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COVID-19's Impact on Hospitals' Ability to Comply with the Seismic Mandates of SB 1953

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Introduction

Among COVID-19's many impacts on California hospitals, the pandemic's interference with hospitals' ability to comply with the seismic retrofitting or rebuilding mandates of Senate Bill (SB) 1953 might be easy to overlook, with the deadline for compliance ten years away. But to comply with the 2030 mandates, hospitals face significant new obstacles that may take years to overcome.

Hospitals have worked hard and spent billions to meet the first seismic requirement (the "2020 requirement") to prevent building collapse after a major earthquake, ensuring that patients and workers are safe. The next requirement (the "2030 requirement") goes further and requires that hospitals are operational after a seismic event.

Hospital construction projects require approximately 10 years from initial planning to project completion. In other words, to achieve compliance in 2030, hospitals must start work today. But with a total cost of compliance reaching as high as \$143 billion¹ according to a recent RAND Corporation study—not including the costs of financing—hospitals will be unable to move forward without confidence in their future operating performance and their ability to secure financing on reasonable terms. Both prerequisites to compliance are now under threat as a result of COVID-19.

The financial damage hospitals have experienced may well be permanent. In many cases, funds obtained to shore up hospitals' liquidity—including Medicare's Accelerated and Advance Payments relief—must be repaid. In the words of one industry leader, the monies received have amounted to just "somewhat of a Band-Aid on liquidity."² And no one knows what the "new normal" for healthcare will be, as emergency room utilization and inpatient and outpatient volumes remain depressed, payer mix deteriorates as high unemployment pushes individuals onto Medi-Cal or into uninsured status, and expenses rise in the face of nursing shortages, reconfiguration of facilities to isolate and treat COVID-19 patients, and significantly higher utilization of personal protective equipment.

These disruptions threaten hospitals' ability to comply with SB 1953's mandate by 2030 in several ways, including the following:

- With large deficits in operating income for the current year, increased expenses, and extreme uncertainty about future performance, hospitals are unable to determine how much operating income they will have available to invest in replacement or retrofitted facilities or to service the additional debt that most hospitals will need to take on to make facilities compliant.

¹ Preston, B., et al.: *Updating the Costs of Compliance for California's Hospital Seismic Safety Standards*. RAND Corporation, 2019. https://www.rand.org/pubs/research_reports/RR3059.html

² Barrow, T.: "Pandemic Could Lead More Hospitals to Breach Debt Covenants." *Modern Healthcare*, May 29, 2020. <https://www.modernhealthcare.com/finance/pandemic-could-lead-more-hospitals-breach-debt-covenants>

- Long-term declines in operating income could also limit the amount of additional indebtedness hospitals could assume under the terms of their existing debt instruments.
- Potential downgrades in credit ratings if operating performance declines continue could make debt both harder to acquire and more expensive, threatening the timing and affordability of financing.
- Until the economic climate improves substantially, voters are unlikely to approve tax levies that would support financing of compliance costs for hospital districts and county hospital authorities.
- The need to respond to increasing COVID-19 spread and commensurate rising COVID-19 hospitalizations is consuming virtually all of hospital leaders' resources, making seismic compliance efforts essentially impossible at this time.

COVID-19 has brought seismic compliance efforts to a standstill and for as long as the virus continues its insidious spread, it will be difficult to restart those efforts. Additionally, hospitals will then need time to recover, stabilize their operations, gain a clearer understanding of what they can expect from future operations, resume planning, and convince voters, lenders, and investors to help them assume the substantial costs of compliance with SB 1953. It is difficult to predict how long this will take.

This report first looks at the financial and operational impacts that California hospitals have sustained thus far and the outlook for ongoing financial losses amid broader economic concerns. It then discusses how these impacts are jeopardizing hospital's compliance with SB 1953's 2030 mandate, with a particular focus on obstacles hospitals may face in taking on debt to fund compliance efforts. The report concludes with case studies from five California hospitals describing how COVID-19 is impeding their efforts to comply with SB 1953.

The Financial and Operational Impacts of COVID-19 on California Hospitals

COVID-19's financial and operational impacts on hospitals are illustrated in Figure 1, which shows year-over-year declines in key indicators of revenue, margin, and volume at the national level.

- Operating margin declined 282% year-over-year in April, as stay-at-home orders and the shutdown of scheduled procedures at hospitals preparing for a potential surge of COVID-19 patients took hold. In May, operating margins remained depressed by 13% year-over-year, notwithstanding some slight improvements in volume and an infusion of federal relief funding.
- Key indicators of volume—including adjusted discharges and emergency department visits—again showed deep declines in April with slight improvements in May. Hospitals remain concerned about the pace at which—or if—volumes will return to pre-pandemic levels.
- While inpatient beds were in some cases occupied by COVID-19 patients, inpatient revenue was still down 25% in April and 12% in May. Even more devastating was the impact on outpatient revenues, which have grown to represent approximately half of hospital and health system revenues as more procedures can now be performed on an outpatient basis. Outpatient revenues were down almost 50% year-over-year in April and were still down 27% in May.

Figure 1: Impact of COVID-19 on Key Indicators of Margin, Volume, and Revenue

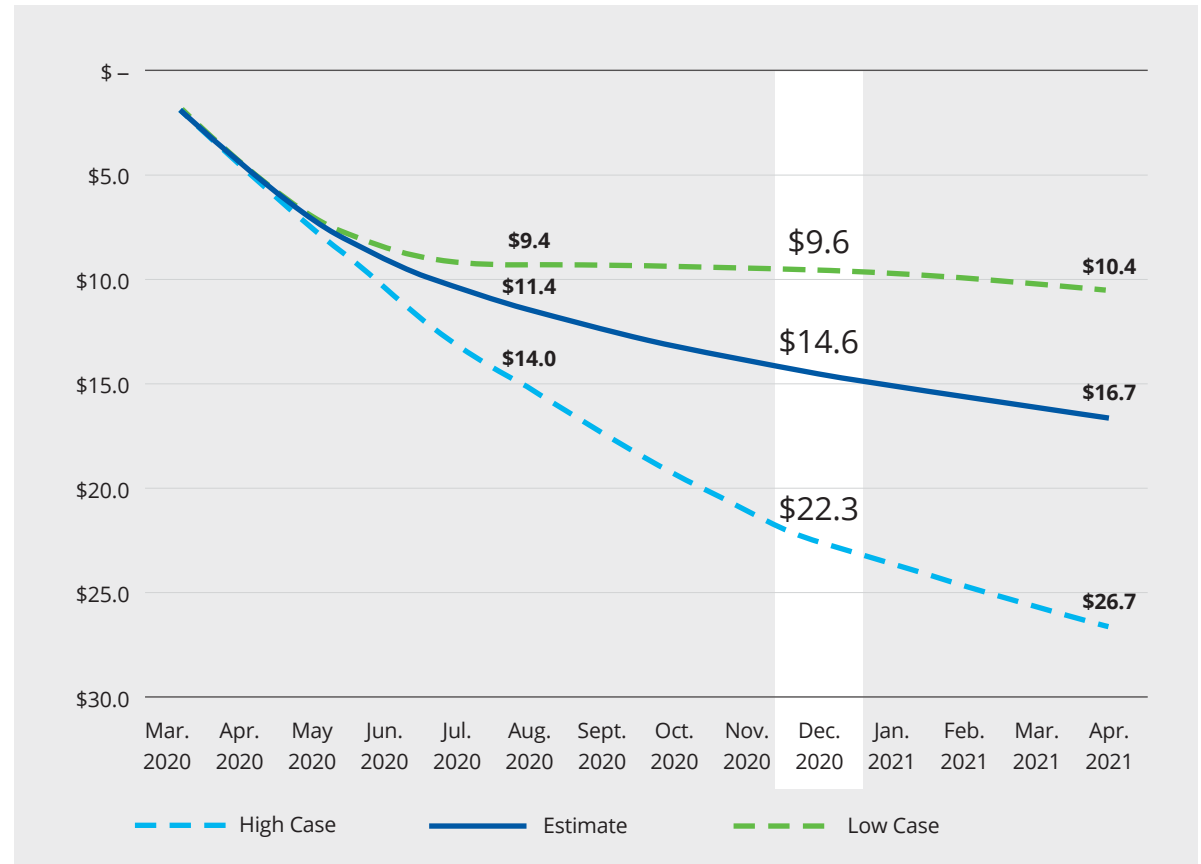
Indicator	Month	Year-Over-Year Decline
Operating Margin	April 2020	-282%
	May 2020	-13%
Adjusted Discharges	April 2020	-41%
	May 2020	-27%
Emergency Department Visits	April 2020	-43%
	May 2020	-33%
Inpatient Revenue	April 2020	-25%
	May 2020	-12%
Outpatient Revenue	April 2020	-49%
	May 2020	-27%

Source: Kaufman, Hall & Associates, LLC. *National Hospital Flash Report* (May 2020, reporting April data, and June 2020, reporting May data). <https://www.kaufmanhall.com/products-services/national-hospital-flash-report>

Within California alone, a report prepared by Kaufman Hall for the California Hospital Association in June estimates that California hospitals are likely to experience cumulative net losses of \$14.6 billion by the end of 2020 (Figure 2). That estimate was made before the resurgence of the virus in late June and early July. If California experiences a long slog and high case loads with COVID-19 rise to forecasted levels, cumulative net losses could exceed \$22 billion by year end. This is a gap that will be difficult or impossible to fill.

COVID-19's broader economic impacts will inevitably affect the ability of hospitals to recover. In April, California's unemployment rate shot to 16.4% and declined only minimally to 16.3% in May (compared to a 4.1% rate in May 2019).³ Any improvements in June will be offset by Governor Newsom's July 1 order to

Figure 2: Estimated net losses for California hospitals due to COVID-19
\$ in Billions (Cumulative)



Source: Kaufman, Hall & Associates, LLC. *The Financial Impact of COVID-19 on California Hospitals* (June 2020).

³ State of California, Employment Development Department. "Employers Added 141,600 Nonfarm Jobs After April's Historic Job Losses," June 19, 2020. <https://www.edd.ca.gov/newsroom/unemployment-june-2020.htm>

reclose certain businesses in 19 California counties, which represent approximately 72% of the state's population, as well as subsequent anticipated closures by counties, and potentially the Governor, as cases rise. For hospitals, the impacts of high unemployment include a decline in patients with employer-sponsored coverage, higher numbers of Medi-Cal patients, increases in uncompensated care, and decisions by patients to defer non-emergency procedures.

Combined, the financial and economic impacts already experienced during the pandemic and the uncertainty of the pace of recovery going forward threaten the ability of hospitals to comply with SB 1953's seismic mandates by 2030, and the Office of Statewide Health Planning and Development's (OSHPD's) deadlines over the next several years that hospitals are required to meet in order to meet that final deadline.

How COVID-19's Impacts Jeopardize the Ability to Comply with SB 1953

Hospitals of all types—not-for-profit, investor-owner, and district or county owned—will need some combination of funding from operations and borrowing to cover the estimated \$143 billion of costs for SB 1953 compliance. COVID-19's disruptions to operations and the economy threaten both these funding sources, although the risks can vary by hospital type.

All hospitals have suffered the financial impacts of sharply reduced volumes and revenues, with a negative impact on operating margins and cash flow; all also face the uncertainty of whether volumes and revenues will return to a pre-pandemic normal. Certain funds that were made available to help mitigate COVID-19's impact on liquidity—particularly Medicare's Accelerated and Advance Payments—will have to be repaid later in the year. Reduced cash flow, required repayment of relief funds, sustained losses, and uncertainty with respect to future operations will limit the resources available from operations to fund seismic compliance for an undeterminable amount of time. Almost all hospitals will need to borrow money to meet seismic compliance requirements but may well encounter new difficulties in doing so. Specific challenges for different hospital types are described below and in the case studies.

Not-for-profit hospitals

Most not-for-profit hospitals already carry some debt; reduced operating income resulting from COVID-19 have exposed hospitals to lower debt service coverage than they had in previous years and puts them at risk of breaching ongoing financial covenants in their debt documents.⁴ Failure to meet debt service coverage requirements and other financially based incurrence tests in debt documents can also restrict hospitals' ability to take on additional indebtedness that could finance seismic compliance work.⁵

For hospitals rated by one of the three major credit-rating agencies (Fitch Ratings, Moody's Investors Service, and S&P Global Ratings), a possible credit-rating downgrade in an environment where all three agencies have given the not-for-profit healthcare sector a negative outlook will raise the costs of accessing capital. Fitch has [already placed 15 hospitals nationwide](#) on a "ratings watch negative" due to coronavirus. Figure 3 illustrates how a rating downgrade from mid-A to mid-BBB (considered a rating category downgrade; i.e., from "good" to "adequate") could affect borrowing costs for a hypothetical hospital seeking to finance \$400 million of a \$600 million replacement facility with a 30-year tax-exempt bond.

⁴ Turner, R., McDermott, G., and Robbins, M.: "In Focus: Potential Debt Covenant Challenges as COVID-19 Reduces Cash Flow and Liquidity." Kaufman, Hall & Associates, LLC, May 2020. <https://www.kaufmanhall.com/ideas-resources/article/focus-potential-debt-covenant-challenges-covid-19-reduces-cash-flow>

⁵ Turner, R.: "In Focus: COVID-19 Adds Master Trust Indenture Risk to Future Borrowing Potential and Other Types of Transactions." Kaufman, Hall & Associates, LLC, June 2020. <https://www.kaufmanhall.com/ideas-resources/article/focus-covid-19-adds-master-trust-indenture-risk-future-borrowing-potential>

Figure 3: Estimated Impact of Credit Rating Downgrade on Financing Costs

Estimated Interest Rate on Bond	Present Value of Interest Paid Over 30-year Term	Incremental Cost (Present Value) of Increased Interest Rate
4.00%	\$194,268,097	–
4.75%	\$235,650,622	\$41,382,536
5.00%	\$249,743,163	\$55,475,076

Assumptions:

- Total construction cost of \$600 million for 300-bed replacement facility (i.e., replacement cost of \$2 million per bed)
- Hospital finances two-thirds of the cost (\$400 million) and funds remainder with cash
- A rating downgrade from mid-A to mid-BBB results in a 75 basis point (0.75%) to 100 basis point (1.00%) increase in borrowing costs
- Estimated interest rates based on market rates as of July 9, 2020

Investor-owned hospitals

Before the pandemic, investor-owned hospitals typically carried significantly lower cash reserves and higher debt leverage than their not-for-profit counterparts. If they are rated, they typically have a lower credit rating than not-for-profit peers, with negative impacts on the cost of accessing capital. They face the possibility of significant cash-flow deficits, near-term refinancing risks, and debt covenant compliance issues as discussed above.⁶

⁶ Peknay, D., and Desai, S.: "A Bumpy Recovery Is Ahead for Hospitals and Other Health Providers as Non-Emergent Procedures Restart." S&P Global Ratings, May 26, 2020. <https://www.spglobal.com/ratings/en/research/articles/200526-a-bumpy-recovery-is-ahead-for-hospitals-and-other-health-providers-as-non-emergent-procedures-restart-11498942>

⁷ Public Policy Institute of California: "Many in State Say the Worst of COVID-19 Is Ahead for U.S., Most Prefer Caution in Easing Restrictions in Their Area." Press Release, June 3, 2020. <https://www.ppic.org/press-release/many-in-state-say-the-worst-of-covid-19-is-ahead-for-u-s-most-prefer-caution-in-easing-restrictions-in-their-area/>

District and county hospitals

In addition to the challenges described for not-for-profit and investor-owned hospitals, district and county hospitals face the unique political risk of passing a referendum with two-thirds voter approval before they can issue general obligation bonds backed by tax levies to fund seismic compliance work. With the state of California (and the nation overall) now in a recession with an uncertain path to recovery, the already difficult effort of passing a referendum that will increase voter taxes has become even harder. Survey results from the Public Policy Institute of California released in June indicate that 60% of California voters are opposed to tax increases.⁷ If district and county hospitals are unable to pass a referendum, they can try to issue revenue-backed bonds, but the funds needed to service this debt will place an additional burden on operating income.

In short, hospitals are facing a common challenge in ongoing disruptions to operations and cash flow and specific challenges with respect to their ability to borrow the funds necessary to achieve compliance with SB 1953's mandates on a timely and affordable basis. Until these challenges have been resolved, hospitals will be unable to move forward with their seismic compliance efforts.

Basic Elements of Hospital Debt Financing

Just as homeowners typically borrow funds in the form of a mortgage when they purchase a home, hospitals rely on debt financing for large capital projects such as construction of a new facility. Basic elements of hospital debt financing include the following:

- **Debt instruments.** Debt instruments can take many forms, including tax-exempt fixed-rate bonds, variable-rate bonds, taxable bonds, and other debt instruments such as a line of credit from a bank. The choice of debt instrument will depend on a variety of factors, including the organization's status (i.e., not-for-profit, government-owned, or investor-owned), credit rating, and the size of the debt to be financed. Hospital districts or county hospital authorities can issue tax-based general obligation bonds if enough voters (e.g., two-thirds) approve a tax levy to support payment of the bonds in a referendum. Interest and principal on revenue-based bonds are paid out of a hospital's operating income.
- **Debt covenants.** Covenants are the terms the bond issuer (i.e., the borrower) agrees to follow. Common financial covenants establish thresholds for debt service coverage and days cash on hand. Debt service coverage covenants establish a ratio of income available for debt service coverage relative to debt service requirements. Days cash on hand are the unrestricted cash reserves hospitals must maintain to ensure that they could fund daily operation and maintenance costs for a defined time period without running out of cash. Given the disruptions to operations caused by COVID-19, debt service coverage is of particular concern as it relies on operating income. Failure to meet debt service coverage can result in a technical violation even if the borrower is still able to make payments, with a worst-case scenario of accelerated payments of the debt. The ability to service debt is also an important component in "incurrence tests" that covenants require if a borrower wants to assume additional indebtedness.
- **Credit ratings.** There are three rating agencies (Fitch Ratings, Moody's Investors Service, and S&P Global Ratings) that measure the creditworthiness of hospitals and health systems based on such factors as their financial strength, ability to repay their debt obligations, market position, and governance and leadership. An organization with a higher rating (e.g., AA, or excellent) can generally issue debt with a lower interest-rate payment than an organization with a lower rating (e.g., BBB, or adequate) because investors who buy the higher-rated organization's bonds have a lower risk that the organization will default on its payments. In addition to ratings, the agencies issue positive, stable, or negative outlooks. A positive outlook means the organization's credit rating may be upgraded, while a negative outlook means the organization may be at risk of a rating downgrade. Ratings and outlooks affect investors' decision to buy a hospital's debt and the interest rate the hospital must pay to issue debt successfully. Credit rating analysts typically will try to separate a disruption such as COVID-19 shutdowns from the organization's long-term credit story, although organizations that were struggling pre-COVID may be more at risk of a rating or outlook downgrade. Not all organizations have the financial resources to be rated by an agency; their choices of debt financing will be more limited and often at a higher cost.

Case Studies

The concerns of California hospital leaders in meeting the 2030 deadline for compliance are described in the short case studies that follow. Common themes in the case studies include the following:

- All hospitals were engaged in consideration of or planning for compliance with SB 1953 by 2030, and some had already begun lining up financing. COVID-19 has brought planning to a standstill. Too many uncertainties over future operations—including potential changes in volume or payer mix—make it impossible to determine how much debt an organization could service or secure.
- Hospital leaders have had to devote almost all their time to responding to the COVID-19 crisis and continue to do so as case numbers continue to climb across much of California. This is resulting in time lost on the necessary planning for work on seismic compliance.
- Although hospitals might not be able to meet the operational standard of SB 1953 by 2030, many could provide emergency and essential services to their communities with existing, seismically compliant facilities.
- For district and county hospitals reliant on voter approval of tax-based bonds to secure affordable financing, post-pandemic economic realities—including a recession, high unemployment, and business closures—make a difficult task almost impossible until the economy recovers.
- The costs of compliance with SB 1953 are creating high opportunity costs, impeding hospitals' ability to provide other benefits to the community. Moreover, the costs of seismic compliance do not add economic benefit; they simply pay for replacement of facilities the hospital already has.

Adventist Health

California Locations: Clearlake, Roseville, Paradise, Willits, St. Helena, Ukiah, Yuba City/Marysville, Bakersfield, Hanford, Lodi, Reedley, Selma, Sonora, Tehachapi, Glendale, Simi Valley, and Los Angeles.

David Larsen, Senior Finance Officer

Adventist Health has 11 facilities affected by SB 1953's seismic compliance mandates. The cost of retrofitting these facilities will range from \$10 million to \$100 million, with a total estimated cost of approximated \$450 million. We will be paying for these costs out of a combination of cash flow from our operations and borrowing; thus far, we have borrowed about one-third to one-half of the funds that will be needed. The disruption and uncertainty around ongoing operating results is not going to make it any easier to secure the additional financings required.

Our biggest concern right now is whether volumes will return to anything near what we were seeing pre-pandemic. There clearly have been fundamental changes in the way people access healthcare as a result of COVID-19. If emergency visits stay down, if we see fewer elective procedures, or if we see a permanent shift in clinical visits toward telehealth, the financial impacts will make it more difficult for us to borrow in the future.

One of our facilities with some of the highest compliance costs has been highly reliant on elective procedures and destination programs that have been decimated by COVID-19. It serves a smaller community and there are real questions about its ability to continue operations, which already faced some challenges before the pandemic, especially when the costs of compliance are added in.

More broadly, the costs of compliance can make it very difficult for us to do some basic capital replacement projects. If we must spend \$450 million on compliance, it is more difficult to invest in clinics and communities that may not have access, or to upgrade technology that may have become outdated but is not yet completely unusable. It diverts funds from other benefits our communities could receive.

Kaweah Delta Medical Center

Visalia, California

Gary Herbst, CEO

Kaweah Delta is a district hospital founded in 1961. One wing of our acute care medical center located on our main campus—the Mineral King Wing—was built in 1969 and is classified as Structural Performance Category (SPC)-2 under the state's seismic rating system. It houses 224 beds (roughly half the beds on the main campus), some of our operating rooms, and several ancillary services. It is sandwiched between two expansion wings that are seismically compliant.

Our planning process began in 1999, when we engaged a planning group to develop a 30-to-50-year plan that would lead to replacement of the Mineral King Wing. The design envisioned a more than \$1 billion replacement and expansion plan that included eight six-story towers. We constructed the first of the eight towers in a \$200 million addition that opened in 2009. This was financed in part by a \$51 million general obligation bond that was barely approved by just over the required two-thirds percentage of voters. The remainder of the costs were funded by revenue-backed bonds, philanthropy, and cash reserves.

As healthcare delivery began to change, with more inpatient procedures migrating to outpatient settings, we reconsidered our initial plan. A second planning firm designed a replacement facility with a denser, more cost-effective footprint. We took this to the voters in April 2016 and were soundly defeated, with an approval rate of about 40%. In hindsight, we probably rushed too quickly to market, trying to take advantage of favorable interest rates and avoid an escalation in costs. But the defeat set us back on our heels, and we waited a couple of years for things to settle down. In the meantime, we launched a community engagement initiative, including formation of a community advisory committee, which I chair, to focus singularly on what we call “the hospital of the future.”

Before COVID-19 hit, we were in the midst of master-facility planning with a third firm, which designed a \$600 million replacement facility. We were able to scale the costs back to between an estimated \$400 million to \$500 million using an incremental approach that would build out a shell and then fill in a few floors at a time. All of this has come to a screeching halt, however, with the arrival of COVID-19.

Kaweah Delta Medical Center *(continued)*

We lost \$28 million in three months and are now \$47 million under budget for the year. We are still above our covenant default levels on existing debt and were just reaffirmed by Moody's at an A3 rating, but our rating outlook has changed from stable to negative, and our rating level may be downgraded. We have budgeted for a 0% operating margin for our next fiscal year, and will be able to achieve that only through a wage freeze, staff layoffs, suspension of our contribution to employee 401K plans for the next two years, changes to eligibility and deductibles in our employee health plan, and restructuring of our physician contracts. At the same time, we have a severe shortage of nurses—50 nurses are currently under quarantine—and part of the financial devastation we have seen is caused by our need to pay for traveling nurses and overtime. We are now spending \$80,000 per pay period in “extra-shift” bonuses alone.

One of our greatest frustrations is that we have an emergency department, operating rooms, and roughly half our beds in

seismically compliant facilities and would be able to provide emergency services in compliant facilities today if a seismic event occurred. A study conducted several years ago by the Federal Emergency Management Agency (FEMA) found that, because of our distance from the nearest fault line and the geology of our area, we are in a low seismic-risk area.

We can only talk about our plans right now. With our losses from earlier this year and a projected 0% operating margin, we have no way of turning Kaweah Delta into an organization that could service the debt on a \$400 million revenue-backed bond and would have few investors interested in such an offering. We are a poor county, with the highest percentage of Medi-Cal enrollees in the state. COVID-19 is going to result in more business closures and more individuals on Medi-Cal or uninsured. The passage of a general obligation bond that would finance the replacement facility through higher taxes on district residents simply is not politically feasible.

Kern Medical

Bakersfield, California

Russell Judd, CEO, and Andrew Cantu, CFO

Kern Medical is the only public hospital in Kern County and transformed to a county Hospital Authority in 2016. We have 222 beds. Our operating rooms, emergency department, and intensive care unit (ICU) are in seismically compliant facilities, as are one neonatal ICU and a medical/surgical unit. To be fully compliant, we will need to replace the facility that houses 120 beds, including our labor and delivery unit, psychiatry unit, and a couple of medical/surgical units, as well as our cafeteria and kitchen. Construction costs are estimated at \$400 million, which includes \$300 million for replacement alone and an additional \$100 million for expansion of our neonatal ICU capabilities and additional operating rooms.

As a public hospital, we would have difficulty financing the project from our cash reserves. We receive significant funding from intergovernmental transfers, but these are often received well after the close of our fiscal year, and some programs require us to put up funds to receive matching dollars. Thus, although we may end our fiscal year on June 30 with \$40 million or \$50 million in reserves, we must do a balancing act with our cash to fund payroll and other ongoing expenses until all of our intergovernmental transfer funds

are received, which can be as late as November. We also recently installed a new electronic health record, which will cost at least \$45 million over the next seven years. We were able to finance \$10 million of that cost but will be paying the remaining \$35 million out of operating cash.

Our financing options for the replacement facility looked bleak even before the pandemic struck. We carry \$300 million in unfunded pension liability on our balance sheet, so are unlikely to attract investors in revenue-backed bonds we issue ourselves. As a Hospital Authority, we need two-thirds of voters to approve a tax-funded bond in a referendum, which was unlikely before the pandemic and is now almost impossible to imagine, given the job losses and economic damage that has occurred. And in a competitive market, with several other hospitals present, the County Board of Supervisors is unlikely to select a "favorite child" to receive county funding for the replacement facility.

Kern County has experienced less of a surge and more of a steady climb in COVID-19 cases. Hospitals in the county have closed down elective surgeries and we may be required to do so as well if cases

Kern Medical *(continued)*

continue to climb. We have been able to avoid shutdown so far but lost several million dollars in April and May when we experienced a significant drop in census.

Right now, we are focused on trying to obtain enough ICU nurses to meet demand. We are working with the county and other hospitals to secure an additional 80 registry ICU nurses to arrive between August 15 and September 1 and have just put down a non-refundable deposit for another 80 ICU nurses to arrive October 1. Costs for these nurses have gone from approximately \$90 an hour pre-COVID to \$135 an hour today, so even with full COVID-19 payment, we cannot cover costs.

In construction, time is everything. For some time now we have communicated with the County Board of Supervisors and our own board the need to make a "go/no go" decision on the replacement facility by 2020. At a minimum, we would need to contract with

an architect seven years before estimated completion, and with architectural fees running at about 7%-10% of total costs, that is not feasible unless we have financing in place. COVID-19 has consumed all of our leadership's energy and resources; all other discussions have stopped. We are now effectively losing a year out of the 10 we have remaining before compliance is required.

With some minor and affordable adjustments, we could have all emergency and essential services in existing, seismically compliant facilities. We have a difficult enough time as is keeping up with other hospitals, as our payer mix is 78% Medi-Cal. We are the public safety net for the county, but in our society and healthcare system, the poorest and most vulnerable also receive the fewest resources. We already have one stroke against us and holding us to the same standard of compliance as all other hospitals in the state simply adds a new level of difficulty and complexity for us.

Mammoth Hospital

Mammoth Lakes, California

Melanie Van Winkle, CFO

Mammoth Hospital is the Southern Mono Healthcare District's 17-bed critical access hospital, located in Mammoth Lakes. Our facilities are structurally sound at SPC-4 and SPC-5, but do not meet OSHPD's non-structural performance category requirements. Retrofitting is not feasible, as we would have no place to house patients while retrofitting work was completed and the resulting rooms would be too small to accommodate our current patient census, which depends on double-occupancy rooms. Instead, we will need to build a replacement facility at a cost of at least \$110 million.

Mammoth Hospital has been a careful steward of its resources and has built cash reserves sufficient to cover some of the replacement costs, but will still require additional financing to pay for the replacement. Passage of a referendum to issue general obligation bonds to finance the remaining portion of the replacement building is uncertain, given that voters recently approved a school district referendum and likely are tapped out, especially given the impacts of COVID-19 on the district's economy.

The economy of Mammoth Lakes and Mono County depends on tourism, and COVID-19 has had a significant impact on tourism revenues. This year was a good snow season, and Mammoth Mountain

would typically have remained open until Memorial Day. Due to COVID-19, the mountain had to close on March 15. The area's summer season, which has been growing in significance, is now threatened by the resurgence of coronavirus in the state, including a growth in positive cases locally after a long period with no hospitalizations. Most of the activities planned for the summer have been cancelled.

The hospital went for 1½ months (half of March and all of April) with no elective procedures, and at 25% of normal volumes for May. As the largest employer in a tight-knit community, and unsure of whether we would see a spike in cases (we had four hospitalizations and one fatality in early March), we felt an obligation to maintain full employment during this time. For the months of March, April, and May, our revenue was down more than \$10.73 million in comparison with the prior year. Even with CARES Act funding figured in, we still had a net loss of almost \$4.5 million. The \$5.7 million we received in Medicare Accelerated and Advance Payments must be repaid.

We bought adjacent land for the new facility several years ago and had begun planning to assess our debt capacity and financing options for the replacement facility, but that work is now on hold. We face too many uncertainties to move forward at this time.

Mission Community Hospital

Panorama City, California

James (Jim) Theiring, CEO

Mission Community Hospital (MCH) is an independent, investor-owned hospital located in the San Fernando Valley. All of MCH's facilities are at a single location, and include an SPC-5 compliant tower that was rebuilt following the 1994 earthquake and two connected facilities built in the 1950s that must be made compliant—a three-story tower (the North Tower) and a single-story building that houses MCH's lab, radiology unit, and emergency department.

MCH has 145 total beds: 85 for acute care and 60 for inpatient psychiatric services. Sixty of the acute-care beds are in the newer, SPC-5 facility, including 50 medical/surgical beds and 10 intensive care beds. In 2011, we converted an additional 25 beds in the North Tower for acute care. Pre-COVID-19, the second floor of the North Tower was used primarily for office space and the first floor was leased to physicians for clinical services.

Since the pandemic struck, the first and second floors of the North Tower have been repurposed to handle the surge in COVID-19 patients. So far, we have had up to 24 confirmed COVID-19 patients in our 85 acute-care beds. In addition, we have patients who are

suspected of being positive and are waiting for test results, or who must receive two negative test results or be symptom-free for 14 days before returning to their skilled nursing facility. Across all three groups (confirmed, suspected, or awaiting double-negative results), we have had up to 80 patients at a time.

The North Tower and connected one-story building are rated SPC-1. Before the COVID-19 pandemic struck, work was approved and ready to begin for a 6-month project that would have separated the connected facilities and made them SPC-2 compliant at a cost of \$500,000 to \$1 million. We had just begun planning for the work that would be required to move the newly SPC-2-compliant facilities to SPC-4D, which would allow their continued operation past 2030. The planning process will cost approximately \$500,000, with an estimated additional cost of \$5 million to \$10 million for the structural soundness work alone.

All plans are currently on hold as MCH adjusts to the financial impacts of COVID-19. We have had three straight months of significant financial losses and were able to participate only in

Mission Community Hospital *(continued)*

the first round of COVID-19 relief funding. Four to five months of losses will wipe out most of our income from 2019, which we were planning to use for seismic compliance work. Most of our reserves have been used up, and we may have to tap into our line of credit to mitigate our COVID-19 operating losses.

We will have to find the funds needed to make the single-story building compliant: the services it houses—including our emergency department—are essential to our operations. Although our

repurposing of beds for COVID-19 patients in the North Tower has proved that this could be a viable site for expanding the services we offer the community, the costs needed to bring the North Tower into compliance would make any such expansion cost prohibitive.

Independent hospitals like MCH tend to be caught up in the wave and forgotten. Although our numbers may be smaller than those at larger health systems, the magnitude of their impact is just as great.

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