Market Analysis

Desert Healthcare District

March 14, 2017

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PREMIER
Engagement Overview

Engagement Overview

- Desert Healthcare District (the “District”) engaged Premier, Inc. (“Premier”) to assess the current and future healthcare service needs in the greater Coachella Valley for a ten-year planning horizon. The scope of this engagement includes evaluation of the following:
  - Current service offerings of Desert Regional Medical Center (“DRMC”) and other area hospitals and healthcare organizations
  - Services residents seek from organizations located outside of the service area
  - Existing gaps in services provided in the service area
  - Service area demographics and health status trends
  - Factors that will influence demand for inpatient and outpatient healthcare services
  - Services that are likely to be needed by residents over a ten-year planning horizon
  - DRMC’s existing infrastructure, and implications related to seismic compliance


PREMIER
Executive Summary

Executive Summary

- On a national level, inpatient utilization is projected to decrease as the value-based care environment pressures hospitals and providers to reduce inpatient utilization and unnecessary procedures (inpatient and outpatient), and there is an increased focus on chronic disease management and prevention for patients. Within the District's service area, total inpatient discharges decreased by 2.0 percent between calendar years ("CY") 2012 and 2015, while the overall use rate (discharges per 1,000 population) decreased by 5.5 percent during this same time period. This trend will continue due to the following:
  - Continued rise of high-deductible insurance plans that constrain medical use
  - Impact of value-based care models (e.g., accountable care organizations, bundled payments, patient-centered medical homes [e.g., Comprehensive Primary Care Plus ("CPC+")], risk-based payment contracts, and performance-based physician incentives) that seek to achieve enhanced coordination of care, better quality outcomes, and reduced costs across care settings
    - Patients treated under these models typically have lower lengths of stay and less readmissions
    - Providers are seeking to reduce preventable hospitalizations for acute and chronic conditions, and preventable readmissions by ensuring patients receive home-based disease management programs and outpatient care, instead of accessing hospital care

Executive Summary

- Shift in volumes from inpatient to observation status through the two-midnight census rule implemented by the Centers for Medicare & Medicaid Services (“CMS”) in October, 2013, and the continued shift in inpatient volume to outpatient care settings for ambulatory case-sensitive admissions (e.g., uncontrolled diabetes, hypertension, dehydration)
- Providers are aggressively increasing intensive medical management for chronic conditions on an outpatient basis

- However, within District’s service area, demand for healthcare services is projected to continue to exist for the following reasons:
  - Service area demographic and health status trends imply that demand for healthcare services will increase during the projection period.
    - The service area’s population age cohort 65 years and older is projected to grow rapidly over the next ten years. As the population ages, the community and its hospitals are likely to experience an increased demand for services such as internal medicine, cardiovascular services, gastroenterology, neurosciences, oncology, orthopedics, pulmonary medicine, and urology, and higher needs for chronic disease management. Further, growth is projected in the population age cohorts 0-14 years, 15-44 years overall and for those whom are female, and 45-64 years. As a result, demand for pediatric (inpatient and outpatient), obstetrics, and elective sub-specialty care will continue to grow in the District’s service area.

Executive Summary

- When compared to state, the District's service area has worse health status outcomes for almost all metrics. Additionally, portions of the District's service area population are underserved, and opportunities exist to improve the overall health of the community with a focus on wellness and prevention through increased access to coordinated primary and specialty care services. This implies an increased demand for inpatient and outpatient healthcare services in the service area.
- Portions of the service area are designated as a Health Professional Shortage Area, Medically Underserved Area, or both, thereby implying that a shortage of primary care physicians exists in this geographic region.
- Most of the healthcare facilities are located in and around the surrounding communities of Palm Springs and Indio. When considering the healthcare needs of the broader service area, there is a geographic misdistribution of these facilities, and patient access limitations exist in the outlying communities (e.g., Mecca, Thermal/Oasis).

- Based upon the service area bed need projections provided on pages 58 through 70 of this report, there is adequate inpatient capacity to support community demand in the service area for general acute care services. However, these projections do not account for in-migration and the regional draw each hospital has for clinical services. When considering each hospital's inpatient volume that originates from the service area, market share, and scope of clinical services provided:
  - DRMC is near- or over-capacity for the following inpatient licensed bed types: critical care, obstetrics, and pediatrics.

Executive Summary

- There is a significant shortage of inpatient psychiatric beds at both Eisenhower Medical Center and Telecare Riverside County Psychiatric Health Facility, and there are no inpatient psychiatric providers for pediatric and adolescent patients. Further, the scope of inpatient and outpatient psychiatric services provided by each facility is limited. Gaps in culturally-appropriate inpatient and outpatient psychiatric clinical programs exist for the following patient cohorts:
  - Pediatric and adolescents
  - Veterans
  - Lesbian, gay, bisexual, and transgenders
  - Geriatrics
  - Latinos
- Patients age 0-14 years represent approximately eight percent (3,475 inpatient discharges) of the service area's total inpatient volume in CY 2015. While DRMC was the market share leader for inpatient pediatric services overall (39.6 percent), almost 28 percent of the service area's pediatric patients left the area for care. This trend implies a need for increased access to pediatric sub-specialty providers across almost all medical and surgical specialties in the District's service area.

Executive Summary

- There is a shortage of ED stations in the District's service area, as well as at DRMC specifically. Given the successful implementation of the Medi-Cal expansion program and the roll-out of the Covered California Healthcare Exchange, demand for ED services in the service area will continue as patients continue to use this modality as a form of primary care, and population growth will result in increased demand for instant access to care.
- Based upon quantitative analyses and qualitative input received from interviewees:
  - Patient access to primary care services provided by community-based clinics is limited. Outpatient clinics operate at- or near-capacity (e.g., facility, provider), and long wait times exist for patients to be seen. Similar to psychiatric services, opportunities exist to provide culturally-appropriate primary care services for the following patient cohorts:
    - Pediatric and adolescents
    - Veterans
    - Lesbian, gay, bisexual, and transgenders
    - Geriatrics
    - Latinos
  - Given that the outpatient clinics are at- or near-capacity, there is very little patient care coordination and chronic disease management services provided.
  - Access to acute rehabilitation, skilled nursing, home health, ambulatory surgery, and imaging services is adequate to meet community needs in the District's service area.


PREMIER
Service Area Overview

Service Area Overview

- The service area was defined by the District as the 25 ZIP Codes located in the Coachella Valley.
- A series of maps are provided on the following pages, including:
  - Service area geographic boundaries
  - Service area overview identifying portions of the geographic region that are designated by the Federal Government as a Health Professional Shortage Area ("HPSA") or Medically Underserved Area ("MUA")
  - Service area overview illustrating healthcare facilities located within this geographic region by facility type

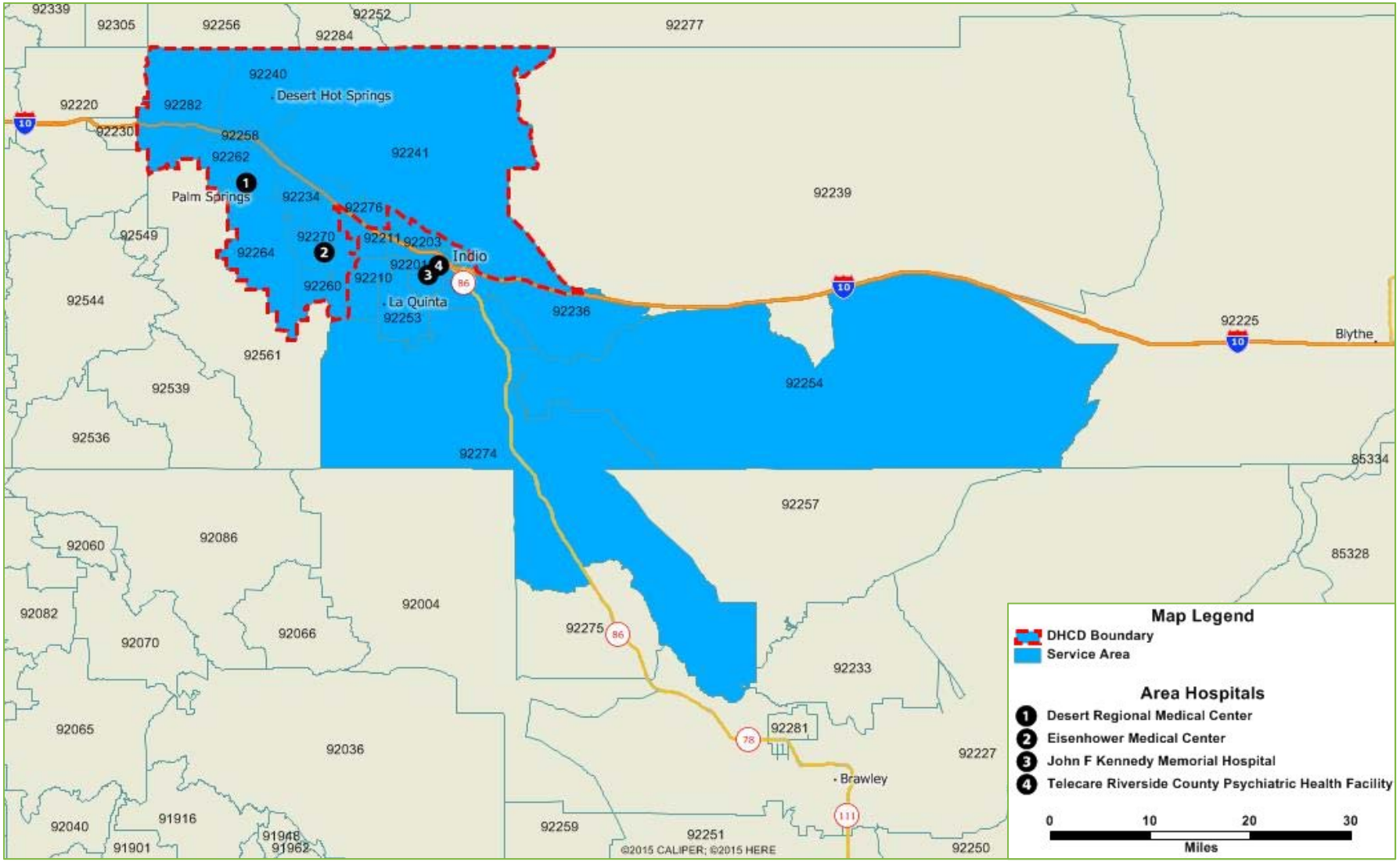
Desert Healthcare District
Coachella Valley Service Area Definition

Desert Healthcare District		East of the District	
ZIP Code	City	ZIP Code	City
92234	Cathedral City	92201	Indio
92235	Cathedral City	92202	Indio
92240	Desert Hot Springs	92203	Indio
92241	Desert Hot Springs	92210	Indian Wells
92255	Palm Desert	92211	Palm Desert
92258	North Palm Springs	92236	Coachella
92260	Palm Desert	92247	La Quinta
92261	Palm Desert	92248	La Quinta
92262	Palm Springs	92253	La Quinta
92263	Palm Springs	92254	Mecca/North Shore
92264	Palm Springs	92274	Thermal/Oasis
92270	Rancho Mirage		
92276	Thousand Palms		
92282	White Water		

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Desert_Healthcare_Patient_Origin_Table.xlsx]DHCD

Source: Desert Healthcare District

Service Area Overview

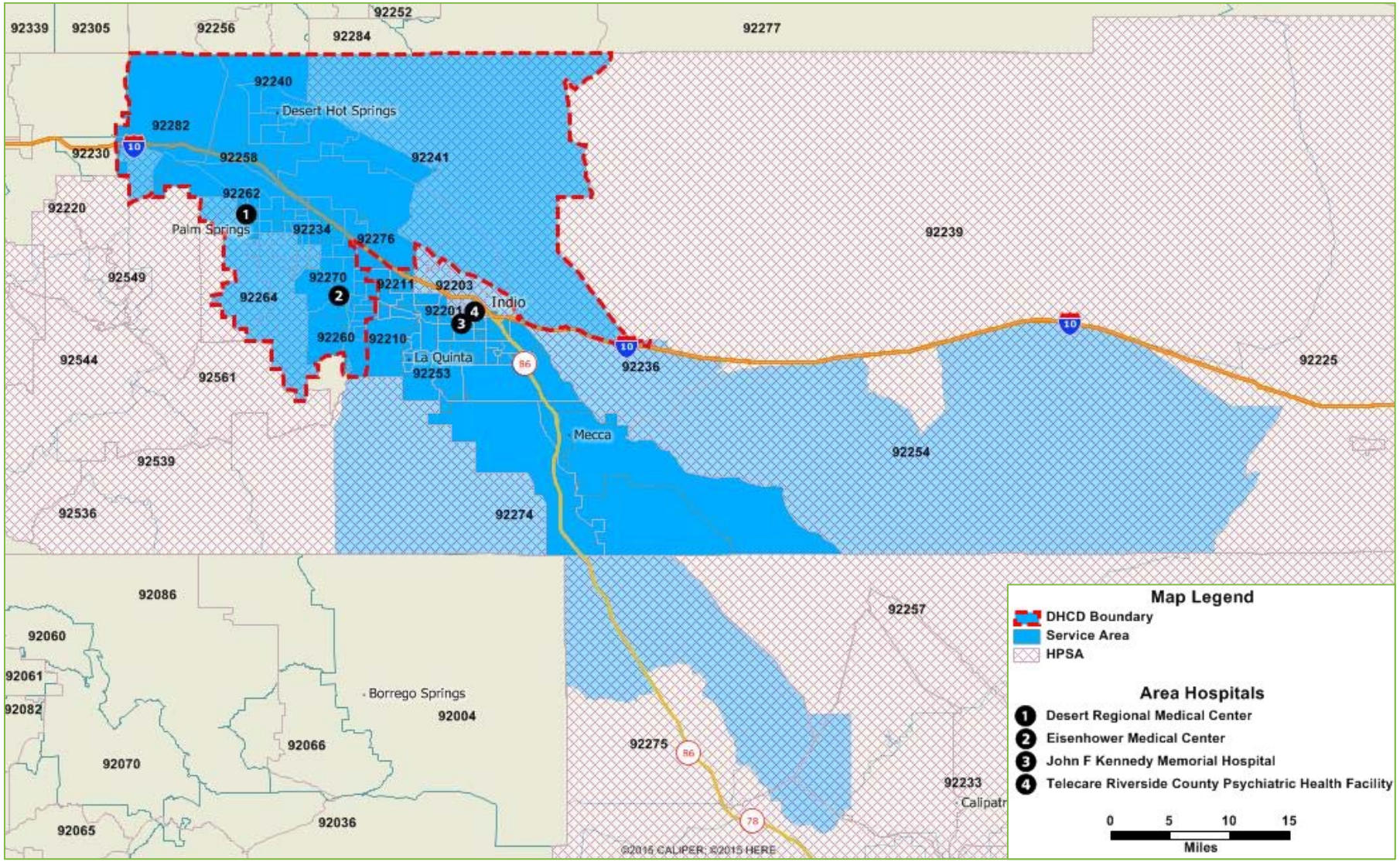


13 Source: Desert Healthcare District, Definitive Healthcare, Maptitude

Health Professional Shortage Areas and Medically Underserved Areas

- The Federal Government defines a HPSA as an area, facility, or population group with a shortage of primary care physicians, as defined by a population-to-primary care physician ratio greater than 3,500:1. Other factors taken into consideration include the poverty rate, infant mortality rate, fertility rate, and indicators of insufficient capacity to meet area need.
- A MUA is defined as an area, facility, or population group with an Index of Medical Underservice ("IMU") less than or equal to 62 out of 100. The IMU is calculated by taking into consideration the ratio of primary medical care physicians per 1,000 population, infant mortality rate, percentage of the population with an income below the poverty level, and the percentage of people age 65 or older. These factors are converted to weighted values and then summed to obtain an IMU score for a particular area.
- Portions of the District's service area have been designated as a HPSA, MUA, or both. Maps illustrating these analyses are provided on the following two pages.

Health Professional Shortage Area



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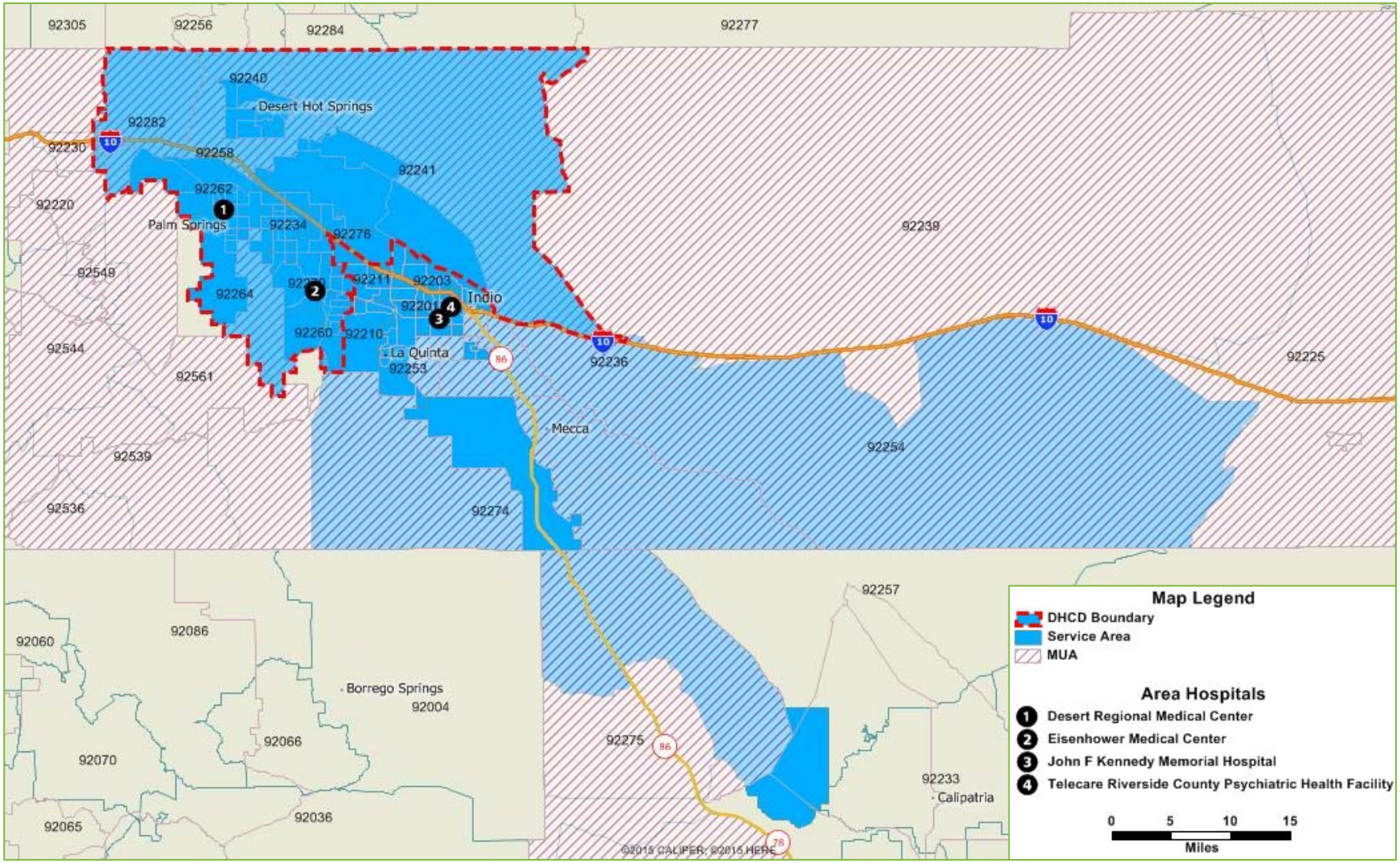
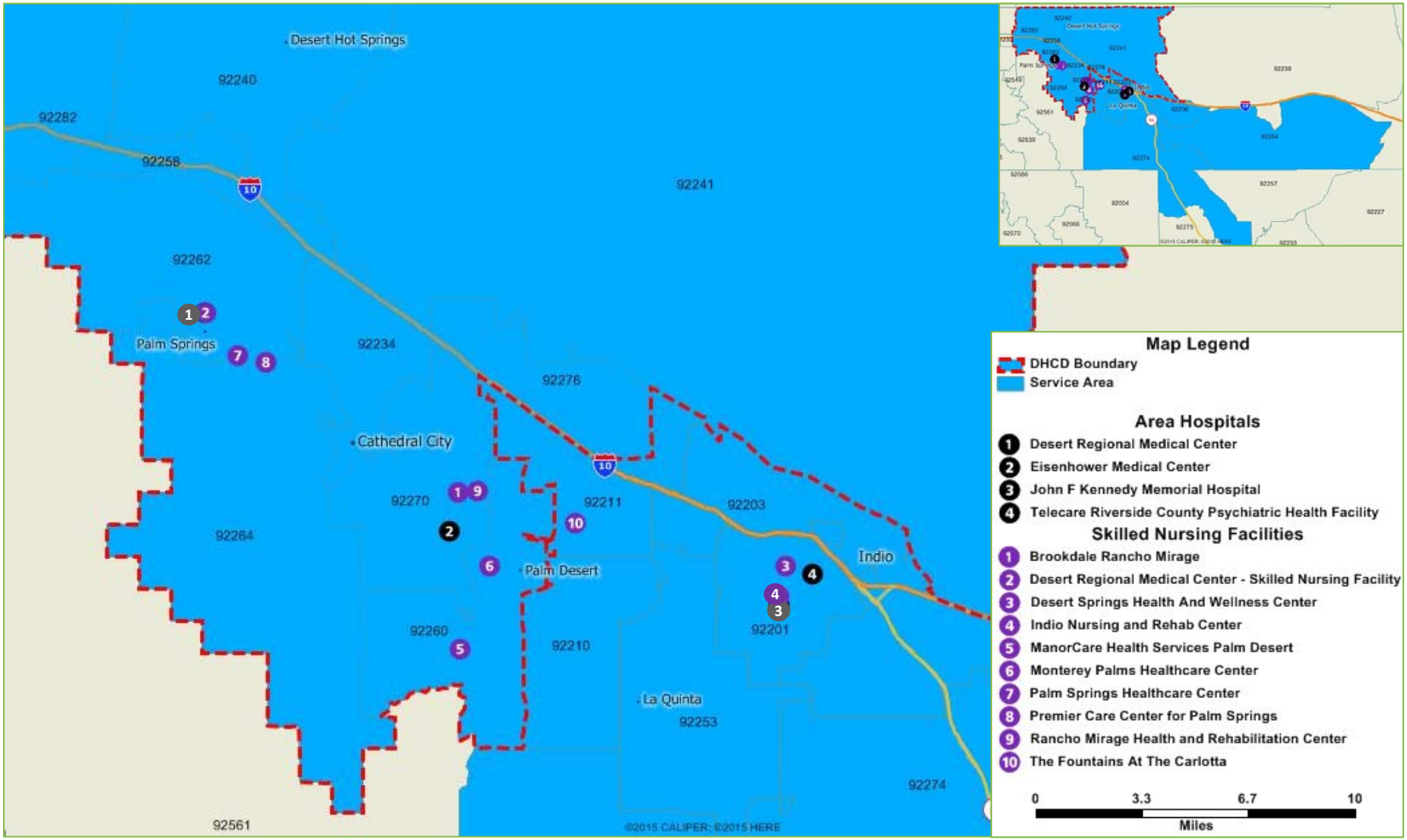
Source: Desert Healthcare District, Definitive Healthcare, Maptitude, Health Resources and Services Administration

Medically Underserved Area



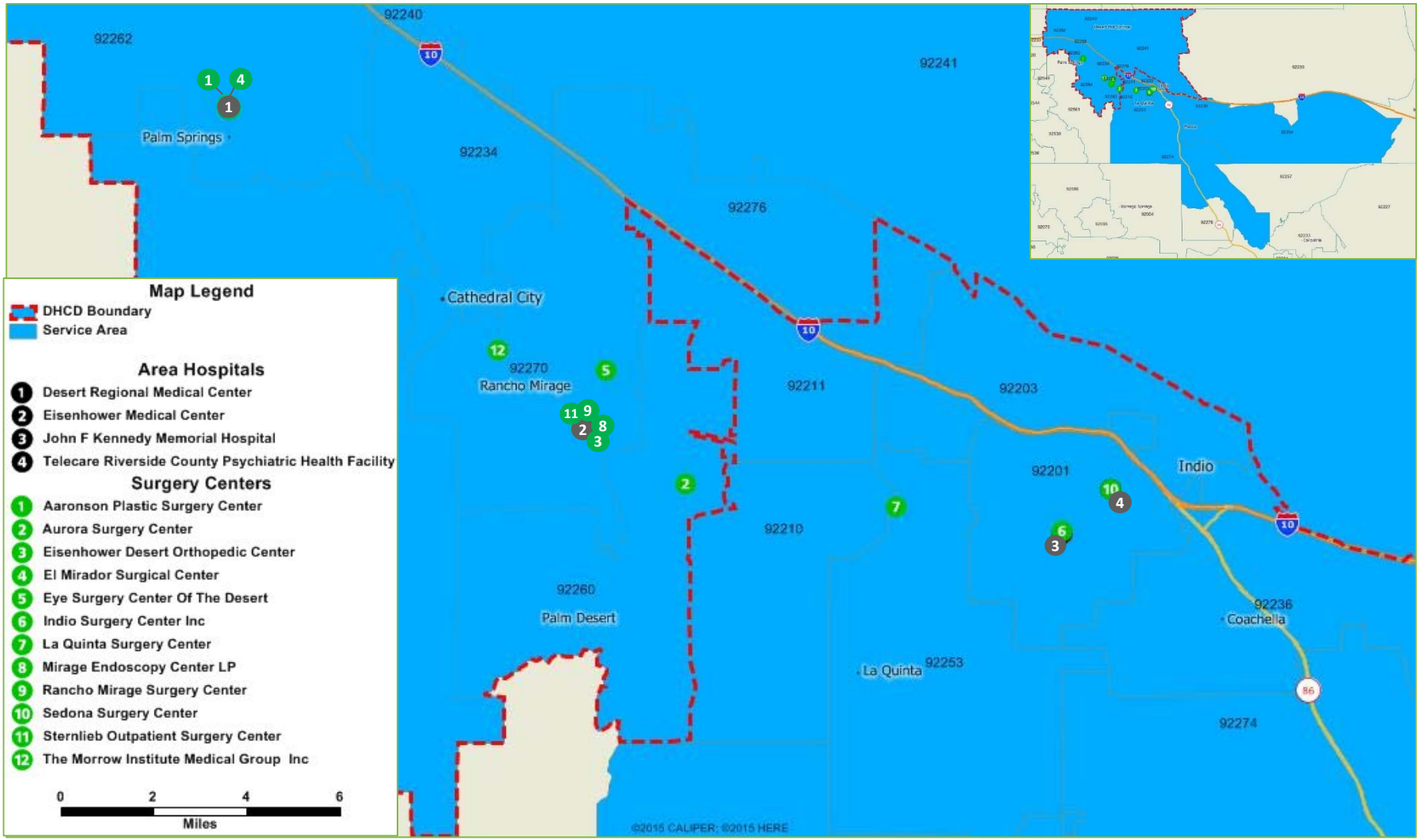
Source: Desert Healthcare District, Definitive Healthcare, Maptitude, Health Resources and Services Administration

Service Area Overview Illustrating Skilled Nursing Facilities



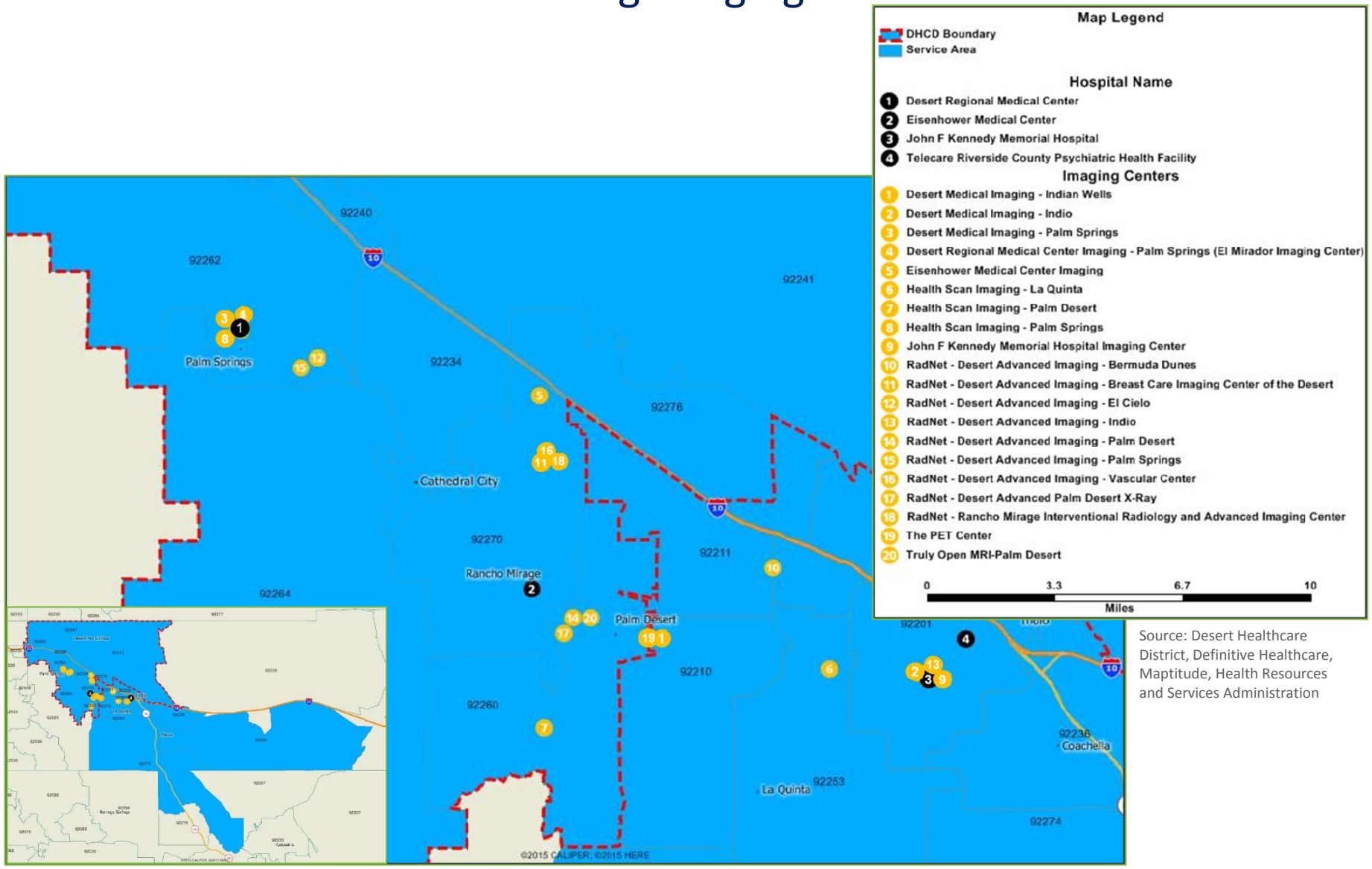
Source: Desert Healthcare District, Definitive Healthcare, Maptitude, Health Resources and Services Administration

Service Area Overview Illustrating Ambulatory Surgery Centers



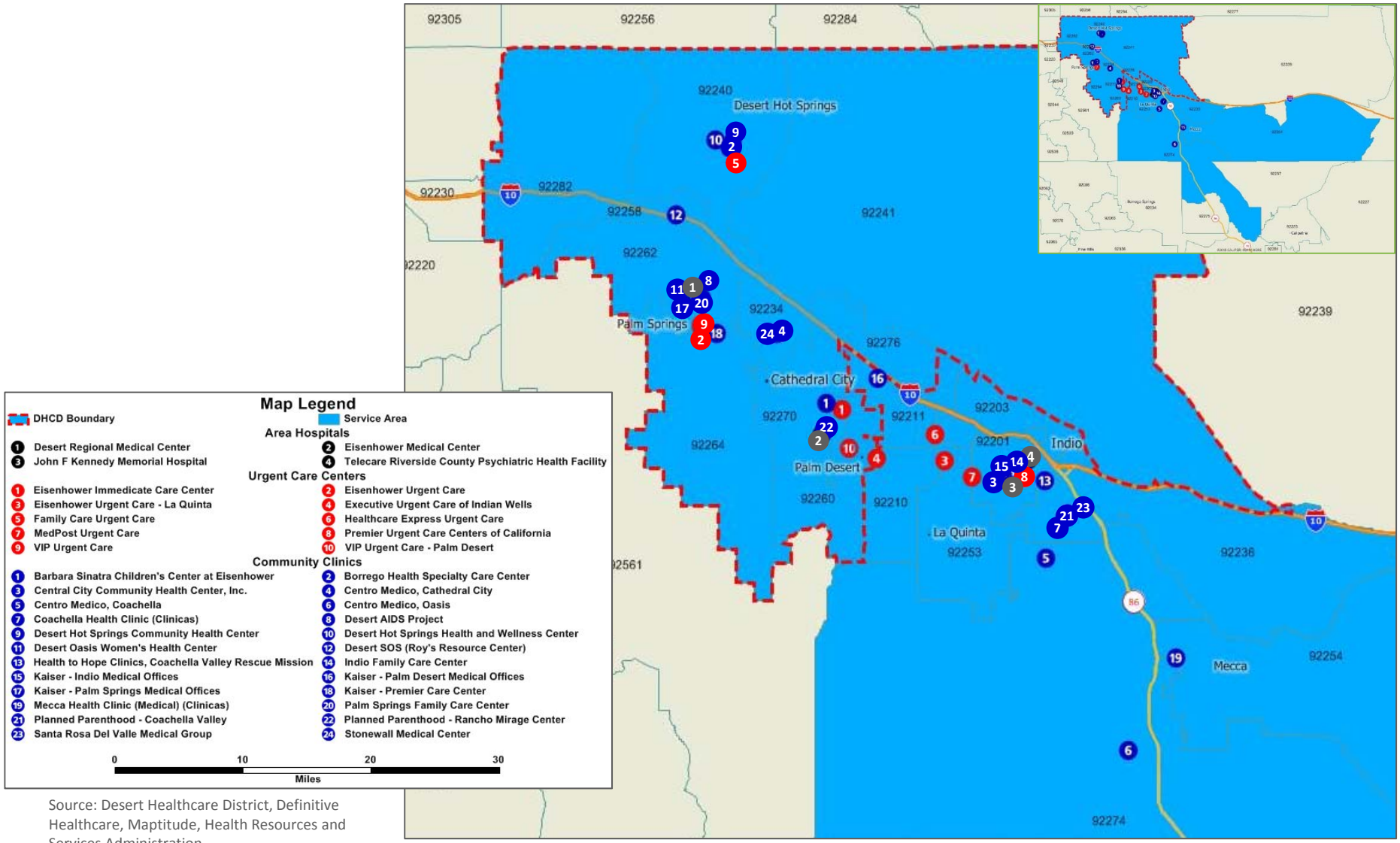
Source: Desert Healthcare District, Definitive Healthcare, Maptitude, Health Resources and Services Administration

Service Area Overview Illustrating Imaging Centers



Source: Desert Healthcare District, Definitive Healthcare, Maptitude, Health Resources and Services Administration

Service Area Overview Illustrating Health Clinics and Urgent Care Centers



Source: Desert Healthcare District, Definitive Healthcare, Maptitude, Health Resources and Services Administration

Population Profile

- The population for the District's service area is projected to experience moderate growth over the next ten years.
  - The table provided on the following page illustrates the projected growth in population for each age cohort (e.g., 0-14 years, 15-44 years, 45-64 years, and 65 years and older) in the District's service area and for the state of California overall.
- Premier validated the District's service area population, and growth trends thereof, by comparing the Claritas, Inc. projection data to the latest data available from the following agencies as of July, 2016: Health Resources and Services Administration, Migration Policy Institute, Clinton Foundation, Health Assessment and Research for Communities, Inc., and the University of Southern California Sol Price Center for Social Innovation. Information collected from these sources indicates that the total population estimated by Claritas, Inc. is understated due to the impact of seasonal residents (e.g., snowbirds) and undocumented, migrant workers. Therefore, Premier adjusted the population statistics in this report to account for these two population cohorts as follows:
  - **Undocumented Residents and Migrant Workers:** The District's service area is located in the Riverside, San Bernardino, and Ontario metropolitan statistical area ("MSA"). According to the Migration Policy Institute, there were 258,214 undocumented residents in this geographic region in CY 2015. Premier calculated the number of undocumented residents in the District's service area based upon the proportion of the population this geographic represented within the overall MSA, and adjusted the annual population upwards to include these residents (26,926 undocumented residents in CY 2015).
  - **Seasonal Residents:** Snowbirds account for an additional 100,000 residents during the winter season. "High" (e.g., winter season) and "low" (e.g. summer season) population estimates were calculated to reflect the shifts in population and seasonal demand for healthcare services within the service area.

Population Profile

- The service area's population age cohort 65 years and older is projected to grow at a rapid compound annual rate (2.4 percent).
  - As the population ages, the community and its hospitals are likely to experience an increased demand for services such as internal medicine, cardiovascular services, gastroenterology, neurosciences, oncology, orthopedics, pulmonary medicine, and urology, and higher needs for chronic disease management.
- The population age cohort 15-44 years overall, and for those whom are female, is projected to grow at moderate rates over the next ten years. This implies that the demand for elective sub-specialty care and obstetrics will continue to grow in the District's service area for the duration of the projection period.
- The population age cohorts 0-14 is projected to increase slowly over the next ten years. As a result, demand for inpatient and outpatient pediatric services will continue to exist in the District's service area over the ten-year projection period.

Desert Healthcare District
Service Area vs. the State of California - Population by Age Cohort
Calendar Years 2016 to 2026

		Estimated 2016		Projected 2021		Projected 2026		
Age Cohort	CAGR[1]	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total	Percent Change 2016 - 2026
Service Area - High Estimate [2]								
0 - 14	0.5%	114,029	19.4%	117,181	18.8%	120,419	18.1%	5.6%
15 - 44	1.4%	210,958	35.9%	225,618	36.1%	241,296	36.3%	14.4%
45 - 64	0.4%	138,432	23.5%	141,282	22.6%	144,190	21.7%	4.2%
65 +	2.4%	124,917	21.2%	140,854	22.5%	158,825	23.9%	27.1%
Total	1.2%	**588,336**	**100.0%**	**624,934**	**100.0%**	**664,731**	**100.0%**	13.0%
Women 15 - 44	1.3%	101,462	17.2%	108,490	17.4%	116,005	17.5%	14.3%
Median Age	0.2%		40.3		40.7		40.8	1.2%
Service Area - Low Estimate [3]								
0 - 14	0.5%	95,883	19.4%	98,492	18.8%	101,172	18.1%	5.5%
15 - 44	1.3%	177,387	35.9%	189,635	36.1%	202,729	36.3%	14.3%
45 - 64	0.4%	116,402	23.5%	118,749	22.6%	121,144	21.7%	4.1%
65 +	2.4%	105,038	21.2%	118,390	22.5%	133,440	23.9%	27.0%
Total	1.2%	**494,710**	**100.0%**	**525,266**	**100.0%**	**558,484**	**100.0%**	12.9%
Women 15 - 44	1.3%	85,316	17.2%	91,188	17.4%	97,463	17.5%	14.2%
Median Age	0.2%		40.3		40.7		40.8	1.2%
California								
0 - 14	0.3%	7,680,367	19.5%	7,792,956	18.9%	7,907,195	18.2%	3.0%
15 - 44	0.4%	16,495,947	41.9%	16,854,986	40.9%	17,221,840	39.7%	4.4%
45 - 64	0.8%	9,944,666	25.3%	10,371,255	25.1%	10,816,143	24.9%	8.8%
65 +	3.5%	5,235,493	13.3%	6,229,524	15.1%	7,412,286	17.1%	41.6%
Total	0.9%	**39,356,473**	**100.0%**	**41,248,721**	**100.0%**	**43,357,464**	**100.0%**	10.2%
Women 15 - 44	0.4%	8,057,276	20.5%	8,205,868	19.9%	8,357,200	19.3%	3.7%
Median Age	0.7%		36.4		37.7		38.0	4.3%

/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Desert_Healthcare_Demographic_Tables_High_Low_Estimate.xlsx]Pop_Table

Source: Claritas, Inc., Health Resources and Services Administration, Migration Policy Institute, Clinton Foundation, Health Assessment and Research for Communities, Inc., Southern California Sol Price Center for Social Innovation

(1) CAGR is the compound annual growth rate, or the percent change in each year

(2) High estimate includes seasonal residents

(3) Excludes seasonal residents.

Projected Population by ZIP Code

Desert Healthcare District
Service Area Population by ZIP Code
Calendar Years 2016 to 2026

			High Estimate [2]					Low Estimate [3]				
ZIP Code	Community Name	CAGR[1]	2016	2021	2026	Percent Change 2016 - 2026	Service Area Population, CY 2016	2016	2021	2026	Percent Change 2016 - 2026	Service Area Population, CY 2016
92201	Indio	1.1%	82,695	87,130	91,897	11.1%	14.1%	69,535	73,239	77,214	11.0%	14.1%
92202	Indio*	-	-	-	-	-	0.0%	-	-	-	-	0.0%
92203	Indio	2.0%	39,330	43,406	47,955	21.9%	6.7%	33,071	36,472	40,278	21.8%	6.7%
92210	Indian Wells	0.6%	6,785	7,008	7,245	6.8%	1.2%	5,706	5,892	6,088	6.7%	1.2%
92211	Palm Desert	1.5%	33,893	36,592	39,548	16.7%	5.8%	28,499	30,752	33,222	16.6%	5.8%
92234	Cathedral City	0.9%	68,353	71,627	75,136	9.9%	11.6%	57,475	60,210	63,134	9.8%	11.6%
92235	Cathedral City*	-	-	-	-	-	0.0%	-	-	-	-	0.0%
92236	Coachella	1.5%	57,101	61,595	66,511	16.5%	9.7%	48,014	51,764	55,873	16.4%	9.7%
92240	Desert Hot Springs	1.4%	49,002	52,616	56,556	15.4%	8.3%	41,204	44,221	47,512	15.3%	8.3%
92241	Desert Hot Springs	2.0%	13,040	14,433	15,991	22.6%	2.2%	10,965	12,127	13,430	22.5%	2.2%
92247	La Quinta*	-	-	-	-	-	0.0%	-	-	-	-	0.0%
92248	La Quinta*	-	-	-	-	-	0.0%	-	-	-	-	0.0%
92253	La Quinta	1.4%	52,293	55,985	60,000	14.7%	8.9%	43,972	47,053	50,407	14.6%	8.9%
92254	Mecca/North Shore	1.4%	17,601	18,824	20,152	14.5%	3.0%	14,800	15,821	16,930	14.4%	3.0%
92255	Palm Desert*	-	-	-	-	-	0.0%	-	-	-	-	0.0%
92258	North Palm Springs	-	-	-	-	-	0.0%	-	-	-	-	0.0%
92260	Palm Desert	0.6%	40,507	41,711	42,994	6.1%	6.9%	34,061	35,068	36,132	6.1%	6.9%
92261	Palm Desert*	-	-	-	-	-	0.0%	-	-	-	-	0.0%
92262	Palm Springs	1.1%	35,392	37,397	39,556	11.8%	6.0%	29,760	31,434	33,235	11.7%	6.0%
92263	Palm Springs*	-	-	-	-	-	0.0%	-	-	-	-	0.0%
92264	Palm Springs	0.6%	24,708	25,467	26,276	6.3%	4.2%	20,776	21,411	22,082	6.3%	4.2%
92270	Rancho Mirage	1.0%	23,379	24,592	25,896	10.8%	4.0%	19,658	20,672	21,759	10.7%	4.0%
92274	Thermal/Oasis	1.0%	32,510	34,157	35,924	10.5%	5.5%	27,337	28,712	30,185	10.4%	5.5%
92276	Thousand Palms	1.1%	10,067	10,632	11,240	11.7%	1.7%	8,465	8,937	9,444	11.6%	1.7%
92282	White Water	1.0%	1,679	1,764	1,855	10.5%	0.3%	1,412	1,483	1,559	10.4%	0.3%
	Total	**1.2%**	**588,336**	**624,934**	**664,731**	**13.0%**	**100.0%**	**494,710**	**525,266**	**558,484**	**12.9%**	**100.0%**

/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Population_by_zip_code.xlsx]Population by ZIP

Source: Claritas, Inc., Health Resources and Services Administration, Migration Policy Institute, Clinton Foundation, Health Assessment and Research for Communities, Inc., Southern California Sol Price Center for Social Innovation

* Represents a ZIP code for P.O. Boxes

(1) CAGR is the compound annual grow th rate, or the percent change in each year

(2) Includes seasonal residents

(3) Excludes seasonal residents

Population Profile by Service Area: High Estimate

Desert Healthcare District
Current District vs. East Valley - Population by Age Cohort
High Estimate[2]
Calendar Years 2016 to 2026

Age Cohort	CAGR[1]	Estimated 2016 Number	Estimated 2016 Percent of Total	Projected 2021 Number	Projected 2021 Percent of Total	Projected 2026 Number	Projected 2026 Percent of Total	Percent Change 2016 - 2026
Current District Service Area								
0 - 14	0.7%	45,991	15.3%	47,732	15.1%	49,507	14.8%	7.6%
15 - 44	1.4%	91,907	30.6%	98,308	31.0%	105,074	31.4%	14.3%
45 - 64	-0.3%	76,334	25.4%	75,092	23.7%	73,828	22.0%	-3.3%
65 +	2.2%	85,788	28.6%	95,699	30.2%	106,638	31.8%	24.3%
Total	1.1%	**300,020**	**100.0%**	**316,831**	**100.0%**	**335,047**	**100.0%**	11.7%
Women 15 - 44	1.4%	44,842	14.9%	48,161	15.2%	51,823	15.5%	15.6%
Median Age	0.1%		48.3		48.6		48.9	1.2%
East Valley Service Area								
0 - 14	0.4%	66,891	23.2%	68,309	22.2%	69,775	21.2%	4.3%
15 - 44	1.3%	118,679	41.2%	126,672	41.1%	135,216	41.0%	13.9%
45 - 64	1.3%	62,856	21.8%	67,179	21.8%	71,805	21.8%	14.2%
65 +	2.9%	39,890	13.8%	45,944	14.9%	52,888	16.0%	32.6%
Total	1.3%	**288,316**	**100.0%**	**308,104**	**100.0%**	**329,684**	**100.0%**	14.3%
Women 15 - 44	1.3%	56,875	19.7%	60,521	19.6%	64,408	19.5%	13.2%
Median Age	0.5%		33.7		34.6		35.5	5.4%

/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/Rev_Demographics/[Desert_Demographic_Tables_High_Estimate.xlsx]Pop_Table

Source: Claritas, Inc., Health Resources and Services Administration, Migration Policy Institute, Clinton Foundation, Health Assessment and Research for Communities, Inc., Southern California Sol Price Center for Social Innovation

Note: The total for each age cohort for the Current District Service Area and the East Valley Service Area when calculated separately may not foot to the combined service area population table by age cohort due to rounding.

(1) CAGR is the compound annual growth rate, or the percent change in each year

(2) High estimate includes seasonal residents

Population Profile by Service Area: Low Estimate

Desert Healthcare District
Current District vs. East Valley - Population by Age Cohort"
Low Estimate[2]
Calendar Years 2016 to 2026

Age Cohort	CAGR[1]	Estimated 2016 Number	Estimated 2016 Percent of Total	Projected 2021 Number	Projected 2021 Percent of Total	Projected 2026 Number	Projected 2026 Percent of Total	Percent Change 2016 - 2026
Current District Service Area								
0 - 14	0.7%	38,673	15.3%	40,122	15.1%	41,596	14.8%	7.6%
15 - 44	1.3%	77,281	30.6%	82,634	31.0%	88,284	31.4%	14.2%
45 - 64	-0.3%	64,186	25.4%	63,119	23.7%	62,030	22.0%	-3.4%
65 +	2.2%	72,136	28.6%	80,440	30.2%	89,598	31.8%	24.2%
Total	1.1%	**252,276**	**100.0%**	**266,314**	**100.0%**	**281,509**	**100.0%**	11.6%
Women 15 - 44	1.4%	37,706	14.9%	40,482	15.2%	43,542	15.5%	15.5%
Median Age	0.1%		48.3		48.6		48.9	1.2%
East Valley Service Area								
0 - 14	0.4%	56,246	23.2%	57,412	22.2%	58,620	21.2%	4.2%
15 - 44	1.3%	99,793	41.2%	106,464	41.1%	113,598	41.0%	13.8%
45 - 64	1.3%	52,853	21.8%	56,462	21.8%	60,325	21.8%	14.1%
65 +	2.9%	33,542	13.8%	38,615	14.9%	44,432	16.0%	32.5%
Total	1.3%	**242,434**	**100.0%**	**258,952**	**100.0%**	**276,975**	**100.0%**	14.2%
Women 15 - 44	1.2%	47,824	19.7%	50,866	19.6%	54,110	19.5%	13.1%
Median Age	0.5%		33.7		34.6		35.5	5.4%

/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/Rev_Demographics/[Desert_Demographic_Tables_Low_Estimate.xlsx]Pop_Table

Source: Claritas, Inc., Health Resources and Services Administration, Migration Policy Institute, Clinton Foundation, Health Assessment and Research for Communities, Inc., Southern California Sol Price Center for Social Innovation

Note: The total for each age cohort for the Current District Service Area and the East Valley Service Area when calculated separately may not foot to the combined service area population table by age cohort due to rounding.

(1) CAGR is the compound annual growth rate, or the percent change in each year

(2) Excludes seasonal residents

Ethnicity Profile

- A large portion of the service area population is Hispanic. Given the projected growth and the fact that statistically, Hispanics have higher incidence rates of diabetes, heart disease, and obesity, it is anticipated that there will be an increased demand for cardiovascular services, endocrinology, gastroenterology, and orthopedics in the District's service area.

Desert Healthcare District
Service Area vs. the State of California - Ethnic Profile
Calendar Years 2016 to 2026

		Estimated 2016		Projected 2021		Projected 2026	
Ethnicity	CAGR[1]	Number	Percent of Total	Number	Percent of Total	Number	Percent of Total
Service Area - High Estimate [2]							
Hispanics	1.5%	272,735	46.4%	293,583	47.0%	316,398	47.6%
Non-Hispanics							
White	0.9%	284,102	48.3%	297,747	47.6%	312,415	47.0%
Black	1.1%	11,495	2.0%	12,129	1.9%	12,813	1.9%
American Indian/Alaskan/Aleutian	0.1%	1,742	0.3%	1,752	0.3%	1,764	0.3%
Asian/Hawaiian/Pacific Islander	1.2%	11,952	2.0%	12,666	2.0%	13,438	2.0%
Other	2.3%	6,310	1.1%	7,057	1.1%	7,902	1.2%
Subtotal	1.0%	315,601	53.6%	331,351	53.0%	348,333	52.4%
Total	1.2%	**588,336**	**100.0%**	**624,934**	**100.0%**	**664,731**	**100.0%**
Service Area - Low Estimate [3]							
Hispanics	1.5%	272,735	55.1%	293,583	55.9%	316,365	56.6%
Non-Hispanics							
White	0.8%	190,476	38.5%	198,079	37.7%	206,206	36.9%
Black	1.1%	11,495	2.3%	12,129	2.3%	12,812	2.3%
American Indian/Alaskan/Aleutian	0.1%	1,742	0.4%	1,752	0.3%	1,764	0.3%
Asian/Hawaiian/Pacific Islander	1.2%	11,952	2.4%	12,666	2.4%	13,437	2.4%
Other	2.3%	6,310	1.3%	7,057	1.3%	7,901	1.4%
Subtotal	0.9%	221,975	44.9%	231,683	44.1%	242,120	43.4%
Total	1.2%	**494,710**	**100.0%**	**525,266**	**100.0%**	**558,484**	**100.0%**
California							
Hispanics	1.6%	15,372,373	39.1%	16,635,860	40.3%	18,014,072	41.5%
Non-Hispanics							
White	-0.2%	14,846,542	37.7%	14,691,869	35.6%	14,547,591	33.6%
Black	0.2%	2,198,666	5.6%	2,224,149	5.4%	2,251,287	5.2%
American Indian/Alaskan/Aleutian	0.2%	163,906	0.4%	165,455	0.4%	167,120	0.4%
Asian/Hawaiian/Pacific Islander	2.1%	5,565,571	14.1%	6,177,171	15.0%	6,860,122	15.8%
Other	2.3%	1,209,415	3.1%	1,354,217	3.3%	1,517,272	3.5%
Subtotal	0.5%	23,984,100	60.9%	24,612,861	59.7%	25,343,391	58.5%
Total	0.9%	**39,356,473**	**100.0%**	**41,248,721**	**100.0%**	**43,357,464**	**100.0%**

lthcare_District/Needs_Assessment/Analysis/[Desert_Healthcare_Demographic_Tables_High_Low_Estimate.xlsx]Ethnicity_Table

Source: Claritas, Inc., Health Resources and Services Administration, Migration Policy Institute

(1) CAGR is the compound annual growth rate, or the percent change in each year

(2) High estimate includes seasonal residents

(3) Excludes seasonal residents.

Socioeconomic Profile

- A large proportion of household incomes in the District's service area are estimated to be below $50,000 in CY 2016 (52.6 percent). During this same time period, the service area is expected to have lower median and average household incomes in comparison to the State.
  - It is likely that a large portion of the service area population is covered by Medi-Cal since the program's eligibility was extended to 138 percent of the Federal Poverty Level.

Desert Healthcare District
Service Area vs. the State of California - Socioeconomic Profile
Calendar Years 2016 to 2026

Socioeconomic Indicator	CAGR[1]	Estimated 2016	Projected 2021	Projected 2026	Percent Change 2016 - 2026
Service Area					
Median Household Income	1.1%	$47,296	$49,904	$52,656	11.3%
Average Household Income	1.4%	$70,294	$75,354	$80,778	14.9%
Income Distribution					
Under $25,000	-0.2%	26.3%	24.6%	22.8%	-1.7%
$25,000 - $49,999	0.6%	26.3%	25.5%	24.7%	6.2%
$50,000 - $99,999	1.4%	27.2%	27.4%	27.6%	15.2%
$100,000 +	3.5%	20.2%	22.5%	25.0%	40.5%
California					
Median Household Income	1.5%	$63,566	$68,640	$74,119	16.6%
Average Household Income	1.8%	$90,633	$99,054	$108,257	19.4%
Income Distribution					
Under $25,000	-0.8%	20.2%	18.5%	16.8%	-8.0%
$25,000 - $49,999	-0.1%	20.9%	19.8%	18.6%	-1.2%
$50,000 - $99,999	0.4%	28.3%	27.5%	26.6%	4.2%
$100,000 +	3.2%	30.6%	34.2%	38.0%	37.6%

sory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Desert_Healthcare_Demographic_Tables_High_Low_Estimate.xlsx]Household_Table

Source: Claritas, Inc.

(1) CAGR is the compound annual growth rate, or the percent change in each year

Health Status Outcomes

- All ZIP Codes in the service area except one (ZIP Code 92274, which is partially located in Imperial County) are located in Riverside County. In general, this geographic region has higher mortality rates for cancer, Alzheimer's disease, coronary heart disease, unintentional injuries, stroke, suicide, motor vehicle accidents, and infants when compared to the State overall. Further, the service area also has higher rates of cancer (e.g. colorectal, lung and bronchus, prostate), obesity, diabetes, high blood pressure, smoking, and low birth weight infants.
  - This implies an increased demand for services such as primary care, cardiovascular, neurosciences, oncology, general surgery, orthopedics, pulmonary medicine, urology, obstetrics and perinatology, neonatology, and chronic disease management.

Desert Healthcare District
Health Status Indicators
Calendar Years 2006 - 2014

Health Status Indicator	Year	Riverside County	Imperial County	California
Age-Adjusted Mortality (Per 100,000 Population)				
All cancers	2010-2014	153.5	132.9	149.9
Breast cancer	2010-2014	20.6	16.3	20.6
Colorectal cancer	2010-2014	15.2	12.7	13.7
Lung, trachea, and bronchus cancer	2010-2014	36.4	28.1	33.4
Prostate cancer	2010-2014	21.2	23.2	20.5
Melanoma of the skin	2009-2013	2.7	Not Reported	2.5
Diabetes	2010-2014	19.1	30.6	20.4
Alzheimer's disease	2010-2014	31.0	11.7	30.4
Coronary heart disease	2010-2014	119.5	106.3	101.7
Unintentional injuries (excluding motor vehicle)	2010-2014	21.8	25.5	20.3
Stroke	2010-2014	35.3	33.5	35.7
Influenza and Pneumonia	2010-2014	11.6	13.7	15.9
Suicide	2010-2014	10.3	7.2	10.3
Motor vehicle	2010-2014	10.0	11.1	7.9
Cancer Incidence				
Breast Cancer	2009-2013	115.5	101.4	121.7
Colorectal Cancer	2009-2013	39.5	33.9	38.3
Lung and Bronchus Cancer	2009-2013	47.3	44.5	46.6
Prostate Cancer	2009-2013	120.3	127.7	119.0

y_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Desert_Healthcare_Health_Status_Indicators.xlsx]Table

Sources: Health Indicators Warehouse, California Cancer Registry

Indicates county metric is less than the respective state metric by more than five percent

Indicates county metric is within five percent of the respective state metric

Indicates county metric is greater than the respective state metric by more than five percent

Health Status Outcomes (continued)

Desert Healthcare District
Health Status Indicators
Calendar Years 2006 - 2014

Health Status Indicator	Year	Riverside County	Imperial County	California
Health Risk Factors				
Percent of adults with obesity	2006-2012	28.7%	28.7%	24.9%
Percent of adults with diabetes	2006-2012	9.6%	11.4%	8.7%
Percent of adults with high blood pressure	2006-2012	27.2%	32.8%	26.2%
Percent of adults who smoke	2006-2012	14.6%	12.4%	12.8%
Age-Adjusted Quality of Life and Social Support				
Percent of adults reporting fair or poor health	2006-2012	19.5%	29.0%	18.4%
Percent of adults, no exercise in last month	2006-2012	24.1%	29.0%	21.3%
Maternal and Child Health				
Birth rate	2013	64.1	87.7	62.5
Infant mortality: all races (1)	2009-2013	5.0	3.4	4.7
Percent of low birth weight infants	2010-2014	6.5%	5.5%	6.7%
Births to mothers aged 15-19 (2)	2010-2014	27.0	50.1	26.4
Census				
Percent of persons under 18 in poverty	2014	23.5%	31.3%	22.6%
Percent uninsured population (<65 years old)	2013	21.9%	21.5%	19.4%

y_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Desert_Healthcare_Health_Status_Indicators.xlsx]Table (2)

Sources: Health Indicators Warehouse, California Cancer Registry

Indicates county metric is less than the respective state metric by more than five percent

Indicates county metric is within five percent of the respective state metric

Indicates county metric is greater than the respective state metric by more than five percent

(1) Metric reported rate is per 1,000 live births

(2) Metric reported rate is per 1,000 women age 15 - 19 years old

Health Status Outcomes (continued)

- The Health Assessment Resource Center's 2016 "Coachella Valley Community Health Survey" further illustrates that portions of the District's service area population are underserved, and opportunities exist to improve the overall health of the community with a focus on wellness and prevention through increased access to coordinated primary and specialty care services.
- Key findings from this study are summarized on the following five pages based on the key themes listed below:
  - Insurance coverage
  - Adult general health status and access to care
  - Adult health screening and utilization of other preventative services
  - Pediatric general health status and access to care
  - Pediatric health screening and utilization of other preventative services

Insurance Coverage

Indicator	Key Findings
Health Coverage	• 14% of adults between 18 and 64 have no health insurance, and 5% of children do not have any kind of health insurance coverage. • Most common reasons for lacking healthcare coverage include a lack of documentation to prove legal residency (15.9%) and the inability to pay premiums (13.7%).
Prescription Coverage	Percent of population that lacks prescription coverage: • Adults: 14.5% • Children: 10.7%
Vision Coverage	Percent of population that lacks vision coverage: • Adults: 40.1% • Children: 18.2%
Dental Coverage	Percent of population that lacks dental coverage: • Adults: 39.8% • Children: 25.1%
Mental Health Coverage	• Adults: 22.3% of adults 18 to 64 have been diagnosed with a mental health disorder; 10.1% of adults 18 to 64 with mental health issues could not get mental healthcare in the past year • Children: 29.8% of children have been diagnosed with a mental health disorder; 61.4% of these children have not visited a mental health professional

Source: Health Assessment Resource Center's 2016 "Coachella Valley Community Health Survey"

Adult Key Findings: General Health Status and Access to Care

Indicator	Key Findings
General Health Status	• 20% of adults in the Coachella Valley rate their health as "fair or "poor".
Utilization	• 85.4% of Coachella Valley adults have visited a healthcare provider within the past year, compared to 83% nationally, with an increasing trend in area residents using urgent care facilities as their usual source of care (10.7% increase since 2013, to 23.7%). 10.5% of adults use the ER or hospital.
Barriers to Receiving Care	• Common barriers to receiving care include understanding what is covered, healthcare provider hours, taking time off work, and not having authorization from an HMO.
Chronic Disease	• The three most common chronic diseases in Coachella Valley adults are hypertension, high cholesterol, and arthritis.
Obesity	• 60.5% of Coachella Valley adults are overweight or obese.
Disability	• 11.0% of Coachella Valley adults have a health problem that requires them to use assistive technology.
Mental Health Concerns	• 25.9% of Coachella Valley adults have had an emotional, mental, or behavioral problem that concerned them in the past year; over half of these (55.5%) felt that their problem was severe enough to require professional help. 19.4% of these people did not know who to contact for help with their problem.

Source: Health Assessment Resource Center's 2016 "Coachella Valley Community Health Survey"

Adult Key Findings: Screening and Other Preventative Services

Indicator	Key Findings
Cholesterol Screening	• Over 22.4% of Coachella Valley adults have never had their blood cholesterol checked.
Prostate-Specific Antigen ("PSA") Test	• 37.1% of men age 40 years and over have never had a PSA test. 62.8% of Hispanic men have never had a PSA test.
Digital Rectal Exam	• 35.8% of men age 40 years or over have never had a digital rectal exam.
Mammography	• 7.1% of women age 40 years and over have never had a mammogram. 17.4% of women have not had a mammogram within the past two years
Pap Test	• 7.2% of adult women in Coachella Valley have never had a Pap smear.
Most Recent Pap Test	• 17.9% of adult women who have had a Pap smear have not had one within the past five years.
Human Papillomavirus ("HPV") Vaccination	• The majority of Coachella Valley adults between the ages of 18 and 33 (78.5%) have not received the HPV vaccine.
Influenza Vaccination	• Approximately half of Coachella Valley adults (56.1%) have not had a flu vaccine within the past year.

Source: Health Assessment Resource Center's 2016 "Coachella Valley Community Health Survey"

Pediatric Key Findings: General Health Status and Access to Care

Indicator	Key Findings
General Health Status	• 3.1% of children have health that is “fair” or “poor”.
Utilization	• 11% of Coachella Valley children have not visited a healthcare provider in the past year
Obesity	• 49% of children 2 to 17 have a BMI percentile that places them in the “overweight” or “obese” category.
Asthma	• 13.7% of children have been diagnosed with asthma.
Mental Health Concerns	• One-quarter of children age 3 and older (24.4%) have trouble with emotions, concentration, behavior, and getting along with others. • Additionally, over 9% of children age 3 and over have been diagnosed with ADD or ADHD.
Mental Health Treatment	• 61.4% of children 3 to 17 with mental health problems have not seen a mental health professional for treatment in the past year. • 13.7% of children 3 to 17 with mental health problems have taken medication for the issue within the past year; 30.5% of children 3 to 17 with mental health problems have received psychological counseling for the issue within the past year.

Source: Health Assessment Resource Center’s 2016 “Coachella Valley Community Health Survey”

Pediatric Key Findings: Screening and Other Preventative Services

Indicator	Key Findings
Delay or Denial of Medical Testing	• 5.8% of children had to have a test or treatment delayed or denied in the past year
Child Dental Visits	• 13.7% of children have never been to a dentist.
Frequency of Child Dental Visits	• 92.2% of children who have been to the dentist have been there within the past year.
Child Hearing Test	• 12.1% of children age 5 and under have never had a hearing test.
Child Vision Exam	• 37.6% of children age 3 and older have not had a vision exam in the past year.
Child HPV Vaccination	• 51.5% of children ages 11 and over have not had the HPV vaccination.
Child Helmet Use	• 14.3% of children age 2 and over never wear a helmet.

Source: Health Assessment Resource Center's 2016 "Coachella Valley Community Health Survey"

Service Area Inpatient Use Rate and Market Share Trends, CY 2012 - 2015

- Between CY 2012 and 2015, total inpatient discharges in the District's service area decreased by 2.0 percent, while the use rate (discharges per 1,000 population) decreased by 5.5 percent. This trend will continue due to the following:
  - Continued rise of high-deductible insurance plans that constrain medical use
  - Impact of value-based care models (e.g., accountable care organizations, bundled payments, patient-centered medical homes [e.g., Comprehensive Primary Care Plus ("CPC+")], risk-based payment contracts, and performance-based physician incentives) that seek to achieve enhanced coordination of care, better quality outcomes, and reduced costs across care settings
    - Patients treated under these models typically have lower lengths of stay and less readmissions
    - Providers are seeking to reduce preventable hospitalizations for acute and chronic conditions, and preventable readmissions by ensuring patients receive home-based disease management programs and outpatient care, instead of accessing hospital care
  - Shift in volumes from inpatient to observation status through the two-midnight census rule implemented by the Centers for Medicare & Medicaid Services ("CMS") in October, 2013, and the continued shift in inpatient volume to outpatient care settings for ambulatory case-sensitive admissions (e.g., uncontrolled diabetes, hypertension, dehydration)
  - Providers are aggressively increasing intensive medical management for chronic conditions on an outpatient basis
- During this same time period, DRMC's market share increased by 1.3 percent, and is likely attributed to the Hospital recapturing a portion of the service area's inpatient volume from John F. Kennedy Memorial Hospital ("JFK"), who experienced a 3.1 percent decrease in market share over the four-year time period.

Service Area Historical Use Rates by Inpatient Service Line, CY 2012 - 2015

Desert Healthcare District

Service Area Historical Use Rates by Inpatient Service Line

Calendar Years 2012 - 2015

Service Line	Use Rate Based on High Population Estimate (1) 2012	2013	2014	2015	Percent Change, CY 2012 - 2015
Cardiology - Diagnostic/Interventional	2.9	2.5	2.3	2.3	-19.8%
Cardiology - Medical	7.0	6.3	5.9	5.7	-18.2%
Cardiology - Surgery	0.7	0.7	0.7	0.8	4.2%
Chemical Dependency	0.3	0.3	0.3	0.4	50.1%
Endocrine	2.1	1.8	1.8	1.9	-9.7%
ENT	0.6	0.5	0.5	0.5	-9.1%
Gastroenterology	6.6	6.1	6.0	6.2	-6.4%
General Medicine	6.2	6.0	6.3	7.1	14.5%
General Surgery	6.4	6.4	6.4	6.0	-7.3%
Gynecology	3.4	3.0	2.6	2.7	-18.4%
Neonatal Intensive Care	225.7	203.6	211.5	215.2	-4.7%
Neurology	4.3	3.9	3.9	3.8	-11.9%
Neurosurgery	0.8	0.8	0.7	0.5	-35.9%
Obstetrics & Deliveries	62.6	58.5	58.3	57.2	-8.7%
Oncology	2.8	2.6	2.6	2.6	-6.9%
Ophthalmology	0.1	0.1	0.1	0.1	-36.9%
Orthopedics	6.8	6.8	7.0	7.0	2.9%
Others NC	-	-	0.1	-	0.0%
Plastic Surgery	0.5	0.5	0.4	0.5	-4.6%
Psychiatry	0.3	0.2	0.2	0.3	8.8%
Pulmonary Medicine	5.9	6.2	5.6	5.5	-7.1%
Rehabilitation	0.0	0.0	0.0	0.0	-51.8%
Spine Surgery	1.0	1.0	1.1	1.3	30.3%
Thoracic & Vascular Surgery	1.4	1.4	1.4	1.2	-18.7%
Transplant	0.1	0.1	0.1	0.0	-21.1%
Urology	3.4	3.4	3.6	3.8	12.7%
Total	**75.3**	**71.5**	**70.9**	**71.1**	**-5.5%**

Source: OSHPD 2012, 2013, 2014, 2015. Excludes normal newborns.
Note: Use rate calculation based on projected population in service area, and reflects consideration of seasonal and migrant populations.
(1) Use rate defined as discharges per 1,000 population.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]Use Rate Analysis

Service Area Inpatient Market Share and Outmigration Trends, CY 2012 - 2015

Desert Healthcare District
Service Area Inpatient Market Share
Calendar Years 2012 - 2015

Hospital	2012 Discharges	2012 Percent Market Share	2013 Discharges	2013 Percent Market Share	2014 Discharges	2014 Percent Market Share	2015 Discharges	2015 Percent Market Share
Service Area Hospitals:								
Eisenhower Medical Center	15,045	35.7%	14,820	36.5%	14,586	35.8%	15,724	38.0%
Desert Regional Medical Center	13,527	32.1%	13,037	32.1%	13,649	33.5%	13,793	33.4%
John F Kennedy Memorial Hospital	8,529	20.2%	7,995	19.7%	7,574	18.6%	7,081	17.1%
Subtotal, Service Area Hospitals	37,101	87.9%	35,852	88.3%	35,809	88.0%	36,598	88.5%
Outmigration:								
Loma Linda University Medical Center	1,385	3.3%	1,322	3.3%	1,381	3.4%	1,374	3.3%
Riverside County Regional Medical Center	858	2.0%	686	1.7%	483	1.2%	330	0.8%
Cedars Sinai Medical Center	183	0.4%	177	0.4%	201	0.5%	184	0.4%
City of Hope Helford Clinical Research Hospital	149	0.4%	144	0.4%	164	0.4%	171	0.4%
Kaiser Foundation Hospital - Riverside	102	0.2%	111	0.3%	113	0.3%	137	0.3%
Ronald Reagan UCLA Medical Center	144	0.3%	120	0.3%	163	0.4%	131	0.3%
University of California San Diego Medical Center	81	0.2%	74	0.2%	112	0.3%	129	0.3%
Keck Hospital of USC	116	0.3%	80	0.2%	150	0.4%	112	0.3%
University of California Irvine Medical Center	110	0.3%	101	0.2%	106	0.3%	109	0.3%
Kaiser Foundation Hospital - Fontana	65	0.2%	61	0.2%	101	0.2%	95	0.2%
Others	1,906	4.5%	1,868	4.6%	1,932	4.7%	1,978	4.8%
Subtotal, Outmigration	5,099	12.1%	4,744	11.7%	4,906	12.0%	4,750	11.5%
Total	**42,200**	**100.0%**	**40,596**	**100.0%**	**40,715**	**100.0%**	**41,348**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2012, 2013, 2014, 2015. Acute care, excludes normal newborns.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 1A

Service Area Inpatient Market Share Trends by Service Line, CY 2015

- In CY 2015, 11.5 percent of patients left the service area for inpatient care. Service lines with high levels of out-migration (greater than 25.0 percent) for inpatient services are identified as follows:
  - ENT – 40.4 percent
  - Gynecology – 29.3 percent
  - Neurosurgery – 41.4 percent
  - Oncology – 25.9 percent
  - Ophthalmology – 31.4 percent
  - Spine Surgery – 31.3 percent
  - Transplant – 100.0 percent
- The table provided on the following page illustrates market share by inpatient service line for each hospital in the service area, and the proportion of patients that received care outside of this geographic area for each service line in CY 2015.

Service Area Total (All Ages) Inpatient Market Share, CY 2015

Desert Heathcare District
Service Area Inpatient Market Share by Service Line - All Ages
Calendar Year 2015

	Service Area Mix		Percent Market Share					
			Service Area			Outmigration		
Service Line	Discharges	Percent of Total Discharges	Eisenhower Medical Center	Desert Regional Medical Center	John F Kennedy Memorial Hospital	Loma Linda University Medical Center	Others	Total
Cardiology - Diagnostic/Interventional	1,341	3.2%	47.7%	37.4%	7.3%	1.3%	6.3%	100.0%
Cardiology - Medical	3,342	8.1%	47.0%	32.4%	14.9%	1.0%	4.7%	100.0%
Cardiology - Surgery	444	1.1%	55.0%	24.5%	0.2%	8.6%	11.7%	100.0%
Chemical Dependency	221	0.5%	43.4%	32.6%	10.4%	1.4%	12.2%	100.0%
Endocrine	1,115	2.7%	39.0%	29.9%	16.6%	6.5%	8.0%	100.0%
ENT	309	0.7%	28.8%	23.0%	7.8%	26.5%	13.9%	100.0%
Gastroenterology	3,600	8.7%	46.0%	31.8%	10.4%	4.1%	7.7%	100.0%
General Medicine	4,152	10.0%	47.9%	26.9%	13.6%	2.7%	8.9%	100.0%
General Surgery	3,467	8.4%	43.4%	26.8%	16.9%	3.7%	9.3%	100.0%
Gynecology	632	1.5%	15.3%	41.1%	14.2%	9.7%	19.6%	100.0%
Neonatal Intensive Care	1,609	3.9%	0.1%	66.7%	27.6%	2.9%	2.7%	100.0%
Neurology	2,183	5.3%	48.8%	32.9%	6.5%	4.5%	7.2%	100.0%
Neurosurgery	307	0.7%	25.4%	32.6%	0.7%	11.1%	30.3%	100.0%
Obstetrics & Deliveries	5,736	13.9%	0.5%	53.1%	43.3%	0.7%	2.4%	100.0%
Oncology	1,488	3.6%	44.6%	24.3%	5.2%	7.4%	18.5%	100.0%
Ophthalmology	51	0.1%	21.6%	35.3%	11.8%	19.6%	11.8%	100.0%
Orthopedics	4,074	9.9%	52.8%	24.3%	11.1%	3.0%	8.8%	100.0%
Plastic Surgery	268	0.6%	48.1%	17.2%	20.1%	4.1%	10.4%	100.0%
Psychiatry	168	0.4%	45.8%	31.0%	7.1%	3.0%	13.1%	100.0%
Pulmonary Medicine	3,187	7.7%	40.4%	29.0%	20.6%	2.5%	7.5%	100.0%
Rehabilitation	1	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Spine Surgery	735	1.8%	55.1%	13.6%	0.0%	2.9%	28.4%	100.0%
Thoracic & Vascular Surgery	683	1.7%	53.4%	29.7%	5.1%	2.2%	9.5%	100.0%
Transplant	27	0.1%	0.0%	0.0%	0.0%	37.0%	63.0%	100.0%
Urology	2,208	5.3%	51.6%	24.5%	12.4%	3.4%	8.1%	100.0%
Total	**41,348**	**100.0%**	**38.0%**	**33.4%**	**17.1%**	**3.3%**	**8.2%**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2015. Includes acute care across all ages; excludes normal newborns.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 2C

Service Area Inpatient Market Share Trends, CY 2012 - 2015

- Patients age 0-14 years represent 8.4 percent of the service area's total inpatient volume in CY 2015. While DRMC was the market share leader for inpatient pediatric services overall (39.6 percent), almost 28 percent of the service area's pediatric patients left the area for care.
  - Notably, Loma Linda University Medical Center was the dominant provider of most pediatric sub-specialty services during this time period. This trend implies a need for increased access to pediatric sub-specialty providers across almost all medical and surgical specialties in the District's service area.
- The table provided on the following page illustrates pediatric-specific market share by inpatient service line for each hospital in the service area, and the proportion of pediatric patients that received care outside of this geographic area for each in CY 2015.

Service Area Pediatric Inpatient Market Share, CY 2015

Desert Healthcare District
Service Area Inpatient Pediatric Market Share by Service Line - Pediatric (Ages 0 - 14 Years)
Calendar Year 2015

	Service Area Mix		Percent Market Share					
			Service Area			Outmigration		
Service Line	Discharges	Percent of Total Discharges	Eisenhower Medical Center	Desert Regional Medical Center	John F Kennedy Memorial Hospital	Loma Linda University Medical Center	Others	Total
Cardiology - Diagnostic/Interventional	3	0.1%	0.0%	0.0%	0.0%	66.7%	33.3%	100.0%
Cardiology - Medical	17	0.5%	0.0%	5.9%	0.0%	76.5%	17.6%	100.0%
Cardiology - Surgery	17	0.5%	0.0%	0.0%	0.0%	88.2%	11.8%	100.0%
Endocrine	106	2.9%	5.7%	4.7%	34.0%	46.2%	9.4%	100.0%
ENT	100	2.7%	14.0%	19.0%	11.0%	46.0%	10.0%	100.0%
Gastroenterology	186	5.0%	9.1%	15.6%	22.6%	44.6%	8.1%	100.0%
General Medicine	195	5.3%	7.7%	20.0%	19.5%	36.9%	15.9%	100.0%
General Surgery	207	5.6%	21.7%	26.6%	22.7%	23.7%	5.3%	100.0%
Gynecology	8	0.2%	12.5%	25.0%	0.0%	62.5%	0.0%	100.0%
Neonatal Intensive Care	1,609	43.5%	0.1%	66.7%	27.6%	2.9%	2.7%	100.0%
Neurology	104	2.8%	0.0%	3.8%	3.8%	62.5%	29.8%	100.0%
Neurosurgery	18	0.5%	0.0%	0.0%	0.0%	72.2%	27.8%	100.0%
Obstetrics & Deliveries	7	0.2%	0.0%	14.3%	85.7%	0.0%	0.0%	100.0%
Oncology	91	2.5%	0.0%	1.1%	4.4%	69.2%	25.3%	100.0%
Ophthalmology	8	0.2%	0.0%	25.0%	12.5%	37.5%	25.0%	100.0%
Orthopedics	116	3.1%	0.9%	13.8%	6.9%	56.9%	21.6%	100.0%
Plastic Surgery	14	0.4%	7.1%	0.0%	28.6%	35.7%	28.6%	100.0%
Psychiatry	10	0.3%	0.0%	20.0%	10.0%	50.0%	20.0%	100.0%
Pulmonary Medicine	562	15.2%	10.3%	19.4%	53.0%	13.0%	4.3%	100.0%
Spine Surgery	11	0.3%	0.0%	0.0%	0.0%	81.8%	18.2%	100.0%
Thoracic & Vascular Surgery	8	0.2%	0.0%	12.5%	0.0%	87.5%	0.0%	100.0%
Transplant	1	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%
Urology	77	2.1%	11.7%	22.1%	29.9%	27.3%	9.1%	100.0%
Total	**3,475**	**94.0%**	**4.9%**	**39.6%**	**27.8%**	**20.5%**	**7.2%**	**100.0%**

Source: OSHPD 2015. Ages 0-14, acute care, excludes normal newborns. Loma Linda includes Children's Hospital.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 2CP

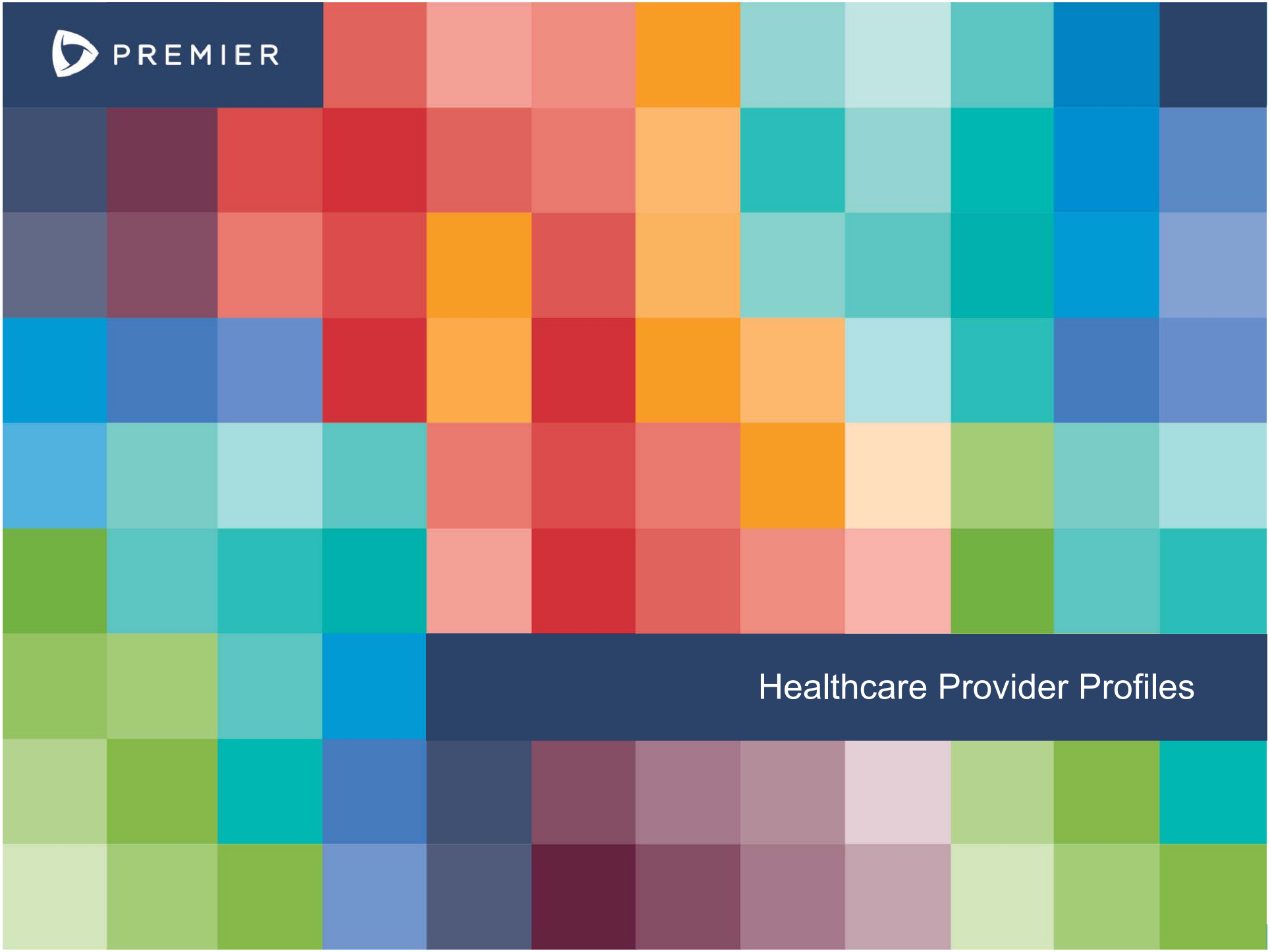
Service Area Inpatient Market Share by Payer, CY 2015

Desert Healthcare District
Service Area Inpatient Market Share by Payer
Calendar Year 2015

Hospital	Medicare		Medi-Cal		Private		Other	Total
	HMO	FFS	HMO	FFS	HMO	PPO		
Eisenhower Medical Center	33.5%	62.8%	26.2%	13.6%	34.9%	77.1%	11.1%	38.0%
Desert Regional Medical Center	52.1%	18.3%	36.7%	37.2%	33.8%	13.6%	56.9%	33.4%
John F Kennedy Memorial Hospital	4.9%	9.0%	29.4%	32.0%	16.8%	1.4%	15.8%	17.1%
Loma Linda University Medical Center	0.1%	0.6%	2.6%	8.1%	2.1%	0.9%	3.4%	2.3%
Riverside County Regional Medical Center	0.0%	0.2%	0.2%	3.0%	1.3%	0.1%	2.0%	0.8%
Cedars Sinai Medical Center	0.2%	0.9%	0.1%	0.2%	0.6%	0.2%	0.1%	0.4%
City of Hope Helford Clinical Research Hospital	0.0%	0.5%	0.0%	0.7%	0.6%	0.1%	1.3%	0.4%
Kaiser Foundation Hospital - Riverside	1.0%	0.0%	0.1%	0.0%	0.9%	0.0%	0.1%	0.3%
Ronald Reagan UCLA Medical Center	0.1%	0.5%	0.1%	0.1%	0.4%	0.8%	0.5%	0.3%
University of California San Diego Medical Center	0.0%	0.5%	0.3%	0.3%	0.3%	0.0%	0.6%	0.3%
Keck Hospital of USC	0.5%	0.4%	0.0%	0.1%	0.3%	0.0%	1.0%	0.3%
University of California Irvine Medical Center	0.2%	0.4%	0.2%	0.1%	0.3%	0.2%	0.2%	0.3%
Kaiser Foundation Hospital - Fontana	0.8%	0.0%	0.0%	0.0%	0.6%	0.0%	0.0%	0.2%
Others	4.3%	5.5%	3.1%	3.8%	5.7%	6.4%	6.7%	4.8%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
N =	**5,254**	**11,196**	**8,292**	**5,351**	**8,073**	**1,303**	**1,879**	**41,348**
Payer Mix =	**12.7%**	**27.1%**	**20.1%**	**12.9%**	**19.5%**	**3.2%**	**4.5%**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2015. Acute care, excludes normal newborns.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 3C


PREMIER
Healthcare Provider Profiles

Service Area Hospital Profiles, CY 2015

- There are three general acute care hospitals, and one psychiatric facility, located within the service area. The table provided to the right illustrates key statistics for each facility in CY 2015.
  - Given that DRMC is the only facility that operates a comprehensive emergency department and a Level II Trauma Center, it can be implied that a portion of DRMC's patients require higher levels of care (e.g., higher acuity) when compared to those treated at other hospitals in the service area.
  - Additionally, DRMC is the market leader for obstetrics (deliveries) in the service area.

Desert Healthcare District
Profile of Service Area Hospitals
CY 2015

	Desert Regional Medical Center	Eisenhower Medical Center	John F. Kennedy Memorial Hospital	Telecare Riverside County Psychiatric Health Facility
Total Inpatient Beds [1]	385	489	156	16
Total Discharges	19,725	19,375	7,228	789
Total Patient Days	88,849	79,283	22,421	5,036
Average Length of Stay	4.5	4.1	3.1	6.4
Average Daily Census	243.4	217.2	61.4	13.8
Occupancy Rate	63.2%	44.4%	39.4%	86.2%
Licensed ED Level	Comprehensive	Basic	Basic	N/A
ED Stations	28	43	12	N/A
ED Visits	71,937	78,070	42,085	N/A
ED Visits per Station	2,569.2	1,815.6	3,507.1	N/A
Admissions through ED	11,176	14,315	3,759	N/A
Percent Admissions through ED	15.5%	18.3%	8.9%	N/A
Trauma Designation	Level II	N/A	N/A	N/A
Number of ORs - Non-Cardiac	10	16	7	N/A
Inpatient OR Cases	5,258	6,801	2,444	N/A
Outpatient OR Cases	2,476	15,294	1,733	N/A
Number of ORs - Cardiac	1	2	0	N/A
Cardiovascular Surgeries - Adult	175	2,990	0	N/A
Cardiovascular Surgeries - Pediatrics	0	0	0	N/A
Cardiac Cath Labs	3	2	1	N/A
Cardiac Cath Procedures	2,295	1,320	306	N/A
Total Live Births	3,214	0	2,180	N/A

Source: California Automated Licensing Information and Report Tracking System and Premier, Inc.
(1) Includes all bed types (general acute care and other).
N/A indicates service is not provided by hospital.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Coachella_Inpatient_Capacity_Analysis.xlsx]Hospital Analysis

Service Area Hospital Profiles, CY 2015 (continued)

	Desert Regional Medical Center	Eisenhower Medical Center	John F. Kennedy Memorial Hospital	Telecare Riverside County Psychiatric Health Facility
Facility Type	General Acute Care	General Acute Care	General Acute Care	Psychiatric
Hospital Compare Star Rating	★	★★★★	★★	Not Rated
Academic Affiliations	• University of California – Riverside	• University of Southern California • Loma Linda University School of Medicine	None	None
Clinical Services Not Provided	• Psychiatry • Transplant	• Maternal and Fetal Medicine • Transplant • Skilled nursing	• Acute rehabilitation • Cardiac surgery • Psychiatry • Neurosurgery • Spine surgery • Transplant	N/A; Scope of services limited to psychiatric care
Centers of Excellence	• Bariatric Surgery • Cancer • Cardiac • Stroke	• Cancer • Cardiac • Neurosciences • Orthopedics	• Coronary • Orthopedics	None

Source: Hospital Compare, Definitive Healthcare, and facility websites

Service Area Hospital Profiles, CY 2015 (continued)

	Desert Regional Medical Center	Eisenhower Medical Center	John F. Kennedy Memorial Hospital	Telecare Riverside County Psychiatric Health Facility
Other Certifications	• American College of Surgeons Commission on Cancer • American Heart Association • American Society for Respiratory Care • Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program • Society for Chest Pain Centers	• American College of Surgeons Commission on Cancer • American Association of Cardiovascular and Pulmonary Rehabilitation • California Mammography Quality Standards Accreditation	• American Heart Association • Blue Cross Distinction Center for Hip & Knee Replacement Surgery	• Commission on Accreditation of Rehabilitation Facilities

Source: Hospital Compare, Definitive Healthcare, and facility websites

Inpatient General Acute Care Capacity Analysis by Hospital and Licensed Bed Type, CY 2015

- Although an excess of inpatient beds existed in the service area in CY 2015 (all hospitals combined), DRMC experienced a shortage of inpatient capacity for obstetrics and critical care services. This is attributed to: 1) the Hospital's Emergency Department ("ED") and trauma designations; 2) DRMC operates the largest obstetrics program in the service area; and 3) the large regional draw DRMC has for inpatient services, and the number of patients that seek care at the Hospital from outside of the service area (e.g., in-migration).

Desert Healthcare District
Service Area Hospital Inpatient General Acute Care Capacity Analysis by Licensed Bed Type
CY 2015

	Desert Regional Medical Center					Eisenhower Medical Center					John F. Kennedy Memorial Hospital					
Bed Type	Total Licensed Beds	Total Patient Days	Average Daily Census	Occupancy Percentage	Bed (Need)/ Surplus	Total Licensed Beds	Total Patient Days	Average Daily Census	Occupancy Percentage	Bed (Need)/ Surplus	Total Licensed Beds	Total Patient Days	Average Daily Census	Bed Need	Occupancy Percentage	Bed (Need)/ Surplus
Medical/Surgical	238	52,535	143.9	60.5%	68	377	68,393	187.4	49.7%	156	81	13,658	37.4	45	46.2%	36
Obstetrics	28	8,480	23.2	83.0%	(3)	0	0	0.0	N/A	0	26	4,466	12.2	17	47.1%	9
Pediatric	14	1,431	3.9	28.0%	8	6	207	0.6	9.5%	5	22	1,289	3.5	5	16.1%	17
Critical Care	31	10,138	27.8	89.6%	(7)	70	6,052	16.6	23.7%	47	16	3,008	8.2	11	51.5%	5
Neonatal Intensive Care	30	8,060	22.1	73.6%	0	0	0	0.0	N/A	0	11	0	0.0	0	0.0%	11
Rehabilitation	12	2,826	7.7	64.5%	2	23	4,631	12.7	55.2%	8	0	0	0.0	0	N/A	0
Total	**353**	**83,470**	**228.7**	**64.8%**	**68**	**476**	**79,283**	**217.2**	**45.6%**	**216**	**156**	**22,421**	**61.4**	**78**	**39.4%**	**78**

Note: Utilization statistics for each hospital reflect total inpatient volume (e.g., patients that originate from inside and outside of the service area).

	Total Service Area Inpatient General Acute Care					
Bed Type	Total Licensed Beds	Total Patient Days	Average Daily Census	Bed Need	Occupancy Percentage	Bed (Need)/ Surplus
Medical/Surgical	696	134,586	368.7	434	53.0%	262
Obstetrics	54	12,946	35.5	48	65.7%	6
Pediatric	42	2,927	8.0	11	19.1%	31
Critical Care	117	19,198	52.6	71	45.0%	46
Neonatal Intensive Care	41	8,060	22.1	30	53.9%	11
Rehabilitation	35	7,457	20.4	25	58.4%	10
Total	**985**	**185,174**	**507.3**	**619**	**51.5%**	**366**

Source: California Automated Licensing Information and Report Tracking System and Premier, Inc.

ry_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Coachella_Provider_Analysis.xlsx]Hospital Summary (2)

Service Area Skilled Nursing Facilities, CY 2015

- The table provided below identifies the skilled nursing facilities located in the service area. Based upon a review of each facility's CY 2015 utilization statistics, excess skilled nursing facility capacity exists in the District's service area.

Desert Healthcare District
Service Area Skilled Nursing Facility Inpatient Capacity Analysis
CY 2015

Facility Name	Total Licensed Beds	Total Patient Days	Average Daily Census	Occupancy Percentage	Bed (Need)/ Surplus
Brookdale Rancho Mirage	45	11,638	31.9	70.9%	11
Desert Regional Medical Center - Skilled Nursing Facility	32	5,379	14.7	46.1%	16
Desert Springs Health and Wellness Center	68	21,690	59.4	87.4%	5
Indio Nursing and Rehab Center	99	32,227	88.3	89.2%	6
ManorCare Health Services Palm Desert	178	49,751	136.3	76.6%	34
Monterey Palms Healthcare Center	99	36,125	99.0	100.0%	(6)
Palm Springs Healthcare Center	99	34,387	94.2	95.2%	(1)
Premier Care Center for Palm Springs	99	33,174	90.9	91.8%	3
Rancho Mirage Health and Rehabilitation Center	99	30,457	83.4	84.3%	11
The Fountains at the Carlotta	59	15,153	41.5	70.4%	15
Total	**877**	**269,981**	**739.7**	**84.3%**	**98**

Source: California Automated Licensing Information and Report Tracking System and Premier, Inc.
Note: Statistics reflect total patient utilization, defined as those patients that originate from inside and outside of the service area.
https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Coachella_Provider_Analysis.xlsx]SNF Summary

Psychiatric Services

- According to the Health Assessment Resource Center, in CY 2013 nearly 90,000 Coachella Valley adults reported some sort of mental, emotional, or behavioral concern, and nearly 19,000 parents reported similar concerns for their children. Further, a recent study published by the Regional Access Project Foundation concluded that a significant shortage of mental health providers (e.g., facilities, professionals) and crisis centers existed throughout the Coachella Valley. The study specifically cited long wait times for outpatient services for adults, limited outpatient access for pediatric and adolescent patients, and a severe shortage of inpatient psychiatric services for adult, pediatric, and adolescent patients combined.
  - Patients with mild symptoms often go untreated, and patients with severe conditions seek treatment in the service area's three hospital emergency rooms. According to a 2016 article published by the Desert Sun, nearly 5,000 psychiatric patients were treated across the three emergency departments in CY 2013.
  - **Inpatient Access:** Eisenhower Medical Center and Telecare Riverside County Psychiatric Health Facility are the only providers of inpatient psychiatric services in the District's service area. In CY 2015, both facilities experienced a shortage of inpatient capacity. This trend is likely attributed to the growing demand and large regional draw for inpatient psychiatric services, with a large portion of each facility's patients originating from outside of the District's service area (e.g., in-migration).
    - Eisenhower Medical Center operates the inpatient Center for Geropsychiatry, a voluntary inpatient program for seniors 65 years and older who are experiencing symptoms of depression, anxiety, bipolar disorder, psychotic disorder, or other behavioral problems.

Psychiatric Services (continued)

- Telecare Riverside County Psychiatric Health Facility is the only crisis stabilization unit in the service area. The facility, which is funded by the Riverside County Department of Mental Health, provides treatment to patients age 18 years and older who have been diagnosed with a serious mental illness.
- There are no inpatient providers of psychiatric services for pediatric and adolescent patients.

- **Outpatient Access:** Outpatient psychiatric services are fragmented, and are provided by a variety of providers, including hospitals, outpatient centers, and community clinics.
  - Eisenhower Medical Center treats approximately 500 to 800 commercially insured patients per month on an outpatient basis through its mental health clinic for disorders related to depression and anxiety.
  - San Gorgonio Memorial Hospital Behavioral Center, which recently relocated to Indio, provides outpatient mental health services to adults.
  - Community-based clinics provide some outpatient mental health care services. However, in addition to overall access being limited, gaps in culturally-appropriate services exist for the following psychiatric patient cohorts:
    - Pediatric and adolescents
    - Veterans
    - Lesbian, gay, bisexual, and transgenders
    - Geriatrics
    - Latinos

Service Area Inpatient Psychiatric Capacity, CY 2015

Desert Healthcare District
Service Area Inpatient Psychiatric Capacity Analysis by Licensed Bed Type
CY 2015

Facility Name	Total Licensed Beds	Total Patient Days	Average Daily Census	Occupancy Percentage	Bed (Need)/ Surplus
Eisenhower Medical Center	13	4,745	13.0	100.0%	(3)
Telecare Riverside County Psychiatric Health Facility	16	5,036	13.8	86.2%	(1)
Total	**29**	**9,781**	**26.8**	**92.4%**	**(3)**

Source: California Automated Licensing Information and Report Tracking System and Premier, Inc.

Note: Statistics reflect total patient utilization, defined as those patients that originate from inside and outside of the service area.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Coachella_Provider_Analysis.xlsx]Psych

Service Area Community Clinics Overview, CY 2015

Desert Healthcare District
Service Area Community Clinics Overview
CY 2015

	Barbara Sinatra Childrens Center at Eisenhower	Borrego Health Specialty Care Center	Central City Community Health Center, Inc.	Centro Medico, Cathedral City	Centro Medico, Coachella	Centro Medico, Oasis	Coachella Health Clinic	Desert AIDS Project	Desert Hot Springs Community Health Center	Desert Hot Springs Health & Wellness Center
License Category	Psychology	FQHC	FQHC	FQHC	FQHC	FQHC	FQHC	FQHC	FQHC	FQHC
Rural Health Clinic	No	No	No	No	No	No	No	No	No	No
Health Services Provided:										
Medical		✓	✓	✓	✓	✓	✓	✓	✓	✓
Dental				✓	✓			✓		✓
Vision				✓						
Mental Health	✓		✓	✓	✓		✓	✓		
Substance Abuse			✓					✓		
Domestic Violence										
Basic Lab		✓	✓				✓	✓		
Radiological Services										
Urgent Care				✓					✓	
Pharmacy		✓								
Women's Health (OB/GYN, Family Planning, Midwives)				✓				✓		
Total Patients Treated	480	Not Reported	1,069	55,208	4,232	3,965	3,680	2,261	7,804	2,906
Total Patient Encounters	6,027	Not Reported	2,266	125,323	16,125	12,688	8,937	23,139	23,912	8,407
Average Encounters per Patient	12.6	Not Reported	2.1	2.3	3.8	3.2	2.4	10.2	3.1	2.9
Provider FTEs (1)	Not Reported	Not Reported	2.0	31.3	5.0	3.8	3.0	16.1	7.9	2.7
Encounters per Provider FTE	N/A	Not Reported	1,133.0	4,002.7	3,225.0	3,330.2	2,989.0	1,434.5	3,038.4	3,113.7
Spanish as Primary Language (% of Patients)	Not Reported	Not Reported	70.0%	56.0%	73.0%	88.0%	39.0%	35.0%	29.0%	46.0%
Federal Poverty Level - Percent of Patients:										
Under 100%	Not Reported	Not Reported	76.6%	43.7%	64.2%	77.6%	34.9%	32.7%	0.0%	70.2%
100-138%	Not Reported	Not Reported	0.5%	10.9%	17.9%	18.4%	2.9%	17.5%	64.5%	17.5%
139-200%	Not Reported	Not Reported	0.0%	2.7%	2.0%	2.6%	1.1%	10.6%	16.0%	5.6%
201-400%	Not Reported	Not Reported	15.2%	0.0%	0.0%	0.0%	0.2%	8.9%	5.9%	0.0%
Above 400%	Not Reported	Not Reported	0.0%	0.0%	0.0%	0.0%	0.5%	3.4%	0.0%	0.0%
Unknown	Not Reported	Not Reported	7.8%	42.6%	15.9%	1.4%	60.4%	26.8%	13.6%	6.7%

Source: US Department of Health & Human Services, California Automated Licensing Information and Report Tracking System, facility websites, and Premier, Inc.
Note: Excludes Kaiser because scope of services are not reported, and these facilities are not available to the general public.
(1) Reflects physicians, advanced practice clinicians, certified nurse midwives, dentists, registered dental hygienists, psychiatrists, clinical psychologists, licensed clinical social workers, chiropractors, physical therapists, optometrists, and any other professional who is able to be reimbursed through the Medi-Cal program.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Coachella_Provider_Analysis.xlsx]Clinic Summary

Service Area Community Clinics Overview, CY 2015 (continued)

Desert Healthcare District
Service Area Community Clinics Overview
CY 2015

	Desert Oasis Women's Health Center	Desert Services, Outreach, and Shelter (Roy's Resource Center)	Health to Hope Clinics, Coachella Valley Rescue Mission	Indio Family Care Center	Mecca Health Clinic (91275 66th Ave, Suite 300, Mecca, CA 92254)	Mecca Health Clinic (91275 66th Ave, Suite 500, Mecca, CA 92254)	Palm Springs Family Care Center	Planned Parenthood - Coachella Valley	Planned Parenthood - Rancho Mirage Center	Santa Rosa Del Valle	Stonewall Medical Center
License Category	FQHC	FQHC	FQHC	FQHC	FQHC	FQHC	FQHC	Other	Other	No	FQHC
Rural Health Clinic	No	No	No	No	No	No	No	No	No	Yes	No
Health Services Provided:											
Medical		✓	✓	✓		✓	✓	✓	✓	✓	✓
Dental		✓			✓						
Vision											
Mental Health	✓	✓	✓			✓					
Substance Abuse		✓	✓								
Domestic Violence											
Basic Lab					✓	✓					
Radiological Services					✓	✓					
Urgent Care											
Pharmacy											
Women's Health (OB/GYN, Family Planning, Midwives)	✓	✓	✓	✓		✓	✓	✓	✓	✓	
Total Patients Treated	2,065	Not Reported	Not Reported	Not Reported	2,259	6,445	Not Reported	6,165	7,954	Not Reported	Not Reported
Total Patient Encounters	6,379	Not Reported	Not Reported	Not Reported	4,882	18,354	Not Reported	12,265	15,212	Not Reported	Not Reported
Average Encounters per Patient	3.1	Not Reported	Not Reported	Not Reported	2.2	2.8	Not Reported	2.0	1.9	Not Reported	Not Reported
Provider FTEs (1)	3.5	Not Reported	Not Reported	Not Reported	1.1	4.6	Not Reported	2.0	2.5	Not Reported	Not Reported
Encounters per Provider FTE	1,827.8	Not Reported	Not Reported	Not Reported	4,358.9	4,016.2	Not Reported	6,102.0	6,012.6	Not Reported	Not Reported
Spanish as Primary Language (% of Patients)	39.0%	Not Reported	Not Reported	Not Reported	39.0%	72.0%	Not Reported	21.0%	5.0%	Not Reported	Not Reported
Federal Poverty Level - Percent of Patients:											
Under 100%	64.1%	Not Reported	Not Reported	Not Reported	44.9%	65.0%	Not Reported	64.8%	62.4%	Not Reported	Not Reported
100-138%	19.6%	Not Reported	Not Reported	Not Reported	3.4%	4.9%	Not Reported	8.8%	13.3%	Not Reported	Not Reported
139-200%	9.8%	Not Reported	Not Reported	Not Reported	0.8%	1.4%	Not Reported	4.1%	7.8%	Not Reported	Not Reported
201-400%	0.0%	Not Reported	Not Reported	Not Reported	0.4%	0.6%	Not Reported	1.3%	4.0%	Not Reported	Not Reported
Above 400%	0.0%	Not Reported	Not Reported	Not Reported	0.2%	0.6%	Not Reported	0.4%	1.1%	Not Reported	Not Reported
Unknown	6.5%	Not Reported	Not Reported	Not Reported	50.4%	27.4%	Not Reported	20.6%	11.5%	Not Reported	Not Reported

Source: US Department of Health & Human Services, California Automated Licensing Information and Report Tracking System, facility websites, and Premier, Inc.
Note: Excludes Kaiser because scope of services are not reported, and these facilities are not available to the general public.
(1) Reflects physicians, advanced practice clinicians, certified nurse midwives, dentists, registered dental hygienists, psychiatrists, clinical psychologists, licensed clinical social workers, chiropractors, physical therapists, optometrists, and any other professional who is able to be reimbursed through the Medi-Cal program.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Coachella_Provider_Analysis.xlsx]Clinic Summary (2)

Service Area Ambulatory Surgery Centers Overview

Desert Healthcare District
Overview of Service Area Ambulatory Surgery Centers
CY 2015

Facility	Services Provided																	Number of Operating Rooms	Estimated Number of Procedures, CY 2014	Average Procedures per Operating Room
	Cardiology	Dental	Dermatology	Gastroenterology	General Surgery	Gynecology	Neurology	Ophthalmology	Oral Surgery	Orthopedics	Otolaryngology	Pain Management	Plastic Surgery	Podiatry	Radiation Oncology	Urology	Vascular Surgery			
Aaronson Plastic Surgery Center													✓					2	N/A	N/A
Aurora Surgery Center					✓	✓	✓			✓	✓	✓	✓	✓		✓		2	602	301
Eisenhower Desert Orthopedic Center										✓								2	N/A	N/A
El Mirador Surgical Center			✓	✓		✓	✓	✓		✓	✓	✓		✓		✓		6	12,432	2,072
Eye Surgery Center of the Desert			✓					✓					✓					3	N/A	N/A
Indio Surgery Center, Inc.		✓ (Peds)																3	N/A	N/A
La Quinta Surgery Center							✓			✓		✓						1	N/A	N/A
Mirage Endoscopy Center, LP				✓														2	7,050	3,525
Rancho Mirage Surgery Center	✓		✓	✓			✓			✓	✓	✓	✓			✓		3	1,756	585
Sedona Surgery Center					✓	✓		✓		✓		✓	✓	✓	✓	✓		3	N/A	N/A
Sternlieb Outpatient Surgery Center									✓									2	N/A	N/A
The Morrow Institute Medical Group, Inc.													✓					2	N/A	N/A
Total Ambulatory Surgery Center Operating Rooms																		**31**		

Source: Definitive Healthcare, facility websites
Note: Excludes procedure rooms located in physician offices.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_ASC_Overview.xlsx]ASC Summary

Service Area Imaging Centers Overview

Desert Healthcare District
Overview of Service Area Imaging Centers
CY 2015

Facility	Imaging Services Provided									
	Bone Density Scans (DXA)	CT	Interventional Radiology	Mammography	MRI	Nuclear Medicine	PET	Radiation Therapy	Ultrasound	X-Ray
Desert Medical Imaging - Indian Wells		✓			✓				✓	
Desert Medical Imaging - Indio		✓			✓				✓	
Desert Medical Imaging - Palm Springs		✓			✓				✓	
Desert Regional Medical Center Imaging (El Mirador Imaging Center)	✓	✓		✓	✓		✓		✓	✓
Eisenhower Medical Center Imaging		✓	✓		✓	✓	✓		✓	✓
Health Scan Imaging - La Quinta					✓				✓	✓
Health Scan Imaging - Palm Desert		✓			✓				✓	
Health Scan Imaging - Palm Springs		✓			✓				✓	
John F. Kennedy Memorial Hospital Imaging Center	✓	✓		✓	✓				✓	✓
RadNet - Desert Advanced Imaging - Bermuda Dunes										✓
RadNet - Desert Advanced Imaging - Breast Care Imaging Center of the Desert	✓			✓	✓				✓	
RadNet - Desert Advanced Imaging - El Cielo										✓
RadNet - Desert Advanced Imaging - Indio				✓					✓	✓
RadNet - Desert Advanced Imaging - Palm Desert		✓			✓					✓
RadNet - Desert Advanced Imaging - Palm Springs				✓	✓	✓			✓	✓
RadNet - Desert Advanced Imaging - Vascular Center									✓ (Vascular Ultrasound Only)	
RadNet - Desert Advanced Imaging Palm Desert X-Ray										✓
RadNet - Rancho Mirage Interventional Radiology and Advanced Imaging Center		✓	✓	✓	✓		✓		✓	✓
The PET Center							✓			
Truly Open MRI-Palm Desert					✓					

Source: Definitive Healthcare, facility websites
https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Imaging_Center_Analysis.xlsx]Summary

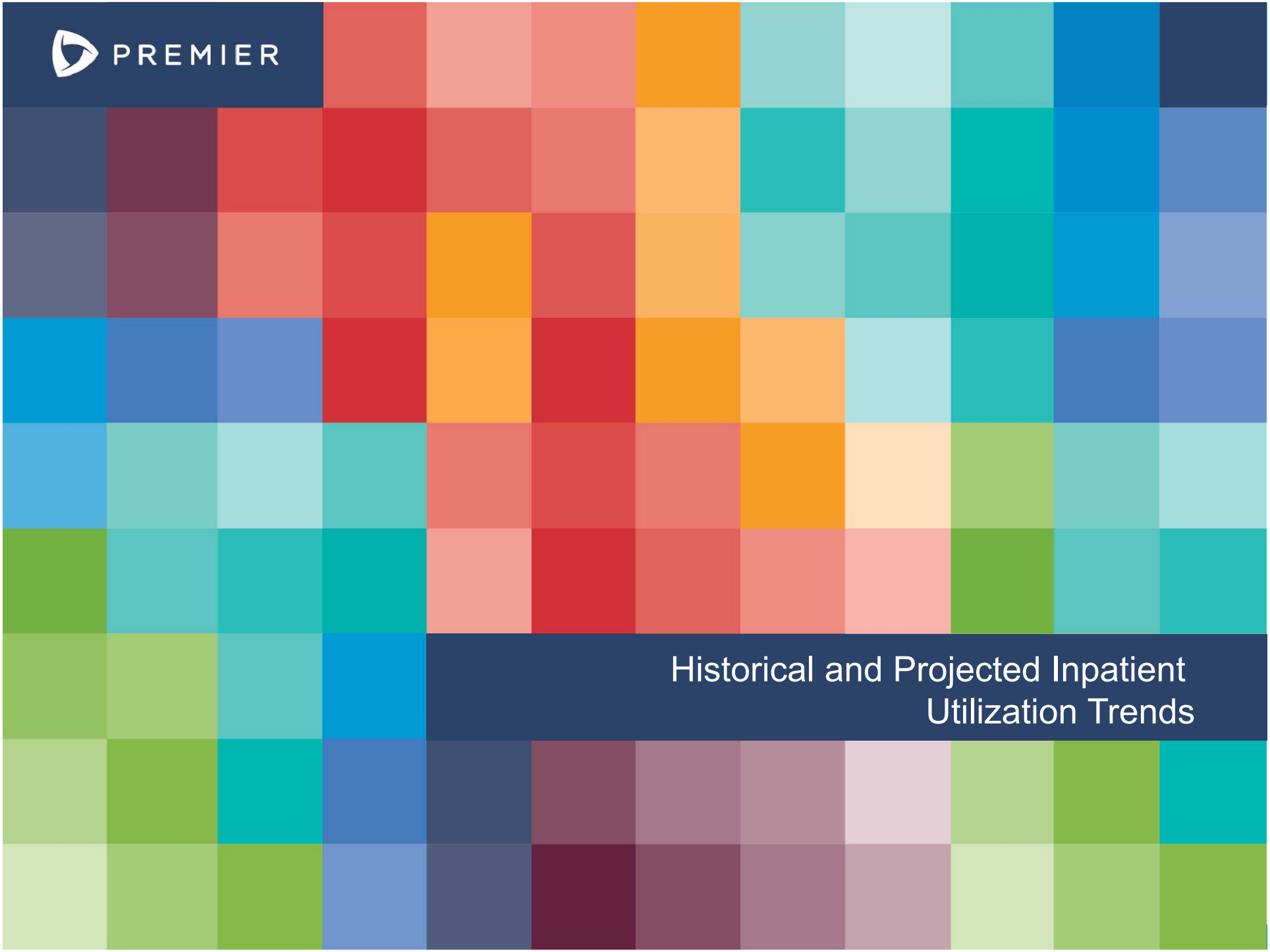
Service Area Home Health Agencies Overview

Desert Healthcare District
Overview of Service Area Home Health Agencies
CY 2015

Home Health Agency	Number of Patients	Number of Visits	Average Visits per Patient	Accepts	
				Medicare	Medi-Cal
Addus HomeCare - Palm Desert	Not Reported	Not Reported	N/A	Yes	Yes
Care Dimensions of the Desert	975	10,435	10.7	Yes	Yes
Desert Home Health Services, Inc.	1,955	2,161	1.1	Yes	No
Desert Oasis Healthcare	2,457	22,600	9.2	Yes	No
Guardian Angel Home Care, Inc.	263	3,678	14.0	Yes	Yes
Healthy Living at Home Palm Desert, LLC	Not Reported	Not Reported	N/A	Yes	No
Home Health Angels	223	3,352	15.0	Yes	No
Live Life Home Health, LLC	98	1,485	15.2	Yes	No
Maxim Healthcare Services Palm Desert	Not Reported	Not Reported	N/A	No	Yes
Maxim Healthcare Services Rancho Mirage	149	33,169	222.6	No	Yes
Mission Home Health of Rancho Mirage	1,788	26,833	15.0	Yes	Yes
ResCare HomeCare Greater Palm Springs Area	Not Reported	Not Reported	N/A	Yes	Yes
Sanrose Home Health Services, Inc.	51	695	13.6	Yes	Yes
VNA California - Palm Desert	2,845	41,546	14.6	Yes	Yes

Source: California Automated Licensing Information and Report Tracking System, Definitive Healthcare, facility websites, and Premier, Inc.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Coachella_Provider_Analysis.xlsx]Home Health


PREMIER
Historical and Projected Inpatient Utilization Trends

Assumptions: Use Rates by Service Line

- Overall inpatient use rates (discharges per 1,000 population) for the service area decreased between CY 2012 and 2015. This trend is expected to continue across most medical and surgical inpatient service lines for the duration of the projection period, and is attributed to the following:
  - Continued rise of high-deductible insurance plans that constrain medical use
  - Impact of value-based care models (e.g., accountable care organizations, bundled payments, patient-centered medical homes [e.g., Comprehensive Primary Care Plus ("CPC+")], risk-based payment contracts, and performance-based physician incentives) that seek to achieve enhanced coordination of care, better quality outcomes, and reduced costs across care settings
    - Patients treated under these models typically have lower lengths of stay and less readmissions
    - Providers are seeking to reduce preventable hospitalizations for acute and chronic conditions, and preventable readmissions by ensuring patients receive home-based disease management programs and outpatient care, instead of accessing hospital care
  - Shift in volumes from inpatient to observation status through the two-midnight census rule implemented by the Centers for Medicare & Medicaid Services ("CMS") in October, 2013, and the continued shift in inpatient volume to outpatient care settings for ambulatory case-sensitive admissions (e.g., uncontrolled diabetes, hypertension, dehydration)
  - Providers are aggressively increasing intensive medical management for chronic conditions on an outpatient basis

Assumptions: Use Rates by Service Line (continued)

- Between CY 2007 and 2015, the number of births in the United States for women ages 15-44 years decreased by 7.9 percent. According to the Centers for Disease Control and Prevention, national fertility rates experienced a sharp decline across all ethnic cohorts during this time period, specifically: white fertility rates decreased by 8 percent, black fertility rates decreased by 6 percent, and Hispanic fertility rates decreased by 13 percent. Additionally, the teen childbirth rate also decreased by 46 percent during this same time period. Similarly, birth rates in the service area have decreased over the time period, CY 2012 through 2015. This trend will likely continue due to:
  - Changing social behaviors and lifestyle choices, including delaying marriage and parenthood to accommodate advanced schooling and careers
  - Increased access to contraception
  - Recovery from the recent economic downturn
  - Leveling off of the number of Mexican immigrants and their share of the total United States population. According to the National Center for Health Statistics, annual births to foreign-born women account for the largest driver of birth-related volume since 1970, with immigrants from Mexico representing the largest national-origin group in the United States. However, the number of Mexican immigrants and their proportion of the total United States immigrant population has decreased since the economic downturn in 2008, thereby resulting in a decrease in the number of reported births.

Assumptions: Use Rates by Service Line (continued)

- While the total number of new cancer cases is expected to increase from 1.5 million per year in CY 2010 to 1.9 million per year in CY 2020 throughout the United States, the incidence rate for new diagnoses is expected to remain relatively flat, and the increase in new cases is attributed to an aging population.[1] Use rates for oncology and hematology services are expected to increase slightly over the projection period because:
  - Cancer patients are living longer and will experience an increased use of healthcare services
  - The service area has higher mortality rates for cancer when compared to the State overall, thereby implying increased demand for these services

[1] Centers for Disease Control and Prevention

Total Service Area Inpatient Discharges by Service Line

- Although use rates are projected to decrease for almost all inpatient medical and surgical service lines, total volume in the service area is expected to increase due to population growth and aging of the population.

Desert Healthcare District
Service Area Inpatient Discharges by Service Line
CY 2012 - 2026

Service Lines	Historical Inpatient Discharges				Projected Inpatient Discharges		
	2012	2013	2014	2015	2016	2021	2026
Cardiology - Diagnostic	1,612	1,434	1,341	1,341	1,344	1,375	1,439
Cardiology - Medical	3,942	3,571	3,371	3,342	3,349	3,426	3,586
Cardiology - Surgery	411	369	411	444	445	455	476
Chemical Dependency	142	165	194	221	224	238	253
Endocrine	1,191	1,040	1,055	1,115	1,127	1,192	1,261
ENT	328	294	304	309	312	330	350
Gastroenterology	3,709	3,479	3,432	3,600	3,626	3,756	3,896
General Medicine	3,497	3,384	3,635	4,152	4,161	4,256	4,455
General Surgery	3,606	3,606	3,680	3,467	3,474	3,554	3,720
Gynecology	744	674	598	632	638	666	695
Neonatal Intensive Care	1,660	1,506	1,573	1,609	1,613	1,635	1,672
Neurology	2,389	2,199	2,229	2,183	2,199	2,278	2,363
Neurosurgery	462	451	382	307	308	315	329
Obstetrics & Deliveries	6,058	5,721	5,770	5,736	5,748	5,878	6,143
Oncology	1,542	1,495	1,465	1,488	1,506	1,602	1,705
Ophthalmology	78	68	65	51	52	55	58
Orthopedics	3,819	3,859	4,038	4,074	4,103	4,250	4,409
Others NC	0	0	48	0	0	0	0
Plastic Surgery	271	282	243	268	269	275	288
Psychiatry	149	124	141	168	170	181	192
Pulmonary Medicine	3,311	3,518	3,233	3,187	3,210	3,333	3,517
Rehabilitation	2	2	2	1	1	1	1
Spine Surgery	544	548	619	735	737	762	807
Thoracic & Vascular Su	810	820	807	683	684	700	733
Transplant	33	33	39	27	27	29	31
Urology	1,890	1,954	2,040	2,208	2,218	2,298	2,425
TOTAL	**42,200**	**40,596**	**40,715**	**41,348**	**41,543**	**42,838**	**44,803**

Source: OSHPD Inpatient Database and Premier, Inc.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]Service Area Volume

DRMC: Projected Inpatient Market Share by Service Line

- In order to evaluate DRMC's capacity while considering community need for inpatient healthcare services, Premier assumed that the Hospital would experience a three percentage point increase in overall market share by CY 2021. DRMC's market share levels were projected to remain flat each year thereafter.

Desert Regional Medical Center
Inpatient Discharge Market Share by Service Line
CY 2012 - 2026

Service Lines	Historical Inpatient Market Share				Projected Inpatient Market Share		
	2012	2013	2014	2015	2016	2021	2026
Cardiology - Diagnostic/Interventional	33.4%	34.2%	36.5%	37.4%	38.4%	40.4%	40.4%
Cardiology - Medical	29.0%	31.9%	31.7%	32.4%	33.4%	35.4%	35.4%
Cardiology - Surgery	24.8%	26.0%	24.3%	24.5%	25.5%	27.5%	27.5%
Chemical Dependency	30.3%	41.2%	23.2%	32.6%	33.6%	35.6%	35.6%
Endocrine	23.4%	25.9%	29.8%	29.9%	30.9%	32.9%	32.9%
ENT	17.4%	16.3%	18.4%	23.0%	24.0%	26.0%	26.0%
Gastroenterology	27.4%	28.0%	31.3%	31.8%	32.8%	34.8%	34.8%
General Medicine	28.0%	25.3%	28.5%	26.9%	27.9%	29.9%	29.9%
General Surgery	27.0%	24.7%	26.1%	26.8%	27.8%	29.8%	29.8%
Gynecology	48.3%	42.1%	44.3%	41.1%	42.1%	44.1%	44.1%
Neonatal Intensive Care	58.6%	60.2%	63.3%	66.7%	67.7%	69.7%	69.7%
Neurology	32.1%	33.9%	33.8%	32.9%	33.9%	35.9%	35.9%
Neurosurgery	26.0%	23.9%	28.5%	32.6%	33.6%	35.6%	35.6%
Obstetrics & Deliveries	52.6%	52.7%	54.0%	53.1%	54.1%	56.1%	56.1%
Oncology	19.3%	16.9%	22.3%	24.3%	25.3%	27.3%	27.3%
Ophthalmology	28.2%	23.5%	32.3%	35.3%	36.3%	38.3%	38.3%
Orthopedics	24.5%	25.8%	25.3%	24.3%	25.3%	27.3%	27.3%
Others NC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Plastic Surgery	24.4%	19.1%	17.7%	17.2%	18.2%	20.2%	20.2%
Psychiatry	28.9%	27.4%	23.4%	31.0%	32.0%	34.0%	34.0%
Pulmonary Medicine	28.1%	28.5%	29.6%	29.0%	30.0%	32.0%	32.0%
Rehabilitation	0.0%	50.0%	0.0%	100.0%	100.0%	100.0%	100.0%
Spine Surgery	8.3%	9.5%	12.4%	13.6%	14.6%	16.6%	16.6%
Thoracic & Vascular Surgery	25.8%	32.3%	32.3%	29.7%	30.7%	32.7%	32.7%
Transplant	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Urology	23.2%	24.2%	25.4%	24.5%	25.5%	27.5%	27.5%
Total	**32.1%**	**32.1%**	**33.5%**	**33.4%**	**34.3%**	**36.3%**	**36.2%**

Source: OSHPD Inpatient Database and Premier, Inc.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]Market Share Adjustments

DRMC: Projected Hospital Discharges Originating from the Service Area

- The table provided to the right illustrates total projected discharges originating from the service area for DRMC. This projected utilization excludes in-migration (patients receiving care at DRMC who originate from outside of the service area).

Desert Regional Medical Center
Service Area Inpatient Discharges by Service Line
CY 2012 - 2026

	Historical Inpatient Discharges				Projected Inpatient Discharges		
Service Lines	2012	2013	2014	2015	2016	2021	2026
Cardiology - Diagnostic/Interventional	539	491	490	502	516	556	582
Cardiology - Medical	1,144	1,140	1,069	1,084	1,120	1,214	1,271
Cardiology - Surgery	102	96	100	109	114	125	131
Chemical Dependency	43	68	45	72	75	85	90
Endocrine	279	269	314	333	348	392	414
ENT	57	48	56	71	75	86	91
Gastroenterology	1,017	975	1,075	1,145	1,189	1,307	1,356
General Medicine	979	856	1,036	1,118	1,162	1,274	1,333
General Surgery	975	889	962	930	967	1,060	1,109
Gynecology	359	284	265	260	269	294	307
Neonatal Intensive Care	973	906	995	1,073	1,092	1,139	1,165
Neurology	767	745	753	719	746	818	849
Neurosurgery	120	108	109	100	103	112	117
Obstetrics & Deliveries	3,188	3,017	3,115	3,044	3,108	3,296	3,444
Oncology	297	253	326	361	381	437	465
Ophthalmology	22	16	21	18	19	21	22
Orthopedics	934	996	1,022	989	1,037	1,159	1,203
Others NC	0	0	0	0	0	0	0
Plastic Surgery	66	54	43	46	49	55	58
Psychiatry	43	34	33	52	54	61	65
Pulmonary Medicine	931	1,002	957	923	962	1,065	1,124
Rehabilitation	0	1	0	1	1	1	1
Spine Surgery	45	52	77	100	108	127	134
Thoracic & Vascular Surgery	209	265	261	203	210	229	240
Transplant	0	0	0	0	0	0	0
Urology	438	472	519	540	565	631	666
TOTAL	**13,527**	**13,037**	**13,643**	**13,793**	**14,268**	**15,544**	**16,238**

Source: OSHPD Inpatient Database and Premier, Inc.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]DRMC Volume

Average Length of Stay

- Premier projected a small decrease in the service area's average length of stay ("ALOS") for most inpatient service lines to reflect the pending impact of value-based care models and risk-based contracts.

Desert Healthcare District
Service Area Inpatient Average Length of Stay by Service Line
CY 2012 - 2026

	Historical Inpatient Average Length of Stay				Projected Inpatient ALOS		
Service Lines	2012	2013	2014	2015	2016	2021	2026
Cardiology - Diagnostic/Interventional	2.9	3.2	3.1	3.2	3.2	2.9	2.9
Cardiology - Medical	2.5	2.6	2.7	2.9	2.8	2.7	2.7
Cardiology - Surgery	7.7	7.8	7.5	7.6	7.5	7.3	7.3
Chemical Dependency	3.4	3.2	3.7	3.7	3.7	3.7	3.7
Endocrine	3.4	3.3	3.2	3.1	3.0	2.8	2.8
ENT	3.3	3.1	3.1	3.2	3.1	2.9	2.9
Gastroenterology	3.5	3.5	3.5	3.4	3.4	3.1	3.1
General Medicine	5.2	5.2	5.4	5.2	5.1	4.9	4.9
General Surgery	6.3	6.0	6.3	6.1	6.1	5.7	5.7
Gynecology	2.5	2.6	2.7	2.9	2.9	2.6	2.6
Neonatal Intensive Care	6.5	6.8	6.6	5.6	5.6	5.6	5.6
Neurology	3.5	3.4	3.6	3.4	3.4	3.2	3.2
Neurosurgery	5.3	6.1	6.8	8.1	8.1	6.4	6.4
Obstetrics & Deliveries	2.1	2.2	2.2	2.1	2.1	2.1	2.1
Oncology	6.1	6.0	5.7	5.1	5.1	5.1	5.1
Ophthalmology	2.5	3.6	4.4	4.1	4.0	3.6	3.6
Orthopedics	3.6	3.6	3.6	3.5	3.4	3.0	3.0
Others NC	0.0	0.0	3.4	0.0	0.0	0.0	0.0
Plastic Surgery	5.1	5.8	5.9	6.3	6.3	5.3	5.3
Psychiatry	3.1	4.7	5.0	4.4	4.4	4.4	4.4
Pulmonary Medicine	4.6	4.4	4.4	4.9	4.9	4.9	4.9
Rehabilitation	17.0	19.0	8.0	3.0	3.0	3.0	3.0
Spine Surgery	4.0	4.1	4.2	3.9	3.8	3.5	3.5
Thoracic & Vascular Surgery	5.6	5.8	5.2	5.5	5.5	5.1	5.1
Transplant	18.5	16.6	18.8	14.0	14.0	14.0	14.0
Urology	3.7	3.8	3.8	3.7	3.6	3.2	3.2

Source: OSHPD Inpatient Database and Premier, Inc.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]ALOS

Percent of Inpatient Days Allocated by Bed Type

- In order to project utilization by licensed bed type, Premier allocated patient days by bed type for each inpatient service line.
  - Note: Actual patient days by bed type by inpatient service line were not available for the market or DRMC. In the absence of this data, Premier assigned these allocations based upon our experience and understanding of the marketplace.

Desert Healthcare District

Service Area Inpatient Discharges and Patient Days by Service Line - Cross Walk by Bed Type

CY 2015

Service Lines	Med/Surg (Acute)	Critical Care (ICU and CCU)	Pediatrics	OB (Perinatal)	NICU	Rehab	Psych	TOTAL
Cardiology - Diagnostic/Interventional	74.8%	25.0%	0.2%	0.0%	0.0%	0.0%	0.0%	100.0%
Cardiology - Medical	74.4%	25.0%	0.6%	0.0%	0.0%	0.0%	0.0%	100.0%
Cardiology - Surgery	74.5%	25.0%	0.5%	0.0%	0.0%	0.0%	0.0%	100.0%
Chemical Dependency	75.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Endocrine	71.8%	25.0%	3.2%	0.0%	0.0%	0.0%	0.0%	100.0%
ENT	87.2%	10.0%	2.8%	0.0%	0.0%	0.0%	0.0%	100.0%
Gastroenterology	85.1%	10.0%	4.9%	0.0%	0.0%	0.0%	0.0%	100.0%
General Medicine	84.3%	10.0%	5.7%	0.0%	0.0%	0.0%	0.0%	100.0%
General Surgery	68.1%	25.0%	6.9%	0.0%	0.0%	0.0%	0.0%	100.0%
Gynecology	89.7%	10.0%	0.3%	0.0%	0.0%	0.0%	0.0%	100.0%
Neonatal Intensive Care	0.0%	0.0%	25.0%	0.0%	75.0%	0.0%	0.0%	100.0%
Neurology	81.0%	15.0%	4.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Neurosurgery	74.5%	25.0%	0.5%	0.0%	0.0%	0.0%	0.0%	100.0%
Obstetrics & Deliveries	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	100.0%
Oncology	87.3%	10.0%	2.7%	0.0%	0.0%	0.0%	0.0%	100.0%
Ophthalmology	97.2%	2.5%	0.3%	0.0%	0.0%	0.0%	0.0%	100.0%
Orthopedics	86.9%	10.0%	3.1%	0.0%	0.0%	0.0%	0.0%	100.0%
Others NC	75.0%	25.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Plastic Surgery	89.7%	10.0%	0.3%	0.0%	0.0%	0.0%	0.0%	100.0%
Psychiatry	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Pulmonary Medicine	57.0%	25.0%	18.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	0.0%	100.0%
Spine Surgery	89.6%	10.0%	0.4%	0.0%	0.0%	0.0%	0.0%	100.0%
Thoracic & Vascular Surgery	74.6%	25.0%	0.4%	0.0%	0.0%	0.0%	0.0%	100.0%
Transplant	74.9%	25.0%	0.1%	0.0%	0.0%	0.0%	0.0%	100.0%
Urology	95.2%	2.5%	2.3%	0.0%	0.0%	0.0%	0.0%	100.0%

Source: Premier, Inc.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]Days to Bed Type Cross Walk

Occupancy Rates by Bed Type

Bed Type	Occupancy Rate
Medical/Surgical	85%
Critical Care (Intensive Care, Coronary Care)	75%
Obstetrics (Perinatal)	75%
Neonatal Intensive Care	75%
Pediatrics	75%
Psychiatric	75%
Rehabilitation	75%

Projected Service Area Bed Need

Desert Healthcare District
Service Area Projected Bed Need
CY 2012 - 2026

	Historical				Projected		
	2012	2013	2014	2015	2016	2021	2026
Medical Surgical							
Service Area:							
Total Licensed Beds in Service Area	696	696	696	696	696	696	696
Bed Need at Optimal Occupancy (Rounded Up)	361	353	359	363	360	349	366
Total Service Area Bed (Need)/Surplus	**335**	**343**	**337**	**333**	**336**	**347**	**330**
DRMC:							
Total Licensed Beds at DRMC	238	238	238	238	238	238	238
Bed Need at Optimal Occupancy (Rounded Up)	96	93	100	101	104	108	113
Total Bed (Need)/Surplus at DRMC	**142**	**145**	**138**	**137**	**134**	**130**	**125**
Critical Care							
Service Area:							
Total Licensed Beds in Service Area	117	117	117	117	117	117	117
Bed Need at Optimal Occupancy (Rounded Up)	90	87	87	88	87	85	89
Total Service Area Bed (Need)/Surplus	**27**	**30**	**30**	**29**	**30**	**32**	**28**
DRMC:							
Total Licensed Beds at DRMC	31	31	31	31	31	31	31
Bed Need at Optimal Occupancy (Rounded Up)	25	24	25	25	26	27	28
Total Bed (Need)/Surplus at DRMC	**6**	**7**	**6**	**6**	**5**	**4**	**3**
Pediatrics							
Service Area:							
Total Licensed Beds in Service Area	42	42	42	42	42	42	42
Bed Need at Optimal Occupancy (Rounded Up)	37	36	37	36	36	36	38
Total Service Area Bed (Need)/Surplus	**5**	**6**	**5**	**6**	**6**	**6**	**4**
DRMC:							
Total Licensed Beds at DRMC	14	14	14	14	14	14	14
Bed Need at Optimal Occupancy (Rounded Up)	14	13	14	14	14	15	15
Total Bed (Need)/Surplus at DRMC	**0**	**1**	**0**	**0**	**0**	**(1)**	**(1)**
Obstetrics (Perinatal)							
Service Area:							
Total Licensed Beds in Service Area	54	54	54	54	54	54	54
Bed Need at Optimal Occupancy (Rounded Up)	48	46	46	45	45	46	48
Total Service Area Bed (Need)/Surplus	**6**	**8**	**8**	**9**	**9**	**8**	**6**
DRMC:							
Total Licensed Beds at DRMC	28	28	28	28	28	28	28
Bed Need at Optimal Occupancy (Rounded Up)	25	24	25	24	25	26	27
Total Bed (Need)/Surplus at DRMC	**3**	**4**	**3**	**4**	**3**	**2**	**1**

Source: OSHPD Inpatient Database and Premier, Inc.

Note: Projected bed need is based on volume that originates from the service area only, and does not consider in-migration.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]Total Bed Need Summary

Projected Service Area Bed Need (continued)

Desert Healthcare District
Service Area Projected Bed Need
CY 2012 - 2026

	Historical				Projected		
	2012	2013	2014	2015	2016	2021	2026
Neonatal Intensive Care							
Service Area:							
Total Licensed Beds in Service Area	41	41	41	41	41	41	41
Bed Need at Optimal Occupancy (Rounded Up)	30	29	29	25	25	26	26
Total Service Area Bed (Need)/Surplus	**11**	**12**	**12**	**16**	**16**	**15**	**15**
DRMC:							
Total Licensed Beds at DRMC	30	30	30	30	30	30	30
Bed Need at Optimal Occupancy (Rounded Up)	18	17	19	17	17	18	18
Total Bed (Need)/Surplus at DRMC	**12**	**13**	**11**	**13**	**13**	**12**	**12**
Rehabilitation							
Service Area:							
Total Licensed Beds in Service Area	35	35	35	35	35	35	35
Bed Need at Optimal Occupancy (Rounded Up)	1	1	1	1	1	1	1
Total Service Area Bed (Need)/Surplus	**34**	**34**	**34**	**34**	**34**	**34**	**34**
DRMC:							
Total Licensed Beds at DRMC	12	12	12	12	12	12	12
Bed Need at Optimal Occupancy (Rounded Up)	0	1	0	1	1	1	1
Total Bed (Need)/Surplus at DRMC	**12**	**11**	**12**	**11**	**11**	**11**	**11**
Psychiatric							
Service Area:							
Total Licensed Beds in Service Area	29	29	29	29	29	29	29
Bed Need at Optimal Occupancy (Rounded Up)	2	3	3	3	3	3	4
Total Service Area Bed (Need)/Surplus	**27**	**26**	**26**	**26**	**26**	**26**	**25**
DRMC:							
Total Licensed Beds at DRMC	0	0	0	0	0	0	0
Bed Need at Optimal Occupancy (Rounded Up)	1	1	1	1	1	1	2
Total Bed (Need)/Surplus at DRMC	**(1)**	**(1)**	**(1)**	**(1)**	**(1)**	**(1)**	**(2)**

Source: OSHPD Inpatient Database and Premier, Inc.

Note: Projected bed need is based on volume that originates from the service area only, and does not consider in-migration.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]Total Bed Need Summary (2)

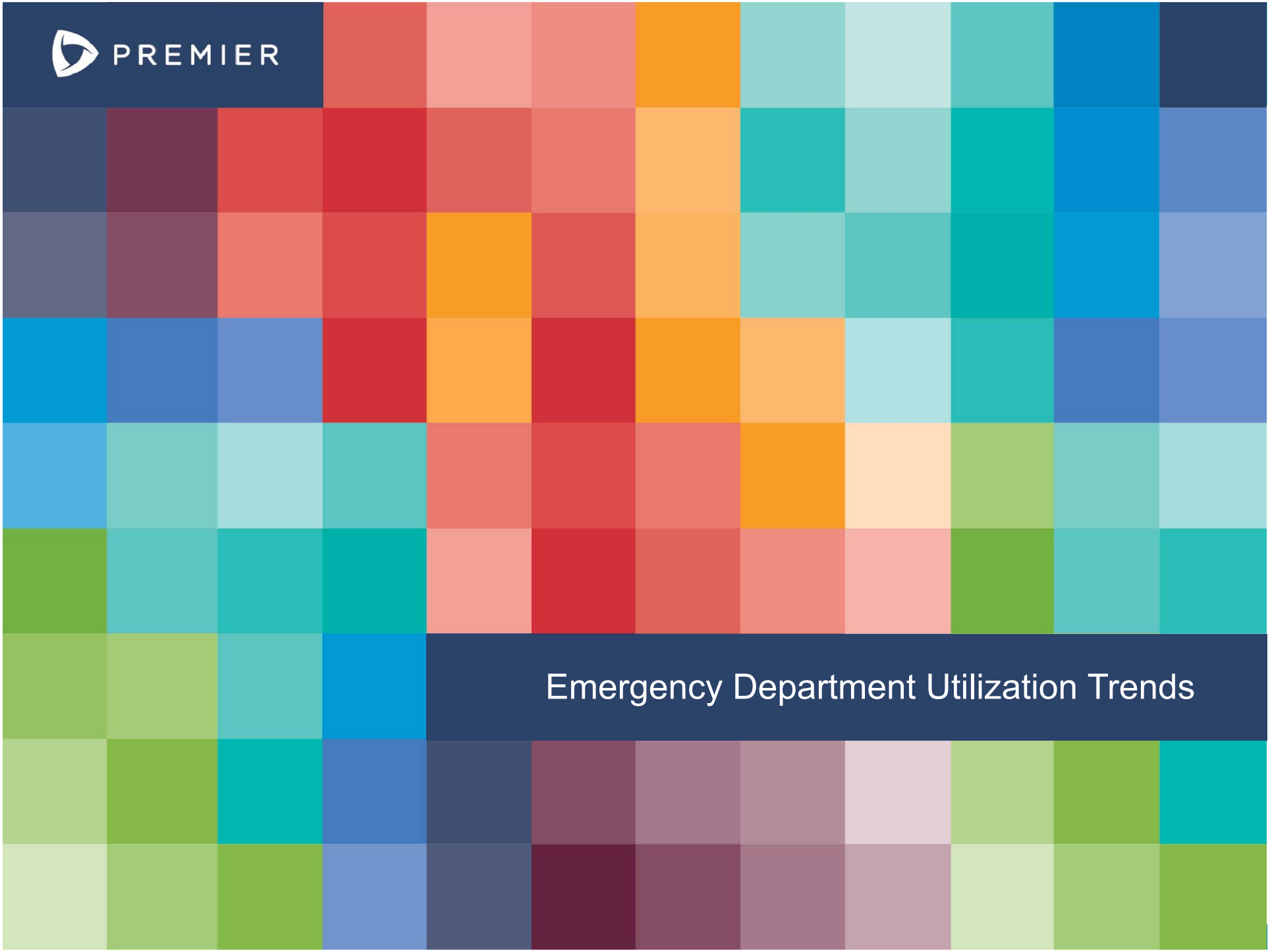
Summary of Projected Service Area Bed (Need)/Surplus

Desert Healthcare District
Service Area Projected Bed Need Summary by Licensed Bed Type
CY 2016 - 2026

Service Line	Projected Bed (Need)/Surplus 2016	2021	2026
Service Area			
Medical Surgical	336	347	330
Critical Care	30	32	28
Pediatrics	6	6	4
Obstetrics (Perinatal)	9	8	6
Neonatal Intensive Care	16	15	15
Rehabilitation	34	34	34
Psychiatric	26	26	25
Total Bed (Need)/Surplus in the Service Area	**457**	**468**	**442**
Desert Regional Medical Center			
Medical Surgical	134	130	125
Critical Care	5	4	3
Pediatrics	0	(1)	(1)
Obstetrics (Perinatal)	3	2	1
Neonatal Intensive Care	13	12	12
Rehabilitation	11	11	11
Psychiatric	(1)	(1)	(2)
Total Bed (Need)/Surplus at Desert Regional Medical Center	**165**	**157**	**149**

Desert_Healthcare_District/Needs_Assessment/Analysis/[Inpatient_Model.xlsx]Overview

Source: OSHPD Inpatient Database and Premier, Inc.
Note: Projected bed need is based on volume that originates from the service area only, and does not consider in-migration.


PREMIER
Emergency Department Utilization Trends

Historical Service Area Emergency Department Utilization and Market Share Trends, CY 2013 - 2015

- Total ED visits increased by almost 16 percent between CY 2013 and 2015. Given the successful implementation of the Medi-Cal expansion program and the roll-out of the Covered California Healthcare Exchange, demand for ED services in the service area will continue as patients continue to use this modality as a form of primary care, and population growth will result in increased demand for instant access to care.
  - It should be noted that while the impact of healthcare reform and the expansion of coverage through Covered California resulted in increased access to providers who are willing to treat patients who were previously uninsured, there is a shortage of primary care providers and limited access to such services within the District's service area (evidenced by the HPSA and MUA analyses). Combined with the fact that residents in the District's service area have worse health status outcomes when compared to the State overall, it is likely that patients in this community will continue to utilize the ED as their primary source for healthcare services, particularly for conditions that could have been treated in a clinic or primary care physician office.
- The table provided on the following page illustrates the service area's total ED visits for the three-year time period, CY 2013 through 2015, and each facility's market share thereof.

Historical Service Area Emergency Department Utilization and Market Share Trends, CY 2013 – 2015 (continued)

Desert Healthcare District
Service Area Emergency Department Utilization and Market Share Trends
CY 2013 - 2015

	Total Emergency Department Visits				Emergency Department Visits Market Share			
Facility	2013	2014	2015	Percent Change, CY 2013 - 2015	2013	2014	2015	Change, CY 2013 - 2015
Desert Regional Medical Center	62,916	67,971	71,937	14.3%	37.9%	37.8%	37.4%	-0.5%
Eisenhower Medical Center	66,964	73,259	78,070	16.6%	40.4%	40.8%	40.6%	0.3%
John F. Kennedy Memorial Hospital	36,018	38,427	42,085	16.8%	21.7%	21.4%	21.9%	0.2%
Total	**165,898**	**179,657**	**192,092**	**15.8%**	**100.0%**	**100.0%**	**100.0%**	
Use Rate (Visits per 1,000 Population)	*292.4*	*312.8*	*330.5*	*13.0%*				

Source: California Automated Licensing Information and Report Tracking System

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Emergency_Department_Analysis.xlsx]Utilization Trends

Historical Service Area Emergency Department Capacity Analysis, CY 2013 - 2015

- Within the service area, there is an overall shortage of ED capacity (e.g., stations), with capacity constraints existing at both DRMC and John F. Kennedy Memorial Hospital.

Desert Healthcare District
Service Area Emergency Department Capacity Analysis
CY 2013 - 2015

	Calendar Year		
	2013	2014	2015
Total ED Visits			
Desert Regional Medical Center	62,916	67,971	71,937
Eisenhower Medical Center	66,964	73,259	78,070
John F. Kennedy Memorial Hospital	36,018	38,427	42,085
Total Emergency Department Visits	**165,898**	**179,657**	**192,092**
Service Area ED Capacity Analysis:			
Total ED Stations in Service Area	81	83	83
ED Station Need @ 2,000 Visits per Station	83	90	97
Service Area ED Station (Need)/Surplus	**(2)**	**(7)**	**(14)**
ED Station Capacity and Need by Facility:			
Desert Regional Medical Center - Total Existing Stations (1)	28	28	28
ED Station Need @ 2,000 Visits per Station	32	34	36
Desert Regional Medical Center ED Station (Need)/Surplus	**(4)**	**(6)**	**(8)**
Eisenhower Medical Center - Total Existing Stations	41	43	43
ED Station Need @ 2,000 Visits per Station	34	37	40
Eisenhower Medical Center ED Station (Need)/Surplus	**7**	**6**	**3**
John F. Kennedy Memorial Hospital - Total Existing Stations	12	12	12
ED Station Need @ 2,000 Visits per Station	19	20	22
John F. Kennedy Memorial Hospital ED Station (Need)/Surplus	**(7)**	**(8)**	**(10)**

Source: California Automated Licensing Information and Report Tracking System and Premier, Inc.
Note: Numbers may not foot due to rounding.
(1) Excludes planned expansion of Desert Regional Medical Center Emergency Department, resulting in 8 incremental emergency department stations in the future.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Emergency_Department_Analysis.xlsx]Capacity Analysis

Projected Emergency Department Utilization and Resource Needs: Assumptions

Factor	Assumption

Use Rate (ED Visits per 1,000 population)	• Historical utilization for ED services (e.g. visits) for the service area was identified using the OSHPD ALIRTS database
	• To project ED visits for CY 2016 and beyond, the CY 2015 use rate was held constant for the duration of the projection period. This is based upon the following assumptions:
	  • Recent increases in ED utilization resulting from expanded access to healthcare services through healthcare reform have stabilized
	  • No major changes to the local healthcare delivery system (e.g., significant expansion of primary care and/or urgent care centers that would redirect use of the ED) are anticipated
	  • Care management models (e.g., care coordination, patient navigation, and education) that temper ED utilization are not widely deployed throughout the community
	• It should be noted that in the future, providers will be incentivized to reduce unnecessary utilization of the ED. Thus, should one or of these models be deployed in the service area on a large enough scale, the community would likely experience a decrease in its ED use rate

Projected Emergency Department Utilization and Resource Needs: Assumptions (continued)

Factor	Assumption
Service Area Population Growth Rate	• 1.2 percent per year
Growth in Service Area ED Visits	• Total ED visits in the service area are projected to increase at the rate of population growth (1.2 percent annually)
Market Share	• Market share for DRMC is projected to increase by three percentage points for the three-year time period, CY 2016 – 2018, and will remain flat for each year thereafter
ED Visits per Station	• 2,000 visits per station per year

Projected Emergency Department Utilization and Resource Needs

Desert Healthcare District
Service Area Projected Emergency Department Utilization and Station Need
CY 2013 - 2026

	Historical			Projected		
	2013	2014	2015	2016	2021	2026
Service Area Utilization						
Total ED Visits	165,898	179,657	192,092	194,431	206,526	219,678
Visits per 1,000 Population	*292.4*	*312.8*	*330.5*	*330.5*	*330.5*	*330.5*
Total ED Stations in the Service Area (All Hospitals)	81	83	83	83	83	83
ED Station Need @ 2,000 Visits per Station	83	90	97	98	104	110
Service Area ED Station (Need)/Surplus	**(2)**	**(7)**	**(14)**	**(15)**	**(21)**	**(27)**
Desert Regional Medical Center						
Total ED Visits	62,916	67,971	71,937	74,757	83,538	88,858
Percent Market Share	*37.9%*	*37.8%*	*37.4%*	*38.4%*	*40.4%*	*40.4%*
Total Existing ED Stations [(1)]	28	28	28	28	28	28
ED Station Need @ 2,000 Visits per Station	32	34	36	38	42	45
DRMC ED Station (Need)/Surplus	**(4)**	**(6)**	**(8)**	**(10)**	**(14)**	**(17)**

Source: California Automated Licensing Information and Report Tracking System and Premier, Inc.

(1) Excludes planned expansion of Desert Regional Medical Center Emergency Department, resulting in 8 incremental emergency department stations in the future.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Premier_Emergency_Department_Analysis.xlsx]ED Projections


PREMIER
Desert Regional Medical Center
Seismic Compliance Summary

Seismic Compliance Summary

- In the most recent available “Seismic Evaluation Report and Hazus Supplemental Evaluation Report” for Building 1 (Main Hospital and Additions) last revised in January, 2010, three items requiring additional field observation and five items reported as a deficiency were noted in the main hospital and its additions:
  - Items requiring additional field observation:
    - Structural separations
    - Partition bracing
    - Parapets, cornices, ornamentation, and appendages
  - Items reported as a deficiency:
    - Adjacent buildings
    - Pre-Northridge Earthquake Welded Moment Frame Joints
    - Brace connection strength
    - Plan irregularities
    - Steel columns

Seismic Compliance Summary (continued)

- According to the SB 1953 Seismic Evaluation Compliance Plan, revised in 2006:
  - Buildings 1, 2, and 4 were also determined to need retrofitting before the 2013 deadline. Evidence of completion has been submitted to Premier for Building 1 only (Main Hospital and Additions)
    - The structural retrofit strategy for Building 2 (East Tower) involves the removal of the existing exterior curtain wall system and replacing it with a system that can accommodate the expected lateral displacements of the building
    - Buildings 1, 2, and 4 are scheduled for demolition and replacement by 2030 to meet Seismic Performance Category ("SPC")-5 guidelines. All other buildings will receive nonstructural upgrades
  - The seismic status by 2013 should be:
    - Building 1: Main Hospital and Additions; SPC-2
    - Building 2: East Tower; SPC-2
    - Building 3: Women and Infants Hospital; SPC-3
    - Building 4: North Wing; SPC-2
    - Building 5: Central Plant; SPC-4
    - Building 6: Shipping and Receiving; SPC-4

Seismic Compliance Summary (continued)

- The seismic status by 2013 should be (continued):
  - Building 7: Surgery Wing; SPC-4
  - Building 8: West Tower; SPC-3
  - Building 9: Lobby; SPC-3
  - Building 10: Admitting; SPC-4
  - Building 11: Elevator Tower; SPC-4
  - Building 12: Dinah Shore Waiting Area; SPC-3

- In the most recent available "Seismic Evaluation Report and Hazus Supplemental Evaluation Report" for Building 4 (North Wing) last revised in May, 2008, the structure failed to achieve qualification for SPC-2 licensing. As of the date of this report, documentation was not provided to Premier to indicate if the building met the 2013 deadline of reaching this license.
- In the most recent available "Seismic Evaluation Report and Hazus Supplemental Evaluation Report" for Building 2 (East Tower) last revised in June, 2008, the structure failed to achieve qualification for SPC-2 licensing. As of the date of this report, documentation was not provided to Premier to indicate if the building met the 2013 deadline of reaching this license.
- A detailed summary of the areas that must be addressed to meet SPC criteria for Buildings 1, 2, and 4 are provided on the following pages. As of the date of this report, documentation for the remaining buildings summarizing the detail required to meet SPC criteria was not provided to Premier.

Summary of Seismic Evaluation Criteria That Did Not Pass Inspection:

Building 1: Main Hospital and Additions (Source: OSHPD Report Dated January, 2010)

Area That Did Not Pass Inspection	Criteria/Requirement
Adjacent Buildings	There is no immediately adjacent structure that is less than half as tall or has floors/levels that do not match those of the building being evaluated. A neighboring structure is considered to be “immediately adjacent” if it is within two inches times the number of stories away from the building being evaluated
Pre-Northridge Earthquake Welded Moment Frame Joints	Welded steel moment frame beam-column joints are designed and constructed in accordance with recommendations in FEMA 267, Interim Guidelines: Evaluation, Repair, modification, and Design of Welded Steel moment Frame structures, August 1995
Connection Strength	All the brace connections are able to develop the yield capacity of the diagonals
Plan Irregularities	There is significant tensile capacity at re-entrant corners or other locations of plan irregularities
Steel Columns	The columns in the lateral force resisting frames are substantially anchored to the building foundation
Structural Separations	At structural separations, partitions in exit corridors have seismic or control joints

Summary of Seismic Evaluation Criteria That Did Not Pass Inspection:

Building 1: Main Hospital and Additions (Source: OSHPD Report Dated January, 2010) (continued)

Area That Did Not Pass Inspection	Criteria/Requirement
Partition Bracing	In exit corridors, the tops of partitions that only extend to the ceiling line have lateral bracing
Parapets, Cornices, Ornamentation, and Appendages	There are no laterally unsupported unreinforced masonry parapets or cornices above the highest anchorage level with height/thickness ratios greater than 1.5. Concrete parapets with height/thickness ratios greater than 1.5 have vertical reinforcement. Cornices, parapets, signs, and other appendages that extend above the highest anchorage level or cantilever from exterior wall faces and other exterior wall ornamentation are reinforced and well anchored to the structural system

Summary of Seismic Evaluation Criteria That Did Not Pass Inspection:

Building 2: East Tower (Source: OSHPD Report Dated June, 2008)

Area That Did Not Pass Inspection	Criteria/Requirement
Beam Penetrations	All openings in frame-beam webs have a depth less than ¼ of the beam depth and are located in the center half of the frame beams
Joint Webs	All web thicknesses within joints of moment resisting frames meet the American Institute for Steel Construction ("AISC") criteria for web shear
Girder Flange Continuity Plates	There are girder flange continuity plates at joints
Pre-Northridge Earthquake Welded Moment Frame Joints	Welded steel moment frame beam-column joints are designed and constructed in accordance with recommendations in FEMA 267, Interim Guidelines: Evaluation, Repair, modification, and Design of Welded Steel moment Frame structures, August 1995
Plan Irregularities	There is significant tensile capacity at re-entrant corners or other locations of plan irregularities

Summary of Seismic Evaluation Criteria That Did Not Pass Inspection:

Building 2: East Tower (Source: OSHPD Report Dated June, 2008) (continued)

Area That Did Not Pass Inspection	Criteria/Requirement
Masonry Partitions	There are no unbraced unreinforced masonry or hollow clay tile partitions in critical care areas, clinical laboratory service spaces, pharmaceutical service spaces, radiological service spaces, and central and sterile supply areas, exit corridors, elevator shafts, or stairwells
Structural Separations	At structural separations, partitions in exit corridors have seismic or control joints
Partition Bracing	In exit corridors, the tops of partitions that only extend to the ceiling line have lateral bracing
Masonry Veneer	Masonry veneer is connected to the back-up with corrosion-resistant ties spaced 24 inches on center maximum with at least one tie for every 2-2/3 square feet
Cladding Panels in Moment Frame Buildings	For moment frame buildings of steel or concrete, panels are isolated form the structural frame to absorb predicted inter-story drift without collapse

Summary of Seismic Evaluation Criteria That Did Not Pass Inspection:

Building 2: East Tower (Source: OSHPD Report Dated June, 2008) (continued)

Area That Did Not Pass Inspection	Criteria/Requirement
Cladding Panel Condition	Cladding panel connections appear to be installed properly. No connection element is severely deteriorated or corroded. There is no cracking in the panel materials indicative of substantial structural distress. There is no substantial damage to exterior cladding due to water leakage. There is no substantial damage to exterior wall cladding due to temperature movements
Metal Stud Back-Up Systems, General	Additional steel studs frame window and door openings. Corrosion of veneer ties, tie screws, studs, and stud tracks is minimal. Stud tracks are adequately fastened to the structural frame
Masonry Veneer with Stud Back-Up	Masonry veneer more than 30 feet above the ground is supported by shelf angles or other elements at each floor level. Masonry veneer is adequately anchored to the back-up at locations of through-wall flashing. Masonry veneer is connected to the back-up with corrosion-resistant ties spaced 24 inches on center maximum and with at least one tie for every 2-2/3 square feet

Summary of Seismic Evaluation Criteria That Did Not Pass Inspection:

Building 4: North Wing (Source: OSHPD Report Dated May, 2008)

Area That Did Not Pass Inspection	Criteria/Requirement
Vertical Discontinuities	All shear walls, infilled walls, and frames are continuous to the foundation
Adjacent Buildings	There is no immediately adjacent structure that is less than half as tall or has floors/levels that do not match those of the building being evaluated. A neighboring structure is considered to be “immediately adjacent” if it is within two inches times the number of stories away from the building being evaluated
Reinforcing	The total vertical and horizontal reinforcing steel in reinforced masonry walls is greater than 0.002 times the gross area of the wall with a minimum of 0.0007 in either of the two directions; the spacing of reinforcing steel is less than 48 inches; and all vertical bars extend to the top of the walls
Masonry Partitions	There are no unbraced unreinforced masonry or hollow clay tile partitions in critical care areas, clinical laboratory service spaces, pharmaceutical service spaces, radiological service spaces, and central and sterile supply areas, exit corridors, elevator shafts, or stairwells
Structural Separations	At structural separations, partitions in exit corridors have seismic or control joints

Summary of Seismic Evaluation Criteria That Did Not Pass Inspection:

Building 4: North Wing (Source: OSHPD Report Dated May, 2008) (continued)

Area That Did Not Pass Inspection	Criteria/Requirement
Partition Bracing	In exit corridors, the tops of partitions that only extend to the ceiling line have lateral bracing
Parapets, Cornices, Ornamentation, and Appendages	There are no laterally unsupported unreinforced masonry parapets or cornices above the highest anchorage level with height/thickness ratios greater than 1.5. Concrete parapets with height/thickness ratios greater than 1.5 have vertical reinforcement. Cornices, parapets, signs, and other appendages that extend above the highest anchorage level or cantilever from exterior wall faces and other exterior wall ornamentation are reinforced and well anchored to the structural system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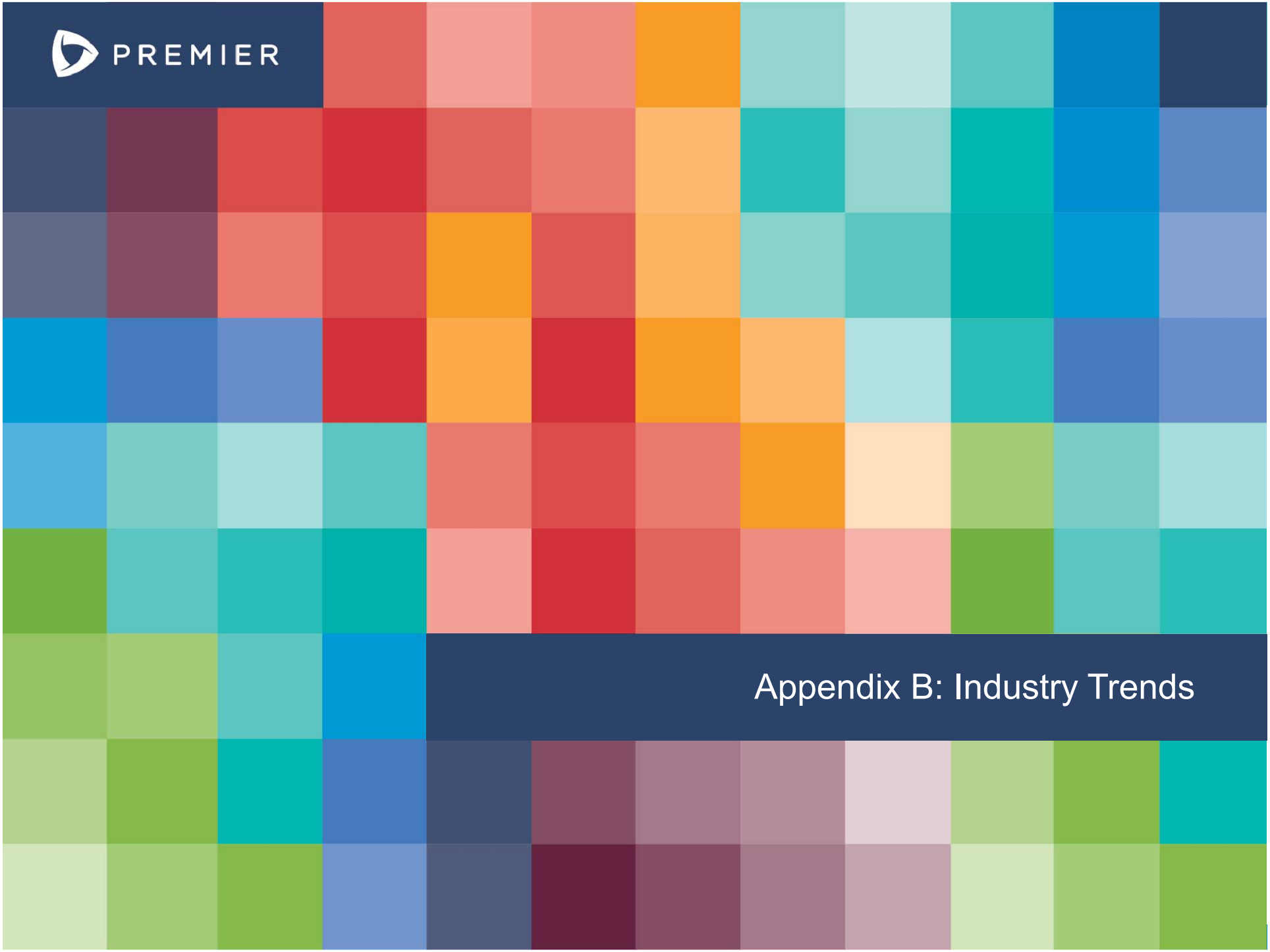
Appendix A: Interviews Completed Regarding
Community Health Status/Demographic Trends

Appendix A: Interviews Completed Regarding Health Status/Demographic Trends

Name	Title/Organization
Tricia Gehrlein	Associate Director, Clinton Foundation
Jenna LeComte-Hinely, PhD	Chief Executive Officer, Health Assessment and Research for Communities, Inc.
Gary Painter, PhD	Director of Social Policy, University of Southern California Sol Price Center for Social Innovation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Appendix B: Industry Trends

Overall Covered California Enrollment

- Statewide, over 1.5 million individuals selected health plans through Covered California during its fourth open enrollment period, ending in February, 2017
  - Over 360,000 new enrollees
- In 2016, Blue Shield of California was the market share leader for Covered California enrollment. The table below illustrates the Covered California plans and their respective market share as of June 2016 (most recent data available)

Health Plan	Market Share
Blue Shield of California	29.4%
Anthem Blue Cross of California	25.1%
Kaiser Permanente	23.0%
Health Net	11.8%
Other	10.8%

92 http://news.coveredca.com/2017/02/covered-california-finishes-fourth-open.html

Covered California Enrollment – Riverside County

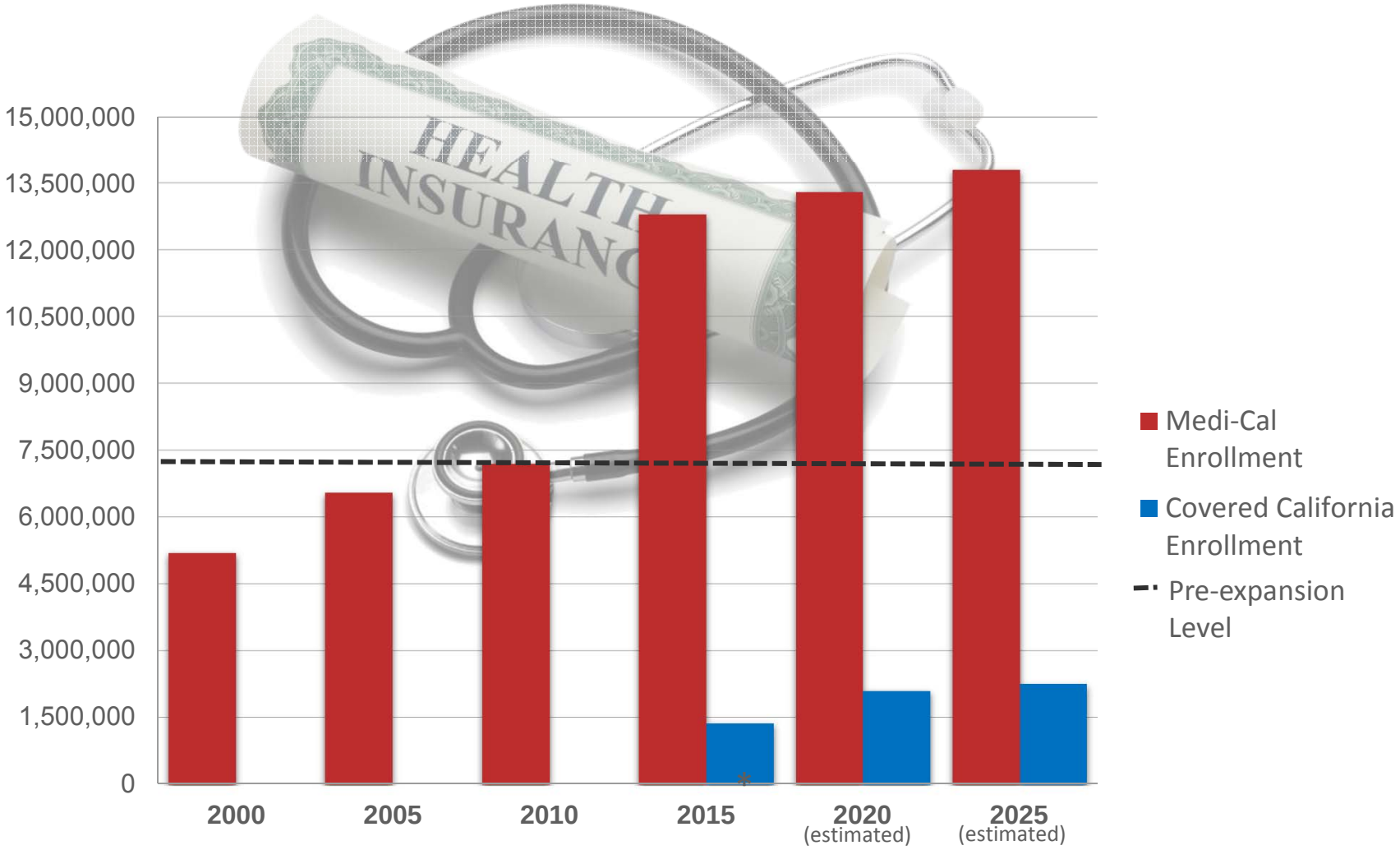
- 70,310 enrollees had active coverage in Riverside County through Covered California as of June, 2016. Of these enrollees, 71.7% were at or below 250% of the federal poverty level
- The tables below illustrate the Covered California health plans and metal tiers in Riverside County in 2016

Health Plan	Market Share
Blue Shield of California	31.0%
Molina Healthcare	20.8%
Health Net	20.0%
Kaiser Permanente	17.7%
Anthem Blue Cross of California	10.5%

Metal Tier	Market Share
Minimum Coverage	0.7%
Bronze	22.8%
Silver	66.7%
Gold	5.6%
Platinum	4.3%

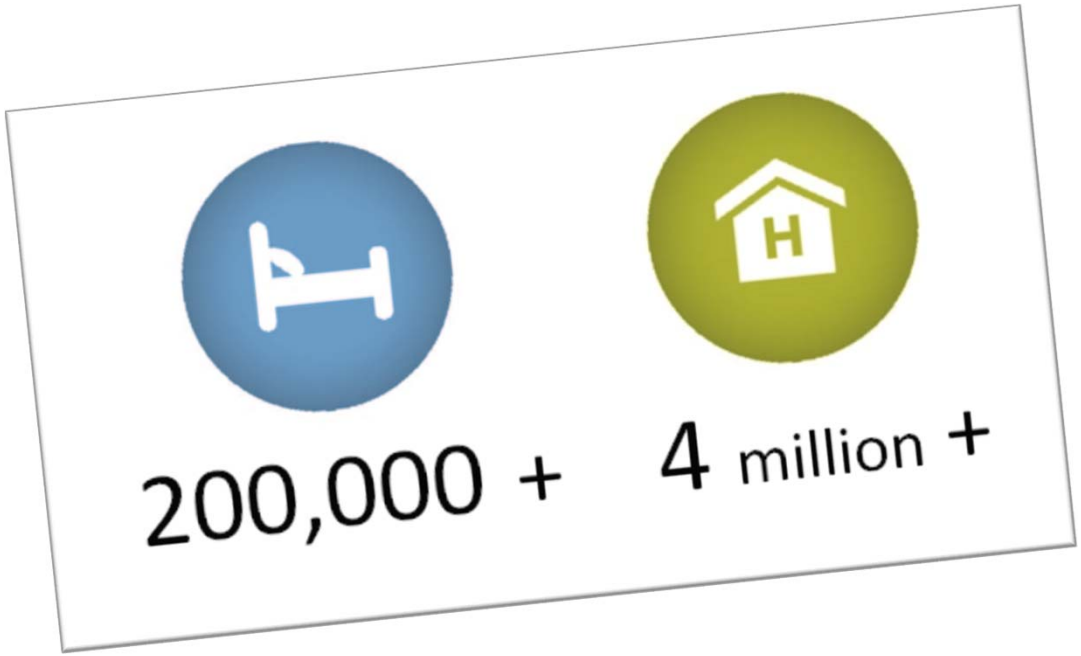
93 http://news.coveredca.com/2017/02/covered-california-finishes-fourth-open.html

Medi-Cal and Covered California Enrollment



Demand for Health Services Surges

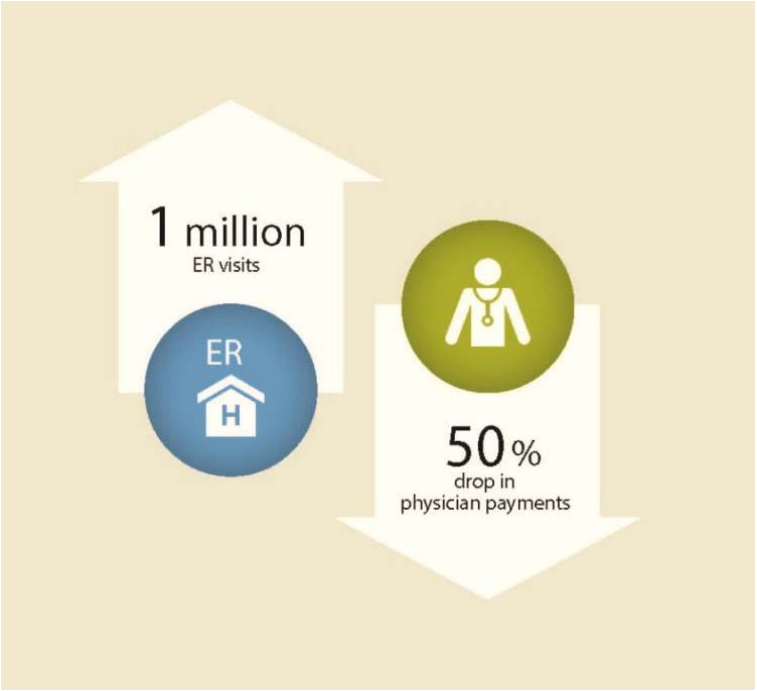
- Medi-Cal expansion is driving increased demand
- More than 200,000 additional Medi-Cal inpatients
- 4 million more Medi-Cal outpatient visits



Source: CHA, C. Duane Dauner, March 18, 2016

Coverage Does Not Equal Access

- Demand for care increased Medi-Cal ED visits by 1 million
- Low payments to doctors have reduced access
- Medi-Cal patients turn to overcrowded hospital EDs



Source: CHA, C. Duane Dauner, March 18, 2016

Medi-Cal Funding and Accountability Act

(CHA Medi-Cal Hospital Fee Protection)

- Extends current law
- Locks in protections for hospitals and the state (24% net benefit)
- Prohibits Legislature from changing protections
- $10 billion (2014-2016)
- $18 billion (2009-2016)

Source: CHA, C. Duane Dauner, March 18, 2016

The California Children's Education and Health Care Protection Act of 2016

- Extends the Proposition 30 income tax increase through 2030
- Funds Proposition 2, Proposition 98, state budget and Medi-Cal
- Provides up to $2 billion for Medi-Cal
- Benefit to hospitals

Source: CHA, C. Duane Dauner, March 18, 2016

HHS Goals: Aggressive Shift to Value-Based Payments – Still the Future?

Volume to Value

	2016	2018
Alternative payment models	30% of all Medicare payments	50% of all Medicare payments
Value-based payments	85% of all Medicare payments	90% of all Medicare payments

Better Care. Smarter Spending. Healthier People.

Learning Action Network

- HHS, private payers, large employers, providers, consumers, and state & federal partners
- Develop common approaches to core issues
- Collaborate to generate evidence, share approaches & remove barriers
- Create implementation guides for payers and purchasers

Cost & quality Transparency

- Expand patients' access to cost and quality information to enable smarter decision-making
- Improve HIT interoperability to inform care across the continuum

Better Care. Smarter Spending. Healthier People.

Volume to Value — Still the Future?

	2016	2018
Track 1: Value-based payments	**85%** of all Medicare payments	**90%** of all Medicare payments
Track 2: Alternative payment models*	**30%** of all Medicare payments	**50%** of all Medicare payments

HHS Goals	Description
Incentives	▪ Promote value-based payment systems — Test new alternative payment models — Increase linkage of Medicaid, Medicare FFS, and other payments to value ▪ Bring proven payment models to scale
Care Delivery	▪ Encourage the integration and coordination of clinical care services ▪ Improve population health ▪ Promote patient engagement through shared decision making
Information	▪ Create transparency on cost and quality information ▪ Bring electronic health information to the point of care for meaningful use

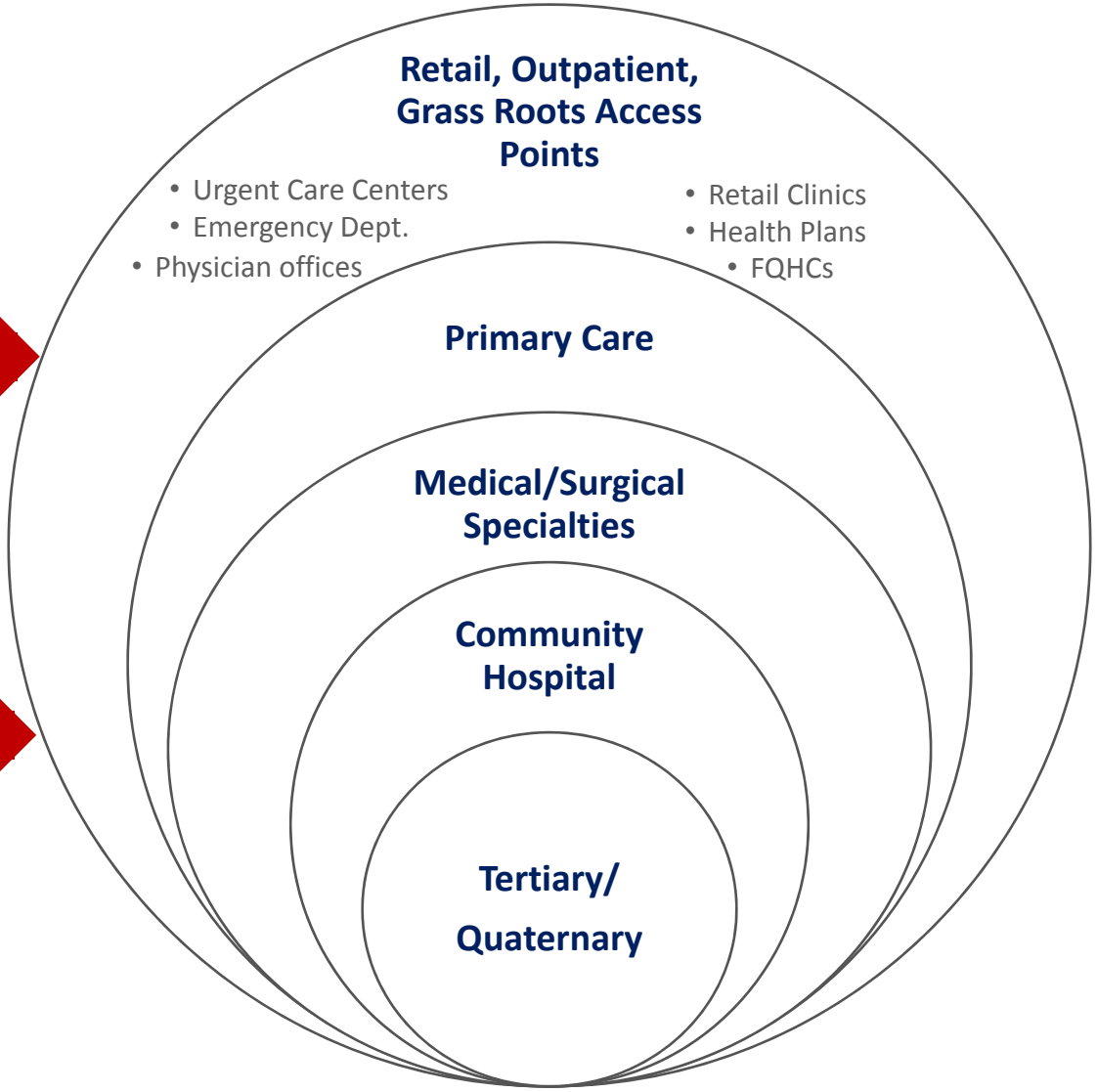
Population Health Continuum and Access Points

Commercial

- HMO, PPO
- Direct to Employers
- Federal, State, Commercial Exchanges
- Bundle Payment

CMS

- ACO – Pioneer, MSSP, NextGen
- Medicare Advantage
- Bundled Payment
- Medicaid HMO
- Medicaid Fee-for-Service
- Dual Eligible (HMO, other managed care)



Transparency

- Quality will be tracked more vigilantly and quality scores will be readily available to the consumer
  - Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") Measures
  - CAHPS Clinician and Group Surveys Physician Quality Reporting System Outcome Measures
  - CMS measures
    - Hospital Compare
    - Star Ratings

CMS: Comprehensive Primary Care Initiative (CPCI)

- Initiated in seven markets in 2012
  - Goal: Alter volume incentives in FFS by paying the PCP a monthly management fee to coordinate care
    - Risk stratify patients
    - Offer a care management plan (multiple chronic conditions)
    - Develop plan for patient and caregiver engagement
  - Health insurers signed on:
    - 38 insurers
    - 500 practices
    - 2,200 physicians
    - 2.7 million patients

Has Not Worked Yet

CMS: CPCI Expansion (5-Year Demonstration)

Comprehensive Primary Care Plus (CPC+)

- Expansion (Target)
  - 20 regions
  - 5,000 practices
  - 20,000 physicians
  - 25 million patients
  - Added incentives:
    - Quality
    - Utilization
- Pay a monthly fee for patient care management
  - Track 1 – Medicare FFS and managed fee/patient (risk stratified)
  - Track 2 – Reduced Medicare FFS and higher management fee (stimulates alternative delivery models, not just visits)

Problems:

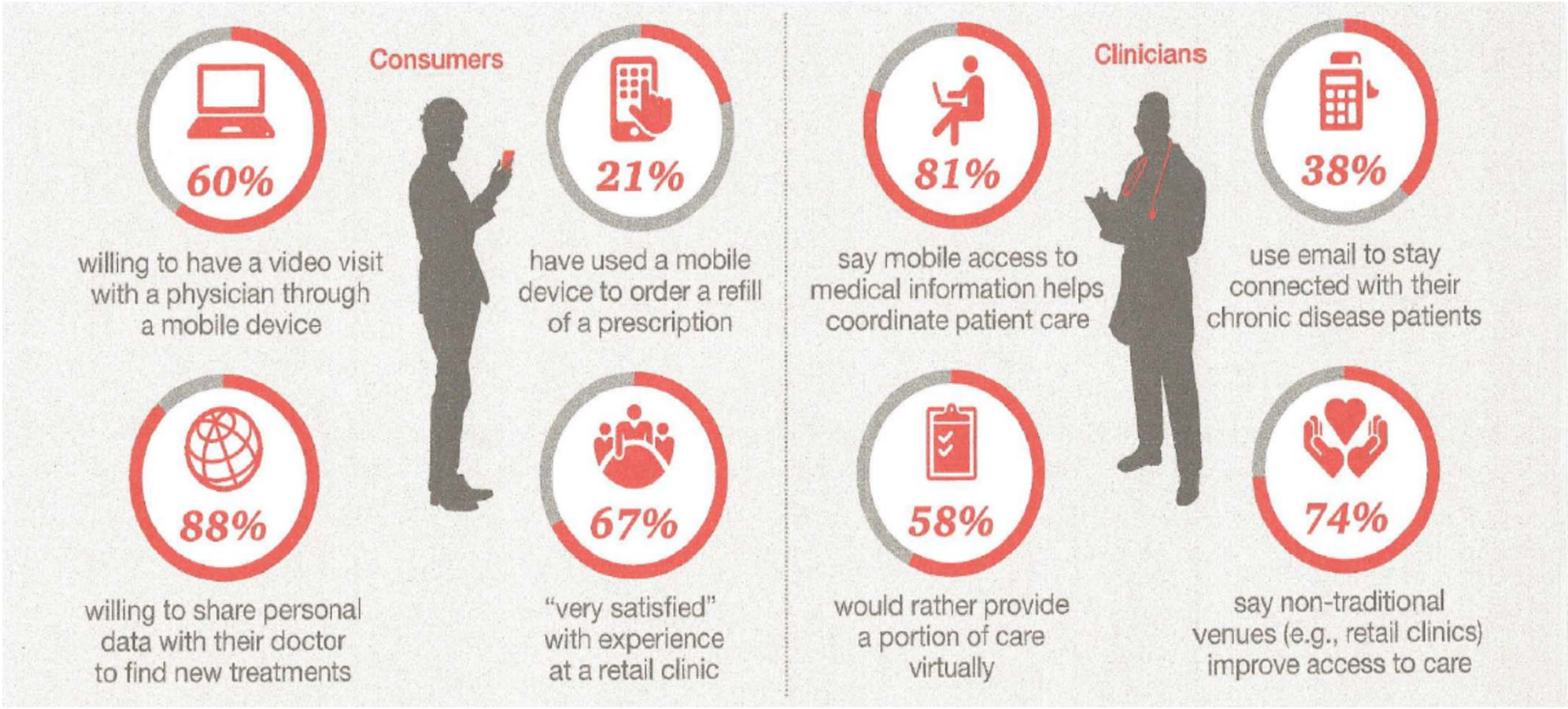
- State laws/regulations
- Bad experiences with earlier pilot
- Conflict with APM?
- Doctors don't share in savings, return money if targets are not achieved
- Health plans need to participate

Retail Health

- Clinic walk-ins at big box retail stores is expected to increase by 30 percent per year
- Usually staffed by Nurse Practitioners other advanced practice nurses, or Physician Assistants
- Cost:
  - $110 in a retail clinic, compared to over $160 in a physician office, and $570 in an Emergency Department

Source: The Advisory Board Company, National Institutes of Health "Comparing costs and quality of care at retail clinics," Mehrotra, 2009

More Mobile, More Accessible, More Connected



HRI Consumer Survey, PwC, 2015 and *HRI Clinician Workforce Survey*, PwC, 2014 and 2015

Telehealth Drives Volume, Increases Quality of Care and Access, and Reduces Costs (e.g., Readmissions, Unnecessary Emergency Department Visits)

Common Examples of Telehealth in Rural Communities

- Audiology
- Behavioral Health
- Cardiology
- Chronic Care Management
- Dentistry
- Dermatology
- Emergency Care
- Gastroenterology
- Hepatology
- Home Monitoring
- Intensive Care (e-ICU)
- Long-term Care
- Obstetrics
- Ophthalmology
- Pharmacy
- Radiology
- Stroke Interventions

Case Study: Expansion of Access to Specialty Care in Rural Communities

- Project ECHO (Extension for the Community Healthcare Outcomes) was created to increase the capacity for better chronic condition management in rural New Mexico
- The ECHO model™ is designed to extend specialty care to rural patients through area providers. ECHO utilizes videoconferencing to provide the following:
  - Direct support from specialists to primary care providers (PCPs) on patient cases
  - Increased knowledge for PCPs through shared case-based learning and mentorship
  - Assistance with patient treatment plan development and monitoring
  - Opportunities to participate in research are provided, but are not mandatory
- Services offered: endocrinology, diabetes, HIV/AIDS, child and youth epilepsy, dementia, palliative care, high-risk pregnancy, chronic pain and headache management, Hepatitis C, integrated addictions and psychiatry, rheumatology, behavioral health, community health worker specialist training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Appendix C: Supplemental Inpatient
Market Share Analyses

Service Area Inpatient Market Share, CY 2014

Desert Heathcare District
Service Area Inpatient Market Share by Service Line - All Ages
Calendar Year 2014

	Service Area Mix		Percent Market Share					
			Service Area			Outmigration		
Service Line	Discharges	Percent of Total Discharges	Eisenhower Medical Center	Desert Regional Medical Center	John F Kennedy Memorial Hospital	Loma Linda University Medical Center	Others	Total
Cardiology - Diagnostic/Interventional	1,341	3.3%	47.6%	36.5%	8.2%	1.0%	6.7%	100.0%
Cardiology - Medical	3,371	8.3%	47.1%	31.7%	15.2%	1.1%	4.9%	100.0%
Cardiology - Surgery	411	1.0%	49.9%	24.3%	0.0%	6.6%	19.2%	100.0%
Chemical Dependency	194	0.5%	48.5%	23.2%	18.6%	0.0%	9.8%	100.0%
Endocrine	1,055	2.6%	37.6%	29.8%	20.2%	5.5%	6.9%	100.0%
ENT	304	0.7%	24.3%	18.4%	14.8%	22.7%	19.7%	100.0%
Gastroenterology	3,432	8.4%	45.6%	31.3%	9.8%	3.8%	9.4%	100.0%
General Medicine	3,635	8.9%	45.7%	28.5%	13.8%	2.9%	9.0%	100.0%
General Surgery	3,680	9.0%	42.0%	26.1%	19.6%	2.9%	9.3%	100.0%
Gynecology	598	1.5%	17.6%	44.3%	12.4%	7.9%	17.9%	100.0%
Neonatal Intensive Care	1,573	3.9%	0.3%	63.3%	30.1%	3.4%	3.1%	100.0%
Neurology	2,229	5.5%	46.1%	33.8%	8.4%	4.3%	7.4%	100.0%
Neurosurgery	382	0.9%	36.1%	28.5%	0.8%	9.2%	25.4%	100.0%
Obstetrics & Deliveries	5,770	14.2%	0.4%	54.0%	42.8%	0.4%	2.3%	100.0%
Oncology	1,465	3.6%	43.1%	22.3%	6.6%	11.3%	16.7%	100.0%
Ophthalmology	65	0.2%	26.2%	32.3%	4.6%	21.5%	15.4%	100.0%
Orthopedics	4,038	9.9%	44.3%	25.3%	15.7%	3.4%	11.3%	100.0%
Other/NC	48	0.1%	47.9%	12.5%	0.0%	2.1%	37.5%	100.0%
Plastic Surgery	243	0.6%	35.0%	17.7%	30.0%	5.3%	11.9%	100.0%
Psychiatry	141	0.3%	48.2%	23.4%	8.5%	8.5%	11.3%	100.0%
Pulmonary Medicine	3,233	7.9%	36.6%	29.6%	24.2%	2.8%	6.8%	100.0%
Rehabilitation	2	0.0%	50.0%	0.0%	0.0%	0.0%	50.0%	100.0%
Spine Surgery	619	1.5%	52.8%	12.4%	0.0%	4.5%	30.2%	100.0%
Thoracic & Vascular Surgery	807	2.0%	46.8%	32.3%	8.9%	3.3%	8.6%	100.0%
Transplant	39	0.1%	0.0%	0.0%	0.0%	35.9%	64.1%	100.0%
Urology	2,040	5.0%	49.8%	25.4%	10.4%	3.6%	10.7%	100.0%
Total	**40,715**	**100.0%**	**35.8%**	**33.5%**	**18.6%**	**3.4%**	**8.7%**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2014. Includes acute care across all ages; excludes normal newborns.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 2C

Service Area Inpatient Market Share, CY 2013

Desert Heathcare District
Service Area Inpatient Market Share by Service Line
Calendar Year 2013

	Service Area Mix		Percent Market Share					
Service Line	Discharges	Percent of Total Discharges	Eisenhower Medical Center	Desert Regional Medical Center	John F Kennedy Memorial Hospital	Loma Linda University Medical Center	Others	Total
Cardiology - Diag/Intervention	1,434	3.5%	52.4%	34.2%	7.7%	1.1%	4.5%	100.0%
Cardiology - Medical	3,571	8.8%	46.5%	31.9%	14.7%	1.0%	5.9%	100.0%
Cardiology - Surgery	369	0.9%	52.6%	26.0%	0.0%	5.1%	16.3%	100.0%
Chemical Dependency	165	0.4%	35.8%	41.2%	12.7%	0.0%	10.3%	100.0%
Endocrine	1,040	2.6%	38.0%	25.9%	22.5%	5.7%	8.0%	100.0%
ENT	294	0.7%	29.6%	16.3%	12.6%	29.9%	11.6%	100.0%
Gastroenterology	3,479	8.6%	45.7%	28.0%	13.5%	3.2%	9.6%	100.0%
General Medicine	3,384	8.3%	47.4%	25.3%	14.3%	2.8%	10.2%	100.0%
General Surgery	3,606	8.9%	42.9%	24.7%	21.4%	2.9%	8.1%	100.0%
Gynecology	674	1.7%	18.7%	42.1%	13.9%	7.9%	17.4%	100.0%
Neonatal Intensive Care	1,506	3.7%	0.1%	60.2%	33.9%	3.5%	2.3%	100.0%
Neurology	2,199	5.4%	47.6%	33.9%	7.1%	4.3%	7.1%	100.0%
Neurosurgery	451	1.1%	38.4%	23.9%	0.7%	10.2%	26.8%	100.0%
Obstetrics & Deliveries	5,721	14.1%	0.6%	52.7%	44.1%	0.6%	1.9%	100.0%
Oncology	1,495	3.7%	47.7%	16.9%	7.2%	9.1%	19.1%	100.0%
Ophthalmology	68	0.2%	23.5%	23.5%	13.2%	13.2%	26.5%	100.0%
Orthopedics	3,859	9.5%	40.9%	25.8%	19.8%	3.3%	10.2%	100.0%
Plastic Surgery	282	0.7%	37.2%	19.1%	23.8%	4.6%	15.2%	100.0%
Psychiatry	124	0.3%	46.8%	27.4%	8.1%	4.8%	12.9%	100.0%
Pulmonary Medicine	3,518	8.7%	39.7%	28.5%	23.5%	2.3%	6.0%	100.0%
Rehabilitation	2	0.0%	0.0%	50.0%	0.0%	50.0%	0.0%	100.0%
Spine Surgery	548	1.3%	50.2%	9.5%	0.0%	5.8%	34.5%	100.0%
Thoracic & Vascular Surgery	820	2.0%	49.5%	32.3%	7.6%	2.7%	7.9%	100.0%
Transplant	33	0.1%	0.0%	0.0%	0.0%	39.4%	60.6%	100.0%
Urology	1,954	4.8%	51.2%	24.2%	10.6%	3.6%	10.4%	100.0%
Total	**40,596**	**100.0%**	**36.5%**	**32.1%**	**19.7%**	**3.3%**	**8.4%**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2013. Acute care, excludes normal newborns.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 2B

Service Area Inpatient Market Share, CY 2012

Desert Heathcare District
Service Area Inpatient Market Share by Service Line
Calendar Year 2012

	Service Area Mix		Percent Market Share					
Service Line	Discharges	Percent of Total Discharges	Eisenhower Medical Center	Desert Regional Medical Center	John F Kennedy Memorial Hospital	Loma Linda University Medical Center	Others	Total
Cardiology - Diag/Intervention	1,612	3.8%	49.4%	33.4%	9.7%	1.3%	6.2%	100.0%
Cardiology - Medical	3,942	9.3%	50.1%	29.0%	14.5%	0.7%	5.7%	100.0%
Cardiology - Surgery	411	1.0%	46.2%	24.8%	0.0%	10.5%	18.5%	100.0%
Chemical Dependency	142	0.3%	34.5%	30.3%	21.1%	1.4%	12.7%	100.0%
Endocrine	1,191	2.8%	43.5%	23.4%	21.3%	5.1%	6.6%	100.0%
ENT	328	0.8%	29.0%	17.4%	15.9%	24.7%	13.1%	100.0%
Gastroenterology	3,709	8.8%	44.3%	27.4%	14.4%	3.2%	10.7%	100.0%
General Medicine	3,497	8.3%	42.0%	28.0%	16.4%	3.3%	10.4%	100.0%
General Surgery	3,606	8.5%	41.8%	27.0%	18.8%	3.2%	9.2%	100.0%
Gynecology	744	1.8%	20.4%	48.3%	10.8%	7.0%	13.6%	100.0%
Neonatal Intensive Care	1,660	3.9%	0.3%	58.6%	35.4%	2.7%	3.0%	100.0%
Neurology	2,389	5.7%	46.8%	32.1%	10.1%	4.0%	7.0%	100.0%
Neurosurgery	462	1.1%	38.5%	26.0%	1.1%	9.3%	25.1%	100.0%
Obstetrics & Deliveries	6,058	14.4%	0.4%	52.6%	44.5%	0.5%	2.0%	100.0%
Oncology	1,542	3.7%	46.1%	19.3%	6.4%	10.1%	18.2%	100.0%
Ophthalmology	78	0.2%	37.2%	28.2%	6.4%	6.4%	21.8%	100.0%
Orthopedics	3,819	9.0%	41.6%	24.5%	19.2%	3.4%	11.3%	100.0%
Plastic Surgery	271	0.6%	33.6%	24.4%	23.6%	8.9%	9.6%	100.0%
Psychiatry	149	0.4%	36.9%	28.9%	16.8%	4.7%	12.8%	100.0%
Pulmonary Medicine	3,311	7.8%	36.4%	28.1%	25.4%	2.3%	7.8%	100.0%
Rehabilitation	2	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Spine Surgery	544	1.3%	55.3%	8.3%	0.2%	4.8%	31.4%	100.0%
Thoracic & Vascular Surgery	810	1.9%	52.2%	25.8%	8.6%	3.3%	10.0%	100.0%
Transplant	33	0.1%	0.0%	0.0%	0.0%	42.4%	57.6%	100.0%
Urology	1,890	4.5%	48.7%	23.2%	12.5%	3.8%	11.9%	100.0%
Total	**42,200**	**100.0%**	**35.7%**	**32.1%**	**20.2%**	**3.3%**	**8.8%**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2012. Acute care, excludes normal newborns.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 2A

Service Area Inpatient Market Share by Payer, CY 2014

Desert Healthcare District
Service Area Inpatient Market Share by Payer
Calendar Year 2014

Hospital	Medicare		Medi-Cal		Private		Other	Total
	HMO	FFS	HMO	FFS	HMO	PPO		
Eisenhower Medical Center	33.2%	59.9%	22.5%	12.4%	24.6%	47.2%	29.8%	35.8%
Desert Regional Medical Center	53.1%	19.1%	37.2%	35.3%	41.1%	26.3%	40.2%	33.5%
John F Kennedy Memorial Hospital	4.7%	10.1%	32.1%	36.1%	17.8%	15.3%	13.0%	18.6%
Loma Linda University Medical Center	2.2%	1.1%	4.4%	7.8%	3.2%	3.2%	2.9%	3.4%
Riverside County Regional Medical Center	0.0%	0.2%	0.8%	3.6%	2.7%	0.2%	2.4%	1.2%
Cedars Sinai Medical Center	0.0%	1.4%	0.1%	0.1%	0.2%	0.5%	0.3%	0.5%
City of Hope Helford Clinical Research Hospital	0.0%	0.7%	0.0%	0.5%	0.2%	0.7%	0.5%	0.4%
Ronald Reagan UCLA Medical Center	0.1%	0.7%	0.0%	0.2%	0.2%	1.1%	0.5%	0.4%
Keck Hospital of USC	0.5%	0.7%	0.0%	0.0%	0.3%	0.7%	0.2%	0.4%
Kaiser Foundation Hospital - Riverside	1.1%	0.0%	0.0%	0.0%	1.2%	0.1%	0.1%	0.3%
University of California San Diego Medical Center	0.1%	0.5%	0.3%	0.2%	0.0%	0.3%	0.2%	0.3%
University of California Irvine Medical Center	0.2%	0.4%	0.3%	0.1%	0.3%	0.1%	0.3%	0.3%
Kaiser Foundation Hospital - Fontana	0.6%	0.0%	0.0%	0.0%	1.5%	0.0%	0.1%	0.2%
Others	4.3%	5.4%	2.3%	3.6%	6.6%	4.5%	9.4%	4.7%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
N =	**5,291**	**10,943**	**6,932**	**6,163**	**4,008**	**4,438**	**2,940**	**40,715**
Payer Mix =	**13.0%**	**26.9%**	**17.0%**	**15.1%**	**9.8%**	**10.9%**	**7.2%**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2014. Acute care, excludes normal newborns.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 3C

Service Area Inpatient Market Share by Payer, CY 2013

Desert Healthcare District
Service Area Inpatient Market Share by Payer
Calendar Year 2013

Hospital	Medicare		Medi-Cal		Private		Other	Total
	HMO	FFS	HMO	FFS	HMO	PPO		
Eisenhower Medical Center	36.8%	61.8%	17.7%	8.7%	26.1%	43.5%	25.2%	36.5%
Desert Regional Medical Center	50.0%	18.3%	36.4%	34.8%	39.8%	27.9%	37.3%	32.1%
John F Kennedy Memorial Hospital	4.7%	11.1%	37.8%	39.9%	21.0%	17.5%	15.6%	19.7%
Loma Linda University Medical Center	1.7%	1.0%	3.9%	9.1%	2.5%	3.2%	3.7%	3.3%
Riverside County Regional Medical Center	0.0%	0.1%	1.8%	3.4%	1.5%	0.3%	8.4%	1.7%
Cedars Sinai Medical Center	0.3%	0.9%	0.1%	0.1%	0.1%	0.7%	0.3%	0.4%
City of Hope Helford Clinical Research Hospital	0.0%	0.5%	0.0%	0.6%	0.1%	1.0%	0.1%	0.4%
Ronald Reagan UCLA Medical Center	0.1%	0.5%	0.1%	0.1%	0.1%	0.7%	0.3%	0.3%
Kaiser Foundation Hospital - Riverside	1.0%	0.0%	0.0%	0.0%	1.3%	0.0%	0.1%	0.3%
University of California Irvine Medical Center	0.3%	0.3%	0.3%	0.1%	0.2%	0.2%	0.2%	0.2%
Keck Hospital of USC	0.3%	0.4%	0.0%	0.0%	0.1%	0.3%	0.0%	0.2%
University of California San Diego Medical Center	0.1%	0.3%	0.1%	0.2%	0.0%	0.3%	0.1%	0.2%
Kaiser Foundation Hospital - Fontana	0.4%	0.0%	0.0%	0.0%	0.9%	0.0%	0.0%	0.2%
Providence Saint John's Health Center	0.0%	0.3%	0.0%	0.0%	0.0%	0.4%	0.1%	0.1%
Others	4.2%	4.7%	1.7%	3.0%	6.3%	4.0%	8.7%	4.5%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
N =	**5,453**	**12,110**	**5,073**	**5,691**	**3,989**	**4,428**	**3,852**	**40,596**
Payer Mix =	**13.4%**	**29.8%**	**12.5%**	**14.0%**	**9.8%**	**10.9%**	**9.5%**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2013. Acute care, excludes normal newborns.

https://share.premierinc.com/sites/pcs/ICD/Folder/West_Coast_Advisory_Services/Clients/Desert_Healthcare_District/Needs_Assessment/Analysis/[Coachella OSHPD Tables.xlsx]Table 3B

Service Area Inpatient Market Share by Payer, CY 2012

Desert Healthcare District
Service Area Inpatient Market Share by Payer
Calendar Year 2012

Hospital	Medicare		Medi-Cal		Private		Other	Total
	HMO	FFS	HMO	FFS	HMO	PPO		
Eisenhower Medical Center	37.8%	59.7%	18.2%	8.1%	22.8%	40.8%	22.8%	35.7%
Desert Regional Medical Center	50.3%	18.5%	38.5%	35.7%	40.6%	29.9%	35.3%	32.1%
John F Kennedy Memorial Hospital	4.5%	12.5%	37.4%	40.2%	21.8%	18.2%	13.8%	20.2%
Loma Linda University Medical Center	1.8%	1.2%	3.7%	9.4%	2.8%	3.2%	2.8%	3.3%
Riverside County Regional Medical Center	0.0%	0.2%	0.0%	2.9%	2.2%	0.5%	14.0%	2.0%
Cedars Sinai Medical Center	0.2%	0.9%	0.0%	0.1%	0.1%	0.7%	0.3%	0.4%
City of Hope Helford Clinical Research Hospital	0.0%	0.7%	0.0%	0.3%	0.1%	0.7%	0.1%	0.4%
Ronald Reagan UCLA Medical Center	0.0%	0.5%	0.0%	0.2%	0.1%	0.8%	0.4%	0.3%
Keck Hospital of USC	0.1%	0.4%	0.0%	0.2%	0.3%	0.5%	0.1%	0.3%
University of California Irvine Medical Center	0.3%	0.3%	0.4%	0.1%	0.3%	0.2%	0.1%	0.3%
Kaiser Foundation Hospital - Riverside	0.6%	0.0%	0.0%	0.0%	1.5%	0.0%	0.0%	0.2%
University of California San Diego Medical Center	0.0%	0.2%	0.1%	0.2%	0.0%	0.4%	0.2%	0.2%
Kindred Hospital Riverside	0.0%	0.4%	0.0%	0.1%	0.0%	0.0%	0.6%	0.2%
Pioneers Memorial Healthcare District	0.1%	0.1%	0.1%	0.3%	0.0%	0.1%	0.4%	0.2%
Others	4.3%	4.2%	1.7%	2.3%	7.3%	3.8%	9.1%	4.3%
Total	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
N =	**4,832**	**13,203**	**5,003**	**5,994**	**4,169**	**5,154**	**3,845**	**42,200**
Payer Mix =	**11.5%**	**31.3%**	**11.9%**	**14.2%**	**9.9%**	**12.2%**	**9.1%**	**100.0%**

Source: California Office of Statewide Health Planning and Development Inpatient Database, 2012. Acute care, excludes normal newborns.

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DESERT HEALTHCARE DISTRICT

DESERT HOSPITAL
MAY 1997 LEASE
TRANSACTION SUMMARY

Pre-Lease Agreement

- Parties and Term. Desert Healthcare District (District), Desert Hospital Corporation (DHC), and Tenet Healthsystem Desert Inc. (Tenet). The term of the Lease is 30 years from May 30, 1997, until May 29, 2027.
- Transfer of Assets and Liabilities to Tenet. The leased assets include the real property, equipment and other tangible personal property used at the Hospital and related businesses. Tenet agreed to assume all hospital contracts and employee obligations for paid time off, sick pay and payroll taxes.

Pre-Lease Agreement (continued)

- Assets and Liabilities retained by District. Assets which were retained by the District included the accounts receivable, the assets of the Foundation and the Las Palmas Medical Plaza Partnership.
- Consideration. Tenet paid the District the following amounts for Prepaid Rent: An amount necessary ($95 million) to defease DHC's outstanding indebtedness under the 1990, 1992 and 1993 Bonds, $15.5 million cash, and $8 million for inventory and prepaid expenses. The Transfer Agreement also included the assumption of all liabilities including $9.6 million and $35 million in the 1985 and 1987 Series A Revenue Bonds.

Pre-Lease Agreement (continued)

- Representations, Warranties and Additional Covenants. The District and DHC provided over 45 representations and warranties regarding their authority to enter the transaction and additional covenants which address the operation of the Hospital, third party and government approvals, and the various actions that needed to be taken to close the transaction. Tenet also agreed to hire all Hospital employees to perform comparable services for the same compensation.

Pre-Lease Agreement (continued)

- Indemnification. The District was responsible for indemnifying Tenet for claims related to the Hospital operations prior to closing. Tenet is obligated to indemnify the District for any breach of its representations and for any claims or liabilities arising after closing related to Tenet's operation of the Hospital.
- District Taxes. Tenet has no right to seek indemnification against District tax revenues for any type of claim under the Pre-Lease.

The Tenet Lease

- Parties and Term. District and Tenet. The Lease has a term of 30 years and expires May 29, 2027.
- Rent. Rent was prepaid as describe in the Pre-Lease.
- Taxes and Assessments. Tenet is required to pay all real and personal property taxes and pay all city, county, state, federal income or franchise taxes chargeable against Tenet.
- Limitations on use of Leased Assets. **Tenet must continuously operate the Hospital and Desert Businesses for the Benefit of the District residents and maintain and operate the premises as an acute care community hospital and ancillary service.**

The Tenet Lease (continued)

- Compliance with Laws, Covenants, and Restrictions. **Tenet is required to comply with all applicable laws during the term of the Lease including all laws relating to the operations and building codes.**
- Seismic Compliance Upgrades. In the event Tenet is required to upgrade the buildings at the Hospital to comply with seismic requirements (AB 1953) and the cost of those upgrades exceed $12.5 million, then Tenet has the right to terminate the Lease and the District is responsible for the remaining prepaid rent.

The Tenet Lease (continued)

- Maintenance of Hospital. **Tenet is required, at its sole cost and expense, to maintain the Leased Premises in the same condition and repair as it was at commencement of the Lease**.
- Alterations, Additions, and Improvements. Tenet must obtain prior consent from District for any improvements that have a net book value in excess of $1 million (plus CPI index) at the normal expiration of the Lease (2027) or it may not be included in the Termination Assets.

The Tenet Lease (continued)

- Compliance with Insurance. Tenet is required to maintain "all risk" insurance in an amount equal to "full replacement value" which shall be renewed at least every 5 years to cover new improvements. Tenet is also required to maintain comprehensive general liability, professional liability, malpractice, and employer's compensation insurance. Tenet is obligated to carry earthquake insurance coverage comparable to other hospitals in Southern California, provided such coverage is available and reasonable. The District may require proof of compliance with these insurance requirements.

The Tenet Lease (continued)

- Operating Covenants. There are a series of operating covenants that address how Tenet is required to operate the Hospital:
  1. **Non-Discrimination in Operations:** All major decisions for the Hospital must be made without discrimination against District residents. No Core Services at the Hospital may be relocated to JFK in order close or materially reduce the services at Desert Hospital.

The Tenet Lease

Operating Covenants (continued)

2. **Termination of Core Services:** Tenet may not **terminate** or materially reduce a "Core Service" prior to May 2000. Any decision after will not be made without providing the District, the Medical Staff and the local governing board notice and an opportunity to be heard. Notice must include a financial analysis of the affected Core Service and its availability in the community. The District may hold public hearings on the proposed action at which Tenet must participate.
3. **Assignment and Subleases:** Tenet may not sublease Hospital without the District's consent.

The Tenet Lease

Operating Covenants (continued)

4. **Licensing and Accreditation:** Tenet must use best efforts to maintain Hospital licensure and accreditation, and commercially reasonable efforts to participate in Medicare, Medi-Cal and other third-party programs. However, this is qualified if new laws substantially modify disproportionate share payments.

5. **Capital Projects:** Tenet was required to use reasonable efforts to complete certain capital projects that existed at the Hospital in 1997.

THE TENET LEASE

Operating Covenants (continued)

6. Governance of the Hospital: Tenet was required to establish a local governing board to provide community participation. The board has 13 members, two of whom can be elected District board members. Notwithstanding the local governing board, Tenet's corporate board of directors retains ultimate decision-making power.

THE TENET LEASE

Operating Covenants (continued)

7. **Other Obligations:** Tenet is obligated to:

   (i) provide the District with an annual report on the operation of the Hospital; (ii) maintain donor identification on the various buildings; (iii) obtain District consent before changing the Hospital's charity care policy; (iv) provide space for the District and Foundation in the Stergios Building; and (v) the District has the right to inspect the Leased Premises during the term of the Lease.

The Tenet Lease (continued)

- **Events of Default**. Events of default by Tenet include:
  i. the failure to pay or perform any material covenant or condition of the agreement.
  ii. the subjection of any right or interest of the District to attachment or levy.
  iii. appointment of a receiver to take possession of the property
  iv. an assignment for the benefit of creditors, or filing of a bankruptcy,
  v. a reorganization or dissolution to avoid bankruptcy.

The Tenet Lease (continued)

- **Right of First Offer and Refusal**. The District may not sell, assign, lease, or transfer its interest in the hospital, without first offering it to Tenet. If Tenet declines, the District may seek offers from other parties. If the District receives an offer from a third party, Tenet has the right of first refusal
- **Limitations on Sale**. District may not sell, assign, lease or in any manner transfer the hospital or any part of it to any person or entity, which either directly or through any Affiliate that operates health facilities or provides health care services other than Tenet

The Tenet Lease (continued)

- **Remedies**. In the event of an uncured default by Tenet, the District has the right to seek injunctive relief or specific performance or terminate the Lease and is not obligated to reimburse Tenet for Prepaid Rent.
- **Non-Competition Clause**. Neither the District nor any of its affiliates (including the Foundation) may directly compete with Tenet in providing health care services within the boundaries of the District. This includes directly providing financial support to a competing hospital. **This non-competition covenant does not apply to the newly annexed area.**

The Tenet Lease (continued)

- **Termination**. In general, the District will be required to purchase from Tenet all of the improvements to the Hospital at the lesser of their FMV or then book value. The District will also be required to purchase the inventory at book value and prepaid expenses.
- **Misc. Provisions**. At the end of the Lease are a series of miscellaneous provisions that include a requirement that disputes comply with a meet confer process and then binding arbitration.

VMG HEALTH

Desert Regional Medical Center

VALUATION DATE: August 28, 2018
DISTRIBUTION DATE: October 15, 2018

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Desert Regional Medical Center

EXECUTIVE SUMMARY

Executive Summary

Valuation Overview

Value Management Group, LLC d/b/a VMG Health ("VMG") has been engaged by Desert Healthcare District (the "District) & Desert Healthcare Foundation to provide a third party, independent fair market value ("FMV") analysis of Desert Regional Medical Center (the "Hospital").

The intended user of this analysis is Desert Healthcare District and the Desert Healthcare Foundation and its duly authorized representatives. Our valuation analysis does not constitute a fairness opinion or investment advice in that we will not conduct all of the steps necessary to issue such an opinion. The term FMV means the price at which property would change hands between a willing buyer and willing seller when the former is not under any compulsion to buy and the latter is not under any compulsion to sell, both parties having reasonable knowledge of the relevant facts.

VMG has not taken any steps in auditing the financials statements provided. We have relied upon the representation that the latest internal financial statements are accurate and represent the financial and operational assets of the Hospital in a reasonable manner. The obligation of VMG is solely a corporate obligation, and no officer, principal, director, employee, agent, shareholder, or controlling person shall be subjected to any personal liability whatsoever to any person or entity, nor will any such claim be asserted by or on behalf of any other party to this agreement or any person relying on the opinion. Where appropriate, VMG considered the factors set forth in Revenue Ruling 59-60, 1959-1, C.b. 237, including:

- The nature of the business and the history of the enterprise from its inception;
- The economic outlook in general and the condition and outlook of the specific industry in particular;
- The book value of the stock and the financial condition of the enterprise;
- The earning capacity of the enterprise;
- The dividend-paying capacity of the enterprise;
- Whether or not the enterprise has goodwill or other intangible value;
- Prior sales of the stock and the size of the block of stock to be valued; and,
- The market price of stock of corporations engaged in the same or a similar line of business, having their stocks actively traded on an exchange or over-the-counter market.

Qualifying Assumptions

The valuation opinion presented in this report is contingent on the following list of qualifying assumptions.

1. Desert Healthcare District (the "District" or "Lessor") is a political subdivision of the State of California. The District was established to own and operate an acute-care hospital located at 1150 N. Indian Canyon Dr. in Palm Springs, CA, which is now commonly known as Desert Regional Medical Center (the "Hospital"). The District entered into a Hospital Lease Agreement (the "Hospital Lease") on May 30, 1997 with a subsidiary of Tenet Healthcare, Inc. ("Tenet" or "Lessee") for a 30 year term whereby Tenet would lease from the District all real property and personal property ("Leased Premises") which were used in the operation of the Hospital and its related activities including outpatient centers, clinics, physician practices, and medical office buildings (collectively, the "Desert Business").

2. The Hospital Lease included provisions related to termination by Lessee or Lessor during, or at expiration of the 30 year lease period. Upon expiration or early termination of the Hospital Lease, all alterations, additions or improvements to the leased premises made by Lessee, including any additional or replacement items of personal property acquired by the Lessee during the term of the Hospital Lease (collectively, the "Termination Assets"), would be transferred to the Lessor; provided, however, that the Lessor would purchase and pay Lesse the cumulative fair market value or net book value, whichever is less, of the identified Termination Assets upon termination or expiration. VMG was not provided a list of the specific Termination Assets and their associated net book values, nor has VMG provided an opinion on their current fair market value, however, we acknowledge the potential for adjustments related to the Termination Assets' where appropriate in this report.

3. Seismic renovation and retrofit activities in California hospitals are dictated by a broad legislative and regulatory framework, all of which originated with California SB 1953. This legislation established seismic safety goals for California hospitals and mandated compliance for hospital structural support systems by January 2030. VMG was provided a copy of the Phase 0 Seismic Evaluation Services Report of September 2018 prepared by Simpson, Gumpertz & Heger, which evaluated both structural and non-structural requirements, and estimated a range between $84 million and $141 million (“Seismic Upgrade Costs”). A more detailed Phase 1 report is scheduled to be completed in December 2018. The Hospital Lease term is set to expire in 2027, prior to the January 2030 compliance deadline established by California SB 1953. VMG understands the Hospital Lease dictates that the Lessee is only responsible for costs to comply with California SB 1953 during the term of the Hospital Lease, and if the Hospital Lease is terminated or allowed to expire, the District would be required to pay any remaining costs to comply with the law. Where appropriate, this report acknowledges the potential impact of Seismic Upgrade Cost and the uncertainty regarding the estimate indicated in the Seismic and PML Assessment, but VMG does not have an opinion as to the amount of Seismic Upgrade Costs.

4. VMG understands the District is evaluating its strategic options, given the above pending seismic upgrade requirements, the remaining lease term, and has requested VMG provide a current Fair Market Value ("FMV") opinion for the Hospital as of a current date. Accordingly, VMG estimated the Fair Market Value of the Business Enterprise Value ("BEV") of the Hospital. Given that the BEV estimate does not account for the impact of the remaining Hospital Lease term and other factors specific to the Hospital and the District, we have acknowledged "placeholder" adjustments detailed further on the following pages in order to assist the District with understanding the estimated value of their current ownership position.

5. Tenet has provided VMG with unaudited internal financial statements for the reporting entity "694 - Desert Regional Medical Center." Tenet provided Income Statement data for the fiscal year ("FY") periods ended December 31, 2015, 2016, 2017 and the trailing twelve months ("TTM") ended May 31, 2018 and Balance Sheet data for FY 2017 and as of May 31, 2018. VMG has not independently audited or confirmed the accuracy of the data provided and we are relying on the data as materially true and correct. To the extent that the information provided to VMG is inaccurate, we reserve the right to amend our analysis accordingly.

6. We understand the financial statements provided by Tenet do not include allocation of certain corporate overhead and management-related costs which would typically be incurred at the Hospital level. Tenet provided a list of certain costs typically directly charged to its facilities as well as a list of pooled allocations typically charged to its facilities. VMG was not provided a specific list of corporate overhead charges currently included in the TTM 2018 financials or the actual amounts incurred in any period, but we have discussed with Tenet the items currently captured at the corporate level and included an estimated Management Fee in the Normalized Base Year Income Statement which is applicable to those charges not currently included in the TTM 2018 period. The selected Management Fee of 2.0% of Net Revenue is based on proprietary data obtained by VMG and is detailed further in this report.

7. VMG understands the Hospital is currently operated by a large public company as a part of the Desert Care Network, which includes JFK Memorial Hospital and Hi-Desert Medical Center. The Hospital may benefit operationally and financially from this affiliation through network management, improved contracting strength or expense management. If the Hospital is not affiliated with Tenet or the Desert Care Network, the future impact, if any, to its financial performance is unknown.

8. VMG understands that the Hospital financial statements do not include revenues and expenses associated with certain physician practice operations which contribute to the operations of the Hospital. These entities are captured under separate financial statements, which were provided to VMG for the most recent TTM 2018 period. VMG has calculated the net loss during the TTM 2018 period and adjusted the Normalized Base Year Income Statement to include the TTM 2018 losses of approximately $6.8 million. These adjustments are detailed further in this report.

9. VMG understands the Hospital participates in the Hospital Qualify Assurance Fee ("HQAF") program which provides a supplemental source of revenue to participating California hospitals which serve Medi-Cal and uninsured patients. The Hospital also incurs related assessment fees associated with participation in the HQAF program. These costs are typically accrued for on a monthly basis by the Hospital, but the TTM 2018 Income Statement has been adjusted in the Normalized Base Year to eliminate the impact of an accrual which occurred for a full twelve month period during FYE 2017. These adjustments are detailed further in this report.

10. El Mirador Medical Plaza is an MOB owned by the District and leased to Tenet. VMG understands that a majority of the suites in the MOB are owner occupied and that El Mirador Medical Plaza will revert back to the District along with the Hospital at the expiration of the Lease. Additionally, VMG understands that the Stergios Building, where the District's office is located, will also revert back to the District at the expiration of the Lease. VMG has not included any adjustments to this analysis for these properties.

11. Three distinct approaches to estimate the BEV were explored - Cost, Market, & Income Approaches. Ultimately, VMG relied upon the Income Approach in determining value due to the ability to factor a discrete cash flow projection unique to the Hospital and the lack of available directly comparable transaction data to be utilized in the Market Approach. Additionally, it was our determination that the Cost Approach did not provide adequate consideration to the going concern value of the Hospital.

12. BEV, reflects the value of the Hospital operations inclusive of a normalized level of cash-free working capital. Working capital includes accounts receivables and other current assets less non-interest bearing current liabilities that permit a business to conduct daily operations and maintain liquidity. Normalized net working capital is estimated at approximately 8.0% of net operating revenue based the observed net working capital for comparable publicly traded companies which further detailed in this analysis.

Executive Summary

Business Enterprise Value Recommendation

Based on and subject to the facts, limiting conditions, and assumptions presented in this report and the attached exhibits, as of a current date, the FMV of the business enterprise value ("BEV") of the Hospital is reasonably represented in a range between approximately **$580 million and $640 million**.

Range of Fair Market Value, BEV Level	Low (5.0%)	Midpoint	High (+5.0%)
Fair Market Value Indication, Business Enterprise Level	$580,000,000	$610,000,000	$640,000,000

Implied Market Multiples	Financial Metric ($)	Low	Mid	High
BEV/ NBY EBITDA	96,468,473	6.01x	6.32x	6.63x
BEV/ NBY Revenue	544,133,376	1.07x	1.12x	1.18x
BEV/ Year 1 EBITDA	94,983,961	6.11x	6.42x	6.74x
BEV/ Year 1 Revenue	559,522,715	1.04x	1.09x	1.14x

Business Enterprise Value reflects the value of the Hospital inclusive of a normalized level of cash-free net working capital. Net working capital includes accounts receivables and other current assets less non-interest-bearing current liabilities that permit a business to conduct daily operations and maintain liquidity. Normalized net working capital is estimated to be 8.0% of net operating revenue. Incremental net working capital requirements are projected at 8.0% of net operating revenue throughout the projection period.

Please refer to the following pages for further detail regarding adjustments to the Midpoint BEV presented above.

The adjustments to the BEV presented below have been identified and calculated, where appropriate, based on parameters of the Hospital Lease. The midpoint BEV of $610 million is inclusive of a normalized level of net working capital which is controlled by the lessee.

The BEV reflects the value of the Hospital and its associated cash flows into perpetuity. Given that the District would not have access to the cash flow generated by the Hospital until the expiration in approximately nine years, the present value of the projected cash flows during the first nine years of the Income Approach's Discounted Cash Flow Projection are included below as a reduction to the BEV. These cash flows are estimated at approximately $299 million and result in a BEV (less working capital and the remaining lease term value) of approximately $267 million.

Two adjustments below are included as placeholders ("TBD") due to the uncertainty regarding the current value of these items. The District would be required to incur the necessary Seismic upgrade costs to comply with state requirements. Additionally, Termination Assets, as defined in the Hospital Lease, must be purchased by the District upon Termination of the Hospital Lease.

ADJUSTMENTS TO BEV	
Value Indication, Business Enterprise Value (Including Working Capital)	$610,000,000
Less: Normalized Working Capital included in Business Enterprise Calculation	*(44,000,000)*
Subtotal - Business Enterprise Value, less Working Capital (rounded)	$566,000,000
Less: Value Indication for Total Year 1 - Year 9 Present Value of Cash Flows	($299,231,472)
Subtotal - Business Enterprise Value, Adjusted for Remaining Lease Term & Working Capital	$267,000,000
Less: Seismic Upgrade Cost	*TBD*
Less: Termination Assets	*TBD*
BEV Adjusted for Remaining Lease Term, Seismic Requirements, Working Capital & Termination Assets	TBD

Executive Summary

Situational Analysis

Desert Regional Medical Center was initially established in 1948 and was operated by the District until the establishment of the Hospital Lease which allowed Tenet to take over the operations and bring it into their portfolio of health care facilities in the region. The Hospital is located in Palm Springs, CA, and is a member of Desert Care Network which was established by Tenet Healthcare. Desert Care Network includes Desert Regional Medical Center, High Desert Medical Center, and John F. Kennedy Memorial Hospital as well as four skilled nursing facilities, eight physician practices, two ambulatory surgery centers, and two urgent care facilities.

During the trailing twelve months ended ("TTM") May 31, 2018, the Hospital generated total net operating revenue of approximately $562.9 million, an increase of 4.6% from FYE 2017 net operating revenue of approximately $538.2 million. Overall, earnings before interest, taxes, depreciation, and amortization ("EBITDA") was approximately $133.1 million (23.6% of net operating revenue) in TTM 2018 and approximately $112.1 million (20.8% of net operating revenue) in FYE 2017. The Hospital's admissions remained relatively constant compounded annually from 19,738 in FYE 2015 to 19,694 in TTM 2018. The Hospital's patient days increased 1.6% compounded annually from 88,855 in FYE 2015 to 92,271 in TTM 2018.

During TTM 2018, the largest payors as a percentage of net collections were Commercial (33.9%) and Medicare (16.1%). Other payors include Managed Medicare (15.9%) and Medicaid (13.4%). Desert also is largest provider of charity care in its community. According to staffing data provided by hospital management, the Hospital employs approximately 1,933 full-time equivalent ("FTE") employees. The average FTE per adjusted occupied bed was 5.3 in TTM 2018, and the average hourly salary per FTE was approximately $46.49 during TTM 2018.

As previously mentioned, the Hospital is located in Palm Springs, California, which is in Riverside County. Recent population estimates indicate that the population of Riverside County increased 2.6% compounded annually, from approximately 1,558,985 residents in 2000 to approximately 2,423,266 residents in 2017. The Hospital is situated in an area with a seasonal population change in which the overall population usually decreases during the summer months and experiences an increase in population during the winter months. The Hospital's closest competitors in terms of proximity are Eisenhower Medical Center and John F. Kennedy Memorial Hospital. As mentioned above John F. Kennedy Memorial Hospital is also a part of the Desert Care Network operated by Tenet.

This engagement was conducted in accordance with generally accepted valuation methodologies. In the valuation of a privately-held business, three general approaches are considered in the determination of value: Cost Approach, Market Approach, and the Income Approach. The nature and characteristics of the business and the objective of the engagement indicate which approach, or approaches, are most applicable for valuation purposes. The Income Approach was fully relied upon, the applicability of which is discussed later in this report.

Desert Regional Medical Center

MARKET OVERVIEW

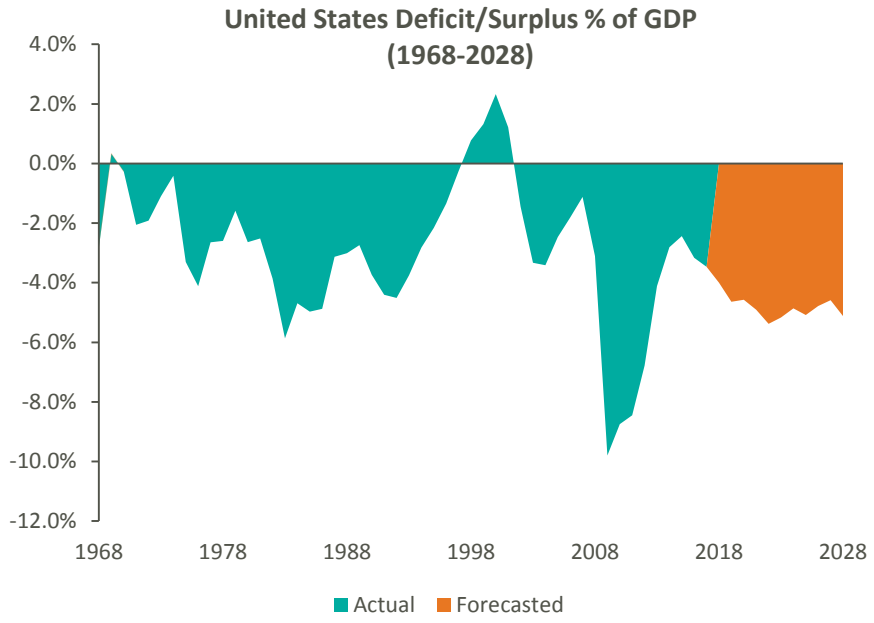
Desert Regional Medical Center

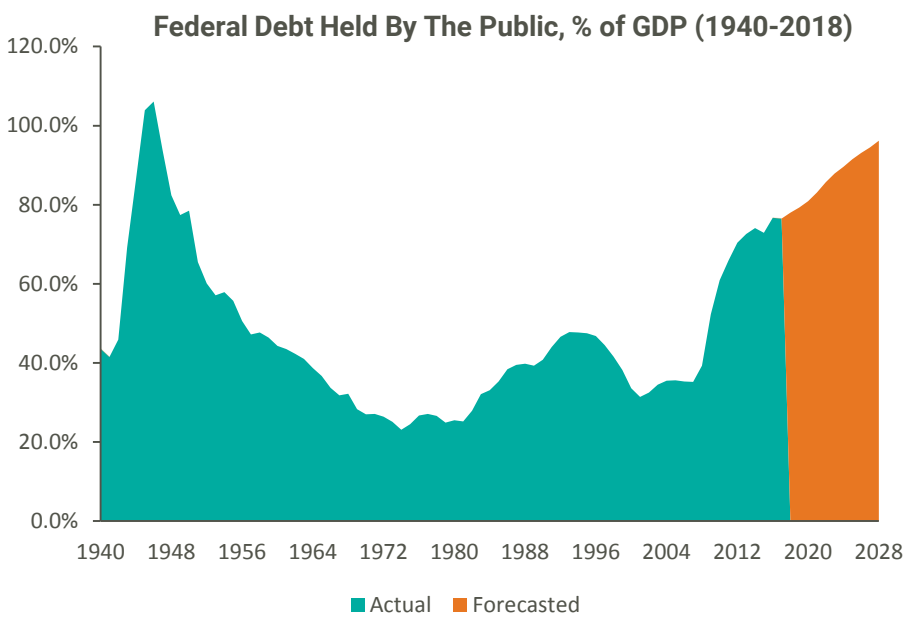
ECONOMIC ANALYSIS

Market Overview

Economic Analysis

The federal budget deficit continues to be an area of concern for lawmakers. According to estimates from the Congressional Budget Office ("CBO"), the federal deficit as a percent of GDP increased from -3.2% of GDP in 2016 to -3.5% of GDP in 2017. The CBO projects that the federal deficit as a percentage of GDP will increase to -4.0% in 2018 increasing further to -5.4% by 2022. As a result, the federal debt held by the public as a percentage of GDP is projected to increase from 76.5% in 2017 to 85.7% in 2022. The increased deficits are projected to be driven by declines in revenue as a result of the Tax Cuts and Jobs Act of 2017. In its report, the CBO notes the increased uncertainty associated with estimating the economic impact of recent changes in fiscal policy. Deficit reduction has been identified as a priority of the Trump administration. However, in order to accomplish this revenue reductions resulting from the Tax Cuts and Jobs Act of 2017 must be off-set by economic growth and/or additional spending cuts.





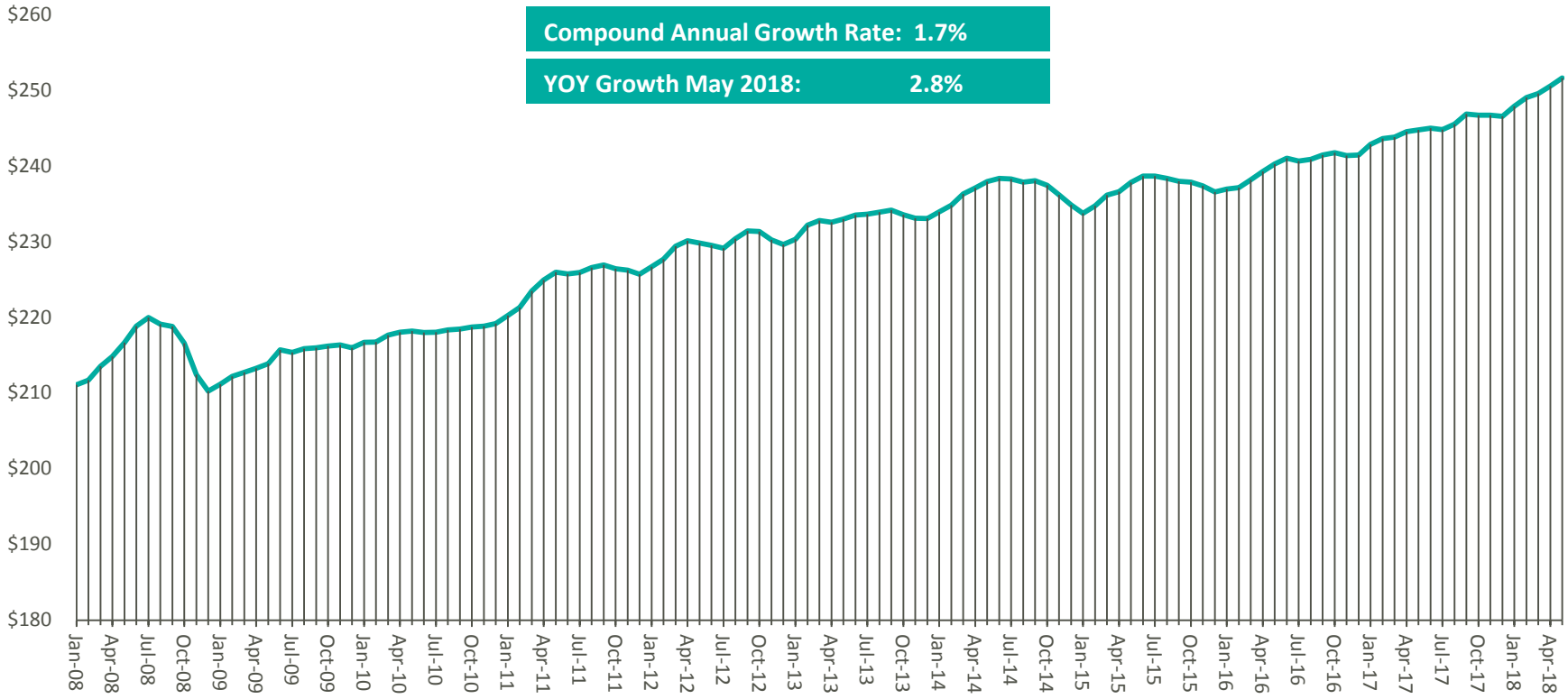
Source: The Budget and Economic Outlook: 2018 to 2028 published by the Congressional Budget Office

Market Overview

Economic Analysis

Presented in the chart below is the Consumer Price Index for Urban Consumers ("CPI-U") from April 2008 to April 2018. The CPI-U measures the average change in price for a market basket of goods and services over time for urban consumers. The percentage change in the CPI-U is commonly used to measure the general inflation in the price of goods and services for urban consumers in the United States. From January 2008 to May 2018, CPI-U increased at a compound annual rate of approximately 1.7%. More recently, CPI-U has increased 2.8% from May 2017 to May 2018.

Unadjusted Consumer Price Index For Urban Consumers



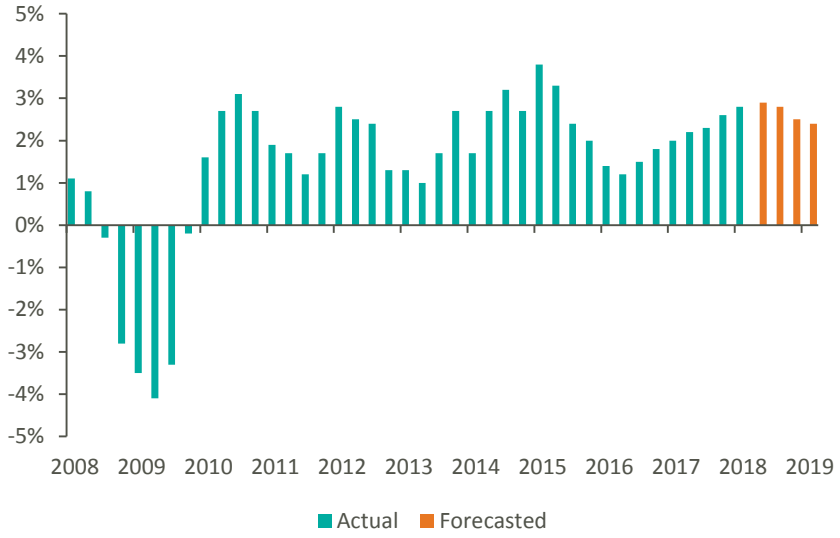
Source: Bureau of Labor Statistics

Market Overview

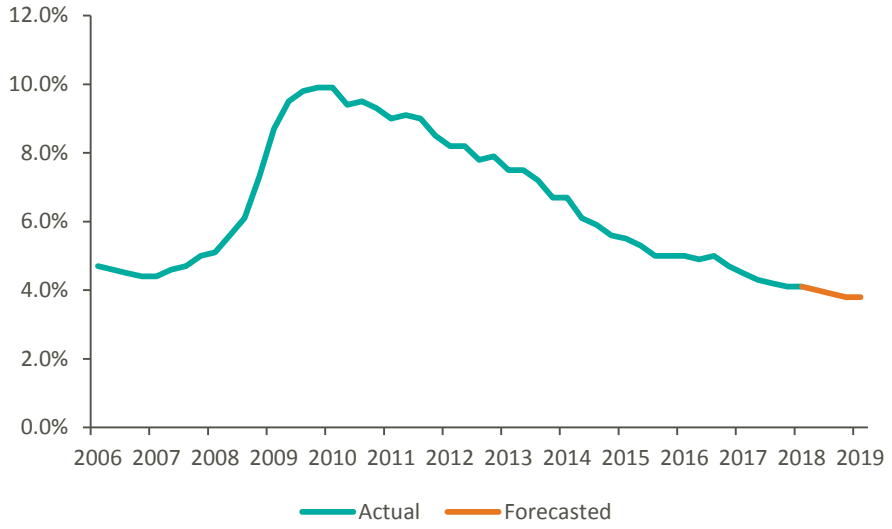
Economic Analysis

Since the recovery from the recession in 2008 and 2009, annual real GDP growth has ranged from a low of 1.0% in Q1 of 2013 to a high of 3.8% in Q1 of 2015. For Q1 of 2018, YOY growth in real GDP was 2.8%. Overall, YOY quarterly real GDP growth has averaged 2.5% over the past four quarters. According to the Survey of Professional Forecasters, real GDP growth is expected to grow at an average rate of 2.7% over the next four quarters. The unemployment rate reached 10% in October of 2009, the highest rate in over 30 years. Since that time, the unemployment rate has declined to 4.1% as of March 2018 and is expected to decrease over the next three quarters according to the Survey of Professional Forecasters.

Year Over Year Growth Real GDP
Quarterly From Q1 2008 to Forecast Q1 2019



Unemployment Rate
Quarterly from Q1 2006 to Forecast Q1 2019

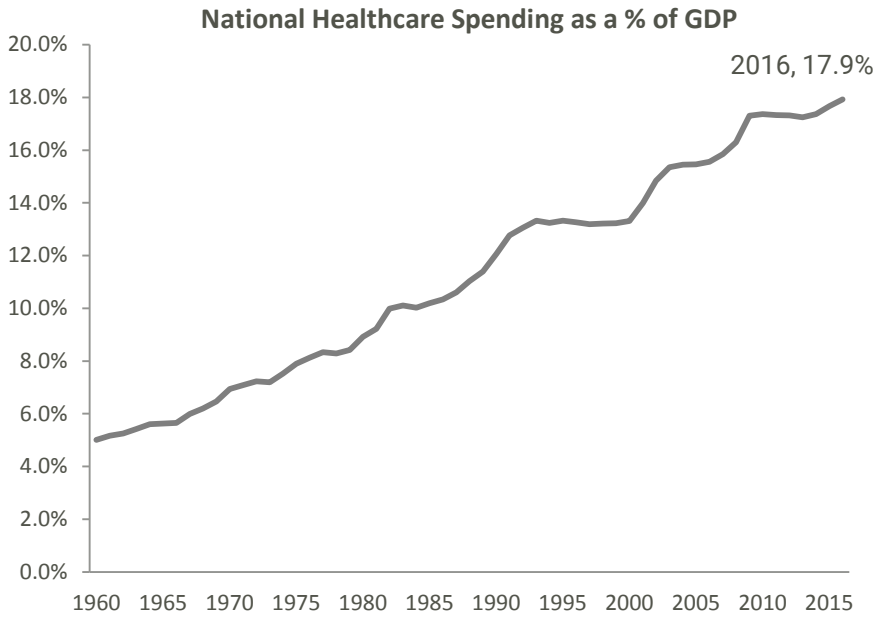


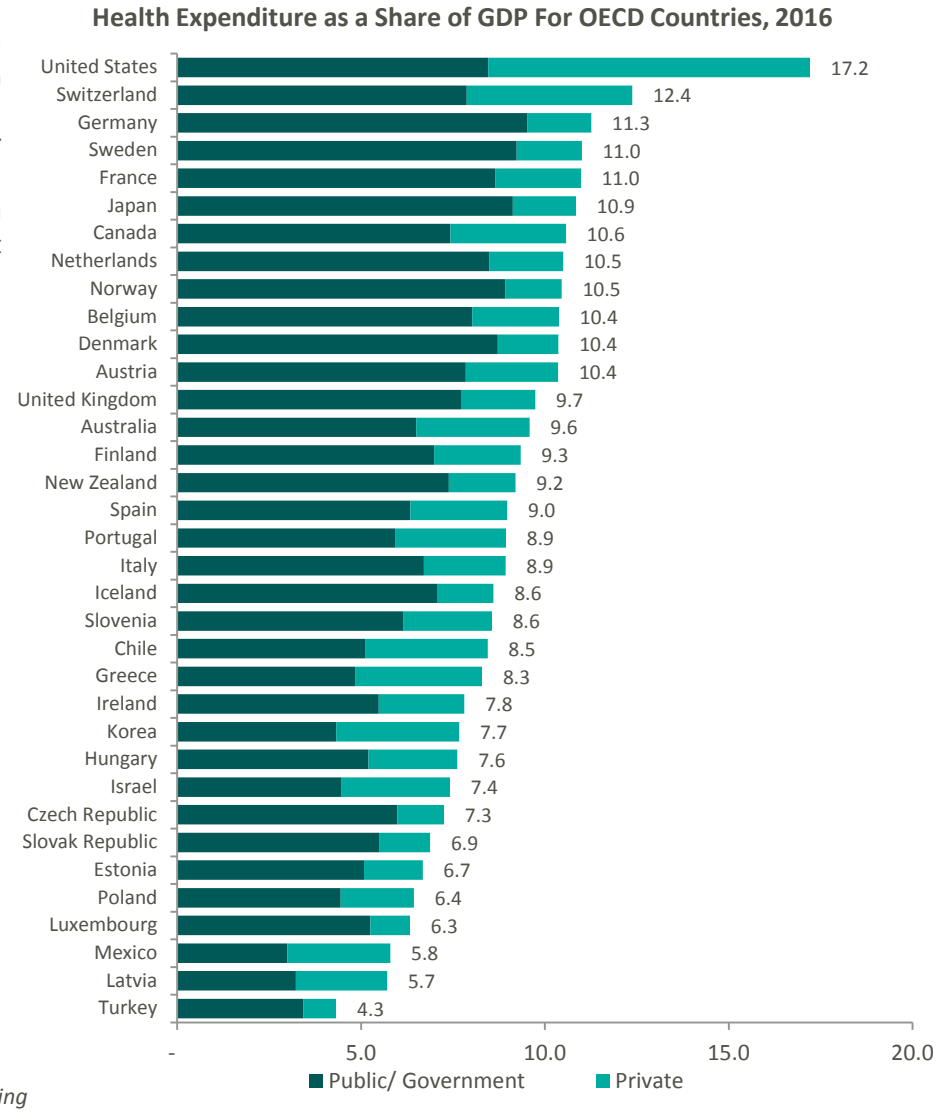
Source: Federal Reserve Bank of St. Louis, United States Bureau of Labor Statistics, and the Survey of Professional Forecasters

Market Overview

United States Healthcare System

According to the Center for Medicare and Medicaid Services ("CMS") healthcare spending as a percentage of GDP has increased from 5.0% in 1960 to 17.9% in 2016. More recently, healthcare expenditures as a percentage of GDP increased from 17.2% in 2013 to 17.9% in 2016 after remaining relatively flat for the previous five years. According to the OECD, the United States spends more on healthcare, both per capita, and as a share of GDP, than any other country in the world as illustrated in the chart on the right.





Source: CMS and Bureau of Economic Analysis & *OECD.Stat Health Expenditure & Financing*

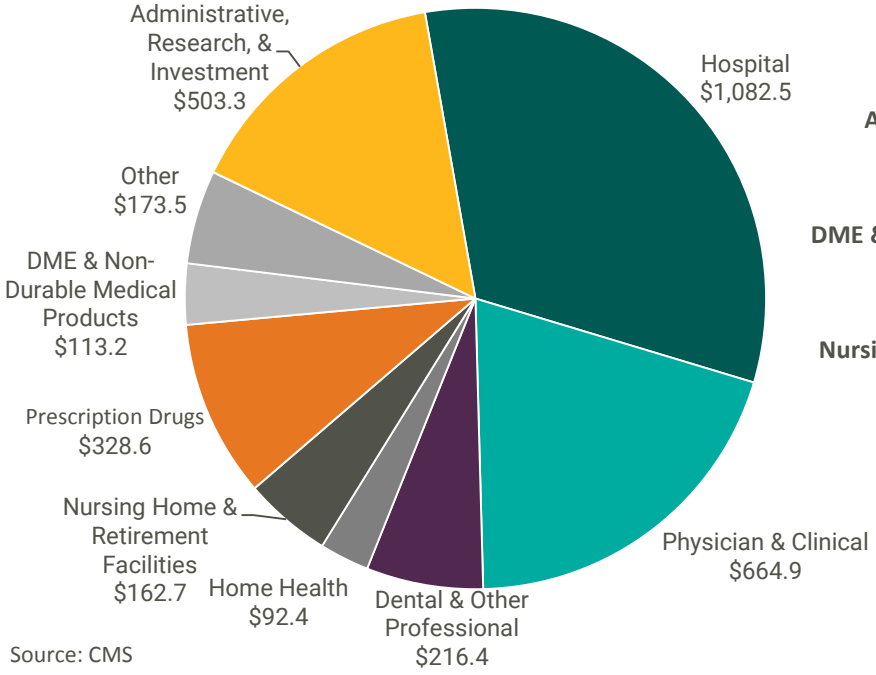
Market Overview

United States Healthcare System

Healthcare spending growth in the United States moderated in 2016 as compared to 2014 and 2015 when ACA coverage expansions and double digit growth in prescription drug spending caused overall healthcare spending to increase more than 5.0% annually. Overall, from 2015 to 2016 total national health expenditures increased 4.3% from approximately $3.2 trillion in 2015 to approximately $3.3 trillion in 2016. In 2016 hospital care and physician & clinical services were the largest spending categories accounting for $1,082.5 billion (33.8% of total) and $664.9 billion (20.7% of total) of the total health expenditures, respectively. From 2010 to 2016 hospital services and prescription drugs have experienced the largest growth in spending with an average annual growth rate of 4.7% and 4.4%, respectively. According to CMS, the increase in hospital spending is primarily attributable to an increase in overall utilization and acuity of services. While the large increase in prescription drug spending is the result of a shift from small molecule drugs to specialty pharmaceuticals which are more expensive. It should be noted that spending on prescription drugs increased just 1.3% in 2016 due to fewer new drug approvals, slower growth in brand-name drug spending, and pricing decreases for generic drugs.

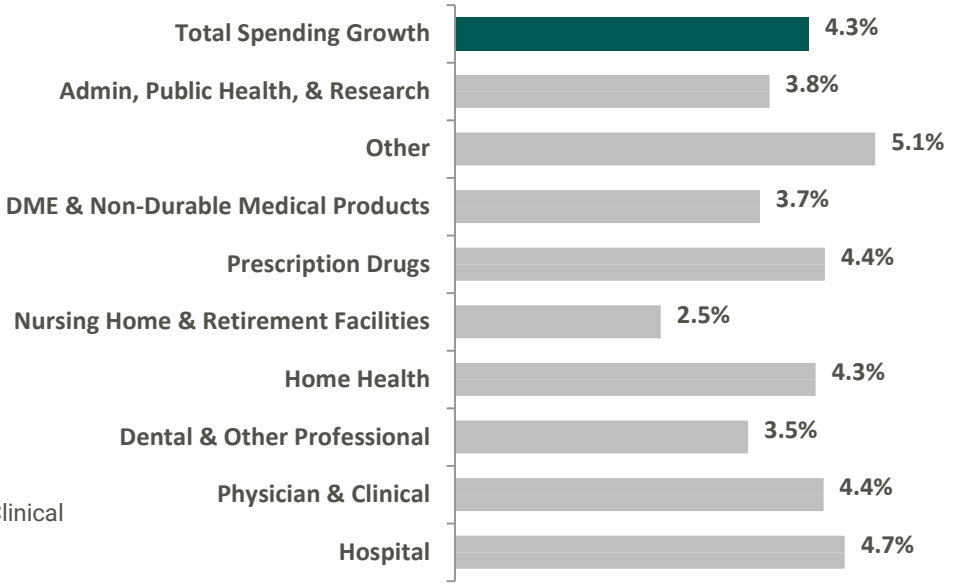
National Health Expenditures by Category 2016 (in Billions)

Total 2016 Spending $3.3 Trillion



Source: CMS

Annual Healthcare Spending Growth by Category 2010-2016



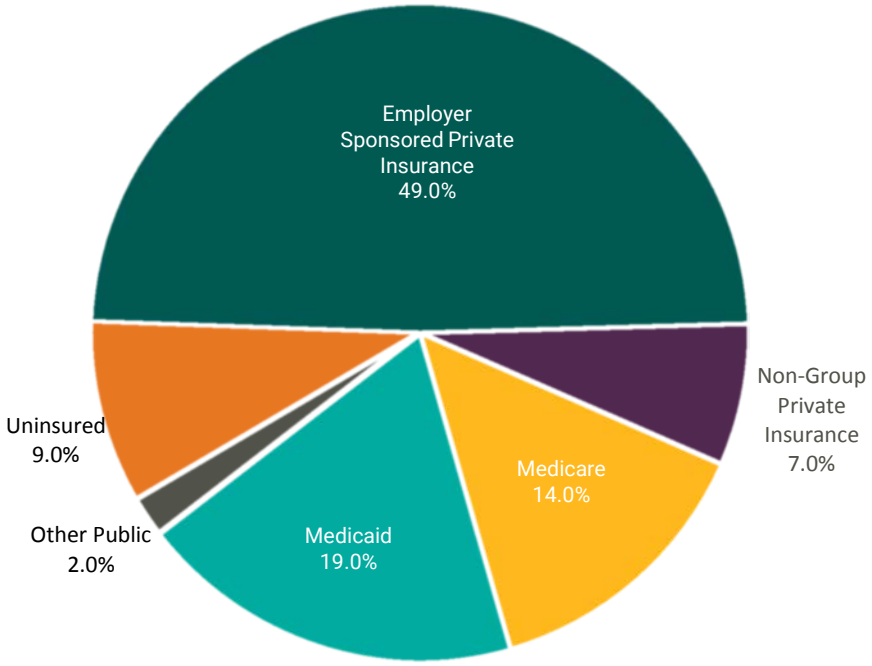
Market Overview

United States Healthcare System

A number of private and public sources combine to finance healthcare expenditures in the United States. The majority of Americans under the age of 65 have health coverage through a private insurance provider. According to the Kaiser Family Foundation, during 2016 approximately 49% of Americans had employer based private insurance while approximately 7.0% obtained private insurance through the individual plan market. The largest government payors, Medicaid and Medicare covered approximately 19.0% and 14.0% of Americans, respectively. According to CMS, private health insurance accounted for approximately 35.0% of total national health expenditures in 2016. Over the same time period, Medicare and Medicaid accounted for 21.0% and 18.2% of total spending, respectively.

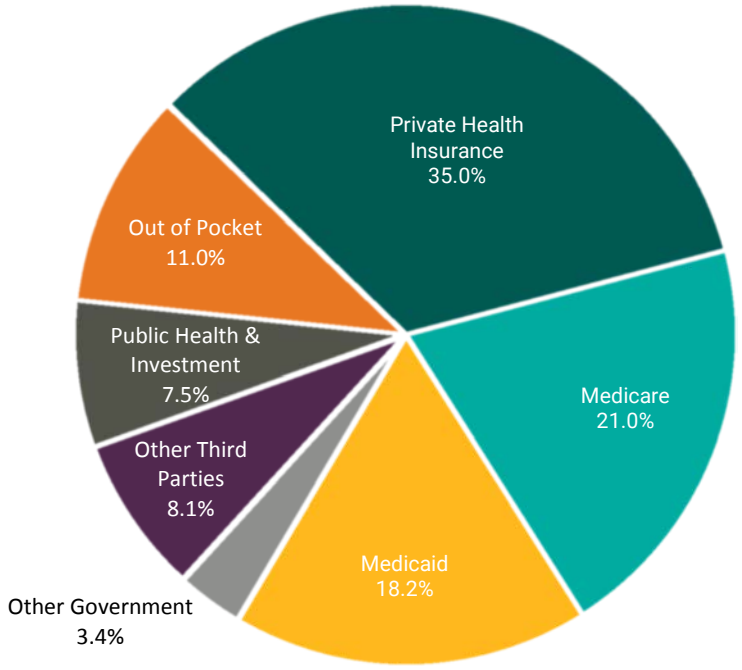
Health Coverage by Payor 2016

Percentage of Total Population



National Healthcare Expenditures by Payor 2016

Total 2016 Spending $3.3 Trillion

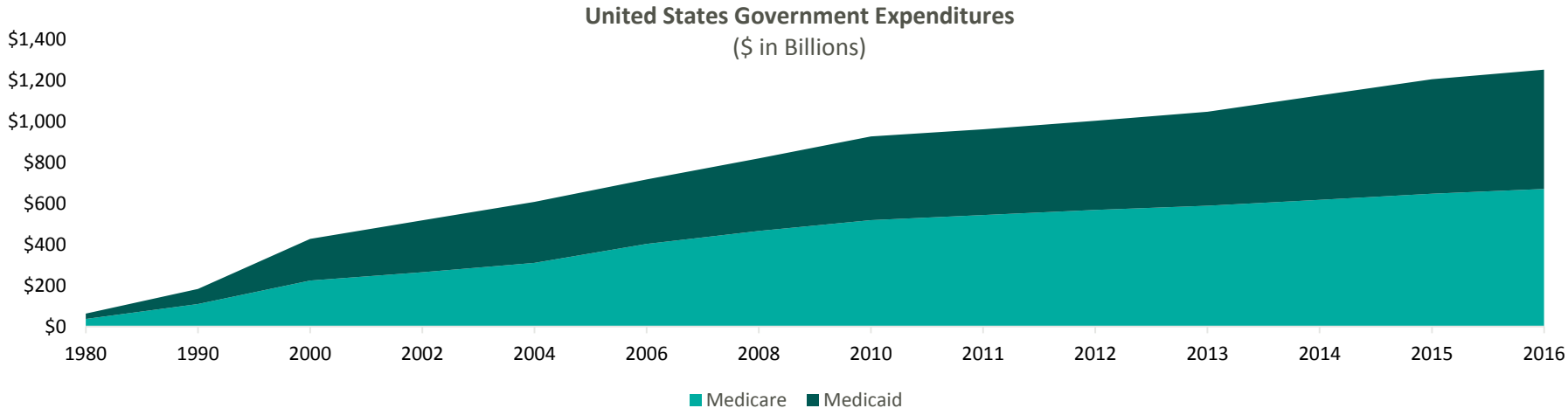


Sources: Kaiser Family Foundation and CMS

Government Funding

During 2016 Medicare provided federal health insurance for approximately 57.1 million[1] people who are elderly, disabled, have end-stage renal disease, or amyotrophic lateral sclerosis (also known as Lou Gehrig's disease). Individuals become eligible for Medicare on the basis of age when they reach 65 while disabled individuals become eligible for Medicare 24 months after they become eligible for benefits under the Social Security Disability Insurance program. Since 1980, Medicare spending has grown 8.4% compounded annually from approximately $37.4 billion in 1980 to approximately $672.1 billion in 2016. More recently total Medicare spending growth has slowed, increasing 4.4% compounded annually from $519.8 billion in 2010 to $672.1 billion in 2016.

Medicaid is a joint federal–state program that pays for healthcare services for a variety of low-income individuals. The Medicaid program, created in 1965 by the same legislation that created Medicare, replaced an earlier program of federal grants given to states to provide medical care to low income residents. As of 2016, approximately 75.0 million[2] people were enrolled in the Medicaid program. It should be noted that certain individuals, often referred to as "dual-eligible," are covered by both Medicaid and Medicare. Since 1980, Medicaid spending has grown 9.0% compounded annually from approximately $26.0 billion in 1980 to approximately $582.4 billion in 2016[3]. More recently Medicaid expenditures increased 8.3% compounded annually from $458.9 billion in 2013 to $582.4 billion in 2016 due to the expansion of coverage resulting from The Patient Protection and Affordable Care Act.

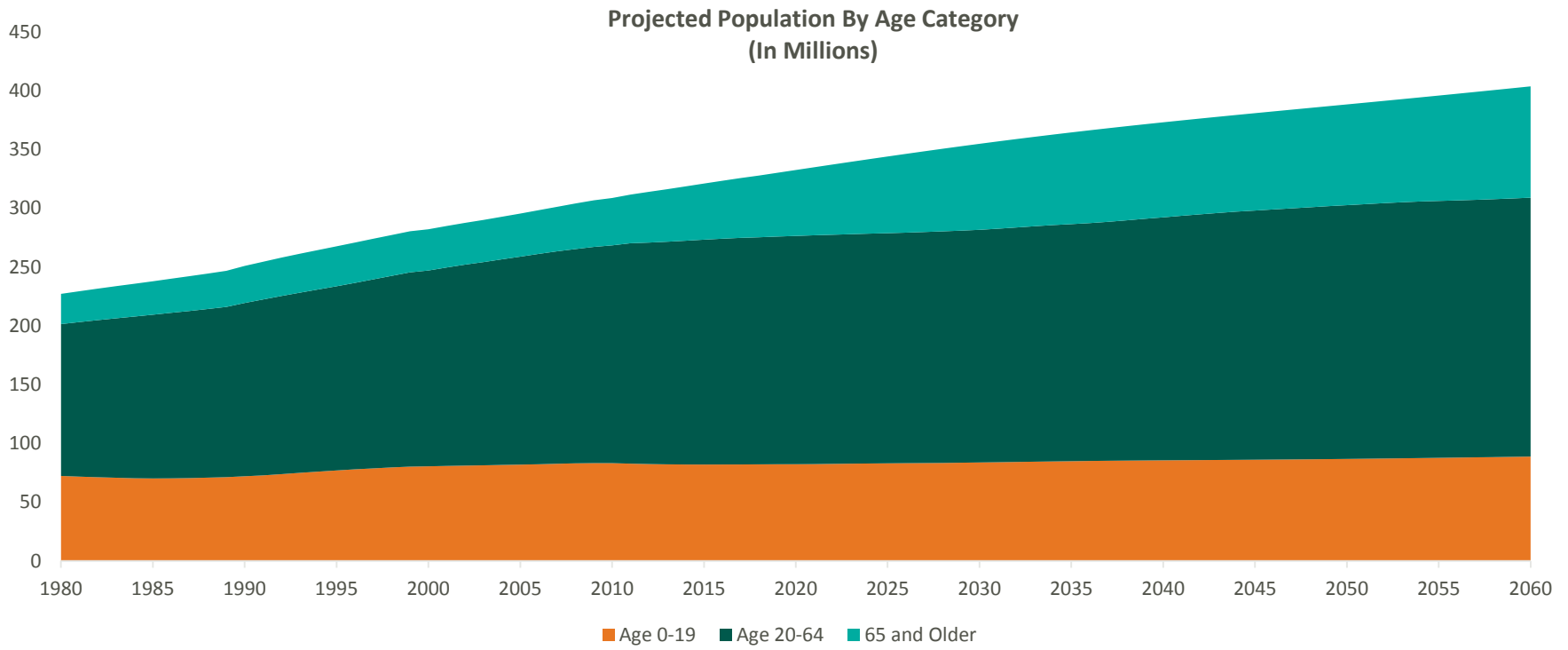


1. Medicare Enrollment Dashboard published by CMS
2. Medicaid & Children's Health Insurance Program ("CHIP") monthly applications, eligibility determinations, and enrollment report published by CMS
3. Healthcare Expenditure data published by CMS

Market Overview

Demographic Analysis

Presented in the chart below is a summary of the United States' historical and projected population by age category from 1980 to 2060 provided by the U.S. Census Bureau. As of 2017, there were approximately 50.8 million Americans (15.6% of the total population) 65 years of age or older. In addition, there are approximately 63.3 million Americans (19.5% of the total population) between the ages of 50 and 64 who will become eligible for Medicare over the next 10-15 years. Based on projections published by the U.S. Census Bureau, the total percentage of the United States' population over the age of 65 is projected to increase from 15.6% in 2017 to 19.7% by 2027 and 21.6% by 2037. The aging of the United States' population is projected to drive increased demand for a variety of healthcare services. However, the projected increase in the number of Medicare beneficiaries and the historical increases in spending per beneficiary is forcing policy makers to re-evaluate how Medicare pays for healthcare services.



Source: United States Census Bureau

Market Overview

Local Demographics

The Hospital is located in Palm Springs, California, which is in Riverside County. Recent population estimates indicate that the population of Riverside County increased 2.6% compounded annually, from approximately 1,558,985 residents in 2000 to approximately 2,423,266 residents in 2017. Approximately 13.9% of the population of Riverside County is over the age of 65 (Source: United States Census Bureau). According to the United States Department of Labor, the June unemployment rate for the Riverside-San Bernardino-Ontario, CA metropolitan statistical area ("MSA") was 4.7%. Furthermore, according to the Centers for Medicare and Medicaid Services, Riverside County had 352,217 people enrolled in Medicare.

In addition, the 2016 median household income of Riverside County, California, was $59,951, which is 10.0% lower than the 2016 California state median income of $66,637.

Population Estimates	1990	2000	2005	2010	2011	2012	2013	2014	2015	2016	2017
RIVERSIDE COUNTY	1,193,156	1,558,985	1,931,785	2,202,001	2,235,890	2,264,804	2,291,406	2,321,738	2,352,080	2,386,522	2,423,266
**CAGR since 1990*	*N/A*	*2.7%*	*3.3%*	*3.1%*	*3.0%*	*3.0%*	*2.9%*	*2.8%*	*2.8%*	*2.7%*	*2.7%*
**CAGR since 2000*		*N/A*	*4.4%*	*3.5%*	*3.3%*	*3.2%*	*3.0%*	*2.9%*	*2.8%*	*2.7%*	*2.6%*
**CAGR since 2010*				*N/A*	*1.5%*	*1.4%*	*1.3%*	*1.3%*	*1.3%*	*1.4%*	*1.4%*

**CAGR = Compounded annual growth rate.*

Source: U.S. Census Bureau Population Finder for RIVERSIDE COUNTY, CALIFORNIA

Population estimates are from July 1st of that year.

According to the United States Census Bureau, the top five industries in Riverside County are listed below:

- Educational services, and healthcare and social assistance (20.6%);
- Retail trade (13.0%);
- Arts, entertainment, and recreation, and accommodation and food services (11.4%)
- Professional, scientific, and management, and administrative and waste management services (10.2%); and,
- Manufacturing (8.9%).

Market Overview

Local Demographics

According to the United States Department of Labor Bureau of Labor Statistics, the April 2016 Metropolitan Area Occupational Employment and Wage Estimate relevant for the Hospital is detailed below:

SOC Code	Occupation Title	Employment(1)	Median Hourly	Mean Hourly	Mean Annual(2)	Mean RSE(3)
29-1141	Registered Nurses	27,720	$45.72	$46.88	$97,520	2.0%
29-2034	Radiologic Technologists	1,620	$34.19	$33.57	$69,820	2.0%
29-2061	Licensed Practical and Licensed Vocational Nurses	7,210	$23.11	$23.26	$48,390	1.9%
29-2071	Medical Records and Health Information Technicians	1,740	$19.24	$22.46	$46,720	3.1%
29-2099	Health Technologists and Technicians, All Other	2,760	$19.94	$20.32	$42,260	2.1%
31-1014	Nursing Assistants	7,120	$14.61	$15.87	$33,000	2.9%
31-9092	Medical Assistants	8,600	$14.31	$14.92	$31,040	1.4%
31-9093	Medical Equipment Preparers	540	$22.46	$22.57	$46,940	2.8%
31-9094	Medical Transcriptionists	310	$22.00	$21.12	$43,940	7.5%

(1) Estimates for detailed occupations do not sum to the totals because the totals include occupations not shown separately. Estimates do not include self-employed workers.

(2) Annual wages have been calculated by multiplying the hourly mean wage by a "year-round, full-time" hours figure of 2,080 hours; for those occupations where there is not an hourly mean wage published, the annual wage has been directly calculated from the reported survey data.

(3) The relative standard error (RSE) is a measure of the reliability of a survey statistic. The smaller the relative standard error, the more precise the estimate.

Overview of Hospital Types

Hospital is general term used to describe a facility which provides a wide variety of inpatient and outpatient healthcare services to patients. The most common hospital type is a general short term acute care hospital, however there are different types of general acute care hospitals and other specialty hospitals (rehabilitation, behavioral, long term, and children's). Most of the hospitals operate as part of a network of hospitals and outpatient facilities designed to provide comprehensive health services to patients within the community. Below is a brief description of the different types of hospitals.

- General Acute Care Hospitals – Also known as short terms hospitals, these hospitals provide a wide range of medical and surgical services including inpatient, intensive, trauma, neo-natal, cardiac, and other specialty care along with emergency diagnostic services. Care is intended to be on a short term basis with most hospital stays lasting three to six days. In addition, general acute care hospitals provide a wide range of outpatient services including surgery, physician services, primary care services, laboratory, diagnostic imaging, cardiology, and physical therapy among others. Outpatient services can be provided in hospital outpatient departments, freestanding facilities, or combination of the two. General acute care hospitals are generally separated into two categories: urban and rural hospitals. Urban hospitals tend to be larger as measured in terms of total revenue and number of beds. In addition, urban hospitals are more likely to have additional designations for trauma, cardiology, neurology, or other types of specialty emergency services. Of the almost 7,000 Medicare licensed hospitals as of 2017, 3,399 (49.2% of the total Medicare licensed hospital) were general acute care hospitals. This includes a segment of general acute care hospitals that specialize in one line of care such as surgery, cardiac care, or orthopedics.

- Critical Access Hospital – The "Critical Access Hospital" designation was created by the Balanced Budget Act of 1997 in response to a string of rural hospital closures. In order for a hospital to be classified as a Critical Access Hospital, it must meet the following requirements: the hospital must have 25 acute care inpatient beds or fewer, provide emergency care services 24/7, maintain an annual average length of stay of 96 hours or fewer, and be located at least 35 miles away from another hospital. The primary advantage of the Critical Access Hospital designation is that the provider is reimbursed on a cost-based methodology as opposed to a prospective payment system. In general, critical access hospitals can provide a limited range of services as compared to general acute care hospitals. Patients requiring intensive emergency or specialty care must be transferred to larger urban hospitals. In 2017, there were 1,346 Medicare licensed critical access hospitals (19.5% of the total Medicare licensed hospitals).

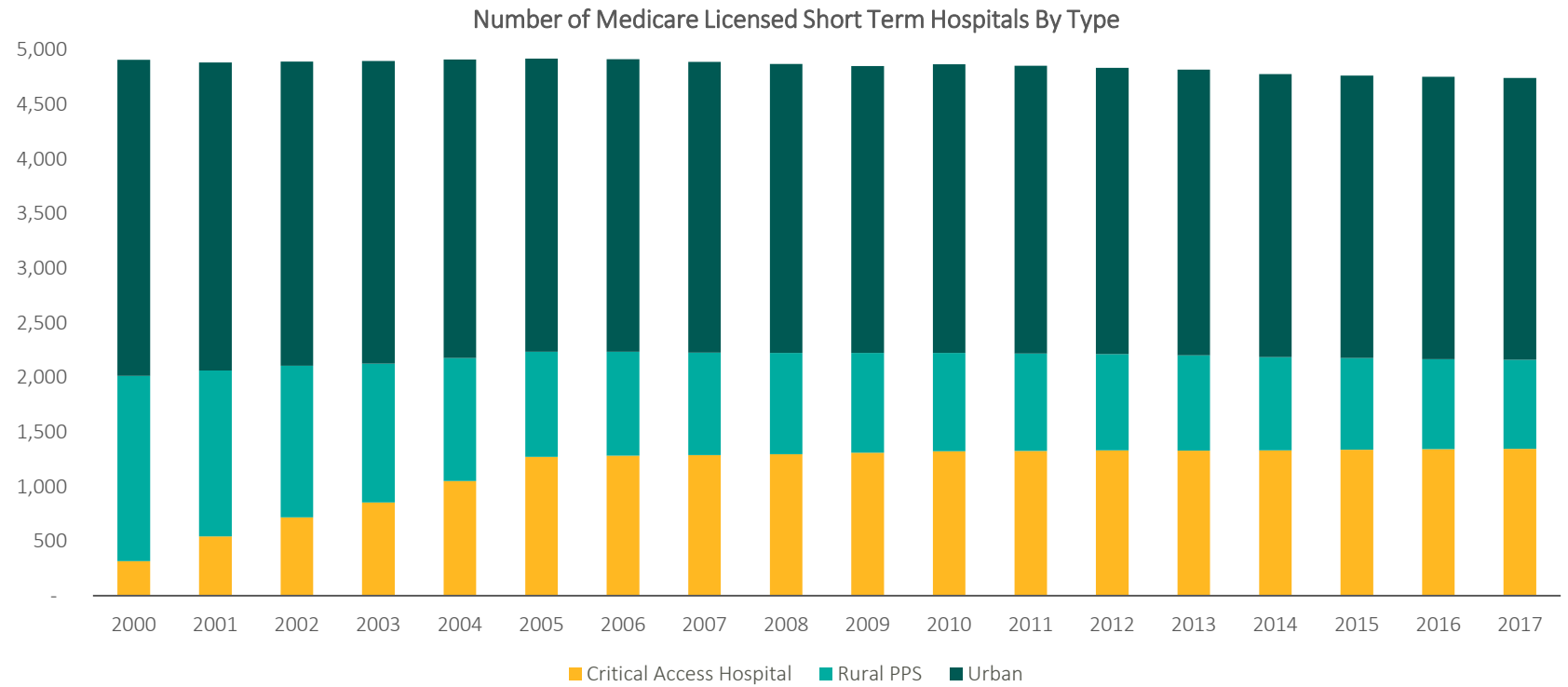
- Non-Participating Provider – A non-participating hospital accepts Medicare patients but does not agree to accept the Medicare approved amount as full payment. However, there are limits on the amounts that non-participating providers can charge for services. There are approximately 783 non-participating hospitals as of 2017 (11.3% of the total Medicare licensed hospitals). A majority of these hospitals are operated by the Department of Veteran Affairs or the Indian Health Service.

- Rehabilitation Hospital – Also known as an inpatient rehabilitation facility ("IRF"), is a specialized facility type focused on restoring patient's physical and cognitive abilities. Patients in these hospitals have significant physical and cognitive disabilities due to an array of medical conditions such as strokes, hip fractures, brain injuries, spinal cord injuries, orthopedic problems, neuromuscular disease, and debilitating neurological conditions. IRFs can operate as a freestanding hospital or a hospital within a hospital ("HIH"). A HIH is a facility which will lease space from a general acute care hospital and then operate as a separately licensed hospital, while freestanding IRFs operate independently. The majority of rehab hospital patients are transferred from general acute care hospitals. IRFs differ from general acute care hospitals in that their patients typically have a longer length of stay with conditions that require rehabilitative services on an inpatient basis. In addition, IRFs tend to have an older patient base as compared to acute care hospitals. CMS reimburses IRFs based on a separate fee schedule known as the IRF Prospective Payment System ("IRF PPS"). In order to be reimbursed under the IRF PPS, the facility must meet a number of criteria regarding the severity of patients that are admitted to the hospital. As of 2017 there were approximately 282 freestanding IRFs (4.1% of total the Medicare licensed hospitals).
- Behavioral Hospital – Specialize in the treatment of individuals with mental illness and behavioral issues. For behavioral hospitals, there are often different types of facilities that treat patients with different mental or behavioral problems. An acute inpatient psychiatric facility provides high levels of care to patients with mental illness. Sometimes these patients may be a harm to others or themselves, therefore, there is 24-hour monitoring and treatment by a psychiatrist. Special treatment facilities treat patients with specific or severe behavioral disorders, such as an eating disorder. These facilities classify and treat patients by severity of condition. Comprehensive treatment centers specialize in the use of medication and abstinent-based treatment. This treatment when combined with behavioral therapy are used to help patients with substance abuse problems and addiction. Residential treatment centers treat patients in a non-hospital setting. This includes social activities and outdoor programs, making these facilities less intensive and demanding. As of 2017 there were approximately 584 inpatient behavioral hospitals (8.5% of the total Medicare licensed hospitals).
- Long Term Acute Care Hospital ("LTACH") – These hospitals are designed to meet the needs of patients with serious medical problems that require a longer hospital stay and more focused medical treatment. The average patient stay at an LTACH is between 20-30 days. As with IRFs, LTACHs can operate as a HIH or freestanding facility. Both types of LTACHs receive their patients on referral from general acute care hospitals. These patients have serious and complex medical issues usually stemming from complex infectious disease, heart failure, respiratory failure, pulmonary disease, renal disease, trauma, or a complex surgery that requires a long recovery. As of 2017 there were approximately 411 LTACHs (6.0% of the total Medicare licensed hospitals).
- Children's Hospital – Focus on the care and treatment of children (this includes any patient from infancy to 18 years of age). All medical physicians working within the hospital have experience caring for children and all doctors are specially trained. As of 2017 there were approximately 98 children's hospitals (1.4% of the total Medicare licensed hospitals).

Market Overview

Total Medicare Licensed Facilities

Presented in the chart below is the number of Medicare licensed general acute care hospitals by type from 2000 to 2017, excluding specialty hospitals and nonparticipating providers as defined on the previous page. As of 2017, there were a total of 4,743 general acute care hospitals. Of the total licensed hospitals, approximately 54.4% were urban hospitals and 45.6% were rural hospitals. Rural hospitals are further segmented into rural hospital hospitals that bill under the prospective payment system (herein referred to as "Rural PPS" hospitals) and Critical Access Hospitals which are reimbursed on a cost basis. Overall, the total number of Medicare licensed hospitals has declined 0.2% compounded annually from 4,911 in 2000 to 4,743 in 2017. Over the same time period the number of urban hospitals declined 0.7% compounded annually while the number of rural hospitals increased 0.4% compounded annually. The number of critical access hospitals increased significantly from 2000 to 2006 as rural hospitals converted to the newly created critical access designation. It should be noted that multiple hospitals can be operated under a single Medicare certification.



Source: 2017 Medicare Provider of Services File

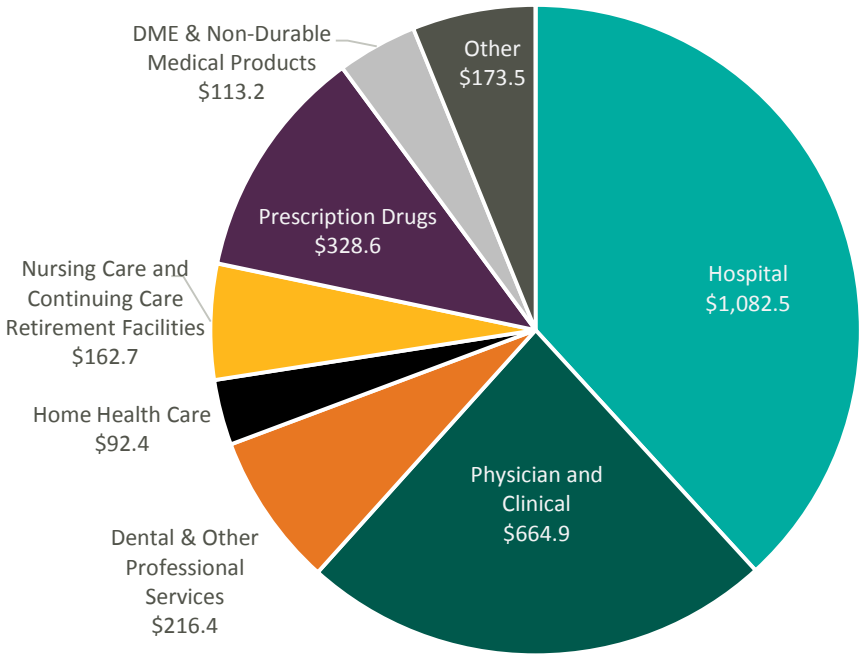
Market Overview

Analysis Of Total Hospital Spending

According to the national health expenditure data published by CMS, spending on hospital services accounted for the largest percentage of total personal health expenditures. Personal health expenditures represents health expenditures spent directly for patient care. During 2016 total expenditures on hospital services were approximately $1.1 trillion or approximately 38.2% of total national personal health expenditures. Total hospital spending has increased 4.7% compounded annually from $822.3 billion in 2010 to $1.1 trillion in 2016. The growth in hospital spending has accounted for a significant portion of growth in total national healthcare expenditures in recent years.

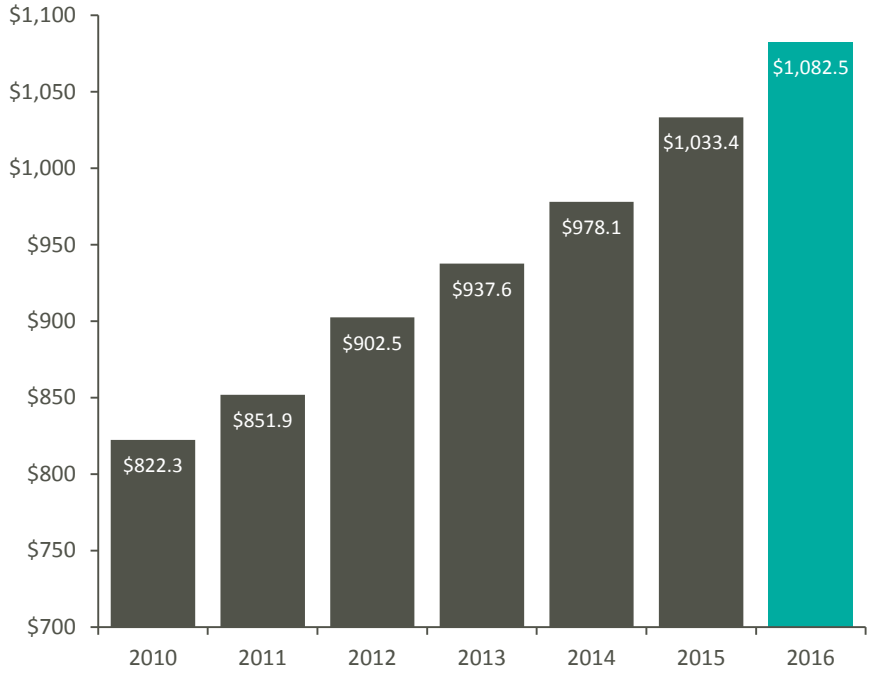
Personal Health Expenditures By Service (In Billions)

Total 2016 Expenditures: $2.8 Trillion



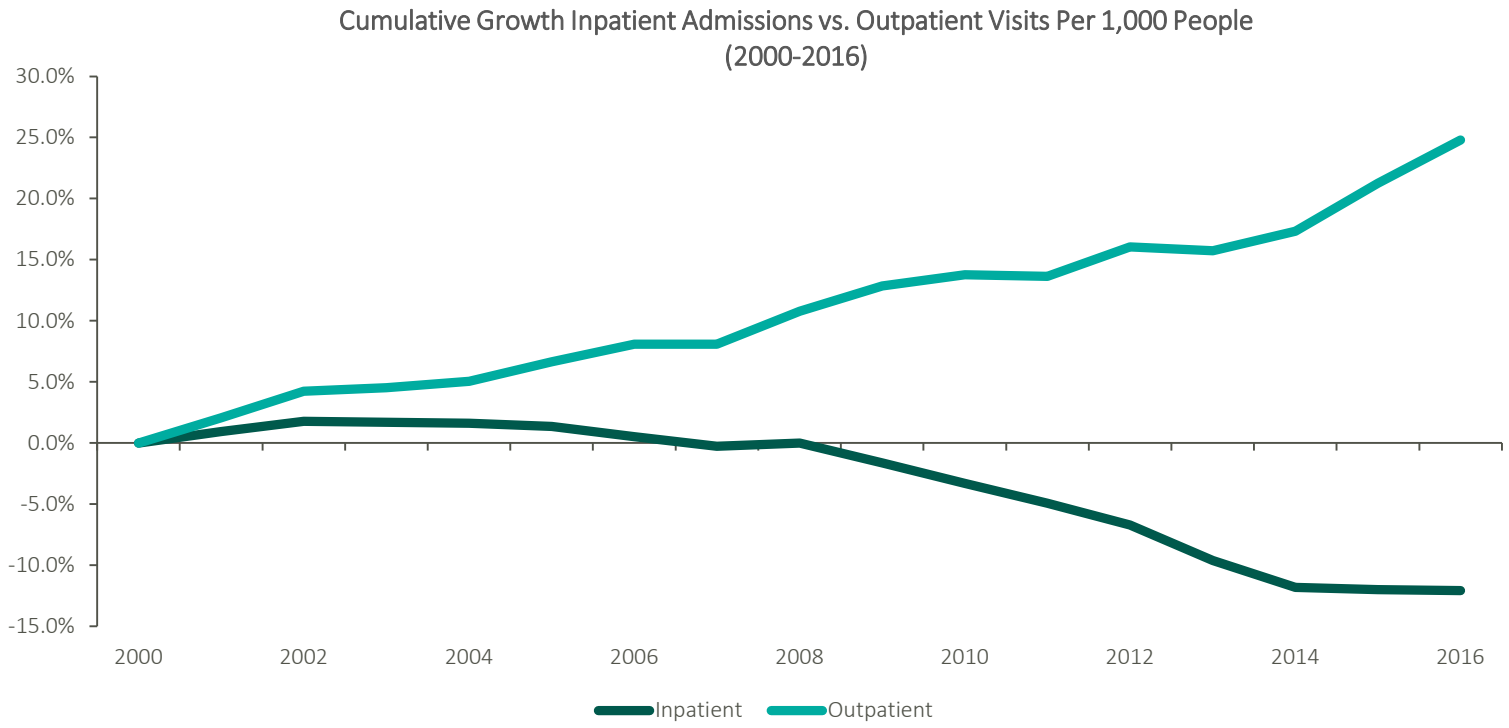
Growth in Hospital Spending (In Billions)

CAGR: 4.7%



Source: CMS

As mentioned previously, acute care hospitals provide a variety of inpatient and outpatient services. Presented in the chart below is the cumulative growth in inpatient admissions vs. outpatient visits per 1,000 people from 2000 to 2016 based on data published by the American Hospital Association. Since 2000, the number of inpatient admissions per 1,000 people has decreased 12.1% cumulatively. Over the same time period, the total number of outpatient visits per 1,000 individuals has increased 24.8% cumulatively from 2000 to 2016. These volume trends are the result of an increased migration of services from the inpatient setting to the outpatient setting due to technological advances and pressure from payors to reduce costs.

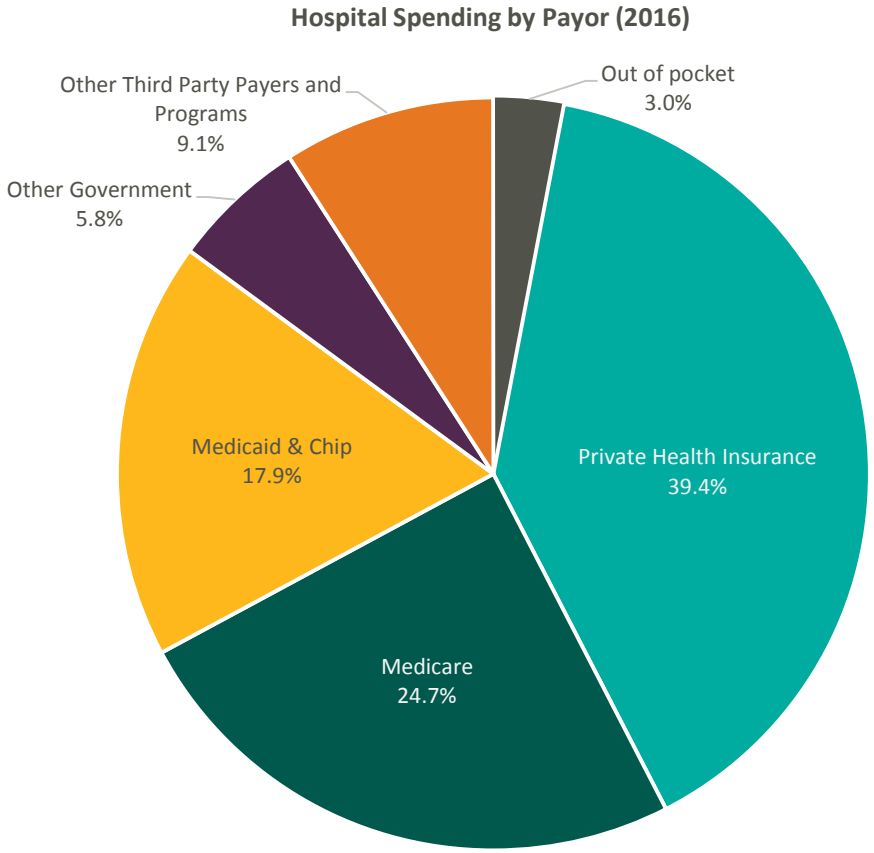


Source: American Hospital Association

Market Overview

Analysis Of Hospital Payor Mix

Presented in the chart below is the percentage of total hospital spending by payor for 2016 based on data published by CMS. As illustrated in the chart the below, hospital spending was comprised primarily of private health insurance, Medicare, and Medicaid which accounted for approximately 39.4%, 24.7%, and 17.9%, respectively of the total 2016 hospital spending. Payment rates from private health insurers are negotiated with the individual payors and typically are paid a predetermined rate per diagnosis, per-diem, discount of charges, or other contractual arrangements. The following pages give additional detail on the Medicare reimbursement methodology.



Source: CMS

Healthcare Overview

The Patient Protection and Accountable Care Act ("PPACA") and the Health Care and Education Reconciliation Act, signed into law on March 23, 2010, have significantly changed the way that healthcare services in the United States are covered, delivered, and reimbursed. The overall goal of this comprehensive legislation is to extend health coverage to millions of uninsured legal U.S. residents through a combination of private sector health insurance reforms and public program expansion. In order to fund the expansion of insurance coverage, PPACA contains measures designed to promote quality and cost efficiency in health care delivery in order to generate budgetary savings for the Medicare & Medicaid programs. The statutes and regulations of the PPACA have been the subject of various administrative appeals and lawsuits, however some of the key provisions of the legislation include:

Individual Mandate: The legislation contains an "Individual Mandate" which requires most Americans to maintain "minimum essential" health insurance coverage. Those that do not comply with the mandate will be required to make a "shared responsibility payment" to the federal government in the form of a tax penalty. The tax penalty for non-exempt individuals without health coverage in 2014 was the greater of 1.0% of income or $95 per individual and increased to 2.5% of income or $695 per individual in 2016. For individuals under the age of 18 the tax penalty is reduced 50%.

Health Exchanges: To assist individuals who are not exempt from the individual mandate and who do not receive health insurance through an employer or government program in obtaining insurance coverage, PPACA established health exchanges. Health exchanges are government regulated organizations which provide competitive markets for buying health insurance for individuals and small employers. Certain states have established their own health exchanges while other states have chosen to utilize the federal government's health insurance exchange. Individuals who purchase a plan through the exchange may be eligible for a premium credit or cost sharing subsidy.

Employer Mandate: The employer mandate provision of PPACA requires the imposition of penalties on employers with over 50 employees that do not offer affordable health insurance to employees working 30 or more hours per week. In February of 2014, the implementation of the employer mandate was delayed until January 1, 2016 for companies with 50 to 100 employees. For companies with more than 100 employees, the percentage of full-time workers required to be covered was reduced to 70% in 2014 & 2015. In 2016 and subsequent years employers with over 100 employees must offer health coverage to 95% of employees. Affordable health insurance is defined as premiums of no more than 9.5% of an employee's income and the employer must pay 60% of the actuarial value of a worker's coverage. Companies that fail to comply with the employer mandate can face fines of up to $2,000 for each employee not covered.

Medicaid Expansion: PPACA extended eligibility under Medicaid to almost all individuals under the age of 65 with incomes up to 138% of the Federal Poverty Limit ("FPL") beginning in 2014. Under PPACA the federal government will pay 100% of the cost of Medicaid expansion in 2014 through 2016. Federal funding will be reduced to 90% over the course of a four year period from 2017 through 2020 and will remain at 90.0% after 2021. Historically, the income levels for Medicaid eligibility were determined by the state and were typically around 106% of the FPL. Initially, PPACA required all states to expand Medicaid coverage or face possible reductions in existing funding for the Medicaid programs. However, the constitutionality of this mandate was challenged in September of 2011 in the court case of the National Federation of Independent Businesses vs. Sebelius (Secretary of the Department of HHS). The Supreme Court ruled that Congress had no authority to require the states to expand their respective Medicaid programs. Congress may offer grants to the individual states for expanding Medicaid coverage but existing Medicaid funding cannot be threatened. As a result of the ruling, the individual states were given the choice to expand Medicaid coverage. Please see the following page for additional detail on the states that elected to expand Medicaid and the resulting increase in enrollment.

PPACA also contains a number of provisions designed to improve the quality and efficiency of medical care provided to Medicare and Medicaid beneficiaries. These provisions include: the prohibition of Medicare or Medicaid funds from paying for the treatment of Hospital-Acquired Conditions ("HACs"); reductions in reimbursement for hospitals with excessive readmissions; creation of the Medicare value-based purchasing program; and the creation of the Center for Medicare & Medicaid Innovation to further explore potential hospital payment bundles.

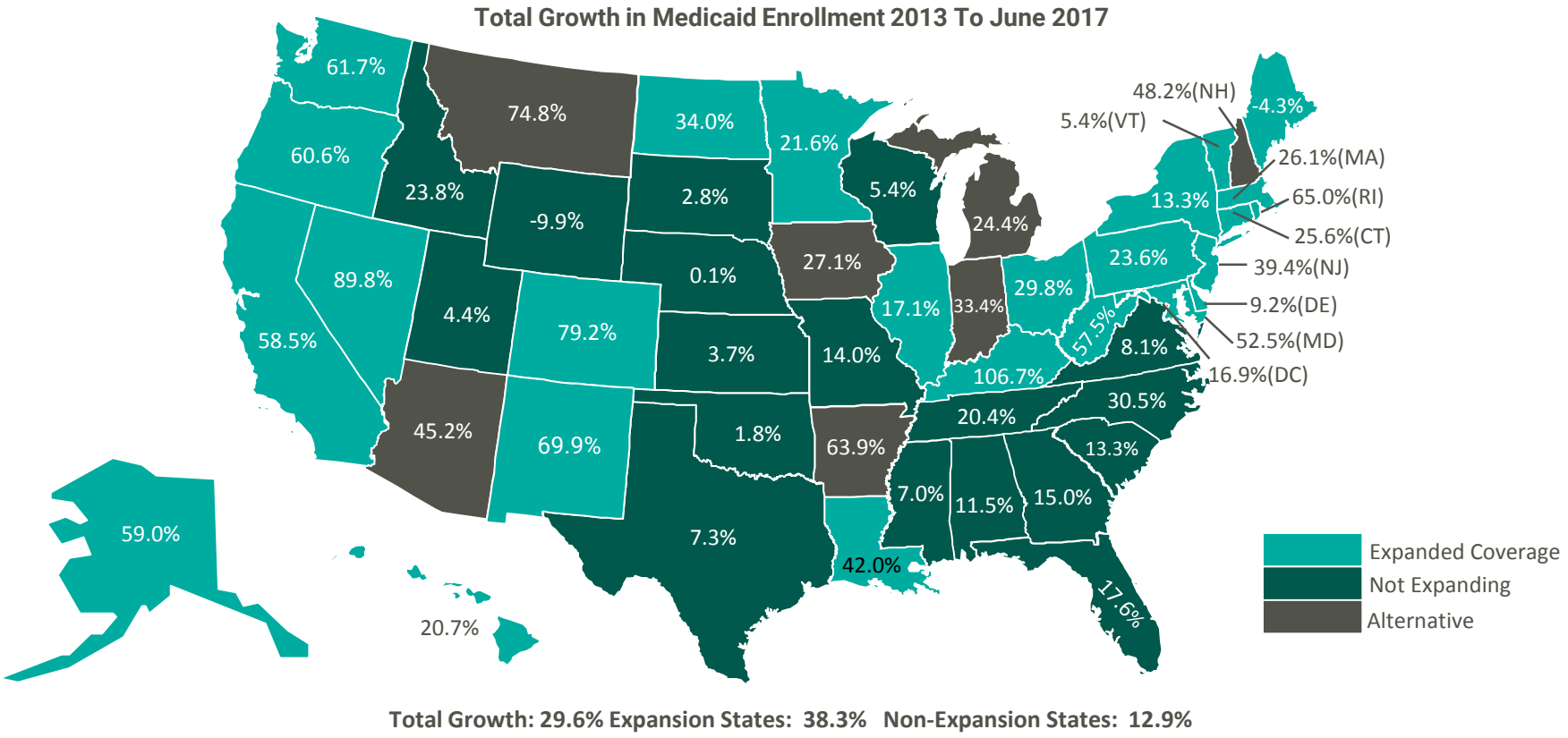
PPACA also establishes a number of additional health insurance reforms including:

- Establishes a minimum medical loss ratio of 85% for large group plans and 80% for small group plans.
- Health insurers may not establish lifetime or annual limits on the dollar value of benefits.
- May not rescind coverage of any enrollee except in instances of fraud.
- Health insurers must reimburse hospitals for emergency services provided to enrollees without the need for prior authorization and without regard to whether or not there is an existing contract with the provider.
- Extends dependent coverage until the age of 26

Market Overview

Healthcare Overview (Continued)

Presented in the chart below is the total growth in Medicaid enrollment by state from 2013 through June 2017. Medicaid enrollment in states that have chosen to expand Medicaid coverage has increased 38.3% from 2013 to 2017. Over the same time period, Medicaid enrollment in states that have not elected to expand Medicaid coverage has increased 12.9% from 2013 to 2017.



Total Growth: 29.6% Expansion States: 38.3% Non-Expansion States: 12.9%

Source: CMS Enrollment Report June 2017

PPACA also contains a number of provisions designed to reduce Medicare and Medicaid program spending. These provisions include negative adjustments to the annual inflation updates for the Medicare fee schedules and reductions to the Medicare and Medicaid Disproportionate Share Hospital Payments ("DSH"). Beginning in 2010, CMS has made negative adjustments to the annual market basket updates for Medicare's IPPS, OPPS, LTACH PPS, and IRF PPS fee schedules. Below is a summary of the proposed changes to the Medicare and Medicaid DSH programs:

Medicare DSH Payments: In addition to payments made under the inpatient prospective payment system for services provided directly to beneficiaries, Medicare makes payments to hospitals which treat a disproportionately high share of low-income patients. Prior to October 31, 2013, Medicare DSH payments were made based on statistical information defined by CMS and calculated as a percentage add-on to the MS-DRG payments. PPACA revised the DSH adjustment effective for discharges occurring on or after October 31, 2013. Under the revised methodology, hospitals will receive 25% of the amount they previously would have received under the pre-PPACA formula. This portion is referred to as the "Empirically Justified Payment".

Hospitals that qualify for the Empirically Justified Payment are also eligible to receive additional payments for uncompensated care, referred to as the "UC DSH Payment". The UC DSH payment comprises the remaining 75% of the total DSH payments that would have been paid under the historical formula. Each eligible hospital will receive a UC DSH payment based on its share of uninsured low income days (which is the sum of the Medicaid days and Medicare SSI days). The total UC DSH payments are calculated at 75% of DSH payments that would have been made under previous methodology and will be reduced annually by the percentage change in uninsured individuals under the age of 65.

Medicaid DSH Payments: In addition, CMS makes Medicaid DSH payments to states who then determine the methodology for distributing the payments to the individual hospitals. Federal law requires that state Medicaid programs make DSH payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. In the fiscal year 2016 Medicaid DSH payments totaled approximately $19.1 billion. PPACA called for reductions in Medicaid DSH payments beginning in 2014. However, the decision not to expand Medicaid coverage by certain states have resulted in several delays in the Medicaid DSH cuts. Most recently, The Bipartisan Budget Act of 2018 pushed Medicaid DSH reductions back to FY 2020. In FY 2020 Medicaid DSH payments are scheduled to be reduced by $4.0 billion increasing to $8.0 billion annually from FY 2020 to FY 2025.

Sources: MedPac and Medicaid & CHIP Payment and Access Commission

Medicare Payment Overview

Medicare payments for inpatient services are made per the Inpatient Prospective Payment System, known as (“IPPS”). Under the IPPS, hospitals are paid a pre-determined amount for each hospital discharge based on the patient’s diagnosis, called a Diagnosis Related Group (”DRG”). DRG payments are based on national averages and not on specific hospitals costs, but DRG payments are adjusted by a predetermined geographic adjustment factor assigned to the hospital’s locale. DRG rates are adjusted by an update factor each federal fiscal year, which begins October 1st. The index used to adjust the DRG rates is referred to as the market basket index. This index gives consideration to the inflation experienced by hospitals in purchasing its required goods and services.

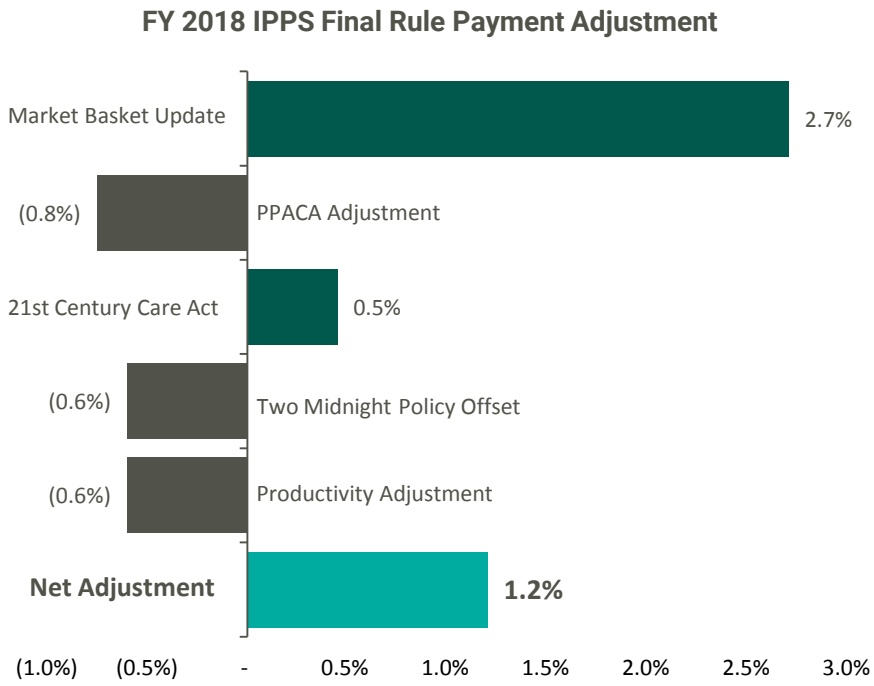
The majority of hospital outpatient services furnished to patients are paid by Medicare through the Outpatient Prospective Payment System (“OPPS”). These outpatient services are classified into Ambulatory Payment Classifications (“APCs”). A patient may be assigned into a single or multiple APCs depending on the service ordered during the patient encounter. Medicare pays a set price for each group, regardless of the actual costs incurred in providing care. Medicare sets the payment rate for each APC based on historical median cost data and adjusts the payment for geographic location. Similar to the payments based on DRGs, APC payments are updated each federal fiscal year based on the market basket index. The following services are paid based on other fee schedules established by Medicare: physical, occupational and speech therapy; durable medical equipment; diagnostic laboratory services; and services at freestanding surgical centers and diagnostic facilities.

CMS adopted a final rule on August 22, 2007 that established Medicare Severity DRGs (“MS-DRGs”). The rule’s goal was to refine the DRG weighting system to fully capture differences in severity of illness among patients, replacing 538 DRGs with 745 MS-DRGs. The switch to the MS-DRG system was intended to be budget neutral in that total Medicare payments to hospitals should not increase or decrease solely due to changes in documentation and coding practices. In order to ensure that improvements in coding and documentation do not lead to an increase in aggregate payments without a corresponding growth in patient severity, CMS will initiate a negative coding adjustment every fiscal year.

IPPS FY 2018 Final Rule

On August 2, 2017 the Centers for Medicare and Medicaid Services released the Inpatient Prospective Payment System fiscal year (FY) 2018 final rule which called for a **1.2% increase** in hospital operating payments for hospitals reporting all quality metrics. The increase is slightly below the proposed increase of 1.6%. The increase is the result of the following adjustments:

- Market Basket Update (Inflation) – The hospital market basket update for FY 2018 of positive 2.7%.
- PPACA Reduction – The ACA mandated reduction for FY 2018 of negative 0.8%.
- 21st Century Care Act – One time increase mandated by 21st Century Care Act of positive 0.5%
- Two-Midnight Policy Offset – One time adjustment to offset the previous increase related to Two-Midnight Rule of negative 0.6%.
- Productivity Adjustment – The productivity adjustment for FY 2018 of negative 0.6%.



Changes to DSH Payments

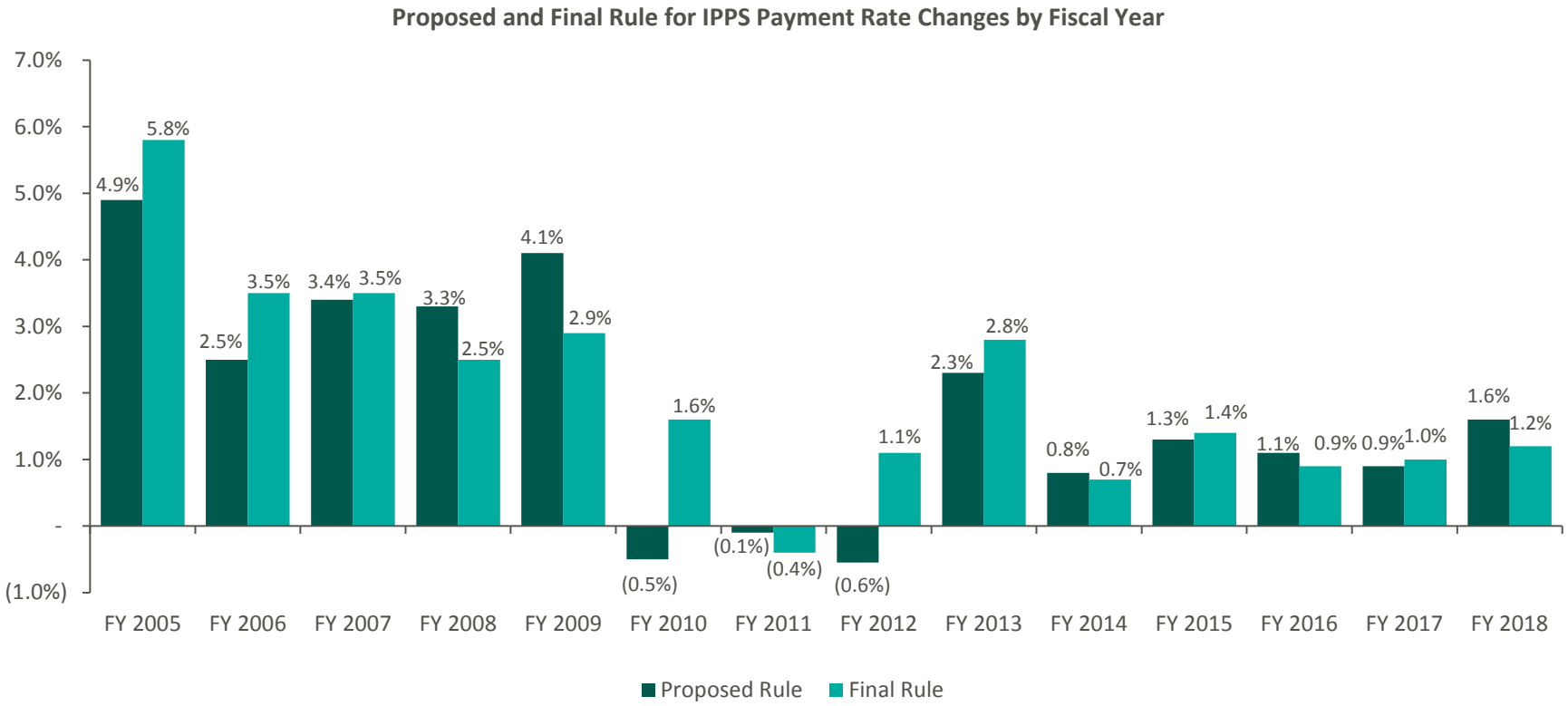
Medicare is making two changes to the calculation for uncompensated care payments to DSH hospitals. First, CMS finalized the proposal to incorporate data from the National Health Expenditure Accounts into its estimate of the percentage change in the rate of uninsurance. The percentage change in the rate of uninsurance is utilized in calculating the total amount of uncompensated care payments available to be distributed. In addition, CMS will incorporate uncompensated care cost data from worksheet S-10 of the FY 2014 cost reports, in combination with the Medicare and Medicaid low income days, to determine the distribution of uncompensated care payments to individual hospitals.

Based on these changes, CMS estimates that it will distribute roughly $6.8 billion in uncompensated care payments in FY 2018, an increase of approximately $800 million from FY 2017. As required by the ACA and subsequent legislation, this amount is equal to 75% of what otherwise would have been paid as Medicare DSH payments under the original formula, adjusted for the change in uninsured individuals and other factors.

Sources: CMS FY 2018 IPPS Final Rule Fact Sheet

Historical IPPS Reimbursement

Presented in the chart below are the net proposed and final IPPS payment increases for the past thirteen years. Since FY 2010 the average annual payment increase has been approximately 1.1% which is below the average annual increase for the five prior years of 3.6%. The decrease in the annual updates is primarily due to the productivity adjustment mandated by the PPACA and the documentation and coding adjustment mandated by the American Taxpayer Relief Act. It should be noted that payment increases presented below do not reflect any DSH or outlier payment adjustments.



Source: CMS Proposed and Final Rule Factsheets

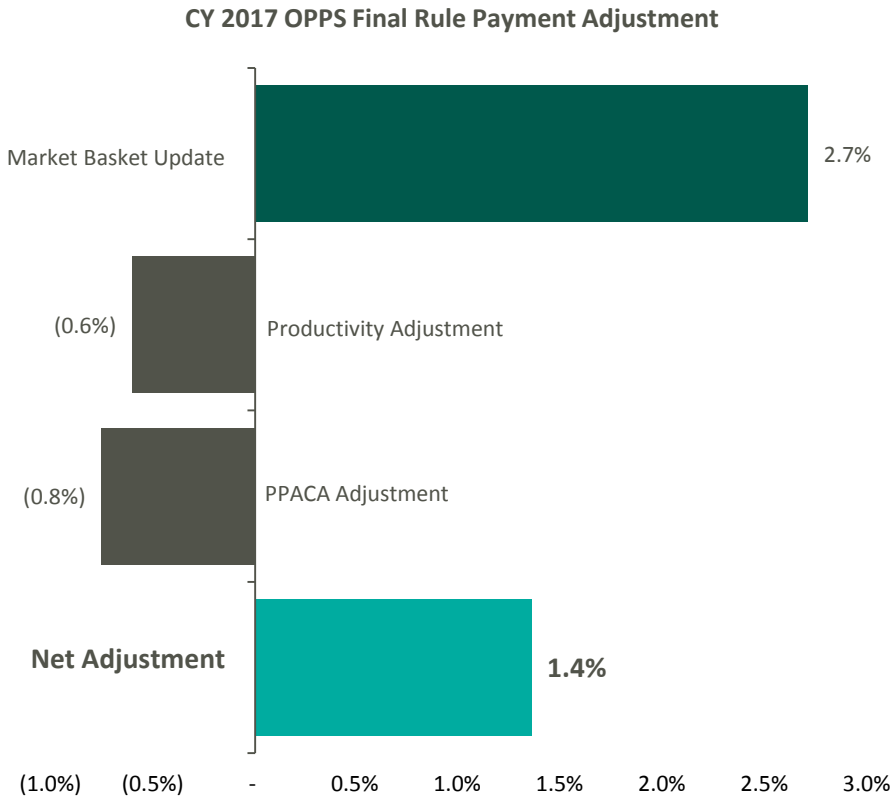
OPPS CY 2017 Final Rule

On November 1, 2016, CMS released the CY 2017 OPPS final payment update which resulted in an **increase of 1.4%** for hospital outpatient departments ("HOPDs"). The increase is the result of the following adjustments:

- Inflation Update – The OPPS market basket update for CY 2017 is positive 2.7%.
- Productivity Adjustment – The multi-factor productivity adjustment for CY 2017 is negative 0.6%.
- PPACA Reduction – The PPACA mandated reduction for CY 2017 is negative 0.8%.

Other miscellaneous payment provisions from the CY 2017 ruling include:

- Certain provider-based departments that started billing under the OPPS on and/or after November 2, 2015 will no longer be paid for most services under the OPPS. On January 1, 2017 these facilities will be reimbursed at a site neutral rate. Services provided in a dedicated emergency department will continue to be paid under the OPPS.



Sources: CMS CY 2017 OPPS Final Rule Fact Sheet

Desert Regional Medical Center

HISTORICAL OPERATIONS ANALYSIS

Executive Summary

Selected Financial Data

Selected Financial Data	FYE 2015	FYE 2016	FYE 2017	TTM 2018
Total Net Operating Revenue	491,063,987	549,132,545	538,194,797	562,925,293
Operating Expenses	367,253,350	423,350,259	426,119,146	429,861,588
EBITDA	123,810,637	125,782,286	112,075,651	133,063,705
Earnings before Taxes	109,090,945	110,351,215	95,837,470	117,226,839
Percentage of Net Revenue:				
Operating Expenses	74.8%	77.1%	79.2%	76.4%
EBITDA	25.2%	22.9%	20.8%	23.6%
Earnings before Taxes	22.2%	20.1%	17.8%	20.8%

The summary above presents certain operating results for FYE 2015, 2016, 2017, and TTM 2018. Net operating revenue increased 5.8% compounded annually, from approximately $491.1 million in FYE 2015 to approximately $562.9 million in TTM 2018. More recently, net operating revenue increased 4.6%, from approximately $538.2 million in FYE 2017 to approximately $562.9 million in TTM 2018.

Operating expenses increased 6.7% compounded annually, from approximately $367.3 million in FYE 2015 to approximately $429.9 million in TTM 2018. More recently, operating expenses increased 0.9%, from approximately $426.1 million in FYE 2017 to approximately $429.9 million in TTM 2018.

As a result of the operating expenses growth rate exceeding the net operating revenues growth rate, EBITDA as a percentage of net revenue decreased from approximately 25.2% in FYE 2015 to 23.6% in TTM 2018.

Note: Detailed Income Statement can be found in the Appendix.

Income Statement Analysis – FYE 2017 vs. TTM 2018

Net Operating Revenue:

Net operating revenue increased 4.6%, from approximately $538.2 million in FYE 2017 to approximately $562.9 million in TTM 2018. The increase in net operating revenue is detailed below:

- Total Net Patient Revenue increased 1.5%, from approximately $484.1 million in FYE 2017 to approximately $491.3 million in TTM 2018;
- Total Supplemental Payments increased 34.1% from approximately $53.3 million in FYE 2017 to approximately $71.5 million in TTM 2018.

Operating Expenses:

Operating expenses increased 0.9%, from approximately $426.1 million in FYE 2017 to approximately $429.9 million in TTM 2018. The Hospital's operating expenses as a percentage of net operating revenue fluctuated as follows:

- Employee salaries & wages expense for TTM 2018 was 33.2% of net operating revenue (below 34.8% in FYE 2017);
- Employee benefits expense for TTM 2018 was 9.1% of net operating revenue (below 9.5% in FYE 2017);
- Occupancy costs for TTM 2018 were 1.0% of net operating revenue (same as in FYE 2017);
- Drugs & medical supplies expense for TTM 2018 was 13.6% of net operating revenue (below 14.0% in FYE 2017);
- Other medical costs for TTM 2018 were 6.7% of net operating revenue (above 6.6% in FYE 2017);
- Insurance expense for TTM 2018 was 1.2% of net operating revenue (below to 1.4% in FYE 2017); and,
- General & administrative expenses for TTM 2018 were 11.6% of net operating revenue (below 12.0% in FYE 2017).

As a result of the higher increase in net operating revenue compared to the slight increase in operating expenses as a percentage of net operating revenue, the Hospital's EBITDA margin increased from 20.8% in FYE 2017 to 23.6% in TTM 2018.

Executive Summary

Volume Analysis

Total Hospital Volume:	FYE 2015	FYE 2016	FYE 2017	TTM 2018
Utilization Statistics:				
Admissions	19,738	20,184	19,650	19,694
Growth		2.3%	(2.6%)	0.2%
Adjusted Admissions	28,041	28,740	28,669	28,622
Growth		2.5%	(0.2%)	(0.2%)
Patient Days	88,855	97,083	92,724	92,271
Growth		9.3%	(4.5%)	(0.5%)
Adjusted Patient Days	126,233	138,239	135,282	134,100
Growth		9.5%	(2.1%)	(0.9%)
Outpatient Visits	159,534	164,406	168,102	167,037
Growth		3.1%	2.2%	(0.6%)
Census Data:				
Average Daily Census	243.44	265.25	254.04	252.80
Other Key Statistics:				
Case Mix Index	n/a	1.57	1.54	1.61

Illustrated above are the Hospital's volume statistics for FYE 2015, 2016, 2017, and TTM 2018. The Hospital's admissions remained relatively constant compounded annually from 19,738 in FYE 2015 to 19,694 in TTM 2018. More recently, the Hospital's admissions increased 0.2% from 19,650 in FYE 2017 to 19,694 in FYE 2017.

The Hospital's patient days increased 1.6% compounded annually from 88,855 in FYE 2015 to 92,271 in TTM 2018. More recently, patient days decreased 0.5% from 92,724 in FYE 2017 to 92,271 in TTM 2018.

Executive Summary

Staffing Analysis

Historical Staffing Summary	FYE 2015	FYE 2016	FYE 2017	TTM 2018
Hospital Employed FTEs	1,720	1,976	1,951	1,933
Growth		14.9%	(1.3%)	(0.9%)
Paid Hours	3,577,600	4,110,080	4,058,080	4,020,640
Growth		14.9%	(1.3%)	(0.9%)
Paid Hours per Adjusted Patient Day	28.3	29.7	30.0	30.0
Growth		4.9%	0.9%	(0.0%)
FTEs per Adjusted Occupied Bed	5.0	5.2	5.3	5.3
Growh		5.2%	0.6%	(0.0%)
Average Hourly Salary per FTE	$45.14	$46.39	$46.13	$46.49
Growth		2.8%	(0.6%)	0.8%
Average Hourly Benefits per FTE	$12.34	$12.09	$12.54	$12.75
Growth		(2.1%)	3.7%	1.7%

As shown above, the Hospital's staff currently consists of approximately 1,933 full-time equivalent ("FTE") employees as of TTM 2018, a 0.9% decrease from 1,951 employees in FYE 2017.

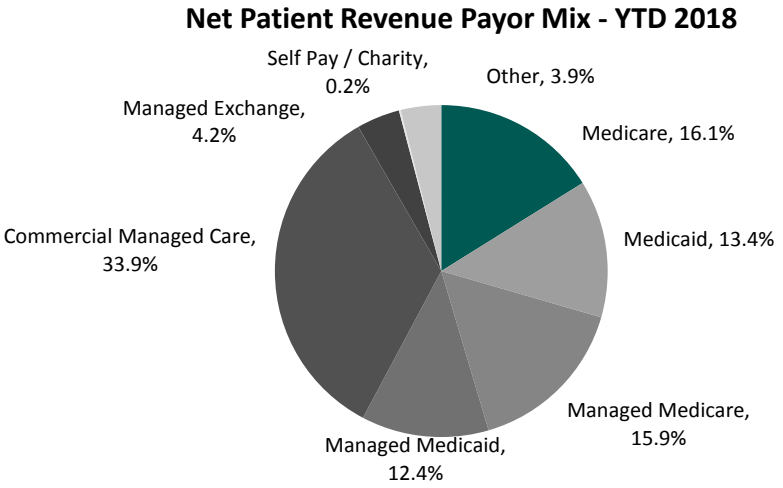
The average hourly salary per FTE was approximately $46.49 during TTM 2018, which represented a 0.8% increase over the FYE 2017 average hourly salary per FTE of approximately $46.13. The average FTE per adjusted occupied bed was 5.3 in TTM 2018.

Historical Operations Analysis

Payor Mix Analysis

Historical Payor Mix Expressed as % of Net Patient Revenue	FYE 2015	FYE 2016	FYE 2017	YTD 2018
Medicare	14.2%	14.5%	15.7%	16.1%
Medicaid	14.0%	12.7%	14.1%	13.4%
Managed Medicare	15.6%	16.9%	17.3%	15.9%
Managed Medicaid	12.7%	13.7%	13.5%	12.4%
Commercial Managed Care	31.7%	34.0%	30.5%	33.9%
Managed Exchange	4.9%	4.0%	4.3%	4.2%
Self Pay / Charity	1.3%	1.4%	1.3%	0.2%
Other	5.7%	2.9%	3.4%	3.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: Hospital's payor mix report which is reported in terms of net patient revenue.



Illustrated above is the Hospital's payor mix based on net collections for FYE 2015, 2016, 2017, and YTD 2018. During YTD 2018, the largest payors as a percentage of net collections were Commercial Managed Care (33.9%) and Medicare (16.1%). Other payors include Managed Medicare (15.9%) and Medicaid (13.4%).

Desert Regional Medical Center

Valuation Overview

IRS Revenue Ruling 59-60 is a landmark ruling by the IRS that provides general guidelines for the valuation of closely held companies. We define FMV as established by IRS Revenue Ruling 59-60 as "the amount at which property would change hands between a willing seller and a willing buyer when neither is acting under compulsion and when both have reasonable knowledge of all relevant facts and circumstances." IRS Revenue Ruling 59-60 calls for examination of the following elements in connection with the subject Hospital:

- The nature and history of the Hospital from inception;
- The economic outlook in general and the outlook for the specific specialty area and market area of the Hospital;
- The financial condition of the Hospital;
- The earning capacity of the Hospital;
- The dividend paying capacity of the Hospital;
- The goodwill or other intangible value of the Hospital;
- Prior sales of the stock and the size of the block of stock to be valued; and,
- The market prices of Hospitals in the same or similar specialty areas.

In light of the general guidelines set forth in IRS Revenue Ruling 59-60, VMG's investigation and analysis includes the following:

- Interviews with management concerning past, present and prospective operating results of the Hospital;
- Analysis of the financial condition and historical operating and financial performance of the Hospital;
- Consideration of the economic outlook in general and the outlook for the specific specialty area and market area of the Hospital;
- With the assistance of Hospital personnel, our analysis estimates the earning and dividend paying capacity of the Hospital; and,
- Consideration of the Cost, Market, and Income Approaches to value.

As discussed, we have considered the use of the Cost, Market and Income Approaches to value. The following briefly describes each approach:

- Cost Approach - estimates the cost to recreate a business;
- Market Approach - estimates value by examining the value of similar businesses in a free and open market; and,
- Income Approach - estimates value by projecting a future income stream attributable to a business and then discounts those earnings back to present value.

Each approach is suitable in different situations. The subsequent sections of this report provide the benefits and challenges of using the three approaches.

Valuation Overview

Selection of the Income Approach

While we have considered the use of each approach to value, we have relied on the Income Approach to value the Hospital. Unlike the Cost and Market Approach, the Income Approach evaluates the future economic income stream that is specific to the Hospital. In determining the applicability of the Cost or Market Approach, we considered the following difficulties:

- Cost Approach
  - The book value of the Hospital's identified tangible assets may not reflect market value.
  - Does not consider the going-concern, goodwill, or other intangible value of the Hospital.

- Market Approach
  - Similar publicly traded companies have diversified business lines and are not "pure play" acute care hospital operators and are not comparable to the Subject Hospital from a size or growth standpoint.
  - Many of the private transactions involve hospitals with low or negative profitability. Additionally, there are very few transaction observations involving California Hospitals which have a similar dependence on the revenue generated through the Hospital Quality Assurance Fee program.

It should be noted that Market Approach results were considered in the determination of the selected value indication as the results support the Income Approach.

The following sections discuss in more detail the application of the Cost, Market, and Income Approaches to the Hospital.

Desert Regional Medical Center

Cost Approach

Cost Approach

General Assumptions

The Cost Approach, also known as the asset or build-up approach, is a method that attempts to value a business by identifying and valuing each tangible and intangible asset. The valuation premise used in this method may be one of the following:

- Value in continued use as part of a going concern;
- Value in place as part of a mass assemblage of assets;
- Value in exchange as part of an orderly disposition or forced liquidation.

The Cost Approach can be considered to provide a "floor" or lowest minimum value related to a business. This method may be an appropriate method when the Market Approach and Income Approach produce a value lower than the Cost Approach. In determining the applicability of the Cost Approach, we must also consider the earnings generated by the business as indicated in its historical and projected financial statements.

Under this approach, the identified tangible and intangible assets are valued based on the cost associated with "recreating" each asset. The asset components are examined and the related valuation assumptions for each are noted in the appendix.

Identified Tangible Assets:

Non Cash Net Working Capital - We have determined the normalized net working capital excluding cash to be 26.6% of net operating revenue, or approximately $43.5 million.

Net Fixed Assets – The value of net fixed assets was determined to be $93.1 million based on either the balance sheet as of May 31, 2018, or a fair market value analysis as of May 31, 2018.

As a result, the BEV of the Hospital under the cost approach is estimated at approximately $136.6 million. VMG has **not relied upon** the value indication produced by the Cost Approach as the book value of the Hospital's identified tangible assets does not consider the going-concern, goodwill, or other intangible value of the Hospital.

Desert Regional Medical Center

Market Approach

Market Approach

General Assumptions

The Market Approach estimates value by comparing the subject entity to similar businesses, business ownership interests, securities, or other assets that have been purchased or sold. The underlying premise of the Market Approach to valuation is the economic principle of substitution— assets of similar utility should have similar relative value. The Market Approach relies on observable market data to estimate indications of value. Appropriate market comparisons can provide some evidence of the value of a business or a business interest. The Market Approach uses relative value measures called "multiples" where selected fundamental financial or operational variables (typically revenue and/or EBITDA) are multiplied to derive a value indication.

In our application of the Market Approach, we considered two distinct methods: the Guideline Public Company Method ("GPCM") and the Merger & Acquisition Method ("M&A Method"). These methods are summarized below and discussed in greater detail on the following pages.

- **Guideline Public Company Method:** is a method whereby market multiples are derived from the market prices of stocks of companies that are engaged in the same or similar lines of business and actively traded on a free and open public market. Market multiples are developed by dividing the value of a publicly traded company's stock or invested capital by a financial measure, such as revenue, EBITDA or net income—these multiples provide an indication of how much a knowledgeable investor in the marketplace is willing to pay for an ownership interest in a company. The selected market multiples are then applied to the financial measure of the subject to provide a value indication. The selected guideline public companies should be similar to the subject business in terms of industry, product, market, growth and risk.

- **Merger & Acquisition Method:** is a method whereby pricing multiples are derived from transactions of ownership interests in companies engaged in the same or similar lines of business. This method reviews published data regarding actual transactions in either publicly traded or privately held companies. Similar to the GPCM, market multiples are developed by dividing the TIC paid by the seller by the financial metrics of the target company. In judging whether a reasonable basis for comparison exists, consideration must be given to certain factors, such as the similarity of ownership interest acquired, investor characteristics, the extent to which reliable data is known about the selected transactions (i.e. ownership interest acquired, consideration paid, and target company financial information) and whether the price paid for the guideline companies was negotiated at an arms-length transaction and not forced/distressed sale.

Source: The Market Approach to Valuing a Business – Second Edition by Shannon Pratt

Market Approach

Guideline Public Company Method

The GPCM derives a value for the subject company by applying the observed market multiples for similar publicly traded companies. These similar companies are referred to as “guideline” companies. The TIC for the guideline companies is estimated by adding the market value of firm’s equity plus the book value of the firm’s outstanding debt, non-controlling interest, and preferred equity. Non-controlling interests (“NCI”) represent the estimated value of the minority shareholders ownership interest in the firm’s consolidated businesses. It is common for healthcare guideline companies to operate facilities in partnership with third parties including physicians and non-profit health systems. In this case, the entities' consolidated financial statements include 100% of the assets, liabilities, revenue and expenses of the facilities in which the guideline companies have sufficient ownership and rights to assert “significant influence” over the facility operations as defined by accounting standards. The value of the NCI is recorded on the balance sheets of the guideline companies at the fair value at the time of acquisition adjusted annually by net income attributable to the NCI less distributions to the NCI.

The BEV value indication derived for the guideline companies are then divided by the firm’s consolidated revenue and EBITDA to derive applicable market multiples for the subject entity. It should be noted that consolidated EBITDA has been adjusted to account for the earnings in unconsolidated affiliates (i.e. partnerships of the guideline company which are accounted for under the equity method of accounting). Based on the publicly available financial statements for the guideline companies, VMG is unable to adjust the consolidated revenue to account for the unconsolidated affiliates. Since the TIC value indications presented for the guideline companies include the estimated equity values of NCI, VMG has not reduced the consolidated EBITDA by the net income attributable to NCI.

In order to utilize this approach, similar businesses must be identified that have publicly available data. When selecting guideline companies, several factors are considered, including but not limited to the following:

- Similarity of services offered by the subject company;
- Size of the subject company, in terms of revenue, assets, number of operating locations, etc.;
- Product/service line diversification;
- Geographic diversification;
- Profitability of the company;
- Capital structure;
- Historical and prospective growth rates of the company; and
- Financial risk of the company.

Please see the following pages for a description of companies considered for the GPCM.

Market Approach

Guideline Public Company Method

Public Company Comparables

A variety of public companies specialize in the ownership and operation of acute care hospitals. The companies we have identified are traded on the NYSE and NASDAQ. We have provided a brief description of the companies below.

- **Community Health Systems, Inc. (CYH):** Community Health Systems, Inc., together with its subsidiaries, owns, leases, and operates general acute care hospitals in the United States. It offers general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric, and rehabilitation services, as well as skilled nursing and home care services. The company also provides outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers, and home health and hospice agencies. As of December 31, 2016, it owned or leased 155 hospitals, including 152 general acute care hospitals and 3 stand-alone rehabilitation or psychiatric hospitals with an aggregate of 26,222 licensed beds in 21 states. The company was founded in 1985 and is headquartered in Franklin, Tennessee.
- **HCA Healthcare, Inc. (HCA):** HCA Healthcare, Inc., through its subsidiaries, provides health care services in the United States and England. The company operates general, acute care hospitals that offer medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic, and emergency services; and outpatient services, such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology, and physical therapy services. It also operates psychiatric hospitals, which provide therapeutic programs comprising child, adolescent and adult psychiatric care, and adolescent and adult alcohol and drug abuse treatment and counseling. In addition, the company operates outpatient health care facilities consisting of freestanding ambulatory surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, rehabilitation and physical therapy centers, radiation and oncology therapy centers, physician practices, and various other facilities. As of December 31, 2016, it operated 166 general, acute care hospitals with 43,778 licensed beds; 3 psychiatric hospitals with 412 licensed beds; and 1 rehabilitation hospital, as well as 118 freestanding surgery centers. The company was formerly known as HCA Holdings, Inc. HCA Healthcare, Inc. was founded in 1968 and is headquartered in Nashville, Tennessee.
- **Quorum Health Corporation (QHC):** Quorum Health Corporation provides hospital and outpatient healthcare services in the United States. Its general hospital and outpatient healthcare services include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetric, diagnostic, psychiatric, and rehabilitation services. Quorum Health Corporation offers its healthcare services through its hospitals and affiliated facilities, including urgent care centers, diagnostic and imaging centers, physician clinics, and surgery centers. The company, through its subsidiary, Quorum Health Resources, LLC, provides management advisory and consulting services to non-affiliated hospitals. As of December 31, 2016, it owned or leased 36 hospitals with an aggregate of approximately 3,459 licensed beds in 16 states. The company was incorporated in 2015 and is headquartered in Brentwood, Tennessee.

Source: S&P Capital IQ, www.capitaliq.com

Market Approach

Guideline Public Company Method

- **LifePoint Health, Inc. (LPNT):** LifePoint Health, Inc., through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in the United States. Its hospitals offer a range of medical and surgical services, such as general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation, and pediatric services, as well as specialized services, including open-heart surgery, skilled nursing, psychiatric care, and neuro-surgery. The company's hospitals also provide various outpatient services comprising same-day surgery, laboratory, X-ray, respiratory therapy, imaging, sports medicine, and lithotripsy. In addition, it owns and operates schools of nursing and other allied health professions. As of December 31, 2016, the company operated 72 hospital campuses, including 9,424 licensed beds in 22 states. The company was formerly known as LifePoint Hospitals, Inc. and changed its name to LifePoint Health, Inc. in May 2015. LifePoint Health, Inc. was founded in 1997 and is based in Brentwood, Tennessee.
- **Tenet Healthcare Corp. (THC):** Tenet Healthcare Corporation, together with its subsidiaries, operates as a diversified healthcare services company. It operates in three segments: Hospital Operations and Other, Ambulatory Care, and Conifer. The company's general hospitals offer acute care services, operating and recovery rooms, radiology and respiratory therapy services, clinical laboratories, and pharmacies. It also provides intensive and critical care, and coronary care units; physical therapy, orthopedic, oncology, and outpatient services; tertiary care services, including open-heart surgery, neonatal intensive care, and neurosciences; quaternary care in heart, liver, kidney, and bone marrow transplants areas; tertiary and quaternary pediatric, and burn services; and limb-salvaging vascular procedures, acute level 1 trauma services, intravascular stroke care, minimally invasive cardiac valve replacement, imaging technology, and telemedicine access for various medical specialties. In addition, the company offers ambulatory surgery and urgent care centers, imaging centers, and short-stay surgical hospitals, as well as Aspen's hospitals and clinics; healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions; and microhospitals, physician practices, and health plans. Further, it provides accounts receivable and health information management, and revenue integrity and patient financial services; patient communications and engagement services; and clinical integration, financial risk management, and population health management services. As of February 27, 2017, the company operated 80 general acute care hospitals, 20 short-stay surgical hospitals, and approximately 470 outpatient centers, as well as 239 ambulatory surgery, 34 urgent care, and 21 imaging centers in the United States; and 9 private hospitals and clinics in the United Kingdom. Tenet Healthcare Corporation was founded in 1967 and is headquartered in Dallas, Texas.
- **Universal Health Services (UHS):** Universal Health Services, Inc., through its subsidiaries, owns and operates acute care hospitals, behavioral health facilities, and ambulatory centers. The company's hospitals offer general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, pediatric services, pharmacy services, and/or behavioral health services. As of February 28, 2017, it owned and/or operated 26 inpatient acute care hospitals, 4 free-standing emergency departments, 1 surgical hospital, and 319 inpatient and 33 outpatient behavioral health care facilities located in 37 states, Washington, D.C.; the United Kingdom; Puerto Rico; and the U.S. Virgin Islands. The company was founded in 1978 and is headquartered in King of Prussia, Pennsylvania.

Source: S&P Capital IQ, www.capitaliq.com

Market Approach

Guideline Public Company Method

The table below summarizes the key valuation multiples for the identified publicly traded hospital companies. Due to Community Health Systems, Inc. ("CYH") and Quorum Health Corporation ("QHC") being an outlier in relation to TTM EBITDA multiples, VMG has calculated multiples both with and without CYH & QHC. The mean trailing twelve month ("TTM") revenue multiples with and without CYH & QHC are 1.1x and 1.3x, respectively, while the median multiples are 1.0x and 1.3x, respectively. The mean TTM EBITDA multiples with and without CYH & QHC are 11.3x and 8.5x, respectively, while the median multiples are 9.2x and 8.6x, respectively. This data was sourced on August 22, 2018, and the TTM is as of the last reported quarter.

Company Name	Ticker	Market Capitalization	Total Debt	Minority Interest	Preferred Equity	Cash & Short-Term Investments	Business Enterprise Value
Community Health Systems, Inc.	CYH	$340,818	$13,715,000	$590,000	-	$208,000	$14,437,818
HCA Healthcare, Inc.	HCA	$44,401,162	$33,192,000	$1,864,000	-	$913,000	$78,544,162
LifePoint Health, Inc.	LPNT	$2,499,732	$2,928,400	$135,400	-	$143,800	$5,419,732
Quorum Health Corporation	QHC	$120,236	$1,199,412	$17,013	-	$2,822	$1,333,839
Tenet Healthcare Corporation	THC	$3,276,718	$14,867,000	$2,159,000	-	$403,000	$19,899,718
Universal Health Services, Inc.	UHS	$11,467,395	$3,990,464	$78,968	-	$76,886	$15,459,941

		Operating Revenue			*Operating EBITDA*		
Company Name	Ticker	TTM Revenue	FY + 1 Revenue	FY + 2 Revenue	TTM EBITDA	FY + 1 EBITDA	FY + 2 EBITDA
Community Health Systems, Inc.	CYH	$13,975,000	$13,923,850	$13,220,249	$825,000	$1,603,707	$1,552,429
HCA Healthcare, Inc.	HCA	$45,210,000	$46,199,801	$48,372,743	$8,481,000	$8,768,293	$9,239,939
LifePoint Health, Inc.	LPNT	$6,239,000	$6,304,101	$6,427,871	$660,700	$741,383	$763,346
Quorum Health Corporation	QHC	$1,858,462	$1,944,077	$1,982,244	$80,722	$148,978	$169,200
Tenet Healthcare Corporation	THC	$18,769,000	$18,140,912	$18,028,498	$2,663,000	$2,602,447	$2,655,960
Universal Health Services, Inc.	UHS	$10,553,520	$10,819,941	$11,348,893	$1,701,019	$1,770,035	$1,872,305

		Implied Multiples					
Company Name	Ticker	TTM Revenue	FY + 1 Revenue	FY + 2 Revenue	TTM EBITDA	FY + 1 EBITDA	FY + 2 EBITDA
Community Health Systems, Inc.	CYH	1.0x	1.0x	1.1x	17.5x	9.0x	9.3x
HCA Healthcare, Inc.	HCA	1.7x	1.7x	1.6x	9.3x	9.0x	8.5x
LifePoint Health, Inc.	LPNT	0.9x	0.9x	0.8x	8.2x	7.3x	7.1x
Quorum Health Corporation	QHC	0.7x	0.7x	0.7x	16.5x	9.0x	7.9x
Tenet Healthcare Corporation	THC	1.1x	1.1x	1.1x	7.5x	7.6x	7.5x
Universal Health Services, Inc.	UHS	1.5x	1.4x	1.4x	9.1x	8.7x	8.3x
Market Multiples	*Mean:*	*1.1 x*	*1.1 x*	*1.1 x*	*11.3 x*	*8.4 x*	*8.1 x*
	Median:	*1.0 x*	*1.1 x*	*1.1 x*	*9.2 x*	*8.8 x*	*8.1 x*
Market Multiples - Excluding CYH & QHC	*Mean:*	*1.3 x*	*1.3 x*	*1.2 x*	*8.5 x*	*8.2 x*	*7.8 x*
	Median:	*1.3 x*	*1.3 x*	*1.2 x*	*8.6 x*	*8.2 x*	*7.9 x*

Market Approach

Guideline Public Company Method

Although the concept of using publicly traded guideline companies as surrogates is intended to be based on comparability, it is often not possible to identify public companies similar to the subject business. There are many key differences between small to mid-size companies similar to the Hospital and publicly traded companies, such as commercial payor negotiating leverage, service mix, patient mix, access to capital, and geographic diversification. In addition, external microeconomic and macroeconomic events cause fluctuations in the prices of public company common stock prices, which will result in changes in the calculated public company market caps and enterprise values.

With consideration to the mentioned disadvantages of the guideline company method, we believe that the key differences identified above are applicable in the consideration of the Hospital's value under this method. For these reasons, the guideline companies do not reflect comparable market multiples for valuing the Hospital. We **have not relied** upon the pricing multiples and subsequent value indications generated by the guideline company method to establish the value of the Hospital.

Market Approach

Merger & Acquisition Method

The M&A Method relies on the observation of recent transactions involving the sale of businesses or business units that are similar to the subject Hospital ("Guideline Transactions"). The general notion of the M&A Method is consistent with the GPCM in that a relationship is developed between the price of transactions to a fundamental financial variable which can be used to arrive at an indication of value. These multiples may be stated as BEV to revenue, BEV to EBITDA, or another relevant relationship. In order to utilize this approach, Guideline Transactions must be identified which have available, reliable and relevant data.

In order to identify Guideline Transaction multiples, we have extensively reviewed and analyzed information on transactions involving **Hospitals**. In performing this analysis, VMG utilized the following multi-tiered approach:

- Reviewed Market Commentary: Considered public commentary from Hospital operators regarding the current M&A environment. This commentary provides background regarding the range of multiples buyers are utilizing to price transactions, the volume of M&A activity and the motivations for all involved parties.

- Gathered Generally Comparable Publicly Announced M&A Transactions: VMG reviewed available data for publicly announced Hospital transactions published by Irving Levin Associates, Capital IQ, and the Securities and Exchange Commission ("SEC").

- Proprietary Transaction Information: VMG has developed extensive knowledge of factors driving Hospital transaction pricing. In addition, VMG maintains an internal database of all Hospital valuations performed by VMG.

Public Transaction Database

In order to apply the M&A method for the Hospital, VMG has created a database of acquisition multiples for publicly announced transactions. Sources of information initially include Irving Levin and Capital IQ, but additional sources are utilized to refine and verify public data available, including American Hospital Directory, Electronic Municipal Market Access, U.S. Securities & Exchange Commission (8-K reports, 10-K reports, etc.), attorney general offices, and online / general research. In certain instances, proprietary information obtained by VMG is utilized. The sample set below primarily consists of independent single-site acute care hospitals and large health systems. VMG has omitted transactions where insufficient data was publicly available, or where the multiples calculated were unreliable (primarily involving multiples of EBITDA). In addition, VMG has excluded transactions involving the affiliation or merger of two or more entities as these transactions do not produce accurate acquisition multiples. VMG has presented below the consolidated data for all acute care hospital transactions of non-distressed hospitals since January 2014:

VMG Complete Data Set

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.6x	8.6x
Mean	0.7x	8.8x
25th Percentile	0.4x	7.0x
75th Percentile	1.0x	9.9x
High	1.7x	20.4x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	119	70

For all observed transaction multiples, the BEV to revenue multiples ranged from a low of 0.1x to a high of 1.7x, with a median multiple of 0.6x and a mean multiple of 0.7x. The BEV to EBITDA multiples ranged from a low of 0.8x to a high of 20.4x, with a median multiple of 8.6x and a mean multiple of 8.8x.

Market Approach

Merger & Acquisition Method

Additionally, VMG considered transaction multiples from a subset of the transactions presented on the prior page in order to develop an understanding of market multiples in relation to target hospital profitability. We have applied the following criteria in order to obtain additional information from a set of transactions similar to the subject Hospital:

EBITDA Margin Greater than 5.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.7x	8.4x
Mean	0.8x	8.2x
25th Percentile	0.6x	6.7x
75th Percentile	1.1x	9.4x
High	1.7x	20.4x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	53	51

EBITDA Margin Greater than 10.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	1.0x	7.9x
Mean	1.0x	7.4x
25th Percentile	0.8x	6.2x
75th Percentile	1.3x	8.9x
High	1.7x	10.7x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	26	24

EBITDA Margin Greater than 15.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	1.3x	7.6x
Mean	1.1x	6.9x
25th Percentile	0.6x	5.3x
75th Percentile	1.4x	8.7x
High	1.7x	9.6x
Low	0.1x	3.3x
Number of Observations with Reported Statistics	10	8

In each chart above certain transactions were eliminated (based on the target's EBITDA margin) to illustrate the relationship between profitability and the implied valuation multiples. As the charts above indicate, as profitability increases, the implied transaction BEV / EBITDA multiples declines.

Market Approach

Merger & Acquisition Method

Based on the observed transaction multiples of the merger and acquisition method, as well as consideration of the unique characteristics of the subject Hospital, it is our opinion that the appropriate BEV to revenue multiple is reasonably represented in a range between approximately **1.1x and 1.3x** and a BEV to EBITDA multiple is reasonably represented in a range between approximately **5.5x and 7.5x** for an interest in an acute care hospital similar to the Hospital.

Multiple	Range of Multiple Selections (Control Level)			Year 1	Value Indication (Rounded)		
	Low		High		Low		High
BEV/Revenue	1.1x	to	1.3x	$506,850,753	$560,000,000	to	$660,000,000
BEV/EBITDA	5.5x	to	7.5x	$94,983,961	$520,000,000	to	$710,000,000
Selected Multiple Range					$ 520,000,000	to	$ 710,000,000
Midpoint (BEV/EBITDA) & (BEV/Revenue)					$610,000,000		

As illustrated in the chart, we applied the selected range of revenue and EBITDA multiples to the Hospital's Year 1 revenue and EBITDA. Based on the average of the revenue and EBITDA multiple selections, VMG has calculated a blended average BEV for the Hospital of approximately **$610 million**. We have utilized the Market Approach to corroborate the results of the Income Approach.

Desert Regional Medical Center

Income Approach

Income Approach

General Assumptions

The Income Approach provides for two general methods for determining value: the capitalization of a single period's net cash flow or the discounting of several future periods' net cash flow. We have employed the multi-period method (the discounted cash flow method) which allows for the forecasting of a finite period of annual net cash flows. An important assumption of any method of the Income Approach is that the business or asset being valued remains a going concern.

The first step of the discounted cash flow methodology is to estimate the net cash flows available to the firm (total invested capital level). For purposes of the discounted cash flow methodology employed in our analysis, we have defined net cash flow as follows:

- Earnings before interest, taxes, depreciation, and amortization ("EBITDA")
- Less: depreciation, amortization, and other applicable non-cash expenses
- Less: applicable federal and state income taxes payable
- Plus: depreciation, amortization, and other applicable non-cash expenses
- Less: incremental capital expenditure requirements
- Less: incremental working capital requirement
- Equals: net cash flow to invested capital

Because we are calculating net cash flow to invested capital, we have eliminated interest expense in the projection period. Estimated net cash flows are projected for five years and then into perpetuity. The projected or future net cash flows are then discounted to arrive at a present value. The discount rate (also known as the required rate of return, cost of capital, or hurdle rate) incorporates the estimated time value of money, inflation, and the risks associated with the business entity. As mentioned before, this approach is based on the fundamental valuation principle that the value of a business is equal to the present value (or worth) of the future benefits of ownership.

Please see the following pages for more detail on the application of the Income Approach.

Income Approach

General Assumptions

Discount rate	12.0%
Terminal growth rate	3.0%
Tax rate	28.0%
Inflation Rate	3.0%
Incremental Non-Cash Net Working Capital requirements	8.0%
Terminal Capital Expenditures	2.5%

- **Discount rate:** The discount rate above refers to the estimated weighted average cost of capital ("WACC"). This discount rate is an after-tax rate and is described in detail, along with the WACC calculations, on the following pages.
- **Terminal growth rate:** The rate that operating revenue and expenses are expected to grow beyond Year 5 of our projections and into perpetuity.
- **Tax rate:** The blended federal and state income tax rate applicable to businesses operating in California.
- **Inflation rate ("CPI"):** The estimated rate of inflation, as reflected by the Consumer Price Index.
- **Incremental non-cash net working capital requirements:** Non-cash net working capital is current assets (accounts receivable, inventory, etc.) less current liabilities (accounts payable and other accrued expenses) and is required to conduct day-to-day operations, maintain liquidity, and to recognize revenue and expenses on an accrual accounting basis. Please note the net working capital value does not include cash. Although these items are not reported on the income statement, an increase in non-cash net working capital should be considered as a use of cash. We are projecting incremental non-cash net working capital to be 8.0% of incremental net operating revenue. In other words, for every $1 increase in net operating revenue, non-cash net working capital will increase by $0.08.
- **Forecast Development:** All forecast assumptions were based on input from Hospital management and reviewed by VMG along with the District's financial consultants.
- **Terminal Capital Expenditures:** The estimated level of capital expenditures allowing the Hospital to maintain operations into perpetuity.

The income statement used to formulate the normalized base year is the income statement for the fiscal year ended May 31, 2018. Non-recurring and non-operational items are adjusted out of the normalized income statement to give a clearer picture of the entity's operations. In addition, the normalized income statement applies federal and state income taxes and eliminates interest expense. All these adjustments are made to make the normalized base year income statement a more accurate base from which to project the income statement in Year 1.

Income Approach

Development of the Normalized Base Year

Non-recurring and non-operational items are adjusted out of the TTM 2018 income statement to give a clearer, more accurate picture of the Hospital's operations from which to project the income statement in Year 1.

Major adjustments include the following:

1. Management indicated several one-time or non-recurring expenses were included in the Hospital's TTM 2018 income statement. Please refer to Appendix Normalized Base Year Schedule 1 for additional detail;
2. Medicaid Supplemental - Income Provider' and 'Medicaid Supplemental - Assessment Provider' accounts are related to the Hospital's participation in the Hospital Qualify Assurance Fee ("HQAF") program Please refer to Appendix Normalized Base Year Schedule 2 for additional detail regarding this adjustment.

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year
Hospital Operating Revenue				
Patient Revenue				
Gross Inpatient Revenue		$2,562,224,502	-	$2,562,224,502
Inpatient Contractual	*1*	(2,220,650,822)	$2,653,632	(2,217,997,190)
Net Inpatient Revenue		341,573,680	2,653,632	344,227,312
Gross Outpatient Revenue	*1*	1,161,536,693	($1,870,000)	1,159,666,693
Outpatient Contractual		(1,009,294,506)	-	(1,009,294,506)
Net Outpatient Revenue		152,242,187	(1,870,000)	150,372,187
Net Patient Revenue before Bad Debt		$493,815,867	$783,632	$494,599,499
Bad Debt	*1*	(2,546,776)	($585,481)	(3,132,257)
Total Net Patient Revenue		$491,269,091	$198,151	$491,467,242
Supplemental Payments				
Medicaid DSH		7,203,734	-	7,203,734
Medicaid Supplemental - Income Provider	*2*	97,750,754	(28,134,779)	69,615,975
Medicaid Supplemental - Assessment Provider	*2*	(33,794,251)	9,144,711	(24,649,540)
Electronic Health Record Incentives		301,700	-	301,700
Total		71,461,937	(18,990,068)	52,471,869
Other Revenue				
Rental Income		-	-	-
Other Revenue		194,265	-	194,265
Total		194,265	-	194,265
Total Net Operating Revenue		$562,925,293	($18,791,917)	$544,133,376
Total Operating Expenses	*3,4*	429,861,588	17,803,316	447,664,904
EBITDA		133,063,705	(36,595,232)	96,468,473

Income Approach

Development of the Normalized Base Year

Non-recurring and non-operational items are adjusted out of the TTM 2018 income statement to give a clearer, more accurate picture of the Hospital's operations from which to project the income statement in Year 1.

Major adjustments include the following:

3. Management Fees not captured in the Hospital's TTM 2018 Income Statement have been estimated at 2.0% of revenue. Please refer to Appendix Normalized Base Year Schedule 3, which provides support for the selected level of revenue;
4. Physician losses not captured in the TTM 2018 financial statements have been added in the Normalized Base Year. Please refer to Appendix Normalized Base Year Schedule 4 for supporting calculations.

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year
Hospital Operating Revenue				
Patient Revenue				
Gross Inpatient Revenue		$2,562,224,502	-	$2,562,224,502
Inpatient Contractual	*1*	(2,220,650,822)	$2,653,632	(2,217,997,190)
Net Inpatient Revenue		341,573,680	2,653,632	344,227,312
Gross Outpatient Revenue	*1*	1,161,536,693	($1,870,000)	1,159,666,693
Outpatient Contractual		(1,009,294,506)	-	(1,009,294,506)
Net Outpatient Revenue		152,242,187	(1,870,000)	150,372,187
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Total Net Patient Revenue		$491,269,091	$198,151	$491,467,242
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Medicaid DSH		7,203,734	-	7,203,734
Medicaid Supplemental - Income Provider	*2*	97,750,754	(28,134,779)	69,615,975
Medicaid Supplemental - Assessment Provider	*2*	(33,794,251)	9,144,711	(24,649,540)
Electronic Health Record Incentives		301,700	-	301,700
Total		71,461,937	(18,990,068)	52,471,869
Other Revenue				
Rental Income		-	-	-
Other Revenue		194,265	-	194,265
Total		194,265	-	194,265
Total Net Operating Revenue		$562,925,293	($18,791,917)	$544,133,376
Total Operating Expenses	*3,4*	429,861,588	17,803,316	447,664,904
EBITDA		133,063,705	(36,595,232)	96,468,473

Income Approach

Revenue Assumptions

REVENUE ASSUMPTIONS:		Normalized Base Year	Projection Period				
			Year 1	Year 2	Year 3	Year 4	Year 5
INPATIENT REVENUE							
Volume Assumptions							
Admissions per year		19,694	19,792	19,891	19,991	20,091	20,191
Growth		-	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
Inpatient Reimbursement (per Admission)							
Gross Inpatient Charge per Admission	% of NBY Charges	$130,102	$132,704	$135,358	$138,065	$140,826	$143,643
Inpatient Contractual per Admission	86.6%	(112,623)	(114,875)	(117,173)	(119,516)	(121,907)	(124,345)
Average Net Inpatient Revenue per Admission		$17,479	$17,828	$18,185	$18,549	$18,920	$19,298
Growth		*0.8%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Inpatient Gross Charges		$2,562,224,502	$2,626,536,337	$2,692,462,399	$2,760,043,205	$2,829,320,290	$2,900,336,229
Estimated Inpatient Contractual		(2,217,997,190)	(2,273,668,919)	(2,330,738,009)	(2,389,239,533)	(2,449,209,446)	(2,510,684,603)
Net Inpatient Revenue		**$344,227,312**	**$352,867,418**	**$361,724,390**	**$370,803,672**	**$380,110,844**	**$389,651,626**
Growth		*0.8%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*

Hospital inpatient admissions are projected to increase 0.5% per year throughout the projection period. Therefore, admissions are projected to increase from 19,694 in the NBY to 20,191 in Year 5.

Gross inpatient charge per admission is projected to increase by 2.0% in each year throughout the projection period. Inpatient Contractual Allowances are projected to remain at the NBY level as a percentage of gross inpatient charges. Net Inpatient Revenue per Admission is projected to increase at 2.0% annually from approximately $17,479 in the NBY to $19,298 in Year 5.

Based on these assumptions, net inpatient revenue is projected to increase by approximately 2.5% compounded annually throughout the projection period, from approximately $344.2 million in the NBY to approximately $389.7 million in Year 5.

Income Approach

Revenue Assumptions

REVENUE ASSUMPTIONS:		Normalized Base Year	Projection Period				
			Year 1	Year 2	Year 3	Year 4	Year 5
OUTPATIENT REVENUE							
Outpatient Volume							
Outpatient Visits per year		167,037	171,213	175,493	179,881	184,378	188,987
Growth		-	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
Outpatient Reimbursement							
Gross Charge per Outpatient Visit	% of NBY Charges	$6,943	$7,081	$7,223	$7,368	$7,515	$7,665
Outpatient Contractual per Admission	87.0%	(6,042)	(6,163)	(6,286)	(6,412)	(6,540)	(6,671)
Average Net Revenue per Outpatient Visit		$900	$918	$937	$955	$974	$994
Growth		*(1.2%)*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Outpatient Gross Charges		$1,159,666,693	$1,212,431,528	$1,267,597,162	$1,325,272,833	$1,385,572,747	$1,448,616,307
Estimated Outpatient Contractual		(1,009,294,506)	(1,055,217,406)	(1,103,229,798)	(1,153,426,754)	(1,205,907,671)	(1,260,776,470)
Net Outpatient Revenue		**$150,372,187**	**$157,214,122**	**$164,367,364**	**$171,846,079**	**$179,665,076**	**$187,839,837**
Growth		*(1.2%)*	*4.5%*	*4.6%*	*4.6%*	*4.5%*	*4.5%*

Hospital outpatient visits are projected to increase 2.5% per year throughout the projection period. Therefore, outpatient visits are projected to increase from 167,037 in the NBY to 188,987 in Year 5.

Gross outpatient charges per visit are projected to increase by 2.0% in each year throughout the projection period. Outpatient Contractual Allowances are projected to remain at the NBY level as a percentage of gross outpatient charges. Net Outpatient Revenue per Visit is projected to increase at 2.0% annually from approximately $900 in the NBY to $994 in Year 5.

Based on these assumptions, net outpatient revenue is projected to increase by approximately 4.5% compounded annually throughout the projection period, from approximately $160.4 million in the NBY to approximately $187.8 million in Year 5.

Income Approach

Revenue Assumptions

HOSPITAL OPERATING REVENUE SUMMARY							
Total Patient Revenue							
Total Gross Charges (IP & OP)		3,721,891,195	3,838,967,865	3,960,059,561	4,085,316,038	4,214,893,037	4,348,952,536
Total Contractuals (IP & OP)		(3,227,291,696)	(3,328,886,325)	(3,433,967,807)	(3,542,666,287)	(3,655,117,117)	(3,771,461,073)
Net Patient Revenue before Bad Debt		494,599,499	510,081,539	526,091,754	542,649,751	559,775,920	577,491,463
Net Inpatient Revenue		$344,227,312	$352,867,418	$361,724,390	$370,803,672	$380,110,844	$389,651,626
Net Outpatient Revenue		$150,372,187	$157,214,122	$164,367,364	$171,846,079	$179,665,076	$187,839,837
Net Patient Revenue before Bad Debt		$494,599,499	$510,081,539	$526,091,754	$542,649,751	$559,775,920	$577,491,463
Growth		*0.2%*	*3.1%*	*3.1%*	*3.1%*	*3.2%*	*3.2%*
	NBY % of Total Gross Charges						
Bad Debt	0.1%	(3,132,257)	(3,230,786)	(3,332,694)	(3,438,107)	(3,547,156)	(3,659,977)
Growth		*23.0%*	*3.1%*	*3.2%*	*3.2%*	*3.2%*	*3.2%*
Total Net Patient Revenue		491,467,242	506,850,753	522,759,060	539,211,644	556,228,764	573,831,486
Growth		*0.0%*	*3.1%*	*3.1%*	*3.1%*	*3.2%*	*3.2%*
Supplemental Payments							
Medicaid DSH	*No Growth*	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734
Medicaid Supplemental - Income Provider	*No Growth*	69,615,975	69,615,975	69,615,975	69,615,975	69,615,975	69,615,975
Medicaid Supplemental - Assessment Provider	*No Growth*	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)
Electronic Health Record Incentives	*No Growth*	301,700	301,700	301,700	301,700	301,700	301,700
Total		52,471,869	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869
Growth		*-26.6%*	-	-	-	-	-
Other Revenue							
Other Revenue	*Increase at CPI*	194,265	200,093	206,096	212,279	218,647	225,206
Total		194,265	200,093	206,096	212,279	218,647	225,206
Growth		*0.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*
Total Net Operating Revenue		**$544,133,376**	**$559,522,715**	**$575,437,025**	**$591,895,792**	**$608,919,280**	**$626,528,561**
Growth		*(3.3%)*	*2.8%*	*2.8%*	*2.9%*	*2.9%*	*2.9%*

Total net patient revenue before bad debt is projected to increase at 3.1% compounded annually, from approximately $494.6 million in the NBY to approximately $577.5 million in Year 5. Bad debt is projected to increase 3.1% compounded annually, from approximately $3.1 million in the NBY to approximately $3.7 million in Year 5. Supplemental payments (including Medicaid payments) have no growth projected. Furthermore, other revenue is projected to increase at the CPI (3.0%) throughout the projection period.

Based on the aforementioned volume and reimbursement growth assumptions, total net operating revenue is projected to increase at a 2.9% compounded annual growth rate, from approximately $544.1 million in the NBY to approximately $626.5 million in Year 5.

Income Approach

Expense Assumptions & Capital Expenditures

Total operating expenses as a percentage of revenue are projected to decrease from 82.3% in the NBY to 86.1% in Year 5 based on expense projections provided by Hospital management. Employee salaries & wages, medical supplies, and general & administrative expenses comprise the majority of the operating expense over the projection period.

	Normalized Base Year	Projection Period				
		Year 1	Year 2	Year 3	Year 4	Year 5
Operating Expenses:						
Employee Salaries & Wages	34.4%	34.8%	35.2%	35.7%	36.1%	36.6%
Employee Benefits	9.5%	9.6%	9.7%	9.8%	10.0%	10.1%
Occupancy Costs	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Supplies	14.1%	14.3%	14.4%	14.6%	14.8%	15.0%
Medical Costs	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%
Insurance	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
General & Administrative	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%
Total Operating Expenses	82.3%	83.0%	83.8%	84.5%	85.3%	86.1%

It should be noted that operating expenses as a percentage of revenue increase throughout the projection period. The estimated operating expenses imply an EBITDA margin of between 17.7% in the Normalized Base Year and 13.9% in Year 5 consistent with the observed comparable hospital EBITDA margins presented in the Supplemental D-Exhibits.

Capital Expenditures

Capital expenditures are investments in equipment and other long-term tangible assets that are necessary for the operation of the Hospital. These items are usually recorded on the balance sheet but must be recognized as cash consumption for the purposes of the Income Approach. Desert Regional Medical Center management provided capital expenditure estimates for Years 1 through 3. Capital expenditures are projected at 2.5% of net operating revenue in Year 4 and Year 5. Terminal capital expenditures are projected at approximately 2.5% of net operating revenue, as illustrated in the chart below:

DEPRECIATION SCHEDULE:	Projection Period				
	Year 1	Year 2	Year 3	Year 4	Year 5
Capital Expenditures Projection Detail (provided by Hospital Management):	*Note: Years 2018, 2019 and 2020 Capital Expenditures were provided by Management in the "3.0 DRMC Capital Plan.pptx" document. Years 2021 forward are projected as a percent of revenue at 2.5%.*				
Equipment - Replacement	2,386,000	2,374,000	-		
Business Development	2,217,000	1,500,000	3,380,000		
Facility Maintenance (Infrastructure)	3,077,000	4,860,000	2,700,000		
ALCM (Replacement Equipment and Replacement of Pumps)	3,200,000	3,279,000	4,050,000		
Other Capital	3,027,000	2,423,000	3,249,000		
Total Capital Expenditures	13,900,000	14,400,000	13,400,000	15,200,000	15,700,000
% of Revenue (Rounded)	*2.5%*	*2.5%*	*2.3%*	*2.5%*	*2.5%*

Income Approach

Discount Rate Assumptions

The selection of an appropriate discount rate is an integral part of the valuation process. Two factors must be considered in estimating the present value of any projected cash flow stream:

- Financial Risk: The risk inherent in an entity's financial structure (i.e., the utilization of debt vs. equity financing).
- Business Risk: The uncertainty associated with the economy, operations and specific risk profile.

The WACC is a discount rate that takes into account the required rate of return necessary to justify investment based on the prevailing economic, market, industry and specific company risks, as well as the capital structure, as of the valuation date.

Most business entities have a capital structure consisting of both debt and equity. The party lending debt capital to a business requires a return on the debt, which comes out of the business in the form of interest payments. Lenders have a higher claim against assets of a business and therefore, are exposed to less risk than are the equity investors. Because of the lower risk level, the cost of debt is less than the cost of equity. Also, the interest payments are tax deductible to the business entity, which further lowers the cost of debt.

Equity investors require a higher rate of return on their investment than do debt holders, because their claim on a facility's assets are secondary to that of the debt holder. In addition, a business entity is not required to pay dividends, whereas interest payments are usually fixed over the term of the debt.

The WACC incorporates the claims of both the debt and equity holders in proportion to their relative capital contribution. To estimate an enterprise's WACC, both the subject entity's capital structure and the prevailing industry averages are examined as of the valuation date.

Income Approach

Discount Rate Assumptions

In estimating the WACC for this valuation, we relied on the capital asset pricing model ("CAPM"). The basic formula for computing the after-tax WACC is as follows:

$$WACC = (K_e * W_e) + (K_d * [1 - t] * W_d)$$

WACC = Weighted average cost of capital
K_e = Cost of common equity capital
K_d = Cost of debt capital
W_e = Equity as a percentage of total capital
W_d = Debt as a percentage of total capital
t = Blended federal and state income tax rate

The equity portion of the WACC was calculated by using the CAPM. The basic formula for computing the equity portion is as follows:

$$K_e = R_f + (R_m * B_i) + R_s + R_u$$

K_e = Expected rate of return on the subject security
R_f = Rate of return on a risk free security
R_m = Risk premium associated with the market
B_i = Beta for related companies in the industry
R_s = Risk premium associated with a small company
R_u = Risk premium associated with the specific company

Please see the following pages and Appendix B for more detail on each component utilized in the CAPM and development of the WACC.

CAPM - Risk Free Rate ("R_f")

The "risk-free rate" is a proxy for the return available on a security that the market generally regards as free of default risk. The rate of return on a risk-free security was found by looking at the yields of U.S. Treasury securities. Ideally, the duration of the security used as an indication of the risk-free rate should match the horizon of the projected cash flows, which are being discounted (which is into perpetuity in the present case). We used a 20-year Treasury rate, which was equal to 3.1% as of August 22, 2018.

CAPM – Equity Risk Premium ("R_m")

The equity risk premium is the additional return an investor expects to receive to compensate for the risk associated with investing in equities as opposed to investing in riskless assets. The market risk premium utilized was based on figures provided in the *Duff & Phelps 2017 Valuation Handbook – Guide to Cost of Capital ("2017 Valuation Handbook")* published by Duff & Phelps, LLC. Per the *2017 Valuation Handbook,* the market risk premium utilized for the Hospital was 6.0%.

CAPM - Beta ("B_i")

The beta is a measure of statistical volatility, or systemic risk, of an industry in comparison to the market as a whole. Beta is used to measure the price sensitivity of a company, or in this case an industry, in relation to changes in overall market prices. The levered beta utilized was 0.635 based on the average unlevered beta of 0.429 as reported by Capital IQ for the following select guideline companies: Community Health Systems, Inc. (CYH), HCA Healthcare, Inc. (HCA), LifePoint Health, Inc. (LPNT), Quorum Health Corp. (QHC), Tenet Healthcare Corp. (THC), and Universal Health Services (UHS).

CAPM – Small Company Premium ("R_s")

The small company or small size premium is the additional return an investor expects to receive to compensate for the additional risk associated with investing in a small and inherently more risky company. Per the *2017 Valuation Handbook,* the small company risk premium utilized for the Hospital was 5.6%.

Specific Company Risk Premium ("R_u")

The final common component of the CAPM model is the specific company risk premium. The specific company risk quantifies the risk associated with the specific operations of the company or the "unsystematic" risk of the company. Our selection of a company specific risk premium adjusts not only for the additional risks inherent in the operations, but also accounts for the mitigating factors present in the operations. These risks are relative to the public markets from which the market equity risk premium, industry risk premium and small company risk premium were derived. The specific company premium selected was based on certain factors that included the margin of the Hospital as compared to other comparable California Hospitals and the Hospitals significant dependence on government subsidies and particall. The specific company risk is estimated to be approximately 5.0%.

Cost of Equity Conclusion ("K_e")

Based on the aforementioned factors, the cost of equity derived through the CAPM method is presented in the schedule on the following page and in Appendix B.

Source: Cost of Capital – Estimation and Applications 2nd Edition by Shannon P. Pratt.

Income Approach

Discount Rate Assumptions

Cost of Equity Calculation	
Market Risk Premium (RM)[5]	6.0%
x Subject Company Re-levered Beta	0.635
= Adjusted Market Risk Premium	3.8%
+ Risk-Free Rate of Return (RF)[6]	3.1%
+ Size Premium[7]	5.6%
+ Specific Company Risk Premium[8]	5.0%
= **Cost of Equity**	**17.5%**

Federal & State Income Tax Rate ("t")

To calculate the after-tax cost of debt component in the WACC formula, we utilized the blended state and federal income tax rate applicable to the Hospital, which was approximately 28.0%.

Cost of Debt ("K_d")

The cost of debt utilized in the calculation of the WACC was based on the available Moody's yield on seasoned corporate bonds, rating Baa, as of the valuation date, which was approximately 4.8%.

Capital Structure ("W_e" and "W_d")

We reviewed capital structures for public companies operating in the industry, the current capital structure of the Hospital, and our experience with similar businesses in selecting the capital structure utilized in the WACC analysis. Please see the following page for further detail.

Income Approach

Discount Rate Assumptions

WACC Conclusion

BETA CALCULATION

Ticker	Company Name	Levered 5 Year [1]	S&P Credit Rating	Market Capitalization	Total Debt	Cash & ST Investments	Minority Interest	Debt/ BEV[2]	Debt/ Equity	Effective Tax Rate	Unlevered Beta
CYH	Community Health Systems, Inc.	1.058	CCC+	$340,818	$13,715,000	$208,000	$590,000	93.6%	1473.4%	n/a	
HCA	HCA Healthcare, Inc.	0.634	BB+	$44,401,162	$33,192,000	$913,000	$1,864,000	41.8%	71.7%	33.1%	0.423
LPNT	LifePoint Health, Inc.	0.661	BB-	$2,499,732	$2,928,400	$143,800	$135,400	52.6%	111.1%	28.5%	0.342
QHC	Quorum Health Corporation	0.389	B-	$120,236	$1,199,412	$2,822	$17,013	89.7%	873.9%	n/a	
THC	Tenet Healthcare Corporation	1.181	B	$3,276,718	$14,867,000	$403,000	$2,159,000	73.2%	273.5%	45.0%	0.472
UHS	Universal Health Services, Inc.	0.603	BB+	$11,467,395	$3,990,464	$76,886	$78,968	25.7%	34.6%	29.1%	0.480
Average		**0.754**									**0.429**
Median		**0.647**									**0.448**

Average Unlevered Beta for Comps	0.429
D/E, Target Company	66.7%
Federal & State Income Tax Expense	28.0%
Re-Levered Beta, Subject Company[4]	**0.635**

WACC

Market Risk Premium (RM)[5]	6.0%
x Subject Company Re-levered Beta	0.635
= Adjusted Market Risk Premium	3.8%
+ Risk-Free Rate of Return (RF)[6]	3.1%
+ Size Premium[7]	5.6%
+ Specific Company Risk Premium[8]	5.0%
= **Cost of Equity**	**17.5%**
x Equity as a Percent of Total Capital	60.0%
= **Cost of Equity Portion**	**10.5%**
Cost of Debt[9]	4.8%
x Tax Rate[10]	28.0%
= **After-Tax Cost of Debt**	**3.5%**
x Debt as a Percent of Total Capital	40.0%
= **Cost of Debt Portion**	**1.4%**

WACC	11.9%
Selected WACC	12.0%

Footnotes:

(1) Capital IQ - Levered Beta 5 Year computed taking the slope of a weekly regression line of the percentage change of the stock relative to the percentage price change in the S&P 500 as of August 22, 2018.

(2) Capital IQ - average of public companies debt structure as of August 22, 2018.

*(3) Unlevered Beta = Levered Beta / (1 + ((D/E) * (1 - T)) + P/E)*

*(4) Re-levered Beta = Unlevered Beta * (1 + ((D/E) * (1 - T)) + P/E)*

(5) The equity risk premium of 6.0% was selected based upon VMG's review of published articles and academic studies that attempt to quantify the expected market risk premium for U.S. common stocks by utilizing both historical and forward looking sources. The selected 6.0% equity risk premium was considered to reasonably represent a consensus viewpoint of the market equity risk premium.

(6) Yield of 20-year U.S. Treasury securities as of August 22, 2018, as published by Federal Reserve Statistical Release.

(7) Duff & Phelps: 2017 Valuation Handbook, Market Cap

(8) Risk associated with the specific operations of the company or the "unsystematic" risk of the company.

(9) Moody's yield on seasoned corporate bonds, rating Baa as of August 22, 2018, as published by Capital IQ.

(10) Blended State and Federal Tax rate for California.

Company Specific Risk Premium	Capital Structure (Debt to BEV) 40.0%	50.0%	60.0%
4.0%	11.3%	10.0%	8.7%
5.0%	11.9%	10.5%	9.1%
6.0%	12.5%	11.0%	9.5%
7.0%	13.1%	11.5%	9.9%

Income Approach

Valuation Conclusion

In utilizing the assumptions for volume, revenues, expenses, net working capital and capital expenditures, we have estimated the after-tax free cash flows of the Hospital for the next five years. An estimated after-tax WACC of 12.0% was applied to the future after-tax free cash flows to arrive at a present value.

Goodwill, including all intangible assets, is created in a transaction when the purchase price exceeds the value of the working capital and fixed assets purchased by the buyer. Depending on the structure of the transaction, asset purchases and some stock purchases may result in an allocation of the purchase price to goodwill for tax purposes. The buyer's ability to amortize the goodwill for tax purposes results in an additional tax shield that is not reflected in the discounted cash flow. The Tax Amortization Benefit ("TAB") is simply the present value of the tax savings from this additional tax shield. We have applied this TAB to the control level valuation.

The FMV indication of the business enterprise value of the Hospital with the tax amortization benefit is approximately **$610.0 million.** We **have fully relied** on the Income Approach to value the Hospital.

Desert Regional Medical Center

Valuation Reconciliation & Summary

Valuation Reconciliation & Summary

Valuation Reconciliation

After obtaining value indications under the Cost, Market, and Income Approaches, we examined the value outcomes based on the following factors:

- **Cost Approach:** The Cost Approach utilizes book values for certain fixed assets and may not reflect fair market value. Based on this factor, **we have not relied** on the Cost Approach to generate a value indication.

- **Market Approach:** Typically, the M&A method is a reasonable approach to apply in acute care hospital valuations when the appropriate diligence has been performed to understand and accurately calculate market multiples. However, given the specific facts and circumstances surrounding the Hospital, we **have not relied** upon the pricing multiplies and value indications generated by the M&A method to establish the value of the Hospital. We have utilized the Market Approach to corroborate the results of the Income Approach.

- **Income Approach:** Unlike the Cost and Market Approach, the Income Approach evaluates the future economic income stream that is specific to the Hospital. Accordingly, we **have fully relied** on the Income Approach value indication.

Reconciliation of Valuation Approaches	Value	Weight	Conclusion
Income Approach Value Indication (Midpoint)	$610,000,000	100.0%	$610,000,000
Cost Approach Value Indication	n/a	-	-
Market Approach Value Indication (Midpoint)	$610,000,000	-	-
Fair Market Value Indication, Business Enterprise Level			$610,000,000

Based on and subject to the facts, limiting conditions, and assumptions presented in the report and attached exhibits, it is our opinion that the FMV of the Hospital at the business enterprise level is reasonably represented as approximately **$610.0 million.**

Valuation Reconciliation & Summary

Valuation Summary

Based on and subject to the facts, limiting conditions, and assumptions presented in this report and attached exhibits, as of a current date, the FMV of the business enterprise value ("BEV") of the Hospital is reasonably represented in a range between approximately **$580 million and $640 million**.

Range of Fair Market Value, BEV Level	Low (5.0%)	Midpoint	High (+5.0%)
Fair Market Value Indication, Business Enterprise Level	$580,000,000	$610,000,000	$640,000,000

Business Enterprise Value reflects the value of the Hospital inclusive of a normalized level of cash-free net working capital. Net working capital includes accounts receivables and other current assets less non-interest-bearing current liabilities that permit a business to conduct daily operations and maintain liquidity. Normalized net working capital is estimated to be 8.0% of net operating revenue. Incremental net working capital requirements are projected at 8.0% of net operating revenue throughout the projection period.

Desert Regional Medical Center

Statement of Limiting Conditions & Appraisers' Certification

Statement of Limiting Conditions

Statement of Limiting Conditions

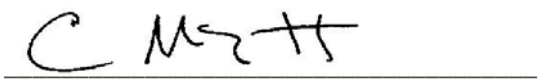
The value recommendations contained in this report are qualified as follows:

- The facts described in this report were provided by management or obtained from independent third parties including the Center's accountants, published sources, and commercial databases. We have accepted this information without further verification. Our value recommendations assume this information is materially true and correct.
- The value recommendations assume competent management in the context of a going concern.
- Neither our employment nor the fee for this assignment is contingent upon the reported value(s). No professional involved in this assignment has any financial interest in the property appraised.
- Certain matters are outside the purview of our expertise. As a result, our value recommendations assume: (1) The company complies fully with all federal, state, and local laws and ordinances; (2) Funding for pensions and health care liabilities, if any, is adequate; and (3) There are no undisclosed factors that might render the company materially more or less valuable. Any statements in this report about the above issues are based on management representations. The user is responsible for independent investigation of these matters, and his own determination of their impact on the recommended value(s).
- Nothing contained in the report should be construed as either investment, legal, or tax advice. This valuation is intended only for the use of the addressee and only for the purpose described. All other uses of this report are unauthorized and prohibited. The report may not be distributed, either in whole or part, to any third party, and mere possession of the report does not convey a right of reliance.
- VMG Health has not, as part of this assignment, examined either the historical, interim, or prospective financial statements according to generally accepted auditing standards, and so expresses no opinion thereon in this valuation report.
- Any estimates of future performance described in this report (or the exhibits hereto), pertain to a specific valuation method. This method matches performance scenarios with their associated risk rates as a means of quantifying the value parameters. Use of either the future performance scenarios or the discount rate separately or outside the valuation context is unauthorized and prohibited. Actual operating results may vary materially from those described.
- The fee for this assignment is provided only for the preparation of this report for the specific valuation date. All other services including updates of value for any other date; preparation and testimony in court or before governmental agencies; or meetings about the valuation report after its delivery will be provided at additional cost for fees and expenses.

Appraisers' Certification

Appraisers' Certification

- Neither VMG Health nor any individuals signing or associated with this report have any present or future contemplated interest in the assets being appraised.
- Neither our employment nor our compensation in connection with this report is in any way contingent upon the conclusions reached or values estimated.
- The report analysis, opinions, and conclusions are limited by the reported assumptions and limiting conditions and represent our unbiased professional analysis, opinions, and conclusions.
- We have not made a personal inspection of the property that is the subject of this report, but have extensively discussed the operations of the business with management.
- No persons other than the undersigned or those acknowledged in this report prepared analysis, values, and conclusions set forth in this report.
- To the best of our knowledge and belief, the statements of fact contained in this report are true and correct.



Colin M. McDermott CFA CPA/ABV
Managing Director
VMG Holdings LLC

Contributing Appraisers: David LaMonte, CFA and Blake Madden

WE VALUE HEALTHCARE

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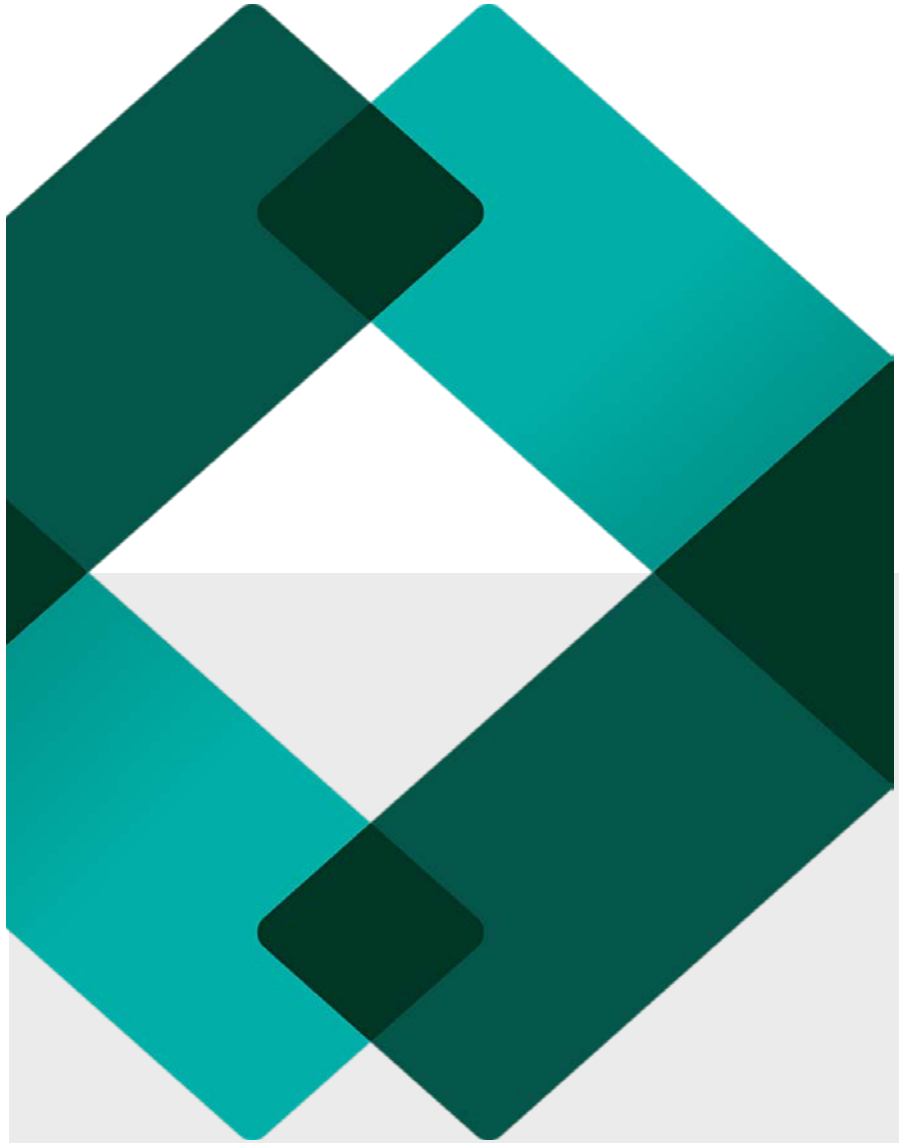


VMG HEALTH

Desert Regional Medical Center

Valuation Exhibits

Distributed on Thursday, October 18, 2018

Desert Regional Medical Center

Executive Summary

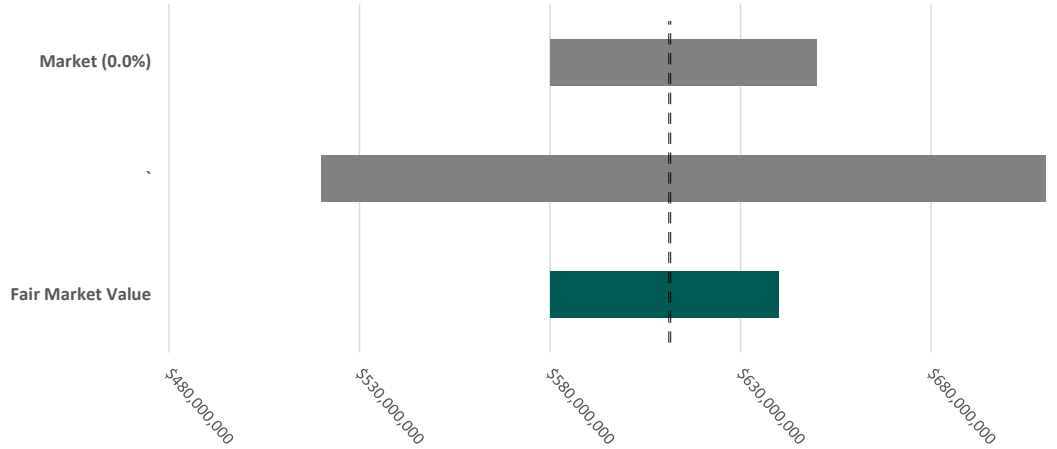
DESERT REGIONAL MEDICAL CENTER
VALUATION RECONCILIATION

FINAL REPORT

Reconciliation of Valuation Approaches	Value	Weight	Conclusion
Income Approach Value Indication (Midpoint)	$610,000,000	100.0%	$610,000,000
Cost Approach Value Indication	n/a	-	-
Market Approach Value Indication (Midpoint)	$610,000,000	-	-
Fair Market Value Indication, Business Enterprise Level			$610,000,000

**The value indications above are inclusive of a normalized level of cash-free net working capital.*

Reconciliation of Valuation Approaches - BEV Level



Range of Fair Market Value, BEV Level	Low (5.0%)	Midpoint	High (+5.0%)
Fair Market Value Indication, Business Enterprise Level	$580,000,000	$610,000,000	$640,000,000

Implied Market Multiples	Financial Metric ($)	Low	Mid	High
BEV/ NBY EBITDA	96,468,473	6.01x	6.32x	6.63x
BEV/ NBY Revenue	544,133,376	1.07x	1.12x	1.18x
BEV/ Year 1 EBITDA	94,983,961	6.11x	6.42x	6.74x
BEV/ Year 1 Revenue	559,522,715	1.04x	1.09x	1.14x

DESERT REGIONAL MEDICAL CENTER
BUSINESS ENTERPRISE VALUE ADJUSTMENTS

FINAL REPORT

ADJUSTMENTS TO BEV	
Value Indication, Business Enterprise Value (Including Working Capital)	$610,000,000
Less: Normalized Working Capital included in Business Enterprise Calculation	*(44,000,000)*
Subtotal - Business Enterprise Value, less Working Capital (rounded)	$566,000,000
Less: Value Indication for Total Year 1 - Year 9 Present Value of Cash Flows	($299,231,472)
Subtotal - Business Enterprise Value, Adjusted for Remaining Lease Term & Working Capital	$267,000,000
Less: Seismic Upgrade Cost	*TBD*
Less: Termination Assets	*TBD*
BEV Adjusted for Remaining Lease Term, Seismic Requirements, Working Capital & Termination Assets	TBD

Notes:
1. Calculated on the prior page.
2. Calculated on the Working Capital page in Exhibit A.
3. Calculations based on an assumed nine year period until the current Hospital Lease Agreement expires at May 30, 2027. Given that the financial data provided to VMG was through a historical period ended May 30, 2018, there are an estimated nine years remaining in the lease term.

Desert Regional Medical Center

Historical Financials & Operations

DESERT REGIONAL MEDICAL CENTER
HISTORICAL RESTATED BALANCE SHEET

FINAL REPORT

Fiscal Year End December 31,	FYE 2017	May-31 2018	FYE 2017	May-31 2018
ASSETS:				
Current Assets:				
Cash & Equivalents	$65,218	$2,750	0.0%	0.0%
Net Patient Receivables	109,933,068	110,424,102	31.1%	32.9%
Prepaid Expenses	2,343,626	1,943,633	0.7%	0.6%
Inventory	6,838,808	6,796,874	1.9%	2.0%
Physician / Group Guarantees & Other Receivable	28,447,822	26,147,270	8.1%	7.8%
Other Current Assets	(258,627)	5,398,848	(0.1%)	1.6%
Medicaid Supplemental Payment Receivable	91,174,585	69,620,022	25.8%	20.8%
Total Current Assets	238,544,500	220,333,499	67.6%	65.7%
Property, Plant & Equipment:				
Buildings & Improvements	134,701,822	137,519,653	38.1%	41.0%
Capitalized Leases	16,732,230	17,052,582	4.7%	5.1%
Equipment	92,243,711	94,946,925	26.1%	28.3%
Land & Land Improvements	6,194,989	6,194,989	1.8%	1.8%
Construction in Progress	1,238,020	2,042,061	0.4%	0.6%
Accumulated Depreciation	(159,158,131)	(164,664,039)	(45.1%)	(49.1%)
Net Property, Plant & Equipment	91,952,641	93,092,171	26.0%	27.8%
Other Non-current Assets:				
Investments and Other Long-Term Assets	315,210	291,094	0.1%	0.1%
Net Intangible Assets	22,319,818	21,733,298	6.3%	6.5%
Total Other Non-current Assets	22,635,028	22,024,392	6.4%	6.6%
Total Assets	353,132,169	335,450,062	100.0%	100.0%

DESERT REGIONAL MEDICAL CENTER
HISTORICAL RESTATED BALANCE SHEET

FINAL REPORT

Fiscal Year End December 31,	FYE 2017	May-31 2018	FYE 2017	May-31 2018
LIABILITIES:				
Current Liabilities:				
Accounts Payable	16,556,550	15,741,196	4.7%	4.7%
Accrued Liabilities	13,469,021	15,786,094	3.8%	4.7%
Other Current Liabilities	5,668,468	4,957,592	1.6%	1.5%
Current Portion of Capital Lease Obligation	4,441,205	4,788,363	1.3%	1.4%
Estimted Physician / Group Guarantee Liability	24,046,504	25,208,543	6.8%	7.5%
Medicaid Assessment Payable	30,107,689	13,966,633	8.5%	4.2%
Total Current Liabilities	94,289,437	80,448,421	26.7%	24.0%
Long-Term Liabilities:				
Capitalized Lease Obligation, net of Current Portion	3,197,158	2,951,612	0.9%	0.9%
Deferred Income	615,522	541,894	0.2%	0.2%
Other Long-Term Liabilities	2,095,906	2,162,166	0.6%	0.6%
Total Long-Term Liabilities	5,908,586	5,655,672	1.7%	1.7%
Total Liabilities	100,198,023	86,104,093	28.4%	25.7%
EQUITY AND INTERCOMPANY:				
Intercompany Accounts	(177,670,315)	(265,661,759)	(50.3%)	(79.2%)
Common Stock and Additional Paid-in Capital	118,624,448	254,864,205	33.6%	76.0%
Retained Earnings	311,980,013	260,143,523	88.3%	77.6%
Total Equity and Intercompany	252,934,146	249,345,969	71.6%	74.3%
Total Liabilities & Equity and Intercompany	$353,132,169	$335,450,062	100.0%	100.0%

Sources: Balance Sheet detail provided for entity "694 - Desert Regional Medical Center" for the fiscal year ended December 31, 2017 ("FYE 2017") and as of May 31, 2018.
Note: FYE 2017 period information is based on the "Period 13 2017" Balance Sheet detail provided.

DESERT REGIONAL MEDICAL CENTER
HISTORICAL WORKING CAPITAL ANALYSIS

FINAL REPORT

ACTUAL WORKING CAPITAL CALCULATION ($)		FYE 2017	May 31 / TTM 2018	Normalized Base Year
Current Assets:				
Cash & Equivalents	*Excluded from cash-free working capital*	-	-	-
Net Patient Receivables		109,933,068	110,424,102	110,424,102
Prepaid Expenses		2,343,626	1,943,633	1,943,633
Inventory		6,838,808	6,796,874	6,796,874
Physician / Group Guarantees & Other Receivable		28,447,822	26,147,270	26,147,270
Other Current Assets		(258,627)	5,398,848	5,398,848
Medicaid Supplemental Payment Receivable		91,174,585	69,620,022	69,620,022
Total Current Assets		238,479,282	220,330,749	220,330,749
Current Liabilities:				
Accounts Payable		16,556,550	15,741,196	15,741,196
Accrued Liabilities		13,469,021	15,786,094	15,786,094
Other Current Liabilities		5,668,468	4,957,592	4,957,592
Current Portion of Capital Lease Obligation	*Excluded from working capital*	-	-	-
Estimted Physician / Group Guarantee Liability		24,046,504	25,208,543	25,208,543
Medicaid Assessment Payable		30,107,689	13,966,633	13,966,633
Total Current Liabilities		89,848,232	75,660,058	75,660,058
Total Working Capital (Rounded)		148,631,000	144,671,000	144,671,000
Total Net Operating Revenue (Rounded)		538,195,000	562,925,000	544,133,000
Working Capital as a % Total Net Operating Revenue (Rounded)		**27.6%**	**25.7%**	**26.6%**

Normalized Working Capital Calculation	
NBY Net Operating Revenue	$544,133,376
Times: Required Net Working Capital Level	8.0%
Equals: Normalized Net Working Capital (Rounded)	**$43,530,000**

FINAL REPORT

Net Working Capital (Excluding Cash) as a % of Revenue											
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	High	Low	Average	Median	Desert Regional Medical Center
FYE - 2	11.0%	8.0%	7.4%	15.6%	3.4%	6.9%	**15.6%**	**3.4%**	**8.7%**	**7.7%**	**n/a**
FYE - 1	10.8%	6.7%	7.1%	11.8%	3.6%	4.5%	**11.8%**	**3.6%**	**7.4%**	**6.9%**	**n/a**
FYE	7.7%	7.4%	6.8%	10.5%	4.0%	4.0%	**10.5%**	**4.0%**	**6.8%**	**7.1%**	**27.6%**
TTM	10.5%	7.8%	7.5%	9.7%	3.3%	4.6%	**10.5%**	**3.3%**	**7.2%**	**7.7%**	**25.7%**
Average	**9.8%**	**7.7%**	**7.9%**	**9.9%**	**4.0%**	**6.8%**	**12.4%**	**5.6%**	**7.7%**	**7.6%**	**26.7%**
Median	**10.5%**	**7.8%**	**7.4%**	**10.5%**	**3.6%**	**4.6%**	**11.8%**	**3.6%**	**7.4%**	**7.7%**	**26.7%**

Other Related Working Capital Statistics											
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	High	Low	Average	Median	Desert Regional Medical Center
FY Total Asset Turnover	0.8x	1.3x	1.0x	1.0x	0.8x	1.0x	**1.3x**	**0.8x**	**1.0x**	**1.0x**	**1.7x**
FY Accounts Receivable Turnover	5.1x	7.1x	7.7x	5.5x	6.0x	7.1x	**7.7x**	**5.1x**	**6.4x**	**6.5x**	**5.1x**
FY Inventory Turnover	22.0x	17.6x	30.5x	22.9x	39.2x	46.5x	**46.5x**	**17.6x**	**29.8x**	**26.7x**	**11.3x**
FY Avg. Days Inventory Out.	16.7 Days	20.8 Days	12.0 Days	16.0 Days	9.3 Days	7.9 Days	**20.8 Days**	**7.9 Days**	**13.8 Days**	**14.0 Days**	**5.8 Days**
FY Days Cash on Hand	5.4 Days	7.1 Days	6.2 Days	4.7 Days	15.1 Days	1.5 Days	**15.1 Days**	**1.5 Days**	**6.7 Days**	**5.8 Days**	**0.0 Days**
FY Avg. Days Sales Out.	71.3 Days	51.8 Days	47.6 Days	66.0 Days	60.8 Days	51.4 Days	**71.3 Days**	**47.6 Days**	**58.2 Days**	**56.3 Days**	**82.0 Days**
FY Avg. Days Payables Out.	35.7 Days	31.7 Days	18.0 Days	41.6 Days	39.8 Days	26.2 Days	**41.6 Days**	**18.0 Days**	**32.2 Days**	**33.7 Days**	**13.4 Days**

Source: Capital IQ as of August 22, 2018.

DESERT REGIONAL MEDICAL CENTER
HISTORICAL RESTATED INCOME STATEMENT

FINAL REPORT

Fiscal Year End December 31,	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
Hospital Operating Revenue										
Patient Revenue										
Gross Inpatient Revenue	2,172,776,766	2,466,134,357	2,508,873,783	2,562,224,502	2,562,224,502	442.5%	449.1%	466.2%	455.2%	470.9%
Inpatient Contractual	(1,856,157,763)	(2,106,525,179)	(2,167,492,991)	(2,220,650,822)	(2,217,997,190)	(378.0%)	(383.6%)	(402.7%)	(394.5%)	(407.6%)
Net Inpatient Revenue	316,619,003	359,609,178	341,380,792	341,573,680	344,227,312	64.5%	65.5%	63.4%	60.7%	63.3%
Gross Outpatient Revenue	914,018,727	1,045,447,306	1,151,497,930	1,161,536,693	1,159,666,693	186.1%	190.4%	214.0%	206.3%	213.1%
Outpatient Contractual	(775,273,263)	(892,476,375)	(998,786,817)	(1,009,294,506)	(1,009,294,506)	(157.9%)	(162.5%)	(185.6%)	(179.3%)	(185.5%)
Net Outpatient Revenue	138,745,464	152,970,931	152,711,113	152,242,187	150,372,187	28.3%	27.9%	28.4%	27.0%	27.6%
Net Patient Revenue before Bad Debt	455,364,467	512,580,109	494,091,905	493,815,867	494,599,499	92.7%	93.3%	91.8%	87.7%	90.9%
Bad Debt	(14,573,495)	(14,301,275)	(10,016,605)	(2,546,776)	(3,132,257)	(3.0%)	(2.6%)	(1.9%)	(0.5%)	(0.6%)
Total Net Patient Revenue	440,790,972	498,278,834	484,075,300	491,269,091	491,467,242	89.8%	90.7%	89.9%	87.3%	90.3%
Supplemental Payments										
Medicaid DSH	8,436,631	7,962,995	7,402,065	7,203,734	7,203,734	1.7%	1.5%	1.4%	1.3%	1.3%
Medicaid Supplemental - Income Provider	62,013,094	68,421,637	67,523,469	97,750,754	69,615,975	12.6%	12.5%	12.5%	17.4%	12.8%
Medicaid Supplemental - Assessment Provider	(26,897,084)	(30,390,480)	(21,947,306)	(33,794,251)	(24,649,540)	(5.5%)	(5.5%)	(4.1%)	(6.0%)	(4.5%)
Electronic Health Record Incentives	1,020,542	497,371	301,700	301,700	301,700	0.2%	0.1%	0.1%	0.1%	0.1%
Total	44,573,183	46,491,523	53,279,928	71,461,937	52,471,869	9.1%	8.5%	9.9%	12.7%	9.6%
Other Revenue	5,699,832	4,362,188	839,569	194,265	194,265	1.2%	0.8%	0.2%	0.0%	0.0%
Total Net Operating Revenue	**491,063,987**	**549,132,545**	**538,194,797**	**562,925,293**	**544,133,376**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

DESERT REGIONAL MEDICAL CENTER
HISTORICAL RESTATED INCOME STATEMENT

FINAL REPORT

Fiscal Year End December 31,	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
Operating Expenses:										
Employee Salaries & Wages										
Employee Salaries & Wages	161,480,723	190,660,210	187,195,604	186,925,096	186,925,096	32.9%	34.7%	34.8%	33.2%	34.4%
Total	161,480,723	190,660,210	187,195,604	186,925,096	186,925,096	32.9%	34.7%	34.8%	33.2%	34.4%
Employee Benefits										
Payroll Taxes	11,763,690	14,067,020	13,885,432	13,998,001	13,998,001	2.4%	2.6%	2.6%	2.5%	2.6%
Employee Benefits	32,383,647	35,607,391	36,987,851	37,264,605	37,577,605	6.6%	6.5%	6.9%	6.6%	6.9%
Total	44,147,337	49,674,411	50,873,283	51,262,606	51,575,606	9.0%	9.0%	9.5%	9.1%	9.5%
Occupancy Costs										
Rent / Lease - Real Property	715,595	852,565	877,241	785,280	785,280	0.1%	0.2%	0.2%	0.1%	0.1%
Utilities	3,899,993	3,330,300	3,499,157	3,678,255	3,678,255	0.8%	0.6%	0.7%	0.7%	0.7%
Property Taxes	1,242,032	1,193,427	1,271,050	1,147,173	1,147,173	0.3%	0.2%	0.2%	0.2%	0.2%
Total	5,857,620	5,376,292	5,647,448	5,610,708	5,610,708	1.2%	1.0%	1.0%	1.0%	1.0%
Supplies										
Medical Supplies	38,219,014	42,323,381	40,338,078	41,083,832	41,083,832	7.8%	7.7%	7.5%	7.3%	7.6%
Drugs & Pharmaceuticals	26,510,658	30,850,978	30,247,697	31,110,577	31,110,577	5.4%	5.6%	5.6%	5.5%	5.7%
Non-medical Supplies	5,721,203	4,824,614	4,536,075	4,518,902	4,518,902	1.2%	0.9%	0.8%	0.8%	0.8%
Total	70,450,875	77,998,973	75,121,850	76,713,311	76,713,311	14.3%	14.2%	14.0%	13.6%	14.1%
Medical Costs										
Other Clinical Expenses	15,880	10,538	1,173,820	1,403,631	1,403,631	0.0%	0.0%	0.2%	0.2%	0.3%
Medical Fees	22,918,405	28,155,709	32,217,548	34,086,074	34,086,074	4.7%	5.1%	6.0%	6.1%	6.3%
Physician Income Assist	1,531,647	1,490,747	1,974,964	2,002,993	2,002,993	0.3%	0.3%	0.4%	0.4%	0.4%
Total	24,465,932	29,656,994	35,366,332	37,492,698	37,492,698	5.0%	5.4%	6.6%	6.7%	6.9%
Insurance										
Malpractice Insurance	3,986,073	7,591,366	6,394,474	5,692,256	5,692,256	0.8%	1.4%	1.2%	1.0%	1.0%
Other Insurance	676,531	842,166	900,543	949,693	949,693	0.1%	0.2%	0.2%	0.2%	0.2%
Total	4,662,604	8,433,532	7,295,017	6,641,949	6,641,949	0.9%	1.5%	1.4%	1.2%	1.2%
General & Administrative										
Advertising	1,391,452	1,554,035	1,466,182	1,110,287	1,110,287	0.3%	0.3%	0.3%	0.2%	0.2%
Information Technology	7,562,988	8,179,456	9,697,950	9,480,068	9,480,068	1.5%	1.5%	1.8%	1.7%	1.7%
Charitable Contributions	864,838	1,145,921	972,447	1,561,160	1,561,160	0.2%	0.2%	0.2%	0.3%	0.3%
Equipment Rent / Lease Expense	953,797	1,584,208	1,502,505	1,330,460	1,330,460	0.2%	0.3%	0.3%	0.2%	0.2%
Non-medical Professional Fees	3,217,597	3,291,038	4,713,103	4,299,393	4,299,393	0.7%	0.6%	0.9%	0.8%	0.8%
Conifer Collection Fees	12,705,711	13,447,841	13,027,365	13,114,847	13,114,847	2.6%	2.4%	2.4%	2.3%	2.4%
License Fees	858,407	899,169	836,289	769,873	769,873	0.2%	0.2%	0.2%	0.1%	0.1%
Other Controllable Expenses	13,375,934	15,129,997	16,342,488	16,561,992	16,311,992	2.7%	2.8%	3.0%	2.9%	3.0%
Other Non-medical Expenses	7,705,587	8,261,334	7,421,385	7,713,207	7,713,207	1.6%	1.5%	1.4%	1.4%	1.4%
Repairs & Maintenance	7,551,948	8,056,848	8,639,898	9,273,933	9,273,933	1.5%	1.5%	1.6%	1.6%	1.7%
Management Fees	-	-	-	-	10,882,668	-	-	-	-	2.0%
Physician Subsidy	-	-	-	-	6,857,648	-	-	-	-	1.3%
Total	56,188,259	61,549,847	64,619,612	65,215,220	82,705,536	11.4%	11.2%	12.0%	11.6%	15.2%
Total Operating Expenses	367,253,350	423,350,259	426,119,146	429,861,588	447,664,904	74.8%	77.1%	79.2%	76.4%	82.3%
EBITDA	123,810,637	125,782,286	112,075,651	133,063,705	96,468,473	25.2%	22.9%	20.8%	23.6%	17.7%
Depreciation & Amortization Expense	14,211,402	14,814,437	15,734,886	15,442,515	15,442,515	2.9%	2.7%	2.9%	2.7%	2.8%
Operating Income	109,599,235	110,967,849	96,340,765	117,621,190	81,025,958	22.3%	20.2%	17.9%	20.9%	14.9%
Other Income (Expense)	(221,558)	(254,082)	(107,895)	(540)	-	(0.0%)	(0.0%)	(0.0%)	(0.0%)	-
Interest Expense	286,732	362,552	395,400	393,811	-	0.1%	0.1%	0.1%	0.1%	-
Earnings Before Income Taxes	109,090,945	110,351,215	95,837,470	117,226,839	81,025,958	22.2%	20.1%	17.8%	20.8%	14.9%
Federal & State Income Tax Expense	-	-	-	-	22,673,980	-	-	-	-	4.2%
Earnings After Income Taxes	$109,090,945	$110,351,215	$95,837,470	$117,226,839	$58,351,978	22.2%	20.1%	17.8%	20.8%	10.7%

Sources: Management provided financials for the fiscal years ended December 31, 2015, 2016, and 2017 and the trailing twelve month period ended May 31, 2018.
Normalized Base Year based on the trailing twelve month period ended May 31, 2018. Normalized Base Year eliminates any unusual or nonrecurring items from revenue and expenses.

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
Utilization Statistics									
Acute Admissions	18,508	18,945	18,565	18,641	18,641	2.4%	(2.0%)	0.4%	-
Psych Admissions	-	1	2	-	-	n/a	100.0%	(100.0%)	n/a
Rehab Admissions	200	217	190	178	178	8.5%	(12.4%)	(6.3%)	-
SNF Admissions	1,030	1,021	893	875	875	(0.9%)	(12.5%)	(2.0%)	-
Admissions	**19,738**	**20,184**	**19,650**	**19,694**	**19,694**	**2.3%**	**(2.6%)**	**0.2%**	**-**
Avg Length of Stay ("ALOS")	4.5	4.8	4.7	4.7	4.7	6.8%	(1.9%)	(0.7%)	-
Patient Days	88,855	97,083	92,724	92,271	92,271	9.3%	(4.5%)	(0.5%)	-
Outpatient ER Visits	61,248	63,484	63,875	63,650	63,650	3.7%	0.6%	(0.4%)	-
Outpatient Surgeries	2,476	2,641	2,786	2,731	2,731	6.7%	5.5%	(2.0%)	-
Other Outpatient Visits	95,810	98,281	101,441	100,656	100,656	2.6%	3.2%	(0.8%)	-
Total Outpatient Visits	**159,534**	**164,406**	**168,102**	**167,037**	**167,037**	**3.1%**	**2.2%**	**(0.6%)**	**-**
Outpatient Equivalent Factor	1.4	1.4	1.5	1.5	1.5	0.2%	2.5%	(0.4%)	(0.1%)
Adjusted Patient Days	126,233	138,239	135,282	134,100	134,033	9.5%	(2.1%)	(0.9%)	(0.1%)
Adjusted Admissions	28,041	28,740	28,669	28,622	28,608	2.5%	(0.2%)	(0.2%)	(0.1%)
Census Data									
Beds in Service	372	372	372	372	372	-	-	-	-
Calendar Days	365	366	365	365	365	0.3%	(0.3%)	-	-
Avg Daily Census ("ADC")	243.4	265.3	254.0	252.8	252.8	9.0%	(4.2%)	(0.5%)	-
Percent Occupancy	65.4%	71.3%	68.3%	68.0%	68.0%	9.0%	(4.2%)	(0.5%)	-
Percent Adjusted Occupancy	93.0%	101.5%	99.6%	98.8%	98.7%	9.2%	(1.9%)	(0.9%)	(0.1%)
Consumer Price Index									
Charity	n/a	1.4516	1.4888	1.5845		n/a	2.6%	6.4%	-
Medicare	n/a	1.7136	1.654	1.8102		n/a	(3.5%)	9.4%	-
Medicare Managed Care	n/a	1.5929	1.6078	1.5799		n/a	0.9%	(1.7%)	-
Medicaid	n/a	1.7468	1.7158	1.8701		n/a	(1.8%)	9.0%	-
Medicaid Managed Care	n/a	1.4111	1.3595	1.4421		n/a	(3.7%)	6.1%	-
Self Pay / Uninsured	n/a	1.2718	1.4366	1.3823		n/a	13.0%	(3.8%)	-
Commercial / Other	n/a	1.8479	2.0029	1.7573		n/a	8.4%	(12.3%)	-
Managed Care	n/a	1.465	1.3696	1.4996		n/a	(6.5%)	9.5%	-
Managed Exchange	n/a	1.445	1.5389	1.4712		n/a	6.5%	(4.4%)	-
Total CMI	**n/a**	**1.5681**	**1.5365**	**1.6085**		**n/a**	**(2.0%)**	**4.7%**	**-**

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
Other Key Statistics									
Total Emergency Room Visits	72,981	75,940	76,250	76,700	76,700	4.1%	0.4%	0.6%	-
Emergency Room Admits	11,733	12,456	12,375	13,050	13,050	6.2%	(0.7%)	5.5%	-
Total Surgeries	7,734	8,128	8,166	8,114	8,114	5.1%	0.5%	(0.6%)	-
Inpatient Surgeries	5,258	5,487	5,380	5,383	5,383	4.4%	(2.0%)	0.1%	-
Outpatient Surgeries	2,476	2,641	2,786	2,731	2,731	6.7%	5.5%	(2.0%)	-
Gross Charge & Net Revenue Statistics									
Gross Charge Ratios									
Gross Inpatient Charge per Admission	110,081	122,183	127,678	130,102	130,102	11.0%	4.5%	1.9%	-
Gross Inpatient Charge per Patient Day	24,453	25,402	27,057	27,768	27,768	3.9%	6.5%	2.6%	-
Gross Outpatient Charge per Visit	5,729	6,359	6,850	6,954	6,943	11.0%	7.7%	1.5%	(0.2%)
Net Patient Revenue Ratios									
Net Inpatient Revenue per Admission	16,041	17,817	17,373	17,344	17,479	11.1%	(2.5%)	(0.2%)	0.8%
Net Inpatient Revenue per Patient Day	3,563	3,704	3,682	3,702	3,731	4.0%	(0.6%)	0.5%	0.8%
Net Outpatient Revenue per Visit	870	930	908	911	900	7.0%	(2.4%)	0.3%	(1.2%)
Total Net Patient Revenue per Adj. Admission	15,719	17,337	16,885	17,164	17,180	10.3%	(2.6%)	1.7%	0.1%
Total Net Patient Revenue per Adj. Patient Day	3,492	3,604	3,578	3,663	3,667	3.2%	(0.7%)	2.4%	0.1%
Total Operating Expense Ratios									
Per Adj. Admission	13,097	14,730	14,864	15,019	15,648	12.5%	0.9%	1.0%	4.2%
Per Adj. Patient Day	2,909	3,062	3,150	3,206	3,340	5.3%	2.9%	1.8%	4.2%

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
Historical Staffing Ratios									
Employed FTE's	1,720	1,976	1,951	1,933	1,933	14.9%	(1.3%)	(0.9%)	-
Paid Hours	3,577,600	4,110,080	4,058,080	4,020,640	4,020,640	14.9%	(1.3%)	(0.9%)	-
Paid Hours per Adj. Patient Day	28.3	29.7	30.0	30.0	30.0	4.9%	0.9%	(0.0%)	0.1%
FTEs per Adj. Occupied Bed	5.0	5.2	5.3	5.3	5.3	5.2%	0.6%	(0.0%)	0.1%
P/L Salary	$45.14	$46.39	$46.13	$46.49	$46.49	2.8%	(0.6%)	0.8%	-
P/L Benefits	$12.34	$12.09	$12.54	$12.75	$12.83	(2.1%)	3.7%	1.7%	0.6%
Employee Salaries & Wages:									
Employee Salaries & Wages	161,480,723	190,660,210	187,195,604	186,925,096	186,925,096	18.1%	(1.8%)	(0.1%)	-
% of Revenue	*32.9%*	*34.7%*	*34.8%*	*33.2%*	*34.4%*				
Employee Benefits & Taxes:									
Payroll Taxes	11,763,690	14,067,020	13,885,432	13,998,001	13,998,001	19.6%	(1.3%)	0.8%	-
% of Salaries & Wages	*7.3%*	*7.4%*	*7.4%*	*7.5%*	*7.5%*				
Employee Benefits	32,383,647	35,607,391	36,987,851	37,264,605	37,577,605	10.0%	3.9%	0.7%	0.8%
% of Salaries & Wages	*20.1%*	*18.7%*	*19.8%*	*19.9%*	*20.1%*				
Occupancy Costs:									
Rent / Lease - Real Property	715,595	852,565	877,241	785,280	785,280	19.1%	2.9%	(10.5%)	-
% of Revenue	*0.1%*	*0.2%*	*0.2%*	*0.1%*	*0.1%*				
Utilities	3,899,993	3,330,300	3,499,157	3,678,255	3,678,255	(14.6%)	5.1%	5.1%	-
% of Revenue	*0.8%*	*0.6%*	*0.7%*	*0.7%*	*0.7%*				
Property Taxes	1,242,032	1,193,427	1,271,050	1,147,173	1,147,173	(3.9%)	6.5%	(9.7%)	-
% of Revenue	*0.3%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*				

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
Supplies									
Medical Supplies	38,219,014	42,323,381	40,338,078	41,083,832	41,083,832	10.7%	(4.7%)	1.8%	-
% of Revenue	*7.8%*	*7.7%*	*7.5%*	*7.3%*	*7.6%*				
Per Adj. Admission	1,363	1,473	1,407	1,435	1,436	8.0%	(4.5%)	2.0%	0.1%
Per Adj. Patient Day	303	306	298	306	307	1.1%	(2.6%)	2.7%	0.1%
Drugs & Pharmaceuticals	26,510,658	30,850,978	30,247,697	31,110,577	31,110,577	16.4%	(2.0%)	2.9%	-
% of Revenue	*5.4%*	*5.6%*	*5.6%*	*5.5%*	*5.7%*				
Per Adj. Admission	945	1,073	1,055	1,087	1,087	13.5%	(1.7%)	3.0%	0.1%
Per Adj. Patient Day	210	223	224	232	232	6.3%	0.2%	3.8%	0.1%
Non-medical Supplies	5,721,203	4,824,614	4,536,075	4,518,902	4,518,902	(15.7%)	(6.0%)	(0.4%)	-
% of Revenue	*1.2%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*				
Per Adj. Admission	204	168	158	158	158	(17.7%)	(5.7%)	(0.2%)	0.1%
Per Adj. Patient Day	45	35	34	34	34	(23.0%)	(3.9%)	0.5%	0.1%
Medical Costs									
Other Clinical Expenses	15,880	10,538	1,173,820	1,403,631	1,403,631	(33.6%)	11038.9%	19.6%	-
% of Revenue	*0.0%*	*0.0%*	*0.2%*	*0.2%*	*0.3%*	*(5,342)*	*1,163,282*	*229,811*	-
Medical Fees	22,918,405	28,155,709	32,217,548	34,086,074	34,086,074	22.9%	14.4%	5.8%	-
% of Revenue	*4.7%*	*5.1%*	*6.0%*	*6.1%*	*6.3%*	*5,237,304*	*4,061,839*	*1,868,526*	-
Physician Income Assist	1,531,647	1,490,747	1,974,964	2,002,993	2,002,993	(2.7%)	32.5%	1.4%	-
% of Revenue	*0.3%*	*0.3%*	*0.4%*	*0.4%*	*0.4%*	*(40,900)*	*484,217*	*28,029*	-
Insurance									
Malpractice Insurance	3,986,073	7,591,366	6,394,474	5,692,256	5,692,256	90.4%	(15.8%)	(11.0%)	-
% of Revenue	*0.8%*	*1.4%*	*1.2%*	*1.0%*	*1.0%*				
Other Insurance	676,531	842,166	900,543	949,693	949,693	24.5%	6.9%	5.5%	-
% of Revenue	*0.1%*	*0.2%*	*0.2%*	*0.2%*	*0.2%*	*165,635*	*58,377*	*49,150*	-

FINAL REPORT

Fiscal Year End December 31st	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year
						% / $ Growth			
General & Administrative									
Advertising	1,391,452	1,554,035	1,466,182	1,110,287	1,110,287	11.7%	(5.7%)	(24.3%)	-
% of Revenue	*0.3%*	*0.3%*	*0.3%*	*0.2%*	*0.2%*				
Information Technology	7,562,988	8,179,456	9,697,950	9,480,068	9,480,068	8.2%	18.6%	(2.2%)	-
% of Revenue	*1.5%*	*1.5%*	*1.8%*	*1.7%*	*1.7%*				
Charitable Contributions	864,838	1,145,921	972,447	1,561,160	1,561,160	32.5%	(15.1%)	60.5%	-
% of Revenue	*0.2%*	*0.2%*	*0.2%*	*0.3%*	*0.3%*				
Equipment Rent / Lease Expense	953,797	1,584,208	1,502,505	1,330,460	1,330,460	66.1%	(5.2%)	(11.5%)	-
% of Revenue	*0.2%*	*0.3%*	*0.3%*	*0.2%*	*0.2%*	*630,411*	*(81,703)*	*(172,045)*	-
Non-medical Professional Fees	3,217,597	3,291,038	4,713,103	4,299,393	4,299,393	2.3%	43.2%	(8.8%)	-
% of Revenue	*0.7%*	*0.6%*	*0.9%*	*0.8%*	*0.8%*	*73,441*	*1,422,065*	*(413,710)*	-
Conifer Collection Fees	12,705,711	13,447,841	13,027,365	13,114,847	13,114,847	5.8%	(3.1%)	0.7%	-
% of Revenue	*2.6%*	*2.4%*	*2.4%*	*2.3%*	*2.4%*				
License Fees	858,407	899,169	836,289	769,873	769,873	4.7%	(7.0%)	(7.9%)	-
% of Revenue	*0.2%*	*0.2%*	*0.2%*	*0.1%*	*0.1%*				
Other Controllable Expenses	13,375,934	15,129,997	16,342,488	16,561,992	16,311,992	13.1%	8.0%	1.3%	(1.5%)
% of Revenue	*2.7%*	*2.8%*	*3.0%*	*2.9%*	*3.0%*				
Other Non-medical Expenses	7,705,587	8,261,334	7,421,385	7,713,207	7,713,207	7.2%	(10.2%)	3.9%	-
% of Revenue	*1.6%*	*1.5%*	*1.4%*	*1.4%*	*1.4%*	*555,747*	*(839,949)*	*291,822*	-
Repairs & Maintenance	7,551,948	8,056,848	8,639,898	9,273,933	9,273,933	6.7%	7.2%	7.3%	-
% of Revenue	*1.5%*	*1.5%*	*1.6%*	*1.6%*	*1.7%*	*504,900*	*583,050*	*634,035*	-
Net Operating Revenue	491,063,987	549,132,545	538,194,797	562,925,293	544,133,376	11.8%	(2.0%)	4.6%	(3.3%)
% of Revenue	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*				
Total Operating Expenses	367,253,350	423,350,259	426,119,146	429,861,588	447,664,904	15.3%	0.7%	0.9%	4.1%
% of Revenue	*74.8%*	*77.1%*	*79.2%*	*76.4%*	*82.3%*				
EBITDA	**123,810,637**	**125,782,286**	**112,075,651**	**133,063,705**	**96,468,473**	**1.6%**	**(10.9%)**	**18.7%**	**(27.5%)**
% of Revenue	*25.2%*	*22.9%*	*20.8%*	*23.6%*	*17.7%*				

FINAL REPORT

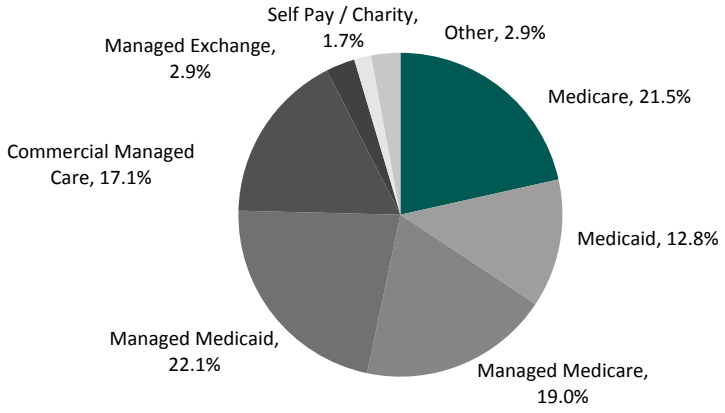
Historical Payor Mix Expressed as % of Gross Charges	FYE 2015	FYE 2016	FYE 2017	YTD 2018
Medicare	21.0%	20.8%	21.6%	21.5%
Medicaid	15.6%	13.6%	12.6%	12.8%
Managed Medicare	18.7%	19.0%	20.1%	19.0%
Managed Medicaid	19.4%	21.7%	21.2%	22.1%
Commercial Managed Care	16.9%	17.8%	16.2%	17.1%
Managed Exchange	2.6%	2.4%	2.9%	2.9%
Self Pay / Charity	1.3%	1.7%	1.7%	1.7%
Other	4.5%	3.0%	3.7%	2.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: Hospital's payor mix report which is reported in terms of gross charges.

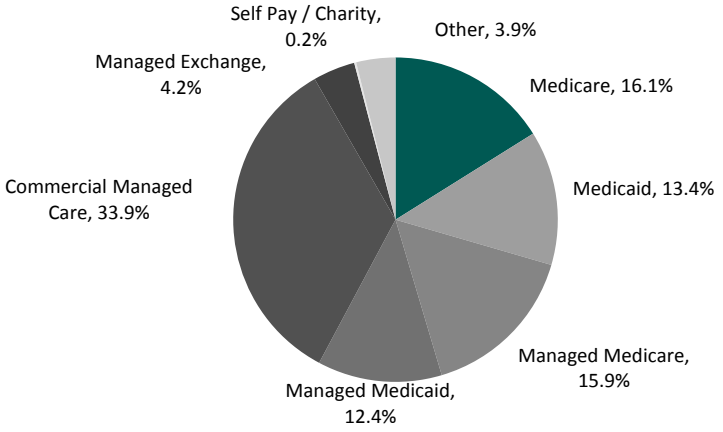
Historical Payor Mix Expressed as % of Net Patient Revenue	FYE 2015	FYE 2016	FYE 2017	YTD 2018
Medicare	14.2%	14.5%	15.7%	16.1%
Medicaid	14.0%	12.7%	14.1%	13.4%
Managed Medicare	15.6%	16.9%	17.3%	15.9%
Managed Medicaid	12.7%	13.7%	13.5%	12.4%
Commercial Managed Care	31.7%	34.0%	30.5%	33.9%
Managed Exchange	4.9%	4.0%	4.3%	4.2%
Self Pay / Charity	1.3%	1.4%	1.3%	0.2%
Other	5.7%	2.9%	3.4%	3.9%
Total	100.0%	100.0%	100.0%	100.0%

Source: Hospital's payor mix report which is reported in terms of net patient revenue.

Gross Charges Payor Mix - YTD 2018



Net Patient Revenue Payor Mix - YTD 2018



Sources: Management provided payor mix reports for FYE 2015, FYE 2016, FYE 2017 and for the year-to-date period ended May 31, 2018.

Desert Regional Medical Center

Income Approach Analysis

DESERT REGIONAL MEDICAL CENTER
NORMALIZED INCOME STATEMENT

FINAL REPORT

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year	TTM 2018	Normalized Base Year
Hospital Operating Revenue						
Patient Revenue						
Gross Inpatient Revenue		$2,562,224,502	-	$2,562,224,502	455.2%	470.9%
Inpatient Contractual	*1*	(2,220,650,822)	$2,653,632	(2,217,997,190)	(394.5%)	(407.6%)
Net Inpatient Revenue		341,573,680	2,653,632	344,227,312	60.7%	63.3%
Gross Outpatient Revenue	*1*	1,161,536,693	($1,870,000)	1,159,666,693	206.3%	213.1%
Outpatient Contractual		(1,009,294,506)	-	(1,009,294,506)	(179.3%)	(185.5%)
Net Outpatient Revenue		152,242,187	(1,870,000)	150,372,187	27.0%	27.6%
Net Patient Revenue before Bad Debt		$493,815,867	$783,632	$494,599,499	87.7%	90.9%
Bad Debt	*1*	(2,546,776)	($585,481)	(3,132,257)	(0.5%)	(0.6%)
Total Net Patient Revenue		$491,269,091	$198,151	$491,467,242	87.3%	90.3%
Supplemental Payments						
Medicaid DSH		7,203,734	-	7,203,734	1.3%	1.3%
Medicaid Supplemental - Income Provider	*2*	97,750,754	(28,134,779)	69,615,975	17.4%	12.8%
Medicaid Supplemental - Assessment Provider	*2*	(33,794,251)	9,144,711	(24,649,540)	(6.0%)	(4.5%)
Electronic Health Record Incentives		301,700	-	301,700	0.1%	0.1%
Total		71,461,937	(18,990,068)	52,471,869	12.7%	9.6%
Other Revenue						
Rental Income		-	-	-	-	-
Other Revenue		194,265	-	194,265	0.0%	0.0%
Total		194,265	-	194,265	0.0%	0.0%
Total Net Operating Revenue		$562,925,293	($18,791,917)	$544,133,376	100.0%	100.0%

DESERT REGIONAL MEDICAL CENTER
NORMALIZED INCOME STATEMENT

FINAL REPORT

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year	TTM 2018	Normalized Base Year
Operating Expenses:						
Employee Salaries & Wages						
Employee Salaries & Wages		186,925,096	-	186,925,096	33.2%	34.4%
Total		186,925,096	-	186,925,096	33.2%	34.4%
Employee Benefits						
Payroll Taxes		13,998,001	-	13,998,001	2.5%	2.6%
Employee Benefits	*1*	37,264,605	313,000	37,577,605	6.6%	6.9%
Total		51,262,606	313,000	51,575,606	9.1%	9.5%
Occupancy Costs						
Rent / Lease - Real Property		785,280	-	785,280	0.1%	0.1%
Utilities		3,678,255	-	3,678,255	0.7%	0.7%
Property Taxes		1,147,173	-	1,147,173	0.2%	0.2%
Total		5,610,708	-	5,610,708	1.0%	1.0%
Supplies						
Medical Supplies		41,083,832	-	41,083,832	7.3%	7.6%
Drugs & Pharmaceuticals		31,110,577	-	31,110,577	5.5%	5.7%
Non-medical Supplies		4,518,902	-	4,518,902	0.8%	0.8%
Total		76,713,311	-	76,713,311	13.6%	14.1%
Medical Costs						
Other Clinical Expenses		1,403,631	-	1,403,631	0.2%	0.3%
Medical Fees		34,086,074	-	34,086,074	6.1%	6.3%
Physician Income Assist		2,002,993	-	2,002,993	0.4%	0.4%
Non-patient Provisions		-	-	-	-	-
Total		37,492,698	-	37,492,698	6.7%	6.9%
Insurance						
Malpractice Insurance		5,692,256	-	5,692,256	1.0%	1.0%
Other Insurance		949,693	-	949,693	0.2%	0.2%
Total		6,641,949	-	6,641,949	1.2%	1.2%
General & Administrative						
Advertising		1,110,287	-	1,110,287	0.2%	0.2%
Information Technology		9,480,068	-	9,480,068	1.7%	1.7%
Charitable Contributions		1,561,160	-	1,561,160	0.3%	0.3%
Non-medical Contracted Departments		-	-	-	-	-
Equipment Rent / Lease Expense		1,330,460	-	1,330,460	0.2%	0.2%
Non-medical Professional Fees		4,299,393	-	4,299,393	0.8%	0.8%
Conifer Collection Fees		13,114,847	-	13,114,847	2.3%	2.4%
License Fees		769,873	-	769,873	0.1%	0.1%
Other Controllable Expenses	*1*	16,561,992	(250,000)	16,311,992	2.9%	3.0%
Other Non-medical Expenses		7,713,207	-	7,713,207	1.4%	1.4%
Repairs & Maintenance		9,273,933	-	9,273,933	1.6%	1.7%
Management Fees	*3*	-	10,882,668	10,882,668	-	2.0%
Physician Subsidy	*4*	-	6,857,648	6,857,648	-	1.3%
Total		65,215,220	17,490,316	82,705,536	11.6%	15.2%
Total Operating Expenses	*3,4*	429,861,588	17,803,316	447,664,904	76.4%	82.3%

DESERT REGIONAL MEDICAL CENTER
NORMALIZED INCOME STATEMENT

FINAL REPORT

Normalized Base Year	Footnotes	TTM 2018	Adjustments	Normalized Base Year	TTM 2018	Normalized Base Year
EBITDA		133,063,705	(36,595,232)	96,468,473	23.6%	17.7%
Depreciation & Amortization Expense		15,442,515	-	15,442,515	2.7%	2.8%
Operating Income		117,621,190	(36,595,232)	81,025,958	20.9%	14.9%
Other Income (Expense)	*5*	(540)	540	-	(0.0%)	-
Interest Expense	*6*	393,811	(393,811)	-	0.1%	-
Earnings Before Income Taxes		117,226,839	(36,200,881)	81,025,958	20.8%	14.9%
Federal & State Income Tax Expense	*7*	-	22,673,980	22,673,980	-	4.2%
Earnings After Income Taxes		$117,226,839	($58,874,861)	$58,351,978	20.8%	10.7%

Sources: Management provided financials for the trailing twelve month period ended May 31, 2018.
Normalized Base Year based on the trailing twelve month period ended May 31, 2018. Normalized Base Year eliminates any unusual or nonrecurring items from revenue and expenses.

FINAL REPORT

Footnotes to Normalized Base Year Income Statement	
Footnote	Description
1	Management indicated several one-time or non-recurring expenses were included in the Hospital's TTM 2018 income statement. Please refer to Normalized Base Year Schedule 1 for additional detail.
2	Medicaid Supplemental - Income Provider' and 'Medicaid Supplemental - Assessment Provider' accounts are related to the Hospital's participation in the Hospital Qualify Assurance Fee ("HQAF") program Please refer to Normalized Base Year Schedule 2 for additional detail regarding this adjustment.
3	Management Fees not captured in the Hospital's TTM 2018 Income Statement have been estimated at 2.0% of revenue. Please refer to Normalized Base Year Schedule 3, which provides support for the selected level of revenue.
4	Physician losses not captured in the TTM 2018 financial statements have been added in the Normalized Base Year. Please refer to Normalized Base Year Schedule 4 for supporting calculations.
5	Eliminated Other Income (Expense) to projected only recurring patient service revenue.
6	Eliminated interest expense to derive debt-free operations.
7	Calculated a blended federal and state income tax rate for California businesses to be applied to the earnings before taxes.

DESERT REGIONAL MEDICAL CENTER
NORMALIZED BASE YEAR SUPPORTING SCHEDULE 1 - NON-RECURRING ITEMS IDENTIFIED BY MANAGEMENT

FINAL REPORT

Period	January-18	February-18	February-18	March-18	April-18	June-18	June-18	Total 2018 Other Normalizing Adjustments	Adjustments Included in NBY
	Valuation Acct Chng	IEHP OP PCR Adj	IEHP True-Up Q1 '18	Pension 2017 True-UP	CDHP Penalties Q2 '18	Allianz Sttlmnt Q2 '18	PCR / Historical Q2 '18		
	Note 1	*Note 2*	*Note 3*	*Note 4*	*Note 5*	*Note 6*	*Note 7*		
Adjustment to Account									
Inpatient Contractual			$2,653,632					$2,653,632	$2,653,632
Gross Outpatient Revenue		($1,037,000)					($833,000)	($1,870,000)	($1,870,000)
Bad Debt	($261,000)					($324,481)		($585,481)	($585,481)
Total Operating Revenue Adjustment	*($261,000)*	*($1,037,000)*	-	-	-	*($324,481)*	*($833,000)*	*$198,151*	*$198,151*
Operating Expenses									
Employee Benefits	-	-	-	$313,000	-	-	-	$313,000	$313,000
Other Controllable Expenses	-	-	-	-	($250,000)	-	-	($250,000)	($250,000)
Total Operating Expenses	-	-	-	*$313,000*	*($250,000)*	-	-	*$63,000*	*$63,000*
Total Adjustments	($261,000)	($1,037,000)	-	($313,000)	$250,000	($324,481)	($833,000)	$135,151	$135,151

Notes:

1) *Valuation Acct Chng - Management changed the bad debt methodology to align with the 2019 uncollectible valuation. The new approach begins "aging" while patients are in-house vs. the Hospital's historical practice of aging once accounts receivable exceeds 30 days. Management adjusted the reserve percentages under this new method, which impacted the Hospital's bottom line outside the normal operation.*

2) *IEHP OP PCR Adj – Management revisited the cancer center outpatient percent to charge ratio during Q1 to account for the trend of higher reimbursement specific to radiation oncology and chemo patients. The Hospital's rate increase from historical PCR reflected paid claims from Oct. '17 to Feb '18. Over this time period, the PCR increased from 20.37 to 24.1%.*

3) *IEHP True-Up Q1 '18 – In Oct. '17 we had a discussion with IEHP regarding the available funds for the quality risk pool. We understood at that time they had $7.5M in funds for DRMC based on 4 metrics. This was in line with the 2016/2017 fund disbursements. When we received the actual cash for Q1 & Q2 2017 in Feb. 2018 (due to IEHP delayed payment trending) we received <$1.1> less than anticipated. We clarified immediately with IEHP in March and understood $7.5M was their total pool of which DRMC was eligible to receive 5.2% on our percentage of the total. Total funds in 2016 were $84M which dropped to $30.7M in 2017. We reduced our estimate for Q3 & Q4 2017 in March 2018 for <$965K>. In addition, we are taking a monthly "hit" to forecast and to prior 2018 month reserves.*

4) *Pension 2017 True-Up – Management allocates annually the final "matching" for employees upon meeting certain eligibility requirements. Management uses a per pay period matching estimate for all employees. In March this estimated expense accrual is trued-up to the actual funds transferred to 401k accounts.*

5) *CDHP Penalties Q2 '18 – Management was notified by CDHP in April that the Hospital was going to be paying a minimum of two $125K penalties, which were accrued.*

6) *Allianz Sttlmnt Q2 '18 – Allianz is an insurance company that Management settled prior year claims, which netted the facility with a favorable net revenue adjustment.*

7) *PCR / Historical Q2 '18 – Management updated the Hospital's Managed OP Historical PCR based on current 6 month trending $204K balance along with a $629K "credit" balance for prior period paid claims. The Hospital's historical practice of applying a PCR*

DESERT REGIONAL MEDICAL CENTER
NORMALIZED BASE YEAR SUPPORTING SCHEDULE 2 - MEDICAID SUPPLEMENTAL PAYMENT & ASSESSMENT FEE ADJUSTMENT

FINAL REPORT

Medicaid Supplemental - Income Provider' and 'Medicaid Supplemental - Assessment Provider' accounts are related to the Hospital's participation in the Hospital Qualify Assurance Fee ("HQAF") program which provides funding for supplemental payments to California hospitals that serve Medi-Cal and uninsured patients. The Hospital accrues Supplemental Revenue and related Assessment Fees as detailed in teh exhibits below.

							TTM 2018	TTM 2018	TTM 2018	TTM 2018	TTM 2018	TTM 2018	TTM 2018	TTM 2018		Note:
Source Income Statement Account	VMG Income Statement Account	FYE 2017 - Janaury	FYE 2017 - February	FYE 2017 - March	FYE 2017 - April	FYE 2017 - May	FYE 2017 - June	FYE 2017 - July	FYE 2017 - August	FYE 2017 - September	FYE 2017 - October	FYE 2017 - November	FYE 2017 - December	FYE 2017 - Period 13	FYE 2017 Total	
4791 - Medicaid Supplemental - Income Provider Fee State	Medicaid Supplemental - Income Provider	-	-	-	-	-	-	-	-	-	-	-	63,654,523	3,868,946	67,523,469	1
4796 - Medicaid Supplemental - Assessment Provider Fee State	Medicaid Supplemental - Assessment Provider	-	-	-	-	-	-	-	-	-	-	-	(25,352,385)	3,405,079	(21,947,306)	1

		TTM 2018	TTM 2018	TTM 2018	TTM 2018	TTM 2018							
Source Income Statement Account	VMG Income Statement Account	YTD 2018 - January	YTD 2018 - February	YTD 2018 - March	YTD 2018 - April	YTD 2018 - May	FYE 2017 Total Accrued	TTM 2018 Total Accrued	TTM 2018 Months Accrued	FYE 2017 Months to Eliminate	FYE 2017 Avg Monthly Accrual	Adjustment	Normalized Base Year	
4791 - Medicaid Supplemental - Income Provider Fee State	Medicaid Supplemental - Income Provider	6,045,457	6,045,457	6,045,457	6,045,457	6,045,457	67,523,469	97,750,754	17 Months	5 Months	5,626,956	28,134,779	125,885,533	2
4796 - Medicaid Supplemental - Assessment Provider Fee State	Medicaid Supplemental - Assessment Provider	(2,369,389)	(2,369,389)	(2,369,389)	(2,369,389)	(2,369,389)	(21,947,306)	(33,794,251)	17 Months	5 Months	(1,828,942)	(9,144,711)	(42,938,962)	2

Notes:
(1) During December 2017, Medicaid Supplemental Income & Assessment Fee accrual occurred for the full FYE 2017 period. The TTM 2018 Income Statement is overstated as a result as it included the December 2017 accruals.
(2) The Adjustment above eliminates an estimated 5 month period of accruals from FYE 2017 based on the Average accrued Income and Assessment Fee per month during FYE 2017.

FINAL REPORT

Summary of VMG Data for Management Fees Observed for Acute Care Hospitals

Comparable Facility	Selected Comparable ("X")	Fee % of Net Revenue
Comparable #1		2.2%
Comparable #2	X	1.1%
Comparable #3	X	2.2%
Comparable #4		1.1%
Comparable #5	X	2.9%
Comparable #6	X	1.9%
Comparable #7		3.0%
Comparable #8		3.8%
Comparable #9	X	2.5%
Comparable #10	X	2.5%
Comparable #11	X	2.0%
Comparable #12	X	4.4%
Comparable #13	X	0.5%
Comparable #14	X	2.0%
Comparable #15	X	1.9%
Comparable #16	X	2.5%
Comparable #17		1.0%
Comparable #18		1.0%
Comparable #19		2.0%
Comparable #20	X	2.0%
Comparable #21		0.6%
Comparable #22		n/a
Comparable #23		n/a
Interview Response #1		1.3%
Interview Response #2		n/a
Interview Response #3		0.8%
Interview Response #4		1.8%
Third Party Quote		2.0%

Summary Data - All Data Points

Low	High	Mean	Median
0.5%	4.4%	1.9%	2.0%

Note: Please refer to the supplemental exhibits for a list of management services provided by Tenet at the Hospital.

DESERT REGIONAL MEDICAL CENTER
NORMALIZED BASE YEAR SUPPORTING SCHEDULE 4 - PHYSICIAN PRACTICE FOUNDATION SUBSIDY CALCULATION

FINAL REPORT

Line Item	FYE 2017	YTD May 2017	YTD May 2018	TTM 2018
Gross Patient Revenue	12,585,570	4,493,209	7,796,591	15,888,952
Revenue Deductions	9,167,991	3,013,359	5,880,135	12,034,767
Total Net Patient Revenue	**3,417,579**	**1,479,850**	**1,916,456**	**3,854,185**
Other Revenue	1,488,390	454,419	945,477	1,979,448
Total Net Operating Revenue	**4,905,969**	**1,934,269**	**2,861,933**	**5,833,633**
Bad Debt	109,954	43,247	(4,719)	61,988
Total Operating/Collectible Revenue	**4,796,015**	**1,891,022**	**2,866,652**	**5,771,645**
Salaries, Wages, & Benefits	90,150	2,002	159,709	247,857
Supplies	408,279	87,786	246,436	566,929
Medical & Clinical Fees	5,873,174	2,785,368	2,941,254	6,029,060
Other Professional Fees	171,226	75,641	171,618	267,203
Other Fees & Services	2,364,466	879,495	1,932,093	3,417,064
Utilities & Telephones	208,374	79,508	111,298	240,164
Repairs, Maintenance, & Equipment Rental	171,720	70,987	76,503	177,236
Total OCE	289,422	121,111	143,769	312,080
Rent & REIT	961,969	334,623	655,308	1,282,654
Other NCE	113,373	26,836	59,195	145,732
EHR Incentive	(27,460)	(1,960)	-	(25,500)
Depreciation & Amortization	619	350,828	317,752	(32,457)
Interest Expense	612	188	847	1,271
Total Expenses	**10,625,924**	**4,812,413**	**6,815,782**	**12,629,293**
Total Pre-Tax Income	**(5,829,909)**	**(2,921,391)**	**(3,949,130)**	**(6,857,648)** *

Note: Pre-tax income above was provided for the Physician Practice operations applicable to the operations of Desert Regional Medical Center. These Physician Practice's are accounted for under the Desert Foundation and have not historically been included in the Hospital Income Statements provided. The above Pre-tax Income (Loss) is applied as an expense for the Hospital in the NBY.

FINAL REPORT

DISCOUNTED CASH FLOW - ASSUMPTIONS

Incremental Working Capital Requirements	8.0%	
Normalized Working Capital	8.0%	$43,531,000 = x Normalized Base Year Revenue
Standard Inflation Rate (CPI)	3.0%	
Terminal Growth Rate	3.0%	
CA - Income Tax Rate (Blended Federal & State)	28.0%	CA

VOLUME GROWTH	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Inpatient Admissions	n/a	2.3%	(2.6%)	0.2%	-	0.5%	0.5%	0.5%	0.5%	0.5%
Outpatient Visits	n/a	3.1%	2.2%	(0.6%)	-	2.5%	2.5%	2.5%	2.5%	2.5%
Total Adj. Patient Days	126,233	138,239	135,282	134,100	134,033	135,538	137,072	138,635	140,228	141,851
Growth	*n/a*	*9.5%*	*(2.1%)*	*(0.9%)*	*(0.1%)*	*1.1%*	*1.1%*	*1.1%*	*1.1%*	*1.2%*

NET REVENUE GROWTH	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Net Inpatient Revenue per Inpatient Admissions	n/a	11.1%	(2.5%)	(0.2%)	0.8%	2.0%	2.0%	2.0%	2.0%	2.0%
Net Outpatient Revenue per Outpatient Visits	n/a	7.0%	(2.4%)	0.3%	(1.2%)	2.0%	2.0%	2.0%	2.0%	2.0%
Avg. Net Patient Revenue Revenue per Adj. Patient Day	$3,492	$3,604	$3,578	$3,663	$3,667	$3,740	$3,814	$3,889	$3,967	$4,045
Growth	*n/a*	*3.2%*	*(0.7%)*	*2.4%*	*0.1%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*

SUPPLIES ASSUMPTIONS: *Supplies per Adj. Patient Day Growth*		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Total Adj. Patient Days		126,233	138,239	135,282	134,100	134,033	135,538	137,072	138,635	140,228	141,851
Medical Supplies per Adj. Patient Day	*Increase at CPI*	$302.76	$306.16	$298.18	$306.37	$306.52	$315.72	$325.19	$334.94	$344.99	$355.34
Total Medical Supplies		$38,219,014	$42,323,381	$40,338,078	$41,083,832	$41,083,832	$42,791,627	$44,574,153	$46,434,855	$48,377,346	$50,405,416
Growth		*n/a*	*10.7%*	*(4.7%)*	*1.8%*	-	*4.2%*	*4.2%*	*4.2%*	*4.2%*	*4.2%*
Total Adj. Patient Days		126,233	138,239	135,282	134,100	134,033	135,538	137,072	138,635	140,228	141,851
Drugs & Pharmaceuticals per Adj. Patient Day	*Increase at CPI*	$210.01	$223.17	$223.59	$231.99	$232.11	$239.07	$246.25	$253.63	$261.24	$269.08
Total Drugs & Pharmaceuticals		$26,510,658	$30,850,978	$30,247,697	$31,110,577	$31,110,577	$32,403,798	$33,753,609	$35,162,619	$36,633,563	$38,169,311
Growth		*n/a*	*16.4%*	*(2.0%)*	*2.9%*	-	*4.2%*	*4.2%*	*4.2%*	*4.2%*	*4.2%*

FTE/STAFFING COMPENSATION ASSUMPTIONS:		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Total FTEs		1,720.0	1,976.0	1,951.0	1,933.0	1,933.0	1,954.7	1,976.8	1,999.4	2,022.3	2,045.7
Paid Hours per Adj. Patient Day		28.3	29.7	30.0	30.0	30.0	30.0	30.0	30.0	30.0	30.0
Growth		*n/a*	*4.9%*	*0.9%*	*(0.0%)*	*0.1%*	-	-	-	-	-
Average Salary per FTE					$96,702	$96,702	$99,603	$102,591	$105,669	$108,839	$112,104
Growth	*3.0% Annual Growth*				*n/a*	-	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*
Total FTE Salaries					$186,925,096	$186,925,096	$194,695,301	$202,805,516	$211,271,423	$220,109,460	$229,336,865
Payroll Taxes	*% of salaries*	*7.5%*			$13,998,001	$13,998,001	$14,579,878	$15,187,216	$15,821,191	$16,483,033	$17,174,032
Employee Benefits	*% of salaries*	*20.1%*			$37,264,605	$37,577,605	$39,139,651	$40,770,050	$42,471,954	$44,248,667	$46,103,655
Total Employee Salaries, Wages & Benefits					$238,187,702	$238,500,702	$248,414,830	$258,762,783	$269,564,568	$280,841,160	$292,614,553
per Adj. Patient Day					$1,776	$1,779	$1,833	$1,888	$1,944	$2,003	$2,063
Growth					*n/a*	*0.2%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*

REVENUE ASSUMPTIONS:		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
INPATIENT REVENUE											
Volume Assumptions											
Admissions per year		19,738	20,184	19,650	19,694	19,694	19,792	19,891	19,991	20,091	20,191
Growth		*n/a*	*2.3%*	*(2.6%)*	*0.2%*	-	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
Average Length of Stay ("ALOS")		4.5	4.8	4.7	4.7	4.7	4.7	4.7	4.7	4.7	4.7
Patient Days		88,855	97,083	92,724	92,271	92,271	92,732	93,196	93,662	94,130	94,601
Inpatient Reimbursement (per Admission)											
Gross Inpatient Charge per Admission	% of NBY Charges	$110,081	$122,183	$127,678	$130,102	$130,102	$132,704	$135,358	$138,065	$140,826	$143,643
Inpatient Contractual per Admission	86.6%	(94,040)	(104,366)	(110,305)	(112,758)	(112,623)	(114,875)	(117,173)	(119,516)	(121,907)	(124,345)
Average Net Inpatient Revenue per Admission		$16,041	$17,817	$17,373	$17,344	$17,479	$17,828	$18,185	$18,549	$18,920	$19,298
Growth		*n/a*	*11.1%*	*(2.5%)*	*(0.2%)*	*0.8%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Inpatient Gross Charges		$2,172,776,766	$2,466,134,357	$2,508,873,783	$2,562,224,502	$2,562,224,502	$2,626,536,337	$2,692,462,399	$2,760,043,205	$2,829,320,290	$2,900,336,229
Estimated Inpatient Contractual		(1,856,157,763)	(2,106,525,179)	(2,167,492,991)	(2,220,650,822)	(2,217,997,190)	(2,273,668,919)	(2,330,738,009)	(2,389,239,533)	(2,449,209,446)	(2,510,684,603)
Net Inpatient Revenue		**$316,619,003**	**$359,609,178**	**$341,380,792**	**$341,573,680**	**$344,227,312**	**$352,867,418**	**$361,724,390**	**$370,803,672**	**$380,110,844**	**$389,651,626**
Growth		*n/a*	*13.6%*	*(5.1%)*	*0.1%*	*0.8%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
OUTPATIENT REVENUE											
Outpatient Volume											
Outpatient Visits per year		159,534	164,406	168,102	167,037	167,037	171,213	175,493	179,881	184,378	188,987
Growth		*n/a*	*3.1%*	*2.2%*	*(0.6%)*	-	*2.5%*	*2.5%*	*2.5%*	*2.5%*	*2.5%*
Outpatient Reimbursement											
Gross Charge per Outpatient Visit	% of NBY Charges	$5,729	$6,359	$6,850	$6,954	$6,943	$7,081	$7,223	$7,368	$7,515	$7,665
Outpatient Contractual per Admission	87.0%	(4,860)	(5,428)	(5,942)	(6,042)	(6,042)	(6,163)	(6,286)	(6,412)	(6,540)	(6,671)
Average Net Revenue per Outpatient Visit		$870	$930	$908	$911	$900	$918	$937	$955	$974	$994
Growth		*n/a*	*7.0%*	*(2.4%)*	*0.3%*	*(1.2%)*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Outpatient Gross Charges		$914,018,727	$1,045,447,306	$1,151,497,930	$1,161,536,693	$1,159,666,693	$1,212,431,528	$1,267,597,162	$1,325,272,833	$1,385,572,747	$1,448,616,307
Estimated Outpatient Contractual		(775,273,263)	(892,476,375)	(998,786,817)	(1,009,294,506)	(1,009,294,506)	(1,055,217,406)	(1,103,229,798)	(1,153,426,754)	(1,205,907,671)	(1,260,776,470)
Net Outpatient Revenue		**$138,745,464**	**$152,970,931**	**$152,711,113**	**$152,242,187**	**$150,372,187**	**$157,214,122**	**$164,367,364**	**$171,846,079**	**$179,665,076**	**$187,839,837**
Growth		*n/a*	*10.3%*	*(0.2%)*	*(0.3%)*	*(1.2%)*	*4.5%*	*4.6%*	*4.6%*	*4.5%*	*4.5%*

REVENUE ASSUMPTIONS:		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
HOSPITAL OPERATING REVENUE SUMMARY											
Total Patient Revenue											
Total Gross Charges (IP & OP)		$3,086,795,493	3,511,581,663	3,660,371,713	3,723,761,195	3,721,891,195	3,838,967,865	3,960,059,561	4,085,316,038	4,214,893,037	4,348,952,536
Total Contractuals (IP & OP)		(2,631,431,026)	(2,999,001,554)	(3,166,279,808)	(3,229,945,328)	(3,227,291,696)	(3,328,886,325)	(3,433,967,807)	(3,542,666,287)	(3,655,117,117)	(3,771,461,073)
Net Patient Revenue before Bad Debt		455,364,467	512,580,109	494,091,905	493,815,867	494,599,499	510,081,539	526,091,754	542,649,751	559,775,920	577,491,463
Net Inpatient Revenue		$316,619,003	$359,609,178	$341,380,792	$341,573,680	$344,227,312	$352,867,418	$361,724,390	$370,803,672	$380,110,844	$389,651,626
Net Outpatient Revenue		$138,745,464	$152,970,931	$152,711,113	$152,242,187	$150,372,187	$157,214,122	$164,367,364	$171,846,079	$179,665,076	$187,839,837
Net Patient Revenue before Bad Debt		$455,364,467	$512,580,109	$494,091,905	$493,815,867	$494,599,499	$510,081,539	$526,091,754	$542,649,751	$559,775,920	$577,491,463
Growth		*n/a*	*12.6%*	*(3.6%)*	*(0.1%)*	*0.2%*	*3.1%*	*3.1%*	*3.1%*	*3.2%*	*3.2%*
	NBY % of Total Gross Charges										
Bad Debt	0.1%	(14,573,495)	(14,301,275)	(10,016,605)	(2,546,776)	(3,132,257)	(3,230,786)	(3,332,694)	(3,438,107)	(3,547,156)	(3,659,977)
Growth		*n/a*	*(1.9%)*	*(30.0%)*	*(74.6%)*	*23.0%*	*3.1%*	*3.2%*	*3.2%*	*3.2%*	*3.2%*
Total Net Patient Revenue		440,790,972	498,278,834	484,075,300	491,269,091	491,467,242	506,850,753	522,759,060	539,211,644	556,228,764	573,831,486
Growth		*n/a*	*13.0%*	*(2.9%)*	*1.5%*	*0.0%*	*3.1%*	*3.1%*	*3.1%*	*3.2%*	*3.2%*
Supplemental Payments											
Medicaid DSH	*No Growth*	8,436,631	7,962,995	7,402,065	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734	7,203,734
Medicaid Supplemental - Income Provider	*No Growth*	62,013,094	68,421,637	67,523,469	97,750,754	69,615,975	69,615,975	69,615,975	69,615,975	69,615,975	69,615,975
Medicaid Supplemental - Assessment Provider	*No Growth*	(26,897,084)	(30,390,480)	(21,947,306)	(33,794,251)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)	(24,649,540)
Electronic Health Record Incentives	*No Growth*	1,020,542	497,371	301,700	301,700	301,700	301,700	301,700	301,700	301,700	301,700
Total		44,573,183	46,491,523	53,279,928	71,461,937	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869
Growth		*n/a*	*4.3%*	*14.6%*	*34.1%*	*-26.6%*	-	-	-	-	-
Other Revenue											
Other Revenue	*Increase at CPI*	5,699,832	4,362,188	839,569	194,265	194,265	200,093	206,096	212,279	218,647	225,206
Total		5,699,832	4,362,188	839,569	194,265	194,265	200,093	206,096	212,279	218,647	225,206
Growth		*n/a*	*-23.5%*	*-80.8%*	*-76.9%*	*0.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*	*3.0%*
Total Net Operating Revenue		**$491,063,987**	**$549,132,545**	**$538,194,797**	**$562,925,293**	**$544,133,376**	**$559,522,715**	**$575,437,025**	**$591,895,792**	**$608,919,280**	**$626,528,561**
Growth		*n/a*	*11.8%*	*(2.0%)*	*4.6%*	*(3.3%)*	*2.8%*	*2.8%*	*2.9%*	*2.9%*	*2.9%*

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REVENUE SUMMARY: *Footnotes:*	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Revenue:										
Total Patient Revenue	455,364,467	512,580,109	494,091,905	493,815,867	494,599,499	510,081,539	526,091,754	542,649,751	559,775,920	577,491,463
Bad Debt & Other Deductions	(14,573,495)	(14,301,275)	(10,016,605)	(2,546,776)	(3,132,257)	(3,230,786)	(3,332,694)	(3,438,107)	(3,547,156)	(3,659,977)
Supplemental Payments	44,573,183	46,491,523	53,279,928	71,461,937	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869
Other Revenue	5,699,832	4,362,188	839,569	194,265	194,265	200,093	206,096	212,279	218,647	225,206
Total Net Operating Revenue	**$491,063,987**	**$549,132,545**	**$538,194,797**	**$562,925,293**	**$544,133,376**	**$559,522,715**	**$575,437,025**	**$591,895,792**	**$608,919,280**	**$626,528,561**
Growth	*n/a*	*11.8%*	*(2.0%)*	*4.6%*	*(3.3%)*	*2.8%*	*2.8%*	*2.9%*	*2.9%*	*2.9%*
Implied Volume Statistics										
Outpatient Equivalency Factor	1.42	1.42	1.46	1.45	1.45	1.46	1.47	1.48	1.49	1.50
Admissions	19,738	20,184	19,650	19,694	19,694	19,792	19,891	19,991	20,091	20,191
Growth	*n/a*	*2.3%*	*(2.6%)*	*0.2%*	*-*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
Adj. Admissions	28,041	28,740	28,669	28,622	28,608	28,929	29,256	29,590	29,930	30,276
Growth	*n/a*	*2.5%*	*(0.2%)*	*(0.2%)*	*(0.1%)*	*1.1%*	*1.1%*	*1.1%*	*1.1%*	*1.2%*
Patient Days	88,855	97,083	92,724	92,271	92,271	92,732	93,196	93,662	94,130	94,601
Growth	*n/a*	*9.3%*	*(4.5%)*	*(0.5%)*	*-*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*
Adj. Patient Days	126,233	138,239	135,282	134,100	134,033	135,538	137,072	138,635	140,228	141,851
Growth	*n/a*	*9.5%*	*(2.1%)*	*(0.9%)*	*(0.1%)*	*1.1%*	*1.1%*	*1.1%*	*1.1%*	*1.2%*
Implied Reimbursement Statistics										
Net Patient Revenue per Adj. Admission	15,719	17,337	16,885	17,164	17,180	17,521	17,868	18,223	18,584	18,953
Growth	*n/a*	*10.3%*	*(2.6%)*	*1.7%*	*0.1%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Net Operating Revenue per Adj. Admission	17,512	19,107	18,773	19,668	19,021	19,341	19,669	20,003	20,345	20,694
Growth	*n/a*	*9.1%*	*(1.7%)*	*4.8%*	*(3.3%)*	*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.7%*
Net Patient Revenue per Adj. Patient Day	3,492	3,604	3,578	3,663	3,667	3,740	3,814	3,889	3,967	4,045
Growth	*n/a*	*3.2%*	*(0.7%)*	*2.4%*	*0.1%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*	*2.0%*
Net Operating Revenue per Adj. Patient Day	3,890	3,972	3,978	4,198	4,060	4,128	4,198	4,269	4,342	4,417
Growth	*n/a*	*2.1%*	*0.2%*	*5.5%*	*(3.3%)*	*1.7%*	*1.7%*	*1.7%*	*1.7%*	*1.7%*

EXPENSE ASSUMPTIONS:	*Footnotes:*	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5
Operating Expenses:											
Employee Salaries & Wages											
Employee Salaries & Wages	*See Assumptions Summary*	$161,480,723	$190,660,210	$187,195,604	$186,925,096	$186,925,096	$194,695,301	$202,805,516	$211,271,423	$220,109,460	$229,336,865
Employee Benefits											
Payroll Taxes	*See Assumptions Summary*	11,763,690	14,067,020	13,885,432	13,998,001	13,998,001	14,579,878	15,187,216	15,821,191	16,483,033	17,174,032
Employee Benefits	*See Assumptions Summary*	32,383,647	35,607,391	36,987,851	37,264,605	37,577,605	39,139,651	40,770,050	42,471,954	44,248,667	46,103,655
Occupancy Costs											
Rent / Lease - Real Property	*Increase at CPI*	715,595	852,565	877,241	785,280	785,280	808,838	833,104	858,097	883,840	910,355
Utilities	*Increase at CPI*	3,899,993	3,330,300	3,499,157	3,678,255	3,678,255	3,788,603	3,902,261	4,019,329	4,139,908	4,264,106
Property Taxes	*Increase at CPI*	1,242,032	1,193,427	1,271,050	1,147,173	1,147,173	1,181,588	1,217,036	1,253,547	1,291,153	1,329,888
Supplies											
Medical Supplies	*See Assumptions Summary*	38,219,014	42,323,381	40,338,078	41,083,832	41,083,832	42,791,627	44,574,153	46,434,855	48,377,346	50,405,416
Drugs & Pharmaceuticals	*See Assumptions Summary*	26,510,658	30,850,978	30,247,697	31,110,577	31,110,577	32,403,798	33,753,609	35,162,619	36,633,563	38,169,311
Non-medical Supplies	*Increase at CPI*	5,721,203	4,824,614	4,536,075	4,518,902	4,518,902	4,654,469	4,794,103	4,937,926	5,086,064	5,238,646
Medical Costs											
Other Clinical Expenses	*% of Revenue*	15,880	10,538	1,173,820	1,403,631	1,403,631	1,443,329	1,484,381	1,526,838	1,570,751	1,616,175
Medical Fees	*% of Revenue*	22,918,405	28,155,709	32,217,548	34,086,074	34,086,074	35,050,106	36,047,024	37,078,049	38,144,449	39,247,545
Physician Income Assist	*% of Revenue*	1,531,647	1,490,747	1,974,964	2,002,993	2,002,993	2,059,642	2,118,224	2,178,810	2,241,474	2,306,295
Insurance											
Malpractice Insurance	*Increase at CPI*	3,986,073	7,591,366	6,394,474	5,692,256	5,692,256	5,863,024	6,038,914	6,220,082	6,406,684	6,598,885
Other Insurance	*Increase at CPI*	676,531	842,166	900,543	949,693	949,693	978,184	1,007,529	1,037,755	1,068,888	1,100,954
General & Administrative											
Advertising	*Increase at CPI*	1,391,452	1,554,035	1,466,182	1,110,287	1,110,287	1,143,596	1,177,903	1,213,241	1,249,638	1,287,127
Information Technology	*Increase at CPI*	7,562,988	8,179,456	9,697,950	9,480,068	9,480,068	9,764,470	10,057,404	10,359,126	10,669,900	10,989,997
Charitable Contributions	*% of Revenue*	864,838	1,145,921	972,447	1,561,160	1,561,160	1,605,313	1,650,973	1,698,194	1,747,036	1,797,558
Equipment Rent / Lease Expense	*% of Revenue*	953,797	1,584,208	1,502,505	1,330,460	1,330,460	1,368,088	1,407,001	1,447,244	1,488,868	1,531,924
Non-medical Professional Fees	*Increase at CPI*	3,217,597	3,291,038	4,713,103	4,299,393	4,299,393	4,428,375	4,561,226	4,698,063	4,839,005	4,984,175
Conifer Collection Fees	*% of Revenue*	12,705,711	13,447,841	13,027,365	13,114,847	13,114,847	13,485,765	13,869,336	14,266,029	14,676,334	15,100,758
License Fees	*Increase at CPI*	858,407	899,169	836,289	769,873	769,873	792,969	816,758	841,261	866,499	892,494
Other Controllable Expenses	*% of Revenue*	13,375,934	15,129,997	16,342,488	16,561,992	16,311,992	16,773,333	17,250,411	17,743,810	18,254,139	18,782,029
Other Non-medical Expenses	*Increase at CPI*	7,705,587	8,261,334	7,421,385	7,713,207	7,713,207	7,944,603	8,182,941	8,428,430	8,681,282	8,941,721
Repairs & Maintenance	*Increase at CPI*	7,551,948	8,056,848	8,639,898	9,273,933	9,273,933	9,552,151	9,838,716	10,133,877	10,437,893	10,751,030
Management Fees	*% of Revenue*	-	-	-	-	10,882,668	11,190,454	11,508,740	11,837,916	12,178,386	12,530,571
Physician Subsidy	*% of Revenue*	-	-	-	-	6,857,648	7,051,598	7,252,164	7,459,592	7,674,137	7,896,065
Total Operating Expenses		$367,253,350	$423,350,259	$426,119,146	$429,861,588	$447,664,904	$464,538,754	$482,106,693	$500,399,255	$519,448,398	$539,287,578
Growth		*n/a*	*15.3%*	*0.7%*	*0.9%*	*4.1%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*	*3.8%*
Operating Expense Per Adj. Patient Day		$2,909	$3,062	$3,150	$3,206	$3,340	$3,427	$3,517	$3,609	$3,704	$3,802
Per Adj. Patient Day Growth		*n/a*	*5.3%*	*2.9%*	*1.8%*	*4.2%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*	*2.6%*

DEPRECIATION SCHEDULE:		Projection Period				
		Year 1	Year 2	Year 3	Year 4	Year 5
		Note: Years 2018, 2019 and 2020 Capital Expenditures were provided by Management in the "3.0 DRMC Capital Plan.pptx" document. Years 2021 forward are projected as a percent of revenue at 2.5%.				
Capital Expenditures Projection Detail (provided by Hospital Management):						
Equipment - Replacement		2,386,000	2,374,000	-		
Business Development		2,217,000	1,500,000	3,380,000		
Facility Maintenance (Infrastructure)		3,077,000	4,860,000	2,700,000		
ALCM (Replacement Equipment and Replacement of Pumps)		3,200,000	3,279,000	4,050,000		
Other Capital		3,027,000	2,423,000	3,249,000		
Total Capital Expenditures		13,900,000	14,400,000	13,400,000	15,200,000	15,700,000
% of Revenue (Rounded)		*2.5%*	*2.5%*	*2.3%*	*2.5%*	*2.5%*
Depreciation Assumptions						
Net Initial Fixed Assets (Book Value) Less Land	$86,897,182					
Straight-line Depreciation Years (Initial Assets)	15.0					
Depreciation of Initial Net Fixed Assets		$5,793,145	$5,793,145	$5,793,145	$5,793,145	$5,793,145
Capital Expenditures per Year		13,900,000	14,400,000	13,400,000	15,200,000	15,700,000
Straight-line Depreciation Yrs (New Assets)	10.0	695,000	1,390,000	1,390,000	1,390,000	1,390,000
			720,000	1,440,000	1,440,000	1,440,000
				670,000	1,340,000	1,340,000
					760,000	1,520,000
						785,000
Total Depreciation		**6,488,145**	**7,903,145**	**9,293,145**	**10,723,145**	**12,268,145**

DESERT REGIONAL MEDICAL CENTER
DISCOUNTED CASH FLOW ANALYSIS - INCOME APPROACH

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	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Terminal Year
Hospital Operating Revenue																			
Net Inpatient Revenue	316,619,003	359,609,178	341,380,792	341,573,680	344,227,312	352,867,418	361,724,390	370,803,672	380,110,844	389,651,626									
Net Outpatient Revenue	138,745,464	152,970,931	152,711,113	152,242,187	150,372,187	157,214,122	164,367,364	171,846,079	179,665,076	187,839,837									
Net Patient Revenue before Bad Debt	455,364,467	512,580,109	494,091,905	493,815,867	494,599,499	510,081,539	526,091,754	542,649,751	559,775,920	577,491,463									
Bad Debt & Other Deductions	(14,573,495)	(14,301,275)	(10,016,605)	(2,546,776)	(3,132,257)	(3,230,786)	(3,332,694)	(3,438,107)	(3,547,156)	(3,659,977)									
Total Net Patient Revenue	440,790,972	498,278,834	484,075,300	491,269,091	491,467,242	506,850,753	522,759,060	539,211,644	556,228,764	573,831,486									
Supplemental Payments	44,573,183	46,491,523	53,279,928	71,461,937	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869	52,471,869									
Other Revenue	$5,699,832	$4,362,188	$839,569	$194,265	$194,265	$200,093	$206,096	$212,279	$218,647	$225,206									
Total Net Operating Revenue	**491,063,987**	**549,132,545**	**538,194,797**	**562,925,293**	**544,133,376**	**559,522,715**	**575,437,025**	**591,895,792**	**608,919,280**	**626,528,561**	**645,324,418**	**664,684,150**	**684,624,675**	**705,163,415**	**726,318,318**	**748,107,867**	**770,551,103**	**793,667,636**	**817,477,665**
Growth %	n/a	11.8%	(2.0%)	4.6%	(3.3%)	2.8%	2.8%	2.9%	2.9%	2.9%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Operating Expenses:																			
Employee Salaries & Wages	161,480,723	190,660,210	187,195,604	186,925,096	186,925,096	194,695,301	202,805,516	211,271,423	220,109,460	229,336,865									
Employee Benefits	44,147,337	49,674,411	50,873,283	51,262,606	51,575,606	53,719,529	55,957,266	58,293,145	60,731,700	63,277,687									
Occupancy Costs	5,857,620	5,376,292	5,647,448	5,610,708	5,610,708	5,779,029	5,952,400	6,130,972	6,314,901	6,504,348									
Supplies	70,450,875	77,998,973	75,121,850	76,713,311	76,713,311	79,849,895	83,121,865	86,535,399	90,096,973	93,813,373									
Medical Costs	24,465,932	29,656,994	35,366,332	37,492,698	37,492,698	38,553,077	39,649,629	40,783,696	41,956,674	43,170,015									
Insurance	4,662,604	8,433,532	7,295,017	6,641,949	6,641,949	6,841,207	7,046,444	7,257,837	7,475,572	7,699,839									
General & Administrative	56,188,259	61,549,847	64,619,612	65,215,220	82,705,536	85,100,715	87,573,573	90,126,783	92,763,117	95,485,449									
Total Operating Expenses	367,253,350	423,350,259	426,119,146	429,861,588	447,664,904	464,538,754	482,106,693	500,399,255	519,448,398	539,287,578									
Growth %	n/a	15.3%	0.7%	0.9%	4.1%	3.8%	3.8%	3.8%	3.8%	3.8%									
EBITDA	**123,810,637**	**125,782,286**	**112,075,651**	**133,063,705**	**96,468,473**	**94,983,961**	**93,330,331**	**91,496,537**	**89,470,882**	**87,240,983**	**89,858,213**	**92,553,959**	**95,330,578**	**98,190,495**	**101,136,210**	**104,170,297**	**107,295,406**	**110,514,268**	**113,829,696**
EBITDA %	25.2%	22.9%	20.8%	23.6%	17.7%	17.0%	16.2%	15.5%	14.7%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
Depreciation & Amortization Expense	14,211,402	14,814,437	15,734,886	15,442,515	15,442,515	6,488,145	7,903,145	9,293,145	10,723,145	12,268,145	13,859,801	15,497,312	17,183,948	18,226,183	18,600,535	13,260,422	13,728,746	14,139,019	19,757,394
Operating Income	109,599,235	110,967,849	96,340,765	117,621,190	81,025,958	88,495,816	85,427,186	82,203,392	78,747,737	74,972,838	75,998,412	77,056,648	78,146,630	79,964,313	82,535,675	90,909,874	93,566,660	96,375,248	94,072,301
Other Income (Expense)	(221,558)	(254,082)	(107,895)	(540)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Expense	286,732	362,552	395,400	393,811	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Earnings Before Income Taxes	109,090,945	110,351,215	95,837,470	117,226,839	81,025,958	88,495,816	85,427,186	82,203,392	78,747,737	74,972,838	75,998,412	77,056,648	78,146,630	79,964,313	82,535,675	90,909,874	93,566,660	96,375,248	94,072,301
Federal & State Income Tax Expense @ 28.0%	-	-	-	-	22,673,980	24,764,315	23,905,602	23,003,468	22,036,452	20,980,099	21,267,092	21,563,224	21,868,240	22,376,893	23,096,453	25,439,856	26,183,320	26,969,264	26,324,817
Earnings After Income Taxes	109,090,945	110,351,215	95,837,470	117,226,839	58,351,978	63,731,501	61,521,584	59,199,923	56,711,285	53,992,739	54,731,320	55,493,424	56,278,390	57,587,419	59,439,222	65,470,019	67,383,340	69,405,984	67,747,485

DESERT REGIONAL MEDICAL CENTER
DISCOUNTED CASH FLOW ANALYSIS - INCOME APPROACH

FINAL REPORT

	FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Terminal Year
Earnings After Income Taxes	109,090,945	110,351,215	95,837,470	117,226,839	58,351,978	63,731,501	61,521,584	59,199,923	56,711,285	53,992,739	54,731,320	55,493,424	56,278,390	57,587,419	59,439,222	65,470,019	67,383,340	69,405,984	67,747,485
Cash Flow Adjustments:																			
Plus: Depreciation & Amortization						6,488,145	7,903,145	9,293,145	10,723,145	12,268,145	13,859,801	15,497,312	17,183,948	18,226,183	18,600,535	13,260,422	13,728,746	14,139,019	19,757,394
Less: Required Annual Capital Expenditures						(13,900,000)	(14,400,000)	(13,400,000)	(15,200,000)	(15,700,000)	(16,133,110)	(16,617,104)	(17,115,617)	(17,629,085)	(18,157,958)	(18,702,697)	(19,263,778)	(19,841,691)	(19,757,394)
Less: Incremental Working Capital Requirements						(1,231,147)	(1,273,145)	(1,316,701)	(1,361,879)	(1,408,742)	(1,503,669)	(1,548,779)	(1,595,242)	(1,643,099)	(1,692,392)	(1,743,164)	(1,795,459)	(1,849,323)	(1,904,802)
Net Discretionary Cash Flow						55,088,499	53,751,585	53,776,367	50,872,552	49,152,142	50,954,342	52,824,853	54,751,479	56,541,417	58,189,407	58,284,580	60,052,849	61,853,990	65,842,682
Terminal Value																			731,585,361
						0.5	1.5	2.5	3.5	4.5	5.5	6.5	7.5	8.5	9.5	10.5	11.5	12.5	12.5
Present Value Factor (mid-point convention)						0.9449	0.8437	0.7533	0.6726	0.6005	0.5362	0.4787	0.4274	0.3816	0.3407	0.3042	0.2716	0.2425	0.2425
Present Value of Cash Flows						52,053,739	45,348,637	40,508,523	34,215,307	29,516,261	27,320,087	25,288,388	23,402,415	21,578,115	19,827,717	17,732,274	16,312,719	15,001,768	177,435,177

Sum of Present Values (Year 1 to Year 13)	368,105,950
Present Value of Terminal	177,435,177
Fair Market Value Indication (Business Enterprise Level)	**$545,541,127**

Net Fixed Assets & Normalized Working Capital Value	136,600,000				
Indicated Intangible Asset Value	408,941,127				
Tax Amortization Benefit	63,533,379				
Fair Market Value Indication (Business Enterprise Level) with Tax Amortization Benefit	**$610,000,000**	**6.4x**	**Year 1 EBITDA**	**1.1x**	**Year 1 Revenue**

Terminal Growth Rate \ Discount Rate	11.0%	11.5%	12.0%	12.5%	13.0%
2.5%	670,000,000	630,000,000	600,000,000	570,000,000	540,000,000
3.0%	690,000,000	**650,000,000**	**610,000,000**	**580,000,000**	550,000,000
3.5%	700,000,000	660,000,000	620,000,000	590,000,000	560,000,000

DESERT REGIONAL MEDICAL CENTER
DISCOUNTED CASH FLOW ANALYSIS - INCOME APPROACH

FINAL REPORT

		FYE 2015	FYE 2016	FYE 2017	TTM 2018	Normalized Base Year	Projection Period Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Year 11	Year 12	Year 13	Terminal Year
Hospital Operating Revenue																				
Net Inpatient Revenue		64.5%	65.5%	63.4%	60.7%	63.3%	63.1%	62.9%	62.6%	62.4%	62.2%									
Net Outpatient Revenue		28.3%	27.9%	28.4%	27.0%	27.6%	28.1%	28.6%	29.0%	29.5%	30.0%									
Net Patient Revenue before Bad Debt		92.7%	93.3%	91.8%	87.7%	90.9%	91.2%	91.4%	91.7%	91.9%	92.2%									
Bad Debt & Other Deductions		(3.0%)	(2.6%)	(1.9%)	(0.5%)	(0.6%)	(0.6%)	(0.6%)	(0.6%)	(0.6%)	(0.6%)									
Total Net Patient Revenue		89.8%	90.7%	89.9%	87.3%	90.3%	90.6%	90.8%	91.1%	91.3%	91.6%									
Supplemental Payments		9.1%	8.5%	9.9%	12.7%	9.6%	9.4%	9.1%	8.9%	8.6%	8.4%									
Other Revenue		1.2%	0.8%	0.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%									
Total Net Operating Revenue		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Operating Expenses:																				
Employee Salaries & Wages		32.9%	34.7%	34.8%	33.2%	34.4%	34.8%	35.2%	35.7%	36.1%	36.6%									
Employee Benefits		9.0%	9.0%	9.5%	9.1%	9.5%	9.6%	9.7%	9.8%	10.0%	10.1%									
Occupancy Costs		1.2%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%									
Supplies		14.3%	14.2%	14.0%	13.6%	14.1%	14.3%	14.4%	14.6%	14.8%	15.0%									
Medical Costs		5.0%	5.4%	6.6%	6.7%	6.9%	6.9%	6.9%	6.9%	6.9%	6.9%									
Insurance		0.9%	1.5%	1.4%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%									
General & Administrative		11.4%	11.2%	12.0%	11.6%	15.2%	15.2%	15.2%	15.2%	15.2%	15.2%									
Total Operating Expenses		74.8%	77.1%	79.2%	76.4%	82.3%	83.0%	83.8%	84.5%	85.3%	86.1%									
EBITDA		25.2%	22.9%	20.8%	23.6%	17.7%	17.0%	16.2%	15.5%	14.7%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
Depreciation & Amortization Expense		2.9%	2.7%	2.9%	2.7%	2.8%	1.2%	1.4%	1.6%	1.8%	2.0%	2.1%	2.3%	2.5%	2.6%	2.6%	1.8%	1.8%	1.8%	2.4%
Operating Income		22.3%	20.2%	17.9%	20.9%	14.9%	15.8%	14.8%	13.9%	12.9%	12.0%	11.8%	11.6%	11.4%	11.3%	11.4%	12.2%	12.1%	12.1%	11.5%
Other Income (Expense)		(0.0%)	(0.0%)	(0.0%)	(0.0%)	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Interest Expense		0.1%	0.1%	0.1%	0.1%	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Earnings Before Income Taxes		22.2%	20.1%	17.8%	20.8%	14.9%	15.8%	14.8%	13.9%	12.9%	12.0%	11.8%	11.6%	11.4%	11.3%	11.4%	12.2%	12.1%	12.1%	11.5%
Federal & State Income Tax Expense @	28.0%	-	-	-	-	4.2%	4.4%	4.2%	3.9%	3.6%	3.3%	3.3%	3.2%	3.2%	3.2%	3.2%	3.4%	3.4%	3.4%	3.2%
Earnings After Income Taxes		22.2%	20.1%	17.8%	20.8%	10.7%	11.4%	10.7%	10.0%	9.3%	8.6%	8.5%	8.3%	8.2%	8.2%	8.2%	8.8%	8.7%	8.7%	8.3%

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US$ in thousands

BETA CALCULATION

Ticker	Company Name	Levered 5 Year [1]	S&P Credit Rating	Market Capitalization	Total Debt	Cash & ST Investments	Minority Interest	Preferred Equity	Debt/ BEV[2]	Debt/ Equity	Effective Tax Rate	Unlevered Beta
CYH	Community Health Systems, Inc.	1.058	CCC+	$340,818	$13,715,000	$208,000	$590,000	-	93.6%	1473.4%	n/a	
HCA	HCA Healthcare, Inc.	0.634	BB+	$44,401,162	$33,192,000	$913,000	$1,864,000	-	41.8%	71.7%	33.1%	0.423
LPNT	LifePoint Health, Inc.	0.661	BB-	$2,499,732	$2,928,400	$143,800	$135,400	-	52.6%	111.1%	28.5%	0.342
QHC	Quorum Health Corporation	0.389	B-	$120,236	$1,199,412	$2,822	$17,013	-	89.7%	873.9%	n/a	
THC	Tenet Healthcare Corporation	1.181	B	$3,276,718	$14,867,000	$403,000	$2,159,000	-	73.2%	273.5%	45.0%	0.472
UHS	Universal Health Services, Inc.	0.603	BB+	$11,467,395	$3,990,464	$76,886	$78,968	-	25.7%	34.6%	29.1%	0.480
Average		**0.754**										**0.429**
Median		**0.647**										**0.448**

Average Unlevered Beta for Comps	0.429
D/E, Target Company	66.7%
Federal & State Income Tax Expense	28.0%
Re-Levered Beta, Subject Company[4]	**0.635**

WACC

	Market Risk Premium (RM)[5]	6.0%
x	Subject Company Re-levered Beta	0.635
=	Adjusted Market Risk Premium	3.8%
+	Risk-Free Rate of Return (RF)[6]	3.1%
+	Size Premium[7]	5.6%
+	Specific Company Risk Premium[8]	5.0%
=	**Cost of Equity**	**17.5%**
x	Equity as a Percent of Total Capital	60.0%
=	**Cost of Equity Portion**	**10.5%**
	Cost of Debt[9]	4.8%
x	Tax Rate[10]	28.0%
=	**After-Tax Cost of Debt**	**3.5%**
x	Debt as a Percent of Total Capital	40.0%
=	**Cost of Debt Portion**	**1.4%**

WACC	11.9%
Selected WACC	12.0%

Footnotes:

(1) *Capital IQ- Levered Beta 5 Year computed taking the slope of a weekly regression line of the percentage change of the stock relative to the percentage price change in the S&P 500 as of August 22, 2018.*

(2) *Capital IQ- average of public companies debt structure as of August 22, 2018.*

(3) *Unlevered Beta = Levered Beta / (1 + ((D/E) * (1 - T)) + P/E)*

(4) *Re-levered Beta = Unlevered Beta * (1 + ((D/E) * (1 - T)) + P/E)*

(5) *The equity risk premium of 6.0% was selected based upon VMG's review of published articles and academic studies that attempt to quantify the expected market risk premium for U.S. common stocks by utilizing both historical and forward-looking sources. The selected 6.0% equity risk premium was considered to reasonably represent a consensus viewpoint of the market equity risk premium.*

(6) *Yield of 20-year U.S. Treasury securities as of August 22, 2018, as published by Federal Reserve Statistical Release.*

(7) *Duff & Phelps: 2017 Valuation Handbook, Market Cap*

(8) *Risk associated with the specific operations of the company or the "unsystematic" risk of the company.*

(9) *Moody's yield on seasoned corporate bonds, rating Baa as of August 22, 2018, as published by Capital IQ.*

(10) *Blended State and Federal Tax rate for California.*

Company Specific Risk Premium	*Capital Structure (Debt to BEV)*		
	40.0%	50.0%	60.0%
4.0%	11.3%	10.0%	8.7%
5.0%	11.9%	10.5%	9.1%
6.0%	12.5%	11.0%	9.5%
7.0%	13.1%	11.5%	9.9%

Desert Regional Medical Center

Market Approach Analysis

DESERT REGIONAL MEDICAL CENTER
MARKET APPROACH INDICATION - SUMMARY

FINAL REPORT

Multiple	Range of Multiple Selections (Control Level)			Year 1	Value Indication (Rounded)		
	Low		High		Low		High
BEV/Revenue	1.1x	to	1.3x	$506,850,753	$560,000,000	to	$660,000,000
BEV/EBITDA	5.5x	to	7.5x	$94,983,961	$520,000,000	to	$710,000,000

Selected Multiple Range	$ 520,000,000	to	$	710,000,000

Midpoint (BEV/EBITDA) & (BEV/Revenue)	$610,000,000

VMG Complete Data Set

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.6x	8.6x
Mean	0.7x	8.8x
25th Percentile	0.4x	7.0x
75th Percentile	1.0x	9.9x
High	1.7x	20.4x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	119	70

State of California Transactions

	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.7x	n/a
Mean	0.7x	n/a
25th Percentile	0.7x	n/a
75th Percentile	0.7x	n/a
High	0.7x	n/a
Low	0.7x	n/a
Number of Observations with Reported Statistics	1	n/a

EBITDA Margin Greater than 5.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	0.7x	8.4x
Mean	0.8x	8.2x
25th Percentile	0.6x	6.7x
75th Percentile	1.1x	9.4x
High	1.7x	20.4x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	53	51

EBITDA Margin Greater than 10.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	1.0x	7.9x
Mean	1.0x	7.4x
25th Percentile	0.8x	6.2x
75th Percentile	1.3x	8.9x
High	1.7x	10.7x
Low	0.1x	0.8x
Number of Observations with Reported Statistics	26	24

EBITDA Margin Greater than 15.0%

Metric	Business Enterprise Value / Revenue	Business Enterprise Value / EBITDA
Median	1.3x	7.6x
Mean	1.1x	6.9x
25th Percentile	0.6x	5.3x
75th Percentile	1.4x	8.7x
High	1.7x	9.6x
Low	0.1x	3.3x
Number of Observations with Reported Statistics	10	8

VMG Observations:

1) Limited information was available for transactions occurring in California.
2) VMG's Complete data set was reviewed and eliminated to determine the impact of the acquired hospital's EBITDA margin (as reported) on the reported transaction multiples (BEV / Revenue and BEV / EBITDA).
3) As EBITDA margins increase from at least 5.0%, at least 10.0%, and to at least 15.0%, the BEV / Revenue multiples show an upward trend.
4) As EBITDA margins increase from at least 5.0%, at least 10.0%, and to at least 15.0%, the BEV / EBITDA multiples show a downward trend.

Notes & Sources

Source: Irving Levin Associates, Capital IQ, online articles and VMG internal data. Data set includes transactions that occurred from January 01, 2014 to June 30, 2018.

DESERT REGIONAL MEDICAL CENTER
PUBLIC GUIDELINE COMPANY COMPARABLES

FINAL REPORT
US$ in thousands

Capitalization Data

Company Name	Ticker	Market Capitalization	Total Debt	Minority Interest	Preferred Equity	Cash & Short-Term Investments	Business Enterprise Value
Community Health Systems, Inc.	CYH	$340,818	$13,715,000	$590,000	-	$208,000	$14,437,818
HCA Healthcare, Inc.	HCA	$44,401,162	$33,192,000	$1,864,000	-	$913,000	$78,544,162
LifePoint Health, Inc.	LPNT	$2,499,732	$2,928,400	$135,400	-	$143,800	$5,419,732
Quorum Health Corporation	QHC	$120,236	$1,199,412	$17,013	-	$2,822	$1,333,839
Tenet Healthcare Corporation	THC	$3,276,718	$14,867,000	$2,159,000	-	$403,000	$19,899,718
Universal Health Services, Inc.	UHS	$11,467,395	$3,990,464	$78,968	-	$76,886	$15,459,941

		Operating Revenue			*Operating EBITDA*		
Company Name	Ticker	TTM Revenue	FY + 1 Revenue	FY + 2 Revenue	TTM EBITDA	FY + 1 EBITDA	FY + 2 EBITDA
Community Health Systems, Inc.	CYH	$13,975,000	$13,923,850	$13,220,249	$825,000	$1,603,707	$1,552,429
HCA Healthcare, Inc.	HCA	$45,210,000	$46,199,801	$48,372,743	$8,481,000	$8,768,293	$9,239,939
LifePoint Health, Inc.	LPNT	$6,239,000	$6,304,101	$6,427,871	$660,700	$741,383	$763,346
Quorum Health Corporation	QHC	$1,858,462	$1,944,077	$1,982,244	$80,722	$148,978	$169,200
Tenet Healthcare Corporation	THC	$18,769,000	$18,140,912	$18,028,498	$2,663,000	$2,602,447	$2,655,960
Universal Health Services, Inc.	UHS	$10,553,520	$10,819,941	$11,348,893	$1,701,019	$1,770,035	$1,872,305

Implied Multiples

Company Name	Ticker	TTM Revenue	FY + 1 Revenue	FY + 2 Revenue	TTM EBITDA	FY + 1 EBITDA	FY + 2 EBITDA
Community Health Systems, Inc.	CYH	1.0x	1.0x	1.1x	17.5x	9.0x	9.3x
HCA Healthcare, Inc.	HCA	1.7x	1.7x	1.6x	9.3x	9.0x	8.5x
LifePoint Health, Inc.	LPNT	0.9x	0.9x	0.8x	8.2x	7.3x	7.1x
Quorum Health Corporation	QHC	0.7x	0.7x	0.7x	16.5x	9.0x	7.9x
Tenet Healthcare Corporation	THC	1.1x	1.1x	1.1x	7.5x	7.6x	7.5x
Universal Health Services, Inc.	UHS	1.5x	1.4x	1.4x	9.1x	8.7x	8.3x
Market Multiples	*Mean:*	*1.1 x*	*1.1 x*	*1.1 x*	*11.3 x*	*8.4 x*	*8.1 x*
	Median:	*1.0 x*	*1.1 x*	*1.1 x*	*9.2 x*	*8.8 x*	*8.1 x*
Market Multiples - Excluding CYH & QHC	*Mean:*	*1.3 x*	*1.3 x*	*1.2 x*	*8.5 x*	*8.2 x*	*7.8 x*
	Median:	*1.3 x*	*1.3 x*	*1.2 x*	*8.6 x*	*8.2 x*	*7.9 x*

Footnotes:

1) *Source: Capital IQ as of August 22, 2018.*
2) *Business Enterprise Value ("BEV") is defined as Market Value of Equity plus Interest-bearing Debt and minority interest less Cash and Cash Equivalents.*

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Revenue Growth								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 2	4.3%	7.5%	16.3%	2.0%	12.2%	10.2%	8.7%	8.8%
FYE - 1	(5.1%)	4.6%	22.0%	(2.2%)	5.3%	8.0%	5.4%	4.9%
FYE	(16.7%)	5.1%	(1.1%)	(3.1%)	(2.3%)	6.6%	(1.9%)	(1.7%)
TTM	(9.0%)	3.7%	(0.8%)	(10.3%)	(2.1%)	1.4%	(2.9%)	(1.5%)
Year 1	(0.4%)	2.2%	1.0%	4.6%	(3.3%)	2.5%	1.1%	1.6%
Year 2	(5.1%)	4.7%	2.0%	2.0%	(0.6%)	4.9%	1.3%	2.0%
Year 3	0.9%	4.7%	1.0%	0.9%	3.9%	4.0%	2.5%	2.4%

EBITDA Growth								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 2	(3.7%)	6.6%	16.7%	(2.7%)	17.7%	12.4%	7.8%	9.5%
FYE - 1	(17.0%)	3.8%	8.7%	(53.2%)	6.3%	2.4%	(8.2%)	3.1%
FYE	(54.8%)	0.2%	(8.5%)	(12.8%)	(1.6%)	1.8%	(12.6%)	(5.0%)
TTM	(10.0%)	3.0%	(1.3%)	(16.3%)	10.8%	(1.6%)	(2.6%)	(1.4%)
Year 1	94.4%	3.4%	12.2%	84.6%	(2.3%)	4.1%	32.7%	8.1%
Year 2	(3.2%)	5.4%	3.0%	13.6%	2.1%	5.8%	4.4%	4.2%
Year 3	(0.9%)	4.7%	(0.4%)	0.8%	3.6%	3.7%	1.9%	2.2%

EBITDA Margins								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 2	12.6%	19.9%	12.9%	10.8%	12.3%	18.3%	14.5%	12.7%
FYE - 1	11.0%	19.8%	11.5%	5.2%	12.4%	17.4%	12.9%	12.0%
FYE	6.0%	18.9%	10.6%	4.7%	12.5%	16.6%	11.5%	11.6%
TTM	5.9%	18.8%	10.6%	4.3%	14.2%	16.1%	11.7%	12.4%
Year 1	11.5%	19.0%	11.8%	7.7%	14.3%	16.4%	13.4%	13.1%
Year 2	11.7%	19.1%	11.9%	8.5%	14.7%	16.5%	13.7%	13.3%
Year 3	11.5%	19.1%	11.7%	8.5%	14.7%	16.4%	13.7%	13.2%

Capital Expenditures as a % of Revenue								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 3	4.6%	5.9%	4.6%	3.2%	5.6%	4.8%	4.8%	4.7%
FYE - 2	4.9%	6.0%	5.3%	2.7%	4.5%	4.2%	4.6%	4.7%
FYE - 1	4.0%	6.7%	6.3%	3.7%	4.5%	5.3%	5.1%	4.9%
FYE	3.7%	6.9%	7.5%	3.0%	3.7%	5.6%	5.1%	4.6%
TTM	4.2%	7.3%	7.3%	2.6%	3.3%	6.5%	5.2%	5.4%

Net Working Capital (Including Cash) as a % of Revenue								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 3	11.9%	10.3%	14.7%	13.9%	3.0%	6.1%	10.0%	11.1%
FYE - 2	12.0%	10.0%	12.9%	15.6%	5.3%	7.6%	10.6%	11.0%
FYE - 1	12.1%	8.4%	8.6%	13.0%	7.2%	4.8%	9.0%	8.5%
FYE	11.4%	9.2%	8.6%	10.7%	7.2%	4.8%	8.7%	8.9%
TTM	12.0%	9.9%	9.8%	9.9%	5.4%	5.3%	8.7%	9.8%

Cash Free Net Working Capital as a % of Revenue								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 3	9.1%	8.6%	10.4%	13.8%	1.9%	5.7%	8.2%	8.8%
FYE - 2	11.0%	8.0%	7.4%	15.6%	3.4%	6.9%	8.7%	7.7%
FYE - 1	10.8%	6.7%	7.1%	11.8%	3.6%	4.5%	7.4%	6.9%
FYE	7.7%	7.4%	6.8%	10.5%	4.0%	4.0%	6.8%	7.1%
TTM	10.5%	7.8%	7.5%	9.7%	3.3%	4.6%	7.2%	7.7%

Capital Structure - Debt / BEV								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
FYE - 3	71.2%	47.1%	39.4%	n/a	67.8%	22.5%	49.6%	47.1%
FYE - 2	81.6%	51.2%	44.4%	n/a	72.3%	22.2%	54.4%	51.2%
FYE - 1	92.2%	51.6%	54.4%	84.1%	77.1%	28.5%	64.6%	65.7%
FYE	92.8%	50.1%	57.6%	85.5%	78.5%	27.2%	65.3%	68.1%
TTM	93.6%	41.8%	52.6%	89.7%	73.2%	25.7%	62.8%	62.9%

Additional Comparable Data (as a % of FYE Revenue)								
Time Period	CYH	HCA	LPNT	QHC	THC	UHS	Mean	Median
SW&B	47.7%	46.1%	48.1%	55.7%	47.5%	48.4%	48.9%	47.9%
Supplies	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
COGS	65.1%	62.8%	67.8%	67.8%	63.8%	59.2%	64.4%	64.4%
SG&A	2.5%	n/a	1.1%	3.2%	1.7%	1.0%	1.9%	1.7%
D&A	5.4%	4.9%	5.4%	4.0%	4.4%	4.2%	4.7%	4.6%

Footnotes:

1) Source: Capital IQ as of August 22, 2018.

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Guideline Company	Company Description
CYH	Community Health Systems, Inc., together with its subsidiaries, owns, leases, and operates general acute care hospitals in the United States. It offers general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetrics, diagnostic, psychiatric, and rehabilitation services, as well as skilled nursing and home care services. The company also provides outpatient services at urgent care centers, occupational medicine clinics, imaging centers, cancer centers, ambulatory surgery centers, and home health and hospice agencies. As of December 31, 2016, it owned or leased 155 hospitals, including 152 general acute care hospitals and 3 stand-alone rehabilitation or psychiatric hospitals with an aggregate of 26,222 licensed beds in 21 states. The company was founded in 1985 and is headquartered in Franklin, Tennessee.
HCA	HCA Healthcare, Inc., through its subsidiaries, provides health care services in the United States and England. The company operates general, acute care hospitals that offer medical and surgical services, including inpatient care, intensive care, cardiac care, diagnostic, and emergency services; and outpatient services, such as outpatient surgery, laboratory, radiology, respiratory therapy, cardiology, and physical therapy services. It also operates psychiatric hospitals, which provide therapeutic programs comprising child, adolescent and adult psychiatric care, and adolescent and adult alcohol and drug abuse treatment and counseling. In addition, the company operates outpatient health care facilities consisting of freestanding ambulatory surgery centers, freestanding emergency care facilities, urgent care facilities, walk-in clinics, diagnostic and imaging centers, rehabilitation and physical therapy centers, radiation and oncology therapy centers, physician practices, and various other facilities. As of September 30, 2017, it owned and operated 177 hospitals and 119 freestanding surgery centers. The company was formerly known as HCA Holdings, Inc. HCA Healthcare, Inc. was founded in 1968 and is headquartered in Nashville, Tennessee.
LPNT	LifePoint Health, Inc., through its subsidiaries, owns and operates community hospitals, regional health systems, physician practices, outpatient centers, and post-acute facilities in the United States. Its hospitals offer a range of medical and surgical services, such as general surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, rehabilitation, and pediatric services, as well as specialized services, including open-heart surgery, skilled nursing, psychiatric care, and neuro-surgery. The company's hospitals also provide various outpatient services comprising same-day surgery, laboratory, X-ray, respiratory therapy, imaging, sports medicine, and lithotripsy. In addition, it owns and operates schools of nursing and other allied health professions. As of December 31, 2016, the company operated 72 hospital campuses, including 9,424 licensed beds in 22 states. The company was formerly known as LifePoint Hospitals, Inc. and changed its name to LifePoint Health, Inc. in May 2015. LifePoint Health, Inc. was founded in 1997 and is based in Brentwood, Tennessee.
QHC	Quorum Health Corporation provides hospital and outpatient healthcare services in the United States. Its general hospital and outpatient healthcare services include general acute care, emergency room, general and specialty surgery, critical care, internal medicine, obstetric, diagnostic, psychiatric, and rehabilitation services. Quorum Health Corporation offers its healthcare services through its hospitals and affiliated facilities, including urgent care centers, diagnostic and imaging centers, physician clinics, and surgery centers. The company, through its subsidiary, Quorum Health Resources, LLC, provides management advisory and consulting services to non-affiliated hospitals. As of January 5, 2018, it owned or leased 31 hospitals with an aggregate of approximately 3,000 licensed beds. The company was incorporated in 2015 and is headquartered in Brentwood, Tennessee.
THC	Tenet Healthcare Corporation, together with its subsidiaries, operates as a diversified healthcare services company. It operates in three segments: Hospital Operations and Other, Ambulatory Care, and Conifer. The company's general hospitals offer acute care services, operating and recovery rooms, radiology and respiratory therapy services, clinical laboratories, and pharmacies. It also provides intensive and critical care, and coronary care units; physical therapy, orthopedic, oncology, and outpatient services; tertiary care services, including open-heart surgery, neonatal intensive care, and neurosciences; quaternary care in heart, liver, kidney, and bone marrow transplants areas; tertiary and quaternary pediatric, and burn services; and limb-salvaging vascular procedures, acute level 1 trauma services, intravascular stroke care, minimally invasive cardiac valve replacement, imaging technology, and telemedicine access for various medical specialties. In addition, the company offers ambulatory surgery and urgent care centers, imaging centers, and short-stay surgical hospitals, as well as Aspen's hospitals and clinics; healthcare business process services in the areas of hospital and physician revenue cycle management and value-based care solutions; and microhospitals, physician practices, and health plans. Further, it provides accounts receivable and health information management, and revenue integrity and patient financial services; patient communications and engagement services; and clinical integration, financial risk management, and population health management services. As of February 27, 2017, the company operated 80 general acute care hospitals, 20 short-stay surgical hospitals, and approximately 470 outpatient centers, as well as 239 ambulatory surgery, 34 urgent care, and 21 imaging centers in the United States; and 9 private hospitals and clinics in the United Kingdom. Tenet Healthcare Corporation was founded in 1967 and is headquartered in Dallas, Texas.
UHS	Universal Health Services, Inc., through its subsidiaries, owns and operates acute care hospitals, behavioral health facilities, and ambulatory centers. The company's hospitals offer general and specialty surgery, internal medicine, obstetrics, emergency room care, radiology, oncology, diagnostic care, coronary care, pediatric services, pharmacy services, and/or behavioral health services. As of February 28, 2017, it owned and/or operated 26 inpatient acute care hospitals, 4 free-standing emergency departments, 1 surgical hospital, and 319 inpatient and 33 outpatient behavioral health care facilities located in 37 states, Washington, D.C.; the United Kingdom; Puerto Rico; and the U.S. Virgin Islands. The company was founded in 1978 and is headquartered in King of Prussia, Pennsylvania.

Source: Capital IQ as of August 22, 2018.

Desert Regional Medical Center

Supplemental Exhibits

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**The list of services below was provided to VMG by Tenet*

Directly Charged Corporate Services - Potentially Included in EBITDA

Accounting & Tax
- Annual audit support
- Property taxes and appeals
- Physical asset inventory
- Records retention

Conifer Health Solutions
- Patient access
- Billing
- Call center and patient communications
- Collections
- Claim adjudication
- Claim follow-up
- Maintenance of systems & applications
- Patient & physician satisfaction management and reporting
- Performance analysis and reporting

Contracted Services
- Food and nutrition services (Sodexo or Morrison)
- Environmental services (Crothall or Aramark)
- Security (US security or Universal Protection)
- Document management (Dex Imaging)
- Dialysis (Davita or Fresenius)
- Waste management
- Linen

Human Resources
- Applicant tracking and background screening
- Health insurance and benefit plans
- Human resources business systems
- Recruitment and retention
- Labor relations
- Learning and development tools (includes .edu)
- Worker's compensation
- 401(k) matching
- AIP (non c suite)
- Employee surveys

Information Services
- Core applications - licensing and support for corporate clinical and financial systems

Operations
- Accreditation compliance
- Business development application and tools
- Clinical quality program implementation administration costs
- Health Information Patient Protection Act costs
- Insurance (property, auto, earthquake, and other)
- Lease administration costs
- Legal fees
- Malpractice expenses
- Patient safety survey supply rebates
- Dues and subscriptions (AHA, FAH, etc.)

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Corporate Services Included in Pooled Allocation

Accouting / Business Office
- Development of accounting policies and procedures
- Maintenance of general ledger chart of accounts (additions, deletions, changes)
- Maintenance of transaction code (posting) table
- Maintenance of corporate Chargemaster (additions, deletions, changes)
- Maintenance of appropriate Information Decision Support Systems

Accounts Payable
- Check printing and distribution to vendors/hospitals
- Annual 1099 report preparation
- Set up of new vendors

Business Development

Cash Management
- Set up new bank accounts
- Handle any wire transfers
- Sweeping of accounts to corporate concentration account
- Reconciliation of accounts payable/payroll disbursement accounts
- Management of cash flow

Communications and Public Relations
- Provide support through all media in crisis situations
- Provide support with local advertising and public relations efforts

Compliance
- Compliance program management and oversight for ethics, training, policies and procedures
- Privacy and security program management and oversight
- Coding/billing compliance management and oversight

Construction and Design
- Project oversight and review
- Physical plant oversight and management
- Environmental safety and controls
- Utility management
- Preventive maintenance

Human Resources
- Hospital C-suite AIP
- Employee benefit design, including legal review, evaluation of cost and preparation of commuication materials
- Employee benefits administration, including:
  - *Payroll/Benefit interface issues*
  - *Processing communication materials*
  - *Claims processing*
  - *Retirement processing*
  - *Retirement plan non-discrimination testing*
- Employee compensation support function, including:
  - *Market review*
  - *Merit process*
- Answering employee questions and assisting employees with benefit issues
- Workers compensation risk management consulting
- Policies and procedures drafting and production, including employee handbook
- Human Resources Customer Services support for general HR operations and policy interpretation

Internal Audit
- Periodic audits/site visits to ensure adherence to policies/procedures and GAAP guidelines

Legal
- Routine legal services performed by in-house counsel, but not legal services provided by outside counsel
- Review and provide language recommendations for non-physician contracts
- Draft standard contracts for various services

Managed Care Contracting
- Standard contracting for HMOs, PPOs, risk, etc.
- Evaluation of risk arrangements

Miscellaneous Other Items
- Real estate manager review of purchases and lease terms

Patient Care Operations
- Complete outcomes assessments
- Provide quality assurance support to facility quality assurance personnel

Payroll
- Filing and administration of payment of all payroll taxes: FICA, federal, state, local, FUI, SUI
- Generation of W-2s annually
- Check printing and distribution to hospitals

Purchasing
- Development and execution of corporate purchasing contracts
- Provide assistance with IMMS systems problems/issues

Reimbursement (Government Programs)
- Preparation and filing of annual Medicare, Medi-Cal, and other cost reports
- Provide assistance in maintenance and operation of Medicare log system and monthly contractual allowables
- Recording of receivables/reserves on all cost reports
- Filing and follow-up administration of appeals
- Maintenance of corporate chargemaster (additions, deletions, changes)

Risk Management
- Risk manager support on all risk management issues
- Review of patient and visitor incident reporting, lawsuits, etc.

Tax
- Preparation and filing of all federal and state tax returns
- Preparation and filing of all franchise tax returns
- Handle procurement of federal tax ID numbers
- Provide tax advice and research

Fixed Assets
- Maintain fixed asset system
- Reconciliation of fixed asset system to general ledger

Governmental Affairs
- Keep facilities apprised of status on state and federal legislative actions

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Facility Name	County	Type of Entity	Owner	Total Revenue ($)	EBITDA ($)	EBITDA % Revenue
RIVERSIDE COMMUNITY HOSPITAL	Riverside County	For Profit	HCA INC.	481,047,690	135,576,014	28.2%
PARADISE VALLEY HOSPITAL	San Diego County	For Profit	PRIME HEALTHCARE INC.	138,361,286	(1,845,668)	(1.3%)
UC SAN DIEGO HEALTH HILLCREST - HILLCREST MED CTR	San Diego County	Other	UNIVERSITY OF CALIFORNIA	1,553,151,142	177,592,067	11.4%
GROSSMONT HOSPITAL	San Diego County	Hospital District of Authority	SHARP HEALTHCARE	733,270,951	75,784,020	10.3%
EL CENTRO REGIONAL MEDICAL CENTER	Imperial County	Local Government	NA	134,611,951	7,518,921	5.6%
SAN GORGONIO MEMORIAL HOSPITAL	Riverside County	Hospital District of Authority	NA	84,854,800	13,918,048	16.4%
ST JOSEPH HOSPITAL	Orange County	Church	ST JOSEPH HEALTH SYSTEM	621,526,486	36,761,717	5.9%
SCRIPPS MERCY HOSPITAL	San Diego County	Nonprofit	SCRIPPS HEALTH	768,710,640	80,700,954	10.5%
COMMUNITY HOSPITAL OF SAN BERNARDINO	San Bernardino County	Nonprofit	DIGNITY HEALTH	246,888,612	3,540,754	1.4%
COMMUNITY HOSPITAL OF HUNTINGTON PARK	Los Angeles County	For Profit	AVANTI HOSPITALS LLC	42,932,059	(1,517,497)	(3.5%)
WEST COVINA MEDICAL CENTER, INC	Los Angeles County	For Profit	NA	10,561,520	(225,626)	(2.1%)
SAN ANTONIO REGIONAL HOSPITAL	San Bernardino County	Other	NA	302,673,469	14,804,584	4.9%
SHARP MEMORIAL HOSPITAL	San Diego County	Other	SHARP HEALTHCARE	1,207,797,609	271,362,235	22.5%
PARKVIEW COMMUNITY HOSPITAL MEDICAL CENTER	Riverside County	Nonprofit	NA	164,094,073	11,970,332	7.3%
WHITE MEMORIAL MEDICAL CENTER	Los Angeles County	Church	ADVENTIST HEALTH SYSTEM	428,003,728	51,061,884	11.9%
SAINT FRANCIS MEDICAL CENTER	Los Angeles County	Church	VERITY HEALTH SYSTEM	458,953,563	47,750,525	10.4%
PALOMAR HEALTH DOWNTOWN CAMPUS	San Diego County	Hospital District of Authority	PALOMAR POMERADO HEALTH	543,078,376	97,925,739	18.0%
TRI-CITY MEDICAL CENTER	San Diego County	Hospital District of Authority	NA	336,628,574	818,613	0.2%
ST BERNARDINE MEDICAL CENTER	San Bernardino County	Nonprofit	DIGNITY HEALTH	355,939,536	(29,984,308)	(8.4%)
SAN GABRIEL VALLEY MEDICAL CENTER	Los Angeles County	Physician Ownership	AHMC HEALTHCARE INC	180,269,581	5,445,248	3.0%
CITY OF HOPE HELFORD CLINICAL RESEARCH HOSPITAL	Los Angeles County	Other	CITY OF HOPE DEVELOPMENT CENTER	931,465,137	174,664,470	18.8%
ST JUDE MEDICAL CENTER	Orange County	Church	ST JOSEPH HEALTH SYSTEM	495,834,901	39,168,994	7.9%
PRESBYTERIAN INTERCOMMUNITY HOSPITAL	Los Angeles County	Nonprofit	INTERHEALTH	621,726,807	63,248,608	10.2%
ST MARY MEDICAL CENTER	Los Angeles County	Church	DIGNITY HEALTH	286,693,613	(4,887,066)	(1.7%)
SHARP CHULA VISTA MEDICAL CENTER	San Diego County	For Profit	SHARP HEALTHCARE CORPORATION	371,747,006	18,887,790	5.1%
HOAG MEMORIAL HOSPITAL PRESBYTERIAN	Orange County	Nonprofit	ST. JOSEPH HEALTH SYSTEM	971,311,925	126,873,200	13.1%
AHMC ANAHEIM REGIONAL MEDICAL CENTER	Orange County	Nonprofit	AHMC HEALTHCARE INC	214,312,233	3,653,539	1.7%
GARDEN GROVE HOSPITAL & MEDICAL CENTER	Orange County	For Profit	PRIME HEALTHCARE INC	86,282,898	5,040,961	5.8%
POMONA VALLEY HOSPITAL MEDICAL CENTER	Los Angeles County	Nonprofit	NA	535,610,935	67,119,919	12.5%
SHARP CORONADO HOSPITAL AND HLTHCR CTR	San Diego County	For Profit	SHARP HEALTHCARE	96,156,828	13,533,001	14.1%
METHODIST HOSPITAL OF SOUTHERN CA	Los Angeles County	Nonprofit	NA	306,095,350	45,486,196	14.9%
GLENDALE ADVENTIST MEDICAL CENTER	Los Angeles County	Nonprofit	ADVENTIST HEATLH	410,471,694	8,772,502	2.1%
ARROWHEAD REGIONAL MEDICAL CENTER	San Bernardino County	Local Government	NA	626,599,356	106,666,961	17.0%
REDLANDS COMMUNITY HOSPITAL	San Bernardino County	Federal Government	NA	183,972,149	21,300,936	11.6%
HI-DESERT MEDICAL CENTER	San Bernardino County	Hospital District of Authority	TENET HEALTHCARE CORP	58,475,860	3,607,288	6.2%
ALHAMBRA HOSPITAL MEDICAL CENTER	Los Angeles County	For Profit	NAME:	205,828,578	25,943,840	12.6%
RIVERSIDE UNIVERSITY HEALTH SYSTEM-MEDICAL CENTER	Riverside County	Local Government	NA	540,551,729	59,993,060	11.1%
ST MARY MEDICAL CENTER	San Bernardino County	Nonprofit	ST JOSEPH HEALTH SYSTEM	335,525,969	55,514,826	16.5%
SCRIPPS MEMORIAL HOSPITAL LA JOLLA	San Diego County	Other	SCRIPPS HEALTH	584,332,489	136,510,464	23.4%
CORONA REGIONAL MEDICAL CENTER	Riverside County	For Profit	UHS OF DELAWARE INC.	170,166,912	12,107,489	7.1%
PIONEERS MEMORIAL HEALTHCARE DISTRICT	Imperial County	Hospital District of Authority	NA	115,922,925	5,993,830	5.2%
UNIVERSITY OF CALIFORNIA IRVINE MED CENTER	Orange County	Local Government	THE REGENTS OF THE UNIVERSITY OF CAL	1,044,731,823	94,193,729	9.0%
BEVERLY HOSPITAL	Los Angeles County	Nonprofit	NA	178,624,363	12,430,122	7.0%
CITRUS VALLEY MEDICAL CENTER-IC CAMPUS	Los Angeles County	For Profit	CITRUS VALLEY HEALTH PARTNERS	404,024,601	28,320,155	7.0%
HEMET VALLEY MEDICAL CENTER	Riverside County	Physician Ownership	PHYSICIANS FOR HEALTHY HOSPITALS	151,225,108	9,573,425	6.3%
PIH HOSPITAL - DOWNEY	Los Angeles County	Nonprofit	INTERHEALTH	162,904,938	6,716,725	4.1%
SCRIPPS GREEN HOSPITAL	San Diego County	Nonprofit	SCRIPPS HEALTH	404,408,620	91,378,869	22.6%
WEST ANAHEIM MEDICAL CENTER	Orange County	For Profit	PRIME HEALTHCARE INC	102,231,617	1,206,929	1.2%

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Facility Name	County	Type of Entity	Owner	Total Revenue ($)	EBITDA ($)	EBITDA % Revenue
LONG BEACH MEMORIAL MEDICAL CENTER	Los Angeles County	Other	MEMORIAL HEALTH SERVICES	684,899,570	94,142,504	13.7%
SCRIPPS MEMORIAL HOSPITAL - ENCINITAS	San Diego County	Nonprofit	SCRIPPS HEALTH	277,870,528	33,135,249	11.9%
VICTOR VALLEY GLOBAL MEDICAL CENTER	San Bernardino County	Nonprofit	NA	91,465,627	16,509,948	18.1%
HUNTINGTON BEACH HOSPITAL	Orange County	For Profit	PRIME HEALTHCARE INC	45,507,938	(2,977,874)	(6.5%)
JOHN F KENNEDY MEMORIAL HOSPITAL	Riverside County	For Profit	TENET HEALTHCARE CORP	116,831,585	234,975	0.2%
COLLEGE HOSPITAL COSTA MESA	Orange County	For Profit	COLLEGE HEALTH ENTERPRISES	87,656,691	25,918,740	29.6%
FAIRVIEW DEVELOPMENTAL CENTER	Orange County	Local Government	CA DEPARTMENT OF DEVELOPMENTAL SERVI	132,429,048	(7,256,843)	(5.5%)
LOS ALAMITOS MEDICAL CENTER	Orange County	For Profit	TENET HEALTHCARE	213,158,448	31,916,314	15.0%
MISSION HOSPITAL REGIONAL MED CENTER	Orange County	Nonprofit	ST JOSEPH HEALTH SYSTEM	573,294,579	52,902,196	9.2%
FOUNTAIN VALLEY REGIONAL HOSPITAL & MEDICAL CENTER	Orange County	For Profit	TENET HEALTHCARE CORP.	410,711,698	97,650,554	23.8%
EISENHOWER MEDICAL CENTER	Riverside County	For Profit	NA	698,126,344	55,628,333	8.0%
LA PALMA INTERCOMMUNITY HOSPITAL	Orange County	For Profit	PRIME HEALTHCARE INC	53,761,232	(1,905,728)	(3.5%)
LAKEWOOD REGIONAL MEDICAL CENTER	Los Angeles County	For Profit	TENET HEALTHCARE CORP	189,897,458	24,990,415	13.2%
CHINO VALLEY MEDICAL CENTER	San Bernardino County	For Profit	PRIME HEALTHCARE INC	101,454,090	11,725,803	11.6%
SAN DIMAS COMMUNITY HOSPITAL	Los Angeles County	For Profit	PRIME HEALTHCARE INC	63,847,060	4,968,534	7.8%
PLACENTIA LINDA HOSPITAL	Orange County	For Profit	TENET HEALTHCARE CORP	97,997,622	22,811,496	23.3%
FOOTHILL PRESBYTERIAN HOSPITAL	Los Angeles County	Nonprofit	CITRUS VALLEY HEALTH PARTNERS	90,062,423	10,296,187	11.4%
SADDLEBACK MEMORIAL MEDICAL CENTER	Orange County	Nonprofit	MEMORIAL HEALTH SERVICES	371,662,851	56,350,564	15.2%
POMERADO HOSPITAL	San Diego County	Hospital District of Authority	PALOMAR HEALTH	180,982,235	39,596,983	21.9%
EAST LOS ANGELES DOCTORS HOSPITAL	Los Angeles County	For Profit	AVANTI HOSPITALS LLC	72,491,073	6,254,685	8.6%
LOS ANGELES COMMUNITY HOSPITAL	Los Angeles County	For Profit	ALTA HOSPITALS SYSTEM LLC	152,068,944	43,855,892	28.8%
ORANGE COAST MEMORIAL MEDICAL CENTER	Orange County	For Profit	MEMORIAL HEALTH SERVICES	306,606,238	28,905,230	9.4%
MENIFEE VALLEY MEDICAL CENTER	Riverside County	Physician Ownership	PHYSICIANS FOR HEALTHY HOSPITALS	39,639,009	(2,141,870)	(5.4%)
KECK HOSPITAL OF USC	Los Angeles County	Other	NA	799,378,303	(38,226,216)	(4.8%)
SOUTHWEST HEALTHCARE SYSTEM	Riverside County	For Profit	UHS OF DELAWARE INC.	283,012,754	57,639,224	20.4%
DESERT VALLEY HOSPITAL	San Bernardino County	For Profit	PRIME HEALTHCARE SERVICES INC.	138,103,427	16,270,085	11.8%
COMMUNITY HOSPITAL OF LONG BEACH	Los Angeles County	Nonprofit	MEMORIAL HEALTH SERVICES	70,234,113	(1,482,862)	(2.1%)
WHITTIER HOSPITAL MEDICAL CENTER	Los Angeles County	For Profit	AHMC HEALTHCARE INC	129,000,118	16,533,640	12.8%
MONTEREY PARK HOSPITAL	Los Angeles County	For Profit	AHMC HEALTHCARE INC	108,202,371	17,805,644	16.5%
GARFIELD MEDICAL CENTER	Los Angeles County	For Profit	AHMC HEALTHCARE INC.	300,578,013	13,494,534	4.5%
GREATER EL MONTE COMMUNITY HOSPITAL	Los Angeles County	Nonprofit	AHMC HEALTHCARE INC.	78,247,343	10,462,801	13.4%
ANAHEIM GLOBAL MEDICAL CENTER	Orange County	For Profit	KPC HEALTHCARE INC	69,432,681	5,684,443	8.2%
CHAPMAN GLOBAL MEDICAL CENTER	Orange County	For Profit	INTEGRATED HEALTHCARE HOLDINGS INC.	49,432,776	6,679,313	13.5%
ORANGE COUNTY GLOBAL MEDICAL CENTER	Orange County	For Profit	INTEGRATED HEALTHCARE HOLDINGS INC.	189,370,651	45,191,951	23.9%
SOUTH COAST GLOBAL MEDICAL CENTER	Orange County	For Profit	INTEGRATED HEALTHCARE HOLDINGS INC.	56,344,502	2,282,033	4.1%
ALVARADO HOSPITAL MEDICAL CENTER	San Diego County	For Profit	PRIME HEALTHCARE INC	134,841,300	(7,148,127)	(5.3%)
MONTCLAIR HOSPITAL MEDICAL CENTER	San Bernardino County	Nonprofit	PRIME HEALTHCARE INC	48,147,032	2,282,523	4.7%
COAST PLAZA HOSPITAL	Los Angeles County	For Profit	AVANTI HOSPITALS LLC	43,381,532	(3,435,737)	(7.9%)
TEMECULA VALLEY HOSPITAL	Riverside County	For Profit	UHS OF DELAWARE INC.	116,283,061	26,298,270	22.6%
COLLEGE MEDICAL CENTER	Los Angeles County	For Profit	COLLEGE HEALTH ENTERPRISES INC	123,650,526	15,315,941	12.4%
MARTIN LUTHER KING, JR. COMMUNITY HOSPITAL	Los Angeles County	Nonprofit	NA	213,511,423	39,414,408	18.5%

Source: cms.gov; CMS Cost Report Data and Medicare Provider of Services File. Includes identified hospitals located within a 100 mile radius of Desert Regional Medical Center excluding certain outliers when reported EBITDA was below -10% or above +30%, or in instances in which a hospital EBITDA was not reported.

Metric	EBITDA % Revenue
Average	9.6%
Median	10.2%
High	29.6%
Low	(8.4%)
25th %	4.5%
75th %	14.9%

FINAL REPORT

Population Estimates	1990	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Riverside	1,170,413	1,558,985	1,616,634	1,687,147	1,771,656	1,856,542	1,931,785	2,012,370	2,075,183	2,109,712	2,146,725	2,189,641	2,236,146	2,264,919	2,291,452	2,322,455	2,352,892	2,387,741
**CAGR since 1990*	*n/a*	*2.9%*	*3.0%*	*3.1%*	*3.2%*	*3.4%*	*3.4%*	*3.4%*	*3.4%*	*3.3%*	*3.2%*	*3.2%*	*3.1%*	*3.0%*	*3.0%*	*2.9%*	*2.8%*	*2.8%*
**CAGR since 2000*		*n/a*	*3.7%*	*4.0%*	*4.4%*	*4.5%*	*4.4%*	*4.3%*	*4.2%*	*3.9%*	*3.6%*	*3.5%*	*3.3%*	*3.2%*	*3.0%*	*2.9%*	*2.8%*	*2.7%*

**CAGR = Compounded annual growth rate.*

Source: United States Census Bureau Population Finder for Riverside

01/18/2019

Desert Regional Medical Center Retrofit Project Phase 1

Desert Regional Medical Center
Palm Spring, CA
18 January 2019

SGH Project 187112

SIMPSON GUMPERTZ & HEGER
Engineering of Structures and Building Enclosures

PREPARED FOR:

Desert Healthcare District
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1. INTRODUCTION

The Desert Healthcare District (DHD) commissioned Simpson Gumpertz & Heger Inc. (SGH) to evaluate the Desert Regional Medical Center (DRMC) to gain a more detailed understanding of potential design and construction work associated with attaining compliance with the Alquist Hospital Seismic Safety Act (AHSSA, aka SB 1953). This report is a compilation of the work completed under Phase 1 of the referenced project and builds upon the information presented in the Phase 0 report.

1.1 Background

The Alquist Hospital Seismic Safety Act (AHSSA aka SB1953) was established in 1995 in response to unexpected poor seismic performance of hospitals during the 1994 Northridge earthquake. The AHSSA requires that all General Acute Care (GAC) hospital buildings comply with certain building code regulations by 1 January 2030. This requirement is intended to provide higher confidence that a building will retain a high level of functional recovery following a major earthquake. The 1995 California Building Code, Title 24 (CBC), with a few specific modifications, was designated the target building code regulations for attaining acceptable performance. Specific Structural Performance Category (SPC) and Nonstructural Performance Category (NPC) definitions primarily establish a common vocabulary for stakeholders, design professionals, contractors and the California Office of Statewide Health Planning and Development (OSHPD).

The original AHSSA regulations require buildings rated SPC 2 or NPC 2 comply with SPC 5 and NPC 4 by 1 January 2030. Because of the compliance timelines associated with the AHSSA, SPC 1 buildings and NPC 1 buildings are currently not a concern at many medical centers in California, including the DRMC, which does not have any SPC 1 or NPC 1 buildings. SPC 2 through SPC 4 and NPC 2 through NPC 4 are performance categories applicable to the DRMC. The introduction of DRMC compliance with AHSSA and related standards is described in the Phase 0 report, so it is not repeated here.

The DRMC comprises twenty independent buildings with approximately 550,000 sq ft of occupiable space. Seventeen of the twenty buildings were designed and constructed under a permit led by the California State Office of Statewide Health Planning and Development (OSHPD), which typically minimizes the need for seismic retrofit construction. However, these “compliant” buildings require engineering consulting to confirm compliance with nonstructural seismic performance regulations. Phase 0 results describe the existing status of the DRMC,

general compliance with the AHSSA today and the defined scope of work, schedule and fee for our work in Phase 1.

1.2 Objectives

Based on Phase 0 findings, SGH's Phase 1 objective is to develop actionable structural retrofit strategies for three Structural Performance Category (SPC) 2 buildings, including the development of a rough order of magnitude cost for the related construction. Additionally, our Phase 1 work describes the scope of engineering work and estimated professional fees associated with developing nonstructural evaluation reports and construction documents to attain Nonstructural Category (NPC) 4 compliance for twenty buildings at the DRMC. Phase 1 also includes a cost model appropriate for estimating potential construction costs to bring twenty buildings into compliance with NPC 4 requirements.

1.3 Existing Buildings

The DRMC comprises twenty structurally separated buildings. The SPC/NPC ratings, posted by OSHPD and listed below, are confirmed per our review of the documents listed above.

Table 1: Existing Buildings and SPC/NPC Ratings

Building Number	OSHPD Building Number	Building Name	SPC	NPC
1	BLD-01393	Main Hospital & Additions	2	2
2	BLD-02932	East Tower	2	2
3	BLD-01395	Woman & Infants Hospital	3	2
4	BLD-01396	North Wing	2	2
5	BLD-01397	Central Plant	4	2
6	BLD-01398	Shipping/Receiving	4	2
7	BLD-01399	Surgery Wing	4	2
8	BLD-01400	West Tower (Sinatra Tower)	3	2
8A	BLD-03720	West Tower Corridor 1	3	2
8B	BLD-03721	West Tower Corridor 2	3	2
8C	BLD-03722	West Tower Corridor 3	3	2
8D	BLD-03723	West Tower Corridor 4	3	2
8E	BLD-03725	West Tower Corridor 5	3	2
9	BLD-01401	Lobby	3	2
10	BLD-01402	Admitting	4	2
11	BLD-01403	Elevator Tower	4	2
11.1	BLD-03764	Elevator Tower Corridor 1	3	2
11.2	BLD-03765	Elevator Tower Corridor 2	3	2
12	BLD-01404	Dinah Shore Waiting Area	3	2
13	BLD-03741	Medical Records Building	3	2

Buildings rated SPC 3, SPC 4 or SPC 5 may continue to function as a General Acute Care (GAC) building beyond 1 January 2030 without retrofit or analytical validation. Buildings rated SPC 2 must be analyzed and or retrofit to confirm compliance with SPC 4D before 1 January 2030.

Buildings rated NPC 2 must be evaluated to establish a record of existing conditions and required scope of work to bring the building into compliance with NPC 4.

1.4 Scope of Work

To complete the Phase 1 objectives, SGH performed the following scopes of work:

1. Per the AHSSA, a structural analysis using the *Seismic Evaluation and Retrofit of Existing Buildings*, ASCE 41-17, Damage Control performance level. SGH used the linear elastic analysis method with United States Geological Survey (USGS) based seismic design factors for:

    - Main Hospital & Additions (Building 1).
    - East Tower (Building 2).

- North Wing (Building 4).

2. Work with Swinerton Builders (Swinerton) to develop a conceptual cost estimate for seismic retrofit concepts based on evaluation results described in Item 1.

3. Identify and describe scopes of work and estimated fee for developing nonstructural evaluation reports and construction documents for buildings that are rated NPC 2, but require only fire sprinkler bracing to achieve NPC 4 (based on Phase 0 results).

4. Identify and describe scopes of work and estimated fee for developing nonstructural evaluation reports and construction documents for buildings that are rated NPC 2 and were designed between 1973 and 1983, with construction documents that show details of equipment/systems bracing and anchorage (based on Phase 0 results).

5. Identify and describe scopes of work and estimated fee for developing nonstructural evaluation reports and construction documents for buildings that are rated NPC 2 and designed before 1973 (based on Phase 0 results).

6. Work with Swinerton to develop a representative cost model and strategy for executing archetypical construction activities associated with the identified scopes of work for each building as described in the construction document scopes of work.

7. Develop presentation materials for DHD.

8. Develop written documents describing scope of work and estimated fees for consulting, OSHPD review and potential construction cost, including phasing and sequencing for scope of work described in Items 1-6.

2. DOCUMENT REVIEW

2.1 Construction Drawings

- Architectural, Electrical, HVAC, Plumbing and Structural drawings for the General Hospital Building dated 24 May 1950.

- Architectural, Electrical, HVAC, Plumbing and Structural drawings for Alterations & Additions to the Desert Hospital dated 5 March 1956.

- Architectural and Structural drawings for Alterations & Additions to the Desert Hospital dated 1 August 1962.

- Architectural, Electrical, Mechanical, Plumbing and Structural drawings for A-B-C Wings Remodel dated 10 February 1971.

- Electrical, Mechanical, Plumbing and Structural drawings for Desert Hospital dated February 1967 (East Tower drawings).

- Architectural, Electrical, Mechanical, Plumbing and Structural drawings for Desert Hospital Phase I Expansion dated 24 July 1991 (Women and Infants drawings).

- Architectural, Civil, Electrical, Mechanical, Plumbing and Structural drawings for Additions & Alterations to Desert Hospital Diagnostic & Treatment Center dated March 1971 (North Wing drawings).

- Architectural, Electrical, Mechanical, Plumbing and Structural drawings for Central Power Plant for Desert Hospital dated 30 October 1974.

- Architectural, Electrical, Mechanical, Plumbing and Structural drawings for Desert Hospital – Palm Springs Phase 1 Addition 'Revised' dated 4 February 1977.

2.2 Codes and Standards

- 2016 California Existing Building Code (CEBC).

- American Society of Civil Engineers (ASCE); ASCE 41-17, Seismic Evaluation and Retrofit of Existing Buildings.

- American Concrete Institute (ACI); ACI 318-14, Building Code Requirements for Structural Concrete.

- American Institute of Steel Construction (AISC); AISC 360, Specifications for Structural Steel Buildings.

- American Wood Council (AWC); NDS 2015, National Design Specification for Wood Construction.

2.3 Information Provided by Others

Mr. John T. Greenwood of Prest Vuksic Architects (PVA) provided documents that inform completed, OSHPD reviewed, projects in the subject buildings and a description of the scopes of work completed as part of these projects. This data was used to develop cost models for work associated with attaining nonstructural seismic compliance. The referenced documents are listed below:

- Project Index dated November 28, 2018 (7 pages).

- Annotated architectural plans identified "PVA Mark Up 11-28-18", S-200 through S-206.

- Architectural plans (departments identified).

- Architectural, Electrical, Mechanical, Plumbing and Structural drawings for Desert Hospital Phase I Expansion dated 24 July 1991 (Women and Infants drawings).

Mr. John Austin of Swinerton Builders (Swinerton) developed construction cost estimates for conceptual seismic retrofit and nonstructural compliance retrofit work associated with attaining compliance with the AHSSA. The referenced documents are listed below:

- Desert Regional Medical Center, Conceptual SPC 4 ROM Estimate Summary dated 14 December 2018.
- Desert Regional Medical Center, Conceptual SPC 4 ROM Estimate Floor by Floor Summary dated 14 December 2018.
- Desert Regional Medical Center, Conceptual NPC 4 ROM Estimate dated 19 December 2018.

3. STRUCTURAL ANALYSIS/EVALUATION (SPC 4D)

SGH completed ASCE 41-17, Tier 2 Structural Seismic Evaluations for three buildings:

- Main Hospital & Additions (Building 1).
- East Tower (Building 2).
- North Wing (Building 4).

The linear elastic analysis method, using USGS based seismic design factors, was used to evaluate building performance for the following targets per regulatory requirements related to attaining SPC 4D promulgated in the California Building Code (CBC). The performance requirement required by the CBC/ASCE 41 indicate attaining two independent performance goals as described in the definition of Enhanced Performance Objectives.

CBC Chapter 34, Section 3412A.2.3.2 describes the requirements necessary to evaluate an existing building for compliance with SPC 4D using ASCE 41. Specifically, the section requires that the following criteria are met, in addition to confirming certain nonstructural elements meet performance targets.

- “Damage Control Structural Performance Level” at BSE-1E Hazard Level.
- “Collapse Prevention Structural Performance Level” at BSE-2E Hazard Level

The Damage Control Structural Performance Level (DC) is defined as a post-earthquake damage state between the Life Safety Structural Performance Level (LS) and the Immediate Occupancy Structural Performance Level (IO). ASCE 41 prescribes “Acceptance Criteria” associated with LS and IO; the DC Acceptance Criteria is determined by taking a value that is halfway between the values listed for LS and IO. BSE-1E is the seismic hazard level associated with the representative spectral response parameters of the seismic hazard having a 20% probability of exceedance in 50 years.

The Collapse Prevention Structural Performance Level (CP) is defined as a post-earthquake damage state in which a structure has damaged components and continues to support gravity loads but retains no margin against collapse. ASCE 41 prescribes "Acceptance Criteria" associated with CP. BSE-2E is the seismic hazard level associated with the representative spectral response parameters of the seismic hazard having a 5% probability of exceedance in 50 years.

We found that each building has structural deficiencies that prevent them from meeting the required objectives. We developed conceptual retrofits for these deficiencies and Swinerton Builders developed cost estimates for construction the retrofits (presented in later sections).

3.1 Main Hospital & Additions (Building 1)

3.1.1 Description of Existing Structural Systems

The Main Hospital & Additions building is a primarily a sprawling one-story structure, comprising 6 in. thick reinforced concrete walls, with a one-way concrete joist roof system. A second story was added over a portion of the building in 1967 and comprises structural steel framed space supported by the one-story reinforced concrete wall building.

3.1.2 Seismic Analysis

The seismic analysis for the Main Hospital & Additions follows the ASCE 41-17 criteria described above. The analysis identified three structural irregularities:

- In-Plane Discontinuity Irregularity; ASCE 41-17, Section 7.3.1.1.1
- Weak Story Irregularity; ASCE 41-17, Section 7.3.1.1.3
- Torsional Strength Irregularity; ASCE 41, Section 7.3.1.1.4

ASCE 41 does not allow using linear elastic analysis methods for structures with the identified irregularities, which means that future analyses and final retrofit designs should be performed using nonlinear procedures described in ASCE 41 chapter 7.

However, SGH used linear elastic methods to evaluate the building, considering the irregularities, by using a three-dimensional finite element model for the Main Hospital Building & Additions (using ETABS structural analysis software) to evaluate the seismic performance of the existing structure, understand the severity of the identified irregularities and develop a conceptual retrofit scheme that could be evaluated for cost estimating purposes. The model

comprises frame and thin-shell elements with stiffness modification factors as prescribed in ASCE 41.

The structural model comprises the Main Hospital building and all its additions, except the 1967 addition, which is modeled independently. The one-story portion is modeled as a contiguous single-story building with concrete walls and rigid roof diaphragm. The roof height varies at various locations within the model as identified in the record drawings. The elevated, steel framed 1967 addition comprises one additional floor and roof above the one-story building and is laterally supported by discontinuous steel-braced frames. Parts of the building also include a basement level, which is not modeled.

3.1.3 Roof and Floor Diaphragms

The roof of the one-story portion is a one-way concrete joist system connected directly to the vertical elements of the seismic force resisting system. The steel-framed portion comprises 3-1/4 in. light-weight concrete fills over a 24-gauge fluted metal deck at the floor level, and 2-3/4 in. Zonolite fill over a 26-gauge fluted metal deck at the roof level.

Linear analysis indicates that the roof diaphragms for the one-story structure and the floor diaphragm for the steel framed addition, have adequate strength to span to vertical seismic force resisting system elements of the proposed retrofit scheme. Elements of the steel framed addition roof diaphragm have low capacities and require strengthening to meet the targeted performance criteria.

3.1.4 Walls and Wall Connections

Analysis indicates that the irregularities in the existing structural system will have a detrimental effect on the building behavior in a seismic event. The reinforced concrete walls supporting the two-story steel framed addition will likely be overloaded during a seismic event, necessitating strengthening to meet the targeted performance goals.

Several concrete walls throughout the one-story structure are inadequate to resist prescribed seismic forces. The wall inadequacies include effects of the noted irregularities, inadequate connection of vertical additions to original walls, overloading associated with the two-story steel framed addition and numerous openings.

ASCE 41, Section 7.2.11 requires structural walls and their anchorages resist out-of-plane inertial forces. The connections of the roof and floor diaphragms to walls are adequate to resist prescribed out-of-plane inertial forces.

3.1.5 Concrete Columns and Wall Piers

Reinforced concrete columns and narrow wall piers frame the openings in interior and exterior walls at several locations throughout the one-story building. Most columns and wall piers are shear-critical, necessitating retrofit to meet the targeted performance goals.

3.1.6 Steel Braced Frames

Discontinuous steel braced frames laterally support the 1967 two-story steel framed addition to the Main Hospital building. The braced frame connections have inadequate strength to meet the targeted performance goals. The discontinuous braced frames represent a primary structural irregularity that adversely affects the existing structure's behavior in a seismic event.

Given the number and severity of deficiencies associated with the steel braced frames and their effects on the supporting structure, their replacement with a new seismic force resisting system will likely be more economically efficient than retrofitting the frame and adding supplement elements and foundations.

3.1.7 Foundations

New foundations are required to support new walls. Additional of concrete must be added to the existing footings below thickened walls. Most existing reinforced concrete foundations are adequate to resist prescribed forces and do not require retrofit to meet target performance goals.

3.2 East Tower (Building 2)

3.2.1 Description of Existing Structural Systems

The East Tower is a three-story pre-Northridge steel special moment frame (SMF) building, with reinforced concrete floor and roof slabs, supported by structural steel columns that elevate the second floor above the one-story building below. The structural steel columns are founded on reinforced concrete spread footings.

3.2.2 Seismic Analysis

The seismic analysis for the East Tower follows the ASCE 41-17 criteria described above. SGH evaluated the East Tower by using a three-dimensional linear elastic finite element model (using ETABS structural analysis software) to evaluate the seismic performance of the existing structure and develop a conceptual retrofit scheme that could be evaluated for cost estimating purposes. The model comprises frame and thin-shell elements with stiffness modification

factors as prescribed in ASCE 41. The structural model comprises four stories above a basement.

3.2.3 Roof and Floor Diaphragms

The roof and floor systems are one-way reinforced concrete slabs with slab thickness varying between 4 to 6 in. and supported on structural steel framing. The diaphragm at the first-floor level transfers seismic shear forces between the perimeter walls and the interior moment frames. Because of the low capacity of the floor element(s) at each level, the reinforced concrete slab, diaphragm chord, collectors and their connections are all deficiencies that require retrofit to meet target performance goals.

3.2.4 Steel Special Moment Frames

Beams associated with the special moment frames are inadequately braced at their bottom flanges. This condition requires mitigation to achieve the targeted performance objectives. Existing moment frame beam-column connections also lack the strength necessary to meet the target performance goals and require retrofit.

Analysis indicates that the column baseplates are deficient and must be retrofit to meet the targeted performance goals. Analysis also indicates that the SMF does not meet the OSHPD mandated story drift criteria at the second-floor level, requiring the addition of structural elements to stiffen the seismic force resisting at this level.

3.2.5 Walls and Wall Connections

The existing reinforced concrete walls are adequate to resist prescribed forces and do not require retrofit to meet target performance goals.

The connection between the reinforced concrete walls and roof/floor diaphragms comprises (2) #4 steel reinforcing dowels at 12 in. on-center. This connection has insufficient strength to resist prescribed in-plane shear forces, requiring retrofit.

ASCE 41, Section 7.2.11 requires structural walls and their anchorages adequately resist out-of-plane inertial forces. Our analysis of the walls and the connection to the roof and floor diaphragms shows that the walls and their anchorage are adequate to resist prescribed out-of-plane inertial forces.

3.2.6 Foundations

Analysis indicates that the existing spread footings supporting the moment frame columns cannot adequately resist the uplift forces transferred from the SMF columns when resisting seismic loads.

3.3 North Wing (Building 4)

3.3.1 Description of Existing Structural Systems

The North Wing comprises two levels, one story above ground and one story below ground. The exterior walls comprise 10 in. thick, two-wythe clay masonry above 10 in. thick reinforced concrete basement walls. The walls and three interior columns are supported on reinforced concrete shallow foundations below a 4 in. thick reinforced concrete slab-on-grade. The elevated floor slab comprises a 4.5 in. reinforced concrete one-way slab supported on reinforced concrete beams. The 2.25 in. light-weight concrete over metal deck roof is supported on structural steel beams and steel posts.

3.3.2 Seismic Analysis

The North Wing seismic analysis follows ASCE 41-17 criteria described above. The analysis identified two structural irregularities:

- Out-of-Plane Discontinuity; ASCE 41-17, Section 7.3.1.1.2
- Torsional Strength Irregularity; ASCE 41, Section 7.3.1.1.4

ASCE 41 does not allow using linear elastic analysis methods for structures with the identified irregularities, which means that future analyses and final retrofit designs should be performed using nonlinear procedures described in ASCE 41 Chapter 7.

However, SGH used linear elastic methods to evaluate the building, considering the irregularities, by using two, three-dimensional finite element models (using ETABS structural engineering software) to develop a conceptual retrofit scheme that could be evaluated for cost estimating purposes. Each model comprises frame and thin-shell elements with stiffness modification factors as prescribed in ASCE 41. The models can be described as:

- Two-story model including roof level with masonry walls and main level with concrete walls.
- Single-story model with roof level and masonry walls only.

The two-story model provides results specific to the structural response considering the identified deficiencies, while the single-story model captures the effects of building behavior when founded partially below grade. Enveloped results describe the largest force demands on the seismic force resisting system, which provide a reasonable estimate for developing conceptual retrofit solutions.

3.3.3 Roof and Floor Diaphragms

The roof system has a 2.5 ft step along the southern elevation, north of the interface between Building 1 and Building 4. Both roofs comprise 2-1/4 in. light-weight insulating concrete fill over a 24-gauge fluted metal deck that is not directly connected to the vertical elements of the seismic force resisting system. Because of the step in the roof diaphragm, and the low capacity of the roof element(s), the analysis indicates that the roof metal deck, diaphragm chord connections and shear transfer from roof diaphragm to columns are all deficiencies that require mitigation. The first-floor diaphragm has adequate strength to span to vertical seismic force resisting system elements (walls) and transfer forces between the diaphragm and walls.

3.3.4 Walls and Wall Connections

The reinforced masonry and reinforced concrete walls are adequate to resist prescribed in-plane shear forces and do not require retrofit to meet target performance goals.

The connection between the reinforced masonry walls and roof/floor diaphragms comprises #5 steel reinforcing dowels at 32 in. on-center. This connection has insufficient strength to resist prescribed forces, requiring retrofit.

ASCE 41, Section 7.2.11 requires structural walls and their anchorages adequately resist out-of-plane inertial forces. Our analysis of the walls and the connection to the roof and floor diaphragms shows that the connections are adequate to resist prescribed out-of-plane inertial forces.

3.3.5 Foundations

The reinforced concrete foundations are adequate to resist prescribed forces and do not require retrofit to meet target performance goals.

4. STRUCTURAL RETROFIT (SPC 4D)

4.1 Main Hospital & Additions (Building 1)

4.1.1 Description of Identified Deficiencies Requiring Retrofit

The following deficiencies were identified in the structural analysis/evaluation for SPC 4D. Following the description of each deficiency is a brief description of the proposed retrofit:

1. Walls and wall connections

    - Deficiency: Several walls lack the strength necessary to resist forces transferred from the elevated steel addition. Other walls are overloaded because of irregularities and numerous openings in the existing structure.
    - Retrofit: Increase the thickness of the deficient walls. Dowel a section of concrete on to the face of existing walls, diaphragms, and foundations.

2. Concrete columns and wall piers

    - Deficiency: Shear critical columns frame interior and exterior openings.
    - Retrofit: Add layers of fiber-reinforced polymer to increase the shear strength of columns and slender wall piers.

3. Steel braced frames

    - Deficiency: Welded connection at the top and bottom of braces lack the strength necessary to meet the target performance objectives.
    - Retrofit: Replace the existing braced frame system with reinforced concrete walls.

4. Foundations

    - Deficiency: Existing foundations lack the strength necessary to support the retrofitted walls. New walls also require new footings.
    - Retrofit: Cast and dowel new reinforced concrete footings around the existing footings. Cast new footings underneath the new walls.

4.1.2 Main Hospital & Additions Conceptual Construction Cost Estimate

Swinerton developed a conceptual cost estimate for the proposed retrofit elements described in Section 4.1.1. The estimated direct cost for the Main Hospital & Additions seismic retrofit is $30,564,082 and the estimated cost, including normal extra contractor general conditions, general requirements, insurance and fees, 10% contingency and 20% escalation, is $50,237,006. All cost estimates are provided for reference in Appendix A.

4.2 East Tower (Building 2)

4.2.1 Description of Identified Deficiencies Requiring Retrofit

The following deficiencies were identified in the structural analysis/evaluation for SPC 4D. Following the description of each deficiency is a brief description of the proposed retrofit:

1. Chord and collector connections

    - Deficiency: The chords and collectors at the first floor are insufficient to resist diaphragm seismic forces and transfer loads into the basement walls.
    - Retrofit: This deficiency is mitigated by the addition of new walls between the second floor and foundation levels.

2. Steel special moment frame beams

    - Deficiency: The special moment frame beams are inadequately braced at their bottom flanges.
    - Retrofit: Brace the bottom flange using gusset plates and braces.

3. Steel special moment frame connections

    - Deficiency: Some special moment frame connections lack adequate strength to meet the target performance goals.
    - Retrofit: Reinforce existing connections with supplemental flange plates.

4. Story drift

    - Deficiency: Story drift at the second-floor level exceeds the acceptance criteria.
    - Retrofit: Add walls between the second-floor and foundation levels to stiffen the base of the structure and reduce story drift at the second-floor level.

5. Foundations

    - Deficiency: Inadequate uplift capacity for tensile loads in moment frame columns.
    - Retrofit: Add reinforced concrete walls at the first and basement levels to distribute column tensile loads into new reinforced concrete footings adjacent and connected to existing column footings.

4.2.2 East Tower Conceptual Construction Cost Estimate

Swinerton developed a conceptual cost estimate for the proposed retrofit elements described in Section 4.2.1. The estimated direct cost for the East Tower seismic retrofit is $20,690,965 and the estimated cost, including normal extra contractor general conditions, general requirements, insurance and fees, 10% contingency and 20% escalation is $34,008,944. All cost estimates are provided for reference in Appendix A.

4.3 North Wing (Building 4)

4.3.1 Description of Identified Deficiencies and the Proposed Retrofit

The following deficiencies were identified in the structural analysis/evaluation for SPC 4D. Following the description of each deficiency is a brief description of the proposed retrofit:

1. Metal deck diaphragm at the upper and lower roofs.

    - Deficiency: The diaphragm has insufficient strength to transfer seismic forces from the diaphragm to the vertical elements of the seismic force resisting system. Roof braces are added to increase the strength of the diaphragm.
    - Retrofit: Add steel bracing in the perimeter framing bays at the upper roof and lower roof.

2. Shear transfer mechanism to transfer forces from the lower to upper roofs.

    - Deficiency: The connection between the lower and upper roof diaphragms has insufficient strength to transfer seismic forces between levels.
    - Retrofit: Add supplemental steel connections and brace elements at the change in elevation between upper and lower roofs.

3. Chord and collector connections.

    - Deficiency: The chords and collectors at the first floor are insufficient to resist diaphragm seismic forces and transfer loads into the basement walls.
    - Retrofit: Install steel members as chords and collectors at the upper roof and Fiber Reinforced Polymer (FRP) strengthening at the first-floor level.

4. Connections between the concrete bond beams and reinforced masonry walls.

    - The existing detail between the concrete bond beams and reinforced masonry walls are not adequate to resist the seismic forces transferred between the two elements.
    - Retrofit: Add reinforced concrete element between the concrete bond beams and reinforced masonry walls.

5. Connections between the reinforced masonry walls and reinforced concrete basement walls.

    - The existing detail between the reinforced masonry walls and reinforced concrete basement walls are not adequate to resist the seismic forces transferred between the two elements.
    - Retrofit: Add reinforced concrete element between the concrete bond beams and reinforced masonry walls.

4.3.2 North Wing Conceptual Construction Cost Estimate

Swinerton developed a conceptual cost estimate for the proposed retrofit elements described in Section 4.3.1. The estimated direct cost for the North Wing seismic retrofit is $4,189,253 and

the estimated cost, including normal extra contractor general conditions, general requirements, insurance and fees, 10% contingency and 20% escalation is $6,885,714. All cost estimates are provided for reference in Appendix A.

4.4 Material Testing for SPC 4D Projects

The California Building Code (CBC) and OSHPD will require a certain level of material testing for any structural retrofit project. Our Phase 1 SPC 4D evaluations are based on rudimentary material properties anticipated for structures constructed around the dates indicated on the referenced construction drawings. The following materials are representative of the materials that will eventually need to be tested to determine appropriate design values for use when designing the final SPC 4D retrofits:

- Concrete
- Steel Reinforcing
- Structural Steel
- Metal Deck
- Masonry
- Mortar
- Grout
- Plywood
- Lumber

Without a specific material testing plan, Swinerton estimated a cost allowance for construction costs associated with anticipated material testing. The cost is based on recent experience with similar projects completed in other locations in California. The estimated direct cost for material testing required for all three buildings is $1,108,886 and the estimated cost, including normal extra contractor general conditions, general requirements, insurance and fees, 10% contingency and 20% escalation is $1,822,633. All cost estimates are provided for reference in Appendix A.

4.5 Cost Estimates for SPC 4D

SPC 4D retrofit costs are described for each of three buildings in the sections above. These costs are specific to the retrofit scope described for each building. Swinerton developed cost estimates for the retrofit scope. A summary of costs for SPC 4D retrofit is shown in Table 2.

Table 2: Cost Estimates for SPC 4D

Building	Direct Construction Cost	DCC + Costs & Fees	DCC + Cost & Fees + 10% Contingency + 20% Escalation
Main Hospital	$30,564,082	$38,058,338	$50,237,006
East Tower	$20,690,965	$25,764,351	$34,008,944
North Wing	$4,189,253	$5,216,450	$6,885,714
Subtotal	*$55,444,300*	*$69,039,139*	*$91,131,664*
Materials Testing	$1,108,886	$1,380,783	$1,822,633
Total	***$56,553,186***	***$70,419,922***	***$92,954,297***

The costs estimate presents three values for both building specific work and an allowance for material testing (assumed to be 2% of the project construction cost). The three estimates are:

1. Direct construction cost.
2. Direct construction cost plus general conditions, general requirements, insurance, fee.
3. Direct construction cost plus general conditions, general requirements, insurance, fee and 10% contingency and 20% escalation (based on starting construction after 2024).

The cost estimate excludes costs related to:

- Permit fees
- Plan check fees
- Design fees
- Builder's risk
- Utility costs
- Payment or performance bond premiums
- Costs for testing and inspection
- Hazardous material identification, testing and abatement
- Security guard services
- Owner's consultants and design fees
- Owner equipment
- Correction of existing code deficiencies beyond those associated with the AHSSA

4.6 Construction Schedule for SPC 4D Retrofit

SPC 4D retrofit costs are described for each of three buildings in the sections above. These costs consider construction occurring while the DRMC is fully operational. This assumption includes installing proper infection control measures, preparing and mobilizing contractors away from hospital entrances and construction activity is used to minimize disruption to existing operations and hospital staff. The estimated construction duration for this scenario is approximately 26 months. If the identified buildings were vacant before, during and after construction, the duration could be reduced to approximately 20 months, resulting in potential construction cost savings. Because construction schedule is highly dependent on operational parameters, further study is necessary to establish a proper link between construction cost and schedule. Construction schedule is typically refined during the development of construction documents.

5. NONSTRUCTURAL EVALUATION (NPC 4)

The AHSSA requires buildings rated NPC 2 be evaluated and modified (if required) to comply with NPC 4 before 1 January 2030. The first requirement is submission of a full nonstructural engineering evaluation for NPC 2 buildings to OSHPD for review and approval by 1 January 2024. The nonstructural evaluation must also consider elements required to achieve NPC 5. By 1 January 2026, the DRMC must submit a complete set of construction documents to bring all NPC 2 buildings into compliance with NPC 5. A building permit for all nonstructural retrofit projects must be received by 1 January 2028, with the construction work completed by 1 January 2030.

All twenty buildings will require a detailed nonstructural evaluation. The level of effort required for the evaluation report developed for each building varies as described in Section 1.4. All NPC retrofit projects will mitigate deficiencies identified in the associated nonstructural evaluation report. At this point in time, we assume that necessary infrastructure to achieve NPC 5 will be required as a separate construction project and will be assigned a placeholder cost for Phase 1.

The following sections describe an assumed scope of work and level of effort required by a licensed structural engineer to develop a full nonstructural evaluation report for each building based on its age, specific building information and regulatory requirements. Based on this assumed scope of work, SGH and Swinerton developed a cost model that describes an estimated cost for the construction associated with nonstructural compliance for NPC 4. NPC 4

is a conservative estimate of compliance and represents a realistic goal if no complete nonstructural evaluation report exists for each building. The nonstructural evaluation report may also explore the applicability of NPC 4D; a level of nonstructural seismic performance category that intends to reduce to the extent of nonstructural retrofit, effective 1 July 2019.

5.1 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Main Hospital & Additions (Building 1)

The Main Hospital & Additions building is the oldest building at DRMC. Because the building was originally constructed in the 1950s, with constant additions, modifications and remodel projects occurring throughout the building's history, this building represents the greatest challenge for attaining nonstructural seismic compliance. The building is identified as a type that is "designed before 1973" as described in Section 1.4. The building comprises approximately 96,000 sq ft of occupiable space. Much of the space has been renovated over the last 60 years.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Identify specific wall types (for those being retrofit).
- Create construction details for ceiling and wall retrofit.
- Create anchorage details for equipment and components.
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $770,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.2 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings East Tower (Building 2)

The East Tower was built around 1966. Because the building was originally constructed in the 1960s, the building is identified as a type that is "designed before 1973" as described in Section 1.4. The building comprises approximately 40,000 sq ft of occupiable space. Much of the space has been renovated over the last 50 years.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Identify specific wall types (for those being retrofit).
- Create construction details for ceiling and wall retrofit.
- Create anchorage details for equipment and components.
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.

- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $180,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.3 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Woman & Infants Hospital (Building 3)

The Woman & Infants Hospital was built around 1990. Because the building was originally constructed after 1983, the building only requires evaluation and retrofit of the fire sprinkler system. The building comprises approximately 88,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Review fire sprinkler system shop drawings if available.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying fire sprinkler systems in the building.
- Create construction details for bracing fire sprinkler systems.
- Produce calculation package for submission to OSHPD.

- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $160,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.4 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings North Wing (Building 4)

The North Wing was built around 1971. Because the building was originally constructed before 1973, the building is identified as a type that is "designed before 1973" as described in Section 1.4. The building comprises approximately 19,000 sq ft of occupiable space. Much of the space has been renovated over the last 45 years.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).

- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Identify specific wall types (for those being retrofit).
- Create construction details for ceiling and wall retrofit.
- Create anchorage details for equipment and components.
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $86,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.5 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Central Plant (Building 5)

The Central Plant was built around 1974. Because the building was originally designed after 1973, the building is identified as a type that is "designed between 1973 and 1983" as described in Section 1.4. The building comprises approximately 15,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Confirm original approved construction drawings show pertinent nonstructural details.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building (if required).
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Create construction details for ceiling and wall retrofit.
- Create anchorage details for equipment and components.
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the “Designer of Record” for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $100,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.6 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Shipping/Receiving (Building 6)

The Central Plant was built around 1977. Because the building was originally designed after 1973, the building is identified as a type that is “designed between 1973 and 1983” as described in Section 1.4. The building comprises approximately 16,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Confirm original approved construction drawings show pertinent nonstructural details.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Create construction details for ceiling and wall retrofit (if required).
- Create anchorage details for equipment and components (if required).
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $50,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.7 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Surgery Wing (Building 7)

The Surgery Wing was built around 1977. Because the building was originally designed after 1973, the building is identified as a type that is "designed between 1973 and 1983" as described in Section 1.4. The building comprises approximately 105,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Confirm original approved construction drawings show pertinent nonstructural details.

- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Create construction details for ceiling and wall retrofit (if required).
- Create anchorage details for equipment and components (if required).
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the “Designer of Record” for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our

estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $750,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.8 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings West Tower and West Tower Corridors (Building 8 and 8A through 8E)

The West Tower was built around 1977. Because the building was originally designed after 1973, the building is identified as a type that is “designed between 1973 and 1983” as described in Section 1.4. The buildings comprise approximately 110,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Confirm original approved construction drawings show pertinent nonstructural details.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Create construction details for ceiling and wall retrofit (if required).
- Create anchorage details for equipment and components (if required).
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $850,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.9 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Lobby (Building 9)

The Lobby was built around 1990. Because the building was originally constructed after 1983, the building only requires evaluation and retrofit of the fire sprinkler system. The building comprises approximately 6,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Review fire sprinkler system shop drawings if available.

- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying fire sprinkler systems in the building.
- Create construction details for bracing fire sprinkler systems.
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $20,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.10 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Admitting (Building 10)

The Admitting building was built around 1977. Because the building was originally designed after 1973, the building is identified as a type that is "designed between 1973 and 1983" as described in Section 1.4. The building comprises approximately 9,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Confirm original approved construction drawings show pertinent nonstructural details.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Create construction details for ceiling and wall retrofit (if required).
- Create anchorage details for equipment and components (if required).
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.

- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the “Designer of Record” for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $40,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.11 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Elevator Tower and Elevator Tower Corridors (Buildings 11, 11.1, 11.2)

The Elevator Tower and Tower Corridors were built around 1977. Because the building was originally designed after 1973, the building is identified as a type that is “designed between 1973 and 1983” as described in Section 1.4. The buildings comprise approximately 16,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Confirm original approved construction drawings show pertinent nonstructural details.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).

- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Create construction details for ceiling and wall retrofit (if required).
- Create anchorage details for equipment and components (if required).
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $90,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.12 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Dinah Shore Waiting Area (Building 12)

There are no available construction drawings for the Dinah Shore Waiting Area. We understand that the building was built around 1977. Because the building was likely designed after 1973, the building is identified as a type that is "designed between 1973 and 1983" as described in Section 1.4. The building comprises approximately 2,000 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Confirm original approved construction drawings show pertinent nonstructural details.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).
- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Create construction details for ceiling and wall retrofit (if required).
- Create anchorage details for equipment and components (if required).
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.

- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $35,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.13 Scope of Work and Fee for Nonstructural Report and NPC 4 Retrofit Drawings Medical Records Building (Building 13)

The Medical Records Building was built around 1977. Because the building was originally designed after 1973, the building is identified as a type that is "designed between 1973 and 1983" as described in Section 1.4. The building comprises approximately 500 sq ft of occupiable space.

This building will require the following scope of work to complete a nonstructural evaluation report:

- Review all original architectural drawings associated with this building.
- Confirm original approved construction drawings show pertinent nonstructural details.
- Review all remodel project drawings associated with this building.
- Develop and manage site investigations with hospital management and staff.
- Access areas to observe existing conditions above the ceiling.
- Access areas to observe wall construction.
- Walk through the existing building to confirm all equipment and components are identified.
- Perform calculations to confirm adequacy of existing equipment anchorage (optional).
- Perform calculations to confirm adequacy of existing component construction (optional).
- Develop test protocols to confirm existing element anchorage (optional).

- Compile observation data into drawing form for use in report.
- Produce nonstructural evaluation report for submission to OSHPD.
- Iterate with OSHPD during the review phase.

The following scope of work is required to complete nonstructural retrofit construction documents:

- Create plans identifying equipment, components and architectural elements in the building.
- Create plans identifying distributed systems in the building.
- Identify specific ceiling types on reflected ceiling plans (for those being retrofit).
- Create construction details for ceiling and wall retrofit (if required).
- Create anchorage details for equipment and components (if required).
- Develop test plan and test protocols for testing existing construction (optional).
- Produce calculation package for submission to OSHPD.
- Produce construction drawings for submission to OSHPD.
- Produce construction specifications for submission to OSHPD.

A structural engineer can act as the "Designer of Record" for any OSHPD project. Traditionally, structural engineers developed nonstructural evaluation reports and construction documents for nonstructural retrofit projects. Our estimate of scope and fee assumes that SGH will perform the work described above or contract with consultants to provide services as necessary. Our estimate of fee for this work is based on previous experience and estimated construction cost associated with the anticipated nonstructural retrofit for this building.

We estimate a fee of approximately $10,000 is required to complete a nonstructural evaluation report and set of NPC 4 retrofit construction documents for this building.

5.14 NPC 4 Retrofit Construction Cost Model

The existing buildings comprise approximately 550,000 sq ft. of occupiable space. Using an estimate of space for each building and department, we apply an estimate of cost for construction associated with typical retrofit work needed to bring the building into compliance with NPC 4. Because the DRMC does not have any recent nonstructural evaluation reports that include evaluation of required infrastructure to attain NPC 5 considering operational

characteristics, we estimate a placeholder range of $1M to $2M for constructing NPC 5 infrastructure, which typically comprises valving, and tanks for wastewater, water and fuel.

Sections 5.1 through 5.13 describe the scope of work necessary to complete a nonstructural evaluation report that will define the actual scope of work necessary to bring each building at the DRMC into compliance with NPC 4. In consideration of the many areas that have been remodeled, the unit costs are individually developed considering potential savings associated with compliant work in remodeled areas. In addition to recognizing savings associated with previously completed work, costs are developed considering efficiencies related to simultaneous construction, primarily for Building 1, Building 2 and Building 4; each of these buildings require both nonstructural and structural retrofit.

Without a detailed nonstructural evaluation report, our cost model presents uncertainty. To account for this uncertainty, Swinerton developed a cost model that considers a 10% contingency. The cost model also presents costs associated with the contractor's mark-up and escalation (calculated at 20%, assuming construction starts after 2024). Direct costs are identified as "Low" and costs including mark-up, contingency and escalation are identified as "High" in Table 3 below.

Table 3: NPC 4 Retrofit Construction Cost Model

Building Name	Estimate of Affected Area	Consulting Fee Estimate	NPC 4 Cost Estimate (Low)	NPC 4 $/SF Estimate (Low)	NPC 4 Cost Estimate (High)	NPC 4 $/SF Estimate (High)
Main Hospital & Additions	95,913	$770,000	$7,013,131	$74	$9,257,332	$98
East Tower	40,418	$180,000	$1,599,608	$40	$2,111,483	$52
Woman & Infants Hospital	88,486	$160,000	$2,284,060	$26	$3,014,959	$34
North Wing	18,790	$86,000	$777,342	$41	$1,026,092	$55
Central Plant	15,159	$100,000	$1,102,969	$73	$1,455,919	$96
Shipping/Receiving	15,742	$50,000	$642,274	$41	$847,801	$54
Surgery Wing	105,266	$750,000	$6,657,195	$63	$8,787,497	$83
West Tower (Sinatra Tower)	110,614	$850,000	$11,480,166	$104	$15,153,819	$137
Lobby	6,214	$20,000	$154,020	$25	$203,307	$33
Admitting	9,141	$40,000	$360,952	$39	$476,457	$52
Elevator Tower	16,254	$90,000	$805,270	$50	$1,062,956	$65
Dinah Shore Waiting Area	2,006	$35,000	$202,770	$101	$267,657	$133
Medical Records Building	507	$10,000	$24,961	$49	$32,948	$65
Public Spaces	22,881	$15,000	$1,518,001	$66	$2,003,761	$88
Total Medical Center	***547,391***	***$3,156,000***	***$34,622,719***	***$63***	***$45,701,988***	***$84***

At this stage of our evaluation, we recommend considering costs in the range of $38 to $49 million for bringing all buildings at the DRMC into compliance with NPC 4, including professional fees and construction of NPC 5 infrastructure.

5.15 Schedule for NPC 4 Evaluation Reports and Retrofit Construction

Nonstructural Evaluation Reports are based on actual existing conditions that must be collected by the consultant team. Once collected, the data must be synthesized and documented in a format easily accepted and reviewed by OSHPD. Data collection can take many months to complete and may depend on access and operational constraints (e.g. operating suites are available only on weekends). Report generation requires extensive documentation of both existing conditions and existing drawings that may show compliant conditions. Based on similar projects, nonstructural evaluation reports can likely be completed in 20 to 24 months.

NPC 4 retrofit costs are identified in the cost model identified as Table 3 above. The cost model uses a base assumption that construction work is performed on “straight time” in the fully operational medical center. This assumes that proper infection control measures are in place and that remote construction preparation and mobilization is required to minimize disruption to existing operations and hospital staff. The estimated construction duration for this scenario is approximately 16 months. Variations related to working hours (off-hours or weekends) can drastically affect the construction duration and construction cost. Because schedule is highly dependent on operational parameters, further study, including meetings with operational staff, is necessary to establish a proper link between cost and schedule. Construction schedule is typically refined during the construction document development phases of a project.

6. CONCLUSIONS

The DRMC requires seismic retrofit of three buildings and nonstructural retrofit for twenty buildings. Table 4 shows an approximate range of costs for structural retrofit, nonstructural retrofit and total medical center retrofit project costs. These costs represent a reasonable estimate of construction and consulting fees as estimated by Swinerton and SGH, given experience with similar projects of scope and size, completed in the last several years. We recommend that DHD consider the high end of the range, when estimating necessary budgets for completing construction work associated with the AHSSA. Currently, we estimate an appropriate budget range to bring the DRMC into compliance with the AHSSA is between $119 and $180M, which includes estimates of soft costs associated with professional fees, inspection, etc.

Table 4: Structural Retrofit, Nonstructural Retrofit and Total Medical Center Costs

Building Name	Estimate of Affected Area	SPC4D + NPC 4 Cost Estimate (Low)	SPC4D + NPC 4 $/SF (Low)	SPC4D + NPC 4 + 10% Contingency + 20 % Escalation Cost Estimate (High)	SPC4D + NPC 4 + 10% Contingency + 20 % Escalation $/SF (High)
Main Hospital & Additions	95,913	$38,345,273	$400	$60,261,778	$628
East Tower	40,418	$22,470,573	$556	$36,300,427	$898
Woman & Infants Hospital	88,486	$2,444,060	$26	$3,174,959	$34
North Wing	18,790	$5,052,595	$269	$7,997,806	$426
Central Plant	15,159	$1,202,969	$73	$1,555,919	$96
Shipping/Receiving	15,742	$692,274	$41	$897,801	$54
Surgery Wing	105,266	$7,407,195	$63	$9,537,497	$83
West Tower (Sinatra Tower)	110,614	$12,330,166	$104	$16,003,819	$137
Lobby	6,214	$174,020	$25	$223,307	$33
Admitting	9,141	$400,952	$39	$516,457	$52
Elevator Tower	16,254	$895,270	$50	$1,152,956	$65
Dinah Shore Waiting Area	2,006	$237,770	$101	$302,657	$133
Medical Records Building	507	$35,000	$50	$43,000	$66
Public Spaces	22881	$1,533,001	$66	$2,018,761	$88
Material Testing		$1,108,886		$1,822,633	
NPC 5		$1,000,000		$2,000,000	
Subtotal		***$95,330,004***		***$143,809,777***	
Soft Costs[1] (25% Subtotal)		*$23,832,501*		*$35,952,444*	
Total Including Soft Costs	***547,391***	***$119,162,505***	***$217.69***	***$179,762,221***	***$328.40***

Footnote 1: Soft costs include those costs excluded by Swinerton and other project costs typical for this type of work:
The cost estimate excludes costs related to:

- *permit fees*
- *plan check fees*
- *design fees*
- *builder's risk*
- *utility costs*
- *payment or performance bond premiums*
- *costs for testing and inspection*
- *hazardous material identification, testing and abatement*
- *security guard services*
- *owner's consultants and design fees*
- *owner equipment*
- *correction of existing code deficiencies beyond those associated with the AHSSA*

APPENDIX A

Desert Regional Medical Center

Palm Springs California

Conceptual SPC 4 ROM Estimate

December 21, 2018

SUMMARY			
SPC 4D Areas of Work	Direct Cost	Cost w/ Contractor GCs, GRs, Insurance & Fee	Cost w/ 10% Contingency & 20% Escalation
Main Hospital Retrofit Scheme	$ 30,564,082	$ 38,058,338	$ 50,237,006
Building 2 - East Tower Retrofit Scheme	$ 20,690,965	$ 25,764,351	$ 34,008,944
Building 4 - North Wing Retrofit Scheme	$ 4,189,253	$ 5,216,450	$ 6,885,714
SPC Totals	$ 55,444,300	$ 69,039,140	$ 91,131,664
Comprehensive Data Collection MTCAP: OSHPD Materials Testing and Conditions Assessment for Projects			
MTCAP Allowance	$ 1,108,886	$ 1,380,783	$ 1,822,633
Project Totals	**$ 56,553,186**	**$ 70,419,922**	**$ 92,954,297**

Qualifications

Exclusions

1. Permit fees, plan check fees, design fees, Builders Risk.
2. All utility costs.
3. Payment or performance bond premiums.
4. Testing and Inspection costs.
5. Hazardous material identification, abatement or testing.
6. Security guard service.
7. Owner's consultants.
8. Utility costs.
9. Soil, structural, mechanical, engineering.
10. Owner equipment.
11. Correction of existing code deficiencies.

Desert Regional Medical Center
Palm Springs California
Conceptual SPC 4 ROM Estimate - Detailed By Level Summary
December 21, 2018

DETAIL BY LEVEL SUMMARY

SPC 4D Areas of Work	Direct Cost	Cost w/ Contractor GCs, GRs, Insurance & Fee	Cost w/ 10% Contingency & 20% Escalation
Main Hospital Retrofit Scheme	$ 30,564,082	$ 38,058,338	$ 50,237,006
Wing A Strengthening Plan	$ 2,687,830	$ 3,346,881	$ 4,417,883
Wing B Strengthening Plan	$ 615,566	$ 766,502	$ 1,011,782
Wing C Strengthening Plan	$ 4,189,534	$ 5,216,800	$ 6,886,176
Wing D & E Strengthening Plan	$ 6,030,562	$ 7,509,244	$ 9,912,203
Wing F Strengthening Plan	$ 2,039,062	$ 2,539,037	$ 3,351,528
Wing G Strengthening Plan	$ 692,512	$ 862,314	$ 1,138,255
Wing H Strengthening Plan	$ 14,309,016	$ 17,817,560	$ 23,519,179
	Direct Cost	Cost w/ Contractor Costs	Cost w/ Escalation & Contin.
Building 2 - East Tower Retrofit Scheme	$ 20,690,965	$ 25,764,351	$ 34,008,944
Basement	$ 3,767,181	$ 4,690,887	$ 6,191,970
1st Floor	$ 6,079,013	$ 7,569,576	$ 9,991,841
2nd Floor	$ 6,711,761	$ 8,357,472	$ 11,031,863
3rd Floor	$ 1,257,740	$ 1,566,135	$ 2,067,299
4th Floor	$ 1,326,704	$ 1,652,009	$ 2,180,652
Roof	$ 1,548,567	$ 1,928,272	$ 2,545,319
	Direct Cost	Cost w/ Contractor Costs	Cost w/ Escalation & Contin.
Building 4 - North Wing Retrofit Scheme	$ 4,189,253	$ 5,216,450	$ 6,885,714
Exterior Wall	$ 2,449,050	$ 3,049,553	$ 4,025,409
Main Level	$ 63,165	$ 78,653	$ 103,821
Roof	$ 1,677,038	$ 2,088,245	$ 2,756,484
Project SPC 4D Totals	$ 55,444,300	$ 69,039,140	$ 91,131,664
MTCAP - Assume 2% of Overall Cost	$ 1,108,886	$ 1,380,783	$ 1,822,633

Exclusions
1. Permit fees, plan check fees, design fees, Builders Risk.
2. All utility costs.
3. Payment or performance bond premiums.
4. Testing and Inspection costs.
5. Hazardous material identification, abatement or testing.
6. Security guard service.
7. Owner's consultants.
8. Utility costs.
9. Soil, structural, mechanical, engineering.
10. Owner equipment.
11. Correction of existing code deficiencies.

SWINERTON

Desert Regional Medical Center
Palm Springs California
Conceptual NPC 4 ROM Estimate
January 11, 2019

CONFIDENTIAL SWINERTON DOCUMENT

DEPT	AREA (SQ. FT.)	Unit	Unit Cost w/ Contractor Costs: Equipment Bracing	Utility Bracing	Fire Sprinkler Bracing	Ceiling Bracing	Wall Bracing	$/w/ Contractor Mark-up	$/SF	$/w/Contingency	$/SF	$/w/Escalation	$/SF
Building 1 - Main Hospital & Additions	**95,913 SF**	**74 $/SF**						**$ 7,013,131**	**74 $/SF**	**$ 7,714,444**	**82 $/SF**	**$ 9,257,332**	**98 $/SF**
OUTPATIENT MATERNAL FETAL	5,173	$ 43.18	$ 5.78	$ 6.80	$ 27.20	$ 3.40	$ -	$ 223,370	$ 43	$ 245,707	$ 47	$ 294,849	$ 57
CARDIO PULMO	3,772	$ 105.01	$ 13.14	$ 36.18	$ 28.56	$ 27.13	$ -	$ 396,081	$ 105	$ 435,689	$ 116	$ 522,827	$ 139
DR. LOUNGE	1,133	$ 42.16	$ 5.44	$ 10.88	$ 18.36	$ 7.48	$ -	$ 47,767	$ 42	$ 52,544	$ 46	$ 63,053	$ 56
ACUTE REHAB	7,038	$ 53.24	$ 5.64	$ 12.92	$ 27.20	$ 7.48	$ -	$ 374,731	$ 53	$ 412,204	$ 59	$ 494,645	$ 70
BUSINESS SERVICES	4,380	$ 77.68	$ 7.62	$ 23.80	$ 25.70	$ 20.56	$ -	$ 340,252	$ 78	$ 374,278	$ 85	$ 449,133	$ 103
PHY THERAPY	4,936	$ 105.96	$ 7.90	$ 34.27	$ 38.08	$ 25.70	$ -	$ 523,007	$ 106	$ 575,307	$ 117	$ 690,369	$ 140
THERAPY	4,631	$ 105.96	$ 7.90	$ 34.27	$ 38.08	$ 25.70	$ -	$ 490,690	$ 106	$ 539,759	$ 117	$ 647,710	$ 140
POST PARTUM - BLDG 1	8,673	$ 86.69	$ 7.81	$ 33.32	$ 38.08	$ 7.48	$ -	$ 751,831	$ 87	$ 827,014	$ 95	$ 992,417	$ 114
MED SURGE - BLDG 1	4,705	$ 105.96	$ 7.90	$ 34.27	$ 38.08	$ 25.70	$ -	$ 498,531	$ 106	$ 548,384	$ 117	$ 658,060	$ 140
PEDIATRICS	4,180	$ 105.96	$ 7.90	$ 34.27	$ 38.08	$ 25.70	$ -	$ 442,903	$ 106	$ 487,193	$ 117	$ 584,632	$ 140
GI - ENDO	1,669	$ 76.16	$ 6.12	$ 24.48	$ 27.20	$ 18.36	$ -	$ 127,111	$ 76	$ 139,822	$ 84	$ 167,787	$ 101
BUSINESS SERVICES - MED RECORDS	7,430	$ 65.96	$ 6.53	$ 20.40	$ 22.03	$ 17.00	$ -	$ 490,083	$ 66	$ 539,091	$ 73	$ 646,909	$ 87
FACILITIES - ENG	3,565	$ 61.58	$ 6.53	$ 18.70	$ 20.20	$ 16.16	$ -	$ 219,536	$ 62	$ 241,489	$ 68	$ 289,787	$ 81
ADMINISTRATION	11,665	$ 53.04	$ 2.99	$ 17.00	$ 18.36	$ 14.69	$ -	$ 618,712	$ 53	$ 680,583	$ 58	$ 816,699	$ 70
NON-PATIENT CARE	9,400	$ 54.81	$ 4.76	$ 17.00	$ 18.36	$ 14.69	$ -	$ 515,195	$ 55	$ 566,715	$ 60	$ 680,058	$ 72
MECH/ELEC	3,422	$ 40.80	$ 24.48	$ 16.32	$ -	$ -	$ -	$ 139,618	$ 41	$ 153,579	$ 45	$ 184,295	$ 54
PUBLIC CORRIDOR	10,141	$ 80.24	$ -	$ 25.16	$ 27.20	$ 7.48	$ 20.40	$ 813,714	$ 80	$ 895,085	$ 88	$ 1,074,102	$ 106
Building 2 - East Tower	**40,418 SF**	**40 $/SF**						**$ 1,599,608**	**40 $/SF**	**$ 1,759,569**	**44 $/SF**	**$ 2,111,483**	**52 $/SF**
LAB	5,975	$ 50.02	$ 13.30	$ 29.92	$ -	$ 6.80	$ -	$ 298,871	$ 50	$ 328,758	$ 55	$ 394,509	$ 66
ORTHO	9,733	$ 33.32	$ 5.44	$ 17.00	$ -	$ 3.40	$ 7.48	$ 324,304	$ 33	$ 356,734	$ 37	$ 428,081	$ 44
MED SURGE - BLDG 2 - FLR 3	10,170	$ 33.52	$ 5.64	$ 24.48	$ -	$ 3.40	$ -	$ 340,939	$ 34	$ 375,033	$ 37	$ 450,040	$ 44
SNF - BLDG 2	10,170	$ 55.96	$ 5.64	$ 24.48	$ -	$ 18.36	$ 7.48	$ 569,154	$ 56	$ 626,069	$ 62	$ 751,283	$ 74
STAIRCASES	3,360	$ 7.48	$ -	$ 7.48	$ -	$ -	$ -	$ 25,133	$ 7	$ 27,646	$ 8	$ 33,175	$ 10
MECH PENTHOUSE	1,010	$ 40.80	$ 20.40	$ 20.40	$ -	$ -	$ -	$ 41,208	$ 41	$ 45,329	$ 45	$ 54,395	$ 54
Building 3 - Woman & Infants Hospital	**88,486 SF**	**26 $/SF**						**$ 2,284,060**	**26 $/SF**	**$ 2,512,466**	**28 $/SF**	**$ 3,014,959**	**34 $/SF**
LDRP	18,051	$ 32.64	$ -	$ -	$ 32.64	$ -	$ -	$ 589,185	$ 33	$ 648,103	$ 36	$ 777,724	$ 43
NICU	8,148	$ 32.64	$ -	$ -	$ 32.64	$ -	$ -	$ 265,951	$ 33	$ 292,546	$ 36	$ 351,055	$ 43
POST PARTUM - BLDG 3	3,421	$ 32.64	$ -	$ -	$ 32.64	$ -	$ -	$ 111,661	$ 33	$ 122,828	$ 36	$ 147,393	$ 43
EMERGENCY DEPT.	12,801	$ 29.79	$ -	$ -	$ 29.79	$ -	$ -	$ 381,352	$ 30	$ 419,487	$ 33	$ 503,385	$ 39
RADIOLOGY	25,328	$ 20.40	$ -	$ -	$ 20.40	$ -	$ -	$ 516,691	$ 20	$ 568,360	$ 22	$ 682,032	$ 27
PUBLIC SPACE	1,120	$ 28.56	$ -	$ -	$ 28.56	$ -	$ -	$ 31,987	$ 29	$ 35,186	$ 31	$ 42,223	$ 38
HELIPAD	10,126	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
MECH PENTHOUSE - BLDG 3	9,491	$ 40.80	$ 20.40	$ 20.40	$ -	$ -	$ -	$ 387,233	$ 41	$ 425,956	$ 45	$ 511,147	$ 54
Building 4 - North Wing	**18,790 SF**	**41 $/SF**						**$ 777,342**	**41 $/SF**	**$ 855,077**	**46 $/SF**	**$ 1,026,092**	**55 $/SF**
ADMINISTRATION OFFICES (Basement)	9,395	$ 40.80	$ 5.44	$ 12.92	$ 20.40	$ 2.04	$ -	$ 383,316	$ 41	$ 421,648	$ 45	$ 505,977	$ 54
NON-PATIENT CARE (First Floor)	9,395	$ 41.94	$ 5.44	$ 12.92	$ 19.04	$ 2.04	$ 2.50	$ 394,026	$ 42	$ 433,429	$ 46	$ 520,115	$ 55
Building 5 - Central Plant	**15,159 SF**	**73 $/SF**						**$ 1,102,969**	**73 $/SF**	**$ 1,213,266**	**80 $/SF**	**$ 1,455,919**	**96 $/SF**
CENTRAL PLANT	15,159	$ 72.76	$ 20.40	$ 27.20	$ 24.48	$ 0.68	$ -	$ 1,102,969	$ 73	$ 1,213,266	$ 80	$ 1,455,919	$ 96
Building 6 - Shipping/Receiving	**15,742 SF**	**41 $/SF**						**$ 642,274**	**41 $/SF**	**$ 706,501**	**45 $/SF**	**$ 847,801**	**54 $/SF**
EXTERIOR LOADING DOCK	15,742	$ 40.80	$ 5.44	$ 17.00	$ 18.36	$ -	$ -	$ 642,274		$ 706,501		$ 847,801	

SWINERTON

Desert Regional Medical Center
Palm Springs California
Conceptual NPC 4 ROM Estimate
January 11, 2019

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			Unit Cost w/ Contractor Costs										
DEPT	AREA (SQ. FT.)	Unit	Equipment Bracing	Utility Bracing	Fire Sprinkler Bracing	Ceiling Bracing	Wall Bracing	$/w/ Contractor Mark-up	$/SF	$/w/Contingency	$/SF	$/w/Escalation	$/SF
Building 7 - Surgery Wing	**105,266 SF**	**63 $/SF**						**$ 6,657,195**	**63 $/SF**	**$ 7,322,914**	**70 $/SF**	**$ 8,787,497**	**83 $/SF**
KITCHEN	9,606	$ 55.49	$ 5.44	$ 17.00	$ 18.36	$ 14.69	$ -	$ 533,018	$ 55	$ 586,320	$ 61	$ 703,583	$ 73
SPD	4,569	$ 62.97	$ 8.84	$ 20.40	$ 19.04	$ 14.69	$ -	$ 287,701	$ 63	$ 316,471	$ 69	$ 379,765	$ 83
CENTRAL SUPPLY	3,044	$ 55.49	$ 5.44	$ 17.00	$ 18.36	$ 14.69	$ -	$ 168,905	$ 55	$ 185,796	$ 61	$ 222,955	$ 73
SHIPPING/REC	2,314	$ 55.49	$ 5.44	$ 17.00	$ 18.36	$ 14.69	$ -	$ 128,399	$ 55	$ 141,239	$ 61	$ 169,487	$ 73
PHARMACY	4,331	$ 80.44	$ 24.34	$ 20.40	$ 20.40	$ 15.30	$ -	$ 348,387	$ 80	$ 383,225	$ 88	$ 459,870	$ 106
I/T	2,994	$ 55.49	$ 5.44	$ 17.00	$ 18.36	$ 14.69	$ -	$ 166,131	$ 55	$ 182,744	$ 61	$ 219,293	$ 73
ADMIN SERVICES	2,971	$ 55.49	$ 5.44	$ 17.00	$ 18.36	$ 14.69	$ -	$ 164,855	$ 55	$ 181,340	$ 61	$ 217,608	$ 73
ADMINISTRATIVE OFFICES	9,331	$ 55.49	$ 5.44	$ 17.00	$ 18.36	$ 14.69	$ -	$ 517,759	$ 55	$ 569,534	$ 61	$ 683,441	$ 73
CAFETERIA	6,810	$ 55.49	$ 5.44	$ 17.00	$ 18.36	$ 14.69	$ -	$ 377,873	$ 55	$ 415,661	$ 61	$ 498,793	$ 73
OUTPATIENT SERVICES	1,067	$ 80.44	$ 24.34	$ 20.40	$ 20.40	$ 15.30	$ -	$ 85,830	$ 80	$ 94,413	$ 88	$ 113,295	$ 106
SURGICAL/OR	23,624	$ 101.59	$ 11.56	$ 35.90	$ 27.20	$ 26.93	$ -	$ 2,399,920	$ 102	$ 2,639,912	$ 112	$ 3,167,894	$ 134
CATH LAB	6,344	$ 75.00	$ 9.38	$ 25.84	$ 20.40	$ 19.38	$ -	$ 475,825	$ 75	$ 523,408	$ 83	$ 628,089	$ 99
MECH PENTHOUSE	13,061	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
PUBLIC CORRIDOR	15,200	$ 65.96	$ -	$ 25.16	$ 27.20	$ 6.12	$ 7.48	$ 1,002,592	$ 66	$ 1,102,851	$ 73	$ 1,323,421	$ 87
Building 8 - West Tower (Sinatra Tower)	**110,614 SF**	**104 $/SF**						**$ 11,480,166**	**104 $/SF**	**$ 12,628,182**	**114 $/SF**	**$ 15,153,819**	**137 $/SF**
MECH/ELEC	7,780	$ 79.95	$ 22.72	$ 24.48	$ 16.32	$ 2.72	$ 13.71	$ 621,983	$ 80	$ 684,181	$ 88	$ 821,017	$ 106
ICU	18,934	$ 129.71	$ 16.63	$ 37.40	$ 32.30	$ 22.44	$ 20.94	$ 2,455,915	$ 130	$ 2,701,506	$ 143	$ 3,241,808	$ 171
MED SURGE - BLDG 8 - FLR 2	18,934	$ 107.15	$ 7.06	$ 30.60	$ 34.00	$ 18.36	$ 17.14	$ 2,028,797	$ 107	$ 2,231,677	$ 118	$ 2,678,012	$ 141
MED SURGE - BLDG 8 - FLR 3	18,934	$ 107.15	$ 7.06	$ 30.60	$ 34.00	$ 18.36	$ 17.14	$ 2,028,797	$ 107	$ 2,231,677	$ 118	$ 2,678,012	$ 141
MED SURGE - BLDG 8 - FLR 4	18,934	$ 107.15	$ 7.06	$ 30.60	$ 34.00	$ 18.36	$ 17.14	$ 2,028,797	$ 107	$ 2,231,677	$ 118	$ 2,678,012	$ 141
MED SURGE - BLDG 8 - FLR 5	18,934	$ 105.74	$ 5.64	$ 30.60	$ 34.00	$ 18.36	$ 17.14	$ 2,002,081	$ 106	$ 2,202,289	$ 116	$ 2,642,747	$ 140
PENTHOUSE	1,135	$ 23.80	$ 3.40	$ 20.40	$ -	$ -	$ -	$ 27,013	$ 24	$ 29,714	$ 26	$ 35,657	$ 31
MECH PENTHOUSE - BLDG 8	7,029	$ 40.80	$ 20.40	$ 20.40	$ -	$ -	$ -	$ 286,783	$ 41	$ 315,462	$ 45	$ 378,554	$ 54
Building 9 - Lobby	**6,214 SF**	**25 $/SF**						**$ 154,020**	**25 $/SF**	**$ 169,422**	**27 $/SF**	**$ 203,307**	**33 $/SF**
MAIN ENTRANCE/LOBBY	6,214	$ 24.79	$ -	$ -	$ 24.79	$ -	$ -	$ 154,020	$ 25	$ 169,422	$ 27	$ 203,307	$ 33
Building 10 - Admitting	**9,141 SF**	**39 $/SF**						**$ 360,952**	**39 $/SF**	**$ 397,047**	**43 $/SF**	**$ 476,457**	**52 $/SF**
LOBBY/REGISTRATION	6,306	$ 22.95	$ -	$ -	$ 22.95	$ -	$ -	$ 144,723	$ 23	$ 159,195	$ 25	$ 191,034	$ 30
MORGUE	965	$ 80.44	$ 24.34	$ 20.40	$ 20.40	$ 15.30	$ -	$ 77,625	$ 80	$ 85,387	$ 88	$ 102,465	$ 106
MORGUE - OFFICE SPACE	1,870	$ 74.12	$ 16.32	$ 20.40	$ 20.40	$ 17.00	$ -	$ 138,604	$ 74	$ 152,465	$ 82	$ 182,958	$ 98
Building 11 - Elevator Tower	**16,254 SF**	**50 $/SF**						**$ 805,270**	**50 $/SF**	**$ 885,797**	**54 $/SF**	**$ 1,062,956**	**65 $/SF**
ELEVATOR CORRIDOR SPACE	13,932	$ 51.00	$ -	$ 20.40	$ 28.56	$ 2.04	$ -	$ 710,532	$ 51	$ 781,585	$ 56	$ 937,902	$ 67
MECH PENTHOUSE	2,322	$ 40.80	$ 20.40	$ 20.40	$ -	$ -	$ -	$ 94,738	$ 41	$ 104,211	$ 45	$ 125,054	$ 54
Building 12 - Dinah Shore Waiting Area	**2,006 SF**	**101 $/SF**						**$ 202,770**	**101 $/SF**	**$ 223,048**	**111 $/SF**	**$ 267,657**	**133 $/SF**
WAITING ROOM	2,006	$ 101.08	$ 8.16	$ 25.50	$ 27.54	$ 22.03	$ 17.85	$ 202,770	$ 101	$ 223,048	$ 111	$ 267,657	$ 133
Building 13 - Medical Records	**507 SF**	**49 $/SF**						**$ 24,961**	**49 $/SF**	**$ 27,457**	**54 $/SF**	**$ 32,948**	**65 $/SF**
MEDICAL RECORDS ROOM	507	$ 49.23	$ 5.44	$ 5.44	$ 16.32	$ 22.03	$ -	$ 24,961	$ 49	$ 27,457	$ 54	$ 32,948	$ 65
Public Spaces	**22,881 SF**	**66 $/SF**						**$ 1,518,001**	**66 $/SF**	**$ 1,669,801**	**73 $/SF**	**$ 2,003,761**	**88 $/SF**
PUBLIC SPACE	3,863	$ 61.20	$ -	$ 25.16	$ 27.20	$ 8.84	$ -	$ 236,416	$ 61	$ 260,057	$ 67	$ 312,069	$ 81
FACILITIES - ENG	19,018	$ 67.39	$ 5.44	$ 17.00	$ 18.36	$ 14.69	$ 11.90	$ 1,281,585	$ 67	$ 1,409,743	$ 74	$ 1,691,692	$ 89
Total	**547,391**	**SF**						**34,622,717**	**$ 63**	**38,084,989**	**$ 70**	**45,701,987**	**$ 84**

KaufmanHall

New Providers, Facilities, Programs, and Services Board Study Session

DESERT HEALTHCARE DISTRICT

Palm Springs, California | November 16, 2017

Agenda

- Kaufman Hall Engagement Objective
- Study Session Objective
- Market Environment
  - Geography and Healthcare Access Points
  - Gaps, Initiatives & Considerations
  - Key Implications
- Potential Scenarios

Kaufman Hall Engagement Objective

Deliver to the District Board a document that describes a process and framework for development of the healthcare facilities to serve the Coachella Valley communities over the next 20 plus years. The framework will:

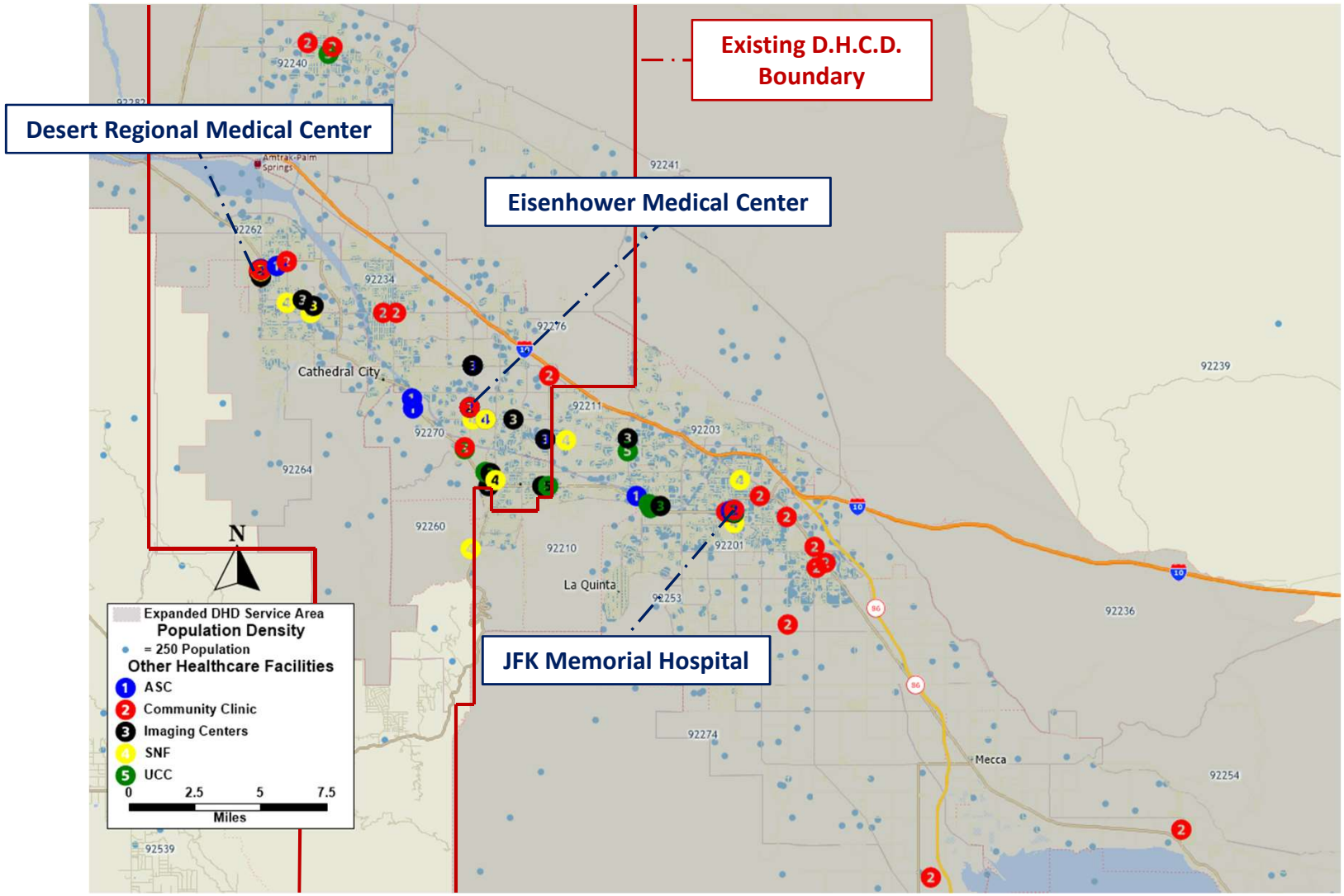
- Describe the anticipated acute care facilities, including hospitals, outpatient facilities (including ambulatory surgery and urgent care sites), as well as physician clinic needs.
- Describe scenarios under which Desert Regional Medical Center ("DRMC") could comply with current seismic requirements.
- Review preliminary estimates of the cost of construction of any seismic retrofit and facilities construction scenario
- Propose a potential relationship between Tenet Healthcare and the District.
- Propose who will own which facilities.
- Propose a funding source for the construction needs, which may include a combination of public and private funding sources.

Study Session Objectives

- ***Confirm a common understanding of the service area fact base*** that will inform the District's preferred approach for addressing elements of Desert Healthcare District's Strategic Priority 1.

- ***Review and discuss some potential scenarios*** for addressing New Providers, Facilities, Programs, and Services within the context of Priority 2 and Priority 3

Geography and Healthcare Access Points



Market Environment | Providers, Facilities, Programs, and Services: Gaps, Initiatives & Considerations

Care Type	Needs	Current/Recent Initiatives & Considerations
General Acute Care	• Current overall surplus of beds in the market; shortage of ED stations • Emerging capacity constraints in obstetrics and critical care • Any delay or failure to address SB1953 seismic issues will reduce DRMC beds from 330 to 217 resulting in a shortfall of 88 beds against a future need of 305	• Utilization trends may soften or reduce inpatient hospital demand growth • Eisenhower Medical Center has voluntary seismic improvements underway which will extend life of some bed units • Small scale inpatient facilities (~10 beds) called micro-hospitals are seen as a way to efficiently provide access to acute care
Behavioral Health	• Current need for local provision of care is not met ✓Market is underserved with respect to behavioral health resources ✓Outpatient psychiatric services are fragmented ✓Travel is a barrier to behavioral health access • Projected market need for 84 beds as well as step down, crisis, and outpatient care capacity	• Significant initiatives from RUHS to address gaps ✓ Recently developed or planned development of crisis stabilization units ✓ CREST and REACH ✓ Board and care services ✓ 200 inpatient beds proposed for western Riverside County
Subacute/ Post Acute Care	• Current overall surplus of rehabilitation and SNF beds at DRMC • Any delay or failure to address SB1953 seismic issues will reduce DRMC beds from 12 to 0 resulting in a shortfall of 12 beds against a future need of 12	• Post-acute care resource availability is an important part of efficient and effective delivery of care across the continuum.

Market Environment | Providers, Facilities, Programs, and Services: Gaps, Initiatives & Considerations

Care Type	Needs	Current/Recent Initiatives & Considerations
Ambulatory Care	• Ancillary ambulatory care for imaging and surgery is adequate in the market	• 12 ASCs with a total of 31 operating rooms as of CY15 • 20 imaging centers • Access issues may relate more to insurance coverage status
Primary Care	• Coachella Valley has large areas classified as Medically Underserved or Health Professional Shortage area • Travel can be barrier to primary care access	• 24 Community Clinics/FQHCs in the service area as of CY2015 • 10 urgent care centers • Access issue is multi-faceted: includes cost/insurance and willingness of providers to accept Medi-Cal
Specialty care	• Travel can be barrier to access of care – particularly cancer and pediatric subspecialties	• Some movement towards deployment of specialists to the Coachella Valley – i.e. Loma Linda's Indio Children's Hospital Outpatient Pavilion • UCSD is collaborating with Eisenhower around areas such as cancer, HIV/AIDS and medical education

Market Environment | New Providers, Facilities, Programs, and Services: Key Implications

- General Acute Hospital Care
  - Seismic SB1953 issues present significant capital investment requirements in the Coachella Valley to ensure that adequate inpatient hospital services are available
  - Although the current bed capacity in the Coachella Valley exceeds requirements, the scale of the seismic issue and future population growth will require retrofit, renovation and/or new construction
  - Potential to rationalize services across hospitals for efficient development of capacity
- Increasing access to primary care, specialty care and behavioral health must recognize that access is a function of several factors including provider supply, travel distance, knowledge of care sources, provider willingness to accept Medi-Cal and the patient's insurance status
- Access to specialty care may be most efficiently developed through partnerships with academic and other tertiary/quaternary centers.
- Behavioral Health has significant pent up demand given limited resources and suboptimal configuration of care delivery system
- Post-acute/skilled nursing/rehabilitation care may be most appropriately provided through partnerships.
- Ambulatory care such as imaging and ambulatory surgery centers are sufficient for the market; development should be aligned with other strategic needs such as physician alignment

Potential Scenarios | New Providers, Facilities, Programs, and Services

	Current	Post Seismic	Scenario W	Scenario X	Scenario Y	Scenario Z
Description	Current Capacity	Capacity After Removing Beds From Service	DRMC Partial Upgrade	DRMC Partial Upgrade Plus New Small Hospital (Micro)	DRMC Reconfigured Plus New Hospital (De Novo)	DRMC Full Seismic Retrofit
Scale	330 Acute 12 Rehab 30 SNF	217 Acute 12 Rehab 32 SNF	+70 Acute +6 ED Bays	+96 Acute +35 Micro Hospital Beds +14 Micro Hospital ED Bays	+163 Acute (De Novo) +14 ED Bays (De Novo)	+92 Acute +6 ED Bays
Geographic Expansion			Ambulatory Geographic Expansion	Inpatient and Ambulatory Geographic Expansion	Inpatient and Ambulatory Geographic Expansion	Ambulatory Geographic Expansion
Capital Required		$	$$	$$$	$$$$$	$$$

Note: Micro-hospitals are small-scale inpatient facilities that offer a wide range of medical services in a small, neighborhood setting. They run 24/7, all year long. They commonly have between eight and 20 beds where patients can be observed or admitted for a short stay.

Potential Scenarios | New Providers, Facilities, Programs, and Services

Care Component	Scenario W	Scenario X	Scenario Y	Scenario Z
Inpatient Acute Care/ED/OB	✓	✓/N	✓/N	✓
Behavioral Health	✓	P	P	P
Rehab/SNF	P	P	P	P
Pediatric Care	P	N	N	P
Ambulatory Services	P	P	P	P
Primary Care	P	P	P	P
Specialty Care	P	P	P	P

✓ = Provided at DRMC
P = Provided at a partner facility
N = Provided at newly constructed facility

Qualifications, Assumptions and Limiting Conditions (v.12.08.06):

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