,799	(2.9%)	128,159
Staffing																
Paid FTE	281.61	273.82	271.52	270.27	280.54	273.60	248.28	275.39	-	-	-	-	271.88	291.95	(6.9%)	297.81
Paid FTE per Adjusted Occupied Bed	7.01	7.27	5.91	5.28	4.98	6.20	5.01	5.88	-	-	-	-	5.85	5.21	12.3%	6.38
Operational Performance																
Gross Revenue Per Adj Pat Day	8,543	8,857	7,794	7,847	7,556	8,303	8,169	8,306					8,172	7,697	6.2%	8,017
Net Revenue Per Adj Pat Day	(50)	4,894	2,479	1,689	1,739	(396)	3,234	167					2,293	1,816	26.2%	2,184
Salaries & Benefits as % of Net Pat Revenue	-3759%	36%	61%	74%	72%	-367%	45%	850%					88%	76%	15.6%	71%
Labor Cost per Adj Pat Day	1,865	1,782	1,510	1,250	1,257	1,456	1,444	1,420					1,498	1,378	8.7%	1,486
Total Expense Per Adj Pat Day	2,983	3,117	2,677	2,328	2,289	2,547	2,741	2,538					2,652	2,357	12.5%	2,691

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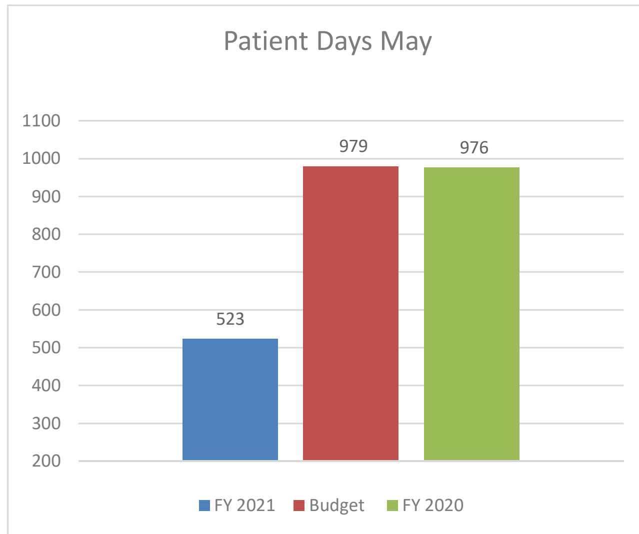
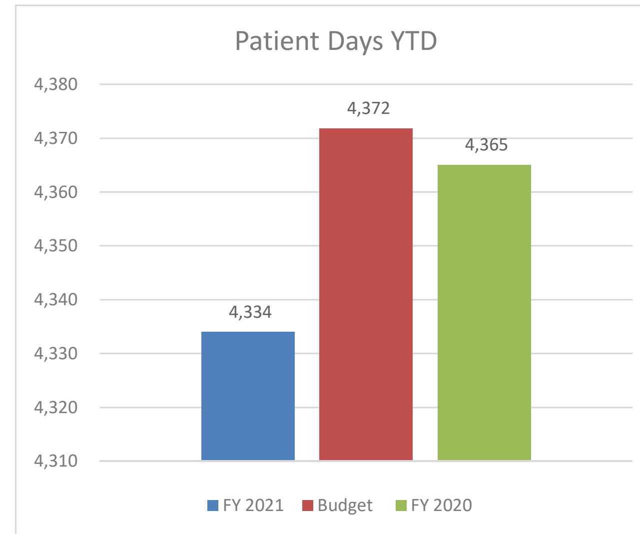
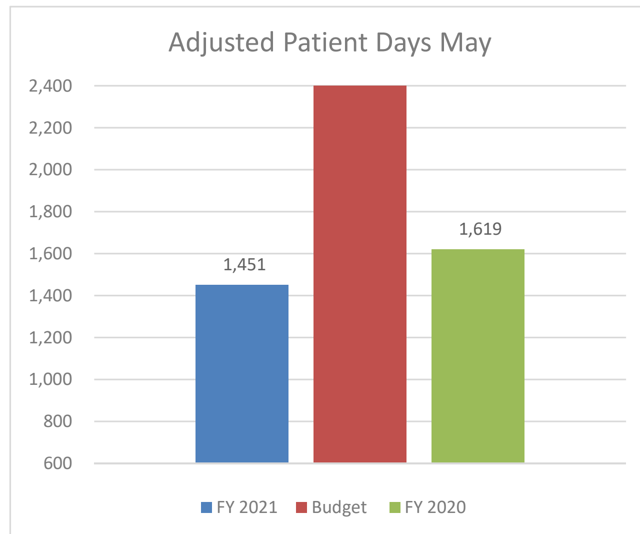
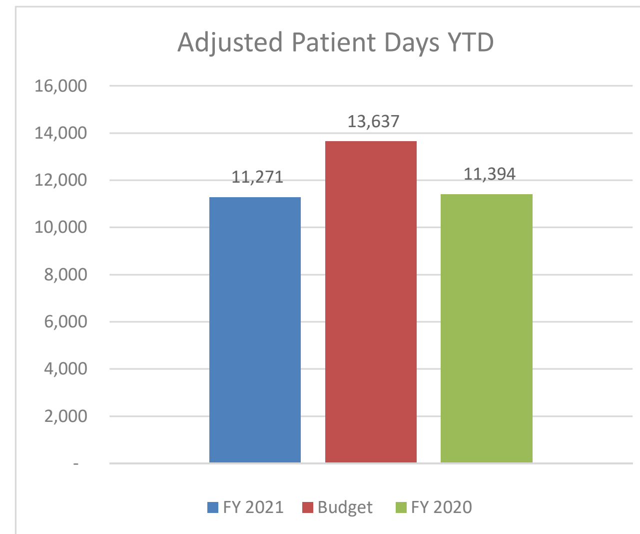
LAKESIDE MEDICAL CENTER
Inpatient









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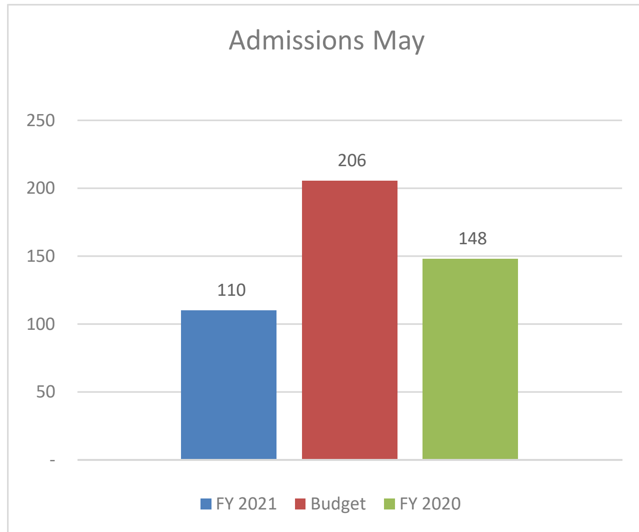
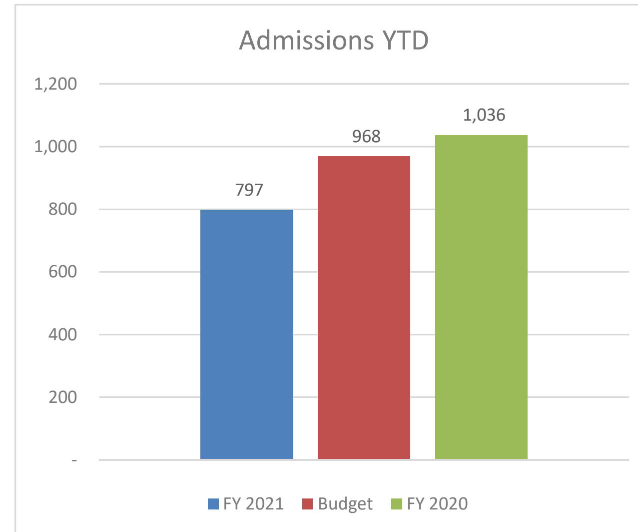
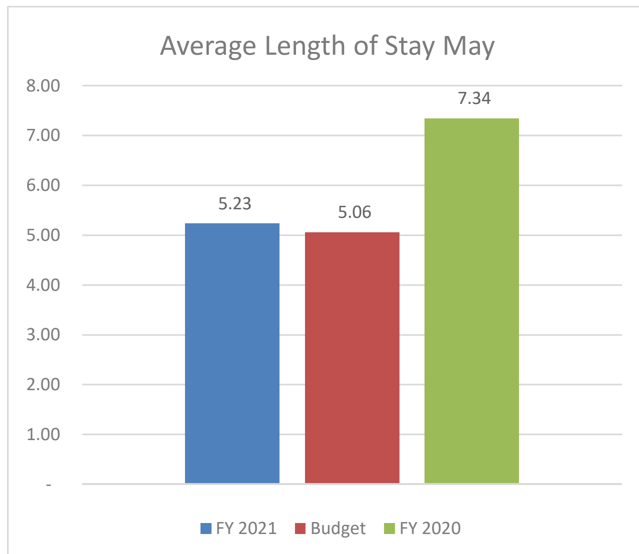
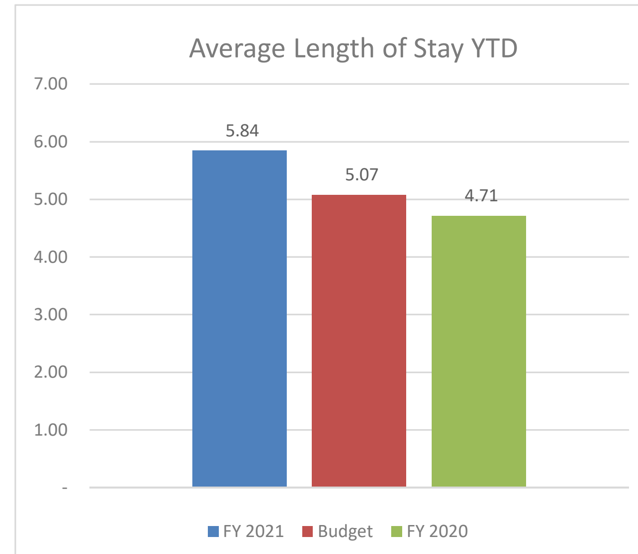
LAKESIDE MEDICAL CENTER
Inpatient









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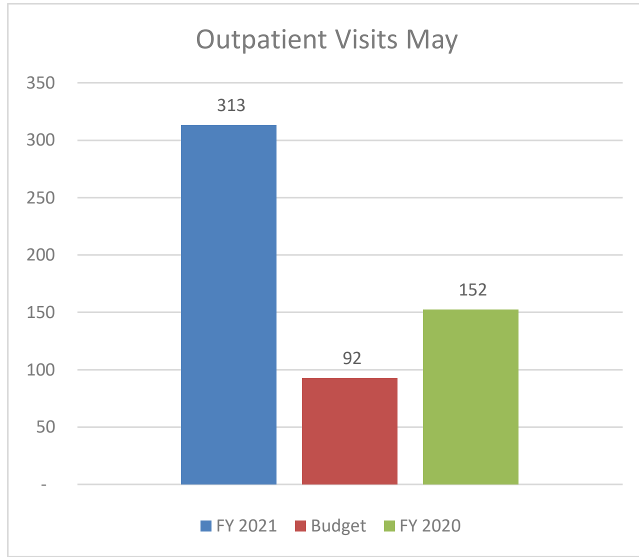
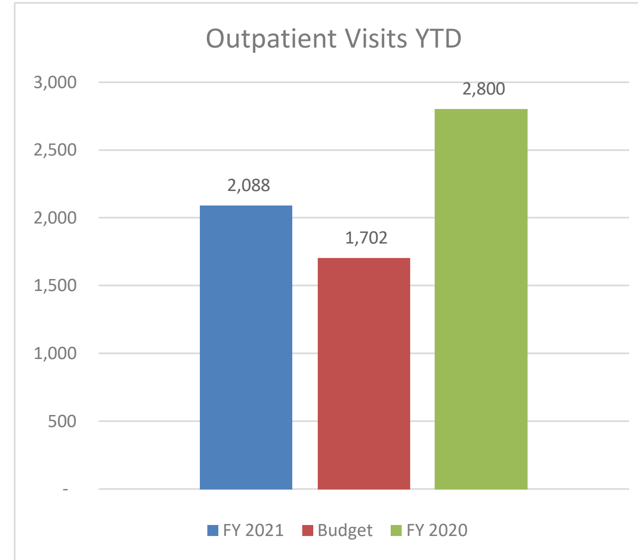
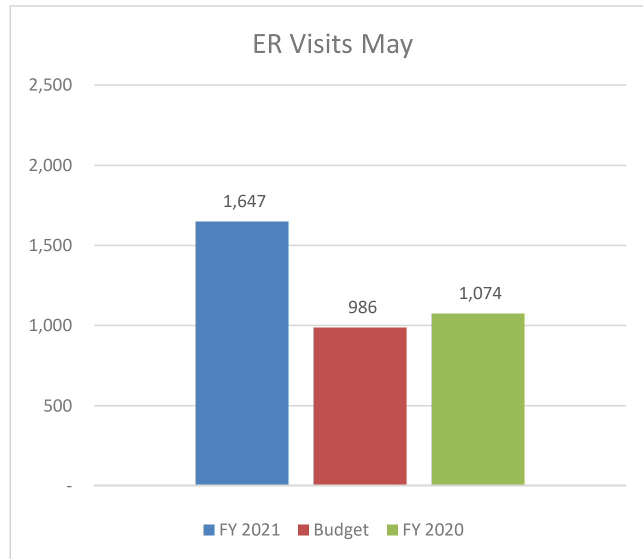
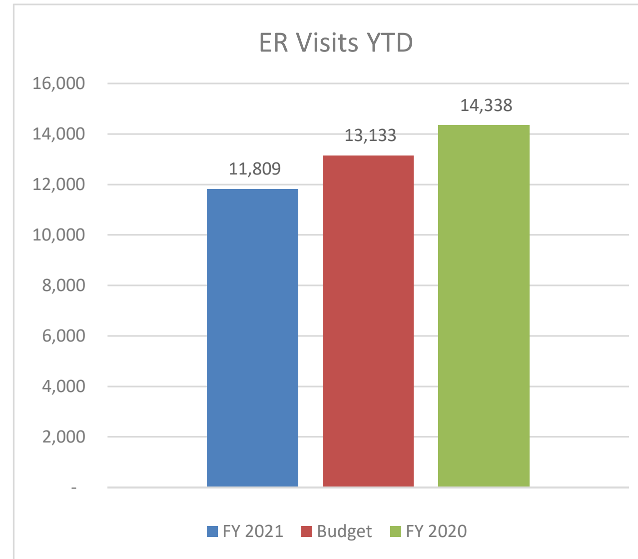
LAKESIDE MEDICAL CENTER
Outpatient









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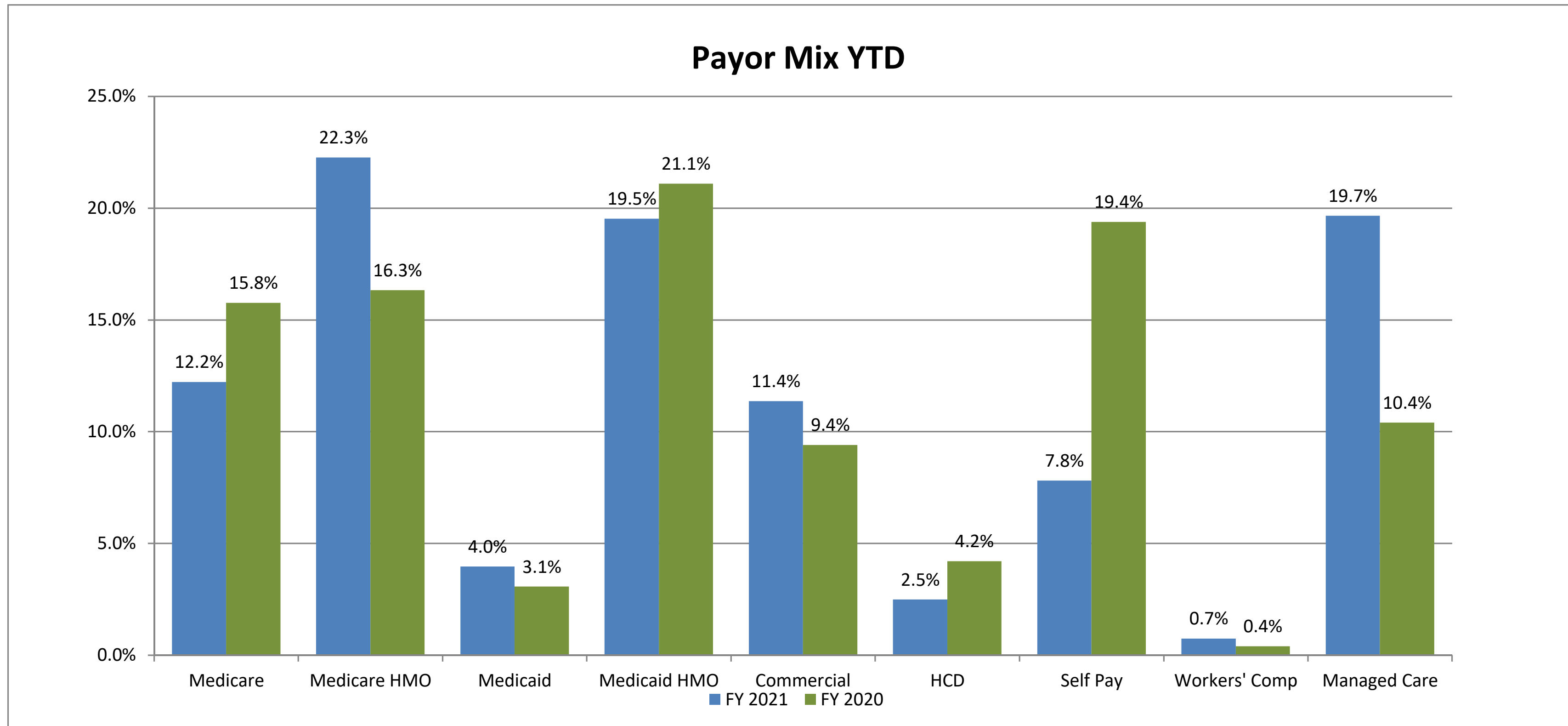
LAKESIDE MEDICAL CENTER
Revenue



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SUPPLEMENTAL INFORMATION

PRIMARY CARE CLINICS

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Primary Care Clinics Statement of Revenues and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
2,066,863	**1,258,245**	**808,618**	**64.3%**	**403,778**	**1,663,085**	**411.9%**	**Gross Patient Revenue**	**14,148,428**	**9,831,783**	**4,316,645**	**43.9%**	**12,184,161**	**1,964,267**	**16.1%**
464,663	224,588	(240,075)	(106.9%)	114,972	(349,691)	(304.2%)	Contractual Allowances	3,713,125	1,770,819	(1,942,306)	(109.7%)	2,209,573	(1,503,552)	(68.0%)
782,187	491,306	(290,881)	(59.2%)	96,417	(685,770)	(711.3%)	Charity Care	5,005,511	3,853,744	(1,151,767)	(29.9%)	4,659,292	(346,219)	(7.4%)
368,549	173,754	(194,795)	(112.1%)	133,496	(235,053)	(176.1%)	Bad Debt	2,531,211	1,379,386	(1,151,825)	(83.5%)	1,808,668	(722,543)	(39.9%)
1,615,400	889,648	(725,752)	(81.6%)	344,885	(1,270,515)	(368.4%)	Total Contractuals and Bad Debts	11,249,847	7,003,949	(4,245,898)	(60.6%)	8,677,532	(2,572,315)	(29.6%)
513,976	383,678	130,298	34.0%	778,072	(264,096)	(33.9%)	Other Patient Revenue	4,053,850	2,990,277	1,063,573	35.6%	3,293,623	760,226	23%
965,440	**752,275**	**213,165**	**28.3%**	**836,965**	**128,474**	**15.4%**	**Net Patient Revenue**	**6,952,430**	**5,818,111**	**1,134,319**	**19.5%**	**6,800,252**	**152,178**	**2.2%**
46.71%	59.79%			207.28%			Collection %	49.14%	59.18%			55.81%		
1,488,547	1,177,007	311,540	26.5%	862,240	626,307	72.6%	Grant Funds	5,905,757	6,183,145	(277,388)	(4.5%)	4,693,678	1,212,079	25.8%
19,439	145,876	(126,437)	(86.7%)	809,249	(789,810)	(97.6%)	Other Financial Assistance	821,081	4,457,960	(3,636,879)	(81.6%)	809,249	11,831	1.5%
1,578	45,034	(43,456)	(96.5%)	5,564	(3,986)	(71.6%)	Other Revenue	71,310	360,272	(288,962)	(80.2%)	60,693	10,617	17.5%
1,509,564	1,367,917	141,647	10.4%	1,677,053	(167,489)	(10.0%)	Total Other Revenues	6,798,148	11,001,377	(4,203,229)	(38.2%)	5,563,621	1,234,527	22.2%
2,475,004	**2,120,192**	**354,812**	**16.7%**	**2,514,018**	**(39,014)**	**(1.6%)**	**Total Revenues**	**13,750,578**	**16,819,488**	**(3,068,910)**	**(18.2%)**	**12,363,873**	**1,386,705**	**11.2%**
							Direct Operational Expenses:							
1,480,781	1,394,572	(86,209)	(6.2%)	1,234,387	(246,394)	(20.0%)	Salaries and Wages	11,669,264	11,484,085	(185,179)	(1.6%)	10,886,764	(782,500)	(7.2%)
429,489	378,735	(50,754)	(13.4%)	424,266	(5,223)	(1.2%)	Benefits	3,248,367	3,068,401	(179,966)	(5.9%)	2,903,918	(344,449)	(11.9%)
165,470	46,754	(118,716)	(253.9%)	56,861	(108,609)	(191.0%)	Purchased Services	802,091	408,195	(393,896)	(96.5%)	630,528	(171,563)	(27.2%)
27,504	119,542	92,038	77.0%	10,092	(17,412)	(172.5%)	Medical Supplies	307,717	938,649	630,932	67.2%	271,380	(36,337)	(13.4%)
25,786	26,518	732	2.8%	1,213	(24,573)	(2,025.1%)	Other Supplies	103,632	212,244	108,612	51.2%	92,055	(11,577)	(12.6%)
61,653	81,658	20,005	24.5%	71,459	9,806	13.7%	Medical Services	494,954	641,757	146,803	22.9%	560,811	65,857	11.7%
51,857	58,982	7,125	12.1%	96,741	44,884	46.4%	Drugs	495,520	463,507	(32,013)	(6.9%)	678,534	183,014	27.0%
5,264	9,629	4,365	45.3%	16,666	11,401	68.4%	Repairs & Maintenance	51,105	77,032	25,927	33.7%	253,878	202,773	79.9%
125,417	127,109	1,692	1.3%	116,344	(9,073)	(7.8%)	Lease & Rental	841,471	968,283	126,812	13.1%	904,485	63,014	7.0%
6,933	7,341	408	5.6%	4,607	(2,326)	(50.5%)	Utilities	56,563	58,728	2,165	3.7%	40,382	(16,181)	(40.1%)
12,164	39,323	27,159	69.1%	13,042	878	6.7%	Other Expense	216,819	327,369	110,550	33.8%	208,468	(8,351)	(4.0%)
4,026	4,334	308	7.1%	3,716	(311)	(8.4%)	Insurance	28,992	34,672	5,680	16.4%	19,297	(9,694)	(50.2%)
2,396,345	2,294,497	(101,848)	(4.4%)	2,049,393	(346,952)	(16.9%)	Total Operational Expenses	18,316,494	18,682,922	366,428	2.0%	17,450,499	(865,995)	(5.0%)
78,659	**(174,305)**	**252,964**	**(145.1%)**	**464,625**	**(385,966)**	**(83.1%)**	**Net Performance before Depreciation & Overhead Allocations**	**(4,565,916)**	**(1,863,434)**	**(2,702,482)**	**145.0%**	**(5,086,626)**	**520,710**	**(10.2%)**

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Primary Care Clinics Statement of Revenues and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
31,525	17,334	(14,191)	(81.9%)	19,268	(12,257)	(63.6%)	Depreciation	253,308	138,672	(114,636)	(82.7%)	146,382	(106,926)	(73.0%)
							Overhead Allocations:							
3,330	2,875	(455)	(15.8%)	2,108	(1,222)	(58.0%)	Risk Mgt	23,221	22,999	(222)	(1.0%)	15,891	(7,330)	(46.1%)
227,981	206,967	(21,014)	(10.2%)	201,835	(26,146)	(13.0%)	Rev Cycle	1,585,122	1,655,737	70,615	4.3%	1,036,783	(548,339)	(52.9%)
2,099	3,852	1,753	45.5%	1,363	(736)	(54.0%)	Internal Audit	18,733	30,813	12,080	39.2%	39,369	20,636	52.4%
18,817	19,768	951	4.8%	18,504	(313)	(1.7%)	Home Office Facilities	139,673	158,148	18,475	11.7%	149,391	9,718	6.5%
41,444	33,232	(8,212)	(24.7%)	30,151	(11,293)	(37.5%)	Administration	303,607	265,856	(37,750)	(14.2%)	271,647	(31,960)	(11.8%)
64,825	47,193	(17,632)	(37.4%)	38,269	(26,556)	(69.4%)	Human Resources	411,875	377,546	(34,329)	(9.1%)	323,987	(87,888)	(27.1%)
11,084	17,241	6,157	35.7%	17,534	6,450	36.8%	Legal	147,919	137,931	(9,988)	(7.2%)	129,490	(18,429)	(14.2%)
8,395	8,048	(347)	(4.3%)	5,647	(2,748)	(48.7%)	Records	60,796	64,386	3,590	5.6%	53,784	(7,012)	(13.0%)
10,663	6,886	(3,777)	(54.9%)	5,293	(5,370)	(101.5%)	Compliance	43,236	55,088	11,851	21.5%	73,722	30,486	41.4%
7,980	7,007	(973)	(13.9%)	-	(7,980)	0.0%	Comm Engage Plan	54,522	56,055	1,533	2.7%	-	(54,522)	0.0%
71,882	82,884	11,001	13.3%	-	(71,882)	0.0%	IT Operations	588,494	663,068	74,574	11.2%	-	(588,494)	0.0%
7,647	8,445	798	9.5%	-	(7,647)	0.0%	IT Security	59,164	67,562	8,398	12.4%	-	(59,164)	0.0%
84,463	40,421	(44,042)	(109.0%)	-	(84,463)	0.0%	IT Applications	367,932	323,367	(44,565)	(13.8%)	-	(367,932)	0.0%
48,653	47,251	(1,402)	(3.0%)	-	(48,653)	0.0%	Security Services	361,352	378,011	16,659	4.4%	-	(361,352)	0.0%
141,685	121,543	(20,142)	(16.6%)	-	(141,685)	0.0%	IT EPIC	776,451	972,347	195,896	20.1%	-	(776,451)	0.0%
26,159	31,665	5,506	17.4%	33,940	7,782	22.9%	Finance	216,859	253,317	36,458	14.4%	265,107	48,249	18.2%
9,271	10,057	786	7.8%	9,596	325	3.4%	Public Relations	60,876	80,455	19,579	24.3%	80,472	19,596	24.4%
11,671	8,303	(3,368)	(40.6%)	121,853	110,182	90.4%	Information Technology	82,814	66,422	(16,392)	(24.7%)	740,131	657,316	88.8%
4,933	4,761	(172)	(3.6%)	2,185	(2,748)	(125.8%)	Corporate Quality	47,508	38,089	(9,419)	(24.7%)	14,310	(33,198)	(232.0%)
10,897	11,235	338	3.0%	10,238	(659)	(6.4%)	Project MGMT Office	74,545	89,882	15,336	17.1%	57,658	(16,887)	(29.3%)
-	1,328	1,328	100.0%	3,526	3,526	100.0%	Managed Care Contract	6,415	10,627	4,211	39.6%	21,886	15,471	70.7%
813,878	720,963	(92,915)	(12.9%)	502,041	(311,837)	(62.1%)	Total Overhead Allocations	5,431,114	5,767,706	336,592	5.8%	3,273,628	(2,157,485)	(65.9%)
3,241,748	**3,032,794**	**(208,954)**	**(6.9%)**	**2,570,702**	**(671,046)**	**(26.1%)**	**Total Expenses**	**24,000,915**	**24,589,300**	**588,385**	**2.4%**	**20,870,509**	**(3,130,406)**	**(15.0%)**
$ (766,744)	**$ (912,602)**	**$ 145,858**	**(16.0%)**	**$ (56,684)**	**$ (710,060)**	**1,252.7%**	**Net Margin**	**$ (10,250,337)**	**$ (7,769,812)**	**$ (2,480,526)**	**31.9%**	**$ (8,506,636)**	**$ (1,743,701)**	**20.5%**
-	59,125	59,125	100.0%	-	-	0.0%	**Capital**	-	712,210	712,210	100.0%	2,744	2,744	100.0%
$ 4,017,004	**$ 964,000**	**$ (3,053,004)**	**(316.7%)**	**$ 2,229,064**	**$ (1,787,940)**	**(80.2%)**	**General Fund Support/ Transfer In**	**$ 9,987,030**	**$ 8,508,000**	**$ (1,479,030)**	**(17.4%)**	**$ 10,554,646**	**$ 567,617**	**5.4%**

Primary Care Clinics Statement of Revenues and Expenses by Month

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Year to Date
Gross Patient Revenue	**1,842,091**	**1,535,619**	**1,685,042**	**1,321,289**	**1,595,963**	**1,870,757**	**2,230,803**	**2,066,863**	**-**	**-**	**-**	**-**	**14,148,428**
Contractual Allowances	509,972	470,624	453,962	303,580	404,818	543,358	562,148	464,663	-	-	-	-	3,713,125
Charity Care	158,009	-	1,751,178	434,796	538,927	530,618	809,796	782,187	-	-	-	-	5,005,511
Bad Debt	788,060	799,873	(860,761)	338,348	289,586	402,163	405,392	368,549	-	-	-	-	2,531,211
Other Patient Revenue	414,367	286,936	350,651	704,172	439,031	439,031	905,685	513,976	-	-	-	-	4,053,850
Net Patient Revenue	**800,416**	**552,056**	**691,315**	**948,737**	**801,664**	**833,649**	**1,359,153**	**965,440**	**-**	**-**	**-**	**-**	**6,952,430**
Collections %	43.45%	35.95%	41.03%	71.80%	50.23%	44.56%	60.93%	46.71%	0.00%	0.00%	0.00%	0.00%	49.14%
Grant Funds	104,059	-	130,321	2,271,653	(629,521)	974,299	1,566,400	1,488,547	-	-	-	-	5,905,757
Other Financial Assistance	-	-	588,890	-	179,158	5,710	27,883	19,439	-	-	-	-	821,081
Other Revenue	9,732	1,689	3,302	809	26,487	13,061	14,654	1,578	-	-	-	-	71,310
Total Other Revenues	113,791	1,689	722,512	2,272,462	(423,876)	993,070	1,608,937	1,509,564	-	-	-	-	6,798,148
Total Revenues	**914,207**	**553,745**	**1,413,827**	**3,221,199**	**377,788**	**1,826,719**	**2,968,090**	**2,475,004**	**-**	**-**	**-**	**-**	**13,750,578**
Direct Operational Expenses:													
Salaries and Wages	1,612,557	1,177,306	1,310,859	1,482,538	1,423,741	1,551,730	1,629,754	1,480,781	-	-	-	-	11,669,264
Benefits	394,482	358,883	404,282	407,085	420,732	406,226	427,189	429,489	-	-	-	-	3,248,367
Purchased Services	35,150	59,503	33,586	71,484	37,746	151,018	248,133	165,470	-	-	-	-	802,091
Medical Supplies	19,841	24,253	46,148	84,529	35,626	41,196	28,620	27,504	-	-	-	-	307,717
Other Supplies	2,686	4,538	8,638	12,332	32,280	4,195	13,176	25,786	-	-	-	-	103,632
Medical Services	92,709	55,338	56,152	45,535	47,251	80,848	55,468	61,653	-	-	-	-	494,954
Drugs	82,365	73,242	60,219	55,947	59,708	49,636	62,547	51,857	-	-	-	-	495,520
Repairs & Maintenance	6,725	4,061	3,703	7,491	3,518	6,010	14,332	5,264	-	-	-	-	51,105
Lease & Rental	105,605	104,935	96,815	102,475	102,093	106,287	97,843	125,417	-	-	-	-	841,471
Utilities	5,024	10,320	7,438	6,515	6,285	6,819	7,229	6,933	-	-	-	-	56,563
Other Expense	26,726	23,914	19,350	30,184	26,817	25,554	52,110	12,164	-	-	-	-	216,819
Insurance	3,716	3,716	2,892	4,649	3,331	3,331	3,331	4,026	-	-	-	-	28,992
Total Operational Expenses	2,387,586	1,900,008	2,050,081	2,310,763	2,199,128	2,432,851	2,639,732	2,396,345	-	-	-	-	18,316,494
Net Performance before Depreciation & Overhead Allocations	**(1,473,379)**	**(1,346,263)**	**(636,254)**	**910,436**	**(1,821,340)**	**(606,132)**	**328,358**	**78,659**	**-**	**-**	**-**	**-**	**(4,565,916)**
Depreciation	20,995	42,335	31,665	31,896	31,706	31,593	31,592	31,525	-	-	-	-	253,308
Overhead Allocations:													
Risk Mgt	2,012	1,749	1,914	1,899	1,713	4,413	6,192	3,330	-	-	-	-	23,221
Rev Cycle	215,318	177,247	193,553	191,807	169,849	197,221	212,145	227,981	-	-	-	-	1,585,122
Internal Audit	261	2,616	2,029	2,200	1,135	1,246	7,147	2,099	-	-	-	-	18,733
Home Office Facilities	17,338	17,140	20,876	18,248	17,620	20,104	9,531	18,817	-	-	-	-	139,673
Administration	23,989	26,119	37,026	49,639	36,008	44,102	45,279	41,444	-	-	-	-	303,607
Human Resources	42,681	36,896	77,803	48,416	60,805	77,147	3,301	64,825	-	-	-	-	411,875
Legal	10,774	17,493	15,799	13,841	14,400	25,673	38,855	11,084	-	-	-	-	147,919
Records	7,126	7,518	8,070	7,478	6,020	8,062	8,127	8,395	-	-	-	-	60,796
Compliance	4,813	5,086	3,125	8,017	5,183	8,271	(1,922)	10,663	-	-	-	-	43,236
Comm Engage Plan	6,756	6,116	6,940	6,621	6,060	6,624	7,424	7,980	-	-	-	-	54,522
IT Operations	50,805	70,691	70,850	96,616	74,267	109,310	44,072	71,882	-	-	-	-	588,494
IT Security	7,989	5,317	9,366	7,739	6,244	7,634	7,228	7,647	-	-	-	-	59,164
IT Applications	23,045	40,862	27,197	44,176	20,639	34,133	93,419	84,463	-	-	-	-	367,932
Security Services	42,428	41,825	46,136	46,399	42,607	47,158	46,146	48,653	-	-	-	-	361,352
IT EPIC	48,185	53,582	65,588	81,914	67,894	180,108	137,495	141,685	-	-	-	-	776,451
Finance	29,725	28,440	28,580	29,666	24,493	25,741	24,055	26,159	-	-	-	-	216,859
Public Relations	11,466	8,342	3,617	5,257	7,654	9,625	5,644	9,271	-	-	-	-	60,876
Information Technology	9,827	8,743	9,357	10,810	11,233	10,196	10,978	11,671	-	-	-	-	82,814
Corporate Quality	5,104	7,241	4,957	5,242	5,965	6,203	7,863	4,933	-	-	-	-	47,508
Project MGMT Office	7,800	8,679	9,051	9,313	8,472	9,555	10,778	10,897	-	-	-	-	74,545
Managed Care Contract	1,205	1,157	1,243	1,204	1,096	508	3	-	-	-	-	-	6,415
Total Overhead Allocations	568,646	572,859	643,078	686,500	589,359	833,035	723,759	813,878	-	-	-	-	5,431,114
Total Expenses	**2,977,227**	**2,515,202**	**2,724,824**	**3,029,159**	**2,820,193**	**3,297,479**	**3,395,083**	**3,241,748**	**-**	**-**	**-**	**-**	**24,000,915**
Net Margin	**$ (2,063,020)**	**$ (1,961,457)**	**$ (1,310,997)**	**$ 192,040**	**$ (2,442,405)**	**$ (1,470,760)**	**$ (426,994)**	**$ (766,744)**	**$ -**	**$ -**	**$ -**	**$ -**	**$ (10,250,337)**
Capital	-	13,568	3,078	(16,646)	-	-	-	-	-	-	-	-	-
Capital Contributions	-	-	-	-	-	-	-	-	-	-	-	-	-
General Fund Support/ Transfer In	2,042,025	-	3,228,001	-	700,000	-	-	4,017,004	-	-	-	-	$ 9,987,030

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Primary Care Clinics - Medical Statement of Revenues and Expenses by Location

FOR THE EIGHT MONTH ENDED MAY 31, 2021

	Clinic Administration	West Palm Beach Clinic	Lantana Clinic	Delray Clinic	Belle Glade Clinic	Lewis Center	Lake Worth Clinic	Jupiter Clinic	West Boca Clinic	Subxone Clinic	Mobile Van 1	Mobile Van Scout	Mobile Van Hero	Total
Gross Patient Revenue	-	1,464,952	2,318,566	1,172,583	857,737	1,087,820	1,690,931	757,020	1,080,614	729,581	7,568	-	-	**11,167,372.80**
Contractual Allowances	-	416,627	610,810	239,550	175,004	157,265	429,097	209,616	425,925	138,239	(25,349)	-	-	2,776,781
Charity Care	-	479,078	726,189	408,471	231,350	441,828	710,189	224,266	201,922	258,062	4,024	-	-	3,685,380
Bad Debt	-	290,059	351,603	221,855	192,383	411,290	142,321	89,913	78,362	349,874	16,784	-	-	2,144,445
Total Contractual Allowances and Bad Debt	-	1,185,763	1,688,602	869,876	598,737	1,010,383	1,281,606	523,795	706,209	746,175	(4,540)	-	-	8,606,606
Other Patient Revenue	-	544,934	585,171	349,981	189,509	260,300	341,970	139,473	188,200	179,088	57,127	-	-	2,835,754
Net Patient Revenue	**-**	**824,123**	**1,215,135**	**652,688**	**448,509**	**337,737**	**751,295**	**372,698**	**562,605**	**162,494**	**69,236**	**-**	**-**	**5,396,520**
Collection %	0.00%	56.26%	52.41%	55.66%	52.29%	31.05%	44.43%	49.23%	52.06%	22.27%	914.87%	0.00%	0.00%	48.32%
Grant Funds	1,646,865	507,309	680,810	331,688	334,100	141,698	472,402	212,714	212,854	396,540	110,105	12,068	23,129	5,082,282
Other Financial Assistance	349,232	3,629	132,235	763	(6,990)	6,530	(24,746)	12,267	(4,079)	(23,024)	31,226	131,246	138,433	746,722
Other Revenue	9,382	10,809	7,038	12,141	11,397	58	6,687	3,236	10,534	13	-	15	-	71,310
Total Other Revenues	2,005,479	521,747	820,082	344,592	338,506	148,285	454,344	228,217	219,309	373,530	141,332	143,329	161,562	5,900,314
Total Revenues	**2,005,479**	**1,345,870**	**2,035,217**	**997,280**	**787,016**	**486,022**	**1,205,638**	**600,915**	**781,914**	**536,023**	**210,567**	**143,329**	**161,562**	**11,296,834**
Direct Operational Expenses:														
Salaries and Wages	2,705,657	1,124,667	1,436,197	744,273	646,419	282,498	1,138,627	445,034	467,802	625,659	185,391	34,064	19,144	9,855,433
Benefits	698,411	316,440	401,314	215,244	190,437	80,526	333,933	117,703	137,983	176,255	65,120	7,176	6,059	2,746,602
Purchased Services	511,730	28,941	68,364	25,240	32,263	11,266	38,629	19,784	25,515	16,274	2,015	2,015	2,015	784,051
Medical Supplies	74,531	23,291	21,478	16,452	16,036	28,497	21,063	9,490	7,695	22,410	2,621	759	616	244,937
Other Supplies	46,709	1,737	12,941	10,834	3,340	2,519	2,577	5,996	2,858	6,350	1,177	2,218	2,678	101,935
Medical Services	24,050	55,154	110,085	54,851	37,027	21,187	97,134	31,354	50,390	13,723	-	-	-	494,954
Drugs	-	223,055	148,059	63,613	39,272	-	11,125	1,747	6,752	586	1,302	-	-	495,511
Repairs & Maintenance	-	1,054	1,236	1,704	2,570	917	18,673	1,246	4,272	2,375	8,159	2,245	862	45,314
Lease & Rental	-	85,997	114,907	59,263	55,044	190	182,036	53,946	79,036	31,438	145	50	135	662,186
Utilities	-	2,972	2,775	898	13,493	1,559	8,297	5,388	4,306	3,214	-	-	-	42,902
Other Expense	96,319	12,206	22,516	7,521	4,808	3,932	14,604	3,248	6,900	7,440	4,127	3,782	1,103	188,505
Insurance	-	4,099	3,335	3,114	1,665	111	2,061	1,070	1,260	601	5,055	2,410	3,838	28,620
Total Operational Expenses	4,157,408	1,879,613	2,343,206	1,203,008	1,042,374	433,201	1,868,759	696,006	794,770	906,325	275,112	54,719	36,449	15,690,949
Net Performance before Depreciation & Overhead Allocations	**(2,151,929)**	**(533,743)**	**(307,988)**	**(205,727)**	**(255,358)**	**52,821**	**(663,120)**	**(95,091)**	**(12,856)**	**(370,302)**	**(64,545)**	**88,610**	**125,113**	**(4,394,115)**
Depreciation	4,028	9,539	9,942	1,198	45,724	217	2,961	1,828	3,197	1,228	50,000	9,256	55,684	194,803
Overhead Allocations:														
Risk Mgt	3,877	2,157	3,735	1,616	1,316	588	2,356	827	1,031	1,406	422	291	296	19,919
Rev Cycle	-	179,959	311,588	134,810	109,813	49,055	196,515	69,005	85,999	117,318	35,222	24,278	24,721	1,338,282
Internal Audit	3,128	1,740	3,013	1,304	1,062	474	1,900	667	832	1,134	341	235	239	16,069
Home Office Facilities	125,766	-	-	-	-	-	-	-	-	-	-	-	-	125,766
Administration	50,692	28,204	48,834	21,129	17,211	7,688	30,799	10,815	13,478	18,387	5,520	3,805	3,874	260,438
Human Resources	93,629	43,559	49,760	27,903	23,252	10,851	38,909	12,401	15,502	24,957	6,201	4,650	4,650	356,225
Legal	24,697	13,741	23,792	10,294	8,385	3,746	15,006	5,269	6,567	8,958	2,690	1,854	1,888	126,887
Records	10,151	5,648	9,779	4,231	3,446	1,540	6,167	2,166	2,699	3,682	1,105	762	776	52,151
Compliance	7,219	4,017	6,954	3,009	2,451	1,095	4,386	1,540	1,919	2,618	786	542	552	37,089
Comm Engage Plan	9,103	5,065	8,770	3,794	3,091	1,381	5,531	1,942	2,420	3,302	991	683	696	46,769
IT Operations	98,259	54,670	94,658	40,954	33,360	14,902	59,700	20,963	26,126	35,640	10,700	7,376	7,510	504,818
IT Security	9,878	5,496	9,516	4,117	3,354	1,498	6,002	2,108	2,627	3,583	1,076	742	755	50,752
IT Applications	61,432	34,180	59,181	25,605	20,857	9,317	37,325	13,106	16,334	22,283	6,690	4,611	4,695	315,617
Security Services	14,196	39,413	68,241	29,525	24,050	10,743	43,039	15,113	18,834	25,694	7,714	5,317	5,414	307,292
IT EPIC	129,641	72,131	124,890	54,035	44,015	19,662	78,767	27,659	34,470	47,023	14,118	9,731	9,909	666,050
Finance	36,208	20,146	34,881	15,092	12,293	5,491	21,999	7,725	9,627	13,133	3,943	2,718	2,767	186,024
Public Relations	10,164	5,655	9,792	4,236	3,451	1,542	6,176	2,169	2,703	3,687	1,107	763	777	52,220
Information Technology	13,827	7,693	13,320	5,763	4,695	2,097	8,401	2,950	3,676	5,015	1,506	1,038	1,057	71,039
Corporate Quality	7,932	4,413	7,642	3,306	2,693	1,203	4,819	1,692	2,109	2,877	864	595	606	40,753
Project MGMT Office	12,447	6,925	11,990	5,188	4,226	1,888	7,562	2,655	3,309	4,515	1,355	934	951	63,946
Managed Care Contract	-	728	1,261	546	444	199	795	279	348	475	143	98	100	5,416
Total Overhead Allocations	722,248	535,541	901,599	396,456	323,465	144,960	576,154	201,051	250,610	345,688	102,493	71,024	72,234	4,643,523
Total Expenses	**4,883,683**	**2,424,693**	**3,254,747**	**1,600,662**	**1,411,562**	**578,378**	**2,447,874**	**898,886**	**1,048,577**	**1,253,241**	**427,605**	**134,999**	**164,367**	**20,529,274**
Net Margin	**$ (2,878,204)**	**$ (1,078,823)**	**$ (1,219,530)**	**$ (603,381)**	**$ (624,546)**	**$ (92,355)**	**$ (1,242,236)**	**$ (297,971)**	**$ (266,662)**	**$ (717,218)**	**$ (217,037)**	**$ 8,329**	**$ (2,806)**	**$ (9,232,440)**
Capital	-	-	-	-	-	-	-	-	-	-	-	-	-	-
General Fund Support/ Transfer In	**$ 9,025,566**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 9,025,566**

Primary Care Clinics- Medical Statement of Revenue and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
1,336,361	**975,918**	**360,443**	**36.9%**	**352,125**	**984,236**	**279.5%**	**Gross Patient Revenue**	**11,167,373**	**7,632,066**	**3,535,307**	**46.3%**	**9,832,867**	**1,334,506**	**13.6%**
252,945	178,183	(74,762)	(42.0%)	102,234	(150,712)	(147.4%)	Contractual Allowances	2,776,781	1,410,793	(1,365,988)	(96.8%)	1,813,245	(963,536)	(53.1%)
452,938	329,519	(123,419)	(37.5%)	65,611	(387,328)	(590.3%)	Charity Care	3,685,380	2,589,703	(1,095,677)	(42.3%)	3,305,227	(380,153)	(11.5%)
271,682	155,581	(116,101)	(74.6%)	117,319	(154,363)	(131.6%)	Bad Debt	2,144,445	1,239,065	(905,380)	(73.1%)	1,666,518	(477,927)	(28.7%)
977,566	663,283	(314,283)	(47.4%)	285,164	(692,402)	(242.8%)	Total Contractuals and Bad Debts	8,606,606	5,239,561	(3,367,045)	(64.3%)	6,784,990	(1,821,617)	(26.8%)
343,305	281,769	61,536	21.8%	549,155	(205,849)	(37.5%)	Other Patient Revenue	2,835,754	2,189,601	646,153	29.5%	2,291,617	544,137	23.7%
702,101	**594,404**	**107,697**	**18.1%**	**616,116**	**85,985**	**14.0%**	**Net Patient Revenue**	**5,396,520**	**4,582,106**	**814,414**	**17.8%**	**5,339,494**	**57,026**	**1.1%**
52.54%	60.91%			174.97%			Collection %	48.32%	60.04%			54.30%		
1,331,048	968,404	362,644	37.4%	759,855	571,193	75.2%	Grant Funds	5,082,282	5,095,355	(13,073)	(0.3%)	3,872,596	1,209,686	31.2%
19,349	145,876	(126,527)	(86.7%)	700,870	(681,521)	(97.2%)	Other Financial Assistance	746,722	4,457,960	(3,711,238)	(83.2%)	700,870	45,852	6.5%
1,578	45,034	(43,456)	(96.5%)	5,564	(3,986)	(71.6%)	Other Revenue	71,310	360,272	(288,962)	(80.2%)	60,693	10,617	17.5%
1,351,975	1,159,314	192,661	16.6%	1,466,288	(114,313)	(7.8%)	Total Other Revenues	5,900,314	9,913,587	(4,013,273)	(40.5%)	4,634,158	1,266,155	27.3%
2,054,076	**1,753,718**	**300,358**	**17.1%**	**2,082,404**	**(28,329)**	**(1.4%)**	**Total Revenues**	**11,296,834**	**14,495,693**	**(3,198,859)**	**(22.1%)**	**9,973,652**	**1,323,182**	**13.3%**
							Direct Operational Expenses:							
1,257,215	1,179,875	(77,340)	(6.6%)	1,066,177	(191,038)	(17.9%)	Salaries and Wages	9,855,433	9,715,767	(139,666)	(1.4%)	9,046,245	(809,188)	(8.9%)
363,723	323,366	(40,357)	(12.5%)	362,007	(1,716)	(0.5%)	Benefits	2,746,602	2,619,127	(127,475)	(4.9%)	2,406,662	(339,940)	(14.1%)
163,278	43,496	(119,782)	(275.4%)	51,238	(112,040)	(218.7%)	Purchased Services	784,051	382,672	(401,379)	(104.9%)	556,591	(227,460)	(40.9%)
16,337	106,162	89,825	84.6%	8,013	(8,323)	(103.9%)	Medical Supplies	244,937	834,325	589,388	70.6%	154,647	(90,290)	(58.4%)
25,637	19,093	(6,544)	(34.3%)	1,259	(24,378)	(1,936.8%)	Other Supplies	101,935	152,744	50,809	33.3%	85,181	(16,754)	(19.7%)
61,653	81,658	20,005	24.5%	71,459	9,806	13.7%	Medical Services	494,954	641,757	146,803	22.9%	560,811	65,857	11.7%
51,857	58,914	7,057	12.0%	96,741	44,884	46.4%	Drugs	495,511	462,975	(32,536)	(7.0%)	678,384	182,873	27.0%
3,383	7,308	3,925	53.7%	13,783	10,400	75.5%	Repairs & Maintenance	45,314	58,464	13,150	22.5%	225,396	180,082	79.9%
102,987	105,943	2,956	2.8%	91,495	(11,492)	(12.6%)	Lease & Rental	662,186	787,081	124,895	15.9%	703,013	40,827	5.8%
5,034	6,008	974	16.2%	3,347	(1,687)	(50.4%)	Utilities	42,902	48,064	5,162	10.7%	32,194	(10,708)	(33.3%)
8,724	33,480	24,756	73.9%	11,938	3,214	26.9%	Other Expense	188,505	281,920	93,415	33.1%	187,182	(1,322)	(0.7%)
3,939	4,293	354	8.3%	3,675	(263)	(7.2%)	Insurance	28,620	34,344	5,724	16.7%	19,040	(9,580)	(50.3%)
2,063,765	1,969,596	(94,169)	(4.8%)	1,781,131	(282,634)	(15.9%)	Total Operational Expenses	15,690,949	16,019,240	328,291	2.0%	14,655,346	(1,035,602)	(7.1%)
(9,690)	**(215,878)**	**206,188**	**(95.5%)**	**301,273**	**(310,963)**	**(103.2%)**	**Net Performance before Depreciation & Overhead Allocations**	**(4,394,115)**	**(1,523,547)**	**(2,870,568)**	**188.4%**	**(4,681,694)**	**287,579**	**(6.1%)**

Primary Care Clinics- Medical Statement of Revenue and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
24,183	12,917	(11,266)	(87.2%)	14,083	(10,099)	(71.7%)	Depreciation	194,803	103,336	(91,467)	(88.5%)	108,087	(86,716)	(80.2%)
							Overhead Allocations:							
2,857	2,464	(393)	(15.9%)	1,734	(1,123)	(64.8%)	Risk Mgt	19,919	19,709	(210)	(1.1%)	13,069	(6,851)	(52.4%)
192,479	174,743	(17,736)	(10.1%)	163,952	(28,527)	(17.4%)	Rev Cycle	1,338,282	1,397,947	59,665	4.3%	842,185	(496,097)	(58.9%)
1,800	3,301	1,500	45.5%	1,121	(680)	(60.6%)	Internal Audit	16,069	26,405	10,336	39.1%	32,376	16,307	50.4%
16,943	17,713	770	4.3%	16,537	(406)	(2.5%)	Home Office Facilities	125,766	141,705	15,939	11.2%	133,514	7,747	5.8%
35,552	28,478	(7,073)	(24.8%)	24,796	(10,756)	(43.4%)	Administration	260,438	227,824	(32,614)	(14.3%)	223,397	(37,041)	(16.6%)
56,066	40,768	(15,298)	(37.5%)	31,328	(24,738)	(79.0%)	Human Resources	356,225	326,147	(30,077)	(9.2%)	265,225	(91,000)	(34.3%)
9,508	14,775	5,267	35.6%	14,420	4,912	34.1%	Legal	126,887	118,199	(8,687)	(7.3%)	106,490	(20,397)	(19.2%)
7,201	6,897	(304)	(4.4%)	4,644	(2,557)	(55.1%)	Records	52,151	55,175	3,024	5.5%	44,231	(7,920)	(17.9%)
9,147	5,901	(3,246)	(55.0%)	4,353	(4,794)	(110.1%)	Compliance	37,089	47,207	10,118	21.4%	60,628	23,539	38.8%
6,845	6,005	(841)	(14.0%)	-	(6,845)	0.0%	Comm Engage Plan	46,769	48,036	1,267	2.6%	-	(46,769)	0.0%
61,661	71,027	9,365	13.2%	-	(61,661)	0.0%	IT Operations	504,818	568,213	63,395	11.2%	-	(504,818)	0.0%
6,560	7,237	677	9.4%	-	(6,560)	0.0%	IT Security	50,752	57,897	7,146	12.3%	-	(50,752)	0.0%
72,453	34,638	(37,815)	(109.2%)	-	(72,453)	0.0%	IT Applications	315,617	277,108	(38,509)	(13.9%)	-	(315,617)	0.0%
41,375	40,184	(1,191)	(3.0%)	-	(41,375)	0.0%	Security Services	307,292	321,472	14,180	4.4%	-	(307,292)	0.0%
121,539	104,156	(17,383)	(16.7%)	-	(121,539)	0.0%	IT EPIC	666,050	833,248	167,198	20.1%	-	(666,050)	0.0%
22,439	27,135	4,696	17.3%	27,912	5,473	19.6%	Finance	186,024	217,078	31,054	14.3%	218,019	31,995	14.7%
7,953	8,618	666	7.7%	7,891	(61)	(0.8%)	Public Relations	52,220	68,946	16,726	24.3%	66,179	13,959	21.1%
10,012	7,115	(2,896)	(40.7%)	100,209	90,198	90.0%	Information Technology	71,039	56,920	(14,119)	(24.8%)	608,669	537,630	88.3%
4,231	4,080	(151)	(3.7%)	1,797	(2,435)	(135.5%)	Corporate Quality	40,753	32,640	(8,113)	(24.9%)	11,768	(28,985)	(246.3%)
9,348	9,628	280	2.9%	8,419	(928)	(11.0%)	Project MGMT Office	63,946	77,024	13,078	17.0%	47,417	(16,529)	(34.9%)
-	1,122	1,122	100.0%	2,864	2,864	100.0%	Managed Care Contract	5,416	8,972	3,556	39.6%	17,778	12,362	69.5%
695,969	615,984	(79,985)	(13.0%)	411,977	(283,992)	(68.9%)	Total Overhead Allocations	4,643,523	4,927,873	284,350	5.8%	2,690,946	(1,952,577)	(72.6%)
2,783,917	**2,598,497**	**(185,420)**	**(7.1%)**	**2,207,191**	**(576,726)**	**(26.1%)**	**Total Expenses**	**20,529,274**	**21,050,449**	**521,175**	**2.5%**	**17,454,379**	**(3,074,895)**	**(17.6%)**
$ (729,842)	**$ (844,779)**	**$ 114,938**	**(13.6%)**	**$ (124,787)**	**$ (605,055)**	**484.9%**	**Net Margin**	**$ (9,232,440)**	**$ (6,554,756)**	**$ (2,677,684)**	**40.9%**	**$ (7,480,727)**	**$ (1,751,714)**	**23.4%**
-	59,125	59,125	100.0%	-	-	0.0%	**Capital**	-	712,210	712,210	100.0%	2,744	2,744	100.0%
$ 4,168,663	**$ 900,000**	**$ (3,268,663)**	**(363.2%)**	**$ 1,907,728**	**$ (2,260,935)**	**(118.5%)**	**General Fund Support/ Transfer In**	**$ 9,025,566**	**$ 7,320,000**	**$ (1,705,566)**	**(23.3%)**	**$ 9,172,408**	**$ 146,842**	**1.6%**

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Primary Care Clinics- Dental Statement of Revenues and Expenses by Location

FOR THE EIGHT MONTH ENDED MAY 31, 2021

	Dental Clinic Administration	West Palm Beach Dental Clinic	Lantana Dental Clinic	Delray Dental Clinic	Belle Glade Dental Clinic	Total
Gross Patient Revenue	**-**	**1,159,478**	**1,299,253**	**326,914**	**195,409**	**2,981,055**
Contractual Allowances	-	296,612	518,055	43,285	78,392	936,344
Charity Care	-	651,744	417,532	189,407	61,448	1,320,131
Bad Debt	-	83,265	236,969	48,645	17,887	386,766
Total Contractual Allowances and Bad Debt	-	1,031,620	1,172,556	281,337	157,727	2,643,241
Other Patient Revenue	-	542,806	273,599	169,217	232,473	1,218,096
Net Patient Revenue	**-**	**670,665**	**400,297**	**214,794**	**270,155**	**1,555,910**
Collection %	-	57.84%	30.81%	65.70%	138.25%	52.19%
Grant Funds	79,191	312,943	172,138	190,089	69,114	823,475
Other Financial Assistance	(4,234)	62,714	(8,558)	11,420	13,018	74,359
Other Revenue	-	-	-	-	-	-
Total Other Revenues	74,957	375,657	163,580	201,509	82,132	897,834
Total Revenues	**74,957**	**1,046,321**	**563,876**	**416,303**	**352,287**	**2,453,744**
Direct Operational Expenses:						
Salaries and Wages	244,278	639,439	338,886	419,409	171,818	1,813,831
Benefits	62,655	183,190	92,234	112,053	51,634	501,766
Purchased Services	-	4,097	5,357	3,355	5,231	18,039
Medical Supplies	-	24,680	25,839	7,138	5,122	62,780
Other Supplies	294	595	530	209	69	1,697
Drugs	-	-	7	2	-	9
Repairs & Maintenance	-	1,215	1,178	1,701	1,697	5,791
Lease & Rental	-	73,533	43,527	40,815	21,410	179,285
Utilities	-	2,931	3,087	1,210	6,433	13,661
Other Expense	1,394	12,003	6,143	6,048	2,727	28,314
Insurance	-	-	-	-	372	372
Total Operational Expenses	308,621	941,683	516,788	591,940	266,513	2,625,545
Net Performance before Depreciation & Overhead Allocations	**(233,664)**	**104,638**	**47,089**	**(175,637)**	**85,773**	**(171,801)**
Depreciation	-	15,574	7,459	6,731	28,740	58,505
Overhead Allocations:						
Risk Mgt	343	1,160	736	716	347	3,302
Rev Cycle	-	96,790	61,385	59,749	28,916	246,840
Internal Audit	277	936	594	578	280	2,664
Home Office Facilities	13,907	-	-	-	-	13,907
Administration	4,482	15,170	9,621	9,364	4,532	43,169
Human Resources	4,650	20,772	11,626	13,951	4,650	55,650
Legal	2,184	7,391	4,687	4,562	2,208	21,032
Records	898	3,038	1,927	1,875	907	8,644
Compliance	638	2,160	1,370	1,334	645	6,148
Comm Engage Plan	805	2,724	1,728	1,682	814	7,752
IT Operations	8,688	29,404	18,648	18,151	8,784	83,676
IT Security	873	2,956	1,875	1,825	883	8,412
IT Applications	5,432	18,384	11,659	11,348	5,492	52,315
Security Services	-	21,198	13,444	13,086	6,333	54,060
IT EPIC	11,463	38,795	24,604	23,949	11,590	110,401
Finance	3,201	10,835	6,872	6,689	3,237	30,834
Public Relations	899	3,042	1,929	1,878	909	8,656
Information Technology	1,223	4,138	2,624	2,554	1,236	11,775
Corporate Quality	701	2,374	1,505	1,465	709	6,755
Project MGMT Office	1,100	3,725	2,362	2,299	1,113	10,599
Managed Care Contract	-	392	248	242	117	999
Total Overhead Allocations	61,763	285,382	179,446	177,298	83,702	787,590
Total Expenses	**370,384**	**1,242,640**	**703,692**	**775,969**	**378,955**	**3,471,640**
Net Margin	**$ (295,427)**	**$ (196,319)**	**$ (139,816)**	**$ (359,666)**	**$ (26,668)**	**$ (1,017,897)**
Capital	-	-	-	-	-	-
General Fund Support/ Transfer In	**$ 961,464**		**-**	**-**	**-**	**961,464**

Primary Care Clinics- Dental Statement of Revenues and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**		**Actual**	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**
730,502	**282,327**	**448,175**	**158.7%**	**51,653**	**678,849**	**1,314.2%**	**Gross Patient Revenue**	**2,981,055**	**2,199,717**	**781,338**	**35.5%**	**2,351,293**	**629,761**	**26.8%**
211,718	46,405	(165,313)	(356.2%)	12,738	(198,980)	(1,562.1%)	Contractual Allowances	936,344	360,026	(576,318)	(160.1%)	396,327	(540,016)	(136.3%)
329,249	161,787	(167,462)	(103.5%)	30,806	(298,443)	(968.8%)	Charity Care	1,320,131	1,264,041	(56,090)	(4.4%)	1,354,065	33,934	2.5%
96,867	18,173	(78,694)	(433.0%)	16,177	(80,690)	(498.8%)	Bad Debt	386,766	140,321	(246,445)	(175.6%)	142,149	(244,617)	(172.1%)
637,834	226,365	(411,469)	(181.8%)	59,721	(578,113)	(968.0%)	Total Contractuals and Bad Debts	2,643,241	1,764,388	(878,853)	(49.8%)	1,892,542	(750,699)	(39.7%)
170,671	101,909	68,762	67.5%	228,917	(58,246)	(25.4%)	Other Patient Revenue	1,218,096	800,676	417,420	52.1%	1,002,007	216,089	21.6%
263,339	**157,871**	**105,468**	**66.8%**	**220,849**	**42,490**	**19.2%**	**Net Patient Revenue**	**1,555,910**	**1,236,005**	**319,905**	**25.9%**	**1,460,758**	**95,152**	**6.5%**
36.05%	55.92%			427.56%			Collection %	52.19%	56.19%			62.13%		
157,499	208,603	(51,104)	(24.5%)	102,385	55,114	53.8%	Grant Funds	823,475	1,087,790	(264,315)	(24.3%)	821,083	2,392	0.3%
90	-	90	0.0%	108,379	(108,289)	(99.9%)	Other Financial Assistance	74,359	-	74,359	0.0%	108,379	(34,021)	(31.4%)
-	-	-	0.0%	-	-	0.0%	Other Revenue	-	-	-	0.0%	-	-	0.0%
157,589	208,603	(51,014)	(24.5%)	210,765	(53,175)	(25.2%)	Total Other Revenues	897,834	1,087,790	(189,956)	(17.5%)	929,462	(31,628)	(3.4%)
420,928	**366,474**	**54,454**	**14.9%**	**431,614**	**(10,685)**	**(2.5%)**	**Total Revenues**	**2,453,744**	**2,323,795**	**129,949**	**5.6%**	**2,390,220**	**63,523**	**2.7%**
							Direct Operational Expenses:							
223,566	214,697	(8,869)	(4.1%)	168,210	(55,356)	(32.9%)	Salaries and Wages	1,813,831	1,768,318	(45,513)	(2.6%)	1,840,519	26,688	1.5%
65,766	55,369	(10,397)	(18.8%)	62,259	(3,507)	(5.6%)	Benefits	501,766	449,274	(52,492)	(11.7%)	497,256	(4,509)	(0.9%)
2,192	3,258	1,066	32.7%	5,623	3,431	61.0%	Purchased Services	18,039	25,523	7,484	29.3%	73,937	55,897	75.6%
11,168	13,380	2,213	16.5%	2,078	(9,089)	(437.3%)	Medical Supplies	62,780	104,324	41,544	39.8%	116,733	53,953	46.2%
149	7,425	7,276	98.0%	(45)	(195)	429.7%	Other Supplies	1,697	59,500	57,803	97.1%	6,874	5,177	75.3%
-	-	-	0.0%	-	-	0.0%	Medical Services	-	-	-	0.0%	-	-	0.0%
-	68	68	100.0%	-	-	0.0%	Drugs	9	532	523	98.3%	150	141	93.9%
1,881	2,321	440	19.0%	2,883	1,002	34.7%	Repairs & Maintenance	5,791	18,568	12,777	68.8%	28,483	22,692	79.7%
22,430	21,166	(1,264)	(6.0%)	24,849	2,419	9.7%	Lease & Rental	179,285	181,202	1,917	1.1%	201,472	22,187	11.0%
1,899	1,333	(566)	(42.5%)	1,261	(639)	(50.7%)	Utilities	13,661	10,664	(2,997)	(28.1%)	8,187	(5,474)	(66.9%)
3,440	5,843	2,403	41.1%	1,104	(2,336)	(211.6%)	Other Expense	28,314	45,449	17,135	37.7%	21,285	(7,029)	(33.0%)
88	41	(47)	(113.8%)	41	(47)	(115.8%)	Insurance	372	328	(44)	(13.4%)	257	(115)	(44.5%)
332,580	324,901	(7,679)	(2.4%)	268,262	(64,318)	(24.0%)	Total Operational Expenses	2,625,545	2,663,682	38,137	1.4%	2,795,153	169,607	6.1%
88,349	**41,573**	**46,776**	**112.5%**	**163,352**	**(75,003)**	**(45.9%)**	**Net Performance before Depreciation & Overhead Allocations**	**(171,801)**	**(339,887)**	**168,086**	**(49.5%)**	**(404,932)**	**233,131**	**(57.6%)**

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Primary Care Clinics- Dental Statement of Revenues and Expenses

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**		**Actual**	**Budget**	**Variance**	**%**	**Prior Year**	**Variance**	**%**
7,342	4,417	(2,925)	(66.2%)	5,185	(2,157)	(41.6%)	Depreciation	58,505	35,336	(23,169)	(65.6%)	38,295	(20,210)	(52.8%)
							Overhead Allocations:							
473	411	(62)	(15.1%)	374	(99)	(26.4%)	Risk Mgt	3,302	3,290	(12)	(0.4%)	2,823	(479)	(17.0%)
35,502	32,224	(3,278)	(10.2%)	37,883	2,381	6.3%	Rev Cycle	246,840	257,790	10,950	4.2%	194,598	(52,242)	(26.8%)
298	551	253	45.8%	242	(56)	(23.3%)	Internal Audit	2,664	4,408	1,744	39.6%	6,993	4,329	61.9%
1,874	2,055	182	8.8%	1,967	93	4.7%	Home Office Facilities	13,907	16,442	2,536	15.4%	15,877	1,970	12.4%
5,893	4,754	(1,139)	(24.0%)	5,355	(537)	(10.0%)	Administration	43,169	38,032	(5,137)	(13.5%)	48,250	5,081	10.5%
8,759	6,425	(2,334)	(36.3%)	6,941	(1,818)	(26.2%)	Human Resources	55,650	51,399	(4,251)	(8.3%)	58,762	3,111	5.3%
1,576	2,466	890	36.1%	3,114	1,538	49.4%	Legal	21,032	19,732	(1,300)	(6.6%)	23,000	1,968	8.6%
1,194	1,151	(42)	(3.7%)	1,003	(191)	(19.0%)	Records	8,644	9,211	566	6.1%	9,553	909	9.5%
1,516	985	(531)	(53.9%)	940	(576)	(61.3%)	Compliance	6,148	7,880	1,733	22.0%	13,094	6,947	53.1%
1,135	1,002	(132)	(13.2%)	-	(1,135)	0.0%	Comm Engage Plan	7,752	8,019	267	3.3%	-	(7,752)	0.0%
10,221	11,857	1,636	13.8%	-	(10,221)	0.0%	IT Operations	83,676	94,855	11,179	11.8%	-	(83,676)	0.0%
1,087	1,208	121	10.0%	-	(1,087)	0.0%	IT Security	8,412	9,665	1,253	13.0%	-	(8,412)	0.0%
12,009	5,782	(6,227)	(107.7%)	-	(12,009)	0.0%	IT Applications	52,315	46,259	(6,056)	(13.1%)	-	(52,315)	0.0%
7,279	7,067	(211)	(3.0%)	-	(7,279)	0.0%	Security Services	54,060	56,539	2,479	4.4%	-	(54,060)	0.0%
20,146	17,387	(2,758)	(15.9%)	-	(20,146)	0.0%	IT EPIC	110,401	139,099	28,698	20.6%	-	(110,401)	0.0%
3,719	4,530	810	17.9%	6,028	2,309	38.3%	Finance	30,834	36,238	5,404	14.9%	47,088	16,254	34.5%
1,318	1,439	121	8.4%	1,704	386	22.7%	Public Relations	8,656	11,509	2,854	24.8%	14,293	5,638	39.4%
1,659	1,188	(472)	(39.7%)	21,643	19,984	92.3%	Information Technology	11,775	9,502	(2,273)	(23.9%)	131,461	119,686	91.0%
701	681	(20)	(3.0%)	388	(313)	(80.8%)	Corporate Quality	6,755	5,449	(1,306)	(24.0%)	2,542	(4,213)	(165.8%)
1,549	1,607	58	3.6%	1,818	269	14.8%	Project MGMT Office	10,599	12,858	2,259	17.6%	10,241	(358)	(3.5%)
-	207	207	100.0%	662	662	100.0%	Managed Care Contract	999	1,654	655	39.6%	4,108	3,109	75.7%
117,909	104,979	(12,930)	(12.3%)	90,065	(27,845)	(30.9%)	Total Overhead Allocations	787,590	839,832	52,242	6.2%	582,682	(204,908)	(35.2%)
457,831	**434,297**	**(23,534)**	**(5.4%)**	**363,511**	**(94,320)**	**(25.9%)**	**Total Expenses**	**3,471,640**	**3,538,850**	**67,210**	**1.9%**	**3,416,130**	**(55,510)**	**(1.6%)**
$ (36,903)	**$ (67,823)**	**$ 30,920**	**(45.6%)**	**$ 68,103**	**$ (105,005)**	**(154.2%)**	**Net Margin**	**$ (1,017,897)**	**$ (1,215,055)**	**$ 197,158**	**(16.2%)**	**$ (1,025,910)**	**$ 8,013**	**(0.8%)**
$ (151,659)	**$ 64,000**	**$ 215,659**	**337.0%**	**$ -**	**$ 151,659**	**0.0%**	**General Fund Support/ Transfer In**	**$ 961,464**	**$ 1,188,000**	**$ 226,536**	**19.1%**	**$ 1,382,238**	**$ 420,774**	**30.4%**

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Clinic Visits - Adults and Pediatrics	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Current Year Total	Current YTD Budget	%Var to Budget	Prior Year Total
West Palm Beach	1,227	929	1,068	836	879	1,119	1,138	1,007					8,203	4,531	81.0%	9,702
Delray	1,061	883	989	776	582	723	600	541					6,155	4,962	24.0%	6,191
Lantana	1,738	1,282	1,379	1,374	1,480	1,638	1,799	1,695					12,385	12,667	(2.2%)	11,190
Belle Glade	616	395	661	451	555	656	622	566					4,522	3,374	34.0%	4,782
Lewis Center	786	695	807	662	696	685	584	541					5,456	1,289	323.3%	1,440
Lake Worth & Women's Health Care	1,153	979	958	907	953	1,339	1,206	1,222					8,717	5,471	59.3%	8,232
Jupiter Clinic	602	407	468	450	527	656	501	415					4,026	2,950	36.5%	2,759
West Boca & Women's Health Care	786	679	730	641	666	798	741	637					5,678	3,214	76.7%	4,546
Mobile Van	16	-	-	1	-	-	-	-					17	98	(82.7%)	1,081
Mobile 2 Clinic	-	-	-	-	-	-	-	-					-	98	(100.0%)	
Mobile 3 Hero	-	-	-	-	-	-	-	-					-	98	(100.0%)	
Mangonia Park	259	203	198	224	261	447	508	523					2,623	897		732
Mangonia Park-Substance	-	-	-	-	-	-	-	-					-	1,187	(100.0%)	2,338
Total Clinic Visits	**8244**	**6,452**	**7,258**	**6,322**	**6,599**	**8,061**	**7,699**	**7,147**	**-**	**-**	**-**	**-**	**57,782**	**40,836**	**41.5%**	**52,993**
Dental Visits																
West Palm Beach	467	334	427	172	159	179	693	691					3,122	3,417	(8.6%)	4,824
Lantana	447	358	473	466	495	558	553	423					3,773	5,006	(24.6%)	3,009
Delray	-	-	-	-	-	-	306	480					786	2,418	(67.5%)	3,171
Belle Glade	-	-	-	2	-	-	201	270					473	1,298	(63.6%)	2,024
Total Dental Visits	**914**	**692**	**900**	**640**	**654**	**737**	**1,753**	**1,864**	**-**	**-**	**-**	**-**	**8,154**	**12,139**	**(32.8%)**	**13,028**
Total Medical and Dental Visits	**9158**	**7,144**	**8,158**	**6,962**	**7,253**	**8,798**	**9,452**	**9,011**	**-**	**-**	**-**	**-**	**65,936**	**52,975**	**24.5%**	**66,021**
Key Ratios																
Collection Ratio													16%			
Bad debt write off as a percentage of total billing													4%			
Collections per visit													28			
Charges Per Visit													173			
Percentage of A/R less than 120 days													72%			
Days in AR													55			
Mental Health Counselors (non-billable)																
West Palm Beach	-	2	-	1	-	-	-	-					3	563	(99.5%)	1,039
Delray	60	41	22	1	3	2	-	-					129	474	(72.8%)	569
Lantana	-	36	2	-	1	-	-	3					42	1,896	(97.8%)	3,317
Belle Glade	26	18	41	21	14	21	18	15					174	232	(25.0%)	582
Mangonia Park	458	205	225	214	205	311	441	387					2,446	832	194.0%	1,445
Lewis Center	308	381	544	678	709	838	729	625					4,812	813	491.9%	983
Lake Worth	12	-	1	-	-	-	-	-					13	598	(97.8%)	969
Jupiter	-	-	-	-	-	-	-	-					-	-	0.0%	1
West Boca	-	-	-	-	-	-	-	-					-	-	0.0%	10
Mobile Van	-	-	-	-	-	-	-	-					-	311	(100.0%)	362
Total Mental Health Screenings	**864**	**683**	**835**	**915**	**932**	**1,172**	**1,188**	**1,030**	**-**	**-**	**-**	**-**	**7,619**	**5,719**	**33.2%**	**9,277**

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SUPPLEMENTAL INFORMATION

MEDICAID MATCH FUND

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Medicaid Match Statement of Revenues and Expenditures

FOR THE EIGHT MONTH ENDED MAY 31, 2021

Current Month								Fiscal Year To Date						
Actual	Budget	Variance	%	Prior Year	Variance	%		Actual	Budget	Variance	%	Prior Year	Variance	%
$ -	$ -	$ -	0.0%	$ -	$ -	0.0%	Patient Revenue	$ -	$ -	$ -	0.0%	$ -	$ -	0.0%
491,667	491,666	1	0.0%	491,667	-	0.0%	PBC Interlocal	3,933,333	3,933,328	5	0.0%	3,933,333	-	0.0%
2	107	(105)	(98.2%)	31	(30)	(93.9%)	Other revenue	23	856	(834)	(97.4%)	966	(944)	(97.7%)
491,669	**491,773**	**(104)**	**(0.0%)**	**491,698**	**(30)**	**(0.0%)**	**Total Revenue**	**3,933,356**	**3,934,184**	**(828)**	**(0.0%)**	**3,934,300**	**(944)**	**(0.0%)**
							Direct Operational Expenses:							
-	-	-	0.0%	-	-	0.0%	Salaries and Wages	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Benefits	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Purchased Services	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Medical Supplies	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Other Supplies	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Contracted Physician Expense	-	-	-	0.0%	-	-	0.0%
-	-	-	-	-	-	0.0%	Medical Services	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Drugs	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Repairs & Maintenance	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Lease & Rental	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Utilities	-	-	-	0.0%	-	-	0.0%
1,449,573	1,449,573	(0)	(0.0%)	1,417,231	(32,343)	(2.3%)	Other Expense	11,596,588	11,596,584	(4)	(0.0%)	11,337,847	(258,740)	(2.3%)
-	-	-	0.0%	-	-	0.0%	Insurance	-	-	-	0.0%	-	-	0.0%
1,449,573	1,449,573	(0)	(0.0%)	1,417,231	(32,343)	(2.3%)	Total Operational Expenses	11,596,588	11,596,584	(4)	(0.0%)	11,337,847	(258,740)	(2.3%)
(957,905)	**(957,800)**	**(105)**	**0.0%**	**(925,533)**	**(32,372)**	**3.5%**	**Net Performance before Overhead Allocations**	**(7,663,232)**	**(7,662,400)**	**(832)**	**0.0%**	**(7,403,548)**	**(259,684)**	**3.5%**
							Overhead Allocations:							
-	-	-	0.0%	-	-	0.0%	Risk Mgt	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Rev Cycle	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Internal Audit	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Legislative Affairs	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Administration	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Human Resources	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Legal	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Records	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Compliance	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Finance	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Communications	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Information Technology	-	-	-	0.0%	-	-	0.0%
-	-	-	0.0%	-	-	0.0%	Total Overhead Allocations	-	-	-	0.0%	-	-	0.0%
1,449,573	**1,449,573**	**(0)**	**(0.0%)**	**1,417,231**	**(32,343)**	**(2.3%)**	**Total Expenses**	**11,596,588**	**11,596,584**	**(4)**	**(0.0%)**	**11,337,847**	**(258,740)**	**(2.3%)**
(957,905)	**(957,800)**	**(105)**	**0.0%**	**(925,533)**	**(32,372)**	**3.5%**	**Net Margin**	**(7,663,232)**	**(7,662,400)**	**(832)**	**0.0%**	**(7,403,548)**	**(259,684)**	**(3.5%)**
$ 957,905	**$ 957,800**	**$ 105**	**0.0%**	**$ 925,533**	**32,372**	**3.5%**	**Total Transfers In**	**$ 7,663,232**	**$ 7,662,400**	**$ 832**	**0.0%**	**$ 7,403,548**	**$ 259,684**	**3.5%**

Medicaid Match Statement of Revenues and Expenditures by Month

	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Year to Date
Patient Revenue	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PBC Interlocal	491,667	491,667	491,667	491,667	491,667	491,667	491,667	491,667	-	-	-	-	3,933,333
Other revenue	3	1	-	8	5	2	2	2	-	-	-	-	23
Total Revenue	**491,669**	**491,668**	**491,667**	**491,674**	**491,672**	**491,669**	**491,669**	**491,669**	**-**	**-**	**-**	**-**	**3,933,356**
Direct Operational Expenses:													
Salaries and Wages	-	-	-	-	-	-	-	-	-	-	-	-	-
Benefits	-	-	-	-	-	-	-	-	-	-	-	-	-
Purchased Services	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Supplies	-	-	-	-	-	-	-	-	-	-	-	-	-
Contracted Physician Expense	-	-	-	-	-	-	-	-	-	-	-	-	-
Medical Services	-	-	-	-	-	-	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-	-	-	-	-	-	-
Repairs & Maintenance	-	-	-	-	-	-	-	-	-	-	-	-	-
Lease & Rental	-	-	-	-	-	-	-	-	-	-	-	-	-
Utilities	-	-	-	-	-	-	-	-	-	-	-	-	-
Other Expense	1,449,573	1,449,573	1,449,573	1,449,573	1,449,573	1,449,573	1,449,573	1,449,573	-	-	-	-	11,596,587
Insurance	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Operational Expenses	1,449,573	1,449,573	1,449,573	1,449,573	1,449,573	1,449,573	1,449,573	1,449,573	-	-	-	-	11,596,587
Net Performance before Overhead Allocations	**(957,904)**	**(957,906)**	**(957,907)**	**(957,899)**	**(957,902)**	**(957,904)**	**(957,905)**	**(957,905)**	**-**	**-**	**-**	**-**	**(7,663,232)**
Overhead Allocations:													
Risk Mgt	-	-	-	-	-	-	-	-	-	-	-	-	-
Rev Cycle	-	-	-	-	-	-	-	-	-	-	-	-	-
Internal Audit**	-	-	-	-	-	-	-	-	-	-	-	-	-
Legislative Affairs	-	-	-	-	-	-	-	-	-	-	-	-	-
Administration**	-	-	-	-	-	-	-	-	-	-	-	-	-
Human Resources	-	-	-	-	-	-	-	-	-	-	-	-	-
Legal	-	-	-	-	-	-	-	-	-	-	-	-	-
Records	-	-	-	-	-	-	-	-	-	-	-	-	-
Compliance**	-	-	-	-	-	-	-	-	-	-	-	-	-
Finance	-	-	-	-	-	-	-	-	-	-	-	-	-
Communications	-	-	-	-	-	-	-	-	-	-	-	-	-
Information Technology	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Overhead Allocations	-	-	-	-	-	-	-	-	-	-	-	-	-
Total Expenses	**1,449,573**	**1,449,573**	**1,449,573**	**1,449,573**	**1,449,573**	**1,449,573**	**1,449,573**	**1,449,573**	**-**	**-**	**-**	**-**	**11,596,587**
Net Margin	**(957,904)**	**(957,906)**	**(957,907)**	**(957,899)**	**(957,902)**	**(957,904)**	**(957,905)**	**(957,905)**	**-**	**-**	**-**	**-**	**(7,663,232)**
Total Transfers In	**$ 957,904**	**$ 957,906**	**$ 957,907**	**$ 957,899**	**$ 957,902**	**$ 957,904**	**$ 957,905**	**$ 957,905**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 7,663,232**

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Medical Staff Appointment(s) for Lakeside Medical Center

2. Summary:

The agenda item represents the practitioner(s) recommended for Medical Staff appointment by the Medical Executive Committee of Lakeside Medical Center.

3. Substantive Analysis:

The practitioner(s) listed below satisfactorily completed the credentialing and privileging process and met the standards set forth within the approved Medical Staff Bylaws. The credentialing and privileging process ensures that all Medical Staff meet specific criteria and standards of professional qualifications; this criterion includes, but is not limited to:

- Current licensure
- Relevant education, training and experience
- Current clinical and professional competence
- Health fitness and ability to perform requested privileges
- Malpractice history and liability insurance coverage
- Immunization status; and
- Applicable life support training

Last Name	First Name	Degree	Specialty	Appointment	Privileges
Hechtman	Jill	MD	Obstetrics & Gynecology	Initial Appointment	Provisional
Lequerica Ziemba	Adriana	PsyD	Clinical Psychology	Initial Appointment	Provisional
Monroig	Miguel	MD	Anesthesiology	Initial Appointment	Provisional
Price	Martin	MD	Radiology	Initial Appointment	Provisional
Ramirez-Caban	Laura	MD	Obstetrics & Gynecology	Initial Appointment	Provisional
Kaufman	Stacy	CRNA	Certified Registered Nurse Anesthetist	Initial Appointment	Provisional Allied Health
Abraham	Mohan	MD	Nephrology	Reappointment	Active
Cosme	Yolanda	MD	Pediatrics	Reappointment	Active
Echavarria	Gonzalo	MD	Anesthesiology	Reappointment	Active
Gunawardene	Ishan	MD	Internal Medicine	Reappointment	Active
Henriquez	Israel	DO	Cardiology	Reappointment	Active
Ingui	Christian	MD	Radiology	Reappointment	Active
Ospina	Jose	MD	Radiology	Reappointment	Active

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

Ottino	Fernando	MD	Nephrology	Reappointment	Active
Plosker	Ari	MD	Radiology	Reappointment	Active
Prigg	Jennifer	DO	Obstetrics & Gynecology	Reappointment	Active
Sanches	Lisa	MD	Obstetrics & Gynecology	Reappointment	Active
Winterrowd	Samantha	MD	Obstetrics & Gynecology	Reappointment	Active

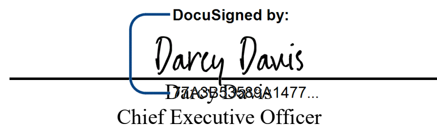
Primary source and secondary source verifications were performed for credentialing and privileging elements in accordance with regulatory requirements. A nationally accredited Credentials Verification Organization (CVO) was utilized to verify the elements requiring primary source verification.

Lakeside Medical Center utilized internal Credentialing staff and the Medical Executive Committee to support the credentialing and privileging process. The Medical Executive Committee is comprised of a multi-specialty panel of practitioners with current privileges at Lakeside Medical Center.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:



Darcy Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

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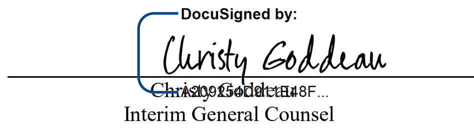
HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

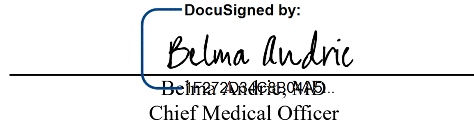
6. Recommendation:

Staff recommends the Board approve the Medical Staff Appointment(s) for Lakeside Medical Center.

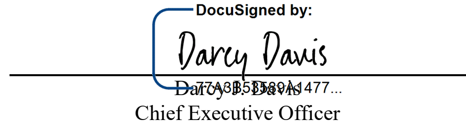
Approved for Legal sufficiency:



Christy Goddeau
Interim General Counsel



Belma Andric, MD
Chief Medical Officer



Darcy J. Davis
Chief Executive Officer

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Recredentialing and Privileging of Healey Center practitioner

2. Summary:

The below practitioner is recommended for approval by the Chief Medical Officer:

Last Name	First Name	Credentials	Specialty
Farber	Jeffrey	MD	Physical Medicine and Rehabilitation

3. Substantive Analysis:

The practitioner has satisfactorily completed the recredentialing and privileging process. The credentialing and privileging process ensures that all facility practitioners meet specific criteria and standards of professional qualifications. This criterion includes, but is not limited to:

- Current licensure
- Relevant education, training and experience
- Current clinical competence
- Health fitness, or ability to perform the requested privileges
- Malpractice history (NPDB query)

Primary source and secondary source verifications were performed for credentialing and privileging elements in accordance with state and federal requirements. A nationally accredited Credentials Verification Organization (CVO) was utilized to verify the elements requiring primary source verification.

The Healey Center utilized internal Credentialing staff and the Chief Medical Officer to support the credentialing and privileging process.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING June 29, 2021

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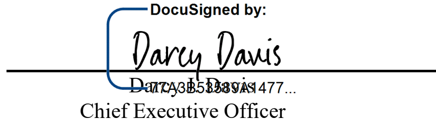


Darcy J. Davis
Chief Executive Officer

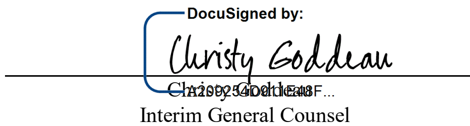
5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

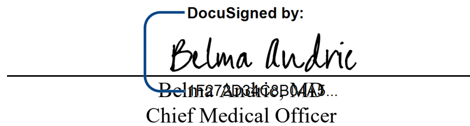
6. Recommendation:

As a result of this comprehensive review, staff recommends the Board approve the recredentialing and privileging of the Healey Center practitioner.

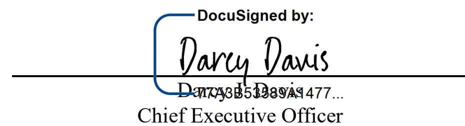
Approved for Legal sufficiency:



Christy Goddeau
Interim General Counsel



Belma Andric, MD
Chief Medical Officer



Darcy J. Davis
Chief Executive Officer

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Proclamation Recognizing the Trauma System's 30th Year

2. Summary:

For three decades, the Health Care District of Palm Beach County has played a key role in Palm Beach County's lifesaving Trauma System. The Health Care District's Board of Commissioners is asked to approve a proclamation that commemorates the 30th anniversary of Palm Beach County's Trauma System and recognizes the many dedicated professionals within the system who play vital roles to support the clinical coordination of patient care.

3. Substantive Analysis:

The Health Care District of Palm Beach County monitors the county's Trauma System from the moment a patient is traumatically injured through rehabilitation. Since May of 1991, when the first lifesaving mission took flight, the Palm Beach County Trauma System has cared for more than 87,000 patients. The Health Care District's Trauma Agency oversees trauma quality and conducts community outreach programs that provide education about injury prevention. The action requested from the Health Care District Board is the approval of Proclamation 2021P-01 to highlight the Trauma System's 30th anniversary that coincided with Trauma Awareness Month and recognize the many dedicated partners who provide continuity of care for traumatically injured residents and visitors.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A
Darcy J. Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

6. Recommendation:

Staff recommends the Board approve Proclamation 2021P-001.

Approved for Legal sufficiency:

DocuSigned by:
Christy Goddeau
Interim General Counsel

DocuSigned by:
Belma Andric, MD
Chief Medical Officer

DocuSigned by:
Darcy J. Davis
Chief Executive Officer

DocuSign Envelope ID: 03200E54-4E87-4969-A60D-D1BFA61AB7F1

PROCLAMATION 2021P-001

A PROCLAMATION OF THE HEALTH CARE DISTRICT BOARD OF COMMISSIONERS TO RECOGNIZE THE PALM BEACH COUNTY TRAUMA SYSTEM ON ITS 30TH YEAR AND COMMEND THE MANY DEDICATED PROFESSIONALS WHOSE WORK SAVES LIVES.

WHEREAS, the Palm Beach County Trauma System, which is monitored for quality by the Health Care District of Palm Beach County, has provided lifesaving, rapid-response care to residents and visitors who suffer serious traumatic injuries for 30 years; and

WHEREAS, the Trauma System treated more than 2,400 trauma patients last year and over 87,000 trauma patients since inception on May 1st, 1991; and

WHEREAS, trauma injury is the leading cause of death among Americans between 1 and 44 years old; and

WHEREAS, the integrated Trauma System provides access to specialized trauma services to seriously injured patients from the scene in Palm Beach County within an average of 20 minutes of injury; and

WHEREAS, rapid and safe transport, comprehensive and immediate treatment, and early rehabilitation of trauma patients reduce the physical, emotional, and financial costs of traumatic injuries; and

WHEREAS, the success of Palm Beach County's integrated emergency-response system is the result of close collaboration between dedicated partners who are committed to saving lives; and

WHEREAS, trauma physicians, specialists, nurses, and other staff at the two Level I Trauma Centers - St. Mary's Medical Center and Delray Medical Center - and their associated rehabilitation centers are dedicated to ensuring that trauma victims receive lifesaving care; and

WHEREAS, Palm Beach County Fire Rescue along with 11 other public and private EMS providers support the pre-hospital component of initial trauma care with dedicated nurses, paramedics, EMTs, 911 communications and dispatch staff, and emergency staff; and

WHEREAS, the Trauma Hawk aeromedical team conducted safe, expedited transfers of 462 trauma patients from the scene and between hospitals in 2020; and

WHEREAS, the staff of the Health Care District's Trauma Agency continuously monitors trauma quality and provides clinical coordination of the entire Trauma System; and

WHEREAS, the Trauma Agency staff conducts outreach programs – an integral part of the county's trauma system – that provide community education about injury prevention such as "Stop the Bleed", driver safety and preventing falls, which is a proven approach to reducing death and disability and saving lives; and

WHEREAS, the Palm Beach County Trauma System is a mature, integrated system that meets or exceeds Florida trauma regulations; and

WHEREAS, the American Trauma Society has declared May 2021 as National Trauma Awareness Month; and

WHEREAS, this year's theme, "Safe and Secure: Safety is a Choice, Prevention is Key" reflects life during the COVID-19 pandemic and the need to slow the spread of the virus to prevent illness and injury; and

NOW, THEREFORE, on this 29th day of June 2021, the HEALTH CARE DISTRICT OF PALM BEACH COUNTY Board of Commissioners, on behalf of the community, does hereby express its appreciation of the dedicated professionals who serve the Palm Beach County Trauma System.

Upon call of a vote, the Chair thereupon declared the proclamation duly passed and adopted on this 29th day of June 2021.

______________________________	______________________________
Leslie B. Daniels, *Chair*	Sean O'Bannon, S*ecretary*

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Proclamation Recognizing National Nurses Week 2021

2. Summary:

National Nurses Week is celebrated May 6th through May 12th. This year National School Nurse Day was celebrated on May 12th, 2021. The Health Care District's Board of Commissioners is asked to approve a proclamation that honors all of the dedicated nursing professionals in our safety net system who have served on the frontlines of the COVID-19 pandemic during this unprecedented time in healthcare.

3. Substantive Analysis:

The Health Care District employs nursing professionals who provide high-quality, safe and compassionate care in the following programs and facilities: Lakeside Medical Center, our acute care, rural teaching hospital in the Glades; the C. L. Brumback Primary Care Clinics; the School Health program, which cares for students from pre-kindergarten through 12th grade in nearly 200 public schools; the Edward J. Healey Rehabilitation and Nursing Center; the Trauma Agency; the Palm Beach County Trauma System; and administrative areas like Employee Health and Corporate Risk Management. The action requested from the Health Care District Board is the approval of Proclamation 2021P-002 to recognize all of the nursing professionals throughout our diverse public health care system for meeting the changing needs in the delivery of care for adults and children during the pandemic.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A
Darcy J. Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

N/A
Committee Name

N/A
Date Approved

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

6. Recommendation:

Staff recommends the Board approve Proclamation 2021P-002.

Approved for Legal sufficiency:

DocuSigned by:
Christy Goddeau
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Christy Goddeau
Interim General Counsel

DocuSigned by:
Steven Hurwitz
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Steven Hurwitz
Chief Administrative Officer

DocuSigned by:
Darcy Davis
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Darcy J. Davis
Chief Executive Officer

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PROCLAMATION 2021P-002

A PROCLAMATION OF THE HEALTH CARE DISTRICT BOARD OF COMMISSIONERS TO RECOGNIZE THE DEDICATED NURSES OF THE HEALTH CARE DISTRICT AND THEIR SAFE, QUALITY AND COMPASSIONATE CARE TO ADULTS AND CHILDREN IN PALM BEACH COUNTY DURING THE COVID-19 PANDEMIC.

WHEREAS, the mission of the Health Care District of Palm Beach County is to provide a health care safety net for Palm Beach County; and

WHEREAS, nurses play a critical role in delivering quality, safe and compassionate care in our system and protecting the health of the public during this unprecedented time of a global COVID-19 pandemic; and

WHEREAS, 182 Health Care District School Nurses provide care to students in nearly 200 public schools during the school year to keep pre-kindergarten through 12th graders healthy and ready to learn; and

WHEREAS, for the 2020-2021 school year, the School Nurses have followed strict protocols of infection control and social distancing for COVID-19 and since November 2020 have conducted over 70,000 COVID-19 screenings and 4,000 rapid COVID-19 tests for symptomatic students with consents; and

WHEREAS, the nursing staff at Lakeside Medical Center, the Health Care District's rural, teaching hospital in Belle Glade, cared for over 23,000 patients in Fiscal Year 2020, working additional hours and expanding their traditional roles in the fight against COVID-19; and

WHEREAS, Lakeside Medical Center's surgical services staff and OR nurses received the national, gold level "Go Clear Award" from the Association of periOperative Registered Nurses for ensuring operating room safety; and

WHEREAS, the nurses at the C. L. Brumback Primary Care Clinics provide primary care services to adult and pediatric patients who in 2020 made over 96,000 medical visits to the network of Federally Qualified Health Clinics; and

WHEREAS, in 2020 the nurses at the C. L. Brumback Primary Care Clinics supported the largest community-wide COVID-19 testing and mass vaccination operation in the county with over 212,000 vaccinations administered; and

WHEREAS, the nurses at the Edward J. Healey Rehabilitation and Nursing Center in Riviera Beach provide skilled nursing services to residents with traumatic injuries or who have debilitating illnesses requiring 24/7 care; and

WHEREAS, the nurses with the Health Care District's Employee Health department support the health and well-being of over 1,300 staff members and provided COVID-19 testing and vaccinations; and

WHEREAS, the nurses with the Health Care District's Trauma Agency, Corporate Risk Management Program and other administrative areas support the District's safety net health care mission; and

WHEREAS, Palm Beach County Fire Rescue's Critical Care Nurses with the Aeromedical team provide initial care on scene and in flight for patients transported by the Health Care District's two Trauma Hawk air ambulances; and

WHEREAS, the designated Trauma Resuscitation Nurses within the county's Trauma System attend to critically injured patients in the county's two Level I Trauma Centers, St. Mary's Medical Center and Delray Medical Center; and

WHEREAS, nurses provide a continuum of care to recovering trauma patients, from admission to discharge; and

WHEREAS, in 2021, National Nurses Week is celebrated from May 6th to May 12th and National School Nurse Day is celebrated on May 12th; and

NOW, THEREFORE, on this 29th day of June 2021, the HEALTH CARE DISTRICT OF PALM BEACH COUNTY Board of Commissioners, on behalf of the community, does express appreciation for the nurses in our safety net system.

Upon call of a vote, the Chair thereupon declared the proclamation duly passed and adopted on this 29th day of June 2021.

______________________________	______________________________
Leslie B. Daniels, *Chair*	Sean O'Bannon, S*ecretary*

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Lakeside Medical Center Confidential Public Records Request Quarterly Report

2. Summary:

Under the provisions of Florida Statute 395.3035(9)(a), staff shall report in writing to the governing board on the number of records for which a public records request has been made and the records have been declared to be confidential under the statute. The report is attached for Board information.

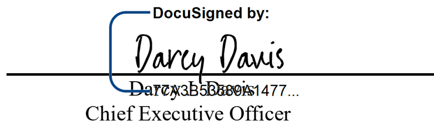
3. Substantive Analysis:

For each such record, the governing Board is provided with a general description of the record, the date on which the record became confidential, whether the public will have access to the record at a future time, and, if so, on what date the public will be granted access to such record. The report also includes each record that had been confidential to which the public has been granted access since the last report.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:



Darcy J. Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

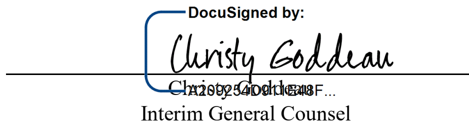
N/A	N/A
Committee Name	Date Approved

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

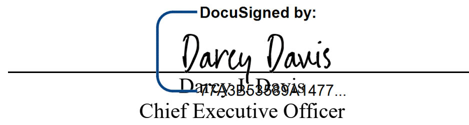
6. Recommendation:

Staff recommends the Board receive and file the attached Lakeside Medical Center Confidential Public Records Request Quarterly Report.

Approved for Legal sufficiency:



Christy Goddeau
Interim General Counsel



Darcy J. Davis
Chief Executive Officer

LAKESIDE MEDICAL CENTER

CONFIDENTIAL PUBLIC RECORDS REQUESTS

Timeframe	Record Description under Section 395.3035	Date Record Declared Confidential	Date Record Accessible to Public	Date Record Released to Public
OCT-DEC 2020	NO REQUESTS DECLARED CONFIDENTIAL	N/A	N/A	N/A
JAN-MAR 2021	NO REQUESTS DECLARED CONFIDENTIAL	N/A	N/A	N/A
APR-JUNE 2021				
JULY-SEPT 2021				

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Sponsored Programs CY2020 Dashboard

2. Summary:

During Calendar Year 2020, the District provided funding to 20 non-profit organizations through Sponsored Programs. This agenda item presents the Sponsored Programs CY2020 Dashboard.

3. Substantive Analysis:

As part of the District's efforts to fulfill its mission to be the health care safety-net for Palm Beach County, the Sponsored Programs funding initiative provides funding to organizations to provide health care services and services that address social determinants of health for uninsured, underinsured and vulnerable Palm Beach County residents.

For CY2020, the District contracted with 20 organizations for a maximum award of $1,265,000. The year-end reconciliation indicated a total expense for the contract period of $1,201,594. The contract period spanned an unusual year where we saw 4 organizations that did not meet their contract maximum due to the impact of COVID-19 while 6 organizations met their contract maximum early in the contract year.

Included with this agenda item is the Sponsored Programs Dashboard for calendar year 2020. Highlights from the Dashboard show that the District's funding supported over 21,000 patients/clients served and over 70,000 visits/services provided by our community partners during the contract period.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

N/A
Darcy J. Davis
Chief Executive Officer

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

6. Recommendation:

Staff recommends the Board receive and file the Sponsored Programs CY2020 Dashboard.

Approved for Legal sufficiency:

DocuSigned by:
Christy Goddeau
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Christy Goddeau
Interim General Counsel

DocuSigned by:
Thomas Cleare
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Thomas W. Cleare
Associate Vice President, Communication
Community Engagement, and Security

DocuSigned by:
Darcy Davis
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Darcy J. Davis
Chief Executive Officer

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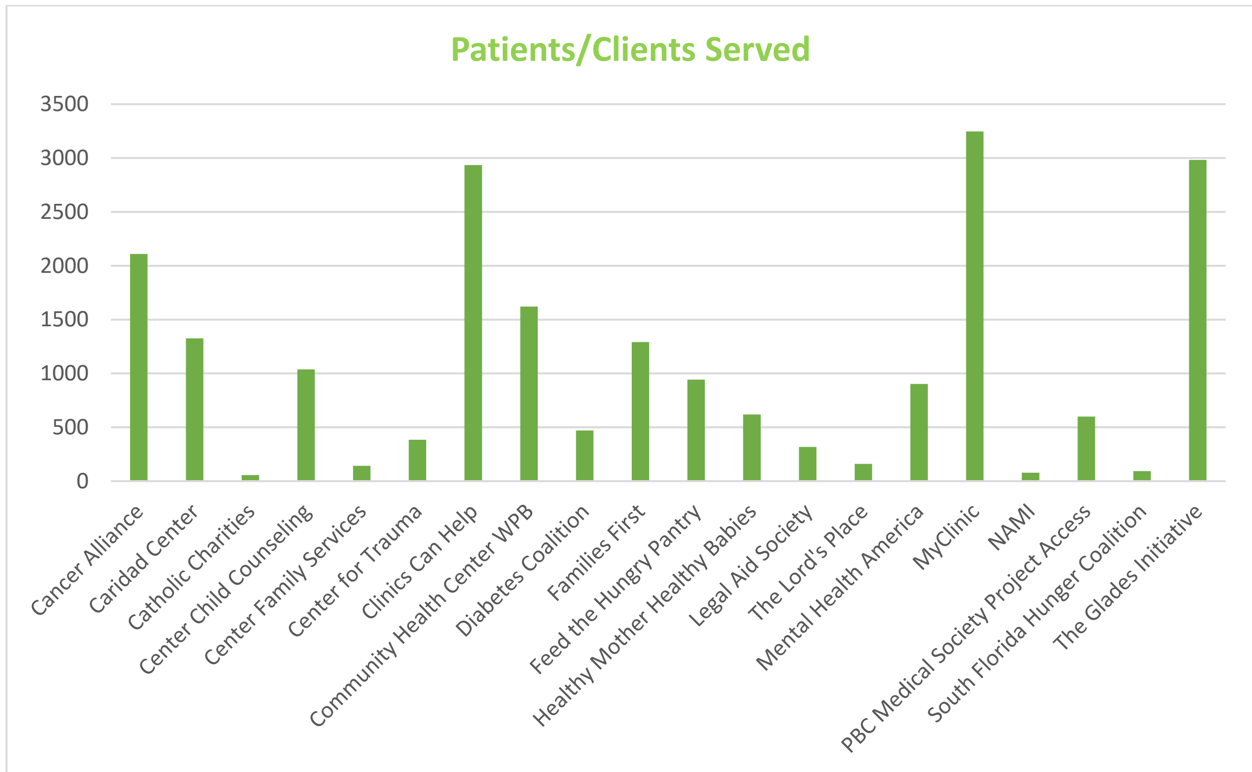
Sponsored Programs Dashboard

Calendar Year 2020

21,156 Patients/Clients Served	**70,741** Visits/Services Provided	**2,118** Individuals Trained in Mental Health First Aid / Prevention
85% % Behavioral Health Patients with Improved Function	**20** Funded Organizations	**52** Distinct Services



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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Internal Audit Charter

2. Summary:

The Health Care District of Palm Beach County (District) has drafted an Internal Audit Charter that outlines the mission, vision, structure, requirements and responsibilities of the Internal Audit function for the District.

3. Substantive Analysis:

The mission of the Internal Audit Department is to provide an independent, objective assurance and consulting function designed to add value and support the District's operations, utilizing a systematic, discipline approach to evaluate and improve the effectiveness of internal controls, through the use of risk assessment, and internal control governance processes.

The vision of Internal Audit is to be an agile and flexible resource, utilizing data analytics to continuously assess the risks associated with strategic objectives and business plans, reflecting development in the internal audit profession.

The charter outlines the details of the structure, requirements, and responsibilities of the department which will report administratively to the Chief Financial Officer and functionally to the Finance and Audit Committee of the Board of Commissioners.

Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

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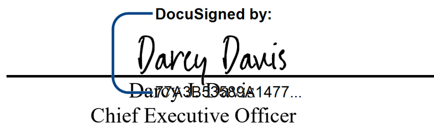


Darcy J. Davis
Chief Executive Officer

4. Reviewed/Approved by Committee:

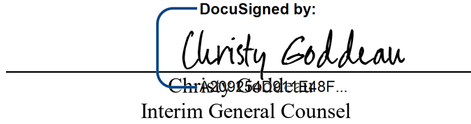
N/A	N/A
Committee Name	Date Approved

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

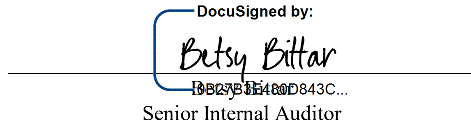
5. Recommendation:

Staff recommends the Board approve the Internal Audit Charter.

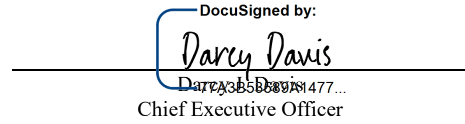
Approved for Legal sufficiency:



Interim General Counsel



Senior Internal Auditor



Chief Executive Officer

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DRAFT

Internal Audit Charter

Health Care District Palm Beach County

June 29, 2021

Health Care District of Palm Beach County
1515 N Flagler Drive, Suite 101
West Palm Beach, FL 33401
P: 561-659-1270 | www.hcdpbc.org

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Table of Contents: Draft Internal Audit Charter

Table of Contents: Draft Internal Audit Charter and Goals 2

I. Mission 3

II. Vision 3

III. Structure 3

IV. Requirements 3

V. Responsibilities 4

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I. Mission

The proposed Mission of the Health Care District of Palm Beach County Internal Audit Department is:

To provide an independent, objective assurance and consulting function designed to add value and support the Health Care District of Palm Beach County's operations, utilizing a systematic, disciplined approach to evaluate and improve the effectiveness of internal controls, through the use of risk assessment, and internal control governance processes.

II. Vision

The proposed Vision of the Health Care District of Palm Beach County Internal Audit Department is to:

1. Be agile and flexible to meet the needs of the District;
2. Be a resource to help to solve problems and offer support;
3. Embrace data analytics and other technologies to be able to continuously assess the risks associated with strategic objectives, business plans and related risks; and
4. Ensure that the model for Internal Audit continues to reflect development in internal audit profession.

III. Structure

1. Internal audit reports administratively to Chief Financial Officer (CFO) and functionally to the Finance and Audit committee of the Board of Commissioners.
2. The Internal Audit Lead will work with the CFO to manage the Finance and Audit Committee agenda with the Chair of the Finance and Audit Committee, and keep the committee informed and educated in emerging trends and successful practices in internal auditing.
3. The Internal Audit Lead will:
    a. Manage the day to day activities of the department, including the relationship with any co-sourced internal auditors.
    b. Manage any additional internal audit staff in ensuring that the department will achieve its goals.
4. The Internal Audit Lead will:
    a. Ensure that the Internal Audit staff maintains appropriate skills and ongoing professional education.
    b. Develop policies and procedures, and maintain the budget for the Internal Audit Department.
    c. Develop a Quality Assurance program for the Internal Audit Department , with an external review every 5 years.
    d. Chair Internal Control Committee.

IV. Requirements

1. Access: The Internal Auditors will be allowed full, free and unrestricted access to records, personnel and physical properties.
2. Independence: Internal Audit may consult with business units in the development and implementation of procedures, and preparation of records but will have no direct authority over, nor responsibility for these items. Internal Audit will not make management decisions or

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engage in any other activity, which could be reasonably construed to compromise their independence.

V. Responsibilities

1. Promote overall risk and controls awareness in the District.
2. Comply with Institute of Internal Auditors (IIA) Standards for the Professional Practice of Internal Auditing.
3. Monitor controls across the various business functions and service lines the District offers while focusing on:
   a. Effectiveness and efficiency of operations;
   b. Reliability of financial reporting; and
   c. Compliance with applicable laws and regulations.
4. Coordinate with other control and monitoring functions (risk management, compliance, security, legal, ethics, IT Security, external audit, and co-sourced internal auditor as needed).
5. Regularly evaluate existing controls and advise on efficient control improvements.
6. Report significant issues to Senior Leadership related to internal control matters, including potential improvements, and provide information concerning such issues through resolution.
8. Assist the Finance and Audit Committee of the Board of Commissioners in accomplishing the objectives of their Charter.
9. Perform a comprehensive annual risk assessment with District Management, from which an internal audit plan will be developed. Based on changing business circumstances, this plan will be continuously evaluated.
   Areas of focus for the annual risk assessment will include but not be limited to:
   a. Major changes in operations, organizational structure, programs, financial and information systems or controls;
   b. An evaluation of HCD Compliance with their policies and procedures and laws and regulations; and
   c. Areas of risk identified by management including potential fraud risk.

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Revisions to Purchasing Policy

2. Summary:

This item presents proposed revisions to the Purchasing Policy.

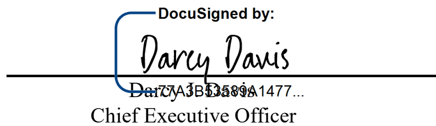
3. Substantive Analysis:

The policy was previously revised and approved by the Board on September 25, 2018. Attached for your review is the revised version of the policy showing the proposed changes.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:



Darcy Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

6. Recommendation:

Staff recommends the Board approve the revisions to the Purchasing Policy.

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

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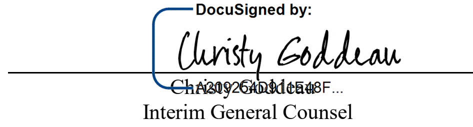
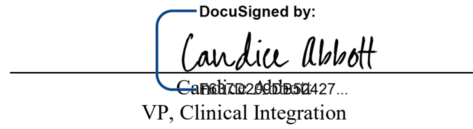
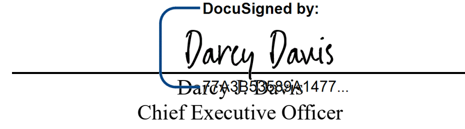


Christy Goddeau
Interim General Counsel



Candice Abbott
VP, Clinical Integration



Darcy J. Davis
Chief Executive Officer

Purchasing Policy

Policy #:	201410-PP	Effective Date:	9/25/2018
Business Unit:	HCD Shared Policies	Last Review Date:	~~02/2020~~
Approval Group:	HCD Finance Policy	Document Owner(s):	Finance
Board Approval Date:	~~03/11/2020~~		

PURPOSE

The District must ensure that quality goods and services are procured in a timely manner, at the most competitive costs. The purchasing policy provides for a consistent and systematic method of procuring goods and services required by the District and its affiliates. This policy defines the responsibilities and authority for purchases and ensures compliance with applicable State and Federal laws.

RESPONSIBILITY

The authority to obligate funds for the purchase of goods (including supplies, materials, finished goods, and equipment) or services is granted to the Chief Financial Officer, unless specifically reserved for the Chief Executive Officer or the District's Board under this policy. This policy applies to the Health Care District and all of its affiliates (collectively the "District" hereafter).

No expenditure is entirely exempt from this policy, however, certain procurements of goods and services, as enumerated below, may be exempted from the purchase requisition requirement. Non-budgeted expenditures in excess of $250,000 require Finance and Audit Committee review and Board approval.

Unless otherwise stated within this policy, all purchases require the submission and approval of a Purchase Requisition and will not be processed through other payment means (check request, payroll deduction, etc.)

POLICY

Exempt From Purchase Requisition Requirements

The goods and services listed below are exempt from the purchase requisition requirement:

- Institutional and professional medical claims payments on behalf of members, patients, and residents.
- Refunds to members, patients, and residents.
- Resident entertainment activity prizes (Healey Center only).
- Dues and memberships in trade and professional organizations (if being reimbursed through expense report or paid by corporate credit card).

- Legal settlements, fines, and penalties.
- Payroll ACH refunds.
- Postage (if being paid through petty cash or through the expense report process).
- Security coverage by individual local police officers if offered through a government agency.
- Travel Authorization expenses to be paid by the District in advance of travel to vendors, including registration fees, hotel costs, airline tickets, and/or train tickets.
- Reimbursement of travel expenses for interview candidates.
- Travel Authorization employee-paid expenses, includes meals, mileage, tolls, taxi, and other miscellaneous trip-related expenses.
- Payroll, court ordered payments, garnishments, payments of taxes, and other amounts withheld from employees pay, including employee reimbursements for mileage, dues, and tuition.
- Other employee reimbursements at the discretion of the Chief Financial Officer.
- Purchasing card purchases at the discretion of the Chief Financial Officer

Contract Requirement

Except where a standard District Purchase Order is authorized (see below), aAny request for goods or services must be accompanied by a fully executed agreement between the parties and must comply with all District legal policies and procedures, unless otherwise approved by HCD General Counsel and the Chief Financial Officer.

Purchase Orders

The District has established a Purchase Order which contains the District's standard contractual terms and conditions. In lieu of a contract, a standard District Purchase Order may be used for purchases of goods and/or services which meet the following requirements:

- The term of the purchase does not exceed one (1) year;
- The amount of the purchase(s) does not exceed $10,000;
- The purchase does not create substantial risk or exposure to the District (e.g., property damage, personal injury, or other risk to the District);
- The purchase does not include any construction services; and,
- The purchase is not defined as a capital asset.

If the Purchaser has questions about the use of a Purchase Order, the Purchaser should contact Purchasing and/or the General Counsel to discuss.

Competitive Bidding and Competitive Quotes

Except when otherwise required by law, aAny expenditure exceeding $5,000 requires the submission of two additional two (2)one competitive bidss or quotess ("bid" hereafter) in total and any expenditure exceeding $10,000 requires the submission of three (3) competitive wo bids in total and justification for selection if the lowest bid is not selected. For non-construction purchases, the Purchaser may opt to make a selection from bidsquotes received, solicit informal competitive bids or complete a formal Request for Proposal (RFP) process (RFP). Pursuant to sections 255.0525 and 255.20, Florida Statutes, unless exempted by law, cConstruction projects require public advertising and formal competitive bidding when the projected cost exceeds $32005,000 (or electrical work which will exceed $75,000) the competitive bid process must follow the requirements of Florida Statue 287.055.

BidsQuotes are not required for the following purchases:

- Utilities including but not limited to electric, water and sewer, natural gas, and telephone.
- Entertainers, artists, and performers.
- Advertisements for legal, promotional or informative matters.
- Costs for training and education, including speakers, events, and programs.
- Renewal of software maintenance where maintenance is provided by software manufacturer or developer.
- Subscriptions to periodicals, newspapers, and clinical databases.

- Services provided to or on behalf of individual members, patients, and residents that are not elsewhere described.
- Licensed health professionals who hold a medical directorship position, serve on a committee, provide services directly to members, patients, and residents whose payments are issued outside of the medical claims system.
- Contracts for goods and services between the District and other governmental entities or non-profit organizations, including PRIDE.
- Attorneys at law, court reporters, investigators, and expert witnesses having specialized skill, or knowledge in an area of legal practice.
- Sole source purchases (as described below).
- Emergency purchases (as described below).
- Cooperative and piggy-back purchases (*see* Purchasing Procedure for further information).
- Except as set forth below, professional services may be purchased without bids when the Purchaser and its applicable corporate officer approve the purchase of professional services from a vendor with distinct field of expertise. Such approval shall be stated on the contract memorandum in support of the purchase. Such purchases shall not exceed five (5) years in duration unless the Purchaser and its applicable corporate officer re-certify that the vendor still maintains a distinct field of expertise.

Bids are required for the purchase of all other pProfessional services and when required by law (e.g. Architectural, Engineering, Landscape Architectural, Surveying and Mapping services (*see* section 287.055, Florida Statutes); Design-Build projects (*see* section 287.055, Florida Statutes); and, financial auditing services (*see* Section 218.391, Florida Statutes).to be used on special projects not to) exceed 12 months.(This exception cannot be renewed and no contract may exceed 12 months)

Formal Competitive Bidding Process (RFP) and Right To Protest Procedure

All formal competitive solicitations for goods and services obtained through the RFP process shall be advertised and internal bid procedures shall be followed. RFPs for construction projects will comply with Florida Statute Chapter 255 Section 20.

Any actual bidder who is aggrieved in connection with a formal competitive bidding process the solicitation or pending award of a contract may timely protest the process and/or award. to the Chief Financial Officer. Protest procedures arewill be contained within the RFP document as posted on the Health Care District's website.

Local vendor preference

Except where limited by applicable law or grant award requirements, iIt is the District's intent to purchase from Palm Beach County approved vendors whenever possible. However, the intent to purchase locally is

constrained by the District's responsibility to ensure that maximum value is obtained for each public dollar spent. Bids ~~and quotations~~ received from all vendors will be evaluated based on price and quality.

Sole Source Purchases

The Chief Financial Officer may designate certain purchases to be justified sole source purchases, where the goods or services being procured are only available from a single supplier due to the specialized nature of the goods or services being provided, the need for compatible equipment or supplies, the relationship of the supplier to the original manufacturer, emergency conditions or the specific needs of the Health Care District.

Emergency Purchases

The Chief Financial Officer may make or authorize others to make emergency procurements when there exists a threat to public health, welfare, safety, property, or other substantial loss to the District. All emergency procurements shall be made with such competition as is practical under the circumstances, Emergency purchases shall require a purchase requisition and must be made in accordance with such terms as required by General Counsel

Compliance with Policy and Chief Financial Officer Discretion

- Purchases of goods or service (may not be split across multiple transactions, vendors, or procurement methods to circumvent established purchasing approval limits).
- The purchasing card program and employee reimbursement process should not be used to procure goods or services that would be subject to a competitive bidding process or could be acquired utilizing contracted pricing.
- Use of multiple procurement methods, e.g. purchase requisitions, purchasing card, etc. for a single purchase does not eliminate the competitive bidding requirement, if the total purchase would be subject to competitive bidding.
- In instances where the application of the policy is unclear and relates to procurements not exceeding $250,000, the Chief Financial Officer may exercise discretion in determining if there has been compliance with policy.

Development of Procedures

The Chief Financial Officer shall establish procedures, authorizations and forms as may be necessary to implement this policy.

EXCEPTIONS

N/A

RELATED DOCUMENTS

Related Policy Document(s)	Purchasing Procedure; P-Card Procedure; Sole Source Procedure; Contracts Procedure.
Related Forms	N/A
Reference(s)	201410-PP
Last Revision	~~2/20/2020~~

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Revision Information/Changes	~~Competitive Bidding and Competitive Quotes "when the projected cost exceeds $325,000 the competitive bid process must follow the requirements of Florida Statue 287.055"~~.
Next Review Date	N/A

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: RFQ for Pre-Qualified Architectural and Engineering firms

2. Summary:

The agenda item presents a pool of pre-qualified architectural and engineering firms for the design, cost estimating, architecture/engineering and related services required for the District and its affiliates. The intent is to select a pool of firms to provide the required services in this RFQ and award a three-year contract with qualified firms.

3. Committee Members:

- Terry L. Megiveron, Senior Project Manager EPMO
- Heather LaScala, Associate Project Manager EPMO
- Lee Newman, Project Manager, EPMO (Chairperson)
- Cindy Dupont, Associate VP, EPMO and School Health
- Robert Forchin, Senior Procurement Analyst / Non-Voting Member
- Raul Gutierrez, Supply Chain Manager / Non-Voting Member

4. Substantive Analysis:

An RFQ was issued on May 11, 2021 for design, construction documents, permitting and construction, supervision for structural and non- structural work, interior alterations of present spaces and to add new services, changing or adding equipment for the District and its affiliates. On June 17, 2021, the evaluation committee met to discuss the seven (7) proposals received. The committee agreed that a respondent most score a minimum of 60 points to qualify to the pool of vendors. The committee decided that Gallo Herbert Architects, Gurri Matute PA, Nelco Architecture, REG Architects, Inc, Robling Architecture, Saltz Michelson Architects, and Slattery & Associates meet the qualification criteria.

The proposals were evaluated based on the following criteria:

Qualification Evaluation Criteria:

- Evidence of capability, experience and skill
- Evidence of successful past performance for similar projects
- Evidence of adequate personnel to perform
- Completeness and responsiveness of Qualifications
- Terminations and/or litigation
- Evidence of required license(s) and certification(s)
- Evidence of small or minority business enterprise

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

5. Vendors:

Company Name	Combined Weighted Score
Gallo Herbert Architects	75
Gurri Matute PA	95
Nelco Architecture	90
REG Architects, Inc	90
Robling Architecture	90
Saltz Michelson Architects	89
Slattery & Associates	65

6. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

Darcy J. Davis
Chief Executive Officer

7. Reviewed/Approved by Committee:

N/A
Committee Name

N/A
Date Approved

8. Recommendation:

The evaluation team recommends the District Board approve Gallo Herbert Architects, Gurri Matute PA, Nelco Architecture, REG Architects, Inc, Robling Architecture, Saltz Michelson Architects, and Slattery & Associates as the pool of pre-qualified architectural and engineering firms for the design, cost estimating, architecture/engineering and related services required for the District and its affiliates.

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

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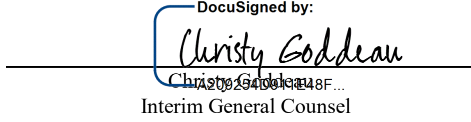
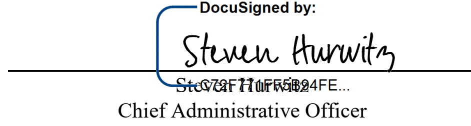
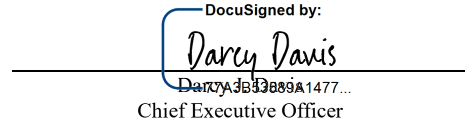


Christy Goddeau
Interim General Counsel



Steven Hurwitz
Chief Administrative Officer



Darcy J. Davis
Chief Executive Officer

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Tentative Millage Rate

2. Summary:

Staff recommends the Board set a proposed tentative millage rate of 0.7261.

3. Substantive Analysis:

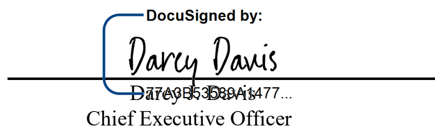
The District tax rate in 2021 was 0.7261 mills. Staff is recommending the 2022 proposed tentative millage rate be set at 0.7261, which is 3.6% over the rolled-back rate of 0.7009 and equal to the 2021 tax rate. The rolled-back rate is the tax rate which generates the same amount of tax revenue as the previous year, excluding new construction. The proposed tentative millage rate represents the tax rate the Board cannot exceed when it sets the final rate at the September TRIM hearings.

The 2021 estimate of taxable values from the County showed an increase of 5.0% over 2020. The increase in taxable values in conjunction with keeping the millage rate flat results in an approximately $7.1 million increase in ad valorem taxes relative to 2021. The proposed budget anticipates spending approximately $21.0 million in reserves, including $6.3 million in assigned reserves, which were designated for the replacement of the two Trauma Hawk helicopters.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☐
Annual Net Revenue		Yes ☐ No ☐
Annual Expenditures		Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:



Darcy J. Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

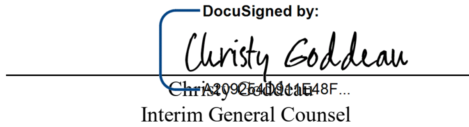
N/A	N/A
Committee Name	Date Approved

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

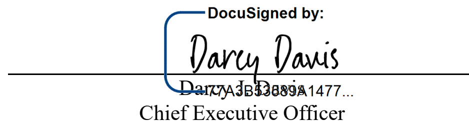
6. Recommendation:

Staff recommends the Board set a proposed tentative millage rate of 0.7261 mills.

Approved for Legal sufficiency:



Christy Goddeau
Interim General Counsel



Darcy J. Davis
Chief Executive Officer

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: OB Service Line at Lakeside Medical Center

2. Summary:

This agenda item is to request an extension for the time needed for the OB Service Line to reach the required goal set forth by the Board.

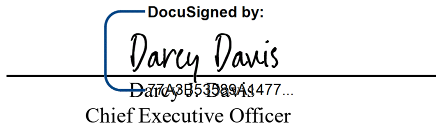
3. Substantive Analysis:

Due to COVID 19, the hospital has seen an overall decline in utilization. Lakeside Medical Center is requesting a twelve (12) month extension to allow the facility to reach its goal as several factors such as community outreach, community events are still a barrier.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:



Darcy J. Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

6. Recommendation:

Staff recommends the Board approve the OB Service Line extension.

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

Approved for Legal sufficiency:

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Christy Goddeau
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Christy Goddeau
Interim General Counsel

DocuSigned by:
Karen Harris
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Karen Harris
VP of Operations

DocuSigned by:
Darcy Davis
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Darcy J. Davis
Chief Executive Officer

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Health Care District Of Palm Beach County Lakeside Medical Center OB Service Line Update

Karen A. Harris

VP of Field Operations

Health Care District
PALM BEACH COUNTY

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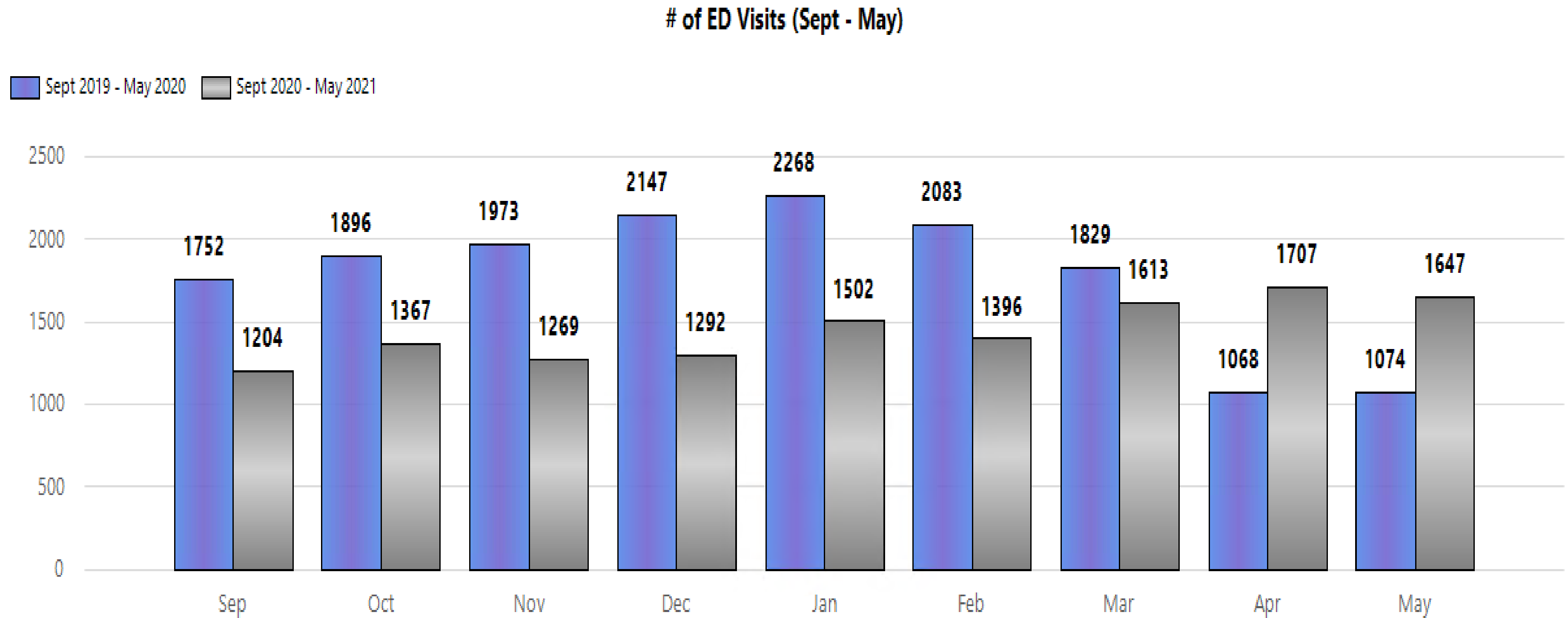
Substantive Analysis

Due to COVID-19, the hospital has seen an overall decline in ***outpatient*** hospital utilization:



Health Care District PALM BEACH COUNTY

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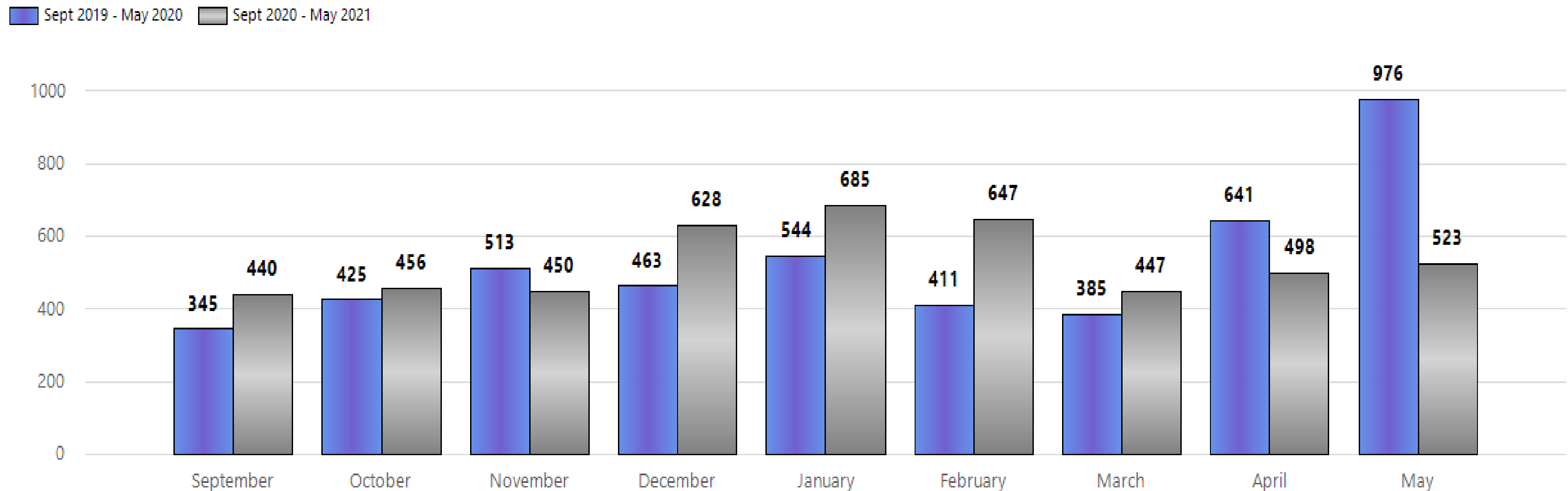
Adjusted In Patient Days

Over a nine (9) month period the In-Patient side of the hospital is beginning to see a recovery in admissions due to COVID although the outpatient side is taking longer to recover.



Health Care District PALM BEACH COUNTY

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General Outreach

- A snap shot of community outreach:

Posters and local bus shelter ads in English, Spanish, and Creole

Lakeside Medical Center
39200 Hooker Hwy
Belle Glade, FL 33430

Return Service Requested

PRSRT STD
US POSTAGE
PAID
WEST PALM BEACH FL
PERMIT NO. 683

Obstetric and Gynecology Services
Servicios de Ginecología y Obstetricia
Sèvis Jinekològ ak Obstetrik

Our office is conveniently located on the 2nd floor of Lakeside Medical Center.

To make an appointment, please call
Para programar una cita, llame al
Pou w pran yon randevou, tanpri rele
561-790-5990

Mass mailer sent to 6,347 homes in Belle Glade, Pahokee, South Bay, and Canal Point

LMC Delivers Babies With Love 365 Days a Year

Participation and education at local events

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Community Outreach Plan

- As opportunities allow, Lakeside stands ready to expand outreach:
  - Dedicated Community Liaison role
  - Utilization of social media, especially Lakeside's Facebook channel
  - Collaboration with our community partners
  - Deployment of new Lakeside Community Ambassador program
  - Participation in several community committees:

PATCH	Healthy mothers, healthy babies
Glades Initiative	Pahokee Chamber
Belle Glade Chamber	LORHN

  - Janet Moreland, AVP/Administrator, continues to grow community presence as Lakeside's primary public representative

Health Care District
PALM BEACH COUNTY

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Summary

- As in-person opportunities reopen, we are asking the Board for a twelve (12) month extension in allowing Lakeside to reach the goal set.

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Internal Audit Timeline

2. Summary:

The Internal Audit Structure as proposed includes a timeline of the past, present and future internal audit models for the District. A proposed structure for fiscal year 2022 is outlined, which would adjust the current model of in-house internal audit co-sourcing with one Audit Firm on a regular basis, to the future model of expanding the in-house internal audit function with additional resources and tools, and co-sourcing with one or more Audit Firms on an as needed basis.

3. Substantive Analysis:

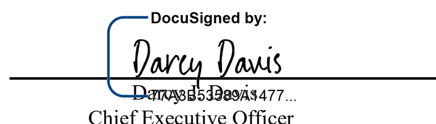
From FY18 through FY20, the District fully out-sourced internal audit after a formal Request for Proposal (RFP). Although the firm was experienced in health care, the costs were prohibitive compared to the value received. In FY21, an in-house auditor was hired, along with an outside firm to co-source the internal audit function.
For FY22, the proposal includes that the in-house internal audit function be further defined by charter, and that additional resources and tools will be added. The intent is to supplement the in-house function by performing a thorough search for a qualified outside firm(s) to co-source on an as needed basis.

Co-sourcing with an outside vendor allows the in-house auditors to retain responsibility, flexibility and control for the internal audit process while relying on the outside entity for specialized technical skills and personnel. Performing a thorough search for qualified firms will ensure that their profiles align with District objectives, providing competent advice and assistance from subject matter experts as needed based on current risks. Using the firm on an as-needed basis will ensure that maximum value can be achieved while saving on long-term investment in staff.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:



Darcy Davis
Chief Executive Officer

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5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

6. Recommendation:

Staff recommends the Board receive and file the Internal Audit Timeline.

Approved for Legal sufficiency:

DocuSigned by: Christy Goddeau
CA2092540911E48F...
Christy Goddeau
Interim General Counsel

DocuSigned by: Betsy Bittar
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Betsy Bittar
Senior Internal Auditor

DocuSigned by: Darcy Davis
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Darcy J. Davis
Chief Executive Officer

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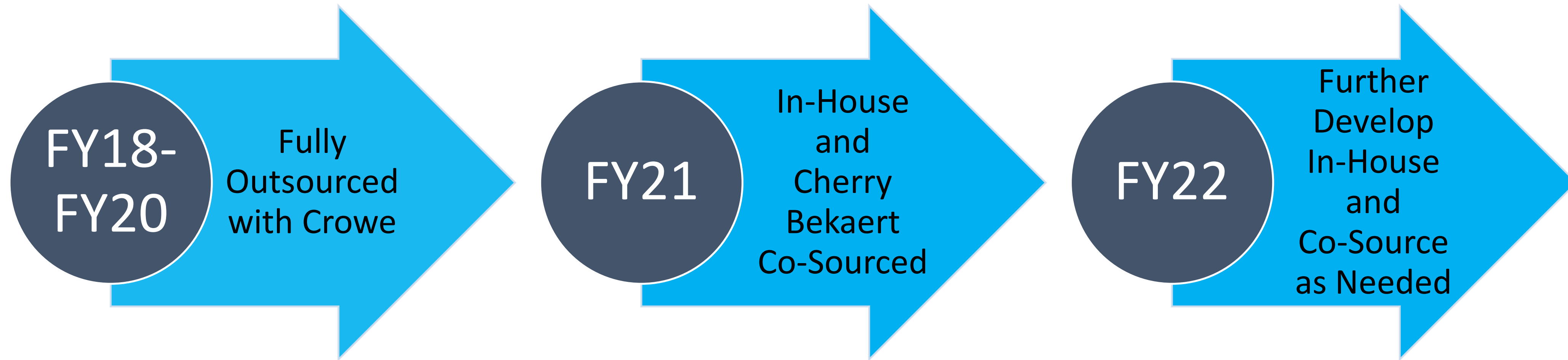
Timeline of Internal Audit Models



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Internal Audit Timeline

- From FY18 through FY20, the District fully out-sourced internal audit after a formal Request for Proposal (RFP). Although the firm was experienced in health care, the costs were prohibitive compared to the value received.
- In FY20, an in-house auditor was hired, along with an outside firm to co-source the internal audit function.
- For FY21, the in-house internal audit function is being further defined by charter, and additional resources and tools will be added. The intent is to supplement the in-house function by performing a thorough search for a qualified outside firm to co-source on an as needed basis.

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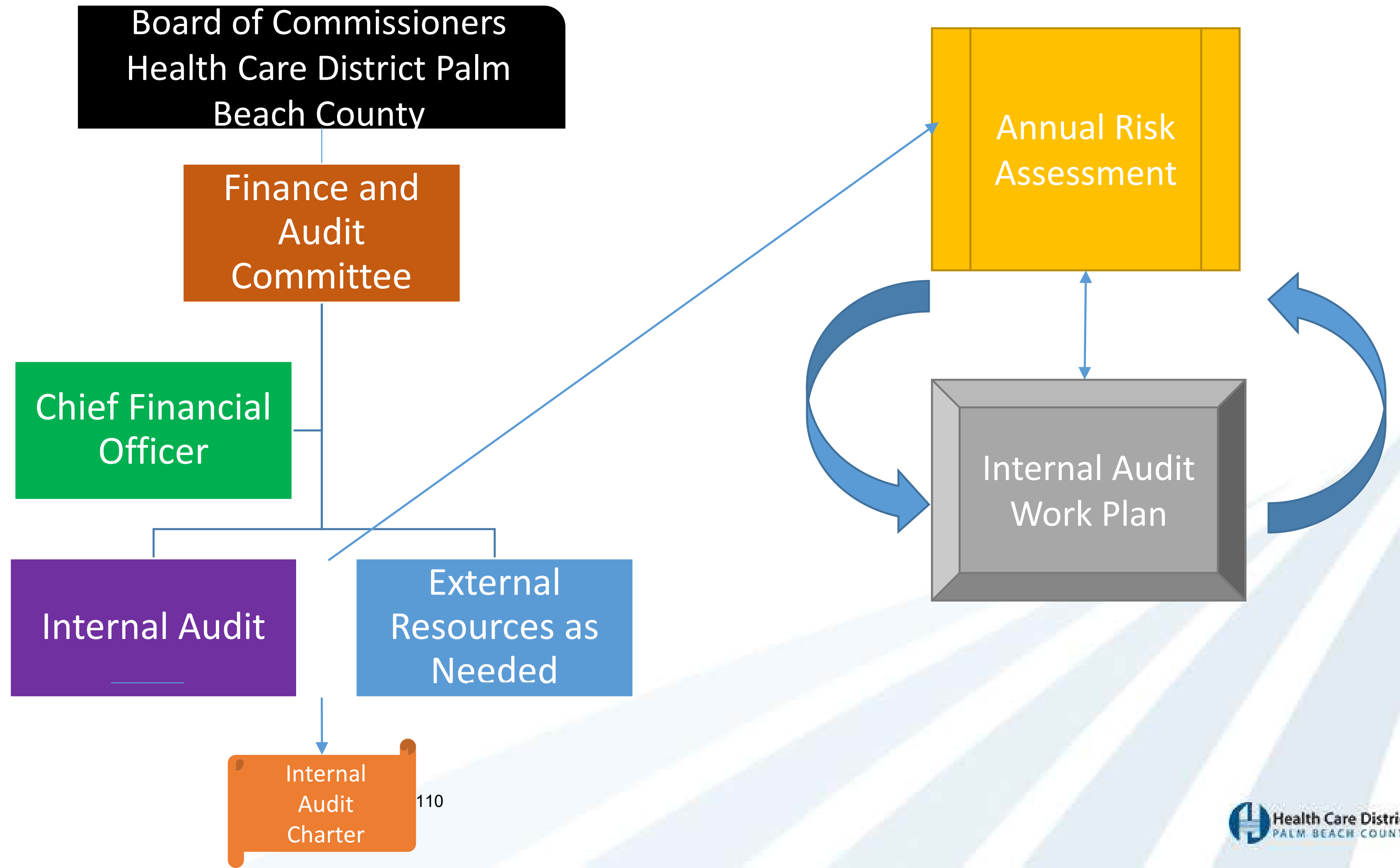
Proposed Internal Audit Structure



Health Care District
PALM BEACH COUNTY

DocuSign Envelope ID: 03200E54-4E87-4969-A60D-D1BFA61AB7F1

Proposed Internal Audit Structure

- Co-sourcing with outside vendor allows in-house auditors to retain responsibility, flexibility and control for the internal audit process while relying on the outside entity for specialized technical skills and personnel.
- Performing a thorough search for qualified firms will ensure their profiles align with District objectives, providing competent advice and assistance from subject matter experts as needed based on current risks.
- Using the firm on an as-needed basis will ensure that maximum value can be achieved while saving on long-term investment in staff.

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Internal Audit Update

2. Summary:

Internal Audit will provide an update on the status of the Internal Audit Work Plan for FY21, a summary of the completed reviews for Conflict of Interest, Sanction Screening, Clinical Documentation and Coding Plan and an update from the Internal Control Committee.

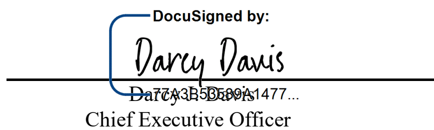
3. Substantive Analysis:

An update of the Internal Audit Work Plan for FY21 was provided, noting the projects that are Complete, Report Drafted, In Progress, and Not Started by both in-house Internal Audit and the co-sourced firm, Cherry Bekaert. A summary of the completed reviews for Conflict of Interest and Sanction Screening reports including the objectives of the review, and a listing of the action plans, based on risk, with action plan owners and due dates were included, along with an overview of the Clinical Documentation and Coding Plan and an update from the Internal Control Committee.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

Reviewed for financial accuracy and compliance with purchasing procedure:



Darcy Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

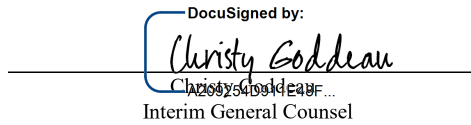
N/A	N/A
Committee Name	Date Approved

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

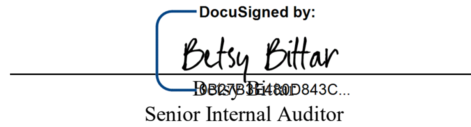
6. Recommendation:

Staff recommends the Board Staff recommends the Board approve the Internal Audit Update.

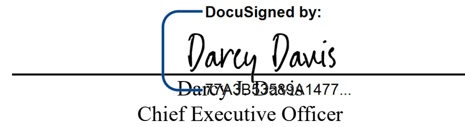
Approved for Legal sufficiency:



Christy Goddeau
Interim General Counsel



Betsy Bittar
Senior Internal Auditor



Darcy Davis
Chief Executive Officer

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Project	Description	Status
Epic Implementation Review	Cherry Bekaert was engaged to perform a pre-implementation review.	Complete
CARES Act Assistance	Cherry Bekaert was engaged to assist management in grant compliance and reporting.	In progress
Change Management	In-house IA will provide guidance to management to develop best practices.	Not started
Business Continuity Plans	Will assist management in review of process.	Not started
Clinical Documentation & Coding of Services	In-House IA to work with management to determine a plan for ongoing auditing and monitoring of Clinical Documentation and Coding	Complete
Vendor Risk and Vendor Management	In-House IA and ICC to further develop and implement a Vendor Risk and Vendor Management process.	In progress
340 B Effectiveness	In-House IA will do mock audit	Not started
Conflict of Interest Policy and Process Review	In-House IA finalized report and worked with management in identifying action plan, owners and timeline of deliverables	Complete
Policy Process review	In-House IA will review process	Not started
Sanction Screening review	In-House IA finalized report and worked with management in identifying action plan, owners and timeline of deliverables	Complete
CCP Vendor Review: Policies and Credentialing	A review of CCP policies (Credentialing, Provider Operations, Claims, Compliance and Utilization Management) and a Credentialing audit for provision of outsourced services to District Cares and Trauma was performed. Both reviews were provided to CCP for their review and input.	Report Drafted

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Conflict of Interest Policy and Process Review

Objectives: The objectives of the review of Conflict of Interest Disclosure for the Health Care District (HCD) of Palm Beach County included:

1. A review of current HCD Conflict of Interest Disclosure Policy and Procedure against current HCD practices to determine if the District is complying.
2. Determine if current HCD Conflict of Interest Disclosure Policy and Procedure is in alignment with regulations and best practices, and recommend any suggested changes.

See detailed findings and due dates in the materials.

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Sanction Screening Review

The objectives of the review of Sanction Screening for the Health Care District of Palm Beach County included:

1. A review of current HCD Sanction Screening Policy and Procedure against current HCD practices to determine if the District is complying.
2. Determine if current HCD Sanction Screening Policy and Procedure is in alignment with regulations and best practices, and recommend any suggested changes.

See detailed findings and due dates in the materials.

Recommendations for both internal audits were rated based on the following criteria:

Rating	Definition
High Risk	This risk severely impacts achieving objectives.
Medium Risk	This risk moderately impacts achieving objectives.
Low Risk	This risk has a low risk for achieving objectives.

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Clinical Documentation and Coding Plan

Based on the Risk Assessment performed for FY21, an item was placed on the internal audit work plan:

In-House IA to work with management to determine a plan for ongoing auditing and monitoring of Clinical Documentation and Coding.

Based on an assessment of risk it was determined that Epic post go-live will be the main focus on -

Revenue Integrity:

- Hospital Observation hours
- Hospital Bed Charges
- Hospital Operating Room and Anesthesia minutes
- Claim Rules
- Router Rules
- Any automation with orders (CDM)
- Modifiers

See detail work plan in the materials.

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Internal Control Committee (ICC) Update

ICC continues to meet monthly with recent areas of focus to include:

- Further review of FY21 risk assessment to further define risks and determine ICC owners and business owners, to ensure that risk assessment is ongoing for any changes in:
  - ✓Regulatory requirements/ legislation
  - ✓Improvements in processes
  - ✓Issues or concerns
  - ✓Changes in leadership or staffing
- A sub-group of ICC has been meeting regularly to determine Vendor Risk and Vendor Management project
- Fraud Risk Assessment brainstorming and risk analysis has started

Internal Audit Report Findings and Action Plan Summary, Owner and Due Date
Conflict of Interest Disclosure Compliance
Health Care District Palm Beach County
April 23, 2021

Rating	Finding	Action Plan	Owner and Due Date
High	Conflict of Interest Disclosure for Contracted Physicians Before Contracting and Annually Thereafter.	Compliance to review the current policy and procedure and related processes for disclosure of conflicts for contracted physicians to ensure that adequate disclosures are obtained and reviewed for contracted providers.	**Compliance Policy Updates:** VP and Chief Compliance and Privacy Officer, due August 6, 2021
Medium	Policy for Review of Sunshine Payments to Providers.	Compliance to update the Conflict of Interest policy to require that an annual review of Conflict of Interest disclosures from providers is compared to the open payments. Also, Compliance should perform education to providers affiliated with the district regarding open payments. The HCD Communications team should also ensure that the website is updated frequently for current providers.	**Compliance Policy Updates:** VP and Chief Compliance and Privacy Officer, due August 6, 2021 **Education to providers:** VP and Chief Compliance and Privacy Officer, due September 30, 2021 **Website updates:** VP, Chief HR and Administrative Officer, due July 16, 2021
Medium	Clear Requirements for Vendors.	Compliance to review current policy, with the Vendor Steering Committee to determine if a Conflict of Interest disclosure should be obtained for all new vendors and ongoing basis. For those vendors that participate in an RFP or RFQ, consider reviewing the Conflicts Disclosure Form to ensure it is complete, and include the requirement in the Conflict of Interest Policy. Also, ensure clarity around the Vendor Screening form, and ensure that is described in the Conflict of Interest Policy. Compliance should also ensure	**Revisions to Conflict of Interest Policy and Forms for Vendors:** Manager of Compliance and Privacy and Vendor Steering

Internal Audit Report Findings and Action Plan Summary, Owner and Due Date
Conflict of Interest Disclosure Compliance
Health Care District Palm Beach County
April 23, 2021

Rating	Finding	Action Plan	Owner and Due Date
		that vendors are given appropriate educational materials and Purchasing should ensure that vendors receive information about the requirement for disclosure of Conflict of Interest in their dealings with the HCD.	Committee: July 30, 2021 **Development of educational materials for Vendors:** Manager of Compliance and Privacy and Vendor Steering Committee: September 30, 2021
Medium	Proper Hand-off of Process When Turnover Occurs.	Compliance to ensure that there is a documented process for Conflict of Interest approval for HR and Compliance to ensure proper handoff when employees leave.	**Process Development:** VP and Chief Compliance and Privacy Officer, due September 30, 2021
Low	Policy Recommendations.	Compliance to finalize suggested changes to policy for approval in accordance with HCD Policy.	**Compliance Policy Updates**: VP and Chief Compliance and Privacy Officer, due August 6, 2021
Low	Employee Annual Disclosure of Conflict of Interest.	Compliance, in response to implementation of Compliance Program Effectiveness Review will ensure that the requirement for annual disclosure of employees is part of the Compliance work plan, and will carry out the annual disclosure process timely in the future.	**Compliance Work Plan Update:** Manager of Compliance and Privacy, Completed

Internal Audit Report Findings and Action Plan Summary, Owner and Due Date
Conflict of Interest Disclosure Compliance
Health Care District Palm Beach County
April 23, 2021

Rating	Finding	Action Plan	Owner and Due Date
Low	Conflict of Interest Disclosure for Students and Volunteers.	Compliance to work with Human Resources to develop a standard process for obtaining and reviewing conflicts of interest for students and volunteers before they start their engagement and ongoing thereafter.	**Process Development:** VP and Chief Compliance and Privacy Officer, due September 30, 2021
Low	Consistent Process for Board Member Disclosure of Conflict of Interest.	Compliance should ensure that the Conflict of Interest policy and Conflict of Interest Disclosure form for Board and Committee members has been updated, and Compliance should manage the process with administrative support to obtain the Board and Committee member disclosures for the next Board meeting in September 2021.	**Process Development:** VP and Chief Compliance and Privacy Officer, due August 20, 2021

Internal Audit Report Findings and Action Plan Summary, Owner and Due Date
Sanction Screening Internal Audit
Health Care District Palm Beach County
April 22, 2021

Rating	Finding	Action Plan	Owner and Due Date
High	Sanction Screening	Compliance to develop a process to ensure the district follows the current policy for sanction screening for the initial screening and ongoing monitoring. All current employees, providers, vendors, board members, students and volunteers should be reviewed once this process has been developed.	**Process Development:** VP and Chief Compliance and Privacy Officer, will work with District Management, due September 30, 2021
Medium	Clarity in Policy on requirement to screen for State Exclusion	Compliance to review and update policy to include the requirement for a review for providers against the state data bases at hire or contract, and then monthly.	**Compliance Policy Updates:** VP and Chief Compliance and Privacy Officer, due August 6, 2021
Medium	Clarity in Policy on Responsibilities for Sanction Screening throughout the District	Compliance to review and update policy to outline clear responsibilities for the initial screening and monthly monitoring for each group to include employees, providers, vendors (contractors and sub-contractors), board members, students and volunteers, as well as the ongoing sanction screening for those groups.	**Compliance Policy Updates:** VP and Chief Compliance and Privacy Officer, due August 6, 2021
Medium	Sanction Screening: Ongoing Monitoring	Compliance to determine if an automated solution can be employed to perform initial and ongoing screening for all groups, to include all required screenings.	**Automated Solution Determination:** VP and Chief Compliance and Privacy Officer, will work with District Management, due October 29, 2021
Low	Clarity in Policy on requirement to screen for National	Compliance to review and update policy to include the requirement for a review for providers against the NPDB at credentialing, and ongoing, to correspond with the detailed	**Compliance Policy Updates**: VP and Chief

Internal Audit Report Findings and Action Plan Summary, Owner and Due Date
Sanction Screening Internal Audit
Health Care District Palm Beach County
April 22, 2021

Rating	Finding	Action Plan	Owner and Due Date
	Practitioner Data Base.	procedures in the HCD Credentialing departments.	Compliance and Privacy Officer, due August 6, 2021
Low	Employment Application Language	Human Resources to update the employment language to include the above language.	**Application Update:** AVP Human Resources, Complete
Low	Sanction Screening: Initial Screening	Compliance to determine if an automated solution can be employed to perform initial screening for all groups, to include all required screenings.	**Automated Solution Determination:** VP and Chief Compliance and Privacy Officer, will work with District Management, due October 29, 2021
Low	Review of Exceptions	HCD Compliance to determine whether the review of exceptions can be centralized.	**Process Development:** VP and Chief Compliance and Privacy Officer, will work with District Management, due September 30, 2021

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Internal Audit Work Plan FY21
Clinical Documentation and Coding Work Plan

Based on the Risk Assessment performed for FY21, an item was placed on the internal audit work plan:

In-House IA to work with management to determine a plan for ongoing auditing and monitoring of Clinical Documentation and Coding.

Rationale: The Office of Inspector General ("OIG") believes that as part of an effective compliance program, organizations should conduct internal monitoring and auditing focusing on high-risk billing and coding issues through performance of periodic audits and risk assessments. This task is one of the seven elements set forth in the Federal Sentencing Guidelines.

In order to develop the plan, Internal Audit met with the Manager of Compliance and Privacy, the VP of Vice President, Clinical Integration and the Manager of Coding to determine the approach and plan for auditing and monitoring for the remainder of FY21. In order to determine the area of focus, risks were evaluated based on discussion of the OIG workplan focus; CMS Guidelines and transmittals, MAC and RAC results, Denial trends, Pepper reports, ACA, JACHO, HRSA surveys, statistics, new service lines, growth.

Through the result of those discussions it was determined that, due to the timing of the go-live of the Epic Implementation, the main focus of the reviews will be to review the Epic post go-live implementation. The in-house Manager of Coding will perform the reviews, and will request the assistance of in-house IA as needed, to focus on the following areas within Epic through September 30, 2021:

Revenue Integrity will be the focused area that will be reviewed to include:

- Hospital Observation hours
- Hospital Bed Charges
- Hospital Operating Room and Anesthesia minutes
- Claim Rules
- Router Rules
- Any automation with orders (CDM)
- Modifiers

The audit approach will be as follows:

1. Auditors: Utilization of independent auditors.
2. Approach: The audit process will be documented, and will include the development of a baseline, with accuracy goals.
3. Ranking of Issues, Severe, High, Medium, Low, Insignificant.
4. Ensure that action plans for resolving issues are developed.
5. Education and Training to be provided when issues are noted.
6. Sample selection: Generally random, unless need focused or judgmental for certain service area
7. Dependent on volume.
8. A new plan will be addressed for FY22, along with Compliance, with the timing as quarterly, and if issues arise, revise frequency. Consideration to co-source as resources are needed.

HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: 2020 Health Care District Audit

2. Summary:

The 2020 Health Care District audited Annual Financial Reports are presented for Board review.

3. Substantive Analysis:

The District's external auditor, RSM US LLP, completed the audit procedures for fiscal year ended September 30, 2020. The opinion provides the assurance that the financial statements are presented fairly, with no material misstatements.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements	N/A	Yes ☐ No ☐
Annual Net Revenue	N/A	Yes ☐ No ☐
Annual Expenditures	N/A	Yes ☐ No ☐

Reviewed for financial accuracy and compliance with purchasing procedure:

DocuSigned by:
Darcy Davis
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Darcy J. Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

N/A
Committee Name

N/A
Date Approved

6. Recommendation:

Staff recommends the Board approve the 2020 Health Care District audited Annual Financial Report.

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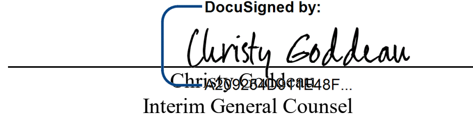
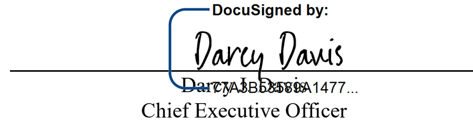
HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

Approved for Legal sufficiency:



Christy Goddeau
Interim General Counsel



Darcy J. Davis
Chief Executive Officer

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Health Care District of Palm Beach County, Florida

Report to the Board of Directors and
Finance and Audit Committee Members
June 18, 2021

THE POWER OF BEING UNDERSTOOD
AUDIT | TAX | CONSULTING

RSM

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June 18, 2021

Board of Directors and Finance and Audit Committee Members
Health Care District of Palm Beach County, Florida
West Palm Beach, Florida

Attention: Board and Committee Members

We are pleased to present this report related to our audit of the financial statements of the Health Care District of Palm Beach County, Florida (the District) as of and for the year ended September 30, 2020.

We have issued the following financial statement and compliance reports for the District:

- Annual Financial Report (District)
- District Hospital Holdings, Inc. (Lakeside)
- District Clinic Holdings, Inc. (Clinics)
- Good Health Foundation, Inc. (Foundation)
- Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance
- Management Letter Required By Chapter 10.550 of the Rules of the Auditor General of the State of Florida
- Independent Accountant's Report relating to the District's compliance with Section 218.415, *Florida Statutes, Local Government Investment Policies*

This report summarizes certain matters required by professional standards to be communicated to you in your oversight responsibility for the District's financial reporting process.

This report is intended solely for the information and use of the Board of Directors and management, and is not intended to be, and should not be, used by anyone other these specified parties. It will be our pleasure to respond to any questions you have about this report. We appreciate the opportunity to continue to be of service to the District.

RSM US LLP

TABLE OF CONTENTS

Required communications 1-3

Significant accounting estimates 4-5

Exhibits

Exhibit A—Significant written communication between management and our firm

- Representation letters

Exhibit B—RSM Health Care Appendix

REQUIRED COMMUNICATIONS

Generally accepted auditing standards (AU-C 260, *The Auditor's Communication With Those Charged With Governance*) require the auditor to promote effective two-way communication between the auditor and those charged with governance. Consistent with this requirement, the following summarizes our responsibilities regarding the financial statement audit as well as observations arising from our audit that are significant and relevant to your responsibility to oversee the financial reporting process.

Our Responsibilities With Regard to the Financial Statement Audit

Our responsibilities under auditing standards generally accepted in the United States of America and *Government Auditing Standards*, issued by the Comptroller General of the United States, have been described to you in our arrangement letter dated September 10, 2020. Our audit of the financial statements does not relieve management or those charged with governance of their responsibilities, which are also described in that letter.

Overview of the Planned Scope and Timing of the Financial Statement Audit

We have issued a separate communication dated January 1, 2021, regarding the planned scope and timing of our audit and identified significant risks.

Accounting Policies and Practices

Preferability of Accounting Policies and Practices
Under generally accepted accounting principles, in certain circumstances, management may select among alternative accounting practices. In our view, in such circumstances, management has selected the preferable accounting practice.

Adoption of, or Change in, Accounting Policies
Management has the ultimate responsibility for the appropriateness of the accounting policies used by the District. The District did not adopt any significant new accounting policies, nor have there been any changes in existing significant accounting policies during the current period.

Significant or Unusual Transactions

The District recognized approximately $13,015,000 of grant funds received from the Coronavirus Aid, Relief and Economic Security Act (CARES Act) as revenues and approximately $16,597,000 as unearned revenues for the year ended. The unearned revenues may be recognized as revenues in future periods if the underlying conditions for recognition are met.

We did not identify any other significant or unusual transactions or significant accounting policies in controversial or emerging areas for which there is a lack of authoritative guidance or consensus.

Management's Judgments and Accounting Estimates
Summary information about the process used by management in formulating particularly sensitive accounting estimates and about our conclusions regarding the reasonableness of those estimates is included in the Summary of Significant Accounting Estimates section.

Basis of Accounting
The basic financial statements were prepared on the assumption that the District will continue as a going concern.

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Audit Adjustments and Uncorrected Misstatements

There were no audit adjustments made to the original trial balance presented to us to begin our audit.

We are not aware of any uncorrected misstatements other than misstatements that are clearly trivial.

Observations About the Audit Process

Disagreements With Management
We encountered no disagreements with management over the application of significant accounting principles, the basis for management's judgments on any significant matters, the scope of the audit or significant disclosures to be included in the financial statements.

Consultations With Other Accountants
We are not aware of any consultations management had with other accountants about accounting or auditing matters.

Significant Issues Discussed With Management
The following is a description of a significant issue arising from the audit that was the subject of correspondence with management:

- Accounting and financial reporting for the CARES Act funding received by the Hospital.

  CARES Act funding of $9,012,429 was available to prevent, prepare for and respond to the Coronavirus and to reimburse the Hospital for related expenses and lost revenues. Therefore, budgeted General Fund contributions in the amount of $10,000,000 was not required to be funded for the year ended. This reduction in General Fund contributions resulted in an increase in the Hospital's losses that are available to be funded by CARES Act funds. However, for revenue recognition purposes an allowance of $10,000,000 was applied against this revenue as management could not determine if HRSA and HHS would allow this adjustment for purposes of determining the net margin loss. Therefore, the Hospital will not recognize revenues related to this portion of the operating loss for the year ended September 30, 2020.

- The effects of the Coronavirus pandemic and employee turnover at the District resulted in the District's financial statement audits being delayed and rescheduled to May 2021.

Significant Difficulties Encountered in Performing the Audit
We did not encounter any significant difficulties in dealing with management during the audit.

Significant Written Communication Between Management and Our Firm

Copies of significant written communication between our firm and the management of the District, including the representation letters provided to us by management, are attached as Exhibit A.

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Internal Control Matters

We have issued, under separate cover, the following reports in connection with our audit, as required by Gover*nment Auditing Standards*, *Uniform Guidance, and Chapter 10.550, Rules of the Auditor General of the State of Florida*:

- Independent Auditor's Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards.*

- Independent Auditor's Report on Compliance for Each Major Federal Program and Report on Internal Control Over Compliance.

- Management Letter Required by Chapter 10.550, *Rules of the Florida Auditor General of the State of Florida.*

- Independent Accountant's Report in Accordance with Chapter 10.550 of the Rules of the Auditor General of the State of Florida, relating to the District's compliance with Section 218.415, *Florida Statutes, Local Government Investment Policies*

SIGNIFICANT ACCOUNTING ESTIMATES

Accounting estimates are an integral part of the preparation of financial statements and are based upon management's current judgment. The process used by management encompasses their knowledge and experience about past and current events, and certain assumptions about future events. You may wish to monitor throughout the year the process used to determine and record these accounting estimates. The following summarizes the significant accounting estimates reflected in the District's September 30, 2020, financial statements.

Significant Accounting Estimates	
Allowances for Doubtful Accounts and Contractual Discounts	
Accounting Policy	Accounts receivable are reduced to their estimated net collectible amounts.
Management's estimation process	Accounts receivable from third-party payors are reported at the estimated realizable amount. Contractual allowances are based on management's review of historical experience and contract provisions. Management determines the allowance for doubtful accounts for self-pay patients, co-insurance and deductibles by identifying potentially uncollectible accounts by historical experience and by considering financial and credit history, and current economic conditions.
Basis for our conclusion on the reasonableness of the estimate	We tested the propriety of information underlying management's estimates, including the patient aging reports utilized by management to obtain the gross accounts receivable balances, the re-performance of the hindsight analysis that analyzed the adequacy of the September 30, 2020 allowances, and we developed our own independent estimate of the net accounts receivable in order to compare our results to management's estimate. Based on the procedures performed, we concluded that management's methodology is reasonable.
Third-Party Payor Settlements	
Accounting policy	Contractual adjustments arising under reimbursement agreements with third-party payors are recognized on an estimated basis in the period the services are rendered and adjusted in future periods as final settlements are determined.
Management's estimation process	Settlements are estimated based on an external specialist and management's review of historical experience, communications received from third-party payors and internal calculations.
Basis for our conclusion on the reasonableness of the estimate	We tested the propriety of information underlying management's estimates. We utilized our third-party specialist to assess management's third-party receivable and liability positions and supporting correspondence and also reviewed the calculations. Based on procedures performed, we concluded that management's methodology is reasonable.

Significant Accounting Estimates	
Self-Insurance Liabilities (Employee Health, Medical Malpractice and General Liability)	
Accounting policy	A liability for unpaid claims and estimated incurred but not reported claims and their related anticipated insurance recoveries are estimated in the period that claims are incurred and adjusted in future periods as final settlements are determined.
Management's estimation process	Management's liability and asset estimates are based on actuarial studies and both current and historical claims information.
Basis for our conclusion on the reasonableness of the estimate	We tested the propriety of information underlying management's estimates, including verification of information provided to the actuary, confirmation with legal counsel and testing of claim activity. Based on procedures performed, we concluded that management's methodology is reasonable.
Medical Claims Payable	
Accounting policy	A liability for medical claims is recognized for unpaid claims and estimated incurred but not reported claims.
Management's estimation process	The estimate of the unpaid claims is based on actuarial studies. The actuary uses subsequent claims run-out and both current and prior claims experience to actuarially determine the amount of the estimated liabilities.
Basis for Our Conclusion on the Reasonableness of the Estimate	We tested management's information, reviewed claims run-out information subsequent to year-end, and reviewed the independent actuary's report. Our actuarial specialist reviewed the computation and the methodology utilized by the District's actuary. Lookback analysis was used to determine the reasonableness of prior estimates. Based on procedures performed, we concluded that management's methodology is reasonable.
Provider Relief Funding	
Accounting Policy	Revenues associated with the CARES Act funding received are recognized in accordance with guidance provided by the AICPA and HHS rules in effect at September 30, 2020.
Management's Estimation Process	Management calculated the revenue recognized for the CARES Act funds by estimating the expenses incurred and operating margin loss due to the Coronavirus, based on the HHS rules in effect at September 30, 2020.
Basis for our conclusion on the reasonableness of the estimate	We tested the Coronavirus-related expenses and the lost operating margin as calculated by management. Based on our procedures, we concluded that management's methodology and estimates are reasonable.

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EXHIBIT A

Significant Written Communication Between Management and Our Firm

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June 18, 2021

RSM US LLP
1555 Palm Beach Lakes Boulevard #Suite 700
West Palm Beach, FL 33401

This representation letter is provided in connection with your audit of the financial statements of the governmental activities, the business type activities, the discretely presented component unit, each major fund and the aggregate remaining fund information of the Healthcare District of Palm Beach County, Florida (the District) as of and for the year ended September 30, 2020, for the purpose of expressing an opinion on whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

We confirm, to the best of our knowledge and belief, that as of the date of this letter:

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit arrangement letter dated September 10, 2020, for the preparation and fair presentation of the financial statements referred to above in accordance with U.S. GAAP.

2. We acknowledge our responsibility for 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.

3. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable and reflect our judgment based on our knowledge and experience about past and current events, and our assumptions about conditions we expect to exist and courses of action we expect to take.

5. Related-party transactions have been recorded in accordance with the economic substance of the transaction and appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP. Types of related party transactions engaged in by the District include:

    a. Those with component units for which the District is accountable.

    b. Interfund transactions, including interfund accounts and advances receivable and payable, sale and purchase transactions, interfund transfers, long-term loans, leasing arrangements and guarantees.

6. The financial statements properly classify all funds and activities in accordance with GASB Statement No. 54, *Fund Balance Reporting and Governmental Fund Type Definitions*, as amended.

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7. All events subsequent to the date of the financial statements, and for which U.S. GAAP requires adjustment or disclosure, have been adjusted or disclosed.

8. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP.

9. We have no direct or indirect legal or moral obligation for any debt of any organization, public or private, or to special assessment bond holders, which is not disclosed in the financial statements.

10. We have complied with all aspects of laws, regulations and provisions of contracts and agreements that would have a material effect on the financial statements in the event of noncompliance. The District is subject to the requirements of Office of Management and Budget Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, or Title 45 U.S. CFR Part 75.501, because it expended (or did not expend) more than $750,000 in federal awards during the year.

11. We have no knowledge of any uncorrected misstatements in the financial statements.

12. Adequate consideration has been given to, and appropriate provision made for, estimated adjustments to revenue, such as for denied claims and changes to home health resource group, resource utilization group, ambulatory payment classification and DRG assignments, as applicable.

13. Recorded valuation allowances are necessary, appropriate and properly supported.

14. All peer review organizations, fiscal intermediary, and third-party payor reports and information have been made available.

15. All required Medicare, Medicaid and similar reports have been properly filed.

16. Management is responsible for the accuracy and propriety of all filed cost reports.

17. All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations, and are patient-related and properly allocated to applicable payors.

18. The employed reimbursement methodologies and principles are in accordance with applicable rules and regulations.

19. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors or other regulatory agencies.

20. All items required to be disclosed, including disputed costs that are being claimed to establish a basis for a subsequent appeal, have been fully disclosed in the cost report.

21. Recorded third-party settlements include differences between filed (and to-be-filed) cost reports and calculated settlements, which are necessary based on historical experience or new or ambiguous regulations that may be subject to differing interpretations. Although

management believes that the entity is entitled to all amounts claimed on the cost reports, management also believes the amounts of these differences are appropriate.

22. There are no instances of noncompliance with laws or regulations, such as those related to Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the basic financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements. This is including, but not limited to, the anti-kickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law) and the False Claims Act.

23. Billings to third-party payors comply in all material respects with applicable coding guidelines (e.g., ICD-10 and CPT-4) and laws and regulations, including those dealing with Medicare and Medicaid antifraud and abuse, and billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies (e.g., the Food and Drug Administration), if required; and properly rendered.

24. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the basic financial statements or on the disclosure in the notes to the basic financial statements.

25. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction, including those related to Medicare and Medicaid antifraud and abuse statutes; deficiencies in financial reporting practices; or other matters that could have a material adverse effect on the basic financial statements.

26. Adequate consideration has been given to, and appropriate provision made for, a continuing care retirement community's obligation to provide future services and the use of facilities to current residents.

27. Adequate consideration has been given to, and appropriate provision made for, a prepaid health care provider's obligation to provide future health care services.

28. Guarantees, whether written or oral, under which the health care entity is contingently liable, including guarantee contracts and indemnification agreements, have been properly recorded or disclosed in the basic financial statements, when applicable.

29. The District is exempt from federal and state income taxes as a governmental entity and is not required under the Internal Revenue Code to file tax returns.

30. Management has evaluated all individuals providing services to the health care entity to determine if they are being properly treated as either independent contractors or employees pursuant to

applicable state and federal laws. Management believes that all individuals being treated as independent contractors meet the criteria to be treated as such, and accordingly, we do not believe there is any exposure for payroll taxes, or penalties or interest for underpayment of payroll or other taxes.

31. Provision has been made, when material, for estimated retroactive adjustments by third-party payors under reimbursement agreements.

32. The District is in compliance with contractual agreements, grants and donor restrictions.

33. The internal controls over the receipt and recording of received contributions are adequate.

34. The District has reported to its risk management department all known asserted and unasserted claims and incidents. Adequate and reasonable provision has been made for losses related to asserted and unasserted malpractice, health insurance, worker's compensation and any other claims.

35. The self-insured actuary specialist used by management to estimate the loss and loss adjustment expense had a sufficient level of competence and experience in loss estimates, including knowledge about the types of self-insurance programs in place at the District, as well as an understanding of the appropriate methods for calculating such loss estimates. We recognize we are responsible for the actuarial amounts and balances and, in our opinion, all such amounts are fairly presented. We further represent that we did not give or cause any instructions to be given to our specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialist.

36. The liability for self-insured claims (and claims adjustment expenses) includes estimates of amounts due on reported claims and claims that have been incurred but that were not reported as of September 30, 2020. Such estimates are based on actuarial projections applied to historical claim payment data. Such liabilities represent the District's best estimate of amounts that are reasonable and adequate to discharge the District's obligations from claims incurred but unpaid as of September 30, 2020. We further represent that we did not give or cause any instructions to be given to our actuary specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.

37. We agree with the findings of the actuary specialist in evaluating the other post-employment benefits (OPEB) liability and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give instructions, or cause any instructions to be given to the specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialist. In addition, we believe that the actuarial assumptions and methods used by the actuary for determining the OPEB liability are appropriate in the circumstances. We did not give instructions, or cause any instructions to be given to the actuary specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the actuary.

38. We are not aware of noncompliance related to Health information Technology for Economic and Clinical Health Act incentive payments and income from Medicare and Medicaid incentive payments

for any year of our participation.

39. We have complied with all of the Terms and Conditions of the Provider Relief Funds that we have received and all information provided as part of our application for payment, as well as all information and reports relating to the payments associated with the Public Health and Social Services Emergency Fund that we are to be provided in the future at the request of the Secretary or Inspector General are, or will be, true, accurate and complete.

40. We billed Medicare in 2019; provide or provided after January 31, 2020 diagnoses, testing or care for individuals with possible or actual cases of COVID-19; are not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; are not currently excluded from participation in Medicare, Medicaid and other Federal health care programs; and do not currently have Medicare billing privileges revoked.

41. Provider Relief Fund payments received were only used by the District to prevent, prepare for and respond to the Coronavirus and to reimburse the District for related expenses and lost revenues.

42. We have appropriately estimated the amount of revenue to recognize under the Provider Relief Fund program based on guidance from HHS as of September 30, 2020.

43. Provider Relief Funding of $10,076,142 was used to prevent, prepare for and respond to the Coronavirus and to reimburse the District for related expenses and lost revenues.

44. The amount of General Fund operating contributions made to the Lakeside Medical Center in each fiscal year is determined after accounting for all other funding sources (patient revenues, Provider Relief Funds (PRF), DSH, LIP and grants) available for Lakeside Medical Center operations. PRF of $9,012,429 was available to Lakeside Medical Center to prevent, prepare for and respond to the Coronavirus and to reimburse Lakeside Medical Center for related expenses and lost revenues. Therefore, budgeted General Fund contributions in the amount of $10,000,000 was not required to be funded for the year ended. This reduction in General Fund contributions resulted in an increase in the Lakeside Medical Center's losses that are available to be funded by PRF. However, for revenue recognition purposes we believe that this amount should have an allowance of $10,000,000 applied against it as we cannot currently determine if HRSA and HHS would allow this adjustment for purposes of determining the net margin loss. Therefore, Lakeside Medical Center will not recognize revenues related to this portion of the operating loss for the year ended September 30, 2020.

Information Provided

45. We have provided you with:

    a. Access to all information of which we are aware that is relevant to the preparation and fair presentation of the basic financial statements such as records, documentation and other matters.

    b. Additional information that you have requested from us for the purpose of the audit.

    c. Unrestricted access to persons within the District from whom you determined it necessary to obtain audit evidence.

    d. Minutes of the meetings of the governing board and committees, or summaries of actions of recent meetings for which minutes have not yet been prepared.

46. All transactions have been recorded in the accounting records and are reflected in the basic financial statements.

47. We have disclosed to you the results of our assessment of risk that the basic financial statements may be materially misstated as a result of fraud.

48. It is our responsibility to establish and maintain internal control over financial reporting. One of the components of internal control is risk assessment. We hereby represent that our risk assessment process includes identification and assessment of risks of material misstatement due to fraud. We have shared with you our fraud risk assessment, including a description of the risks, our assessment of the magnitude and likelihood of misstatements arising from those risks, and the controls that we have designed and implemented in response to those risks.

49. We have no knowledge of allegations of fraud or suspected fraud affecting the District's basic financial statements involving:

    a. Management.

    b. Employees who have significant roles in internal control.

    c. Others where the fraud could have a material effect on the basic financial statements.

50. We have no knowledge of any allegations of fraud or suspected fraud affecting the District's basic financial statements received in communications from employees, former employees, analysts, regulators, or others.

51. We have no knowledge of noncompliance or suspected noncompliance with laws and regulations.

52. We are not aware of any pending or threatened litigation and claims whose effects should be considered when preparing the financial statements.

53. We have disclosed to you the identity of the District's related parties and all the related-party relationships and transactions of which we are aware.

54. We are aware of no significant deficiencies, including material weaknesses, in the design or operation of internal controls that could adversely affect the District's ability to record, process, summarize and report financial data.

55. There have been no communications from regulatory agencies concerning noncompliance with, or deficiencies in, financial reporting practices.

56. Effective August 7, 2019, Healthy Palm Beaches, Inc. surrendered its Certificate of Authority and will no longer operate as a health maintenance organization (HMO) or be regulated by the Florida Office of Insurance and Regulation (OIR). We have complied with the rules and regulations of the Florida OIR related to Healthy Palm Beaches. Inc. through the year ended September 30, 2020 and to the date of this letter.

57. During the course of your audit, you may have accumulated records containing data that should be reflected in our books and records. All such data have been so reflected. Accordingly, copies of such records in your possession are no longer needed by us.

Supplementary Information

58. With respect to supplementary information presented in relation to basic financial statements as a whole:

    a. We acknowledge our responsibility for the presentation of such information.

    b. We believe such information, including its form and content, is fairly presented in accordance with U.S. GAAP.

    c. The methods of measurement or presentation have not changed from those used in the prior period.

    d. When supplementary information is not presented with the audited basic financial statements, we will make the audited basic financial statements readily available to the intended users of the supplementary information no later than the date of issuance of the supplementary information and the auditor's report thereon.

59. With respect to budgetary comparison schedules and other post-employment benefits and pension schedules presented as required by to supplement the basic financial statements:

    a. We acknowledge our responsibility for the presentation of such required supplementary information.

    b. We believe such required supplementary information is measured and presented in accordance with guidelines prescribed by U.S. GAAP.

    c. The methods of measurement or presentation have not changed from those used in the prior period.

In connection with your audit conducted in accordance with *Government Auditing Standards*, we confirm management:

60. Is responsible for the preparation and fair presentation of the financial statements in accordance with the applicable financial reporting framework.

61. Is responsible for compliance with the laws, regulations and provisions of contracts and grant agreements applicable to the auditee.

62. Is not aware of instances that have occurred, or are likely to have occurred, of fraud and noncompliance with provisions of laws and regulations that have a material effect on the financial statements or other financial data significant to the audit objectives, and any other instances that warrant the attention of those charged with governance.

63. Is not aware of any instances that have occurred, or are likely to have occurred, of noncompliance with provisions of contracts and grant agreements that have a material effect on the determination of financial statement amounts.

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64. Is not aware of any instances that have occurred, or are likely to have occurred, of waste or abuse that could be quantitatively or qualitatively material to the financial statements.

65. Is responsible for 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.

66. Acknowledges its responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.

67. Has identified for the auditor previous audits, attestation engagements and other studies related to the audit objectives and whether related recommendations have been implemented.

68. In connection with the audits, you have requested us to perform certain non-audit services for the District to include general support related to the preparation / compilation, review and finalization of the District's Annual Financial Report, the financial statements of District Hospital Holdings, Inc., Good Health Foundation Inc., and District Clinics Holdings, Inc. Additionally, you have requested that we provide expertise and advisory services for the District's privacy and security infrastructure, Information Security policies, procedures and technical systems in order to maintain the confidentiality, integrity and availability of all District Health Care Information Systems as mandated by HIPAA. Management acknowledges its responsibilities as it relates to the non-audit services to be performed by the auditor and its consultants, including a statement that it assumes all management responsibilities; that it oversees the services by designating an individual, preferably within senior management, who possesses suitable skill, knowledge or experience; that it evaluated the adequacy and results of the services performed; and that it accepts responsibility for the results of the services.

In connection with your audit of federal awards conducted in accordance with Subpart F of Title 2 U.S. Code of Federal Regulations (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance), we confirm:

69. Management is responsible for complying, and has complied, with the requirements of Uniform Guidance.

70. Management is responsible for understanding and complying with the requirements of laws, regulations, and the provisions of contracts and grant agreements related to each of its federal programs.

71. Management is responsible for establishing and maintaining, and has established and maintained, effective internal control over compliance for federal programs that provides reasonable assurance that the auditee is managing federal awards in compliance with federal statutes, regulations, and the terms and conditions of the federal award that could have a material effect on its federal programs.

72. Management is responsible for the preparation of the schedule of expenditures of federal awards, acknowledges and understands its responsibility for the presentation of the schedule of expenditures of federal awards in accordance with the Uniform Guidance; believes the schedule of expenditures of federal awards, including its form and content, is fairly presented in accordance with the Uniform Guidance; asserts that methods of measurement or presentation have not changed from those used in the prior period, or if the methods of measurement or presentation have changed, the reasons for such changes have been communicated; and is responsible for any significant assumptions or

interpretations underlying the measurement or presentation of the schedule of expenditures of federal awards.

73. The District received amounts from the U.S. Department of Health and Human Services through the Provider Relief Fund (PRF) program (Federal Assistance Listing Number #93.498) during the year ended September 30, 2020. The District recognized PRF revenue totaling approximately $10,076,000 in its financial statements for the year ended September 30, 2020. In accordance with the 2020 Compliance Supplement Addendum issued in December 2020, this funding is not included on the schedule of expenditures of federal awards for the year ended September 30, 2020.

74. Management will make the audited financial statements readily available to the intended users of the schedule no later than the issuance date by the entity of the schedule of expenditures of federal awards and the auditor's report thereon.

75. Management has identified and disclosed all of its government programs and related activities subject to the Uniform Guidance compliance audit.

76. Management has identified and disclosed to the auditor the requirements of federal statutes, regulations, and the terms and conditions of federal awards that are considered to have a direct and material effect on each major program.

77. Management has made available all federal awards (including amendments, if any) and any other correspondence relevant to federal programs and related activities that have taken place with federal agencies or pass-through entities.

78. Management has identified and disclosed to the auditor all amounts questioned and all known noncompliance with the direct and material compliance requirements of federal awards or stated that there was no such noncompliance.

79. Management believes that the auditee has complied with the direct and material compliance requirements.

80. Management has made available all documentation related to compliance with the direct and material compliance requirements, including information related to federal program financial reports and claims for advances and reimbursements.

81. Management has provided to the auditor its interpretations of any compliance requirements that are subject to varying interpretations.

82. Management is aware of no communications from federal awarding agencies and pass-through entities concerning possible noncompliance with the direct and material compliance requirements, including communications received from the end of the period covered by the compliance audit to the date of the auditor's report.

83. There are no findings and related corrective actions taken for previous audits, attestation engagements, and internal or external monitoring that directly relate to the objectives of the compliance audit, including findings received and corrective actions taken from the end of the period covered by the compliance audit to the date of the auditor's report.

84. Management has provided the auditor with all information on the status of the follow-up on prior audit findings by federal awarding agencies and pass-through entities, including all management decisions,

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when applicable.

85. There are no subsequent events that provide additional evidence with respect to conditions that existed at the end of the reporting period that affect noncompliance during the reporting period.

86. Management has disclosed all known noncompliance with direct and material compliance requirements occurring subsequent to the period covered by the auditor’s report or stated that there were no such known instances.

87. Management has disclosed whether any changes in internal control over compliance or other factors that might significantly affect internal control, including any corrective action taken by management with regard to significant deficiencies and material weaknesses in internal control over compliance, have occurred subsequent to the period covered by the auditor’s report.

88. Federal program financial reports and claims for advances and reimbursements are supported by the books and records from which the basic financial statements have been prepared.

89. The copies of federal program financial reports provided to the auditor are true copies of the reports submitted, or electronically transmitted, to the federal agency or pass-through entity, as applicable.

90. Management has charged costs to federal awards in accordance with applicable cost principles.

91. The reporting package does not contain protected personally identifiable information.

92. Management will accurately complete the appropriate sections of the data collection form.

93. Management has disclosed all contracts or other agreements with service organizations, when applicable.

94. Management has disclosed to the auditor all communications from service organizations relating to noncompliance at those organizations, when applicable.

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Health Care District of Palm Beach County, Florida

DocuSigned by:
Darcy Davis
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Darcy J Davis,
Chief Executive Officer

DocuSigned by:
Candice Abbott
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Candice Abbott
Vice President, Clinical Integration

DocuSigned by:
Jesenia Bruno
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Jesenia Bruno,
Manager, Accounting and Financial Reporting

June 18, 2021

RSM US LLP
100 NE 3rd Ave
Suite 300
Fort Lauderdale, FL 33301

In connection with your examination of Healthcare District of Palm Beach County, Florida's (the District) compliance with *Section 218.415*, *Florida Statutes, Local Government Investment Policies* (the Statute) for the year ended September 30, 2020, in accordance with attestation standards established by the American Institute of Certified Public Accountants, we confirm to the best of our knowledge and belief, the following representations made to you during the course of your engagement:

1. We understand that we are responsible for the District's compliance with the Statute.
2. We are responsible for establishing and maintaining effective internal control over the District's compliance with the Statute.
3. We understand that we are responsible for determining that such criteria (compliance with the Statute) is appropriate for our purposes.
4. There are no known communications from regulatory agencies, internal auditors, or other practitioners concerning the District's possible noncompliance with the Statute.
5. We have made available to you all records relevant to the District's compliance with the Statute.
6. No events or transactions have occurred subsequent to September 30, 2020 that would result in known noncompliance with the Statute.
7. We have performed an evaluation of the District's compliance with the Statute. Based on our evaluation, the District has complied with the Statute during the year ended September 30, 2020.
8. There has been no known noncompliance with the Statute during the year ended September 30, 2020 or through the date of this letter.
9. There has been no knowledge of fraud or suspected fraud affecting the entity involving:
   a. Management,
   b. Employees who have significant roles in the internal control, or
   c. Others where fraud could have a material effect on the District's compliance with the Statute.
10. We acknowledge our responsibility for the design and implementation of programs and controls to provide reasonable assurance that fraud is prevented and detected.
11. We have no knowledge of any allegations of fraud or suspected fraud affecting the District received in communications from employees, former employees, analysts, regulators, or others.
12. We have responded fully to all inquiries made to us by you during your engagement.
13. During the course of your engagement you may have accumulated records containing data which should be reflected in our books and records. All such data have been so reflected. Accordingly, copies of such records in your possession are no longer needed by us.

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Health Care District of Palm Beach County, Florida

DocuSigned by:

Darcy Davis

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Darcy J Davis,
Chief Executive Officer

DocuSigned by:

candice Abbott

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Candice Abbott
Vice President, Clinical Integration

DocuSigned by:

Jesenia Bruno

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Jesenia Bruno,
Manager, Accounting and Financial Reporting

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June 18, 2021

RSM US LLP
1555 Palm Beach Lakes Boulevard
Suite 700
West Palm Beach, Florida 33401

This representation letter is provided in connection with your audits of the financial statements of the District Clinic Holdings, Inc. (the Clinics), a nonprofit organization and component unit of the Health Care District of Palm Beach County, Florida (the District) as of and for the years ended September 30, 2020 and 2019 for the purpose of expressing an opinion on whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

We confirm, to the best of our knowledge and belief, that as of the date of this letter:

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit arrangement letter dated September 10, 2020, for the preparation and fair presentation of the financial statements referred to above in accordance with U.S. GAAP.

2. We acknowledge our responsibility for 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.

3. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable and reflect our judgment based on our knowledge and experience about past and current events, and our assumptions about conditions we expect to exist and courses of action we expect to take.

5. Related-party transactions, including those with the District, and interfund transactions, including interfund accounts and advances receivable and payable, sale and purchase transactions, interfund transfers, long-term loans, and leasing arrangements and guarantees, have been recorded in accordance with the economic substance of the transaction and appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

6. All events subsequent to the date of the financial statements, and for which U.S. GAAP requires adjustment or disclosure, have been adjusted or disclosed (when applicable).

7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP. In that regard, no other litigation or claims asserted against the District require recognition or disclosure for the Clinics.

8. We have no direct or indirect legal or moral obligation for any debt of any organization, public or private, or to special assessment bond holders that is not disclosed in the financial statements.

9. With respect to receivables:

a. Adequate consideration has been given to, and appropriate provision made for, estimated adjustments to revenue, such as for denied claims and changes to resource utilization group, ambulatory payment classification, DSH settlements, and DRG assignments, as applicable.

b. Recorded valuation allowances are necessary, appropriate, and properly supported.

c. All peer review organizations, fiscal intermediary, and third-party payor reports and information have been made available.

10. With respect to contingencies:

a. There are no instances of noncompliance with laws or regulations, such as those related to Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements. This is including, but not limited to, the anti-kickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law), and the False Claims Act.

b. Billings to third-party payors comply in all material respects with applicable coding guidelines (for example, ICD-10 and CPT-4) and laws and regulations, including those dealing with Medicare and Medicaid antifraud and abuse, and billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies (for example, the Food and Drug Administration), if required; and properly rendered.

c. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the financial statements or on the disclosure in the notes to the financial statements.

d. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction, including those related to Medicare and Medicaid antifraud and abuse statutes; deficiencies in financial reporting practices; or other matters that could have a material adverse effect on the financial statements.

e. Adequate consideration has been given to, and appropriate provision made for, a prepaid health care provider's obligation to provide future health care services.

f. Guarantees, whether written or oral, under which the health care entity is contingently liable, including guarantee contracts and indemnification agreements have been properly recorded or disclosed in the financial statements.

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11. The Clinics is controlled by the District, who is its sole corporate member. The Clinics is exempt from federal and state income taxes as a governmental entity and is not required under the Internal Revenue Code to file tax returns.

12. Provision has been made, when material, for estimated retroactive adjustments by third-party payors under reimbursement agreements.

13. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the entity are properly disclosed (when applicable).

14. The Clinics is in compliance with contractual agreements, grants, and donor restrictions.

15. The internal controls over the receipt and recording of contributions are adequate.

16. The Clinics has reported to its risk management department all known asserted and unasserted claims and incidents. Adequate and reasonable provision has been made for losses related to asserted and unasserted malpractice, health insurance, worker's compensation, and any other claims.

17. The self-insured actuary specialist used by management in estimating the loss and loss adjustment expense had a sufficient level of competence and experience in loss estimates, including knowledge about the types of self-insurance programs in place by the Clinics as well as an understanding of the appropriate methods for calculating such loss estimates. We recognize we are responsible for the actuarial amounts and balances and, in our opinion, all such amounts are fairly presented. We further represent that we did not give or cause any instructions to be given to our specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.

18. The liability for self-insured claims (and claims adjustment expenses) includes estimates of amounts due on reported claims and claims that have been incurred but that were not reported as of September 30, 2020. Such estimates are based on actuarial projections applied to historical claim payment data. Such liabilities represent the Clinics' best estimate of amounts that are reasonable and adequate to discharge the Clinics' obligations from claims incurred but unpaid as of September 30, 2020. We further represent that we did not give or cause any instructions to be given to our specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.

19. We agree with the findings of the specialist in evaluating the other post-employment benefits (OPEB) liability and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give instructions, or cause any instructions to be given, to the specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialist. In addition, we believe that the actuarial assumptions and methods used by the actuary for determining the OPEB liability are appropriate in the circumstances. We did not give instructions, or cause any instructions to be given, to the specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the actuary.

20. The Clinics is subject to the requirements of Office of Management and Budget Title 2 U.S. *Code of Federal Regulations* (CFR) Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards*, or Title 45 U.S. CFR Part 75.501. The Clinics grant programs will be subject to the Single Audit performed for the overall District.

21. We have no knowledge of any uncorrected misstatements in the financial statements.

22. We are not aware of noncompliance related to Health information Technology for Economic and Clinical Health Act incentive payments and income from Medicare and Medicaid incentive payments for any year of our participation.

23. We have complied with all of the Terms and Conditions of the Provider Relief Funds that we have received and all information provided as part of our application for payment, as well as all information and reports relating to the payments associated with the Public Health and Social Services Emergency Fund that we are to provide in the future at the request of the Secretary or Inspector General are, or will be, true, accurate and complete.

24. Specifically, we billed Medicare in 2019; provide or provided after January 31, 2020 diagnoses, testing or care for individuals with possible or actual cases of COVID-19; are not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; are not currently excluded from participation in Medicare, Medicaid and other Federal health care programs; and do not currently have Medicare billing privileges revoked.

25. Additionally, Provider Relief Fund payments received were only used by the Clinics to prevent, prepare for and respond to the Coronavirus and to reimburse the Clinics for related expenses and lost revenues.

26. We have appropriately estimated the amount of revenue to recognize under the Provider Relief Fund program based on guidance from HHS as of September 30, 2020.

27. Provider Relief Funding of $227,362 was used to prevent, prepare for and respond to the Coronavirus and to reimburse the Clinics for related expenses and lost revenues.

Information Provided

28. We have provided you with:

a. Access to all information of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation and other matters;

b. Additional information that you have requested from us for the purpose of the audits;

c. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence; and

d. Minutes of the meetings of the board of commissioners and committees, or summaries of actions of recent meetings for which minutes have not yet been prepared;

29. All transactions have been recorded in the accounting records and are reflected in the financial statements.

30. It is our responsibility to establish and maintain internal controls over financial reporting. One of the components of internal control is risk assessment. We hereby represent that our risk assessment process includes identification and assessment of risks of material misstatement due to fraud. We have shared with you our overall internal control framework that addresses the risk of fraud and the controls that we have designed and implemented in response to such risks.

31. We have disclosed to you the results of our assessment of risk that the financial statements may be materially misstated as a result of fraud.

32. We have no knowledge of allegations of fraud or suspected fraud affecting the entity's financial statements involving:

a. Management.

b. Employees who have significant roles in internal control.

c. Others where the fraud could have a material effect on the financial statements.

33. We have no knowledge of allegations of fraud or suspected fraud affecting the entity's financial statements received in communications from employees, former employees, analysts, regulators, or others.

34. We have no knowledge of noncompliance or suspected noncompliance with laws and regulations whose effects were considered when preparing financial statements.

35. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements, when applicable.

36. We have disclosed to you the identity of the entity's related parties and all the related-party relationships and transactions of which we are aware.

37. We are aware of no significant deficiencies, including material weaknesses, in the design or operation of internal controls that could adversely affect the Clinics' ability to record, process, summarize and report financial data.

38. We are aware of no communications from regulatory agencies concerning noncompliance with, or deficiencies in, financial reporting practices.

39. During the course of your audits, you may have accumulated records containing data that should be reflected in our books and records. All such data have been so reflected. Accordingly, copies of such records in your possession are no longer needed by us.

Supplementary Information

40. With respect to the schedule of other post-employment benefits (OPEB) presented as required by the Governmental Accounting Standards Board (GASB) to supplement the basic financial statements:

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a. We acknowledge our responsibility for the presentation of such required supplementary information;

b. We believe such required supplementary information is measured and presented in accordance with guidelines prescribed by the GASB; and

c. The methods of measurement or presentation have not changed from those used in the prior period and/or are in accordance with guidelines prescribed by the GASB.

Compliance Considerations

In connection with your audits, conducted in accordance with *Government Auditing Standards*, we confirm that management:

41. Is responsible for the preparation and fair presentation of the financial statements in accordance with the applicable financial reporting framework.

42. Is responsible for compliance with the laws, regulations and provisions of contracts and grant agreements applicable to the auditee.

43. Is aware of no instances that have occurred, or are likely to have occurred, of fraud and noncompliance with provisions of laws and regulations that have a material effect on the financial statements or other financial data significant to the audit objectives, and any other instances that warrant the attention of those charged with governance.

44. Is aware of no instances that have occurred, or are likely to have occurred, of noncompliance with provisions of contracts and grant agreements that have a material effect on the determination of financial statement amounts.

45. Is aware of no instances that have occurred, or are likely to have occurred, of waste or abuse that could be quantitatively or qualitatively material to the financial statements.

46. Is responsible for 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.

47. Acknowledges its responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.

48. Has a process to track the status of audit findings and recommendations, when applicable.

49. Has identified for the auditor previous audits, attestation engagements and other studies related to the audit objectives and whether related recommendations have been implemented.

50. Acknowledges its responsibilities as it relates to non-audit services performed by the auditor, including a statement that it assumes all management responsibilities; that it oversees the services by designating an individual, preferably within senior management, who possesses suitable skill, knowledge, or experience; and that it evaluates the adequacy and results of the services performed; and that it accepts responsibility for the results of the services.

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District Clinic Holdings, Inc.

DocuSigned by:
Darcy Davis
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Darcy J Davis,
Chief Executive Officer

DocuSigned by:
Candice Abbott
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Candice Abbott
Vice President, Clinical Integration

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Jesenia Bruno
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Jesenia Bruno,
Manager, Accounting and Financial Reporting

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May 18, 2021

RSM US LLP
1515 Palm Beach Lakes Boulevard
Suite 700
West Palm Beach, FL 33401

This representation letter is provided in connection with your audits of the financial statements of District Hospital Holdings, Inc. (the Hospital), a component unit of the Health Care District of Palm Beach County, Florida (the District) as of and for the years ended September 30, 2020 and 2019, for the purpose of expressing an opinion on whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

We confirm, to the best of our knowledge and belief, that as of the date of this letter:

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit arrangement letter dated September 10, 2020, for the preparation and fair presentation of the financial statements referred to above in accordance with U.S. GAAP.

2. We acknowledge our responsibility for 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.

3. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable and reflect our judgment based on our knowledge and experience about past and current events, and our assumptions about conditions we expect to exist and courses of action we expect to take.

5. Related-party transactions, including those with the District, and interfund transactions, including interfund accounts and advances receivable and payable, sale and purchase transactions, interfund transfers, long-term loans, leasing arrangements and guarantees, have been recorded in accordance with the economic substance of the transaction and appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

6. All events subsequent to the date of the financial statements, and for which U.S. GAAP requires adjustment or disclosure, have been adjusted or disclosed (when applicable).

7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP. In that regard, no litigation or claims asserted against the District require recognition or disclosure for the Hospital.

8. We have no direct or indirect legal or moral obligation for any debt of any organization, public or private, or to special assessment bond holders that is not disclosed in the financial statements.

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9. With respect to receivables:

    a. Adequate consideration has been given to, and appropriate provision made for, estimated adjustments to revenue, such as for denied claims and changes to resource utilization group, ambulatory payment classification, DSH settlements and DRG assignments, as applicable.

    b. Recorded valuation allowances are necessary, appropriate, and properly supported.

    c. All peer review organizations, fiscal intermediary, and third-party payor reports and information have been made available.

10. With respect to cost reports:

    a. All required Medicare, Medicaid, and similar reports have been properly filed.

    b. Management is responsible for the accuracy and propriety of all filed cost reports.

    c. All costs reflected on such reports are appropriate and allowable under applicable reimbursement rules and regulations and are patient-related and properly allocated to applicable payors.

    d. The employed reimbursement methodologies and principles are in accordance with applicable rules and regulations.

    e. Adequate consideration has been given to, and appropriate provision made for, audit adjustments by intermediaries, third-party payors, or other regulatory agencies.

    f. All items required to be disclosed, including disputed costs that are being claimed to establish a basis for a subsequent appeal, have been fully disclosed in the cost report.

    g. Recorded third-party settlements include differences between filed (and to-be-filed) cost reports and calculated settlements, which are necessary based on historical experience or new or ambiguous regulations that may be subject to differing interpretations. Although management believes that the entity is entitled to all amounts claimed on the cost reports, management also believes the amounts of these differences are appropriate.

11. With respect to contingencies:

    a. There are no instances of noncompliance with laws or regulations, such as those related to Medicare and Medicaid antifraud and abuse statutes, in any jurisdiction, whose effects are considered for disclosure in the financial statements or as a basis for recording a loss contingency other than those disclosed or accrued in the financial statements. This is including, but not limited to, the anti-kickback statute of the Medicare and Medicaid Patient and Program Protection Act of 1987, limitations on certain physician referrals (the Stark law) and the False Claims Act.

    b. Billings to third-party payors comply in all material respects with applicable coding guidelines (for example, ICD-10 and CPT-4) and laws and regulations, including those dealing with Medicare and Medicaid antifraud and abuse, and billings reflect only charges for goods and services that were medically necessary; properly approved by regulatory bodies (for example, the Food and Drug Administration), if required; and properly rendered.

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c. There have been no internal or external investigations relating to compliance with applicable laws and regulations, including investigations in progress that would have an effect on the amounts reported in the financial statements or on the disclosure in the notes to the financial statements.

d. There have been no oral or written communications from regulatory agencies, governmental representatives, employees, or others concerning investigations or allegations of noncompliance with laws and regulations in any jurisdiction, including those related to Medicare and Medicaid antifraud and abuse statutes; deficiencies in financial reporting practices; or other matters that could have a material adverse effect on the financial statements.

e. Adequate consideration has been given to, and appropriate provision made for, a prepaid health care provider's obligation to provide future health care services.

f. Guarantees, whether written or oral, under which the health care entity is contingently liable, including guarantee contracts and indemnification agreements have been properly recorded or disclosed in the financial statements.

g. We continue to maintain commercial insurance for general liability, director and officer liability, auto, workers' compensation, cyber security and business interruption risk that provides adequate coverage for the risks commensurate with the health care entity's business. Management periodically reviews such insurance coverages and intends to maintain appropriate levels of insurance coverage to address such risks.

12. The Hospital is controlled by the District, which is its sole corporate member. The Hospital is exempt from federal and state income taxes as a governmental entity and is not required under the Internal Revenue Code to file tax returns.

13. Provision has been made, when material, for estimated retroactive adjustments by third-party payors under reimbursement agreements.

14. Pending changes in the organizational structure, financing arrangements, or other matters that could have a material effect on the financial statements of the entity are properly disclosed (when applicable).

15. The health care entity is in compliance with contractual agreements, grants and donor restrictions.

16. The internal controls over the receipt and recording of received contributions are adequate.

17. The health care entity has reported to its risk management department all known asserted and unasserted claims and incidents. Adequate and reasonable provision has been made for losses related to asserted and unasserted malpractice, health insurance, worker's compensation and any other claims.

18. The self-insured loss specialist used by management in estimating the loss and loss adjustment expense had a sufficient level of competence and experience in loss estimates, including knowledge about the types of self-insurance programs in place by the Hospital as well as an understanding of the appropriate methods for calculating such loss estimates. We recognize we are responsible for the actuarial amounts and balances and, in our opinion, all such amounts are fairly presented. We further represent that we did not give or cause any instructions to be given to our specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.

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19. The liability for self-insured claims (and claims adjustment expenses) includes estimates of amounts due on reported claims and claims that have been incurred but that were not reported as of September 30, 2020. Such estimates are based on actuarial projections applied to historical claim payment data. Such liabilities represent the Hospital's best estimate of amounts that are reasonable and adequate to discharge the Hospital's obligations from claims incurred but unpaid as of September 30, 2020. We further represent that we did not give or cause any instructions to be given to our specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialists.

20. We agree with the findings of the specialist in evaluating the other post-employment benefits (OPEB) liability and have adequately considered the qualifications of the specialist in determining the amounts and disclosures used in the financial statements and underlying accounting records. We did not give instructions, or cause any instructions to be given, to the specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the specialist. In addition, we believe that the actuarial assumptions and methods used by the actuary for determining the OPEB liability are appropriate in the circumstances. We did not give instructions, or cause any instructions to be given, to the specialist with respect to the values or amounts derived in an attempt to bias their work, and we are not otherwise aware of any matters that have had an impact on the independence or objectivity of the actuary.

21. We have complied with all aspects of laws, regulations and provisions of contracts and agreements that would have a material effect on the financial statements in the event of noncompliance.

22. We have no knowledge of any uncorrected misstatements in the financial statements.

23. We are not aware of noncompliance related to Health Information Technology for Economic and Clinical Health Act incentive payments and income from Medicare and Medicaid incentive payments for any year of our participation.

24. The Hospital is financially dependent on the District. The District has provided cumulative operating and capital contributions of approximately $146.9 million and $69 million, respectively, to the Hospital since May 2004. The District intends to continue to fund the operations of the Hospital on an ongoing basis, as needed.

25. We have complied with all of the Terms and Conditions of the Provider Relief Funds that we have received and all information provided as part of our application for payment, as well as all information and reports relating to the payments associated with the Public Health and Social Services Emergency Fund that we are to provide in the future at the request of the Secretary or Inspector General are, or will be, true, accurate and complete.

26. Specifically, we billed Medicare in 2019; provide or provided after January 31, 2020 diagnoses, testing or care for individuals with possible or actual cases of COVID-19; are not currently terminated from participation in Medicare or precluded from receiving payment through Medicare Advantage or Part D; are not currently excluded from participation in Medicare, Medicaid and other Federal health care programs; and do not currently have Medicare billing privileges revoked.

27. Additionally, Provider Relief Fund payments received were only used by the Hospital to prevent, prepare for and respond to the Coronavirus and to reimburse the Hospital for related expenses and lost revenues.

28. We have appropriately estimated the amount of revenue to recognize under the Provider Relief Fund program based on guidance from HHS as of September 30, 2020.

29. The amount of General Fund operating contributions made to the Hospital in each fiscal year is determined after accounting for all other funding sources (patient revenues, Provider Relief Funds (PRF), DSH, LIP and grants) available for Hospital operations. PRF of $9,012,429 was available to prevent, prepare for and respond to the Coronavirus and to reimburse the Hospital for related expenses and lost revenues. Therefore, budgeted General Fund contributions in the amount of $10,000,000 was not required to be funded for the year ended. This reduction in General Fund contributions resulted in an increase in the Hospital's losses that are available to be funded by PRF. However, for revenue recognition purposes we believe that this amount should have an allowance of $10,000,000 applied against it as we cannot currently determine if HRSA and HHS would allow this adjustment for purposes of determining the net margin loss. Therefore, the Hospital will not recognize revenues related to this portion of the operating loss for the year ended September 30, 2020.

Information Provided

30. We have provided you with:

    a. Access to all information of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation and other matters;

    b. Additional information that you have requested from us for the purpose of the audits;

    c. Unrestricted access to persons within the entity from whom you determined it necessary to obtain audit evidence; and

    d. Minutes of the meetings of the board of commissioners and committees, or summaries of actions of recent meetings for which minutes have not yet been prepared.

31. All transactions have been recorded in the accounting records and are reflected in the financial statements.

32. It is our responsibility to establish and maintain internal controls over financial reporting. One of the components of internal control is risk assessment. We hereby represent that our risk assessment process includes identification and assessment of risks of material misstatement due to fraud. We have shared with you our overall internal control framework that addresses the risk of fraud that does address fraud risks and the controls that we have designed and implemented in response to risks.

33. We have disclosed to you the results of our assessment of risk that the financial statements may be materially misstated as a result of fraud.

34. We have no knowledge of allegations of fraud or suspected fraud affecting the entity's financial statements involving:

    a. Management.

    b. Employees who have significant roles in internal control.

    c. Others where the fraud could have a material effect on the financial statements.

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35. We have no knowledge of allegations of fraud or suspected fraud affecting the entity's financial statements received in communications from employees, former employees, analysts, regulators, or others.

36. We have no knowledge of noncompliance or suspected noncompliance with laws and regulations whose effects were considered when preparing financial statements.

37. We have disclosed to you all known actual or possible litigation and claims whose effects should be considered when preparing the financial statements, when applicable.

38. We have disclosed to you the identity of the entity's related parties and all the related-party relationships and transactions of which we are aware.

39. We are aware of no significant deficiencies, including material weaknesses, in the design or operation of internal controls that could adversely affect the Hospital's ability to record, process, summarize and report financial data.

40. We are aware of no communications from regulatory agencies concerning noncompliance with, or deficiencies in, financial reporting practices.

41. During the course of your audits, you may have accumulated records containing data that should be reflected in our books and records. All such data have been so reflected. Accordingly, copies of such records in your possession are no longer needed by us.

Supplementary Information

42. With respect to the management's discussion and analysis and the schedule of changes in the total other post-employment benefits (OPEB) liability and related ratios as required by the Governmental Accounting Standards Board (GASB) to supplement the basic financial statements:

    a. We acknowledge our responsibility for the presentation of such required supplementary information;

    b. We believe such required supplementary information, including its form and content, is fairly presented in accordance with guidelines prescribed by the GASB; and

    c. The methods of measurement or presentation have not changed from those used in the prior period.

Compliance Considerations

In connection with your audits, conducted in accordance with *Government Auditing Standards*, we confirm that management:

43. Is responsible for the preparation and fair presentation of the financial statements in accordance with the applicable financial reporting framework.

44. Is responsible for compliance with the laws, regulations and provisions of contracts and grant agreements applicable to the auditee.

45. Is aware of no instances that have occurred, or are likely to have occurred, of fraud and noncompliance with provisions of laws and regulations that have a material effect on the financial

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statements or other financial data significant to the audit objectives, and any other instances that warrant the attention of those charged with governance.

46. Is aware of no instances that have occurred, or are likely to have occurred, of noncompliance with provisions of contracts and grant agreements that have a material effect on the determination of financial statement amounts.

47. Is aware of no instances that have occurred, or are likely to have occurred, of waste or abuse that could be quantitatively or qualitatively material to the financial statements.

48. Is responsible for 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.

49. Acknowledges its responsibility for the design, implementation and maintenance of internal controls to prevent and detect fraud.

50. Has a process to track the status of audit findings and recommendations, when applicable.

51. Has identified for the auditor previous audits, attestation engagements and other studies related to the audit objectives and whether related recommendations have been implemented.

52. Acknowledges its responsibilities as it relates to non-audit services performed by the auditor, including a statement that it assumes all management responsibilities; that it oversees the services by designating an individual, preferably within senior management, who possesses suitable skill, knowledge, or experience; that it evaluates the adequacy and results of the services performed; and that it accepts responsibility for the results of the services.

District Hospital Holdings, Inc.

Darcy J Davis,
Chief Executive Officer

Candice Abbott
Vice President, Clinical Integration

Jesenia Bruno,
Director of Accounting

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June 18, 2021

RSM US LLP
1555 Palm Beach Lakes Boulevard
Suite 700
West Palm Beach, Florida 33401

This representation letter is provided in connection with your audits of the financial statements of Good Health Foundation, Inc., (the Foundation), a nonprofit organization and component unit of the Health Care District of Palm Beach County, Florida (the District), which comprise the statements of financial position as of September 30, 2020 and 2019, the related statements of activities and changes in net assets, statements of cash flows for the years then ended and the related notes to the financial statements, for the purpose of expressing an opinion on whether the financial statements are presented fairly, in all material respects, in accordance with accounting principles generally accepted in the United States of America (U.S. GAAP).

We confirm, to the best of our knowledge and belief, that as of the date of this letter:

Financial Statements

1. We have fulfilled our responsibilities, as set out in the terms of the audit arrangement letter dated September 10, 2020 for the preparation and fair presentation of the financial statements referred to above in accordance with U.S. GAAP.

2. We acknowledge our responsibility for 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.

3. We acknowledge our responsibility for the design, implementation and maintenance of internal control to prevent and detect fraud.

4. Significant assumptions used by us in making accounting estimates, including those measured at fair value, are reasonable and reflect our judgment based on our knowledge and experience about past and current events, and our assumptions about conditions we expect to exist and courses of action we expect to take.

5. Related-party relationships and transactions have been appropriately accounted for and disclosed in accordance with the requirements of U.S. GAAP.

6. All events subsequent to the date of the financial statements, and for which U.S. GAAP requires adjustment or disclosure, have been adjusted or disclosed.

7. The effects of all known actual or possible litigation and claims have been accounted for and disclosed in accordance with U.S. GAAP, when applicable.

8. The Foundation is in compliance with the provisions of IRC Section 501(c)(3) and is exempt from federal income tax under IRC Section 501(a), as evidenced by a determination letter, and from state income tax.

9. Information returns (Form 990) have been filed on a timely basis.

10. The Foundation is in compliance with contractual agreements, grants, and donor restrictions.

11. The Foundation has maintained an appropriate composition of net assets in amounts needed to comply with all donor restrictions.

12. The internal controls over the receipt and recording of received contributions are adequate.

13. The allocation of expenses is reasonable based on the Foundation's current operations.

14. The Foundation has classified net assets as net assets without donor restrictions or net assets with donor restrictions based on its assessment of the donor's intention, as specified in original donor correspondence, when available. When not available, the Foundation used other corroborating evidential matter. To the extent that it was unable to review original donor correspondence to determine the amount of the original gift and donor additions, its determination of such amount was based on its best estimate considering the relevant facts and circumstances. Amounts classified as with donor restrictions are subject to donor-imposed purpose or time restrictions that precluded the Foundation from expending such amounts or recognizing such amounts as without donor restriction as of the balance sheet date. Reclassifications between net asset classes are proper.

15. We have no knowledge of any uncorrected misstatements in the financial statements.

Information Provided

16. We have provided you with:

    a. Access to all information of which we are aware that is relevant to the preparation and fair presentation of the financial statements such as records, documentation and other matters;

    b. Additional information that you have requested from us for the purpose of the audits;

    c. Unrestricted access to persons within the Foundation from whom you determined it necessary to obtain audit evidence; and

    d. Minutes of the meetings of the governing board and committees, or summaries of actions of recent meetings for which minutes have not yet been prepared.

17. All transactions have been recorded in the accounting records and are reflected in the financial statements.

18. We have disclosed to you the results of our assessment of risk that the financial statements may be materially misstated as a result of fraud.

19. We have no knowledge of allegations of fraud or suspected fraud affecting the Foundation's financial statements involving:

    e. Management.

    f. Employees who have significant roles in internal control.

    g. Others where the fraud could have a material effect on the financial statements.

20. We have no knowledge of any allegations of fraud or suspected fraud affecting the Foundation's financial statements received in communications from employees, former employees, regulators or others.

21. We have no knowledge of noncompliance or suspected noncompliance with laws and regulations. Additionally, we specifically represent that we are responsible for determining that we are not subject to the requirements of the Single Audit Act because we have not received, expended or otherwise been the beneficiary of the required amount of federal awards during the period of this audit.

22. We are aware of no known actual or possible litigation and claims whose effects should be considered when preparing the financial statements, and we have not consulted legal counsel concerning litigation or claims.

23. We have disclosed to you the identity of the Foundation's related parties and all the related-party relationships and transactions of which we are aware.

24. We are aware of no significant deficiencies, including material weaknesses, in the design or operation of internal controls that could adversely affect the Foundation's ability to record, process, summarize and report financial data.

25. There have been no communications from regulatory agencies concerning noncompliance with, or deficiencies in, financial reporting practices.

26. During the course of your audits, you may have accumulated records containing data that should be reflected in our books and records. All such data have been so reflected. Accordingly, copies of such records in your possession are no longer needed by us.

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Good Health Foundation, Inc.

DocuSigned by:
Darcy Davis
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Darcy J Davis,
Chief Executive Officer

DocuSigned by:
Candice Abbott
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Candice Abbott
Vice President, Clinical Integration

DocuSigned by:
Jesenia Bruno
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Jesenia Bruno,
Manager, Accounting and Financial Reporting

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EXHIBIT B

RSM Health Care Appendix

Health Care Appendix

GOVERNMENT | SUMMER 2021

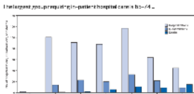
Questions? Your RSM professional can connect you with any of our presenters or authors. Don't miss the latest research reports, insight articles and educational webcasts Visit www.RSMUS.com/Healthcare Subscribe to our industry newsletter.

RSM invites you to access its data-backed reports and insights from senior analysts and experienced professionals to help you navigate the issues and challenges you face as your lead your organization. Here are some highlights.

RESEARCH

Health Care Industry Outlook

These are challenging times. Now more than ever, data-driven analysis can help mitigate uncertainty created by the pandemic's shocks to the economy. Our health care specific insights can help. Our Outlooks are developed by RSM's senior analysts dedicated to studying economic and industry data, market trends and emerging issues.



The Real Economy Health Care Blog

Health care industry analysts interpret data and share timely insights for health care leaders and media.

The Real Economy

Monthly publication to help the middle market anticipate and address unique issues and challenges facing the industries in which they operate. Written by chief economist, Joe Brusuelas, and professionals throughout the firm.

RSM Coronavirus Resource Center

Stay on top of the evolving issues related to the pandemic in order to mitigate risks and plan accordingly. Find insights about the Provider Relief Fund and CARES Act.

REGULATORY & TAX UPDATES

Exclusive access period coming to PPP; other changes forthcoming

Biden-Harris administration announces changes to PPP including a 14-day exclusive access period for businesses with fewer than 20 employees.

IRS extends April 15, 2021 due date for victims of Texas winter storm

IRS postpones certain filing, payment and other time sensitive deadlines for taxpayers affected by Texas winter storms.

New IRS guidance on health FSAs and dependent care assistance programs

Employers can add flexibility to their health flexible spending accounts and dependent care assistance programs per Notice 2021-15.

Guidance issued for employers claiming the Employee Retention Credit

Notice 2021-20 clarifies retroactive changes made to ERTC and PPP interaction and incorporates several previous frequently asked questions.

IRS issues memorandum on section 501(c)(4) examination procedures

The IRS released a memo to TE/GE division examiners providing guidelines on enforcement of the section 506 notification requirement.

American Rescue Plan Act provisions affecting exempt organizations

The American Rescue Plan Act of 2021 extends and expands support for exempt organizations affected by the coronavirus pandemic.

Form 990-T electronic filing mandate now in effect

Taxpayers must electronically file 2020 Forms 990-T with due dates on or after April 15, 2021. Limited exceptions apply.

IRS TE/GE Division releases its fiscal year 2020 accomplishments letter

On February 8, TE/GE released its annual accomplishments letter with information about the divisions efforts in the prior fiscal year, including compliance programs and examinations, determinations, and compliance contacts, educational letters, and outreach.

IRS issues memo to employees regarding section 9100 relief for applications for exemption

The IRS released a memorandum providing interim guidance to TE/GE Division rulings and agreements employees on procedural changes with respect to the provision of section 9100 relief in light of clarification provided in Rev. Proc. 2021-5 on the application of such relief.

American Rescue Plan Act of 2021

The $1.9 trillion relief and stimulus package known as The American Rescue Plan Act of 2021 was signed into law on Thursday, March 11. See RSM's full alert for an overview of the relief package.

Paycheck Protection Program

President Biden has signed the PPP Extension Act of 2021, which will extend the Paycheck Protection Program (PPP) until May 31, 2021. See RSM alert.

EVENTS

HEALTH CARE WEBCASTS– Live and on-demand

- Health care industry webcast series - spring 2021 Financial sustainability and growth in a changing environment
- HHS Provider Relief Fund and AICPA health care expert panel [Recording available]

Click here for more information and recordings

Click here and here to access previous health care on-demand sessions.

ADDITIONAL RSM VIRTUAL EVENTS

See us at HIMSS21! (Aug. 9-13) We are sponsoring the Value of Healthcare Pavilion and sharing many exciting demos and on data analytics, denials, transparency cybersecurity and more.

Watch for our RSM Virtual Health Care Day slated for Thursday, Sept. 30, 2021. Don't miss event includes an economic outlook from our Chief Economist, Joe Brusuelas, a selection of virtual learning and two panels, where you can hear from your peers about COVID recovery and cybersecurity. CPE credits will be available.

Additional events

RSM Classic PGA event

Watch for 2021 dates!

- RSM Welcomes Abraham Ancer to Team RSM
- 2020 RSM Classic Raises More Than $4.6M for Children and Families to Enhance Educational Outcomes

IN THE NEWS

- Exits Versus Investments in 2021, 03/01/2021*
- Exuberance in the Market Translating into Private Equity Valuations, 03/02/2021*
- Hospitals posted higher profits in second half of 2020* even as COVID cases soared, 03/11/2021 [Modern Healthcare]
- His Career in Private Equity, 03/12/2021*
- Trends in Private Equity, 03/30/2021*
- Biden's Infrastructure Bill, 04/07/2021*
- How COVID Has Changed Private Equity Deals, 02/17/2021*
- Exits and Investments in 2021, 02/23/2021*
- Outsourcing Accounting and CFO Sources Versus Keeping Them In-House, 02/24/2021*
- Behavioral Health in the Private Equity Space, 03/05/2021*
- Trends in Healthcare Investing, 03/11/2021*
- What Amazon Care's nationwide expansion means for the telehealth industry, 03/18/2021 [STAT News]
- High Interest Rates, 03/24/2021*
- Jeb Bush, Marilyn Tavenner getting in on healthcare SPAC frenzy, 03/26/2021 [Modern Healthcare]
- Private Equity Trends and Biden's Infrastructure Bill, 04/08/2021*
- Amazon Triggers a "Buy" Signal for this Mega-Trend, 04/09/2021 [Wall Street Daily]

** The Scott Becker Private Equity or Healthcare Podcast*

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Annual Financial Report

For the Fiscal Year Ended September 30, 2020

Dedicated to the health of our community

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Health Care District of Palm Beach County, Florida

Annual Financial Report
September 30, 2020

Prepared by
Finance Department

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Contents

I. Introductory section

Organizational chart 1
District officials 2-3

II. Financial section

Independent auditor's report 4-5

Basic financial statements
Government-wide financial statements
Statement of net position 6
Statement of activities 7-8

Fund financial statements
Balance sheet—governmental funds 9
Statement of revenues, expenditures and changes in fund balances—governmental funds 10
Reconciliation of the statement of revenues, expenditures and changes in fund balances of governmental funds to the statement of activities 11
Statement of net position—proprietary funds 12
Statement of revenues, expenses and changes in net position—proprietary funds 13
Statement of cash flows—proprietary funds 14-15
Statement of fiduciary net position—fiduciary funds 16
Statement of changes in fiduciary net position—pension trust funds 17

Notes to financial statements 18-55

Required supplementary information
Schedule of revenues, expenditures and changes in fund balances—general fund—budget and actual 56-57
Schedule of revenues, expenditures and changes in fund balances—Medicaid Match Fund—budget and actual 58
Notes to required supplementary information 59
Schedule of changes in the total OPEB liability and related ratios 60
Schedule of District proportionate share of net pension liability—Florida Retirement System Plans 61
Schedule of District contributions—Florida Retirement System Plans 62

Individual fund financial statements –Agency funds
Statement of changes in agency fund assets and liabilities—resident agency fund 63

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Contents (Continued)

IV. Compliance section

Independent auditor's report on:
Internal control over financial reporting and on compliance and other matters based on an audit of financial statements performed in accordance with *Government Auditing Standards* 64-65
Compliance for each major federal program and report on internal control over compliance 66-67

Schedule of expenditures of federal awards 68
Notes to schedule of expenditures of federal awards 69
Schedule of findings and questioned costs 70
Management letter 71-72
Independent accountant's report on compliance with *Section 218.415, Florida Statutes, Local Government Investment Policies* 73

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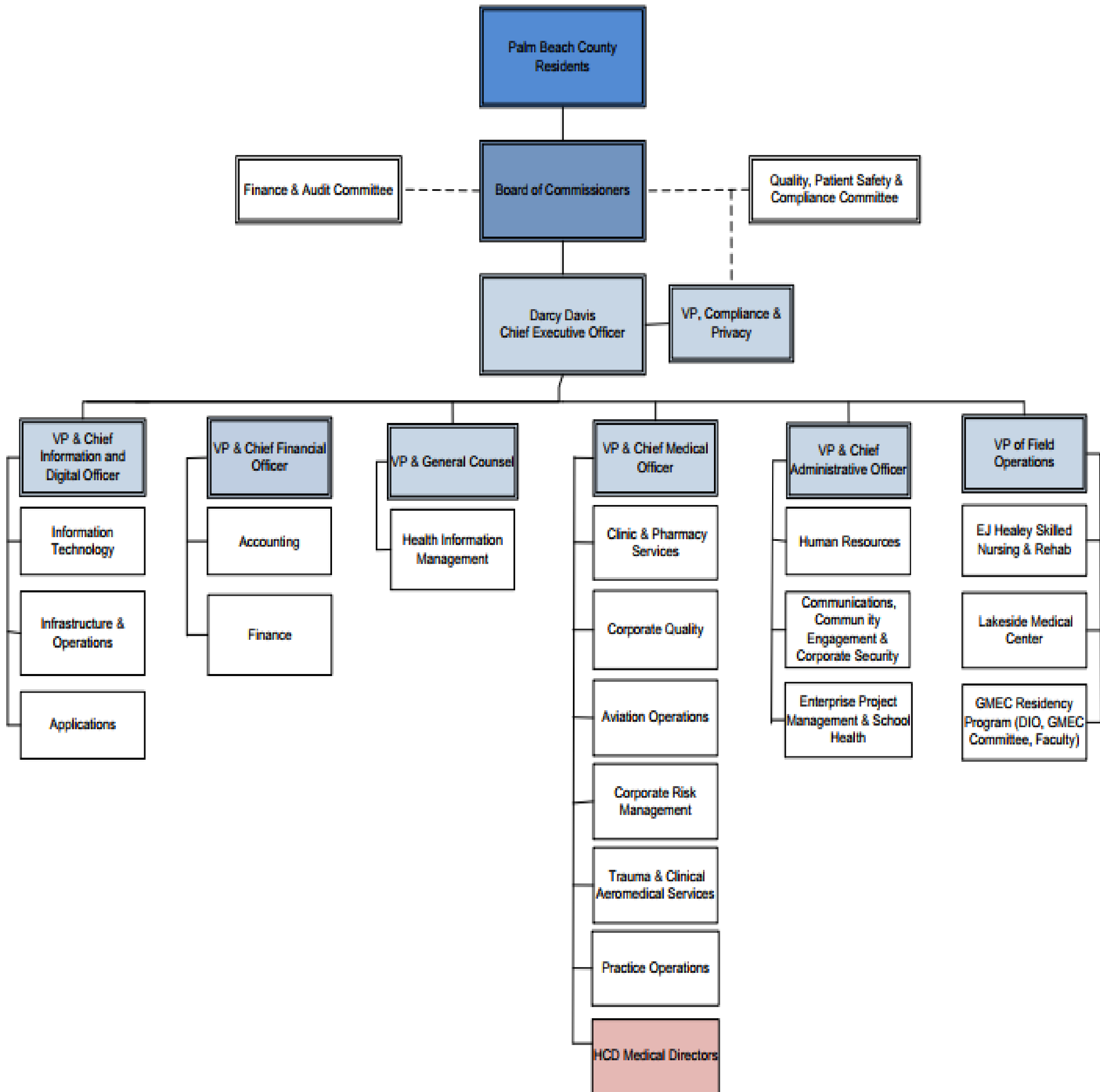
HEALTH CARE DISTRICT OF PALM BEACH COUNTY, FLORIDA
ORGANIZATIONAL CHART



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HEALTH CARE DISTRICT OF PALM BEACH COUNTY, FLORIDA
DISTRICT OFFICIALS

DISTRICT BOARD

Chair	Leslie B. Daniels
Vice-Chair	Nancy C. Banner, P.A
Secretary	Sean O'Bannon
Board Member	Alina Alonso, MD
Board Member	Cory Neering
Board Member	Edward G. Sabin
Board Member	Tammy Jackson-Moore

DISTRICT QUALITY, PATIENT SAFETY AND COMPLIANCE COMMITTEE

Chair	Alina Alonso, MD (Board member)
Committee Member	Dr. David Bohorquez
Committee Member	James Elder
Committee Member	Sharon Larson
Committee Member	Cory Neering (Board member)
Committee Member	Sean O'Bannon (Board member)
Committee Member	Mary Weeks
Committee Member	Kimberly Schulz

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HEALTH CARE DISTRICT OF PALM BEACH COUNTY, FLORIDA
DISTRICT OFFICIALS (CONTINUED)

DISTRICT FINANCE AND AUDIT COMMITTEE

Chair	Edward Sabin (Board member)
Committee Member	Nancy Banner, P.A (Board member)
Committee Member	Joseph Bergeron
Committee Member	Michael Burke
Committee Member	Leslie B. Daniels (Board member)
Committee Member	Mark Marciano
Committee Member	Richard Sartory
Committee Member	Joseph Gibbons

DISTRICT OFFICERS

Chief Executive Officer	Darcy J. Davis
VP & General Counsel	Valerie Shahriari, Esq.
VP & Chief Financial Officer	Joel Snook
VP & Chief Medical Officer	Belma Andric, MD
VP of Field Operations	Karen Harris
VP & Chief Administrative Officer	Steven Hurwitz
VP & Chief Compliance Officer	Vacant
VP & Chief Information and Digital Officer	Patty Lavely (Interim)

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Financial Section

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RSM US LLP

Independent Auditor's Report

The Honorable Chairperson and Members of
the Health Care District Board
Health Care District of Palm Beach County, Florida

Report on the Financial Statements
We have audited the accompanying financial statements of the governmental activities, the business-type activities, the aggregate discretely presented component unit, each major fund, and the aggregate remaining fund information of the Health Care District of Palm Beach County, Florida (the District), as of and for the year ended September 30, 2020, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

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

Auditor's Responsibility
Our responsibility is to express opinions on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards,* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free from material misstatement. The financial statements of the discretely presented component unit Good Health Foundation, Inc. were not audited in accordance with *Government Auditing Standards.*

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 we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Opinions
In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial position of the governmental activities, the business-type activities, the aggregate discretely presented component unit, each major fund and the aggregate remaining fund information of the District, as of September 30, 2020, and the respective changes in financial position and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

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Other Matters

Required Supplementary Information

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

Management has omitted *management's discussion and analysis* that accounting principles generally accepted in the United States of America require to be presented to supplement the basic financial statements. Such missing information, although not a part of the basic financial statements, is required by Governmental Accounting Standards Board, who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic or historical context. Our opinion on the basic financial statements is not affected by this missing information.

Other Information

Our audit was conducted for the purpose of forming opinions on the financial statements that collectively comprise the District's basic financial statements. The accompanying supplementary information such as the Schedule of Expenditures of Federal Awards, as required by Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance) and the individual fund financial statements are presented for purposes of additional analysis and are not a required part of the basic financial statements.

The individual fund financial statements and Schedule of Expenditures of Federal Awards are the responsibility of management and were derived from and relates directly to the underlying accounting and other records used to prepare the basic financial statements. Such information has been subjected to the auditing procedures applied in the audit of the basic financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the basic financial statements or to the basic financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the individual fund financial statements and Schedule of Expenditures of Federal Awards are fairly stated, in all material respects, in relation to the basic financial statements as a whole.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards,* we have also issued our report dated June 18, 2021, on our consideration of the District's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts and grant agreements and other matters. The purpose of that report is solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the District's internal control over financial reporting and compliance.

RSM US LLP

West Palm Beach, Florida
June 18, 2021

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Basic Financial Statements

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Health Care District of Palm Beach County, Florida

Statement of Net Position
September 30, 2020

	Primary Government			Component Unit
	Governmental Activities	Business-Type Activities	Total	Good Health Foundation, Inc.
Assets				
Cash and cash equivalents	$ 31,329,085	$ 18,652,595	$ 49,981,680	$ 443,904
Investments	112,897,536	-	112,897,536	-
Accounts receivable, net	399,912	5,783,416	6,183,328	4,219
Due from other governments	8,563,720	5,828,968	14,392,688	-
Internal balances	5,375,000	(5,375,000)	-	-
Inventories	47,384	666,280	713,664	-
Prepaid expenses and other current assets	6,562,246	779,849	7,342,095	-
Restricted cash	-	1,508,855	1,508,855	-
Capital assets:				
Capital assets not being depreciated	15,480,529	4,745,313	20,225,842	-
Depreciable capital assets, net of accumulated depreciation	5,048,826	52,733,102	57,781,928	-
Total assets	$ 185,704,238	$ 85,323,378	$ 271,027,616	$ 448,123
Deferred Outflows of Resources				
Deferred outflows related to pensions and OPEB	$ 150,327	$ 146,312	$ 296,639	$ -
Liabilities				
Accounts payable	$ 7,796,159	$ 2,266,354	$ 10,062,513	$ -
Accrued expenses	4,495,264	4,361,702	8,856,966	-
Medical benefits payable	1,749,185	-	1,749,185	-
Unearned revenue	2,783,000	16,694,026	19,477,026	-
Estimated third-party payor settlements	-	1,895,903	1,895,903	-
Noncurrent liabilities				
Due within one year:				
Compensated absences	529,686	952,158	1,481,844	-
Estimated self-insured liability	1,663,164	476,918	2,140,082	-
Deferred rent	-	7,548	7,548	-
Due in more than one year:				
Due to other governments	597,531	-	597,531	-
Compensated absences	1,987,779	3,573,215	5,560,994	-
Estimated self-insured liability	-	536,280	536,280	-
Other post-employment benefits	385,967	347,073	733,040	-
Net pension liability	-	275,517	275,517	-
Other long-term liabilities	-	166,718	166,718	-
Total liabilities	$ 21,987,735	$ 31,553,412	$ 53,541,147	$ -
Deferred Inflows of Resources				
Deferred inflows related to pensions and OPEB	$ 2,163	$ 116,211	$ 118,374	$ -
Net Position				
Net investment in capital assets	$ 20,529,355	$ 57,478,415	$ 78,007,770	$ -
Restricted for:				
Statutory reserves	-	1,500,000	1,500,000	-
Donor-restricted contributions	-	8,855	8,855	-
Unrestricted (deficit)	143,335,312	(5,187,203)	138,148,109	448,123
Total net position	$ 163,864,667	$ 53,800,067	$ 217,664,734	$ 448,123

See notes to financial statements.

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Health Care District of Palm Beach County, Florida

Statement of Activities
Fiscal Year Ended September 30, 2020

		Program Revenues		
	Expenses	Charges for Services	Operating Grants and Contributions	Capital Grants and Contributions
Primary government:				
Governmental activities:				
General government	$ 45,980,768	$ 5,413,806	11,486,445	$ -
Managed care	23,488,535	2,071,186	-	-
Trauma services	30,378,504	4,361,162	-	-
School health	22,162,144	1,954,227	-	-
Pharmacy services	5,093,081	449,101	-	-
Funding collaboratives	10,876,344	959,061	-	-
Total governmental activities	137,979,376	15,208,543	11,486,445	-
Business-type activities:				
Healey Center	23,295,442	8,737,698	9,936,652	37,271
Lakeside Medical Center	54,466,177	24,692,089	10,786,270	2,931,652
Primary Care Clinics	32,162,920	9,781,512	10,565,194	-
Total business-type activities	109,924,539	43,211,299	31,288,116	2,968,923
Total primary government	$ 247,903,915	$ 58,419,842	$ 42,774,561	$ 2,968,923
Component unit:				
Good Health Foundation	$ 875,172	$ -	$ -	$ -

General revenues:
Ad valorem taxes
Investment and other income
Transfers
Total general revenues and transfers

Change in net position

Net position—beginning

Net position—ending

See notes to financial statements.

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Net (Expenses)/Revenues and Changes in Net Assets			
Primary Government			Component Unit
Governmental Activities	Business-Type Activities	Total	Good Health Foundation, Inc.
$ (29,080,517)	$ -	$ (29,080,517)	$ -
(21,417,349)	-	(21,417,349)	-
(26,017,342)	-	(26,017,342)	-
(20,207,917)	-	(20,207,917)	-
(4,643,980)	-	(4,643,980)	-
(9,917,283)	-	(9,917,283)	-
(111,284,388)	-	(111,284,388)	-
-	(4,583,821)	(4,583,821)	-
-	(16,056,166)	(16,056,166)	-
-	(11,816,214)	(11,816,214)	-
-	(32,456,201)	(32,456,201)	-
$ (111,284,388)	$ (32,456,201)	$ (143,740,589)	$ -
			$ (875,172)
139,422,224	-	139,422,224	-
7,135,516	23,563	7,159,079	97,092
(22,659,153)	22,659,153	-	-
123,898,587	22,682,716	146,581,303	97,092
12,614,199	(9,773,485)	2,840,714	(778,080)
151,250,468	63,573,552	214,824,020	1,226,203
$ 163,864,667	$ 53,800,067	$ 217,664,734	$ 448,123

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Health Care District of Palm Beach County, Florida

Governmental Funds
Balance Sheet
September 30, 2020

	Major Funds			Total
	General Fund	Medicaid Match Fund	Capital Projects Fund	Total Governmental Funds
Assets				
Cash and cash equivalents	$ 4,099,795	$ 117,376	$ 22,787,765	$ 27,004,936
Investments	112,897,536	-	-	112,897,536
Patient accounts receivable, net	399,912	-	-	399,912
Due from other governments	8,072,054	491,666	-	8,563,720
Due from other funds	-	-	5,375,000	5,375,000
Inventories	47,384	-	-	47,384
Prepaid items and other current assets	6,112,246	-	-	6,112,246
Total assets	$ 131,628,927	$ 609,042	$ 28,162,765	$ 160,400,734
Liabilities and Fund Balances				
Liabilities:				
Accounts payable	$ 6,713,138	$ -	$ 1,083,021	$ 7,796,159
Accrued expenditures	4,495,264	-	-	4,495,264
Medical benefits payable	1,749,185	-	-	1,749,185
Unearned revenue	2,783,000	-	-	2,783,000
Due to other governments	597,531	-	-	597,531
Total liabilities	16,338,118	-	1,083,021	17,421,139
Deferred inflows – unavailable revenues	2,693,737	-	-	2,693,737
Fund balances:				
Nonspendable:				
Inventories	47,384	-	-	47,384
Prepaid items	5,369,481	-	-	5,369,481
Assigned to:				
Subsequent year's budget	51,900,000	-	-	51,900,000
Capital projects	-	-	27,079,744	27,079,744
Medicaid match	-	609,042	-	609,042
Unassigned	55,280,207	-	-	55,280,207
Total fund balances	112,597,072	609,042	27,079,744	140,285,858
Total liabilities and fund balances	$ 128,935,190	$ 609,042	$ 28,162,765	

Amounts reported for governmental activities in the statement of net position are different because:	
Capital assets used in governmental activities are not current financial resources and therefore are not reported in the balance sheet of the governmental funds	20,529,355
Long-term liabilities and related deferred inflows and outflows are not due and payable in the current period and therefore are not reported in the governmental funds:	
Compensated absences	(2,517,465)
Other post-employment benefit (OPEB) liabilities	(385,967)
Net deferred inflows for pensions and OPEB	148,164
Receivables not available to pay for current period expenditures are reported as unavailable revenue in the funds.	2,693,737
An internal service fund is used by the District to charge the costs of health insurance premiums to individual funds. The assets and liabilities of the internal service fund are included in governmental activities	3,110,985
Total net position related to governmental activities	$ 163,864,667

See notes to financial statements.

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Health Care District of Palm Beach County, Florida

Governmental Funds
Statement of Revenues, Expenditures and Changes in Fund Balances
Fiscal Year Ended September 30, 2020

	Major Funds			Total
	General Fund	Medicaid Match Fund	Capital Projects Fund	Governmental Funds
Revenues:				
Ad valorem taxes	$ 139,422,224	$ -	$ -	$ 139,422,224
Intergovernmental	3,051,525	5,900,000	-	8,951,525
Charges for services	1,682,428	-	-	1,682,428
Investment and other income	7,085,736	1,018	48,762	7,135,516
Total revenues	151,241,913	5,901,018	48,762	157,191,693
Expenditures:				
Current:				
General government	20,836,951	17,103,798	-	37,940,749
Managed care	21,694,529	-	-	21,694,529
Trauma services	28,058,256	-	-	28,058,256
School health	20,469,445	-	-	20,469,445
Pharmacy services	4,704,083	-	-	4,704,083
Funding collaboratives	10,045,631	-	-	10,045,631
Capital outlay	-	-	18,765,870	18,765,870
Total expenditures	105,808,895	17,103,798	18,765,870	141,678,563
Revenues over (under) expenditures	45,433,018	(11,202,780)	(18,717,108)	15,513,130
Other financing sources (uses):				
Transfers in	-	11,202,780	21,796,852	32,999,632
Transfers out	(55,658,785)	-	-	(55,658,785)
Total other financing sources (uses)	(55,658,785)	11,202,780	21,796,852	(22,659,153)
Net change in fund balances	(10,225,767)	-	3,079,744	(7,146,023)
Fund balances—beginning	122,822,839	609,042	24,000,000	147,431,881
Fund balances—ending	$ 112,597,072	$ 609,042	$ 27,079,744	$ 140,285,858

See notes to financial statements.

Health Care District of Palm Beach County, Florida

Reconciliation of the Statement of Revenues, Expenditures and Changes in Fund Balances of Governmental Funds to the Statement of Activities
Fiscal Year Ended September 30, 2020

Net change in governmental fund balances		$ (7,146,023)
Amounts reported for governmental activities in the statement of activities are different because:		
Governmental funds report capital outlays as expenditures. However, in the statement of activities, the cost of those assets are depreciated over their estimated useful lives:		
Expenditures for capital assets	$ 16,562,549	
Less current year depreciation	(979,292)	15,583,257
Revenues that are earned but not received within the District's availability period are recognized in the statement of activities when earned and subsequently in the governmental fund financial statements when they become available. The net difference is recorded as a reconciling item.		2,693,737
Compensated absences:		
Governmental funds require recognition of a liability for compensated absences only if payable to employees who terminated their employment at the end of the fiscal year. This will result in a difference between the net change in governmental fund balances and the change in net position for governmental activities.		(293,741)
Other postemployment benefits (OPEB):		
Some expenses reported in the statement of activities are not reported in the governmental funds because they have no effect on current financial statements.		(181,721)
The changes in deferred inflows and outflows for pensions and OPEB are not reported in the fund statements and the net effect is to increase net position.		148,535
An internal service fund is used by the District to charge the costs of health insurance premiums to individual funds. The increase in net position of the internal service fund is reported with governmental activities.		1,810,155
Change in net position of governmental activities		$ 12,614,199

See notes to financial statements.

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Health Care District of Palm Beach County, Florida

Proprietary Funds
Statement of Net Position
September 30, 2020

	Business-Type Activities—Enterprise Funds					Governmental Activities
	Major Funds			Nonmajor Fund		
	Healey Center Fund	Lakeside Medical Center Fund	Primary Care Clinics Fund	Healthy Palm Beaches Fund	Total	Health Insurance Internal Service Fund
Assets						
Current assets:						
Cash and cash equivalents	$ 1,993,198	$ 14,589,494	$ 654,798	$ 1,415,105	$ 18,652,595	$ 4,324,149
Patient accounts receivable, net	792,191	3,182,452	1,808,773	-	5,783,416	-
Due from other governments	758,333	102,193	4,968,442	-	5,828,968	-
Inventories	-	666,280	-	-	666,280	-
Prepaid expenses and other current assets	67,882	495,174	169,605	47,188	779,849	450,000
Total current assets	3,611,604	19,035,593	7,601,618	1,462,293	31,711,108	4,774,149
Noncurrent assets:						
Restricted cash	8,855	-	-	1,500,000	1,508,855	-
Capital assets:						
Land	3,971,465	-	-	-	3,971,465	-
Construction in progress	15,426	758,422	-	-	773,848	-
Depreciable capital assets, net of					-	
accumulated depreciation	14,016,401	35,657,838	3,058,863	-	52,733,102	-
Total noncurrent assets	18,012,147	36,416,260	3,058,863	1,500,000	58,987,270	-
Total assets	$ 21,623,751	$ 55,451,853	$ 10,660,481	$ 2,962,293	$ 90,698,378	$ 4,774,149
Deferred Outflows of Resources						
Deferred outflows related to pensions and OPEB	$ 112,870	$ 13,243	$ 20,199	$ -	$ 146,312	$ -
Liabilities						
Current liabilities:						
Accounts payable	$ 193,480	$ 1,435,256	$ 637,618	$ -	$ 2,266,354	$ -
Accrued salaries and benefits	1,041,436	1,655,750	1,664,516	-	4,361,702	-
Unearned grant revenue – grants	-	15,601	81,565	-	97,166	-
Unearned grant revenue – CARES Act Funding	-	16,596,860	-	-	16,596,860	-
Estimated third-party payor settlements	55,950	1,839,953	-	-	1,895,903	-
Accrued compensated absences	244,244	411,649	296,265	-	952,158	-
Estimated self-insured liability	54,585	383,438	38,895	-	476,918	1,663,164
Deferred rent	-	2,511	5,037	-	7,548	-
Due to other funds	-	-	5,375,000	-	5,375,000	-
Total current liabilities	1,589,695	22,341,018	8,098,896	-	32,029,609	1,663,164
Noncurrent liabilities:						
Accrued compensated absences, less current portion	916,589	1,544,820	1,111,806	-	3,573,215	-
Estimated self-insured liability, less current portion	51,209	440,399	44,672	-	536,280	-
Other long-term liabilities and leases payable	-	28,408	138,310	-	166,718	-
Other postemployment benefits liabilities (OPEB)	120,650	161,956	64,467	-	347,073	-
Net pension liability	275,517	-	-	-	275,517	-
Total Noncurrent liabilities	1,363,965	2,175,583	1,359,255	-	4,898,803	-
Total liabilities	$ 2,953,660	$ 24,516,601	$ 9,458,151	$ -	$ 36,928,412	$ 1,663,164
Deferred Inflows of Resources						
Deferred inflows related to pensions and OPEB	$ 102,110	$ 13,627	$ 474	$ -	$ 116,211	$ -
Net Position						
Net investment in capital assets	$ 18,003,292	$ 36,416,260	$ 3,058,863	$ -	$ 57,478,415	$ -
Restricted for statutory reserves	-	-	-	1,500,000	1,500,000	-
Restricted for donor contributions	8,855	-	-	-	8,855	-
Unrestricted (deficit)	668,704	(5,481,392)	(1,836,808)	1,462,293	(5,187,203)	3,110,985
Total net position	$ 18,680,851	$ 30,934,868	$ 1,222,055	$ 2,962,293	$ 53,800,067	$ 3,110,985

See notes to financial statements.

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Health Care District of Palm Beach County, Florida

Proprietary Funds
Statement of Revenues, Expenses and Changes in Net Position
Fiscal Year Ended September 30, 2020

	Business-Type Activities—Enterprise Funds					Governmental Activities
	Major Funds			Nonmajor Fund		
	Healey Center Fund	Lakeside Medical Center Fund	Primary Care Clinics Fund	Healthy Palm Beaches Fund	Total	Health Insurance Internal Service Fund
Operating revenues:						
Net patient service revenues	$ 8,722,487	$ 24,519,989	$ 9,200,825	$ -	$ 42,443,301	$ -
Charges for services	-	-	-	-	-	15,336,269
Other operating revenues, net	15,211	172,100	580,687	-	767,998	-
Total operating revenues	8,737,698	24,692,089	9,781,512	-	43,211,299	15,336,269
Operating expenses:						
General services	7,680,704	4,913,555	1,176,909	-	13,771,168	-
Nursing services	10,892,819	15,475,032	-	-	26,367,851	-
Medical services	644,848	11,971,171	22,807,978	-	35,423,997	-
Insurance claims, net of recoveries	-	-	-	-	-	12,635,770
General and administrative services	3,134,830	19,018,707	7,941,143	-	30,094,680	890,344
Depreciation	942,241	3,087,712	236,890	-	4,266,843	-
Total operating expenses	23,295,442	54,466,177	32,162,920	-	109,924,539	13,526,114
Operating (loss) income	(14,557,744)	(29,774,088)	(22,381,408)	-	(66,713,240)	1,810,155
Nonoperating revenues (expenses):						
Grant revenue	9,100,001	1,774,141	10,337,832	-	21,211,974	-
Cares Act revenue	836,651	9,012,129	227,362	-	10,076,142	-
Investment income	5,791	11,044	-	-	16,835	-
Income (loss) on disposal of capital assets	9,891	(862)	(2,301)	-	6,728	-
Total nonoperating revenues	9,952,334	10,796,452	10,562,893	-	31,311,679	-
(Loss) income before capital contributions and transfers	(4,605,410)	(18,977,636)	(11,818,515)	-	(35,401,561)	1,810,155
Capital contributions	37,271	2,931,652	-	-	2,968,923	-
Transfers in	3,254,172	8,155,669	11,249,312	-	22,659,153	-
Net (decrease) increase in net position	(1,313,967)	(7,890,315)	(569,203)	-	(9,773,485)	1,810,155
Total net position—beginning	19,994,818	38,825,183	1,791,258	2,962,293	63,573,552	1,300,830
Total net position—ending	$ 18,680,851	$ 30,934,868	$ 1,222,055	$ 2,962,293	$ 53,800,067	$ 3,110,985

See notes to financial statements.

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Health Care District of Palm Beach County, Florida

Proprietary Funds
Statement of Cash Flows
Fiscal Year Ended September 30, 2020

	Business-Type Activities—Enterprise Funds					Governmental Activities
	Major Funds			Nonmajor fund		
	Healey Center Fund	Lakeside Medical Center Fund	Primary Care Clinics Fund	Healthy Palm Beaches Fund	Total	Health Insurance Internal Service Fund
Cash flows from operating activities:						
Receipts from patients, third-party payors, and other funds	$ 8,189,393	$ 23,954,481	$ 8,460,009	$ -	$ 40,603,883	$ 15,321,189
Payments to employees	(7,076,918)	(24,469,413)	(21,541,331)	-	(53,087,662)	-
Payments to suppliers and service providers	(14,594,019)	(26,067,973)	(3,685,850)	(5,253)	(44,353,095)	(13,526,114)
Other receipts	15,211	172,100	580,687	-	767,998	-
Net cash (used in) provided by operating activities	(13,466,333)	(26,410,805)	(16,186,485)	(5,253)	(56,068,876)	1,795,075
Cash flows from noncapital financing activities:						
Grants received	9,100,001	1,878,360	5,992,313	-	16,970,674	-
Cares Act funding	836,651	25,609,289	227,362	-	26,673,302	-
Transfers in from other funds	3,254,172	8,969,322	11,249,312	-	23,472,806	-
Net cash provided by noncapital financing activities	13,190,824	36,456,971	17,468,987	-	67,116,782	-
Cash flows from capital and related financing activities:						
Acquisition of capital assets	-	-	(1,354,523)	-	(1,354,523)	-
Payments of principal and interest on capital leases	-	(9,779)	-	-	(9,779)	-
Net cash used in capital and related financing activities	-	(9,779)	(1,354,523)	-	(1,364,302)	-
Cash flows from investing activities:						
Interest earnings received	5,791	11,044	-	-	16,835	-
Net cash provided by investing activities	5,791	11,044	-	-	16,835	-
Net (decrease) increase in cash and cash equivalents	(269,718)	10,047,431	(72,021)	(5,253)	9,700,439	1,795,075
Cash and cash equivalents—beginning	2,271,771	4,542,063	726,819	2,920,358	10,461,011	2,529,074
Cash and cash equivalents—ending	$ 2,002,053	$ 14,589,494	$ 654,798	$ 2,915,105	$ 20,161,450	$ 4,324,149
Cash and cash equivalents	$ 1,993,198	$ 14,589,494	$ 654,798	$ 1,415,105	$ 18,652,595	$ 4,324,149
Restricted cash	8,855	-	-	1,500,000	1,508,855	-
Total cash and cash equivalents	$ 2,002,053	$ 14,589,494	$ 654,798	$ 2,915,105	$ 20,161,450	$ 4,324,149

(Continued)

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Health Care District of Palm Beach County, Florida

Proprietary Funds

Statement of Cash Flows (Continued)

Fiscal Year Ended September 30, 2020

	Business-Type Activities—Enterprise Funds					Governmental Activities
	Major Funds			Nonmajor Fund		
	Healey Center Fund	Lakeside Medical Center Fund	Primary Care Clinics Fund	Healthy Palm Beaches Fund	Total	Health Insurance Internal Service Fund
Reconciliation of operating income (loss) to net cash provided by (used in) operating activities:						
Operating income (loss)	$ (14,557,744)	$ (29,774,088)	$ (22,381,408)	$ -	$ (66,713,240)	$ 1,810,155
Adjustments to reconcile operating income (loss) to net cash (used in) provided by operating activities:						
Provision for bad debts	-	15,224,452	4,486,018	-	19,710,470	-
Depreciation	942,241	3,087,712	236,890	-	4,266,843	-
Changes in assets and liabilities:		-				
Patient accounts receivable	198,829	(15,693,266)	(5,260,179)	-	(20,754,616)	-
Due from other governments	(758,333)	-	-	-	(758,333)	-
Inventories	-	50,079	-	-	50,079	-
Prepaid expenses and other current assets	(4,945)	(111,518)	(40,159)	-	(156,622)	-
Accounts and medical benefits payable	43,362	(296,998)	50,198	(5,253)	(208,691)	-
Accrued salaries and benefits	438,934	794,528	812,147		2,045,609	-
Due to other funds	-	-	5,375,000	-	5,375,000	-
Unearned grant revenue	-	-	33,345	-	33,345	-
Estimated third-party payor liabilities	26,410	(96,694)	-	-	(70,284)	-
Accrued compensated absences	147,663	402,816	445,738	-	996,217	-
Estimated self-insured liability	40,061	8,465	43,413	-	91,939	(15,080)
OPEB and related deferred inflows/outflows	(3,233)	(4,910)	8,762	-	619	-
Net pension liability and related deferred inflows/outflows	20,422	-	-	-	20,422	-
Deferred rent	-	(1,383)	3,750	-	2,367	-
Net cash (used in) provided by operating activities	$ (13,466,333)	$ (26,410,805)	$ (16,186,485)	$ (5,253)	$ (56,068,876)	$ 1,795,075
Supplemental disclosure of noncash capital and related financing activities:						
Capital asset transfers/adjustments	$ 10,000	$ -	$ -	$ -	$ 10,000	$ -
Capital assets contributed by the District	37,271	2,117,999	-	-	2,155,270	-
	$ 47,271	$ 2,117,999	$ -	$ -	$ 2,165,270	$ -

See notes to financial statements.

Health Care District of Palm Beach County, Florida

Fiduciary Funds
Statement of Fiduciary Net Position
September 30, 2020

	Pension Trust Fund	Resident Agency Fund
Assets		
Cash and cash equivalents	$ -	$ 70,459
Insurance company contracts	72,825,389	-
Total assets	$ 72,825,389	$ 70,459
Liabilities		
Accounts payable	$ -	$ 70,459
Net Position		
Net position restricted for pension benefits	$ 72,825,389	$ -

See notes to financial statements.

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Health Care District of Palm Beach County, Florida

Pension Trust Fund
Statement of Changes in Fiduciary Net Position
Fiscal Year Ended September 30, 2020

Additions:	
Employer contributions	$ 6,467,646
Investment income:	
Interest	17,925
Net appreciation in fair value of investments	4,489,827
Dividends	1,936,847
Net investment income	6,444,599
Total additions	12,912,245
Deductions:	
Benefit payments	10,867,329
Increase in net position	2,044,916
Net position restricted for pension benefits—beginning	70,780,473
Net position restricted for pension benefits—ending	$ 72,825,389

See notes to financial statements.

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Note 1. Summary of Significant Accounting Policies

Reporting entity: The Health Care District of Palm Beach County, Florida (the District) is a political subdivision of the State of Florida and provides a source of funding for medically needy residents as well as comprehensive planning, funding and coordination of general health care and trauma services delivered in Palm Beach County, Florida (the County). The District was established as an independent special taxing district by special statute originally approved by the voters of the County on November 8, 1988, and subsequently codified in Chapter 2003-326, Laws of Florida.

The governing body of the District is a seven-member Board, three of which are appointed by the Palm Beach County Board of County Commissioners and three by the Governor of the State of Florida. The seventh member is the Director of the State's Department of Health, Palm Beach County Health Department. For financial reporting purposes, the District's basic financial statements include all financial activities that are controlled by or are dependent upon actions taken by the District's Board.

Component units are legally separate entities for which the primary government is financially accountable. In accordance with Governmental Accounting Standards Board (GASB) standards, component units are either classified as blended component units or discretely presented component units, depending on the nature of the entity's relationship with the District, the primary government. The accompanying financial statements present the District and its component units, which are entities for which the District is considered financially accountable. Blended component units, although legally separate entities, are, in substance, part of the government's operations. Discretely presented component units are reported in a separate column in the government-wide financial statements to emphasize that they are legally separate from the government. As required by U.S. generally accepted accounting principles (GAAP), these financial statements include the District reporting entity, which consists of the District (primary government) and its blended component units: Healthy Palm Beaches, Inc. (HPB), District Hospital Holdings, Inc. (Lakeside) and District Clinic Holdings, Inc. (the Clinics); and its discretely presented component unit, Good Health Foundation, Inc. (the Foundation).

Blended component units: The District's basic financial statements include HPB, Lakeside and the Clinics as blended component units, based on application of GASB and GAAP criteria as follows:

Healthy Palm Beaches, Inc.: HPB is a legally separate, Florida nonprofit corporation created by the District and operating as a health maintenance organization (HMO). The District's Board is the Board of Directors of HPB, and the District is therefore financially accountable for HPB. The District has determined it also has a financial burden as it financially supports HPB and provides all administrative support functions. HPB is regulated by the Florida Office of Insurance Regulation (OIR). HPB does not issue separate audited financial statements prepared in accordance with GAAP.

A Certificate of Authority to operate HPB as an HMO was approved by the State of Florida Department of Financial Services on November 21, 1996. A Health Care Provider Certificate was issued to HPB by the State of Florida Agency for Health Care Administration (AHCA) on October 29, 1996. HPB contracted with AHCA to provide health care services to Medicaid recipients beginning January 1, 1998, until the sale of the Medicaid HMO on August 1, 2014.

Note 1. Summary of Significant Accounting Policies (Continued)

On August 1, 2014, HPB sold its personal health plan (PHP) Medicaid HMO, leaving the Vita Health (Vita) program as its sole remaining business line. Vita ceased operations as membership declined and as existing members enrolled for coverage through the Health Insurance Marketplace with the District's assistance. HPB closed the Vita plan as of December 31, 2015. Effective August 7, 2019, HPB surrendered its Certificate of Authority and will no longer operate as an HMO or be regulated by the Florida OIR.

District Hospital Holdings, Inc.: Lakeside is a legally separate, Florida nonprofit corporation created by the District for purposes of operating a public hospital in Belle Glade, Florida, known as Lakeside Medical Center. The District's Board is the Board of Directors of Lakeside, and the District is therefore financially accountable for the hospital. Lakeside also has a financial benefit as it is financially dependent on the District, and the District provides administrative support functions. The accounting policies of Lakeside are generally the same as the District. Separate audited financial statements for Lakeside are available by contacting the District's Finance Department at 1515 N. Flagler Drive, Suite 101 West Palm Beach, Florida 33401; telephone 561.659.1270; or on the Web at www.hcdpbc.org.

District Clinic Holdings, Inc.: The Clinics comprise a legally separate, Florida nonprofit corporation created on July 24, 2012 by the District for purposes of operating primary care clinics in Palm Beach County, Florida. The Clinics' initial four locations were operated by the Palm Beach County Health Department (Health Department) until the operations were assumed by the District in June 2013. In January 2013, the District received a federal grant from the Health Resources and Services Administration (HRSA) to operate the Clinics as Federally Qualified Health Center (FQHC) Primary Care Clinics. The Clinics have since expanded their footprint to include ten locations and have expanded services, including dental services. Clinics is included and blended in the District's reporting entity based on the interrelationship of the component unit and the primary government, that they are in substance the same as the primary government. Separate audited financial statements for the Clinics are available by contacting the District's Finance Department at 1515 N. Flagler Drive, Suite 101 West Palm Beach, Florida 33401; telephone 561.659.1270; or on the Web at www.hcdpbc.org.

Although HPB, Lakeside and the Clinics are legally separate entities, the District is the sole corporate member for each entity and they are reported as blended component units of the District. The entities are part of the District's operations as they are essentially managed as departments of the District and the District provides financial and administrative support functions to each entity.

Discretely presented component unit: The primary government financial statements do not include the operations of Good Health Foundation, Inc., a Florida nonprofit corporation organized and operated under the laws of the State of Florida to provide philanthropic resources for the District. The Foundation's mission is to advance the health of residents and visitors in Palm Beach County through access to local quality health care. The Foundation is governed by an independent Board of Directors that consists of no fewer than 5 and no more than 15 Directors with one representative appointed by the board of District Hospital Holdings, Inc., one representative appointed by the board of District Clinic Holdings, Inc., and one representative appointed by the Glades Rural Area Support Board, with the remaining directors elected by the existing Board of Directors. The District provides administrative support functions to the Foundation. Separate audited financial statements of the Foundation are available by contacting the District's Finance Department at 1515 N. Flagler Drive, Suite 101 West Palm Beach, Florida 33401; telephone 561.659.1270; or on the Web at www.lakesidemedical.org.

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Note 1. Summary of Significant Accounting Policies (Continued)

Government-wide and fund financial statements:

Government-wide financial statements: The government-wide financial statements (i.e., statement of net position and statement of activities) report information on all of the nonfiduciary activities of the District and its component units. Eliminations have been made to minimize the double counting of internal activities. These statements distinguish between the governmental and business-type activities of the District. This distinction rests on the nature of the funding for each activity. Governmental activities, which normally are supported by taxes and intergovernmental revenues, are reported separately from business-type activities, which rely to a significant extent on fees charged to external parties.

The statement of activities presents a comparison between direct expenses and program revenues for each segment of the District's business-type activities and each function of the District's governmental activities. The purpose of this comparison is to illustrate the degree to which direct expenses of a program or function are funded by program revenues. Direct expenses are those specifically associated with a program or function. Program revenues typically include charges paid by program users and contributions restricted to meeting the operational requirements of a particular program. Revenues not identified with particular programs or functions, including tax revenues, are presented as general revenues.

Fund financial statements: The fund financial statements provide information about the District's funds, including fiduciary funds and blended component units. Separate financial statements for each fund category—governmental, proprietary and fiduciary—are presented. Major individual governmental and enterprise funds are reported as separate columns in the fund financial statements. Nonmajor funds, when they exist, are aggregated and reported in a single column in the fund financial statements and reported individually in the combining and individual fund financial statements, when required.

Governmental funds: **The District reports the following major governmental funds:**

General Fund*:* The General Fund is the main operating fund of the District used to account for all financial resources except those required to be accounted for in another fund. Resources are generated primarily from ad valorem property taxes, intergovernmental revenues, charges for services, and investment earnings and other income. Expenditures are incurred to provide health care services for medically needy residents, trauma care, school health programs and general government services.

Medicaid Match Fund*:* The Medicaid Match Fund is a special revenue fund used to account for all revenues and expenditures related to the medicaid match program operated by the District. Funding/revenues recorded in this fund for the medicaid match program are received from the County, as required by an interlocal agreement between the entities and further discussed in Note 1.

Capital Projects Fund*:* The Capital Projects Fund is used to account for all financial resources related to future capital acquisitions and major capital replacements.

Enterprise funds: **The District reports the following enterprise funds:**

Major enterprise funds

Healey Center Fund*:* This fund accounts for the activities of the District's skilled nursing facility, the Edward J. Healey Rehabilitation and Nursing Center (the Healey Center). The Healey Center is licensed by AHCA as a skilled nursing facility providing care to Medicare, Medicaid and private-pay residents of Palm Beach County. The Healey Center has provided services since 1913 and has been administered by the District since 1995.

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Note 1. Summary of Significant Accounting Policies (Continued)

Lakeside Medical Center Fund: This fund accounts for all activities of District Hospital Holdings, Inc., a blended component unit, that owns and operates the public hospital in Belle Glade, Florida, known as Lakeside Medical Center. The hospital provides regional health care for all Palm Beach County communities bordering Lake Okeechobee and the surrounding towns.

Primary Care Clinics Fund: This fund accounts for the activities of District Clinic Holdings, Inc., a blended component unit, that owns and operates eight primary care clinics as Federally Qualified Health Centers in Palm Beach County. The primary care clinics, through collaborative efforts with the Palm Beach County Health Department and other local organizations, provide comprehensive health services and, at four locations, dental services to Palm Beach County residents.

Nonmajor enterprise fund

Healthy Palm Beaches Fund: This fund accounts for the activities of Healthy Palm Beaches, Inc. (HPB), a blended component unit of the District. On August 1, 2014, HPB sold its personal health plan (PHP) Medicaid HMO line of business and on December 31, 2015 closed the Vita Health (Vita) program. Vita ceased operations as membership declined and as existing members enrolled for coverage through the Health Insurance Marketplace with the District's assistance. Effective August 7, 2019, HPB surrendered its Certificate of Authority and will no longer operate as an HMO or be regulated by the Florida OIR.

Additionally, the District reports the following fund types:

Internal Service Fund: This fund accounts for and reports on the activities of the District's employee group health self-insurance program.

Fiduciary funds are used to account for assets held by the District in a trustee capacity for individuals, private organizations, other governmental units and other funds. Since the assets do not belong to the District, they are not included in the government-wide financial statements.

Pension trust funds: Used to account for the assets held for the benefit of participating employees and benefit payments to retirees of the District's defined contribution pension plans.

Resident Agency Fund: This fund is used to account for assets held by the District as an agent for residents at the Healey Center.

Measurement focus and basis of accounting: The accounting and financial reporting treatment is determined by the applicable measurement focus and basis of accounting. Measurement focus indicates the type of resources being measured as either *current financial resources* or *economic resources.* The basis of accounting indicates the timing of transactions or events for recognition in the financial statements.

The government-wide, proprietary fund and pension fund financial statements are reported using the *economic resources* measurement focus and *accrual basis* of accounting. Revenues are recorded when earned, and expenses are recorded at the time liabilities are incurred, regardless of when the cash flows take place. Ad valorem property taxes are recognized as revenue in the year for which they are levied. Grants and similar items are recognized as revenue as soon as all eligibility requirements imposed by the provider have been met. The Resident Agency Fund has no measurement focus, but it utilizes the *accrual basis* of accounting for reporting its assets and liabilities. Proprietary funds distinguish operating revenues and expenses from nonoperating items. Operating revenues generally result from providing services and producing and delivering goods in connection with a proprietary fund's principal ongoing operations. All revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

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Note 1. Summary of Significant Accounting Policies (Continued)

The governmental fund financial statements use the flow of *current financial resources* measurement focus and the *modified accrual basis* of accounting. Under the modified accrual basis of accounting, revenues are recognized when they are both measurable and available. “Measurable” refers to whether the amount of the transaction can be determined, and “available” refers to whether the amount is collectible within the current period or soon enough thereafter to pay liabilities of the current period, generally 60 days after the end of the accounting period. Ad-valorem property taxes are recognized as revenue in the year for which they are levied. Primary revenue sources susceptible to accrual include intergovernmental revenues, charges for services and interest. Other revenues are recognized when received. Expenditure-driven grants are recognized as revenue when the qualifying expenditures have been incurred and all other eligibility requirements have been met. Expenditures are generally recognized when the related fund liability is incurred, if measurable. However, expenditures related to compensated absences, pensions, other postemployment benefits (OPEB) and claims and judgments are recorded only when payment is due. Expenditures related to other postemployment benefits are recognized when the District has made a decision to fund those obligations with current available resources.

Assets, deferred outflows of resources, liabilities, deferred inflows of resources and net position:

Cash, cash equivalents and investments: The District’s cash and cash equivalents during 2020 consisted of petty cash, deposits with financial institutions, money market mutual funds and intergovernmental investment pool securities comprised of short-term, highly liquid assets. The District considers all highly liquid investments with an original maturity of three months or less and all deposits available upon demand to be cash equivalents for purposes of the statement of cash flows. Interest earned on cash and cash equivalents is allocated to individual funds based on rolling average cash balances.

The District’s investments consisted of a pooled, fixed-income, managed account investing in U.S. government agency securities, municipal bonds and corporate notes. Investments are held in the General Fund and income from investments are recorded as it is earned. All investments are reported at fair value based on quoted market prices. Purchases and sales of investments are recorded on the trade date. Net realized and unrealized gains and losses on investments are reflected in current operating results as investment income.

In accordance with the District’s investment policy, the District may invest in the following investments:

(a) The Florida Prime fund, an investment fund authorized by Florida Statutes and administered by the State Board of Administration, up to a maximum of 25% of available funds and provided Florida Prime maintains a credit rating from a nationally recognized statistical rating organization (NRSRO) of “AAAm.”

(b) U.S. government securities including Treasury bills, notes and bonds with a maturity of five years or less.

(c) Bonds, mortgage instruments, debentures or notes of U.S. government agencies with a maturity of five years or less up to a maximum of 50% of available funds and a maximum of 25% with any single issuer.

(d) Bonds, mortgage instruments, debentures or notes of federal instrumentalities, up to a maximum of 80% of available funds, with a maturity of 5 years or less and a maximum of 40% with any single issuer.

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Note 1. Summary of Significant Accounting Policies (Continued)

(e) Mortgage-backed securities up to a maximum of 30% of available funds, with a maturity of 5 years or less and a maximum of 20% with any single issuer.

(f) Nonnegotiable interest-bearing time deposits or savings accounts in qualified public depositories as defined in Florida Statutes, Chapter 280.02, up to a maximum of 25% of available funds, with a maturity of one year or less and a maximum of 15% with any single issuer.

(g) Commercial paper of any U.S. corporation that is prime rated "A-1" or higher by a NRSRO at the time of purchase, up to a maximum of 35% of available funds, with a maturity of 270 days or less and a maximum of 5% with any single issuer.

(h) Corporate notes issued by U.S. corporations that have a long-term debt rating of at least "A" by a nationally recognized rating agency at the time of purchase, up to a maximum of 35% of available funds and a maximum of 5% with any single issuer.

(i) Asset backed corporate notes that has a rating of at least "AA" by a NRSRO at time of purchase, up to a maximum of 20% of available funds, with a maturity of 5 years or less and a maximum of 5% with any single issuer.

(j) State and/or local government taxable and/or tax-exempt debt that has a rating of at least "A" by a NRSRO at the time of purchase, up to a maximum of 25% of available funds, with a maturity of 5 years or less and a maximum of 10% with any single issuer.

(k) Securities and Exchange Commission registered money market mutual funds with a minimum rating of "AAAm" from a NRSRO up to a maximum of 75% of available funds and a maximum of 25% with any single fund.

(l) Shares of any open-end and no-load mutual funds registered under the Investment Company Act of 1940, with a rating of "AAAf" by a NRSRO, up to a maximum of 25% of available funds and a maximum of 25% with any single fund.

(m) Intergovernmental Investments Pools with at least AAA rating from a NRSRO, up to a maximum of 25% of available funds and 25% maximum issuer limit.

Generally, the District and its component units follow the District's investment policy. Pension trust funds are authorized to invest in insurance company contracts providing for participant-directed accounts.

Restricted cash: The District classifies certain amounts of cash as restricted assets because the amounts are not currently available and their use is restricted for specific purposes by statutory and legal requirements. In the business-type activities and enterprise funds, restricted cash includes donor-restricted contributions for specific purposes, a state-required insolvency protection account, and a statutory reserve deposit held by the State of Florida.

Patient accounts receivable, net: Patient accounts receivable of the governmental activities and governmental funds include amounts due from patients, third-party payors and others for aeromedical, pharmacy and related medical services. Patient accounts receivable of the business-type activities and enterprise funds include amounts due from patients, third-party payors and others for medical and dental services provided by the Healey Center, Lakeside and the Clinics. Patient accounts receivable are reported at the estimated net realizable amounts due from patients, third-party payors, and others for services rendered by the District.

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Note 1. Summary of Significant Accounting Policies (Continued)

Allowance for contractual discounts: Contractual adjustments under third-party reimbursement programs represent the difference between the established rates for services and amounts reimbursed by third-party payors and are included as a reduction of patient accounts receivable and revenue. The District estimates the allowance for contractual discounts based on historical performance on a payor-specific basis, given its interpretation of the applicable regulations or contract terms and also considering business and economic conditions, trends in health care coverage and other collection indicators. However, the services authorized and provided and resulting reimbursement are often subject to interpretation. These interpretations sometimes result in payments that differ from the District's estimates. Additionally, updated regulations and contract negotiations occur frequently, necessitating the continual review and assessment of the estimation process.

Allowance for doubtful accounts: The District's ability to collect outstanding receivables from patients, third-party payors, and others is critical to its operating performance and cash flows. The primary collection risk lies with uninsured patient accounts or patient accounts for which a balance remains after primary insurance has paid. While differences exist in the models applied, depending upon the revenue center, the District's policy with respect to estimating its allowance for doubtful accounts is to generally reserve the self-pay accounts receivable based on aging and the historical collection experience on self-pay accounts. The District continually monitors its accounts receivable balances and utilizes cash collections data and other analysis to support the basis for its estimates of the provision for doubtful accounts.

Inventories: Inventories consist of pharmaceuticals and medical supplies used by the District's pharmacy operations and Lakeside. The inventories are accounted for using the consumption method, whereby inventories are recorded as expenditures/expenses in the period when consumed. Inventories of supplies used in operations are valued at cost and inventories held for resale are reported at the lower of cost or market.

Prepaid items/expenses: Expenditures/expenses for insurance premiums and other administrative costs applicable to future accounting periods are recorded as prepaid items/expenses and allocated between accounting periods. The cost of prepaid items/expenses is recorded as expenditures/expenses in the period when consumed.

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Note 1. Summary of Significant Accounting Policies (Continued)

Capital assets: Capital assets, which include land, construction in progress, buildings, improvements and furniture, fixtures and equipment, are reported in the applicable governmental or business-type activities column in the government-wide and proprietary fund financial statements. The District defines capital assets for business-type activities as assets with an initial cost of at least $5,000 and an estimated useful life of at least one year. For reporting purposes, capital assets for governmental activities are assets, excluding computer software, with an initial cost of at least $10,000 and an estimated useful life of at least one year, and computer software with an initial cost of at least $50,000 and an estimated useful life of at least one year. Capital assets purchased in the governmental funds are recorded as expenditures at the time of purchase. Capital assets are recorded at historical cost or estimated historical cost, if actual historical cost is not available. Contributed assets are valued at their acquisition value on the date contributed. Capital assets, other than land and construction in progress, are depreciated on a straight-line basis over their estimated useful lives as follows:

Asset	Years
Buildings and improvements	15-30
Air ambulances	7
Furniture, fixtures and equipment	3-20
Vehicles	3-5
Computer software	3-10

Leasehold improvements are recorded at cost and depreciated on a straight-line basis over the shorter of the estimated useful lives of the depreciable assets or the lease term.

The estimated useful lives generally conform to those recommended by the American Hospital Association. All costs related to the construction of facilities are capitalized, including salaries, employee benefits, contracted services and materials. Costs that materially extend the life of existing assets are capitalized. However, the District does not capitalize the costs of normal maintenance and repairs that do not increase the capacity or efficiency of the asset or materially extend the useful life of the asset. Gains and losses on dispositions of capital assets are recorded in the period of disposal.

Medical benefits payable: Medical benefits payable include amounts billed by providers and not yet paid and an estimate of costs incurred for unbilled services provided for the District's managed care programs. The liability is based on historical trends estimated annually by an independent actuary.

Unearned revenue: Unearned revenue represents grants and similar items received for which the District has not met all eligibility requirements imposed by the provider to allow for revenue recognition.

Compensated absences: District policy permits employees to accumulate unused paid time off up to a maximum of 400 hours, which is payable to eligible employees upon termination or retirement at the rate of pay on that date. Employees may also accumulate unused sick leave hours up to a maximum of 400 hours. However, there is no payment to employees for unused sick leave hours upon termination or retirement. All paid time off is accrued when earned in the government-wide and proprietary fund financial statements. A liability for these amounts is reported in the governmental funds only if they have matured, such as amounts related to employee terminations and retirements.

Deferred outflows and inflows of resources: In addition to assets and liabilities, the financial statements will sometimes report a separate section for deferred outflows and/or deferred inflows of resources. The separate financial statement element, *deferred outflows of resources*, represents a consumption of net position that applies to a future period(s) and so will not be recognized as an outflow of resources (expense/expenditure) until that time. The District reported deferred outflows of resources related to pensions and OPEB at year end.

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Note 1. Summary of Significant Accounting Policies (Continued)

The separate financial statement element, *deferred inflows of resources*, represents an acquisition of net position that applies to a future period(s) and so will not be recognized as an inflow of resources (revenues) until that time. The District reported deferred inflows of resources related to pensions and OPEB at year end.

Net position: The government-wide and proprietary funds report net position in three components: net investment in capital assets, restricted net position and unrestricted net position, in accordance with GASB standards. Net investment in capital assets consists of capital assets, net of accumulated depreciation and related liabilities (if any). Restricted net position consists of assets that have constraints placed on them externally by creditors, grantors, contributors, regulations or imposed by law through constitutional provisions or enabling legislation, reduced by liabilities payable from those assets. Unrestricted net position (deficit) consists of all net position that does not meet the definition of net investment in capital assets or restricted net position.

At September 30, 2020, the net position of the government-wide and proprietary funds were restricted for the following purposes:

Statutory reserves: HPB $1.5 million on deposit with the Florida Office of Insurance Regulation (OIR).

Donor-restricted contributions: The Healey Center receives donor-restricted contributions on behalf of the residents. The balance of these donor-restricted contributions was $8,855 at September 30, 2020.

Fund balances: In the fund financial statements, governmental funds report fund balance classifications that comprise a hierarchy based primarily on the extent to which the District is legally bound to honor constraints on the specific purposes for which amounts in the fund balance can be spent. The fund balance classification hierarchy is summarized as follows:

Nonspendable: Nonspendable fund balances include amounts that cannot be spent because they are either: a) not in spendable form, or b) legally or contractually required to be maintained intact.

Restricted: Restricted fund balances include amounts that are restricted to specific purposes either by: a) constraints placed on the use of resources by creditors, grantors, contributors or laws and regulations of other governments/agencies, or b) imposed by law through constitutional provisions or enabling legislation. The District had no restricted fund balances at September 30, 2020.

Committed: Committed fund balances include amounts that can only be used for specific purposes pursuant to constraints imposed by the District's Board of Commissioners through a Board Resolution and remain in place until action is taken by the District Board to remove or revise the limitations. The District had no committed fund balances at September 30, 2020.

Assigned: Assigned fund balances include amounts that are constrained by the District's intent to be used for specific purposes, but are neither restricted nor committed. The District Board has by resolution authorized the District's chief executive officer to assign fund balance. They are also assigned as part of the annual budget process. Assignments are generally temporary and do not require District Board action for removal.

Unassigned: Unassigned fund balances (deficit) include amounts that have not been assigned in other funds and have not been restricted, committed or assigned to specific purposes within the General Fund.

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Note 1. Summary of Significant Accounting Policies (Continued)

Application of resources: The District considers restricted fund balances and net position to be spent when an expenditure is incurred for the restricted purpose. When the District has both restricted and unrestricted resources available to finance a particular program, it is the District's policy to use the restricted resources first before using unrestricted resources. The District considers committed, assigned or unassigned fund balances to be spent when an expenditure is incurred for purposes for which amounts in any of those fund balance classifications could be used.

Minimum fund balance policy: The District's policy is to maintain an adequate fund balance in the General Fund to provide liquidity in the event of an economic downturn or budget shortfall. The Board has adopted a financial goal to maintain a minimum unassigned fund balance in the General Fund equivalent to 15 to 20% of the combined fund's annual expenditures. The District was in compliance with this policy at year end.

Revenues and expenditures/expenses:

Ad valorem property taxes: Under Florida law, the assessment of all properties and the collection of all county, municipal, special district, and school board property taxes are consolidated in the offices of the County Property Appraiser and County Tax Collector, respectively. All property is reassessed according to its fair market value on January 1 of each year, and the property tax rolls are submitted to the State Department of Revenue for review to determine if the tax base is equitable, uniform and in compliance with State law.

The tax levy of the District is established by Board Resolution prior to October 1 of each year during the budget process. The Palm Beach County Property Appraiser incorporates the District's millage rate into the total tax levy, which includes the county, school board, special district, and municipal tax levies. The tax becomes a lien on real and personal property and is receivable by the District on October 1 of each year based upon the taxable value established by the County Property Appraiser as of the prior January 1. Discounts are allowed for early payment at the rate of 4% in the month of November, 3% in the month of December, 2% in the month of January, and 1% in the month of February. Taxes paid in March are without discount. Unpaid taxes become delinquent on April 1 following the year in which they were levied.

On or after April 1 following the tax year, certificates are offered for sale for all delinquent taxes on real property. After sale, tax certificates bear interest, generally at 18% per year. Application for a tax deed on any unredeemed tax certificates may be made by the certificate holder after a period of 2 years. Delinquent taxes on personal property bear interest at 18% per year until the tax is satisfied.

During 2007, the Florida Legislature passed property tax reform legislation limiting the property tax levies of local governments in the State of Florida. For the fiscal year ended September 30, 2020, the maximum tax levy allowed by a majority vote of the governing body is based on a millage rate equal to the current-year rolled-back millage rate plus an increase for growth in per capita Florida personal income. A two-thirds vote of the governing body is required to adopt a rate up to 10% higher than the majority vote maximum millage rate, and a unanimous vote is required to adopt anything higher that. Regardless of the preceding requirements, the District cannot increase its millage rate more than 0.25 mills over the prior year.

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Note 1. Summary of Significant Accounting Policies (Continued)

The total taxable assessed value upon which the fiscal year 2020 tax levy was based was approximately $199.1 billion. For the year ended September 30, 2020, the actual millage rate for the District was 0.7261 mills ($0.7261 per $1,000 of assessed value). The District's maximum ad valorem tax levy is limited by Florida Statutes to 2.00 mills. Actual ad valorem taxes may differ from budgeted amounts due to property tax assessment appeals and corrections.

Intergovernmental revenue: Grant revenue is recorded when the related expenses are incurred and all eligibility requirements and time requirements have been met. Grant funds received in advance of meeting eligibility requirements are reported as unearned revenues in the financial statements.

Other intergovernmental revenue in the General Fund includes contributions from the School District of Palm Beach County for the District's school health programs.

Pursuant to an Interlocal Agreement with Palm Beach County, Florida (the County), the District receives $15 million annually from the County through fiscal year 2035. The funding consists of an operating grant for the Healey Center and funding for the Medicaid Match owed to the State in accordance with Florida law. The District allocates $5.9 million to the Medicaid Match Fund and the remaining $9.1 million to the Healey Center Fund. The funding provided by the County is recorded as intergovernmental revenue in the Medicaid Match Fund as it relates to services for Medicaid-eligible individuals at hospitals and nursing homes throughout the County and is not related to any charges for services.

Net patient service revenues: The District serves patients whose medical costs are generally not paid at established rates and are reimbursable by third-party payors and government programs, such as Medicare and Medicaid, commercial insurance companies and uninsured patients who have limited or no ability to pay. Contractual adjustments under third-party reimbursement programs represent the difference between the established rates for services and amounts reimbursed by third-party payors and are included as a reduction of patient service revenue. The District also records its provision for uncollectible accounts as a direct reduction of patient service revenue. Net patient service revenues for the year ended September 30, 2020, consisted of the following:

Healey Center Fund:	
Managed Care Medicaid	$ 8,053,362
Insurance, private-pay and other revenue	669,125
	8,722,487
Lakeside Medical Center Fund:	
Medicare and Medicaid revenue	5,702,630
Disproportionate share distributions	1,521,544
Insurance, private-pay and other revenue	17,295,815
	24,519,989
Primary Care Clinics Fund:	
Medicare and Medicaid revenue	6,384,040
Insurance, private-pay and other revenue	2,816,785
	9,200,825
Total net patient service revenues	$ 42,443,301

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Note 1. Summary of Significant Accounting Policies (Continued)

Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered and includes estimated retroactive revenue adjustments due to future audits, reviews and investigations. Retroactive adjustments are considered in the recognition of revenue on an estimated basis in the period the related services are rendered, and such amounts are adjusted in future periods when adjustments become known or as years are no longer subject to audits, reviews and investigations. Contractual adjustments under third-party reimbursement programs are recorded on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. There were no material changes to prior year estimates of third-party payor settlements during the year ended September 30, 2020.

The District's basis of reimbursement with major third-party payors is summarized as follows:

Medicare: For Lakeside, inpatient acute care services rendered to Medicare beneficiaries are reimbursed at prospectively determined rates per discharge. These rates vary according to a patient classification system that is based on clinical, diagnostic and other factors. Inpatient non-acute services, outpatient services, and defined capital costs related to Medicare beneficiaries are primarily reimbursed on a prospective reimbursement methodology. The laws and regulations under which the Medicare and Medical Assistance programs operate are complex, subject to frequent change and subject to interpretation. As part of operating under these programs, there is a possibility that governmental authorities may review Lakeside's compliance with these laws and regulations. Such review may result in adjustments to reimbursements previously received and subject Lakeside to fines and penalties. Although no assurances can be given, management believes they have complied with the requirements of these programs. Lakeside's classification of patients under the Medicare program and the appropriateness of their admission are subject to an independent review by a peer review organization under contract with Lakeside. The Medicare cost reports through September 30, 2016, have been audited and finalized by the Medicare Administrative Contractor.

The Medicare cost reports for the Healey Center and Clinics for the fiscal year ended September 30, 2020 was filed in fiscal year 2021. The final determination of amounts earned pursuant to the Medicare program will be subject to review or audit by appropriate governmental agencies or their agents. However, no liability is reasonably expected.

Medicaid: Inpatient and outpatient services rendered to Medicaid beneficiaries were reimbursed under a prospective rate methodology based upon prior year cost reimbursement, whereby Lakeside was paid at a tentative rate based upon the most recent cost report available at the time of rate-setting. Following submission of annual cost reports by Lakeside, a final settlement is determined after audit by the Medicaid fiscal intermediary. Effective July 1, 2013, Lakeside is reimbursed under an inpatient payment method that utilizes Diagnosis Related Groups (DRGs). Payments under DRG assignment are made on a per case basis and are not subject to retrospective rate adjustments. For outpatient services, Lakeside's reimbursement continues to be based on the prospective rate methodology used in prior years. Lakeside's Medicaid cost reports were audited by the Medicaid fiscal intermediary through September 30, 2016. The Healey Center files an annual Medicaid cost report for purposes of determining a prospective Medicaid reimbursement rate. No retroactive adjustments have been made to the filed reports, and no adjustments are expected. A Medicaid cost report is not required for the Clinics.

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Note 1. Summary of Significant Accounting Policies (Continued)

The Centers for Medicare & Medicaid Services (CMS) has implemented a program using recovery audit contractors (RACs) as part of the CMS efforts to assure accurate payments. The program uses the RAC to review claims for potentially improper Medicare payments that may have been made to health care providers and were not detected through existing CMS program reviews. Once a RAC identifies a claim it believes is inaccurate, the RAC makes a deduction from, or addition to, the provider's Medicare reimbursement for the amount of the estimated overpayment or underpayment. The District records an adjustment to revenue for any overpayment or underpayment at the time notice is received from the RAC and the amount can be reasonably estimated. There were no material RAC adjustments, audit recoveries or settlements for prior periods related to the Medicare and Medicaid programs during 2020, and no liability has been recorded for estimated RAC settlements

Payments to the Clinics for Medicare patients changed to a prospective payment system (PPS) effective October 1, 2014, as mandated by the Affordable Care Act of 2010. CMS established a new base rate as of October 1, 2014 at $158.85. A Geographic Adjustment Factor (GAF) is applied to the base rate based on where the services are provided. In addition, the GAF-adjusted rate may also be affected by additional adjustment factors, such as new patients. Generally, the Medicare PPS payment to the Clinics is equal to 80% of the lesser of the Clinics' charges or the PPS rate. The remaining 20% is the responsibility of the patient and/or the patients coinsurance. Effective January 1, 2020, the base rate was increased to $173.50.

Laws and regulations governing the Medicare and Medicaid programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that the recorded estimates will change by a material amount in the near term.

Commercial providers: The District also has reimbursement agreements with commercial insurance carriers, health maintenance organizations, and preferred provider organizations. The basis for reimbursement under these agreements includes prospectively determined rates per discharge, discounts from established charges, prospectively determined per diem rates and capitation. Certain provider contracts provide for review of paid claims for compliance with the terms of the contract and may result in retroactive settlements with providers. In management's opinion, such settlements, when reached, will not vary significantly from the estimated amounts that are recorded in the accompanying financial statements.

Charity care: The District's mission is to provide high-quality, affordable health care to the community. In pursuing its commitment to serve all members of the community, the District provides services to the financially disadvantaged, despite the lack or adequacy of payment for its services. District maintains records to identify and report the level of charity care it provides to the community. These records include the amount of charges foregone for health care services and supplies furnished under the District's charity care policy.

The District provides care to patients who meet certain criteria under its charity care policy without charge or at amounts less than its established rates. Because the District does not anticipate payment when services are rendered and does not pursue collection of amounts determined to qualify as charity care, such amounts are not reported as revenue.

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Note 1. Summary of Significant Accounting Policies (Continued)

Public Medical Assistance Trust Fund: The State of Florida (the State) has established the Public Medical Assistance Trust Fund to provide a method for funding the provision of health care services to indigent persons. Hospitals in the State are required to pay assessments to the trust fund equal to 1.5% of each hospital's prior year net inpatient revenue and 1.0% of each hospital's prior year net outpatient revenue. The assessments are distributed under various programs to hospitals in the State that serve Medicaid patients and uninsured charity care patients. Lakeside received funding for patients under the Disproportionate Share Hospital (DSH) and the Low Income Pool (LIP) programs. The DSH program provides payments to hospitals that serve a disproportionate number of Medicaid and uninsured charity care patients. The LIP program distributes funding to the District and Lakeside to support coverage for Medicaid, uninsured and underinsured patients.

The LIP program is a federal matching program that provides the state with the opportunity to receive additional federal distributions based on a capped annual allotment, which is then distributed by the state to participating health care providers for eligible services. Local governments, such as counties, hospital and health care districts and the Florida Department of Health provide funding for the nonfederal share of the LIP distributions. Revenues from the DSH and LIP programs are reported as operating revenues from disproportionate share distributions in the accompanying statement of revenues, expenditures and changes in net position, net of the required quarterly assessments owed by Lakeside, which are accrued in the fiscal year for which the assessments are made. For the year ended September 30, 2020, Lakeside was not assessed for these programs and its total disproportionate share distributions was approximately $1,521,000, which is recorded in net patient service revenues in the statement of revenues, expenditures and changes in net position—proprietary funds. The receipt of future distributions is contingent upon the continued support of the program by the federal and state governments. The State is considering the future of LIP funding as directed by CMS, and future funding is uncertain. Management expects any loss of federal or state funding for Lakeside will be replaced by additional operating contributions from the District.

Operating revenues and expenses: The statement of revenues, expenses and changes in net position of the District's proprietary funds distinguish between operating and nonoperating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, the principal activity of the District's enterprise funds. Operating revenues also include internal service fund charges to other funds to cover actual premium costs associated with the District's employee group health insurance program. Nonexchange revenues, including interest income, operating grants, contributions, CARES Act funding and other unrestricted revenues, are reported as nonoperating revenues. Grants and contributions of capital assets, or such amounts restricted by donors for the acquisition of capital assets, are reported as capital contributions. Operating expenses include all expenses incurred to provide health care services, other than financing costs. As well as internal service fund expenses incurred for employee health insurance claims and related costs.

Grant revenues and receivables: Grant revenues is recorded when the related expenses are incurred and the eligibility and time requirements have been met. Grant funds received in advance of meeting eligibility requirements are reported as unearned grant revenues. As of September 30, 2020, the Clinics had grant receivables of approximately $4,968,000, of which, approximately 86% was due from HRSA.

Interfund transactions: Transactions between funds during the year consisted of loans, services provided, reimbursements, capital contributions and transfers. Loans are reported in the fund financial statements as due from other funds and due to other funds and are eliminated in the government-wide financial statements. Interfund services are treated as revenue and expenditures/expenses.

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Note 1. Summary of Significant Accounting Policies (Continued)

Reimbursements are when one fund incurs a cost, charges the appropriate benefiting fund and reduces its related cost as a reimbursement. All other interfund transactions are presented as transfers. Transfers within the governmental and business-type activities are eliminated in the government-wide financial statements.

COVID-19 pandemic: In January 2020, the Secretary of the U.S. Department of Health and Human Services (HHS) declared a national public health emergency due to a novel strain of coronavirus (COVID-19). In March 2020, the World Health Organization declared the outbreak of COVID-19 a pandemic. The resulting measures to contain the spread and impact of COVID-19 have adversely affected the District's results of operations. As a result of the COVID-19 pandemic, federal and state governments have passed legislation, promulgated regulations and taken other administrative actions intended to assist health care providers in providing care to COVID-19 and other patients during the public health emergency. Sources of relief include the Coronavirus Aid, Relief and Economic Security Act (the CARES Act), which was enacted on March 27, 2020. During the period ended September 30, 2020, the District was the beneficiary of these stimulus measures. The District's accounting policies for the recognition of these stimulus monies are described below.

CARES Act and PPPHCE Act Funds: During the year ended September 30, 2020, the District received approximately $26,673,000 in payments through the Public Health and Social Services Emergency Fund (the PHSSEF) in both general and targeted distributions. Approximately $10,076,000 of the PHSSEF payments qualified as reimbursement for lost operating margin and incremental expenses and was recognized as CARES Act funding in the statement of revenues, expenses and changes in net position. The recognition of amounts received is conditioned upon the provision of care for individuals with possible or actual cases of COVID-19 after January 31, 2020, certification that payment will be used to prevent, prepare for and respond to COVID-19 and shall reimburse the recipient only for health care-related expenses or lost operating margin that are attributable to COVID-19, and receipt of the funds. The District recognizes grant payments as income when there is reasonable assurance the District has complied with the conditions associated with the grant. The District's estimates could change materially in the future based on operating performance or COVID-19 activities at individual locations, as well as the evolving grant compliance guidance provided by the government. The approximately $16,597,000 that has not been recognized as revenue or that has not been refunded to HHS as of September 30, 2020, is reflected within unearned revenue – CARES Act funding in the statements of net position. Such amounts may be recognized as revenue in future periods if the underlying conditions for recognition are met.

Income taxes: The District's blended component units, Lakeside, HPB and the Clinics, are legally separate nonprofit organizations that are exempt from income taxes under section 501(c)(3) of the Internal Revenue Code. These nonprofit organizations were given governmental entity status by the Internal Revenue Service and are exempt from federal and state income taxes, and are not required under the Internal Revenue Code to file tax returns.

The Foundation, a component unit of the District, is exempt from federal income tax under section 501(c)(3) of the Internal Revenue Code. In addition, the Foundation qualifies for the charitable contribution deduction under section 170(b)(1)(A) and has been classified as an organization other than a private foundation under section 509(a)(2). The Foundation evaluates its uncertain tax positions in accordance with the Financial Accounting Standard Board's (FASB) Accounting Standards Codification (ASC) Topic 740, Income Taxes, which states that management's determination of the taxable status of an entity, including its status as a nonprofit entity, is a tax position subject to the standards required for accounting for uncertainty in income taxes. Management does not believe that the Foundation has any significant uncertain tax positions that would be material to the financial statements. The Foundation is generally not subject to examinations by U.S. tax authorities for tax years prior to 2017.

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Note 1. Summary of Significant Accounting Policies (Continued)

Use of estimates: The preparation of financial statements in conformity with U.S. generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets, deferred outflows of resources, liabilities and deferred inflows of resources and the disclosures of contingent amounts at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Significant estimates include the allowance for contractual adjustments and doubtful accounts, estimated third-party payor settlements, pension liability, other post-employment benefit liability, self-insured liability and medical benefits payable. Actual results could differ from those estimates.

New accounting pronouncements: The GASB issued new statements effective in future years. Management has not completed its analysis of the effects, if any, of these GASB statements on the financial statements of the District as listed below.

GASB Statement No. 84, Fiduciary Activities, was issued January 2017. This statement improves guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. The provisions of this Statement will be effective for the District beginning with its year ending September 30, 2021. *

GASB Statement No. 87, Leases, was issued June 2017. This Statement improves the accounting and financial reporting for leases by governments. The provisions of this Statement will be effective for the District beginning with its year ending September 30, 2022. *

GASB Statement No. 90, Majority Equity Interests-An Amendment of GASB Statements No. 14 and No. 61, was issued August 2018. This Statement improves the consistency and comparability of reporting a government's majority equity interest in a legally separate organization and improves the relevance of financial statement information for certain component units. The provisions of this Statement will be effective for the District beginning with its year ending September 30, 2021. *

GASB Statement No. 91, Conduit Debt Obligations, was issued May 2019. This Statement provides a single method of reporting conduit debt obligations by issuers and eliminates diversity in practice associated with: (1) commitments extended by issuers, (2) arrangements associated with conduit debt obligations, and (3) related note disclosures. The provisions of this Statement will be effective for the District beginning with its year ending September 30, 2023. *

GASB Statement No. 92, Omnibus 2020, was issued January 2020. This statement enhances comparability in accounting and financial reporting and to improve the consistency of authoritative literature by addressing practice issues that have been identified during implementation and application of certain GASB Statements. The requirements of this Statement are effective for the District beginning with its year ending September 30, 2022.

GASB Statement No. 93, Replacement of Interbank Offered Rates, was issued in March 2020. This statement addresses accounting and financial reporting implications that result from the replacement of a LIBOR. The requirements of this Statement are effective for the District beginning with its year ending September 30, 2022. *

*Effective dates represent postponement as per GASB Statement No. 95.

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Note 1. Summary of Significant Accounting Policies (Continued)

GASB Statement No. 94, Public-Private and Public-Public Partnerships and Availability Payment Arrangements, was issued March 2020. This statement improves financial reporting by addressing issues related to public-private and public-public partnership arrangements (PPPs). This Statement also provides guidance for accounting and financial reporting for availability payment arrangements (APAs). The requirements of this Statement are effective for the District beginning with its year ending September 30, 2023.

GASB Statement No. 96, Subscription-Based Information Technology Arrangements, was issued May 2020. This Statement provides guidance on the accounting and financial reporting for subscription-based information technology arrangements (SBITAs) for government end users (governments). The requirements of this Statement are effective for the District beginning with its year ending September 30, 2023.

GASB Statement No. 97, *Certain Component Unit Criteria, and Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans—an amendment of GASB Statements No. 14 and No. 84, and a supersession of GASB Statement No. 32*, was issued June 2020. The primary objectives of this Statement are to: (1) increase consistency and comparability related to the reporting of fiduciary component units in circumstances in which a potential component unit does not have a governing board and the primary government performs the duties that a governing board typically would perform; (2) mitigate costs associated with the reporting of certain defined contribution pension plans, defined contribution other postemployment benefit (OPEB) plans, and employee benefit plans other than pension plans or OPEB plans (other employee benefit plans) as fiduciary component units in fiduciary fund financial statements; and (3) enhance the relevance, consistency, and comparability of the accounting and financial reporting for Internal Revenue Code (IRC) Section 457 deferred compensation plans (Section 457 plans) that meet the definition of a pension plan and for benefits provided through those plans. The requirements of this Statement are effective for the District beginning with its year ending September 30, 2022. Except for the requirement of this Statement that: (1) exempt primary governments that perform the duties that a governing board typically performs from treating the absence of a governing board the same as the appointment of a voting majority of a governing board in determining whether they are financially accountable for defined contribution pension plans, defined contribution OPEB plans, or other employee benefit plans, and (2) limit the applicability of the financial burden criterion in paragraph 7 of Statement 84 to defined benefit pension plans and defined benefit OPEB plans that are administered through trust that meet the criteria in paragraph 30 of Statement 67 or paragraph 30 of Statement 74, respectively, are effective immediately.

Budgetary Control: The excess of transfers out over appropriations in the General Fund in the amount of $443,217, is attributed to the General Fund transferring funds assigned in the prior year for the planned information technology system implementation to the Capital Replacement Fund.

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Note 2. Cash, Cash Equivalents and Investments

Cash and cash equivalents: Cash and cash equivalents include the following unrestricted and restricted assets of the District at September 30, 2020:

	Primary Government		
	Unrestricted	Restricted	Fiduciary Funds
Deposits with financial institutions	$ 18,093,958	$ -	$ 70,459
Intergovernmental investment pool	27,384,979		
Money market mutual funds	4,502,743		-
Deposits with financial institutions restricted for donor contributions	-	8,855	-
Deposits with the State of Florida	-	1,500,000	-
Total	$ 49,981,680	$ 1,508,855	$ 70,459

The District's deposits with financial institutions consisted of demand deposit and money market accounts that were entirely covered by a combination of federal depository insurance and a collateral pool pledged to the State Treasurer of Florida by financial institutions that comply with the requirements of Florida Statutes and have been designated as a qualified public depository by the State Treasurer. Qualified public depositories are required to pledge collateral to the State Treasurer with a market value equal to a percentage of the average daily balance of all government deposits in excess of any federal deposit insurance. In the event of a default by a qualified public depository, all claims for government deposits would be satisfied by the State Treasurer from the proceeds of federal deposit insurance, pledged collateral of the public depository in default and, if necessary, a pro rata assessment to the other qualified public depositories participating in the collateral pool. Accordingly, all deposits with financial institutions are considered fully insured.

Cash equivalents include short-term investments in Securities and Exchange Commission (SEC) registered institutional money market mutual fund and intergovernmental investment pool securities that are available to the District on a next day basis. Restricted cash and cash equivalents include deposits with the State of Florida of $310,000 and monies held in an insolvency protection account with financial institutions segregated and held for the benefit of the Florida OIR in the amount of $420,119. Additional monies held with financial institutions comprise the balance of HPB's statutory reserve of $1.5 million. Restricted cash and cash equivalents also include deposits with financial institutions of $8,855 held for donor-restricted contributions received by the Healey Center.

The cash and cash equivalents of the District's discretely presented component unit, Good Health Foundation, Inc., consist of deposits with financial institutions. At year-end the Foundation's deposits with financial institutions exceeded federal depository insurance limits by approximately $194,000. The Foundation has not experienced any losses in these accounts and does not consider there to be any significant credit risk to these deposits.

Note 2. Cash, Cash Equivalents and Investments (Continued)

Investments: The District's investments consist of the following at September 30, 2020:

Investments	Primary Government – Unrestricted	Fiduciary Funds
U.S. government securities	$ 45,238,187	$ -
U.S. government federal instrumentalities	55,193,265	-
Corporate notes	11,004,889	-
Municipal bonds	1,461,195	-
Insurance company contracts	-	72,825,389
	112,897,536	72,825,389

In accordance with Florida law, the District's investment policy allows it to invest in limited types of investments, including Florida Prime, deposits and time certificates with financial institutions designated as a Florida Qualified Public Depository, U.S. government securities, certain securities of the U.S. government agency and federal instrumentalities, mortgage-backed securities, commercial paper, corporate notes, state and local government debt securities, and interests in investment companies or investment trusts registered under the Investment Company Act of 1940 (money market mutual funds), provided that the portfolio has a weighted-average maturity of 60 days or less and the fund is rated AAAm by Standard & Poor's or the equivalent by another rating agency. No derivative securities are permitted.

GASB Statement No.72, *Fair Value Measurement and Application*, requires that investments be categorized according to the fair value hierarchy levels established by this statement. The hierarchy has three levels. Level 1 inputs are quoted prices in active markets for identical assets or liabilities; Level 2 inputs are inputs other than quoted prices included within Level 1 that are unobservable for the asset or liability, such as quoted prices for similar assets or liabilities in active markets or quoted prices for identical or similar assets or liabilities in markets that are not active; and Level 3 inputs are unobservable inputs such as management's assumption of the default rate. The District's investments are categorized as follows according to the GASB 72 fair value hierarchy as of year-end:

	Fair Value	Fair Value Measurements Level 2	Weighted Average Maturity (Years)
Investment Type:			
U.S. government securities	$ 45,238,187	$ 45,238,187	1.25
U.S. government federal instrumentalities	55,193,265	55,193,265	2.34
Corporate notes	11,004,889	11,004,889	1.50
Municipal bonds	1,461,195	1,461,195	3.61
Total investment at fair value	112,897,536	$ 112,897,536	1.84
Cash equivalents:			
Intergovernmental investment pool – reported at net asset value (NAV)	27,384,979		0.14
Total cash equivalents and Investments	$ 140,282,515		
Portfolio weighted-average to maturity			1.51

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Note 2. Cash, Cash Equivalents and Investments (Continued)

In May 2016, the District entered into an Interlocal Agreement with Florida Cooperative Liquid Assets Securities System (FLCLASS). FLCLASS is an intergovernmental Investment Pool comprised of short term, highly liquid assets. The District currently has $27,384,979 invested with FLCLASS as of September 30, 2020, and has earned $452,370 for the fiscal year ended. FLCLASS is rated 'AAAm' by Standard and Poor's. Public Trust Advisors, LLC serves as the pool's administrator and investment adviser. The pool is subject to the general supervision of the Board of Trustees which is duly elected by the FLCLASS Participants. Wells Fargo Bank, N.A. serves as custodian for the pool. The District's fair value position in the pool is the same as the value of the pool shares and recorded at net asset value (NAV) per share. This method of determining fair value uses member units to which a proportionate share of net assets is attributed. This security is reported as cash equivalents in the financial statements at year-end.

The insurance company contracts are fixed and variable annuity contracts with The Variable Annuity Life Insurance Company (VALIC) that are held by pension plan participants under the District's group contract. Fixed annuity accounts include fixed-return securities with an average duration of five years that are part of the general account assets of VALIC. The variable annuity contracts represent units of interest issued by VALIC in a segregated asset account, which in turn holds investments in the underlying mutual funds. Neither the District nor the participants hold direct investments in the underlying mutual funds. The VALIC insurance contracts are guaranteed by, and subject to the claims of, the general creditors of VALIC. The VALIC investments are not insured or collateralized and are not rated by an NRSRO.

Custodial credit risk: Custodial credit risk is defined as the risk that an entity may not recover cash and investments held by another party in the event of a financial failure. The investment policy requires cash and investments to be fully insured or collateralized or held in independent custodial safekeeping accounts in the name of the District. At year end all investments were held by an independent custodian and were insured or registered, or held by the District or its agent in the District's name, except for the pension fund investments in insurance company contracts, which are all unclassified investment pools.

Interest rate risk: Interest rate risk is the risk that changes in interest rates will adversely affect the fair value of an investment. Generally, the longer the term to maturity, the greater the exposure to interest rate risk. The District's investment policy limits the maturity of investments to match cash and anticipated cash flow requirements.

At September 30, 2020 the District's investment securities and maturities are summarized by investment type as follows:

		Maturities	
Investment Type	Fair Value	Less Than One Year	One to Five Years
U.S. government securities	$ 45,238,187	$ 28,385,523	$ 16,852,664
U.S. government federal instrumentalities	55,193,265	11,574,103	43,619,162
Corporate notes	11,004,889	3,901,992	7,102,897
Municipal bonds	1,461,195	-	1,461,195
Intergovernmental investment pool	27,384,979	27,384,979	-
Total	$ 140,282,515	$ 71,246,597	$ 69,035,918

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Note 2. Cash, Cash Equivalents and Investments (Continued)

Credit risk: Credit risk is the risk that an issuer will not fulfill its obligations. The District's investment policy addresses credit risk by limiting allowable investments to Florida Prime; U.S. government securities; certain U.S. government agency and federal instrumentalities securities, mortgage-backed securities, commercial paper rated at least A-1, corporate notes and state and local government debt securities rated at least A, and money market mutual funds with the highest credit ratings from an NRSRO. Investment securities of the District were rated by S&P as follows at year-end:

Investment Type	Fair Value	S&P Ratings	Percentage of Portfolio
U.S. Treasury notes	$ 45,238,187	AA+	32%
Fannie Mae notes	9,452,108	AA+	7%
Federal Farm Credit notes	12,411,681	AA+	9%
Federal Home Loan Bank	13,736,433	AA+	10%
Federal Home Loan Mortgage Corp.	18,737,651	AA+	13%
Federal Home Loan Mortgage Corp. callable	855,392	AAAm	1%
Intergovernmental investment pool	27,384,979	AAAm	19%
Corporate notes	11,004,889	AA	8%
Municipal bonds	1,461,196	AA+	1%
Total	$ 140,282,516		100%

Concentration of credit risk: Concentration of credit risk is defined as the risk of loss attributed to the magnitude of an investment in a single issuer. The investment policy addresses the concentration of credit risk by limiting the maximum amount that may be invested in any one issuer (see Note 1), except for investments guaranteed by the U.S. government, which are not limited. Investments in mutual funds or pools are excluded from the concentration of credit risk disclosure requirement. There were no investments in any one issuer that represent more than 5% of the District's investments that require disclosure.

Note 3. Accounts Receivable

The accounts receivable of the District at year end include amounts due from third-party payors and patients for health care services. The percentage of total accounts receivable provided by Medicare and Medicaid, patients and insurance and others was approximately 36%, 42% and 22%, respectively. The accounts receivable and related allowances for contractual discounts and allowances for doubtful accounts are summarized as follows:

Fund	Gross Receivables	Allowances for Contractual Discounts	Allowances for Doubtful Accounts	Accounts Receivable, Net
General Fund	$ 6,831,785	$ (2,140,779)	$ (4,291,094)	$ 399,912
Healey Center	916,527	(108,360)	(15,976)	792,191
Lakeside Medical Center	34,648,840	(15,434,376)	(16,032,012)	3,182,452
Primary Care Clinics	4,421,058	(920,967)	(1,691,318)	1,808,773
Total	$ 46,818,210	$ (18,604,482)	$ (22,030,400)	$ 6,183,328

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Note 4. Interfund Transactions

Interfund transactions are reflected as either loans, services provided, or reimbursements. Loans are reported as receivables and payables, as appropriate, are eliminated in the government-wide financial statements and are reported as “due to/due from other funds” in the fund financial statements. Services provided are deemed to be at or near market rates and are treated as revenues and expenditures/expenses. Reimbursements occur when one fund incurs a cost, charges the appropriate benefiting fund, and reduces its related costs as a reimbursement.

The District’s interfund transfers for the year ended September 30, 2020, are summarized as follows:

	Transfers In	Transfers Out
Governmental funds:		
General Fund	$ -	$ 55,658,785
Medicaid Match Fund	11,202,780	-
Capital Projects Fund	21,796,852	-
Enterprise funds:		
Healey Center Fund	3,254,172	-
Lakeside Medical Center Fund	8,155,669	-
Primary Care Clinics	11,249,312	
Total	$ 55,658,785	$ 55,658,785

During 2020 the General Fund transferred approximately $11,203,000 to the Medicaid Match Fund for costs associated with the Medicaid Match Program. The General Fund transferred approximately $21,797,000 to the Capital Projects Fund to be used for future capital purchases and for the implementation of a new District-wide software system and approximately $3,254,000 to the Healey Center Fund, $11,249,000 to the Primary Care Clinics and $8,156,000 to the Lakeside Medical Center Fund to subsidize the operations of those funds.

The District’s due to and from other fund balances for the year ended September 30, 2020, are summarized as follows:

	Due From Other Funds	Due to Other Funds
Governmental funds:		
Capital Projects Fund	$ 5,375,000	$ -
Enterprise funds:		
Primary Care Clinics	-	5,375,000
Total	$ 5,375,000	$ 5,375,000

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Note 5. Related Party Transactions

Lakeside received approximately $301,000 in net patient service revenues from the District for the year ended. The District allocated approximately $5,148,000 to Lakeside for certain support department costs, including personnel, purchasing, legal and administrative costs for the year ended. Lakeside received capital contributions of approximately $2,932,000 representing capital assets placed in service that were purchased by the Capital Projects Fund and the Good Health Foundation Inc.

The Clinics received approximately $966,000 of capitated payments recorded as net patient service revenue in the statement of revenues, expenses and changes in net position from the District for the year ended. The District allocated approximately $4,535,000 to the Clinics for certain support department costs, including personnel, purchasing, legal and administrative costs for the year ended.

The Healey Center received capital contributions of approximately $37,000 representing capital assets placed in service that were purchased by the Capital Projects Fund. The District allocated approximately $2,438,000 to the Healey Center for certain support department costs, including personnel, purchasing, legal and administrative costs for the year ended.

Note 6. Capital Assets

The following table is a summary of capital assets activity of the District for the year ended:

	Balance September 30, 2019	Transfers and Additions	Transfers and Deletions	Balance September 30, 2020
Governmental activities:				
Nondepreciable capital assets:				
Construction in progress	$ -	$ 15,480,529	$ -	$ 15,480,529
Depreciable capital assets:				
Buildings and improvements	4,542,822	181,365	-	4,724,187
Air ambulances	13,961,920	24,188	-	13,986,108
Furniture, fixtures and equipment	7,468,448	876,467	-	8,344,915
Total depreciable capital assets	25,973,190	1,082,020	-	27,055,210
Less accumulated depreciation:				
Buildings and improvements	(2,633,012)	(258,818)	-	(2,891,830)
Air ambulances	(13,856,610)	(42,166)	-	(13,898,776)
Furniture, fixtures and equipment	(4,537,470)	(678,308)	-	(5,215,778)
Total accumulated depreciation	(21,027,092)	(979,292)	-	(22,006,384)
Total depreciable capital assets, net	4,946,098	102,728	-	5,048,826
Governmental activities capital assets, net	$ 4,946,098	$ 15,583,257	$ -	$ 20,529,355

	Balance September 30, 2019	Transfers and Additions	Transfers and Deletions	Balance September 30, 2020
Business-type activities:				
Nondepreciable capital assets:				
Land	$ 3,971,465	$ -	$ -	$ 3,971,465
Construction in progress	1,816,873	717,000	(1,760,025)	773,848
Total nondepreciable capital assets	5,788,338	717,000	(1,760,025)	4,745,313
Depreciable capital assets:				
Buildings and improvements	79,298,111	2,763,557	-	82,061,668
Furniture, fixtures and equipment	14,819,244	1,799,261	(151,162)	16,467,343
Total depreciable capital assets	94,117,355	4,562,818	(151,162)	98,529,011
Less accumulated depreciation:				
Buildings and improvements	(30,964,603)	(3,218,112)	-	(34,182,715)
Furniture, fixtures and equipment	(10,712,376)	(1,048,731)	147,913	(11,613,194)
Total accumulated depreciation	(41,676,979)	(4,266,843)	147,913	(45,795,909)
Total depreciable capital assets, net	52,440,376	295,975	(3,249)	52,733,102
Business-type activities capital assets, net	$ 58,228,714	$ 1,012,975	$ (1,763,274)	$ 57,478,415

Note 6. Capital Assets (Continued)

Depreciation expense was charged to District functions for the year ended as follows:

Governmental activities:	
General government	$ 937,125
Trauma	42,167
Total	$ 979,292
Business-type activities:	
Healey Center	$ 942,241
Lakeside Medical Center	3,087,712
Primary Care Clinics	236,890
Total	$ 4,266,843

Project Commitments: The District has active capital asset projects in process as of September 30, 2020. The significant projects and related commitments as of September 30, 2020, are as follows:

Project	Spent-to-Date	Remaining Commitment
Aeromed helicopters	$ 6,581,365	$ 16,112,997
IT System Implementation	8,646,879	8,646,879
	$ 15,228,244	$ 24,759,875

Land: Lakeside Medical Center was constructed on 50 acres of land owned by the State of Florida. The District leased the land from the State for a period of 50 years ending February 1, 2057. Upon termination of the lease, all improvements on the property become the property of the State, which may also require the District to remove the improvements at the District's expense. As consideration for the lease, the District entered into an agreement with Prison Rehabilitative Industries and Diversified Enterprise, Inc. (PRIDE), an instrumentality of the State, which requires the District to purchase a specified amount of goods and services from PRIDE over a 30-year period as compensation for the land lease (See Note 11 – PRIDE Agreement).

Note 7. Medical Benefits Payable

Medical benefits payable consist of claims for trauma and medical services already rendered to members enrolled in the District's health coverage programs by health care providers, (i.e., physicians and Districts) and incurred but not reported (IBNR) claims for medical services. Services are provided by 12 acute care Districts and approximately 1,100 physicians and other providers in Palm Beach County, Florida. Provider claims are submitted to the District for payment at contracted, negotiated rates and are typically paid in full within 90 days.

Medical benefits payable activity for the year ended are summarized as follows:

Governmental Activities/General Fund:	
Beginning of year liability	$ 5,029,473
Current-year claims and net changes in estimates	12,123,754
Medical benefit payments	(15,404,042)
End of year liability	$ 1,749,185

Note 8. Compensated Absences

Compensated absences liability activity for the year ended are summarized as follows:

	Balance October 1, 2019	Additions	Retirements	Balance September 30, 2020	Amount Due Within One Year
Governmental activities:					
Compensated absences	$ 2,223,724	$ 4,607,798	$ (4,314,057)	$ 2,517,465	$ 529,686
Business-type activities:					
Compensated absences	3,529,156	5,707,258	(4,711,041)	4,525,373	952,158
Total	$ 5,752,880	$ 10,315,056	$ (9,025,098)	$ 7,042,838	$ 1,481,844

The liability for compensated absences has typically been liquidated by the individual funds reporting the liability. For the governmental activities, compensated absences are generally liquidated by the General Fund.

Note 9. Retirement Plans

District defined contribution plan: In October 1990, the District established the Health Care District of Palm Beach County Contribution Plan (the Plan), a defined contribution plan covering District employees not participating in the Florida Retirement System Plan, who are 18 years of age or older and have completed one year of service. The Plan is administered by the Variable Annuity Life Insurance Company (VALIC). For employees hired after September 30, 2012, the District contributes 4% of eligible compensation to the Plan and also makes matching contributions equal to 100% of the participants' elective deferrals up to 4% of eligible compensation. The District contributes 15% of eligible compensation for employees hired prior to October 1, 2012. Contribution rates and benefits of the Plan are established and may be amended by the District Board. For the year ended the District contributed approximately $6,468,000 to the Plan. Employees are not allowed to contribute to the Plan and are fully vested after 6 years of service.

District deferred compensation plan: The District also established and provides its employees with access to a 457(b) deferred compensation plan named the Palm Beach County Health Care District Pension Plan (the 457(b) Plan). Under this plan, an employee is able to contribute pretax wage/salary dollars into a personal retirement account. The 457(b) Plan is administered by VALIC. An employee can defer up to $19,500 of eligible compensation annually. No contributions are required of the District. Contribution rates and benefits of the 457(b) Plan are established by the District Board and may be amended in the future by the District Board.

Lakeside deferred compensation plan: In May 1994, Lakeside established the District District Holdings 457(b) Retirement Plan (the 457(b) Plan), which is a deferred compensation plan. Under the 457(b) Plan, an employee is able to contribute pretax wage/salary dollars into a personal retirement account. The 457(b) Plan is administered by VALIC and does not issue a separate financial report. Plan amendments and contribution rates are approved by the District's Board. An employee can defer up to $19,500 of eligible compensation annually. Contribution rates and benefits of the 457(b) Plan are established by the District Board and may be amended in the future by the District Board.

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Note 9. Retirement Plans (Continued)

The District has adopted the provisions of Internal Revenue Code 457(g) and GASB Statement No. 32, *Accounting and Financial Reporting for Internal Revenue Code Section 457 Deferred Compensation Plans*. Under these provisions, all assets and income of the 457 plans are held in trust for the exclusive benefit of participants. Accordingly, the assets and liabilities of the 457 plans are not reported within the District's financial statements.

Florida Retirement System (FRS):

Plan description: The Florida Retirement System (FRS) Pension Plan is a cost-sharing, multiple-employer qualified defined benefit pension plan with a Deferred Retirement Option Program (DROP) available for eligible employees. The FRS was established and is administered in accordance with Chapter 121, Florida Statutes. The Florida Legislature establishes and amends the contribution requirements and benefit terms of the FRS Pension Plan. Retirees receive a lifetime pension benefit with joint and survivor payment options. FRS membership is compulsory for employees filling regularly established positions in a state agency, county agency, state university, state community college or district school board, unless restricted from FRS membership under sections 121.053 and 121.122, Florida Statutes, or allowed to participate in a nonintegrated defined contribution plan in lieu of FRS membership. Participation by cities, municipalities, special districts, charter schools and metropolitan planning organizations is optional.

Publicly available FRS financial report: FRS issues a publicly available financial report that includes financial statements and required supplementary information. The complete financial report for FRS is available on the Publications page of the Division of Retirement's website at www.frs.myflorida.com or by writing to the Research and Education Section at P.O. Box 9000, Tallahassee, Florida 32315-9000 or by calling toll free 877.377.1737 or 850.488.5706.

Funding policy: The FRS funding policy provides for monthly employer contributions at actuarially determined rates that, expressed as percentages of annual covered payroll, are adequate to accumulate sufficient assets to pay benefits when due based upon plan assumptions. Employer and employee contribution rates are established by state law as a level percentage of payroll. Employer contribution rates are determined using the entry-age actuarial cost method. The consulting actuary recommends rates based on the annual valuation, but actual contribution rates are established by the Florida Legislature. The unfunded actuarial liability resulting from past and future plan benefit changes, assumption changes or methodology changes, and actuarial gains and losses are amortized over 30 years, using level percentage of payroll.

Contributions: Effective July 1, 2011, all enrolled members of the FRS, other than DROP participants, are required to contribute 3% of their salary to the FRS. In addition to member contributions, governmental employers are required to make contributions to the FRS based on state-wide contribution rates established by the Florida Legislature. These rates are updated as of July 1 of each year. The District's contributions to FRS for the fiscal year ended September 30, 2020 was $16,737, and was equal to the required contributions for the year.

Benefits provided: FRS provides retirement, survivor and disability benefits to plan members and beneficiaries. Benefits under the Plan are computed on the basis of age and/or years of service, average final compensation and service credit. Credit for each year of service is expressed as a percentage of the average final compensation. For members initially enrolled before July 1, 2011, the average final compensation is the average of the five highest fiscal years' earnings; for members initially enrolled on or after July 1, 2011, the average final compensation is the average of the eight highest fiscal years' earnings.

Note 9. Retirement Plans (Continued)

The total percentage value of the benefit received is determined by calculating the total value of all service, which is based on the retirement class to which the member belonged when the service credit was earned. Members are eligible for in-line-of-duty or regular disability and survivors' benefits.

Pension liabilities, pension expense, and deferred outflows of resources and deferred inflows of resources related to pensions: At September 30, 2020, the District reported a liability of $218,327 for its proportionate share of the pension plan's net pension liability. The net pension liability was measured as of June 30, 2020, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of July 1, 2020. The District's proportionate share of the net pension liability was based on the District's 2020 fiscal year contributions relative to the 2020 fiscal year contributions of all participating members. At June 30, 2020, the District's proportionate share was 0.0005%, which was an increase of 0.0001% from its proportionate share measured as of June 30, 2019.

For the fiscal year ended September 30, 2020, the District recognized pension expense of $36,196. In addition, the District reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

	FRS	
Description	Deferred Outflows of Resources	Deferred Inflows of Resources
Difference between expected and actual experience	$ 8,356	$ -
Change of assumptions	39,524	-
Net difference between projected and actual earnings on FRS pension plan investments	12,999	-
Changes in proportion and differences between District FRS contributions and proportionate share of contributions	28,054	46,163
District FRS contributions subsequent to the measurement date	4,944	-
Total	$ 93,877	$ 46,163

The deferred outflows of resources related to the pension plan totaling $4,944, resulting from District contributions to the plan subsequent to the measurement date will be recognized as a reduction of the net pension liability in the fiscal year ending September 30, 2021. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to the pension plan will be recognized in pension expense as follows:

Fiscal years ending September 30:	**FRS**
2021	$ 7,252
2022	7,252
2023	7,252
2024	7,252
2025	7,252
Thereafter	6,510
	$ 42,770

Note 9. Retirement Plans (Continued)

Actuarial assumptions: The total pension liability in the June 30, 2019, actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.40%
Salary increases	3.25%, average, including inflation
Investment rate of return	6.80%, net of pension plan investment expense, including inflation

Mortality rates were based on the PUB-2010 base table and varies by member category and sex, projected generationally with Scale MP-2018.

The actuarial assumptions used in the June 30, 2019, valuation were based on the results of an actuarial experience study for the period July 1, 2013 through June 30, 2018.

The long-term expected rate of return on pension plan investments was not based on historical returns, but instead is based on a forward-looking capital market economic model. The allocation policy's description of each asset class was used to map the target allocation to the asset classes shown below. Each asset class assumption is based on a consistent set of underlying assumptions and includes an adjustment for the inflation assumption. The target allocation and best estimates of arithmetic and geometric real rates of return for each major asset class are summarized in the following table:

	FRS			
Asset Class	Target Allocation (1)	Arithmetic Return	(Geometric) Return	Standard Deviation
Cash	1%	2.20%	2.20%	1.20%
Fixed income	19%	3.00%	2.90%	3.50%
Global equity	54%	8.00%	6.70%	17.10%
Real estate (property)	10%	6.40%	5.80%	11.70%
Private equity	11%	10.80%	8.10%	25.70%
Strategic investments	5%	5.50%	5.30%	6.90%
Total	100%			
Assumed Inflation- Mean		2.40%		1.70%

(1) As outlined in the Pension Plan's investment policy .

Discount rate: The discount rate used to measure the total pension liability was 6.80%. The pension plan's fiduciary net position was projected to be available to make all projected future benefit payments of current active and inactive employees. Therefore, the discount rate for calculation the total pension liability is equal to the long-term expected investment rate of return.

Sensitivity of the District's proportionate share of the net pension liability to changes in the discount rate: The following represents the District's proportionate share of the net pension liability calculated using the discount rate of 6.80%, as well as what the District's proportionate share of the net pension liability would be if it were calculated using a discount rate that is one percentage point lower (5.80%) or one percentage point higher (7.80%) than the current rate:

	FRS		
	1% Decrease 5.80%	Current Discount Rate 6.80%	1% Increase 7.80%
District's proportionate share of the net pension liability	$ 348,632	$ 218,327	$ 109,496

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Note 9. Retirement Plans (Continued)

Pension plan fiduciary net position: Detailed information regarding the pension plan's fiduciary net position is available in the separately issued FRS Pension Plan and Other State-Administered Systems Annual Financial Report.

Retiree Health Insurance Subsidy (HIS) Plan:

Plan description: The HIS Plan is a cost-sharing multiple-employer defined benefit pension plan established under Section 112.363, Florida Statutes, and may be amended by the Florida legislature at any time. The benefit is a monthly payment to assist retirees of State-administered retirement systems in paying their health insurance costs and is administered by the Florida Department of Management Services, Division of Retirement.

Benefits provided: For the fiscal year ended September 30, 2020, eligible retirees and beneficiaries received a monthly HIS payment of $5 for each year of creditable service completed at the time of retirement, with a minimum HIS payment of $30 and a maximum HIS payment of $150 per month. To be eligible to receive these benefits, a retiree under a State-administered retirement system must provide proof of health insurance coverage, which may include Medicare.

Contributions: The HIS Plan is funded by required contributions from FRS participating employers as set by the Florida Legislature. Employer contributions are a percentage of gross compensation for all active FRS members. For the fiscal year ended September 30, 2020, the HIS contribution rate was 1.66%. The District contributed 100% of its statutorily required contributions for the current and preceding three years. HIS Plan contributions are deposited in a separate trust fund from which payments are authorized. HIS Plan benefits are not guaranteed and are subject to annual legislative appropriation. In the event legislative appropriation or available funds fail to provide full subsidy benefits to all participants, benefits may be reduced or cancelled. The District's contributions to HIS Plan for the fiscal year ended September 30, 2020 was $2,699 and equaled the required contributions for the year ended.

Pension liabilities, pension expense, and deferred outflows of resources and deferred inflows of resources related to pensions: At September 30, 2020, the District reported a liability of $57,189 and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of July 1, 2020. The District's proportionate share of the net pension liability was based on the District's 2020 fiscal year contributions relative to the 2020 fiscal year contributions of all participating members. At June 30, 2020, the District's proportionate share was 0.0005%, which was the same as the proportionate share measured as of June 30, 2019.

Note 9. Retirement Plans (Continued)

For the fiscal year ended September 30, 2020, the District recognized a credit to pension expense of $6,113. In addition, the District reported deferred outflows of resources and deferred in flows of resources related to pensions from the following sources:

	HIS			
Description	Deferred Outflows of Resources		Deferred Inflows of Resources	
Difference between expected and actual experience	$	2,339	$	45
Change of assumptions		6,149		3,325
Net difference between projected and actual earnings on FRS pension plan investments		46		-
Changes in proportion and differences between District HIS contributions and proportionate share of contributions		1,240		36,738
District HIS contributions subsequent to the measurement date		656		-
Total	$	10,430	$	40,108

The deferred outflows of resources related to the HIS Plan totaling $656, resulting from District contributions to the HIS Plan subsequent to the measurement date will be recognized as a reduction of the net pension liability in the fiscal year ended September 30, 2021. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to the HIS Plan will be recognized as a credit to pension expense as follows:

Fiscal years ending September 30:		HIS
2021	$	(4,210)
2022		(4,210)
2023		(4,210)
2024		(4,210)
2025		(4,210)
Thereafter		(9,284)
	$	(30,334)

Actuarial assumptions: The total pension liability in the July 1, 2020 actuarial valuation was determined using the following actuarial assumptions, applied to all periods included in the measurement:

Inflation	2.40%
Salary increases	3.25%, average, including inflation
Investment rate of return	2.21%

Mortality rates were based on the Generational PUB-2010 table with Projection Scale MP-2018.

The actuarial assumptions used in the June 30, 2020 valuation were based on the results of an actuarial experience study for the period July 1, 2013 through June 30, 2018.

Note 9. Retirement Plans (Continued)

Discount rate: The discount rate used to measure the total pension liability was 2.21%. In general, the discount rate for calculating the total pension liability is equal to the single rate equivalent to discounting at the long-term expected rate of return for benefit payments prior to the projected depletion date. Because the HIS benefit is essentially funded on a pay-as-you-go basis, the depletion date is considered to be immediate, and the single equivalent discount rate is equal to the municipal bond rate selected by the HIS Plan sponsor. The Bond Buyer General Obligation 20-Bond Municipal Bond Index was adopted as the applicable municipal bond index.

Sensitivity of the District's proportionate share of the net pension liability to changes in the discount rate: The following represents the District's proportionate share of the net pension liability calculated using the discount rate of 2.21%, as well as what the District's proportionate share of the net pension liability would be if it were calculated using a discount rate that is one percentage point lower (1.21%) or one percentage point higher (3.21%) than the current rate:

	HIS		
	1% Decrease 1.21%	Current Discount Rate 2.21%	1% Increase 3.21%
District's proportionate share of the net pension liability	$ 66,108	$ 57,189	$ 49,889

Pension plan fiduciary net position: Detailed information regarding the HIS Plan's fiduciary net position is available in the separately issued FRS Pension Plan and Other State-Administered Systems Annual Financial Report.

The following table summarizes the net pension liability, deferred outflow and inflow of resources and pension expense and income as previously disclosed in Note 10 for the FRS and HIS plans:

Plan	Net Pension Liability	Deferred Outflows of Resources	Deferred Inflows of Resources	Pension Expense (Credit)
FRS Plan	$ 218,327	$ 93,877	$ 46,163	$ 36,196
HIS Plan	57,189	10,430	40,108	(6,113)
Total	$ 275,516	$ 104,307	$ 86,271	$ 30,083

Note 10. Other Postemployment Benefits

The District follows GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions* for financial reporting and disclosure for its other postemployment benefits plan (OPEB Plan).

Plan description: The District's OPEB Plan provides health care benefits to eligible retired employees and their spouses and/or beneficiaries. The District Board has the authority to establish and amend the premiums for and the benefit provisions of the OPEB Plan. The OPEB Plan is financed on a "pay as you go" basis and is not administered as a formal qualifying trust. The OPEB Plan does not issue a stand-alone publicly available financial report.

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Note 10. Other Postemployment Benefits (Continued)

Funding policy: The District is required by Florida Statutes, Section 112.0801 to allow retirees to buy health care coverage at the same group insurance rates that current employees are charged, resulting in an implicit health care benefit. Florida law prohibits the OPEB Plan from separately rating retirees and active employees. The OPEB Plan therefore charges both groups an equal, blended rate premium for health insurance. Although both groups are charged the same blended rate premium, GAAP requires the actuarial figures to be calculated using age-adjusted premiums approximating claim costs for retirees separately from active employees. The use of age-adjusted premiums results in the addition of the implicit rate subsidy into the actuarial accrued liability. Plan members receiving benefits contribute 100% of the monthly medical premium, which currently ranges from a minimum of $559 to a maximum of $1,726.

District employees covered by benefit terms: At September 30, 2019, there were 11 retirees and 880 active plan members covered by the benefit terms for the overall District.

Total OPEB liability: The District's total OPEB liability is $733,040. The total OPEB liability was measured as of September 30, 2020, based on an actuarial valuation as of October 1, 2019.

The total OPEB liability based on the October 1, 2019 actuarial valuation was determined using the following actuarial assumptions and other inputs, applied to all periods included in the measurement, unless otherwise specified:

Salary increases	3%
Investment rate of return	Not applicable. The plan is not funded.
Discount rate	2.14%
Healthcare cost trend rates	8.25% in 2020, graded down to 4.5% by 0.25% per year
Mortality	Mortality Pub-2010 Headcount weighted mortality table for general public employer, annuitant and non-annuitant, sex distinct with improvement scale MP-2019

The discount rate used to measure the total OPEB liability was based on a 20-year AA/Aa tax-exempt municipal bond yield.

The following provides the changes to the total OPEB liability for the year ended:

	OPEB
Beginning balance	$ 530,859
Service cost	38,988
Interest	19,146
Difference between expected and actual experience	128,718
Changes of assumptions	50,396
Implicit benefit payments	(35,067)
Net changes	202,181
Ending balance	$ 733,040

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Note 10. Other Postemployment Benefits (Continued)

Sensitivity of the total OPEB liability to changes in the discount rate. The following presents the total OPEB liability of the District, as well as what the District's total OPEB liability would be if it were calculated using a discount rate that is 1-percentage-point lower (1.14%) or 1-percentage-point higher (3.14%) than the current discount rate:

	OPEB Discount Rate		
	1% Decrease 1.14%	Current Discount Rate 2.14%	1% Increase 3.14%
Total OPEB Liability	$ 770,725	$ 733,040	$ 697,556

Sensitivity of the total OPEB liability to changes in the healthcare cost trend rates. The following presents the total OPEB liability of the District, as well as what the District's total OPEB liability would be if it were calculated using healthcare cost trend rates that are 1-percentage-point lower (7.25% decreasing to 3.5%) or 1-percentage-point higher (9.25% decreasing to 5.5%) than the current healthcare cost trend rates:

	OPEB Trend Rate		
	1% Decrease 7.25%	Current Trend Rate 8.25%	1% Increase 9.25%
Total OPEB Liability	$ 674,140	$ 733,040	$ 800,477

OPEB expense and deferred inflows and outflows of resources related to OPEB
For the year ended September 30, 2020, the District recognized OPEB expense of $75,944. In addition, the District reported deferred inflows of resources and deferred outflows of resources as follows:

	OPEB	
Description	Deferred Outflows of Resources	Deferred Inflows of Resources
Difference between expected and actual experience	$ 142,203	$ 26,381
Change of assumptions	50,127	5,722
Total	$ 192,330	$ 32,103

Amounts reported as deferred inflows and outflows of resources related to the OPEB plan will be recognized in OPEB expenses on a straight-line basis as follows:

Fiscal years ending September 30:	OPEB
2021	$ 17,811
2022	17,811
2023	17,811
2024	17,811
2025	17,811
Thereafter	71,172
	$ 160,227

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Note 11. Commitments and Contingencies

Lease commitments: The District, including Lakeside and the Clinics, leases office space, pharmacy warehouse facilities, land for the aeromedical program, general storage space, and equipment under various noncancelable operating lease agreements. These operating leases expire in various years through December 2027. Rent expense was approximately $2,791,000 for the year ended. The future minimum lease payments of the District are summarized as follows:

Years ending September 30:	Operating Leases
2020	$ 2,244,234
2021	2,025,635
2022	1,831,124
2023	1,627,134
2024	1,406,791
Thereafter	1,428,408
Total	$ 10,563,326

Contract commitments: In addition to operating leases, the District and Lakeside have entered into various contracts for services and contracts with physicians and physician groups. The provisions of those contracts are summarized as follows:

Service contracts: The District and Lakeside have entered into various contracts for maintenance agreements, software licenses and other services. The remaining term of the individual service contracts is generally one to four years.

Physician contracts: Lakeside has entered into various employment contracts with physicians and physician groups for services that include payments for hourly, shift, weekend and annual salaries. The remaining term of the individual physician contracts is generally one to three years.

The approximate future minimum payments for these contracts at year end are summarized as follows:

Years ending September 30:	Service Contracts	Physician Contracts
2021	$ 4,055,173	$ 4,414,303
2022	3,979,650	2,345,272
2023	4,112,910	2,031,823
2024	4,246,718	24,000
2025	4,381,091	-
2026	4,516,048	-
	$ 25,291,590	$ 8,815,398

Funding collaborative: The District provides financial support to certain health services agencies, including the Palm Beach County Health Department. The District incurred approximately $8,508,000 related to the Palm Beach County Health Department and approximately $1,230,000 to other local agencies for the fiscal year ended. The District Board approves future funding for these agencies on an annual basis in conjunction with its budgetary process. For the fiscal year 2020, the District budgeted approximately $10,280,000 for the Palm Beach County Health Department and other local agencies.

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Note 11. Commitments and Contingencies (Continued)

Health Department Master Agreement: The District entered into a Master Agreement with the Florida Department of Health in Palm Beach County (the Health Department), effective October 1, 2013, and ending June 30, 2021, whereby the District assumed the financial, administrative and operational responsibility for providing adult and pediatric primary care services to patients formerly served by the Health Department through their FQHC locations in Palm Beach County.

Pursuant to the Master Agreement, the District operates the clinic locations and accounts for all operational activities through the Clinics. Four clinic facility locations are owned by Palm Beach County (C. L. Brumback Health Center in Belle Glade; the Lantana/Lake Worth Health Center; and the Delray Beach Health Center) and the State of Florida (the West Palm Beach Health Center) and utilized by the District without rent. The District pays the Health Department for common expenses incurred by the Health Department for the facilities based on the pro rata square footage used by the District and the Health Department. The total annual common expenses for the facilities paid by the District were approximately $718,000 for the year ended September 30, 2020, including costs related to space for the District's pharmacy and eligibility offices. The portion of these costs allocated to the Clinics was approximately $619,000 for the year ended September 30, 2020.

PRIDE agreement: The District entered into an agreement with PRIDE, an instrumentality of the State of Florida, and a lease with the State of Florida for 50 acres of land for the Lakeside Medical Center facility. The lease is for a term of 50 years ending February 1, 2057. Upon termination of the lease, all improvements on the property become the property of the State, which may also require the District to remove the District facility and improvements at the District's expense. As consideration for the lease, the District entered into an agreement with PRIDE that requires the District to purchase $4,166,667 in goods and services from PRIDE over a 30-year period ending July 12, 2036. Purchases by the District through September 30, 2020, totaled approximately $267,000. If the purchase requirement is not met by July 12, 2036, the District must pay 18% of the unfulfilled purchase commitment on July 12, 2036. The unfulfilled purchase commitment as of September 30, 2020, is reported at net present value, discounted at a rate of 1.23% (20-year U.S. Treasury Rate), and is approximately $563,000. The payments to PRIDE, the 2020 land lease expense of approximately $267,000, and the liability for the lease are recorded by the District and have not been charged to the Lakeside Medical Center facility.

Risk management and litigation: 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 purchases commercial insurance coverages. The District, Lakeside, the Clinics and Healey Center are subject to risk of loss arising in the ordinary course of business, including claims for damages from medical malpractice, personal injuries, employment-related claims, breach of management contracts and for wrongful restriction of or interference with physicians' staff privileges. Except where prohibited, in certain of these actions, plaintiffs may seek punitive or other damages against the District, which are generally not covered by insurance.

The District is an independent special taxing district and a political subdivision of the State of Florida and is entitled to sovereign immunity under the Florida law. For tort actions (with claims arising on or after October 1, 2011), Florida has a limited waiver of sovereign immunity at section 768.28, Florida Statutes. The District's liability for tort is limited to $200,000 per claim and $300,000 in the aggregate. Judgments may be claimed or rendered in excess of the sovereign immunity limits; however, the District cannot be liable for such excess amounts unless the claim/judgment is presented to and approved by the Florida Legislature (i.e., "claims bill"). Additionally, on June 1, 2015, the District obtained an umbrella liability policy for coverage in excess of the self-insured retention levels of $500,000 for professional liability exposures and $500,000 for general liability exposures, as well as underlying insurance policies for employers' liability, business automobile liability, and aviation general liability exposures.

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Note 11. Commitments and Contingencies (Continued)

The policy, with aggregate limits of $5 million, only responds in the event a covered loss results in a claims bill that is approved by the Legislature. The District's management, in consultation with legal counsel, believes all general liability claims are covered by insurance or limited under sovereign immunity and will not have any significant impact on the financial condition of the District in excess of the amounts accrued at year-end.

Self-Insurance – Employee Health
The District offers its employees medical and prescription drug benefits which became self-funded on October 1, 2017. The District is therefore exposed to various risks of loss related to employee health claims incurred in connection with the District's self-insurance program. The District's self-insurance internal service fund is used to account for and finance both uninsured and insured risks of loss.

Coverage is provided as follows: $300,000 self-insured retention per claim and aggregate stop loss of $1,000,000. All operating funds of the District participate in the program and make payments to the health insurance internal service fund based on estimates of the amounts needed to pay prior and current claims, and to maintain an adequate fund net position balance. The estimated liability on pending employee health claims at September 30, 2020 is $1,663,000. Additionally, Healey, Lakeside and the Clinics accrued approximately $107,000, $824,000 and $45,000, respectively, for various other self-insured claims. The estimated liability on pending claims at year end is accounted for based on the requirements of GASB Statement No. 10, which requires that a liability for claims be reported if information prior to the issuance of the financial statements indicated that it is probable that a loss has occurred and the amount of the loss can be reasonably estimated. Liabilities include an amount for claims that have been incurred but not reported (IBNR).

The District's management, in consultation with legal counsel, believes all claims are fully accrued, covered by insurance or limited under sovereign immunity and does not expect any claims that will have a significant impact on the financial condition of the District.

Settlements and related costs: In December 2014, Lakeside was notified by the Agency for Health Care Administration (Florida Medicaid) that payments under the Medicaid DSH program for the State fiscal year ended June 30, 2011, exceeded the calculated Medicaid DSH Limit. Lakeside determined certain amounts received under the Medicaid DSH program for the years of 2013, 2014 and 2015, were estimated to be in excess of the Medicaid DSH Limit for those years. Accordingly, Lakeside accrued approximately $2,492,000 at year end for the estimated Medicaid settlements and related costs of the overpayments.

Compliance with laws and regulations: The health care industry is subject to voluminous and complex laws and regulations of federal, state and local governments. These laws and regulations include, but are not necessarily limited to, matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, anti-kickback and anti-referral laws, false claims prohibitions and Medicare and Medicaid fraud and abuse. In addition, as a tax-exempt entity, the District and its component units are also subject to the laws and regulations related to their tax exemption. Compliance with such laws and regulations can be subject to future government review and interpretation, as well as regulatory actions that are unknown or unasserted at this time. Violations of these laws and regulations could result in significant fines and penalties, including repayments for patient services previously reimbursed and loss of tax-exempt status. Management believes that the District has generally complied with applicable laws and regulations that could have a material impact on the financial statements of the District and is not aware of any pending or threatened investigations involving allegations of potential wrongdoing or noncompliance.

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Note 11. Commitments and Contingencies (Continued)

Grants: The grant revenues received or receivable by the District are subject to audit and adjustment by the grantor agencies, principally the federal government and the State of Florida. Any disallowed claims, including amounts already received, might constitute a liability of the District for the return of those funds. Management believes that all grant expenditures were in compliance with the terms of the grant and applicable federal and state laws and regulations.

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Required Supplementary Information
Unaudited

Health Care District of Palm Beach County, Florida

General Fund
Schedule of Revenues, Expenditures and Changes in Fund Balance – Budget and Actual (Unaudited)
Fiscal Year Ended September 30, 2020

	Budget			Variance With
	Original	Final	Actual	Final Budget
Revenues:				
Ad valorem taxes:				
Current	$ 139,050,000	$ 139,050,000	$ 139,191,016	$ 141,016
Delinquent	100,000	100,000	231,208	131,208
Total ad valorem taxes	139,150,000	139,150,000	139,422,224	272,224
Intergovernmental:				
Grants	-	-	913,542	913,542
Palm Beach County School District	2,783,000	2,783,000	2,137,983	(645,017)
Total intergovernmental	2,783,000	2,783,000	3,051,525	268,525
Charges for services:				
Trauma services – Aeromedical (net)	2,867,584	2,867,584	1,682,428	(1,185,156)
Total charges for services	2,867,584	2,867,584	1,682,428	(1,185,156)
Investment and other income:				
Investment earnings	2,699,513	2,699,513	4,184,874	1,485,361
Other income	3,533,767	3,533,767	2,900,862	(632,905)
Total investment and other income	6,233,280	6,233,280	7,085,736	852,456
Total revenues	151,033,864	151,033,864	151,241,913	208,049
Expenditures:				
General government:				
Administration	1,204,696	981,097	1,225,797	(244,700)
Communications	374,332	139,461	288,718	(149,257)
Community engagement	-	458,471	428,436	30,035
Compliance	380,190	380,190	299,884	80,306
Corporate quality	47,708	47,708	195,379	(147,671)
District facilities	1,063,983	934,310	948,069	(13,759)
Employee health	-	-	504,693	(504,693)
Finance	1,236,628	1,236,628	1,271,507	(34,879)
Internal audit	181,506	181,506	117,038	64,468
Information technology – EPIC	-	-	158,087	(158,087)
Human resources	835,228	880,484	1,370,022	(489,538)
Information technology	3,606,983	3,366,431	3,443,918	(77,487)
Legal	611,216	611,216	638,968	(27,752)
Project management	164,771	489,739	495,214	(5,475)
Records management	277,214	277,214	224,242	52,972
Revenue cycle	-	-	1,011,793	(1,011,793)
Risk management	74,323	74,323	138,612	(64,289)
Security services	-	-	83,549	(83,549)
Transportation	500,000	500,000	-	500,000
Non-departmental	9,316,601	6,816,601	7,993,025	(1,176,424)
Total general government	19,875,379	17,375,379	20,836,951	(3,461,572)

(Continued)

Health Care District of Palm Beach County, Florida

General Fund
Statement of Revenues, Expenditures and Changes in Fund Balances – Budget and Actual (Continued) (Unaudited)
Fiscal Year Ended September 30, 2020

	Budget			Variance With
	Original	Final	Actual	Final Budget
Expenditures (continued):				
Managed care:				
Medical services	25,100,000	21,200,000	12,600,892	$ 8,599,108
Administration	5,178,254	5,178,254	4,908,380	269,874
Claims	772,189	772,189	330,750	441,439
Utilization management	1,460,774	1,460,774	1,346,339	114,435
Customer services	1,316,288	1,316,288	836,253	480,035
Provider services	704,507	704,507	574,399	130,108
Eligibility	1,637,980	1,637,980	744,826	893,154
Mailroom	464,430	464,430	352,690	111,740
Total managed care	36,634,422	32,734,422	21,694,529	11,039,893
Trauma services:				
Medical services	16,069,650	16,069,650	18,804,388	(2,734,738)
Trauma agency	750,190	750,190	687,369	62,821
Aeromedical	8,963,057	8,963,057	8,566,499	396,558
Total trauma services	25,782,897	25,782,897	28,058,256	(2,275,359)
School health:				
School health programs	21,627,553	21,627,553	20,469,445	1,158,108
Total school health	21,627,553	21,627,553	20,469,445	1,158,108
Pharmacy services:				
Pharmacy	4,760,323	4,760,323	4,704,083	56,240
Total pharmacy services	4,760,323	4,760,323	4,704,083	56,240
Funding collaborative:				
County health department grant	10,037,947	10,037,947	9,737,585	300,362
Sponsored programs administration	242,132	242,132	308,046	(65,914)
Total funding collaborative	10,280,079	10,280,079	10,045,631	234,448
Total expenditures	118,960,653	112,560,653	105,808,895	6,751,758
Revenues over expenditures	32,073,211	38,473,211	45,433,018	6,959,807
Other financing uses:				
Transfers out	(55,215,568)	(55,215,568)	(55,658,785)	(443,217)
Net change in fund balances	$ (23,142,357)	$ (16,742,357)	$ (10,225,767)	$ 6,516,590
Fund balance—beginning			122,822,839	
Fund balance—ending			$ 112,597,072	

See notes to required supplementary information.

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Health Care District of Palm Beach County, Florida

Medicaid Match Fund
Schedule of Revenues, Expenditures and Changes in Fund Balance – Budget and Actual (Unaudited)
Fiscal Year Ended September 30, 2020

	Budget			Variance With
	Original	Final	Actual	Final Budget
Revenues:				
Intergovernmental:				
Palm Beach County	$ 5,900,000	$ 5,900,000	$ 5,900,000	$ -
Investment earnings	3,788	3,788	1,018	(2,770)
Total revenues	5,903,788	5,903,788	5,901,018	(2,770)
Expenditures:				
General government:				
Medicaid Match	17,219,356	17,219,356	17,103,798	115,558
Revenues under expenditures	(11,315,568)	(11,315,568)	(11,202,780)	112,788
Other financing sources:				
Transfers in	11,315,568	11,315,568	11,202,780	(112,788)
Net change in fund balances	$ -	$ -	-	$ -
Fund balance—beginning			609,042	
Fund balance—ending			$ 609,042	

See notes to financial statements.

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Budgetary Procedures and Budgetary Accounting

The District's enabling legislation requires the District Board to approve an annual operating budget and establish a millage rate in accordance with Chapter 200, Florida Statutes. The District adopts an annual budget for each fiscal year beginning October 1 and ending September 30, on a basis substantially consistent with accounting principles generally accepted in the United States of America. The General Fund and Medicaid Match Fund budgets are prepared using the modified accrual basis of accounting. The accrual basis of accounting is used for the enterprise fund budgets.

The District's budgeting process is based on annual estimates of revenues and expenditures/expenses and requires that the budget be adopted at the program level. Subsequent amendments to total budgeted revenues or expenditures, transfers of appropriations between funds, and transfers over a specified amount within a fund require approval by the District Board. Program budgets are monitored at the department and account level and transfers within a fund may be approved by management without District Board approval, up to a specified amount.

The District follows the following procedures in establishing the budgetary data reflected in the budget and actual schedules:

- The District's management submits a tentative operating budget to the District Board and the Finance and Audit Committee in July for the ensuing fiscal year commencing October 1. The tentative operating budget includes proposed expenditures/expenses and the revenue sources to finance them.

- The District advises the County Property Appraiser of the proposed millage rate and the date, time and place of the first public hearing for budget acceptance in July.

- Two public hearings are held in September—the first on the tentative budget and proposed millage rate and the second to adopt the final budget and millage rate.

- The budget and related millage rate (tax levy) are legally adopted by District Board Resolution, and the millage rate becomes the basis for the ad valorem taxes levied by the County Tax Collector.

- Appropriations not expended or encumbered lapse at the end of the fiscal year.

The budgeted revenues and expenditures in the accompanying budget and actual financial statements include both the originally adopted and final amended budget for the year ended September 30, 2020. The excess of expenditures over revenues, if any, for the original and final budget in the budget and actual financial statements is appropriated fund balance. Encumbrance accounting, under which purchase orders, contracts and other commitments for the expenditure of funds are recorded in order to reserve that portion of the applicable appropriation, is utilized in the District's General Fund. All encumbrances lapse at fiscal year-end. Multiyear agreements and contractual arrangements that cross fiscal years can be re-encumbered when they have been included in the next fiscal year's approved budget.

The excess of transfers out over appropriations in the General Fund in the amount of $443,217, is attributed to the General Fund transferring funds assigned in the prior year for the planned information technology system implementation to the Capital Replacement Fund.

Health Care District of Palm Beach County, Florida

Schedule of Changes in the Total OPEB Liability and Related Ratios (Unaudited)
September 30, 2020
Last Three Years

	2020	2019	2018
Total OPEB liability			
Service cost	$ 38,988	$ 39,586	$ 266,807
Interest	19,146	18,428	16,223
Difference between expected and actual experience	128,718	-	-
Changes of assumptions	50,396	6,185	(8,236)
Implicit benefit payments	(35,067)	(25,627)	(22,137)
Net change in total OPEB liability	202,181	38,572	252,657
Total OPEB liability – beginning	530,859	492,287	239,630
Total OPEB liability – ending	$ 733,040	$ 530,859	$ 492,287
Covered payroll	$ 83,880,000	$ 79,883,000	$ 76,490,000
District's total liability as a percentage of covered payroll	0.87%	0.66%	0.64%
Measurement date	9/30/2020	9/30/2019	9/30/2018

Notes to Schedule:

(1) Fiscal year 2020 assumption changes since prior valuation:
- Mortality improvement scale was modified from MP-2018 to MP-2019
- Discount rate was lowered from 3.58% to 2.14%

(2) This Schedule is presented to illustrate the requirement to show information for 10 years. However, until a full 10-year trend is compiled, information for those years for which information is available will be presented.

Health Care District of Palm Beach County, Florida

Schedule of District Proportionate Share of Net Pension Liability (Unaudited)
Florida Retirement System Plans
September 30, 2020
Last Seven Years

Florida Retirement System	2020	2019	2018	2017	2016	2015	2014
Districts' proportion of the net pension liability	**0.0005%**	0.0004%	0.0005%	0.0006%	0.0007%	0.0011%	0.0009%
District's proportionate share of the net pension liability	**$ 218,327**	$ 129,871	$ 154,566	$ 189,758	$ 169,053	$ 143,204	$ 57,284
District's covered payroll	**$ 165,210**	$ 185,312	$ 199,062	$ 220,000	$ 241,375	$ 336,632	$ 354,626
District's proportionate share of the net pension liability as a percentage of its covered payroll	**132.15%**	70.08%	77.65%	86.25%	70.04%	42.54%	16.15%
Plan fiduciary net position as a percentage of the total pension liability	**78.85%**	82.61%	84.26%	83.89%	84.88%	92.00%	96.09%

Health Insurance Subsidy Program	2020	2019	2018	2017	2016	2015	2014
Districts' proportion of the HIS liability	**0.0005%**	0.0005%	0.0006%	0.0007%	0.0009%	0.0013%	0.0012%
District's proportionate share of the HIS liability	**$ 57,189**	$ 55,371	$ 64,506	$ 74,483	$ 101,159	$ 134,730	$ 115,803
District's covered payroll	**$ 165,210**	$ 185,312	$ 199,062	$ 220,000	$ 241,375	$ 336,632	$ 354,626
District's proportionate share of the HIS liability as a percentage of its covered payroll	**0.00%**	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Plan fiduciary net position as a percentage of the total HIS liability	**3.00%**	2.63%	2.15%	1.64%	0.97%	0.50%	0.99%

This Schedule is presented to illustrate the GASB 68 requirement to show information for 10 years. However, until a full 10-year trend is complied, the information for those years for which information is available will be presented.

Health Care District of Palm Beach County, Florida

Schedule of District Contributions (Unaudited)
Florida Retirement System Plans
September 30, 2020
Last Seven Years

Florida Retirement System	2020	2019	2018	2017	2016	2015	2014
Contractually required contribution	**$ 16,737**	$ 11,693	$ 14,625	$ 16,701	$ 19,600	$ 31,483	$ 27,040
Contributions in relation to the contractually required contribution	**(16,737)**	(11,693)	(14,625)	(16,701)	(19,600)	(31,483)	(27,040)
Contribution deficiency (excess)	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
District's covered payroll	**$ 165,210**	$ 185,312	$ 199,062	$ 220,000	$ 241,375	$ 336,632	$ 354,626
Contributions as a percentage of covered payroll	**10.13%**	6.31%	7.35%	7.59%	8.12%	9.35%	7.62%

Health Insurance Subsidy Program	2020	2019	2018	2017	2016	2015	2014
Contractually required contribution	**$ 2,699**	$ 2,748	$ 3,305	$ 3,687	$ 4,449	$ 14,617	$ 15,084
Contributions in relation to the contractually required contribution	**(2,699)**	(2,748)	(3,305)	(3,687)	(4,449)	(14,617)	(15,084)
Contribution deficiency (excess)	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
District's covered payroll	**$ 165,210**	$ 185,312	$ 199,062	$ 220,000	$ 241,375	$ 336,632	$ 354,626
Contributions as a percentage of covered payroll	**0.00%**	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%

This Schedule is presented to illustrate the GASB 68 requirement to show information for 10 years. However, until a full 10-year trend is complied, the information for those years for which information is available will be presented.

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Individual Fund Financial Statements

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Agency Fund

Resident Agency Fund: This fund is used to account for assets held as an agent for residents of the Healey Center.

Health Care District of Palm Beach County, Florida

Statement of Changes in Agency Fund Assets and Liabilities—Resident Agency Fund
Fiscal Year Ended September 30, 2020

	Balance October 1, 2019	Additions	Deletions	Balance September 30, 2020
Assets				
Cash and cash equivalents	$ 62,028	$ 523,462	$ (515,031)	$ 70,459
Liabilities				
Accounts payable	$ 62,028	$ 524,263	$ (515,832)	$ 70,459
Net position	$ -	$ (801)	$ 801	$ -

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Compliance Section

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Report on Internal Control Over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance With *Government Auditing Standards*

Independent Auditor's Report

The Honorable Chairperson and Members of
the Health Care District Board
Health Care District of Palm Beach County, Florida

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States, the financial statements of the governmental activities, the business-type activities, the discretely presented component unit, each major fund, and the aggregate remaining fund information of the Health Care District of Palm Beach County, Florida (the District), as of and for the year ended September 30, 2020, and the related notes to the financial statements, which collectively comprise the District's basic financial statements, and have issued our report thereon dated June 18, 2021.

Internal Control Over Financial Reporting

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

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

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

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

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

RSM US LLP

West Palm Beach, Florida
June 18, 2021

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RSM US LLP

Report on Compliance for Each Major Federal Program and
Report on Internal Control Over Compliance

<u>Independent Auditors' Report</u>

The Honorable Chairperson and Members of
the Health Care District Board
Health Care District of Palm Beach County, Florida

Report on Compliance for Each Major Federal Program
We have audited the Health Care District of Palm Beach County, Florida's (the District) compliance with the types of compliance requirements described in the *OMB Compliance Supplement* that could have a direct and material effect on each of the District's major federal programs for the year ended September 30, 2020. The District's major federal programs are identified in the summary of auditor's results section of the accompanying schedule of findings and questioned costs.

Management's Responsibility
Management is responsible for compliance with federal statutes, regulations and the terms and conditions of its federal awards applicable to its federal programs.

Auditor's Responsibility
Our responsibility is to express an opinion on compliance for each of District's major federal programs based on our audit of the types of compliance requirements referred to above. We conducted our audit of compliance in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; and the audit requirements of Title 2 U.S. *Code of Federal Regulations* Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Those standards and the Uniform Guidance require that we plan and perform the audit to obtain reasonable assurance about whether noncompliance with the types of compliance requirements referred to above that could have a direct and material effect on a major federal program occurred. An audit includes examining, on a test basis, evidence about the District's compliance with those requirements and performing such other procedures as we considered necessary in the circumstances.

We believe that our audit provides a reasonable basis for our opinion on compliance for each major federal program. However, our audit does not provide a legal determination of the District's compliance.

Opinion on Each Major Federal Program
In our opinion, the District complied, in all material respects, with the types of compliance requirements referred to above that could have a direct and material effect on each of its major federal programs for the year ended September 30, 2020.

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Report on Internal Control Over Compliance

Management of the District is responsible for establishing and maintaining effective internal control over compliance with the types of compliance requirements referred to above. In planning and performing our audit of compliance, we considered the District's internal control over compliance with the types of requirements that could have a direct and material effect on each major federal program to determine the auditing procedures that are appropriate in the circumstances for the purpose of expressing an opinion on compliance for each major federal program and to test and report on internal control over compliance in accordance with the Uniform Guidance, but not for the purpose of expressing an opinion on the effectiveness of internal control over compliance. Accordingly, we do not express an opinion on the effectiveness of the District's internal control over compliance.

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

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

The purpose of this report on internal control over compliance is solely to describe the scope of our testing of internal control over compliance and the results of that testing based on the requirements of the Uniform Guidance. Accordingly, this report is not suitable for any other purpose.

RSM US LLP

West Palm Beach, Florida
June 18, 2021

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Health Care District of Palm Beach County, Florida

Schedule of Expenditures of Federal Awards
Fiscal Year Ended September 30, 2020

Federal Grantor / Pass-Through Grantor/ Program or Cluster Title	Federal Assistance Listing Number	Contract Number	Pass-Through Entity Identifying Number	Total Federal Expenditures
U.S. Department of Health and Human Services:				
Direct awards:				
Health Resources and Services Administration:				
Consolidated Health Centers (Community Health Centers, Migrant Health Centers, Health Care for the Homeless, Public Housing Primary Care Centers, and School-Based Health Centers):				
Grant Year January 1, 2018 – December 31, 2018	93.224	6 H80CS25684-06-11	Not applicable	$ 2,598
Grant Year January 1, 2019 – December 31, 2019	93.224	6 H80CS25684-07-02	Not applicable	122,647
Grant Year January 1, 2019 – December 31, 2019	93.224	6 H80CS25684-07-03	Not applicable	146,473
Grant Year January 1, 2019 – December 31, 2019	93.224	6 H80CS25684-07-04	Not applicable	89,733
Grant Year January 1, 2019 – December 31, 2019	93.224	6 H80CS25684-07-05	Not applicable	300,000
Grant Year January 1, 2020 – December 31, 2020	93.224	6 H80CS25684-08-00	Not applicable	2,924,610
Grant Year January 1, 2020 – December 31, 2020	93.224	6 H80CS25684-08-03	Not applicable	2,339,688
Grant Year January 1, 2020 – December 31, 2020	93.224	6 H80CS25684-08-05	Not applicable	1,596,880
Grant Year April 15, 2020 – March 14, 2021	93.224	1 H8CCS35088-01-00	Not applicable	133,617
Grant Year April 1, 2020 – March 31, 2021	93.224	1 H8DCS36001-01-00	Not applicable	1,790,935
Grant Year May 1, 2020 – April 30, 2021	93.224	1 H8ECS37839-01-00	Not applicable	300,911
Total Health Centers cluster				9,748,092
Covid-19 – Testing for the Uninsured	93.461	None	Not applicable	667,596
Total U.S. Department of Health and Human Services				10,415,688
U.S Department of the Treasury				
Passed through Palm Beach County				
Covid-19 – Coronavirus Relief Fund	21.019	R2020-0507	None	2,938,777
Total expenditures of federal awards				$ 13,354,465

See notes to schedule of expenditures of federal awards.

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Note 1. Basis of Presentation

The accompanying Schedule of Expenditures of Federal Awards (the Schedule) presents the activity of all federal awards of the Health Care District of Palm Beach County, Florida (the District) for the year ended September 30, 2020, except for the Provider Relief Funds described in Note 5. The information in the Schedule is presented in accordance with the requirements of Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance). Because the Schedule presents only a selected portion of the operations of the District, it is not intended to and does not present the financial position, changes in fund balance/net position or cash flows of the District. The District's reporting entity is defined in Note 1 of the District's basic financial statements.

Note 2. Summary of Significant Accounting Policies

The accompanying Schedule is presented using the modified accrual basis of accounting for expenditures accounted for in the governmental funds and the accrual basis of accounting for expenses of the proprietary fund types, which are described in Note 1 of the District's basic financial statements. Such expenses/expenditures are recognized following the cost principles contained in the Uniform Guidance, wherein certain types of expenditures are not allowable or are limited as to reimbursement.

Note 3. Subrecipient Awards

Of the federal awards presented in the Schedule, the District did not provide any amounts to subrecipients.

Note 4. Indirect Cost Recovery

The District has not elected to use the 10% de minimis indirect cost rate allowed under the Uniform Guidance.

Note 5. Provider Relief Funds

The District received amounts from the U.S. Department of Health and Human Services through the Provider Relief Funds (PRF) program (Federal Assistance Listing Number #93.498) during the year ended September 30, 2020. The District recognized PRF revenue totaling approximately $10,076,000 in its financial statements for the year ended September 30, 2020. In accordance with the 2020 Compliance Supplement Addendum issued in December 2020, this funding is not included in the accompanying schedule of expenditures of federal awards for the year ended September 30, 2020.

I – Summary of Auditor's Results

Financial Statements

Type of report the auditor issued on whether the financial statements audited were prepared in accordance with GAAP:	Unmodified	
Internal control over financial reporting:		
Material weakness(es) identified?	____ Yes	X No
Significant deficiency(ies) identified?	____	X None Reported
Noncompliance material to financial statements noted?	____ Yes	X No

Federal Awards

Internal control over major programs:		
Material weakness(es) identified?	____ Yes	X No
Significant deficiency(ies) identified?	____ Yes	X None Reported
Type of auditor's report issued on compliance for major federal programs:	Unmodified	
Any audit findings disclosed that are required to be reported in accordance with Section 2 CFR 200.516(a)?	____ Yes	X No

Identification of major programs:

CFDA Number	Name of Federal Program or Cluster
93.461	Covid-19 – Testing for the Uninsured
21.019	Covid-19 – Coronavirus Relief Fund

Dollar threshold used to distinguish between type A and type B programs:	$	750,000
Auditee qualified as low-risk auditee?	X Yes	____ No

Section II – Financial Statements Findings

No matters to report.

Section III – Federal Awards Findings and Questioned Costs

No matters to report.

Section IV – Summary of Prior Year Audit Findings

No matters were reported in the prior year.

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RSM US LLP

Management Letter Required By
Chapter 10.550 of the *Rules of the Auditor General* of the State of Florida

The Honorable Chairperson and Members of
the Health Care District Board
Health Care District of Palm Beach County, Florida
West Palm Beach, Florida

Report on the Financial Statements
We have audited the financial statements of the governmental activities, the business-type activities, the discretely presented component unit, each major fund and the aggregate remaining fund information of the Health Care District of Palm Beach County, Florida (the District), as of and for the year ended September 30, 2020, and have issued our report thereon dated June 18, 2021.

Auditor's Responsibility
We conducted our audit in accordance with auditing standards generally accepted in the United States of America; the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States; the audit requirements of Title 2 U.S. Code of Federal Regulations Part 200, *Uniform Administrative Requirements, Cost Principles, and Audit Requirements for Federal Awards* (Uniform Guidance); and Chapter 10.550, Rules of the Auditor General.

Other Reporting Requirements
We have issued our Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of the Financial Statements Performed in Accordance with *Government Auditing Standards*; Independent Auditor's Report on Compliance for Each Major Federal Program and Report on Internal Control over Compliance; Schedule of Findings and Questioned Costs; and Independent Accountant's Report on an examination conducted in accordance with AICPA Professional Standards, AT-C Section 315, regarding compliance requirements in accordance with Chapter 10.550, Rules of the Auditor General. Disclosures in those reports and schedule, which are dated June 18, 2021, should be considered in conjunction with this management letter.

Prior Audit Findings
Section 10.554(1)(i)1., Rules of the Auditor General, requires that we determine whether or not corrective actions have been taken to address findings and recommendations made in the preceding financial audit report. There were no recommendations made in the preceding financial audit report.

Official Title and Legal Authority
Section 10.554(1)(i)4., Rules of the Auditor General, requires that the name or official title and legal authority for the primary government and each component unit of the reporting entity be disclosed in this management letter, unless disclosed in the notes to the financial statements. This is disclosed in Note 1 of the financial statements.

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Financial Condition and Management
Sections 10.554(1)(i)5.a. and 10.556(7), Rules of the Auditor General, require us to apply appropriate procedures and communicate the results of our determination as to whether or not the District has met one or more of the conditions described in Section 218.503(1), Florida Statutes, and to identify the specific condition(s) met. In connection with our audit, we determined that the District did not meet any of the conditions described in Section 218.503(1), Florida Statutes.

Pursuant to Sections 10.554(1)(i)5.b. and 10.556(8), Rules of the Auditor General, we applied financial condition assessment procedures for the District. It is management's responsibility to monitor the District's financial condition, and our financial condition assessment was based in part on representations made by management and review of financial information provided by same. In connection with our audit, we determined that the District did not meet any of the conditions described in Sections 10.554(1)(i)5.b. and 10.556(8).

Section 10.554(1)(i)2., Rules of the Auditor General, requires that we communicate any recommendations to improve financial management. In connection with our audit, we did not have any such recommendations.

Special District Component Units
Section 10.554(1)(i)5.c., Rules of the Auditor General, requires, if appropriate, that we communicate the failure of a special district that is a component unit of a county, municipality, or special district, to provide the financial information necessary for proper reporting of the component unit within the audited financial statements of the county, municipality, or special district in accordance with Section 218.39(3)(b), Florida Statutes. In connection with our audit, we did not note any special district component units that failed to provide the necessary information for proper reporting in accordance with Section 218.39(3)(b), Florida Statutes.

Additional Matters
Section 10.554(1)(i)3., Rules of the Auditor General, requires us to communicate noncompliance with provisions of contracts or grant agreements, or abuse, that have occurred, or are likely to have occurred, that have an effect on the financial statements that is less than material but warrants the attention of those charged with governance. In connection with our audit, we did not note any such findings.

Purpose of This Letter
Our management letter is intended solely for the information and use of the Legislative Auditing Committee, members of the Florida Senate and the Florida House of Representatives, the Florida Auditor General, Federal and other granting agencies, the District's Board, and applicable management, and is not intended to be, and should not be, used by anyone other than these specified parties.

RSM US LLP

West Palm Beach, Florida
June 18, 2021

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RSM US LLP

Independent Accountant's Report

The Honorable Chairperson and Members of
the Health Care District Board
Health Care District of Palm Beach County, Florida

We have examined the Health Care District of Palm Beach County, Florida's (the District) compliance with the requirements of *Section 218.415, Florida Statutes, Local Government Investment Policies* during the period October 1, 2019 to September 30, 2020. Management of the District is responsible for the District's compliance with those requirements. Our responsibility is to express an opinion on the District's compliance with the specified requirements based on our examination.

Our examination was conducted in accordance with attestation standards established by the American Institute of Certified Public Accountants. Those standards require that we plan and perform the examination to obtain reasonable assurance about whether the District complied, in all material respects, with the specified requirements referenced above. An examination involves performing procedures to obtain evidence about whether the District complied with the specified requirements. The nature, timing, and extent of the procedures selected depend on our judgment, including an assessment of the risks of material noncompliance, whether due to fraud or error. We believe that the evidence we obtained is sufficient and appropriate to provide a reasonable basis for our opinion.

Our examination does not provide a legal determination on the District's compliance with the specified requirements.

In our opinion, the District complied, in all material respects, with the specified requirements during the period October 1, 2019 to September 30, 2020.

This report is intended solely for the information and use of the District's Board and applicable management, and the Florida Auditor General, and is not intended to be and should not be used by anyone other than these specified parties.

RSM US LLP

West Palm Beach, Florida
June 18, 2021

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Health Care District
PALM BEACH COUNTY

The health care safety net for our community

Financial report prepared by
the Finance Department of the
Health Care District of Palm Beach County.

1515 N. Flagler Dr. , Suite 101
West Palm Beach, FL 33401-3429
561-659-1270
www.hcdpbc.org

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HEALTH CARE DISTRICT BOARD AND FINANCE & AUDIT COMMITTEE JOINT MEETING
June 29, 2021

1. Description: Trauma Agency Five-Year Plan Update

2. Summary:

Section 64-J-2.007 of the Florida Administrative Code, requires the County's approval of the Trauma Agency Five-Year Plan Update.

3. Substantive Analysis:

The 2021 proposed trauma five-year plan update demonstrates ongoing need and addresses the twelve required components for the Trauma Plan as set forth in Chapter 395, Part II, Florida Statutes, as well as additional components required by rule 64J-2.007. There are no substantive changes proposed in this five-year plan update.

In 2020, Palm Beach County's two trauma centers evaluated 4,605 trauma patients (2,458 at SMMC and 2,147 at DMC), compared to 4,664 in 2019. The volume of patients with significant injury evaluated and treated each year in Palm Beach County justifies maintaining the county's two verified trauma centers.

There were minor changes to the objectives, data collection, quality improvement and Master Service Agreement. The team identified one new objective to promote and facilitate disaster event readiness and preparation throughout the integrated trauma system of Palm Beach County by offering the American College of Surgeons (ACS) Disaster Management and Emergency Preparedness (DMEP) Course biennially. The team also further defined the data collection and updated the quality improvement sections of the plan to further define system-wide quality analysis. Lastly, the Master Service Agreement was updated in conjunction with the legal department to further promote ongoing quality improvement initiatives and accountability across the continuum of care.

Pursuant to rule 64J-2.007, Florida Administrative Code, the District must conduct a public hearing on the plan updates to include public comment at least 60-days prior to submission of the plan updates to Department of Health. In the interim, the Board of County Commissioner's endorsement must be sought, per Florida Administrative Code.

4. Fiscal Analysis & Economic Impact Statement:

	Amount	Budget
Capital Requirements		Yes ☐ No ☒
Annual Net Revenue		Yes ☐ No ☒
Annual Expenditures		Yes ☐ No ☒

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Reviewed for financial accuracy and compliance with purchasing procedure:

DocuSigned by:
Darcy Davis
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Darcy J. Davis
Chief Executive Officer

5. Reviewed/Approved by Committee:

N/A	N/A
Committee Name	Date Approved

6. Recommendation:

Staff recommends the Board approve the Trauma Five-Year Plan update and submission of the same to the Florida Department of Health for approval.

Approved for Legal sufficiency:

DocuSigned by:
Christy Goddeau
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Christy Goddeau
Interim General Counsel

DocuSigned by:
Belma Andric
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Belma Andric, MD
Chief Medical Officer

DocuSigned by:
Darcy Davis
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Darcy J. Davis
Chief Executive Officer

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PALM BEACH COUNTY TRAUMA SERVICE

AREA SIXTEEN

FIVE-YEAR TRAUMA PLAN

2021 – 2026

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INTRODUCTION & BACKGROUND

Introduction

The Health Care District of Palm Beach County (District) began operating Palm Beach County's Trauma Agency in 1991. The District provides leadership and administrative support to ensure the trauma system's operational components -- an enhanced 911 communication and dispatch system, EMS and Fire Rescue, the "Trauma Hawk" aeromedical helicopters, two Level I trauma centers and associated rehabilitation centers -- function as a cohesive unit. Since its inception, the trauma system in Palm Beach County has treated 87,000 trauma victims.

At the national, state and local levels, trauma continues to be a major cause of death and disability. Nationally, fatalities related to preventable injury have risen from the fifth to the third leading cause of death since 2012. According to the Florida Department of Health (FDOH), unintentional injury is the primary cause of death for Florida residents 44 years of age and under, and the fourth leading cause of death across all age groups. Utilizing the CDC's Web-based Injury Statistics Query and Reporting System (WISQARS) online interactive database of injury-related data, Florida rates of unintentional and violence-related injuries were approximately 12.6% and 5.7% higher, respectively, compared to national averages. In 2019, there were 1,349 deaths related to injury in Palm Beach County alone.

To assess the trauma needs in Palm Beach County, the District administers a system-wide quality management program, supplementing the peer review processes of the individual trauma centers. This quality assurance and improvement process includes collecting registry data to review quality of care from the point of injury to final outcome, as well as monitoring local EMS providers, trauma centers, and acute care hospitals for compliance with state trauma statutes and the local trauma ordinance. Specifically, the District administers and evaluates the compliance and quality of the following trauma system components:

- Prehospital Providers
- Level I Trauma Centers/Pediatric Trauma Referral Centers
- Rehabilitation Centers
- Non-Trauma Center Hospitals
- Trauma Review Process

In accordance with national standards, Palm Beach County has an integrated trauma system with the requisite components to ensure proficient trauma care, including those addressing injury prevention and prehospital, acute/inpatient and posthospital care. As an integrated trauma system, objectives of the Palm Beach County trauma system are to:

- Develop and maintain cohesive relationships amongst those in leadership roles for all contributing entities;
- Promote professional resources throughout the integrated trauma system;
- Disseminate trauma-related education and awareness for the general public, non-trauma health care providers and legislative bodies at the local and state levels;
- Contribute to the collection of trauma-related data at the state and national levels;
- Participate in expanding the body of trauma-related research;
- Moderate the financial burden associated with the delivery of trauma care throughout its continuum;
- Utilize technological advancements to promote the organized, effective delivery of trauma care.

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The purpose of this document is to illustrate the fundamental framework of Palm Beach County's trauma system. This includes establishing goals and objectives, plans for implementation, methods for ongoing evaluation of operations and outcomes, and identifying opportunities for ongoing advancement and improvement in the delivery of trauma care throughout the County.

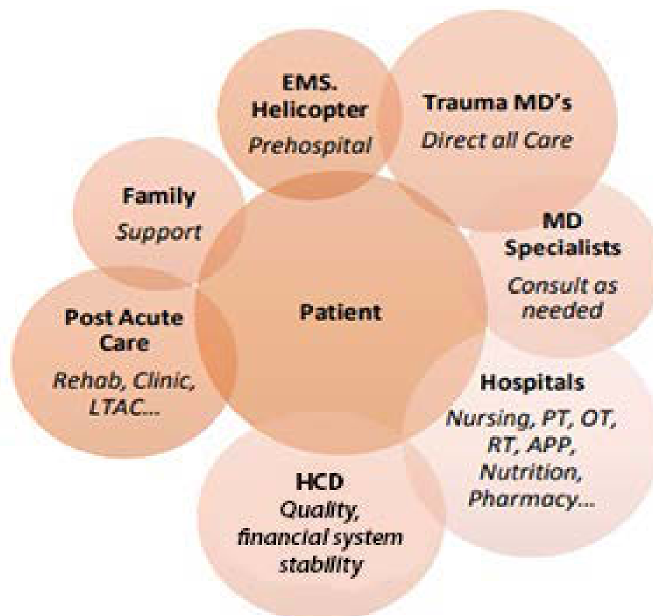
Background

In 1987, as the FDOH was tasked with developing a statewide trauma system, Palm Beach County's trauma system was established at the behest of the Palm Beach County Board of County Commissioners and the Emergency Medical Services Council. Within a few months, the District, an independent taxing district, was created to provide funding for health care services, including trauma care.

In 1999, the Trauma System Report on Timely Access to Trauma Care identified the need for the development of inclusive trauma systems designed to meet the needs of all trauma victims requiring care in the acute setting. The objective of these inclusive trauma systems was to ensure that any trauma victim requiring hospital-based services would be treated at a facility with the resources to provide appropriate care.

Since their verification as Level II trauma centers in 1991, St. Mary's Medical Center (SMMC) and Delray Medical Center (DMC) have been the sole providers of trauma care in Palm Beach County, the same year the County's trauma system began operations. In 2013, DMC became a FDOH-verified Level I trauma center, followed by SMMC in 2014.

From the Everglades to the beach, the District's robust health care network reaches all corners of Palm Beach County. The District's safety-net programs include a public hospital, a skilled nursing facility, a school health program serving 166 schools, 13 Federally Qualified Health Centers (FQHCs) and a nationally recognized, rapid air emergency transport and care unit. The District is led by a seven-member governing Board appointed by Florida's Governor, the Palm Beach County Board of Commissioners, and the State Department of Health. Allocating 93.6% of the $277 million annual budget to the provision and management of health care services, the District manages its budget in a fiscally responsible manner. To ensure and support the county-wide infrastructure for trauma care, the District administers a systematic approach to providing medical care to trauma victims that includes communications, prehospital care, patient transport, trauma center care, and a well-defined management structure.

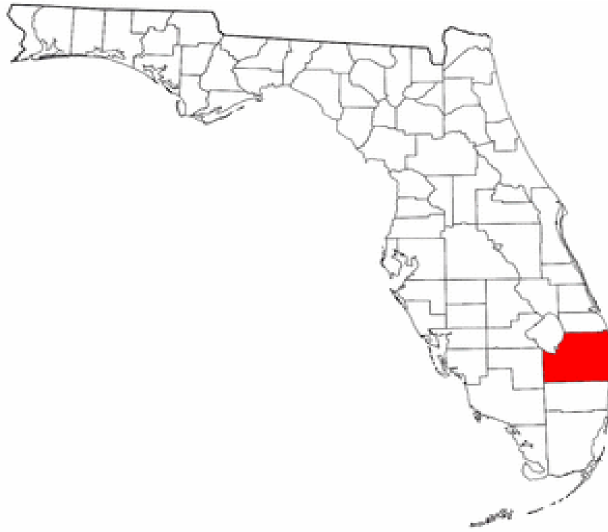


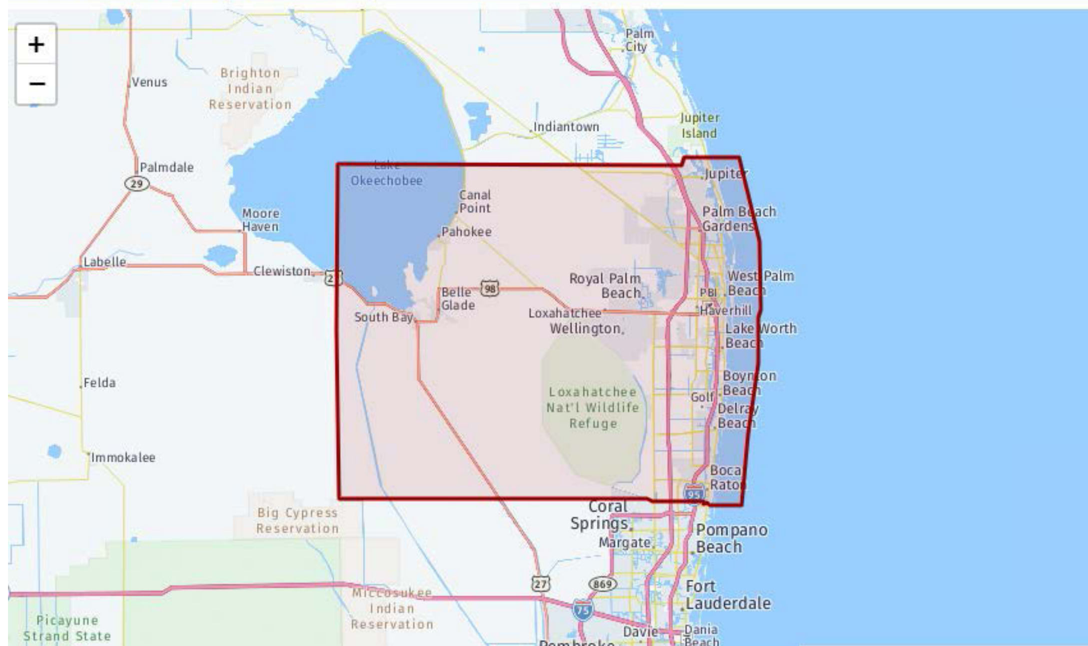
GEOGRAPHIC AREA DESCRIPTION & POPULATION SERVED

Description of Palm Beach County's Physical Environment

By area, Palm Beach County is the second largest in Florida, spanning 2,383 square miles. Extending approximately 45 miles longitudinally and 45 miles by latitude, the County reaches from Lake Okeechobee in the west to the Atlantic Ocean in the east, sharing borders with Martin County to the north and Broward County to the south. Eastern Palm Beach County is predominantly urban and suburban, while central and western Palm Beach County are rural with interspersed wetlands. Separated from the eastern communities by approximately 20 miles of farm land, swamp and marsh, the western communities are 50 miles away and approximately 60 minutes' travel by ground from the nearest trauma center.

Palm Beach County, Florida





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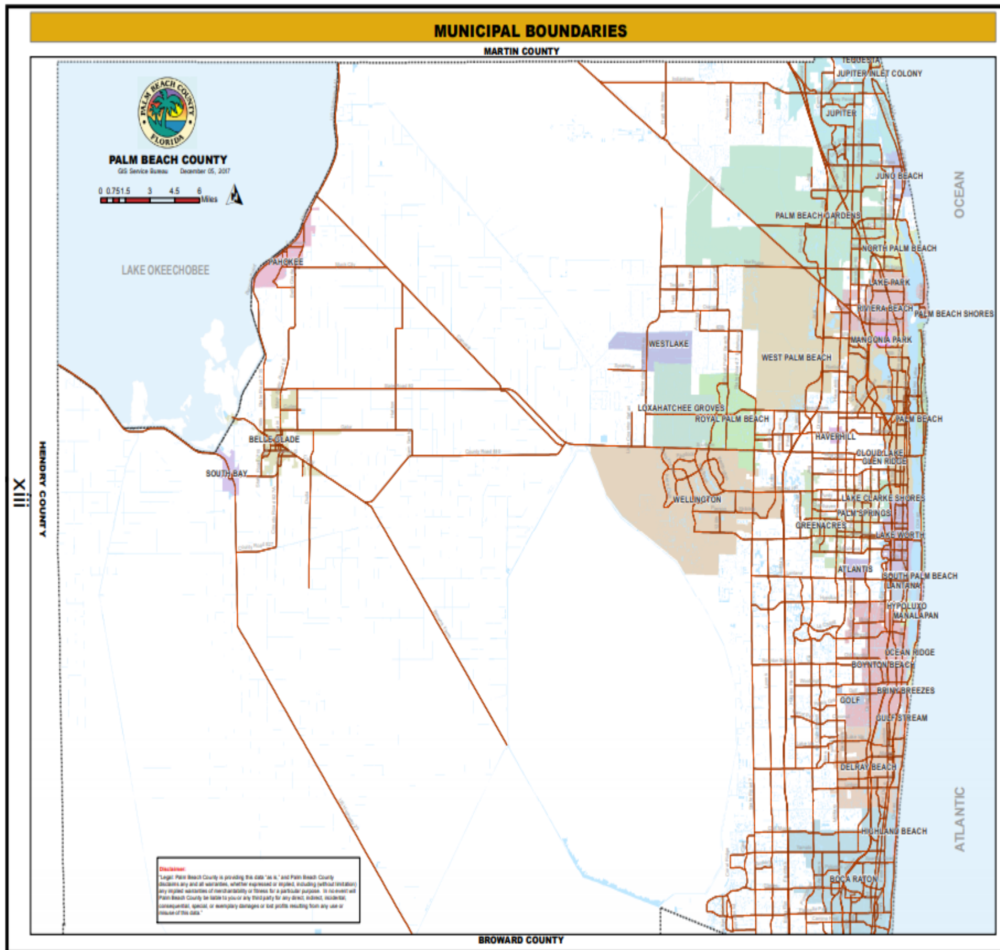
Within the County's borders are four large lakes, Lake Okeechobee (488,000 acres), Lake Mangonia (540 acres), Clear Lake (401 acres) and Lake Osborne (356 acres). In the northern end of the County, the Loxahatchee River runs 7.6 miles, communicating with the Atlantic Ocean via the Jupiter Inlet. The Intracoastal Waterway stretches along the entire eastern coast of the County, with inlets to the Atlantic Ocean at Jupiter, Lake Worth/Palm Beach, South Lake Worth/Boynton and Boca Raton. Traversing County's various waterways are 13 drawbridges, eight in northern area of the County and five in the south. The fourth-busiest freight port in Florida, the Port of Palm Beach covers 971 square miles and serves the Bahamas Paradise Cruise Line.

Major traffic routes for the County include Interstate 95 and Florida's Turnpike, both travelling north-south through the County with speed limits of 65-70 mph. US Highway 1 and A1A also run through the County longitudinally at lower rates of speed, but no less-heavily trafficked. Crossing the County latitudinally are other smaller, lower-speed but heavily-trafficked highways such as US Highway 98.

Annually, approximately 6 million passengers travel through Palm Beach International Airport (PBIA) via ten major airlines that regularly connect through the airport. In addition to commercial flights, PBIA is routinely utilized by cargo carriers such as FedEx and UPS. Operated out of Palm Beach County Fire Rescue (PBCFR) Station Number 81, the Fire Rescue Aviation Battalion is located on PBIA premises and responds to about 1,600 calls each year. Expertly trained in the operation of specialized aircraft rescue and firefighting vehicles, the unit responds to emergencies occurring within and in the vicinity of PBIA, including all general aviation facilities therein. When emergencies occur within PBIA, PBCFR Station Number 81 provides advanced life support (ALS) services to passengers and employees.

The Florida East Coast Railway and South Florida Rail Corridor run north-south through the County. The higher-speed rail route provider, Brightline, has its (current) northern-most stop in West Palm Beach and utilizes the FEC railway, terminating south in Miami. Utilizing the South Florida Rail Corridor, Tri-Rail commuter trains also run from West Palm Beach to Miami with six stations within the County.



Palm Beach County – Population by Municipality, 2019 (U.S. Census Bureau)			
Municipality	**Population**	**Municipality**	**Population**
Atlantis, City of	2,129	Lantana, Town of	12,581
Belle Glade, City of	20,134	Loxahatchee Groves, Town of	3,593
Boca Raton, City of	99,805	Manalapan, Town of	466
Boynton Beach, City of	78,679	Mangonia Park, Town of	2,018
Briny Breezes, Town of	578	North Palm Beach, Village of	13,127
Cloud Lake, Town of	144	Ocean Ridge, Town of	1,956
Delray Beach, City of	69,451	Pahokee, City of	6,315
Glen Ridge, Town of	243	Palm Beach, Town of	8,816
Golf, Village of	269	Palm Beach Gardens, City of	57,704
Greenacres, City of	41,117	Palm Beach Shores, Town of	1,262
Gulf Stream, Town of	985	Palm Springs, Village of	25,216
Haverhill, Town of	2,143	Riviera Beach, City of	35,463
Highland Beach, Town of	3,916	Royal Palm Beach, Village of	40,396
Hypoluxo, Town of	2,839	South Bay, City of	5,200
Juno Beach, Town of	3,655	South Palm Beach, Town of	1,470
Jupiter, Town of	65,791	Tequesta, Village of	6,138
Jupiter Inlet Colony, Town of	453	Wellington, Village of	65,398
Lake Clark Shores, Town of	3,627	West Palm Beach, City of	111,955
Lake Park, Town of	8,556	Westlake, City of	1,447
Lake Worth, City of	38,526		

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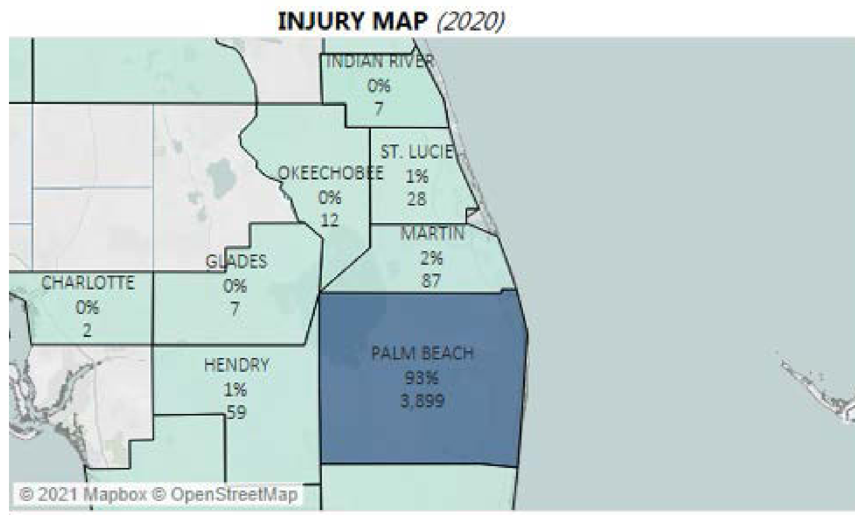
Trauma center catchment areas and geographical boundary lines in Palm Beach County are approved by the District and may be redefined to reflect changes in trauma resource supply and demand, such as population distribution, trauma center capacity and verification status. Boundaries may also be redefined as needed to ensure trauma care is geographically accessible within 25 minutes.

Palm Beach County Population Characteristics

After Miami-Dade and Broward counties, Palm Beach County is the third most populated in Florida and the 25th most populated nationally, with more than 1.5 million residents in 2020. From 2010 to 2019, the population of Palm Beach County increased by 13.4% making Palm Beach County the 10th most densely populated county in Florida. County data from 2017 indicated seasonal population growth by 11% due to part-time residents, peaking from December to February. Additionally, the County has more than7.3 million tourists and routine visitors per year.

Designated Trauma Service Area (TSA) 16, Palm Beach County is comprised of 39 incorporated municipalities, each responsible for enacting and enforcing its own policies and legislation, in addition to abiding by county-issued ordinances. By municipality, the top five most populated areas in the County in 2019 were West Palm Beach, Boca Raton, Boynton Beach, Delray Beach and Jupiter. Palm Beach County is considered a nucleus county, providing trauma care to neighboring counties without sufficient local resources. As illustrated below, while the majority of injuries requiring trauma care management were incurred in Palm Beach County, the two local trauma centers also treated patients whom sustained injuries in seven outlying counties: Indian River, St. Lucie, Okeechobee, Martin, Glades, Charlotte, and Hendry.



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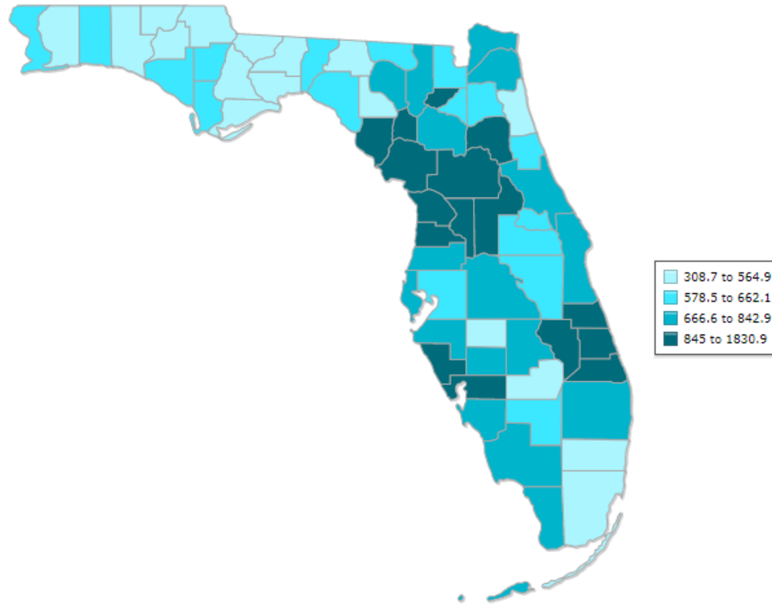
Map and Data from FDOH, Bureau of Community Health Assessment, Division of Public Health Statistics and Performance



Injury Hospitalizations, All Injuries, Rate per 100,000 Population (2019)			
	Hospitalizations Secondary to Injury (N)	Population (N)	Rate
Palm Beach County	11,697	1,456,607	803.0
State of Florida	144,050	21,243,483	678.1

Regarding injury-related hospitalizations, data from the FDOH Bureau of Community Health Assessment, Division of Public Health Statistics and Performance, demonstrates that in 2019, the rate of hospitalization secondary to injury in Palm Beach County was 18.4% higher than the statewide rate.

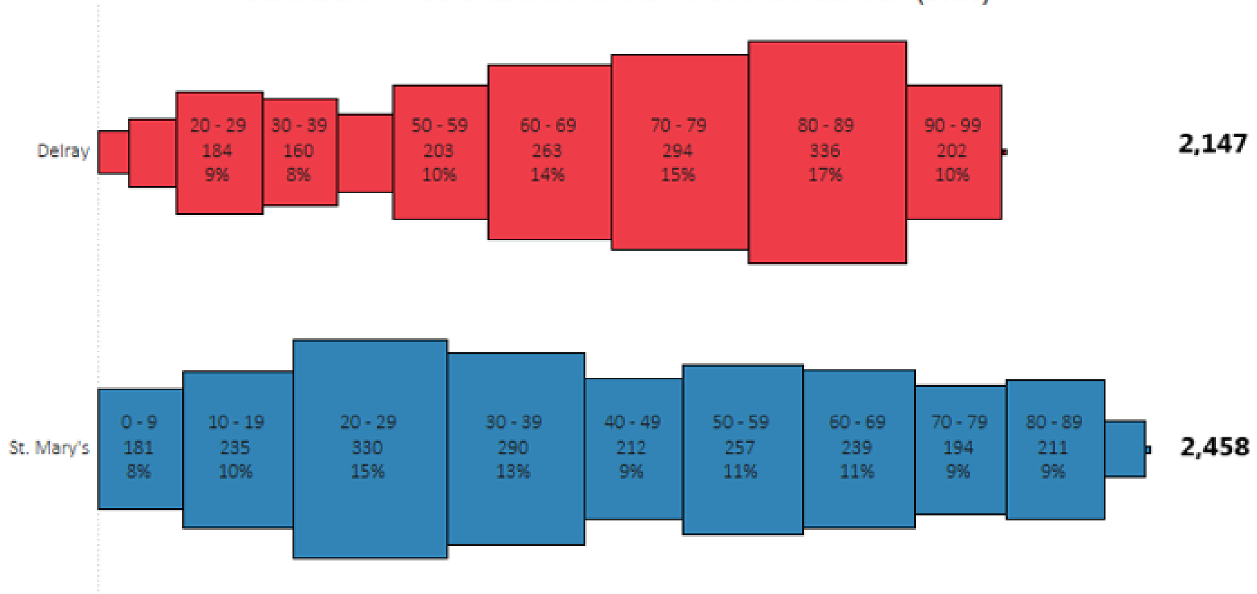
According to U.S. Census Bureau data for 2019, demographic characteristics for Palm Beach County are presented in the table below:

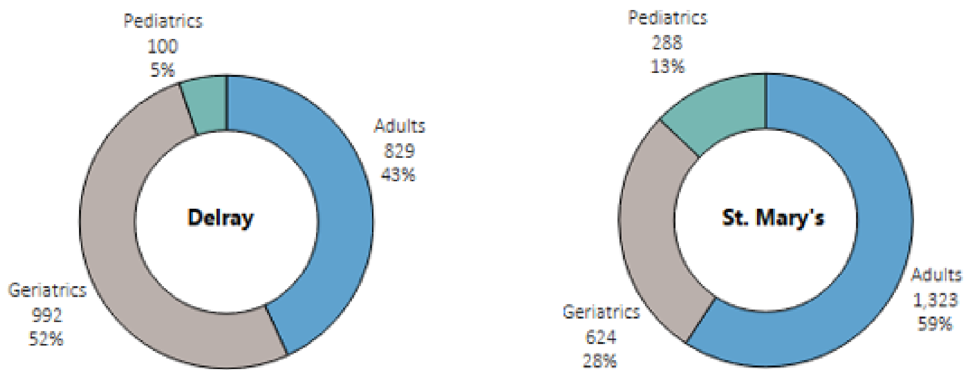
Palm Beach County Demographic Statistics (U.S. Census Bureau)		
Year	**2014**	**2019**
Total Population (N)	1,398,656	1,496,770
Sex (%)		
Male	48.4	48.5
Female	51.6	51.5
Age (Years, %)		
Under 18	19.5	19.0
18-44	31.4	30.9
45-64	26.4	25.8
65 and Over	22.7	24.3
Race/Origin		
White/Not Hispanic or Latino	57.0	53.2
Black/African-American	18.1	19.0

Hispanic/Latino	20.7	23.4
Other	4.3	4.4

Additional demographic data from the U.S. Census Bureau indicate the median household income in the County for 2019 was $66,623, with 11.4% of the total population meeting poverty standards. For residents ages 25 years and over, 89% had achieved at least a high school diploma and 37.7% had completed a Bachelor's degree or more. In regards to population health, approximately 20.1% of the County's residents under age 65 reported a disability, as did 59.5% of residents age 65 and over.

Based on population demographics, the needs of local and neighboring county residents, and potential barriers to access to care due to geographical constraints and resource distribution, area trauma victims are serviced by two state-verified Level I trauma centers, SMMC in West Palm Beach and DMC in Delray Beach. Compared to the northern trauma catchment area, served by SMMC, the population of the southern catchment area tends to be of more advanced age; as such, the trauma patient population at DMC is predominantly adult and geriatric, with fewer pediatric patients than are seen at SMMC.





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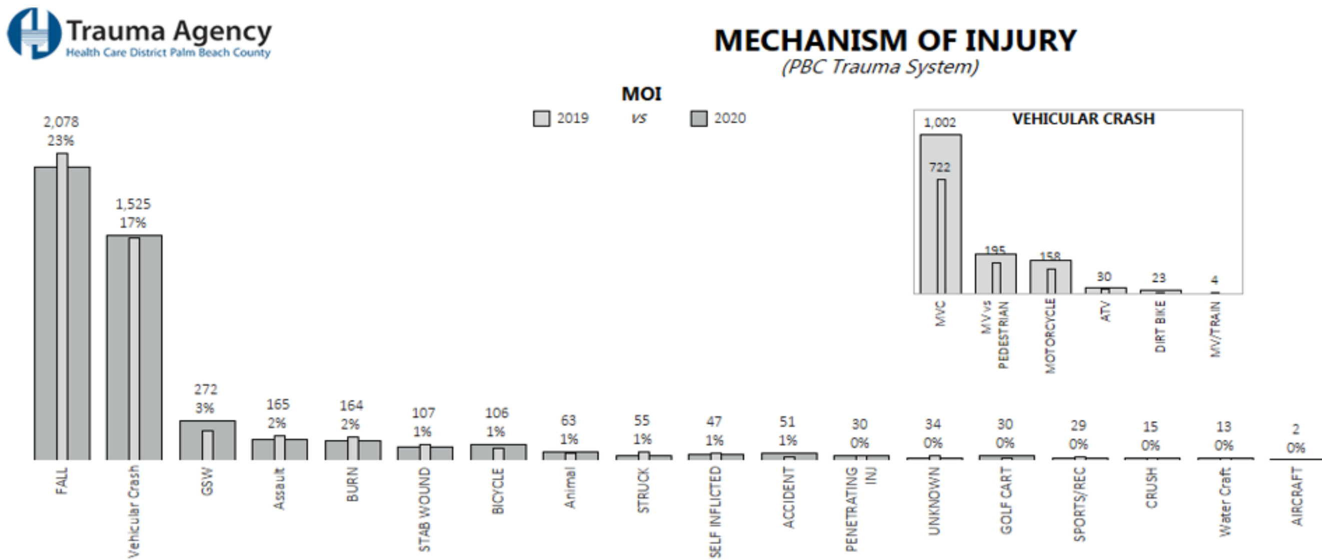
Falling is the most common mechanism of injury for trauma patients treated in Palm Beach County, followed by motor vehicle-related collisions. For purposes of categorization and trending, motor vehicle-associated injuries are further subdivided according to type of vehicle involved. As illustrated in the breakout bar graph below, motor vehicle crashes account for the majority of vehicle-related trauma admissions.



Patient Referral and Transfer Patterns

Surrounding counties contribute to the population of trauma patients treated at SMMC and DMC. North of Palm Beach County, TSA 14 is comprised of Martin, Okeechobee and St. Lucie counties, served by one Level II trauma center in St. Lucie County. To the west, Hendry, Glades, Charlotte and Lee counties are covered under TSA 15, with one Level II trauma center, located in Lee County. To the south, Broward County is a single-county TSA (TSA 18), with two Level I trauma centers and one Level II trauma center. With more available trauma resources to the south of Palm Beach County, the northern Palm Beach County Trauma Center, SMMC, typically receives a greater number of out-of-county trauma patients and interfacility transfers than DMC.

Currently, there is no tertiary care facility with a specialized burn unit within Palm Beach County. Patients with significant chemical or thermal injury are first evaluated by one of the two trauma centers in the County, then transferred to a burn center, if appropriate. Formal and informal transfer agreements for patients with injuries requiring specialized treatment, including significant burns, exist between Palm Beach County hospitals and Jackson Memorial Hospital, Miami; Orlando Regional Medical Center, Orlando; Tampa General Hospital, Tampa; and University of Florida Health Shands Hospital, Gainesville.

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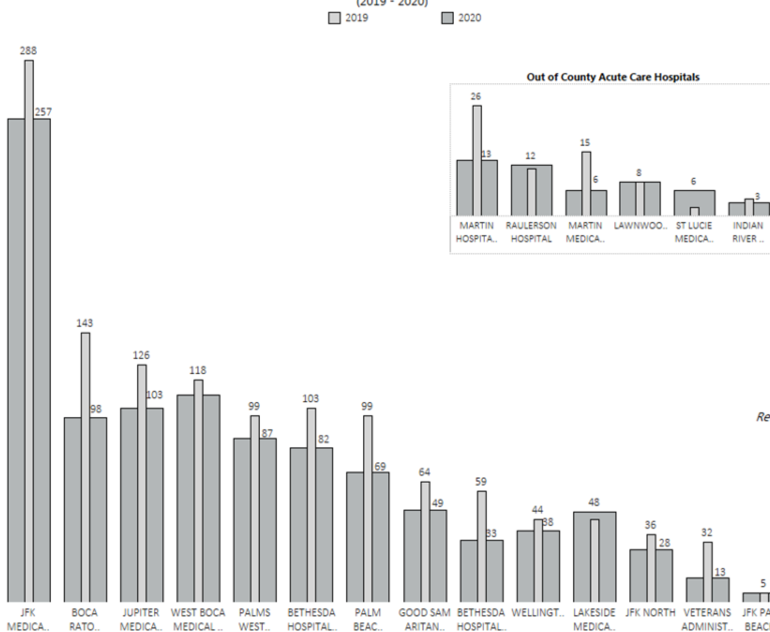
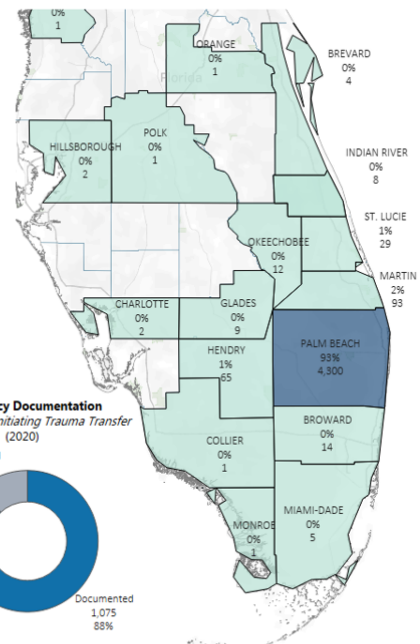
Patients Transported to Palm Beach County Trauma Centers	
Prehospital Trauma Alerts	
St. Mary's Medical Center (N, %)	
• In County	1,505 (88.6%)
• Out of County	194 (11.4%)
Delray Medical Center	
• In County	1,017 (99.8%)
• Out of County	2 (0.2%)
Interfacility Trauma Transfers	
St. Mary's Medical Center	
• In County	600 (84.6%)
• Out of County	109 (15.4%)
Delray Medical Center	
• In County	646 (97.9%)
• Out of County	14 (2.1%)

TRAUMA TRANSFER ANALYSIS





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ORGANIZATIONAL STRUCTURE OF THE PALM BEACH COUNTY TRAUMA AGENCY

Established in 1989, the cornerstone directive of the District is to provide a source of funding for indigent and medically underserved residents of Palm Beach County, maximizing health and well-being of by providing comprehensive planning, funding and coordination of health care service delivery. Continually directing and managing quality assurance initiatives throughout the integrated trauma system, the District provides leadership and administrative support to ensure all operational components of the integrated trauma system function cohesively. Currently, there are six integral staff roles at the District dedicated to the trauma system:

- Trauma Agency Medical Director
    - Belma Andric, MD, Chief Medical Officer, Health Care District of Palm Beach County
    - Provides medical oversight for the District's programs, including the trauma agency
- Executive Director of Corporate Quality
    - Andrea Steele, MBA
    - Responsible for developing and directing quality improvement, assurance initiatives throughout the District, including the trauma agency
- Trauma Director
    - Amelia Stewart, DNP, APRN
    - Responsible for the administrative activities and policies of the District's trauma agency
- Clinical Performance Improvement Coordinator
    - Holly D'Eugenio, RN
    - Assists the Trauma Director in planning and performance improvement operations of the trauma agency
- Trauma Nurse Outreach Coordinator
    - David Summers, RN, CFRN, EMT-P
    - Responsible for coordinating trauma-related community outreach education
- Trauma Registry Analyst
    - Giovanne DiPasquale, BAS
    - Manages the daily operations of the Trauma Registry database; assists in monitoring of compliance for contractual data requirements, accreditation standards, state/federal laws and regulations for the trauma agency

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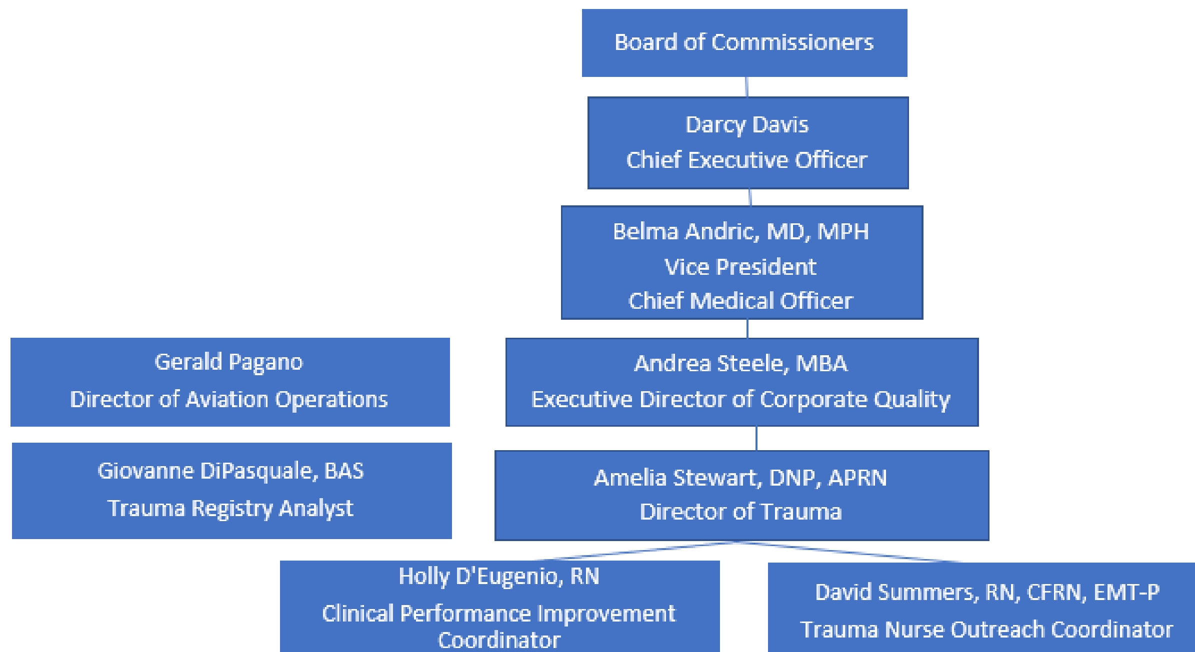

In addition to fulfilling state-mandated requirements, functions and responsibilities of the District's trauma agency include, but are not limited to:

- Developing, implementing, evaluating and revising the local trauma plan;
- Coordinating trauma system activities and functions with the State of Florida's Bureau of Emergency Medical Services;
- Collaborating with the local EMS providers to manage and maintain EMS communications and the 9-1-1 emergency communication system;
- Providing medical oversight of the trauma system including 24-hour per day availability for transfer dispute mediation;
- Maintaining and reviewing emergency transportation service licensure;
- Developing, updating and assuring adherence to trauma transportation policies and protocols in conjunction with local EMS providers;
- Establishing standards, guidelines and criteria for trauma care;
- Facilitating the development of trauma-related ordinances;
- Developing and monitoring protocols for the local integrated trauma system;
- Providing continuous quality assurance and evaluation measures for the local integrated trauma system;
- Assisting in developing and disseminating mass casualty and disaster plans;
- Facilitating coordination of participation in the integrated trauma system by all local hospitals;
- Coordinating prehospital/EMS trauma care for ground and air transport providers and assuring appropriate training/competency maintenance;
- Monitoring aeromedical systems of operation and care;
- Assisting state agencies to: collect and review data throughout the integrated trauma system; review and certify/recertify local trauma centers; and coordinate out-of-state expert reviews of the integrated trauma system;
- Providing staff support to the Local Trauma Advisory Committee and Trauma Quality Improvement

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Committee (TQIC);

- Developing and implementing injury prevention programs and conducting community awareness initiatives;
- Facilitating system funding and ensuring cost-effective care management throughout the trauma care continuum from inpatient admission to discharge, inpatient and outpatient rehabilitative needs, including durable medical equipment and home health care services;
- Developing and updating the budgetary plan for the trauma agency;
- Contractually providing District-sponsored reimbursement to both Level I trauma centers

Recommendations for trauma agency policy and procedure renewal and revision are reviewed for approval by the District Board of Commissioners. Serving voluntarily for a maximum of eight consecutive years, the District Board is comprised of seven members: one representative of the FDOH, three representatives appointed by the Governor of Florida and three representatives appointed by the Palm Beach County Board of Commissioners. Under the Palm Beach County Health Care Act, the District Board is able to levy and assess an ad valorem tax on all eligible property within the District in order to carry out the missions and initiatives set forth by the District.

The Health Care District of Palm Beach County Board of Commissioners

- Leslie B. Daniels, Chair: appointed by Governor Rick Scott
- Nancy C. Banner, P.A., Vice Chair: appointed by Governor Rick Scott
- Sean O’Bannon, Secretary: appointed by the County Commission
- Alina M. Alonso, MD, Director of Florida Department of Health, Palm Beach County
- Tammy Jackson-Moore: appointed by the County Commission
- Cory Neering, City Commissioner, West Palm Beach: appointed by the County Commission
- Edward G. Sabin: appointed by Governor Rick Scott

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TRAUMA SYSTEM STRUCTURE

From the moment of injury through hospitalization, disposition and rehabilitation, the Palm Beach County trauma system has been designed to function cohesively. Essential functions of the trauma system include providing high-quality prehospital care, comprehensive trauma center care, rehabilitation resources, strong leadership throughout the organizational structure and sufficient funding to meet the needs of critically injured patients. To accomplish these, the operational components of the trauma system in Palm Beach County include the District's trauma agency, two Level I trauma centers, local EMS and fire rescue agencies, the aeromedical unit, emergency communications providers, rehabilitation facilities and skilled nursing centers.

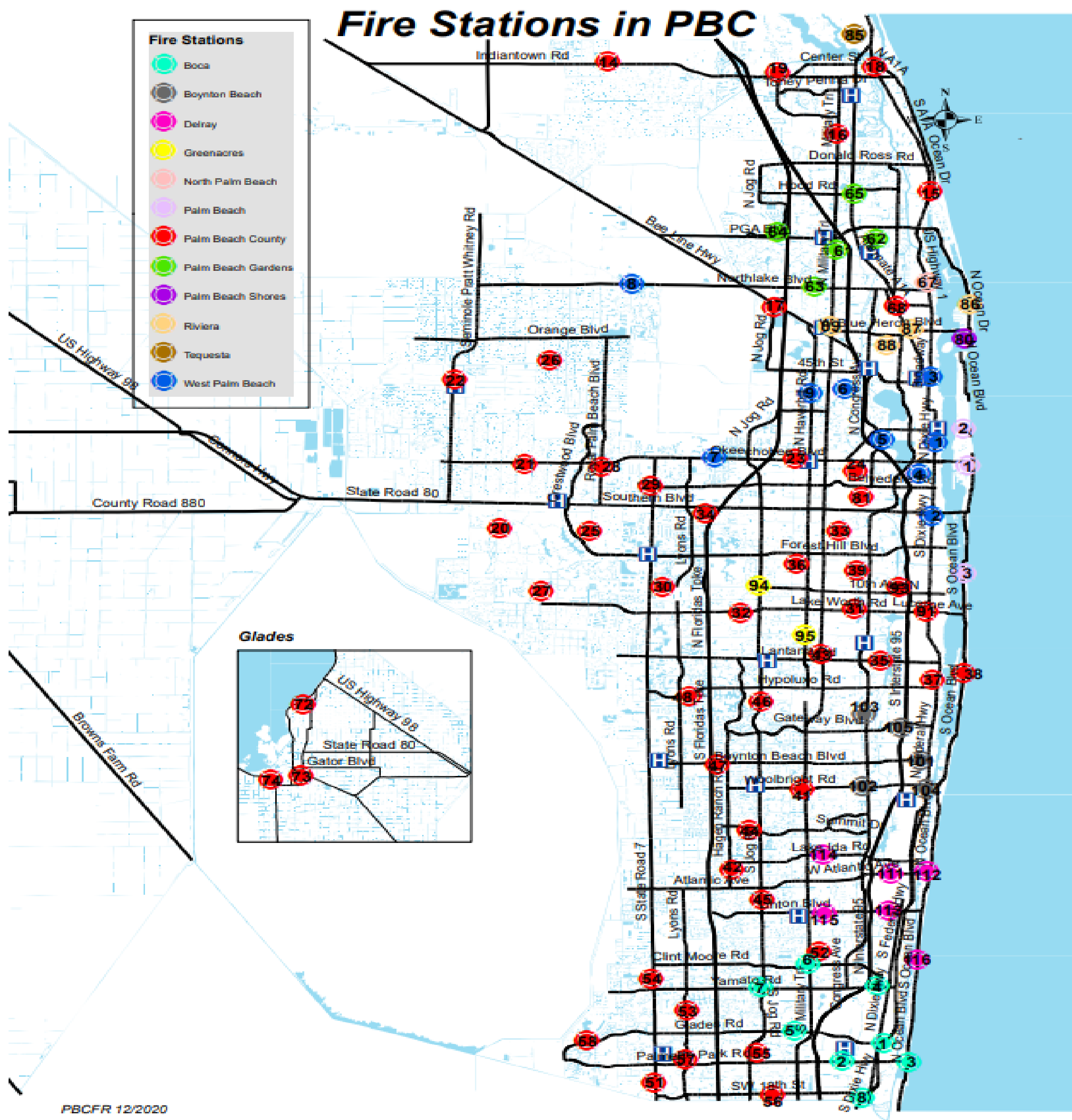
The District maintains contracts with Tenet Healthcare Corporation for the operation of the two state-verified Level I trauma centers, SMMC and DMC, and their affiliated acute rehabilitation centers, St. Mary's Inpatient Rehabilitation Unit and Pine Crest Rehabilitation Center, respectively. The District also maintains contracts with surgeons and physicians providing trauma patient care at these facilities.

Emergency Medical Services

In Palm Beach County, there are 11 EMS agencies and one ALS transport provider active in the treatment and transport of trauma patients throughout the county, in addition to the aeromedical unit, Trauma Hawk. All of these agencies are under medical directorship and are obligated to abide by the Trauma Agency's Uniform Trauma Transport Protocol. The trauma agency of the District cooperates with the Palm Beach County Public Safety Department's EMS Section of Emergency Management Operations to review and license emergency transportation services operating within Palm Beach County.

For trauma life support calls, emergency vehicles are dispatched by response zones, established by each EMS agency. The most readily-available emergency vehicle is dispatched to the scene, with additional units dispatched when multiple emergency calls are received within the same response zone, or when the EMS patient caseload exceeds the response capability of the units dispatched. Countywide, inter-local mutual aid agreements are held by all EMS agencies, allowing units from other agencies to respond to emergency calls outside of their primary response zones in incidents of disaster or inadequate emergency service resources in an adjacent response zone.

Modes of Trauma Transport – Palm Beach County					
Year	**Ground** (N, %)	**Air** (N, %)	**POV*** (N, %)	**Total** (N)	**OOC****
2016	3,424 (84%)	415 (10%)	256 (6%)	4,095	229 (6%)
2017	3,526 (83%)	460 (11%)	246 (6%)	4,232	257 (6%)
2018	3,533 (84%)	444 (11%)	218 (5%)	4,195	262 (6%)
2019	3,920 (84%)	437 (9%)	307 (7%)	4,664	297 (6%)
2020	3,906 (85%)	415 (9%)	284 (6%)	4,605	228 (5%)
*Privately-owned vehicle **Out of County, Transfer In					



- EMS Agencies (Station addresses, Appendix 1):
    - Boca Raton Fire Rescue
    - Boynton Beach Fire Rescue
    - Delray Beach Fire Rescue
    - Greenacres Fire Rescue
    - North Palm Beach Fire
    - Palm Beach County Fire Rescue
    - Palm Beach Fire Rescue
    - Palm Beach Gardens Fire Rescue
    - Riviera Beach Fire Rescue
    - Tequesta Fire Rescue
    - West Palm Beach Fire Department
- ALS Transport Agency: American Medical Response

Established in November 1990, the Trauma Hawk Aeromedical Transport Program was developed in response to escalating trauma care needs due to rapid population growth throughout Palm Beach County. Via a

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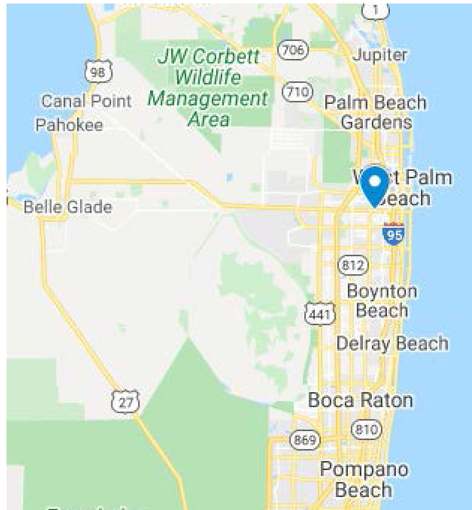
unique partnership between PBCFR and the District, the Trauma Hawk program is comprised of two air ambulances, operated, staffed and maintained by highly trained pilots, mechanics and medical personnel. While the pilots and helicopter mechanics are directly employed by the District, medical crew and ALS transport licensing are contracted for by an interlocal agreement between the District and PBCFR. The District funds and operates the aeromedical program in accordance with the Federal Aviation Regulations Part 135 and is certified as an Air Carrier.

Map: Location of Trauma Hawk



Based at PBIA, each twin engine Sikorsky S76-C+ air ambulance is pilot-operated under the Visual and Instrument Flight Rules. Medical crew members are registered nurses and paramedics educated in flight physiology, certified in ACLS, PTLS and TECC, and trained for the stabilization and transport of neonates. Registered nurse crew members maintain a Trauma Nurse Core Curriculum certification and complete the Transport Nurse Advanced Trauma Course, or an equivalent curriculum.

During calendar year 2020, Trauma Hawk transported 326 trauma patients, 87% from the scene or designated landing zone and 13% as interfacility transfers. Congruent with local commuter travel patterns, 67% of air transports occurred along the heavily-trafficked corridors of I-95, Florida's Turnpike and US Highway 98/Southern Boulevard, with greater concentrations in West Palm Beach, Royal Palm Beach/Wellington and Lake Worth. The remaining aeromedical trauma transports originated west of "20-Mile Bend", the intersection of State Roads 80 and 880. Located roughly 20 miles from West Palm Beach and 20 miles from Lake Okeechobee, trauma transport by air is frequently required due to the duration of ground transport times from the isolated western Palm Beach County communities.

Emergency Medical Services - Training

Palm Beach State College offers associate degrees in EMS and in Fire Science Technology, in addition to certification courses for EMT-basic and paramedic training. Post-secondary vocational certificates are offered for Firefighter and for EMT/Firefighter combination preparations.

Local municipal fire rescue departments are responsible for ensuring personnel maintain appropriate training, competencies and certifications. The Training and Safety Division of PBCFR provides myriad educational opportunities throughout the year at local fire stations and the Chief Herman W. Brice Fire Rescue Complex. In addition, safety alerts and training modules are circulated online, ensuring that PBCFR personnel members remain

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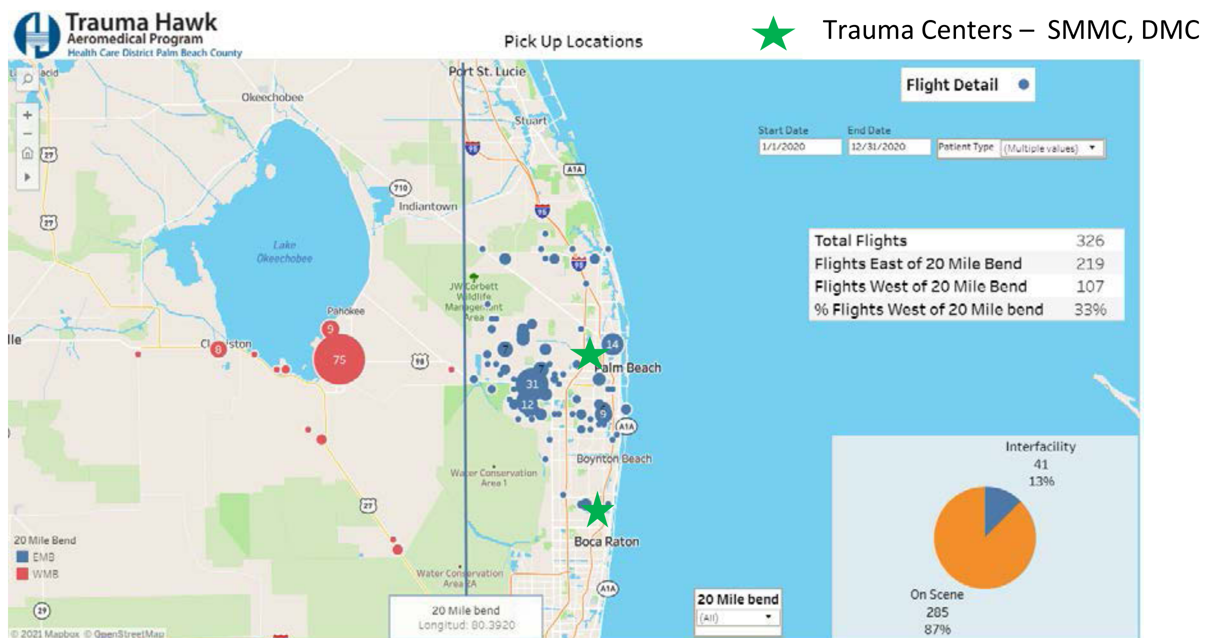
current on vital information and training. Throughout the year, the Training Division offers certifying courses, such as Advanced Cardiac Life Support (ACLS), Prehospital Trauma Life Support (PTLS), and Tactical Emergency Critical Care (TECC). Programs for critical care management, neonatal assessment and stabilization, and professional development and advancement are also offered.

Hospital

In Palm Beach County, there are two Level I trauma centers with SMMC serving the northern catchment area and DMC serving the County's southern catchment area. The trauma center catchment areas and their geographical boundary lines are approved by the District and may be redefined to reflect changes in population distribution.

Map: Trauma Centers, Palm Beach County; SMMC, DMC



- Palm Beach County Non-Trauma Hospitals by Trauma Center Catchment Area:
    - St. Mary's Medical Center Catchment Area -
        - Good Samaritan Medical Center
        - Jupiter Medical Center
        - Lakeside Medical Center
        - Palm Beach Gardens Medical Center
        - Palms West Hospital
        - West Palm Beach Veterans Affairs Medical Center
        - JFK Medical Center – North Campus
    - Delray Medical Center Catchment Area -
        - Bethesda Hospital East
        - Bethesda Hospital West
        - Boca Raton Regional Hospital
        - JFK Medical Center

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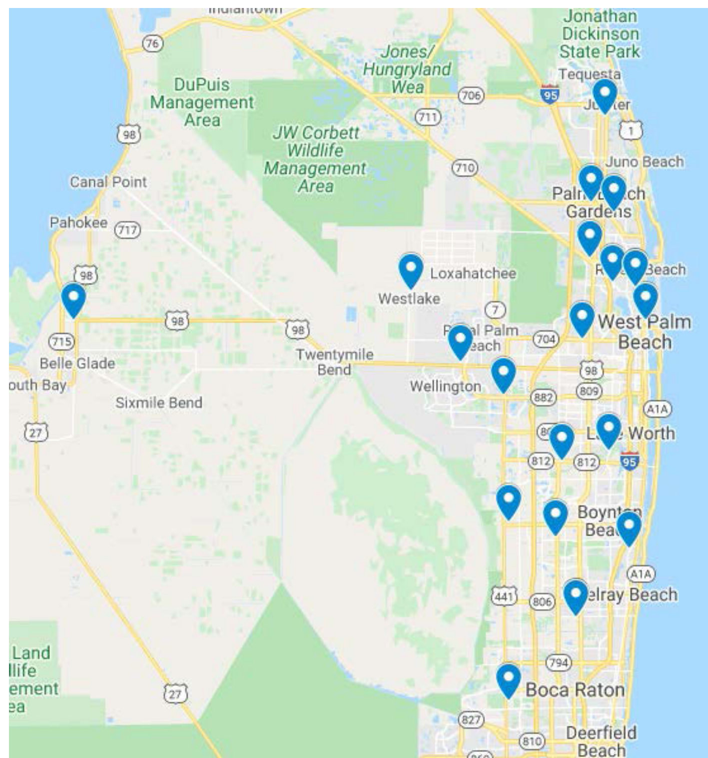
- Wellington Regional Medical Center
- West Boca Medical Center

- Freestanding Emergency Rooms (Parent Hospital/Trauma Center Catchment Area):
  - Emergency Center at Lake Worth (DMC/DMC)
  - Emergency Center West Palm Beach (Good Samaritan Medical Center/SMMC)
  - ER at Westlake (Wellington Regional Medical Center/DMC)
  - JFK Emergency Room Boynton Beach (JFK Medical Center/DMC)
  - JFK Emergency Room Palm Beach Gardens (JFK Medical Center/SMMC)

Map: Hospitals and Free-Standing Emergency Departments, Palm Beach County



Coordination and Integration Between Trauma Centers and Non-Trauma Hospitals

In addition to the two medical centers with Level I trauma centers, the health care needs of Palm Beach County residents and visitors are served by 13 acute care hospitals and five free-standing emergency facilities (Appendix 2). In an inclusive trauma system, all area hospitals are responsible for delivering high-quality emergency care for trauma victims. Although trauma transport and treatment protocols have diminished the rate of under triage of trauma victims to non-trauma hospitals, there are instances in which these facilities must provide initial assessment and treatment for patients meeting trauma criteria, particularly for those arriving to the nearest facility by private vehicle. Interfacility transfer criteria (Appendix 5) have been established and are enforced by protocol-based transfer agreements between the trauma centers and area hospitals, as per Palm Beach County Ordinance No. 91-20.

All interfacility transfers to a trauma center require ALS transport with a minimum crew of one paramedic and one emergency medical technician (EMT), in addition to the vehicle operator. In rare, high-risk cases, a

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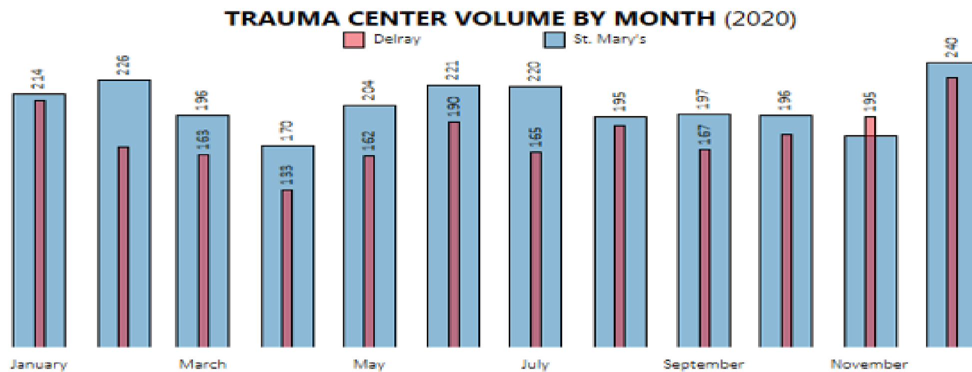
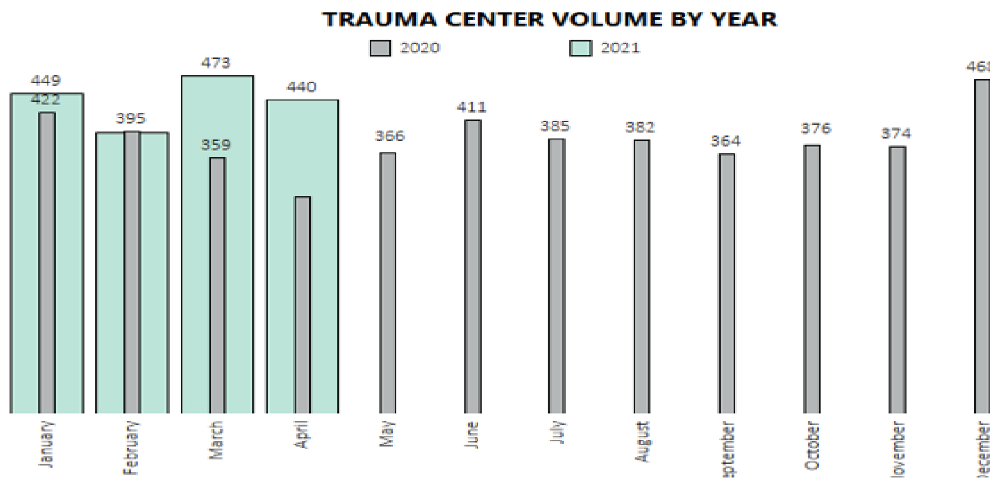
registered nurse may also accompany the patient for interfacility transfer. When an ALS service provider is notified of a trauma transport, the unit is expected to arrive to the transferring facility within 12 minutes. Aeromedical transport is considered on a case-by-case basis and is the decision of the treating provider at the transferring facility.

Rehabilitation

Both SMMC and DMC have affiliated inpatient rehabilitation hospitals capable of meeting the multidisciplinary needs of trauma patients in their rehabilitative phase of recovery. For trauma patients unable to participate in therapy programs prescribed at the acute/inpatient rehabilitation level, referrals can be made to various subacute nursing and restorative care such as the Edward J. Healey Rehabilitation and Nursing Center, funded and operated by the District. Trauma patients whom are determined to be safe for home discharge are referred for home health and outpatient therapy modalities as appropriate.

Per the American College of Surgeons (ACS), a Level I trauma center must annually admit at least 1,200 trauma patients and/or at least 240 patients with an injury severity score (ISS) of 15 or greater. According to Florida State Statute 395.402, a Level I trauma center must be able to treat at least 1,000 patients with an ISS of nine or greater. Based on trauma registry data for 2020, Palm Beach County's two trauma centers evaluated 4,605 trauma patients (2,458 at SMMC and 2,147 at DMC), compared to 4,664 in 2019. In 2019, approximately 50% of trauma patients had an ISS of 9 or greater, while 20% (more than 900 patients) had an ISS of 15 or greater. The volume of patients with significant injury evaluated and treated each year in Palm Beach County justifies maintaining the county's two verified trauma centers.





OBJECTIVES, PROPOSED ACTIONS & IMPLEMENTATION

With the first local trauma plan to obtain approval by the State of Florida, the Palm Beach County trauma system has been in continuous operation since May 1, 1991. As per the Palm Beach County Trauma Ordinance, the plan for the District's trauma agency has been designed to orchestrate the delivery of specialized trauma center services to multiply-injured county residents and visitors. In addition, the plan provides opportunities to develop disaster preparedness strategies, foster trauma-related research and education and bolster multilevel injury prevention programs. To achieve the highest quality trauma care, the trauma system is accountable to its community for ensuring the system design is medically and fiscally sound; appropriate care occurs and continues throughout the trauma continuum from injury to recovery; and the personnel providing trauma care are competent, skilled, licensed and credentialed.

Objective I: Continue to evaluate and revise extant quality assessment metrics and procedures

- Rationale
  - As the primary purpose of the District's trauma agency, the assessment of trauma care services provided in Palm Beach County require:
    - Continuous data evaluation
    - Identification, investigation and correction of system aberrancies
    - Incorporation of findings into practical, evidence-based policies and procedures
- Action Plan (implementation ongoing)
  - Continuously monitor evaluation standards established by the TQIC; apply nationally-accepted benchmarks and evidence-based performance indicators for data collected throughout the trauma system
  - Data indicators will be evaluated and revised as necessary to ensure outcome measurement veracity, as well as compliance with national, state and local standards
  - Trauma centers will report quality assessment data to the appropriate entity each month as contractually specified, including:
    - Morbidity and mortality audit filter reviews
    - The Medical Director's summary of quality improvement evaluations
    - Trauma center calendars and physician call rosters
  - Trauma center accountability for participation in quality assessment will be reinforced via compensatory incentives issued by the District

Objective II: Continue standardized data collection and reporting procedures throughout the trauma system and along the care continuum

- Rationale
  - Accumulating data from multiple sources and settings assists in creating a robust body of evidence from which to extract more reliable statistical indicators that drive practice changes to promote improved patient outcomes
  - Lack of standardization of data collection contributes to incomplete variable entry, leading to inaccurate statistical inferences with potential to negatively impact patient care
- Action Plan (implementation ongoing)
  - Continue to verify the accuracy of collected data throughout the system utilizing computer software, substantiating manually as indicated
  - Review and refine data points and definitions continuously to improve consistency and ensure

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statistical and inferential veracity

- Trauma centers will report data to the appropriate entity in a timely fashion as contractually specified, including:
  - Initial trauma patient information (within 24 hours)
  - Trauma registry data
    - Initial demographics and screens (within two business days)
    - Chart closeout (30 days after discharge)
  - Transfer logs (monthly): into/out of/within the county; any instances of hospital bypass
  - Trauma center workload statistics (monthly)
- Trauma center accountability for participation in data collection will be reinforced via compensatory incentives issued by the District

Objective III: Promote and facilitate disaster event readiness and preparation throughout the integrated trauma system of Palm Beach County

- Rationale
  - By definition, disasters are events that disrupt the community infrastructure to the extent that routine methods of resource allocation and management are insufficient; disaster events are often predictable, and their occurrence is probable
  - While disaster response plans are developed by individual trauma system components and community resource providers at the local level, coordination of these is required in order to mitigate the extent of loss of life, health and property in an event that resource availability is exceeded
  - Minimization of community morbidity and mortality in a disaster event requires a coordinated, cooperative response among community resource providers that do not normally work together
  - The ACS Disaster Subcommittee of the Committee on Trauma has developed the Disaster Management and Emergency Preparedness (DMEP) Course to ensure health care and administrative professionals providing leadership to trauma centers and systems are trained and prepared to effectively respond to disaster events
- Action Plan (ongoing; implementation previously suspended secondary to pandemic)
  - The District will regularly, on a rotating basis, sponsor and facilitate the presentation of the DMEP Course for community partners
  - Presentations and instruction will be provided by local certified experts with trauma and incident command system training, as well as experience in disaster planning and response at the local level
  - Target audience members for the DMEP course includes individuals in leadership positions throughout the trauma system including prehospital, acute care facility and administrative entities
  - The DMEP Course will be offered with course scheduling adjusted to community needs

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TRAUMA AGENCY INCOME, EXPENSES & FISCAL IMPACT

In this unique trauma system model, the primary responsibility of the District is to administer to, evaluate the quality of, and monitor compliance with policies and procedures applicable to the various trauma system components. The District also ensures the financial stability of the whole system by funding inpatient and outpatient costs of trauma care provided to uninsured, eligible Palm Beach County residents.

Owned by Tenet Healthcare Corporation, the two trauma centers in Palm Beach County contract with the District for trauma patient care services, as well as for compensation for inpatient, outpatient and ancillary trauma services provided to eligible uninsured patients. Additional contractual provisions address subspecialist physician and surgeon staffing, Medicaid qualifications and subrogation.

Funding for the trauma system is generated from ad valorem taxes collected from Palm Beach County taxpayers. Additional revenue is generated via transport billing from the aeromedical program and monies collected through subrogation. With many injuries occurring due to third party negligence, personal injury lawsuits are often filed on behalf of trauma victims. In the event that the injured party receives a settlement, private hospitals unable to file liens by law often face difficulties collecting on trauma services rendered. To mitigate financial losses to the trauma system, the District pays the trauma centers directly and, in cases of personal injury settlement, the District is able to file a lien in order to recoup moneys owed for the recipient's trauma care.

Health Care District of Palm Beach County: Trauma Agency Financial Data, Fiscal Year 2020	
Trauma Center Contracts:	
• St. Mary's Medical Center	$8,410,138
• Delray Medical Center	$7,314,170
Aeromedical	$8,566,457
Physician Fee for Service	$2,393,605
Total Trauma System Expenditures	**$26,684,370**
Patient Air Transport Revenue	$2,296,478
Trauma Subrogation Revenue	$879,217
Ad Valorem Taxes	$23,508,675
Total Trauma System Income/Revenue	**$26,684,370**

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TRANSPORTATION SYSTEM DESIGN

In Palm Beach County, there are 11 EMS agencies and one ALS transport provider active in the treatment and transport of trauma patients throughout Palm Beach County, in addition to the aeromedical unit. All of these agencies are under medical directorship and are obligated to abide by the Uniform Trauma Transport Protocols.

Ground Transportation

For trauma calls, ALS emergency vehicles and personnel are dispatched to response zones, established by each EMS agency according to response time and availability. When multiple emergency activations are received within the same response zone, or when the number of patients exceeds the capability of the dispatched units, additional support is requested by the incident commander or paramedic on scene. To permit mutual aid from other agencies and/or the local ALS transport service, interlocal agreements are in place.

Air Transportation

When ground transport to a trauma center is estimated to be greater than 25 minutes, or when ground response to the scene is greater than 10 minutes, air ambulance transport is indicated. Extrication duration exceeding 15 minutes also prompts helicopter dispatch. Contraindications to air transport include patients who are unable to tolerate supine positioning, whose estimated weight exceeds 227 kg, who cannot be restrained physically or chemically and/or who are contaminated with hazardous materials. Ultimately, the flight crew has the final authority to accept or reject the transport.

When helicopter ambulance support is requested or reserved in standby, the PBCFR Communications Center dispatches a dedicated ground unit to secure the landing zone and maintain scene safety. Upon receipt of an aeromedical patient transport request, the goals for dispatch and arrival to the scene or landing zone are five minutes and 15 minutes, respectively. Calculated from average times throughout each calendar month, these times are subject to variables such as weather. Final authority for safe aircraft operation belongs to the pilot in command. In cases of inclement weather conditions or other emergency conditions requiring a change of destination, the pilot in command is authorized to divert to the most appropriate and accessible facility. All diversion cases are documented and reviewed thoroughly.

Water Transportation

EMS transportation by water is provided by the U.S. Coast Guard, locally stationed at the Lake Worth Inlet in Riviera Beach. Units from the U.S. Coast Guard provide first responder interventions while transporting injured patients to land. From there, care of the injured patient is assumed by the appropriate ALS unit until the nearest trauma center is reached.

Trauma Patient Flow Patterns

To determine if a trauma victim meets Trauma Alert criteria for immediate transport to the nearest trauma center, each patient is assessed utilizing a trauma scorecard methodology with either adult (Appendix 3) or pediatric (Appendix 4) victim criteria. If a trauma victim meets any of the red criteria, or any two of the blue criteria, a Trauma Alert is issued. Minimizing on-scene time as best possible, ALS measures are initiated on-scene and are continued in route to the nearest trauma center.

When Trauma Alert activation criteria are not met but the evaluating paramedic has a high index of suspicion for severe injury, a Trauma Alert is issued at the discretion of the EMS provider on scene, documenting the indication(s) per protocol. Alternatively, the patient may be transported to the ED of the closest trauma center without activating the Trauma Alert system. Once the patient has been evaluated by the ED provider at the trauma center, the trauma team is available on-site for trauma consultation or to respond to Trauma Alert activation by

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the ED provider. Deviations from the Uniform Trauma Transport Protocol must be documented by the EMS provider and/or the receiving facility and are subsequently reviewed by the District's trauma agency.

Trauma Bypass

If the in-house trauma surgeon determines the trauma center is unable to safely accept a trauma patient, he or she initiates the bypass protocols defined in the Palm Beach County Trauma Ordinance. In the event the trauma center is placed in bypass status, hospital administration, other trauma centers, hospitals in the trauma center catchment area and the District medical director are notified. If an EMS provider issues a Trauma Alert with intent to transport to the affected trauma center, the EMS provider is notified that the facility is on bypass, directly or via MEDCOM.

Interfacility Trauma Transfer

For patients evaluated at non-trauma center EDs who are determined to have injuries and treatment requirements exceeding the capabilities of the facility, the managing health care provider is able to consult with the on-call trauma surgeon at the trauma center serving the designated catchment area. Criteria for interfacility trauma transfer requiring mandatory consultation with the trauma surgeon are noted below. All transfers must be executed in accordance with the federal Emergency Medical Treatment and Labor Act and Florida Statute 395.1041.

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Interfacility Trauma Transfer Criteria, Palm Beach County	
Head Injuries: GCS 13 or less with absence of impairment, or change of 2 or more points from time of injury Open and/or depressed skull fracture Basilar skull fracture Brain or meningeal hemorrhage New or evolving neurological deficit Lateralized extremity weakness Facial fractures (LeFort II, III) with airway compromise Penetrating injury to head or neck	**Abdominal Injuries:** Physical evidence of blunt abdominal trauma with internal injuries Evidence of peritoneal hemorrhage via ultrasound, diagnostic peritoneal lavage or CT imaging Penetrating wound to abdomen with suspicion of penetration of the peritoneum or hemodynamic instability Ruptured hollow viscous Pregnant patients with abdominal trauma
Thoracic Injuries: Pneumothorax with respiratory compromise* Hemothorax with respiratory compromise Flail chest with respiratory compromise Multiple rib fractures with respiratory compromise Pulmonary contusion with respiratory compromise Penetrating injury to chest Cardiac tamponade Aortic disruption Diaphragmatic rupture Tracheobronchial tree injury Esophageal trauma	**Burn Injuries***** Second degree thermal or chemical burns involving greater than 10% total body surface area (TBSA) Second and/or third degree thermal or chemical burns involving any of the following: face, eyes, ears, hands, feet, genitalia, perineum, major joints (any age) Third degree burns 5% or greater TBSA (any age) Electrical burns, including lightning injury Burns associated with other significant major injury or pre-existing medical disorders in which burn injury poses increased risk of morbidity/mortality Inhalation injury with or without external burn injury
Extremity Injuries: Amputation or open fracture of extremity at or proximal to wrist or ankle Unstable or complex pelvic fractures with hemodynamic instability Vascular injuries documented by arteriogram or loss of distal pulses Gunshot wounds with vascular or neurologic damage Long bone fractures in patient on anticoagulants with high risk of bleeding**	**Spine/Spinal Cord Injuries:** Unstable, potentially unstable fractures Subluxations Neurogenic shock Open spinal wounds Paralysis or injuries with loss of sensory and/or motor function
*Respiratory compromise: requiring supplemental airway support, ventilation management, ventilator support **Refer to Trauma Agency High Risk Anticoagulant/Antiplatelet Drug List, Appendix 5 ***All burn injuries must be evaluated at a Palm Beach County trauma center, prior to transfer to a burn center	

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PALM BEACH COUNTY UNIFORM TRAUMA TRANSPORT PROTOCOL

The Uniform Trauma Transport Protocol for Palm Beach County has been reviewed and approved by all prehospital provider agencies. The Palm Beach County Trauma Ordinance (No. 91-20) is included as Appendix 6.

Dispatch Center Guidelines

Upon receipt of an emergency call through 9-1-1, the dispatch center makes every attempt to record the time at which the call was received; the transmission method of the call; the type of emergency service request; the location and nature of the incident; the number of patients; the perceived extent/severity of the injury; the name of the caller; and the best call back number.

After receiving an emergency call via the enhanced 9-1-1 communication system, either the PBCFR Communications Center or the individual municipal jurisdictional dispatch coordinates communication with both trauma centers and requests aeromedical transport if indicated. All agencies utilize the PBCFR Communications Center to coordinate ground and air ambulance transport to Palm Beach County's two trauma centers and may utilize computer-aided dispatch.

Dispatching of Emergency Vehicles

For trauma life support calls, emergency vehicles staffed with ALS-licensed EMS providers are dispatched by response zones established by each EMS agency. The most readily-available emergency vehicle is dispatched to the scene. When multiple emergency calls are received within the same response zone, or when the patient caseload exceeds the response capability of the EMS units responding to the scene, additional units may be dispatched utilizing two-way 800 MHz radio communication systems. While delivering care to the patient, the paramedic or incident commander on scene is responsible for requesting assistance from additional emergency units, agencies and/or the aeromedical unit.

Trauma Alert Procedure

Upon determining a patient meets Trauma Alert criteria by scorecard methodology, and as specified in the Uniform Trauma Transfer Protocol, a prehospital Trauma Alert is issued to the trauma center. The trauma center transport destination is defined by the District's trauma agency, the Palm Beach County Trauma Ordinance and the Florida Administrative Code (FAC) as the nearest appropriate trauma center. In Palm Beach County, this is determined by GPS for ground transport and line-of-sight for air transport.

Trauma Alert Criteria

With trauma scorecard methodology, prehospital EMS providers follow established guidelines and assess for specific criteria when determining whether an injury victim meets Trauma Alert criteria for transport directly to a trauma center.

Adult Trauma Scorecard Methodology

1. Each EMS provider shall ensure that upon arrival at the location of an incident, the EMT or paramedic shall:

   a. Assess the condition of each adult trauma patient using the adult trauma scorecard methodology to determine whether the patient should be a Trauma Alert.

   b. In assessing the condition of each adult trauma patient, the EMT or paramedic shall evaluate the patient's status for each of the following components: airway, circulation, disability (includes Glasgow Coma Scale [GCS]), soft tissue injury, long bone/skeletal fracture, patient's age and mechanism of injury;

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the patient's age and mechanism of injury shall be used as assessment factors in conjunction with assessment criteria included in (2.), (3.) and (4.) of this section.

2. The EMT or paramedic shall assess all adult trauma patients using the following RED criteria in the order presented; if any ONE of the following conditions is identified, the patient shall be considered a Trauma Alert:

   a. Airway: The patient requires active airway assistance beyond the administration of oxygen, or has a respiratory rate less than 10 or greater than 29 breaths per minute.

   b. Circulation: The patient lacks a radial pulse with a sustained heart rate greater than 120 beats per minute or has a blood pressure less than 90 mmHg.

   c. Disability: The patient exhibits a GCS score of 13 or less, a post-impact seizure, the presence of paralysis, signs suspicious for a spinal cord injury or the loss of sensation.

   d. Soft Tissue: The patient exhibits any of the following (superficial wounds where the depth of the wound can be determined are excluded):

      i. 2nd or 3rd degree burns to 10 percent or more of the total body surface area (TBSA)
      ii. Amputation at or above the wrist or ankle
      iii. Any penetrating injury to the neck, head or torso (excluding superficial wounds of the head and torso where the depth of the wound can be determined)
      iv. Penetrating injury at or above the elbow or knee
      v. GSW to the extremity at or above the wrist or ankle
      vi. Chest wall instability or deformity (suspected flail chest)
      vii. Crushed, degloved, mangled or pulseless extremity

   e. Long Bone/Skeletal Fracture: The patient has signs/symptoms of:

      i. Two or more long bone fracture sites, defined as the
         - Shaft of the humerus
         - Combination of radius and ulna
         - Shaft of the femur
         - Tibia and fibula
      ii. Unstable pelvic fractures secondary to high impact injuries, crush injuries to the torso or significant blunt trauma to the lower abdomen/pelvic area

   f. Mechanism of Injury: Patients exhibiting any of the following:

      i. Severe facial injury/fractures with potential airway compromise
      ii. Electrocution or lightning injury with loss of consciousness or visible signs of injury
      iii. Blunt abdominal trauma or chest trauma in patient with history of paralysis (paraplegia or quadriplegia)
      iv. Patients over 20 weeks gravid with abdominal pain after blunt trauma

3. Should the patient not be identified as a Trauma Alert using the RED criteria listed in (2.) of this section, the trauma patient shall be further assessed using the BLUE criteria and shall be considered a Trauma Alert when any TWO of the six blue criteria included in this section are met:

   a. Circulation: Sustained heart rate 120 beats per minute or greater
   b. Disability: Head injury with loss of consciousness, amnesia or new onset of altered mental status
   c. Soft Tissue: Soft tissue loss from either a major degloving injury involving muscle and/or nerve, a major deep flap avulsion greater than five inches or a penetrating injury to the extremities distal to the elbow or knee

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d. Long Bone Fracture/Skeletal: Obvious or suspected single long bone fracture due to MVC, or any patient with an obvious or suspected single long bone fracture or pelvic fracture on warfarin or anticoagulant/antiplatelet drugs with high risk of bleeding (see Appendix 5)

e. Age: The patient is 55 years of age or greater

f. Mechanism of Injury: Any of the following criteria:

i. The patient has been ejected or thrown from an automobile, motorcycle or golf cart

ii. Motorcycle, golf cart or ATV crash with impact and signs of anatomical injury

iii. The patient has been ejected from a horse (with or without loss of consciousness) with suspected anatomical injury

iv. There is a death in the same passenger compartment of the motor vehicle

v. There is intrusion of more than 12 inches in the roof or occupant side of the motor vehicle, or more than 18 inches of intrusion into any site of the passenger compartment

vi. Vehicle telemetry data is consistent with high risk of injury (vehicle telemetry data, when available, collected at the time of the crash and relayed to dispatch to assist in predicting serious injury)

vii. Fall from 10 feet or more

viii. Pedestrians or bicyclists that are struck, thrown or run over by motorized vehicles traveling at speeds greater than or equal to 20 miles per hour

4. In the event that none of the conditions are identified in the assessment of the adult trauma patient using the criteria above, the EMT or paramedic is permitted to call a Trauma Alert if in his/her judgment, the patient's condition or the nature of the incident warrants such. Where EMT or paramedic judgement is used as the basis for calling a Trauma Alert, it shall be documented as required in accordance with the requirements of Rule 64J-1.014, FAC. The results of the patient assessment shall be recorded and reported in accordance with the requirements of Rule 64-J-1.014, FAC. Any deviation from these protocols shall be documented on the prehospital and/or hospital transfer run report and reviewed by the District.
5. In the event that none of the conditions are identified using the criteria above listed in the assessment of the adult trauma patient, the EMT or paramedic is permitted to transport the patient to the ED at the trauma center if in his/her judgment, the patient's condition or the nature of the incident warrant such. Where EMT or paramedic judgement is used as the basis for transporting to the ED at the trauma center, it shall be documented as required in accordance with the requirements of Rule 64J-1.014, FAC. The results of the patient assessment shall be recorded and reported in accordance with the requirements of Rule 64-J-1.014, FAC.
6. Any deviation from these protocols shall be documented on the prehospital and/or hospital transfer run report and reviewed by the District.

Pediatric Trauma Scorecard Methodology

1. Each EMS provider shall ensure that upon arrival at the location of an incident, the EMT or paramedic shall assess the pediatric trauma patient by evaluating the patient's status for each of the following components: size, airway, circulation, disability, soft tissue injury, long bone fracture/skeletal trauma and mechanism of injury. In assessing the pediatric patient, the criteria for each of the components in (2.), (3.) and (4.) of this section shall be used to determine the transport destination for pediatric trauma patients.
2. The EMT or paramedic shall assess all pediatric trauma patients using the following RED criteria and, if any of the following conditions are identified, the patient shall be considered a pediatric Trauma Alert patient:
    a. Airway: If the patient requires active airway assistance, including manual jaw thrust, continuous

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suctioning, use of other adjuncts to assist ventilation efforts, has a respiratory rate less than 20 breaths per minute in an infant less than one year of age or a respiratory rate below 10 breaths per minute in children ages one-15 years

b. Circulation: The patient has a faint or non-palpable carotid or femoral pulse, or the patient has a systolic blood pressure less than 50 mmHg
c. Disability: The patient exhibits altered mental status (drowsiness, lethargy, the inability to follow commands, unresponsiveness to voice, totally unresponsive), is in a coma, has a post-impact seizure, there is presence of paralysis, loss of sensation or suspicion of spinal cord injury
d. Soft tissue injury: The patient has a major soft tissue disruption or major flap avulsion; 2nd and/or 3rd degree burns to 10% TBSA or more; amputation at or above the wrist or ankle; and/or a major degloving injury
e. If there is any penetrating injury or GSW to the head, neck or torso; any penetrating injury at or above the elbow or knee; or GSW to the extremity at or above the wrist or ankle (superficial wounds where the depth of the wound can be determined are excluded)
f. Long Bone/Skeletal Fracture:
    i. Evidence of open long bone fracture, or multiple fracture/dislocation sites; long bone sites are defined as:
    - Shaft of the humerus
    - Combination of radius and ulna
    - Shaft of the femur
    - Tibia and fibula

    ii. Unstable pelvic fractures secondary to high impact injuries, significant crush injuries or other blunt traumatic injuries
g. Mechanism of Injury: Patients exhibiting any of the following criteria will be Trauma Alerts:
    i. Electrocution or lightning injury with loss of consciousness or visible signs of injury
    ii. Severe facial injury with airway compromise or potential airway compromise
    iii. Blunt abdominal trauma or chest trauma in a patient with history of paralysis (paraplegia or quadriplegia)
    iv. Blunt head, chest, or abdominal trauma in a patient with a bleeding disorder or on anticoagulant/antiplatelet drugs with a high risk of bleeding (see Appendix 5)
    v. Auto versus pedestrian or bicyclist thrown at a distance, run over and/or with impact and signs of anatomical injury
    vi. Ejection from an automobile, ATV, golf cart or horse with visible signs of injury

3. Should the pediatric patient not be identified as a Trauma Alert using the RED criteria listed in (2.) of this section, the trauma patient shall be further assessed using the BLUE criteria listed in this section and shall be considered a Trauma Alert patient when a condition is identified from any TWO of the five components included in this section:
    a. Size: The patient weighs 20 kilograms (44 pounds) or less
    b. Circulation: The carotid or femoral pulse is palpable, but the radial or pedal pulses are not palpable or the systolic blood pressure is less than 90 mmHg
    c. Disability: The patient exhibits symptoms of amnesia or there is loss of consciousness
    d. Soft tissue injury: The patient sustains a penetrating injury to the extremities distal to the elbow or knee
    e. Long bone fracture/Skeletal injury: The patient reveals signs or symptoms of a single, closed long

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bone fracture or dislocation due to MVC, or suspected pelvic fracture or single long bone fracture in a patient with a bleeding disorder; long bone fractures do not include isolated wrist or ankle fractures

f. Mechanism of injury: Pediatric patient exhibiting any of the following criteria:
    i. Ejection, partial or complete, from an automobile
    ii. Death in the same passenger compartment
    iii. Intrusion of more than 12 inches in the roof or occupant side of the motor vehicle, or more than 18 inches intrusion into any site of the passenger compartment
    iv. Vehicle telemetry data consistent with high risk of injury
    v. Fall greater than 10 feet or 2-3 times the length/height of the child

4. In the event that none of the criteria in (2.), (3.) or (4.) of this section are identified in the assessment of the pediatric patient, the EMT or paramedic is permitted to call a Trauma Alert if in his/her judgement, the trauma patient's condition warrants such. Where EMT or paramedic judgment is used as the basis for calling a Trauma Alert, it shall be documented as required in accordance with Rule 64J-1.014, FAC.
5. Any deviation from these protocols shall be documented on the prehospital and/or hospital transfer run report and reviewed by the District.

Trauma Registry Requirements

The paramedic responsible for the treatment and/or transport of a Trauma Alert patient shall complete the Trauma Registry requirements as set forth in accordance with the FAC and the Palm Beach County Uniform Data Format (UDF). The scene run report, along with the trauma scorecard components and times, shall be delivered with the patient to the trauma center, hospital or transport agency.

Trauma Centers and Catchment Areas

- St. Mary's Medical Center Level I Trauma Center and Pediatric Trauma Referral Center
  901 45th Street
  West Palm Beach, Florida 33407
  - Serves the Palm Beach County northern trauma catchment area
- Delray Medical Center Level I Trauma Center and Pediatric Trauma Referral Center
  5352 Linton Boulevard
  Delray Beach, Florida 33484
  - Serves the Palm Beach County southern trauma catchment area

The Palm Beach County trauma center catchment areas and any geographical boundary lines shall be approved by the District and may be redefined to reflect changes in population distribution and trauma center verification, at a minimum. The following criteria will be used by the District's trauma agency to determine trauma center transport designation:

- Geographic access to trauma care within 25 minutes
- Trauma center capacity
- Equitable trauma center patient distribution

Trauma Transport Requirements

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Ground Transport

It shall be the intent of each EMS agency to minimize on-scene time of the Trauma Alert patient, transporting immediately to the nearest trauma center or the designated landing zone after ALS has been initiated and a Trauma Alert issued. The transporting prehospital service provider shall transport the trauma patient with a minimum of one EMT and one paramedic, in addition to the driver. For each Trauma Alert patient, ALS treatment is continued throughout transport, and vital signs are monitored and recorded at least every five minutes.

Aeromedical Transport

Whenever transport of a Trauma Alert patient to a trauma center is more advantageous and/or rapid than by ALS ground unit, air ambulance transport units are utilized. This may include specialized transports as deemed necessary by the incident commander or lead paramedic on scene. In addition to meeting Trauma Alert criteria by scorecard methodology, the following are criteria for helicopter activation:

- Prehospital ground transport to a trauma center is greater than 25 minutes
- Prehospital scene extrication time of a trauma patient is greater than 15 minutes
- Prehospital ground response time to the scene is greater than 10 minutes
- Mass casualty incident has occurred, involving multiple injured patients
- Incident of trauma involving water
- Prehospital ground transport requires augmentation or expediting
- The EMS provider has requested air transport

Aeromedical ground crew training is required for prehospital service providers, law enforcement agencies, trauma centers and hospitals. Each air ambulance is staffed with a registered nurse and a paramedic. Requests for air ambulance transport are made to the PBCFR Communications Center and the air ambulance is dispatched promptly upon receipt of air transport request. Response time goal, calculated as an average over the calendar month, shall be:

- Dispatch within five minutes from flight crew receipt of air ambulance request
- Scene arrival within 15 minutes upon receipt of the call

Adverse weather conditions may delay lift-off or cancel the helicopter air ambulance response. Visibility, ceiling, call location and destination are evaluated by the chief pilot or the pilot in command, whom is the final authority for safe operation of the aircraft during air ambulance transport. The pilot in command may deviate from the destination protocol and transfer the patient to the most appropriate facility based on weather or other emergency conditions that require a change of destination. Each case of diversion will be coordinated, documented and reviewed.

Interfacility Transfer of Trauma Patients

Any trauma patient who presents to an acute care hospital and meets Trauma Alert criteria, or whose condition satisfies the Interfacility Trauma Transfer criteria, shall be stabilized at the acute care hospital as indicated and directed by communication with the receiving trauma surgeon, then immediately transferred to the nearest appropriate trauma center. The method of transport, by air or ground, is determined by the sending hospital to allow the patient the appropriate interfacility medical care while minimizing transport time.

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With the same priority response of ALS ground or air transportation as prehospital Trauma Alert patients, transport services for interfacility trauma transfers are requested through MEDCOM. Hospitals requesting aeromedical transport must have a suitable helipad.

Ground Transport

Interfacility trauma patient transfers to the trauma center by ground transport are conducted by ALS services. For all trauma transfers, the transporting ALS crew must consist of a minimum of three appropriately-trained medical personnel including, at a minimum, one EMT and one paramedic (with critical care certification, if possible), in addition to the driver. Unstable trauma transfers may require a nurse to accompany the patient. Ground ALS service providers must arrive to the transferring acute care facility within 12 minutes of the call for transport of an interfacility trauma patient transfer.

Aeromedical Transport

Air ambulance medical transport is utilized when the interfacility transport of a trauma patient from a non-trauma hospital to a trauma center, or from a trauma center to another medical facility, is determined by the sending facility to be in the patient’s best interests.

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MEDICAL CONTROL & ACCOUNTABILITY

Within the Palm Beach County integrated trauma system, provision of medical control is the responsibility of each entity. For each component of the trauma system, the medical director is accountable for patient outcomes for his or her clinical entity. Ultimately, the goal of medical control is to ensure high-quality, standardized, evidence-based medical treatment.

The physician providing oversight for the District's trauma agency is responsible for trauma system-wide medical direction; duties include, but are not limited to:

- Collaborating with trauma center, ED and prehospital medical directors
- Attending multidisciplinary conferences
- Evaluating protocols, guidelines and ordinances relating to trauma patient care, including those for interfacility transfer and providing recommendations for revision
- Establishing credentialing standards for health care providers involved in trauma patient care
- Conducting quality assessment evaluations and developing improvement programs for the trauma system, recommending revisions to the trauma plan as indicated; includes ongoing needs assessment and justification for resource utilization
- Participating in data collection programs at the county, state and national levels

At the trauma center level, each program has a dedicated medical director. Responsibilities of the trauma director include, but are not limited to:

- Serving as administrator for the trauma service
- Supervising the multidisciplinary trauma team
- Conducting conferences to discuss trauma morbidity and mortality cases
- Acting as liaison for all surgical and medical provider specialties involved in trauma patient care

Medical control in the prehospital setting is accomplished either on-line, via direct communication with local ED and trauma physicians, or off-line via standing orders and procedures delineated in the trauma triage and transport protocols. For each EMS/ALS service provider licensed to operate in Palm Beach County, supervision by a medical director is required. Medical directors are contracted by each agency and are responsible for the following, as defined in Florida State Statue 401.265 and FAC Chapter 64J-1.004:

- Ensuring constituents obtain appropriate didactic training, maintain skills competencies and participate in continuing education
- Developing, reviewing and revising medically accurate standing orders and protocols for the assessment, triage, treatment and transport of patients
- Advising prehospital care providers, directly or indirectly, when standing order protocols are insufficient to guide treatment
- Maintaining Drug Enforcement Administration registration as a medical director authorized to provide controlled substances to an advance ALS provider agency, certifying the compliance with associated security measures and ensuring adherence to written, detailed standard operating procedures for their handling and administration
- Developing and conducting quality assurance reviews of prehospital patient care by EMTs and paramedics
- Participating in data collection for local and state research and quality improvement initiatives
- Acting as liaison between trauma centers and providers of EMS education and training

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In addition to these duties, the medical director providing oversight for the air transport unit must be aware of specific requirements related to aeromedical practice. For each instance of interfacility transfer, the aeromedical unit medical director is responsible for ensuring the appropriate equipment and personnel are in place to provide the necessary patient care.

A medical director is also assigned for each of the EDs for the 14 hospitals operating in Palm Beach County. The ED medical director for a given facility typically has clinical duties in addition to their administrative role. These providers also often participate in providing medical direction and control for EMS agencies.

All trauma-related fatalities undergo autopsy as per the Palm Beach County Medical Examiner's Office, District 15 of the Florida Medical Examiner system. The medical examiner contributes to data collection for the trauma registry and participates in morbidity and mortality conferences for the TQIC.

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EMERGENCY MEDICAL COMMUNICATIONS

In order to be able to access, mobilize, manage and coordinate emergency medical resources, the emergency medical communications system must accommodate sufficient pathways for communication among all trauma system components, including ambulance, fire rescue, law enforcement, hospitals and EDs and disaster management resources. Integral to the overall system, the EMS Section of Emergency Management Operations (Palm Beach County Public Safety Department) has a communications system that includes all hospitals with EDs and meets all the requirements for compliance with the Florida Emergency Medical Services Communications Plan (FEMSCP), Volume I – March 2004 and Volume II – July 2008.

Emergency Medical Services: Citizen Access

To access the emergency medical system, private citizens utilize Palm Beach County's enhanced 9-1-1 program, either by phone or by text message, which allows the dispatcher to see the telephone number and location from which the call has been made. A division of the Public Safety Department, the County's 9-1-1 Program Services maintains the infrastructure that routes 9-1-1 calls, including provisions for translation services and accommodations for the hearing impaired. County and municipal communications centers have adequate equipment to identify the phone number and location of, and nearest available and appropriate emergency for, calls placed to 9-1-1. Staffed with personnel specially trained to respond to emergency calls, the division has 15 public safety answering points. With calls routed based on location, the system coordinates law enforcement, fire rescue and EMS units for all municipal and county departments. Public education programs are in place to ensure appropriate public usage of the enhanced 9-1-1 communication system.

Emergency Medical Services Communications

Local Medical Coordination

Via local medical coordination channels, EMS personnel are able to initiate Trauma Alerts and communicate directly with trauma centers. Information regarding patient condition and real-time updates are relayed to the trauma centers and hospital EDs via the local medical coordination channels. By way of these channels, the trauma team, including the on-duty trauma surgeon, is able to assist and direct the managing EMS crew.

The PBCFR Communications Center has the capability to immediately communicate with the appropriate emergency medical air, ground and water transportation provider, and monitors the Air Secondary frequency as specified in the FEMSCP, Volume I.

Statewide Medical Coordination

Throughout Florida, all hospital EDs and EMS providers are able to utilize the statewide medical coordination channel, MED-8. This channel also allows EMS providers and ED personnel to continue communications if local channels become inaccessible or if the EMS vehicle travels outside the county.

Vehicle Dispatch and Response

In Palm Beach County, vehicle dispatch and response are coordinated by the PBCFR Communications Center and local municipality dispatch agencies. As the emergency medical communications center for the County, the PBCFR Communications Center coordinates ground and air ambulance transport to the county's two trauma centers utilizing a computer aided dispatch system. Differing from the local medical control channels, dispatch and response channels are utilized by MEDCOM, enabling communication between EMS providers, dispatch entities, trauma centers and EDs via designated channels.

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All EMS providers (county, municipal and hospital-owned agencies) are ALS-capable, with every vehicle equipped with the local medical coordination channels necessary to communicate with all EDs and trauma centers throughout the county. By utilizing two-way radios on the 800 MHz band, every EMS provider in Palm Beach County is capable of providing primary first response and medical resource coordination communications to the trauma centers and hospital EDs. If indicated, two private agencies with communications capabilities equivalent to those of the primary responder may be called on by the paramedic on scene for mutual aid, secondary response support and transportation of patients to area EDs and trauma centers.

Medical Resource Coordination

Trauma centers and EDs are equipped with a control base and/or repeater station system dedicated to EMS communications and configured to enable continuous reception of the medical resource channel of Palm Beach County.

Local Scene Coordination

Mass casualty incident (MCI) responses are coordinated by the Emergency Operations Center and MEDCOM, communicating on the 800 MHz band. To facilitate communication, a specific channel is allocated in each MCI.

Medical Alert Paging

MEDCOM utilizes Med-9 as its medical control and medical alert channel. To enable individual and/or group alerting, paging numbers with distinct signals/tones are assigned to personnel.

Communication Coverage

The PBCFR Communications Center resources include radio, pager, cellular phone and landline telephone communications. In case of phone line and cellular reception difficulties, the PBCFR Communications Center has a generator; redundant, uninterruptible power supply (UPS) back-up battery power; and microwave capability. For analysis and planning purposes, automated recording capabilities are in place throughout the emergency medical communications system.

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DATA COLLECTION

Data regarding trauma patient care along the continuum, from the moment of injury to disposition from the acute care setting, is collected to develop a robust body of information by which performance of the trauma system, trauma centers and prehospital providers is objectively evaluated. This data also supports trauma system planning, guides funding, identifies local injury and violence trends to direct community prevention and outreach education and informs trauma center research initiatives. Detailed data analysis is reviewed during TQIC meeting to both trend and review outliers (see "Trauma System Evaluation & Quality Improvement" section).

At the local level, pertinent prehospital and inpatient trauma victim information is captured in the trauma registry maintained at each trauma center and the District via TraumaOne, a trauma registry software platform by Lancet Technology. For each trauma admission, initial demographic data is entered into TraumaOne within three days, with registry information and required metrics updated throughout the admission until discharge. Within 30 days of each final patient disposition, TraumaOne registry information is expected to be completed at the trauma center level. This data then undergoes agency-level evaluation the District via Tableau, an analytical software application utilized for data collection processes and trauma center performance monitoring, as well as to inform research. Analyses are conducted to identify patient care complications and possible deviations from standards of care. As an additional layer of scrutiny, data are manually reviewed for key performance evaluation and quality improvement indicators. For example, all interfacility transfer requests are reviewed by the Trauma Registry Committee, including those from non-trauma hospitals to either trauma center and those from one trauma center to another. Similarly, the Trauma Registry EMS Subcommittee evaluates prehospital and hospital data to identify prehospital clinical care issues for targeted intervention and education, such as under triage and transport delays.

As authorized by Florida Statute 395.404(1), data collected by the trauma centers is submitted to the state via the Next Generation Trauma Registry. Data submitted to the registry are utilized at the state level for research, statewide injury prevention programming, identification of statewide trauma system planning needs and for state-sponsored funding. Administered by the FDOH, the Brain and Spinal Cord Injury Program (BSCIP) was developed to assist eligible Florida residents with traumatic brain and/or spinal cord injuries in accessing resources and services vital to their recovery. This program relies on data maintained in a state-level central registry of trauma victims with moderate to severe brain and spinal cord injuries, informed by data submitted by each verified and provisional trauma center in Florida. The central registry is provided for by Florida Statute 381.74.

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TRAUMA SYSTEM EVALUATION & QUALITY IMPROVEMENT

Trauma Quality Improvement Committee

Integral to the success and advancement of the Palm Beach County Trauma System is the governance and quality oversight provided by the TQIC, designated by Florida Statute 395.401 and sponsored by the District. The TQIC convenes monthly to address trauma-related prehospital, hospital and other pertinent trauma system quality of care issues and concerns.

TQIC is a multi-disciplinary cross-functional committee that meets monthly and is chaired by the District's trauma agency Medical Director. Comprised of 15 members, the multidisciplinary TQIC utilizes information from a variety of sources including the trauma registry, trauma care providers, the medical examiner's office and by referral from other sources to perform a system-wide quality review. The multidisciplinary voting membership on the TQIC is comprised of physician, surgeon, registered nurse and EMS representatives. Non-voting members include the trauma aeromedical director and personnel of the District's trauma agency. Attendance to the confidential meetings, personally or by pre-approved proxy, is strongly encouraged; if a member's meeting attendance falls below 75%, or if a member is absent from three or more meetings in a calendar year, their membership is terminated. Minimum representation in TQIC meetings is sought from the following:

- Trauma Agency Medical Director/Chairperson
- Trauma Medical Director from each trauma center
- Emergency Medicine Physician (not affiliated with a trauma center)
- EMS Medical Director
- Physician/surgeon specialists, pediatrics, neurosurgery
- Trauma Program Director from each trauma center
- Medical examiner
- Aeromedical nurse/paramedic from Trauma Hawk
- Administrators, training officers and medical directors for city and county ALS providers
- Administrators and training officers for BLS providers
- District trauma agency staff

They provide leadership by defining organizational priorities as agreed upon, and continually assessing the need for quality improvement activities. The team ensures that the chosen metrics are being monitored, data is being collected, and those metrics not meeting the required threshold are moved into the quality improvement action phase. Leadership and team-members are tasked with identifying problems, providing corrective actions, as well as presenting and reviewing metrics, outcomes, trends and processes.

The scope of discussion content for the TQIC meetings includes, but is not limited to:

- Trauma system statistical reports
- Prehospital and trauma transport protocol performance indicators
- All trauma-related mortalities
- Updates regarding trauma registry procedures
- Interfacility trauma transfers
- Trauma center research and publications
- Disaster preparedness

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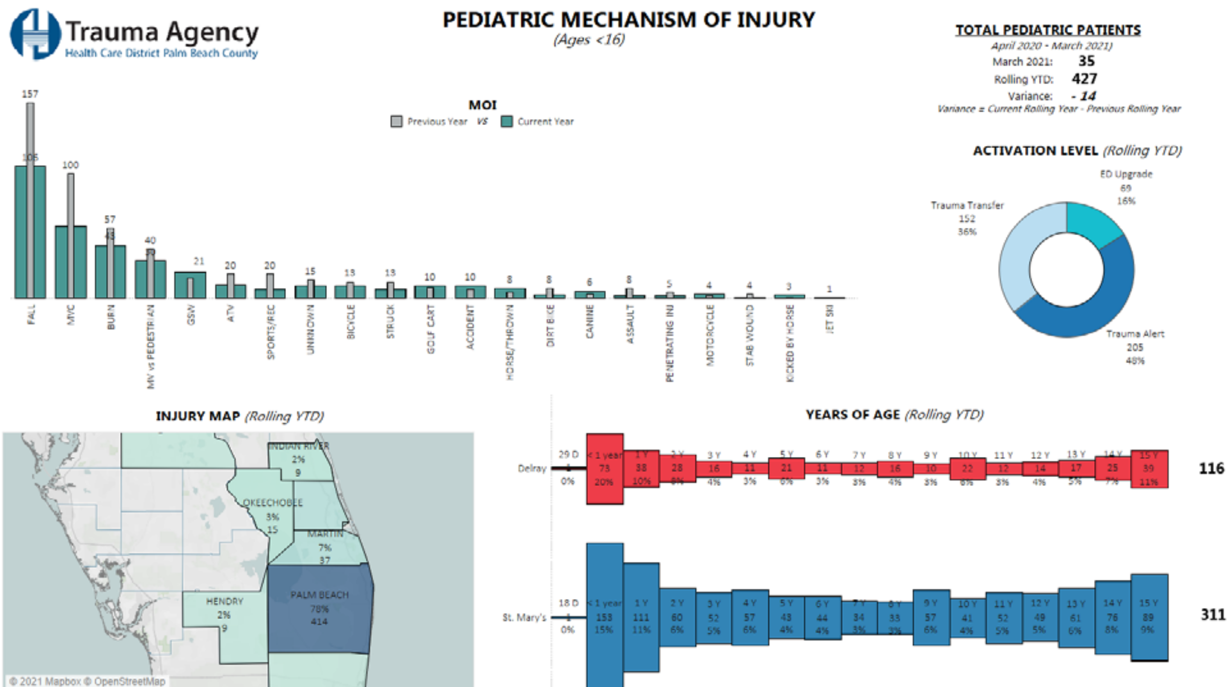
Periodic Performance Evaluation

During TQIC committee meetings, both trauma centers and the District's trauma agency utilize data pulled from Trauma One (trauma database registry) to identify process issues and inconsistencies that arise throughout the system. Identified problems are first reviewed by the trauma centers, with system issues forwarded to the District to be analyzed and reviewed. Indicators of concern include:

- System:
  - Processes of care:
    - Compliance with guidelines, protocols and policies (state, local)
    - Errors in judgement, communication and/or treatment
    - Appropriateness and legibility of documentation
    - Availability of operating room
    - Professional behavior
  - Outcomes of care:
    - Mortality
    - Morbidity/complications
    - Quality of life/functional outcomes
  - Trauma system trends:
    - Community-specific injury patterns and epidemiology
    - Mechanism of Injury, broken down by age group
  - Data collection:
    - Adherence to registry reporting requirements

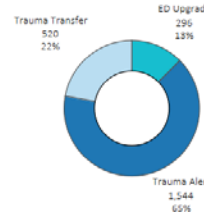
Example: Tableau Dashboards of Mechanism of Injury by age group

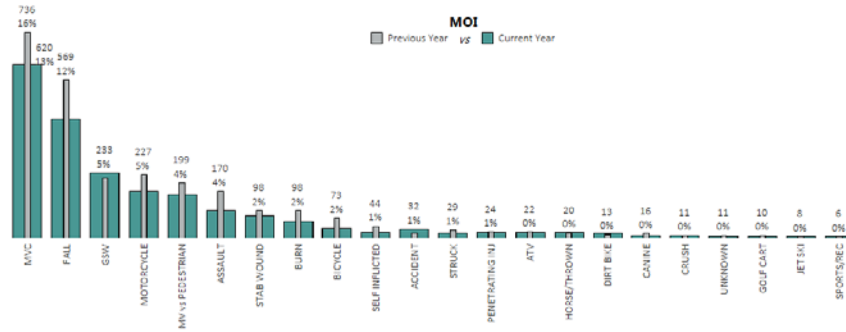


ADULT MECHANISM OF INJURY
(Ages 16 - 65)

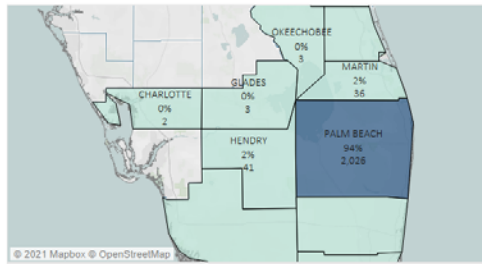
TOTAL ADULT PATIENTS
(April 2020 - March 2021)
March 2021: **228**
Rolling YTD: **2,370**
Variance: ***+121***
Variance = Current Rolling Year - Previous Rolling Year

ACTIVATION LEVEL *(Rolling YTD)*

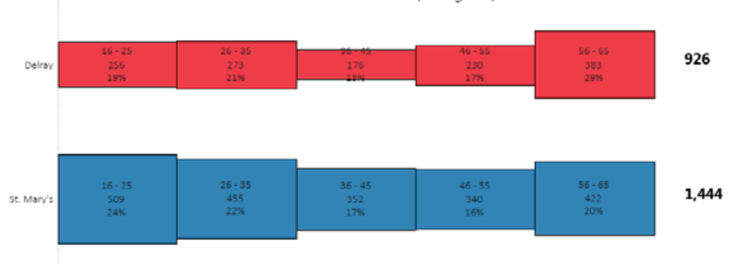




INJURY MAP *(Rolling YTD)*



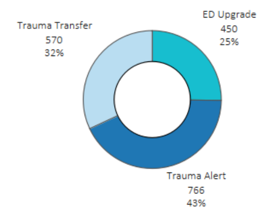
YEARS OF AGE BY DECADE *(Rolling YTD)*

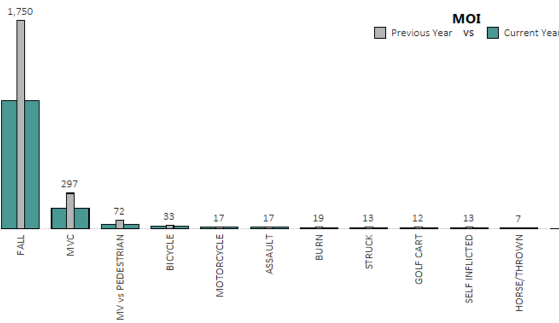


GERIATRIC MECHANISM OF INJURY
(Age >65)

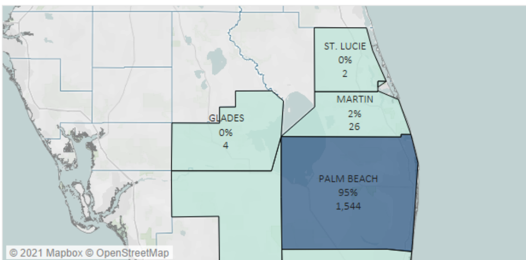
TOTAL GERIATRIC PATIENTS
March 2021: **210**
Rolling YTD: **1,791**
Variance: ***+29***
Variance = Current Rolling Year - Previous Rolling Year

ACTIVATION LEVEL *(Rolling YTD)*

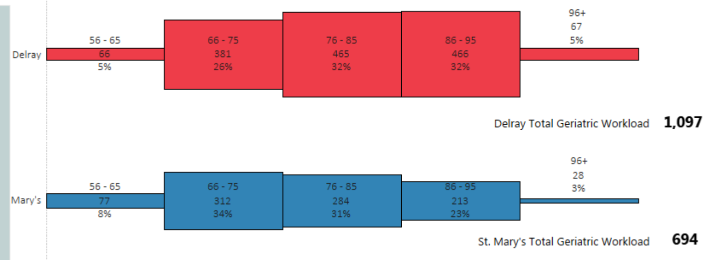




INJURY MAP *(Rolling YTD)*



YEARS OF AGE BY DECADE *(Rolling YTD)*



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- Prehospital:
  - Over/under triage
  - Response to scene time in excess of eight minutes
  - On-scene time greater than 10 minutes
  - Transport time exceeding 20 minutes
- Hospital/Trauma Center:
  - Mortality cases
  - Morbidity cases secondary to treatment, intervention or judgement error
  - Adverse events
  - Failure to follow interfacility transfer guidelines
  - Declined transfers
  - Transfers between trauma centers
  - Trauma patient discharged in less than 24 hours
- Rehabilitation:
  - Transfers to inpatient rehabilitation unit
  - Transfers to a skilled nursing facility

Every two years, the Uniform Trauma Transfer Protocols are reviewed with proposed updates considered and approved by consensus from the following organizations:

- Palm Beach County EMS Medical Directors Association
- Palm Beach County EMS Providers Association
- Palm Beach County Emergency Medicine Forum
- Palm Beach County Emergency Nurses Forum
- TQIC

At the trauma center level, both SMMC and DMC voluntarily participate in the ACS Trauma Quality Improvement Program (TQIP). Data submitted to the trauma registry from each trauma center are in turn submitted to the National Trauma Data Bank, the largest repository of trauma data worldwide. Utilizing this data, TQIP generates biannual reports for each trauma center, comparing performance metrics with other centers of the same level (Level I or II) with risk-adjusted benchmarks. TQIP participation provides an additional, hospital-centric modality for outcomes trending and patient care improvement processes.

Trauma Fatalities

Upon autopsy report availability, each case of trauma-related death is determined to fall under one of two categories: either as a death on-scene or one in which trauma medical care was provided. All 'care provided' cases undergo further review by the agency, as well as by the trauma center at which the death occurred. Trauma deaths at non-trauma facilities are referred to the TQIC for additional review. In such cases, key queries include whether under triage occurred and at what level, if the care received was appropriate and whether trauma triage, treatment and transport protocols were followed.

Quality Control & System Evaluation

The quality control and improvement process for the integrated trauma system depends on system-wide initiatives, as well as trauma center-specific quality and performance improvement processes. EMS agencies conduct their own quality control process with oversight by the respective medical director. Objectives for the ongoing evaluation of the trauma system are to:

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- Provide registry information to the TQIC
- Evaluate the quality of care of every trauma patient, from injury until discharge or death, to measure system effectiveness
- Provide annual quality reports to the District and the State of Florida
- Monitor trauma center compliance with standards as per section 64J-2.011, FAC
- Assess individual trauma surgeon adherence to standards of care and guidelines
- Evaluate interfacility trauma transfers

Although the objectives for system-wide quality analysis vary from those at the component level, trauma registry data is utilized at both levels. System evaluation assesses performance benchmarks for all contributing components, including prehospital, hospital and rehabilitation. Evaluated against state and trauma agency guidelines, system performance assessment evaluates the delivery of medical care based on patient needs, in the context of extant resources, systemwide.

On the other hand, data collected by a particular hospital or prehospital provider evaluates the availability and quality of care provided by that facility or agency. For each trauma center, the State of Florida requires a formal, validated internal quality assurance program incorporating case reviews and special audits to examine trends, identify issues and encourage problem-solving. To evaluate the quality of medical care, health care provider performance is examined for compliance with protocols, guidelines and standards of care for each trauma patient. Evaluations are performed contextually, giving consideration for special and high-risk populations, injury severity, treatments performed, and trauma center patient load.

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MASS CASUALTY & DISASTER PLAN

Palm Beach County is the owner of the Comprehensive Emergency Management Plan (CEMP) and provides the framework for ensuring communities are adequately prepared to respond to, and expeditiously recover from, disasters posing a threat to the lives and property of residents and visitors. Delineating the roles and responsibilities of county agencies, municipalities, constitutional officers, nongovernmental organizations, other taxing districts and contributors from the private sector, the CEMP guides coordination efforts in the event of a disaster.

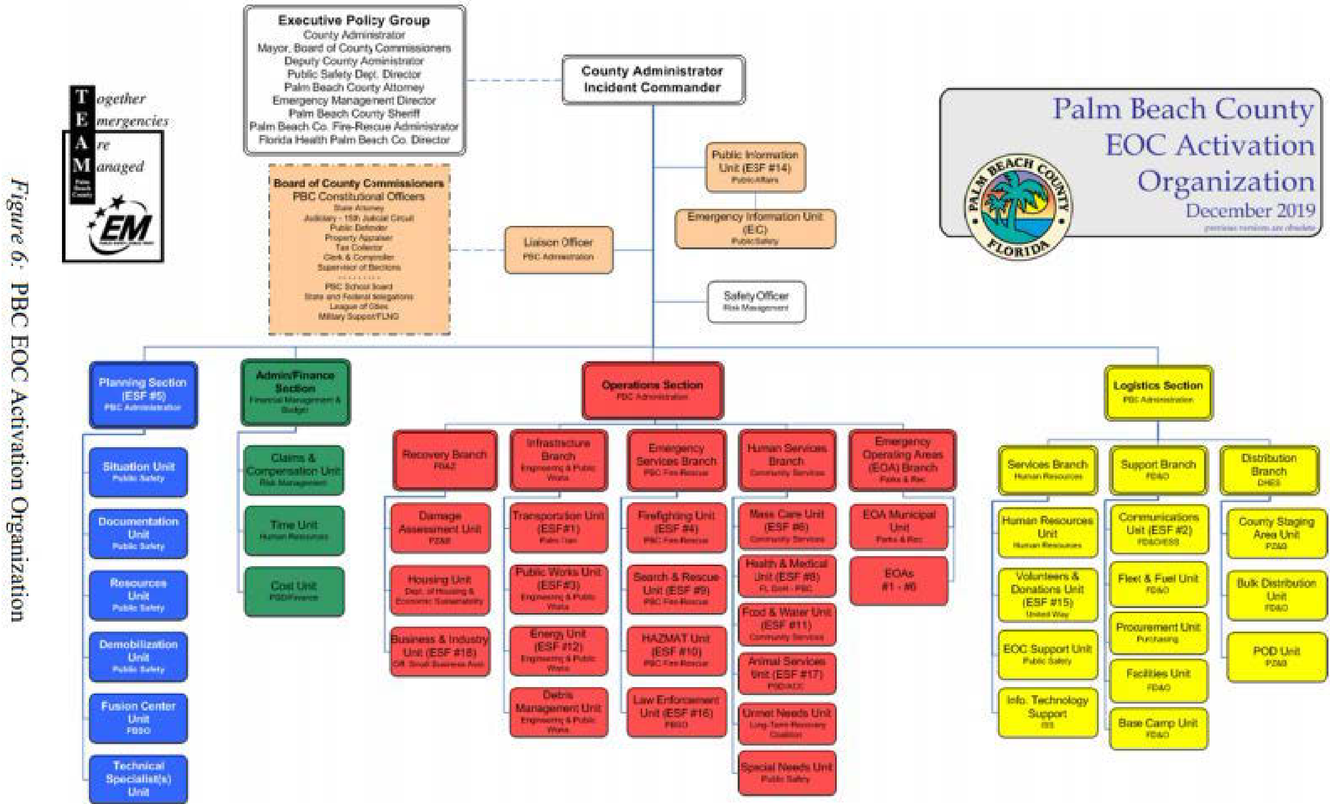

Figure 6: PBC EOC Activation Organization

In the event of a natural or manmade mass casualty event, the trauma system is governed under Emergency Support Function #8 (ESF8), the Health and Medical Unit. Led by the Palm Beach County Health Department, the Health and Medical Unit functions to supply and protect food and water stores, maintain adequate sanitation, provide medical and holistic health services for victims and response workers, prevent and control epidemics and oversee morgue services.

Once the CEMP is activated, the District collaborates with the Health and Medical Unit to coordinate any needs required from the trauma system. Led by PBCFR, the Emergency Services Unit (ES4) governs prehospital functions and works closely with the Health and Medical Unit.

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While the CEMP outlines essential roles and responsibilities for all of the various vital agencies and entities in incidences of actual or potential disaster situations, the Healthcare Emergency Response Coalition (HERC) addresses the practical, medical aspects of disaster management planning. As an initiative of the Palm Beach County Medical Society, HERC was developed to inform and guide the health care community and other county, regional and state agencies in the processes of emergency preparedness for, response to, and recovery from actual and potential disasters affecting Palm Beach County.

Meeting monthly, HERC members represent local hospitals, trauma center emergency department managers, EMS providers, law enforcement agencies, long term care facility representatives and public health officials. In addition to promoting emergency preparedness education, objectives of the coalition are to coordinate emergency response planning and practices for health care providers and facilities; ensure disaster response readiness by conducting community training and exercises; and promote communication regarding emergency management planning between state, regional and local agencies.

Providing multidisciplinary training, exercises and drills compliant with the Homeland Security Exercise and Evaluation Program, HERC also assists health care facilities in conducting hazardous vulnerability analyses, identifying risks and hazards and their potential impact on the community and its health care resources. Linking all local hospitals with interoperable communications systems, HERC has provided Palm Beach County agencies with a means of conducting syndromic surveillance and alerting health care providers of a possible disease outbreak at the earliest stage feasible.

In February 2019, the District sponsored and presented the ACS DMEP Course. In addition to prehospital and acute care providers, including physicians, surgeons and nurses, the target audience for this program includes hospital and public health administrators and emergency management leaders throughout the multidisciplinary health care community. In this one-day course, participants are taught methods of planning and preparation for mass casualty incidents, as well as the medical management of victims. Learning objectives of the DMEP course for health care providers include disaster triage principles, terminology utilized in incident command scenarios, potential injury patterns related to various MCI mechanisms, principles of treatment for injuries and illnesses related to explosives, radiologic dispersal devices and chemical attacks, and how to mobilize and utilize available support assets.

In mass casualty and disaster events, the entire trauma system of prehospital emergency care providers, trauma centers, and non-trauma facilities is impacted. In order to identify potential weaknesses in response to such an event, system wide drills are essential. Spearheaded by HERC, a county-wide mass casualty incident drill event is planned for fall 2021, with expected participation by all EMS agencies and Palm Beach County hospitals. Pending evaluation of the event, the timing for follow up events will be planned accordingly.

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PUBLIC INFORMATION & EDUCATION

Community education regarding injury prevention is a vital component of the Palm Beach County trauma system. Ongoing initiatives are maintained by the District and the trauma centers. With primary objectives of community outreach and injury prevention, the Trauma Nurse Outreach Coordinator is employed full-time by the District. Utilizing statistics derived from the trauma registry database, the Trauma Nurse Outreach Coordinator develops age-appropriate educational programs, targeting risk factors specific to various age groups. In addition, the Trauma Nurse Outreach Coordinator is a certified instructor for TNCC, PHTLS and the ACS courses of the Rural Trauma Team Development Course and DMEP.

Prior to the institution of pandemic precautions, outreach prevention efforts were focused on falls prevention in the elderly and pediatric populations, high-risk driving behaviors amongst teens and adults, pedestrian injuries, motorcycle safety, bicycle and helmet safety and awareness, child passenger seat usage, sports-related concussions in youth, boating-related injuries and first aid and first-on-scene training for nonmedically-trained citizens. National- and state-vetted programs presented to Palm Beach County communities by the District include Stop the Bleed (ACS) and the Active Bystander Program (Florida DOH/FEMA). Grant-funded programs from the FDOT included Motorcycle Crash Injury Patterns for EMS providers and WalkWise Florida for the public. Implementation of some of these programs involved participation by the Trauma Injury Prevention Specialists of SMMC and DMC.

The District continues to actively participate in state, regional and local injury prevention organizations, including the

- Florida Trauma System Advisory Council (FDOH)
- Priority Area Workgroup, Florida Injury and Violence Prevention Advisory Council (FDOH)
- Florida Motorcycle Safety Coalition (Florida Department of Transportation, FDOT)
- Public Information Education Relations Committee (PIER; FDOH, Florida EMS Advisory Council Committee)
- Florida Falls Awareness Coalition
- Florida State Health Improvement Plan Committee (FDOH)
- Florida Teen Safe Driving Coalition (FDOT)
- Florida Occupant Protection Coalition (FDOT)
- Florida EMS for Children (FDOH-EMS)
- SAFEKIDS Palm Beach County
- Water Smart Palm Beach County
- Traffic Safety Committee (Safety Council of the Palm Beaches)
- Palm Beach County Community Traffic Safety Team (FDOT)

The District supports and contracts with the two trauma centers, offering various prevention education and outreach programs. Targeting specific issues identified via local data analysis, these programs strive to prevent injuries utilizing multidisciplinary educational programs designed for the age group concerned and community served. The trauma centers dedicate significant resources to promoting public safety and trauma awareness by participating in safety fairs, first aid stations and community organizations.

APPENDIX 1 – PALM BEACH COUNTY EMS / FIRE RECUE LOCATIONS

Boca Raton Fire Rescue

Station 1
1151 N Federal Hwy
Boca Raton, FL 33432

Station 2
903 W Palmetto Park Rd
Boca Raton, FL 33486

Station 3
100 S Ocean Blvd
Boca Raton, FL 33432

Station 4
351 NW 51st St
Boca Raton, FL 33431

Station 5
2333 W Glades Rd
Boca Raton, FL 33431

Station 6
1901 Clint Moore Rd
Boca Raton, FL 33496

Station 7
3001 W Yamato Rd
Boca Raton, FL 33434

Station 8
190 SW 18th St
Boca Raton, FL 33486

Boynton Beach Fire Rescue

Station 1
200 NE 1st St
Boynton Beach, FL 33435

Station 2
2615 Woolbright Rd
Boynton Beach, FL 33426

Station 3
3501 N Congress Ave
Boynton Beach, FL 33436

Station 4
1919 S Federal Hwy
Boynton Beach, FL 33435

Station 5
2080 High Ridge Rd
Boynton Beach, FL 33426

Delray Beach Fire Rescue

Station 111
501 W Atlantic Ave
Delray Beach, FL 33444

Station 112
35 N Andrews Ave
Delray Beach, FL 33483

Station 113
651 W Linton Blvd
Delray Beach, FL 33444

Station 114
4321 Lake Ida Rd
Delray Beach, FL 33445

Station 115
4000 Old Germantown Rd
Delray Beach, FL 33445

Station 116
3614 S Ocean Blvd
Delray Beach, FL 33487

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Greenacres Fire Rescue

Station 94
2995 S Jog Rd
Greenacres, FL 33467

Station 95
5095 S Haverhill Rd
Greenacres, FL 33463

North Palm Beach Fire Rescue

560 US Hwy 1
North Palm Beach, FL 33408

Palm Beach County Fire Rescue

Station 14
12015 W Indiantown Rd
Jupiter, FL 33478

Station 15
12879 US-1
Juno Beach, FL 33408

Station 16
3550 Military Trail
Jupiter, FL 33458

Station 17
8130 N Jog Rd
West Palm Beach, FL 33412

Station 18
777 US-1
Jupiter, FL 33477

Station 19 (Battalion 1 Headquarters)
322 Central Blvd
Jupiter, FL 33458

Station 20
1000 Greenview Shores Blvd
Wellington, FL 33414

Station 21
14200 Okeechobee Blvd
Loxahatchee Groves, FL 33470

Station 22
5060 Seminole Pratt Whitney Rd
Loxahatchee Groves, FL 33470

Station 23
5471 Okeechobee Blvd
West Palm Beach, FL 33417

Station 38
600 Florida A1A
Manalapan, FL 33462

Station 41
5105 Woolbright Rd
Boynton Beach, FL 33437

Station 42
14276 Hagen Ranch Rd
Delray Beach, FL 33446

Station 43
57th Rd S
Atlantis, FL 33462

Station 44
6670 Flavor Pict Rd
Boynton Beach, FL 33437

Station 45
15450 Jog Rd
Delray Beach, FL 33446

Station 46
7550 Jog Rd
Lake Worth, FL 33467

Station 47
7950 Enterprise Center Blvd
Boynton Beach, FL 33437

Station 48
8560 Hypoluxo Rd
Lake Worth, FL 33467

Station 51
10050 Judge Winikoff Rd
Boca Raton, FL 33428

Station 24
1734 Seminole Blvd
West Palm Beach, FL 33409

Station 25
1060 Wellington Trace
Wellington, FL 33414

Station 26
6085 Avocado Blvd
West Palm Beach, FL 33412

Station 27
3411 S Shore Blvd
Wellington, FL 33414

Station 28
1040 Royal Palm Beach Blvd
Royal Palm Beach, FL 33411

Station 29
10055 Belvedere Rd
Royal Palm Beach, FL 33411

Station 30
9610 Stribling Way
Wellington, FL 33414

Station 31
3400 2nd Ave N
Palm Springs, FL 33461

Station 32
4022 Charleston St
Lake Worth, FL 33467

Station 33
830 Kirk Rd
West Palm Beach, FL 33406

Station 34
231 Benoist Farms Rd S
West Palm Beach, FL 33411

Station 35
2501 Lantana Rd
Lantana, FL 33462

Station 36
5395 Purdy Ln
West Palm Beach, FL 33415

Station 52
4661 Pheasant Way
Boca Raton, FL 33487

Station 53
19950 Lyons Rd
Boca Raton, FL 33434

Station 54
18501 FL-7
Boca Raton, FL 33498

Station 55
6787 Palmetto Cir N
Boca Raton, FL 33433

Station 56
6250 SW 18th St
Boca Raton, FL 33433

Station 57
9030 Vista Del Lago
Boca Raton, FL 33428

Station 58
12245 Glades Rd
Boca Raton, FL 33498

Station 68
1000 Park Ave
West Palm Beach, FL 33403

Station 72
637 S Lake Ave #501
Pahokee, FL 33476

Station 73
525 SW 2nd St
Belle Glade, FL 33430

Station 74
530 US-27
South Bay, FL 33493

Station 81
1000 James L Turnage Blvd
West Palm Beach, FL 33406

Station 91
1020 Lucerne Ave
Lake Worth, FL 33460

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Station 37
626 Greynolds Cir
Lantana, FL 33462

Station 93
1229 N Detroit St
Lake Worth, FL 33461

Palm Beach Fire Rescue

Station 1 (Battalion 97, Ladder 97, Rescue 97)
355 S County Rd
Palm Beach, FL 33480

Station 2 (Engine 98, Rescue 98)
300 N County Rd
Palm Beach, FL 33480

Station 3 (Truck 99, Rescue 99)
2185 S Ocean Blvd
Palm Beach, FL 33480

Palm Beach Gardens Fire Rescue

Station 61
4425 Burns Rd
Palm Beach Gardens, FL 33410

Station 62
11025 Campus Dr
Palm Beach Gardens, FL 33410

Station 63
5161 Northlake Blvd
Palm Beach Gardens, FL 33410

Station 64
11264 Jog Rd
Palm Beach Gardens, FL 33410

Station 65
3913 Hood Rd
Palm Beach Gardens, FL 33410

Riviera Beach Fire Rescue

Station 86
5010 N Ocean Dr
Riviera Beach, FL 33404

Station 87
600 W Blue Heron Blvd
Riviera Beach, FL 33404

Station 88
1920 W Blue Heron Blvd
Riviera Beach, FL 33404

Station 89
7501 N Military Tr
Riviera Beach, FL 33410

Tequesta Fire Rescue

357 Tequesta Dr
Tequesta, FL 33469

West Palm Beach Fire Department

Station 1
500 N Dixie Hwy
West Palm Beach, FL 33401

Station 6
3033 Cumberland Dr
West Palm Beach, FL 33409

Station 2
4301 S Dixie Hwy
West Palm Beach, FL 33407

Station 3
5050 Broadway Ave
West Palm Beach, FL 33407

Station 4
1718 Parker Ave
West Palm Beach, FL 33401

Station 5
700 N Congress Ave
West Palm Beach, FL 33401

Station 7
8007 Okeechobee Blvd
West Palm Beach, FL 33411

Station 8
10965 Northlake Blvd
West Palm Beach, FL 33412

Station 9 (temporary, while station under construction)
4685 N Haverhill Rd
West Palm Beach, FL 33417

APPENDIX 2 – PALM BEACH COUNTY HOSPITAL & FREE-STANDING CLINIC LOCATIONS

Trauma Centers

St. Mary's Medical Center
901 45th St.
West Palm Beach, FL 33407

Delray Medical Center
5352 Linton Blvd.
Delray Beach, FL 33484

Hospitals (Non-Trauma)

Bethesda Hospital East
2815 S Seacrest Blvd
Boynton Beach, FL 33435

Bethesda Hospital West
9655 W Boynton Beach Blvd
Boynton Beach, FL 33472

Boca Raton Regional Hospital
800 Meadows Rd
Boca Raton, FL 33486

Good Samaritan Medical Center
1309 N Flagler Dr
West Palm Beach, FL 33401

JFK Medical Center
5301 S Congress Ave
Atlantis, FL 33462

JFK Medical Center – North Campus
2201 45th St
West Palm Beach, FL 33407

Jupiter Medical center
1210 S Old Dixie Hwy
Jupiter, FL 33458

Lakeside Medical Center
39200 Hooker Hwy
Belle Glade, FL 33430

Palm Beach Gardens Medical Center

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3360 Burns Rd
Palm Beach Gardens, FL 33410

Palms West Hospital
13001 Southern Blvd
Loxahatchee, FL 33470

Wellington Regional Medical Center
10101 Forest Hill Blvd
Wellington, FL 33414

West Boca Medical Center
21644 FL-7
Boca Raton, FL 33428

West Palm Beach Veterans Affairs Medical Center
7305 N Military Trail
West Palm Beach, FL 33410

Freestanding Emergency Rooms

Emergency Center at Lake Worth
6250 Lantana Rd.
Lake Worth, FL 33463

Emergency Center West Palm Beach
5028 Okeechobee Blvd
West Palm Beach, FL 33417

ER at Westlake
16750 Persimmon Blvd
Westlake, FL 33470

JFK Emergency Room Boynton Beach
10921 S Jog Rd
Boynton Beach, FL 33437

JFK Emergency Room Palm Beach Gardens
4797 PGA Blvd
Palm Beach Gardens, FL 33418

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APPENDIX 3 – ADULT TRAUMA ALERT SCORECARD & METHODOLOGY

PALM BEACH COUNTY TRAUMA AGENCY
Adult Trauma Scorecard

The EMT or paramedic shall assess the condition of injured persons with anatomical and physiological characteristics of a person 16 years of age or older for the presence of at least one of the following criteria to determine whether to transport as a Trauma Alert. Once any one of the three criteria below listed is met, it identifies the patient as a Trauma Alert. No further assessment is required to determine the transport destination if the patient:

- Meets color-coded triage system (see below)
- Does not meet the trauma criteria listed, but was transported to a Trauma Center due to EMT or paramedic judgment (reason for transport must be justified in run report)
- Does not meet trauma criteria listed, but was transported to the ED at a Trauma Center due to paramedic judgment (reason for transport must be justified in run report)

	RED	**BLUE**
AIRWAY	ACTIVE AIRWAY ASSISTANCE [1] or RESPIRATORY RATE <10 or >29 BPM	
CIRCULATION	LACK OF RADIAL PULSE WITH A SUSTAINED HEART RATE >120 BPM or BP <90 mmHg	SUSTAINED HEART RATE of ≥120 beats/min
DISABILITY	GCS ≤ 13 or POST-IMPACT SEIZURE or PRESENCE OF PARALYSIS, or SUSPICION OF SPINAL CORD INJURY or LOSS OF SENSATION	HEAD INJURY WITH LOSS OF CONSCIOUSNESS, AMNESIA or NEW ALTERED MENTAL STATUS
SOFT TISSUE	2nd OR 3rd DEGREE BURNS TO 10% or MORE TBSA AMPUTATION AT OR ABOVE THE WRIST or ANKLE ANY PENETRATING INJURY TO NECK, HEAD or TORSO[3] PENETRATING INJURY TO THE EXTREMITY AT or ABOVE ELBOW or KNEE GSW TO THE EXTREMITY AT or ABOVE THE WRIST or ANKLE CHEST WALL INSTABILITY or DEFORMITY (FLAIL CHEST) CRUSHED, MANGLED, DEGLOVED or PULSELESS EXTREMITY	SOFT TISSUE LOSS[2] NON-GSW PENETRATING INJURY TO THE EXTREMITIES DISTAL TO THE ELBOW or DISTAL TO THE KNEE[3]
LONG BONE FRACTURE/ SKELETAL[4]	FRACTURE OF TWO or MORE LONG BONES[4] UNSTABLE PELVIC FRACTURES	SINGLE LONG BONE FX SITE DUE TO MVC[4] SINGLE LONG BONE FX OR PELVIC FRACTURE IN PT WITH BLEEDING DISORDER OR ANTICOAGULATED
AGE		55 YEARS OR OLDER

MECHANISM OF INJURY	SEVERE FACIAL INJURY/FRACTURES WITH POTENTIAL AIRWAY COMPROMISE ELECTROCUTION OR LIGHTNING INJURY WITH LOSS OF CONSCIOUSNESS OR VISIBLE SIGNS OF INJURY BLUNT ABDOMINAL or CHEST TRAUMA IN PATIENT WITH HISTORY OF PARALYSIS (PARAPLEGIA or QUADRIPLEGIA) PREGNANCY ≥20wks WITH ABDOMINAL PAIN AFTER BLUNT TRAUMA[5]	EJECTION or THROWN FROM AUTOMOBILE, MOTORCYCLE, or GOLF CART MOTORCYCLE, GOLFCART, or ATV CRASH WITH SIGNS OF ANATOMICAL INJURY EJECTION or THROWN FROM A HORSE WITH ANATOMICAL INJURY DEATH IN SAME PASSENGER COMPARTMENT INTRUSION INCLUDING ROOF >12 INCHES OCCUPANT SITE; >18 INCHES ANY SITE INTO THE PASSENGER COMPARTMENT VEHICLE TELEMETRY DATA CONSISTENT WITH HIGH RISK OF INJURY[6] FALL 10 FT or MORE AUTO VS. PEDESTRIAN/BICYCLIST THROWN, RUN OVER or WITH IMPACT AND SIGNS OF ANATOMICAL INJURY

RED = any **one (1)** "Trauma Alert" BLUE = any **two (2)** "Trauma Alert

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1. Airway assistance includes manual jaw thrust, continuous suctioning or use of other adjuncts to assist ventilatory efforts
2. Degloving injures or deep flap avulsion (greater than five inches)
3. Excluding superficial wounds of the head and torso in which the depth of the wound can be determined
4. Long bone fracture sites are defined as the (1) shaft of the humerus, (2) radius and ulna, (3) femur, (4) tibia and fibula
5. Pregnant patients meeting RED criteria should be transported to St. Mary's Trauma Center by air whenever possible
6. Vehicle telemetry data, when available, can be relayed to dispatch; it can assist in predicting potential serious injuries using data collected at the time of the crash

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APPENDIX 4 – PEDIATRIC TRAUMA ALERT SCORECARD & METHODOLOGY

PALM BEACH COUNTY TRAUMA AGENCY

Pediatric Trauma Scorecard

The EMT or Paramedic shall assess the condition of those injured individuals with anatomical and physical characteristics of a person 15 years of age or younger for the presence of one or more of the following three criteria to determine the transport destination per 64J-2.005, FAC:

- Patient meets color-coded triage system (see below)
- Patient does not meet the trauma criteria listed, but was transported to a Trauma Center due to EMT or paramedic judgment (reason for transport must be justified in run report)
- Patient does not meet criteria listed, but was transported to the ED at a Trauma Center due to paramedic judgment (reason for transport must be justified in run report)

	RED	BLUE
SIZE		WEIGHT ≤ 20 Kg (44 lbs.)
AIRWAY	ACTIVE AIRWAY ASSISTANCE[1] RESP RATE < 20 IN INFANT < 1 YR RESP RATE < 10 IN CHILDREN 1YR – 15 YR	
CIRCULATION	FAINT or NON-PALPABLE CAROTID or FEMORAL PULSE or SBP < 50 mmHg	CAROTID or FEMORAL PULSES PALPABLE, BUT THE RADIAL OR PEDAL PULSE NOT PALPABLE or SBP < 90 mmHg
DISABILITY	ALTERED MENTAL STATUS[2] or POST-IMPACT SEIZURE or PRESENCE OF PARALYSIS or SUSPICION OF SPINAL CORD INJURY or LOSS OF SENSATION	AMNESIA LOSS OF CONSCIOUSNESS
SOFT TISSUE	MAJOR SOFT TISSUE DISRUPTION[5] or MAJOR FLAP AVULSION 2nd or 3rd DEGREE URNS TO ≥10% TBSA ANY PENETRATING INJURY or GSW TO NECK, HEAD, or TORSO[6] PENETRATING INJURY TO THE EXTREMITY AT or ABOVE THE ELBOW or KNEE GSW TO THE EXTREMITY AT or ABOVE THE WRIST OR ANKLE AMPUTATION AT OR ABOVE THE WRIST or ANKLE MAJOR DEGLOVING INJURY	PENETRATING INJURY TO THE EXTREMITIES DISTAL TO THE ELBOW or DISTAL TO THE KNEE[6]
LONG BONE FRACTURE/ SKELETAL	OPEN LONG BONE FRACTURE or UNSTABLE PELVIC FRACTURE or MULTIPLE FRACTURE SITES or MULTIPLE DISLOCATIONS[4]	SINGLE LONG BONE FX OR DISLOCATION DUE TO MVC[4] or PELVIC FX IN PT WITH BLEEDING DISORDER
MECHANISM OF INJURY	ELECTROCUTION OR LIGHTNING STRIKE SEVERE FACIAL INJURY WITH AIRWAY COMPROMISE BLUNT BLUNT ABDOMINAL or CHEST TRAUMA IN PATIENT WITH HISTORY OF PARALYSIS (PARAPLEGIA or QUADRIPLEGIA) BLUNT HEAD, CHEST, ABDOMINAL TRAUMA IN PT WITH BLEEDING DISORDER OR ON ANTICOAGULANTS WITH A HIGH RISK OF BLEEDING AUTO VS. PEDESTRIAN/BICYCLIST THROWN, RUN OVER or WITH IMPACT AND SIGNS OF ANATOMICAL INJURY EJECTION FROM AUTOMOBILE, ATV, GOLFCART OR HORSE WITH SIGNS OF ANATOMICAL INJURY	EJECTION (PARTIAL or COMPLETE) FROM AUTOMOBILE DEATH IN SAME PASSENGER COMPARTMENT INTRUSION INTRUSION INCLUDING ROOF >12 INCHES OCCUPANT SITE; >18 INCHES ANY SITE INTO THE PASSENGER COMPARTMENT VEHICLE TELEMETRY DATA CONSISTENT WITH HIGH RISK OF INJURY[7] FALL > 10 FT OR 2-3 TIMES THE HEIGHT OF THE CHILD

RED = any **one (1)** "Trauma Alert" BLUE = any **two (2)** "Trauma Alert"

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1. Airway assistance includes manual jaw thrust, continuous suctioning or use of other adjuncts to assist ventilatory efforts
2. Altered mental states include drowsiness, lethargy, inability to follow commands, unresponsiveness to voice, totally unresponsive
3. Long bone fracture sites are defined as the (1) shaft of the humerus, (2) radius and ulna, (3) femur, (4) tibia and fibula
4. Long bone fractures do not include isolated wrist or ankle fractures or dislocations
5. Includes major degloving injury
6. Excluding superficial wounds of the head or torso where the depth of the wound can be determined
7. Vehicle telemetry data, when available, can be relayed to dispatch; the data can assist in predicting potential serious injuries from the data collected at the time of the crash

APPENDIX 5 – HIGH RISK ANTICOAGULANT / ANTIPLATLET DRUG LIST

Oral Agents

Anagrelide (Agrylin)

Apixaban (Eliquis)

Cilostazol (Pletal)

Clopidogrel (Plavix)

Dabigatran (Pradaxa)

Dipyridamole (Persantine, Permole)

Dipyridamole + aspirin (Aggrenox)

Pentoxifylline (Trental)

Prasugrel (Effient)

Rivaroxaban (Xarelto)

Ticagrelor (Brilinta)

Ticlopidine (Ticlid)

Vorapaxar (Zontivity)

Warfarin (Coumadin, Jantoven)

Parenteral Agents

Abciximab (ReoPro)

Alteplase (Activase)

Argatroban

Bivalirudin (Angiomax)

Dalteparin (Fragmin)

Desirudin (Iprivask)

Enoxaparin (Lovenox)

Eptifibatide (Integrillin)

Fondaparinux (Arixtra)

Heparin

Streptokinase

Tinzaparin (Innohep)

Tirofiban hydrochloride (Aggrastat)

Urokinase

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APPENDIX 6 – PALM BEACH COUNTY TRAUMA ORDINANCE

SECTION

I. Short Title
II. Authority and Purpose
III. Definitions
IV. Catchment Areas for Trauma Centers
V. Bypass Protocols
VI. Trauma Treatment and Transportation Protocols
VII. Patient Transfer
VIII. Medical Direction
IX. Data Collection and Quality Assessment Review
X. Administrative Review
XI. Process for the Investigation of Complaints
XII. Corrective Action
XIII. Penalties
XIV. Inclusion in Code
XV. Applicability
XVI. Repeal of Laws in Conflict
XVII. Severability
XVIII. Effective Date

PALM BEACH COUNTY ORDINANCE NO. 91-20

ORDINANCE OF THE BOARD OF COUNTY COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, TO BE KNOWN AS THE PALM BEACH COUNTY TRAUMA ORDINANCE, PROVIDING FOR: SHORT TITLE; AUTHORITY AND PURPOSE; DEFINITIONS; CATCHMENT AREAS FOR TRAUMA CENTERS; BY-PASS PROTOCOLS; PATIENT TRANSFER; MEDICAL DIRECTION; DATA COLLECTION AND QUALITY ASSESSMENT REVIEW; ADMINISTRATIVE REVIEW; PROCESS FOR THE INVESTIGATION OF COMPLAINTS; CORRECTIVE ACTION; PENALTIES; INCLUSION m CODE; APPLICABILITY; REPEAL OF LAWS IN CONFLICT; SEVERABILITY; AND EFFECTIVE DATE.

WHEREAS, the Board of County Commissioners of Palm Beach County, Florida is responsible for the health, safety and welfare of its residents and visitors; and

WHEREAS, the State of Florida, under Chapters 395 and 401 of the Florida Statutes provides for the promulgation of rules and regulations to promote health, safety and welfare for residents and visitors; and

WHEREAS, the purpose of this Ordinance is to establish criteria and standards for the trauma care system, prehospital care and transportation of residents and visitors needing emergency trauma medical services;

NOW THEREFORE BE IT ORDAINED BY THE BOARD OF COUNTY

COMMISSIONERS OF PALM BEACH COUNTY, FLORIDA, that:

SECTION I. SHORT TITLE

This Ordinance shall be known and may be cited as the "Palm Beach County Trauma Ordinance."

SECTION II. AUTHORITY AND PURPOSE

This Ordinance is promulgated pursuant to Chapters 125, 162, 395 and 401, Florida Statutes. The purpose of this Ordinance is to promote the health, safety and welfare of anyone in Palm Beach County who sustains a severe traumatic injury and who is in need of prompt and definitive trauma medical services.

SECTION III. DEFINITIONS

A. ADMINISTRATOR means the executive director of the Health Care District or designee.
B. AGENCY means the Trauma Management Agency which has been designated by the BOARD, pursuant to the TRAUMA IMPLEMENTATION PLAN, to administer and operate the Palm Beach County TRAUMA SYSTEM. The AGENCY is responsible for developing a local TRAUMA IMPLEMENTATION PLAN that is approved by the BOARD and the DEPARTMENT.
C. BOARD means the Board of County Commissioners of Palm Beach County.
D. BYPASS means the transport of a MAJOR TRAUMA PATIENT to a HOSPITAL other than a TRAUMA CENTER.
E. BYPASS PROTOCOLS means the criteria and procedures which govern situations where a MAJOR TRAUMA PATIENT is taken to a HOSPITAL other than the CATCHMENT AREA'S TRAUMA CENTER.
F. CATCHMENT AREA means a geographically defined area within which a TRAUMA CENTER will provide trauma services.
G. DEPARTMENT means the State of Florida Department of Health and Rehabilitative Services.
H. DISTRICT means the Palm Beach County Health Care District, created by Chapter 87450, as amended by Chapter 88-460 of the Laws of Florida. The Health Care DISTRICT is the entity designated by the BOARD, pursuant to the TRAUMA IMPLEMENTATION PLAN, to administer the TRAUMA SYSTEM and is the AGENCY.
I. EMS COUNCIL means the Emergency Medical Services Advisory Council, an advisory agency appointed by the BOARD, pursuant to Palm Beach County Resolution 73-162 which established the EMS COUNCIL as amended by Resolution 90-549, to advise the BOARD on all matters relating to emergency medical services.
J. EMS DIVISION means the agency within the Department of Public Safety of Palm Beach County, which is responsible for regulating and monitoring the PREHOSPITAL SERVICE PROVIDERS and administering MEDCOM.
K. ENFORCEMENT TRAUMA BOARD means a board that is empowered to review and rule on appeals of decisions, corrective actions and/or penalties imposed against TRAUMA CARE PROVIDERS by the ADMINISTRATOR.
L. HOSPITAL means an acute care facility in Palm Beach County licensed pursuant to Chapter 395, Florida Statutes, that is not a TRAUMA CENTER, but which meets the criteria of Chapter 401, Florida Statutes, and 64E-2, FAC, TRAUMA ALERT patients.
M. MAJOR TRAUMA PATIENT means any person who has incurred a single or multisystem physical injury or wound due to external force, violence or burns, and whose injury severity meets the TRAUMA SCORECARD METHODOLOGY criteria and who is in immediate need of trauma services and requirements as specified in 64E-2.017, FAC, and in the RULES AND REGULATIONS.
N. MEDCOM means the centralized emergency medical communication system, administered by the EMS DIVISION, which provides and coordinates medical communications between prehospital and hospital service providers.

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O. MEDICAL DIRECTION means the performance of professional medical duties in supervising and assuming direct responsibility for the medical performance of prehospital or hospital-based trauma medical personnel by licensed physicians as required by Chapters 395 and 401, Florida Statutes.
P. ON-LINE MEDICAL CONTROL means 24-hour-a-day radio or telephone availability of MEDICAL DIRECTION given by physicians to paramedics and emergency medical technicians of the PREHOSPITAL SERVICE PROVIDERS.
Q. PREHOSPITAL MEDICAL DIRECTORS FORUM means the professional organization composed of county PREHOSPITAL SERVICE PROVIDERS medical directors.
R. PREHOSPITAL SERVICE PROVIDER means any entity that is licensed by the State of Florida and possesses a valid Certificate of Public Convenience and Necessity issued by the BOARD pursuant to Palm Beach County Ordinance 87-27.
S. RULES AND REGULATIONS means those RULES AND REGULATIONS attached hereto as Exhibit A and made part hereof by reference to implement the provisions of this Ordinance.
T. TRANSFER AGREEMENT means a written agreement between a HOSPITAL and a TRAUMA CENTER as required by DEPARTMENT Pamphlet HRSP 150-9 and which has been authorized by the AGENCY and DISTRICT.
U. TRAUMA ALERT means the notification to a TRAUMA CENTER or HOSPITAL through MEDCOM, by a TRAUMA CARE PROVIDER, that a MAJOR TRAUMA PATIENT has been identified.
V. TRAUMA CARE PROVIDERS means any of the providers of trauma care in the TRAUMA SYSTEM including PREHOSPITAL SERVICE PROVIDERS, TRAUMA CENTERS, HOSPITALS, rehabilitation centers and subspecialty hospital personnel.
W. TRAUMA CENTER means a facility that is in compliance with DEPARTMENT Pamphlet HRSP 150-9 and has been issued a Certificate of Verification as a state-sponsored or provisional TRAUMA CENTER by the State of Florida.
X. TRAUMA IMPLEMENTATION PLAN means the document developed by the AGENCY in accordance with 64E-2.020, FAC, and approved by the DISTRICT and the BOARD, which defines the utilization of personnel, facilities and equipment for the purpose of providing effective and coordinated trauma medical services.
Y. TRAUMA MEDICAL ADVISORY COMMITTEE or TMAC means the multidisciplinary committee to be established by the AGENCY which is responsible for developing, evaluating and reviewing the TRAUMA SYSTEM QUALITY ASSESSMENT PROGRAM.
Z. TRAUMA REGISTRY means a systemwide database, which documents and integrates medical and system information related to the provision of trauma care. The TRAUMA REGISTRY requirements for TRAUMA CARE PROVIDERS are set forth in the RULES AND REGULATIONS and 64E-2, FAC.
AA. TRAUMA SCORECARD METHODOLOGY means the criteria used by each PREHOSPITAL SERVICE PROVIDER to assess the injury severity of any injured person as defined in 64E-2.017, FAC, and the RULES AND REGULATIONS.
BB. TRAUMA SYSTEM means the organization and utilization of trauma medical services, personnel, facilities and equipment in a defined geographical area, which is planned and operated by the AGENCY in accordance with Chapters 395 and 401, Florida Statutes, and the TRAUMA IMPLEMENTATION PLAN.
CC. TRAUMA SYSTEM MEDICAL DIRECTOR means the medical director employed by the DISTRICT to provide MEDICAL DIRECTION for the TRAUMA SYSTEM.

DD. TRAUMA SYSTEM QUALITY ASSESSMENT PROGRAM means the program designed to objectively and systematically evaluate and monitor the effectiveness and appropriateness of services rendered by TRAUMA CARE PROVIDERS.

EE. TRAUMA TEAM means the initial trauma management group of medical, nursing and paramedical trauma management as defined in DEPARTMENT Verification Standard Six of Pamphlet HRSP 150-9.

FF. TRAUMA TEAM LEADER means the on-duty trauma surgeon at a TRAUMA CENTER.

GG. TRAUMA TREATMENT AND TRANSPORTATION PROTOCOLS means countywide standards as established by this Ordinance in the RULES AND REGULATIONS and those specified in Chapter 401, Florida Statutes, regulating the treatment and transportation of MAJOR TRAUMA PATIENTS that meet the TRAUMA SCORECARD METHODOLOGY criteria.

SECTION IV. CATCHMENT AREAS FOR TRAUMA CENTERS

A. Each TRAUMA CENTER shall have a geographically defined CATCHMENT AREA. The CATCHMENT AREAS shall be established by the AGENCY in accordance with the following criteria

1. Anticipated number and location of MAJOR TRAUMA PATIENTS;
2. Average transportation times to reach the TRAUMA CENTER;
3. Number and type of medical facilities available to treat MAJOR TRAUMA PATIENTS within the CATCHMENT AREA;
4. Consideration of municipal boundaries;
5. Transportation barriers
6. Such other relevant factors as determined by the AGENCY

B. The EMS COUNCIL and/or the TMAC may provide the AGENCY with recommendations regarding CATCHMENT AREA boundaries. These recommendations will be forwarded to the AGENCY for adoption and will be submitted to the BOARD for receive and file.

C. All PREHOSPITAL PROVIDER SERVICES delivering emergency services within a CATCHMENT AREA shall transport or be directed to transport all MAJOR TRAUMA PATIENTS to the CATCHMENT AREA'S designated TRAUMA CENTER, unless the TRAUMA CENTER is on BYPASS.

SECTION V. BYPASS PROTOCOLS

A. BYPASS PROTOCOLS shall be established by the TRAUMA MANAGEMENT AGENCY to decrease or eliminate the episodic overloading of a TRAUMA CENTER and by permitting a PREHOSPITAL SERVICE PROVIDER to deliver MAJOR TRAUMA PATIENTS to hospitals other than TRAUMA CENTERS. BYPASS PROTOCOLS shall be set forth in the RULES AND REGULATIONS and shall be established in accordance with the following criteria:

1. The number of HOSPITALS within the CATCHMENT AREA;
2. The number and licensed capability of hospitals other than TRAUMA CENTERS in the CATCHMENT AREA;
3. The availability of appropriate trauma service beds within each non-Trauma Center HOSPITAL;
4. The number of personnel and each person's level of trauma training required for treating MAJOR TRAUMA PATIENTS within each non-Trauma Center HOSPITAL;

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5. The type of equipment required at each non-Trauma Center HOSPITAL for treating MAJOR TRAUMA PATIENTS;
6. The duration of the BYPASS status;
7. Such other relevant factors as determined by the AGENCY.

B. The TRAUMA TEAM LEADER in each TRAUMA CENTER shall determine a TRAUMA CENTER'S BYPASS status. Whenever a TRAUMA CENTER is on BYPASS status, the TRAUMA TEAM LEADER shall:

1. Inform the TRAUMA CENTER hospital administration that BYPASS has been instituted;
2. Inform all of the TRAUMA CENTERS in the county and HOSPITALS in their catchment area;
3. Document the initiation of BYPASS on forms prescribed by the AGENCY.

C. The TRAUMA CENTER shall notify the PREHOSPITAL SERVICE PROVIDER of the BYPASS status at the time of each TRAUMA ALERT and may request assistance from MEDCOM in said notification.

D. During the period of time that all TRAUMA CENTERS are on BYPASS status, the PREHOSPITAL SERVICE PROVIDERS shall transport or cause to be transported MAJOR TRAUMA PATIENTS to an appropriate HOSPITAL in accordance with approved TRAUMA TREATMENT AND TRANSPORTATION PROTOCOLS.

The TMAC and/or the EMS COUNCIL may make recommendations to the AGENCY regarding BYPASS PROTOCOLS and define the type of patient(s) affected by the protocols. The recommendations of the AGENCY shall be submitted to the DISTRICT which may then submit its recommendations to the BOARD for consideration for adoption in the RULES AND REGULATIONS.

SECTION VI. TRAUMA TREATMENT AND TRANSPORTATION PROTOCOLS

A. Every PREHOSPITAL SERVICE PROVIDER shall transport or cause to be transported each MAJOR TRAUMA PATIENT. The criteria used to determine the transportation of the MAJOR TRAUMA PATIENT to a TRAUMA CENTER shall be set forth in the RULES AND REGULATIONS in accordance with the following criteria:

1. The TRAUMA SCORECARD METHODOLOGY
2. The TRAUMA CENTER'S BYPASS status
3. The availability of appropriate ground or aeromedical transportation.

B. The PALM BEACH COUNTY PREHOSPITAL MEDICAL DIRECTORS FORUM may develop TRAUMA TREATMENT AND TRANSPORTATION PROTOCOLS for submission to the AGENCY, TMAC and/or EMS COUNCIL for review and submittal to the DISTRICT, which may submit its recommendations to the BOARD for consideration for adoption in the RULES AND REGULATIONS.

C. Any situation not described in the TRAUMA TREATMENT AND TRANSPORTATION PROTOCOLS shall be administered through ON-LINE MEDICAL CONTROL.

SECTION VII. PATIENT TRANSFER

A. All HOSPITALS shall have written TRANSFER AGREEMENTS with the TRAUMA CENTERS. All agreements shall be submitted to the AGENCY and the DISTRICT for review and approval prior to the execution of agreements.

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B. TRAUMA CENTERS and HOSPITALS shall develop transfer protocols for MAJOR TRAUMA PATIENTS and shall submit the protocols to the AGENCY for review and approval prior to implementation of the protocol.

C. Any HOSPITAL trauma patient that meets the criteria for a transfer to a TRAUMA CENTER will be considered a MAJOR TRAUMA PATIENT and afforded the same priority of transportation as prehospital scene MAJOR TRAUMA PATIENTS.

D. The TRAUMA CENTERS shall establish written trauma patient TRANSFER AGREEMENTS with hospitals can provide an advanced level of any specialized service not available at the TRAUMA CENTER. All agreements shall be forwarded to the AGENCY and the DISTRICT for review and approval prior to the execution of the agreements.

E. The AGENCY shall establish minimum requirements for inclusion in patient TRANSFER AGREEMENTS.

SECTION VIII. MEDICAL DIRECTION

A. The AGENCY shall annually contract with a State of Florida licensed physician to provide the AGENCY with TRAUMA SYSTEM guidance, direction and evaluation, to provide coordination with the medical community in the implementation of the TRAUMA SYSTEM. The contracted physician shall be titled "TRAUMA SYSTEM MEDICAL DIRECTOR."

B. The PALM BEACH COUNTY PREHOSPITAL MEDICAL DIRECTORS FORUM may develop and submit recommendations regarding prehospital quality assessment criteria and TRAUMA SYSTEM quality assessment criteria for review and comment to the TRAUMA SYSTEM MEDICAL DIRECTOR and/or EMS COUNCIL. Quality assessment criteria, which has been approved by the TRAUMA SYSTEM MEDICAL DIRECTOR and/or EMS COUNCIL shall be forwarded to the AGENCY and the DISTRICT for review and approval. The recommendations of the DISTRICT shall be submitted to the BOARD for adoption in the RULES AND REGULATIONS.

C. MEDICAL DIRECTION for the treatment of MAJOR TRAUMA PATIENTS may be provided by the PREHOSPITAL SERVICE PROVIDER'S medical director or by the TRAUMA TEAM leader at the receiving TRAUMA CENTER in accordance with the TRAUMA TREATMENT AND TRANSPORTATION PROTOCOLS set forth in the RULES AND REGULATIONS.

SECTION IX. DATA COLLECTION AND QUALITY ASSESSMENT REVIEW

A. The AGENCY shall establish and maintain a Trauma System Data Collection System. At a minimum, the system shall collect, integrate and coordinate the TRAUMA SYSTEM QUALITY ASSESSMENT and TRAUMA REGISTRY programs. All TRAUMA CARE PROVIDERS within the county shall submit to the AGENCY the registry and data collection elements set forth in Chapter 401, Florida Statutes; this Ordinance; and the RULES AND REGULATIONS. The AGENCY shall organize and provide the quality assessment data to the TMAC.

B. PREHOSPITAL SERVICE PROVIDERS shall provide TRAUMA REGISTRY data to the EMS DIVISION. TRAUMA REGISTRY data of the PREHOSPITAL SERVICE PROVIDERS shall be forwarded to the AGENCY by the EMS DIVISION. TRAUMA REGISTRY data of the PREHOSPITAL SERVICE PROVIDERS shall be submitted to the EMS Division on a monthly basis and show the previous month's data. The data shall include, but is not limited to:

1. Service utilization
2. Response time evaluation
3. Location of calls
4. Trauma patient assessment and treatment rendered
5. Patient outcome evaluation

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6. As required by Chapters 395 and 401, Florida Statutes
7. As set forth in the RULES AND REGULATIONS
8. As requested by the AGENCY

C. TRAUMA CENTERS shall provide to the AGENCY TRAUMA REGISTRY and QUALITY ASSESSMENT data which shall be submitted pursuant to the requirements of this Ordinance and the RULES AND REGULATIONS. TRAUMA CENTER data shall include the following:

1. TRAUMA TEAM response time
2. Trauma patient demographics
3. Trauma patient admission data and physiological status
4. Diagnostic and procedure data
5. Physician/TRAUMA TEAM utilization
6. Patient discharge and outcome data
7. As required by Chapters 395 and 401, Florida Statutes
8. As required by the AGENCY
9. HOSPITALS shall provide to the AGENCY information including, but not limited to, the information mandated by Chapter 395, Florida Statutes, and the RULES AND REGULATIONS.

The EMS DIVISION will organize and provide PREHOSPITAL SERVICE PROVIDER data to the AGENCY for use by TMAC in the TRAUMA SYSTEM QUALITY ASSESSMENT PROGRAM and shall provide assistance for the program as requested by the TMAC

SECTION X. ADMINISTRATIVE REVIEW

A. The AGENCY and TRAUMA SYSTEM MEDICAL DIRECTOR shall be responsible for monitoring the TRAUMA CARE PROVIDERS' compliance with this Ordinance.

B. Upon request of the AGENCY or the TRAUMA SYSTEM MEDICAL DIRECTOR, immediate access to the trauma facilities of the TRAUMA CARE PROVIDER shall be provided. TRAUMA CARE PROVIDER records of any trauma patients shall be accessible during normal business hours.

SECTION XI. PROCESS FOR THE INVESTIGATION OF COMPLAINTS

A. The ADMINISTRATOR shall have the authority to receive and investigate all written complaints and alleged violations of this Ordinance including the RULES AND REGULATIONS against a TRAUMA CARE PROVIDER. Complaints will be forwarded to the TRAUMA CARE PROVIDER within five (5) working days.

B. Complaints against a PREHOSPITAL SERVICE PROVIDER shall also be forwarded to the EMS DIVISION for review and, if required, investigation pursuant to Palm Beach County Ordinance 87-27. The EMS DIVISION shall notify the ADMINISTRATOR of any findings and actions taken by the EMS DIVISION as a result of a complaint or investigation, or actions to be taken by the EMS DIVISION to secure compliance.

C. The ADMINISTRATOR shall be provided immediate access to the facilities of a TRAUMA CARE PROVIDER for inspection to assist in said investigation. Records of TRAUMA CARE PROVIDERS shall be available for inspection to the ADMINISTRATOR during normal business hours to assist in said investigation.

D. If the ADMINISTRATOR determines through the investigation that there is reasonable cause to believe a violation of the Ordinance has occurred, the ADMINISTRATOR shall notify the AGENCY and the TRAUMA CARE PROVIDER implicated in the alleged violation, in writing, of the investigative conclusions.

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E. The notice of violation shall state the violation(s) and the justification of the ADMINISTRATOR'S conclusions and shall include the following:

1. A statement of the deficiency or violation found
2. The provision of this ordinance or RULES AND REGULATIONS relied upon
3. Any corrective action to be taken
4. The notice of the violation may also require the TRAUMA CARE PROVIDER to take such other action as the ADMINISTRATOR deems appropriate to prevent said deficiency or violation from recurring
5. The period within which the deficiency or violation must be corrected

F. The ADMINISTRATOR shall not investigate any complaint whereby the ADMINISTRATOR has a conflict of interest. All such complaints will be reviewed by an independent investigator with appropriate expertise who shall be engaged by the AGENCY. Said independent investigator shall have all the powers, rights and responsibilities when acting pursuant to this section. All references to the "ADMINISTRATOR" in this Ordinance and included in the RULES AND REGULATIONS shall be deemed to include any such independent investigator.

SECTION XII. CORRECTIVE ACTION

A. There is hereby created an ENFORCEMENT BOARD which shall consist of seven (7) members appointed by the Board of County Commissioners. Membership on such ENFORCEMENT BOARD shall include whenever possible: a TRAUMA CARE PROVIDER representative nominated by the EMS COUNCIL; a person with medical expertise nominated by the DISTRICT; the TRAUMA MEDICAL DIRECTOR; an acute care HOSPITAL representative nominated by the DISTRICT; an individual nominated by the BOARD; a consumer nominated by the BOARD; and a physician or nurse nominated by the DISTRICT.

B. The initial appointments to the ENFORCEMENT BOARD shall be as follows:

1. The TRAUMA CARE PROVIDER and the person with medical experience shall be appointed for a term of one (l) year.
2. The TRAUMA MEDICAL DIRECTOR, the acute care HOSPITAL representative and the individual selected by the BOARD shall be appointed for a term of two (2) years.
   The consumer and the physician or nurse shall be appointed for a term of three (3) years.

Thereafter, any appointment shall be made for a term of three (3) years. Any member may be reappointed to fill any vacancy on the ENFORCEMENT BOARD shall be for the remainder of the unexpired term of office. Members of the ENFORCEMENT BOARD may be removed or suspended for cause.

C. In the event a violation continues beyond the time specified by the ADMINISTRATOR for correction, or if the violation is irreparable or irreversible in nature, the ADMINISTRATOR shall give notice to the alleged violator that an ENFORCEMENT BOARD hearing will be conducted. The notice shall state the time and place of the hearing, as well as the violations which are alleged to occur.

D. At the hearing, the burden of proof shall be on the ADMINISTRATOR to show by a preponderance of evidence that a violation does exist. Where proper notice of the hearing has been provided to

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the alleged violator as provided herein, a hearing may proceed even in the absence of the alleged violator.

E. Proper notice may be presumed where a notice of violation has been mailed to the alleged violator by certified mail and the alleged violator, his agent or other person in the business has accepted the notice, or if a staff person of the DISTRICT testifies under oath that he did hand deliver the notice to the alleged violator.

F. All testimony shall be under oath and recorded. The formal rules of evidence shall not apply, but fundamental due process should be observed and govern the proceedings. Upon determination of the chairperson, who shall be elected at the first meeting from among the members of the ENFORCEMENT BOARD, irrelevant, immaterial or unduly repetitious evidence may be excluded, but all other evidence of a type commonly relied upon by reasonable prudent persons in the conduct of their affairs shall be admissible, whether or not such evidence would be admissible in a trial in the courts of the State of Florida. Any part of the evidence may be received in written form.

At the conclusion of the hearing, the ENFORCEMENT BOARD shall issue findings of fact based on evidence of record and conclusions of law, and shall issue an order which may include notice that it must be complied with by a specified date, and that a fine may be imposed for failure to comply by said date. The order of the ENFORCEMENT BOARD shall be considered final action.

SECTION XIII. PENALTIES

A. Failure to comply with the provisions of the Ordinance shall constitute a violation of this Ordinance. An administrative fine or other corrective action may be assessed against the TRAUMA CARE PROVIDER for violating any provision of this Ordinance or the included RULES AND REGULATIONS.

B. If a fine is levied, the amount of the fine to be levied shall be based upon the following factors:

1. Gravity of the violation
2. Action taken to correct the violation
3. Previous violation(s)

C. Violation of the provisions of this Ordinance shall be punished by a fine not to exceed two-hundred fifty dollars ($250) per day for the first violation and a fine not to exceed five-hundred dollars ($500) per day for each additional violation.

In addition to the sanctions contained herein, the provisions of this Ordinance may be enforced by other appropriate legal action including, but not limited to, administrative action and requests for temporary and permanent injunction and criminal prosecution.

D. It is the intent of this Ordinance to provide additional cumulative remedies.

E. All monies collected pursuant to this Ordinance shall be used for trauma training, trauma injury prevention programs and other related expenses. On an annual basis, the DISTRICT shall submit a report to the BOARD detailing the amount of monies collected during such period pursuant to this Ordinance, and the expenses to which it was applied.

SECTION XIV. INCLUSION ON CODE

The provisions of this Ordinance shall become and be made a part of the Code of Laws and Ordinances of Palm Beach County, Florida.

The sections of this Ordinance may be renumbered or relettered to accomplish such; the word "Ordinance" may be changed to "section," "article" or other appropriate word.

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SECTION XV. APPLICABILITY

It is hereby provided that this Ordinance shall constitute a law applicable in all the incorporated and unincorporated areas of Palm Beach County, Florida, as authorized by Chapters 125, 162, 395, and 401, Florida Statutes.

SECTION XVI. REPEAL OF LAWS IN CONFLICT

Any laws or ordinances in conflict with this Ordinance in Palm Beach County are hereby repealed to the extent of any such conflict.

SECTION XVII. SEVERABILITY

If any section, paragraph, sentence, clause, phrase or word of this Ordinance is, for any reason, held or declared to be unconstitutional, inoperative or void by a court of competent jurisdiction, such holdings shall not affect the remainder of this Ordinance.

SECTION XVIII. EFFECTIVE DATE

This Ordinance shall be effective May 1, 1991. Approved and Adopted by the Board of County Commissioners of Palm Beach County, Florida on the 16th day of April, 1991.

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HEALTH CARE DISTRICT OF PALM BEACH COUNTY

MASTER PARTICIPATING PROVIDER AGREEMENT

TABLE OF CONTENTS –

PROVIDER SERVICES AGREEMENT AND EXHIBITS

Master Participating Provider Agreement 1

I. Scope of Services 1

II. Definitions 2

III. Responsibilities of Provider 6

IV. Responsibilities of District 7

V. Records, Reports, Facilities 7

VI. Term and Termination 9

VII. Palm Beach County Health Care Act: Appropriations 10

VIII. General Terms 11

IX. Public Records 15

Signature Page to Master Participating Provider Agreement 17

Exhibit A – Hospital Provider Additional Terms and Provisions 18

I. Hospital Obligations 18
II. Hospital Services 22
III. Hospital Compensation 24
IV. Hospital Compensation Rates 26

Exhibit B – Non-Hospital Provider Additional Terms and Provisions 27

I. Provider Obligations 27
II. Professional Services 33
III. Claims and Compensation 34
IV. Compensation Rates 6

Exhibit B-1 – Non-Hospital Provider (ASC) Additional Terms and Provisions

Exhibit C – Acknowledgment of Disclosure and Acceptance of Member Financial Responsibility 37

Exhibit D – Business Associate Agreement 38

MASTER PARTICIPATING PROVIDER AGREEMENT

THIS MASTER PARTICIPATING PROVIDER AGREEMENT (the "Agreement"), entered into by and between Health Care District of Palm Beach County a special taxing District established by a special Act of the Florida Legislature ("District") whose address is 1515 N. Flagler Drive, Ste. 101, West Palm Beach, FL 33401-3429, and ___________________________ ("Provider"), whose address is: _______________________________ and shall be effective upon the date the Agreement is executed by the District. The District and Provider may be referred to individually as "Party" or collectively as "the Parties."

RECITALS

WHEREAS, District is a special taxing district established by a special act of the Florida Legislature and provides payment for health care services to Members, as hereinafter defined; and

WHEREAS, Provider is an appropriately licensed health care provider authorized to provide health care services outlined in this Agreement and agrees to provide designated health care services to District's Members pursuant to the terms and conditions set forth in this Master Participating Provider Agreement and all applicable exhibits and attachments incorporated herein; and

WHEREAS, District and Provider desire to enter into this agreement under which Provider will render or arrange for the provision of health care services for District Members as an independent contractor pursuant to the terms and conditions of this Master Participating Provider Agreement.

NOW, THEREFORE, in consideration of the mutual promises and covenants contained herein and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the parties hereto, intending to be legally bound, agree as follows:

AGREEMENT

I. SCOPE OF SERVICES

1. The Parties desire to enter into this Agreement relating to the provision of health care and related services to District Members. By clearly marking each applicable provider type below, Provider agrees to be bound by the terms of this Agreement and the Exhibits and all Exhibit subsections, applicable to the specific provider type upon proper execution of this Agreement:

(a) ______ Hospital Provider (Exhibit A – Hospital Provider); or

(b) ______ Non-Hospital Provider (Exhibit B – Non-Hospital Provider); or

(c) ______ Freestanding ASC Facility (Exhibit B-1-Non-Hospital Provider (ASC)).

DocuSign Envelope ID: 03200E54-4E87-4969-A60D-D1BFA61AB7F1

2. Additional Terms and Provisions relating the specific services being provided will be included as attachments and/or exhibit(s) to this Agreement (collectively referred to as "attachments"). By executing this Agreement and marking the applicable provider type in Section I.1.(a)-(b) above, the Parties agree to the additional terms and provisions contained in the attachments. The additional terms and provisions in the applicable attachment(s) are incorporated in this Agreement, and to the extent the provisions of this Agreement are inconsistent with any additional terms or provisions in the attachment(s), the additional terms and provisions in the attachment(s) will control.

3. The following additional Exhibits are incorporated in and hereby acknowledged as part of this Agreement for all provider types regardless of selection made in I. 1 above:

a. Exhibit C – Acknowledgment of Disclosure and Acceptance of Member Financial Responsibility
b. Exhibit D – Business Associate Agreement

II. DEFINITIONS

For the purposes of this Agreement, the following terms shall have the meanings specified below:

1. Affiliate – A corporation, agency or other entity which has contracted with District to participate in District's provider network.

2. Agreement – This written Master Participating Provider Agreement contract between Provider and District which sets forth the duties and responsibilities of each party.

3. Benefit Plan – A health benefit plan offered by District which includes the terms and conditions of a Member's health care coverage by District.

4. Copayment – An amount authorized under the Member's Benefit Plan which should be collected directly by a Participating Provider of health services from a Member and which amount is the financial responsibility of the Member.

5. Covered Services – Those Medically Necessary health care services rendered to a Member that are: (i) included for payment under the terms of the Benefit Plan; and (ii) are approved for payment by District or are determined by District to have been rendered pursuant to an Emergency.

6. Covering Provider – A Provider designated by Participating Provider to provide coverage in the event Participating Provider is not available. Each Network Provider is required to designate a Covering Provider who meets the same qualifications as the Participating Provider and, whenever possible, the Covering Provider should be a Participating Provider credentialed with the District.

DocuSign Envelope ID: 03200E54-4E87-4969-A60D-D1BFA61AB7F1

7. Credentialing – The process of reviewing and verifying documentation relating to the qualifications of health care practitioners for approval as Participating Providers. Such documentation may include, but is not limited to, education, certifications, licensure, malpractice history, general and professional liability insurance records, and any other documentation required to determine professional qualifications to render Covered Services to Members. Such Credentialing may be performed by District or its designee. Completion of the credentialing process and designation as a Participating Provider is a prerequisite to rendering Covered Services.

8. Emergency or Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain or other acute symptoms, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: (i) serious jeopardy to the health of a patient, including a pregnant woman or a fetus; (ii) serious impairment to bodily functions; (iii) serious dysfunction of any bodily organ or part. With respect to a pregnant woman: (i) that there is inadequate time to effect safe transfer to another hospital prior to delivery; (ii) that a transfer may pose a threat to the health and safety of the patient or fetus; (iii) that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

9. Emergency Care and Emergency Services – Medical screening, examination, and evaluation by a physician, or, if applicable, by other appropriate personnel under the supervision of a physician, to determine whether an emergency medical condition exists; and, if it does, the care, treatment, or surgery for a covered service by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of a hospital.

10. HIPAA – As may be amended, the (a) Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, including its Omnibus Rule; (b) applicable provisions of the Health Information Technology for Economic and Clinical Health (HITECH) Act as incorporated in the American Recovery and Reinvestment Act of 2009; and (c) their accompanying regulations, including the Privacy Rule (as defined herein) and the Security Rule (as defined herein). "Privacy Rule" means the Standards for Privacy of Individually Identifiable Health Information at 45 C.F.R., part 160 and Subparts A and E of 45 C.F.R. 164, providing for Federal privacy protections for an individual's protected health information ("PHI") held by entities subject to HIPAA requirements (each, a "Covered Entity") and describing patient rights with respect to their PHI. "Security Rule" means HIPAA Security Standards (45 C.F.R. Parts 160, 162, and 164).

11. Medically Necessary – The medical or allied care, goods or services furnished or ordered must meet the following conditions:

    (a) be necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;

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(b) be individualized, specific and consistent with symptoms and confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;

(c) be consistent with the generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;

(d) be reflective of the level of service that can be safely furnished, and for which no equally effective and more conservative or less costly treatment is available statewide; and

(e) be furnished in the manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

The fact that a provider has prescribed, recommended or approved medical or allied care, goods, or services does not, in itself, make such care, goods, or services medically necessary or a medical necessity or a covered service.

Medical necessity for inpatient hospital services requires that those services furnished in a hospital on an inpatient basis could not, consistent with the provisions of appropriate medical care, be effectively furnished more economically on an outpatient basis or in an inpatient facility of a different type.

12. Member – A person who is determined by District to be eligible based on the District's eligibility guidelines to receive Covered Services under a Benefit Plan.

13. Non-Participating – A health care provider who has not entered into an agreement with District to provide a specific service.

14. Participating Provider – A provider of health care services, including but not limited to a Participating Hospital and a Participating Physician, who or which has entered into a written agreement with District to provide certain health care services to Members.

15. Participating Hospital – A hospital licensed pursuant to chapter 395, Florida Statutes that has entered into a Participating Hospital Agreement with District to provide services to Members.

16. Participating Physician – A physician who has entered into a Participating Physician Agreement with District to provide services to Members.

17. Payor – A public or private entity or individual which provides and administers funds, insures or is otherwise responsible for paying Participating Providers for Covered Services rendered to a Member under a Benefit Plan. The District is always the payor of last resort.

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18. Peer Review – The ongoing evaluation of a Participating Provider's quality of care, quality of service, and professional conduct, by a committee composed of a provider's peers.

19. Physician – A person with an unrestricted license to practice medicine in the State of Florida.

20. Primary Care Physician (PCP) – A physician's practice that (i) is primarily limited to family practice, internal medicine, or pediatrics; (ii) has entered into a Participating Physician Agreement with District whereby District has designated such physician's practice to provide primary care services to Members; and (iii) is chosen by a Member to have the responsibility for:

    a. following District's primary care practice guidelines;
    b. providing initial and primary medical care to the Member;
    c. maintaining the continuity of the Member's medical care; and
    d. initiating referrals to specialty care physicians and other services.

21. Professional Services – Those Covered Services listed on the applicable attachments:

    a. Exhibit A. II – Hospital Services; or
    b. Exhibit B. II – Professional Services; or
    c. Exhibit B-1 II. – Freestanding ASC Facility.

22. Provider Handbook – The document made available to Participating Providers which summarizes District's Benefit Plan, Utilization Management, Quality Management, Credentialing, Claim Submission, and Provider Responsibilities. The Provider Handbook shall be modified and/or amended by District at District's sole discretion, and all references herein to the Provider Handbook shall include all modifications and amendments to the Provider Handbook.

23. Quality Management – The process designed to objectively and systematically monitor and evaluate the quality and appropriateness of health care, pursue opportunities to improve health care and resolve identified problems.

24. Recredentialing – The review by District of reports and results of Credentialing, Peer Review, Utilization Management, Quality Management and other matters relevant to the credentials of Participating Providers for purposes of determining whether such Participating Providers should continue to provide health care services to Members of District.

25. Referral – A written approval from the Member's Primary Care Physician for health care services from a health care provider who or which is not a Primary Care Physician.

DocuSign Envelope ID: 03200E54-4E87-4969-A60D-D1BFA61AB7F1

26. Sick Care – Non-urgent medical conditions or issues which do not substantially restrict normal activity, but could develop complications if left untreated (e.g., chronic disease).

27. Service Area – The geographic area in which District provides coverage for health care services provided to Members.

28. Specialty Care Physician – A physician who has entered into a Participating Physician Agreement to provide certain specialty medical care services to members upon referral by the Member's Primary Care Physician.

29. Urgent Care – Those medical conditions or issues which, though not life-threatening, could result in serious injury or disability unless medical attention is received (e.g., high fever, animal bites, fractures, severe pain) or substantially restrict a Member's activity (e.g., infectious illnesses, flu, respiratory ailments).

30. Utilization Management – Policies and procedures which are consistent with state law and which are established by District for determining whether, on a prospective, concurrent or retrospective basis, the health care services being rendered are being provided in a manner consistent with efficient use of resources.

31. Well Care – A routine medical visit for one of the following: child preventive care ("CHCUP") visit, family planning, routine follow-up to a previously treated condition or illness, adult physicals, preventative care and any other routine visit for other than the treatment of an illness.

32. Any terms not specifically defined herein shall have the meaning as set forth in the federal and state statutes and rules.

III. RESPONSIBILITIES OF PROVIDER

Provider is an independent contractor to the District. As such, Provider agrees that its obligations and responsibilities include:

1. Provider shall comply with all provisions of this Agreement, including all attachments, applicable Exhibit(s), and any amendments and shall act in good faith in the performance of these Agreement provisions.

2. A more detailed description of each provider type designation and corresponding responsibilities and directives is contained in the attachments of this Agreement.

3. Provider shall comply with all policies, procedures and programs set forth in the Provider Manuals. Provider shall cooperate with District, and if applicable, any state or federal agency, or its designee, during any monitoring or oversight conducted, including monitoring of services to Members.

4. Provider is licensed and has the capacity to render contracted medical and other appropriate services, pursuant to the terms of this Agreement, to Members as defined in this Agreement and the applicable attachments.

5. Provider will render or arrange for the provision of Covered Services to Members in accordance with the terms of this Agreement.

IV. RESPONSIBILITIES OF DISTRICT

1. Administrative Assistance. District, through its Medical Director and such other individuals as District designates, will provide to the Provider:

    a. A system for prior authorization of all Referrals to Participating Providers and written notification of denied claim forms for Professional Services;

    b. A system of pre-admission certification for all hospital admissions;

    c. Current listings of District's Participating Providers; and

    d. A system for verification of a provider's status as a Participating Provider or Non Participating Provider.

2. Administrative Compliance with Laws. District shall provide the administrative personnel, facilities and equipment necessary for the administration of District. District has the sole responsibility and final decision-making authority for: (i) payment of claims for health care services rendered to Members; (ii) determining eligibility for enrollment in District; (iii) termination of a Member's coverage under any Benefit Plan or determination of ineligibility as a District Member; and (iv) all benefit determinations.

V. RECORDS, REPORTS, FACILITIES

1. Confidentiality. Provider agrees that the data and information collected with respect to Provider and Members shall be kept in confidence, in accordance with all applicable state and federal laws, rules and regulations, including without limitation all Health Insurance Portability Act (HIPAA) requirements including 42 CFR § 431 Subpart F, and will not be disclosed in an identified form except to parties authorized through function of law or through specific release. Each Party acknowledges that it is a Covered Entity as defined by the Privacy Rule under the requirements of HIPAA,

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and that it will comply with such regulations on the date that compliance is required by the regulations.

This provision shall not affect or limit Providers' obligation to make available medical records or information concerning Member care to District, any authorized state or federal agency.

The District and Provider have each executed and agree to abide by the terms of a Business Associate Agreement (BAA), attached hereto as Exhibit D, which is incorporated by reference herein. If there are any conflicts between the terms of the Agreement and the BAA, the BAA shall prevail.

Each Party represents that any Business Associate that requests or receives PHI on behalf of such Party shall have entered into an agreement with such Party that contains the written assurances, all as required by the Privacy Rule, subject to any modifications required by federal or Florida law.

2. Fiscal and Medical Record Access / Access to Health Information. Provider shall maintain complete and accurate fiscal and medical records on all Members to whom the Provider has provided health care services. Provider shall maintain such records and such information as may be necessary for the evaluation of the quality, appropriateness and timeliness of services performed under this Agreement. Provider shall give District and Members access to Member's health information including, but not limited to, medical records and billing records, in accordance with the requirements of state and federal law and District's policies and procedures. If the Secretary of Health and Human Services or the United States Comptroller General or any of their duly authorized representatives is entitled to access, pursuant to the provisions of the Social Security Act (the "Act), as amended, and the regulations promulgated under the Act, to any directly pertinent books, documents, papers, and records involving transactions pertaining to the Agreements, Provider shall make the same records available for examination in accordance with the terms and requirements of such laws and regulations. Provider further agrees to comply with the requirements issued as a result of any such inspection or audit and will provide copies of records to District at no cost to District nor to the Member. This provision shall survive termination of this Agreement.

3. Inspection of Facilities. District shall have the right to inspect, at reasonable times, Provider's facilities and medical records pursuant to District's Policies and procedures. Provider agrees to allow other appropriate governmental agencies to inspect and examine through appropriate means the quality, timeliness, and appropriateness of Professional Services rendered by Provider.

4. Medical Record Contents. Provider shall prepare and maintain complete and accurate fiscal, medical and other records. Such records shall include all documents corresponding to District covered services provided by Provider and furnished in any place of service for each Member to whom Provider renders health care services. The

medical record shall include but not be limited to, reports of services provided in Provider's facilities, reports regarding referred services, reports of Emergency, reports of outpatient or inpatient hospital services, and other information as described in District's Provider Handbook. The record keeping system established by Provider shall include without limitation, appropriate records of services, charges, dates, and other commonly accepted informational elements for Professional Services rendered to Members pursuant hereto.

5. Record Retention. Provider shall retain all records related to this Agreement for a period of not less than seven (7) years from the close of this Agreement, or until the resolution of any ongoing inspection, audit, review or investigation, whichever is later. These books and records shall be maintained in accordance with prudent standards of record keeping.

VI. TERM AND TERMINATION

1. Term and Renewal. The date upon which this Agreement shall become effective ("the Effective Date") shall be the day of execution of the Agreement by District. The Term of this Agreement shall commence on the Effective Date and shall continue for a period of two (2) years ("Term") from the Effective Date. Upon conclusion of the Term, the Agreement shall be automatically renewed for successive one year renewal terms unless the Agreement is sooner terminated in accordance with the provisions hereof.

2. Termination upon Breach. Unless Provider's breach is waived by the District in writing, the District may, by written notice to the Provider, terminate the Agreement upon no less than sixty (60) calendar days written notice unless the Provider cures the breach to the satisfaction of the District prior to the expiration of the termination notice. The notice of termination shall specify the nature of termination, the extent to which performance of work under this Contract is terminated, and the date on which such termination shall become effective.

   Waiver of breach of any provisions of this Agreement by the District shall not be deemed to be a waiver of any other breach and shall not be construed to be a modification of the terms of this Agreement. The provisions herein do not limit the District's right to remedies at law or to damages.

3. Immediate Termination. Notwithstanding anything to the contrary herein, the Agreement may be terminated by District, in its sole discretion, immediately upon providing notice to Provider in case of any of the following:
   (a) a suspension or revocation of Provider's license, certification, accreditation, or any other legal document authorizing Provider to provide services to Members; (b) the cancellation or termination of, or the failure to maintain, insurance as required by this Agreement, without replacement coverage having been obtained; (c) failure to comply with District's policies and programs; (d) any allegation of misrepresentation

or fraud by Provider; (e) termination of Medicare/Medicaid certification, or any action by Provider which in the reasonable judgment of District constitutes misjudgment; (f) District's determination that Provider does not meet District's Credentialing and/or Re-credentialing standards; (g) A determination by District that the health of a Member or any Participating Provider is in imminent danger, or that any Participating Provider's ability to practice medicine is effectively impaired by an action by the Agency for Health Care Administration, the Board of Medicine or any other state of federal governmental agency; (h) Upon Provider's merger or dissolution of its health care practice, or its filing for bankruptcy protection under applicable laws; or (h) any violation of Provider obligations as required by the applicable provider attachments to this Master Participating Provider Agreement.

If any of the events listed above occurs with respect to any officer, board member, employee, agent, independent contractor or other individual performing Professional Services on behalf of Provider. District may continue this Agreement provided that, (i) Provider prohibits the affected officer, board member, employee, agent, independent contractor or other individual from providing services under this Agreement; and (ii) Provider must agree to any other conditions imposed by District.

4. Termination without Cause. This Agreement may be terminated by either party upon no less than ninety (90) calendar days written notice, unless a lesser time is mutually agreed upon by both Parties.

5. Post-Termination Services. Upon termination of the Agreement, at District's discretion, Provider agrees to continue providing Professional Services to any Member who has been authorized to receive any Professional Services from Provider, until the occurrence of the earlier of the following events; (i) District successfully obtains another provider to provide Professional Services to the Member; or (ii) the expiration of thirty (30) calendar days from the date of termination of the Agreement.

   At District's request, Provider shall work with District to create a transition plan that shell ensure orderly and reasonable transfer of Member care, assist with coordinating transfer of members, and report any Members with complex medical needs.

   This Section shall not obligate Provider to accept new Members after the date of termination. Provider shall be entitled to receive compensation for such services in accordance with the appropriate Exhibits of this Agreement.

VII. PALM BEACH COUNTY HEALTH CARE ACT: APPROPRIATIONS

1. Palm Beach County Health Care Act and Other Applicable Law. Provider acknowledges that District is a public body corporate and politic subject to the terms of the Palm Beach County Health Care Act (1987 Fla. Laws. 87-450 as amended) and other laws and regulations of the State of Florida and the United States of America now or hereafter enacted, as the same may be modified or amended. If any part of this Agreement, or any obligations of the Provider or District hereunder, are contrary

to, prohibited by, deemed invalid or unenforceable under the Palm Beach County Health Care Act or any other applicable law or regulation of the State of Florida or the United States of America, such provision or obligation shall be inapplicable and be deemed omitted to the extent so contrary, prohibited, invalid or unenforceable, but the remainder hereof shall not be invalidated and shall be given full force and effect.

2. Appropriations. Provider acknowledges and agrees that the duties and obligations of District under this Agreement are subject to budgeting and appropriation by District of funds sufficient to pay such costs in any fiscal year of District. Notwithstanding anything in this Agreement to the contrary, in the event that no funds are appropriated or budgeted by District in any fiscal year to pay the costs associated with District's obligations hereunder or in the event the funds budgeted or appropriated are, or are estimated by the District to be, insufficient to pay the costs associated with the District's obligations hereunder in any fiscal period, then the District will notify Provider of such occurrence and either party may terminate this Agreement by notice in writing to the other party which shall specify a date of termination, which date shall be no earlier than twenty-four (24) hours after the District's giving of such notice. The District shall be the final authority as to the availability of funds. Such termination shall be without penalty or expense to the District other than the compensation due the Provider pursuant to the terms of this Agreement for services rendered prior to the date of termination of this Agreement.

VIII. GENERAL TERMS

1. Advertising and Marketing. Provider agrees that Provider's name, telephone number, address and specialty or service may be included in literature distributed to existing or potential Members or Participating Providers. Any other use of Provider's name by District shall require prior written approval by Provider. Any use of District's name shall be prohibited without prior written approval.

2. Amendments. The provisions of this Agreement may not be amended, supplemented, waived or changed orally or by course of conduct of the Parties. Any amendment, supplement, waiver or modification of this Agreement shall be made in writing and signed by both Parties.

   Notwithstanding, this Agreement shall be automatically amended as necessary to comply with applicable federal or state laws or regulations, including without limitation any applicable laws or regulations under the Medicare and/or Medicaid programs.

3. Assignment. This Agreement, being intended to secure the services of Provider, shall not in any manner be assigned, delegated, or transferred by Provider to another provider, person or entity without the prior written consent of District. Any such transfer or assignment shall be void and without force or effect. District has the right to assign this Agreement to any entity that is controlled by District or to any entity that controls, or is under common control with, District.

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4. Attorneys' Fees. In any legal action or other proceeding brought for the enforcement of this Agreement, or because of an alleged dispute, breach, default or misrepresentation in connection with its provisions, each party shall bear its own attorney's fees, court costs and all expenses, including without limitation, all such fees, costs and expenses incident to appeal.

5. Binding Effect. All of the terms and provisions of this Agreement, whether so expressed or not, shall be binding upon, inure to the benefit of, and be enforceable by the Parties and their respective administrators, executors, legal representatives, heirs, successors and permitted assigns.

6. Compliance with Laws. The Parties agree to comply with all federal and Florida laws, regulations, guidelines, handbooks and contracts applicable to this Agreement.

7. Counterparts. This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same instrument, and will become effective when there exist copies hereof (by facsimile, electronic mail, or otherwise) which, when taken together, bear the authorized signatures of each of the Parties.

8. Entire Agreement. This Agreement, and any documents, addenda, exhibits, and manuals referred to herein, represent the entire understanding and agreement between the parties and supersedes all other negotiations, understandings and representations, if any, made between the parties.

9. Further Assurance. Provider agrees from time to time to execute and deliver documents and take other actions which may be convenient, necessary or expedient to more effectively and completely carry out the intentions of this Agreement as directed by District.

10. Governing Law and Venue. This Agreement, all transactions, and any claims arising out of or relating to this Agreement, including, without limitation, any claims arising in contract, tort, breach of contract, violation of statute, or otherwise shall be governed by Florida law.

    The exclusive venue of any legal or equitable action that arises out of or relating to this Agreement shall be in Palm Beach County, Florida.

11. Section Headings, Construction. The headings of sections in this Agreement are provided for convenience only and will not affect its construction or interpretation. All words used in this Agreement will be construed to be of such gender or number as the circumstances require. Unless otherwise expressly provided, the word "including" does not limit the words or terms preceding it.

12. Indemnification. Provider agrees to indemnify, defend, and hold harmless District, as provided in this Clause.

    a. Scope. The Duty to Indemnify and the Duty to Defend, as described herein (collectively known as the "Duty to Indemnify and Defend"), extend to any completed, actual, pending, or threatened action, suit, claim, or proceeding, whether civil, criminal, administrative, or investigative (including any action by or in the right of Provider), and whether formal or informal, in which District is, was, or becomes involved and which in any way arises from, relates to, or concerns Provider's acts or omissions related to this Agreement (inclusive of all attachments, etc.) (collectively "Proceeding"). No provision of this part, or of any other section of this Agreement (inclusive of all attachments, etc.), whether read separately or in conjunction with any other provision, shall be construed to: (i) waive the District's immunity to suit or limitations on liability; (ii) obligate the District to indemnify the Provider for the Provider's own negligence, or otherwise assume any liability for the Provider's own negligence; or (iii) create any rights enforceable by third parties, as third party beneficiaries or otherwise, in law or in equity.

        i. Duty to Indemnify. Provider agrees to hold harmless and indemnify District and its officers, agents and employees to the full extent permitted by law against any and all liability, claims, actions, suits, judgments, damages, and costs of whatsoever name and description, including attorneys' fees, arising from or relating to any Proceeding.

        ii. Duty to Defend. With respect to any Proceeding, Provider agrees to fully defend District and its officers, agents and employees and shall timely reimburse all of the District's legal fees and costs; provided, however, that the amount of such payment for attorneys' fees and costs is reasonable pursuant to Rule 4-1.5, Rules Regulating the Florida Bar. The District retains the exclusive right to select, retain, and direct its defense through defense counsel funded by Provider pursuant to the Duty to Indemnify and Defend the District.

    b. Contribution. In any Proceeding in which Provider is held to be jointly liable with the District for payment of any claim of any kind (whether for damages, attorneys' fees, costs, or otherwise), if the Duty to Indemnify provision is for any reason deemed to be inapplicable, the Provider shall contribute toward satisfaction of the claim whatever portion is or would be payable by the District in addition to that portion which is or would be payable by Provider, including payment of damages, attorneys' fees, and costs, without recourse against the District.

13. Medical Decisions. District has no right, authority, or control over the operation of Provider's practice or facility or the provision of Professional Services or any other health care services. Operation and maintenance of the offices, facilities and

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equipment of Provider, and the provision of all Professional Services, shall be solely and exclusively under the control and supervision of Provider.

14. No Exclusivity. Nothing contained herein is intended to prohibit or limit:

    a. the ability of Provider to contract with parties other than District to provide health care and medical services; or
    b. the ability of District to contract with parties other than Provider for the provision of health care and medical services.

15. No Guarantee. Utilization Management, precertification and/or identification of benefits does not guarantee or confirm benefits. Benefits are subject to eligibility at the time charges are actually incurred, and other terms, provisions, and exclusions of District.

16. Notices. All notices, unless otherwise specified, shall be in writing and shall be given by personal delivery, facsimile or by certified mail, return receipt requested and shall be addressed to the Party at the address set forth in this Agreement. Each notice shall be deemed received on the date delivered if by personal delivery; on the date telecopied upon confirmation; or on the date on which the return receipt is signed or delivery is refused.

17. Relationship of Parties. The relationship between District and Provider is that of independent contractors, and neither shall be considered a joint venture, partner, agent, representative or other relationship of the other for any purpose expressly or by implication. Except as expressly set forth in this Agreement, neither Party has power or authority to act for, represent, or bind the other Party in any manner. Accordingly, no rights or interests granted herein by District shall be deemed to confer any rights of sovereign immunity to Provider or any of its agents or employees, and as such, all rights and interests of sovereign immunity shall be strictly limited to District under the laws and constitution of the State of Florida. Provider agrees not to assert as a defense or claim any right or sovereign immunity in any legal or other proceeding.

    PROVIDER FURTHER AGREES TO INDEMNIFY AND HOLD DISTRICT HARMLESS FROM ANY AND ALL DAMAGES, CLAIMS, LOSSES, INCLUDING ATTORNEY'S FEES AND COSTS, RESULTING FROM A BREACH OF THIS PROVISION BY PROVIDER, ITS AGENTS, REPRESENTATIVES OR EMPLOYEES.

18. Rights of Other Parties. Nothing contained herein, whether express or implied, is intended to confer any rights or remedies under or by reason of this Agreement on any persons other than the parties hereto and their respective administrators, executors, legal representatives, heirs and permitted assigns, nor is anything in the Agreement intended to relieve or discharge the obligation or liability of any third person to any party to this Agreement nor shall any provision give any third persons any right of subrogation or action over or against any party to this Agreement.

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19. Severability. Wherever possible, each provision of this Contract shall be interpreted in such a manner as to be effective and valid under applicable law, but if any provision shall be found ineffective, then to the extent of such prohibition or invalidity, that provision shall be severed without invalidating the remainder of such provision or the remaining provisions of this Agreement. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable. The invalidity of any part of this Agreement shall not render invalid the remainder of this Agreement or the remainder of such sections if the remainder would conform to the requirements of applicable federal or Florida law. If any two provisions of this Agreement and multiple Exhibits apply, the Parties agree the more restrictive provision shall control in any resulting dispute or analysis of compliance with this Agreement.

20. Sovereign Immunity. This Agreement shall not be construed as constituting a waiver of any rights to sovereign immunity granted to District under the laws and Constitution of the State of Florida.

21. Waivers. No failure or delay in (i) exercising any right or remedy; or (ii) requiring satisfaction of any condition under this Agreement, and no course of dealing between the Parties, operates as a waiver or estoppels of any right, remedy or condition. A waiver made in writing on one occasion is effective only in that instance and only for the purpose that it is given and is not to be construed as a waiver on any future occasion or against any other person. The rights and remedies of the Parties set forth in this Agreement are not exclusive of, but are cumulative to, any rights or remedies now or subsequently existing at law, in equity or by statute.

    Nothing in this Section relieves Provider of its obligation to provide adequate and timely access to medically necessary services for Members.

22. Right of Offset. In the event of any overpayment, duplicate payment, or other payment in excess of that to which Provider is entitled under this Agreement, or there is otherwise an outstanding liability which is owed by Provider to District, the District may, in addition to any other remedy, recover the same by way of offsetting such overpayment, duplicate payment or other payment or liability against current and future amounts due to Provider.

IX. PUBLIC RECORDS

Provider shall comply with Florida's Public Records Act, Chapter 119, Florida Statutes, and, if determined to be acting on behalf of the District as provided under section 119.011(2), Florida Statutes, specifically agrees to:

1. keep and maintain public records that ordinarily and necessarily would be required in order to perform services under this Agreement and as otherwise required by the District;

2. upon request from the District's custodian of public records or designee, provide the

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District with a copy of the requested records or allow the records to be inspected or copied within a reasonable time at a cost that does not exceed the cost provided in Chapter 119, Florida Statutes, or as otherwise provided by law;

3. ensure that public records that are exempt or confidential and exempt from public records disclosure requirements are not disclosed except as authorized by law for the duration of this Agreement and following completion of this Agreement if the Provider does not transfer the records to the District; and

4. upon completion of this Contract, transfer, at no cost, to the District all public records in possession of the Contractor or keep and maintain public records required by the District to perform the service. If the Contractor transfers all public records to the District upon completion of the Contract, the Contractor shall destroy any duplicate public records that are exempt or confidential and exempt from public records disclosure requirements. If the Contractor keeps and maintains public records upon completion of the Contract, the Contractor shall meet all applicable requirements for retaining public records. All records stored electronically must be provided to the District, upon request from the District's custodian of public records or designee, in a format that is compatible with the information technology systems of the District.

IF THE CONTRACTOR HAS QUESTIONS REGARDING THE APPLICATION OF CHAPTER 119, FLORIDA STATUTES, TO THE CONTRACTOR'S DUTY TO PROVIDE PUBLIC RECORDS RELATING TO THIS CONTRACT, CONTACT THE CUSTODIAN OF PUBLIC RECORDS OR DESIGNEE AT HEALTH CARE DISTRICT OF PALM BEACH COUNTY, ATTN: CUSTODIAN OF PUBLIC RECORDS AT 561-804-5781, RECORDSREQUEST@HCDPBC.ORG, 1515 N. FLAGLER DRIVE, SUITE 101, WEST PALM BEACH, FL 33401-3429

[SIGNATURES ON FOLLOWING PAGE]

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and year stated.

PROVIDER:

Name: ______________________________
(Print Business Name)

By: ______________________________
(Authorized Signatory)

Name: ______________________________
(Print Name)

Title: ______________________________

Date: ______________________________

Provider Tax Identification Number:

______

HEALTH CARE DISTRICT OF PALM BEACH COUNTY:

BY: ______________________________
Darcy J. Davis,
Chief Executive Officer

Date: ______________________________

Approved as a Form and Legal Sufficiency:

BY: ______________________________
General Counsel

Date: ______________________________

Exhibit A
TO MASTER PARTICIPATING PROVIDER AGREEMENT

HOSPITAL PROVIDER

ADDITIONAL TERMS AND PROVISIONS

I. HOSPITAL OBLIGATIONS

Provider agrees that Provider's obligations and responsibilities shall include:

1. Admissions. Provider agrees to receive prior authorization by the District for admissions except in an Emergency.

2. Emergency Admissions. In case of an Emergency, Provider agrees to the following conditions:

   a. Provider shall notify District within twenty-four (24) hours after an admission of an individual known to be a Member at the time of admission, or for any patient not known to be a Member at the time of admission, within twenty-four (24) hours after the identification of a patient as a Member.

   b. Provider shall notify District within twenty-four (24) hours after the rendition of outpatient Professional Services to an individual known to be a Member or, for any patient not known to be a Member at the time of admission, within twenty-four (24) hours after the identification of a patient as a Member.

   c. If the Emergency is on a Saturday, Sunday or a holiday, Provider shall provide the notice required under subsection (a) and (b) of this paragraph by the end of the next business day.

   d. Provider shall permit review of the admission as required by District Utilization Management program.

   e. Certification pursuant to the Utilization Management program shall in no event be for a period shorter than the period between the date of Emergency admission and the receipt by Provider of notice of certification.

3. Adjustments. Provider agrees to allow District to review paid claims for a period of one year after the date of service to determine if services were rendered in accordance with District's authorization and the terms of this Agreement. Provider agrees to make any necessary adjustments, including refunds to District, as a result of the review conducted by District.

4. Agreement. Provider agrees to abide by the terms and conditions of this Agreement and provide Professional Services to Members of the District.

5. Complaints or Grievances. Provider agrees to ensure that any complaint or grievance that Provider receives from a Member regarding Provider, District, any Participating Providers, or related support staff is directed to District's customer service department within ten (10) days of receipt. Provider agrees to cooperate with District in resolving any complaints or grievances that a Member has made.

6. Credentialing. Provider agrees to provide documentary evidence of qualifications to District by submitting a completed application form and photocopies of, but not limited to, required licenses, permits, and certifications. This Agreement shall only become effective once District has completed credentialing of the Provider and approved Provider's credentials. Provider shall submit, upon request by District, photocopies of all licenses, permits, certifications, and regulatory approvals that are required to be maintained by Provider, as well as all other information necessary for District to properly credential Provider.

7. Member Verification. Provider agrees to verify eligibility of a Member to receive coverage for Professional Services at the time of the Member's visit and/or admission to a hospital, unless such visit or admission is for Emergency services.

8. Non-Discrimination. Provider agrees not to differentiate or discriminate in the treatment of Members as to the quality of services delivered because of race, sex, sexual orientation, age, religion, national origin, health status, or source of payment, and to observe, protect and promote the rights of Members as patients.

9. Notice Requirement. Provider agrees to notify District, in writing, within one (1) business day, of the occurrence of any of the following: (i) Provider's license to operate in the State of Florida or any other jurisdiction is under investigation, suspended; surrendered, revoked, terminated or is subject to terms of probation or other restrictions, (ii) Provider has become a defendant in any malpractice action or is obligated to provide notice of a possible malpractice claim to its malpractice insurance carrier, or is required to pay damages in any such action by way of judgment or settlement; (iii) Provider is under investigation, disciplined or sanctioned by the Agency for Health Care Administration or any similar agency; (iv) Provider or any officer, representative, agent or employee thereof is indicted or convicted of a felony; (v) any material change in the nature or extent of services rendered by Provider; (vi) any material change in or addition to the information and disclosures submitted by Provider as part of its application for participation; (viii) Provider's exclusion under the United States Medicare or Medicaid Program or any other governmental program for any reason or any agent, officer or employee of Provider becoming a "sanctioned person" under applicable Medicare or Medicaid laws; (ix) any other act, event, occurrence or the like which materially affects Provider's ability to carry out the Provider's duties and obligations under this Agreement.

10. Policies and Procedures. Provider agrees to abide by District's Benefit Plan, Utilization Management, Quality Management, Credentialing, Recredentialing, and Peer Review Policies, and other policies and procedures including, without limitation, policies and

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procedures with reference to the items listed in Section IV. 1. (a) – (d) of the Master Participating Provider Agreement, and as outlined in District's Provider Handbook or such other information made available to the Provider by District. All such policies and procedures may be modified and/or amended by District at District's sole discretion and shall become effective immediately upon notice to Provider.

11. Evidence of Liability Coverage. Provider agrees to submit to District, upon execution hereof, a copy of all insurance policies referenced in Section 12 hereunder. Further, throughout this Agreement, Provider agrees to submit to District written notice of any change in: (i) coverage; (ii) scope; or (iii) any other terms or provisions of such policies.

12. Warranties and Representations. Provider represents and warrants to District that during the term of this Agreement, Provider, and each of its employees, agents, and/or independent contractors providing Professional Services hereunder, shall (i) maintain all licenses required by law to operate and/or practice in the State of Florida; (ii) meet the conditions for hospital participation for the Medicare Program (Title XVIII of the Social Security Act) and the Medicaid program (Title XIX of the Social Security Act); (iii) remain accredited, as applicable, by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, or the Commission on Accreditation for Rehabilitation Facilities; (iv) maintain professional malpractice insurance in the amount of at least $1,000,000 per occurrence and $5,000,000 aggregate, general liability insurance as required by the District, and such other insurance as shall be necessary to insure Provider and its officers, agents, employees and/or independent contractors against any claim(s) for damages arising under this Agreement; and (v) comply with all applicable local, state, and federal legal requirements, as well as all applicable standards and professional ethics and practice. Provider shall provide thirty (30) days written notice to the District prior to cancellation, modification or termination of any such policy of insurance. Throughout the Term, Provider shall provide District with written verification of the existence of such insurance policies or other coverage.

13. Tail Coverage. If Provider's professional malpractice insurance coverage is a claims-made policy and the policy is terminated for any reason during any Term or in the event of cancellation or termination of this Agreement, Provider shall immediately purchase, at Provider's sole expense, "Tail" coverage or other mutually agreed upon coverage that for at least four (4) years immediately following the termination of this Agreement will provide malpractice insurance coverage in an amount of at least $1,000,000 per occurrence, and $5,000,000 in the aggregate, for coverage in connection with Professional Services provided prior to termination of this Agreement. This provision shall survive termination of this Agreement.

14. Hospital Services. Provider agrees to provide Professional Services to Members twenty-four (24) hours a day, seven (7) days per week, as necessary, in accordance with generally accepted standards of practice and hospital management in the community.

15. Preauthorization of Referrals. Provider shall obtain pre-authorization prior to making any referrals of the District Members to another provider, except in cases of Emergency.

16. Participating Providers. Provider shall furnish complete information on treatment, procedures, and diagnostic tests performed prior to a Referral and shall refer or admit Members to only those health care providers who are Participating Providers with District, except in cases of Emergency.

17. Protocols and Providers. Provider shall comply with all District protocols as established or modified by District, relating to the efficient use of resources and the provision of Professional Services to Members, including, but not limited to, protocols related to hospital admissions, lengths-of-stay or usage of services, and Referrals to Specialty Care Physicians and other Participating Providers.

18. Quality Care. Provider shall ensure that health care services provided to Members are of a quality that is consistent with accepted medical, surgical and hospital practices.

Exhibit A
TO MASTER PARTICIPATING PROVIDER AGREEMENT

HOSPITAL PROVIDER

ADDITIONAL TERMS AND PROVISIONS

II. HOSPITAL SERVICES

Provider is licensed to provide services in the State of Florida. Provider agrees to provide the following services to Members. **Provider shall be considered a non-participating provider for all other services not indicated.**

Acute Care Services		**Diagnostic Services**	
Chemical Dependency/Detoxification	**N/A**	Laboratory/Pathology	
Chemotherapy		Nuclear Medicine	
Emergency Room		Specify:	
Medicine			
Obstetrics/Gynecology		Radiology	
Pediatrics		Specify:	
Psychiatric (Adult)		CT	
Psychiatric (Pediatric)		Interventional	
Radiation Therapy		Mammography	
Renal Dialysis		MRI	
Surgery (Inpatient/Outpatient)		MRA	
Specify:		Ultrasound	
General		X-ray	
Cardiovascular			
ENT			
Gastroenterological		**Other Services:**	
Open Heart		Cardiac Catheterization	
Ophthalmological		ECT	
Orthopedic		Hyperbaric Chamber	
Pain Management		Lithotripsy	
Plastic & Reconstructive		Pain Management	
Podiatric		Pulmonary	
Urological		Wound Care	
Vascular			
		Other	
Trauma Services		Specify:	
Other Acute Care Services			
Specify:			
Physical Rehabilitation Services:			
Inpatient Specify:			

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Outpatient Specify: ________________ ________________

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Exhibit A
TO MASTER PARTICIPATING PROVIDER AGREEMENT

HOSPITAL PROVIDER

ADDITIONAL TERMS AND PROVISIONS

III. HOSPITAL COMPENSATION

1. Hospital Compensation.

   District shall compensate Provider for Professional Services rendered to Members in accordance with the compensation schedule in Exhibit A, IV. Provider agrees to accept as payment in full for Covered Services rendered to Members during the term of this Agreement the rates set out in the applicable Attachment(s) hereto, less any Member expenses due from Members. Provider shall collect Copayments and any other Member expenses directly from Members, and shall not waive, discount or rebate any such Copayments, unless such waiver is allowable under Applicable Law. In no event shall Provider attempt to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, except for the collection of Member responsibility in accordance with the terms of the applicable District Benefit Plan.

2. Coordination of Benefits. Provider acknowledges and agrees that District is the Payor of last resort. To that end, if Provider has knowledge that a Member is eligible to receive health care benefits or reimbursement of any kind whatsoever, from a Payor other than District, Provider shall bill such other Payor(s) prior to submitting claims for the same services to District. Provider shall timely provide District with relevant information it has collected from Members regarding coordination of benefits. In any case where a Member is entitled to payment from a Payor other than District, for Professional Services provided pursuant to this Agreement, District will pay Provider for Covered Services that were not paid by the other Payor, provided that Provider is in compliance with all other terms of this Agreement. Further, such District payment to Provider shall not be made to the extent that such payment, when added to all other payments made to Provider for such services, exceeds one hundred percent (100%) of the amount agreed to be paid to Provider by District under this Agreement which amount shall be deemed to mean "one hundred percent (100%) of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment," as that phrase is used in the Florida Insurance Code, §627.4235, (sometimes known and referred to as "the C.O.B. rules"). This provision is subject to applicable federal and/or Florida law concerning coordination of health insurance benefits, including the Florida Insurance Code, §627.4235, and shall be modified to the extent necessary to enable the parties to comply with such law. Provider shall make a good faith effort to obtain information that may be helpful to District in coordinating such benefits, shall otherwise assist District in such coordination of benefits, and shall promptly refund any

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overpayments made by District to Provider pursuant to the foregoing provisions. Provider shall cooperate with District and other Payors in determining whether a Member's illness or injury is covered by auto insurance or other health insurance or otherwise gives rise to a claim by District by virtue of coordination of benefits or subrogation. Provider agrees to take any and all actions reasonable and necessary to assist District in obtaining recoveries from third parties, including, without limitation, by: (i) executing any and all documents that reasonably may be required to enable District to bill and/or collect payments from any third parties; (ii) assigning all rights to recovery and all payments to District; and (iii) assigning the rights to settle claims with third parties on behalf of Provider.

3. Billing Procedures. Provider shall submit claims for payment for Professional Services on a CMS 1500 claim form or UB-92 form, as applicable, within one hundred and eighty (180) days of the date such services are rendered and shall abide by the claims/billing procedures outlined in the Provider Handbook. Claims received after this one hundred and eighty (180) day period may be denied for payment. In submitting claims for reimbursement, Provider shall provide the Member's name, date of birth, financial classification, status and dates of services/dates of discharge.

4. Collections of Copayments. Provider shall collect Copayments from Members as stipulated in the Benefit Plan.

5. Determination of Covered Services. Covered services shall be outlined on the District's website. Provider acknowledges that Provider has an independent responsibility to provide health care services to the Members and that neither any provision of this Agreement, nor any action by District pursuant to the Utilization Management program, in any way absolves Provider of the responsibility to provide appropriate medical care to Members.

6. Non-Covered Services. Provider shall not, either directly or indirectly, bill, charge, or seek compensation from Members for Covered Services rendered; provided, however, that nothing herein shall be construed to prohibit Provider from collecting or pursuing collection of District authorized Copayments or charges for non-Covered Services or seeking payment from other Payors. Prior to providing non-Covered Services to a Member, Provider shall: (i) inform the Member that the services to be provided are not Covered Services; (ii) inform the Member that District will not pay or be liable for such services; (iii) inform the Members that if Provider is seeking compensation for such services, the Member shall be financially liable for such services; and (iv) provide to the Member the form agreement on Exhibit C hereto and obtain such agreement, once fully executed, from the Member. In the event Provider does not fully comply with items (i)-(iv) of this Section 5, the Member shall not be liable to Provider for such non-Covered Services. Provider further agrees that this Section 5 shall survive the termination of this Agreement regardless of the cause giving rise to termination.

7. Pre-Condition of Reimbursement. In addition to other restrictions and limitations hereunder on compensation to Provider, Provider shall only receive compensation for

Professional Services provided to a Member if such Member received such Professional Services pursuant to a Referral from a Participating Provider, except that Provider shall be reimbursed for Professional Services provided to a Member pursuant to an Emergency.

8. Budget Neutrality. With respect to specific changes to the MS-DRGs as published in the Federal Register (or such other grouper as used by District as published by the applicable source), the parties agree that their intent hereunder is to keep the economic benefits to each party under this Agreement the same. If any MS-DRG change has a "Material Financial Impact" (as defined below), the parties agree to work together in good faith to reach an agreement on new rates, such that the agreed upon rate adjustments have the effect of neutralizing any change made to the MS-DRGs. For purposes of this provisions, "Material Financial Impact" shall be a change equal to or greater than [ ] percent (%) of the total amount paid by District to Provider for those Professional Services for which payment under this Agreement is based on the MS-DRG rates (measured from the twelve (12) months prior using the impacted coded service identifier(s) codes).

9. Implementation of Changes to MS-DRG Rates. The parties understand and agree that any claims processed during an "Update Period" (as defined below) that occurs during the term of this Agreement, which claim has a discharge date or date of service of October 1st or later, will be processed and paid using the grouper version in effect on the September 30th immediately prior to such October 1st and the Provider will accept such payment in full. Once the "District Modification Point" (as defined below) has been reached, claims shall be submitted by Provider and processed/administered by District consistent with the DRG related changes. The "Update Period" shall mean the time period between the "DRG Modification Date" (as defined below) and the District Modification Point. "District Modification Point" means the point at which all necessary payor payment system changes/updates have been loaded and completed by District to implement the DRG related changes. "DRG Modification Date" means the point at which all such DRG related changes have been made by CMS and the American Medical Association, which is usually on or about October 1st.

10. 72 Hour Readmissions. For all Inpatient Services, a readmission within three (3) days of the discharge of the first admission for a related diagnosis or for a complication arising out of the first admission is considered part of the original admission for reimbursement. If a Member is readmitted during the three (3) day post-discharge period, then Provider shall only be reimbursed for the admission with the **[higher MS-DRG rate]**. Additionally, if a subsequent admission is reimbursed at a methodology other than the MS-DRG rate, the District shall only reimburse Provider for the MS-DRG rate of the original admission.

11. 30 Day Readmissions. In the event a Member has an "Unplanned Readmission" (as defined below) attributed to Provider (whether the readmission is to the same Provider or whether the Provider was initial admission facility), District shall [ ]. "Unplanned Readmission" means an unplanned readmission as defined under the Medicare Hospital Readmissions Reduction Program and includes, but is not limited to, unplanned

readmissions that happen within thirty (30) days of discharge from the initial admission whether such Member is readmitted to the same hospital or any other applicable acute care hospital for any reason.

Exhibit A
TO MASTER PARTICIPATING PROVIDER AGREEMENT

HOSPITAL PROVIDER

ADDITIONAL TERMS AND PROVISIONS

IV. HOSPITAL COMPENSATION RATES

The District shall compensate Provider for Medically Necessary Services rendered to a Member under one or more of the services as indicated below. By clearly marking each applicable service below, Provider agrees to be bound by that compensation rate. **Provider shall be considered a non-participating provider for all other services not indicated.**

I. **Hospital Inpatient Services:** **70**% of MS-DRG Rate

II. **Hospital Outpatient Services:** **[insert %]** of Medicare Rate*

III. **Emergency Services Rate:** **[insert %] of Medicare Rate***

*The parties understand and agree that any outpatient services for which CMS has assigned a MS-DRG Rate will be paid at 70% of MS-DRG Rate for such hospital outpatient services.

Exhibit B
TO MASTER PARTICPATING PROVIDER AGREEMENT

NON-HOSPITAL PROVIDER

ADDITIONAL TERMS AND PROVISIONS

I. PROVIDER OBLIGATIONS

Provider agrees that Provider's obligations and responsibilities shall include:

1. Standards for Provision of Care

   a. Availability. Provider, for itself and its Participating Providers, agrees that Provider's services shall be available on a twenty-four (24) hours-a-day, seven (7) days-a-week basis. Provider shall ensure that each Member has timely access to Participating Providers in compliance with the following availability schedule: (i) for Urgent Care - within one day of a request from the Member; (ii) Sick Care - within one week following a request from the Member; and (iii) for Well Care - within one month following a request from the Member.

   b. Agreement. Provider, for itself and its Participating Providers, agrees to abide by all terms and conditions of this Agreement, including all attachments and exhibits, and provide applicable Covered Services to Members of District and/or Affiliates. Provider, for itself and its Participating Providers, shall ensure that each Participating Provider: (i) sign, print and date where appropriate on Exhibit B. II in order to set forth such individual's field of practice on Exhibit B. II; (ii) is properly credentialed by the District prior to rendering any medical care pursuant to this Agreement; and (iii) executes Exhibit B. II and returns to District prior to rendering Professional Services hereunder.

   c. Group Practice. Provider represents and warrants as follows:

      i. Provider has authority to contract on behalf of the members of Provider (Provider shall provide agreements demonstrating such authority);
      ii. the terms of this Agreement do not conflict with the terms, agreements, policies and procedures of the Group Practice;
      iii. members of Provider terminated pursuant to Section VII. 3 hereunder shall refrain from rendering any Professional Services to Members;
      iv. upon execution of the Agreement, the Group Practice shall submit necessary applications to credential for each Participating Provider and provide District with a list of all Participating Providers including the name, address, and telephone number for each; and
      v. if Provider seeks to add additional individual members who intend to provide Professional Services hereunder, the Provider shall give District reasonable advance written notice, and shall ensure that the new members of the Group Practice have been approved by District pursuant to District's

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Credentialing procedures prior to such individuals providing Professional Services hereunder. Any deletions or proposed deletions to the list of Participating Providers shall be provided to District within no more than ten (10) days after the Provider has learned or knows that a Participating Provider will no longer be providing services hereunder or intends to discontinue providing services hereunder.

d. Member Verification. Provider agrees to verify each Member's eligibility to receive Professional Services at the time of the Member's office visit and/or admission to a hospital, unless such visit or admission is for Emergency services.

e. Office. Provider agrees that the Professional Services shall be rendered in an office/facility within the Service Area where there is sufficient support staff to enable Provider to provide the Professional Services. Provider shall ensure that the office/facility professionals and support staff are duly licensed or otherwise qualified as required by law. If Provider's office is relocated or expands to additional offices, Provider shall notify District at least thirty (30) days prior to such relocation or expansion and shall have any new location approved by District before providing Professional Services to Members at such location(s).

f. Other Changes to Practice. Provider agrees to notify District in writing within ten (10) days of any change affecting practice including, without limitation, a change in Provider's tax identification number, of any Participating Provider leaving the Provider's practice, and of a telephone number change with respect to Provider.

g. Other Notification. Provider agrees to provide the District with sixty days (60) prior written notice that it will not be available to new Members.

h. Specialty Care Provider Responsibilities. If Exhibit B. II indicates that Provider is designated a Specialty Care Provider, then Provider shall provide Professional Services to a Member upon receiving a Referral from the responsible Primary Care Provider to treat the Member (including authorization for diagnostic services). Failure to document receipt of the Referral may result in non-payment for the Professional Services provided to the Member. Notwithstanding anything to the contrary herein, a Specialty Care Provider is not obligated to obtain a Referral from a Primary Care Provider for Professional Services rendered to a Member pursuant to an Emergency.

i. Formulary. Provider shall only prescribe to Members those medications that are listed in District's formulary in District's Provider Handbook. Any exceptions or substitutions must be pre-approved by District.

j. Preauthorization of Referrals. Provider shall seek preauthorization from District's utilization management department prior to making Referrals to any other provider of health care services, unless such preauthorization is not required pursuant to District's Provider Handbook or other District policies or procedures.

Notwithstanding anything in this Agreement to the contrary, Provider shall not require preauthorization for a Referral pursuant to an Emergency.

k. Requirement for Referrals. Provider shall furnish complete information on treatment, procedures, and diagnostic tests performed by the Participating Provider prior to a Referral and shall refer or admit Members to only those health care providers who are Participating Providers, except in cases of Emergency.

l. Protocols and Providers. Provider shall comply with all District protocols as established or as modified by District, relating to the utilization management and the provision of Covered Services to Members, including, but not limited to, protocols related to hospital admissions, lengths-of-stay, or usage of services, and Referrals to Specialty Care Providers and other Participating Providers.

m. Quality Care. Provider shall ensure that the quality of health care services provided to Members is consistent with applicable laws, regulations, the prevailing standard of medical care, and District's quality program.

n. Monitoring of Services. In the event that Provider's medical practice includes the rendering of medical services to Members through employed or contracted health care providers, within the limitations prescribed in this Agreement and specifically Section 3 hereunder, Provider shall appropriately monitor such Professional Services to ensure the quality and appropriateness of such Professional Services.

2. Licensure, Standing and Insurance

a. Licensure, Warranties and Representations. Provider represents and warrants to District that during the term of this Agreement, Provider, and each of its employees, agents, and/or independent contractors authorized to provide Professional Services hereunder, shall (i) maintain an unrestricted license to practice medicine in the State of Florida; (ii) maintain in effect an unrestricted Drug Enforcement Agency (DEA) Controlled Substance Registration Certificate as required by federal, State, and local laws; and (iii) maintain admitting privileges or appropriate privileges for Provider's field of medicine with at least one Participating Hospital.

b. Evidence of Liability Coverage. Provider agrees to submit to District, upon execution of this Agreement, a Certificate of Insurance demonstrating the required insurance coverage(s) referenced in Section 2.c. hereunder. Further, throughout the term of this Agreement, Provider agrees to submit to District Certificates of Insurance whenever any policy of insurance is renewed, as well as written notice of any change in: (i) coverage; (ii) scope; or (iii) any other terms or provisions of such policies.

c. Liability Insurance. Provider agrees to maintain professional liability insurance coverage for each of its Participating Providers in the amount of at least $250,000 per occurrence and $750,000 in the aggregate, general liability coverage with limits

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of $1 million per occurrence and $3 million in the aggregate, and such other insurance as shall be necessary to insure Provider and its officers, agents, employees and/or independent contractors against any claim(s) for damages arising under this Agreement. Provider shall provide thirty (30) days prior written notice to the District in the event of cancellation, modification or termination of any such policy of insurance. Throughout the term of this Agreement, Provider shall provide District with written verification of the existence of such insurance policies or other coverage; undertake continuing education as required by the State of Florida; authorize District to make inquiries to and obtain the release of information from the National Practitioner Data Bank, state medical licensing bodies, the hospital(s) designated in Provider's Credentialing application, or any other entity having relevant information concerning Provider; and perform all obligations hereunder in accordance with all applicable local, state, and federal legal requirements, as well as all applicable standards of professional ethics and practice. Provider shall also carry Workers' Compensation Insurance as required by Florida law.

d. Tail Coverage. If Provider's professional liability insurance coverage for its Participating Providers is a claims-made policy and any Participating Provider is terminated by Provider, or the policy is terminated for any reason during the term of this Agreement, or upon cancellation or termination of this Agreement, Provider shall immediately purchase, at Provider's sole expense, "Tail" coverage that for at least four (4) years immediately following the termination of this Agreement will provide professional liability insurance coverage in amounts of at least $250,000 per occurrence, and $750,000 in the aggregate, for coverage in connection with Professional Services provided prior to termination of this Agreement. This provision shall survive termination of this Agreement.

e. Notice Requirement. Provider agrees to notify District, in writing, within one (1) business day, of the occurrence of any of the following: (i) any Participating Provider's license to practice or operate in the State of Florida or any other jurisdiction is under investigation (i.e., the issuance of a finding of probable cause), suspended, surrendered, revoked, terminated or is subject to terms of probation or other restrictions, or Provider's privileges, if applicable, at any hospital are modified, reduced, denied, restricted, suspended, revoked or otherwise terminated; (ii) Provider and/or any of its Participating Providers becomes a defendant in any malpractice action or is obligated to provide notice of a possible malpractice claim to his, her or its malpractice insurance carrier, or is required to pay damages in any such action by way of judgment or settlement; (iii) Provider and/or any of its Participating Providers is under investigation (i.e., the issuance of a finding of probable cause), disciplined or sanctioned by the Florida Board of Medicine, the Agency for Health Care Administration or any similar state or federal agency; (iv) Provider or any officer, representative, agent or employee thereof is indicted or convicted of a felony; (v) any Participating Provider becomes incapacitated such that the incapacity may interfere with patient care for thirty (30) substantially consecutive days; (vi) any material change in the nature or extent of services rendered by any Participating Provider; (vii) any material change or addition to the

information and disclosures submitted by Provider as part of its application for participation; (viii) any report filed on a Participating Provider with the National Practitioner Data Bank; (ix) any Participating Provider's exclusion under the United States Medicare or Medicaid Program or any other governmental program for any reason or any agent, officer or employee of Provider's becoming a "sanctioned person" under applicable Medicare or Medicaid laws; (x) any Participating Provider's authorization to prescribe or to administer controlled substances is modified, restricted, suspended, or revoked; or (xi) any other act, event, occurrence or the like which materially affects Provider's ability to carry out Provider's duties and obligations under this Agreement.

3. Program Participation

a. Complaints or Grievances. Provider agrees to ensure that any complaint or grievance that Provider receives from a Member regarding District, Participating Providers, or related support staff is reported to District's customer service department upon receipt. Provider agrees to cooperate with District in resolving any complaints or grievances made by a Member.

b. Credentialing and Joinder. Provider shall cause each of its Participating Providers to participate in and comply with District's credentialing and re-credentialing process and shall satisfy, throughout the term of this Agreement, all credentialing and recredentialing criteria established by the District. Any Provider or other health care professional that is or subsequently becomes associated with Provider during the term of this Agreement shall be credentialed prior to rendering any services to Members, and further shall be required to execute a joinder to this Agreement in the form attached as Exhibit B. II hereunder. Provider agrees to cause each Participating Provider to provide required documentary evidence of qualifications to District including, but not limited to, a completed application form and photocopies of licenses, permits, and certifications.

c. Policies and Procedures. Provider agrees, for itself and its Participating Providers, to abide by District's Benefit Plan, Utilization Management, Quality Management, Credentialing, Recredentialing, Peer Review Policies, and other policies and procedures including, without limitation, policies and procedures regarding the systems listed in Section IV. 1. of the Master Participating Provider Agreement, and as outlined in District's Provider Handbook or other information sent to the Provider by District. All such policies and procedures may be modified and/or amended by District at District's sole discretion and such modification and/or amendment shall become effective immediately upon notice to Provider. Provider shall cause its Participating Providers to participate in any internal or external, Quality Management, Utilization Management, Peer Review and grievance procedures established by District.

d. Participating Provider Directory. A copy of District's provider directory is updated monthly and is available online. This provider directory shall list, by name and

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specialty, those providers that are participating with District. In the event a health care provider is not in the provider directory, except in cases of Emergency, prior to referring a Member to such health care provider, Provider shall contact District's customer service department to verify such health care provider's status.

4. Non-Discrimination. Provider agrees, for itself and its Participating Providers, to not differentiate or discriminate in the treatment of Members as to the quality of services delivered because of race, sex, sexual orientation, age, religion, national origin, health status, or source of payment, and to observe, protect and promote the rights of Members as patients.

Exhibit B
TO MASTER PARTICPATING PROVIDER AGREEMENT

NON-HOSPITAL PROVIDER

ADDITIONAL TERMS AND PROVISIONS

II. PROFESSIONAL SERVICES

Provider is licensed to provide services in the State of Florida. Provider agrees to provide the following Professional Services to Members:

PROVIDER SPECIALTY	PROVIDER LOCATION(S)

(For additional specialties/locations please attach list)

JOINDER TO AGREEMENT

Reference is hereby made to that certain Participating Provider Agreement (the "Agreement"), effective as of __________________________ to which this Exhibit B. II is attached.

Provider Name (Please Print)	Designation (i.e. MD, DO,PA)	Provider Specialty	Signature	Date

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Exhibit B
TO MASTER PARTICIPATING PROVIDER AGREEMENT

NON-HOSPITAL PROVIDER

ADDITIONAL TERMS AND PROVISIONS

III. CLAIMS AND COMPENSATION

1. Provider Compensation. Subject to the limitations and restrictions set forth in accordance with industry standard billing guidelines, the Plan, Provider Handbook, and/or this Agreement, District shall compensate Provider for Professional Services rendered to Members in accordance with the compensation schedule in Exhibit B. IV. Provider agrees to accept, as payment in full, District's reimbursement for Professional Services rendered to a Member; provided, however, that nothing herein shall be construed to prohibit Provider from collecting or pursuing collections of District authorized Copayments, charges for non-Covered Services or payments from other Payors, pursuant to the provisions of Sections III. 3. and 5. herein. In no event shall Provider attempt to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, except for the collection of Member responsibility in accordance with the terms of the applicable District Benefit Plan.

2. Claims Submission. Provider shall promptly submit claims to District for Covered Services rendered to Members. All claims shall be submitted in a form acceptable to and approved by District and shall include any and all medical records pertaining to the claim as requested by District or otherwise required by District's policies and procedures. Claims must be submitted by Provider to District within six (6) months after the following have occurred: discharge for Inpatient services or the date of service of service for outpatient services; and Provider has been furnished with the correct name and address of District member.

3. Co-payments and Deductibles. Provider is solely responsible for collection of co-payments and deductibles, if any, and is further required to demand payment of same by Members.

4. Determination of Covered Services. District will provide a schedule of Covered Services in the Provider Handbook and will notify Provider of any amendments or modifications to such schedule. Provider acknowledges and agrees that Provider has an independent responsibility to provide health care services to the Members and that no provision in this Agreement, and no action by District pursuant to the Utilization Management program or otherwise, in any way relieves Provider of its responsibility to provide appropriate medical care to Members.

5. Non-Covered Services. Provider shall not, either directly or indirectly, bill, charge, or seek compensation from Members for Covered Services rendered; provided, however, that

nothing herein shall be construed to prohibit Provider from (i) collecting or pursuing collection authorized Copayments; (ii) charging Members for non-Covered Services; or (iii) seeking payment from other Payors, as authorized. Prior to providing or charging a Member for non-Covered Services, Provider shall: (i) inform the Member in writing in advance that the services to be provided are not Covered Services; (ii) inform the Member in writing that District will not pay or be liable for such services; and (iii) inform the Member in writing that if Provider is seeking compensation for such services, the Member shall be financially liable for such services. In the event Provider does not fully comply with items (i)-(iii) of Section III. 5. of this Exhibit, Provider agrees that the Member shall not be liable to Provider for such non-Covered Services. Provider further agrees that this Section III. 5. of this Exhibit shall survive the termination of this Agreement regardless of the cause giving rise to termination.

6. <u>Coordination of Benefits; Recoveries from Third Parties.</u> Provider acknowledges and agrees that District is the Payor of last resort. To that end, if Provider has knowledge that a Member is eligible to receive health care benefits or reimbursement of any kind whatsoever, from a Payor other than District, Provider shall bill such other Payor(s) prior to submitting claims for the same services to District. Provider shall timely provide District with relevant information it has collected from Members regarding coordination of benefits. In any case where a Member is entitled to payment from a Payor other than District, for Professional Services provided pursuant to this Agreement, District will pay Provider for Covered Services that were not paid by the other Payor, provided that Provider is in compliance with all other terms of this Agreement. Further, such District payment to Provider shall not be made to the extent that such payment, when added to all other payments made to Provider for such services, exceeds one hundred percent (100%) of the amount agreed to be paid to Provider by District under this Agreement which amount shall be deemed to mean "one hundred percent (100%) of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment," as that phrase is used in the Florida Insurance Code, §627.4235, (sometimes known and referred to as "the C.O.B. rules"). This provision is subject to applicable federal and/or Florida law concerning coordination of health insurance benefits, including the Florida Insurance Code, §627.4235, and shall be modified to the extent necessary to enable the parties to comply with such law. Provider shall make a good faith effort to obtain information that may be helpful to District in coordinating such benefits, shall otherwise assist District in such coordination of benefits, and shall promptly refund any overpayments made by District to Provider pursuant to the foregoing provisions. Provider shall cooperate with District and other Payors in determining whether a Member's illness or injury is covered by auto insurance or other health insurance or otherwise gives rise to a claim by District by virtue of coordination of benefits or subrogation. Provider agrees to take any and all actions reasonable and necessary to assist District in obtaining recoveries from third parties, including, without limitation, by: (i) executing any and all documents that reasonably may be required to enable District to bill and/or collect payments from any third parties; (ii) assigning all rights to recovery and all payments to District; and (iii) assigning the rights to settle claims with third parties on behalf of Provider.

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7. Adjustments. Provider agrees to make any necessary adjustments, including refunds to District, as a result of the District's review of claims. In the event District determines that a claim has been overpaid, District may make a written request for repayment specifying the basis for the retroactive denial or overpayment within twelve months after the date that the payment was made, except that claims for overpayment may be sought beyond that time from providers convicted of fraud pursuant to section 817.234, Florida Statutes. District may, in accordance with applicable laws, adjust future payments to Provider to recoup any overpayment to Provider.

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Exhibit B
TO MASTER PARTICIPATING PROVIDER AGREEMENT

NON-HOSPITAL PROVIDER

ADDITIONAL TERMS AND PROVISIONS

IV. COMPENSATION RATES

1. Provider agrees to accept as payment in full for Covered Services rendered to Members during the Term of this Agreement the rates set out in the applicable Attachment(s) hereto, less any member expenses due from Members. Provider shall collect Copayments and any other member expenses directly from Members, and shall not waive, discount or rebate any such Copayments, unless such waiver is allowable under Applicable Law. District shall compensate Provider as follows:

   a. For a Professional Service for which the Medicare program has established a reimbursement rate, seventy percent (70%) of the adopted Medicare reimbursement rate; or

   b. For a Professional Service for which the Medicare program has not established a reimbursement rate and where Medicare has deemed the Professional Service is reimbursable, and for which District has established a reimbursement rate in District's schedule of usual and customary reimbursement rates ("District's Fee Schedule"), seventy percent (70%) of the reimbursement rate in District's Fee Schedule; or

   c. **Compensation for Physician Assistant and Advanced Practice Registered Nurse:** The District shall compensate a Physician Assistant (PA) and Advanced Practice Registered Nurse (APRN) for professional services rendered to District members at a rate of eight-five percent (85%) of the rate outlined above in Sections 1.a and 1.b respectively.

   d. Professional Services are reimbursed as outlined above and according to the reimbursement standards as outlined in the Provider Handbook.

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Exhibit B-1

TO MASTER PARTICIPATING PROVIDER AGREEMENT

NON-HOSPITAL PROVIDER (ASC)

ADDITIONAL TERMS AND PROVISIONS

I. FREESTANDING ASC OBLIGATIONS

1. Adjustments. Provider agrees to allow District to review paid claims for a period of one year after the date of service to determine if services were rendered in accordance with District's authorization and the terms of this Agreement. Provider agrees to make any necessary adjustments, including refunds to District, as a result of the review conducted by District.

2. Agreement. Provider agrees to abide by the terms and conditions of this Agreement and provide Professional Services to Members of the District.

3. Complaints or Grievances. Provider agrees to ensure that any complaint or grievance that Provider receives from a Member regarding Provider, District, any Participating Providers, or related support staff is directed to District's customer service department within ten (10) days of receipt. Provider agrees to cooperate with District in resolving any complaints or grievances that a Member has made.

4. Credentialing. Provider agrees to provide documentary evidence of qualifications to District by submitting a completed application form and photocopies of, but not limited to, required licenses, permits, and certifications. This Agreement shall only become effective once District has completed credentialing of the Provider and approved Provider's credentials. Provider shall submit, upon request by District, photocopies of all licenses, permits, certifications, and regulatory approvals that are required to be maintained by Provider, as well as all other information necessary for District to properly credential Provider.

5. Member Verification. Provider agrees to verify eligibility of a Member to receive coverage for Professional Services at the time of the Member's visit and/or admission to a hospital, unless such visit or admission is for Emergency services.

6. Non-Discrimination. Provider agrees not to differentiate or discriminate in the treatment of Members as to the quality of services delivered because of race, sex, sexual orientation, age, religion, national origin, health status, or source of payment, and to observe, protect and promote the rights of Members as patients.

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7. Notice Requirement. Provider agrees to notify District, in writing, within one (1) business day, of the occurrence of any of the following: (i) Provider's license to operate in the State of Florida or any other jurisdiction is under investigation, suspended; surrendered, revoked, terminated or is subject to terms of probation or other restrictions, (ii) Provider has become a defendant in any malpractice action or is obligated to provide notice of a possible malpractice claim to its malpractice insurance carrier, or is required to pay damages in any such action by way of judgment or settlement; (iii) Provider is under investigation, disciplined or sanctioned by the Agency for Health Care Administration or any similar agency; (iv) Provider or any officer, representative, agent or employee thereof is indicted or convicted of a felony; (v) any material change in the nature or extent of services rendered by Provider; (vi) any material change in or addition to the information and disclosures submitted by Provider as part of its application for participation; (viii) Provider's exclusion under the United States Medicare or Medicaid Program or any other governmental program for any reason or any agent, officer or employee of Provider becoming a "sanctioned person" under applicable Medicare or Medicaid laws; (ix) any other act, event, occurrence or the like which materially affects Provider's ability to carry out the Provider's duties and obligations under this Agreement.

8. Policies and Procedures. Provider agrees to abide by District's Benefit Plan, Utilization Management, Quality Management, Credentialing, Recredentialing, and Peer Review Policies, and other policies and procedures including, without limitation, policies and procedures with reference to the items listed in Section IV. 1. (a) – (d) of the Master Participating Provider Agreement, and as outlined in District's Provider Handbook or such other information made available to the Provider by District. All such policies and procedures may be modified and/or amended by District at District's sole discretion and shall become effective immediately upon notice to Provider.

9. Evidence of Liability Coverage. Provider agrees to submit to District, upon execution hereof, a copy of all insurance policies referenced in Section 10 hereunder. Further, throughout this Agreement, Provider agrees to submit to District written notice of any change in: (i) coverage; (ii) scope; or (iii) any other terms or provisions of such policies.

10. Warranties and Representations. Provider represents and warrants to District that during the term of this Agreement, Provider, and each of its employees, agents, and/or independent contractors providing Professional Services hereunder, shall (i) maintain all licenses required by law to operate and/or practice in the State of Florida; (ii) meet the conditions for hospital participation for the Medicare Program (Title XVIII of the Social Security Act) and the Medicaid program (Title XIX of the Social Security Act); (iii) remain accredited, as applicable, by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association, or the Commission on Accreditation for Rehabilitation Facilities; (iv) maintain professional malpractice insurance in the amount of at least $1,000,000 per occurrence and $5,000,000 aggregate, general liability insurance as required by the District, and such other insurance as shall be necessary to insure Provider and its officers, agents, employees and/or independent contractors against any claim(s) for damages arising under this Agreement; and (v) comply with all applicable local, state, and federal legal requirements, as well as all

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applicable standards and professional ethics and practice. Provider shall provide thirty (30) days written notice to the District prior to cancellation, modification or termination of any such policy of insurance. Throughout the Term, Provider shall provide District with written verification of the existence of such insurance policies or other coverage.

11. Tail Coverage. If Provider's professional malpractice insurance coverage is a claims-made policy and the policy is terminated for any reason during any Term or in the event of cancellation or termination of this Agreement, Provider shall immediately purchase, at Provider's sole expense, "Tail" coverage or other mutually agreed upon coverage that for at least four (4) years immediately following the termination of this Agreement will provide malpractice insurance coverage in an amount of at least $1,000,000 per occurrence, and $5,000,000 in the aggregate, for coverage in connection with Professional Services provided prior to termination of this Agreement. This provision shall survive termination of this Agreement.

12. ASC Services. Provider agrees to provide Professional Services to Members twenty-four (24) hours a day, seven (7) days per week, as necessary, in accordance with generally accepted standards of practice and hospital management in the community.

13. Preauthorization of Referrals. Provider shall obtain pre-authorization prior to making any referrals of the District Members to another provider, except in cases of Emergency.

14. Participating Providers. Provider shall furnish complete information on treatment, procedures, and diagnostic tests performed prior to a Referral and shall refer or admit Members to only those health care providers who are Participating Providers with District, except in cases of Emergency.

15. Protocols and Providers. Provider shall comply with all District protocols as established or modified by District, relating to the efficient use of resources and the provision of Professional Services to Members.

16. Quality Care. Provider shall ensure that health care services provided to Members are of a quality that is consistent with accepted medical, surgical and hospital practices.

Exhibit B-1

TO MASTER PARTICIPATING PROVIDER AGREEMENT

NON-HOSPITAL PROVIDER (ASC)

ADDITIONAL TERMS AND PROVISIONS

II. ASC SERVICES

Provider shall provide the following services in a freestanding ASC

Select all that apply:

ENT
Gastroenterological
Opthalmological
Orthopedic
Pain Management
Plastic & Reconstructive
Podiatric
Urological
Other:

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Exhibit B-1

TO MASTER PARTICIPATING PROVIDER AGREEMENT

NON-HOSPITAL PROVIDER (ASC)

ADDITIONAL TERMS AND PROVISIONS

III. COMPENSATION.

1. Freestanding ASC Facility Fee Rates. District shall compensate Provider for Professional Services rendered to Members in accordance with the compensation schedule in Exhibit B-1, IV. Provider agrees to accept as payment in full for Covered Services rendered to Members during the term of this Agreement the rates set out in the applicable Attachment(s) hereto, less any Member expenses due from Members. Provider shall collect Copayments and any other Member expenses directly from Members, and shall not waive, discount or rebate any such Copayments, unless such waiver is allowable under Applicable Law. In no event shall Provider attempt to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, except for the collection of Member responsibility in accordance with the terms of the applicable District Benefit Plan.

2. Coordination of Benefits.Provider acknowledges and agrees that District is the Payor of last resport. To that end, if Provider has knowledge that a Member is eligible to receive health care benefits or reimbursement of any kind whatsoever, from a Payor other than District, Provider shall bill such other Payor(s) prior to submitting claims for the same services to District. Provider shall timely provide District with relevant information it has collected from Members regarding coordination of benefits. In any case where a Member is entitled to payment from a Payor other than District, for Professional Services provided pursuant to this Agreement, District will pay Provider for Covered Services that were not paid by the other Payor, provided that Provider is in compliance with all other terms of this Agreement. Further, such District payment to Provider shall not be made to the extent that such payment, when added to all other payments made to Provider for such services, exceeds one hundred percent (100%) of the amount agreed to be paid to Provider by District under this Agreement which amount shall be deemed to mean "one hundred percent (100%) of the total reasonable expenses actually incurred of the type of expense within the benefits described in the policies and presented to the insurer for payment," as that phrase is used in the Florida Insurance Code, §627.4235, (sometimes known and referred to as "the C.O.B. rules"). This provision is subject to applicable federal and/or Florida law concerning coordination of health insurance benefits, including the Florida Insurance Code, §627.4235, and shall be modified to the extent necessary to enable the parties to comply with such law. In no event shall Provider attempt to bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against any Member, except for the collection of Member responsibility in accordance with the terms of the applicable District Benefit Plan. Provider shall make a good faith effort to obtain information that may be helpful to

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District in coordinating such benefits, shall otherwise assist District in such coordination of benefits, and shall promptly refund any overpayments made by District to Provider pursuant to the foregoing provisions. Provider shall cooperate with District and other Payors in determining whether a Member's illness or injury is covered by auto insurance or other health insurance or otherwise gives rise to a claim by District by virtue of coordination of benefits or subrogation. Provider agrees to take any and all actions reasonable and necessary to assist District in obtaining recoveries from third parties, including, without limitation, by: (i) executing any and all documents that reasonably may be required to enable District to bill and/or collect payments from any third parties; (ii) assigning all rights to recovery and all payments to District; and (iii) assigning the rights to settle claims with third parties on behalf of Provider.

3. Billing Procedures. Provider shall submit claims for payment for Professional Services on a CMS 1500 claim form or UB-92 form, as applicable, within one hundred and eighty (180) days of the date such services are rendered and shall abide by the claims/billing procedures outlined in the Provider Handbook. Claims received after this one hundred and eighty (180) day period may be denied for payment. In submitting claims for reimbursement, Provider shall provide the Member's name, date of birth, financial classification, status and dates of services.

4. Collections of Copayments. Provider shall collect Copayments from Members as stipulated in the Benefit Plan.

5. Determination of Covered Services. Covered services shall be outlined on the District's website. Provider acknowledges that Provider has an independent responsibility to provide health care services to the Members and that neither any provision of this Agreement, nor any action by District pursuant to the Utilization Management program, in any way absolves Provider of the responsibility to provide appropriate medical care to Members.

6. Non-Covered Services. Provider shall not, either directly or indirectly, bill, charge, or seek compensation from Members for Covered Services rendered; provided, however, that nothing herein shall be construed to prohibit Provider from collecting or pursuing collection of District authorized Copayments or charges for non-Covered Services or seeking payment from other Payors. Prior to providing non-Covered Services to a Member, Provider shall: (i) inform the Member that the services to be provided are not Covered Services; (ii) inform the Member that District will not pay or be liable for such services; (iii) inform the Members that if Provider is seeking compensation for such services, the Member shall be financially liable for such services; and (iv) provide to the Member the form agreement on Exhibit C hereto and obtain such agreement, once fully executed, from the Member. In the event Provider does not fully comply with items (i)-(iv) of this Section 6, the Member shall not be liable to Provider for such non-Covered Services. Provider further agrees that this Section 6 shall survive the termination of this Agreement regardless of the cause giving rise to termination.

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7. Pre-Condition of Reimbursement. In addition to other restrictions and limitations hereunder on compensation to Provider, Provider shall only receive compensation for Professional Services provided to a Member if such Member received such Professional Services pursuant to a Referral from a Participating Provider, except that Provider shall be reimbursed for Professional Services provided to a Member pursuant to an Emergency.

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Exhibit B-1

TO MASTER PARTICIPATING PROVIDER AGREEMENT

NON-HOSPITAL PROVIDER (ASC)

ADDITIONAL TERMS AND PROVISIONS

IV. ASC RATES

Freestanding ASC Facility Rate: [ ] of Medicare ASC Rate

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Exhibit C

ACKNOWLEDGEMENT OF DISCLOSURE AND ACCEPTANCE OF MEMBER FINANCIAL RESPONSIBILITY

____
Name of Member (the "Member")

The Member or the Member's legal representative hereby acknowledges that he or she has been informed that the following health care services to be provided to the Member have not been approved for payment under the Member's health benefit program. Accordingly, the undersigned agrees that the Member or Member's legal representative, and not the applicable health benefit program, will bear full financial responsibility for payment of all charges for these services.

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____

____

Date: ______________________________________

____
Signature of Member or Member's Legal Representative

Witness: ____________________________

Print Name: __________________________

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Exhibit D

BUSINESS ASSOCIATE AGREEMENT

This **Business Associate Agreement ("BAA")** is entered into by and between the Health Care District of Palm Beach County, together with all of its divisions and subsidiaries ("Covered Entity"), and[name of vendor or provider], ("Business Associate"). The terms of this BAA are effective as of the date of the last signature ("Effective Date").

RECITALS

Pursuant to the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and Standards for the Privacy and Security of Individually Identifiable Health Information, found at 45 C.F.R. Parts 160, 162 and 164, Covered Entity is required to protect certain individually identifiable health information ("Protected Health Information", or "PHI");

Covered Entity is also required to protect PHI that is in an electronic format ("Electronic Protected Health Information" or "EPHI");

Pursuant to the provisions of the Health Information Technology for Economic and Clinical Health Act (the "HITECH Act"), Covered Entity is required to comply with additional privacy and security obligations, as well as obligations related to the breach of unsecured PHI or EPHI;

In order to protect the privacy and security of PHI, including EPHI, created or maintained by or on behalf of Covered Entity, HIPAA requires Covered Entity to enter into "business associate agreements" with certain individuals and entities providing services for or on behalf of the Covered Entity if such services require the use or disclosure of PHI or EPHI ("Business Associates");

Covered Entity and Business Associate have entered into, or are entering into, or may subsequently enter into, agreements or other documented arrangements (collectively, the "Business Arrangements") which require or may require Business Associate to access, create, receive, use, disclose, or maintain PHI and/or EPHI on behalf of Covered Entity;

Covered Entity and Business Associate desire to enter into this BAA to enable both parties to comply with HIPAA, the HITECH Act and other applicable law.

The Parties for good and valuable consideration agree as follows:

1. **Incorporation of Recitals.** The foregoing Recitals are true and correct and are adopted and incorporated herein by reference.

2. **Definitions.** The following terms used in this agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health

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Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

2.1 Covered Entity – Shall mean the Health Care District of Palm Beach County together with all of its divisions and subsidiaries.

2.2 Business Associate – Shall mean [name of vendor or provider].

2.3 Business Arrangements – Shall mean documented arrangements by and between Covered Entity and Business Associate whereby Business Associate will access, create, receive, use, disclose, or maintain PHI and/or EPHI on behalf of Covered Entity.

2.4 HIPAA Rules – Shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 C.F.R. Parts 160, and 164.

2.5 HITECH Act – Shall mean the Health Information Technology for Economic and Clinical Health Act.

2.6 HHS – Shall mean the United States Department of Health and Human Services.

2.7 Any terms used, but not otherwise defined, in this BAA shall have the same meaning as those terms have under HIPAA and the HITECH Act.

3. **Purpose.** Covered Entity and Business Associate have entered into certain Business Arrangements whereby Business Associate may access, create, receive, use, disclose, or maintain PHI and/or EPHI on behalf of Covered Entity. Such Business Arrangements shall be conducted in a manner that ensures the privacy and security of PHI and EPHI in accordance with HIPAA, the HITECH Act and with all applicable federal and state laws and regulations.

4. **Term and Termination.**

4.1 The term of this BAA shall commence the earlier of the Effective Date of this BAA or the date upon which Business Associate first accessed, created, received, used, disclosed, or maintained PHI on behalf of Covered Entity.

4.2 Covered Entity, at its sole discretion, may immediately terminate this BAA upon the occurrence of the any of the following:

i. Business Associate's breach of any material obligation under this BAA or the Covered Entity may alternatively give the Business Associate (5) days verbal notice prior to written notice requiring the Business Associate to cure the privacy breach within thirty (30) days. Failure to cure the privacy breach within the designated timeframe is grounds for the immediate termination of this Agreement.

ii. A violation of any provision of HIPAA, the HITECH Act, or applicable federal and/or state law or regulation relating to the privacy and security of PHI.

4.3 Upon the termination of all Business Arrangements, either party may terminate this BAA by providing written notice to the other party.

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4.4 Upon termination of this BAA for any reason, Business Associate agrees either to return to Covered Entity by secure method of return or to destroy all PHI received from Covered Entity in a secure method or otherwise through the performance of services for Covered Entity, that is in the possession or control of Business Associate or its agents. The destruction should be accompanied by certification of secure destruction. In the case of PHI which is not feasible to "return or destroy," Business Associate shall extend the protections of this BAA to such PHI and limit further uses and disclosures of such PHI to those purposes that make the return or destruction infeasible, for so long as Business Associate maintains such PHI. Business Associate further agrees to comply with HIPAA, the HITECH Act and other applicable state or federal law, which may require a specific period of retention, redaction, or other treatment of such PHI.

5. **Use or Disclosure of Protected Health Information**. Except as otherwise required by law, Business Associate shall not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by the Covered Entity. Furthermore, Business Associate shall use or disclose PHI (i) solely for the benefit of Covered Entity and only for the purpose of performing services, including data aggregation services, for Covered Entity as such services are defined in the Business Arrangements between Covered Entity and Business Associate, (ii) as necessary for the proper management and administration of Business Associate to carry out its legal responsibilities, provided that such uses are permitted under federal and state law.

5.1 Identify Research projects conducted by Business Associate, third parties for which PHI may be relevant, obtain on behalf of Covered Entity documentation of individual authorizations or an Institutional Review Board or a Privacy Board waiver that meets the requirements of 45 C.F.R. §164.512(i)(1) (each an "Authorization" or "Waiver") related to such projects, provide Covered Entity with copies of such Authorizations or Waivers, subject to confidentiality obligations ("Required Documentation"); and disclose PHI for such Research.

5.2 Make PHI available for reviews preparatory to Research and obtain and maintain written representations in accordance with 45 C.F.R. §164.512(i)(1)(ii) that the requested PHI is sought solely as necessary to prepare a Research protocol or for similar purposes preparatory to Research, that the PHI is necessary for the Research, and that no PHI will be removed in the course of the review. Use the PHI to create a Limited Data Set in compliance with 45 C.F.R. 164.514(e) for Research, Health Care Operations or Public Health purposes.

6. Business Associate agrees that all disclosures of PHI shall be the minimum necessary to accomplish the intended purpose of the disclosure and consistent with the Covered Entity's minimum necessary policies and procedures. Except to the extent necessary to perform its obligations under the Business Arrangements, Business Associate may not de-identify PHI received from, or created on behalf of, Covered Entity without the express written authorization of Covered Entity.

7. **Appropriate Safeguards.** Business Associate will use appropriate safeguards to prevent use or disclosure of PHI other than as expressly provided by this BAA. Business Associate will

implement administrative, physical and technical safeguards that reasonably protect the confidentiality, integrity and availability of the PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Business Associate acknowledges and agrees that the Business Associate will comply with 45 C.F.R. §§ 164.308, 164.310, 164.312 and 164.316 to the same extent as if it were a Covered Entity. To the extent feasible, Business Associate will use commercially reasonable efforts to ensure that the technology safeguards used by Business Associate to secure PHI will render such PHI unusable, unreadable and indecipherable to individuals that are not authorized to acquire or have access to such PHI. Such technology safeguards should meet or exceed security guidance issued by HHS.

8. **Reporting of Improper Use or Disclosure.** Business Associate agrees that it shall report to the Covered Entity any use or disclosure of PHI not provided for by this BAA as required at 45 CFR 164.410. Such report shall be made within five (5) business days of discovery. Further, Business Associate shall report any successful "security incident" of which it becomes aware within five (5) business days of discovery. In addition to Business Associates obligations under Section 7, Business Associate agrees to mitigate to the extent practical any harmful effect that is known to Business Associate and is a result of a use or disclosure of PHI by Business Associate in violation of this BAA.

9. **Data Breach Notification and Mitigation.**

9.1 Business Associate agrees to implement reasonable systems for the discovery and prompt reporting of any "breach" of "unsecured PHI" as those terms are defined by 45 C.F.R. § 164.402 or any "breach" of unencrypted "personal information" as those terms are defined by § 501.171, F.S. (collectively referred to as a "HIPAA Breach"). Business Associate will, following the discovery of a HIPAA Breach, notify Covered Entity immediately and in no event later than three (3) business days after Business Associate discovers such HIPAA Breach, unless Business Associate is prevented from doing so by 45 C.F.R. § 164.412 concerning law enforcement investigations. For purposes of reporting a HIPAA Breach to Covered Entity, the discovery of a HIPAA Breach shall occur as of the first day on which such HIPAA Breach is known to the Business Associate or, by exercising reasonable diligence, would have been known to the Business Associate. No later than seven (7) business days following a HIPAA Breach, Business Associate shall provide Covered Entity with sufficient information to permit Covered Entity to comply with the HIPAA Breach notification requirements set forth at 45 C.F.R. § 164.400 *et seq* as well as the notification requirements of § 501.171, F.S. Following a HIPAA Breach, Business Associate will have a continuing duty to inform Covered Entity of new information learned by Business Associate regarding the HIPAA Breach.

9. **Sub-Contractors and Agents.** In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the Business Associate agree to the same restrictions, conditions, and requirements that apply to the Business Associate with respect to such information. Business Associate agrees that anytime PHI is provided or made available to any sub-contractors or agents, Business Associate must obtain satisfactory written assurances from the sub-contractor or agent that contains the same terms, conditions and restrictions on the use and disclosure of PHI as contained in this BAA.

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10. **Right of Access to Designated Record Sets.** If the Business Associate maintains any PHI that is part of the "Designated Record Set" as that term is defined under HIPAA, the Business Associate shall make such PHI available, for inspection and copying, to an individual as required under 45 C.F.R. 164.524. Prior to providing access, but within the time frame specified in 45 C.F.R. 164.524, the Business Associate shall notify the Covered Entity of the request for access and ascertain if there are any legitimate reasons that access should not be granted.

11. **Amendment and Incorporation of Amendments.** If the Business Associate maintains any PHI that is part of the "Designated Record Set" as that term is defined under HIPAA, the Business Associate shall make such PHI available for amendment as required under 45 C.F.R. 164.526 and shall, within ten (10) days, provide Covered Entity with a copy of the Amendment. Prior to allowing the amendment, Business Associate shall notify the Covered Entity of the request to amend and ascertain if there are any legitimate objections to the amendment. In the event that Covered Entity accepts an amendment to the Designated Record Set, Business Associate agrees to incorporate any amendments to PHI in accordance with 45. C.F.R. 164.526.

12. **Accounting of Disclosures.** At the request of Covered Entity, Business Associate shall make available all information required for Covered Entity to provide an accounting of disclosures of PHI with respect to an individual requesting such accounting in accordance with 45 C.F.R. §164.528, as amended by Section 13405(c) of the HITECH Act and any related regulations or guidance in accordance with such provision. Business Associate shall provide the Covered Entity such information necessary to provide an accounting within thirty (30) days of the Covered Entity's request or such shorter time as may be required by state or federal law. Such accounting obligations shall survive termination of this BAA and shall continue as long as Business Associate maintains PHI. In the event that Business Associate receives a request for an accounting it shall notify Covered Entity within five (5) business days of receipt of such request.

13. **Records and Audit.** If Business Associate receives a request, made by or on behalf of HHS, requiring Business Associate to make available its internal practices, books, and records relating to the use and disclosure of the PHI to HHS for the purpose of determining the compliance of Covered Entity with HIPAA, then Business Associate shall promptly notify Covered Entity that Business Associate has received such a request. Business Associate shall make its books and records relating to the use and disclosure of PHI by Covered Entity available to HHS and its authorized representatives for purposes of determining the compliance of Covered Entity with HIPAA.

14. **Interpretation.** An ambiguity in this BAA shall be resolved in favor of a meaning that permits Covered Entity and Business Associate to comply with HIPAA, the HITECH Act and other applicable law.

15. **Regulatory References.** A reference in this BAA to a section of HIPAA or the HITECH Act shall mean the section as currently in effect or as amended.

16. **Amendment.** Covered Entity and Business Associate agree that amendment of this BAA may be required to ensure that both parties are in compliance with HIPAA, the HITECH and/or other applicable federal or state law.

17. **Governing Law.** This BAA shall be governed by the laws of Florida.

18. **Binding Nature and Assignment.** This BAA shall be binding on the Parties hereto and their successors and assigns, but neither Party may assign this BAA without the prior written consent of the other, which consent shall not be unreasonably withheld.

19. **Notices.** Whenever under this BAA one party is required to give notice to the other, such notice shall be deemed to have been given if in writing and sent by (i) personal delivery; (ii) certified or registered mail, return receipt requested; (iii) overnight delivery service with proof of delivery or facsimile with return facsimile acknowledging receipt to the address listed below:

COVERED ENTITY
Health Care District of Palm Beach County
1515 N Flagler Drive, Suite 101
West Palm Beach, FL 33401

BUSINESS ASSOCIATE
____
____
____

Either Party may at any time change its address for notification purposes by providing the other party written notice stating the change and setting forth the new address.

20. **Entire Agreement.** This BAA consists of this document, and constitutes the entire agreement between the Parties. There are no understandings or agreements relating to this BAA which are not fully expressed in this BAA and no change, waiver or discharge of obligations arising under this BAA shall be valid unless in writing and executed by the Party against whom such change, waiver or discharge is sought to be enforced.

21. **Counterparts.** This BAA may be executed in one or more counterparts, each of which shall be deemed an original.

22. **Third Party Beneficiaries.** Nothing in this BAA shall be considered or construed as conferring any right or benefit on a person not a party to this BAA nor imposing any obligations on either Party hereto to persons not a party to this BAA.

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IN WITNESS WHEREOF, BUSINESS ASSOCIATE and COVERED ENTITY have executed this BAA on the date set forth below.

BUSINESS ASSOCIATE
[name of vendor or provider]

By:__________________________________

Name:________________________________

Title:_________________________________

Date:_________________________________

COVERED ENTITY
HEALTH CARE DISTRICT OF PALM BEACH COUNTY

By:__________________________________
General Counsel
Date: ________________________________

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APPENDIX 8 – PUBLIC HEARING NOTICE

HEALTH CARE DISTRICT OF PALM BEACH COUNTY TRAUMA PLAN PUBLIC HEARING MEETING SCHEDULE FOR June 2021

A Public Hearing to receive public comments on the Trauma Agency five year plan update for Palm Beach County will be held on:

June 29, 2021, 2:00 PM (immediately following Good Health Foundation Board meeting

Location: 1515 N. Flagler Drive, Suite 101, West Palm Beach, FL, 33401, and conducted remotely as a Zoom webinar, open to the public in person or via Zoom link:

https://zoom.us/j/5507895592?pwd=REZ4TWtYUXowQWNpWTBaVXRsZ1dDQT09

Via Telephone dial-in access:

(646) 558-8656 / Meeting ID: 550 789 5592 / Password: 946503

Meeting agenda will be posted on the District's website, **hcdpbc.org,** once prepared.

In accordance with Section 286.0105, Florida Statutes, should any person seek to appeal any decision made by the Health Care District of Palm Beach County Board of Commissioners with respect to any matter considered at this meeting(s), such person will need to ensure that a verbatim record of the proceedings is made, which record includes the testimony and evidence upon which the appeal is to be based.

In accordance with the Americans with Disabilities Act of 1990, any person needing special accommodations to participate in this meeting(s) must advise the District at least three (3) business days before the meeting by contacting Heidi Bromley at (561) 804-5968 or via email at **hbromley@hcdpbc.org.** Any persons who are deaf, hard of hearing, deaf/blind or speech disabled should contact the District using the Florida Relay service by dialing 7-1-1.
5-22/2021

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