Marin Healthcare District
Strategic Planning
Final Report

"Preparing for the Future"

Prepared for

Marin Healthcare District

September 28, 2007

KURT SALMON ASSOCIATES

www.kurtsalmon.com

Table of Contents

Executive Summary

Executive Summary

Kurt Salmon Associates (KSA) is pleased to present the Marin Healthcare District (MHD) Board with the Final Report from our 6-month strategic planning engagement. The MHD Board hired KSA to facilitate its strategic planning process with respect to current and future governance and strategic directions for Marin General Hospital (MGH). We thank you for selecting KSA to assist you with this important work. It has taken the knowledge and wisdom of each Board Member to successfully navigate through this process and it has been our pleasure to provide our expertise and guidance.

Background

The current MHD Board's single strategic issue is the situation in which the Sutter will no longer be operating and managing MGH. This was not an amicable parting, given the acrimony and finger-pointing between the District, various public factions, and the Sutter hospital leadership during the length of the relationship. Faced with the imminent transition of the hospital to District control and with multiple governance and operational factors to consider, the MHD Board engaged KSA to provide strategic planning services to assist the Board in selecting the best course for the future of MGH.

Process

The first step in this process was understanding the history and current environment for the District and MGH. KSA thoroughly reviewed the many previous studies, reports and opinions regarding the existing hospital and its future. A market assessment was completed as well as a strategic facility plan review and financial assessment. Input was gathered through confidential interviews with key stakeholders, as well as multiple interviews and conversations with other community leaders and functional experts. KSA also conducted a confidential survey among 829 physicians and nurses at MGH.

As themes began to emerge and data was collected and analyzed, KSA synthesized this information to provide a conceptual framework with private and public governance options. For each direction, assumptions were identified and verified. KSA further outlined the associated governance models and completed individual market demand and financial assessments for each option. Transition and strategic timelines were overlaid on each option, which then provided the MHD Board with realistic decision parameters and the challenges associated with each option.

Executive Summary

With input from the Board and multiple stakeholders, KSA identified two governance options that were closely examined. These governance options were chosen because MGH's success hinges on whether the hospital governance can be depoliticized and stabilized. It is KSA's opinion that this is a foundational issue for MGH's future success. Part of MGH's success will depend on the District's ability to develop a governance structure that provides a barrier between the hospital's operational oversight and the politics within the District. A hospital cannot be expected to succeed in a highly volatile and unstable political landscape. Therefore, the KSA strategic planning process focused on:

Public Governance	Private Governance
Definition ● District hires professional management to lead and manage MGH. ● Governing model includes District Board governance with MGH Operating Board.	**Definition** ● MGH is leased or sold to a third party that governs MGH privately.
MGH at New Site ● MHD governs MGH and builds a new 180-200 bed facility at a new site. A new MGH must grow services; current site will provide sub-acute and outpatient services. **Upgrade MGH at Current Site** ● MHD governs and maintains MGH at the current site with a similar number of beds and scope of services.	**Lease MGH** ● MHD leases MGH to a hospital operator that manages MGH with little to no oversight by District Board. MGH remains at current site with services determined by lessee. **Sell MGH** ● MHD sells MGH and invests proceeds to support community health care and wellness – the District becomes a philanthropic organization. ● MGH will be controlled by the owner and maintained or changed at their direction.

Executive Summary

The Transition Agreement with Sutter limited the timing and manner in which the District Board can pre-plan and make decisions for the hospital. For example, the Board will be unlikely to conclude on Lease or Sale propositions until it can provide detailed hospital financial and other due diligence information per the Transition Agreement. Given the limitations of the Transition Agreement and the uncertainty of when Sutter will notify the District of its intent to separate, KSA acknowledged this fact and recommended that the MHD Board must be prepared to govern and operate the hospital for some length of time upon Sutter's departure. This refocused the MHD Board on the responsibilities for the future of MGH and provided impetus for pragmatic decision-making.

Based on our assessments and findings, KSA believes that each strategic direction option is realistic and has some level of viability. This viability assumes rational economic behavior of the marketplace (MGH will remain competitive in its reimbursement rates with other local hospitals) and a rational leadership response to competitive threats (MGH will respond assertively, rather than passively, to threats from competitors). KSA believes through its analysis and under various assumptions that MGH can be fiscally sound and remain a valuable asset to the community under all four scenarios. However, there are four important assumptions that must be met in order for any scenario to succeed:

- The governance and oversight of the hospital must be depoliticized and provide stability. The MHD Board must operate with transparency and competence. The MHD Board can no longer allow divisive constituent voices to derail its progress towards a viable, strategic future for the hospital. When appropriate, the Board must meet in Closed Session to discuss the strategic aspects of hospital governance. A governance structure must be in place that creates stability for MGH.
- The MHD Board must gain the trust of physicians, nurses, and other key hospital staff in order to ensure the future of the hospital and its current and future care delivery. The medical staff must remain reasonably in tact for the hospital to be viable.
- The District Board must bring in a competent management team to prepare for the Hospital's transition. Anything less will not give physicians and hospital staff the confidence they need to remain in place.
- The MHD Board must successfully complete all necessary tasks associated with the Transition Agreement. Tasks must be completed thoroughly, in a timely manner, and progress must be communicated to the MGH staff and other stakeholders.

With this in mind, KSA can summarize its recommendations into two major areas, which are further outlined in detail in the KSA Recommendations Summary section of this report:

***Management*: The MHD Board must immediately hire an outside management group or team to complete the transition, provide management services, and obtain transition financing through the transition date.**

***Partners*: The Board must stabilize the current situation and provide some level of communication so the current medical staff will choose to stay and practice at MGH. The MHD Board must also develop its plan to recruit key physicians, nurses, and other hospital staff. The Board must view physicians and care providers as partners in delivering quality, efficient and effective care within the community. Further, the Board must be willing to explore all options for the hospital's success, including joint-ventures, collaborations, and unique contractual agreements with MGH medical staff.**

Additionally, KSA emphasizes the many action steps, some of which are more complex than others, that must be executed with thoroughness and precision, both prior to and after the transition.

In spite of the many challenges ahead, it is KSA's opinion that there are many community stakeholders and available expert resources to assist the District with its agenda for MGH. With a compelling vision for the future, bolstered by competent leadership and the regained trust of physicians, staff, and the community, MGH will be a sound, viable hospital.

Thank you for choosing KSA. We look forward to your progress and to a bright future for MGH.

Summary of Situation

Background and Planning Process

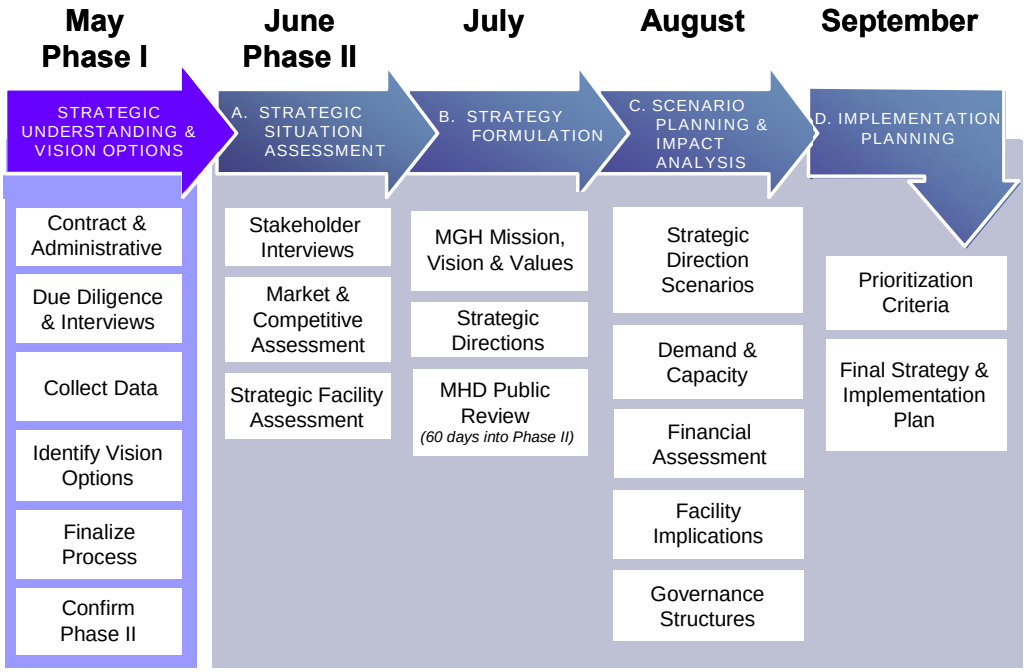
Marin Healthcare District will regain direct control of Marin General Hospital Corporation upon termination of the lease with Sutter Health Corporation (Sutter) sometime between January 2009 and July 2010. Sutter will provide MHD with one-year notice of the Transfer Date. This begins a Preparation Period phase, during which MHD will coordinate activities to prepare for the transfer. Sutter will supply access and information to aid MHD in the preparation tasks. At the time of transfer, MHD will have full control of governance and management of MGH. For planning purposes, the District must assume the earliest possible Transfer Date.

Simultaneously, MGH is required to comply with state-mandated seismic building codes outlined in Senate Bill 1953, commonly referred to as SB1953. The aim of SB1953 is to assure that hospital facilities will be able to withstand and operate through a significant seismic event. It requires MGH to fortify or replace facilities by 2013. If significant building is in process at the time of the 2013 deadline, an extension to 2015 may be obtained.

Considering these major pivotal decisions, MHD Board members received a wide range of public input and resolved to study the options before them.

KSA was engaged by the MHD Board in April 2007 to undertake a strategic option evaluation study and facilitate discussions for Board selection of a strategic direction for operation of MGH.

The strategic planning process conducted was as follows:



Background and Planning Process

This report is the summary of the process, assessments, findings and recommendations.

This study builds on many previous planning efforts and information. The planning team reviewed and considered the following items:

- California Office of Statewide Healthcare Planning Data (OSHPD) discharge database 2001-2005
  - Acute care discharges for MHD residents for all hospitals in California
  - All discharges from MGH
- CMS Cost Reports 2001-2005
  - MGH Medicare cost reports
- Financial Statements - Sutter Health and Affiliates with other financial information for MGH - consolidated years ended December 31, 2006 and 2005 with report of independent auditors
- A Review of Health Services Developments in Marin County, September 15, 2006, The Lewin Group
- Options for the Future of Marin General Hospital: A Strategic Assessment, July 12, 2005
- Marin General Hospital, Marin Market Demand Analysis, August 2003
  - Population data from Association of Bay Area Governments (ABAG)
- Summary Timeline of the Settlement Agreement
- Marin General Hospital Master Site and Facility Plan, 2004
- SB 1953 - Amended Compliance Plan Marin General Hospital, Thistlewaite Architecture Group, January 10, 2007

Current Situation: Issues Facing MGH

At the commencement of the process, there were five strategic areas for study. Through our Board strategic work sessions and with public input at the MHD Board meetings, these areas were confirmed and clarified for study.

FUTURE VISION
- Mission and Vision
- Goals, Strategies, and Priorities

- What is the desired community oversight for health care?
- How should MHD ensure care is available to District residents?
- What quality levels can be ensured?

SERVICE DEVELOPMENT
- Grow/Focus, Maintain, Sunset Service Lines
- Geographic Penetration & Outreach Efforts

- How should the District provide for essential community care?
- Is the community need large enough to efficiently offer services or should we partner with others?

FINANCE AND REIMBURSEMENT
- Reimbursement Rates
- Financial Impacts of Strategies
- Hospital Viability
- Ability to Fund Facilities

- What is the prognosis for MGH as an independent hospital?
- How much risk is there for commercial reimbursement?
- Can MGH pay for facility upgrades from operating profits?
- How much community support is required?

MEDICAL STAFF
- Recruitment
- Retention

- What happens if all our doctors leave? What can we do to keep them?
- How can MGH recruit new doctors?
- How should a community hospital relate to independent physicians/groups?

FACILITY AND CAPITAL INVESTMENTS
- SB 1953 Compliance
- Enable Strategy & Service Development

- Are we required to comply with SB1953 or do we qualify for exemption?
- What is the minimum requirements to comply with SB1953?
- What facility investment is needed to support MGH in the long-term?

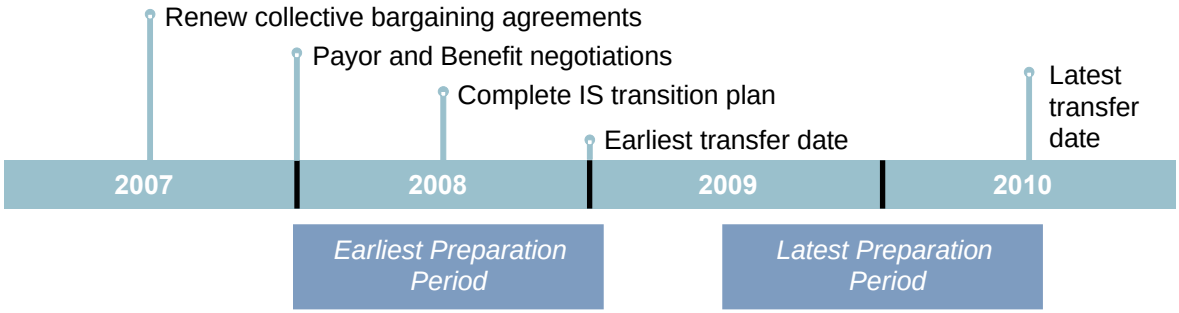
Current Situation: Transition and Strategic Timelines

Marin Healthcare District is held to the Transition Agreement with Sutter that outlines key activities and dates prior to the Transfer Date. This timeline places limitations of information availability required for some options. It also outlines requirements that must be met independent of long-term plans for MGH.

Transition Timeline

The Transfer Date (the day Sutter turns MGH over to MHD) is determined by Sutter and can occur any day between January 2009 and July 2010. Sutter must give one year notice of the Transfer Date.

- A significant amount of work requiring expertise and additional resources will be needed in order to accomplish the 80+ tasks required during the Preparation Period



The planning that MHD can conduct prior to the Preparation Period is limited by access to data, facilities and staff. MGH has a limited obligation to provide proprietary data - such as patient data, volumes, payor data, finance data, or physician data – prior to the Preparation Period. MHD has limited access to the facility to conduct evaluations or facility planning. MHD is limited to minimal interactions with current MGH staff and physicians. Those stipulations limit the options and plans MHD can undertake prior to the Preparation Period.

Once the Preparation Period is started, MHD will have broader access to data, facilities and staff in order to prepare to govern and oversee MGH operations. During this phase, the new management team will work jointly with the Sutter management team to prepare for the transfer. Although MHD will have access to data during the Preparation Period, the confidentiality agreement restricts MHD from providing data to outside parties. MHD cannot provide data to any potential buyer or lessee until after the Transfer Date.

Source: *Timeline for Settlement Agreement and Marin General Hospital Compliance Plan.*

KSA Recommendation Summary

Key Findings and Conclusions

During the process, KSA has endeavored to fairly evaluate the range of potential strategic directions available to the District. Through strategic planning discussions, two main governance models were identified:

Public Governance	Private Governance
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KSA assessed and evaluated the opportunities each model presents.

Key Findings and Conclusions

Based on our strategic planning work sessions with the MHD Board, interviews with community members, input from a variety of stakeholders, and KSA expertise, we believe the following to be elements of the future mission:

- The District must ensure that MGH remains in the community to provide acute care services to the residents of Marin
- The District must ensure that residents have access to high-quality health care and services
  - Requires collaboration with the County, other providers and the community
- MGH must be an excellent place for physicians to practice and for patients to improve their health

During the course of conducting the assessments, KSA developed an understanding of the realities of the market in Marin, the needs and priorities for providing care, and opinions on the strategic direction options. Our findings and opinions include:

- All options are possible and viable. Each has challenges and opportunities, but no option is infeasible, if preferred by the community.
- All options require significant changes to historical MHD Board governance and management.
- All options require building and enhancing physician and hospital staff support.
- MGH is a community asset that can, under certain assumptions, be viable under a Public Governance model.
- Under realistic competitive threats, MGH can remain a viable entity. KSA conducted our assessment using the conservative, realistic assumptions based on the strategic planning discussions, the market data, comparable hospital experience, and KSA's experience with similar hospitals. Some of these sensitivities analyses included:
  - *Risk of inpatient loss due to transition and physician recruitment delays*. During the years surrounding the transition, the physicians at MGH are assumed to have higher attrition rates. The need to recruit is understood, but takes time to add new staff and have them in full practice. We assumed that these changes in physicians would result in a loss of approximately 10% of discharges per year (1,100 discharges) for 2008-2012. After the transition is complete and recruitment is successful, the volumes return to projected levels by 2014.

Key Findings and Conclusions

- *Risk of ambulatory services loss.* The sensitivities assume that ambulatory services competition will significantly increase and MGH will lose 20% of all outpatient surgical and invasive diagnostic procedures. We also assume that related services, such as lab and radiology, could also be lost. Hospital-based ambulatory services, for example – ER visits, were assumed to remain at MGH. KSA does assume that MGH management will be proactive in developing and instituting plans to maintain/enhance ambulatory services in order to remain competitive.
- *Risk of reduction in commercial reimbursement rates.* The reimbursement rates from commercial contracts will be renegotiated at, or shortly after, the transfer. The MGH commercial reimbursements were compared to other similar Bay Area hospitals – both independent and within systems. The analysis indicates that MGH rates are slightly above some comparators, but within a reasonable range. KSA believes that although some adjustment will occur, the changes will not be out of the range that other similar hospitals receive. Our conservative assumption is a reduction of 10%. We also assume that the management team will be effective at negotiating contracts.

- KSA conducted sensitivity analysis on these assumptions and scenarios as well. Scenarios that place MGH into financial jeopardy assume that ***no action*** is taken in response to a competitive threat or downturn in profitability. We think this is an unrealistic scenario, given that competent management must respond to such changes in competition, physicians and payor dynamics.
- Due to the Transition Confidentiality Agreements currently in place, the MHD Board cannot disclose required operations and financial data to any potential lessee or buyer until after the Transfer Date. Therefore, the MHD Board must be prepared to govern MGH for some time period regardless of preferred long-term direction. It is KSA's opinion that a successful agreement will require minimal restrictive terms on future MGH operations. Our assessment indicates that these options also require considerable public education and voter support in order to achieve approval.
- KSA advises the MHD Board to select the strategic direction that provides the greatest probability for a strong, successful MGH. Elements to consider are:
  - Stabilizing MGH operations
  - Minimizing impact of politics on MGH direction and operations
  - Enhancing relationships with physicians, nurses and other key staff
  - Ensuring the future financial viability of MGH and ability to provide community services
  - Increasing public support and laying foundation for public investment (i.e., bond financing) in remodel/build

Recommendation Summary

KSA has developed seven specific recommendations for the MHD Board:

1. **Continue Transition Agreement activities** - MHD must continue to complete the Transition Agreement activities on time.
2. **Contract with a hospital management company** – hire a local organization or comprehensive hospital management company for overall management support. The management group must continue planning and executing the Transition Activities, through the Preparation Period and it is recommended that they contracted at least 12-months or more post-Transfer Date or longer.
3. **Create an operating Board Governance structure** - a governance model that utilizes an Operating Board structure enables MGH to conduct day-to-day governance responsibilities effectively without slow downs and disruptions. To prepare for this Operating Board, a Transition Board of Directors will be developed immediately to oversee the day-to-day transition activities with the management company and District executive leadership. Using an Operating Board provides MGH with significantly broader expertise versus a small elected Board.
4. **Secure transition financing** for accessing capital to fund the transition and other ongoing planning such as facility, physician development and ambulatory planning, as well as the additional capital needs for the transition.
5. **Start facility development planning** by January 2008. This is required for all future governance models. The future operation of MGH requires a facility plan *regardless* if it is publicly or privately governed at time of construction.
6. **Start physician development planning** by creating and executing a plan within the next 12 months. This must be created and executed in tandem with regular communication to the medical staff.
7. **Create an ambulatory plan** to support needs of physicians to practice in a convenient setting and in support of a partnership model with MGH medical staff.

Recommendation Summary

1. **<u>Continue Transition Agreement activities</u>** - MHD must continue to complete the Transition Agreement activities on time.
   - Consistent forward movement will increase credibility
   - Solid operating plan is beneficial to all future options
   - Lease or sale are not options to consider today

There are multiple activities that must be taken in order to successfully transition MGH back to District control. Although it was appropriate for the Board to focus on the future strategic direction of MGH, it is now important to make certain that the necessary and required steps of the Transition Agreement are carefully planned and executed.

The MHD Board must regard the hospital as an on-going business concern. As such, the MHD Board has a fiduciary duty to develop solid plans around the Transition Agreement activities, secure necessary interim financing, and make business decisions which will ensure employee retention and continuity of care before, during and after Sutter is released from its current lease obligation.

The MHD Board must demonstrate that it can function as a governing body and not be distracted by vocal detractors and confounding opinions. The MHD Board was elected to serve the health care needs of the District and must see to its most valuable asset --- MGH. Without a successful transition, the strategic options outlined in this document become less viable.

In order to ensure forward movement and the continued success of MGH, the Board must:

a) Develop and abide by operating principles which guide discussion, debate and decision-making among Board Members

b) Agree to and abide by a consistent policy for external communication. Board Members should attempt to deliver consistent messages for the benefit of MGH staff and community members.

c) Utilize appropriate, skilled advisors for aid in decision-making (i.e., Legal Counsel, other trusted advisors) and reduce the perception of indecision by ceasing the response to the whims, complaints and unsolicited advice from individuals.

d) Develop a Communication Plan for providing consistent information and updates to MGH employees and to the community.

e) Develop a standard communication meeting with the MGH medical staff; possibly a monthly standing meeting to communicate progress and allow medical staff members to communicate back to the District.

Recommendation Summary

The Transition Agreement allows MHD broader access to the operations, finance and facility data during the Preparation Period. This information is covered by a confidentiality agreement that restricts the District from disclosure to outside parties. Therefore, the District cannot provide due diligence access required to lease or sell the hospital until after the Transfer Date.

The MHD Board must continue the transition activities that prepare for transfer of operations. In addition to the operational planning, the MHD Board must ensure that strategic and long-term facility planning are conducted as well. Two critical elements of the strategic planning – ambulatory services and physician development – are detailed in Recommendations 6 and 7. The Board will regularly review the performance of MGH against select quality metrics.

Recommendation Summary

2. **Contract with a hospital management company** - contract with a local organization or comprehensive hospital management company for overall management support. The management group must continue planning and executing the Transition Activities, through the Preparation Period and it is recommended that they contracted at least 12-months post-Transfer Date or longer.
   - Management group will provide needed staff, resources and expertise to conduct transition plan through the preparation
   - Provide continuity through the transition to placement of permanent staff after transfer
   - Provide expertise in coordinating various consulting constituencies through additional planning beyond the transition requirements
   - Give medical staff an understanding of the level of competence available to stabilize and operate MGH

The planning and operating activities required to prepare for governing MGH are many and complex. The MHD Board and Executive Director do not have the time or expertise required and will need additional staff. The most expeditious and coordinated approach to securing necessary staff is through a management group. It can offer MHD the staff and functional expertise and has experience in hospital operations. Secondly, the MHD Board must be prepared for an early transition date. Today, the human resources are not available for the transition and the Board must assure they are available, regardless of the transition date. Hiring capable expertise will also be challenging during the transition period.

After transition, a plan for recruiting and transferring to permanent staff can be made.

Specific expertise that the management group can provide is:

- Finance and Contracting
- Information Technology
- Public Relations, Communications and Marketing
- Licensing
- Human Resources and Benefits
- Physician Relations and Development
- Ambulatory Care Development

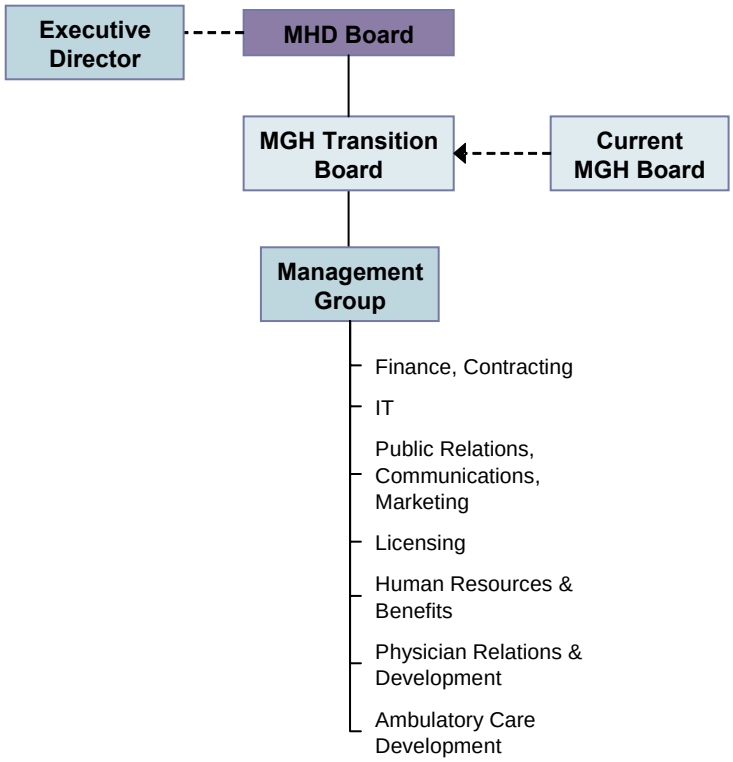
We recommend that one management group be hired as opposed to individuals or small groups specializing in each area. The management group will be better prepared to quickly coordinate between functional groups. The responsibilities and roles will be more easily understood and reduce conflict and confusion between staff. Additionally, the District does not currently have a robust management team in place to oversee and coordinate multiple independent staff.

Time is of the essence in completing the critical transition plan activities and strategic planning activities. A management group will improve the results.

Recommendation Summary

3. **<u>Create an operating Board Governance structure</u>** - KSA recommends a governance model that will utilize an Operating Board structure to enable MGH to conduct day-to-day governance responsibilities effectively without slow downs and disruptions. To prepare for this Operating Board, a Transition Board of Directors will be developed immediately to oversee the day-to-day transition activities with the management company and District executive leadership. Using an Operating Board provides MGH with significantly broader expertise versus a small elected Board.
   - The District Board can focus on developing it's oversight responsibilities (e.g., fiduciary, quality assurance), while the Transition Board can focus on the transition activities
   - Begin the process of organization development by creating the distribution of responsibility between the District Board and the Operating Board.

It is our opinion, based on observations and interactions with Board members and the community, that the creation of a Transition Board will aid the process. The community is highly involved in the process, and important operating decisions must be made in a timely fashion. By creating the Transition Board to focus on the routine operating activities, the recommended MHD Board will be able to focus and engage the community on the critical oversight, such as quality and facility capital planning.



Recommendation Summary

The Transition Board will report to the MHD Board on the progress in meeting the transition plan activities, facility planning, physician development planning, and other tasks. At the Transfer Date, the Transition Board can become the MGH Operating Board and will have sufficient experience and background to take over hospital governance. A key reason for developing an Operating Board model is to bring a broad array of community perspective and local expertise in the operational oversight MGH.

Long-Term Governance Structure

MHD will maintain governance oversight with an MGH Operating Board.

- KSA recommends that the MHD Board functions as an "Oversight Board" to the new MGH Operating Board with as limited a role as legally possible.
- KSA recommends that the Transition Board's structure, roles and responsibilities becomes the structure for the future MGH Operating Board.
- The succession process for appointing new MGH Operating Board members will be defined to provide for continuity, as well as the infusion of new thinking. Board position of both 2 years and 3 years with staggered terms will meet this objective.
- The MHD Board will have approval authority of new MGH Operating Board members, however it is assumed that this approval authority will be more of an administrative responsibility rather than a protracted debate and approval process.
- KSA recommends that a portion of the current MGH Board Members be considered for positions on the new MGH Operating Board to maintain continuity. The current Board members bring the experience of overseeing the hospital operations. They are fluent in the organization's processes, people, and plans. They can provide new Board members with the historical context of decisions and experience.

Main duties of each Board:

MHD Board	MGH Board
Public Policy Direction	Operational Oversight
Ownership of Public Asset	Financial Management/Budget Annual Budget Approval
Mission Adherence	Hiring and Evaluating the CEO
Strategic Plan Approval	Facility Planning/Development
Fiduciary Oversight (Audit)	Strategic Plan Development
Quality Assurance Policy	Physician Strategy
Approve Major Capital	MGH Board Members Nomination
Approve MGH Board Members	

Recommendation Summary

The starting activities of the Transition Board will be to:

1. Oversee the execution of transition plan tasks.
2. Secure interim financing (with the management team) to fund transition activities – jointly with MHD Board.
3. Begin facility planning process. The Board will hire necessary planning groups and hold planning sessions with MGH physicians and staff. Progress reports will be provided to the MHD Board on a regular basis.
4. Begin physician development planning in coordination with current physician groups. Evaluate future physician needs by specialty for both retirement and to meet growing/changing health care needs.

Recommended Approach to Development of Transition Board

MHD must work with their legal counsel to develop Articles of Understanding* for the development, roles and responsibilities of a MGH Transition Board. This will include:

- Relation of MGH Transition Board to MHD Board
- Membership, roles and responsibilities of MGH Transition Board and reporting structure
- Definition of MHD Board reserved powers
- Redefined role of Executive Director
- Development of job descriptions for MGH Transition Board Members and recommended composition of the MGH Transition Board
- MHD must identify prospective Board Members based on the MGH Transition Board job descriptions and recommended composition of the Transition Board.
- KSA recommends a skills-based selection process and a focus on prospective candidates that can provide a full complement of strategic and business expertise for the benefit of MGH.
- The hospital CEO, Chief of Staff, and Chief Nursing Officer are ex-office members of the MGH Board. KSA does not recommend that Board members be selected solely on the basis of constituency representation. This is how the MHD Board is elected and such a process for the selection of Transition Board Members will be redundant and may not be productive.
    - Varied experiences and skill sets will ensure that the Board collectively has the ability to oversee operations and make prudent decisions. We recommend, at minimum, Board members with the following skills/experience be represented: community/public health, business acumen and public relations, human resources, operations, facilities or real estate, business planning, and clinicians. Additional skills may be outlined as necessary by the MHD Board.

**Note: It is assumed that MHD's legal counsel will provide the appropriate legal advice and action steps necessary to create the MGH Transition Board*

Recommendation Summary

4. **Secure transition financing** - develop interim financial plan for accessing capital to fund facility planning, physician development and ambulatory planning, as well as the additional capital needs for the transition.

MHD will need access to additional working capital during the planning and preparation phases. It will need to develop a transition budget starting today and going through the Transfer Date.

The major areas that funding will need to support are:

- Management group fees to pay staff to complete transition agreement activities
- Facility planning activities
- Ambulatory development planning and possible capital to begin developments – depends on Transfer Date
- Physician support and recruitment

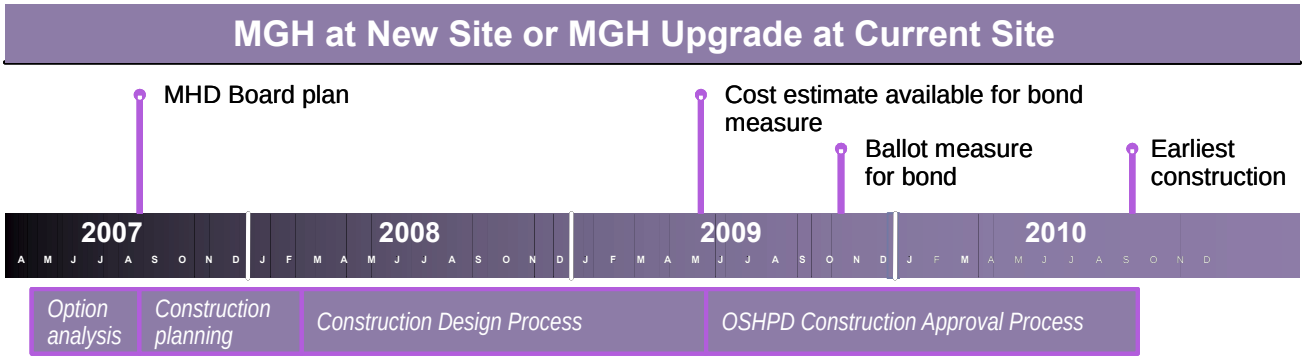
Upon better understanding of the budget, financing will be needed to smooth cash flow timing and facilitate planning expenses.

The MHD Board needs to begin securing financing immediately or as soon as feasibly possible. If the management company is engaged quickly, they can provide support with financing expertise to identify and secure the financing arrangement.

Recommendation Summary

5. **<u>Start facility development planning</u>** - begin facility planning in early 2008. This is required for all future governance models. The future operation of MGH requires a facility plan *<u>regardless</u>* if it is publicly or privately governed at time of construction.
   - A viable, ready-to-go plan is required either for a bond measure or a lease/sale
   - Lessee or buyer will not want to enter negotiations so close to deadline without some type of plan in place -- strengthens the value of MGH

MHD must ensure that a plan is progressing to upgrade MGH to meet seismic requirements by 2013. Due to the length of the facility planning process prior to construction, activities must be initiated by early 2008 at the latest.



This timeline illustrates the major phases in planning that are required. The construction design process is the detailed planning phase that brings the planning team together with physicians, staff, patients, and the community to develop new spaces based on needs. After the space needs are understood, a cost estimator can create the specific estimate of the construction costs. This is required prior to seeking General Obligation Bond funding approval.

The process will require a team of architects, planners, engineers and cost estimators to work with the District and MGH to develop the final facility plan.

Recommendation Summary

For the facility planning team, we recommend the following structure and responsibilities:

- Project Manager (Part of management group or outside owner's representative)
  - Oversees the facility planning team to ensure completion on time and within budget
  - Provides a main point of contact with the District
  - Coordinates the various planning specialists on the team (e.g., engineers, parking consultant, cost estimator)
  - Identifies and advises the District on construction issues or roadblocks
- MGH Planning Team
  - A MGH liaison and department staff (as available) that work with the facility planning team throughout the process to define and provide guidance on specific hospital needs
- Architects – work with the Project Manager and MGH Planning Team
  - Develops plans and design concepts
  - Ensures compliance with building codes and other requirements of 'authorities having jurisdiction'
  - Coordinates the building planning team
- Engineers – work mainly with the Architects
  - Provides specific technical expertise (e.g., mechanical infrastructure, land/site)
- Equipment Planners – work with Project Manager and MGH Planning Team
  - Coordinates and specifies required equipment
  - Coordinates with architects and engineers for infrastructure needs (e.g., power ventilation) and architects for building needs (e.g., reinforced floor)
- Planning Consultants – works with Project Manager and MGH Planning Team
  - Specialists in particular areas such as facility space needs, parking, traffic and transportation, environmental design, etc.
  - Create specific elements of the overall plan by working with the relevant hospital groups

Recommendation Summary

This is an activity the Transition Board can oversee and report progress to the MHD Board. We anticipate the planning process to require 18-months to complete if a timely schedule is developed and adhered to. During this timeframe, detailed cost estimates will be prepared, which are required for a bond measure. If a lease or sale is pursued after transfer, this plan can be provided to a potential lessee/buyer in order to allow them to meet the seismic requirements.

The planning process to build new hospital facilities is complex. In order to be successful, strategic goals and objectives must be clearly articulated and a comprehensive business model developed. These are critical pre-requisites to planning a new facility. Participation of physicians, clinical and support staff who use the buildings invariably creates a better facility for patients and those who work there. The major phases and steps included in the development of a major addition or replacement hospital are:

Confirm Service Line Priorities
Prior to beginning the physical planning, the clinical and administrative leadership of the hospital agree on the services the hospital will offer. This step may include the evaluation of multiple service mixes. As part of this process, the organization will ensure it has the appropriate clinical resources to meet the selected service mandate.

Prepare a Business Plan for Service Delivery
Specific information on the health care needs and utilization patterns of the hospital's service area population is collected to support a business model. The business plan supports the number of beds, operating rooms and other components the hospital must include to meet its service delivery goals. The business plan may be used to develop a master plan for development. The Master Plan addresses and supplies 'order of magnitude' quantities for the major capital components of the development project including clinical facilities, parking and other capital expenditures required as part of the capital development.

Develop the Architectural Program
The architectural program describes the functional and space requirements of the building required to meet the service delivery goals and anticipated patient volume of the business plan. This is the first stage of the physical design process and is developed in consultation with the clinical and support staff. It projects the required floor area by department considering the current and projected operational models of the organization. Industry-recognized standards are used to aggregate room by room space components and calculate additional area for circulation, interior and exterior walls and mechanical and electrical equipment. Architectural programs provide valuable information about the building plan prior to beginning the architectural design and are critical to the budgeting process.

Equipment Planning Services may be provided by the owner's in-house purchasing team, an independent consultant, or as part of an integrated facilities planning team. The role of sophisticated technology in medical care will continue to increase and corroborates the importance of equipment planner from the outset of the planning process.

Development of Architectural Documents

Architectural documents are prepared to show the intent of the plan and design for construction. Document packages are developed for the owner's review and approval in three stages: Schematic Design, Design Development and Construction Documents. During Schematic Design, the clinical and support staff of the hospital continue to participate in the planning process as the architect works with the architectural program to develop the floor plans for the new building. At the end of Schematic Design, the floor plans are fixed. During Design Development, the consultant team expands to incorporate the input of structural, mechanical, plumbing, electrical and data engineers into the building plans. The true complexity of health care construction requires a great deal of coordination among these professionals and the design process may take 2 years or longer to complete. The architect generally maintains responsibility for the entire consulting team.

In complex projects, multiple construction packages each with a unique set of construction documents will be released to mirror the construction phasing. Construction coordination is usually assigned to the owner's project manager.

Initiate Local Approval Process

Most urban communities have some form of planning regulations to accommodate both technical and community input in the development process. Engaging the support of the community at an early stage of the development may facilitate local approval process. The zoning requirements of parcels used for health care facilities may be subject to a number of approvals not encountered in more standard commercial or residential zoning. The local authorities will also require an Environmental Impact Review (E.I.R.). The E.I.R. will address the potential changes to the surrounding neighborhood resulting from the development project including changes in traffic volumes, parking volumes and changes to the physical nature of the site.

Recommendation Summary

Development of Cost Opinions
Cost opinions are critical to ensure the project scope is maintained within the projected capital budget. The complexity of the planning/design process, evolving technology in health care and a complex building process are each a component in increasing the scope and consequently the capital budget.

State Agency Review
All health care facilities in the State are subject to the review of the Office of Statewide Health Planning & Development (OSHPD)**.** The agency's review process involves a series of plan checks, revisions and reviews. This process can be anticipated to last 12-18 months.

Recommendation Summary

6. **Start physician development planning** - begin physician development planning by creating and executing a plan by the end of 2008. This must be created and executed in tandem with regular communication to the medical staff.
   - A detailed physician assessment must be conducted to determine specific physician needs by practice and specialty
   - A recruitment support plan must be developed in concert with existing physicians/groups
   - Use interim financing to begin assisting local physicians in recruitment and possible ambulatory developments
   - Regular communications and input must occur with the current MGH medical staff
   - This must be a major aspect of a contract with a management company

The medical and hospital staff are critically important to MGH – without their support, no plan will succeed. MHD, with assistance from the Transition Board and Management Group, must ensure the relationship with the physicians is enhanced and new recruiting is successful.

The Transition Board and Management Group must create a physician development plan as soon as feasibly possible. It will evaluate current and future physician recruitment needs and outline recruitment steps. Evaluation of the opportunities to enhance the relationship with current physicians must be conducted. This will also give MGH the opportunity over the next 12 months to work directly with the medical staff to understand their issues and to chart a mutual path.

The medical staff and hospital staff need regular communications from the MHD Board, Transition Board, and management group on updates of progress and planning. They must participate and provide feedback on planning for MGH.

The current physicians on staff at MGH are aging and many will retire or reduce practice time over the next 5-10 years. Due to high costs of recruiting new partners, physicians are leaving practice without a new physician in place. The hospital can work jointly with physicians to ensure new physicians are ready to take over.

The high cost of living also hampers the number of primary care physicians in Marin. These physicians are vital to the future of MGH, as they provide patients and specialty referrals. MGH's physician development planning must examine other successful primary care models and increase physicians supporting MGH. To date, Kaiser has had the most success offering primary care in Marin due to the high level of integration and support. MGH will need to consider and implement arrangements to support independent medical groups through partnerships in order to serve community needs. The arrangements must bring MGH and primary care physicians together to provide care to the community.

Recommendation Summary

7. **<u>Create an ambulatory plan</u>** - create an ambulatory strategy and implementation plan to support needs of physicians to practice in a convenient setting.
    - Active development of the ambulatory platform will increase physician practice and provide MGH with a very competitive platform in Marin County
    - This will include the assessment and development of possible clinical joint ventures with existing MGH physician groups
    - Easy to access and dedicated patient-oriented facilities will attract patients
    - Migration out of MGH will open capacity for acute care needs
    - This must be a major aspect of a contract with a management company

MGH anticipates an increased level of competition for ambulatory services in the future. The threat comes not only from Sutter, but a variety of other providers including physician-owned developments. It must create a plan to increase and improve its network of locations and services.

The development of new ambulatory care locations will have many benefits and allow for support of physician practice patterns. The physicians can efficiently see patients and perform procedures while avoiding delays caused by inpatient complexity.

Some aspects of ambulatory care that KSA advises MHD for planning consideration are:

- Ambulatory surgery and procedures (e.g., ENT, Plastics, GI)
- Key program continuity services (e.g., cardiac rehab, stroke rehab)
- Specific disease-focused programs (e.g., orthopedics sports medicine)

The hospital will have critical resources (e.g., operating rooms) become available as ambulatory services migrate to the new locations. The management group can develop this planning with participation and direction from the Transition Board. The MHD Board must view physicians and key clinical staff as partners in providing quality, compassionate care. As such, the MHD Board must remain open to reasonable partnerships with clinicians.

Action Steps

The seven recommendations, oversight, responsibility and timeframes are summarized below for easy reference:

	Oversight	Responsibility	Timeframe
1. Continue Transition Agreement Activities A. Outline activities to be completed	MGH Transition Board, Executive Director	Management Group	Ongoing
2. Contract for Hospital Management Services A. RFP for Services i. Finance Services ii. Contracting iii. Public Relations, Communications, Marketing iv. Licensing v. Human Resources, Benefits vi. Physician Relations & Development vii. Ambulatory Care Development B. Review RFP Responses C. Negotiate Terms/Agreement D. Finalize Contract	MHD Board	MGH Transition Board, Executive Director	October 2007-January 2008
3. Create Transition Board A. Board Member Selection B. Determine oversight roles and bylaws	MHD Board	MHD Board	October 2007-March 2008
4. Secure Transition Financing	MHD Board	Executive Director	January 2008-March 2008
5. Start Facility Development Plan A. Contract for Project Manager i. RFP for Services ii. Review RFP Responses iii. Negotiate Terms/Agreement iv. Finalize Contract B. If required by plan, secure land C. As Required by Plan, Secure Permits, Zoning & Covenants D. Conduct Facility Planning and Design Process E. Complete OSHPD Approval Process	MGH Transition Board, Executive Director	MGH Transition Board, Executive Director Project Manager	Beginning 2008
6. Start Physician Development Plan A. Create Communication Plan and Execute B. Solidify/Enhance Support of Current Physicians C. Conduct Physicians Needs Assessment D. Identify Critical Needs and Recruit Targets	MGH Transition Board, Executive Director	Management Group	January through December 2008
7. Create Ambulatory Plan A. Develop Strategy to Enhance Existing Ambulatory Sites B. Identify New Sites i. As Required, Conduct Facility Planning ii. Secure Clinical Practice Sites C. Create Operating Plans D. Offer Joint Venture Arrangements with Physicians as viable E. Hire/Staff Operations	MGH Transition Board, Executive Director	Management Group	January through December 2008

Note: *This plan assumes an MGH Transition Board is in place. If not, all activities outlined for the Transition Board would revert to the MHD Board.*

Assessment Overviews

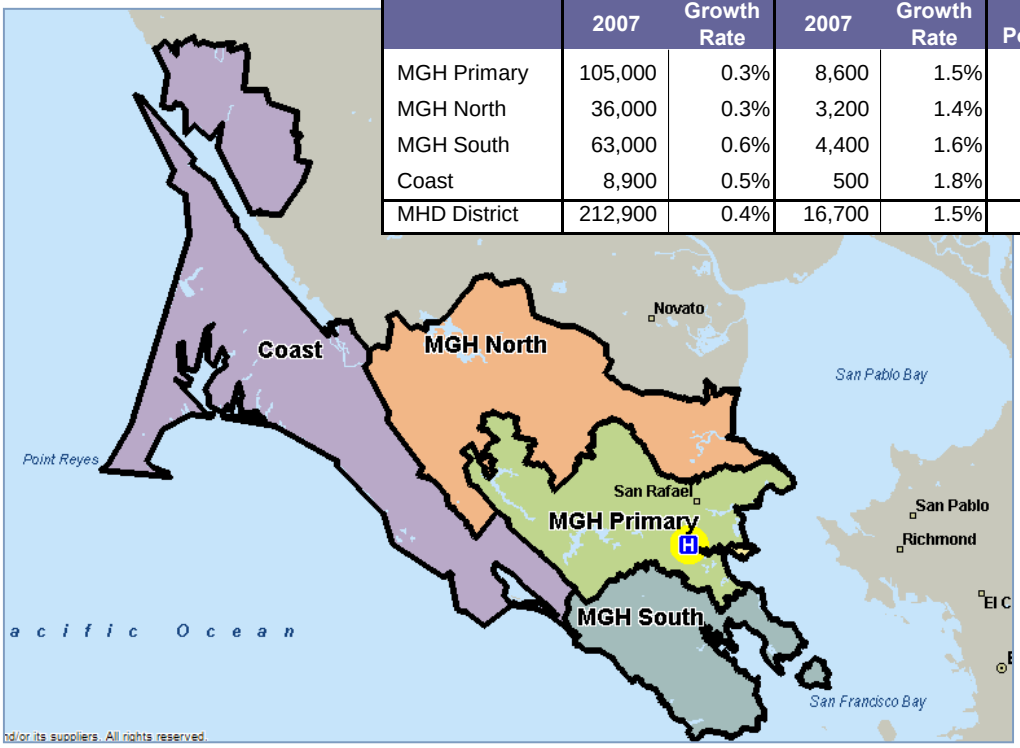
Assessment Overviews – Market

The MHD encompasses Marin County except for Novato and portions of western Marin. This is the area defined as the market for MGH. Some patients come from outside the District, but they are considered in-migration.

KSA classified the District into four submarkets:

- MGH Primary is the area immediately surrounding the hospital where MGH is the market leader with the largest share; typically over 45%
- MGH North and MGH South are areas where MGH has significant market share, typically 25-45%
- The Coast area is the west portion of Marin. In this area, market share is split relatively equally between multiple providers

	Population		Discharges		Use Rate / 1,000 Population	2007 Market Share	
	2007	Growth Rate	2007	Growth Rate		Kaiser	MGH
MGH Primary	105,000	0.3%	8,600	1.5%	82	21%	56%
MGH North	36,000	0.3%	3,200	1.4%	89	37%	44%
MGH South	63,000	0.6%	4,400	1.6%	70	19%	46%
Coast	8,900	0.5%	500	1.8%	56	34%	31%
MHD District	212,900	0.4%	16,700	1.5%	78	24%	50%



Source: *Marin General Hospital, Marin Market Demand Analysis, August 2003. OSHPD 2001-2005 extrapolated. KSA analysis.*

Source: *Marin General Hospital, Marin Market Demand Analysis, August 2003. Population Data from Association of Bay Area Governments. Office of Statewide Health Care Planning Data (OSHPD) 2001-2005 extrapolated.*

Market Discharges

Market discharges are projected based on the future population growth and aging, and use rates by age cohort.

These projections indicate that the District will have an increasing need for inpatient services mainly due to older patients using services at higher rates.

Total Use Rates per 1,000 Population				
	2001	2005	2010	2015
Overall	83.3	84.3	88.0	93.5

Note: Excludes Normal Newborns in DRG 391.

Source: OSHPD Discharge Data and KSA Projections.

The total acute care discharges in the Marin market will grow at a high rate of 1.6% per year. An additional 4,400 incremental discharges will be added by 2022.

Marin Healthcare District Projected Discharges

Excludes Normal Newborns	2007	2012	2017	2022	Annual Growth
MGH Primary	8,600	9,200	10,000	10,800	
MGH North	4,400	4,800	5,200	5,600	
MGH South	3,100	3,400	3,700	3,900	
Coast	500	600	600	700	
Total	**16,600**	**18,000**	**19,500**	**21,000**	**1.6%**

Source: OSHPD Discharge Data and KSA Projections.

- The majority of the need will be in MGH's Primary market immediately surrounding the hospital as this is where the majority of the population center is.
- The North region is growing and may off-set some competitive erosion due to Sutter Novato expansion plans
- The South and Coast markets will continue to be small portions of the health care needs of the District.

Source: *OSHPD Discharge Data for discharge years 2001-2005. Excludes Normal Newborns DRG 391 and non-acute care discharges.*

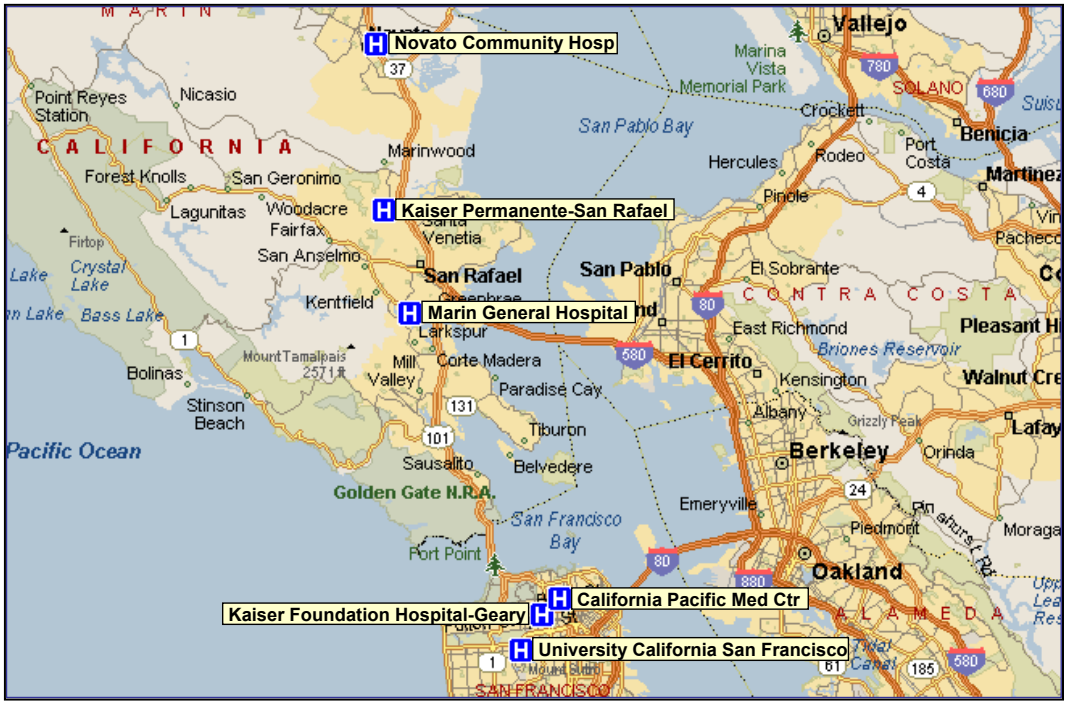
Assessment Overviews – Market

Hospitals

Patients in the MHD seek services at Marin hospitals and travel to San Francisco for care.

Hospital	Beds
Novato Community	47
Kaiser San Rafael	120
MGH	150
CPMC	756
Kaiser Geary	247
UCSF	574

Source: Lewin Group, AHA.



MGH is the primary provider to patients with 44% of the care in 2005, but is slipping:

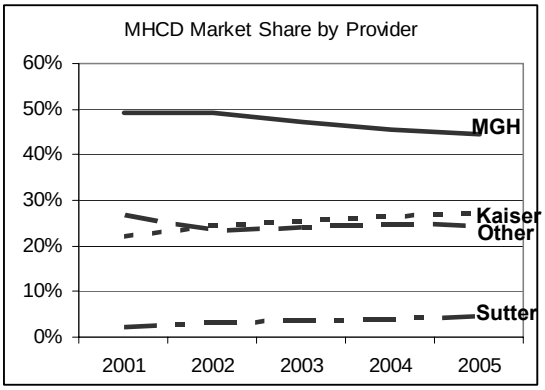
- -10% change from 2001-2005
- - 4.8 market share points in past 5 years

Kaiser has grown steadily during the same period:

- +22% change
- + 4.9 market share points

Sutter Novato Community Hospital has doubled discharges from the market in the past five years:

- +118% change but on small base of 200 discharges



Source: OSHPD Discharge Data 2001-2005.

Consolidation is occurring with fewer residents seeking care at hospitals outside the area.

More Marin County residents are choosing Kaiser for their health care insurance.

Note: *Includes discharges from District ZIP codes only. Beds is staffed beds in 2005 for NCH, Kaiser San Rafael and MGH from Lewin Group report "A Review of Health Services Developments in Marin County" September 15, 2006. CPMC, Kaiser Geary and UCSF beds are 2006 staffed beds from 2007 AHA Guide. Based on OSHPD Discharge Data for 2001-2005.*

Source: *OSHPD Discharge Data for discharge years 2001-2005. Excludes Normal Newborns, non-acute care discharges.*

MGH Future Demand and Sizing

Assessment of future bed need for MGH was based on two discharge/bed scenarios.

Maintain Current Size/Scope

- It has been assumed total discharges will be stable at 10,000-11,000 per year

	Historical - OSHPD					Estimates		Projections			
	2001	2002	2003	2004	2005	2006	2007	2010	2012	2017	2022
Discharges	10,250	10,350	10,380	9,940	10,050	10,500	10,600	10,300	10,300	10,300	10,300
Bed Need	150	150	150	150	150	150	160	150	150	150	150

Source: OSHPD Discharge Data and KSA Projections.

- Market share declines by approximately 10 market share points as Sutter offers competing services in Novato and ambulatory services at Marin Square
- MGH maintains 150 beds
  - 133 Acute care beds
  - 17 Psychiatry beds

Grow Services at a New Site:

- Estimate range of 13,000 to 14,000 discharges

	Historical - OSHPD					Estimates		Projections			
	2001	2002	2003	2004	2005	2006	2007	2010	2012	2017	2022
Discharges	10,250	10,350	10,380	9,940	10,050	10,500	10,600	11,000	11,500	12,700	13,700
Bed Need	150	150	150	150	150	150	160	160	170	180	200

Source: OSHPD Discharge Data and KSA Projections.

- Approximately 200 beds
  - 183 Acute care beds
  - 17 Psychiatry beds
- New MGH would increase discharges
  - Increase market shares in Central and Southern Marin:
    - Overall market share growth of approximately 5% over 10-year period due to improved location and growth focus
    - Key service line growth in Neurosciences, Cardiovascular, Oncology, Orthopedics and Trauma by 10-25%
  - Decrease of discharges from northern District area due to Sutter Novato Community expansion

Notes: *Market share growth estimates evaluated based on market dynamics and current market share based on OSHPD 2001-2005 discharge trends. Bed estimates based on 85% occupancy rate.*

Assessment Overviews – Facility

KSA's approach to facility assessment was streamlined based on previous MGH planning and KSA experience.

Analysis of the facility requirements and future needs included consideration of:

- Seismic upgrade laws currently applicable to MGH. SB1953 requires portions of the hospital to be upgraded or replaced by 2013. If a construction project, to meet compliance, is in process at the time of the deadline an extension may be granted.
- Suitability for the current facility to meet the needs of modern clinical practice
  - The majority of the facility is dated and requires significant modifications to enable up-to-date clinical technology
- Market competitiveness of facility:
  - When choice is available, providers and patients will use modern up-to-date facilities in which to give and receive care. With the large number of Bay Area hospitals either replacing or updating facilities, MGH will need to update to be competitive to physicians and patients.
  - Modern facilities and equipment enhances the recruitment and retention of the high-quality physicians and nursing staff important for success

For the strategic direction discussions, there are two facility options that are considered:

- New wing on the current site – applied for MHD governed or lease options
- New hospital at new site – applied for MHD governed option only

Details of the facility options were based on previous planning efforts – KSA has not evaluated or recommended these plans. We used facility plans completed for the MGH Master Plan to provide the future size of the hospital.

For updating the cost opinion, we reviewed other comparable projects either planned or currently in construction around the Bay Area. This information provided a current construction cost opinion and was then factored for construction inflation. This is not a substitute for detailed cost estimating. The project cost opinions in this assessment lack the benefit of appropriate up-to-date facility plans and MGH input.

Lastly, KSA added factors to represent non-construction costs, such as furnishings, planning fees, permits and contingency funds. All of these calculations equal the total cost opinion for the project.

KSA provides these cost opinions as information for the MHD Board and community to develop an understanding of the relative range of costs that will be required at MGH.

Facility Analysis Assumptions

1. No new cost estimates were undertaken for this review. Cost estimates are detailed analysis of the specific project under consideration. This will be conducted in future planning steps.
2. Updates to previous cost ranges reflect order of magnitude comparison to cost opinions of projects currently being contemplated in the San Francisco Bay Area.
3. Cost opinions reflect project scope and information gleaned from studies completed January 2004 and January 2007.
4. Escalation is calculated to the assumed mid-point of construction, assuming a start in fourth quarter of 2008.
5. Escalation reflects 12% per annum. This reflects the low end of the escalation seen in 2006 and is in line with construction cost escalation seen in other institutional building types.
6. The new tower option adds 80 acute care beds to 70 currently in the West Wing. Retrofit of central tower areas is required to fit 21 beds.
7. New site option assumes 180 beds at a new site. Mental Health beds will remain at current site only if basic services (dietary, pharmacy, lab, records) can be maintained on-site or provided from a remote site.
8. Site development costs include relocations and parking structure for 660 cars.
9. Other project costs include professional/management fees, testing and inspection, geotech analysis, surveys, permits and fees.
10. All costs are rounded to the nearest $1,000,000.

Exclusions:

1. Land and easement acquisition, environmental impacts mitigation and development costs.
2. Finance and other development charges.
3. Accelerated schedules, charges for restrictions on contractors' working hours.

New Wing on Current Site

This option was described in the Master Site & Facility Plan, completed in January 2004. It proposes the construction of a new wing to include 80 patient beds, an invasive services suite, including supply and sterile processing support and diagnostic imaging services.

This plan includes major components of:

- Site development – preparation, 320-car parking ramp, utility and traffic changes
- New construction of approximately 265,000 square feet
- Retrofit of the Central Wing, approximately 75,000 square feet and demolition of the East Wing and disconnection of seismically compliant structures from other nonconforming structures
- Maintenance of approximately 100,000 square feet

The construction would begin in 2011 and, due to the complex phasing and desire to minimize impacts on ongoing hospital operations, require 4-5 years to complete. The cost analysis and project timeline assume 2014 as the mid-point of construction.

	Current MGH	Current Site New Tower
Beds		
East/Central	**139**	**24**
West Wing	**79**	**79**
New Tower	**-**	**82**
Mental Health	**17**	**17**
Total	**235**	**202**
BGSF/Bed		
Building Square Feet		
New		265,000
Retrofit		75,000
Maintain		100,975
Remodel (Non-Acute)		
Mental Health		36,500
Total Building Square Feet		**477,000**
Construction Cost		
Retrofit/Remodel Existing Facilities		$ 21,000,000
Cost/SF		$ 230
New Construction		$ 176,000,000
Cost/SF		$ 663
Site Development Costs		$ 15,000,000
Parking		$ 6,400,000
Make Ready		$ 8,800,000
Sub-Total		**$ 212,000,000**
Escalation at 12% per year		$ 127,000,000
Construction Total		**$ 339,000,000**
Project Costs		
Furniture, Fittings & Equipment (30%)		$ 64,000,000
Other Project Costs (45%)		$ 95,000,000
Total		**$ 498,000,000**

Source: MGH Master Site & Facility Plan, KSA Analysis

Construction costs are approximately $339 million.

Related Project Costs include the furniture, fittings, equipment, and other cost-planning fees (architect, engineering, etc.), permit fees, and contingency fund. These costs are approximately $159 million.

The total construction and project costs are projected at approximately $498 million.

Assessment Overviews – Facility

Discussion:

This option represents, in KSA's opinion, the most feasible plan. The hospital must be improved in order to both meet seismic compliance and maintain competitive facilities. This plan achieves the requirements at the lowest current capital cost and puts MGH on solid footing until 2030.

The new beds will provide patients with private rooms – increasing comfort, privacy, and safety. Upgrades to the surgical suites will create modern operating rooms to support current practices and procedures. New support spaces (example: radiology and lab) will ensure MGH can operate through and after a seismic event.

The investment maintains much of MGH as it is today and builds at the current site. It will continue to experience limitations on access to the site and will need to address parking.

New Hospital at New Site

This option has been proposed and some preliminary planning previously completed in the Master Site and Facility Plan (January 2004).

The plan assumes construction of a new 180-bed hospital on a brown field site to accommodate all acute care patients. The current site would be maintained with approximately 20 sub-acute psychiatry beds and outpatient care services. The new facility would meet all seismic requirements through 2030.

This plan includes major components of:

- Site development – preparation, 660-car parking ramp, utility and traffic changes
- New construction of approximately 405,000 square feet at a new site
- Maintenance of approximately 36,500 square feet on the current site
  - Assumes that all support services would be done remotely from the new facility or outsourced and no space on-site would be required

	Current MGH	New Site Acute Care
Beds		
East/Central	**139**	
West Wing	**79**	
New Tower	**-**	**180**
Mental Health	**17**	**17**
Total	**235**	**197**
BGSF/Bed		
Building Square Feet		
New		405,000
Retrofit		
Maintain		
Remodel (Non-Acute)		
Mental Health		36,500
Total Building Square Feet		**442,000**
Construction Cost		
Retrofit/Remodel Existing Facilities		
Cost/SF		
New Construction		$ 244,000,000
Cost/SF		$ 602
Site Development Costs		$ 24,000,000
Parking		$ 11,880,000
Make Ready		$ 12,200,000
Sub-Total		**$ 268,000,000**
Escalation at 12% per year		$ 161,000,000
Construction Total		**$ 429,000,000**
Project Costs		
Furniture, Fittings & Equipment (30%)		$ 80,000,000
Other Project Costs (45%)		$ 121,000,000
Total		**$ 630,000,000**
Land Cost		**$ 120,000,000**
Total		**$ 750,000,000**

Source: MGH Master Site & Facility Plan, KSA Analysis

This requires buildable land to be available by Fall 2008. Construction would occur in 2011-2013. Construction costs are approximately $429 million. Project costs are approximately $201 million. The total construction and project costs are projected at approximately $630 million.

The land required to construct the hospital is a minimum of 20 buildable acres. The land is assumed to cost $6 million per acre for a total land cost of $120 million. The total cost of the new hospital option with land, construction and project costs is $750 million. Some discussion has occurred expressing interest in a land grant from the State. This would certainly be a positive development for this option; however, until the reality of the land grant is imminent, KSA recommends planning continues to account for land costs. Community philanthropy may also be sought to pay for land cost.

The current site was proposed to be maintained to provide for inpatient mental health and ambulatory services. KSA recommends, through a facility planning process, that the relocation of these services to the new site be considered. Inpatient mental health would be the only care on the current campus that would be 24-hours and require expanded support services (meals, linen, pharmacy, etc.). We advise that co-location at the new site must be considered for operational efficiency and access. For ambulatory services, they may be relocated to a new site with enhanced access or remain. If services were effectively relocated, the District could sell the current site and offset the new land cost and development. No estimate of the potential value of the current site has been developed as part of this planning.

Discussion:

The option for a new hospital represents a great opportunity for Marin and its residents to receive care in a modern, state-of-the-art facility. Important community benefits and values can be embodied in the new facility. It would draw world-class physicians and care providers to build on MGH's strong clinical programs. Quality, efficiency and modern practice can be built into the new hospital. In short, it would be a great benefit to Marin.

A new hospital would provide all new, private patient rooms – maximizing privacy and comfort while supporting quality initiatives. The entire hospital would be on solid footing for the next 30 years. A new site may be selected to increase access – vehicle and air support.

The main obstacle to its implementation, in our opinion, is the ability to fund the construction. Marin residents, community leaders, donors, physicians, staff and, in fact, the community-at-large would ***all*** be required to support the project. For the differential in cost between the new wing at the current site and the new hospital, the additional benefits are substantial. The facility construction costs are higher than a new wing, but would be a better use of the public's funding.

The ability to make this option a reality is to rest on the skills of visionary leaders. The MHD Board must champion this cause in every way. They must develop unanimity in purpose and approach. Dissention in the Board will magnify concerns and doubts of the public and donors. A project champion, likely a positive, dynamic, non-political and well respected community member, will be needed to facilitate the efforts. Diverse constituents, community groups, and county leaders/government must be brought together in support of the new hospital.

If the MHD Board is able to gain support for a vision of a new hospital in Marin, philanthropy and community support will be instrumental in making it a reality. If available, land can be located and acquired through public or private funding. Philanthropic support is critical to funding the project at the lowest cost to tax payers. It provides money for equipment, furnishings, planning costs, and contingencies that put the project on solid footing. That said, donors require a successful plan that is fully supported by the MHD Board and local government. They require assurance that the hospital will be built and operate successfully before they make commitments to donate.

Assessment Overviews – Facility

Retrofit the Existing Hospital

The costs associated with retrofitting the existing hospital are to upgrade approximately 140,000 square feet. The cost opinion is approximately $100 million.

	Current MGH	Current Site Retrofit
Beds		
East/Central	**139**	**54**
West Wing	**79**	**79**
New Tower	**-**	**-**
Mental Health	**17**	**17**
Total	**235**	**150**
Building Square Feet		
New		
Additional Area		139,400
Maintain		100,975
Remodel (Non-Acute)		
Mental Health		36,500
Total Building Square Feet		**277,000**
Construction Cost		
Retrofit/Remodel Existing Facilities		$ 32,000,000
Cost/SF		$ 230
New Construction		$ -
Cost/SF		-
Site Development Costs		$ 2,000,000
Parking		$ -
Make Ready		$ 1,500,000
Sub-Total		**$ 34,000,000**
Escalation at 12% per year		$ 29,000,000
Construction Cost Total		**$ 63,000,000**
Project Costs		
Furniture, Fittings & Equipment (30%)		$ 10,000,000
Other Project Costs (45%)		$ 15,000,000
Total Construction and Project Cost		**$ 88,000,000**

Source: MGH Master Site & Facility Plan, KSA Analysis

Discussion:

There are several issues with feasibility of undertaking a retrofit, including, but not limited to:

- The possible retrofit phasing requires approximately five years to complete. During this time, 30-40 beds will remain out of service in different parts of the Hospital. This places MGH at a critical disadvantage, as 25% of beds may be unavailable, physicians will have difficulty admitting patients, and the ER would be on diversion and transferring patients due to lack of bed availability. The extensive construction required to retrofit creates noise and other potential hazards to staff and patients, to say nothing of expensive operational adjustments to accommodate closed service areas.
- Financially, MGH will simultaneously be funding the retrofit and losing a quarter of patient revenues. The loss of this patient revenue for an extended period of time has not, as yet, been accounted for.
- Physician and staff morale would possibly decline sharply, as some portion of the staff will be decreased during this process. Remaining staff would have to care for patients in less than ideal environments with constant construction interruptions.
- Upon completion, investments and management effort will be required to build physicians, staff, and patients back up to the original levels. The five-year retrofit period will provide competitors a large window to attract away MGH's best physicians and staff.
- During the same time period, many other San Francisco and Bay Area hospitals will complete new facilities. While following the retrofit MGH will be seismically up to code, it will still be basically the same facility competing with newer more contemporary facilities. We believe this will make it more difficult for the hospital to attract physicians, staff and patients.
- Lastly, the retrofit will require MGH to undergo additional construction prior to 2030. The investment in retrofitting will be voided by a new wing or facility within 10-15 years.

For all these reasons, KSA advises that the retrofit option be considered only as an option of last resort for maintaining the hospital. This option may not be feasible to implement – determination is dependent on the ability to secure a construction firm to conduct the work and willingness of the medical staff to continue at MGH during construction. KSA has concerns on both of these and does not recommend a retrofit be undertaken unless no other option is available.

Basis for Financial Analysis

Creation and evaluation of the future financial situation of MGH was a detailed collaborative process between KSA and the MHD Board. KSA conducted all analyses and recommended the planning assumptions based on our judgment and experience. We debated the assumptions, findings, and implications with the Board in order to further refine the analyses.

Financial analysis conducted during this process relied on available data at this time. The primary source for data was the 2001-2005 cost reports purchased from the Cost Report Data Resources, LLC as derived from the MGH cost reports to Centers for Medicare and Medicaid Services. This information was supplemented with financial data from OSHPD and Sutter Healthcare audited financial statements publicly available.

While this information provides a basis for high-level financial assessment, it lacks sufficient detail to provide comprehensive and detailed assessment of both the current and future financial health of MGH. No clinical service line financial information was available, therefore, this analysis and assessment provides an estimate and guideline as is reasonably available at this time.

Major Assumptions

The major assumptions applied are based on:

- Assessment and understanding of the current MGH situation based on currently available data
- KSA's experience in similar community hospital settings – community hospitals in California, Bay Area hospitals, and western US in similar market situations
- Consideration of consistency/comparability to qualitative data gathered through community interviews and discussion/review with previous planners/reports

The overarching approach, given limited information, was to apply assumptions that KSA believes are both realistic and conservative.

The assessment considered many factors that will influence the financial outcomes. We endeavored to evaluate and integrate all factors that were quantifiable and represented a material impact to the planning. This section represents a summary of the assessment.

The future financial situation for MGH can be outlined in:

- Revenues and potential changes
- Expenses and potential changes
- Capital investments and funding

Revenue and Potential Changes

Projections of revenue and impacts of changes are based on the historical relationship between patient revenue and discharges. We have assumed an inflation growth rate of 3% per year. To this projection, we have included the potential changes to both volumes and reimbursement rates.

Discharges

During transition, some turnover of medical staff is expected. MHD must recruit physicians to replace retiring physicians as well incrementally new physicians. This medical staff change will result in variability and loss of discharges until stabilization and full integration of new patients.

The financial assessment considers the impact of discharge loss at different rates; MGH can remain viable with a loss of up to10% of discharges – 1,100 fewer patients per year – in a proportional mix.

At this time, without service line financial data provided, we are unable to assess the impact of drops in procedural volumes. From experience, we would anticipate that significant reductions in specific procedural-based inpatient services will have material negative impact on the financial performance. Management must proactively work to maintain and grow these services in concert with MGH physicians. So as individual physicians make determinations on what to do, MGH can remain viable, but if whole procedural-based physician practices leave, MGH's viability is questionable.

Commercial Reimbursement

We have evaluated MGH's overall commercial reimbursement as compared to a wide range of Bay Area hospitals. Although MGH is currently receiving reasonable reimbursement, the range of reimbursement is not significantly lower at other hospitals. The possible reduction may be small. Based on this data, an assumption of a 10% loss in reimbursement would keep MGH in line with other hospitals.

Hospital	Net Commercial Reimbursement % of Gross
Washington Hospital	51%
North Bay - Vaca Valley Campus	49%
Marin General	**48%**
North Bay Medical Center	43%
Sutter (21 Hospitals)	43%
El Camino	41%
Queen of the Valley	39%

Source: OSHPD Financial Data and KSA Projections.

We have concluded sensitivities of financial analysis of reimbursement reductions up to 10%. It is our opinion that this level of reduction is the maximum expected, given the situation. We would not anticipate this level of reduction to be realistic – but a very conservative assumption at this point.

With the 10% reduction in commercial reimbursements, it is believed that MGH can remain viable.

Source: 2005 OSHPD Hospital Annual Financial Data Profile. 2001-2005 Medicare Cost Reports

Volumes - Outpatient

It is expected that competitors, including Sutter, will increase outpatient activities in Central Marin and attract patients away from MGH. KSA evaluated the potential outpatient volumes that may be at risk and assessed the impacts. The potential loss is equivalent to 20% of outpatient surgical/procedural cases and related ancillary services (i.e., lab, radiology).

At this level of outpatient volume loss, MGH can continue to operate. The margin would be small, but positive.

Expenses and Potential Changes

The assessment of future operating expenses is also based on the historical rates of expenses as related to patient volumes. Potential changes in the future operating expenses are based on the projected volume changes. Additional adjustments include:

- **Salaries, wages and benefits** are scheduled to be renegotiated in 2008. We have assumed a one-time increase of 6% related to this contract negotiation. After that, an ongoing 3% per year inflation rate is applied.
- **Cost of severance** – as applicable. In assessments that include a decline in volumes, the nursing staff required would decline. To account for this, it was assumed that severance cost per FTE was equal to 50% of the previous year's salary expense. This is effectively equal to a 6-month severance package, including benefits. For the new wing scenario, there is a total staffing loss of 40-50 staff in the transition period from 2008-2011 related to the assumed loss of discharges. This assumption has increased impact, when considering the retrofit option as 35-40 beds would need to be closed and staffing reduced proportionately.
- **Physician-related costs** – it is assumed that MGH will need to invest in physician recruitment and retention. The current medical staff is comprised of 270 active physicians. These physicians are aging and will need to be replaced by new physicians – 80-110 physicians over the next ten years. Additional physicians are needed to support service line development planning. It was assumed that MGH would invest $10 million between 2010-2013 and $1 million per year ongoing in support of physicians.
- **Overhead expense** reduction was assumed to occur in 2010 to represent the change in overhead costs. The reduction assumed was $4 million and is consistent with KSA's experience at other hospitals and understanding of costs at MGH.

Capital Investments and Funding

The single largest capital investment a hospital makes is its facility. The sheer magnitude of the undertaking and completion of facility construction will dictate much of the success and challenges for the life of the hospital. This investment in MGH requires the community support. Residents of Marin have universally agreed on the importance of a high-quality hospital to the community. It serves the needs of all residents for critical care, emergency, trauma, obstetrics, and mental health. It supports the County disaster planning and emergency response. The importance of MGH is agreed on by all.

The cost of maintaining and improving MGH in its current service mix configuration to prepare it for the next generation is expensive. The hospital construction costs are above levels that the hospital operations can support. Capital costs must be supported from sources outside the hospital in order for it to continue. To the extent that MGH can fund construction from operations, we have assumed it will be up to $100 million. Some additional debt capacity may exist, but requires evaluation closer to the time of construction. The remaining construction cost must be supported externally.

The public governance option will require public funding through General Obligation bonds. A private governance option is not likely to invest sufficient capital and maintain all current services, as there is no business case to do so.

Conclusions

It is our assessment that MGH, with required facility construction capital from the public, will continue to have positive operating performance and remain viable despite facing significant threats to volumes and reimbursement with increased costs. Projections of specific outcomes and numbers will certainly be off by some margin in the future, as influenced by factors as they materialize over time.

We do believe this assessment is flexible and has tested sufficient assumptions to provide confidence in the recommendations.

Other Factors Considered

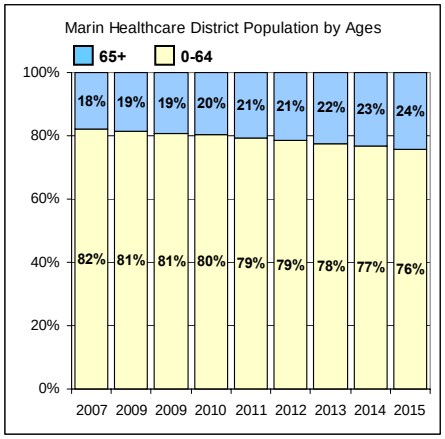
The financial assessment considered additional factors and included them as feasible:

- Payor Mix – Data on the overall payor mix of MGH was compared and found similar to other Bay Area independent hospitals.

Payor Mix					
	Medicare	Medi-Cal	Commercial	County	Other
Marin General	**45%**	**10%**	**39%**	**4%**	**3%**
El Camino	48%	6%	44%	0%	2%
North Bay	40%	26%	24%	6%	4%
North Bay - Vaca Valley	48%	13%	31%	5%	3%
Queen of the Valley	50%	10%	36%	2%	2%
Sutter	32%	12%	50%	1%	5%
Washington Hospital	50%	17%	30%	0%	3%

Source: OSHPD Financial Data.

Over the planning horizon, the mix will shift as the population ages. Every year, 1% of the population will move into the 65+ age cohort. The shift in population will translate to changes in the overall payor mix within the District.



Source: Claritas.

	2005 Actual	2015 Estimate
Medicare	47%	54%
Medi-Cal	9%	8%
Commercial	34%	30%
County	4%	3%
Other	7%	6%

Source: OSHPD Financial Data and KSA Projections.

The impact of these changes have not been modeled as the future reimbursement rates and costs are highly uncertain. As the payor mix shifts from commercial payors to government payors, MGH will need to be more competitive to maintain/attract commercial patients. Cost management will be required to secure margin based on fixed reimbursement rates.

The payor mix of MGH with regards to financial reimbursements is not known at this time. The Medicare cost report data sources do not provide detailed information to assess the impact of any future change in payor mix. We recommend further evaluation when additional data is available from MGH.

Source: 2005 OSHPD Hospital Annual Financial Data Profile. 2001-2005 Medicare Cost Reports, Claritas Population Data 2007.

Assessment Overviews – Financial

- Impacts of service line changes on future financial situation – similar to the payor mix, data on service line revenues and expenses is not available for assessment at this time. We recommend further evaluation when additional data is available from MGH.

Transition Period Financial Projections

During the transition period from 2006 to 2009, it is uncertain what changes may occur. This analysis assumes steady growth in revenues and expenses, except for:

- Discharges are expected to be 5% below projected levels due to uncertainty on physician changes in 2008 and 2009.
- This analysis shows the margin continues to be positive partially due to paying off of debt as outlined in transition plan results in declining interest expense.

	2006	2007	2008	2009
Income Statement				
		Transition Period		
Total Revenue	**260,310,000**	**270,040,000**	**253,200,000**	**262,860,000**
Total Operating Expenses	**242,250,000**	**249,620,000**	**246,030,000**	**249,960,000**
Strategic Investments	**0**	**0**	**0**	**0**
Excess of Revenue over Expenses from Operations	**18,070,000**	**20,420,000**	**7,170,000**	**12,900,000**
Operating Margin	6.9%	7.6%	2.8%	4.9%
Investment Income and Interest	**0**	**0**	**0**	**0**
Excess Revenue over Expenses from All Sources (Net Income)	**18,070,000**	**20,420,000**	**7,170,000**	**12,900,000**
Total Margin	6.9%	7.6%	2.8%	4.9%
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)				
Excess Revenue over Expenses from All Sources (Net Income)	18,070,000	20,420,000	7,170,000	12,900,000
+ Add Back of Interest Expense	340,000	170,000	60,000	0
+ Add Back of Depreciation Expense	13,940,000	13,980,000	14,150,000	14,370,000
EBITDA Net Income	**32,350,000**	**34,570,000**	**21,380,000**	**27,270,000**
EBITDA Margin	12.4%	12.8%	8.4%	10.4%

The operating margin in the Transition Period is positive as interest costs are paid down.

Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA) represents the income excluding the non-cash charge for depreciation and payments for interest related to financing requirements. These two items are significant at MGH and will not be controlled by the management team. The depreciation is especially important to consider as it represents the investment by the public in the future facility of the hospital. Hospital operations cannot support this amount of investment.

Source: *CMS Cost Report Data for 2001-2005. OSHPD financial data.*

Note: This preliminary financial analysis is based on data available at this time. It is sensitive to the accuracy and validity of the data and subject to assumptions. Changes in the assumptions, even at some small percentage changes, impact the projected future values. KSA has conducted this analysis and supports the results based on the understanding that this is an estimate done in good faith and assuming data is correct. Assumptions applied are deemed reasonable, based on information known about MGH and KSA experience in similar settings.

Future Financial Projections

For the Projection Period of 2010 through 2015, additional assumptions outlined on previous pages were included. It must be understood that these forward looking financial projections are highly variable and dependent on consistently changing information – this projection is but a single option for discussion.

	2010	2011	2012
Income Statement			
Total Revenue	**241,520,000**	**248,290,000**	**269,070,000**
Total Operating Expenses	**253,430,000**	**263,860,000**	**285,620,000**
Strategic Investments	**1,000,000**	**2,000,000**	**3,000,000**
Excess of Revenue over Expenses from Operations	**(12,910,000)**	**(17,570,000)**	**(19,550,000)**
Operating Margin	-5.3%	-7.1%	-7.3%
Investment Income and Interest	**2,430,000**	**10,860,000**	**17,010,000**
Excess Revenue over Expenses from All Sources (Net Income)	**(10,480,000)**	**(6,710,000)**	**(2,540,000)**
Total Margin	-4.3%	-2.7%	-0.9%
Earnings Before Interest, Taxes, Depreciation and Amortization (EBITDA)			
Excess Revenue over Expenses from All Sources (Net Income)	(10,480,000)	(6,710,000)	(2,540,000)
+ Add Back of Interest Expense	0	2,500,000	5,000,000
+ Add Back of Depreciation Expense	14,640,000	16,540,000	18,780,000
EBITDA Net Income	**4,160,000**	**12,330,000**	**21,240,000**
EBITDA Margin	1.7%	5.0%	7.9%

Some notable changes occur in this period:

- Total Revenue declines sharply as driven by the assumptions in discharge and outpatient volumes and commercial reimbursement rates. The net change between 2009-2010 is -$21.3 million
- Total Operating Expenses rise by $3.5 million between 2009-2010. This is due to assumed increases in staffing costs and offset to some degree by the reduction in expenses due to lower volumes.
- Investment Income is increased – this accounts for the one-time issuance of the bonds and spending related to the 3-5 year time horizon of construction. The bond proceeds would be invested during the construction period until they are required to be spent.
- EBITDA has add backs for interest expenses related to operations supported debt issuance and depreciation of the new facility construction.

Source: CMS Cost Report Data for 2001-2005. OSHPD financial data.

Note: This preliminary financial analysis is based on data available at this time. It is sensitive to the accuracy and validity of the data and subject to assumptions. Changes in the assumptions, even at some small percentage changes, impact the projected future values. KSA has conducted this analysis and supports the results based on the understanding that this is an estimate done in good faith and assuming data is correct. Assumptions applied are deemed reasonable, based on information known about MGH and KSA experience in similar settings.

Strategic Direction Not Recommended At This Time

Private Governance of MGH

- Lease
- Sale

Private Governance of MGH

Transfer of MGH to private governance would occur through a long-term lease or sale to a private entity. Control of MGH is relinquished by the public in exchange for consideration.

- Lease MGH to a for-profit or not-for-profit hospital operator
  - Limited MHD governance role and local control - given past MHD experience, a willing company may require an agreement that significantly limits District Board influence on operations of MGH
- Sell MGH to an outside entity that agrees to operate MGH for at least a defined period
  - MHD will focus efforts on other aspects of community health and wellness as a philanthropic foundation

A qualified hospital operator can run MGH either in similar size and scope or adjust the services as preferred. The ability of the community to control or influence the hospital's decisions will be limited.

The MHD District's mission and vision may change if the hospital is privately governed. The current mission articulated the District's roles and responsibilities as oversight of a lease. This can be maintained if MGH is leased, but if MGH is sold, the MHD mission will change.

Sample of a new Mission Statement after a sale of MGH:

The Marin Healthcare District/Community Foundation

- Supports access to high-quality essential health care services for the residents of Marin
- Provides funding for community primary care and wellness providers in collaboration to increase the health of our community
- Advocates for the highest quality care in Marin County

Source: *Marin General Site and Facility Master Plan and Marin General Hospital S.B. 1953 Compliance Plan.*

Strategy Elements

A significant issue here will be finding a company willing to lease and endure the public input process. The study to gauge potential interest in a lease or sale conducted by Geoff Lang in the summer of 2007 indicated there were no interested parties at this time. The large capital requirements, highly political environment and timing were cited as the main deterrents. As we do not anticipate material changes in these factors, we believe finding a suitable lessee or buyer is highly unlikely.

If a company can be found and is willing to upgrade the facility to meet the 2030 seismic requirements, they will require a lease of more than 30 years in order to support the capital investment. A shorter lease term may be an option - a 20-year lease that brings the lessee only to the 2030 seismic deadline. This option requires significantly less capital for facility upgrades, but leaves MHD without a compliant hospital at the end of the lease.

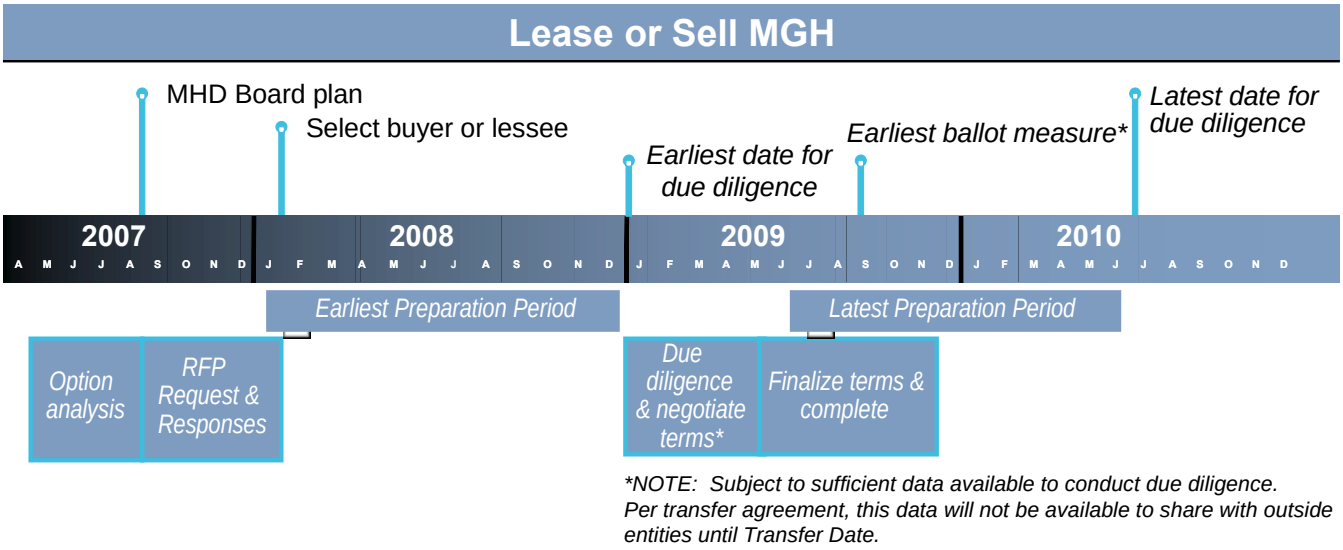
Covenants stipulating required services and time period would be desirable; however, limited covenants may be required to find a company willing to lease or buy MGH. The covenants limit the ability to adjust services to a viable/profitable balance. Therefore, potential lessees or buyers do not prefer covenants. Each one will require the District to give a concession.

The MHD Board must overcome its credibility issues with the public and gain public support for a renewed Lease option and a possible bond measure to maintain the facility or a sale. These options require the majority of District voters to approve the deal. The District will need to negotiate terms and then communicate with the public to garner passage. From our discussions and observations, some significant level of public resistance will need to be overcome.

The value of MGH to a lessee or buyer is more than just the land or building; it's the ongoing patients and physicians. To secure and enhance MGH's value, MGH must retain key physician and nursing staff; recruitment will be the responsibility of new lessee or buyer.

Transition and Strategic Timeline

If a Management Company is hired, it is our understanding that the Confidentiality Agreement within the Transfer Agreement can be extended to the Management Company. If the Management Company is interested in a lease or purchase of MGH, terms could be negotiated ahead of the Transfer Date. A ballot measure for the lease or sale by the Management Company could not occur until after July 1, 2010. Effective start of the lease or sale would most likely be Fall 2010.



NOTE: Subject to sufficient data available to conduct due diligence. Per transfer agreement, this data will not be available to share with outside entities until Transfer Date.

KSA advises that although a lease or sale are viable long-term strategic directions, the MHD Board cannot currently conduct activities to forward them at this time. The MHD Board has no ability to negotiate terms until after the Transfer Date. We recommend that the MHD Board move forward with plans to govern MGH, per the transition agreement. If the MHD Board wishes to consider the transfer of MGH to private control, the appropriate time to do so is at or after the Transfer Date. At that time, the MHD Board can provide interested parties with the required information to conduct due diligence.

Source: *Timeline for Settlement Agreement and Marin General Hospital Compliance Plan.*

Public Governance of MGH

Public Governance Options SWOT Analysis		
	Lease MGH	**Sell MGH**
Strengths	• Maintains hospital access for local residents • Likely will not require tax dollars for hospital • Maintains MGH as a community asset • Minimizes political manipulation of MGH	• Maintains hospital access for local residents • Will not require tax dollars for hospital • Ability to use funds from sale to address other community needs • Avoids political manipulation of MGH
Weaknesses	• Need to limit contractual covenants in order to lease • No or minimal guarantees about current or future services • Lack of public support for MHD Board and process required to pass ballot measure • MHD oversight may be an issue • May be protracted legal fight	• Need to limit contractual covenants in order to sell • Sale price will be discounted for seismic upgrades • No or minimal guarantees about current or future services or whether hospital stays open in the future • Lack of public support for MHD Board and ability to pass ballot measure • May be protracted legal fight
Opportunities	• Potential for expansion with strong leasing partners • Ability to select strong operator and maintain oversight of key metrics	• Dissolution of MHD Board to create Foundation and/or significant change in mission and operating structure
Threats	• Aggressive competition • Lessee would most likely require public funding for seismic and other upgrades • Legal and political fight to get lease deal on ballot	• Aggressive competition • Legal and political fight to accomplish sale

Thank You

Thank you for this opportunity to work with you on this important planning. KSA has enjoyed working with the MGH Board and the many community members to understand, discuss and develop a plan for the future of MGH. Your commitments to the future health care services in Marin are inspiring. We appreciate the challenges of debating and determining the plan for MGH. This is an important decision and we are encouraged by the great strides that have been made.

We look forward to seeing your progress in the coming months and years.

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