State of Nevada
Department of Health and Human Services
Letter of Approval Application Form

Section I. APPLICANT IDENTIFICATION AND CERTIFICATION

1.1 *Identification of Legal Applicant:* Identify the applicant as defined in NAC 439A.240: *a natural person, trust, estate, partnership, corporation (including an association, joint stock company and insurance company), state, political subdivision or instrumentality or a legal entity recognized by the State.*

Applicant Name: Washoe Barton Medical Clinic, dba Carson Valley Medical Center
Address: 1107 Highway 395 N. Gardnerville, NV 89410

1.2 *Project Information*

Project Title: Carson Valley Medical Center Expansion Project

1.3 *Description of Legal Applicant*

a. Type of Organization

☐Private for Profit Corporation
☐Public for Profit Corporation
☒Private Non-Profit Corporation
☐General Partnership
☐Limited Partnership
☐State Organization
☐County Organization
☐Other (Specify):

b. If a corporation, indicate where and when incorporated:
Where: State of Nevada
When: May 13, 1998

c. Identify principals having 25% or more ownership:

Name of Individual	Percentage Owned
Barton Healthcare System	50%
Renown Health	50%

d. If a corporation, attach an appendix labeled **Appendix A** with a list of the chairman, directors and officers. **(ATTACHED)** If a partnership, attach an appendix labeled **Appendix B** with a list of general and limited partners, if any. **(N/A)**

1.4 *Contact Person*: Identify the individual designated as the contact person who will receive all notices and communications pertaining to this application.

Name: Jeff Prater
Title: Chief Executive Officer
Organization: Carson Valley Medical Center
Address: 1107 Highway 395 N. Gardnerville, NV 89410
Office Phone: 775-782-1586
Cell Phone: 907-903-3637
Email Address: jprater@cvmchospital.org

State of Nevada
Department of Health and Human Services
Letter of Approval Application Form

Certification and Signature: This section should be completed and signed by the person who is authorized to commit the applicant to the project and to the expenditure of funds.

In accordance with NRS 439A.100 and the accompanying regulations, I hereby certify that this application is complete and correct to the best of my knowledge and belief. I understand that the applicant for a letter of approval has the burden of proof to satisfy all applicable criteria for review. I also understand that this application and all information submitted is public information and will be made available for public review and inspection.

Printed Name: Jeff Prater Title: Chief Executive Officer

Signature: _____ Date: 3/1/2021

Submit the original and four (4) copies along with a check for $9,500 payable to the Department of Health and Human Services for the application fee to:

Primary Care Office
4150 Technology Way, Suite 300
Carson City, NV 89706

Note: NAC 439A.595 states that the applicant for a letter of approval has the burden of proof to satisfy all applicable criteria for review contained in NAC 439A.637, inclusive.

Section II. PROJECT DESCRIPTION

2.1 *Project Summary:* Provide a **one-page** description of the proposed project.

Project: The three-year expansion project at Carson Valley Medical Center consists of an approximately 44,000 square foot building expansion designed for our inpatient services, emergency room, radiology department, and surgery department to adhere to the current FGI Guidelines for healthcare building codes and standards, improving the delivery of patient care – all without disruption to current operations.

The project will allow CVMC to convert to all private rooms for inpatient care (as opposed to our current model with shared rooms – which limits our ability to admit patients in need of care when there are patients with infectious conditions in the shared space), adds emergency room bays to accommodate our growing ER volumes, and reconfigures our surgical services department to add an operating room and procedural rooms to meet current standards of care for the types of surgeries and procedures we are equipped to perform at CVMC.

The expansion project allows for CVMC to continue to provide the same level of service to our community; not adding new health services but increasing efficiencies, improving patient safety and infection control precautions, and adding capacity for current and future demands on our local healthcare system.

The expansion project costs do not include medical equipment, which is managed through our annual capital equipment replacement process.

2.2 *Project Capital Expenditure Estimates*:

Total dollar amount	$29,362,018
For new square footage only	$29,362,018

2.3 *Project Location*:

Project Location	**Carson Valley Medical Center**
Address	**1107 Highway 395 N. Gardnerville, NV 89410**

a. Attach an appendix labeled Appendix C with documentation of ownership, lease or option to purchase. **–Appendix C Attached.**

b. Attach an appendix labeled Appendix D with a location map which includes street names and a facility plot plan and/or schematic. **- Appendix D Attached.**

2.4 *Project Schedule*: Complete the following schedule for the proposed project.

Step	Target Date
Use permit	7/23/2021
Building permit	8/31/2021
Groundbreaking/construction begins	9/1/2021
Construction ends	10/2/2023
Entire project completed	12/6/2023
Licensing & certification	12/6/2023
Services begin	12/6/2023

2.5 *Project Organization and Planning:*

a. Attach an appendix labeled Appendix E with an organization chart(s) showing lines of managerial and fiscal responsibility for all individuals and entities involved in this project. Show the proposed project's place in its parent organization, if appropriate.

Appendix E Attached : CVMC Organizational Chart

b. Describe the process by which this project was developed.

In 2019, a comprehensive market assessment was conducted with CVMC leadership and Guidehouse (f/k/a Navigant Consulting, Inc.) with the purpose of assessing current and future (10-year) demands on the local healthcare systems. This assessment identified gaps in local healthcare services that could be fulfilled by CVMC as well as services that CVMC currently provides that are at risk of nearing capacity and therefore limiting access for local patients in the very near future.

As a part of this assessment, Guidehouse assessed CVMC's current infrastructure to support current and future healthcare delivery and provided a facility master plan indicating the need for both facility improvement and enhancement projects as well as a facility expansion to accommodate the healthcare needs of the residents of the Carson Valley. This process spanned over the course of 2019 included feedback from the community, CVMC staff, CVMC management and leadership, and the CVMC Board of Directors.

CVMC collaborated with Elevation Healthcare Advisory Group and Gilbane Building Company to produce a facility expansion plan that offered a fiscally responsible solution to provide the space needed to continue to provide essential healthcare services to the community while maintaining continuous business operations throughout the process. This facility expansion plan was approved by CVMC's Board of Directors December 11, 2019; and re-approval (after COVID-19 delay) was obtained February 9, 2021.

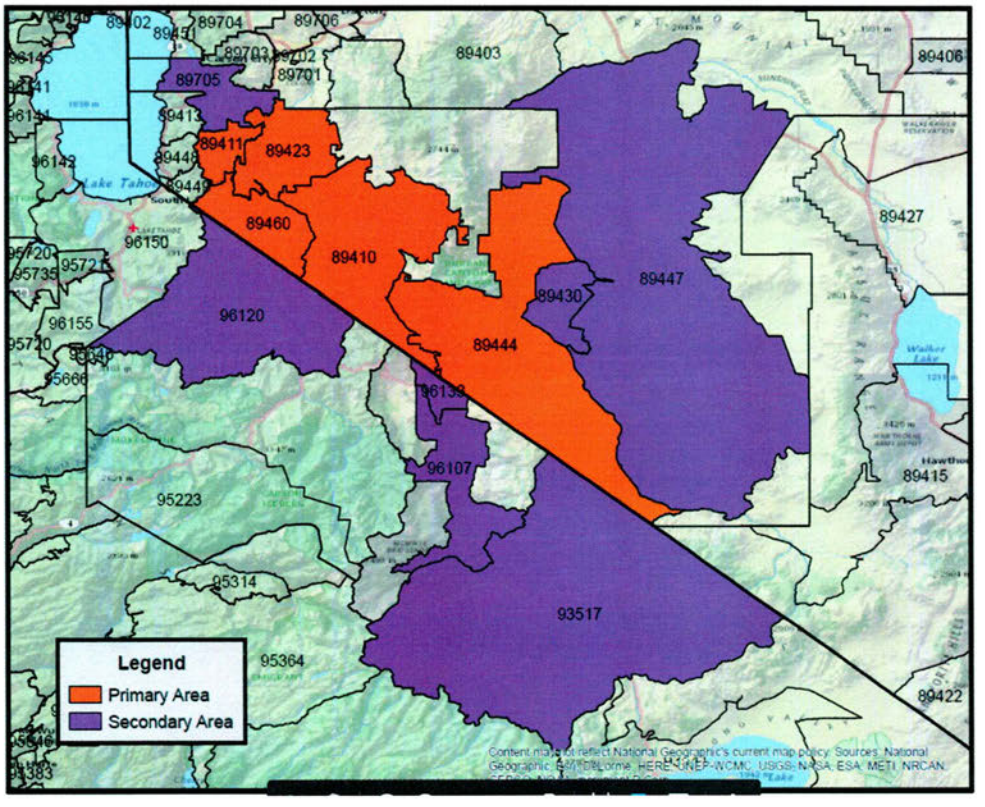
Section III. NEED FOR THE PROJECT TO BE UNDERTAKEN

Pursuant to NAC 439A.605, the applicant must demonstrate that the population to be served has a need for the project to be undertaken based upon:

3.1 *Project Service Area and Population*

a. Identify the proposed service area.

Carson Valley Medical Center serves a population of approximately 55,623 in our primary and secondary service areas – see service area map and population counts and projections below. CVMC's primary and secondary service area covers portions of Douglas and Lyon Counties in Nevada and Mono and Alpine Counties in CA.



b. Identify the total population for the proposed service area and estimate the number of persons who will have a need for the proposed project. Use a population projection for the year which is five years from the year that the application is filed. Population projections are available from the State Demographer. If other estimates are used, cite the source of such information and show the method used to derive the estimates.

Projected growth rate determined by county per the Nevada State Demographer and California State Demographer. Current county populations obtained from USPS. At the projected growth rate, the five-year projected population for CVMC's service area is 57,578.

CVMC's services are available to the entire population, with the expectation – per the CDC - that approximately 84.6% of US adults have annual contact with their healthcare provider. Therefore, it is anticipated that 48,710 people in our service area would potentially use the services of CVMC and benefit from the CVMC expansion project.

Zip Code	City	County	Current Population	5 Year Projected Growth Rate	2026 Projected Population
PRIMARY SERVICE AREA					
89410	Gardnerville	Douglas	11,256	2%	11,369
89460	GV Ranchos	Douglas	13,479	2%	13,749
89423	Minden	Douglas	11,238	2%	11,463
89411	Genoa	Douglas	929	2%	948
89444	Wellington	Lyon	2677	9%	2,918
	PSA Population		39,377		40,446
SECONDARY SERVICE AREA					
89705	S. Carson City	Douglas	5,393	2%	5,501
96107	Coleville	Mono, CA	1,094	3%	1,127
89447	Yerington	Lyon	7,987	9%	8,706
93517	Bridgeport	Mono, CA	670	3%	690
89430	Smith	Lyon	289	9%	315
96133	Topaz	Mono, CA	81	3%	83
96120	Markleeville	Alpine, CA	732	-3%	710
	SCA Population		16,246		17,132
Total Service Area			**55,623**		**57,578**

Source(s):			*Zip-code.com data*	*NV State Demographer*
			USPS	*CA State Demographer*

3.2 *Existing Providers of Similar Services*:

Provide information regarding existing providers of services similar to those proposed in this application. Explain the assumption that existing providers will not be able to meet the projected needs of the target population.

CVMC is the only hospital located in the identified service area. Carson Tahoe Regional Medical Center (located in North Carson City), Barton Hospital (located in South Lake Tahoe, CA) and Renown Health (located in Reno) all provide some hospital services to residents in our community in their regional scope. It can be assumed that these facilities are also addressing the increased demand in healthcare services in their own community's population growth.

Patients needing medical care should not be expected to travel outside of our community for their healthcare needs when a there is a facility that provides the necessary services exists. Furthermore, transferring patients out of our community taxes EMS systems by taking their services out of our community and incurring additional costs to do so.

An example of the impact of the limitations within the region was during the COVID-19 related patient surges in 2020. Beds were limited regionally and CVMC had to transfer out of state on occasion. The private acute care hospital rooms, expanded emergency room space and additional operating rooms that are proposed in our expansion plan would have allowed us to take care of more patients in our own community without transferring them or delaying their care.

Section IV. FINANCIAL FEASIBILITY

4.1 *Capital Expenditures*:

Cost	Total Project	Portion @ New Square Footage
Land acquisition	$0	$0
Architectural & engineering cost	$2,237,006	$2,237,006
Site development	$1,320,000	
Construction expenditure	$22,635,738	
Fixed equipment (not construction expense)	$500,000	
Major medical equipment	$0	
Other equipment and furnishings	$0	
Other (specify) Click here to enter text	$0	
10% Contingency	$2,692,274	
TOTAL PROJECT COST	$29,362,018	

Note: Contingency included for all components of budget to mitigate unforeseen residual impacts from COVID to the labor and supply chain costs.

4.2 *Proposed Funding of Project:*
Funds available as of application filing date:

The Hospital has total cash and investments of $43.4 Million as of December 31, 2020. These funds will be available to use to start the project while the bond issue is being completed. The proposed funding is to issue bonds and use internal funds to ensure the organization has strong cash reserves during the project.

Attach in an appendix labeled Appendix F with evidence that funds are available – Attached.

4.3 *Long-Term Financing*:

Section marked as confidential/proprietary

4.4 *Project Financing*

a. Provide information regarding the construction financing. Note that "financing" includes all project capital expenditures regardless of funding source.

Construction Financing:

Funding	Amount	Percent of Total
From applicant's funds	$0	0%
Amount to be financed	$29,362,018	100%
Total capital expenditures	$29,362,018	100%

b. Construction loan information
Source of construction loan: Click or tap here to enter text.

Section marked as confidential/proprietary

c. Provide information about existing short and long-term loans not related to the proposed project that are held by the applicant.

Lender	Interest Rate	Term	Annual Payment	Remaining Principal
Heritage Bank	5.25%	15	312,783	1,824,643
US Bank	3.05% *	15	729,528	4,633,051

* Rate increases to 5% for the last 3 years of the term of the loan

4.5 *Financial Sustainability*: NAC 439A.625 requires the applicant demonstrate that it will be able to operate in a manner which is financially feasible as a result of the proposed project without unnecessarily increasing the cost to the user or payer for health service provided by the applicant.

Explain how the proposed facility is expected to become financially self-supporting within 3 years after completion or, if the new construction is an addition to an existing facility, that the financial viability of the existing facility will not be adversely affected by the proposed project.

The project will be self-supporting within 3 years of completion of the project. Carson Valley Medical Center is a financially strong organization. This project enhances the long term financial viability while adding capacity.

Carson Valley Medical Center modeled the impact of the project under three scenarios:

1. Baseline Model: No expansion of space
2. Strategic Model: Full success of the growth plan with the space expansion,
3. Risk Model: Reflecting the financial impact of the project, debt with only minimal growth realized. **(See Appendix J for the Risk Model)**

The Baseline Model actually demonstrates only our inability to serve our predicted market growth.

The Risk Model demonstrates that Carson Valley Medical Center can financially support the project and debt even if the population growth projections do not come to fruition or growth is slower than predicted. At no point over the period from construction to nine years does Carson Valley Medical Center drop below a positive Operating Margin or a Debt Service Coverage Ratio of 2.0

The Strategic Model supports that we need to grow to our service capacity for the predicted population growth and is financially sound, as demonstrated below:

Section marked as confidential/proprietary

Section marked as confidential/proprietary

4.6 *Financial Feasibility*: Provide a response to each of the following criteria related to financial feasibility.

a. The ability of the applicant to obtain any required financing for the proposed project;

Carson Valley Medical Center is confident about the ability to successfully issue tax exempt bonds to fund the project. Cain Brothers has reviewed the last three years of audited financials, which has shown strong operational performance, demonstrating our ability to be successful in the bond market. The bond market is currently favorable; Capital markets are currently offering the Hospital a favorable borrowing environment: High demand for tax-exempt bonds from investors, and low levels of supply for new bonds results in historically low interest rates.

b. The extent to which the proposed financing may adversely affect the financial viability of the applicant's facility because of its effect on the long-term and short-term debt of the applicant;

The Hospital is going into the project with strong cash reserves. Additionally, the Risk Model, as noted in section 4.5, demonstrates that the Hospital can financially support the project and debt even if the population growth projections do not come to fruition.

c. The availability and degree of commitment to the applicant of the financial resources required to operate the proposed project until the project or the applicant's facility becomes financially self-supporting;

Carson Valley Medical Center has sufficient cash reserves to support the operations of the Hospital during and after the project construction, as documented in Appendix F. Even in the Risk Model (Appendix J), the organization is projected to be cash flow positive and has sufficient cash reserves to support operations.

d. The relationship between the applicant's estimated costs of operation, proposed charges and estimated revenues;

Carson Valley Medical Center's financial review of the project looked at both the Strategic Model and Risk Model. The anticipated population growth shows modeled revenues exceeding the cost of operations, see table in section 4.5. Even in the Risk Model, the financial health of the Hospital is still in positive margins and cash flow, as show in Appendix J

e. The level at which the affected health services of the applicant must be used for the applicant to break even financially and the likelihood that those levels will be achieved;

The historical volume of patients cared for by the Hospital are sufficient for the Hospital to be at break even or better as demonstrated by the Risk Model discussed in section 4.5.

f. Whether the applicant's projected costs of operation and charges are reasonable in relationship to each other and to the health services provided by the applicant.

Carson Valley Medical Center is sensitive to the cost of health care to our community. In 2020 a pricing study was done to compare charges to the local market. Our costs are comparable to other health care providers in the area. The project financial analysis was prepared with the assumption of no charge increases over the projection period.

g. Whether the projected revenues to be received by the applicant are likely to be from governmental programs if the applicant will be eligible for reimbursement from those programs.

Carson Valley Medical Center, as a Critical Access Hospital, will be cost reimbursed for the Medicare patients served from the Federal Medicare program. The table below lists our payor mix. We do not anticipate the project impacting our current payor mix.

Source	Percentage
Medicare	57%
Medicaid	10%
Insurance	25%
Other	6%
Self Pay	2%

4.7 *Ability to Support Operations*:

a. Identify the source and amount of funds committed to the applicant which may be required to operate the proposed project or the applicant's facility until such time as the project becomes financially self-supporting.

Source	Amount
Cash and Investments	$43,412,038

c. If an existing facility, attach an appendix labeled Appendix G with copies of financial statements for the three preceding fiscal years including statements of revenues/expenses and balance sheets.

Appendix G Attached.

d. For a new facility, attach an appendix labeled Appendix H with a pro-forma revenue/expense statement for each of the first three full years of operation of the proposed project.

N/A

4.8 *Bed Information*:

Existing number of licensed beds	23
Number added by new construction	2
Conversion from other use	n/a
Number to be removed	n/a
Projected number of licensed beds	25

4.9 *Line Drawings*: Attach an appendix labeled Appendix I with scale drawings of all new construction and/or remodeling.

Appendix I Attached

Section V. EFFECT ON COSTS TO CONSUMER OR PAYOR

5.1 *Effect on Cost of Healthcare*: NAC 439A.635 requires the applicant demonstrate that the proposed project will not have an unnecessarily adverse effect on the cost of health services to users or payers.

Explain how the proposed project will result in a significant savings in costs to users or payers without an adverse effect on the quality of care or, if the proposed project will not result in a significant savings in costs to the user or payer for health services, the extent to which costs of the service are justified by:

a. A clinical or operational need.

The 2018 edition of the FGI Guidelines has been adopted by the State of Nevada as a minimum design guideline. The prescriptive components for spaces, such as minimum clear floor area, clearances, and air exchanges etc., cannot be met within the existing facility. The expansion project is designed to meet all FGI guidelines, improve efficiencies in care with improved workflows, reduce patient safety risk factors with current building design, and improve infection control measures through the elimination of shared inpatient rooms.

b. A corresponding increase in the quality of care.

The FGI guidelines is driven by Evidence Based Design (EBD). These design components along with the required functional program and Safety Risk Assessment (SRA) drive the design components and support the increased quality of care by improving workflows/efficiencies, reducing patient safety issues with current building, and improving infection control measures through the elimination of shared inpatient rooms.

c. A significant reduction in risks to the health of the patients to be served by the applicant.

Evidence Based Design components within the design improve the environment of care which reduces the risk to patients and providers. This has a positive effect on reducing the total overall cost of care by mitigating errors and reducing the average length of stay.

5.2 *Effect on cost*: Provide a response to the following criteria related to the effect on costs.

a. The added costs to the applicant resulting from any proposed financing for the project.

The added cost will be in the form of interest costs from bonds issued. The incremental costs for the increased patients anticipated will be offset by the related patient revenues supported by the predicted market growth in our community over the next ten years. Our cost per patient seen is projected to decrease with the project, as our fixed costs will be spread over a larger number of patients cared for.

b. The relationship between project costs of construction, remodeling or renovation and the prevailing cost for similar activity in the area.

The cost of construction is estimated to be the prevailing cost for the area as we are using local companies for the construction labor and supplies.

c. The health or other benefits to be received by users compared to the cost to users or payers resulting from the proposed project.

The cost of the project is not going to impact the costs to our patients or payors. The project will expand the number of patients that can be cared for and this will allow the hospital to keep the

cost for services stable with our current costs to our patients. The project will provide for a better patient experience, improved infection control, and the ability to keep more patients locally in their community through private inpatient rooms as compared to the current double occupancy arrangement the hospital has currently.

d. Whether alternative methods of providing the proposed service are available which provide a greater benefit for the cost without adversely affecting quality of care.

There is not a viable alternative method of providing the services to our community, we are the only hospital in the immediate community.

5.3 Demonstrate that the proposed project will not have an unnecessary adverse effect on the costs of health services to the user or payer.

Carson Valley Medical Center modeled the financial analysis of the project without any increases in the price for services.

Section VI. APPROPRIATENESS

6.1 Location:

a. Describe the location of the proposed project including the time for travel and distance to other facilities for required transfers of patients or transfers in the event of an emergency.

The location of the CVMC expansion project is at our main hospital facility, located at 1107 Highway 395 N, Gardnerville NV 89410. Carson Tahoe Hospital, in Carson City, is located 20 miles away; approximately a 35-minute drive from Carson Valley Medical Center. Barton Memorial Hospital, in South Lake Tahoe, is 15 miles away; approximately a 45-minute drive over mountainous terrain with additional travel challenges due to winter weather.

b. Describe the distance and the time for travel required for the population to be served to reach the applicant's facility and other facilities providing similar services.

An important distinction when considering travel time for medical care in the Northern Nevada region is the populations south of our main hospital campus. Those patients live 30 minutes away from CVMC - on average – putting their health at risk in the event of a transfer or bypass due to CVMC services being limited due to our current space constraints in the ER and inpatient areas. Travel to another facility would be over an hour- a critical time difference in many medical cases.

c. Describe the nature of and requirements for zoning for the area surrounding the proposed location of the project.

The new construction will be contained entirely within the existing hospital parcel 1220-10-610-010. Zoning*: GC - General Commercial Zoning District* :Land Use*: C - Commercial

6.2 Effect on existing costs and quality of care: Explain the extent to which:

a. The proposed project is likely to stimulate competition which will result in a reduction in costs for the user or payer.

The CVMC expansion project allows for better access to our current services, which are often limited by our space and building layout. There will be no direct cost impact to the user or payer as result of this expansion project. Improved access to CVMC services could indirectly save users costs on travel and coordination of care outside of their community.

b. The proposed project is likely to increase costs to the user or payer through reductions in market shares for services if those reductions would increase costs per unit of service.

There will be no direct cost impact to the user or payer as result of this expansion project.

c. The proposed project contains innovations or improvements in the delivery or financing of health services which will significantly reduce the cost of health care to the user or payer or enhance the quality of care.

There will be no direct cost impact to the user or payer as result of this expansion project. The intent of this project is to increase the quality of care for patients utilizing CVMC for their healthcare needs in several ways – continuing to be able to care for patients in their own community; offering private patient rooms which provides a more healing environment without the infection control concerns and limitations of the current shared inpatient rooms; and a more efficient and accessible emergency room which allows CVMC to reduce the time patients spend in the Emergency Room and meet the current and future demands for emergency medical services in our community.

6.3 *Reduction, Elimination or Relocation of Health Services or Facility:*
If the proposed project involves the reduction, elimination or relocation of an existing health facility or service, how will the needs of the population currently being served continue to be met?

N/A

6.4 *Consistency with Existing System*: Explain whether the proposed project is consistent with the existing system of health care, based upon:

a. The effect of the proposed project on the availability and the cost of existing health services in the area of required personnel.

Currently, our services and staffing are limited by our current facility's space limitations. CVMC has the staffing required to meet current volumes and a staffing plan to accommodate increased volumes due to increased capacity as a result of the expansion as well as general population growth.

b. The extent to which the applicant will have adequate arrangements for referrals to and from other health facilities in the area which provide for avoidance of unnecessary duplication of effort, comprehensive and continuous care of patients, and communication and cooperation between related facilities or services.

CVMC currently has transfer agreements and referral relationships with all local healthcare providers; this will not change as a result of the CVMC expansion plan.

6.5 *Applicant History:* Describe the quality of care provided by the applicant for any existing health facility or service owned or operated by the applicant based upon:

a. Whether the applicant has had any adverse action taken against it with regard to a license or certificate held by the applicant and the results of that action.

CVMC has no history of adverse action with respect to license or certification.

b. The extent to which the applicant has previously provided similar health services.

The services addressed in the CVMC expansion project – Acute Care, ICU, Emergency, Radiology, and Surgical Services are all currently provided at CVMC.

c. Any additional evidence in the record regarding the applicant's quality of care.

CVMC is a CMS rated 3-star hospital; and 4-star rated hospital for patient surveys – quality data and scoring available on www.medicare.gov/hospitalcompare. The CVMC Emergency Department has also been recognized by Press Ganey for ED CAHPS scores ranking in the top percentile in the nation.

6.6 *Accessibility:* Explain the extent to which equal access by all persons in the area to the applicant's facility or service will be provided, based upon:

a. Whether any segment of the population in the area will be denied access to health services similar to those proposed by the applicant as a result of the proposed project.

CVMC currently provides care, without exclusion, to the residents and visitors of the Carson Valley. In the Emergency Room, CVMC adheres to EMTALA and provides care, regardless of the patient's ability to pay. CVMC offers a generous charity care and financial assistance program and employs a patient advocate to assist patients in navigating the healthcare system.

b. The extent to which the applicant will provide uncompensated care, exclusive to bad debt, and the effect of the proposed project on the cost to local and state governments and other facilities for providing care to indigents.

CVMC provides uncompensated care to the indigent and underinsured population. In 2019, the cost uncompensated care totaled $622,000. Our financial modeling included an increase in

uncompensated care at the same percentage we provide today applied to the higher patient volume growth expected over the ten years. Additionally, we estimated higher uncompensated care for 2021 and part of 2022 due to impact of COVID on the local economy. We do not anticipate any cost impact to the local or state government programs related to the project expansion or other facilities.

c. The extent to which financial barriers to access by persons of low income, including any financial preconditions to providing service, will prevent those persons from obtaining needed health services.

Recognizing and addressing financial and other barriers to accessing healthcare is a priority at CVMC. Over the years, we have added an Urgent Care and two Rural Health Clinics with a sliding fee scale to address some of these barriers. CVMC offers a generous charity care and financial assistance program and employs a patient advocate to assist patients with their unique challenges to accessing healthcare services. We do not anticipate that this project will negatively impact low income patients from obtaining needed services.

6.7 *Referrals:* Provide the following information for each health facility/program with which the applicant will have an arrangement for referrals.

Facility: Renown Health
Agreement for: Patient Transfer Agreement

Facility: Barton Healthcare System
Agreement for: Patient Transfer Agreement

Facility: Carson Tahoe Regional Healthcare
Agreement for: Patient Transfer Agreement

Facility: South Lyon Medical Center
Agreement for: Patient Transfers in a Disaster

Section VII. HEALTH CARE ACCESS

7.0 *Healthcare Distribution, Access and Outcomes:*
Describe the extent to which the project is consistent with the purposes set forth in NRS 439A.020 and the priorities set forth in NRS 439A.081. Including without limitation:

a. The impact of the project on other health care facilities;

CVMC is the only hospital serving the immediate community and therefore it is assumed that the expansion project should not impact other healthcare facilities who are also experiencing population growth in their own communities. The expansion project will not affect current transfer agreements with other regional facilities.

b. The need for any equipment that the project proposes to add, the manner in which such equipment will improve the quality of health care and any protocols provided in the project for avoiding repetitive testing;

The expansion project will utilize all current equipment or replacement equipment based on our capital equipment replacement process and thus does not include additional medical equipment.

c. The impact of the project on disparate health outcomes for different populations in the area that will be served by the project;

The impact on all populations will be improved access to care locally. This will benefit our aging population with increasing chronic conditions and our local tribal populations with an increased prevalence of diabetes. Having accessible, consistent healthcare for these conditions could increase their compliance with medical advice and remove some barriers for treatment, including extended travel time for care.

d. The manner in which the project will expand, promote or enhance the capacity to provide primary health care in the area that will be served by the project;

Additional capacity in our Emergency Room and our inpatient unit (by removing the same-gender and isolation limitations of shared rooms) will increase access to these key primary healthcare services in our community. In the past two years, CVMC has had to transfer out 105 patients due to these space limitations.

e. Any plan by the applicant to collect and analyze data concerning the effect of the project on health care quality and patient outcomes in the area served by the project;

CVMC will continue to collect and analyze quality data for our Critical Access Hospital as we currently do.

f. Any plan by the applicant for controlling the spread of infectious diseases;

CVMC currently has a comprehensive infection control plan. A major driver of the CVMC expansion plan is concerns over infection control in our current facility. The expansion plan will address the shared treatment areas by providing all private acute care rooms, additional private ER rooms, improved spaces for separating clean and dirty supplies and an upgraded air handling system. The expansion will adopt all current FGI guidelines for spaces, such as minimum clear floor area, clearances, and air exchanges to ensure patient safety, and infection control standards can be met.

g. The manner in which the applicant will coordinate with and support existing health facilities and practitioners, including, without limitation, mental health facilities, programs for the treatment and prevention of substance abuse and providers of nursing services.

CVMC plans to continue to coordinate and support existing healthcare practitioners, mental health facilities, nursing homes, and substance abuse programs as part of our routine business partnerships and regional healthcare model. CVMC is an active participant in the Douglas County Behavioral Health task force (as a result of this partnership, CVMC has also recently expanded its own behavioral health services to the community), the Quad County Health Coalition (which includes other local healthcare facilities and providers, public health officials, and nursing home facilities), and is an strong supporter in the programs provided by the Partnership of Community Resources – a nonprofit organization dedicated to preventing substance abuse in our community.

Carson Valley Medical Center Expansion Plan

Certificate of Need Application

Appendices

Appendix A: List of Chairmen, Directors and Officers	Attached
Appendix B: List of General and Limited Partners	N/A
Appendix C: Documentation of Ownership, Lease or Option to Purchase	Attached
Appendix D: Location Map	Attached
Appendix E: Organization Chart	Attached
Appendix F: Evidence of Available Funds	Attached
Appendix G: Financial Statements	Attached
Appendix H: New Facility Pro-Forma	N/A
Appendix I: Scale Drawings	Attached
Appendix J: Risk Model	Attached

Appendix A: List of Chairmen, Directors and Officers

Carson Valley Medical Center

1107 Highway 395 N Gardnerville, NV 89410

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Washoe Barton Medical Clinic, dba Carson Valley Medical Center Board of Directors

Dawn Ahner, Director /Chairperson
Kelly Neiger Secretary Treasurer
Ann Beck, Director
Paul Fry III, MD, Director
Sy Johnson, Director
Clint Purvance, MD (Member)

Jeff Prater, CEO President of Board *(non voting)*
Colleen Reid, CFO Director of Finance of Board (*non voting)*
Evan Easley, MD Chief Medical Officer *(non voting)*
Robert Silk, MD, Chief of Staff Ex-Officio Member *(non voting)*

Updated 01/2021

Appendix C: Documentation of Ownership, Lease or Option to Purchase

A.P. No. 1220-10-610-010
Escrow No. 2000-30535-JB
R.P.T.T. $ 13,000.00

WHEN RECORDED MAIL TO:
Grantee
1107 Highway 395
Gardnerville, Nv 89410

GRANT, BARGAIN and SALE DEED

FOR A VALUABLE CONSIDERATION, receipt of which is hereby acknowledged,

Barton Memorial Nevada Medical Clinic, Inc., a Nevada non-profit corporation

do(es) hereby *GRANT, BARGAIN and SELL* to

Washoe Barton Medical Clinic, a Nevada Non-Profit Corporation,

the real property situate in the County of Douglas, State of Nevada, described as follows:

Being a portion of Sections 3 and 10, Township 12 North, Range 20 East., M.D.B.& M. being further described as follows:

Parcel 4 as set forth on Parcel Map for Jacobsen Family trust, filed for record in the Office of the County Recorder of Douglas County, State of Nevada, recorded May 13, 1991, in Book 591, Page 1851, as Document No. 250593.

TOGETHER with all tenements, hereditaments and appurtenances, including easements and water rights, if any, thereto belonging or appertaining, and any reversions, remainders, rents, issues or profits thereof.

Date Nov 2, 2000

Barton Memorial Nevada Medical Clinic, Inc., a
Nevada non-profit corporation

William G. Gordon

By: William G. Gordon
Its: Chief Executive Officer

State of Nevada
County of Washoe See Attached California All Purpose Acknowledgment

This instrument was acknowledged before me on _____, by

_____

_____
Notarial Officer

0503336

BK1100PG2752

CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California
County of El Dorado } ss.

On Nov. 2, 2000 (Date), before me, Rhonda Fischer, Notary Public (Name and Title of Officer (e.g., "Jane Doe, Notary Public")),
personally appeared William G. Gordon (Name(s) of Signer(s)),

☒ personally known to me
☐ proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

WITNESS my hand and official seal.

RHONDA FISCHER
Commission # 1160777
Notary Public - California
El Dorado County
My Comm. Expires Nov 7, 2001

Place Notary Seal Above

Rhonda Fischer
Signature of Notary Public

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document
Title or Type of Document: Grant Bargain & Sale Deed
Document Date: 11/2/00 Number of Pages: 9
Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer
Signer's Name: William G Gordon RIGHT THUMBPRINT
☐ Individual
☒ Corporate Officer — Title(s): CFO
☐ Partner — ☐ Limited ☐ General
☐ Attorney in Fact
☐ Trustee
☐ Guardian or Conservator
☐ Other: _____

Signer Is Representing: _____

0503336

BK1100PG2753

REQUESTED BY
FIRST AMERICAN TITLE CO.

IN OFFICIAL RECORDS OF
DOUGLAS CO., NEVADA

2000 NOV 15 AM 11:50

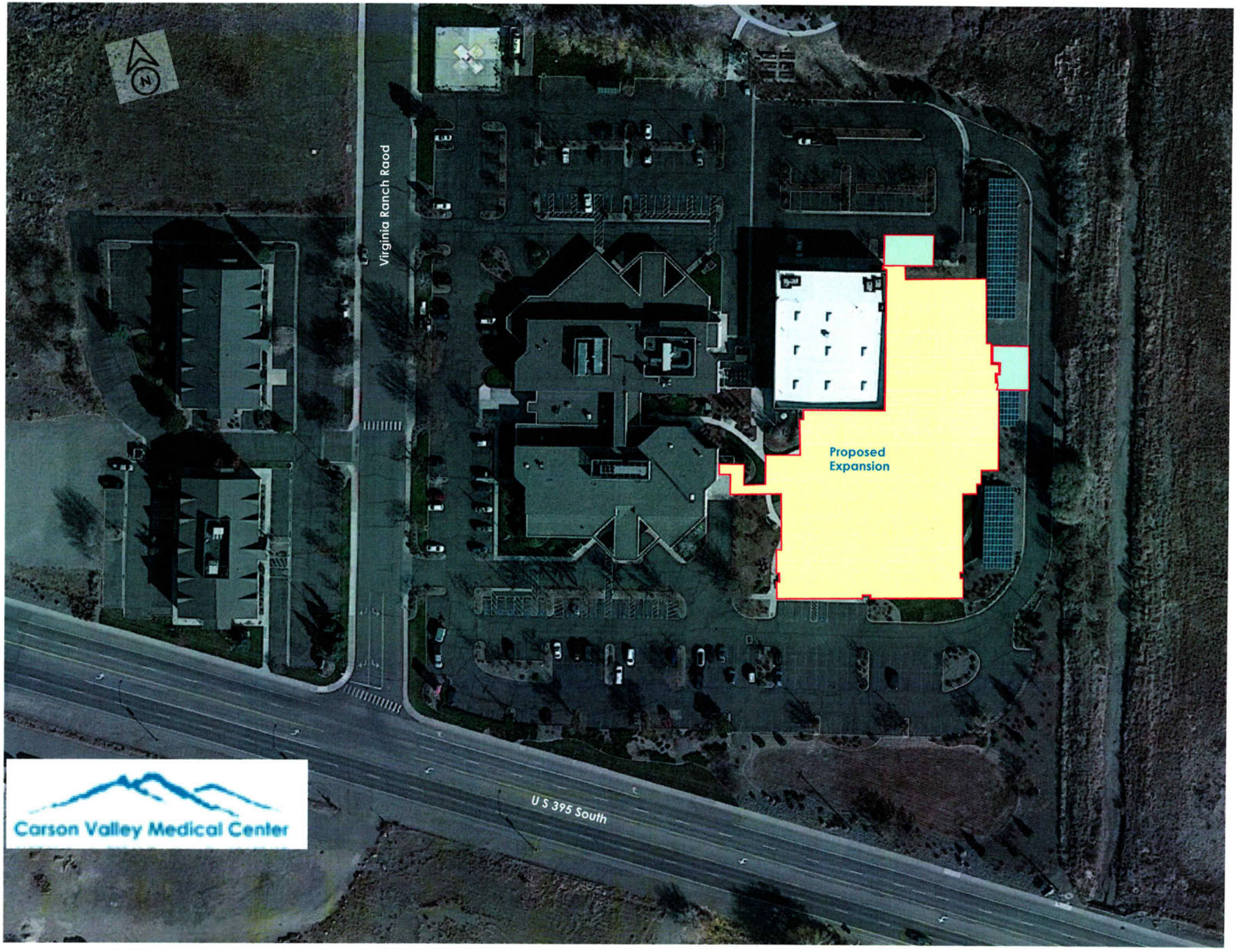
LINDA SLATER
RECORDER

$ 9.00 PAID KO DEPUTY

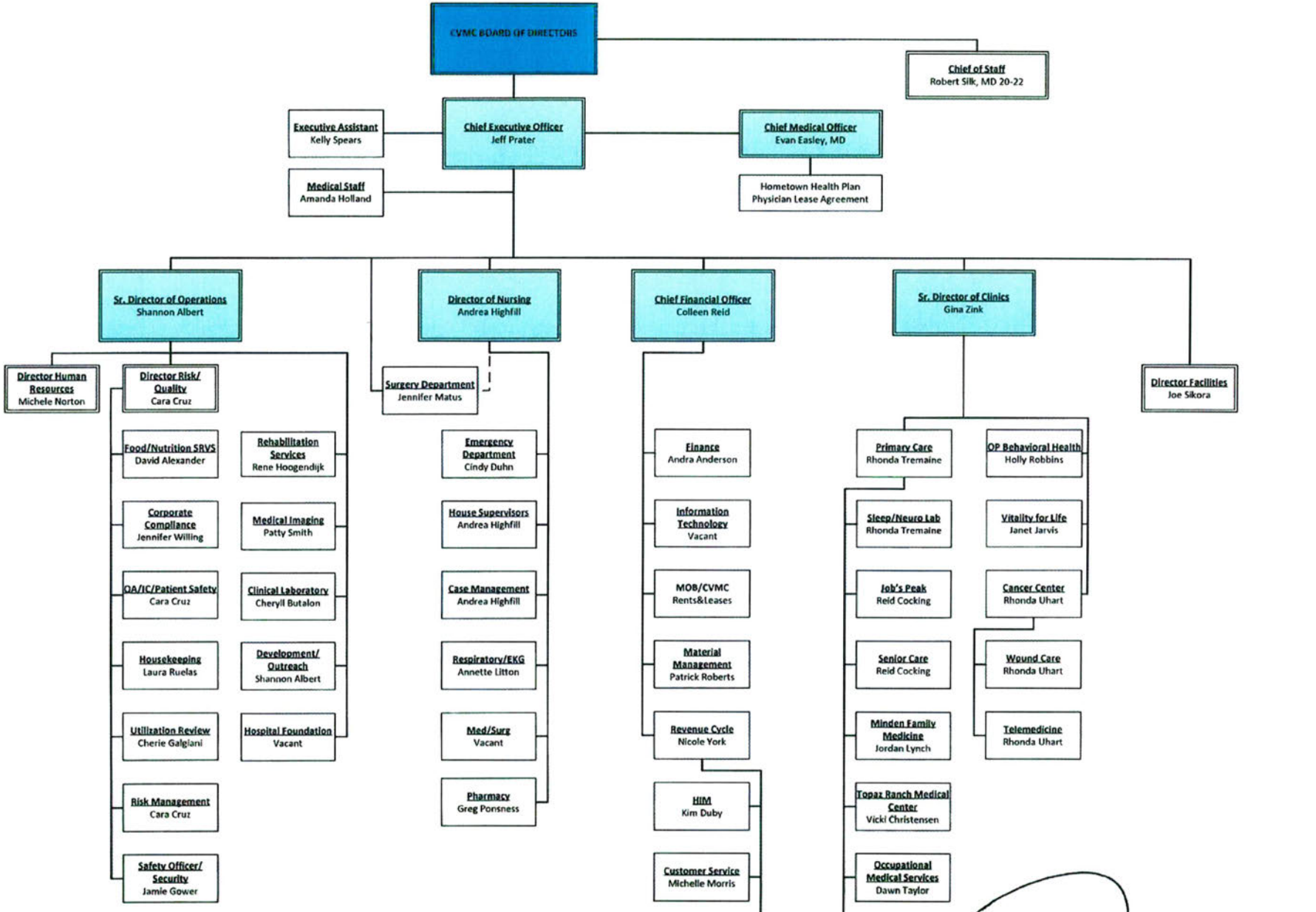
0503336

BK1100PG2754

Appendix D: Location Map


Virginia Ranch Raod
Proposed
Expansion
U S 395 South
Carson Valley Medical Center

Appendix E: Organization Chart



Carson Valley Medical Center

Jeff Prater, CEO
Updated: 12/8/2020

Appendix F: Evidence of Available Funds

Appendix F – Summary of Cash Available for the Project

Carson Valley Medical Center Summary of cash available for the Contraction Project	12/31/2020
Cash	$ 35,764,482
Investments	23,069,200
Total Cash & Investments	58,833,682
Less pending obligations	
Medicare Advance Funds	7,069,096
CAREs Act funds not used in 2020	3,112,406
SBA Paycheck projection plan funds - pending forgivene	5,240,142
Pending current liabilities	15,421,644
Net Cash & Investments available for the project	$ 43,412,038

Carson Valley Medical Center Consolidated
Balance Sheet
The Period Ending December, 2020
Unaudited

	Dec-2019	December	November	Change
Assets				
Current Assets:				
Cash	15,177,395	35,764,482	35,590,444	174,038
Net Patient A/R	9,329,131	10,430,942	9,719,460	711,481
Other A/R	1,386,829	3,828,364	3,198,474	629,890
Inventories	1,704,310	1,824,686	1,784,622	40,064
Prepaid Expense	511,759	139,292	250,461	(111,169)
Deposits and Other	-	-	-	-
Total Current Assets	28,109,424	51,987,766	50,543,462	1,444,304
Property, Plant & Equipment	55,289,168	57,286,785	57,224,494	62,291
Less Accum. Depreciation	(27,311,011)	(29,834,772)	(29,609,729)	(225,043)
Net Property, Plant & Equip	27,978,156	27,452,013	27,614,765	(162,752)
Long Term Investments	21,370,887	23,069,200	22,787,235	281,965
Total Long Term Investments	21,370,887	23,069,200	22,787,235	281,965
Other Assets				
Restricted to Use	1,291,772	1,301,562	1,301,190	373
Total Other Assets	1,291,772	1,301,562	1,301,190	373
Total Assets	78,750,241	103,810,540	102,246,651	1,563,889
Liabilities and Net Assets				
Current Liabilities:				
Accounts Payable	3,138,073	3,723,989	3,757,722	(33,733)
Accrued Salary & Benefits	1,547,722	2,189,922	2,120,644	69,278
Current Portion L-T Debt	739,833	784,365	784,365	-
Due to 3rd Party Payors	658,000	8,871,841	8,716,419	155,423
Other Current Liabilities	115,334	3,449,734	4,089,586	(639,852)
Short Term Debt	-	5,240,142	5,240,142	-
Total Current Liabilities	6,198,962	24,259,994	24,708,877	(448,884)
Net Long Term Debt	6,481,954	5,658,427	5,723,736	(65,309)
Other Long Term Liabilities	413,118	377,016	377,016	-
Total Liabilities	13,094,034	30,295,437	30,809,629	(514,193)
Total Net Assets	65,656,207	73,515,103	71,437,022	2,078,082
Total Liability & Net Assets	78,750,241	103,810,540	102,246,651	1,563,889

Appendix G: Financial Statements

Consolidated Financial Statements
December 31, 2017 and 2016

Washoe Barton Medical Clinic d/b/a Carson Valley Medical Center

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Independent Auditor's Report 1

Consolidated Financial Statements

Consolidated Balance Sheets 3
Consolidated Statements of Operations and Changes in Net Assets 4
Consolidated Statements of Cash Flows 5
Notes to Consolidated Financial Statements 6

EideBailly

CPAs & BUSINESS ADVISORS

Independent Auditor's Report

The Board of Directors
Washoe Barton Medical Clinic
d/b/a Carson Valley Medical Center
Gardnerville, Nevada

Report on the Consolidated Financial Statements
We have audited the accompanying consolidated financial statements of Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center (Medical Center), which comprise the consolidated balance sheets as of December 31, 2017 and 2016, and the related consolidated statements of operations and changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements
Management is responsible for the preparation and fair presentation of these consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated financial statements.

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

4310 17th Ave. S. | P.O. Box 2545 | Fargo, ND 58108-2545 | T 701.239.8500 | F 701.239.8600 | EOE

Opinion
In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center as of December 31, 2017 and 2016, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Eide Bailly LLP

Fargo, North Dakota
May 29, 2018

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	2017	2016
Assets		
Current Assets		
Cash and cash equivalents	$ 13,980,477	$ 20,913,293
Receivables		
Patient, net of estimated uncollectibles of $1,400,700 in 2017 and $2,499,700 in 2016	8,622,564	8,180,502
Estimated third-party payor settlements	1,175,004	673,191
Other	43,003	28,990
Supplies	1,318,762	1,200,836
Prepaid expenses and other	424,816	308,845
Total current assets	25,564,626	31,305,657
Assets Limited as to Use	1,264,329	1,180,705
Property and Equipment, Net	23,609,549	24,224,782
Other Assets		
Long-term investments	14,750,814	5,637,288
Land held for investment	187,000	187,000
Total other assets	14,937,814	5,824,288
Total assets	$ 65,376,318	$ 62,535,432

See Notes to Consolidated Financial Statements

Carson Valley Medical Center
Consolidated Balance Sheets
December 31, 2017 and 2016

	2017	2016
Liabilities and Net Assets		
Current Liabilities		
Current maturities of long-term debt	$ 729,597	$ 703,632
Accounts payable	1,791,701	2,028,114
Accrued expenses	1,754,874	1,669,494
Current portion of deferred revenue	133,889	467,690
Total current liabilities	4,410,061	4,868,930
Long-Term Liabilities		
Other long-term liabilities	167,573	167,573
Deferred revenue	-	133,887
Long-term debt, less current maturities and unamortized debt issuance costs of $158,153 in 2017 and $173,582 in 2016	7,937,355	8,653,075
Total liabilities	12,514,989	13,823,465
Unrestricted Net Assets	52,861,329	48,711,967
Total liabilities and net assets	$ 65,376,318	$ 62,535,432

Carson Valley Medical Center
Consolidated Statements of Operations and Changes in Net Assets
Years Ended December 31, 2017 and 2016

	2017	2016
Unrestricted Revenues, Gains, and Other Support		
Net patient service revenue	$ 64,891,168	$ 60,723,576
Provision for bad debts	(10,446,791)	(9,594,717)
Net patient service revenue less provision for bad debts	54,444,377	51,128,859
Other income	883,944	1,056,555
Total revenues, gains, and other support	55,328,321	52,185,414
Expenses		
Salaries and wages	18,737,391	17,310,287
Medical fees	7,380,308	7,510,757
Employee benefits	4,697,799	4,469,265
Supplies	11,002,336	9,169,418
Purchased services	3,080,601	3,408,626
Other operating costs	1,404,599	1,344,279
Depreciation	2,864,464	2,806,229
Professional fees	813,960	615,488
Utilities	617,926	544,735
Rent and lease	528,458	514,084
Interest and amortization	352,296	384,053
Gain on disposal of assets	-	(22,600)
Total expenses	51,480,138	48,054,621
Operating Income	3,848,183	4,130,793
Other Income		
Rental income	152,872	165,040
Investment income	202,052	115,567
Other nonoperating income	4,985	63,160
Other income, net	359,909	343,767
Revenues in Excess of Expenses	4,208,092	4,474,560
Change in Unrealized Gains and Losses on Investments	(58,730)	(11,867)
Change in Unrestricted Net Assets	4,149,362	4,462,693
Net Assets, Beginning of Year	48,711,967	44,249,274
Net Assets, End of Year	$ 52,861,329	$ 48,711,967

Carson Valley Medical Center
Consolidated Statements of Cash Flows
Years Ended December 31, 2017 and 2016

	2017	2016
Operating Activities		
Change in net assets	$ 4,149,362	$ 4,462,693
Adjustments to reconcile change in net assets to net cash from operating activities		
Depreciation	2,864,464	2,806,229
Interest expense attributed to amortization of debt issuance costs	15,429	15,430
Provision for bad debts	10,446,791	9,594,717
Net realized and unrealized gains and losses on investments	139,687	48,096
Gain on disposal of assets	-	(22,600)
Changes in assets and liabilities		
Patient accounts receivable	(10,888,853)	(11,061,015)
Estimated third-party settlements	(501,813)	426,030
Other accounts receivable	(14,013)	48,366
Supplies	(117,926)	84,743
Prepaid expenses and other	(115,971)	104,023
Accounts payable	(236,413)	226,152
Accrued expenses	85,380	214,721
Deferred revenue	(467,688)	(467,638)
Net Cash From Operating Activities	5,358,436	6,479,947
Investing Activities		
Purchase of property and equipment	(2,249,231)	(1,455,465)
Increase in assets limited as to use	(83,624)	(3,450)
Purchases of investments	(9,962,823)	(321,315)
Purchase of land held for investment	-	(187,000)
Proceeds from the sale of property and equipment	-	25,635
Proceeds from the sale of investments	709,610	180,226
Net Cash Used For Investing Activities	(11,586,068)	(1,761,369)
Financing Activity		
Principal payments on long-term debt	(705,184)	(999,993)
Net Increase (Decrease) in Cash and Cash Equivalents	(6,932,816)	3,718,585
Cash and Cash Equivalents, Beginning of Year	20,913,293	17,194,708
Cash and Cash Equivalents, End of Year	$ 13,980,477	$ 20,913,293
Supplemental Disclosure of Cash Flow Information		
Cash paid during the year for interest	$ 336,867	$ 368,623

See Notes to Consolidated Financial Statements

Note 1 - Organization and Significant Accounting Policies

Organization

Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center (Medical Center), a Nevada nonprofit corporation, is a 23-bed critical access hospital located in Gardnerville, Nevada. The Medical Center provides primarily inpatient, emergency, surgery, physical therapy, and various other outpatient services to the local residents of the Carson Valley area. The Medical Center also provides medical office space to local medical professionals.

Carson Valley Medical Center Foundation (Foundation), a Nevada nonprofit corporation, was formed in 2008 to expand community awareness of the Medical Center and to raise and manage donor funds for programs, activities, and capital construction. As the Medical Center has control over the Foundation, the Foundation is included as a consolidated entity. The Medical Center currently funds operating expenses of the Foundation.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Medical Center and the Foundation (collectively referred to as the "Organization"). All material intercompany accounts and transactions have been eliminated in consolidation.

Income Taxes

The Medical Center and Foundation are organized as Nevada nonprofit corporations and have been recognized by the Internal Revenue Service (IRS) as exempt from federal income taxes under Internal Revenue Code Section 501(c)(3). The Medical Center and Foundation are annually required to file a Return of Organization Exempt from Income Tax (Form 990) with the IRS. In addition, the Medical Center and Foundation are subject to income tax on net income that is derived from business activities that are unrelated to their exempt purpose. The Organization has determined it is not subject to unrelated business income tax and has not filed an Exempt Organization Business Income Tax Return (Form 990T) with the IRS.

The Organization believes that it has appropriate support for any tax positions taken affecting its annual filing requirements, and as such, does not have any uncertain tax positions that are material to the consolidated financial statements. The Organization would recognize future accrued interest and penalties related to unrecognized tax benefits and liabilities in income tax expense if such interest and penalties are incurred.

Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding assets limited as to use.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. The Organization does not have a policy to charge interest on past due accounts. Payments of patient receivables are allocated to the specific claims identified in the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Organization 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 Organization 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 Organization 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 Organization's process for calculating the allowance for doubtful accounts for self-pay patients has not significantly changed from December 31, 2016 to December 31, 2017. The Organization maintains an allowance for doubtful accounts from third-party payors and approximately 45% and 42% of the write offs for the years ended December 31, 2017 and 2016 are from third-party payors. The Organization has not significantly changed its charity care or uninsured discount policies during fiscal years 2017 or 2016.

Supplies

Supplies are stated at lower of cost (first-in, first-out) or net realizable value

Investments and Investment Income

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the performance indicator unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the performance indicator unless the investments are trading securities. Investment income on funds held under indenture agreements is recorded as other operating revenue while all other investment income is recorded as nonoperating revenue in the consolidated statements of operations and changes in net assets.

Assets Limited as to Use

Assets limited as to use include assets held by a trustee under the bond indenture agreement. Amounts required to meet current liabilities of the Organization have been classified as current assets.

Property and Equipment

Property and equipment acquisitions in excess of $5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. The estimated useful lives of property and equipment are as follows:

Building	30 years
Equipment	3-15 years
Leasehold improvements	10 years
Electronic medical records system	7 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to unrestricted net assets, and are excluded from the performance indicator, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as restricted net assets. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when donated or when acquired long-lived assets are placed in service.

Land Held for Investment

The asset is a vacant parcel of land that the Organization is holding for potential development. This land held for investment was originally recorded at $187,000 in 2016. No impairment was recorded for the years ended December 31, 2017 and 2016.

Impairment of Long-Lived Assets

The Organization considers whether indicators of impairment are present and performs the necessary analysis to determine if the carrying values of assets are appropriate. No impairment was identified for the years ended December 31, 2017 and 2016.

Debt Issuance Costs

Debt issuance costs are amortized over the life of the related debt using the straight-line method, which approximates the effective interest method. Amortization of debt issuance costs is included in interest expense in the accompanying consolidated statements of operations and changes in net assets.

Temporarily and Permanently Restricted Net Assets

Temporarily restricted net assets are those whose use by the Organization has been limited by donors to a specific time period or purpose. Permanently restricted net assets have been restricted by donors to be maintained by the Organization in perpetuity. At December 31, 2017 and 2016, the Organization did not have any temporarily or permanently restricted net assets.

Net Patient Service Revenue

The Organization has agreements with third-party payors that provide for payments to the Organization at amounts different from its established rates. Payment arrangements include prospectively determined rates, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including 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.

The Organization recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered, as noted above. For uninsured patients that do not qualify for charity care, the Organization 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 Organization's uninsured and other self-pay patients will be unable or unwilling to pay for the services provided. Thus, the Organization records a significant provision for bad debts related to uninsured and other self-pay patients in the period the services are provided.

Net patient service revenue, but before the provision for bad debts, recognized for the years ended December 31, 2017 and 2016 from these major payor sources, is as follows:

	2017	2016
Net patient service revenue		
Third-party payors	$ 60,842,734	$ 56,033,265
Self-pay	4,048,434	4,690,311
Total all payors	$ 64,891,168	$ 60,723,576

Performance Indicator

Revenues in excess of expenses is the performance indicator and excludes unrealized gains and losses on investments other than trading securities, transfers of assets to and from related parties for other than goods and services, and contributions of long-lived assets, including assets acquired using contributions which were restricted by donors.

Charity Care

The Organization provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less that established rates. Since the Organization does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was $543,000 and $417,000 for the years ended December 31, 2017 and 2016, calculated by multiplying the ratio of cost to gross charges for the Organization by the gross uncompensated charges associated with providing charity care to its patients.

Donor-Restricted Gifts

The Organization reports contributions restricted by donors as increases in unrestricted net assets if the restrictions expire (that is, when a stipulated time restriction ends or purpose restriction is accomplished) in the reporting period in which the revenue is recognized. All other donor-restricted contributions are reported as increases in temporarily or permanently restricted net assets, depending on the nature of the restrictions. When a restriction expires, temporarily restricted net assets are reclassified to unrestricted net assets and reported in the statement of changes in net assets as net assets release from restrictions.

Contributions are recognized when cash, securities or other assets, an unconditional promise to give, or notification of a beneficial interest is received. Conditional promises to give are not recognized until the conditions on which they depend have been substantially met.

Electronic Health Record (EHR) Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that demonstrate meaningful use of certified EHR technology.

To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the federal government or its designee. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) allowable costs as defined by the Centers for Medicare & Medicaid Services (CMS) and (2) the Medicare share. Once the initial attestation of meaningful use is completed, critical access hospitals receive the entire EHR incentive payment for submitted allowable costs of the respective periods in a lump sum, subject to a final adjustment on the cost report.

The Organization recognizes EHR incentive payments as revenue when there is reasonable assurance that the Organization will comply with the conditions attached to the incentive payments. As the entire EHR incentive payment is received in a lump sum for critical access hospitals and the Organization must annually attest to increasingly stringent meaningful use criteria, the EHR incentive payment is first recognized as a deferred revenue with a ratable recognition of revenue over a specified time period. EHR incentive payments are included in other operating revenue in the accompanying consolidated financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur. Management has estimated the expected revenue to be recognized during the next fiscal year and recorded this portion as a current liability.

The Organization received an EHR incentive payment of $2,806,449 in 2014. Of that amount, the Organization recognized $467,690 of EHR incentive payments in other revenue in the consolidated statements of operations and changes in net assets for both years ended December 31, 2017 and 2016. At December 31, 2017 and 2016, the Organization had deferred revenue of $133,889 and $601,577 (current and non-current) recorded in the consolidated balance sheets.

Financial Instruments and Credit Risk

Deposit concentration risk is managed by placing cash, money market accounts and investments with financial institutions believed to be creditworthy. At times, amounts on deposit may exceed insured limits or include uninsured investments in money market mutual funds. To date, the Organization has not experienced losses in any of these accounts. Although the fair values of investments are subject to fluctuation on a year-to-year basis, management believes that the investment policies and guidelines are prudent for the long-term welfare of the Organization.

Note 2 - Net Patient Service Revenue

The Organization has agreements with third-party payors that provide for payments to the Organization at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare. The Organization is licensed as a Critical Access Hospital (CAH). The Organization is reimbursed for most inpatient and outpatient services under a cost reimbursement methodology less sequestration, with final settlement determined after submission of annual cost reports by the Organization subject to audits thereof by the Medicare Administrative Contractor (MAC). The Organization's Medicare cost reports have been audited by the MAC through the year ended December 31, 2015. Clinical services are paid on a cost basis or fixed fee schedule.

Medicaid. Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a contract at retrospectively determined cost-based rates. Outpatient services are reimbursed based upon prospectively determined rates. The Organization's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through the year ended December 31, 2015.

The Organization has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

A summary of percentages of revenues by payor for the years ended December 31, 2017 and 2016 is as follows:

	2017	2016
Medicare	58%	59%
Medicaid	13%	12%
Commercial	26%	26%
Other	3%	3%
	100%	100%

Laws and regulations governing the Medicare, Medicaid, Commercial, and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient service revenue for the years ended December 31, 2017 and 2016 increased approximately $83,000 and $120,000 due to adjustments of previous estimates as a result of final settlements for years that are no longer likely subject to audits, reviews, and investigations.

A summary of patient service revenue and contractual adjustments for the years ended December 31, 2017 and 2016 is as follows:

	2017	2016
Total patient service revenue	$ 170,378,125	$ 159,183,896
Total contractual adjustments	(105,486,957)	(98,460,320)
Net patient service revenue	64,891,168	60,723,576
Less provision for bad debts	(10,446,791)	(9,594,717)
Net patient service revenue less provision for bad debt	$ 54,444,377	$ 51,128,859

Note 3 - Investments and Investment Income

Assets Limited as to Use

Assets limited as to use, stated at cost, consisted of the following at December 31, 2017 and 2016:

	2017	2016
Under bond indenture agreement - held by trustee		
Cash and cash equivalents	$ 1,264,329	$ 1,180,705

Long-Term Investments

The composition of long-term investments at December 31, 2017 and 2016 is shown in the following table. Government bonds, corporate bonds, and foreign bonds are stated at fair value.

	2017	2016
Cash and cash equivalents	$ 152,096	$ 57,042
Government bonds	5,628,914	2,480,634
Corporate bonds	8,457,044	2,890,445
Foreign bonds	512,760	209,167
	$ 14,750,814	$ 5,637,288

Investment Income

Investment income and gains and losses on investments, assets limited as to use, and cash equivalents consists of the following for the years ended December 31, 2017 and 2016:

	2017	2016
Other income		
Interest and dividend income	$ 283,009	$ 151,796
Realized gains and losses on investments, net	(80,957)	(36,229)
	$ 202,052	$ 115,567
Other changes in unrestricted net assets		
Change in unrealized gains and losses on investments	$ (58,730)	$ (11,867)

Note 4 - Property and Equipment

Property and equipment consisted of the following at December 31, 2017 and 2016:

	2017		2016	
	Cost	Accumulated Depreciation	Cost	Accumulated Depreciation
Land and improvements	$ 3,691,416	$ 522,422	$ 3,685,380	$ 452,428
Buildings and fixed equipment	30,274,085	14,578,213	29,986,670	13,472,432
Major movable equipment	13,718,172	9,726,501	12,980,476	8,702,187
Construction in progress	753,012	-	199,303	-
	$ 48,436,685	$ 24,827,136	$ 46,851,829	$ 22,627,047
Net property and equipment		$ 23,609,549		$ 24,224,782

Construction in progress at December 31, 2017 consists of various projects. The total estimated cost to complete the projects is $105,835 as of December 31, 2017, which will be financed with operating funds.

Note 5 - Leases

The Organization leases various equipment and facilities under noncancelable long-term lease agreements. Total lease expense for the years ended December 31, 2017 and 2016 for all operating leases was $528,458 and $514,084.

Minimum future lease payments for the operating leases are as follows:

Years Ending December 31,	Amount
2018	$ 352,577
2019	43,321
2020	45,925
Total minimum lease payments	$ 441,823

The Organization leases building space to various lessees under long-term leases. Rental income totaled $152,872 and $165,040 for the years ended December 31, 2017 and 2016.

Future minimum lease payments receivable on these leases are as follows:

Years Ending December 31,	Amount
2018	$ 109,932
2019	83,367
2020	81,563
2021	12,754
Total minimum payments receivable	$ 287,616

Note 6 - Long-Term Debt

The following presents long-term debt activities for the years ended December 31, 2017 and 2016:

	2017	2016
Douglas County, Nevada, Hospital Revenue and Refunding Bonds, Series 2013, collateralized by a pledge of the Organization's gross receipts (A)		
3.05% bonds, due in monthly installments of $60,771 including interest, through April 2025	$ 4,330,105	$ 4,855,789
5.0% bonds, due in varying monthly installments beginning May 2025 through April 2028	2,058,377	2,058,377
Unamortized debt issuance costs based upon effective interest rate of 6.62%	(158,153)	(173,582)
5.25% mortgage payable to bank, due in monthly installments of $26,066 including interest, through January 2028, secured by building	2,436,623	2,616,123
	8,666,952	9,356,707
Less current maturities	(729,597)	(703,632)
Long term debt, less current maturities	$ 7,937,355	$ 8,653,075

Long-term debt maturities are as follows:

Years Ending December 31,	Amount
2018	$ 729,597
2019	756,596
2020	784,365
2021	813,853
2022	844,222
Thereafter	4,896,472
Unamortized debt issuance costs	(158,153)
Total	$ 8,666,952

(A) Under the terms of the Revenue and Refunding Bonds, the Organization is required to maintain certain deposits with a trustee. Such deposits are included in assets limited as to use in the consolidated financial statements. The Revenue and Refunding Bonds also place limits on the incurrence of additional borrowings and requires the Organization to satisfy certain measures of financial performance as long as the bonds are outstanding.

Note 7 - Post-Retirement Benefits

The Organization has a 401(k) retirement plan (Plan) for all benefit status employees. The Organization matches up to the first 3% of the employee contribution and one-half of the next 1% saved by the employee, for a maximum matching contribution of 3.5%. The Plan has a one year waiting period and then a vesting schedule of 5 years beginning with year two – 25%, year three – 50%, year four – 75%, and year five – 100%. Total retirement plan expense for the years ended December 31, 2017 and 2016 was $332,899 and $314,259.

Note 8 - Concentrations of Credit Risk

The Organization grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2017 and 2016 was as follows:

	2017	2016
Medicare	43%	43%
Medicaid and other government	24%	19%
Commercial insurance	27%	29%
Self pay	4%	6%
Other third-party payors and patients	2%	3%
	100%	100%

Note 9 - Functional Expenses

The Organization provides health care services to residents within its geographic location. Expenses related to providing these services by functional class for the years ended December 31, 2017 and 2016 are as follows:

	2017	2016
Patient healthcare services	$ 43,673,368	$ 40,341,723
General and administrative	7,704,675	7,504,327
Fundraising	102,095	208,571
	$ 51,480,138	$ 48,054,621

Note 10 - Fair Value Measurements

The Organization reports certain assets and liabilities at fair value in the consolidated financial statements. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction in the principal; or most advantageous, market at the measurement date under current market conditions regardless of whether that price is directly observable or estimated using another valuation technique. Inputs used to determine fair value refer broadly to the assumptions that market participants would use in pricing the asset or liability, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset or liability based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing the asset or liability based on the best information available. A three-tier hierarchy categorizes the inputs as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that can be accessed at the measurement date.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. These include quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, inputs other than quoted pries that are observable for the asset or liability, and market-corroborated inputs.

Level 3 – Unobservable inputs for the asset or liability. In these situations, inputs are developed using the best information available in the circumstances.

In some cases, the inputs used to measure the fair value of an asset or a liability might be categorized within different levels of the fair value hierarchy. In those cases, the fair value measurement is categorized in its entirety in the same level of the fair value hierarchy as the lowest level input that is significant to the entire measurement. Assessing the significance of a particular input to the entire measurement requires judgment, taking into account factors specific to the asset or liability. The categorization of an asset within the hierarchy is based upon the pricing transparency of the asset and does not necessarily correspond to an assessment of the quality, risk or liquidity profile of the asset or liability.

The fair values for government bonds, corporate bonds, and foreign bonds are determined using a variety of techniques including quoted market prices of similar items, broker/dealer quotes, or models using interest rates or yield curves and are included in level two investments.

Assets measured at fair value on a recurring basis and the related fair values of these assets at December 31, 2017 and 2016 are as follows:

	Quoted Prices in Active Markets (Level 1)	Other Observable Inputs (Level 2)	Unobservable Inputs (Level 3)
December 31, 2017			
Assets			
Government bonds	$ -	$ 5,628,914	$ -
Corporate bonds			
Commercial	-	85,396	-
Financial institutions	-	6,253,140	-
Pharmaceuticals	-	26,358	-
Consumer goods	-	131,615	-
Utilities cooperative	-	193,366	-
Food and beverage	-	169,648	-
Natural resources	-	97,836	-
Certificates of deposit	-	1,499,685	-
Foreign bonds	-	512,760	-
Total	$ -	$ 14,598,718	$ -
December 31, 2016			
Assets			
Government bonds	$ -	$ 2,480,634	$ -
Corporate bonds			
Communications	-	45,155	-
Information technology	-	102,997	-
Financial institutions	-	2,222,357	-
Pharmaceuticals	-	52,701	-
Consumer goods	-	25,296	-
Industrial goods	-	110,004	-
Utilities cooperative	-	64,581	-
Food and beverage	-	126,433	-
Transportation	-	140,921	-
Foreign bonds	-	209,167	-
Total	$ -	$ 5,580,246	$ -

Note 11 - Related-Party Transaction

Renown Health, a 50% member of the Organization, provides certain support services to the Organization including clinic physicians, information technology services, and human resources support. During the years ended December 31, 2017 and 2016, the Organization incurred expenses of $2,175,312 and $2,416,266 to Renown Health for these services. The Organization had accounts payable due to Renown Health of $214,190 and $513,391 at December 31, 2017 and 2016 which are included in accounts payable in the accompanying consolidated financial statements.

Barton Healthcare System, a 50% member of the Organization, provides certain support services to the Organization including information technology and purchasing. During the years ended December 31, 2017 and 2016, the Organization incurred expenses of $2,034,385 and $1,274,092 to Barton Healthcare System for these services. The Organization had accounts payable due to Barton Healthcare System of $59,131 and $130,832 at December 31, 2017 and 2016 which are included in accounts payable in the accompanying consolidated financial statements.

The Organization enrolls its employees in a managed care organization, Hometown Health Plan, which is owned by Renown Health. Annual premium expenses incurred to Hometown Health Plan were $3,180,071 and $2,987,064 for the years ended December 31, 2017 and 2016.

Note 12 - Workers' Compensation

The Organization maintains a workers' compensation policy with the Nevada Retail Network Self Insured Group (NRNSIG), a self-insured group for qualified organizations in the state of Nevada. Members are selected and admitted based on certain criteria including an assessment of financial health as well as geographic location. Premiums paid are established annually based on the experience of the pool and the Organization. The Organization paid premiums of $112,139 and $111,480 for the years ended December 31, 2017 and 2016. There were no accrued premiums at December 31, 2017 and 2016. The Organization's policy with NRNSIG may be terminated by the member at any time with advance notification and may be terminated by the self-insured group based on certain criteria of non-compliance as specified in the bylaws of NRNSIG. Management has determined that at December 31, 2017 and 2016, no liability was needed as there were no known significant outstanding claims.

Note 13 - Contingencies

Professional Liability

The Organization has professional liability coverage to provide protection for professional liability losses on a claims-made basis subject to a limit of $5 million per claim and an annual aggregate limit of $15 million with a $50,000 deductible per claim. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, would be uninsured. Management's estimate of the Organization's liability for expected losses from reported and unreported incidents is based on information obtained from the Organization's actuary and claims managers. The liability is shown as an other noncurrent liability in the accompanying consolidated financial statements.

Litigation, Claims, and Disputes

The Organization is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. Management assesses the ultimate settlement of any litigation, claims, and disputes in process in determining whether a liability should be recorded or a disclosure should be presented.

The health care industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by health care providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 14 - Subsequent Events

The Organization has passed a resolution on May 25, 2018, authorizing the interim Chief Executive Officer to negotiate the terms and conditions of the purchase of a medical office building located in Gardnerville, Nevada, which has been appraised at $3 million. The purchase has an anticipated closing date of June 29, 2018.

The Organization has evaluated subsequent events through May 29, 2018, the date which the consolidated financial statements were available to be issued.

Consolidated Financial Statements
December 31, 2018 and 2017

Washoe Barton Medical Clinic d/b/a Carson Valley Medical Center

EideBailly

Carson Valley Medical Center
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CPAs & BUSINESS ADVISORS

Independent Auditor's Report

The Board of Directors
Washoe Barton Medical Clinic
d/b/a Carson Valley Medical Center
Gardnerville, Nevada

Report on the Consolidated Financial Statements

We have audited the accompanying consolidated financial statements of Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center (Medical Center), which comprise the consolidated balance sheets as of December 31, 2018 and 2017, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements

Management is responsible for the preparation and fair presentation of these consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

Auditor's Responsibility

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated financial statements.

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

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Opinion
In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center as of December 31, 2018 and 2017, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Eide Bailly LLP

Fargo, North Dakota
May 31, 2019

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	2018	2017
Assets		
Current Assets		
Cash and cash equivalents	$ 16,083,216	$ 13,980,477
Receivables		
Patient, net of estimated uncollectibles of $723,500 in 2018 and $1,400,700 in 2017	8,729,253	8,622,564
Estimated third-party payor settlements	415,704	1,175,004
Other	16,924	43,003
Supplies	1,531,019	1,318,762
Prepaid expenses and other	497,358	424,816
Total current assets	27,273,474	25,564,626
Assets Limited as to Use	1,270,508	1,264,329
Property and Equipment, Net	26,230,671	23,609,549
Other Assets		
Long-term investments	14,986,750	14,750,814
Land held for investment	187,000	187,000
Total other assets	15,173,750	14,937,814
Total assets	$ 69,948,403	$ 65,376,318

See Notes to Consolidated Financial Statements

Carson Valley Medical Center
Consolidated Balance Sheets
December 31, 2018 and 2017

	2018	2017
Liabilities and Net Assets		
Current Liabilities		
Current maturities of long-term debt	$ 756,596	$ 729,597
Accounts payable	2,399,429	1,791,701
Accrued expenses	1,916,234	1,754,874
Current portion of deferred revenue	-	133,889
Total current liabilities	5,072,259	4,410,061
Long-Term Liabilities		
Other long-term liabilities	455,234	167,573
Long-term debt, less current maturities and unamortized debt issuance costs of $142,723 in 2018 and $158,153 in 2017	7,196,220	7,937,355
Total liabilities	12,723,713	12,514,989
Net Assets		
Without donor restrictions	57,189,041	52,861,329
With donor restrictions	35,649	-
Total net assets	57,224,690	52,861,329
Total liabilities and net assets	$ 69,948,403	$ 65,376,318

Carson Valley Medical Center
Consolidated Statements of Operations
Years Ended December 31, 2018 and 2017

	2018	2017
Revenues, Gains, and Other Support Without Donor Restrictions		
Net patient service revenue	$ 61,136,379	$ 64,891,168
Provision for bad debts	(3,112,928)	(10,446,791)
Net patient service revenue less provision for bad debts	58,023,451	54,444,377
Other income	734,998	883,944
Total revenues, gains, and other support	58,758,449	55,328,321
Expenses		
Salaries	20,016,389	18,722,829
Contract labor	857,991	914,082
Employee benefits	5,397,511	4,712,511
Medical professional fees	8,152,853	7,371,488
Other professional fees	1,037,853	483,758
Supplies	10,912,278	10,996,323
Utilities	615,144	619,572
Other purchased services	2,788,510	2,511,560
Rent and lease	286,883	528,458
Insurance	594,099	316,617
Interest	327,914	352,296
Depreciation	2,771,218	2,864,464
Other operating costs	1,120,178	1,086,180
Loss on disposal of assets	6,303	-
Total expenses	54,885,124	51,480,138
Operating Income	3,873,325	3,848,183
Other Income		
Rental income	214,769	152,872
Investment income	229,829	202,052
Other nonoperating income	38,141	4,985
Other income, net	482,739	359,909
Revenues in Excess of Expenses	4,356,064	4,208,092
Change in Unrealized Gains and Losses on Investments	(9,100)	(58,730)
Transfer to Net Assets With Donor Restrictions	(19,252)	-
Change in Net Assets Without Donor Restrictions	$ 4,327,712	$ 4,149,362

See Notes to Consolidated Financial Statements

Carson Valley Medical Center
Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2018 and 2017

	2018	2017
Net Assets Without Donor Restrictions		
Revenues in excess of expenses	$ 4,356,064	$ 4,208,092
Change in unrealized gains and losses on investments	(9,100)	(58,730)
Transfer to net assets with donor restrictions	(19,252)	-
Change in net assets without donor restrictions	4,327,712	4,149,362
Net Assets With Donor Restrictions		
Contributions for specific purposes	16,397	-
Transfer from net assets without donor restrictions	19,252	-
Change in net assets with donor restrictions	35,649	-
Change in Net Assets	4,363,361	4,149,362
Net Assets, Beginning of Year	52,861,329	48,711,967
Net Assets, End of Year	$ 57,224,690	$ 52,861,329

See Notes to Consolidated Financial Statements

Carson Valley Medical Center
Consolidated Statements of Cash Flows
Years Ended December 31, 2018 and 2017

	2018	2017
Operating Activities		
Change in net assets	$ 4,363,361	$ 4,149,362
Adjustments to reconcile change in net assets to net cash from operating activities		
Depreciation	2,771,218	2,864,464
Interest expense attributed to amortization of debt issuance costs	15,430	15,429
Provision for bad debts	3,112,928	10,446,791
Net realized and unrealized gains and losses on investments	146,593	139,687
Loss on disposal of assets	6,303	-
Contributions restricted by donors	(16,397)	-
Changes in assets and liabilities		
Patient accounts receivable	(3,219,617)	(10,888,853)
Estimated third-party settlements	759,300	(501,813)
Other accounts receivable	26,079	(14,013)
Supplies	(212,257)	(117,926)
Prepaid expenses and other	(72,542)	(115,971)
Accounts payable	607,728	(236,413)
Accrued expenses	449,021	85,380
Deferred revenue	(133,889)	(467,688)
Net Cash From Operating Activities	8,603,259	5,358,436
Investing Activities		
Purchase of property and equipment	(5,398,643)	(2,249,231)
Increase in assets limited as to use	(6,179)	(83,624)
Purchases of investments	(18,123,940)	(9,962,823)
Proceeds from the sale of investments	17,741,411	709,610
Net Cash Used For Investing Activities	(5,787,351)	(11,586,068)
Financing Activities		
Principal payments on long-term debt	(729,566)	(705,184)
Contributions restricted by donors	16,397	-
Net Cash Used For Financing Activities	(713,169)	(705,184)
Net Change in Cash and Cash Equivalents	2,102,739	(6,932,816)
Cash and Cash Equivalents, Beginning of Year	13,980,477	20,913,293
Cash and Cash Equivalents, End of Year	$ 16,083,216	$ 13,980,477
Supplemental Disclosure of Cash Flow Information		
Cash paid during the year for interest	$ 312,484	$ 336,867

See Notes to Consolidated Financial Statements

Note 1 - Organization and Significant Accounting Policies

Organization

Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center (Medical Center), a Nevada nonprofit corporation, is a 23-bed critical access hospital located in Gardnerville, Nevada. The Medical Center provides primarily inpatient, emergency, surgery, physical therapy, and various other outpatient services to the local residents of the Carson Valley area. The Medical Center also provides medical office space to local medical professionals.

Carson Valley Medical Center Foundation (Foundation), a Nevada nonprofit corporation, was formed in 2008 to expand community awareness of the Medical Center and to raise and manage donor funds for programs, activities, and capital construction. As the Medical Center has control over the Foundation, the Foundation is included as a consolidated entity. The Medical Center currently funds operating expenses of the Foundation.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Medical Center and the Foundation (collectively referred to as the "Organization"). All material intercompany accounts and transactions have been eliminated in consolidation.

Income Taxes

The Medical Center and Foundation are organized as Nevada nonprofit corporations and have been recognized by the Internal Revenue Service (IRS) as exempt from federal income taxes under Internal Revenue Code Section 501(c)(3). The Medical Center and Foundation are annually required to file a Return of Organization Exempt from Income Tax (Form 990) with the IRS. In addition, the Medical Center and Foundation are subject to income tax on net income that is derived from business activities that are unrelated to their exempt purpose. The Organization has determined it is not subject to unrelated business income tax and has not filed an Exempt Organization Business Income Tax Return (Form 990T) with the IRS.

The Organization believes that it has appropriate support for any tax positions taken affecting its annual filing requirements, and as such, does not have any uncertain tax positions that are material to the consolidated financial statements. The Organization would recognize future accrued interest and penalties related to unrecognized tax benefits and liabilities in income tax expense if such interest and penalties are incurred.

Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding assets limited as to use.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. The Organization does not have a policy to charge interest on past due accounts. Payments of patient receivables are allocated to the specific claims identified in the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Organization 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 Organization 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 Organization 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 Organization's process for calculating the allowance for doubtful accounts for self-pay patients has changed from December 31, 2017 to December 31, 2018. The Organization began calculating contractual adjustments on self-pay patients during December 31, 2018 thus reporting as an allowance for contractual adjustment rather than allowance for doubtful accounts. Due to the change in calculation, the Organization does not maintain a significant allowance for doubtful accounts from third-party payors. Approximately 45% of the write offs for the year ended December 31, 2017 was from third-party payors. The Organization has not significantly changed its charity care or uninsured discount policies during fiscal years 2018 or 2017.

Investments and Investment Income

Investments in equity securities with readily determinable fair values and all investments in debt securities are measured at fair value in the consolidated balance sheets. Investment income or loss (including realized gains and losses on investments, interest, and dividends) is included in the performance indicator unless the income or loss is restricted by donor or law. Unrealized gains and losses on investments are excluded from the performance indicator unless the investments are trading securities. Investment income on funds held under indenture agreements is recorded as other operating revenue while all other investment income is recorded as nonoperating revenue in the consolidated statements of operations.

Supplies

Supplies are stated at lower of cost (first-in, first-out) or net realizable value

Assets Limited as to Use

Assets limited as to use include assets held by a trustee under the bond indenture agreement. Amounts required to meet current liabilities of the Organization have been classified as current assets.

Property and Equipment

Property and equipment acquisitions in excess of $5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. The estimated useful lives of property and equipment are as follows:

Building	30 years
Equipment	3-15 years
Leasehold improvements	10 years
Electronic medical records system	7 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to net assets without donor restrictions, and are excluded from the performance indicator, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as net assets with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when donated or when acquired long-lived assets are placed in service.

Land Held for Investment

The asset is a vacant parcel of land that the Organization is holding for potential development. This land held for investment was originally recorded at $187,000 in 2016. No impairment was recorded for the years ended December 31, 2018 and 2017.

Impairment of Long-Lived Assets

The Organization considers whether indicators of impairment are present and performs the necessary analysis to determine if the carrying values of assets are appropriate. No impairment was identified for the years ended December 31, 2018 and 2017.

Debt Issuance Costs

Debt issuance costs are amortized over the life of the related debt using the straight-line method, which approximates the effective interest method. Debt issuance costs are included within long-term debt on the consolidated balance sheets. Amortization of debt issuance costs is included in interest expense in the accompanying consolidated statements of operations.

Net Assets with Donor Restrictions

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. Donor-imposed restrictions are released when a restriction expires, that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource was restricted has been fulfilled, or both.

At December 31, 2018, the Organization has net assets with donor restrictions of $35,649 to be used for capital purchases. There were no net assets with donor restrictions at December 31, 2017.

Net Patient Service Revenue

The Organization has agreements with third-party payors that provide for payments to the Organization at amounts different from its established rates. Payment arrangements include prospectively determined rates, reimbursed costs, discounted charges, and per diem payments. Net patient service revenue is reported at the estimated net realizable amounts from patients, third-party payors, and others for services rendered, including 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.

The Organization recognizes patient service revenue associated with services provided to patients who have third-party payor coverage on the basis of contractual rates for the services rendered, as noted above. For uninsured patients that do not qualify for charity care, the Organization 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 Organization's uninsured and other self-pay patients will be unable or unwilling to pay for the services provided. Thus, the Organization records a significant provision for bad debts related to uninsured and other self-pay patients in the period the services are provided.

Net patient service revenue, but before the provision for bad debts, recognized for the years ended December 31, 2018 and 2017 from these major payor sources, is as follows:

	2018	2017
Net patient service revenue		
Third-party payors	$ 55,948,480	$ 60,842,734
Self-pay	5,187,899	4,048,434
Total all payors	$ 61,136,379	$ 64,891,168

Performance Indicator

Revenues in excess of expenses is the performance indicator and excludes unrealized gains and losses on investments other than trading securities, transfers of assets to and from related parties for other than goods and services, and contributions of long-lived assets, including assets acquired using contributions which were restricted by donors.

Charity Care

The Organization provides healthcare services to patients who meet certain criteria under its charity care policy without charge or at amounts less that established rates. Since the Organization does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was $693,000 and $543,000 for the years ended December 31, 2018 and 2017, calculated by multiplying the ratio of cost to gross charges for the Organization by the gross uncompensated charges associated with providing charity care to its patients.

Donor-Restricted Gifts

The Organization reports contributions restricted by donors as increases in net assets without donor restrictions if the restrictions expire (that is, when a stipulated time restriction ends or purpose restriction is accomplished) in the reporting period in which the revenue is recognized. All other donor-restricted contributions are reported as increases in net assets with donor restrictions, depending on the nature of the restrictions. When a restriction expires, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the consolidated statements of changes in net assets as net assets released from restrictions.

Contributions are recognized when cash, securities or other assets, an unconditional promise to give, or notification of a beneficial interest is received. Conditional promises to give are not recognized until the conditions on which they depend have been substantially met.

Electronic Health Record (EHR) Incentives

The American Recovery and Reinvestment Act of 2009 (ARRA) amended the Social Security Act to establish incentive payments under the Medicare and Medicaid programs for certain hospitals and professionals that demonstrate meaningful use of certified EHR technology.

To qualify for the EHR incentive payments, hospitals and physicians must meet designated EHR meaningful use criteria. In addition, hospitals must attest that they have used certified EHR technology, satisfied the meaningful use objectives, and specify the EHR reporting period. This attestation is subject to audit by the federal government or its designee. The EHR incentive payment to hospitals for each payment year is calculated as a product of (1) allowable costs as defined by the Centers for Medicare & Medicaid Services (CMS) and (2) the Medicare share. Once the initial attestation of meaningful use is completed, critical access hospitals receive the entire EHR incentive payment for submitted allowable costs of the respective periods in a lump sum, subject to a final adjustment on the cost report.

The Organization recognizes EHR incentive payments as revenue when there is reasonable assurance that the Organization will comply with the conditions attached to the incentive payments. As the entire EHR incentive payment is received in a lump sum for critical access hospitals and the Organization must annually attest to increasingly stringent meaningful use criteria, the EHR incentive payment is first recognized as a deferred revenue with a ratable recognition of revenue over a specified time period. EHR incentive payments are included in other operating revenue in the accompanying consolidated financial statements. The amount of EHR incentive payments recognized are based on management's best estimate and those amounts are subject to change with such changes impacting the period in which they occur. Management has estimated the expected revenue to be recognized during the next fiscal year and recorded this portion as a current liability.

The Organization received an EHR incentive payment of $2,806,449 in 2014. Of that amount, the Organization recognized $118,533 and $467,690 of EHR incentive payments in other revenue in the consolidated statements of operations for the years ended December 31, 2018 and 2017. At December 31, 2017, the Organization had deferred revenue of $133,889 recorded in the consolidated balance sheets. There is no deferred revenue as of December 31, 2018.

Financial Instruments and Credit Risk

Deposit concentration risk is managed by placing cash, money market accounts and investments with financial institutions believed to be creditworthy. At times, amounts on deposit may exceed insured limits or include uninsured investments in money market mutual funds. To date, the Organization has not experienced losses in any of these accounts. Although the fair values of investments are subject to fluctuation on a year-to-year basis, management believes that the investment policies and guidelines are prudent for the long-term welfare of the Organization.

Functional Allocation of Expenses

The costs of program and supporting services activities have been summarized on a functional basis in Note 11, which presents the natural classification detail of expenses by function. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

The consolidated financial statements report certain categories of expenses that are attributed to more than one program or supporting function. Therefore, expenses require allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as interest, are allocated to a function based on a square-footage.

Reclassifications

Certain reclassifications of amounts previously reported have been made to the accompanying consolidated financial statements to maintain consistency between periods presented. The reclassification had no impact on previously reporting net assets or changes in net assets.

Note 2 - Liquidity and Availability

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of the consolidated balance sheet date, comprise the following:

	2018	2017
Operating cash and equivalents	$ 16,083,216	$ 13,980,477
Receivables		
Patient, net	8,729,253	8,622,564
Other	16,924	43,003
Assets limited as to use	1,270,508	1,264,329
Long-term investments	14,986,750	14,750,814
	41,086,651	38,661,187
Less amounts not available to be used within one year		
Net assets with donor restrictions	(35,649)	-
Other assets limited as to use	(1,270,508)	(1,264,329)
	(1,306,157)	(1,264,329)
Financial assets available for general expenditure	$ 39,780,494	$ 37,396,858

Assets limited as to use include assets held by a trustee under the bond indenture agreement and are not available for general expenditure within the next year. Net assets with donor restrictions are restricted for capital purchases and may be used if restrictions are met.

As part of a liquidity management plan, cash in excess of daily requirements is invested in investments.

Note 3 - Net Patient Service Revenue

The Organization has agreements with third-party payors that provide for payments to the Organization at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare. The Organization is licensed as a Critical Access Hospital (CAH). The Organization is reimbursed for most inpatient and outpatient services under a cost reimbursement methodology less sequestration, with final settlement determined after submission of annual cost reports by the Organization subject to audits thereof by the Medicare Administrative Contractor (MAC). The Organization's Medicare cost reports have been audited by the MAC through the year ended December 31, 2016. Clinical services are paid on a cost basis or fixed fee schedule.

Medicaid. Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a contract at retrospectively determined cost-based rates. Outpatient services are reimbursed based upon prospectively determined rates. The Organization's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through the year ended December 31, 2016.

The Organization has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

A summary of percentages of revenues by payor for the years ended December 31, 2018 and 2017 is as follows:

	2018	2017
Medicare	61%	58%
Medicaid	10%	13%
Commercial	26%	26%
Other	3%	3%
	100%	100%

Laws and regulations governing the Medicare, Medicaid, Commercial, and other programs are extremely complex and subject to interpretation. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. Net patient service revenue for the years ended December 31, 2018 and 2017 increased approximately $196,000 and $83,000 due to adjustments of previous estimates as a result of final settlements for years that are no longer likely subject to audits, reviews, and investigations.

A summary of patient service revenue and contractual adjustments for the years ended December 31, 2018 and 2017 is as follows:

	2018	2017
Total patient service revenue	$ 190,355,144	$ 170,378,125
Total contractual adjustments	(129,218,765)	(105,486,957)
Net patient service revenue	61,136,379	64,891,168
Less provision for bad debts	(3,112,928)	(10,446,791)
Net patient service revenue less provision for bad debt	$ 58,023,451	$ 54,444,377

Note 4 - Property and Equipment

Property and equipment consisted of the following at December 31, 2018 and 2017:

	2018		2017	
	Cost	Accumulated Depreciation	Cost	Accumulated Depreciation
Land and improvements	$ 4,297,353	$ 603,439	$ 3,691,416	$ 522,422
Buildings and fixed equipment	34,933,876	15,911,315	30,274,085	14,578,213
Major movable equipment	13,656,339	10,202,538	13,718,172	9,726,501
Construction in progress	60,395	-	753,012	-
	$ 52,947,963	$ 26,717,292	$ 48,436,685	$ 24,827,136
Net property and equipment		$ 26,230,671		$ 23,609,549

Construction in progress at December 31, 2018 represents purchase of a 3D Mammography system and expansion of the Minden Family Medicine facility. The estimated cost to complete the 3D Mammography system is $306,000. The estimated cost to complete the Minden Family Medicine facility expansion is $481,000. Both projects will be financed by operating funds.

Note 5 - Fair Value Measurement

The Organization reports certain assets and liabilities at fair value in the consolidated financial statements. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction in the principal; or most advantageous, market at the measurement date under current market conditions regardless of whether that price is directly observable or estimated using another valuation technique. Inputs used to determine fair value refer broadly to the assumptions that market participants would use in pricing the asset or liability, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset or liability based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing the asset or liability based on the best information available. A three-tier hierarchy categorizes the inputs as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that can be accessed at the measurement date.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. These include quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, inputs other than quoted pries that are observable for the asset or liability, and market-corroborated inputs.

Level 3 – Unobservable inputs for the asset or liability. In these situations, inputs are developed using the best information available in the circumstances.

In some cases, the inputs used to measure the fair value of an asset or a liability might be categorized within different levels of the fair value hierarchy. In those cases, the fair value measurement is categorized in its entirety in the same level of the fair value hierarchy as the lowest level input that is significant to the entire measurement. Assessing the significance of a particular input to the entire measurement requires judgment, taking into account factors specific to the asset or liability. The categorization of an asset within the hierarchy is based upon the pricing transparency of the asset and does not necessarily correspond to an assessment of the quality, risk or liquidity profile of the asset or liability.

The fair values for government bonds, corporate bonds, and foreign bonds are determined using a variety of techniques including quoted market prices of similar items, broker/dealer quotes, or models using interest rates or yield curves and are included in level two investments.

The following table presents assets measured at fair value on a recurring basis, except those measured at cost, at December 31, 2018:

Assets	Total	Fair Value Measurements at 12/31/18 Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets Limited as to Use				
Under bond indenture agreement - held by trustee				
Cash and cash equivalents (at cost)	$ 1,270,508	$ -	$ -	$ -
Long-Term Investments				
Government bonds	$ 4,714,512	$ -	$ 4,714,512	$ -
Corporate bonds				
Commercial	198,910	-	198,910	-
Financial institutions	6,387,894	-	6,387,894	-
Pharmaceuticals	166,229	-	166,229	-
Consumer goods	615,850	-	615,850	-
Food and beverage	166,380	-	166,380	-
Natural resources	136,831	-	136,831	-
Certificates of deposit	1,879,258	-	1,879,258	-
Foreign bonds	688,091	-	688,091	-
	14,953,955	$ -	$ 14,953,955	$ -
Money market funds (at cost)	32,795			
	$ 14,986,750			

The following table presents assets measured at fair value on a recurring basis, except those measured at cost, at December 31, 2017:

Assets	Total	Fair Value Measurements at 12/31/17 Using: Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Assets Limited as to Use				
Under bond indenture agreement - held by trustee				
Cash and cash equivalents (at cost)	$ 1,264,329	$ -	$ -	$ -
Long-Term Investments				
Government bonds	$ 5,628,914	$ -	$ 5,628,914	$ -
Corporate bonds				
Commercial	85,396	-	85,396	-
Financial institutions	6,253,140	-	6,253,140	-
Pharmaceuticals	26,358	-	26,358	-
Consumer goods	131,615	-	131,615	-
Utilities cooperative	193,366	-	193,366	-
Food and beverage	169,648	-	169,648	-
Natural resources	97,836	-	97,836	-
Certificates of deposit	1,499,685	-	1,499,685	-
Foreign bonds	512,760	-	512,760	-
	14,598,718	$ -	14,598,718	$ -
Money market funds (at cost)	152,096			
	$ 14,750,814			

Note 6 - Leases

The Organization leases various equipment and facilities under noncancelable long-term lease agreements. Total lease expense for the years ended December 31, 2018 and 2017 for all operating leases was $286,883 and $528,458. The Organization does not have any future lease obligations at December 31, 2018.

The Organization leases building space to various lessees under long-term leases. Rental income totaled $214,769 and $152,872 for the years ended December 31, 2018 and 2017.

Future minimum lease payments receivable on the leases are as follows:

Years Ending December 31,	Amount
2019	$ 262,617
2020	268,555
2021	233,856
2022	225,240
2023	186,291
Total minimum payments receivable	$ 1,176,559

Note 7 - Long-Term Debt

The following presents long-term debt activities for the years ended December 31, 2018 and 2017:

	2018	2017
Douglas County, Nevada, Hospital Revenue and Refunding Bonds, Series 2013, collateralized by a pledge of the Organization's gross receipts (A)		
3.05% bonds, due in monthly installments of $60,771 including interest, through April 2025	$ 3,788,162	$ 4,330,105
5.0% bonds, due in varying monthly installments beginning May 2025 through April 2028	2,058,377	2,058,377
Unamortized debt issuance costs based upon effective interest rate of 6.62%	(142,723)	(158,153)
5.25% mortgage payable to bank, due in monthly installments of $26,066 including interest, through January 2028, secured by building	2,249,000	2,436,623
	7,952,816	8,666,952
Less current maturities	(756,596)	(729,597)
Long term debt, less current maturities	$ 7,196,220	$ 7,937,355

Long-term debt maturities are as follows:

Years Ending December 31,	Amount
2019	$ 756,596
2020	784,365
2021	813,853
2022	844,222
2023	875,814
Thereafter	4,020,689
Unamortized debt issuance costs	(142,723)
Total	$ 7,952,816

(A) Under the terms of the Revenue and Refunding Bonds, the Organization is required to maintain certain deposits with a trustee. Such deposits are included in assets limited as to use in the consolidated financial statements. The Revenue and Refunding Bonds also place limits on the incurrence of additional borrowings and requires the Organization to satisfy certain measures of financial performance as long as the bonds are outstanding.

Note 8 - Post-Retirement Benefits

The Organization has a 401(k)-retirement plan (Plan) for all benefit status employees. The Organization matches up to the first 3% of the employee contribution and one-half of the next 1% saved by the employee, for a maximum matching contribution of 3.5%. The Plan has a one year waiting period and then a vesting schedule of 5 years beginning with year two – 25%, year three – 50%, year four – 75%, and year five – 100%. Total retirement plan expense for the years ended December 31, 2018 and 2017 was $358,960 and $332,899.

Note 9 - Concentration of Credit Risk

The Organization grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2018 and 2017 was as follows:

	2018	2017
Medicare	46%	43%
Medicaid and other government	14%	24%
Commercial insurance	26%	27%
Self pay	11%	4%
Other third-party payors and patients	3%	2%
	100%	100%

Note 10 - Related-Party Transaction

Renown Health, a 50% member of the Organization, provides certain support services to the Organization including clinic physicians, information technology services, and human resources support. During the years ended December 31, 2018 and 2017, the Organization incurred expenses of $2,675,151 and $2,175,312 to Renown Health for these services. The Organization had accounts payable due to Renown Health of $567,269 and $214,190 at December 31, 2018 and 2017 which are included in accounts payable in the accompanying consolidated financial statements.

Barton Healthcare System, a 50% member of the Organization, provides certain support services to the Organization including information technology and purchasing. During the years ended December 31, 2018 and 2017, the Organization incurred expenses of $1,092,651 and $2,034,385 to Barton Healthcare System for these services. The Organization had accounts payable due to Barton Healthcare System of $41,577 and $59,131 at December 31, 2018 and 2017 which are included in accounts payable in the accompanying consolidated financial statements.

The Organization enrolls its employees in a managed care organization, Hometown Health Plan, which is owned by Renown Health. Annual premium expenses incurred to Hometown Health Plan were $3,825,024 and $3,180,071 for the years ended December 31, 2018 and 2017.

Note 11 - Functional Expenses

The Organization provides healthcare services to residents within its geographic location. Expenses related to providing these services by functional class for the year ended December 31, 2018 are as follows:

	Healthcare Services	General and Administrative	Fundraising	Total
Salaries	$ 16,932,215	$ 3,027,449	$ 56,725	$ 20,016,389
Contract labor	857,991	-	-	857,991
Employee benefits	4,496,918	886,685	13,908	5,397,511
Medical professional fees	8,017,037	135,816	-	8,152,853
Other professional fees	220,394	809,671	7,788	1,037,853
Supplies	10,844,229	63,880	4,169	10,912,278
Utilities	508,734	106,410	-	615,144
Other purchased services	2,005,349	693,987	89,174	2,788,510
Rent and lease	267,314	19,569	-	286,883
Insurance	339,662	254,437	-	594,099
Interest	282,984	44,930	-	327,914
Depreciation	2,720,188	51,030	-	2,771,218
Other operating costs	659,797	439,994	20,387	1,120,178
Loss on disposal of assets	-	6,303	-	6,303
	$ 48,152,812	$ 6,540,161	$ 192,151	$ 54,885,124

Expenses related to providing these services by functional class for the year ended December 31, 2017 are as follows:

	Healthcare Services	General and Administrative	Fundraising	Total
Salaries	$ 15,904,956	$ 2,788,430	$ 29,443	$ 18,722,829
Contract labor	914,082	-	-	914,082
Employee benefits	3,914,602	794,556	3,353	4,712,511
Medical professional fees	7,235,382	136,106	-	7,371,488
Other professional fees	163,164	312,371	8,223	483,758
Supplies	10,930,827	62,086	3,410	10,996,323
Utilities	543,361	76,211	-	619,572
Other purchased services	1,846,545	621,841	43,174	2,511,560
Rent and lease	492,949	35,509	-	528,458
Insurance	62,413	254,204	-	316,617
Interest	48,271	304,025	-	352,296
Depreciation	2,864,464	-	-	2,864,464
Other operating costs	701,626	370,062	14,492	1,086,180
	$ 45,622,642	$ 5,755,401	$ 102,095	$ 51,480,138

Note 12 - Workers' Compensation

The Organization maintains a workers' compensation policy with the Nevada Retail Network Self Insured Group (NRNSIG), a self-insured group for qualified organizations in the state of Nevada. Members are selected and admitted based on certain criteria including an assessment of financial health as well as geographic location. Premiums paid are established annually based on the experience of the pool and the Organization. The Organization paid premiums of $109,626 and $112,139 for the years ended December 31, 2018 and 2017. There were no accrued premiums at December 31, 2018 and 2017. The Organization's policy with NRNSIG may be terminated by the member at any time with advance notification and may be terminated by the self-insured group based on certain criteria of non-compliance as specified in the bylaws of NRNSIG. Management has determined that at December 31, 2018 and 2017, no liability was needed as there were no known significant outstanding claims.

Note 13 - Contingencies

Professional Liability

The Organization has professional liability coverage to provide protection for professional liability losses on a claims-made basis subject to a limit of $5 million per claim and an annual aggregate limit of $15 million with a $25,000 deductible per claim. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, would be uninsured. Management's estimate of the Organization's liability for expected losses from reported and unreported incidents is based on information obtained from the Organization's actuary and claims managers. The liability is shown as another noncurrent liability in the accompanying consolidated financial statements. The Organization recorded a liability of $455,234 and $167,573 as of the years ended December 31, 2018 and 2017.

Litigation, Claims, and Disputes

The Organization is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. Management assesses the ultimate settlement of any litigation, claims, and disputes in process in determining whether a liability should be recorded or a disclosure should be presented.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 14 - Change in Accounting Policy

As of January 1, 2018, the Organization adopted the provisions of Accounting Standards Update (ASU) 2016-14, *Presentation of Financial Statements for Not-For-Profit Entities*. The provisions of the ASU replace the existing three classes of net assets with two new classes (net assets without donor restrictions and net assets with donor restrictions). The ASU introduces new disclosure requirements to provide information about what is included or excluded from the Organization's intermediate measure of operations as well as disclosures to improve the consolidated financial statement user's ability to assess the Organization's liquidity and exposure to risk. The ASU also introduces new reporting requirements to present expenses by both function and natural classification in a single location and to present investment returns on the consolidated statements of operations net of external and direct internal investment expenses.

The Organization has adopted this standard as management believes the standard improves the usefulness and understandability of the Organization's financial reporting.

Note 15 - Subsequent Events

The Organization has entered into commitments in the amount of $2.6 million for the purchase of a CT scanner and reconstruction of the pharmacy. Both projects are anticipated to be completed in 2019 and will be financed by operating funds.

The Organization has evaluated subsequent events through May 31, 2019, the date which the consolidated financial statements are available to be issued.

Consolidated Financial Statements
December 31, 2019 and 2018

Washoe Barton Medical Clinic d/b/a Carson Valley Medical Center

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Carson Valley Medical Center
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Independent Auditor's Report

The Board of Directors
Washoe Barton Medical Clinic
d/b/a Carson Valley Medical Center
Gardnerville, Nevada

Report on the Consolidated Financial Statements
We have audited the accompanying consolidated financial statements of Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center (Medical Center), which comprise the consolidated balance sheets as of December 31, 2019 and 2018, and the related consolidated statements of operations, changes in net assets, and cash flows for the years then ended, and the related notes to the consolidated financial statements.

Management's Responsibility for the Consolidated Financial Statements
Management is responsible for the preparation and fair presentation of these consolidated 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 consolidated financial statements that are free from material misstatement, whether due to fraud or error.

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

An audit involves performing procedures to obtain audit evidence about the amounts and disclosures in the consolidated financial statements. The procedures selected depend on the auditor's judgment, including the assessment of the risks of material misstatement of the consolidated 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 consolidated 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 consolidated 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 consolidated financial statements referred to above present fairly, in all material respects, the financial position of Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center as of December 31, 2019 and 2018, and the results of their operations, changes in net assets, and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

Change in Accounting Principle
As discussed in Note 14 to the consolidated financial statements, the Medical Center has adopted the provisions of Financial Accounting Standards Board Accounting Standards Update No. 2016-18, *Statement of Cash Flows (Topic 230) Restricted Cash*. Accordingly, the December 31, 2018 statement of cash flows has been adjusted to adopt this standard. Our opinion is not modified with respect to this matter.

Eide Bailly LLP

Fargo, North Dakota
May 12, 2020

Carson Valley Medical Center
Consolidated Balance Sheets – Assets
December 31, 2019 and 2018

	2019	2018
Assets		
Current Assets		
Cash and cash equivalents	$ 15,185,377	$ 16,083,216
Receivables		
Patient	9,321,148	8,729,253
Estimated third-party payor settlements	1,406,000	499,000
Other	-	16,924
Supplies	1,704,310	1,531,019
Prepaid expenses and other	511,759	497,358
Total current assets	28,128,594	27,356,770
Assets Limited as to Use	1,291,773	1,270,508
Property and Equipment, Net	27,791,158	26,230,671
Other Assets		
Long-term investments	21,370,887	14,986,750
Land held for investment	187,000	187,000
Total other assets	21,557,887	15,173,750
Total assets	$ 78,769,412	$ 70,031,699

Carson Valley Medical Center
Consolidated Balance Sheets – Liabilities and Net Assets
December 31, 2019 and 2018

	2019	2018
Liabilities and Net Assets		
Current Liabilities		
Current maturities of long-term debt	$ 784,365	$ 756,596
Accounts payable		
Trade	2,831,729	2,399,429
Estimated third-party payor settlements	658,000	83,296
Other	19,171	-
Accrued expenses	1,923,638	1,916,234
Total current liabilities	6,216,903	5,155,555
Long-Term Liabilities		
Other long-term liabilities	458,879	455,234
Long-term debt, less current maturities and unamortized debt issuance costs of $127,294 in 2019 and $142,723 in 2018	6,437,421	7,196,220
Total liabilities	13,113,203	12,807,009
Net Assets		
Without donor restrictions	65,595,033	57,189,041
With donor restrictions	61,176	35,649
Total net assets	65,656,209	57,224,690
Total liabilities and net assets	$ 78,769,412	$ 70,031,699

Carson Valley Medical Center
Consolidated Statements of Operations
Years Ended December 31, 2019 and 2018

	2019	2018
Revenues, Gains, and Other Support Without Donor Restrictions		
Patient service revenue	$ 66,566,493	$ 58,023,451
Other income	841,757	734,998
Total revenues, gains, and other support	67,408,250	58,758,449
Expenses		
Salaries	21,840,122	20,016,389
Contract labor	1,025,767	857,991
Employee benefits	6,238,952	5,397,511
Medical professional fees	8,062,903	8,152,853
Other professional fees	1,329,509	1,037,853
Supplies	13,996,469	10,912,278
Utilities	559,097	615,144
Other purchased services	3,238,590	2,788,510
Rent and lease	231,560	286,883
Insurance	288,308	594,099
Interest	300,883	327,914
Depreciation	2,492,257	2,771,218
Other operating costs	1,196,615	1,120,178
Loss on disposal of assets	7,202	6,303
Total expenses	60,808,234	54,885,124
Operating Income	6,600,016	3,873,325
Other Income		
Rental income	268,744	214,769
Net investment income	1,490,352	229,829
Other nonoperating income	6,330	38,141
Other income, net	1,765,426	482,739
Revenues in Excess of Expenses	8,365,442	4,356,064
Change in Unrealized Gains and Losses on Investments	8,206	(9,100)
Net Assets Released from Restrictions	32,344	-
Transfer to Net Assets With Donor Restrictions	-	(19,252)
Change in Net Assets Without Donor Restrictions	$ 8,405,992	$ 4,327,712

See Notes to Consolidated Financial Statements

Carson Valley Medical Center
Consolidated Statements of Changes in Net Assets
Years Ended December 31, 2019 and 2018

	2019	2018
Net Assets Without Donor Restrictions		
Revenues in excess of expenses	$ 8,365,442	$ 4,356,064
Change in unrealized gains and losses on investments	8,206	(9,100)
Net assets released from restrictions	32,344	-
Transfer to net assets with donor restrictions	-	(19,252)
Change in net assets without donor restrictions	8,405,992	4,327,712
Net Assets With Donor Restrictions		
Contributions for specific purposes	57,871	16,397
Net assets released from restrictions	(32,344)	-
Transfer from net assets without donor restrictions	-	19,252
Change in net assets with donor restrictions	25,527	35,649
Change in Net Assets	8,431,519	4,363,361
Net Assets, Beginning of Year	57,224,690	52,861,329
Net Assets, End of Year	$ 65,656,209	$ 57,224,690

See Notes to Consolidated Financial Statements

Carson Valley Medical Center
Consolidated Statements of Cash Flows
Years Ended December 31, 2019 and 2018

	2019	2018 (Restated)
Operating Activities		
Change in net assets	$ 8,431,519	$ 4,363,361
Adjustments to reconcile change in net assets to net cash from operating activities		
Depreciation	2,492,257	2,771,218
Interest expense attributed to amortization of debt issuance costs	15,429	15,430
Net realized and unrealized gains and losses on investments	(487,479)	146,593
Loss on disposal of assets	7,202	6,303
Contributions restricted by donors	(57,871)	(16,397)
Changes in assets and liabilities		
Patient accounts receivable	(591,895)	(106,689)
Estimated third-party settlements	(332,296)	759,300
Other accounts receivable	16,924	26,079
Supplies	(173,291)	(212,257)
Prepaid expenses and other	(14,401)	(72,542)
Accounts payable	451,471	607,728
Accrued expenses	11,049	449,021
Deferred revenue	-	(133,889)
Net Cash From Operating Activities	9,768,618	8,603,259
Investing Activities		
Purchase of property and equipment	(4,059,946)	(5,398,643)
Purchases of investments	(23,269,159)	(18,123,940)
Proceeds from the sale of investments	17,372,501	17,741,411
Net Cash Used For Investing Activities	(9,956,604)	(5,781,172)
Financing Activities		
Principal payments on long-term debt	(746,459)	(729,566)
Contributions restricted by donors	57,871	16,397
Net Cash Used For Financing Activities	(688,588)	(713,169)
Net Change in Cash, Cash Equivalents, and Restricted Cash	(876,574)	2,108,918
Cash, Cash Equivalents and Restricted Cash, Beginning of Year	17,353,724	15,244,806
Cash, Cash Equivalents, and Restricted Cash, End of Year	$ 16,477,150	$ 17,353,724
Cash and Cash Equivalents	$ 15,185,377	$ 16,083,216
Assets Limited to Use Held by Trustee for Bond Indenture	1,291,773	1,270,508
Total cash, cash equivalent, and restricted cash	$ 16,477,150	$ 17,353,724
Supplemental Disclosure of Cash Flow Information		
Cash paid during the year for interest	$ 285,454	$ 312,484

See Notes to Consolidated Financial Statements

Note 1 - Organization and Significant Accounting Policies

Organization

Washoe Barton Medical Clinic, d/b/a Carson Valley Medical Center (Medical Center), a Nevada nonprofit corporation, is a 23-bed critical access hospital located in Gardnerville, Nevada. The Medical Center provides primarily inpatient, emergency, surgery, physical therapy, and various other outpatient services to the local residents of the Carson Valley area. The Medical Center also provides medical office space to local medical professionals.

Carson Valley Medical Center Foundation (Foundation), a Nevada nonprofit corporation, was formed in 2008 to expand community awareness of the Medical Center and to raise and manage donor funds for programs, activities, and capital construction. As the Medical Center has control over the Foundation, the Foundation is included as a consolidated entity. The Medical Center currently funds operating expenses of the Foundation.

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of the Medical Center and the Foundation (collectively referred to as the "Organization"). All material intercompany accounts and transactions have been eliminated in consolidation.

Income Taxes

The Medical Center and Foundation are organized as Nevada nonprofit corporations and have been recognized by the Internal Revenue Service (IRS) as exempt from federal income taxes under Internal Revenue Code Section 501(c)(3). The Medical Center and Foundation are annually required to file a Return of Organization Exempt from Income Tax (Form 990) with the IRS. In addition, the Medical Center and Foundation are subject to income tax on net income that is derived from business activities that are unrelated to their exempt purpose. The Organization has determined it is not subject to unrelated business income tax and has not filed an Exempt Organization Business Income Tax Return (Form 990T) with the IRS.

The Organization believes that it has appropriate support for any tax positions taken affecting its annual filing requirements, and as such, does not have any uncertain tax positions that are material to the consolidated financial statements. The Organization would recognize future accrued interest and penalties related to unrecognized tax benefits and liabilities in income tax expense if such interest and penalties are incurred.

Use of Estimates

The preparation of consolidated financial statements in conformity with generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements. Estimates also affect the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

Cash and Cash Equivalents

Cash and cash equivalents include highly liquid investments with an original maturity of three months or less, excluding assets limited as to use. For purposes of the consolidated statement of cash flows, the Organization considers all cash with an original maturity of three months or less as cash and cash equivalents.

Patient Receivables

Patient receivables are uncollateralized patient and third-party payor obligations. The Organization does not have a policy to charge interest on past due accounts. Payments of patient receivables are allocated to the specific claims identified in the remittance advice or, if unspecified, are applied to the earliest unpaid claim.

Patient accounts receivable are reduced by an allowance for doubtful accounts. In evaluating the collectability of accounts receivable, the Organization 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.

Investments in Debt Securities

Debt securities are carried at fair market value, with unrealized gains and losses being excluded from the performance indicator.

Investments in Equity Securities

Investments in equity securities with readily determinable fair values are measured at fair value in the balance sheets. Investment income or loss (including realized and unrealized gains and losses on investments, interest, and dividends) is included in the performance indicator. Investments in equity securities without readily determinable fair values are measured at cost minus impairment (if any) and adjusted for any observable price changes in orderly transactions of identical securities or similar securities of the same issuer. Investments in equity securities without readily determinable fair values are considered annually for indicators of impairment. There were no impairments for the year ended December 31, 2019.

Supplies

Supplies are stated at lower of cost (first-in, first-out) or net realizable value

Assets Limited as to Use

Assets limited as to use include assets held by a trustee under the bond indenture agreement. Amounts required to meet current liabilities of the Organization have been classified as current assets.

Property and Equipment

Property and equipment acquisitions in excess of $5,000 are capitalized and recorded at cost. Depreciation is provided over the estimated useful life of each depreciable asset and is computed using the straight-line method. The estimated useful lives of property and equipment are as follows:

Building	30 years
Equipment	3-15 years
Leasehold improvements	10 years
Electronic medical records system	7 years

Gifts of long-lived assets such as land, buildings, or equipment are reported as additions to net assets without donor restrictions, and are excluded from the performance indicator, unless explicit donor stipulations specify how the donated assets must be used. Gifts of long-lived assets with explicit restrictions that specify how the assets are to be used and gifts of cash or other assets that must be used to acquire long-lived assets are reported as net assets with donor restrictions. Absent explicit donor stipulations about how long those long-lived assets must be maintained, expirations of donor restrictions are reported when donated or when acquired long-lived assets are placed in service.

Land Held for Investment

The asset is a vacant parcel of land that the Organization is holding for potential development. This land held for investment was originally recorded at $187,000 in 2016.

Impairment of Long-Lived Assets

The Organization considers whether indicators of impairment are present and performs the necessary analysis to determine if the carrying values of assets are appropriate. No impairment was identified for the years ended December 31, 2019 and 2018.

Debt Issuance Costs

Debt issuance costs are amortized over the life of the related debt using the straight-line method, which approximates the effective interest method. Debt issuance costs are included within long-term debt on the consolidated balance sheets. Amortization of debt issuance costs is included in interest expense in the accompanying consolidated statements of operations.

Net Assets with Donor Restrictions

Net assets, revenues, gains, and losses are classified based on the existence or absence of donor-imposed restrictions. Some donor-imposed restrictions are temporary in nature, such as those that will be met by the passage of time or other events specified by the donor. Other donor-imposed restrictions are perpetual in nature, where the donor stipulates that resources be maintained in perpetuity. Donor-imposed restrictions are released when a restriction expires, that is, when the stipulated time has elapsed, when the stipulated purpose for which the resource was restricted has been fulfilled, or both.

At December 31, 2019 and 2018, the Organization has net assets with donor restrictions of $61,176 and $35,649 to be used for capital purchases and specific purposes.

Patient Service Revenue

Patient service revenue is reported at the amount that reflects the consideration to which the Organization expects to be entitled in exchange for providing patient care. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and includes variable consideration for retroactive revenue adjustments due to settlement of audits, reviews and investigations. Generally, the Organization bills the patients and third-party payors several days after the services are performed and/or the patient is discharged from the facilities. Revenue is recognized as performance obligations are satisfied.

Performance obligations are determined based on the nature of the services provided by the Organization. Revenue for performance obligations satisfied over time is recognized based on actual charges incurred in relation to total expected (or actual) charges. The Organization believes that this method provides a faithful depiction of the transfer of services over the term of the performance obligation based on the inputs needed to satisfy the obligation. Generally, performance obligations satisfied over time relate to patients in our Organization receiving inpatient acute services, outpatient, or clinic services. The Organization measures the performance obligation (associated with inpatient acute services) from admission into the Organization to the point when it is no longer required to provide services to that patient, which is generally at the time of discharge. Revenue for performance obligations satisfied at a point in time is recognized when goods or services are provided, and the Organization does not believe it is required to provide additional goods or services to the patient.

The Organization determines the transaction price based on standard charges for goods and services provided, reduced by contractual adjustments provided to third-party payors, discounts provided to uninsured patients in accordance with the Organization's policy, and/or implicit price concessions provided to uninsured patients. The Organization determines its estimates of contractual adjustments and discounts based on contractual agreements, its discount policies and historical experience. The Organization determines its estimate of implicit price concessions based on its historical collection experience with this class of patients.

Settlements with third-party payors for retroactive adjustments due to audits, reviews or investigations are considered variable consideration and are included in the determination of the estimated transaction price for providing patient care. These settlements are estimated based on the terms of the payment agreement with the payor, correspondence from the payor and the Organization's historical settlement activity, including an assessment to ensure that it is probable that a significant reversal in the amount of cumulative revenue recognized will not occur when the uncertainty associated with the retroactive adjustment is subsequently resolved. Estimated settlements are adjusted in future periods as adjustments become known (that is, new information becomes available), or as years are settled or are no longer subject to such audits, reviews and investigations.

Consistent with the Organization's mission, care is provided to patients regardless of their ability to pay. Therefore, the Organization has determined it has provided implicit price concessions to uninsured patients and patients with other uninsured balances (for example, copays and deductibles). The implicit price concessions included in estimating the transaction price represent the difference between amounts billed to patients and the amounts the Organization expects to collect based on its collection history with those patients.

The Organization provides health care services to patients who meet certain criteria under its charity care policy without charge or at amounts less than established rates. Since the Organization does not pursue collection of these amounts, they are not reported as patient service revenue. The estimated cost of providing these services was $622,000 and $693,000 for the years ended December 31, 2019 and 2018, calculated by multiplying the ratio of cost to gross charges for the Organization by the gross uncompensated charges associated with providing charity care to its patients.

Performance Indicator

Revenues in excess of expenses is the performance indicator and excludes contributions of long-lived assets, which include assets acquired using contributions which were restricted by donors.

Donor-Restricted Gifts

The Organization reports contributions restricted by donors as increases in net assets without donor restrictions if the restrictions expire (that is, when a stipulated time restriction ends, or purpose restriction is accomplished) in the reporting period in which the revenue is recognized. All other donor-restricted contributions are reported as increases in net assets with donor restrictions, depending on the nature of the restrictions. When a restriction expires, net assets with donor restrictions are reclassified to net assets without donor restrictions and reported in the consolidated statements of changes in net assets as net assets released from restrictions.

Contributions are recognized when cash, securities or other assets, an unconditional promise to give, or notification of a beneficial interest is received. Conditional promises to give are not recognized until the conditions on which they depend have been substantially met.

Financial Instruments and Credit Risk

Deposit concentration risk is managed by placing cash, money market accounts and investments with financial institutions believed to be creditworthy. At times, amounts on deposit may exceed insured limits or include uninsured investments in money market mutual funds. To date, the Organization has not experienced losses in any of these accounts. Although the fair values of investments are subject to fluctuation on a year-to-year basis, management believes that the investment policies and guidelines are prudent for the long-term welfare of the Organization.

Functional Allocation of Expenses

The costs of program and supporting services activities have been summarized on a functional basis in Note 11, which presents the natural classification detail of expenses by function. Accordingly, certain costs have been allocated among the programs and supporting services benefited.

The consolidated financial statements report certain categories of expenses that are attributed to more than one program or supporting function. Therefore, expenses require allocation on a reasonable basis that is consistently applied. Costs not directly attributable to a function, such as interest and depreciation, are allocated to a function based on a square-footage.

New Accounting Pronouncements

In May 2014, the FASB issued Accounting Standards Update No. 2014-09 (ASU 2014-09), *Revenues from Contracts with Customers (Topic 606).* The guidance provides a principles-based approach for determining revenue recognition and supersedes all existing guidance, such as current transaction and industry-specific revenue recognition guidance. The core principle of ASU 2014-09 is that an entity will recognize revenue to depict the transfer of goods or services to customers in amounts that reflect the consideration (payment) to which the entity expects to be entitled in exchange for those goods or services. ASU 2014-09 identifies a five-step process in order to recognize revenue. In addition, there is also more comprehensive guidance for transactions such as service revenue, contract modifications and multiple-element arrangements.

The Organization has applied the guidance retrospectively to the prior reporting period. The Organization has elected to apply certain allowable practical expedients when applying the guidance. For completed contracts, the Organization did not restate contracts that began and ended within the same annual reporting period. For completed contracts that have variable consideration, the Organization used the transaction price at the date the contract was completed rather than estimating variable consideration amounts in the comparative reporting period. For the prior year presented, the Organization will not disclose the amount of the transaction price allocated to the remaining performance obligations and an explanation of when the Organization expects to recognize that amount as revenue. The Organization has applied the above practical expedients consistently to all contracts within all reporting periods presented. The Organization does not believe the effect of applying these expedients has a material impact on the amounts presented or disclosed.

The adoption of the new standard resulted in changes to the presentation and disclosure of revenue related to uninsured and underinsured patients. Prior to the adoption of ASU 2014-09, the Organization presented a separate provision for bad debts related to 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). Under ASU 2014-09, the estimated uncollectible amounts due from these patients are generally considered a direct reduction to patient service revenue and resulted in a material reduction in the amounts previously presented as provision for bad debts. As such, the 2018 provision for bad debts of $3,112,928 has been reclassified and presented as a reduction to patient service revenue in the current presentation. The adoption of the new standard did not have an impact on recognition of total operating revenues for any period and there was no cumulative effect of a change in accounting principle recorded, but did result in expanded footnote disclosures.

As of January 1, 2019, the Organization adopted the provisions of Accounting Standards Update 2016-01 (ASU 2016-01), *Financial Instruments—Overall (Subtopic 825-10): Recognition and Measurement of Financial Assets and Financial Liabilities*. This update affects current U.S. generally accepted accounting principles primarily as it relates to the accounting for equity investments, financial liabilities under the fair value option, and the presentation and disclosure requirements for financial instruments. ASU 2016-01 also supersedes the guidance that requires (1) classification of equity securities with readily determinable fair values into different categories (i.e., trading or available-for-sale), and (2) recognition of changes in fair value of available-for-sale securities as a component of net assets without donor restrictions.

As of January 1, 2019, the Organization adopted the provisions of Accounting Standards Update 2016-18 (ASU 2016-18), *Statement of Cash Flows (Topic 230) Restricted Cash*. This update requires that a statement of cash flows explain the change during the period in the total of cash, cash equivalents, and amounts generally described as restricted cash or restricted cash equivalents, by including amounts generally described as restricted cash and restricted cash equivalents with cash and cash equivalents when reconciling the beginning-of-period and end-of-period total amounts shown on the statement of cash flows. Retrospective application of this amendment is required.

The Organization has adopted these standards as management believes the standards improve the usefulness and understandability of the Organization's financial reporting.

Reclassification

Certain reclassifications of amounts previously reported have been made to the accompanying consolidated financial statements to maintain consistency between periods presented. The reclassification had not impact on previously reported net assets.

Note 2 - Liquidity and Availability

Financial assets available for general expenditure, that is, without donor or other restrictions limiting their use, within one year of the consolidated balance sheet date, comprise the following:

	2019	2018
Operating cash and equivalents	$ 15,185,377	$ 16,083,216
Receivables		
Patient	9,321,148	8,729,253
Estimated third-party payor settlements	1,406,000	499,000
Other	-	16,924
Assets limited as to use	1,291,773	1,270,508
Long-term investments	21,370,887	14,986,750
	48,575,185	41,585,651
Less amounts not available to be used within one year		
Net assets with donor restrictions	(61,176)	(35,649)
Other assets limited as to use	(1,291,773)	(1,270,508)
	(1,352,949)	(1,306,157)
Financial assets available for general expenditure	$ 47,222,236	$ 40,279,494

Assets limited as to use include assets held by a trustee under the bond indenture agreement and are not available for general expenditure within the next year. Net assets with donor restrictions are restricted for capital purchases and specific programs and may be used if restrictions are met.

As part of a liquidity management plan, cash in excess of daily requirements is invested in investments.

Note 3 - Net Patient Service Revenue

The Organization has agreements with third-party payors that provide for payments to the Organization at amounts different from its established rates. A summary of the payment arrangements with major third-party payors follows:

Medicare. The Organization is licensed as a Critical Access Hospital (CAH). The Organization is reimbursed for most inpatient and outpatient services under a cost reimbursement methodology less sequestration, with final settlement determined after submission of annual cost reports by the Organization subject to audits thereof by the Medicare Administrative Contractor (MAC). The Organization's Medicare cost reports have been audited by the MAC through the year ended December 31, 2016. Clinical services are paid on a cost basis or fixed fee schedule.

Medicaid. Inpatient services rendered to Medicaid program beneficiaries are reimbursed under a contract at retrospectively determined cost-based rates. Outpatient services are reimbursed based upon prospectively determined rates. The Organization's Medicaid cost reports have been audited by the Medicaid fiscal intermediary through the year ended December 31, 2017.

The Organization has also entered into payment agreements with certain commercial insurance carriers and other organizations. The basis for payment to the Organization under these agreements includes prospectively determined rates per discharge, discounts from established charges, and prospectively determined daily rates.

A summary of percentages of revenues by payor for the years ended December 31, 2019 and 2018 is as follows:

	2019	2018
Medicare	61%	61%
Medicaid	10%	10%
Commercial	27%	26%
Other	2%	3%
	100%	100%

Laws and regulations governing the Medicare, Medicaid, and other programs are extremely complex and subject to interpretation. In addition, the ability to estimate the collectability of uninsured and other self-pay patients is contingent on the patient's ability or willingness to pay for the services provided. As a result, there is at least a reasonable possibility that recorded estimates will change by a material amount in the near term. The net patient service revenue for the years ended December 31, 2019 and 2018 decreased approximately $222,000 and $196,000 due to changes in previous estimates as a result of final settlements and years that are no longer likely subject to audits, reviews, and investigations and changes in estimated settlements.

Generally, patients who are covered by third-party payors are responsible for related deductibles and coinsurance, which vary in amount. The Organization also provides services to uninsured patients, and offers those uninsured patients a discount, either by policy or law, from standard charges. The Organization estimates the transaction price for patients with deductibles and coinsurance and from those who are uninsured based on historical experience and current market conditions. The initial estimate of the transaction price is determined by reducing the standard charge by any contractual adjustments, discounts and implicit price concessions based on historical collection experience. Subsequent changes to the estimate of the transaction price are generally recorded as adjustments to patient service revenue in the period of the change. The ability to estimate the collectability of uninsured and other self-pay patients is contingent on the patient's ability or willingness to pay for the services provided. Subsequent changes that are determined to be the result of an adverse change in the patient's ability to pay are recorded as bad debt expense. Bad debt expense for the years ended December 31, 2019 and 2018 was not significant.

The nature, amount, timing and uncertainty of revenue and cash flows are affected by several factors that the Hospital considers in its recognition of revenue. Following are some of the factors considered:

- Payors (for example, Medicare, Medicaid, managed care or other insurance, patient) have different reimbursement/payment methodologies
- Length of the patient's service/episode of care
- Geography of the service location
- Organization's line of businesses that provided the service (for example, hospital, physician services, etc.)

Substantially all of the Organization's net patient service revenue is recognized over time.

Note 4 - Property and Equipment

Property and equipment consisted of the following at December 31, 2019 and 2018:

	2019		2018	
	Cost	Accumulated Depreciation	Cost	Accumulated Depreciation
Land and improvements	$ 4,386,632	$ 875,850	$ 4,297,353	$ 603,439
Buildings and fixed equipment	37,331,237	17,022,975	34,933,876	15,911,315
Major movable equipment	13,213,832	9,412,185	13,656,339	10,202,538
Construction in progress	170,467	-	60,395	-
	$ 55,102,168	$ 27,311,010	$ 52,947,963	$ 26,717,292
Net property and equipment		$ 27,791,158		$ 26,230,671

Construction in progress at December 31, 2019 represents various space improvements, vehicle purchases, and upgrades to information and communication technology systems. All projects are anticipated to be completed by May 2020, with costs to complete estimated at $515,000. All projects will be financed by operating funds.

Note 5 - Fair Value Measurement

The Organization reports certain assets and liabilities at fair value in the consolidated financial statements. Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction in the principal; or most advantageous, market at the measurement date under current market conditions regardless of whether that price is directly observable or estimated using another valuation technique. Inputs used to determine fair value refer broadly to the assumptions that market participants would use in pricing the asset or liability, including assumptions about risk. Inputs may be observable or unobservable. Observable inputs are inputs that reflect the assumptions market participants would use in pricing the asset or liability based on market data obtained from sources independent of the reporting entity. Unobservable inputs are inputs that reflect the reporting entity's own assumptions about the assumptions market participants would use in pricing the asset or liability based on the best information available. A three-tier hierarchy categorizes the inputs as follows:

Level 1 – Quoted prices (unadjusted) in active markets for identical assets or liabilities that can be accessed at the measurement date.

Level 2 – Inputs other than quoted prices included within Level 1 that are observable for the asset or liability, either directly or indirectly. These include quoted prices for similar assets or liabilities in active markets, quoted prices for identical or similar assets or liabilities in markets that are not active, inputs other than quoted pries that are observable for the asset or liability, and market-corroborated inputs.

Level 3 – Unobservable inputs for the asset or liability. In these situations, inputs are developed using the best information available in the circumstances.

In some cases, the inputs used to measure the fair value of an asset or a liability might be categorized within different levels of the fair value hierarchy. In those cases, the fair value measurement is categorized in its entirety in the same level of the fair value hierarchy as the lowest level input that is significant to the entire measurement. Assessing the significance of a particular input to the entire measurement requires judgment, taking into account factors specific to the asset or liability. The categorization of an asset within the hierarchy is based upon the pricing transparency of the asset and does not necessarily correspond to an assessment of the quality, risk or liquidity profile of the asset or liability.

The fair values for government bonds, corporate bonds, and foreign bonds are determined using a variety of techniques including quoted market prices of similar items, broker/dealer quotes, or models using interest rates or yield curves and are included in level two investments.

The following table presents assets measured at fair value on a recurring basis, except those measured at cost and net asset value (NAV) per share (or its equivalent, such as member units or an ownership interest in partners' capital), at December 31, 2019:

		Fair Value Measurements at December 31, 2019		
Assets	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-Term Investments				
Mutual funds	$ 12,201,591	$ 12,201,591	$ -	$ -
Government bonds	3,697,284	-	3,697,284	-
Corporate bonds				
Financial institutions	368,981	-	368,981	-
Pharmaceuticals	74,092	-	74,092	-
Consumer goods	467,616	-	467,616	-
Food and beverage	20,585	-	20,585	-
Natural resources	123,484	-	123,484	-
Asset and mortgage backed	2,901,399		2,901,399	
Certificates of deposit	304,359	-	304,359	-
Foreign corporation bonds	428,680	-	428,680	-
	20,588,071	$ 12,201,591	$ 8,386,480	$ -
International Equity Funds (at NAV)	747,335			
Money market funds (at cost)	35,481			
	$ 21,370,887			

The International Equity Fund is reported at fair value as reported by the fund manager based on discounted cash flows, estimated market values, and other unobservable inputs. The International Equity Fund reports fair value using a calculated NAV. There are no redemption limitations, except as noted below, or unfunded commitments at December 31, 2019.

Name of Fund	Redemption	Redemption	Redemption Availability
International Equity Fund	First Business Day	15th of the Month	Available within 10 business days.

The following table presents assets measured at fair value on a recurring basis, except those measured at cost, at December 31, 2018:

		Fair Value Measurements at December 31, 2018		
Assets	Total	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Long-Term Investments				
Government bonds	$ 4,714,512	$ -	$ 4,714,512	$ -
Corporate bonds				
Commercial	198,910	-	198,910	-
Financial institutions	1,943,552	-	1,943,552	-
Pharmaceuticals	166,229	-	166,229	-
Consumer goods	615,850	-	615,850	-
Food and beverage	166,380	-	166,380	-
Natural resources	136,831	-	136,831	-
Asset and mortgage backed	4,444,342		4,444,342	
Certificates of deposit	1,879,258	-	1,879,258	-
Foreign corporation bonds	688,091	-	688,091	-
	14,953,955	$ -	14,953,955	$ -
Money market funds (at cost)	32,795			
	$ 14,986,750			

Note 6 - Leases

The Organization leases various equipment and facilities under noncancelable long-term lease agreements. Total lease expense for the years ended December 31, 2019 and 2018 for all operating leases was $179,634 and $286,883. The Organization does not have any future lease obligations at December 31, 2019 and 2018.

The Organization leases building space to various lessees under long-term leases. Rental income totaled $268,744 and $214,769 for the years ended December 31, 2019 and 2018.

Future minimum lease payments receivable on the leases are as follows:

Years Ending December 31,	Amount
2020	$ 268,555
2021	233,856
2022	225,240
2023	186,291
2024	155,489
Total minimum payments receivable	$ 1,069,431

Note 7 - Long-Term Debt

The following presents long-term debt balances at December 31, 2019 and 2018:

	2019	2018
Douglas County, Nevada, Hospital Revenue and Refunding Bonds, Series 2013, collateralized by a pledge of the Organization's gross receipts (A)		
3.05% bonds, due in monthly installments of $60,771 including interest, through April 2025	$ 3,229,456	$ 3,788,162
5.0% bonds, due in varying monthly installments beginning May 2025 through April 2028	2,058,377	2,058,377
Unamortized debt issuance costs based upon effective interest rate of 3.41%	(127,294)	(142,723)
5.25% mortgage payable to bank, due in monthly installments of $26,066 including interest, through January 2028, secured by building	2,061,247	2,249,000
	7,221,786	7,952,816
Less current maturities	(784,365)	(756,596)
Long term debt, less current maturities	$ 6,437,421	$ 7,196,220

Long-term debt maturities are as follows:

Years Ending December 31,	Amount
2020	$ 784,365
2021	813,853
2022	844,222
2023	875,814
2024	908,515
Thereafter	3,122,311
Unamortized debt issuance costs	(127,294)
Total	$ 7,221,786

(A) Under the terms of the Revenue and Refunding Bonds, the Organization is required to maintain certain deposits with a trustee. Such deposits are included in assets limited as to use in the consolidated financial statements. The Revenue and Refunding Bonds also place limits on the incurrence of additional borrowings and requires the Organization to satisfy certain measures of financial performance as long as the bonds are outstanding.

Note 8 - Post-Retirement Benefits

The Organization has a 401(k)-retirement plan (Plan) for all benefit status employees. The Organization matches up to the first 3% of the employee contribution and one-half of the next 1% saved by the employee, for a maximum matching contribution of 3.5%. The Plan has a one year waiting period and then a vesting schedule of 5 years beginning with year two – 25%, year three – 50%, year four – 75%, and year five – 100%. Total retirement plan expense for the years ended December 31, 2019 and 2018 was $403,949 and $358,960.

Note 9 - Concentration of Credit Risk

The Organization grants credit without collateral to its patients, most of whom are insured under third-party payor agreements. The mix of receivables from third-party payors and patients at December 31, 2019 and 2018 was as follows:

	2019	2018
Medicare	43%	46%
Medicaid and other government	17%	14%
Commercial insurance	27%	26%
Self pay	10%	11%
Other third-party payors and patients	3%	3%
	100%	100%

Note 10 - Related-Party Transaction

Renown Health, a 50% member of the Organization, provides certain support services to the Organization including clinic physicians, information technology services, and human resources support. During the years ended December 31, 2019 and 2018, the Organization incurred expenses of $2,009,955 and $2,675,151 to Renown Health for these services. The Organization had accounts payable due to Renown Health of $616,638 and $567,269 at December 31, 2019 and 2018 which are included in accounts payable in the accompanying consolidated financial statements.

Barton Healthcare System, a 50% member of the Organization, provides certain support services to the Organization including information technology and purchasing. During the years ended December 31, 2019 and 2018, the Organization incurred expenses of $958,222 and $1,092,651 to Barton Healthcare System for these services. The Organization had accounts payable due to Barton Healthcare System of $44,082 and $41,577 at December 31, 2019 and 2018 which are included in accounts payable in the accompanying consolidated financial statements.

The Organization enrolls its employees in a managed care organization, Hometown Health Plan, which is owned by Renown Health. Annual premium expenses incurred to Hometown Health Plan were $4,418,049 and $3,825,024 for the years ended December 31, 2019 and 2018.

Note 11 - Functional Expenses

The Organization provides healthcare services to patients within its geographic location. Expenses related to providing these services by functional class for the year ended December 31, 2019 are as follows:

	Healthcare Services	General and Administrative	Fundraising	Total
Salaries	$ 18,008,587	$ 3,759,269	$ 72,266	$ 21,840,122
Contract labor	1,025,767	-	-	1,025,767
Employee benefits	5,080,909	1,152,184	5,859	6,238,952
Medical professional fees	7,930,456	132,447	-	8,062,903
Other professional fees	460,448	864,376	4,685	1,329,509
Supplies	13,950,229	39,329	6,911	13,996,469
Utilities	417,195	141,171	731	559,097
Other purchased services	2,262,953	837,695	137,942	3,238,590
Rent and lease	203,000	28,560	-	231,560
Insurance	27,821	260,487	-	288,308
Interest	259,656	41,227	-	300,883
Depreciation	2,409,443	82,814	-	2,492,257
Other operating costs	713,587	443,149	39,879	1,196,615
Loss on disposal of assets	-	7,202	-	7,202
	$ 52,750,051	$ 7,789,910	$ 268,273	$ 60,808,234

Expenses related to providing these services by functional class for the year ended December 31, 2018 are as follows:

	Healthcare Services	General and Administrative	Fundraising	Total
Salaries	$ 16,932,215	$ 3,027,449	$ 56,725	$ 20,016,389
Contract labor	857,991	-	-	857,991
Employee benefits	4,496,918	886,685	13,908	5,397,511
Medical professional fees	8,017,037	135,816	-	8,152,853
Other professional fees	220,394	809,671	7,788	1,037,853
Supplies	10,844,229	63,880	4,169	10,912,278
Utilities	508,734	106,410	-	615,144
Other purchased services	2,005,349	693,987	89,174	2,788,510
Rent and lease	267,314	19,569	-	286,883
Insurance	339,662	254,437	-	594,099
Interest	282,984	44,930	-	327,914
Depreciation	2,720,188	51,030	-	2,771,218
Other operating costs	659,797	439,994	20,387	1,120,178
Loss on disposal of assets	-	6,303	-	6,303
	$ 48,152,812	$ 6,540,161	$ 192,151	$ 54,885,124

Note 12 - Workers' Compensation

The Organization maintains a workers' compensation policy with the Nevada Retail Network Self Insured Group (NRNSIG), a self-insured group for qualified organizations in the state of Nevada. Members are selected and admitted based on certain criteria including an assessment of financial health as well as geographic location. Premiums paid are established annually based on the experience of the pool and the Organization. The Organization paid premiums of $127,338 and $109,626 for the years ended December 31, 2019 and 2018. There were no accrued premiums at December 31, 2019 and 2018. The Organization's policy with NRNSIG may be terminated by the member at any time with advance notification and may be terminated by the self-insured group based on certain criteria of non-compliance as specified in the bylaws of NRNSIG. Management has determined that at December 31, 2019 and 2018, no liability was needed as there were no known significant outstanding claims.

Note 13 - Contingencies

Professional Liability

The Organization has professional liability coverage to provide protection for professional liability losses on a claims-made basis subject to a limit of $5 million per claim and an annual aggregate limit of $15 million with a $25,000 deductible per claim. Should the claims-made policy not be renewed or replaced with equivalent insurance, claims based on occurrences during its term, but reported subsequently, would be uninsured. Management's estimate of the Organization's liability for expected losses from reported and unreported incidents is based on information obtained from the Organization's actuary and claims managers. The liability is shown as other noncurrent liabilities in the accompanying consolidated financial statements. The Organization recorded a liability of $458,879 and $455,234 as of December 31, 2019 and 2018.

Litigation, Claims, and Disputes

The Organization is subject to the usual contingencies in the normal course of operations relating to the performance of its tasks under its various programs. Management assesses the ultimate settlement of any litigation, claims, and disputes in process in determining whether a liability should be recorded, or a disclosure should be presented.

The healthcare industry is subject to numerous laws and regulations of federal, state, and local governments. Compliance with these laws and regulations, specifically those relating to the Medicare and Medicaid programs, can be subject to government review and interpretation, as well as regulatory actions unknown and unasserted at this time. Federal government activity has increased with respect to investigations and allegations concerning possible violations by healthcare providers of regulations, which could result in the imposition of significant fines and penalties, as well as significant repayments of previously billed and collected revenues from patient services.

Note 14 - Adjustment Resulting from Change in Accounting Policy

As disclosed in Note 1, the Organization adopted the provisions of ASU 2016-18, *Statement of Cash Flows (Topic 230) Restricted Cash* as of January 1, 2019. Following is a summary of the effects of the change in accounting principle in the Organization's December 31, 2018 statement of cash flows:

	As Previously Reported	Change in Accounting Principle	As Adjusted
Investing Activities			
Increase in assets limited as to use	$ (6,179)	$ 6,179	$ -
Net cash used for investing activities	(5,787,351)	6,179	(5,781,172)
Net Change in Cash, Cash Equivalents, and Restricted Cash	2,102,739	6,179	2,108,918
Cash, Cash Equivalents, and Restricted Cash, Beginning of Year	13,980,477	1,264,329	15,244,806
Cash, Cash Equivalents, and Restricted Cash, End of Year	16,083,216	1,270,508	17,353,724

Note 15 - Subsequent Events

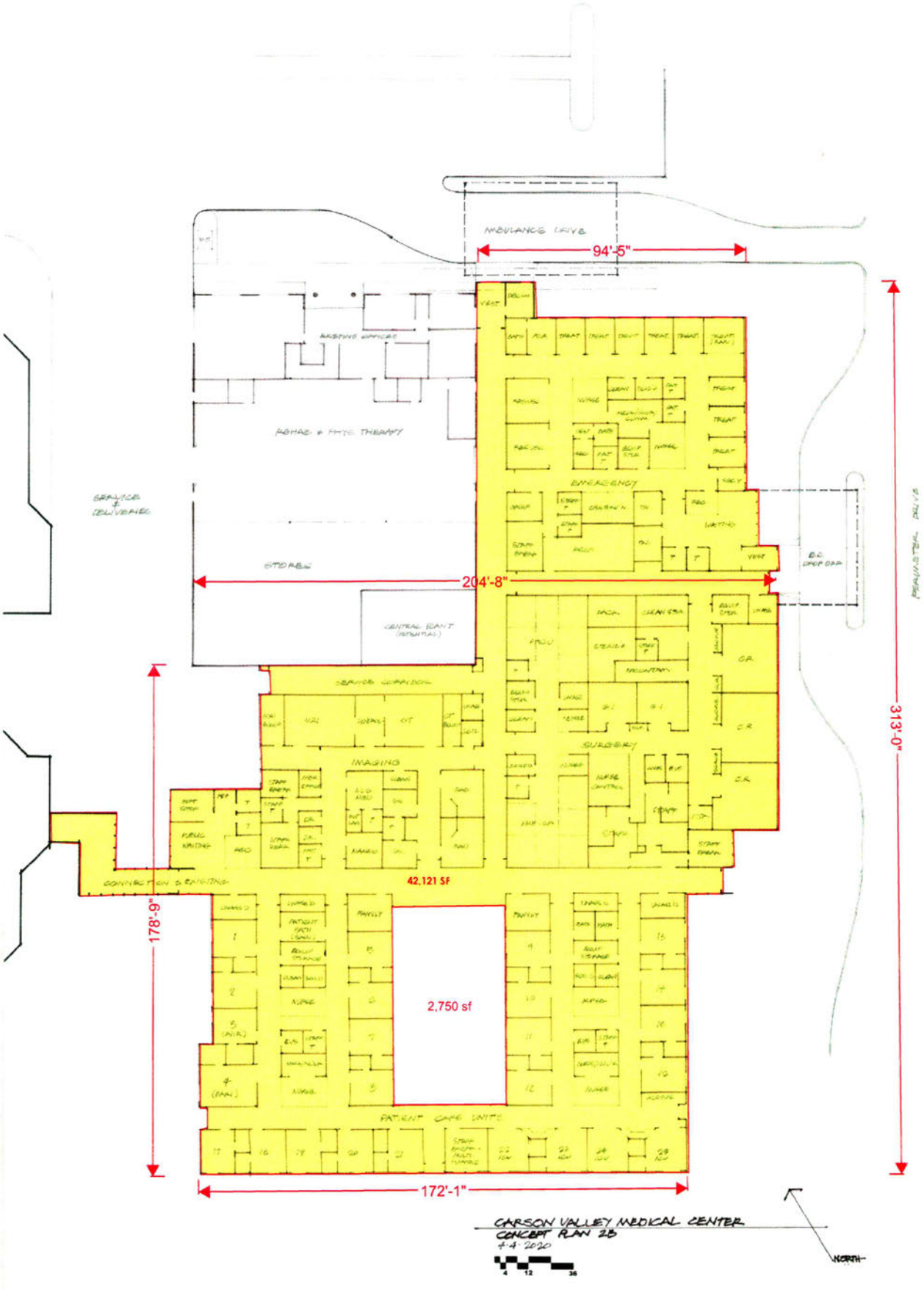
Subsequent to year-end, the Organization has been impacted by the effects of the world-wide coronavirus pandemic. The Organization is closely monitoring its operations, liquidity, and capital resources and is actively working to minimize the current and future impact of this unprecedented situation. As of the date of issuance of these financial statements, the full impact of the Organization's financial position is not known.

The Organization applied for and was granted a $5.2 million loan under the Paycheck Protection Program administered by a Small Business Administration approved partner. The loan was received after year-end and is uncollateralized and fully guaranteed by the Federal government. The loan accrues interest, but payments are not required to begin for six months to one year after the funding of the loan. The Organization is eligible for loan forgiveness of up to 100% of the loan upon meeting certain requirements. The Organization intends to take measures to maximize the loan forgiveness but cannot reasonably determine at this time the portion of the loan, if any, that will ultimately be forgiven.

During April and May 2020, the Organization received two payments totaling approximately $5.4 million from the Department of Health and Human Services (HHS) as part of the CARES Act Provider Relief Fund to support healthcare relates expenses or lost revenue attributable to COVID-19. These funds are subject so specific HHS terms and conditions.

The Organization has evaluated subsequent events through May 12, 2020, the date which the consolidated financial statements are available to be issued.

Appendix I: Scale Drawings


AMBULANCE DRIVE
94'-5"
EXISTING OFFICES
REHAB & PHYS THERAPY
SERVICE & DELIVERIES
EMERGENCY
204'-8"
CENTRAL PLANT (POTENTIAL)
SURGERY
IMAGING
42,121 SF
2,750 sf
313'-0"
178'-9"
172'-1"
PATIENT CARE UNITS
CARSON VALLEY MEDICAL CENTER
CONCEPT PLAN 2B
4.4.2020
NORTH

DLR Group

Appendix J: Risk Model

Section marked as confidential/proprietary

Section marked as confidential/proprietary