Adventist Health Relationship with Mendocino Coast Healthcare District

Adventist Health's Position

Adventist Health's proposal has two main short-term objectives: 1) improve the financial position of MCDH to make it sustainable (which it is currently not), and 2) keep the District solvent.

The first can only be achieved by turning a $2M per year loss into a profitable operation while also making a $1.5M a year lease payment. Put another way, with current losses plus the lease Adventist Health is taking on a $3.5M per year risk from the District. To overcome this, Adventist Health will invest substantial efforts and resources to the operations on top of the benefits of being a Critical Access Hospital.

The second will be achieved by paying those lease payments to the District which will allow it to pay the existing debts and put funds into a reserve.

If the financial position of MCDH cannot be turned around, the seismic challenges are irrelevant because it would be extremely ill advised to invest in an unsustainable hospital, and we should look for a different way to deliver healthcare in the district.

Due Diligence

Items for Discussion

1. Labor & Delivery solutions. Will AH train all of its ER doctors and nurses to deliver babies in the ER? Yes. This is currently the practice in Willits.
2. If MCDH invests money into the existing hospital (ongoing repairs, seismic upgrades), the Medicare reimbursements will increase. How will that increase be shared? There is no plan to share risks or rewards of operations or investments. Similarly, if Medicare reimbursements were to decrease, the District would not be liable for making up the shortfall.
3. If AH invests money in the hospital (for deferred maintenance, EHR), will that affect the lease payments? Would AH be content to capture the Medicare increase instead? We do not intend to offset the lease payments.
4. Propose a profit-sharing plan that would capture the value of leasing our business (not just the facilities) with MCDH's share of the profits being put into a sinking fund for a new hospital. The business is currently not profitable and if included in the lease calculation would reduce the FMV lease payment. To put it another way, we are leasing the franchise and are the ones exclusively taking risk on it. The District is trading the operational opportunities and risks for a stable lease payment.
5. What is AH's opinion/judgement on the whether MCDH should pursue the seismic upgrades or build a new hospital? Should we put off the new hospital until after 2030? The first step is to try to make MCDH successful and see what the market will support. Current estimates are that to bring all California hospitals into 2030 seismic compliance would cost $150 BILLION dollars and that there will be modifications to the seismic requirements. We will know a lot more about both in 4 or 5 years.

6. How long did it take to plan, design, construct and license Howard Memorial? About 6 years.

7. Does AH own the rights to the engineering design of Howard? Probably, but even that would not meet today's OSHPD design codes.

8. Perform a 10-year cash flow analyses, with several scenarios, of MCDH's finances post affiliation. Use that information to determine if the lease fee offered by AH is sufficient. The lease is a product of two FMV studies. It will be inflated annually by the CPI. Remember that AH is taking sole risk for operations. However, if the District were to make a significant addition to the assets, we could agree to a re-appraisal.

9. Will the meetings of the new Board be open to the public? Sometimes? No, they would not be. We would make routine reports to the District in addition to a fairly detailed annual report to the public.

10. Will the new Board have any involvement in creating and recommending approval of the budget (much as our finance committee does now)? Yes

11. What can be done to include Ambulance Service in the lease package, given the apparent legal constraints on providing services outside the District boundaries? Since all assets and operations of the District are included in the lease, the ambulance services will also be included. We will research the issue of District boundaries.

12. What assurances/commitments are there that ambulance service on the Coast won't suffer? We can include a commitment in the lease that ensures continued ambulance services.

13. Will AH take responsibility for the lease payment to the owners of NCFHC's facilities? Yes. Since all assets and operations will be included. NCFHC is currently an operation of the District so both its revenues and its expense would move to AH.

14. Is AH interested in having a Crisis Stabilization Unit located in the remaining portion of the hospital, with the resulting benefit being to reduce the costs of the ER? It makes sense on the surface, but we will have a much better idea after we begin operations.

15. What are the specifics of the exit clauses? Will this just be a force majeure clause or something broader? It would be broader and would include unforeseen things like significant reimbursement changes such as the elimination (without replacement) of Critical Access Hospital status.

16. Home Health loses a good deal of money. How will AH expand this service without it becoming a financial drain? We don't know much yet about how MCDH runs specific services. Once we do, we can answer that question better. We do know that we run Home Health in many challenging markets and do ok in them.

17. How many C-level executives will be stationed at MCDH on a daily basis? Who will be the person with day-to-day decision-making authority? Likely a local president and nursing executive.