Pajaro Valley Health Care District

Service and Sphere of Influence Review

Adopted Version (November 5, 2025)

Local Agency Formation Commission of Santa Cruz County

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EXECUTIVE SUMMARY

Introduction

This Service and Sphere of Influence Review provides information about the services and boundaries of the Pajaro Valley Health Care District. The report will be used by the Local Agency Formation Commission to conduct its statutorily required review and update process. The Cortese-Knox-Hertzberg Act requires that the Commission conduct periodic reviews and updates of Spheres of Influence for all cities and districts in Santa Cruz County (Government Code section 56425). It also requires LAFCO to conduct a review of municipal services before adopting Sphere updates (Government Code section 56430). Finally, this report represents a significant milestone as it serves as the inaugural service and sphere of influence review for the healthcare district.

The service review process does not require LAFCO to initiate changes of organization based on service review conclusions or findings; it only requires that LAFCO make determinations regarding the delivery of public services in accordance with Government Code Section 56430. However, LAFCO, local agencies, and the public may subsequently use the determinations and related analysis to consider whether to pursue changes in service delivery, government organization, or spheres of influence.

Service and sphere reviews are informational documents and are generally exempt from environmental review. LAFCO staff has conducted an environmental review of the District's existing sphere of influence pursuant to the California Environmental Quality Act (CEQA) and determined that this report is exempt from CEQA. Such an exemption is due to the fact that it can be seen with certainty that there is no possibility that the activity in question may have a significant effect on the environment (Section 15061[b][3]).

Special Legislation

Senate Bill 418, signed into law on February 4, 2022, established the Pajaro Valley Health Care District in direct response to the Watsonville Community Hospital filing Chapter 11 bankruptcy on December 21, 2021. The District was created to safeguard essential health care services for the community by placing the hospital under a more accountable public governance structure. Recognizing the importance of strong, impartial oversight, Senate Bill 969 was enacted on July 1, 2022, and explicitly affirmed LAFCO's pivotal role as the independent authority charged with guiding and monitoring the District to ensure its governance remains transparent, sustainable, and aligned with the public interest.

Under Senate Bill 969, LAFCO is tasked with establishing the District's sphere of influence within one year of formation and after conducting a comprehensive municipal service review of health care delivery by December 31, 2025, and every five years thereafter. The law also requires the District to provide annual reports to LAFCO in 2023 and 2024, ensuring that oversight remains active during the District's formative years. In fulfilling these responsibilities, LAFCO adopted the District's inaugural sphere of influence on January 4, 2023, designating the boundary as coterminous with the District's service area.

Through these statutory responsibilities and actions, LAFCO serves as something more than a regulatory body. As another public, independent and neutral entity, LAFCO provides accountability and transparency while also acting as a partner committed to the

District's long-term success. By offering objective analysis, fostering public trust, and ensuring stability, LAFCO helps create the conditions under which the District can remain viable, effective, and focused on delivering reliable health care services to the community.

The District encompasses approximately 26,000 parcels within 108 square miles between two counties: Santa Cruz County (79.5 square miles; 22,994 parcels; $16.7 billion in assessed value) and Monterey County (26.6 square miles; 2,608 parcels; $0.85 billion in assessed value). The current population within PVHCD's entire service area is approximately 92,500. An overview map is shown as **Figure 1** on page 8.

Principal LAFCO

Since the District is in multiple counties, the principal county's LAFCO has purview over PVHCD. A "principal county" is the county that contains "the greater portion of the entire assessed value, as shown on the last equalized assessment roll of the county or counties, of all taxable property within a district or districts for which a change or organization or reorganization is proposed" (Government Code Section 9002[k]). Under this criteria, Santa Cruz LAFCO serves as the principal LAFCO for the Pajaro Valley Health Care District. The principal LAFCO and its Commission are statutorily responsible for PVHCD's proposed boundary changes, sphere amendments, and service reviews. As the principal LAFCO, Santa Cruz LAFCO has kept, and will continue to keep, Monterey LAFCO fully informed of any actions involving the multi-county healthcare district.

Health Care Districts in California

Healthcare districts remain an essential part of California's safety net system, particularly for rural and underserved areas where private hospitals or large health systems are absent. Today, the Association of California Healthcare Districts indicates that there are 76 healthcare districts statewide, a modest decline from the higher counts recorded a decade ago. While the overall number has not changed dramatically, the stability of healthcare districts that continue to operate hospitals has become a growing concern to LAFCOs around the state. These districts often represent the sole provider of emergency and acute care for their communities, yet they are disproportionately vulnerable to both fiscal stress and service disruption. We are seeing first-hand their vulnerability deepening by the recent changes in federal policy affecting Medicaid (Medi-Cal in California) and Medicare that are expected to place additional financial and operational pressures on healthcare districts statewide. Based on LAFCO's understanding, Congress and the Centers for Medicare & Medicaid Services (CMS) have advanced measures that tighten Medicaid eligibility and verification, phased out some pandemic-era policy flexibilities, and adjusted Medicare reimbursement rates. These actions are projected to reduce federal matching funds, increase administrative workload for eligibility renewals, and shift reimbursement timing and amounts for hospitals serving a high proportion of publicly funded program patients.

California's Department of Health Care Services has signaled that the State will work to mitigate coverage losses, but the combination of federal reductions and the State's current budget constraints creates uncertainty. Healthcare districts, which already operate on thin margins providing safety-net services, are especially vulnerable to increased uncompensated care if Medi-Cal enrollment declines or renewals lapse. Changes to Medicare payment rules, such as modifications to inpatient and physician fee schedules, may further erode revenue stability and require budget adjustments to better

plan for the coming fiscal years. For the Pajaro Valley Health Care District and Watsonville Community Hospital, these federal actions carry heightened risk. The Hospital serves a disproportionately large Medi-Cal and uninsured patient population, so any decrease in federal reimbursements could quickly translate into revenue shortfalls. The district may face higher administrative costs to assist patients with renewals, potential service reductions or deferred capital projects to balance budgets, and greater urgency to secure operational partnerships or supplemental funding.

Across California, hospital-owning health care districts face mounting structural challenges. Many operate on thin or negative margins and only a handful of days' cash on hand, leaving them unable to absorb revenue shocks or unexpected capital project costs. Federal and state reimbursement pressures, particularly related to Medi-Cal and Medicare, have eroded operating revenues. At the same time, workforce shortages and rising labor expenses continue to strain already fragile budgets, while legacy debt, costly lease arrangements, and aging infrastructure create additional ongoing financial burdens. These combined factors have forced some districts to suspend services, pursue bankruptcy, or seek dissolution. Recent cases have highlighted the seriousness of these potential risks or outcomes. In Riverside County, LAFCO is actively overseeing the potential dissolution of the Palo Verde Healthcare District after its hospital curtailed core services due to cash flow and staffing problems. In Santa Cruz County, the Pajaro Valley Health Care District was specifically created to acquire and move the Watsonville Community Hospital out of bankruptcy in 2022. Despite initial stabilization efforts, including voter approval of bond financing, the District continues to face exposure to revenue losses, high operating costs, and the need for long-term and sustainable management partnerships. These examples underscore both the fragility of hospital-owned districts and the urgent need for coordinated effective solutions.

LAFCO's role in this environment is both independent and supportive. By statute, LAFCO must evaluate service feasibility and determine whether a district can remain a viable public provider. Through service reviews and the authority to pursue reorganizations, LAFCO serves as an impartial arbiter of fiscal and operational sustainability. At the same time, this Commission recognizes that preserving essential access to health care is paramount for residents of both counties. LAFCO's approach therefore balances objective oversight with proactive assistance, using its convening authority to bring counties, health systems, state agencies, and local voters into the process of charting a sustainable path forward.

For the Pajaro Valley Health Care District, this service and sphere review is meant to provide a better understanding of the District's purpose, disclose its current status as an independent special district, and identify its ongoing challenges and opportunities. Specifically, LAFCO will evaluate the District's fiscal condition, governance capacity, and service delivery model to determine whether it can remain viable in its current form. Options may include pursuing new partnerships, secure additional revenue sources, and/or considering possible governance options alternatives. In every scenario, LAFCO's priority remains the same - ensuring that the residents of the Pajaro Valley retain reliable access to emergency and acute care services, while promoting fiscal responsibility and long-term stability.

Governance Options

LAFCO is concerned that the Pajaro Valley Health Care District's ongoing operating deficits, declining revenues, and rising expenses indicate a pattern of fiscal instability that threatens its long-term sustainability and legitimacy as a public entity. Continued shortfalls suggest the District may lack sufficient financial resilience to meet its service and operational obligations without the need for structural changes or external support. Based on LAFCO's analysis, the District has ended with an annual deficit in its first three years of existence. A full review of PVHCD's financial performance is analyzed in this report (refer to page 11).

Given PVHCD's ongoing fiscal and operational challenges, it is prudent for LAFCO to evaluate the full range of governance options alternatives available to ensure the long-term continuity of essential health services in the region. Under the Cortese-Knox-Hertzberg Act, LAFCO's role is not to dictate outcomes but to assess organizational structures, identify viable alternatives, and safeguard the public's interest in accessible and sustainable healthcare delivery. The District has several potential pathways to consider - from remaining a stand-alone governmental entity with internal fiscal adjustments, to pursuing partnerships, consolidation, or even dissolution. It is important to note that each alternative carries distinct implications for service continuity, financial stability, and local accountability. By outlining these options, LAFCO provides a framework for informed decision-making by the District, its constituents, and potential partner agencies. **Table 1** provides a summary of the potential governance options for PVHCD's consideration. The report includes a more detail discussion about each identified option (refer to page 20).

Table 1: Potential Governance Options

Options	Description	LAFCO Action Requirement
1) Continue as an Independent Special District	Consideration of additional funding through voter-approval may be required to continue as a stand-alone agency	No; but may be used as a facilitator or resource
2) Reorganization with Another Healthcare District	Consideration of dissolution and concurrent annexation into a neighboring healthcare district	Yes; a change of organization will require LAFCO approval
3) Consolidation with Another Healthcare District	Consideration of a merger with neighboring healthcare district and creating a new healthcare district	Yes; a change of organization will require LAFCO approval
4) Transfer of Operations or Sale to a Private Owner	Consideration of a transfer of partial or full service responsibility to a private entity	Perhaps; if PVHCD transfers service responsibility then a mandatory dissolution may be triggered
5) Enactment of Additional Special Legislation	Consideration if assistance from State Legislature is needed to address ongoing challenges	No; but may be used as a facilitator or resource
6) Establishment of a Receivership	Consideration if there is extreme insolvency; may help transfer responsibilities if PVHCD is unable to operate on its own	No; but may be used as a facilitator or resource

Footnote: Options listed above are for discussion purposes only; PVHCD has full discretion to consider, explore, and/or implement these and/or other potential options to address their ongoing challenges.

Key Findings

The following are key findings of the 2025 Service and Sphere of Influence Review for the Pajaro Valley Health Care District:

1. **The District provides services in two counties.**
   PVHCD encompasses 108 square miles in two separate counties and provides a broad range of health care services to ensure the continued availability of critical medical care within the Pajaro Valley community. Day-to-day operations are managed by the Chief Executive Officer with 625 employees as of December 31, 2024. At the center of the District's operations is Watsonville Community Hospital, a full-service acute care facility offering emergency services and other essential services and programs. It is estimated that approximately 93,000 residents currently live within PVHCD's jurisdiction, mostly in the Watsonville area.

2. **Santa Cruz LAFCO is the principal LAFCO for the district.**
   State law allows healthcare districts to be located within multiple counties as long as the lands are contiguous. When multiple counties are involved, State law assigns authority to the principal county's LAFCO. Santa Cruz LAFCO is the principal LAFCO for PVHCD. Santa Cruz LAFCO is statutorily responsible for any changes of organization related to the District. In the event that a proposed boundary change involves Monterey County, Santa Cruz LAFCO will coordinate with Monterey LAFCO before, during, and after the process is completed.

3. **The District is financially distressed.**
   PVHCD experienced a deficit in its first three years of existence since 2022. Financial statements from 2022 to 2024 showed a loss of $30 million in 2022, $13.1 million in 2023, and $94,000 in 2024. While this has been a positive trend, LAFCO staff believes that the negative operating margins may continue as the District struggles with both anticipated and unexpected challenges it currently faces as a healthcare district.

4. **The District is complying with website requirements under State law.**
   Senate Bill 929 was signed into law in September 2018 and requires all independent special districts to have and maintain a website by January 1, 2020. It outlines minimum website data requirements agencies must provide including contact information, financial reports, and meeting agendas/minutes. PVHCD maintains a website and meets all the minimum requirements outlined in SB 929. LAFCO recommends that the District continue to keep its website updated to ensure that their information and latest news are easily accessible to its constituents and the public.

5. **The District's sphere of influence is coterminous with its jurisdictional limits.**
   In January 2023, the Commission adopted a multi-county sphere of influence for the healthcare district in accordance with Senate Bill 418's statutory deadline. PVHCD's initial multi-county sphere is coterminous with its jurisdictional boundary. It is recommended that the sphere be amended to include 78 parcels within Santa Cruz County currently unrepresented to ensure that a logical service provider is designated for the entire southern portion of the county. It is important to note that a sphere amendment does not automatically result in annexation. PVHCD must first indicate it is willing and capable of adding additional territory into its service area and further analysis would be required should annexation be considered in the foreseeable future.

Recommended Actions

Based on the analysis and findings in the 2025 Service and Sphere of Influence Review for the Pajaro Valley Health Care District, the Executive Officer recommends that the Commission:

1. Find that pursuant to Section 15061(b)(3) of the State CEQA Guidelines, LAFCO determined that the sphere of influence review is not subject to the environmental impact evaluation process because it can be seen with certainty that there is no possibility that the activity in question may have a significant effect on the environment and the activity is not subject to CEQA;

2. Determine, pursuant to Government Code Section 56425, the Local Agency Formation Commission of Santa Cruz County is required to develop and determine a sphere of influence for the Pajaro Valley Health Care District, and review and update, as necessary;

3. Determine, pursuant to Government Code Section 56430, the Local Agency Formation Commission of Santa Cruz County is required to conduct a service review before, or in conjunction with an action to establish or update a sphere of influence; and

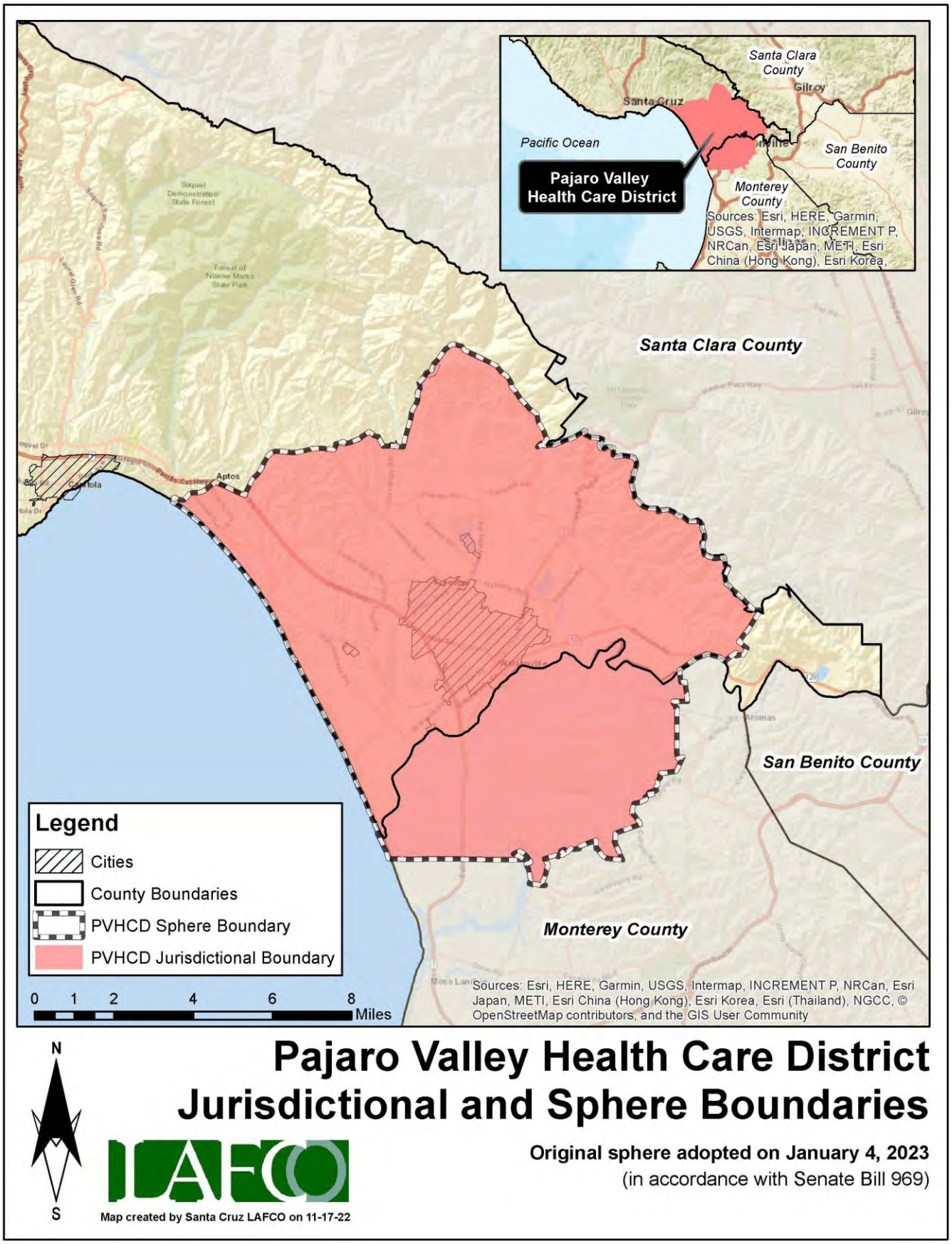
4. Adopt the resolution (LAFCO No. 2025-14) approving the 2025 Service and Sphere Review for the Pajaro Valley Health Care District with the following conditions:

    a. Provide annual reports to LAFCO beyond the statutory requirements under SB 418. The 2025 and 2026 annual reports should be presented to LAFCO during a regular public meeting for commission discussion and consideration. The annual reports should be submitted to LAFCO no later than January 31, 2026 (2025 annual report) and January 31, 2027 (2026 annual report) respectively;

    b. Coordination between the Pajaro Valley Health Care District and Santa Cruz LAFCO to explore the identified options within the 2025 service review and any other alternative actions. A status update should be provided to the commission no later than April 1, 2026 (six month update) and November 4, 2026 (one year update); and

    c. Direct the Executive Officer to distribute a copy of the adopted service and sphere review to the Pajaro Valley Health Care District and any other interested or affected parties, including but not limited to Monterey LAFCO as the affected LAFCO, the Counties of Monterey and Santa Cruz, Salinas Valley Health, Salud Para La Gente and the Community Health Trust of the Pajaro Valley.

Figure 1: Vicinity Map



DISTRICT OVERVIEW

History

The Pajaro Valley Health Care District was created under special legislation (Senate Bill 418) on February 4, 2022 to provide adequate governmental oversight to the Watsonville Community Hospital, which filed for Chapter 11 bankruptcy on December 21, 2021. A subsequent bill, Senate Bill 969, was also signed into law on July 1, 2022 to clearly outline LAFCO's purview over the newly formed district. **Appendix A** provides a copy of the two legislative bills. In addition to the Santa Cruz County, the District also serves a portion of Monterey County, including Pajaro, Las Lomas, and Aromas. PVHCD operates pursuant to the California Health Care District Law (Health & Safety Code Sections 32000 – 32498.9). The District's service area encompasses 25,602 parcels within approximately 108 square miles: Santa Cruz County consists of 79.5 square miles (22,994 parcels) and the remaining 28.6 square miles (2,608 parcels) are located in Monterey County.

Services and Operations

The Pajaro Valley Health Care District provides a broad range of health care services to ensure the continued availability of critical medical care within the south Santa Cruz County community. As of December 31, 2024, the day-to-day operations are managed by the Chief Executive Officer along with a staff of 625 employees. At the center of the District's operations is Watsonville Community Hospital, a full-service acute care facility offering emergency services, inpatient and surgical care, advanced cardiac and vascular procedures, diagnostic imaging and laboratory services, maternity and pediatric care (including newborn and Level II NICU services), pharmacy services, rehabilitation and wound care, urology and vascular specialties, and programs addressing substance-use treatment. These services collectively provide the Pajaro Valley region with essential, locally accessible hospital-based care. PVHCD owns the Pajaro Valley Health Care District Hospital Corporation also known as the Watsonville Community Hospital (the "Hospital").

The Hospital is a 501(c)(3) component unit of the District and operates a 106-bed acute care hospital and other patient services. It is important to note that the District and the Hospital were both created to purchase the operations and certain assets of the Watsonville Community Hospital and to operate the hospital facility. The Hospital's assets were acquired in September of 2022. Hospital land and improvements (buildings) were subsequently acquired in October of 2024. **Appendix B** provides a copy of the District's Community Health Needs Assessment, which is a community-level evaluation tool that helps identify and prioritize local health challenges within Watsonville Community Hospital's service area.

In addition to hospital operations, the District invests in and supports community health through strategic partnerships, grant programs, and initiatives identified in its Community Health Needs Assessment. These efforts focus on improving access to primary care, addressing chronic disease, and reducing barriers such as food insecurity and transportation limitations. The District collaborates with community-based organizations, including the Community Health Trust of Pajaro Valley, to promote prevention, wellness, and equity-driven initiatives designed to improve long-term population health outcomes.

LAFCO staff recognizes that the District's role extends beyond operating a hospital: it functions as a public agency entrusted with stewarding a critical community asset. By providing governance oversight, financial sustainability, and efficient service delivery, the District ensures that health care services remain both accountable to the public and responsive to the region's diverse needs. LAFCO views these responsibilities as essential to maintaining stability in the local health care system, and Santa Cruz LAFCO is committed to supporting the District in its mission to deliver reliable, equitable, and culturally competent care to the residents of the Pajaro Valley.

Population and Growth

Based on staff's analysis, the population of PVHCD in 2025 is estimated to be 93,000. The Association of Bay Area Governments (ABAG) and the Association of Monterey Bay Area Governments (AMBAG) provide population projections for cities and counties in the Coastal Region. Official growth projections are not available for special districts. In general, the Coastal Region is anticipated to have slow growth over the next fifteen years. **Table 2** shows the anticipated population for each local agency within PVHCD. The average rate of change within both counties is approximately 1.30%.

Population Projection

Based on the projections for the cities and counties within the District's service area, LAFCO staff was able to develop a population forecast for PVHCD. Staff increased the District's 2025 population amount by 1.30% each year. Under this assumption, LAFCO staff projects that the entire population of PVHCD will be approximately 96,000 by 2040.

Table 2: Projected Population

Area	2025	2030	2035	2040	Average
City of Watsonville	55,187	56,829	58,332	59,743	2.78%
Monterey County (Unincorporated)	105,682	106,007	106,323	106,418	0.25%
Santa Cruz County (Unincorporated)	137,896	139,105	140,356	141,645	0.86%
Pajaro Valley Health Care District	**92,477**	**93,675**	**94,889**	**96,119**	**1.30%**

Disadvantaged Unincorporated Communities

State law requires LAFCO to identify and describe all "disadvantaged unincorporated communities" (DUCs) located within or contiguous to the existing spheres of influence of cities and special districts that provide fire protection, sewer, and/or water services. DUCs are defined as inhabited unincorporated areas within an annual median household income that is 80% or less than the statewide annual median household income.

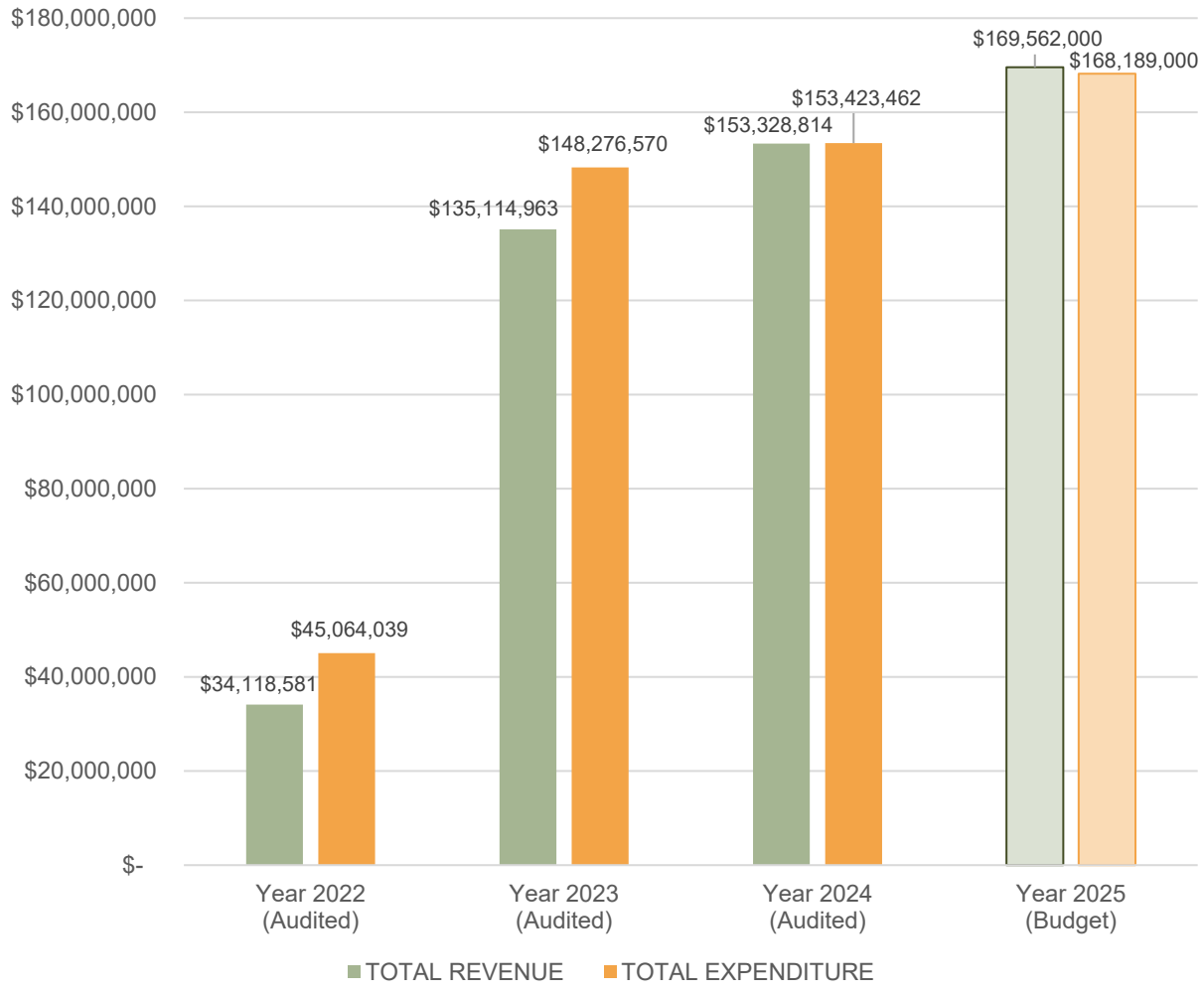
In 2025, the California statewide annual median household income was $109,266, and 80% of that is $87,413. LAFCO staff utilized the ArcGIS mapping program to locate potential DUCs in Santa Cruz County. It is important to note that the Pajaro Valley Health Care District is not subject to SB 244 because it does not provide water, sewer, or fire service, and therefore, no further analysis is required.

FINANCES

This section will highlight the District's financial performance during the most recent fiscal years. 2024 is the latest audited financial statement available. LAFCO will evaluate PVHCD's financial health from 2022 to 2025. A comprehensive analysis of the District's financial performance during the past four years is shown in **Table 4** on page 16. **Table 5** on page 17 also provides an overview of the District's assets and liabilities during the past three fiscal years. **Appendix C** provides a copy of the financial documents used to conduct LAFCO's evaluation of the District's fiscal health.

At the end of the 2024 calendar year, total revenue collected by PVHCD was approximately $153.3 million, representing a 13% increase from the previous year ($135.1 million in 2023). Total expenses for the 2024 calendar year were approximately $153.4 million, which increased from the previous year by 3% ($148.3 million in 2023). The District has ended with an annual deficit in its first three years of existence, as shown in **Figure 2**. While the 2025 budget expects to end with a marginal surplus for the first time, LAFCO staff believes that this negative trend may continue as the District struggles with the impact of both anticipated and unexpected challenges it currently faces as a healthcare district.

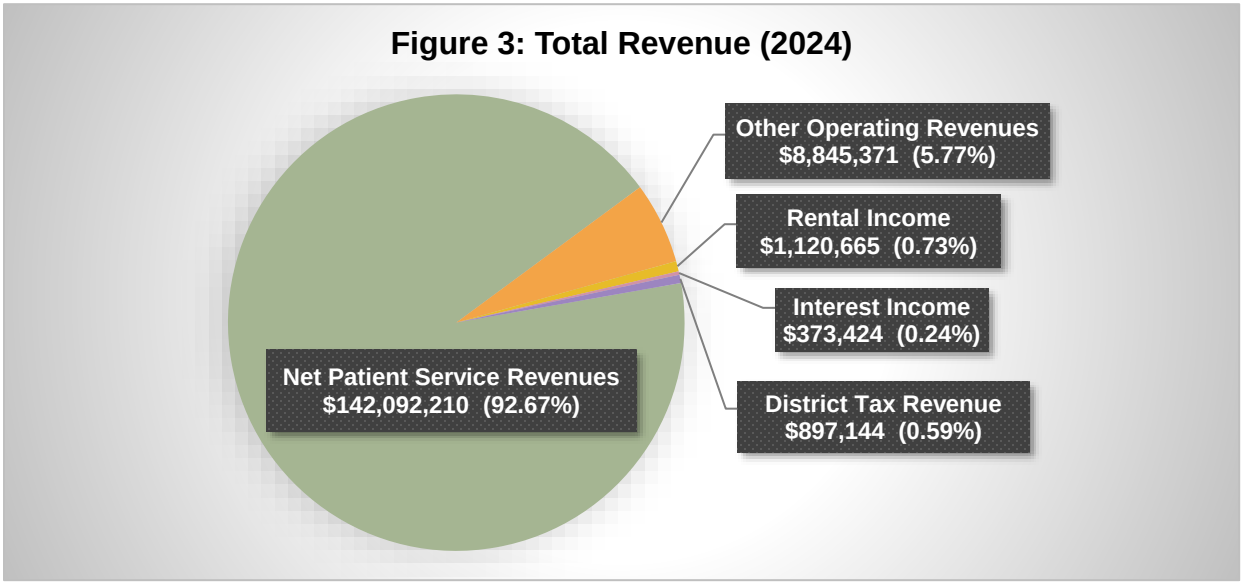
Figure 2: Statement of Revenues & Expenditures



Revenues

PVHCD's total revenues can be categorized into two budgetary groups: Operating Revenue and Non-Operating Revenue. The District's primary source of revenue is from net patient services. In 2024, patient service revenues totaled approximately $142 million, which represents 93% of the District's entire revenue stream. Other revenue sources include rental income ($1.1 million or 0.73%) and Interest Income ($373,424 or 0.24%). **Figure 3** provides a breakdown for each revenue stream.

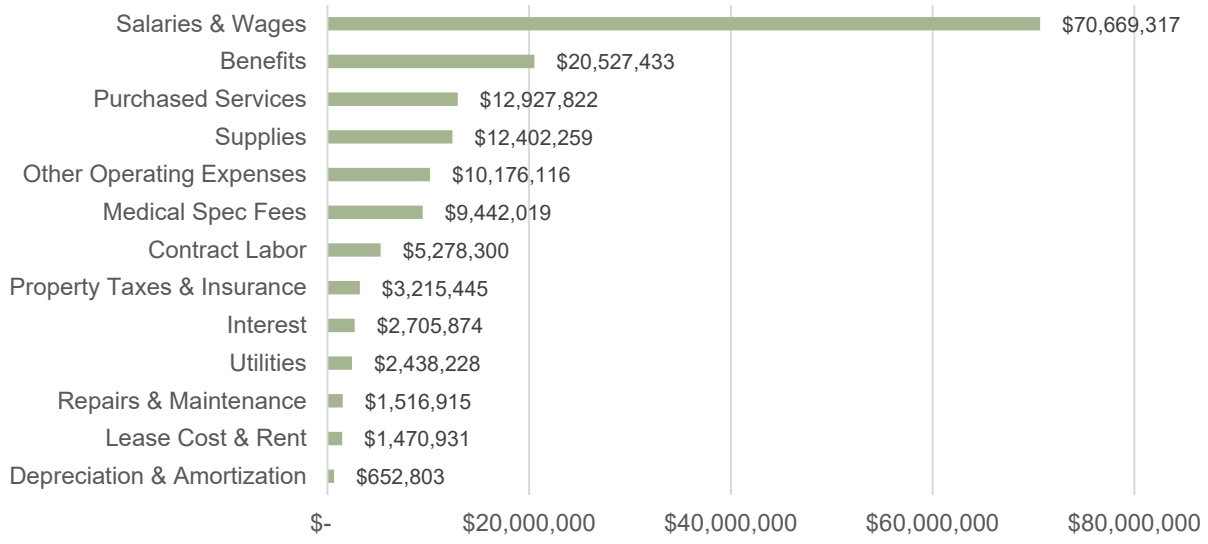
Figure 3: Total Revenue (2024)



Expenditures

PVPCD's total expenditures includes a number of different line items ranging from Salaries & Wages to Repairs & Maintenance. **Figure 4** shows that in 2024, Salaries & Wages represent approximately 46% of the District's entire operational expenses. The remaining expenditures are based on the costs associated with operational tasks including but not limited to utilities, rent, and contract labor.

Figure 4: Total Expenditure (FY 2023-24)



Assets & Liabilities

District Assets

As of December 31, 2024, the District had approximately $95 million in total assets. This represents an increase of approximately $30 million or 46% from 2023's total assets of $65 million. Total assets can be categorized into two types: Current Assets and Non-Current Assets. Current assets are resources such as cash, receivables, and other items expected to be used or converted within a year, while non-current assets are long-term investments like land, buildings, and equipment that support a healthcare district's operations over multiple years. In 2024, current assets were approximately $37 million and non-current assets were approximately $57 million. As shown in **Figure 5**, capital assets represented 61% of total assets, with Capital Assets totaling $45 million or 48% of the District's entire asset amount. **Figure 6** provides a detailed breakdown of the District's total assets in 2024.

Figure 5: Total Assets (2024)

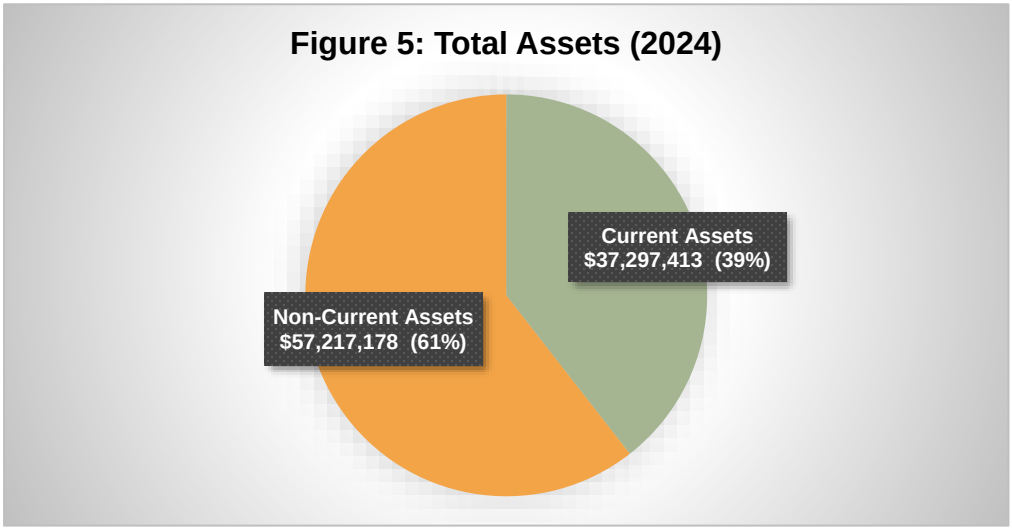
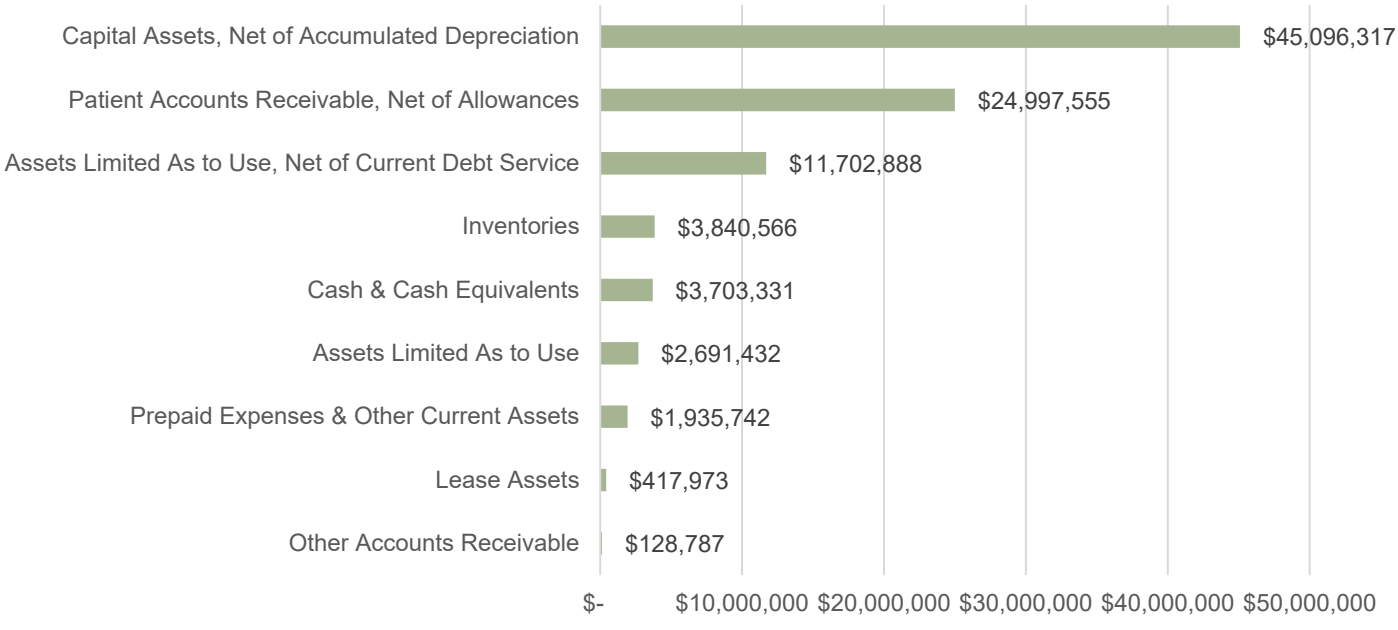


Figure 6: Total Assets (2024)



District Liabilities

As of December 31, 2024, the District had approximately $99 million in total liabilities. This represents an increase of approximately $31 million or 45% from 2023's total liabilities of $68 million. Total liabilities can be categorized into two types: Current Liabilities and Non-Current Liabilities. Current liabilities are obligations a healthcare district must pay within one year, such as accounts payable and short-term debt, while non-current liabilities are longer-term obligations like bonds, leases, or pension liabilities that extend beyond one year. As shown in **Figure 7**, Non-Current Liabilities represented 67% of total liabilities, with Debt Borrowing totaling $66 million or 66% of the District's entire liability amount. **Figure 8** provides a detailed breakdown of the District's total liabilities in 2024.

Figure 7: Total Liabilities (2024)

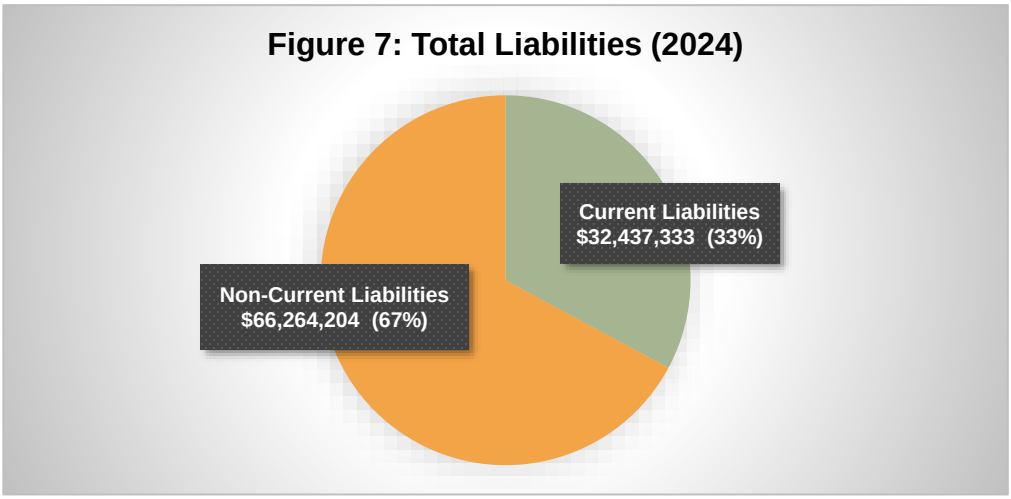
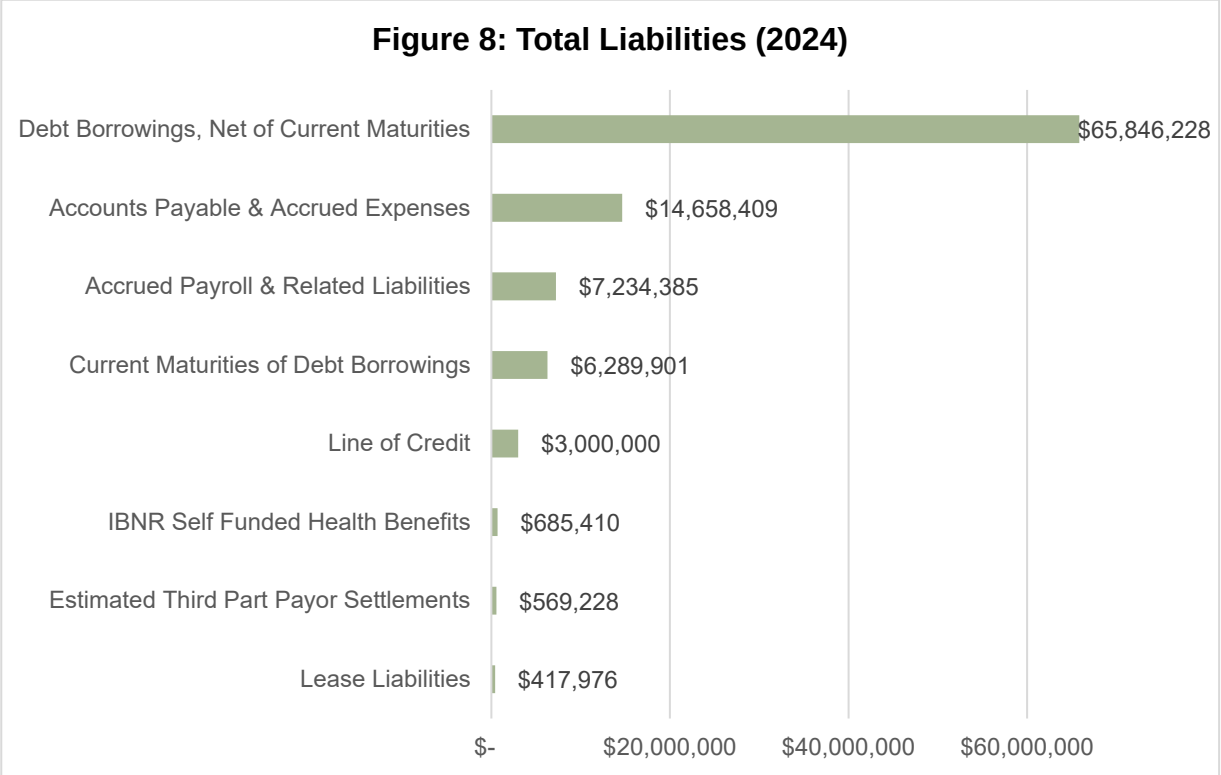


Figure 8: Total Liabilities (2024)



Net Position

Net position represents the District's overall financial health by showing the difference between what it owns (assets) and what it owes (liabilities). A positive net position means the district has resources available for future services, while a negative net position indicates financial strain. As of December 31, 2024, the total fund balance ended with approximately negative $3.4 million. The following table highlights the net position from 2022 to 2025. As shown in the table below, the District's net position has decreased over the years. This consecutive negative balance is extremely concerning and leaves PVHCD unprepared for any additional unintended expenses, major capital improvement projects, or emergency contingency funds.

Table 3: Net Position

	2022 (Audited)	2023 (Audited)	2024 (Audited)	2025 (Budget)
Ending Balance	**$9,717,164**	**$(3,444,443)**	**$(3,539,091)**	**$(2,166,091)**
Change from Previous Year ($)	-	$(13,161,607)	$(94,648)	$1,373,000

Table 4: Total Revenues & Expenditures

Year End = December 31	Year 2022 (Audited)	Year 2023 (Audited)	Year 2024 (Audited)	Year 2025 (Budget)
REVENUE				
Operating Revenues				
Net Patient Service Revenues	$ 33,308,250	$ 129,114,224	$ 142,092,210	$ 159,425,000
Other Operating Revenues	$ 532,944	$ 5,367,526	$ 8,845,371	$ 10,137,000
Total Operating Revenues	**$ 33,841,194**	**$ 134,481,750**	**$ 150,937,581**	**$ 169,562,000**
Non-Operating Revenues				
Rental Income	$ 277,387	$ 529,666	$ 1,120,665	$ -
Interest Income	$ -	$ 103,547	$ 373,424	$ -
District Tax Revenue	$ -	$ -	$ 897,144	$ -
Total Non-Operating Revenues	**$ 277,387**	**$ 633,213**	**$ 2,391,233**	**$ -**
TOTAL REVENUE	**$ 34,118,581**	**$ 135,114,963**	**$ 153,328,814**	**$ 169,562,000**
EXPENDITURE				
Operating Expenses				
Salaries & Wages	$ 17,381,952	$ 70,156,726	$ 70,669,317	$ 106,711,000
Benefits	$ 6,100,838	$ 21,460,602	$ 20,527,433	$ -
Contract Labor	$ 2,414,616	$ 6,931,655	$ 5,278,300	$ -
Supplies	$ 3,688,032	$ 8,319,794	$ 12,402,259	$ 14,243,000
Medical Spec Fees	$ 2,876,058	$ 7,751,461	$ 9,442,019	$ 12,452,000
Purchased Services	$ 5,579,962	$ 13,458,807	$ 12,927,822	$ 12,774,000
Lease Cost & Rent	$ 1,649,758	$ 1,914,944	$ 1,470,931	$ 4,911,000
Repairs & Maintenance	$ 316,371	$ 1,359,867	$ 1,516,915	$ 1,577,000
Utilities	$ 712,745	$ 2,466,097	$ 2,438,228	$ 2,409,000
Depreciation & Amortization	$ 384,786	$ 1,979,831	$ 652,803	$ 1,850,000
Other Operating Expenses	$ 2,906,562	$ 6,190,016	$ 10,176,116	$ 8,506,000
Property Taxes & Insurance	$ 731,821	$ 2,444,845	$ 3,215,445	$ 2,459,000
Interest	$ 320,538	$ 3,841,925	$ 2,705,874	$ 297,000
Total Operating Expenses	**$ 45,064,039**	**$ 148,276,570**	**$ 153,423,462**	**$ 168,189,000**
Non-Operating Expenses				
	$ -	$ -	$ -	$ -
Total NonOperating Expenses	**$ -**	**$ -**	**$ -**	**$ -**
TOTAL EXPENDITURE	**$ 45,064,039**	**$ 148,276,570**	**$ 153,423,462**	**$ 168,189,000**
Surplus/(Deficit)	**$ (10,945,458)**	**$ (13,161,607)**	**$ (94,648)**	**$ 1,373,000**
NET POSITION				
Gain from Acquisition of Hospital	$ 20,662,622	$ -	$ -	$ -
Beginning of Year	$ -	$ 9,717,164	$ (3,444,443)	$ (3,539,091)
End of Year	**$ 9,717,164**	**$ (3,444,443)**	**$ (3,539,091)**	**$ (2,166,091)**

Table 5: Total Assets & Liabilities

Year End = December 31	**Year 2022 (Audited)**	**Year 2023 (Audited)**	**Year 2024 (Audited)**
ASSETS			
Current Assets			
Cash & Cash Equivalents	$ 8,660,568	$ 6,639,515	$ 3,703,331
Assets Limited As to Use	$ -	$ -	$ 2,691,432
Patient Accounts Receivable, Net of Allowances	$21,266,511	$15,195,777	$ 24,997,555
Other Accounts Receivable	$ 1,498,921	$ -	$ 128,787
Inventories	$ 2,158,403	$ 3,841,424	$ 3,840,566
Prepaid Expenses & Other Current Assets	$ 2,510,580	$ 2,260,013	$ 1,935,742
Total Current Assets	**$36,094,983**	**$27,936,729**	**$ 37,297,413**
Non-Current Assets			
Assets Limited As to Use, Net of Current Debt Service	$ -	$ -	$ 11,702,888
Capital Assets, Net of Accumulated Depreciation	$ 3,015,808	$ 3,138,796	$ 45,096,317
Lease Assets	$34,759,953	$33,549,419	$ 417,973
Total Non-Current Assets	**$37,775,761**	**$36,688,215**	**$ 57,217,178**
TOTAL ASSETS	**$73,870,744**	**$64,624,944**	**$ 94,514,591**
Deferred Outflows of Resources, Net of Inflows	$ -	$ -	$ 647,855
TOTAL ASSETS & DEFERRED OUTFLOWS	**$73,870,744**	**$64,624,944**	**$ 95,162,446**
LIABILITIES			
Current Liabilities			
Line of Credit	$ -	$ -	$ 3,000,000
Current Maturities of Debt Borrowings	$ 1,702,035	$ 3,120,987	$ 6,289,901
Accounts Payable & Accrued Expenses	$ 6,922,004	$ 6,531,695	$ 14,658,409
Accrued Payroll & Related Liabilities	$ 8,641,862	$ 9,014,485	$ 7,234,385
Estimated Third Part Payor Settlements	$ 1,597,184	$ 728,871	$ 569,228
IBNR Self Funded Health Benefits	$ 2,787,581	$ 1,706,135	$ 685,410
Total Current Liabilities	**$21,650,666**	**$21,102,173**	**$ 32,437,333**
Non-Current Liabilities			
Debt Borrowings, Net of Current Maturities	$ 7,478,951	$12,408,100	$ 65,846,228
Lease Liabilities	$35,023,963	$34,559,114	$ 417,976
Total Non-Current Liabilities	**$42,502,914**	**$46,967,214**	**$ 66,264,204**
TOTAL LIABILITIES	**$64,153,580**	**$68,069,387**	**$ 98,701,537**
NET POSITION			
Invested In Capital Assets, Net of Related Debt	$ 2,891,822	$ 3,138,796	$ 45,096,317
Restricted	$ 2,600,000	$ 2,600,000	$ 14,394,320
Unrestricted	$ 4,225,342	$ (9,183,239)	$ (63,029,728)
Total Net Position	**$ 9,717,164**	**$ (3,444,443)**	**$ (3,539,091)**
TOTAL LIABILITIES & NET POSITION	**$73,870,744**	**$64,624,944**	**$ 95,162,446**

GOVERNANCE

The Pajaro Valley Health Care District is governed by a five-member Board of Directors, with four-year terms of office. The initial Board of Directors for the Pajaro Valley Health Care District were appointed on March 22, 2022, by the Santa Cruz County Board of Supervisors. This board was established to guide the new district in overseeing the acquisition and operation of Watsonville Community Hospital. District boundaries include areas around the Santa Cruz-Monterey County line, and its Sphere of Influence is coterminous with the current boundaries. Currently, the at-large elections include voters from both counties.

District-Based Elections

Pursuant to Health and Safety Code Section 32498.6, within five years from the date of its first meeting, the Board is required to adopt a resolution to divide representation of the district into zones and number the zones consecutively. The zones shall be effective for the next district election after the resolution of the Board for which there is time to implement the zones and elections within the zones. It is LAFCO's understanding that the District held its first board meeting on March 24, 2022; therefore, the zone-based election process should be established by March 2027.

Local Accountability & Board Structure

The current Board is as follows:

Table 6: Board of Directors

Board Member	Term of Office
Jose (Tony) Nuñez, Chair	Appointed: March 22, 2022 Term Ends: November 7, 2028
Alexandra Friel	Appointed: March 22, 2022 Term Ends: November 7, 2028
Katherine (Katie) Gabriel-Cox	Appointed: March 22, 2022 Term Ends: November 7, 2028
Joe Gallagher	Appointed: November 8, 2022 Term Ends: November 3, 2026
Marcus Pimentel	Appointed: November 8, 2022 Term Ends: November 3, 2026

Board meetings are typically held on the fourth Wednesday of the month at 5:00 pm. These Board meetings are typically held at the Community Health Trust of Pajaro Valley located on the District's campus (Kathleen King Community Room - 85 Nielson Street, Watsonville) which are open to the public. Public hearing notices are provided through online posting. Based on LAFCO's analysis, members of the public have the option to join the meeting virtually or in-person.

Challenges and Opportunities

As previously stated, recent federal policy changes affecting Medicaid and Medicare are expected to place additional financial and operational pressures on healthcare districts. Based on LAFCO's understanding, Congress and the Centers for Medicare & Medicaid Services (CMS) have advanced measures that tighten Medicaid eligibility and verification, phase out some pandemic-era policy flexibilities, and adjusted Medicare reimbursement rates. These actions are projected to reduce federal matching funds, increase administrative workload for eligibility renewals, and shift reimbursement timing and amounts for hospitals serving a high proportion of publicly funded program patients. While historically it has always been difficult to operate a healthcare district in California, the recent changes have impacted all existing healthcare districts, especially those in rural areas, immensely. The following section discusses current challenges and identifies possible opportunities for PVHCD to review and consider.

Fiscal & Operational Concerns

The last two audits (2023 and 2024) included the auditor's "going concerns" about the District. LAFCO understands that an auditor's "going concern" assessment is designed to evaluate whether there is substantial doubt about an agency's ability to continue operating and meeting its financial obligations for at least one year beyond the date of its financial statements. More importantly, the auditor's role is not to make the initial determination, but rather to review and evaluate the accuracy of management's own assessment and disclosures of such uncertainties. If management's evaluation or disclosures are determined to be insufficient, the auditor has the authority to issue a modified audit opinion. The 2024 audit includes a statement from the auditor which declares:

> *"The Hospital has reduced its annual losses since emerging from bankruptcy in 2022, however it suffered significant losses from operations in 2023 and has experienced cash flow difficulties since the District acquired them in September 2022. The Combined unit also has only 9 days cash on hand and significant debt obligations. These conditions raise substantial doubt about the Hospital's ability to continue as a going concern… The financial statements do not include any adjustments that might result from the outcome of this uncertainty. In view of these matters, continuation as a going concern is dependent on continued operations of the District and the Hospital, which in turn is dependent on the District's and the Hospital's ability to increase collections, decrease expenses, and raise additional capital… The Hospital was the victim of a cyberattack in November 2024. The attack levied a significant impact on operations and temporarily slowed cash collections. Recovery efforts are ongoing. The District has Cyber Attack insurance and is working closely with the insurer and related vendors."*

LAFCO has identified significant fiscal concerns regarding the Pajaro Valley Health Care District and its operation of Watsonville Community Hospital. While the Hospital has reduced its losses since emerging from bankruptcy in 2022, it continues to report significant operating deficits and has experienced cash flow difficulties since the District acquired it in September 2022. Collectively, the District and Hospital currently maintain only nine days worth of cash on hand and carry substantial debt obligations. These conditions, taken together, raise substantial doubt about the District's ability to sustain operations over the coming year, which is why the independent auditor noted their

concern with a formal going concern disclosure, underscoring the severity of the financial risk. In addition to its financial difficulties, the District suffered a cyberattack in November 2024 that disrupted hospital operations and temporarily reduced cash collections. The District maintains cyber insurance coverage and is actively working with its insurer and recovery vendors, and has hardened its cyber security systems since the incident.

LAFCO is particularly concerned that the District's long-term viability hinges on its ability to simultaneously increase revenue collections, reduce expenses, and raise additional capital - all while managing its existing debt obligations. Without immediate corrective measures, the District's limited liquidity and persistent losses may compromise its capacity to meet payroll, vendor payments, and debt service. These conditions represent a serious risk not only to the fiscal health of the District, but also to the continuity of critical hospital services relied upon by residents throughout the region. In light of these conditions, LAFCO recommends that the District take immediate steps to stabilize operations. This includes preparing a detailed, near-term cash flow forecast; pursuing bridge financing or other short-term liquidity options; and expediting efforts to improve billing and collections. At the same time, the District should consider alternative governmental options as it explores potential partners.

LAFCO Staff Recommendation: *The District should continue providing annual reports to LAFCO beyond the statutory requirements under SB 418. The 2025 and 2026 annual reports should be presented to LAFCO during a regular public meeting for commission discussion and consideration. The annual reports should be submitted to LAFCO no later than January 31, 2026 and January 31, 2027 respectively.*

Potential Governance Options

Given PVHCD's ongoing fiscal and operational challenges, it is prudent for LAFCO to evaluate the full range of governance options available to ensure the long-term continuity of essential health services in the region. Under the Cortese-Knox-Hertzberg Act, LAFCO's role is not to dictate outcomes but to assess organizational structures, identify viable alternatives, and safeguard the public's interest in accessible and sustainable healthcare delivery. The District has several potential pathways forward to continue ensuring adequate services are provided to the community. It is important to note that each alternative carries distinct implications for service continuity, financial stability, and local accountability. By outlining these options, LAFCO provides a framework for informed decision-making by the District, its constituents, and potential partner agencies.

1) **Continue as an Independent Special District:** PVHCD remains as a stand-alone public entity but pursues internal remedies, including but not limited to: Tighter cost control, management changes, service reductions, contract operations, targeted revenue measures (special tax, assessments), or additional short-term borrowing.

   LAFCO's Role**:** LAFCO does not levy taxes, but it could explore the development of a fiscal analysis under a special study (if directed by the commission) to evaluate the viability of the public agency and to set policy expectations for ongoing oversight. LAFCO's findings and recommendations may encourage the need for voter-approved revenue measures, but the outcome will ultimately depend on the voters.

2) **Reorganization with Another Healthcare District:** In this scenario, PVHCD is dissolved, and its geography, responsibilities, and assets are transferred over to a neighboring district.

   LAFCO's Role**:** Any change of organization (ex. dissolution, annexation, consolidation) falls under LAFCO's authority. A reorganization may be initiated by PVHCD, the Counties of Santa Cruz and/or Monterey, or residents within PVHCD's jurisdictional boundary. This option would require an in-depth analysis of the benefit and constraints involving such a significant change in governance.

3) **Consolidation with Another Healthcare District:** PVHCD and another neighboring healthcare district would merge to create a new healthcare district. This step is similar to a reorganization but rather than recommending dissolving PVHCD and concurrently annexing the dissolved area into a successor agency, this option would merge the two districts and create a brand new one.

   LAFCO's Role**:** Any change of organization (ex. dissolution, annexation, consolidation) falls under LAFCO's authority. Similar to a reorganization, consolidation may be initiated by PVHCD, the Counties of Santa Cruz and/or Monterey, or residents within PVHCD's jurisdictional boundary. This option would also require an in-depth analysis of the benefit and constraints involving such a significant change in governance.

4) **Transfer of Operations or Sale to a Private Owner/ Long-Term Lease or Management Contract:** PVHCD may transfer operation or ownership of the hospital/clinical operations to a private operator or management company (sale, lease, management agreement, joint venture). Watsonville Community Hospital's history shows that this path has been successful in the past but offers no reassurance to the residents regarding sustainability and trust.

   LAFCO's Role**:** While LAFCO plays no role in the consideration of partnerships and/or transfers of operation, Senate Bill 418 does include a clause that states:

   > "*The district shall notify the Santa Cruz County local agency formation commission if the district sells the Watsonville Community Hospital to another entity or stops providing health care services at the facility. If the commission receives notification…it shall order the dissolution of the district."*

   Therefore, if PVHCD does explore some type of partnership that transfers over healthcare services to another entity, then a mandatory dissolution may be triggered.

5) **Enactment of Additional Special Legislation:** Legislature-driven action can support the District to determine a successor agency, identify additional funding, or restructure existing governance. Previous special legislation (SB 418 that established PVHCD) shows that legislative solutions are possible.

   LAFCO's Role**:** While LAFCOs prefer changes of organization, such as district formations, to follow the guidelines under the Cortese-Knox-Hertzberg Act, the

Commission understands why PVHCD had to be created through special legislation in 2022. That said, special legislation may be needed once again to help address the ongoing challenges facing PVHCD. LAFCO may play a facilitator role in coordinating with local, regional, and state leaders to explore special legislation.

6) **Establishment of a Receivership:** In extreme insolvency, courts or the state may appoint a receiver, or the district may be subject to state agency oversight. While not a common option, Santa Cruz County has seen a court receivership step in to help a failing private water system (Big Basin Water Company) within the past year.

   LAFCO's Role**:** A court receiver is a neutral third party appointed by a judge to temporarily take control of an organization's operations, assets, and finances when it is unable to manage them effectively on its own. The receiver's primary duty is to act in the best interest of creditors, stakeholders, and the public by stabilizing the entity, preventing waste or misuse of assets, and developing a path forward. LAFCO could play a facilitating or resource role under a potential receivership.

LAFCO Staff Recommendation: *The District should coordinate with LAFCO to explore the identified options and any other alternative actions. A status update should be provided to the commission no later than April 1, 2026 (six month update) and November 4, 2026 (one year update).*

Website Requirements

Senate Bill 929 was signed into law in September 2018 and requires all independent special districts to have and maintain a website by January 1, 2020. SB 929 identifies several components that must be found within an agency's website. Additionally, the Special District Leadership Foundation (SDLF), an independent, non-profit organization formed to promote good governance and best practices among California's special districts, has also outlined recommended website elements as part of its District Transparency Certificate of Excellence. This program was created as an effort to promote transparency in the operations and governance of special districts to the public.

LAFCO conducted a thorough review of the District's website based on SB 929's criteria and the recommendations set by the SDLF. **Table 7** on page 23 summarizes staff's findings on whether their website meets the statutory requirements. At present, PVHCD does meet all the benchmarks. The District must provide a link or a copy of LAFCO's adopted service and sphere reviews for public access, including this edition once the report has been adopted by the commission.

Table 7: Website Transparency

Website Components	Status (Yes = ✓)
Required Items (SB 929 Criteria and SDLF Benchmarks)	
1. Names and Contact Information of Board Members*	✓
2. Board Member Term Limits	✓
3. Names of Key Staff, including General Manager	✓
4. Contact Information for Staff	✓
5. Election/Appointment Procedure & Deadlines	✓
6. Board Meeting Schedule*	✓
7. Mission Statement	✓
8. Description of District's Services/Functions and Service Area	✓
9. Authorizing Statute/Enabling Act	✓
10. Adopted District Budgets*	✓
11. Financial Audits*	✓
12. Archive of Board Meeting Agendas & Minutes*	✓
13. Link to State Controller's Webpages for District's reported Board Member and Staff Compensation	✓
14. Link to State Controller's Webpages for District's reported Financial Transaction Report	✓
15. Reimbursement & Compensation Policy / Annual Policies	✓
16. Home Page Link to Agendas/Board Packets	✓
17. SB 272 - Compliance-Enterprise Catalogs	✓
18. Machine Readable/Searchable Agendas	✓
19. Recipients of Grant Funding or Assistance	✓
20. Link or Copies of LAFCO's Service & Sphere Reviews	✓
Total Score (out of a possible 20)	**20 (100%)**

SPHERE OF INFLUENCE

Cortese-Knox-Hertzberg Act

City and special district spheres of influence define the probable physical boundaries and service area of a local agency, as determined by the Commission (Government Code Section 56076). The law requires that spheres be updated at least once every five years either concurrently or subsequently in preparation of Municipal Service Reviews. Spheres are determined and amended solely at the discretion of the Commission. In determining the sphere of influence for each local agency, the Commission is required by Government Code Section 56425(e) to consider certain factors, including:

- The present and planned uses in the area, including agricultural and open-space lands;
- The present and probable need for public facilities and services in the area;
- The present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide;
- The existence of any social or economic communities of interest in the area if the commission determines that they are relevant to the agency; and
- For an update of a sphere of influence of a city or special district that provides public facilities or services related to sewers, municipal and industrial water, or structural fire protection, that occurs pursuant to subdivision (g) on or after July 1, 2012, the present and probable need for those public facilities and services of any disadvantaged unincorporated communities within the existing sphere.

Current Sphere Boundary

Santa Cruz LAFCO adopted a multi-county sphere of influence for the District on January 4, 2023. PVHCD's multi-county sphere is coterminous with its jurisdictional boundary, as shown in **Figure 9** on page 25.

Proposed Sphere Amendment

Senate Bill 418 defines the district's territory as all lands within the Pajaro Valley Unified School District boundary, excluding lands north and west of a specific line. In general, the boundary begins at the Pacific Ocean and the projected centerline of Aptos Beach Drive, then follows a path using the centerlines of various roads including Rio Del Mar Boulevard, Bonita Drive, Freedom Boulevard, Hames Road, Browns Valley Road, Hazel Dell Road, Mount Madonna Road, and Gaffey Road before running northeasterly to the Santa Cruz County line. While Santa Cruz LAFCO initially established a coterminous sphere, further research shows that 78 parcels (designated as agricultural lands) were excluded in the jurisdictional boundary – resulting in the development of an unrepresented portion of Santa Cruz County, as shown in **Figure 10** on page 26. Therefore, staff is recommending that the sphere be amended to include the 78 parcels within Santa Cruz County to ensure that a logical service provider is designated for the entire southern portion of the county. It is important to note that a sphere amendment does not automatically result in annexation. PVHCD must be willing and capable of adding additional territory into its service area.

Figure 7: Current Sphere Map

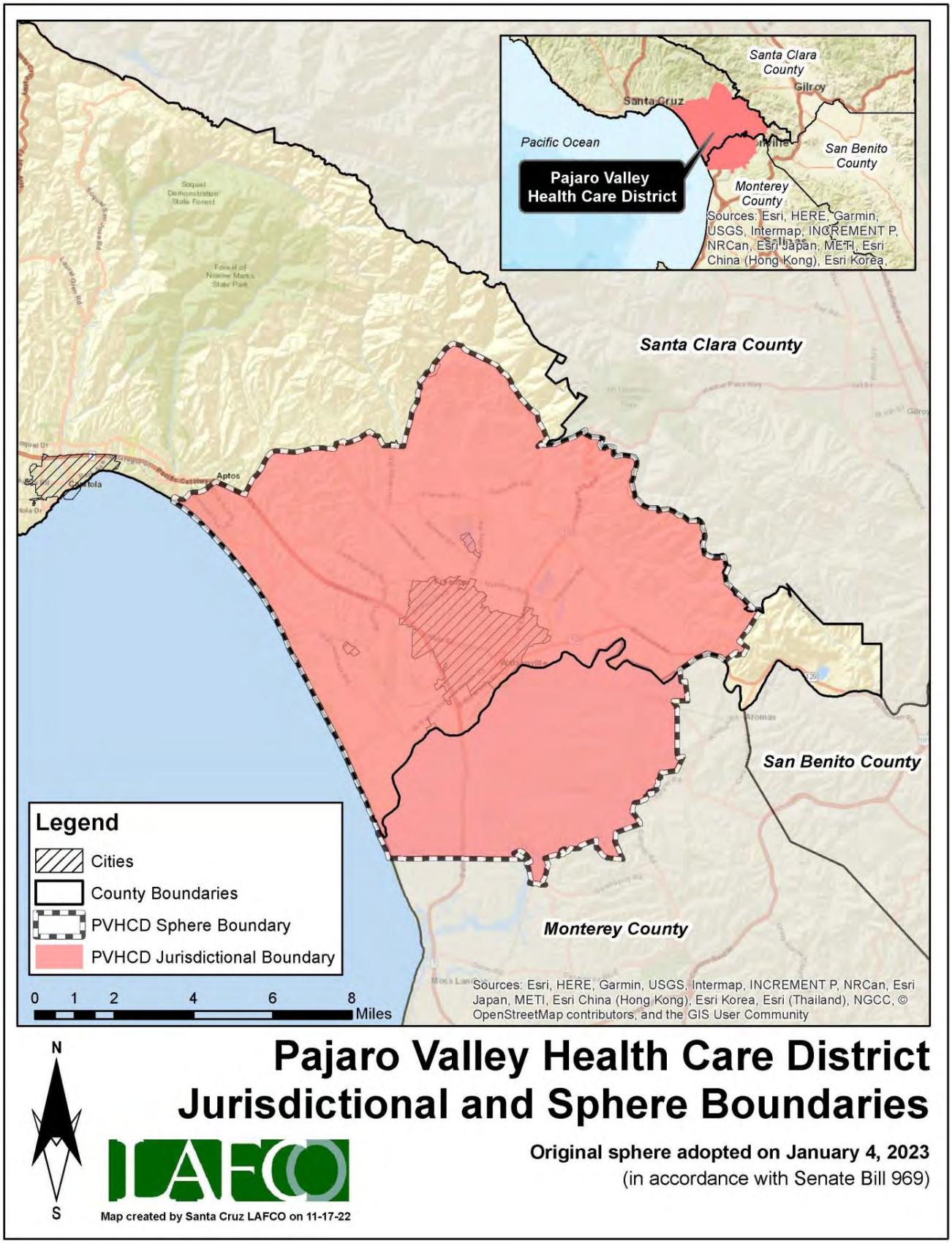
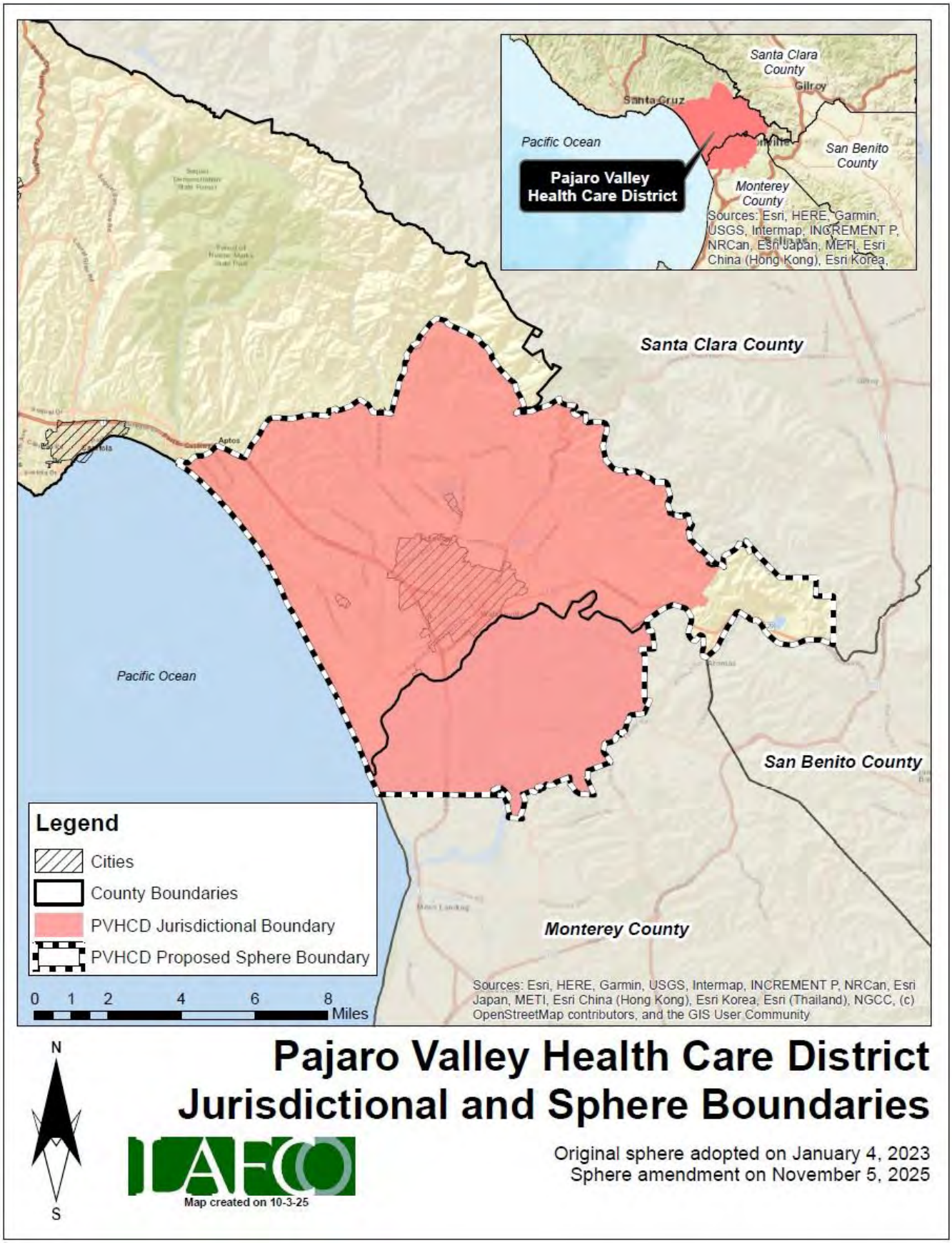


Figure 8: Proposed Sphere Map



DISTRICT SUMMARY	
Pajaro Valley Health Care District	
Formation	Health & Safety Code §32000 et seq. (Health Care District Law)
Board of Trustees	Governed by a five-member Board of Directors. Board members are elected to four-year terms with voters from Monterey and Santa Cruz Counties.
Contact Person	Stephen Gray, Chief Executive Officer
Employees	625 employees as of December 31, 2024
Facilities	**Owned**: 45, 65, 75, 85 Nielson Street, Watsonville, CA 95076 **Leased/Operated:** 99 Airport Boulevard, Freedom, CA 95076 1820 Main Street, Watsonville, CA 95076
District Area	PVHCD encompasses approximately 108 square miles between two counties: Santa Cruz County (79.5 square miles) and Monterey County (26.6 square miles).
Sphere of Influence	The sphere boundary is coterminous with the District's jurisdictional limits and includes lands from both counties.
2025 Budget	Total Revenue = $169,562,000 Total Expenditure = $168,189,000 Projected Net Position (Beginning Balance) = $(3,539,091)
Contact Information	Mailing Address: 75 Nielson Street Watsonville CA 95076 Phone Number: 831-763-6040 Email Address: info@pvhcd.org Website: https://www.pvhcd.org/
Public Meetings	Meetings are typically held on the fourth Wednesday of the month, at 5:00 pm. These Board meetings are typically held at the District's administrative office in Watsonville and are open to the public.
Mission Statement	**Mission:** We are the trusted, equitable healthcare partner and provider our diverse families, friends, and neighbors deserve. **Vision:** To be our community's champion and advocate for health and wellness to improve the lives of our community for generations to come.

SERVICE AND SPHERE REVIEW DETERMINATIONS

The following service and sphere review determinations fulfill the requirements outlined in the Cortese-Knox-Hertzberg Act.

Service Provision Determinations

Government Code Section 56430 requires LAFCO to conduct a municipal service review before, or in conjunction with, an action to establish or update a sphere boundary. Written statements of determination must be prepared with respect to each of the following:

1. **Growth and population projections for the affected area.**
   PVHCD encompasses 108 square miles. It is estimated that approximately 93,000 residents currently live within PVHCD's jurisdiction, mostly in the Watsonville area. LAFCO staff projects that the District's population may reach 96,000 by 2040.

2. **The location and characteristics of any disadvantaged unincorporated communities within or contiguous to the sphere of influence.**
   PVHCD is not subject to SB 244 because it does not provide water, sewer, or fire service.

3. **Present and planned capacity of public facilities, adequacy of public services, and infrastructure needs or deficiencies including needs or deficiencies related to sewers, municipal and industrial water, and structural fire protection in any disadvantaged, unincorporated communities within or contiguous to the sphere of influence.**
   PVHCD provides a broad range of health care services to ensure the continued availability of critical medical care within the community. Day-to-day operations are managed by the Chief Executive Officer with a staff of 625 employees. At the center of the District's operations is Watsonville Community Hospital, a full-service acute care facility offering emergency services, inpatient and surgical care, advanced cardiac and other essential services.

4. **Financial ability of agencies to provide services.**
   PVHCD's primary source of revenue is from patient revenue. The District has experienced consecutive annual deficits since inception (2022 to 2024). LAFCO staff believes that this negative trend may continue unless the District can identify an additional source of revenue or reduce its annual costs.

5. **Status of, and opportunities for, shared facilities.**
   LAFCO encourages more collaborative efforts with neighboring districts and local agencies within both Monterey and Santa Cruz Counties.

6. **Accountability for community service needs, including governmental structure and operational efficiencies.**
   The District currently has a website and meets the requirements under SB 929. LAFCO encourages PVHCD to continue updating the website for more transparency.

7. **Any other matter related to effective or efficient service delivery, as required by commission policy.**
   No additional local LAFCO policies are specifically relevant to this service review.

Sphere of Influence Determinations

Government Code Section 56425 requires LAFCO to periodically review and update spheres of influence in concert with conducting municipal service reviews. Spheres are used as regional planning tools to discourage urban sprawl and encourage orderly growth. Written statements of determination must be prepared with respect to each of the following:

1. **The present and planned land uses in the area, including agricultural and open-space lands.**
   The present and planned land uses are based on the general plans from the County and the City of Watsonville, which range from urban to rural uses. General plans anticipate growth centered on existing urban areas and the maintenance of agricultural production, rural residential uses, and environmental protection in rural areas.

2. **The present and probable need for public facilities and services in the area.**
   PVHCD has adopted a multi-year strategic plan to assess the community health needs within its service area.

3. **The present capacity of public facilities and adequacy of public services that the agency provides or is authorized to provide.**
   The Watsonville Community Hospital is a public, non-profit community healthcare provider; a 106-bed acute care facility serving Watsonville and the surrounding culturally diverse tri-county area along California's Central Coast. The hospital offers a wide range of quality medical and surgical services including cardiac care, diagnostic imaging, emergency services, maternity services, orthopedics, pediatrics, rehabilitation services, robotic surgery, urology, vascular surgery, and wound care.

4. **The existence of any social or economic communities of interest in the area if the commission determines that they are relevant to the agency.**
   The District provides essential services to the Pajaro Valley. This is a social and economic community of interest which is relevant to the provision of public services provided by the Pajaro Valley Health Care District.

5. **For an update of a sphere of influence of a city or special district that provides public facilities or services related to sewers, municipal and industrial water, or structural fire protection, that occurs pursuant to subdivision (g) on or after July 1, 2012, the present and probable need for those public facilities and services of any disadvantaged unincorporated communities within the existing sphere of influence.**
   The District does not provide services related to sewers, municipal and industrial water, or structural fire protection. Therefore, this determination is not applicable.

APPENDICES

Appendix A: Formation Documents (Special Legislation)

Appendix B: Community Health Needs Assessment (2023 Edition)

Appendix C: Financial Documents (2022 to 2025)

APPENDIX A:

FORMATION DOCUMENTS (SPECIAL LEGISLATION)

Senate Bill No. 418

CHAPTER 1

An act to add Chapter 9 (commencing with Section 32498.5) to Division 23 of the Health and Safety Code, relating to health care districts, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor February 4, 2022. Filed with Secretary of State February 4, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

SB 418, Laird. Pajaro Valley Health Care District.

Existing law, the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000, provides the authority and procedures for the initiation, conduct, and completion of changes of organization and reorganization of cities and districts by local agency formation commissions.

This bill would create the Pajaro Valley Health Care District, as specified, except that the bill would authorize the Pajaro Valley Health Care District to be organized, incorporated, and managed, only if the relevant county board of supervisors chooses to appoint an initial board of directors.

The bill would require, within 5 years of the date of the first meeting of the Board of Directors of the Pajaro Valley Health Care District, the board of directors to divide the district into zones and number the zones consecutively. The bill would require that, after formation, the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000 govern any organizational changes for the Pajaro Valley Health Care District. The bill would require the district to notify the County of Santa Cruz local agency formation commission (LAFCO) when the district, or any other entity, acquires the Watsonville Community Hospital. The bill would require the LAFCO to order the dissolution of the district if the hospital has not been acquired by January 1, 2024. The bill would require the district to notify the LAFCO if the district sells the Watsonville Community Hospital to another entity or stops providing health care services at the facility, and would require the LAFCO to dissolve the district under those circumstances, as specified.

This bill would make legislative findings and declarations as to the necessity of a special statute for the creation of the Pajaro Valley Health Care District within the Counties of Santa Cruz and Monterey.

This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Watsonville Community Hospital is a 106-bed hospital located in the Pajaro Valley, which straddles southern County of Santa Cruz and northern County of Monterey on California's central coast. The hospital provides important acute care and emergency services in a culturally diverse community where the nearest alternative hospital can be up to an hour away during regularly congested commutes.

(b) Watsonville Community Hospital employs 620 people and has a medical staff of over 200 physicians. It provides a range of quality medical services, including pediatrics, obstetrics and gynecology, internal medicine, family medicine, anesthesiology, wound care, gastroenterology, orthopedics, cardiovascular disease, dermatology, and more. In 2020, the hospital delivered more babies than any other hospital in the County of Santa Cruz. Serving a significant immigrant population, the hospital provides care to those without English language proficiency in their preferred language.

(c) The community of Watsonville has historically faced many health and economic disparities. The pandemic has resulted in the loss of employment and school closures, and has caused nonessential workers and at-risk populations to stay home. Overcrowded and substandard housing conditions, food insecurity, lack of transportation, and the high cost of housing have intensified disparities overnight. The Pajaro Valley saw dramatic and disproportionate rates of COVID-19 infections, hospitalizations, and death as compared to the rest of the County of Santa Cruz.

(d) Over the last 21 years of for-profit ownership, the hospital administration has changed 20 times. Due to this history, partners of the Pajaro Valley Healthcare District Project all believe community ownership will provide more consistent management, oversight, and stability for the patients, staff, and community. Public ownership through a local hospital district also creates financing and funding opportunities not otherwise available to a for-profit or nonprofit entity.

(e) Originally incorporated in 1902 as a privately owned for-profit entity, the Watsonville Community Hospital board of directors voted in 1950 to reorganize to nonprofit status. This allowed a bond sale and access to federal and state grants for construction of a new hospital, which opened in 1969. That facility was seriously damaged in the 1989 Loma Prieta earthquake. With funding from the Federal Emergency Management Agency, the current facility, which replaced the 1969 facility and opened in 1998, is sufficient to keep pace with the growing needs of the community. In 1998, the previously not-for-profit hospital was sold to a for-profit company, Community Health Systems (CHS). The proceeds of the sale were contributed to a community trust, the Community Health Trust of Pajaro Valley. This trust also held a right of first refusal if CHS were to decide to sell the hospital.

(f) In 2015, Community Health Systems reorganized and formed a new subsidiary, Quorum Health Resources, consisting of its small hospitals.

Facing financial difficulties, Quorum decided to sell Watsonville Community Hospital in 2019, and the Community Health Trust of Pajaro Valley had the option to acquire the hospital. However, at that time, the Community Health Trust of Pajaro Valley decided not to purchase the hospital, and it was sold to a company called Halsen Healthcare and the hospital operated under a corporation named Watsonville Hospital Corporation (WHC). The real estate for the hospital was purchased by a subsidiary of Medical Properties Trust (MPT), a real estate investment trust, and then leased back to WHC.

(g) In January 2021, MPT, after declaring numerous events of default, exercised its stock pledge and replaced the Halsen-appointed board of directors with a new independent board of directors, and the new board designated Prospect Medical Holdings as the new hospital manager. However, this change in management did not solve the hospital's liquidity crisis. To remain in operation, the hospital has had to borrow millions of dollars to address operating losses and the hospital remains in default on its operating loan from another subsidiary of MPT regarding the real property of the hospital.

(h) In 2020 and 2021, during the COVID-19 epidemic, with rising costs of labor and supplies, the hospital experienced significant financial losses. As of August 2021, WHC had a year-to-date cashflow shortfall of over $17,000,000. It also fell into arrears in its obligations to suppliers, employees, and lenders.

(i) Watsonville Community Hospital has been essential in serving its community's primarily low-income, underinsured, and uninsured populations of color for over a century and proved crucial in serving those disproportionately impacted by COVID-19 throughout the pandemic. This is evidenced by 43 percent of the hospital's gross revenue coming from the Medi-Cal program and an additional 30 percent of its gross revenue coming from the Medicare Program, serving the aged and disabled.

(j) The Pajaro Valley Healthcare District Project (PVHDP), a nonprofit organization, was created by the County of Santa Cruz, the City of Watsonville, Salud Para La Gente, and the Community Health Trust of Pajaro Valley, for the purpose of forming a new California health care district. For several years, the partners of PVHDP have been concerned about the continuance of operations and the financial viability of Watsonville Community Hospital, and have been working together to explore the possibility of community ownership.

(k) PVHDP has initiated a process to establish and capitalize a local health care district to purchase the hospital on behalf of the community through the Chapter 11 bankruptcy/restructuring process commenced by WHC, to prevent the hospital's closure and loss of critical community services. With strong community and stakeholder support, the PVHDP partners are well positioned to engage the Legislature, the Governor, and private funders. In addition, WHC and PVHDP intend to seek emergency funding from public and private entities to support the short-term operating capital needs of the hospital and eventual acquisition of the hospital.

(*l*) If PVHDP cannot raise sufficient funds to acquire and operate the hospital, WHC intends to close the hospital and liquidate the assets. For this reason, PVHDP believes it is critical to the health and welfare of the community that it will be able to keep this important hospital open under the stewardship of the community, rather than under another for-profit operator. To do this, it is imperative that emergency funding and urgency legislation be considered immediately in the 2021–22 legislative session.

(m) It is necessary to permit the formation of the Pajaro Valley Health Care District for the above-described purposes.

SEC. 2. Chapter 9 (commencing with Section 32498.5) is added to Division 23 of the Health and Safety Code, to read:

Chapter 9. Pajaro Valley Health Care District

32498.5. (a) A local hospital district designated as the Pajaro Valley Health Care District is hereby formed within the Counties of Santa Cruz and Monterey. The Pajaro Valley Health Care District may be organized, incorporated, and managed as provided in this division, and may exercise the powers granted or necessarily implied by this division, only if the relevant county board of supervisors chooses to appoint an initial board of directors, as described in Section 32100. All other provisions of this division apply to the Pajaro Valley Health Care District, except as provided in this chapter.

(b) The territory of the district shall be the following area: Situated in the Counties of Santa Cruz and Monterey, State of California; being all the lands within the boundary of the Pajaro Valley Unified School District, excepting the lands to the north and west of the following described line: beginning at a point on the edge of the Pacific Ocean at the intersection with the projected centerline of Aptos Beach Drive; thence along said projected centerline to the intersection of the centerline of Aptos Beach Drive and the centerline of Rio Del Mar Boulevard; thence along the centerline of Rio Del Mar Boulevard in a northeasterly direction to the intersection of the centerline of Rio Del Mar Boulevard and the centerline of Bonita Drive; thence along the centerline of Bonita Drive in a westerly direction to the intersection of the centerline of Bonita Drive and the centerline of Freedom Boulevard; thence along the centerline of Freedom Boulevard in a northerly and easterly direction to the intersection of the centerline of Freedom Boulevard and the centerline of Hames Road; thence along the centerline of Hames Road in an easterly direction to the end of the centerline of Hames Road and the beginning of the centerline of Browns Valley Road; thence along the centerline of Browns Valley Road in a northerly and easterly direction to the end of the centerline of Browns Valley Road and the beginning of the centerline of Hazel Dell Road; thence along the centerline of Hazel Dell Road in an easterly and southerly direction to the intersection of the centerline of Hazel Dell Road and the centerline of Mount Madonna Road; thence along the centerline of Mount Madonna Road in a southerly direction to the intersection of the centerline of Mount

Madonna Road and the centerline of Gaffey Road; thence along the centerline of Gaffey Road 1300 feet, more or less, in an easterly direction to a point on the centerline of Gaffey Road; thence leaving the centerline of Gaffey Road 90 feet, more or less, in a northeasterly direction to a point on the Santa Cruz County line.

(c) Following the formation of the district, the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000 (Division 3 (commencing with Section 56000) of Title 5 of the Government Code) governs any change of organization.

32498.6. (a) Notwithstanding any other law, within five years of the date of the first meeting of the Board of Directors of the Pajaro Valley Health Care District, the board of directors shall adopt a resolution to divide the district into zones and number the zones consecutively.

(b) In establishing these zones, the board of directors shall provide for representation in accordance with demographic and geographic factors of the entire area of the district, including population factors. The board of directors shall fix the time and place for a hearing on the proposed establishment of zones. At this hearing, any elector of the district may present their views and plans in relation to the proposed zoning, but the board of directors shall not be bound thereby and their decision, in the resolution adopted, shall be final.

(c) The zones shall be effective for the next district election after the resolution of the board of directors for which there is time to implement the zones and elections within the zones.

32498.7. (a) The district shall notify the County of Santa Cruz local agency formation commission (LAFCO) of when the district, or any other entity, acquires the Watsonville Community Hospital.

(b) If the district does not acquire the Watsonville Community Hospital through the bankruptcy proceeding pursuant to Chapter 11 (commencing with Section 1101) of Title 11 of the United States Code by January 1, 2024, the LAFCO shall order the dissolution of the district.

32498.8. (a) The district shall notify the Santa Cruz County local agency formation commission if the district sells the Watsonville Community Hospital to another entity or stops providing health care services at the facility.

(b) If the commission receives notification subject to subdivision (a), it shall order the dissolution of the district.

(c) The dissolution of the district pursuant to this section is not subject to any of the following:

(1) Chapter 1 (commencing with Section 57000) to Chapter 7 (commencing with Section 57176), inclusive, of Part 4 of Division 3 of Title 5 of the Government Code.

(2) Determinations pursuant to subdivision (b) of Section 56881 of the Government Code.

(3) Requirements for commission-initiated changes of organization described in paragraph (3) of subdivision (a) of Section 56375 of the Government Code.

(4) Sections 99 and 99.01 of the Revenue and Taxation Code.

SEC. 3. The Legislature finds and declares that a special statute is necessary and that a general statute cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances surrounding the operation of the Watsonville Community Hospital. .

SEC. 4. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

The imminent financial collapse of the Watsonville Community Hospital is a serious threat to the public health and safety of the residents of the region, as it is one of two hospitals serving the County of Santa Cruz and the only hospital serving the City of Watsonville and surrounding area. An urgency statute to form a local health care district is necessary to allow local officials the opportunity to purchase the Watsonville Community Hospital and ensure the continuance of hospital operations at the earliest possible time.

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Senate Bill No. 969

CHAPTER 90

An act to add Section 32498.9 to the Health and Safety Code, relating to public health.

[Approved by Governor July 1, 2022. Filed with Secretary of State July 1, 2022.]

LEGISLATIVE COUNSEL'S DIGEST

SB 969, Laird. Pajaro Valley Health Care District.

Existing law, the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000, provides the authority and procedures for the initiation, conduct, and completion of changes of organization and reorganization of cities and districts by local agency formation commissions.

Existing law creates the Pajaro Valley Health Care District, as specified, and authorizes the Pajaro Valley Health Care District to be organized, incorporated, and managed, only if the relevant county board of supervisors chooses to appoint an initial board of directors. Existing law requires, within 5 years of the date of the first meeting of the Board of Directors of the Pajaro Valley Health Care District, the board of directors to divide the district into zones and number the zones consecutively. Existing law requires the Cortese-Knox-Hertzberg Local Government Reorganization Act of 2000 to govern any organizational changes for the district after formation. Existing law requires the district to notify the County of Santa Cruz local agency formation commission (LAFCO) when the district, or any other entity, acquires the Watsonville Community Hospital. Existing law requires the LAFCO to dissolve the district under certain circumstances.

This bill would require the LAFCO to develop and determine a sphere of influence for the district within one year of the district's date of formation, and to conduct a municipal service review regarding health care provision in the district by December 31, 2025, and by December 31 every 5 years thereafter. The bill also would require the district to annually report to the commission regarding health care provision in the district in 2023 and 2024, as specified.

The people of the State of California do enact as follows:

SECTION 1. Section 32498.9 is added to the Health and Safety Code, to read:

32498.9. (a) Within one year of the district's date of formation, the Santa Cruz County local agency formation commission shall develop and

determine a sphere of influence for the district pursuant to Section 56426.5 of the Government Code, unless the district is dissolved before that date.

(b) The district shall make annual reports to the commission, by December 31, 2023, and December 31, 2024, regarding health care service provision within the boundaries of the district, using the indices outlined in paragraphs (1) to (6), inclusive, of subdivision (a) of Section 56430 of the Government Code, unless the district is dissolved before the date the report is required.

(c) By December 31, 2025, and by December 31 every five years thereafter, the commission shall conduct a municipal service review regarding health care service provision within the boundaries of the district pursuant to Section 56430 of the Government Code, unless the district is dissolved before the date the municipal service review is required.

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APPENDIX B:

COMMUNITY HEALTH NEEDS ASSESSMENT (2023 EDITION)

2023 COMMUNITY HEALTH NEEDS ASSESSMENT

Watsonville Community Hospital Service Area
Pajaro Valley Healthcare District

Sponsored by

WATSONVILLE COMMUNITY HOSPITAL

2023-0413-02

Prepared by
www.PRCCustomResearch.com

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INTRODUCTION

PROJECT OVERVIEW

Project Goals

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors, and needs of residents in the service area of Watsonville Community Hospital in Watsonville, California. A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status.

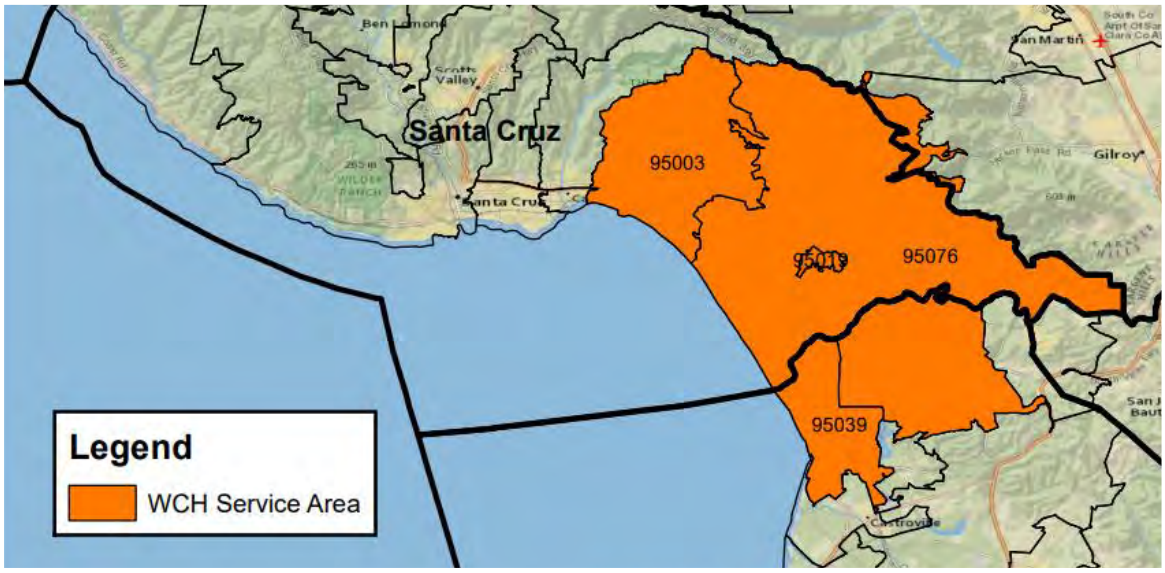
This assessment was conducted on behalf of Watsonville Community Hospital by PRC, Inc., a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Methodology

Quantitative data input for this assessment includes secondary research (vital statistics and other existing health-related data) that allows for comparison to benchmark data at the state and national levels. Qualitative data input includes primary research among community leaders gathered through an Online Key Informant Survey.

Community Defined for This Assessment

The study area for this effort (referred to as the "WCH Service Area" in this report) is the Pajaro Valley Healthcare District, which includes ZIP Codes 95003, 95019, 95039, and 95076 in southern Santa Cruz County and northern Monterey County in California. This community definition, determined based on the residences of most recent patients of Watsonville Community Hospital, is illustrated in the following map.



Online Key Informant Survey

To solicit input from community key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey also was implemented as part of this process. A list of recommended participants was provided by Watsonville Community Hospital; this list included names and contact information for physicians, public health representatives, other health professionals, social service

providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 41 community representatives took part in the Online Key Informant Survey, as outlined in the table that follows:

ONLINE KEY INFORMANT SURVEY PARTICIPATION	
KEY INFORMANT TYPE	NUMBER PARTICIPATING
Physicians	7
Public Health Representatives	5
Other Health Providers	10
Social Services Providers	2
Other Community Leaders	17

Through this process, input was gathered from individuals whose organizations work with low-income, minority, or other medically underserved populations. Final participation included representatives of the organizations outlined below.

- Central California Alliance for Health
- City of Watsonville
- Coastal Health Partners
- Community Action Board
- Community Bridges
- Community Bridges WIC Program
- Community Health Trust of Pajaro Valley
- County of Santa Cruz
- Dientes Community Dental Care
- Doctors on Duty
- Elderday Adult Day Health Care
- Hospice of Santa Cruz County
- Kaiser Permanente
- Meals on Wheels, Santa Cruz
- Monterey County Public Health
- Monterey County Supervisor
- Pajaro Valley Health Care District
- Pajaro Valley Prevention and Student Assistance
- Salud Para La Gente
- Santa Cruz Community Health Centers
- Santa Cruz County Health Services Agency
- Santa Cruz County Office of Education
- Santa Cruz County Public Health
- Santa Cruz Health Information Organization
- Second Harvest Food Bank
- United Way of Santa Cruz County
- Watsonville Community Hospital
- Watsonville Health Center

In the online survey, key informants were asked to rate the degree to which various health issues are a problem in their own community. Follow-up questions asked them to describe why they identify problem areas as such and how these might better be addressed. Results of their ratings, as well as their verbatim comments, are included throughout this report as they relate to the various other data presented.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Watsonville Community Hospital Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension, SparkMap (sparkmap.org)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- National Cancer Institute, State Cancer Profiles
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that ZIP Code-level data are not available for all measures; for these indicators, data is taken from Santa Cruz County as a whole. Throughout this report, chart labels signify whether the data presented are ZIP Code-level based (WCH Service Area) or county-level based (Santa Cruz County).

Benchmark Data

California and National Data

Where possible, state and national data are provided as an additional benchmark against which to compare local findings.

Healthy People 2030

Healthy People provides 10-year, measurable public health objectives — and tools to help track progress toward achieving them. Healthy People identifies public health priorities to help individuals, organizations, and communities across the United States improve health and well-being. Healthy People 2030, the initiative's fifth iteration, builds on knowledge gained over the first four decades.

The Healthy People 2030 framework was based on recommendations made by the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030. After getting feedback from individuals and organizations and input from subject matter experts, the US Department of Health and Human Services (HHS) approved the framework which helped guide the selection of Healthy People 2030 objectives.

Determining Significance

For the purpose of this report, “significance” of secondary data indicators (which might be subject to reporting error) is determined by a 15% variation from the comparative measure.

Information Gaps

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community’s health needs. In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly medical conditions that are not specifically addressed.

Public Comment

Watsonville Community Hospital will use its website as a tool to solicit public comments and ensure that these comments are considered in the development of future CHNAs.

IRS FORM 990, SCHEDULE H COMPLIANCE

For nonprofit hospitals, a Community Health Needs Assessment (CHNA) also serves to satisfy certain requirements of tax reporting, pursuant to provisions of the Patient Protection & Affordable Care Act of 2010. To understand which elements of this report relate to those requested as part of hospitals' reporting on IRS Schedule H (Form 990), the following table cross-references related sections.

IRS FORM 990, SCHEDULE H (2022)	See Report Page
Part V Section B Line 3a A definition of the community served by the hospital facility	6
Part V Section B Line 3b Demographics of the community	21
Part V Section B Line 3c Existing health care facilities and resources within the community that are available to respond to the health needs of the community	92
Part V Section B Line 3d How data was obtained	6
Part V Section B Line 3e The significant health needs of the community	11
Part V Section B Line 3f Primary and chronic disease needs and other health issues of uninsured persons, low-income persons, and minority groups	Addressed Throughout
Part V Section B Line 3g The process for identifying and prioritizing community health needs and services to meet the community health needs	12
Part V Section B Line 3h The process for consulting with persons representing the community's interests	6
Part V Section B Line 3i The impact of any actions taken to address the significant health needs identified in the hospital facility's prior CHNA(s)	98

SUMMARY OF FINDINGS

Significant Health Needs of the Community

The following "Areas of Opportunity" represent the significant health needs of the community, based on the information gathered through this Community Health Needs Assessment. From these data, opportunities for health improvement exist in the Watsonville Community Hospital Service Area with regard to the following health issues (see also the summary tables presented in the following section).

The Areas of Opportunity were determined after consideration of various criteria, including: standing in comparison with benchmark data; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue. These also take into account those issues of greatest concern to the community key informants giving input to this process.

AREAS OF OPPORTUNITY IDENTIFIED THROUGH THIS ASSESSMENT	
ACCESS TO HEALTH CARE SERVICES	▪ Primary Care Visits ▪ Uninsured Children
CANCER	▪ Leading Cause of Death ▪ Colorectal Cancer Screening ▪ Prostate Cancer Incidence
DIABETES	▪ Key Informants: *Diabetes* ranked as a top concern.
HEART DISEASE & STROKE	▪ Leading Cause of Death
INJURY & VIOLENCE	▪ Unintentional Injury Deaths
MENTAL HEALTH	▪ Suicide Deaths ▪ Key Informants: *Mental Health* ranked as a top concern.
NUTRITION, PHYSICAL ACTIVITY & WEIGHT	▪ Low Food Access ▪ Key Informants: *Nutrition, Physical Activity & Weight* ranked as a top concern.
ORAL HEALTH	▪ Access to Dentists
SOCIAL DETERMINANTS OF HEALTH	▪ Housing Burden ▪ Unemployment ▪ Education Levels ▪ Key Informants: *Social Determinants of Health* ranked as a top concern.
SUBSTANCE USE	▪ Excessive Drinking ▪ Drug Overdose Deaths
TOBACCO USE	▪ Cigarette Smoking

Community Feedback on Prioritization of Health Needs

Prioritization of the health needs identified in this assessment ("Areas of Opportunity" above) was determined based on a prioritization exercise conducted among providers and other community leaders (representing a cross-section of community-based agencies and organizations) as part of the Online Key Informant Survey.

In this process, these key informants were asked to rate the severity of a variety of health issues in the community. Insofar as these health issues were identified through the data above and/or were identified as top concerns among key informants, their ranking of these issues informed the following priorities:

1. Social Determinants of Health
2. Diabetes
3. Mental Health
4. Nutrition, Physical Activity & Weight
5. Substance Use
6. Oral Health
7. Access to Health Care Services
8. Heart Disease & Stroke
9. Injury & Violence
10. Tobacco Use
11. Cancer

Hospital Implementation Strategy

Watsonville Community Hospital will use the information from this Community Health Needs Assessment to develop an Implementation Strategy to address the significant health needs in the community. While the hospital will likely not implement strategies for all of the health issues listed above, the results of this prioritization exercise will be used to inform the development of the hospital's action plan to guide community health improvement efforts in the coming years.

Summary Tables:
Comparisons With Benchmark Data

The following tables provide an overview of indicators in the WCH Service Area, grouped by health topic.

Reading the Summary Tables

Note that blank table cells in the tables that follow signify that data are not available for that indicator.

In the following tables, WCH Service Area results are shown in the larger, gray column. *For indicators where ZIP-level based data results are not available, county-level based data (Santa Cruz County) results are shown (marked as [COUNTY-LEVEL]).*

The columns to the right of the WCH Service Area column provide comparisons between local data and any available state and national findings, and Healthy People 2030 objectives. Symbols indicate whether the WCH Service Area (or Santa Cruz County) compares favorably (), unfavorably (), or comparably () to these external data.

SOCIAL DETERMINANTS	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Linguistically Isolated Population (Percent)	10.8	7.4	4.0	
Population in Poverty (Percent)	9.8	12.3	12.6	8.0
Children in Poverty (Percent)	12.7	16.2	17.1	8.0
No High School Diploma (Age 25+, Percent)	25.0	15.8	11.1	
Unemployment Rate (Age 16+, Percent)	5.0 [COUNTY-LEVEL]	3.9	3.3	
Housing Exceeds 30% of Income (Percent)	41.9	40.0	30.3	25.5
		better	similar	worse

OVERALL HEALTH	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
"Fair/Poor" Overall Health (Percent)	20.3	17.3	16.1	
		better	similar	worse

ACCESS TO HEALTH CARE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Uninsured (Adults 18-64, Percent)	9.8	9.8	12.1	7.6
Uninsured (Children 0-18, Percent)	4.1	3.4	5.3	7.6
Routine Checkup in Past Year (Percent)	60.5	63.1	73.6	
Primary Care Doctors per 100,000	104.1 [COUNTY-LEVEL]	81.1	76.4	
		better	similar	worse

CANCER	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Cancer Deaths per 100,000 (Age-Adjusted)	124.9 [COUNTY-LEVEL]	134.5	149.4	122.7
Cancer Incidence per 100,000 (Age-Adjusted)	444.8 [COUNTY-LEVEL]	394.7	442.3	
Female Breast Cancer Incidence per 100,000 (Age-Adjusted)	139.1 [COUNTY-LEVEL]	121.0	127.0	
Prostate Cancer Incidence per 100,000 (Age-Adjusted)	118.5 [COUNTY-LEVEL]	95.4	110.5	
Colorectal Cancer Incidence per 100,000 (Age-Adjusted)	34.9 [COUNTY-LEVEL]	33.5	36.5	
Lung Cancer Incidence per 100,000 (Age-Adjusted)	34.7 [COUNTY-LEVEL]	37.6	54.0	
Breast Cancer Screening in Past 2 Years (Women 50-74, Percent)	71.5	69.6	78.2	80.5
Cervical Cancer Screening in Past 3 Years (Women 21-65, Percent)	81.2	80.7	82.8	84.3
Colorectal Cancer Screening (Age 50-75, Percent)	54.8	61.0	72.4	74.4
		better	similar	worse

DIABETES	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Diabetes Prevalence (Percent)	8.4	9.3	10.1	
		better	similar	worse

DISABLING CONDITIONS	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Disability Prevalence (Percent)	11.9	10.6	12.6	
		better	similar	worse

HEART DISEASE & STROKE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Heart Disease Deaths per 100,000 (Age-Adjusted)	53.7 [COUNTY-LEVEL]	84.6	91.5	127.4
Stroke Deaths per 100,000 (Age-Adjusted)	30.6 [COUNTY-LEVEL]	37.6	37.6	33.4
High Blood Pressure Prevalence (Percent)	27.6	28.5	32.7	42.6
High Blood Cholesterol Prevalence (Percent)	33.7	35.3	36.4	
		better	similar	worse

INFANT HEALTH & FAMILY PLANNING	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
No Prenatal Care in First 6 Months (Percent of Births)	3.1 [COUNTY-LEVEL]	3.7	6.1	
Low Birthweight (Percent of Births)	5.8 [COUNTY-LEVEL]	6.9	8.2	
Infant Deaths per 1,000 Live Births	4.0 [COUNTY-LEVEL]	4.0	5.6	5.0
Teen Births per 1,000 Females 15-19	9.9 [COUNTY-LEVEL]	15.6	19.3	
		better	similar	worse

INJURY & VIOLENCE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Unintentional Injury Deaths per 100,000 (Age-Adjusted)	45.1 [COUNTY-LEVEL]	35.8	50.4	43.2
Motor Vehicle Crash Deaths per 100,000 (Age-Adjusted)	8.5 [COUNTY-LEVEL]	9.9	11.5	10.1

INJURY & VIOLENCE (continued)	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Homicide Deaths per 100,000 (Age-Adjusted)	3.2 [COUNTY-LEVEL]	5.1	6.4	5.5
Violent Crimes per 100,000	403.6 [COUNTY-LEVEL]	440.5	416.0	
		better	similar	worse

MENTAL HEALTH	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Suicide Deaths per 100,000 (Age-Adjusted)	13.9 [COUNTY-LEVEL]	10.5	13.8	12.8
Mental Health Providers per 100,000	171.0	174.7	155.8	
		better	similar	worse

NUTRITION, PHYSICAL ACTIVITY & WEIGHT	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Fast Food Restaurants per 100,000	69.4 [COUNTY-LEVEL]	80.4	75.9	
Population With Low Food Access (Percent)	26.9	13.3	22.2	
No Leisure-Time Physical Activity (Percent)	15.6	19.2	22.0	21.8
Recreation/Fitness Facilities per 100,000	17.7	13.0	11.9	
Obese (Percent)	26.1	26.0	29.0	36.0
		better	similar	worse

ORAL HEALTH	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Dental Visit in Past Year (Percent)	57.5	62.3	64.8	45.0
Dentists per 100,000	32.3	46.7	37.3	
		better	similar	worse

RESPIRATORY DISEASE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Lung Disease Deaths per 100,000 (Age-Adjusted)	20.8 [COUNTY-LEVEL]	30.5	39.1	
COVID-19 Deaths per 100,000	100.6 [COUNTY-LEVEL]	255.7	337.9	
Asthma Prevalence (Percent)	9.8	9.2	9.7	
COPD Prevalence (Percent)	5.7	5.3	6.4	
		better	similar	worse

SEXUAL HEALTH	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
HIV Prevalence per 100,000	214.6 [COUNTY-LEVEL]	406.0	379.7	
Chlamydia Incidence per 100,000	275.2 [COUNTY-LEVEL]	452.2	481.3	
Gonorrhea Incidence per 100,000	78.0 [COUNTY-LEVEL]	198.5	206.5	
		better	similar	worse

SUBSTANCE ABUSE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Excessive Drinking (Percent)	22.4 [COUNTY-LEVEL]	18.4	19.0	
Drug Overdose Deaths per 100,000 (Age-Adjusted)	17.2 [COUNTY-LEVEL]	14.5	22.4	
		better	similar	worse

TOBACCO USE	WCH Service Area	WCH SERVICE AREA vs. BENCHMARKS		
		vs. CA	vs. US	vs. HP2030
Cigarette Smoking (Percent)	13.1	11.1	13.5	6.1
		better	similar	worse

COMMUNITY DESCRIPTION

POPULATION CHARACTERISTICS

Total Population

Total Population
(Estimated Population, 2020)

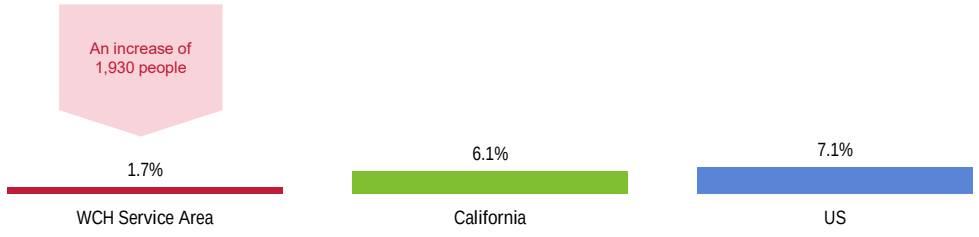
	TOTAL POPULATION	TOTAL LAND AREA (SQUARE MILES)	POPULATION DENSITY (PER SQUARE MILE)
WCH Service Area	117,575	178.16	660
California	39,538,223	155,857.45	254
United States	331,449,281	3,533,018.38	94

Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

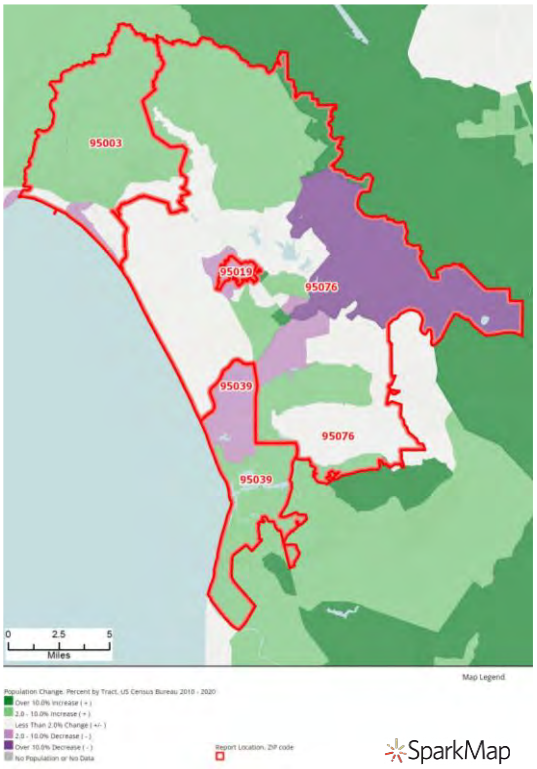
Population Change

A significant positive or negative shift in total population over time impacts health care providers and the

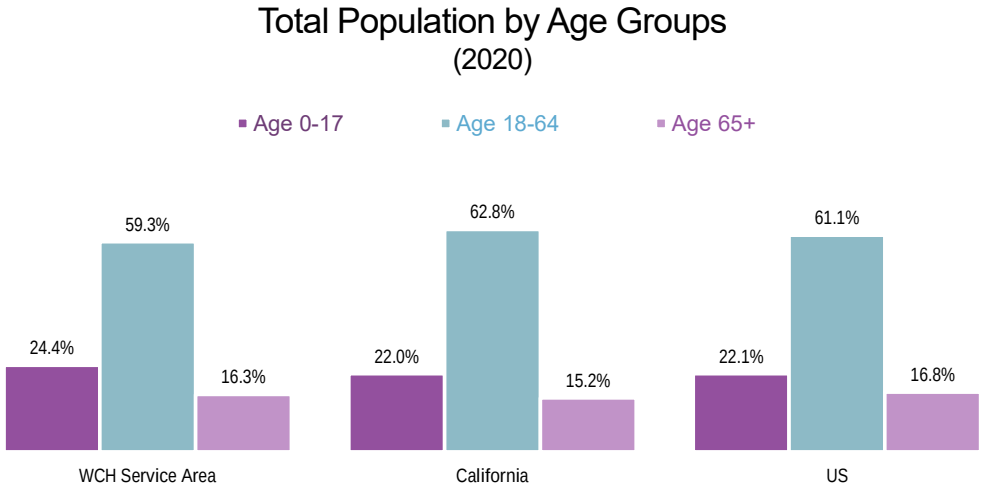
Change in Total Population
(Percentage Change Between 2010 and 2020)



Sources: US Census Bureau Decennial Census (2010-2020).
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

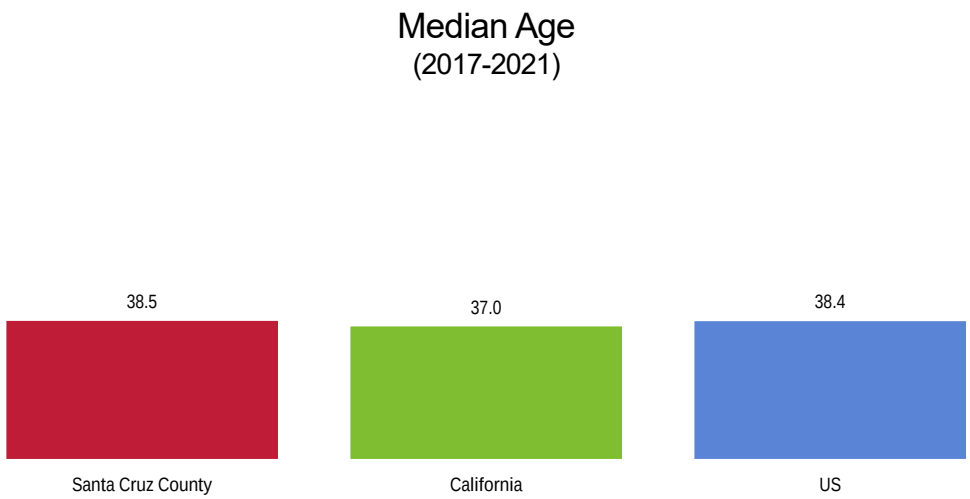


Age

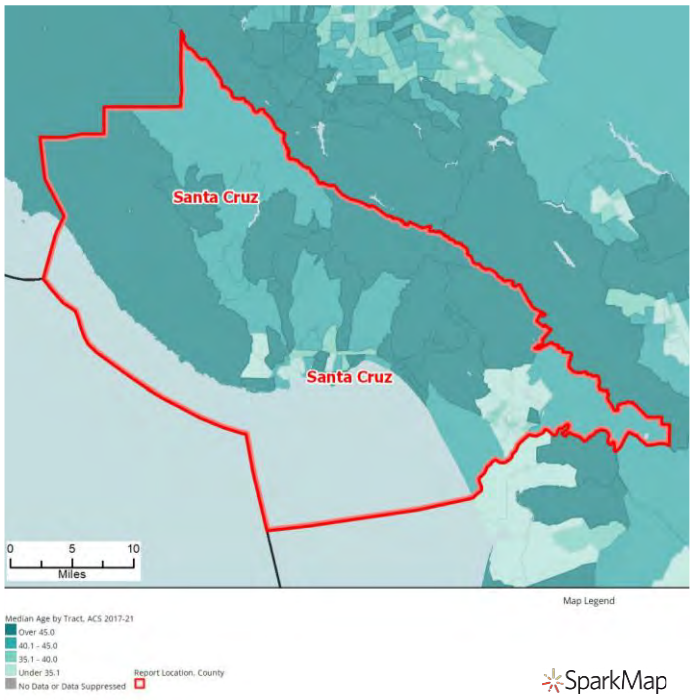


Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

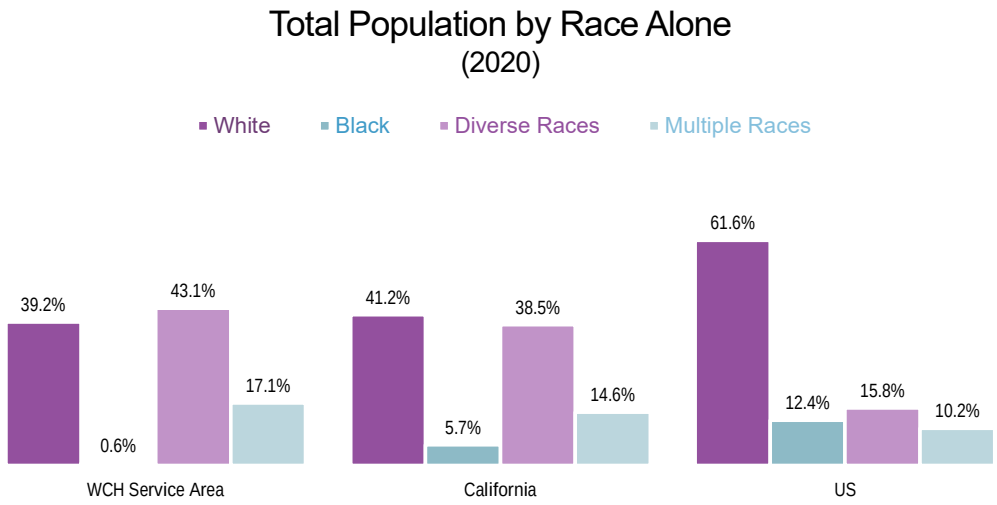
Median Age

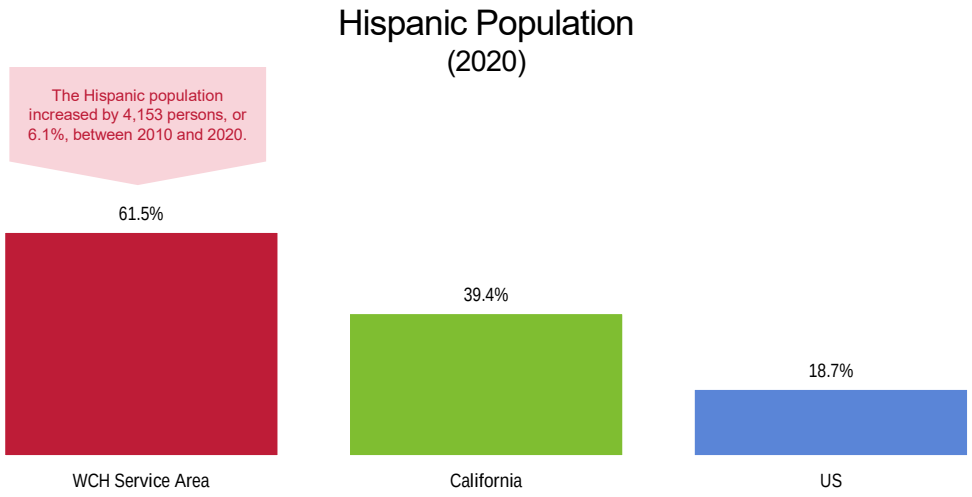


Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).



Race & Ethnicity

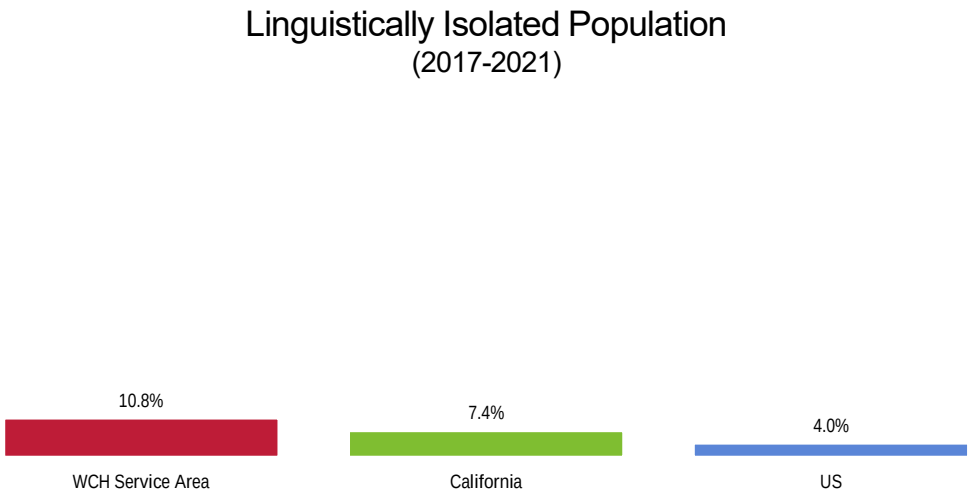




Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: People who identify their origin as Hispanic, Latino, or Spanish may be of any race.

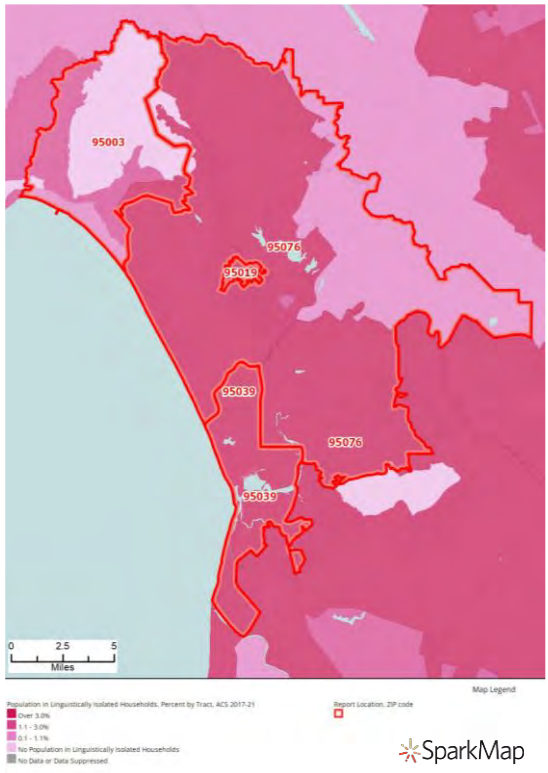
Linguistic Isolation

This indicator reports the percentage of the population age 5 years and older who live in a home in which:



Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes: This indicator reports the percentage of the population age 5+ who live in a home in which no person age 14+ speaks only English, or in which no person age 14+ speak a non-English language and speak English "very well."



SOCIAL DETERMINANTS OF HEALTH

ABOUT SOCIAL DETERMINANTS OF HEALTH

Social determinants of health (SDOH) are the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. Examples of SDOH include:

- Safe housing, transportation, and neighborhoods
- Racism, discrimination, and violence
- Education, job opportunities, and income
- Access to nutritious foods and physical activity opportunities
- Polluted air and water
- Language and literacy skills

SDOH also contribute to wide health disparities and inequities. For example, people who don't have access to grocery stores with healthy foods are less likely to have good nutrition. That raises their risk of health conditions like heart disease, diabetes, and obesity — and even lowers life expectancy relative to people who do have access to healthy foods.

Just promoting healthy choices won't eliminate these and other health disparities. Instead, public health organizations and their partners in sectors like education, transportation, and housing need to take action to improve the conditions in people's environments.

– Healthy People 2030 (https://health.gov/healthypeople)

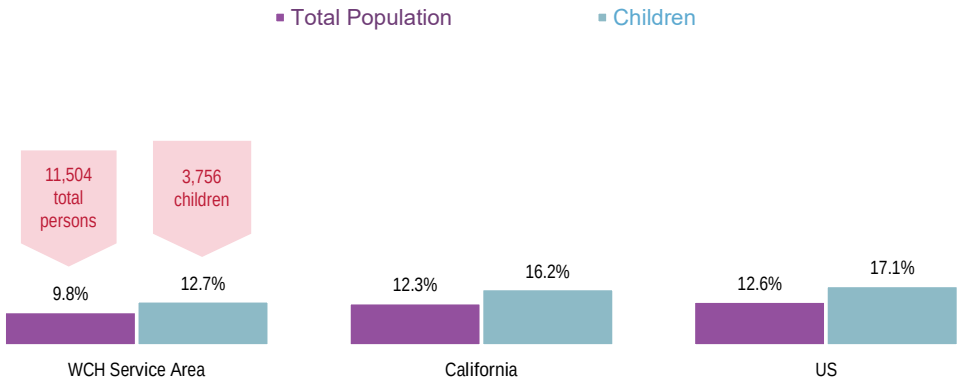
Poverty

Poverty is considered a key driver of health status. This indicator is relevant because poverty creates barriers to accessing health services, healthy food, and other necessities that contribute to health status. The following chart and maps outline the proportion of our population below the federal poverty threshold, as well as the percentage of children in the WCH Service Area living in poverty, in comparison to state and national proportions.

Percent of Population in Poverty

(2017-2021)

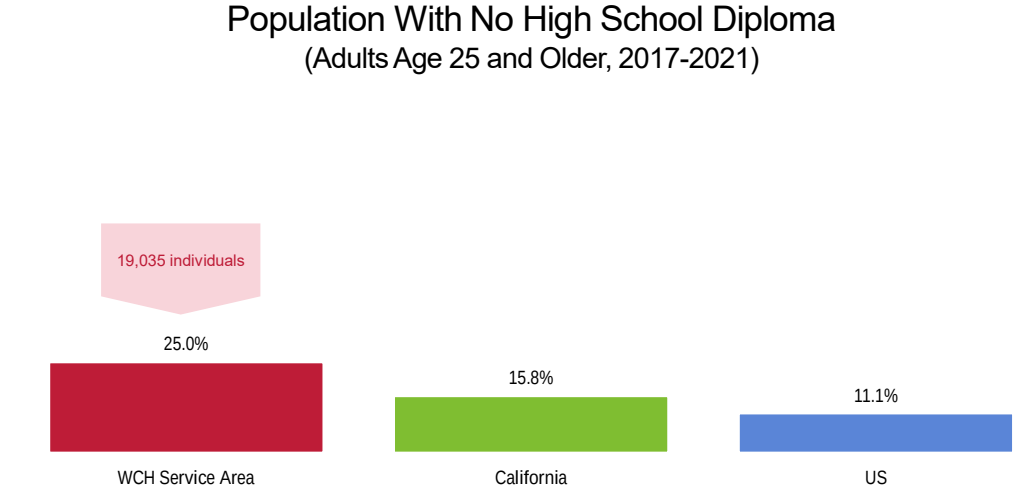
Healthy People 2030 = 8.0% or Lower



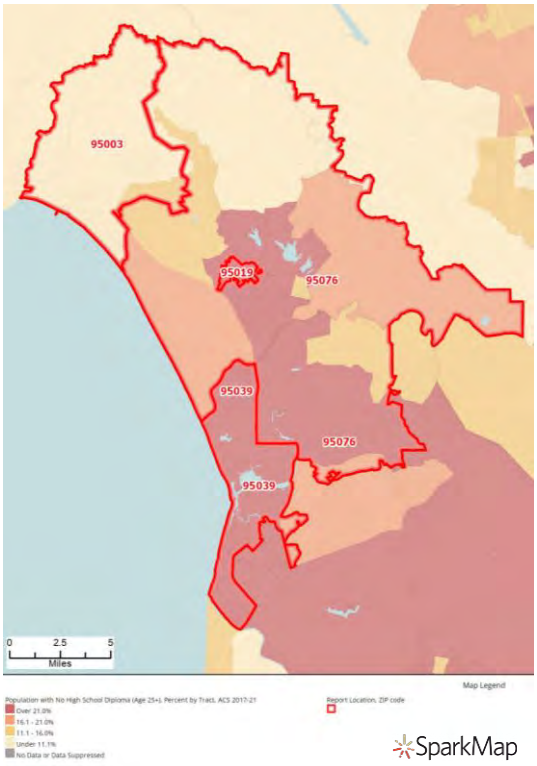
Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Education

Education levels are reflected in the proportion of our population age 25 and older without a high school

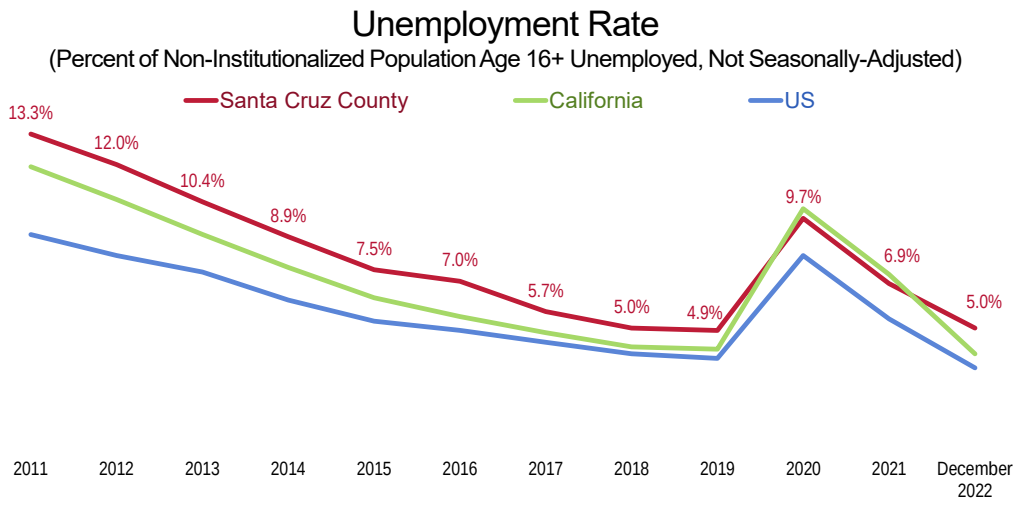


Sources: US Census Bureau American Community Survey 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).



Employment

Changes in unemployment rates in Santa Cruz County over the past several years are outlined in the



Sources: US Department of Labor, Bureau of Labor Statistics.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Housing Burden

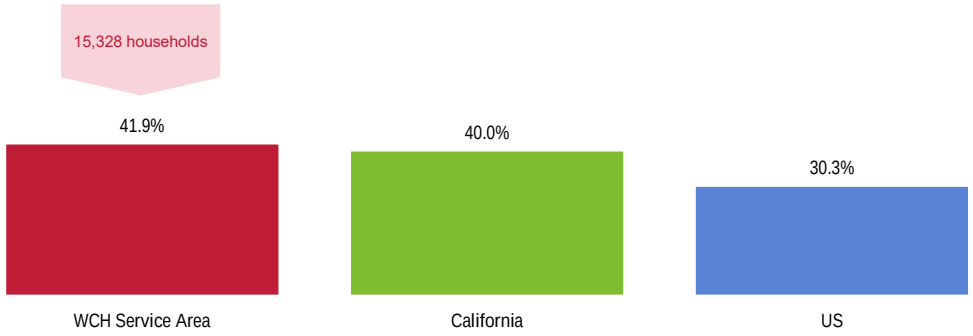
"Housing burden" reports the percentage of the households where housing costs (rent or mortgage costs) exceed 30% of total household income.

The following chart shows the housing burden in the WCH Service Area. This serves as a measure of housing affordability and excessive shelter costs. The data also serve to aid in the development of housing

Housing Costs Exceed 30 Percent of Household Income

(Percent of Households; 2017-2021)

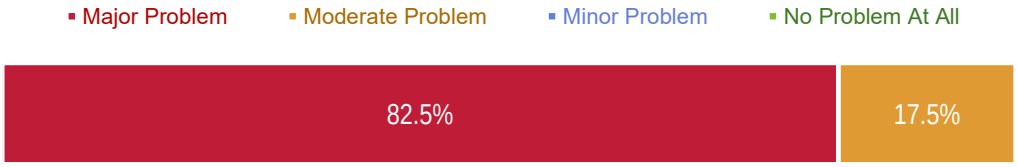
Healthy People 2030 Target = 25.5% or Lower



Sources: US Census Bureau, American Community Survey, 5-year estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Perceptions of Social Determinants of Health as a Problem in the Community

(Key Informants; WCH Service Area, 2023)



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Housing

> Housing and income disparities. – Social Services Provider
>
> Lack of housing for homeless population, lack of support from community leaders, TOO MUCH STIGMA. – Other Health Provider
>
> Housing costs, homelessness, poverty. – Other Health Provider
>
> Not enough housing or shelter beds for individuals who are without. – Other Health Provider
>
> Housing is a big problem in CA but especially for South County. If you do not have a home, how do you have health. Education services are limited at Cabrillo, and UCSC does not provide services in South County. – Community Leader
>
> High cost of housing in our area, storm damage in Watsonville and Pajaro, fears of accessing services due to immigration status. – Community Leader
>
> Massive lack of affordable housing. Very low wages in the ag industry. Systemic racism. – Community Leader
>
> There is little affordable housing options, which leads multiple families living in households together. – Social Services Provider
>
> High cost of living in economy driven by ag with seasonal work. – Other Health Provider
>
> There is serious inequity between socioeconomic groups in our community. It is clear that people cannot attend to their health properly if they are unhoused, hungry, facing eviction, have inadequate transportation, or live in an environment filled with toxic chemicals. I am optimistic that CalAIM/Enhanced Care Management may be able to address some of these issues for people in the Medi-Cal system with the most complex medical situations, but the general inequity is a much more stubborn issue, especially related to housing costs and severely limited affordable housing. – Community Leader
>
> Housing costs (from the generations of political refusal to prioritize building housing and the re-use of entry level housing stock for 2nd homes and vacation rentals), the federal designation that 95076 and surrounding zips are rural (thereby lowering federal reimbursement rates), the reduction of services over two decades within the Watsonville Community Hospital from corporate for-profit leadership. – Community Leader

Income/Poverty

> Income and work drive a lot of our patients’ decisions when seeking treatments that may cost more money or will require them to miss work for a period of time. – Physician
>
> Low-income population. – Community Leader
>
> Residents in South County tend to be of lower income, live in overcrowded housing, and don't have equitable access to green space and recreation facilities. – Public Health Representative
>
> Majority of patients I see are living in poverty and experience some type of SDOH. – Physician

Impact on Health

> According to all of these metrics, Watsonville has been identified as one of the least "healthiest" communities in the state of California. These social determinants of health have a massive impact on the success of people in South Santa Cruz County and the progress in our community because our residents cannot focus on anything else other than surviving. – Community Leader
>
> SDH are the main determinant of morbidity, mortality and quality of life in our under-served communities. Elected officials need to take responsibility for addressing the SDH, which when properly addressed, can improve the health and well-being of our HPI quartile 1 and 2 communities. – Public Health Representative
>
> South County is disproportionately impacted by social determinants. – Physician

Homelessness

> Huge issue here. Homelessness. Food desert. Poor health literacy. Pesticides. – Physician
>
> Health disparities are worse in Watsonville. Homelessness is a big issue statewide, and Watsonville is no exception. We faired poorer in the pandemic with COVID-19 deaths (the number one cause of death in South County), and eviction increased. South County also suffered through the floods, which were devasting. – Public Health Representative Access to Care/Services
>
> Accessing care, specialist care can take months to access. – Other Health Provider

Built Environment

> The Social Determinants are predictors of health. The built environment contributes and/or limits to the health of the community. As an example, we don't have enough housing, and there is no real focus on building wealth anymore. We keep talking about rental housing but not wealth building. Educational and certificated outcomes post-high school need improvement. – Community Leader
>
> Safe infrastructure. The recent Pajaro flood, with the levees breaking, is a prime example. Everyone has known for years that those levees were in imminent danger of collapsing. But nobody took action to prevent the disaster. This would have never happened with the levees in Los Gatos, for example. The lives of the poor brown people are not valued the way those of wealthy white people in other areas of the county. There's systemic racism in this country, and our county is sadly a heightened example of this injustices of our nation. We rely on farmworkers for the food we need to survive. They are truly essential workers. But we have a system in place that allows their continued exploitation by agricultural companies, landlords, and other elites in the area. Our county government doesn't invest in the areas where these communities live. It's disgraceful. – Community Leader

Racism

> Systemic racism and underinvestment in South County because it breeds inequity and lack of opportunity for our young people. – Other Health Provider
>
> The underlying historical racism plays a major factor in ZIP codes determining life span, adverse childhood experiences, and social determinants of health. Lack of quality resources (i.e. it is vital for the local hospital to have efficient technology and equipment). – Community Leader

Vulnerable Populations

> Because this region is a major food production area, with a large population of migrant farmworker families, where there are significant levels of exploitation, limited services, and limited investment in health and other services. Many migrant families have limited knowledge of their rights and awareness of the limited social services available to them. They live in fear of having their families separated and being deported. And powerful agricultural companies have significant influence over elected officials and legislation. – Community Leader

Access to Care/Services

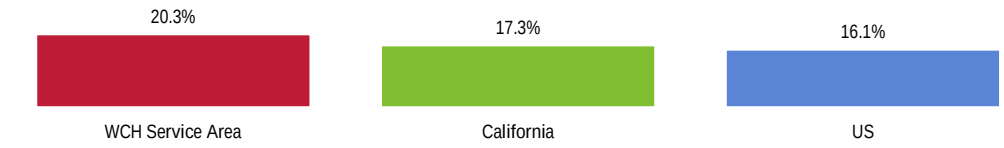
> Accessing care, specialist care can take months to access – Other Health Provider

HEALTH STATUS

OVERALL HEALTH STATUS

The CDC's Behavioral Risk Factor Survey, from which these data are derived, asked respondents:

"Would you say that in general your health is: excellent, very good, good, fair, or poor?"



Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

MENTAL HEALTH

ABOUT MENTAL HEALTH & MENTAL DISORDERS

About half of all people in the United States will be diagnosed with a mental disorder at some point in their lifetime. …Mental disorders affect people of all age and racial/ethnic groups, but some populations are disproportionately affected. And estimates suggest that only half of all people with mental disorders get the treatment they need.

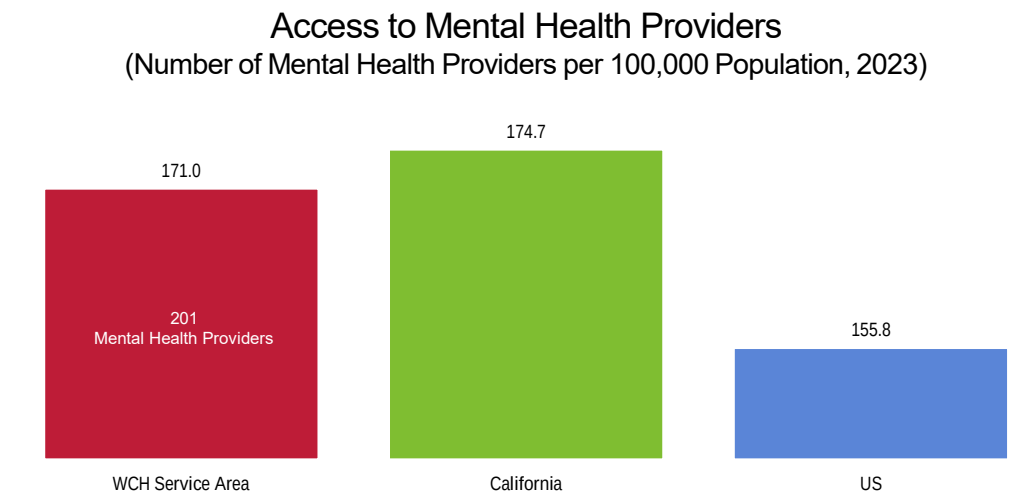
In addition, mental health and physical health are closely connected. Mental disorders like depression and anxiety can affect people's ability to take part in healthy behaviors. Similarly, physical health problems can make it harder for people to get treatment for mental disorders. Increasing screening for mental disorders can help people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Mental Health Providers

Here, "mental health providers" includes psychiatrists, psychologists, clinical social workers, and counselors who specialize in mental health care.

Note that this indicator only reflects providers practicing in the WCH Service Area and residents in the WCH Service Area; it does not account for the potential demand for services from outside the area, nor the potential availability of providers in surrounding areas.

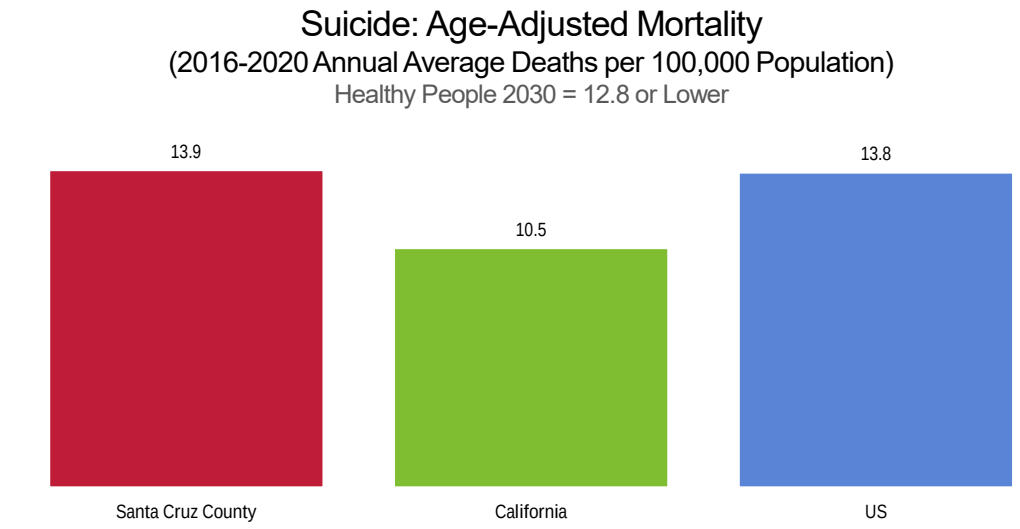


Sources: Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes: This indicator reports the rate of the county population to the number of mental health providers including psychiatrists, psychologists, clinical social workers, and counsellors that specialize in mental health care.

Suicide

The following reports the rate of death in Santa Cruz County due to intentional self-harm (suicide) in comparison to statewide and national rates. Here, these rates are age-adjusted to account for age



Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

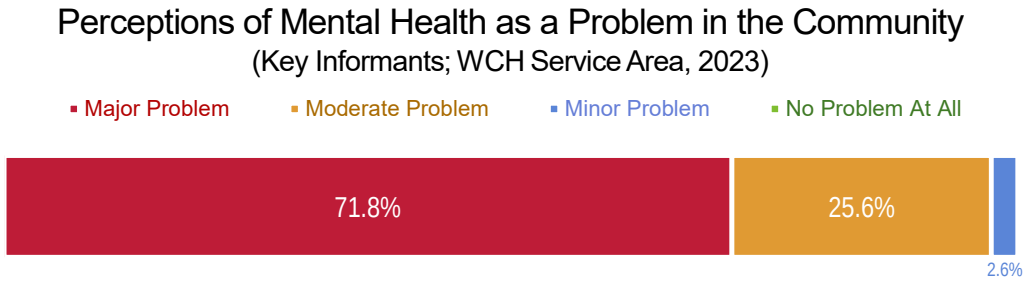
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

AGE-ADJUSTED DEATH RATES

In order to compare mortality in the region with other localities (in this case, California and the United States), it is necessary to look at rates of death — these are figures which represent the number of deaths in relation to the population size (such as deaths per 100,000 population, as is used here).

Furthermore, in order to compare localities without undue bias toward younger or older populations, the common convention is to adjust the data to some common baseline age distribution. Use of these “age-adjusted” rates provides the most valuable means of gauging mortality against benchmark data, as well as Healthy People 2030 objectives.

Note that deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10). Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

No mild to moderate mental health services. No long-term mental health location for patients, except in San Jose or San Francisco. – Community Leader

Although more providers are screening for mental health disorders, autism and developmental delay, individuals that are referred for further evaluation, diagnosis and treatment can wait months or years before being seen, even when health care providers contact mental health services providers and the managed care plans repeatedly regarding the referral. – Public Health Representative

Lack of services and stigma that comes with it. – Other Health Provider

Access to psychiatrists, access to counseling. Also, there is a great amount of stress in the patients I see related to basic needs like food, housing, employment that impact mental health by worsening or exacerbating existing conditions. I also see many kids who are not succeeding in school academically and have no normal outlets for fun like sports or other after-school activities because families can't afford or don't have time to get kids there; as a result, I see kids come home from school or spend entire summer/winter vacations lying around their house instead of doing developmentally appropriate activities to engage and provide fun. This also can worsen/exacerbate existing or predisposing conditions. finally, there is also a lot of familial strife that i see- divorce, substance abuse, immigration issues, teen pregnancies, etc. that also contribute to mental health concerns. – Physician

Lack of available resources such as outpatient and inpatient programs. – Other Health Provider

Psychiatric inpatients beds, children's crisis stabilization unit, housing and substance use. – Other Health Provider

Access to care in a timely manner. – Other Health Provider

Not enough of anything, physical centers for adults and youth in crises. Providers trained to support mental health within schools, community and within health care systems. Changing societal interaction and social media. – Community Leader

Significantly limited availability of resources. – Physician

It is often difficult to access mental health services – not enough providers in the community. Many people with mental health issues are unhoused and difficult to engage precisely because of their mental health issues, further contributing to homelessness issues. Also, mental health issues of older adults are often undiagnosed, misdiagnosed, and untreated. – Community Leader

Incidence/Prevalence

Increased volume. – Community Leader

Mental health has been declining since even before the pandemic. Loneliness and depression are big factors and social media is contributing. – Public Health Representative

High rates of anxiety and depression. – Physician

Lack of Providers

> Lack of physicians. – Other Health Provider
>
> Not enough providers with clinical training and expertise. – Social Services Provider

Culturally Relevant Information

> Culturally relevant information that de-stigmatizes mental health; lack of value in cultural best practices to address mental health; ignoring the toll that financial hardships and fear that people are dealing with; responding to those that speak up about mental health with "pull yourself up by the boot straps"; lack of empathy and concern the depth that racism has with mental health. – Community Leader

Disease Management

> It doesn't exist. People are self-treating. – Physician

Follow Up/Support

> Lack of ongoing continuum of care to support individuals on a recovery path. The county has only 38 residential mental health beds that are not locked/inpatient units. There are extremely limited partial hospitalization or intensive outpatient services to support people in the community. There is insufficient appropriate housing for people experiencing homelessness and mental illness, and stigma and NIMBYism prevent development of more, even if funds are available. And there is a workforce challenge that adversely impacts the services that do exist. – Public Health Representative

Income/Poverty

> I think the biggest challenges are multi-faceted and tie into low income, and lack of time to model well-being and overall health. – Community Leader

Language Barrier

> Depression and anxiety. Lack of bilingual behavioral health providers. – Other Health Provider

Prevention/Screenings

> Prevention services and lack of licensed staff to serve their needs. – Public Health Representative

Social Norms/Community Attitude

> The cultural norms in our largely Latino community discourage asking for help and knowing what depression and other mental health issues feel like and are. Also, the availability of service providers for older adults and other vulnerable populations. – Community Leader

DEATH, DISEASE & CHRONIC CONDITIONS

CARDIOVASCULAR DISEASE

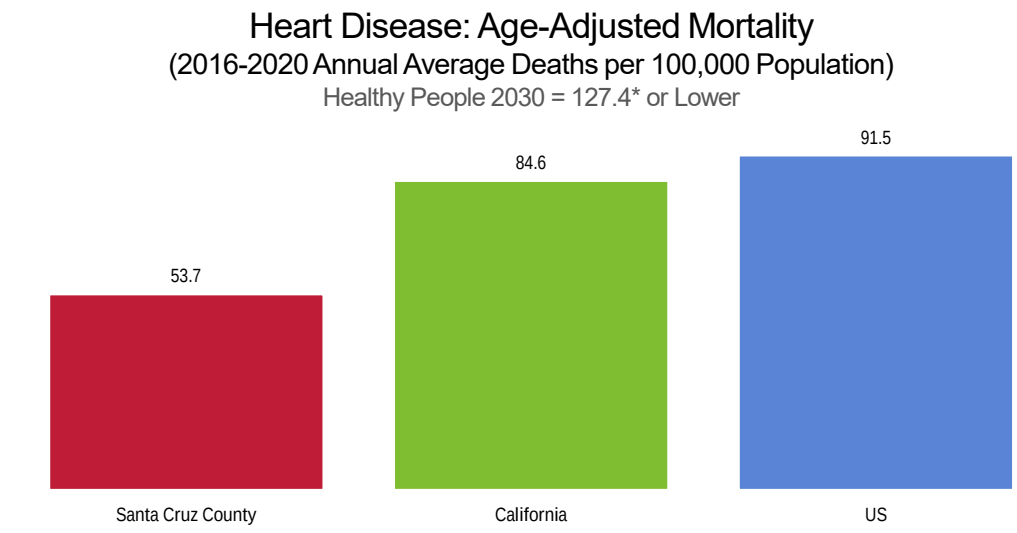
ABOUT HEART DISEASE & STROKE

Heart disease and stroke can result in poor quality of life, disability, and death. Though both diseases are common, they can often be prevented by controlling risk factors like high blood pressure and high cholesterol through treatment.

In addition, making sure people who experience a cardiovascular emergency — like stroke, heart attack, or cardiac arrest — get timely recommended treatment can reduce their risk for long-term disability and death. Teaching people to recognize symptoms is key to helping more people get the treatment they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Heart Disease Deaths

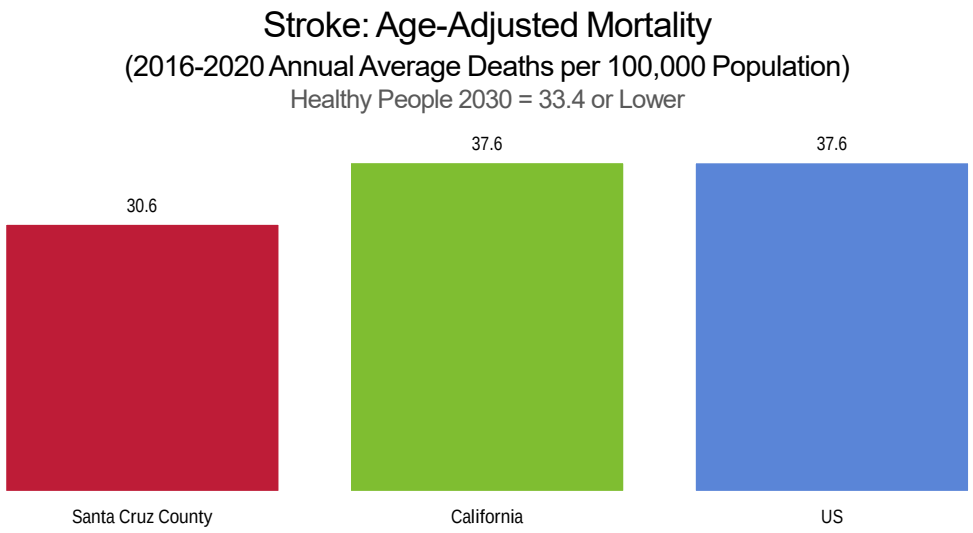


Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.
*The Healthy People 2030 objective for coronary heart disease has been adjusted here to account for all diseases of the heart.

Stroke Deaths

Stroke, a leading cause of death in Santa Cruz County and throughout the nation, shares many of the same



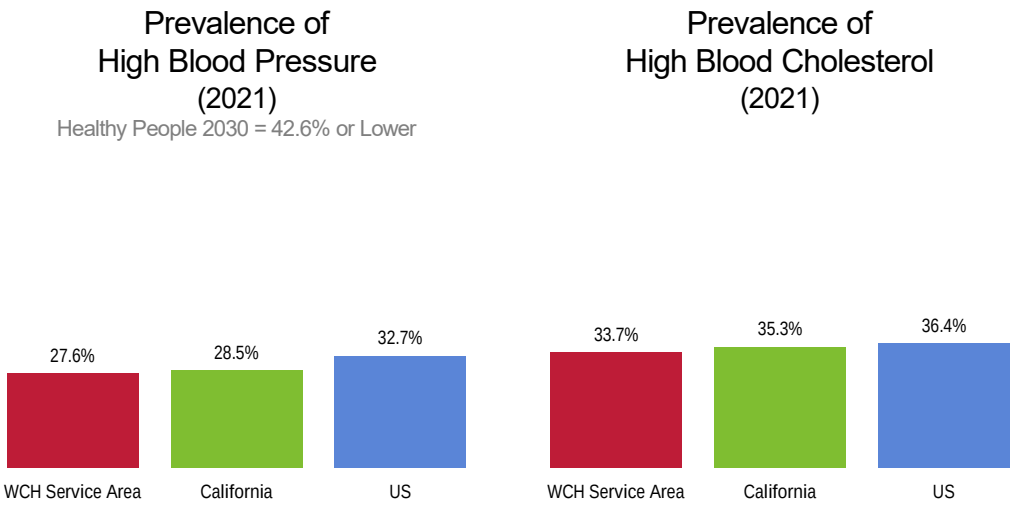
Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Blood Pressure & Cholesterol

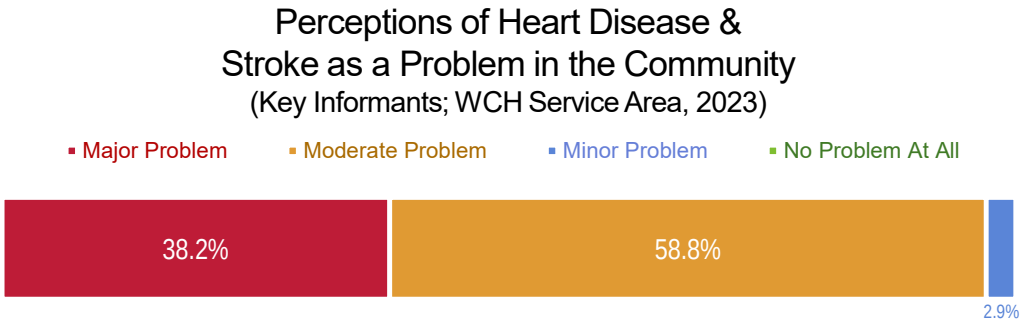
The CDC's Behavioral Risk Factor Survey asked:

"Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?"

"Have you ever been told by a doctor, nurse, or other health professional that your cholesterol is high?"



Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Lifestyle

> Eating and exercise absence. – Community Leader
>
> Poor diet, lack of exercise, alcohol and unsafe neighborhoods. – Other Health Provider
>
> Poor nutrition, low activity levels, smoking and alcohol and drug use. – Other Health Provider

Access to Care/Services

> Complex heart and medical, access to specialty care and services. – Social Services Provider
>
> No cardiology service at WCH, yet you're planning a cath lab. We can't even get a consultation. – Physician
>
> There is no STEMI center in Watsonville. Need specialists like cardiologist and interventional cardiologist. Also need Latino doctors to treat the community. – Public Health Representative

Incidence/Prevalence

> The majority of people who attend our program have some kind of heart disease and/or have experienced strokes. The prevalence of heart disease appears to be very high locally. – Community Leader
>
> Population health assessment. – Other Health Provider

Aging Population

> We have an aging community that is susceptible to heart disease and stroke because of cultural norms around exercise and nutrition. – Community Leader

Co-Occurrences

> Diabetes raises the risk for cardiovascular disease and stroke. – Community Leader

Disease Management

> Although health care providers at FQHCs provide evidence based, best practice treatment recommendations to patients to control blood pressure, cholesterol and prediabetes/diabetes, there is still reluctance among some patients at increased risk for heart disease and stroke to follow health care provider recommendations for treatment, even when Medi-Cal covers the cost of these treatments. Communities in the 1st and 2nd HPI quartiles lack the time, money and immediate access to safe places to be physically active, resulting in sedentary lifestyles and increased risk of heart disease and stress. – Public Health Representative

Lack of Providers

> Fewer cardiologists and neurologists in the area affect access. Lower income or rural geography affect access to healthier food, transportation, and assistance at home. – Physician

CANCER

ABOUT CANCER

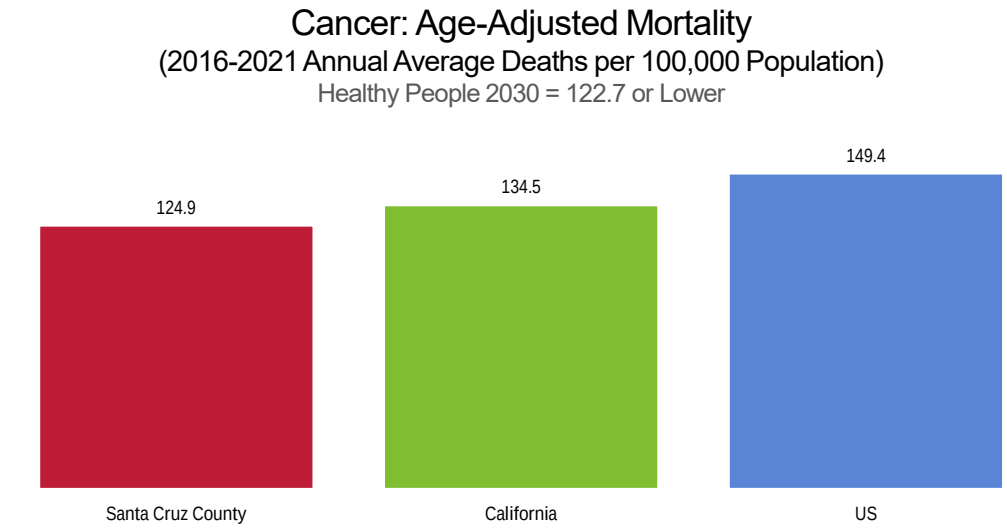
Cancer is the second leading cause of death in the United States. …The cancer death rate has declined in recent decades, but over 600,000 people still die from cancer each year in the United States. Death rates are higher for some cancers and in some racial/ethnic minority groups. These disparities are often linked to social determinants of health, including education, economic status, and access to health care.

Interventions to promote evidence-based cancer screenings — such as screenings for lung, breast, cervical, and colorectal cancer — can help reduce cancer deaths. Other effective prevention strategies include programs that increase HPV vaccine use, prevent tobacco use and promote quitting, and promote healthy eating and physical activity. In addition, effective targeted therapies and personalized treatment are key to helping people with cancer live longer.

– Healthy People 2030 (https://health.gov/healthypeople)

Age-Adjusted Cancer Deaths

Cancer is a leading cause of death in Santa Cruz County and throughout the United States. Age-adjusted

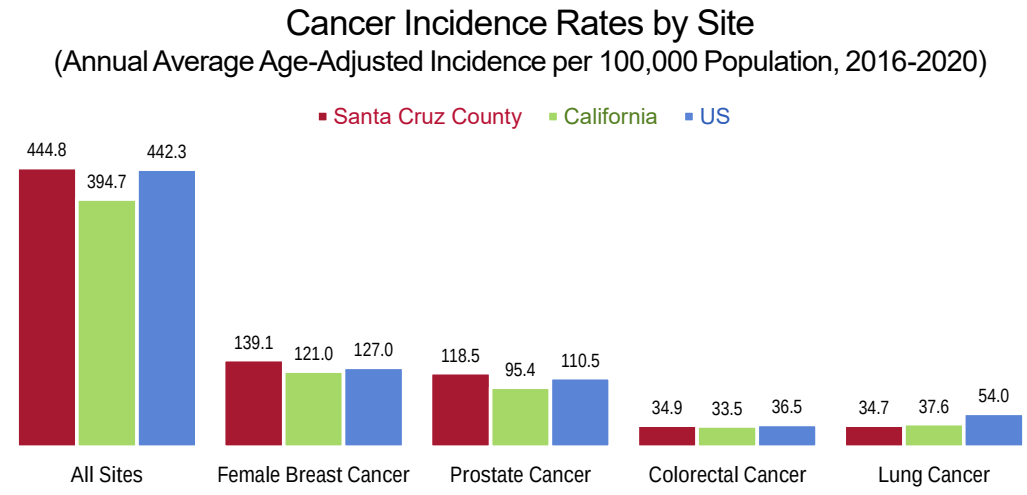


Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Cancer Incidence

"Incidence rate" or "case rate" is the number of newly diagnosed cases in a given population in a given year, regardless of outcome. These rates are also age-adjusted. It is usually expressed as cases per 100,000 population per year.



Sources: State Cancer Profiles.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes: This indicator reports the age adjusted incidence rate (cases per 100,000 population per year) of cancers, adjusted to 2000 US standard population age groups (under age 1, 1-4, 5-9, ..., 80-84, 85 and older).

Cancer Screenings

FEMALE BREAST CANCER

The US Preventive Services Task Force (USPSTF) recommends biennial screening mammography for women age 50 to 74 years.

CERVICAL CANCER

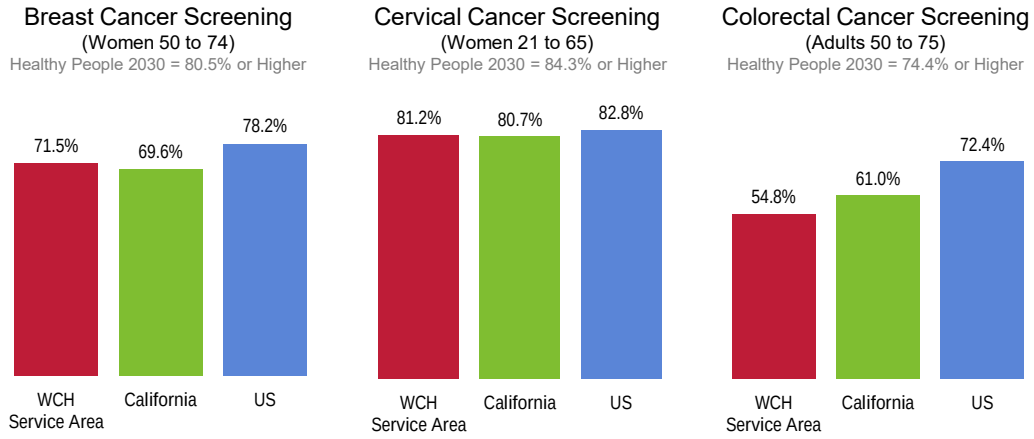
The US Preventive Services Task Force (USPSTF) recommends screening for cervical cancer every 3 years with cervical cytology alone in women age 21 to 29 years. For women age 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting). The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (i.e., cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer.

COLORECTAL CANCER

The US Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.

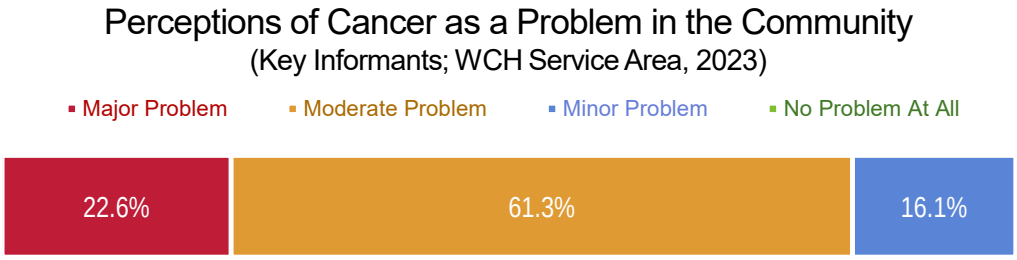
– US Preventive Services Task Force, Agency for Healthcare Research and Quality, US Department of Health & Human Services

Note that other organizations (e.g., American Cancer Society, American Academy of Family Physicians, American College of Physicians, National Cancer Institute) may have slightly different screening guidelines.



Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: Each indicator is shown among the age group specified. Breast cancer screenings are mammograms among females age 50-74 in the past 2 years. Cervical cancer screenings are Pap smears among women 21-65 in the past 3 years. Colorectal cancer screenings include the percentage of population age 50-75 years who report having had 1) a fecal occult blood test (FOBT) within the past year, 2) a sigmoidoscopy within the past 5 years and a FOBT within the past 3 years, or 3) a colonoscopy within the past 10 years.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Only access is in North County, which is already very impacted. – Other Health Provider
>
> No availability in South County. – Physician
>
> No hematology oncology access at all at Watsonville. Yet asked to admit these patients. – Physician
>
> Most oncology services are not readily available in South County. – Other Health Provider

Environmental Contributors

> We are surrounded by agriculture and pesticides are used. – Social Services Provider
>
> Cancer rates in the Pajaro Valley, especially among youth, are disproportionately high because of various reasons, including the use of harmful pesticides in the agriculture industry that is very prevalent in the region. – Community Leader

Vulnerable Populations

> The exploitation of migrant farmworkers is a significant issue in South County. Among this meta-issue, farmworkers and their families are regularly exposed to high levels of dangerous pesticides, and as a result cancer rates in the area are far higher than national averages, particularly among infants and children. Many infants are born with health conditions and defects due to the contaminated environment they live in, including cancer and conditions that develop into cancer. This is further exacerbated by the poorer levels of health care many immigrant farmworker families have access to. This is one of the biggest, dirty secrets to the agricultural sector, and because south Santa Cruz County and north Monterey County produce a significant amount of the nation's food, this issue, including the resultant cancer rates and less than adequate treatment options and quality of care available to the farmworkers in the area, deserves a lot of attention. The status quo is downright shameful. – Community Leader

RESPIRATORY DISEASE

ABOUT RESPIRATORY DISEASE

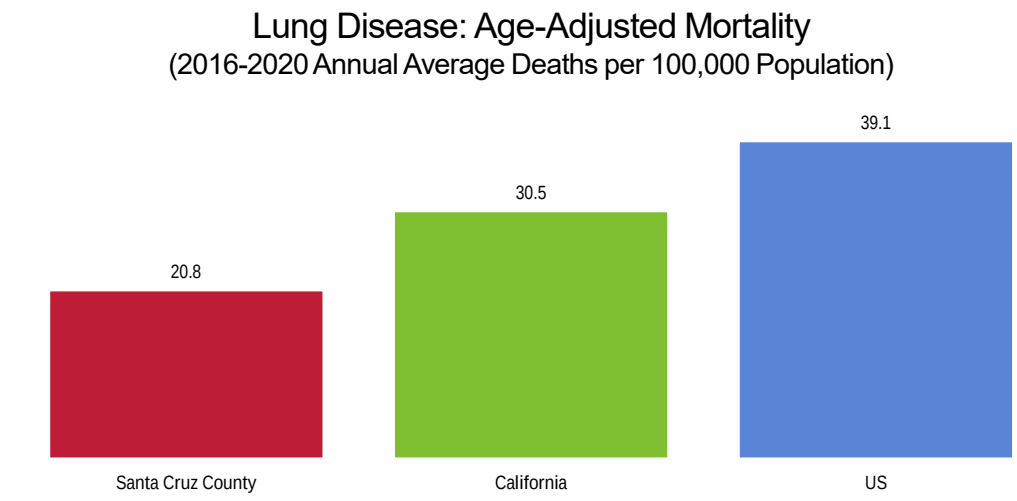
Respiratory diseases affect millions of people in the United States. …More than 25 million people in the United States have asthma. Strategies to reduce environmental triggers and make sure people get the right medications can help prevent hospital visits for asthma. In addition, more than 16 million people in the United States have COPD (chronic obstructive pulmonary disease), which is a major cause of death. Strategies to prevent the disease — like reducing air pollution and helping people quit smoking — are key to reducing deaths from COPD.

– Healthy People 2030 (https://health.gov/healthypeople)

Note that this section also includes data relative to COVID-19 (coronavirus disease).

Lung Disease Deaths

Note: Here, lung disease reflects chronic lower respiratory disease deaths and includes conditions such as emphysema, chronic bronchitis, and asthma.



Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
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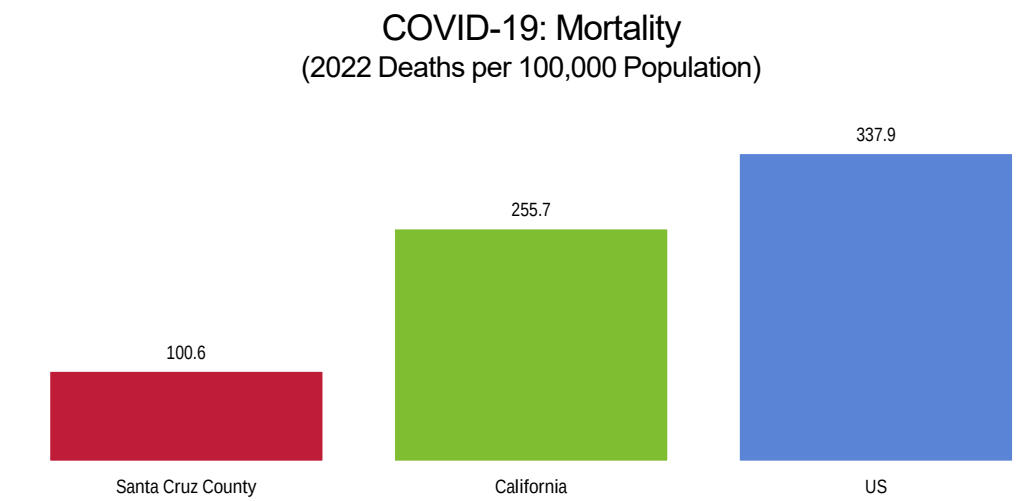
COVID-19 (Coronavirus Disease) Deaths



Sources: Johns Hopkins University. Accessed via ESRI. Additional data analysis by CARES. 2022.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population.

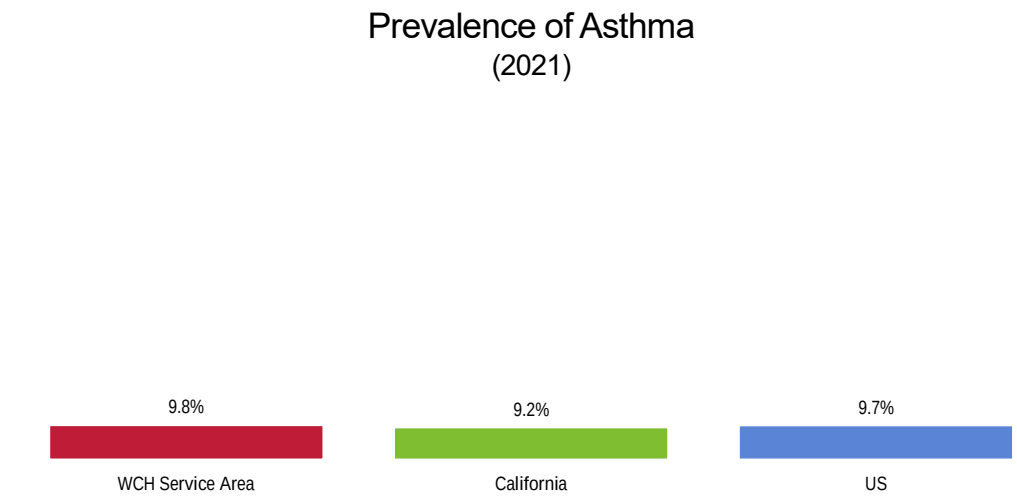
Asthma Prevalence

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had asthma?"

"Do you still have asthma?"

Prevalence includes those responding "yes" to both.



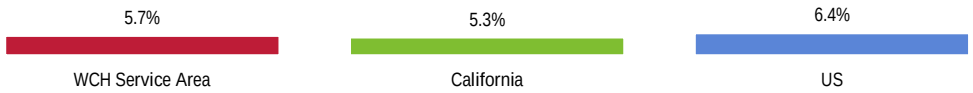
Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: Includes those who have ever been diagnosed with asthma and report that they still have asthma.

COPD Prevalence

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

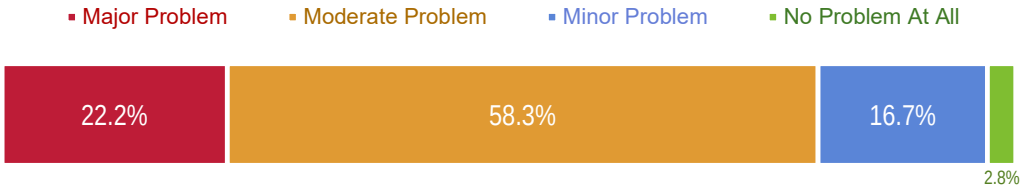
"Has a doctor, nurse, or other health professional ever told you that you had COPD (chronic obstructive pulmonary disease), emphysema, or chronic bronchitis?"

Prevalence of Chronic Obstructive Pulmonary Disease (COPD)
(2021)



Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: Includes those who have ever been diagnosed with chronic obstructive pulmonary disease (COPD), including emphysema and chronic bronchitis.

Perceptions of Respiratory Diseases as a Problem in the Community
(Key Informants; WCH Service Area, 2023)



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Housing

> Families live in crowded houses or attend day care and are exposed to a lot. Many parents don't/cant take off work, so kids with mild illness go to school and day care and spread it to others. Families not always knowledgeable on what to look out for, so mild illness can worsen before they decide to seek medical care. – Physician
>
> High rates due to multifamily housing, insufficient housing. – Physician

Access to Vaccines

> COVID, RSV and flu are rising. We need to increase community's vaccination rate and access to COVID and flu therapeutics. – Public Health Representative

Environmental Contributors

> I am not positive, but it seems that we may have some contamination due to pesticides. – Social Services Provider

Incidence/Prevalence

> Death and illness. – Other Health Provider

INJURY & VIOLENCE

ABOUT INJURY & VIOLENCE

INJURY ► In the United States, unintentional injuries are the leading cause of death in children, adolescents, and adults younger than 45 years. …Many unintentional injuries are caused by motor vehicle crashes and falls, and many intentional injuries involve gun violence and physical assaults. Interventions to prevent different types of injuries are key to keeping people safe in their homes, workplaces, and communities.

Drug overdoses are now the leading cause of injury deaths in the United States, and most overdoses involve opioids. Interventions to change health care providers' prescribing behaviors, distribute naloxone to reverse overdoses, and provide medications for addiction treatment for people with opioid use disorder can help reduce overdose deaths involving opioids.

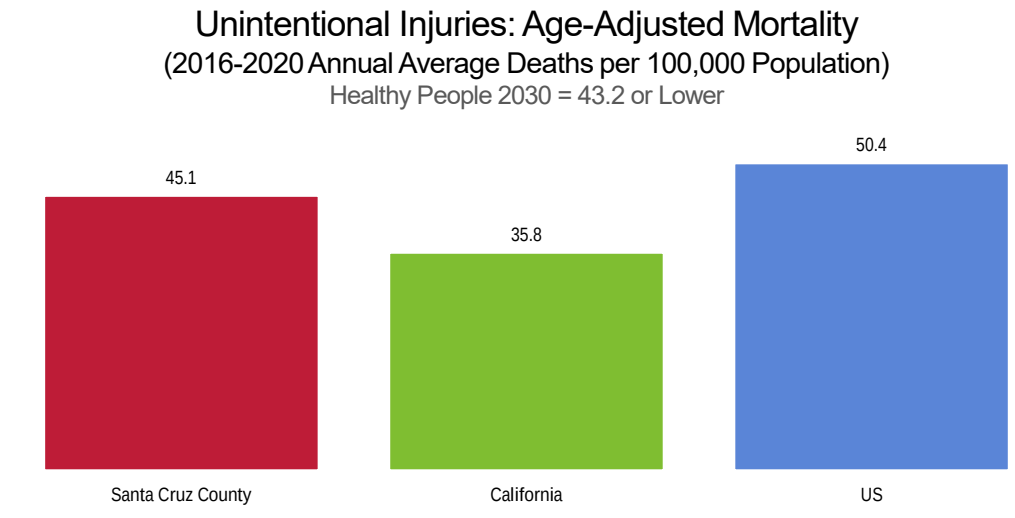
VIOLENCE ► Almost 20,000 people die from homicide every year in the United States, and many more people are injured by violence. …Many people in the United States experience physical assaults, sexual violence, and gun-related injuries. Adolescents are especially at risk for experiencing violence. Interventions to reduce violence are needed to keep people safe in their homes, schools, workplaces, and communities.

Children who experience violence are at risk for long-term physical, behavioral, and mental health problems. Strategies to protect children from violence can help improve their health and well-being later in life.

– Healthy People 2030 (https://health.gov/healthypeople)

Unintentional Injury

Age-Adjusted Unintentional Injury Deaths



Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
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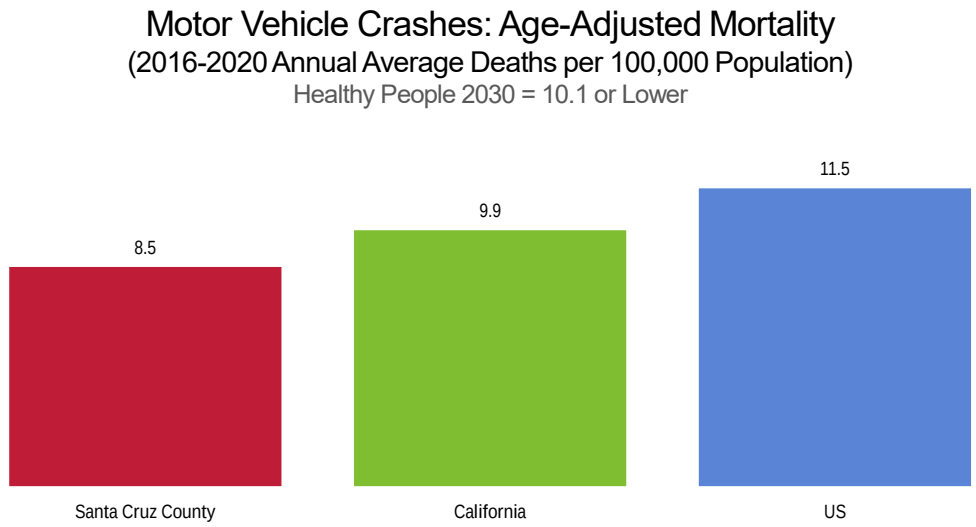
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Age-Adjusted Motor Vehicle Crash Deaths



Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
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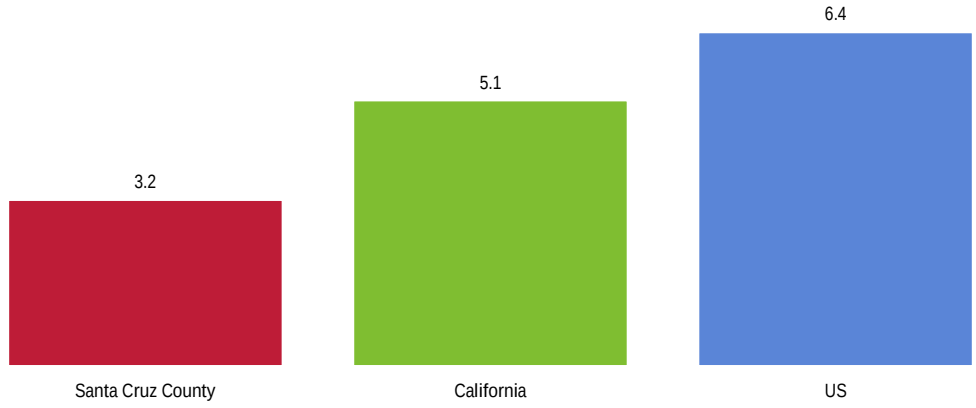
Intentional Injury (Violence)

Age-Adjusted Homicide Deaths

RELATED ISSUE
See also *Mental Health (Suicide)* in the **General Health Status** section of this report.



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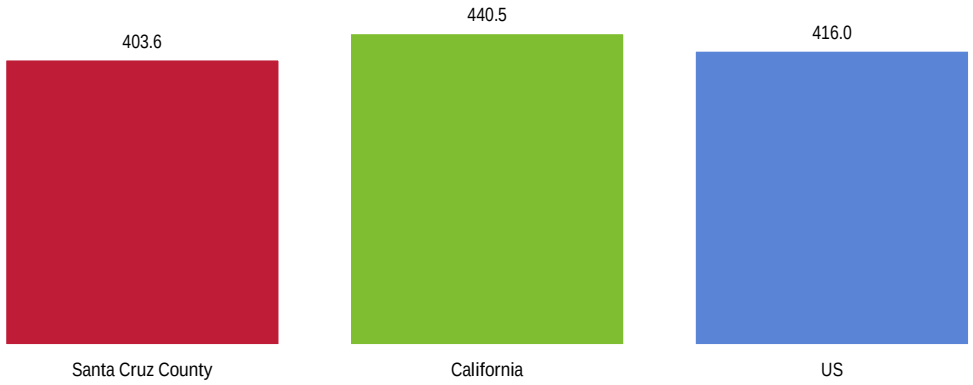
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.

Violent crime is composed of four offenses (FBI Index offenses): murder and non-negligent manslaughter; forcible rape; robbery; and aggravated assault.

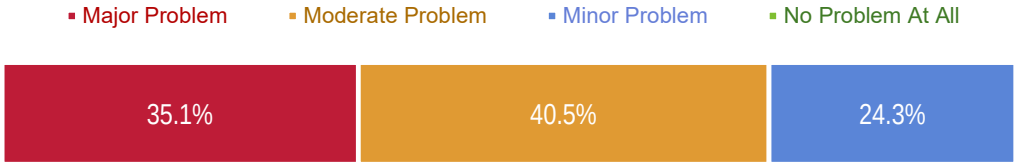
Note that the quality of crime data can vary widely from location to location, depending on the consistency and completeness of reporting among various jurisdictions.

Violent Crime
(Reported Offenses per 100,000 Population, 2015-2017)



Sources: Federal Bureau of Investigation, FBI Uniform Crime Reports (UCR).
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: This indicator reports the rate of violent crime offenses reported by the sheriff's office or county police department per 100,000 residents. Violent crime includes homicide, forcible rape, robbery, and aggravated assault.
Participation by law enforcement agencies in the UCR program is voluntary. Sub-state data do not necessarily represent an exhaustive list of crimes due to gaps in reporting. Also, some institutions of higher education have their own police departments, which handle offenses occurring within campus grounds; these offenses

Perceptions of Injury & Violence as a Problem in the Community
(Key Informants; WCH Service Area, 2023)



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Incidence/Prevalence

> We have many traffic-related deaths, and we have a lot of violence that is upticking in our community. – Social Services Provider
>
> We have a prevalence of pedestrian/cyclist injuries, domestic violence, and youth violence is on the rise. – Community Leader

> I see a lot of patients complain to me that their child is being bullied at school or there is concern for gang violence. At Aptos High, there was a homicide a couple years ago, and a recent threat at the football game for violence. In talking with colleagues at the county office of education, there have been increases in fights and dangerous behaviors across the county. Often when I look at the local newspaper, there is a headline of a stabbing or a hit-and-run or some other type of violent event. Also, a lot of homeless people walking around downtown. – Physician

Behavioral Health

> Suicide and youth mental health is important. We need to reduce the stigma and support our youth. – Public Health Representative
>
> Just no behavioral health to speak of. – Physician

Gang Violence

> Gangs. Social pressures. Availability of guns. – Community Leader
>
> Gangs and domestic violence continue to plague our community. I believe root causes include economic hardships and lack of safe spaces for children and youth, recreational activities and family space for activities. – Community Leader

Denial/Stigma

> People are getting injured and not seeking services for whatever reasons, such as fear and stigma. – Other Health Provider

Social Norms/Community Attitude

> Injury and violence are significant issues in our community because of social norms that have been solidified from decades of disinvestment and exclusion that have made finding success more difficult for some in our community. This has created social issues that lead to violence and injuries happening more regularly than in other communities. – Community Leader

Vulnerable Populations

> Farmworkers experience sexual violence in fields. Also, violence and gang involvement is too high. Farmworkers experience injuries from physical labor. – Physician

DIABETES

ABOUT DIABETES

More than 30 million people in the United States have diabetes. …Some racial/ethnic minorities are more likely to have diabetes. And many people with diabetes don't know they have it.

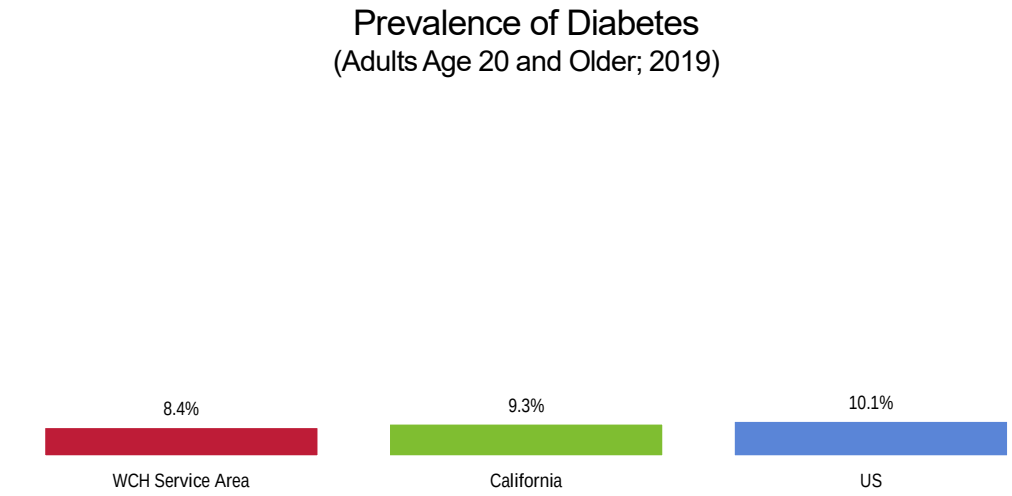
Poorly controlled or untreated diabetes can lead to leg or foot amputations, vision loss, and kidney damage. But interventions to help people manage diabetes can help reduce the risk of complications. In addition, strategies to help people who don't have diabetes eat healthier, get physical activity, and lose weight can help prevent new cases.

– Healthy People 2030 (https://health.gov/healthypeople)

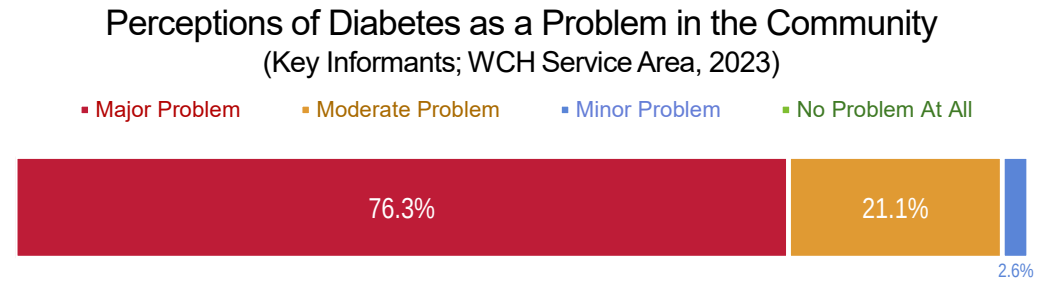
Prevalence of Diabetes

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Has a doctor, nurse, or other health professional ever told you that you had diabetes?"



Sources: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Need for more education and prevention. – Community Leader
>
> The biggest challenges are education and access to healthy foods and preventative measures they can take to reduce the chances of becoming diabetic, as well as receiving care. – Community Leader
>
> Accessible information, medication, safe exercise, and culturally appropriate nutrition education. – Physician
>
> Lack of knowledge, lack of access to testing and medication, cost barriers, poor nutrition, food deserts and low activity rates. – Other Health Provider
>
> Education and access to affordable medication. – Other Health Provider
>
> Education, supporting a healthy lifestyle and eating habit changes. Individuals cannot afford some of the healthier foods and are not educated on the long-term damages of their choices. – Other Health Provider
>
> Poor understanding by community leaders of the root causes of overweight, obesity and diabetes, and insufficient commitment by leaders to take responsibility for the root causes. Poorer communities lack money, time and immediate access to safe spaces to be active compared to wealthy communities, thus contributing to the root causes and inequities in morbidity and mortality when it comes to diabetes. – Public Health Representative
>
> Education regarding disease progression, diet. Income related access or lack of healthier foods. – Physician
>
> Since diabetes is a significant problem in the Latino population, there doesn't appear to be enough information in the community about diabetes care and cultural issues, e.g., how to prepare and eat healthy Mexican/Latino foods, in general, and on a limited income, in particular. The long-term effects of DMII are great and cause a huge amount of disability, trauma, and expense. A more culturally appropriate and motivating education is needed in the whole community. – Community Leader

Access to Affordable Healthy Food

> The lack of access to healthy foods and safe places to recreate. Long working hours prevent individuals from accessing healthcare services during traditional business hours. Lack of health insurance or limited coverage to purchase necessary medications and testing supplies. – Public Health Representative
>
> Access to healthy foods at low costs, cultural diet high in carbs, knowledge of and willingness to make early lifestyle changes and obesity. – Other Health Provider
>
> Access to nutritious food, education, and support. – Other Health Provider
>
> Options for healthy eating and outdoor access for physical movement. – Social Services Provider
>
> Lack of healthy options and routine checkups. Prices in medications. – Other Health Provider
>
> Access to affordable healthy foods and knowing how to prepare cultural foods. – Public Health Representative
>
> Healthy food desserts in neighborhoods, access to low-cost healthy nourishment, motivation for physical and active lifestyles. – Community Leader

Access to Care/Services

> The lack of an effective diabetes health center. The lack of public health approach to the prevention diagnosis and treatment of diabetes. – Community Leader

> Timely access to care and regular follow-up. – Other Health Provider
>
> Access to diagnosis. – Community Leader

Affordable Medications/Supplies

> Being able to afford/access medications. Having time and resources to shop for healthy food and exercise, understanding recommendations of the doctors, not enough primary care doctors to care for these patients. – Physician
>
> Access to testing supplies at a reasonable price. Access to healthy food choices. Time for physical activity and support for weight loss. – Physician

Disease Management

> Not prioritizing their own care, not following treatment protocols and social determinants. – Other Health Provider
>
> Management, health literacy and access to preventive care. – Physician

Built Environment

> Access to safe physical activity, reliance on cheap, convenience foods and obesity. – Community Leader

Culturally Relevant Information

> Culturally relevant information on remedies to prevent or mitigate diabetes. – Community Leader

Housing

> Housing costs deplete all available income for farmworkers and low-wage earners that are unable to afford the "time" to cook their own food and fall to low cost, high-sugar and fat options, soda, chips, fast food, etc. – Community Leader

DISABLING CONDITIONS

ABOUT DISABILITY & HEALTH

Studies have found that people with disabilities are less likely to get preventive health care services they need to stay healthy. Strategies to make health care more affordable for people with disabilities are key to improving their health.

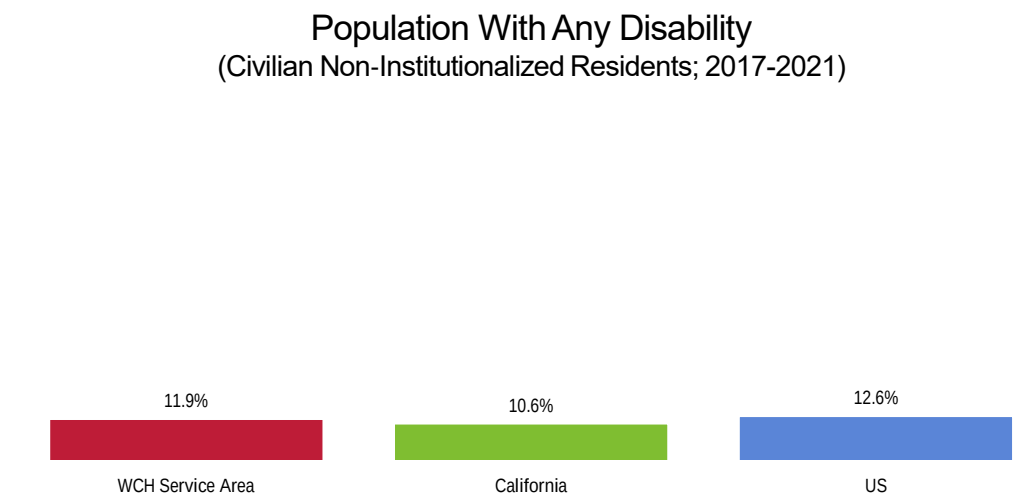
In addition, people with disabilities may have trouble finding a job, going to school, or getting around outside their homes. And they may experience daily stress related to these challenges. Efforts to make homes, schools, workplaces, and public places easier to access can help improve quality of life and overall well-being for people with disabilities.

– Healthy People 2030 (https://health.gov/healthypeople)

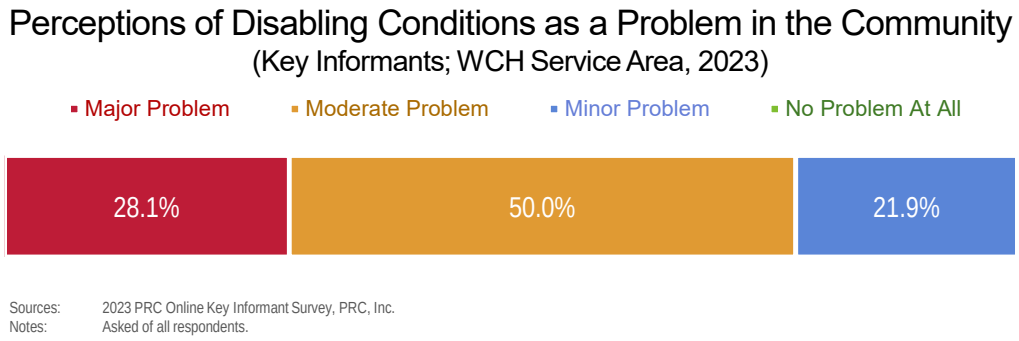
Disability

Disability data come from the US Census Bureau's American Community Survey (ACS), Survey of Income and Program Participation (SIPP), and Current Population Survey (CPS). All three surveys ask about six disability types: hearing difficulty, vision difficulty, cognitive difficulty, ambulatory difficulty, self-care difficulty, and independent-living difficulty.

Respondents who report any one of the six disability types are considered to have a disability.



Sources: US Census Bureau, American Community Survey.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> They exist, with few resources to support. – Physician
>
> Not enough supports for those who are physically disabled, sidewalks and infrastructure limitations for those in wheelchairs. – Social Services Provider
>
> Santa Cruz County has very limited access to care, especially for those who require home, or residential/board and care support. As our population ages, we are seeing more people experiencing a nexus of cognitive decline, medical complications, behavioral health complications, and homelessness, and they are cycling through the emergency room or crisis unit because the appropriate level/type of care does not exist. – Public Health Representative

Vulnerable Populations

> Undocumented, indigenous language speakers, newly arrived immigrants, homeless youth, and adults cannot navigate systems to access services. – Community Leader
>
> They are significant issues because the majority of residents in the region are blue-collar workers who are constantly dealing with chronic pain and loss of vision and hearing. At the same time, they do not make enough money to seek or afford care to address these issues and take simple steps to correct them. – Community Leader

Affordable Care/Services

> Many of the individuals residing in the community cannot afford vision and dental services. Left unmanaged, both vision and dental lead to other health issues or are an indicator of health issues. The other issue within the community is lack of mobility due to sedentary lifestyles. – Other Health Provider

Awareness/Education

> Level of education affects what people know about resources available, treatment options and a degree of assertiveness in requesting evaluation or assistance. – Physician

Co-Occurrences

> Many folks experience chronic pain, contributes to mental health issues, disruption in work and economic instability. – Physician

Aging Population

> Caring for our senior community, more needs to be done to ensure our senior community are engaged and active. – Community Leader

Impact on Caregivers/Families

> Poor health affects the family as a whole. – Other Health Provider

BIRTHS

BIRTH OUTCOMES & RISKS

ABOUT INFANT HEALTH

Keeping infants healthy starts with making sure women get high-quality care during pregnancy and improving women's health in general. After birth, strategies that focus on increasing breastfeeding rates and promoting vaccinations and developmental screenings are key to improving infants' health. Interventions that encourage safe sleep practices and correct use of car seats can also help keep infants safe.

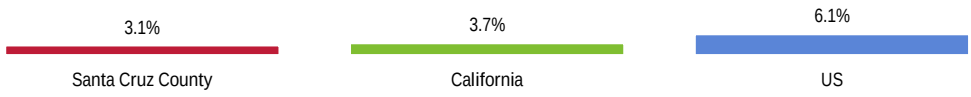
The infant mortality rate in the United States is higher than in other high-income countries, and there are major disparities by race/ethnicity. Addressing social determinants of health is critical for reducing these disparities.

– Healthy People 2030 (https://health.gov/healthypeople)

Prenatal Care

Early and continuous prenatal care is the best assurance of maternal and infant health.

Lack of Prenatal Care in the First Six Months of Pregnancy
(Percentage of Live Births, 2017-2019)

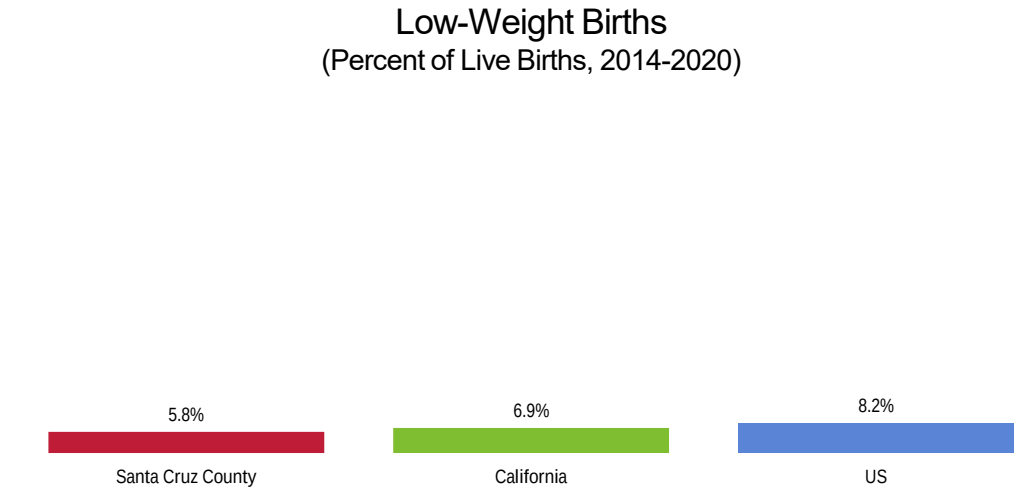


Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER. Centers for Disease Control and Prevention, Wide-Ranging Online Data for Epidemiologic Research.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Note: This indicator reports the percentage of women who did not obtain prenatal care before their seventh month of pregnancy (if at all).

Low-Weight Births

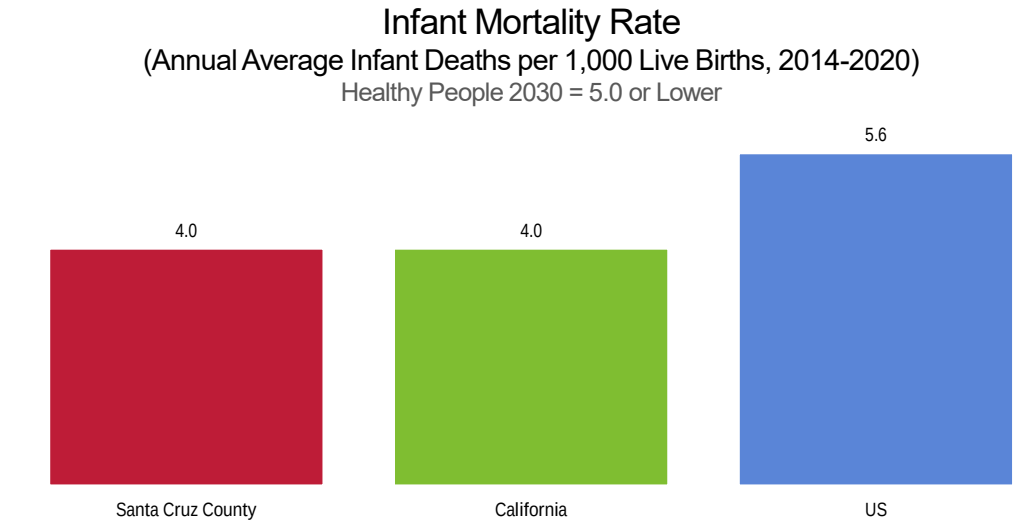
Low birthweight babies, those who weigh less than 2,500 grams (5 pounds, 8 ounces) at birth, are much more prone to illness and neonatal death than are babies of normal birthweight.



Sources: University of Wisconsin Population Health Institute, County Health Rankings.
Note: This indicator reports the percentage of total births that are low birth weight (Under 2500g).

Infant Mortality

Infant mortality includes the death of a child before his/her first birthday, expressed as the number of such deaths per 1,000 live births.



Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: Infant deaths include deaths of children under 1 year old.

FAMILY PLANNING

ABOUT FAMILY PLANNING

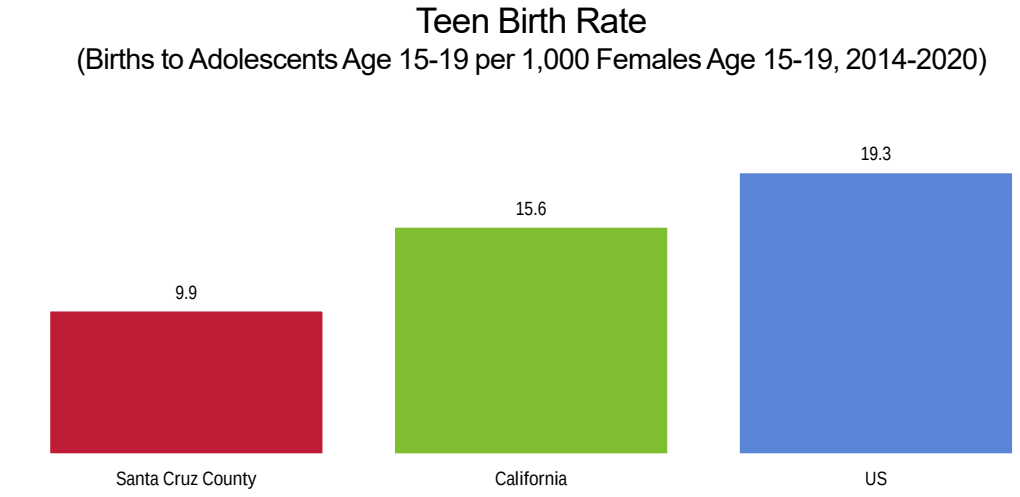
Nearly half of pregnancies in the United States are unintended, and unintended pregnancy is linked to many negative outcomes for both women and infants. …Unintended pregnancy is linked to outcomes like preterm birth and postpartum depression. Interventions to increase use of birth control are critical for preventing unintended pregnancies. Birth control and family planning services can also help increase the length of time between pregnancies, which can improve health for women and their infants.

Adolescents are at especially high risk for unintended pregnancy. Although teen pregnancy and birth rates have gone down in recent years, close to 200,000 babies are born to teen mothers every year in the United States. Linking adolescents to youth-friendly health care services can help prevent pregnancy and sexually transmitted infections in this age group.

– Healthy People 2030 (https://health.gov/healthypeople)

Births to Adolescent Mothers

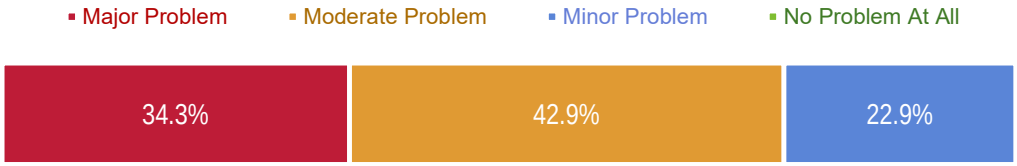
Here, teen births include births to women ages 15 to 19 years old, expressed as a rate per 1,000 female population in this age cohort.



Sources: Centers for Disease Control and Prevention, National Vital Statistics System.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Perceptions of Infant Health & Family Planning as a Problem in the Community

(Key Informants; WCH Service Area, 2023)



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Awareness/Education

> Education. Social and family influences. – Community Leader

Culturally Relevant Information

> Culturally relevant information and continued support from prenatal to birth. – Community Leader

Cost of Housing

> The majority of child-bearing adults now reside in and around the 95076 ZIP code, as the 95060 and surrounding ZIP codes are now one of the highest cost/least affordable housing in the United States. Due to the systematically under-invested health care systems in the 95076 and surrounding areas, there are not adequate resources and care options to even match what is in the 95060 ZIP codes. Those 95060 resources are now (like Sutter Maternity Center and Dominican) turning into boutique service providers, as traffic patterns can make for a 50-minute commute from the South Santa Cruz County. – Community Leader

High Birth Rate

> The birth rate is now again rising in South County. – Public Health Representative

Income/Poverty

> Because of low wages and high cost of living, many families are not able to afford the prenatal care or family planning care and services that is needed to get their kids on the right path to health. – Community Leader

Lack of Family Planning

> Family planning is not done with planning at all. There is no wraparound health planning for pregnant women. – Community Leader

Vulnerable Populations

> Because this region is a major food production area, with a large population of migrant farmworker families, where there are significant levels of exploitation, limited services, and limited investment in health and other services. Many migrant families have limited knowledge of their rights and awareness of the limited social services available to them. They live in fear of having their families separated and being deported. And powerful agricultural companies have significant influence over elected officials and legislation. – Community Leader

Prenatal Care

> Prenatal care. – Community Leader

Female Reproductive Care

> Female reproductive health access. – Community Leader

Early Childhood Development

> Lack of quality, affordable and accessible early childhood development for all communities. What we see are the consequences of lack of ECD, including poor and delayed academic performance and achievement among our students, up to and including high school students, which impacts their opportunities for higher education and lifelong earning potential. – Public Health Representative

MODIFIABLE HEALTH RISKS

NUTRITION

ABOUT NUTRITION & HEALTHY EATING

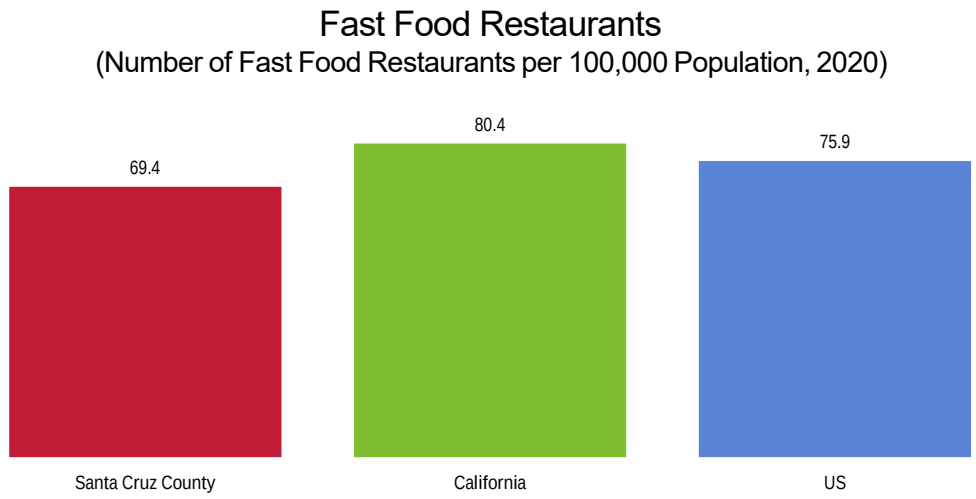
Many people in the United States don't eat a healthy diet. …People who eat too many unhealthy foods — like foods high in saturated fat and added sugars — are at increased risk for obesity, heart disease, type 2 diabetes, and other health problems. Strategies and interventions to help people choose healthy foods can help reduce their risk of chronic diseases and improve their overall health.

Some people don't have the information they need to choose healthy foods. Other people don't have access to healthy foods or can't afford to buy enough food. Public health interventions that focus on helping everyone get healthy foods are key to reducing food insecurity and hunger and improving health.

– Healthy People 2030 (https://health.gov/healthypeople)

Food Environment: Fast Food

Here, fast food restaurants are defined as limited-service establishments primarily engaged in providing food services (except snack and nonalcoholic beverage bars) where patrons generally order or select items and pay before eating.



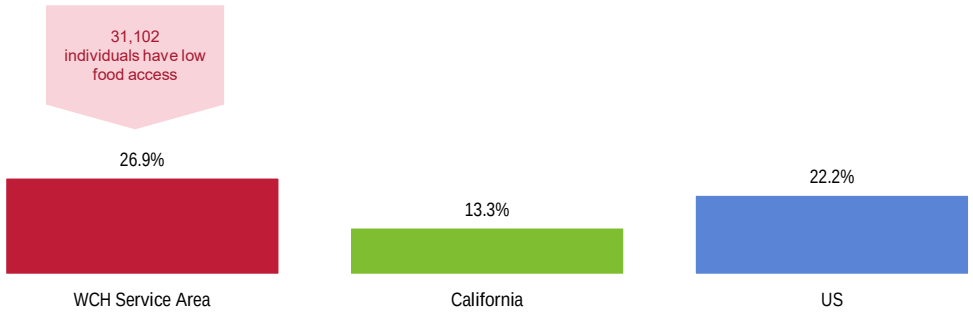
Sources: US Census Bureau, County Business Patterns. Additional data analysis by CARES.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Low Food Access

Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store (or 10 miles in rural areas).

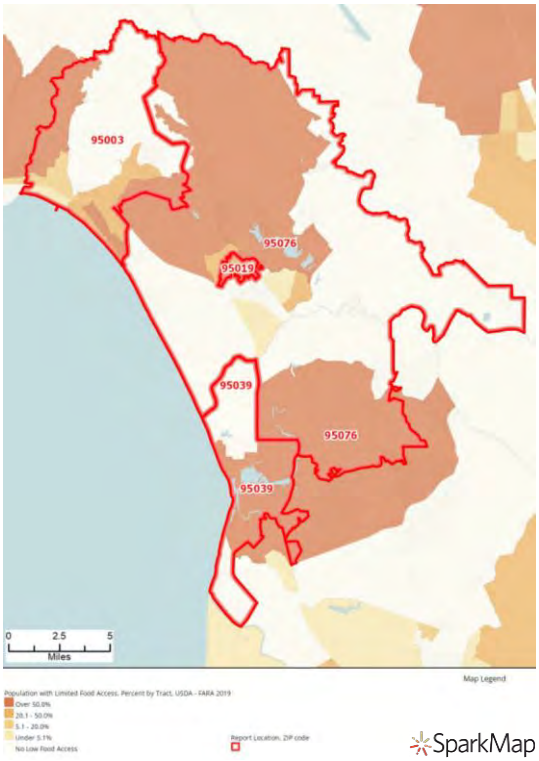
Population With Low Food Access

(Percent of Population Far From a Supermarket or Large Grocery Store, 2019)



Sources: US Department of Agriculture, Economic Research Service, USDA - Food Access Research Atlas (FARA).
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes: Low food access is defined as living more than 1 mile from the nearest supermarket, supercenter, or large grocery store for urban census tracts, and 10 miles for rural ones.



PHYSICAL ACTIVITY

ABOUT PHYSICAL ACTIVITY

Physical activity can help prevent disease, disability, injury, and premature death. The Physical Activity Guidelines for Americans lays out how much physical activity children, adolescents, and adults need to get health benefits. Although most people don't get the recommended amount of physical activity, it can be especially hard for older adults and people with chronic diseases or disabilities.

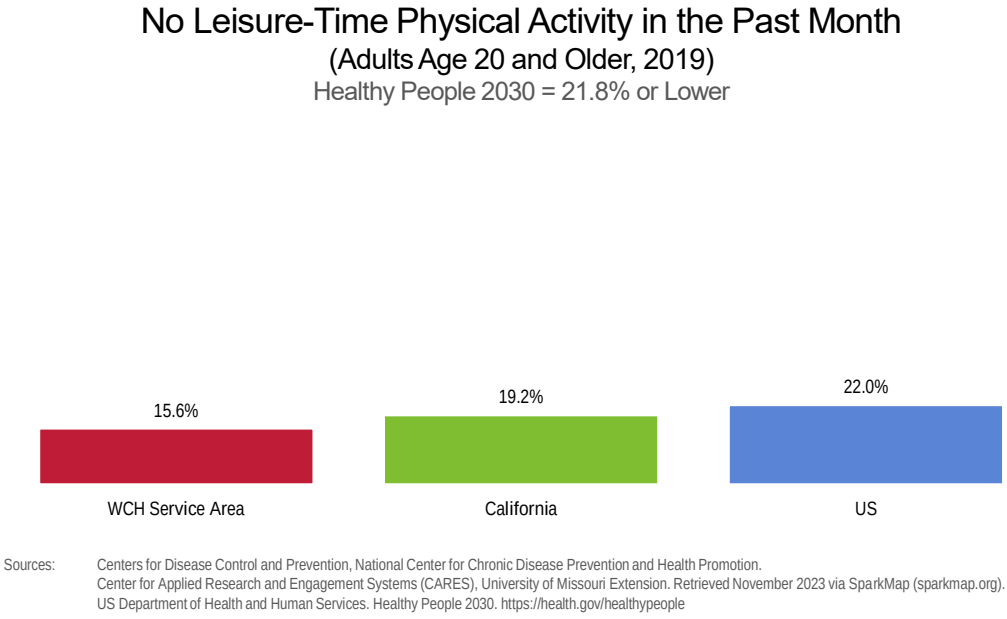
Strategies that make it safer and easier to get active — like providing access to community facilities and programs — can help people get more physical activity. Strategies to promote physical activity at home, at school, and at childcare centers can also increase activity in children and adolescents.

– Healthy People 2030 (https://health.gov/healthypeople)

Leisure-Time Physical Activity

Leisure-time physical activity includes any physical activities or exercises (such as running, calisthenics, golf, gardening, walking, etc.) which take place outside of one's line of work.

Below is the percentage of WCH Service Area adults age 20 and older who report no leisure-time physical activity in the past month. This measure is important as an indicator of risk for significant health issues such

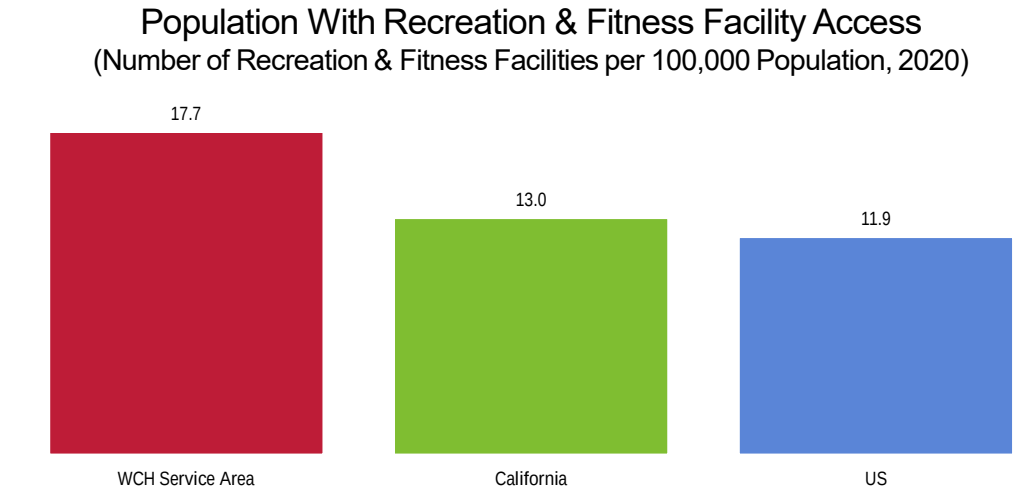


Sources: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Access to Physical Activity

Here, recreation/fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities."

Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.



Sources: US Census Bureau, County Business Patterns. Additional data analysis by CARES.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes: Recreation and fitness facilities include establishments engaged in operating facilities which offer "exercise and other active physical fitness conditioning or recreational sports activities." Examples include athletic clubs, gymnasiums, dance centers, tennis clubs, and swimming pools.

WEIGHT STATUS

ABOUT OVERWEIGHT & OBESITY

Obesity is linked to many serious health problems, including type 2 diabetes, heart disease, stroke, and some types of cancer. Some racial/ethnic groups are more likely to have obesity, which increases their risk of chronic diseases.

Culturally appropriate programs and policies that help people eat nutritious foods within their calorie needs can reduce overweight and obesity. Public health interventions that make it easier for people to be more physically active can also help them maintain a healthy weight.

– Healthy People 2030 (https://health.gov/healthypeople)

Body Mass Index (BMI), which describes relative weight for height, is significantly correlated with total body fat content. The BMI should be used to assess overweight and obesity and to monitor changes in body weight. In addition, measurements of body weight alone can be used to determine efficacy of weight loss therapy. BMI is calculated as weight (kg)/height squared (m^2). To estimate BMI using pounds and inches, use: [weight (pounds)/height squared ($inches^2$)] x 703.

In this report, overweight is defined as a BMI of 25.0 to 29.9 kg/m^2 and obesity as a BMI ≥30 kg/m^2. The rationale behind these definitions is based on epidemiological data that show increases in mortality with BMIs above 25 kg/m^2. The increase in mortality, however, tends to be modest until a BMI of 30 kg/m^2 is reached. For persons with a BMI ≥30 kg/m^2, mortality rates from all causes, and especially from cardiovascular disease, are generally increased by 50 to 100 percent above that of persons with BMIs in the range of 20 to 25 kg/m^2.

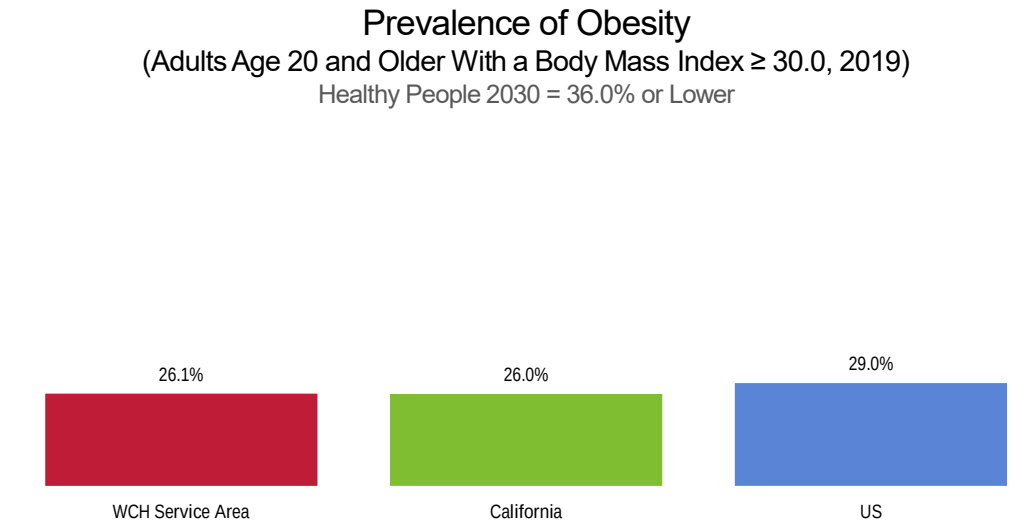
– Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

CLASSIFICATION OF OVERWEIGHT AND OBESITY BY BMI	BMI (kg/m^2)
Underweight	<18.5
Healthy Weight	18.5 – 24.9
Overweight	25.0 – 29.9
Obese	≥30.0

Source: Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults: The Evidence Report. National Institutes of Health. National Heart, Lung, and Blood Institute in Cooperation With The National Institute of Diabetes and Digestive and Kidney Diseases. September 1998.

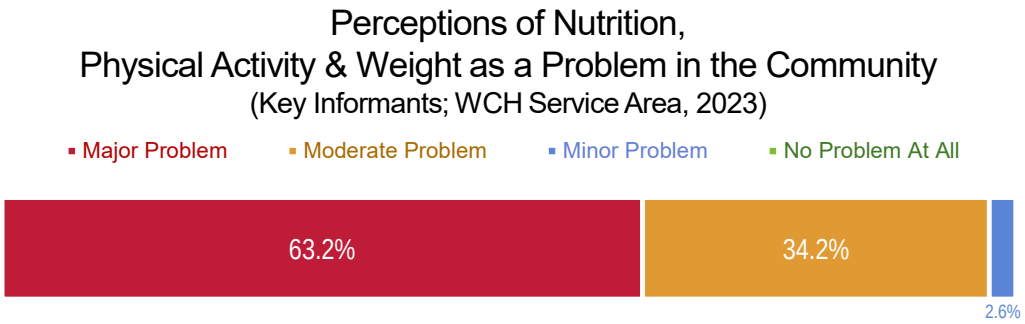
Obesity

"Obese" includes respondents with a BMI value ≥30.0.



Sources: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: The definition of obesity is having a body mass index (BMI), a ratio of weight to height (kilograms divided by meters squared), greater than or equal to 30.0.

Key Informant Input:



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Awareness/Education

> There is a lack of education about nutrition, physical activity, and weight and a lack of open and public recreation facilities. There are also societal norms that make obtaining this education and engaging in physical activity extremely challenging for younger generations. – Community Leader
>
> There is a huge divide in health literacy between socioeconomic groups. A great deal more community education is needed to change the culture around health promotion. We should look at some of the health promotion strategies used in the UK for educating the general population – simple, easy-to-understand messages that are repeated everywhere (Eat your five a day, Every Mind Matters, Scroll Free September, etc.). – Community Leader
>
> Consistent, reliable and accessible education. More time on working for income for basic needs, less discretionary income or time for exercise and community activities. – Physician
>
> Knowledge about healthy foods, knowing how to prepare, being able to afford healthy foods, having time/money to join gym or sign kids up for sports, knowledge about early childhood nutrition related to excess bottle use and early introduction of junk foods. – Physician
>
> Lack of early education about nutrition. Consumption of cheap/fast food. Gyms being too expensive for low-income residents. – Other Health Provider

Built Environment

> Incomplete streets. Lack of grocery stores. Transportation. – Public Health Representative
>
> We need more open spaces for the community to access physical activity. We need to do better as a community to motivate the community to practice healthy behaviors. – Community Leader
>
> Lack of safe places to play and be active, stress due to poor living conditions and high cost of living, reliance on high-calorie and inexpensive foods. – Community Leader
>
> Not enough outdoor locations for exercise. Food is expensive, and there are not enough healthy food options. Too many fast food restaurants. – Social Services Provider
>
> Lack of safe spaces, culturally relevant information in these areas, and lack of sensitivity to cultural lens when it comes to viewing the meaning of "healthy." – Community Leader

Nutrition

> Poor food choices due to food prices. – Other Health Provider
>
> Communities continue to have easy access to unhealthy foods, including fast food restaurants and highly processed foods in retail grocery stores. HPI quartile 1 and 2 communities with highest risk of overweight and chronic disease have the fewest resources to live physically active lives. – Public Health Representative

Obesity

> There is a stark equity gap between the children in South County and their counterparts in Santa Cruz cities with regards to BMI in our K-12th grade students. – Community Leader
>
> Nonexistent, wild obesity rates and poverty. – Physician

Access to Affordable Healthy Food

> Access to healthy food that is affordable and safe space for physical activity. – Physician

Income/Poverty

> In a low-income and low-education community, people often have to work multiple jobs in order to maintain a living income. This leads to very little time dedicated to focusing on personal well-being, such as time to exercise, cook fresh meals, and learn about better choices. On a more systemic level, the food supply system in this country sets most people up for failure when trying to maintain a healthy weight. – Physician

Lifestyle

> Screen time, food deserts, lack of information about healthy habits. – Other Health Provider

SUBSTANCE USE

ABOUT DRUG & ALCOHOL USE

Substance use disorders can involve illicit drugs, prescription drugs, or alcohol. Opioid use disorders have become especially problematic in recent years. Substance use disorders are linked to many health problems, and overdoses can lead to emergency department visits and deaths.

Effective treatments for substance use disorders are available, but very few people get the treatment they need. Strategies to prevent substance use — especially in adolescents — and help people get treatment can reduce drug and alcohol misuse, related health problems, and deaths.

– Healthy People 2030 (https://health.gov/healthypeople)

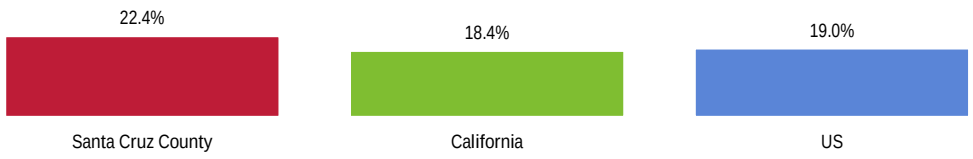
Excessive Alcohol Use

Excessive drinking includes heavy and/or binge drinking:

HEAVY DRINKING ► men reporting 2+ alcoholic drinks per day or women reporting 1+ alcoholic drink per day in the month preceding the interview.

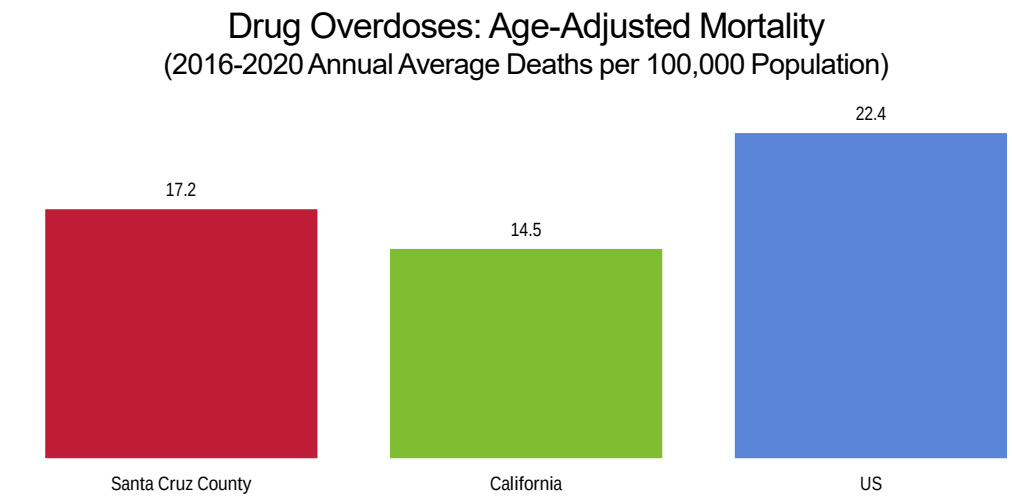
BINGE DRINKING ► men reporting 5+ alcoholic drinks or women reporting 4+ alcoholic drinks on any single occasion during the past month.

Engage in Excessive Drinking
(2020)

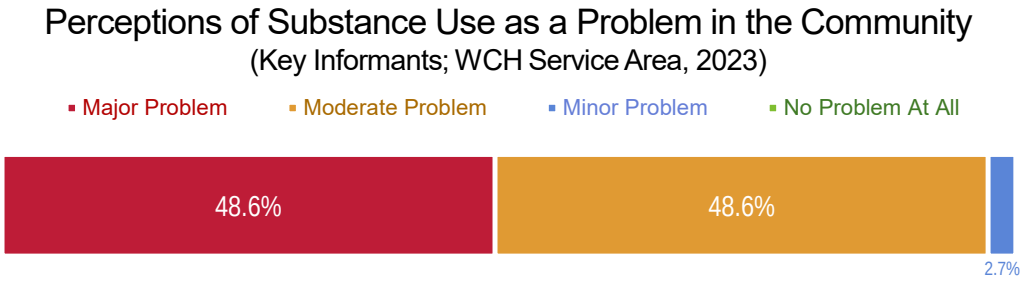


Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via County Health Rankings.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: Excessive drinking is defined as the percentage of the population who report at least one binge drinking episode involving five or more drinks for men and four or more for women over the past 30 days, or heavy drinking involving more than two drinks per day for men and more than one per day for women, over the same time period.

Drug Overdose Deaths



Sources: Centers for Disease Control and Prevention, National Vital Statistics System. Accessed via CDC WONDER.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople
Notes: Deaths are coded using the Tenth Revision of the International Statistical Classification of Diseases and Related Health Problems (ICD-10).
Rates are per 100,000 population, age-adjusted to the 2000 US Standard Population.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> There needs to be a wider variety of substance use treatment options in the community. The available resources don't fit the needs of many people, especially younger people of high school or college age. – Community Leader
>
> Don't know. Maybe safe injection sites. Poverty. Racism. – Community Leader
>
> Lack of available and affordable programs. – Other Health Provider
>
> Access to treatment. – Other Health Provider

Incidence/Prevalence

> I don't think anyone can solve this one. Why does it seem that most of my patients use methamphetamines? – Physician
>
> Substance use, fentanyl crisis. – Public Health Representative

Awareness/Education

> I think the greatest barrier is residents are unaware what the problems are and where they can access services. – Community Leader

Denial/Stigma

> The stigma that comes with asking for help and admitting that someone might have an issue. – Community Leader

Disease Management

> Patients do not seek out treatment, limited ability in primary care to provide these services. – Physician

Funding

> Limitations with funding streams, stigma, asking for help and peer pressure to continue to use. Limited programs/services. – Social Services Provider

Most Problematic Substances

Note below which substances key informants (who rated this as a "major problem") identified as causing the most problems in the WCH Service Area.

SUBSTANCES VIEWED AS MOST PROBLEMATIC IN THE COMMUNITY (Among Key Informants Rating Substance Use as a "Major Problem")	
ALCOHOL	36.4%
METHAMPHETAMINE OR OTHER AMPHETAMINES	27.3%
HEROIN OR OTHER OPIOIDS	27.3%
PRESCRIPTION MEDICATIONS	6.0%
MARIJUANA	3.0%

TOBACCO USE

ABOUT TOBACCO USE

Most deaths and diseases from tobacco use in the United States are caused by cigarettes. Smoking harms nearly every organ in the body and increases the risk of heart disease, stroke, lung diseases, and many types of cancer. Although smoking is widespread, it's more common in certain groups, including men, American Indians/Alaska Natives, people with behavioral health conditions, LGBT people, and people with lower incomes and education levels.

Several evidence-based strategies can help prevent and reduce tobacco use and exposure to secondhand smoke. These include smoke-free policies, price increases, and health education campaigns that target large audiences. Methods like counseling and medication can also help people stop using tobacco.

– Healthy People 2030 (https://health.gov/healthypeople)

Cigarette Smoking Prevalence

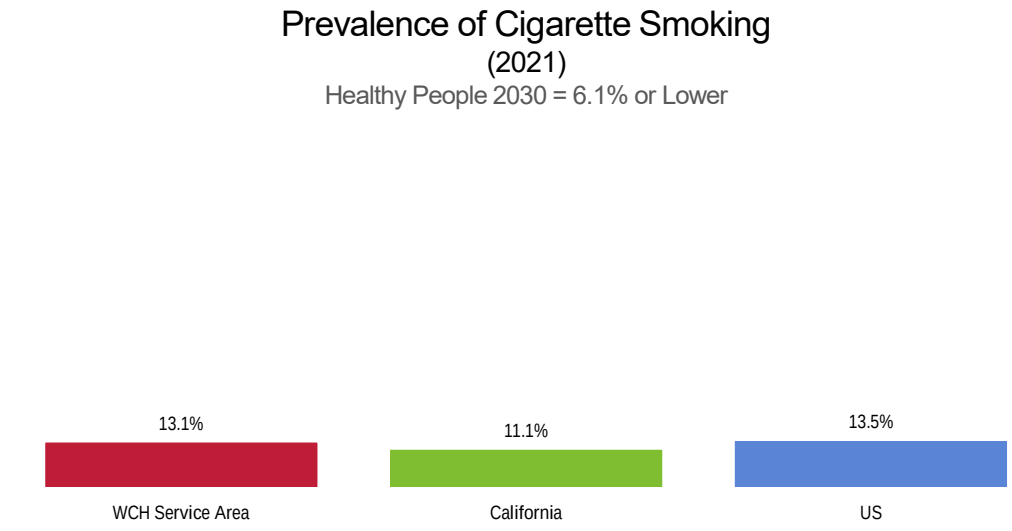
Tobacco use is linked to the two major leading causes of death: cancer and cardiovascular disease. Note

The CDC Behavioral Risk Factor Surveillance Survey asked respondents:

"Have you smoked at least 100 cigarettes in your entire life?"

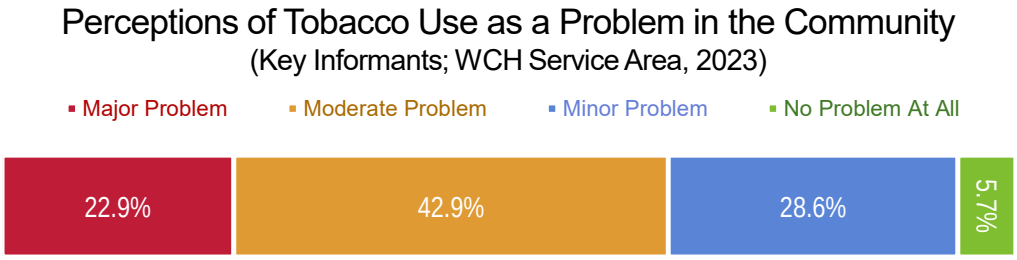
"Do you now smoke cigarettes every day, some days, or not at all?"

Cigarette smoking prevalence includes those who report having smoked at least 100 cigarettes in their lifetime and who currently smoke every day or on some days.



Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Notes: Includes those who report having smoked at least 100 cigarettes in their lifetime and currently smoke cigarettes every day or on some days.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

E-Cigarettes

> Vaping has become an epidemic. – Other Health Provider

Incidence/Prevalence

> Perhaps I should have selected "moderate problem" instead. – Community Leader

Social Norms/Community Attitude

> Socially accepted. – Other Health Provider

Teen/Young Adult Usage

> With vaping, it seems that more youth are using tobacco. – Social Services Provider

SEXUAL HEALTH

ABOUT HIV & SEXUALLY TRANSMITTED INFECTIONS

Although many sexually transmitted infections (STIs) are preventable, there are more than 20 million estimated new cases in the United States each year — and rates are increasing. In addition, more than 1.2 million people in the United States are living with HIV (human immunodeficiency virus).

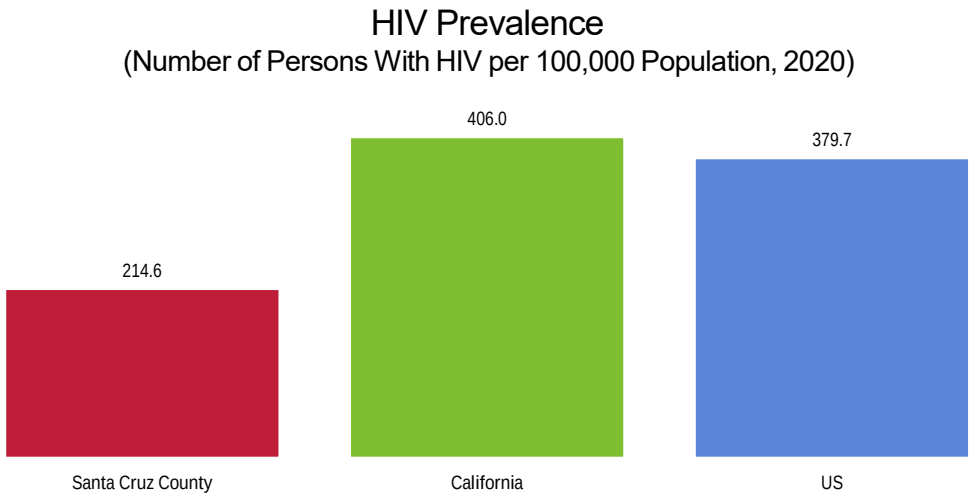
Adolescents, young adults, and men who have sex with men are at higher risk of getting STIs. And people who have an STI may be at higher risk of getting HIV. Promoting behaviors like condom use can help prevent STIs.

Strategies to increase screening and testing for STIs can assess people's risk of getting an STI and help people with STIs get treatment, improving their health and making it less likely that STIs will spread to others. Getting treated for an STI other than HIV can help prevent complications from the STI but doesn't prevent HIV from spreading.

– Healthy People 2030 (https://health.gov/healthypeople)

HIV

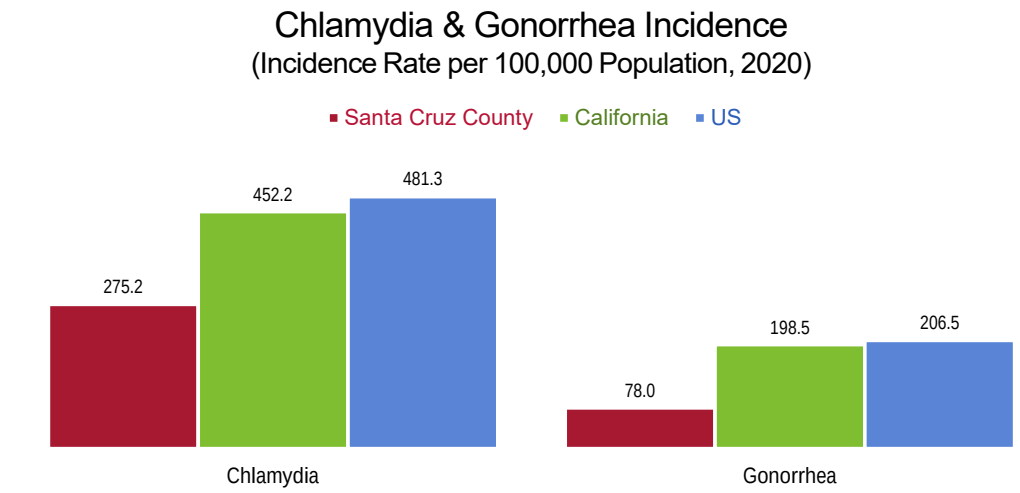
The following chart outlines the prevalence of HIV in our county, expressed as a rate per 100,000



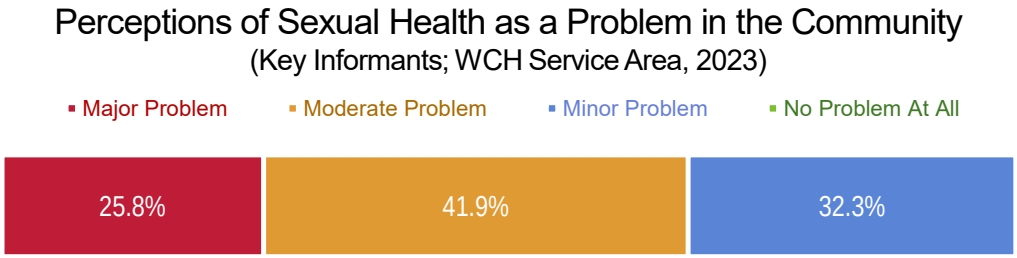
Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Sexually Transmitted Infections (STIs)

Chlamydia & Gonorrhea



Sources: Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a “major problem,” reasons related to the following:

Incidence/Prevalence

> We recently learned that chlamydia in school-age children was on the rise in South County from Co. Santa Cruz Communicable Disease Unit. – Community Leader
>
> Higher rates of STIs. – Physician
>
> We are experiencing rising rates of sexually transmitted infections, particularly syphilis and congenital syphilis, and recurring Mpox infections. As a nation, women's reproductive rights have been reduced. – Public Health Representative

> Syphilis and Mpox are rising. – Public Health Representative

Awareness/Education

> We need to promote better sexual health choices and education. – Social Services Provider
>
> Lack of education. – Other Health Provider

Social Norms/Community Attitude

> Societal norms and lack of education. – Community Leader

ACCESS TO HEALTH CARE

BARRIERS TO HEALTH CARE ACCESS

ABOUT HEALTH CARE ACCESS

Many people in the United States don't get the health care services they need. …People without insurance are less likely to have a primary care provider, and they may not be able to afford the health care services and medications they need. Strategies to increase insurance coverage rates are critical for making sure more people get important health care services, like preventive care and treatment for chronic illnesses.

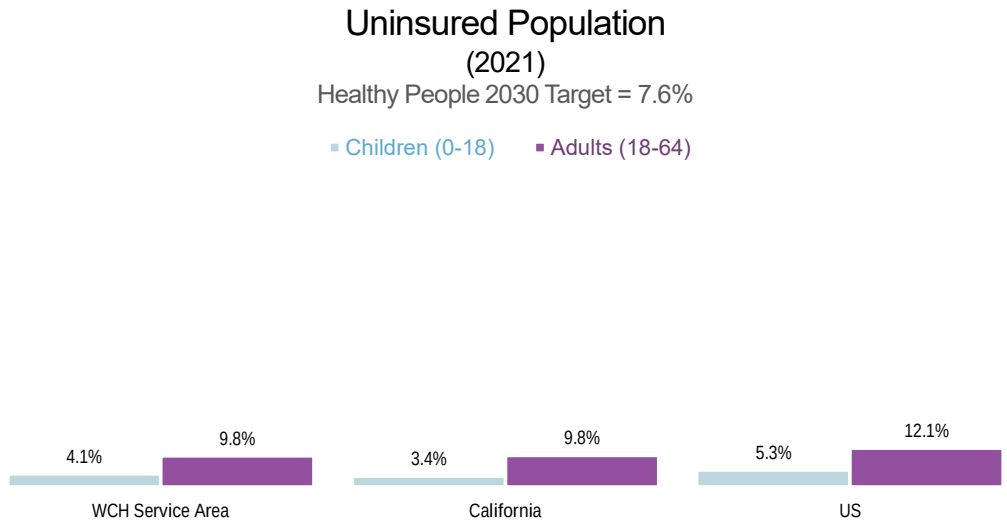
Sometimes people don't get recommended health care services, like cancer screenings, because they don't have a primary care provider. Other times, it's because they live too far away from health care providers who offer them. Interventions to increase access to health care professionals and improve communication — in person or remotely — can help more people get the care they need.

– Healthy People 2030 (https://health.gov/healthypeople)

Lack of Health Insurance Coverage

Here, lack of health insurance coverage reflects respondents age 18 to 64 (thus excluding the Medicare population) who have no type of insurance coverage for health care services – neither private insurance nor government-sponsored plans.

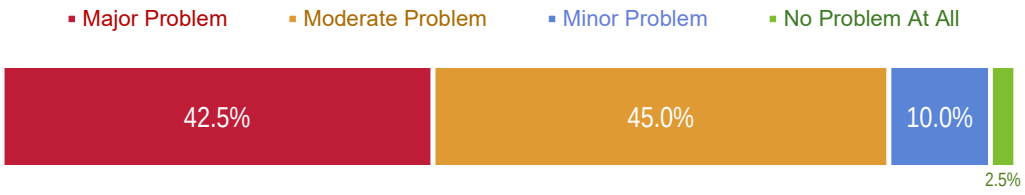
Health insurance coverage is a critical component of health care access and a key driver of health status. The following chart shows the latest figures for the prevalence of uninsured adults (age 18 to 64 years) and



Sources: US Census Bureau, Small Area Health Insurance Estimates.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Perceptions of Access to Health Care Services as a Problem in the Community

(Key Informants; WCH Service Area, 2023)



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> The majority of residents in South Santa Cruz County have to leave the area to get most services. – Community Leader
>
> Not enough services available for the community and some restrictions in regard to medical coverage. – Other Health Provider
>
> The biggest issue is the safety and well-being of community members if they access care at WCH. Services are woefully inadequate – no in-person cardiology; critical care weekdays only; no in-person GI a majority of the time; limited access to PCPs and specialists in the community to support these services; and massive pressure from the ER to admit patients who are too sick to be there or who have issues thar cannot be managed there (which can lead to, and has led to, unnecessary DEATHS). – Physician
>
> Better access to SDOH, behavioral health, and enhanced care management and community support. – Other Health Provider

Lack of Providers

> A significant issue is the limited access to health care services, particularly for residents in rural and underserved areas. The shortage of health care professionals, including primary care physicians and specialists, is exacerbated by doctors' hesitancy to work in this region. The high cost of living in California and lower reimbursement rates for services in South Santa Cruz County make it less attractive, leading to staffing shortages. These challenges underscore the urgent need for innovative solutions, improved infrastructure, and increased incentives to attract health care professionals and ensure access to health care. Solutions can include direct or indirect employment of physicians by the health care district, student loan forgiveness, working with lenders to assist physicians with home purchases, and including physicians in discussions about strategic plans and heeding their advice since they are, in fact, the most likely to understand the needs of the community they serve. – Physician
>
> Patient safety at WCH given lack of access to specialty care. – Physician
>
> Not enough primary care doctors. Not enough specialty care doctors. Not enough psychiatrists. – Community Leader
>
> Limited specialty medical providers available in health insurance networks. No dental care or dental specialty care is available to majority of low income Medi-Cal recipients. – Other Health Provider
>
> Need more specialists, especially those willing to see Medi-Cal recipients. – Other Health Provider

Vulnerable Populations

> Hesitancy around accessing services due to immigration status; ability to access services due to language barriers, transportation. Also, few primary care providers, long wait times for appointments. Difficult to recruit doctors. High rates of uninsured and underinsured. – Physician

> Chronic systematic barriers that over decades created barriers that limit largely Latino populations in the south Santa Cruz and northern Monterey County's from having basic access to primary care and specialty care services. The investments in health care have typically been in and around the 95060 ZIP code by private and county health agencies. The "Santa Cruz County Health Improvement Partnership" had been led largely by northern Santa Cruz area health providers, and due to the "corporate ownership" of the Watsonville Community Hospital and their decision NOT to be a part of this partnership nor the Santa Cruz County emergency management council. As recently as during COVID-19, even the progressive leadership within the Santa Cruz County Health Agency through implicit bias redirected health outreach efforts and marketing to be targeted to and tailored for English-speaking populations and to the unhoused (even through the unhoused are less than 1% of county's population). – Community Leader
>
> Existing systems are not accessible to the most vulnerable, including undocumented, indigenous language speakers, homeless adults and youth and newly arrived immigrants. – Community Leader

Access to Care for Uninsured/Underinsured

> Many are uninsured and make low wages. – Community Leader

Access to Vaccines

> So COVID-19 emergency ended, there is less access to vaccines, especially for those that are homebound. People also do not feel vaccines are important – need a trusted person in the community to share importance. Also, a lot of people did not go to the doctor during the COVID-19 pandemic, so there are a lot of people who have delayed care for routine health maintenance. – Public Health Representative

Income/Poverty

> The biggest challenge in accessing health care services in our community is due to economic burdens, language barriers, historical racism, which has deepened mistrust in receiving adequate healthcare and lack of quality health care services. – Community Leader

Behavioral Health

> Access to mental health. – Community Leader

Transportation

> Transportation to/from clinics/health care settings. – Social Services Provider

PRIMARY CARE SERVICES

ABOUT PREVENTIVE CARE

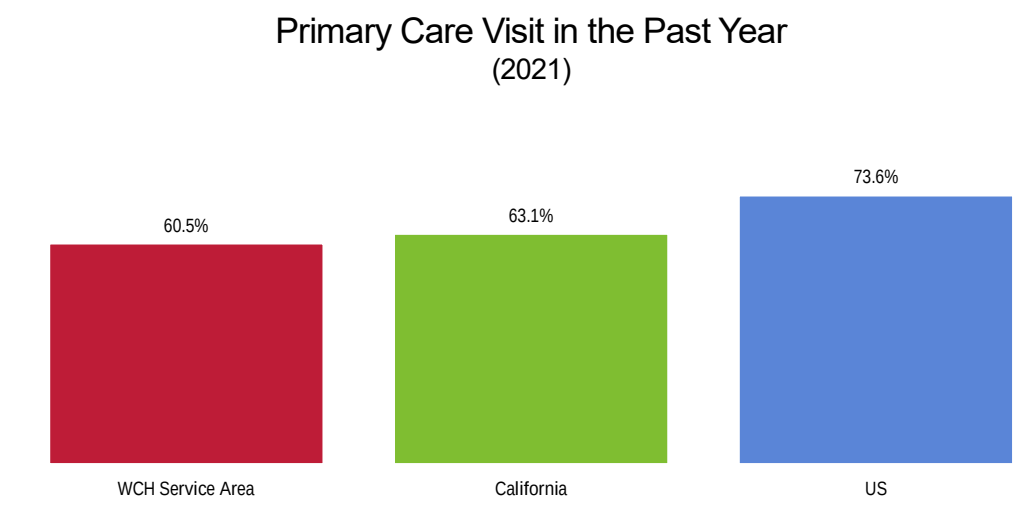
Getting preventive care reduces the risk for diseases, disabilities, and death — yet millions of people in the United States don't get recommended preventive health care services.

Children need regular well-child and dental visits to track their development and find health problems early, when they're usually easier to treat. Services like screenings, dental check-ups, and vaccinations are key to keeping people of all ages healthy. But for a variety of reasons, many people don't get the preventive care they need. Barriers include cost, not having a primary care provider, living too far from providers, and lack of awareness about recommended preventive services.

Teaching people about the importance of preventive care is key to making sure more people get recommended services. Law and policy changes can also help more people access these critical services.

– Healthy People 2030 (https://health.gov/healthypeople)

Primary Care Visits

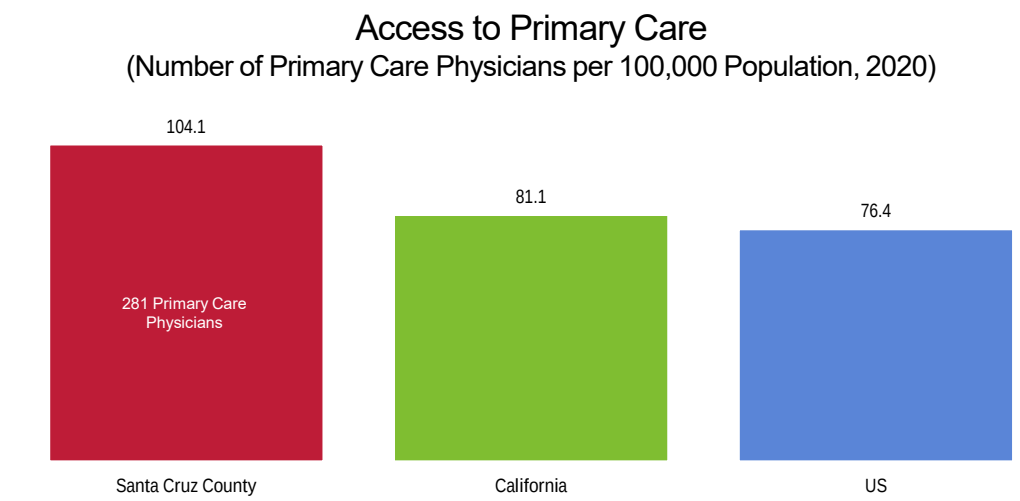


Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: This indicator reports the number and percentage of adults age 18 and older with one or more visits to a doctor for routine checkup within the past one year.

Access to Primary Care

Doctors classified as “primary care physicians” by the AMA include: general family medicine MDs and DOs, general practice MDs and DOs, general internal medicine MDs and general pediatrics MDs. Physicians age 75 and over and physicians practicing subspecialties within the listed specialties are excluded.

Note that this indicator takes into account only primary care physicians. It does not reflect primary care access available through advanced practice providers, such as physician assistants or nurse practitioners.



Sources: Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).

Notes: Doctors classified as "primary care physicians" by the AMA include: General Family Medicine MDs and DOs, General Practice MDs and DOs, General Internal Medicine MDs, and General Pediatrics MDs. Physicians age 75 and over and physicians practicing sub-specialties within the listed specialties are excluded.

ORAL HEALTH

ABOUT ORAL HEALTH

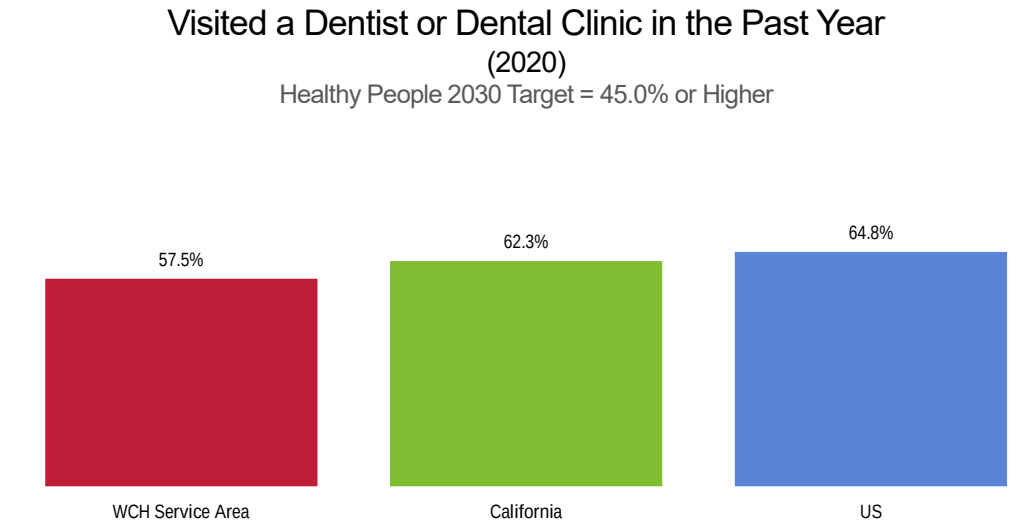
Tooth decay is the most common chronic disease in children and adults in the United States. …Regular preventive dental care can catch problems early, when they're usually easier to treat. But many people don't get the care they need, often because they can't afford it. Untreated oral health problems can cause pain and disability and are linked to other diseases.

Strategies to help people access dental services can help prevent problems like tooth decay, gum disease, and tooth loss. Individual-level interventions like topical fluorides and community-level interventions like community water fluoridation can also help improve oral health. In addition, teaching people how to take care of their teeth and gums can help prevent oral health problems.

– Healthy People 2030 (https://health.gov/healthypeople)

Dental Visits

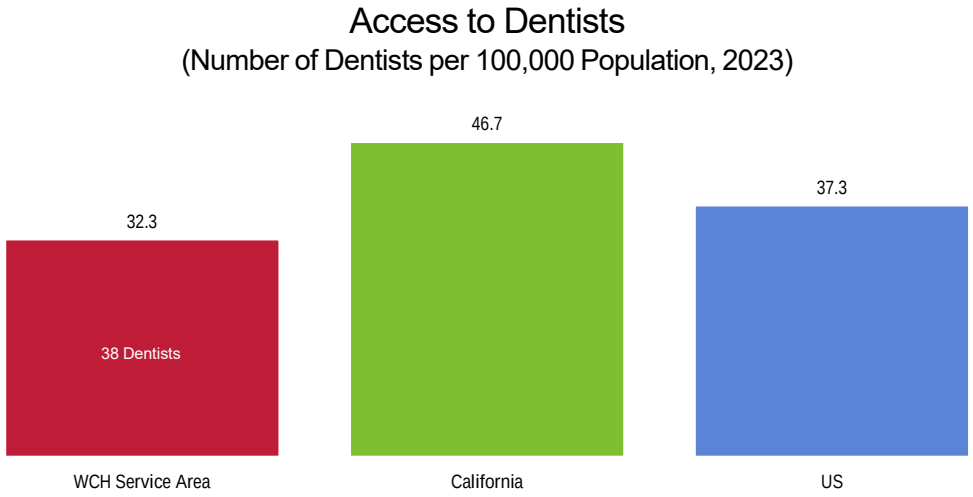
The following chart shows the percentage of WCH Service Area adults age 18 and older who have visited a



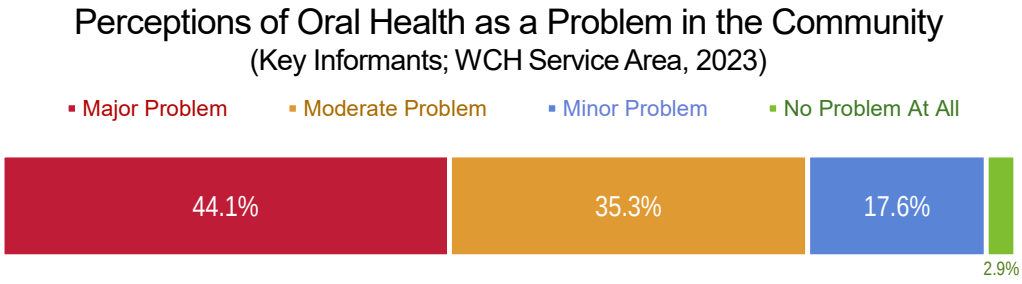
Sources: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System. Accessed via the PLACES Data Portal.
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
US Department of Health and Human Services. Healthy People 2030. https://health.gov/healthypeople

Access to Dentists

This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD), who are licensed by the state to practice dentistry and who are practicing within the scope of that license.



Sources: Centers for Medicare and Medicaid Services, National Plan and Provider Enumeration System (NPPES).
Center for Applied Research and Engagement Systems (CARES), University of Missouri Extension. Retrieved November 2023 via SparkMap (sparkmap.org).
Notes: This indicator reports the number of dentists per 100,000 population. This indicator includes all dentists — qualified as having a doctorate in dental surgery (DDS) or dental medicine (DMD) — who are licensed by the state to practice dentistry and who are practicing within the scope of that license.



Sources: 2023 PRC Online Key Informant Survey, PRC, Inc.
Notes: Asked of all respondents.

Top Concerns

Among those rating this issue as a "major problem," reasons related to the following:

Access to Care/Services

> Only one of three Medi-Cal patients in SC County are able to access the dentist. There are no specialty providers offering services to Medi-Cal patients outside of Dientes. Sugar-sweetened beverages are too available, especially to youth. – Other Health Provider
>
> Many of the older adults in our program have serious oral health issues that have not been treated for many years. Many of them are missing all or most of their teeth, leading us to believe that they have not had good oral health care most of their lives. The care they can receive through Medi-Cal at Western Dental appears to be substandard much of the time. – Community Leader

> I believe it is a major problem because children drop off from seeing their dental providers around the age of 9, and adult teeth may come into a compromised mouth or, worse, start out with untreated decay. – Community Leader
>
> Many folks need access to dental care, and there aren't enough facilities/providers. – Physician

Incidence/Prevalence

> There are a lot of cavities in the children I see, many kids have been traumatized by painful dental work, many parents are concerned about needing sedation or even general anesthesia to complete dental work for their child, many lost days of work and school. – Physician
>
> Poor hygiene. – Other Health Provider

Nutrition

> Bottle use, high consumption of sugar-sweetened beverages. – Community Leader
>
> Children with high level of decay on primary teeth. Sugary sweets at a young age. – Other Health Provider

Affordable Care/Services

> Oral health is not highly prioritized when it's not included in primary health benefits and out-of-pocket expenses. – Community Leader

Awareness/Education

> A lack of education about the importance of good oral health and a lack of resources to obtain the care. – Community Leader

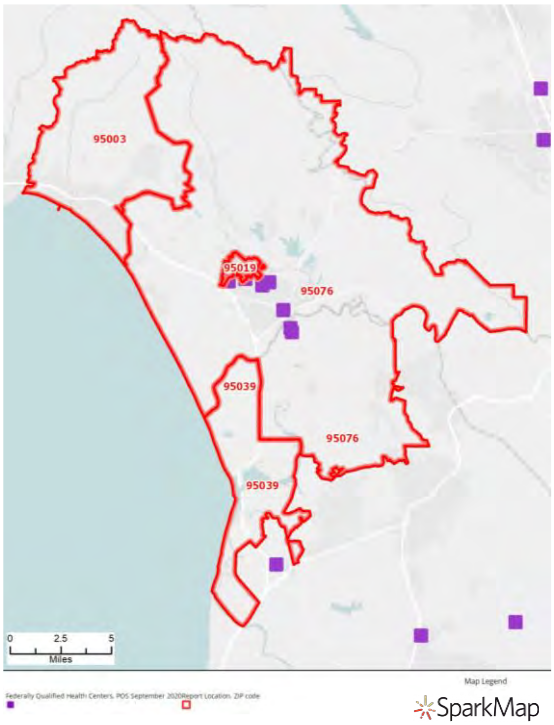
LOCAL RESOURCES

HEALTH CARE RESOURCES & FACILITIES

Federally Qualified Health Centers (FQHCs)

FQHCs are community assets that provide health care to vulnerable populations; they receive federal funding to promote access to ambulatory care in areas designated as medically underserved.

The following map details Federally Qualified Health Centers (FQHCs) within the WCH Service Area.



Resources Available to Address Significant Health Needs

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) identified by key informants as available to address the significant health needs identified in this report. This list only reflects input from participants in the Online Key Informant Survey and should not be considered to be exhaustive nor an all-inclusive list of available resources.

Access to Health Care Services

- 211 Santa Cruz County
- CAB
- Carelon
- Central Coast Alliance Managed Medical
- Chief of Staff
- City of Watsonville
- Clinica Del Valle Del Pajaro
- Coastal Health Partners
- Community Health Trust
- County Behavioral Health
- County Clinics
- County HSA Watsonville Clinic
- County of Santa Cruz
- County Public Health Nurse
- Dientes
- Doctor's Offices
- Elderday Adult Day Health Care
- Encompass Community Services
- Enhance Care Management
- Faith-Based Networks
- Food Bank
- Homeless Network
- Homeless Persons Health Project
- Hospitals
- Insurance
- Kaiser
- Loaves and Fishes
- Lucile Packard
- Pajaro Valley Healthcare District
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- PAMF/Sutter
- Salud Para La Gente
- Santa Cruz Community Health
- Second Harvest Food Bank
- South County Non-Profit Health Coalition
- Watsonville Community Hospital
- Watsonville Health Center
- WIC

Cancer

- Brown Berets
- Center for Farmworker Families
- Community Bridges
- Esperanza Community Farms
- Jacob's Heart
- Kaiser
- PAMF/Sutter
- Salud Para La Gente
- United Farm Workers
- Watsonville Community Hospital

Diabetes

- CalAIM
- Central California Alliance for Health
- City and County Health Department
- Clinica de Salud
- Community Bridges
- Community Gardens
- Community Health Trust
- Community Health Workers
- County of Santa Cruz Health Services
- County Public Health Nutrition Services
- Diabetes Health Center
- Diabetic Support Groups
- Dietitians
- Doctor's Offices
- Enhance Care Management
- Farmer's Market
- Federally Qualified Health Centers
- Food Bank
- Health Trust Diabetes Center
- Homeless Persons Health Project
- Hospitals
- Kaiser
- LPCH Endocrinology
- Pajaro Valley Health Trust
- Pajaro Valley Unified School District
- PAMF/Sutter
- ParkRx
- Public TV and Radio

- Salud Para La Gente
- Santa Cruz Community Health
- School System
- Second Harvest Food Bank
- Stanford
- Watsonville Community Hospital
- Watsonville Health Center
- WIC

Disabling Conditions

- Community Action Board
- Community Bridges
- County Clinics
- Montecito Manor
- Recuperative Care Center
- Salud Para La Gente
- Watsonville Community Hospital

Heart Disease & Stroke

- American Heart Association
- CalAIM
- Community Health Workers
- Community Health Trust of Pajaro Valley
- County Nutrition Case Management Program
- Dientes
- Doctor's Offices
- Dominican's Acute Rehab Unit
- Dominican Hospital
- Encompass Community Services
- Enhance Care Management
- Federally Qualified Health Centers
- Loaves and Fishes
- PAMF/Sutter
- Parks and Recreation
- Public TV and Radio
- Salud Para La Gente
- Santa Cruz Community Health
- Stroke Center - Cabrillo College
- Watsonville Community Hospital
- WIC

Infant Health & Family Planning

- Community Bridges
- County HSA Watsonville Clinic
- Doctor's Offices
- Family Resource Collective
- First 5 of Santa Cruz County
- Hospitals
- Infant/Planning Services
- La Manzana
- Salud Para La Gente
- Santa Cruz Community Foundation
- United Way
- Watsonville Community Hospital
- Watsonville Health Center
- WIC

Injury & Violence

- Churches
- City of Watsonville
- Community Bridges
- County Office of Education
- Digital NEST
- Food Bank
- Hospitals
- Jovenes SANOS
- Monarch Services
- Outreach Counselors
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- Police Activities League
- Police Department
- School System
- Watsonville Community Hospital
- Watsonville Police Department
- Youth Center

Mental Health

- Central California Alliance for Health
- Community Action Board
- Community Bridges
- Community Health Trust
- County Behavioral Health
- County Clinics
- County Mental Health Services
- County Outpatient Services
- Doctor's Offices
- Early Head Start
- Encompass Community Services
- Head Start
- HSA County Behavioral Health Services
- Jovenes SANOS
- Kaiser
- Mobile Emergency Response Team
- National Alliance on Mental Illness
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- ParkRx

- Salud Para La Gente
- Santa Cruz County Behavioral Health
- Santa Cruz County Mental Health Resources
- Santa Cruz County Office of Education
- Santa Cruz County Soquel
- School System
- Second Harvest Food Bank
- Telecare
- Watsonville Community Hospital

Nutrition, Physical Activity, & Weight

- City and County Health Department
- City of Watsonville
- Community Health Trust of Pajaro Valley
- County Health Services Agency
- County Nutrition Case Management Program
- Diabetes Health Center
- Doctor's Offices
- Doctors on Duty
- Food Bank
- Friends of Santa Cruz Parks
- Friends of Watsonville Parks
- Health Centers
- Life Lab
- Loaves and Fishes
- Pajaro Valley Unified School District
- ParkRx
- Parks and Recreation
- Safe Routes to Schools Program
- Salud Para La Gente
- Salud Y Carino
- School System
- Second Harvest Food Bank
- Stanford
- Teen Kitchen Project
- Watsonville Community Hospital
- Watsonville Parks and Community Services
- WIC
- YMCA
- Youth Sports Leagues

Oral Health

- Big Smile
- Central California Alliance for Health
- County Clinics
- Dental Offices
- Diabetes Health Center
- Dientes
- Oral Health Access Coalition
- Salud Para La Gente
- Second Harvest Food Bank
- Western Dental
- WIC

Respiratory Diseases

- Community Providers
- County Clinics
- County Health Services Agency
- Doctor's Offices
- Dominican Hospital
- Hospitals
- Kaiser
- Salud Para La Gente
- Vaccines
- Watsonville Community Hospital

Sexual Health

- Access Support Network
- Care Teams
- Community Providers
- County Clinics
- County Office of Education
- County Public Health
- County-Sponsored Sexual Health Education
- Doctors on Duty
- Dominican Hospital
- Federally Qualified Health Centers
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Unified School District
- Planned Parenthood
- Salud Para La Gente
- School System
- Watsonville Community Hospital

Social Determinants of Health

- CAB
- Cabrillo
- Catholic Charities
- Center for Farmworker Health
- CHISPA
- City of Watsonville
- Community Action Board
- Community Action Network
- Community Based Organizations
- Community Bridges
- Community Health Trust of Pajaro Valley
- County Health Services Agency
- County Human Services Department

- County of Santa Cruz
- Doctor's Offices
- Encompass Community Services
- Family Resource Collective
- Food Bank
- Health and Human Services
- Housing Element
- Housing Matters
- La Manzana
- Loaves and Fishes
- National Alliance on Mental Illness
- Non-Profits and Faith-Based Groups
- Pajaro Rescue Mission
- Pajaro Valley Prevention and Student Assistance
- Pajaro Valley Shelter Services
- Pajaro Valley Unified School District
- Public Health Department
- Raices Y Carino
- Salud Para La Gente
- Salvation Army
- Santa Cruz County Health Department
- Second Harvest Food Bank
- South County Triage Group
- UCSC
- United Way
- Watsonville Community Hospital
- Watsonville Law Center
- WIC

Substance Use

- County Clinics
- County of Santa Cruz
- Elevate Addiction Services
- Encompass Community Services
- Janus
- Pajaro Valley Prevention and Student Assistance
- Salud Para La Gente
- Santa Cruz County Behavioral Health

Tobacco Use

- County Clinics
- Pajaro Valley Prevention and Student Assistance

APPENDIX

EVALUATION OF PAST ACTIVITIES

Watsonville Community Hospital gained not-for-profit status in 2022; as such, this is the first Community Health Needs Assessment completed pursuant to IRS regulations. Watsonville Community Hospital will evaluate actions taken to address the needs identified in this assessment from this point forward.

APPENDIX C:

FINANCIAL DOCUMENTS (2022 TO 2025)

WATSONVILLE COMMUNITY HOSPITAL

Consolidated 2025 Budget

In Thousands (000's)	Sept YTD Annualized	2025 Base	2025 Initiatives	2025 Budget
Inpatient Revenue	375,444	386,947	16,599	403,546
Outpatient Revenue	746,495	735,692	39,177	774,870
Total Gross Patient Revenue	**1,121,939**	**1,122,639**	**55,777**	**1,178,416**
Deductions from Revenue	961,727	961,809	43,168	1,004,977
Provision for Bad Debt	14,590	14,010	4	14,014
Collectible Patient Revenue	**145,622**	**146,821**	**12,604**	**159,425**
Other Revenue	8,316	7,973	600	10,137
Total Net Revenue	**153,938**	**154,794**	**13,204**	**169,562**
Salaries, Wages & Benefits	96,010	102,643	4,068	106,711
Medical Specialist Fees	9,354	9,713	1,211	12,452
Supplies	12,555	13,042	1,201	14,243
Repairs & Maintenance	1,561	1,577	-	1,577
Utilities	2,400	2,494	(85)	2,409
Purchased Services	12,110	12,524	250	12,774
Lease Cost & Rent	1,529	4,587	324	4,911
Property Tax & Insurance	3,199	2,459	-	2,459
Other Expenses	10,132	8,457	49	8,506
Total Operating Expenses	**148,849**	**157,496**	**7,017**	**166,042**
EBITDA	**5,089**	**(2,702)**	**6,187**	**3,520**
Depreciation & Amortization	258	1,569	281	1,850
Interest/Financed Leases	3,654	297	-	297
Net Operating Income/Loss	**1,178**	**(4,569)**	**5,906**	**1,373**

Audited Financial Statements
and Other Financial Information

PAJARO VALLEY
HEALTH CARE DISTRICT

December 31, 2024

Pajaro Valley Health Care District

Audited Financial Statements and Other Financial Information

Table of Contents

JWT & Associates, LLP

Advisory Assurance Tax

1111 East Herndon, Suite 211, Fresno, California 93720
Voice: (559) 431-7708 Fax:(559) 431-7685

Report of Independent Auditors

The Board of Directors
Pajaro Valley Health Care District
Watsonville, California

Opinion

We have audited the accompanying combined financial statements of Pajaro Valley Health Care District (the District) and Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (the Hospital), collectively referred to as the "Combined Unit," as of December 31, 2024 and 2023, which comprise the combined statements of net position as of December 31, 2024 and 2023, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial positions of the business-type activities and the discretely presented component unit of the District, as of December 31, 2024 and 2023, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material

misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

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

Emphasis of Matter – Going Concern

The accompanying financial statements have been prepared assuming that the District will continue as a going concern. As discussed in Note 12 to the financial statements, the Hospital has reduced the annual losses since emerging from bankruptcy in 2022, however there is only 9 days cash on hand and significant liabilities that, if went unpaid, would cause significant challenges for the District. These conditions raise substantial doubt about the District's ability to continue as a going concern. Management's plans regarding these matters are also described in Note 10 and in the Management's Discussion and Analysis. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to this matter.

JWT & Associates, LLP

Fresno, California
May 28, 2025

Pajaro Valley Health Care District

Management's Discussion and Analysis

For the Year Ended December 31, 2024

Management of the Pajaro Valley Health Care District (the District) has prepared this annual discussion and analysis in order to provide an overview of performance for the fiscal year ended December 31, 2024, in accordance with the Governmental Accounting Standards Board Statement No. 34, Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments. The District wholly owns the Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (the Hospital). Together they are referenced as the Combined Unit. The intent of this document is to provide additional information on the Combined Unit's financial performance as a whole and a prospective look at revenue, operating expenses, and capital development plans. This discussion should be reviewed in conjunction with the audited financial statements for the fiscal year ended December 31, 2024, and accompanying notes to the financial statements to enhance one's understanding of the Combined Unit's financial performance.

Introduction

The Combined Unit offers readers of our financial statements this narrative overview and analysis of our financial activities for the year ended December 31, 2024. We encourage readers to consider the information presented here in conjunction with the Combined Unit's financial statements, including the notes thereto.

The Combined Unit is governed by a five-member elected board of directors. Day-to-day operations are managed by the Chief Executive Officer. The Combined Unit employed 625 employees on December 31, 2024, and had monthly payroll of approximately $5.9M, not including benefits.

Required Financial Statements

The Combined Unit's financial statements offer short-term and long-term information about its activities. The statement of net position includes all of the Combined Unit's assets and liabilities at December 31, 2024 and provides information about the nature and amounts of investments in resources (assets) and the obligations to Combined Unit creditors (liabilities). The statement of net position also provides the basis for evaluating the capital structure of the Combined Unit and assessing the liquidity and financial flexibility of the Combined Unit.

All revenue and expenses for the years ended December 31, 2024, and 2023 are accounted for in the statement of revenue, expenses, and changes in net position. The statement can be used to determine whether the Combined Unit has successfully recovered all its costs through its patient service revenue and other revenue sources. Revenue and expenses are reported on an accrual basis, which means the related cash could be received or paid in a subsequent period.

The final required statement is the statement of cash flows. This statement reports cash receipts, cash payments and net changes in cash resulting from operations, investing and financial activities for the years ended December 31, 2024, and 2023. They also provide answers to such questions as where cash came from, what cash was used for and what the change in the cash balance was during the reporting period.

Pajaro Valley Health Care District

Management's Discussion and Analysis

For the Year Ended December 31, 2024

Financial Analysis of the Combined Unit

The Combined Unit's net position, the difference between assets and liabilities, is a way to measure financial health or financial position. Over time, sustained increases or decreases in the Combined Unit's net position are one indicator of whether its financial health is improving or deteriorating. However, other nonfinancial factors such as changes in economic conditions, population growth and new or revised government regulations and legislation should also be considered. In 2024, the Combined Unit's net position decreased by approximately $95K.

Financial Summary

- Total assets ended at $95.2 million being largely comprised of net patient AR ($25M) and real property assets ($45M). Total cash and cash equivalents at year end were $18.1 million (see the Statements of Cash Flows for changes) which includes the restricted bond funds ($14.4M).

- Current assets ended at $37.3M compared to current liabilities which ended at $32.4M. The current ratio for this year was 1.15.

- Net operating revenues were $150.9M and operating expenses were $153.4M. There was non operating income of $2.4M.

- The decrease in net position was $95k. See footnotes for more information.

Items Affecting Operations

The challenges facing the Combined Unit this fiscal period were largely similar, although varying in degree of intensity, to those issues facing the health care industry in general and for rural health care facilities in particular. Where the immediate environment and circumstances uniquely influence the Combined Unit, these areas are also highlighted in the discussion below:

- Reimbursement: Medicare and Medi-Cal programs continue to reimburse the Hospital at rates that are less than the cost to provide services to patients.

- Labor: Physician positions continue to be difficult to recruit in rural areas. Physician groups are demanding higher rates and subsidies. We lost three physician groups in 2024 (Hospitalist and two Radiology groups). Soliciting new groups, negotiating contracts and onboarding them onto the medical staff is time consuming (4 to 6+ months). Additionally, securing interim coverage is expensive.

- The Hospital emerged from bankruptcy and was purchased by The District on September 1, 2022, with limited working capital. The District continues to work to stabilize operations.

- The District has secured multiple funding sources to address the cashflow challenges. The District has also applied to new inter-governmental transfer programs for 2025-26.

Items Affecting Operations (continued)

- The Hospital renegotiated all major payor contracts to improve reimbursement. As of December 31, 2023, all were implemented. As contracts expire, the Hospital has been successful in renegotiating new terms.

- The Hospital faces challenges recruiting staff due to the high cost of living in the area and thus relies on contracted resources to supplement staffing. These resources come at a slightly higher cost.

- The Hospital employs staff from 5 different unions that have resulted in protracted negotiations. As of 12/31/24, three contracts were expired and in negotiations. Updated contracts were all subsequently ratified in Q1 2025.

- The Hospital was the victim of a cyber attack in November 2024. The attack levied a significant impact on operations and temporarily slowed cash collections. Recovery efforts are ongoing. The District has Cyber Attack insurance and is working closely with the insurer and related vendors. The Hospital's Accounts Payable backlog has increased, causing the need for more payment plans with vendors. The Hospital is implementing growth strategies and securing additional funding, along with expense reduction efforts.

- The District received $1.0 million in loan forgiveness from the County of Santa Cruz in exchange for supporting the County's Pediatric Stabilization unit while they build a new facility.

In summary, the external environment continues to challenge rural healthcare providers in particular, with continuing declines in reimbursement, increases in uncompensated care and ongoing cash constraints. The Combined Unit strives to improve relationships within our community through collaboration with community leaders and service groups, outreach to neighboring healthcare facilities, improving access to care and recruitment of quality medical providers.

The Combined Unit's employees continue to work to find ways to improve patient care and service to its patients and community, while striving to improve its financial position and overall fiscal performance.

The Hospital received Distressed Hospital loan proceeds of $8,300,000 on November 1, 2023. These funds were used to maintain operations and in support of some Hospital projects to stabilize operations. The six-year loan is zero interest and has an 18-month grace period before repayment. The Hospital received approval for loan modification resulting in an additional 12 month deferral for payments, which will preserve $1.8M in working capital in the short term. The Hospital will seek further loan modification up to loan forgiveness as the program allows.

Items Affecting Operations (continued)

The District passed Measure N on the March 2024 ballot. Measure N is a $116M general obligation bond program intended to renovate the Hospital and improve services to the community. Measure N allows the Hospital to modernize and expand our facility. The District sold the first tranche of bonds in Sept 2024 for $53.5 million. The District used $40 million to purchase the Hospital building and land through the locally controlled accountable Pajaro Valley Health Care District.

The District has a line of credit with Santa Cruz County Bank, secured by community guarantors. In November 2024, a fourth guarantor was added, thereby increasing the line of credit from $3.0 million to $4.0 million. As of 12/31/24, the District has drawn $3.0 million. The District subsequently advanced the additional $1.0 million to help cover expenses during the cyber attack recovery.

The Pajaro Valley Healthcare District Philanthropy Foundation is a non-profit 501(c)3 corporation in existence to raise funds and secure grants for Watsonville Community Hospital activities and services. In 2024 they were able to secure $2.4M in grants, including a three year $1.48 million Medi-Cal Capacity Grant.

Management utilizes a daily cash tracking tool to capture deposits, track expenditures and forecast future liabilities and cash balances. Management has implemented additional reporting and monitoring tools to aid the leadership in achieving its financial turnaround plans.

Pajaro Valley Healthcare District

Combined Statement of Net Position

	December 31 2024	December 31 2023
Assets		
Current Assets		
Cash and cash equivalents	$ 3,703,331	$ 6,639,515
Assets limited as to use	2,691,432	-
Patient accounts receivable, net of allowances	24,997,555	15,195,777
Other accounts receivable	128,787	-
Inventories	3,840,566	3,841,424
Prepaid expenses and other current assets	1,935,742	2,260,013
Total current assets	37,297,413	27,936,729
Assets limited as to use, net of current debt service	11,702,888	-
Capital assets, net of accumulated depreciation	45,096,317	3,138,796
Lease assets	417,973	33,549,419
Total assets	94,514,591	64,624,944
Deferred outflows of resources, net of inflows	647,855	-
	$ 95,162,446	$ 64,624,944
Liabilities and Net Position		
Current liabilities		
Line of credit	$ 3,000,000	$ -
Current maturities of debt borrowings	6,289,901	3,120,987
Accounts payable and accrued expenses	14,658,409	6,531,695
Accrued payroll and related liabilities	7,234,385	9,014,485
Estimated third party payor settements	569,228	728,871
IBNR self funded health benefits	685,410	1,706,135
Total current liabilities	32,437,333	21,102,173
Debt borrowings, net of current maturities	65,846,228	12,408,100
Lease liabilities	417,976	34,559,114
Total liabilities	98,701,537	68,069,387
Net position		
Invested in capital assets, net of related debt	45,096,317	3,138,796
Restricted	14,394,320	2,600,000
Unrestricted	(63,029,728)	(9,183,239)
Total net position	(3,539,091)	(3,444,443)
Total liabilities and net position	$ 95,162,446	$ 64,624,944

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combined Statement of Revenues, Expenses and Changes in Net position

	Year Ended December 31	
	2024	2023
Operating revenues		
Net patient service revenues	$ 142,092,210	$ 129,114,224
Other operating revenues	8,845,371	5,367,526
Total operating revenues	150,937,581	134,481,750
Operating expenses		
Salaries & wages	70,669,317	70,156,726
Employee benefits	20,527,433	21,460,602
Contract labor	5,278,300	6,931,655
Supplies	12,402,259	8,319,794
Medical specialist fees	9,442,019	7,751,461
Purchased services	12,927,822	13,458,807
Lease cost and rent	1,470,931	1,914,944
Repairs & maintenance	1,516,915	1,359,867
Utilities	2,438,228	2,466,097
Depreciation and amortization	652,803	797,794
Other operating expenses	10,176,116	7,372,053
Property taxes & insurance	3,215,445	2,444,845
Interest	2,705,874	3,841,925
Total operating expenses	153,423,462	148,276,570
Operating income (loss)	(2,485,881)	(13,794,820)
Nonoperating revenues		
Rental income	1,120,665	529,666
Interest income	373,424	103,547
District tax revenue	897,144	-
Total nonoperating revenues (expenses)	2,391,233	633,213
Increase/(decrease) in net position	(94,648)	(13,161,607)
Net position, beginning of the year	(3,444,443)	9,717,164
Net position, end of year	$ (3,539,091)	$ (3,444,443)

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combined Statement of Cash Flows

	Year Ended December 31	
	2024	2023
Cash flows from operating activities		
Cash received for operations	$ 138,141,499	$ 137,341,169
Cash payments to suppliers and contractors	(50,416,192)	(53,842,286)
Cash payments to employees and benefit programs	(93,997,575)	(92,326,152)
Net cash (used in) operating activities	(6,272,268)	(8,827,269)
Cash flows from noncapital financing activities		
Changes in assets limited to use	(14,394,320)	-
District tax revenues	897,144	-
Net cash (used in) noncapital financing activities	(13,497,176)	-
Cash flows from investing activities		
Net purchase of capital assets and changes in other assets	(44,267,871)	(175,098)
Interest income	373,424	103,547
Rental income	1,120,665	529,666
Net cash (used in) investing activities	(42,773,782)	458,115
Cash flows from financing activities		
Line of credit	3,000,000	-
Proceeds from debt borrowings	59,923,235	9,095,000
Prepayments of debt borrowings	(3,316,193)	(2,746,899)
Net cash provided by financing activities	59,607,042	6,348,101
Decrease in cash and cash equivalents	(2,936,184)	(2,021,053)
Cash and cash equivalents at beginning of year	6,639,515	8,660,568
Cash and cash equivalents at end of year	$ 3,703,331	$ 6,639,515

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combined Statement of Cash Flows (continued)

	Year Ended December 31	
	2024	2023
Reconciliation of operating income (loss) to net cash provided by operating activities		
Operating income	$ (2,485,881)	$ (13,794,820)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation	652,803	797,794
Changes in operating assets and liabilities		
Receivables	(9,930,565)	7,569,656
Inventories	858	(1,683,021)
Prepaid expenses and other current assets	324,271	295,812
Accounts payable and accrued expenses	8,126,714	(435,554)
Accrued payroll and related expenses	(1,780,100)	372,623
Estimated third party payor settements	(159,643)	(868,313)
IBNR self funded health benefits	(1,020,725)	(1,081,446)
Net cash (used in) operating activities	$ (6,272,268)	$ (8,827,269)

See accompanying notes to the financial statements

Pajaro Valley Health Care District

Notes to the Financial Statements

For the Year Ended December 31, 2024

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES

Organization: Pajaro Valley Health Care District, (the District) is a public entity organized under Local District Law as set forth in the Health and Safety Code of the State of California. The District is a political subdivision of the State of California and is generally not subject to federal or state income taxes. The District is governed by a five-member Board of Directors, elected from within the district to specified terms of office. The District is located in Watsonville, California. The District wholly owns the Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (the Hospital). The Hospital is a 501(c)(3) component unit of the District and operates a 106 -bed acute care hospital and other patient services. The District also operates a clinic that serves patients in the area. The District's mission is to provide health care services primarily to individuals who reside in the local geographic area. A combining statement presenting both District and Hospital operations is presented in the supplementary information to these combined financial statements.

The District and the Hospital were both created to purchase the operations and certain assets of the Watsonville Community Hospital (WCH) and operate the hospital facility. WCH assets were acquired in September of 2022. Hospital land and improvements (buildings) were acquired in October of 2024.

The District has a Professional Services Agreement (PSA) with Coastal Health Partners (CHP). CHP is incorporated under the laws of the State of California and operates as a corporation. This agreement calls for CHP to provide physicians to the District 1206(b) clinic. The District provides support staff to CHP through the Hospital and passes those expenses onto the District Clinic.

The Combined Unit (the District and the Hospital) maintains its financial records in conformity with guidelines set forth by the Local Health Care District Law and the Office of Statewide Health Planning and Development of the state of California.

Basis of Preparation: The accounting policies and financial statements of the Combined Unit generally conform with the recommendations of the audit and accounting guide, *Health Care Organizations*, published by the American Institute of Certified Public Accountants. The financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB). For purposes of presentation, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operational revenues and expenses.

The Combined Unit uses proprietary fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on GASB Statement Number 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, as amended, the District has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Financial Statement Presentation: The Combined Unit applies the provisions of GASB 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments* (Statement 34), as amended by GASB 37, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments: Omnibus*, and Statement 38, *Certain Financial Statement Note Disclosures*. Statement 34 established financial reporting standards for all state and local governments and related entities. Statement 34 primarily relates to presentation and disclosure requirements. The impact of this change was related to the format of the financial statements; the inclusion of management's discussion and analysis; and the preparation of the statement of cash flows on the direct method. The application of these accounting standards had no impact on the total net assets.

Management's Discussion and Analysis: Statement 34 requires that financial statements be accompanied by a narrative introduction and analytical overview of the Combined Unit's financial activities in the form of "management's discussion and analysis" (MD&A). This analysis is similar to the analysis provided in the annual reports of organizations in the private sector.

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

Cash and cash equivalents: Cash and cash equivalents include deposits with financial institutions and investments in highly liquid debt instruments with an original maturity of three months or less. Cash and cash equivalents exclude amounts whose use is limited by board designation or by legal restriction.

Patient Accounts Receivable: Patient accounts receivable consists of amounts owed by various governmental agencies, insurance companies and private patients. The Combined Unit manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectability and providing for allowances on their accounting records for estimated contractual adjustments and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Supplies: Inventories are consistently reported from year to year at cost determined by average costs and replacement values which are not in excess of market. The Combined Unit does not maintain levels of inventory values such as those under a first-in, first out or last-in, first out method.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 15 years for equipment. The Combined Unit periodically reviews its capital assets for value impairment. As of December 31, 2024 the Combined Unit has determined that no capital assets are impaired.

Compensated Absences: The employees of the Combined Unit earn vacation, paid time off, holiday and float benefits at varying rates. These accrual rates are determined based on the employee's years of service, full time equivalent (FTE) status, and union affiliation. This benefit can accumulate up to specified maximum levels. Accumulated vacation, paid time off, and float benefits are paid to an employee upon either termination or retirement. The combined liability for vacation, paid time off, and float liabilities as of December 31, 2024 and 2023 totaled $4,057,874 and $4,279,528, respectively.

Some employees also have a Legacy bank of hours that can be utilized, once they have exhausted all other accruals, and is payable at one half of their hourly rate of pay upon termination or retirement. The liability for these hours as of December 31, 2024 and 2023 totaled $869,222 and $902,141, respectively.

Risk Management: The Combined Unit is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters.

Net position: Net position is presented in three categories. The first category of net position is "invested in capital assets, net of related debt". This category of net position consists of capital assets (both restricted and unrestricted), net of accumulated depreciation and reduced by the outstanding principal balances of any debt borrowings that were attributable to the acquisition, construction, or improvement of those capital assets.

The second category is "restricted" net position. This category consists of externally designated constraints placed on assets by creditors (such as through debt covenants), grantors, contributors, law or regulations of other governments or government agencies, or law or constitutional provisions or enabling legislation. The third category is "unrestricted" net position. This category consists of net position that does not meet the definition or criteria of the previous two categories.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Net Patient Service Revenues: Net patient service revenues are reported in the period at the estimated net realized amounts from patients, third-party payors and others including estimated retroactive adjustments under reimbursement agreements with third-party programs. Normal estimation differences between final reimbursement and amounts accrued in previous years are reported as adjustments of current year's net patient service revenues.

Financial Assistance: The Hospital offers a financial assistance policy for its patients. The financial assistance policy describes the Hospital's policy for both charity care (free care) and discounted care, and the process for patients who need help paying for their emergency and medically necessary care. The intent of this policy is to satisfy the requirements of Section 501(r) of the Internal Revenue Code and California Health and Safety Code sections 127400 to 127446. Because the Combined Unit does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues. Services provided are recorded as gross patient service revenues and then written off entirely as an adjustment to net patient service revenues.

Operating Revenues and Expenses: The Combined Unit's statement of revenues, expenses and changes in net assets distinguishes between operating and non-operating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the Combined Unit's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Non-operating revenues and expenses are those transactions not considered directly linked to providing health care services.

Income taxes: The District operates under the purview of the Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income. However, income from the unrelated business activities of the District may be subject to income taxes.

The Hospital is exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). Thus, no provision for income taxes is included in the accompanying financial statements. The Hospital follows the accounting guidance for accounting for uncertainty in income taxes. The Hospital is subject to federal and state income taxes to the extent it has unrelated business income. In accordance with the guidance for uncertainty in income taxes, management has evaluated its material tax positions and determined that there are no income tax effects with respect to its financial statements. The Hospital is subject to examination by federal or state authorities within the three-year statute of limitations applied to tax filings. The Hospital management has not been notified of any impending examination and no examinations are currently in process.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Revenue Recognition: As previously stated, net patient service revenues are reported at amounts that reflect the consideration to which the Combined Unit expects to be entitled in exchange for patient services. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and include variable consideration for retroactive revenue adjustments due to settlement of third-party payor audits, reviews, and investigations. Generally, the Combined Unit bills the patients and third-party payors several days after the patient receives healthcare services at the Combined Unit. Revenue is recognized as services are rendered.

The Combined Unit has agreements with third-party payors that provide for payments to the Combined Unit at amounts different from its established rates. Payment arrangements include prospectively determined rates per day, discharge or visit, reimbursed costs, discounted charges and per diem payments. 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.

NOTE 2 – CASH AND CASH EQUIVALENTS

As of December 31, 2024 and 2023, the Combined Unit had deposits in a financial institution of $3,703,331 and $6,639,515, respectively. All these funds are in the form of cash and cash equivalents, which were collateralized in accordance with the California Government Code ("CGC"), except for $250,000 per account that is federally insured.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the Combined Unit's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the Combined Unit's deposits.

California law also allows financial institutions to secure Combine Unit deposits by pledging first trust deed mortgage notes having a value of 150% of the Combined Unit's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the Combined Units.

Combined Unit investment policies allow investments in U.S. Government securities and state and local agency funds which invest in U.S. Government securities. These investments, when present, are stated at quoted market values. Changes in market value between years are reflected as a component of investment income in the accompanying statement of revenues, expenses, and changes in net position.

NOTE 3 – ASSETS LIMITED AS TO USE

Assets limited as to use are comprised of the remaining funds received from bond issuance. These remaining funds will be used to upgrade the emergency room, perinatal unit, various equipment, and energy efficiency projects.

Assets limited as to use as of December 31, 2024 and 2023 were comprised of the following:

	2024	2023
Cash and cash euivalents held by U.S. Bank under agreements	$ 14,394,320	$ -
Less current portion	(2,691,432)	-
Net assets limited as to use	$ 11,702,888	$ -

NOTE 4 - NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS

The Combined Unit renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, commercial insurance companies, health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Patient service revenues from these programs approximate 93.2% of gross patient service revenues for the year ended December 31, 2024.

The Medicare Program reimburses the Hospital on a cost basis payment system for inpatient and outpatient hospital services. The cost-based reimbursement is determined based on filed Medicare cost reports. Clinic services are reimbursed based on fee schedules.

The Combined Unit contracts to provide services to Medi-Cal, HMO and PPO inpatients on negotiated rates. Certain outpatient reimbursement is subject to a schedule of maximum allowable charges for Medi-Cal and to a percentage discount for HMOs and PPOs.

Both the Medicare and Medi-Cal program's administrative procedures preclude final determination of amounts due to the Combined Unit for services to program patients until after patients' medical records are reviewed and cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. The Medicare and Medi-Cal cost reports are subject to audit and possible adjustment. Management is of the opinion that no significant adverse adjustment to the recorded settlement amounts will be required upon final settlement.

Medicare and Medi-Cal revenue accounted for approximately 55% of the Combined Unit’s net patient revenues for the year ended December 31, 2024. Laws and regulations governing the Medicare and Medi-Cal 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.

NOTE 5 - CONCENTRATION OF CREDIT RISK

The Combined Unit grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the Combined Unit and management does not believe that there is any credit risk associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the Combined Unit. Concentration of patient accounts receivable at December 31, 2024 and 2023, were as follows:

	2024	2023
Medicare	$ 74,881,383	$ 34,412,365
Medi-Cal	28,028,570	43,776,399
Other third party payors	44,219,148	50,431,841
Self pay and other	35,432,353	22,023,987
Gross patient accounts receivable	182,561,454	150,644,592
Less allowances for contractual adjustments and bad debts	(157,563,899)	(135,517,104)
Net patient accounts receivable	$ 24,997,555	$ 15,127,488

NOTE 6 - CAPITAL ASSETS

Capital assets as of December 31, 2024 were comprised of the following:

	Balance at 12/31/2023	Transfers & Additions	Transfer & Retirements	Balance at 12/31/2024
CIP	$ 989,966	$ 242,426	$ -	$ 1,232,392
Land	-	9,632,081	-	9,632,081
Buildings	-	30,664,627	-	30,664,627
Equipment	2,795,443	2,017,897	-	4,813,340
Software	1,071,732	53,293	-	1,125,025
Totals at historical cost	4,857,141	42,610,324	-	47,467,465
Less accumulated depreciation	(1,718,345)	(652,803)	-	(2,371,148)
Capital assets, net	$ 3,138,796	$ 41,957,521	$ -	$ 45,096,317

NOTE 6 - CAPITAL ASSETS (continued)

Capital assets as of December 31, 2023 were comprised of the following:

	Balance at 12/31/2022	Transfers & Additions	Transfer & Retirements	Balance at 12/31/2023
CIP	$ 965,266	$ 24,700	$ -	$ 989,966
Equipment	1,738,255	1,057,188	-	2,795,443
Software	1,020,683	51,049	-	1,071,732
Totals at historical cost	3,724,204	1,132,937	-	4,857,141
Less accumulated depreciation	(920,551)	(797,794)	-	(1,718,345)
Capital assets, net	$ 2,803,653	$ 335,143	$ -	$ 3,138,796

NOTE 7 - DEBT BORROWINGS

Long-term debt consists of a note payable, a line of credit, and finance lease agreements as follows:

	2024	2023
District debt		
Santa Cruz County	$ 1,300,004	$ 1,700,000
Mako Surgical	299,790	795,000
Phillips Medical	65,278	-
Bond Payable 24A	46,145,000	-
Bond Payable 24B	7,205,000	-
Premiums, net of accumulated accretion	1,751,435	-
Total District debt:	56,766,507	2,495,000
Hospital debt		
David and Lucille Packard Foundation	2,294,266	4,715,253
Distressed Hospital Loan	8,300,000	8,300,000
Alliance Advance	3,500,000	-
Philips Medica Capital Lease (multiple finance leases	1,275,356	18,834
Total Hospital debt:	15,369,622	13,034,087
Total debt borrowings	72,136,129	15,529,087
Less current maturities	(6,289,901)	(3,120,987)
Debt borrowings, net of current maturities	$ 65,846,228	$ 12,408,100

NOTE 7 - DEBT BORROWINGS (continued)

Santa Cruz County: The District has a note payable with the County of Santa Cruz, for the purpose of funding a Letter of Credit with the Santa Cruz County Bank, which was a requirement of the Hospital lease agreement. Interest at 0% with four principal payments in the amount of $150,000 due the last day of each quarter, beginning September of 2025. $1,000,000 is to be forgiven over 15 months beginning July of 2024, in exchange for providing youth crisis services.

Mako Surgical: The District assumed an agreement to purchase a surgical robotic arm and related systems for hip and knee applications. The interest rate is 0%. At the time, there were four remaining principal payments of $120k, $200k, $280k, and $315k. The agreement includes an annual supply rebate program, which has the potential to fully offset these payments. The final payment, less supply rebates, is due in March of 2026.

Phillips Medical: The District entered a settlement agreement to lease a Philips Diamond Select Advance Azurion 7 Cath Lab with Intrasight and repay related construction costs which were previously advanced by Philips Medical Capital. The interest rate is 4.38%, with an initial payment of $395,100, followed by three months at $0.00, three months at $10,573.16, and 66 months at $21,386.59. The final payment on the lease is in June of 2030. The Constructions costs are payable in 60 monthly installments of $1,994.50 with the final installment due in December of 2028.

Bond Payable 24A: Tax exempt general obligation bonds (election 2024); interest at 5.00% due semiannually; principal due in annual amounts ranging from $620,000 on September 1, 2041 to $5,760,000 on September 1, 2054; collateralized by property taxes.

Bond Payable 24B: Taxable general obligation bonds (election 2024); interest at 5.00% due semiannually; principal due in annual amounts ranging from $310,000 on September 1, 2034 to $1,285,000 on September 1, 2040; collateralized by property taxes.

David and Lucille Packard Foundation: The Hospital is a co-borrower on a note payable collateralized by community pledges to the Pajaro Valley Healthcare District Project (the Project). As community pledges are received, the Project will make annual principal payments, with the first payment due on March 31, 2024, and the final payment due on January 31, 2026. The Hospital will relieve the debt and recognize revenue as principal payments are made by the Project. Interest at 0.5% will be paid by the Hospital bi-annually on March 31st and September 30th, with the final payment due on January 31, 2026.

Distressed Hospital Loan: The Hospital received Distressed Hospital loan proceeds of $8,300,000 on November 1, 2023. These funds were used to maintain operations and in support of some Hospital projects to stabilize operations. The six-year loan is zero interest and has an 18-month grace period before repayment. The legislation behind the Distressed Hospital Loan allows for the possibility of loan forgiveness, that has not been confirmed as of 12/31/24. However, a loan modification was approved in April of 2025, providing an additional 12 months of deferral.

Alliance Advance: Interest free Advance from Central California Alliance for Health against future Hospital Quality Assurance Private Hospital Directed Payment expected in April of 2025.

NOTE 8 – LINE OF CREDIT

In November of 2024, the District increased its $3.0 million line of credit to $4.0 million with Santa Cruz County Bank, secured by community guarantors. The LOC has an interest rate of 1% plus prime (8.75% at December 31, 2024) and matures on November 5, 2026. Accrued interest on any outstanding principal is due monthly. As of December 31, 2024, the District had drawn $3,000,000 on the credit line.

NOTE 9 - RETIREMENT PLANS

The Hospital sponsors two 401(a) defined contribution retirement plans for employer contributions: one for service and maintenance employees payable on a calendar year-end that contributes 6% or higher depending on years of service of gross annual earnings; the second 401(a) plan covers other non-management, non-highly compensated employees and contributes 6% of gross earnings bi-weekly. The Hospital also sponsors a 457(b) deferred compensation plan for employee contributions, withheld from bi-weekly earnings.

In 2024, The Hospital made bi-weekly payment to Principal totaling $2,329,363 in 401(a) employer contributions, and $3,913,589 in 457(b) Employee Contributions. Additionally, 401(a) employer contributions were made in September of 2024 for the SEIU Service & Maintenance 2023 plan year totaling $461,190.

Accrued payroll and related liabilities include $108,424 of 401(a) employer liabilities, calculated from the final two pay period of the year and contributed to the plan in January of 2024. 401(a) liabilities for SEIU Service & Maintenance employees was $526,675 as of December 31, 2024.

NOTE 10 - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of December 31, 2024, the Combined Unit had $1,232,392 in construction-in-progress for the Cardio Cath Lab. Approximately $0 in remobilization fees are remaining to complete construction. The project is complete. The Combined Unit is waiting for a certificate of occupancy to place the Cath Lab in service.

Litigation: The Combined Unit may from time-to-time be involved in litigation and regulatory investigations which arise in the normal course of doing business. As of December 31, 2024, management is not aware of any legal matters or potential regulatory investigations.

Medical Malpractice Insurance: The Combined Unit maintains commercial malpractice liability insurance coverage under a claims made and reported policy covering losses up to $15 million per claim and $25 million in the aggregate for all claims, subject to a deductible of $150,000 Indemnity & Expense each claim. The District plans to maintain the insurance coverage by renewing its current policy, or by replacing it with equivalent insurance.

NOTE 10 - COMMITMENTS AND CONTINGENCIES (continued)

Workers Compensation Program: The Hospital workers compensation policy is through BETA Healthcare Group and renews in July 2025. Annual premium is $1,155,232. The district workers compensation policy is through Travelers and renews in Oct 2025. The annual premium is $28,160.

Health Insurance Portability and Accountability Act: The Health Insurance Portability and Accountability Act (HIPAA) was enacted August 21, 1996, to ensure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Management believes the Combined Unit is in compliance with HIPAA as of December 31, 2024 and 2023.

Regulatory Environment: The Combined Unit is subject to several laws and regulations. These laws and regulations include matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Government activity has increased with respect to possible violations of statues and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Combined Unit is in compliance with all applicable government laws and regulations and is not aware of any future actions or unasserted claims at this time.

NOTE 11 - LEASES

During 2024 the District purchased the hospital building from Medical Properties Trust, Inc., therefore this lease is no longer included. The Combined Unit has multiple equipment and building leases, only one was required to be capitalized under GASB 87. The District leases office space used for the Urology Center with a remaining term of 69 months and a fixed monthly payment during the term. All other lease arrangements are either immaterial or have a term of 12 months or less.

This lease does not have a readily determinable discount rate. The estimated borrowing rate is 9.5%. Variable lease costs are excluded from the present value of lease obligations. The District's lease agreements do not contain any material restrictions, covenants, or any material residual value guarantees.

NOTE 11 – LEASES (continued)

Lease related assets and liabilities as of December 31, 2024 and 2023 consist of the following:

Lease assets:	2024	2023
MPT	$ -	$ 32,414,776
Urology center	417,973	502,704
Other	-	631,939
Total lease assets	$ 417,973	$ 33,549,419

Lease liabilities:	2024	2023
MPT	$ -	$ 33,446,113
Urology center	417,976	507,764
Other	-	605,237
Total lease liabilities	$ 417,976	$ 34,559,114

Maturities of lease liabilities under noncancellable operating leases as of December 31, 2024, are as follows:

Years ending December 31,	
2025	$ 93,876
2026	93,876
2027	93,876
2028	93,876
Thereafter	164,292
Total	539,796
Less imputed interest	(121,820)
Present value of lease liabilities	$ 417,976

NOTE 12 – GOING CONCERN

The accompanying financial statements have been prepared assuming that the Combined Unit will continue as a going concern. The Hospital has reduced its annual losses since emerging from bankruptcy in 2022, however it suffered significant losses from operations in 2023 and has experienced cash flow difficulties since the District acquired them in September 2022. The Combined unit also has only 9 days cash on hand and significant debt obligations. These conditions raise substantial doubt about the Hospital's ability to continue as a going concern. Management's plans regarding these matters are described above in the Management's Discussion and Analysis. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. In view of these matters, continuation as a going concern is dependent on continued operations of the District and the Hospital, which in turn is dependent on the District's and the Hospital's ability to increase collections, decrease expenses, and raise additional capital.
The Combined Unit's management continues its efforts to improve its financial position and overall fiscal performance. Initiatives were created during the budget cycle that are tracked to see their overall impact to performance. Service offerings are reviewed to identify opportunities to grow business and gain more revenues.

Management utilizes a daily cash tracking tool to capture deposits, track expenditures and forecast future liabilities and cash balances. Management has implemented additional reporting and monitoring tools to aid the leadership in achieving its financial turnaround plans.

The Hospital was the victim of a cyber attack in November 2024, The attack levied a significant impact on operations and temporarily slowed cash collections. Recovery efforts are on going. The District has Cyber Attack insurance and is working closely with the insurer and related vendors.

The District has secured multiple funding sources to address the cashflow challenges. The District continues to seek new funding sources. The District has applied to new inter-governmental transfer programs for 2025-26.

The Hospital received Distressed Hospital loan proceeds of $8,300,000 on November 1, 2024. These funds were used to maintain operations and in support of certain Hospital projects to further stabilize operations. The six-year loan is at 0.0% interest and has an 18-month grace period before repayment begins. The Hospital received approval for loan modification resulting in an additional 12 month deferral for payments, which will preserve $1.8M in working capital in the short term. The Hospital will seek further loan modification up to loan forgiveness as the program allows.

The District passed Measure N on the March 2024 ballot. Measure N is a $116M general obligation bond program intended to renovate the Hospital and improve services to the community. Measure N allows the hospital to modernize and expand the facility. The District sold the first tranche of bonds in Sept 2024 for $53.5 million. The District used $40 million to purchase the hospital building and land.

NOTE 12 – GOING CONCERN (continued)

The District has a $3.0 million line of credit with Santa Cruz County Bank, secured by community guarantors. In November 2024, a fourth guarantor was added, thereby increasing the line of credit from $3.0 million to $4.0 million As of December 31, 2024, the District has drawn $3.0M on the credit line. The District subsequently advanced the additional $1.0 million to help cover expenses during the cyber attack recovery.

The Pajaro Valley Healthcare District Philanthropy Foundation is a non-profit 501(c)3 corporation in existence to raise funds and secure grants for Hospital activities and services. In 2024, they were able to secure $2.4M in grants, including a three year $1.48 million Medi-Cal Capacity Grant.

The District received $1.0 million in loan forgiveness from the County of Santa Cruz in exchange for supporting the County's Pediatric Stabilization unit while they build a new facility.

NOTE 13 – SUBSEQUENT EVENTS

Management evaluated the effect of subsequent events on the combined financial statements through May 28, 2024, the date the combined financial statements are issued, and determined that there are no material subsequent events that have not been disclosed.

SUPPLEMENTARY SCHEDULES

Pajaro Valley Healthcare District

Combining Statement of Net Position

December 31, 2024

	District	Hospital	Eliminations	Total
Assets				
Current Assets				
Cash and cash equivalents	$ 1,168,762	$ 2,534,569	$ -	$ 3,703,331
Assets limited to use	2,691,432	-	-	2,691,432
Patient accounts receivable, net of allowances	20,452	24,977,103	-	24,997,555
Other accounts receivable	527,743	101,044	(500,000)	128,787
Inventories	20,859	3,819,707	-	3,840,566
Prepaid expenses and other current assets	213,951	1,721,791	-	1,935,742
Total current assets	4,643,199	33,154,214	(500,000)	37,297,413
Assets limited to use, net of current debt service	11,702,888	-	-	11,702,888
Capital assets, net of accumulated depreciation	43,469,615	1,626,702	-	45,096,317
Lease assets	417,973	-	-	417,973
Due from district	-	11,525,293	(11,525,293)	-
Total assets	60,233,675	46,306,209	(12,025,293)	94,514,591
Deferred outflows of resources, net of inflows	647,855	-	-	647,855
	$ 60,881,530	$ 46,306,209	$ (12,025,293)	$ 95,162,446
Liabilities and Net Position				
Current liabilities				
Line of credit	$ -	$ 3,000,000	$ -	$ 3,000,000
Current maturities of debt borrowings	1,358,666	4,931,235	-	6,289,901
Accounts payable and accrued expenses	961,831	14,196,578	(500,000)	14,658,409
Accrued payroll and related liabilities	195,132	7,039,253	-	7,234,385
Estimated third party payor settements	-	569,228	-	569,228
IBNR self funded health benefits	-	685,410	-	685,410
Total current liabilities	2,515,629	30,421,704	(500,000)	32,437,333
Debt borrowings, net of current maturities	55,431,775	10,414,453	-	65,846,228
Lease liabilities	417,976	-	-	417,976
Due to hospital	11,525,293	-	(11,525,293)	-
Total liabilities	69,890,673	40,836,157	(12,025,293)	98,701,537
Net position				
Invested in capital assets, net of related debt	43,469,615	1,626,702	-	45,096,317
Restricted	14,394,320	-	-	14,394,320
Unrestricted	(66,873,078)	3,843,350		(63,029,728)
Total net position	(9,009,143)	5,470,052	-	(3,539,091)
Total liabilities and net position	$ 60,881,530	$ 46,306,209	$ (12,025,293)	$ 95,162,446

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combining Statement of Revenues, Expenses and Changes in Net position

For The Year Ended December 31, 2024

	District	Hospital	Eliminations	Total
Operating revenues				
Net patient service revenues	$ 2,991,509	$ 139,100,701	$ -	$ 142,092,210
Other operating revenues	601,300	8,744,071	(500,000)	8,845,371
Total operating revenues	3,592,809	147,844,772	(500,000)	150,937,581
Operating expenses				
Salaries & wages	3,142,722	67,526,595	-	70,669,317
Employee benefits	460,350	20,067,083	-	20,527,433
Contract labor	-	5,278,300	-	5,278,300
Supplies	99,459	12,302,800	-	12,402,259
Medical specialist fees	373,982	9,068,037	-	9,442,019
Purchased services	395,443	12,532,379	-	12,927,822
Lease cost and rent	291,685	1,679,246	(500,000)	1,470,931
Repairs & maintenance	594	1,516,321	-	1,516,915
Utilities	23,681	2,414,547	-	2,438,228
Depreciation	578,272	74,531	-	652,803
Other operating expenses	48,982	10,127,134	-	10,176,116
Property taxes & insurance	1,044,353	2,171,092	-	3,215,445
Interest	2,378,025	327,849	-	2,705,874
Total operating expenses	8,837,548	145,085,914	(500,000)	153,423,462
Operating income (loss)	(5,244,739)	2,758,858	-	(2,485,881)
Nonoperating revenues (expenses)				
Rental income	1,120,665	-	-	1,120,665
Interest income	373,424	-	-	373,424
District tax revenue	897,144	-	-	897,144
Total nonoperating revenues (expenses)	2,391,233	-	-	2,391,233
Increase/(decrease) in net position	(2,853,506)	2,758,858	-	(94,648)
Net position, beginning of the year	(6,155,637)	2,711,194	-	(3,444,443)
Net position, end of year	$ (9,009,143)	$ 5,470,052	$ -	$ (3,539,091)

See accompanying notes to the financial statements

JWT & Associates, LLP

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Independent Auditors Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

The Board of Directors
Pajaro Valley Health Care District
Watsonville, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the combined financial statements of the business-type activities of the Pajaro Valley Health Care District (the District) as of and for the year ended December 31, 2024, and the related notes to the combined financial statements, which collectively comprise the District's combined financial statements, and have issued our report thereon dated May 28, 2025.

Internal Control over Financial Reporting

In planning and performing our audit of the combined financial statements, we considered the District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's combined financial statements will not be prevented or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given those limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's combined financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the combined financial statement. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the District's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

JJW & Associates, LLP

Fresno, California
May 28, 2025

Pajaro Valley Health Care District

Schedule of Findings and Questioned Costs

For the Year Ended December 31, 2024

I. Summary of Auditor's Results

Type of auditor's report issued:	Unmodified	
Internal Control over financial reporting:		
Material weakness identified?	___yes	_X_ no
Significant deficiency(ies) identified that are not considered to be material weaknesses?	___yes	_X_ no
Noncompliance material to financial statements noted?	___yes	_X_ no

II. Current Year Audit Findings and Questioned Costs

Financial Statement Findings

None reported

III. Prior Year Audit Findings and Questioned Costs

None reported

Audited Financial Statements
and Other Financial Information

PAJARO VALLEY
HEALTH CARE DISTRICT

December 31, 2023

JWT & Associates, LLP
Advisory Assurance Tax

Pajaro Valley Health Care District

Audited Financial Statements and Other Financial Information

Table of Contents

JWT & Associates, LLP

Advisory Assurance Tax

1111 East Herndon, Suite 211, Fresno, California 93720
Voice: (559) 431-7708 Fax:(559) 431-7685

Report of Independent Auditors

The Board of Directors
Pajaro Valley Health Care District
Watsonville, California

Opinion

We have audited the accompanying combined financial statements of Pajaro Valley Health care District (the District) and Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (the Hospital), collectively referred to as the "Combined Unit," as of December 31, 2023 and 2022, which comprise the combined statements of net position as of December 31, 2023 and 2022, and the related combined statements of revenues, expenses, and changes in net position, and cash flows for the years then ended, and the related notes to the combined financial statements.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial positions of the business-type activities and the discretely presented component unit of the District, as of December 31, 2023 and 2022, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinion

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor's Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from

fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

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

Emphasis of Matter – Going Concern

The accompanying financial statements have been prepared assuming that the District will continue as a going concern. As discussed in Note 10 to the financial statements, the Hospital has reduced the annual losses since emerging from bankruptcy in 2022, however it has suffered significant losses from operations and has experienced cash flow difficulties. These conditions raise substantial doubt about the District's ability to continue as a going concern. Management's plans regarding these matters are also described in Note 10 and in the Management's Discussion and Analysis. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. Our opinion is not modified with respect to this matter.

JWT & Associates, LLP

Fresno, California
March 27, 2024

Pajaro Valley Health Care District

Management's Discussion and Analysis

For the Year Ended December 31, 2023

Management of the Pajaro Valley Health Care District (the District) has prepared this annual discussion and analysis in order to provide an overview of performance for the fiscal year ended December 31, 2023, in accordance with the Governmental Accounting Standards Board Statement No. 34, Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments. The District wholly owns the Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (the Hospital). Together they are referenced as the Combined Unit. The intent of this document is to provide additional information on the Combined Unit's financial performance as a whole and a prospective look at revenue, operating expenses, and capital development plans. This discussion should be reviewed in conjunction with the audited financial statements for the fiscal year ended December 31, 2023, and accompanying notes to the financial statements to enhance one's understanding of the Combined Unit's financial performance. Being the first full year of operation, the prior comparison year is a 4-month period.

Introduction

The Combined Unit offers readers of our financial statements this narrative overview and analysis of our financial activities for the year ended December 31, 2023. We encourage readers to consider the information presented here in conjunction with the Combined Unit's financial statements, including the notes thereto.

The Combined Unit is governed by a five-member elected board of directors. Day-to-day operations are managed by the Chief Executive Officer. The Combined Unit employed 663 employees on December 31, 2023, and had monthly payroll of approximately $5.85M, not including benefits.

Required Financial Statements

The Combined Unit's financial statements offer short-term and long-term information about its activities. The statement of net position includes all of the Combined Unit's assets and liabilities at December 31, 2023 and provides information about the nature and amounts of investments in resources (assets) and the obligations to Combined Unit creditors (liabilities). The statement of net position also provides the basis for evaluating the capital structure of the Combined Unit and assessing the liquidity and financial flexibility of the Combined Unit.

All revenue and expenses for the years ended December 31, 2023, and 2022 are accounted for in the statement of revenue, expenses, and changes in net position. The statement can be used to determine whether the Combined Unit has successfully recovered all its costs through its patient service revenue and other revenue sources. Revenue and expenses are reported on an accrual basis, which means the related cash could be received or paid in a subsequent period.

The final required statement is the statement of cash flows. This statement reports cash receipts, cash payments and net changes in cash resulting from operations, investing and financial activities for the years ended December 31, 2023, and 2022. They also provide answers to such questions as where cash came from, what was cash used for and what was the change in the cash balance during the reporting period.

Pajaro Valley Health Care District

Management's Discussion and Analysis

For the Year Ended December 31, 2023

Financial Analysis of the Combined Unit

The Combined Unit's net position, the difference between assets and liabilities, is a way to measure financial health or financial position. Over time, sustained increases or decreases in the Combined Unit's net position are one indicator of whether its financial health is improving or deteriorating. However, other nonfinancial factors such as changes in economic conditions, population growth and new or revised government regulations and legislation should also be considered. In 2023, the Combined Unit's net position decreased by approximately $13.2M (see footnotes).

Financial Summary

- Total assets ended at $64.6 million being largely comprised of net patient AR $15.2M) and lease assets ($33.5M). Total cash and cash equivalents at year end were $6.6 million (see the Statements of Cash Flows for changes).
- Current assets ended at $27.9M compared to current liabilities which ended at $21M. The current ratio for this year was 1.33.
- Net operating revenues were $134.5M and operating expenses were $148.3M. There was an operating loss of $13.8M
- The decrease in net position was $13.2M See footnotes for more information.

Items Affecting Operations

The challenges facing the Combined Unit this fiscal period were largely similar, although varying in degree of intensity, to those issues facing the health care industry in general and for rural health care facilities in particular. Where the immediate environment and circumstances uniquely influence the Combined Unit, these areas are also highlighted in the discussion below:

- Reimbursement: Medicare and Medi-Cal programs continue to look for ways to reduce reimbursement.
- Labor: Physician positions continue to be difficult to recruit in rural areas.
- The Hospital emerged from bankruptcy and was purchased by The District on September 1, 2022, with limited working capital. The District continues to work to stabilize operations.
- The District has secured multiple funding sources to address the cashflow challenges.

Items Affecting Operations (continued)

- The Hospital renegotiated all major payor contracts to improve reimbursement. As of December 31, 2023, all were implemented.

- The Hospital faces challenges recruiting staff due to the high cost of living in the area and thus relies on contracted resources to supplement staffing. These resources come at a slightly higher cost.

- The District leases hospital real estate from Medical Properties Trust. The Hospital operations must cover this lease payment along with all deficits of The District.

In summary, the external environment continues to challenge rural healthcare providers in particular, with continuing declines in reimbursement, increases in uncompensated care and ongoing labor and health insurance issues. The Combined Unit strives to improve relationships within our community through collaboration with community leaders and service groups, outreach to neighboring healthcare facilities, improving access to care and recruitment of quality medical providers.

The Combined Unit's employees are working together to continue to find ways to make progress on improving how the Combined Unit organizes and processes work in such a way that it continues to improve patient care and service to its patients and community, while striving to improve its financial position and overall fiscal performance.

The Hospital received Distressed Hospital loan proceeds of $8,300,000 on November 1, 2023. These funds were used to maintain operations and in support of some Hospital projects to stabilize operations. The six-year loan is zero interest and has an 18-month grace period before repayment. The legislation behind the Distressed Hospital Loan allows for the possibility of loan forgiveness, however that has not been confirmed as of 12/31/23.

The District placed Measure N on the March 2024 ballot. Measure N is a $116M general obligation bond program intended to renovate the Hospital and improve services to our community. Measure N will allow the Hospital to modernize and expand our facility. It will also allow us to purchase the Hospital building and land through the locally controlled accountable Pajaro Valley Health Care District. The purchase would eliminate the current $3.0M annual lease payments to the third-party owner, allowing those funds to be reinvested in supporting staff and patient care.

The District obtained a $3.0 million line of credit with Santa Cruz County Bank, secured by community guarantors. As of 12/31/23, the District had not drawn on the credit line. The Pajaro Valley Healthcare District Philanthropy Foundation is a newly formed non-profit 501(c)3 corporation in existence to raise funds and secure grants for Watsonville Community Hospital activities and services. In 2023 they were able to secure a $250K grant for the purchase of anesthesia machines. Additionally, they secured $60K in grants to support translation services to support patient care for non-English speaking patients.

Management has implemented a cash management plan and is actively managing its revenue cycle (collections) activities. Additionally, the District (Hospital) is opening a Cath Lab in Q2 2024 which will provide new revenue generating opportunities. Other expense initiatives are also planned for 2024.

Pajaro Valley Healthcare District

Combined Statement of Net Position

	December 31 2023	December 31 2022
Assets		
Current Assets		
Cash and cash equivalents	$ 6,639,515	$ 8,660,568
Patient accounts receivable, net of allowances	15,195,777	21,266,511
Other accounts receivable	-	1,498,921
Inventories	3,841,424	2,158,403
Prepaid expenses and other current assets	2,260,013	2,510,580
Total current assets	27,936,729	36,094,983
Capital assets, net of accumulated depreciation	3,138,796	3,015,808
Lease assets	33,549,419	34,759,953
Total assets	$ 64,624,944	$ 73,870,744
Liabilities and Net Position		
Current liabilities		
Current maturities of debt borrowings	$ 3,120,987	$ 1,702,035
Accounts payable and accrued expenses	6,531,695	6,922,004
Accrued payroll and related liabilities	9,014,485	8,641,862
Estimated third party payor settements	728,871	1,597,184
IBNR self funded health benefits	1,706,135	2,787,581
Total current liabilities	21,102,173	21,650,666
Debt borrowings, net of current maturities	12,408,100	7,478,951
Lease liabilities	34,559,114	35,023,963
Total liabilities	68,069,387	64,153,580
Net position		
Invested in capital assets, net of related debt	3,138,796	2,891,822
Restricted	2,600,000	2,600,000
Unrestricted	(9,183,239)	4,225,342
Total net position	(3,444,443)	9,717,164
Total liabilities and net position	$ 64,624,944	$ 73,870,744

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combined Statement of Revenues, Expenses and Changes in Net position

	Year Ended December 31	
	2023	2022
Operating revenues		
Net patient service revenues	$ 129,114,224	$ 33,308,250
Other operating revenues	5,367,526	532,944
Total operating revenues	134,481,750	33,841,194
Operating expenses		
Salaries & wages	70,156,726	17,381,952
Employee benefits	21,460,602	6,100,838
Contract labor	6,931,655	2,414,616
Supplies	8,319,794	3,688,032
Medical specialist fees	7,751,461	2,876,058
Purchased services	13,458,807	5,579,962
Lease cost and rent	1,914,944	1,649,758
Repairs & maintenance	1,359,867	316,371
Utilities	2,466,097	712,745
Depreciation and amortization	1,979,831	384,786
Other operating expenses	6,190,016	2,906,562
Property taxes & insurance	2,444,845	731,821
Interest	3,841,925	320,538
Total operating expenses	148,276,570	45,064,039
Operating income (loss)	(13,794,820)	(11,222,845)
Nonoperating revenues		
Rental income	529,666	277,387
Interest income	103,547	-
Total nonoperating revenues (expenses)	633,213	277,387
Net income/(loss) before extraordinary item	(13,161,607)	(10,945,458)
Gain from acquisition of hospital	-	20,662,622
Increase/(decrease) in net position	(13,161,607)	9,717,164
Net position, beginning of the year	9,717,164	-
Net position, end of year	$ (3,444,443)	$ 9,717,164

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combined Statement of Cash Flows

	Year Ended December 31	
	2023	2022
Cash flows from operating activities		
Cash received for operations	$ 137,341,168	$ 12,352,408
Cash payments to suppliers and contractors	(52,660,249)	(18,622,904)
Cash payments to employees and benefit programs	(92,326,152)	(12,053,347)
Net cash (used in) operating activities	(7,645,233)	(18,323,843)
Cash flows from noncapital financing activities		
Gain from acquisition of hospital	-	20,662,622
Net cash provided by noncapital financing activities	-	20,662,622
Cash flows from investing activities		
Purchases of property, plant & equipment	(1,357,134)	(3,136,584)
Interest income	103,547	-
Rental income	529,666	277,387
Net cash (used in) investing activities	(723,921)	(2,859,197)
Cash flows from financing activities		
Proceeds from debt borrowings	9,095,000	
Prepayments of debt borrowings	(2,746,899)	9,180,986
Net cash provided by financing activities	6,348,101	9,180,986
Increase in cash and cash equivalents	(2,021,053)	8,660,568
Cash and cash equivalents at beginning of year	8,660,568	-
Cash and cash equivalents at end of year	$ 6,639,515	$ 8,660,568

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combined Statement of Cash Flows (continued)

	Year Ended December 31	
	2023	2022
Reconciliation of operating income (loss) to net cash provided by operating activities		
Operating income	$ (13,794,821)	$ (11,222,845)
Adjustments to reconcile operating income to net cash provided by operating activities:		
Depreciation	1,979,831	384,786
Changes in operating assets and liabilities		
Receivables	7,569,656	(22,765,432)
Inventories	(1,683,021)	(2,158,403)
Prepaid expenses and other current assets	295,812	(2,510,580)
Accounts payable and accrued expenses	(435,554)	6,922,004
Accrued payroll and related expenses	372,623	8,641,862
Estimated third party payor settements	(868,313)	1,597,184
IBNR self funded health benefits	(1,081,446)	2,787,581
Net cash (used in) operating activities	$ (7,645,233)	$ (18,323,843)

See accompanying notes to the financial statements

Pajaro Valley Health Care District

Notes to the Financial Statements

For the Year Ended December 31, 2023

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES

Organization: Pajaro Valley Health Care District, (the District) is a public entity organized under Local District Law as set forth in the Health and Safety Code of the State of California. The District is a political subdivision of the State of California and is generally not subject to federal or state income taxes. The District is governed by a five-member Board of Directors, elected from within the district to specified terms of office. The District is located in Watsonville, California. The District wholly owns the Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (the Hospital). The Hospital is a 501(c)(3) component unit of the District and operates a 106 -bed acute care hospital and other patient services. The District's mission is to provide health care services primarily to individuals who reside in the local geographic area. A combining statement presenting both District and Hospital operations is presented in the supplementary information to these combined financial statements.

The District and the Hospital were both created to purchase the operations and certain assets of the Watsonville Community Hospital (WCH) and operate the hospital facility. WCH assets were acquired in September of 2022.

The District has a Professional Services Agreement (PSA) with Coastal Health Partners (CHP). CHP is incorporated under the laws of the State of California and operates as a corporation. This agreement calls for CHP to provide physicians to the District 1206(b) clinic. The District provides support staff to CHP through the Hospital and passes those expenses onto the District Clinic.

The Combined Unit (the District and the Hospital) maintains its financial records in conformity with guidelines set forth by the Local Health Care District Law and the Office of Statewide Health Planning and Development of the state of California.

Basis of Preparation: The accounting policies and financial statements of the Combined Unit generally conform with the recommendations of the audit and accounting guide, *Health Care Organizations*, published by the American Institute of Certified Public Accountants. The financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB). For purposes of presentation, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operational revenues and expenses.

The Combined Unit uses proprietary fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on GASB Statement Number 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, as amended, the District has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Financial Statement Presentation: The Combined Unit applies the provisions of GASB 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments* (Statement 34), as amended by GASB 37, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments: Omnibus*, and Statement 38, *Certain Financial Statement Note Disclosures*. Statement 34 established financial reporting standards for all state and local governments and related entities. Statement 34 primarily relates to presentation and disclosure requirements. The impact of this change was related to the format of the financial statements; the inclusion of management's discussion and analysis; and the preparation of the statement of cash flows on the direct method. The application of these accounting standards had no impact on the total net assets.

Management's Discussion and Analysis: Statement 34 requires that financial statements be accompanied by a narrative introduction and analytical overview of the Combined Unit's financial activities in the form of "management's discussion and analysis" (MD&A). This analysis is similar to the analysis provided in the annual reports of organizations in the private sector.

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

Cash and cash equivalents: Cash and cash equivalents include deposits with financial institutions and investments in highly liquid debt instruments with an original maturity of three months or less. Cash and cash equivalents exclude amounts whose use is limited by board designation or by legal restriction.

Patient Accounts Receivable: Patient accounts receivable consists of amounts owed by various governmental agencies, insurance companies and private patients. The Combined Unit manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectability and providing for allowances on their accounting records for estimated contractual adjustments and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Supplies: Inventories are consistently reported from year to year at cost determined by average costs and replacement values which are not in excess of market. The Combined Unit does not maintain levels of inventory values such as those under a first-in, first out or last-in, first out method.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 15 years for equipment. The Combined Unit periodically reviews its capital assets for value impairment. As of December 31, 2023 the Combined Unit has determined that no capital assets are impaired.

Compensated Absences: The employees of the Combined Unit earn vacation, paid time off, holiday and float benefits at varying rates. These accrual rates are determined based on the employee's years of service, full time equivalent (FTE) status, and union affiliation. This benefit can accumulate up to specified maximum levels. Accumulated vacation, paid time off, holiday, and float benefits are paid to an employee upon either termination or retirement. The combined liability for vacation, paid time off, holiday, and float liabilities as of December 31, 2023 and 2022 totaled $4,279,528 and $4,137,292, respectively.

Some employees also have a Legacy bank of hours that can be utilized, once they have exhausted all other accruals, and is payable at one half of their hourly rate of pay upon termination or retirement. The liability for these hours as of December 31, 2023 and 2022 totaled $902,141 and $982,045, respectively.

Risk Management: The Combined Unit is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters.

Net position: Net position is presented in three categories. The first category of net position is "invested in capital assets, net of related debt". This category of net position consists of capital assets (both restricted and unrestricted), net of accumulated depreciation and reduced by the outstanding principal balances of any debt borrowings that were attributable to the acquisition, construction, or improvement of those capital assets.

The second category is "restricted" net position. This category consists of externally designated constraints placed on assets by creditors (such as through debt covenants), grantors, contributors, law or regulations of other governments or government agencies, or law or constitutional provisions or enabling legislation. The third category is "unrestricted" net position. This category consists of net position that does not meet the definition or criteria of the previous two categories.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Net Patient Service Revenues: Net patient service revenues are reported in the period at the estimated net realized amounts from patients, third-party payors and others including estimated retroactive adjustments under reimbursement agreements with third-party programs. Normal estimation differences between final reimbursement and amounts accrued in previous years are reported as adjustments of current year's net patient service revenues.

Financial Assistance: The Hospital offers a financial assistance policy for its patients. The financial assistance policy describes the Hospital's policy for both charity care (free care) and discounted care, and the process for patients who need help paying for their emergency and medically necessary care. The intent of this policy is to satisfy the requirements of Section 501(r) of the Internal Revenue Code and California Health and Safety Code sections 127400 to 127446. Because the Combined Unit does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues. Services provided are recorded as gross patient service revenues and then written off entirely as an adjustment to net patient service revenues.

Operating Revenues and Expenses: The Combined Unit's statement of revenues, expenses and changes in net assets distinguishes between operating and non-operating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the Combined Unit's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Non-operating revenues and expenses are those transactions not considered directly linked to providing health care services.

Income taxes: The District operates under the purview of the Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income. However, income from the unrelated business activities of the District may be subject to income taxes.

The Hospital is exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). Thus, no provision for income taxes is included in the accompanying financial statements. The Hospital follows the accounting guidance for accounting for uncertainty in income taxes. The Hospital is subject to federal and state income taxes to the extent it has unrelated business income. In accordance with the guidance for uncertainty in income taxes, management has evaluated its material tax positions and determined that there are no income tax effects with respect to its financial statements. The Hospital is subject to examination by federal or state authorities within the three-year statute of limitations applied to tax filings. The Hospital management has not been notified of any impending examination and no examinations are currently in process.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Recently Adopted Accounting Pronouncement: In June 2017 the Governmental Accounting Standards Board released GASB 87 regarding changes in the way leases are accounted for. GASB 87 superseded GASB 13 and GASB 62 and more accurately portrays lease obligations by recognizing lease assets and lease liabilities on the statement of net position and disclosing key information about leasing arrangements. GASB 87 increases the usefulness of financial statements by requiring recognition of certain operating lease obligations to recognize the inflows of resources based upon the provisions of the lease contracts. The Combined Unit has adopted GASB 87 effective September 1, 2022, in accordance with the timetable established by GASB 87.

Other new GASB pronouncements recently issued were GASB's 84 (Fiduciary Activities) 88 (Certain Disclosures Related to Debt, including Direct Borrowings and Direct Placements) 89 (Accounting for Interest Cost Incurred Before the End of a Construction Period) and 91 (Conduit Debt Obligation) have been analyzed by Combined Unit management and have been determined to have no impact upon the financial statements.

Revenue Recognition: As previously stated, net patient service revenues are reported at amounts that reflect the consideration to which the Combined Unit expects to be entitled in exchange for patient services. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and include variable consideration for retroactive revenue adjustments due to settlement of third-party payor audits, reviews, and investigations. Generally, the Combined Unit bills the patients and third-party payors several days after the patient receives healthcare services at the Combined Unit. Revenue is recognized as services are rendered.

The Combined Unit has agreements with third-party payors that provide for payments to the Combined Unit at amounts different from its established rates. Payment arrangements include prospectively determined rates per day, discharge or visit, reimbursed costs, discounted charges and per diem payments. 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.

NOTE 2 – CASH AND CASH EQUIVALENTS

As of December 31, 2023 and 2022, the Combined Unit had deposits in a financial institution of $6,639,515 and $8,660,568, respectively. $2,600,000 of these funds are restricted and not available for use to the Combined Unit. All of these funds are in the form of cash and cash equivalents, which were collateralized in accordance with the California Government Code ("CGC"), except for $250,000 per account that is federally insured.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the Combined Unit's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the Combined Unit's deposits.

NOTE 2 – CASH AND CASH EQUIVALENTS (continued)

California law also allows financial institutions to secure Combine Unit deposits by pledging first trust deed mortgage notes having a value of 150% of the Combined Unit's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the Combined Units.

Combined Unit investment policies allow investments in U.S. Government securities and state and local agency funds which invest in U.S. Government securities. These investments, when present, are stated at quoted market values. Changes in market value between years are reflected as a component of investment income in the accompanying statement of revenues, expenses, and changes in net position.

NOTE 3 - NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS

The Combined Unit renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, commercial insurance companies, health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Patient service revenues from these programs approximate 86.6% of gross patient service revenues for the year ended December 31, 2023.

The Medicare Program reimburses the Hospital on a cost basis payment system for inpatient and outpatient hospital services. The cost-based reimbursement is determined based on filed Medicare cost reports. Clinic services are reimbursed based on fee schedules.

The Combined Unit contracts to provide services to Medi-Cal, HMO and PPO inpatients on negotiated rates. Certain outpatient reimbursement is subject to a schedule of maximum allowable charges for Medi-Cal and to a percentage discount for HMOs and PPOs.

Both the Medicare and Medi-Cal program's administrative procedures preclude final determination of amounts due to the Combined Unit for services to program patients until after patients' medical records are reviewed and cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. The Medicare and Medi-Cal cost reports are subject to audit and possible adjustment. Management is of the opinion that no significant adverse adjustment to the recorded settlement amounts will be required upon final settlement.

Medicare and Medi-Cal revenue accounted for approximately 56% of the Combined Unit’s net patient revenues for the year ended December 31, 2023. Laws and regulations governing the Medicare and Medi-Cal 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.

NOTE 4 - CONCENTRATION OF CREDIT RISK

The Combined Unit grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the Combined Unit and management does not believe that there is any credit risk associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the Combined Unit. Concentration of patient accounts receivable at December 31, 2023 and 2022, were as follows:

	2023	2022
Medicare	$ 34,412,365	$ 33,608,188
Medi-Cal	43,776,399	45,145,391
Other third party payors	50,431,841	59,234,298
Self pay and other	22,023,987	11,100,868
Gross patient accounts receivable	150,644,592	149,088,745
Less allowances for contractual adjustments and bad debts	(135,448,815)	(127,822,234)
Net patient accounts receivable	$ 15,195,777	$ 21,266,511

NOTE 5 - CAPITAL ASSETS

Capital assets as of December 31, 2023 were comprised of the following:

	Balance at 12/31/2022	Transfers & Additions	Transfer & Retirements	Balance at 12/31/2023
CIP	$ 965,266	$ 24,700	$ -	$ 989,966
Equipment	1,738,255	1,057,188	-	2,795,443
Software	1,038,183	33,549	-	1,071,732
Totals at historical cost	3,741,704	1,115,437	-	4,857,141
Less accumulated depreciation	(725,896)	(992,449)	-	(1,718,345)
Capital assets, net	$ 3,015,808	$ 122,988	$ -	$ 3,138,796

NOTE 6 - DEBT BORROWINGS

Long-term debt consists of a note payable, a line of credit, and finance lease agreements as follows:

	2023	2022
District debt		
Santa Cruz County	$ 1,700,000	$2,700,000
Mako Surgical	795,000	-
Total District debt:	2,495,000	2,700,000
Hospital debt		
David and Lucille Packard Foundation	4,715,253	6,357,000
Distressed Hospital Loan	8,300,000	-
Multiple finance leases; imputed interest ranging from 10-11%; monthly lease payments ending in August of 2024:	18,834	123,986
Total Hospital debt:	13,034,087	6,480,986
Total debt borrowings	15,529,087	9,180,986
Less current maturities	(3,120,987)	(1,702,035)
Debt borrowings, net of current maturities	$12,408,100	$7,478,951

Santa Cruz County: The District has a note payable with the County of Santa Cruz, for the purpose of funding a Letter of Credit with the Santa Cruz County Bank, which is a requirement of the Hospital lease agreement. Interest at 0% with principal payments in the amount of $500,000 due bi-annually on June 30th and December 31st. The first payment is due on June 30, 2023, with final payment due on December 31st, 2025.

Mako Surgical: The District assumed an agreement to purchase a surgical robotic arm and related systems for hip and knee applications. The interest rate is 0%. At the time, there were four remaining principal payments of $120k, $200k, $280k, and $315k. The agreement includes an annual supply rebate program, which has the potential to fully offset these payments. The final payment, less supply rebates, is due in March of 2026.

David and Lucille Packard Foundation: The Hospital is a co-borrower on a note payable collateralized by community pledges to the Pajaro Valley Healthcare District Project (the Project). As community pledges are received, the Project will make annual principal payments, with the first payment due on March 31, 2023, and the final payment due on January 31, 2026. The Hospital will relieve the debt and recognize revenue as principal payments are made by the Project. Interest at 0.5% will be paid by the Hospital bi-annually on March 31st and September 30th, with the final payment due on January 31, 2026.

NOTE 6 - DEBT BORROWINGS (continued)

Distressed Hospital Loan: The Hospital received Distressed Hospital loan proceeds of $8,300,000 on November 1, 2023. These funds were used to maintain operations and in support of some Hospital projects to stabilize operations. The six-year loan is zero interest and has an 18-month grace period before repayment. The legislation behind the Distressed Hospital Loan allows for the possibility of loan forgiveness, however that has not been confirmed as of 12/31/23.

The District also obtained a $3.0 million line of credit with Santa Cruz County Bank, secured by community guarantors. The LOC has an interest rate of 1% plus prime and matures on November 5, 2026. Accrued interest on any outstanding principal is due monthly. As of December 31, 2023, the District had not drawn on the credit line.

NOTE 7 - RETIREMENT PLANS

The Hospital sponsors two 401(a) defined contribution retirement plans for employer contributions: one for service and maintenance employees payable on a calendar year-end that contributes 6% or higher depending on years of service of gross annual earnings; the second 401(a) plan covers other non-management, non-highly compensated employees and contributes 6% of gross earnings bi-weekly. The Hospital also sponsors a 457(b) deferred compensation plan for employee contributions, withheld from bi-weekly earnings.

Accrued payroll and related liabilities include $154,208 of 401(a) employer liabilities, calculated from the final two pay period of the year and contributed to the plan in January of 2024. 401(a) liabilities for SEIU Service & Maintenance employees was $552,800 as of December 31, 2023.

NOTE 8 - COMMITMENTS AND CONTINGENCIES

Construction-in-Progress: As of December 31, 2023, the Combined Unit had $989,966 in construction-in-progress for the Cardio Cath Lab. Approximately $52,400 in remobilization fees are remaining to complete construction. Funds for these fees will come from earnings.

Litigation: The Combined Unit may from time-to-time be involved in litigation and regulatory investigations which arise in the normal course of doing business. As of December 31, 2023, management is not aware of any legal matters or potential regulatory investigations.

Medical Malpractice Insurance: The Combined Unit maintains commercial malpractice liability insurance coverage under a claims made and reported policy covering losses up to $15 million per claim and $25 million in the aggregate for all claims, subject to a deductible of $150,000 Indemnity & Expense each claim. The District plans to maintain the insurance coverage by renewing its current policy, or by replacing it with equivalent insurance.

NOTE 8 - COMMITMENTS AND CONTINGENCIES (continued)

Workers Compensation Program: The Hospital workers compensation policy is through travelers and renews in Oct 2024. Annual premium is $1,188,473. The district workers compensation policy is through travelers and renews in Oct 2024. The annual premium is $20,898.

Health Insurance Portability and Accountability Act: The Health Insurance Portability and Accountability Act (HIPAA) was enacted August 21, 1996, to ensure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Management believes the Combined Unit is in compliance with HIPAA as of December 31, 2023 and 2022.

Regulatory Environment: The Combined Unit is subject to several laws and regulations. These laws and regulations include matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Government activity has increased with respect to possible violations of statues and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Combined Unit is in compliance with all applicable government laws and regulations and is not aware of any future actions or unasserted claims at this time.

NOTE 9 - LEASES

The Combined Unit has multiple equipment and building leases. The District leases the building and land for the Hospital from Medical Properties Trust, Inc with a remaining term of 319 months and an estimated annual increase to base rent of 2% based on CPI. The District also leases office space for a urology center near the Hospital. This lease has 79 months remaining and a fixed monthly payment during the term. All other lease arrangements are either immaterial or have a term of 12 months or less.

Neither lease has a readily determinable discount rate. The estimated borrowing rate for the Hospital building and land and for the urology center is 9.5%. The urology center lease requires payment of common area maintenance, which represent the majority of variable lease costs. Variable lease costs are excluded from the present value of lease obligations. The District's lease agreements do not contain any material restrictions, covenants, or any material residual value guarantees.

NOTE 9 – LEASES (continued)

Lease related assets and liabilities as of December 31, 2023 and 2022 consist of the following:

Lease assets:	2023	2022
MPT	$ 32,414,776	$ 33,042,270
Urology center	502,704	554,503
Other	631,939	1,163,180
Total lease assets	$ 33,549,419	$ 34,759,953

Lease liabilities:	2023	2022
MPT	$ 33,446,113	$ 33,300,104
Urology center	507,764	557,177
Other	605,237	1,166,684
Total lease liabilities	$ 34,559,114	$ 35,023,965

Total operating lease expense for the year ended December 31, 2023, was $1,914,944. Future minimum rental payments required under operating lease obligations as of December 31, 2023, are summarized as follows:

Years ending December 31,	
2024	$ 3,544,634
2025	3,385,886
2026	3,192,676
2027	3,239,280
Thereafter	85,982,188
Total	99,344,664
Less imputed interest	(64,785,550)
Present value of lease liabilities	$ 34,559,114

The weighted average reamining lease term for these leases is 25 years and the weighted average discount rate is 9.5%.

NOTE 10 – GOING CONCERN

The accompanying financial statements have been prepared assuming that the Combined Unit will continue as a going concern. The Hospital has reduced its annual losses since emerging from bankruptcy in 2022, however it has suffered significant losses from operations and has experienced cash flow difficulties since the District acquired them in September 2022. These conditions raise substantial doubt about the Hospital's ability to continue as a going concern. Management's plans regarding these matters are described above and in the Management's Discussion and Analysis. The financial statements do not include any adjustments that might result from the outcome of this uncertainty. In view of these matters, continuation as a going concern is dependent on continued operations of the District and the Hospital, which in turn is dependent on the District's and the Hospital's ability to increase collections, decrease expenses, and raise additional capital.

The Combined Unit's management is working to continue to find ways to make progress on improving how the Combined Unit organizes and processes work in such a way that it continues to improve patient care and service to its patients and community, while striving to improve its financial position and overall fiscal performance.

The Hospital received Distressed Hospital loan proceeds of $8,300,000 on November 1, 2023. These funds were used to maintain operations and in support of certain Hospital projects to further stabilize operations. The six-year loan is at 0.0% interest and has an 18-month grace period before repayment begins. The legislation behind the Distressed Hospital Loan allows for the possibility of loan forgiveness, however that has not been confirmed as of December 31, 2023.

The District has placed Measure N on the March 2024 ballot. Measure N is a $116M general obligation bond program intended to renovate the Hospital and improve services to the community. Measure N will allow the hospital to modernize and expand the facility. It will also allow the District to purchase the hospital building and land. The purchase would eliminate the current $3.0M annual lease payments to the third-party owner, allowing those funds to be reinvested in supporting staff and patient care.

The District obtained a $3.0 million line of credit with Santa Cruz County Bank, secured by community guarantors. The LOC has an interest rate of 1% plus prime and matures on November 5, 2026. Accrued interest on any outstanding principal is due monthly. As of December 31, 2023, the District had not drawn on the credit line. The Pajaro Valley Healthcare District Philanthropy Foundation is a newly formed non-profit 501(c)3 corporation in existence to raise funds and secure grants for Hospital activities and services. In 2023, they were able to secure a $250K grant for the purchase of anesthesia machines. Additionally, they secured $60K in grants to support translation services to support patient care for non-English speaking patients.

Management has implemented a cash management plan and is actively managing its revenue cycle (collections) activities. Additionally, the District (Hospital) is opening a Cath Lab in Q2 2024 which will provide new revenue generating opportunities. Other expense initiatives are also planned for 2024.

NOTE 11 – SUBSEQUENT EVENTS

Management evaluated the effect of subsequent events on the combined financial statements through March 27, 2024, the date the combined financial statements are issued, and determined that there are no material subsequent events that have not been disclosed.

SUPPLEMENTARY SCHEDULES

Pajaro Valley Healthcare District

Combining Statement of Net Position

December 31, 2023

	District	Hospital	Eliminations	Total
Assets				
Current Assets				
Cash and cash equivalents	$ 2,784,641	$ 3,854,874	$ -	$ 6,639,515
Patient accounts receivable, net of allowances	34,066	15,161,711	-	15,195,777
Other accounts receivable	-	-	-	-
Inventories	20,859	3,820,565	-	3,841,424
Prepaid expenses and other current assets	765,157	1,494,856	-	2,260,013
Total current assets	3,604,723	24,332,006	-	27,936,729
Capital assets, net of accumulated depreciation	3,090,877	47,919	-	3,138,796
Lease assets	32,940,084	609,335	-	33,549,419
Due from district	-	9,160,814	(9,160,814)	-
Total assets	$ 39,635,684	$ 34,150,074	$ (9,160,814)	$ 64,624,944
Liabilities and Net Position				
Current liabilities				
Current maturities of debt borrowings	$ 1,200,000	$ 1,920,987	$ -	$ 3,120,987
Accounts payable and accrued expenses	(106,224)	6,637,919	-	6,531,695
Accrued payroll and related liabilities	274,306	8,740,179	-	9,014,485
Estimated third party payor settements	-	728,871	-	728,871
IBNR self funded health benefits	-	1,706,135	-	1,706,135
Total current liabilities	1,368,082	19,734,091	-	21,102,173
Debt borrowings, net of current maturities	1,295,000	11,113,100	-	12,408,100
Lease liabilities	33,967,426	591,688	-	34,559,114
Due to hospital	9,160,814	-	(9,160,814)	-
Total liabilities	45,791,322	31,438,879	(9,160,814)	68,069,387
Net position				
Invested in capital assets, net of related debt	3,090,877	47,919	-	3,138,796
Restricted	2,600,000	-	-	2,600,000
Unrestricted	(11,846,515)	2,663,276		(9,183,239)
Total net position	(6,155,638)	2,711,195	-	(3,444,443)
Total liabilities and net position	$ 39,635,684	$ 34,150,074	$ (9,160,814)	$ 64,624,944

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combining Statement of Revenues, Expenses and Changes in Net position

For The Year Ended December 31, 2023

	District	Hospital	Eliminations	Total
Operating revenues				
Net patient service revenues	$ 2,488,045	$ 126,626,179	$ -	$ 129,114,224
Other operating revenues	932,754	5,085,425	(650,653)	5,367,526
Total operating revenues	3,420,799	131,711,604	(650,653)	134,481,750
Operating expenses				
Salaries & wages	2,977,295	67,179,431	-	70,156,726
Employee benefits	557,809	20,902,793	-	21,460,602
Contract labor	-	6,931,655	-	6,931,655
Supplies	27,227	8,292,567	-	8,319,794
Medical specialist fees	178,908	7,572,553	-	7,751,461
Purchased services	224,819	13,233,988	-	13,458,807
Lease cost and rent	270,683	1,644,261	-	1,914,944
Repairs & maintenance	295	1,359,572	-	1,359,867
Utilities	13,239	2,452,858	-	2,466,097
Depreciation and amortization	1,979,831	-	-	1,979,831
Other operating expenses	35,062	6,154,954	-	6,190,016
Property taxes & insurance	99,492	2,345,353	-	2,444,845
Interest	3,773,502	68,423	-	3,841,925
Total operating expenses	10,138,162	138,138,408	-	148,276,570
Operating income (loss)	(6,717,363)	(6,426,804)	(650,653)	(13,794,820)
Nonoperating revenues (expenses)				
Rental income	529,666	-	-	529,666
Interest income		103,547		103,547
Management fees	(650,653)	-	650,653	-
Total nonoperating revenues (expenses)	(120,987)	103,547	650,653	633,213
Increase/(decrease) in net position	(6,838,350)	(6,323,257)	-	(13,161,607)
Net position, beginning of the year	682,713	9,034,451	-	9,717,164
Net position, end of year	$ (6,155,637)	$ 2,711,194	$ -	$ (3,444,443)

See accompanying notes to the financial statements

JWT & Associates, LLP

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Independent Auditors Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

The Board of Directors
Pajaro Valley Health Care District
Watsonville, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the combined financial statements of the business-type activities of the Pajaro Valley Health Care District (the District) as of and for the year ended December 31, 2023, and the related notes to the combined financial statements, which collectively comprise the District's combined financial statements, and have issued our report thereon dated March 27, 2024.

Internal Control over Financial Reporting

In planning and performing our audit of the combined financial statements, we considered the District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's combined financial statements will not be prevented or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given those limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's combined financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the combined financial statement. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the District's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

JWT & Associates, LLP

Fresno, California
March 27, 2024

Pajaro Valley Health Care District

Schedule of Findings and Questioned Costs

For the Year Ended December 31, 2023

I. Summary of Auditor's Results

Type of auditor's report issued:	Unmodified	
Internal Control over financial reporting:		
Material weakness identified?	___yes	_X_ no
Significant deficiency(ies) identified that are not considered to be material weaknesses?	___yes	_X_ no
Noncompliance material to financial statements noted?	___yes	_X_ no

II. Current Year Audit Findings and Questioned Costs

Financial Statement Findings

None reported

III. Prior Year Audit Findings and Questioned Costs

None reported

Audited Financial Statements
and Other Financial Information

PAJARO VALLEY
HEALTH CARE DISTRICT

December 31, 2022

JWT & Associates, LLP
Advisory Assurance Tax

Pajaro Valley Health Care District

Audited Financial Statements and Other Financial Information

December 31, 2022

JWT & Associates, LLP

Advisory Assurance Tax

1111 East Herndon, Suite 211, Fresno, California 93720
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Report of Independent Auditors

The Board of Directors
Pajaro Valley Health Care District
Watsonville, California

Opinions

We have audited the accompanying financial statements of the business-type activities and the discretely presented component unit of the Pajaro Valley Health Care District (the District), as of and for the year ended December 31, 2022, and the related notes to the financial statements, which collectively comprise the District's basic financial statements as listed in the table of contents.

In our opinion, the financial statements referred to above present fairly, in all material respects, the respective financial positions of the business-type activities and the discretely presented component unit of the District, as of December 31, 2022, and the respective changes in financial position, and, where applicable, cash flows thereof for the year then ended in accordance with accounting principles generally accepted in the United States of America.

Basis for Opinions

We conducted our audits in accordance with auditing standards generally accepted in the United States of America. Our responsibilities under those standards are further described in the Auditor's Responsibilities for the Audit of the Financial Statements section of our report. We are required to be independent of the District, and to meet our other ethical responsibilities, in accordance with the relevant ethical requirements relating to our audits. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our audit opinions.

Responsibilities of Management for the Financial Statements

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

In preparing the financial statements, management is required to evaluate whether there are conditions or events, considered in the aggregate, that raise substantial doubt about the District’s ability to continue as a going concern for twelve months beyond the financial statement date, including any currently known information that may raise substantial doubt shortly thereafter.

Auditor’s Responsibilities for the Audit of the Financial Statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinions. Reasonable assurance is a high level of assurance but is not absolute assurance and therefore is not a guarantee that an audit conducted in accordance with generally accepted auditing standards will always detect a material misstatement when it exists. The risk of not detecting a material misstatement resulting from fraud is higher than for one resulting from error, as fraud may involve collusion, forgery, intentional omissions,

misrepresentations, or the override of internal control. Misstatements are considered material if there is a substantial likelihood that, individually or in the aggregate, they would influence the judgment made by a reasonable user based on the financial statements.

In performing an audit in accordance with generally accepted auditing standards, we:

- Exercise professional judgment and maintain professional skepticism throughout the audit.
- Identify and assess the risks of material misstatement of the financial statements, whether due to fraud or error, and design and perform audit procedures responsive to those risks. Such procedures include examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements.
- Obtain an understanding of internal control relevant to the audit in order to design audit procedures that are appropriate in the circumstances, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, no such opinion is expressed.
- Evaluate the appropriateness of accounting policies used and the reasonableness of significant accounting estimates made by management, as well as evaluate the overall presentation of the financial statements.
- Conclude whether, in our judgment, there are conditions or events, considered in the aggregate, that raise substantial doubt about the District's ability to continue as a going concern for a reasonable period of time.

We are required to communicate with those charged with governance regarding, among other matters, the planned scope and timing of the audit, significant audit findings, and certain internal control-related matters that we identified during the audit.

Required Supplementary Information

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

JWT & Associates, LLP

Fresno, California
October 25, 2023

Pajaro Valley Health Care District

Management's Discussion and Analysis

For the Year Ended December 31, 2022

Management of the Pajaro Valley Health Care District (the District) has prepared this annual discussion and analysis in order to provide an overview of performance for the fiscal year ended December 31, 2022 in accordance with the Governmental Accounting Standards Board Statement No. 34, Basic Financials Statements; Management's Discussion and Analysis for State and Local Governments. The District wholly owns the Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (the Hospital). Together they are referenced as the Combined Unit. The intent of this document is to provide additional information on the Combined Unit's financial performance as a whole and a prospective look at revenue, operating expenses and capital development plans. This discussion should be reviewed in conjunction with the audited financial statements for the fiscal year ended December 31, 2022 and accompanying notes to the financial statements to enhance one's understanding of the Combined Unit's financial performance. Being the first year of operation, there is no prior year analysis.

Introduction

The Combined Unit offers readers of our financial statements this narrative overview and analysis of our financial activities for the year ended December 31, 2022. We encourage readers to consider the information presented here in conjunction with the Combined Unit's financial statements, including the notes thereto.

The Combined Unit is governed by a five-member elected board of directors. Day-to-day operations are managed by the Chief Executive Officer. The Combined Unit employed 593 employees on December 31, 2022 and had monthly payroll of approximately $4.25M, not including benefits.

Required Financial Statements

The Combined Unit's financial statements offer short-term and long-term information about its activities. The statement of net position includes all of the Combined Unit's assets and liabilities at December 31, 2022 and provides information about the nature and amounts of investments in resources (assets) and the obligations to Combined Unit creditors (liabilities). The statement of net position also provide the basis for evaluating the capital structure of the Combined Unit and assessing the liquidity and financial flexibility of the Combined Unit.

All revenue and expenses for years ended December 31, 2022 are accounted for in the statement of revenue, expenses and changes in net position. The statement can be used to determine whether the Combined Unit has successfully recovered all of its costs through its patient service revenue and other revenue sources. Revenue and expenses are reported on an accrual basis, which means the related cash could be received or paid in a subsequent period.

The final required statement is the statement of cash flows. This statement reports cash receipts, cash payments and net changes in cash resulting from operations, investing and financial activities for the years ended December 31, 2022. They also provide answers to such questions as where did cash come from, what was cash used for and what was the change in the cash balance during the reporting period.

Pajaro Valley Health Care District

Management's Discussion and Analysis

For the Year Ended December 31, 2022

Financial Analysis of the Combined Unit

The Combined Unit's net position, the difference between assets and liabilities, is a way to measure financial health or financial position. Over time, sustained increases or decreases in the Combined Unit's net position are one indicator of whether its financial health is improving or deteriorating. However, other nonfinancial factors such as changes in economic condition, population growth and new or revised government regulations and legislation should also be considered. In 2022, the Combined Unit's net position increased by approximately $9.7M largely due to an extraordinary gain (see footnotes).

Financial Summary

- Total assets ended at $73.9 million being largely comprised of net patient AR ($21.3M) and lease assets ($34.8M). Total cash and cash equivalents at year end were $8.7 million (see the Statements of Cash Flows for changes).
- Current assets ended at $36.1M compared to current liabilities which ended at $21.7M. The current ratio for this year was 1.66.
- Net operating revenues were $33.8M and operating expenses were $45.1M. There was an operating loss of $10.9M
- The increase in net position was $9.7M due to an extraordinary gain of $20.7M. See footnotes for more information.

Items Affecting Operations

The challenges facing the Combined Unit this fiscal period were largely similar, although varying in degree of intensity, to those issues facing the health care industry in general and for rural health care facilities in particular. Where the immediate environment and circumstances uniquely influence the Combined Unit, these areas are also highlighted in the discussion below:

- Reimbursement: Medicare and Medi-Cal programs continue to look for ways to reduce reimbursement.
- Labor: Physician positions continue to be difficult to recruit in rural areas.
- Hospital emerged from bankruptcy and was purchased by The District on September 1, 2022, with limited working capital. The District continues to work through transition activities to stabilize operations.

Items Affecting Operations (continued)

- The Hospital Corporation renegotiated all major payor contracts to improve reimbursement. As of December 31, 2022, only one was implemented and the remaining were implemented in 2023.

- The Hospital faces challenges recruiting staff due to the high cost of living in the area and thus relies on contracted resources to supplement staffing. These resources come at a higher cost.

- The District leases hospital real estate from Medical Properties Trust. The Hospital operations must cover this lease payment along with all deficits of The District.

In summary, the external environment continues to challenge rural healthcare providers in particular, with continuing declines in reimbursement, increases in uncompensated care and ongoing labor and health insurance issues. The Combined Unit strives to improve relationships within our community through collaboration with community leaders and service groups, outreach to neighboring healthcare facilities, improving access to care and recruitment of quality medical providers.

The Combined Unit's employees are working together to continue to find ways to make progress on improving how the Combined Unit organizes and processes work in such a way that it continues to improve patient care and service to its patients and community, while striving to improve its financial position and overall fiscal performance.

Pajaro Valley Healthcare District

Combined Statement of Net Position

December 31, 2022

Assets	
Current Assets	
Cash and cash equivalents	$ 8,660,568
Patient accounts receivable, net of allowances	21,266,511
Other accounts receivable	1,498,921
Inventories	2,158,403
Prepaid expenses and other current assets	2,510,580
Total current assets	36,094,983
Capital assets, net of accumulated depreciation	3,015,808
Lease assets	34,759,953
Total assets	73,870,744
Liabilities and Net Position	
Current liabilities	
Current maturities of debt borrowings	1,702,035
Accounts payable and accrued expenses	6,922,004
Accrued payroll and related liabilities	8,641,862
Estimated third party payor settements	1,597,184
IBNR self funded health benefits	2,787,581
Total current liabilities	21,650,666
Debt borrowings, net of current maturities	7,478,951
Lease liabilities	35,023,963
Total liabilities	64,153,580
Net position	
Invested in capital assets, net of related debt	2,891,822
Restricted	2,600,000
Unrestricted	4,225,342
Total net position	9,717,164
Total liabilities and net position	$ 73,870,744

Pajaro Valley Healthcare District

Combined Statement of Revenues, Expenses and Changes in Net position

For The Year Ended December 31, 2022

Operating revenues	
Net patient service revenues	$ 33,308,250
Other operating revenues	532,944
Total operating revenues	33,841,194
Operating expenses	
Salaries & Wages	17,381,952
Benefits	6,100,838
Contract Labor	2,414,616
Supplies	3,688,032
Medical Spec Fees	2,876,058
Purchased Services	5,579,962
Lease Cost and Rent	1,649,758
Repairs & Maintenance	316,371
Utilities	712,745
Depreciation and amortization	384,786
Other Operating Exp	2,906,562
Prop Taxes & Ins	731,821
Interest	320,538
Total operating expenses	45,064,039
Operating income (loss)	(11,222,845)
Nonoperating revenues	
Rental income	277,387
Total nonoperating revenues (expenses)	277,387
Net income/(loss) before extraordinary item	(10,945,458)
Gain from acquisition of hospital	20,662,622
Increase/(decrease) in net position	9,717,164
Net position, beginning of the year	-
Net position, end of year	$ 9,717,164

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combined Statement of Cash Flows

For The Year Ended December 31, 2022

Cash flows from operating activities		
Cash received for operations	$	12,352,408
Cash payments to suppliers and contractors		(18,622,904)
Cash payments to employees and benefit programs		(12,053,347)
Net cash provided by operating activities		(18,323,843)
Cash flows from noncapital financing activities		
Gain from acquisition of hospital		20,662,622
Net cash provided by noncapital financing activities		20,662,622
Cash flows from investing activities		
Purchases of property, plant & equipment		(3,136,584)
Rental income		277,387
Net cash used in investing activities		(2,859,197)
Cash flows from financing activities		
Proceeds from debt borrowings		9,180,986
Net cash provided by financing activities		9,180,986
Increase in cash and cash equivalents		8,660,568
Cash and cash equivalents at beginning of year		-
Cash and cash equivalents at end of year	$	8,660,568

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combined Statement of Cash Flows (continued)

For The Year Ended December 31, 2022

Reconciliation of operating income (loss) to net cash provided by operating activities	
Operating income	$ (11,222,845)
Adjustments to reconcile operating income to net cash provided by operating activities:	
Depreciation	384,786
Changes in operating assets and liabilities	
Receivables	(22,765,432)
Inventories	(2,158,403)
Prepaid expenses and other current assets	(2,510,580)
Accounts payable and accrued expenses	6,922,004
Accrued payroll and related expenses	8,641,862
Estimated third party payor settements	1,597,184
IBNR self funded health benefits	2,787,581
Net cash provided by operating activities	$ (18,323,843)

See accompanying notes to the financial statements

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES

Organization: Pajaro Valley Health Care District, (the District) is a public entity organized under Local District Law as set forth in the Health and Safety Code of the State of California. The District is a political subdivision of the State of California and is generally not subject to federal or state income taxes. The District is governed by a five-member Board of Directors, elected from within the district to specified terms of office. The District is located in Watsonville, California. The District wholly owns the Pajaro Valley Health Care District Hospital Corporation dba Watsonville Community Hospital (the Hospital). The Hospital is a 501(c)(3) component unit of the District and operates a 106 -bed acute care hospital and other patient services. The District's mission is to provide health care services primarily to individuals who reside in the local geographic area. A combining statement presenting both District and Hospital operations is presented in the supplementary information to these combined financial statements.

The District and the Hospital were both created to purchase the operations and certain assets of the Watsonville Community Hospital (WCH) and operate the hospital facility. WCH assets were acquired in September of 2022.

The District has a Professional Services Agreement (PSA) with Coastal Health Partners (CHP). CHP is incorporated under the laws of the State of California and operates as a corporation. This agreement calls for CHP to provide physicians to the District 1206(b) clinic. The District provides support staff to CHP through the Hospital and passes those expenses onto the District Clinic.

The Combined Unit (the District and the Hospital) maintains its financial records in conformity with guidelines set forth by the Local Health Care District Law and the Office of Statewide Health Planning and Development of the state of California.

Basis of Preparation: The accounting policies and financial statements of the Combined Unit generally conform with the recommendations of the audit and accounting guide, *Health Care Organizations*, published by the American Institute of Certified Public Accountants. The financial statements are presented in accordance with the pronouncements of the Governmental Accounting Standards Board (GASB). For purposes of presentation, transactions deemed by management to be ongoing, major or central to the provision of health care services are reported as operational revenues and expenses.

The Combined Unit uses proprietary fund accounting. Revenues and expenses are recognized on the accrual basis using the economic resources measurement focus. Based on GASB Statement Number 20, *Accounting and Financial Reporting for Proprietary Funds and Other Governmental Entities That Use Proprietary Fund Accounting*, as amended, the District has elected to apply the provisions of all relevant pronouncements of the Financial Accounting Standards Board (FASB), including those issued after November 30, 1989, that do not conflict with or contradict GASB pronouncements.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Financial Statement Presentation: The Combined Unit applies the provisions of GASB 34, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments* (Statement 34), as amended by GASB 37, *Basic Financial Statements - and Management's Discussion and Analysis - for State and Local Governments: Omnibus*, and Statement 38, *Certain Financial Statement Note Disclosures*. Statement 34 established financial reporting standards for all state and local governments and related entities. Statement 34 primarily relates to presentation and disclosure requirements. The impact of this change was related to the format of the financial statements; the inclusion of management's discussion and analysis; and the preparation of the statement of cash flows on the direct method. The application of these accounting standards had no impact on the total net assets.

Management's Discussion and Analysis: Statement 34 requires that financial statements be accompanied by a narrative introduction and analytical overview of the Combined Unit's financial activities in the form of "management's discussion and analysis" (MD&A). This analysis is similar to the analysis provided in the annual reports of organizations in the private sector.

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

Cash and cash equivalents: Cash and cash equivalents include deposits with financial institutions and investments in highly liquid debt instruments with an original maturity of three months or less. Cash and cash equivalents exclude amounts whose use is limited by board designation or by legal restriction.

Patient Accounts Receivable: Patient accounts receivable consists of amounts owed by various governmental agencies, insurance companies and private patients. The Combined Unit manages its receivables by regularly reviewing the accounts, inquiring with respective payors as to collectability and providing for allowances on their accounting records for estimated contractual adjustments and uncollectible accounts. Significant concentrations of patient accounts receivable are discussed further in the footnotes.

Supplies: Inventories are consistently reported from year to year at cost determined by average costs and replacement values which are not in excess of market. The Combined Unit does not maintain levels of inventory values such as those under a first-in, first out or last-in, first out method.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Capital Assets: Capital assets consist of property and equipment and are reported on the basis of cost, or in the case of donated items, on the basis of fair market value at the date of donation. Routine maintenance and repairs are charged to expense as incurred. Expenditures which increase values, change capacities, or extend useful lives are capitalized. Depreciation of property and equipment and amortization of property under capital leases are computed by the straight-line method for both financial reporting and cost reimbursement purposes over the estimated useful lives of the assets, which range from 10 to 30 years for buildings and improvements, and 3 to 15 years for equipment. The Combined Unit periodically reviews its capital assets for value impairment. As of December 31, 2022 the Combined Unit has determined that no capital assets are impaired.

Compensated Absences: The employees of the Combined Unit earn vacation, paid time off, holiday and float benefits at varying rates. These accrual rates are determined based on the employee's years of service, full time equivalent (FTE) status, and union affiliation. This benefit can accumulate up to specified maximum levels. Accumulated vacation, paid time off, holiday, and float benefits are paid to an employee upon either termination or retirement. The combined liability for vacation, paid time off, holiday, and float liabilities as of December 31, 2022 totaled $4,137,292.

Some employees also have a Legacy bank of hours that can be utilized, once they have exhausted all other accruals, and is payable at one half of their hourly rate of pay upon termination or retirement. The liability for these hours as of December 31, 2022 totaled $982,045.

Risk Management: The Combined Unit is exposed to various risks of loss from torts; theft of, damage to, and destruction of assets; business interruption; errors and omissions; employee injuries and illnesses; natural disasters; and medical malpractice. Commercial insurance coverage is purchased for claims arising from such matters.

Net position: Net position is presented in three categories. The first category of net position is "invested in capital assets, net of related debt". This category of net position consists of capital assets (both restricted and unrestricted), net of accumulated depreciation and reduced by the outstanding principal balances of any debt borrowings that were attributable to the acquisition, construction, or improvement of those capital assets.

The second category is "restricted" net position. This category consists of externally designated constraints placed on assets by creditors (such as through debt covenants), grantors, contributors, law or regulations of other governments or government agencies, or law or constitutional provisions or enabling legislation. The third category is "unrestricted" net position. This category consists of net position that does not meet the definition or criteria of the previous two categories.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Net Patient Service Revenues: Net patient service revenues are reported in the period at the estimated net realized amounts from patients, third-party payors and others including estimated retroactive adjustments under reimbursement agreements with third-party programs. Normal estimation differences between final reimbursement and amounts accrued in previous years are reported as adjustments of current year's net patient service revenues.

Financial Assistance: The Hospital offers a financial assistance policy for its patients. The financial assistance policy describes the Hospital's policy for both charity care (free care) and discounted care, and the process for patients who need help paying for their emergency and medically necessary care. The intent of this policy is to satisfy the requirements of Section 501(r) of the Internal Revenue Code and California Health and Safety Code sections 127400 to 127446.Because the Combined Unit does not pursue collection of amounts determined to qualify as charity care, they are not reported as net patient service revenues. Services provided are recorded as gross patient service revenues and then written off entirely as an adjustment to net patient service revenues.

Operating Revenues and Expenses: The Combined Unit's statement of revenues, expenses and changes in net assets distinguishes between operating and non-operating revenues and expenses. Operating revenues result from exchange transactions associated with providing health care services, which is the Combined Unit's principal activity. Operating expenses are all expenses incurred to provide health care services, other than financing costs. Non-operating revenues and expenses are those transactions not considered directly linked to providing health care services.

Income taxes: The District operates under the purview of the Internal Revenue Code, Section 115, and corresponding California Revenue and Taxation Code provisions. As such, it is not subject to state or federal taxes on income. However, income from the unrelated business activities of the District may be subject to income taxes.

The Hospital is exempt from income taxes under Section 501(c)(3) of the Internal Revenue Code (IRC). Thus, no provision for income taxes is included in the accompanying financial statements. The Hospital follows the accounting guidance for accounting for uncertainty in income taxes. The Hospital is subject to federal and state income taxes to the extent it has unrelated business income. In accordance with the guidance for uncertainty in income taxes, management has evaluated its material tax positions and determined that there are no income tax effects with respect to its financial statements. The Hospital is subject to examination by federal or state authorities within the three-year statute of limitations applied to tax filings. The Hospital management has not been notified of any impending examination and no examinations are currently in process.

NOTE 1 - ORGANIZATION AND ACCOUNTING POLICIES (continued)

Recently Adopted Accounting Pronouncement: In June 2017 the Governmental Accounting Standards Board released GASB 87 regarding changes in the way leases are accounted for. GASB 87 superseded GASB 13 and GASB 62 and more accurately portrays lease obligations by recognizing lease assets and lease liabilities on the statement of net position and disclosing key information about leasing arrangements. GASB 87 increases the usefulness of financial statements by requiring recognition of certain operating lease obligations to recognize the inflows of resources based upon the provisions of the lease contracts. The Combined Unit has adopted GASB 87 effective September 1, 2022, in accordance with the timetable established by GASB 87.

Other new GASB pronouncements recently issued were GASB's 84 (Fiduciary Activities) 88 (Certain Disclosures Related to Debt, including Direct Borrowings and Direct Placements) 89 (Accounting for Interest Cost Incurred Before the End of a Construction Period) and 91 (Conduit Debt Obligation) have been analyzed by Combined Unit management and have been determined to have no impact upon the financial statements.

Revenue Recognition: As previously stated, net patient service revenues are reported at amounts that reflect the consideration to which the Combined Unit expects to be entitled in exchange for patient services. These amounts are due from patients, third-party payors (including health insurers and government programs), and others and include variable consideration for retroactive revenue adjustments due to settlement of third-party payor audits, reviews, and investigations. Generally, the Combined Unit bills the patients and third-party payors several days after the patient receives healthcare services at the Combined Unit. Revenue is recognized as services are rendered.

The Combined Unit has agreements with third-party payors that provide for payments to the Combined Unit at amounts different from its established rates. Payment arrangements include prospectively determined rates per day, discharge or visit, reimbursed costs, discounted charges and per diem payments. 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.

NOTE 2 – CASH AND CASH EQUIVALENTS

As of December 31, 2022, the Combined Unit had deposits in a financial institution of $8,660,568. All of these funds are in the form of cash and cash equivalents, which were collateralized in accordance with the California Government Code ("CGC"), except for $250,000 per account that is federally insured.

Under the provisions of the CGC, California banks and savings and loan associations are required to secure the Combined Unit's deposits by pledging government securities as collateral. The market value of pledged securities must equal at least 110% of the Combined Unit's deposits. California law also allows financial institutions to secure Combine Unit deposits by pledging first trust deed mortgage notes having a value of 150% of the Combined Unit's total deposits. The pledged securities are held by the pledging financial institution's trust department in the name of the Combined Units.

NOTE 2 – CASH AND CASH EQUIVALENTS (continued)

Combined Unit investment policies allow investments in U.S. Government securities and state and local agency funds which invest in U.S. Government securities. These investments, when present, are stated at quoted market values. Changes in market value between years are reflected as a component of investment income in the accompanying statement of revenues, expenses, and changes in net position.

NOTE 3 - NET PATIENT SERVICE REVENUES AND REIMBURSEMENT PROGRAMS

The Combined Unit renders services to patients under contractual arrangements with the Medicare and Medi-Cal programs, commercial insurance companies, health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Patient service revenues from these programs approximate 98% of gross patient service revenues for the year ended December 31, 2022.

The Medicare Program reimburses the Hospital on a cost basis payment system for inpatient and outpatient hospital services. The cost-based reimbursement is determined based on filed Medicare cost reports. Clinic services are reimbursed based on fee schedules.

The Combined Unit contracts to provide services to Medi-Cal, HMO and PPO inpatients on negotiated rates. Certain outpatient reimbursement is subject to a schedule of maximum allowable charges for Medi-Cal and to a percentage discount for HMOs and PPOs.

Both the Medicare and Medi-Cal program's administrative procedures preclude final determination of amounts due to the Combined Unit for services to program patients until after patients' medical records are reviewed and cost reports are audited or otherwise reviewed by and settled with the respective administrative agencies. The Medicare and Medi-Cal cost reports are subject to audit and possible adjustment. Management is of the opinion that no significant adverse adjustment to the recorded settlement amounts will be required upon final settlement.

Medicare and Medi-Cal revenue accounted for approximately 63% of the Combined Unit’s net patient revenues for the year ended December 31, 2022. Laws and regulations governing the Medicare and Medi-Cal 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.

NOTE 4 - CONCENTRATION OF CREDIT RISK

The Combined Unit grants credit without collateral to its patients and third-party payors. Patient accounts receivable from government agencies represent the only concentrated group of credit risk for the Combined Unit and management does not believe that there is any credit risk associated with these governmental agencies. Contracted and other patient accounts receivable consist of various payors including individuals involved in diverse activities, subject to differing economic conditions and do not represent any concentrated credit risks to the Combined Unit. Concentration of patient accounts receivable at December 31, 2022, were as follows:

	2022
Medicare	$ 33,608,188
Medi-Cal	45,145,391
Other third party payors	59,234,298
Self pay and other	11,100,868
Gross patient accounts receivable	149,088,745
Less allowances for contractual adjustments and bad debts	(127,822,234)
Net patient accounts receivable	$ 21,266,511

NOTE 5 - CAPITAL ASSETS

Capital assets as of December 31, 2022 were comprised of the following:

	Balance at 12/31/2021	Transfers & Additions	Transfer & Retirements	Balance at 12/31/2022
CIP	$ -	$ 965,266	$ -	$ 965,266
Equipment	-	1,738,255	-	1,738,255
Software	-	1,038,183	-	1,038,183
Totals at historical cost	-	3,741,704	-	3,741,704
Less accumulated depreciation	-	(725,896)	-	(725,896)
Capital assets, net	$ -	$ 3,015,808	$ -	$ 3,015,808

NOTE 6 - DEBT BORROWINGS

Long-term debt consists of a note payable, a line of credit, and finance lease agreements as follows:

District debt		
The District has a note payable with the County of Santa Cruz, for the purpose of funding a Letter of Credit with the Santa Cruz County Bank, which is a requirement of the Hospital lease agreement. Interest at 0% with principal payments in the amount of $500,000 due bi-annually on June 30th and December 31st. The first payment is due on June 30, 2023, with final payment due on December 31st, 2025.	$	2,700,000
Total District debt:		2,700,000
Hospital debt		
Note payable to the David and Lucille Packard Foundation; the Hospital is a co-borrower on a note payable collatoralized by community pledges to the Pajaro Valley Healthcare District Project (the Project). As community pledges are received, the Project will make annual principal payments, with the first payment due on March 31, 2023, and the final payment due on January 31, 2026. The Hospital will relieve the debt and recognize revenue as principal payments are made by the Project. Interest at 0.5% will be paid by the Hospital bi-annually on March 31st and September 30th, with the final payment due on January 31, 2026.		6,357,000
Multiple finance leases; imputed interest ranging from 10-11%; monthly lease payments ending in August of 2024:		123,986
Total Hospital debt:		6,480,986
Total debt borrowings		9,180,986
Less current maturities		(1,702,035)
Debt borrowings, net of current maturities	$	7,478,951

NOTE 7 - RETIREMENT PLANS

The Hospital sponsors two 401(a) defined contribution retirement plans for employer contributions: one for service and maintenance employees payable on a calendar year-end that contributes 6% or higher depending on years of service of gross annual earnings; the second 401(a) plan covers other non-management, non-highly compensated employees and contributes 6% of gross earnings bi-weekly. The Hospital also sponsors a 457(b) deferred compensation plan for employee contributions, withheld from bi-weekly earnings.

Accrued payroll and related liabilities include $174,217 of 401(a) employer liabilities, calculated from the final two pay period of the year and contributed to the plan in January of 2023. 401(a) liabilities for SEIU employees was minimal.

NOTE 8 - COMMITMENTS AND CONTINGENCIES

Operating leases: The Combined Unit leases various equipment and facilities under operating leases expiring at various dates. Total building and equipment rent expense for the year ended December 31, 2022, was $1,571,712. Future minimum lease payments for the succeeding years under operating leases as of December 31, 2022, other than those disclosed in Note 9, that have remaining terms in excess of one year are not material.

Construction-in-Progress: As of December 31, 2022, the Combined Unit had $965,266 in construction-in-progress for the Cardio Cath Lab. Approximately $25,000 in remobilization fees are remaining to complete construction. Funds for these fees will come from earnings.

Litigation: The Combined Unit may from time-to-time be involved in litigation and regulatory investigations which arise in the normal course of doing business. As of December 31, 2022, management is not aware of any legal matters or potential regulatory investigations.

Medical Malpractice Insurance: The Combined Unit maintains commercial malpractice liability insurance coverage under a claims made and reported policy covering losses up to $15 million per claim and $25 million in the aggregate for all claims, subject to a deductible of $150,000 Indemnity & Expense each claim. The District plans to maintain the insurance coverage by renewing its current policy, or by replacing it with equivalent insurance.

Workers Compensation Program: The Hospital workers compensation policy is through travelers and renews in Oct 2023. Annual premium is $1,755,002. The district workers compensation policy is also through travelers and renews in Oct 2024. The annual premium is $17,775.

NOTE 8 - COMMITMENTS AND CONTINGENCIES (continued)

Health Insurance Portability and Accountability Act: The Health Insurance Portability and Accountability Act (HIPAA) was enacted August 21, 1996, to ensure health insurance portability, reduce health care fraud and abuse, guarantee security and privacy of health information, and enforce standards for health information. Organizations are subject to significant fines and penalties if found not to be compliant with the provisions outlined in the regulations. Management believes the Combined Unit is in compliance with HIPAA as of December 31, 2022.

Regulatory Environment: The Combined Unit is subject to several laws and regulations. These laws and regulations include matters such as licensure, accreditation, government health care program participation requirements, reimbursement for patient services, and Medicare and Medi-Cal fraud and abuse. Government activity has increased with respect to possible violations of statues and regulations by health care providers. Violations of these laws and regulations could result in expulsion from government health care programs together with the imposition of significant fines and penalties, as well as significant repayments for patient services previously billed. Management believes that the Combined Unit is in compliance with all applicable government laws and regulations and is not aware of any future actions or unasserted claims at this time.

NOTE 9 - LEASES

The Combined Unit has multiple equipment and building leases. The District leases the building and land for the Hospital from Medical Properties Trust, Inc with a remaining term of 321 months and an annual increase to base rent of 2%. The District also leases office space for a urology center near the Hospital. This lease has 91 months remaining and a fixed monthly payment during the term. All other lease arrangements are either immaterial or have a term of 12 months or less.

Neither lease has a readily determinable discount rate. The estimated borrowing rate for the Hospital building and land and for the urology center is 9.5%. The urology center lease requires payment of common area maintenance, which represent the majority of variable lease costs. Variable lease costs are excluded from the present value of lease obligations. The District's lease agreements do not contain any material restrictions, covenants, or any material residual value guarantees.

NOTE 9 – LEASES (continued)

Lease related assets and liabilities as of December 31, 2022 consist of the following:

Lease assets:	2022
MPT	$ 33,042,270
Urology center	554,503
Other	1,163,180
Total lease assets	$ 34,759,953

Lease liabilities:	2022
MPT	$ 33,300,104
Urology center	557,177
Other	1,166,684
Total lease liabilities	$ 35,023,965

Total operating lease expense for the year ended December 31, 2022 was $1,571,712. Future minimum rental payments required under operating lease obligations as of December 31, 2022 are summarized as follows:

Years ending December 31,	
2023	$ 3,542,186
2024	3,544,634
2025	3,385,886
2026	3,192,676
Thereafter	89,221,468
Total	102,886,850
Less imputed interest	(67,862,885)
Present value of lease liabilities	$ 35,023,965

The weighted average reamining lease term for these leases is 25.7 years and the weighted average discount rate is 9.5%.

NOTE 10 – GAIN FROM ACQUISITION OF HOSPITAL

For the year ended December 31, 2022, the Combined Unit recognized an extraordinary gain of $20,662,622. This extraordinary gain was generated as a result of acquiring the operations and certain assets of the Watsonville Community Hospital in September 2022. The District purchased the Hospital at a discounted price out of bankruptcy, which generated the gain.

NOTE 11 – SUBSEQUENT EVENTS

Management evaluated the effect of subsequent events on the combined financial statements through October 25, 2023, the date the combined financial statements are issued, and determined that there are no material subsequent events that have not been disclosed.

SUPPLEMENTARY SCHEDULES

Pajaro Valley Healthcare District

Combining Statement of Net Position

December 31, 2022

	District	Hospital	Eliminations	Total
Assets				
Current Assets				
Cash and cash equivalents	$ 2,748,593	$ 5,911,975	$ -	$ 8,660,568
Patient accounts receivable, net of allowances	3,242	21,263,269	-	21,266,511
Other accounts receivable	-	1,498,921	-	1,498,921
Inventories	15,409	2,142,994	-	2,158,403
Prepaid expenses and other current assets	581,562	1,929,018	-	2,510,580
Total current assets	3,348,806	32,746,177	-	36,094,983
Capital assets, net of accumulated depreciation	2,885,858	129,950	-	3,015,808
Lease assets	33,721,877	1,038,076	-	34,759,953
Due from district	-	3,205,566	(3,205,566)	-
Total assets	39,956,541	37,119,769	(3,205,566)	73,870,744
Liabilities and Net Position				
Current liabilities				
Current maturities of debt borrowings	-	1,702,035	-	1,702,035
Accounts payable and accrued expenses	412,552	6,509,452	-	6,922,004
Accrued payroll and related liabilities	231,003	8,410,859	-	8,641,862
Estimated third party payor settements	-	1,597,184	-	1,597,184
IBNR self funded health benefits	-	2,787,581	-	2,787,581
Total current liabilities	643,555	21,007,111	-	21,650,666
Debt borrowings, net of current maturities	2,700,000	4,778,951	-	7,478,951
Lease liabilities	33,987,142	1,036,821	-	35,023,963
Due to hospital	3,205,566	-	(3,205,566)	-
Total liabilities	40,536,263	26,822,883	(3,205,566)	64,153,580
Net position				
Invested in capital assets, net of related debt	2,885,858	5,964	-	2,891,822
Restricted	2,600,000	-	-	2,600,000
Unrestricted	(4,803,145)	9,028,487	-	4,225,342
Total net position	682,713	9,034,451	-	9,717,164
Total liabilities and net position	$ 41,218,976	$ 35,857,334	$ (3,205,566)	$ 73,870,744

See accompanying notes to the financial statements

Pajaro Valley Healthcare District

Combining Statement of Revenues, Expenses and Changes in Net position

For The Year Ended December 31, 2022

	District	Hospital	Eliminations	Total
Operating revenues				
Net patient service revenues	$ 451,860	$ 32,856,390	$ -	$ 33,308,250
Other operating revenues	754,870	87,518	(309,444)	532,944
Total operating revenues	1,206,730	32,943,908	(309,444)	33,841,194
Operating expenses				
Salaries & Wages	919,690	16,462,262	-	17,381,952
Benefits	175,378	5,925,460	-	6,100,838
Contract Labor	-	2,414,616	-	2,414,616
Supplies	25,443	3,662,589	-	3,688,032
Medical Spec Fees	37,514	2,838,544	-	2,876,058
Purchased Services	480,077	5,099,885	-	5,579,962
Lease Cost and Rent	1,353,548	296,210	-	1,649,758
Repairs & Maintenance	96	316,275	-	316,371
Utilities	5,848	706,897	-	712,745
Depreciation and amortization	384,786	-	-	384,786
Other Operating Exp	49,608	2,856,954	-	2,906,562
Prop Taxes & Ins	28,644	703,177	-	731,821
Interest	273,907	46,631	-	320,538
Total operating expenses	3,734,539	41,329,500	-	45,064,039
Operating income (loss)	(2,527,809)	(8,385,592)	(309,444)	(11,222,845)
Nonoperating revenues (expenses)				
Rental income	277,387	-	-	277,387
Management fees	(309,444)	-	309,444	-
Total nonoperating revenues (expenses)	(32,057)	-	309,444	277,387
Net income/(loss) before extraordinary item	(2,559,866)	(8,385,592)	-	(10,945,458)
Gain from acquisition of hospital	3,242,579	17,420,043	-	20,662,622
Increase/(decrease) in net position	682,713	9,034,451	-	9,717,164
Net position, beginning of the year	-	-	-	-
Net position, end of year	$ 682,713	$ 9,034,451	$ -	$ 9,717,164

See accompanying notes to the financial statements

JWT & Associates, LLP

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Independent Auditors Report on Internal Control over Financial Reporting and on Compliance and Other Matters Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

The Board of Directors
Pajaro Valley Health Care District
Watsonville, California

We have audited, in accordance with the auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in Government Auditing Standards issued by the Comptroller General of the United States, the combined financial statements of the business-type activities of the Pajaro Valley Health Care District (the District) as of and for the year ended December 31, 2022, and the related notes to the combined financial statements, which collectively comprise the District's combined financial statements, and have issued our report thereon dated October 25, 2023.

Internal Control over Financial Reporting

In planning and performing our audit of the combined financial statements, we considered the District's internal control over financial reporting (internal control) as a basis for designing audit procedures that are appropriate in the circumstances for the purpose of expressing our opinion on the combined financial statements, but not for the purpose of expressing an opinion on the effectiveness of the District's internal control. Accordingly, we do not express an opinion on the effectiveness of the District's internal control.

A deficiency in internal control exists when the design or operation of a control does not allow management or employees, in the normal course of performing their assigned functions, to prevent, or detect and correct, misstatements on a timely basis. A material weakness is a deficiency, or a combination of deficiencies, in internal control, such that there is a reasonable possibility that a material misstatement of the entity's combined financial statements will not be prevented, or detected and corrected on a timely basis. A significant deficiency is a deficiency, or a combination of deficiencies, in internal control that is less severe than a material weakness, yet important enough to merit attention by those charged with governance.

Our consideration of internal control was for the limited purpose described in the first paragraph of this section and was not designed to identify all deficiencies in internal control that might be material weaknesses or significant deficiencies. Given those limitations, during our audit we did not identify any deficiencies in internal control that we consider to be material weaknesses. However, material weaknesses may exist that have not been identified.

Compliance and Other Matters

As part of obtaining reasonable assurance about whether the District's combined financial statements are free from material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements, noncompliance with which could have a direct and material effect on the combined financial statement. However, providing an opinion on compliance with those provisions was not an objective of our audit, and accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under Government Auditing Standards.

Purpose of this Report

The purpose of this report is solely to describe the scope of our testing of internal control and compliance and the results of that testing, and not to provide an opinion on the effectiveness of the District's internal control or on compliance. This report is an integral part of an audit performed in accordance with Government Auditing Standards in considering the District's internal control and compliance. Accordingly, this communication is not suitable for any other purpose.

JWT & Associates, LLP

Fresno, California
October 25, 2023

Pajaro Valley Health Care District

Schedule of Findings and Questioned Costs

For the Year Ended December 31, 2022

I. Summary of Auditor's Results

Type of auditor's report issued:	Unmodified	
Internal Control over financial reporting:		
Material weakness identified?	___yes	_X_ no
Significant deficiency(ies) identified that are not considered to be material weaknesses?	___yes	_X_ no
Noncompliance material to financial statements noted?	___yes	_X_ no

II. Current Year Audit Findings and Questioned Costs

Financial Statement Findings

None reported

III. Prior Year Audit Findings and Questioned Costs

None reported