Effect of Purchase of Daniel Freeman Hospitals by Tenet Healthcare Corporation on the Availability and Accessibility of Health Care Services

Prepared for:
Office of the California Attorney General

Prepared By:
The Lewin Group, Inc.
Health Care Planning & Policy

November 1, 2001

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Introduction and Project Scope

This report, prepared for the Office of the California Attorney General assesses the potential effects of the acquisition of Daniel Freeman Hospitals, Inc. (DFH, Inc.), owner of Daniel Freeman Memorial Hospital (Inglewood, CA) and Daniel Freeman Marina Hospital (Marina del Rey, CA) by Tenet Healthcare Corporation (Tenet) on the availability and accessibility of health care services.

The Lewin Group and Lucy Johns (dba Health Care Planning & Policy) analyzed the health impacts of the proposed transfer of ownership by performing the following tasks:

- Review of documents, including the Application for Approval submitted to the California Attorney General on August 24, 2001, the Asset Purchase Agreement dated June 7, 2001, the Applicant's Health Impact Assessment, and other materials;
- Analysis of data regarding DFH, Inc. services and finances and the utilization of other health care providers in Los Angeles;
- Interviews with representatives of the communities and parties potentially affected by the transaction, including: Board members and management staff of DFH, Inc. (including members of the committee that negotiated sale of the hospitals to Tenet); members of Carondelet Health System (CHS) corporate staff; representatives of Tenet Healthcare Corporation; staff from the Los Angeles County Department of Public Health (including the Emergency Medical Services Agency); and representatives of community organizations concerned with health and human services in Los Angeles, particularly in the areas served by DFH, Inc.;
- Development of proposed mitigation measures to reduce or eliminate the potential for adverse health effects from the transaction; and
- Attendance at the Attorney General's October 18, 2001 public meeting concerning this transaction.

The report is organized into the following chapters:

- Chapter 1: History and Description of the Transaction
- Chapter 2: Summary of Viewpoints Regarding the Transaction
- Chapter 3: Services Provided by Daniel Freeman Hospitals, Inc.
- Chapter 4: DFH, Inc. Finances, Charity Care, Community Benefits, and Quality Measurement
- Chapter 5: Summary of Findings and Recommendations

The Lewin Group wishes to express its appreciation to those who provided input and data for the study.

Chapter 1: History and Description of the Transaction

This chapter provides background information on the proposed transaction.

Daniel Freeman Hospitals, Inc. (DFH, Inc.) is a California nonprofit public benefit corporation that owns and operates Daniel Freeman Memorial Hospital (Memorial) and Daniel Freeman Marina Hospital (Marina) in west-central Los Angeles. The sole corporate member of DFH, Inc. is Carondelet Health System, Inc. (CHS), a nonprofit organization based in Missouri. CHS is sponsored by the Sisters of St. Joseph of Carondelet. CHS is the parent corporation of 14 nonprofit hospitals operating in the United States.

Memorial opened in 1954 on property donated to the Sisters of St. Joseph of Carondelet. Memorial is licensed for 335 general acute care beds and 29 skilled nursing beds[1]. Marina was purchased by the Sisters of St. Joseph of Carondelet in 1980. Marina has 105 general acute care, 21 skilled nursing, and 40 acute psychiatric licensed beds.

DFH, Inc. reported substantial operating losses over the past four fiscal years[2], increasing from $5.1 million in 1998 to $23.9 million in 2001. The fiscal year (FY) 2002 budget, prepared this summer, indicated a net operating loss of $23.2 million. At the end of FY 2001, liabilities, including long term debt of $97.3 million, exceeded assets by $35.9 million. Short-term loans from CHS and the local Province of the Sisters of St. Joseph of Carondelet enabled DFH, Inc. to meet payroll and obligations to vendors during the last year.

Both Memorial and Marina have substantial capital needs for equipment, for facilities maintenance, and to achieve compliance with S.B. 1953, which mandates that hospitals meet seismic standards by 2008 and 2030. Current DFH, Inc. management estimates that capital needs for the hospitals range from $100 million to over $150 million for the next five years. DFH, Inc. does not have the resources or financing capacity to fund these needs, and CHS has indicated that the capital and operating requirements of its other hospitals prevent making these resources available.

A number of factors contributed to DFH, Inc.'s poor financial performance. The Los Angeles health care market is highly competitive. Not being members of an organized, multi-hospital delivery system, Memorial and Marina have limited leverage in managed care negotiations. A high proportion of revenue for the hospitals is generated from government payers, and Medicare reduced reimbursement in the Balanced Budget Act of 1997. The lack of capital investment has made it difficult to maintain attractive, competitive facilities and to attract and retain key medical staff. Local competition has been stiff – Tenet, a national, for-profit hospital chain, has competed vigorously for patients and staff in both Inglewood (Centinela Hospital, a few blocks south of Memorial) and Marina del Rey (Brotman Hospital). Historical problems with financial reporting made it difficult for management and the Board of Directors to identify and address problems in a timely fashion.

[1] As of 1999.
[2] DFH, Inc.'s fiscal year ends June 30.

Recognizing the deteriorating financial condition of DFH, Inc. and concerned about payment of long-term debt, in September 2000 CHS retained Cambio Health Solutions, Inc. (Cambio) to conduct a performance enhancement, operations assessment, and viability assessment for the hospitals. In November 2000, CHS hired bankruptcy counsel, capital advisors (to help restructure DFH, Inc.'s long-term debt), and Kauffman Hall (to study the potential for divestiture). In December 2000, CHS and DFH, Inc. received Cambio's conclusion: "Daniel Freeman Hospitals cannot be financially viable in either the short term or the long term....fundamentally due to the lack of needed capital and the inability to access needed capital in a short period of time[3]."

Cambio's review, the constraints of the California market, DFH, Inc.'s substantial capital needs, and the on-going requirements of other CHS hospitals, persuaded CHS and DFH, Inc. that sale was the preferred course. CHS and DFH, Inc. representatives believed that sale had the potential to keep the hospitals open. CHS requested Kauffman Hall to conduct a national search for prospective buyers and to assist with the sale. CHS also put its Santa Marta Hospital in Boyle Heights (Los Angeles) up for sale, positioning itself to exit the California market. After soliciting interest from a variety of faith-based, non-profit and for-profit organizations, a negotiating committee of CHS and DFH, Inc. representatives decided that a proposal from Tenet to acquire the DFH, Inc. hospitals was the best offer.

CHS stated to the Lewin Group that if sale of the DFH, Inc. is not completed, it will close both DFH, Inc. hospitals.

Under the Asset Purchase Agreement (APA):

- Tenet would purchase the assets of Memorial, Marina, and Freeman Health Ventures, Inc., a wholly-owned subsidiary of DFH, Inc.
- DFH, Inc. would survive as a corporate entity after the sale and would retain some assets, such as cash and investments and accounts receivable. These assets would be available to help repay long-term debt and other obligations that would remain the responsibility of DFH, Inc. and not be assumed by Tenet.
- DFH, Inc. would retain responsibility for the majority of the hospitals' liabilities, including long-term debt, malpractice and other insurance claims, and accounts payable (except for those associated with contracts and leases assumed by Tenet).
- The purchase price for the assets would be $55 million, subject to several adjustments before closing. Sixteen ($16) million of the purchase price would be placed in escrow accounts to indemnify Tenet against various risks and unforeseen liabilities.

Since the purchase price (and retained assets) would not be sufficient to offset DFH, Inc.'s debt (and other liabilities), the sale of DFH, Inc. would not lead to creation of a community health care fund (a frequent mitigation for such transactions in California). This sale thus would generate a significant financial loss for CHS and its constituent hospitals.

[3] Executive Summary of Performance Enhancement/Operations Assessment and Viability Assessment for Daniel Freeman Hospitals, Inc., Cambio Health Solutions, LLC.

In the APA, Tenet agrees to establish a local governing board at each hospital that will, among other duties, participate in and approve the hiring of the hospital CEO and Medical Director, oversee preparation of annual operating plans and budgets, and monitor performance on a periodic basis[4].

The APA includes other commitments by Tenet, as follows[5]:

- Tenet will provide charity care at each hospital at a level "equivalent, in the aggregate, to the average annual level of charity care that [DFH, Inc.] provided at [the] hospital(s) during the three full fiscal years ending June 30, 2000," as reported on DFH Inc.'s IRS Form 990 for these years, for as long as it operates each hospital. The 990s include charity care values based on established charges as specified in audited financial statements[6]. Compliance with this term "shall be determined by using a methodology similar to that used [by Tenet now]."
- Tenet will conduct a planning process to determine the operating and capital needs of the hospitals "on an aggregate basis," in consultation with the local governing boards, physicians, employees, community and elected leaders, and Los Angeles County health officials, within 90 days after the Closing.
- Tenet will adhere to the *Ethical and Religious Directives for Catholic Health Care Services (Directives)* promulgated by the National Conference of Catholic Bishops at the Daniel Freeman Hospitals, Inc. site for an indefinite period. Tenet, as operator of DFH, Inc., "shall not, directly or indirectly, enter into any partnerships or joint ventures which provide, directly or indirectly, abortions, assisted suicide or euthanasia." The local Province of the Sisters of Carondelet and the local Archbishop may enforce this commitment.
- Tenet will maintain Basic Emergency Room services at Memorial for not less than two years and maintain emergency and / or ambulatory care services for the local communities served by both hospitals for not less than three years after the Closing.
- Tenet will provide obstetrical and neonatal intensive care services at a facility owned by Tenet or an affiliate in Inglewood for not less than three years after the Closing.
- For as long as Tenet or an affiliate operates a hospital in Inglewood, it will provide reproductive healthcare services for acute care patients (other than at Memorial).
- As long as there is no "substantial reduction in the level of reimbursements" under Medicare and Medi-Cal, Tenet will use its best efforts to participate in these programs.
- While Tenet retains the right to set terms of employment, it will continue to employ current employees for ninety days and will consider factors such as loyalty and dedication when making employment decisions for the next two years.
- Tenet's obligations under the APA are binding on its successors in interest.

[4] Asset Purchase Agreement Executive Summary.
[5] *Ibid.*
[6] Note: the charity care amounts in the audited financial statements differ from charity care as reported to the Office of Statewide Health Planning and Development.

Tenet also agrees to certain capital commitments, including:

- Making available no less than $25 million in capital expenditures for healthcare facilities owned or operated within the historical service areas of the two hospitals and Centinela Hospital during the five years following the closing, and
- Making an additional $25 million in capital expenditures in this area within the subsequent 5 year period.

Tenet also makes commitments in the APA to the Sisters of St. Joseph of Carondelet, including maintaining the convent on the Memorial campus, continuing the current "Sister Service Arrangements" with Sisters Salazar and McCann for no less than three years, continuing the current "Sister Service Arrangements" with the seven sisters involved in clinical operations and in human resources for no less than one year, and anticipating that the other seven Sisters missioned at the two hospitals in the pastoral care departments will be retained by Tenet.

Lastly, Tenet agrees that its right to use the "Daniel Freeman" name is subject to compliance with certain agreements and enforceable by the Province, including adherence to the *Directives*, satisfying the charity care commitments, maintaining a chapel, maintaining pastoral care and chaplaincy programs, and allowing Catholic Mass to be said on a regular basis.

Individuals interviewed during the course of this study, and participants in the October 18, 2001 public meeting had numerous comments regarding the proposed terms of the sale and the provisions of the Asset Purchase Agreement. These observations are summarized in the next chapter.

Chapter 2: Summary of Viewpoints Regarding the Transaction

A number of viewpoints regarding the acquisition were expressed during interviews and at the October 18, 2001 public hearing on the Transaction. These comments are summarized below.

Interviews

Interviews were conducted both on-site and by telephone. The interviews served to identify elements of the acquisition that stakeholders considered likely to impact the health of the community and access to high quality hospital services.

The Purpose of the Sale. Interviewees perceive that sale is the best strategy to save the hospitals from closure. The reasons include: the need for major capital improvements of both facility and services; the weak market position and leverage with managed care plans of freestanding hospitals in Los Angeles; and belief (informed by the success of Cambio's efforts to date) that performance of the hospitals can be improved. Fundamentally, sale is viewed as preferable to bankruptcy or closure of the hospitals, which all consider very disruptive.

The Purpose of the Acquisition. In contrast to the statements that sale ensures a future for Memorial and Marina, there is considerable community concern that closure of one or both would be a logical outcome of the Tenet acquisition. Some, however, believe that the acquisition is in Tenet's strategic interest and that closure is not consistent with a $55 million investment in the hospitals. For example, Tenet reportedly may implement plans to reduce outmigration from the area served by Memorial and build services attractive to the community. Observers suggest that control of additional acute hospital capacity would strengthen Tenet's market position in Los Angeles, would eliminate one competitor, and that land acquired as part of the sale would provide new options for the regional system operated by Tenet in the area.

Circumstances and Terms of the Sale. Perceptions of the bidding process vary, with some finding it thorough and thoughtful and others finding it abbreviated and incomplete. Some observers in the community and some physicians question whether the decision to sell was warranted. Observers commented that the sales price was too low, in part because it does not allow creation of a community foundation and because of Marina's value as real estate. One interviewee recognized that other bidders would be challenged to offer substantial sums for the hospitals given their financial condition and that they operate "in Tenet's back yard."

Tenet's Strengths and Daniel Freeman Hospitals Inc.'s Weaknesses. Interviewees report that Tenet, a long-established, profitable, nation-wide chain brings many strengths to DFH, Inc., including: integration of DFH into a regional system, managed care experience, and a culture of management accountability. In contrast, Memorial and Marina have suffered management and oversight deficiencies in the last four to five years and have been freestanding hospitals.

Tenet Dominance of the West-Central Los Angeles Healthcare Market. Some interviewees expressed concern that if the acquisition is approved, Tenet will dominate

the private hospital market from Century City to Torrance, an area with millions of people and considerable economic activity. Some physicians believe the loss of competition would be detrimental to them and to the choices available to their patients.

Tenet's History as a Purchaser and Operator. To some, Tenet's history as purchaser of other hospitals in southern California shows reason for concern about the future of Memorial and Marina. Such actions reportedly include: EMTALA violations at U.C. Irvine Medical Center; five closures of hospitals within two to three years of purchase all during the 1990s; and operating hospitals at low staffing levels.

The Daniel Freeman Memorial Emergency Room. Tenet's commitment to keep Memorial's ER open for a minimum of two years, while preferable to closure, raised universal concern for two primary reasons. First is the role played by the Memorial ER in the Los Angeles Emergency Medical Services (EMS) system. The Memorial ER currently accepts approximately 6,600 911 calls (paramedic runs) annually from a "designated service area". Memorial's emergency room volume is too large to be accommodated by nearby facilities. The second reason is accessibility of the ER to uninsured and underinsured patients. Community representatives and Memorial physicians share this concern, noting that this service is a major source of charity care.

Community Perceptions of Daniel Freeman Memorial and Centinela. Centinela, originally an orthopedic hospital now owned by Tenet, has a different reputation among interviewees than Memorial regarding concern for its local community. Centinela's programs in cardiology and sports medicine are marketed widely and outside the Inglewood community. Memorial, by contrast, has long been perceived as "the community hospital." Through the Freeman Hospitals Foundation and Community Trust Fund, Memorial supports a network of small community agencies and programs serving a variety of social, mental health, and medical needs of local residents through grants, in-kind contributions, and management assistance. Tenet's community benefit programs, while present, are less recognized by community members providing input to this study.

The Definition and Measurement of Charity Care. The definition and measurement of charity care are a great concern among community advocates. Sources of statistics for charity care vary significantly in the amounts reported (IRS 990 filings; audited financial statements; OSHPD reports).

Importance of Daniel Freeman Marina. Daniel Freeman Marina, although bypassed by local residents for serious illness, presents a friendly and convenient site for low-level acute care, as well as offering an emergency room close to home for elderly residents of Marina del Rey. The behavioral health services responds to serious needs. The emergency room serves local emergency and urgent care needs.

The Future under Tenet's Leadership. Interviewees recognize that Tenet has not presented a vision or clear plans for either site. This creates uncertainty for stakeholders and observers of the hospitals. Among the scenarios suggested by informants include: closure of one or both of the hospitals; physician and employee attrition; emphasizing rehabilitation and Medi-Cal services at Memorial (to maximize disproportionate share hospital funds), while moving cardiology and other specialty care to other facilities; developing a "feeder system" for Tenet's University of Southern California medical facilities; and developing new programs and marketing strategies to reduce patient outmigration from Memorial's service area to other Los Angeles facilities.

The October 18, 2001 Public Hearing

At a public meeting conducted by the Office of the Attorney General on October 18, 2001, in Inglewood, California, representatives of DFH Inc., including Sisters of Carondelet, staff from both hospitals, and physicians made the case for the proposed sale. Tenet presented overviews of its nationwide system, its record in southern California, its academic affiliations, and its community-oriented programs at Centinela.

The number of speakers voicing concern or opposition equaled the proponents. Several questioned the bidding process and acquisition terms, the fate of the hospitals' emergency rooms, and the provision of charity care after the sale. Others emphasized the importance of the Marina emergency room to the neighboring elderly and to the residents of Venice.

Several additional concerns also arose, as follows:

Broad Impact of Closure. Many speakers placed the prospect of closure of DFH in the context of an urban area already under serious strain. Health services for poor people are "overburdened" from growing needs not coupled to resources to pay for them. Los Angeles County facilities face significant uncertainty when the federal waiver that provides financial support ends. The future of the Watts Health Clinic, located in Memorial's service area, also is uncertain. As Congresswoman Maxine Waters stated for the public meeting:

> *". . .[I]t has come clear to me that there are some issues on which there is consensus: Our community cannot afford to have the hospital [Memorial] close or have its services 'regionalized.' We cannot afford for the ER to shut down or be relocated elsewhere. "*

Women's Health Services. Questions were raised about the application of the *Directives* to a commercial, secular company and about Tenet's ongoing ability to contract with entities not bound by these requirements.

Medi-Cal and Medicare. Tenet's agreement to participate in Medicare and Medi-Cal as long as reimbursement rates "are not substantially reduced" was viewed as inconsistent with the historical community service commitments of the hospitals and with the needs of the many service area residents who rely on these programs.

Employee Protections. Some attendees indicated that Tenet's plans for current hospital employees are not deemed adequate for their protection.

SEIU Report

Late in October, 2001, The Lewin Group and the Office of the California Attorney General received a report from the Service Employees International Union (SEIU) entitled, *Staffing and Labor Practices at Tenet Healthcare Corporation Hospitals in Los Angeles and Orange Counties.* Because this report recently was received, Tenet Healthcare has not had the opportunity to respond. Hospital staffing is a complex and the California Department of Health Services is evaluating these matters on a state-wide level.

Chapter 3: Services Provided by Daniel Freeman Hospitals, Inc.

This chapter discusses services provided by Daniel Freeman Hospitals, Inc. It begins by identifying the geographic areas served historically by Memorial and Marina, and then assesses the principal inpatient and outpatient programs potentially affected by the transaction.

The two DFH, Inc. hospitals share a common mission: "to provide comprehensive healthcare services with compassion and professionalism, inspired by ethical, moral and human concern for the dignity of each person." Although the two hospitals share some managers and some physicians practice at both facilities, they are operated as separate entities and primarily serve non-overlapping service areas.

Memorial and Marina Service Areas

The Applicant defined the service areas for Memorial and Marina hospitals by examining the number of discharges and emergency room visits from each hospital by zip code of patient residence. The outcome of this analysis is portrayed in Table 1 below.

Table 1
Applicant's Definition of Daniel Freeman Hospitals' Service Areas
2001

	Memorial	Marina
Number of Zip Codes		
• Primary service area	13	6
• Secondary service area	16	21
• Total	29	27
Discharges (1999)		
• Primary service area	10,826	2,151
• Secondary service area	3,052	1,169
• Other areas	2,240	1,583
• Total	16,118	4,903
Percent of Discharges (1999)		
• Primary service area	67%	44%
• Secondary service area	19%	24%
• Other areas	14%	32%
• Total	100%	100%
Percent of Emergency Room Visits		
• Primary service area	75%	56%
• Secondary service area	14%	18%
• Other areas	11%	26%
• Total	100%	100%

Source: "Daniel Freeman Hospitals: An Analysis of the Community Health Impact of the Proposed Sale of Daniel Freeman Hospitals to Tenet Healthsystem," August 24, 2001.

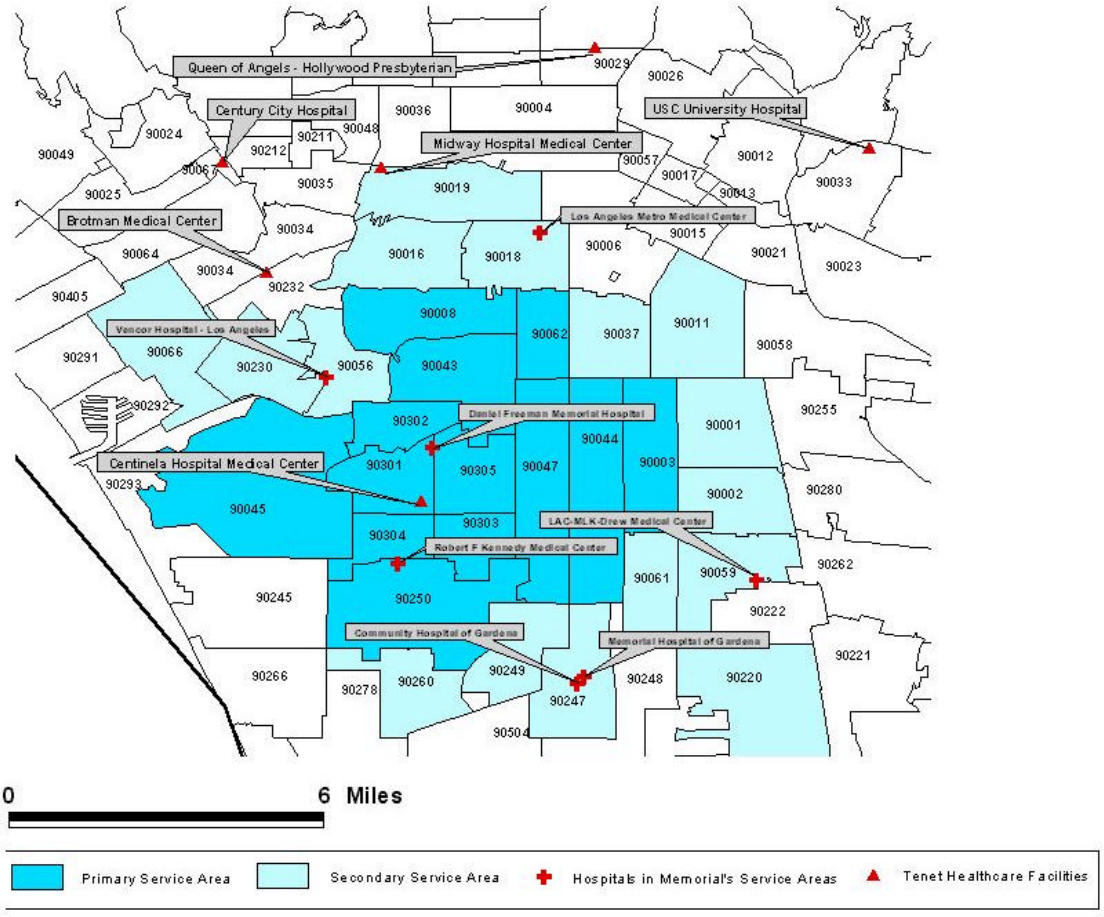
The Applicant's approach to defining the primary and secondary service areas (PSA and SSA) for Memorial and Marina hospitals is consistent with current professional practice

and we concur with the definition. Two-thirds of Memorial's discharges (and 75 percent of emergency room visits) were accounted for by residents of 13 PSA zip codes in 1999.

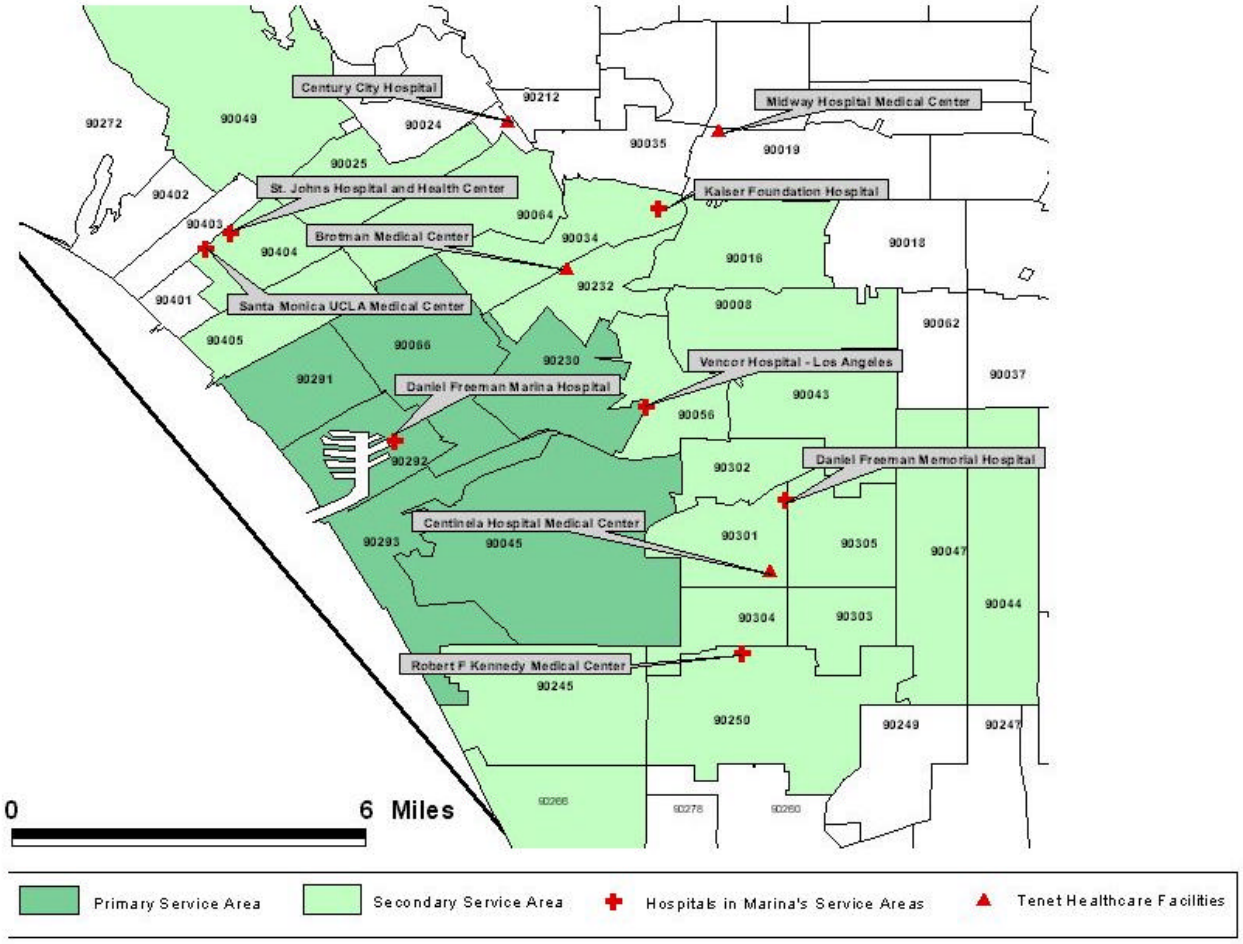
A comparatively high proportion of Marina's patients resided outside its PSA and SSA. Over fifty percent of these "non-resident" inpatient cases are for behavioral health (psychiatry and substance abuse) services.

The following maps portray the geographic areas served by the two hospitals. The maps also identify the locations of area hospitals, including Tenet Healthcare facilities.

Daniel Freeman Memorial Hospital



Daniel Freeman Marina Hospital



Service Area Demographics and Health Status Indicators

In 1999, there were 557,647 residents in the Memorial Primary Service Area. Memorial PSA residents' demographic and socioeconomic characteristics have changed since 1990, the population becoming more diverse and poor, as shown in Table 2. Latinos and Asian / Pacific Islanders increased, while white, African-American and American Indian / Other residents in the area declined.

Table 2
Primary Service Area Population
Daniel Freeman Memorial Hospital

	1990	1999	% Change
Total	538,517	557,647	4%
< 100% Federal Poverty Limit	111,728	151,387	35%
Males	257,947	270,949	5%
Females	280,570	286,698	2%
Latinos	171,311	235,165	37%
Whites	71,323	58,153	-18%
Blacks	272,693	236,468	-13%
American Indians/Other	3,366	3,171	-6%
Asian/Pacific Islander	19,824	24,690	25%
< 5 years	51,479	49,660	-4%
5-19 years	122,657	137,011	12%
20-44 years	228,151	215,513	-6%
45-65 years	89,568	101,436	13%
65+ years	46,662	54,027	16%

Sources: LAC DHS Office of Planning, US Census Bureau, Population Estimation and Projection System, LAC Urban Research Division

Memorial's Secondary Service Area population was 729,669 in 1999, grew comparatively fast between 1990 and 1999 (11 percent versus the PSA's 4 percent), and exhibited growing Latino, declining white and African-American populations, and a growing number of households at or below 100 percent of the Federal Poverty Level (FPL).

As shown in Table 3, in 1999 there were 170,431 residents in the PSA for Marina, a slight decline from 1990. As in Memorial's primary service area, the Marina PSA has shown significant growth of Latinos, a decline in the white population, and more households living in poverty. While 9.7 percent of persons in Memorial's PSA are 65 years of age and older, this statistic exceeds 13 percent in the Marina PSA.

Table 3
Primary Service Area Population
Daniel Freeman Marina Hospital
1990 and 1999

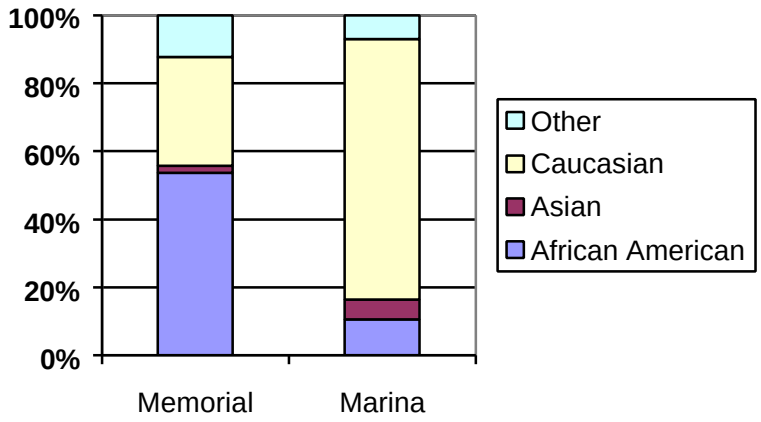
	1990	1999	% Change
Total	172,166	170,431	-1%
< 100% Federal Poverty Limit	16,772	22,955	37%
Males	86,683	85,663	-1%
Females	85,483	84,768	-1%
Latinos	37,568	51,399	37%
Whites	108,630	87,321	-20%
Blacks	9,795	10,357	6%
American Indians/Other	844	1,508	79%
Asian/Pacific Islander	15,329	19,846	29%
< 5 years	9,174	11,295	23%
5-19 years	24,174	25,240	4%
20-44 years	86,445	71,063	-18%
45-65 years	33,223	40,604	22%
65+ years	19,150	22,229	16%

Sources: LAC DHS Office of Planning, US Census Bureau, Population Estimation and Projection System, LAC Urban Research Division

Marina's SSA population was 768,138 in 1999, an increase of 2 percent from 1990. The Latino population also was growing in the SSA as were the number of households living in poverty (up 34 percent from 1990).

The differences between the Memorial and Marina primary service areas are reflected in patient discharge data. More than one-half of the discharges from all residents of Memorial's PSA were African-American in 1999; three-quarters of the discharges for residents of the Marina PSA were Caucasian. These findings are shown below.

Discharges by Ethnicity for Memorial and Marina Primary Service Areas, 1999

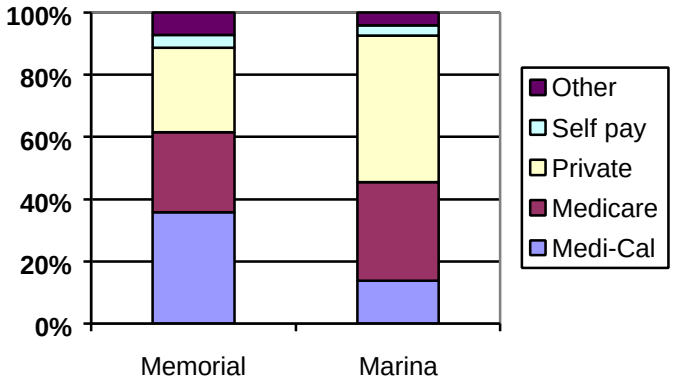


Source: Lewin Group analysis of OSHPD discharge data for 1999.

In addition, in 1999 approximately 31 percent of inpatients from Memorial's PSA were of Latino descent, while 19 percent of inpatients in Marina's PSA were Latinos.

As shown below, the two primary service areas also differ in terms of the mix of discharges by payer source. Medi-Cal is the largest payer in Memorial's PSA, while private sources and Medicare cover the large majority of residents in Marina's PSA.

Discharges by Payer for Memorial and Marina Primary Service Areas, 1999



Source: Lewin Group analysis of OSHPD discharge data for 1999.

Data from the Los Angeles County Health Survey (1997) suggest that the health status of the population in Memorial's PSA is about average for the county, with two major exceptions, as shown in Table 4. The percentage reporting "fair/poor" self-perceived health status (a good predictor of need for medical care) far exceeds the County

percentage. The percentage of households reporting children with asthma in the Inglewood Health District is double the percentage for the county.

Table 4
Selected Health Indicators of the Inglewood and Los Angeles County Population
1997

Health Status Indicator	Inglewood Health District	Los Angeles County
Adult smokers	17%	18%
Heavy alcohol users	6	5
Seat belts	87	89
Reported health status		
Fair/poor	51	21
Good	28	27
Adults with diabetes	6	6
Adults with hypertension	18	16
Adults with arthritis	16	18
Children with asthma	14	7
Adults with no regular source of medical care	26	25

Source: Los Angeles County Department of Health Services, *L.A. Health Profiles*, 1999.

Other health status indicators point to comparatively high incidence of certain health problems in Inglewood, including heart disease and diabetes within the African-American population[7]. Interviewees also indicated that a high number of renal dialysis centers are present in the community.

[7] Services Planning Area (SPA) 8 Community Health Council.

Daniel Freeman Memorial Hospital Services

Memorial, opened in 1954, operates 364 licensed beds in a complex of buildings on a roughly 20-acre site in Inglewood, CA. Compliance with seismic safety requirements varies among the buildings, with one required to be conforming or removed from service by 2008, five requiring conformance by 2030, and two fit for use through 2030 and beyond. Licensed beds and utilization statistics published in 1999 are shown in Table 5.

Table 5
Selected Inpatient Capacity and Utilization Statistics
Daniel Freeman Memorial Hospital, 1999

Licensed Bed Classification	Licensed Beds	Patient Days	Hospital Discharges	Licensed Bed Occupancy Rate
Medical/Surgical Acute	181	40,424	7,932	61.1%
Perinatal	32	8,985	3,056	76.9%
Pediatric Acute	19	2,137	747	30.8%
Intensive Care	13	3,097	196	65.3%
Coronary Care	12	3,012	243	68.8%
Intensive Care Newborn Nursery	13	7,062	603	148.8%
Rehabilitation Center	65	9,007	495	38.0%
Sub-total - General Acute Care	**335**	**73,724**	**13,272**	**60.2%**
Skilled Nursing	29	6,312	659	59.6%
Hospital Total	**364**	**80,036**	**13,931**	**60.2%**

Source: OSHPD Annual Utilization Report of Hospitals, 1999 (including occupancy rates that were reported to be over 100 percent for the Intensive Care Newborn Nursery).

Utilization data reported to the Office of Statewide Health Planning and Development (OSHPD) for 2000 (and internally reported data for fiscal year 2001), show slight declines in most services, substantial decline in perinatal and neonatal, and some increase in rehabilitation and skilled nursing discharges and patient days.

Data filed by the Applicant indicate that the average daily census of inpatients at Memorial has fallen during fiscal year 2001, while emergency room visits have increased. Table 6 compares these statistics for 2000 and 2001 through the 11 months ended in May for these fiscal years.

Table 6
Selected Utilization Statistics
Daniel Freeman Memorial Hospital, 2000 and 2001

Service	Eleven Months Ended May 31,		Change
	2000	2001	
Average Daily Census			
Acute Services	120.7	112.3	-7%
Maternal/Child	36.8	30.5	-17%
Rehabilitation	25.0	23.0	-8%
Skilled Nursing	17.3	18.6	8%
Hospital	199.8	184.4	-8%
Deliveries	2,159	1,641	-24%
Emergency Department			
ER Patients Admitted	5,360	5,540	3%
Other ER Visits	30,924	33,113	7%
Total ER Visits	36,284	38,653	7%

Source: Daniel Freeman Hospitals, Inc.

Inpatient census at Memorial fell 8 percent in fiscal year 2001 to 184 patients. The largest declines were experienced in the maternal/child service. Emergency department volume, however, increased and exceeded 40,000 visits for the year.

Memorial provides a range of services, none of which is unique when compared to other hospitals nearby or within an area bounded roughly by Santa Monica, downtown, and Torrance. Services mentioned during interviews as especially important to the surrounding community include the following.

Emergency Services. Memorial's emergency room department (ER) is one of 81 ERs (down from 100 over the last decade) in Los Angeles County's Emergency Medical System (EMS). A Trauma Center until 1997, the department is a Basic ER experiencing rising volume. Paramedics bring 6,600 patients (about one per hour) annually to the ER. Two elements of the former Trauma Center, a helipad and a paramedic training program, remain in place, although the former rarely is used.

The Memorial ER serves two distinct and equally important needs. First, it is a component of the EMS through a "designated service area." A written (but not contractual) arrangement with the Los Angeles EMS Agency defines a geographic area around the hospital within which all 911 paramedic runs must be accepted. Under this arrangement, no paramedic runs from the defined area may be diverted by Memorial except for "internal disasters" and with the permission of the EMS Agency Director.

Only six other Los Angeles hospitals (Centinela is one of the six) have a similar, designated service area arrangement with the EMS Agency.

The importance of Memorial's ER to the EMS is suggested by the following indicators[8]:

- Memorial's emergency department is approved for pediatrics (EDAP designation).
- Memorial's emergency department ranks 13th among all Los Angeles Hospitals in number of 911 paramedic runs (7/99-6/00).
- In an internal point ranking by EMS of the importance of its 81 hospitals to the system, Memorial ranks in the top 40 percent.

The Memorial ER also provides, through an agreement with the City of Los Angeles, a Sexual Assault Response Team (SART) to treat victims of sexual assault. While physicians treat any physical injury, a trained SART nurse employed by Memorial provides counseling and referrals, collects evidence, and interacts with police. If emergency contraception (EC) is needed, a prescription to be filled at an off-site pharmacy is provided. Services are reimbursed by the City of Los Angeles.

According to EMS Agency officials, any decrease in Memorial's ER capacity would "seriously destabilize" paramedic and emergency service in a large area of west-central LA. The Agency sees no readily available, substitute capacity in the region.

Memorial's ER serves a second need: provision of ambulatory medical care to thousands of neighborhood residents who lack access to personal physicians. Some are Medi-Cal and Medicare beneficiaries. Reportedly, over 25 percent of visits are for uninsured patients. The Memorial ER, like many inner-city ERs, is the safety net medical provider in a large area distant from the nearest County operated facilities, Martin Luther King Medical Center (MLK) and Harbor Medical Center.

The ER has been staffed by the same physician group for many years under a contract with Memorial. Unlike many inner-city ERs, there reportedly is no trouble receiving needed consultation from the medical staff. Quality of care is monitored through voluntary participation in the nationwide Quality Indicator Project of the Maryland Hospital Association.

Maternal and Child Health. Maternal and Child Health (MCH) services at Memorial include the Maternity Center, labor and delivery, neonatal intensive care, and pediatric beds. The Maternity Center provides high-risk prenatal, labor, and delivery services, including midwifery. Midwifery reportedly is appealing to Latinas and their families.

Deliveries have declined in recent years, partly due to competition from a new unit opened in 2001 at Robert F. Kennedy Medical Center (RFK), as well as from Centinela. The majority of patients delivering at Memorial are covered by Medi-Cal. Private patients from Memorial's service area reportedly are delivered at Centinela and elsewhere in Los Angeles, especially Cedars-Sinai.

To accommodate the large number of high-risk births, Memorial has a Level II neonatal intensive care nursery (NICU) capable of saving babies weighing under 500 grams. Surgery is the only reason very low birth weight babies are referred to other Los Angeles

[8] Source: LA County EMS Agency.

hospitals. The NICU is staffed by a physician group that also covers the NICU at California Hospital. Audiology services in the NICU are provided by Memorial's long-established Audiology Department, whose strong relationships to local residents reportedly result in better compliance with hearing aids and other treatments for the hearing impaired.

Memorial serves older children in its 19 pediatric beds, a relative rarity in urban community hospitals. The service supports the ER's EDAP service and is said to be important especially during winter months, when acute respiratory illness rises among the young. The unit's low occupancy is typical for community-hospital inpatient pediatric beds.

Rehabilitation. Rehabilitation services are provided by the Daniel Freeman Memorial Centers for Rehabilitation. Three of the programs are certified by the Commission on Accreditation of Rehabilitation Facilities (CARF): the Comprehensive Inpatient Rehabilitation Program, the Pain Management Inpatient and Outpatient Program, and the Brain Injury Day Treatment Program. Approximately 60 percent of patients are outside referrals, including Kaiser patients paid under contract. Internally-generated referrals reportedly have declined, in part due to reduction in some of the specialties that traditionally refer patients for rehabilitation services.

Rehabilitation at Memorial enjoys a regional reputation for clinical excellence. However, clinical staff and facilities reportedly need upgrades to remain competitive and state-of-the-art, especially for neurosurgery.

Cardiac Care. Cardiology and cardiac surgery have been important and relatively large services at Memorial for many years. A Congestive Heart Failure (CHF) clinic is available to provide case management and to prevent crisis admissions. The cardiac surgery program performs fewer bypass surgeries than recommended by the American College of Cardiology and American Heart Association (200-300) but still achieves excellent outcomes. According to the recently published California Coronary Artery Bypass Graft (CABG) study, Memorial had the lowest risk-adjusted "observed to expected mortality rate" (.52) of any hospital reporting in Los Angeles County.

Cardiology services exemplify the interconnections that enable individual hospital departments to provide high quality care. Cardiology is a critical service supporting the ER, while cardiac surgery and the catheterization laboratory (cath lab) in turn support a comprehensive, high quality cardiology service. The cath lab itself relies on strong laboratory and radiology services.

Inpatient Services Market Analysis

The following characteristics are important to assess in evaluating the potential health impacts of a hospital transfer of ownership or acquisition on specific services:

- **Large Size.** Large inpatient services could be difficult to accommodate at alternative facilities, if the acquisition or transfer of ownership results in service closures.
- **High Market Share Overall or for Distinct Populations.** A relatively high market share indicates that the hospital provides a significant proportion of the care available to a service area population.

- **Low Out-Migration.** If few patients travel out of the service area for care, this indicates a relatively high reliance on local facilities. Alternatively, high levels of out-migration indicate that local facilities are being by-passed in favor of care elsewhere. This could occur because managed care channels patients out of an area, because local physicians prefer to hospitalize out of the area, because patients choose non-local hospitals, and for other reasons.
- **High Levels of In-Migration.** High levels of in-migration indicate that the hospitals have physicians or programs attractive to patients from a wide geographic area, either because alternatives are not readily available or because the programs have unique competencies and reputations that attract patients from remote areas.
- **High Dependence on Emergency Room Visits.** Programs with a high proportion of admissions through the emergency room would be most affected by any changes to the emergency room services resulting from a transaction.

We reviewed the Applicant's Health Impact Analysis and performed independent analyses to assess the relative importance of these factors to understanding inpatient use at Memorial and Marina. The following table presents our summary analysis of inpatient services offered at Memorial. Shaded cells are assigned to services with the above characteristics.

Table 7
Assessment of Inpatient Services Based on Inpatient Discharge Data by Service
Daniel Freeman Memorial Hospital, Calendar Year 1999

Service	Size	Overall Share	Special Population	Low Out-Migration	High In-Migration	ER Dependent	Overall Rating
Burns					■		
Cardiology	■		■	■		■	■
Cardiothoracic surgery		■	■				
Dental/oral surgery				■		■	
Dermatology				■	■		
Gastroenterology	■		■			■	
General medicine	■		■	■		■	■
General surgery	■		■			■	
Gynecology							
HIV services						■	
Medical oncology			■				
Neonatology	■		■				
Neurology	■		■	■		■	■
Neurosurgery						■	
Normal newborn	■	■	■	■			■
Obstetrics	■		■	■			
Ophthalmology						■	
Orthopedics							
Other services							
Otolaryngology						■	
Pediatrics	■		■			■	
Plastic surgery							
Psychiatry						■	
Rehabilitation	■	■	■	■	■		■
Rheumatology						■	
Substance abuse							
Surgical oncology					■		
Transplants							
Trauma				■		■	
Urology							
Vascular surgery			■				
Ventilator support				■		■	

Source: The Lewin Group, 2001.
Size = 500 or more discharges
Overall share = PSA market share exceeds 20 percent
Special population = PSA market shares by payer, service, and ethic cohort exceed 20 percent
Low outmigration = Over 40 percent of PSA and SSA residents receive care at PSA or SSA hospitals
High inmigration = Greater than 25 percent of Memorial's discharges are from non PSA or SSA residents
ER dependent = Greater than 50 percent of discharges originate in the Emergency Room

Findings leading to the results in Table 7 are discussed below.

The largest inpatient services in FY 1999 were as follows. These services are shaded in the previous table.

Service	Discharges
Obstetrics	3,043
General medicine	2,765
Normal newborn	2,223
Cardiology	1,354
Gastroenterology	813
Neonatology	707
Neurology	688
Pediatrics	614
General surgery	591
Rehabilitation	483

Source: The Lewin Group, 2001.

Memorial's share of the PSA market in 1999 was greater than 20 percent only for three services: rehabilitation (23%), cardiothoracic surgery (22%), and normal newborns (21%). However, when market shares are calculated by service, payer, and ethnicity, the hospital's role in serving African American and Medi-Cal consumers becomes more evident. Memorial's market shares exceeded 20 percent for the following services in this more detailed "special population" analysis.

Inpatient Services with Market Shares Greater than 20 Percent By Payer and Ethnicity
Daniel Freeman Memorial Hospital
1999

Payer	African American	Caucasian	Hispanic
Medi-Cal	Normal Newborn Obstetrics Neonatology Neurology Pediatrics	Normal Newborn Obstetrics Pediatrics	Normal Newborn Obstetrics Neonatology
Medicare	Cardiology Cardiothoracic surgery Gastroenterology General medicine General surgery Medical oncology Neurology Rehabilitation Vascular surgery	Cardiology Cardiothoracic surgery	
Private	Cardiology Medical Oncology		

Source: The Lewin Group, 2001.

A relatively small number of residents (below 60 percent) of the Memorial PSA left the area for services outside of the PSA or SSA. Services with relatively low levels of outmigration include ventilator support, rehabilitation, neurology, cardiology, dental/oral surgery, general medicine, normal newborn, dermatology, trauma, and obstetrics.

Conversely, a relatively high proportion of Memorial's rehabilitation, dermatology, and surgical oncology cases (more than 30 percent) traveled to the hospital from outside the PSA and SSA for care in 1999.

In 1999, 6,086 inpatients (or 38 percent of total) were first seen in Memorial's emergency room. Services with ER admissions comprising more than 50 percent of all inpatient cases are shown below.

Service	Admitted through ER	ER admissions percent of total
Substance abuse	16	89%
Psychiatry	19	86%
Ventilator support	124	83%
Dental/oral surgery	7	78%
Neurology	523	76%
Pediatrics	454	74%
General medicine	2,018	73%
Gastroenterology	597	73%
Cardiology	969	72%
HIV services	23	72%
Otolaryngology	38	67%
Trauma	24	63%
Neurosurgery	42	59%
Ophthalmology	13	59%
General surgery	315	53%

Source: The Lewin Group, 2001.

Based on the assessment summarized in Table 7, five Memorial inpatient services emerge as highly important for its service area populations: cardiology, general medicine, neurology, obstetrics, and rehabilitation. Also important are gastroenterology, general surgery, and pediatrics. These services, with the exceptions of rehabilitation and obstetrics, rely highly on the hospital's emergency room as the primary source for admissions. Thus if Tenet were to maintain the Memorial emergency room at its current scope, these services also would be important to maintain.

Outmigration Analysis

A large number of residents of the Memorial PSA sought inpatient services at hospitals located either in the secondary service area or elsewhere in Los Angeles. Tenet indicated that acquiring DFH, Inc. would provide it with the opportunity to reduce this outmigration.

Table 8 shows that only 29 percent of the residents of Memorial's PSA received inpatient care from the three hospitals located in the PSA. Another 10 percent were discharged

from one of the seven hospitals in Memorial's SSA. 60 percent of inpatients left the area for inpatient care at Kaiser hospitals, Cedars-Sinai, and other Los Angeles hospitals.

Table 8
PSA Resident Discharges by Location of Hospital Discharge
Daniel Freeman Memorial Hospital
1999

Payer	PSA Hospitals	SSA Hospitals	Other Hospitals	All PSA Cases
Payer				
Medi-Cal	7,597	4,444	14,067	26,108
Medicare	7,641	1,232	10,021	18,894
Private	4,117	301	15,384	19,802
Self pay	1,588	88	1,292	2,968
County	-	1,047	1,557	2,604
Other Government	70	262	981	1,313
Other	455	107	877	1,439
	21,468	7,481	44,179	73,128
Distribution				
Medi-Cal	29%	17%	54%	100%
Medicare	40%	7%	53%	100%
Private	21%	2%	78%	100%
Self pay	54%	3%	44%	100%
County	0%	40%	60%	100%
Other Government	5%	20%	75%	100%
Other	32%	7%	61%	100%
	29%	10%	60%	100%

Source: The Lewin Group, 2001.

Outmigration of PSA residents from the PSA and SSA was particularly high for patients with private insurance coverage, and was lower for self-pay, Medicare, and Medi-Cal consumers.

Table 9 shows the distribution of discharges for residents of Memorial's primary service area by hospital.

Table 9
Memorial PSA Resident Discharges by Hospital and Payer Source
Daniel Freeman Memorial Hospital
1999

	Medi-Cal	Medicare	Private	Self Pay	Other	Total
PSA Hospitals						
Daniel Freeman Memorial	4,826	3,587	2,140	218	55	10,826
Centinela Hospital	1,715	2,724	1,135	1,260	466	7,300
Robert F. Kennedy	1,056	1,330	842	110	4	3,342
Subtotal	7,597	7,641	4,117	1,588	525	21,468
SSA Hospitals						
L.A. County MLK/Drew	1,967	310	76	6	1,199	3,558
L.A. Metropolitan Medical Center	1,414	366	39	4	36	1,859
Memorial Hospital of Gardena	1,023	222	94	70	9	1,418
Midway Hospital Medical Center	22	190	113	4	11	340
Community Hospital of Gardena	18	103		3	7	131
Kedren Mental Health Center		2			125	127
Vencor Hospital - Los Angeles		39	8	1	-	48
Subtotal	4,444	1,232	330	88	1,387	7,481
Other Hospitals						
Kaiser - West L.A.	255	1,483	3,089	9	4	4,840
Cedars Sinai	892	707	2,106	88	78	3,871
L.A. County Harbor-UCLA	1,762	246	66	4	1,334	3,412
California Hospital Medical Center	1,903	571	229	122	54	2,879
L.A. County USC Medical Center	1,197	108	65	399	803	2,572
Little Company of Mary Hospital	451	462	1,119	35	33	2,100
St. Francis Medical Center - Lynwood	1,228	506	128	84	13	1,959
Torrance Memorial Medical Center	198	168	1,523	1	19	1,909
Kaiser - Harbor City	118	365	1,213	18	-	1,714
Kaiser - Sunset	92	378	918	5	-	1,393
UCLA Medical Center	292	369	664	13	35	1,373
Brotman Medical Center	232	847	127	50	17	1,273
Good Samaritan - L.A.	174	424	388	22	12	1,020
Subtotal	8,794	6,634	11,635	850	2,402	30,315
All other hospitals	5,273	3,387	3,720	442	1,042	13,864
Total	26,108	18,894	19,802	2,968	5,356	73,128

Source: The Lewin Group, 2001.

Capacity Analysis

The following tables analyze occupancy rates both with and without the availability of the licensed bed and emergency room capacity at Memorial. In these analyses, we assume that the inpatient and emergency room care provided at Memorial (based on OSHPD data from 1999) would be absorbed by other facilities located in the current Memorial primary and secondary service areas.

Table 10
Licensed Bed Capacity in Memorial's Primary and Secondary Service Areas
With and Without Availability of Daniel Freeman Memorial Hospital
1999

Licensed Bed Category	PSA and SSA Licensed Beds		PSA and SSA Average Daily Census	Area Occupancy Rates	
	Including Memorial	Excluding Memorial		Including Memorial	Excluding Memorial
Medical/Surgical Acute	1,249	1,068	597	48%	56%
Perinatal	200	168	71	36%	42%
Pediatric Acute	87	68	33	37%	48%
Intensive Care	123	110	69	56%	62%
Coronary Care	45	33	28	62%	84%
Intensive Care Newborn Nursery	66	53	53	80%	100%
Rehab Center	99	34	45	46%	133%
Acute Psychiatry	234	234	110	47%	47%
Skilled Nursing	197	168	119	61%	71%
Total	2,300	1,936	1,125	49%	58%

Source: The Lewin Group, 2001

Table 10 indicates that if Memorial closed, the number of licensed beds in the combined PSA and SSA region served by the hospital would decline from 2,300 to 1,936. If all inpatient care that had been provided at Memorial shifted to other area hospitals, occupancy rates would increase from 49 percent to 58 percent. For two services, intensive care newborn nursery and rehabilitation, there would not be sufficient licensed bed capacity in the area to accept Memorial's volume, unless certain hospitals in the area converted current unused medical/surgical beds accommodate these patients.

Regarding Emergency Room care, we prepared the following analysis to demonstrate the impact of closing the Memorial Emergency Room.

Table 11
Emergency Room Visit Capacity in Memorial's Service Areas
With and Without Availability of Memorial's Emergency Room
1999

		Visits	Stations	Capacity	Capacity Utilization
Memorial PSA					
	With Memorial	88,792	50	100,000	89%
	Without Memorial	88,792	34	68,000	131%
Memorial PSA + SSA					
	With Memorial	187,937	101	202,000	93%
	Without Memorial	187,937	85	170,000	111%

Source: The Lewin Group, 2001.

Capacity is estimated based on an assumed 2,000 visits per emergency room station (or bed)[9]. If Memorial closed, ER capacity remaining in the two other hospitals in the PSA (Memorial and RFK, a combined 34 stations) would not be sufficient to accommodate Memorial's ER volume. A large number of patients would need to travel to hospitals located in the SSA or elsewhere in Los Angeles to access emergency room services.

Travel times between Memorial and the two other PSA hospitals are approximately six to eight minutes[10]. Travel times between Memorial and the SSA hospitals range from 19 minutes (to MLK, which currently is operating at capacity) to 28 minutes (to Midway Hospital Medical Center).

Daniel Freeman Marina Hospital

The Sisters of St. Joseph of Carondelet purchased Daniel Freeman Marina Hospital, formerly known as Marina Mercy Hospital, in 1980. The Marina Hospital occupies a site of about 8 acres. It is a 166 licensed bed facility, with the majority of beds classified as either medical, surgical or acute psychiatric. As shown in Table 12, occupancy rates are highest for acute psychiatric and intensive care beds.

[9] Based on the Applicant's Health Impact Assessment. The Lewin Group discussed this statistic with a healthcare architectural and space planning firm, which confirmed 2,000 to be reasonable for planning purposes.

[10] Determined using www.MapQuest.com. Travel times can vary significantly depending on traffic conditions.

Table 12
Selected Capacity and Utilization Statistics
Daniel Freeman Marina Hospital, 1999

Licensed Bed Classification	Licensed Beds	Patient Days	Hospital Discharges	Licensed Bed Occupancy Rate
Medical/Surgical Acute	93	11,182	2,679	32.1%
Intensive Care	12	3,018	286	68.9%
Acute Psychiatric	40	9,808	1,167	70.5%
Skilled Nursing	21	4,963	478	64.7%
Hospital Total	166	28,971	4,610	47.6%

Source: OSHPD Annual Utilization Report of Hospitals, 1999 (including occupancy rates).

Fifteen of Marina's general acute beds are used for chemical dependency recovery services. Marina handled approximately 19,000 emergency room visits in 1999. Other area hospitals provide all of the services that are offered at Marina; many specialty services including obstetrics, neonatal intensive care, trauma care, and cardiac catheterization are not available at the hospital. Most inpatient acute care at Marina is associated with emergency room utilization, and thus the hospital reports a number of cardiology, neurology, and general medicine admissions.

Data filed by the Applicant indicate that, like Memorial, the average daily census of inpatients at Marina also has fallen during fiscal year 2001, while emergency room visits have increased. Table 13 compares these statistics for 2000 and 2001 through the 11 months ended in May for these fiscal years.

Table 13
Selected Utilization Statistics
Daniel Freeman Marina Hospital, 2000 and 2001

Service	Eleven Months Ended May 31,		Change
	2000	2001	
Average Daily Census			
Acute Services	37.0	33.3	-10%
Substance Abuse	9.7	9.4	-3%
Mental Health	28.4	26.1	-8%
Transitional Rehab Center (SNF)	13.1	12.8	-2%
Hospital	88.2	81.6	-7%
Emergency Department			
ER Patients Admitted	2,553	2,601	2%
Other ER Visits	15,897	16,800	6%
Total ER Visits	18,450	19,401	5%

Source: Daniel Freeman Hospitals, Inc.

The average daily census of acute care patients fell by 10 percent from 37.0 to 33.3 during the recently completed fiscal year. Marina provided more than 20,000 emergency room visits during 2001, an increase from 19,000 in 1999.

Emergency Services. While Marina residents often utilize other hospitals for acute inpatient care, many rely on the Basic ER at Marina Hospital for emergency services. Over one-fourth of emergency room visits are for individuals residing outside of Marina's primary or secondary service areas. These visits have been growing in recent years. In 1999, 46 percent of emergency medical services were for non-urgent care, while approximately 16 percent resulted in admission to the hospital. ER services are provided by a physician group employed exclusively at the Marina Hospital.

Rehabilitation. Marina's 20-bed Transitional Rehabilitation Center comprises skilled nursing beds for rehabilitation patients of lower acuity than those at Memorial. Marina also offers outpatient physical rehabilitation services. The Transitional Rehabilitation Center is directed by the Chief of the Centers at Memorial. Most of the patients receiving rehabilitation services at Marina are orthopedic patients.

Behavioral Health. The Behavioral Health services at Marina includes chemical dependency and psychiatric services provided in 15 chemical dependency and 40 acute psychiatric beds. The average daily census for chemical dependency is about 9 and for psychiatry approximately 22. The chemical dependency unit is an "open unit" which means that individuals are placed there voluntarily and are often residents of the Marina Del Rey area. The psychiatric unit at Marina is a locked unit that can accept involuntary patients (including 5150 cases). Some psychiatry patients are found by "psychiatric emergency teams" who collaborate with law enforcement.

Behavioral Health services are managed by Universal Health Services, a for-profit hospital chain and program manager. Universal provides a clinical and administrative team, as well as the Medical Director.

Table 14 summarizes our assessment of Marina's inpatient services. The table indicates that the psychiatry and substance abuse services are relatively important, but also serve a large number of patients from outside Marina's primary and secondary service areas. The other relatively highly ranked acute inpatient services, cardiology, neurology, gastroenterology, general medicine, rheumatology, and ventilator support reflect usage of Memorial's emergency room (and subsequent admission) by Medicare and privately insured patients.

Table 14
Assessment of Inpatient Services Based on Inpatient Discharge Data by Service
Daniel Freeman Marina Hospital, Calendar Year 1999

Service	Size	Overall Share	Special Population	Low Out-Migration	High In-Migration	ER Dependent	Overall Rating
Cardiology							
Cardiothoracic surgery							
Dental/oral surgery							
Dermatology							
Gastroenterology							
General medicine							
General surgery							
Gynecology							
HIV services							
Medical oncology							
Neonatology							
Neurology							
Neurosurgery							
Normal newborn							
Obstetrics							
Ophthalmology							
Orthopedics							
Other							
Otolaryngology							
Pediatrics							
Plastic surgery							
Psychiatry							
Rehabilitation							
Rheumatology							
Substance abuse							
Surgical oncology							
Transplants							
Trauma							
Urology							
Vascular surgery							
Ventilator support							

Source: The Lewin Group, 2001.
Size = 500 or more discharges
Overall share = PSA market share exceeds 20 percent
Special population = PSA market shares by payer, service, and ethic cohort exceed 20 percent
Low outmigration = Over 40 percent of PSA and SSA residents receive care at PSA or SSA hospitals
High inmigration = Greater than 25 percent of Marina's discharges are from non PSA or SSA residents
ER dependent = Greater than 50 percent of discharges originate in the Emergency Room

Table 15 shows that outmigration was pronounced from Marina's primary service area during 1999. Approximately 50 percent of inpatient care for residents of Marina's primary service area was delivered by hospitals outside of the PSA or SSA. Medi-Cal outmigration from the area was high in part because Marina does not provide services for obstetrics or pediatrics patients.

Table 15
PSA Resident Discharges by Location of Hospital Discharge
Daniel Freeman Marina Hospital
1999

Payer Category		PSA Hospitals	SSA Hospitals	Other Hospitals	All PSA Cases
Payer					
	Medi-Cal	102	520	1,987	2,609
	Medicare	1,061	2,443	2,593	6,097
	Private	838	4,487	3,647	8,972
	Self pay	134	182	334	650
	County	–	2	349	351
	Other Government	–	15	187	202
	Other	16	46	199	261
		2,151	7,695	9,296	19,142
Distribution					
	Medi-Cal	4%	20%	76%	100%
	Medicare	17%	40%	43%	100%
	Private	9%	50%	41%	100%
	Self pay	21%	28%	51%	100%
	County	–	1%	99%	100%
	Other Government	–	7%	93%	100%
	Other	6%	18%	76%	100%
		11%	40%	49%	100%

Source: The Lewin Group, 2001.

Table 16 shows the distribution of discharges for residents of Marina's primary service area by hospital and payer category. In 1999, Santa Monica – UCLA and St. John's Hospital each admitted more inpatients from Marina's primary service area than Marina.

Table 16
PSA Resident Discharges by Hospital and Payer Source
Daniel Freeman Marina Hospital
1999

	Medi-Cal	Medicare	Private	Self Pay	Other	Total
PSA Hospitals						
Daniel Freeman Marina	102	1,061	838	134	16	2,151
SSA Hospitals						
Santa Monica - UCLA	188	335	1,972	25	10	2,530
St. John's Hospital	2	904	1,232	53	17	2,208
Kaiser - West L.A.	22	497	823	2	1	1,345
Daniel Freeman Memorial	215	491	284	21	1	1,012
Centinela Hospital	58	169	102	80	33	442
Robert F. Kennedy	31	26	69	1	1	128
Vencor Hospital - Los Angeles	4	21	5	-	-	30
Subtotal	520	2,443	4,487	182	63	7,695
Other Hospitals						
UCLA Medical Center	646	394	958	23	27	2,048
Cedars Sinai	169	476	1,101	52	22	1,820
Brotman	181	868	244	55	10	1,358
L.A. County Harbor-UCLA	177	21	4	-	295	497
Subtotal	1,173	1,759	2,307	130	354	5,723
All other hospitals	814	834	1,340	204	381	3,573
	2,609	6,097	8,972	650	814	19,142

Source: The Lewin Group, 2001.

Table 17
Licensed Bed Capacity in Marina's Primary and Secondary Service Areas
With and Without Availability of Daniel Freeman Marina Hospital
1999

Licensed Bed Category	PSA and SSA Licensed Beds		PSA and SSA Average Daily Census	Area Occupancy Rates	
	Including Marina	Excluding Marina		Including Marina	Excluding Marina
Medical/Surgical Acute	1,359	1,266	649	48%	51%
Perinatal	134	134	79	59%	59%
Pediatric Acute	61	61	18	30%	30%
Intensive Care	134	122	76	57%	62%
Coronary Care	34	34	8	24%	24%
Intensive Care Newborn Nursery	42	42	37	88%	88%
Rehab Center	99	99	45	46%	46%
Acute Psychiatry	111	71	66	59%	93%
Skilled Nursing	176	155	116	66%	75%
Total	2,150	1,984	1,094	51%	55%

Source: The Lewin Group, 2001.

Table 17 indicates that if Marina closed, the number of licensed beds in the combined PSA and SSA region served by the hospital would decline from 2,150 to 1,984. The area might have difficulty serving all of Marina's acute psychiatry inpatients particularly during peak periods, unless existing capacity is converted to accept psychiatric patients.

Table 18
Emergency Room Visit Capacity in Marina's Service Areas
With and Without Availability of Marina's Emergency Room
1999

		Visits	Stations	Capacity	Capacity Utilization
Marina PSA					
	With Marina	19,048	8	16,000	119%
	Without Marina	19,048	–	68,000	–
Marina PSA + SSA					
	With Marina	231,000	116	232,000	100%
	Without Marina	231,000	108	216,000	107%

Source: The Lewin Group, 2001.

Table 18 shows that if Marina closed, patients would need to travel to hospitals located in the SSA or elsewhere in Los Angeles for emergency room services. Travel times between Marina and six hospitals in the SSA (including Memorial) range from 13 minutes (to Memorial) to 19 minutes (to St. John's)[11].

[11] Determined using www.MapQuest.com. Travel times can vary significantly depending on traffic conditions.

Chapter 4: Daniel Freeman Hospitals, Inc. Finances, Charity Care, Community Benefits and Quality Measurement

Chapter 5 discusses several issues relevant to the potential health impacts of the acquisition of Daniel Freeman Hospitals, Inc. by Tenet Healthcare, including

- the financial condition of DFH, Inc. and the impact of the hospitals' financial performance on Carondelet Health System,
- charity care and community benefit services historically provided by DFH, Inc.,
- hospital quality measurement, and
- concerns about hospital staffing raised during the study.

The discussion that follows informs the recommendations provided in Chapter 6.

Financial Condition of Daniel Freeman Hospitals, Inc.

The Lewin Group has performed an independent review of the financial condition of the DFH, Inc. to assess the urgency of the proposed sale. Audited financial statements indicate an organization in severe financial distress. Table 19 shows total operating revenue, operating expenses, operating losses, and total losses reported by Memorial, Inc. during fiscal years 1998 through 2001.

Table 19
Revenues, Expenses, and Losses
Daniel Freeman Hospitals, Inc.
FY 1998-2001

($millions)	1998	1999	2000	2001
Operating revenue	$208.5	$206.6	$193.5	$183.8
Operating expenses	213.6	215.6	206.0	207.7
Operating loss	(5.1)	(9.0)	(12.5)	(23.9)
Impairment and extraordinary losses	(5.8)	-	-	(18.2)
Non operating items	(2.6)	(0.4)	2.2	(0.1)
Total loss	(13.5)	(9.4)	(10.3)	(42.2)

Source: Lewin Group 2001, based on Audited Financial Statements, 1998 through 2001.

A number of factors have contributed to the declining financial performance at the hospitals. These include:

- A weak market position for the hospitals, leading to limited leverage with managed care organizations. The hospitals are competing locally with well-organized hospital systems, including Tenet Healthcare, and other prominent Los Angeles hospitals (e.g., Cedars Sinai, UCLA, and others) that draw many patients from the areas served by the two hospitals.

- Managed care contracts with reimbursement rates below the cost of care, and higher than anticipated costs for managed care contracts under which the hospitals assumed financial risk.
- Limited access to capital, making it difficult to maintain the hospitals' appearance and to attract and retain medical staff.
- Declining inpatient care volume.
- A lack of expense controls.
- Heavy reliance of the hospitals on public payers (Medi-Cal and Medicare, whose payments were reduced under the Balanced Budget Act of 1997).
- Below industry-standard financial reporting, leading to incomplete understanding of (and optimism about) the true financial standing and performance of the hospitals.
- Overly optimistic revenue and accounts receivable accounting, which required negative revenue adjustments by the hospitals' auditors of $5.1 million in 1999 and $5.7 million in 2000 (Operating losses would have been reduced by these amounts if prior year revenue had been stated correctly).
- Below industry-standard billing and accounts receivable practices.
- The acquisition of Prairie Medical Group, which resulted in a $15 million write-off of goodwill during FY 2001.
- A decline in Medi-Cal disproportionate share (DSH) funding in 2001 to $6.4 million, from the $9.3 million average from the prior three fiscal years.
- Other factors identified in various third-party reports, including Cambio's assessment.

As shown in Table 20, DFH, Inc.'s liabilities exceeded its assets by more than $35 million at the end of FY 2001. Ongoing losses have required working capital loans from the Carondelet Health System and the Sisters of St. Joseph of Carondelet local Province during the latest fiscal year to meet payroll and other obligations.

Table 20
Assets, Liabilities and Net Assets
Daniel Freeman Hospitals, Inc.
FY 1998-2001

($millions)	1998	1999	2000	2001
Total assets	$153.5	$145.5	$140.0	$116.7
Total liabilities	129.8	131.1	135.2	152.6
Net assets	23.7	14.4	4.8	(35.9)

Source: Lewin Group 2001, based on Audited Financial Statements, 1998 through 2001.

Capital spending at the hospitals has been minimal in recent years. As shown in Table 21, building and equipment expenditures ($15.5 million) have been well below

depreciation and amortization expense ($45.6 million – a proxy for the amount of capital expenditure needed for maintenance purposes) for the last four years. The hospitals reportedly require a total of over $100 million to meet capital needs associated with SB 1953 compliance and ongoing operations[12]:

- An estimated $70 million for facility upgrades at the Memorial campus to comply with SB 1953 seismic upgrades, and another $5 million at Marina.
- Memorial needs $10 million in new equipment and $10 million in replacement equipment; Marina needs another $2.8 million.

Current DFH, Inc. management indicates that capital expenditure needs may exceed $150 million for the two hospitals.

Table 21
Capital Spending and Depreciation Expense
Daniel Freeman Hospitals, Inc.
FY 1998-2001

($millions)	1998	1999	2000	2001
Capital expenditures	$1.8	$4.3	$7.0	$2.4
Depreciation and amortization expense	12.1	11.2	11.3	11.0

Source: Lewin Group 2001, based on Audited Financial Statements, 1998 through 2001.

Both hospitals require significant seismic upgrading by 2008, as shown in Table 22. Memorial appears to be in greater compliance with seismic standards than the nearby Tenet hospitals.

[12] Cambio Healthcare Solutions, LLC.

Table 22
Seismic Condition of Memorial and Selected Tenet Healthcare Facilities

Hospital	Total Buildings	Acute Care Licensed Beds	Number of Buildings		
			SPC-1	SPC-2	SPC-3+
Daniel Freeman Memorial	8	335	1	5	2
Daniel Freeman Marina	3	105	1	2	0
Centinela Hospital Medical Center	10	348	9	0	1
Brotman Medical Center	3	341	3	0	0
Midway Hospital Medical Center	4	204	3	0	1

Source: Office of Statewide Health Planning and Development, 2001.

SPC-1: These buildings pose a significant risk of collapse and a danger to the public after a strong earthquake. These buildings must be retrofitted, replaced or removed from acute care service by January 1, 2008.

SPC-2: These are buildings do not significantly jeopardize life, by may not be repairable or functional following strong ground motion. These buildings must be brought into compliance with the Alquist Act by January 1, 2020 or be removed from acute care service.

SPC-3,4,5: These buildings may be used to 2030 and beyond.

As shown in Table 23, liabilities and debts at the hospitals have grown in recent years. Debt stood at $97.3 million at the end of FY 2001, and accounts payable and other short-term liabilities were approximately $39.0 million. Long term debt and most liabilities would not be assumed by Tenet Healthcare upon acquisition, but would be retained by the Carondelet Health System and offset by the purchase proceeds and other CHS resources over time.

Table 23
Selected Liabilities and Long Term Debt
Daniel Freeman Hospitals, Inc.
FY 1998-2001

($millions)	1998	1999	2000	2001
Current liabilities[13]	$37.8	$33.7	$43.6	$51.7
Accounts payable and accrued liabilities	25.9	19.8	33.2	39.0
Long term debt	83.4	83.6	80.7	7.4
Current debt maturities	4.4	9.5	7.7	89.9
Total debt	87.8	93.1	88.4	97.3

Source: Lewin Group 2001, based on Audited Financial Statements, 1998 through 2001.

Table 24 shows DFH, Inc.'s long term debt balances at the end of fiscal years 2000 and 2001. The $75.4 million bond issue that was due on July 1, 2001 was refinanced by the Carondelet Health System on June 21, 2001. This debt now is the obligation of CHS and its other constituent hospitals. At the time the refinancing was completed, a note was established between DFH, Inc. and CHS, payable on the demand of CHS. Thus the debt, while refinanced, remains an obligation of DFH, Inc. to be paid from the proceeds of the sale to Tenet, from accounts receivable that would be collected by DFH, Inc. after the sale, and from other resources.

The table also shows that DFH, Inc. has borrowed substantial working capital funds from CHS and from the Sisters of St. Joseph of Carondelet. The debts total $97.4 million, an amount that exceeds the $55 million purchase price and the value of the other various assets retained by DFH, Inc. after the sale.

[13] Excluding current maturities of long-term debt and of capital lease obligations.

Table 24
Year-End Short Term and Long Term Debt Balances
Daniel Freeman Hospitals, Inc.
FY 2000-2001

Obligation ($millions)	2000	2001	Comments
Taxable series 1997 bonds	$75.4	-	Repaid on June 21, 2001 by CHS.
Intercompany note payable to CHS	-	$75.4	Due on demand by CHS.
CHS commercial paper	4.7	9.5	For working capital needs.
Note payable to CHS	-	2.0	Due on demand by CHS.
Note payable to Sisters of St. Joseph of Carondelet	-	5.0	Due November 2010. First six months interest free.
Note payable to CHS	1.8	1.7	For working capital needs.
Other	1.8	0.6	
Subtotal	83.8	94.2	
Capital lease obligations	4.6	3.2	
Total	88.4	97.4	

Source: Lewin Group 2001, based on Audited Financial Statements, 1998 through 2001.

The Official Statement for debt issued to refinance the 1997 bond issue includes the following disclaimer regarding the sale:

> *CHS management estimates that the sale proceeds and final liquidation of retained assets and liabilities may result in a net deficit, leaving some amounts loaned to the Hospitals as unpaid, which will remain the responsibility of the Obligated Group Members or other Constituent Corporations. Upon final liquidation and wind-up of the Hospitals' operations, the Obligated Group Members or other Constituent Corporations may make net asset transfers to the Hospitals or to CHS, or pay assessments to CHS in order to service any remaining unpaid amounts*[14].

In our assessment, DFH, Inc. does not have the ability to raise new debt from the capital markets due to its poor financial performance and current financial position. CHS is not likely to advance funding to the hospitals, since the only source for these proceeds would be other hospitals in the CHS system which have their own capital and operating requirements. Other CHS hospitals already have advanced funds to DFH, Inc. and have accepted responsibility for the $75 million bond issue and are not likely to advance additional resources if sale is not accomplished.

We conclude that sale of the two DFH, Inc. hospitals to a buyer with access to adequate capital is necessary if the hospitals are to continue operating.

[14] Official Statement.

Impact of DFH, Inc. Financial Distress on CHS

CHS assists its member hospitals by consolidating services such as purchasing, insurance and employee benefit programs, financial planning, personnel services, and human resources. Overall, CHS can be described as a "decentralized" system that relies heavily on member hospital boards for independent decision-making. The system maintains minimal resources and reserves at the central-office level. If one hospital experiences financial difficulties, other hospitals in the CHS system can share resources to assist with these obligations, if available.

Financial difficulties at DFH, Inc. have affected the CHS and its constituent hospitals. On February 12, 2001, Standard & Poor's downgraded CHS debt from 'A-' to 'BBB+' based in part on "significant operating issues at the system's Los Angeles, California facilities."[15] In issuing this downgrade, the S&P analyst included the following comments:

> *Management is taking strong steps to reverse the losses at Daniel Freeman, including engaging consultants and replacing senior management, but several factors limit CHS' potential success in this market. First, there is significant competition from other hospitals, and their lack of market dominance in this area has limited Daniel Freeman's leverage in contract negotiations. In addition, DF's Marina and Memorial hospitals are located far enough away that it does not allow them to achieve meaningful enough economies of scale. Some of these issues could most likely only be addressed if DF hospitals were part of a larger provider network in this region. Given these limitations, management is re-assessing the logic of its presence in this market. While efforts to reduce costs and improve financial performance are continuing, management is also evaluating its options with regard to these facilities.*[16]

As shown in Table 25, without DFH Inc., CHS would have reported positive total income in FY 2000. DFH Inc. generated 19 percent of total operating revenue for the system, 42 percent of the operating losses, and 44 percent of the charity care charges.

[15] Standard & Poor's Corporation, RatingsDirect, February 12, 2001.
[16] *Ibid.*

Table 25
Summary Financial Information for CHS and DFH, Inc.
FY Ended June 30, 2000

($millions)	CHS	DFH
Operating revenue	995.2	193.5
Operating expenses	1,024.8	206.0
Operating loss	(30.0)	(12.5)
Non operating items	23.4	2.2
Total loss	6.7	(10.3)
Total Assets	1,027.0	140.0
Total Liabilities	579.3	135.2
Net Assets	447.8	4.8
Long Term Debt	375.4	88.4
Charity Care Charges	19.6	8.6

Source: Lewin Group 2001, based on Audited Financial Statements, 1998 through 2001.

At the end of FY 2001, DFH, Inc. reported net assets of negative $35.9 million. This negative balance would increase to at least negative $57 million and potentially to $73 million (if Tenet claims escrow accounts established as part of the transaction) if the sale is completed based on current terms. CHS and its other constituent hospitals would absorb and fund this loss through time and would be responsible for liabilities remaining in DFH, Inc. after closing.

Charity Care

The reported dollar value of patient care charges assigned to "charity care" for Memorial and Marina varies substantially by data source and over time.

OSHPD defines *charity care* by contrasting charity care and bad debt. According to OSHPD, "the determination of what is classified as ... charity care can be made by establishing whether or not the patient has the ability to pay. The patient's accounts receivable must be written off as bad debt if the patient has the ability but is unwilling to pay off the account." All hospitals are required to maintain written documentation regarding their charity care criteria and to maintain written documentation regarding all charity care determinations.

Table 26 provides charity care charges for the last several fiscal years from audited financial statements and from filings with OSHPD.

Table 26
Charity Care Charges Reported to Various Sources
Daniel Freeman Memorial and Marina Hospitals
1998-2001

Charity Care Charges	1998	1999	2000	2001	Average[17]
Audited Financial Statements	$5,238,000	$3,648,000	$8,632,000	$6,687,000	$6,051,250
Asset Purchase Agreement Schedule 10.5					
Memorial	3,345,000	2,190,000	5,453,000		3,662,667
Marina	1,893,000	1,458,000	3,179,000		2,176,667
DFH, Inc.	5,238,000	3,648,000	8,632,000		5,839,333
Memorial % of DFH	64%	60%	63%		63%
Original OSHPD Reports					
Memorial	3,644,552	2,785,676	8,178,938		4,869,722
Marina	2,488,832	1,932,879	4,046,632		2,822,781
DFH, Inc.	6,133,384	4,718,555	12,225,570		7,692,503
Memorial % of DFH	60%	59%	67%		63%
Audits / Original OSHPD	85%	77%	71%		76%
Final OSHPD Reports					
Memorial	15,969,197	15,858,001	NA[18]		15,913,599
Marina	2,488,832	1,932,879	3,948,534		2,790,082
DFH, Inc.	18,458,029	17,790,880			18,703,681
Memorial % of DFH	87%	89%	NA		85%

Sources: Source: The Lewin Group, 2001, based on DFH, Inc. audited financial statements, the Asset Purchase Agreement, and OSHPD disclosure reports.

According to the hospitals' audited financial statements, charity care charges averaged approximately $6.0 million over the last four fiscal years, with 63 percent of this total provided by Memorial. Schedule 10.5 of the Asset Purchase Agreement indicates that Tenet would commit to maintaining charity care at Memorial and Marina (for as long as the hospitals are operated) based on the audited financial statement results.

"Original" Disclosure Reports filed with OSHPD indicate that charity care charges averaged approximately $7.7 million over the three fiscal years ended June 30, 2000, with 63 percent of this total provided by Memorial. The "original" reports are those filed

[17] Calculated over the number of years for which data are available in the table.
[18] FY 2000 has not yet been audited. Minor revisions were submitted for Marina.

within a few months of the end of each fiscal year, before they are revised by the hospitals as allowed by OSHPD regulations. Over the three years, charity care reported in the Audited Financial Statements was approximately 76 percent of the amount included in the Original OSHPD Disclosure Reports.

Both the Audited Financial Statements and the Original OSHPD Disclosure Reports primarily include "traditional charity care charges" for patients whose inability to pay is determined at or shortly after the time they register with the hospitals as inpatients or outpatients. The Audited Financial Statements and Original OSHPD Disclosure Reports are completed at different times, with the audits completed before the Disclosure Reports are filed with the State of California.

Because Memorial has qualified for Medi-Cal disproportionate share funds, DFH, Inc. has submitted revised, "Final" OSHPD Disclosure Reports. The revisions resulted in a substantially higher amount of reported charity care for fiscal years 1998 and 1999, and thus higher Medi-Cal DSH revenues. Revisions to FY 2000 have not yet been submitted.

The "Final OSHPD Reports" for Memorial include the following categories of adjustments allowed by OSHPD that increased the reported charity care amounts for fiscal years 1998 and 1999.

- **Reclassification of Medi-Cal charges.** Charges originally assigned to Medi-Cal were reclassified by the hospital to charity care, either because (a) services provided for Medi-Cal beneficiaries were determined not to be covered by Medi-Cal benefits or because (b) patient accounts originally billed to Medi-Cal were denied by the State (or Medi-Cal managed care plans) because patients were determined to be ineligible for the program.
- **Adjustments to the Audited Financial Statements.** An under-reporting of traditional charity care charges in the audited financial statements was found and corrected in the OSHPD reports.
- **Patient Care Programs for Low-Income Consumers.** Charges for specific patient care programs for "vulnerable populations" were reclassified to charity care. These community benefit programs are allowed to be assigned to charity care by OSHPD because they are designed for vulnerable, low-income patients[19].

The Final OSHPD Reports thus supplement "traditional charity care" by adding charges for Medi-Cal denials (and uncovered services) and for selected patient care programs designed for low-income consumers. For all of these data sources, charity care charges are calculated based on the hospitals' gross prices, rather than estimated cost or net revenue collections.

Table 27 shows the adjustments that were made to the FY 1998 and 1999 reports by Memorial's OSHPD Disclosure Report consultants. The adjustments added $12.3 million and $13.1 million to reported charity care charges in those years, thereby qualifying the hospital for an increased level of DSH funding.

[19] Source: Memorial's OSHPD Disclosure Report consultant. Additional details regarding the patient care programs included in the adjustments to be provided after November 1, 2001.

Table 27
Adjustments to Charity Care Charges in OSHPD Disclosure Reports
Daniel Freeman Memorial Hospital
1998-1999

Charity Care Charges ($millions)		1998	1999
Original OSHPD Reports			
	Memorial	$3.6	$2.8
Adjustments			
	Services provided to Medi-Cal patients not covered by Medi-Cal or denied	4.0	4.1
	Correction to reflect the audited financial statements	-	2.2
	Health care services "provided to targeted vulnerable populations"[20]	8.3	6.7
Final OSHPD Reports		15.9	15.8

Source: Provided by Memorial's OSHPD Disclosure Report consultants.

Based on the data in Tables 26 and 27, we conclude that "traditional charity care" charges at DFH, Inc. based on audited financial statements averaged approximately $6.0 million annually. Traditional charity care based on the initially filed OSHPD Disclosure Reports averaged $7.7 million annually. Charity care after adding Medi-Cal denials and charges for specific patient programs for vulnerable populations averaged $18.7 million.

The dollar values for charity care reported above represent "gross patient care charges" that have been assigned (or "written off") to this category rather than the actual cost of services provided for the hospitals' charity patients. While most hospitals (and OSHPD) generally account for charity care based on gross charges, this accounting convention creates measurement problems both when comparing hospitals and when evaluating trends and changes in the actual level of charity care provided. For example, a hospital can increase its reported charity care charges simply by implementing price increases in its "charge master." One hospital can appear to have higher charity care than another because it has a higher "markup" of charges compared to costs.

A growing number of healthcare organizations (including Catholic facilities) are determining the actual cost of charity care patients by multiplying charity care charges by ratios of costs to charges. Table 28 shows this ratio for Memorial and Marina for the last four fiscal years.

[20] As defined by DFH, Inc.'s OSHPD Disclosure Report consultants.

Table 28
Ratio of Cost to Charges
Memorial and Marina Hospitals
1998-2001

	1998	1999	2000	2001
Ratio of cost to charges				
Memorial	0.36	0.32	0.32	0.29
Marina	0.37	0.34	0.33	0.30

Source: The Lewin Group, 2001 based on OSHPD filings and interim (May 2001) unaudited financial statements for Memorial and Marina. Gross charges include (and operating expenses exclude) bad debts.

This ratio in Table 28 is calculated as follows:

$$\frac{\text{Total Operating Expenses (Excluding Bad Debt)}}{\text{Gross Patient Charges + Other Operating Revenue}}$$

Although other formulas are possible, we used this ratio because it is consistent with the methodology used by the American Hospital Association (AHA) and the Medicare Payment Advisory Commission (MedPAC) to evaluate the financial performance of hospitals in the United States. An alternative formula, (Total Operating Expenses – Other Operating Revenue) / Gross Patient charges, results in a slightly lower ratio of cost to charges for the hospitals.

The ratio presented in Table 28 indicates that gross charges at the hospitals increased faster than operating expenses over the last several years, leading to a declining ratio of cost to charges.

Establishing future expectations for the charity care services at Memorial and Marina assuming Tenet acquires the hospitals is challenging. During interviews, Tenet representatives indicated that they plan to implement improved Medi-Cal eligibility determination procedures. Cambio also recognized this need, encouraging the hospital to hire staff to assist patients with Medi-Cal applications. Tenet Healthcare also may implement additional cost containment initiatives to improve the performance of Marina and Memorial hospitals. The transaction itself will change the cost structure of the hospitals, for example eliminating interest expense ($5.5 million) but adding taxes to be paid by the newly for-profit hospitals.

The following analysis estimates charity care costs at Memorial and Marina based on average charges for fiscal years 1998 through 2001 and the most recent ratio of cost to charges for the hospitals.

Table 29
Estimated Cost of Charity Care Provided Historically by DFH, Inc.

Charity Care		Memorial	Marina	Combined
Average charity charges (see Table 26)				
	Traditional Charity Care (Based on Audits)	3,662,667	2,176,667	5,839,333
	Traditional Charity Care (Original OSHPD)	4,869,722	2,822,781	7,692,503
	Adjusted Charity Care	15,913,599	2,790,082	18,703,681
Ratio of cost to charges (see Table 28)		0.29	0.30	0.29
Charity care costs				
	Traditional Charity Care (Based on Audits)	1,062,173	653,000	1,715,173
	Traditional Charity Care (Original OSHPD)	1,412,219	846,834	2,259,053
	Adjusted Charity Care	4,614,944	837,025	5,451,969

Source: The Lewin Group, 2001.

The cost of traditional charity care ranges from $1.7 million based on the audited financial statements to $2.3 million based on OSHPD filings. The hospitals have provided an average of $5.5 million in charity care if the adjustments in the Final OSHPD Disclosure Reports are included in the analysis.

As shown in Table 30, approximately three-fourths of the “traditional charity care” charges for DFH, Inc. were associated with patients who first arrived at the Memorial or Marina emergency rooms.

Table 30
Charity Care Charges Generated by Emergency Room Patients
Daniel Freeman Hospitals, Inc.
1999-2001

Charity Care Charges		1999	2000	2001
Total charity charges				
	Memorial	$4,198,078	$5,202,423	$3,048,260
	Marina	1,809,186	2,898,724	708,605
	DFH, Inc.	6,007,264	8,101,147	3,756,865
Charity care, with ER as first site of care				
	Memorial	2,905,481	3,939,059	2,376,572
	Marina	1,459,922	2,344,020	556,636
	DFH, Inc.	4,365,403	6,283,079	2,933,208
ER- derived charity care as % of total charity care charges				
	Memorial ER %	69.2%	75.7%	78.0%
	Marina ER %	80.7%	80.9%	78.6%
	DFH, Inc.	72.7%	77.6%	78.1%

Source: Daniel Freeman Hospitals, Inc.

We note that charity care for any one hospital can vary significantly from year to year due to changes in Medi-Cal eligibility rules, health insurance expansion initiatives, economic growth, hospital service changes and closures, and other variables. DFH, Inc. has been a consistent and generous provider of charity care services for the Los Angeles area.

DFH, Inc. and Tenet Healthcare Charity Care Policies

Both Daniel Freeman Hospitals, Inc. and Tenet Healthcare have established charity care policies and procedures that define charity care (and distinguish charity from bad debt), establish eligibility criteria and screening procedures, and determine financial liability for patient care. These policies and procedures are described below.

Daniel Freeman Hospitals, Inc.

CHS has an established charity care goal for each affiliated hospital. The goal is determined annually to "maintain a balance of taking care of the poor along with the ability to maintain quality and quantity of services[21]." Currently, CHS recommends an amount between 5 to 10 percent of net income before charity care as the goal.

[21] DFH, Inc. Charity Care Policy, Updated 4/00.

At Memorial and Marina, Patient Business Services staff (located in the admissions and financial counseling, outpatient registration, emergency room, and business office departments) identify potential charity care patients and screen them for financial need.

The following patients are identified as eligible for charity care in the DFH, Inc. charity care policies:

- Those with yearly incomes less than current federal and state defined poverty guidelines who are not eligible for Medi-Cal.
- Those who are eligible for Medi-Cal but for whom the hospital does not receive Medi-Cal reimbursement.
- Those who are uninsured or underinsured, do not qualify for local, state or federal programs, and for whom it is determined that full payment of medical bills would cause financial hardship.
- Uninsured patients treated when County Hospital capacity is full.
- Those who have pre-arranged for charity care, such as members of a religious order, lay mission workers, and Venice Family Clinic patients.
- Other individuals at the discretion of the Patient Business Services Director or the Chief Financial Officer.

The DFH, Inc. policies indicate that the hospitals will provide emergency care to all individuals who present at the emergency rooms, without consideration of patient ability to pay. After an indigent[22] emergency room patient is determined to be stable, every attempt is made to transfer the patient to a hospital that receives government funding to provide indigent care. If indigent patients cannot be transferred to such a facility immediately after stabilization, then the hospital will continue to provide care until transfer or well discharge is possible.

Patients potentially eligible for charity care fill out two forms: a Financial Statement (that collects income, asset, and family information) and a Medi-Cal screening sheet. Accounts that initially were assigned to bad debt and later determined to be charity accounts are to be reclassified to charity care.

Tenet Healthcare

Tenet Healthcare policies define charity care as "health care services that are provided, which Tenet never expects to receive reimbursement for, because of the patient's inability to pay[23]." Charity care determinations are made at Tenet facilities based on a patient's ability, not willingness, to pay for care.

Factors that Tenet employees consider when determining eligibility for charity care include: the patient's gross income (if it is within a pre-established range, based on Federal Poverty Guidelines), net worth and liquidity, employment status and capacity for

[22] Indigent care is defined in the DFH, Inc. Charity Care Policy as "Those patients who cannot afford to pay for the services they receive in the hospital. They include patients who are not eligible for Medicare of Medi-Cal, and those who do not have private or employer-provided health insurance."
[23] Tenet Business Office Procedure Manual, 4/7/00.

future earnings, living expenses and financial obligations, previous exhaustion of all other available resources, and catastrophic illnesses[24].

Charity care provided at Tenet facilities is assigned to "statutory" and "non-statutory" categories. Statutory charity care is defined by participation in federal, state, or county indigent care programs. Charity care obligations that result from facility purchase agreements are considered statutory charity care. Non-statutory charity care is "patient charity care meeting the general charity care criteria; however, there may not be state or county programs in which the facility participates or where the facility does not have specific obligations to provide charity care[25]."

Tenet's policies strongly suggest that charity care determinations be made at admission or shortly thereafter, and that accounts are posted to charity during the month decisions are made. Retrospective eligibility also is possible. The policies allow only a portion of a patient's bill to be classified as charity care.

Tenet operates a Medical Eligibility Program (MEP) through which it determines whether patients are eligible to receive health coverage or benefits through a third party payer. Coverage by any third party (including Medicaid, Medi-Cal, Medially Indigent Programs, and Crime Victim Compensation) must not be possible before pursuing eligibility for charity care. Tenet also utilizes its Syndicated Office Systems (SOS) staff to determine whether patients are eligible for charity care. Employees of the SOS "will not, at any time, represent or otherwise suggest to the patient, that he / she will be relieved of the debt by way of a write off to charity care[26]."

Patients at Tenet facilities are assisted by Patient Financial Counselors (PCF). If the PCF determines that the patient has "no viable source of payment"[27] then they ask patients to complete a Confidential Financial Statement (Application) form. If the applicant meets financial criteria, then the PCF verifies and submits all relevant paperwork to the facility Business Office Manager (BOM) or Director of Patient Services (DPS) for review and approval for assignment to charity care. The MEP supervisor must also review the relevant paperwork for appropriateness and completeness of the supporting documentation.

Tenet's policies also indicate that some accounts automatically qualify for charity care or adjustment, such patients with prior charity care approval, patients who have exhausted their Medicaid benefits, and patients who are identified as transient or homeless.

Comparison of Charity Care Policies

The charity care policies of DFH, Inc. and Tenet Healthcare differ in the following respects.

- DFH, Inc. policies suggest an annual target for charity care.

[24] Ibid. Catastrophic illnesses are "where the medical bills exceed the family's gross annual income, and / or net worth and liquidity."
[25] Ibid.
[26] Ibid.
[27] Ibid.

- DFH, Inc. policies also indicate that charity care is available when county operated facilities are full.
- DFH, Inc. policies assign charges for Medi-Cal patients for whom the hospital does not receive payment to charity.
- DFH, Inc. policies indicate that after ER patients are stable, the hospitals should attempt transfer to a county hospital. Tenet's policies do not mention this procedure.
- Tenet distinguishes between "statutory" and "non-statutory" charity care.
- Tenet's policies indicate the participation of staff from multiple departments in the charity care determination process.
- Tenet's policies specify that portions of a patient bills can be classified as charity care.
- Tenet's policies indicate that SOS employees "will not, at any time, represent or otherwise suggest to the patient, that he / she will be relieved of the debt by way of a write off to charity care."

In general, Tenet Healthcare's policies and procedures are more detailed and explicit than those of DFH, Inc.

Daniel Freeman Community Benefit Services

The IRS Form 990 (submitted annually by not-for-profit organizations) identifies community benefits in addition to charity care that historically have been provided by DFH, Inc hospitals. These include: educational programs and departments, the Professional Nurse Case Management (PNCM) program, the Maternity Center, patient transportation services, free stroke support group meetings, a collaboration with Great Beginnings for Black Babies, occasional free accommodations for patient families, publications and community outreach, holiday gift boxes for needy senior citizens, and other community benefit services. The IRS Form 990 for 2000 reports that DFH, Inc. provided $12.2 million in "net expense"[28] for community benefit services. The $12.2 million represented 7.2 percent of the combined hospitals' operating expenses in FY 2000.

The $12.2 million in net expense represented 7.2 percent of the combined hospitals operating expenses in FY 2000. Charity care and net losses incurred in serving Medi-Cal patients comprised a significant portion of the $12.2 million in net expense.

The Lewin Group reviewed DFH, Inc. certain schedules and analyses supporting the IRS Form 990 submission. Table 31 highlights selected, significant community benefit programs sponsored or funded by DFH, Inc. during FY 2000.

[28] Calculated as the difference between total expense for community benefit services (measured based on the ratio of cost to charges or other cost accounting methods) and any offsetting revenues for these services.

Table 31
Summary of Selected Community Benefit Services Excluding Charity Care
Daniel Freeman Hospitals, Inc.
2000

Community Benefit	Memorial	Marina	Combined
Cash and in-kind donations for community needs	$166,479	$70,412	$236,891
Patient transportation van	108,270		108,270
Professional Nursing Case Management	286,227		286,227
Women of Color	23,718		23,718
Community Trust Fund	58,569	58,569	117,138
Community Clinic Association of Los Angeles County	57,913		57,913
Emergency Alert Response System	15,314		15,314
	$716,490	$128,981	$845,471

Source: The Lewin Group, 2001, based on Daniel Freeman Hospitals, Inc., IRS Form 990.

Interviews with community representatives and testimony at the Public Hearing confirm that DFH, Inc. hospitals have been a recognized contributor to the community's health and welfare.

Quality of Care

In a highly competitive environment like Los Angeles, publicly available information about quality of care assists patients and payers to make informed choices when selecting a hospital for care or for contracting. The DFH, Inc. hospitals participate in two, voluntary quality of care programs involving standardized comparisons among hospitals (for ER and cardiac surgery). They do not participate in two other voluntary, quality improvement programs that would provide significant, public information to patients and purchasers:

- The California Institute for Health Systems Performance (Sacramento) sponsors and recently published the first state-wide *Results from the Patients' Evaluation of (Hospital) Performance (PEP-C) Survey*. Participation by Los Angeles hospitals in this survey now includes the seven Kaiser hospitals, UCLA, MLK, Cedars-Sinai, City of Hope, and three smaller hospitals.
- The Leapfrog Group of large employers (including several in Los Angeles County) sponsors the "Initial Leaps in Patient Safety" hospital quality initiative. Hospital participants in this new initiative will be announced by the end of 2001.

Although competition may enhance quality (through incentives for investment in new equipment and in quality management programs that support optimal care), it also can undermine quality if lower than desirable volumes result. Thus, splitting of obstetrical volume among the three private hospitals in the Inglewood-Hawthorne area can result in

none reaching the number of deliveries per year recommended by the American College of Obstetrics and Gynecology (1,500) to promote high quality of care. The multi-site practice characteristic of obstetrics reportedly strains the resources of the Memorial perinatal group. Competition among hospitals and local physicians, as well as compliance with the *Directives* affects these care patterns.

Chapter 5: Summary of Findings and Recommendations

This chapter draws from the preceding report and makes recommendations to mitigate the potential negative health impacts of the proposed transaction.

In brief, our assessment of the health effects of the proposed transaction finds that the financial condition of DFH, Inc. requires sale to an organization with access to capital, improved market position, and management expertise. However, our assessment does not conclude that there will be "no significant negative impacts from this transaction on the availability and accessibility of health care services"[29] without additional mitigation measures. The following section summarizes these findings.

Summary of Findings

This summary of findings is organized to conform with the requirements of Section 999.5(e)6 (California Code of Regulations).

(A) Effect on Emergency, Reproductive Health, and Any Other Health Care Services

Several factors in the Los Angeles health care environment are important to recognize as context for the evaluation of health impacts of this transaction, including:

- The scheduled elimination of the federal 1115 waiver funding that has provided substantial support for the Los Angeles County Health Services system.
- Continued growth in the number of uninsured persons from a softening economy and other factors.
- Potential retirement of acute hospital bed capacity in Los Angeles due to compliance with SB 1953 seismic requirements.
- A nearby primary care facility, the Watts Health Clinic, is operated by an organization currently in conservatorship. Loss of the facility could increase demand on surrounding emergency rooms.

Emergency Services. The Emergency Department at Memorial currently provides more than 40,000 visits per year (including 6,600 911 emergencies, ranking it 13th out of 81 Los Angeles hospitals in the volume of paramedic runs in the County).

The Emergency Department at Memorial is one of only six in Los Angeles that serves a "designated service area" under agreement with the Los Angeles Emergency Medical Services Agency.

In addition to its role in the Emergency Medical Services system, the Emergency Department at Memorial provides ambulatory care to thousands of local Medi-Cal, Medicare, and uninsured patients.

[29] Applicant's Health Impact Analysis, August 24, 2001.

The Basic Emergency Department at Marina provides over 20,000 visits, primarily to local Medicare patients, to non-affluent Venice residents, and for psychiatric emergency services. Approximately 46 percent (10,000 visits) was classified as urgent care in recent years.

The possible closure of the Emergency Department at Memorial is viewed as a "disaster" by the EMS Agency, since the Memorial's services could not be absorbed by neighboring hospitals without their expansion. The perceived possibility of closure of the Emergency Department at Memorial also is viewed as unacceptable by local elected officials and community representatives. Travel times to emergency services for residents of Memorial's primary service area would increase substantially unless alternative capacity were developed at other local hospitals.

A significant proportion of the inpatient care and charity care at Memorial and Marina is derived from patients who first arrive at the emergency rooms.

Reproductive Health Services. The Maternity Center at Memorial is a valued local resource serving high-risk pregnant women eligible for Medi-Cal with prenatal and delivery services. Memorial has a Level II neonatal intensive care unit capable of treating virtually any baby delivered at the hospital.

Competition between Memorial, Centinela, and Robert F. Kennedy Medical Center obstetrical services for physicians, staff, and patients creates the potential for declining volume at any one site despite professional obstetrical standards that call for 1,500 deliveries a year or more at a hospital to maintain quality of care.

Obstetrics services at Memorial are less dependent on the Memorial emergency room than other programs at the hospital.

The DFH Inc. hospitals have operated under the *Ethical and Religious Directives for Catholic Health Care Services*. Tenet shall be bound by the *Directives* at the DFH Inc. hospital sites and the parties have agreed that this obligation shall "run with the land." The application of the prohibition in the Asset Purchase Agreement (section 10.6 (d)) on abortion, assisted suicide, and euthanasia to partnerships and joint ventures involving Tenet lacks clarity.

Other Services. Memorial's comprehensive rehabilitation program is well-known beyond the local community.

Memorial provides a valued cardiology clinic to manage pervasive cardiac disease in the primary service area.

The pediatric beds at Memorial enable the ER to maintain its accessibility for pediatric care.

Marina's psychiatric and substance abuse services draw a large number of psychiatric and substance abuse patients who reside outside its primary and secondary service areas. The ER serves substantial urgent care need within its service area. None of these services is unique within the DFH, Inc. service areas.

(B) Effect on the Level and Type of Charity Care Historically Provided

The dollar amount of charity care historically provided by DFH, Inc. varies substantially depending on the data source and has been adjusted significantly during the last few

years. The variability in reported charity care amounts and the potential changes to Medi-Cal eligibility procedures and the cost structure of the hospitals under Tenet's ownership makes establishing future expectations for charity care challenging.

Traditional charity care charges at DFH, Inc. based on audited financial statements have averaged approximately $6.0 million annually. Traditional charity care based on the initially filed OSHPD Disclosure Reports averaged $7.7 million annually. Charity care after adding Medi-Cal denials and charges for specific patient programs for vulnerable populations averaged $15.9 million.

The cost of traditional charity care (derived by applying the hospitals' ratio of cost to charges) ranges from $1.7 million based on the audited financial statements to $2.3 million based on OSHPD filings. The hospitals have provided an average of $5.5 million in charity care if the adjustments (for Medi-Cal denials and additional services provided for vulnerable populations) in the Final OSHPD Disclosure Reports are included in the analysis.

Approximately three-fourths of the "traditional charity care" charges for DFH, Inc. were associated with patients who first arrived at the Memorial or Marina emergency rooms.

As described in Chapter 4, DFH, Inc. charity care policies and procedures differ from those of Tenet Healthcare. In general, Tenet Healthcare's policies and procedures are more detailed and explicit than those of DFH, Inc.

(C) Effect On The Services To Medi-Cal, County Indigent And Other Classes Of Patients

Daniel Freeman Memorial Hospital qualifies for disproportionate share funding from the Medi-Cal program, and is a substantial provider of services for Medi-Cal and indigent patients. Memorial does not have contracts to serve County Indigent patients.

Certain patient populations are served disproportionately at Memorial and Marina. Memorial's market shares exceed 20 percent for African-American residents of Memorial's primary service area for maternal and child health services, cardiology, general medicine and surgery, and medical oncology. Memorial's shares also exceed 20 percent for Latinos with Medi-Cal coverage who use the hospital's obstetrics programs.

Marina's emergency department and inpatient services are utilized by a number of Medicare patients from its service areas.

(D) Effect On Community Benefit Programs

DFH, Inc. provided community benefits (including charity care costs) amounting to $12.2 million in FY 2000, representing 7.2 percent of the combined hospitals operating expenses. The DFH, Inc. hospitals have been recognized contributors to the health and welfare of their service areas. Particular community benefits include cash and in-kind donations, a van service for patient transportation, a professional nursing case management program, support for Women of Color, funds provided by the Community Trust Fund, and support for the Community Clinic Association of Los Angeles County and the Emergency Alert Response System. These particular community benefits generated net expense of approximately $850,000 during FY 2000.

(E) Effect On Staffing and Employee Rights

Late in October, 2001, The Lewin Group and the Office of the California Attorney General received a report from the Service Employees International Union (SEIU) entitled, *Staffing and Labor Practices at Tenet Healthcare Corporation Hospitals in Los Angeles and Orange Counties.* This report raises several questions regarding the transaction and reports findings regarding staffing levels and labor practices in Tenet facilities. Tenet Healthcare has not had the opportunity to respond to the SEIU report.

(F) Effect of Mitigation Measures Proposed by the Applicant

Tenet has agreed to: create a local governing board that will approve the appointments of hospital management and medical directors; provide charity care equivalent to the average of the preceding three years provided by DFH, Inc.; conduct a hospital operations planning process that will involve physicians, employees, community residents, elected officials and Los Angeles County Department of Health Services within 90 days; maintain the Memorial ER for at least two years and the capacity for emergency and/or ambulatory care "in the hospitals' service areas" for at least three years; continue obstetrical and neonatal services in Inglewood for at least three years; abide by the *Directives;* provide reproductive health services at another facility in Inglewood not bound by the *Directives*; participate in Medi-Cal and Medicare so long as payments are not "substantially reduced"; invest $50 million in capital improvements over 10 years in its hospitals in the service areas; and continue many religious activities pursued by the Sisters in their hospitals.

Testimony at the Public Meeting from elected officials, community residents, community organizations, and unions indicated dissatisfaction with the mitigation measures and noted the power of the Attorney General to strengthen them. Closure or reduction of Memorial's emergency services capacity would create particular problems for the service areas and the Emergency Medical Services system.

The mitigation measures proposed by the Applicant address important services provided by DFH, Inc., but are too short in duration and limited in scope.

(G) Alternatives Including Closure

In our assessment, DFH, Inc. does not have the ability to raise new debt from the capital markets due to its poor financial performance and current financial position. CHS is not likely to advance funding to the hospitals, since the only source of funds would be other hospitals in the CHS system which have their own capital and operating requirements. CHS has indicated its intent to close the hospitals if sale to Tenet cannot be accomplished.

Sale of the two DFH, Inc. hospitals to a buyer with access to adequate capital is necessary if the hospitals are to continue operating.

Recommendations for Additional Feasible Mitigation Measures

Stronger mitigation than that proposed by Tenet and accepted by DFH, Inc. appears warranted based on the findings of this report. Additional feasible mitigation measures should include:

1. Current levels and types of emergency room services and current arrangements with the County of Los Angeles EMS need to be maintained in the Daniel Freeman Memorial Hospital primary service area for at least five years.
2. Tenet should be required to develop a charity care policy at Memorial that is similar to existing policies at that hospital and should be required to provide a minimum level of charity care based on a ratio of cost to charges for at least five years.
3. Tenet's commitment to provide obstetrical services including high-risk prenatal and neonatal intensive care services in Inglewood needs to be extended to at least five years.
4. Tenet should be required to continue the most significant community benefit programs now being offered or subsidized by Memorial.
5. The comprehensive planning process that Tenet agreed to conduct should be a public process allowing input from the community and Los Angeles Emergency Medical Services Agency.
6. If Marina is closed within the next five years, Tenet should be required to establish an urgent care facility that meets existing urgent care needs in the area served by Marina.
7. Tenet should be required to give reasonable notice to the Attorney General of its intent to terminate participation in Medicare and Medi-Cal programs at any hospitals in Inglewood.
8. The Governing Board of Memorial should have authority to provide input on any plans to consolidate significant Memorial services at another Tenet site.