PUBLIC HOSPITAL DISTRICT NO. 4,
KING COUNTY, WASHINGTON
D/B/A SNOQUALMIE VALLEY HOSPITAL

HOSPITAL CONSULTANT REPORT REGARDING
THE SERIES 2015A AND SERIES 2015B
HOSPITAL REVENUE BONDS

Management Consultant Review dated February 22, 2107

As set forth in the Trust Indenture, based on the audited financial results, Public Hospital District No. 4 (the "District") has two Covenant Requirements to maintain. The first covenant is a Debt Service Coverage Requirement of 1.20, and the second covenant is a Days Cash on Hand requirement of 50. For Fiscal Year 2015, the District did not meet the Coverage Requirement of 1.20. The main cause for not meeting the Coverage Requirement for Fiscal Year 2015 was due to language in the Trust Indenture that did not allow for an exclusion in the calculation for capitalized interest. Although the District does not yet have its final audited financial statements for 2016, the District does not expect to meet the Coverage Requirement for fiscal year 2016. When this became evident toward the end of 2016, the District took the opportunity to review its operations to improve its Debt Service Coverage with a view to restoring compliance with the Coverage Requirement in 2017 and beyond.

Pursuant to Section 6.3(2) of the Indenture, the District is required to retain a management consultant to look at the rates, fees and operations of the District. In addition, the consultant is also required to provide a recommendation regarding the "District Surplus Property" and its impact on restoring compliance with the Coverage Requirement.

2015 Background

The District moved into its new Hospital campus in May of 2015. The move presented a number of issues in regards to handling current patient services, balancing staff and volume changes, and marketing the new location.

Consulting Review

To complete the Trust Indenture requirement related to the failure to meet the 2015 Coverage Requirement and a review of preliminary 2016 results, our review focused on the following four areas of opportunity:

- Inpatient admission process;
- Operational department productivity;
- Rate and fee structure opportunities;
- Revenue growth through volume growth

Of the four areas of opportunity, there are two areas the District has the ability to control with greater influence. These two areas are the inpatient admission process which can affect the type of patient the District admits, and the ability to control costs through operational department productivity.

Admission Process Changes

The payer mix for Swing Bed patients in quarters two and three of 2016 was unfavorable compared to budget. Specifically, there was an excess of Medicaid days in those periods. Management began working with the Swing Bed Intake Team and the Social Work department to address the need to improve payer mix through interventions on both the patient intake and discharge processes. The changes in process took effect at the end of the third quarter of 2016.

The Swing Bed Intake process allows the hospital to set and adjust the criteria for acceptance of patients transferring from an acute setting at another hospital to a swing bed at SVH for skilled nursing and rehabilitation. Working with the nurses of the Swing Bed Intake Team, management changed the intake criteria such that only patients with Medicare and Commercial insurance confirmed as primary payers are now accepted into the Swing Bed Program. Additionally, patients are screened for medical acuity and potential long length of stay. Patients with a projected long length of stay are only accepted into the Swing Bed Program if they have commercial insurance as a secondary to their Medicare benefit. Patients with no secondary coverage or Medicaid as secondary coverage who are projected to have a length of stay that will exceed the number of days of coverage provided by their primary insurer are not accepted into the Swing Bed Program.

There are some patients who, despite improved intake processes, experience very long lengths of stay and convert their coverage from Medicare or commercial to Medicaid. The Social Work department has made a focused effort to improve the discharge process for the patients, allocating more department time and resources to their successful discharge. In 2016, the number of inpatients with Medicaid coverage dropped from a high point of six during the second quarter to two in the 4th quarter; this was the result of the process changes referenced above. The Social Work department has also begun the discharge planning process upon admission working directly with patients on their discharge plan from the start of their stay in the Swing Bed program.

These changes have greatly helped the hospital to increase the number of Medicare and commercial payer days by minimizing the number of beds occupied by patients whose length of stay has exceeded their Medicare or commercial payer benefit. This increase in Medicare and commercial days has had a positive financial effect for the District.

To quantify these changes in admission processes, we took the fiscal year 2015 Medicare cost report and modeled the impact of changes in swing bed days by payer. For the analysis, a total of 750 days was moved out of the Medicaid payer mix and 600 days were moved into Medicare and 150 days were moved into Commercial payers.

The following table shows the change in days by payer group:

	Original	Updated	Change
Medicare/Medicare Advantage Days	4,731	5,331	600
Medicaid Days	2,629	1,879	(750)
Commercial Days	-	150	150

The impact of the payer mix changes in days has a number of impacts to the organization. By adjusting the admission process and looking to accept more Medicare patients the District will pick up additional cost based reimbursement on the cost report by pulling more days into the Medicare category and allowing for more overhead costs to be reimbursed at a higher rate than the Medicaid days. Additionally, by shifting the days to a commercial payer again the District picks up more revenue than a Medicaid patient day. The final impact is a small offset of Medicaid revenue.

The net impact of all these changes is positive, with the overall increase in revenue to the District being approximately $425,000.

Operational Analysis

The District has conducted two separate productivity assessments in Fiscal Year 2016. The first assessment was conducted by Eide Bailly on the three departments of Nursing, Emergency Room, and Rehabilitation Therapies, this assessment began in the second quarter of 2016. The District then expanded this effort with the implementation of a benchmarking program purchased from Truven AOI, a subsidiary of IBM and a leader in providing hospital benchmarking solutions. The productivity assessment conducted by Truven looked at all remaining departments within the District. The Truven benchmarking analysis was conducted in the second half of 2016.

In assessing the two reports the District has opportunity to improve its department level productivity to the 50th percentile in a number of departments, some departments are already achieving this threshold. Management has already charged the operations managers with meeting the 50th percentile benchmark within the first quarter of 2017. In addition, as departments achieve the 50th percentile goal management is continuing to push departments to find additional efficiencies and move past the 50th percentile.

Departmental level productivity is a component of two items, the first being the hours worked in the department, and the second being the department statistical volume. As has been mentioned, there is volume opportunity for some of the ancillary departments.

In addition to the productivity opportunities, the District has identified some non-salary related expense reductions in conjunction with the operational analysis.

The following table shows the operational impact of the estimated savings if the District where to achieve the 50th percentile productivity benchmark in the identified units and implement the non-salary related expense reductions:

	Savings Potential
Departmental labor savings - at 50th percentile	$ 2,323,000
Non - labor savings	180,000
Total savings opportunity	$ 2,503,000
Cost Report Impact (estimated)	45%
Estimated savings after Cost Report Impact	**$ 1,126,350**

The departmental labor savings of $2.3 million is made up of different components and not all the savings impact clinical areas. The changes are in staff scheduling in both the acute and swingbed nursing unit and emergency department. In addition, the District has made changes in many administrative areas, including human resource department restructuring, marketing department restructuring, administrative positions restructuring of general counsel duties and not filling the COO position. As of the date of this report, management has indicated that approximately 85% of the proposed $2.3 million of savings has been implemented and has realized an amount sufficient in the current fiscal year to believe they are on track to accomplish the annual saving goal.

We recommend the District make this a top priority for Fiscal Year 2017. Management has already been in discussions with department directors and have established a goal of achieving the 50th percentile and other expense reductions within the first quarter of 2017. Once the 50th percentile is achieved we recommend the District continue to enhance operations and try to move all departments to an even higher level of efficiency.

Benchmark or comparative reference data help to place a facility's data into context and should be used as "guidelines" to a measured performance target and there are a number of factors that need to be considered. Such things like patient mix, technology, staff training, staff mix, facility layout, physician practice patterns as well as volumes all have impacts.

Setting productivity benchmarks and standards is one piece in a facility's plan to improve efficiency, service/quality, clinical outcomes, and financial performance. The benchmark standards and other operational changes must be combined with process standardization and improvement for any program to be effective. Emphasis must be placed on consistent process improvement through process mapping, gathering data, identifying and initiating improvements.

Rate and Fee Structure

We looked at the rates and fees structure of the District. We reviewed the market charge data, which was obtained from a database by Optum, Inc., and is compiled by them based on Medicare Provider Analysis and Review (MedPAR) data of claims filed to Medicare for the year ending December 31, 2015, as this is the most complete and latest data available. Information is only available for services with adequate volumes of service reported and, accordingly, our analysis only includes the peer group's market charges for which data was available since the market information is based on information from 2015 for the peer group of hospitals and the District. We chose the peer group of hospitals based upon a sampling of hospitals within a 35 mile radius of the District.

The hospitals chosen in the peer group were:

- Swedish Issaquah
- Overlake Hospital Medical Center
- Evergreen Health Monroe
- St. Elizabeth Hospital

In the analysis of the market charge data of the 110 CPT codes that were reviewed; 44 showed the District was higher than the market average and 66 showed the District was lower than the market average.

The following breaks down some of the outpatient department charge comparisons:

- Radiology charges on average were higher than the peer group;
- Lab charges on average were lower than the peer group;
- Injection charges on average were lower than the peer group;
- Therapy charges on average were higher than the peer group;
- Emergency room charges on average were lower than the peer group.

The review completed was not a full pricing and market structure analysis but it provides some guidance as to the current pricing structure of the District. Because of the consumerism push in health care and the fee structure of charges is continually changing, we recommend, in Fiscal Year 2017, the District look further at its charge structure and its strategy around pricing to determine its optimal market position. The District conducts a Chargemaster review every two years, with the next review to be scheduled in Fiscal Year 2017. We recommend the District move forward with the Chargemaster review and consider a detailed market pricing study.

Revenue Growth through Volume Growth

Part of the strategy of building a new Hospital was to relocate from the old location to a new location which was much more accessible to the people of the Snoqualmie market service area. While the District has seen an increase in volumes in both inpatient and outpatient volumes, there is still opportunity for the District to improve on further volume growth, mainly in outpatient volumes.

The District has the opportunity and capacity to expand volume growth in outpatient service areas, especially in the Emergency Room department and Imaging Services department. To accomplish this the District's strategies are:

- Move to a Level 5 designation Emergency Room Trauma facility, which the District is currently pursuing.
- A marketing campaign to highlight the new Trauma designation and the new Emergency Room department.
- Recruit providers to fill open positions and enhance the clinic outpatient revenue streams.
- Explore rebranding through an affiliation strategy.

We agree with the District's strategy to grow and enhance its market position related to outpatient ancillary services, and recommend the ancillary service volume growth be focused strategies for Fiscal Year 2017.

Debt Service Coverage Ratio Calculation

As mentioned earlier the District has greater control over two of the opportunities and if those two opportunities are achieved it has a significant impact on the District's debt service coverage.

The District started to work on these initiatives in the fourth quarter of 2016. After adjusting for the Medicare cost report estimate adjustment for fiscal year 2016, the following shows the District's unaudited debt service coverage by quarter for 2016:

	1st Qtr 2016	2nd Qtr 2016	3rd Qtr 2016	4th Qtr 2016
Change in Net Position [a]	(262,000)	(756,000)	(1,442,000)	(144,000)
Add:				
Interest expense [b]	1,472,470	1,472,470	1,472,470	1,472,470
Depreciation and Amortization Expense [b]	816,103	816,103	816,103	816,103
Less:				
Taxation for bond principal and interest [c]	(909,594)	(909,594)	(909,594)	(909,594)
Income available for debt service	1,116,980	622,980	(63,020)	1,234,980
Maximum Annual Debt Service [d]	918,797	918,797	918,797	918,797
Debt Service Coverage Ratio calculation	1.22	0.68	(0.07)	1.34

Footnotes to table:

(a) Change in Net Position was calculated by taking the unaudited monthly financial statements and allocating the final the estimated third party settlement adjustment through each of the twelve months. The estimated third party settlement adjustment for each month was based on Medicare days by month.

(b) Interest expense and depreciation/amortization was calculated by taking the year end expense amount and dividing by four.

(c) Taxation for bond principal and interest revenue was calculated by taking the year end revenue amount and dividing by four.

(d) Annual debt service was calculated by taking the maximum annual debt service and dividing by four.

If the District achieves both the admission process changes and the productivity benchmarks described above, and the estimated impact/savings is added to the District's financial performance as of December 31, 2016, the District's debt service Coverage Requirement would be:

	12/31/15	Unaudited 12/31/16	With Process Improvements 12/31/16
Change in Net Position	(5,888,631)	(2,604,993)	(2,604,993)
Add:			
Operational savings	-	-	1,126,350
Admission process improvement	-	-	425,000
Interest expense	4,338,096	5,889,881	5,889,881
Depreciation and Amortization Expense	2,038,791	3,264,412	3,264,412
Bond Closing Costs Expense	2,427,491	-	-
Less:		-	
Taxation for bond principal and interest	(2,769,884)	(3,638,374)	(3,638,374)
Income available for debt service	145,863	2,910,926	4,462,276
Maximum Annual Debt Service	3,675,188	3,675,188	3,675,188
Debt Service Coverage Ratio calculation	0.04	0.79	1.21

District Surplus Property

We also assessed the "District Surplus Property" and the ability to sell this property for a cash infusion to the District. If the "Surplus Property" were to be sold, it would certainly have a positive impact on the cash position of the District. This would enhance its performance in meeting the Days Cash on Hand covenant requirement. However, this covenant was met for Fiscal Year 2015 and the unaudited December 2016 financials the Days Cash on Hand is again exceeding the covenant requirement.

	12/31/15	12/31/16
Minimum Days Cash on Hand requirement	50	55
Operating Expenses	31,003,259	32,279,804
Less: Depreciation and Amortization Expense	(2,038,791)	(3,264,412)
Operating Expense per Covenant	28,964,468	29,015,392
Expense per day	79,355	79,494
Cash on Hand	7,347,118	6,158,090
Days Cash on Hand	92.59	77.47
Is Days Cash on Hand Adequate?	YES	YES

The potential sale of the "District Surplus Property" would only help satisfy the debt service coverage covenant if the "Surplus Property" is sold at a gain. The purchase price of the land was $7,050,000 and if the land was sold at a gain, then the gain on sale would run through non-operating income in the year in which the sale occurred and it would have a positive impact on the Change in Net Position. If a loss on the sale were to occur then it would have a negative impact on the Change in Net Position.

We do not know the probability of whether or not the "Surplus Property" can be sold at a gain or if it would be sold at a loss. In talking with management, it appears the property site has some issues around zoning which may or may not hurt the sales price.

Our recommendation for the Surplus Property would be to hold on selling the property and the District to focus on the other revenue and operational changes for Fiscal Year 2017.

Please let us know if there are any questions related to the information and recommendations in this report.

Sincerely,

Eide Bailly LLP

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