



Doctors Medical Center Planning Options

May 17, 2007

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Planning Approach and Purpose

On March 8, 2007, Wellspring Management Services, LLC, formerly known as Speltz & Weis LLC and wholly-owned by Huron Consulting Group, was retained by the Doctors Medical Center Management Authority, JPA to conduct a profitability analysis of Doctors Medical Center's existing services and to develop a series of potential operating models in an effort to reduce annual operating losses and determine long-term feasibility.

The planning process was performed with the understanding that the current monthly financial losses do not allow the flexibility to consider initiatives that require extended implementation periods. The business planning process included analytic and quantitative analysis, including:

- 1. Service Line Profitability** – We developed a contribution margin analysis of specific DMC clinical services, as well overall outpatient services. Contribution margin is defined as net patient revenue less direct expenses. Contribution margin is the most direct measure of the revenue and expenses associated with a particular service line.
- 2. Inpatient Market Share** – Inpatient market share contributed to the planning analysis in a number of significant ways. Market share is used to evaluate product line performance, identify potential partner organizations, and as a proxy for the role DMC plays in the greater Contra Costa healthcare environment.
- 3. Interviews with key stakeholders** – Including physicians, hospital administrators, representatives of the JPA and Leadership of CCRMC.

The planning process concludes with the presentation of two potential options for future operations. The two potential operating options are described and outlined in relation to the key components, underlying rationale, service components, locations; etc. Each option also includes an evaluation of: community impact; advantages/ disadvantages; implementation risks; financial impact, and timeliness of implementation.



Potential Improvement Initiatives and Synergies

Current and Potential Improvement Initiatives

The assessment identified the following improvement opportunities:

Initiatives Currently Underway:

- ◆ **Denials Management** – A Wellspring team is working with DMC Business Office staff to facilitate cash collections on denied and under-paid claims. To date over \$2.5 million has been identified for collections, nearly \$1 million of which has been received.
- ◆ **Managed Care Rates** – We are currently renegotiating rates with managed care payors. DMC has given contract termination notice to specific managed care payors unless rates are adjusted to cover the total cost of caring for their members.

Initiatives Identified But Not Yet Implemented:

- ◆ **Revenue Cycle** – Opportunity has been identified surrounding the use of collection agencies, the pre-registration process and other process improvements throughout the revenue cycle. Once fully implemented these initiatives will yield \$1.5 million annually.
- ◆ **Reimbursement** – Opportunity has been identified for DSH qualification for DMC. Qualifying for DSH will allow for both federal and state funding annually of \$1.6 million. One time payments for 2005 and 2006 will also be received towards the end of 2007 and 2008.
- ◆ **Labor** – Process improvements were identified which will lead to significant efficiencies and reduced labor costs. Once fully implemented these initiatives will yield \$4.6 million annually.
- ◆ **Non-Labor** – Significant cost reduction opportunities related to supplies and purchased services were identified. These initiatives will yield \$1.6 million annually on a fully implemented basis.

Potential Improvement Initiatives

IMPROVEMENT INITIATIVES (\$ IN MILLIONS)					
	2007	2008	2009	2010	Total
Revenue Cycle (Including Denials)	\$ 3.1	\$ 3.5	\$ 3.5	\$ 3.5	\$ 13.6
Non-Labor	0.3	1.6	1.6	1.6	5.1
Labor	0.6	4.6	4.6	4.6	14.4
Reimbursement	0.4	0.9	1.6	1.6	4.5
Managed Care Rates	1.0	2.9	2.9	2.9	9.7
One Time Initiatives (Revenue Cycle & Reimbursement)	2.3	2.2	-	-	4.5
Less: Implementation Costs	(3.3)	(1.5)	-	-	(4.8)
TOTAL	\$ 4.3	\$ 14.2	\$ 14.2	\$ 14.2	\$ 46.9

Note: This assumes implementation of initiatives is to begin July 1, 2007 except for the Denials initiative, which began in March 2007

Potential Synergies Between DMC & CCRMC

In addition to the improvement opportunities identified during the assessment, this planning process has also identified the potential for significant savings as a result of collaboration between DMC and CCRMC in administrative, operational and support functions, as well as clinical collaboration. These synergies should be included in any future DMC operating model.

Savings within administrative, operational and support functions include collaboration in areas such as Group Purchasing Organizations, cross coverage opportunities for physicians, contracting, sharing resources on 'difficult to fill' positions, etc. Once these synergies are fully implemented they will result in savings of \$2.7 million annually.

Opportunities for clinical collaboration are based on the following:

- ◆ Increased Orthopedic referrals of 1 case per week
- ◆ Increased General Med/Surg referrals of 5% or 90 cases annually
 - Annual Contribution Margin related to this volume is \$200K
- ◆ Potential Synergy for Cardiology volume

Potential Synergies Between DMC & CCRMC (cont'd)

- ◆ Total opportunity due to fully implemented synergies is \$2.9 million.
- ◆ Implementation costs are estimated at \$675 K between 2007 & 2008

SYNERGY INITIATIVES BY YEAR (IN \$ MILLIONS)					
	2007	2008	2009	2010	Total
Operational					
Various Administrative & Support Functions	0.2	1.5	2.7	2.7	7.1
Clinical					
Orthopedic Volume	0.03	0.03	0.1	0.1	0.26
General Med/Surg Volume	0.07	0.07	0.1	0.1	0.34
TOTAL	\$ 0.3	\$ 1.6	\$ 2.9	\$ 2.9	\$ 7.7

Inpatient and Outpatient Service Assessment

Wellspring Matrix Example

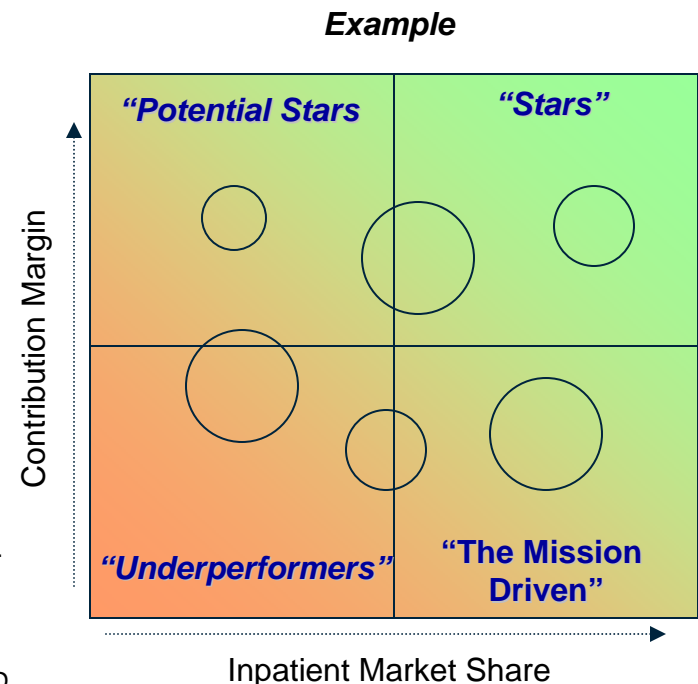
The Wellspring Matrix is a valuable tool in evaluating the Hospital's service line performance. The Wellspring Matrix is a 4 quadrant graph where each hospital service line is plotted by contribution margin and inpatient market share.

Each service line is categorized into their respective quadrant based on the following definitions.

- ◆ **“Stars”** – often “Centers of Excellence” which should be maximized for return and strategic importance.
- ◆ **“Potential Stars”** – service lines that should be promoted to the community to maximize total financial return to the institution.
- ◆ **“The Mission Driven”** – service lines that under perform financially but fill a community need; efficiency should be evaluated to improve financial performance.
- ◆ **“Underperformers”** – service lines that, in relative terms, under perform financially and in terms of fulfilling community need; program evaluation is in order.

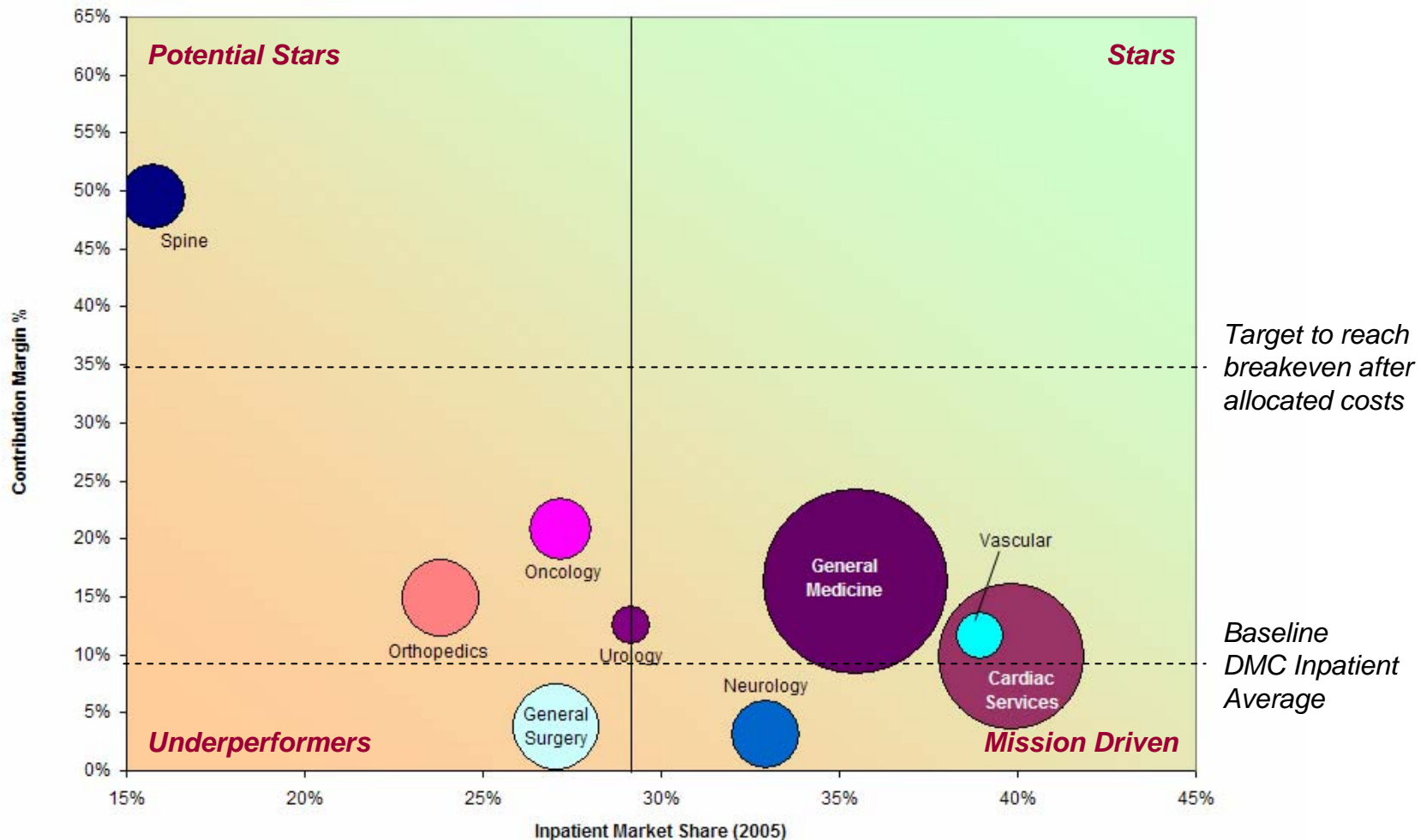
Data Definitions:

- ◆ **Contribution Margin percentage** is defined as the percent of net revenue after expenses.
- ◆ **Market Share** is an indicator of the strategic value of a particular service line. High market share indicates market clout and the relative importance of the service line within the community.
- ◆ Financial data: July-December 2006 per internal data. Market share data: 2005 per OSHPD.
- ◆ The size of each “bubble” indicates an area's relative size based on volume.



Inpatient Analysis: The Wellspring Matrix

Pre Implementation of Initiatives and Synergies



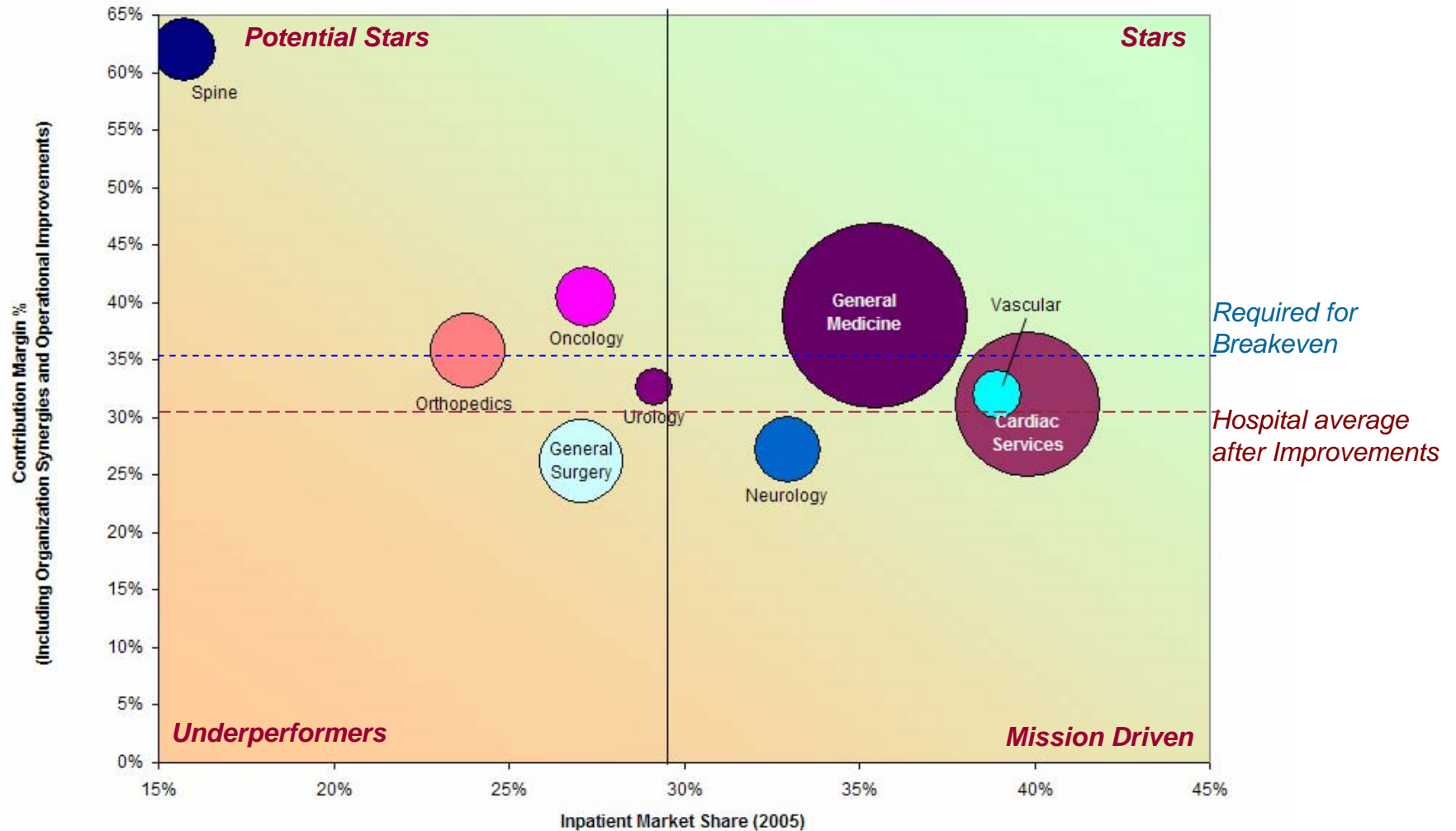
Closed Service Lines Not Plotted:

- ◆ Behavioral Health: 20% share; -42% margin
- ◆ Neonatology: 20% share, -630% margin
- ◆ Obstetrics: 22% Share, -201% margin

NOTE: Financial data: FY 2006 per internal data.
 Market share data: 2005 per OSHPD.
 The size of each "bubble" indicates an area's relative size based on volume

Inpatient Analysis: The Wellspring Matrix

Post Implementation of Initiatives and Synergies



NOTE: Financial data: FY 2006 per internal data.
 Market share data: 2005 per OSHPD.
 The size of each "bubble" indicates an area's relative size based on volume

Outpatient Services: Contribution Margin

Outpatient encounters account for 34% of Net Patient Revenue. For the period July-Dec 2006 outpatient services had a negative 7% contribution margin. Factoring in the organization improvements/synergies improve the contribution margin to 17% in 2009.

Outpatient Service: Full Year Baseline (1)					
Outpatient Service	Patient Encounters	Baseline payments with AB915 (2)	Baseline Contribution Margin	Baseline Contribution Margin %	2009 Contribution Margin (3)
Oncology (Non-Rad Onc.)	1,770	\$ 1,927,513	\$ 908,754	47%	62%
Outpatient Radiology	16,938	\$ 3,108,972	\$ 434,049	14%	40%
Infusion Center	368	\$ 666,281	\$ 59,704	9%	35%
Radiation Oncology (4)	1,056	\$ 3,065,107	\$ 267,986	9%	31%
Emergency Services	32,970	\$ 9,371,610	\$ (245,239)	-3%	23%
Sleep Center	3,662	\$ 597,822	\$ 83,092	14%	29%
Burn Clinic (5)	2,702	\$ 221,730	\$ (12,065)	-5%	
Ambulatory Surgery	3,118	\$ 4,750,084	\$ (1,311,656)	-28%	-4%
Cath Lab	332	\$ 833,363	\$ (280,754)	-34%	-8%
General Medical	1,886	\$ 1,459,443	\$ (799,216)	-55%	-26%
Wound Care	596	\$ 100,751	\$ (35,585)	-35%	-23%
PT/OT/SP	2,374	\$ 178,524	\$ (163,131)	-91%	-52%
Breast Center	5,234	\$ 375,308	\$ (194,418)	-52%	-37%
Cardiology (Non-Cath)	250	\$ 84,463	\$ (135,247)	-160%	-122%
Diabetes Management (6)	764	\$ 37,328	\$ (27,926)	-75%	-69%
Obstetrics/GYN (O/P) (5)	618	\$ 90,211	\$ (460,336)	-510%	
Outpatient Total	74,664	\$ 26,874,608	\$ (1,932,536)	-7%	17%

Payments do not cover direct cost of care even after implementing improvement opportunities (2009)

- (1) Annualized based on July through December 2006 actual
- (2) Includes allocated Medi-CAL AB915 funding (\$911,679/Year per 2006)
- (3) Includes organization synergies and operational improvements
- (4) Revised upward from initial version to account clarification of expense groupings
- (5) Closed programs
- (6) includes \$7,159 in external funding

Outpatient Services: Contribution Margin

Observations concerning specific DMC outpatient services.

- ◆ **Emergency Department (ED)** – The ED has historically experience negative contribution margins, due at least in part to DMC’s payor mix. Proposed improvement initiatives will allow this department to cover the direct cost of care. However, even with implemented improvements the ED will not attain a 35% margin, which is needed to cover the full cost of care (including overhead costs).
- ◆ **Ambulatory Surgery** – Currently, Ambulatory Surgery services are located within the inpatient surgery area, which has a significant fixed cost structure. Thus, Ambulatory Surgery exhibits a negative contribution margin. Proposed operational improvements will increase the service's margin.
- ◆ **The Cath Lab** – A well utilized interventional Cath Lab should generate significant positive contribution. The operating loss generated by the Cath Lab appears to be the result of: a significant decrease in patient volume since the period of ED diversion in the fall of 2006; over staffing in the lab (since rectified); and low payor collections rates for Cath Lab patients.
- ◆ **Wound Care** – Wound Care is a hospital-based outpatient clinic. The service is closely aligned with vascular care, diabetes and traumatic injury.

Outpatient Services: Contribution Margin

- ◆ **Breast Center** – The Breast Center is a component of the Cancer Center. While it does not generate a positive contribution margin, the Breast Center it is a significant feeder to the Cancer Center. Within DMC's current care model breast cancer is predominantly treated through the Infusion Center and Radiation Oncology.
- ◆ **Cardiology (non-cath)** – Includes cardiac diagnostic testing and mentoring (stress and echo testing and Holter monitoring), and is one component of the comprehensive medical cardiology program.
- ◆ **Diabetes Management** – Diabetes is a significant public health issue in both California and Contra Costa county. This program provides clinical testing, disease management and the coordination of clinical care. The program includes support from Chevron. Insurance payments are insufficient to cover Diabetes Management costs but the center generates inpatient volume and its care management component program helps limit unnecessary clinical service utilization.

Potential Program Restructuring Components

In order to improve functioning within specific areas, as well as overall viability, DMC should restructure specific programs by using the following approach:

- ◆ Revise staffing and other resources so that capacity is in line with demand
- ◆ Redesign processes to improve efficiency and reduce non-value added activities and redundancies
- ◆ Avoid using high-cost staff, technology, equipment or facility resources when lower cost options are available
- ◆ Align programs with the County's healthcare network to maximize synergies and take advantage of cross-referral opportunities
- ◆ Improve contracted payor rates and terms
- ◆ Pursue opportunities to improve volume from payors with favorable payment rates
- ◆ Eliminate service components that are non-value added or do not contribute to a sufficiently positive contribution margin (i.e., at least 35%)

Specific Service Line Assessments

Oncology Service Line: Assessment and Options

DMC offers greater Contra Costa County a full service, accredited Cancer Center.

- ◆ The Cancer Center includes;
 - Outpatient and Inpatient Infusion
 - Radiation Therapy
 - The Linear Accelerator is 15 years old and in need of replacement
 - The Center does not offer the current standard of care in radiation therapy (IMRT)
 - DMC's current capital plan (2007-2010) includes \$4.3 Million for the purchase of IMRT and a new Linear accelerator
 - Oncology-related inpatient surgery
 - A Breast Center for the diagnosis and treatment of breast cancer
 - Cancer Support and monitoring including a Cancer Registry and patient support functions
- ◆ Oncology care is increasingly an outpatient service line (infusion and radiation therapy)
- ◆ Investment is needed to maintain a market competitive facility.

Oncology Service Line: Assessment and Options

Assessment Summary

- ◆ Oncology services are projected to have a positive contribution margin in excess of variable overhead of \$377,000 in 2007 assuming operational improvements and synergies, as well as a 6-8% volume increase
- ◆ Due to proposed operational improvements and some volume increases, 3 year projections yield a positive contribution margin of over \$4.0 Million in 2009 for a fully functional oncology program
- ◆ In order to be fully functional and realize a positive margin, oncology services require over \$4.3 Million of capital investments, primarily related to IMRT and a new linear accelerator
- ◆ A source of funding for needed capital improvements has not been secured, options include
 - Local public funding
 - State public funding
 - Private support from another provider
 - Philanthropy
- ◆ Specific payor contracts were identified as primary drivers of negative contribution margins within oncology services, especially radiation oncology
- ◆ Negotiations with specific payors are being held to determine if acceptable rates can be arranged
- ◆ DMC has notified specific payors of our intent to terminate agreements unless DMC receives payments in excess of the cost of providing care
- ◆ A potential competitor intends to open a Cancer Center in northern Oakland in 2009-10. This may not materially impact current and projected volumes due to the general lack of transportation resources available to DMC patients

Oncology Service Line: Assessment and Options

P & L By Service Component

Oncology Service Line Components	Contribution Margin net of Incremental Overhead*				
	Baseline	2007	2008	2009	2010
Inpatient Oncology	\$56,666	\$165,439	\$384,381	\$420,179	\$362,648
O/P Breast Center	(253,326)	(230,331)	(150,935)	(116,970)	(112,457)
O/P Infusion	469,446	543,794	870,893	910,001	839,832
O/P Oncology	60,807	67,113	91,364	93,087	82,527
O/P Radiation Therapy	(405,287)	(169,111)	1,563,441	1,553,971	1,411,497
Oncology Total	\$ (71,694)	\$ 376,903	\$ 2,759,144	\$ 2,860,269	\$ 2,584,046
Oncology Related Capital Expenditures					
CapEx	\$ 0	\$ 500,000	\$ 1,882,750	\$ 1,882,750	\$ 0

* *Contribution Margin net of Incremental Overhead is defined as payments less direct expenses less variable overhead. Incremental overhead is used since this is the expense that would be eliminated if the service line was discontinued.*

Pro forma contribution margin Includes:

- ◆ Actual and expected renegotiated payor rates
- ◆ Purchase of IMRT in 2007 and a new linear accelerator in 2009.
- ◆ Incremental patient volume from IMRT implementation
- ◆ Identified Improvement Initiatives, net of implementation costs
- ◆ Identified CCRMC synergies, net of implementation costs

Oncology Service Line: Assessment and Options

Oncology Baseline EBIDA by Financial Class July – December 2006

Financial Class	Payments	Direct Expenses	Contribution Margin	Fully Allocated Overhead Expenses	EBIDA	Percent Cost Coverage
<u>Government Payors</u>						
Medicare	\$2,821,430	\$2,201,449	\$619,981	\$1,398,893	\$(778,912)	78%
Medi-CAL	223,834*	436,508	(212,674)	242,449	(455,123)	33%
<u>Insurance Payors (Negotiated)</u>						
Medi-CAL HMO	455,428	692,666	(237,240)	347,740	(584,978)	44%
Medicare HMO	1,121,024	1,046,495	74,528	613,237	(538,709)	68%
Managed Care (HMO)	1,540,581	1,527,536	13,044	925,067	(912,023)	63%
PPO Contract	2,059,602	1,072,405	987,196	652,693	334,504	119%
Other Payors	91,400	100,056	(8,656)	63,208	(71,864)	56%
<u>Other Financial Classes</u>						
Self Pay	2,377	45,106	(42,730)	21,331	(64,060)	4%
Product Line Total	\$8,315,676	\$7,122,221	\$1,193,449	\$4,164,119	\$(2,970,665)	76%

Note: Traditional Medicare and Medi-Cal account for 36% of total revenues. Payors with negotiated rates comprise the remaining 64% of total revenues.

Cardiology Service Line: Assessment and Options

DMC is not currently offering a full continuum of cardiology services.

- ◆ Cardiology Services currently account for 20% of all inpatient discharges and 18% of patient days.
- ◆ The service line consists of; emergency care (including observation), inpatient medical cardiology, in- and outpatient interventional cardiology (Cath Lab) and outpatient diagnostic testing.
- ◆ Cardiac surgery and EP procedures have been curtailed since DMC since declared bankruptcy.
 - The program needs to be rejuvenated in order to build cardiac surgery capacity and maximize the ability to perform interventional caths
 - Programmatic, rather than capital investments are required to maintain the program going forward (e.g., staff, education, marketing, physician/EMS outreach)
 - DMC may also elect to investigate establishing an agreement with another facility to provide cardiac surgical referral capabilities
- ◆ The product line profitability analysis indicates that the cardiovascular service at DMC under-performs its peers in terms of financial contribution.

Cardiology Service Line: Assessment and Options

Assessment Summary

- ◆ Cardiology related services are projected to have annualized negative contribution margin in excess of variable overhead of (\$1.24 Million) for fiscal 2007
- ◆ With operational improvements and the reintroduction of cardiac surgery, the cardiology program would generate contribution margin in excess of variable overhead of \$654,000 in 2010.
- ◆ DMC's Cardiology program is currently experiencing low patient volume.
 - The Cath Lab averages 2.4 patients and 4.3 procedures per day (YTD 2007)
 - DMC has not performed an EP (inpatient) since November 2006 due to equipment issues
 - Cardiac surgery volume was 60 cases in 2005 and 33 cases in 2006
- ◆ Annual volume projections beginning in 2008 assume approximately 100 Cardiac Surgery and 90 EP procedures
- ◆ The cost of reintroducing Cardiac Surgery at DMC would include:
 - \$1,319,000 a year in incremental staffing (CV ICU staff and perfusionists)
 - \$295,000 in capital expenditures (OR equipment)
- ◆ An additional \$1 Million in capital is required to bring cardiology related areas to a fully functional level
- ◆ There are two potential operating models for cardiology service going forward
 1. Emphasize medical and basic outpatient cardiology but discontinue interventional catheterization and do not pursue re-activation of cardiac surgery capability
 2. Re-establish a full cardiology service line including cardiac surgery and EP
- ◆ Elimination of all cardiac services except outpatient and inpatient medical cardiology may affect
 - Current physician referral patterns
 - EMS utilization of the ED
 - Practice volume of current vascular and cardiology physicians

Cardiology Service Line: Assessment and Options

P & L By Service Component Cardiology without Cath and Surgery

Cardiology Service Line Components	Contribution Margin net of Incremental Overhead*				
	Baseline	2007	2008	2009	2010
Inpatient Cardiology - Cath	\$ (643,637)	\$ 0	\$ 0	\$ 0	\$ 0
Inpatient Cardiology – EP**	506,920	0	0	0	0
Inpatient Cardiology - Surgery	266,065	0	0	0	0
Inpatient Cardiology - Medical	(1,227,562)	(1,038,763)	(215,093)	(6,593)	(98,190)
O/P Cardiology	(164,805)	(205,576)	(165,377)	(146,276)	(138,318)
O/P Cath	(489,202)	0	0	0	0
Cardiology Total	\$ (1,752,233)	\$ (1,244,339)	\$ (380,470)	\$ (152,870)	\$ (236,509)
CapEx	\$ 0	\$ 0	\$ 0	\$ 0	\$ 0

- *Contribution Margin net of Incremental Overhead is defined as payments less direct expenses less variable overhead. Incremental overhead is used since this is the expense that would be eliminated if the service line was discontinued.*

** *This P&L assumes no EP procedures after the elimination of interventional cardiology. Additional work is required to confirm this or whether some EP procedures can be performed in this business model.*

Pro forma contribution margin Includes:

- ◆ Actual and expected renegotiated payor rates.
- ◆ Identified Improvement Initiatives, net of implementation costs
- ◆ Identified CCRMC synergies, net of implementation costs

Cardiology Service Line: Assessment and Options

P & L By Service Component Cardiology Program Development Including CV Surgery and EP

Cardiology Service Line Components	Contribution Margin net of Incremental Overhead*				
	Baseline	2007	2008	2009	2010
Inpatient Cardiology - Cath	\$ (643,637)	\$ (525,752)	\$ (123,210)	\$ (414)	\$(41,520)
Inpatient Cardiology - EP	506,920	207,213	1,168,158	1,107,477	1,019,944
Inpatient Cardiology - Surgery	266,065	109,314	169,361	217,250	192,542
Inpatient Cardiology - Medical	(1,227,562)	(951,107)	(240,814)	(39,506)	(138,064)
O/P Cardiology	(164,805)	(163,344)	(168,333)	(149,232)	(141,274)
O/P Cath	(489,202)	(439,481)	(288,399)	(238,950)	(237,487)
Cardiology Total	\$ (638,106)	\$ (1,763,157)	\$ 516,763	\$ 896,624	\$ 654,141
CapEx	\$ 0	\$ 1,284,765	\$ 0	\$ 0	\$ 0

* *Contribution Margin net of Incremental Overhead is defined as payments less direct expenses less variable overhead. Incremental overhead is used since this is the expense that would be eliminated if the service line was discontinued.*

Pro forma contribution margin Includes:

- ◆ Actual and expected renegotiated payor rates.
- ◆ Identified Improvement Initiatives, net of implementation costs
- ◆ Identified CCRMC synergies, net of implementation costs

Cardiology Service Line: Assessment and Options

Cardiology Baseline EBIDA by Financial Class July – December 2006

Financial Class	Payments	Direct Expenses	Contribution Margin	Overhead Expenses*	EBIDA	Percent Cost Coverage
<u>Government Payors</u>						
Medicare*	\$7,271,946	\$5,533,418	\$1,738,529	\$3,252,255	(\$1,513,727)	89%
Medi-CAL*	769,326	1,589,205	(819,879)	986,643	(1,805,522)	30%
Corrections (CDCR)**	274,982	269,861	5,121	151,259	(146,138)	65%
<u>Insurance Payors (Negotiated)</u>						
Managed Care (HMO)	934,091	949,620	(15,528)	457,302	(472,830)	66%
Medicare HMO	1,409,771	1,270,442	138,329	779,950	(640,621)	69%
PPO Contract	1,163,731	885,254	278,477	416,415	(137,938)	89%
Medi-CAL HMO	187,978	341,013	(153,035)	184,808	(337,843)	36%
Other Payors	30,219	71,900	(41,681)	33,916	(75,597)	29%
<u>Other Financial Classes</u>						
Self Pay	8,250	468,436	(460,186)	272,599	(732,785)	1%
Product Line Total	\$12,050,194	\$11,379,147	\$670,147	\$6,535,148	\$(5,864,001)	67%

• Traditional Medicare and Medi-cal represent 67% of total revenue leaving only 33% with contracted payors.

• ** CDCR was initiated in Q4 2006 and is expected to be profitable after a normal payment cycle is established

Baseline P& L Information

Baseline P & L: Viability of Current State

Despite the impact of previously identified improvement opportunities and potential synergies with CCRMC, DMC's EBIDA will remain negative without significant additional funding sources.

Given that DMC has significant immediate and long-term capital needs that cannot be funded by current operations (despite the impact of any improvement efforts), the current operating model requires additional funding.

FINANCIAL COMPONENT	PROJECTIONS BY YEAR (IN \$ MILLIONS)				
	2007	2008	2009	2010	TOTAL
Projected EBIDA, Current Operating Model	\$ (23.9)	\$ (23.9)	\$ (23.9)	\$ (23.9)	\$ (96.2)
Net Improvement Initiative Benefits (As Identified in Assessment, Net of Implementation Costs, including one time Initiatives)	4.3	14.2	14.2	14.2	46.9
County Operational and Clinical Synergies, Net of Implementation	(0.1)	1.2	2.9	2.9	6.9
Projected Cash Burn After Improvement Initiatives & Synergies	(19.7)	(8.5)	(6.8)	(6.8)	(41.8)
Capital Expenditures	(9.0)	(6.6)	(5.6)	(4.0)	(25.3)
TOTAL CASH BURN AND CAPITAL EXPENDITURES	\$ (28.7)	\$ (15.1)	\$ (12.4)	\$ (10.8)	\$ (67.0)

Note: Excludes CMAC funding that was approved in 2006 and received in 2007 and Ad Valorem and Parcel Tax revenue

Current and Potential Improvement Initiatives

The assessment identified the following improvement opportunities:

Initiatives Currently Underway:

- ◆ **Denials Management** – A Wellspring team is working with DMC Business Office staff to facilitate cash collections on denied and under-paid claims. To date over \$2.5 million has been identified for collections, nearly \$1 million of which has been received.
- ◆ **Managed Care Rates** – We are currently renegotiating rates with managed care payors. DMC has given contract termination notice to specific managed care payors unless rates are adjusted to cover the total cost of caring for their members.

Initiatives Identified But Not Yet Implemented:

- ◆ **Revenue Cycle** – Opportunity has been identified surrounding the use of collection agencies, the pre-registration process and other process improvements throughout the revenue cycle. Once fully implemented these initiatives will yield \$1.5 million annually.
- ◆ **Reimbursement** – Opportunity has been identified for DSH qualification for DMC. Qualifying for DSH will allow for both federal and state funding annually of \$1.6 million. One time payments for 2005 and 2006 will also be received towards the end of 2007 and 2008.
- ◆ **Labor** – Process improvements were identified which will lead to significant efficiencies and reduced labor costs. Once fully implemented these initiatives will yield \$4.6 million annually.
- ◆ **Non-Labor** – Significant cost reduction opportunities related to supplies and purchased services were identified. These initiatives will yield \$1.6 million annually on a fully implemented basis.

Baseline P & L: Potential Improvement Initiatives

IMPROVEMENT INITIATIVES (\$ IN MILLIONS)					
	2007	2008	2009	2010	Total
Revenue Cycle (Including Denials)	\$ 3.1	\$ 3.5	\$ 3.5	\$ 3.5	\$ 13.6
Non-Labor	0.3	1.6	1.6	1.6	5.1
Labor	0.6	4.6	4.6	4.6	14.4
Reimbursement	0.4	0.9	1.6	1.6	4.5
Managed Care Rates	1.0	2.9	2.9	2.9	9.7
One Time Initiatives (Revenue Cycle & Reimbursement)	2.3	2.2	-	-	4.5
Less: Implementation Costs	(3.3)	(1.5)	-	-	(4.8)
TOTAL	\$ 4.3	\$ 14.2	\$ 14.2	\$ 14.2	\$ 46.9

Note: This assumes implementation of initiatives is to begin July 1, 2007 except for the Denials initiative, which began in March 2007

Baseline P & L: Potential Synergies Between DMC & CCRMC

- ◆ Total opportunity due to fully implemented synergies is \$2.9 million.
- ◆ Implementation costs are estimated at \$675 K between 2007 & 2008

SYNERGY INITIATIVES BY YEAR (IN \$ MILLIONS)					
	2007	2008	2009	2010	Total
Operational					
Various Administrative & Support Functions	0.2	1.5	2.7	2.7	7.1
Clinical					
Orthopedic Volume	0.03	0.03	0.1	0.1	0.26
General Med/Surg Volume	0.07	0.07	0.1	0.1	0.34
TOTAL	\$ 0.3	\$ 1.6	\$ 2.9	\$ 2.9	\$ 7.7

Baseline P & L: Capital Expenditure Needs

Department	2007	2008	2009	TOTAL
Laboratory	321,500	123,000	-	444,500
Cath Lab	989,000	-	-	989,000
Radiation Therapy	500,000	1,882,750	1,882,750	4,265,500
Quality Management	256,000	-	-	256,000
Radiology	435,000	1,075,000	1,200,000	2,710,000
Anesthesiology	120,000	80,000	80,000	280,000
Nursing	340,000	550,000	-	890,000
Respiratory Therapy	33,000	33,000	33,000	99,000
Pharmacy	-	200,000	350,000	550,000
Endoscopy	350,000	-	-	350,000
Surgery	728,000	326,000	26,000	1,080,000
CT	-	-	1,000,000	1,000,000
Information Technology	4,102,000	1,982,000	819,000	6,903,000
Roof Replacement	133,333	133,333	133,334	400,000
Other	782,000	243,000	67,000	1,092,000
TOTALS	9,089,833	6,628,083	5,591,084	21,309,000

Note: Highlighted Items represent program specific capital

There is limited opportunity to alter the capital budget based on changes in programs

Assessment and Overview of Operating Model Options

Assessment of Future State Options and Components

- ◆ During the course of this assessment, various operating models and features were investigated, including the allocation of services by location
 - DMC facilities are not appropriately sized/configured to meet current demand (i.e., there is over-capacity in the current campus)
 - DMC's buildings require seismic upgrades the cost of which has yet to be determined
- ◆ We were asked to evaluate the Pinole campus to assess potential opportunities to house all or part of current DMC services because of the following reasons:
 - DMC previously operated the facility at Pinole
 - The Pinole facility has an inpatient bed license
 - The Pinole facility is still available for lease according to Tenet Healthcare System
 - The Pinole campus is proximal to several significant/potential referral physicians
 - Capacity at Pinole is more in line with current DMC inpatient volumes
 - Seismic issues with the Pinole buildings are thought to be minimal or nonexistent
- ◆ At present, the Pinole campus was deemed not to be a viable service location for DMC
- ◆ Please refer to next page for issues related to operating on the Pinole campus

Pinole Campus Issues

There are multiple issues with the Pinole campus which currently preclude a move to this location

- ◆ The Pinole campus requires at least \$5 Million in immediate capital investment in order to begin operating as an inpatient healthcare facility
 - This amount is associated with fire/life/safety and access improvements/renovations that OSHPD is very likely to require prior certifying the facility for use
 - OSHPD may require additional improvements costing at least \$1 Million
- ◆ The OSHPD review and approval process can be lengthy and costly
 - OSHP requires improvements to be made and operations to commence prior to conducting a compliance review
 - If deficiencies are found during the review process, these may have to be addressed in a very short time frame and at a currently undeterminable cost
 - If deficiencies are found that cause a significant, additional financial burden, hospital operations may be jeopardized if not addressed
- ◆ The current size and configuration of the Pinole facility are appropriate for current, constrained inpatient volumes, but may not allow for significant volume and capacity increased needed to improve the viability of critical programs (e.g., oncology, ancillaries, ED, etc.)
- ◆ The Pinole campus cannot support the Cancer Center
- ◆ Support structures and facilities at the Pinole campus (e.g., parking) will not support increases in current volumes
- ◆ Locating programs in proximity to potential referral sources does not guarantee significant volume increases from those referral sources
- ◆ Relocation to the Pinole property and sale of the current DMC campus may be a long process which does not address current financial needs while significantly increasing long term financial risk

Potential Future Operating State: Single Campus – San Pablo

DMC has an opportunity to maximize utilization of the current campus while creating opportunities for near and longer term cost savings, efficiencies and growth:

- ◆ Continue current operations, but determine extent of restructuring needed in specific outpatient programs (Wound Center, Ambulatory Surgery, Cath Lab, PT/OT/Speech, Cardiology, Sleep Center, Diabetes Management), and inpatient Oncology and inpatient Cardiology.
- ◆ Retain Emergency Services
- ◆ Specific administrative and support functions are combined with CCRMC functions, potentially into a shared services organization
- ◆ Attempt to secure funding for current and projected capital needs
- ◆ Attempt to increase primary care referral base
- ◆ Re-size operations to meet current demand with ability to increase capacity in line with potential volume improvements
 - Staffed Beds: Approx 100 near term, allow potential to increase capacity per demand
 - ED Capacity: Approx 24 beds
- ◆ Restructure financially marginal programs
 - I/P Services: Investigate re-initiation of cardiac surgery program
 - O/P Services: Reinvest in Cancer Center
 - Restructure other programs as necessary

Potential Future Operating State: Single Campus – San Pablo

- ◆ Rationale and assumptions associated with future operations at the San Pablo campus
 - Continues DMC service mission
 - Causes minimal disruption to community healthcare services
 - Avoids straining other healthcare provider systems serving the community
 - Requires significant investment in order to meet capital and service needs and avoid negative cash flow
 - Requires significant efforts to improve primary care referral base
 - Requires significant effort to improve relationships with and commitment of current physician base
 - Requires significant efforts to retain current high quality staff
 - Requires the support of key contracted payors
 - Requires additional funding sources to be secured

Potential Future Operating State: Single Campus – San Pablo

- ◆ Advantages of continuing operations at the San Pablo campus
 - Continue current services without short term disruption
 - Avoids removing capacity or services from the community in the near term
- ◆ Disadvantages of continuing operations at the San Pablo campus
 - May exhaust existing District resources
 - Structural deficits will continue, though at diminished levels in comparison to current operations
 - Timeframe required to implement necessary improvements is much longer than the current financial position allows without
 - Short term funding of approximately \$5 million by August 2007 and an additional \$5 million by January 2008
 - Additional longer term funding required even after full implementation of approximately \$4 million/year for operations and \$4 million/year for capital expenditures
- ◆ Risks associated with continuing operations at the San Pablo campus
 - Significant current financial risk without commitment to improvement initiatives and additional funding
 - Additional financial risks may be identified in the coming months
 - If current physicians begin moving volume away from DMC due to uncertainty of the current situation, financial losses will accelerate
 - If specific programs/services are re-structured, this may affect volume in related areas as well as decreasing the need for some portion of current support structures
 - Unless an alternative operating option (i.e., other than current state) is determined and enacted within 60-90 days, the current rate of cash burn will necessitate either significant additional funding or a notice of closure by the fall of 2007

Potential Future Operating State: Single Campus – San Pablo

- ◆ Financial implications of continuing operations at the San Pablo campus
 - Estimated cash loss from operations of \$3-\$4 million after full implementation
 - Estimated capital expenditures of approximately \$25.3 Million will be required through 2010
- ◆ Timeline for improving viability of operations on the San Pablo campus
 - Determine programs to be restructured by June 30, 2007
 - Begin restructuring specific programs and other improvement/synergistic initiatives immediately upon decision approval
- ◆ Contingencies/Rules for progression associated with attempting to improve viability of operations at the San Pablo campus
 - Only viable with significant and clear commitments for additional funding
 - Requires some programmatic restructuring based on financial viability and criticality of specific programs
 - Requires commitment to maximizing operational improvement initiatives
 - Requires realization of synergies with CCRMC



Current and Future State Financial Projections

Restructured OP Programs

Financial Summary					
Options	2007	2008	2009	2010	TOTAL
<i>Change in hospital financial position (contribution margin with incremental overhead) of including program on go forward basis:</i>					
Outpatient Programs					
Wound Center	(39,462)	857	28,629	29,484	19,509
Ambulatory Surgery	(1,387,048)	(884,009)	93,191	274,090	(1,903,776)
Cath Lab	(172,572)	390,796	566,439	536,232	1,320,895
PT/OT/ST	(164,482)	(51,533)	21,703	27,041	(167,271)
Cardiology Outpatient	(125,470)	(91,000)	(72,456)	(66,652)	(355,577)
Sleep Lab	66,218	177,571	233,114	222,748	699,651
Diabetes Management	(30,665)	(16,869)	(7,365)	(5,819)	(60,718)
TOTAL	(1,853,481)	(474,187)	863,255	1,017,124	(447,289)

Outpatient Programs above had Contribution Margin of less than 35%. Program restructuring has been included in the figures in 2008 forward. Restructuring includes increasing volume and negotiating better rates with payors.

Note: The Contribution Margin with Incremental Overhead also includes Improvement Initiatives and Synergies

Potential Program Restructuring Components

In order to improve functioning within specific areas, as well as overall viability, DMC should restructure specific programs by using the following approach

- ◆ Revise staffing and other resources so that capacity is in line with demand
- ◆ Redesign processes to improve efficiency and reduce non-value added activities and redundancies
- ◆ Avoid using high-cost staff, technology, equipment or facility resources when lower cost options are available
- ◆ Align programs with the County's healthcare network to maximize synergies and take advantage of cross-referral opportunities
- ◆ Improve contracted payor rates and terms
- ◆ Pursue opportunities to improve volume from payors with favorable payment rates
- ◆ Eliminate service components that are non-value added or do not contribute to a sufficiently positive contribution margin (i.e., at least 35%)

These programs should be re-energized using a very focused business improvement approach with rigorous tracking of improvement opportunities and regular P&L monitoring.

New Funding Requirements by Option

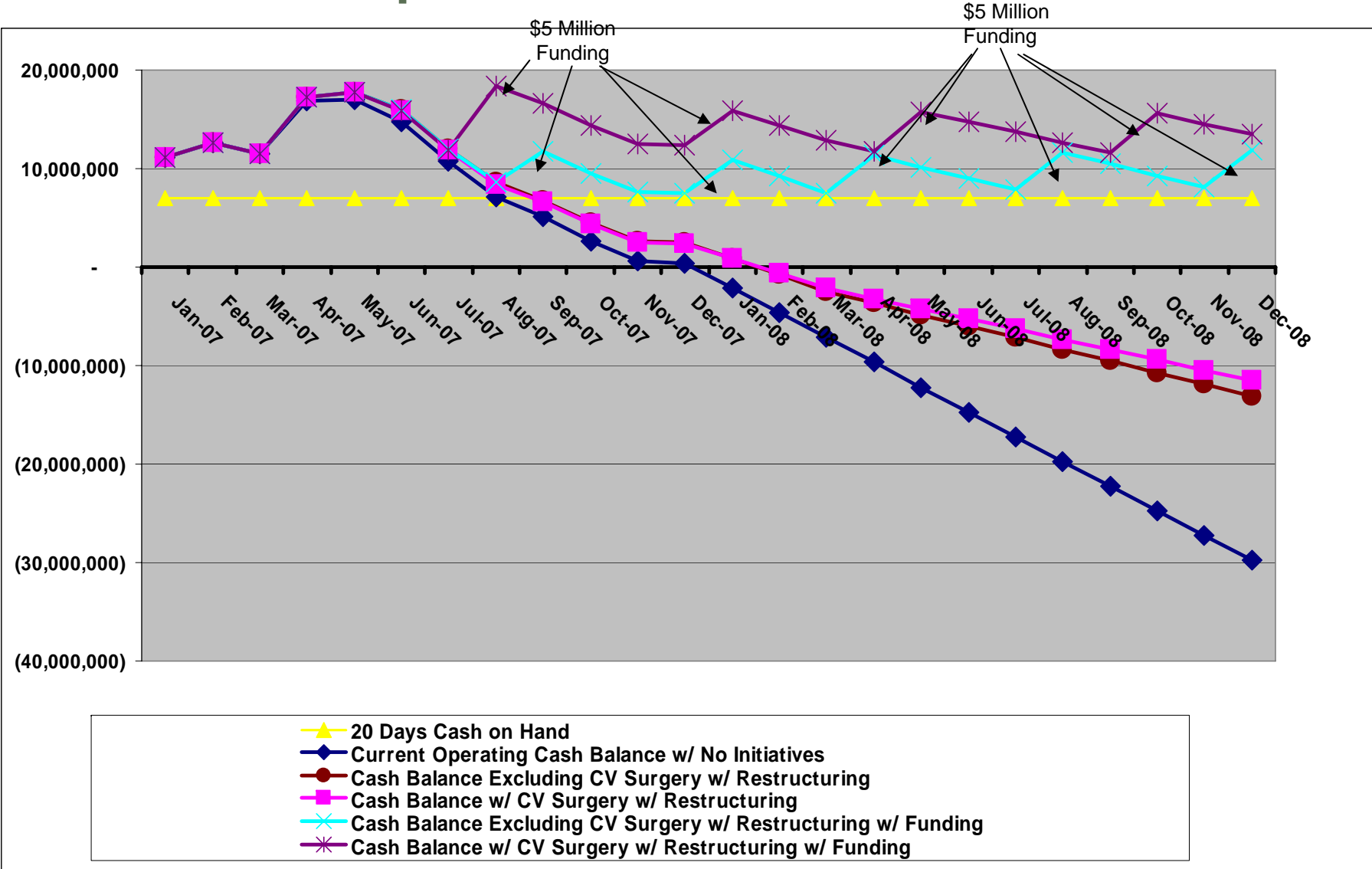
The information below does not include allocations for seismic retrofitting of current DMC buildings or a creditor settlement.

OPTION	FINANCIAL SUMMARY (\$Millions)				
	2007	2008	2009	2010	TOTAL
<i>Incremental Funding Required for Operations</i>					
Full implementation (improvement initiatives, synergies & program restructuring) but excluding cardiac surgery	\$ (0.5)*	\$ (8.1)	\$ (6.8)	\$ (3.9)	\$ (19.4)
Full implementation (improvement initiatives, synergies & program restructuring) but including cardiac surgery	(0.4)*	(6.3)	(5.4)	(2.9)	(14.9)
<i>NET CAPITAL EXPENDITURES**</i>					
Full implementation excluding cardiac surgery	(4.1)	(7.4)	(6.1)	(4.8)	(22.3)
Full implementation including cardiac surgery	(4.7)	(8.0)	(6.1)	(4.8)	(23.6)

•The funding required represents the funding from operations less the CMAC funding received in 2006 of \$5.8.

**The capital expenditures have been delayed and pushed out 6 months. A portion of the funding required for capital expenditures may be met through financing options.

Cash Flow Graph



Note: This graph assumes that all capital expenditures will be paid for out of available cash. It is likely that a portion of the capital expenditure plan will be financed which will reduce some of the funding requirements reflected above.

Business Planning Summary

Business Planning Summary

- ◆ DMC has significant opportunity to improve operations and its financial position through
 - Operational improvements
 - Synergistic alignment with CCRMC
 - Specific programmatic restructuring
- ◆ Once all improvement opportunities have been realized, DMC will continue to exhibit a structural imbalance due to
 - An unfavorable payor mix – most commercial business is with Kaiser
 - Minimum volumes in some areas
 - Weak market position for negotiating with contracted payors
 - Deferred capital maintenance
- ◆ Short-term funding requirements during implementation are:
 - \$5 million 8/07
 - \$5 million 1/08
 - \$5 million 4/08
 - \$5 million 8/08
- ◆ Potential short-term sources
 - California Medical Assistance Commission (CMAC)
 - Inter-Governmental transfers
 - Capital contributions from other providers
 - Near term, sun-setting parcel tax increase
- ◆ Long-term funding requirements are \$4-\$6 million/year after implementation. Potential long-term sources
 - Parcel tax increase
 - Payor rate improvements
 - Re-Aligned payor mix
 - Philanthropy
- ◆ Potential financing options to fund a portion of the capital expenditure needs

Business Planning Summary (continued)

- ◆ Service availability
 - Current service configuration is largely maintained
 - Staffed Beds: Approx 100 near term, allow potential to increase capacity per demand
 - ED Capacity: Approx 24 beds
 - Investigate re-initiation of cardiac surgery program and EP procedures without interventional cardiology
 - Reinvest in Cancer Center
 - Determine extent of restructuring needed in specific outpatient programs (Wound Center, Ambulatory Surgery, Cath Lab, PT/OT/Speech, Cardiology, Sleep Center, Diabetes Management)

- ◆ Healthcare reform (if and when it happens) may alter this business strategy

Business Planning Summary

◆ NEXT STEPS: In order to finalize and enact a viable plan of action, we recommend the following decision making timeline:

ACTIVITY	TIMEFRAME							
	May 31	Jun 30	Jul 31	Aug 31	Sep 30	Oct 31	Nov 30	Dec 31
Public Input and Discussion	■							
Update Profit and Loss Data with First Quarter, 2007 Information		■						
Determine Extent and Areas of Program Restructuring			★					
Final Decision Re: Improvement Initiative Implementation			★					
Begin Improvement Implementation			▶					
Obtain Commitment for Additional Incremental Near Term Funding			■					
Secure Near Term Incremental Funding (\$5 million 8/07, \$5 million 1/08)					★			★