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Report to El Camino Hospital District

Addressing Certain Issues Relevant to the Audit and Service Review Conducted by the Local Agency Formation Commission for Santa Clara County

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1.0 Introduction

El Camino Hospital District (the "District") is a political subdivision of the State of California, formed by a vote of the District's electorate in 1956,[1] and organized pursuant to Division 23 of the California Health and Safety Code. Five entities are affiliated with the District:[2] El Camino Hospital Corporation, a nonprofit public benefit corporation ("ECH"), El Camino Hospital Foundation, CONCERN: Employee Assistance Program, El Camino Surgery Center, LLC, and Silicon Valley Medical Development, LLC.[3] The District receives a portion of the one percent ad valorem tax assessed on real property within the District's boundaries.[4] The District collects an additional tax approved by the District's voters dedicated to servicing debt that the District incurred to build the Mountain View hospital.[5]

The Local Agency Formation Commission for Santa Clara County ("LAFCO") is an agency authorized under California law to oversee the boundaries of cities and special districts. Encouraging orderly boundaries, discouraging urban sprawl, and preserving agricultural and open space lands are the key goals of LAFCO.[6] LAFCO is currently conducting its recurring five-year service review of the District, which includes an audit designed to answer specific LAFCO questions regarding the District. LAFCO engaged Harvey M. Rose Associates, LLC ("Harvey Rose") to conduct an audit and service review of the District. Harvey Rose is not licensed by the California Board of Accountancy.[7] A revised draft of Harvey Rose's Audit and Service Review of the District report was submitted to LAFCO on July 11, 2012 (the "Harvey Rose Report").[8] We have reviewed the Harvey Rose Report. The Harvey Rose Report states that "[t]he Audit was conducted in accordance with *Government Auditing Standards,*

[1] History of the District accessed on July 23, 2012 (http://www.elcaminohospitaldistrict.org/About).
[2] Section 32121, subsection o, of the California Health and Safety Code states, among other things, that each local healthcare district shall have and may "establish, maintain, and carry on its activities through one or more corporations, joint ventures, or partnerships for the benefit of the health care district".
[3] Report of Independent Auditors and Consolidated Financial Statements with Supplemental Information for the District for the years ended June 30, 2011 and 2010.
[4] According to Santa Clara County's *2011 – 2012 Assessor's Annual Report*, residential parcels represent two-thirds of the total assessed value of all real property in Santa Clara County, and non-residential real property, including commercial, industrial, retail and agricultural properties, account for the remaining one-third.
[5] Report of Independent Auditors and Consolidated Financial Statements with Supplemental Information for the District for the years ended June 30, 2011 and 2010.
[6] Santa Clara County Local Agency Commission (www.santaclara.lafco.ca.gov).
[7] California Department of Consumer Affairs, California Board of Accountancy, Search Results for Licensed Firms accessed on July 22, 2012 (www2.dca.ca.gov).
[8] Drafts of Harvey Rose's Service Review and Audit of the District report were submitted to LAFCO on April 23, 2012, May 23, 2012 and July 11, 2012. In addition, a PowerPoint presentation of Harvey Rose's Service Review and Audit of the District report was submitted to LAFCO on May 30, 2012.

December 2011 Revision" and that "[t]he Service Review was conducted in accordance with … the CKH Act." We have not evaluated whether Harvey Rose met those standards.

1.1 Engagement of KPMG

KPMG LLP ("KPMG") was engaged to analyze certain issues that the District and ECH believe are relevant to LAFCO's service review and audit of the District. Specifically, KPMG was asked to gather, review and analyze relevant information and reach conclusions on the following three questions:

1. How do the community benefits provided by the District compare to those provided by other comparable health care districts in California?
2. How do the community benefits provided by ECH compare to those provided by other comparable hospitals in the Bay Area?[9]
3. How does the District and the people and community served by the District benefit from ECH serving people and communities outside the District's boundaries?

The KPMG engagement team that prepared this report includes professionals with experience in financial accounting and operational issues for a wide range of health care providers, including for-profit, nonprofit, government-owned, network, and stand-alone providers. This report summarizes KPMG's analysis and conclusions and the information on which we have relied.

1.2 Procedures Performed and Data and Other Information Relied Upon

Out analysis, in summary consisted of:

- Review and analysis of publicly available documentation and information;
- Review and analysis of documents provided by the District and ECH representatives; and
- Interviews with ECH senior management.

[9] Comparable "Bay Area" hospitals were selected from hospitals in the North Bay, South Bay, East Bay or Santa Clara service regions used by OSHPD.

The types of documents and information that we have reviewed and analyzed include:

- Community Benefit Reports made publicly available by the District, ECH and other bodies;
- Audited Financial Statements made publicly available by the District and comparable districts;
- Data gathered from all hospitals in California and made publicly available on-line by the Office of Statewide Health Planning & Development ("OSHPD") of the State of California; and
- Interviews with ECH senior management.

Appendix A, attached to this report, lists the data and other information that we gathered and reviewed.

2.0 Summary of Our Conclusions

Based on our review and analysis of information obtained and provided to us, we offer the following three conclusions:

1. Relative to comparable health care districts in California, for the amount of ad valorem tax revenues that it receives, the District provides a high level of community benefits, which benefits the District and the people and communities served by the District.
2. Relative to comparable hospitals in the Bay Area, ECH provides a high level of community benefits to the people and community that it serves.
3. The District and the people and community served by the District benefit from ECH serving people and communities outside of the District's boundaries.

3.0 Background

3.1 History of Health Care districts[10]

In 1945, the California Legislature enacted the Local Hospital District Act (section 32000 et seq. of the California Health and Safety Code); legislation that enabled a community, with voter approval, to form a special district and impose property taxes to support the construction and operation of hospitals. Residents in these districts elect local boards to oversee the spending of tax receipts in pursuit of improved community health. The meetings of these publicly elected officials are open meetings subject to the provisions of the Ralph M. Brown Act, providing for public input and transparency relative to board actions. As noted above, the District was formed by a vote of the District's electorate in 1956.

In 1994, the State Legislature broadened the scope of activity of a hospital district beyond hospitals and renamed the statute the Local Health Care District Law.

California's health care districts can be found throughout the State, in both urban and rural settings and offer a variety of services including community grant making, chronic disease management education, senior services, ambulance services, primary care clinics, dental clinics, nutritional counseling, physical education, long term care and skilled nursing, senior housing and acute hospital care.

3.2 Mission and Powers of the District

The mission and powers of the District are found in the California Health and Safety Code[11] and the Amended and Restated Bylaws of the District (the "District's Bylaws").[12]

[10] Association of California Healthcare District's History of Healthcare Districts (www.achd.org/historyofhcd.php).
[11] California Health and Safety Code Section 32121.
[12] Amended and Restated Bylaws of the District Adopted January 17, 2012.

Section 32121 of the California Health and Safety Code ("Section 32121") states, among other things, that each local health care district shall have and may:

- Establish, maintain, and operate, or provide assistance in the operation of, one or more health facilities or health services…at any location within or without the district for the benefit of the district and the people served by the district (subsection j);
- Acquire, maintain, and operate ambulances or ambulance services within and without the district (subsection l);
- Establish, maintain, and operate, or provide assistance in the operation of, free clinics, diagnostic and testing centers, health education programs, wellness and prevention programs, rehabilitation, aftercare, and any other health care services provider, groups, and organizations that are necessary for the maintenance of good physical and mental health in the communities served by the district (subsection m); and
- Do any and all other acts and things necessary to carry out this division (subsection k).

The District Bylaws state the purpose of the District in the similar terms as Section 32121, quoted above. Under both, the District is to carry out its purpose for the benefit of the District and the people and communities served by the District.

4.0 Analyses and Bases for Our Conclusions

4.1 Conclusion No. 1: Relative to comparable health care districts in California, for the amount of ad valorem tax revenues that it receives, the District provides a high level of community benefits which benefits the District and the people and communities served by the District.

We have identified health care districts and health care systems (operated both for-profit and nonprofit) in California which we believe are comparable to the District. Unlike the District, not all of the health care districts and health care systems in California prepare Community Benefit Reports ("CB Reports") or audited financial statements, or make them readily accessible to the public. We gathered CB Reports and audited financial statements from publicly available resources, such as websites, as well as by direct requests to these health care districts.

We organized our analysis as follows:

- Identification Of Comparable Health Care Districts;
- Analysis of Available Audited Financial Statements;
- Community Benefit Reporting;
- Analysis of Community Benefit at the District Hospital Level;
- Administration of the District's Community Benefit Program;
- Transparency: Availability of Bylaws and Meetings Open to Public; and
- Conclusions.

Our analyses provide the bases for our conclusion.

4.1.1 Identification of Comparable Health Care Districts

As of June 30, 2012, there were 74 health care districts in California. As shown in the table below, of the 74 districts, 41 operate a hospital; six operate ambulance services; four operate clinics; three operate skilled nursing facilities; eight operate other "community-based services"; and one is inactive and in a state of reorganization. The remaining eleven districts, including the District, have sold or leased their hospitals to for-profit or nonprofit health care systems.

Summary of California Health Care districts[13]	Count
Health care districts operating:	
Hospital	41
Ambulance Services	6
Clinics	4
Skilled Nursing	3
Other "community based services"	8
Inactive health care districts	1
Health care districts that sold or leased their hospital to another health system	11
Total health care districts	**74**

To develop a representative sample of health care districts in California, we referred to the whitepaper issued by the District to LAFCO on November 4, 2011,[14] as well as the California State Controller Special Districts Annual Report, FY 2009-10. From the 73 active health care districts in California,[15] as of June 30, 2012, we first selected all eleven health care districts that, like the District, have sold or leased their hospital facilities to for-profit or nonprofit health care systems.[16] From the remaining 62 active health care districts in California, we selected eight more health care districts based on the following combined criteria:

- Taxes Allocated and Levied: First, we selected all health care districts with at least $1 million in annual tax receipts (20 out of the remaining 62 health care districts).[17]
- Comparable Geographies: From those 20, we selected all health care districts that were classified as Urban by the Association of California Health care Districts (8 out of 20 health care districts).

[13] Health care district operational categories were taken from the list of active / non-active health care districts that was provided by the Association of California Health Care Districts on July 5, 2012.
[14] The District, Information Re Local Health Care Districts, As Requested by Santa Clara County LAFCO, November 4, 2011.
[15] The Association of California Health Care Districts noted that Indian Valley Healthcare District is currently inactive and in a state of re-organization.
[16] In 1985, the Marin Healthcare District leased Marin General Hospital to Marin General Hospital Corporation. On July 1, 2010, control of the Marin General Hospital returned to the Marin Healthcare District. Obtained from the District whitepaper issued by the District to LAFCO on November 4, 2011.
[17] Annual tax receipts, as per the Special Districts Annual Report, for the fiscal year ended June 30, 2010, California State Controller, include "county allocation", "voter approved levy" and "homeowners property tax relief". We also selected Washington Township Health Care District as it received $8,200,000 in tax receipts per its audited financial statements.

The following table lists our final sample of 19 California health care districts that we believe are comparable to the District for the purposes of our analysis.

				Per California State Controller FY 10	
Line Number	**Health Care District Name**	**Urban / Rural**	**Leased or sold hospital facilities**	**Property Tax Revenue (1% Ad Valorem)**	**Total Property Tax Revenue**
1	Palomar Health	Urban		$12,426,860	$27,609,000
2	**El Camino Hospital District**	**Urban**	**Yes**	**9,289,236**	**16,017,000**
3	Grossmont Healthcare District	Urban	Yes	5,597,317	11,146,000
4	Sequoia Healthcare District	Urban	Yes	7,957,708	8,012,000
5	Tri-City Hospital District	Urban		7,300,523	7,372,000
6	Peninsula Health Care District	Urban	Yes	4,194,447	4,223,000
7	Desert Healthcare District	Urban	Yes	3,297,061	3,348,000
8	Salinas Valley Memorial Healthcare System	Urban		3,168,089	3,188,000
9	West Contra Costa Healthcare District	Urban		2,860,331	2,899,000
10	Beach Cities Health District	Urban		2,417,727	2,439,000
11	Camarillo Healthcare District	Urban		2,020,749	2,041,000
12	Sonoma Valley Health Care District	Urban		-	1,886,000
13	Fallbrook Hospital District	Rural	Yes		1,476,000
14	Mark Twain Hospital District	Rural	Yes		879,000
15	Mt. Diablo Health Care District	Urban	Yes	245,228	248,000
16	Eden Township Healthcare District	Urban	Yes	-	-
17	Marin Healthcare District	Urban	Yes	-	-
18	Petaluma Health Care District	Urban	Yes	-	-
19	Washington Township Health Care District	Urban		-	-

Note: See Appendix B.1 for further details.

4.1.2 Analysis of Available Audited Financial Statements

California requires its health care districts to engage external auditors and to publish audited financial statements at least annually:

> At least once each year the board shall engage the services of a qualified accountant of accepted reputation to conduct an audit of the books of the hospital and prepare a report. The financial statement of the district with the auditor's certification, including any exemptions or qualifications as part of such certification, shall be published in the district by the board pursuant to Section 6061 of the Government Code. *California Health and Safety Code Section 32133.*

For all 19 health care districts selected, we searched for audited financial statements. As we note in Appendix B.1, the District and six other of the 19 health care districts publish audited financial statements that are readily available on the districts' websites.[18] Through direct inquiries of the remaining 12 health care districts and/or accessing the Electronic Municipal Market Access website,[19] we were able to collect an additional ten audited financial statements. In total, we were able to collect 17 out of 19 sets of audited financial statements for our analysis. We were unable to obtain audited financial statements for Tri-City and Mark Twain hospital districts.

According to the District's Audited Financial Statements for the fiscal year ended June 30, 2011, the District incurred a total of $193,000 of general and administrative expenses, representing approximately 1% of the District's tax receipts.[20] The District has no staff. Any general and administrative support needed to operate the District, other than the service of the District's board members, is provided almost entirely by ECH. As a result, compared to the other health care districts that we analyzed, the District's general and administrative expenses are the lowest in dollars as well as a percentage of tax receipts. The people and communities served by the District thereby benefit because virtually all of the District's tax receipts are available to spend directly on community benefits and health care rather than overhead. If the duties of the District were dissolved to a successor agency, it would be most reasonable to expect that the successor agency would have to establish its own general and administrative capabilities, resulting in higher expenses and leaving less money to spend on community benefits and health care.

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[18] The District's website provides access to its audited financial statements for the fiscal years ended June 30, 2009 through 2011 (http://www.elcaminohospitaldistrict.org/Financials).
[19] Electronic Municipal Market Access website (http://emma.msrb.org/).
[20] The District's general and administrative expenses consist of depreciation, amortization, professional fees and purchased services. The District reported no salaries, occupancy, information technology or other general and administrative expenses.

4.1.3 Community Benefit Reporting

Community benefit, as defined in Health and Safety Code Section 127345 (Article 2), is a hospital's activities that are intended to address community needs and priorities primarily through disease prevention and improvement of health status, including, but not limited to, any of the following:

- Health care services rendered to vulnerable populations including, but not limited to, charity care and the unreimbursed cost of providing services to the uninsured, underinsured, and those eligible for Medi-Cal, Medicare, California Children's Services Program, or county indigent programs;
- The unreimbursed cost of services included in subdivision (d) of Section 127340;
- Financial or in-kind support of public health programs;
- Donation of funds, property, or other resources that contribute to a community priority;
- Health care cost containment;
- Enhancement of access to health care or related services that contribute to a healthier community;
- Services offered without regard to financial return because they meet a community need in the service area of the hospital, and other services including health promotion, health education, prevention, and social services; and
- Food, shelter, clothing, education, transportation, and other goods or services that help maintain a person's health.

We were able to obtain CB Reports for certain private nonprofit hospitals in our sample as a result of SB 697 (Chapter 812, Statutes of 1994) Health and Safety Code. The Hospital Community Benefit Program ("HCBP") results from SB 697, passed by the California Legislature in 1994. SB 697 states that private nonprofit hospitals "assume a social obligation to provide community benefits in the public interest". A private nonprofit hospital in California is required to:

- Conduct a community needs assessment every three years;
- Develop a community benefit plan in consultation with the community; and
- Annually submit a copy of its plan to the OSHPD.[21]

[21] Office of Statewide Planning and Development (http://www.oshpd.ca.gov/HID/SubmitData).

We sought to obtain CB reports for all 19 of the comparable health care districts or associated hospitals via district and hospital websites, direct requests to OSHPD, or direct requests to the health care districts. We note that health care districts are not required to issue CB Reports. However, as noted earlier at 4.1.1, eleven of the 19 health care districts have sold or leased their hospitals to for-profit or nonprofit health care systems, of which eight are required to issue CB Reports. As of June 30, 2012, OSHPD's online listing of CB Report submissions highlighted that ECH was one of only three such hospitals (i.e., ECH, Grossmont Hospital, and Sequoia Hospital) which were subject to HCBP reporting requirements and had filed 2011 CB Reports with OSHPD.

The District is not required to report on its contributions to community benefit; nevertheless the District issued a joint 2011 CB Report with ECH, and broke out how District funds were used for community benefit. Furthermore, of the CB Reports that we reviewed for health care districts that received ad valorem tax revenue or their hospitals noted in Appendix B.2, the joint CB Report by the District and ECH is the only one to break out how district tax receipts designated for community benefit were spent by program type.

4.1.4 Analysis of Community Benefit at the District Hospital Level

In 2011, the District received $5,782,000 of unrestricted ad valorem tax revenue that its Board designated to support community benefit programs. We note that in that same year, the District contributed $5,040,000 to community benefit programs which were administered by ECH.[22] District-funded community benefit programs included community health education, community-based clinical services, health care support services, grants, sponsorships and means-tested program benefits such as food stamps.[23]

On a consolidated basis, the District, ECH and their component units reported $31,158,650 in 2011 in spending for community-based programs. Additionally, ECH reported that its unreimbursed costs to serve Medi-Cal beneficiaries totaled $23,639,790 in 2011. On a consolidated basis, the District, ECH

[22] Per the District's Board Finance Presentation for the fiscal year ended 2011, we note that "As the District's designated Community Benefit funds are transferred to ECH for administration by the Hospital, we understand from ECH management that the Hospital places these funds in a uniquely identifiably account within its accounting records. These funds as they await receiving an authorization by the Community Benefit Advisory Committee to be expended these funds earn investment income."

[23] 2011 Community Benefit Report, District/ECH.

and their component units reported total community benefits spending of $54,798,440 in 2011. See table below.

Program Type	Amount
Subsidized health services funded through hospital operations	$20,616,112
Financial and in-kind contributions	4,002,154
Traditional charity care funded through hospital operations	2,772,576
Community Health Improvement Services	1,857,998
Health professions education funded through hospital operations	1,171,764
Clinical research funded through hospital operations	402,216
Community benefit operations funded through hospital operations	185,830
Government-sponsored health care (means-tested programs)	150,000
Sub total	**$31,158,650**
Government-sponsored health care (unreimbursed Medi-Cal care)	23,639,790
Total Community Benefit, FY 2011	**$54,798,440**

Analysis of Community Benefit at the District Hospital Level Based on Audited Financial Statements

To compare community benefit spending by ECH to that of other health care districts and their hospitals, as shown in Appendix C.1, we compared community benefit spending as a percentage of operating expenses as reported by the districts or hospitals in their audited financial statements.

For the eleven health care districts that sold or leased their hospital facilities to for-profit or nonprofit health care systems, we used the operating expense per the health care system consolidated audited financial statements (that the hospital facilities were sold or leased to) and the associated community benefit spending at the health care system level, if available, for this comparison. We recognize that analyzing community benefits spending system-wide may not reflect the level of benefits received by the local community in which a particular facility is located. For the remaining eight health care districts, we used the operating expense per the health care districts' audited financial statements and the community benefit spending, if available, noted in section 4.1.2 for this comparison.

Of the 19 health care districts or hospitals for which we had audited financial statements and community benefit spending, community benefit spending as a percentage of operating expenses ranges from 3.0% to 14.3%. ECH's percentage, 9.5%, is the second highest.

We further analyzed community benefit spending excluding unreimbursed cost to serve Medi-Cal / Medicaid beneficiaries. On this basis, community benefit spending as a percentage of operating expenses ranges from 2.1% to 11.0%. ECH has the second highest percentage at 5.4%. The following table summarizes our observations, which are detailed in Appendix C.1.

Health Care District Name	Hospital / Health Care System Name	Fiscal Year	Total Community Benefit as % of Operating Expenses	Total Community Benefit less Total Unpaid Cost of Medi-Cal / Medicaid as % of Operating Expenses
Sonoma Valley Health Care District	Sonoma Valley Hospital	2011	14.3%	11.0%
El Camino Hospital District	**El Camino Hospital**	**2011**	**9.5%**	**5.4%**
Grossmost Healthcare District	Sharp HealthCare	2011	6.0%	4.8%
Sequoia Healthcare District	Catholic Healthcare West / Dignity Health	2011	9.1%	4.8%
Peninsula Health Care District	Sutter Health and Affiliates	2010	8.9%	3.8%
Petaluma Health Care District	St. Joseph Health System	2010	6.8%	N/A[24]
Mt. Diablo Health Care District	John Muir Health	2010	3.0%	2.1%

Analysis of Community Benefit at the District Hospital Level Based on OSHPD Data

We also performed the same comparison using OSHPD data for operating expenses, as noted in Appendix C.2, which allowed us to compare eight district-related hospitals, not all of which publish audited financial statements. We found that total community benefit spending as a percentage of operating expenses ranges from 1.3% to 14.1%. ECH's percentage is 9.8%, placing it fifth highest out of the eight hospitals that we analyzed. We further analyzed community benefit spending excluding unreimbursed cost to serve Medi-Cal / Medicaid beneficiaries, which allowed us to compare seven of the eight district-related hospitals. Of this subset, community benefit spending as a percentage of operating expenses ranges from 1.6% to 10.9%. By that measure, ECH's percentage is 5.6%, placing it third

[24] Total Unpaid Costs of Medi-Cal / Medicaid were not specifically identified in the Community Benefit Reports of Petaluma Health Care District.

highest out of the seven hospitals. The following table summarizes our observations, which are detailed in Appendix C.2.

Health Care District Name	Hospital / Medical Center Name (affiliation shown in parenthesis)	Latest Fiscal Year Available	Total Community Benefit as % of Operating Expenses	Total Community Benefit as % of Operating Expenses excluding Medi-Cal / Medicaid
Sonoma Valley Health Care District	Sonoma Valley Hospital	2011	14.1%	10.9%
Grossmont Healthcare District	Grossmont Hospital (Sharp)	2011	10.7%	8.4%
Petaluma Health Care District	Petaluma Valley Hospital (St. Joseph)	2010	11.7%	N/A[25]
El Camino Hospital District	**El Camino Hospital**	**2011**	**9.8%**	**5.6%**
Eden Township Healthcare District	Eden Medical Center (Sutter)	2009	9.0%	4.1%
Mark Twain Hospital District	Mark Twain St. Joseph's Hospital	2011	1.3%	2.8%
Sequoia Healthcare District	Sequoia Hospital (CHW/DIGNITY)	2011	8.2%	2.7%
Marin Healthcare District	Marin General Hospital	2010	11.0%	1.6%

Based upon our analysis of publicly available data, the District, ECH and their component units, relative to comparable health care districts in California, make above-average community benefit expenditures as a percentage of total operating expenses.

4.1.5 Administration of the District's Community Benefit Program

The District's community benefit program, administered by ECH, has a structured process for addressing community needs. The District's process includes a triennial county health assessment, soliciting input from current partners on community needs and from the Community Benefit Advisory Council, reviewing the U.S. Surgeon General's National Prevention Strategy Report and the California Healthy Kids Survey, and examining data from the County Public Health Department.

[25] Total Unpaid Costs of Medi-Cal / Medicaid were not specifically identified in the Community Benefit Reports of Petaluma Health Care District.

Based on our interviews with ECH senior management and review of the District's CB Report, we learned that after thorough review and selection of partners, programs are selected for funding. These programs are described in the Annual Community Benefit Plan and submitted to the District's Board. The District reinforces transparency in community benefit spending by requiring community benefit partners to submit Interim and Annual Reports, as well as voluntarily producing a joint CB Report with ECH.

As a result of the efforts of the District and ECH to help the underserved in their community, the District and ECH were recognized by the Association of Fundraising Professionals, Silicon Valley as the 2011 Outstanding Corporate Grantmaker: Over 300 Employees.

4.1.6 Transparency: Availability Bylaws and Meetings Open to the Public

We reviewed the health care district and associated hospital websites for the District and ECH as well as the other ten health care districts that sold or leased their hospital to a for-profit or nonprofit health care system. Based on our review of these websites, we found that the District and ECH is highly transparent in its reporting to the public around board activities. For example, we found that the District and ECH provide ready access to board meeting schedules, minutes of prior meetings, and both District and ECH Bylaws via their websites. Further, per the District's Bylaws all directors of ECH, other than the CEO, are nominated and elected by the District's Board of Directors.

In addition, we reviewed two other health care district and associated hospital websites (i.e., Palomar Health / Palomar Medical Center / Pomerado Hospital and Washington Township Health Care District / Washington Hospital) noting that each shared a website with its associated hospital, each provided information around upcoming board meeting schedules and prior meeting minutes, however, neither included their audited financial statements on their websites.

4.1.7 Conclusions

The District is highly transparent in its reporting of community benefit expenses relative to comparable health care districts. The District makes it easy for the people and community served by the District to learn the nature, recipients and aggregate dollar amount of its expenditures for community benefit

programs. The District is one of only two comparable health care districts in California that voluntarily publish community benefit reports.[26]

The District is highly transparent in its financial reporting. The District reports its spending and other elements of its operations and financial condition by posting its annual financial statements on its website.[27] The District's annual financial statements are audited by an independent accounting firm. Of the 19 comparable health care districts that we researched, only seven, including the District, make their audited financial statements readily accessible to their communities via their websites.

We analyzed ECH's community benefit expense as a percentage of total operating expenses, both with and without the unreimbursed cost of serving Medi-Cal / Medicaid beneficiaries. We analyzed both audited financial statements and data reported to the OSHPD. Based upon our analysis of audited financial statements and community benefit reports, the District, ECH and their component units, relative to comparable health care districts in California, make above-average community benefit expenditures as a percentage of total operating expenses. When unreimbursed costs of serving Medi-Cal / Medicaid beneficiaries are excluded, ECH's community benefits expense as a percentage of total operating expense is the second highest of comparable hospitals with publicly reported data.

The District spends very little on general and administrative expenses, which leaves more of its tax receipts available for community benefits and health care for the people and communities served by the District. In 2011, the District incurred a total of $193,000 in general and administrative expenses or approximately 1% of the District's tax receipts. Based on our review of the audited financial statements published by comparable health care districts, the District's general and administrative expenses are the lowest.

Relative to comparable health care districts in California, for the amount of ad valorem tax revenues that it receives, the District provides a high level of community benefits which benefits the District and the people and communities served by the District.

[26] OSHPD notes on its website that Mark Twain St. Joseph's Hospital is a rural hospital with no community benefit filing requirements.

[27] District audited financials are available for fiscal years ended June 30, 2009 through June 30, 2011 (http://www.elcaminohospitaldistrict.org/Financials).

The District and ECH are highly transparent in their reporting to the public about board activities. For example, we found that the District and ECH provided ready access to board meeting schedules, prior meeting minutes, and both District and ECH Bylaws on their websites. Further, per the District's Bylaws all directors of ECH, other than the CEO, are nominated and elected by the District's Board of Directors.

4.2 Conclusion No. 2: Relative to comparable hospitals in the Bay Area, ECH provides a high level of community benefits to the people and community that it serves.

We have identified Bay Area hospitals which we believe to be comparable to ECH. Unlike ECH, not all of the hospitals that we sampled make their CB Reports and audited financial statements publicly available on their websites. Nevertheless, we gathered any information that we could from publicly available sources as well as by direct inquiries to hospitals.

We organized our analysis as follows:

- Identification of Comparable Hospitals;
- Analysis of Community Benefit Reporting; and
- Conclusions.

Our analyses provide the bases for our conclusion.

4.2.1 Identification of Comparable Hospitals

We used publicly available data from the website of the OSHPD to develop a representative sample of hospitals to compare with ECH.[28] We selected eleven hospitals in Santa Clara County.[29] Additionally, we identified 68 more hospitals in the "Bay Area", which we defined as located in the North Bay, South Bay, East Bay and Santa Clara service regions used by OSHPD. We filtered these 68 hospitals down to nine whose net patient service revenue varied from that of ECH by less than $150 million and included three additional hospitals (i.e., Eden Medical Center (Sutter); Valley Care Medical Center, and Sutter

[28] Office of Statewide Planning and Development (http://www.oshpd.ca.gov).
[29] We did not select the Children's Recovery Center of Northern California, which according to OSHPD had net patient revenues of only $7.5 million for the fiscal year ending June 30, 2010.

Delta Medical Center (Sutter)) in East Bay communities that are relatively similar to that of ECH's. As shown in the following table, our final sample consists of 20 comparable hospitals in the Bay Area:

Line Number	Hospital / Medical Center Name (affiliation shown in parenthesis)	Hospital Service Area	Licensed Beds	Net Patient Revenue	Subject to HCBP Reporting	2011 CB Report Issued
1	Stanford University Hospital & Clinics	Santa Clara	613	$1,790,243,000	Yes	Yes
2	Santa Clara Valley Medical Center	Santa Clara	574	810,171,000		
3	Lucile Salter Packard Children's Hospital at Stanford	Santa Clara	311	747,332,000	Yes	Yes
4	John Muir Medical Center-Walnut Creek Campus	East Bay	330	666,975,000	Yes	Yes
5	Alta Bates Medical Summit Medical Center (Sutter)	East Bay	527	643,405,000	Yes	
6	San Francisco General Hospital and Trauma Center	West Bay	645	527,709,000		
7	**El Camino Hospital**	**Santa Clara**	**542**	**522,729,000**	**Yes**	**Yes**
8	Good Samaritan Hospital - San Jose	Santa Clara	429	479,481,000		
9	Alameda County Medical Center	East Bay	475	445,314,000		
10	Mills-Peninsula Medical Center (Sutter)	Santa Clara	340	436,153,000	Yes	
11	Alta Bates Medical Summit Medical Center - Summit Campus Hawthorne	East Bay	399	432,411,000	Yes	
12	Washington Hospital – Fremont	East Bay	359	408,506,000		
13	Eden Medical Center (Sutter)	East Bay	271	318,156,000	Yes	Yes
14	Regional Medical Center of San Jose	Santa Clara	247	312,652,000		
15	O'Connor Hospital (DCHS)	Santa Clara	358	278,753,000	Yes	Yes
16	ValleyCare Medical Center	East Bay	242	207,649,000	Yes	Yes
17	Sutter Delta Medical Center (Sutter)	East Bay	145	163,442,000	Yes	
18	St. Louise Regional Hospital	Santa Clara	93	83,901,000	Yes	Yes
19	Kaiser Foundation Hospital-Santa Clara	Santa Clara	327	N/A	Yes	Yes
20	Kaiser Foundation Hospital-San Jose	Santa Clara	242	N/A	Yes	Yes

4.2.2 Analysis of Community Benefit Reporting

We sought to obtain CB reports for all 20 Bay Area hospitals that we studied via hospital websites, as well as by requesting them from OSHPD. Based on OSHPD's listing of private nonprofit hospitals in California that are subject to HCBP requirements, we observed that 14 of the hospitals are subject to

HCBP reporting requirements, but only 10 of them, including ECH, had filed their 2011 reports with OSHPD by the due date.[30]

Analysis of Community Benefit at the Hospital Level Based on Audited Financial Statements

To compare ECH with other hospitals that we identified in the Bay Area, we used the hospitals' audited financial statements to compute community benefit expense as a percentage of total operating expenses. The percentages range from 3.0% to 15.4%. ECH has the second highest percentage out of seven hospitals at 9.5%. The hospital with the highest percentage is a children's hospital. For four hospitals in our sample, no audited financial statements are available for individual hospitals, so we relied upon audited financial statements issued by their parent health care systems. The visibility of the people of Santa Clara County into the operations, financial condition and community benefit expenses of these four hospitals is obviously limited. Appendix D.1 shows the results of our comparison in detail.

We re-performed our analysis excluding unreimbursed cost of serving Medi-Cal / Medicaid beneficiaries from total community benefit expenses, which allowed us to compare six hospitals. The percentages range from 2.1% to 5.4%. ECH has the highest percentage at 5.4%. The following table summarizes our analyses.

Hospital / Health Care System Name (affiliation shown in parenthesis)	Latest Fiscal Year Available	Total Community Benefit as % of Operating Expenses	Total Community Benefit as % of Operating Expenses Excluding Medi-Cal / Medicaid
El Camino Hospital	**2011**	**9.5%**	**5.4%**
Daughters of Charity Health System ("DCHS")	2009	8.5%	3.2%
Sutter Health and Affiliates ("Sutter")	2010	8.9%	3.8%
Lucile Salter Packard Children's Hospital at Stanford	2011	15.4%	3.2%
Stanford University Hospital & Clinics	2011	8.3%	2.7%
ValleyCare Health System ("ValleyCare Health")	2010	5.9%	N/A[31]
John Muir Health	2010	3.0%	2.1%

[30] As of June 30, 2012, we confirmed that OSHPD's online community benefit report listing listed ten out of the fourteen hospitals as having submitted CB Reports for 2011 (http://www.oshpd.ca.gov/HID/SubmitData/).
[31] Total Unpaid Costs of Medi-Cal / Medicaid were not specifically identified in the Community Benefit Reports.

Analysis of Community Benefit at the Hospital Level Based on OSHPD Data

We also performed the same comparison using OSHPD data, which allowed us to compare seven hospitals. We found that community benefit expense as a percentage of total operating expenses ranges from 4.3% to 15.7%. We re-performed our analysis excluding unreimbursed cost of serving Medi-Cal / Medicaid beneficiaries from total community benefit expenses which allowed us to compare six hospitals. Community benefit expenses excluding unreimbursed costs of serving Medi-Cal / Medicaid beneficiaries ranges from 2.4% to 5.6% of total operating expenses. ECH has the third highest community benefit expense as a percentage of operating expenses, and the highest percentage when unreimbursed Medi-Cal / Medicaid costs are excluded. Appendix D.2 shows the results of our comparison in detail.

Hospital Name (affiliation shown in parenthesis)	Latest Fiscal Year Available	Total Community Benefit as % of Operating Expenses	Total Community Benefit as % of Operating Expenses, Excluding Medi-Cal / Medicaid
El Camino Hospital	**2011**	**9.8%**	**5.6%**
Eden Medical Center (Sutter)	2009	9.0%	4.6%
Lucile Salter Packard Children's Hospital at Stanford	2011	15.7%	3.3%
St. Louise Regional Hospital	2011	9.5%	3.1%
Stanford University Hospital & Clinics	2011	8.4%	2.8%
Good Samaritan Hospital - San Jose	2010	4.3%	2.4%
O'Connor Hospital (DCHS)	2011	12.4%	N/A[32]

4.2.3 Conclusions

ECH is highly transparent in reporting community benefits to the people of the District and the population that it serves. Unlike several other Bay Area hospitals, ECH is current in submitting its CB Reports to OSHPD.

[32] Total Unpaid Costs of Medi-Cal / Medicaid were not specifically identified in the Community Benefit Reports.

ECH is, based on available audited financial statements and CB Reports, on par with comparable hospitals in terms of community benefit expenses as a percentage of total operating expenses, and is a leader when unreimbursed cost of serving Medi-Cal / Medicaid beneficiaries is excluded.

Relative to comparable hospitals in the Bay Area, ECH provides a high level of community benefits to the people and the community that it serves as measured by transparency and spending on community benefits as a proportion of total operating expenses.

4.3 Conclusion No. 3: The District and the people and community served by the District benefit from ECH serving people and communities outside of the District's boundaries.

Under California's Local Health Care District Law and the District's Bylaws, the District may purchase and operate facilities inside and outside of its district boundaries. Within the District's boundaries, ECH owns and operates acute inpatient and outpatient facilities on the Mountain View campus of ECH, as well as the El Camino Surgery Center and an outpatient dialysis center. ECH also provides services through its Los Gatos campus and the Rose Garden and Evergreen dialysis centers, which are located outside of the District boundaries but all within Santa Clara County.

To assess the benefits that the District receives by providing services outside of the District, we interviewed seven members of ECH's management including:

- Michael King, Chief Financial Officer;
- Matt Harris, Controller;
- Cal James, Chief of Strategy;
- Cecile Currier, Vice President, Professional Corporate and Community Health Services;
- Barbara Avery, Director of Community Benefits;
- Eric Pifer, MD, Chief Medical Officer; and
- Chris Ernst, Vice President, Marketing and Corporate Communications.

In addition, ECH provided us with a database of its inpatient discharges from fiscal years 2008 through 2012, as well as internal year-end utilization and financial summary reports. From the inpatient database, we analyzed the patient origin, by zip code, of inpatient discharges from the Mountain View and Los Gatos facilities. The table below in Section 4.3.1 below summarizes our analyses.

Based on the interviews that we conducted and our analysis of inpatient discharge data, we determined that ECH provides an array of health care services within the District and throughout Santa Clara County. Serving residents outside of the District furthers the mission of the District and enables ECH to (1) provide efficient high-quality health care services to the population that it serves and (2) promotes the long-term financial viability of the hospital.

4.3.1 Residency of ECH Mountain View's inpatients

Over the past five fiscal years, Mountain View's inpatient discharges have declined, from 21,036 in 2008 to 18,819 in 2012. During this period, approximately one-half of Mountain View's inpatients lived in zip codes within the District's boundaries or Sphere of Influence ("SOI"). Approximately 90% of Mountain View's inpatients lived within Santa Clara County. See table below.

Residency of Patients by Zip Code	Mountain View Campus Discharges				
	FY2008	FY2009	FY2010	FY2011	FY2012
Within District (1)	4,454	4,551	4,506	4,259	4,116
Partially Outside District but Within SOI (2)	4,838	4,594	4,220	4,196	3,835
Outside District but Within SOI (3)	1,471	1,394	1,371	1,370	1,177
Subtotal	10,763	10,539	10,097	9,825	9,128
% of Total	51.2%	50.4%	49.6%	49.6%	48.5%
Outside District and SOI but Within Santa Clara County	8,338	8,427	8,282	8,002	7,792
Subtotal	19,101	18,966	18,379	17,827	16,920
% of Total	90.8%	90.7%	90.3%	89.9%	89.9%
Outside Santa Clara County	1,935	1,952	1,976	1,999	1,899
% of Total	9.2%	9.3%	9.7%	10.1%	10.1%
Total	21,036	20,918	20,355	19,826	18,819

Note (1): Includes zip codes 94022, 94023, 94024, 94035, 94039, 94040, 94041, 94042, 94043, 94085.
Note (2): Includes zip codes 94086, 94087, 94088, 94089.
Note (3): Includes zip codes 95014, 94015.
Source: ECH admissions database provided by ECH management.

We also analyzed the nature of the services provided at the Mountain View campus to inpatients that live outside of the District or its SOI (See Appendix E). Inpatients who come to the Mountain View campus

from outside the District and its SOI, of whom the vast majority are residents of Santa Clara County, receive a full array of services. The capabilities of ECH's Mountain View campus benefit residents of Santa Clara County, whether they live inside or outside of the District.

4.3.2 Residency of ECH Los Gatos' inpatients

Over the past three fiscal years, Los Gatos's inpatient discharges have increased 35%, from 2,830 in 2010 to 3,813 in 2012. Consistent with the Mountain View campus, at least 90% of Los Gatos's inpatients each year lived within Santa Clara County.

As identified on ECH's website and confirmed by ECH management and our data analysis, ECH's Los Gatos campus provides several unique services to the residents of the District, its SOI and Santa Clara County that are not provided on its Mountain View campus including:

- Inpatient rehabilitation for patients who have suffered from stroke, neurological or orthopedic surgery, and degenerative neurological disorders such as Parkinson's disease and multiple sclerosis;
- A comprehensive array of urological services including kidney stone treatment, treatment of benign prostatic hyperplasia with the only GreenLight XPS laser technology in Northern California, treatment of urologic malignancies, and surgical treatment for incontinence;
- Unique hospital-based health program just for men (only one in Santa Clara County) that are designed to diagnose and treat benign prostate disease and erectile dysfunction, testosterone deficiency, and male incontinence; and
- A recently opened Sleep Disorder program to identify and address problems related to dyssomnia, parasomnia, and medical or psychiatric conditions.

The volume of inpatient services provided on the Los Gatos campus to people who live in the District and SOI has grown significantly since its opening with an emphasis on Orthopedics and Rehabilitation (see Appendix F).

4.3.3 Identification and quantification of benefits to the District and its residents by ECH serving populations residing both within and outside the District

ECH is an award-winning hospital which attracts patients to its Mountain View campus from outside of the District for health care services. ECH's awards that demonstrate its expertise in delivery quality health care include:

- U.S. News & World Report 2011-2012 Best Regional Hospital – San Jose Metro Region with recognition for its orthopedics program;
- Blue Shield of California designated ECH as a Blue Shield Distinction Center for Bariatric Surgery, Knee and Hip Replacement, and Spine Surgery;
- American Nurses Credentialing Center awarded ECH Magnet designation for organizations that provide the very best in nursing care;
- American Association of Cardiovascular and Pulmonary Rehabilitation has consistently recognized ECH since 2003 for their commitment to enhancing standards of care in the delivery of their cardiac and pulmonary rehabilitation programs;
- Joint Commission Gold Seal of Approval for ECH's Stroke Center;
- American Heart Association and American Stroke Association Gold Plus Award;
- American Society for Metabolic and Bariatric Surgery designation of ECH as a Bariatric Surgery Center of Excellence; and
- Bay Area Parent Magazine 2011 Silver Award for Best Hospital to have a baby.

As confirmed by ECH management, a benefit of operating a larger hospital with a broad array of specialties is that ECH is able to remain an independent community hospital and not require a merger with a large health system to obtain access to specialty services, assistance in recruitment of physicians, and access to financing of capital expansion and improvement projects. These are among many of reasons for mergers, as identified by Moody's Investors Service in its publication on *U.S. Not-For-Profit Healthcare Outlook Remains Negative for 2012*, dated January 25, 2012.

This status as an independent community hospital allows ECH to remain accountable to the residents of the District. If the District sold or leased ECH to a for-profit or nonprofit system, the residents of the District and the population that it serves would have less or no insight into ECH's operations and influence on its decision-making.

In order to offer a particular service or capability, a hospital must earn enough net patient service revenue to cover its costs. To some extent, employee overtime and supplies expense in an acute care hospital vary based upon the volume and intensity of services provided. However, most of the costs of an acute care hospital are fixed. ECH operates in a way that allows it to spread its fixed costs over a larger volume of patients. By offering a high level of service, and drawing approximately half of its patients from outside the District and its SOI, the Mountain View campus has doubled the number of patients who help pay its fixed operating costs. By operating at Los Gatos, and drawing patients from outside the District and its SOI, ECH has spread fixed costs across more patients. As the volumes on the Mountain View campus have declined or remained constant over the past five years, volumes on the Los Gatos campus have grown. The combined growth in campus volumes, as presented in Appendix G, enables ECH to spread its costs and become more efficient.

We used ECH's internal management reports to obtain income from operations generated by the Mountain View and Lost Gatos campuses. As shown in the below summary, in each full year of operations, the Los Gatos campus has generated positive operating income. In the latest two fiscal years, Los Gatos and ECH as a whole have increased total income from operations and operating margins.

Financial Performance	ECH Income from Operations				
	FY2008	FY2009	FY2010	FY2011	FY2012
Income from Operations ($ in millions)					
Mountain View	$50.7	$52.5	$1.6	$35.2	$52.3
Los Gatos (1)	0	(5.4)	1.7	12.3	17.3
Total	$50.7	$47.1	$3.3	$47.5	$69.6
ECH Operating Margin (2)	12.1%	10.1%	0.6%	7.8%	10.8%

Note (1): As Los Gatos operations began April 9, 2009, FY2009 reflects three months of start up expenses.
Note (2): Calculation of operating margin includes the provision for bad debt as a deduction from revenue.
Source: ECH audited financial statements (2008-2011) and internal ECH monthly financial reports (2012).

Not only has the Los Gatos campus contributed to the improvements in the operating performance of ECH, it has also improved ECH's cash position by generating positive cash flow from operations each year. In fact, cumulative cash flow of $60,800,000 from the Los Gatos's operations through June 30, 2012 (excluding $17,400,000 of non-cash depreciation expense and $17,500,000 of cost allocations from the Mountain View campus) now exceeds Los Gatos's original purchase price of $53,700,000. The

positive cash flow of the Los Gatos campus generates more resources for ECH to devote to health care, which benefits the District and its residents.

Financial Performance	ECH Cash & Investments				
	FY2008	FY2009	FY2010	FY2011	FY2012
Los Gatos Cash From Operations (in millions) (1)	$0	($5.4)	$6.5	$27.5	$32.2
ECH Cash & Investments (in millions) (2)	$410.6	$392.3	$284.7	$374.1	$460.0
ECH Days Cash on Hand (3)	442	368	212	267	320

Note (1): Reflects $25.9M of Income from Operations plus $17.4M of Depreciation expense and $17.5M of allocations from the Mountain View campus.
Note (2): Includes Cash, Short and Long Term Investments, and Board Designated Funds.
Note (3): Excludes provision for bad debts.
Source: ECH audited financial statements (2008-2011) and internal ECH monthly financial reports (2012).

By serving populations resident outside the District, ECH has increased its revenue, operating margin and financial stability which benefits the District and its residents.

As identified by ECH management, the ability to serve a population larger than just the District, avoid duplication of services, become more efficient, and improve its financial position, enables ECH to attract and fund more highly qualified and specialized physicians that often require multi-year income subsidies and investments in high-tech clinical equipment, much less the high costs associated with recruitment. These investments further contribute to the benefits, such as specialized cancer and cardiac services, available to District residents as a result of ECH providing services to all of Santa Clara County.

4.3.4 Conclusions

Historically, 90% of ECH's inpatients, on both the Mountain View and Los Gatos campuses, are residents of Santa Clara County. The expansion of services on the Los Gatos campus that do not duplicate those on the Mountain View campus provides improved access to quality health care for all residents of Santa Clara County. As a larger hospital with a broad array of specialties, ECH is able to remain an independent community hospital and be more accountable to the residents of the District. Offering services at Los Gatos also enables ECH to improve its long-term financial viability.

Serving patients from outside the District and its SOI, as well as operating the Los Gatos campus, have enabled ECH to spread its fixed costs over a larger volume of patients. As the volumes on the Mountain View campus have declined or remained constant over the past three years, volumes on the Los Gatos campus have grown. The combined growth in campus volumes enables ECH to spread its costs and become more efficient.

By serving a larger population, ECH is able to attract more highly qualified and specialized physicians which, in turn, contribute to the broad array of services that are provided to the residents of Santa Clara County. The businesses that pay property taxes allocated to the District benefit by the availability of efficient, award winning high-quality health care services to employees, regardless of their residency.

The District and the people and community served by the District benefit from ECH serving people and communities outside of the District's boundaries.

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