SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS
REGULAR MEETING AGENDA
Thursday, February 7, 2013
6:00 p.m. Public Session

Location: Community Meeting Room
177 First Street West, Sonoma CA 95476

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER	Boerum	
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration. At all times please use the microphone.*	Boerum	
3. CONSENT CALENDAR: A. Board of Directors Minutes 01.10.13 B. Quality Committee Minutes 11.28.12 C. Governance Committee Minutes 11.26.12 D. Finance Committee Minutes 12.04.12 E. Medical Staff Appointments and Reappointments 12.20.12 F. Medical Staff Appointments and Reappointments 02.07.13	Boerum	Inform/Action
4. SONOMA VALLEY HOSPITAL CAPITAL CAMPAIGN UPDATE	Plenty	Inform
5. STRATEGIC PLANNING PROCESS UPDATE FOR FY2014	Mather	Inform
6. SONOMA VALLEY HOSPITAL 2012 ANNUAL REPORT	Mather	Inform
7. FINANCE COMMITTEE RECOMMENDATION TO APPROVE FINANCING PLAN FOR CONSTRUCTION PROJECT EXPANDED SCOPE	Fogg	Inform/Action
8. CONSTRUCTION COMMITTEE: A. Status Report B. Recommendation to Approve Budget Increase for Construction Project C. Recommendation to Approve Scope Increase for Construction Project	Coss	Inform/Action

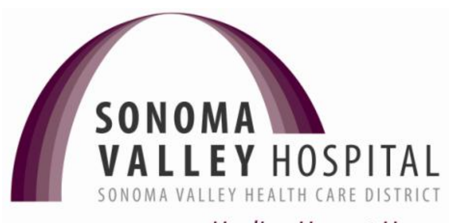
AGENDA ITEM	RECOMMENDATION	
9. FINANCIAL REPORT: A. December 2012 Financial Report	Reid	Inform
10. ADMINISTRATIVE REPORT: A. Dashboard for December 2012	Mather	Inform
11. OFFICER & COMMITTEE REPORTS: A. Chair Report B. Quality Committee C. Governance Committee: 1. Position on Medicare Funding D. JPA/Northern California Health Care Authority	 Boerum Nevins Carruth Boerum	 Inform Inform Inform/Action Inform
12. ADJOURN: *The next regularly scheduled meeting of the SVHCD Board will be held on Thursday, March 7, 2013.*		

3.A.

BOARD MINUTES
01.10.13

3.B.

QUALITY MINUTES
11.28.12



SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
REGULAR MEETING MINUTES
Wednesday, November 28, 2012
Schantz Conference Room

Committee Members Present	Committee Members Absent	Community Members Present	Administrative Staff Present
Sharon Nevins, Vice Chair Dr. Jerome Smith Dr. Paul Amara Joel Hoffman Jane Hirsch Brenda Epperly Dr. Howard Eisenstark John Perez Maida Herbst	Kevin Carruth, Chair Bob Burkhart	None	Dr. Robert Cohen, Chief Medical Officer Leslie Lovejoy, Chief Quality & Nursing Officer Mark Kobe, Director of Nursing Laura Gallmeyer, Contracts Analyst

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* *The vision of the SVHCD is that:* *SVH will be a nationally recognized, compassionate place of healing and known for excellence in clinical quality. We serve as the guide and indispensable link for our community's health care journey.*		
1. CALL TO ORDER	5:04 p.m. Mr. Carruth, the Quality Committee Chair was absent, therefore, Ms. Nevins, the Vice Chair, presided at the meeting.		
2. PUBLIC COMMENT *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	There was no public comment.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
3. CONSENT CALENDAR: A. Prior Meeting Minutes 10.24.12 B. Tracking Report for Uncorrected Items		**MOTION:** by Hirsch; second by Hoffman, to approve the Consent Calendar and carried. All in favor; none opposed.	
4. INTRODUCE THE NEW QUALILTY COMMITTEE MEMBERS	*Sharon Nevins, Vice Chair*		
	Ms. Nevins introduced the new Quality Committee members and gave a brief summary of their backgrounds.		
5. CONTRACT ADMINISTRATION	*Laura Gallmeyer (on behalf of Ellen Shannahan)*	**MOTION:** by Amara; second by Hirsch to approve the contract administration policy and brought to the Board. All in favor; none opposed.	
	Ms. Lovejoy briefly explained the purpose of the contract administration policy and procedure was that the Joint Commission and the State of California required on an annual basis for the SVHCD Board of Directors to be apprised of the contract process, how SVH reviews the contracts, the quality improvement efforts around them, and what contracts the Hospital have (clinical and non-clinical). Ms. Gallmeyer then presented the contract process.		
6. ACKNOWLEDGEMENT CONCERNING CONFIDENTIAL INFORMATION	*Sharon Nevins, Vice Chair*		
	Ms. Nevins explained the policy concerning the acknowledgement of confidential information for each Board Committee member to fill out, sign, and submit to the Board Clerk.		
7. QUALITY TRAINING FOR THE BOARD AND COMMITTEES	*Sharon Nevins, Vice Chair*		
	Ms. Nevins discussed the quality training for the Board and Board Committees for next year in order to understand the responsibilities as a Board Committee for the concept of quality. Dr. Eisenstark suggested having a physician from UCSF, who has the expertise on quality and safety, provide the training. Ms. Nevins recommended bringing this back at next month's meeting.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
8. QUALITY COMMITTEE CHARTER REVIEW FEEDBACK FROM MEMBERS	*Sharon Nevins, Vice Chair*	MOTION: by	
	Ms. Nevins discussed the current Quality Committee Charter, especially granting initial approvals for credentialing and reappointments from two Quality Committee members approving and temporarily grants credentials and privileges pending Board approval at the next Board meeting when the Quality Committee Chair and Vice Chair are not available. Dr. Smith added that this was already in the Medical Staff Bylaws. Dr. Eisenstark asked about the process and wording of the credentialing and reappointments. Ms. Nevins recommended adding to next month's agenda and deleting the word "policy" in the document, which the Charter is not.		
9. QUALITY COMMITTEE REPORT TO THE BOARD FOR 2012	*Sharon Nevins, Vice Chair*		
	Ms. Nevins recommended bringing this back at next month's meeting.		
10. QUALITY COMMITTEE WORK PLAN FOR 2013	*Sharon Nevins, Vice Chair*		
	Ms. Nevins recommended bringing this back at next month's meeting.		
11. QUALITY REPORT	*Leslie Lovejoy*		
	Ms. Lovejoy reported surveyors recently visited the Hospital. A federal survey was conducted by CMS who visited the SNF department. There were very few deficiencies and SVH worked on action plans. The deficiencies from the State pharmacy survey, which the Hospital had opportunities for improvement, particularly from crash carts. SVH was in the process of redefining the entire crash cart and standardizing to one type. All crash carts and contents at the Hospital are now up-to-date. IV fluid bags were also one of the deficiencies. The Environmental Services staff now has access to cleaning the medication areas under supervision by using a crash cart check list. The Hospital received a complaint from The Joint Commission and accepted the investigation and response provided by the Chief Quality and Nursing Officer and Director of Nursing.		
12. DASHBOARD	*Leslie Lovejoy*		
	Ms. Lovejoy said the 2013 dashboard indicators had been identified and was presented to the Board for approval. The Board recommended the dashboard should be done on a quarterly basis than on a monthly basis.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
13. POLICIES & PROCEDURES:	*Leslie Lovejoy*		
A. Adult Hypoglycemia	It was suggested by the Committee that the policy needed to be a protocol rather than a policy. Therefore, it was recommended to amend and brought back at January's meeting.		
14. CLOSING COMMENTS	*Sharon Nevins, Vice Chair*		
	There was no closing comment		
15. ADJOURN	6:15 p.m.		
16. UPON ADJOURNMENT OF THE REGULAR OPEN SESSION	*Sharon Nevins, Vice Chair*		
	There was no comment.		
17. REPORT OF CLOSED SESSION	*Sharon Nevins, Vice Chair*	**MOTION:** by Hirsch; second by Epperly to forward the Creden-tialing Report to the Board and carried. All in favor; none opposed.	

3.C.

GOVERNANCE MINUTES 11.26.12

SONOMA VALLEY HEALTH CARE DISTRICT
GOVERNANCE COMMITTEE
REGULAR MEETING MINUTES
Monday, November 26, 2012
Schantz Conference Room

Committee Members Present	Committee Members Absent	Administrative Staff Present
Kevin Carruth, Chair Peter Hohorst Paula Davis		Kelly Mather, CEO

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* *The vision of the SVHCD is that:* *SVH will be a nationally recognized, compassionate place of healing and known for excellence in clinical quality. We serve as the guide and indispensable link for our community's health care journey.*		
1. CALL TO ORDER	9:07 a.m.		
2. PUBLIC COMMENT *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Committee consideration.*	There was no public comment.		
3. CONSENT CALENDAR: A. Prior Meeting Minutes 10.24.12		**MOTION:** by Hohorst; seconded; to approve the Consent Calendar and carried. All in favor; none opposed.	
4. GOVERNANCE COMMITTEE REPORT TO THE BOARD FOR 2013	*Kevin Carruth, Chair*		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
	Mr. Carruth recommended a summary report compared to the Work Plan and the Charter. He suggested bringing it back at next month's meeting. There was a Bylaws change that was also recommended and Mr. Hohorst was to provide the wording.		
5. DEVELOP GOVERNANCE COMMITTEE WORK PLAN FOR 2013	*Kevin Carruth, Chair*		
	Mr. Carruth suggested not developing the Work Plan until a Board assessment had been done.		
6. REVIEW CHARTER FOR RECOMMENDED CHANGES	*Kevin Carruth, Chair*		
	Mr. Carruth recommended having every Board Committee to include at their next meeting's agenda the following: 1) To review what they did in 2012 and prepare a brief summary report to the Board in relation to the Charter and the Work Plan; 2) To review their Charters for changes; and 3) Develop a Work Plan for 2013. He strongly recommended that the CEO attend each Board Committee meetings for further discussions.		
7. UPDATE – BOARD POLICY ON CEO EVALUATION, COMPENSATION, SCHEDULE, ETC.	*Peter Hohorst*		
	Mr. Carruth recommended to review the documents, get feedback from the CEO, and brought back at next month's meeting.		
8. CEO CHANGE ORDER AUTHORITY	*Kelly Mather*		
	Ms. Mather discussed the Project Change Order policy. Mr. Hohorst would revise the wording.		
9. ACKNOWLEDGEMENT CONCERNING CONFI-DENTIAL INFORMATION	*Kevin Carruth, Chair*		
	Mr. Carruth advised that the Policy Concerning Confidential Information should be included in all of the Board Committee agenda packets for the Committees to sign and submit to the Board Clerk.		
10. CLOSING COMMENTS	*Kevin Carruth, Chair*		
	There was no closing comment.		
11. ADJOURN	10:40 a.m.		

3.D.

FINANCE MINUTES 12.04.13

SONOMA VALLEY HEALTH CARE DISTRICT
FINANCE COMMITTEE
REGULAR MEETING MINUTES
Tuesday, December 4, 2012
Schantz Conference Room

Committee Members Present	Committee Members Absent	Administrative Staff Present
Richard Fogg, Chair Bill Boerum Sharon Nevins Shari Glago Mary Smith Dr. Subhash Mishra Steve Barclay Richard Conley Phil Woodward		Rick Reid, CFO Kelly Mather, CEO Jeannette Tarver, Director of Finance Peter Hohorst, Board Chair Michelle Donaldson, Assistant Hospital Administrator & Director of Surgery

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
MISSION AND VISION STATEMENTS	*The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.* *The vision of the SVHCD is that:* *SVH will be a nationally recognized, compassionate place of healing and known for excellence in clinical quality. We serve as the guide and indispensable link for our community's health care journey.*		
1. CALL TO ORDER	5:00 p.m. Mr. Fogg introduced the two new Finance Committee members and discussed their backgrounds. Each attendee briefly introduced themselves.		
2. PUBLIC COMMENT *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item*	There was no public comment.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
comes up for Committee consideration.			
3. CONSENT CALENDAR: A. Prior Meeting Minutes 10.23.12		**MOTION:** by Nevins; second by Barclay, to approve the Consent Calendar with minor revisions and carried. All in favor; none opposed.	
4. DEVELOP FINANCE COMMITTEE WORK PLAN FOR 2013	*Richard Fogg, Chair*		
	Mr. Reid discussed the proposed Work Plan for 2013 recommended by the Governance Committee. Ms. Nevins suggested having the Committee educate themselves on perspective environment reports. She and Ms. Glago would put together a presentation and proposal at the February 2013 meeting.		
5. FINANCE COMMITTEE CHARTER REVIEW & FEEDBACK FROM COMMITTEE MEMBERS	*Richard Fogg, Chair*		
	Mr. Fogg briefly discussed getting feedback from the Committee of the Charter to be brought to the Board. Mr. Fogg recommended adding a sentence that read, "the Finance Committee Chair will sit in the Audit Committee" under the "General" section of the Charter. Ms. Glago suggested having the Finance Committee Chair draft his perspective of the year in review at next month's meeting.		
6. UPDATES	*Rick Reid, CFO*		
	Mr. Reid reported SVH received the first year reimbursement for EHR of $1.2 million. SVH was in final review with the Napa State contract and expected to be finalized in January 2013 with a retroactive date back in July 1, 2012. Consolidations with Palm Drive Hospital went well. Implemented Paragon for the Admitting and Finance departments on November 4, 2012. Some reorganization changes took place in the I.T. department. Have added an Analyst, Clinical Educator, and Project Manager. The Project Manager would not be managing personnel, but would be managing the implementation of the project. There were also changes made in the Steering Committee.		
7. OCTOBER 2012 FINANCIALS	*Rick Reid, CFO*		
	Mr. Reid reported volumes were under budget for inpatient and under budget for SNF		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
	days. Over budget for outpatient revenue. Under budget by 4 for surgical cases. Total operating revenue was almost $4 million on a budget for almost $4 million. Revenue was over budget by $2,002. Operating expenses were under budget by $9,885. Operating margin was right on budget. Net income before restricted contributions of $54,488 on a budget of $18,915 and received restricted contributions of $12,633. EBIDA before restricted contributions was 9% on a budget of 7%. Year-to-date expenses were $17 million and on a year-to-date basis revenue was under budget by $53,000. Expenses were under budget by $252,000. Operated margin was $199,000. Net income before restricted contributions of $159,000 on a budgeted loss of $37,000. $196,000 better than budget for a net income after restricted contributions of $290,000 on a budget of $152,000. Net revenue was right on budget and made up for the losses with lower inpatient revenue by better outpatient revenue. Community Benefit (SVH's charity care policy) had a couple of large write-offs from patients who did not have the means to pay for the healthcare they received. Bad debts were better than budget, due to lower volume of self-paid patients than what was budgeted for the month. Mr. Reid announced the new self pay payment policy given a 60% discount and an additional 10% if paid within 21 days. SVH would start tracking the cash receipts from that and would do a year to year comparison. On the expense side salaries were under budget and FTEs were under budget by 6. Salaries, wages, and agency costs were under budget by $16,243. The Hospital accrued of about $140,000 a year for the EHR. There were no restricted Foundation contributions, but last month SVH had $114,000 for the Radiology Room.		
8. PROJECTED CASH FLOWS	*Rick Reid, CFO*		
	Mr. Reid discussed the projected cash flow. The goal was to have accounts payable down between 45 and 50 days.		
9. RECOMMENDATION FROM CONSTRUCTION COMMITTEE ON FINANCING	*Rick Reid, CFO*		
	Mr. Reid reported the funding and financing of $41,239,000 that was approved by the Board. A recommended budget adjustment of $1,370,000 was not approved by the Board. SVH received donations as of the end of October 2012 of $2,064,354 with a total cash of $33,564,354. He added at last month's Construction Committee meeting the Committee approved the changes in the existing part of the second floor when the project was not in scope. The cost of the total project would be $1,200,000. The total expected cash was $8,000,000 with an adjusted gap of $2,245,000. The Committee recommended bringing this back at next month's meeting.		

AGENDA ITEM	DISCUSSION	CONCLUSIONS/ ACTION	FOLLOW-UP/ RESPONSIBLE PARTY
10. ACKNOWLEDGEMENT CONCERNING CONFIDENTIAL INFORMATION	*Rick Reid, CFO*		
	This agenda item was recommended by the Committee to be brought back to the Governance Committee to adjust the wording on the second sentence of the form.		
11. ADJOURN	7:00 p.m.		

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Richard Fogg, Chairman

5.

STRATEGIC PLANNING PROCESS

Meeting Date: February 7, 2013

Prepared by: Kelly Mather, CEO

Agenda Item Title: Strategic Planning Process Update for FY 2014

Recommendation:

The strategic map and the market assessment from the 2012 three year rolling strategic plan has been updated and we plan to continue with these strategies until the end of FY 2013. By April 2013 a new strategic plan will be presented for approval which will reflect the changing market, a more regional approach and will be based on significant stakeholder involvement.

Background and Reasoning:

The cost of using a strategic planning expert for the last two years has been over $30,000 per year and these experts did not have enough local knowledge to capture the unique Northern California market. With the CHA market analysis and task force report, we think we can create a stronger strategic plan at very little cost. Marin General is not yet ready to create a regional strategic plan, but we plan to use their strategic map in this process and we are working on system wide goals for FY 2014. Sharon Nevins, Michelle Donaldson and I are working together to assess the findings and make recommendations for the new top 5 – 6 strategies.

Consequences of Negative Action/Alternative Actions:

If we continue using the previous approach, we will likely miss an opportunity to prepare for changes unique and specific to Northern California.

Financial Impact:

We have had one stakeholder event with the physicians, administrative team and board on January 29th which was well attended and well received. It is imperative that we have our strategic plan completed by the time we do budget assumptions for FY 2014. This should not cost more than last year and will likely cost under $10,000.

Board Committee:

None

Attachments:

Updated Strategic Map

Sonoma Valley Hospital Strategic Map, 2013

Goal	Initiative	Initiative	Person	Target Date
Staff Wellness	Staff participation rate > 85%	Health Improvement dashboard tracking	DK	1/2013
Staff Satisfaction	65th percentile on staff satisfaction	75% participation rate	PD	2/2013
Service Line Growth	Targeted marketing for Ortho, Bariatrics, Women	Destination hospital	MD	3/2013
Care Management	Medicare profitability	Cost Accounting system	LL	4/2013
Patient Centered Care	Facility upgrades for patient healing & experience	Consistent 75th percentile for ER and Inpatient	MK	5/2013
Medical Staff Engagement	Succession plan & recruitment	Checklist reliability system	RC	6/2013
Financial Stability	Meet national benchmarks	Increase cash > 30 days	RR	7/2013
Community Health	Active Aging wellness program for Seniors	Better access to care & prevention for Latinos	DK	7/2013
Philanthropy	Complete Capital Campaign	Begin Legacy Giving	KM	8/2013
Quality & Safety	Culture of Safety	Nursing education	LL	9/2013
Regional Care System	Continue District Hospital Systemization	Promote Health Plan partners	KM	10/2013
Master Facility Plan	Complete Phase 1 w/ New Wing	Plan new Medical Office Building	KM	11/2013
High Technology	Most Wired level of 6	Meaningful use – Stage 2	RC/RR	12/2013

Prepared as part of the Sonoma Valley Hospital
2012 Three-Year Rolling Strategic Plan

Transforming for Tomorrow

Category	1980 ($235.6B)	2009 ($2,330.1B)
Other,[3]	11.4%	15.5%
Nursing Home Care	6.48%	5.88%
Other Medical Durables and Non-durables	5.88%	3.35%
Prescription Drugs	5.11%	10.73%
Home Health Care	1.01%	2.93%
Other Professional,[4]	7.1%	7.3%
Physician Services	20.25%	21.71%
Hospital Care	42.67%	32.58%

Source: Centers for Medicare & Medicaid Services, Office of the Actuary. Data released January 6, 2011.

(1) Excludes medical research and medical facilities construction.

(2) CMS completed a benchmark revision in 2009, introducing changes in methods, definitions and source data that are applied to the entire time series (back to 1960). For more information on this revision, see http://www.cms.gov/nationalhealthexpenddata/downloads/benchmark2009.pdf.

(3) "Other" includes net cost of insurance and administration, government public health activities, and other personal health care.

(4) "Other professional" includes dental and other non-physician professional services.

Source: American Hospital Association

Hospitals will Continue to Treat Sicker Patients That Require Specialized Care

Inpatient Case-mix Index (CMI) for the years 2001-2010

California State Expenditures Are Historically Low

California per capita costs historically below many other states, 8% below the U.S. average, and growing at slower rate

Per capita health expenditures, 2009
Dollars

State	Per capita health expenditures, 2009 (Dollars)
CA	6,238
UT	5,031
NV	5,735
WA	6,782
U.S. average	6,815
IL	7,076
FL	7,156
NJ	7,730
NY	8,341
MA	9,278

8%

CA growth of 5.7% CAGR vs. 5.9% CAGR for U.S. overall from 1994-2009

SOURCE: National Health Expenditure Accounts 1998-2009 Issued 2011

Consistently Lower Utilization Levels Have Been a Major Contributor to California's Healthcare Cost Advantage

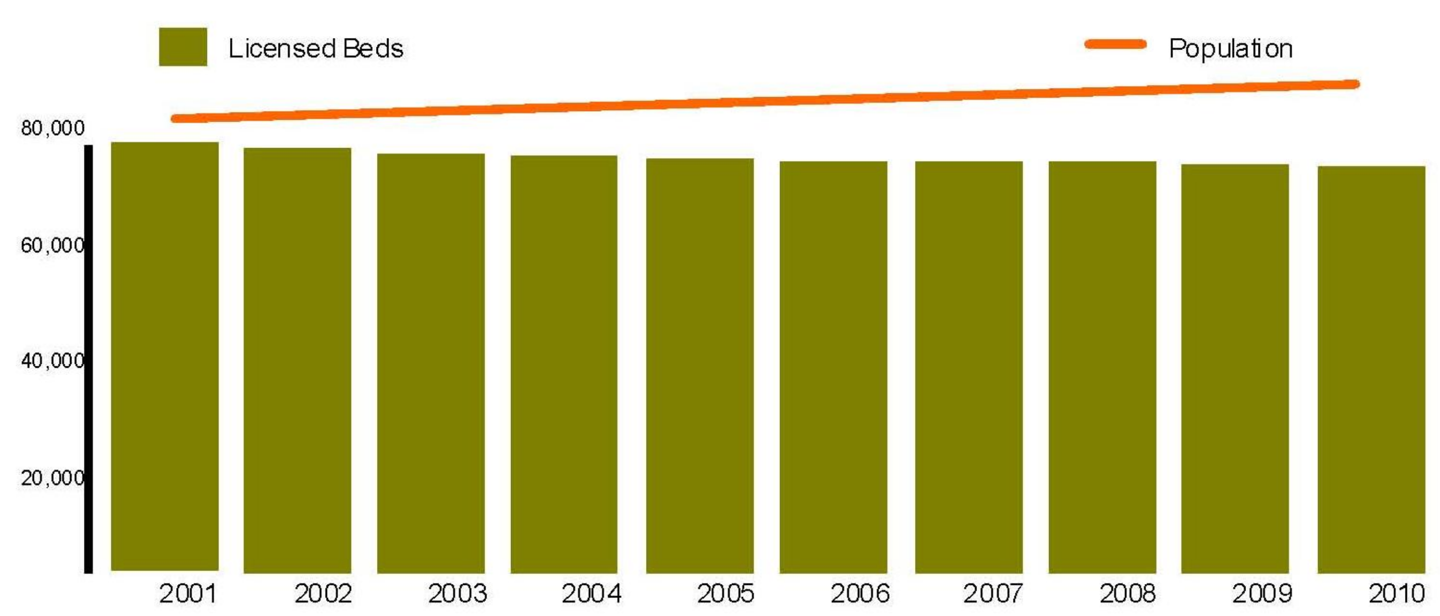
Consistently lower utilization levels have been a major contributor to California's healthcare cost advantage

Utilization rates in 2010[1]

Number of encounters/days per 1,000 population

	California	U.S.	California ranking
Admission	92	114	13th
ER visits	294	412	2nd
Inpatient days	468	614	7th
Outpatient visits	1,388	2,108	5th

Provider Capacity
Hospital Beds



Provider Capacity

Physicians

	Total MDs	MDs per 100K Population	Total DOs	DOs per 100K Population
Active Physicians in California - 2009	89,254	242.8	3,309	9.0
Active Patient Care Physicians – 2009	77,208	210.1	2,868	7.8

- Nationally, nearly one quarter (24.7%) of the active physicians in the workforce are age 60 or older.
- California has the highest percentage of those over 60 years of age at 29.2%, or nearly one-third of all active physicians.

Expected Medicare Shortfall Over the Next 10 Years

2009 2010 2011 2012 2013 2014 2015 2016 2017 2018 2019

$3.6

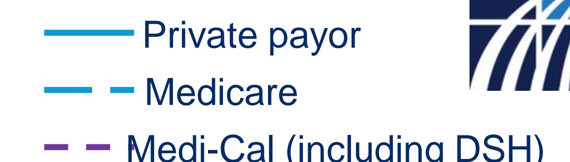
$8.8

Hospitals face more than $17 billion in Medicare payment reductions over the next ten years, creating massive financial burdens on top of historical payment shortfalls.

$ Billions

Hospital Medicare Losses
Medicare Reductions PPACA

Cost Shift In CA



Private payor
Medicare
Medi-Cal (including DSH)

Annual ratio of hospital profit to costs by payor category[1]

45
40
35
30
25
20
15
10
5
0
-5
-10
-15
-20
-25
-30

2000 2001 2002 2003 2004 2005 2006 2007 2008 2009

Reductions in Medicare and Medi-Cal reimbursement have required hospitals to increase charges to private payors to maintain overall profitability

1 Profit-to-cost ratio calculated by payor category in each year using the formula: (Net Patient Revenue – Hospital Costs) / (Hospital Costs)

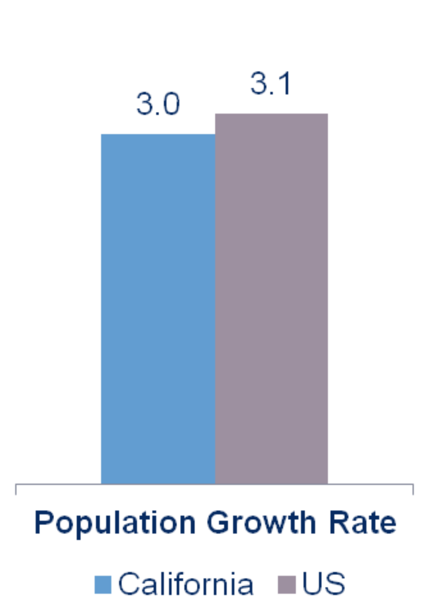
SOURCE: OSHPD Quarterly Data Files, 2000-09

Transforming for Tomorrow Task Force

In late February, the Transforming for Tomorrow Task Force adopted a three phased approach to assess the environment, identify transformational strategies for California hospitals, and develop consensus on recommendations to be adopted by CHA's Board of Directors

	Phase 1: Identify / Prioritize Strategic Issues	**Phase 2: Formulate Core Strategies**	**Phase 3: Document Proposed Actions**
	Isolate and evaluate the "big issues" facing CHA Members	Identify and "stress-test" potential strategies against market evolution scenarios	Flesh out the detail and isolate actions for consideration by the CHA
Activities	■ Stakeholder interviews ■ Develop a strategic fact-base – Demographics and population health needs – Relative financial/operational health of CA hospitals and providers – Level of integration in key markets ■ Establish strategic positioning of CHA members (current/forward looking) ■ Isolate and prioritize strategic imperatives	■ Evaluate applicable industry leading practices and market trends ■ Identify a set of 'strategic destinations' for CA hospitals ■ Frame potential strategies / actions ■ Member/hospital level ■ Association level ■ Test 'strategic destinations' and related strategies against market evolution scenarios ■ Core strategies ■ Situation-specific strategies	■ Prepare report of findings and recommendations ■ Isolate actions for consideration by CHA ■ Identify potential capability gaps ■ Support review and presentation of findings to the CHA Board and/or other stakeholder groups

Population growth in California is slightly below the national average, with higher observed growth concentrated in smaller counties



County Population Growth Rate

10%
8%
6%
4%
2%
0%
-2%
-4%

Imperial
Kern
Riverside
Placer
Trend Line
San Diego
Orange
Calveras
Plumas
Los Angeles

-
1,000,000
2,000,000
3,000,000
10,000,000

County Population

Source: US Census American Community Survey 2007, US Census 2010, Deloitte Analysis

Aging

Virtually all projected growth in the state will be driven by seniors (aged 55+)

Population Distribution 2010-2020

Year

Year	Under 55	55 to 65	Over 65
2010	29	4	4
CAGR	0%	3%	6%
2020	29	5	7

0 10 20 30 40 50

Population in Millions

- Under 55
- 55 to 65
- Over 65

Change in Population Aged >55

Percentage Change

8% 7% 6% 5% 4% 3% 2% 1% 0%

Median: 4%

El Dorado
Amador
Kings
Los Angeles
Santa Clara
San Mateo

Counties

Source: American Community Survey 2007, US Census 2010, Deloitte Analysis

Beyond coverage shifts, aging will also drive a significant increase in the utilization of inpatient services

Chronic Illness vs. Current Utilization Rates

Medicare Inpatient Utilization / 1000

260
240
220
200
180
160
140
120

25% 30% 35% 40% 45% 50% 55%

Chronic Disease Incidence

Kings
Stanislaus
Colusa
Lake
Glenn
Tehama
Calaveras

For every 1% change in the incidence of chronic disease there is a corresponding increase in utilization of 6%

Source: California HealthCare Foundation

Caregiver Shortage

Primary care physician supply could constrain the ability to manage the increase of chronic disease and other increases in utilization in several parts of the state

Health Status

Percentage of adults with one or more chronic illnesses

28-35%
35-39%
39-43%
44-49%
No data

San Francisco
San Jose
Los Angeles

The combination of low caregiver supply and are poor health status is evident throughout California

Caregiver Supply

Number of primary care physicians per 1,000

1.3-2.5
1.1-1.3
0.8-1.1
0.2-0.7
No data

San Francisco
San Jose
Los Angeles

Source: AMA Physicians Master File, California Health Care Foundation

Diversity Index

In addition, the level of ethnic diversity in California creates a unique challenge in the delivery of care, with most counties above the national average

California Diversity Distribution

Diversity Index Score

1.00
0.75
0.50
0.25
0.00

Los Angeles
Riverside
Sacramento
San Francisco
CA Average
US Average
Nevada

Counties

- Racial and ethnic variation contributes to the complexity of care delivery – non-white patients tend to report less satisfaction with caregivers understanding / responding to their care preferences
- Diversity is associated in many regions with gaps in care – even when minority Americans have similar access to care, they often receive significantly fewer services and poorer quality care

Source: US Census 2010, Deloitte Analysis; Commonwealth Fund, Kaiser Family Foundation and American College of Cardiology Foundation 2002, Lisa Cooper-Patrick 1999

Competitive Dynamics

These factors exacerbate a highly competitive environment today, in which most counties are trending toward market consolidation

California Competitive Dynamics by County

○ = 75,000 discharges

2010 HHI Concentration Index

1.0
0.8
0.6
0.4
0.2
0.0
-0.2

Highly Concentrated Becoming More Competitive

Highly Concentrated Becoming More Concentrated

Competitive Becoming More Competitive

Competitive Becoming More Concentrated

Highly Concentrated Markets

More Competitive Markets

Inyo
Lake
Merced
Madera
Kings
Stanislaus
Sacramento
San Diego
Orange
San Bernardino
Los Angeles
Contra Costa
San Joaquin
Alameda

% Change HHI 2007-2010

-20% -15% -10% -5% 0% 5% 10% 15% 20%

Markets Becoming More Competitive

Markets Becoming More Concentrated

Source: OSPHD 2010 and Deloitte Analysis

Effect of 'Systemness' on Revenue and Cost

Systems in California are able to command higher commercial reimbursement and more effectively manage dis-economies of scale

Market Basket Cost per Episode

15,000
14,500
14,000
13,500
13,000
12,500
12,000
11,500
11,000
10,500
10,000

Independent

System

0 10,000 20,000 30,000 40,000 50,000

Total Discharges

Revenue per Adjusted Patient Day

5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0

System

Independent

0 10,000 20,000 30,000 40,000 50,000

Total Discharges

Source: Data Advantage 2010, OSPHD 2010, Deloitte Analysis

Methodology Revenue per adjusted patient day is calculated by dividing total net revenue by adjusted patient days. Market Basket Cost per episode is calculated using the most common DRGs across CA hospitals in 2010. DRGs were weighted using state-wide average case load per DRG to arrive at an equally weighted market basket of DRGs by provider

Access to Capital

Given existing performance, a proportion of California hospitals could struggle to access capital to fund transformation

Percentage of California Hospitals

100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%

Day Cash on Hand
Total Operating Revenue
Debt to Capitalization
Operating Margin
Days AR
Debt Service Coverage

AA- to AA
A to A+
BBB+ to A-
BBB- to BBB
Junk

Depending on the metric, between 25% and 95% of California hospitals perform at the lower end of investment grade hospitals, which could limit their access to debt markets

Source: OSPHD 2010, FitchRatings Nonprofit Hospital and Healthcare System Medians for Investment-Grade Ratings 2011, Deloitte Analysis

Methodology: Ratings assigned to hospitals based on median figures reported in FitchRatings Nonprofit Hospital and Healthcare System Medians for Investment-Grade Ratings 2011

Exchange Exposure

55% of the workers in the state are employed by firms of less than 100 employees, firms most likely to push employees to the exchange

Source: State of California, Employment Development Department, Labor Market Information Division, Deloitte Analysis
Note: Conversion rates are estimates based on national conversations with employers, payers, and opinion leaders. Actual conversion rates will depend on the state of the legislation post-Supreme Court decision and existing incentives

Profitability Challenges at Medicare Rates

While many hospitals report operating profits today, most will likely be unprofitable as reimbursement approaches Medicare rates

A substantial proportion of the hospitals that are profitable today will not be profitable at Medicare rates

Source: OSPHD 2010, Deloitte Analysis

Methodology: Percentage of CA hospitals profitable under Medicare calculated using per episode Market Basket cost and revenue

Vulnerability Index: Exposure vs. Readiness

Capacity in Question
Near-term threats may challenge these providers, despite readiness for tomorrow

Transformational Leaders
These organizations are best in a position to lead and thrive in the new environment

Acutely Vulnerable
These organizations are most at risk for failure and potential acquisition

Challenged Sustainability
Repositioning will be required for these organizations to survive longer-term

Note: Care in the above boxes refers to discharges.; Source: Deloitte Analysis

Exposure Metrics
(Environment)

Assessed at County Level

Current Environmental Challenges
(What does it look like today?)

- **Competition Level:** Is there a lot of competition in my backyard
- **Health Status:** More Chronic conditions = sicker population – In "Managed Care" environment want healthier population
- **Payor Mix:** Higher Commercial mix = Better Reimbursement levels
- **Diversity Index:** More diverse population, more complex/costlier to deliver care
- **Workforce Strength:** More PCPs, better access to care

Future Market Shifts
(What will it look like tomorrow?)

- **Wealth Distribution:** If trend is toward higher household income, greater ability to afford coverage
- **Aging:** If trend is toward older population, more likely to have chronic care needs.
- **Coverage Shift:** Higher proportion of people employed in firms <50 people, higher risk for transition to Exchange
- **Population Growth:** Growing population = more opportunity to serve target populations / preserve census as admit rate decreases under tighter management

TFT Results – Individual Counties, Current vs. Future Exposure

Current vs. Future Exposure Drivers of Change

Readiness Metrics
(Facility Characteristics)

Assessed at Provider Level

Financial Durability

(Will I have access to cash to "Transform"? If not, who does?)

- **Scale:** Bigger is better, but not only factor…
- **Cost Effectiveness:** I might be big, but am I also lean? More cost effective = better able to adapt to lower reimbursement environment.
- **Profitability:** Multiple measures - margin / return on assets. Can I preserve/improve current profitability?
- **Capital Structure:** How would a bond company assess my facility – Impacts ability to access to cash.

Capabilities

(Do I have "the right stuff"?)

- **Brand / Reputation:** Higher patient satisfaction = better reputation.
- **Value:** Quality / Cost
  - **Quality**: Readmission and Mortality Rates
  - **Cost**: Cost Effectiveness
- **Technological Integration:** HIE usage. Technology adoption on fast track.
- **Payor Alignment:** Integration of financing
  - HMO % of commercial plans in county
  - Financing and Delivery Integration
    - IDS Designation: Yes / No (very few)
    - ACO Affiliated: Yes / No

Summary of Conclusions

California has long built a reputation for being on the leading edge of care and innovation. However, demographic and coverage shifts as well as forecasted challenges in the reimbursement and labor markets will challenge several hospitals as they prepare to transform for tomorrow.

- Demographic trends and coverage shifts will require organizations to innovate their care model to, among other considerations, address primary care supply, cost management, the evolving health needs of an aging population and the imperative to transition from ‘providing care’ to ‘managing health’
- Scale is important, but integration will be critical in driving revenue and cost leadership to support sustainable margins at significantly reduced levels of reimbursement
- California’s high proportion of small business and active legislature will likely increase the impact of the health insurance exchange, which will be a key future driver of financial risk
- California hospitals show early signs of readiness for the future, but some face significant near-term challenges to sustainability

Core Strategies to Support Transformation Journey

The key conclusions from the Fact Base led the Task Force to develop a set of Core Strategies applicable to all California hospitals

Key Fact Base Conclusions	Core Strategies from the Task Force
Demographic and coverage shifts will require organizations to innovate their care model to, among other considerations, address caregiver supply, cost levels, the needs of an aging population and the transition from 'providing care' to 'managing health'	• Begin testing methods for reducing cost and improving quality beginning with hospitals' self-insured populations • Acquire care management technology that incorporates performance management and predictive analytics capabilities
Scale is important, but integration will be critical in driving revenue and cost leadership to support sustainable margins at significantly reduced levels of reimbursement	• Develop new models to drive greater clinical integration by aligning incentives with community physicians • Develop strategic partnerships that augment actual and virtual scale, leveraging shared networks and technology as enablers
California's high proportion of small business and active legislature will likely increase the impact of the health insurance exchange, which will be a key future driver of financial risk	• Evaluate and prioritize current health plan relationships in preparation for Exchange-based competition • Increase outreach to employers and other institutional purchasers to drive stickiness and explore pay for performance
California hospitals show early signs of readiness for the future, but some face significant near-term challenges to sustainability	• Develop initiatives to boost cost performance in preparation for additional payer and purchaser pressure on reimbursement • Access financing to support needed infrastructure and capability investments

In addition to the Core Strategies, California hospitals could choose one of several possible 'destinations' to create differentiation and drive enhanced revenue or cost performance over time

Profitability Levers

Declining Reimbursement

Unit Cost Inflation

Per Unit Reimbursement or Cost

Time

Improve Revenue Performance

Improve Cost Efficiency

Strategic Destinations

The Innovator
Deliver superior outcomes/service to realize superior reimbursement

The Diversifier
Extend consumer relationships to achieve a greater 'share of wallet'

The Aggregator
Use actual and virtual scale to drive a sustainable unit cost advantage

The Health Manager
Integrate care across the continuum to decrease utilization and total cost

The Connector
Focus service mix and direct extended care to other high value providers

The Innovator – Detailed Description

The Innovator delivers the best products differentiated by exceptionally higher quality and improved experience to extract leading reimbursement and draw patients from a broad geographic area

Destination Strategies

- Achieve incrementally higher reimbursement through market recognition as a 'best product' provider'
- Launch a focused unit to disrupt existing care practices, focusing on identifying demonstrably improved outcomes
- Optimize environment for development and delivery of innovative health care services
- Use outcomes-based payments for physicians to align incentives to reward excellence in clinical care
- Set a defined annual target for innovation investments
- Develop infrastructure to achieve and maintain 'magnet' status for innovative procedures
- Leverage status to develop preferred contracts with managed care organizations and potential retail offerings

Illustrative Metrics

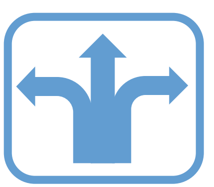
- 50%+ of volume from outside primary service area
- 35%+ premium earned on innovative services
- Center of Excellence reimbursement
- Out-of-network commercial rates
- Revenue from 'retail' offerings
- 25% of services fully redesigned every 5 years

Key Competencies

- Top 5 national recognition for one or more key services
- Superior brand recognition among consumers
- Recognition by industry press (e.g., USNews and World Report)
- Innovation culture and infrastructure
- High-caliber innovation resources
- Incentive compensation to reward entrepreneurialism and smart risk taking

Early Signals	***'Innovation Center'*** This California delivery system has developed multiple tools to use in innovating care. The system created a small consulting group that applies design principles to 're-imagine' care processes, and launched a learning laboratory designed to test care delivery improvements through a simulated clinical environment.

The Diversifier – Detailed Description



The Diversifier extends its brand strength and capabilities into adjacent and new lines of business to supplement declining margins within core services

Destination Strategies

- Achieve revenue growth through deep consumer pocket-book penetration and diversification into new lines of business
- Capitalize on existing consumer base; develop a 'plug and play' structure to enable partners to easily access the organization's consumers (e.g., for growth, licensing, etc.)
- Leverage existing brand, reputation and consumer relationships to extend into adjacent products and services, such as:
  - Capitalize on customer segments seeking enhanced personalization, service, or convenience (e.g., 'Gold Card' service)
  - Diversify focus into retail health products to capture greater health spend (e.g., complementary and alternative medicine)
- Monetize unique capabilities to pursue institutional market opportunities

Illustrative Metrics

- 25% of revenues and up to 50% of income earned from non-core businesses
- 50%+ overlap in customers for both traditional and non-core products (consumer-driven diversification)
- 20% of management incentive compensation is dedicated to the incubation (and success) of non-core opportunities

Key Competencies

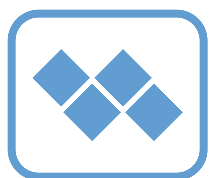
- Strong brand preference / permission within target market
- Commercialization orientation and experience to identify and manage opportunities for diversification
- Solid balance sheet or access to private / public investment capital to support inorganic growth
- Able to manage connection to the core

Early Signals

'Ventures'

This California health system is developing a significant portfolio of ventures that extend its mission and brand into adjacent health care businesses such as wellness, medical devices, IT, and management. The system is also actively marketing its extensive customer base to monetize potential opportunities in clinical research.

The Aggregator – Detailed Description



The Aggregator combines significant actual scale and cumulative 'virtual' scale to deliver a durable unit cost advantage in facility-based services

Focus: Cost

Destination Strategies

- Seek to operate profitability at or below Medicare reimbursement by reducing unit costs by using economies of scale as a primary strategic lever
- Reinforce scale / cost advantage through aggressive narrow or concentric network strategies with select insurance providers and purchasers
- Launch distinctive corporate services 'products' that can be offered to affiliates to augment existing scale (e.g., supply chain / purchasing management, IT services, etc.)
- Regionalize the delivery of specific bundles, where possible (e.g., offer transcutaneous valve procedures at a single location in San Diego county)
- Create a community of practice to share / develop industry-leading methods for achieving efficiencies

Illustrative Metrics

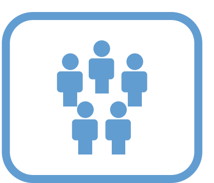
- 80% of all care is delivered as value-based 'bundles'
- 50% of currently community-based care is aggregated into regional medical centers
- 25%+ of volume used for purchasing discounts is derived from virtual scale provided by affiliate contracts
- 100% of cost inflation is managed at CPI (2.7%) or better

Key Competencies

- Able to develop, drive, and measure individual adoption of standardized, evidence-based practices (90% compliance)
- 'Lean' culture and infrastructure to support top decile cost and quality outcomes and continuous improvement
- Profitable at or close to Medi-Cal rates

Early Signals	***'Regional Referral Centers'*** This Northern California multi-hospital system has recently consolidated many of its shared services and clinical functions such as financial services and laboratory. It is using its deep footprint in specific markets to regionalize the provision of key services, such as cardiology and orthopedics to drive significant reductions in capital and variable cost.

The Health Manager – Detailed Description



The Health Manager uses its capabilities in clinical and technology integration to improve health, drive significant reductions in utilization over time, and manage cost within a budgeted care environment

Focus: Cost

Destination Strategies

- Attempt to achieve cost leadership through a reduction in demand/utilization through health maintenance
- Invest in performing critical delivery functions only; launch a platform to allow affiliated providers to plug in and play specific roles in managing member health
- Develop 'connective tissue' to provide customized health and care management across ambulatory, acute and post-acute settings
- Use informatics and customer analytics to assess individual risk, identify personalized treatment options, and predict outcomes
- Leverage technology to place consumers in 'drivers seat'; provide mobile access to virtual care plans, records, and self-service
- Exploit expertise in managing utilization and cost by aggressively assuming performance risk

Illustrative Metrics

- 80% of Health Manager revenues received as global payments (e.g., capitation)
- Up to 60% of care cost managed is provided by affiliates
- 25%+ of all interactions are initiated by system prior to the need for care (e.g., prevention / health maintenance)

Key Competencies

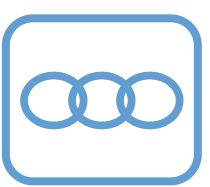
- Experience in managing receipt and distribution of global payments (e.g., capitation or similar)
- Advanced analytics capability integrating risk, internal / external clinical information, product options and pricing
- Framework for evaluating and applying comparative effectiveness data (e.g., internal / external providers, service offerings, pricing, etc.)

Early Signals

'Toward Global Capitation'

This coastal collaborative has a 5 year plan to transition the majority of its revenue to global capitation, after having successfully implemented a shared savings model to its affiliated physician population. The network also recently launched the first phase of its 'care navigator' program to coordinate individualized care plans for high risk individuals.

The Connector – Detailed Description



The Connector delivers a very narrow set of facility-based services and directs patients to the most appropriate site of care for other services through a network of affiliated high-value providers

Focus: Cost

Destination Strategies

- Narrow service mix to high frequency community-based ambulatory and acute care services
- For all other services, develop a regional delivery network of ambulatory, tertiary, quaternary and post-acute care partners based on quality, cost, and proximity
- Work with preferred network partners to create 'frictionless' connections
- Develop virtual care collaborations where possible (e.g., administration of TPA for stroke, neuro telemedicine consults, etc.)
- For all others, develop expedited transfers (to/from partners) with appropriate health information
- Leverage regional network partners to maximize access to resources such as technology, purchasing, and performance improvement

Illustrative Metrics

- Performs only 50% of the services of a typical California medical center, and uses partnerships for remaining 50%
- 50% of patients triaged are referred to lower- or higher-acuity network partners without receiving care
- 50% of admitted patients receive a 'virtual' consult in collaboration with a regional network partner

Key Competencies

- Competency in virtual collaboration and related technology
- Proficient in team-based care, leveraging non-physician providers and collaboration across organizations
- Active network management function:
- Screens potential network partners based on value
- Negotiates support from network partners (e.g., equipment to support remote monitoring and virtual consultations)

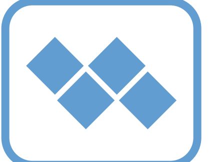
Early Signals

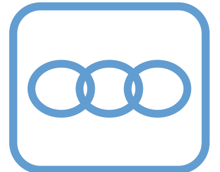
'Optimized Access'

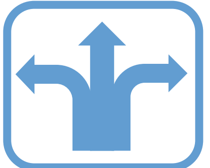
This Southern California rural hospital is currently rationalizing its acute care services to determine what will continue to be performed locally. The organization's vision is to become an optimized access point for care, and is using cost and other measures to prioritize potential partners for select secondary, tertiary and quaternary care referrals.

Destination Selection – Leading Characteristics

Each Destination's unique characteristics should be considered in the evaluation of strategic fit







	Aggregator	Health Manager	Connector	Innovator	Diversifier
Focus	Cost			Revenue	
Leadership Role	Leading acquisitions to develop critical mass / scale economies	Integrating the system of care to prevent the prevalence and progression of disease	Assembling value-added network of secondary and tertiary providers	Leading the research, design, and introduction of best in class methods	Using brand loyalty, consumer insight, and trusted partners to monetize relationships
Leverage Point	Scale	Utilization Management	Focus	Leading Products	Relationships
Key Enabler	Efficiency and Standardization	Physician and Continuum Alignment	Efficient and Effective Transitions	Continuous Disruption	Commercialization
Success Measure	Cost per Service	Utilization per Member	'Directed' Outmigration	Quality and Outcomes	Share of Consumer Discretionary Spend
Required Capital	High	Medium	Low	High	Medium

7.

FINANCING PLAN FOR CONSTRUCTION PROJECT

Sonoma Valley Hospital Sonoma Valley Healthcare District

Building Program
Finance Committee Recommendations
February 7, 2013

Finance Committee Charge

The Finance Committee was charged to answer the question:

Can The Hospital Afford to Expand the Scope of the Building Project?

Can The Hospital Afford to Expand the Scope of the Building Project?

- Based upon our review of the project cash flows and hospital 3 year projected cash flows, we feel the funding plan is sufficient to cover the expanded project scope:
  - Changes from the October 9, 2012 special board meeting, $1,370,000
  - Second Floor projects, $1,200,000

Finance Committee Recommendations

The Finance Committee recommends to the District Board the following items:

1. To Authorize the CFO to negotiate and enter into a 5 year capital lease for approximately $2.2 million for the movable equipment and furniture at an interest rate of approximately 3%.
   - At least 5 vendors will be included in the process.
   - The CFO will update the Finance Committee on the terms of the lease.
   - The lease should be completed within 60 days.

Finance Committee Recommendations
Continued

2. Authorize the CFO to obtain financing of the donations to cover the timing differences or to utilize the Line of Credit (LOC) or a combination of the two financing vehicles.
   - The CFO will keep the committee updated on all terms of the transaction.
   - This should be completed prior to the end of August 2013.

Meeting Date: February 7, 2013

Prepared by: Board Finance Committee and Rick Reid, CFO

Agenda Item Title: New Wing Financing Proposal

Recommendation: The Board Finance Committee makes the following recommendation to the District Board:

- Based upon our review of the project cash flows and hospital 3 year projected cash flows, we feel the funding plan is sufficient to cover the expanded project scope:
    - Changes from the October 9, 2012 special board meeting, $1,370,000
    - Second Floor projects, $1,200,000
- Authorize the CFO to negotiate and enter into a 5 year capital lease for approximately $2.2 million for the movable equipment and furniture at an interest rate of approximately 3%. At least 5 vendors will be included in the process. The CFO will update the Finance Committee on the terms of the lease. The lease should be completed within 60 days.
- Authorize the CFO to obtain financing of the donations to cover the timing differences or to utilize the Line of Credit (LOC) future donations or a combination of the two financing vehicles. The CFO will keep the committee updated on all terms of the transaction. This should be completed prior to the end of August 2013.

Background and Reasoning: The funding obtained from the GO bond was never sufficient to fully pay for the project. The capital campaign has been very successful in raising over $9 million in donations, pledges and anticipated donations. Even with this additional money, there is still a shortfall for paying for the furniture and equipment, and timing differences for paying for the construction and the receipt of the donated funds. A 5 year capital lease for approximately $2.2 million will cover the remaining shortfall and the use of the District's LOC will cover the timing differences. This will allow the project to be fully completed and will provide the District with a state of the art Emergency Department and new Surgical Center. The Construction Committee that was established after the October 9 special board meeting has recommended the scope changes to the District Board.

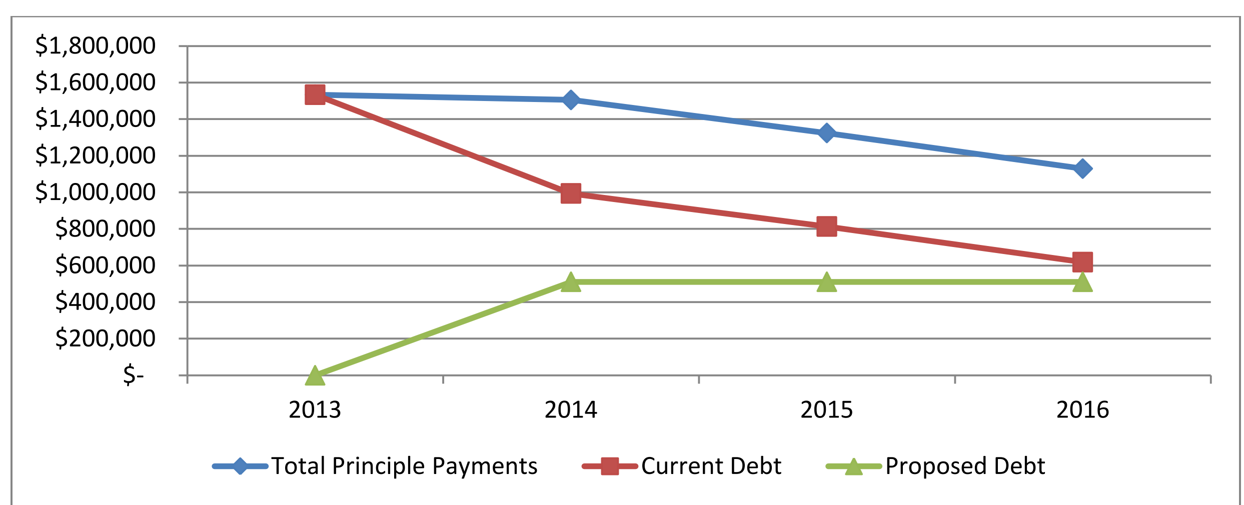
Consequences of Negative Action/Alternative Actions: The new surgery center will not be completed and will increase the overall cost of the project due to this delay. Not completing the 2nd floor items will increase operating costs by approximately $600,000 per year in additional RN staffing costs due to the inefficient floor layout.

Financial Impact: The following is a summary of the principle and interest payments for the next 3 fiscal years. This includes the principle and interest for the CEC loan and the Capital lease and the interest only for the LOC. The principle payments do not include the LOC principle payments; those will be paid from the donations as they are received.

Fiscal Year	Interest	Principle	Total
2014	$ 177,853	$ 511,000	$ 688,853
2015	$ 106,850	$ 511,000	$ 617,850
2016	$ 68,500	$ 511,000	$ 579,500

The principle payments will be available due to the reductions of existing debt. As the following chart and graph show, long term debt payments are projected to decrease over the next 3 years even with the additional financing. The 2013 amount below represent principle payments for a full year not the remaining portion.

Non GP Bond Principle Payments	**2013**	**2014**	**2015**	**2016**
Current Debt	$ 1,533,382	$ 993,657	$ 813,095	$ 618,261
Proposed Debt	$ -	$ 511,000	$ 511,000	$ 511,000
Total Principle Payments	$ 1,533,382	$ 1,504,657	$ 1,324,095	$ 1,129,261



Selection Process and Contract History: The leasing company will be selected through a bidding process which will include at least 5 separate vendors. The selection will be made based upon the most favorable rate for a 5 year capital lease with a $1 purchase option at the end of the term.

Board Committee: Finance Committee

Attachments: Financing Proposal presented to the Board's Finance Committee on January 22, 2013 and 3 year financial projection.

Date: **January 22, 2013**

To: **SVH Finance Committee**

From: **Rick Reid, CFO**

Re: **Building Project Supplemental Financing Plan**

Management's Proposal

Management recommends to the finance committee and to the District Board that the building project be completed and that the following financing components be adopted to finance the timing differences in the receipt of the pledged capital contributions and to execute the following to fill the remaining funding shortfalls:

- Utilize the Board Approved California Energy Commission Loan of $1,065,000 for 15 years at 3%.
- Obtaining a 5 year Capital Lease for the movable equipment and furniture at approximately 3%.
- Utilize the Line of Credit (LOC) or a Loan using the Pledges as collateral to cover the timing differences of the receipts of the contributions. (Management anticipates the final approval from Union Bank for the LOC by the end of January 2013.)

The plan will impact the operational costs starting in fiscal year 2014 for interest and principle payments on the CEC loan and the capital lease. The proposal is not anticipated to have a material impact on the 2013 financial results. Only LOC interest expense will hit the operational budget for the LOC draws. All principle payments will be made out of the donations received in the month received. The interest calculations reflect a full period of expense. This allows for the projections to be conservatively stated accounting for any adverse timing of the donations. The amortization schedule is a straight line estimate schedule. This is also meant to be conservative. The actual schedule payment schedule not be materially different from the stated amounts in this proposal.

The following is a summary of the principle and interest payments for the next 3 fiscal years. This includes the principle and interest for the CEC loan and the Capital lease and the interest only for the LOC. The principle payments do not include the LOC principle payments; those will be paid from the donations as they are received.

Summary of 3 year Impact of Financing Plan				
	1	**2**	**3**	**4**
	Fiscal Year	**Interest**	**Principle**	**Total**
1	2014	$ 180,909	$ 511,000	$ 691,909
2	2015	$ 108,405	$ 511,000	$ 619,405
3	2016	$ 70,056	$ 511,000	$ 581,056

For Details on the above amounts, please see the attached Operational Impact of Financing Plan Document.

Management is recommending to the finance committee that they recommend to the District Board the following financing plan. 1) The CFO be authorized to negotiate and enter into a 5 year capital lease for approximately $2.2 million at a rate estimated to be at or around 3%. At least 5 vendors will be included in this process. 2) Timing differences between the required payment of project costs be funded using the Union Bank LOC and that once the monies are received from the donors, those amounts will be paid to Union Bank to reduce the LOC outstanding balance. This plan will incur additional interest costs for the next 5 years ranging from approximately $148,959 (Equipment lease $66,000 plus LOC of $82,959 See Operation Impact on Financing plan attached) in 2014 to $26,000 in 2017. (The annual interest costs of the CEC loan are not included in this because the CEC loan was already approved by the District Board.) The annual principle payments are approximately $511,000 per year.

Sources and Uses of Project Funds

The following is the sources and uses statement for the building project.

Sources of Fundings		**11/30/2012**
1	GO Bond	$ 31,000,000
2	Interest Earned on Bond Money	$ 500,000
3	Donations Received	$ 2,064,354
4	Pledges to be collected	$ 2,980,022
5	Matching Gift	$ 2,000,000
6	Gifts to be Match	$ 2,000,000
7	Equipment Lease	$ 2,200,000
8	CEC Loan	$ 1,065,000
9	Total Project Funding	$ 43,809,376
Uses of Funds		
1	Board Approved Budget	$ 41,239,376
2	Adjustment due to OSHPD Approvals Delays	$ 1,370,000
3	2nd Floor Projects	$ 1,200,000
4	Total Project Costs	$ 43,809,376

The project is estimated to be completed in November 2013. The project has approximately $7 million dollars of pledges and anticipated future donations that will be received over the next 4 years. The chart below is the cash balance by month through the construction period and includes the anticipated receipt of the donations, receipt of the CEC loan, capital leases and the monthly project payments. The

Board approved CC loan is expected to be received in November 2013. This will be a repayment to the Hospital for the items covered under the loan. The capital leases are expected to be paid out over a 4 month period from July 2013 through October 2013. The difference in the remaining balance and the construction payments is proposed to be covered with the use of the Union Bank LOC.

The projected cash flows for the building project are attached to this report. Please see the attachment titled Building Project – Projected Cash Flow and Financing Plan.

Union Bank Line of Credit or a Loan against the Donation Pledges

Management anticipates the final approval of the Union Bank LOC by the end of January 2013. The total amount of the LOC will be $5 million. One of the requirements of Union Bank is that the LOC will be used to replace the GE operational loan, as previously presented to Finance Committee and the District Board, due to the fact that the current GE loan is secured by the District's Accounts Receivable and Assets. The balance of the GE loan is approximately $800,000. The Union Bank LOC will be secured by the District's Accounts Receivable. The LOC is not anticipated to be used during FY 2013 and therefore will have no impact on the 2013 operational financial performance.

The alternative to using the LOC is to take out a loan against the pledges. Management will work with financing companies and bring back to the Finance Committee and the District Board what the solution will be. Management has not made any formal request at this time.

The following is the listing of anticipated draws and repayments all will be used to cover the timing differences between the receipt of the pledged donations and the projected payments.

Period	Draws/ (Payments)	LOC Balance	Interest Expense
7/31/2013	$ 61,767	$ 61,767	$ 206
8/31/2013	$ 1,406,456	$ 1,468,223	$ 4,894
9/30/2013	$ 1,083,824	$ 2,552,047	$ 8,507
10/31/2013	$ 462,431	$ 3,014,478	$ 10,048
11/30/2013	$ 272,049	$ 3,286,527	$ 10,955
Remainder of FY 2014	$ (1,345,388)	$ 1,941,139	$ 45,293
FY 2015	$ (1,335,389)	$ 605,750	$ 24,230
FY 2016	$ (575,492)	$ 30,258	$ 1,210
FY 2017	$ (30,258)	$ 0	$ 0

5 Year Capital Leases

Management is currently getting proposals for at least 5 financing companies. Based upon the discussions to date, the anticipated interest rate is not expected to exceed 3%. Equipment and furniture

will be leased as a capital lease. The lease will include a $1 bargain purchase option that will be payable at the end of the lease term.

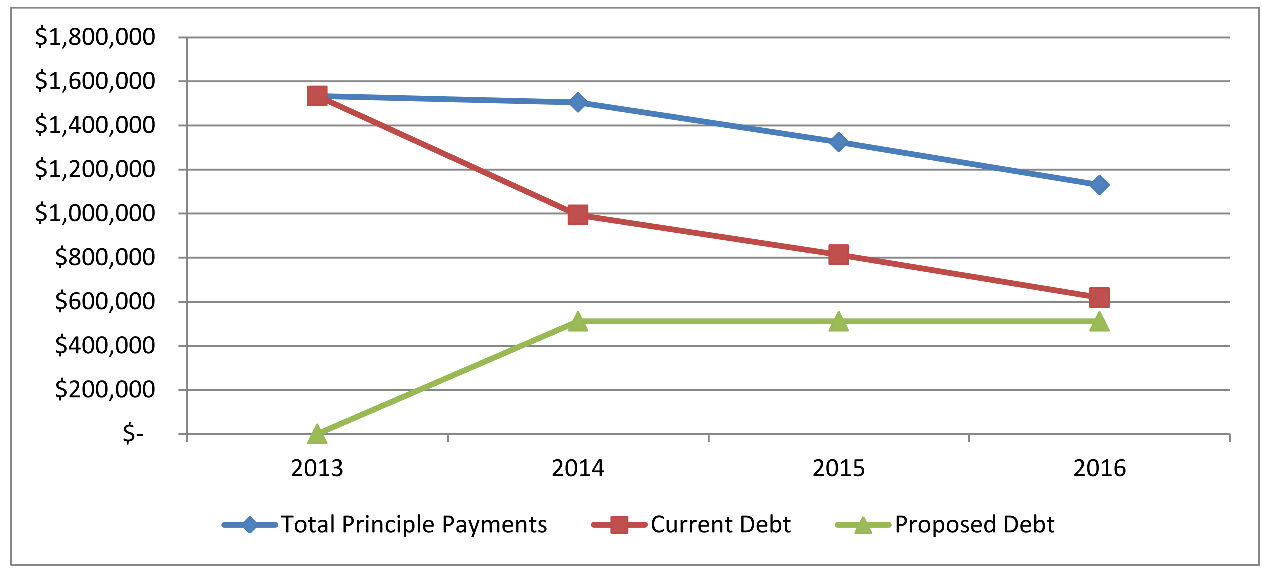
The following is an amortization schedule of the repayments:

Fiscal Year	Beginning Lease Balance	Principle Payment	Interest Expense	Total Annual Payment	Ending Balance
2014	$ 2,200,000	$ 440,000	$ 66,000	$ 506,000	$ 1,760,000
2015	$ 1,760,000	$ 440,000	$ 52,800	$ 492,800	$ 1,320,000
2016	$ 1,320,000	$ 440,000	$ 39,600	$ 479,600	$ 880,000
2017	$ 880,000	$ 440,000	$ 26,400	$ 466,400	$ 440,000
2018	$ 440,000	$ 440,000	$ 13,200	$ 453,200	$ 0

Cash Flow for New Debt Principle Payments

Over the period of 2014 – 2016, a current non-GO bond debt will be paid down from $1,533,382 to $618,261. The required payments for the new debt will be made from the amounts currently being paid on the existing debt. The principle payments for the GO bond are not included in this schedule because the funding source is not the operations of the hospital but the GO bond tax revenue. Also the principle payments for the line of credit or other donation financing will be made from future donations and not from hospital operations. The following table and graph show the current principle payments and the proposed principle payments:

Non GP Bond Principle Payments	**2013**	**2014**	**2015**	**2016**
Current Debt	$ 1,533,382	$ 993,657	$ 813,095	$ 618,261
Proposed Debt	$ -	$ 511,000	$ 511,000	$ 511,000
Total Principle Payments	$ 1,533,382	$ 1,504,657	$ 1,324,095	$ 1,129,261


$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$-
2013
2014
2015
2016
Total Principle Payments
Current Debt
Proposed Debt

Sonoma Valley Hospital
Building Project - Projected Cash Flow & Financing Plan
Supplemental Schedule

	1	2	3	4	5	6	7	8	9	10	11
	Periods	10/31/2012	11/30/2012	12/31/2012	1/31/2013	2/28/2013	3/31/2013	4/30/2013	5/31/2013	6/30/2013	7/31/2013
1	**Cash Balance At Beginning of Month**	$ 17,844,383	$ 16,659,141	$ 15,415,692	$ 13,668,822	$ 11,397,574	$ 8,968,304	$ 6,891,121	$ 4,569,510	$ 2,666,905	$ 1,744,278
2	**Current Pledges at 9/30/2012**	$ -	$ -	$ 1,115	$ 4,345	$ 1,267	$ 151,667	$ 2,684	$ 5,600	$ 503,283	$ 4,684
3	**Pledged Collected**	$ 14,565	$ 252,890								
4	**Pledged to be Matched**						$ 1,000,000			$ 1,000,000	
5	**Anticipated Pledges**				$ 10,000	$ 10,000		$ 210,000	$ 200,000		$ 10,000
6	**Approved CEC Loan**										
7	**Capital Leases**										$ 550,000
8	**Project Payments**	$ (1,199,807)	$ (1,496,339)	$ (1,747,985)	$ (2,285,594)	$ (2,440,537)	$ (3,228,851)	$ (2,534,295)	$ (2,108,206)	$ (2,425,910)	$ (2,709,615)
9	**LOC Draws or Other Financing**										$ 400,652
10	**Cash After LOC Draws or Other Financing**	$ 16,659,141	$ 15,415,692	$ 13,668,822	$ 11,397,574	$ 8,968,304	$ 6,891,121	$ 4,569,510	$ 2,666,905	$ 1,744,278	$ (0)

Sonoma Valley Hospital
Building Project - Projected Cash Flow & Financing Plar
Supplemental Schedule

	1	12	13	14	15	16	17	18	19	20
	Periods	8/31/2013	9/30/2013	10/31/2013	11/30/2013	Remainder of 2014	FY 2015	FY 2016	FY 2017	Totals
1	**Cash Balance At Beginning of Month**	$ (0)	$ (0)	$ (0)	$ (0)	$ (0)	$ 0	$ 0	$ 0	
2	**Current Pledges at 9/30/2012**	$ 1,267	$ 2,067	$ 1,017	$ 1,267	$ 595,388	$ 585,389	$ 575,491	$ 50,600	$ 2,487,132
3	**Pledged Collected**									$ 267,455
4	**Pledged to be Matched**									$ 2,000,000
5	**Anticipated Pledges**	$ 150,000	$ 150,000			$ 750,000	$ 750,000			$ 2,240,000
6	**Approved CEC Loan**				$ 1,065,000					$ 1,065,000
7	**Capital Leases**	$ 550,000	$ 550,000	$ 550,000						$ 2,200,000
8	**Project Payments**	$ (1,957,723)	$ (1,635,891)	$ (1,013,448)	$ (1,338,316)					$ (28,122,514)
9	**LOC Draws or Other Financing**	$ 1,256,456	$ 933,824	$ 462,431	$ 272,049	$ (1,345,388)	$ (1,335,389)	$ (575,491)	$ (50,600)	
10	**Cash After LOC Draws or Other Financing**	$ (0)	$ (0)	$ (0)	$ (0)	$ 0	$ 0	$ 0	$ 0	

The purpose of this plan was to project the income effect and the cash flows for the next 3 fiscal years of Sonoma Valley Hospital implementation of Management's proposal for financing the remaining portion of the building project. Management's plan consists of the following:

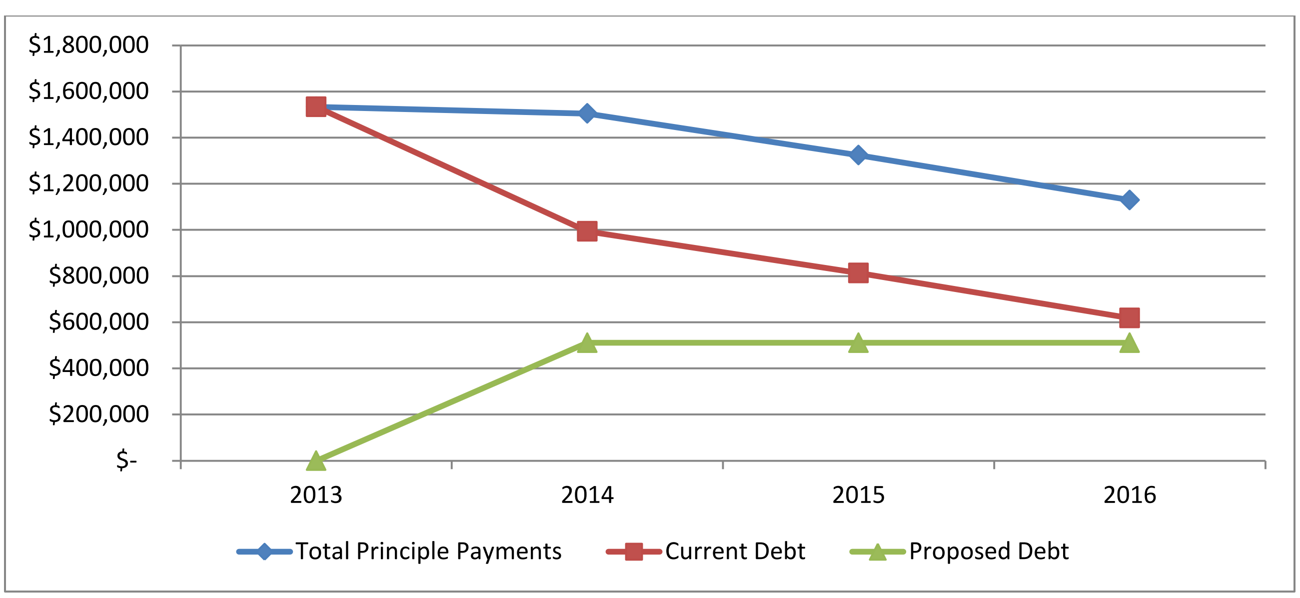
- Utilize the Board Approved California Energy Commission Loan of $1,065,000 for 15 years at 3%.
- Obtaining a 5 year Capital Lease for the movable equipment and furniture at approximately 3%.
- Utilize the Line of Credit (LOC) or a Loan using the Pledges as Collegial, to cover the timing differences of the receipts of the contributions.

The Sonoma Valley Hospital's 3 year financial plan was based on the operating performance from 2010 to 2012 and the Budgeted 2013 trended forward. The years reported in the projection refer to the fiscal year of Sonoma Valley Hospital, July 1 through June 30. The main operating assumption for this projection is safe, quality patient care will be provided at Sonoma Valley Hospital in a cost effective manner.

There is an overall philosophy at the hospital that costs will be controlled and the hospital will be operated with the right amount of resources being expended that is required for the patients being served. In short, there will be an environment where good cost control and good stewardship of the hospital's limit resources will be maintained. The assumptions that were used to create the plan are detailed below

Over the period of 2014 – 2016, a current non-GO bond debt will be paid down from $1,533,382 to $618,261. The required payments for the new debt will be made from the amounts currently being paid on the existing debt. The principle payments for the GO bond are not included in this schedule because the funding source is not the operations of the hospital but the GO bond tax revenue. Also the principle payments for the line of credit or other donation financing will be made from future donations and not from hospital operations. The following table and graph show the current principle payments and the proposed principle payments:

Non GP Bond Principle Payments	**2013**	**2014**	**2015**	**2016**
Current Debt	$ 1,533,382	$ 993,657	$ 813,095	$ 618,261
Proposed Debt	$ -	$ 511,000	$ 511,000	$ 511,000
Total Principle Payments	$ 1,533,382	$ 1,504,657	$ 1,324,095	$ 1,129,261



Based upon the projections and the above non-GO Bond principle payment schedules, the new debt will not be an additional drain on the hospital's limited resources, but it will not have a negative effect due to the fact that the total principle debt payments are decreasing from $1,533,382 in 2013 to $1,129,261 in 2016. This is an increase in available cash of $404,121.

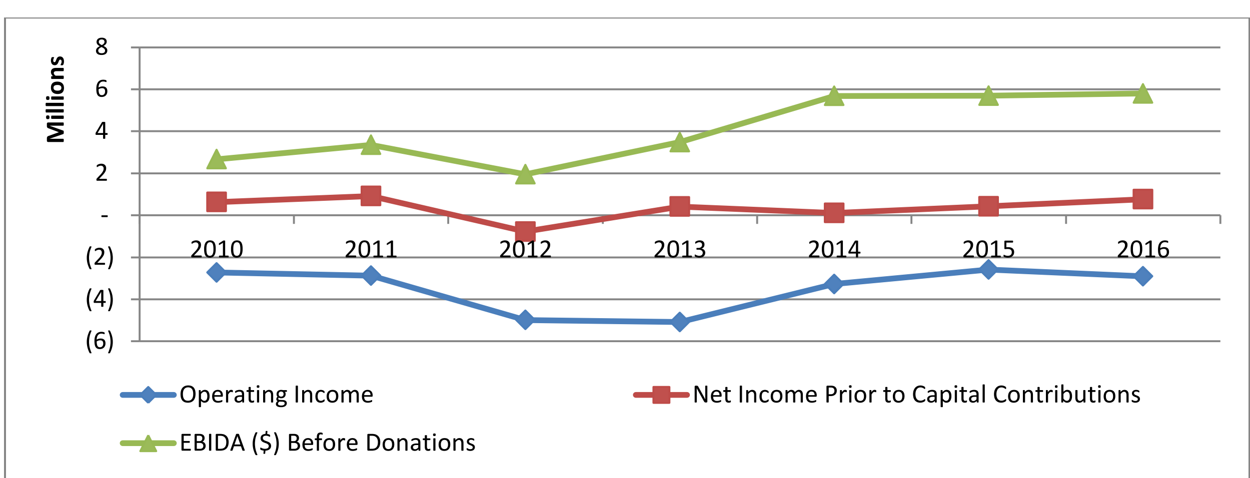
The projections show operating income improvements due to the following factors:

1. Minor improvements in number of patients due to the expansion of the market per the market study.
2. Increases in reimbursement due to recent contract negotiations completed in 2013.
3. Consistent cost management of the daily hospital operations.

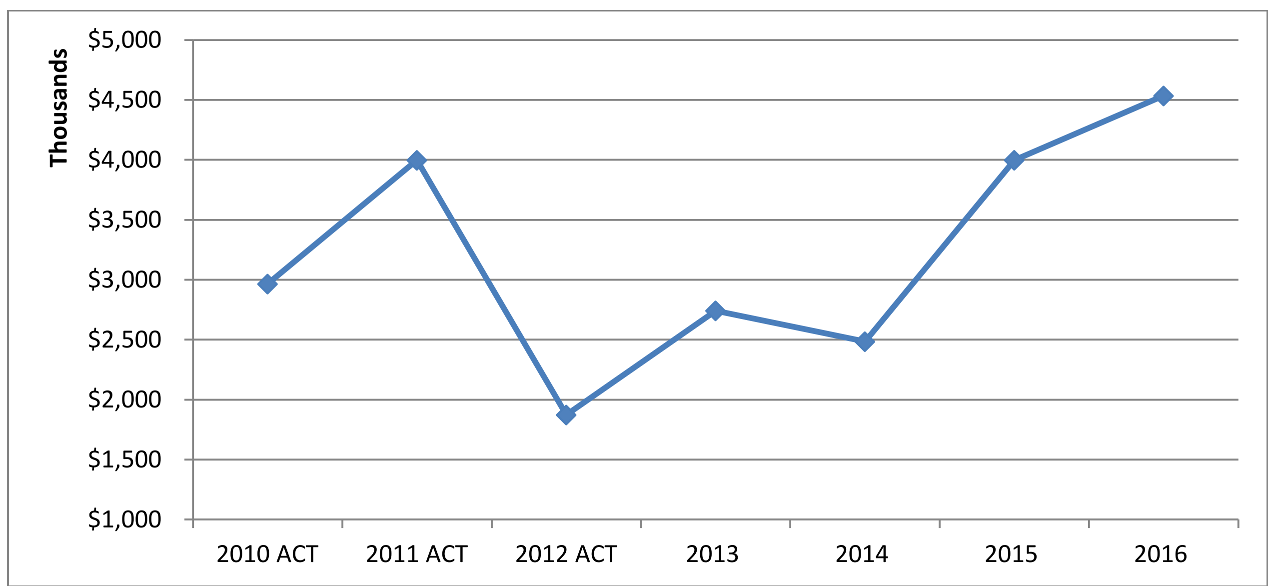
Based upon the projections, the following are Key Financial Indicators:

	2014	2015	2016
Operating Income	($3,276,930)	($2,584,893)	($2,906,798)
Net Income before Contributions	$110,514	$423,703	$765,798
EBIDA before Contributions	$5,686,409	$5,693,094	$5,797,983
EBIDA Margin before Contributions	7.3%	10.9%	11.0%
Cash Balance	$2,483,821	$3,996,953	$4,533,455
Days Cash on Hand	20	30	34

As the graph shows, that is improvement in the operating performance indicators.



The cash balances also show good improvement over the projection period.



The following is a listing of the critical assumptions underlying the 3 year projection:

1. The operating performance from 2010 -2012 and budgeted 2013 has been trended forward.
2. Inpatient volume for 2014-2015 is projected to increase by 0.5% and 0.0% in 2016. This increase is due to the projected market increase from 2012 to 2016 adjusted for the market utilization per the market study. This represents approximately 7 inpatients per year. This is consistent with the 3 year strategic plan.

3. Outpatient volume for 2014 – 2016 is projected to increase by 1%. This is based upon the increase in the primary market per the recently completed market study. It is also consistent with the trend in outpatient utilization.
4. There is no volume growth related to the new building.
5. Prices are projected to increase by 5% per year with an effective increase of 1.7% for 2014 and 2015. 2016 is projected to increase by 0.2%. The decrease in the effective reimbursement increase is due to the Medicare projected increase decreasing from 2.% to 0.0% in 2016. The rationalization that health care reform will be funded by decreases in Medicare funding.
6. Length of stay is held constant at the 2013 level of 3.8 days.
7. Case mix is held constant at the 2013 budgeted level. This is a conservative assumption. With surgeries increasing the case mix will increase.
8. The patient mix of inpatient and outpatients is held constant at the 2013 budgeted level.
9. Staffing is increased consistent with the increase in patients per adjusted occupied bed. There are no productivity improvements build into the projection. Even though management is implementing a variety of improvements, none are included.
10. Payer mix is fairly consistent with the budgeted 2013 amounts. This does not include any changes resulting from the introduction of Western Health Advantage or the health insurance exchanges. Self pay is also consistent with current utilization.
11. FTE per occupied bed are consistent with budgeted 2013. The projection does not include any productivity improvements that are currently being made. This increases the conservatism of the projections.
12. Wage increases will be 3% effective in January of each year, yielding an effective wage increase of 1.5%. The 3% increase is higher than in the past by 1%.
13. The benefit to salary percentage is increased by 1% per year. This is reflective of the improvements in SVH's benefit plan that will start to be implemented in 2013.
14. General inflation is 2.5% and supply inflation is 4%, consistent with the 2013 budgeted levels
15. Rental costs are consistent with 2013 budgeted amounts.
16. Utilities are estimated to increase by 25% in 2014 with the completion of the new building.
17. GO bond revenue is equal to the GO Bonds principle plus interest payments.
18. Property Tax Revenues are composed of the Parcel tax plus GO bond Revenue.
19. GO Bond interest starts to be fully expensed in 2014. It is being capitalized as part of the project for those amounts related to the projects not put into service, consistent with the accounting rules.
20. The new building is put into service in 2014. This causes an increase in depreciation expense and GO bond interest expense. Approximately $1.5 million per year starting in 2014. The 2013 interest is less because the project will not be put into service until the end of 2013.
21. The capital budget in 2013 and 2014 will be reduced to $500,000. This is due to the implementation of the new building and the fact that the OR and ED will be new and will not

have equipment replacement needs outside of the building project. The capital budget will be increased in 2015 to $1,250,000.

22. Contributions from the capital campaign total $9,000,000. These amounts will be received over the next 4 years.
23. The GO Bond covered $31 million of the project. The funding gap is approximately 12 million dollars. $9 million will be covered from contributions. Another $1 million will be funded through the prior approved California Energy Commission (CEC) loan. This leaves a difference of $2 million. Management's financing plan calls for taking out a capital lease for the furniture and equipment for $2 million. The debt service requirements of the lease and the CEC loan are approximately $600,000 per year. The principle portion is approximately $511,000 and will be paid from the available funds from the repayment of the existing debt. The interest portion of approximately $100,000 is included in the operating costs. The current capital leases, which expire during the projection period, will not be renewed.

8.

CONSTRUCTION COMMITTEE

Sonoma Valley Hospital - Phase 1 - Expansion.

Project Update/ Dashboard - Increment 1 & 3 — Tuesday, January 15, 2013

Schedule	Status	Target	Actual
MRI relocation	Green	9/26/2012	9/26/2012
Complete New Entrance	Green	9/27/2012	9/27/2012
Start New Building	Green	9/27/2012	9/27/2012
Install Footings	Green	12/31/2012	12/27/2012
Steel Top Out	Yellow	2/13/2013	
Deck Pour Completion	Yellow	4/9/2013	
Enclose Building Exterior	Yellow	7/8/2013	
Interior Wall Close Up	Yellow	6/28/2013	
Permanent Power	Yellow	8/23/2013	
Substantial Completion	Yellow	10/28/2013	
Final Completion	Yellow	11/12/2013	On Schedule
Generator On Line	Yellow	5/31/2013	
Chillers On Line	Yellow	5/13/2013	

Contract	Status	Target	Actual
Board Request, $1,369,624	Red	2/7/2013	In Progress
GMP Sign off	Yellow	2/8/2013	In Progress
Change Order#10	Yellow	2/8/2013	In Progress

Budget

Status	Item	Amount
Green	July Approved Budget	$39,739,376
Green	August Approved Infrastructure	$1,500,000
Green	Total Board Approved Budget	**$41,239,376**
Red	Board Review/Funding, Feb 7th	$1,369,624
Yellow	CEO Committee Recommended Two West	$1,200,000
Yellow	Total Requested Budget	**$43,809,000**
Yellow	Project Contingency	$465,432
Yellow	Donor Wall/Fountain Utilities	$22,307
Yellow	South Lot Fence Extention 48'	$13,320
Yellow	IT Basement Fire Alarm Change Order	$40,000
Yellow	Remaining Project Contengency	$389,805

Code	Potential Project Risks	Est Dollar Amount
Green	None at this Time	$0

Critical Issues	Status	Date	Comments
Project Funding	Red	2/7/2013	Outstanding
NPC -3 Extention	Red	10/15/2012	Pending NPC2 Approval
IT Network Coordination	Yellow	2/15/2013	In Progress
Potential Weather Delay	Yellow	On going	On Schedule
PG&E Coordination	Yellow	2/13/2013	In Progress
DIA for South Parking Lot	Green	In progress	
Facility Impacts			
Steel Erection - Complete	Yellow	2/13/2013	Noise
Welding Structure	Yellow	2/13/2013	Welding Flash
Chiller Installation	Yellow	1/18/2013	Street closure
Upcoming Activites			
PG&E Conduit Install	Green	2/13/2013	In progress
Chiller Yard Enclosure	Green	1/21/2013	In progress
Steel Erection - Start	Green	1/7/2013	In progress

Owner Decisions	Target Date	Completion Date
Security Final Operation Sign Off	1/29/2013	In Progress
IS Infrastructure and Cabling	10/1/2012	In Progress
IS Network Equipment Final Design	2/15/2013	In Progress
Voice IP / vs. Tele Switch - RFP evaluation	2/1/2013	In Progress
Site Signage - Exterior - Pricing to be confirmed	2/15/2013	In Progress
Nurse Call - 2 west - Submitted to OSHPD	10/31/2012	1/10/2013
Medical Equipment Project coordination	1/30/2013	In Progress
Med Gas Room/ MPOE room Infrastructure- to OSHPD	10/19/2012	11/12/2012
Materials Management - Final Permit	2/22/2013	In Progress
Licencing - Prepare Project Description	11/30/2012	1/8/2013
Donor Wall and Fountain	1/1/2013	In Progress
Two west Waiting Room	2/15/2013	In Progress
PBX - Coordination verification	2/15/2013	In Progress
4th Street Light	2/28/2013	In Progress

Red	Yellow	Green
Critical or High Impact	Potential Risk / Unresolved/ Medium Impact	On Track

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

Meeting Date: February 7, 2013
Prepared by: Kevin D. Coss, SVH Owner Representative on behalf of the CEO Construction Committee
Agenda Item Title: Recommendation to Approve Budget Increase for New Wing Project

Recommendation:
Increase the Hospital New Wing Project (Phase I) from the total approved August 2012 Budget of **$41,239,376** to **$42,609,376.**

Background:
This recommendation has been reviewed and discussed at a special meeting of the board October 9, 2012. After reviewing the detail of the Project Budget and Schedule, Administration recommended having a CEO Construction Committee made up of at least two Board members make a formal recommendation to increase the budget.

The Project duration has been extended eight months due to OSHPD approval delays and additional phasing for site and upgrades estimated cost $900,000, South Lot lease payment extension through November 2013 and city required design changes estimated cost $200,000 and Medical Gas System Upgrades oxygen and nitrous oxide supply system to meet NFPA and OSHPD codes $270,000 for a total request of $1,200,000. These costs could not have been avoided.

Consequences of Negative Action/Alternative Actions:
There is an alternative to reduce the project scope within construction of the Surgery department by just doing a Warm Shell and not purchasing the O.R. Equipment. The impact of this would be an estimated saving of $3,500,000 (High level estimate requires further study). However, donors have now pledged money to complete the Surgery department and, therefore, we have committed to completing this project by accepting their donation.

Financial Impact:
The CEO Construction Committee (October 30), analysis concludes that a buyback to complete the Surgery Infill in one year would cost $5,300,000 and inflation estimated at 3% per year after the first year**.** This Committee recommends we move forward with the full project as planned and has requested the Finance Committee to analyze the recommendation.

Selection Process and Contract History:
Work to continue to be performed by the Design-Build Team and the budget will be monitored by the Project Manager, Owners Representative, and CEO Construction Committee.

Meeting Date: February 7, 2013
Prepared by: Kevin D. Coss, SVH Owner Representative on behalf of the CEO Construction Committee
Agenda Item Title: Recommendation to Approve Scope Increase of New Wing Project to Include New Med/Surg Reconfiguration

Recommendation:
It is recommended that we increase the budget and scope of the New Wing (Phase 1) project (which includes a previous recommendation) by $1.2 million from **$42,609,376** to **$43,809,376**. The scope change includes 6 Projects on the 2nd Floor South to allow the Med-Surgical Unit to move from their current space to 2nd Floor South due to the New Wing connection with surgery on the 2nd floor and improves the patient rooms.

Budget:

Nurse Station/Med Room construction:	$212,180
Isolation Room/Clean Utility/ADA Shower/Nourishment construction:	$598,368
Surgery Waiting Room Wall – Patient Path of travel to Surgery	$ 40,000
10% Project Contingency:	$ 85,055
Permit Fees:	$ 40,000
FF&E:	$ 50,500
Total Projected Construction:	**$1,026,103** *
15 - Patient Room refurbishments	**$173,897**

Room refurbishments may include: flooring, laminate for vanity, closet and headwall, FF&E and will be done according to affordability.

Background:
The Med-Surg Unit occupies 2nd Floor North. The unit must move to 2nd Floor South due to the New Wing connection. Napa State would move from 2nd Floor Southwest to the Northeast and ICU. 2nd Floor South does not have the same configuration as the North side. To accommodate the differences and eliminate existing inefficiencies 6 projects were identified and designed. The purpose for each project is as follows:

Isolation Room: No isolation room within allowable proximity to South Nurse Station.

Clean Utility Room: Inadequate storage capacity and inconvenient layout on the South side. Create one-stop room for linen, supplies and equipment in current Solarium Conference Room.

ADA Shower: OSHPD requires a percentage of construction budget spent on ADA upgrades.

Nurse Station: Remove high traffic flow from center of Nurse Station by relocating hand wash sink. Create U-shape Nurse Station with a single corridor outside Nurse Station to access Med Room and wash facility.

Med Prep Room: Current nourishment function in med prep room requires a 2nd sink to be added thereby reducing usable space. Remove nourishment function from high traffic med room. Create work pods: Medication dispensing on East, Med prep for 2 nurses on West. Create ADA accessible entrance.

Nourishment Room: Create family-centered nourishment room with an area for family members to prepare nourishment for patient and provide hospitality. Separate area for Nurse to provide nourishment to patient.

Surgery Waiting Room Wall: Current DBT designed waiting room has low wall near west corridor. A full height wall will allow west corridor patient path of travel from Med Surg to Surgery to separate clinical and public functions.

Consequences of Negative Action/Alternative Actions:

Isolation Room: The hospital would have to staff North Nursing station to provide care for Isolation patients which will increase operating costs by 1 FTE or $150k per year.

Clean Utility Room: Inadequate storage for supplies, clean linen and equipment creates dysfunctional work flow issues. The Solarium Conference Room would become unusable/dead space within the Med Surg Unit. Nurses would have to add many steps which decrease their efficiency and satisfaction.

Med Prep/Nurse Station/Nourishment Room: The hospital has not changed the nurses' station since the West Wing was built. The current station does not accommodate the new processes or the Electronic Medical Record. This improvement not only increases efficiency of Nurse work flow, it improves patient/visitor satisfaction by providing family centered care and hospitality.

Surgery Waiting Room Wall: The new surgery waiting room will serve both surgery waiting and inpatient family members. It is important to reduce noise and increase privacy in the patient path of travel from Med- Surg to Surgery. Otherwise, we will have to increase the route and use the East corridor through the Napa State area.

Financial Impact:

If we do not make these recommended changes, Staffing the North Nurse Station could cost up to $400,000 annually based on a previous study of operating SNF in two locations during mold remediation.

Selection Process and Contract History:

Projects based on Otto Construction & Design Build Team development with Med Surg Unit. This project has been in design since 2010.

Note: *Costs based on non-OSHPD approved drawings. Drawings are being submitted to OSHPD. OSHPD comments and existing field conditions during construction could increase project budget requirements.

9.

FINANCIALS
DEC. 2012

Sonoma Valley Hospital
Sonoma Valley Health Care District
December 31, 2012 Financial Report

District Board

February 7, 2013

December’s Patient Volumes

	Actual	Budget	Variance	Prior Year
Acute Discharges	**117**	**135**	**-18**	**130**
Acute Patient Days	**456**	**476**	**-20**	**455**
SNF Patient Days	**671**	**781**	**-110**	**685**
Outpatient Gross Revenue (in thousands)	**$8,302**	**$8,032**	**$270**	**$7,838**
Surgical Cases	**126**	**132**	**-6**	**132**

Summary Statement of Revenues and Expenses Month of December 31, 2012

		Actual		Budget		Variance	Percentage		Prior Year
1 Total Operating Revenue	$	4,095,592	$	3,999,018	$	96,574	2%	$	4,260,885
2 Total Operating Expenses	$	4,481,870	$	4,414,413	$	(67,457)	-2%	$	4,583,683
3 Operating Margin	$	(386,278)	$	(415,395)	$	29,117	7%	$	(322,798)
4 NonOperating Rev/Exp	$	476,130	$	459,942	$	16,188	4%	$	310,279
5 Net Income before Restricted Cont.	$	89,852	$	44,547	$	45,305	102%	$	(12,519)
6 Restricted Contribution	$	43,788	$	47,500	$	(3,712)	-8%	$	-
7 Net Income with Restricted Contributions	$	133,640	$	92,047	$	41,593	45%	$	(12,519)
8 EBIDA before Restricted Contributions	$	328,466	$	299,911	$	28,555		$	195,612
9 EBIDA before Restricted Cont. %		8%		7%		1%			5%
10 Net Income without GO Bond Activity	$	10,084	$	(36,275)	$	46,359		$	(136,075)

Summary Statement of Revenues and Expenses Year to Date December 31, 2012

		Actual	Budget	Variance	Percentage	Prior Year
1	Total Operating Revenue	$ 23,306,653	$ 23,478,642	$ (171,989)	-1%	$ 23,436,363
2	Total Operating Expenses	$ 25,913,252	$ 26,205,245	$ 291,993	1%	$ 25,234,244
3	Operating Margin	$ (2,606,599)	$ (2,726,603)	$ 120,004	4%	$ (1,797,881)
4	NonOperating Rev/Exp	$ 2,776,580	$ 2,759,652	$ 16,928	1%	$ 1,906,007
5	Net Income before Restricted Cont.	$ 169,981	$ 33,049	$ 136,932	414%	$ 108,126
6	Restricted Contribution	$ 428,078	$ 285,000	$ 143,078	50%	$ -
7	Net Income with Restricted Contributions	$ 598,059	$ 318,049	$ 280,010	88%	$ 108,126
8	EBIDA before Restricted Contributions	$ 1,612,212	$ 1,565,233	$ 46,979		$ 1,384,866
9	EBIDA before Restricted Cont. %	7%	7%	0%		6%
10	Net Income without GO Bond Activity	$ (571,355)	$ (736,883)	$ 165,528		$ (633,210)

To: SVH Finance Committee
From: Rick Reid, CFO
Date: January 22, 2013
Subject: Financial Report for the Month Ending December 31, 2012

Overall Results for December 2012

Overall for December, SVH has net income of $133,641 on budgeted income of $92,047, for a favorable difference of $41,593. Total net patient service revenue was under budget by ($92,895). Risk contracts were over budget by $191,047, bringing the total operating revenue to $4,095,593 or $96,575 over budget. Expenses were $4,481,870 on a budget of $4,414,413 or ($67,457) over budget. The EBIDA prior to the restricted donations for the month was $328,475 or 8.0%.

Patient Volumes

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	117	135	-18	130
Acute Patient Days	456	476	-20	455
SNF Patient Days	671	781	-110	685
OP Gross Revenue	$8,302	$8,032	$270	$7,838
Surgical Cases	126	132	-6	132

Overall Payer Mix - December

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	51.7%	48.3%	3.4%	48.8%	47.4%	1.4%
Medi-Cal	10.9%	13.3%	-2.4%	14.1%	13.3%	0.8%
Commercial	35.2%	35.0%	0.2%	33.6%	35.9%	-2.3%
Self Pay	2.2%	3.4%	-1.2%	3.5%	3.4%	0.1%
Total	100%	100%		100%	100%	

Net Operating Revenues

Net operating revenues for December were $4.1 million on a budget of $4.0 million or $96,575 over budget.

Inpatient Net Revenue is under budget by ($128,128) or 8%, due to the following:

- Medicare discharges under budget by 4, the impact was ($47,405), offset by favorable rates of $85,656, net variance over budget $38,251
- Medi-Cal patient days under budget by 47, with an unfavorable rate variance for a total impact of ($166,785)

347 Andrieux Street, Sonoma, CA 95476-6811 ♦ 707.935-5000 ♦ Fax 707.935.5433

- Other patient days under budget by 10, with an unfavorable rate variance for a total impact of ($110,479)
- Commercial patient days over budget by 11, with a favorable rate variance for a total impact of $110,885

Skilled Nursing Home:

- Volume was under budget by 110 days and patient acuity was over budget, net impact ($56,087)

Outpatient:

- Volume was over budget by $34,412, due to higher volume and better commercial insurance utilization, offset by self pay discounts taken.

Home Care:

- Volume was over budget by 34 visits or $6,969 over budget

Contract Revenue:

- Napa State volume was over budget due to two large cases. Napa State revenue was over budget by $200,812, in addition fiscal year 2012 was adjusted to actual for an increase of $41,145

Expenses

December's expenses were $4.5 million on a budget of $4.4 million or over budget by ($67,457). The primary cause was the two large Napa State cases.

The following is a summary of the operating expense variances for the month of December:

- Total productivity FTE's were under budget at 284, on a budget of 288. Total salaries and Agency Fees were on budget by a total of $525.
- Professional Fees are over budget by $30,092 due to the adjustment of the Napa State revenue to actual for 7/1/11-6/30/12. The additional expense for prior year was $30,178, which is off set by the $41,145 of income in the contract revenue.
- Supplies are over budget by ($16,339) due to Special Procedures inventory count adjustment being over ($16,957) and the high dollar drugs ordered by the pharmacy being over ($23,508). Surgery supplies were on budget.
- Purchase services are over budget by ($82,717) due to a Napa State patient being transferred to Marin General being over ($59,885).
- Other expenses were under budget by $51,090 due to reduced spending in Administration.

Capital Campaign Summary:

For the month of December the Hospital received $43,788 in capital campaign donations. The total amount received from the Capital Campaign to date is $2,361,724, offset with spending of $648,056. The funds are included on line 16, Specific Funds on the Balance Sheet. Included on line 16 is also $21,764 for miscellaneous restricted funds and $114,334 received from the Foundation for the X-ray machine.

	Receipts	Spending	Balance
Emergency Dept.	$1,001,000	$0	$1,001,000
Operating Room	$0	$0	$0
General	$1,360,724	$648,056	$712,668
Total Capital Campaign	**$2,361,724**	**$648,056**	**$1,713,668**
X-Ray Machine	$114,334	$0	$114,334
Misc. Restricted Funds	$21,764	$0	$21,764
Total Specific Funds	**$2,497,822**	**$648,056**	**$1,849,766**

Other Outpatient Volume Comparison

These comparisons are for actual FY 2013 compared to actual FY 2012. These are not budget comparisons.

Outpatient & ER Visits

	OP Visits				ER – Inpatient				ER - Outpatient			
	CY	PY	Change	%	CY	PY	Change	%	CY	PY	Change	%
July	4,091	4,304	-213	-5.0%	109	114	-5	-4.4%	729	772	-43	-5.6%
Aug	4,392	4,692	-300	-6.4%	106	105	1	.9%	778	718	60	8.4%
Sept	3,888	4,757	-869	-18.3%	111	107	4	3.1%	677	693	-16	2.3%
Oct	4,456	4,640	-184	-4.0%	95	108	-13	-12%	706	679	27	4.0%
Nov	3,931	4,582	-651	-14.2%	101	107	-6	-5.6%	631	632	-1	-0.2%
Dec	3,583	4,212	-629	-14.9%	100	119	-19	-16%	693	622	71	11.4%
YTD	24,341	27,187	-2,247	-8.4%	622	660	-38	-2.9%	4,214	4,116	98	1.1%

Outpatient Procedures

	Dec 2012	Dec 2011	Change	CY YTD	PY YTD	Change
Labor & Delivery	1	1	0	4	1	3
ACU	1	5	-4	10	11	-1
Clinical Lab	1,145	1,370	-225	7,897	9,223	-1,326
ECHO	57	54	3	320	360	-41
EKG	142	152	-10	857	921	-64
Medical Imaging	491	614	-123	3,174	3,867	-693
Mammography	230	267	-37	1,495	1,592	-87
Nuclear Medicine	20	22	-2	133	147	-14
MRI	80	75	5	476	483	-7
Ultrasound	222	220	2	1,380	1,401	-21
CT Scanner	163	164	-1	1,015	1,047	-32
Wound Care	110	70	40	575	538	37
Offsite PT	581	827	-246	4,498	4,863	-365
Occ. Health	234	254	-20	1,746	2,034	-288
Speech Therapy	16	11	5	109	128	-19
Offsite Occ. Therapy	90	106	-16	652	570	82
Total	3,583	4,212	-629	24,341	27,187	-2,846

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended December 2012

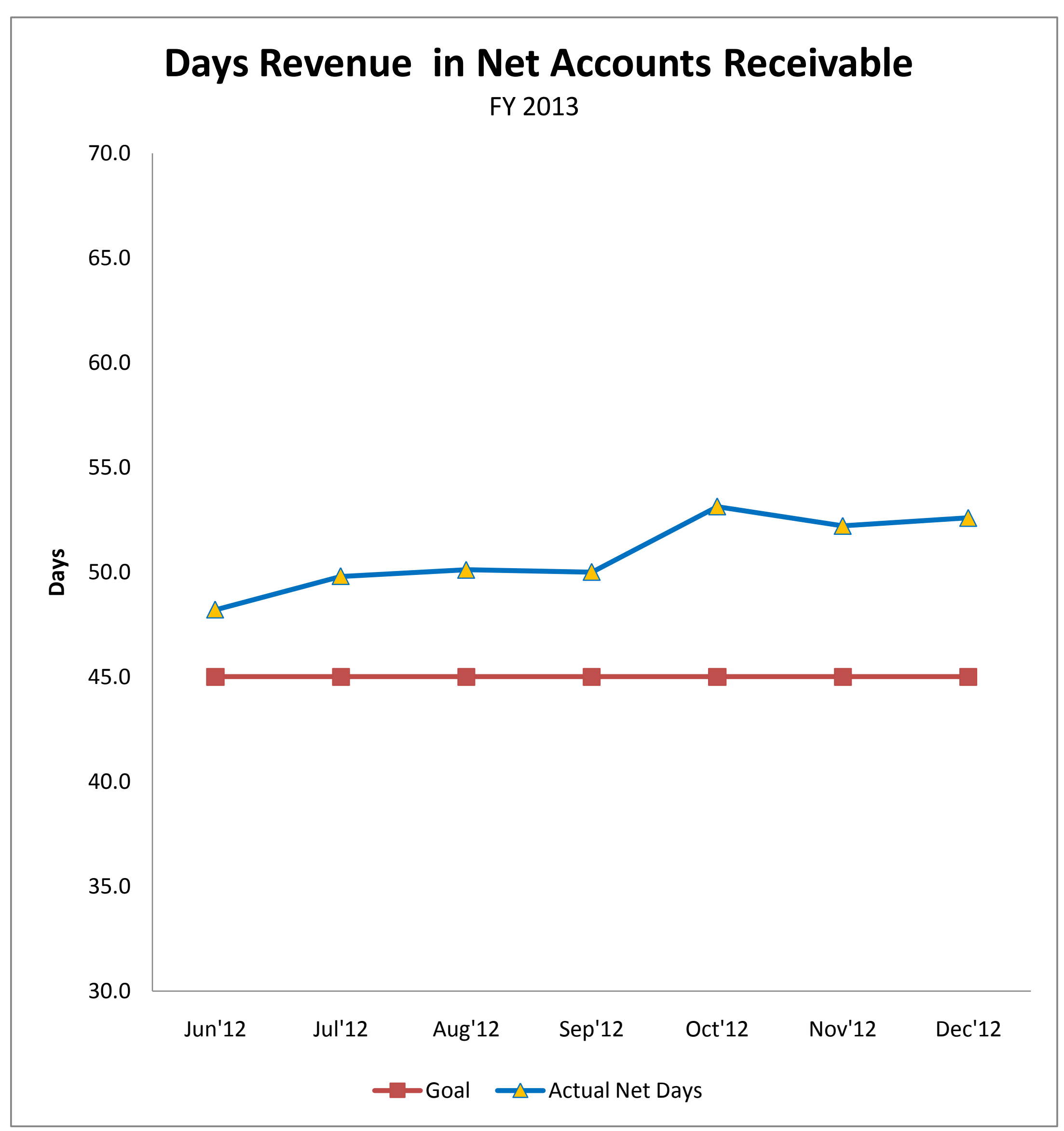
		Month				Year-To- Date				YTD
		This Year		Variance		This Year		Variance		
		Actual	Budget	$	%	Actual	Budget	$	%	Prior Year
	Volume Information									
1	Acute Discharges	117	135	(18)	-13%	683	760	(77)	-10%	776
2	SNF Days	671	781	(110)	-14%	3,817	4,141	(324)	-8%	3,554
3	Home Care Visits	940	906	34	4%	5,695	5,514	181	3%	5,645
4	Gross O/P Revenue (000's)	8,302	8,032	270	3%	$ 51,040	$ 49,705	1,334	3%	$ 45,840
	Financial Results									
	Gross Patient Revenue									
5	Inpatient	$ 5,347,313	$ 5,538,095	(190,782)	-3%	$ 30,327,356	$ 31,133,382	(806,026)	-3%	$ 29,622,520
6	Outpatient & Emergency	8,027,351	7,765,612	261,739	3%	49,359,779	48,083,933	1,275,846	3%	44,319,264
7	SNF	2,285,338	2,268,056	17,282	1%	12,472,738	12,153,136	319,602	3%	11,138,396
8	Home Care	275,001	266,137	8,864	3%	1,679,744	1,621,493	58,251	4%	1,521,058
9	Total Gross Patient Revenue	$ 15,935,003	$ 15,837,900	97,103	1%	$ 93,839,617	$ 92,991,944	847,673	1%	$ 86,601,238
	Deductions from Revenue									
10	Contractual Discounts	$ (11,844,585)	$ (11,631,521)	(213,064)	-2%	$ (69,916,834)	$ (68,335,457)	(1,581,377)	-2%	$ (62,219,729)
11	Bad Debt	(250,000)	(339,354)	89,354	26%	(1,600,000)	(1,992,512)	392,512	20%	(2,025,000)
12	Charity Care Provision	(242,990)	(176,703)	(66,287)	-38%	(1,195,532)	(1,037,509)	(158,023)	-15%	(835,643)
13	Prior Period Adjustments	-	-	-	0%	-	-	-	0%	-
14	Total Deductions from Revenue	$ (12,337,575)	$ (12,147,578)	(189,997)	*	$ (72,712,366)	$ (71,365,478)	(1,346,888)	*	$ (65,080,372)
15	Net Patient Service Revenue	$ 3,597,428	$ 3,690,322	(92,894)	-3%	$ 21,127,251	$ 21,626,466	(499,215)	-2%	$ 21,520,866
16	Risk contract revenue	$ 487,705	$ 296,658	191,047	64%	$ 2,055,531	$ 1,779,948	275,583	15%	$ 1,839,062
17	Net Hospital Revenue	$ 4,085,133	$ 3,986,980	98,153	2%	$ 23,182,782	$ 23,406,414	(223,632)	-1%	$ 23,359,928
18	Other Operating Revenue	$ 10,460	$ 12,038	(1,578)	-13%	$ 123,872	$ 72,228	51,644	72%	$ 76,437
19	Total Operating Revenue	$ 4,095,593	$ 3,999,018	96,575	2%	$ 23,306,654	$ 23,478,642	(171,988)	-1%	$ 23,436,365
	Operating Expenses									
20	Salary and Wages and Agency Fees	$ 1,994,500	$ 1,995,025	525	0%	$ 11,588,955	$ 11,769,312	180,357	2%	$ 11,125,470
21	Employee Benefits	715,160	$ 710,588	(4,572)	-1%	4,332,086	4,234,283	(97,803)	-2%	3,808,248
22	Total People Cost	$ 2,709,660	$ 2,705,613	(4,047)	0%	$ 15,921,041	$ 16,003,595	82,554	1%	$ 14,933,718
23	Med and Prof Fees (excld Agency)	$ 420,096	$ 390,004	(30,092)	-8%	$ 2,278,180	$ 2,353,144	74,964	3%	$ 2,761,724
24	Supplies	503,958	487,619	(16,339)	-3%	3,003,664	2,896,266	(107,398)	-4%	2,925,344
25	Purchased Services	470,671	387,954	(82,717)	-21%	2,353,109	2,293,620	(59,489)	-3%	1,962,644
26	Depreciation	180,238	199,672	19,434	10%	1,079,035	1,198,032	118,997	10%	934,500
27	Utilities	85,711	82,610	(3,101)	-4%	503,443	495,660	(7,783)	-2%	470,433
28	Insurance	19,375	20,374	999	5%	121,250	122,244	994	1%	121,461
29	Interest	28,365	25,681	(2,684)	-10%	183,130	154,086	(29,044)	-19%	162,176
30	Other	63,796	114,886	51,090	44%	470,400	688,598	218,198	32%	962,244
31	Operating expenses	$ 4,481,870	$ 4,414,413	(67,457)	-2%	$ 25,913,252	$ 26,205,245	291,993	1%	$ 25,234,244
32	Operating Margin	$ (386,277)	$ (415,395)	29,118	7%	$ (2,606,598)	$ (2,726,603)	120,005	4%	$ (1,797,879)
	Non Operating Rev and Expense									
33	Electronic Health Records & Misc. Rev.	$ 163,772	$ 147,250	16,522	11%	$ 949,502	$ 883,500	66,002	7%	$ 32,063
34	Donations	10,000	-	10,000	0%	10,000	-	10,000	0%	15,117
35	Professional Center/Phys Recruit	-	-	-	0%	-	-	-	0%	(1,566)
36	Physician Practice Support-Prima	(65,630)	(65,630)	-	0%	(393,780)	(393,780)	-	0%	(351,050)
37	Parcel Tax Assessment Rev	244,432	250,000	(5,568)	-2%	1,469,522	1,500,000	(30,478)	-2%	1,470,107
38	GO Bond Tax Assessment Rev	153,567	158,333	(4,766)	-3%	921,402	949,998	(28,596)	-3%	921,400
39	GO Bond Interest	(30,011)	(30,011)	-	0%	(180,066)	(180,066)	-	0%	(180,064)
40	Total Non-Operating Rev/Exp	$ 476,130	$ 459,942	16,188	4%	$ 2,776,580	$ 2,759,652	16,928	1%	$ 1,906,007
41	Net Income / (Loss) prior to Restricted Contributior	$ 89,853	$ 44,547	45,306	102%	$ 169,982	$ 33,049	136,933	*	$ 108,128
42	Capital Campaign Contribution	$ 43,788	$ 47,500	(3,712)	-8%	$ 313,744	$ 285,000	28,744	10%	$ -
43	Restricted Foundation Contributions	$ -	$ -	-	0%	$ 114,334	$ -	114,334	100%	$ -
44	Net Income / (Loss) w/ Restricted Contributions	$ 133,641	$ 92,047	41,594	45%	$ 598,060	$ 318,049	280,011	88%	$ 108,128
45	Net Income w/o GO Bond Activity	$ 10,085	$ (36,275)	46,360	128%	$ (571,354)	$ (736,883)	165,529	22%	$ (633,208)

Sonoma Valley Health Care District
Balance Sheet
For The Period Ended
As of December 31, 2012

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 2,006,788	$ 1,046,269	$ 2,093,462
2	Trustee Funds	339,459	339,459	143,815
3	Net Patient Receivables	8,172,226	8,080,021	7,590,193
4	Other Accts/Notes Rec	4,552,278	4,360,687	3,726,806
5	Allow Uncollect Accts	(1,629,821)	(1,675,948)	(1,930,774)
6	3rd Party Receivables	44,923	1,467,524	1,067,337
7	Due Frm Restrict Funds	-	-	-
8	Inventory	887,934	933,079	1,025,861
9	Prepaid Expenses	1,198,317	1,255,270	1,554,511
10	Total Current Assets	$ 15,572,104	$ 15,806,361	$ 15,271,211
11	Board Designated Assets	$ 186,193	$ 186,193	$ 253,467
12	Property,Plant & Equip, Net	10,669,234	10,701,170	9,810,607
13	Hospital Renewal Program	20,592,634	18,571,818	11,329,510
14	Unexpended Hospital Renewal Funds	14,541,543	14,008,248	20,791,945
15	Investments	-	-	36,984
16	Specific Funds	1,849,766	2,453,340	547,976
17	Other Assets	313,616	315,277	515,689
18	Total Assets	$ 63,725,090	$ 62,042,407	$ 58,557,389
	Liabilities & Fund Balances			
	Current Liabilities:			
19	Accounts Payable	$ 7,349,043	$ 5,590,883	$ 4,255,300
20	Accrued Compensation	3,038,895	2,831,352	2,912,420
21	Interest Payable	714,262	571,410	714,308
22	Accrued Expenses	255,629	228,312	241,014
23	Advances From 3rd Parties	1,305,849	1,349,994	613,602
24	Deferred Tax Revenue	2,377,805	2,776,389	2,391,503
25	Current Maturities-LTD	1,365,409	1,398,707	1,383,216
26	Other Liabilities	83,975	83,975	-
27	Total Current Liabilities	$ 16,490,867	$ 14,831,022	$ 12,511,363
28	Long Term Debt, net current portion	$ 37,738,378	$ 37,849,221	$ 38,412,770
29	Fund Balances:			
30	Unrestricted	$ 6,929,057	$ 6,849,164	$ 7,564,612
31	Restricted	2,566,788	2,513,000	68,644
32	Total Fund Balances	$ 9,495,845	$ 9,362,164	$ 7,633,256
33	Total Liabilities & Fund Balances	$ 63,725,090	$ 62,042,407	$ 58,557,389

Sonoma Valley Hospital
Statistical Analysis
FY 2013

	ACTUAL	BUDGET	ACTUAL												
	Dec-12	Dec-12	Nov-12	Oct-12	Sep-12	Aug-12	Jul-12	Jun-12	May-12	Apr-12	Mar-12	Feb-12	Jan-12	Dec-11	Nov-11
Statistics															
Acute															
Acute Patient Days	456	476	351	443	347	432	396	354	363	436	435	399	448	455	449
Acute Discharges	117	135	104	121	109	117	115	107	116	129	128	145	125	130	133
SNF Days	671	781	638	576	617	682	633	688	729	618	672	567	662	685	543
HHA Visits	940	906	921	1,043	802	1,052	937	941	989	997	1,023	950	967	913	911
Emergency Room Visits	793	768	732	801	788	884	838	810	863	717	783	692	791	741	739
Gross Outpatient Revenue (000's)	$8,302	$8,032	$8,485	$8,935	$8,151	$9,014	$8,153	$7,667	$8,120	$7,880	$8,707	$7,983	$8,640	$7,838	$7,863
Equivalent Patient Days	2,353	2,550	2,213	2,214	2,202	2,509	2,202	2,355	2,362	2,236	2,451	2,214	2,412	2,374	2,115
Births	13	17	14	9	11	16	9	15	6	23	11	10	9	17	19
Surgical Cases - Inpatient	32	38	35	37	37	40	41	28	37	38	37	31	33	43	43
Surgical Cases - Outpatient	94	94	95	91	97	98	82	92	99	99	117	84	99	89	101
Total Surgical Cases	126	132	130	128	134	138	123	120	136	137	154	115	132	132	144
Medicare Case Mix Index	1.51	1.40	1.47	1.29	1.49	1.40	1.61	1.50	1.64	1.36	1.29	1.40	1.32	1.47	1.39
Income Statement															
Net Revenue (000's)	4,085	3,987	3,679	3,963	3,707	3,926	3,822	4,832	3,741	3,739	3,925	3,867	3,924	4,247	3,668
Operating Expenses (000's)	4,482	4,414	4,235	4,407	4,221	4,312	4,257	5,278	4,686	4,413	4,372	4,160	4,230	4,584	3,973
Net Income (000's)	134	92	174	67	65	127	31	889	343	(14)	24	36	23	(13)	16
Productivity															
Total Operating Expense Per Equivalent Patient Day	$1,905	$1,731	$1,914	$1,990	$1,917	$1,719	$1,933	$2,241	$1,984	$1,974	$1,784	$1,879	$1,746	$1,931	$1,878
Productive FTEs	284	288	266	281	291	284	281	285	285	274	271	272	266	274	256
Non-Productive FTE's	33	30	47	36	39	37	41	34	28	28	28	26	35	27	39
Total FTEs	317	318	313	316	330	321	322	318	313	302	303	299	300	302	295
FTEs per Adjusted Occupied Bed	4.24		4.24	4.43	4.37	3.97	4.53	4.05	4.11	4.05	3.84	3.80	3.84	3.94	4.19
Balance Sheet															
Days of Expense In General Operating Cash	14		7	12	14	13	14	13	15	20	16	20	25	23	23
Net Days of Revenue in AR	53		52	53	50	50	50	48	47	46	45	44	45	45	43



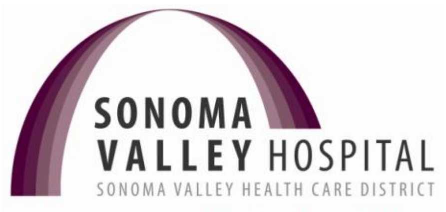
Days in A/R	Jun'12	Jul'12	Aug'12	Sep'12	Oct'12	Nov'12	Dec'12
Actual Net days	48.2	49.8	50.1	50.0	53.1	52.2	52.6
Goal	45.0	45.0	45.0	45.0	45.0	45.0	45.0

Sonoma Valley Hospital
Statement of Cash Flows
For the Period Ended

	Current Month	Year To Date
Operating Activities		
Net Income (Loss)	133,641	598,060
Adjustments to reconcile change in net assets to net cash provided by operating activities:		
Depreciation and amortization	180,238	1,079,035
Net changes in operating assets and liabilities:		
(Increase)/Decrease Patient accounts receivable - net	(138,332)	(610,819)
(Increase)/Decrease Other receivables and other assets	1,232,671	3,409,624
(Increase)/Decrease Prepaid expenses	56,953	(628,837)
(Increase)/Decrease in Inventories	45,145	(23,797)
(Decrease)/Increase in Deferred revenues	(442,729)	(2,035,907)
(Decrease)/Increase in Accounts payable, accrued expenses	2,135,912	1,905,840
Net Cash Provided/(Used) by operating activities	3,203,499	3,693,199
Investing Activities		
Net Purchases of property, plant and equipment - Other Fixed Assets	(146,840)	(472,820)
Net Purchases of property, plant and equipment - GO Bond Purchases	(2,020,816)	(6,650,317)
Net Proceeds and Distributions from investments	-	36,839
Net Book Value of Assets Disposed	(1,462)	(1,462)
Change in Restricted Funds	-	-
Change in Limited Use Cash	70,279	4,378,708
(Payment)/Refund of Deposits		
Net cash Provided/(Used) by investing activities	(2,098,839)	(2,709,052)
Financing Activities		
Proceeds (Repayments) from Borrowings - Banks & Carriers	(144,141)	(768,208)
Proceeds (Repayments) from Borrowings - Other		
Net Intercompany Borrowings/(Repayments)		
Change in Post Retirement Obligations & Other Net Assets	-	-
Net Equity Transfers to related entities (Cash and Non-Cash)		
Net cash Provided/(Used) by financing activities	(144,141)	(768,208)
Net increase/(Decrease) in cash and cash equivalents	960,519	215,939
Cash and Equivalents at beginning of period	1,046,269	1,790,849
Cash and Equivalents at December 31, 2012	2,006,788	2,006,788

10.

ADMINISTRATIVE REPORT



To: Sonoma Valley Health Care District Board of Directors
From: Kelly Mather
Date: 2/1/13
Subject: Administrative Report

Summary:

We have ended the first six months of the fiscal year ahead of budget. December volumes picked up and have continued through January.

Phase 1 Construction Project & Campus Expansion Plans
The Construction Committee and Finance Committee have reviewed the proposed budget and scope increases for the New Wing (Phase 1) project. Recommendations will be made to the Board on February 7th. We are still on track to open in fall 2013. We have discussed the Medical Office Building options with a few physicians. We are looking forward to their responses.

Strategic Planning & Marketing
The FY 2014 strategic plan is in process and expected to be presented at the March 7th board meeting. A meeting with the Board, physicians and administrative team was held on January 29th and it was very positive. Meritage IPA has an ACO (Accountable Care Organization) that was approved in January and there was a great deal of discussion about what our hospital should do locally and how to continue to reduce costs below Medicare reimbursement. The marketing and communications team had great success with the Joint Pain seminar attendance, and now we are focusing on Weight Loss Surgery. The Women's Health program will be launched with Dr. Bose with fundraisers for a patient navigator and sponsored mammograms in May. Western Health Advantage has approximately 750 lives in Sonoma County. They think we will see another increase this summer. The "Healing Here at Home" tag line will be a major feature with marketing geared to attract the attention of people leaving our community for care. Senior Wellness opened five days per week and we are already seeing new members.

Leadership and Organizational Results (Dashboard)
As you can see from the December dashboard, our results for patient satisfaction continue to be high for inpatient and emergency. Surgery took a big dip in December. The Value Based Purchasing clinical score is back at 100% now that the Electronic Health Record changes have been implemented. The staff satisfaction survey has over 75% participation, and we expect those results at the end of February. Inpatient volumes continue much lower than prior year, yet outpatient revenue continues to be high. Community benefit and outreach activities for January include school wellness classes, reading with kids at Sassarini, and senior project mentoring.

Philanthropy
The Hospital capital campaign now has pledges of $6.6 million (assuming we will meet the first $1 million of the matching grant), which means we are likely going to be at $9 million by August. We are growing our campaign cabinet with the addition of Geri and Bill Brinton. 100% of our leaders have also participated.

DECEMBER 2012 DASHBOARD

PERFORMANCE GOAL	OBJECTIVE	METRIC	ACTUAL RESULT	GOAL LEVEL
Service Excellence	High In-Patient Satisfaction	Press Ganey percentile ranking of current mean score	Inpatient 88.1 mean at 64th percentile	>70th = 5 (stretch) >60th = 4 >50th = 3 (Goal) >40th = 2 <40th=1
	High Out-Patient Satisfaction	Press Ganey monthly mean score	Outpatient 91.7% Surgery 87.5 % Emergency 90.1%	>93% = 5 (stretch) >92%=4 >91% =3 (Goal) >90%=2 <90%=1
Quality	Excellent Clinical Outcomes	Value Based Purchasing Clinical Score	100%	100% for 12 mos= 5 100% 6/12 mos=4 100% 3/12 mos =3 >90%=2 <80%=1
People	Highly Engaged and Satisfied Staff	Press Ganey percentile ranking of current mean score	2012 74.7% mean score at 58th percentile (survey due 2/2013)	>70th = 5 (stretch) >65th=4 >60th=3 (Goal) >55th=2 <55th =1
Finance	Financial Viability	YTD EBIDA	7% (before restricted contributions)	>10% (stretch) >9%=4 >8% (Goal) <7%=2 <6%=1
	Efficiency and Financial Management	FY 2013 Budgeted Expenses	$25,913,252 (actual) $26,205,245 (budget)	<2% =5 (stretch) <1% = 4 <Budget=3 (Goal) >1% =2 >2% = 1
Growth	Inpatient Volumes	1% increase (acute discharges over prior year)	683 YTD FY 2013 776 YTD FY 2012	>2% (stretch) (Outpt) >1%=4 >0% (Goal) <0%=2 (Inpt) <5%=1
	Outpatient Volumes	2% increase (gross outpatient revenue over prior year)	$51 million YTD $45.8 million in 2012	
Community	Community Benefit Hours	Hours of time spent on community benefit activities	708 hours in just 6 months	>1000 = 5 >800 = 4 >600 = 3 >400 = 2 >200 = 1

FY 2012 TRENDED RESULTS

MEASUREMENT	Goal	Jul 2012	Aug 2012	Sep 2012	Oct 2012	Nov 2012	Dec 2012	Jan 2012	Feb 2012	Mar 2012	Apr 2012	May 2012	Jun 2012
Inpatient Satisfaction	>86%	86.3	85.6	85.2	84.2	88.8	88.1	86.5	88.2	83.7	87.5	87.9	86.9
Outpatient Satisfaction	>92%	91.	94.2	94.4	92	93.7	91.7	90.5	90.5	91.6	91.7	91	90.9
Surgery Satisfaction	>92%	90.2	91.9	90.8	93.8	91.9	87.5	91.5	93.7	92.9	91.5	90.1	90.5
Emergency Satisfaction	>85%	87.3	88.2	82.5	84.5	87.2	90.1	81.9	85.6	87.8	88.9	88.7	88.2
Value Based Purchasing Clinical Score	>75	100	90	90	91	91	100	70	88.8	100	100	100	100
Staff Satisfaction	75%	75	75	75	75	75	75	72	75	75	75	75	75
Turnover	<12%	7.9	7.9	7.6	7.6	7.6	8.6	9.0	9.0	7.9	7.9	7.9	7.9
EBIDA	>8%	9	9	8	8	7	7	6	6	6	6	7	9
Net Revenues	>3.9m	3.83	3.98	3.7	3.96	3.7	4.09	3.9	3.9	3.9	3.76	3.76	4.85
Expense Management	<4.3m	4.2	4.3	4.2	4.4	4.4	4.5	4.2	4.1	4.3	4.4	4.7	5.2
Net Income	>50	29	125	65	55	174	90	23	35	25	-15	342	889
Days Cash on Hand	>35	16	13	14	12	7	14	25	20	16	18	15	13
A/R Days	<55	50	50	50	53	52	53	63	57	59	59	59	60
Total FTE's	<321	322	321	330	316	313	317	300	299	303	302	313	318
FTEs/AOB	<4.5	4.53	4.53	4.37	4.43	4.24	4.24	3.84	3.8	3.84	4.05	4.1	4.06
Inpatient Discharges	>148	115	117	109	121	104	117	125	145	152	129	116	107
Outpatient Revenue	$7.5m	8.1	9.0	8.1	8.9	8.5	8.3	8.6	8.0	8.7	7.8	8.1	7.7
Surgeries	>130	123	138	97	128	130	126	132	115	154	137	136	120
Home Health	>900	937	1052	802	1043	921	940	967	950	1023	997	989	941
Births	>15	9	16	11	9	14	13	9	10	11	23	6	15
SNF days	>630	633	682	617	576	638	671	662	567	672	618	729	688
MRI	>120	84	95	82	130	99	100	96	93	141	94	149	83
Cardiology (Echos)	>70	78	56	74	72	67	75	93	75	92	74	77	68
Laboratory	>12.5	12.6	12.9	11.7	13.7	12.2	11.9	13.4	12.8	14.0	14.5	12.5	12.6
Radiology	>850	892	876	811	931	819	811	1006	961	1011	1143	899	790
Rehab	>2587	2612	2798	2455	2471	2175	2051	2135	2526	2690	2674	2697	2520
CT	>356	304	326	281	327	295	279	323	336	278	293	419	301
ER	>775	838	823	788	801	732	741	791	804	783	717	863	810
Mammography	>475	404	487	472	629	556	475	440	519	493	458	539	481
Ultrasound	>300	312	352	275	336	287	290	319	336	319	336	314	321
Occupational Health	>550	585	538	465	521	451	405	526	574	521	462	615	567

11.C.

GOVERNANCE: MEDICARE FUNDING

Meeting Date: February 7, 2013

Prepared by: Kevin Carruth, Chair, Governance Committee

Agenda Item Title: Position on Medicare Funding

Recommendation:
The Governance Committee (GC) Chair recommends the Board approve the position on Medicare funding taken by the GC Chair as detailed in the attached letter prepared by the CEO.

Background:
On October 4, 2013, the Board amended the Governance Charter to have the GC take legislative positions on behalf of the District/Hospital when, because of the timing of hearings or for other similar reasons, there is not sufficient time to wait until the next Board meeting for Board action.

The CEO indicated that a letter was needed immediately and there was not time to wait, even for a quickly scheduled Brown Act noticed GC meeting in 72 hours. Upon obtaining the bill analysis, and the likely impact on the District/Hospital from the CEO, the GC Chair independently authorized the CEO to send the attached letter. The GC was unable to schedule a meeting after the letter was sent due to the CEO's concern over the time necessary to schedule and hold a GC meeting. Therefore, this matter was never formally acted upon by the GC and it is being brought to the Board directly for its action without a GC recommendation.

Consequences of Negative Action/Alternative Actions:
The position taken in the attached letter will be rescinded for lack of approval, and the District/Hospital will not be able to continue in its current position on this issue.

Financial Impact:
See attached letter.

Selection Process and Contract History:
Not applicable.

Board Committee:
The GC has not met and taken action on this issue.

Attachment:
January 18, 2013, Letter from Kelly Mather

January 18, 2013

Toby Douglas
Director, DHCS
Dept. of Health and Human Services
P.O. Box 997413, MS: 0000
Sacramento, CA 95889-7413
Toby.Douglas@dhcs.ca.gov

Re: Implementation of Rate Reductions for Distinct-Part Skilled Nursing Facilities

Dear Mr. Douglas:

Sonoma Valley Hospital is an 83 bed acute care facility with a 27 bed skilled nursing unit. We have been providing skilled nursing since 1978. Our skilled nursing facility has received a 5 star rating from Medicare, and this unit is a vital resource to our community.

We are writing today to urge the California Department of Health Care Services (DHCS) not to proceed with implementation of devastating cuts to reimbursement for Medi-Cal services provided by distinct-part skilled nursing facilities (DP/SNFs).

2011's AB 97 reduced Medi-Cal reimbursement rates for DP/SNF to rates that were applicable in the 2008-2009 rate year, less 10%, effective June 1, 2011, resulting in an effective rate decrease for most facilities of 25%. Cuts of this magnitude will have a devastating impact on the access of Medi-Cal beneficiaries to medically necessary skilled-nursing services.

These cuts will result in lack of access and a need for resident relocation in our area. We are very concerned about the lack of available services to our local community. Current reimbursements from Medi-Cal do not cover our expenses and further reductions will likely result in a reduction in services.

Thank you for your consideration.

Sincerely,

Kelly Mather
President and Chief Executive Officer

cc: Diana Dooley, Secretary, CA Health and Human Services Agency