Sonoma Valley Hospital – Observations

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Executive Summary

- To keep Sonoma Valley Hospital (SVH) and its Emergency Department open for all of us, real estate parcel taxes - now $250 per year - are critical. Barring major improvements in Medicare and Medi-Cal reimbursements, that will continue to be true.

- Nationally, rural hospitals are struggling to stay open. In part this is because Medicare and Medi-Cal fail to pay the full cost to serve those patients. Fewer than half of California's 78 Healthcare Districts still operate hospitals. Twelve of the remaining 35 are SVH peers in terms of size and services, but only SVH is not classified as a "Rural, Critical Access Hospital." The others are reimbursed for actual costs plus 1 percent. Sonoma Valley Hospital is not and does not qualify for that benefit. The effect is large continuing losses.

- About 61 percent of Sonoma Valley Hospital revenues come from serving Medicare and Medi-Cal patients. Over the last three years SVH Medicare and Medical losses averaged $11.2 million per year.

- Moreover, half or more of the District's population are Kaiser members. They use the Hospital's Emergency Department, but nearly all of their other medical needs are handled at Kaiser facilities.

- By law, Emergency Departments must be part of a hospital and, as a practical matter, having a hospital is critical to attract and retain doctors that practice in Sonoma Valley.

- We live in an earthquake zone threatened by wildfires. We are served only by, often congested, two lane roads in all directions. During the 2017 wildfires, only Route 116 was available for evacuation. It barely moved. Individual medical emergencies such as heart attacks, strokes, severe accidents and other ailments require the immediate professional attention that only a fully licensed emergency room can provide. Travel times to the nearest hospitals outside of Sonoma can be an hour or more.

- Urgent care centers lack diagnostic imaging, on-site doctors, surgery facilities, laboratories, and other critical resources. Most are open only limited hours. Emergency ambulances can only deliver patients to a licensed Emergency Department – not to an urgent care center.

- Over the last couple of years, our Hospital has made major progress.
    - Since August 2016, the Centers for Medicare and Medicaid has ranked SVH in the top quartile of hospitals nationwide (4 of 5 stars) for the quality of its care.
    - SVH's 2019 financial results were the best in years – net income of $198,477 after including parcel tax revenues and SVH Foundation donations. This was $3.6 million better than 2018 results.
    - To accomplish that turnaround, SHV shut one money-losing operation (Obstetrics) and transferred Skilled Nursing and Home Care to experienced providers. Those changes cut 2019 labor costs by roughly $3 million versus 2018. Employee transfers to the new operators, reduced headcount by about 90 full time equivalent employees but only six employees were actually let go in 2019.
    - In Feb. 2018, SVH affiliated with UCSF, one of America's best hospitals. That move is already bearing fruit in SVH's "Stroke Ready accreditation" and reduction of annual SVH physician support cost of $500,000 or more. Accreditation allows stroke victims to be brought by ambulance to SVH and immediately connect with UCSF neurologists to evaluate, treat and/or transfer those patients.
    - Great strides have also been made in philanthropy. Annual donations are now $1 to $2 million per year. Another $18.5 million has been pledged to build a new Diagnostic Center.

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Table of Contents

Exhibits in the Appendix

1. The Board of Directors[1]

- Sonoma Valley Healthcare District directors are elected by the voters who represent the 42,000 people who live in the District. Directors serve without pay and devote significant amounts of volunteer time beyond the Board meetings in carrying out their responsibilities. In terms of healthcare and hospital expertise, Sonoma Valley Hospital (SVH) has its most capable Board in many years.

    - Dr. Michael Mainardi, is a retired physician who specialized in internal medicine and gastroenterology for 39 years. He was Medical Director of an ambulatory surgery center, President of a specialty physician group, a 25-year member of the clinical faculty of UCSF, and he retired as an Associate Clinical Professor of Medicine at UCSF. In recent years, he has been Chairman of the Sonoma Valley Community Health Center while also serving as a member of the SVH Quality Committee.

    - Sharon Nevins, has been Chief Financial Officer of the Department of Health for the City and County of San Francisco and Acting Chief Financial Officer of Laguna Honda Hospital. She has also consulted for not for profit hospitals, teaching and research hospitals, and Federal and state governments. She has a BA from the University of Missouri, an MA from the Stanford School of Medicine and an MBA from the Stanford Graduate School of Business. She also Chairs the SVH Finance Committee.

    - Jane Hirsch, RN, MS, is Clinical Professor Emeritus in the UCSF School of Nursing and a former Director of the Nursing & Health Systems Leadership Graduate Program at UCSF. She was Chief Nursing Officer for nine years at the UCSF Medical Center and she received her graduate degree from the UCSF School of Nursing. She is an editor of *Clinical Nursing,* a widely used nursing resource book and she serves as Chair of the Health Care District's Quality Committee.

    - Bill Boerum is serving his third four-year term on the Board plus two years after he was first appointed. He is Chair of the Northern California Health Care Authority - a consortium of five hospital districts - and was Vice Chair and a member of the Executive Committee of the Association of California Healthcare Districts. He is also Chairman Emeritus of Sister Cities International and was President of the Sonoma Sister Cities Association. He is an Economics graduate of Manhattan College with an MBA from Cornell University.

    - Chairman of the Board, Joshua Rymer, has been a Vice President and Partner at the Boston Consulting Group in London, New York and San Francisco and he headed up the Firm's West Coast Financial Services Practice. He was a Vice President for Strategy at Charles Schwab & Co., and later, President and CEO of Terradatum, a real estate software company headquartered in Sonoma. He has a BA and a BS degree from the University of Pennsylvania and an MBA from Stanford. He has been a SVH director for five years, was formerly President of the Sonoma Valley Fund, and served on the Board of Community Foundation, Sonoma County.

[1]Though commonly thought of as the Directors of the Sonoma Valley Hospital, they are publicly elected to serve on the Board of Directors of the Sonoma Valley Healthcare District which, under its Bylaws, governs Sonoma Valley Hospital.

2. Today's Difficult Healthcare Environment for Sonoma's Hospital

- An April 21, 2019 *New York Times* story was titled, "Hospitals Stand to Lose Billions Under Medicare for All." It also said," On average, the government program (Medicare) pays hospitals about 87 cents for every dollar of their costs." "Some hospitals, especially struggling rural centers, would close virtually overnight according to policy experts." Dr. Kevin Schulman, a Stanford professor of medicine, is quoted saying, "Hospitals could lose as much as $151 billion in annual revenues – a 16 percent decline - under Medicare for all."

    - A February 7, 2018 *NBC News* story corroborates the *New York Times* piece. It quoted Gerard Anderson a professor of health policy at Johns Hopkins in saying "In general, hospitals lose money on Medicare and Medicaid patients. . ." and "If you have a small rural hospital that is Medicare dependent . . . they're losing money. That is why rural hospitals are in trouble right now."

- Small hospitals, particularly small rural hospitals, are at risk all over the United States and yet their services are critically important to their communities. When such hospitals close, the extra time and cost to transport patients to alternative emergency rooms and hospitals can be catastrophic - particularly for medical events such as heart attacks, strokes, and major accidents which are all critically time sensitive.

- SVH admissions/discharges and patient days have been trending downward for several years. Discharges dropped 15% from FY '17 to FY '19 while patient days fell nearly 20%. The decline has continued in FY '20 with discharges dropping from 348 to 309 and patient days falling 15% over the first four months of the fiscal year.

- California's District Hospitals, including SVH, have had significant financial problems in recent years.

    - Of the 78 hospital Districts shown on the Association of California District Hospitals' Web site, only 35 (fewer than half) currently operate hospitals. Of those 36, only 16 (again, fewer than half) reported profits in 2018.

    - Those that had profits were typically large (with net revenues of more than $200 million per year), had significantly smaller discounts from Gross Revenues to Net Revenue than average, or were designated "Rural Hospitals"

    - Of the 13 District hospitals in the SVH peer group (peer group defined as hospitals with inpatient surgery and gross revenues up to $500 million – SVH gross revenues were $264 million in FY '19), only SVH is not designated as a "Rural Hospital." That qualifies them for Medicare reimbursement of actual costs. SVH recovered only 71 percent of its actual costs for serving Medicare patients in FY '19 and 91 percent of actual costs for serving Medi-Cal patients. Thus, If SVH served only Medicare and Medi-Cal patients, ultimately, it would likely have to close because of the losses and negative cash flows.

    - Profitable District hospitals also have a smaller proportion of Medicare and Medicaid patients than SVH and a much larger proportion of commercially insured patients that are profitable to serve.

    - In FY '18, Medicare gross revenues averaged 44 percent of total revenues for all District hospitals. For SVH, that figure was 62 percent, the second highest for all District hospitals. That same year, total Medicare and Medi-Cal were 60 percent of SVH net revenues and by 2019, it was 61 percent.

- In FY 2019, Sonoma Valley Hospital had net revenues of $57 million. It spent $44 million in direct costs to serve its patients. That left $17 million in overhead costs to operate the Hospital. Medicare and Medicaid, despite representing 63 percent of the patients, contributed only $3 million to cover the overhead while insurers for the other 37 percent of the patients covered $11.2 million of the $17.2 million in overhead costs. The result was a $3 million loss before adding back the parcel taxes that sustained the Hospital.

- Exhibits 1a and 1c show net revenues, direct costs, indirect costs (overhead) and operating margin for Medicare, Medi-Cal, and all other payers in fiscal 2017, 2018 and 2019. It shows SVH had direct margin of only $1.9 million in FY '17, $2.7 million in FY '18, and $3.0 million in FY '19 serving Medicare and Medi-Cal patients. That calculation includes only costs directly tied to the provision of those services. It does not include overhead. When overhead is included, Medicare and Medi-Cal losses were (- $11.2 million) in FY '17, (- $12.7 million) in FY '18, and (- $9.8 million) in FY '19. These are astonishing numbers. The U.S. Government's Medicare and California's Medi-Cal reimbursements are dramatically lower than the costs of actually providing the services. Exhibit 1d provides some margin analytics. Exhibit 1c show 2019 net revenues, direct costs, and indirect costs and operating margin by payer.

- In short, without a parcel tax, General Obligation Bonds (GO Bonds), and philanthropy, Sonoma Valley Hospital could not exist.

- SVH, like all public and private hospitals, must take everyone who walks through the door. it does not have the option to refuse service for non-payment or underpayment.

- Sonoma has a significant number of hardship cases averaging about $300,000 per year over the last three years. In addition, bad debt losses have averaged nearly $2 million a year over that same period. Nonetheless, the biggest single cause of the losses is Federal and State underpayment for the medical services they offer and the Hospital must provide at a loss.

3. <u>Kaiser</u>

- Also adversely impacting SVH viability is Kaiser's large market share in Sonoma Valley.

- In 2017, Kaiser's share of Sonoma County's insured individuals and households was ~42%. (See Exhibit 2.) Further, reports from knowledgeable sources indicated Kaiser's market share in Sonoma Valley was even higher. By some estimates as high as 64 percent. To be conservative, Kaiser's market share of the Sonoma Valley Health Care District is likely 50 percent or more.

- That means most of the medical needs for Kaiser member's outpatient diagnostics and procedures - half or more of our population - will not be done at our Hospital. Instead, Kaiser facilities and doctors outside the Valley, most likely in Petaluma or Santa Rosa, will do them. Further, the physicians serving Kaiser members will not be Sonoma doctors. Most will be doctors who live and practice in other towns.

- Nonetheless, Kaiser patients are regular users of the SVH Emergency Department. Thus, SVH provides important emergency care to Kaiser patients but has no opportunity to provide other, services to them.

- When asked some years ago whether Kaiser would build or operate a facility in Sonoma Valley, the response (to paraphrase) was, 'We need a market of more than 100,000 people to support one of our facilities'.

4. The Importance of Sonoma Valley Hospital's Emergency Department

- It is critically important for the 42,000 people living in and others visiting the Sonoma Valley Healthcare District to have access to a licensed Emergency Department (ED) - sometimes also called an Emergency Room (or ER). The ED must be capable of responding to a broad range of medical emergencies while operating 24 hours a day, seven days a week.

- Our Emergency Department currently treats about 10,000 patients each year and by law must accept patients whether they can afford to pay for their treatment or not.

- California law requires that a licensed Emergency Department be attached to a hospital capable of treating life-threatening medical emergencies. To be licensed for Standby[2], Basic, or Comprehensive emergency medical services, a facility must provide the following onsite: Intensive care service with adequate monitoring and therapeutic equipment; Laboratory service; Radiology service; Surgical services that are immediately available for life-threatening situations (Basic and Comprehensive); post-anesthesia recovery; dietary services; and, a blood bank. In addition, California Health and Safety Code Section 128700 (c) states that "emergency department" is defined as being located "in a hospital licensed to provide emergency medical services, the location in which those services are provided".

- Sonoma Valley Fire and Rescue Service (SVFRS), which operates Emergency Medical Service (EMS) ambulances serving our Valley can only take patients to licensed Emergency Departments. They cannot take patients to urgent care centers.

- Most urgent care facilities operate without on-site physicians, lack sophisticated diagnostic and laboratory capability, and are open only for limited hours. They are capable of treating urgent care issues such as flu, colds, or broken bones, but not life-threatening emergencies.

- Those life threating medical emergencies, such as heart attacks, strokes, and severe accidents, require immediate attention. Minutes matter when delays can result in permanent damage - or worse – that might have been averted with more timely care

- Sonoma Valley is prone to wildfires and earthquakes both of which can produce large numbers of medical casualties.

- Our Valley is accessible only by frequently congested two-lane roads in all directions. Mass evacuation of the injured to distant out-of-Valley hospitals could quickly become impossible, or nearly so. During the 2017 wildfires, three of the four routes out of Sonoma Valley were closed. Only Route 116 to Petaluma was open, but the streets to access it were so congested that, for many residents, just getting to 116 took hours. When it was finally reached, Route 116 traffic moved at a crawl. Moreover, the limited number of ambulances available could not have begun to handle the crises if they had to move a large number of people from Sonoma to Emergency facilities in Petaluma, Napa, or Santa Rosa.

[2] Standby EDs are an exception granted only four times for rural communities located at great distance from a hospital. They serve to receive emergency cases via ambulances, stabilize them, and, if needed, have them transported on to a Hospital with a Basic or Comprehensive Emergency Department as quickly as possible.

5. Parcel Taxes

- As suggested above, given the Medicare and Medi-Cal losses, the write offs from provision of charity care, the bad debts arising those who do not pay their bills, and the absence of any opportunity to provide anything more than Emergency services to half or more of Sonoma Valley's residents (the Kaiser members), Sonoma Valley's residents – including the Kaiser-covered residents - will need to continue to vote for, and pay parcel taxes to keep the Hospital open.

- Also as pointed out above, the ironic truth is that Federal (Medicare) and State (Medi-Cal) health care programs do not reimburse full costs of hospital care for those covered by the programs - a deficit of roughly $11 million per year. And, because SVH must serve anyone, regardless of ability to pay, Sonoma Valley property owners must subsidize our Hospital if we are to keep SVH and its Emergency facilities open.

6. Community Survey

- SVH periodically conducts community perception surveys to gain an understanding of how Sonoma Valley residents feel about the hospital and how those feelings may have changed. The most recent survey was conducted in mid-2019 (see Exhibit 3). The prior survey was conducted in 2015.

- Most evaluations in the 2019 survey remained positive, although the survey showed a consistent decline in positive ratings and increase in negative ratings.

- While 83 percent of all respondents see SVH as important to the health of the community, that is a drop of 11 percentage points since the previous survey.

- The community continues to feel the Emergency Department is essential for the Valley (93 percent).

- Although 67 percent of respondents rate SVH as well-regarded, that is an 11 percent drop from 2015's 78 percent. Those with an unfavorable opinion of SVH followed the same pattern with 17percentt of respondents having an unfavorable opinion, up from 9 percent in the 2015 survey.

- For online survey respondents (people on an SVH email list that receive periodic news from the Hospital), overall satisfaction with SVH dropped from 65 percent to 55 percent and the percent unsatisfied increased from 8 percent to 14 percent.

- The percent of respondents likely to use SVH again dropped to 65 percent down from 78 percent in 2015.

- The reasons given for not using SVH in the future included:
    - SVH lack needed services (41 percent in 2019 – 9 percent in 2015)
    - Had a bad past experience (39 percent)
    - Insurance restrictions (32 percent)
- The percent of phone respondents (chosen randomly) who have heard mostly positive things about SVH fell from 49 percent in 2015 to 29 percent in 2019.
- Given the narrow margin of 1 to 2 percent by which the most recent parcel tax was passed, these results give cause for concern about its passage next time.

7. Financial Stability of Sonoma Valley Hospital

- **Operating Results**

  - SVH net revenues (after discounts)[3] have been relatively stable over the last 10 years growing from $40 million in FY 2010 to $57 million in FY 2019[4]. (See Exhibit 4 In the Appendix.) There have been small ups and downs, but net revenues have exceeded $50 million in every year since FY 2014.

  - At the same time, the Hospital's "Operating Margin" (profits or losses from day-to-day operation of the Hospital) has shown losses every year over the past 10 years and those losses have been volatile from year to year. Those losses averaged ($4.9 million) a year ranging from a loss of ($7.5 million) in FY 2013 to the smallest Operating Margin loss of ($2.8 million) in FY 2019.[5], [6]

  - After adding and deducting non-operating revenues and expenses (such as parcel tax proceeds, physician practice support payments, and donations, the losses are cut roughly in half. By that measure (called "Net Income/(Loss) Before Restricted Contributions and Extraordinary Items"), losses averaged ($1.3 million) a year over the ten years but grew significantly to ($2.4 million) in FY '17 and ($3.4 million) in FY '18.

  - As mentioned previously, among the major reasons for the poor financial results were continuing large losses from serving Medicare and Medical patients and the dominant position of Kaiser. In addition, while, many in the community wanted the Obstetrics Department kept open, its FY '18 losses exceeded ($500,000). Skilled Nursing also posted losses of +/- ($300,000) and Home Health care lost ($150,000) to ($200,000) a year. The Hospital's CEO and Board tried very hard to accommodate Community wishes to keep all three service lines open. Ultimately, they decided to enter into a management agreement with Ensign Group to operate Skilled Nursing and transferred operation of Home Care to the UCSF affiliate, Hospice by the Bay. The continuing losses forced the closure of Obstetrics.

  - With those changes behind them, strong evidence began to emerge of a substantial financial turnaround in late FY 2019.

  - The Hospital's FY 2019 "people cost" (payroll) was cut by roughly $3 million a year to $35 million compared with $38 million in FY '18 and FY '17. "Full time equivalent" employee head count was reduced about 90 full time equivalents (about 28 percent of the Hospital staff). Understandably, these difficult decisions led to some level of employee dissatisfaction and public criticism by former employees. Less well known, however, was the small number of employees who lost their jobs. Though SVH now has reduced the headcount by about 90 full

[3] Each hospital, including SVH, maintains a "Chargemaster" which lists the charges for all services the hospital might perform, some 10.000+ services. All patients are charged or billed the same amount for any given procedure. The billed or charged amount, however, is rarely, paid by the patient or the patient's insurer. The difference between the charged amount and the collected amount is the "discounted amount" or "Net Revenue".

[4] The Fiscal Year for Sonoma Valley Hospital runs from July 1 of each year to the following June 30th.

[5] Hospital Accounting is highly complex. Start with the enormous discounts received by payers such as Medicare, Medi-Cal and other payers, Add: uncertainties about the timing and amounts paid by Medi-Cal, and occasionally Medicare, the complexities of General Obligation Bonds and their effects on financial statements, similar vagaries of Government Accounting Standards such as requiring hospitals to "depreciate" assets not paid for by the Hospital. Then add the complexities of accounting for restricted donations, and the required accruals associated with Parcel Taxes and General Obligation Bonds (GO Bonds) . It can be daunting for a lay person to understand hospital financial statements. Subsequent footnotes explain some of those complexities. Suffice to say if one does not understand them it is easy to draw incorrect conclusions from the financial statements.

[6] The $2.8 million loss is from the Draft Audited Statements of Oct. 17, 2019.

time equivalents, most of those affected were transferred to Ensign Group and Hospice by the Bay. Others were offered transfers to other positions. In fact, only six employees were let go in 2019. At the same time, however, there are reports some of the employees transferred to Ensign have since left because of dissatisfaction with lower pay and increased workloads. There do not appear to have been similar voluntary quits at Hospice by the Bay.

- As described elsewhere in this report, SVH was also able to reduce annual Physician Support costs by $500,000 to $550,000 per year.

- Another positive development in FY '19 was the large ($9 million) positive "California Medi-Cal Adjustment" that was partially offset by "Matching Fees" of $3 million. "Matching Fees" are costs shared among participating hospitals for efforts to re-negotiate amounts paid by Medi-Cal. The resulting FY '19 net revenue gain was $6 million. Counterpart prior year net gains from "Prior Period Adjustments" less "Matching Fees" were $4 million in 2018 and $3 million in 2017. The improved FY 19 net revenue gain was not a fluke. Much of it arose from the first-time inclusion of three new groups of Affordable Care Act patients into Medi-Cal coverage. In addition, there may have been a reduction in the number of hospitals participating in the "Matching Fee" program thus increasing the amount allocated to SVH. In any case, it was positive news. SVH budgets a comparable net revenue gain of $4 million for FY '20

- With all the above changes behind them, FY 2019's "Net Income Before Restricted Contributions" went from the FY 18 loss of ($3.4 million) to Net Income of $198,477 in FY '19. This $3.6 million year-over-year improvement resulted in the Hospital's first profit since 2012.

- Even more revealing, when $2.3 million of "depreciation" from GO Bond and philanthropy funded assets is added back to more correctly measure financial results, SVH had FY '19 income/cash flow of more than $2.5 million[7] - roughly $ 3.6 million better than 2018's counterpart loss of ($1.1 million).

[7] One not well understood aspect of the Hospital's operating statements is the unusual "treatment" of depreciation under Government Accounting Standards Board principles. Namely, in most businesses the actual cost to purchase an asset is depreciated over its useful life. In theory this amortizes those "out of pocket" costs, reflects the decline in the asset's value, and helps measure/reflect the future costs/cash needed to replace the asset at the end of its useful life. For SVH, assets financed by GO Bonds or philanthropy must be depreciated on the Hospital's financial statements even though the cost to acquire those assets arose from philanthropy or is being paid for by taxpayers. As a result, while "depreciation" may reflect the decline in value of the asset(s), it does not reflect the Hospital's actual costs. Moreover, assuming comparable future philanthropy or bond issuances, there would never be a need to generate cash to replace the depreciated asset(s). This "depreciation" is simply a bookkeeping entry, not a real expense for the Hospital. As a result, that "depreciation" can be "added back" to provide a more reliable estimate of income and cash flow.

- **The Balance Sheet**

  - The Draft Audited June 30, 2019 Statements (Exhibit 6) show that at year end, Sonoma Valley Hospital had cash and cash equivalents of s $5.7 million. This is more than double the $2.3 million at the end of the prior year and $1.6 million more than FY '17.

  - At October 31, 2019, the Hospital had one of its strongest balance sheets in the last 10 years. (Exhibit 5.) That was not clear until the $3.3 million sale of a SVH land parcel, a few blocks from the Hospital, was closed in July.[8] It resulted in: a $2 million reduction of fixed assets (the land's cost); the pay-off of the $2 million Note incurred in its purchase; a profit of $2 million, and equal amounts in cash, and Hospital net worth (so called, "Fund Balances").

  - After that sale SVH's net worth (Fund Balances) was more than $22 million for the first time versus $6 million in 2010 and $15.8 million in 2018. This improvement is largely because of the GO Bond financing[9] which, over the years since 2010, has had taxpayers pay down the debt that helped finance construction of the new Emergency Room and Surgery Center. In 2014, the Long-Term Debt totaled $41 million. By October 31, 2019, it was down to $33 million. It will be paid off by August 2031.

  - Nonetheless, solvency remains an issue. In recent years, "Working Capital" (Current Assets less Current Liabilities) has been negative. At the end of FY '19 it was a negative ($2.9 million) – meaning if SVH had to pay all of its short-term obligations it's cash would be insufficient by $2.9 million to do that. But by October 31, 2019, that shortfall was cut to ($1.1 million). At the same time, Accounts Payable had been reduced by $1.1 million, the Union Bank Line of Credit paid down by $625,000, and Cash and Money Market Funds stood at $2.7 million.

  - Further solvency improvement can help reduce the risk of cash problems that might arise if Medi-Cal or Medi-Cal reimbursements or Intergovernmental Transfer Payments (IGT) are delayed. Such events can – and have - stretched Hospital resources in the past making it difficult to meet accounts payable obligations. One recent report, however, of an employee having to use his or her credit card to pay a vendor appears to have been in error. The card was used in good faith by the employee to pay a cable service bill because the cable company was threatening to turn off phone service. The employee did not know, however, that the cable company was wrong - the bill had already been paid. Moreover, the Hospital also has a credit card that might have been used to pay the vendor if the bill had needed to be paid.

[8] SVH retained approximately 1/3rd of the parcel which continues to serve as a Hospital parking lot.

[9] A not well understood consequence of using General Obligation Bonds (GO Bonds) to fund recent major improvements - such as the new ER, the surgery center, and related equipment, - is that the "debt service" on those bonds (interest expense and principal repayments) is not paid by the Hospital, but by the District's property owners through taxes. Over time, that strengthens the Hospital's balance sheet by reducing its Go Bond Debt and increasing its net worth (Fund balance) by $1.1 million or more every year. It will pay off all the GO Bond debt by August of 2031.

- It may be difficult, particularly since District Hospital real property (including General Obligation Bond financed real property[10]) cannot be used as collateral, but it would be very helpful if SVH could secure long term financing to further pay down the Union Bank line of credit. That would likely reduce interest expenses while enhancing solvency.

8. The Sonoma Valley Hospital Foundation and Philanthropy

- For nearly 40 years, the Sonoma Valley Foundation has stimulated philanthropic support for the Hospital's capital equipment needs and programs.

- In recent years, the scale of that support has dramatically increased. Where in the '80s, '90s, $100,000 to $250,000 of annual philanthropy might have been raised, those amounts increased significantly from 2006 through 2010 with roughly $1 million going to support the Women's health program. Further, between 2012 and 2015, more than $10 million was raised for the new Emergency Room and Surgery Center.

- Since then, Foundation philanthropy has continued to rise. In 2016, SVH received $1 million from the Foundation. In 2017, another $1 million. In 2018 $1.2 million and in 2019, $2 million. Those amounts do not include the $18.5 million pledged for the North Bay Diagnostic Center.

- Over the years, more than $30 million of philanthropic support has been donated or pledged to the Hospital. The Foundation is an important presence in our Community and a vitally important factor in SVH's viability.

- The numbers of donors have increased as well. More than 450 individuals and families donated to the Foundation in the last half of 2017 and first half of 2018. Of them, five families donated or pledged at least $12 million in total. Clearly, there is substantial philanthropic support behind keeping the Hospital and the Emergency facilities open and using the latest in equipment and capabilities.

- There have been comments that the Diagnostic Center is being built "by the wealthy for the wealthy." The hospital and emergency department obviously have value for wealthy donors who help make it possible. However, the predominant beneficiaries of that generosity are the Valley's 42,000 residents. No less than the parcel tax and General Obligation bonds, philanthropy has been critical to keeping Sonoma Valley Hospital, its Emergency facilities and its doctors available to serve everyone.

- Selected pages of the Foundation's 2019 Annual Report are included as Exhibit 7 of the Appendix.

9. Strategic Planning at Sonoma Valley Hospital

- A review of the SVH Strategic Plan, including recent updates, reveals a level of planning and detailed monitoring that goes beyond anything seen in earlier SVH Strategic plans. That does not mean the Plan will succeed, but the conception, delineation, and tracking of priorities are clear:

- In May of 2019, the Strategic Plan was summarized in a nine-page pdf: *Vision 2020 And Beyond* (attached to this Report as Exhibit 8). Key points include:

[10] Yet another vagary of hospital financials is that GO Bond finances show up on the SVH Balance sheet. That is, all of the GO Bond tax collections from taxpayers and the payments to the bond holders to service the debt are handled by the County. SVH neither receives the tax proceeds nor pays those bills. Instead, the County receives the taxes and makes the payments. Nonetheless, like the parcel taxes, the SVH Balance sheet must record accruals for the tax payments to be received and the deferred tax revenue as a liability. This complicates any analysis of solvency by distorting the Hospital's current assets and current liabilities.

- Retain our high-quality Emergency Department services including stroke care arising from UCSF's assistance in certification of SVH as a Stroke Ready hospital.
- Develop high quality SVH North Bay Diagnostic Center, starting with recruitment of one or more leading UCSF specialists and adding more specialties over time.
- Develop a comprehensive Bariatric Medicine Institute.
- Develop a holistic acute and chronic pain management service line in collaboration with the Sonoma Valley Community Healthcare Center.
- Provide comprehensive health services for Sonoma Valley's women including a breast surgeon and 3D Mammography equipment.
- Pursue growth in orthopedics, cardiology, general surgery, endoscopy, vascular, ophthalmology, and surgery - including provision of offices for UCSF doctors to practice with local and other North Bay patients.

- Become a 5-Star hospital. When viewed in the context of the North Bay and the Bay Area, achievement of a 4-Star rating is a significant achievement. Only Petaluma Hospital and Sutter Santa Rosa Regional Hospital are also rated 4-Star in the North Bay. There are no 5-Star hospitals in the Bay Area. It is not unreasonable to believe that SVH can become a 5-Star hospital. Although one might assume that large hospitals dominate the 5-Star list, small hospitals have a disproportionate share of 5-Star ratings.

- Given the high cost to build and operate an Emergency Department, the Hospital cannot survive solely on revenues it generates, particularly since it must have all the facilities and capabilities of a hospital in order to treat everyone who comes through the front door whether or not they can afford to pay for the care they receive.

- SVH must generate additional revenues to help carry those costs since operating a 75 to 100 bed hospital is no longer feasible for a district serving only 42,000 people.

- Moreover, without access to all the facilities and services of a hospital, Sonoma would find it nearly impossible to attract and retain excellent physicians who need such facilities to help diagnose and properly treat their patients. In short: no hospital means substantially fewer high caliber physicians in the Valley.

- High quality out-patient diagnostic capabilities and procedures are one way to generate those additional revenues, particularly when augmented by an affiliate relationship with one of the Nation's foremost hospitals (UCSF). Its physicians can bring their expertise to bear on diagnosing and treating emergencies and complex cases. Moreover, some UCSF doctors may practice part time in the Valley.

- The cost to create the Center is an estimated $21 million. Of that, philanthropic support of $18.5 million support has already been pledged to the Sonoma Valley Hospital Foundation.

Phase 1 is scheduled to break ground in December 2019 with replacement of the existing CT Scanner (near the end of its useful life) with a new, more powerful scanner. Phase 2 will commence when the remaining $2.5 million of Foundation support is in hand to replace the aging MRI and build out the rest of the facilities. SVH will then have state of the art CT Scanning and MRI equipment plus Mammography, Ultrasound, Radiology, Laboratory, and Cardiology equipment and services. It will also have offices for visiting physicians, including UCSF specialists.

10. The SVH - UCSF Relationship

- In February, 2018, SVH became the first small community hospital to affiliate with UCSF. (See Exhibit 11) Supported by several community members, the CEO actively pursued and negotiated the agreement in a matter of months. UCSF is ranked the 7th best hospital in the U.S. by US News and World Report. It is one of the top two hospitals in California.

- The UCSF arrangement initially focused on three areas of cooperation and both parties anticipated more areas would be added over time.

    - Sonoma Valley Hospital could publicize the affiliation in its communications with the public and the medical community and incorporate it into its signage, advertising, and marketing.
    - UCSF would oversee a Chief Medical Officer (at SVH's expense). That was to ensure the ongoing quality of care UCSF requires from any affiliate. Dr. Sabrina Kidd now fills that role and is on staff at UCSF.
    - UCSF and SVH have formed a joint planning group tasked with exploring and evaluating opportunities for mutually beneficial collaborations.

- UCSF has no interest in managing, owning, or investing in community hospitals. Instead, their interest is to fulfill part of the original mission of University of California teaching hospitals; namely, to serve at the center of a regional network that draws on UCSF's unique expertise and capabilities for specialty care facilities and practices, particularly in handing complex and difficult cases. They insist, however, on high quality care from affiliates. One reason the affiliation agreement came together so quickly is that, from the start, SVH met the UCSF quality of care standards. In August 2016 the government's Centers for Medicare and Medicaid (CMS) gave Sonoma Valley Hospital an overall rating of four stars out of a possible five. That places the hospital among the top 25 percent in the nation in terms of the quality of its patients' outcomes.

- Though some in Sonoma have expressed the view that nothing much has come of the affiliation, it is clear the relationship is benefiting SVH in important ways.

    - In 2019, UCSF was instrumental in supporting certification of SVH as a "Stroke Ready" hospital. UCSF now provides a remote Neurologist to help SVH quickly determine if a stroke patient can be treated at SVH or needs to be immediately transferred. The Stroke Ready designation allows Emergency Management Services (EMS) to direct stroke victims to the SVH Emergency Department instead of directing them to other hospitals outside the Valley.
    - UCSF's relationship with Marin Health and Prima, the physician foundation that serves our community and Marin, has resulted in an annual reduction of $500,000 to $550,000 in SVH physician support costs. Those savings are expected to be ongoing.
    - In August 2019 UCSF completed the installation of their "EPIC" hospital operating platform in the Prima offices. This gives some SVH primary care physicians and community members an advantage when scheduling specialist appointments with UCSF physicians. In addition, patients can use EPIC's My Chart app to communicate with their doctor, schedule appointments, access their medical information and history, review recent and prior test and lab results, reorder prescriptions, be reminded of appointments, the need for immunizations such as flu shots, and more.

    - When SVH completes its state-of-the-art Diagnostic Center (including the new and more capable CT Scanner and MRI), UCSF's CEO has committed to making SVH their diagnostic center for the North Bay. That commitment is helping raise funds for the Outpatient Diagnostic Center (with $18.5 million in pledges to fund the expected $21 million cost).

- To pursue other future benefits, SVH's CEO and the Planning Group meet quarterly to discuss additional ways to cooperate and benefit both organizations. Among promising areas:

    - There are unutilized areas in the hospital, such as the old Emergency Department, that could serve as clinics for specialty physicians including those from UCSF. There, community members could access visiting doctors from UCSF and elsewhere. SVH might benefit from their diagnostic expertise and perhaps additional procedures would be done at SVH that otherwise would go elsewhere.
    - One or more prominent UCSF specialists may begin seeing North Bay patients in Sonoma in late 2019 or 2020. The specialist(s) may also see those patients for their initial, pre-op and post-op visits at the Prima offices.

    - Once SVH has the new CT Scanner and MRI, UCSF physicians may also begin to refer other of their North Bay patients - in Sonoma, Napa. Mendocino, and Solano counties - to SVH for diagnostic testing, their initial meeting, as well as pre-op and post-op appointments. Patients would likely travel to UCSF for the procedure but prefer the opportunity to reduce their trips to San Francisco by 75 percent. In addition, it might mean SVH could begin to capture some of the procedures as well.

11. The Reimbursement Environment for Diagnostic Imaging

- The reimbursement environment has changed since the Affordable Care Act became effective on January 1, 2014. Although we should anticipate continued pressure to reduce the cost of health care, frequently brought about through changes to Medicare reimbursement terms, we are not aware at this time of any pending or proposed regulations that may bring further significant changes to reimbursement policies.

- A former SVH employee, has expressed a belief that there are pending CMS reimbursement rules changes effective in 2021 that could substantially alter the reimbursement landscape and drive significant outpatient diagnostic testing away from SVH to independent, lower cost providers. However, our inquiries to CMS have been unable to confirm this concern and we have been unable to find documentation to support her contention.

- We believe, however, that SVH will continue to face Medicare/Medi-Cal and other third-party pressure for insureds to have outpatient diagnostic procedures performed in physician offices or other outpatient facilities. To date, this trend (leakage) has not been significant. The acquisition of current generation major diagnostic equipment, including a CT, MRI and 3-D Mammography, will also make it more difficult to convince physicians to send their patients to facilities with prior generation diagnostic equipment, even if it is lower cost.
- The fact remains that the existing diagnostic equipment has or is nearing the end of its useful life. It must be replaced in order to have the latest diagnostic capabilities to service inpatient, outpatient and Emergency Department diagnostic needs.

12. Destination Medicine

- The term "Destination Medicine" has a number of different meanings and the distinctions between them are worth understanding. For some, it means recruiting widely recognized physicians known for their expertise in a particular specialty. Their superb reputations draw patients who want the best possible care to the "destinations" where the doctors practice. The concept often involves specialties in which profits are thought to be high. The doctors earn big money as do the medical infrastructure that supports them. Examples might include plastic surgery, bariatric medicine, and other specialties.

Another variation of "Destination Medicine" is low cost. Patients are drawn to doctors and facilities in other countries where costs for major procedures are significantly lower. Finally, the term also refers to medical institutions that offer superbly qualified specialists in many fields. Those institutions are known to coordinate excellent patient care in something of a "one stop shop" Such institutions include Mayo Clinic, Cleveland Clinic and others.

- Some express the view that the "Destination Medicine" opportunities, in which a particular specialist MD(s) are the draw is a strategy SVH should aggressively pursue. "Why not live and practice in the beautiful Wine Country?" In such cases, the physicians are the entrepreneurs who build their own practice and reputation. They can relocate nearly at will. That can be a risk. At the same time there are strong SVH supporters willing to provide financial and public support for such efforts. If successful, these would only add to the bottom line while enhancing the Hospital's reputation.
- UCSF involvement in the SVH Diagnostic Center may yield opportunities to draw on UCSF physicians whose expertise and regional or national reputation may well draw patients from the North Bay and beyond. Those doctors can collaborate with other UCSF specialists in complex cases. As such, the UCSF affiliation may evolve into the institutional form of "Destination Medicine." UCSF's world class reputation is the draw that attracts superb physicians and patients who greatly respect them. Namely, complete the Diagnostic Center, provide strong support to building the UCSF relationship. Draw ever more of its top physicians to focus their North Bay patient diagnostics in Sonoma, and perhaps some of their practice and their procedures in Sonoma as well. Over time attract ever greater numbers and ranges of specialists, and with that, generate more revenues and an ever-stronger reputation for SVH.
- Finally, a caution: A significant part of SVH's strategy is predicated on building and retaining the close affiliation with UCSF. All the work done to date is to be commended. The affiliation helps UCSF build its own flow of revenue generating patients in the North Bay and accomplishes that without the requirement for UCSF to build or necessarily invest in new facilities. It can also help UCSF match the counterpart expansion efforts of Stanford in the South Bay. Nurturing mutual benefits and commitments must remain a top SVH priority to keep the relationship strong and avert disappointments that might weaken the affiliation. Large institutions can sometimes quickly and seemingly arbitrarily change directions in ways that adversely affect those who depend on them.

13. Compensation of the Hospital's CEO

- Sonoma Valley Hospital CEO compensation has been a perennial topic of discussion over many years with some saying it is excessive. Hospital CEO compensation is often public and hospital associations publish annual surveys that break the data down by size of the hospitals in beds, total employees, annual gross revenues, operating expenses, and location. Equally relevant, by law, the total direct compensation for all employees of California District Hospitals is made available to the public annually. The SVH Board has a Compensation Committee and it uses such data and compensation consultants with the intention of compensating the SVH CEO at a salary and bonus compensation in line with hospital CEOs at comparable facilities.

- Of the 35 California District Hospitals in operation today, seven of the eight hospitals that are roughly comparable in size to SVH reported as required and operate with a CEO and reported compensation information to publicpay.ca.gov for 2018. CEO total compensation[11] for the seven hospitals with gross revenues of $110 to $353 million (SVH gross revenues for 2018 were $264 million) ranged from a low of $375,991 to a high of $676,189 with a median of $461,173. Total compensation for the SVH CEO that year was $434,084.

- CEO total compensation as a percent of gross revenue is another measure of the appropriateness of compensation. SVH CEO total compensation as a percent of gross revenue was 0.16 percent which compares with and is lower than the comparable District median of 0.21 percent. Total wages for the five highest paid employees are also a relevant measure of appropriateness of executive compensation. Again, the SVH ratio of 0.44 percent is considerably lower than the 0.63 percent average. Exhibit 9 provides some of the comparisons between SVH and comparable District hospitals.

- Further, because of losses as the turnaround steps began, there was no salary increase in FY '18.

- Executive compensation is a function both of the size and complexity of the job. Running SVH with an Emergency Department and the lowest ratio of net patient revenue to gross patient revenue increases the complexity of running SVH. The limited opportunities to serve Kaiser members (roughly half of our population) is also a significant challenge as is the $11 million of annual losses resulting from Medicare and Medi-Cal reimbursements at significantly less than cost.

- Unpopular and difficult as some of her decisions may have been (e.g., closing Obstetrics and out-sourcing Skilled Nursing and Home Health functions), the CEO must be credited for the recent turnaround in the financial results of SVH. She also played a major role in (a) achieving the Centers for Medicare and Medi-Cal Services (CMS) 4- Star rating in August 2016; (b) creating and developing the UCSF affiliation; and (c) being a dedicated and effective force in greatly expanding the levels of philanthropic support for SVH. These are all measures that have enhanced SVH's value and reputation as a health care provider, regionally and in the Valley.

14. Seismic Code 2030 - Exposure and Issues

- Following the 6.7 magnitude Northridge earthquake in 1994 that damaged 11 hospitals, Legislation was passed requiring California hospitals to upgrade facilities or replace them. The law created a two-step process, beginning, as of 2008, with a requirement that all buildings must be able remain standing after an earthquake. That deadline was ultimately extended to 2020, an extension of 12 years. The second step, with a deadline of 2030, was to require that all buildings would remain in operation after an earthquake. That deadline remains unchanged.

- At this point, only 23 of the state's 418 hospitals are in compliance with the 2030 code. A Rand study reported that retrofitting the remaining 395 hospitals will cost $47- 143 billion.

- Given the order of magnitude of the cost of compliance, the history of the first phase extension, and the reality that even compliance will not assure that hospitals are standing and operating, hospital industry associations and leaders believe that the 2030 code will not stand unchanged and let California's healthcare facilities close. SVH board and management share the prevailing industry view. At this time SVH plans no action with respect to the 2030 code.

- Exhibit 10, in the Appendix, provides the Seismic analysis of Peter Horhost, an engineer and former member of the Sonoma Valley Hospital Board.

[11] Total wages reported in Box 5 of the employee's W-2 plus amounts paid by the employer toward the employer sponsored retirement plan plus health, dental, and/or vision benefits for the employee and dependents.

15. Plan B – What Other Options Might Exist

- Over the years, Sonoma Valley citizens have asked, "Do we really need - or can we afford - a hospital that seems to require constant taxpayer and philanthropic support? What other alternatives might exist to the current Hospital and its Emergency Department that might meet the medical needs of our residents?

- Among the suggestions have been: 1: Sell the Hospital to a financially stronger hospital or hospital chain; 2) Bring in a professional hospital management organization to operate the Hospital; 3) Consider applying for Rural Critical Access status which would qualify SVH to receive a higher level of Medicare and Medi-Cal reimbursements 4) Attempt to obtain a license for a "Stand Alone Emergency Room;" or, 5) Develop a "souped up" urgent care facility nearly as good as an Emergency Department.

- All of those ideas were explored at one time or another over the last ten or fifteen years. None have been found to be workable.

    a) Sell SVH to a financially stronger hospital or hospital chain. Over the years a number of attempts were made to solicit the interest of larger hospitals and hospital chains. In particular, discussions were held with Memorial and Sutter Hospitals in Santa Rosa, and while both are pleased to have SVH feed acute care patients to them, neither wanted to buy or operate the Hospital. In 2000 Sutter Health was prepared to acquire SVH but quickly backed away because of its deteriorating financial results. Cirrus Health of Texas proposed building a Surgery Center in the Valley but possible siting of that facility became problematic and they backed away. Conversations have also been held with Kaiser, particularly because of the large number of Kaiser members in the Valley. The response was that our population is too small to support its own Kaiser facility, particularly if it drew members away from other Kaiser facilities, such as the ones in Petaluma and Santa Rosa. From Kaiser's standpoint, having access to the SVH Emergency Department provides what they need in Sonoma Valley and to date they have not been interested in helping subsidize its operation beyond fees for Kaiser Emergency Room visits. Nor is UCSF interested in owning more hospitals. Instead it wishes to pursue mutually beneficial affiliations with existing quality hospitals such as Marin General and Sonoma Valley Hospital.

    b) Engage a professional hospital management organization to run the hospital. Hospital management companies might be approached to take over the management of the Hospital, but none would subsidize any future SVH losses. e.g. for serving Medicare/Medi-Cal patients. Unlike publicly owned District hospitals, they are for-profit entities. Particularly given the small size of the Hospital, and its history of losses they would almost certainly demand a fee that ensures their profits from the agreement. Further, given State mandated staffing requirements, there is no evidence a different organization would be more efficient or make changes that would make the hospital more profitable or more highly rated for safety. The financially troubled Sebastopol Healthcare District brought in an outside operator as a last-ditch effort to save it. It failed with the operator accused of fraud and the Hospital was closed. Present ratings for quality care at SVH already place it in the top quartile of America's rated hospitals.

    c) Consider applying for Rural Critical Access Hospital (CAH) status. Rural Critical Access hospitals were established in 1997 by Congress in response to large numbers of closures of rural hospitals. The Centers for Medicare and Medicaid Services (CMS) administers the designation. If it is received, payments to the hospitals are enhanced with the intention to cover their costs for Medicare and Medicaid patients. Though SVH has looked into the program several times, it is

clear, SVH would not qualify. One key requirement is that the hospital must be more than 35 miles away from the nearest hospital or more than 15 miles away in areas with mountainous terrain or only secondary roads. Queen of the Valley in Napa is 16 miles from the Sonoma Town Square, Petaluma Valley hospital is 14 miles, and Santa Rosa Memorial Hospital is 21 miles away, all on secondary roads. Moreover, it appears that it has become ever harder to receive the designation from CMS and the other bodies that authorize the designation. Finally, a recent effort, with help from a prominent politician was also unsuccessful.

d) Attempt to obtain a license for a "Stand Alone Emergency Room." This effort is highly unlikely to ever succeed. First, there are only four exceptions ever approved in California as "Freestanding Emergency Departments". They are: Western Sierra Medical Clinic in Downieville, Community Medical Center-Oakhurst, Redwood Coast Medical Services in Gualala, and Naval Hospital Lemoore in Lemoore. Though called Emergency facilities, these are essentially urgent care centers. They are licensed in the absence of hospitals in Rural areas and permitted to accept emergency and ambulance patients and provide basic urgent/emergency care pending transport to a hospital. None advertise themselves as "emergency centers" and none operate 24/7.

   Further, to be licensed in California for Standby, Basic, or Comprehensive emergency medical services, the facility must provide the following services onsite: Intensive care service with adequate monitoring and therapeutic equipment; Laboratory service; Radiology service; Surgical services that are immediately available for life-threatening situations (Basic and Comprehensive); Post-anesthesia recovery; dietary services, and a Blood bank. In addition, California Health and Safety Code Section 128700 (c) states that "emergency department" is defined by its being located "in a hospital licensed to provide emergency medical services, the location in which those services are provided[12].

   It is difficult to imagine the finances of a licensed stand-alone emergency room would result in smaller losses than the current operation of SVH. In fact, the losses would probably be much larger. That is, given the need to provide all of the required facilities, equipment, staffing, and services required of a hospital, it would have very large losses if it generated revenues only from Emergency patients. Better to continue pursuing outpatient surgery, developing a first-rate, philanthropy supported, Diagnostic Center, encourage UCSF not only to use the Diagnostic Center, but also have some of its doctors practice in Sonoma, and pursue other of the opportunities described in the SVH Strategic Plan.

e) Finally, develop a "souped up" urgent care facility as good, or nearly as good as an Emergency Department. Urgent care facilities are not the same as an Emergency Department. Most do not operate 24/7. Those available in Sonoma Valley, such as the one at Safeway, operates 7 days a week 9AM to 5PM and is closed from 12 to 1PM. Urgent care facilities have no direct access to an MRI, a CT Scanner, a full-scale medical laboratory, an on-site doctor to treat a medical emergency. Moreover, by law, an ambulance can only deliver a patient to an Emergency Department and not to an urgent care facility. A heart attack, stroke or severely injured Sonoma Valley resident would be left to wait for an ambulance and the ride to a distant hospital which would chew up precious minutes. This might also occur during a crowded commute hour, during inclement weather, or when an accident slows or stops traffic. Moreover, the urgent care facility would be completely inadequate to be of help in the event of severe wildfire, earthquake, Mass shooting or other community disaster event.

[12] (See Freestanding Emergency Departments: Do They Have a Role in California? Issued by the California Healthcare Foundation July, 2009. Pages 6-10).

16) Additional Thoughts

- Operating in a difficult healthcare environment that has closed many small hospitals nationwide and in Sonoma County, the Sonoma Valley Hospital Board, CEO, hospital staff, and physicians who practice there deserve kudos for all they have accomplished over the last few years. Individually or collectively, they have:
    - Earned 4-Star safety accreditation from the Centers for Medicare and Medicaid;
    - Achieved a major turnaround of SVH financial results in 2019;
    - Made and executed difficult but necessary decisions to close or restructure popular but financially unsustainable departments and operations, including Obstetrics, Skilled Nursing and Home Health Care.
    - Launched an affiliation with UCSF which is already strengthening the Hospital;
    - Developed a strategy for creating a superb new Diagnostic Center; and,
    - In alliance with the Sonoma Valley Hospital Foundation, greatly increased philanthropic support for critically needed facilities improvements;

- With assistance from a firm specializing in strategies to clearly communicate a business's key characteristics to those it serves, the Hospital is now developing a major program to increase community awareness of its expanded capabilities and vital role in the Valley's physical and economic health. Among the messages to be communicated should be a critical reminder that, absent significantly higher reimbursement by Medicare, Medi-Cal, and/or Kaiser – all of which are unlikely, it will be critically important to continue supporting parcel taxes and philanthropy. To that end it might be useful to:
    - Engage and significantly expand volunteer participation of community members and organizations in a variety of efforts to ensure all audiences in the district are aware of the vital role the hospital plays in the Valley,
    - In addition to hospital website and emails, explore the use of a weekly or monthly page or columns in local newspapers to publicize hospital developments, programs, issues, etc., similar to pages in the *Index Tribune* devotes to local schools and civic government.
    - Consider how to focus on and respond to the 2019 community survey results that showed declining favorable assessments and increasing unfavorable perspectives.
    - Expand in-person presentations and discussions on hospital/health subjects to local groups, like those offered at Vintage House. Topics might go beyond medicine and disease to ways to improve individual health and fitness.
    - Local doctors and nurses, as well as other hospital staff, board members and UCSF representatives might be recruited to present or participate in various outreach efforts, programs or presentations.

- It may be possible to enlist community leaders willing to participate in an aggressive effort to obtain Rural/Critical Access status for Sonoma Valley Hospital. While the odds of success may be low, the reward for succeeding is very high – in the form of millions of dollars of additional annual revenues and profits each year. A well-organized full-court press in Sacramento and Washington DC might succeed and is warranted, given the potential financial benefit. A number of local residents have extensive experience and personal relationships that could be brought to bear

- With the UCSF relationship central in the hospital's future, it will be important for the public to support SVH's effort to explore more opportunities for mutually beneficial programs and ways to expand UCSF's presence and involvement in the Community. The Hospital might also consider exploring with UCSF, ways for local doctors - in addition to those at Prima - to acquire some form of USCF affiliation status, perhaps with access to its EPIC software. That could enhance their practices and the effort to bring it about could burnish the Hospital's reputation for actively supporting our local doctors.

- SVH may also wish to amplify its efforts to involve physicians in key issues and strategic decisions being made by the hospital, especially those that may directly or indirectly impact their practices and income.

- In financial statements, the Hospital might want to consider reporting net income adjusted for depreciation on fixed assets not purchased with SVH-generated funds. Perhaps this could be as simple as an additional line on the monthly and annual operating statements.

- The Hospital has done a good job of recruiting experts to serve on its committees and in other volunteer roles. Some have been encouraged to run for a Board seat. That effort should be continued and perhaps amplified. The incumbent Board represents the success of such work over many years. On-going recruitment effort must continue, with input and candidates from all segments of the community. Strong, highly qualified directors that work well together are critical if the hospital is to avoid the rancor and divisive atmosphere of ten to 15 years ago that can distract from its mission and endanger public support.

- This report, together with updates and related healthcare news can be found on our website by clicking: here.

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Definitions

1. General Obligation Bonds (GO Bonds) — A general obligation bond (GO) is a municipal bond backed by the credit and taxing power of the issuing jurisdiction (i.e., the Sonoma Valley Health Care District) rather than the revenue from its activities. General obligation bonds are issued with the belief that the District will be able to repay its debt obligation through taxation or revenue from its service. SVH bonds were passed with a parcel tax as the reimbursement mechanism.

2. SVH Foundation/Sonoma Valley Hospital Foundation - (a nonprofit 501 (c) 3 corporation with a mission of cultivating community support and raising funds for SVH.

3. FY (Fiscal Year) – The year from July 1 through June 30 of following year

4. SNF – Skilled Nursing Facility

5. UCSF – University of California San Francisco Health

6. Medi-Cal -- California's Medicaid health care program. This program pays for a variety of medical services for children and adults with limited income and resources. Medi-Cal is supported by federal and state taxes.

7. Medicare -- Medicare is the federal health insurance program for: People who are 65 or older, certain younger people with disabilities & people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD)

8. Kaiser -- Kaiser Permanente, an integrated managed care consortium based in Oakland, California, founded in 1945 by industrialist Henry J. Kaiser.

9. Critical Access Hospital Status - In general, hospitals that (a) have 25 or fewer acute care inpatient beds, (b) are located more than 35 miles from another hospital or 15 miles in areas with mountainous terrain or only secondary roads, (c) maintain an annual average length of stay of 96 hours or less for acute care patients, and (d) provide 24/7 emergency care services. Unlike Acute Care Hospitals, Medicare reimbursements to Critical Access Hospitals essentially cover all costs. For additional criteria,
   See: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs

10. Parcel Tax - A real estate levied in the same amount on all parcels. The current parcel tax levied to support SVH is $250/parcel/year.

11. Operating Margin - A measure of profitability, indicating how much of each dollar of revenue is left over after both direct costs of services rendered and operating expenses.

12. Non-operating revenues and expenses - Includes non-operating revenue such as interest income, gains from the sale of assets, lawsuit proceeds, and revenues from other sources not connected to operations.

13. Full time equivalent employee (FTE) – One or more employees working a standard work period. For example, if the standard work week is 40 hours, two workers each working 20 years equals one FTE and one worker working 40 hours equals one FTE.

14. California Medi-Cal Adjustments – Additional reimbursements from Medi-Cal that are calculated by an independent agency in the year following the year service was provided. The additional reimbursements are typically received by SVH in the fourth fiscal quarter (April-June) following the year service was provided.

15. California Medi-Cal Adjustments Expense or Matching Fees – SVH share of the independent agency fees for calculating the California Medi-Cal Adjustments.

16. Depreciation – Allocation of the cost of a tangible asset over the useful life of the asset.

17. Draft Audited Statement -- A financial statement audit is the examination of an entity's financial statements and accompanying disclosures by an independent auditor. The result of this examination is a report by the auditor, attesting to the fairness of presentation of the financial statements and related disclosures. A draft audit statement is one that has not been finalized.

18. Total Fund Balance/Net Worth – Assets minus liabilities. In nonprofit entities such as SVH, this typically is called Total Fund Balance or Fund Balance. In for profit entities, it is called Net Worth.

19. Real property – Land and any improvements to the land, including buildings, plants and subterranean improvements.

20. Deferred tax revenues — For SVH, parcel tax revenues not yet received by the hospital.

21. Commercially insured -- Patients insured by commercial health insurance, i.e., any healthcare policy that is *not* administered or provided by a government program.

22. Overhead – Cost that is not associated with a business activity. In the case of SVH, costs that are not associated with any revenue-generating service.

The Appendix