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PALM DRIVE HEALTH CARE DISTRICT

UNITED STATES BANKRUPTCY COURT

NORTHERN DISTRICT OF CALIFORNIA

SANTA ROSA DIVISION

In Re: PALM DRIVE HEALTH CARE DISTRICT, a California local health care district, Debtor.	Bk. No.: 14-10510-AJ Chapter 9 **DEBTOR'S OPPOSITION TO PALM DRIVE HEALTH CARE FOUNDATION'S EMERGENCY MOTION FOR APPOINTMENT OF MEDIATOR** Date: May 16, 2014 Time: 10:00 a.m. Place: U.S. Bankruptcy Court 99 South "E" Street Santa Rosa, CA 95404 Judge: The Honorable Alan Jaroslovsky

Palm Drive Hospital District ("District" or "Debtor") opposes the Palm Drive Health Care Foundation's Emergency Motion For Appointment Of Mediator (the "Motion") brought by Palm Drive Health Care Foundation (the "Foundation"), seeking an order compelling the District to enter into mediation with the Foundation on a proposal the Foundation has made to operate the District's health care facilities (the "Foundation Proposal"). As grounds for its opposition, the District states:

I. There Is No Legal Basis for the Relief Sought

The Motion from the very start is premised on a faulty position on the applicable law. The Motion asks for an order pursuant to Bankruptcy Code § 105(a) granting the relief sought. However, § 105 is not one of the provisions of other chapters of the Bankruptcy Code that even applies in a Chapter 9 bankruptcy case. And this absence of § 105 from Chapter 9 is an instance of the much broader, constitutionally-based principle that the bankruptcy court does not and may not interfere with the regular governmental operations of the Chapter 9 debtor, or its property or revenues. Thus, this Court cannot grant the relief sought by the Motion.

The subject matter of the Motion is outside the scope of the jurisdiction of this Court in a Chapter 9 bankruptcy case. In a Chapter 9 case, constitutional limitations recognized by Congress in the Bankruptcy Code prohibit the bankruptcy court from any role in the operations of the debtor.

> "*Notwithstanding any power of the court*, unless the debtor consents or the plan so provides, the court may not, by any stay, order, or decree, in the case or otherwise, interfere with —
>
> (1) any of the political or governmental powers of the debtor;
> (2) any of the property or revenues of the debtor; or
> (3) the debtor's use or enjoyment of any income-producing property."
>
> Bankruptcy Code § 904 (emphasis added).

The absence of § 105 from Chapter 9 is one of the plainest examples of the broad scope of this limitation of the court's power. Bankruptcy Code § 901(a) does not incorporate § 105 – the court's usual power in other chapters of the Code to make orders in aid of its enumerated powers in other sections – into Chapter 9. *See* COLLIER ON BANKRUPTCY ¶ 904.01.

The limitation established by § 904 is recognized as complete, except for two specific exceptions not relevant here. The court may make an order with the debtor's consent (the District does not and will not consent to the relief sought in the Motion), and the court may rule on the confirmability of a proposed plan of adjustment of debts. COLLIER ¶¶ 904.01 and

904.02.

The prohibition on interference with the Chapter 9 debtor's normal governmental processes, and use of its property, is "absolute." *In re City of Stockton*, 478 B.R. 8, 20 (Bankr. E.D. Cal. 2012). The statutory language:

> " '[n]otwithstanding any power of the court, . . .the court may not, by any stay, order, or decree, in the case or otherwise . . .' is so comprehensive that it can only mean that a federal court can use no tool in its toolkit – no inherent authority power, no implied equitable power, no Bankruptcy Code § 105 power, no writ, no stay, no order – to interfere with a municipality regarding political or governmental powers, property or revenues, or use or enjoyment of income-producing property. 11 U.S.C. § 904. As a practical matter, the § 904 restriction functions as an anti-injunction statute – and more."
>
> 478 B.R. at 20.

Here the Foundation asks the Court to interfere with the Debtor's governmental processes by attempting to force the Debtor to mediate what proposal from what party – if any – the District may or may not choose to select as a method of realigning the profile of the health care services the District provides. Indeed, the Foundation makes so bold as to ask that a mediator be appointed "to address the . . . health care crisis facing the residents of the [District] in the wake of the closure of [the Hospital]." Motion, p. 2. Such a sweeping interference with the District's public powers is beyond the jurisdiction of the Court.

II. The District Has Broad Statutory Discretion To Manage Its Activities for the Benefit of the Residents

As a local health care district under California law, the District is empowered to select and manage the provision of health care services over a very wide range and according to the discretion of its Board of Directors. The District's Board has the powers (among many in § 32121):

> To establish, maintain, and operate, or provide assistance in the operation of, one or more health facilities or health services, including, but not limited to, outpatient programs, services, and facilities; retirement programs, services, and facilities; chemical dependency programs, services, and facilities; or other health care programs, services, and facilities and activities at any location within or without the district for the benefit of the district and the people served by the district.
>
> Cal. Health & Safety Code § 32121(j).

The District's Board of Directors is empowered to:

> (1) Enter into contracts with health provider groups, community service groups, independent physicians and surgeons, and independent podiatrists, for the provision of health services.
> (2) Provide assistance or make grants to nonprofit provider groups and clinics already functioning in the community.
> (3) Finance experiments with new methods of providing adequate health care.
>
> Cal. Health & Safety code § 32126.5(a).

The District's Board may:

> establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the health care district.
>
> Cal. Health & Safety Code § 32121(o)

To make the discretion as broad as conceivably necessary, the California Legislature has ultimately authorized the District's Board:

> To do any and all other acts and things necessary to carry out this division [which specifies a health care district's powers].
>
> Cal. Health & Safety Code § 32121(k).

All of these powers are governmental functions entrusted to the District, to be exercised through its elected board. These powers are provided in Chapter 2 of Division 23 of the Cal. Health & Safety Code, specifying the role of the board of directors of a local health care district.

It is readily apparent from the powers entrusted to the Board of Directors that it may in its discretion choose what organizations or entities that it might contract with to assist it in providing, or through which it might provide, health care services to the residents of the District. The corollary of this must be that the Board also has the power to decline to contract or affiliate with any particular organization or entity. It is this discretion that the Debtor's

Board of Directors has been applying in its consideration of the Foundation Proposal.

Pursuant to Bankruptcy Code § 904, this Court does not have the power to play a role in directing who or what the District may choose to work with or thorough in carrying out its very broad governmental functions.

A. The Foundation's Proposed Mediation Is Particularly Inappropriate

The District notes that the mediation the Foundation seeks is an odd specimen. There is no litigation or contested matter pending between the Foundation and the District that might be thought a suitable subject for possible mediation. The Foundation does not have a creditor claim against the District. Indeed, the Foundation's present posture is that of a respondent to an RFP that seems to feel that its views on the merits of its Proposal should somehow be dispositive. On the contrary, it is for the District's elected Board – giving such weight as the Board chooses to the input of its management team and engaged consultants – to determine what proposals hold the best promise of soundly and sustainably restoring health care services in the District on a realigned basis.

B. The District Has Given Great Attention to the Foundation Proposal

The District issued a formal Request for Proposals ("RFP") from parties who may be interested in assisting the District with the realignment of its healthcare services. The RFP was explicit that: "The District reserves the right and ability to reject any and all proposals, [and] to commence discussions or negotiations with any one or more applicants . . . ." *See* Declaration of Chris Dawson ("Dawson Decl."), filed concurrently, ¶ 5 and *passim*. In so reserving its freedom of action, the District was exercising its governmental power for its elected Board to make the final evaluation and decision on any proposals submitted. The Board was also acting responsibly in keeping a wide range of options available in its difficult circumstances.

The Foundation was one of the parties that submitted a proposal or letter of intent expressing interest in submitting a proposal. The District identified the Foundation Proposal as worthy of consideration, and has devoted extensive time and attention to

understanding it, evaluating it, discussing it with the Foundation's leadership, and attempting through such discussions to obtain refinements to that Proposal such that it might become more worthy of consideration. As recently as Wednesday, May 7, 2014, the Foundation agreed that significant progress was being made in these discussions, and a joint press release so advising the interested public was issued on that date. Dawson Decl., Exh. B. The District has not rejected the Foundation Proposal, and expected discussions about it to continue. Dawson Decl., ¶ 7, ¶¶ 9-15.

There is nothing in this history to suggest that there is any necessity for the burden and expense of mediation concerning the Foundation Proposal. Indeed, considering the inevitable delay occasioned by the selection of a mediator and setting up the process, mediation might well delay rather than expedite the discussions between the District and the Foundation.

A more appropriate path would be for the Foundation to obtain – and share – an independent evaluation of its Proposal by a health care consulting firm, as was agreed between the District and the Foundation at a meeting between Board President Chris Dawson and Foundation leadership on May 7, 2014. *See* Dawson Decl., ¶¶ 11-13. Indeed, so clearly was this accepted as the appropriate path that the Foundation agreed to issuance of a joint press release so stating. Dawson Decl., ¶ 14. Gail Thomas, the Foundation's declarant in support of the Motion, was present at the May 7 meeting and agreed then with the appropriate path as described here, and with the issuance of the joint press release. Dawson Decl., ¶ 15.

C. *The Foundation Proposal Is Far From The Only Viable Option for the District*

The Motion is premised on the unwarranted and unsupported assertion that the Foundation Proposal offers the only viable, or indeed best option ("compelling" is their term), and therefore is urgently in need of assistance from this Court. But in fact the District is also – as is its prerogative as a public agency and as it reserved the right to do under its RFP – conducting preliminary discussions with other parties who have expressed

interest in assisting the District in restoring a range of health care services.

These parties are organizations with significant medical operations and operating experience. They include a major national health care company, HealthSouth. Dawson Decl., ¶ 21. They include St. Joseph Health Sonoma County, an organization that operates two hospitals in the County – Santa Rosa Memorial and Petaluma Valley – and numerous other facilities. Dawson Decl., ¶ 22. St. Joseph Health has already taken actions helpful to the residents of the District in this difficult time, by expanding the capacity of its Emergency Department at Santa Rosa Memorial and extending the hours of its southwest Santa Rosa Urgent Care Center on Sebastopol Road. The District is entering into discussions with St. Joseph Health on the longer-term possibilities for partnering between the District and St. Joseph Health. Dawson Decl., *id*.

Most recently, the District has received an expression of interest from a nearby public hospital district for a possible partnering arrangement. Discussions of this expression of interest are in a very early stage, but appear to offer some prospect for resuming health care services with substantial cost efficiencies through shared administrative and other resources and services. The District intends to follow up this expression of interest in depth, as potentially having substantial merit. Dawson Decl., ¶ 24.

In addition to the proposals received from outside parties, the Board has directed District staff – with the valuable assistance of Huron Consulting – to consider how the District itself might resume providing health care services with a realigned profile. This effort takes into account the District's fiscal constraints, the history of its experience as a full-service acute care hospital, and the alternative distinct service offerings that might be possible on a financially sustainable basis. It also considers what the District might undertake on its own, and what it might better undertake in partnership with other public or private entities. Dawson Decl., ¶ 26.

Thus, the Foundation's premise that the District must immediately conclude its discussions with the Foundation – and, they imply, on terms acceptable to them – is false.

Other important options are emerging, and the District is quite properly exploring them concurrently with its discussions with the Foundation. The District is – and should be – free to make its own decisions as to what is the best approach for restoring medical services in the District. And as noted above, Bankruptcy Code § 904 provides absolute protection to the District in making such operational decisions.

In overview, then, the District Board has been considering multiple options for resumption of health care services in the District, with a variety of different possible service profiles. Some of these options are not mutually exclusive; that is, it might be possible to undertake some services itself, and also partner with one entity for one or more types of medical services and with other entities for other types of medical services. Such multiple partnering is a recognized method by which a local health care district such as the District may choose to most advantageously utilize its resources for the benefit of its residents. Dawson Decl., ¶ 27; Cal. Health & Safety Code § 32121(o).

III. Conclusion

The Court lacks jurisdiction to make the order for mediation that the Foundation's Motion would seeks. That alone rules out the relief sought in the Motion.

As a practical matter, the requested relief is also impractical and inappropriate. It would intrude on the broad discretion that the District's elected officials are afforded under the California Health & Safety Code. It would be a diversion and a burden on the District's essential broad focus on realigning its service profile in the best manner possible consistent with fiscal constraints.

For all of the above reasons, the Foundation's Motion should be denied in its entirety.

Dated: May 15, 2014

FOX ROTHSCHILD LLP

/s/ Dale L. Bratton
Dale L. Bratton
Attorneys for Debtor
Palm Drive Health Care District

EXHIBITS A - E

EXHIBIT A

MEMORANDUM

To: Board of Directors, Palm Drive Health Care District

From: Thomas M. Harlan, Chief Executive Officer

Date: April 22, 2014

Re: Evaluation / Observations Regarding Palm Drive Foundation Proposal for continued services at Palm Drive Hospital

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Along with our advisors, including Huron Consulting Group, Archer Norris and Fox Rothschild, I have reviewed the proposal received from the Foundation and offer the following observations:

Financial Feasibility

Although the Foundation Proposal includes a well-intended, interesting and well thought out plan given the short turnaround timeframe provided, it is not financially feasible as presented. The most significant issues regarding our read of the financial feasibility include:

- Neither the proposal nor the cash flow projections address the costs associated with the Chapter 9 case and any anticipated Plan of Debt Adjustment that would need to be approved by the Bankruptcy Court. While our own cash flow projections contemplate that both costs of the case and the recovery for unsecured creditors are financed through patient care and associated revenue, the Foundation proposes that these revenue streams be used to off- set operating losses. The District is then left with no money to address the Bankruptcy. The only reference to a recovery is payment of $100,000 of prepetition liability to the ED physicians as a critical vendor. In short, the Foundation Proposal appears to be relying on existing District accounts receivable revenue, but does not provide for the actual or projected debts owed to creditors and the costs of the bankruptcy proceeding. In order to become more viable, the Foundation Proposal will need to include an infusion of new capital both for ongoing operations and for the facility/infrastructure.

- The “base case” operation, prior to cash from new programs, continues to be a significant operating loss ranging from nearly $750,000 in 2015 to more than $1.2 million in both 2016 and 2017. The profitability comes from the development of the new programs. Through the Foundation’s own statement, the details of these new programs have yet to be developed and the numbers included in the plan are initial high level projections. Further, staff knows from prior experience and analysis that some of these programs do not traditionally generate a positive operating margin for hospitals. At this point, the entire plan depends on the successful development of these programs.

- There is no capital budget, and their cash flow does not support capital investment. Capital will be needed for facility items, new program development, replacement of IT infrastructure currently provided through Marin and/or Sonoma Valley Hospital, etc. For

example, the proposal outlines very real facility and infrastructure issues that need to be addressed, yet there is no capital to address these items. It is suggested that in future years the district will be able to retain the excess tax proceeds to address capital investment, but it is staff's opinion that even so, available cash flow is not sufficient to address the necessary capital needs outlined.

- The separate cash flow projections and the cash flow and balance sheet provided as part of the proposal aren't consistent and not all numbers seem to make sense.

  The Proposal raises numerous economic issues of less immediate impact that the Board will need to carefully consider.

Legal / Regulatory Issues

- California Health & Safety Code Section 1265 and 1265.3 set forth the requirements for CDPH approval of the assumption of operational control of an acute care hospital by a management company. The Foundation proposal provides that sole responsibility for management would be delegated to the Foundation, suggesting a Marin General model of separate operational control of the hospital through a non-profit corporation. The proposal suggests that the Foundation as Management Company would operate the Hospital and that the District would retain a role in overseeing the remaining strictly "district" affairs, such as the bankruptcy proceeding and collection of parcel tax revenues. Unfortunately, the sample management contract, mostly derived from the former Brim management contract, is more of a management personnel and consulting services agreement, with no delegation of existing District Board authority. Thus substantial revisions involving delineation of delegated authority and legally required reservations of authority by the District would have to occur before the Agreement could be submitted by the Foundation for approval by the State. The outcome of the State review process is unknown and the time it will take is unknown, though local CDPH officials suggest a lot more time would be needed than that allowed for under present closure plans.

- A significant impediment to the Foundation assumption of management authority is the proposal to place a CEO (Dr. Gude) who already has substantial contractual services under agreement with the District. This is a conflict of interest issue. Specifically, this is a Professional and Administrative Services Agreement that covers the following services:
  1. Intensivist Coverage Services 24/7/365.
  2. Telemedicine Coverage Services for certain specialties 24/7/365
  3. Medical Director ICU
  4. Medical Director RT Services
  5. Combined MD services 20 hours per month

  Compensation provided under these existing agreements provide for a maximum payment of $10,900 monthly.

  Additionally there is an Office Lease with OffSite Care for Dr. Gude's hospital office.

  The CEO of Palm Drive Hospital is considered to be a senior public official subject to all conflict of interest laws and regulations under the Political Reform Act and Section 1090

of the Government Code. Similar conflicts rules exist for non-profit corporations acting as governing bodies of hospitals. It does not matter if the CEO is paid or not, or whether the decisions he or she is involved in have outcomes that benefit or hurt them financially. Any financial interest in an outcome precludes participation in the decision by the conflicted public official and sometimes precludes the agency's participation entirely in a contract. Healthcare Districts are exempted from the contracting prohibition under Section 1090 if a medical staff member, as a public official, has medical director or coverage agreements, but the conflicted official may not participate in the decision impacting him or her financially. It also appears that a service arrangement unique to the hospital, such as the telemedicine program, would not be exempt from Section 1090. It is our understanding that the proposed CEO has an interest in the company that would "donate" certain information management systems to the hospital. Donations by referring physicians to hospitals in which the physician provides services under contract are subject to compliance limitations under the Stark and fraud and abuse regulatory schemes.

Indirect conflicts would also exist, e.g., decisions ancillary to the public agency CEO's own contracts like department budgets, ER operations, decisions impacting referral sources to the CEO's practice and companies, and the fundamental and ongoing issue of whether to maintain operations of the Hospital. Hospitals ordinarily do not engage CEO's or other managers who do business with the hospital in any significant way. Certainly public hospitals do not. While some levels of board or management conflicts are manageable through non-participation, there can be conflicts with direct and indirect scope that render non participation impracticable.

It has been suggested the CFO of Dr. Gude's company, Offsite Care, is also the proposed CFO under the Foundation's Proposal. If true, that would also present a perhaps unmanageable conflict of interest scenario given the CFO's status as a public official, the scope of the CFO's role in determining operational budgets, and Dr. Gude's contractual arrangements with the Hospital. The CFO would not be exempt from the Section 1090 prohibition from contracting with an entity in which an agency officer has a financial interest.

There are other conflicts scenarios presented in the Proposal, such as a physician with a hospital based practice on the Board of the Foundation, and other board members employed as managers of departments under the proposed management contract. While real, those are probably "manageable" conflicts situations. The CEO level conflicts envisioned may not be. The impact of conflicts on the regulatory review of the new management by state and federal regulators is also unclear.

- The proposed operating structure (with multiple people reporting to a Foundation Board) is inconsistent with state and accreditation requirements to have one CEO / Administrator "in charge".

In addition to the above, the Proposal and proposed Management Contract raise numerous management contracting issues of less immediate impact that the Board will need to consider.

Options

Staff believes that the Board can pursue one of 2 options:

- Proceed to closure next week as planned while simultaneously initiating more detailed negotiations with the Foundation and/or other proposals and alternatives in the hope that an agreement can be reached in the future and the facility can reopen under new management.

- Request an immediate grant of $1,600,000 from the Foundation, received by noon Thursday April 24th, non-refundable, to allow for continued operations through May 30 of the current reduced level of services while negotiations continue with the Foundation and discussions continue with state and other regulators. This is a "no-strings attached" grant, with no commitment to enter into a contract. Despite such a payment, I am not entirely certain that I will be able to actually hold the hospital together for another month. This amount does assume that in some areas I would need to bring in contract/agency staff to ensure adequate staffing.

Please be aware that the Board of Directors is obligated to direct management to meet federal and state quality assurance mandates during a period of fiscal crisis, including the safety and quality of care of present or potential patients whose care might be impacted by financial issues. Management has been in close contact with state licensing officials and surveyors who are overseeing the transitions from full to reduced, to closure of services. Management is complying with guidance from licensing officials arising from their observations and surveys and Management must continue to have Board support for its compliance with the guidance of regulatory officials, including the consistency of information provided to the community concerning the District's ability to provide services or discontinue them, and the timing thereof.

EXHIBIT B

For Immediate Release

PALM DRIVE FOUNDATION AND DISTRICT BOARD RESUME TALKS

May 7, 2014 – Sebastopol, Calif – The Palm Drive Health Care District Ad-hoc committee met today with the Palm Drive Foundation in continued conversation about the Foundations proposal to re-open the hospital.

Both sides report good progress on key aspects of the proposal, and have worked out a plan to have further analysis done on critical details of the proposal. The goal continues to be a careful analysis, as quickly as possible, to determine the viability of the proposal, with the understanding that any plan would need to be approved by the full district board.

EXHIBIT C

HEALTHSOUTH®

Dawn M. Gideon
Managing Director
Huron Consulting Group
599 Lexington Avenue, 25th Floor
New York, NY 10022

Dear Ms. Gideon:

This letter is in response to the RFP posted for Palm Drive Hospital in Sebastopol, CA. While we certainly appreciate the opportunity to respond by noon today, we would not be able to commit to our level of interest without touring the property and having a better understanding of improvements that would need to be made to convert the existing hospital to a rehabilitation hospital. With that said, we do remain very interested in exploring this opportunity to open a 40 – 50 bed rehabilitation hospital.

HealthSouth is the nation's largest owner and operator of inpatient rehabilitation services in the country with 103 hospitals. Our current hospitals in California are located in in Bakersfield and Tustin. In addition, we hope to start construction on a new location in Modesto by August of this year, pending OSHPD approval.

We believe there is a need for inpatient rehabilitation services in the Sebastopol-Santa Rosa area and feel we would be a great asset to the community by offering the highest quality of care for the type of patients we treat. In addition, we bring a large number of high-paying jobs as most of our employees are nurses and therapists and as a for-profit company, tax revenue as well.

HealthSouth offers expertise in many rehabilitation programs and treatments designed to meet the needs of specific conditions. Our goal is to restore and strengthen patients so they can return to their highest level of independence. We mainly treat the following types of patients:

- Stroke
- Amputations
- Arthritis
- Brain Injury
- Hip Fractures
- Joint Replacement
- Multiple Trauma
- Neurological Disorders
- Other Orthopedic Injuries/Conditions
- Spinal Cord Injury

3660 Grandview Parkway, Suite 200 • Birmingham, AL 35243
205 967-7116 • Fax 205 262-8708
www.healthsouth.com

HealthSouth takes a unique approach to rehabilitation that is patient-focused and results-driven:

- **Specialization:** Unlike skilled nursing homes, each HealthSouth hospital is dedicated full time to rehabilitation. All decisions and resources are focused on rehabilitation. Typical length of stay is 12-14 days.
- **Results-driven:** Every minute of every day, the focus is on results. We work hard to get each patient strong, functional and as independent as possible.
- **The team approach:** Qualified and passionate rehabilitation experts work together to plan and execute quality treatment.
- **Accreditation and certification:** All HealthSouth hospitals are fully accredited. In addition, many HealthSouth hospitals have received special certifications for their excellence in service related to specific conditions.
- **Continuum of care:** HealthSouth helps patients transition from their current hospital to HealthSouth, and then helps them transition to more independent rehabilitation as they progress.
- Experienced **leadership** with a strong company **mission.**
- Leading-edge **rehabilitation technology**.

Additional information can be found on our website located at www.healthsouth.com

Thank you again for your consideration. I look forward to hearing from you soon.

Warm Regards,

Melanie Lewis
VP Development
HealthSouth

EXHIBIT D

St. Joseph Health

Petaluma Valley • Santa Rosa Memorial

April 18, 2014

Dear Palm Drive Hospital Healthcare District Board,

St. Joseph Health – Sonoma County (SJH-SC), including Santa Rosa Memorial and Petaluma Valley Hospitals, has a great interest in supporting the communities in Sonoma County to obtain the necessary health care services required to improve the health and quality of life of its residents. As Palm Drive Hospital approaches changes in its scope of services, we support participating in solutions that would preserve access to identified outpatient medical services in its community. These solutions could be achieved through various options including private means or public-private partnerships.

Due to the aggressive RFP time frame, SJH-SC is not able to provide a comprehensive response to the RFP by April 18th, 2014. Through further conversations, details regarding space, equipment, scope of services, locations and other operational details or logistics could be worked out in order to develop an inclusive proposal.

While our intent would be to develop a long-term plan to provide necessary health care services to the Sebastopol community, we also recognize the importance of supporting the community through this transitional period. After speaking with local health care officials and other key stakeholders we have assessed our internal operations and have expanded our urgent and emergent safety net capabilities. This adjustment increases ED capacity at Santa Rosa Memorial Hospital as well as expands the hours of operation at our southwest Santa Rosa Urgent Care Center on Sebastopol Road.

We look forward to discussing short- and long-term plans and other opportunities with the Palm Drive Health Care District and are prepared to help develop a viable plan for health care services in this community.

Sincerely,

Todd Salnas
President

1165 Montgomery Drive • Santa Rosa, CA 95405 • T: (707) 546-3210

www.stjosephhealth.org

EXHIBIT E

Physicians United

A Proposal for Hospital Operation for Palm Drive Hospital

Presented by Dr. Michael Bollinger

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1. Introduction and Background

2. Framework and Organization

3. Financial Proforma and Comprehensive Business Plan

Introduction and Background

Palm Drive, founded in 1941, is an independent, non-profit facility operated by the Palm Drive Health Care District. In 1974, the Hospital was reconstructed at its present site, and in 1991, extensive renovations were completed. Palm Drive Hospital was licensed for 37 beds, five intensive care beds and the remainder medical-surgical beds. The Hospital provides a full range of primary acute care services including respiratory care, emergency care, intensive care, and outpatient ambulatory care services.

The Hospital is supported by revenues from inpatient and outpatient services as well as by parcel taxes (since 2003) paid by residents in the Health Care District's service area. In addition, the Palm Drive Health Care Foundation, a nonprofit organization, supports the Hospital by seeking charitable bequests and directing fundraising activities.

Palm Drive Hospital states in its mission statement that it exists to deliver access to quality and compassionate health care services responsive to the needs of its community.

The vision of Palm Drive Hospital is to be the gateway for community access to a continuum of health care services. Palm Drive Hospital will distinguish itself through:

- Providing quality health care services at Palm Drive Hospital to assure appropriate access to local care for the communities it serves.
- Developing partnerships among physicians who serve to align incentives, attract new medical providers, and strengthen the Hospital's capability to provide and manage the care of their patients.
- Encouraging a culture that supports employees and providers in developing their skills and resources to design complementary health services to better meet the needs of Palm Drive Hospital's communities.
- Being resourceful in integrating skills and resources to design complementary health services to better meet the needs of Palm Drive's communities.
- Creating opportunities to share programs and services with other health systems that are cost effective in improving quality and accessibility of services.

Physicians United seeks the opportunity to continue the vision and the mission of Palm Drive Hospital in a manner designed to meet the needs and the realities of the 21st century, while respecting the history of the hospital in the community.

The landscape of the healthcare industry has undergone drastic changes, resulting from increasingly complex regulation, changes in the way revenues are generated, and technology changes occurring at blinding speed. Many of the changes have made it difficult or impossible for smaller hospitals to operate profitably in a full service model. Some analysts predict that one in three small hospitals (of generally the same size as Palm Drive) will close within the next few years, unable to make the changes necessary to operate profitably under the new rules, revenue models, and patient expectations.

Physicians United believes that they understand what is needed to succeed in the current framework of regulation and insurance to provide extraordinary care in a sustainable, profitable way. The group of physicians proposes a plan which respects the realities of providing health care services in Sonoma County and seeks to preserve critical urgent and emergency services to our communities in the west county, while limiting or eliminating services that have not been profitable for Palm Drive Hospital.

Framework and Organization

Physicians United would move immediately to begin the process of reopening the emergency room, preferring, if logistically possible, to take over operations in a seamless manner on the morning of April 29, 2014. The operations going forward initially would be the intensive care unit, radiology, the lab, and an outpatient and specialty surgery center, with at least 5 inpatient beds staffed by nursing personnel with the appropriate requisite credentials. The hospital will also provide dietary services as required under law for a hospital with inpatient beds.

Under management by Physicians United, the hospital will operate as a 24-hour facility for emergency and inpatient care, with specialty surgery services taking place in the timeframe from 6:00am to 3:00pm. The new model would envision transferring patients needing longer term care to other local hospitals, which are designed to more efficiently provide longer term care consistent with the mission and vision of Palm Drive Hospital.

While it is not possible to state the exact date that individual services will be available at the hospital after the Physicians United offer is accepted, the shorter the duration of time the hospital has ceased operation, the shorter amount of time it will take to reorganize services and reopen the doors. The prospective operations will be limited as described above, but the quality of care will never be compromised. The hospital's current license, which is currently suspended, will be renewed. The renewal of the current license is the believed to be consistent with the Physicians United vision for the hospital and the most expedient path to reopening the hospital. Physicians United also intends to continue using the services of the Huron Healthcare Group to assist in designing and implementing the

structure of the hospital going forward. We believe that the continued involvement of Huron will be a distinct asset to the management of the transition process of Palm Drive from a failing local hospital to a model for local healthcare in the 21st century.

In order to increase efficiency and improve quality, most administrative services, including medical billing, will be outsourced to third party providers, allowing hospital staff to concentrate on patient care and to reduce the number of full-time equivalent employees to help keep overall administrative and regulatory costs down. These services will be contracted by and be the responsibility of Physicians United, and the costs for these services are built into the financial model presented in this proposal.

The proposal by Physicians United initially intends to use the entire facility, less the 32-bed inpatient ward. This ward may or may not be necessary to the venture in the future, either in its current form, which is not likely, or in some other manner to respond to a demonstrated need for the community for additional services which will be complimentary, sustainable, and within the mission and vision of Palm Drive Hospital.

Physicians United will contract with Huron Healthcare Group at the outset to manage the operations and establish best practices for the ongoing operation of the hospital. Physicians United believes that engaging the best professionals will save money overall and will give the hospital the best foundation for successful future operations.

Physicians United is a group of medical professionals with a history of working with Palm Drive Hospital, as well as successful outside practices. The startup cost funding is coming from unencumbered funds derived from the successful operation of their outside practices. Physicians working at Palm Drive will be compensated based on personal production with a sliding scale formula resulting in baseline production producing a fair compensation with additional physician production earning significant incentives.

Physicians United expects additional staff to consist of 10 full-time staff members plus additional part-time staff, as necessary to meet the needs of patients and the community. The sharp difference in staffing from the past is attributed to eliminating positions which were administrative (which will be provided in the management contract with Huron) restructuring services and scheduling to reduce staffing inefficiencies and eliminating unnecessary services and the positions which were attributed to those services.

The ongoing operations of the hospital will be the responsibility of Physicians United, but Physicians United understands the ongoing interest of the District Board in overseeing the operations and will welcome the structured input of the District Board, Physicians United

proposes quarterly meetings between the management committee of Physicians United and the District Board during the length of the contract.

Physicians United requests that the Hospital District repair and maintain the structure and exterior of the facility during the period of the contract at its cost, with Physicians United taking responsibility for the interior maintenance of the hospital. To the extent that any physical remodeling of the building is required, Physicians United expects that the owner of the building make reasonable alterations at its cost.

During the startup period, Physicians United requests a rent of $1 per year, with an annual review to determine whether the arrangement is acceptable going forward. In addition, the startup funding is expected to be recovered during the period of the contract through profitable operation and improved cash flow. Physicians United requests that the return of the startup funding of $3,000,000 be guaranteed by the Hospital District during the term of the contract and secured with a lien on the hospital property.

Financial Proforma and Comprehensive Business Plan

Funding to restart the hospital will exceed $3,000,000, which has already been committed to Physicians United by a member of the group. Sustainable, profitable operations are expected to be attained within the first year of operation. See following proforma financial information. All questions regarding the financial information can be referred to Dillwood Burkel & Millar LLP, CPAs (DBM). DBM will be operating in concert with Physicians United to maintain the books and records of the organization and the ongoing hospital operations which will be open for the review of the District Board at any time during normal business hours. Physicians United looks forward to an open and honest relationship with the District resulting in a successful venture and long term sustainable healthcare services to the west county.

Exhibit I. Three-Year Projected Profit and Loss (Cash Basis)

For the Years Ending June 30,	2015	2016	2017
Gross Charges	$ 65,909,091	$ 69,204,545	$ 72,664,773
Contractual Adjustments	(45,374,091)	(47,642,795)	(50,024,935)
Net Patient Revenues	20,535,000	21,561,750	22,639,838
Non-operating Revenue			
Tax Revenues	2,000,000	2,060,000	2,121,800
	2,000,000	2,060,000	2,121,800
Total Revenue	22,535,000	23,621,750	24,761,638
Expenses			
Physician's Fees	4,390,000	4,521,700	4,657,351
Salaries and Benefits	5,600,000	5,768,000	5,941,040
Purchased Services and Professional Fees	2,575,000	2,652,250	2,731,818
Equipment Rental	510,000	525,300	541,059
Supplies	4,300,000	4,429,000	4,561,870
Insurance	390,000	401,700	413,751
Utilities and Other	320,000	329,600	339,488
Total Expenses	18,085,000	18,627,550	19,186,377
Net Income	$ 4,450,000	$ 4,994,200	$ 5,575,261

Exhibit II. Three-Year Projected Expenses as a Percentage of Net Patient Revenues

For the Years Ending June 30,	2015	2016	2017
Physician's Fees	21%	21%	21%
Salaries and Benefits	27%	27%	26%
Purchased Services and Professional Fees	13%	12%	12%
Equipment Rental	2%	2%	2%
Supplies	21%	21%	20%
Insurance	2%	2%	2%
Utilities and Other	2%	2%	1%
Total Expenses as a % of Net Patient Revenues	88%	86%	85%

Exhibit III. Projected Profit and Loss (Cash Basis) for Fiscal Year Ending June 30, 2015

	ER	Intensive Care	Outpatient Surgical	Imaging	Lab	Pharmacy	**Total Operating**	Non Operating	**Total**
Gross Charges	$ 10,000,000	$ 3,000,000	$ 27,409,091	$ 13,000,000	$ 6,500,000	$ 6,000,000	**$ 65,909,091**	$ -	**$ 65,909,091**
Contractual Adjustments	(6,900,000)	(2,070,000)	(18,809,091)	(8,970,000)	(4,485,000)	(4,140,000)	**(45,374,091)**	-	**(45,374,091)**
Net Patient Revenues	3,100,000	930,000	8,600,000	4,030,000	2,015,000	1,860,000	**20,535,000**	-	**20,535,000**
Non-operating Revenue									
Tax Revenues	-	-	-	-	-	-	-	2,000,000	**2,000,000**
	-	-	-	-	-	-	-	2,000,000	**2,000,000**
Total Revenue	3,100,000	930,000	8,600,000	4,030,000	2,015,000	1,860,000	**20,535,000**	2,000,000	**22,535,000**
Expenses									
Physician's Fees	1,400,000	220,000	2,520,000	150,000	100,000	-	**4,390,000**	-	**4,390,000**
Salaries and Benefits	1,500,000	800,000	600,000	1,000,000	1,000,000	700,000	**5,600,000**	-	**5,600,000**
Purchased Services and Professional Fees	60,000	80,000	430,000	200,000	300,000	5,000	**1,075,000**	1,500,000	**2,575,000**
Equipment Rental	-	-	110,000	200,000	100,000	100,000	**510,000**	-	**510,000**
Supplies	500,000	300,000	1,500,000	900,000	500,000	600,000	**4,300,000**	-	**4,300,000**
Insurance	50,000	50,000	250,000	20,000	20,000	-	**390,000**	-	**390,000**
Utilities and Other	50,000	60,000	120,000	50,000	20,000	20,000	**320,000**	-	**320,000**
Total Expenses	3,560,000	1,510,000	5,530,000	2,520,000	2,040,000	1,425,000	**16,585,000**	1,500,000	**18,085,000**
Net Income (Loss)	$ (460,000)	$ (580,000)	$ 3,070,000	$ 1,510,000	$ (25,000)	$ 435,000	**$ 3,950,000**	$ 500,000	**$ 4,450,000**

Exhibit IV. Projected Profit and Loss (Cash Basis) for Fiscal Year Ending June 30, 2016

	ER	Intensive Care	Outpatient Surgical	Imaging	Lab	Pharmacy	**Total Operating**	Non Operating	**Total**
Gross Charges	$ 10,500,000	$ 3,150,000	$ 28,779,545	$ 13,650,000	$ 6,825,000	$ 6,300,000	**$ 69,204,545**	$ -	**$ 69,204,545**
Contractual Adjustments	(7,245,000)	(2,173,500)	(19,749,545)	(9,418,500)	(4,709,250)	(4,347,000)	**(47,642,795)**	-	**(47,642,795)**
Net Patient Revenues	3,255,000	976,500	9,030,000	4,231,500	2,115,750	1,953,000	**21,561,750**	-	**21,561,750**
Non-operating Revenue									
Tax Revenues	-	-	-	-	-	-	-	2,060,000	**2,060,000**
	-	-	-	-	-	-	-	2,060,000	**2,060,000**
Total Revenue	3,255,000	976,500	9,030,000	4,231,500	2,115,750	1,953,000	**21,561,750**	2,060,000	**23,621,750**
Expenses									
Physician's Fees	1,442,000	226,600	2,595,600	154,500	103,000	-	**4,521,700**	-	**4,521,700**
Salaries and Benefits	1,545,000	824,000	618,000	1,030,000	1,030,000	721,000	**5,768,000**	-	**5,768,000**
Purchased Services and Professional Fee	61,800	82,400	442,900	206,000	309,000	5,150	**1,107,250**	1,545,000	**2,652,250**
Equipment Rental	-	-	113,300	206,000	103,000	103,000	**525,300**	-	**525,300**
Supplies	515,000	309,000	1,545,000	927,000	515,000	618,000	**4,429,000**	-	**4,429,000**
Insurance	51,500	51,500	257,500	20,600	20,600	-	**401,700**	-	**401,700**
Utilities and Other	51,500	61,800	123,600	51,500	20,600	20,600	**329,600**	-	**329,600**
Total Expenses	3,666,800	1,555,300	5,695,900	2,595,600	2,101,200	1,467,750	**17,082,550**	1,545,000	**18,627,550**
Net Income (Loss)	$ (411,800)	$ (578,800)	$ 3,334,100	$ 1,635,900	$ 14,550	$ 485,250	**$ 4,479,200**	$ 515,000	**$ 4,994,200**

Exhibit V. Projected Profit and Loss (Cash Basis) for Fiscal Year Ending June 30, 2017

	ER	Intensive Care	Outpatient Surgical	Imaging	Lab	Pharmacy	**Total Operating**	Non Operating	**Total**
Gross Charges	$ 11,025,000	$ 3,307,500	$ 30,218,523	$ 14,332,500	$ 7,166,250	$ 6,615,000	**$ 72,664,773**	$ -	**$ 72,664,773**
Contractual Adjustments	(7,607,250)	(2,282,175)	(20,737,023)	(9,889,425)	(4,944,713)	(4,564,350)	**(50,024,935)**	-	**(50,024,935)**
Net Patient Revenues	3,417,750	1,025,325	9,481,500	4,443,075	2,221,538	2,050,650	**22,639,838**	-	**22,639,838**
Non-operating Revenue									
Tax Revenues								2,121,800	**2,121,800**
	-	-	-	-	-	-	-	2,121,800	**2,121,800**
Total Revenue	3,417,750	1,025,325	9,481,500	4,443,075	2,221,538	2,050,650	**22,639,838**	2,121,800	**24,761,638**
Expenses									
Physician's Fees	1,485,260	233,398	2,673,468	159,135	106,090	-	**4,657,351**	-	**4,657,351**
Salaries and Benefits	1,591,350	848,720	636,540	1,060,900	1,060,900	742,630	**5,941,040**	-	**5,941,040**
Purchased Services and Professional Fee	63,654	84,872	456,187	212,180	318,270	5,305	**1,140,468**	1,591,350	**2,731,818**
Equipment Rental	-	-	116,699	212,180	106,090	106,090	**541,059**	-	**541,059**
Supplies	530,450	318,270	1,591,350	954,810	530,450	636,540	**4,561,870**	-	**4,561,870**
Insurance	53,045	53,045	265,225	21,218	21,218	-	**413,751**	-	**413,751**
Utilities and Other	53,045	63,654	127,308	53,045	21,218	21,218	**339,488**	-	**339,488**
Total Expenses	3,776,804	1,601,959	5,866,777	2,673,468	2,164,236	1,511,783	**17,595,027**	1,591,350	**19,186,377**
Net Income (Loss)	$ (359,054)	$ (576,634)	$ 3,614,723	$ 1,769,607	$ 57,302	$ 538,868	**$ 5,044,811**	$ 530,450	**$ 5,575,261**