Sonoma Valley Hospital
Business Plan for New Facility
October 2006

The Sonoma Valley Healthcare District plans to replace its current facility with a new hospital that we expect to open in 2012. (For simplicity in preparing the accompanying financial projections, we have assumed the facility will open on July 1, 2012, the beginning of our 2013 fiscal year.)

Background – Initial Plan and Defeat of Measure C

In early 2006 management developed plans for a hospital that would contain 40 acute care beds (medical/surgical, ICU and OB), along with 28 skilled nursing (SNF) beds. The facility was sized to meet the demand forecast for the year 2020, as determined by demographic studies undertaken by several outside consultants. The District management and Board concluded that it is impracticable to construct the new facility at the current site, even if nearby open land is used. At the time, we could find no site with both adequate space and a willing seller, so the Board sought the community's input in selecting among sites that would require the use of eminent domain. The Board chose property immediately west of 5th Street West known as the Leveroni site. This generated far more opposition than expected and a very active campaign was mounted to defeat the bond (Measure C) that would have financed construction at this site. In addition to the site, the size of the bond, $148 million, was also an issue.

During the election (Measure C was a mail ballot, with the 'polls' open for a month) a community member announced that he had secured options from willing sellers for a roughly 15 acre site south of Napa Road and east of Broadway (the 'Broadway site').. The Board could not call off an election that had begun, but it announced at the next Board meeting that it had no intention of building on land requiring eminent domain when willing sellers with an appropriate site were available.

Measure C was defeated by a nearly four to one ratio. Even before the election was completed, several local citizens formed a 'Plan B Committee', dedicated to bringing the community together around a hospital solution that would pass the 67% threshold required for bond measures. The Committee held community meetings around the issue and eventually transformed into the Sonoma Valley Healthcare Coalition. The District Board, recognizing that it had lost considerable credibility and that any successful campaign would almost certainly require the endorsement of the independent Coalition, gave the group its formal support. This support included funding consultants that would assist the Coalition to analyze various options for a new facility.

Summary of Current Proposal

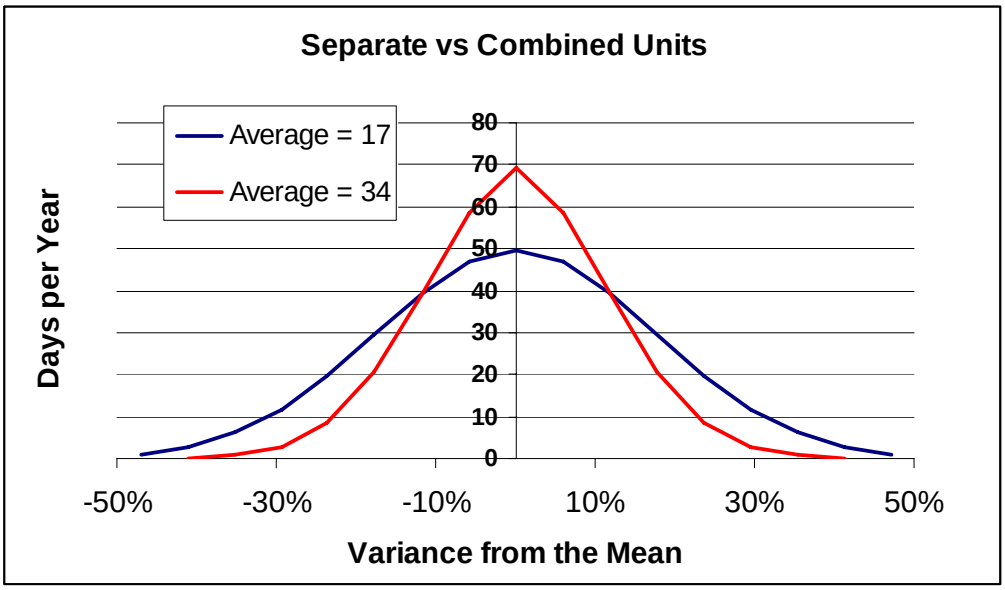
The current plan involves a somewhat smaller (56 bed) facility on land (the Broadway site) that does not require eminent domain. In addition to being smaller, the facility makes use of less expensive construction for its business and support functions and moves as much clinical activity as possible out of the most expensive "I" construction, resulting in a lower cost. We also plan on shifting a portion of the capital burden from the taxpayers to a combination of philanthropy and private investment. As a result of these changes, we expect the required tax-supported debt to decline by over $50 million, to roughly $95 million.

Sizing and Staffing the Facility

For a description of our market, see EXHIBIT 1

We continue to use the demand forecast upon which the 68 bed facility was sized, but believe that a newly discovered ability to use 'swing beds' will allow us to meet that demand with fewer beds. We had asked the State Department of Health Services ('DHS') several times in the past whether we were eligible to use swing beds and they consistently told us no. However, we have been assured by a licensing consultant that DHS is wrong on this point and have reviewed letters overturning the local DHS decision for hospitals in precisely our circumstances. (The decision turns on our status as a rural hospital, because only rural facilities may employ swing beds. Local DHS offices have used the Medicare payment designation as the controlling criterion, but the underlying legislation clearly shows that it is the census designation that determines our status. By that criterion, we are rural.)

The swing bed concept allows the same patient room to house either an acute or skilled nursing patient. Absent that designation, Medicare requires a patient who no longer qualifies for acute care to be transferred to a physically separate skilled nursing unit. If swing beds are employed, the patient stays in the same bed and the payment designation changes without a physical transfer. This saves labor costs in two ways. Most obviously, there is no need to transport the patient to separate unit, or incur the costs (such as housekeeping preparation for a new room) attendant to the transfer. More importantly, however, is the impact of combing two small units into a single larger unit. Small hospitals face enormous staffing difficulties because the lower the average census, the greater the variability in the daily census. By combing the SNF and acute units, both of which have a current average daily census of roughly 18, we eliminate a substantial portion of that variability. The graph below illustrates the impact.



The effect of having a single unit is illustrated by calculating the number of days the census will vary by more than 30% of the mean. A unit that averages 17 will exceed that variance some 45 days a year, while one with an average census of 34 only about 8 times. With a combined unit, we

estimate that we will need 5.5 fewer FTEs to serve the same patient load. This includes the impact of placing the ICU adjacent to the acute/SNF unit.

The statistical implication of combining the units is just as important in determining the required number of beds. Just as we must staff for extreme variances, we must have beds for those extreme days if we are to meet the community's service demand. With two separate units, we have to operate at a much lower average daily census in order to meet the extreme demand days than we do with one unit that is twice as large. As a result we need many more total beds with two separate units.

The new facility will provide other opportunities to reduce staffing. Our current hospital was designed around an inpatient-centered workflow, because when it was constructed, inpatients accounted for 85% of our activity. With the vast majority of our patients now receiving service on an outpatient basis, this has led to much inefficiency. One example is the way we accommodate outpatient surgery, a service that was essentially non-existent when the hospital was designed. Newly designed facilities place all of the functions required by outpatient surgery adjacent to the surgery suites. Patients check in, are prepped, operated on, recover and are discharged all from the same area, with all of the service provided by a single, integrated staff. In our facility, patients first check into the third floor, where they are prepped, then transported to the first floor for the surgery and post-op recovery. They are then transported back to the third floor, where they complete their recovery and receive discharge instructions. To treat patients in this fashion, we must staff redundantly, because in addition to the transport requirement, we cannot leave patients unattended on the third floor.

Such inefficiencies permeate our operations. We estimate that we can save as many as fifteen FTE's by taking advantage of the space adjacencies in a new facility. The architects involved in developing the space program agree with this estimate. However, to ensure that our financial projections are conservative in nature, we have included only an eleven FTE reduction, reflecting the positions our middle managers believe is the minimum savings.

Facility Construction and Related Costs

With fewer beds than the previous plan, we now estimate that the facility will require roughly 115,000 square feet. The facility will be housed in three separate buildings, as shown below.

Building Type	**Square Feet**
"I" Space – most stringent OSHPD requirements	70,826
OSHPD "III" Space – Clinical functions allowed, 15% lower cost than "I"	26,088
Tilt-Up – Support services, 60% savings over "I"	18,225
Total	115,139

The total cost of construction, escalation, equipment, land and Site preparation is $130,600,000. See EXHIBIT 2 for the detail behind this number. We expect to fund this from the following sources.

Net proceeds from sale of current site	$ 5,000,000
Reimbursement from Medical Office Building Developer	3,600,000
Philanthropy	15,000,000
Private Investment	12,000,000
Interest earnings on General Obligation Bonds	2,000,000
Tax-supported General Obligation Bonds	93,000,000
Total	$130,600,000

Private Investment

We expect to finance 50% of the OSHPD III building (which is almost exclusively devoted to imaging and surgery) and 50% of the imaging equipment though physician joint ventures. The total private investment is set at $12,000,000 for the purposes of our projections. We have held discussions with both California Advanced Imaging (the 60-70 member group that provides our radiologists) and Marin IPA. Both have expressed interest and California Advanced Imaging has provided a non-binding letter of intent.

We don't know the precise nature of the relationship we will have with the investing physicians, and won't for at least several years. However, we are confident that their involvement will lead to both an increased market share and cost savings. For purposes of the financial projection we have included only a one-time 15% increase to outpatient imaging and surgery volumes. We have not included any cost savings nor any improvement in inpatient market share; we believe this is conservative. This assumptions is based on discussion with management for California Advanced Imaging, who told us that utilization has increased by as much as 25% when physicians have become actively involved in their ventures. (They are involved in roughly ten hospital-physician joint ventures.)

For simplicity, we assumed that we will pay the investors a 15% return, or $1.8 million per year. (This is included in the projections as interest expense, but appropriately not considered as a reimbursable cost for Medicare and Medi-Cal.) The actual terms will undoubtedly include profit participation. *This is a conservative assumption, because the profits generated by our revenue improvement assumptions are modest. In fact, the effect in fiscal 2013 is a $1,350,000 improvement in operations, before paying the investors and a $450,000 decline in operating margin after taking the return into account.* In effect, we are only assuming that the joint venture approach provides the District with a relatively low cost source of capital, rather than a source of additional cash.

Physician Recruitment

As, physician recruitment remains the cornerstone of our long-term strategy, the following two paragraphs are repeated from our April Business Plan.

> Having a robust medical staff is they key to maintaining our market share. Attracting physicians to Sonoma County is a difficult task, because they are in demand nation-wide,

reimbursement levels are below the rest of the Bay Area and the cost of living is high. In addition, physicians are increasingly reluctant to become involved in the business aspects of practicing medicine and face a difficult, if not impossible, task in attempting to find commercial financing to begin practicing on their own. As a result, essentially all new physicians in Sonoma County are underwritten by a larger organization, such as Kaiser, one of the hospitals or few large independent physician practices that are located in Santa Rosa. In Sonoma Valley, aside from the two physicians who work for the local clinic, only the hospital has both the capital and incentive to bring new doctors into the community. (The 'clinic' is Sonoma Valley Community Health Center, an organization developed by the hospital but spun off several years ago so that it could become a federally qualified rural health clinic and thus be eligible for additional grants.)

One component of our strategy is the development on an integrated medical group and construction, on the new campus, of a facility designed to support such a group. We believe that the ability to offer physicians a cost-effective, 'hassle-free' work environment is critical to recruitment. (It also offers significant advantages in terms of quality and patient convenience.) We know that the promise of this type of arrangement played an important role in recruiting several of our new physicians.

Our most recent experience has reinforced the importance of this strategy in two respects. First, we saw a five- percent increase in acute admissions during fiscal 2006, the first increase in almost a decade. While we cannot say conclusively that this increase resulted from the five specialists and three primary care physicians we have recruited over the past 18 months, it is unlikely that total demand fluctuated to that degree. Second, we have instituted a 'mini' medical office within the hospital, by hiring a manager to oversee the staffing of physician offices that are available to physicians whose primary practice is elsewhere. Physicians can practice here as little as four hours a week and only pay the incremental costs of providing the staffing necessary to support them. This has proved instrumental in attracting a number of part-time specialists.

Our financial projections call for annual physician recruiting expense of $500,000. Based on our experience, this should be sufficient to recruit 15 to 20 physicians in the six years prior to the new facility opening. At this level of recruitment we are confident that we will expand physician capacity within the Valley, mitigating one of the constraints we have faced historically to expanding our market share.

Philanthropy

We have included $15 million dollars in donations as a source of funds for the new facility. While we have not undertaken a formal feasibility study for a capital fund raising campaign, we have held numerous informal discussions over the past several years with individuals who have the capacity to make substantial ($1 million plus each). Based on those discussions, our recent success in significantly increasing operating donations from the same donor cohort and the substantial wealth of the Valley, we believe our $15 million target is extremely realistic.

Financial Projections

We have experienced a decline in inpatient volume during the first three months of fiscal 2007. It is impossible to know whether this represents erosion of market share, or simply a statistical variance consistent with our relatively small average volume. As our outpatient volume remains strong (net outpatient revenue is 1% ahead of budget through the same period), we are inclined to

view the inpatient decline as a statistical fluctuation. However, we are also preparing projections for considering the renewal of the District's parcel tax, and we believe it is only responsible to assume that there is a volume effect for the purposes of those projections. We also believe it is important that those projections associated with the option we present to the Sonoma Valley Healthcare Coalition. Accordingly, for both projections we have assumed that the decline in volume we have experienced during the first quarter of fiscal 2007 will persist throughout the entire year and that volume will remain somewhat depressed throughout the following five-year period that precedes the opening of the new facility. In fiscal 2013, when the new facility comes on line, we have assumed that our market share reverts to the historical levels we have experienced for the past several years. *We believe this is a very conservative assumption*.

Otherwise, we have used the demographic projections prepared by Mike Watt as the basis for our projections. Utilization rates were held constant, except that commercial outpatient utilization was increased at 3% per year throughout the projections, which is a lower rate of increase than we have experienced over the past five years.

We also held staff productivity constant, until the final year of the projection, when we expect the design of the new facility to allow the type of efficiencies discussed previously.

With regard to expenses, we have adjusted the model to take into account two significant changes that have taken place since the original model was developed, a substantial increase in wage rates for nurses and other clinical personnel, and the imposition of nurse staffing ratios. The projections prepared in April did not take adequately allow for these factors and as a result staffing costs were understated. We have now reconciled the model to both the actual fiscal 2006 results and the 2007 budget, so we have more confidence in these newer projections, which reflect higher operating costs than the prior forecast.

Here is a summary of the remaining assumptions:

General Inflation	2% per year
Wage Inflation	7% per year for clinical positions, 5% for others
Supply Inflation	Varies by component – Overall average roughly 7%
Commercial Insurance Rates	5% annual increases, from recently renegotiated base rates
Medicare Payment Rates	3% annual increases, from the reclassified base rates
Medi-Cal Payment Rates	Increases at half the inflation rate
Donations	$500,000 per year
Parcel Tax	$3 million through 2012, then sunsets

To enhance comparability across the projection period, we held depreciation constant. As this is a non-cash expense, the assumption used has no impact on our cash flow predictions. We are assuming that a general obligation bond will pass in fiscal 2007, so we are reimbursing operations in that year for the $1,750,000 incurred to plan the new facility. Since the community will be bearing the debt service associated with the general obligation bonds, that cash outflow is not included in the projections.

Please note that the amounts included for the parcel tax subsequent to fiscal 2007 are only management's assumptions at this point. The Board has not adopted the resolution necessary to put a renewal of this tax on the ballot, nor have they decided on the amount and duration of such a tax. However, based on discussions held at both the Board and Finance Committee, we believe it is appropriate to include these proceeds. The Sonoma Valley Healthcare Coalition's steering committee unanimously endorsed a renewal of the tax at its October 16 meeting and the prior tax passed with an 84% vote.

The results of the projections are shown in EXHIBT 3. In summary, they show a relatively stable cash position across the years, with slight improvements in operations and cash through FY 2012, primarily as the result of steadily increasing outpatient volume. The facility becomes operationally profitable in FY 2013, when the new facility opens, because market share increases to historical levels and the adjacencies of the new building allow for staff reductions. Cash flow is also assisted in that year because the hospital will be able to partially use its bond reserve funds to pay debt service.

EXHIBIT 1

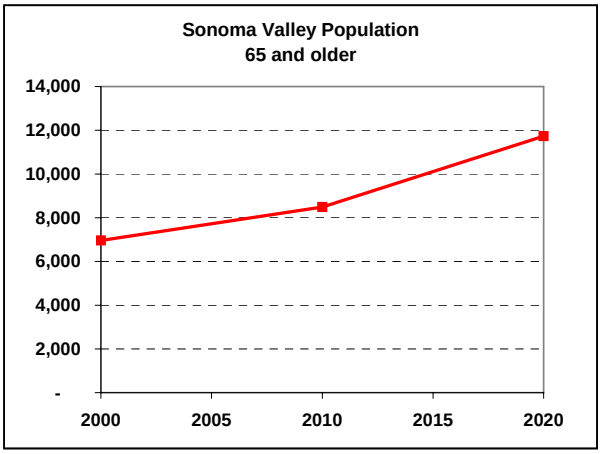
Market Analysis – from April 2006 Business plan

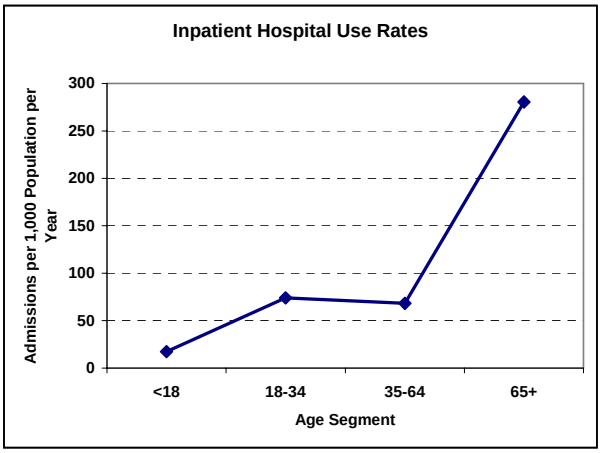
The hospital serves some 44,000 people in the Sonoma Valley. Historically, over 90% of our admissions have come from the Valley, and although there are no outpatient market data available, our internal information indicates that at least that proportion of our outpatient business also comes from the local population. Our inpatient market share through the early 1990's was fairly stable at nearly 60%. However, Kaiser then introduced a Medicare HMO product that it priced far more aggressively than the Health Plan of the Redwoods ('HPR') product with which we competed. (HPR's bankruptcy in 2002 aggravated the situation.) While Kaiser's penetration in the rest of the county exceeded its local success, it still took some 20% of the senior market locally. This, coupled with Kaiser's continued success in the commercial market, eroded our market share to its current 50%. Kaiser is the most significant competitor, with an overall market share of roughly 18%. No other hospital or system has more than 5 to 7% share.

Other than those who are insured through Kaiser, anyone residing in the Valley can use the hospital for elective procedures and everyone, including Kaiser members, utilizes our emergency services. While we do not provide 'tertiary' services such as invasive cardiology or organ transplant surgery, these are a small minority of total inpatient demand. Our analysis shows that we provide the services required by more than 90% of the people who are hospitalized in the Valley.

A shortage of local primary care physicians has also worked to constrain our market share. The federal government has recognized this situation by designating the Valley has an HPSA – Health Professional Shortage Area. Because hospitals can provide no service without a physician's order, our market can never be larger than the patient population served by our local physicians.

While we expect the local population to continue growing at the relatively slow rate of 1% per year, we are projecting a much greater increase in the demand for healthcare services. Our demographic projections were prepared by Mike Watt, who expects that more than half of the overall population increase will occur in the over 65 age cohort. As this segment of the population uses inpatient hospital services at a far higher rate than the younger cohorts, overall demand will increase accordingly. The graphs below illustrate these factors





As the baby boomers age, they will enter the cohort that begins to use inpatient hospital services at rates four and five times more frequently than the younger populations. As a result, we expect inpatient demand in 2020 to be 30% higher than current levels. Interestingly, we have already seen a similar impact on outpatient services as this cohort began to turn 50, when outpatient utilization rates start to increase sharply.

Our financial projections assume a constant market share at our current 50% rate. PacifiCare has entered the local Medicare HMO market and although there penetration in the first year has been relatively low, they have been successful in stemming the loss to Kaiser, at least within the Valley. Because our physician recruitment efforts have added primary care capacity, we expect to serve our aging population locally.

EXHIBIT 2

Cost Estimate for New Facility at Broadway Site

Building	"I Space"	"OSHPD III"	"Tilt-up"	Total
Square Feet	70,826	26,088	18,225	115,139
Cost Per Square Foot	575	500	235	
Base Construction Cost	40,724,950	13,044,000	4,282,875	58,051,825
Escalation – Year 1 (8%)				4,644,146
Escalation – Years 2-4 (6%)				11,285,275
Construction plus escalation				73,981,246
Design Costs				7,398,125
OSHPD Fee				1,294,672
EIR Costs				530,000
Site and Offsite Costs				5,600,000
Consulting and Legal				3,150,000
Move-in and Start-up Costs				370,000
Equipment, including escalation				24,257,267
Land Acquisition and rounding				14,018,690
Total Costs				130,600,000

EXHIBIT 3

Financial Projections

		2006-7	2007-8	2008-9	2009-10	2010-11	2011-12	2012-13
Fee for Service Revenue								
Acute Inpatient		15,032,950	16,102,408	16,945,523	17,825,541	18,766,567	19,758,094	21,049,733
Skilled Nursing		3,213,733	3,435,562	3,593,205	3,900,818	4,225,120	4,566,905	5,038,533
OP & Emergency		18,504,401	20,531,540	22,221,010	24,057,432	26,053,962	28,224,953	33,192,588
Home Health		1,789,374	1,926,106	2,020,556	2,119,709	2,223,802	2,333,082	2,510,190
Bad Debts		(1,279,215)	(1,423,283)	(1,543,316)	(1,683,659)	(1,836,025)	(2,001,461)	(2,363,865)
Community Benefit		(926,967)	(1,031,365)	(1,118,345)	(1,220,043)	(1,330,453)	(1,450,334)	(1,712,946)
		36,334,275	39,540,967	42,118,633	44,999,798	48,102,973	51,431,239	57,714,233
Risk Contract Revenue		1,155,054	1,233,692	1,283,896	1,336,144	1,390,517	1,447,104	1,544,608
Other Operating Revenue		148,569	151,541	154,571	157,663	160,816	164,032	167,313
Total Revenue		37,637,898	40,926,199	43,557,100	46,493,605	49,654,306	53,042,376	59,426,154
Expenses								
People Costs		27,212,239	29,146,304	31,145,953	33,333,031	35,909,634	38,652,473	40,569,962
Supplies		4,862,817	5,294,555	5,637,836	6,023,584	6,436,629	6,878,976	7,643,311
Purchased Services		4,177,439	4,204,465	4,361,158	4,451,856	4,544,475	4,639,055	4,125,131
Depreciation		1,131,000	1,131,000	1,131,000	1,131,000	1,131,000	1,131,001	1,131,002
Utilities		836,185	852,908	869,967	887,366	905,113	923,216	941,680
Insurance		415,981	440,603	458,209	477,831	498,360	519,841	563,279
Interest & Return to JV Investors		287,530	280,773	233,046	184,754	135,487	95,103	1,865,868
Other Costs		1,129,975	948,574	967,546	986,897	1,006,635	1,026,767	1,047,303
Total Expenses		40,053,165	42,299,183	44,804,714	47,476,318	50,567,332	53,866,433	57,887,535
Operating Margin		(2,415,267)	(1,372,984)	(1,247,614)	(982,714)	(913,026)	(824,057)	1,538,619
Non Operating Items								
Donations		500,000	500,000	500,000	500,000	500,000	500,000	500,000
Fundraising Expense		(211,280)	(219,344)	(227,811)	(236,702)	(246,037)	(255,839)	(266,131)
Physician Practice Support		(635,000)	(500,000)	(500,000)	(500,000)	(500,000)	(500,000)	(500,000)
Tax Assessment Revenue		2,018,000	3,000,000	3,000,000	3,000,000	3,000,000	3,000,000	-
Interest Income		125,219	135,063	171,045	181,126	202,279	237,410	290,960
		1,796,939	2,915,719	2,943,234	2,944,424	2,956,242	2,981,571	24,829
Surplus / (Deficit)		(618,328)	1,542,735	1,695,620	1,961,710	2,043,217	2,157,514	1,563,448
Cash Flow								
Operating Margin		(2,415,267)	(1,372,984)	(1,247,614)	(982,714)	(913,026)	(824,057)	1,538,619
Depreciation		1,131,000	1,131,000	1,131,000	1,131,000	1,131,000	1,131,001	1,131,002
Amoritization		21,080	19,815	18,626	17,509	16,458	15,471	14,543
Cash From Operations		(1,263,186)	(222,169)	(97,988)	165,795	234,433	322,415	2,684,164
Working Capital Changes (A/R only)		(134,356)	(421,702)	(338,981)	(378,893)	(408,089)	(437,690)	(826,257)
Non Operating Items		1,796,939	2,915,719	2,943,234	2,944,424	2,956,242	2,981,571	24,829
Estate booked in 06, received in 07		600,000						
Workers Comp Accrual Change		25,000		-	-	-	-	-
Liab ins to claims made		50,000	25,000	25,000				
Capital Expenditures								
Clinical		(500,000)	(500,000)	(500,000)	(500,000)	(500,000)	(500,000)	-
Info Systems		(250,000)	(250,000)	(250,000)	(250,000)	(250,000)	(250,000)	-
Facilities		(250,000)	(250,000)	(250,000)	(250,000)	(250,000)	(250,000)	-
Debt Princ Payments		(955,192)	(1,433,696)	(1,381,309)	(1,387,328)	(1,090,051)	(837,424)	(720,000)
Use of Bond Reserve Funds								432,359
New Facility Costs/Reimb		(250,000)	1,750,000					
Change in Cash		(1,130,795)	1,613,152	149,957	343,998	692,535	1,028,872	1,595,095
Beginning Cash		3,633,262	2,502,467	4,115,619	4,265,576	4,609,574	5,302,109	6,330,981
Ending Cash	#	2,502,467	4,115,619	4,265,576	4,609,574	5,302,109	6,330,981	7,926,076