***DRAFT***

# PENDENCY PLAN
## San Benito Health Care District d/b/a Hazel Hawkins Memorial Hospital

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The Pendency Plan was reviewed and adopted by the Board of Directors of the San Benito Health Care District at the meeting of May 22, 2023.

May 22, 2023

## SUMMARY

This report proposes to take a number of actions related to the budget for the San Benito Health Care District d/b/a Hazel Hawkins Memorial Hospital (the "District") and financial plan through calendar year 2024. If approved by the Board of Directors (the "Board") of the District, this report will serve as the District's "Pendency Plan" that will serve as the District's budget, and guide financial decision-making and policy for the District, during the pendency of a bankruptcy case filed under chapter 9 of title 11 of the United States Code (the "Bankruptcy Code").

The District is currently contemplating filing a bankruptcy case to restructure its obligations with the goal of providing continued health care services to the population it currently serves. The District's financial condition became acute in mid-2022 as a result of a series of unanticipated events, including, a significant Medicare overpayment claim and related extended repayment plan, a corresponding reduction in Medicare payments, an accrued tax liability, private payor payment delays, inflationary pressures, and COVID-related operating losses. These unanticipated events eroded the District's working capital, which, for systemic reasons, has historically been lower than the average for California critical access hospitals. On November 4, 2022, the District declared a fiscal emergency and has since engaged in a series of initiatives to replenish depleted working capital. However, the District's short-term initiatives cannot resolve the long-term liabilities that render the District unable to generate sufficient positive cash-flow to maintain its current operations indefinitely.

The District has engaged with its principal creditors in a confidential neutral evaluation process provided for under California law and in nonconfidential negotiations that preceded and followed the neutral evaluation process. Although the District made material headway with certain constituencies, the District has been unable to reach a comprehensive agreement to address labor costs, which is the District's most significant expense. The District's bankruptcy filing is intended to address the labor costs, among other things, and the Pendency Plan is intended to provide the framework for stabilizing operations assuming those changes.

## I.

## DISCUSSION

The Pendency Plan represents the spending levels the District must maintain to remain solvent for a sufficient period to effectuate either a partnership with a larger health care system or an independent operational restructuring for long-term solvency.

### A. The District's Current Cash Forecast

The District is insolvent without material changes to its budget. The District's current cash forecast is attached hereto as **Attachment A**. The District currently holds approximately $9.2 million of cash-on-hand, which the District's current cash forecast indicates will erode to approximately $5.4 million by December 31, 2023. The District incurs operating costs per day exceeding $410,000. As such, the District currently holds approximately 23 days of cash-on-hand to cover operating costs, which will reduce to approximately 13 days by December 2023. These amounts of cash-on-hand are substantially below the 222.48 median days cash-on-hand for all California critical access hospitals[1] and lower than the District's average days cash-on-hand for the last four fiscal years as reported in the District's publicly available audited financial statements:

| Date | Days Cash on Hand |
|---|---|
| 6/30/2019 | 45.84 |
| 6/30/2020 | 65.06 |
| 6/30/2021 | 49.12 |
| 6/30/2022 | 37.07 |

The limited cash on hand projected is critical and risks the District's ability to maintain operations. Additionally, the District operates critical health care services, including two skilled nursing facilities, that do not permit the District to continue current operations until the District reaches a zero cash balance. The District must retain sufficient working capital to fund the cost of safely transitioning patient care should the District be required to reduce services.

In light of the District's current cash forecast, the District is unable to generate sufficient revenues to offset expenses and does not possess sufficient working capital to absorb further losses from operations beyond the projected period.

### B. The District's Short-Term Stabilization Efforts

On November 4, 2022, the District adopted a fiscal emergency declaration as a result of unanticipated events in mid-2022 that depleted the District's available cash-on hand and prompted a cash-flow crisis. Specifically, beginning in the third quarter of 2022, the District incurred approximately $5 million of unanticipated expenses as a result of the following:

[1] *See* CAH Financial Indicators Report: Summary of Indicator Medians by State dated May 2022.

- **Medicare Overpayment Claim.** On June 30, 2022, Noridian Healthcare Solutions provided the District with a notice that, according to Noridian's calculations, the District was overpaid on Medicare reimbursements during the fiscal year ended June 30, 2022 in the amount of approximately $5.2 million. The District entered into an extended repayment plan, which required the District to remit payments in the amount of $441,036.22 per month through July 8, 2023. Noridian stated that failure to make these payments would result in "100% withholding" of Medicare payments until the overpayment amount is paid in full and was unwilling to negotiate a repayment plan over a longer period at reduced monthly amounts.

- **Reduction in Medicare Payments.** The District was further informed that future payments for the fiscal year ended June 30, 2023 would be reduced by approximately $5.2 million according to new rates that reduced previous reimbursement rates by 20% for inpatient services and 13% for outpatient services.

- **Private Payor Payment Delays.** On August 10, 2022, the District's managed care provider agreement ended with Anthem. From August 2022 through December 2022, Anthem delayed payments for both commercial and Medi-Cal insured patients. Over $4 million in claims were delayed due to these contractual and processing issues. The effects of delayed and lower reimbursement during the approximately five-month period in which the District and Anthem were "out of contract" eroded the District's cash reserves.

- **Inflationary Pressures.** The recent and well-documented inflationary pressures affecting the national and global economies has further increased the cost of operating the District, which has not been offset by revenue.

- **COVID-Related Operating Losses.** As set forth in the District's 2021 Audited Financial Statements, the District experienced a net operating loss of approximately $9.5 million during the 2020 fiscal year, which was due mainly to the impact of COVID-19. The District's operating losses continued in fiscal year 2021, and, although improved, totaled approximately $3.6 million during that year. Collectively, these significant COVID-related operating losses in previous years were exacerbated by the above, recent events that have continued to negatively impact cash flow.

As discussed above, the District historically holds working capital substantially below that of the median days cash-on-hand held by all California critical access hospitals. As such, based on its then-current cash forecast, the District adopted a fiscal emergency declaration after concluding that the District would not be able to pay its obligations within the next 60 days. The District's December 2022 cash forecast is set forth in **Table 1** below:

**Table 1 - Initial Cash Forecast - December 2022 through February 2023**

| Description | Forecast December 2022 | Forecast January 2023 | Forecast February 2023 | Forecast 12/3/2022 - 02/25/23 |
|---|---|---|---|---|
| Beginning cash balance | $ 4,037,354 | $ 2,560,249 | $ (744,729) | $ 4,037,354 |
| Operations | | | | |
| Net cash flow | (1,393,106) | (3,054,977) | (5,003,995) | (9,452,078) |
| Supplemental cash excluded from initial forecast | | | | |
| HQAF Direct Grant | - | - | - | - |
| Cost report settlement | - | - | - | - |
| Other | - | - | - | - |
| Payment of deferred payroll taxes | (1,144,000) | - | - | (1,144,000) |
| | (2,537,106) | (3,054,977) | (5,003,995) | (10,596,078) |
| Financing | | | | |
| Advances | | | | |
| Property tax advance | 1,335,000 | - | - | 1,335,000 |
| Outpatient supplemental | - | - | - | - |
| CHFFA loan (net of repayments) | - | - | - | - |
| | 1,335,000 | - | - | 1,335,000 |
| Restructuring expense | (150,000) | (150,000) | (150,000) | (450,000) |
| Capital expenditures | (125,000) | (100,000) | (100,000) | (325,000) |
| **Ending cash balance** | **$ 2,560,249** | **$ (744,729)** | **$ (5,998,724)** | **$ (5,998,724)** |

The District's initial objective was to implement a series of initiatives to resolve its immediate cash-flow crisis and preserve operations long enough to pursue a long-term restructuring. The District undertook the following initiatives to achieve its short-term stabilization objective:

## Financing Initiatives

- **Property Tax Advance.** In December 2022, the District obtained an approximately $1 million advance transfer of the District's property tax receipts collected by the County of San Benito, California, which was an advance payment of funds scheduled to be received in April 2023.

- **CHFFA Loan.** In December 2022, the District negotiated and obtained approval of a $3 million loan from the California Health Facilities Financing Authority. The proceeds of this loan were received in January 2023.

## Operational Initiatives

- **Operational Savings.** Implemented staffing reductions, reduced reliance on registry and third party staffing agencies, deferred wage increases, implemented a hiring freeze, and aggressively pursued other operational initiatives.

- **Cash Management.** Implemented strong controls on spending and cash management, resulting in increased net cash flow from operations. From December 2022 through February 2023, the District's efforts resulted in over $1.9 million in improved cash flow in just 3 months (see **Table 3**).

- **Surplus Property.** Listed for sale a surplus property with an estimated market value of $1.6 million.

- **Anthem Provider Agreement.** In January 2023, the District and Anthem (the District's largest non-governmental payor) entered into a new provider agreement which is expected to generate $2 million in annual cash flow in 2023.

- **Reduced Medicare Recoupment.** In December 2022, the District and Noridian entered into an extended repayment payment plan, thereby reducing monthly recoupment payments from $440,000 to approximately $60,000.

- **CARES Act Deferral.** As expenses increased during the COVID-19 pandemic, Congress authorized the CARES Act that included provisions that permitted the District to defer payment of the employer's portion of its payroll tax liabilities. The District paid half of the deferred employer payroll taxes in December 2021 and was required to pay the second half of the deferred employer payroll taxes ($1.1 million) in December 2022 in addition to its regular tax payments. The District deferred the December 2022 payment.

- **Home Health Closure.** In January 2023, the District closed the home health department to eliminate operating losses associated with the department.

The District's financing initiatives and cash management policies materially improved the District's cash on hand. As set forth below in **Table 2**, the District's actual performance reflects material improvements over the projections in **Table 1**. By way of example, the District's cash position as of February 25, 2023 improved from the projected deficit of $6.0 million (**Table 1**) to actual cash on hand of approximately $5.1 million (**Table 2**).

[*Continued on next page.*]

**Table 2 - Actual - December 2022 through February 2023**

| Description | Actual December 2022 | Actual January 2023 | Actual February 2023 | Forecast |
|---|---|---|---|---|
| Beginning cash balance | $ 3,353,180 | $ 5,724,320 | $ 5,066,342 | $ 3,353,180 |
| Operations | | | | |
| Net cash flow | 591,506 | (3,447,625) | (4,688,371) | (7,544,490) |
| Supplemental cash excluded from initial forecast | | | | |
| HQAF Direct Grant | - | - | 979,971 | 979,971 |
| Cost report settlement | - | - | 988,669 | 988,669 |
| Other | (150,000) | - | 12,531 | (137,469) |
| Payment of deferred payroll taxes | - | - | - | - |
| | 441,506 | (3,447,625) | (2,707,200) | (5,713,319) |
| Financing | | | | |
| Advances | | | | |
| Property tax advance | 2,272,418 | - | - | 2,272,418 |
| Outpatient supplemental | - | - | 3,029,540 | 3,029,540 |
| CHFFA loan (net of repayments) | - | 3,059,185 | - | 3,059,185 |
| | 2,272,418 | 3,059,185 | 3,029,540 | 8,361,143 |
| Restructuring expense | (264,660) | (148,670) | (217,500) | (630,830) |
| Capital expenditures | (78,124) | (120,868) | (12,002) | (210,994) |
| **Ending cash balance** | **$ 5,724,320** | **$ 5,066,342** | **$ 5,159,180** | **$ 5,159,180** |

As discussed above and as reflected in **Attachment A**, the short-term stabilization initiatives have successfully extended the date by which the District will run out of cash. However, the District's initiatives were only intended to stabilize the District's financial condition in the short-term to provide sufficient time for the District to implement a long-term stabilization plan.

## C. The District's Long-Term Stabilization Options

The District has limited available options to stabilize its operations and continue providing health care services for the community into the future. The District has explored a series of alternative approaches and identified those that are both implausible, given the District's finances, and those that are potential viable avenues for long-term stabilization.

### 1. Principal Long-Term Strategies Deemed Not Viable to Effect a Long-Term Restructuring

***Capital Improvements to Maintain Independent Operations.*** In 2020 and 2021, the District engaged ADAMS Management Services Corporation ("ADAMS") to prepare a study (the "ADAMS Study") of potential options for the District to continue providing its current level of health care services to the community. The ADAMS Study is attached hereto as **Attachment B**. In short, the ADAMS Study concluded that the District needed to expand services to meet anticipated growing demand in the community and to increase market share to 70% for local inpatient services. Collectively, keeping pace with demand and expanding market share was projected to stabilize net operating income for the long term.

The ADAMS Study presented three alternative scenarios by which the District could achieve target growth sufficient to remain independent—each of which required the District to expand its facilities to accommodate increased service line expansions:

- **Scenario 1:** The first scenario contemplated renovating and expanding the District's current facilities to address seismic issues and accommodate the Americans with Disabilities Act, departmental adjacencies, and other issues. The scenario contemplating expanding the hospital's capacity to approximately 60 beds. Another drawback was that renovating the hospital would not replace its original infrastructure and would have an approximately 15-year life. The projected project cost was approximately ***$213 million***, excluding the loss of revenue during renovations.

- **Scenario 2:** The second scenario contemplated replacing acute services located in non-seismic compliant buildings and expanding hospital capacity to approximately 60 to 70 beds. The drawbacks were the expected extreme disruptions to ongoing operations and the 25 to 30 year life of infrastructure. The projected cost was approximately ***$267 million***, excluding the loss of revenue during renovations.

- **Scenario 3:** The third scenario contemplated entirely replacing the District's acute care infrastructure and leveraging the existing campus to become an ambulatory, sub-acute care, and administrative site for the District. The projected project life would be 40 to 70 years given the replacement of existing infrastructure. The total project cost was projected at ***$245 million***, excluding the loss of revenue during construction.

The District adopted Scenario 3 as a component of its Strategic Plan. Although the District implemented some other recommendations from the ADAMS Study, including recruitment of certain specialties, the District did not take material steps toward initiating the capital improvement project.

The District identified two material obstacles to implementing the ADAMS Study recommendations. ***First***, each option required expansion of the hospital's beds, which would require redesignation of the hospital from its current designation as Critical Access Hospital (limited to 25 beds) to a traditional acute care hospital. This new designation was likely to result in recoupment liability for the increased reimbursement the District realized from its Critical Access Hospital designation. ***Second***, as discussed above, the District does not hold sufficient working capital and does not generate sufficient net operating income to fund the capital improvement projects that would keep the District operating profitably and independently while maintaining the same or greater services the District provides today. Accordingly, the District concluded that it was unable to implement the capital improvements outlined in the ADAMS Study.

***Continued Cash Management.*** The District analyzed whether its short-term cash management initiatives that effected its successful short-term stabilization efforts would be sufficient to stabilize the District in the long-term. The District concluded that a variety of factors

render its short-term cash management initiatives inadequate to resolve the District's long-term finances, including as follows:

- **Projected Shortfalls.** The District's cash management initiatives have resulted in approximately $4 million in savings from operations annually. However, as set forth in the forecast in **Attachment A**, the District anticipates a cash flow shortfall (including capital expenditures but excluding restructuring expenditures) exceeding $600,000 through December 2023. Moreover, the cash flow shortfall is expected to increase to $6.1 million in calendar year 2024. The 2024 projected cash flow shortfalls would result in critically low cash by August 2024 and a zero cash balance by November 2024.

- **Advance Payments.** The District stabilized short-term operations in Fiscal Year 2022-2023 through, among other things, obtaining advance payments from a variety of governmental and private sources. However, the advance payments necessarily reduce expected revenue for the periods during which the District originally expected to realize the now-advanced payments.

- **Labor Cost.** The majority of the District's workforce is represented by four unions under collective bargaining agreements or memoranda of understanding. These documents specify, among other things, the wages and benefits that must be provided to represented employees. The union agreements also establish a baseline for certain wages and benefits for non-represented employees.

  The District identified three reasons that modifications to the benefits is the area of labor costs that represent the most likely source of savings without materially altering the competitiveness of the District's wage and benefits offerings. ***First***, the District's labor costs represent the vast majority of the District's annual expenses—labor constituted 67.7% of the District's net patient service revenue for fiscal year ended June 30, 2022 and exceeded 70% for the previous two fiscal years. As such, labor costs represent the most significant source of potential savings for the District. ***Second***, the District's benefits offerings have long been identified as inconsistent with market benefits. By way of example, the ADAMS Study indicated that the District's benefits load as of 2020 (e.g., 55.9% of salaries and wages) was well in excess of the benefits load at comparable non-system facilities (e.g., 39.3% of salaries and wages) and within a broader comparison group (e.g., 36.9% of salaries and wages). *See* **Attachment B**. ***Third***, given the District's materially below-average working capital, the cash burn rate associated with the District's operations are not sustainable without modifications to labor costs.

  The District has engaged all four of its unions in negotiations and discussions, but they have not resulted in material progress toward a resolution that would reduce labor expenses. Accordingly, the District is unable to realign its most significant expense.

As such, the District's management has concluded that its short-term cash management initiatives, alone, are insufficient to restructure the District's liabilities for continued long-term operations.

### 2. Principal Potentially Viable Long-Term Restructuring Strategies

***Transaction with Larger Health Care System.*** The District concluded that a transaction with a larger health care system is an optimal long-term stabilization strategy after analyzing the District's strategic objectives, its current assets and strategic challenges, and past outcomes from California hospital district bankruptcies. ***First***, the District concluded its principal objective was the continuation, or expansion, of the health care services that the District currently provides to the community. The District is acutely aware that it is the sole provider of certain critical health care services in San Benito County, California. The District's mission statement requires that the District consider a transaction that "ensure[s] the healthcare needs of the community are fulfilled." Accordingly, the District concluded that its strategic objectives will be best served by identifying a strategic partner that can preserve health care services that the District no longer is financially able to provide independently.

***Second***, the District concluded that its current assets and strategic challenges are best suited to a transaction with another health system. The District operates the only hospital and is the sole health care provider across a number of critical service lines in San Benito County. However, as addressed in the ADAMS Study, the District has lacked sufficient working capital to expand its service offerings to capture sufficient market share in the community to continue independent operations. The District believes that a larger health care system will have greater access to capital and benefit from economies of scale that the District cannot achieve independently. Accordingly, the District concluded that a larger health system will be equipped to capture greater market share and absorb market rate labor costs more effectively than the District can in its current composition.

***Third***, the District's survey of California health care district bankruptcy outcomes over the last 30 years confirms that a transaction is the best outcome to preserve health care in the community. Between 1991 and 2020, 20 California hospital districts filed bankruptcy cases.[2] In 50% of these cases, the district was able to continue providing the same or reduced health care services after a partnership or sale. In 25% of cases, the district was able to continue operations at its acute care hospital independently. In the other 25% of cases, the district closed completely and provided either limited or no community services (e.g., ambulance services or community grants). Accordingly, the District concluded that a transaction had the highest likelihood of success for preserving health care services for the District.

***Independent Operations with Reduced Services.*** The District concluded that it is unable to continue operating independently and offering the same level of services to the community based on, among other things, the District's longstanding inability to generate sufficient working capital to implement a long-term strategic plan or even maintain sufficient cash on hand to address short-term cash flow challenges. However, the District is undertaking a thorough analysis of potential alternatives in the event the District is unable to complete a

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[2] *See* Mary H. Rose & Rebecca J. Winthrop, *So Many Troubled California Health Care Districts, So Many Have Filed Chapter 9—Lessons to be Learned*, 35 Cal. Bankr. J. 189, 193-198 (2020).

transaction with a larger health system. As set forth below, although not as optimal as a transaction, the District concluded that it will be able to continue operations with reduced services to the community.

## II.

## THE PENDENCY PLAN

The District's Pendency Plan is intended to permit sufficient time for the District to effectuate its optimal long-term reorganization strategy—a transaction—while providing for sufficient time to effectuate its alternative of independent operations with reduced services if a transaction does not materialize. In both cases, the District will continue implementation of its successful, short-term reorganizational initiatives. Accordingly, the Pendency Plan is best addressed in the three sub-sections set forth below.

### A. Phase 1: Continued Implementation and Expansion of Stabilization Initiatives

The District will continue its short-term stabilization initiatives and formalize the initiatives as ordinary-course cash management strategies where appropriate. In addition, the District anticipates that the following initiatives will result in necessary enhancements to cash flow—improving cash flow over projections by at least $2.3 million through December 31, 2023—to effect the District's long-term stabilization objectives:

#### Financing Initiatives

- **Property Tax Advance.** The District has notified the Board of Supervisors of the County of San Benito, California that it will request the 85% advance of property taxes collected in the upcoming fiscal year, pursuant to Section 6 of Article XVI of the California Constitution. The District anticipates the advance payment will result in the District obtaining $2.3 million in July 2023, which would normally be realized by the District in April 2024.

- **State Legislative Funding Proposal.** The District is collaborating with state leaders and providing input on potential legislation intended to address the financial challenges faced by similar health systems throughout California. The District has most recently provided input on Assembly Bill 112, which is intended to provide a source of funding to financially distressed hospitals. As of this Pendency Plan, the California state legislature passed AB 112, which was signed by the Governor on May 15, 2023. However, the District understands that there is still a substantial amount of work to implement the program. The timing of the availability of funding will be a crucial element. The District is hopeful that the continued efforts of the District's state representatives will result in a funding source capable of bridging any near-term cash needs at a lower cost than can be obtained commercially.

- **Commercial Bridge Financing.** On April 27, 2023, the District's Board of Directors approved Resolution No. 2022-26. The Resolution authorized the District's Interim Chief Executive Officer, or a designee, to enter into a line of credit with a commercial lender on behalf of the District in an amount not to exceed $10 million. If executed and drawn, a line of credit will permit the District to bridge potential cash shortfalls given the District's limited access to working capital. The District anticipates that it would only draw on such line of credit if, and to the extent, no other more affordable options exist to preserve operations. The District is in negotiations with potential lenders and understands that they are capable of providing debtor-in-possession financing in a bankruptcy case.

## Operational Initiatives

- **Continued Operational and Cash Management Initiatives.** The District will continue to implement its operational and cash management initiatives set forth above.

- **Benefits Realignment.** As set forth above, the District's most significant expense is associated with labor costs, which the District intends to modify in a bankruptcy case to resolve its continued negative cash flow position.

  Absent agreement from the unions, the District intends to modify and/or reject the union collective bargaining agreements and memoranda of understanding in a bankruptcy case, as authorized by 11 U.S.C. § 365. ***If these agreements are rejected, the District anticipates maintaining wages at a similar or identical level as it currently provides to employees.*** Instead, the District anticipates making the following adjustments to benefits for all employees: (i) transitioning from the District's self-insured model of providing employee health care insurance benefits by increasing premiums to market levels while the District negotiates a CalPERS or commercial health care insurance policy; (ii) terminating the defined benefit plan on a going-forward basis, continuing to fund accrued liabilities under the defined benefit plan to satisfy all current obligations, and transitioning to a 401(k) or similar retirement plan; (iii) combining all leave benefits into a single paid leave category and capping annual leave benefit accrual at 30 days while leaving unchanged all current, accrued leave; (iv) modifying standby compensation; and (v) modifying education benefits. A summary outlining the proposed modifications in greater detail is attached hereto as **Attachment C**.

  If the above modifications are implemented by July 1, 2023, the District anticipates improving its cash flow from a net negative $600,000 to a net positive $1.9 million through the end of calendar year 2023. The District also anticipates that the modifications would permit the District to operate at a net negative cash flow of only $1.5 million in calendar year 2024 as compared to the current projected negative net cash flow of $6.1 million.

- **Revenue Cycle and Billing Enhancements.** The District regularly engages revenue cycle audit companies and has implemented an analysis of its billing practices to enhance revenue capture. These processes are ongoing and the District is not able to determine the amount by which these initiatives will enhance revenue.

Based on the anticipated modifications set forth above, the District has developed a cash-flow projection attached hereto as **Attachment D**. These modifications constitute the District's Phase 1 Pendency Plan. Assuming the Phase 1 Pendency Plan is fully implemented by July 1, 2023, the District anticipates that it can extend operations without material reduction in services through July 2024. Accordingly, the District will be required to pursue one of two alternatives to complete its long-term stabilization objectives.

## B. Phase 2: Pursuit of Transaction with Larger Health System

As set forth above, the District's optimal outcome is a transaction with a larger health system. The District has solicited interest in a potential transaction to a broad array of potential partners; however, as of the date of this Pendency Plan, the District has not entered into definitive documentation with a potential partner. As such, the Pendency Plan is intended to preserve the District's operations in their current form—with no service reductions—for a commercially reasonable period necessary to market the District for a transaction.

Although the operational initiatives in the Phase 1 Pendency Plan permit the District to operate through July 2024 with sufficient working capital, the District cannot independently continue its current operations and service lines indefinitely. Importantly, the Phase 1 Pendency Plan still reflects a negative $1.5 million net cash flow in calendar year 2024. Accordingly, the District has considered the following factors to determine the date by which the District must identify a transaction partner or transition to an independent reorganization strategy:

- **Safe Transfer of Patient Care.** In the event the District reduces services, the District's paramount concern will be the safe and orderly transition of patient care. The transition of patient care will require the District to provide adequate notice to its patients to identify new providers. Depending on the service line, the District anticipates this process may take months and will require the District to make a decision on any service line reduction with sufficient cash on hand to effectuate a patient care transition.

- **Election Requirements.** Certain transaction formats will require the affirmative vote of the District's citizens. In those cases, the District would be required to pass a resolution calling the vote. The District anticipates that such resolution would not be passed unless and until the District has entered into a definitive agreement with a transaction partner. The County of San Benito, California has informed the District of two principal options to effectuate an election with varied timing and costs:

    - **March 2024 Primary Election.** The District may hold a required vote, if any, during the March 5, 2024 primary election. The District would need

to pass a resolution authorizing the vote not later than December 8, 2023. The current estimated cost to the District is between approximately $30,000 and $60,000.

- **Special Election.** The County of San Benito, California informed the District that it may hold a vote by calling a special election at any time, pursuant to California Elections Code § 9342. Under this procedure, the District's Board of Directors would need to pass a resolution calling a vote not later than 88 days prior to the anticipated election date, pursuant to California Elections Code §§ 1405 (b) or 1410. The current estimated cost to the District is between approximately $500,000 and $625,000 for an election center vote and between approximately $400,000 and $425,000 for a mail-in vote.

- **Cash Flow Realization.** In the event the District reduces its service offerings, the District anticipates a lag in realizing the cash flow benefits of the restructuring. Accordingly, a service reduction must be timed with sufficient cash on hand to absorb the lag in the District's realization of the net cash flow benefits.

- **Employee Matters.** Depending on the circumstances, the District may be required to provide certain notice to employees concerning the termination or modification of a service line.

Based on the foregoing, the District currently anticipates that it may continue efforts to identify a transaction partner and enter into definitive transaction documents through approximately October 2023. This will provide a sufficient marketing period for the District and sufficient runway to reduce service lines, if necessary, to compensate for the ongoing projected cash flow shortfalls.

## C. Optional Phase 3: Implementation of Service Reduction Absent a Transaction

The District will be required to implement an independent operational restructuring if it is unable to identify a transaction partner. As set forth above, the District's projected cash-flow following implementation of the Phase 1 Pendency Plan will still result in negative $1.5 million net cash flow in calendar year 2024. Even though the Phase 1 Pendency Plan substantially limits losses from operations, a long-term restructuring will require the District to bolster its working capital and operate at consistently positive net cash flow.

The District is undertaking an analysis of its service lines based on their cost and community need. This analysis also includes consideration of the interconnected nature of service lines within the District—e.g., certain service lines require others to continue operations—and state law requirements that obligate the District to provide certain complementary service lines or minimum staffing levels. Following consideration of these and other factors, the District will establish a service line reduction plan that permits the District to generate positive net cash flow following implementation. Importantly, the District will only be required to address an annual cash flow shortfall of approximately $1.5 million as a result of the cash flow enhancements in the Phase 1

Pendency Plan. The District is confident that it will be capable of bridging this cash flow shortfall with relatively limited service line reductions, coupled with enhanced operational efficiencies.

## III.

## RESERVATION OF RIGHTS AND LIMITATIONS

This Pendency Plan is intended to set forth the guiding principles that will inform financial decision-making during the pendency of a bankruptcy case. Nothing contained in this Pendency Plan constitutes a final determination by the Board of Directors for any decision for which a vote is otherwise required.

The cash flow forecasts and related projections contained in this Pendency Plan are necessarily forward-looking and include certain material assumptions that may be affected by future or unanticipated events. As such, the District reserves the right to modify, supplement, adjust, or otherwise change the cash forecasts at any time. The District's management is permitted to make nonmaterial modifications to the cash forecasts and implement, omit, or adjust the initiatives seth forth in this Pendency Plan as a result. By contrast, any material modification to the initiatives set forth in this Pendency Plan must be adopted by a further resolution of the Board of Directors of the District.

Nothing contained in this Pendency Plan should be considered an admission of liability, a waiver of claims, defenses, or any other right of the District, or an election of remedies of the District. Moreover, the District reserves all rights to modify, supplement, amend, or otherwise change this Pendency Plan. Importantly, the District may modify the proposals set forth in Phase 1, Phase 2, or Optional Phase 3 of this Pendency Plan and nothing contained herein constitutes a commitment that any of the actions set forth in the Pendency Plan will or will not be implemented or a limitation of potential restructuring alternatives that the District may implement.

## IV.

## CONCLUSION

Based on the current cash forecast attached as **Attachment A**, the District is insolvent and will have critical levels of cash on hand by August 2024. The modifications proposed in this Pendency Plan are intended to place the District in a position of fiscal solvency so that it may fulfill its mission, to the extent possible, to "ensure the healthcare needs of the community are fulfilled." The District intends to seek bankruptcy protection and continue its good faith creditor negotiations to fulfill this mission and continue the delivery of essential, high quality patient care to the community.

## List of Attachments

| | |
|---|---|
| **Attachment A** | Current Cash Forecast |
| **Attachment B** | ADAMS Study |
| **Attachment C** | Summary of Proposed Benefit Modifications |
| **Attachment D** | Phase 1 Pendency Plan Cash Forecast |

**Attachment A**
**Current Cash Forecast**

## San Benito Health Care District

### Financial Forecast

**2023 - Current Cash Forecast**

| Description | Actual January | Actual February | Actual March | Forecast April | Forecast May | Forecast June | Forecast July | Forecast August | Forecast September | Forecast October | Forecast November | Forecast December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Recurring Revenue | $ 8,485,482 | $ 8,818,794 | $ 10,498,166 | $ 11,908,253 | $ 9,300,000 | $ 9,300,000 | $ 12,676,000 | $ 9,110,000 | $ 10,709,000 | $ 9,095,000 | $ 9,105,000 | $ 11,756,000 | $ 120,761,694 |
| Net Supplemental Revenue | 118,152 | 3,606,972 | 6,287,151 | 104,486 | - | 4,452,036 | 2,467,865 | (1,138,622) | - | 2,433,531 | - | - | 18,331,571 |
| **Total Cash Receipts** | **8,603,634** | **12,425,766** | **16,785,317** | **12,012,739** | **9,300,000** | **13,752,036** | **15,143,865** | **7,971,378** | **10,709,000** | **11,528,531** | **9,105,000** | **11,756,000** | **139,093,266** |
| Operating Cash Disbursements | 12,051,259 | 12,073,426 | 10,895,228 | 12,758,287 | 10,720,445 | 10,790,005 | 12,651,930 | 10,394,772 | 12,682,772 | 10,368,772 | 10,389,772 | 11,992,772 | 137,769,439 |
| **Operating Cash Flow** | **(3,447,625)** | **352,340** | **5,890,089** | **(745,549)** | **(1,420,445)** | **2,962,031** | **2,491,935** | **(2,423,393)** | **(1,973,772)** | **1,159,759** | **(1,284,772)** | **(236,772)** | **1,323,826** |
| Restructuring Expenses | 148,670 | 217,500 | 346,008 | 50,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 2,762,178 |
| Other Non-Operating Expenses | 120,868 | 12,002 | 91,156 | 19,762 | 150,000 | 200,000 | 250,000 | 200,000 | 250,000 | 200,000 | 200,000 | 250,000 | 1,943,788 |
| Loans | 3,059,185 | - | - | - | - | - | - | - | - | - | - | - | 3,059,185 |
| **Net Cash Flow** | **$ (657,978)** | **$ 122,838** | **$ 5,452,925** | **$ (815,311)** | **$ (1,820,445)** | **$ 2,512,031** | **$ 1,991,935** | **$ (2,873,393)** | **$ (2,473,772)** | **$ 709,759** | **$ (1,734,772)** | **$ (736,772)** | **$ (322,955)** |
| *% of Revenue* | *-8%* | *1%* | *32%* | *-7%* | *-20%* | *18%* | *13%* | *-36%* | *-23%* | *6%* | *-19%* | *-6%* | *0%* |
| **Beginning Cash Balance** | **$ 5,724,320** | **$ 5,066,342** | **$ 5,189,180** | **$ 10,642,105** | **$ 9,826,794** | **$ 8,006,349** | **$ 10,518,380** | **$ 12,510,315** | **$ 9,636,921** | **$ 7,163,150** | **$ 7,872,909** | **$ 6,138,137** | **$ 5,724,320** |
| Net Cash Flow | (657,978) | 122,838 | 5,452,925 | (815,311) | (1,820,445) | 2,512,031 | 1,991,935 | (2,873,393) | (2,473,772) | 709,759 | (1,734,772) | (736,772) | (322,955) |
| Bridge Loan | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **Ending Cash Balance** | **$ 5,066,342** | **$ 5,189,180** | **$ 10,642,105** | **$ 9,826,794** | **$ 8,006,349** | **$ 10,518,380** | **$ 12,510,315** | **$ 9,636,921** | **$ 7,163,150** | **$ 7,872,909** | **$ 6,138,137** | **$ 5,401,365** | **$ 5,401,365** |

## San Benito Health Care District

### Financial Forecast

**2024 - Current Cash Forecast**

| Description | Forecast January | Forecast February | Forecast March | Forecast April | Forecast May | Forecast June | Forecast July | Forecast August | Forecast September | Forecast October | Forecast November | Forecast December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Recurring Revenue | $ 8,500,000 | $ 8,800,000 | $ 10,500,000 | $ 11,900,000 | $ 9,300,000 | $ 9,300,000 | $ 12,700,000 | $ 9,100,000 | $ 10,700,000 | $ 9,100,000 | $ 9,100,000 | $ 11,800,000 | $ 120,800,000 |
| Net Supplemental Revenue | 100,000 | 2,600,000 | 6,300,000 | 100,000 | - | 1,600,000 | 2,500,000 | (1,100,000) | - | 2,400,000 | - | - | 14,500,000 |
| **Total Cash Receipts** | **8,600,000** | **11,400,000** | **16,800,000** | **12,000,000** | **9,300,000** | **10,900,000** | **15,200,000** | **8,000,000** | **10,700,000** | **11,500,000** | **9,100,000** | **11,800,000** | **135,300,000** |
| Operating Cash Disbursements | 11,200,000 | 11,200,000 | 13,480,000 | 11,200,000 | 11,200,000 | 11,200,000 | 11,200,000 | 13,480,000 | 11,200,000 | 11,200,000 | 11,200,000 | 11,200,000 | 138,960,000 |
| **Operating Cash Flow** | **(2,600,000)** | **200,000** | **3,320,000** | **800,000** | **(1,900,000)** | **(300,000)** | **4,000,000** | **(5,480,000)** | **(500,000)** | **300,000** | **(2,100,000)** | **600,000** | **(3,660,000)** |
| Restructuring Expenses | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | - | - | - | - | - | - | - | 1,250,000 |
| Other Non-Operating Expenses | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 1,200,000 |
| Loans | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **Net Cash Flow** | **$ (2,950,000)** | **$ (150,000)** | **$ 2,970,000** | **$ 450,000** | **$ (2,250,000)** | **$ (400,000)** | **$ 3,900,000** | **$ (5,580,000)** | **$ (600,000)** | **$ 200,000** | **$ (2,200,000)** | **$ 500,000** | **$ (6,110,000)** |
| *% of Revenue* | *-34%* | *-1%* | *18%* | *4%* | *-24%* | *-4%* | *26%* | *-70%* | *-6%* | *2%* | *-24%* | *4%* | *-5%* |
| **Beginning Cash Balance** | **$ 5,401,365** | **$ 2,451,365** | **$ 2,301,365** | **$ 5,271,365** | **$ 5,721,365** | **$ 3,471,365** | **$ 3,071,365** | **$ 6,971,365** | **$ 1,391,365** | **$ 791,365** | **$ 991,365** | **$ (1,208,635)** | **$ 5,401,365** |
| Net Cash Flow | (2,950,000) | (150,000) | 2,970,000 | 450,000 | (2,250,000) | (400,000) | 3,900,000 | (5,580,000) | (600,000) | 200,000 | (2,200,000) | 500,000 | (6,110,000) |
| Bridge Loan | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **Ending Cash Balance** | **$ 2,451,365** | **$ 2,301,365** | **$ 5,271,365** | **$ 5,721,365** | **$ 3,471,365** | **$ 3,071,365** | **$ 6,971,365** | **$ 1,391,365** | **$ 791,365** | **$ 991,365** | **$ (1,208,635)** | **$ (708,635)** | **$ (708,635)** |

**Attachment B**
**ADAMS Study**

# ADAMS Strategic Plan

Hazel Hawkins
MEMORIAL HOSPITAL

# Strategic Planning

## *Hazel Hawkins Memorial Hospital*

*October 12, 2022*

ADAMS®

# Vision for Today

- September 2020 Strategic Plan:
  - Improved Customer Experience
  - Improved Patient Experience
  - Adding/Increasing service volumes
  - Community Education
  - Facility Master Planning & enabling projects

- Today's focus:
  - Market Changes/Growth
  - Provider Changes/Opportunities
  - Identification of gaps in services
  - Opportunities to improve referral patterns and limit out-migration.
  - Develop agreement on 2-3 courses of action to build revenue within the next 3-5 years, without major capital investment.

# Agenda

- Market Position Changes
  - Market Volumes
  - Hazel Hawkins Market Position
- Volume Trends
  - Acute Care
  - Ambulatory
- Provider Base
  - Recruitment/Attrition
  - Referral Patterns
  - Recruitment Opportunities
- Barriers and Missing Services
  - Service Line Development
  - Space Considerations
- Revenue Building Strategies
  - Outpatient Imaging
  - Surgical Services
  - GI/Endo
  - Oncology Services
  - Cardiac Diagnostics/NI Vascular
- Course Direction

Hazel Hawkins
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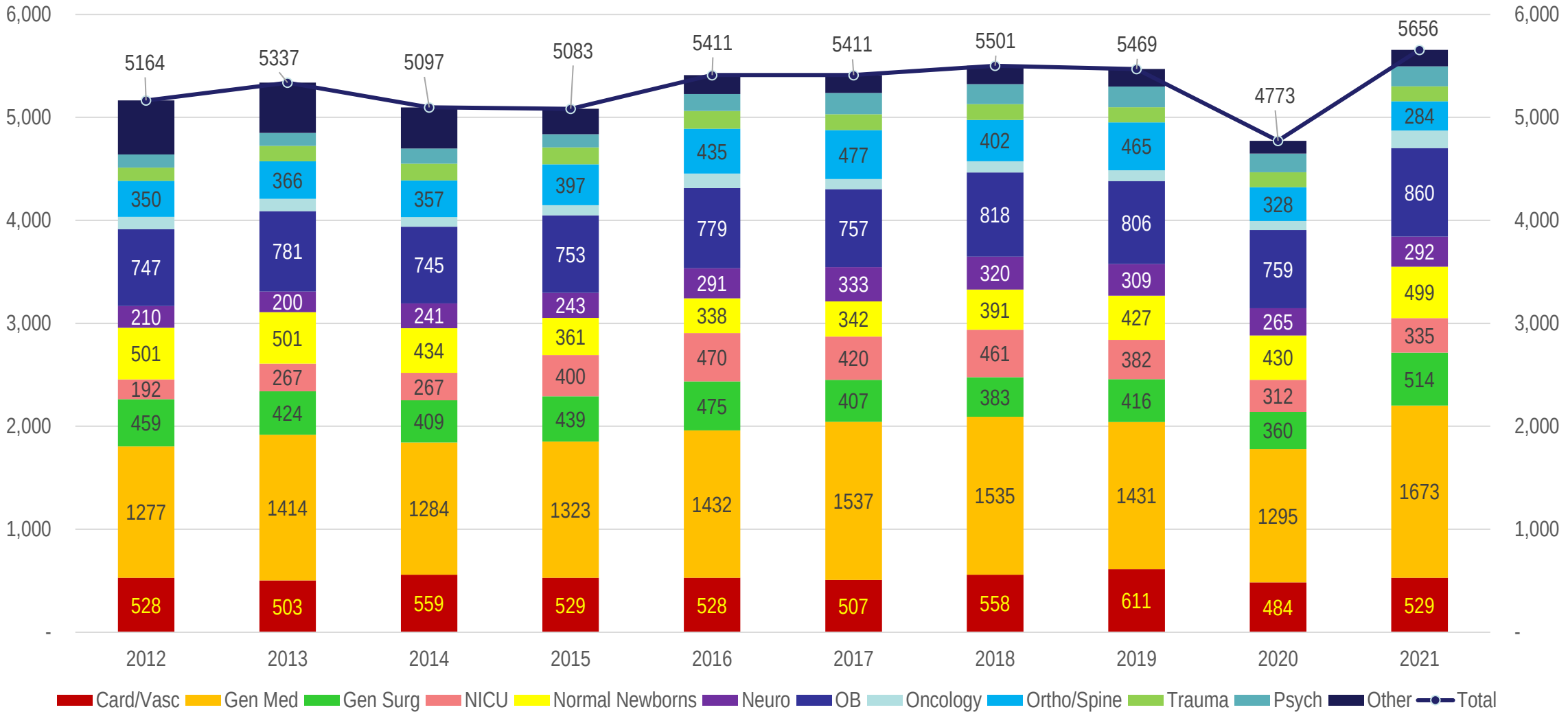
# Market Position

ADAMS®

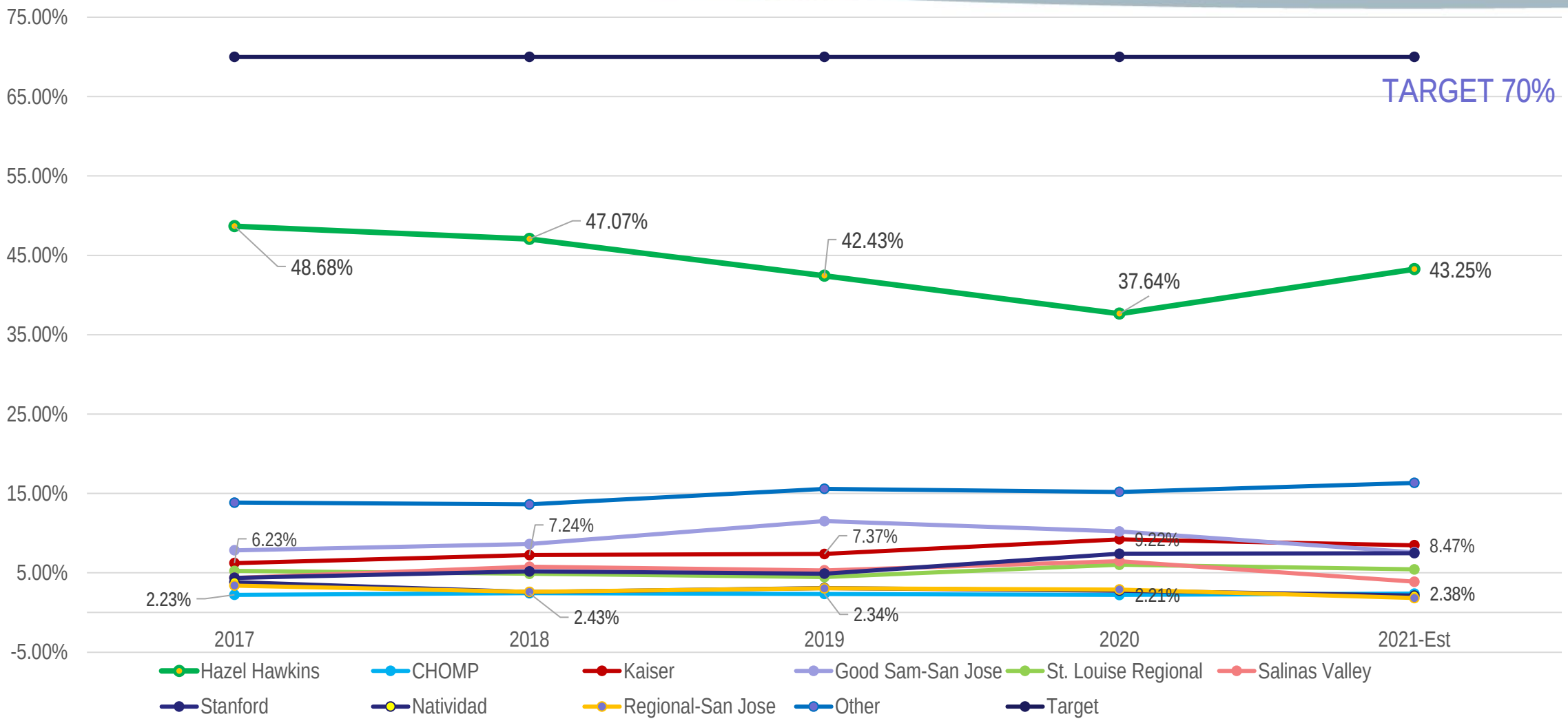
# Inpatient Discharges by Service

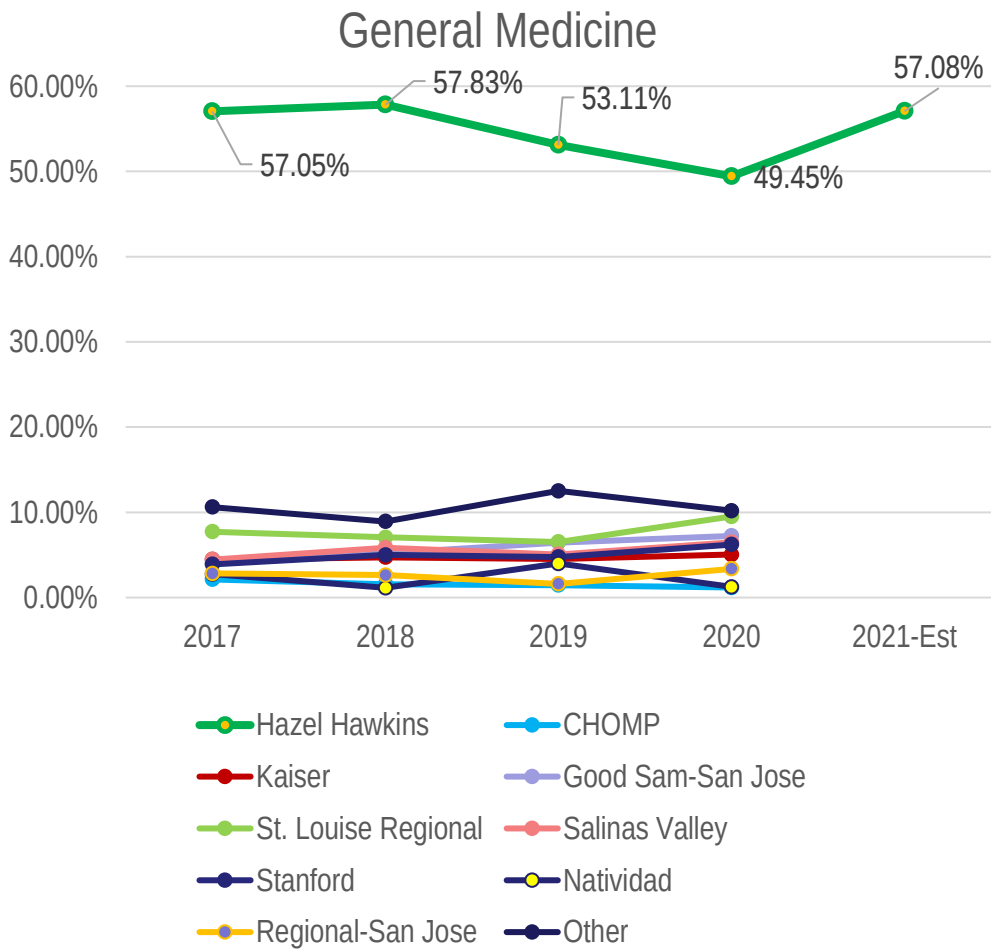
*San Benito County*

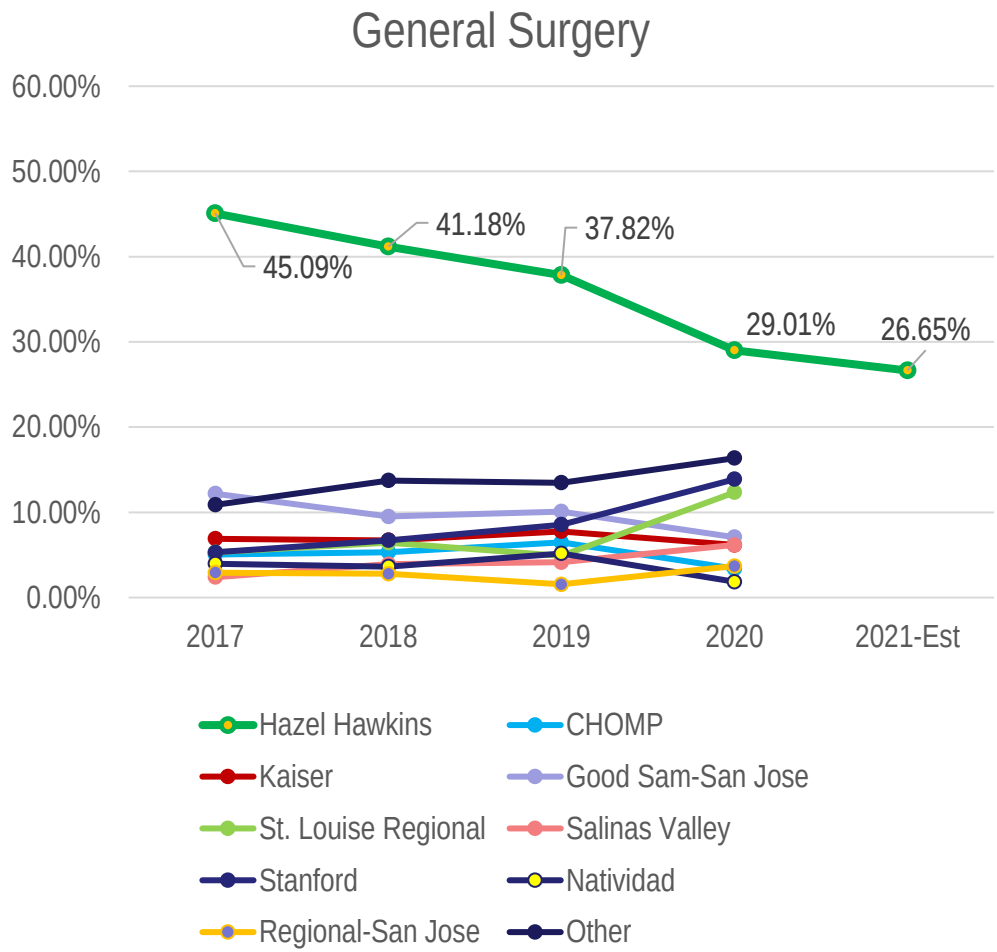


# IP Market Share

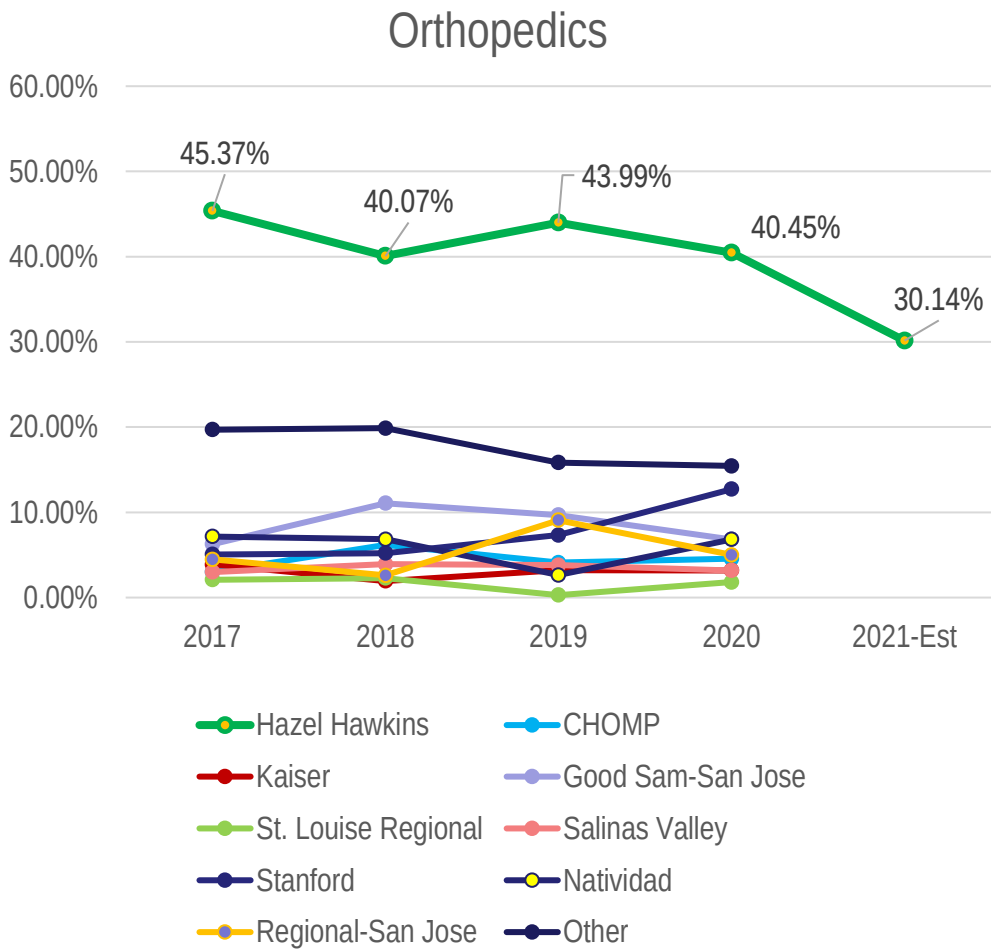
*2017-2021*

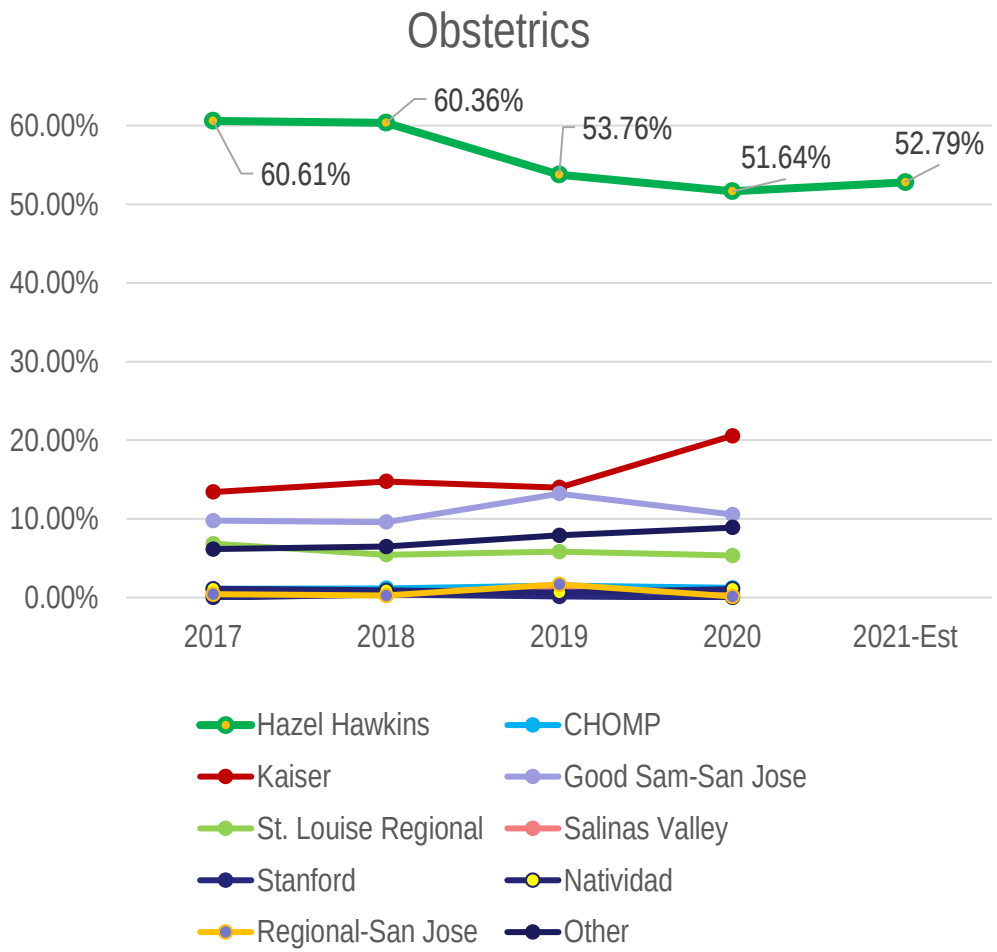



General Medicine
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
57.05%
57.83%
53.11%
49.45%
57.08%
2017
2018
2019
2020
2021-Est
Hazel Hawkins
CHOMP
Kaiser
Good Sam-San Jose
St. Louise Regional
Salinas Valley
Stanford
Natividad
Regional-San Jose
Other


General Surgery
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
45.09%
41.18%
37.82%
29.01%
26.65%
2017
2018
2019
2020
2021-Est
Hazel Hawkins
CHOMP
Kaiser
Good Sam-San Jose
St. Louise Regional
Salinas Valley
Stanford
Natividad
Regional-San Jose
Other

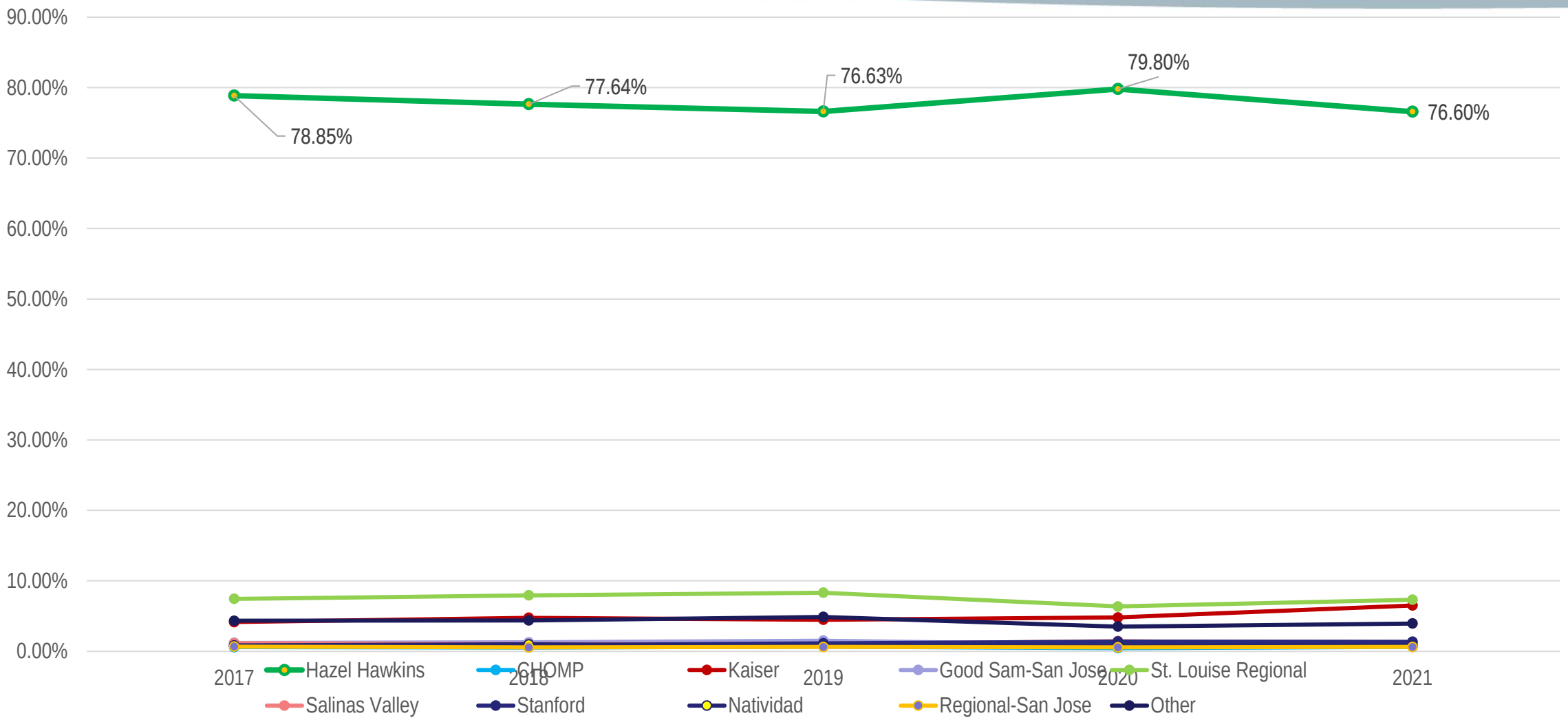
# IP Market Share
*2017-2021*



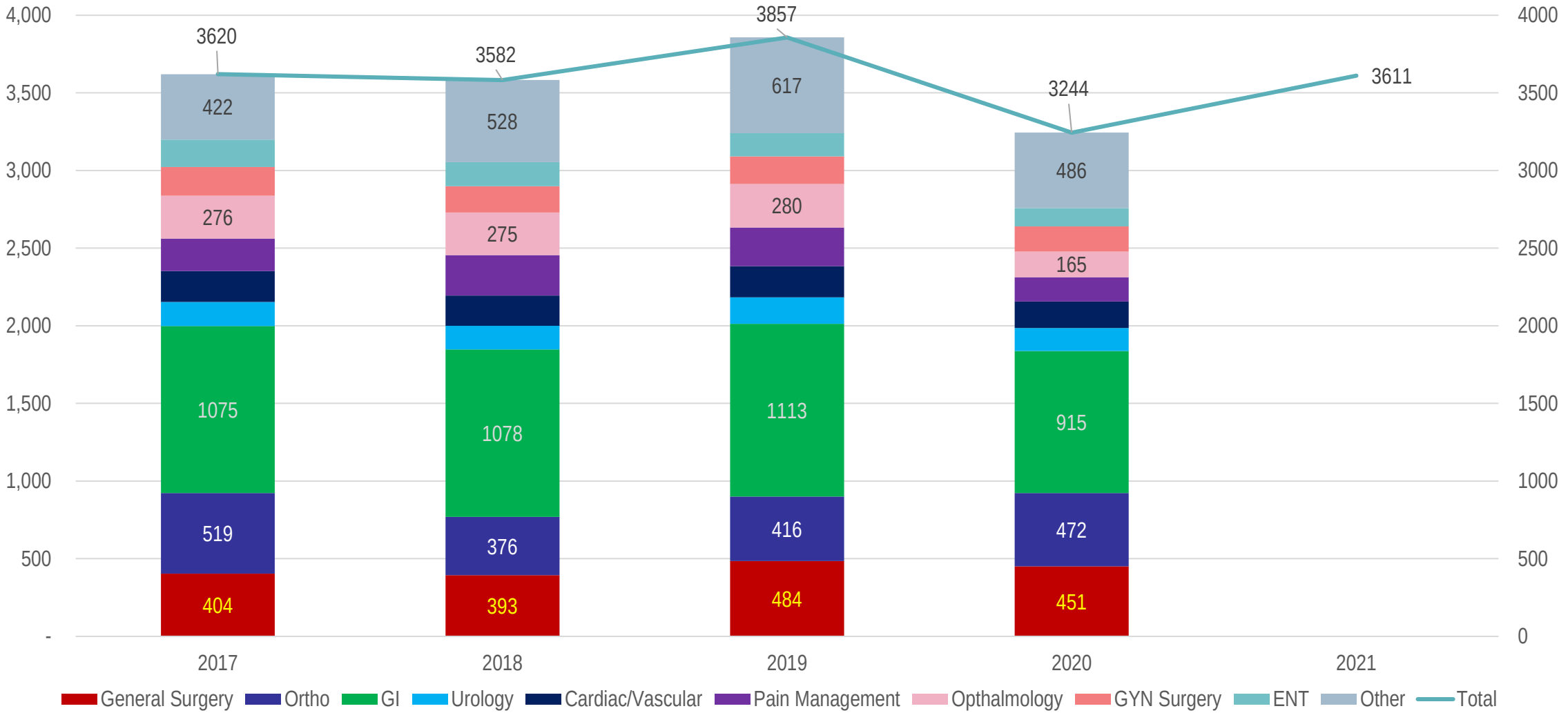
# OP ER Market Share

*2017-2021*



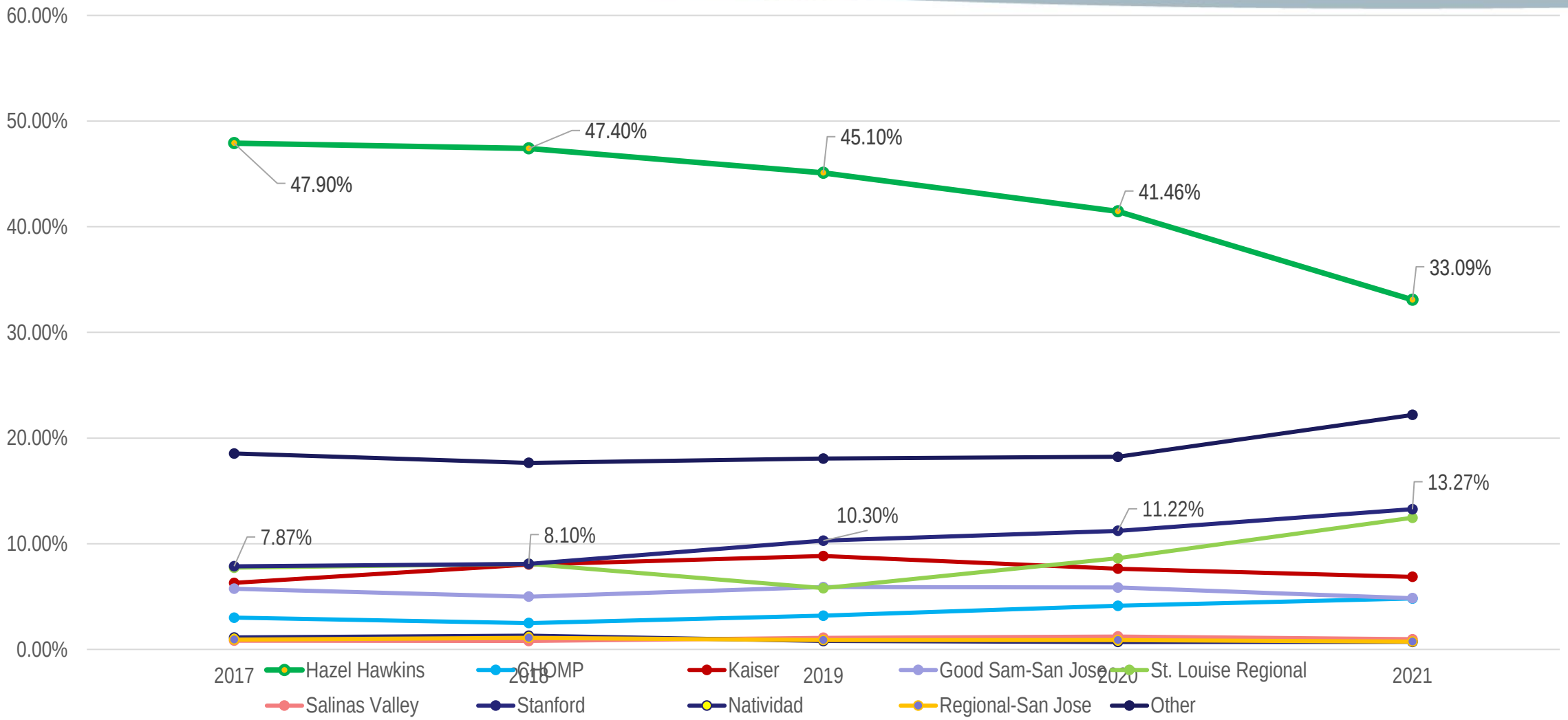
# Ambulatory Surgery Encounters

*Stark Service Area-Hospitals Only*



# Hospital ASC Market Share

*2017-2021*




Does not include non-hospital ASC Volumes

| Hazel Hawkins Memorial Hospital<br>Ambulatory Surgery & GI | Outpatient | | | | |
|---|---|---|---|---|---|
| | Service Area | In-Migration | Total Cases | Outpatient Market-2019 | OP Market Share |
| Cosmetic Procedures | - | - | - | 344 | 0.0% |
| ENT | 18 | 1 | 19 | 993 | 1.8% |
| Gastroenterology | 787 | 116 | 903 | 3,307 | 23.8% |
| General Surgery | 294 | 51 | 345 | 916 | 32.1% |
| Gynecology | 96 | 15 | 111 | 734 | 13.1% |
| Neurosurgery | - | - | - | 132 | 0.0% |
| Obstetrics | - | - | - | 43 | 0.0% |
| Opthalmology | 116 | 18 | 134 | 2,319 | 5.0% |
| Orthopedics | 142 | 15 | 157 | 3,086 | 4.6% |
| Pain | 241 | 26 | 267 | 1,471 | 16.4% |
| Pulmonology | - | - | - | 75 | 0.0% |
| Spine | - | - | - | 211 | 0.0% |
| Thoracic Surgery | - | - | - | 74 | 0.0% |
| Urology | 15 | 4 | 19 | 1,319 | 1.1% |
| Vascular | - | - | - | 60 | 0.0% |
| **Grand Total** | **1,709** | **246** | **1,955** | **15,084** | **11.3%** |

*Source:HHMH Surgical Services Case Log, Advisory Board*

- The Service Area generated over 15,000 ambulatory surgery and endoscopy procedures in 2019.
  - Only about 25% of those were done in a hospital setting.
- HHMH captured about 11% of those volumes.

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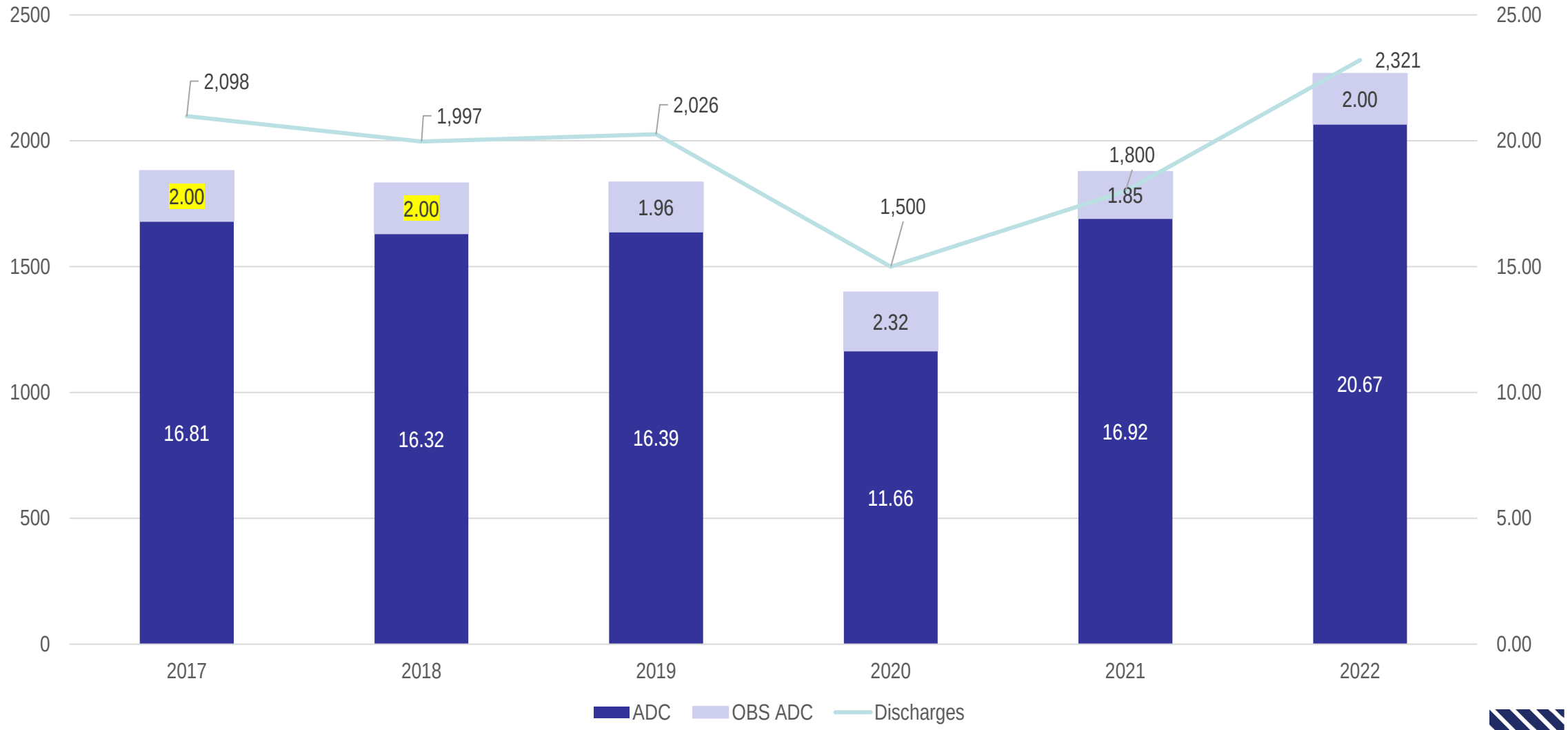
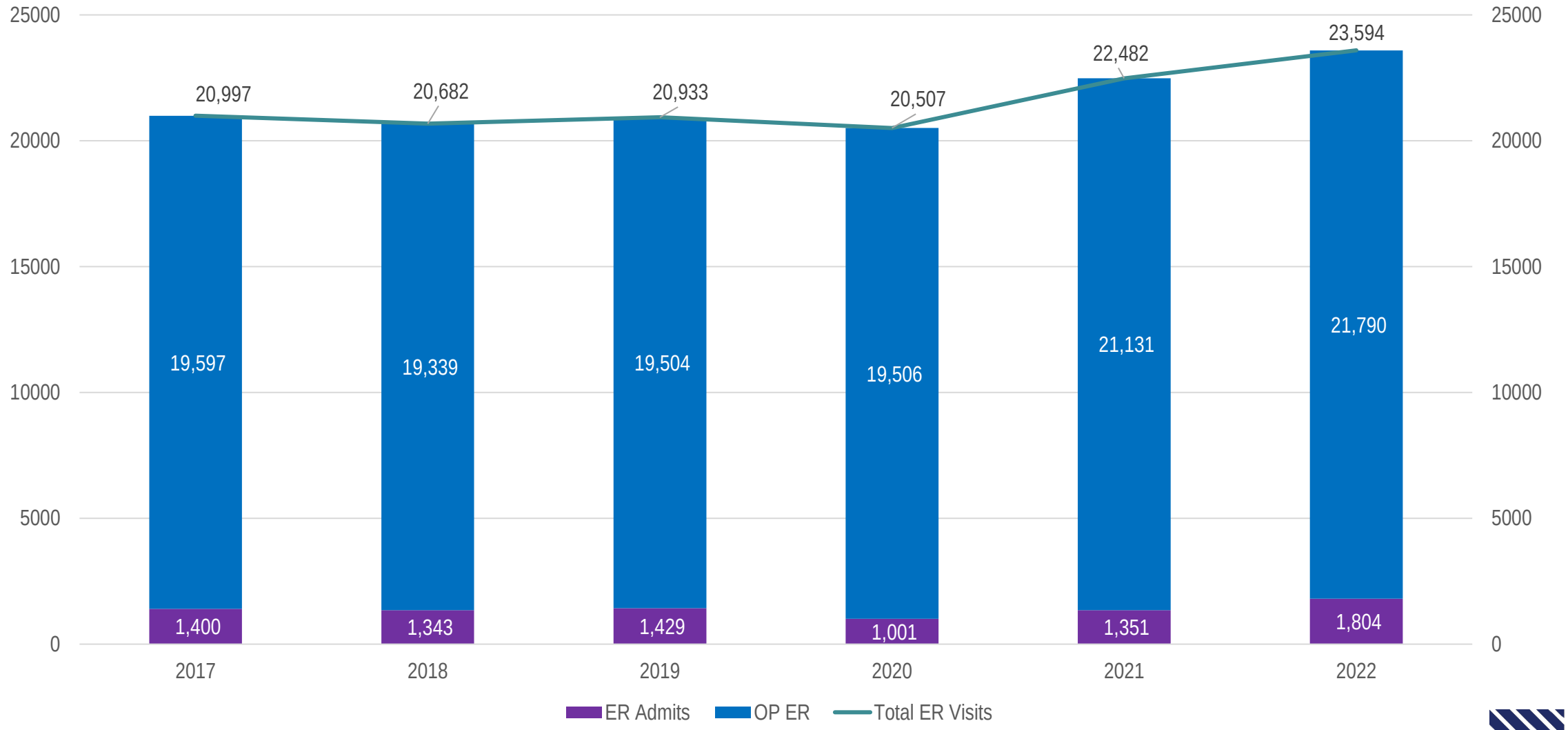
# Hospital Volume Trends

ADAMS®

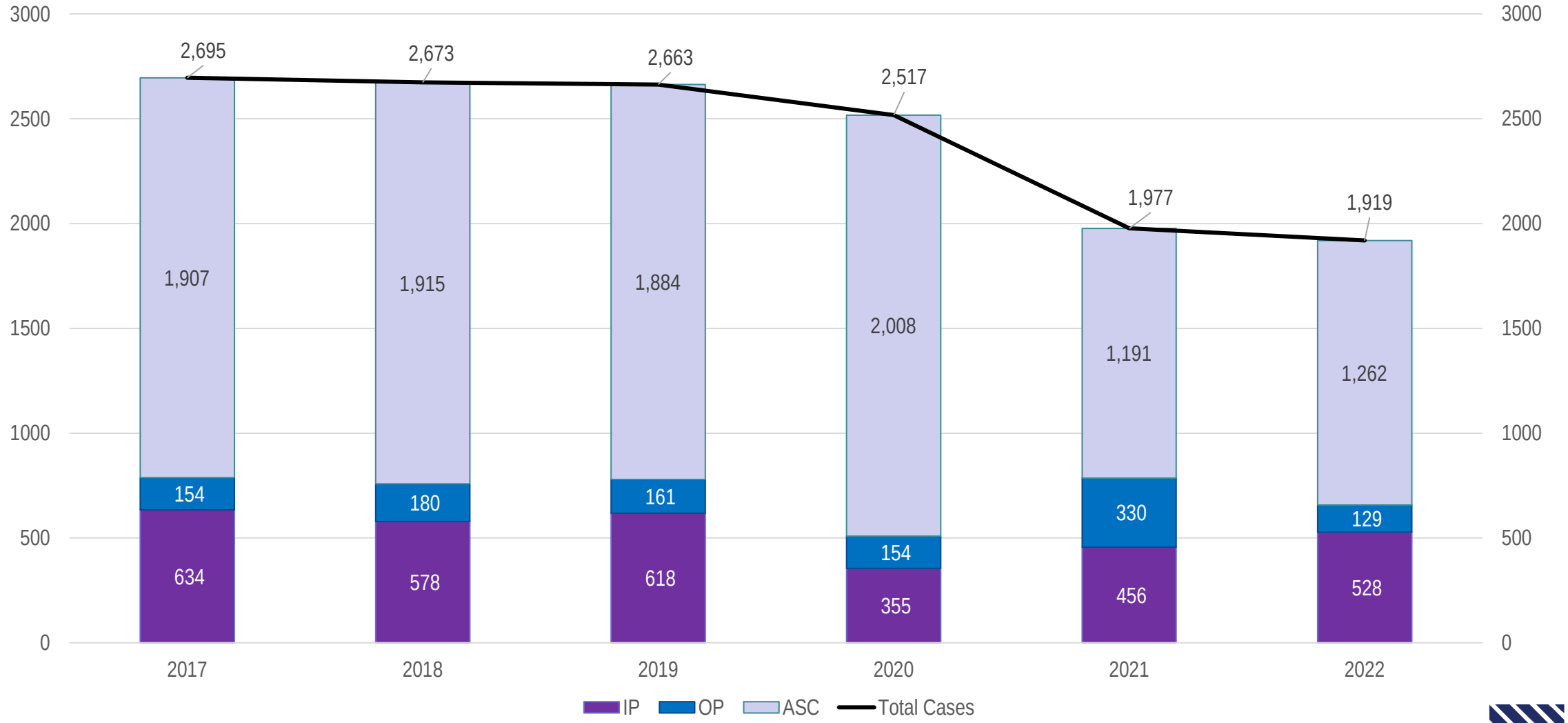
# Inpatient Discharges & Average Daily Census



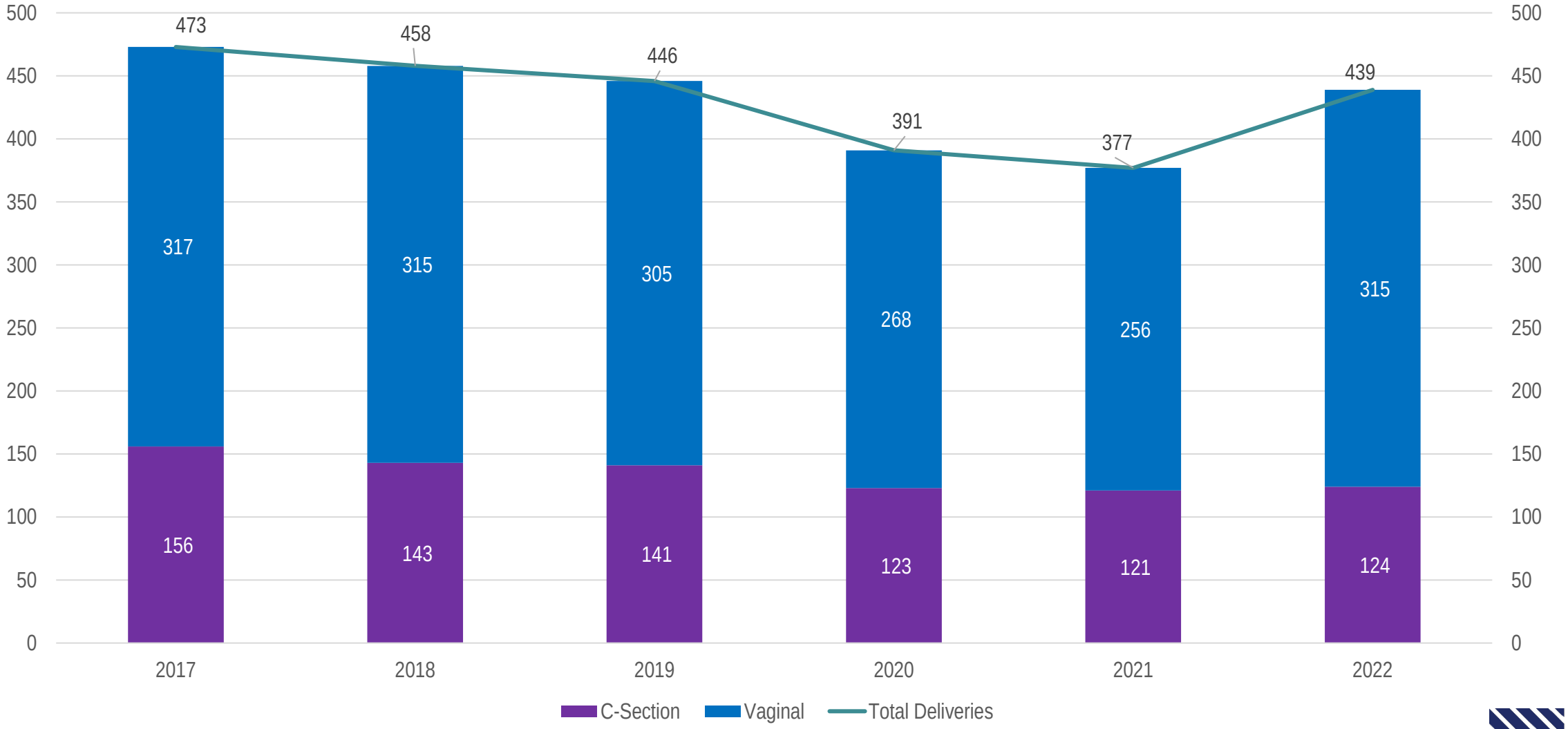
# ER Visits



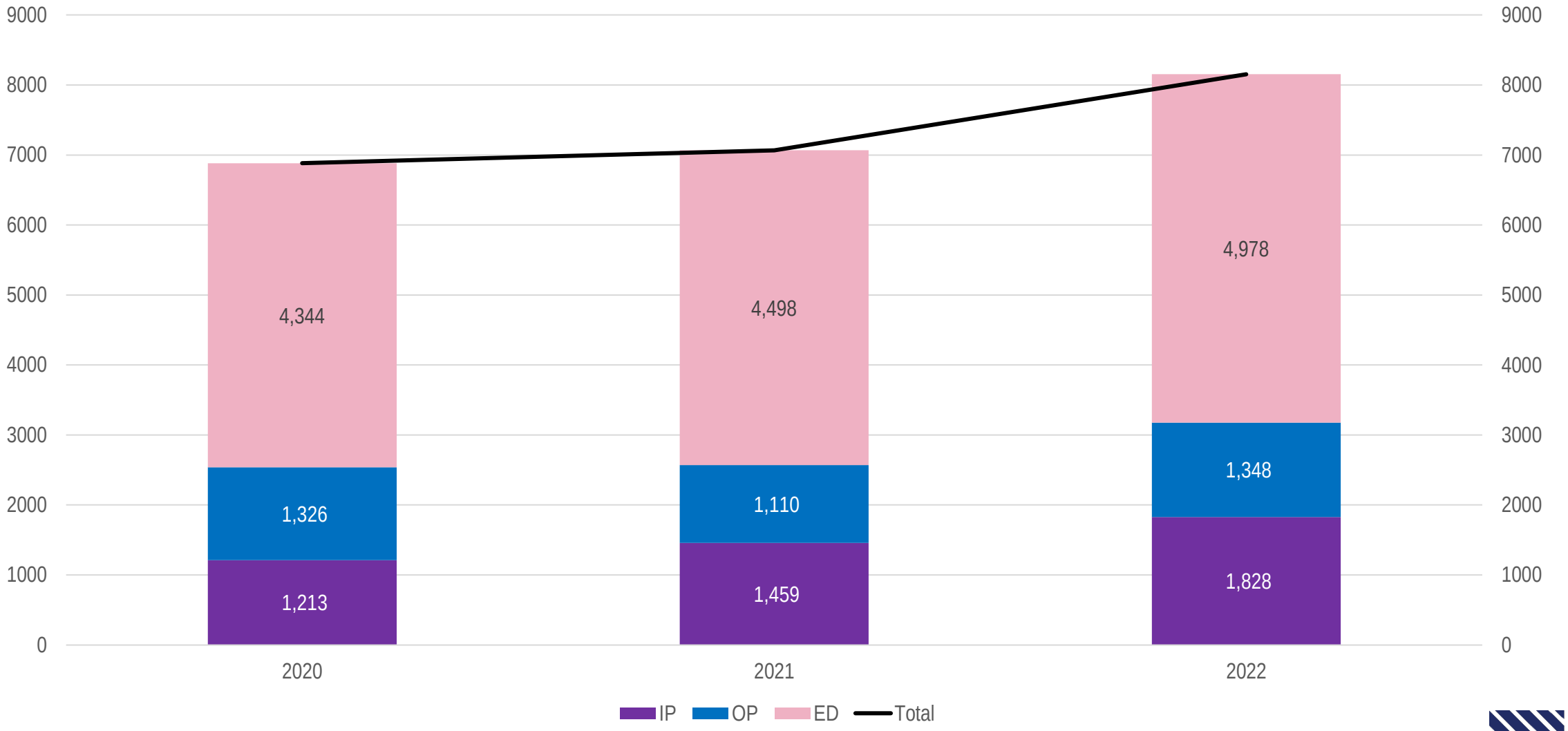
# Surgical Cases



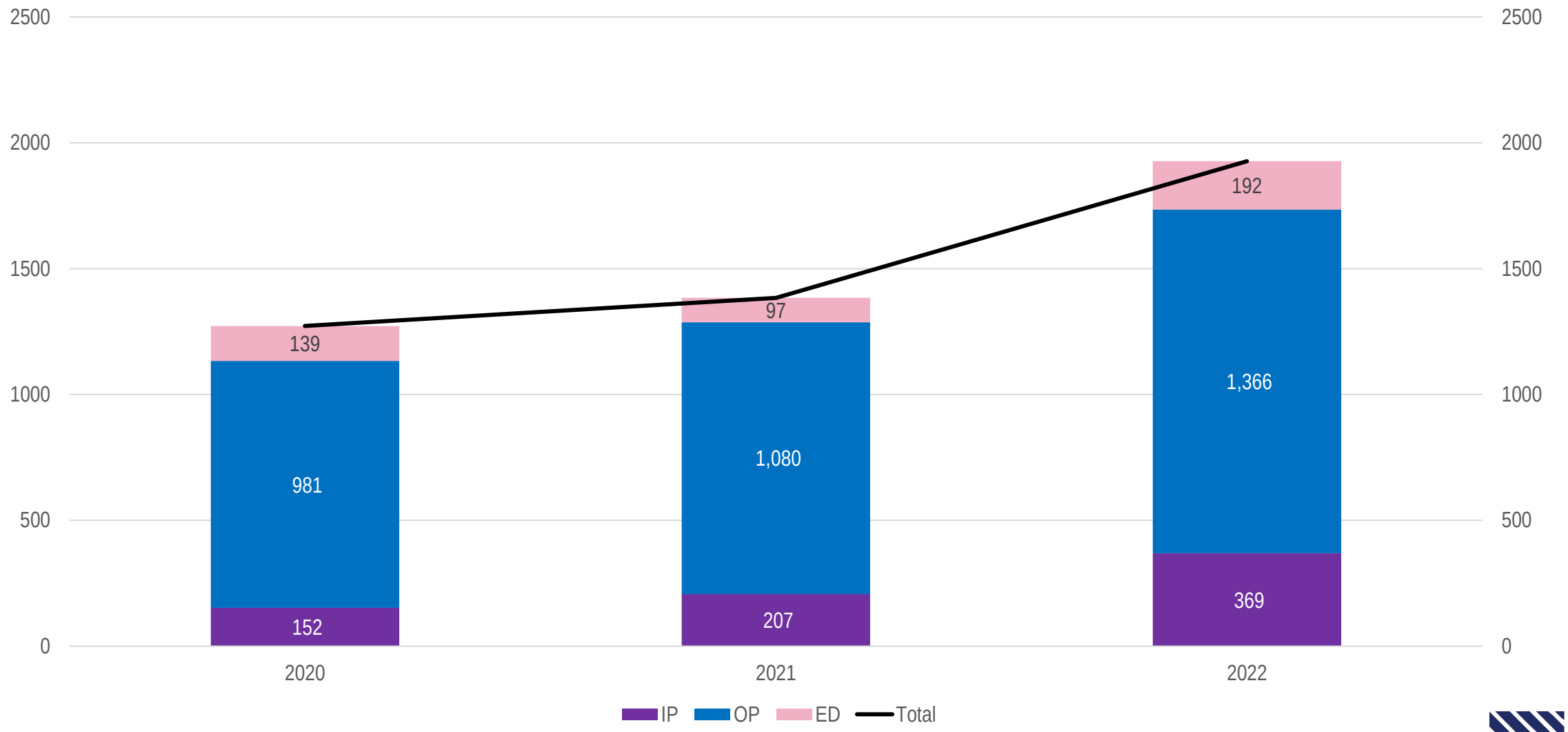
# Deliveries



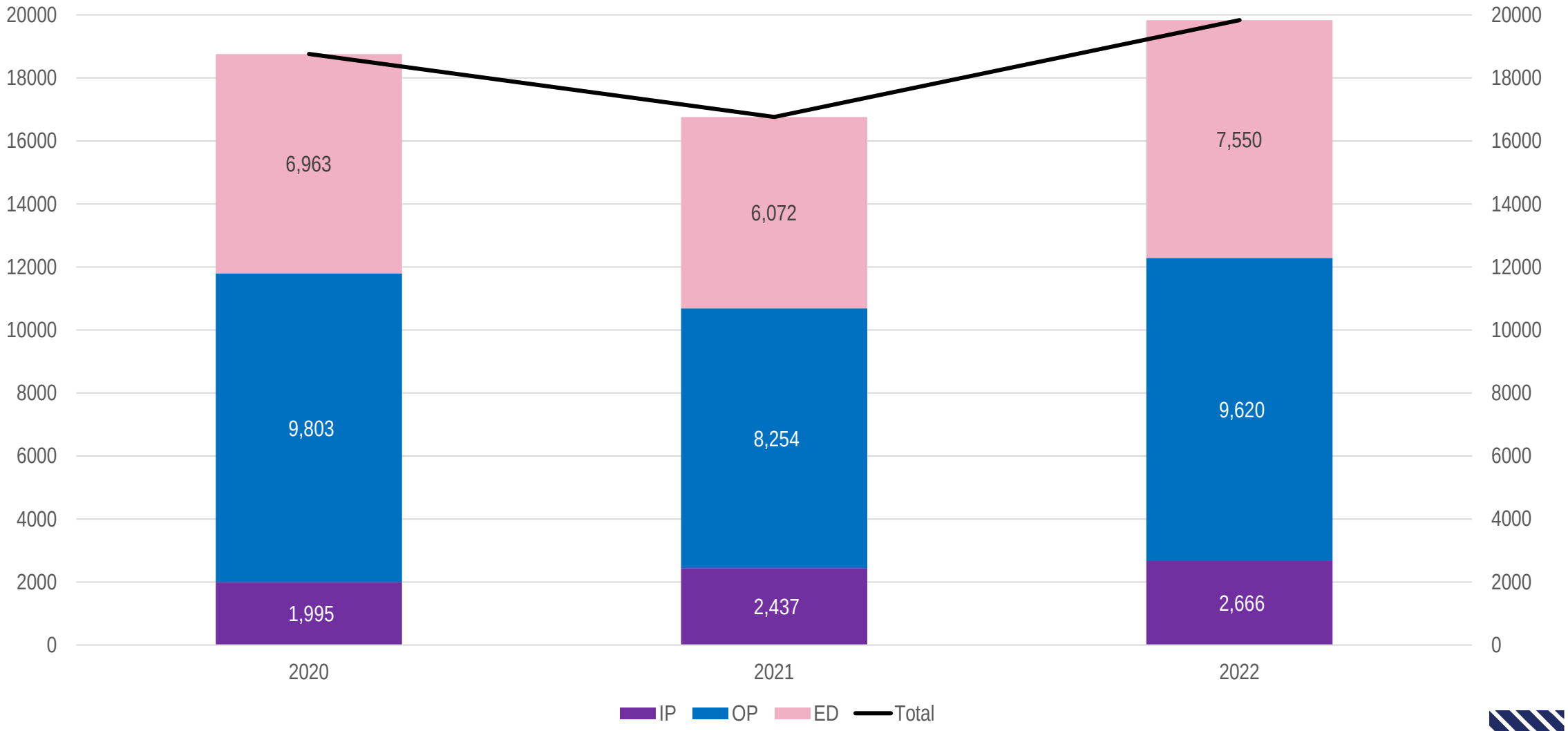
# CT

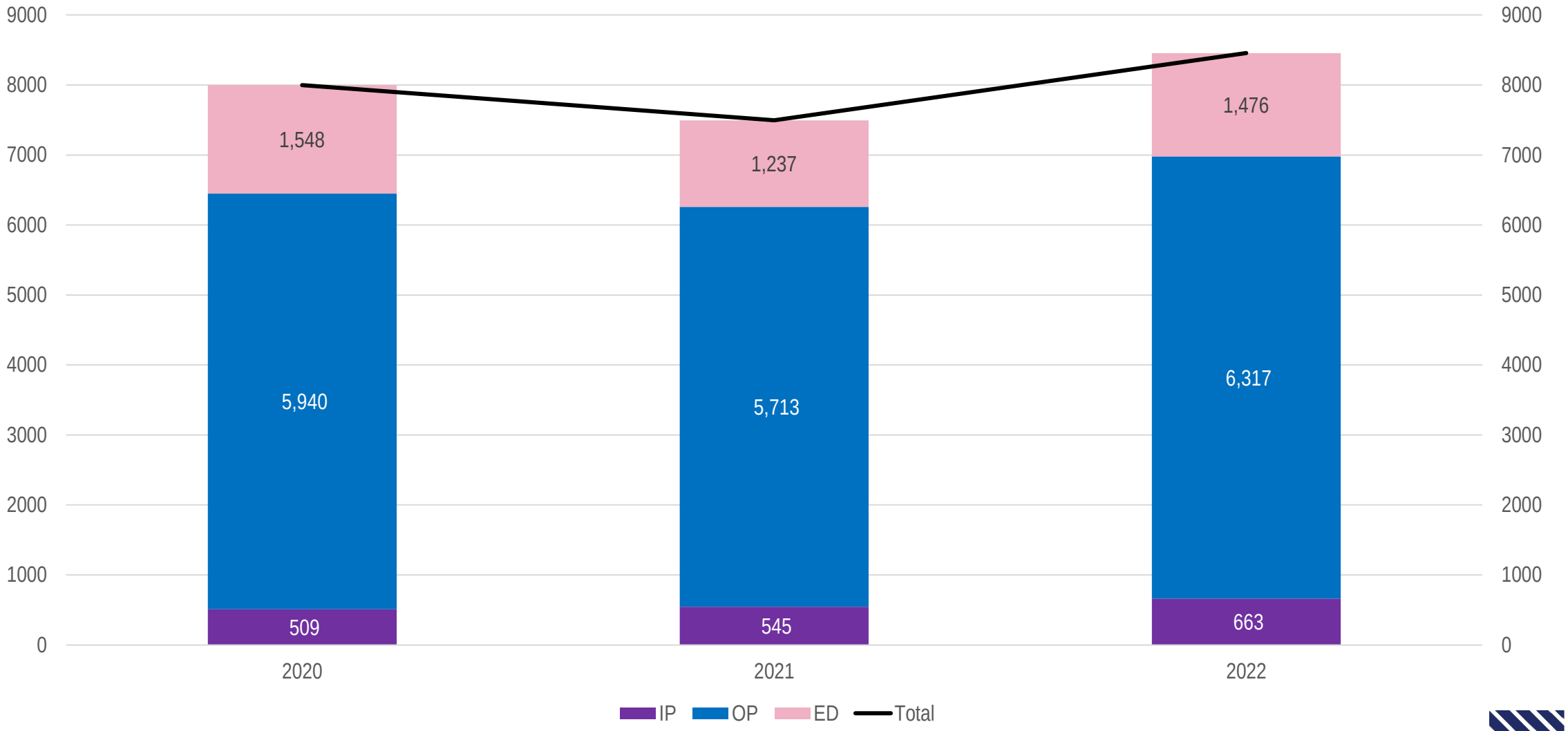


# MRI

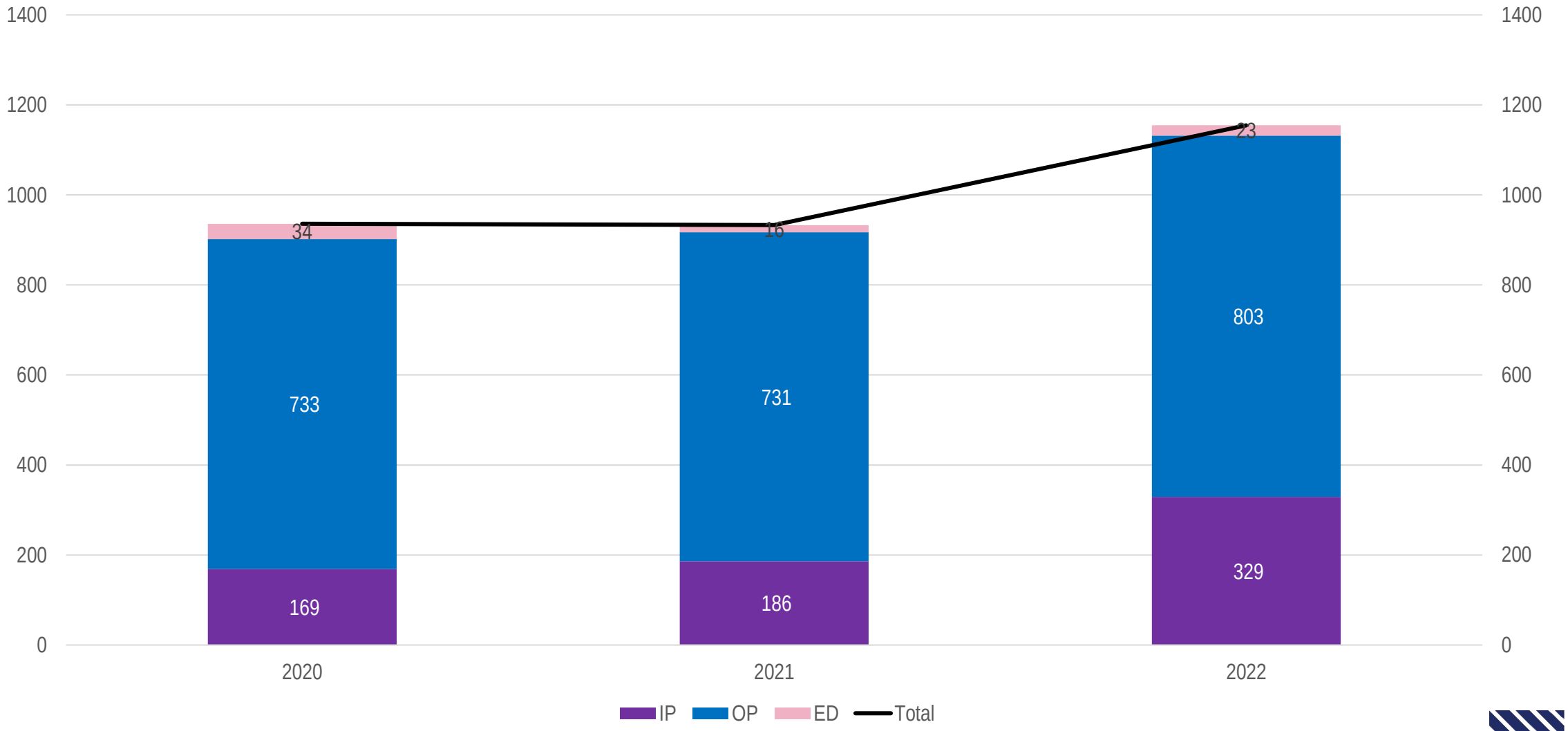


# X-Ray

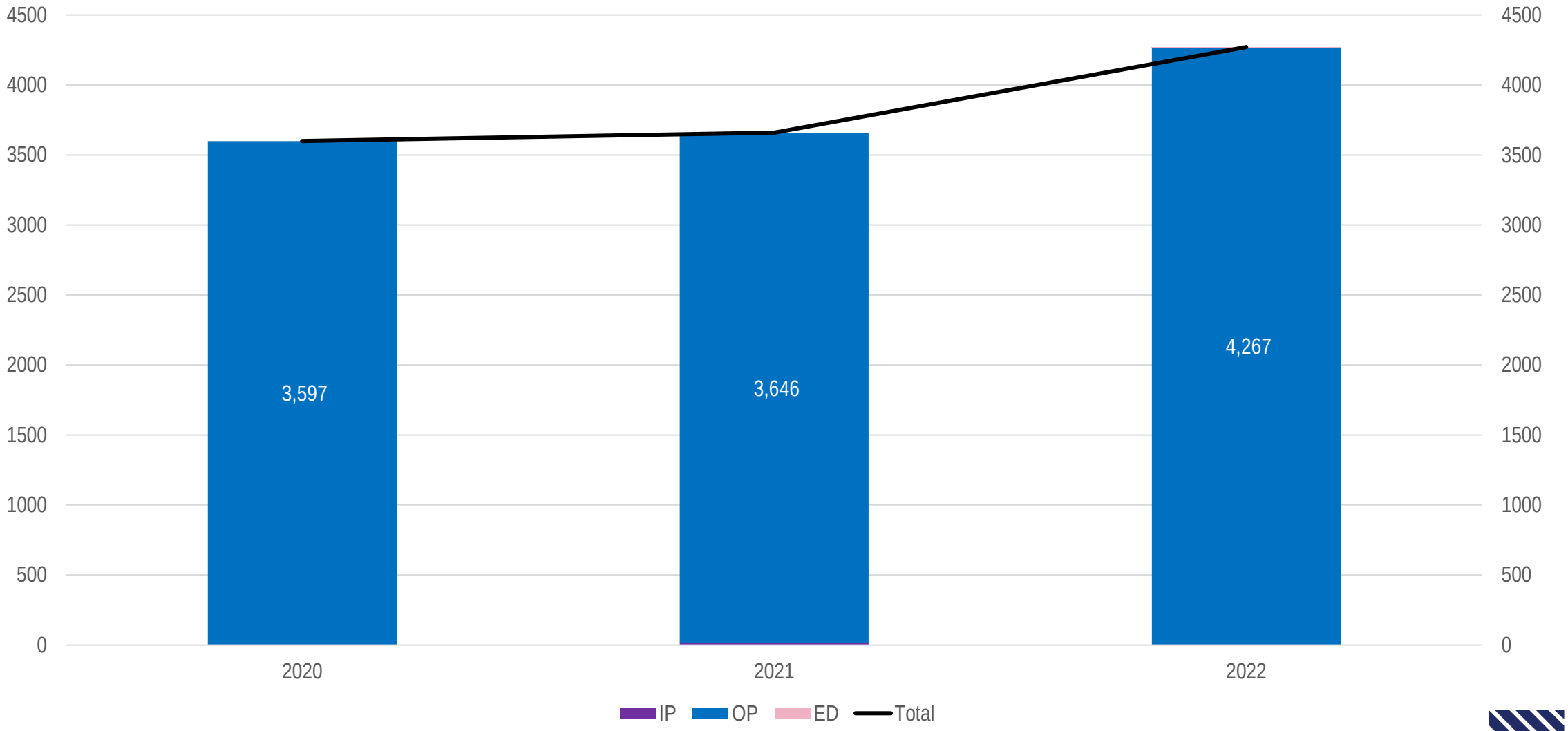



9000
8000
7000
6000
5000
4000
3000
2000
1000
0
1,548
5,940
509
1,237
5,713
545
1,476
6,317
663
2020
2021
2022
IP
OP
ED
Total

# Echo



# Mammo



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# Provider Base

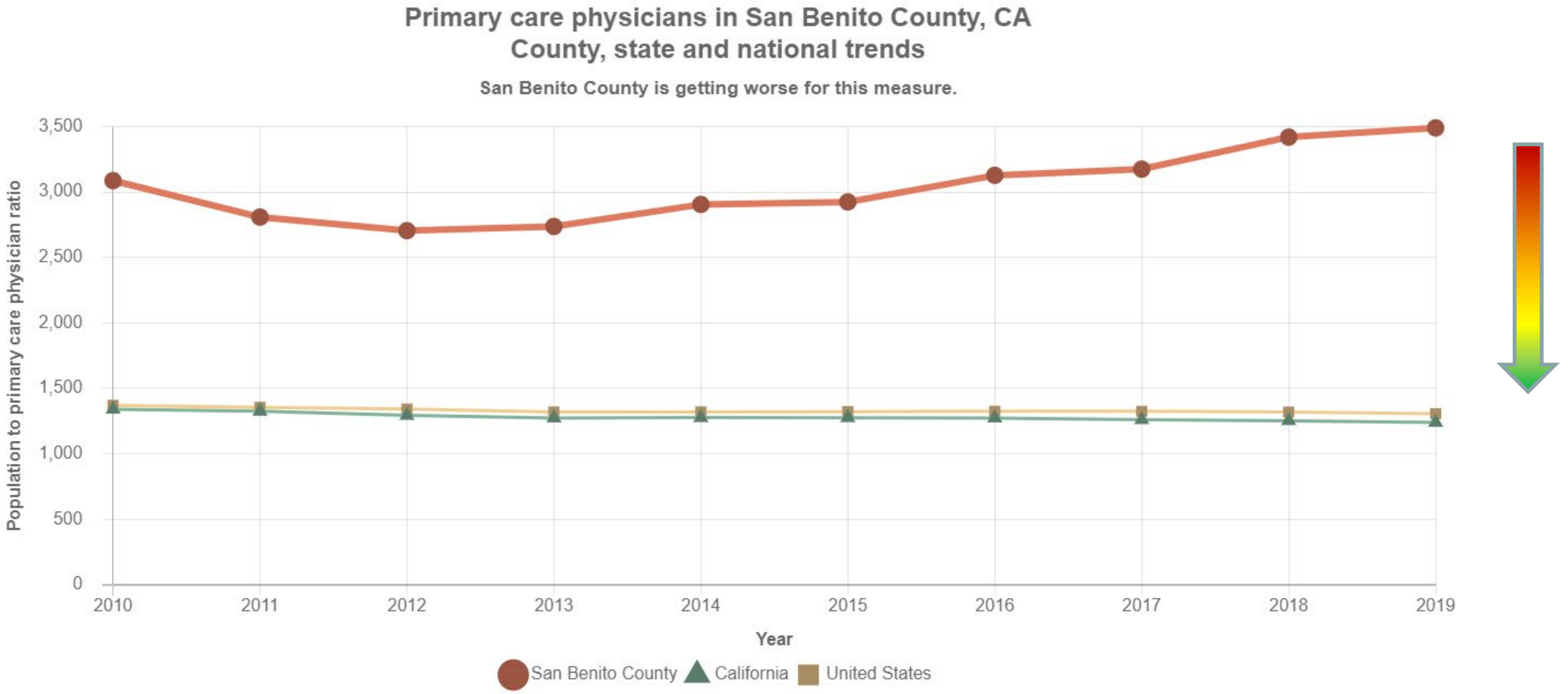
ADAMS®

| | San Benito (SN) County | Trend | Error Margin | Top U.S. Performers | California |
|---|---|---|---|---|---|
| **Clinical Care** | | | | | |
| Uninsured | 9% | | 8-10% | 6% | 9% |
| Primary care physicians | 3,490:1 | | | 1,010:1 | 1,240:1 |
| Dentists | 2,000:1 | | | 1,210:1 | 1,130:1 |
| Mental health providers | 780:1 | | | 250:1 | 240:1 |
| Preventable hospital stays | 2,575 | | | 2,233 | 3,067 |
| Mammography screening | 39% | | | 52% | 37% |
| Flu vaccinations | 48% | | | 55% | 43% |
| Other primary care providers | 2,560:1 | | | 580:1 | 1,370:1 |

| | San Benito (SN) County | Trend | Error Margin | Top U.S. Performers | California |
|---|---|---|---|---|---|
| **Health Behaviors** | | | | | |
| Adult smoking | 12% | | 10-14% | 15% | 10% |
| Adult obesity | 30% | | 29-32% | 30% | 26% |
| Food environment index | 9.2 | | | 8.8 | 8.9 |
| Physical inactivity | 25% | | 23-28% | 23% | 22% |
| Access to exercise opportunities | 82% | | | 86% | 93% |
| Excessive drinking | 20% | | 19-21% | 15% | 19% |
| Alcohol-impaired driving deaths | 28% | | 21-35% | 10% | 28% |
| Sexually transmitted infections | 436.3 | | | 161.8 | 599.1 |
| Teen births | 16 | | 14-18 | 11 | 16 |
| Frequent physical distress | 12% | | 11-14% | 10% | 11% |
| Frequent mental distress | 12% | | 11-14% | 13% | 12% |
| Diabetes prevalence | 11% | | 10-12% | 8% | 9% |

- High Level Primary Care analysis shows that the market is significantly understaffed.

Source: County Health Rankings & Roadmaps




Notes:
The data in this table reflect the average population served by a single primary care physician.

Source: County Health Rankings & Roadmaps

- Provider needs models are based on a mixture of population and productivity models for your specific market. Key consideration is given to:
  - Demographics; Age and Sex
  - Uninsured population
- Provider FTEs were compiled with the assistance of the facility to ensure all providers were accounted for:
  - Advanced Practice Providers are accounted for as a percentage of the Physician FTE capacity, based on specialty group.

# Provider Needs
## *Summary*

| Specialty Group | Provider Specialty | Provider Demand | | APP Supply | | Physician Supply | | Effective Provider Supply | | Expected Provider Retirement | Percent Provider Retirement | Provider Surplus (Shortage) | | Recommended Recruitment | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2022 | 2027 | 2022 | 2027 | 2022 | 2027 | 2022 | 2027 | | | 2022 | 2027 | Physician | APP |
| Primary Care | Family Practice | 23.7 | 24.7 | 7.8 | 7.0 | 9.3 | 8.9 | 13.2 | 12.4 | (0.80) | -6.1% | (10.5) | (12.3) | 3.0 | 3.0 |
| Primary Care | Geriatric Medicine | 2.1 | 2.2 | 0.0 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | - | 0.0% | (1.1) | (1.2) | 1.0 | 0.4 |
| Primary Care | Internal Medicine | 17.8 | 18.5 | 1.0 | 1.0 | 4.0 | 3.0 | 4.5 | 3.5 | (1.00) | -22.2% | (13.3) | (15.0) | 4.0 | 4.0 |
| Primary Care | Pediatrics | 10.5 | 11.0 | 1.4 | 1.4 | 2.0 | 2.0 | 2.7 | 2.7 | - | 0.0% | (7.8) | (8.3) | 2.0 | 2.0 |
| Primary Care | Hospitalist | 2.2 | 2.3 | 0.0 | 0.0 | 2.9 | 2.8 | 2.9 | 2.8 | (0.10) | -3.4% | 0.7 | 0.5 | 0.0 | 0.0 |
| **Primary Care** | **Primary Care** | 56.3 | 58.6 | 10.2 | 9.4 | 19.2 | 17.7 | 24.3 | 22.4 | (1.90) | -7.8% | (32.0) | (36.2) | 10.0 | 9.4 |
| Medical Specialties | Allergy/Immunology | 0.8 | 0.8 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (0.8) | (0.8) | 0.5 | 0.0 |
| Medical Specialties | Cardiology | 3.0 | 3.2 | 0.0 | 0.0 | 1.4 | 0.8 | 1.4 | 0.8 | (0.60) | -44.4% | (1.7) | (2.4) | 1.0 | 0.0 |
| Medical Specialties | Dermatology | 2.1 | 2.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (2.1) | (2.2) | 1.0 | 0.0 |
| Medical Specialties | Endocrinology | 0.7 | 0.8 | 0.0 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | - | 0.0% | 0.3 | 0.2 | 0.0 | 0.0 |
| Medical Specialties | Gastroenterology | 1.8 | 1.9 | 0.0 | 0.0 | 0.4 | 0.4 | 0.4 | 0.4 | - | 0.0% | (1.4) | (1.5) | 1.0 | 0.0 |
| Medical Specialties | Hematology/Oncology | 1.5 | 1.6 | 0.0 | 0.0 | 0.2 | 0.2 | 0.2 | 0.2 | - | 0.0% | (1.3) | (1.4) | 1.0 | 0.0 |
| Medical Specialties | Infectious Disease | 0.6 | 0.6 | 0.0 | 0.0 | 0.4 | 0.4 | 0.4 | 0.4 | - | 0.0% | (0.2) | (0.2) | 0.0 | 0.0 |
| Medical Specialties | Nephrology | 0.8 | 0.8 | 0.0 | 0.0 | 0.2 | 0.1 | 0.2 | 0.1 | (0.15) | -65.2% | (0.5) | (0.7) | 0.0 | 0.0 |
| Medical Specialties | Neurology | 1.7 | 1.8 | 0.0 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | - | 0.0% | (0.7) | (0.8) | 0.0 | 0.0 |
| Medical Specialties | Physical Medicine | 1.2 | 1.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (1.2) | (1.2) | 0.0 | 0.0 |
| Medical Specialties | Psychiatry | 7.2 | 7.4 | 0.0 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | - | 0.0% | (6.2) | (6.4) | 1.0 | 2.0 |
| Medical Specialties | Pulmonology | 1.2 | 1.3 | 0.0 | 0.0 | 0.4 | 0.4 | 0.4 | 0.4 | - | 0.0% | (0.8) | (0.9) | 0.6 | 0.0 |
| Medical Specialties | Radiation Therapy | 0.6 | 0.7 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (0.6) | (0.7) | 0.0 | 0.0 |
| Medical Specialties | Rheumatology | 0.7 | 0.8 | 0.0 | 0.0 | 0.5 | 0.5 | 0.5 | 0.5 | - | 0.0% | (0.3) | (0.3) | 0.0 | 0.0 |
| Medical Specialties | Other Medical Specialties | 0.9 | 0.9 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (0.9) | (0.9) | 0.0 | 0.0 |
| **Medical Specialties** | **Medical Specialties** | 24.9 | 25.9 | 0.0 | 0.0 | 6.4 | 5.7 | 6.4 | 5.7 | (0.75) | -11.7% | (18.4) | (20.2) | 6.1 | 2.0 |

- Note:
  - APP Providers in Primary Care are considered to manage 50% of a Physician's Workload

# Provider Needs
## *Summary*

| Specialty Group | Provider Specialty | Provider Demand | | APP Supply | | Physician Supply | | Effective Provider Supply | | Expected Provider Retirement | Percent Provider Retirement | Provider Surplus (Shortage) | | Recommended Recruitment | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 2022 | 2027 | 2022 | 2027 | 2022 | 2027 | 2022 | 2027 | | | 2022 | 2027 | Physician | APP |
| Surgical Specialties | Cardiothoracic Surgery | 0.5 | 0.5 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (0.5) | (0.5) | 0.0 | 0.0 |
| Surgical Specialties | General Surgery | 7.3 | 7.6 | 0.6 | 0.6 | 3.0 | 3.0 | 3.1 | 3.1 | - | 0.0% | (4.2) | (4.5) | 2.0 | 1.0 |
| Surgical Specialties | Neurosurgery | 1.0 | 1.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (1.0) | (1.0) | 0.0 | 0.0 |
| Surgical Specialties | OB/GYN | 7.6 | 8.0 | 1.8 | 1.8 | 2.9 | 2.4 | 3.3 | 2.8 | (0.50) | -15.0% | (4.3) | (5.1) | 3.0 | 2.0 |
| Surgical Specialties | Opthalmology | 4.0 | 4.2 | 0.0 | 0.0 | 1.8 | 0.8 | 1.8 | 0.8 | (1.00) | -57.1% | (2.3) | (3.4) | 0.0 | 0.0 |
| Surgical Specialties | Orthopedic Surgery | 4.6 | 4.7 | 1.0 | 1.0 | 1.8 | 1.3 | 2.0 | 1.5 | (0.50) | -25.0% | (2.6) | (3.2) | 2.0 | 1.0 |
| Surgical Specialties | Otolaryngology | 1.5 | 1.6 | 0.0 | 0.0 | 0.1 | 0.1 | 0.1 | 0.1 | - | 0.0% | (1.5) | (1.5) | 0.8 | 0.0 |
| Surgical Specialties | Plastic Surgery | 1.1 | 1.2 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (1.1) | (1.2) | 0.0 | 0.0 |
| Surgical Specialties | Urology | 2.3 | 2.4 | 0.0 | 0.0 | 0.3 | 0.3 | 0.3 | 0.3 | - | 0.0% | (2.1) | (2.2) | 1.0 | 0.0 |
| Surgical Specialties | Vascular Surgery | 0.9 | 1.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | - | 0.0% | (0.9) | (1.0) | 0.0 | 0.0 |
| Surgical Specialties | Other Surgical Specialties | 3.1 | 3.2 | 0.0 | 0.0 | 2.0 | 2.0 | 2.0 | 2.0 | - | 0.0% | (1.1) | (1.2) | 0.0 | 0.0 |
| **Surgical Specialties** | **Surgical Specialties** | 34.0 | 35.4 | 3.3 | 3.3 | 11.7 | 9.7 | 12.5 | 10.5 | (2.00) | -16.0% | (21.5) | (24.9) | 8.8 | 4.0 |
| Hospital-Based | Anesthesiology | 12.7 | 13.2 | 2.0 | 0.0 | 1.8 | 1.8 | 3.8 | 1.8 | (2.00) | -53.3% | (8.9) | (11.4) | 1.3 | 1.3 |
| Hospital-Based | Emergency | 8.7 | 9.1 | 0.3 | 0.3 | 2.0 | 1.8 | 2.1 | 1.9 | (0.25) | -11.8% | (6.6) | (7.2) | 3.3 | 0.0 |
| Hospital-Based | Radiology | 13.4 | 13.9 | 0.0 | 0.0 | 0.8 | 0.8 | 0.8 | 0.8 | - | 0.0% | (12.6) | (13.2) | 0.0 | 0.0 |
| Hospital-Based | Pathology | 8.5 | 8.9 | 0.0 | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | - | 0.0% | (7.5) | (7.9) | 0.0 | 0.0 |
| **Hospital-Based** | **Hospital-Based** | 43.3 | 45.0 | 2.3 | 0.3 | 5.5 | 5.3 | 7.6 | 5.4 | (2.25) | -29.5% | (35.7) | (39.7) | 4.6 | 1.3 |

| Clinic | Type | Exam Rooms | Max Providers/Day: Physician | APP | Other Provider | Target Exam Rooms 3/MD, 2/APP |
|---|---|---|---|---|---|---|
| *First Street* | Primary Care | 7 | 2 | 6 | 1 | 20 |
| *Fourth Street* | Primary Care/OB | 7 | 2 | 4 | | 14 |
| *San Juan Bautista* | Primary Care | 3 | 1 | 1 | | 5 |
| *Sunset / Annex* | Primary Care | 9 | 7 | 3 | | 27 |
| *Barragan Center* | Primary Care/Endocrine | 6 | 4 | 2 | 1 | 18 |
| *Multi-Specialty (MSC)* | Specialist Clinic | 6 | 6 | 0 | | 18 |
| *Orthopedic Specialty* | Surgical Specialists | 6 | 3 | 0 | | 9 |
| ***Current Exam Room Needs*** | | ***44*** | | | | ***111*** |
| *Recruitment Plan* | Primary Care | | 10 | 10 | | 50 |
| | Medical Specialists | | 6 | | 2 | 22 |
| | Surgical Specialists | | 3 | 4 | | 17 |
| | | | | | | 89 |
| ***Exam Room Needs-2026*** | | | | | | ***200*** |

*Note: Target Exam Rooms 3/MD, 2/APP, 1 Office for Virtual/Prov*

- Current State:
  - Current facilities lack adequate exam room space.
  - Buildings are relatively small and lack a cohesive appearance/attachment to HHMH.
- Impact of Recruitment Plan:
  - Significant additional clinic space needs to be acquired.
- Evolving Care Models:
  - Expansion of Virtual Care will impact the types/numbers of rooms needed for providers.

- Target Recruitment Areas:
  - Primary Care:
    - 10 MDs plus 10 APPs
  - Specialists:
    - OB/GYN & APP support
    - Ortho & APP support
    - GI
    - ENT
    - Urology

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# Barriers/Missing Services

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- What service limitations at Hazel Hawkins result in patients being sent to other systems for care?

# Market Opportunity Summary

## Opportunity Identification

**Procedural Splitting**

- **$9.2M** in additional procedural opportunity from loyalist & splitter physicians within Hazel Hawkins Memorial Hospital's defined primary markets

**PCP Referral Opportunity**

- **$32.6M** in remaining downstream PCP referral opportunity from all PCPs based within the above-defined market

## Outreach Execution

- Develop **initiatives** around prioritized action items
- Plan **approach strategy** and develop **talking points** for conversations
- Log **visit reports** on physician or practice group level
- **Track change in referral/procedural activity** to Hazel Hawkins Memorial Hospital over a user-defined time period

***Small changes can drive quick returns***

| | | | | | | |
|---|---|---|---|---|---|---|
| **$9.2M** Estimated Procedural Opportunity | + | **$32.6M** PCP Downstream Opportunity | x | 1% | = | **$454K** Estimated Potential Return |




Data covers May 2021 – April 2022
Source: Optum Market Advantage

- Physician Offices
  - Option 1: 3rd Floor Women's Center
    - 30 exam rooms
    - Capacity for up to 10 providers at a time
  - Option 2: Medical Office Complex
    - Developer Build?
    - Existing Space Lease?

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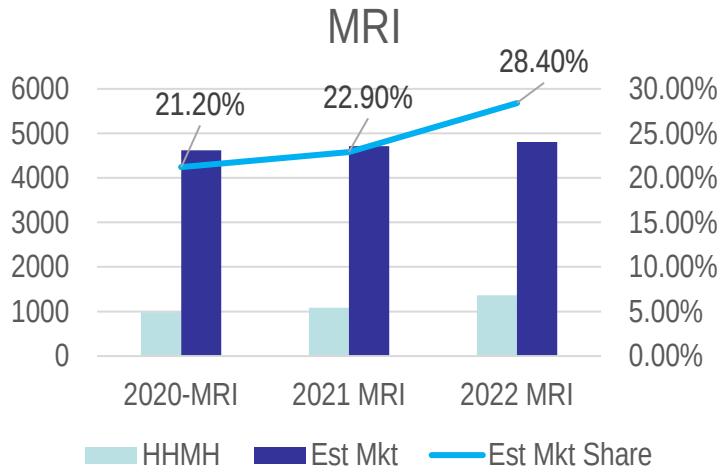
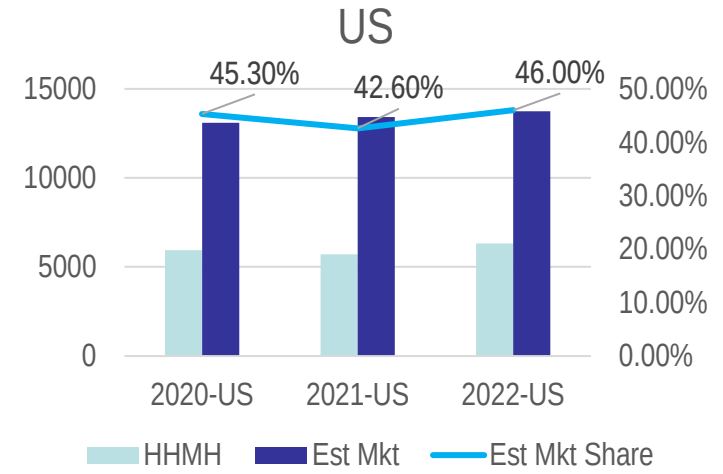
# Revenue Building Strategies

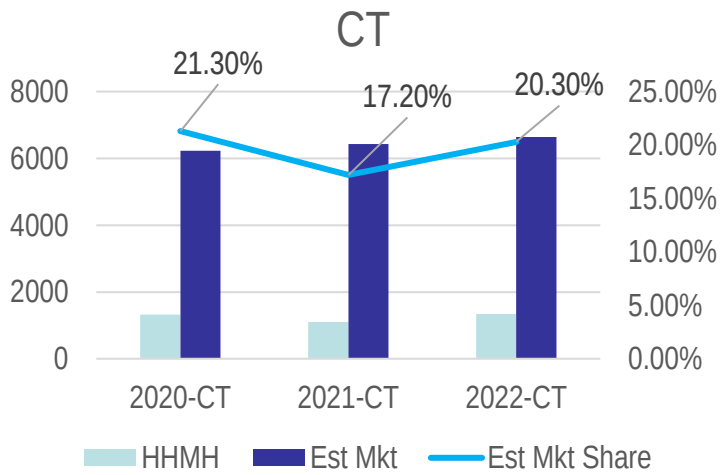
ADAMS®

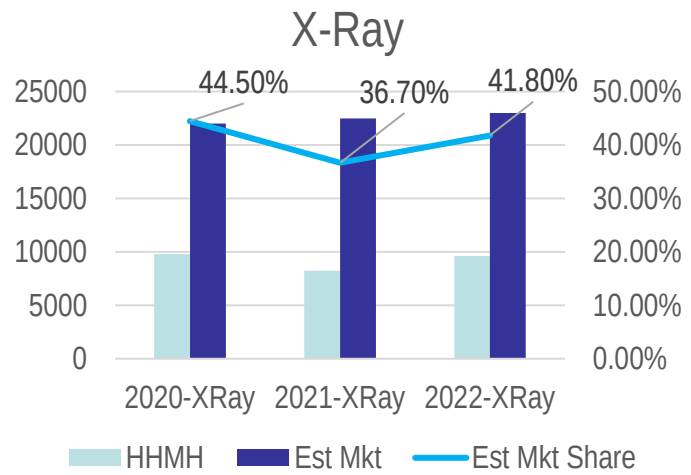
- Provider Recruitment Strategies:
  - Precepting APP Students
  - Precepting Medical Students
  - National Search Firms
  - Internal Provider Recruiter

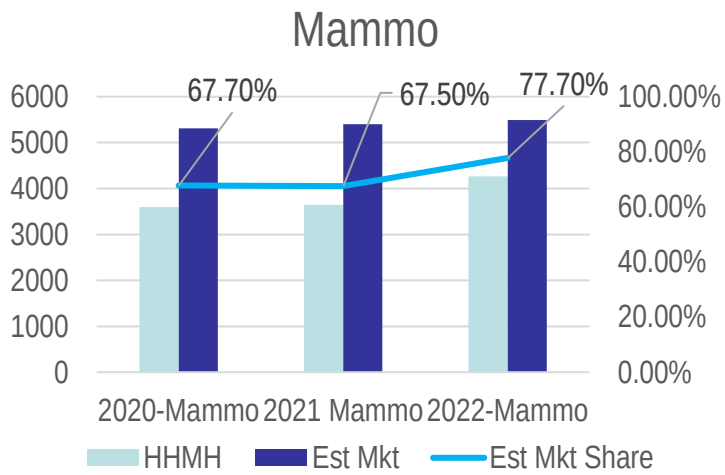
- Outpatient Imaging
  - Payor preference for non-hospital services which don't exist in Hollister.



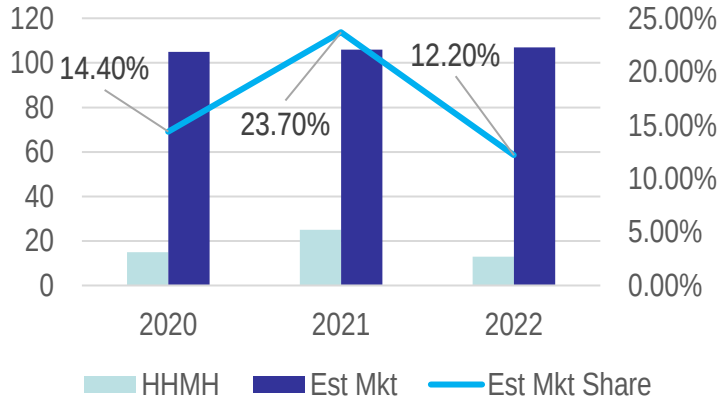



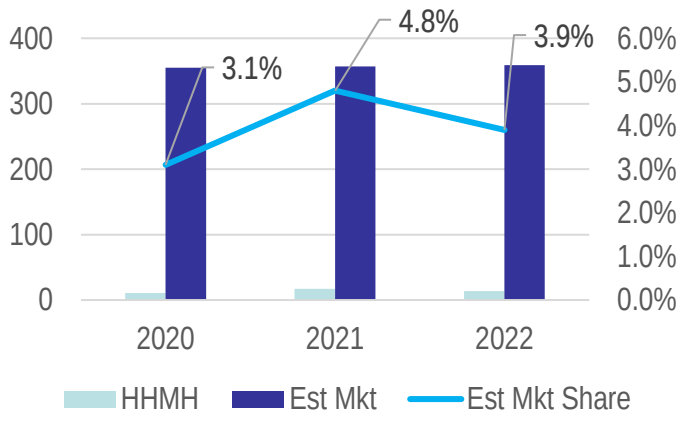



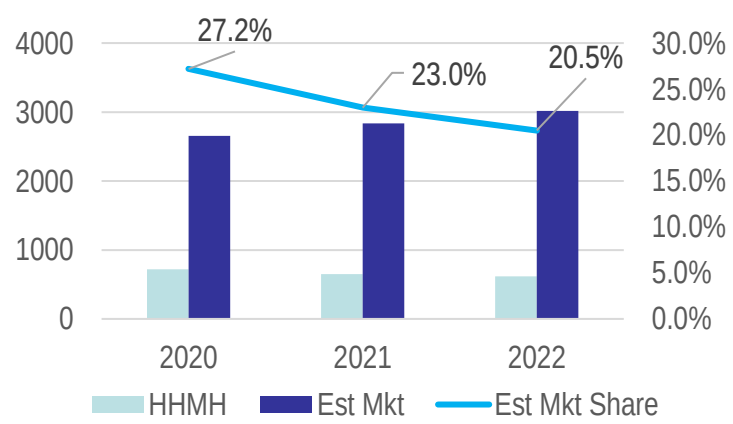
## Breast Surgery



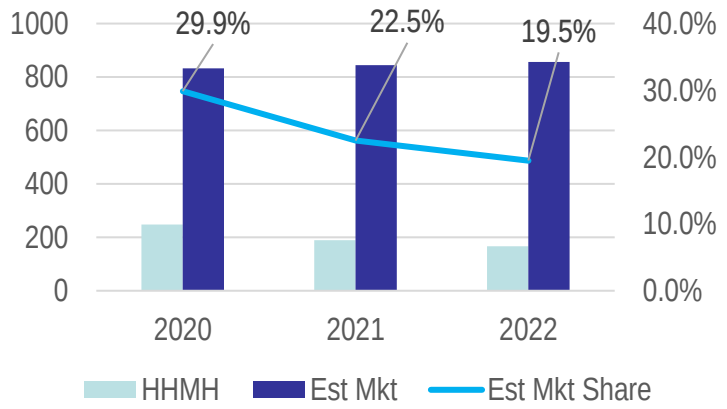

## ENT



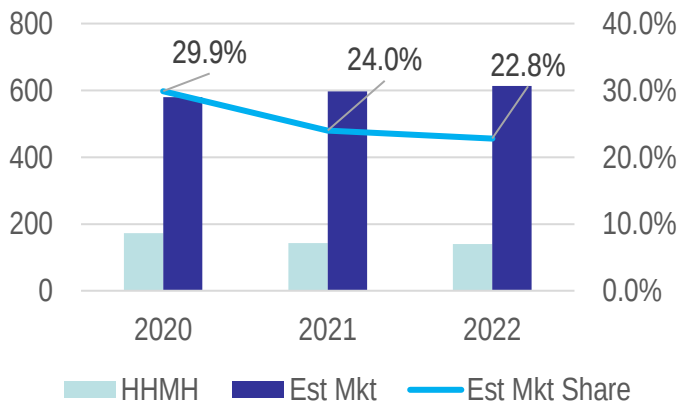

## GI/Endo



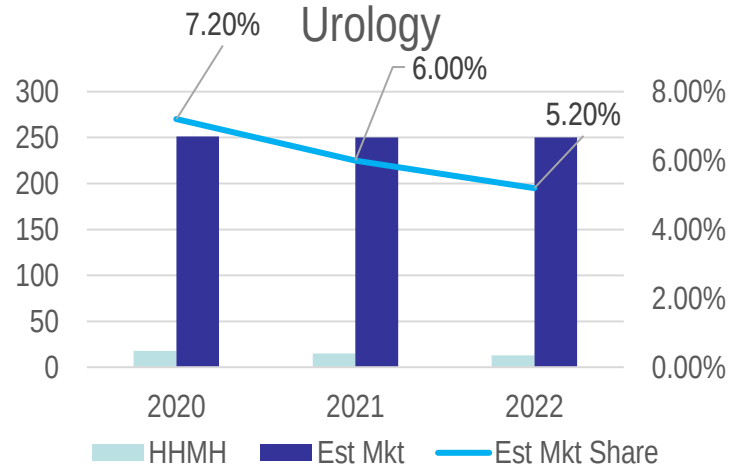

## General Surgery




## Ortho




## Urology



- Surgical Services:
  - General Surgery
    - Breast Program Development
    - Bariatrics
  - Orthopedic Surgery
    - Joint Replacement
- Gastroenterology
  - Endo Procedures
- Urology
  - Lithotripsy
  - Prostate

- Medical Oncology
  - Infusion
  - Clinic
- Non-Chemo Infusion
- Cardiac Imaging/NI Vascular

- Other Ideas/Considerations?

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# Course Direction

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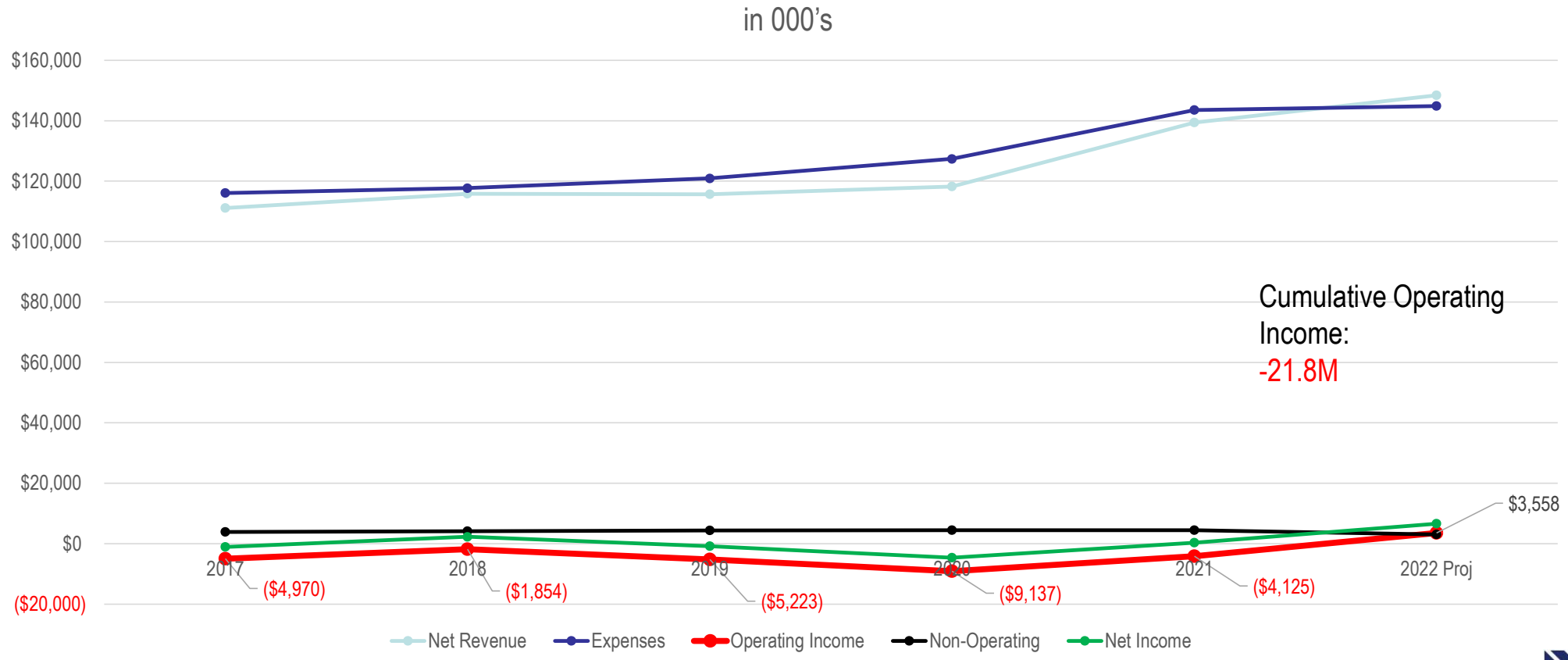
- Priorities from workshop:
  1) Provider Recruitment
     A) Primary Care Recruitment
     B) Medical Office Building Development
  2) Practice Management
  3) Breast Surgery Program
  4) Outpatient GI
  5) Outpatient Imaging

- Re-Ordered Priorities, considering cost and time factors:
  1) Outpatient GI
     - Relatively low cost of expanding services in current GI Procedure room in ASC.
     - Contract opportunity in progress.
  2) Breast Surgery Program
     - Relatively low cost of adding Mammotome to expand service capabilities.
  3) Practice Management
     - Work on referral patterns for surgical and GI services.
       – Data Sources (Optum vs. Internal)
     - Imaging data sharing to improve reporting of imaging back to providers.
  4) Provider Recruitment
     - Primary Care Providers
     - New Primary Care office in same complex as MSC, if space is still available for lease.

# ADAMS Salaries and Benefits Analysis

# HHMH Financial Trends




Cumulative Operating Income:
-21.8M

# 2020 Benchmark Comparison

| 2020 Comparison to CA Hospitals<br>Fiscal Year 2020 | Revenues/Expenses per Adjusted Patient Day<br>Hazel Hawkins Memorial Hospital | Best Comparable Non-System Facilities | Broader Comparison Group | Variance to Best Comparables | | Variance to Broader Comparison Group | |
|---|---|---|---|---|---|---|---|
| **Gross Patient Revenue** | $ 2,537.05 | $ 2,485.48 | $ 2,763.20 | $ 51.57 | $ 6,029,049 | $(226.15) | $ (26,439,197) |
| Deductions from Revenue | $ 1,644.99 | $ 1,522.77 | $ 1,689.12 | $ 122.22 | $ 14,288,740 | $ (44.13) | $ (5,159,238) |
| **Net Patient Revenue** | $ 892.06 | $ 962.71 | $ 1,074.08 | $ (70.65) | $ (8,259,691) | $(182.02) | $ (21,279,958) |
| Other Operating Revenue | $ 108.39 | $ 70.72 | $ 58.28 | $ 37.67 | $ 4,404,000 | $ 50.11 | $ 5,858,360 |
| **Total Operating Revenue** | $ 1,000.45 | $ 1,033.43 | $ 1,132.36 | $ (32.98) | $ (3,855,692) | $(131.91) | $ (15,421,598) |
| **Expenses** | | | | | | | |
| Salaries & Wages | $ 419.10 | $ 384.92 | $ 407.03 | $ (34.18) | $ (3,995,984) | $ (12.07) | $ (1,411,104) |
| Employee Benefits | $ 234.24 | $ 151.27 | $ 150.12 | $ (82.97) | $ (9,700,023) | $ (84.12) | $ (9,834,469) |
| Physician Pro. Fees | $ 122.20 | $ 92.15 | $ 77.46 | $ (30.05) | $ (3,513,146) | $ (44.74) | $ (5,230,553) |
| Other Pro. Fees | $ 34.88 | $ 47.59 | $ 47.93 | $ 12.71 | $ 1,485,926 | $ 13.05 | $ 1,525,676 |
| Supplies | $ 91.18 | $ 115.09 | $ 110.27 | $ 23.91 | $ 2,795,318 | $ 19.09 | $ 2,231,812 |
| Purchased Services | $ 92.66 | $ 105.91 | $ 164.28 | $ 13.25 | $ 1,549,058 | $ 71.62 | $ 8,373,094 |
| Depreciation | $ 35.63 | $ 49.32 | $ 42.41 | $ 13.69 | $ 1,600,498 | $ 6.78 | $ 792,650 |
| Leases & Rentals | $ 15.24 | $ 14.58 | $ 18.53 | $ (0.66) | $ (77,161) | $ 3.29 | $ 384,634 |
| Insurance | $ 2.32 | $ 7.86 | $ 7.95 | $ 5.54 | $ 647,681 | $ 5.63 | $ 658,203 |
| Interest | $ 15.24 | $ 16.47 | $ 19.81 | $ 1.23 | $ 143,799 | $ 4.57 | $ 534,279 |
| All Other Expenses | $ 26.49 | $ 50.89 | $ 60.04 | $ 24.40 | $ 2,852,604 | $ 33.55 | $ 3,922,331 |
| **Total Operating Expenses** | $ 1,089.18 | $ 1,036.05 | $ 1,105.83 | $ (53.13) | $ (6,211,428) | $ 16.65 | $ 1,946,551 |
| **Operating Income** | $ (88.73) | $ (2.62) | $ 26.53 | $ (86.11) | $ 2,355,737 | $(115.26) | $ (17,368,150) |
| Non-Operating Income/Expense | $ 48.93 | $ 80.91 | $ 86.74 | $ (31.98) | $ (3,738,782) | $ (37.81) | $ (4,420,367) |
| **Net Income** | $ (39.80) | $ 78.29 | $ 113.27 | $(118.09) | $ (1,383,045) | $(153.07) | $ (21,788,517) |
| Salaries & Wages (% Net Rev) | 41.9% | 37.2% | 35.9% | | | | |
| Benefits Load (% Salaries & Wages) | 55.9% | 39.3% | 36.9% | | | | |

Source: HCAi

# 2020 Benchmark Comparison

| 2020 Comparison to CA Hospitals<br>Fiscal Year 2020 | Hazel Hawkins Memorial Hospital | Best Comparable Non-System Facilities | Broader Comparison Group |
|---|---|---|---|
| **Hours per Adjusted Patient Day** | | | |
| Management & Supervision | 0.85 | 1.09 | 1.14 |
| Technical & Specialist | 1.77 | 2.06 | 2.11 |
| Registered Nurses | 1.63 | 1.81 | 1.95 |
| Licensed Voc. Nurses | 0.32 | 0.44 | 0.59 |
| Aides & Orderlies | 1.10 | 1.04 | 1.26 |
| Clerical & Other Admin. | 1.42 | 2.13 | 1.84 |
| Environ. & Food Services | 0.92 | 0.95 | 0.99 |
| All Other Employees | 0.31 | 1.00 | 0.84 |
| **Total Productive Hours** | 8.32 | 10.52 | 10.72 |
| | | | |
| **Total Paid Hours** | 9.95 | 12.09 | 12.31 |
| *% Non Productive* | *16.4%* | *13.0%* | *12.9%* |
| | | | |
| **Patient Days** | *35,895* | *24,474* | *21,078* |
| General Acute | *4,267* | *3,189* | *3,172* |
| Psych | - | - | 584 |
| Rehab | - | - | - |
| LTC | 31,628 | 21,285 | 17,322 |
| *% LTC* | *88.1%* | *87.0%* | *82.2%* |
| | | | |
| **Adjusted Patient Days** | 116,910 | 72,932 | 54,614 |

Source: HCAi

# 2020 Benchmark Comparison

| Best Comparable Non-System Facilities | Broader Comparison Group |
|---|---|
| BARTON MEMORIAL HOSPITAL | ALAMEDA HOSPITAL |
| CENTRAL VALLEY SPECIALTY HOSPITAL | BARTON MEMORIAL HOSPITAL |
| EASTERN PLUMAS HEALTH CARE | BEAR VALLEY COMMUNITY HOSPITAL |
| GEORGE L. MEE MEMORIAL HOSPITAL | CATALINA ISLAND MEDICAL CENTER |
| HAZEL HAWKINS MEMORIAL HOSPITAL | CENTRAL VALLEY SPECIALTY HOSPITAL |
| KERN VALLEY HOSPITAL DISTRICT | CHILDREN'S HEALTHCARE ORGANIZATION OF NO CA - PEDIATRIC HOSP |
| LOMPOC VALLEY MEDICAL CENTER | EASTERN PLUMAS HEALTH CARE |
| MAYERS MEMORIAL HOSPITAL | GEORGE L. MEE MEMORIAL HOSPITAL |
| MODOC MEDICAL CENTER | HAZEL HAWKINS MEMORIAL HOSPITAL |
| OAK VALLEY HOSPITAL DISTRICT | HEALDSBURG DISTRICT HOSPITAL |
| OJAI VALLEY COMMUNITY HOSPITAL | HEALTHBRIDGE CHILDREN'S HOSPITAL - ORANGE |
| ORCHARD HOSPITAL | JEROLD PHELPS COMMUNITY HOSPITAL |
| RIDGECREST REGIONAL HOSPITAL | JOHN C. FREMONT HEALTHCARE DISTRICT |
| SONOMA VALLEY HOSPITAL | KERN VALLEY HOSPITAL DISTRICT |
| TAHOE FOREST HOSPITAL | LOMPOC VALLEY MEDICAL CENTER |
| | MAYERS MEMORIAL HOSPITAL |
| | MODOC MEDICAL CENTER |
| | MOUNTAINS COMMUNITY HOSPITAL |
| | OAK VALLEY HOSPITAL DISTRICT |
| | OJAI VALLEY COMMUNITY HOSPITAL |
| | ORCHARD HOSPITAL |
| | PACIFICA HOSPITAL OF THE VALLEY |
| | POMERADO HOSPITAL |
| | RIDGECREST REGIONAL HOSPITAL |
| | SENECA HEALTHCARE DISTRICT |
| | SONOMA VALLEY HOSPITAL |
| | SOUTHERN INYO HOSPITAL |
| | SURPRISE VALLEY COMMUNITY HOSPITAL |
| | TAHOE FOREST HOSPITAL |
| | TRINITY HOSPITAL |
| | WEST COVINA MEDICAL CENTER |

Source: HCAi

# ADAMS Financial Pro-Forma Projection

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MEMORIAL HOSPITAL

# Financial Pro-Forma Projection

## *Hazel Hawkins Memorial Hospital*

*February 14, 2022*


ADAMS®

- Critical Access Status:
  - Critical Access status remains through FY 2022.
  - IP Revenue per case returns to pre-CAH status averages in FY 2023.
- Revenues:
  - Gross charges increase 2% annually.
  - Annual net revenue/case increases 2%.
- Expenses:
  - Variable expenses grow with volumes plus 2% inflation.
  - Fixed expenses grow by 2% inflation.

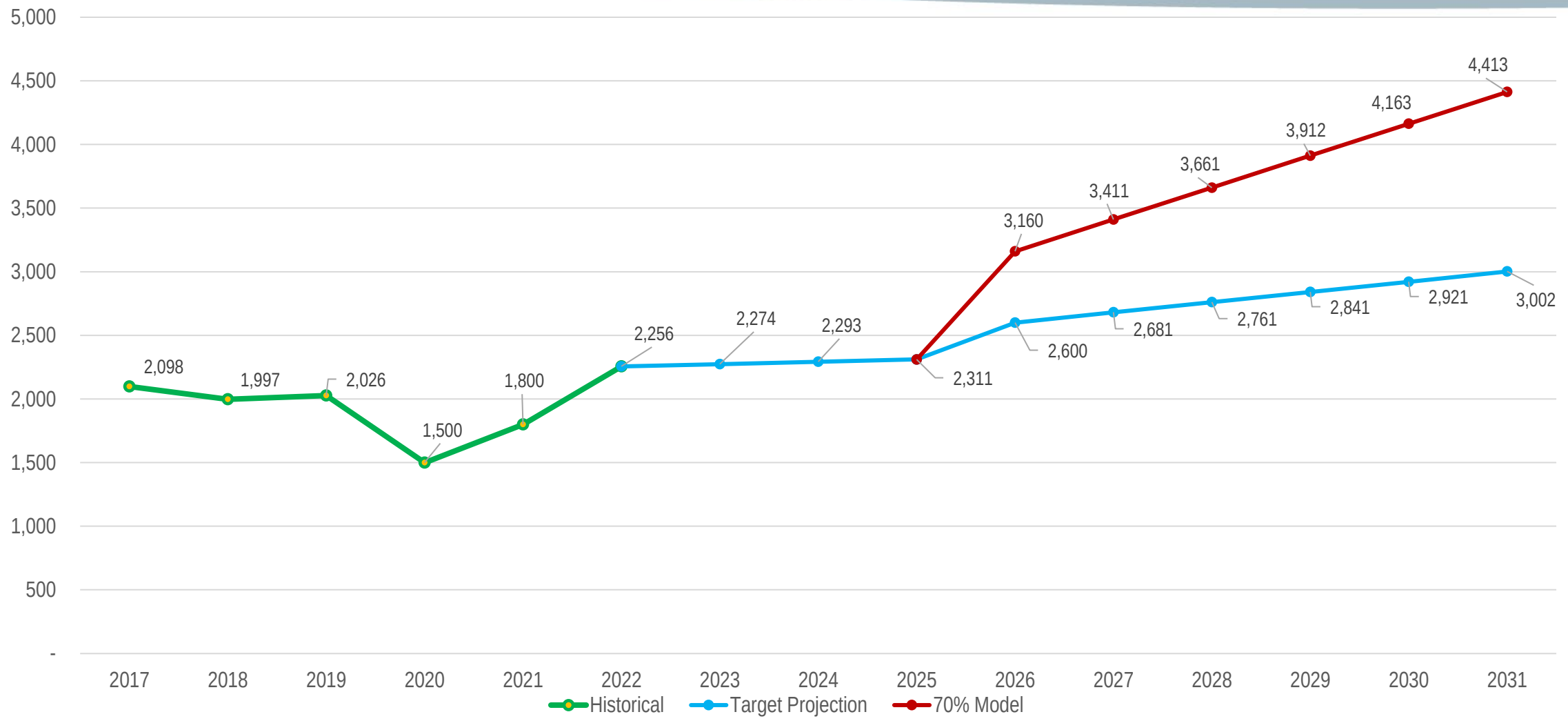
- Salaries & Wages:
  - Variable departments grow with volumes.
  - Wages increase annually at the lower of prior 3 years rate or 4%.
  - Productivity & Registry targets from Quorum report achieved over 5 years.
- Benefits:
  - Health Benefits inflate at 5% plus change in FTEs (historical average-9%).
  - All other benefits inflate based on historical percentage of paid Salaries & Wages.
- Volume Models:
  - Target Model from Master Plan is the low-performance model.
  - 70% Model from Master Plan is the high-performance model.
- Capital Investment is based on a greenfield replacement facility.
  - Includes development of ambulatory property currently under consideration.

Hazel Hawkins
MEMORIAL HOSPITAL

# Financial Model Comparisons

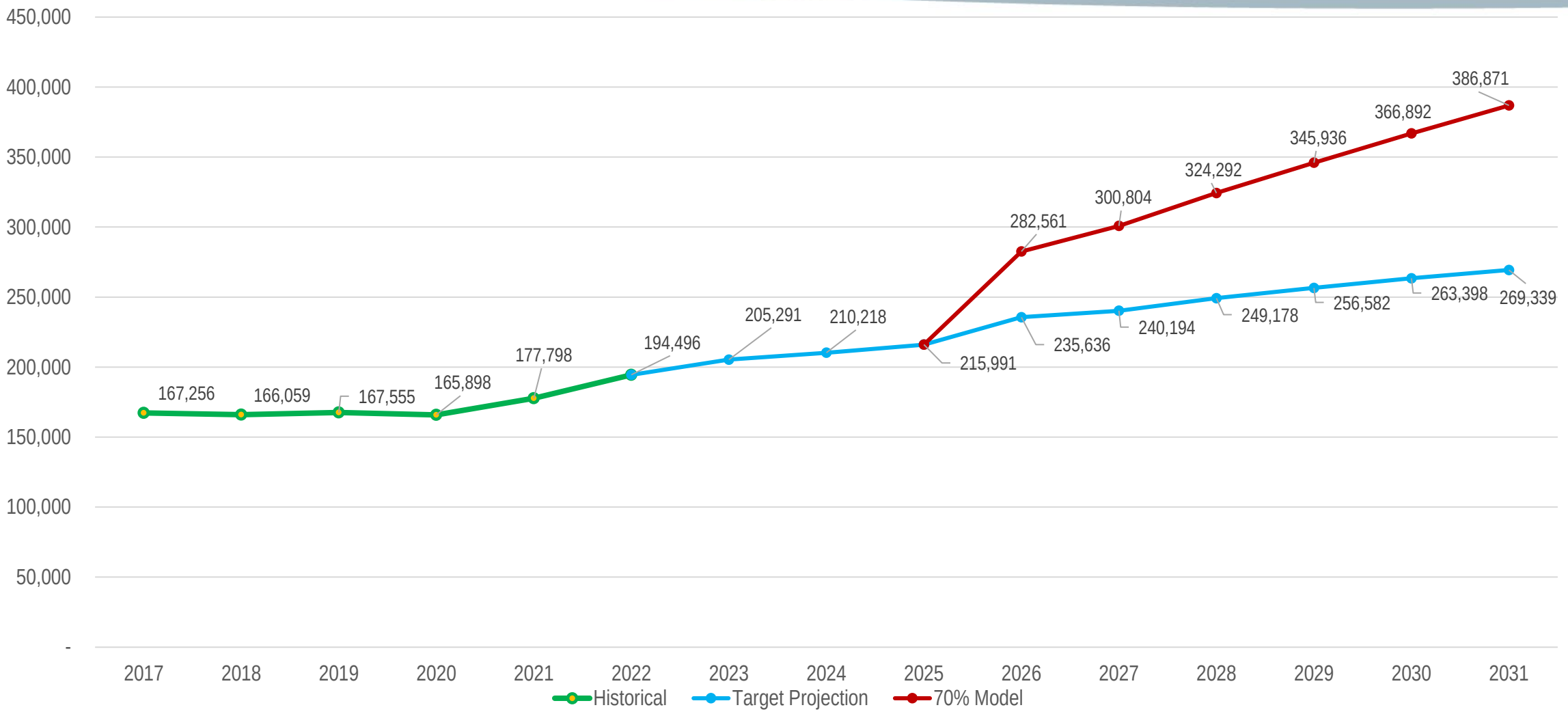

ADAMS®

# IP Discharges
*2017-2031*



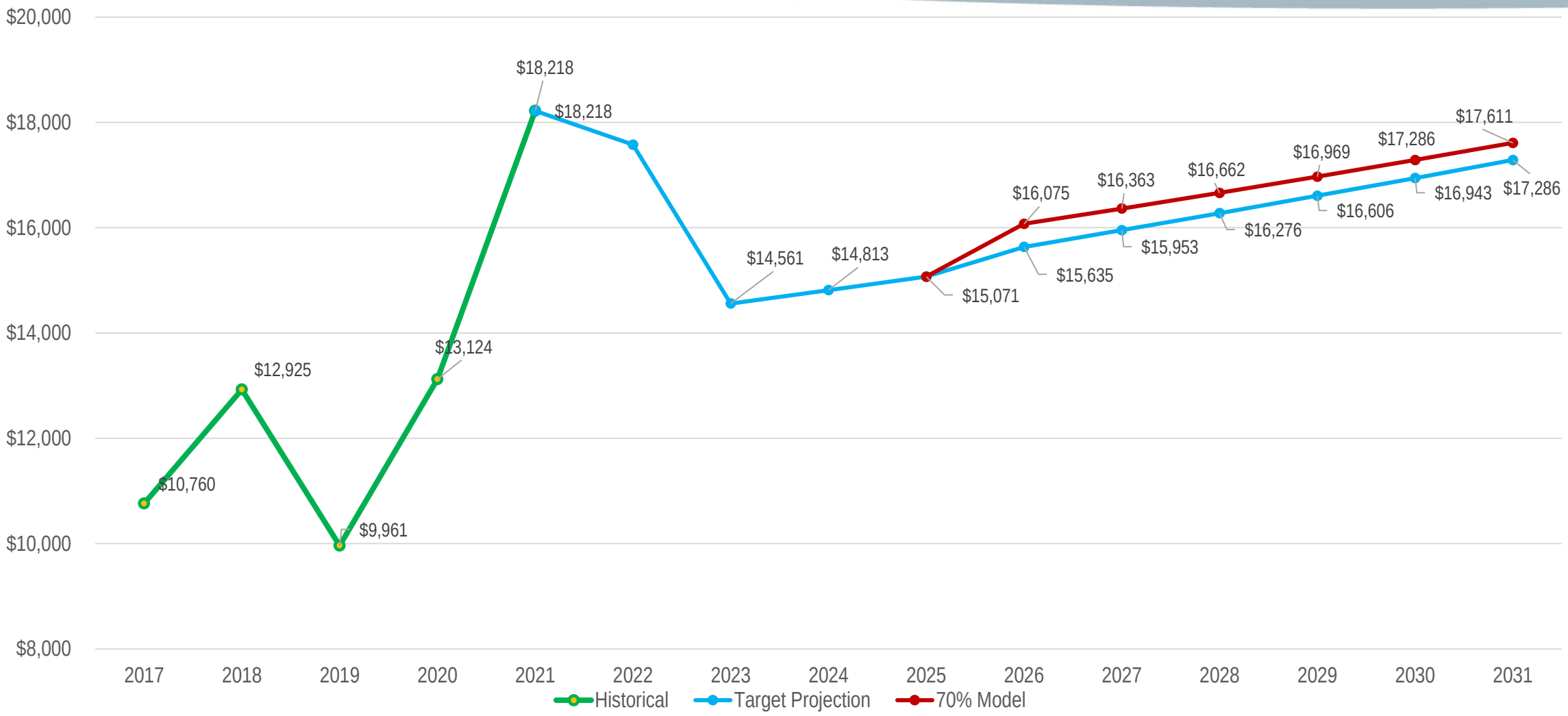
# Outpatient Encounters

*2017-2031*



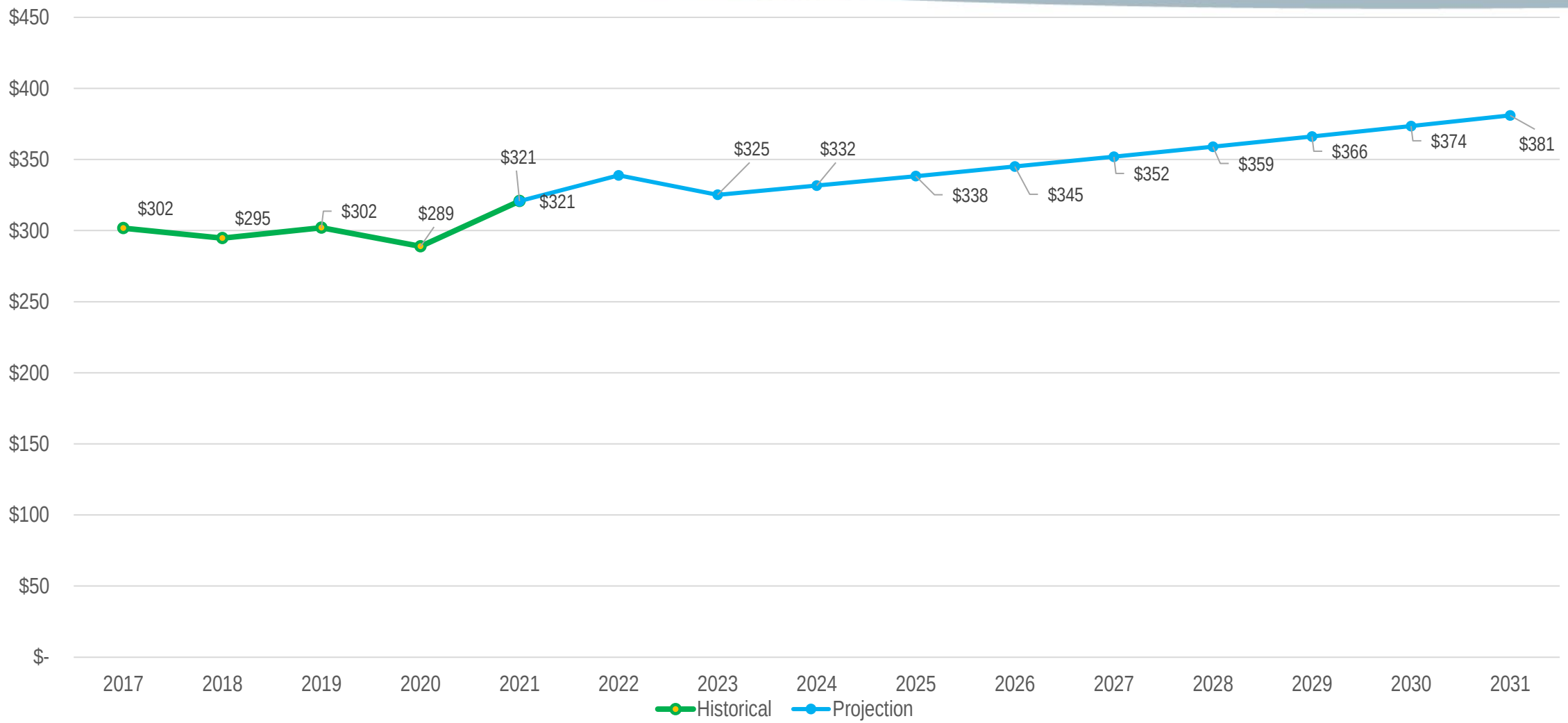
# IP Net Revenue per Case

*2017-2031*



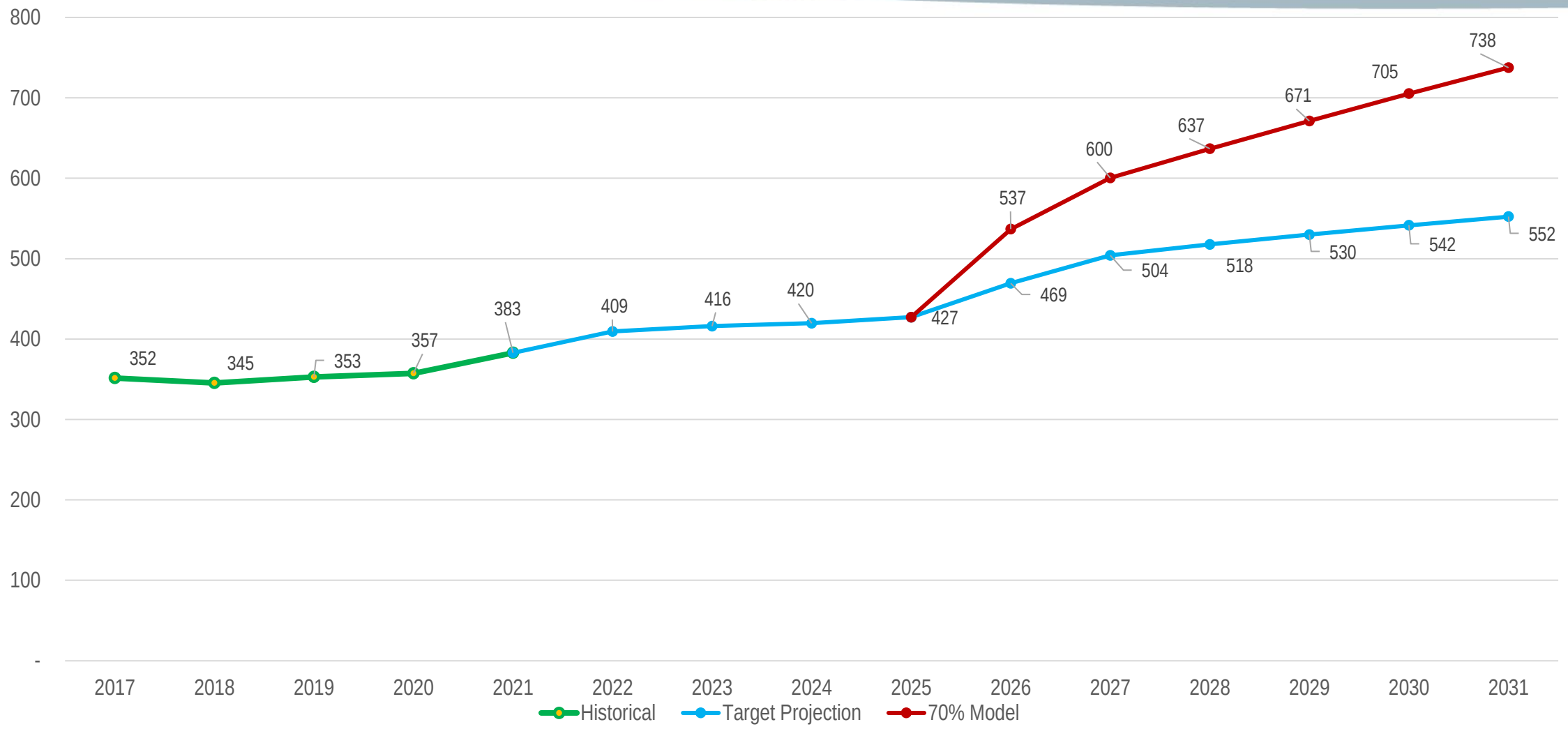
# OP Net Revenue per Encounter

*2017-2031*



# Hospital FTEs

*2017-2031*



| Hazel Hawkins Memorial Hospital<br>Income Statement Projections-Target Model Volumes<br>FYE 06/30 | 2017 | 2018 | 2019 | 2020 | 2021 | Projection Period 2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Revenues** | | | | | | | | | | | | | | | |
| Gross Charges | $ 356,475,851 | $ 358,711,116 | $ 351,936,025 | $ 300,688,046 | $ 338,361,316 | $ 399,502,192 | $ 426,914,739 | $ 447,366,754 | $ 469,603,941 | $ 528,695,201 | $ 553,569,223 | $ 585,441,303 | $ 616,218,179 | $ 647,122,034 | $ 677,829,235 |
| Contractuals | (247,934,800) | (245,441,158) | (239,383,563) | (192,314,789) | (207,277,580) | (253,174,567) | (282,503,359) | (295,406,323) | (309,563,841) | (350,673,246) | (367,813,803) | (390,208,503) | (411,781,275) | (433,533,389) | (455,137,728) |
| Net Patient Revenues | 108,541,051 | 113,269,957 | 112,552,463 | 108,373,257 | 131,083,736 | 146,327,625 | 144,411,380 | 151,960,431 | 160,040,099 | 178,021,955 | 185,755,420 | 195,232,800 | 204,436,905 | 213,588,645 | 222,691,507 |
| Other Operating Revenues | 2,563,675 | 2,552,266 | 3,124,099 | 9,864,665 | 8,328,243 | 2,190,864 | 2,208,681 | 2,226,855 | 2,245,392 | 2,264,299 | 1,083,585 | 1,103,257 | 1,123,322 | 1,143,789 | 1,164,665 |
| **Net Revenues** | **111,104,726** | **115,822,223** | **115,676,562** | **118,237,922** | **139,411,979** | **148,518,489** | **146,620,061** | **154,187,285** | **162,285,491** | **180,286,254** | **186,839,005** | **196,336,057** | **205,560,227** | **214,732,434** | **223,856,172** |
| **Expenses** | | | | | | | | | | | | | | | |
| Salaries & Wages | 46,049,464 | 46,856,060 | 49,053,172 | 51,645,119 | 60,520,498 | 61,924,816 | 65,711,032 | 69,186,115 | 73,405,931 | 82,348,672 | 89,961,998 | 95,225,165 | 100,550,012 | 105,995,612 | 111,573,579 |
| Benefits | 23,187,583 | 23,503,771 | 24,818,372 | 27,385,123 | 30,371,736 | 32,008,550 | 34,301,726 | 35,852,249 | 37,707,233 | 41,578,793 | 44,610,542 | 46,509,569 | 48,388,531 | 50,264,259 | 52,154,536 |
| Professional Fees | 13,382,296 | 13,890,751 | 14,200,621 | 15,596,203 | 16,613,614 | 17,062,349 | 18,084,699 | 19,251,372 | 20,421,379 | 21,523,359 | 22,628,809 | 23,666,369 | 24,707,539 | 25,609,536 | 26,515,288 |
| Supplies | 10,622,928 | 10,836,043 | 10,522,582 | 10,942,052 | 12,451,021 | 14,063,786 | 14,828,311 | 15,455,059 | 16,138,543 | 17,975,480 | 18,677,425 | 19,593,734 | 20,462,266 | 21,317,482 | 22,155,341 |
| Purchased Services | 11,392,844 | 11,417,173 | 11,181,312 | 10,868,872 | 12,387,120 | 11,858,401 | 12,112,553 | 12,354,804 | 12,601,901 | 12,853,939 | 13,111,017 | 13,373,238 | 13,640,702 | 13,913,516 | 14,191,787 |
| Occupancy Expenses | 8,931,809 | 8,896,579 | 8,772,217 | 8,665,122 | 8,924,134 | 9,324,813 | 9,509,975 | 9,700,174 | 9,894,178 | 10,092,061 | 10,293,902 | 10,499,780 | 10,709,776 | 10,923,971 | 11,142,451 |
| Other Expenses | 514,928 | 353,448 | 538,462 | 525,090 | 453,845 | 592,413 | 609,878 | 622,075 | 634,517 | 647,207 | 660,151 | 673,354 | 686,821 | 700,558 | 714,569 |
| Interest Expense | 1,993,088 | 1,921,985 | 1,813,128 | 1,747,885 | 1,814,927 | 1,562,309 | 1,421,162 | 1,301,347 | 1,175,373 | 1,043,261 | 904,611 | 767,163 | 637,461 | 500,484 | 430,853 |
| **Total Expenses** | **116,074,941** | **117,675,809** | **120,899,867** | **127,375,465** | **143,536,895** | **148,397,437** | **156,579,336** | **163,723,195** | **171,979,053** | **188,062,772** | **200,848,455** | **210,308,372** | **219,783,108** | **229,225,419** | **238,878,404** |
| **Other Non Operating Revenues/Expenses** | **3,875,060** | **4,119,445** | **4,394,431** | **4,484,948** | **4,424,968** | **3,745,613** | **3,820,525** | **3,896,936** | **3,974,874** | **4,054,372** | **4,135,459** | **4,218,168** | **4,302,532** | **4,388,582** | **4,476,354** |
| **Net Income** | **(1,095,155)** | **2,265,859** | **(828,873)** | **(4,652,595)** | **300,052** | **3,866,664** | **(6,138,750)** | **(5,638,975)** | **(5,718,687)** | **(3,722,146)** | **(9,873,991)** | **(9,754,147)** | **(9,920,350)** | **(10,104,403)** | **(10,545,878)** |
| **Additional Depreciation** | - | - | - | - | - | - | - | 258,333 | 258,333 | 11,529,167 | 12,471,301 | 12,471,301 | 12,471,301 | 12,471,301 | 12,471,301 |
| **Additional Interest Expense** | - | - | - | - | - | - | - | 187,500 | 184,015 | 8,992,899 | 9,655,424 | 9,466,157 | 9,269,792 | 9,066,063 | 8,854,695 |
| **Adjusted Net Income** | **$ (1,095,155)** | **$ 2,265,859** | **$ (828,873)** | **$ (4,652,595)** | **$ 300,052** | **$ 3,866,664** | **$ (6,138,750)** | **$ (6,084,808)** | **$ (6,161,036)** | **$ (24,244,212)** | **$ (32,000,717)** | **$ (31,691,605)** | **$ (31,661,443)** | **$ (31,641,768)** | **$ (31,871,874)** |
| **Net Income by Funstional Operation** | | | | | | | | | | | | | | | |
| Hosptial | $ 2,611,772 | $ 6,571,353 | $ 3,538,511 | $ 1,824,253 | $ 9,906,866 | $ 13,052,042 | $ 3,711,998 | $ 5,054,485 | $ 5,904,846 | $ (11,217,566) | $ (15,905,563) | $ (14,311,889) | $ (12,921,515) | $ (11,599,365) | $ (10,458,703) |
| Clinics | (3,920,092) | (4,841,989) | (5,789,250) | (7,721,191) | (7,044,144) | (7,902,691) | (8,387,032) | (9,446,826) | (10,069,481) | (10,644,090) | (13,020,735) | (13,560,297) | (14,113,110) | (14,558,308) | (15,019,317) |
| Home Health | 239,744 | 480,952 | 184,387 | 513,293 | (755,801) | (589,117) | (732,660) | (813,854) | (902,434) | (998,742) | (1,106,177) | (1,221,783) | (1,346,120) | (1,479,779) | (1,623,392) |
| SNF | (26,579) | 55,544 | 1,237,479 | 731,051 | (1,806,870) | (693,570) | (731,055) | (878,613) | (1,093,967) | (1,383,813) | (1,968,243) | (2,597,636) | (3,280,698) | (4,004,316) | (4,770,462) |
| **Net Income** | **$ (1,095,155)** | **$ 2,265,859** | **$ (828,873)** | **$ (4,652,595)** | **$ 300,052** | **$ 3,866,664** | **$ (6,138,750)** | **$ (6,084,808)** | **$ (6,161,036)** | **$ (24,244,212)** | **$ (32,000,717)** | **$ (31,691,605)** | **$ (31,661,443)** | **$ (31,641,768)** | **$ (31,871,874)** |

| Hazel Hawkins Memorial Hospital<br>Income Statement Projections-70% Volume Model<br>FYE 06/30 | 2017 | 2018 | 2019 | 2020 | 2021 | Projection Period<br>2022 | 2023 | 2024 | 2025 | 2026 | 2027 | 2028 | 2029 | 2030 | 2031 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Revenues** | | | | | | | | | | | | | | | |
| Gross Charges | $ 356,475,851 | $ 358,711,116 | $ 351,936,025 | $ 300,688,046 | $ 338,361,316 | $ 399,502,192 | $ 426,914,739 | $ 447,366,754 | $ 469,603,941 | $ 629,349,606 | $ 684,937,609 | $ 750,053,374 | $ 815,173,803 | $ 881,793,469 | $ 949,629,650 |
| Contractuals | (247,934,800) | (245,441,158) | (239,383,563) | (192,314,789) | (207,277,580) | (253,174,567) | (282,503,359) | (295,406,323) | (309,563,841) | (424,998,983) | (464,804,287) | (511,787,914) | (558,814,165) | (607,090,570) | (656,324,348) |
| Net Patient Revenues | 108,541,051 | 113,269,957 | 112,552,463 | 108,373,257 | 131,083,736 | 146,327,625 | 144,411,380 | 151,960,431 | 160,040,099 | 204,350,623 | 220,133,322 | 238,265,460 | 256,359,639 | 274,702,898 | 293,305,301 |
| Other Operating Revenues | 2,563,675 | 2,552,266 | 3,124,099 | 9,864,665 | 8,328,243 | 2,190,864 | 2,208,681 | 2,226,855 | 2,245,392 | 2,264,299 | 1,083,585 | 1,103,257 | 1,123,322 | 1,143,789 | 1,164,665 |
| **Net Revenues** | **111,104,726** | **115,822,223** | **115,676,562** | **118,237,922** | **139,411,979** | **148,518,489** | **146,620,061** | **154,187,285** | **162,285,491** | **206,614,923** | **221,216,908** | **239,368,717** | **257,482,961** | **275,846,687** | **294,469,966** |
| **Expenses** | | | | | | | | | | | | | | | |
| Salaries & Wages | 46,049,464 | 46,856,060 | 49,053,172 | 51,645,119 | 60,520,498 | 61,924,816 | 65,731,246 | 69,228,160 | 73,471,521 | 91,203,812 | 102,831,683 | 111,547,652 | 120,493,384 | 129,753,433 | 139,224,173 |
| Benefits | 23,187,583 | 23,503,771 | 24,818,372 | 27,385,123 | 30,371,736 | 32,008,550 | 34,304,229 | 35,857,454 | 37,715,353 | 45,373,860 | 50,061,407 | 53,297,265 | 56,524,421 | 59,768,719 | 63,005,372 |
| Professional Fees | 13,382,296 | 13,890,751 | 14,200,621 | 15,596,203 | 16,613,614 | 17,062,349 | 18,084,699 | 19,251,372 | 20,421,379 | 21,523,359 | 22,628,809 | 23,666,369 | 24,707,539 | 25,609,536 | 26,515,288 |
| Supplies | 10,622,928 | 10,836,043 | 10,522,582 | 10,942,052 | 12,451,021 | 14,063,786 | 14,828,311 | 15,455,059 | 16,138,543 | 21,217,972 | 22,847,840 | 24,752,245 | 26,622,934 | 28,502,062 | 30,386,119 |
| Purchased Services | 11,392,844 | 11,417,173 | 11,181,312 | 10,868,872 | 12,387,120 | 11,858,401 | 12,112,553 | 12,354,804 | 12,601,901 | 12,853,939 | 13,111,017 | 13,373,238 | 13,640,702 | 13,913,516 | 14,191,787 |
| Occupancy Expenses | 8,931,809 | 8,896,579 | 8,772,217 | 8,665,122 | 8,924,134 | 9,324,813 | 9,509,975 | 9,700,174 | 9,894,178 | 10,092,061 | 10,293,902 | 10,499,780 | 10,709,776 | 10,923,971 | 11,142,451 |
| Other Expenses | 514,928 | 353,448 | 538,462 | 525,090 | 453,845 | 592,413 | 609,878 | 622,075 | 634,517 | 647,207 | 660,151 | 673,354 | 686,821 | 700,558 | 714,569 |
| Interest Expense | 1,993,088 | 1,921,985 | 1,813,128 | 1,747,885 | 1,814,927 | 1,562,309 | 1,421,162 | 1,301,347 | 1,175,373 | 1,043,261 | 904,611 | 767,163 | 637,461 | 500,484 | 430,853 |
| **Total Expenses** | **116,074,941** | **117,675,809** | **120,899,867** | **127,375,465** | **143,536,895** | **148,397,437** | **156,602,052** | **163,770,445** | **172,052,763** | **203,955,470** | **223,339,420** | **238,577,067** | **254,023,038** | **269,672,280** | **285,610,611** |
| **Other Non Operating Revenues/Expenses** | **3,875,060** | **4,119,445** | **4,394,431** | **4,484,948** | **4,424,968** | **3,745,613** | **3,820,525** | **3,896,936** | **3,974,874** | **4,054,372** | **4,135,459** | **4,218,168** | **4,302,532** | **4,388,582** | **4,476,354** |
| **Net Income** | **(1,095,155)** | **2,265,859** | **(828,873)** | **(4,652,595)** | **300,052** | **3,866,664** | **(6,161,466)** | **(5,686,225)** | **(5,792,397)** | **6,713,824** | **2,012,947** | **5,009,818** | **7,762,455** | **10,562,990** | **13,335,710** |
| **Additional Depreciation** | - | - | - | - | - | - | - | 258,333 | 258,333 | 11,529,167 | 12,471,301 | 12,471,301 | 12,471,301 | 12,471,301 | 12,471,301 |
| **Additional Interest Expense** | - | - | - | - | - | - | - | 187,500 | 184,015 | 8,992,899 | 9,655,424 | 9,466,157 | 9,269,792 | 9,066,063 | 8,854,695 |
| **Adjusted Net Income** | **$ (1,095,155)** | **$ 2,265,859** | **$ (828,873)** | **$ (4,652,595)** | **$ 300,052** | **$ 3,866,664** | **$ (6,161,466)** | **$ (6,132,058)** | **$ (6,234,746)** | **$ (13,808,241)** | **$ (20,113,779)** | **$ (16,927,640)** | **$ (13,978,638)** | **$ (10,974,375)** | **$ (7,990,287)** |
| **Net Income by Funstional Operation** | | | | | | | | | | | | | | | |
| Hosptial | $ 2,611,772 | $ 6,571,353 | $ 3,538,511 | $ 1,824,253 | $ 9,906,866 | $ 13,052,042 | $ 3,689,282 | $ 5,007,235 | $ 5,831,136 | $ (781,595) | $ (4,018,625) | $ 452,077 | $ 4,761,289 | $ 9,068,028 | $ 13,422,884 |
| Clinics | (3,920,092) | (4,841,989) | (5,789,250) | (7,721,191) | (7,044,144) | (7,902,691) | (8,387,032) | (9,446,826) | (10,069,481) | (10,644,090) | (13,020,735) | (13,560,297) | (14,113,110) | (14,558,308) | (15,019,317) |
| Home Health | 239,744 | 480,952 | 184,387 | 513,293 | (755,801) | (589,117) | (732,660) | (813,854) | (902,434) | (998,742) | (1,106,177) | (1,221,783) | (1,346,120) | (1,479,779) | (1,623,392) |
| SNF | (26,579) | 55,544 | 1,237,479 | 731,051 | (1,806,870) | (693,570) | (731,055) | (878,613) | (1,093,967) | (1,383,813) | (1,968,243) | (2,597,636) | (3,280,698) | (4,004,316) | (4,770,462) |
| **Net Income** | **$ (1,095,155)** | **$ 2,265,859** | **$ (828,873)** | **$ (4,652,595)** | **$ 300,052** | **$ 3,866,664** | **$ (6,161,466)** | **$ (6,132,058)** | **$ (6,234,746)** | **$ (13,808,241)** | **$ (20,113,779)** | **$ (16,927,640)** | **$ (13,978,638)** | **$ (10,974,375)** | **$ (7,990,287)** |

- Neither model represents a financeable scenario.

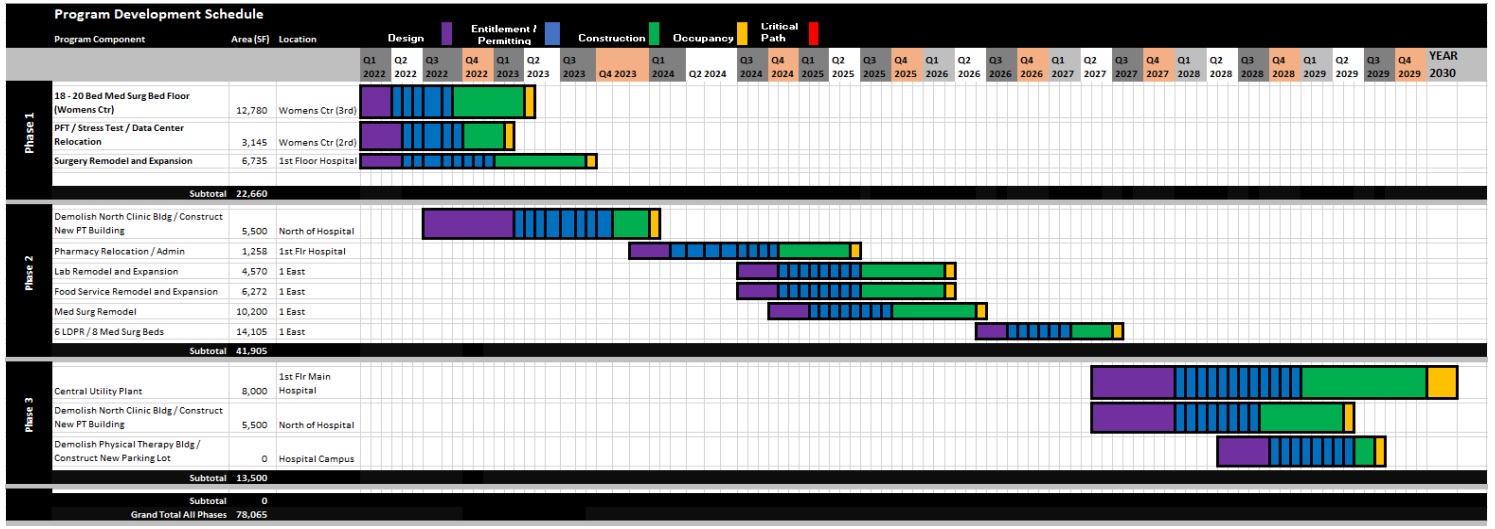
- 2020 Benchmark Comparison (CHHS Open Data) Shows:
  - Net Revenue:
    - For all comparable facilities, 12% below average. Approximately $14M negative variance. (Systems fare better on these metrics)
    - For comparable independent facilities, 1.7% below average. Approximately $1.9M negative variance.
  - Operating Expenses:
    - Salaries & Benefits expenses were $13M-$16M higher than benchmarks, whether compared to systems or independent facilities
      - FTEs did not drive this variance in 2020, Rates & Benefits were the drivers.
    - Purchased Services, Supplies & Professional Fees were favorable to benchmarks.
  - Overall Operating Income $9-$11M less than Benchmarks.

**Hazel Hawkins Memorial Hospital**
**Scenario 1**
**Option of Probable Costs**

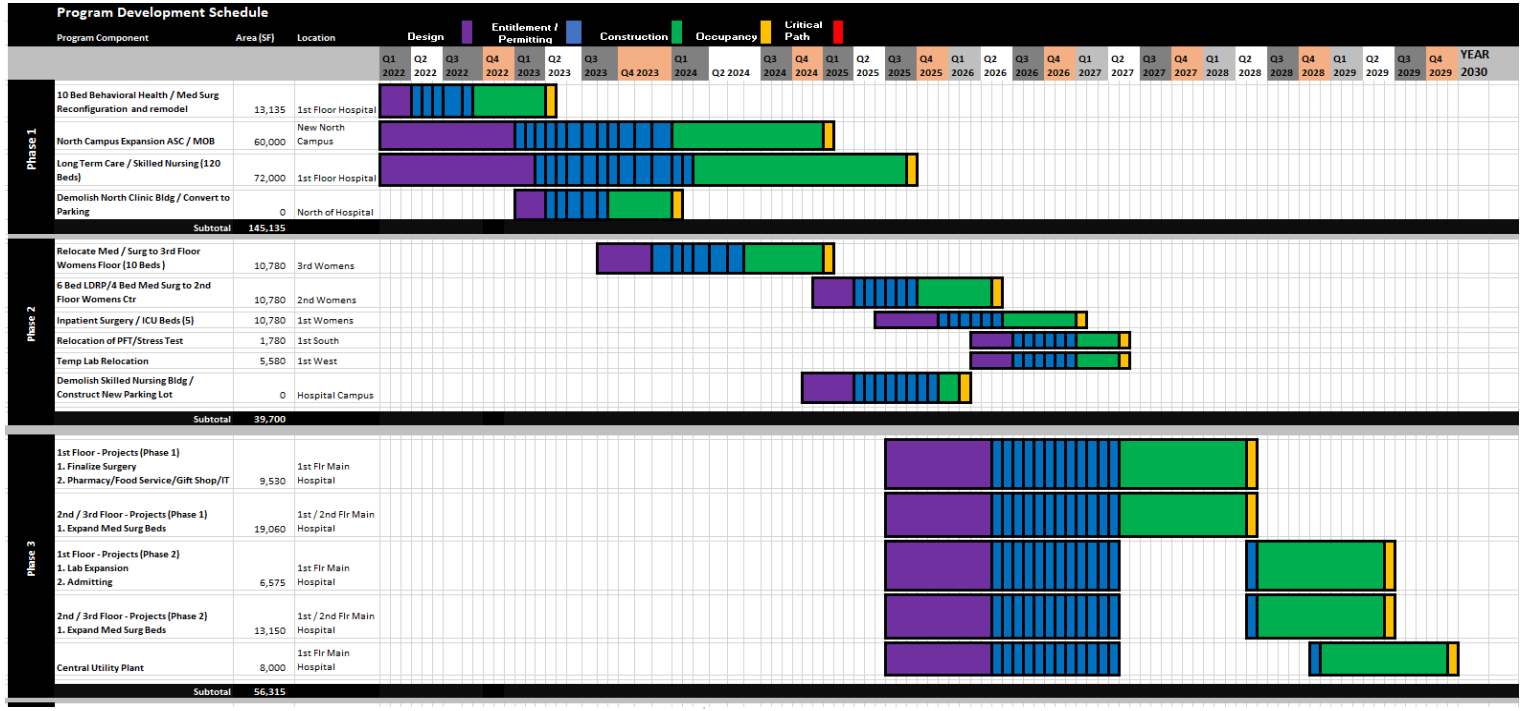
| | Total SF | | Projected Costs |
|---|---|---|---|
| Construction | 72,439 | | $ 67,893,399 |
| Construction/Design Contingency | | | $ 7,730,404 |
| Escalation | | 2-5 Years | $ 23,070,769 |
| Site Costs (Demo/Parking Lot Exp) | | | $ 2,383,000 |
| Soft Costs (Arch, Permits, Certification) | | | $ 13,001,134 |
| Equipment & Furnishings | | | $ 10,225,838 |
| IT Costs | | | $ 3,919,335 |
| Project Contingency | | | $ 5,257,655 |
| | | | $ 133,481,534 |
| Medical Office Building | | | $ 79,590,364 |
| Total Project | | | $ 213,071,899 |

- Projected Cost per Year of Life:
  - Hospital Only: $8.9M

- Renovation and Expansion of Facility:
  - Renovation will address Seismic Issues as well as accommodate ADA, Departmental adjacencies and other FGI Issues.
  - Expands capacity to approximately 60 Beds
  - Lengthy Phase Project
- Doesn't replace original infrastructure, likely 15-year life.



- Replacement of acute services located in buildings that are not compliant with seismic codes.
  - Expands capacity to approximately 60-70 Beds
  - Extremely disruptive to ongoing operations
- Doesn't replace all existing infrastructure, likely 25–30-year life.




**Hazel Hawkins Memorial Hospital**
**Scenario 2**
**Option of Probable Costs**

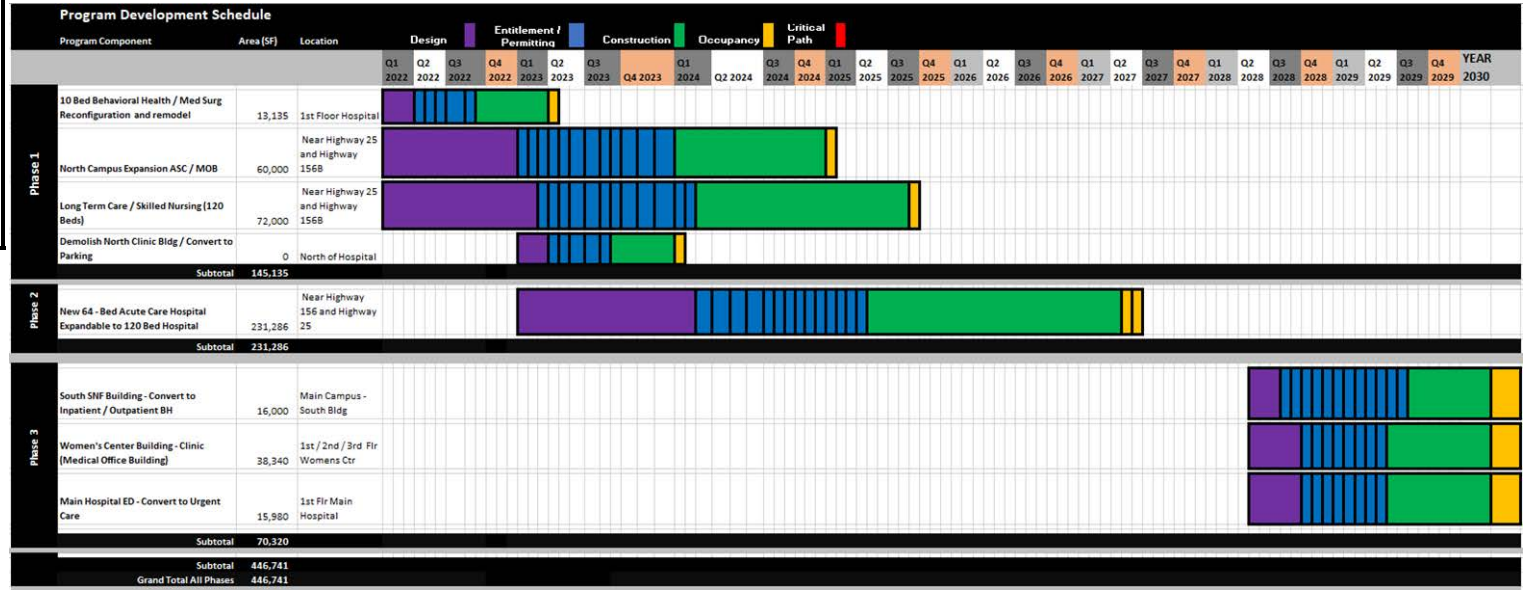
| | Total SF | | Projected Costs |
|---|---|---|---|
| Construction | 94,252 | | $ 104,533,372 |
| Construction/Design Contingency | | | $ 11,760,801 |
| Escalation | | 2-5 Years | $ 28,110,124 |
| Site Costs (Demo/Parking Lot Exp) | | | $ 2,383,000 |
| Soft Costs (Arch, Permits, Certification) | | | $ 19,779,529 |
| Equipment & Furnishings | | | $ 6,581,729 |
| IT Costs | | | $ 7,068,900 |
| Project Contingency | | | $ 7,605,367 |
| | | | $ 187,822,822 |
| Medical Office Building | | | $ 79,590,364 |
| Total Project | | | $ 267,413,186 |

- Projected Cost per Year of Life:
  - Hospital Only: $6.3M

**Hazel Hawkins Memorial Hospital**
**Recommended Direction-Replacement Hopsital**
**Option of Probable Costs**

| | Total SF | | Projected Costs |
|---|---|---|---|
| Construction | 100,000 | | $ 88,047,409 |
| Construction/Design Contingency | | | $ 12,268,627 |
| Escalation | | 4 Years | $ 43,295,447 |
| Site Costs (Demo/Parking Lot Exp) | | | $ 23,485,560 |
| Soft Costs (Arch, Permits, Certification) | | | $ 20,633,599 |
| Equipment & Furnishings | | | $ 28,462,500 |
| IT Costs | | | $ 7,500,000 |
| Project Contingency | | | $ 9,019,885 |
| | | | $ 232,713,026 |
| Buildout of 3-WC into New Clinic | | 1 Year | $ 9,458,435 |
| Renovation of 2-WC to Clinic | | 6 Years | $ 12,677,041 |
| Total Project | | | $ 245,390,068 |

- Replacement of the Acute Care Infrastructure provides a number of benefits.
  - Lowest Impact on current operations and fastest scenario to completion.
  - Leverages the existing campus to become the Ambulatory and Administrative site for the system.
  - Existing Hospital infrastructure can be redeveloped into additional sub-acute beds. (SNF, Psych, etc.)
- New Hospital infrastructure has a projected life of 40-70 years.




- Projected Cost per Year of Life:
  - Hospital Only: $5.8M over 40 years

Hazel Hawkins
MEMORIAL HOSPITAL

# Discussion


ADAMS®

**Attachment C**
**Summary of Proposed Benefit Modifications**

***DRAFT***

# SUMMARY OF PROPOSED BENEFITS MODIFICATIONS
## San Benito Health Care District d/b/a Hazel Hawkins Memorial Hospital

Prepared by:

Mary Casillas, Interim Chief Executive Officer
Mark Robinson, Chief Financial Officer
Carol Fox, Senior Managing Director, B. Riley Advisory Services

**DISCLAIMER**

**This summary of proposed benefits modifications is submitted in connection with the Pendency Plan dated May 22, 2023 and should be reviewed in connection therewith. The below summary sets forth a proposal concerning employee benefits modifications and does not implement employee benefits modifications. The proposal is subject to material change and the District reserves the right to implement alternative proposals with respect to employee benefits or other labor expenses.**

**Importantly, the District has not yet modified its current benefits in accordance with the below summary. Moreover, the District cannot modify employee benefits for employees represented by unions under collective bargaining agreements or memoranda of understanding with the District unless the District obtains the voluntary consent of the affected unions or addresses the related agreements in a bankruptcy case. If you are an employee represented by a union, you should contact your union representative for more information.**

Dated: May 22, 2023

## I.

## SUMMARY

This *Summary of Proposed Benefits Modifications* (the "Summary") outlines the proposed modifications to several categories of employee benefits (collectively, the "Benefits") necessary to effect a reduction in the labor costs of the San Benito Health Care District d/b/a Hazel Hawkins Memorial Hospital to achieve the cash flow targets set forth in the "Phase 1 Pendency Plan." The discussion of the proposed modifications are divided into five categories: (i) leave benefits; (ii) retirement plan benefits; (iii) health insurance benefits; (iv) standby compensation; and (v) education benefits.

As set forth more fully below, this Summary identifies the current Benefits with specific reference to the Benefits offered to each of the four unions (collectively, the "Unions") with represented employees at the District. The comparison is relevant because the agreements (collectively, the

"Agreements") the District maintains with the Unions establish a baseline of Benefits offered to both the represented employees and unrepresented employees.

The District's agreements and the associated Unions are as follows:

- The California Nurses Association ("CNA"), pursuant to that certain *Memorandum of Understanding Between San Benito Health Care District/Hazel Hawkins Hospital and The California Nurses Association (January 1, 2016 – December 31, 2019)* (the "CNA Agreement") as amended and supplemented by that certain *Tentative Agreement Reached July 18, 2022, Between the California Nurses Association and Hazel Hawkins Memorial Hospital* (the "CNA Ratified Agreement");

- National Union of Healthcare Workers ("NUHW"), pursuant to that certain *Collective Bargaining Agreement with San Benito Health Care District dba Hazel Hawkins Hospital (July 1, 2019 – June 30, 2022)* (the "NUHW Agreement");

- Engineers and Scientists of California, Local 20, IFPTE (AFL-CIO & CLC) ("ESC"), pursuant to that certain *Memorandum of Understanding* (as amended and supplemented from time to time, the "ESC Agreement");[3] and

- 17 active employees are represented by the California Licensed Vocational Nurses' Association, Inc. ("CLVNA" and, together with CNA, NUHW, and ESC, the "Unions"), pursuant to that certain *Memorandum of Understanding Between San Benito Health Care District and California Licensed Vocational Nurses' Association, Inc. (January 1, 2017 – November 30, 2018)* (the "CLVNA Agreement") as amended and supplemented by that certain *Tentative Agreement Reached August 28, 2022, between California Licensed Vocational LVNs' Association and Hazel Hawkins Memorial Hospital* (the "CLVNA Ratified Agreement").[4]

After identifying the relevant Benefits offered to represented employees of each Union under their respective Agreements, this Summary identifies the proposed modifications to the Benefits for all employees of the District. As set forth more fully in the accompanying Pendency Plan, the District anticipates that the Benefits modifications addressed in this Summary, if implemented, would result in an annual savings of $4.3 million to the District and permit the District to continue current operations, without a service reduction, through July 2024.

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[3] The District and ESC negotiated the *Tentative Agreement HHMH to Clinical Laboratory Scientists and Medical Laboratory Technicians 10/21/2022*; however, in light of the District's fiscal emergency, the District's Board never approved the tentative agreement.

[4] In light of their size, the District has not attached copies of the Agreements to this Summary and cites relevant portions herein.

Importantly, the District has held non-confidential discussions with each of the Unions outlining the proposed Benefits modifications. However, as of the date of this Summary, the District has not reached a voluntary agreement with any of the Unions to implement the Benefits modifications addressed herein.

## II.

## CURRENT BENEFITS AND PROPOSED MODIFICATIONS

### A. Leave Benefits and Cash-Out Policy

The District currently provides two types of leave benefits to represented employees depending on the Union to which a represented employee is a member: (i)(a) vacation and holiday, or (b) paid time off ("PTO"); and (ii) sick leave (collectively, the "Leave Benefits"). The District also provides a "cash out" policy (the "Cash-Out Policy") that permits represented employees to "cash out" unused Leave Benefits. This section addresses the current Leave Benefits and Cash-Out Policy offered to represented employees of each Union and proposed modifications to the Leave Benefits and the Cash-Out Policy.

#### 1. The District's Current Leave Benefits and Cash-Out Policy for Represented Employees

##### a. PTO and Cash-Out Policy (CNA & CLVNA)

CNA and CLVNA represented employees only accrue PTO. PTO accrual is based on seniority as follows:

**CNA & CLVNA Vacation Accrual**

| Years of Service | PTO Days Accrued Per Year |
|---|---|
| 1 | 20 |
| 2 | 21 |
| 3 | 22 |
| 4 | 23 |
| 5 | 30 |
| 6 | 31 |
| 7 | 32 |
| 8 | 33 |
| 9 | 34 |
| 10 | 35 |
| 20 | 38 |

*See* CNA Ratified Agmt., Arts. 15 & 17 at 4-5; CLVNA Ratified Agmt., Arts. 15-17 at 3. CNA and CLVNA represented employees may accrue up to a maximum of 304 PTO hours and are not eligible to "cash-out" PTO accrued in excess of the 304 PTO hour cap. *See* CNA Ratified Agmt., Arts. 15 & 17 at 5; CLVNA Ratified Agmt., Arts. 15-17 at 3. CNA and CLVNA represented employees are permitted to request "cash out" of up to 50 hours of accrued PTO hours every

December, provided that such represented employee has at least 40 hours of accrued PTO remaining following the "cash out." *See* CNA Ratified Agmt., Art. 15 & 17, § A.8. at 6; CLVNA Ratified Agmt., Art. 15 & 17, § A.8. at 4.

Under the CNA Ratified Agreement and the CLVNA Ratified Agreement, the District agreed that CNA and CLVNA Represented Employees would be authorized to retain their legacy accrued vacation and holiday leave (the "CNA and CLVNA Legacy Leave") and apply for payment of up to 100 accrued and unused hours in December 2022 and apply for payment of the balance of accrued and unused hours in July 2023 (the "CNA and CLVNA Legacy Leave Policy"). *See* CNA Ratified Agmt., Art. 15 & 17, § A.8. at 6; CLVNA Ratified Agmt., Art. 15 & 17, § A.8. at 4. In light of the District's fiscal emergency, the District informed CNA and CLVNA that it would freeze implementation of the CNA and CLVNA Legacy Leave Policy and has not made payments on account of CNA and CLVNA Legacy Leave.

### b. Vacation and Holiday and Cash-Out Policy (NUHW & ESC)

NUHW and ESC represented employees accrue both vacation and holiday leave. Vacation accrual is based on seniority as follows:

**NUHW & ESC Vacation Accrual**

| Years of Service | Vacation Days Accrued Per Year |
|---|---|
| 1 | 10 |
| 2 | 11 |
| 3 | 12 |
| 4 | 13 |
| 5 | 15 |
| 6 | 17 |
| 7 | 18 |
| 8 | 19 |
| 9 | 20 |
| 10 | 22 |
| 20 | 23 |

*See* NUHW Agmt., Art. 17 § 1 at 19; ESC Agmt., Art. 16, § 1 at 15. NUHW and ESC represented employees may accrue up to a maximum of 240 vacation hours, and the District is required to pay all accrued and unused vacation in excess of the 240 hour cap. *See* NUHW Agmt., Art. 17 § 5 at 20; ESC Agmt., Art. 16, § 4 at 16.

NUHW and ESC represented employees are entitled to 9 paid holidays per year. NUHW Agmt., Art. 15 §§ 1-4 at 17-18; ESC Agmt., Art. 14 §§ 1-4 at 13-14. The District is required to pay NUHW and ESC represented employees 100% of the value of paid holidays earned and unused in excess of a 40-hour cap. *See* NUHW Agmt., Art. 15 § 8 at 18; ESC Agmt., Art. 14 § 8 at 14.

Based on the foregoing, the combined vacation and holiday accruals for NUHW and ESC represented employees is as follows based on seniority:

**NUHW & ESC Combined Leave Accrual**

| Years of Service | Combined Leave Days (Vacation & Holiday) Accrued Per Year |
|---|---|
| 1 | 19 |
| 2 | 20 |
| 3 | 21 |
| 4 | 22 |
| 5 | 24 |
| 6 | 26 |
| 7 | 27 |
| 8 | 28 |
| 9 | 29 |
| 10 | 31 |
| 20 | 32 |

**c. Sick Leave (All Unions)**

Represented employees earn sick leave at the rate of one day per calendar month, e.g., 12 days per year, up to a total of 80 days, e.g., 640 hours. *See* CNA Agmt., Art. 16 § 1 at 18; NUHW Agmt., Art. 16 at 19; ESC Agmt., Art. 15 at 15; CLVNA Agmt., Art. 16 § B at 13. The District is required to pay NUHW represented employees 50% of the value of sick leave earned and unused in excess of the 640-hour cap. *See* NUHW Agmt., Art. 16 at 19. Pursuant to ratified agreements, CNA, CLVNA, and ESC represented employees are not entitled to earn sick leave in excess of the 640-hour cap. *See* ESC Agmt., Art. 15 at 15.

**2. The District's Proposed Modifications to Leave Benefits and the Cash-Out Policy**

**Modification 1: Combined Leave Benefits Capped at 30 Days per Year.** The District proposes to combine all paid leave—vacation, holiday, PTO, and sick leave—into a single paid category with accrual rates based on seniority. The combined paid leave category would be capped at total accrual of 30 days. The proposed policy for all employees is set forth below:

| Years of Service | Combined Leave Benefits Accrued Per Year |
|---|---|
| 1 | 20 |
| 2 | 21 |
| 3 | 22 |
| 4 | 23 |
| 5 | 30 |
| 6 | 30 |
| 7 | 30 |
| 8 | 30 |
| 9 | 30 |
| 10 | 30 |
| 20 | 30 |

**Modification 2: Cap Cash-Out Policy at 30 Days.** The District proposes to cap the Cash-Out Policy for accrued and unused Leave Benefits at 30 days, e.g., 240 hours, per year. This modification will not apply to earned and unused Leave Benefits eligible for cash-out under the prior Cash-Out Policy as of the effective date of the modification. Additionally, the District will honor accrued leave treated under the CNA and CLVNA Legacy Leave Policy, subject to a cash-out calendar consistent with the District's cash forecast.

### 3. Projected Financial Result of Proposed Modifications to Leave Benefits and Cash-Out Policy

The District estimates that these modifications to the Leave Benefits and Cash-Out Policy will result in approximately $2.8 in annual savings.

## B. The Defined Benefit Plan

### 1. The District's Current Defined Benefit Plan

Effective January 1, 2005, the District began a single-employer defined benefit plan (the "Defined Benefit Plan"), commonly referred to as a "pension" plan.[5] The Defined Benefit Plan is defined as a "governmental plan," under 414(d) of title 26 of the United States Code (the "Internal Revenue Code") and § 3(32) of the Employee Retirement Income Security Act of 1974.

The Defined Benefit Plan became effective January 1, 2005 with a plan year end of December 31. Benefitted full and part-time employees are eligible to participate in the Defined Benefit Plan following three years of consecutive employment. The retirement formula is based on a percentage of the employee's compensation in each calendar year. Credit for past service is given to benefitted full and part-time employees during the period of 1999 through current at the same retirement formula of the employee's compensation in each consecutive calendar year in which the employee completed 1,000 hours of service.

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[5] Through December 31, 2003, the District provided retirement benefits for substantially all of its full-time employees under a defined contribution matching plan (the "Defined Contribution Plan"). The Defined Contribution Plan became effective January 1, 1995 with a plan year end of December 31. The District's contributions matched the contributions of the employees up to a 3.5% limit, subject to certain limitations under the Defined Contribution Plan. In addition to the 3.5% contribution by the District, employees could have contributed up to $12,000. Employees become fully vested in the employer contributions after completion of 5 years of service. Total Defined Contribution Plan assets were $31,598,692 and $34,571,553 as of June 30, 2022 and 2021 respectively. No employer contributions have been made to this part of the Defined Contribution Plan after December 31, 2003. A part of the Defined Contribution Plan, however, still includes the 457 plan that employees still currently contribute. The District does not propose modifying the Defined Contribution Plan as part of this Proposal.

As of January 1, 2022, there were 280 active participants in the Defined Benefit Plan, 118 retired participants, 132 terminated vested participants entitled to future benefits, 22 active participants (frozen status) for a total of 552 total participants.

Pursuant to the Agreements, the District is required to "contribute an amount sufficient, in combination with any required employee contributions, to fund a benefit equal to one and three tenths percent (1.3%) of the employee's annual compensation in each calendar year" to the Defined Benefit Plan. *See* CNA Agmt., Art. 21 at 24; NUHW Agmt., Art. 20 § 5 at 23; ESC Agmt., Art. 19 § 5 at 19; CLVNA Agmt., Art. 21 at 19. As the required funded benefit is a percentage of the represented employee's annual compensation, negotiated annual wage and merit increases with the Unions necessarily result in a direct incremental increase in the District's Defined Benefit Plan funding requirements.

For the fiscal year ended June 30, 2021, the actuarially determined contributions for the District for the 2020 plan year was $3,545,809, which amount includes liabilities for the current plan year and accrued and unpaid long-term liabilities under the plan. For the fiscal year ended June 30, 2021, the District only made actual contributions of $2,702,669, which represent solely the current year plan liabilities and do not account for accrued, long term plan liabilities.

For the fiscal year ended June 30, 2022, the actuarially determined contributions for the District for the 2021 plan year was $3,438,240, which amount includes liabilities for the current plan year and accrued and unpaid long-term liabilities under the plan. For the fiscal year ended June 30, 2022, the District only made actual contributions of $2,738,385, which represent solely the current year plan liabilities and do not account for accrued, long term plan liabilities.

## 2. The District's Proposed Modifications to the Defined Benefit Plan

The District proposes terminating the Defined Benefit Plan with respect to going-forward participation and, as a result, will not include going-forward plan year contributions. However, the District will continue to satisfy the actuarially determined long-term liabilities of the Defined Benefit Plan to ensure current Defined Benefit Plan participants' current liabilities can be satisfied under the plan. The District will offer an alternative retirement policy, such as a 401(k) plan, for employees' going-forward retirement contributions.

The District expects the impact on vested employees and non-vested employees to be as follows with respect to amounts already contributed under the Defined Benefit Plan:

- **Vested Employees:** Employees that are vested in the Defined Benefit Plan will be entitled to the full amount of their benefits accrued under the Defined Benefit Plan through the date of termination. If the employee wishes to make contributions to a retirement plan going-forward, the employee will be eligible to make going-forward contributions to an alternative plan.

  *Illustration:* By way of example, an employee that has been employed by the District for 10 years and contributed to the Defined Benefit Plan for 10 years will expect to receive the benefit equal to 10 years of contributions upon eligibility to

withdraw under the Defined Benefit Plan. However, the employee will no longer be able to make contributions to the Defined Benefit Plan.

- **Nonvested Employees:** Employees that are not vested in the Defined Benefit Plan upon the date of its termination, but who have contributed to the Defined Benefit Plan, will be eligible to either withdraw the contributed funds or roll the contributed funds over to a new retirement plan. A withdrawal of contributed funds without rolling the funds over to a qualifying retirement plan may result in tax consequences.

  *Illustration:* By way of example, an employee that has been employed by the District for two years and contributed to the Defined Benefit Plan for two years is not yet vested in the Defined Benefit Plan. The employee may withdraw all contributed funds, but may face tax consequences, or may roll-over the contributed funds into an alternative, qualifying retirement plan such as a 401(k).

### 3. Projected Financial Result of Proposed Modifications to Leave Benefits and Cash-Out Policy

The District estimates that terminating going-forward, current liabilities under the Defined Benefit Plan will result in annual net savings of approximately $1.9 million. This figure represents the $2.7 million plan year funding liabilities that the District will no longer make, less the $800,000 of long-term funding liabilities the District will continue to make to satisfy long-term liabilities under the Defined Benefit Plan.

## C. The Health Insurance Benefits

### 1. The District's Current Health Insurance Benefits

The District provides health benefits to Represented Employees through a self-funded plan financed by the District's operations (the "Self-Insured Plan"). Under the Self-Insured Plan, the District collects premiums from enrollees and takes on the responsibility of paying employees' and dependents' medical claims. Accordingly, the District currently bears the risk of payment for its members' medical claims.

The current premiums paid by represented employees on a per pay period basis are as follows:

**Current Employee Health Insurance Premium (Per Pay Period)**

| | CNA & CLVNA | | NUHW & ESC | |
|---|---|---|---|---|
| **Tier** | **Full-Time** | **Part-Time** | **Full-Time** | **Part-Time** |
| EE Only | $46.15 | $69.23 | $6.92 | $35.19 |
| EE +1 | $92.31 | $115.38 | $41.54 | $62.31 |
| EE +2 | $92.31 | $115.38 | $41.54 | $62.31 |
| EE +3 | $92.31 | $115.38 | $41.54 | $62.31 |

Additionally, non-Union hourly employees pay $15 per month for a single plan and $95 per month for a family plan. Exempt employees pay $125 per month for a single plan and $250 per month for a family plan.

### 2. The District's Proposed Modifications to the Health Insurance Benefits

The District's long-term objective is to transition from the Self-Insured Plan to a commercial or CalPERS health insurance plan to mitigate the risk the District bears for health insurance claims. The District currently incurs approximately $15 million in annual expenses associated with the Self-Insured Plan.

The District is continuing to obtain quotes for commercial or CalPERS insurance plans to replace the current Self-Insured Plan. However, the District has encountered difficulties obtaining quotes in light of the utilization it reports under the current Self-Insured Plan. In short, "utilization" refers to the extent to which members of a health insurance plan make claims on the plan. The District understands that the main driver of the utilization under the Self-Insured Plan are a combination of its generous benefits and significantly lower-than-market employee contributions under the Self-Insured Plan.

As a result of the delay in obtaining quotes, the District proposes a two-phased approach to transitioning from the Self-Insured Plan. ***First***, the District proposes continuing the Self-Insured Plan in the short term with immediate increases to premiums consistent with other commercial policies. The proposed premium rate increases are as follows for all employees:

**Proposed Employee Health Insurance Premium**
**(Per Pay Period)**

| Tier | Full Time | Part Time |
|---|---|---|
| EE Only | $92.31 | $115.38 |
| EE +1 | $138.46 | $161.54 |
| EE +2 | $161.54 | $184.62 |
| EE +3 | $184.62 | $207.69 |

The District may also consider additional modifications during this interim period, including copayments and deductibles. ***Second***, the District anticipates changing to a commercial or CalPERS health insurance plan within the next year, which will replace the Self-Insured Plan in its entirety.

### 3. Projected Financial Result of Proposed Modifications to Health Insurance Benefits

The District estimates that the immediate interim modification to the health insurance benefits—the increases to premiums—will result in approximately $1.14 million in annualized savings. Additional interim modifications, including copayments and deductibles, will result in incremental additional savings. Without a commercial or CalPERS plan, the District cannot currently analyze the savings of its long-term transition from the Self-Insured Plan but anticipates it will be materially greater than the immediate interim modification to premiums.

## D. Standby Compensation

### 1. Current Standby Compensation Policies

The Agreements provide the following compensation (the "Standby Compensation") for represented employees scheduled to stand by and be available for recall to the District's facilities, should the need arise as follows:

- **CNA.** CNA represented employees who are placed on standby duty beyond his or her regularly scheduled work day or work week are compensated for such standby time at **one-half (1/2) times the represented employee's straight time hourly rate**, regardless whether the represented employee is called in to work while on standby. *See* CNA Agmt., Art. 22 § 1.B. at 12. The standby rate increases to three-quarters (3/4) of the straight time hourly rate if the represented employee is on standby during a national holiday. *See id.*, § 1.D. at 12.

- **NUHW.** NUHW represented employees who are placed on standby duty beyond his or her regularly scheduled work day or work week are compensated for such standby time at **one-quarter (1/4) times the represented employee's straight time hourly rate**, increasing to one-half (1/2) times the represented employee's straight time hourly rate on national holidays, regardless whether the represented employee is called in to work while on standby. *See* NUHW Agmt., Art. 9 § 7.B., 7.D. at 9. Lead Surgical Technologists, MRI Technologists, Radiology Staff Technologists, Radiology Senior Technologists, Respiratory Care Practitioners, Surgical Technologists, and Ultrasound Technologists are compensated for standby time at **one-half (1/2) times the represented employee's straight time hourly rate**, increasing to three-fourths (3/4) times the represented employee's straight time hourly rate on national holidays, regardless whether the represented employee is called in to work while on standby. *See id.*

- **ESC.** ESC represented employees who are placed on standby duty beyond his or her regularly scheduled work day or work week are compensated for such standby time at **one-half (1/2) times the represented employee's straight time hourly rate**. *See* ESC Agmt., Art. 12 § 1.B. at 12.

- **CLVNA.** CLVNA represented employees who are placed on standby duty beyond his or her regularly scheduled work day or work week are allowed ***compensatory time off*** **equal to one-half (1/2) of the time on standby duty, *or compensated* for standby time at one-half (1/2) times the represented employee's straight time hourly rate**, regardless whether the represented employee is called in to work while on standby. *See* CLVNA Agmt., Art. 12 § A.2. at 9. The standby compensation rate increases to three-quarters (3/4) of the straight time hourly rate if the represented employee is on standby during a national holiday. *See id.*, Art. 12 § A.3. at 9.

### 2. The District's Proposed Modifications to Standby Compensation

The District proposes the following modifications to Standby Compensation: (i) reducing Standby Compensation for CNA represented employees to $25 per hour; and (ii) reducing Standby Compensation for all other employees to the California Minimum Wage. If called in to work while on standby, all employees will be entitled to their straight time hourly rate, unless the hours worked constituted overtime in which case the employee would be entitled to payment at overtime or applicable differential rates.

### 3. Projected Financial Result of Proposed Modifications to Standby Compensation

The District anticipates that the proposed modifications to Standby Compensation will result in $585,000 of annual savings.

## E. Education Leave

### 1. Current Education Leave

The Agreements provide the following leave benefits for represented employees to obtain continuing education (the "Education Leave") that vary by Union:

- **CNA.** The CNA Ratified Agreement provides that CNA represented employees will receive **40 hours of Continuing Education Pay per year** which amount is forfeited if unused. *See* CNA Ratified Agmt., Art. 22 § 3.C. at 8. Educational leave for part-time represented employees is prorated. *See id.*

- **NUHW.** NUHW represented employees in certain full-time and part-time positions are eligible for reimbursement of up to **the minimum hours required to obtain necessary re-licensure** as part of the represented employee's position at the represented employee's straight time hourly rate. *See* NUHW Agmt., Art. 21 § K at 37.

- **ESC.** ESC represented employees in all full-time and part-time positions are eligible to receive 30 hours of educational leave on July 1 of each two year licensing cycle to attend classes/courses for the represented employee to maintain their license, e.g., **15 hours per year**. *See* ESC Agmt., Art. 31 at 44. Education leave for regular part-time represented employees is be prorated based upon their full-time equivalent status. *See id.*

- **CLVNA.** The CLVNA Ratified Agreement provides that CLVNA represented employees will receive **40 hours of Continuing Education Pay per year** which amount is forfeited if unused. *See* CLVNA Ratified Agmt., Art. 24 at 6. Educational leave for part-time represented employees was prorated. *See* CLVNA Agmt., Art. 22 § K.4.a. at 32.

### 2. The District's Proposed Modifications to Education Leave

The District proposes modifying Education Leave to offer 15 hours education pay per year to represented employees in all Unions for necessary re-licensure as part of the represented employee's position which amount is forfeited if not used in the applicable year. The District is willing to permit accrual, and waive forfeiture, where a licensing period is two years; however, forfeiture would apply if Education Leave is unused during the relevant two year licensure period.

### 3. Projected Financial Result of Proposed Modifications to Education Leave

The District anticipates that the proposed modifications to Education Leave will result in $208,000 of annual savings.

## III.

## CONCLUSION

The proposed Benefits modifications are projected to result in an annual aggregate savings of $4.3 million for the District. Assuming the Benefits modifications are implemented by July 1, 2023, the District anticipates that the Benefits modifications would result in $2.3 million of enhanced cash flow in calendar year 2023. This cash flow enhancement in 2023 is projected to result in a positive net cash flow for the year of $1.9 million rather than the currently-projected $600,000 cash flow shortfall. Importantly, the District would achieve these savings without modifying employee wages and salaries and while maintaining competitive Benefits offerings.

**Attachment D**
**Phase 1 Pendency Plan Cash Forecast**

## San Benito Health Care District

### Financial Forecast

**2023 - Phase 1 Pendency Plan Cash Forecast**

| Description | Actual January | Actual February | Actual March | Forecast April | Forecast May | Forecast June | Forecast July | Forecast August | Forecast September | Forecast October | Forecast November | Forecast December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Recurring Revenue | $ 8,485,482 | $ 8,818,794 | $ 10,498,166 | $ 11,908,253 | $ 9,300,000 | $ 9,300,000 | $ 12,676,000 | $ 9,110,000 | $ 10,709,000 | $ 9,095,000 | $ 9,105,000 | $ 11,756,000 | $ 120,761,694 |
| Net Supplemental Revenue | 118,152 | 3,606,972 | 6,287,151 | 104,486 | - | 4,452,036 | 2,467,865 | (1,138,622) | - | 2,433,531 | - | - | 18,331,571 |
| **Total Cash Receipts** | **8,603,634** | **12,425,766** | **16,785,317** | **12,012,739** | **9,300,000** | **13,752,036** | **15,143,865** | **7,971,378** | **10,709,000** | **11,528,531** | **9,105,000** | **11,756,000** | **139,093,266** |
| Operating Cash Disbursements | 12,051,259 | 12,073,426 | 10,895,228 | 12,758,287 | 10,720,445 | 10,790,005 | 12,388,930 | 10,044,772 | 12,157,772 | 10,018,772 | 10,039,772 | 11,642,772 | 135,581,439 |
| **Operating Cash Flow** | **(3,447,625)** | **352,340** | **5,890,089** | **(745,549)** | **(1,420,445)** | **2,962,031** | **2,754,935** | **(2,073,393)** | **(1,448,772)** | **1,509,759** | **(934,772)** | **113,228** | **3,511,826** |
| Restructuring Expenses | 148,670 | 217,500 | 346,008 | 50,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | 2,762,178 |
| Other Non-Operating Expenses | 120,868 | 12,002 | 91,156 | 19,762 | 150,000 | 200,000 | 250,000 | 200,000 | 250,000 | 200,000 | 200,000 | 250,000 | 1,943,788 |
| Loans | 3,059,185 | - | - | - | - | - | - | - | - | - | - | - | 3,059,185 |
| **Net Cash Flow** | **$ (657,978)** | **$ 122,838** | **$ 5,452,925** | **$ (815,311)** | **$ (1,820,445)** | **$ 2,512,031** | **$ 2,254,935** | **$ (2,523,393)** | **$ (1,948,772)** | **$ 1,059,759** | **$ (1,384,772)** | **$ (386,772)** | **$ 1,865,045** |
| *% of Revenue* | *-8%* | *1%* | *32%* | *-7%* | *-20%* | *18%* | *15%* | *-32%* | *-18%* | *9%* | *-15%* | *-3%* | *1%* |
| **Beginning Cash Balance** | **$ 5,724,320** | **$ 5,066,342** | **$ 5,189,180** | **$ 10,642,105** | **$ 9,826,794** | **$ 8,006,349** | **$ 10,518,380** | **$ 12,773,315** | **$ 10,249,921** | **$ 8,301,150** | **$ 9,360,909** | **$ 7,976,137** | **$ 5,724,320** |
| Net Cash Flow | (657,978) | 122,838 | 5,452,925 | (815,311) | (1,820,445) | 2,512,031 | 2,254,935 | (2,523,393) | (1,948,772) | 1,059,759 | (1,384,772) | (386,772) | 1,865,045 |
| Bridge Loan | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **Ending Cash Balance** | **$ 5,066,342** | **$ 5,189,180** | **$ 10,642,105** | **$ 9,826,794** | **$ 8,006,349** | **$ 10,518,380** | **$ 12,773,315** | **$ 10,249,921** | **$ 8,301,150** | **$ 9,360,909** | **$ 7,976,137** | **$ 7,589,365** | **$ 7,589,365** |

## San Benito Health Care District

### Financial Forecast

**2024 - Phase 1 Pendency Plan Cash Forecast**

| Description | Forecast January | Forecast February | Forecast March | Forecast April | Forecast May | Forecast June | Forecast July | Forecast August | Forecast September | Forecast October | Forecast November | Forecast December | Total |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Recurring Revenue | $ 8,500,000 | $ 8,800,000 | $ 10,500,000 | $ 11,900,000 | $ 9,300,000 | $ 9,300,000 | $ 12,700,000 | $ 9,100,000 | $ 10,700,000 | $ 9,100,000 | $ 9,100,000 | $ 11,800,000 | $ 120,800,000 |
| Net Supplemental Revenue | 100,000 | 2,600,000 | 6,300,000 | 100,000 | - | 1,600,000 | 2,500,000 | (1,100,000) | - | 2,400,000 | - | - | 14,500,000 |
| **Total Cash Receipts** | **8,600,000** | **11,400,000** | **16,800,000** | **12,000,000** | **9,300,000** | **10,900,000** | **15,200,000** | **8,000,000** | **10,700,000** | **11,500,000** | **9,100,000** | **11,800,000** | **135,300,000** |
| Operating Cash Disbursements | 10,840,000 | 10,840,000 | 12,960,000 | 10,840,000 | 10,840,000 | 10,840,000 | 10,840,000 | 12,960,000 | 10,840,000 | 10,840,000 | 10,840,000 | 10,840,000 | 134,320,000 |
| **Operating Cash Flow** | **(2,240,000)** | **560,000** | **3,840,000** | **1,160,000** | **(1,540,000)** | **60,000** | **4,360,000** | **(4,960,000)** | **(140,000)** | **660,000** | **(1,740,000)** | **960,000** | **980,000** |
| Restructuring Expenses | 250,000 | 250,000 | 250,000 | 250,000 | 250,000 | - | - | - | - | - | - | - | 1,250,000 |
| Other Non-Operating Expenses | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 100,000 | 1,200,000 |
| Loans | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **Net Cash Flow** | **$ (2,590,000)** | **$ 210,000** | **$ 3,490,000** | **$ 810,000** | **$ (1,890,000)** | **$ (40,000)** | **$ 4,260,000** | **$ (5,060,000)** | **$ (240,000)** | **$ 560,000** | **$ (1,840,000)** | **$ 860,000** | **$ (1,470,000)** |
| *% of Revenue* | *-30%* | *2%* | *21%* | *7%* | *-20%* | *0%* | *28%* | *-63%* | *-2%* | *5%* | *-20%* | *7%* | *-1%* |
| **Beginning Cash Balance** | **$ 7,589,365** | **$ 4,999,365** | **$ 5,209,365** | **$ 8,699,365** | **$ 9,509,365** | **$ 7,619,365** | **$ 7,579,365** | **$ 11,839,365** | **$ 6,779,365** | **$ 6,539,365** | **$ 7,099,365** | **$ 5,259,365** | **$ 7,589,365** |
| Net Cash Flow | (2,590,000) | 210,000 | 3,490,000 | 810,000 | (1,890,000) | (40,000) | 4,260,000 | (5,060,000) | (240,000) | 560,000 | (1,840,000) | 860,000 | (1,470,000) |
| Bridge Loan | - | - | - | - | - | - | - | - | - | - | - | - | - |
| **Ending Cash Balance** | **$ 4,999,365** | **$ 5,209,365** | **$ 8,699,365** | **$ 9,509,365** | **$ 7,619,365** | **$ 7,579,365** | **$ 11,839,365** | **$ 6,779,365** | **$ 6,539,365** | **$ 7,099,365** | **$ 5,259,365** | **$ 6,119,365** | **$ 6,119,365** |