November 25, 2019

NOTICE

The Kaweah Delta Health Care District Board of Directors will meet in an Audit and Compliance Committee meeting at 2:00 PM on Tuesday, December 03, 2019 in the Kaweah Delta Medical Center – Acequia Wing – Executive Office Conference Room {400 W. Mineral King, Visalia}.

The Board of Directors of the Kaweah Delta Health Care District will meet in a Closed Audit and Compliance Committee meeting immediately following the 2:00 PM meeting on Tuesday, December 03, 2019 in the Kaweah Delta Medical Center – Executive Office - Acequia Wing Conference Room {400 W. Mineral King, Visalia} pursuant to Government Code 54956.9(d)(2).

All Kaweah Delta Health Care District regular board meeting and committee meeting notices and agendas are posted 72 hours prior to meetings in the Kaweah Delta Medical Center, Mineral King Wing entry corridor between the Mineral King lobby and the Emergency Department waiting room.

The disclosable public records related to agendas are available for public inspection at the Kaweah Delta Medical Center – Acequia Wing, Executive Offices (Administration Department) {1st floor}, 400 West Mineral King Avenue, Visalia, CA and on the Kaweah Delta Health Care District web page http://www.kaweahdelta.org.

KAWEAH DELTA HEALTH CARE DISTRICT
Nevin House, Secretary/Treasurer

Cindy Moccio

Cindy Moccio
Board Clerk
Executive Assistant to CEO

DISTRIBUTION:
Governing Board
Legal Counsel
Executive Team
Chief of Staff
http://www.kaweahdelta.org/about/agenda.asp

KAWEAH DELTA HEALTH CARE DISTRICT BOARD OF DIRECTORS
AUDIT AND COMPLIANCE COMMITTEE

Tuesday, December 03, 2019

Kaweah Delta Medical Center – Acequia Wing
400 West Mineral King Avenue, Visalia CA
Executive Office Conference Room

ATTENDING: Directors; Herb Hawkins (Chair) & Lynn Havard Mirviss; Gary Herbst, CEO; Tom Rayner, Senior VP Chief Operating Officer; Malinda Tupper, VP Chief Financial Officer; Regina Sawyer, VP Chief Nursing Officer; Dennis Lynch, Legal Counsel; Ben Cripps, Compliance and Privacy Officer; Suzy Plummer, Director of Internal Audit; Sravan Sharma, Compliance Manager; Lisa Wass, Compliance Analyst

GUESTS: Jennifer Stockton, Director of Finance; Brian Conner, Moss Adams; Abigail Pike, Moss Adams

OPEN MEETING – 2:00 PM

Call to order – Herb Hawkins, Audit and Compliance Committee Chair

Public / Medical Staff participation – Members of the public wishing to address the Committee concerning items not on the agenda and within the subject matter jurisdiction of the Committee may step forward and are requested to identify themselves at this time. Members of the public or the medical staff may comment on agenda items after the item has been discussed by the Committee but before a Committee recommendation is decided. In either case, each speaker will be allowed five minutes.

1. **401K Audit Results –** *Brian Conner, Moss Adams*
2. **Written Reports** – Committee review and discussion of written reports
   - 2.1 Compliance Program Activity Report – *Ben Cripps*
   - 2.2 Annual Cash Audits – *Suzy Plummer*
   - 2.3 Compliance Policies for Review and Approval – *Ben Cripps*
     - A. CP.03 Physician Contracts and Relationships
     - B. CP.13 Federal and State False Claims Act and Employee Protection Provisions
3. **Verbal Reports**
   - 3.1 Compliance Program – Provide an update on the status of Compliance Program activity – *Ben Cripps*

3.2 Internal Audit Update – Provide an update on the status of Internal Audit activity – *Suzy Plummer*

4. **Approval of Closed Meeting Agenda** – Kaweah Delta Medical Center Acequia Wing – Executive Office Conference Room – immediately following the open meeting
   - Conference with Legal Counsel – Anticipated Litigation
     Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (11 cases) – *Ben Cripps and Dennis Lynch (Legal Counsel)*

Adjourn Open Meeting – Herb Hawkins*, Audit and Compliance Committee Chair*

CLOSED MEETING – Immediately following the 2:30 PM open meeting
Call to order – *Herb Hawkins, Audit and Compliance Committee Chair*

1. **Conference with Legal Counsel - Anticipated Litigation -** Significant exposure to litigation pursuant to Government Code 54956.9(d)(2) (11 cases) – *Ben Cripps and Dennis Lynch (Legal Counsel)*

Adjourn – *Herb Hawkins, Audit and Compliance Committee Chair*

In compliance with the Americans with Disabilities Act, if you need special assistance to participate at this meeting, please contact the Board Clerk (559) 624-2330. Notification 48 hours prior to the meeting will enable the District to make reasonable arrangements to ensure accessibility to the Kaweah Delta Health Care District Board of Directors meeting.

Report Of Independent Auditors and
Financial Statements with Supplementary Information

Kaweah Delta Health Care District
Employees' Salary Deferral Plan

December 31, 2018 and 2017

Table of Contents

Report of Independent Auditors

To the Plan Administrator of
Kaweah Delta Health Care District Employees' Salary Deferral Plan

Report on the Financial Statements

We have audited the accompanying financial statements of Kaweah Delta Health Care District Employees' Salary Deferral Plan (the Plan), which comprise the statements of fiduciary net position as of December 31, 2018 and 2017, and the related statement of changes in fiduciary net position for the year ended December 31, 2018, and the related notes to the financial statements.

Management's Responsibility for the Financial Statements

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

Auditor's Responsibility

Our responsibility is to express an opinion on these financial statements based on our audit. We conducted our audit in accordance with auditing standards generally accepted in the United States of America. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's judgment including the assessment of the risks of material misstatement of the financial statements, whether due to fraud or error. In making those risk assessments, the auditor considers internal control relevant to the Plan's preparation and fair presentation of the financial statements in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the Plan's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the fiduciary net position of the Plan as of December 31, 2018 and 2017, and the changes in fiduciary net position for the year ended December 31, 2018, in accordance with accounting principles generally accepted in the United States of America.

Other Matter - Supplementary Information

Our audits were conducted for the purpose of forming an opinion on the financial statements as a whole. The schedule of assets as of December 31, 2018, is presented for the purpose of additional analysis and is not a required part of the financial statements. Such information is the responsibility of the Plan's management and was derived from and relates directly to the underlying accounting and other records used to prepare the financial statements. The information has been subjected to the auditing procedures applied in the audit of the financial statements and certain additional procedures, including comparing and reconciling such information directly to the underlying accounting and other records used to prepare the financial statements or to the financial statements themselves, and other additional procedures in accordance with auditing standards generally accepted in the United States of America. In our opinion, the information is fairly stated in all material respects in relation to the financial statements taken as a whole.

Other Matter – Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the Management's Discussion and Analysis on pages 4 to 7 be presented to supplement the basic financial statements. Such information, although not a part of the basic financial statements, is required by the Governmental Accounting Standards Board who considers it to be an essential part of financial reporting for placing the basic financial statements in an appropriate operational, economic, or historical context. We have applied certain limited procedures to the required supplementary information in accordance with auditing standards generally accepted in the United States of America, which consisted of inquiries of management about the methods of preparing the information and comparing the information for consistency with management's responses to our inquiries, the basic financial statements, and other knowledge we obtained during our audit of the basic financial statements. We do not express an opinion or provide any assurance on the information because the limited procedures do not provide us with sufficient evidence to express or provide any assurance.

Stockton, California
_____, 2019

Management Discussion and Analysis

Kaweah Delta Health Care District's (the "District") discussion and analysis of the financial activities of the Kaweah Delta Health Care District Employees' Salary Deferral Plan (the "Plan") is designed to assist the reader in focusing on significant financial issues, provide an overview of the Plan's financial activity, and identify changes in the Plan's financial position for the years ended December 31, 2018 and 2017. Please read it in conjunction with the audited financial statements and supplementary information in this report.

Financial Highlights

- Fiduciary net position totaled $212.9 million at December 31, 2018, an increase of $10.4 million, or 5.1%, from December 31, 2017. Fiduciary net position increased by $36.3 million, or 21.8%, to $202.5 million at December 31, 2017 from December 31, 2016.

- The increase to the Plan's 2018 net assets of $10.4 million consists of total Plan additions of $19.3 million, offset by total Plan deductions of $8.9 million. The increase in the Plan's 2017 net assets of $36.3 million consists of total Plan additions of $45.0 million, as offset by total Plan deductions of $8.7 million. Total plan additions include employee and employer contributions, interest and dividends, appreciation or depreciation in the fair value of investments and investment expenses. Total Plan deductions include benefits paid to participants and administrative expenses. Total Plan additions decreased in 2018 from 2017 due mainly to the investment performance of the Plan assets in 2018.

- Benefits paid to participants, which include amounts directly paid to participants and/or beneficiaries (including direct rollovers), certain deemed distributions of participant loans and other distributions, totaled $8.9 million at December 31, 2018, for an increase of $164,000, or 1.9%, from December 31, 2017. The increase in benefits paid to participants was partially attributable to the number of distributions made to long-term participant retirees.

The Plan continues to retain an investment consultant to identify opportunities to improve investment returns. The consultant performs plan design review, investment research, investment performance evaluation and other related services.

Overview of the Financial Statements – The following Management's Discussion and Analysis is intended to serve as an introduction to the Plan's financial statements. The basic financial statements are:

- Statements of fiduciary net position

- Statement of changes in fiduciary net position

- Notes to financial statements

This report also contains supplemental information to the basic financial statements which provides a schedule of assets held at year end.

The basic financial statements contained in this report are described below:

- Statements of fiduciary net position is a point in time snapshot of account balances at year-end. It reports the assets available for future payments to participants, and any current liabilities that are owed as of the statement date. The resulting net position value [assets less liabilities equals the net assets] represents the value of net assets held in trust for pension benefits.

- Statement of changes in fiduciary net position displays the effect of Plan fund transactions that occurred during the Plan year [additions less deductions equals the net increase (decrease) in fiduciary net position]. This net increase (decrease) in fiduciary net position reflects the change in the net assets value of Plan net position from the prior year to the current year. Both statements are in compliance with Governmental Accounting Standards Board (GASB) pronouncements.

- Notes to financial statements are an integral part of the financial statements and provide additional information that is essential for a comprehensive understanding of the data provided in the financial statements. These notes describe the accounting and administrative policies under which the Plan operates, and provide additional levels of detail for selected financial statement items.

Financial Analysis

The condensed Plan statements of fiduciary net position as compared to prior years are as follows (in thousands):

	Years Ended December 31,		
	2018	2017	2016
ASSETS			
Investments	$ 199,453	$ 191,348	$ 155,742
Receivables	13,473	11,170	10,485
TOTAL ASSETS	212,926	202,518	166,227
LIABILITIES	-	-	-
NET POSITION AVAILABLE FOR BENEFITS	**$ 212,926**	**$ 202,518**	**$ 166,227**

The condensed statements of changes in the Plan's fiduciary net position as compared to prior year are as follows (in thousands):

	December 31, 2018	December 31, 2017
ADDITIONS TO NET ASSETS ATTRIBUTED TO		
Investment (loss) income	$ (5,838)	$ 23,227
Interest income on notes receivable from participants	271	258
Contributions		
Participant	14,946	12,512
Employer	8,654	6,993
Rollovers	1,314	2,037
Contributions	24,914	21,542
Total additions	19,347	45,027
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO		
Benefits paid to participants	8,907	8,743
Administrative expenses	32	(7)
Total deductions	8,939	8,736
CHANGE IN NET POSITION	10,408	36,291
NET POSITION AVAILABLE FOR BENEFITS		
Beginning of year	202,518	166,227
End of year	$ 212,926	$ 202,518

Fiduciary Net Position increased $10.4 million, or 5.1%, in 2018. This increase is attributable to contributions net of benefits paid, offset by negative market conditions generating an overall investment loss. Net position available for benefits increased $36.3 million, or 21.8%, in 2017. This increase is attributable to contributions net of benefits paid, with overall investment income from positive market conditions in the investment market.

Investment (loss) income The Plan had an investment loss of $5.8 million in 2018 compared to investment income of $23.2 million in 2017. The stock market is the principal investment forum utilized by the Plan for participant-directed investments and market performance has a considerable impact on investment returns. The 2018 investment losses reflected the significant decline in equity markets in late 2018, while the 2017 market returns were moderate to strong. With the help of the Plan's investment consultant, investment performance continues to be carefully monitored and fund replacements are made, when appropriate.

Participant Contributions continued to follow an upward trend with an increase in employee deferrals of $2.4 million, or 19.5%, in 2018 from 2017 levels. The increase is attributable to an increase in participation rate of 1%, to 60% in 2018 from 59% in 2017, as well as an increase in average deferral percent of 7.1% in 2018 as compared to 6.8% in 2017.

Employer Contributions increased $1.7 million, or 23.8%, in 2018 from 2017 levels. The increase is primarily attributable to a 34.1% increase in participants with an excess of 11 years of service in 2018 as compared to 2017, which is matched at the higher rates allowed under the Plan.

Benefits Paid to Participants and Beneficiaries increased slightly in 2018 over 2017, continuing an upward trend due, in part, to long-term participant retirees.

Contacting the Plan

Questions concerning any of the information provided in this report or requests for additional financial information should be addressed to:

Kaweah Delta Health Care District Employees' Retirement Plan
Attn: Dianne Cox, VP of Human Resource
400 W. Mineral King Avenue
Visalia, California 93291

Financial Statements

Kaweah Delta Health Care District Employees' Salary Deferral Plan
Statements of Fiduciary Net Position
December 31, 2018 and 2017 (in thousands)

	2018	2017
ASSETS		
Investments		
Mutual funds	$ 140,875	$ 137,989
Self-directed brokerage accounts	971	545
Other	704	772
Investments at fair value	142,550	139,306
Group fixed annuity contract, at contract value	56,903	52,042
Total investments	199,453	191,348
Receivables		
Notes receivable from participants	4,616	3,903
Employer contributions	8,857	7,267
Total Receivables	13,473	11,170
TOTAL ASSETS	212,926	202,518
FIDUCIARY NET POSITION	$ 212,926	$ 202,518

See accompanying notes.

Kaweah Delta Health Care District Employees' Salary Deferral Plan
Statement of Changes in Fiduciary Net Position
Year Ended December 31, 2018 (in thousands)

ADDITIONS TO NET ASSETS ATTRIBUTED TO		
Investment loss		
Net depreciation in fair value of investments	$	(15,081)
Interest		1,625
Dividends		7,886
		(5,570)
Less investment expenses		(268)
Net investment loss		(5,838)
Interest income on notes receivable from participants		271
Contributions		
Participant		14,946
Employer		8,654
Rollovers		1,314
		24,914
Total additions		19,347
DEDUCTIONS FROM NET ASSETS ATTRIBUTED TO		
Benefits paid to participants		8,907
Administrative expenses		32
Total deductions		8,939
CHANGE IN FIDUCIARY NET POSITION		10,408
FIDUCIARY NET POSITION		
Beginning of year		202,518
End of year	$	212,926

See accompanying notes.

NOTE 1 – DESCRIPTION OF PLAN

The following description of the Kaweah Delta Health Care District Employees' Salary Deferral Plan (the Plan) provides only general information. Participants should refer to the Plan Agreement, as amended, for a more complete description of Plan provisions.

General – The Plan, established July 1, 1984, is a single employer 401(k) salary deferral defined contribution plan covering substantially all employees of Kaweah Delta Health Care District (the District). The District is the Plan's sponsor and serves as plan administrator. The Plan is not subject to the provisions of the Employee Retirement Income Security Act of 1974 (ERISA) as the District is a governmental agency. At December 31, 2018, the Plan covered 2,904 active participants.

Eligibility – There is no minimum age or service requirement for participation in the Plan. If an employee elects to participate in the Plan, the date of entry is the first day of the payroll period. Participants must complete at least 1,000 hours of service during the Plan year, and be employed as of the last day of the Plan year, to be eligible to receive any employer paid match contributions.

Contributions

Participant contributions – Each year, participants may defer any amount of pretax annual compensation, as defined in the Plan, up to regulatory limits. Participants can change or terminate a deferral election on a prospective basis as of each payroll period. Participants who have attained age 50 before the end of the Plan year are eligible to make catch-up contributions. Participants may also contribute amounts representing distributions from other qualified defined benefit or defined contribution plans, as defined in the Plan.

Employer match contributions – The District may elect to make discretionary matching contributions to the Plan. The employer match is based on the Plan year and includes defined compensation earned during the entire plan year even while an individual is not a participant in the Plan. The District matches 100% of employee contributions, up to the percentage of eligible compensation deferred to the Plan based upon years of service as shown in the below table:

Years of Service	Tiered match formula
Less than 1	0%
1-2	100% up to 3% of Plan Compensation
3-5	100% up to 4% of Plan Compensation
6-10	100% up to 5% of Plan Compensation
11 or more	100% up to 6% of Plan Compensation

Employer other contribution – The District may elect to make a discretionary employer contribution to the Plan, limited to eligibility of the CEO position. There was no contribution of this type in 2018.

Participant accounts – Each participant's account is credited with the participant's contributions and District discretionary contributions, if any, and Plan earnings or losses. Plan earnings and losses are allocated based on participant investment choices. Participant accounts are charged with an allocation of administrative expenses that are paid by the Plan, or based on specific participant transactions as defined. The benefit to which a participant is entitled is the benefit that can be provided from the participant's vested account. Participants direct the investment of their account into various investment options offered by the Plan.

Vesting – Participants are vested immediately in their contributions plus actual earnings thereon. Vesting in the District's contribution portion of their accounts is based on years of continuous service. A participant is fully vested after five years of credited service or in the event of death. For participants with a break in service, only vesting service earned after the participant's reemployment commencement date shall be counted when determining the participant's vested percentage. (See Note 10 for subsequent amendment). The District has included prior service with certain predecessor employers.

Notes receivable from participants – Under the terms of the Plan agreement, loans are provided under a separate written loan policy. Loans are initiated through the Lincoln Alliance program only and serviced by Lincoln Retirement Services Company, LLC (LRSC). Participants may borrow a minimum of $1,000 from their deferral and rollover accounts. The loans are secured by the balance in the participant's account. Participants may have a maximum of two (2) loans with a minimum payment period of thirty-six (36) months. Non-residential loans have a maximum payment period of five (5) years and residential loans have a maximum payment period of twenty (20) years. Under the terms of the loan policy, a participant with an outstanding loan may suspend loan payments for up to twelve (12) months for any period during which the participant is on an unpaid leave of absence, or on paid leave of absence if the participant's rate of pay during the paid leave of absence is less than the loan repayment amount. The interest rate on plan loans is based on the quarterly prime interest plus by one percent (1%). As of December 31, 2018, the rates of interest on outstanding loans ranged from 4.25% - 7.0% with various maturities through August 2038.

Payment of benefits – On termination of service or death, disability, or retirement, a participant may elect to receive either a lump-sum amount equal to the value of the participant's vested interest in his or her account, a partial lump-sum, or installments over a specified period not to exceed the life or life expectancy of the participant and a designated beneficiary. A participant who terminates employment with a vested interest in his or her account of $5,000 or less will receive an involuntary lump-sum distribution; absent an election by the participant, the Plan will make the distribution as an automatic rollover to an individual retirement account. Participants are allowed to receive in-service distributions for financial hardship, attainment of age 59-1/2 or if a qualified reservist, subject to a $1,000 minimum, as defined in the Plan.

Forfeitures – Forfeitures are the non-vested portion of a participant's account that is lost upon termination of employment. Forfeitures are retained in the Plan and may be used by the District to reduce the matching contribution or pay administrative fees. The amount of unallocated forfeitures as of December 31, 2018 and 2017 amounted to $112,750 and $218,321, respectively. For the year ended December 31, 2018, District matching contributions were reduced by $203,183 from forfeited non-vested accounts and $30,846 was used for payment of administrative expenses.

NOTE 2 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Basis of accounting – The financial statements have been prepared in accordance with accounting principles generally accepted in the United States of America as applied to governmental units, using the accrual method of accounting. The Governmental Accounting Standards Board (GASB) is the accepted standard setting body for establishing governmental accounting and financial reporting principles.

Use of estimates – The preparation of financial statements in conformity with generally accepted accounting principles requires the use of estimates and assumptions that may affect certain amounts and disclosures. Accordingly, actual results could differ from those estimates.

Investment valuation – Investments of the Plan are reported at fair value, except for the group fixed annuity contract, which is s reported at contract value.

Fair value is the price that would be received to sell an asset or paid to transfer a liability (the "exit price") in an orderly transaction between market participants at the measurement date. See Note 4 for discussion of fair value measurements.

The group fixed annuity contract is valued at contract value as a cost-based measurement, as the contract is substantially non-participating. Contract value is the amount participants normally would receive if they were to initiate permitted transactions under the terms of the Plan. See Note 5.

Income recognition – Purchases and sales of securities are recorded on a trade-date basis. Dividends are recorded on the ex-dividend date. Interest income is recorded on the accrual basis. The net appreciation or depreciation in fair value of investments consists of both the realized gains and losses and unrealized appreciation and depreciation of those investments.

Notes receivable from participants – Notes receivable from participants are measured at amortized cost, which represents unpaid principal balance plus accrued but unpaid interest. Delinquent notes receivable from participants are reclassified as distributions. No allowance for credit losses has been recorded as of December 31, 2018 or 2017.

Payment of benefits – Benefits are recorded when paid.

Expenses – Certain expenses of maintaining the Plan are paid directly by the District and are excluded from these financial statements. Fees related to the administration of notes receivable from participants are charged directly to the participant's account and are included in administrative expenses. Investment related expenses are included in net appreciation or depreciation in fair value of investments.

Revenue sharing – The Plan has a revenue sharing arrangement with its recordkeeper, LRSC, in which certain revenue earned by LRSC from the Plan investments, is used to offset LRSC recordkeeping expenses and the excess revenue is allocated to participants. Total revenue sharing in 2018 was $_____ and is netted in administrative expenses on the statement of changes in fiduciary net position.

NOTE 3 – INVESTMENTS

Investment securities are exposed to various risks that can affect the value of the Plan investments such as custodial credit risk, foreign currency risk interest rate risk, credit risk, and concentration risk.

Custodial credit risk – Custodial credit risk is the risk that in the event of a failure by the counterparty, the Plan will not be able to recover the value of its investments that are in the possession of an outside party. The Plan policies do not specifically address custodial credit risk, but all the Plan's investments are insured or registered, or held by the Plan or its agent in the Plan's name.

Foreign currency risk – Foreign currency risk is the risk that changes in exchange rates will adversely impact the fair value of an investment denominated in a foreign currency. The Plan's foreign currency risk exposure resides within the international mutual fund holdings. The Plan does not hold any direct investments or instruments denominated in a foreign currency.

Interest rate risk and credit risk– The Plan does not hold any direct investments in fixed income securities.

Concentration risk – Investments representing 5% or more of total investments consist of the following as of December 31 (in thousands):

	2018	2017
Mutual funds		
MFS® Growth Fund Class R6	$ 24,382	$ 26,730
Invesco Diversified Dividend Fund Class R6	$ 14,783	$ 17,218
PGIM Total Return Bond Fund Class R6	$ 15,150	$ 13,155
American Funds Fundamental Investors® Class R6	$ 10,046	$ 11,240
American Funds EuroPacific Growth Fund® Class R6	*	$ 15,151
Group fixed annuity contract		
Lincoln National Life Insurance Co	$ 56,903	$ 52,042
Self-directed brokerage accounts	*	*
Other	*	*

* Balance not 5% or more of total investments at year-end.

The Plan has an investment policy statement that provides guidance for selection, monitoring and evaluation of the investment options for the Plan. The policy is designed to provide flexibility for participants to make prudent investment decisions based on their individual needs, in order to address the various types of investment risk described above.

NOTE 4 – FAIR VALUE MEASUREMENTS

The framework for measuring fair value provides a hierarchy that prioritizes the inputs to valuation techniques used to measure fair value. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1) and the lowest priority to unobservable inputs (Level 3).

The three levels of the fair value hierarchy are described as follows:

Level 1 – Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities the plan has the ability to access.

Level 2 – Inputs to the valuation methodology include quoted prices for similar assets or liabilities in active markets; quoted prices for identical or similar assets or liabilities in inactive markets; inputs other than quoted prices that are observable for the asset or liability; and inputs that are derived principally from or corroborated by observable market data by correlation or other means. If the asset or liability has a specified (contractual) term, the Level 2 input must be observable for substantially the full term of the asset or liability.

Level 3 – Inputs to the valuation methodology are unobservable and significant to the fair value measurement.

The asset or liability's fair value measurement level within the fair value hierarchy is based on the lowest level of any input that is significant to the fair value measurement. Valuation techniques maximize the use of relevant observable inputs and minimize the use of unobservable inputs.

Following is a description of the valuation techniques used for assets measured at fair value. There have been no changes in the techniques used at December 31, 2018 and 2017.

Mutual funds (registered investment companies) – Valued at the daily closing price as reported by the fund. These funds are required to publish their daily net asset value (NAV) and to transact at that price. The funds held by the Plan are deemed to be actively traded. Mutual funds held by the Plan are open-end mutual funds that are registered with the U.S. Securities and Exchange Commission.

Self-directed brokerage accounts – Accounts primarily consist of mutual funds or common stocks that are valued on the basis of readily determinable market prices.

The valuation methods used by the Plan may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Furthermore, although the Plan believes its valuation methods are appropriate and consistent with other market participants, the use of different methodologies or assumptions to determine the fair value of certain financial instruments could result in a different fair value measurement at the reporting date.

The following table discloses the fair value hierarchy of the Plan's assets by level as of December 31, 2018 and 2017 (in thousands):

	Fair Value Measurement at December 31, 2018			
	Level 1	Level 2	Level 3	Total
Mutual funds	$ 140,875	$ -	$ -	$ 140,875
Self-directed brokerage accounts	971	-	-	971
Other	704	-	-	704
Total assets in the fair value hierarchy	$ 142,550	$ -	$ -	$ 142,550

	Fair Value Measurement at December 31, 2017			
	Level 1	Level 2	Level 3	Total
Mutual funds	$ 137,989	$ -	$ -	$ 137,989
Self-directed brokerage accounts	545	-	-	545
Other	772	-	-	772
Total assets in the fair value hierarchy	$ 139,306	$ -	$ -	$ 139,306

NOTE 5 – GROUP FIXED ANNUITY CONTRACT WITH INSURANCE COMPANY

In 2003, the Plan entered into an unallocated group fixed annuity contract with Lincoln National Life Insurance Co. (Lincoln). Lincoln maintains the contributions in its general account. The account is credited with earnings on the accumulated balance and charged for participant withdrawals and administrative expenses. The contract issuer is contractually obligated to repay the principal and a specified interest rate that is guaranteed to the Plan. The crediting rate is established by the contract issuer but may not be less than 3%. The crediting rate is declared quarterly; contributions received in any quarter will earn interest at the declared rate for that quarter and the next three quarters. When contributions are beyond the initial four-quarter period, they will earn interest at a portfolio rate each quarter established by the contract issuer.

The contract is reported at contract value by Lincoln. Contract value is the amount received by participants if they were to initiate permitted transactions under the terms of the Plan. Contract value, as reported to the Plan by Lincoln, represents contributions made under the contract, plus earnings, less participant withdrawals and administrative expenses. Participants may ordinarily direct the withdrawal or transfer of all or a portion of their investment at contract value; there is a 20% restriction on the amount that can be transferred from this investment option in a 12-month period.

The Plan's ability to receive amounts due is dependent on the issuer's ability to meet its financial obligations, which may be affected by future economic and regulatory developments.

The contract does not permit Lincoln to terminate the agreement except if the Plan fails to qualify as exempt under the tax code. Lincoln may prohibit new participants under the contract if Lincoln discontinues offering this type of contract. The Plan can elect to discontinue the contract with a 3 month written notice. Upon contract discontinuance, amounts may be withdrawn subject to a market value adjustment or according to a withdrawal schedule over 5 years with defined adjustments to the interest rate over that period. No events are probable of occurring that might limit the Plan's ability to transact at contract value with the contract issuer and that also would limit the ability of the Plan to transact at contract value with the participants.

NOTE 6 – TAX STATUS

The Plan document is a volume submitter governmental defined contribution plan that received a favorable opinion letter from the Internal Revenue Service on March 31, 2014, which stated that the plan, as then designed, was in accordance with applicable sections of the Internal Revenue Code (IRC). Although the Plan has been amended since the date of the opinion letter, the Plan administrator believes that the Plan is designed and is currently being operated in compliance with the applicable requirements of the IRC.

NOTE 7 – RISKS AND UNCERTAINTIES

The Plan invests in various investment securities. Investment securities are exposed to various risks, such as interest rate, market volatility, and credit risks. It is reasonably possible, given the level of risk associated with investment securities, that changes in the values of the investments in the near term could materially affect a participant's account balance and the amounts reported in the statement of fiduciary net position.

NOTE 8 – PLAN TERMINATION

Although it has not expressed any intent to do so, the District, by duly adopted resolution, has the right to terminate the Plan and discontinue its contributions at any time. If the Plan is terminated, amounts allocated to a participant's account become fully vested.

NOTE 9 – SUBSEQUENT EVENTS

The Plan was amended effective January 1, 2019 to modify years of service with respect to breaks in service for vesting. Employees employed on or after January 1, 2019 will be credited with vesting years of service earned from their employment commencement date.

The Plan was amended effective January 1, 2020 to change the definition of eligible compensation for the employer match contribution, to remove the $1,000 minimum on in-service distributions, and to remove any loan requirements and the six-month suspension of deferrals for hardship withdrawals.

Supplementary Information

Kaweah Delta Health Care District Employees' Salary Deferral Plan
Schedule of Assets
December 31, 2018 (in thousands)

Identity of Issue, Borrower, Lessor, or Similar Party	Description of Investment, Including Maturity Date, Rate of Interest, Collateral, Par, or Maturity Value	Current Value
Oppenheimer Developing Markets Fund Class Y	Mutual fund	$ 4,292
American Funds EuroPacific Growth Fund® Class R6	Mutual fund	8,869
American Funds Fundamental Investors® Class R6	Mutual fund	10,046
Janus Henderson Triton Fund Class I	Mutual fund	4,506
American Funds American Balanced Fund® Class R6	Mutual fund	2,390
PIMCO StocksPLUS® Small Fund Institutional Class	Mutual fund	683
PIMCO Income Fund Institutional Class	Mutual fund	5,924
JPMorgan Small Cap Value Fund Class R6	Mutual fund	2,493
MFS® Growth Fund Class R6	Mutual fund	24,382
Invesco Diversified Dividend Fund Class R6	Mutual fund	14,783
PGIM Total Return Bond Fund Class R6	Mutual fund	15,150
PIMCO StocksPLUS® Absolute Return Fund Institutional Class	Mutual fund	5,270
PIMCO StocksPLUS® International Fund (Unhedged) Institutional Class	Mutual fund	2,973
American Century Mid Cap Value Fund R6 Class	Mutual fund	5,963
Janus Henderson Enterprise Fund Class N	Mutual fund	5,781
Fidelity® 500 Index Fund	Mutual fund	7,379
Fidelity® Mid Cap Index Fund	Mutual fund	1,882
Fidelity® Small Cap Index Fund	Mutual fund	1,265
Fidelity® U.S. Bond Index Fund	Mutual fund	4,580
Fidelity® Inflation-Protected Bond Index Fund	Mutual fund	4,135
Fidelity® International Index Fund	Mutual fund	3,073
Fidelity® Real Estate Index Fund	Mutual fund	5,056
Total mutual funds		140,875
TD Ameritrade Brokerage Account	Mutual fund	971
Lincoln National Life Insurance Co	Group Fixed Annuity Contract	56,903
Other (Multi-Fund accounts)		704
Total investments		199,453
Participant loans	Interest rates range from 4.25% to 7.0%, maturing through August 2038	4,616
		$ 204,069

COMPLIANCE PROGRAM ACTIVITY REPORT – Open Meeting
Ben Cripps, Compliance and Privacy Officer
August 2019 through October 2019

EDUCATION

Live Presentations by Compliance Department –

- Compliance and Patient Privacy – New Hire Orientation
- Compliance and Patient Privacy – Information System Services – Applications and MD Support
- Compliance and Patient Privacy – Management Orientation
- Compliance Investigations – Patient Financial Services

Written Communications sent from Compliance Department –

- Privacy Matters Article – What is Snooping – Bulletin Board / All Staff Communication
- Compliance Matters Article – Doing the Right Thing – Bulletin Board / All Staff Communication
- Compliance Matters Article – The False Claims Act– Bulletin Board / All Staff Communication

PREVENTION AND DETECTION

- **California Department of Public Health (CDPH) All Facility Letters (AFL)** – Review and distribute AFL's to areas potentially affected by regulatory changes; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk
- **Medicare and Medi-Cal Monthly Bulletins** – Review and distribute bulletins to areas potentially affected by the regulatory change; department responses reviewed and tracked to address the regulatory change and identify potential current/future risk
- **Office of Inspector General (OIG) Monthly Audit Plan Updates** – Review and distribute OIG Audit Plan issues to areas potentially affected by audit issue; department responses reviewed and tracked to identify potential current/future risk
- **California State Senate and Assembly Bill Updates** – Review and distribute legislative updates to areas potentially affected by new or changed bill; department responses reviewed and tracked to address regulatory change and identify potential current/future risk
- **Patient Privacy Walkthrough** – Monthly observations of privacy practices throughout Kaweah Delta; issues identified communicated to area Management for follow-up and education
- **KD HUB (Cerner)** – Participation in system enhancements and optimization and risk mitigation strategies
- **User Access Privacy Audits** – Daily monitoring of user access to identify potential privacy violations
- **Office of Inspector General (OIG) Exclusion Attestations** – Quarterly monitoring of department OIG Exclusion List review and attestations
- **Medicare PEPPER Report Analysis** – Quarterly review of Medicare Inpatient Rehabilitation, Hospice, Mental Health, and Acute Inpatient PEPPER statistical reports to identify outlier and/or areas of risk; evaluate with Kaweah Delta leadership quarterly at PEPPER Review meeting

- **Fair Market Value (FMV) Oversight** – Ongoing oversight and administration of physician payment rate setting and contracting activities including Physician Recruitment, Medical Directors, Call Contracts, and Exclusive and Non-Exclusive Provider Contracts
- **Medicare Recovery Audit Contractor (RAC) and Medicare Probe Audit Activity** – Records preparation, tracking, appeal timelines, and reporting
- **Licensing Applications** – Forms preparation and submission of licensing application to the California Department of Public Health; ongoing communication and follow-up regarding status of pending applications
- **Federally Qualified Health Center** – Participation in current and future state planning/working sessions; ongoing regulatory counsel and support, evaluating impact and identifying risk mitigation strategies; policy manual review in progress
- **KD Hub Non–Employee User Access** – Oversight and administration of non-employee user onboarding, privacy education, and user profile tracking; evaluate, document, and respond to requests for additional system access; on-going management of approximately 950 non-employee KD Hub users
- **Kaweah Delta Medical Foundation (KDMF) FairWarning User Access Implementation** – Oversight and administration of the FairWarning implementation at KDMF
- **Kaweah Delta Medical Foundation Compliance and Privacy Assessment** – Oversight, administration, and consultation; leading a comprehensive review and evaluation of Compliance and Privacy practices at KDMF; recommendations and policy/form revisions as appropriate
- **The Joint Commission Survey** – Participation in The Joint Commission Survey; Command Center oversight; gathering information, coordinating interviews, and follow-up as requested by the surveyors; scribe and Lead Surveyor Escort support
- **Palliative Care Physician and Nurse Practitioner Billing** – Research and consultation; clarification of billing regulations; facilitation and implementation of process to capture new revenue for Palliative Care Physician and Nurse Practitioner Inpatient Consultations
- **Senate Bill 1447** – Research and consultation; clarification of regulatory guidance concerning the applicability of Senate Bill 1447 to Kaweah Delta Skilled Nursing and Rehabilitation Pharmacy services; recommendation provided to Pharmacy Leadership concerning the licensing of Automated Drug Delivery System
- **Rural Health Clinic (RHC) Home Visits** – Research and consultation; researched regulatory guidance and evaluated billing processes for RHC Home visits; drafted communication outlining the billing and documentation requirements
- **Skilled Nursing Facility (SNF) Resident Assessment Instrument (RAI) Form** – Research and consultation; clarification of regulatory guidance concerning the applicability of new required language; recommendation provided to SNF Leadership, including revisions to the RAI to meet the intent of the regulatory change
- **Graduate Medical Education (GME) Rural Health Clinic (RHC) Mental Health Recording –** Research and consultation; researched regulatory guidance concerning privacy and consent requirements for recording Resident Mental Health visits; recommendation provided to GME and RHC Leadership; consent form and policy drafted for RHC/GME Leadership

- **Medicare Secondary Payor Questionnaire** – A review of forty-five (45) randomly selected encounters for February to August 2019 resulted in a 96% compliance rate for the completion of the Medicare Secondary Payer Questionnaire, a process currently managed by Patient Access. A system upgrade was implemented in October 2019 to further enhance the registrar's ability to provide complete and accurate information. Compliance will continue to monitor this issue and conduct future reviews.
- **Rural Health Clinic (RHC) Co-Signature Requirements –** All Lindsay RHC Physician Assistant (PA) notes for July and August 2019 were reviewed to evaluate Physician compliance with federal and state co-signature requirements. The review noted that 28% of PA notes contained a Provider co-signature; exceeding the statutory requirement of 10%.
- **Outpatient Nuclear Medicine Probe Audit** – Noridian (Medicare Claims Administrator) initiated a new pre-payment Targeted Probe and Educate (TPE) review of Nuclear Medicine claims. Kaweah Delta was selected for the review based on data analysis indicating increased utilization compared to the previous utilization period. Phase I commenced August 2019, focusing on Tomographic Imaging. The results of the review are pending.
- **Outpatient Physical Therapy Probe Audit** – Noridian (Medicare Claims Administrator) initiated a new pre-payment Targeted Probe and Educate (TPE) review of Outpatient Physical Therapy claims. Kaweah Delta was selected for the review based on data analysis indicating increased utilization compared to the previous utilization period. Phase I commenced October 2019, focusing on Therapeutic Exercise. The results of the review are pending.

Kaweah Delta Health Care District
Internal Audit Department
Cash Audit Annual Report
10/28/19

Overview:

The District maintains 46 cash drawers totaling $18,120.00 throughout the organization to support the collection of payments. Internal Audit is responsible to audit the funds that are not patient specific, as well as the two Patient Accounting drawers. Patient Accounting is responsible to audit the remaining drawers at least annually. Of the $18,120.00, drawers totaling $7,475.00 are maintained in a variety of areas to accept and make change for patient payments. The remaining $10,645.00 is maintained in other areas, including The Lifestyle Center, Health Information Management, Dietary, and the Retail Pharmacy to accept customer payments and to facilitate ongoing business operations. Funds are audited with results being communicated to Management. Should any issues or material discrepancies be identified, Internal Audit and Patient Accounting Management require Management in the affected area to develop an action plan to address the issues. Follow up is completed by Internal Audit or Patient Accounting to ensure that action plan was implemented. In addition, any time that Management reports missing balances from a cash fund, a joint investigation is completed by Internal Audit and Patient Accounting. As part of the investigation, appropriate staff members are interviewed, process walk throughs are completed and recommendations are made to Management for correction of the issue or issues identified.

Observations:

Variances of greater than five dollars were noted in two cash drawers. Management has been notified and corrective action has been taken to address and correct the variances, as well as to educate staff. When these drawers were re-audited no issues were identified.

We also noted that there is inconsistency on the party of Management in many areas to conduct random audits of cash drawers as outlined in the policy. Management has been reminded of this responsibility. New guidelines for monitoring and auditing of cash drawers in 2020 will be established and discussed with responsible parties.

Policy Number: CP.03	Date Created: 11/15/2019
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Compliance & Privacy Officer)	

Physician Contracts and Relationships

Purpose:

The purpose of this Policy and Procedure is to establish guidelines for the orderly processing of negotiating, documenting, and administering contracts between Kaweah Delta Health Care District ("Kaweah Delta") and physician(s) or physician groups. This policy must be followed prior to entering into any arrangement (i) in which Kaweah Delta engages physicians to provide services or space/items to Kaweah Delta, or (ii) in which Kaweah Delta provides any services, space, staff, equipment or items to physicians.

Policy:

It is the policy of Kaweah Delta to comply with all state and federal laws. Kaweah Delta shall execute contracts with physicians and physician groups ("physician(s)") that comply with all applicable laws and regulations, including those designed to prevent the provision of improper payments, inappropriate referrals, and/or inappropriate inducements to refer. To that end, Kaweah Delta will negotiate, document, and administer Agreements that comply with the following standards:

I. The Agreement shall be set out in writing and signed by all parties. The terms of the Agreements must be commercially reasonable.

II. The arrangement must be commercially reasonable, and the compensation under the arrangement must be set in advance, established at fair market value through an arms-length transaction, and must not take into account the volume or value of referrals for an item or service reimbursable by a state or federal program or other business generated between the parties.

III. All items and services covered by an Agreement with physician(s) must address a legitimate need of Kaweah Delta, must actually be provided by the physician(s), and must be specifically described in sufficient detail in the Agreement.

IV. The Agreement shall specify the compensation terms in sufficient and measurable detail.

V. The term of the Agreement shall be for not less than twelve (12) months, or longer than thirty-six (36) months unless approved by the Chief Executive

Officer (CEO) and Board in consultation with Legal Counsel and allowable under District Law. Contracts shall not automatically renew.

VI. The services performed under the Agreement shall not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

VII. All Agreements between Kaweah Delta and physician(s) for any purpose shall be prepared by, or in collaboration with, Kaweah Delta's Legal Counsel for signature by the parties**.**

VIII. Any payment to physician(s) shall be made only pursuant to an Agreement that has been formally executed between Kaweah Delta and the physician(s). Medical Director payments will be made only pursuant to approved time records submitted by the physicians. Likewise, payments to physician(s) will require documentation of availability and/or services rendered.

IX. Gifts and financial benefits to a physician or their office shall not exceed the annual physician non-monetary compensation threshold as established by the Federal Stark Law. Any gift or benefit provided to physician(s) or a physician's office must first be approved, documented, and tracked through the Medical Staff Office.

Procedure:

I. Fair Market Value (FMV) – State and federal law require a documented and objective determination that the payment between Kaweah Delta and physician(s) is consistent with FMV. Such determination may be evidenced by an approved vendor-written appraisal/valuation, an approved published third-party source, or as otherwise approved by Legal Counsel. The Compliance and Privacy Officer (CPO) (or designee) will oversee the management and administration of the FMV process.

The CPO (or designee) must be contacted before entering into negotiations of any physician Agreement to evaluate the FMV compensation needs. The negotiated rate must be reviewed and approved by the CPO (or designee) before Legal Counsel is engaged to draft or modify the Agreement. The FMV compensation process will be documented and administered in the following manner:

A. Medical Director Agreements – The Compliance Department will maintain an updated listing of all Medical Director positions by specialty and the corresponding FMV range. Vice President(s) (VP) (or designee) may negotiate rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CPO).

B. Recruitment Agreements – The Compliance Department will maintain a listing of physician recruitment needs by specialty and the corresponding FMV range. The Physician Recruitment Compensation Committee (VP of HR, KDHCD CMO, and KDMF CEO) will approve

the negotiated rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CPO).

C. Exclusive and Non-Exclusive Provider Agreements – The FMV rate must be established through an independent and external FMV assessment. The VP (or designee) will work with the CPO (or designee) to engage Legal Counsel and a third-party valuation firm. The CPO (or designee) will facilitate the Fair Market Valuation process to ensure the data and assumptions are documented and appropriate.

~~C.~~1. Changes to compensation terms and/or methodologies must be reviewed by the Executive Team and formally approved by the CPO and CEO. This provision and approval process applies to all Exclusive and Non-Exclusive ~~–~~Provider A~~a~~greements including ~~–~~new or potential agreements, contract renewals, and agreements that allow for compensation changes throughout the term of the agreement.

D. Space Lease Agreement - The VP (or designee) will work with the CPO (or designee) and Legal Counsel to establish the FMV rate. The Space Lease calculation must be reviewed by the CPO (or designee) and approved by Legal Counsel.

II. Medical Director Agreements

A. New and existing Medical Director Agreements shall be prepared and executed using the process outlined in Exhibit A.

B. The VP is responsible for ensuring the necessity of a Medical Director position and ensuring the physician satisfies any qualification or training requirements and provides required services.

C. Compliance will maintain a listing of Medical Director positions required by federal, state, or Joint Commission accreditation. Compliance must be contacted immediately of a statute, regulation, or other standard requiring a Medical Director position. If a new Medical Director position is not required, the VP must demonstrate the necessity and/or benefit to Kaweah Delta, and present the need to the Executive Team for review and approval.

D. Semi-Annually, Compliance will provide a listing of all Medical Director positions to the Executive Team for review and evaluation. Medical Director positions not required by federal, state, or Joint Commission accreditation will be reviewed by the Executive Team to evaluate and demonstrate the necessity and/or benefit to Kaweah Delta.

E. Monthly payments to Medical Directors must be supported by approved time records as follows:

1. Physician(s) must track time spent on activities/responsibilities outlined in the Agreement.

2. Physician(s) shall record activities by date in the electronic time record system. Physician(s) may use a method other than electronic to document and submit time records when approved by the responsible VP and by Finance Department.

3. Physician(s) time records submitted in any format must include an attestation statement signed by the physician(s) (electronic signature process is used in the electronic time record system).

4. The responsible VP (or designee) must review and approve time records and approve the payment amount to authorize payment. Evidence of such approval must include an original or electronic signature by the VP.

5. Upon receipt of the approved time record and payment amount, Accounts Payable will process the payment for the amount approved by the VP.

6. The responsible VP (or designee) will promptly meet with the Medical Director if they fail to (i) submit time records in a timely manner or (ii) provide services in the manner set forth in the Agreement. Recurring performance issues shall be immediately reported to the CPO.

III. New and existing and Exclusive and Non-Exclusive Physician Provider Agreements shall be prepared and executed using the processes outlined in Exhibits B, C, and D.

IV. Physician Lease of Space Agreements shall be negotiated by the responsible VP (or designee).

The proposed lease rate shall be at FMV.

1. Market analysis must be documented.
2. Rate must be reviewed by the CPO (or designee) and approved by Legal Counsel.

V. Physician Recruitment Agreements shall be negotiated by the Physician Recruiter or responsible VP (or designee) consistent with AP.126 – (AP126) Physician Recruitment Policy (v.2).

A. The terms of the Agreement shall follow current physician recruitment guidelines approved by the Board of Directors.

B. The proposed income guarantee shall be at FMV.

1. Market analysis must be documented.

2. Compensation arrangement must be approved by the CPO (or designee).

IV. Information on all signed Agreements will be maintained in the contract database (see AP.69 Requirement for Contracting with Outside Service Providers).

X. Modifications – In the event physician(s) requests any modifications to the Agreement language, the VP (or designee) shall forward the requests to

Legal Counsel for consideration. If the changes are agreeable, a modified Agreement or Addendum will be provided to the VP (or designee). If changes are not agreeable, Legal Counsel will provide explanations to the VP (or designee).

XI. Board Approval – Board Approval is required as described below:

A. Medical Director Agreements – New or established Medical Director Agreements do not require review and approval by the Board if the expense has been accounted for within the current fiscal budget.

B. Non-Exclusive Providers Agreements – New or established Non-Exclusive Provider Agreements do not require review and approval by the Board if the expense has been accounted for in the current fiscal year budget.

C. Exclusive Provider Agreements – All new or unbudgeted Exclusive Provider Agreements must be submitted to the Board of Directors for review and approval.

VI. Monitoring –

A. The Compliance and/or Internal Audit Departments may complete periodic audits of Medical Directors and Physician Providers Agreements.

B. Prior to the expiration of the Agreement, the VP (or designee) is required to evaluate position duties, requirements, and hours, and to solicit input from key stakeholders including Kaweah Delta staff and/or Medical Staff as appropriate.

VII. Gifts and other financial benefits given to a physician(s) or their office staff shall be recorded by the Medical Office.

A. Any employee/department must contact the Medical Staff Office prior to giving any gifts/financial benefit.

B. The Medical Staff Office must confirm that total financial benefits to the physician(s) and their office do not exceed the annual physician non-monetary compensation threshold for the current calendar year.

C. The Medical Staff Office will log the gift/financial benefit.

D. The value of a gift given to a group of physicians shall be divided and attributed to each physician equally.

Any violators may be subject to disciplinary action for violating Kaweah Delta policy.

"These guidelines, procedures, or policies herein do not represent the only medically or legally acceptable approach, but rather are presented with the recognition that acceptable approaches exist. Deviations under appropriate circumstances do not represent a breach of a medical standard of care. New knowledge, new techniques, clinical or research data, clinical experience, or clinical or bio-ethical circumstances may provide sound reasons for alternative approaches, even though they are not described in the document."

EXHIBIT A

MEDICAL DIRECTOR CONTRACT CHECKLIST

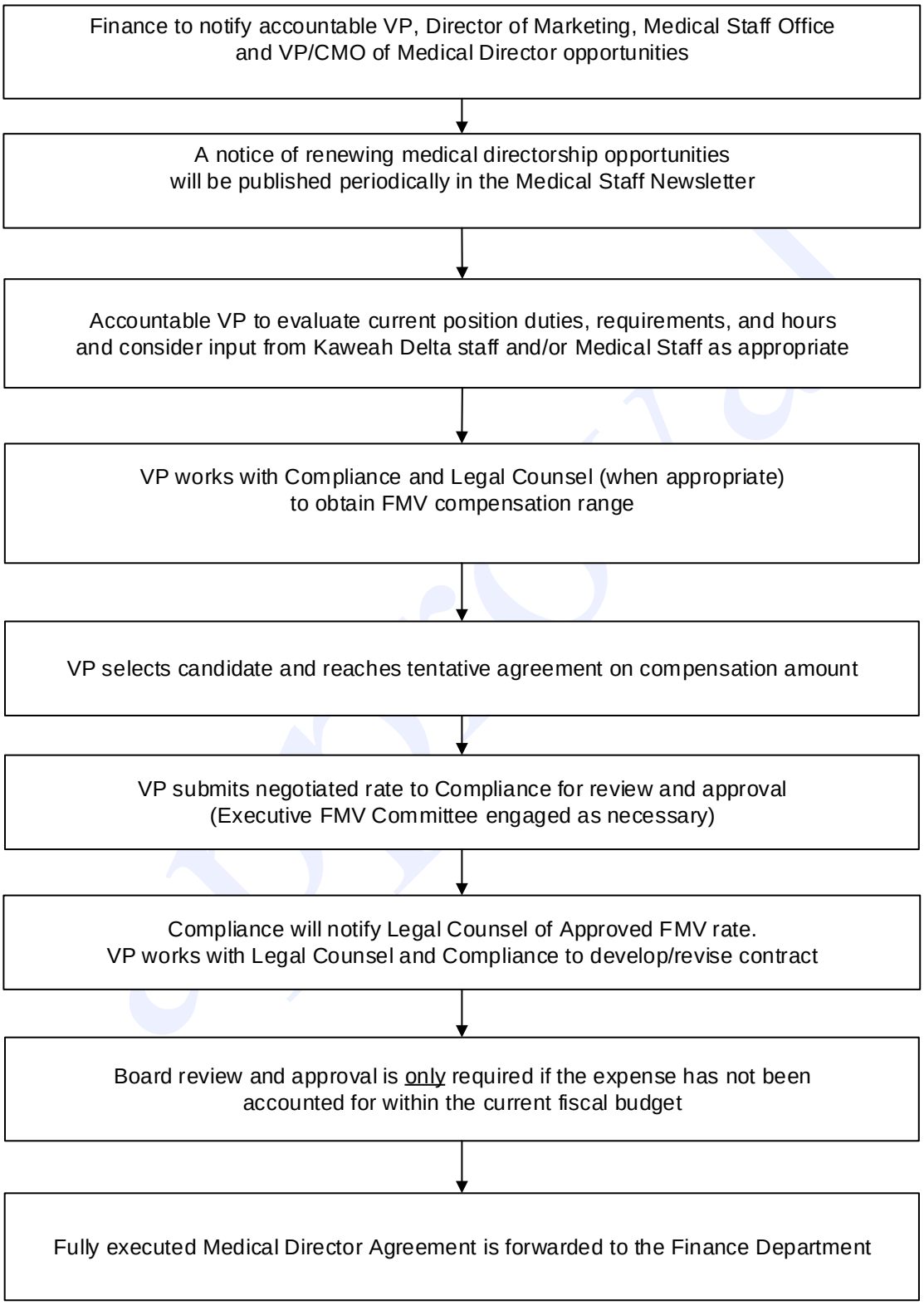


EXHIBIT B

PROVIDER CONTRACT RENEWALS

Exclusive and Non-Exclusive Provider Agreements

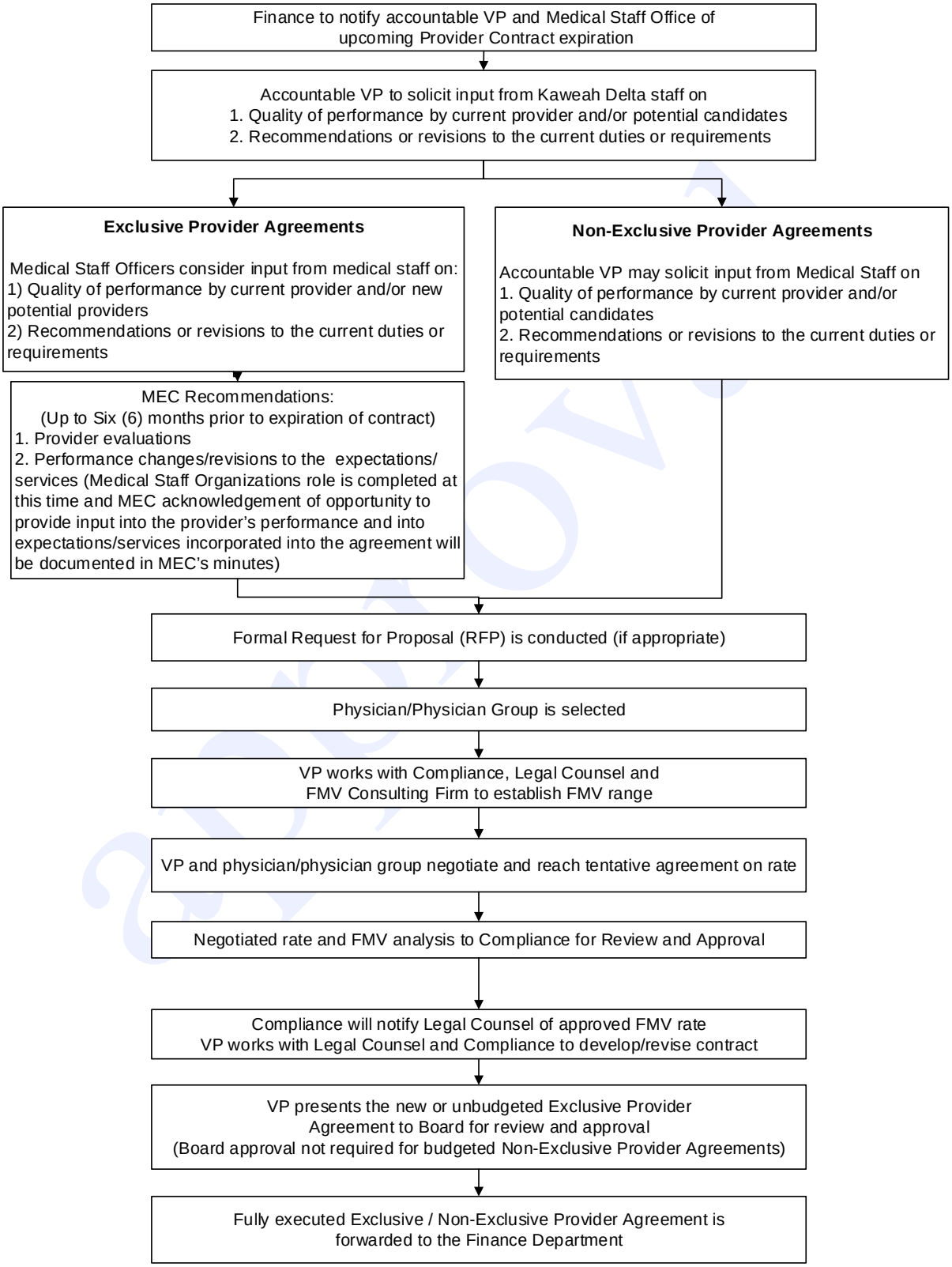


EXHIBIT C

NEW PROVIDER CONTRACT

Exclusive Provider Agreements

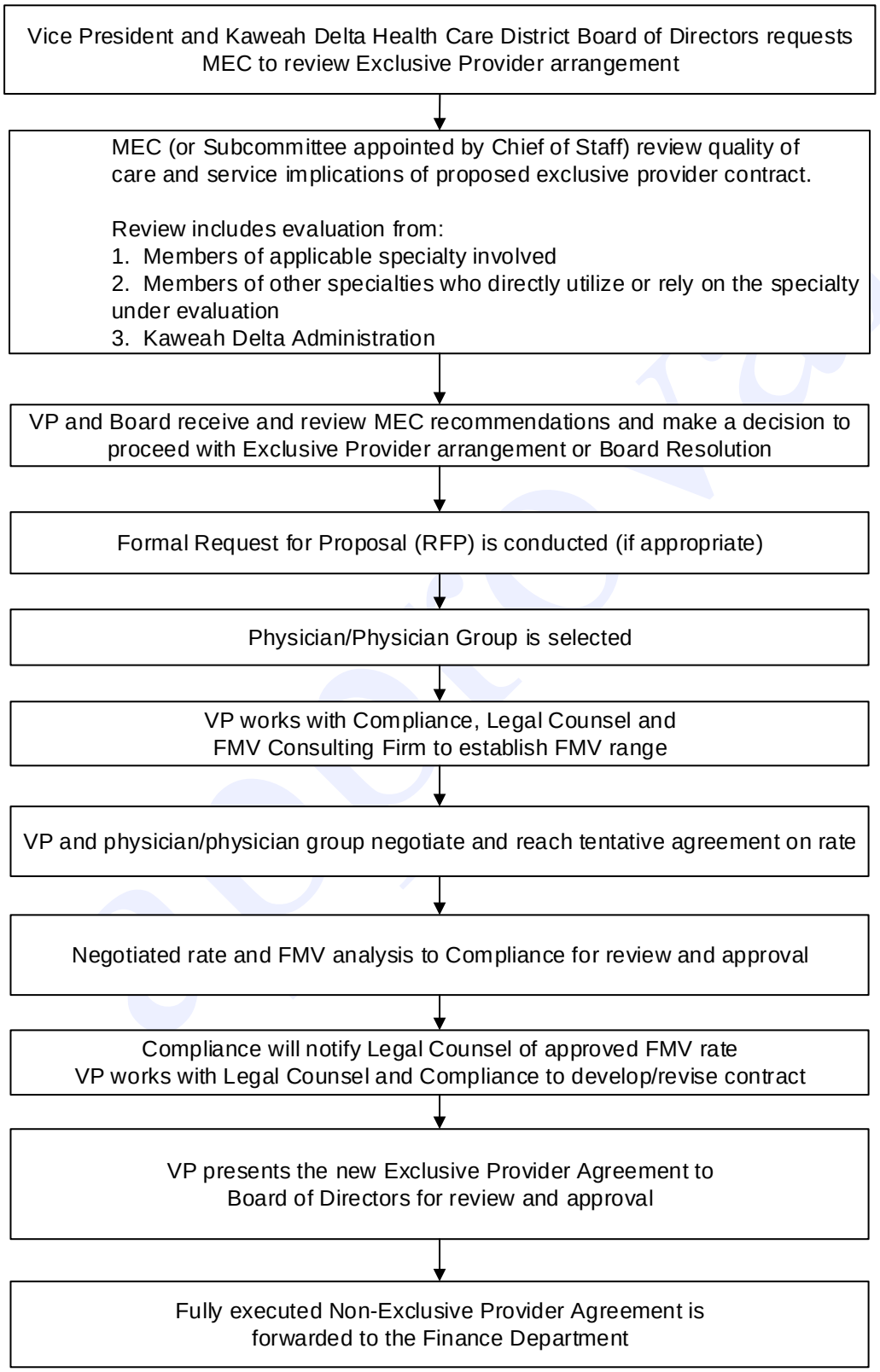
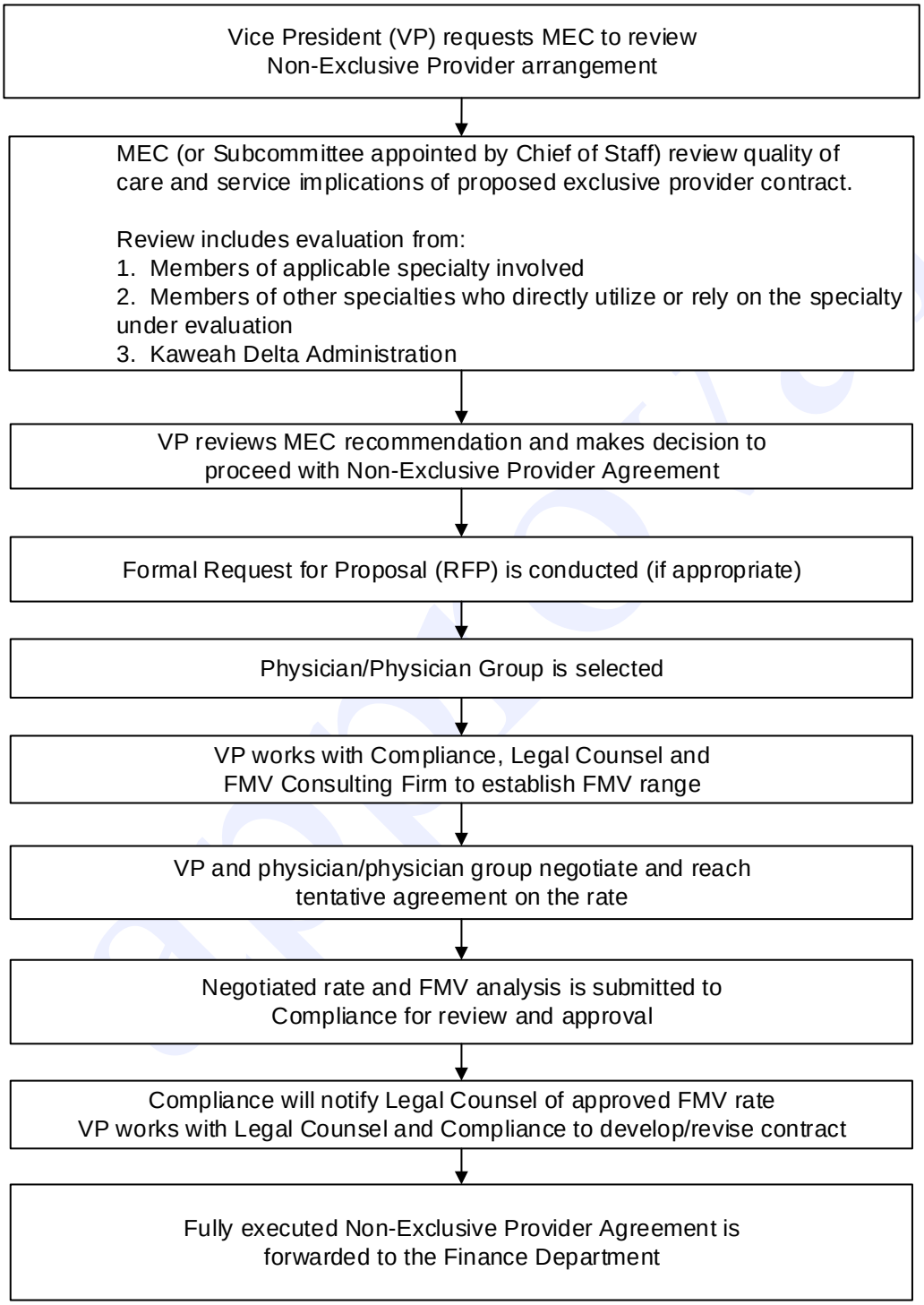


EXHIBIT D

NEW PROVIDER CONTRACT

Non-Exclusive Provider Agreements



Policy Number: CP.03	Date Created: 11/15/2019
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Compliance & Privacy Officer)	

Physician Contracts and Relationships

Purpose:

The purpose of this Policy and Procedure is to establish guidelines for the orderly processing of negotiating, documenting, and administering contracts between Kaweah Delta Health Care District ("Kaweah Delta") and physician(s) or physician groups. This policy must be followed prior to entering into any arrangement (i) in which Kaweah Delta engages physicians to provide services or space/items to Kaweah Delta, or (ii) in which Kaweah Delta provides any services, space, staff, equipment or items to physicians.

Policy:

It is the policy of Kaweah Delta to comply with all state and federal laws. Kaweah Delta shall execute contracts with physicians and physician groups ("physician(s)") that comply with all applicable laws and regulations, including those designed to prevent the provision of improper payments, inappropriate referrals, and/or inappropriate inducements to refer. To that end, Kaweah Delta will negotiate, document, and administer Agreements that comply with the following standards:

I. The Agreement shall be set out in writing and signed by all parties. The terms of the Agreements must be commercially reasonable.

II. The arrangement must be commercially reasonable, and the compensation under the arrangement must be set in advance, established at fair market value through an arms-length transaction, and must not take into account the volume or value of referrals for an item or service reimbursable by a state or federal program or other business generated between the parties.

III. All items and services covered by an Agreement with physician(s) must address a legitimate need of Kaweah Delta, must actually be provided by the physician(s), and must be specifically described in sufficient detail in the Agreement.

IV. The Agreement shall specify the compensation terms in sufficient and measurable detail.

V. The term of the Agreement shall be for not less than twelve (12) months, or longer than thirty-six (36) months unless approved by the Chief Executive

Officer (CEO) and Board in consultation with Legal Counsel and allowable under District Law. Contracts shall not automatically renew.

VI. The services performed under the Agreement shall not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

VII. All Agreements between Kaweah Delta and physician(s) for any purpose shall be prepared by, or in collaboration with, Kaweah Delta's Legal Counsel for signature by the parties**.**

VIII. Any payment to physician(s) shall be made only pursuant to an Agreement that has been formally executed between Kaweah Delta and the physician(s). Medical Director payments will be made only pursuant to approved time records submitted by the physicians. Likewise, payments to physician(s) will require documentation of availability and/or services rendered.

IX. Gifts and financial benefits to a physician or their office shall not exceed the annual physician non-monetary compensation threshold as established by the Federal Stark Law. Any gift or benefit provided to physician(s) or a physician's office must first be approved, documented, and tracked through the Medical Staff Office.

Procedure:

I. Fair Market Value (FMV) – State and federal law require a documented and objective determination that the payment between Kaweah Delta and physician(s) is consistent with FMV. Such determination may be evidenced by an approved vendor-written appraisal/valuation, an approved published third-party source, or as otherwise approved by Legal Counsel. The Compliance and Privacy Officer (CPO) (or designee) will oversee the management and administration of the FMV process.

The CPO (or designee) must be contacted before entering into negotiations of any physician Agreement to evaluate the FMV compensation needs. The negotiated rate must be reviewed and approved by the CPO (or designee) before Legal Counsel is engaged to draft or modify the Agreement. The FMV compensation process will be documented and administered in the following manner:

A. Medical Director Agreements – The Compliance Department will maintain an updated listing of all Medical Director positions by specialty and the corresponding FMV range. Vice President(s) (VP) (or designee) may negotiate rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CPO).

B. Recruitment Agreements – The Compliance Department will maintain a listing of physician recruitment needs by specialty and the corresponding FMV range. The Physician Recruitment Compensation Committee (VP of HR, KDHCD CMO, and KDMF CEO) will approve

the negotiated rates up to the 50th percentile. Negotiations between the 51st and 65th percentiles require documented justification and CEO approval. Negotiations beyond the 65th percentile require Executive FMV Committee approval (CEO, Board Chair, and CPO).

C. Exclusive and Non-Exclusive Provider Agreements – The FMV rate must be established through an independent and external FMV assessment. The VP (or designee) will work with the CPO (or designee) to engage Legal Counsel and a third-party valuation firm. The CPO (or designee) will facilitate the Fair Market Valuation process to ensure the data and assumptions are documented and appropriate.

1. Changes to compensation terms and/or methodologies must be reviewed by the Executive Team and formally approved by the CPO and CEO. This provision and approval process applies to all Exclusive and Non-Exclusive Provider Agreements including new or potential agreements, contract renewals, and agreements that allow for compensation changes throughout the term of the agreement.

D. Space Lease Agreement - The VP (or designee) will work with the CPO (or designee) and Legal Counsel to establish the FMV rate. The Space Lease calculation must be reviewed by the CPO (or designee) and approved by Legal Counsel.

II. Medical Director Agreements

A. New and existing Medical Director Agreements shall be prepared and executed using the process outlined in Exhibit A.

B. The VP is responsible for ensuring the necessity of a Medical Director position and ensuring the physician satisfies any qualification or training requirements and provides required services.

C. Compliance will maintain a listing of Medical Director positions required by federal, state, or Joint Commission accreditation. Compliance must be contacted immediately of a statute, regulation, or other standard requiring a Medical Director position. If a new Medical Director position is not required, the VP must demonstrate the necessity and/or benefit to Kaweah Delta, and present the need to the Executive Team for review and approval.

D. Semi-Annually, Compliance will provide a listing of all Medical Director positions to the Executive Team for review and evaluation. Medical Director positions not required by federal, state, or Joint Commission accreditation will be reviewed by the Executive Team to evaluate and demonstrate the necessity and/or benefit to Kaweah Delta.

E. Monthly payments to Medical Directors must be supported by approved time records as follows:

1. Physician(s) must track time spent on activities/responsibilities outlined in the Agreement.

2. Physician(s) shall record activities by date in the electronic time record system. Physician(s) may use a method other than electronic to document and submit time records when approved by the responsible VP and by Finance Department.

3. Physician(s) time records submitted in any format must include an attestation statement signed by the physician(s) (electronic signature process is used in the electronic time record system).

4. The responsible VP (or designee) must review and approve time records and approve the payment amount to authorize payment. Evidence of such approval must include an original or electronic signature by the VP.

5. Upon receipt of the approved time record and payment amount, Accounts Payable will process the payment for the amount approved by the VP.

6. The responsible VP (or designee) will promptly meet with the Medical Director if they fail to (i) submit time records in a timely manner or (ii) provide services in the manner set forth in the Agreement. Recurring performance issues shall be immediately reported to the CPO.

III. New and existing and Exclusive and Non-Exclusive Physician Provider Agreements shall be prepared and executed using the processes outlined in Exhibits B, C, and D.

IV. Physician Lease of Space Agreements shall be negotiated by the responsible VP (or designee).

The proposed lease rate shall be at FMV.

1. Market analysis must be documented.
2. Rate must be reviewed by the CPO (or designee) and approved by Legal Counsel.

V. Physician Recruitment Agreements shall be negotiated by the Physician Recruiter or responsible VP (or designee) consistent with AP.126 – (AP126) Physician Recruitment Policy (v.2).

A. The terms of the Agreement shall follow current physician recruitment guidelines approved by the Board of Directors.

B. The proposed income guarantee shall be at FMV.

1. Market analysis must be documented.

2. Compensation arrangement must be approved by the CPO (or designee).

IV. Information on all signed Agreements will be maintained in the contract database (see AP.69 Requirement for Contracting with Outside Service Providers).

X. Modifications – In the event physician(s) requests any modifications to the Agreement language, the VP (or designee) shall forward the requests to

Legal Counsel for consideration. If the changes are agreeable, a modified Agreement or Addendum will be provided to the VP (or designee). If changes are not agreeable, Legal Counsel will provide explanations to the VP (or designee).

XI. Board Approval – Board Approval is required as described below:

A. Medical Director Agreements – New or established Medical Director Agreements do not require review and approval by the Board if the expense has been accounted for within the current fiscal budget.

B. Non-Exclusive Providers Agreements – New or established Non-Exclusive Provider Agreements do not require review and approval by the Board if the expense has been accounted for in the current fiscal year budget.

C. Exclusive Provider Agreements – All new or unbudgeted Exclusive Provider Agreements must be submitted to the Board of Directors for review and approval.

VI. Monitoring –

A. The Compliance and/or Internal Audit Departments may complete periodic audits of Medical Directors and Physician Providers Agreements.

B. Prior to the expiration of the Agreement, the VP (or designee) is required to evaluate position duties, requirements, and hours, and to solicit input from key stakeholders including Kaweah Delta staff and/or Medical Staff as appropriate.

VII. Gifts and other financial benefits given to a physician(s) or their office staff shall be recorded by the Medical Office.

A. Any employee/department must contact the Medical Staff Office prior to giving any gifts/financial benefit.

B. The Medical Staff Office must confirm that total financial benefits to the physician(s) and their office do not exceed the annual physician non-monetary compensation threshold for the current calendar year.

C. The Medical Staff Office will log the gift/financial benefit.

D. The value of a gift given to a group of physicians shall be divided and attributed to each physician equally.

Any violators may be subject to disciplinary action for violating Kaweah Delta policy.

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EXHIBIT A

MEDICAL DIRECTOR CONTRACT CHECKLIST

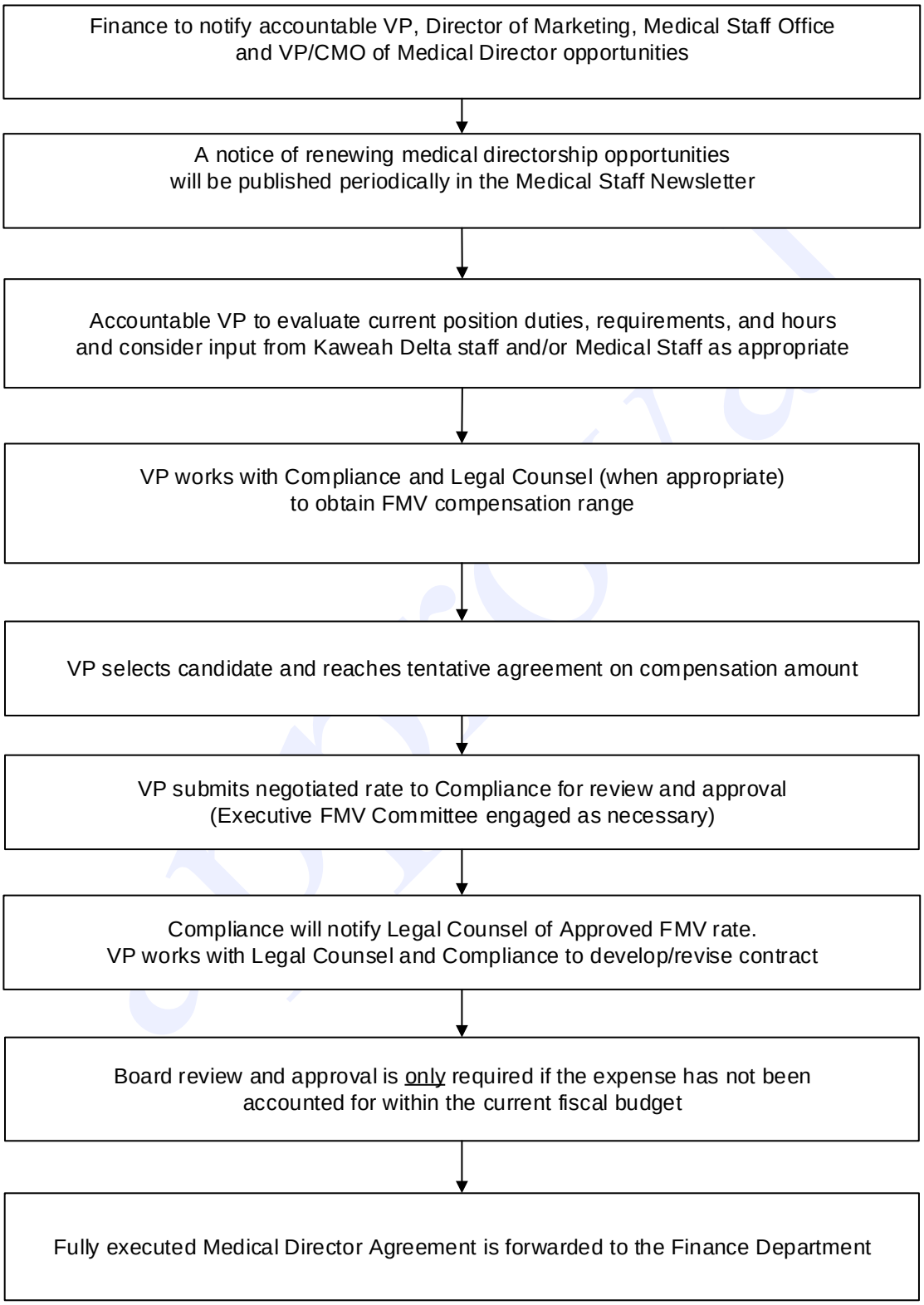


EXHIBIT B

PROVIDER CONTRACT RENEWALS

Exclusive and Non-Exclusive Provider Agreements

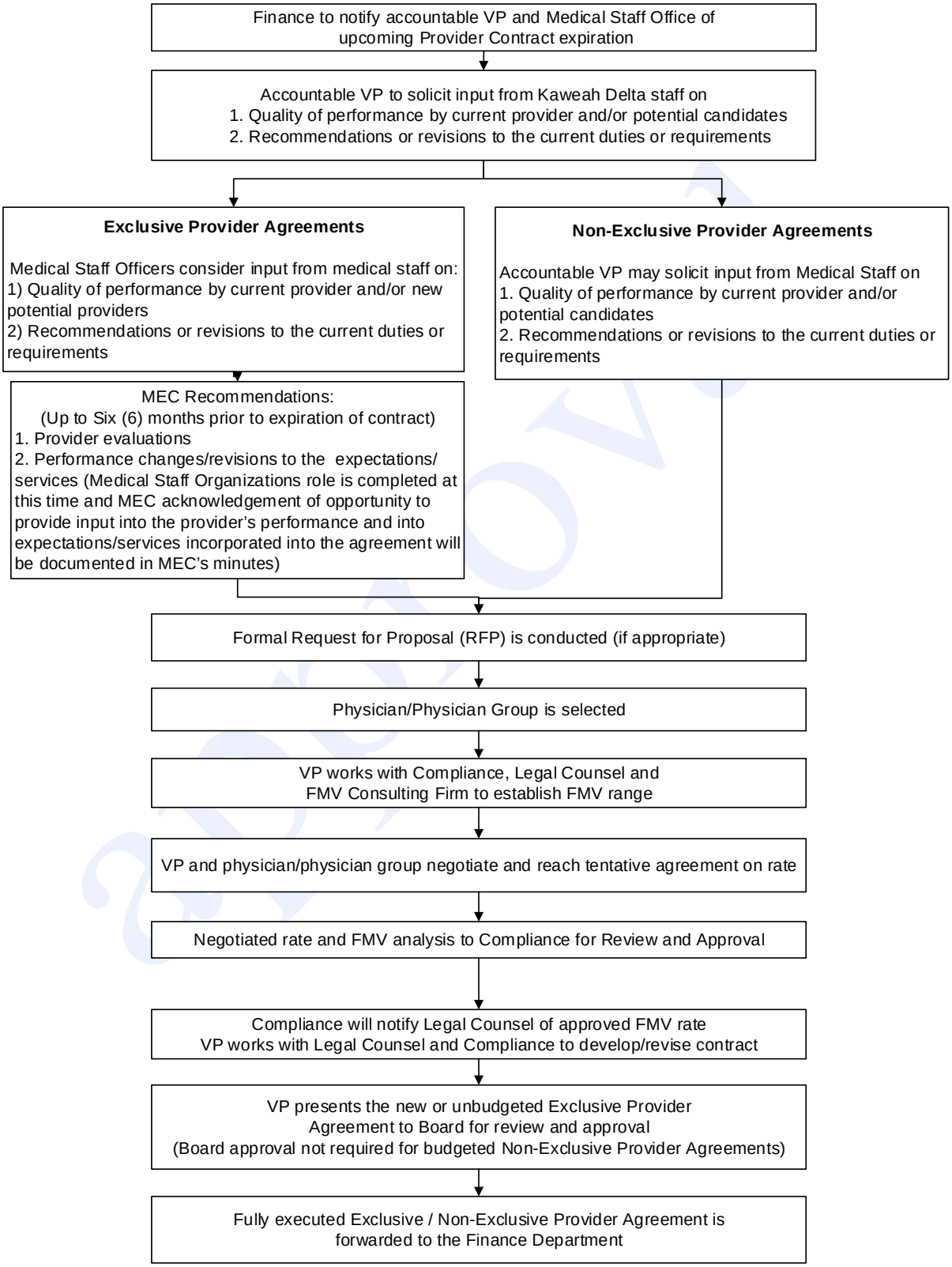


EXHIBIT C

NEW PROVIDER CONTRACT

Exclusive Provider Agreements

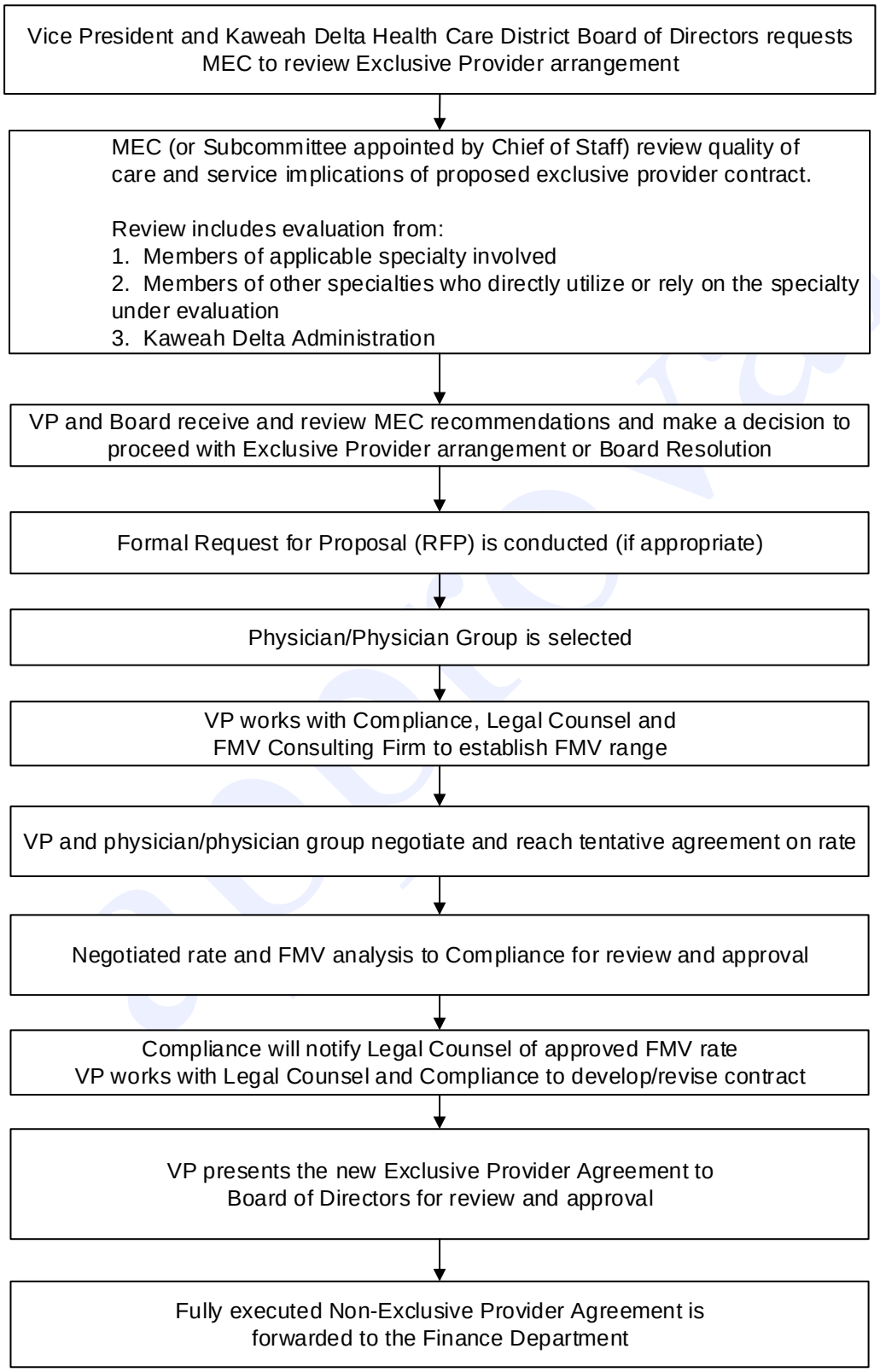
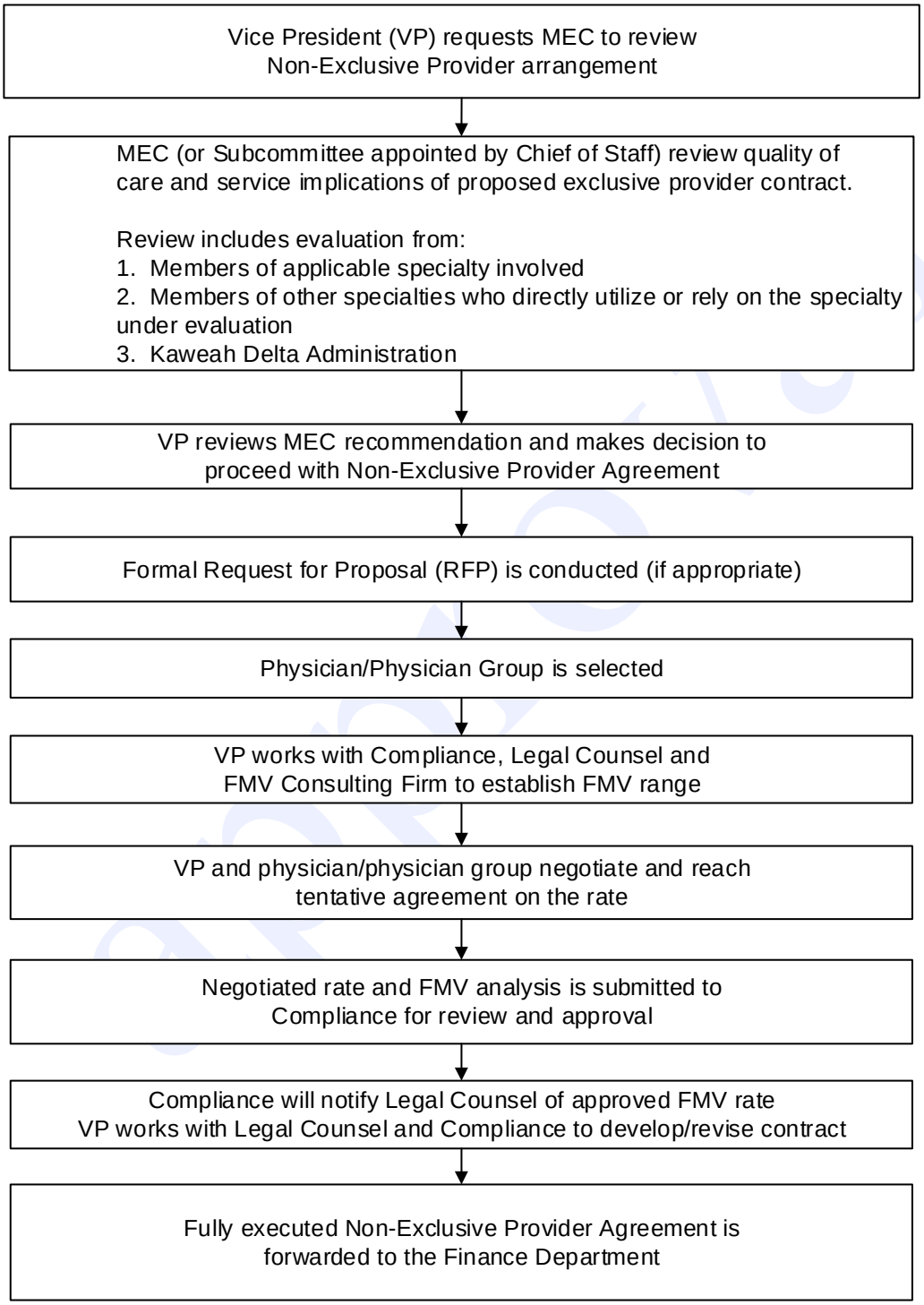


EXHIBIT D

NEW PROVIDER CONTRACT

Non-Exclusive Provider Agreements



Policy Number: CP.13	Date Created: 11/15/2019
Document Owner: Lisa Wass (Compliance Analyst)	Date Approved: Not Approved Yet
Approvers: Board of Directors (Administration), Compliance Committee, Ben Cripps (Compliance & Privacy Officer)	

Federal and State False Claims Act and Employee Protection Provisions

Purpose: Kaweah Delta Health Care District ("Kaweah Delta") acknowledges its responsibilities to establish policies and procedures under the Federal Deficit Reduction Act to provide information and education to its employees, agents and contracted work force regarding the federal False Claims Act, the Federal Whistleblower's Act as well California law on these subjects. The following policy is established in order to help our employees, agents and contractors understand the provisions of the federal and state laws regarding submitting false claims for reimbursement, as well as to further inform our employees of their right to report violations at the state and federal levels as well as to their supervisor or through Kaweah Delta's Compliance structure.

Policy: Detailed information regarding both state and federal false claims laws and whistleblower laws will be distributed to employees via this policy as well as through the various educational courses and orientation programs ongoing throughout the system. Employees are strongly encouraged to report any observations they might make regarding potential violations to their supervisor, the Kaweah Delta Compliance and Privacy Officer, or through the Kaweah Delta Confidential Compliance Hotline (1-800-998-8050). Every concern will be investigated in accordance with policy CP.05 Compliance and Privacy Issues Investigation and Resolution.

Federal False Claims Act - The False Claims Act (FCA) is a federal statute that covers fraud involving any federally funded contract or program, including the Medicare and Medicaid (Medi-Cal) programs. The Act establishes liability for any person who knowingly presents or causes to be presented a false or fraudulent claim to the U. S. Government for payment.

The term "knowingly" is defined to mean that a person, with respect to information:

- Has actual knowledge of falsity of information in the claim;
- Acts in deliberate ignorance of the truth or falsity of the information in a claim; or
- Acts in reckless disregard of the truth or falsity of the information in a claim

The Act does not require proof of a specific intent to defraud the United States Government. Instead health care providers can be prosecuted for a wide variety of conduct that leads to the submission of fraudulent claims to the Government, such as knowingly making false statements, falsifying records, or otherwise causing a false claims to be submitted.

Claim - For purposes of the False Claims Act, a "claim" includes any request or demand for money that is submitted to the U.S. Government or its contractors.

Liability - Health care providers and suppliers (persons and organizations) who violate the False Claims Act can be subject to civil monetary penalties from $10,957 and $21,916 for each false claim submitted. In addition to this civil penalty, providers and suppliers can be required to pay three (3) times the amount of damages sustained by the U.S. Government (See 31 USC §3729(a)). If a provider or supplier is convicted of a False Claims Act violation, the Office of Inspector General (OIG) may seek to exclude the provider or supplier from participation in federal health care programs.

California False Claims Act - The California FCA, enacted in 1987, is a state statute that covers fraud involving state funded contracts or programs, including Medi-Cal. The act establishes liability for any person who knowingly presents or causes to be presented a false claim for payment or approval or causes to be made or used a false statement to get a false claim paid or approved.

The California FCA closely mirrors the structure and content of the Federal False Claims Act. However, the California FCA does contain some provisions that differ from the federal statute. For example, the California FCA imposes liability upon a provider for an inadvertent submission of a false claim when the provider subsequently discovers the falsity but fails to disclose it within a reasonable period of time after the discovery of the false claim. Further, the California FCA states that liability is triggered if a provider conspires to defraud by getting a false claim allowed or paid.

The term "knowingly" for the California FCA is the identical to the federal False Claims Act. As with the federal statute, proof of specific intent to defraud is not required.

Damages for the California FCA are similar to its federal counterpart. Any provider who violates the California FCA is liable to the state for three (3) times the amount of damages. Such a provider is also responsible for the costs of a civil action to recover the penalties and damages. Finally, any provider who violates the state statute may be liable for a civil penalty for each false claim. A "claim" is defined as any request or demand for money or services.

***Employee Protection - Qui Tam* "Whistleblower" Provision -** To encourage individuals to come forward and report misconduct involving false claims, both the federal False Claims Act and the California FCA include "qui tam" or whistleblower provisions. These provisions allow a person who is the "original source" to file a *qui tam* action and the party bringing the action is known as the "relator." "Original

source" is defined as direct and independent knowledge of the information on which the allegations are based and has voluntarily provided the information to the Government before filing a lawsuit on behalf of the U.S. Government or State of California. There are many different types of health care fraud that can be the basis of a qui tam action. These include, but are not limited to: add-on services, up-coding and unbundling, kickbacks, false certification and information, lack of medical necessity, fraudulent cost reports, grant or program fraud, and billing for inadequate patient care.

~~If an investigator/ surveyor requests to interview a District~~Kaweah Delta employee ~~during their visit, District~~Kaweah Delta staff has~~s~~ve the right to request the presence of ~~another District staff member,~~ their supervisor, the Director of Risk Management, and/or the Compliance and Privacy Officer ~~be present~~ during an ~~the~~ interview with a government investigator/inspector~~, as appropriate~~. Additionally, employees, or an employee's representative, have the right to discuss possible regulatory violations and/or patient safety concerns with the California Department of Public Health's (CDPH) inspector(s) privately during the course of an investigation or inspection ~~by the Department~~. (~~As referenced in policy~~See AP.91 Unannounced Regulatory Survey Plan for Response).

The False Claims Act is an increasingly significant enforcement tool due to the whistleblower provisions which entitle relators to recover a percentage of the penalty imposed. Law enforcement officials are using these acts and the whistleblower protections to pursue high penalty fraud allegations against hospitals, physicians, and other health care providers. However, individuals seeking whistleblower status must meet several criteria (e.g. "original source") to prevail as outlined below.

Health Insurance Portability and Accountability Act (HIPAA) Exception – Section 164.502(j)(1) of HIPAA permits a member of a covered entity's workforce or a business associate to disclose PHI with a Government Agency and/or Attorney due to the workforce member or business associate's belief in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided by the covered entity potentially endangers one or more patients, workers, or the public.

***Qui Tam* Procedure -** The relator must file his or her lawsuit on behalf of the Government in a federal district court or for the State of California in the name of California if state funds are involved. The lawsuit will be filed "under seal," meaning that the lawsuit is kept confidential while the state and/or federal Government reviews and investigates the allegations contained in the lawsuit and decides how to proceed.

Rights of Parties to *Qui Tam* Actions - If the Government determines that the lawsuit has merit and decides to intervene, the prosecution of the lawsuit will be directed by the U.S. Department of Justice. If the state proceeds with the action, it shall have the responsibility for prosecuting the action. If the federal government or state decides not to intervene, the whistleblower can continue with the lawsuit on his or her own.

Award to *Qui Tam* Whistleblowers - If the federal and/or state lawsuit is successful, and provided certain legal requirements are met, the relator may receive a percentage award of the total amount recovered or settlement made. If the federal and/or state does not proceed with the action and the *qui tam* plaintiff proceeds with the action, the relator may receive a percentage award of the penalties and damages. The whistleblower may also be entitled to reasonable expenses including attorney's fees and costs for bringing the lawsuit. All such expenses, fees and costs will be awarded against the defendant and in no circumstances will they be the responsibility of the federal government or state.

No Retaliation - In addition to a financial award, the False Claims Act entitles whistleblowers to additional relief, including employment reinstatement, back pay, and any other compensation arising from retaliatory conduct against a whistleblower for filing an action under the False Claims Act or committing other lawful acts, such as investigating a false claim or providing testimony for, or assistance in, a False Claims Act action. ~~This includes~~Additionally, ~~anti~~non-retaliation and whistleblower protections are afforded to county patients' rights advocates who are ~~may be~~ contracted individuals or entities~~, who are contracted individuals or entities~~.

Reporting a Concern – Employees are required to report any concerns of suspected non-compliance pursuant to Compliance Policy Compliance Program Administration. Concerns should be reported immediately to Kaweah Delta Leadership, the Compliance and Privacy Officer, the Compliance Hotline at 1(800) 998-8050, or the Kaweah Delta Compliance Advocate at (559) 738-8100.

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