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February 7, 2024

San Benito Health Care District
911 Sunset Drive
Hollister, CA 95023-5602

Re: Letter of Intent Joint Power Authority

The County of San Benito ("County") propose a potential collaboration with the San Benito Health Care District ("District") to form a Joint Powers Authority ("JPA") to capitalize, govern, and oversee the management of Hazel Hawkins Memorial Hospital.

JPAs are authorized under California Government Code § 6500, et seq., and provide a mechanism for one or more public agencies to jointly exercise powers in common to the members. In the formation of the JPA, a specific purpose is established, in this case will be focused on the operation and financing of healthcare services. JPA's have the authority to issue bonds or to enter into contracts with outside agencies, to ensure fulfillment of stated goals.

It is understood that in 2022, the District experienced significant challenges related to its cash flow, and, as a result, the District engaged with and hired a third-party, B. Riley, to improve the performance of the hospital, medical clinics, and skilled nursing facilities. B. Riley assisted in stabilizing operations and, more recently, the District experienced positive cash flow and positive net income on a consolidated basis. Notwithstanding these recent successes, which are to be commended, the District has declared Chapter 9 bankruptcy, and the County shares the concern expressed by the District board that continued operation under the current structure may not a viable way to assure our sizable and growing community that our citizens' future healthcare needs will be met.

As you are aware, the County engaged the healthcare management consulting firm, ECG, to provide an analysis of our local healthcare market, the future demand for services, the financial performance of HHMH, the clinics, and the SNFs, and to provide advice on strategic challenges, opportunities, and potential solutions. ECG subsequently developed a detailed business plan for the future operation of the hospital and clinics. The plan is focused on the establishment of a new medical group and restructuring of existing clinics. Additionally, the plan assumes that the JPA will establish partnerships with larger regional provider organizations to better meet local needs in areas such as cardiovascular medicine, stroke care, and others. A summary of this business plan is attached as Exhibit A.

The business plan demonstrates that the hospital could improve its operating margin and rebuild cash reserves, while gradually funding the now-frozen pension plan and investing in capital improvements. If effectively executed, the business plan will build the organization's cash reserves to over $100 million in year 10.

In consideration of this work and ECG's advice, the County proposes the formation of a JPA that will oversee and establish a broader community governing structure the hospital, medical clinics, and skilled nursing facilities.

The purpose of the JPA will be to:

- To foster and capitalize on the further development of and expansion of a local healthcare system to deliver high-quality healthcare services to the residents of the County and the District
- To ensure a sufficient foundation of local support and long-term financial stability
- To provide mechanisms for expanding access to care by recruiting and building a local sustainable group (>25) of medical providers.
- To maintain a locally operated healthcare delivery system focusing on a mission to serve the healthcare needs of our community versus equity shareholders.
- To operate efficient health care services by eliminating unnecessary duplication of services and resources.
- To establish a formal structure for business discussions and decision-making leading to collaborative activities.
- To oversee the additional capitalization required by the District.

The JPA will appoint an operating board to include representation by each member of the JPA. The County and the District will propose a slate of representatives to be approved by the other JPA member(s). Additionally, we are suggesting that the operating board include 3-5 additional members to include healthcare experts, community members with needed skills, and physicians.

Significant components of the County's proposal are outlined below:

1. The assets of the District will remain assets of the District, and the long-term and current liabilities will remain. The District will continue to receive supplemental tax revenue, and public bonds will be repaid as specified in current indentures.
2. The County and the District will create a JPA for the purpose of operating the hospital, skilled nursing facilities, and physician clinics owned by the District. The JPA will drive collaboration, provide financial support, and set strategic direction for the organization, enabling the community to maintain locally owned, controlled, and governed healthcare. A locally controlled health system under the JPA will allow members of our community to determine how the healthcare needs of our community are met, which serves we support and need, and what investment meets the needs of our community versus those of a private, third-party organization, particularly one that is based out-of-state.
    a. The JPA will develop an operating board, consisting of representation by the member organizations, but adding new members with different expertise, bringing

essential skills and perspectives (e.g., physicians, finance experts, healthcare administrators). A 9 to 11-member board is recommended.

b. The JPA board will be responsible for selecting the Chief Executive Officer "CEO."

3. The JPA will enter into strategic partnership agreements for various clinical services with academic organizations, such as Stanford Healthcare, or larger regional hospitals, such as Salinas Valley Health, to bolster the ability of the hospital to offer complex care, such as stroke, cardiology, neurosciences, etc.
4. The JPA will provide $12-15 million of new capital for hospital operations, consisting of a minimum of $5 million from the County and $7-10 million of public debt issued to the JPA (not the District). JPA debt is not an obligation of the JPA members unless the members choose to become liable. The incurrence of JPA debt is not subject to a public vote. This new capital will support growth and any immediate liquidity concerns. Additional capital available to the organization may also include a ~$7 million receivable under the federal Employee Retention Tax Credit program and $10 million previously committed by HCIA under California's Distressed Hospital Loan program. This capital will be used to fund the following:
    a. Development of a new medical group consisting of 25 physicians over a period of 5 years. These physicians will fill an increasing gap in physician capacity in the area and will drive growth to the hospital. San Benito County currently has a shortage of over 50 physicians.
    b. Funding of currently deferred capital projects, growth capital (including a cardiac catheterization lab), and future routine capital.
    c. Funding of an Electronic Medical Records ("EMR") system to replace the hospital's current antiquated system at a cost of $10 million.
    d. Funding of the unfunded employee pension liability overtime at the rate of $1-2 million per year
    e. Increasing days cash on hand (reserves) from 53 days in year 1 to 113 days in year 10. Business plan projections include:
        i. The 2023-2024 reduction of costs in employee benefits;
        ii. An increase in the severity and complexity of hospitalized patients (Case Mix Index or "CMI") from 1.15 to 1.30;
        iii. 2% growth in revenue per service; and
        iv. Volume increases of 3-5% per year.
5. The District board will have the following reserve powers:
    a. Approval of the JPA's annual operating and capital budget;
    b. JPA capital projects approval if over $5 million;
    c. Approval of strategic plan or business plan; and
    d. Approval of new services or service discontinuation.
6. The County of San Benito may adopt new development fees or other appropriate fees under the existing Community Services District (CSD) to supplement hospital revenues. These funds for <u>future</u> development are not included in the ECG business plan, <u>and financing of the business plan is not contingent on these fees</u>. The City of Hollister and the City of San Juan Bautista could choose to impose similar fees as well.

8. The District will file a Plan of Reorganization with the U.S. Bankruptcy Court in San Jose that includes the terms and capitalization plan for the JPA, and essential components outlined in the ECG business plan.

Completion of this transaction will require the approval of the San Benito County Board of Supervisors, the District Board, and the U.S. Bankruptcy Court in San Jose. It also requires the execution of the JPA Agreement, the JPA Loan Agreement, and the adoption of Articles and Bylaws for the JPA.

We propose that over the next 60-90 days the County and the District work collaboratively to (1) codify the business plan and JPA formation as the centerpiece of the District's Plan of Reorganization and (2) agree on a finalized JPA Agreement and Loan Agreement, and (3) begin the process of selecting candidates for the JPA operating board.

This letter is meant to express the County's general intent only and does not constitute an offer which may be binding or create any legal rights or obligations between the parties. The parties are free to negotiate the terms of any agreement which may be reached between them with respect to the hospital.

The County looks forward to engaging in discussions around the hospital and the formation of a JPA which the County believes to be the best path forward for the community, retaining local control of the hospital and clinic and ensuring that resident needs are met for generations.

Sincerely,

By: _____
Ray Espinosa
County Administrator
County of San Benito

By: _____
Mary Casillas
Chief Executive Officer
San Benito Health Care District

Enclosures:

a. Draft JPA Agreement
b. Timeline
c. Summary of ECG Business Plan
d. Full Narrative – Business Plan

DRAFT
FOR DISCUSSION

JOINT POWERS AGREEMENT ESTABLISHING A COORDINATED SYSTEM FOR HEALTH CARE SERVICES

This Joint Powers Agreement establishing a Community Collaborative for Health Care Services (hereinafter, the "Agreement") is entered into by and between the San Benito Healthcare District and the County of San Benito ("Parties") as of _____, pursuant to the provisions of Title I, Division 7, Chapter 5, Article I (Sections 6500, et seq.) of the California Government Code (hereinafter, the "Act") relating to joint exercise of powers by public agencies.

Recitals

A. The Parties are a local healthcare district organized pursuant to the Local Health Care District Law (California Health and Safety Code sections 32000 et seq., hereinafter referred to as "District Law") of the State of California, and a County government. The District owns and operates a licensed acute care hospital, two skilled nursing facilities, related ancillary services and a number of physician clinics (the "Facilities") in the geographic boundaries of the San Benito Health Care District and the County of San Benito, California (herein referred to as "the Region")

B. The Parties wish to form a joint powers authority entity (hereinafter, "JPA') pursuant to the Act to assist in pursuing the joint mission of providing healthcare services in the Region. The Parties desire to establish this cooperative relationship for the following purposes:

i. To oversee the management and operations of the Facilities, and to oversee the development and implementation of a business plan;
ii. To create a broader governance structure for the health care operations that would include board members with needed expertise to guide the future of health care services in the Region;
iii. To foster and capitalize the further development and expansion of a local healthcare delivery system to provide high quality services to residents of the Region;
iv. To ensure a sufficient foundation of local support through a transparent governance model with participation of residents who may have disparate ideas.
v. To ensure long-term financial stability for the organization;
vi. To provide mechanisms for expanding access to care through the formation of a new, sustainable, multi-specialty group (>25) of medical providers;
vii. To increase public confidence in the local healthcare delivery system, increasing the likelihood that patients will choose to receive their care locally; and

viii. To maintain a locally operated health care delivery system focusing on serving the healthcare needs of the residents in the Region, and to preserve and enhance access to the broadest range of services possible to all residents, regardless of their ability to pay.

NOW, THEREFORE, THE PARTIES HEREBY AGREE TO THE TERMS AND CONDITIONS SET FORTH BELOW.

Agreement

1. Recitals. The Recitals set forth above are true and correct.

2. General Purpose of Agreement. The purpose of this Agreement is to establish a cooperative relationship by and among the Parties through the creation of a joint powers agency (JPA) that is able to operate healthcare services efficiently and effectively in the Region. The JPA shall seek to expand services and to improve the financial viability of the organization. The Parties intend that additional public agencies within the Region, such as cities, may join the JPA in the future subject to the applicable terms and conditions stated in this Agreement.

3. Joint Powers Authority Created. Pursuant to Section 6506 of the Act, the Parties create a public entity, separate and apart from the Parties to this Agreement, to be known as the San Benito Health Care Authority (hereinafter, the "Authority"). The debts, liabilities, and obligations of the Authority shall not constitute the debts, liabilities, and/or obligations of any of the Member Parties.

6. Governance.

A. Operating Board ("Operating Board"). The JPA shall be governed by an Operating Board. The Operating Board, as the governing and administrative body of the JPA, shall formulate and set policy, and shall exercise the powers set forth in this Agreement to accomplish its purpose. Appointments to the Operating Board shall be made through the following process:

(i) Each JPA Agency shall recommend a slate of two board members to represent that Agency on the Operating Board. Each party's slate shall be subject to the approval of the other Agency. Any subsequent Agency that joins the JPA may be given one additional seat on the board;

(ii) The four board members appointed by the JPA Agencies shall serve as the nominating committee for all remaining community board members. There shall be no fewer than three and no more than seven appointed community members.

B. Term of Office of Directors. Each Director shall serve a two (2) year term of office. All Directors shall serve at the will and pleasure of their respective Agencies and may be replaced at any time and without cause by the member Agency that initially appointed the Director. Any replacement Director shall serve out the balance of the term of the Director being replaced.

7. Meetings of the Operating Board.

A. Conducting Meetings. The Board shall hold regular meetings at least monthly and shall adopt bylaws for conducting their meetings and other business. All meetings of the Board, including without limitation regular, adjourned regular, and special meetings, shall be called, noticed, and conducted, in accordance with the provisions of the Ralph M. Brown Act (commencing with Section 54950 of the California Government Code).

B. Quorum and Decision-Making Methods. A majority of voting members of the Board shall constitute a quorum. Each Director, or alternate, shall be entitled to one vote. Decisions shall be made by supermajority votes of at least seventy-five percent (75%) of the voting members present, except where otherwise required by law or established by Board bylaws or other provisions of this Agreement.

C. Board Officers. The Board shall have a Chair to preside over and conduct all meetings, and a Vice Chair who shall succeed the Chair and preside in the absence of the Chair. The offices of Chair and Vice Chair shall rotate through each of the seats on the Board annually in a manner to be determined by the bylaws.

8. Limitation on Powers. Nothing in this Agreement shall authorize activities that corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the California Business and Professions Code.

9. Appointed Officers. Pursuant to section 6505.6 of the Act, the Operating Board shall appoint an Auditor and a Treasurer for the JPA to perform the duties required by law, as well as provide any other services that may be desired by the JPA. Should the County Auditor and County Treasurer be willing to serve, they may serve the JPA as Auditor and Treasurer, or the JPA may select another eligible Auditor and Treasurer to perform such duties. Such officers shall receive no compensation for holding the appointed office but shall be compensated for the cost of providing services per written agreement with the Authority. Under general authority provided by Government Code sections 6505 et seq, the Operating Board may appoint an executive officer to manage the operations of the Authority.

10. **Activities of the JPA.** The activities of the JPA shall include the following:

A. **Operational and Strategic Oversight.** The Operating Board shall oversee the management of the healthcare Facilities.

B. **Financial Management and Oversight.** Except for assets and liabilities specifically excluded from the scope of this agreement, all financial activities related to the Facilities shall be overseen by the JPA.

C. **Business Planning.** The Operating Board of the JPA shall develop and approve a business plan for the health care system and shall oversee its implementation. The business plan shall be subject to the reserve approval rights specified in Section 5(C) of this Agreement.

D. **Budget.** The Operating Board of the JPA shall approve an annual budget each year subject to the reserve approval rights specified in Secon 5(C) of this agreement.

E. **Medical Staff Oversight.** The operating board shall receive reports and credentialling recommendations from the medical staff and shall approve all physician privileges.

F. **Quality.** The Operating Board shall oversee quality and shall seek improvement where needed.

G. **Medical Group Development and Provider Employment.** The Operating Board shall oversee the development of a new multi-specialty medical group and shall have the authority to re-structure existing rural clinics.

H. **Other Activities.** The JPA shall also be responsible for the following other activities under this Agreement:

iv. Labor management, employment policies and benefit programs;
ix. Pooled financing, issuance of bonds and other funding vehicles (revenue, general obligation and other short term and long term);
x. Fundraising-philanthropy in partnership with the Hazel Hawkins Hospital Foundation;
xi. Contracting negotiations with various third party and government payers inclusive of Medical, managed care, commercial PPO, HMO, existing medical groups, and IPA's;
v. Regulatory compliance and accreditation;
xii. Such other projects which may be added in the future by agreement among the Parties;
xiii. Joint venture activities relating to inpatient and outpatient services;
xiv. Management activities;
xv. Development and implementation of insurance/provider networks; and
xvi. Sharing and crossover of managed care contractual rates.

5. Powers and Duties.

A. Authority. The JPA shall have the powers specified in Section 4 and other powers that are set forth in section 32121 of the District Law. Such powers shall be exercised in the manner provided in the Act subject only to the restrictions set forth in this Agreement. The. JPA is authorized in its own name to perform all acts necessary for the exercise of common powers.

B. Assessments. Pursuant to Section 6504 of the Act, the JPA is empowered, and by this Agreement required, to assess the Parties to finance the entire operation of the JPA as specified below:

(i) The County of San Benito shall contribute $5 million of initial capital to the JPA.

(ii) The San Benito Health Care District shall delegate management all of the Assets and Liabilities associated with the Facilities, except for those specified in Exhibit A. Specifically excluded from the JPA's scope of financial management shall be a fund of $500,000 each year, which shall be exclusively managed by the District in furtherance of wellness and preventive care for residents in the Region.

(iii) All administrative expenses of the JPA shall be paid from the operating budget of the Facilities.

(iii) All supplemental tax payments, grants, and income and expense related to Federal Disproportionate Share ("DSH") and Quality Assurance Fee ("QAF") programs shall be managed by the JPA.

(iv) The County of San Benito may serve as a credit facility to the JPA for the purpose of providing capital during the first ten (10) years of this Agreement. The current estimated need for such capital is between $7-10 million. The JPA may, at its sole discretion, issue municipal debt instruments to fulfill the need for this capital.

(v) The County of San Benito may, at its sole discretion, adopt new development fees to provide an additional source of capital for the facilities.

C. Reserve Powers. The San Benito Health Care District shall have the right to approve (i) the JPA business plan, (2) JPA expenditures greater that $5 million, (iii) agreement to enter into partnership with third party health systems, and (iv) any discontinuation of service.

10. Fiscal Year and Annual Budget/Financing.

A. Fiscal Year. The JPA's fiscal year shall be the twelve (12) month period commencing each _____, except if the effective date of this Agreement is other than _____, the first fiscal year shall be the short year commencing the effective date and ending the following _____.

B. Annual Budget. The JPA shall operate only under an approved fiscal year budget. Once adopted annually for each fiscal year, the total annual expenditure budget may only be increased by unanimous vote of the Operating Board. The JPA will adopt a preliminary annual budget no later than _____ for the following fiscal year and will adopt a final budget prior to _____.

C. Budget Elements. The budget policy shall include, but is not limited to, the following components:

i. **Operation and Maintenance Expenses**. The costs of operating and maintaining Facilities and the equipment housed therein shall include, but will not be limited to, personnel salaries and benefits, office and computer supplies and other consumables, payments for lease facilities, medical equipment, and expenses necessary to repair facility equipment due to normal wear and tear from ordinary usage.

ii. **Capital Expenditures.** Capital expenditures shall include the costs of Facility improvements, medical equipment, strategic growth investments as approved in the business plan, and the original purchase of equipment, hardware, software, and other fixed asset type items typically having a useful life of more than one (1) year. All costs associated with capital purchases, such as installation, shall be capitalized. Replacement of such equipment at the end of its useful life shall be a capital item. Capital expenditures shall be paid in accordance with a budget established in the business plan and shall be paid for through available cash or JPA debt.

11. Funding and Cost Allocation. The JPA's annual budget shall include a reasonable provision for contingencies as well as financing for the maintenance, upgrade, or ultimate replacement of key fixed assets and structures. The JPA shall endeavor to provide its services in the most cost-effective manner available without compromising quality standards. For the first ten years of this Agreement, the JPA shall contribute $2 million per year to the San Benito Healthcare District's now-frozen employee pension fund. Additional contributions to the pension fund shall be made based on annual actuarial studies and professional advice.

12. Appeals to the Operating Board. Any member agency shall have the right to appeal any implemented or recommended policy or procedure to the JPA's Operating Board for final determination should, in the opinion of the member agency, such policy or procedure pose a significant adverse impact on the member agency. In such cases, a unanimous vote of the JPA's Operating Board (excluding the Directors from the appealing agency) shall be required to approve the policy or recommendation.

13. Term of Agreement and Termination Provisions. This Agreement shall be deemed to go into effect on _____ (the "Effective Date") and shall continue in full force and effect until rescinded or terminated, as set forth below.

A. Termination of Individual Membership. Any member may terminate its participation in this Agreement by giving written notice to the JPA Operating Board not less than eighteen months before the start of the fiscal year, which termination shall be effective only on the beginning of the next fiscal year. If a member terminates its participation in this Agreement any and all assets and liabilities of the JPA shall become assets and liabilities of the San Benito Healthcare District, except for debt issued to the JPA under Section 5(B)(iv) of this agreement, shall become assets and liabilities of the San Benito Healthcare District. The member requesting Termination shall bear any expenses specifically related to termination.

B. Rescission of Agreement by All Parties. At any time, this Agreement may be rescinded and terminated, and the Authority may be dissolved, by a unanimous vote of all Parties.

15. Membership. Membership in the Authority shall be open to all cities, independent districts, and other public agencies which have an interest in providing healthcare services in the Region.

A. Admission of New Members. The Operating Board has the authority to admit new members to the Authority, after noticing existing members and an opportunity for them to be heard at a public meeting. The Board shall set the terms and conditions for admitting new members (either individually or generally) that it deems appropriate.

B. Cost of Admitting New Members. The Operating Board shall determine the cost of admitting any new members to the JPA, such as on-going assessments or charges that new members will be required to pay to the JPA.

C. New Member Obligations. Each agency accepted as a new member shall be required to pay any assessments established by the Operating Board, and sign a copy of this Agreement, or an acknowledgement that it is bound to all the terms and conditions herein (at the discretion of the JPA).

16. Amendments to Agreement. This Agreement may be amended or modified only by a unanimous vote of the Member Agencies that are Parties to this Agreement. Any amendments to this Agreement shall be in writing and signed by all members.

17. Severability. Should any part, term, portion or provision of this Agreement, or the application thereof to any person or circumstances, be in conflict with any State or Federal law, or otherwise be rendered unenforceable or ineffectual, the validity of the remaining parts, terms, portions, or provisions or the application thereof to other persons or circumstances, shall be deemed severable and shall not be affected thereby, provided such remaining portions or provisions can be construed in substance to continue to constitute the Agreement that the Parties intended to enter into in the first instance.

18. **Insurance.** The JPA shall be required to obtain insurance or join a self-insurance program in which one or more of the Parties participate, appropriate for its operations. Any and all insurance coverages provided by the JPA shall name each and every Party to this agreement as an additional insured for all liability arising out of or in connection with the operations by or on behalf of the named insured in the performance of this Agreement. Minimum Levels of the insurance or self-insurance program shall be set by the JPA in its ordinary course of business. The JPA shall also require all contractors and subcontractors to have insurance appropriate for their operations.

19. **Indemnity.** The JPA shall indemnify, defend and hold harmless the Parties their officers, agents, servants, employees, and volunteers from any and all claims, losses, costs or liability resulting to any person, firm, or corporation, or any other public or private entity for damages of any kind, including, but not limited to, injury, harm, sickness, or death to persons and/or property from any cause whatsoever arising from, or in any way connected with, the performance of its operations and exercise of its powers, except from any such claim arising solely out of acts or omissions attributable to the member Party or its officers, employees, volunteers, or agents.

20. **Successors.** This Agreement shall be binding upon and shall inure to the benefit of the successors of the Parties hereto.

21. **Notice of Creation.** A notice of the creation of the JPA by this Agreement shall be filed by the Authority with the Secretary of State pursuant to Section 6503.5 of the Act.

22. **Other Notices.** Notices to the JPA required or permitted to be given under this Agreement shall be in writing. Delivery of such notices shall be conclusively taken and sufficiently given forty-eight (48) hours after deposit in the United States Mail, return receipt requested, with the postage thereon fully prepaid, addressed to the Authority as follows:

[Insert address of principle place of business]

Notices to the Parties shall be provided in the same manner as above, addressed as set forth in the signature page hereto. The JPA may change its address above for notices by giving written notice as described above to all Parties. Any Party may change its address for notices by giving written notice as described above to the Authority.

23. **Counterparts.** This Agreement may be executed in any number of counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute but one and the same instrument.

24. **Entire Agreement.** This Agreement contains the final and entire agreement of the Member Parties and supersedes all other agreements, written or oral, heretofore made by the parties. The parties shall not be bound by any terms, conditions, statements, or representations, oral or written, not contained herein.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed and attested by their proper officers thereunto duly authorized, as of the day and year first above written.

Dated: _____ [PARTY NAME]

By: _____

_____

Address: _____

_____

Dated: _____ [PARTY NAME]

By: _____

_____

Address: _____

_____

Dated: _____ [PARTY NAME]

By: _____

_____

Address: _____

_____

**

EXHIBIT A

TBD

Timetable for Operationalizing the JPA

Assumes SBHD is deemed eligible for Chapter 9 bankruptcy

Deemed Eligible

- Determination that the San Benito Healthcare District is eligible for Chapter 9 bankruptcy protection

Negotiation of Definitive Agreements

- JPA Agreement
- JPA Loan Agreement

Approval of the U.S. Bankruptcy Court

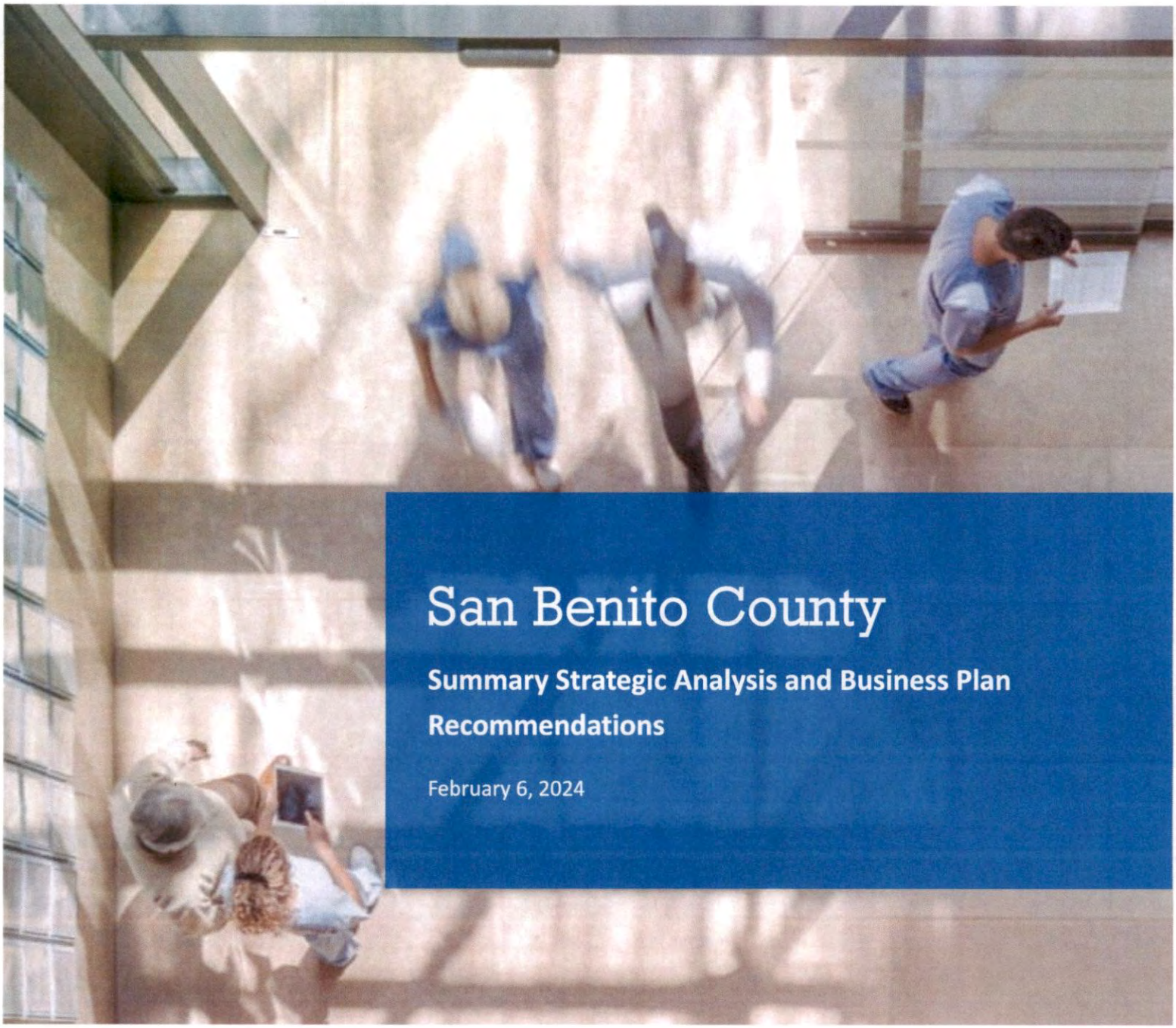
- Plan of Reorganization
- JPA-related Agreements

Establish Operating Board

- Slates created by Healthcare District and County
- Outside Directors nominated

Commence Operations

- JPA Operating Board begins overseeing implementation of the business plan
- JPA Operating Board selects management



San Benito County

Summary Strategic Analysis and Business Plan Recommendations

February 6, 2024

ECG MANAGEMENT CONSULTANTS

A Siemens Healthineers Company

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Overview

Background

ECG is pleased to submit our strategic recommendations for Hazel Hawkins Memorial Hospital (HHMH) and the future of healthcare in San Benito County. It is our perspective that the County of San Benito (COSB) and the San Benito Health Care District (SBHCD) can partner to create a viable path HHMH. In this report, we provide our recommendations for actionable strategies that will set the foundation to keep HHMH a locally controlled hospital.

In November 2022, HHMH declared a fiscal emergency with inflation, insurance reimbursement declines, and the pandemic as leading factors. By May 2023, HHMH voted to file chapter 9 bankruptcy. Given HHMH's current state and as it seeks partners (including out-of-state operators and for-profit entities), San Benito County leadership became concerned that the county could possibly lose its only locally controlled full-service hospital, skilled nursing facilities, and rural clinics.

As a result of the healthcare district exploring partnership options, COSB wanted to ensure that the future strategic direction of the hospital best met the needs of the community. As a result, the county engaged ECG to evaluate its strategic options and perform an assessment of HHMH. ECG has been working with COSB and its advisers (who have both legal and investment banking backgrounds) since July 2023 to provide a strategic analysis on future options for HHMH.

Overview of ECG and Engagement Objectives

ECG is a leading national consulting firm with a more than 50-year history of advising health systems, hospitals, medical groups, payers, and providers on a range of issues, including finance, strategy, hospital facilities, operational performance improvement, and interim leadership. COSB hired ECG to advise on the following key questions:

- Can a community the size of San Benito County support a Critical Access Hospital?
- Is there a future path to financial sustainability for HHMH?
- What core strategies are needed to ensure a financially sustainable future for the hospital?
- What options does the county have to support the hospital?

ECG's engagement with COSB had the following key objectives in two phases:

1. Phase One
    a. Meet with COSB executives to discuss the engagement objective, scope, timeline, and deliverable.
    b. Collect publicly available information about HHMH, including regional and national Critical Access Hospital benchmarks.
    c. Identify a range of strategic and operational scenarios for financial evaluation.
    d. Prepare and summarize the financial impact of the scenarios identified above.
    e. Prepare a brief assessment of the strategic considerations associated with each scenario.
    f. Prepare an executive summary of the results from the financial and strategic impact of the scenarios.
2. Phase Two
    a. Develop a preliminary strategic financial feasibility forecast with scenario sensitivities as well as a strategic business plan.
    b. Develop capital assumptions and financial forecast scenarios based on feedback from county leadership.
    c. Develop a detailed physician provider workforce assessment throughout San Benito County.
    d. Provide a strategic business plan summary report to meet long-term financial sustainability objectives.

ECG is extremely grateful to be hired to advise county leadership on HHMH's future viability. We are honored to work with the county's committed leadership team and the Board of Supervisors to help protect locally controlled and locally led healthcare for the residents of San Benito County. Thank you for trusting us with this ever-important task.

HHMH's Current State

HHMH Background

HHMH is a 25-bed critical access hospital located in Hollister, California, and has served San Benito County for more than 100 years. The organization converted to a Critical Access Hospital in March 2020 and serves a critical healthcare need for the community in San Benito County. The hospital provides primary and specialty care, orthopedics, obstetrics (OB), skilled nursing, surgical services, diagnostic imaging, laboratory services, emergency services, multiple rural health clinics, and more. HHMH in addition to the 25-bed critical access hospital, is composed of five rural clinics, two specialty centers, a home health agency, four satellite lab/draw stations, and two skilled nursing facilities (119 beds of SNFs). The organization is operated, and all assets are owned by the SBHCD and receives annual tax revenue support for locally controlled healthcare from the taxpayers of San Benito County.

Factors Contributing to HHMH'S Current Position

For the last 100 years, HHMH has been an essential community hospital providing care to its residents and has served as a leading employer in San Benito County. However, given circumstances outlined in the previous sections, HHMH is at an inflection point. A multitude of factors have contributed to HHMH's current vulnerable position, including the following:

- **Challenging Payer Mix:** San Benito County has proven to be a difficult healthcare payer environment to operate in, with a high percentage of Medi-Cal patients.
- **1099 Physician Contract Model:** HHMH does not employ or align physicians, and the lack of an integrated medical group, physicians who live and work full time in San Benito County have created staffing difficulties at HHMH and made local patient access to physicians extremely difficult. It appears over the years, SBHCD leadership prioritized investment in physical facilities and has not pursued the development of a locally supported physician and medical groups. The current 1099 model is less sustainable because providers are not fully integrated with the health system and some do not even live in the region full time. It is ECG's opinion that not investing in physicians and building a locally supported medical group has been a significant strategic failure. Building an aligned physician group or network has been one the more significant strategies that all hospitals in the U.S. have been deeply involved in over the past two decades. The State of California has even created special support for district hospitals to form and operate medical groups (e.g., 1206B exemption).
- **Out-Migration:** Due to lack of local physicians in multiple specialties, patient out-migration is a significant issue for HHMH, with 57% of inpatient (IP) cases leaving San Benito County for care

in 2021 (source: HCAI data). Both low acuity and higher-acuity cases are leaving the county. Leading factors of out-migration include the following:

  - **Physician shortages** in the market are prevalent. Based on an analysis of provider supply in San Benito County, ECG estimates a current shortage of over 50 physicians in the county (source: ECG independent research through ECG's Provider Network and Community Planning practice).
  - **A lack of local physician access** is leading patients to go elsewhere for both ambulatory and inpatient care. Appointment wait times for crucial services are too long. ECG's Provider Network and Community Planning Practice reached out to various provider offices in the region and found long wait times for third next available appointment that included (source: ECG independent research) the following:
    - Obstetrics/Gynecology: 39 days
    - Hematology-Oncology: 90 days
    - Psychiatry: 120 days
    - Cardiology: 52 days
    - Urology: 52 days
    - Adult Primary Care: 26 days

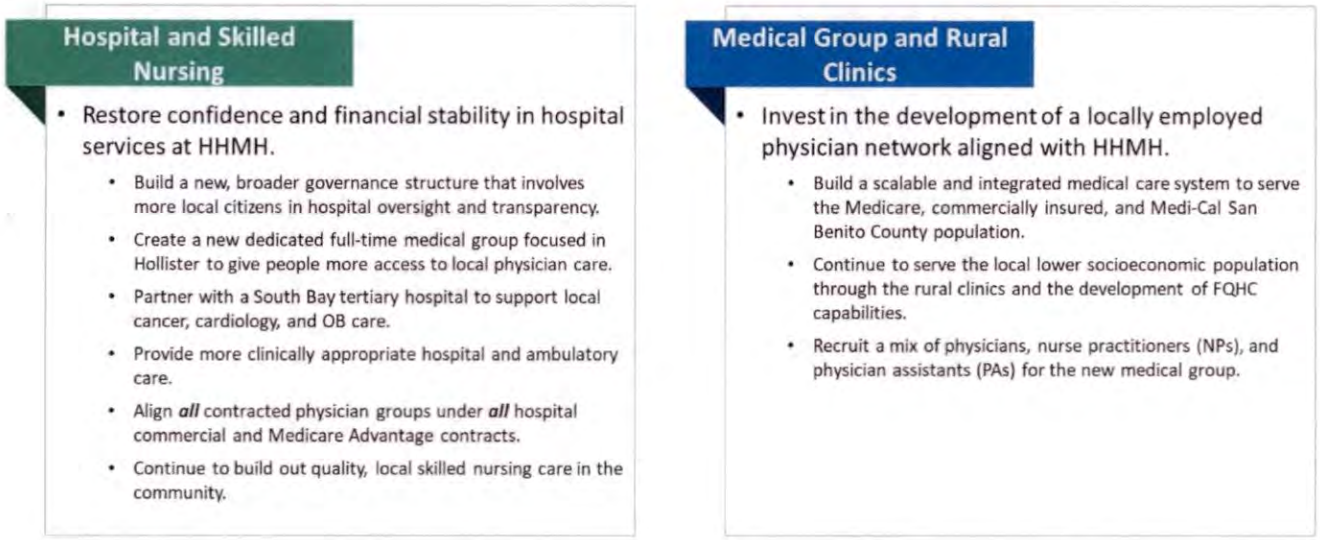
- **No Significant Clinical Partnership:** Without clinical program partnerships with other South Bay tertiary providers or other larger programs, people leave for care and have few alternatives to return for more routine care. Care is not kept local and integrated, causing patients to leave the county for care.
- **Hospital Reputation:** Issues regarding hospital reputation, district financial difficulties, issues with medical billing for some members of the community cause distrust in healthcare for San Benito County residents.

Proposed Business Plan Strategies

The Future of Healthcare at HHMH

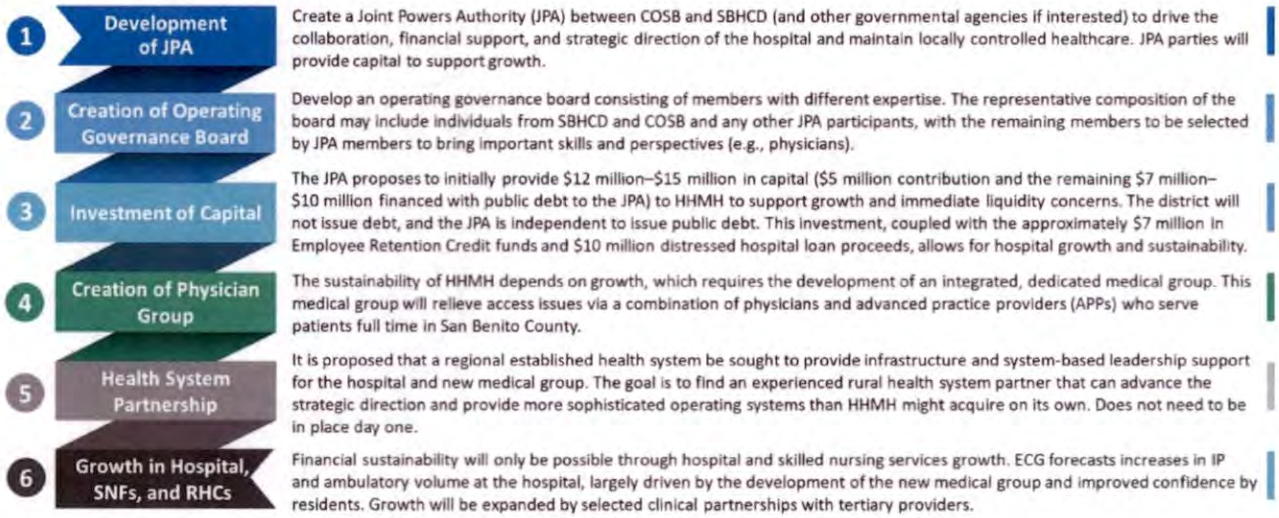
As part of this process, ECG outlined the vision (figure 1) for HHMH to remain a viable community hospital. This vision is anchored in the HHMH staying locally controlled and expanding the quality of healthcare and access to all residents of San Benito County. Perhaps most importantly, a key driver of this concept is further investing in medical providers or a medical group who are aligned and integrated with HHMH to keep care more local and to increase volume of healthcare served locally.

FIGURE 1: Proposed Vision for Healthcare in San Benito County



To achieve this vision, ECG is advising the county to develop six critical strategies summarized in figure 2.

FIGURE 2: Core Strategies for HHMH to Remain a Viable Hospital



With the necessary investment, governance and oversight, ECG believes HHMH has a path to financial sustainability under local control. Just reducing operating expenses is not a viable option for long-term sustainability; there must be a strategy of growth built on physician recruitment, clinical program partnerships, the expansion of clinical services, an infusion of capital, and instilling in the community that safe and effective healthcare can be delivered by HHMH.

Strategy One: Development of a Joint Powers Authority (JPA)

ECG and other county advisers are recommending a JPA among the district, San Benito County, and any other governmental agencies to oversee decision-making, strategic thinking, and control of HHMH. JPAs are exercised when the public officials of two or more agencies agree to create another legal entity or establish a joint approach to work on a common problem, fund/invest in a project, or act as a larger broader representative body for a specific important activity. JPAs offer another way for governments to deliver services (source: Government's Working Together, California State Legislature Senate Local Government Committee). As part of this proposed JPA, the district will maintain ownership of all assets relating to the hospital, SNFs, and rural clinics and will continue to collect all current and future tax revenue. ECG believes that a JPA will benefit the community by:

- Creating better channels of communication between the district and COSB and the community.
- Improving real-time collaboration between the district and COSB on strategic planning and decision-making.

- Maintaining local control and local input assuring that a broad array of healthcare services remains in the community through HHMH (as opposed to the district selling hospital assets to an out-of-state operator and/or for-profit entity to determine local healthcare services).
- Improving financial support for HHMH. COSB being more invested and directly involved in supporting the long-term future of HHMH, the county will have a clearer sense on the overall direction of the hospital and be more comfortable to providing incremental funding support for growth strategies.

Strategy Two: Creation of a Community-Based Operating Governance Board

ECG recommends creating a community-based operating governance board composed of a broader spectrum of community members. Via the JPA, there will be an elected county board of supervisors and elected district members serving on the JPA board. ECG also recommends creating an operating governance board similar to most non-profit community hospitals by adding nonelected members. These nonelected members will have the best interest of the hospital and be able to add specific expertise to oversee hospital operations. These boards will bring more local citizens to oversee and guide HHMH, they build trust among varying factions of the community, will be closer to patients and employees of the hospital, and can build solid expertise to govern a complex entity.

For example, a local prominent physician can serve on the board to guide the expansion of the medical group. Having a community governing board for not-for-profit hospitals is very common and allows hospitals to be nimbler and more focused on strategy. Also, having a larger board of nonelected community-based members allows for greater continuity as district- and county-elected officials are at the behest of election cycles.

Strategy Three: Investment of Capital

As the JPA executes on the strategies outlined in the report, along with investment in capital from JPA members, free cash flows will be improved. Sources of this improved liquidity include the following:

- Distressed Hospital Loan: $10 million
- Employee Retention Credit: $7 million
- JPA Funding: $12 million–$15 million ($5 million contribution and remaining $7 million-$10 million financed with public debt to the JPA)

In addition to the funding sources above, ECG projects that by year five (assuming the JPA executes on the other five strategies), the hospital will have 93 days cash on hand (DCOH) ($47 million) to maintain liquidity and invest in growth and other commitments.

If invested correctly, this additional cash can make a significant difference at HHMH. Figure 3 outlines potential uses of this capital.

FIGURE 3: Potential Uses of Capital

Medical Group Development	In addition to the cash generation projected from operations, the capital investments will be toward developing the medical group to serve local citizens and drive growth.
Deferred Capital Expenditures	HHMH management has outlined the immediate need for infrastructure upgrades within the hospital, which can be funded through the influx of cash.
EHR Funding	Additional capital will be used to fund HHMH's new and enhanced EHR, possibly through the health system management company. This will help attract physicians and improve patient care.
Pension Liability Funding	SBHCD has an unfunded pension liability that over time will be addressed with the additional cash and growth initiatives.
Reserves to Assist with Liquidity Concerns	While HHMH has immediate capital needs to address, a portion of the added cash can be used to build up reserves and curb DCOH concerns in the future.

Strategy Four: Creation of a Physician Group

ECG believes that to create a sustainable growth future for HHMH, it is crucial that the organization has an integrated local medical staff that is committed full time to the San Benito County residents. As noted previously, HHMH's lack of an employed network of physician providers has led to issues with staffing, specifically in the SNFs, and additional billing nuances create difficulties for patients.

The current physician strategy at HHMH is to not employ physicians but to use a 1099 model to staff physicians in the rural clinics and new providers to the community often join an independent practice. This is resulting in many providers working part time in Hollister and the other time in communities north of San Benito County. In ECG's view, this does not take into account the realities of a rural/small town medical practice in 2024. District hospitals in California have alternative models (e.g., HHMH, as a district hospital, is exempt from California Health and Safety Code Section 1206 and is legally permitted to employ physicians via 1206b clinics) to employ physicians and allied providers to build solid, committed, self-perpetuating medical communities in smaller communities and more rural areas. Ongoing financial subsidies for these providers will be required, but without a change in physician strategy, it is unlikely HHMH's financial situation will improve.

ECG recommends, beginning immediately and continuing over the next five to seven years, for the JPA to develop a medical group with 25 to 30 dedicated providers from a range of specialties, with the

inclusion of advanced practice providers (APPs) to support physicians. Though recruiting and retaining providers to smaller communities will be difficult, San Benito County and the city of Hollister is home to a fast growing market, comparatively lower-cost-of -living, moderate housing costs. These factors makes Hollister and San Benito County an attractive location (when compared to high-cost-of-living areas like Salinas Valley, Monterrey or San Jose – South Bay) for young medical professionals interested in rural practice. Young physicians today are largely seeking employment in a supported medical group situation. Very few young physicians are seeking independent practice opportunities or working in independent groups. They prefer employment in supported medical groups.

A reimagined medical staff at HHMH is crucial to ensuring high-quality care to members of its community, growth of inpatient and ambulatory services, and improvement to its reputation from residents. As part of this strategy, ECG recommends that a 25 to 30 provider group can consist of the following:

- **28.5 providers over next seven years**
  - **9.0 primary care (MDs, APPs)**
    - 3.0 in community
    - 6.0 net new
  - **9.5 surgical (e.g., General Surgery, OB/Gyn, Orthopedics)**
    - 3.0 in community
    - 6.5 net new
  - **10.0 medical (e.g., Oncology, Cardiology, Gastroenterology, Pulmonology)**
    - 2.0 in community
    - 8.0 net new

Strategy Five: Health System Partnership

As a part of the county's proposal for a JPA, ECG recommends that the JPA could partner with a larger health system to provide operating systems support and other expertise to HHMH. ECG recommends that HHMH finds an experienced not-for-profit and mission-aligned health system in California to provide expertise and support in the following areas:

- Support development of new medical group by providing expertise.
- Provide experience in strategic deployment of large amounts of capital.
- Potentially enable medical record use. HHMH management has stressed the important of an EHR upgrade within the organization. Through a partnership, HHMH has potential to join the

EHR of a local system. An upgraded EHR will help integrate care and provide a better patient and provider experience.

- Drive progress at HHMH, and execute the strategic business plan. The systems with which the JPA has been in contact have a track record of success and are familiar with the local healthcare landscape. Their experience in the state and expertise with California rural hospital turnarounds is crucial to growth at HHMH.

Additionally, looking for tertiary health systems that will not operate or invest in HHMH, but offer varying levels of support to local healthcare, ECG and The County of San Benito have reached out to tertiary health systems to vet their interest. Stanford Health Care as one such prestigious academic health system expressed interest in an opportunity to partner with Hazel Hawkins Memorial Hospital on supporting clinical care. Stanford offers a Second Opinion Program that provides access to expertise to their vast expertise network for care without patients having to leave their community (source: Stanford Health Care).

During these conversations, clinical partnerships have been discussed for high acuity specialties such as cancer, high-risk obstetrics, and cardiology. Similar discussions have been held with multiple health systems in the region relating to similar partnerships. These partnerships will help to enhance care offerings to San Benito County residents who would otherwise seek care elsewhere.

Strategy Six: Growth in the Hospital, SNFs, and RHCs

ECG believes that the JPA will position HHMH for improved financial outlook at the hospital largely driven by growth resulting from capital investments in medical group development, and improved community reputation. Given these factors, ECG believes HHMH has further opportunity to improve financial operations for the hospital, SNF, and RHCs. Key strategies include:

- Clinical Service Line Expansion at Hospital: By expanding on the clinical services offered at HHMH and keeping more cases local, case mix index (CMI; which measures patient acuity) at HHMH is expected to increase to a level in line with other California Critical Access Hospitals. This increase in CMI will correspond to increases in revenue. With a new physician base, ECG has forecasted a 10% increase in overall market share driven by the following:
    - **Cardiology:** Develop a cath lab at HHMH to help keep more cardiology cases in the community.
    - **OB:** In 2021, HHMH delivered 412 births, 49% of the San Benito County total. This market share of births is low in relation to the clinical capability and facilities available at the hospital. Based on the growth rate of births in the county from 2017 to 2021 (3.2% CAGR), ECG estimates over 1,000 births by 2027. This creates significant opportunity to

keep more births at HHMH for a service that residents should not have to out-migrate for. Obstetric clinical partnerships are a way to further support local care.

  - **General Surgery/Orthopedics:** Adding more dedicated general and orthopedic providers allows for lower-acuity surgeries to stay local. Given favorable rates for these surgeries, HHMH will be able to serve these patients locally.

- **Clinic Strategy:** ECG recommends continuing to serve the local lower socioeconomic population through the rural clinics and by converting two rural clinics to FQHCs in the long term. FQHCs offer a vehicle to serve Medi-Cal patients in a more efficient and sustainable manner.
- **SNF Strategy:** The SNFs remain one of the most profitable components (and serve as a critical mission to the local community) of HHMH, but there is capacity to grow volume here and use the HHMH provider base and improved reputation to reach capacity (recommend target of 85%–90%).

Financial Summary

ECG conducted multiple sensitivity analyses to determine the future financial sustainability of HHMH. This included the testing of various volume and expense growth levels, medical group development of different sizes, FQHC conversion and various financial impacts, the inclusion of capital commitments such as a new EHR, and much more. Two final financial forecast scenarios were ultimately developed: the status quo (baseline) and a growth scenario. An overview of each scenario and the resulting outlook is seen in figure 4.

FIGURE 4: Financial Scenario Overview

Status Quo (baseline)	Growth Scenario

• Assumes that no material changes are made to the hospital and its operations
  • Minimal volume growth aside from the already high-performing SNFs
  • No development of a medical group
  • Expenses growing at inflationary levels
  • Less revenue growth than growth scenario due to a lack of a medical group
  • No FQHC conversion of rural clinics
  • No JPA development/funding
  • $3 million downward pro forma adjustment to labor expense
  • Employee Retention Credit
  • Distressed hospital loan
 	
Outlook: In the absence of outside assistance or substantial changes, ECG forecasts HHMH's financial position to continue deteriorating as expenses outpace revenue.
	• Increase hospital IP occupancy to roughly 90% by year 10
	• SNF to reach capacity (90%) by year 2
	• Development of a medical group leading to increases in volume/revenue
	• Conversion of two rural clinics to FQHC status
	• $3 million downward pro forma adjustment to labor expense
	• Inclusion of the following items:
	  • Employee Retention Credit
	  • Distressed hospital loan
	  • Gradual pension payment
	  • EHR funding
	
	Outlook: In the growth scenario, ECG forecasts net income margin to increase from 4% to 8% in the 10-year period, largely led by increased IP and ambulatory services volume at the hospital, with increasing liquidity.

The following additional items were also included in ECG's analysis:

- Status Quo (baseline)
  - Employee Retention Credit: $7 million favorable pro forma adjustment to 2023 financials
  - Distressed hospital loan: $10 million favorable pro forma cash adjustment, $10 million associated liability
- Growth Scenario (the same additions mentioned above, in addition to those below)
  - Gradual pension payment: $2 million annual pension payment, $2 million associated cash decrease annually
  - EHR funding: $2 million annual capital commitment in years one to five

- JPA funding: $12 million–$15 million ($5 million contribution and remaining $7 million–$10 million financed with public debt to the JPA)

The resulting summary-level financial projections for each scenario are seen in figure 5.

FIGURE 5: Financial Summary of Scenarios

	Historical		Forecast									
	2023	Nov. 2023 TTM	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Status Quo (baseline)												
Operating Income	$(1,018,530)	$2,933,447	$154,948	$(1,869,879)	$(3,929,619)	$(5,226,364)	$(5,918,239)	$(6,017,683)	$(6,441,472)	$(6,716,398)	$(7,193,800)	$(7,866,222)
EBIDA	$6,239,017	$10,340,818	$8,327,304	$6,443,359	$4,437,707	$3,207,846	$2,595,260	$2,587,141	$2,261,361	$1,720,793	$1,028,782	$242,480
EBIDA Margin	4.1%	6.9%	5.5%	4.1%	2.8%	2.0%	1.6%	1.5%	1.3%	1.0%	0.6%	0.1%
Operating Cash	$14,441,825	$18,849,384	$35,909,306	$35,114,765	$32,309,491	$28,003,195	$22,807,680	$19,233,907	$15,310,911	$11,642,345	$8,066,653	$3,646,778
Operating DCOH	35.0	48.4	88.6	83.4	74.0	62.4	49.7	41.1	32.0	23.8	16.1	7.1
Growth Scenario												
Operating Income	$(1,018,530)	$2,933,447	$2,091,338	$2,298,824	$2,077,104	$3,734,047	$5,204,917	$7,265,337	$9,129,696	$10,969,987	$12,881,716	$14,689,706
EBIDA	$6,239,017	$10,340,818	$12,163,693	$12,212,062	$12,244,430	$14,168,256	$15,418,416	$17,070,161	$19,032,529	$20,407,179	$21,904,298	$23,398,409
EBIDA Margin	4.1%	6.9%	7.6%	7.2%	6.9%	7.6%	7.9%	8.5%	9.1%	9.4%	9.8%	10.1%
Operating Cash	$14,441,825	$18,849,384	$37,183,402	$39,285,752	$40,402,326	$42,994,648	$46,651,951	$54,004,258	$63,281,722	$74,769,823	$88,510,924	$103,678,867
Operating DCOH	35.0	48.4	89.1	89.0	87.1	89.0	93.0	104.7	119.1	136.4	157.3	179.4

Under the growth scenario, there is a path to long-term financial sustainability that depends on executing the strategic plan. However, under the status quo scenario, inflationary expense increases will outpace revenue and erode margins. Under the status quo scenario, days cash on hand (DCOH) increases initially as a result of the Employee Retention Credit and the distressed hospital loan. However, without significant changes to operations, ECG forecasts DCOH to decline substantially as margins erode. On the other hand, the growth scenario forecasts DCOH to be over 150 days by year 10. ECG tested a variety of scenarios to analyze the impact on liquidity. This included additional pension funding (both scenarios assume a $2 million pension payment for the first 10 years), EHR investment, and medical group subsidy. In addition, ECG assumed HHMH will exit bankruptcy and salaries will increase to a level in line with historical amounts. Under reasonable assumptions relating to these items, the growth scenario continued to show substantial improvements in DCOH.

Conclusion

Given the approaches outlined in this document, ECG believes a community hospital in this growing market, with JPA support and relatively good facilities, can be successful and can stay under local control and not be sold to a for-profit provider. A future path must be about growth of services, which inherently is about developing a dedicated medical staff. As such, we recommend that district and county leadership continue to explore options to collaborate.

Appendix A
Market Assessment

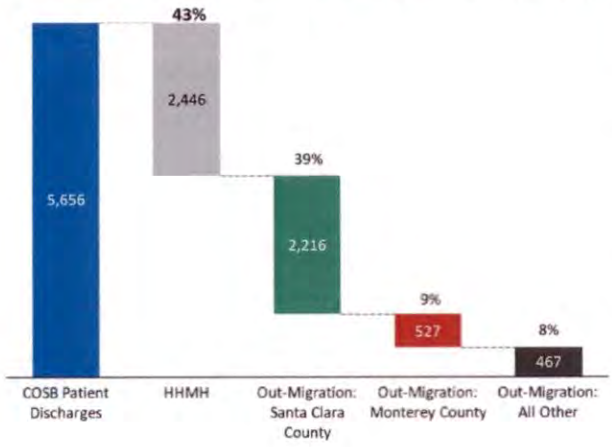
APPENDIX A

Market Assessment

Based on ECG's assessment, San Benito County is a growing market that can support a Critical Access Hospital like Hazel Hawkins Memorial Hospital (HHMH). From 2019 to 2022, San Benito County grew at a rate more than 2.5% higher than that of Monterey County and California. ECG expects this trend to continue as new developments are arising in the county and housing remains more affordable than that of surrounding areas.

Out-migration is an issue that needs to be addressed at HHMH, as 57% of inpatient (IP) cases are occurring outside of San Benito County (source: HCAI). In 2021, 39% of San Benito County residents sought IP care in Santa Clara County, led by Stanford Health Care and Good Samaritan Hospital–San Jose. Just under 10% of San Benito County residents received IP care in Monterey County, led by Salinas Valley Health Medical Center and Community Hospital of the Monterey Peninsula. HHMH's low CMI—over 0.50 less than that of Salinas Valley, Good Samaritan–San Jose, and Stanford Health Care—suggests that higher-acuity cases are often leaving the county (source: HCAI).

IP Discharges of Patients Living in San Benito County (2021)



Top-Five Out-Migration IP Discharge Destinations (2021)

Facility	Out-Migration Discharges (2021)	Discharge Market Share
Stanford Health Care	422	7%
Good Samaritan–San Jose	422	7%
Kaiser Permanente San Jose Medical Center	350	6%
St. Louise Regional Hospital	323	6%
Salinas Valley	232	4%
All Other	1,461	26%

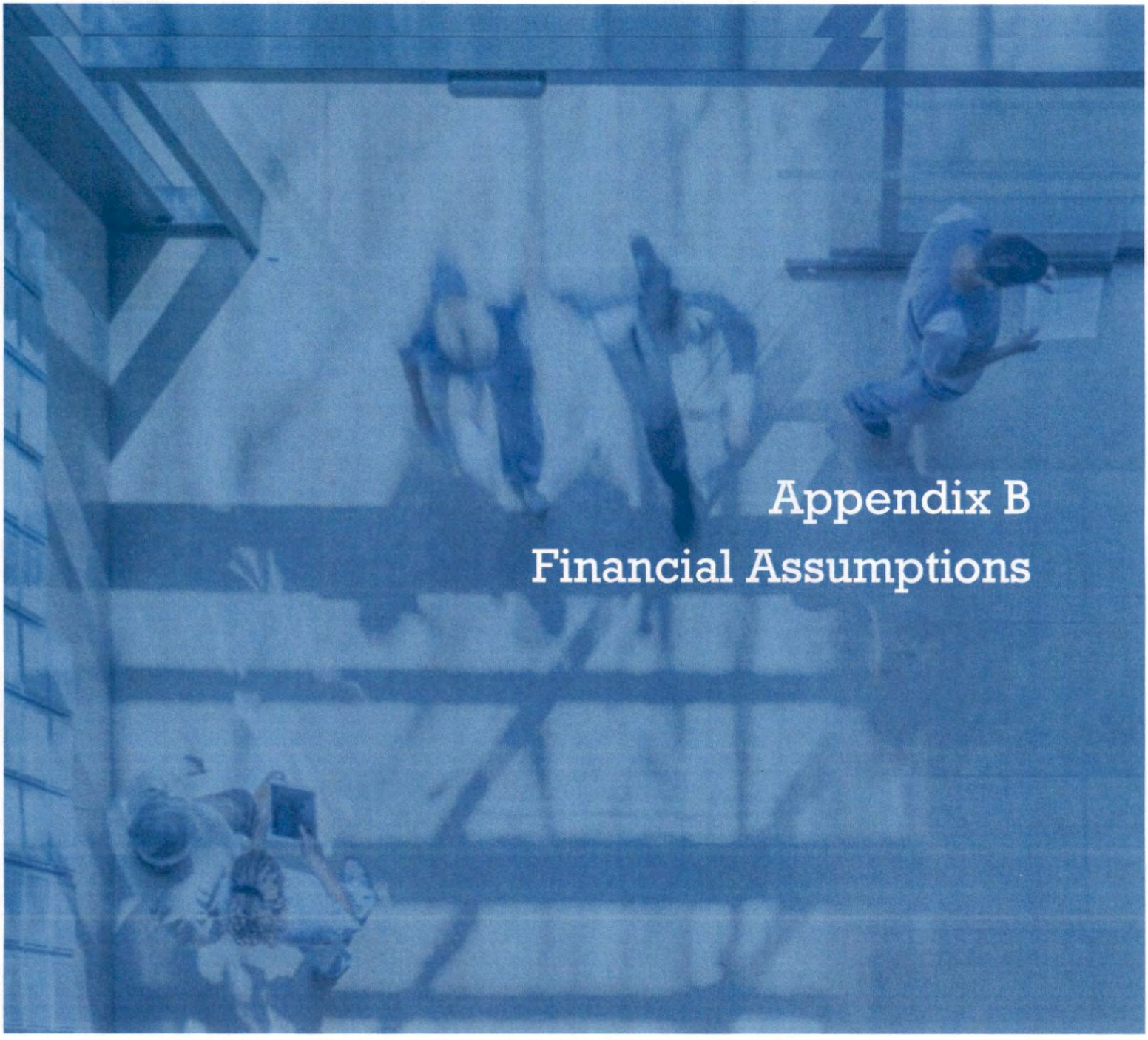
Provider Shortage

Based on an analysis of provider supply in San Benito County, ECG estimates a current shortage of over 50 physician FTEs in the county.

Specialty	Current Shortage	Growth Need	Physician Succession Risk
Core Specialties			
Adult Primary Care	8.8	2.1	2.4
Pediatrics	4.2	0.6	1.7
Obstetrics/Gynecology	4.4	0.6	-
Psychiatry	4.2	0.5	0.4
Core Specialties Total	**21.6**	**3.8**	**4.5**
Medical Specialties			
Allergy/Immunology	1.0	0.1	-
Cardiology	2.4	0.4	0.8
Dermatology	2.0	0.2	0.2
Endocrinology	0.5	0.1	-
Gastroenterology	2.2	0.2	0.3
Hematology-Oncology	2.0	0.2	0.2
Infectious Disease	1.5	0.2	-
Interventional Radiology	0.8	0.1	-

Specialty	Current Shortage	Growth Need	Physician Succession Risk
Medical Specialties *(continued)*			
Nephrology	1.1	0.1	0.2
Neurology	1.9	0.2	-
Physical Medicine/Rehab	1.8	0.2	-
Pulmonology/Critical Care	2.3	0.2	-
Rheumatology	1.1	0.1	-
Medical Specialties Total	**20.6**	**2.3**	**1.7**
Surgical Specialties			
General Surgery	3.6	0.4	-
Ophthalmology	1.4	0.3	-
Orthopedic Surgery	3.0	0.3	-
Otolaryngology	1.2	0.2	-
Urology	1.5	0.2	0.1
Surgical Specialties Total	**10.7**	**1.4**	**0.1**
Grand Total	**52.5**	**7.4**	**6.3**

This shortage stresses the need for a committed medical group in San Benito County that can attract young professionals to the region.



Appendix B
Financial Assumptions

APPENDIX B

Financial Assumptions

Key Operating Assumptions: Status Quo (baseline)

Hospital

- **Annual inpatient (IP) volume increases, years 1–10**
  - Medicare: 0.5%
  - Medi-Cal: 0.5%
  - Commercial: 0.5%
- Year 1 acute IP discharges: 2,141
- Year 10 acute IP discharges: 2,238
- **Annual IP revenue per discharge increases, years 1–10**
  - Medicare, Medi-Cal, and commercial: 1.25%
- **CMI remaining consistent**
- **Outpatient**
  - Visit growth of 0.5% annually; year 1: 111,574; year 10: 116,697
  - Revenue per visit growth of 1.5% annually
- **Labor expense decrease:** $3 million pro forma adj.

SNF

- **3.0% discharge growth in year 1, tapering off to 0% in year 5**
- **Revenue per patient day growth**
  - 2% annually
- **Inflationary expense projections**

Rural Clinics

- **No conversion of clinics to FQHC**
- **RHC visit growth**
  - 0.5% annually
- **RHC revenue per visit growth**
  - 1.0% annually
- **Inflationary expense projections**

Medical Group

- **n/a**

Key Operating Assumptions: Growth Scenario

Hospital

- **~10% market share increase from 2023 to year 10**
- **Annual IP volume increases, years 1–5**
  - Medicare: 3%
  - Medi-Cal: 3%
  - Commercial: 5%
- Year 1 acute IP discharges: 2,202
- Year 10 acute IP discharges: 2,749[1]
- **Annual IP revenue per discharge increases years 1–10**
  - Medicare, Medi-Cal, Commercial: 1.5%
- **CMI increase: 1.15 to 1.30**
- **Outpatient**
  - Visit growth in line with aggregate IP growth; year 1: 114,905; year 10: 145,572.
  - Revenue per visit growth: 2% annually
- **Labor expense decrease:** $3 million pro forma adj.

SNF

- **90% occupancy in year 2,** assume SNFs can be staffed at this level
- **Revenue per patient day growth**
  - 2% annually
- **Inflationary expense projections**

Rural Clinics

- **Conversion of two largest rural clinics to FQHCs**
  - 4180 Sunset
  - 4187 Fourth Street
- Increased revenue per visit growth at the two FQHCs
- **RHC visit growth**
  - 2% annually

Medical Group

- **28.5 providers over seven years**
  - **9.0 primary care (MDs, NPs, and PAs)**
    - 3.0 in community
    - 6.0 net new
  - **9.5 surgical**
    - 3.0 in community
    - 6.5 net new
  - **10.0 medical**
    - 2.0 in community
    - 8.0 net new
- **MGMA West Region median compensation benchmarks**
- **Additional annual overhead**
  - Physician: $175,000
  - APP: $100,000

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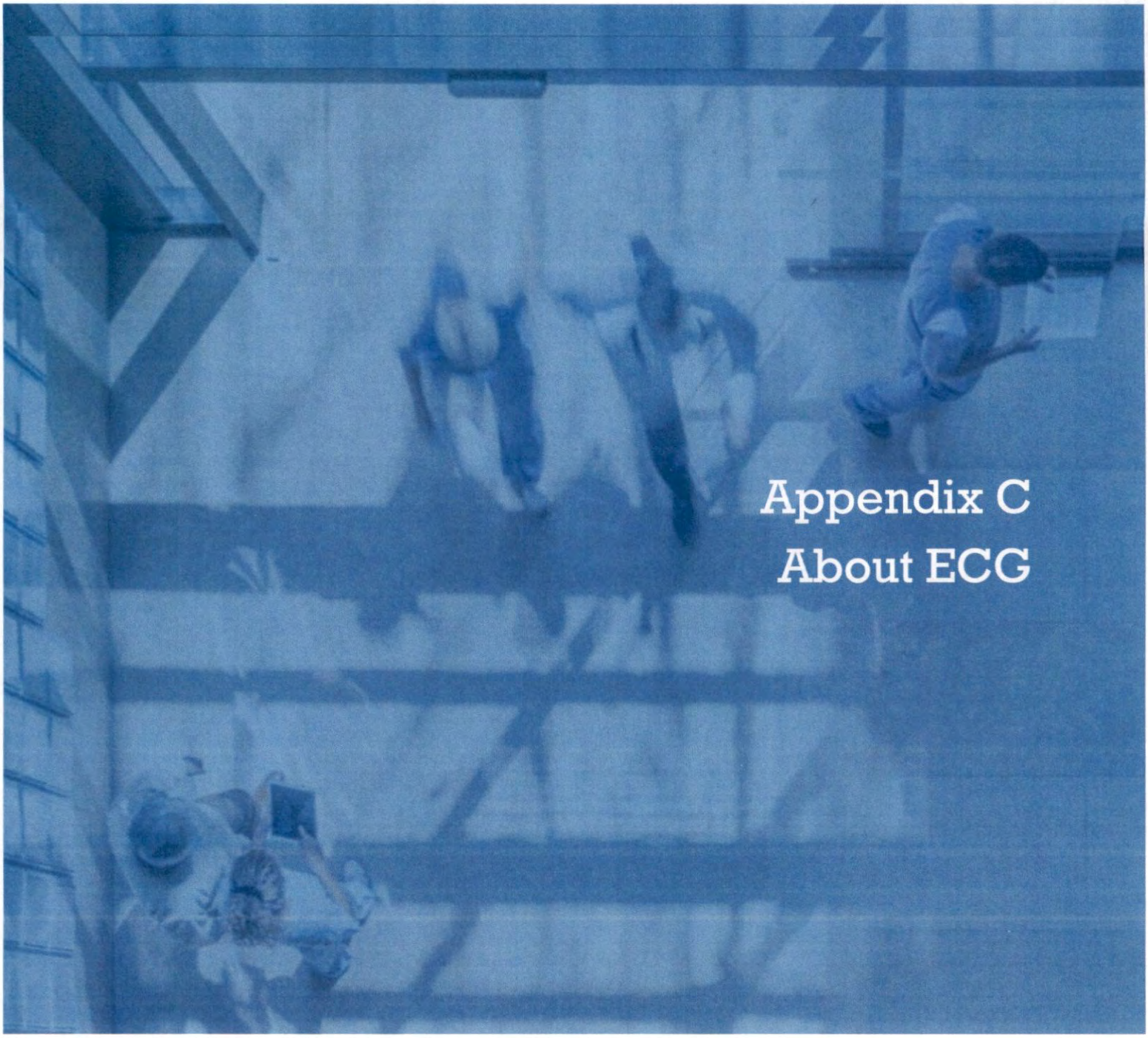
1 Growth is predicated on general surgery, OB/GYN, cardiology, and other focused specialties.



Appendix C
About ECG

APPENDIX C

About ECG

ECG has organized a team of professionals with an extensive background in strategic planning, competitive market analysis, advanced demand modeling, and comprehensive merger and acquisition planning. We are forward thinking; we challenge ourselves and our clients to plan for the health systems of tomorrow, envision the evolution of care delivery, foresee breakthroughs in treatment and technology, and imagine a care environment that will dramatically change health outcomes for our clients' communities.

ECG is a national healthcare consulting firm composed of approximately 240 consultants, with nine offices nationwide: Atlanta, Boston, Chicago, Dallas, Minneapolis, San Diego, Seattle, St. Louis, and Washington, DC.

Since our founding in 1973, ECG has specialized in providing consulting assistance exclusively to healthcare providers. We have completed nearly 17,700 major consulting projects for more than 3,100 leading healthcare organizations. Our clients include hospitals and health systems, children's hospitals, health sciences centers, faculty practice plans, physician group practices, and research organizations. More than 80% of our clients ask us to lead additional projects—a statistic that we believe underscores the high quality and value of our work.

The evolution of the US healthcare market toward value-based care is creating unprecedented change—in clinical services, payment reforms, organizational structures and leadership, technology enablers and disruptors, and patient expectations. Further, the pace of this change continues to accelerate. ECG's seasoned consultants help organizations navigate the country's ever-changing healthcare delivery system and have the experience and insight to address the most difficult challenges.

Tackling today's complex and interconnected healthcare problems requires knowledge and expertise across multiple disciplines, and that is what we deliver to our clients every day. ECG believes it is crucial to understand how the various strategic, clinical, operational, financial, and technological components of the successful 21st-century healthcare organization interact. Therefore, we take a strategic approach and bring an integrated perspective to every project, recognizing how each component is informed by an understanding of its consequences for the other areas.

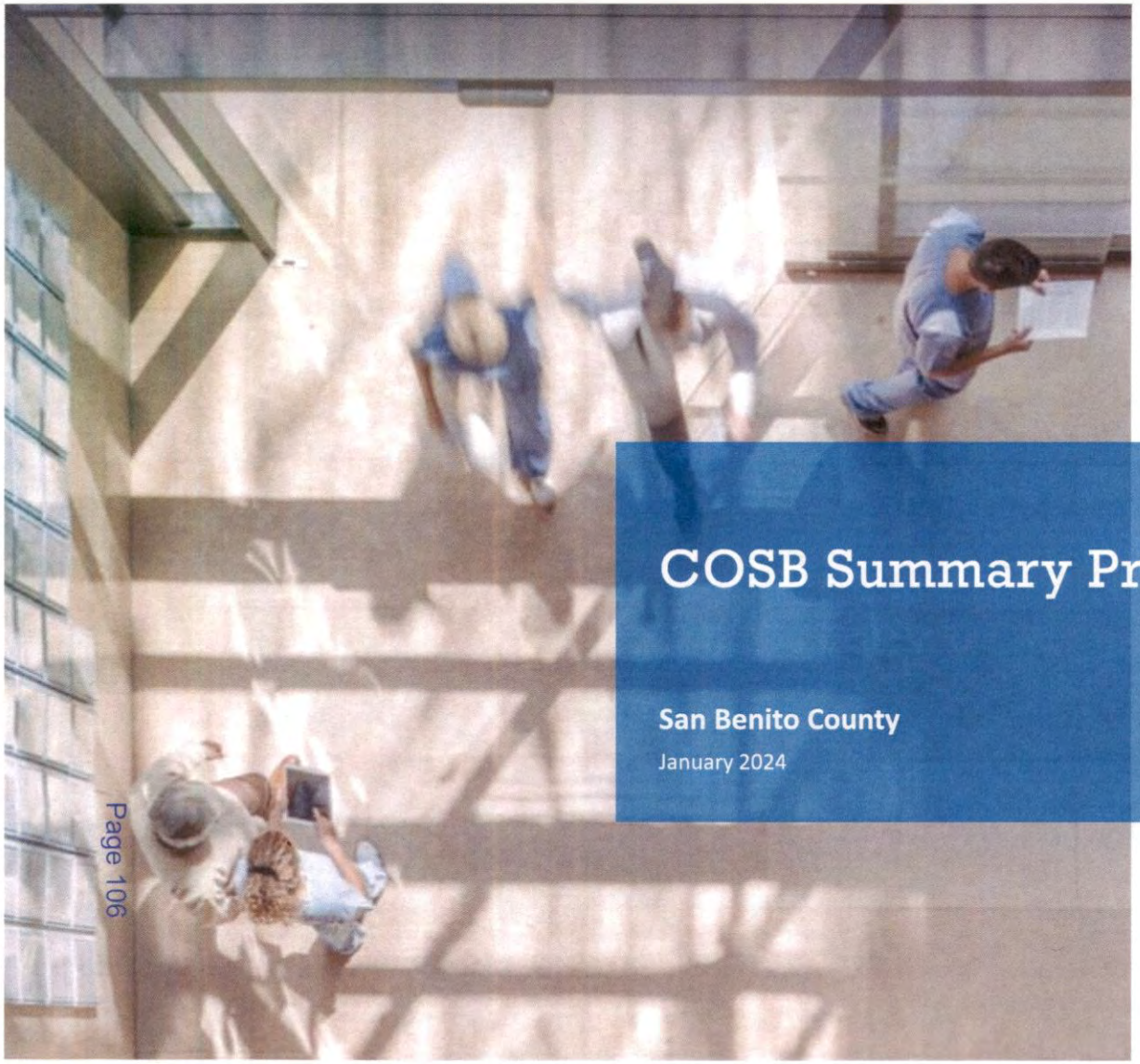
ECG has a long history of assisting healthcare providers and organizations to better understand their environments and craft the transformational strategies and tactics needed to achieve their strategic, business, and mission objectives. We know there is no "one size fits all" approach and pride ourselves on our ability to tailor recommendations based on local market dynamics, strategic strengths, financial realities, and leadership objectives. Successful planning requires deep industry knowledge and expertise, rigorous data and analytics, strategic foresight, political and organizational savvy, and most important of all, practical solutions that can be implemented.

ECG was named top overall healthcare management consulting firm in a *2021 Best in KLAS* report.

ECG has worked with: 17 of the 20 members of *U.S. News & World Report*'s Best Hospitals Honor Roll

85 of 100 Great Hospitals in America as ranked by

PRELIMINARY PROPOSAL FOR DISCUSSION



COSB Summary Proposal

San Benito County

January 2024

Agenda

1. Meeting Objectives
2. Summary of Proposal – County of San Benito (COSB) to San Benito Health Care District (SBHCD)
3. Vision, Strategies, and Funding
4. Financial Analyses
5. Next Steps

Our Objectives

1. Discuss the County of San Benito's (COSB) proposal to work with San Benito Health Car District (SBHCD) and support Hazel Hawkins Memorial Hospital (HHMH)

2. Present our vision, strategies, and funding options for HHMH

3. Discuss the process to work together to reach an optimal option for locally contr healthcare for San Benito County citizens

Summary of Proposal to SBHCD

Development of JPA

Create a Joint Powers Authority (JPA) between COSB and SBHCD (and other governmental agencies if interested) to drive collaboration, financial support, strategic direction of the hospital, and maintain locally controlled healthcare. JPA parties will provide capital to support growth.

Creation of Operating Governance Board

Develop an operating governance board consisting of members with different expertise. The representative composition of the Board may include individuals from SBHCD and from COSB, any other JPA participants with the remaining members to be selected by JPA members to bring important skills and perspectives (e.g., physicians).

Investment of Capital

The JPA proposes to initially provide $12-15M in capital ($5M contribution and remaining $7-$10M will be financed with public debt to the JPA) to HHMH to support growth and immediate liquidity concerns. The district will not issue debt and the JPA is independent to issue public debt. This investment, coupled with the ~$7M in Employee Retention Tax Credit funds, and $10M distressed hospital loan proceeds allows for hospital growth and sustainability.

Creation of Physician Group

Sustainability of HHMH is dependent on growth, which requires the development of an integrated, dedicated medical group. This medical group will relieve access issues via a combination of physicians and APPs who serve patients full-time in San Benito County.

Health System Partnership

It is proposed that a regional established health system is sought to provide infrastructure, and system-based leadership support for the hospital and new medical group. The goal is to find an experienced rural health system partner that can help advance the strategic direction and provide more sophisticated operating systems that HHMH might acquire on its own. Does not need to be in place day one.

Growth in Hospital, SNF, & RHCs

Financial sustainability will only be possible through hospital and skilled nursing services growth. ECG forecasts increases in inpatient and ambulatory volume at the hospital, largely driven by the development of the new medical group and improved confidence by residents. Growth will be expanded by selected clinical partnerships with tertiary providers.

Hazel Hawkins – Health System Vision

Hospital & Skilled Nursing

- Restore confidence and financial stability in hospital services at Hazel Hawkins.
  - Build new broader governance structure that involves more local citizens in hospital oversight – transparency
  - Create new dedicated full-time medical group focused in Hollister to give local people more access to local physician care
  - Partner with South Bay tertiary hospital to support local cancer, cardiology care and OB care
  - Provide more clinically appropriate hospital and ambulatory care
  - Align ALL contracted physician groups under ALL hospital commercial and Medicare Advantage contracts
  - Continue to build out quality, local skilled nursing care in the community

Medical Group & Rural Clinics

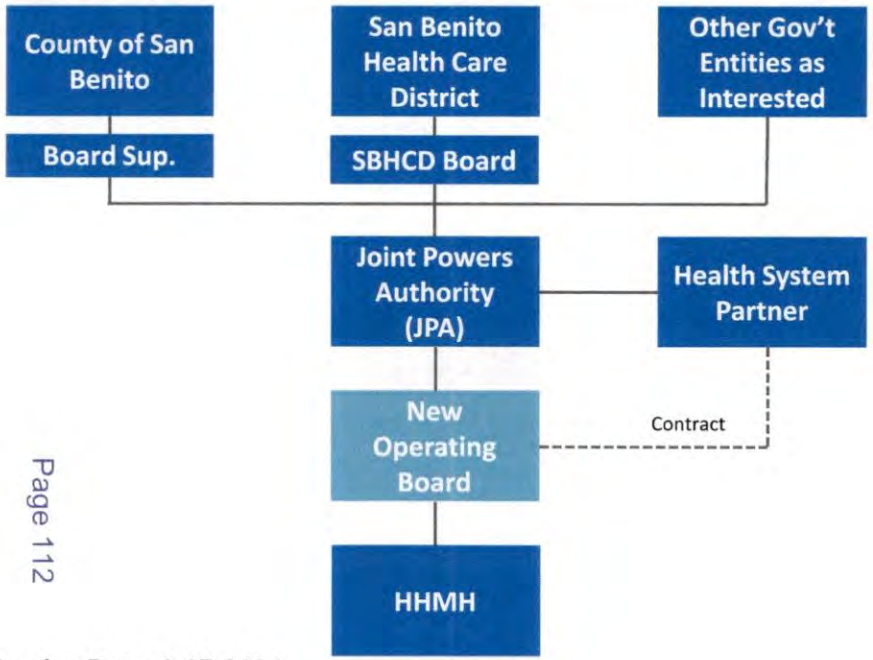
- Invest in the development of a locally employed physician network aligned with Hazel Hawkins
  - Build a scalable and integrated medical care system to serve the Medicare, commercially insured, and Medi-Cal San Benito County population
  - Continue to serve the local lower socio-economic population through the rural clinics and through the development of FQHC capabilities
  - Recruit a mix of physicians, nurse practitioners and physician assistants for the new medical group

Strategies and Funding

Development of JPA

The County proposes a Joint Powers Authority (JPA) to govern HHMH, with Board seats offered to each involved party. The JPA will enter into a contract with a local system to support the operations of HHMH.

JPA Governance Structure



Proposal Overview

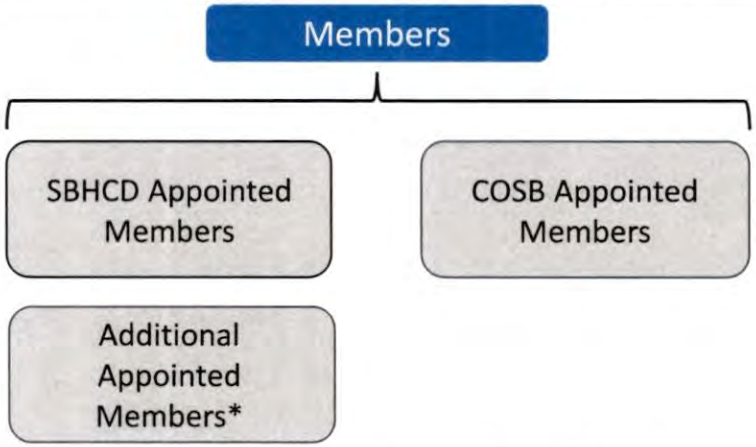
- The Joint Powers Authority (JPA), **consisting of the San Benito Healthcare District, the County of San Benito, and possibly others as interested,** will come together to support a new vision to invest, grow, and manage HHMH.
- The District will continue to own all assets relating to the hospital, SNF, and rural clinics, and will continue to collect all current and future tax revenue.
- The County of San Benito proposes the possibility of adopting of an ongoing fee for any new Community Facilities District "CFD" (a special tax district formed when property owners within a geographic area agree to impose a tax) on the property to fund hospital services.
- The JPA will enter into a contract with an experienced rural health system providing HHMH with oversight, operating systems, and functional expertise.
- The JPA will delegate specific operational and governance authorities to the new local community board selected by the JPA.

Meeting Date: 1-17-2024

Creation of Operating Governance Board

The County proposes the creation of an operating governance Board made up of local community members to help guide hospital strategy and operations.

Potential Operating Governance Board Composition



- **Physicians, nurses, and other providers** will be ideal options for new operating governance board members.

Key Characteristics and Implications

- The operating governance Board is to be **comprised of local community members**, starting with four appointments from both the San Benito Health Care District and the County of San Benito, as well as additional members.
- The JPA partners will jointly select the additional members, potentially **including healthcare providers** and others to help drive the strategic mission of HHMH.
- All Board members will be **local San Benito County residents** with varying backgrounds and areas of expertise.
- To ensure the success of HHMH going forward, this operating governance **Board made up of community members is imperative.** To improve the reputation of the organization, provide broader input into strategic and operational decisions, as well as support quality developments. Residents must feel that the governing body has additional skills necessary to drive change for people of San Benito County.

Investment of Capital

With the combination of the distressed hospital loan, employee retention tax credit, and JPA funding, HHMH will be provided with a substantial influx of cash that can be deployed within the new organization under new broader public governance and experienced rural hospital management.

2024 HHMH Capital Additions

Capital Items	Amount ($M)
Distressed Hospital Loan	$10M
Employee Retention Tax Credit	$7M
JPA Contribution	$5M
Public Debt Issued to JPA	$7M-$12M
Total Additional Capital in 2024	**$29-32M**

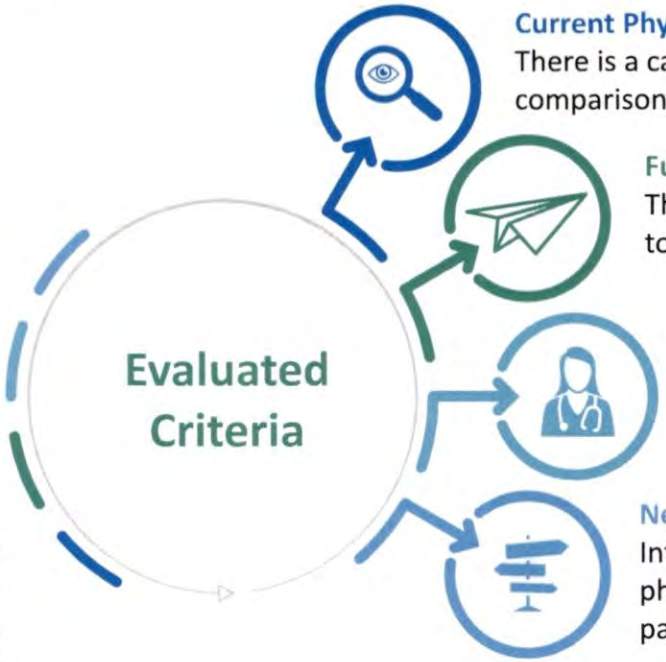
These potential uses of capital have been included in financial sensitivity analyses and forecast a financially sustainable organization when doing so.

Potential Uses of Capital

Medical Group Development	In addition to the cash generation projected from operations, the capital investments will be invested in developing the medical group to serve local citizens and drive growth.
Deferred Capital Expenditures	HHMH management has outlined the immediate need for infrastructure upgrades within the hospital which can be funded through the influx of cash.
EMR Funding	Additional capital will be used to fund HHMH's new and enhanced EMR, possibly through the health system management company. This will help attract physicians and improve patient care.
Pension Liability Funding	SBHCD has an unfunded pension liability that over time will be addressed with the additional cash and growth initiatives.
Reserves to Assist with Liquidity Concerns	While HHMH has immediate capital needs to address, a portion of the added cash can be used to build up reserves and curb days cash on hand concerns in the future.

Creation of Physician Group

ECG performed an analysis of overall physician needs in the County of San Benito. The physician need analysis for the County of San Benito was summarized into four categories.



Current Physician Shortage/(Surplus)
There is a calculated shortage of physicians in the community based on a comparison of physician demand less verified physician supply.

Future Incremental Growth Need
There is an additional projected demand for physician services due to anticipated population growth over the next five years.

Known Succession Risk
There are physicians in the service area over age 60 who will eventually require succession replacement.

New-Patient Access Barriers
Information gathered during primary source verifications indicates physicians have long average days to third next, non-urgent new-patient appointment.

Current Shortage
52.5 Physician FTEs

Future Incremental Growth Need
7.4 Physician FTEs

Known Succession Risk
6.3 Physician FTEs

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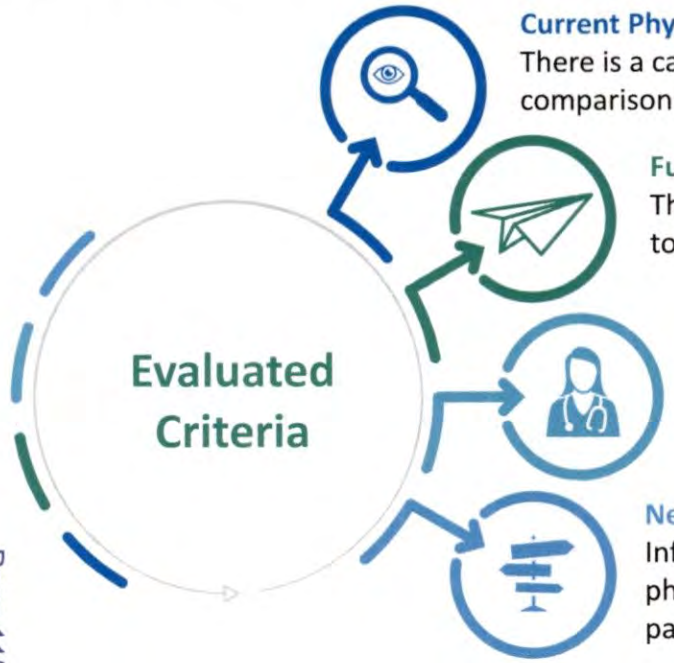

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New-Patient Access Barriers
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Creation of Physician Group *Cont.*

The development of an integrated medical group is critical to support the local population and combat the physician shortages in the market. In addition, medical group development is needed to grow local healthcare services.

Medical Group Development: Key Assumptions

- **28.5 providers over 7 years**
  - **9 Primary Care (MDs, NPs, PAs)**
    - 3 in community
    - 6 net new
  - **9.5 Surgical**
    - 3 in community
    - 6.5 net new
  - **10 Medical**
    - 2 in community
    - 8 net new
- **MGMA West Region median compensation benchmarks**
- **Overhead costs:**
  - One-time EMR cost per provider: $20,000
  - Additional annual physician overhead: $175,000
  - Additional annual APP overhead: $100,000

Total annual support costs per provider and staffing ratio of physicians to APPs is assumed in all financial analyses.

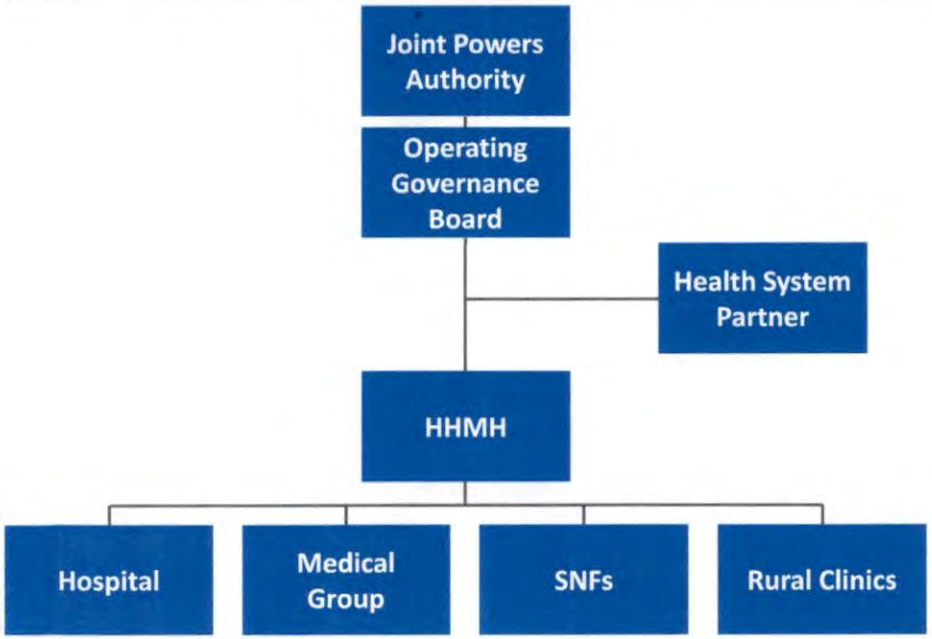
Key Insights

- To create a sustainable future for HHMH, **it is crucial that the organization has an integrated medical staff that is committed full time to the County of San Benito residents**.
  - HHMH's lack of an employed network of providers has led to issues with staffing, specifically in the SNF, and additional billing nuances creating difficulties for patients.
- Over 5 to 6 years, ECG forecasts the development of a **medical group with 25-30 dedicated providers from a range of specialties**, with the inclusion of APPs to support physicians.
- ECG has included **substantial overhead for providers in its analyses, including EMR funding**, and projects a financially sustainable future through overall growth
- Though recruiting and retaining providers will be difficult, a growing market and comparatively affordable living **makes Hollister and the County of San Benito an attractive location for young professionals interested in rural practice.**
- A reimagined medical staff at HHMH is crucial to ensuring high quality care to members of its community, growth of inpatient and ambulatory services, and **improving its reputation in the eyes of local residents.**

Health System Partnership

As a part of the County's proposal for a JPA, it is proposed that the JPA would partner with a health system to provide operating systems and other expertise to HHMH.

HHMH Management Structure



Management Initiatives

- As a result of HHMH's bankruptcy, declining volumes, and shrinking service profile, it is proposed that the JPA brings in a comprehensive and experienced health system to partner with the enterprise operating a community-based hospital.
- Partnering with a local health system will help grow HHMH's scope as a critical access hospital. **This could also evolve into clinical partnerships with the selected system or others, including academics.**

Contract Rationale

- Expertise in new medical group development
- Experience in strategic deployment of large amounts of capital
- Potential for new EMR development
- Drive progress at HHMH and execute the strategic business plan
- Expertise in CA rural hospital turn-arounds

Meeting Date: 1-17-2024

Growth in Hospital, SNF, & RHCs

ECG forecasts an improved financial outlook at the hospital largely driven by growth resulting from reduced outmigration, medical group development, and improved community reputation.

Hospital: Strategic Initiatives & Goals

Volume Growth (IP and OP)	Financial sustainability at the hospital is contingent upon growth in patient volume, specifically Medicare and Commercial payers. As a result of consistent staffing and improved reputation, occupancy is forecasted to increase from ~70% to ~90%.
Revenue Increase (IP and OP)	As higher acuity cases remain local and CMI increases, revenue per unit of service in both the inpatient and outpatient setting is forecasted to slightly increase, specifically for Medicare and Commercial payers.
Service Line Expansion	HHMH has the opportunity to partner with regional tertiary systems on certain specialties such as cancer, OB, and cardiac. Through preliminary discussions, multiple organizations have expressed interest in discussions.
CMI Increase	By expanding on the services offered at HHMH and keeping more cases local, CMI at HHMH is expected to increase to a level in line with other California critical access hospitals. This increase in CIM will correspond to increases in revenue.
Improved Community Reputation	Growth in the hospital is dependent on an improved reputation of the hospital within the community. To reduce outmigration, specifically with higher acuity cases, the County of San Benito population must have trust and confidence in its local healthcare provider. This will be done by investing in a medical group with high quality providers dedicated to San Benito County.

Key Assumptions – Growth Scenario

- **~10% market share increase from 2023 to Year 10**
- **Annual inpatient volume increases Y1-Y5**
  - Medicare: 3%
  - Medi-Cal: 3%
  - Commercial: 5%
- **Annual inpatient revenue per discharge increases Y1-10**
  - Medicare, Medi-Cal, Commercial: 1.5%
- **CMI Increase: 1.15 to 1.30**
- **Outpatient**
  - Visit growth in line with aggregate IP growth
  - Revenue per visit growth: 2% annually
- **Labor expense decrease:** $3M pro forma adj.
- **Inclusion of the following additional items:**
  - Employee retention tax credit: $7M
  - Distressed hospital loan: $10M
  - Gradual pension funding: $2M annually
  - EMR funding: (initial) $10M

Financial Analysis

Financial Sensitivity Analysis Overview

ECG has developed preliminary financial sensitivity analyses for the following scenarios:

Status Quo

- Assumes that no material changes are made to the hospital and its operations.
  - Stable volume declines with minimal volume growth aside from the already high performing SNF
  - No development of a medical group
  - Expenses growing at inflationary levels
  - Less revenue growth than baseline scenario due to lack of medical group.
  - No FQHC conversion of rural clinics.
  - No JPA development/funding
  - $3M downward pro forma adjustment to labor expense
  - Employee retention tax credit
  - Distressed hospital loan

» **Outlook:** In the absence of outside assistance or substantial changes, ECG forecasts HHMH's financial position to continue deteriorating as expenses outpace revenue.

Growth Scenario

- Increase hospital inpatient occupancy to roughly 90% by year 10
- SNF to reach capacity (90%) by year two
- Development of a medical group leading to increases in volume/revenue.
- Conversion of two rural clinics to FQHC status.
- $3M downward pro forma adjustment to labor expense
- Inclusion of the following items:
  - Employee retention tax credit
  - Distressed hospital loan
  - Gradual pension payment
  - EMR funding

» **Outlook:** In the growth scenario, ECG forecasts net income margin to increase from 4% to 8% in the 10-year period, largely led by increased inpatient and ambulatory services volume at the hospital, with increasing liquidity.

Key Operating Assumptions – Status Quo

Four status quo financial forecast models were developed using the following key assumptions for the hospital, SNF, rural clinics, and medical group financials:

Hospital

- **Annual inpatient volume increases Y1-Y10**
  - Medicare: 0.5%
  - Medi-Cal: 0.5%
  - Commercial: 0.5%
- **Annual inpatient revenue per discharge increases Y1-10**
  - Medicare, Medi-Cal, Commercial: 1.25%
- **CMI remains consistent**
- **Outpatient**
  - Visit growth of 0.5% annually
  - Revenue per visit growth of 1.5% annually
- **Labor expense decrease:** $3M pro forma adj.

SNF

- **3.0% discharge growth in Y1, tapering off to 0% in Y5.**
- **Revenue per patient day growth**
  - 2.0% annually
- **Inflationary expense projections**

Rural Clinics

- **No conversion of clinics to FQHC**
- **Rural Health Clinic visit growth:**
  - 0.5% annually
- **Rural Health Clinic revenue per visit growth:**
  - 1.0% annually
- **Inflationary expense projections**

Medical Group

- **N/A**

Note: Status quo model also assumes no JPA development/funding, or cath lab development.

Key Operating Assumptions – Growth Scenario

Growth scenario was developed using the following key assumptions for the hospital, SNF, rural clinics, and medical group financials:

Hospital

- **~10% market share increase from 2023 to Year 10**
- **Annual inpatient volume increases Y1-Y5**
  - Medicare: 3%
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- **Annual inpatient revenue per discharge increases Y1-10**
  - Medicare, Medi-Cal, Commercial: 1.5%
- **CMI Increase: 1.15 to 1.30**
- **Outpatient**
  - Visit growth in line with aggregate IP growth
  - Revenue per visit growth: 2% annually
- **Labor expense decrease:** $3M pro forma adj.

SNF

- **90% occupancy in year 2,** assume SNFs can be staffed at this level
- **Revenue per patient day growth**
  - 2% annually
- **Inflationary expense projections**

Rural Clinics

- **Conversion of two largest rural clinics to FQHC**
  - 4180 Sunset
  - 4187 4th Street
- Increased revenue per visit growth at the two FQHC clinics
- **Rural Health Clinic visit growth:**
  - 2% annually

Medical Group

- **28.5 providers over 7 years**
  - **9 Primary Care (MDs, NPs, PAs)**
    - 3 in community
    - 6 net new
  - **9.5 Surgical**
    - 3 in community
    - 6.5 net new
  - **10 Medical**
    - 2 in community
    - 8 net new
- **MGMA West Region median compensation benchmarks**
- **Additional annual overhead:**
  - Physician: $175k
  - APP: $100k

Additional Key Operating Assumptions by Scenario

The status quo and growth scenarios also include the following items:

Status Quo – Additional Items Included

- **Employee retention tax credit**
  - $7M favorable pro forma adjustment to 2023 financials
- **Distressed hospital loan**
  - $10M favorable pro forma cash adjustment, $10M associated liability. Principal payments

Growth – Additional Items Included

- **Employee retention tax credit**
  - $7M favorable pro forma adjustment to 2023 financials
- **Distressed hospital loan**
  - $10M favorable pro forma cash adjustment, $10M associated liability. Principal payments
- **Gradual pension payment**
  - $2M annual pension payment (could be greater)
- **EMR funding**
  - $2M annual capital commitment in years 1-5
- **JPA Funding**
  - $12-15M - $5M contribution $7-10M in long-term debt issued to JPA.

Scenario Analysis Comparison: Financial Summary

Under the growth scenario, there is a path to long-term financial sustainability that is dependent on execution of the strategic plan. However, under the status quo scenario expenses will outpace revenue and erode margins.

	Historical		Forecast									
	2023	Nov 2023 TTM	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10
Status Quo												
Operating Income	($1,018,530)	$2,933,447	$154,948	($1,869,879)	($3,929,619)	($5,226,364)	($5,918,239)	($6,017,683)	($6,441,472)	($6,716,398)	($7,193,800)	($7,866,222)
EBIDA	$6,239,017	$10,340,818	$8,327,304	$6,443,359	$4,437,707	$3,207,846	$2,595,260	$2,587,141	$2,261,361	$1,720,793	$1,028,782	$242,480
EBIDA Margin	4.1%	6.9%	5.5%	4.1%	2.8%	2.0%	1.6%	1.5%	1.3%	1.0%	0.6%	0.1%
Operating Cash	$14,441,825	$18,849,384	$35,909,306	$35,114,765	$32,309,491	$28,003,195	$22,807,680	$19,233,907	$15,310,911	$11,642,345	$8,066,653	$3,646,778
Operating DCOH	35.0	48.4	88.6	83.4	74.0	62.4	49.7	41.1	32.0	23.8	16.1	7.1
Growth												
Operating Income	($1,018,530)	$2,933,447	$2,091,338	$2,298,824	$2,077,104	$3,734,047	$5,204,917	$7,265,337	$9,129,696	$10,969,987	$12,881,716	$14,689,706
EBIDA	$6,239,017	$10,340,818	$12,163,693	$12,212,062	$12,244,430	$14,168,256	$15,418,416	$17,070,161	$19,032,529	$20,407,179	$21,904,298	$23,398,409
EBIDA Margin	4.1%	6.9%	7.6%	7.2%	6.9%	7.6%	7.9%	8.5%	9.1%	9.4%	9.8%	10.1%
Operating Cash	$14,441,825	$18,849,384	$37,183,402	$39,285,752	$40,402,326	$42,994,648	$46,651,951	$54,004,258	$63,281,722	$74,769,823	$88,510,924	$103,678,867
Operating DCOH	35.0	48.4	89.1	89.0	87.1	89.0	93.0	104.7	119.1	136.4	157.3	179.4

Next Steps

- Develop a plan for collaboration discussions moving forward
- Schedule additional follow-up meetings if interested

Appendix

Medical Group Development - Physician Shortages & Succession Risks

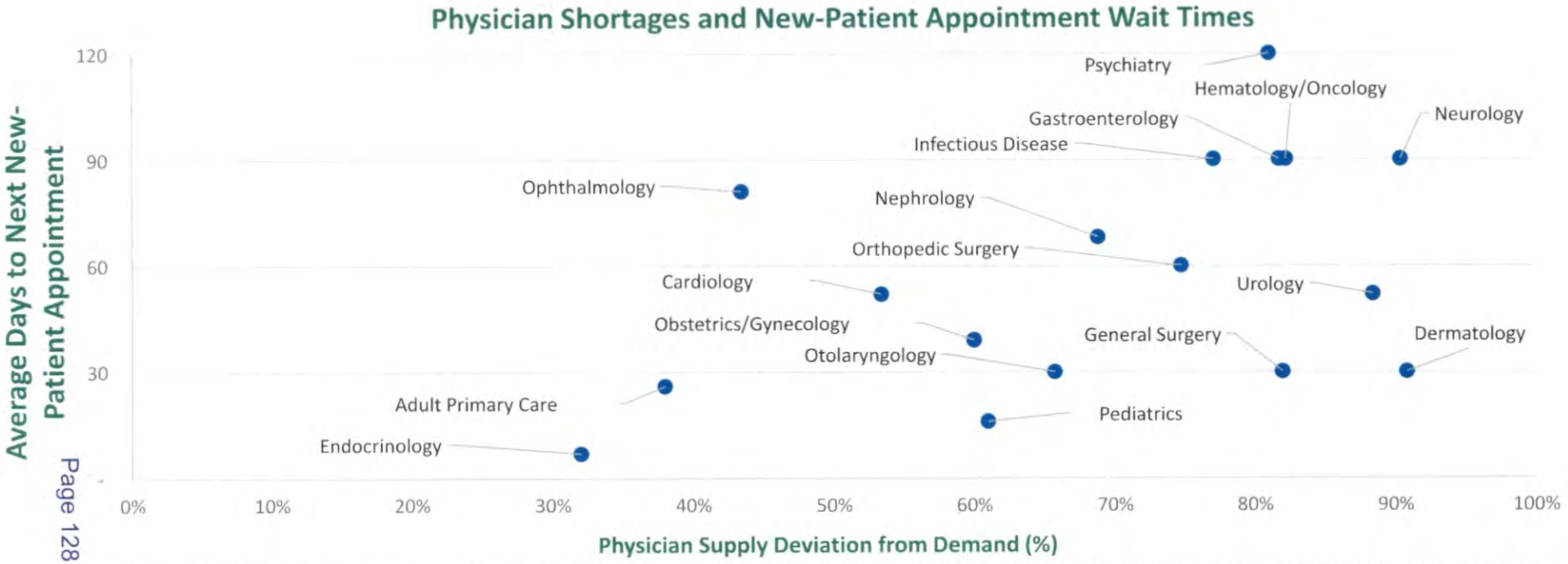
There is a shortage of almost 60 physician FTEs in the San Benito County in the evaluated specialties based on the current physician supply plus projected incremental demand due to population growth.

Specialty	Current Shortage[1]	Growth Need[2]	Physician Succession Risk[3]
Core Specialties			
Adult Primary Care[4]	8.8	2.1	2.4
Pediatrics	4.2	0.6	1.7
Obstetrics/Gynecology	4.4	0.6	-
Psychiatry	4.2	0.5	0.4
Core Specialties Total	**21.6**	**3.8**	**4.5**
Medical Specialties			
Allergy/Immunology	1.0	0.1	-
Cardiology	2.4	0.4	0.8
Dermatology	2.0	0.2	0.2
Endocrinology	0.5	0.1	-
Gastroenterology	2.2	0.2	0.3
Hematology/Oncology	2.0	0.2	0.2
Infectious Disease	1.5	0.2	-
Interventional Radiology	0.8	0.1	-
Medical Specialties *(continued)*			
Nephrology	1.1	0.1	0.2
Neurology	1.9	0.2	-
Physical Medicine/Rehab	1.8	0.2	-
Pulmonology/Critical Care	2.3	0.2	-
Rheumatology	1.1	0.1	-
Medical Specialties Total	**20.6**	**2.3**	**1.7**
Surgical Specialties			
General Surgery	3.6	0.4	-
Ophthalmology	1.4	0.3	-
Orthopedic Surgery	3.0	0.3	-
Otolaryngology	1.2	0.2	-
Urology	1.5	0.2	0.1
Surgical Specialties Total	**10.7**	**1.4**	**0.1**
Grand Total	**52.5**	**7.4**	**6.3**

1 Represents the average current specialty demand, based on 2023 San Benito county demographics, less the current supply of physician FTEs.
2 Represents the projected incremental demand due to demographic changes from 2023 to 2028.
3 Physician FTEs age 60 or greater are considered potential succession risks.
4 Adult primary care includes family medicine and internal medicine.

Current Shortages and New-Patient Wait Time Magnitude

Specialties with the largest deviations between current physician supply and demand also have among the longest new-patient appointment wait times. These specialists have lengthy referral backlogs that impede timely access to care.



Note: Allergy/immunology, interventional radiology, physical medicine/rehabilitation, pulmonology/critical care, rheumatology are not included on the scatter plot as there are no physician FTEs in San Benito County.

Physician Supply Verification

ECG's primary source verification methodology quantifies time spent in clinical practice for individual physicians at all locations, confirms specialty/subspecialty, and measures new patient access.

Physicians were initially identified through various sources:

- State licensure database
- Hospital staff and large group provider listings in the region
- Third-party provider databases
- Provider directories

Additional research was necessary when calls did not yield accurate data or sources are not cooperative:

- Noncooperative practices
- Physicians who cannot be located as listed

A physician had a presence in the defined market. → **The physician was verified either by phone . . .** → **. . . or via other research methods.** → **A clinical FTE was assigned.**

Calls were made to most practices to determine the following:

- Specialties and subspecialties
- Clinical practice locations
- Time spent in clinical practice in each location (by zip code)
- Acceptance of new patients (any new patient, Medicare, and Medicaid)
- Wait time for new patient appointment (third available baseline)

Clinical FTEs were preliminarily assigned based on the following:

- Any physician with a 0.1 or greater FTE for clinical practice in the defined market area
- With an FTE based on 0.1 for each half day of practice up to a maximum FTE of 1.0
- Regardless of age