

SONOMA VALLEY HEALTH CARE DISTRICT BUSINESS PLAN

EXECUTIVE SUMMARY

The primary goal of this business plan is to generate and sustain a profit from operations. We want to achieve this goal soon enough to:

1. Ensure the taxpayers that an extension of the parcel tax is not essential for survival and
2. Supplement GO bonds as the sole method of financing capital projects needed in the future.

This is a challenge for a hospital such as Sonoma Valley Hospital (SVH). SVH is a small hospital (81 beds in total) serving a relatively slow-growing population. Sonoma is close enough to other hospitals and medical communities that SVH loses significant market share to those other medical communities.

Over the past decade, Sonoma Valley Hospital has never generated an operating profit. Only voter approved parcel taxes and the generosity of our donors has kept the hospital open. Nevertheless, we believe that we can achieve financial stability, without operating tax support, for the following reasons:

- Our cost structure is such that we can become profitable with a relatively small increase in volume. SVH staffs many departments at minimal fixed levels, and therefore has unused capacity and high fixed costs.
- The service demand of the local population can provide the necessary volume increases if SVH realizes relatively small increases in market share --- repairing the “market share leaks”.
- SVH has several departments that perform at high levels of efficiency and quality when compared with neighboring competitors. For certain service lines, this means that SVH is attractive to the physicians who perform those services. A surgeon working at SVH can perform procedures more quickly and with better outcomes.
- SVH is close enough to neighboring medical communities that it is feasible for physicians to split their practices between SVH and other sites.
- SVH has already implemented critical support functions to ensure that such splitting of practices does not impair quality of care and is attractive to physicians. These include:
 - a) A hospitalist program,
 - b) An IT plan that will ensure communication and connection between the hospital, physicians and patients,
 - c) Offices within the hospital for physicians,
 - d) Practice management support (scheduling, billing and collection, non-physician staff),
 - e) A business alliance with Marin Independent Practice Association (MIPA) and Marin Medical Practice Company (MMPC).
- MIPA, which uses the information services of MMPC, is the only physician organization available to doctors who do not want to associate with Sutter, the local Sisters of St. Joseph of Orange hospitals or Kaiser. Physicians affiliated with MIPA and MMPC will have
 - a) Negotiating strength with health plans,
 - b) An information network that has an EMR (Electronic Medical Record) and qualified as one of the first RHIOs (Regional Health Information Organizations) and
 - c) Very efficient and effective physician practice management support.

- We have identified several service lines that can provide the volume increases necessary to achieve profitability. This has been demonstrated by analysis of historical trends, market share data, and current patient referral patterns.
- At the highest level, outpatient surgery and diagnostic procedures will be the focus of SVH's future. In terms of medical specialties, the emphasis will be on orthopedics, general surgery, gastroenterology, gynecology, urology, ophthalmology, vascular surgery and medical specialties where outpatient services are the predominant treatment modality.
- We believe our approach to securing this potential market is beginning to prove successful. This is substantiated by successful physician recruitments, promising recruitment negotiations in process, the cooperation of the medical staff, and short term increases in the inpatient census.
- The Board's recent decision to identify a specific site for the development of a new facility should put an end to the controversy and uncertainty that has surrounded the hospital in recent years. We believe this will have a significantly positive impact on physician recruitment and donor giving, two key areas of our business plan.
- The potential for donor support is significant but unmeasured at this time. Within the next few months this potential will be assessed and incorporated in the financing of SVH's future. Our confidence in this potential is substantiated by the activities of the Sonoma Valley Foundation, Gary D. and Marcia L. Nelson Community Care Fund, the community-driven development of the Carolyn J. Stone Women's Health and Wellness Center, and the annual Sonoma Valley Vintners and Growers Harvest Wine Auction.
- The District electorate has been enormously supportive, having passed five-year parcel taxes in 2003 and 2007. The second measure passed with a 74% majority, despite the community rancor stemming from the failed Measure C election. We have little doubt with the current site and a successfully communicated business plan we will pass a bond measure for a new facility next spring.
- Even if the primary goal of operational financial self-sufficiency is realized, we do not believe that SVH can survive independently in the longer term. SVH has supported the development of the JPA with other Districts for this reason. This does not mean that SVH needs to be fully affiliated with another entity. However, SVH must seek the benefits that come with affiliation:
 - a) Shared administrative costs. Examples include basic financial management services such as purchasing, accounting, revenue management.
 - b) Shared clinical services. Examples include: physician call coverage, hospitalist services, anesthesiology, OB/GYN and neonatal services.
 - c) For levels of care beyond SVH's capability, arrangements and systems that ensure that our patients can be treated on a timely basis in the most appropriate setting and in the

most effective manner. Examples include: transfer agreements for neonatal cases and other specialties that are not medically appropriate for SVH.

The remainder of this document provides contextual background, amplifies the points made above and details additional elements of our business plan.

THE ROLE OF THE NEW FACILITY AND SITE IN THIS EVOLUTION OF THE BUSINESS PLAN

This evolution of the Business Plan recognizes the necessity of a new facility. SVH's current facilities do not meet the State's seismic safety standards and are inefficiently designed and excessively costly to operate. However, this evolution also recognizes these critical truths:

- If SVH does not execute the actions described in this plan, it will fail financially and will not exist to operate a new facility. Implication: this plan is being executed now and will work regardless of the site selected.
- The most important aspect of a plan for a new facility is demonstration of community support, without which this plan cannot be implemented. Implication: leadership and wisdom are critical on a broad community-wide basis. Acrimony and controversy will cause this plan to fail.
- Construction costs increase significantly over time. Implication: speed is critical.
- Until site evaluations (e.g., Environmental Impact Reports) and facility plans are approved (e.g., OSHPD), a site cannot be considered "secure". Implication: the plan must work regardless of the site.

This evolution of the Business Plan is based upon certain site and facility assumptions that therefore might change. It also is based upon a strategy that will achieve its goal regardless of the specific site but that will not achieve its goal if the site selection and development process follows historical patterns of public dissension.

The aspect of this plan that WILL be influenced by the site, and that is not yet complete, is breaking the new facility project into components that can be staged and financed over time. We believe this is necessary due to the egregious inflation rate of construction costs and the limited willingness of taxpayers to absorb additional public debt.

At this time the staging and financing plans are still work in progress, and will be completed by the end of November. However, the desired general structure of the staging plan is as follows:

1. Segment the new facility project into these facility components
 - a. Acute inpatient facilities required by regulation to support a Basic Emergency service --
- which we believe to be the clear need and want of the SV community
 - b. Acute inpatient facilities desired by the community (e.g., OB)
 - c. Skilled nursing facilities
 - d. Outpatient surgical and diagnostic facilities that require adjacency to the inpatient facilities
 - e. Outpatient facilities that do not require adjacency to the inpatient facilities
 - f. Non-clinical office space for administrative functions, public meetings, food services
 - g. Non-structural elements such as HVAC, {add more here}

9/23/2008; 10:33:51 AM

C:\Documents and Settings\ISKC\Desktop\Post to svhdotcom\Business Plan\Business_Plan_Executive Summary for website.doc

- h. Equipment critical for “immediate” replacement due to obsolescence or competitive requirements
 - i. Equipment that is required for the new facilities
 - j. Information systems
 - i. Infrastructure --- e.g., hardware
 - ii. Critical applications --- e.g., the McKesson Paragon system, and an Electronic Medical Record system
 - k. Parking
 - l. Existing facilities
 - m. Physician offices--existing and new
 - n. Affordable housing for providers. Physician and nurse recruitment efforts clearly indicate the challenge posed by high housing costs.
2. Estimate the costs of each
 3. Identify alternative financing options for each
 4. Using information regarding desired adjacencies and the feasibility of using existing facilities determine staging options that do not undermine the objective of realizing positive operating margins in the near term
 5. Evaluate each component in terms of its relative urgency in terms of regulations (e.g., seismic upgrade timing requirements) and competitive requirements
 6. Secure alternative sources of financing wherever possible

It is critical to understand that the size of the GO bond being planned to build the new facility is dependent on the completion of these tasks.

THE NEED FOR A NEW FACILITY AND THE SITE SELECTION PROCESS

The current facility does not meet the seismic safety standards generated by SB 1953. The age of its infrastructure and the operational inefficiency inherent in its inpatient-centered design also prescribe replacement. Several studies (including one just completed) have confirmed that the District will have to acquire additional land to solve this problem. The renewal effort will be costly, and even though we expect significant improvement in operating results over the next several years, they will not be sufficient to support the level of debt required in this effort.

The District has wrestled with this issue for over a decade, first attempting to affiliate with a larger organization that would joint venture with the District taxpayers in building a facility and managing a new facility. It held substantive discussions with Sutter in the late 90’s, but owing to profitability issues at both Sutter Santa Rosa and the District, that undertaking was ultimately abandoned. During this period we identified a number of potential sites, but none emerged as a clear first choice. At that point the District renewed its efforts to identify a site and hired a CEO with the clear direction to bring a new hospital decision before the voters.

9/23/2008; 10:33:51 AM

C:\Documents and Settings\ISKC\Desktop\Post to svhdotcom\Business Plan\Business_Plan_Executive Summary for website.doc

In the spring of 2006 Measure C was put before the voters, asking if they wanted to finance a \$148 million bond to build a new facility on some 40 undeveloped acres near the corner of Leveroni Rd and 5th Street West. The Board had sought considerable community input on the site decision, because all three of the sites identified as feasible were only available through the use of eminent domain. Out of this effort came the community's apparent endorsement of the Leveroni site. However, the announcement of Measure C was met with immediate and substantial opposition. Midway through the month-long mail ballot, a community member announced that he had secured options from willing sellers for some 15 acres near the southeast intersection of Napa Road and Broadway. At that point the Board withdrew support for Measure C and it was roundly defeated.

Anticipating that defeat, several community members formed a committee to explore an alternative approach that would meet with the community's approval. That work evolved into the Sonoma Valley Health Care Coalition, a citizen group that, with the approval and financial support of the District, worked for a year to develop a recommendation to the Board regarding a new hospital. In late spring 2007 the Coalition ultimately recommended that the Board pursue two alternatives – to secure sufficient land either at Broadway (but only above the Urban Growth Boundary) or adjacent to the existing site to make a replacement facility possible. The District adopted the Coalition's recommendation and appointed a negotiating team to implement it. The negotiating team met with the Board monthly and eventually brought them the following two options.

- Work with a developer and contractor, the Swenson Group, to build on 7.5 acres at the Broadway site.
- Acquire the additional vacant land near the existing site and develop a new facility that incorporates the existing buildings to the extent feasible.

As the negotiating committee pursued its objectives, the CEO commissioned an entirely new team of architects (Tsang and HKS) and construction managers (Montgomery Corp.). This new team evaluated the physical and regulatory feasibility of constructing a new facility of both sites.

Both groups conveyed their findings to the Board, and on October 10, 2007 the Board selected the second option.

The Sonoma Valley community has been studying alternative sites and configurations for a new facility for at least 11 years. A detailed review of the documentation produced during those eleven years provides valuable information to guide future decisions. Some of this information provides technical support for the Business Plan, and some provides lessons regarding decision processes.

Technical information includes:

1. Seismic requirements and status of the current facility
2. Demographic changes and consequent requirements for numbers of hospital beds and the number of physicians by specialty
3. Critical departmental adjacencies required to optimize patient flow, quality of care, and costs
4. Recommendations to minimize construction costs by allocating space into different categories (in terms of State regulations) of buildings

5. Preliminary estimates of the size of the required facilities. It is critical to note that this information requires professional review and updating.
6. Criteria for evaluating the relative merits of different sites.
7. Cost estimates
8. Financial forecasts

This technical information is documented in numerous reports that are listed in Appendix I. Rather than provide that detail in this report, SVH will provide access as requested and appropriate.

Lessons regarding the decision process include:

1. The beauty and value of the land in Sonoma Valley has made site selection a politically difficult process. It has also delayed decisions and therefore cost tens of millions of dollars in escalated construction costs.
2. The complexity of hospital design and site selection is great and requires the input of numerous professionals with different specialties. Within these professions and between these professions, there is considerable room for disagreement. The state of our healthcare “system” and failure to reform it are evidence of this. Most recently, SVH engaged a team of architects and engineers to review prior recommendations, to evaluate alternatives, and provide information to the Board to support Board decisions. This team has been directed to act independently and objectively. Their work has been subjected to peer review by other professionals--- e.g., architect’s design is reviewed by other architects.
3. The evolution of medical technology has been, and will continue to be, fast and difficult to predict. Procedures that used to require many days of care in an acute hospital are now being done in physicians’ offices. The general trends of greatest relevance to SVH are
 - a. The trend towards shorter hospital stays. Example: the dramatic decline in the average length of stay for hip replacements. Implication for SVH: fewer beds are needed, and more capacity is needed for ambulatory procedures and outpatient rehabilitative services.
 - b. The trend toward procedures being done in outpatient and physician office settings. Example, many urological procedures are now performed in physicians offices. Implication for SVH: design and manage the Surgery Department in the same manner as an “Ambulatory Surgery Center.” We have already begun to do so and do not believe that the current facility poses significant constraints to do even more.
 - c. Increasing sub-specialization. Example, within orthopedic surgery surgeons increasingly specialize on specific body parts, also specialties in vascular and brachytherapy. Implication for SVH: seek affiliation with groups providing the broader spectrum of service; or, recognize and focus on selected niches.
 - d. The increased capacity of information technology to connect hospitals, physicians and patients. Example: the Electronic Medical Record (EMR). Implication for SVH: the new facility plan will include an updated IT plan that includes an EMR.

ECONOMICS OF A HOSPITAL WITH 24 HOUR EMERGENCY SERVICE

To appreciate the financial impact of the business plan it is first necessary to gain a basic understanding of the economics that underlie a small hospital such as ours. We provide emergency

9/23/2008; 10:33:51 AM

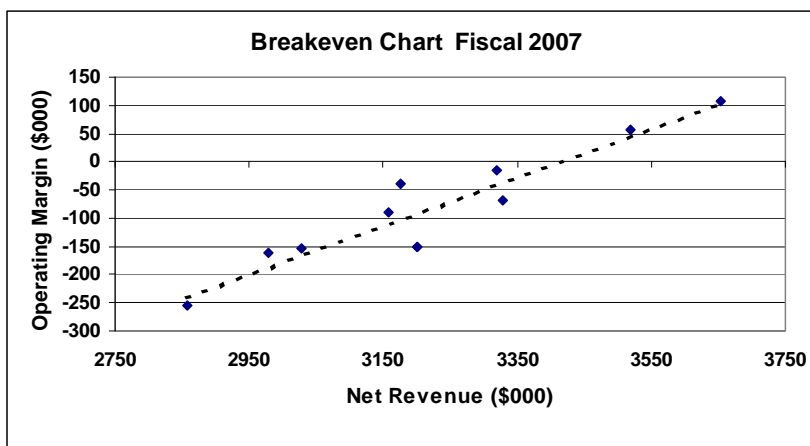
C:\Documents and Settings\ISKC\Desktop\Post to svhdotcom\Business Plan\Business_Plan_Executive Summary for website.doc

medical services around the clock despite the considerable financial burden that imposes. In addition to the physician, nursing and clerical personnel who directly staff the department, our emergency services are supported by diagnostic technicians who are on site 24 hours a day, as well as an intensive care ward always ready to accept patients. We also have a surgery crew and an array of physicians on call around the clock, all of who are being compensated. All of these costs are completely fixed. Combined with the ‘normal’ administrative and other fixed costs any enterprise incurs, the result is an economic profile in which, on average, over 40% of our costs are fixed.

A profile of *some* of these fixed costs is shown in the following table.

Cost Element	Approximate Annual Cost
Emergency Room – Direct costs only	\$2,150,000
Physician call coverage	600,000
Staff on call for Emergency Room	850,000
Diagnostic staff on site for Emergency Room	250,000
OB department	1,350,000
ICU department	1,200,000

Because these costs are fixed, additional revenue directly increases the operating margin. The chart below, which relates operating margin to net revenue, is drawn from our monthly financial statements over the 2007 fiscal year. The dotted ‘best fit’ line conforms to a fixed cost of 40%.



With high fixed costs, relatively small changes in volume produce substantial differences in operating margins. This is especially relevant to our business plan because the 40% figure is *an average*. In developing the business plan we analyzed the contribution to profit, the “contribution margin” by

general service lines, to identify those areas that would produce the greatest return. As the results below illustrate, surgery and outpatient imaging are the areas where increasing volume provides the most potential for improving the hospital's profit.

<u>Service Line</u>	<u>Contribution Margin</u>
Inpatient Services	
Medicine	25-35%
Surgery	40-50%
Obstetrics	70-75%
Outpatient Services	
Surgery	75-85%
Imaging	50-60%
Lab	90-95%
Rehab	30-35%

“Contribution” multiplied by additional net reimbursement yields the increase in profit.

To capitalize on a percent contribution margin requires being able to increase volume. For some services with high fixed costs, that ability is limited and the service has little potential to generate positive operating margins. To illustrate: because the emergency room's cost are entirely fixed, 100% of any additional revenue increases profit. However, because we already serve all of that market, no growth is possible. Therefore, we have not included it above. So clearly the next question is “Which service line affords the greatest potential increase in volume and therefore operating margins?”

POTENTIAL FOR INCREASING MARKET SHARE AND PROFIT

By providing two additional pieces of information to the table in the prior section, we can determine where we should focus our efforts.

Note that we have focused on the non-Kaiser market share because it will require a much longer term strategy to go after their market. This longer term strategy cannot be executed by SVH independently and is a primary driver for the need to eventually affiliate with a larger organization or network, such as the JPA and /or other affiliates. In addition, this longer term strategy requires implementing a plan for ensuring that when our current primary care physicians retire, they are succeeded by SVH-cooperative physicians. Detailed Inpatient Market Share statistics are shown below in Appendix II.

The table below provides aggregate estimates.

<u>Service Line</u>	<u>Current SVH Annual \$</u>	<u>Non- Kaiser Market Share</u>	<u>Contribution Margin</u>
Inpatient Services			
Medicine	5,750,000	85-90%	25-35%
Surgery	6,250,000	30-40%	40-50%
Obstetrics	1,750,000	60-70%	70-75%
Outpatient Services			
Surgery	5,700,000	40-50%	75-85%
Imaging	2,500,000	60-70%	50-60%
Lab	1,600,000	85-90%	90-95%
Rehab	600,000	50-60%	30-35%

Our targets should be those areas that hold the most potential for improving profits. That potential is a function of the three factors outlined above, which can be viewed as containing the answers of the following three questions.

1. How big is the market?
2. Can we improve our share of that market?
3. If we do, what will the payoff be?

By simply applying the factors above, we can arrive at a range of potential profit improvement, as reflected in the following table.

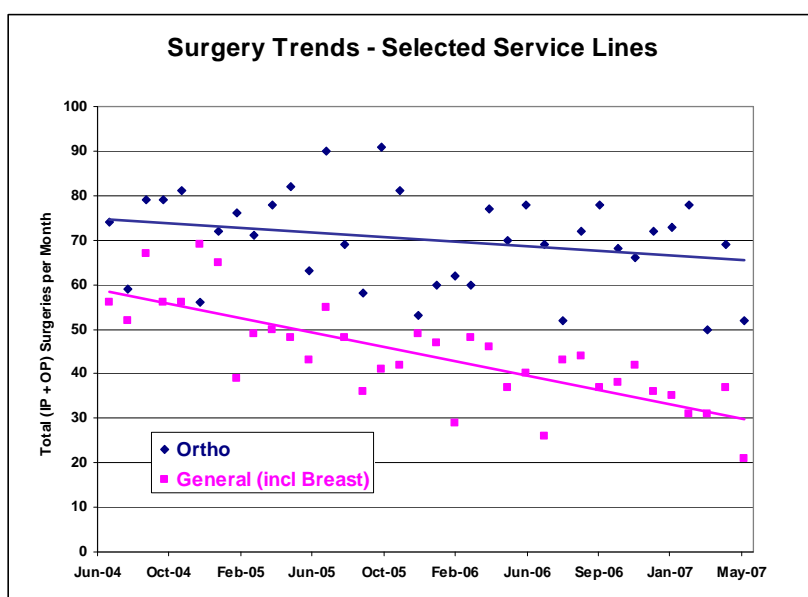
<u>Service Line</u>	<u>Non-Kaiser Market Available</u>	<u>Potential Gain</u>	<u>Marginal Profit</u>
Inpatient Services			
Medicine	600,000 – 900,000	50,000 – 150,000	15,000 – 50,000
Surgery	3,750,000 – 4,500,000	1,000,000 – 3,250,000	500,000 – 1,600,000
Obstetrics	500,000 – 750,000	50,000 – 75,000	25,000 – 50,000
Outpatient Services			
Surgery	2,750,000 – 3,500,000	1,250,000 – 2,750,000	1,000,000 – 2,250,000
Imaging	700,000 – 900,000	175,000 – 500,000	100,000 – 300,000
Lab	150,000 – 250,000	15,000 – 75,000	10,000 – 60,000
Rehab	250,000 – 300,000	50,000 – 150,000	20,000 – 50,000

These amounts assume we will not be increasing our primary care physician capacity. Given this reality over the short term, we do not believe there is as much potential in those areas that do not require a primary care referral, such as inpatient medicine, as there is in areas such as surgery.

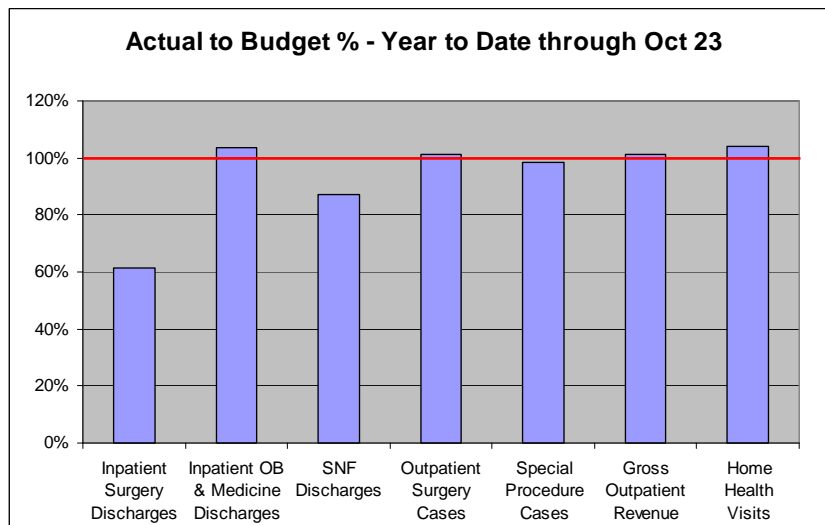
Clearly, surgery should be our target. Success in this service line has more potential than the other areas combined, and with its possibility for increasing our annual profit by some \$1.5 to nearly \$4 million, could make the hospital profitable.

RECENT TRENDS WITHIN SURGERY

Although we will be working on increasing all of our surgery volumes, we will turn our attentions first to general and orthopedic surgery. These are the two largest sectors within the market, and as the chart below reflects, we have seen steadily decreasing volumes in both of these areas over the past several years.



These trends are entirely consistent with the departure of specialists in both areas over the same time frame. Appendix II provides a detailed analysis of the trends in our surgical volumes. Most recently, the impact has been concentrated in inpatient surgery. Our fiscal 2008 budget simply extended the volume levels we saw over 2007. Over the first few months, our volumes have conformed to budget very closely, with one exception. Our inpatient surgery admissions are significantly below budget, as reflected in the following chart.



Analysis indicates that the negative variance in SNF admissions stems entirely from the shortfall in surgical inpatient volume. This is another reason to focus on surgery. The related increase in SNF, outpatient diagnostics and therapy volumes were not taken into account in the profit improvement calculations provided in the preceding section.

In addition to orthopedics and general surgery, our discussions with our PCPs and with surgeons in our larger market area indicate real opportunities in several other specialties:

- Breast surgery. The SVH community has benefited from the services a well-respected breast surgeon and now is also benefiting from the concerted efforts of the Women's Health and Wellness program described later in this plan.
- Vascular surgery. SVH has a Wound Care clinic with relatively high volumes, and the vascular surgeons attending that clinic have begun to perform certain procedures here.
- Ophthalmologic procedures
- Podiatry (minimally invasive foot and ankle surgery)
- Gynecology. Although SVH has a 90% share of non-Kaiser medical cases it only has a 48% share of inpatient gynecological cases. Further, it only has one OB/Gyn and in order to improve the coverage of OB and increase the volume of Gyn procedures one of our highest physician recruitment priorities is to recruit at least one more OB/Gyn. Physician demand statistics indicate that our population needs about 1.6 Obstetricians and 3 Gynecologists.
- Urological procedures
- Pain Management. We have been performing some interventional procedures, however with the development of our Pain Management program the types of procedures and volumes are anticipated to increase.
- Plastic Surgery.

On a more general level, we are constantly evaluating existing referral patterns to determine where SV residents are obtaining surgical services and why they are not using SVH. If at all possible and feasible, we are working to have the surgeons treat the SV patients at SVH. In the process, we are learning what we can do to make that happen.

OUR APPROACH TO ATTRACTING SURGICAL SPECIALISTS

Increasing SVH surgical volume requires attracting specialists who want to work here and to whom the local primary care physicians will refer.

We will explain our approach in three parts:

- 1) Our understanding of the economic realities of this market
- 2) Our understanding of the unique situation of SVH in this market
- 3) The actions we are taking to respond to those conditions

Economic Realities

- The non-Kaiser population in SV does not generate enough demand to support the optimal number of physicians for most non-primary care specialties. This means that there is not enough revenue to support enough physicians that can share call coverage. This means that many specialists must work in several locations.
- Kaiser dominates this market and has 50% of the insured residents of Sonoma County as members. Sutter has changed its business strategy in the North Bay area to focus on developing its medical foundation (SMF) and minimizing its inpatient role. Without effective organization, independent physicians face ominous competition in attracting new patients and negotiating with health plans. A few years ago, they participated in the Health Plan of the Redwoods (HPR), and when HPR closed, many independent physicians suffered serious financial harm.
- Currently, the best alternative for physicians is to participate in the Marin Independent Practice Association, (MIPA). MIPA, which uses the information services of MMPC, is the only physician organization available to doctors who do not want to associate with Sutter, the local Sisters of St. Joseph of Orange hospitals or Kaiser. Physicians affiliated with MIPA and MMPC will have
 - a) Negotiating strength with health plans,
 - b) An information network that has an EMR (Electronic Medical Record) and qualified as one of the first RHIOs (Regional Health Information Organizations) and communications via the Internet with patients,
 - c) Very efficient and effective physician practice management support.
 MIPA's long-term goal is to transition from a managed care contracting model to a fully integrated group practice, and they have developed a true medical group named Prima.
- Physicians face increasing economic pressure. As a result they will seek to capture a portion of the facility reimbursement for profitable outpatient services, particularly elective surgery and imaging. In the absence of a strategy that allows the hospital and local physicians cooperate economically, we will almost certainly face direct competition from the physicians over the only profitable components of our business. The Federal government has recently changed reimbursement rules related to ambulatory procedures and also changed regulations related to hospital-physician joint ventures. This and several interviews with planners throughout the State indicate that although hospital-physician joint ventures are theoretically desirable, they are legally and financially problematic. Nevertheless, SVH is actively working with its legal counsel to determine legal arrangements that are financially beneficial to both SVH and its physicians and are legally feasible.

9/23/2008; 10:33:51 AM

C:\Documents and Settings\ISKC\Desktop\Post to svhdotcom\Business Plan\Business_Plan_Executive Summary for website.doc

If possible, these arrangements will be implemented as soon as possible and prior to the opening of new facilities.

- Certain surgical specialties, particularly general and orthopedic surgery, are responsible for a disproportionate share of a hospital's profitable activities. In addition to their obvious role in driving elective surgery volume, they are a major referral source for imaging, diagnostic testing and rehabilitation services. SVH's SNF primarily serves as a rehabilitation facility.

UNIQUE SITUATION OF SVH

SVH exists within the economic context described above. SVH also has additional circumstances that influence our approach to increasing surgical volumes. These are:

- SVH is close enough to neighboring medical communities that it is feasible for physicians to split their practices between SVH and other sites.
- Because our relative isolation does not allow them to round both on patients at SVH and other local hospitals, all of our primary care physicians practice exclusively at our facility. This makes them inclined, *all other things being equal*, to keep their patients local.
- SVH has several departments, including Surgery and Imaging, which perform at high levels of efficiency and quality when compared with neighboring competitors. For certain service lines, this means that SVH is attractive to the physicians who perform those services. A surgeon working at SVH can perform procedures more efficiently and with better outcomes.
- SVH has a history of working with our physicians on business matters. We were closely aligned in managing our joint risk contract with Health Plan of the Redwoods, when the physicians were organized locally in the Valley of the Moon Medical Group. Subsequent to the bankruptcy of HPR, VMMG effectively merged in the Marin IPA. While we do not work as closely with MIPA as we did with VMMG, we have maintained close ties with that organization.
- MIPA has organized a group medical practice called Prima. Their board has authorized extending the group into Sonoma, and two of our recently recruited primary care physicians have recently joined the Sonoma Prima Medical Office.
- We have no desire to put the physicians in a subordinate role within the local health care system, through a hospital-controlled foundation or any other means. This will make it easier to develop economic partnerships with the physicians, where we concentrate on improving the aggregate financial outcome.

Actions

Taking this environment into account, we have developed the following strategies.

- SVH encourages and supports physicians who “split” their practices. Most of SVH’s current proceduralists do so. SVH has already implemented critical support functions to ensure that such splitting of practices does not impair quality of care and is attractive to physicians. These include:
 - a) A hospitalist program, ‘Split’ specialists also require that local internists who they trust follow their inpatients. As a result, it is critical that we maintain our hospitalist program. We are redesigning that program, and integrating it with our local office-based internists. We need to ensure that specialists who we are encouraged to work here are introduced to the program and become comfortable with it.
 - b) An IT plan that will ensure communication and connection between the hospital, physicians and patients. In working with MIPA on our IT strategy, we will focus on enhancing ‘connectivity’ with our physicians. Our most recent IT improvement, the PACS installation in imaging, is a good example of this strategy. By making information readily available to specialists whose primary practice is a nearby community, we make it easier for them to operate here.
 - c) Clinical Office Space within the hospital for physicians,
 - d) Practice management support (scheduling, billing and collection, non-physician staff),
- We have redesigned our medical staff office to do more than merely provide clerical support. The Director of Physician Relations, who maintains close contact with the doctors who practice here, now staffs that office. The objective is to ensure that we are doing everything we can to foster their desire to refer to the hospital.
- We have reoriented our specialist recruitment efforts to always closely involve our primary care physicians, to ensure that they are comfortable referring to the surgeons we are encouraging to practice here.
- We will not recruit physicians to “compete” with existing physicians if doing so would cause financial hardship to the existing physicians. If demand is insufficient to support the additional physician, and if, in the judgment of the medical staff, the current quality of care is good.
- We will continue to actively support the success of MIPA.
- We will work cooperatively with other local hospitals and MIPA to encourage the rationalization of specialists across the region. As noted above, other local hospitals and SVH have lost surgeons and other specialists because there was not enough work for a ‘fractional’ doctor. We will explore joint recruiting and coverage efforts. An important component of this strategy is continuing to make part-time office space and staff available locally and on a basis that makes it financially feasible for specialists to split their practices.
- We are actively working with legal counsel and financial consultants to determine how we can joint venture with physicians in a manner that is both financially feasible and meets legal guidelines.

9/23/2008; 10:33:51 AM

C:\Documents and Settings\ISKC\Desktop\Post to svhdotcom\Business Plan\Business_Plan_Executive Summary for website.doc

We have already embarked on these strategies and have enjoyed some early success:

- Two recently-recruited primary care physicians have joined Prima in Sonoma
- A general surgeon has joined our staff and splits his practice between SVH, Petaluma and Sebastopol
- An orthopedic surgeon has joined our staff and splits his practice between SVH and Petaluma
- In January an orthopedic surgery group, which currently has about 30% of SVH's orthopedic market share, will be joining the office of our current highest producing surgeon. This has the potential of increasing our orthopedic surgical volume and the volume of related services (imaging, lab, PT) by 50-75%.
- Two vascular surgeons have agreed to perform procedures at SVH and split their practice between Marin and Sonoma
- Two additional ophthalmologists have joined our staff and we are working with them and our other dedicated ophthalmologist to continue to grow our surgical services for this specialty
- The hospitalist program is being successfully rebuilt
- We have a tentative agreement with a Marin-based orthopedic surgery group to treat their Sonoma patients at SVH
- We have a new podiatrist on staff that specializes in minimally invasive foot and ankle surgery.

OTHER VOLUME OPPORTUNITIES

While our first priority is improving surgery volumes, there are several other service lines we are developing, including: hospitalist services, occupational health, women's health services, and integrative health.

- Hospitalist services
 - 1) Hospitalists care for many of our inpatients in both the medical/surgical and skilled nursing settings. At this time about 50 % of our inpatients are served by the hospitalists.
 - 2) The benefits of a hospitalist program are:
 - a) Ensures physician oversight of inpatients throughout their stay
 - b) Ensures coordination and continuity of care through different stages of a patient stay --- e.g., from surgery to ICU to Med/Surg acute to SNF rehab to Home Health.
 - c) Allows primary care physicians to focus on their office practices, if they choose to participate in the program. A requirement of the rebuilt program is clear and frequent communication with the primary care physician of the patient.
 - 3) The initial program was begun three years ago and incurred start-up problems. In September we began rebuilding the program by engaging a consultant who had successfully developed over 30 hospitalist programs and by gaining the cooperation and support of the medical staff as a whole. Several of SVH's primary care physicians have stepped up to manage and develop and participate in the new program, which is now being staffed with a combination of dedicated hospitalists and several internal medicine physicians. Doing so has demonstrated the lesson of the Chinese calligraphy for "crisis", which is a combination of "danger" and "opportunity".

Our rebuilding has demonstrated opportunity, upon which we are capitalizing. That opportunity is showing the following:

- a) A hospitalist program focuses on managing the care of the inpatients, including the SNF patients, and this requires a joint effort between primary care physicians, specialists and nurses, as well as the hospitalists. The rebuilding is effectively integrating these groups and showing significant cooperation. One of our business goals is building a “cooperative medical community”. Rebuilding the hospitalist program has demanded this cooperation.
- b) It is probable that our prior program caused under-utilization of our inpatient services. In the few weeks since the advent of the new program, appropriate utilization has increased significantly. Our redesigned hospitalist program will encourage potential medically appropriate admissions that were previously turned away.

- Our SNF is a profitable service that primarily provides rehabilitation services. We believe our SNF volume can increase in two ways.
 - 1) Working with local primary care physicians and the discharge planners at other facilities to encourage local patients who have had surgery out of town to obtain their post-acute services at our SNF. Even if we are successful in bringing ‘home’ 100% of those surgeries that can be done at our hospital, there will always be a substantial number of tertiary procedures performed elsewhere.
 - 2) Making sure our utilization management and discharge planning personnel encourage patients to continue receiving care here (to the extent medically appropriate) rather than being transferred to a less acute nursing home setting.

The SNF has recently had an average daily census of 17 and has a capacity of 27. We believe that it is possible to increase that average census to 22 within the next year.

- We have rebuilt an Occupational Health department that lost its dedicated medical director last year. Under new leadership, that program has grown significantly and generates revenue in several ways:
 - a) Directly through its services billed to workers compensation insurance companies. Under the leadership of a new department manager, the department has reached its break-even target sooner than expected. Its growth has been significant enough to warrant an effort to recruit a full time medical director with a specialty in this service.
 - b) Indirectly through referrals to SVH diagnostic and therapeutic services.
 - c) Indirectly through referrals to specialists when procedures are required.

It should be noted that SVH occupation medicine department recognizes the need for conservatism in its case management and is therefore an attractive provider for employers and their workers compensation insurers.
- We have built an integrative medicine service line that has added valuable services for the community:
 - a) Successfully recruited a now-busy neurologist who specializes in pain management.
 - b) Provided leadership for the development of the Women’s Health and Wellness Center.

- The leadership of the Integrative Medicine Service is also working with community leaders to develop a Women's Health and Wellness Center. The momentum and potential of this activity is described in greater detail in the next section of this document.

WOMEN'S HEALTH AND WELLNESS

Named to honor twenty three years of dedicated fundraising service and support to SVH, The Carolyn J. Stone Center for Women's Health and Wellness is positioned to play a major role in our future. This initiative will result in quality health care; it is a public relations star and a high performance philanthropy vehicle. For the past year a Community Advisory Committee of 40 local women has worked to develop and execute a plan to ensure that women living in Sonoma have local access to the highest quality of medical care. The SVH Foundation has already raised over 1 million dollars for this cause. These funds have been used to purchase digital mammography, a bone density scanner, portable ultra sound, several pieces of equipment for our Birth Center, and to underwrite the first year salary of the Center's first employee –A Program Coordinator/ Nurse Navigator.

Their detailed current plan is contained in Appendix IV, but the following is a list of the activities currently underway.

- Recruitment of a Physician Director
- Recruitment of the Program Coordinator/Nurse Navigator
- On going discussions with The UCSF Center of Excellence for Women's Health to define and orchestrate a mutually desired affiliation.
- Production of a 4 part educational outreach series in collaboration with UCSF
- Exploration of grant opportunities by our Community Advisory group and UCSF Development Director
- Discussion with UCSF to explore provider sharing opportunities in the areas of Gynecology, OB and minimally invasive gynecological surgery

A limited analysis of the business potential of the WHW program indicates the following:

- SVH has a 48% share of the OB services for SV residents and a 45% share of the Gynecological inpatient services. Since SVH provides OB services only for women with low risk of complications, it is unlikely that the OB market share can be significantly increased. On the other hand, there is significant opportunity to increase the volume of Gynecological services.
- Gynecological services are increasingly performed in ambulatory settings and therefore the inpatient market share is not directly indicative of the market demand.
- An analysis of the number of physicians needed for OB/Gyn indicates that SVH's population requires 1.2 Obstetricians and 2.5 to 3 Gynecologists. This suggests that the volume gynecological procedures performed at SVH could be doubled, at a minimum.
- SVH currently has one OB/Gyn and SVH performs about 250 deliveries a year. Currently in the United States, the average obstetrician performs 150 deliveries a year.
- This is problematic in two ways:
 - a) The low volume of deliveries does not provide sufficient volume to maintain necessary skill levels for the providers other than the OB/Gyn physician.

- b) Only one Obstetrician cannot cover the service by himself full time.
- In response to these problems SVH's medical staff and its single OB/Gyn have developed and are executing a plan to ensure service quality and recruit at least one additional OB/Gyn to the community. Key elements of this plan are:
 - 1) Recruitment of at least one additional OB/Gyn, preferably a woman
 - 2) Engaging the cooperation of the Sonoma Valley Community Health Center (SVCHC), since most of the deliveries are for their patients.
 - 3) Evaluating the possibility of contracting with a larger anesthesiology group, which would assimilate our current anesthesiologists and provide 24/7 coverage for OB services.
 - 4) Implementing review processes to ensure maximum quality of care. This includes regular peer review by physicians associated with the University of California, Davis and also San Francisco.

COST MANAGEMENT

Although the dominant focus of the Business Plan is increasing service volumes, it has become readily apparent that SVH has both the need and opportunity to improve its efficiency.

The following initiatives are in process to meet this objective:

- 1) Change staffing and pay practices in certain departments to "flex" more.

Staffing in certain departments is not adjusted as much as it can be to match changes in service volumes. Whereas certain departments have minimal staffing requirements established by regulation and by quality of care standards, there are opportunities to improve. SVH recently completed an analysis which compared actual staffing with mandated State guidelines. The analysis shows that SVH over staffed and incurred excessive costs of at least \$750,000 on an annual basis.

To realize these benefits requires implementing changes in the policies, procedures, systems used to schedule services and staff. These changes will be implemented next year, after SVH passes an imminent JCAHO survey that could be done anytime after January 1, 2008.

- 2) Use the current facilities more efficiently.

SVH will continue to operate in its current facilities for a least five more years. SVH recently retained the services of an architect/engineering team to evaluate the feasibility of making better use of the current facilities. The following is a list of the changes being considered:

- a) Moving the Ambulatory Care Unit (ACU) from the 3rd floor of the West Wing into the area currently used by Administration. This would reduce patient transportation time and costs and improve the communications between the Surgery Department and the ACU.
- b) Moving the family waiting room for surgery to a room closer to the Surgery Department. This would improve communications between the surgeons, surgical staff, and families.

- c) Moving Outpatient Physical Therapy out of the West Wing basement and to the ground floor. The benefit of doing so would be to have a more attractive setting for patients. The exact location is not yet determined.
- d) Bringing together the two geographically-separate Outpatient Physical and Occupational Therapy centers to one location. This is potentially more efficient and is clearly more attractive to patients. It is not clear if this is feasible within the current facilities. If the current facility can be used, it is likely that SVH would extend its schedule past normal business hours. Again, this would be potentially more efficient in terms of costs and would be more attractive to patients, who would not need to lose time away from work to receive therapy.
- e) Move the administrative staff, who are currently spread throughout the facilities, into a common area. This would greatly improve communications and enable the sharing of support staff. The exact location has not yet been determined.

3) Acquire information systems that have evident short-term benefits.

Applications that have been identified as high priorities are:

- a) Time and attendance. Required to address the staffing efficiency initiative described above.
- b) Surgery scheduling and management. Required to support the desired increase in surgical volumes.
- c) Occupational medicine practice and revenue management. Required to improve net revenues and continue growing this service line.
- d) PACs (Picture Archiving). Already installed and running.
- e) Upgrading the hospital's main system. Required because of obsolescence of the existing software, to increase net revenues, to provide more efficient clinical service documentation, and to provide data for management decisions and performance monitoring.

These are described in greater detail in the next section.

4) Evaluate sharing certain administrative functions with other healthcare organizations.

One of the principle reasons for developing the Joint Powers Authority with other local district hospitals was the potential for cost sharing. Functions that appear to have the greatest potential for cost sharing include the following:

- a) Purchasing
- b) Revenue management
- c) Information systems
- d) Staff recruiting
- e) Call coverage for certain medical specialties

INFORMATION TECHNOLOGY

SVH's current IT infrastructure and applications are in need of upgrading, and have been kept going through the efforts of a skilled and dedicated IT department. A detailed plan is included in Appendix

III. We believe that upgrading the IT infrastructure and applications must occur soon and we are actively pursuing alternatives for financing this upgrading.

LONGER TERM GOAL - AFFILIATION

Even if the primary goal of operational financial self-sufficiency is realized, we do not believe that SVH can survive independently in the longer term. SVH has supported the development of the JPA with other Districts for this reason. This does not mean that SVH needs to be fully affiliated with another entity. However, SVH must seek the benefits that come with affiliation:

- Shared administrative costs. Examples include basic financial management services such as purchasing, accounting, revenue management.
- Shared clinical services. Examples include: physician call coverage, hospitalist services, anesthesiology, OB and neonatal services.
- For levels of care beyond SVH's capability, arrangements and systems that ensure that our patients can be treated on a timely basis in the most appropriate setting and in the most effective manner. Examples include: transfer agreements for neonatal cases and high risk OB cases.

A long-term risk is the specter of being cut off from the HMO market. Sutter's impending exit from Santa Rosa and the Sisters of St Joseph of Orange's demonstrated behavior portend a situation where those two systems essentially abandon the HMO market locally. The risk is they will insist on prices that the insurance companies either decline (as in CalPer's exit from Napa County last year) or that require premium levels that put Kaiser at an even greater competitive advantage than they now enjoy. In the long run, we must work with MIPA and other independent facilities to provide an alternative network.

COMMUNICATION PLAN

As this Business Plan indicates, SVH is engaged in many business initiatives including but not limited to a financial turnaround, the design and financing of new facilities, and the development of several new services. Communicating the progress and status of this work is challenging and demands that we place a high priority on developing more effective communications processes. As the passing of the Parcel Tax affirmed, a large majority of residents are willing to support SVH. However, we believe that many Sonoma residents are unaware of the services and a quality of care already being provided. Again, this demands more effective communications with our community.

Our public relations and communications strategy needs to do three things:

1. Build community trust
2. Educate as to the quality and extent of services,
3. Build support and enthusiasm for the construction of new facilities and service lines.

With the SVHCD Board's site decision, a path toward the future opened up. An immediate shift of focus away from past problems and toward future solutions is the order of the day. It seems the right time to heal ourselves and SVH from the mire and exhaustion of past discord and confusion. It's time to move forward with the following suggested methods.

The matrix below offers a broad outline of our approach to improving public relations and communications. More detailed tasks will be added as we move ahead.

It needs to be noted that many community members with extensive marketing and public relations experience have come forward with offers of assistance. Sonoma is a small town and our networking abilities and our active engagement of the community will play a major role in our success.

EFFORTS

OBJECTIVES

Branding	Trust, clarity of services and expertise
Marketing	Increase market share for Surgery, Imaging , Continuing Care Programs
New Facility Campaign	Build community enthusiasm and support

TOOLS:

Branding

- Develop the message, the strategy and the initial printed collateral (graphics, tag line, brochure, printed ad campaign). This is fast tracked for completion in early 2008 and financed with philanthropy

Marketing

- Continuation of the bi monthly Healthcare Page to focus on SVH surgeons and our surgical excellence, on diagnostic technology and excellence, and on our new Carolyn J. Stone Center for Women's Health and Wellness.
- Ad campaign in alignment with the new branding strategic plan
- Focus on customer service as the front line of marketing. For example: possible concierge welcome for SVH lobby, an improved emergency room waiting experience, a proactive promotion of all SVH staff understanding their role in opinion building.
- Routine press releases to announce our program development progress

New Facility Campaign

- Establish a hospital spokesperson
- Issue routine progress reports/press releases
- Stay "on message"
- Use "new hospital" images and 3D models as soon and as often as possible
- Use concise, clear messaging.
- Do not release total cost figures without accompanying break down chart for individual homeowners to determine their exact personal tax responsibility based on their home's appraised value.
- Agendize a positive forward moving initiative for discussion at each Board Meeting to publicly highlight SVH progress (like Women's Health Center)
- Design and implement.

9/23/2008; 10:33:51 AM

C:\Documents and Settings\ISKC\Desktop\Post to svhdotcom\Business Plan\Business_Plan_Executive Summary for website.doc

- * Outreach speakers program to as many community groups as possible
- * Hospital neighborhood outreach
- * Ongoing CEO breakfast meetings with the major share holders
- * Vitalize SVH web site as a community information source
- * Utilize the popularity of the Index Tribune's Letter to the Editor
- * Email Blasts of progress reports/press releases and SVH messaging
- * PCP aid in distributing printed PR materials to their patients

THE BOTTOM LINE – FINANCIAL FORECAST

The following is our current forecast of the financial impact of implementing the business plan. The

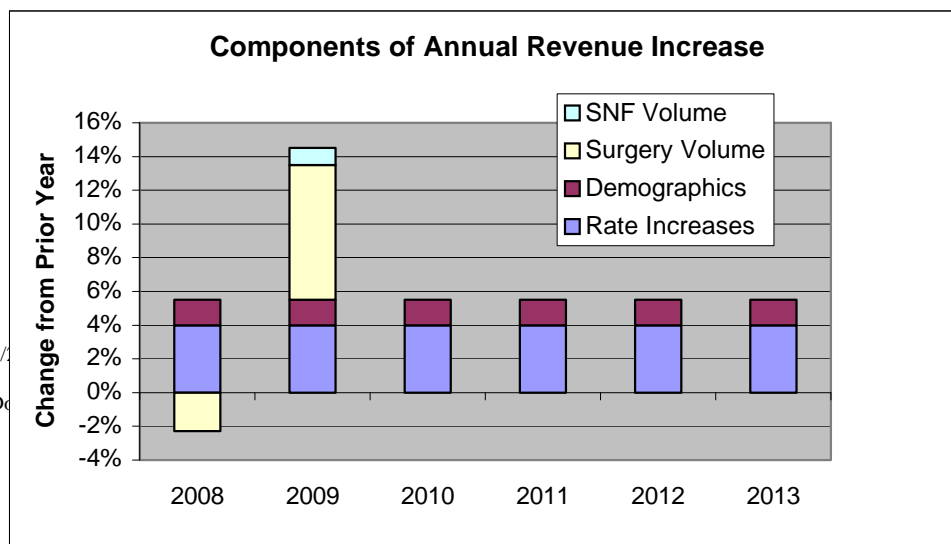
Business Plan Projections - Initial Calculations

	2008	2009	2010	2011	2012	2013
	(\$ 000's)					
Net Revenue	39,340	45,810	48,420	51,180	54,100	57,160
Net Expense	(40,860)	(44,520)	(47,150)	(50,200)	(53,440)	(56,330)
Operating Margin	(1,520)	1,290	1,270	980	660	830
Cash Flow	1,740	2,150	2,710	2,810	2,820	540
Ending Cash	3,000	5,150	7,860	10,680	13,500	14,040

Assumptions and Notes

- 1 The primary driver of increased revenue is capturing, by fiscal 2009, 75% of the potential additional surgery volume outlined in the business plan. No further volume surgery volume increases (except those related to demographic changes) are assumed thereafter.
- 2 A secondary, but less significant, source of additional volume is an increased SNF census.
- 3 The parcel tax is sustained at \$3,000,000 per year through 2012. This is done in order to generate surplus cash that can be used as a source of funds for the new facility and its related equipment and systems. Note, however, that we have assumed annual capital expenditures of \$1 million. At some point over the next few years we are likely to face a major infrastructure replacement, and this is not incorporated in the projection.
- 4 For simplicity, we have not incorporated the financial impact of opening the new facility mid way through 2013. So, for example, there are no savings from better adjacencies
- 5 Beginning with fiscal 2009, we expect clinical salaries to increase at 7% per year and other positions at 5%
- 6 Donations are held constant at \$500,000 per year.

Here are the components of the annual revenue increases. As a reminder, inpatient surgery volume is down substantially so far this year. Our projections assume some improvement over the remainder of the year.



basis for this forecast was the work we did for the parcel tax forecast. The underlying model is the one we developed several years ago and it has proved reasonably accurate. However, we will refine it as we work with the Camden Group to verify our assumptions and gain further insight into the local market. In particular, we plan to amend the model to accommodate different market shares by service line.

APPENDIX I: INDEX OF PLANNING STUDIES AND DATA

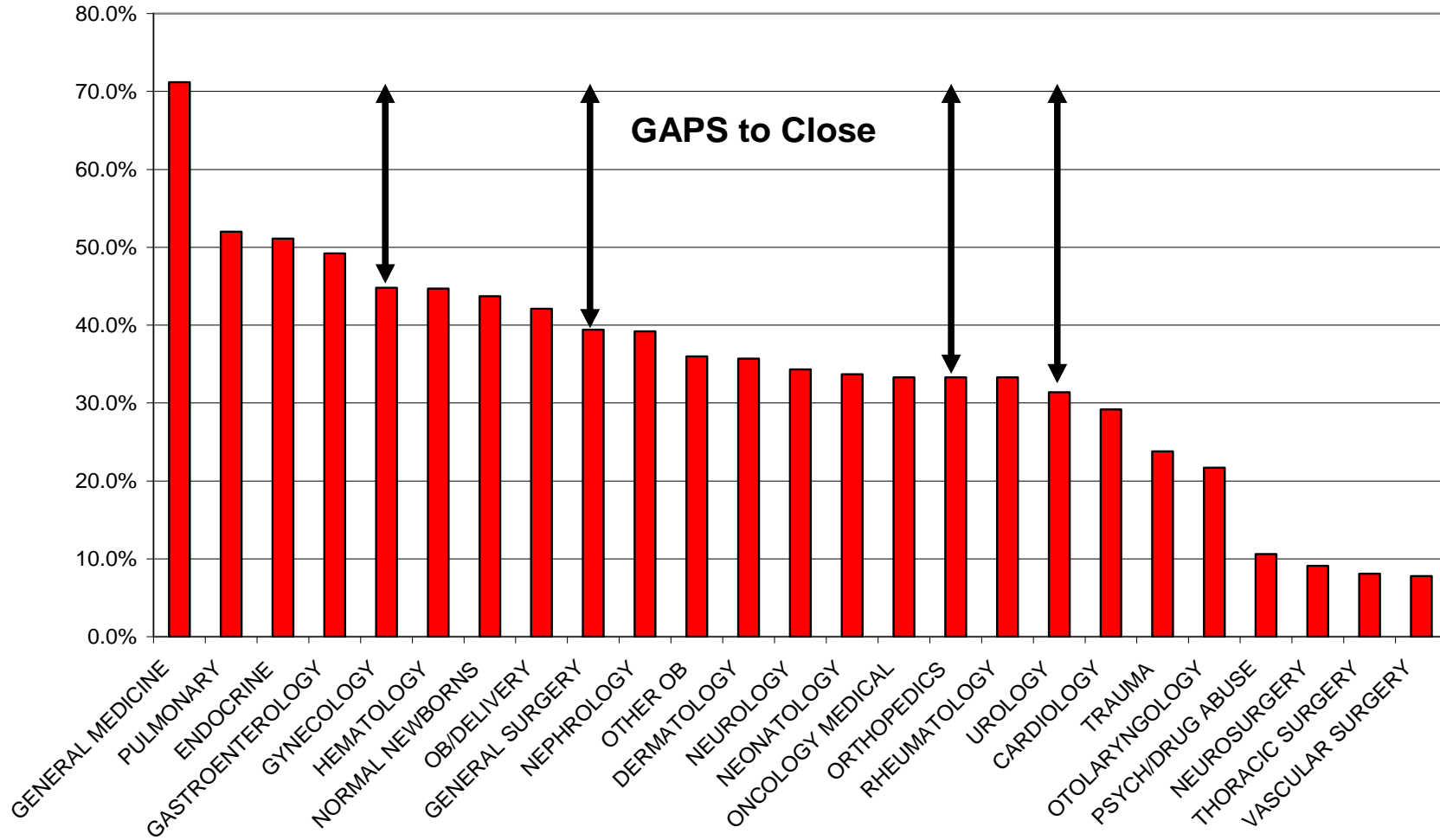
- 1) Seismic requirements and status of the current facility
 - a. Dasse Design Inc., February 1998
 - b. Montgomery Corp., “West Wing Seismic Status and Implications to Hospital Operations”, October 2007
- 2) Demographic changes and consequent requirements for numbers of hospital beds and the number of physicians by specialty
 - a. Mike Watt, “Sonoma Valley Hospital Projections”, December 2004
 - b. Marian Jennings, “Summary of Strategic Brainstorming Session”, September 2004
 - c. New Facility Steering Committee, supported by Rossiter, “New Medical Center Review”, November 2005
 - d. Friends of Sonoma Valley Hospital, “Update on the Planning Process for Sonoma Valley Health Care”, November 2005
- 3) Critical departmental adjacencies required to optimize patient flow, quality of care, and costs
 - a. Anshen + Allen, “Preliminary Site Master Plan”, December 1996
 - b. Anshen + Allen, “Facilities Planning Task Force, Executive Summary”, January 1999
 - c. Anshen + Allen, “Master Plan & Program Report”, September 2005
- 4) Recommendations to minimize construction costs by allocating space into different categories (in terms of State regulations) of buildings
 - a. Previously cited Anshen + Allen reports
 - b. SVH, “The Broadway Plan”,
- 5) Preliminary estimates of the size of the required facilities. It is critical to note that this information requires professional review and updating.
 - a. Previously cited Anshen + Allen documents and the SVH Broadway Plan
- 6) Criteria for evaluating the relative merits of different sites.
 - a. The Coalition Report
- 7) Financial forecasts
 - a. Report by SVH for “The Broadway Plan”
 - b. Report by HFS Consultants regarding the preceding

These reports are available for review and copying in SVH’s Administrative. Some are available in electronic format.

APPENDIX II: RECENT TRENDS IN UTILIZATION

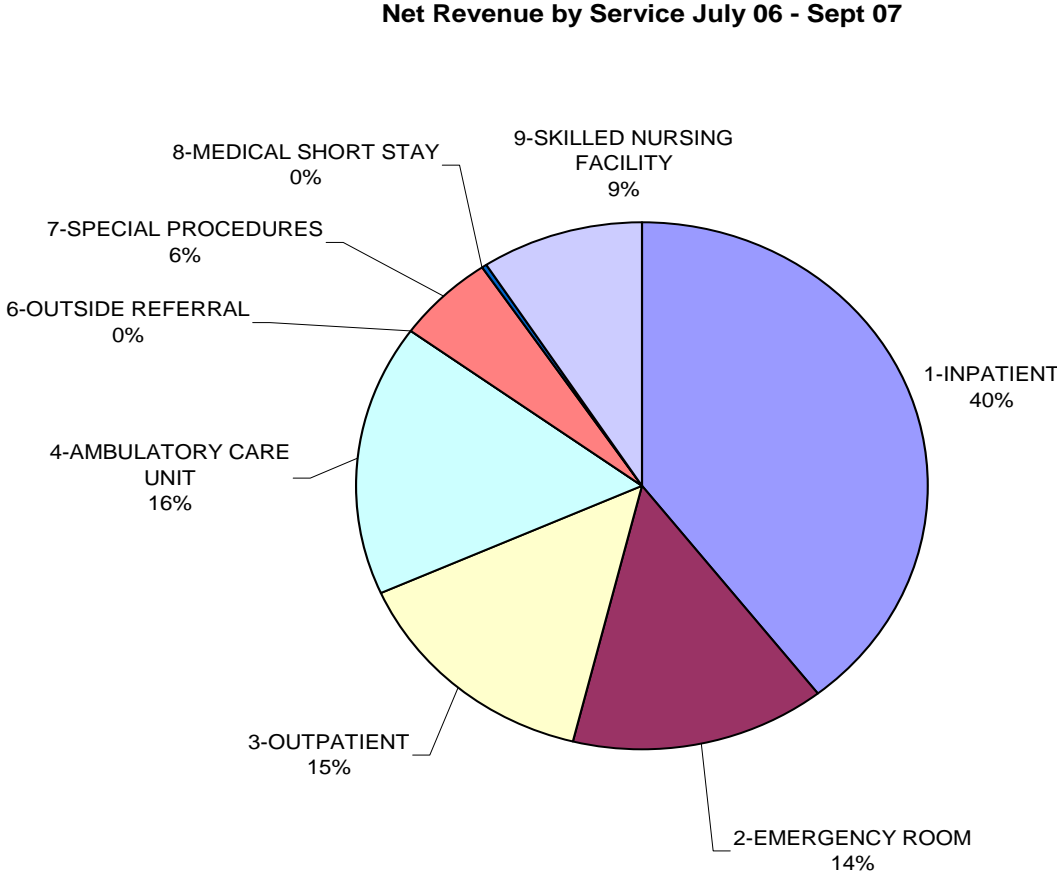
The graphs and charts on the following pages provide detailed information regarding the trends in SVH utilization over the past three years.

2005 Inpatient Market Share



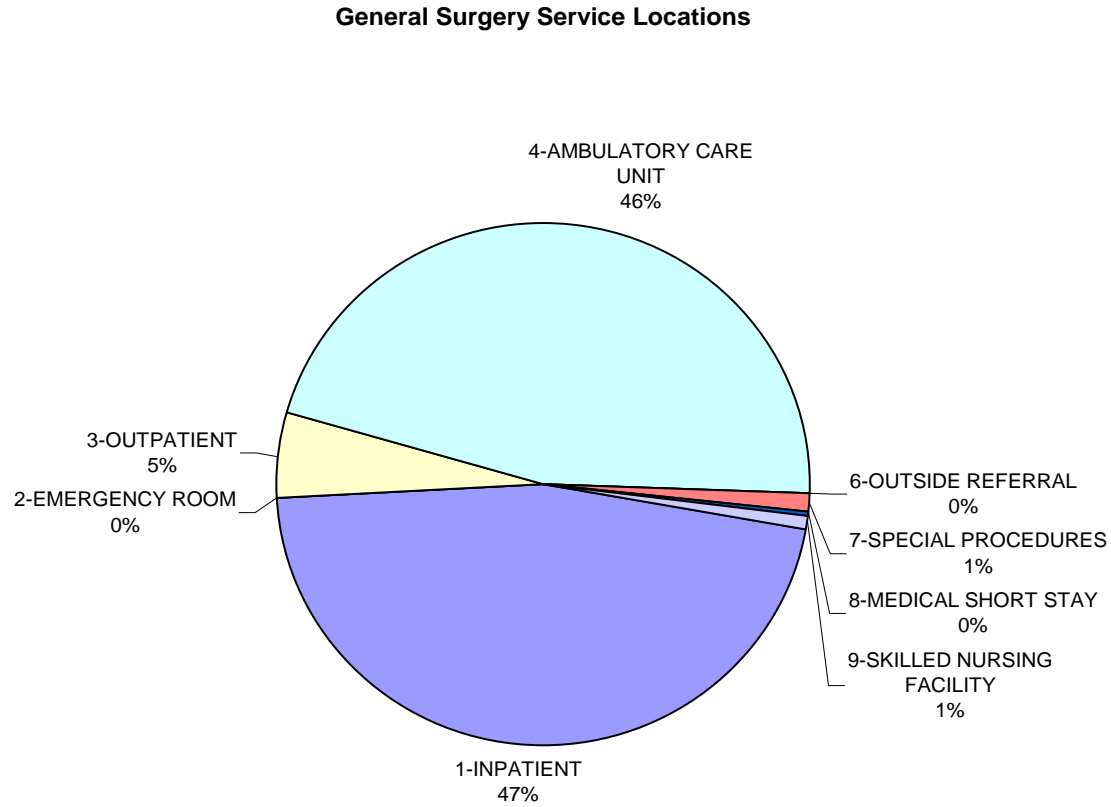
Overall Net Revenues by Service

Only 49% of SVH net revenue was from inpatient services. The remainder is outpatient services provided in various locations. “Outpatient” refers to outpatient diagnostic services.

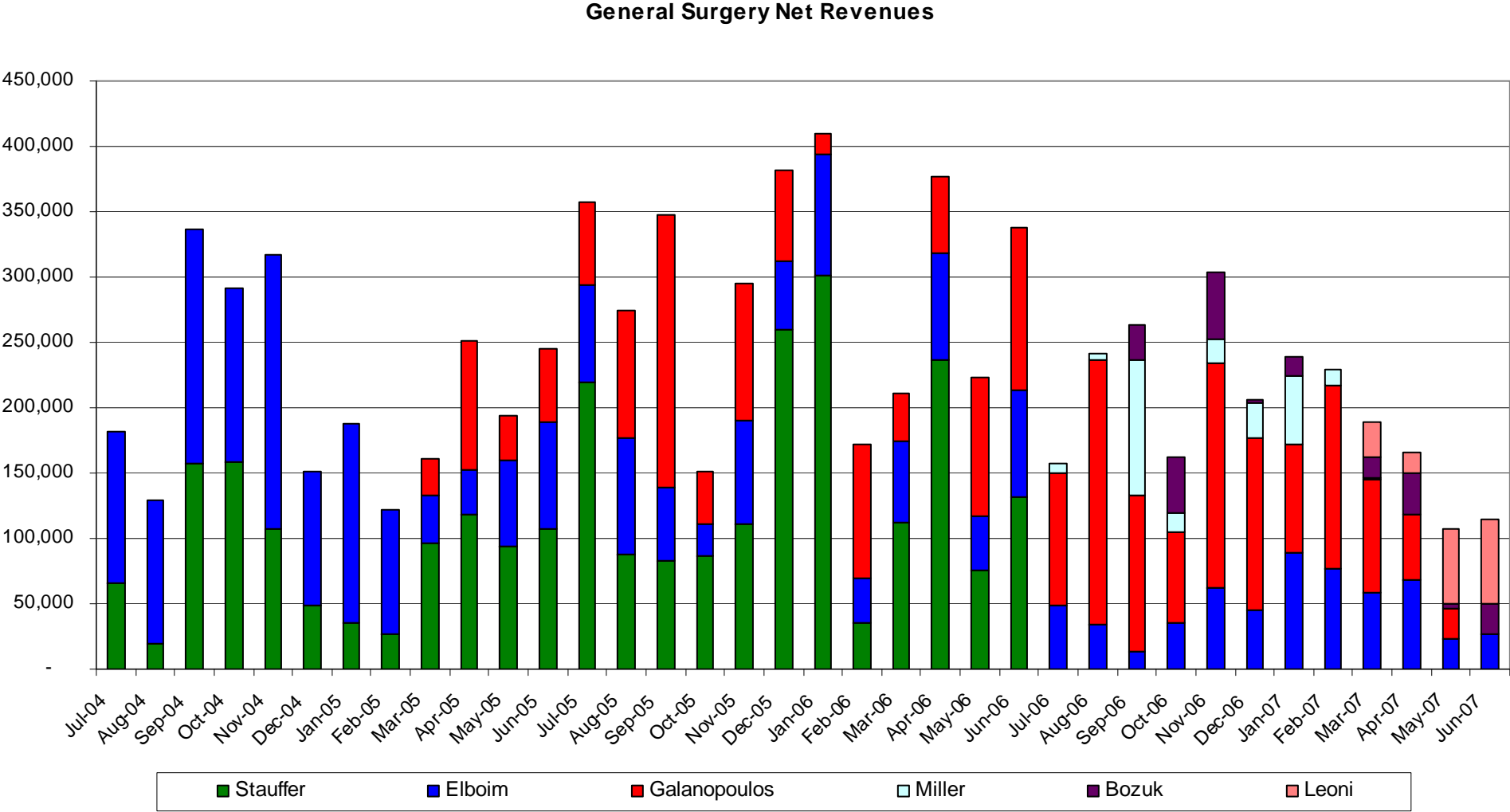


General Surgery

Over 50% of SVH's procedures were performed in an ambulatory or outpatient setting.

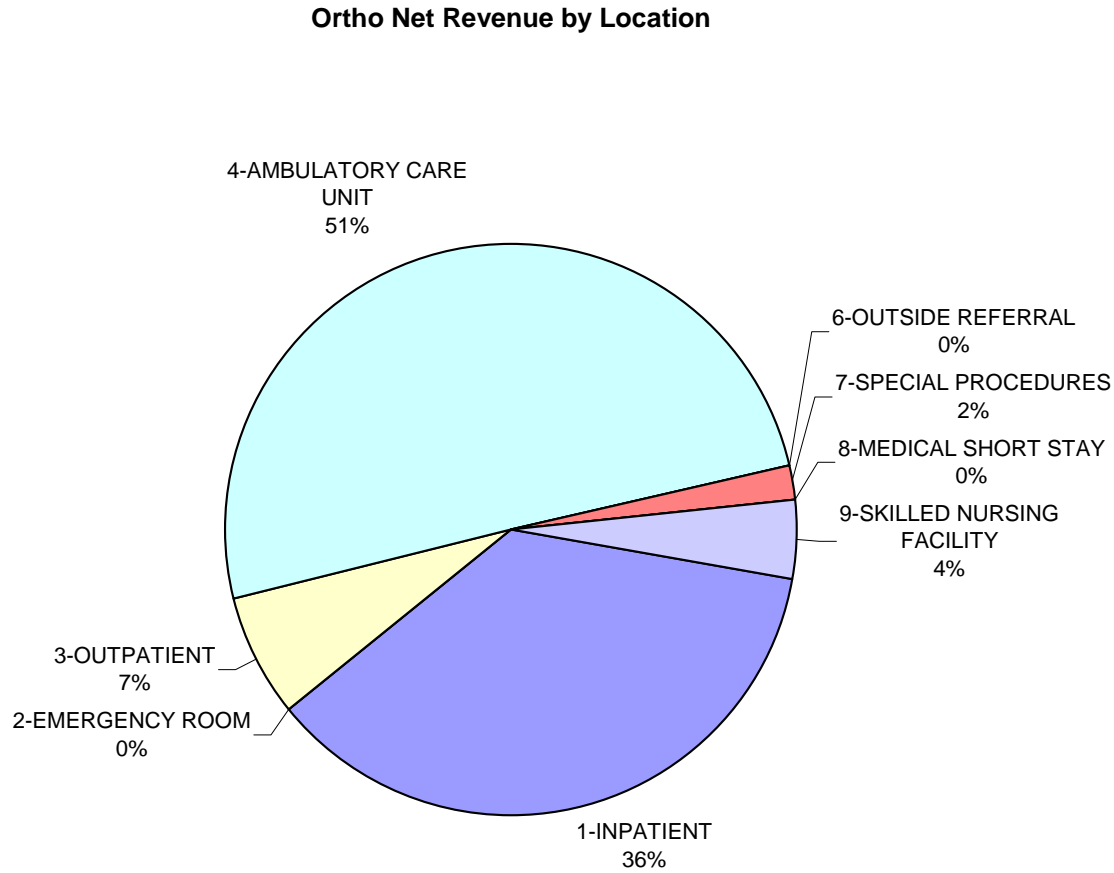


The exodus of several general surgeons has significantly eroded SVH's net revenues from general surgery.



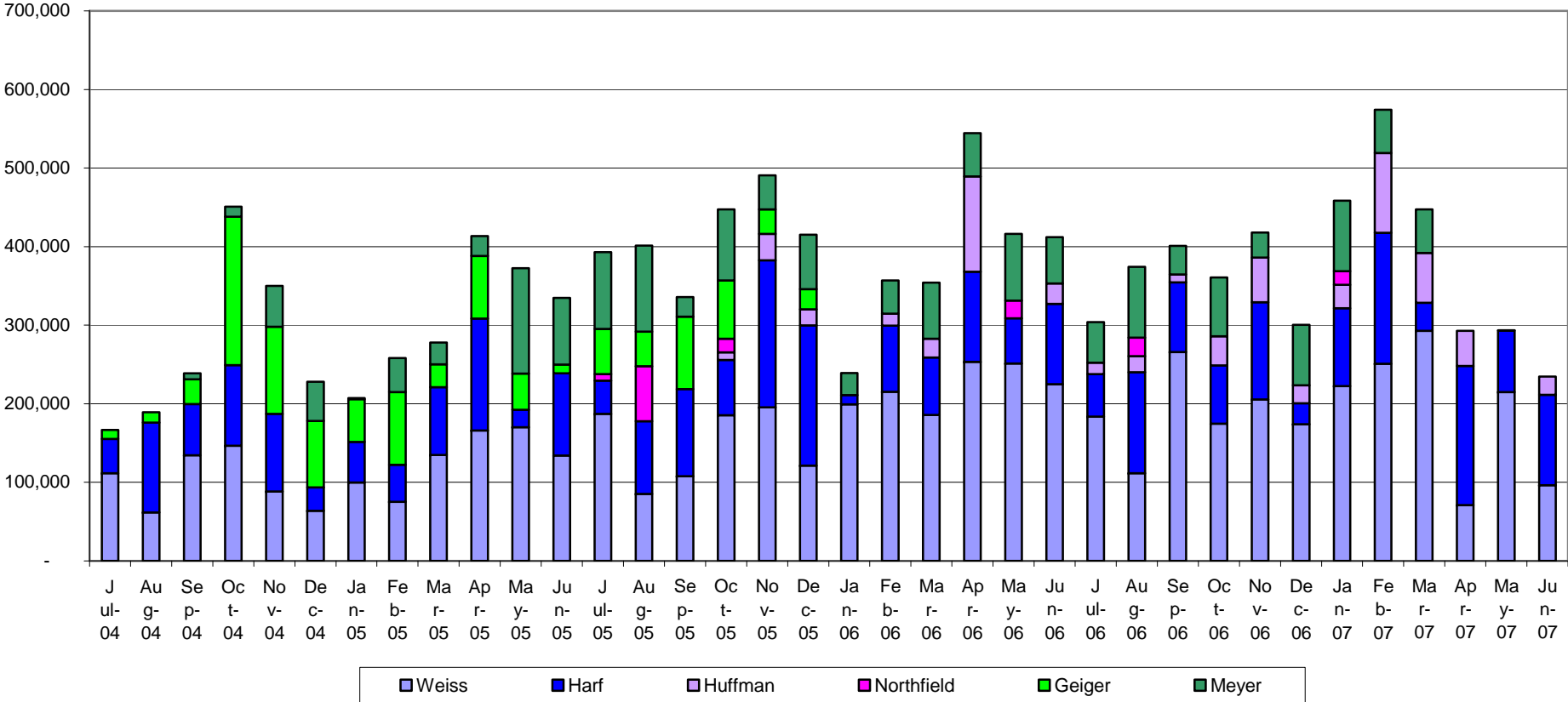
Orthopedic Surgery

Only 40% of orthopedic procedures are provided for inpatients.



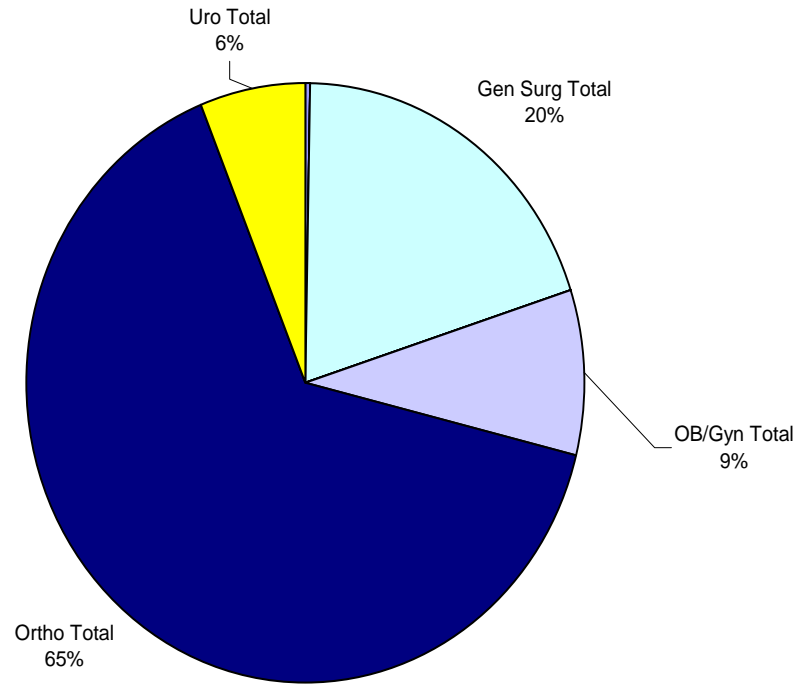
The decrease in orthopedic net revenue can be directly linked to the exodus of 2 surgeons.

Ortho Net Revenue Trends

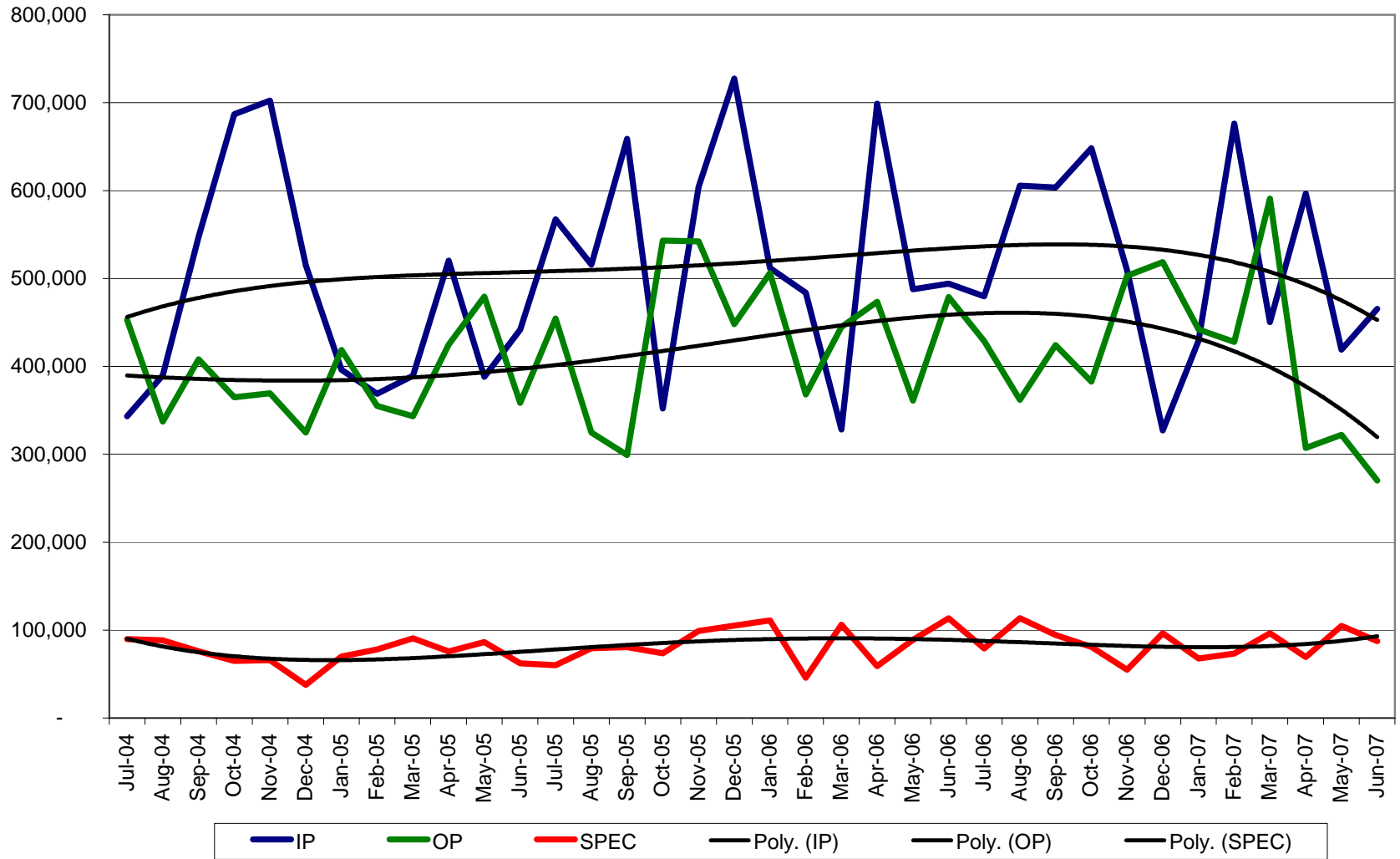


Orthopedic surgeries account for the majority of ambulatory surgical procedures.

Ambulatory Surgical Mix by Specialty



Trends in Net Revenues for Procedures by Type, with Trendlines



9/23/2008; 10:33:51 AM

C:\Documents and Settings\ISKC\Desktop\Post to svhdotcom\Business Plan\Business_Plan_Executive Summary for website.doc

APPENDIX III.

Information Technology Plan 2007

1. **Disaster Recovery (Dell PowerVault 24-tape)**– Currently, have several independent tape drives that comprise the backup solution for all data at SVH. Several of them are failing due to age of the equipment and the manner that they were implemented. A capital project was approved to install an auto tape loader to backup up to 9TB (terabyte) uncompressed or 19TB compressed. This project also includes an upgrade in infrastructure within the main server room to increase speed of backup for all the data servers. This does not include the archive for PACS.
2. **Network and Data Management** – The current infrastructure does not allow for an efficient management of passwords and access to data. Currently, multiple servers have to be changed manually to setup for a new user because we don't have a centralized policy manager, such as Active Directory. Active Directory and Dynamic Host Configuration Protocol (DHCP) need to be implemented in the current facility to provide the IT department the necessary tools to handle more systems called for by the overall business plan.
3. **Infrastructure Redundancy for Critical Systems** – Implementation of a virtual LAN (aka VLAN) will provide more flexibility and redundancy in critical areas of the hospital.
4. **Secured Physician Remote access to PACS** – We are currently evaluating other systems in comparison to Citrix remote access solution.
5. **Physician Data Sharing of Lab Results** – Currently, working with MMPC to come up with a strategy to share lab results data between SVH and MMPC. A recommendation was put forth to MMPC's Board to support one-third of the cost to upgrade the Lab system in order to share data. Upgrading the lab system is required to be able to share data.
6. **HL7 Interface Engine (Mirth HL7 Engine)** - This is required to support any data sharing within and outside the SVH LAN/WAN.
7. **Server Virtualization** – If we are going stay in the current main server room location, it is recommended that we should implement server virtualization to support additional information systems mentioned in the overall business plan. Need to conduct research on different solutions available in the market today.
8. **Thin client deployment at the desktop** (Citrix or similar) – We are currently measuring the ROI of deploying thin client architecture versus PC based desktop solution to improve data availability and security.
9. **Expand Wireless Network** – To provide free public Internet access, separate from the hospital network, for the following use:
 - a. SNF patients during their long stay
 - b. Physicians who would like to access their own practice management software
 - c. Visitors

10. **Core HIS – McKesson Paragon Upgrade Plan** – Bring the hospital’s main system to the current version. McKesson only supports the current and one-version back. We are currently two versions behind on the main system. We need to keep up with the system upgrades if we wish to keep up with regulatory requirements.
- a. **DL4 Lab System** – Currently, obsolete and is not capable of sharing data to the physician group as desired. Our version is three versions behind the most current available. An upgrade to Paragon Lab 6.x or 7.x is a pre-requisite to upgrading to Paragon 8.x.
 - b. **DL4 Care Plan System** – Currently, obsolete and is too cumbersome to use and has been criticized by the Joint Commission. Care plan documentation is going to be done on paper to meet compliance. Our system is three versions behind the most current available version. An upgrade to Paragon Clinical Care Station 6.x or 7.x is required prior to upgrading to Paragon 8.x.
 - c. **Print Services Server upgrade** - A capital project has been approved to replace the servers used to print face sheets and orders. This will improve efficiency in registration by reducing the time the patient has to wait for the face sheet to sign. This is also a pre-requisite to upgrade to 7.x.
 - d. **Database Server upgrade** – The main servers for Paragon, both production & test environments, need to be upgraded due to the age of the equipment. They are about 5 years old. This is also a pre-requisite to upgrade to 7.x. The current specification for the database server replacement will handle the needs for the Lab and Care Plan system upgrades.
 - e. **Horizons Meds Manager (HMM 8.0) Pharmacy System** – This system’s maintenance support will also expire soon. Our current version is one behind now and will be two versions behind when HMM 11 comes out in about a month.
11. **Time and Attendance / Scheduling System (KRONOS)** – A capital project has been approved and implementation is scheduled to start in January.
12. **Surgery Scheduling and Management** – Required to support the desired increase in surgical volumes.
- a. Should include a web-based view-only application available to physicians.
 - b. Installing Paragon OR Manager requires installing Paragon Resource Scheduling. But installing Paragon Resource Scheduling will also promote efficiency in patient flow for many departments including PT, OH, Wound Care, Cardiopulmonary, and other services.
13. **Occupational Medicine Practice and Revenue Management** – Systoc information system or something comparable is required to improve net revenues.
14. **Decision Support System** – To provide executive level accessible data for management decisions and performance monitoring. Possible solutions are SQL Reporting Services and/or Paragon Web Stations for Executives.

APPENDIX IV.
Sonoma Valley Hospital
Physician Retention & Recruitment Update

Specialty / Service Line	Physician / Group	Status
Orthopedics	<i>Mt. Tam Orthopedic Group</i> – Large ortho group based in Marin, including Jack Keohane, MD. They currently see approximately 20-25% of the SV orthopedic market.	Expected to start seeing patients in Sonoma in November / December. Will be sharing office space with Dr. Noah Weiss. Primary care physicians have very favorable opinion of this group, and some currently refer to them.
	<i>Napa Valley Orthopedic Group</i> – Large ortho group based in Napa, including Jason Huffman, MD. They currently see approximately 15-18% of the SV orthopedic market.	Met with SV primary care physicians, favorable impression.
	<i>Mark Northfield, MD</i> – Split practice between Sonoma and Petaluma. General orthopedics including joint replacements.	Started Sonoma office in July. Positive feedback from patients and physicians.
	<i>Brian Cable, MD</i> – Orthopedic group in Marin. Currently seeing some Sonoma patients.	Interested in Sonoma office hours.
	<i>Peter Redko, DPM</i> – Podiatrist specializing in minimally invasive foot & ankle surgery.	Started Sonoma office in August. Likes operating in Sonoma, anticipates increased surgical volumes of 12-16 cases/month in January.
General Surgery	<i>Michael Bozuk, MD</i> – Split practice between Sonoma, Petaluma, Novato and Sebastopol.	Started Sonoma office in August 2007 (Originally began seeing Sonoma patients in July 2006; not busy enough then.) Positive feedback from patients and physicians. Likes operating in SVH OR (efficient and great staff). Surgical case volume growing.
	<i>Paul Stauffer, MD</i> – Busy general surgeon, left SVH in July 2006.	Has maintained his privileges at SVH and some interest in coming back (possibly joining practice with Dr. Bozuk). Has great rapport with medical staff, especially primary care physicians, and the community.
	<i>Surgery Group of Napa Valley</i> - General & Vascular surgery group in Napa, including Wendell Wenneker, MD.	Per consultant, they are interested in the possibility of expanding to Sonoma.
	<i>Call coverage physicians:</i> Cesar Veluz, MD, Elpidio Mariano, MD, Peter Leoni, MD, Peter Caravella, MD	These surgeons provide call coverage for the ED; however they do not have Sonoma office hours.
GI/Endoscopy	<i>Stephen Steady, MD</i> – Split practice in Sonoma and Petaluma.	Very busy Sonoma practice. Interested in joint venture/investment opportunity with SVH, and expanding GI services.
	<i>Stephen DeNigris, MD</i> – Split practice in Petaluma and Santa Rosa.	Sees some Sonoma patients, but interested in joint venture/investment opportunity with SVH and expanding Sonoma business.
	<i>Ali Vaziri, MD</i> – Napa based.	Has recently been approved for privileges at SVH. Possible interest in joint venture or expanding business into Sonoma.
Vascular Surgery	<i>Laura Pak, MD & Melinda Aquino, MD</i> (Cardiology Associates of Marin) – Dr. Pak has been seeing patients one day/month in Sonoma through our wound care program. Many SV vascular patients are referred to this group.	Dr. Aquino to open Sonoma office in November, and will start doing procedures (performed one urgent procedure in our OR in October). Dr. Pak will continue to stay involved with wound care, and possibly perform some vascular procedures. Potential to recapture surgical services, as well as grow cardiac services, and further collaborate with wound care, nephrology, and diabetic education.

Specialty / Service Line	Physician / Group	Status
Ophthalmology	<i>William Bartlett, MD</i> – North Bay Eye Associates, large ophthalmology group based in Santa Rosa.	Opened Sonoma office 5 years ago, and has been instrumental in creating a successful, high quality ophthalmology service at SVH. Very happy with OR services, feels same quality and patient experience as ASC. Surgical volume has been growing steadily.
	<i>Mark Schluter, MD & Sonja Schluter, MD</i> – Formerly with Eye Associates of Sebastopol (Dr. Suslov’s group).	Opened Sonoma office in October 2007, and has performed a couple of surgical cases. Interested in further development and growth of ophthalmology services at SVH.
OB/Gyn	<i>Billie Guerra, DO</i> – Petaluma based.	Interested in seeing Sonoma patients. Anticipated to start taking OB call in November.
	<i>UCSF</i> – Collaboration	Working with UCSF to collaborate on women’s health services, especially Gyn services. Potential to have physicians split practices.
Urology	<i>David Rudnick, MD</i> – Split practice Petaluma and Sonoma	Has Sonoma office hours, and likes operating in our OR. Interested in possibly bringing in a new partner in the next couple of years to split Sonoma/Petaluma area.
	<i>J. Nevin Smith, MD</i> – Sonoma based	Decreased surgical procedures (refers to Rudnick).
	<u>Napa Urology Group</u>	Per consultant, potential interest in a Sonoma office.
Anesthesiology	<i>Anesthesiology Consultants of Marin</i> – Large anesthesia group based in Marin, interested in expanding to Sonoma. Works with several of the Marin based physicians/groups SVH is collaborating with.	Benefits include access to a larger pool of anesthesiologists, improved OB services, improved peer review process, ability to develop a program that is financially self-sufficient. Current anesthesiologists will be given opportunity to work with this group.
Pain & Palliative Care	<i>Aimee Chagnon, MD</i> – Sonoma based.	Has opened an outpatient clinic at SVH, and is working with current anesthesiologist on the interventional procedures.
Hospitalist Program	<i>Marin Hospitalist Medical Group</i> – Large Marin based group.	Currently working on a contractual relationship with this group as the business entity for our restructured hospitalist program. Consultant continues to work on the recruitment of hospitalists.
Plastic Surgery	<u><i>Eiler Sommerhaug, MD</i></u> – <i>Petaluma based.</i>	Currently performs reconstructive surgical procedures at SVH. Possible interest in bringing elective cases to SVH.
	<i>Rebecca Jackson, MD & William McClure, MD</i> – Napa Valley Plastic Surgery.	Currently perform some reconstructive surgical procedures at SVH. They have a private ASC for elective cases.
	<i>John Emery, MD</i> – Sonoma based.	Currently performs some reconstructive and elective surgical procedures at SVH.
Occupational Medicine	Due to growth and expansion opportunities, need for physician who specializes in Occupational Medicine and can function as the F/T Medical Director.	Currently exploring recruitment opportunities with local physicians.
Primary Care Physicians	Currently have good portion of PCP market; however due to significant number of aging PCPs, need to look at possible transition plans.	Working with PRIMA Medical group to explore recruitment of additional internist into the Sonoma office.



Sonoma Valley Hospital Business Plan

October 31, 2007

FOCUSED PLAN

- A true “turnaround” plan
- Financial emphasis
- In healthcare quality drives demand which drives revenues
- Does not cover all actions under consideration



Goal: Profit from Operations

- Ensure taxpayers that extension of parcel tax will not be necessary
- Supplement GO Bonds as only financing method for capital
 - Credit worthiness
 - Revenue bonds
 - Encourage philanthropy

Reasons for Confidence

- New management team: competent, pragmatic
- Understanding causes of historic financial problems
- Knowing that many of these problems can be resolved
- Preliminary indications of success in attacking those problems
- Only modest increases in service volumes can produce financial improvements
- Only modest changes can improve staff efficiency
- Demonstrated excellence in OR and Diagnostic services
- Demonstrated Medical Staff cooperation
- Demonstrated community support

Understanding the problem - **General Causes**

- Ineffective recruiting & physician support
- PCP referrals to other providers & exodus of surgeons
- Distraction from operations management over past several years
- Inpatient utilization management issues
- High fixed staffing levels

Problems: symptoms

- Significant decline in procedure volumes

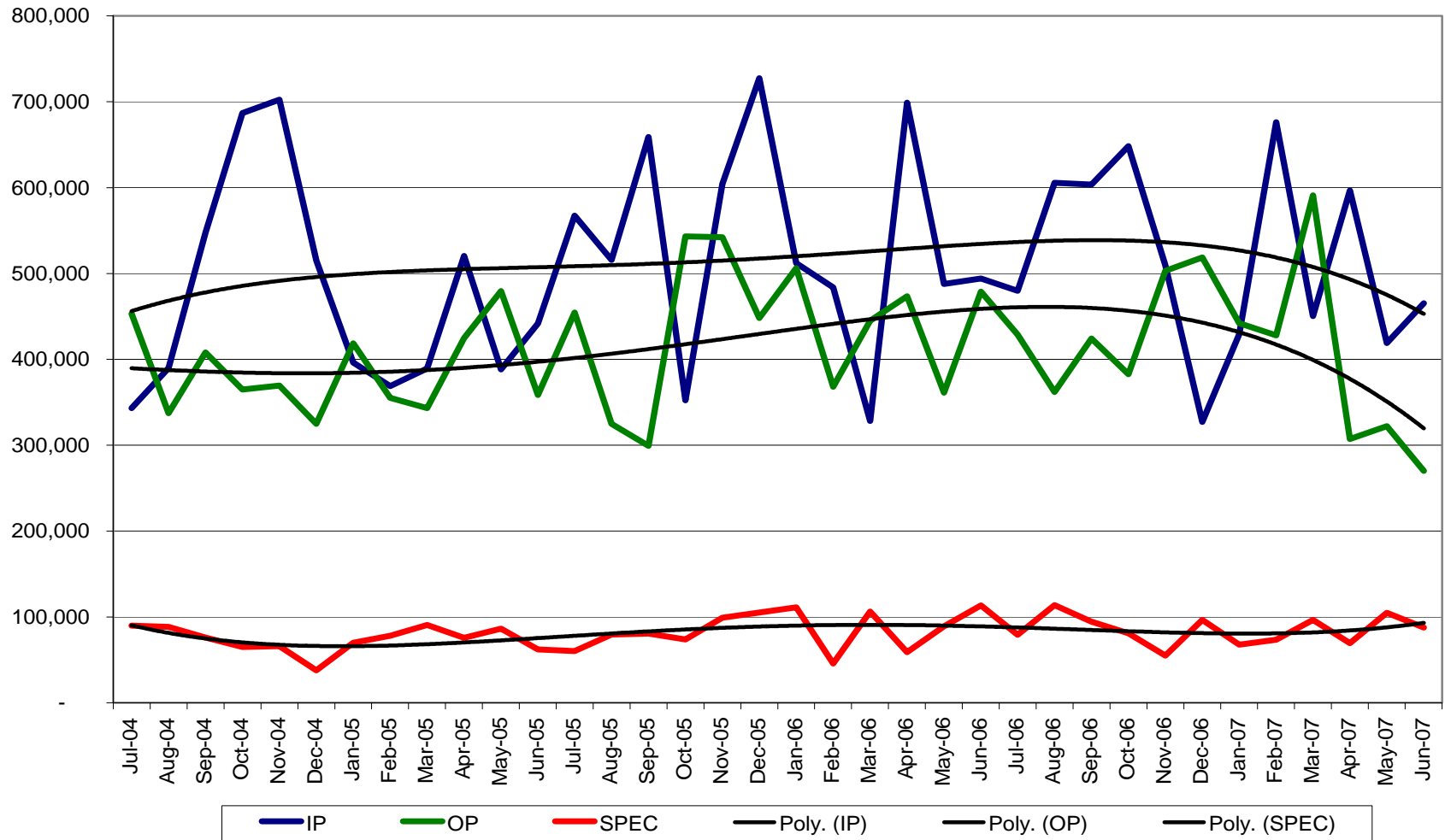
- Market share gaps in:
 - General surgery
 - Orthopedic surgery
 - Gynecology
 - Urology
 - Others

- Both IP and OP volume declines

- IP has biggest financial impact

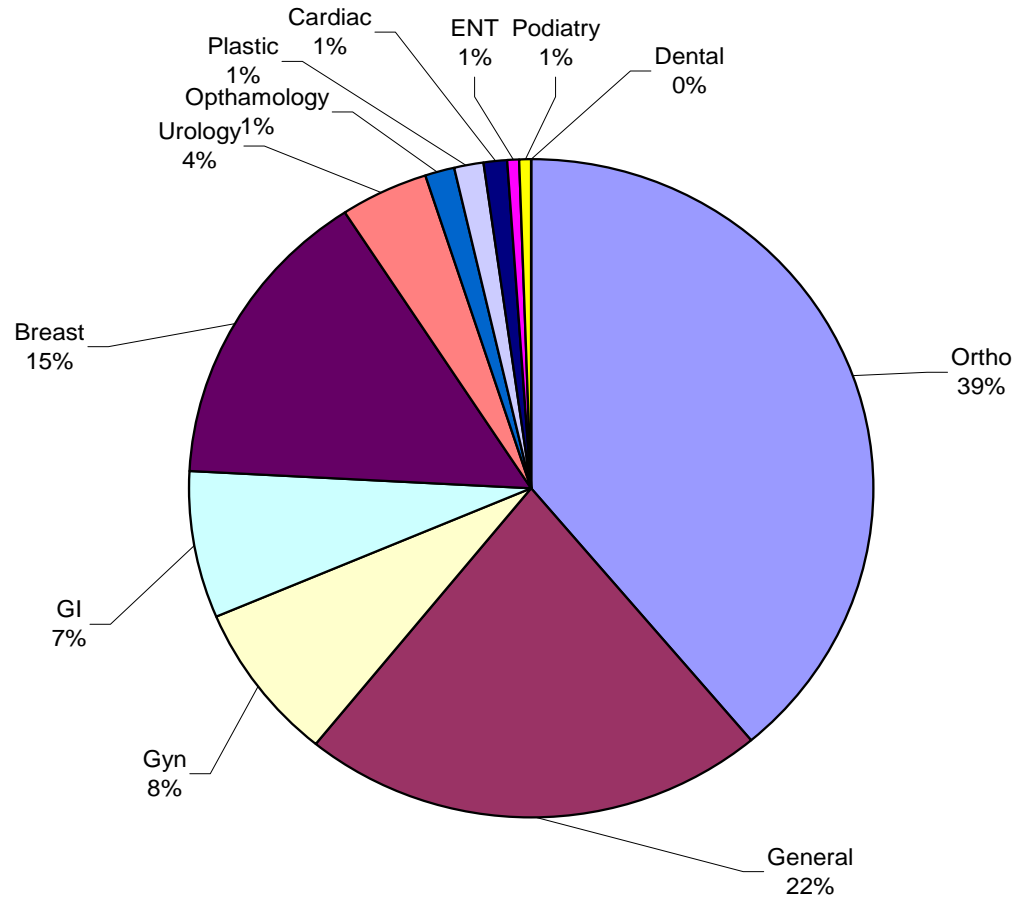
Problems: details

Trends in Net Revenues for Procedures by Type, with Trendlines



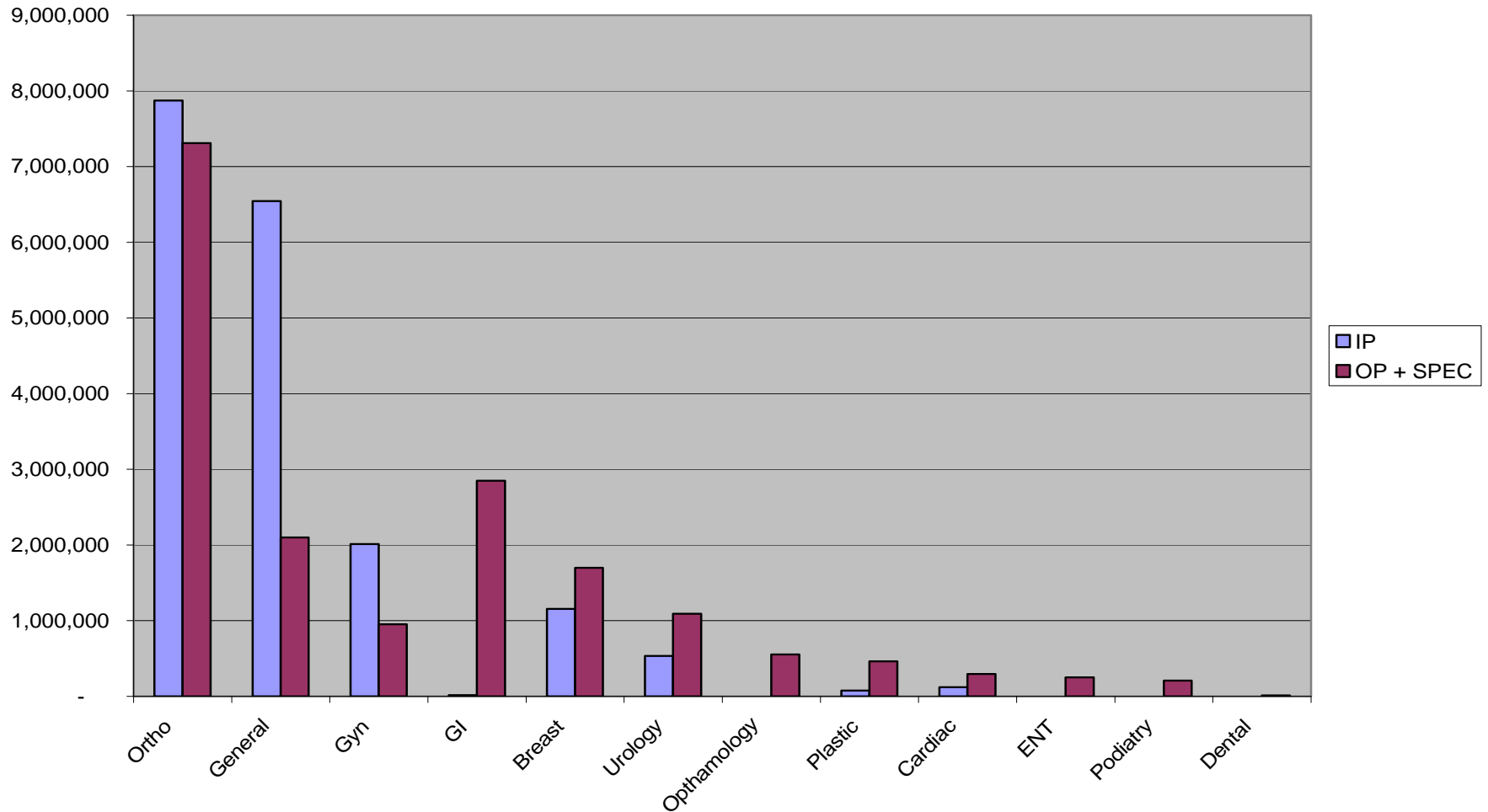
Surgical Service Mix

Surgical Procedure Net Reimbursement June 2004 - June 2007

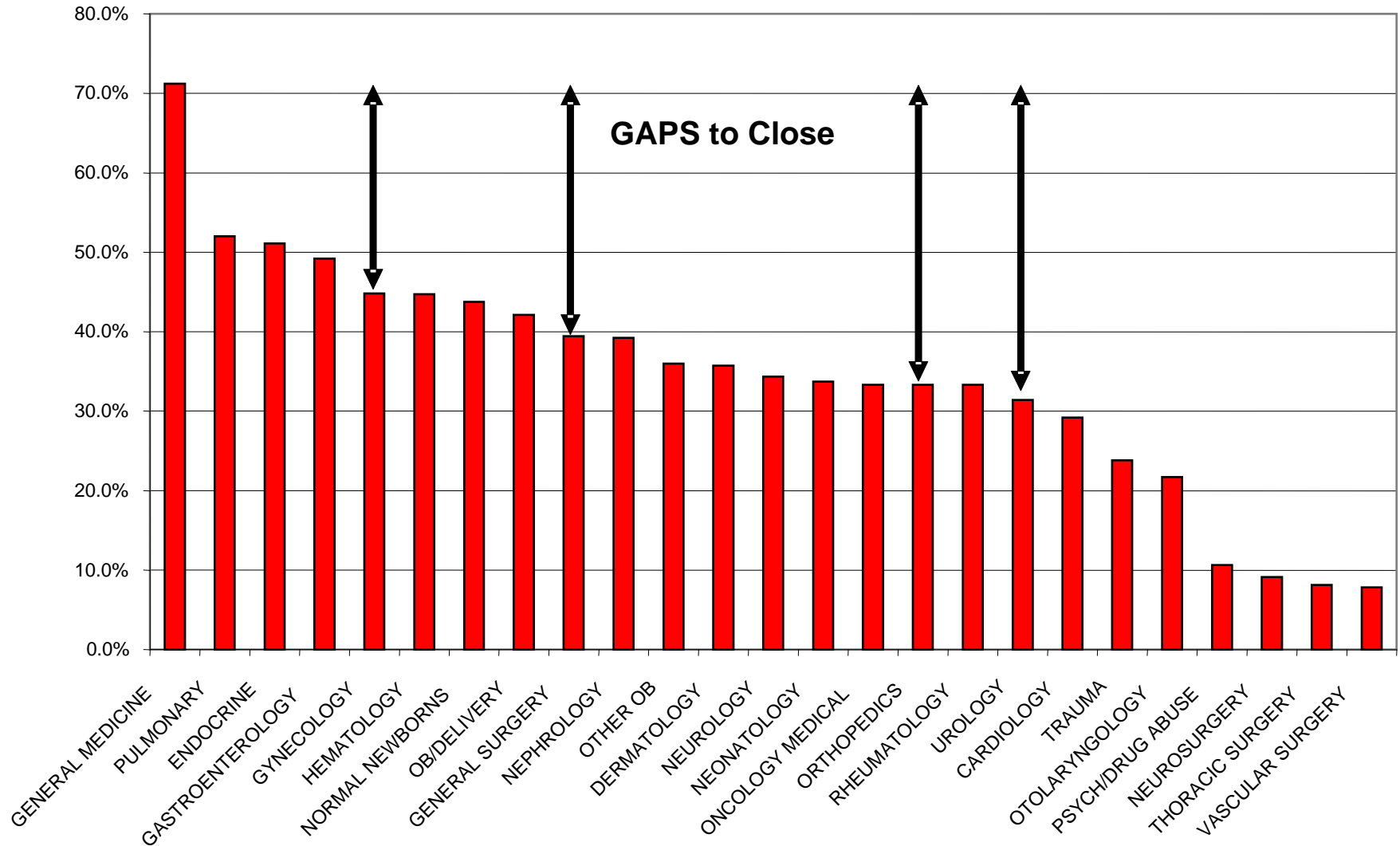


Mix of Surgical Revenues

Surgical Net Reimbursement 2004 - 2007



Opportunity: 2005 IP Market Share



Understanding the Causes of Volume Decreases

- Exodus of several surgeons:
 - Inadequate demand to support “right number” of specialists
 - Loss of primary care physician referrals
 - Failure to engage PCPs in recruitment
 - High cost of living in our area
 - Community dissension

- Proximity to alternative hospitals & specialists

- Hospitalist program start-up problems



SVH Targets

- Increase surgical volumes
- Orthopedics
- General surgery
- Gynecology
- Urology
- Outpatient emphasis

Actions to Increase Volumes

- Accept market reality
- Encourage split practices
- Recruit existing physicians from neighboring communities
- Engage PCPs in recruitment
- “Sell” efficiency & quality of OR & Diagnostic services
- Rebuild hospitalist program with cooperation of existing PCPs
- Communications & PR

Other Actions

- Cooperation with and support of existing SV physicians
- Support for split practices
 - Hospitalists
 - Practice management
 - Hospital offices or local physician sharing
- Support of and by MIPA and its medical group PRIMA
- Participation in the JPA
- Support of the Women's Health & Wellness program
- Development of a legal arrangement for SVH/physician joint ventures that are financially and legally feasible
- Possible redeployment of departments within existing facilities to gain efficiencies

Physician Recruitments/Negotiations

In Process

- Orthopedics
- Hospitalist
- Anesthesiology
- Gynecology (UCSF)
- OB/Gyn
- General surgery
- WHW directorship

Successful

- General surgery (1+)
- Ortho (1+)
- Neurology (1+)
- Vascular (1+)
- Podiatry (1+)
- Ophthalmology (2+)

Preliminary Estimate of Bottom Line Impact

(in '000s)		<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>
Net Revenue		39,320	45,320	47,920	50,670	53,570	56,610
Net Expense		(41,010)	(44,400)	(47,050)	(50,090)	(53,330)	(56,210)
	Operating Margin	(1,690)	920	870	580	240	400
	Cash Flow	1,570	1,830	2,290	2,360	2,350	1,050

Forecast Assumptions

- Basis for parcel tax forecast
- Used for earlier plans; has proven to predict variances actually experienced
- Reflects volume variances in this year
- Capture 74% of surgery volume by 2009
- Increased SNF census related to the above
- Excludes cost containment initiatives
- Salary increases in 2009 of 7% (clinical)
- Parcel tax thru 2012 continues at \$3 million
- Donations: \$500,000 per year
- Excess accumulated cash used for financing non-GO bond expenditures

Next Business Planning Tasks

- Execute Communications & Public Relations program
- Segment and stage new facility project
- Determine alternative financing methods
- Engage potential donors in planning
- Engage in detailed facility design
- Execute flexible staffing
- Execute and test impact of rebuilt hospitalist program
- Legally and financial feasible joint venture arrangements with physicians
- Verify financial forecasts
- Prepare for Bond Measure



PUBLIC RELATIONS & COMMUNICATIONS

- Informing our community about what we do well now
- Increase use of our physicians and services
- Inform community about ongoing changes
- Gain support for Bond measure & fund raising

Site Decision --- Context

- “Where” is less important to hospital success than “what” (see Business Plan) or “how” (process)
- My understanding:
 - Most beautiful spot on earth
 - Valuable land
 - Limited land
- Ten years of hospital planning efforts & expertise

Site Decision

- Due diligence was done
- Professionals & independent experts:
 - Negotiating team → secure land with executable legal documents
 - Architect/engineers →
 - Prove physical capacity to house space program & desired adjacencies of departments
 - Compare sites in terms of regulatory/approval challenges --- e.g., EIR, traffic
 - Presented findings to Board



SVH Business Plan Status

Strategic Planning Committee
February 2008



Framework for BP Status Evaluation

- What initiatives?
- What results?
- What lessons? (Fire/aim/fire/aim/fire)
- Copies of sections of prior presentation are used

SVH Targets from prior presentation

- Increase surgical volumes --- **see next slide; OP yes & IP no**
- Orthopedics --- **slow start up of Marin group**
- General surgery --- **+1 from Petaluma, return of an expatriate?**
- Gynecology --- **WHW power, WIP, analysis needed, link to OB**
- Urology --- **WIP; analysis needed**
- Outpatient emphasis --- **see next slide**

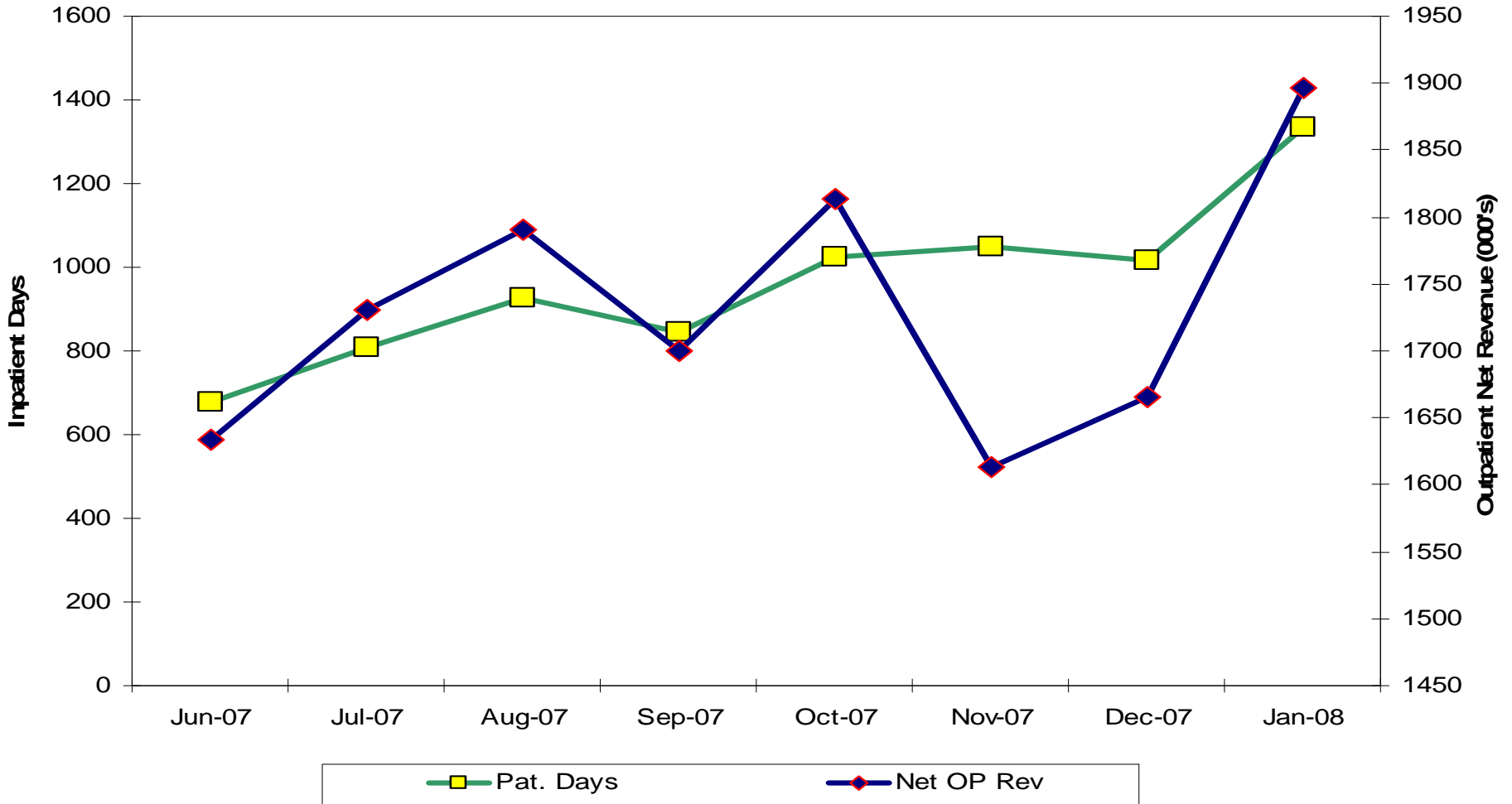
Results thru yesterday

	Current Day			Month -to- Date				Year -to- Date			% Variance Act/Budg	% Variance Act/Pr. Yr
	Actual	Budget	% Variance	Prior Year	Actual	Budget	% Variance Act/Budg	Prior Year	Actual	Budget		
Discharges												
Acute				100	62	79	-22%	1,040	951	1,034	-8%	-9%
SNF				18	15	20	-27%	256	225	258	-13%	-12%
Patient Days												
Acute	16	16	-3%	359	287	297	-3%	3,912	3,769	3,867	-3%	-4%
SNF	24	17	38%	299	409	313	31%	4,008	3,934	4,007	-2%	-2%
Total Patient Days	40	34	18%	658	696	610	14%	7,920	7,703	7,874	-2%	-3%
Average Patient Days				37	39	34	14%	34	33	34	-2%	-3%
Surgical Cases												
Inpatient	0	0	0%	13	29	-55%	302	424	-29%			
Outpatient (ACU)	0	0	0%	62	52	19%	760	734	4%			
Special Proc Cases	0	0	0%	85	53	59%	766	751	2%			
Gross O/P Revenue (000's) (Excluding HHA)				3,274	3,334	3,188	5%	40,668	44,915	43,277	4%	10%

Actions to Increase Volumes

<u>Initiative</u>	<u>Result/lessons</u>
Recruit existing physicians from neighboring communities	Marin: ortho, vascular, hospitalists Petaluma: ortho, hospitalists, Gen Surg
Engage PCPs in recruitment	Need trial period
“Sell” efficiency & quality of OR & Diagnostic service	Feedback is very positive from surgeons
Rebuild hospitalist program with cooperation of existing PCPs	PCPs rescued the service. Inpatient use is up largely due to this.
Communications & PR	Positive press coverage

Increases in Patient Days & OP Net Revenue





Turnaround Results

- Net income:
 - Nov: (\$24,000)
 - Dec: + \$322,000
 - January: +\$155,000

- February thru yesterday
 - Census: 14% over prior year
 - OP surgeries: 19% over prior year
 - Special procedures: 59% over prior year

Other Actions

- Cooperation with and support of existing SV physicians --- **see hospitalist results, neurology**
- Support for split practices
 - Hospitalists --- **rebuilding is WIP**
 - Practice management --- **Prima priority**
 - Hospital offices or local physician sharing --- **packed Prof. Center**
- Support of and by MIPA and its medical group PRIMA --- **need plan & expertise**
- Participation in the JPA --- **see separate slide**
- Support of the Women's Health & Wellness program --- **bone densitometry, digital mammography → lessons about OSHPD**
- Development of a legal arrangement for SVH/physician joint ventures that are financially and legally feasible --- **opinion by legal counsel; still WIP; link to PVH?**
- Possible redeployment of departments within existing facilities to gain efficiencies --- **deferred until after bond measure passes**

Next Business Planning Tasks

- Execute Communications & Public Relations program --- **improved press coverage**
- Segment and stage new facility project --- **Space plan updated; staging proposed; conceptual design done**
- Determine alternative financing methods --- **staged financing proposed; initial bond measure election; to do: philanthropic campaign, turnaround to support revenue bonds & leasing**
- Engage potential donors in planning --- **feedback on BP supported current staged financing plan**
- Engage in detailed facility design --- **deferred until bond measure passes**
- Execute flexible staffing --- **WIP; identified major opportunity with “pay practices” that lead to excessive premium pay**
- Execute and test impact of rebuilt hospitalist program --- **support of local PCPs; increase in daily census**
- Legally and financial feasible joint venture arrangements with physicians --- **WIP**
- Verify financial forecasts --- **deferred due to cash crunch in January; potential donors, revenue bond financing require completion**
- Prepare for Bond Measure --- **WIP for April 8 election for initial GO bond**

Profile of combined JPA entities

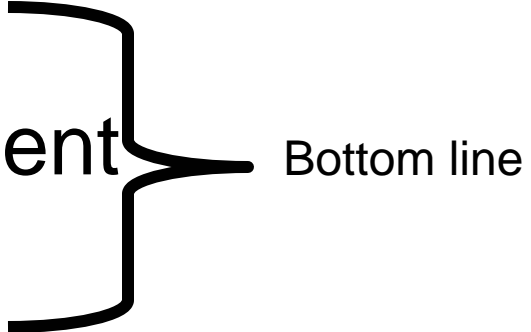
District	Healdsburg	Mendocino	Palm Drive	SVH	All
Net Patient Revenue	\$17 million	\$32 million	\$15 million	\$37 million	\$101 million
Full Time Employees	176	196	180	352	904



Important market conditions

- Sutter exodus (?) from acute care business in Santa Rosa
- Memorial cutbacks in psych, rehab, snf
- PVH financial pressures
- PVH physician pressures

Highest Business Plan Priorities

- Marin ortho group
 - General surgery recruitment
 - Labor cost management
 - Pass bond measure
 - Planning information
- 
- Bottom line