

**Sutter Medical Center of Santa Rosa
Health Care Access Agreement
Background and Business Plan**

November 20, 2008

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SMCSR HCAA Background

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SMCSR HCAA Business Plan

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**Sutter Medical Center of Santa Rosa
Health Care Access Agreement
Background**

A. Summary

The landscape of health care in Sonoma County dramatically shifted in the last twelve years due to changes such as population trend dynamics, commercial insurance market conditions and utilization of and reimbursement for government funded programs. Today, hospitals in our community struggle to find creative solutions to deal with the financial challenges made more difficult by rising health care costs, low hospital admissions, rising construction costs and state earthquake safety mandates.

Hospital economics are complex. One of the most critical issues impacting a hospital's financial health is the cost associated with planning for expected hospital occupancy and bed demand in a community. To ensure adequate level and scope of services, hospitals plan for expected occupancy rates months and years in advance based on trends to ensure appropriate staffing levels, supplies and levels of care.

This advanced planning means that hospitals spend financial resources on staff and supplies (some of which are perishable) well in advance of patients occupying hospital beds. Hence, in addition to the fixed cost of the bed, a hospital also incurs variable costs even before the patient arrives. If beds go unoccupied, the cost of an empty bed is very high due to these fixed and variable cost components. When a hospital has a low and/or falling occupancy rate, as in the case with Sutter Medical Center of Santa Rosa ("SMCSR") and of most Sonoma County hospitals, financial resources are drained to cover for fixed and variable expenses of empty hospital beds.

In Sonoma County, the population is not large enough or growing at a rate large enough to support the number of inpatient hospital beds in the community. From 2000 to 2008, Sonoma County's average annual growth rate was 0.6% which is essentially a flat population growth. If that trend continues for another decade, the population growth will not occur fast enough to absorb the excess capacity in the marketplace. The excess capacity of hospital beds and low patient volumes are key factors causing a financial challenge for SMCSR and other community hospitals to deal with rising inpatient costs.

Another critical issue impacting the financial health of a hospital is the mix of patients it treats. Financially healthy hospitals have a high percentage of commercially insured patients. Commercially insured patients pay for the cost of the care provided and help shift surpluses to cover the financial losses incurred by providing care for the uninsured, indigent and under-funded government program patients who do not cover the cost of care.

The changes to the commercial insured population in Sonoma County since 2002 have greatly impacted the viability of hospitals in Sonoma County. In 2002, Kaiser had a 44% share of commercially insured patients. By 2007, Kaiser's service area share grew to 61%. The change is critical because this means the six non-Kaiser hospitals in Sonoma County now share the remaining 39% of the commercially insured population among them. All six community hospitals have vastly fewer commercial insurance patients now to offset the financial losses incurred treating the patients who do not cover the cost of care.

For SMCSR, this situation is more dramatic than at other hospitals because SMCSR treats a higher percentage of uninsured, indigent and Medi-Cal patients in Sonoma County. The Health Care Access Agreement ("HCAA") with the County of Sonoma ("County") does not reimburse or subsidize SMCSR for treatment of the uninsured, indigent or Medi-Cal patients. At SMCSR, only 25% of patients are commercially insured patients covering the cost of care while 75% of the patients at SMCSR do not cover the cost of care. This unbalanced patient mix has contributed to SMCSR losing over \$108 million dollars since 2001 and where today operating costs continue to increase while patient admissions and revenues steadily decrease.

The shifts in Sonoma County's health care community were escalating in 2003, but were not yet fully realized at the time SMCSR made its assumptions in drafting the 2004 Business Plan. The 2004 Business Plan anticipated building a larger hospital at the Wells Fargo Center for the Arts ("Wells Fargo"). In 2001, the occupancy rate at SMCSR was 66% which is close to the national average. In 2004, the occupancy rate had decreased by five percent to 61%. By the end of 2006, the occupancy rate had decreased 21% from 2001 levels to a dismal 45%. The decreased patient volume trend at SMCSR has continued. Patient volume during the first ten months of 2008 was 30% lower than during the same months in 2006.

By the end of 2006, it was clear the future model SMCSR had planned in the 2004 Business Plan was not financially viable. At that time, SMCSR entered into discussions with Santa Rosa Memorial Hospital ("Memorial") for Memorial's purchase of SMCSR inpatient services. After SMCSR and Memorial decided to end negotiations in early 2008, SMCSR began investigating options such as retrofitting the Chanate Campus or resizing the planned new hospital for the Wells Fargo site to a smaller hospital that matches the significantly lower patient demand.

After evaluating numerous options to meet the HCAA and state earthquake requirements, SMCSR determined building a right-sized hospital on the Wells Fargo site was the preferred option. This new Business Plan is proposed to replace the outdated and financially infeasible 2004 Business Plan ("2004 Business Plan"). This new Business Plan provides a plan for a 70-bed acute care hospital that will meet the requirements of the HCAA and state earthquake requirements. At the new SMCSR hospital, SMCSR will provide the inpatient acute care services currently provided under the HCAA at the Chanate campus, including obstetrics, nursery care including a level III neonatal intensive care, , intensive care, emergency services, supporting ancillary services and a full range of women's reproductive health services.

The new 70-bed acute care hospital is the appropriate size for SMCSR matched to the lower patient occupancy and continued decreased patient demand. The national trend is for lower inpatient needs in the future with technological advances decreasing hospital length of stay as well as utilization. The new hospital will also provide efficiencies which will enable lower inpatient trends.

The smaller hospital also helps mitigate the impacts of the bed expansions at Kaiser and Memorial which will add approximately 120 additional beds¹ into the community further exacerbating the excess bed capacity problem for the District Hospitals. SMCSR, Memorial and the District Hospitals face the reality of continued decreased service areas with the growth of Kaiser. Unless Sonoma County's employers begin supporting non-Kaiser health plans to change the patient mix at non-Kaiser hospitals, the future is uncertain for the financially challenged community hospitals.

The new 70 bed hospital will meet the requirements of the HCAA and enable SMCSR to continue delivering high quality health care in Sonoma County.

B. Background

In 1996, SMCSR, an affiliate of Sutter Health, entered into a HCAA with the County to provide access to health care services to the residents of Sonoma County through 2016. The HCAA also required SMCSR to submit a business plan to address compliance with new state seismic safety standards enacted in 1995.

In September 2004, pursuant to a provision of the HCAA, SMCSR developed the 2004 Business Plan for a larger replacement hospital at the Wells Fargo site. In the view of SMCSR the 2004 Business Plan was founded upon the stated requirements that the proposed new hospital would:

¹ Kaiser will also double its Emergency Department by adding 17 additional treatment rooms.

1. Reduce the overall costs of health care in Sonoma County.
2. Achieve operating income targets within two years after the opening of the hospital.
3. Achieve nominal earnings targets within two years after the opening of the hospital.
4. Cost \$203 million to build.

In the view of SMCSR, a key provision also included in the 2004 Business Plan was that if viable financial performance could not be achieved by SMCSR before construction, SMCSR would not move forward with the construction of a replacement hospital and would begin examining alternatives that would also satisfy the terms of the HCAA.

This business plan was submitted to and approved by Sutter Health. In November 2004, the County's Board of Supervisors also approved this plan.

Since 2004, providing health care in Sonoma County has grown increasingly complex and financially challenging. SMCSR experienced significant financial losses, reduced patient census, and faced escalating construction costs on the approved replacement hospital. SMCSR is not alone. Financial challenges are causing most Sonoma County health care providers to reevaluate the care they provide and pursue changes in order to sustain quality, affordable care in this community well into the future.

In 2006, SMCSR realized the future indicated unsustainable hospital losses due to patient payer mix, population trends, staffing shortages, duplication of services and excess bed capacity at Sonoma County hospitals. SMCSR entered into discussions with Memorial for Memorial's purchase of SMCSR inpatient services. In March 2008, after more than a year of negotiations, SMCSR and Memorial agreed to end negotiations. Since this time, SMCSR has been evaluating options while continuing to maintain its obligations under the HCAA with the County. These options include, but are not limited to, retrofitting the Chanate campus or building a new facility.

C. Shifts in Sonoma County's Health Care Delivery System

In 1996, the health care system in Sonoma County was positioned to accommodate the growth trend seen in the previous decade. Since 1996, the landscape of Sonoma County's health care delivery system changed significantly and most dramatically in the last five years. These changes have contributed to a vastly different health care delivery system than the one anticipated when Sutter Health and the County negotiated the 1996 agreement.

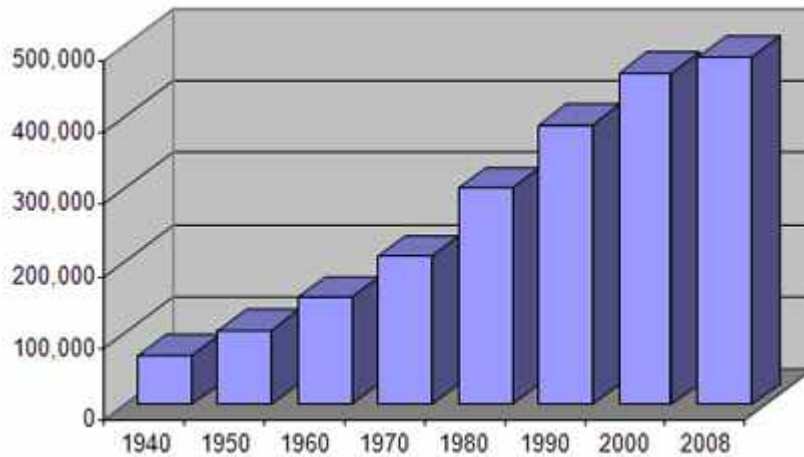
The health care system in Sonoma County today faces difficult challenges to provide access to health care to all segments of the community. Most of the challenges facing health care providers today in Sonoma County can be traced back to the shifts in the health care landscape over the last 12 years.

1. Population Growth Shift

SMCSR analyzed several factors projecting future demand for service in Sonoma County prior to entering into the HCAA with the County. One of the biggest factors for projecting demand is population growth projections which in 1996 anticipated a continued growth rate in Sonoma County similar to the previous 10 years. The significant growth seen between the 1980s and early 1990s predicted a marketplace with ample growth potential. However, beginning in the late 1990's and continuing to impact growth rates today, voter approved Urban Growth Boundaries dramatically changed the booming trends of the 1980's and early 1990's in Sonoma County. Additionally, the listing of the Sonoma County Tiger Salamander on the endangered species list by the US Fish & Wildlife service in 2003 brought current and future

planned development in most of Sonoma County to a slow crawl. Consequently, the average annual growth rate in Sonoma County has fallen to 0.6% per year from 2000 through 2008.

Figure 1: 1940-2008 Sonoma County Population Growth



Source: County of Sonoma website

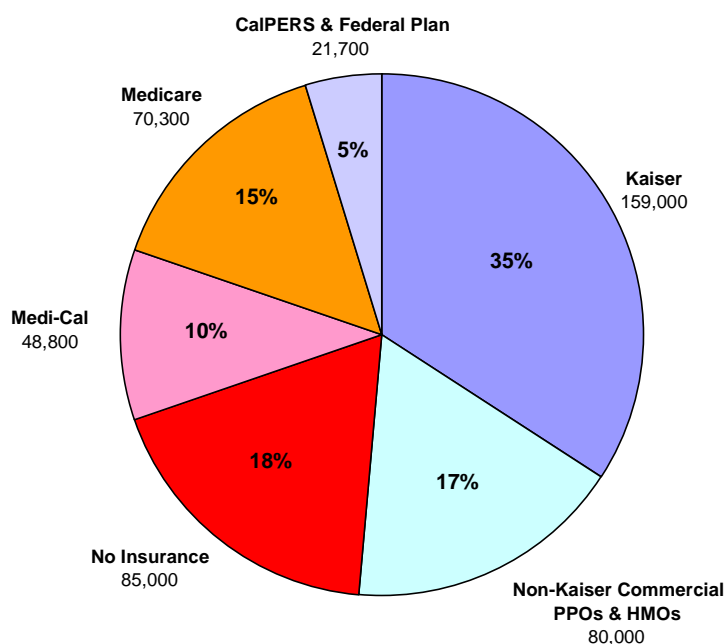
http://www.sonoma-county.org/cao/citizens_guide/sonoma_county_population.htm

2. Population Shift to Increased Uninsured and Indigent Population

Since 2000, Sonoma County has seen a dramatic decrease in the number of commercially insured patients. This is significant because hospitals are required by law to treat the indigent and uninsured, which account for 18% of the population. The commercially insured patients and plans allow hospitals to absorb the financial losses associated with the low reimbursement rates for Medi-Cal, Medi-Care and the uninsured.

A major impact in Sonoma County was the closure of Health Plan of the Redwoods in 2002. This closure changed the balance of insured patients. Many shifted to other plans, but many simply became additional uninsured patients. As Figure 2 illustrates, 43% of Sonoma County residents are either uninsured or on a government subsidized program which does not cover the full cost of care.

**Figure 2: Sonoma County Total Population
2007 Healthcare Coverage**



Source: Rose, Bleys. "Kaiser Role in Serving Uninsured to Expand." *The Press Democrat* [Santa Rosa] 27 Jan 2007.

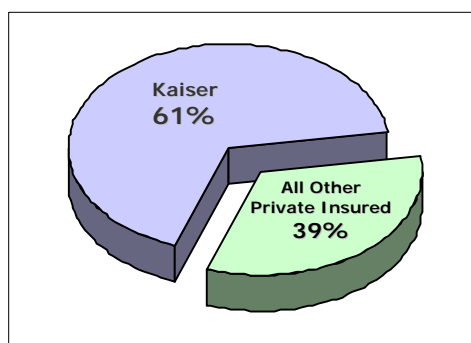
3. Commercial Insurance Market Shift to Kaiser

Also since 2000, Kaiser Permanente increased its commercial market share from a 44% market share in 2000 to 61% market share in 2007. Figure 3 demonstrates that today the six non-Kaiser hospitals share up 39% of the commercially insured patients while still treating the now significantly growing uninsured and indigent population.

Hospitals that serve a disproportionately high Medi-Cal/uninsured patient population and receive reimbursement that is well below cost must make up for the gap by shifting unpaid costs to commercial health plans. Sonoma County simply does not have the number of non-Kaiser commercial patients that allow hospitals long term to absorb this loss on services provided to beneficiaries of government programs and the uninsured.

Commercial insurance has significantly increased in recent years to keep up with its share of cost coverage by paying above cost of care. This cost-shifting drives up health care costs for employers and consumers and places the six Sonoma County community hospitals at a competitive disadvantage to Kaiser. Kaiser does not face this same cost-shifting dynamic because Kaiser is a member-based HMO serving its own commercially paid for patients. Consequently, Kaiser

Figure 3: Sonoma County Commercial Patients



Source: Rose, Bleys. "Kaiser Role in Serving Uninsured to Expand." *The Press Democrat* [Santa Rosa] 27 Jan 2007.

does not share the same financial burden of caring for the indigent that SMCSR and other community hospitals carry.

While caring for the poor is an obligation central to the mission of not-for-profit and district hospitals, the lack of support from area employers creates significant financial pressure that challenges the viability of SMCSR and other hospitals in the area and makes it increasingly difficult to continue to care for the low-income and uninsured Sonoma County residents. Many of the County’s largest employers insure a significant portion of their employees through Kaiser.

4. Bed Capacity Shift to Decreased Occupancy Rates

Higher hospital occupancy rates spread hospital fixed costs over a larger number of patients, and therefore result in lower overall inpatient costs – to patients, employers and the community at-large. An analysis of occupancy rates in Sonoma County indicates excess bed capacity and, thus, growing inpatient costs.

To provide healthcare services to future incoming patients, hospitals plan for expected occupancy rates. Hospitals spend financial resources to ensure that staff and supplies (some of which are perishable) are available to care for the patient, should a bed become occupied. Hence, in addition to the fixed cost of the bed, a hospital also incurs variable costs even before the patient arrives. If beds go unoccupied, the cost of such an empty bed is very high due to these fixed and variable cost components.

According to a report² by *The American Journal of Managed Care* (AJMC), hospital underutilization was one of the top five factors that contribute to inpatient expenditure growth. Since 2001, the occupancy rates for five of the eight Sonoma County hospitals were below national, state, and county averages.

Figure 4: Licensed Bed Occupancy Rates for Sonoma County Hospitals

Occupancy rates in **red bold** indicate occupancy below national, state and Sonoma County averages.

| Occupancy Rates for Licensed Beds | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|------------|------------|------------|------------|------------|------------|
| Healdsburg District Hospital | 19% | 19% | 22% | 38% | 39% | 51% |
| Kaiser Foundation Hospital - Santa Rosa | 66% | 73% | 77% | 72% | 61% | 76% |
| Palm Drive Hospital | 29% | 40% | 36% | 32% | 34% | 31% |
| Petaluma Valley Hospital | 52% | 52% | 48% | 51% | 51% | 56% |
| Santa Rosa Memorial Hospital | 59% | 62% | 59% | 62% | 60% | 62% |
| Sonoma Valley Hospital | 41% | 37% | 38% | 39% | 41% | 42% |
| Sutter Medical Center of Santa Rosa | 66% | 64% | 64% | 61% | 51% | 45% |
| Sutter Warrack Hospital | 31% | 34% | 24% | 18% | ** | ** |
| Sonoma County | 54% | 57% | 54% | 55% | 53% | 56% |
| Statewide Benchmark | 58% | 59% | 61% | 60% | 60% | 61% |
| Nationwide³ | 67% | 68% | 68% | * | 69% | * |

Source: California Healthcare Foundation (CHCF) dashboard, *Financial Health of California Hospitals* <http://www.calhospitalfinance.net/>.

* Data not available

** Included in SMCSR

² Joel W. Hay, PhD, Department of Pharmaceutical Economics & Policy, University of Southern California; Hospital Cost Drivers: An Evaluation of 1998–2001 State-Level Data.

³ Source: <http://www.cdc.gov/nchs/hus.htm>.

When a hospital has low and falling occupancy rates, as in the case of most Sonoma County hospitals, financial resources are drained to cover for fixed and variable expenses of empty hospital beds. This leakage of a hospital's finances reduces funds otherwise available for investments in new technology, new and enhanced services and other improvements. Moreover, for a hospital like SMCSR, where a large percent of the reimbursement for the occupied beds does not adequately reimburse servicing the bed, as in the case of government-based reimbursements, it not only adds to the financial distress of the hospital but also impedes improvements.

As noted in Figure 4, all hospitals in Sonoma County are below the state average except Kaiser and Memorial. However, with Memorial's completed expansion and Kaiser's expansions in 2010/2011, Sonoma County's excess bed capacity problem is expected to worsen for SMCSR and the District Hospitals. This is neither a positive scenario for the stability and financial sustainability of the healthcare delivery network in Sonoma County nor for the quality care that residents of the County deserve.

5. Technology Shifts Further Reducing Bed Demand

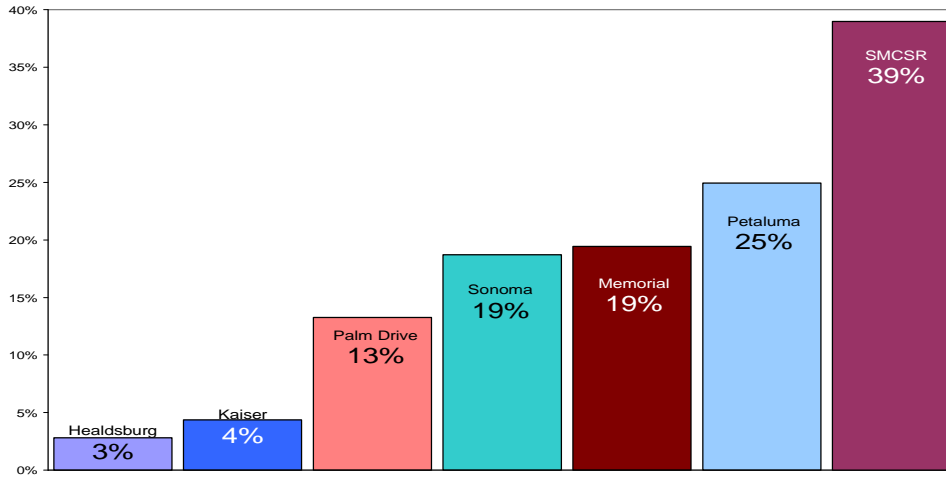
In addition to the planned bed capacity growth, the dynamic nature of the healthcare industry brings in changes everyday that impact the number of beds required. Advances in technology are reducing the need for inpatient hospitalization. Less invasive approaches to diagnosis, treatment and surgical procedures as well as replacement of surgery with medical and pharmaceutical intervention results in not only shorter and fewer intensive-care stays, but also supports the shift of care from inpatient to less-expensive outpatient settings, thereby reducing the need for inpatient capacity. These changes will further exacerbate the excess bed problem in Sonoma County in the future by further decreasing bed demand.

6. SMCSR Patient Mix Shift - Unsustainable Hospital Economics

As discussed, hospital economics work when the hospital is sized correctly for the population it serves and also has a large enough number of commercially insured patients to balance the financial losses incurred by treating uninsured, indigent and Medi-Cal patients. Hospitals sustain financial losses with uninsured and indigent patients because they either do not pay for the care or the government programs paying for their care cover only part of the actual cost of care.

Figure 5 demonstrates why SMCSR was impacted more than other Sonoma County hospitals in the last 12 years by the shifts in population and insurance coverage due to its significantly higher percentage of uninsured, Medi-Cal and County Medical Service Program (CMSP) patients. Low reimbursement rates for these patients create operating losses on a daily basis and have exacerbated the financial shortfalls at SMCSR. The County or HCAA does not reimburse or subsidize SMCSR for treatment of the uninsured, indigent or Medi-Cal patients.

Figure 5: Percent of Hospital's Cases that are Medi-Cal, County Indigent (CMSP) and Other Indigent



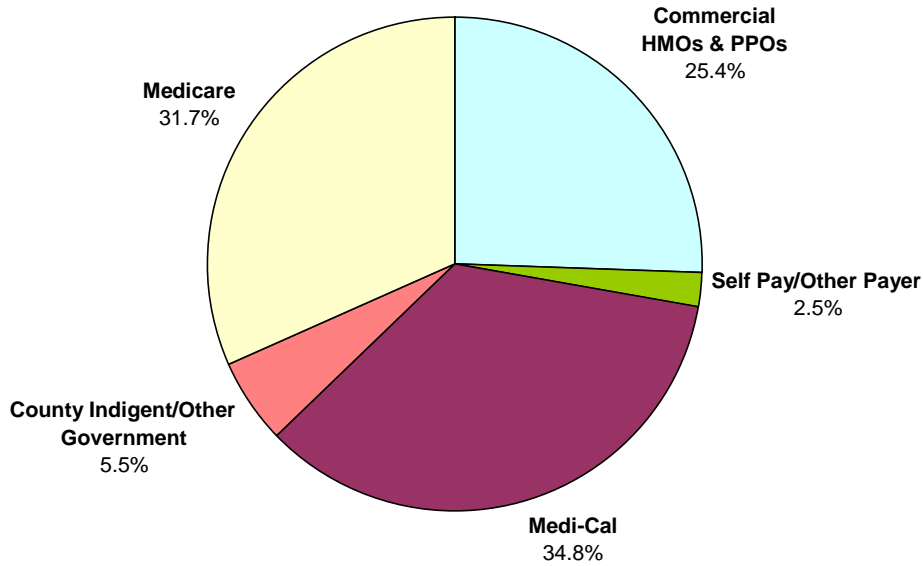
Source: 2007 OSHPD Inpatient data.

SMCSR serves a significant percentage of the uninsured, Medi-Cal, CMSP and indigent population. The percentage of inpatients at SMCSR that are covered by Medi-Cal is the highest of any hospital in Sonoma County. In 2007, SMCSR's costs for serving Medi-Cal patients exceeded reimbursements by over \$3 million.

Sutter Health has contributed over \$245 million dollars to SMCSR since the HCAA began in 1996 through 2008 to cover operating losses and capital expenditures as a result of its community service and obligations under the HCAA. Through this analysis, details of which are described in this section, SMCSR determined that these factors and the likely ongoing substantial financial losses have led to an unstable and unsustainable health care delivery system within the County.

Although Medicare reimbursement rates are higher than Medi-Cal, Medicare also pays below cost. Therefore, in order for hospitals to offset the losses sustained by providing services to beneficiaries of government programs, they need to have a large number of commercial patients. As illustrated in Figure 6, SMCSR's payer mix is 72.5% government program patients (Medicare, Medi-Cal and CMSP) and only 25% Commercial Insurance patients. By these numbers, approximately 3 of every 4 patients are government payers which pay below cost and only 1 out of every 4 patients is a commercial patient or pays the full cost of care.

Figure 6: 2007 SMCSR Patient Payer Mix



Source: 2007 OSHPD Inpatient data. Payer mix calculated by patient discharges.

In July 2008, Medi-Cal implemented a 10% cut in reimbursement rates to hospitals. These Medi-Cal cuts will further erode an already under-funded Medi-Cal program. The 10% cut will also exacerbate the decline in providers willing to serve this most vulnerable population, making it harder and more expensive for all Californians to meet their health care needs. The Medi-Cal cuts implemented in July and October are expected to result in a \$10 million annual reduction to SMCSR’s Medi-Cal revenue.

This means the problem for SMCSR (and other Sonoma County hospitals) is they have virtually no opportunity to offset losses in the future because Kaiser’s dominance prevents SMCSR from increasing the number of insured patients. Sonoma County’s larger employers would need to shift their health care contracts to non-Kaiser health plans in order to provide SMCSR, Memorial and the District Hospitals a way to become more financially sustainable. Until the dynamic of hospital economics changes, the current system is built on the backs of a shrinking pool of non-Kaiser commercially insured patients.

Sonoma County is growing at a rate of 0.6% per year. This flat population growth combined with the uninsured population, excess bed capacity, Kaiser dominance and lower government reimbursement rates create an environment of unsustainable hospital economics.

7. SMCSR Decreased Patient Census Shift

SMCSR is treating a significantly lower population base than ever anticipated in 1996 at the start of the HCAA or in 2004 when considering plans for a new hospital. Between 2002 and 2006, SMCSR’s (Chanate and Warrack campuses) Average Daily Census (“ADC”) decreased by 22%. Due to the declining inpatient volume, SMCSR’s Warrack campus closed its acute care service in June 2006. Furthermore, in 2007 and through October 2008, SMCSR experienced a further 33% decline in ADC from 2006 volumes. SMCSR experienced a 48% overall decrease in ADC between 2002 and 2008 (through October 31, 2008).

The reason for the downward shift in patient volume are numerous including the market shift to Kaiser, use of technology in treatment, increase of outpatient care options, closure of the psychiatric facility by the County, impact of discussions to transfer services to Memorial, as well as excess bed capacity and duplication of services at other facilities in the County.

D. HCAA Requirements

The County and SMCSR entered into a HCAA in 1996, to provide County residents access to the inpatient hospital services of the Chanate facility and to maintain the operation of the Family Practice Residency Program. As a key tenet of the HCAA, SMCSR took over operation of the former Sonoma County Community Hospital under a lease agreement that extends for a term through March 26, 2016 (with renewal options beyond 2016)⁴. According to the HCAA, the scope of services that SMCSR is required to provide encompasses those health care services which SMCSR was licensed to provide and which have been customarily provided by Community Hospital to Sonoma County residents in 1996.

1. Hospital Licensed Services

Health care services listed on SMCSR's license (then Community Hospital) and offered at the time the HCAA was signed included the following⁵:

- a. General acute care
- b. Perinatal
- c. Intensive care
- d. Intensive care newborn nursery (NICU)
- e. Pediatric
- f. Coronary care
- g. Acute psychiatric⁶
- h. Skilled nursing
- i. Basic emergency
- j. Podiatric services
- k. Cardiac cath lab
- l. Respiratory care
- m. Physical therapy
- n. Outpatient services
- o. Occupational therapy
- p. Nuclear medicine services

⁴ The HCAA specifies that if "more than fifty percent (50%) of the Services (determined on the basis of net revenues) in facilities located on non-County owned property, County shall have the option of extending the Term of this Agreement for additional five (5) years."

⁵ Source: HCAA – Sutter Sonoma Medical Center and County of Sonoma, March 25, 1996, Section 10.11.4.

⁶ Historically, SMCSR had a contract with the County to manage and provide acute psychiatric services (formerly Oakcrest Inpatient Psychiatric Services Facility) and was licensed for 30 beds. In 2006, Sonoma County reduced the number of psychiatric beds from 30 to 18. In June 2007, the acute psychiatric program at SMCSR was terminated by the County and these beds were removed from SMCSR's license.

2. Additional Health Care Services

The following services are also specified:

- a. A full range of women's health services (e.g., preventive care, labor and delivery, birth control, sterilization and pregnancy termination procedures)
- b. Inpatient care for jail inmates in the custody of the Sonoma County Sheriff's Department
- c. Sexual assault services supervised by the Sonoma County Courts
- d. Treatment and/or quarantine services
- e. Inpatient and emergency services for HIV/AIDS or other communicable disease patients
- f. Inpatient services for persons in County's residential alcohol service program

E. Additional Health Services at Wells Fargo Campus

What follows in the next section is a Health Care Access Agreement Business Plan ("HCAA Plan") proposing the construction of a new 70-bed hospital to be owned and operated by SMCSR at the Wells Fargo campus.

The Wells Fargo campus is anticipated to include health care providers in addition to SMCSR's new hospital. The information below is provided to present a complete picture of what SMCSR contemplates for the Wells Fargo campus. Although not part of the HCAA Plan, Wells Fargo campus is planned to include a privately financed and owned medical office building ("MOB") and a second general acute care hospital ("Physicians Medical Center") to be owned and operated by a partnership comprised of Sutter Health entities and qualified physician investors. The MOB and the Physicians Medical Center are in the planning stage. Syndication of the partnership is expected to occur during the first half of 2009.

The MOB will be designed to enhance the efficiency at the Wells Fargo campus. The MOB is planned to be a 60,000 to 80,000 square foot structure that may house physicians affiliated with Sutter Medical Foundation North Bay ("SMFNB"), physicians independent of SMFNB, and supplemental hospital services. SMFNB is an affiliate of Sutter Health and a multi-specialty group currently offering the services of approximately 60 physicians. SMFNB is an Internal Revenue Code 501(c)(3) charity subject to the Sutter Health and Affiliates Medical Foundation Charity Care and Low Income Uninsured Policy. The MOB will be privately financed and owned.

The Physicians Medical Center is planned to be about 100,000 square feet with a heli-stop. It is planned to be licensed as a general acute care hospital and will have the core services required to be a general acute care hospital with 24 hour inpatient care including medical, nursing, surgical, anesthesia, laboratory, radiology and pharmacy. The Physicians Medical Center will focus on surgical inpatient and outpatient services including invasive cardiac care services. The Physicians Medical Center is planned to include 24 beds, 4 intensive care beds, 30 universal care stations, 8 operating rooms, 2 procedure rooms, 2 endovascular rooms, imaging services including CT, MRI and basic imaging capabilities and supporting ancillary services. The Physicians Medical Center will be privately financed and owned. It is envisioned that the land and building will be leased by their owner to the Physicians Medical Center partnership, which will operate the Physicians Medical Center. Final details will not be known until syndication is completed.

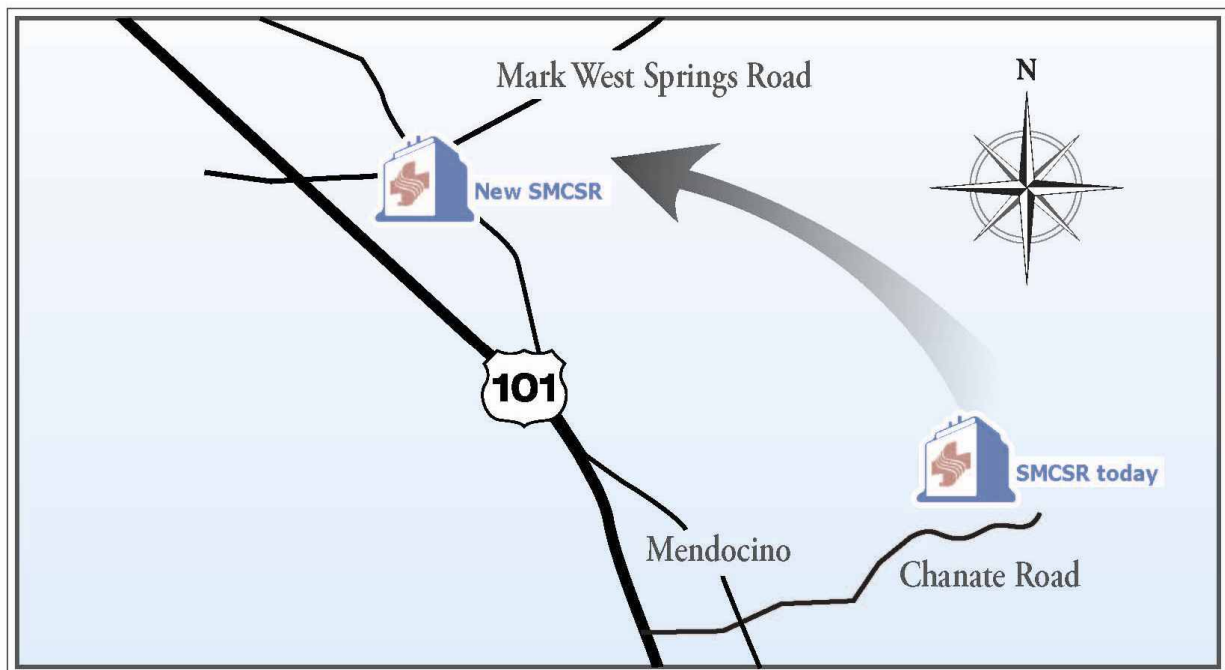
Because Sutter Health is an Internal Revenue Code section 501(c)(3) charity, the Physicians Medical Center partnership organizational documents will ensure that the partnership is operated and managed in a manner that furthers the charitable purposes of Sutter Health by promoting health for a broad cross-section of the community. Specifically, the partnership and the Physicians Medical Center will be

operated and managed in a manner that provides access to patient care services based upon medical necessity, without regard to the patient's ability to pay, including patients covered by Medi-Cal, Medicare and CMSP. The Physicians Medical Center will be subject to the Sutter Health and Affiliates Policy on Financial Assistance for Uninsured Patients, Including Charity Care.

Although the Physicians Medical Center, the MOB or SMFNB will not be part of the HCAA or the HCAA Business Plan, the above information is provided to provide a complete picture of what SMCSR contemplates for the Wells Fargo campus. The above information is based on anticipated plans which may be subject to change.

Sutter Medical Center of Santa Rosa Health Care Access Agreement Business Plan

November 20, 2008



A. Plan to Continue to Meet HCAA

SMCSR will continue to meet and comply with the terms of the HCAA by providing health care services in a new hospital at the Wells Fargo campus. SMCSR plans to build a new 70-bed acute care SMCSR hospital (“New SMCSR”) at the Wells Fargo campus that will be owned and operated by SMCSR. The New SMCSR will be a two-story, approximately 125,000 square foot facility and will be licensed as a general acute care hospital. SMCSR will focus on the following inpatient acute care services including obstetrics, nursery care including a level III neonatal intensive care, medical and surgical care, intensive care, emergency services, supporting ancillary services and a full range of women’s reproductive health services. A more detailed description of the New SMCSR is provided in section B.

1. Hospital Licensed Services

The SMCSR will provide access to all of the HCAA services. The following table summarizes the HCAA licensed hospital services:

Figure 7: HCAA SMCSR Licensed Services

| HCAA Service | Currently at SMCSR | New SMCSR |
|---|--------------------|-----------|
| General acute care | Yes | Yes |
| Perinatal | Yes | Yes |
| Intensive Care | Yes | Yes |
| Intensive Care Newborn Nursery | Yes | Yes |
| Pediatric | Yes | Yes |
| Coronary Care | Yes | Yes |
| Skilled Nursing* | Yes | Yes |
| Basic Emergency | Yes | Yes |
| Podiatric Services | Yes | Yes |
| Cardiac Cath Lab | Yes | Yes |
| Respiratory Care | Yes | Yes |
| Physical Therapy | Yes | Yes |
| Outpatient Services | Yes | Yes |
| Occupational Therapy | Yes | Yes |
| Nuclear Medicine | Yes | Yes |
| * SMCSR will hold any patient requiring a skilled nursing bed that is not available in the community until such time that the patient is able to go home or a bed in the community becomes available. | | |

2. Additional Health Care Services

SMCSR will also continue to provide the following additional services identified in the HCAA at the New SMCSR:

- Ø **Access to Women’s Reproductive Services:** SMCSR will continue to provide a full range of women’s health services including preventive care, labor and delivery, birth control, sterilization and pregnancy termination procedures at the New SMCSR.
- Ø **Access for Jail Inmates:** SMCSR will provide inpatient care for jail inmates in the custody of the Sonoma County Sheriff’s Department.

- Ø **Access to Sexual Assault Services:** Sexual assault services supervised by the Sonoma County Superior and Municipal Courts.
- Ø **Access to Quarantine Services:** Treatment and/or quarantine of any person deemed to be a threat to public health by the Sonoma County Public Health Officer.
- Ø **Access for HIV/AIDS Patients:** Inpatient care, after-hours coverage and emergency services, for HIV/AIDS Clinic and HIV Early Intervention Clinic Program. Inpatient care for persons with HIV/AIDS or other communicable diseases.
- Ø **Access for County's Residential Alcohol Service Program Patients:** Evaluation, consultation, medical services and medications for patients from County's residential alcohol services program who require acute care services.

3. Residency Program

a. Continuation of the Family Medicine Residency Program

The Residency Program ("Program") is a three-year residency in Family Medicine affiliated with University of California, San Francisco ("UCSF") and fully accredited by the Accreditation Council for Graduate Medical Education ("ACGME"). Since 1996, SMCSR has been the sole sponsor and funding source for the Program after taking over the sponsorship from Sonoma County's Community Hospital as part of the HCAA between SMCSR and Sonoma County.

SMCSR is in the final stage of implementing the transfer of sponsorship of the Program to a consortium of Sonoma County health care organizations to ensure a strong future for the Program. SMCSR formed the consortium of community partners in 2007 to guarantee the Program prospers amidst the changes in health care services currently taking place in Sonoma County.

The membership and governance of the Consortium includes representatives from the major health care organizations in Santa Rosa including SMCSR, SMFNB, Sutter Medical Group of the Redwoods, the Sonoma County Department of Health Services, Southwest Community Health Center ("Southwest"), Memorial, Kaiser and UCSF.

In October 2008, the Sonoma County Board of Supervisors approved a five year business plan for the transfer and operation of the Program to the newly incorporated Santa Rosa Family Medicine Residency Consortium ("Consortium"). In the five year business plan, SMCSR will continue to be the major funding source to the Program and will continue as the major participating site for the Program. With the approval of the Board of Supervisors, SMCSR anticipates approval by ACGME transferring sponsorship to the Consortium in early 2009.

As the sponsor, the Consortium will directly employ the thirty-six residents and six administrators and will contract with SMFNB for faculty. Other community-based healthcare providers are prepared to participate in substantive and meaningful roles. In addition to SMCSR as a major participating site, Kaiser committed its continued support locally with resident rotations as well as becoming a second major participating site for the Residency in 2011. Southwest will continue to operate the Family Practice Center, where the residents obtain the majority of their clinical training. Together, Sutter, Kaiser and Southwest will be the three main pillars of the Program.

b. Continuation of Outpatient Services

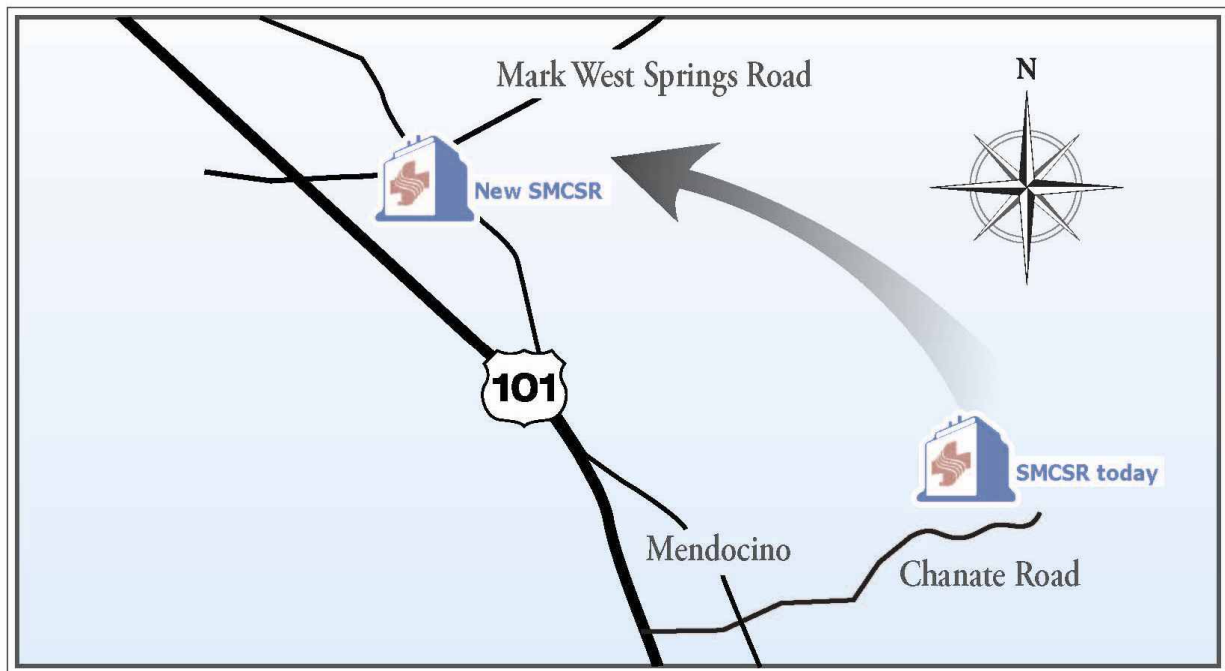
From 1996 to 2004, SMCSR operated the Family Practice Center as an outpatient department of SMCSR on the Chanate campus. In 2004, SMCSR, with the consent of the County, subleased Clinic C of the Family Practice Center to Southwest. In 2007, SMCSR, with the consent of the County, subleased the remainder of the Family Practice Center to Southwest and entered into an Affiliation Agreement with SMCSR, Southwest and SMFNB. Under this agreement, Southwest now operates the entire Family Practice Center as a Federally Qualified Health Center and Southwest coordinates SMCSR's provision of outpatient specialty care. The Sutter Health guaranty in the HCAA remains in effect and will continue to apply to the outpatient services provided by Southwest in accordance with and through the term of the HCAA. SMCSR plans to provide continued access to outpatient specialty care through the Affiliation Agreement with Southwest. Although the Lease with the County will be terminated when SMCSR vacates the Chanate campus, negotiations with the County will include a new lease or sublease for Southwest to continue operations at this site.

4. Seismic Compliance

SMCSR acute care facilities are subject to the compliance requirements of the Hospital Facilities Seismic Safety Act as amended by California Senate Bill 1953 as well as Senate Bill 1661. The Chanate campus is comprised mostly of aged buildings that carry a non-conforming seismic performance rating of SPC-1, which coupled with the proximity to seismically sensitive areas, make retrofit a difficult and complex option especially while maintaining ongoing care.

After evaluating the cost and process for retrofitting the Chanate campus, SMCSR determined the preferred option was to build a new hospital at the Wells Fargo campus. In 2005, Sutter Health applied for and received extensions that extended the compliance deadline to January 1, 2013, from the original 2008 date for SMCSR Chanate and Warrack campuses. The timeline for the approval process and construction anticipate the completion of the New SMCSR in fall 2012.

B. New SMCSR



1. Program Description

The New SMCSR at the Wells Fargo campus will be a modern general acute care hospital owned and operated by SMCSR. In addition to meeting SB 1953 seismic safety requirements, the New SMCSR will incorporate a number of features that increase efficiency and flexibility of hospital operations. The existing Chanate campus has hospital operations spread out on the campus in numerous buildings making hospital operations inefficient. The New SMCSR will be located in one building enabling the new facility to implement patient-centered care concepts and take advantage of advances in technology and care delivery.

The New SMCSR will have 70 licensed beds and will include an additional 16 station Universal Care Unit (“UCU”). The UCU is an improved care model in health care that will provide increased efficiencies, operational flexibility and increase the capacity of departments such as the emergency and surgery departments.

The New SMCSR will feature all private rooms, maximizing the comfort and privacy for each patient and allowing greater flexibility in admissions. Currently, gender matching and infection control issues prevent full utilization of double-occupancy rooms at the Chanate campus. Private rooms will eliminate these constraints and will substantially improve utilization of the New SMCSR 70 licensed beds. Technological and treatment advancements have and will continue to decrease the need for inpatient hospitalization admissions and decrease the length of stays. SMCSR has factored in these trends and efficiencies in planning the New SMCSR.

The New SMCSR will have diagnostic imaging services including computed tomography (CT), nuclear medicine, radiology/fluoroscopy and ultrasound. A mobile docking station will also be included for special imaging equipment and new technology such as magnetic resonance imaging (MRI), positron emission tomography (PET), PET/CT and others.

A summary of the New SMCSR is as follows:

The New SMCSR includes the following 70 licensed beds:

- 20 Medical/Surgical beds
- 8 Intensive/Critical Care beds (ICU/CCU beds)
- 30 Perinatal beds
 - 10 Labor Delivery Recovery Postpartum beds (LDRP beds)
 - 20 Postpartum private beds
- 12 Neonatal Intensive Care Unit beds (NICU) beds

In addition to the licensed beds listed above, the following services will also be provided:

- 12 Emergency Department (“ED”) bays with physicians on duty 24 hours per day, 365 days per year and on call specialists
- 16 Universal Care Unit stations

Supporting ancillary services including:

- 2 Operating rooms
- 1 Procedure room for endoscopy
- 1 C-section operating room
- 1 Cardiac Cath lab

2. New SMCSR Green Design and Construction

SMCSR’s design of the New SMCSR employs significant “Green” and sustainable design and construction practices. The following “Green” building practices are anticipated to be implemented at the New SMCSR at Wells Fargo:

- Ø **Reducing Auto Emissions:** The New SMCSR provides for reducing auto emissions through a complete Transportation Management Plan including bike storage, lockers and showers for staff who bike or walk to work, preferred parking for car pools, electric vehicles and free-of-cost electric charging station.
- Ø **Green Space:** The New SMCSR maximizes green space and landscaped areas, shades parking and minimizes hard surface areas to reduce heat island effect. Planting of native, drought resistant, water conservative plants, and utilization of smart irrigation controllers and low flow emitting irrigation devices are planned. Bioswales will be used in the parking lots to reduce the amount of hydrocarbon run off in storm water. Storm water plans, including retention of storm run off, will be in full compliance with County regulations and will meet or exceed all water quality control standards. The use of treated waste water to irrigate landscaping will be investigated with the County.
- Ø **Energy Efficient Hospital Design:** The New SMCSR is designed to be highly energy efficient and includes site placement to reference sun tracking patterns and seasons, low heat island roofing, energy efficient plant equipment (boilers, chillers, generators), fully controlled lighting and thermal comfort systems, thermally efficient building skin and glazing materials, interior day lighting to reduce energy demand, fluorescent and LED lighting and site lighting designed to avoid light pollution.

Ø **Construction Process and Selection of Materials:** SMCSR will implement a complete construction waste management and recycling plan for all construction components of the New SMCSR. SMCSR will utilize materials with high feasible recycled content and low or no emitting materials such as adhesives, sealants, paints, coatings, carpet and flooring systems. SMCSR intends to purchase materials from sustainable processes. It is anticipated that SMCSR will, when possible, procure building materials locally to reduce green house gases (“GHGs”) in transporting materials to the site. SMCSR plans to use on-site soil to reduce the amount of import or export of materials to/from the site. In addition, SMCSR plans to use the most water efficient toilets, urinals and fully automated faucets throughout the New SMCSR. A major goal of the New SMCSR is to reduce GHGs whenever possible.

3. Universal Care Unit

The UCU will better integrate clinical services by concentrating similar functions performed in multiple departments through a single observation space. The UCU will be located adjacent to the ED and allows for greater flexibility in caring for shorter stays and patients in need of observation. The majority of the UCU patients will be discharged to home, admitted to the New SMCSR or transferred to another facility (e.g., psychiatric hospital).

The UCU will be used for ED overflow outpatients, observation patients (Medicare designation for patients who stay less than 24 hours), pre-operative patients and post-operative outpatient surgery patients.

UCU stations will allow greater capacity in the ED by allowing patients to be cared for in the UCU who need observation, non-critical patients awaiting test results or consultations and patients awaiting transfers. The UCU stations will increase the capacity of the ED by moving patients with low level needs to the UCU and free up the ED beds for patients requiring higher level of emergency care. The UCU will allow for greater capacity of licensed beds by utilizing stations for observation patients, outpatient surgery extended recovery patients and other patients who would otherwise occupy a licensed bed.

For the last three months, SMCSR has averaged 4.8 patients per day that could have been cared for in a UCU station if the Chanate campus had a UCU. If there were a need for licensed beds during these times, these patients could have been cared for in the UCU which would have freed up the use of licensed beds.

4. Emergency Department Demand & Capacity

SMCSR engaged Cattaneo & Stroud (“C&S”) to review demand and existing capacity of emergency department (“ED”) services in Sonoma County over the past few years utilizing the Office of Statewide Health Planning and Development (“OSHPD”) Emergency Department Patient Encounter Data 2005-2007 and OSHPD ALIRTS data reports from 2002-2007. The C&S model accounts for current population figures, projected growth and aging of the population to adjust for the growing elderly population who require increased medical care and utilize the ED more frequently.

Based on that analysis, C&S projects ED visits in Sonoma County will grow by 8% to 2014 relative to 2007 levels. C&S was aware of changes taking place with Kaiser doubling the size of its ED to 34 bays. Taking this change into account, together with the decrease in 3 bays in the New SMCSR, the number of ED bays in Sonoma County will increase by 15%, from 81 to 93. This percentage increase does not take into account the positive impacts of the 16 station UCU at SMCSR on increasing ED capacity.

A standard used in both academic studies⁷ and for planning purposes is 2000 visits per bay per year. In evaluating ED demand, a measure that can indicate if there are capacity problems in a county is if the average number of visits per ED bay station is over 2000. The statistic for Sonoma County in 2007 was 1600, or 80% of capacity. With the expected growth in visits factored in for population and increased aging population and the increase in the number of bays, the measure for 2014 will rise slightly to 1520, or 76% of capacity. Thus, this measure demonstrates that even when taking into account the increases expected from an increased aging population, there is ample ED capacity in Sonoma County through 2014.

To summarize, C&S concluded the possibility of capacity problems in Sonoma County in the near future to be unlikely. Moreover, this analysis only addressed ED and did not take into account the 16 UCU stations at SMCSR which will increase ED capacity at SMCSR and in Sonoma County.

5. Bed Demand & Capacity

In addition to reviewing ED services in Sonoma County, C&S also provided a similar review of inpatient services. This review also utilized OSHPD data and accounted for current population figures, projected growth and aging of the population by cohort to adjust for the growing elderly population. The C&S review provided a projected bed need by bed type for 2014 as illustrated in Figure 8.

As Figure 8 demonstrates, the New SMCSR will not have an invasive cardiology program which reduces the estimated inpatient bed demand in 2014 to 69 beds.

⁷ Planning a new emergency department: One Pacific Northwest hospital's experience. *Journal of Emergency Nursing*, Volume 29, Issue 4, Pages 330 - 334 L. Forsythe.

Figure 8: SMCSR Adjusted Inpatient Demand 2014 Less Invasive Cardiology

| Licensed Beds | 2014 Projected Bed Demand | (Less) Invasive Cardiology Bed Demand | 2014 Projected Bed Demand (Less) Invasive Cardiology |
|----------------------|--------------------------------------|--|---|
| Med/Surg | 48 | -10 | 38 |
| ICU/CCU | 9 | -2 | 7 |
| Perinatal | 16 | 0 | 16 |
| NICU | 8 | 0 | 8 |
| Total | 81 | -12 | 69 |

The combined bed supply for Med/Surg and Perinatal services is 50 licensed beds. Perinatal beds will serve as swing beds for Med/Surg as needed at times of peak demand. In addition to the 50 licensed beds, there will be 16 UCU stations. The UCU will be used for ED overflow outpatients, observation patients (Medicare designation for patients who stay less than 24 hours), pre-operative patients and post-operative patients.

The C&S inpatient demand of 69 beds in 2014 was completed in September 2008 based on actual 2007 SMCSR utilization. Since this time, C&S has reviewed Sonoma County hospital inpatient demand and found that over the past 10 years hospitals in Sonoma County have, on average, seen about a 0.7% per year decline in cases, with the total number of patient days virtually flat. However, the most recent, preliminary data from all Sonoma facilities excluding Kaiser⁸ indicate that cases have declined by 4.5% and patient days are down by 7.1% in the 12 months prior to June 2008, which represents a decrease in ADC of 30 beds countywide for the non-Kaiser hospitals.

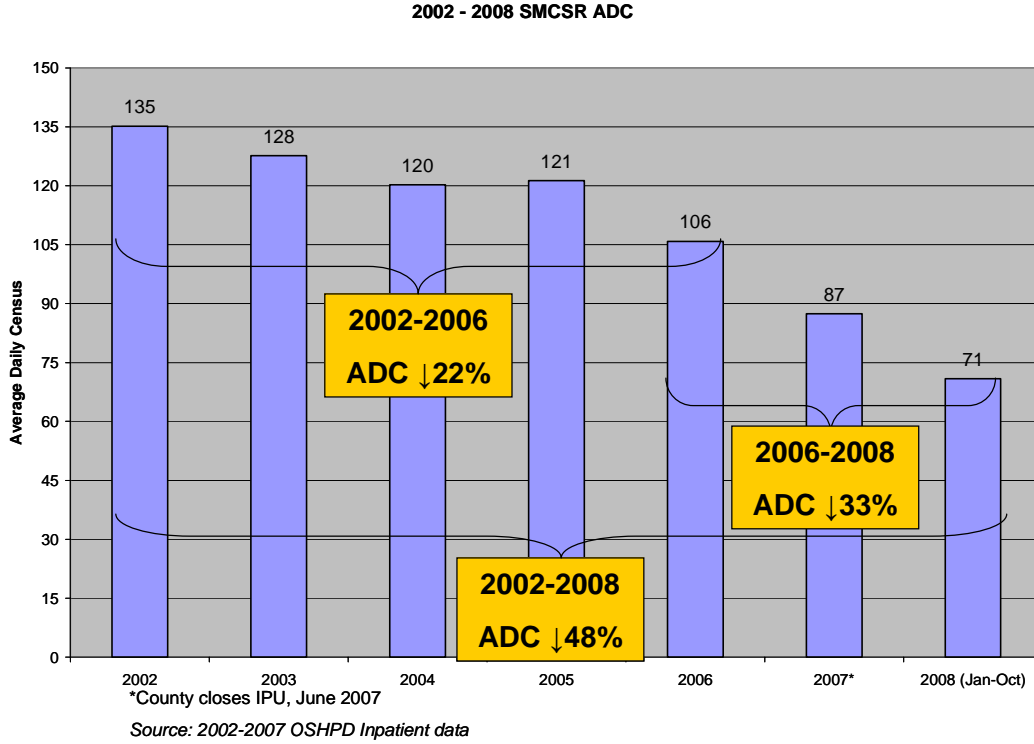
6. SMCSR Decreasing Inpatient Demand

From 2002 to October 2008, SMCSR's ADC has decreased by 48%. SMCSR is essentially treating half the number of patients it did just six years ago. The reason for the downward shift in patient volume are numerous including the commercially insured market shift to Kaiser, use of technology in treatment, increase of outpatient care options, closure of the psychiatric facility, impact of discussions to transfer services to Memorial, as well as excess bed capacity and duplication of services at other facilities in the County.

As Figure 9 demonstrates, between 2002 and 2006, SMCSR's (Chanate and Warrack campuses) patient days decreased resulting in a 22% decrease in ADC. Due to the declining inpatient volume, SMCSR's Warrack campus closed its acute care service in June 2006. Furthermore, in January 2007 through October 2008, SMCSR experienced a further 33% decline in ADC from 2006 volumes. SMCSR experienced a 48% overall decrease in ADC between 2002 and 2008 (through October 31, 2008).

⁸ See OSHPD Quarterly Hospital Profile reports for 7/01/06-6/30/08 (<http://www.oshpd.ca.gov/ihpc/AggFourReport.asp?ReportYearQtr=20082&HospitalType=CO&BedSizeCategory=&TeachRurl=0&TypeControlNum=0&CountyNumber=49&Select=1>).

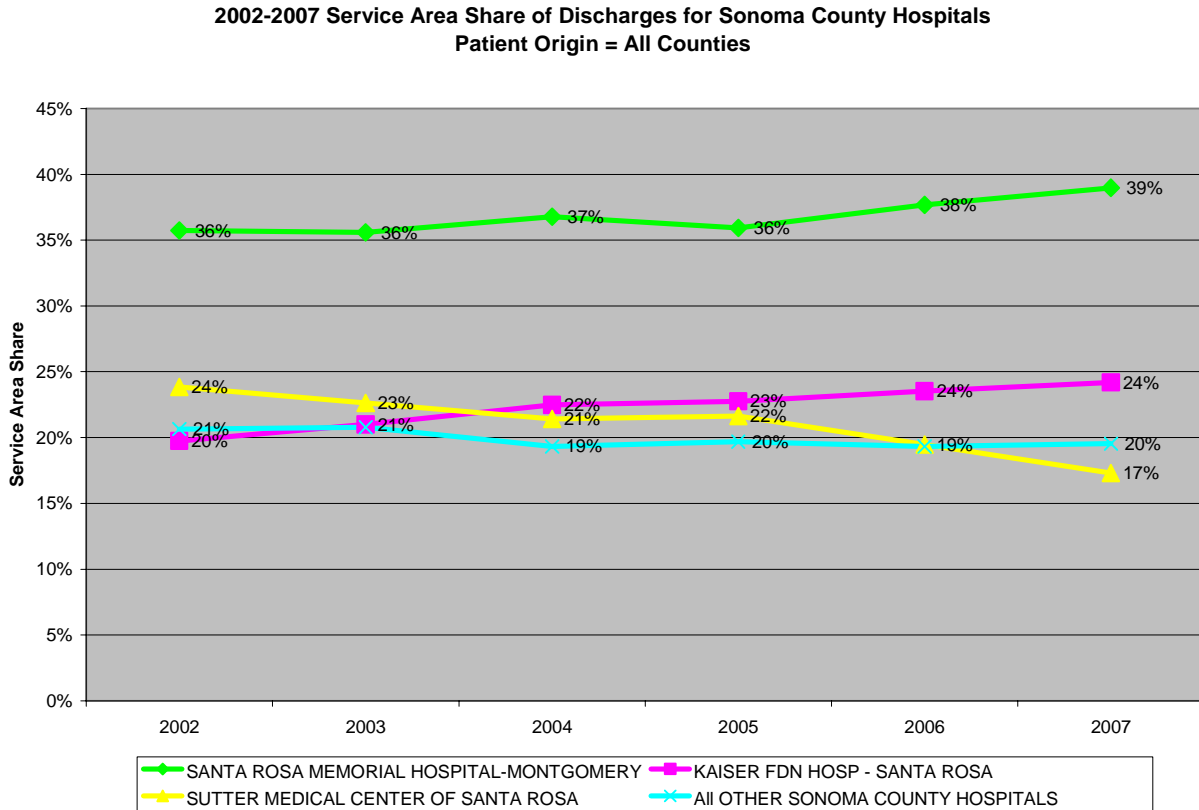
Figure 9: SMCSR's Decreased Patient Volume



In the last six month period, May 2008 through October 2008, SMCSR had an ADC of 65 patients. This decreased demand trend is expected to continue declining in the coming years at SMCSR and other non-Kaiser hospitals for the numerous reasons discussed above.

Hospitals in Sonoma County continue to provide care in a changing environment. Over the past five years changes in service area share (the percent of total patient cases at each hospital) have shifted as some hospitals have increased while others have decreased service area share. As illustrated in Figure 10, the service area share for Memorial and Kaiser has continued to increase by 3% and 4%, respectively. Over the same time period, the district hospitals have seen a slight decrease in service area share. SMCSR's service area share has significantly eroded by 7%.

Figure 10: SMCSR’s Decreasing Service Area Share



Source: OSHPD Inpatient data, 2002-2007.

7. Sonoma County Decreasing Demand Trend for Inpatient Hospital Services

In Sonoma County and across the nation, hospitals are experiencing decreased demand for services. Technology plays an important part in our lives today and nowhere is that more apparent than in health care. Technological advances, pharmaceutical options and treatment innovations make hospital stays shorter and more services possible on an outpatient basis decreasing demand for inpatient hospitalization admissions today and in the future. For example, numerous surgeries which formerly were considered “major” surgery requiring longer hospital stays such as an appendectomy are today done by minimally invasive procedures such as laparoscopic surgery. SMCSR is just one of numerous hospitals in Sonoma County experiencing a decreasing demand trend.

8. New SMCSR Potential Expansion Capability

Current flat population growth in Sonoma County and the decreasing trend for inpatient hospital services make it unlikely that SMCSR will need to expand its facility in the future. However, the New SMCSR design allows for expansion, if needed in the future. Some or all of the following 29 bed additions could be accommodated, if needed and financially feasible:

- Medical Surgical– 10 additional beds
- Critical Care – 4 additional beds
- NICU – 3 additional beds

- Post Partum – 10 additional beds
- LDRP – 2 additional beds
- Emergency Department – 4 additional treatment rooms and support space
- Radiology – 2 additional radiological rooms (e.g., 1 rad room, MRI)
- Surgery – 2 additional operating rooms and support space.

If SMCSR determines that expansion of the New SMCSR is needed and desired in the future, SMCSR would likely request funding for expansion from Sutter Health. In evaluation of any request for capital project funding, a number of factors are considered, including but not limited to, community need, financial feasibility, availability of debt and equity for investment and capital expenditure payback time. Since any potential expansion decision will be based upon future considerations, no commitment regarding future expansion can be made at this time.

C. Timeline

The following timeline and milestones are anticipated for the New SMCSR:

- December 31, 2008 – OSHPD submittal
- January 1, 2009 – EIR process started
- Spring 2009 – County considers and takes action on the Business Plan (defined below)
- Fall 2009 – Hospital design completed
- January 1, 2010 – OSHPD review and phase permits begin
- Summer 2010 – Entitlements received (i.e., OSHPD and County permits) & EIR approval
- Summer 2010 – Construction starts
- Summer 2012 – Construction completed
- Fall 2012 – Hospital licensure and occupancy.

D. Request for Approval

SMCSR’s new Health Care Access Business Plan (“Business Plan”) will ensure the HCAA agreement continues to be met and provide the community with access to quality health care until the extended term of the agreement of 2021. We request the Board of Supervisors consider and approve the Business Plan.

Construction of the New SMCSR in accordance with the Business Plan will enable SMCSR to provide the services under the HCAA to Sonoma County residents without the need for the continuation of the Lease. Therefore, as a part of the approval of the Business Plan, SMCSR and the County will enter into good faith negotiations for termination of the Lease as to SMCSR (or alternatively a sublease for the FPC) with the goal of returning the real property to the County at the time the New SMCSR begins operations.

E. Conclusion

This Business Plan meets the HCAA criteria and enables SMCSR to continue delivering quality health care in Sonoma County. The New SMCSR 70-bed acute care hospital will allow SMCSR to manage the anticipated continued lower patient demand for inpatient services with the advent of future technological advances, pharmaceutical alternatives and outpatient trends.

Nearly all of Sonoma County non-Kaiser hospitals are experiencing low occupancy rates well below state and national averages. Sonoma County’s excess hospital beds cost SMCSR and other Sonoma County

hospitals millions of dollars per year. This excess capacity diverts needed resources away from the delivery of health care services to cover the fixed costs of empty beds.

The New SMCSR is appropriately sized based on SMCSR current and projected future demand. As demonstrated, SMCSR patient census declined 48% over the last six years and in the last six months ending October 31, 2008 to an ADC of 65 patients. The decreasing demand trend is expected to continue due to Sonoma County's flat population growth projections and the expansions of Memorial and Kaiser resulting in SMCSR decreasing service area share.

Technology will continue to enable inpatient hospital stays to become even shorter and significantly decrease demand with more outpatient and pharmaceutical treatment options becoming available every year. The New SMCSR is designed to take advantage of efficiencies and flexibilities such as private rooms, utilization of all hospital services in a modern building and the UCU providing additional capacity to departments as needed.

SMCSR will continue to meet and comply with the terms of the HCAA by moving its current operations from the aged Chanate campus to a new, modern medical center at the Wells Fargo Campus. SMCSR strongly urges the County to consider and approve this plan.