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, 2018 and 2017

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

FOR THE YEARS ENDED JUNE 30, 2018 AND 2017

TABLE OF CONTENTS

VAVRINEK, TRINE, DAY & CO., LLP
Certified Public Accountants

VALUE THE *difference*

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 (Medical Center), an enterprise fund of the County of San Bernardino, California (County), as of and for the years ended June 30, 2018 and 2017, and the related notes to the financial statements, which collectively comprise the Medical Center's 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 the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audits to obtain reasonable assurance about whether the financial statements are free from material misstatement.

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the financial statements. The procedures selected depend on the auditor's 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 entity's internal control. Accordingly, we express no such opinion. An audit also includes evaluating the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluating the overall presentation of the financial statements.

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

Opinion

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medical Center as of June 30, 2018 and 2017, and the changes in its financial position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

10681 Foothill Blvd., Suite 300, Rancho Cucamonga, CA 91730 P 909.466.4410 F 909.466.4431 W vtdcpa.com

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, 2018 and 2017, the changes in its financial position, or where applicable, its cash flows for the years 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.

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 November 27, 2018, 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 solely to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the Medical Center's internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* in considering the Medical Center's internal control over financial reporting and compliance.

Vavrinek, Trine, Day & Co. LLP

Rancho Cucamonga, California
November 27, 2018

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF NET POSITION

JUNE 30, 2018 AND 2017

(In Thousands)

	2018	2017
ASSETS		
Current Assets:		
Cash and cash equivalents	$ 316,388	$ 239,707
Restricted investments held with fiscal agent	25,225	19,021
Patient accounts receivable, net of contractual allowances and estimated uncollectables of $156,619 in 2018 and $151,995 in 2017	42,301	35,693
Receivable from other governments	45,073	61,191
Due from County	3,366	1,318
Other receivables	1,672	4,701
Supplies inventories	2,663	2,368
Prepaid expenses and other assets	4,032	3,498
Total Current Assets	440,720	367,497
Noncurrent Assets:		
Restricted investments held with fiscal agent	22,237	29,681
Restricted investments held with fiscal agent - interest	307	292
Capital assets:		
Land and improvements	25,440	25,440
Buildings and improvements	548,599	548,602
Equipment	182,063	176,534
Construction-in-progress	4,410	1,760
Total capital assets	760,512	752,336
Less accumulated depreciation	(415,220)	(392,779)
Total capital assets, net of accumulated depreciation	345,292	359,557
Total Noncurrent Assets	367,836	389,530
Total Assets	808,556	757,027
DEFERRED OUTFLOWS OF RESOURCES		
Deferred amount on refunding	17,440	19,519
Deferred outflows related to pensions	100,879	98,022
Total deferred outflows of resources	$ 118,319	$ 117,541

See accompanying notes to basic financial statements.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF NET POSITION, Continued

JUNE 30, 2018 AND 2017

(In Thousands)

	2018	2017
LIABILITIES		
Current Liabilities:		
Accounts payable	$ 24,936	$ 30,197
Accrued salaries and benefits	30,794	27,711
Other accrued liabilities	2,769	2,573
Capital lease obligations	1,100	1,679
Certificates of participation	24,920	23,630
Interest payable	7,723	8,253
Arbitrage payable	81	81
Due to County	1,640	163
Settlements due to third-party payors	91,484	57,015
Total Current Liabilities	185,447	151,302
Noncurrent Liabilities:		
Long-term compensated absences	7,040	6,938
Long-term settlements due to third-party payors	5,337	4,484
Net pension liability	210,298	203,926
Capital lease obligations, less current installments	1,156	2,283
Certificates of participation, less current installments (net of bond discount)	332,417	357,152
Total Noncurrent Liabilities	556,248	574,783
Total Liabilities	741,695	726,085
DEFERRED INFLOWS OF RESOURCES		
Deferred inflows related to pensions	30,355	37,653
NET POSITION		
Net investment in capital assets	3,139	(5,668)
Restricted for debt service	40,046	40,741
Unrestricted	111,640	75,757
Total Net Position	$ 154,825	$ 110,830

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, 2018 AND 2017

(In Thousands)

	2018	2017
OPERATING REVENUES		
Net patient service revenue	$ 342,236	$ 381,617
Supplemental revenues	164,050	134,553
Other	10,199	10,287
Total Operating Revenues	516,485	526,457
OPERATING EXPENSES		
Salaries and benefits	277,852	263,888
Supplies	93,765	97,026
Professional services	59,693	52,762
Purchased services	50,743	47,622
Insurance	5,154	5,784
Utilities	10,131	9,117
Depreciation and amortization	22,655	23,805
Rent	4,467	3,464
Other	6,686	6,401
Total Operating Expenses	531,146	509,869
Operating Income (Loss)	(14,661)	16,588
NONOPERATING REVENUES (EXPENSES)		
State debt service funding	24,637	18,826
Investment income/loss	437	(51)
Interest expense on debt	(21,072)	(22,651)
PRIME funding	40,387	36,696
Direct grants - designated public hospital	6,506	2,244
Other nonoperating revenues (expenses)	(895)	184
Total Nonoperating Revenues, Net	50,000	35,248
Income Before Transfers	35,339	51,836
Transfers from the County	8,656	16,913
Change in Net Position	43,995	68,749
Net Position, Beginning of Year	110,830	42,081
Net Position, End of Year	$ 154,825	$ 110,830

See accompanying notes to basic financial statements.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF CASH FLOWS

YEARS ENDED JUNE 30, 2018 AND 2017

(In Thousands)

	2018	2017
CASH FLOWS FROM OPERATING ACTIVITIES		
Receipts from patients and third-party payors	$ 560,667	$ 558,502
Payments to suppliers	(235,056)	(224,666)
Payments to employees	(278,450)	(266,660)
Net Cash Provided by Operating Activities	47,161	67,176
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
PRIME funding received	42,018	60,693
Transfers from the County	8,656	16,913
Other nonoperating income (expense)	(895)	184
Direct grants - designated public hospital	6,506	2,244
Net Cash Provided by Noncapital Financing Activities	56,285	80,034
CASH FLOWS FROM CAPITAL AND RELATED FINANCING ACTIVITIES		
Purchase of capital assets	(8,390)	(4,727)
State debt service funding	24,637	18,826
Principal payments on capital lease obligations	(1,706)	(2,319)
Principal payments on certificates of participation	(23,671)	(22,380)
Interest paid on debt	(19,297)	(20,602)
Net Cash Used in Capital and Related Financing Activities	(28,427)	(31,202)
CASH FLOWS FROM INVESTING ACTIVITIES		
Interest on investments	437	(51)
Proceeds (sale) of investments	1,225	1,537
Net Cash Provided by Investing Activities	1,662	1,486
Increase in Cash and Cash Equivalents	76,681	117,494
Cash and Cash Equivalents, Beginning of Year	239,707	122,213
Cash and Cash Equivalents, End of Year	$ 316,388	$ 239,707

See accompanying notes to basic financial statements.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

STATEMENTS OF CASH FLOWS, Continued

YEARS ENDED JUNE 30, 2018 AND 2017

(In Thousands)

	2018	2017
RECONCILIATION OF OPERATING INCOME (LOSS) TO NET CASH USED IN OPERATING ACTIVITIES		
Operating Income (Loss)	$ (14,661)	$ 16,588
Adjustments to reconcile operating loss to net cash used in operating activities:		
Depreciation and amortization	22,655	23,805
Pension expense	(3,783)	(4,662)
Decrease (Increase) in:		
Patient accounts receivable	(6,608)	12,127
Receivables from other governments	14,487	(27,183)
Due from County	(2,048)	12,340
Other receivables	3,029	(603)
Supplies inventories	(295)	50
Prepaid expenses and other assets	(534)	(1,234)
Increase (Decrease) in:		
Accounts payable	(5,261)	10,864
Accrued salaries and benefits	3,185	1,890
Other accrued liabilities	196	1,220
Due to third-party payors	35,322	22,221
Due to County	1,477	(247)
Net Cash Provided by Operating Activities	$ 47,161	$ 67,176
NONCASH CAPITAL AND FINANCING ACTIVITIES:		
Lease Purchase of Capital Assets	$ -	$ 2,089

See accompanying notes to basic financial statements.

NOTE #1 – SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

A. General

The County of San Bernardino (County) Arrowhead Regional Medical Center (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), and 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 #8.

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 74 percent of self-pay accounts receivable at June 30, 2017, to 91 percent of self-pay accounts receivable at June 30, 2018. The increase was the result of payor class trends becoming more predictable since Medi-Cal expansion that occurred as a result of the Affordable Care Act.

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 #15 for further details.

O. Reclassifications

Certain amounts in the 2017 financial statements have been reclassified to conform to the 2018 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

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 contracts 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, 2018 and 2017, 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, 2018 and 2017 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.

R. Current Accounting Pronouncements

Governmental Accounting Standard No. 75

GASB Statement No. 75, *Accounting and Financial Reporting for Postemployment Benefits Other Than Pensions*. The objective of this Statement is to establish 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 of this Statement are effective for fiscal years beginning after June 15, 2017. This Statement did not have an 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. 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. This Statement did not have an effect on the Medical Center's financial statements.

Governmental Accounting Standard No. 85

GASB Statement No. 85, *Omnibus 2017*. The objective of this Statement is to address practice issues that have been identified during implementation and application of certain GASB Statements. This Statement addresses a variety of topics including issues related to blending component units, goodwill, fair value measurement and application, and postemployment benefits. The requirements of this Statement are effective for periods beginning after June 15, 2017. This Statement did not have an effect on the Medical Center's financial statements.

Governmental Accounting Standard No. 86

GASB Statement No. 86, *Certain Debt Extinguishment Issues*. The objective of this Statement is to improve consistency in accounting and financial reporting for in-substance defeasance of debt by providing guidance for transactions in which cash and other monetary assets acquired with only existing resources – resources other than the proceeds of refunding debt – are placed in an irrevocable trust for the sole purpose of extinguishing debt. The requirements of this Statement are effective for periods beginning after June 15, 2017. This Statement did not have an effect on the Medical Center's financial statements.

S. Future Accounting Pronouncements

Governmental Accounting Standard No. 83

GASB Statement No. 83, *Certain Asset Retirement Obligations*. The objective of this Statement is to provide financial statement users with information about asset retirement obligations that were not addressed in GASB standards by establishing uniform accounting and financial reporting requirements for these obligations. The requirements of this Statement are effective for periods beginning after June 15, 2018. The Medical Center has not determined its effect of this Statement.

Governmental Accounting Standard No. 84

GASB Statement No. 84, *Fiduciary Activities.* The objective of this Statement is to improve guidance regarding the identification of fiduciary activities for accounting and financial reporting purposes and how those activities should be reported. The requirements of this Statement are effective for periods beginning after December 15, 2018. The Medical Center has not determined its effect of this Statement.

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

S. Future Accounting Pronouncements, (Continued)

Governmental Accounting Standard No. 87

GASB Statement No. 87, *Leases*. The objective of this Statement is to better meet the information needs of financial statement users by improving accounting and financial reporting for leases by governments. The requirements of this Statement are effective for periods beginning after December 15, 2019. The Medical Center has not determined its effect of this Statement.

Governmental Accounting Standard No. 88

GASB Statement No. 88, *Certain Disclosures Related to Debt, including Direct Borrowings and Direct Placements.* The objective of this Statement is to improve the information that is disclosed in notes to government financial statements related to debt, including direct borrowings and direct placements. The requirements of this Statement are effective for periods beginning after June 15, 2018. The Medical Center has not determined its effect of this Statement.

Governmental Accounting Standard No. 89

GASB Statement No. 89, *Accounting for Interest Cost Incurred before the End of a Construction Period.* The objective of this Statement are to enhance the relevance and comparability of information about capital assets and the cost of borrowing for a reporting period and to simplify accounting for interest cost incurred before the end of a construction period. The requirements of this Statement are effective for periods beginning after December 15, 2019. The Medical Center has not determined its effect of this Statement.

Governmental Accounting Standard No. 90

GASB Statement No. 90, *Majority Equity Interests-(an amendment of GASB Statements No. 14 and No. 61).* The primary objectives of this Statement are to improve consistency and comparability of reporting a government's majority equity interest in a legally separate organization and to improve the relevance of financial statement information for certain component units. It defines a majority equity interest and specifies that a majority equity interest in a legally separate organization should be reported as an investment if a government's holding of the equity interest meets the definition of an investment. For all other holdings of a majority equity interest in a legally separate organization, a government should report the legally separate organization as a component unit, and the government or fund that holds the equity interest should report an asset related to the majority equity interest using the equity method. The requirements of this Statement are effective for reporting periods beginning after December 15, 2018. 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, 2018 and 2017 are classified in the accompanying financial statements as follows:

	2018	2017
Cash and cash equivalents	$ 316,388	$ 239,707
Investments held with fiscal agent for debt service - current	25,225	19,021
Investments held with fiscal agent for debt service - noncurrent	22,237	29,681
Total Cash and Investments	$ 363,850	$ 288,409

The Medical Center's cash and investments as of June 30, 2018 and 2017 consisted of the following:

	2018	2017
Deposits with County Treasury	$ 316,388	$ 239,707
Investments	47,462	48,702
Total Cash and Investments	$ 363,850	$ 288,409

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 #12), 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.

(In Thousands)

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

Interest Rate Risk, (Continued)

Weighted average maturity of the Medical Center's Investments Held with Bond Trustee as of June 30, 2018:

Investment Type	Amount	Weighted Average Maturity (in years)
Held by bond trustee:		
Money market mutual funds	$ 25,225	daily
Guaranteed investment contracts	4,751	10.08
U.S. Treasury Bonds	17,486	4.38
Total	$ 47,462	

Weighted average maturity of the Medical Center's Investments Held with Bond Trustee as of June 30, 2017:

Investment Type	Amount	Weighted Average Maturity (in years)
Held by bond trustee:		
Money market mutual funds	$ 19,021	daily
Federal Agencies Securities	6,194	0.89
Guaranteed investment contracts	4,751	11.08
U.S. Treasury Bonds	18,736	5.38
Total	$ 48,702	

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, 2018 and 2017:

		Rating as of June 30, 2018		
Investment Type	Amount	Ba3*	Aaa	Exempt**
Held by bond trustee:				
Money market mutual funds	$ 25,225	$ -	$ 25,225	$ -
Guaranteed investment contracts	4,751	4,751	-	-
U.S. Treasury Bonds	17,486	-	-	17,486
Total	$ 47,462	$ 4,751	$ 25,225	$ 17,486

* The company with whom the Medical Center has the guaranteed investment contract received long-term ratings of Ba3/BBB 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.

(In Thousands)

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

Credit Risk, (Continued)

Investment Type	Amount	Rating as of June 30, 2017 Ba1*	Aaa	Exempt**
Held by bond trustee:				
Money market mutual funds	$ 19,021	$ -	$ 19,021	$ -
Federal Agencies Securities	6,194	-	6,194	-
Guaranteed investment contracts	4,751	4,751	-	-
U.S. Treasury Bonds	18,736	-	-	18,736
Total	$ 48,702	$ 4,751	$ 25,215	$ 18,736

***** 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.

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 or 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. Presented below are investments that represented five percent or more of the Medical Center's total investments as of June 30, 2018 and 2017:

June 30, 2018

Issuer	Investment Type	Amount
MBIA Investment Management Corp.	Guaranteed Investment Contract	$ 4,751

June 30, 2017

Issuer	Investment Type	Amount
Fed Natl Mrg Assn	Federal Agency Securities	$ 6,194
MBIA Investment Management Corp.	Guaranteed Investment Contract	4,751

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

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, 2018 and 2017.

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:

Level 1 — 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.

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.

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

Fair Value Measurements (Continued)

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, 2018 and 2017 of $316,388 and $239,707, 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, 2018 and 2017. 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.

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. The valuation of 2a7 money market mutual funds are at one-dollar net asset value (NAV) per share. The redemption frequency is daily and redemption notice of period of intra-daily. This type of investment primarily invests in short term U.S. Treasury and government securities (including repurchase agreements collateralized by U.S. Treasury and government agency securities). The Medical Center has the following recurring fair value measurements as of June 30, 2018 and 2017:

(In Thousands)

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

Fair Value Measurements (Continued)

June 30, 2018	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:				
U.S. Treasury Bonds	$ -	$ 17,486	$ -	$ 17,486
Investments measured at the net asset value:				
Money market mutual funds				25,225
Investments not measured at fair value:				
Guaranteed investment contracts				4,751
Total Investments				$ 47,462

June 30, 2017	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	$ -	$ 6,194	$ -	$ 6,194
U.S. Treasury Bonds	-	18,736	-	18,736
Total	$ -	$ 24,930	$ -	24,930
Investments measured at the net asset value:				
Money market mutual funds				19,021
Investments not measured at fair value:				
Guaranteed investment contracts				4,751
Total Investments				$ 48,702

(In Thousands)

NOTE #3 – 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, 2018 and 2017, the Medi-Cal program represented approximately 61 percent and 59 percent, respectively, and the Medicare program represented approximately 27 percent and 25 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, 2015, for Medi-Cal. Adjustments as a result of such audits are recorded in the year the amounts can be determined.

A. Net Patient Service Revenue

Net patient service revenue is comprised of the following for the years ended June 30, 2018 and 2017. Revenue at established rates is computed as if charity care patient revenue was recognized.

	2018	2017
Revenue at established rates	$ 1,413,227	$ 1,397,293
Enhanced payment program	16,608	-
Medi-Cal new eligible	1,206	33,228
Special pharmacy	26,344	34,499
Medi-Cal contractual adjustments	(762,372)	(741,139)
Medicare contractual adjustments	(193,908)	(188,905)
Other payors contractual adjustments	(109,962)	(118,996)
Provision for bad debts, net	(29,887)	(34,363)
Changes in third-party payor estimates	(19,020)	-
Net Patient Service Revenue	$ 342,236	$ 381,617

(In Thousands)

NOTE #3 – NET PATIENT SERVICE REVENUE, (CONTINUED)

A. Net Patient Service Revenue, (Continued)

Gross patient service revenue by payor for the years ended June 30, 2018 and 2017 were:

	2018	2017
Medi-Cal	66%	69%
Medicare	20%	20%
Other payors	11%	8%
Self-pay	3%	3%

B. Net Patient Accounts Receivable

At June 30, 2018 and 2017, net patient accounts receivable consisted of:

	2018	2017
Gross patient accounts receivable at established rates	$ 169,645	$ 145,846
Enhanced payment program	16,573	-
Medi-Cal new eligible, net	-	24,445
Special pharmacy	1,786	3,088
Allowances:		
Medi-Cal	(73,536)	(75,608)
Medicare	(35,375)	(28,537)
Other payors	(17,462)	(18,210)
Uncollectable accounts	(19,330)	(15,331)
Net Patient Accounts Receivable	$ 42,301	$ 35,693

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").

For the years ended June 30, 2018 and 2017, the Medical Center recorded total Medi-Cal inpatient and outpatient net revenue of $193,603 and $206,449, respectively and related receivables of $12,960 and $16,764, respectively.

Medi-Cal New Eligible – Beginning January 1, 2014, the Affordable Care Act (ACA) provides 100% matching of federal medical assistance percentages (FMAP) for newly eligible Medi-Cal patients. As a result, the Medical Center estimated the difference between cost and interim payments received. The Medical Center recorded estimated additional reimbursement for differences between cost and interim payments received of $1,206 and $33,228 for the years ended June 30, 2018 and 2017, respectively, which is included in net patient revenues. As of June 30, 2018 and 2017, $0 and $24,445 is included in net patient accounts receivable. This program ended June 30, 2017.

(In Thousands)

NOTE #3 – NET PATIENT SERVICE REVENUE, (CONTINUED)

B. Net Patient Accounts Receivable, (Continued)

Enhanced Payment Program (EPP) –EPP is a funding pool that is used to supplement the base rates the Medical Center receives through Medi-Cal managed care contracts. EPP is meant to meet the managed care rule's exception that allows payments that provide a uniform increase within a class of providers such as a pre-determined increase over contracted rates. As a result of participating in the EPP program, the Medical Center recognized $16,608 in net patient revenue and $16,573 of net patient accounts receivable for the year ended June 30, 2018. The revenue is estimated based on analysis prepared by the California Association of Public Hospitals (CAPH) in development of the program, however actual amounts earned will not be known until fiscal year 2019. The Medical Center recognized 44% of the estimated amount.

NOTE #4 – SUPPLEMENTAL REVENUES

At June 30, 2018 and 2017, supplemental revenue consisted of:

	2018	2017
AB 85 Realignment and Managed Care Rate Range Supplemental	$ 52,854	$ 40,756
Global Payment Program	37,478	34,821
Quality Incentive Program	21,137	-
SB 208 Seniors Persons with Disabilities	20,545	17,730
Other Supplemental Medi-Cal	15,485	16,459
AB 915	4,716	3,342
Supplemental risk pool funding	7,880	15,492
Whole Person Care Program	2,454	3,067
Physician Non-Physician Practitioner	1,126	522
SB 239 Quality Assurance	375	2,364
Total Supplemental revenue	$ 164,050	$ 134,553

NOTE #4 – SUPPLEMENTAL REVENUES, (CONTINUED)

AB 85 Realignment and Managed Care Rate Range Supplemental – 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. AB 85 includes provisions for rate range intergovernmental transfers (IGT) for Medi-Cal managed care plans covering inpatient and outpatient services. Capitation rate ranges for DHCS County Organized Health Systems managed care programs were developed in accordance with rate setting guidelines established by CMS, As a result of participating in the AB 85 rate range IGT, the Medical Center recognized $52,854 and $40,756 in redirected realignment revenue formula for the fiscal years ending June 30, 2018 and 2017, respectively.

Global Payment Program – California has created a 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 $37,478 and $34,821 in GPP funding in fiscal years ended June 30, 2018 and 2017, respectively.

Quality Incentive Program (QIP) – QIP is meant to meet the Managed Care Rule's exception that allows payments tied to performance. QIP converts funding from previously existing supplemental payments into a value based structure. QIP payments are tied to the achievement of performance on a set of clinically established quality measures for Medi-Cal managed care enrollees. As a result of participating in the QIP program, the Medical Center recognized $21,137 in supplemental revenue and due from other government for the year ended June 30, 2018. The revenue is estimated based on analysis prepared by the California Association of Public Hospitals (CAPH) in development of the program, however actual amounts earned will not be known until fiscal year 2019. The Medical Center recognized 56% of the estimated amount.

NOTE #4 – SUPPLEMENTAL REVENUES, (CONTINUED

Supplemental Funding – Seniors and Persons with Disabilities (SPD) – Effective October 19, 2010, SB 208 allows the State's Department of Health Care Services to implement changes to the federal Waiver that expired on October 31, 2010. SB 208 implements provisions of the Waiver for specified uninsured adults that are not otherwise eligible for Medicare or Medi-Cal. SB 208 allows the State to implement additional goals of the Waiver to improve health care delivery systems and health care outcomes for SPD. This is accomplished by transferring the responsibility for the provision of care from the Medi-Cal FFS program to health plans under the managed Medi-Cal program. Senate Bill 208 (Chapter 714, Statutes of 2010) provided for the possibility of a voluntary IGT relating to Medi-Cal managed care services provided by DPHs. The purpose of the IGT program is to provide funding to preserve and strengthen the availability and quality of services provided by DPHs and their affiliated public providers, to the extent permitted by law. This IGT program consists of two IGT agreements to provide a portion of the nonfederal share of risk-based payments to managed care health plans as described in Welfare and Institutions Code, Sections 14182.15(d)(1) and 14182.15(d)(2). IGTs provide the ability for the Medical Center to receive matching federal funds to increase reimbursement for care to the SPD population. The Medical Center recognized additional reimbursement of $20,545 for the year ended June 30, 2018, and $17,730 for the year ended June 30, 2017.

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, 2018 and 2017 were $7,880 and $15,492, respectively.

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 $4,716 and $3,342 in AB-915 funds for the years ended June 30, 2018 and 2017, respectively.

(In Thousands)

NOTE #5 – SETTLEMENTS DUE TO THIRD-PARTY PAYORS

At June 30, 2018 and 2017, due to third-party payors consisted of:

	2018	2017
Medi-Cal settlement (Section 1115 Waiver)	$ 31,155	$ 24,143
Disproportionate share hospital (DSH) settlements	58,951	31,975
Medicare cost reports settlements	1,378	897
Current settlements due to third-party payors	$ 91,484	$ 57,015

	2018	2017
Medi-Cal new eligible rate differences	$ 5,337	$ 4,484
Non-current settlements due to third-party payors	$ 5,337	$ 4,484

Effective November 1, 2010, CMS and the State agreed on the standard terms and conditions of the 5-year renewal of the waiver officially called the California Bridge to Reform Demonstration (Section 1115 Waiver). The Section 1115 Waiver established the Low Income Health Program, which provides federal matching funding for enrollees. The funds available through the Waiver help California implement health care reform through investments in its safety net delivery system and expansion of coverage for adults. Due to the complexity of the program, the Medical Center has recorded an estimated settlement of $31,155 and $24,143 related to the Section 1115 Waiver for the years ended June 30, 2018 and 2017, respectively.

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 $40,387 and $36,696 in PRIME funding in fiscal years ended June 30, 2018 and 2017, respectively. The Medical Center had $17,436 and $19,077 in PRIME receivables at June 30, 2018 and 2017, 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.

(In Thousands)

NOTE #7 – 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, 2018 and 2017, the Medical Center received direct grants totaling $6,506 and $2,244 respectively, which has been reported as non-operating revenue.

NOTE #8 – 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:

	2018	2017
Cost of caring for Charity Care patients	$ 15,206	$ 12,320

NOTE #9 – STATE DEBT SERVICE FUNDING

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 Thousands)

NOTE #9 – STATE DEBT SERVICE FUNDING, (CONTINUED)

In accordance with the master lease agreement, the Medical Center is obligated to make aggregate lease payments to the Inland Empire Public Facilities Corporation (Corporation), a component unit of the County, 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 2018 and 2017 amounted to $24,637 and $18,826, 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, 2018 and 2017.

NOTE #10 – CAPITAL ASSETS

A summary of capital assets activity for the years ended June 30, 2018 and 2017 is as follows:

June 30, 2018	Beginning Balance	Additions	Deletions	Ending Balance
Capital assets not being depreciated:				
Construction-in-progress	$ 1,760	$ 2,650	$ -	$ 4,410
Total capital assets not being depreciated	1,760	2,650	-	4,410
Capital assets being depreciated:				
Land and improvements	25,440	-	-	25,440
Buildings and improvements	548,602	-	(3)	548,599
Equipment	176,534	5,770	(241)	182,063
Total capital assets being depreciated	750,576	5,770	(244)	756,102
Less accumulated depreciation:				
Land and improvements	(1,843)	(197)	-	(2,040)
Buildings and improvements	(242,984)	(15,128)	-	(258,112)
Equipment	(147,952)	(7,330)	214	(155,068)
Total accumulated depreciation	(392,779)	(22,655)	214	(415,220)
Total capital assets being depreciated, net	357,797	(16,885)	(30)	340,882
Total capital assets, net	$ 359,557	$ (14,235)	$ (30)	$ 345,292

(In Thousands)

NOTE #10 – CAPITAL ASSETS, (CONTINUED)

June 30, 2017	Beginning Balance	Additions	Deletions	Ending Balance
Capital assets not being depreciated:				
Construction-in-progress	$ 1,822	$ 1,705	$ (1,767)	$ 1,760
Total capital assets not being depreciated	1,822	1,705	(1,767)	1,760
Capital assets being depreciated:				
Land and improvements	25,440	-	-	25,440
Buildings and improvements	547,386	1,216	-	548,602
Equipment	170,992	5,662	(120)	176,534
Total capital assets being depreciated	743,818	6,878	(120)	750,576
Less accumulated depreciation:				
Land and improvements	(1,657)	(186)	-	(1,843)
Buildings and improvements	(227,935)	(15,049)	-	(242,984)
Equipment	(139,502)	(8,570)	120	(147,952)
Total accumulated depreciation	(369,094)	(23,805)	120	(392,779)
Total capital assets being depreciated, net	374,724	(16,927)	-	357,797
Total capital assets, net	$ 376,546	$ (15,222)	$ (1,767)	$ 359,557

NOTE #11 – 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, 2018 and 2017.

The Medical Center is allocated a portion of the County's overhead costs. Such expenses totaled $4,757 and $4,579 for the years ended June 30, 2018 and 2017, respectively, and are included as operating expense in the accompanying statements of revenues, expenses, and changes in net position.

Transfers from the County were $8,656 and $16,913 for the years ended June 30, 2018 and 2017, respectively. Current year transfers included $8,000 to fund the Medical Center’s debt service payments with the remainder being for capital additions.

Amounts due to the County in the amount of $1,640 and $163 or the years ended June 30, 2018 and 2017, 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 $3,366 and $1,318 for the years ended June 30, 2018 and 2017, respectively. Current year amounts due from the County relate to prisoner pharmacy, Department of Behavioral Health, and cash collection due from the County’s Central Collection Department.

(In Thousands)

NOTE #11 – TRANSACTIONS WITH THE COUNTY, (CONTINUED)

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

NOTE #12 – LONG-TERM OBLIGATIONS

The following is a summary of changes in long-term obligations for the fiscal years ended June 30, 2018 and 2017:

	June 30, 2018				
	Beginning Balance	Additions	Reductions	Ending Balance	Due within One Year
Certificates of Participation					
Series 1994	$ 98,070	$ -	$ (5,235)	$ 92,835	$ -
Series 1995	4,815	-	(4,815)	-	-
Series 1996	61,875	-	(490)	61,385	515
Series 2009 A	175,065	-	(13,090)	161,975	16,995
Series 2009 B	43,880	-	-	43,880	7,410
Total Certificates of Participation, Gross	383,705	-	(23,630)	360,075	24,920
Less: Discount on debt	(2,923)	-	185	(2,738)	
Total Certificates of Participation	380,782	-	(23,445)	357,337	24,920
Capital lease obligations	3,962	-	(1,706)	2,256	1,100
Total	$ 384,744	$ -	$ (25,151)	$ 359,593	$ 26,020

	June 30, 2017				
	Beginning Balance	Additions	Reductions	Ending Balance	Due within One Year
Certificates of Participation					
Series 1994	$ 103,035	$ -	$ (4,965)	$ 98,070	$ 5,235
Series 1995	9,320	-	(4,505)	4,815	4,815
Series 1996	62,340	-	(465)	61,875	490
Series 2009 A	187,510	-	(12,445)	175,065	13,090
Series 2009 B	43,880	-	-	43,880	-
Total Certificates of Participation, Gross	406,085	-	(22,380)	383,705	23,630
Less: Discount on debt	(3,149)	-	226	(2,923)	-
Total Certificates of Participation	402,936	-	(22,154)	380,782	23,630
Capital lease obligations	4,192	2,089	(2,319)	3,962	1,679
Total	$ 407,128	$ 2,089	$ (24,473)	$ 384,744	$ 25,309

NOTE #12 – 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), a component unit of the County of San Bernardino.

Certificates of participation at June 30, 2018 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, 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.

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.

On August 1, 2017, the Corporation made the final debt service payment for the Medical Center Series 1995 Certificates of Participation in the amount of $4,971. This amount consisted of $4,815 in principal and $156 in interest.

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 #12 – 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. The 2009 A Refunding Certificates of Participation are subject to optional redemption in whole or in part on any date in such order of maturity as the County determines and by lot within a maturity, on or after August 1, 2019, at the redemption price equal to the principal amount thereof to be redeemed, together with interest accrued and unpaid to the date fixed for redemption, without premium.

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. The 2009 B Refunding Certificates of Participation are subject to optional redemption in whole or in part on any date in such order of maturity as the County determines and by lot within a maturity, on or after August 1, 2019, at the redemption price equal to the principal amount thereof to be redeemed, together with interest accrued and unpaid to the date fixed for redemption, without premium.

B. Debt Service Requirements

The total annual debt service requirements to maturity for the outstanding Certificates of Participation as of June 30, 2018 are summarized as follows:

	Total	
Fiscal Year	Principal	Interest
2019	$ 24,920	$ 18,036
2020	26,230	16,749
2021	27,765	15,231
2022	29,500	13,579
2023	31,085	11,962
2024-2028	180,960	33,244
2029	39,615	972
Totals	$ 360,075	$ 109,773

(In Thousands)

NOTE #12 – 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 2021, 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, 2018, are as follows:

Fiscal Year		
2019	$	1,116
2020		741
2021		445
Total minimum lease payments		2,302
Less Amount Representing Interest		(46)
Present value of net minimum lease payments		2,256
Less Current Portion of Capital Lease Obligations		(1,100)
Capital lease obligations, excluding current portion	$	1,156

The gross value of equipment acquired under capitalized leases at June 30, 2018 and 2017 was $27,784 and $27,811, net of accumulated amortization of $26,646 and $21,650, respectively.

NOTE #13 – 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, 2018 and 2017, totaled $81 and $81, respectively.

NOTE #14 – OPERATING LEASES

The Medical Center leases various equipment on a short-term basis which are primarily cancellable with sixty (60) to ninety (90) days advance written notice. Total future minimum lease payments under non-cancelable lease agreements with terms greater than one (1) year as of June 30, 2018 are not significant. Rent expense for operating leases for the years ended June 30, 2018 and 2017, totaled $4,467 and $3,464, respectively.

(In Thousands)

NOTE #15 – 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 #15 – 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, 2018 are 22.41 percent for Tier 1 General members and 19.36 percent for Tier 2 General members.

The employee contribution rates for the fiscal year ended June 30, 2018 were between 7.90 percent and 14.87 percent for Tier 1 General members and between 8.45 percent for Tier 2 General members. For the fiscal year ended June 30, 2017 rates were between 7.89 percent and 14.86 percent for Tier 1 General members and between 7.73 percent and 8.37 percent for Tier 2 General members. The Medical Center's proportionate share of the County's contribution to the Plan was $32,911 and $31,205 for the years ended June 30, 2018 and 2017.

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

At June 30, 2018 and 2017, the Medical Center reported a liability of $210,298 and $203,926, respectively, for its proportionate share of the County's net pension liability. The net pension liability was measured as of June 30, 2017, 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 2017 actual contributions to the County's pension plan relative to the total contributions of the County as a whole. At June 30, 2017, the Medical Center's proportion was 9.6429 percent, which was a decrease of .2984 percent from its proportion measured as of June 30, 2016.

(In Thousands)

NOTE #15 – RETIREMENT PLAN, (CONTINUED)

For the years ended June 30, 2018 and 2017, the Medical Center recognized pension expense of $29,129 and $26,543 respectively. The Medical Center reported deferred outflows of resources and deferred inflows of resources related to pensions from the following sources:

June 30, 2018	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 22,497
Changes in actuarial assumptions	53,741	-
Net difference between projected and actual earnings on pension plan investments	7,636	-
Changes in proportion and differences between employer contributions and proportionate share of contributions	6,591	7,858
Employer contributions paid by the Medical Center to SBCERA subsequent to the measurement date	32,911	-
Total	$ 100,879	$ 30,355

June 30, 2017	Deferred Outflows of Resources	Deferred Inflows of Resources
Differences between expected and actual experience	$ -	$ 30,873
Changes in actuarial assumptions	14,082	-
Net difference between projected and actual earnings on pension plan investments	44,175	-
Changes in proportion and differences between employer contributions and proportionate share of	8,560	6,780
Employer contributions paid by the Medical Center to SBCERA subsequent to the measurement date	31,205	-
Total	$ 98,022	$ 37,653

(In Thousands)

NOTE #15 – RETIREMENT PLAN, (CONTINUED)

The $32,911 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, 2019. 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, 2018
2019	$ 7,457
2020	13,351
2021	8,825
2022	(1,227)
2023	7,642
Thereafter	1,565
Total	$ 37,613

Actuarial assumptions. The Medical Center's proportion of the County's total pension liability in the June 30, 2017 and 2016 actuarial valuations were determined using the following actuarial assumptions, applied to all periods included in the measurement:

	June 30, 2018	June 30, 2017
Actuarial valuation date	June 30, 2017	June 30, 2016
Actuarial cost method	Entry age actuarial cost method	Entry age actuarial cost method
Actuarial Assumptions:		
Investment rate of return	7.25%	7.50%
Inflation	3.00%	3.25%
Projected Salary increases	General: 4.50% to 14.50%	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	0.70% of payroll	0.60% of payroll

The actuarial assumptions used to determine the total pension liability as of June 30, 2017 and 2016, were based on the results of the June 30, 2017 and 2014 Actuarial Experience Studies (experience study), respectively, which covered the periods from July 1, 2013 through June 30, 2016 for the 2017 experience study, and from July 1, 2010 through June 30, 2013 for the 2014 experience study. They are the same assumptions used in the June 30, 2017 and 2016 actuarial valuations, respectively.

Mortality rates used in the actuarial valuation dated June 30, 2017 are based on the Headcount-Weighted RP 2014 Health Annuitant Mortality Table projected generationally using the two-dimensional mortality improvement scale MP-2016. For healthy General male members, the ages are set forward one year. No adjustment is made for healthy General female members. For all General members that are disabled, the ages are set forward seven years. Beneficiaries are assumed to have the same mortality as a General member of the opposite sex who is receiving a service (non-disability) retirement.

(In Thousands)

NOTE #15 – RETIREMENT PLAN, (CONTINUED)

Mortality rates used in the actuarial valuation dated June 30, 2016 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 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 long-term expected rate of return on Plan investments used in the June 30, 2017 and 2016 valuations were 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 SBCERA 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, 2017 Valuation Date		As of June 30, 2016 Valuation Date	
Asset Class	**Investment Classification**	**Target Allocation***	**Long-Term Expected Real Rate of Return (Arithmetic)**	**Target Allocation***	**Long-Term Expected Real Rate of Return (Arithmetic)**
Large Cap U.S. Equity	Domestic Common and Preferred Stock	8.00%	5.61%	5.00%	5.94%
Small Cap U.S. Equity	Domestic Common and Preferred Stock	2.00%	6.37%	2.00%	6.50%
Developed International Equity	Foreign Common and Preferred Stock	6.00%	6.96%	6.00%	6.87%
Emerging Market Equity	Foreign Common and Preferred Stock	6.00%	9.28%	6.00%	8.06%
U.S. Core Fixed Income	U.S. Government and Municipals/Corporate Bonds	2.00%	1.06%	2.00%	0.69%
High Yield/Credit Strategies	Corporate Bonds/Foreign Bonds	13.00%	3.65%	13.00%	3.10%
Global Core Fixed Income	Foreign Bonds	1.00%	0.07%	1.00%	0.30%
Emerging Market Debt	Emerging Market Debt	6.00%	3.85%	6.00%	4.16%
Real Estate	Real Estate	9.00%	4.37%	9.00%	4.96%
International Credit	Foreign Alternatives	11.00%	6.75%	10.00%	6.76%
Absolute Return	Domestic Alternatives/Foreign Alternatives	13.00%	3.56%	13.00%	2.88%
Other Real Assets	Domestic Alternatives/Foreign Alternatives	5.00%	6.35%	6.00%	6.85%
Long/Short Equity	Domestic Alternatives/Foreign Alternatives	0.00%	0.00%	3.00%	4.86%
Private Equity	Domestic Alternatives/Foreign Alternatives	16.00%	8.47%	16.00%	9.64%
Cash & Equivalents	Short-Term Cash Investment Funds	2.00%	-0.17%	2.00%	-0.03%
	Total	100.00%		100.00%	

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

(In Thousands)

NOTE #15 – RETIREMENT PLAN, (CONTINUED)

Discount rate. The discount rate used to measure the total pension liability were 7.25% and 7.50% for the years ended June 30, 2017 and 2016, respectively. The projection of cash flows used to determine the discount rates assumed that contributions from participating employers and active members are made at the actuarially determined contribution rates. For this purpose, only employer and member contributions that are intended to fund benefits of current members and their beneficiaries are included. Projected employer contributions that are intended to fund the service cost of future members and their beneficiaries, as well as projected contributions from future members, are not included. Based on those assumptions, the Plan's fiduciary net position was projected to be available to make all projected future benefits payments of current members. Therefore, the long-term expected rate of return on Plan investments, of 7.25% and 7.50% were applied to all periods of projected benefit payments to determine the total pension liability as of June 30, 2017 and 2016, respectively.

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 using the discount rates of 7.25% and 7.50% as of June 30, 2017 and 2016, respectively, as well as what the employers' allocated net pension liability would be if it were calculated using a discount rate that is 1-percentage-point lower or 1-percentage-point higher than the current rate:

June 30, 2018	1.00% Decrease (6.25%)	Current Discount Rate	1.00% Increase (8.25%)
Medical Centers's proportionate share of the County's net pension liability	$ 369,154	$ 210,298	$ 79,635

June 30, 2017	1.00% Decrease (6.50%)	Discount Rate (7.50%)	1.00% Increase (8.50%)
Medical Centers's proportionate share of the County's net pension liability	$ 340,640	$ 203,926	$ 90,637

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 #16 – 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, 2018 and 2017 was $5,154 and $5,784, respectively.

NOTE #17 – 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)

YEARS ENDED JUNE 30, 2018 AND 2017
(In Thousands)

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

	2018	2017	2016	2015
Medical Center's proportion of the net pension liability	9.6429%	9.9413%	9.6247%	9.9238%
Medical Center's proportionate share of the County's net pension liability	$ 210,298	$ 203,926	$ 156,238	$ 142,685
Medical Center's covered payroll	$ 145,524	$ 140,811	$ 139,029	$ 136,500
Medical Center's net pension liability as a percentage of covered payroll	144.51%	144.82%	112.38%	104.53%
Plan fiduciary net position as a percentage of the total pension liability	77.90%	76.86%	80.98%	82.47%
Measurement date	6/30/2017	6/30/2016	6/30/2015	6/30/2014

Notes to Schedule:

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

Change in Assumptions

In 2018, the actuarial assumptions used in the June 30, 2017 valuation were based on the results of an actuarial experience study for the three year period of July 1, 2013 through June 30, 2016. Amounts reported in 2018 primarily reflect a decrease of 0.25% for both the investment rate of return and inflation rate, an increase of 0.1% of payroll for administrative expenses, and adjustments of projected salary increases and mortality rates to more closely reflect actual experience. Mortality rates used in the June 30, 2017 actuarial valuation are based on the Headcount-Weighted RP 2014 Healthy Annuitant Mortality Table rather than on the RP-2000 Combined Healthy Mortality Table, which was used to determine amounts reported prior to 2018.

COUNTY OF SAN BERNARDINO
ARROWHEAD REGIONAL MEDICAL CENTER

REQUIRED SUPPLEMENTARY INFORMATION (UNAUDITED)

YEARS ENDED JUNE 30, 2018 AND 2017
(In Thousands)

COST SHARING RETIREMENT PLAN
SCHEDULE OF CONTRIBUTIONS
LAST TEN YEARS*

	2018	2017	2016	2015
Contractually required contribution	$ 32,911	$ 31,205	$ 30,662	$ 27,810
Contributions in relation to the contractually required contribution	(32,911)	(31,205)	(30,662)	(27,810)
Contribution deficiency (excess)	$ -	$ -	$ -	$ -
Medical Center's covered payroll	$ 153,606	$ 145,524	$ 140,811	$ 139,029
Contributions as a percentage of covered payroll	21.43%	21.44%	21.78%	20.00%

Note to Schedule:

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

OTHER REPORT

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 (Medical Center), an enterprise fund of the County of San Bernardino, (County) California, as of and for the year ended June 30, 2018, 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 November 27, 2018. Our report included an emphasis-of-matter describing 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.

10681 Foothill Blvd., Suite 300, Rancho Cucamonga, CA 91730 P 909.466.4410 F 909.466.4431 W vtdcpa.com

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
November 27, 2018