COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

(An Enterprise Fund of the
County of San Bernardino, California)

Independent Auditors' Reports
and Financial Statements

For the Years Ended June 30, 2016 and 2015

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

FOR THE YEARS ENDED JUNE 30, 2016 AND 2015

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INDEPENDENT AUDITORS' REPORT

To the Board of Supervisors and Audit Committee
Arrowhead Regional Medical Center
County of San Bernardino, California

Report on the Financial Statements

We have audited the accompanying financial statements of the Arrowhead Regional Medical Center (the "Medical Center"), an enterprise fund of the County of San Bernardino (the "County"), as of and for the years ended June 30, 2016 and 2015, and the related notes to the 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.

Auditors' Responsibility

Our responsibility is to express an opinion on these financial statements based on our audits. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's 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 entity'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 organization'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.

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Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medical Center as of June 30, 2016 and 2015, and the results of its changes in financial position and cash flows thereof for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Emphasis of Matter

Individual Fund Financial Statements

As discussed in Note 1, the financial statements present only the Medical Center Enterprise Fund of the County and do not purport to, and do not, present fairly the financial position of the County as of June 30, 2016 and 2015, the changes in its financial position, or where applicable, its cash flows for the year then ended in accordance with accounting principles generally accepted in the United States of America. Our opinion is not modified with respect to this matter.

Implementation of new accounting standards

As discussed in Note 1 to the financial statements, the Medical Center adopted Governmental Accounting Standards Board (GASB) Statement No. 72, *Fair Value Measurement and Application*, effective July 1, 2014. Our opinion is not modified with respect to the matter.

Other Matters

Required Supplementary Information

Accounting principles generally accepted in the United States of America require that the schedule of proportionate share of the net pension liability and schedule of contributions on pages 42 and 43 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 the 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 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. Our opinion on the basic financial statements is not affected by this missing information.

Other Reporting Required by *Government Auditing Standards*

In accordance with *Government Auditing Standards*, we have also issued our report dated December 16, 2016, on our consideration of the Medical Center's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Medical Center's internal control over financial reporting and compliance.

Vavrinek, Trine, Day & Co. LLP

Rancho Cucamonga, California
December 16, 2016

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF NET POSITION

JUNE 30, 2016 AND 2015

(In Thousands)

	2016	2015
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 122,213	$ 72,371
Restricted investments held with fiscal agent	11,924	4,939
Patient accounts receivable, net of contractual allowances and estimated uncollectables of $132,941 in 2016 and $141,958 in 2015	31,098	38,594
Other medi-cal receivables, net of estimated uncolectables of $13,207 in 2016 and $3,829 in 2015	12,470	19,689
Receivable from other governments	55,474	32,266
Due from County	13,658	7,187
Other receivables	10,881	37,835
Supplies inventories	2,418	1,755
Prepaid expenses and other assets	2,264	3,433
Total Current Assets	262,400	218,069
Noncurrent Assets:		
Restricted investments held with fiscal agent	38,312	45,045
Restricted investments held with fiscal agent - interest	295	308
Capital assets:		
Land and improvements	25,440	24,753
Buildings and improvements	547,386	545,441
Equipment	170,992	160,546
Construction-in-progress	1,822	1,261
Total capital assets	745,640	732,001
Less accumulated depreciation	(369,094)	(346,483)
Total capital assets, net of accumulated depreciation	376,546	385,518
Total Noncurrent Assets	415,153	430,871
Total Assets	677,553	648,940
DEFERRED OUTFLOWS OF RESOURCES		
Deferred charge on refunding	21,897	24,275
Deferred outflows related to pensions	51,211	54,303
Total deferred outflow of resources	$ 73,108	$ 78,578

See accompanying notes to basic financial statements.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF NET POSITION, Continued

JUNE 30, 2016 AND 2015

(In Thousands)

	2016	2015
LIABILITIES		
Current Liabilities:		
Accounts payable	$ 19,333	$ 23,793
Accrued salaries and benefits	25,877	19,457
Accrued termination benefits	15	15
Other accrued liabilities	1,353	1,615
Due to third-party payors	29,305	40,906
Capital lease obligations	1,924	2,381
Certificates of participation	22,380	21,270
Interest payable	8,808	9,222
Arbitrage payable	81	81
Due to County	410	313
Total Current Liabilities	109,486	119,053
Noncurrent Liabilities:		
Long-term compensated absences	6,867	9,954
Long-term due to third-party payors	9,973	5,016
Net pension liability	156,238	142,685
Capital lease obligations, less current installments	2,268	2,911
Certificates of participation, less current installments (net of bond discount)	380,556	402,710
Total Noncurrent Liabilities	555,902	563,276
Total Liabilities	665,388	682,329
DEFERRED INFLOWS OF RESOURCES		
Deferred inflows related to pensions	43,192	76,260
Total deferred inflow of resources	43,192	76,260
NET POSITION		
Net investment in capital assets	(8,685)	(19,479)
Restricted for debt service	41,723	41,070
Unrestricted	9,043	(52,662)
Total Net Position (Deficit)	$ 42,081	$ (31,071)

See accompanying notes to basic financial statements.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF REVENUES, EXPENSES, AND CHANGES IN NET POSITION

YEARS ENDED JUNE 30, 2016 AND 2015

(In Thousands)

	2016	2015
OPERATING REVENUES		
Net patient service revenue	$ 448,135	$ 408,446
Other	7,572	9,939
Total Operating Revenues	455,707	418,385
OPERATING EXPENSES		
Salaries and benefits	240,750	225,654
Medi-Cal matching fund expense	7,482	4,018
Supplies	97,067	83,929
Professional services	52,587	43,625
Purchased services	43,002	41,092
Insurance	10,983	11,047
Utilities	9,332	9,089
Depreciation and amortization	23,172	22,327
Rent	3,769	3,911
Other	5,452	5,536
Total Operating Expenses	493,596	450,228
Operating Loss	(37,889)	(31,843)
NONOPERATING REVENUES (EXPENSES)		
State debt service funding	18,855	16,501
AB85 rate range	45,666	36,386
Investment income	1,722	1,243
Interest expense on debt	(24,026)	(25,092)
DSRIP funding	(1,171)	36,849
PRIME funding	43,064	-
Supplemental risk pool funding	(3,028)	36,001
Direct grants - designated public hospital	3,147	3,053
Other nonoperating revenues (expenses)	(7)	(151)
Total Nonoperating Revenues, Net	84,222	104,790
Income Before Transfers	46,333	72,947
Transfers from the County	26,819	17,208
Change in Net Position	73,152	90,155
Net Position (Deficit), Beginning of Year	(31,071)	(121,226)
Net Position (Deficit), End of Year	$ 42,081	$ (31,071)

See accompanying notes to basic financial statements.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF CASH FLOWS

YEARS ENDED JUNE 30, 2016 AND 2015

(In Thousands)

	2016	2015
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from patients and third-party payors	$ 461,053	$ 490,562
Payments to suppliers	(233,793)	(251,956)
Payments to employees	(253,840)	(245,962)
Net Cash Used in Operating Activities	(26,580)	(7,356)
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
DSRIP funding	(1,171)	36,849
Supplemental risk pool funding received	40,036	-
AB85 rate range funding received	45,666	36,386
Transfers from the County	26,819	17,208
Other nonoperating income (expense)	(7)	(151)
Direct grants - designated public hospital	3,147	3,053
Net Cash Provided by Noncapital Financing Activities	114,490	93,345
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchase of capital assets	(12,279)	(5,838)
State debt service funding	18,855	16,501
Principal payments on capital lease obligations	(3,021)	(3,142)
Principal payments on certificates of participation	(21,044)	(19,999)
Interest paid on debt	(22,062)	(23,153)
Net Cash Used in Capital and Related Financing Activities	(39,551)	(35,631)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest on investments	1,722	1,243
Investment activity, net	(239)	229
Net Cash Provided by Investing Activities	1,483	1,472
Increase in Cash and Cash Equivalents	49,842	51,830
Cash and Cash Equivalents, Beginning of Year	72,371	20,541
Cash and Cash Equivalents, End of Year	$ 122,213	$ 72,371

See accompanying notes to basic financial statements.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF CASH FLOWS, Continued

YEARS ENDED JUNE 30, 2016 AND 2015

(In Thousands)

	2016	2015
RECONCILIATION OF OPERATING LOSS TO NET CASH USED IN OPERATING ACTIVITIES		
Operating Loss	$ (37,889)	$ (31,843)
Adjustments to reconcile operating loss to net cash used in operating activities:		
Depreciation and amortization	23,172	22,327
Pension expense	(16,423)	(16,989)
Decrease (Increase) in:		
Patient accounts receivable	7,496	8,528
Other medi-cal receivables	7,219	(19,689)
Receivables from other governments	(23,208)	(31,684)
Due from County	(6,471)	23,433
Other receivables	26,954	52,381
Supplies inventories	(663)	118
Prepaid expenses and other assets	1,169	(106)
Increase (Decrease) in:		
Accounts payable	(4,460)	3,581
Accrued salaries and benefits	3,333	(3,320)
Other accrued liabilities	(262)	(27,948)
Due to third-party payors	(6,644)	17,200
Due to County	97	(3,345)
Net Cash Provided by (Used in) Operating Activities	$ (26,580)	$ (7,356)
NONCASH CAPITAL AND FINANCING ACTIVITIES:		
Lease Purchase of Capital Assets	$ 1,921	$

See accompanying notes to basic financial statements.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. General

The County of San Bernardino (the "County") Arrowhead Regional Medical Center (the "Medical Center") is classified as a level II trauma center with eight trauma bays and four additional "swing" trauma rooms that can be used during an emergency. In addition, the Medical Center provides 456 patient beds and has 24 private treatment rooms for diagnosis and treatment of urgent care patients. During fiscal year 2000, the Medical Center assumed the inpatient operations, consisting of 90 beds, from the previously separate Department of Behavioral Health.

The Medical Center is owned by the County, which is a legal subdivision of the state of California charged with governmental powers, and is reflected in the County's comprehensive annual financial report as an enterprise fund. The County's powers are exercised through the Board of Supervisors, which, as the governing body of the County, is responsible for the legislative control of the County and the Medical Center.

These financial statements present only the Medical Center and do not purport to, and do not, present fairly the financial position of the County and the changes in its financial position and cash flows, where applicable, in conformity with accounting principles generally accepted in the United States of America.

B. Basis of Accounting

The basic financial statements of the Medical Center are presented using the economic resources measurement focus and the accrual basis of accounting in conformity with accounting principles generally accepted in the United States of America. Accordingly, all assets, deferred outflows, liabilities (whether current or noncurrent), deferred inflows are included on the Statements of Net Position. The Statements of Revenues, Expenses and Changes in Net Position present increases (revenues) and decreases (expenses) in total net position. Under the accrual basis of accounting, revenues are recognized in the period in which they are earned while expenses are recognized in the period in which the liability is incurred, regardless of the timing of related cash flows.

The basic financial statements include the statements of Net Position, Statements of Revenues, Expenses and Changes in Net Position, and Statements of Cash Flows.

Operating revenues include those generated from direct patient care and related support services. Operating expenses include the cost of providing patient care, administrative expenses, and depreciation on capital assets. Revenues and expenses not meeting this definition are reported as nonoperating revenues and expenses.

C. Charity Care

The Medical Center provides care to patients who meet certain criteria under its charity care policy without charge or at an amount less than its established rates. Because the Medical Center does not pursue collection of amounts determined to qualify as charity care, they are not reported as revenue. However, the Medical Center monitors the level of charity care provided. See Note #9.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, (CONTINUED)

D. Net Patient Service Revenue

The Medical Center recognizes net patient service revenue, less contractual allowances associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered including Medicare and Medi-Cal. For uninsured patients that do not qualify for charity care, the Medical Center recognizes revenue on the basis of its standard rates for services provided (or on the basis of discounted rates, if negotiated or provided by policy). On the basis of historical experience, a significant portion of the Medical Center's uninsured patients will be unable or unwilling to pay for the services provided. Thus, the Medical Center records a significant provision for bad debts related to uninsured patients in the period the services are provided.

Net patient service revenue included estimated retroactive adjustments under reimbursement agreements with third-party payors. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods as final settlements are determined. As a result, there is at least a reasonable possibility that recorded estimates could change by a material amount in the near term.

E. Patient Receivables

Accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Medical Center analyzes its past history and identifies trends for each of its major payor sources of revenue to estimate the appropriate allowance for doubtful accounts and provision for bad debts. Management regularly reviews data about these major payor sources of revenue in evaluating the sufficiency of the allowance for doubtful accounts. For receivables associated with services provided to patients who have third-party coverage, the Medical Center analyzes contractually due amounts and provides an allowance for doubtful accounts and a provision for bad debts, if necessary (for example, for expected uncollectible deductibles and copayments on accounts for which the third-party payor has not yet paid, or for payors who are known to be having financial difficulties that make the realization of amounts due unlikely). For receivables associated with self-pay patients (which includes both patients without insurance and patients with deductible and copayment balances due for which third-party coverage exists for part of the bill), the Medical Center records a significant provision for bad debts in the period of service on the basis of its past experience, which indicates that many patients are unable or unwilling to pay the portion of their bill for which they are financially responsible. The difference between the standard rates (or the discounted rates if negotiated) and the amounts actually collected after all reasonable collection efforts have been exhausted is charged off against the allowance for doubtful accounts.

The Medical Center's allowance for doubtful accounts for self-pay patients increased from 89 percent of self-pay accounts receivable at June 30, 2015, to 97 percent of self-pay accounts receivable at June 30, 2016. The increase was the result of the trend experienced in the collection of amounts from self-pay patients in fiscal year 2016. The Medical Center has not changed its charity care or uninsured discount policies during fiscal years 2016 or 2015. The Medical Center does not maintain a material allowance for doubtful accounts from third-party payors, nor did it have significant write-offs from third-party payors.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, (CONTINUED)

F. Cash and Cash Equivalents

For purposes of the Statements of Cash Flows, the Medical Center considered all highly liquid investments with a maturity of three months or less when purchased to be cash equivalents. The Medical Center maintains a certain portion of its cash on deposit with the County Treasurer.

G. Restricted investments held with fiscal agent

Restricted investments held with fiscal agent represent funds held by a trustee which are legally restricted for bond reserve accounts. Restricted investments held with fiscal agent that are required for obligations classified as current liabilities are reported as current assets.

H. Capital Assets

Buildings, improvements, and equipment with a historical cost over $5 are capitalized. Contributed capital assets are reported at their acquisition value at the date of donation. Depreciation expense is provided using the straight-line method over the estimated useful lives of the respective classes of capital assets. Equipment under capitalized leases is amortized using the straight-line method over the lesser of minimum lease terms or estimated useful lives. The estimated useful lives for computing depreciation expense are as follows:

Buildings	40 years
Improvements	3 to 25 years
Equipment	3 to 20 years

I. Supplies Inventories

The Medical Center's inventory consists primarily of pharmaceuticals and medical supplies which are stated at lower of average cost or market.

J. Prepaid Expenses and Other Assets

The Medical Center's prepaid expenses and other assets are primarily prepayments for pharmaceuticals and medical supplies, rent, equipment and maintenance contracts.

K. Compensated Absences

The Medical Center accrues annual leave for employees at rates based upon length of service and job classification and compensatory time based upon job classification and hours worked, in accordance with County policy.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, (CONTINUED)

L. Net Position

Net position of the Medical Center is classified in three components. *Net investment in capital assets* consist of capital assets net of accumulated depreciation and reduced by the balances of any outstanding borrowings used to finance the purchase or construction of those assets. *Restricted net position* consists of net position with constraints placed on the use either by (1) external groups such as creditors, grantors, contributors or laws or regulations of other governments, or (2) law through constitutional provisions or enabling legislation. Restricted net position is reduced by any liabilities payable from restricted assets. *Unrestricted net position* is remaining net position that does not meet the definition of net investment in capital assets or restricted.

M. Use of Estimates

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

N. Deferred Outflows/Inflows Of Resources

In addition to assets, the statement of net position will sometimes report a separate section for deferred outflows of resources. This 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 then.

In addition to liabilities, the statement of net position will sometimes report a separate section for deferred inflows of resources. This 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 (revenue) until that time.

The deferred amount on refunding reported in the statement of net position as a deferred outflows of resources results from the difference in the carrying value of refunded debt and its reacquisition price. This amount is deferred and amortized over the shorter of the life of the refunded or refunding debt.

Other amounts reported as deferred outflows of resources and deferred inflows of resources are related to the Medical Center’s proportion of the County’s pension plan and will be recognized in pension expense in future periods. See Note #16 for further details.

O. Reclassifications

Certain amounts in the 2015 financial statements have been reclassified to conform to the 2016 presentation.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, (CONTINUED)

P. Pensions

For purposes of measuring the net pension liability, deferred outflows of resources and deferred inflows of resources related to pensions, and pension expense, information about the fiduciary net position of the County's cost-sharing multiple-employer defined benefit retirement plan (the Plan) administered by the San Bernardino County Employee's Retirement Association (SBCERA) and additions to/deductions from the Plans' fiduciary net position have been determined on the same basis as they are reported by the Plan. For this purpose, benefit payments (including refunds of employee contributions) are recognized when due and payable in accordance with the benefit terms. Investments are reported at fair value.

Q. Fair Value Measurement

As of July 1, 2015, the Medical Center retrospectively applied Governmental Accounting Standards Board ("GASB") Statement No. 72, *Fair Value Measurement and Application*. GASB Statement No. 72 provides guidance for determining a fair value measurement for reporting purposes and applying fair value to certain investments and disclosures related to all fair value measurements. The Medical Center categorizes the fair value measurements of its investments based on the hierarchy established by generally accepted accounting principles. The fair value hierarchy, which has three levels, is based on the valuation inputs used to measure an asset's fair value: Level 1 inputs are quoted prices in active markets for identical assets; Level 2 inputs are significant other observable inputs; Level 3 inputs are significant unobservable inputs. The Medical Center does not have any investments that are measured using Level 3 inputs. Money market investments that have remaining maturity at the time of purchase of one-year or less and guaranteed investment contacts are measured at amortized cost.

The Medical Center is a participant in the San Bernardino Treasurer's Pool (County Pool). The County Pool is an external investment pool and is not registered with the Securities Exchange Commission (SEC). The County Pool is rated by Fitch ratings (NRSRO) at AAAf/S1+. The San Bernardino County Treasury Oversight Committee conducts County Pool oversight. Cash on deposit in the County Pool at June 30, 2016 and 2015, is stated at fair value. The County Pool values participant shares on an amortized cost basis during the year and adjusts to fair value at year-end. The fair value adjustment at June 30, 2016 and 2015 had no material effect on the Medical Center's investment income. For further information regarding the County Pool, refer to the County of San Bernardino Annual Financial Report.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, (CONTINUED)

R. Current Accounting Pronouncements

Governmental Accounting Standard No. 72

GASB Statement No. 72*, Fair Value Measurement and Application*, requires disclosures to be made about fair value measurements, the level of fair value hierarchy, and valuation techniques. These disclosures should be organized by type of asset or liability reported at fair value. It also requires additional disclosures regarding investments in certain entities that calculate net asset value per share (or its equivalent). The requirements of this Statement are effective for financial statements for periods beginning after June 15, 2015. The Medical Center implemented the standard as of July 1, 2014. The Medical Center has determined that this statement applies to certain investments held by the Medical Center and are disclosed in Note #2 of the Medical Center's financial statements

Governmental Accounting Standard No. 73

In June 2015, GASB issued Statement No. 73*, Accounting and Financial Reporting for Pensions and Related Assets That Are Not within the Scope of GASB Statement No. 68, and Amendments to Certain Provisions of GASB Statements Nos. 67 and 68*. The provisions in Statement No. 73 are effective for fiscal years beginning after June 15, 2015 except those provisions that address employers and governmental nonemployer contributing entities for pensions that are not within the scope of Statement No. 68, which are effective for fiscal years beginning after June 15, 2016. The Medical Center has determined that this statement does not have a material effect on the Medical Center's financial statements.

Governmental Accounting Standard No. 76

GASB Statement No. 76, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments* objective is to identify in the context of the current governmental financial reporting environment the hierarchy of generally accepted accounting principles (GAAP). The "GAAP hierarchy" consists of the sources of accounting principles used to prepare financial statements of state and local governmental entities in conformity with GAAP and the framework for selecting those principles. This Statement reduces the GAAP hierarchy to two categories of authoritative GAAP and addresses the use of authoritative and nonauthoritative literature in the event that the accounting treatment for a transaction or other event is not specified within a source of authoritative GAAP. This Statement supersedes Statement No. 55, *The Hierarchy of Generally Accepted Accounting Principles for State and Local Governments*. The requirements of this Statement are effective for financial statements for periods beginning after June 15, 2015, and should be applied retroactively. The Medical Center implemented the standard as of July 1, 2014. The Medical Center has determined that this statement does not have a material effect on the Medical Center's financial statements.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, (CONTINUED)

R. Current Accounting Pronouncements (continued)

Governmental Accounting Standard No. 79

GASB Statement No. 79, *Certain External Investment Pools and Pool Participants* address accounting and financial reporting for certain external investment pools and pool participants. Specifically, it establishes criteria for an external investment pool to qualify for making the election to measure all of its investments at amortized cost for financial reporting purposes. The requirements of this statement are effective for reporting periods beginning after June 15, 2015, except for the provisions in paragraphs 18, 19, 23–26, and 40, which are effective for reporting periods beginning after December 15, 2015. The Medical Center implemented the standard as of July 1, 2014. The Medical Center has determined that this statement does not have a material effect on the Medical Center's financial statements.

S. Future Accounting Pronouncements

Governmental Accounting Standard No. 74

In June 2015, GASB issued Statement No. 74, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*. Statement No. 74 replaces Statements No. 43, *Financial Reporting for Postemployment Benefit Plans Other Than Pension Plans*, as amended, and No. 57, *OPEB Measurements by Agent Employers and Agent Multiple-Employer Plans*. It also includes requirements for defined contribution OPEB plans that replace the requirements for those OPEB plans in Statement No. 25, *Financial Reporting for Defined Benefit Pension Plans and Note Disclosures for Defined Contribution Plans*, as amended, Statement No. 43, and Statement No. 50, *Pension Disclosures*. The provisions in Statement No. 74 are effective for fiscal years beginning after June 15, 2016. The Medical Center has not determined its effect on the financial statements.

Governmental Accounting Standard No. 75

In June 2015, GASB issued Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*. Statement No. 75 establishes new accounting and financial reporting requirements for governments whose employees are provided with OPEB, as well as for certain nonemployer governments that have a legal obligation to provide financial support for OPEB provided to the employees of other entities. The provisions in Statement No. 75 are effective for fiscal years beginning after June 15, 2017. The Medical Center has not determined its effect on the financial statements.

Governmental Accounting Standard No. 77

In August 2015, GASB issued Statement No. 77, *Tax Abatement Disclosures.* The requirements of this Statement are effective for reporting periods beginning after December 15, 2015. The disclosures are intended, among other things, to assist users of financial statements in assessing (1) whether a government's current-year revenues were sufficient to pay for current-year services (known as interperiod equity), (2) whether a government complied with finance-related legal and contractual obligations, (3) where a government's financial resources come from and how it uses them, and (4) a government's financial position and economic condition and how they have changed over time. The Medical Center has not determined its effect on the financial statements.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES, (CONTINUED)

S. *Future Accounting Pronouncements, (Continued)*

Governmental Accounting Standard No. 78

GASB Statement No. 78**,** *Pensions Provided through Certain Multiple-Employer Defined Benefit Pension Plans.* The objective of this statement is to address a practice issue regarding the scope and applicability of Statement No. 68, *Accounting and Financial Reporting for Pensions*. This issue is associated with pensions provided through certain multiple-employer defined benefit pension plans and to state or local governmental employers whose employees are provided with such pensions. The requirements of this statement are effective for reporting periods beginning after December 15, 2015. The Medical Center has not determined the effect, if any, on the financial statements.

Governmental Accounting Standard No. 80

GASB Statement No. 80**,** *Blending Requirements for Certain Component Units – an amendment of GASB No. 14.* The objective of this statement is to improve financial reporting by clarifying the financial statement presentation requirements for certain component units. This statement amends the blending requirements established in paragraph 53 of Statement No. 14, *The Financial Reporting Entity*, as amended. The requirements of this statement are effective for reporting periods beginning after June 15, 2016. The Medical Center has not determined the effect, if any, on the financial statements.

Governmental Accounting Standard No. 81

GASB Statement No. 81, *Irrevocable Split-Interest Agreements*. The objective of this Statement is to improve accounting and financial reporting for irrevocable split-interest agreements by providing recognition and measurement guidance for situations in which a government is a beneficiary of the agreement. The requirements of this Statement are effective for financial statements for periods beginning after December 15, 2016. The Medical Center has not determined the effect, if any, on the financial statements.

Governmental Accounting Standard No. 82

GASB Statement No. 82, *Pension Issues-An Amendment of GASB Statements No. 67, and No. 73*. The objective of this Statement is to address certain issues that have been raised with respect to Statements No. 67, *Financial Reporting for Pension Plans*, No. 68, *Accounting and Financial Reporting for Pensions*, and No. 73, *Accounting and Financial Reporting for Pensions and Related Assets That Are Not within the Scope of GASB Statement No. 68, and Amendments to Certain Provisions of GASB Statements Nos. 67 and 68*. Specifically, this Statement addresses issues regarding (1) the presentation of payroll-related measures in required supplementary information, (2) the selection of assumptions and the treatment of deviations from the guidance in an Actuarial Standard of Practice for financial reporting purposes, and (3) the classification of payments made by employers to satisfy employee (plan member) contribution requirements. The requirements of this Statement are effective for reporting periods beginning after June 15, 2016. The Medical Center has not determined its effect on the financial statements.

(In Thousands)

NOTE #2 – CASH, CASH EQUIVALENTS, AND INVESTMENTS

The Medical Center maintains a certain portion of its cash with the County Treasury for investment purposes to maximize interest earnings. Interest on the pooled funds is allocated based on the Medical Center's average daily balance. The Medical Center's share of the investment activity in the pooled funds managed by the County is not material to the total held by the County. The equity in the County Treasury is carried at fair value based on the value of each participating dollar as provided by the County Treasurer.

Investment policies and related credit, custodial credit, concentration of credit, interest rate and foreign currency risks applicable to the Medical Center’s pooled funds are those of the County and are disclosed in the County’s basic financial statements.

The Medical Center’s cash and restricted investments held with fiscal agent as of June 30, 2016 and 2015 are classified in the accompanying financial statements as follows:

	2016	2015
Cash and cash equivalents	$ 122,213	$ 72,371
Held with fiscal agent for debt service - current	11,924	4,939
Held with fiscal agent for debt service - noncurrent	38,312	45,045
Total Cash and Investments	$ 172,449	$ 122,355

The Medical Center’s cash and investments as of June 30, 2016 and 2015 consisted of the following:

	2016	2015
Deposits with County Treasury	$ 122,213	$ 72,371
Investments	50,236	49,984
Total Cash and Investments	$ 172,449	$ 122,355

(In Thousands)

NOTE #2 – CASH, CASH EQUIVALENTS, AND INVESTMENTS, (CONTINUED)

Investments Authorized by Debt Agreements

Investment of debt proceeds and reserves held by bond trustees are governed by provisions of the trust agreements created in connection with the issuance of debt (see Note #13), rather than the general provisions of the California Government Code. The Medical Center's bond reserves are held in money market mutual funds, U.S. Treasury Securities, and guaranteed investment contracts.

Interest Rate Risk

Interest rate risk is the risk that changes in market interest rates will adversely affect the fair value of an investment. Generally, the longer the maturity of an investment, the greater the sensitivity of its fair value to changes in market interest rates. The Medical Center's investments held by bond trustees are monitored for interest rate risk by measuring the weighted average maturity.

Weighted average maturity of the Medical Center's Investments Held with Bond Trustee as of June 30, 2016:

Investment Type	Amount	Weighted Average Maturity (in years)
Held by bond trustee:		
Money market mutual funds	$ 11,924	daily
Federal Agencies Securities	13,315	0.89
Guaranteed investment contracts	4,751	12.08
U.S. Treasury Bonds	20,246	6.38
Total	$ 50,236	

Weighted average maturity of the Medical Center's Investments Held with Bond Trustee as of June 30, 2015:

Investment Type	Amount	Weighted Average Maturity (in years)
Held by bond trustee:		
Money market mutual funds	$ 4,939	daily
Federal Agencies Securities	20,236	1.32
Guaranteed investment contracts	4,751	13.08
U.S. Treasury Bonds	20,058	7.38
Total	$ 49,984	

(In Thousands)

NOTE #2 – CASH, CASH EQUIVALENTS, AND INVESTMENTS, (CONTINUED)

Credit Risk

Generally, credit risk is the risk that an issuer of an investment will not fulfill its obligation to the holder of the investment. This is measured by the assignment of a rating by a nationally recognized statistical rating organization. Presented below is the minimum rating (where applicable) required by the Medical Center's debt agreements and the actual rating for each investment type as of June 30, 2016 and 2015:

Investment Type	Amount	Rating as of June 30, 2016 A*	Aaa	Exempt**
Held by bond trustee:				
Money market mutual funds	$ 11,924	$ -	$ 11,924	$ -
Federal Agencies Securities	13,315	-	13,315	-
Guaranteed investment contracts	4,751	4,751	-	-
U.S. Treasury Bonds	20,246	-	-	20,246
Total	$ 50,236	$ 4,751	$ 25,239	$ 20,246

* The company with whom the Medical Center has the guaranteed investment contract received long-term ratings of Ba1/A- from Moody's / Standard & Poor's.

** U.S. Treasury Bonds are exempt from GASB 40 disclosure requirements. U.S Treasury Bonds received long-term ratings of Aaa/AA+ from Moody's / Standard & Poor's.

Investment Type	Amount	Rating as of June 30, 2015 A*	Aaa	Exempt**
Held by bond trustee:				
Money market mutual funds	$ 4,939	$ -	$ 4,939	$ -
Federal Agencies Securities	20,236	-	20,236	-
Guaranteed investment contracts	4,751	4,751	-	-
U.S. Treasury Bonds	20,058	-	-	20,058
Total	$ 49,984	$ 4,751	$ 25,175	$ 20,058

* The company with whom the Medical Center has the guaranteed investment contract received long-term ratings of Ba1/A- from Moody's / Standard & Poor's.

** U.S. Treasury Bonds are exempt from GASB 40 disclosure requirements. U.S Treasury Bonds received long-term ratings of Aaa/AA+ from Moody's / Standard & Poor's.

NOTE #2 – CASH, CASH EQUIVALENTS, AND INVESTMENTS, (CONTINUED)

Concentration of Credit Risk

An increased risk of loss occurs as more investments are acquired from one issuer (i.e., lack of diversification). This results in a *concentration of credit risk*.

GASB Statement No. 40 requires disclosure of investments by amount and issuer that represent five percent of more of the total investments held. This requirement excludes investments issued or explicitly guaranteed by the United States Government, investments in mutual funds, external investment pools, and other pooled investments. As of June 30, 2016 and 2015, none of the Medical Center's investments by issuer represented five percent or more of the Medical Center's total investments.

Custodial Credit Risk

Custodial credit risk for *deposits* is the risk that, in the event of the failure of a depository financial institution, a government will not be able to recover its deposits or will not be able to recover collateral securities that are in the possession of an outside party. The California Government Code and the County Treasurer's investment policy do not contain legal or policy requirements that would limit the exposure to custodial credit risk for deposits or investments, other than the following provision for deposits: The California Government Code requires that a financial institution secure deposits made by state or local governmental units by pledging securities in an undivided collateral pool held by a depository regulated under state law. The market value of the pledged securities in the collateral pool must equal at least 110 percent of the total amount deposited by the public agencies. California law also allows financial institutions to secure deposits by pledging first trust deed mortgage notes having a value of 150 percent of the secured public deposits.

GASB Statement No. 40 requires that disclosure be made with respect to custodial credit risks relating to deposits. The Medical Center did not have any cash with fiscal agent in excess of federal depository insurance limits held in uncollateralized accounts at June 30, 2016 and 2015.

Fair Value Measurements

The Medical Center categorizes its fair value measurements within the fair value hierarchy established by generally accepted accounting principles. The hierarchy is based on the valuation inputs used to measure the fair value of the asset. The hierarchy gives the highest priority to unadjusted quoted prices in active markets for identical assets or liabilities (Level 1 measurements) and the lowest priority to unobservable inputs (Level 3 measurements). The three levels of the fair value hierarchy are described as follows:

<u>Level 1</u> — Inputs to the valuation methodology are unadjusted quoted prices for identical assets or liabilities in active markets that the Medical Center has the ability to access.

NOTE #2 – CASH, CASH EQUIVALENTS, AND INVESTMENTS, (CONTINUED)

Fair Value Measurements (continued)

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;
- Inputs that are derived principally from or corroborated by observable market data by correlation or other means.

Level 3 — Inputs to the valuation methodology are unobservable and significant to the fair value measurement. Unobservable inputs reflect the Medical Centers' own assumptions about the inputs market participants would use in pricing the asset or liability (including assumptions about risk). Unobservable inputs are developed based on the best information available in the circumstances and may include the Medical Center's own data.

The asset's level within the hierarchy is based on the lowest level of input that is significant to the fair value measurement. Valuation techniques used need to maximize the use of observable inputs and minimize the use of unobservable inputs. The determination of what constitutes observable requires judgment by the Medical Center's management. Medical Center management considers observable data to be that market data which is readily available, regularly distributed or updated, reliable, and verifiable, not proprietary, and provided by multiple independent sources that are actively involved in the relevant market. The categorization of an investment within the hierarchy is based upon the relative observability of the inputs to its fair value measurement and does not necessarily correspond to Medical Center management's perceived risk of that investment.

In instances where inputs used to measure fair value fall into different levels in the above fair value hierarchy, fair value measurements in their entirety are categorized based on the lowest level input that is significant to the valuation. The Medical Center’s assessment of the significance of particular inputs to these fair value measurements requires judgment and considers factors specific to each asset or liability. Deposits and withdrawals in the County Treasury are made on the basis of $1 and not fair value. Accordingly, the Medical Center’s proportionate share of investments in the County Treasury at June 30, 2016 and 2015 of $122,213 and $72,371, respectively, is an uncategorized input not defined as a Level 1, Level 2, or Level 3 input.

The following is a description of the valuation methods and assumptions used by the Medical Center to estimate the fair value of its investments. There have been no changes in the methods and assumptions used at June 30, 2016 and 2015. The methods described may produce a fair value calculation that may not be indicative of net realizable value or reflective of future fair values. Medical Center management 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.

(In Thousands)

NOTE #2 – CASH, CASH EQUIVALENTS, AND INVESTMENTS, (CONTINUED)

Fair Value Measurements (continued)

When available, quoted prices are used to determine fair value. When quoted prices in active markets are available, investments are classified within Level 1 of the fair value hierarchy. For investments classified within Level 2 of the fair value hierarchy, the Medical Center's custodians generally uses a multi-dimensional relational model. Inputs to their pricing models are based on observable market inputs in active markets. The inputs to the pricing models are typically benchmark yields, reported trades, broker-dealer quotes, issuer spreads and benchmark securities, among others. The Medical Center's Level 2 investments consist of investments in U.S. government and agency obligations that did not trade on the Medical Center's fiscal year end date. The Medical Center has the following recurring fair value measurements as of June 30, 2016 and 2015:

June 30, 2016	Fair Value Measurements Using			
Investment Type	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Held by bond trustee:				
Federal Agencies Securities	$ -	$ 13,315	$ -	$ 13,315
U.S. Treasury Bonds	-	20,246	-	20,246
Total	$ -	$ 33,561	$ -	33,561
			Money market mutual funds	11,924
			Guaranteed investment contracts	4,751
			Total investment portfolio	$ 50,236

(In Thousands)

NOTE #2 – CASH, CASH EQUIVALENTS, AND INVESTMENTS, (CONTINUED)

Fair Value Measurements (continued)

June 30, 2015	Fair Value Measurements Using			
Investment Type	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)	Total
Held by bond trustee:				
Federal Agencies Securities	$ -	$ 20,236	$ -	$ 20,236
U.S. Treasury Bonds	-	20,058	-	20,058
Total	$ -	$ 40,294	$ -	40,294
			Money market mutual funds	4,939
			Guaranteed investment contracts	4,751
			Total investment portfolio	$ 49,984

NOTE #3 – AB 85 HEALTH REDIRECTION

With California electing to implement a state-run Medicaid Expansion afforded by the Affordable Care Act, the State anticipates that counties' costs and responsibilities for the health care services for the indigent population will decrease, as much of this population becomes eligible for coverage through Medi-Cal or the Exchange. On June 27, 2013, Governor Brown signed into law AB 85 that provides a mechanism for the State to redirect State health realignment funding to fund social service programs.

The redirected amount is determined according to respective formula options for California's twelve public hospital system counties. County groups will have an option to either have 60 percent of health realignment redirected, or, to use a formula-based approach that takes into account a county's cost and revenue experience, and redirect 80 percent of the savings realized by the county. For fiscal year ending June 30, 2016 and 2015, the Medical Center received $45,666 and $36,386 in redirected realignment revenue under the AB 85 formula, respectively. Because the revenues received are not based upon services provided to patients, they have been classified as nonoperating revenue in the accompanying statement of revenues, expenses, and changes in net position.

NOTE #4 – NET PATIENT SERVICE REVENUE

The Medical Center provides services to eligible patients under Medi-Cal and Medicare programs. For the fiscal years ended June 30, 2016 and 2015, the Medi-Cal program represented approximately 55 percent and 61 percent, respectively, and the Medicare program represented approximately 27 percent and 23 percent, respectively, of the Medical Center's net patient service revenue. Medi-Cal inpatient services are reimbursed at contractually agreed-upon per diem rates and outpatient services are reimbursed under a schedule of maximum allowances. Medicare inpatient services are reimbursed based upon pre-established rates for Medicare Severity-Diagnostic Related Group (MS-DRG). Outpatient services are reimbursed based on prospectively determined payments per procedure under a system called Ambulatory Payment Classifications. Certain defined capital and medical education costs related to Medicare beneficiaries continue to be paid based on a cost-reimbursement methodology. The Medical Center is reimbursed for cost-reimbursable items at a tentative rate, with final settlement determined after submission of annual cost reports by the Medical Center and audits thereof by the fiscal intermediary. The Medical Center's classification of patients under these programs and the appropriateness of their admissions are subject to an independent review by a peer review organization under contract with the Medical Center. Final reports on the results of such audits have been received through June 30, 2011 for Medicare and June 30, 2014, for Medi-Cal. Adjustments as a result of such audits are recorded in the year the amounts can be determined.

Medi-Cal – The Medicaid program is referred to as Medi-Cal in California. Medi-Cal fee-for-service (“FFS”) inpatient hospital payments are made in accordance with the federal Medicaid hospital financing waiver and legislation enacted by the State of California. Medi-Cal outpatient FFS services are reimbursed based on a fee schedule. The total payments made to the Medical Center will include a combination of Medi-Cal inpatient FFS payments, Medi-Cal Disproportionate Share Hospital (“DSH”) payments and the Safety Net Care Pool (“SNCP”).

Effective November 2011, the Medical Center is also eligible to receive incentive payments designed to encourage delivery system innovation in preparation for the implementation of federal health care reform.

California has created and is testing a new global payment approach for the uninsured, which assists designated public hospital systems. This will help to focus on the value, not volume, of care provided to the uninsured, such as providing more primary and preventive care. The authority to implement the new Global Payment Program for Public Health Systems (GPP) is contingent upon CMS review and approval of the specific factors and parameters to be used in establishing the “points” system. Approximately $2.9 billion in combined federal and state shares of expenditures has been allocated towards this new approach for demonstration year 11 as a part of CMS’s approval of the California Medi-Cal 2020 demonstration extension, a portion of which is disproportionate share hospital (DSH) funding. The total amount available for the GPP is a combination of a portion of the State’s DSH allotment that would otherwise be allocated to public hospitals and the amount associated with the SNCP (Safety Net Care Pool) provided under the “Bridge to Reform” Section 1115 waiver. Amounts for future years will be determined after completion of the first required uncompensated care report. The Medical Center received $44,261 in GPP funding in fiscal year ended June 30, 2016 and $31,187 in DSH and SCNP funding in the fiscal year ended June 30, 2015 Because the revenues generated are based upon services provided to patients, they have been classified as net patient service revenue in the accompanying Statements of Revenues, Expenses, and Changes in net Position.

For the years ended June 30, 2016 and 2015, the Medical Center recorded total Medi-Cal inpatient and outpatient net revenue of $186,630 and $196,532, respectively and related receivables of $21,889 and $43,598, respectively.

NOTE #4 – NET PATIENT SERVICE REVENUE, (CONTINUED)

Assembly Bill 915 – California's Assembly Bill 915 (AB-915) was passed by the State Legislature and signed into law in 2002. This bill provides for the payment of a supplemental reimbursement to acute care hospitals owned by certain public entities that provide outpatient services to Medi-Cal beneficiaries. The Medical Center recorded $5,517 and $7,691 in AB-915 funds for the years ended June 30, 2016 and 2015, respectively. Because the revenues generated are based upon services provided to patients, they have been classified as net patient service revenue in the accompanying Statements of Revenues, Expenses, and Changes in Net Position.

NOTE #5 – DELIVERY SYSTEM REFORM INCENTIVE POOL

On November 2, 2010, the federal government approved California's five-year, $10 billion "Bridge to Reform" Section 1115 waiver proposal. The Section 1115 waiver helps the state transition to the federal reforms that took effect in January 2014. The waiver promotes a public hospital delivery system transformation, and implements a series of improvements to public hospitals' delivery system to strengthen their infrastructure, prepare them for full implementation of reform and test strategies to slow the rate of growth in health care costs throughout the state. Within the SNCP (Safety Net Care Pool), a Delivery System Reform Incentive Pool has been establish to support the ability of California's public hospitals efforts to enhance the quality of care and health of the patients and families they serve. The processes for distribution of these funds have been developed jointly by the state, public hospitals systems and the federal Centers for Medicare and Medicaid Services. The four areas for which funding will be available under the Delivery System Reform Incentive Program are 1) Infrastructure Development 2) Innovation and Redesign 3) Population-Focused Improvement, and 4) Urgent Improvement in Care.

The amount to be received by the hospitals is dependent upon certain milestones and was transitioned to the Public Hospital Redesign and Incentives in Medi-Cal Program (PRIME) discussed in Note #6 below. The Medical Center's share of these revenues for the years ended June 30, 2016 and 2015 were ($1,171) and $36,849, respectively. Because the revenues received are not based upon services provided to patients, they have been classified as nonoperating revenue in the accompanying statement of revenues, expenses, and changes in net position.

NOTE #6 – PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL PROGRAM (PRIME) FUNDING

California's next Section 1115 Medicaid Waiver, Medi-Cal 2020, was approved on December 31, 2015. The Medi-Cal 2020 initiatives include a Global Payment Program (GPP), a Whole Person Care Pilot program, a Dental Transformation initiative and the introduction of the Public Hospital Redesign and Incentives in Medi-Cal program (PRIME). PRIME builds upon the successes of the Delivery System Reform Incentive Payment Program (DSRIP) established under the 2010 Bridge to Reform waiver, continuing to encourage a transition to value-based care as it enters Demonstration Year (DY) 11. The waiver strives to further expand access, improve quality of care and outcomes, and control the cost of care. The PRIME demonstration approved through December 31, 2020 is available to eligible designated public hospital (DPH) systems, as well as district municipal public hospitals (DMPHs) and contracted providers.

NOTE #6 – PUBLIC HOSPITAL REDESIGN AND INCENTIVES IN MEDI-CAL PROGRAM (PRIME) FUNDING, (CONTINUED)

Incentive funding is available to eligible entities based upon successful performance on a designated set of core metrics. PRIME pool funding will not exceed $7.464 billion over five years, of which $1.4 billion will be available annually to DPHs and $200 million to district municipal public hospitals (DMPH) during DY11-DY13. Participating health systems will incur a phase down in the final two years with a 10 percent decrease in funding during DY14, and a 15 percent decrease in DY15. Centers for Medicare and Medicaid Services (CMS) is prepared to authorize a five-year extension of the necessary authorities for a pool focused on delivery system reform in the public provider system. The pool will build off of the 2010-2015 Delivery System Reform Incentive Program, but the new, redesigned pool, PRIME, will support the state's efforts towards the adoption of robust alternative payment methodologies (APMs) and support better integration, improved health outcomes and increased access to healthcare services, particularly for those with complex health care needs.

California will use this pool to fund public provider system projects that will change care delivery and strengthen those systems' ability to receive payment under risk-based alternative payment models. As these delivery system changes occur, the state has committed to adopting alternative payment models that align with HHS' delivery system reform goals where the provider is accountable for quality and cost of care. CMS and the state will measure the success of the DSRIP PRIME pool by the progress in adopting robust alternative payment methodologies for Medi-Cal payments to designated public hospital systems, including shifting risk through capitation from Medi-Cal managed care health plans (MCPs) to designated public hospital systems, and other risk sharing arrangements. Contracts between MCPs and DPHs will include language requiring the provider to report on a broad range of metrics to meet quality benchmark goals. Over the course of the demonstration, payments will increasingly move towards pay for performance. The public health care systems will become self-sustaining entities that are not reliant on pool funds beyond 2020. To achieve such sustainability, 50 percent of all Medi-Cal managed care beneficiaries assigned to designated public hospital systems in the aggregate will receive all of or a portion of their care under a contracted alternative payment model by January 2018; 55 percent by January 2019; and 60 percent by the end of the waiver renewal period in 2020.

Funding for this pool will not exceed $7.464 billion in combined federal and state shares of expenditures over a five-year period for designated public hospital systems and district/municipal public hospitals to support reforms to care delivery, provider organization and adoption of alternative payment methodologies. The demonstration will provide up to $1.4 billion annually for the designated public hospital systems and up to $200 million annually for the district/municipal public hospitals for the first three years of the demonstration. The pool will then phase down by 10 percent in the fourth year of the demonstration and by an additional 15 percent in the fifth year of the demonstration.

The state will develop an evaluation plan for the PRIME program which will assess the impact of the program on the public delivery system and Medi-Cal beneficiaries. This evaluation will also measure a broad range of metrics and data related to the quality of care and health outcomes of all Medicaid beneficiaries, including those with low socioeconomic status, served by participating providers. The Medical Center received $43,064 in PRIME funding in fiscal year ended June 30, 2016 and $36,849 in DSRIP funding in the fiscal year ended June 30, 2015. The Medical Center has $43,064 in PRIME receivables at June 30, 2016. Because the revenues received are not based upon services provided to patients, they have been classified as nonoperating revenue in the accompanying Statements of Revenues, Expenses, and Changes in Net Position.

NOTE #7 – SUPPLEMENTAL RISK POOL FUNDING

As a part of the Affordable Care Act (ACA), California opted to participate in the Medicaid Expansion program, which expands Medicaid coverage to the most poor of the uninsured of the country, enabling more families to receive medical coverage. The ACA requires insurance companies and health plans to spend at least 85 percent of premium dollars on medical care as opposed to administrative cost. If they fail to meet these standards, the insurance companies and health plans are required to issue a rebate to providers who treat their patients or refund money to the State, jeopardizing their standing for future dollars. The dollar amount the Provider (Medical Center) receives is based on the number of Medicaid Expansion members and/or volume of services provided to the Health Plan Medicaid Expansion beneficiaries.

The Medical Center's share of these revenues for the years ended June 30, 2016 and 2015 were ($3,028) and $36,001, respectively. Because the revenues received are not based upon services provided to patients, they have been classified as nonoperating revenue in the accompanying Statements of Revenues, Expenses, and Changes in Net Position

NOTE #8 – HOSPITAL FEE PROGRAM

AB 1383 of 2009, as amended by AB 1653 on September 8, 2010, established a series of Medicaid supplemental payments funded through a "Quality Assurance Fee" and a "Hospital Fee Program", which are imposed on certain California hospitals. The effective date of the Hospital Fee Program is April 1, 2009 through December 31, 2013 and is predicated in part on the enhanced Federal Medicaid Assistance Percentage ("FMAP") contained in the American Reinvestment and Recovery Act ("ARRA"). The Hospital Fee Program made supplemental payments to hospitals for various health care services and support the State's effort to maintain health care coverage for children. The Medical Center, as a designated public hospital, is exempt from paying the "Quality Assurance Fee"; however, the Medical Center was eligible to receive supplemental payments under the Hospital Fee Program.

Under the Hospital Fee Program, designated public hospitals were eligible to receive direct grants (Direct Grants) for each approved federal fiscal year. For the fiscal year ended June 30, 2016 and 2015, the Medical Center received direct grants totaling $3,147 and $3,053 respectively, which has been reported as non-operating revenue.

(In Thousands)

NOTE #9 – CHARITY CARE

Charity care is that portion of patient care services provided by the Medical Center for which a third-party payer is not responsible and a patient does not have the ability to pay. Eligibility for Charity Care is considered for those individuals, who are uninsured, underinsured, ineligible for any governmental health care benefit program, and unable to pay for their care, based upon a determination of financial need. Charity Care is made in accordance with the patient's financial need as determined by the Federal Poverty Level (FPL) in effect at the time of financial determination. The Medical Center maintains records to identify and monitor the level of charity care it provides. These records include the amount of charges foregone for services and supplies furnished under its charity care policy. The following information measures the level of charity care provided during the fiscal years ended June 30:

	2016	2015
Cost of caring for Charity Care patients	$ 5,719	$ 3,645

NOTE #10 – CAPITAL CONTRIBUTIONS

In 1991, the County Board of Supervisors approved the construction and financing plan of the Arrowhead Regional Medical Center project. The Inland Empire Public Facilities Corporation (Corporation) financed the project through the issuance of Certificates of Participation. The Corporation is a nonprofit public benefit corporation formed on May 30, 1986, to serve the County, including the Medical Center, by financing, refinancing, acquiring, constructing, improving, leasing, and selling buildings, building improvements, equipment, land, land improvements, and any other real or personal property for the benefit of the residents of the County. The Corporation is included in the County's reporting entity as a blended component unit. In fiscal year 1999, the Medical Center Project assets and liabilities were contributed to the Medical Center.

In accordance with the master lease agreement, the County is obligated to make aggregate lease payments each year as consideration for the use and occupancy of the Medical Center in an amount designated to be sufficient to pay the annual principal and interest due with respect to any construction debt outstanding. Senate Bill 1732 (SB-1732) was passed by the California Legislature and signed into law in October 1998. The law permits qualifying medical centers to receive reimbursement, in addition to their Medi-Cal contract reimbursement, for a portion of the debt service of qualified projects. Under SB-1732, the Medical Center estimates that it will receive proceeds equal to 51.27 percent of the total debt service costs. Amounts received by the Medical Center in SB-1732 funds during fiscal years 2016 and 2015 amounted to $18,855 and $16,501, respectively, which are included as nonoperating revenues in the accompanying Statements of Revenues, Expenses, and Changes in Net Position. The Medical Center had no related receivables at June 30, 2016 and 2015.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED JUNE 30, 2016 AND 2015
(In Thousands)

NOTE #11 – CAPITAL ASSETS

A summary of capital assets activity for the years ended June 30, 2016 and 2015 is as follows:

June 30, 2016	Beginning Balance	Additions	Deletions	Ending Balance
Capital assets not being depreciated:				
Construction-in-progress	$ 1,261	$ 3,207	$ (2,646)	$ 1,822
Total capital assets not being depreciated	1,261	3,207	(2,646)	1,822
Capital assets being depreciated:				
Land and improvements	24,753	687	-	25,440
Buildings and improvements	545,441	1,945	-	547,386
Equipment	160,546	11,074	(628)	170,992
Total capital assets being depreciated	730,740	13,706	(628)	743,818
Less accumulated depreciation:				
Land and improvements	(1,512)	(145)	-	(1,657)
Buildings and improvements	(213,000)	(14,935)		(227,935)
Equipment	(131,971)	(8,092)	561	(139,502)
Total accumulated depreciation	(346,483)	(23,172)	561	(369,094)
Total capital assets being depreciated, net	384,257	(9,466)	(67)	374,724
Total capital assets, net	$ 385,518	$ (6,259)	$ (2,713)	$ 376,546

June 30, 2015	Beginning Balance	Additions	Deletions	Ending Balance
Capital assets not being depreciated:				
Construction-in-progress	$ 799	$ 1,406	$ (944)	$ 1,261
Total capital assets not being depreciated	799	1,406	(944)	1,261
Capital assets being depreciated:				
Land and improvements	24,753	-	-	24,753
Buildings and improvements	544,516	925	-	545,441
Equipment	156,100	4,733	(287)	160,546
Total capital assets being depreciated	725,369	5,658	(287)	730,740
Less accumulated depreciation:				
Land and improvements	(1,321)	(191)	-	(1,512)
Buildings and improvements	(198,171)	(14,829)	-	(213,000)
Equipment	(124,669)	(7,307)	5	(131,971)
Total accumulated depreciation	(324,161)	(22,327)	5	(346,483)
Total capital assets being depreciated, net	401,208	(16,669)	(282)	384,257
Total capital assets, net	$ 402,007	$ (15,263)	$ (1,226)	$ 385,518

NOTE #12 – TRANSACTIONS WITH THE COUNTY

The Medical Center uses the treasury function of the County and at times maintains a cash overdraft with the County which can be repaid only through collection of receivables. The Medical Center had no cash overdrafts as of June 30, 2016 and 2015.

The Medical Center is allocated a portion of the County's overhead costs. Such expenses totaled $3,594 and $4,022 for the years ended June 30, 2016 and 2015, respectively, and are included as operating expense in the accompanying statements of revenues, expenses, and changes in net position.

Transfers from the County were $26,819 and $17,208 for the years ended June 30, 2016 and 2015, respectively. During the year ending June 30, 2016, a rebate was due the Medical Center related to the Medical Center’s participation in the County’s Risk Management Internal Service Fund in the amount of $11,427 and was transferred to the Medical Center to be applied against future amounts due the Risk Management Internal Service Fund. The remaining amounts transferred in the current year from the County, as well as transfers in the year ending June 30, 2015, were mostly related to the funding of debt service payments of the Medical Center.

Amounts due to the County in the amount of $410 and $313 for the years ended June 30, 2016 and 2015, respectively, represents amounts due to Collection, Sheriff, General Fund, Mental and Behavioral Health Departments, Architecture & Engineering for services provided and other departments related to services provided.

Amounts due from the County were $13,658 and $7,187 for the years ended June 30, 2016 and 2015, respectively. During the year ending June 30, 2016, a rebate was due the Medical Center related to the Medical Center’s participation in the County’s Risk Management Internal Service Fund in the amount of $11,427. The $11,427 will be applied against future amounts due the Risk Management Internal Service Fund. Other amounts are due from the County’s Central Collection Department for cash collected on behalf of the Medical Center. For the year ended June 30, 2015, the largest portion of the amounts due from the County was from the Behavioral Health Department in the amount of $5,721 in addition to amounts owed the Medical Center for cash collected on behalf of the Medical Center.

The year end balances noted above for due to / due from are expected to be received and repaid within the next fiscal year.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

NOTES TO FINANCIAL STATEMENTS

YEARS ENDED JUNE 30, 2016 AND 2015
(In Thousands)

NOTE #13 – LONG-TERM OBLIGATIONS

The following is a summary of changes in long-term obligations for the fiscal years ended June 30, 2016 and 2015:

	June 30, 2016				
	Beginning Balance	Additions	Reductions	Ending Balance	Due within One Year
Certificates of Participation					
Series 1994	$ 107,730	$ -	$ (4,695)	$ 103,035	$ 4,965
Series 1995	13,545	-	(4,225)	9,320	4,505
Series 1996	62,785	-	(445)	62,340	465
Series 2009 A	199,415	-	(11,905)	187,510	12,445
Series 2009 B	43,880	-	-	43,880	-
Total Certificates of Participation, Gross	427,355	-	(21,270)	406,085	22,380
Less: Discount on debt	(3,375)	-	226	(3,149)	-
Total Certificates of Participation	423,980	-	(21,044)	402,936	22,380
Capital lease obligations	5,292	1,921	(3,021)	4,192	1,924
Total	$ 429,272	$ 1,921	$ (24,065)	$ 407,128	$ 24,304

	June 30, 2015				
	Beginning Balance	Additions	Reductions	Ending Balance	Due within One Year
Certificates of Participation					
Series 1994	$ 112,175	$ -	$ (4,445)	$ 107,730	$ 4,695
Series 1995	17,500	-	(3,955)	13,545	4,225
Series 1996	63,205	-	(420)	62,785	445
Series 2009 A	210,820	-	(11,405)	199,415	11,905
Series 2009 B	43,880	-	-	43,880	-
Total Certificates of Participation, Gross	447,580	-	(20,225)	427,355	21,270
Less: Discount on debt	(3,601)	-	226	(3,375)	-
Total Certificates of Participation	443,979	-	(19,999)	423,980	21,270
Capital lease obligations	8,434	-	(3,142)	5,292	2,381
Total	$ 452,413	$ -	$ (23,141)	$ 429,272	$ 23,651

NOTE #13 – LONG-TERM OBLIGATIONS, (CONTINUED)

A. Certificates of Participation

The Medical Center's certificates of participation were issued by the Inland Empire Public Facilities Corporation (Corporation).

Certificates of participation at June 30, 2016 consist of the following:

Series 1994

The Medical Center Series 1994 Certificates of Participation were dated February 1, 1994, in the amount of $283,245 with interest rates from 4.60 percent to 7.00 percent.

The Series 1994 Certificates maturing on August 1, 2019, August 1, 2024, August 1, 2026, and August 1, 2028, are subject to optional redemption in whole or in part on any date in such order of maturity as the Corporation shall determine and by lot within a maturity, plus interest accrued to the redemption date.

The Series 1994 Certificates maturing through August 1, 2017, August 1, 2020, and August 1, 2022, are not subject to optional redemption prior to maturity. On December 17, 2009 the Corporation issued the 2009 Series B Refunding Certificates and used the proceeds of the 2009 Series B Certificates along with other available funds to refund $44,325 of the Series 1994 Certificates.

Series 1995

The Series 1995 Certificates of Participation were dated June 1, 1995, in the amount of $363,265 with interest rates from 4.80 percent to 7.00 percent.

The Series 1995 Certificates maturing on August 1, 2022, are subject to optional redemption, in whole or in part, on any date in such order of maturity as the Corporation shall determine and by lot within a maturity, plus interest accrued to the redemption date.

The Series 1995 Certificates maturing on and prior to August 1, 2011 and on August 1, 2017 are not subject to optional redemption prior to maturity. On December 17, 2009 the Corporation issued the 2009 Series A Refunding Certificates and used the proceeds of the 2009 Series A Certificates along with other available funds to refund $45,065 of the Series 1995 Certificates.

Series 1996

The Series 1996 Certificates of Participation were dated January 1, 1996, in the amount of $65,070, with interest rates from 5.00 percent to 5.25 percent.

The Series 1996 Certificates are subject to optional redemption, in whole or in part, on any date in such order of maturity as the Corporation shall determine and by lot within a maturity, plus interest accrued to the redemption date.

(In Thousands)

NOTE #13 – LONG-TERM OBLIGATIONS, (CONTINUED)

A. Certificates of Participation, (Continued)

Series 2009 A

The Medical Center Series 2009 A Refunding Certificates of Participation were issued on December 17, 2009, in the amount of $243,980. The proceeds were used to refund a portion of the Certificate of Participation, Series 1995 and all of the outstanding Certificate of Participation, Series 1998 and fund a payment with respect to the termination of a Swap agreement entered into in connection with the execution and delivery of the Certificate of Participation, Series 1998. Interest rates on the 2009 A series range from 3.00 percent to 5.5 percent.

Series 2009 B

The Medical Center Series 2009 B Refunding Certificates of Participation were issued on December 17, 2009, in the amount of $44,750. The proceeds were used to refund a portion of the outstanding Certificate of Participation, Series 1994. Interest rates on the 2009 B series range from 3.00 percent to 5.25 percent.

B. Debt Service Requirements

The total annual debt service requirements to maturity for the outstanding Certificates of Participation as of June 30, 2016 are summarized as follows:

	Total	
Fiscal Year	Principal	Interest
2017	$ 22,380	$ 20,540
2018	23,630	19,299
2019	24,920	18,036
2020	26,230	16,749
2021	27,765	15,231
2022-2026	165,095	51,127
2027-2029	116,065	8,630
Totals	$ 406,085	$ 149,612

(In Thousands)

NOTE #13 – LONG-TERM OBLIGATIONS, (CONTINUED)

C. Capital Lease Obligations

The Medical Center has various lease agreements with financial institutions and medical equipment manufacturers expiring at various dates through fiscal year ending 2020, providing for monthly payments at various interest rates. Equipment acquired under these agreements has been accounted for as capital leases.

Future minimum lease payments on capital leases as of June 30, 2016, are as follows:

Fiscal Year		
2017	$	1,998
2018		1,302
2019		699
2020		324
Total minimum lease payments		4,323
Less Amount Representing Interest		(131)
Present value of net minimum lease payments		4,192
Less Current Portion of Capital Lease Obligations		(1,924)
Capital lease obligations, excluding current portion	$	2,268

The gross value of equipment acquired under capitalized leases at June 30, 2016 and 2015 was $25,722 and $23,802, net of accumulated amortization of $18,976 and $16,266, respectively.

NOTE #14 – ARBITRAGE PAYABLE

Interest earned in excess of interest expense related to tax-exempt debt issued for public purposes must be remitted to the federal government following the end of each period of five bond years of the Certificates of Participation. The amount of excess investment earnings calculated as of June 30, 2016 and 2015, totaled $81 and $81, respectively.

NOTE #15 – OPERATING LEASES

Rent expense for operating leases for the years ended June 30, 2016 and 2015, totaled $3,769 and $3,911, respectively.

(In Thousands)

NOTE #16 – RETIREMENT PLAN

Plan Description. Employees of the Medical Center participate in the County of San Bernardino's (County) cost-sharing multiple-employer defined benefit retirement plan (the Plan) administered by the San Bernardino County Employee's Retirement Association (SBCERA). The Plan is governed by the San Bernardino Board of Retirement (Board) under the California County Employees' Retirement Law of 1937 (CERL) and the California Public Employees' Pension Reform Act of 2013 (PEPRA). The Plan's authority to establish and amend the benefit terms are set by the CERL and PEPRA, and may be amended by the California state legislature and in some cases require approval by the County of San Bernardino Board of Supervisors and/or the SBCERA Board. SBCERA issues a stand-alone financial report, which may be obtained by contacting the Board of Retirement, 348 W. Hospitality Lane, 3rd Floor, San Bernardino, California 92415-0014.

Benefits Provided. SBCERA provides retirement, disability, death and survivor benefits. SBCERA administers the Plan which provides benefits for two membership classifications, General and Safety, and those benefits are tiered based upon date of SBCERA membership. Safety membership is extended to those involved in active law enforcement and fire suppression. All other members, including the Medical Center's employees, are classified as General members. Generally, those who become members prior to January 1, 2013 are Tier 1 members. All other members are Tier 2. An employee who is appointed to a regular position, whose service is at least fifty percent of the full standard of hours required, are members of SBCERA, and are provided with pension benefits pursuant to Plan requirements.

The CERL and PEPRA establish benefit terms. Retirement benefits for the General Tier 1 and General Tier 2 Plans are calculated on the basis of age, average final compensation and service credit as follows:

	General – Tier 1	**General – Tier 2**
Final Average Compensation	Highest 12 consecutive months	Highest 36 consecutive months
Normal Retirement Age	The later of age 55 or the age at which the member vests in his/her benefits under the CERL, but not later than age 70	The later of age 55 or the age at which the member vests in his/her benefits under the CERL, but not later than age 70
Early Retirement: Years of service required and/or age eligible for	Age 70 any years	Age 70 any years
	10 years age 50	5 years age 52
	30 years any age	N/A
Benefit	At normal retirement age, 2.0% per year of final average compensation for every year of service credit	At age 67, 2.5% per year of final average compensation for every year of service credit
Benefit Adjustments	Reduced before age 55, increased after 55 up to age 65	Reduced before age 67
Final Average Compensation Limitation	Internal Revenue Code section 401(a)(17)	Government Code section 7522.10

NOTE #16 – RETIREMENT PLAN, (CONTINUED)

An automatic cost of living adjustment is provided to benefit recipients based on changes in the local region Consumer Price Index (CPI) up to a maximum of 2 percent per year. Any increase greater than 2 percent is banked and may be used in years where the CPI is less than 2 percent. There is a one-time 7 percent increase at retirement for members hired before August 19, 1975. The Plan also provides disability and death benefits to eligible members and their beneficiaries, respectively. For retired members, the death benefit is determined by the retirement benefit option chosen. For all other members, the beneficiary is entitled to benefits based on the members years of service or if the death was caused by employment. General members are also eligible for survivor benefits which are payable upon a member's death.

Contributions. Participating employers and active members (i.e County), including the Medical Center and the Medical Center's employees, are required by statute to contribute a percentage of covered salary to the Plan. This requirement is pursuant to Government Code sections 31453.5 and 31454, for participating employers and Government Code sections 31621.6, 31639.25 and 7522.30 for active members. The contribution requirements are established and may be amended by the SBCERA Board pursuant to Article 1 of the CERL, which is consistent with the Plan's actuarial funding policy. The contribution rates are adopted yearly, based on an annual actuarial valuation, conducted by an independent actuary, that requires actuarial assumptions with regard to mortality, expected future service (including age at entry into the Plan, if applicable and tier), and compensation increases of the members and beneficiaries. The combined active member and employer contribution rates are expected to finance the costs of benefits for employees that are allocated during the year, with an additional amount to finance any unfunded accrued liability. Participating employers may pay a portion of the active members' contributions through negotiations and bargaining agreements. Employer contribution rates for the year ended June 30, 2016 are 22.49 percent fir Tier 1 General members and 19.39 percent for Tier 2 General members.

Employee contribution rates for the fiscal year ended June 30, 2016 and 2015 ranged between 7.81 percent and 14.21 percent for Tier 1 General members and between 7.70 percent and 8.4 percent for Tier 2 General members. The Medical Center's proportionate share of the County's contribution to the Plan was $30,662 and $27,801 for the years ended June 30, 2016 and 2015.

Pension Liabilities, Pension Expense, and Deferred Outflows of Resources and Deferred Inflows of Resources Related to Pensions

At June 30, 2016 and 2015, the Medical Center reported a liability of $156,238 and $142,685, respectively, for its proportionate share of the County's net pension liability. The net pension liability was measured as of June 30, 2015, and the total pension liability used to calculate the net pension liability was determined by an actuarial valuation as of that date. The Medical Center's proportion of the County's net pension liability was based on the Medical Center's FY 2015 actual contributions to the County's pension plan relative to the total contributions of the County as a whole. At June 30, 2015, the Medical Center's proportion was 9.6247 percent, which was a decrease of .2991 percent from its proportion measured as of June 30, 2014.

(In Thousands)

NOTE #16 – RETIREMENT PLAN, (CONTINUED)

For the years ended June 30, 2016 and 2015, the Medical Center recognized pension expense of $14,239 and $10,812 respectively. The Medical Center reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

June 30, 2016	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 25,962
Changes in actuarial assumptions	17,950	
Net difference between projected and actual earnings on pension plan investments	-	9,159
Changes in proportion and differences between employer contributions and proportionate share of contributions	2,599	8,071
Employer contributions paid by the Medical Center to SBCERA subsequent to the measurement date	30,662	-
Total	$ 51,211	$ 43,192

June 30, 2015	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 27,185
Changes in actuarial assumptions	23,167	
Net difference between projected and actual earnings on pension plan investments	-	43,701
Changes in proportion and differences between employer contributions and proportionate share of contributions	3,335	5,374
Employer contributions paid by the Medical Center to SBCERA subsequent to the measurement date	27,801	-
Total	$ 54,303	$ 76,260

(In Thousands)

NOTE #16 – RETIREMENT PLAN, (CONTINUED)

The $30,662 reported as deferred outflows of resources related to pensions resulting from the Medical Center's contributions to the County's plan subsequent to the measurement date will be recognized as a reduction of the net pension liability in the year ended June 30, 2017. Other amounts reported as deferred outflows of resources and deferred inflows of resources related to the Medical Center's proportion of the County's pension plan will be recognized in pension expense as follows:

Year ended June 30	June 30, 2016
2017	$ (10,056)
2018	(10,056)
2019	(3,089)
2020	2,851
2021	(1,712)
Thereafter	(581)
Total	$ (22,643)

Actuarial assumptions. The Medical Center's proportion of the County's total pension liability in the June 30, 2015 and 2014 actuarial valuations were determined using the following actuarial assumptions, applied to all periods included in the measurement:

	June 30, 2016	June 30, 2015
Actuarial valuation date	June 30, 2015	June 30, 2014
Actuarial cost method	Entry age actuarial cost method	Entry age actuarial cost method
Actuarial Assumptions:		
Investment rate of return	7.50%	7.50%
Inflation	3.25%	3.25%
Projected Salary increases	General: 4.60% to 13.75%	General: 4.60% to 13.75%
Cost of Living Adjustments	Consumer price index with a 2.00% maximum	Consumer price index with a 2.00% maximum
Administrative Expenses	0.60% of payroll	0.60% of payroll

Mortality rates used in the latest actuarial valuation dated June 30, 2015 are based on the RP-2000 Combined Healthy mortality table projected 20 years to 2020 using Projection Scale BB. For healthy General members, no adjustments are made. For General members that are disabled, the ages are set forward seven years for males and set forward eight years for females. Beneficiaries are assumed to have the same mortality as a General member of the opposite sex who is receiving a service (non-disability) retirement.

The actuarial assumptions used in the June 30, 2015 and 2014 valuations were based on the results of the June 30, 2014 Review of Economic Assumptions and Actuarial Experience Study for the three year period of July 1, 2010 through June 30, 2013.

(In Thousands)

NOTE #16 – RETIREMENT PLAN, (CONTINUED)

The long-term expected rate of return on Plan investments was determined using a building block method in which expected future real rates of return (expected returns, net of inflation) are developed for each major asset class. This information is combined to produce the long-term expected rate of return by weighting the expected future real rates of return by the target asset allocation percentage, and by adding expected inflation and subtracting expected investment expenses and a risk margin. The target allocations (approved by the Board) and projected arithmetic real rates of return for each major asset class, after deducting inflation, but before deducting investment expenses, used in the derivation of the long-term expected investment rate of return assumptions, are summarized in the table below.

Long-Term Expected Real Rate of Return

		As of June 30 2015 Valuation Date	
Asset Class	**Investment Classification**	**Target Allocation***	**Long-Term Expected Real Rate of Return (Arithmetic)**
Large Cap U.S. Equity	Domestic Common and Preferred Stock	5.00%	5.94%
Small Cap U.S. Equity	Domestic Common and Preferred Stock	2.00%	6.50%
Developed International Equity	Foreign Common and Preferred Stock	6.00%	6.87%
Emerging Market Equity	Foreign Common and Preferred Stock	6.00%	8.06%
U.S. Core Fixed Income	U.S. Government and Agency/Corporate Bonds	2.00%	0.69%
High Yield/Credit Strategies	Corporate Bonds/Foreign Bonds	13.00%	3.10%
Global Core Fixed Income	Foreign Bonds	1.00%	0.30%
Emerging Market Debt	Emerging Market Debt	6.00%	4.16%
Real Estate	Real Estate	9.00%	4.96%
Cash & Equivalents	Short-Term Cash Investment Funds	2.00%	-0.03%
International Credit	Foreign Alternatives	10.00%	6.76%
Absolute Return	Domestic Alternatives/Foreign Alternatives	13.00%	2.88%
Real Assets	Domestic Alternatives/Foreign Alternatives	6.00%	6.85%
Long/Short Equity	Domestic Alternatives/Foreign Alternatives	3.00%	4.86%
Private Equity	Domestic Alternatives/Foreign Alternatives	16.00%	9.64%
Total	**Total**	100.00%	

* For actuarial purposes, target allocations only change once every three years based on the triennial actuarial experience study.

Discount rate. The discount rate used to measure the Plan's total pension liability was 7.50 percent. The projection of cash flows used to determine the discount rate assumed employer and member contributions will be made at rates equal to the actuarially determined contribution rates. For this purpose, only employee and employer contributions that are intended to fund benefits of current Plan members and their beneficiaries are included. Projected employer contributions that are intended to fund the service costs of future Plan members and their beneficiaries, as well as projected contributions from future Plan members, are not included. Based on those assumptions, the Plan's fiduciary net position was projected to be available to make all projected future benefit payments of current Plan members. Therefore, the long-term expected rate of return on pension plan investments was applied to all periods of projected benefit payments to determine the total pension liability.

(In Thousands)

NOTE #16 – RETIREMENT PLAN, (CONTINUED)

Sensitivity of the Medical Center's proportionate share of the County's net pension liability to changes in the discount rate. The following table presents the Medical Center's proportionate share of the County's net pension liability calculated using the discount rate of 7.50 percent, as well as what the Medical Center's proportionate share of the County's net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower (6.50%) or 1-percentage-point higher (8.50%) than the current rate:

June 30, 2016	**1.00% Decrease (6.50%)**	**Current Discount Rate (7.50%)**	**1.00% Increase (8.50%)**
Medical Centers's proportionate share of the County's net pension liability	$ 290,280	$ 156,238	$ 45,307

June 30, 2015	**1.00% Decrease (6.50%)**	**Current Discount Rate (7.50%)**	**1.00% Increase (8.50%)**
Medical Centers's proportionate share of the County's net pension liability	$ 252,157	$ 142,685	$ 52,023

Pension plan fiduciary net position. Detailed information about the County's collective net pension liability is available in the County's separately issued Comprehensive Annual Financial Report (CAFR). The County of San Bernardino's financial statements may be obtained by contacting the County of San Bernardino's Auditor-Controller/Treasurer/Tax Collector's office at 268 W. Hospitality Lane, San Bernardino, California 92415-0018. Detailed information about the SBCERA's fiduciary net position is available in a separately issued SBCERA comprehensive annual financial report. That report may be obtained on the Internet at www.SBCERA.org; by writing to SBCERA at 348 W. Hospitality Lane, Third Floor, San Bernardino, California 92415-0014.

NOTE #17 – SELF-INSURANCE

The Medical Center participates in the County's self-insurance programs for general liability, unemployment insurance, employee dental insurance, medical malpractice, and workers' compensation claim-related risks.

The activities related to the self-insurance programs are accounted for in the County's Risk Management Funds, separate internal service funds of the County, except for unemployment insurance and employee dental insurance, which are accounted for in the General Fund of the County. The Medical Center participates in these plans through a premium based arrangement that consists of annual amounts not subject to adjustment for adverse claims. Insurance premium expense for the years ended June 30, 2016 and 2015 was $10,983 and $11,047, respectively.

NOTE #18 – CONTINGENCIES

The Medical Center is the defendant in various lawsuits and other claims arising in the ordinary course of its operations. In the opinion of County Counsel and County officials, the ultimate outcome of these matters will have no significant effect on the financial condition or operations of the Medical Center.

The healthcare industry is subject to numerous laws and regulations of federal, state and local governments. Compliance with these laws and regulations is subject to periodic government review, interpretation and audits, as well as regulatory actions unknown and unasserted at this time. Management believes that the Medical Center is in compliance with government law and regulations related to fraud and abuse and other applicable areas. While no material regulatory inquiries have been made, compliance with such laws and regulations can be subject to future governmental review and interpretation, as well as regulatory actions unknown or unasserted at this time.

REQUIRED SUPPLEMENTARY INFORMATION

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

REQUIRED SUPPLEMENTARY INFORMATION (UNAUDITED)

YEAR ENDED JUNE 30, 2016
(In Thousands)

COST SHARING RETIREMENT PLAN
SCHEDULE OF THE MEDICAL CENTER'S PROPORTIONATE SHARE OF THE COUNTY'S NET PENSION LIABILITY
LAST TEN YEARS*

	2016	2015
Medical Center's proportion of the net pension liability	9.6247%	9.9238%
Medical Center's proportionate share of the County's net pension liability	$ 156,238	$ 142,685
Medical Center's covered-employee payroll	$ 213,543	$ 211,612
Medical Center's net pension liability as a percentage of covered employee payroll	73.16%	67.43%
Plan fiduciary net position as a percentage of the total pension liability	80.98%	82.47%
Measurement date	6/30/2015	6/30/2014

Notes to Schedule:

*-Fiscal year 2015 was the first year of implementation, therefore, only two years are shown.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

REQUIRED SUPPLEMENTARY INFORMATION (UNAUDITED)

YEAR ENDED JUNE 30, 2016
(In Thousands)

COST SHARING RETIREMENT PLAN
SCHEDULE OF CONTRIBUTIONS
LAST TEN YEARS*

	2016	2015
Contractually required contribution	$ 30,662	$ 27,801
Contributions in relation to the contractually required contribution	(30,662)	(27,801)
Contribution deficiency (excess)	$ -	$ -
Medical Center's covered-employee payroll	$ 221,813	$ 213,543
Contributions as a percentage of covered-employee payroll	13.82%	13.02%

Note to Schedule:

*-Fiscal year 2015 was the first year of implementation, therefore, only two years are shown.

OTHER REPORT

Vavrinek, Trine, Day & Co., LLP
Certified Public Accountants

INDEPENDENT AUDITORS' REPORT ON INTERNAL CONTROL OVER FINANCIAL REPORTING AND ON COMPLIANCE AND OTHER MATTERS BASED ON AN AUDIT OF FINANCIAL STATEMENTS PERFORMED IN ACCORDANCE WITH *GOVERNMENT AUDITING STANDARDS*

To the Board of Supervisors and Audit Committee
Arrowhead Regional Medical Center
County of San Bernardino, California

We have audited, 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, the financial statements of Arrowhead Regional Medical Center (the "Medical Center"), an enterprise fund of the County of San Bernardino, (the "County") California, as of and for the year ended June 30, 2016, and the related notes to the financial statements, which collectively comprise the Medical Center's basic financial statements, and have issued our report thereon dated December 16, 2016. Our report included an emphasis-of-matter regarding the Medical Center's adoption of Governmental Accounting Standards Board (GASB) Statement No. 72, *Fair Value Measurement and Application,* effective July 1, 2014, and that the financial statements present only the Medical Center and do not purport to, and do not, present fairly the financial position of the County.

Internal Control over Financial Reporting

In planning and performing our audit of the financial statements, we considered the Medical Center's internal control over financial reporting (internal control) to determine the 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 Medical Center's internal control. Accordingly, we do not express an opinion on the effectiveness of the Medical Center'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 Medical Center'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 determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the 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.

Vavrinek, Trine, Day & Co. LLP

Rancho Cucamonga, California
December 16, 2016