Assessment of the Effects of the Proposed Acquisition of Madera Community Hospital by St. Agnes Medical Center

Prepared for the Office of the California Attorney General

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Contents

Scope of Report and Qualifications

I have been retained by the Office of the California Attorney General (OCAG) to provide an independent analysis of the effects of the proposed acquisition of Madera Community Hospital (within Madera County) by St. Agnes Medical Center (within Fresno County).

Qualifications

Glenn Melnick, Ph.D., is an expert in health economics and health care markets and the Blue Cross of California Professor of Health Care Finance at the USC Price School of Public Policy at the University of Southern California (CV Included in Appendix). Dr. Melnick joined the USC faculty in 1996, and previously, he served as a faculty member of the UCLA School of Public Health. Dr. Melnick is currently the Director of the USC Center for Health Financing, Policy, and Management. Dr. Melnick has served as an expert witness for the Federal Trade Commission. He has been published in the *American Journal of Public Health*, *Health Affairs*, *Medical Care*, *Journal of Health Politics*, *Policy and Law*, *Health Policy Reform: Competition and Controls*, and *Journal of Ambulatory Care Management*. Dr. Melnick has also been published in the *New York Times*, *The Wall Street Journal,* and other media outlets.

Scope of Report

Specifically, I have been asked to assess whether the proposed acquisition of Madera Community Hospital by St. Agnes Medical Center creates potential negative effects on the availability and accessibility of health services and/or competition.

This report analyzes two sets of potential effects of the proposed transaction:

1) A health impact analysis including potential effects on the availability and accessibility of health care services to the communities served by Madera Community Hospital.

2) An analysis of the effects on hospital market structure and competition of the acquisition of Madera Community Hospital by St. Agnes Medical Center.

In addition, I have been asked to develop and recommend potential Conditions that the OCAG might consider as a means of addressing potential concerns in these two areas, should the OCAG approve the transaction. This report sets forth the data used in conducting the analysis as well my conclusions and recommendations. The two sets of analyses are conducted pursuant to and in accordance with the California Code of Regulations[1] (below).

Regulations Regarding Assessment of the Effects on the Availability or Accessibility of Health Care Services

The information contained in the independent health care impact statement shall be used in considering whether the agreement or transaction may create a significant effect on the

[1]https://www.law.cornell.edu/regulations/california/11-CCR-Sec-999-5.

availability or accessibility of health care services as set forth in subsection (8) of subdivision (f) of section 999.5 of Chapter 15, Division 1, of Title 11 of the California Code of Regulations:

> (f) Factors to Be Considered in Making a Decision
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> (8) In making a determination on whether to consent to any agreement or transaction for which written consent is required by section 999.5(a)(1) of these regulations, the Attorney General shall consider whether the agreement or transaction may create a significant effect on the availability or accessibility of health care services to the affected community.
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> > (A) It is the policy of the Attorney General to closely scrutinize any agreement or transaction that restricts the type or level of health care services that may be provided at the health facility or facility that provides similar health care. Potential adverse effects on availability or accessibility of health care may be mitigated through provisions negotiated between the parties to the transaction, through conditions adopted by the Attorney General in consenting to the proposed transaction, or through any other appropriate means.
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> > (B) It is the policy of the Attorney General, in consenting to an agreement or transaction involving a general acute care hospital, to require for a period of at least five years that a minimum level of annual charity care costs be incurred by the hospitals that are the subject of the agreement or transaction. The minimum level of annual charity care costs should be based on the historic level of charity care that the hospital has provided. The definition and methodology for calculating charity care costs should be consistent with the definitions and methodology established by the Office of Statewide Health Planning and Development. The Attorney General shall retain complete discretion to determine whether this policy shall be applied in any specific transaction under review.
> >
> > (C) It is the policy of the Attorney General, in consenting to an agreement or transaction involving a general acute care hospital, to require for a period of at least five years the continuation at the hospital of existing levels of essential health care services, including but not limited to emergency room services. The Attorney General shall retain complete discretion to determine whether this policy shall be applied in any specific transaction under review.

Regulations pertaining to the scope and contents of the independent health impact statement are set forth in subsections (5) and (6) of subdivision (e) of section 999.5, as follows:

> (e) Procedure for Review of Notice

(5) The Attorney General shall prepare an independent health care impact statement for any agreement or transaction that satisfies either of the following conditions:

(A) The agreement or transaction directly affects a general acute care hospital as defined in Health and Safety Code section 1250(a) that has more than 50 acute care beds; or

(B) There is a fair argument that the agreement or transaction may result in a significant effect on the availability or accessibility of existing health care services.

(6) The independent health care impact statement shall contain the following information:

(A) An assessment of the effect of the agreement or transaction on emergency services, reproductive health services and any other health care services that the hospital is providing.

(B) An assessment of the effect of the agreement or transaction on the level and type of charity care that the hospital has historically provided.

(C) An assessment of the effect of the agreement or transaction on the provision of health care services to Medi-Cal patients, county indigent patients, and any other class of patients.

(D) An assessment of the effect of the agreement or transaction on any significant community benefit program that the hospital has historically funded or operated.

(E) An assessment of the effect of the agreement or transaction on staffing for patient care areas as it may affect availability of care, on the likely retention of employees as it may affect continuity of care, and on the rights of employees to provide input on health quality and staffing issues.

(F) An assessment of the effectiveness of any mitigation measure proposed by the applicant to reduce any potential adverse effect on health care services identified in the impact statement.

(G) A discussion of alternatives to the proposed agreement or transaction including closure of the hospital.

(H) Recommendations for additional feasible mitigation measures that would reduce or eliminate any significant adverse effect on health care services identified in the impact statement.

> The information contained in the independent health care impact statement shall be used in considering whether the agreement or transaction may create a significant effect on the availability or accessibility of health care services as set forth in section 999.5(f)(8) of the regulations. Copies of the health care impact statement shall be made available to any person or entity that has requested a copy.

Regulations Regarding Assessment of the Competitive Effects of Transaction

Regulations pertaining to the competitive effects of the transaction as set forth in subsection (9) of subdivision (f) of section 999.5 of Chapter 15, Division 1, of Title 11 of the California Code of Regulations are as follows:

> (9) In making a determination on whether to consent to any agreement or transaction for which written consent is required by section 999.5(a)(1) of these regulations, the Attorney General shall consider whether the effect of the agreement or transaction may be substantially to lessen competition or tend to create a monopoly.

Materials Relied Upon for Preparation of Report

In preparation of this report the following materials served as input:

- A review of press releases and news articles related to the proposed transaction.
- The Notice to the Attorney General as well as supplemental information provided by the Hospital.
- Interviews with community members and health care providers and organizations, health plan representatives, and others (Summary of all interviews included in Appendix).
- Detailed data for both Madera Community Hospital and St. Agnes Medical Center based on reports submitted by the Hospitals to Department of Health Access and Information (HCAI) and other agencies.
- Data available from other sources, including data from the RAND pricing study.
- Published reports and data related to Madera County.
- WWW Websites for the Hospitals and other relevant organizations.
- Published literature on hospital mergers and acquisitions and hospital markets and competition and hospital systems.
- Records of state licensing and federal certification from the California Department of Public Health (CDPH) and from the Centers for Medicare and Medicaid Services (CMS).

Executive Summary and Overview of the Proposed Transaction and Key Findings

This Executive Summary and Overview Section of the Report provides a brief summary of the parties and the proposed transaction and an overview of our analyses, findings, and additional factors that the OCAG might consider in approving the transaction. Additional details and supporting data are provided in the remainder of the report.

Madera Community Hospital and Madera County

Madera Community Hospital is located in Madera County California. Madera County is located in the center of California and covers 2,153 square miles. The total population in Madera County is approximately 150,000+ residents.

There are two (2) licensed general acute care hospitals in Madera County: Madera Community Hospital and Valley Children's Hospital. Valley Children's is a general acute care hospital, but it is designated as a Children's Hospital under Welfare and Institutions Code section 10727. Children's Hospitals are licensed as general acute care hospitals, but Children's Hospitals are generally considered specialty hospitals as they focus on the pediatric population and do not generally serve adult populations. As such, Madera Community Hospital is the only truly general acute care hospital in Madera County serving both adult and pediatric populations.

Madera Community Hospital has 106 licensed general acute beds. Madera Community Hospital is licensed to provide emergency services and a range of general acute care inpatient services, including all eight basic services pursuant to Health and Safety Code section 1250 (a), as well as supplemental services including obstetrics/maternity care and intensive care services. Madera Community Hospital also operates three rural health clinics in Madera County as well as other outpatient services. Madera Community Hospital and its related outpatient entities are highly utilized by residents of Madera County. As the only general acute care hospital in the County serving both adults and children, residents of Madera County are highly dependent on Madera Community Hospital for access to emergency care, maternity services, and other inpatient health care services as well as the Hospital's outpatient clinic-based services in Madera, Chowchilla and Mendota. These outpatient clinic-based services, operated by Madera Community Hospital, are highly utilized by and particularly important to low-income populations in Madera County.

While Madera Community Hospital's historical financial performance has been relatively stable, in recent years it has substantially deteriorated. Historically, Madera Community Hospital has averaged $80-90+ million per year in net patient revenue in recent years. Between 2016 and 2020, the Hospital reported three years of positive net profit margin and two years of negative net profit margin. The cumulative net income over the five-year period was a loss of $1.3 million. The onset of the COVID-19 pandemic changed the financial picture for many hospitals, especially small and rural hospitals including Madera Community Hospital.

While Madera Community Hospital is not licensed as a rural hospital by government agencies, it has many of the characteristics and financial pressures of a small rural hospital. A recent study by a leading research team regarding the financial stability of small rural hospitals in the United States reported that, "More than 600 rural hospitals--30 percent of all rural hospitals in the country–are at risk of closing in the near future."[2] The study cites two driving factors affecting the long-term survival of many rural hospitals: substantial and sustained financial losses from patient care and limited financial reserves to offset sustained losses.

Madera Community Hospital has incurred substantial financial losses over recent years, especially since the onset of the COVID-19 pandemic. Madera Community Hospital reported sustained financial losses in each of the four quarters for 2020 and 2021. Cumulative losses for the eight quarters of 2020 and 2021 reached $16 million from patient operations and a slightly smaller but significant $14+ million on total hospital operations. Recent financial losses seem to be more related to rapid and sustained increases in operating costs rather than significant reductions in demand and/or revenue.

There is a growing body of research that focuses on the financial status and sustainability of small and rural hospitals in the United States.[3] While Madera Community Hospital is not officially designated as a rural hospital by government agencies, it has many of the characteristics and financial pressures of a small, rural hospital.[4] For example, California law describes rural hospitals as follows:

> "Rural hospitals serve as the 'hub of health,' and through that role attract and retain in their communities physicians, nurses, and other primary care providers."

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[2]Rural Hospitals at Risk of Closing: Center for Health Care Quality and Payment Reform; www.chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.

[3]Cecil G. Sheps Center for Health Services Research. 160 rural hospital closures: January 2005–present. Chapel Hill (NC): University of North Carolina at Chapel Hill; 2019: www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/; Kaufman B., et al. The rising rate of rural hospital closures. J Rural Health. 2016; 32(1):35–43; Thomas S., et al. 2012–14 profitability of urban and rural hospitals by Medicare payment classification. Chapel Hill (NC): University of North Carolina, Cecil G. Sheps Center for Health Services Research.

[4]Criteria for government agency definition of rural hospitals are quite limited and were developed more than 30+ years ago and have not been updated. See Appendix for Legislative criteria for definition of Rural Hospital in California, Health & Safety Code, § 124800. Recent research shows that many non-rural hospitals are very similar to those formally designated as rural hospitals (www.shepscenter.unc.edu/product/2012-14-profitability-of-urban-and-rural-hospitals-by-medicare-payment-classification)

> "The rural hospital is often one of the largest employers in the community. The closure of such a hospital means the loss of a source of employment. This has an economic impact beyond the health sector."
>
> "Rural hospitals are an important link in the Medi-Cal program, and without special consideration that takes into account their unique circumstances, rural hospitals will be unable to continue providing services to Medi-Cal patients."[5]

Madera Community Hospital clearly meets these (and other) legislative criteria for designation as a rural hospital. It is important to note that this law and related criteria have not been updated for more than 30+ years, despite substantial and significant changes in the hospital markets in California.

Research on small, rural hospitals paints a concerning picture that is similar to the one we see for Madera Community Hospital in recent years: financial losses, rising expenses due to workforce shortages, and lack of access to capital. Most small and rural hospitals, like Madera Community Hospital, tend to serve older, poorer, and sicker communities where higher percentages of patients are covered through Medicare and Medicaid (Medi-Cal is California's health insurance program for low-income populations) and have more uninsured patients.[6] Madera County ranks 34th out of California's 58 counties in terms of annual household income and more than half the population is covered by government sponsored health insurance programs, including Medi-Cal. According to a recent California County Health Rankings Report, Madera County ranks 38th out of all 58 California Counties in overall health status and health outcomes. These factors can result in long-term unprofitability and financial distress.

Importantly, the researchers found that:

> *"For many rural hospitals, the financial choice may be to merge or go out of business."*[7]

This appears to be the situation that faces Madera Community Hospital.

Madera Community Hospital has recently sustained substantial and continuing financial losses with limited financial reserves to offset the losses. The proposed transaction is consistent with the national trend where financially distressed hospitals either merge with a more stable financial partner or the hospital is forced to close. The proposed transaction would provide the option for Madera Community Hospital to remain open and viable and to continue to provide needed services to Madera County residents.

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[5]See Appendix for Legislative criteria for definition of Rural Hospital in California, Health & Safety Code, § 124800.
[6]https://chqpr.org/downloads/Rural_Hospitals_at_Risk_of_Closing.pdf.
[7]Rural Hospital Mergers from 2005 through 2016, D. Williams Jr., et al. www.shepscenter.unc.edu/wp-content/uploads/dlm_uploads/2018/08/Rural-Hospital-Mergers.pdf.

In summary, the transaction, should it be approved, could likely generate substantial benefits for Madera County residents, health care consumers and the broader community. At the same time, there are also likely negative effects on competition, prices, and other concerns, that need to be identified, assessed, and considered in the review process.

The Proposed Transaction

The proposed transaction involves Madera Community Hospital and St. Agnes Medical Center. St. Agnes Medical Center is located in Fresno County and is part of Trinity Health, a large national health care system, headquartered in Michigan. Under the transaction, St. Agnes Medical Center, as part of Trinity Health, will execute a formal affiliation agreement with Madera Community Hospital whereby Madera Community Hospital will be operated by and under the control of St. Agnes Medical Center and Trinity Health. For all intents and purposes, the affiliation agreement can be considered to have the same meaning as Madera Community Hospital being acquired by St. Agnes Medical Center and Trinity Health and/or also as a merger of the two hospitals, Madera Community Hospital and St. Agnes Medical Center. For purposes of this report, the transaction will be referred to as either an acquisition or a merger event.

St. Agnes Medical Center is a large general acute care hospital with a wide range of acute and other services and is located in neighboring Fresno County (approximately 22 miles from Madera Community Hospital). St. Agnes Medical Center is part of a large national health system (Trinity Health) headquartered outside of California (in Michigan). While it is more financially stable than Madera Community Hospital, the acquisition of what is essentially a small rural hospital locally governed by members of the community underscores the need to carefully consider the competitive, community, and equity impacts of the proposed transaction.[8] Research covering these types of transactions where the acquired hospital, had, pre-transaction been locally governed, and, post-transaction, is governed by a multi-hospital system that is headquartered outside of the community raises concerns of lack of familiarity with local health care needs and market factors and increased administrative burden and timelines for needed upper-level approvals (e.g., hiring, credentialing, etc.).

Competitive Impact Analysis

Analysis of the competitive impact of the acquisition begins with a determination of whether the parties to the transaction (Madera Community Hospital and St. Agnes Medical Center) are, prior to the transaction, direct competitors and therefore engage in what is known as horizontal competition. Direct competition exists when firms compete in the same or

[8]Per Madera Community Hospital Community Benefits Report (June 2020), the hospital is governed by a Board of Trustees that includes 21 members comprised of community members and local physicians. https://www.maderahospital.org.

overlapping geographic and product markets and are therefore viewed as potential substitutes to each other. The greater the overlap, the greater the risk for negative competitive impacts, all other factors equal.

Market Overlap and Market Concentration, Pre- and Post-Transaction

The first step in the competitive analysis is to determine the degree of overlap in the service areas of the merging parties (i.e., do they compete in the same geographic and product markets). Considerable overlap suggests the parties are direct competitors and allowing the merger to proceed would reduce horizontal competition.

We calculate pre- and post-merger Herfindahl-Hirschman Index (HHIs) for the relevant geographic market. The larger the pre-transaction HHI and the greater the difference in pre- and post-merger HHIs, the greater the risk to horizontal competition.[9] Along these lines, three inter-related analyses were conducted to assess the likely effects on horizontal competition:

- overlapping primary service;
- overlapping product and payor markets; and
- calculation of pre-post concentration measures (HHIs).

Pre-transaction, Madera Community Hospital has a large market share of the Madera County hospital services market. St. Agnes Medical Center also draws a substantial number of patients from Madera County (as well as Fresno and other counties). St. Agnes Medical Center, located in Fresno, is 22+ miles from Madera Community Hospital with an estimated 30–40-minute travel time between the two facilities.

As detailed elsewhere in the report, our analysis found that there is substantial overlap in the geographic markets served by both hospitals. Madera Community Hospital is the most important hospital serving Madera County residents. St. Agnes Medical Center is the second most important provider of general acute care hospital services to Madera County residents. Many of the primary zip codes served by Madera Community Hospital are also served by St. Agnes Medical Center. Both hospitals serve a wide range of payors with substantial overlap for the same payors.

The combined share of the market for Madera Community Hospital and St. Agnes Medical Center, should the transaction be approved, would be in excess of 60%. Our analyses indicate

[9]In some cases, analysts conduct a more detailed statistical analysis of patient demand for hospital services in the market, referred to as Diversion Analysis. Given the significant effects of the analysis of the HHIs and the substantial change in HHIs pre and post transaction, it was determined that a Diversion Analysis was not needed as it would yield similar results to the HHI analysis.

that the transaction would result in a significant increase in market concentration in a market that is already highly concentrated:[10]

- The HHI value, pre-transaction, is 4,378
- The HHI value, post-transaction would increase to 6,484

Competitive Considerations

There is an extensive literature documenting the effects of increased hospital market concentration on a wide range of health system performance measures. The proposed transaction would lead to a more concentrated hospital market in the region. The starting HHI value, pre-transaction, is already highly concentrated. The HHI value, post -transaction, would increase substantially. This means that there is a substantial likelihood that the transaction will result in increased prices – to the detriment of government and private insurers and their enrollees. This conclusion is supported by an extensive published literature on hospital mergers and acquisition of hospitals by multi-hospital systems.[11] Additional research has shown that even when mergers result in lower operating costs, the cost savings are not necessarily passed on to consumers in the form of lower prices.[12]

Data show that Madera Community Hospital is in a precarious financial position. The proposed transaction could be beneficial to the financial stability of Madera Community Hospital and to the patients it serves. At the same time, approval of the transaction to stabilize the financial status of the hospital does not mean that the likely anti-competitive effects of the increased market concentration can or should be ignored. Rather, they need to be mitigated by conditions that would apply to the transaction to help ensure the public interest.

Health Impact Analysis - Access and Availability of Services

While the merger, should it be approved, would allow Madera Community Hospital to maintain operations and continue to service the community, which is important to a rural, disadvantaged

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[10]Market concentration is measured by calculating the Herfindahl–Hirschman Index (HHI), a commonly accepted measure of market concentration. More details on the calculation and interpretation of this measure are provided later in the report. The results provided here refer to all patients, including inpatients and outpatients.

[11]Dafny, Leemore. 2009. "Estimation and Identification of Merger Effects: An Application to Hospital Mergers." *Journal of Law and Economics* 52 (3): 523–50; Dafny, L., et al. 2020. "Changes in Quality of Care after Hospital Mergers and Acquisitions." *New England Journal of Medicine* 384, 51–59; Gowrisankaran, G., et al. 2015. "Mergers When Prices Are Negotiated: Evidence from the Hospital Industry." *American Economic Review* 105 (1): 172–203; Haas-Wilson, Deborah and Christopher Garmon. 2011. "Hospital Mergers and Competitive Effects: Two Retrospective Analyses." *International Journal of the Economics of Business* 18 (1): 17–32.

[12]Schmitt, Matt, "Do Hospital Mergers Reduce Costs?" *Journal of Health Economics* 52 (2017): 74-94.

community where traveling can be difficult, there are also potential post-transaction risks to access and availability that need to be considered in the review process.

Access and Availability of Services Considerations

Research has shown that mergers that result in concentrated markets and reduced competition can also result in less quality competition and reduced services and reduced access to needed services. There is also a growing body of literature studying the impact of the acquisition of independent hospitals (like Madera Community Hospital) by systems.[13] This literature documents that there is a risk that service availability can actually decline following the acquisition of an independent, locally governed hospital by a large multi-hospital system, such as Trinity.

A recent study in the journal Health Affairs reported that elimination of existing, available service lines by rural hospitals can have serious health consequences.[14] Further, the researchers found that in some cases independent rural hospitals (such as Madera Community Hospital) that become affiliated with another hospital (as proposed in this transaction) reported a post-transaction decrease in the availability of obstetric and outpatient primary care services, as well as a reduction in the availability of on-site diagnostic technologies and nonemergency outpatient services, compared with similar hospitals that remained independent. The study also found that rural hospitals that merged were more likely than hospitals that remained unaffiliated to eliminate certain services lines in the first- and second-years post-merger, specifically for maternal/neonatal and surgical care.

Merged hospitals in rural areas also showed reductions in the volume of mental/substance use disorder stays, whereas hospitals that remained unaffiliated showed increased volumes. The study authors also noted that mergers can present mixed results for some rural communities. Although they may enable a hospital to remain in business, access to some services may be reduced. Mergers may provide funds, resources, and strategic direction for hospitals to realign their services to achieve financial solvency, but reduction of service lines within the acquiring hospital or health system might not be consistent with the health needs of the community.

In addition, and notably, Madera Community Hospital is currently an important provider of reproductive health care services, including services for women and other sub-populations. Some of these reproductive health services are prohibited by the Ethical and Religious Directives (ERDs) of the Catholic Church. If Madera Community Hospital is prevented from maintaining its current level of health care services in this area, it would create accessibility and availability problems for the residents of the county. This could be particularly problematic in

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[13]Oyeka, O., et al. (2018). *The Rural Hospital and Health System Affiliation Landscape-A Brief Review*. Retrieved from http://www.public-health.uiowa.edu/.

[14]Henke, Rachel Mosher, et al. "Access to Obstetric, Behavioral Health, and Surgical Inpatient Services After Hospital Mergers in Rural Areas: Study examines access to care in rural areas where hospitals have merged." *Health Affairs* 40.10 (2021): 1627-1636.

instances of medical emergencies that require these prohibited services given the limited emergency service options in the county, and county residents' high dependence on Madera Community Hospital for emergency services. The Hospital's rural clinics also play an important role in providing non-emergency reproductive health care services to the community.

In summary, all of these factors and potential risks to access and availability of services related to the transaction need to be assessed, along with mitigating conditions, during the review process.

The Parties to the Transaction

The proposed transaction involves the two hospitals, whereby St. Agnes Medical Center will execute a formal affiliation agreement with Madera Community Hospital whereby the acquired hospital will be operated by and under the control of both St. Agnes Medical Center and Trinity Health, a large national health care system, headquartered in Michigan.

Saint Agnes Medical Center

Saint Agnes Medical Center was founded by the Sisters of the Holy Cross in 1929 as a 75-bed hospital on Fruit and Floradora Avenues in Fresno County. St. Agnes has continued to grow and expand both its inpatient and outpatient capacity. Saint Agnes Care, a nonprofit subsidiary of Saint Agnes Medical Center, was founded and now includes primary, specialty, and urgent care clinics with more than 80 providers at 20 locations in Fresno and Clovis. Saint Agnes Medical Care has established and maintains partnerships with other local health care provider organizations including Dignity Health, Valley Children's Hospital, Fresno Surgical Hospital and Summit Surgical.

Importantly, Saint Agnes Medical Center, as part its routine filings, reports to the State of California that it is owned by and is part of a national health care system – Trinity Health. According to the Trinity Health website:

> Trinity Health is one of the largest not-for-profit, Catholic health care systems in the nation. It is a family of 115,000 colleagues and nearly 26,000 physicians and clinicians caring for diverse communities across 25 states. Nationally recognized for care and experience, the Trinity Health system includes 88 hospitals, 131 continuing care locations, the second largest PACE program in the country, 125 urgent care locations and many other health and well-being services. Based in Livonia, Michigan, its annual operating revenue is $20.2 billion with $1.2 billion returned to its communities in the form of charity care and other community benefit programs.

Madera Community Hospital

Madera Community Hospital is a not-for-profit community hospital and health care organization. Currently, Madera Community Hospital is an independent entity and is not associated with any other hospital or health system. The hospital is locally governed by a Board

of Trustees which provides governance and oversight. The current board is composed of over a dozen community and business leaders. Madera Community Hospital was founded in 1971 and is located at 1250 E. Almond Avenue in Madera, California. The hospital contains 106 licensed acute care beds including an intensive care unit and a licensed Emergency Department (fully staffed by board certified physicians). Madera Community Hospital, as part its routine filings, reports to the State of California that it also operates rural health care clinics.

Madera Community Hospital is located in Madera County, California. The total population of the county is approximately 150,000+ residents. There are two (2) licensed hospitals in Madera County: Madera Community Hospital and Valley Children's Hospital. And, while Valley Children's is licensed as a general acute care hospital, Valley Children's Hospital primarily serves children and younger populations.

Madera Community Hospital is thus the only general acute care hospital in the County serving adult and pediatric patients. The majority of hospital services (basic inpatient, emergency, and surgery) provided by Madera Community Hospital are to residents of Madera County. Residents of Madera County are highly dependent on Madera Community Hospital for access to health care services to meet their health care needs. In addition, Madera Community Hospital operates several rural health clinics that provide needed services on an outpatient basis.

Madera Community Hospital's financial performance, which historically had been relatively stable, has become unstable and deteriorated substantially in recent years. The onset of the COVID-19 pandemic appears to have changed the financial picture for many hospitals and especially small and rural hospitals, including Madera Community Hospital. Madera Community Hospital has accumulated substantial and continuing financial losses since the onset of the COVID-19 pandemic. Cumulative losses for the eight quarters of 2020 and 2021 reached $16 million from patient operations and a slightly smaller but significant $14+ million on total hospital operations. Recent financial losses seem to be more related to rapid and sustained increases in operating costs rather than significant reductions in hospital utilization and/or patient service revenue.

The Hospital has sustained continuing substantial financial losses with limited financial reserves to offset the losses. The proposed transaction is thus consistent with the national trend where financially distressed hospitals either merge with a more stable financial partner or the hospital closes. The proposed transaction would allow Madera Community Hospital to remain open and viable and to continue to provide needed services to Madera County residents.

While the merger, should it be approved, has the potential to generate benefits for consumers and the community, there are also potential risks that needed to be identified, assessed, and considered in the approval process.

The Proposed Transaction

The proposed transaction is a combination of Madera Community Hospital in Madera County and St. Agnes Medical Center in Fresno County. St. Agnes Medical Center is a large general acute care hospital with a wide range of acute and other services. St. Agnes Medical Center is part of a large national health system (Trinity Health) and is more financially stable than Madera Community Medical Center.

Profile of Acquiring Hospital – St. Agnes Medical Center

Mission and Organization

St. Agnes Medical Center provided the following description of their mission and organization in a recent Community Needs Assessment Report (2019):

> **Our Mission:** We, Saint Agnes Medical Center and Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.
>
> **About:** Saint Agnes Medical Center (SAMC, Saint Agnes) is a Catholic health care ministry, not-for-profit hospital with 436 acute care beds, located in the city of Fresno, California. SAMC serves the community members of Fresno, Madera, Kings, and Tulare counties. In May 2013, SAMC became a member of one of the nation's largest Catholic Health systems with the merger of Catholic Health East and Trinity Health. Trinity Health employs more than 95,000 people in 21 states and returns more than $1 billion to its communities annually in the form of charity care and other community benefit programs. SAMC's 2,533 staff and 902 active volunteers work diligently to serve the needs of 1.1 million patrons in its service area. Our growth continues with Saint Agnes Care, a nonprofit subsidiary of Saint Agnes Medical Center comprised of primary, specialty and urgent care clinics, which now includes a network of more than 80 providers at 20 locations in Fresno and Clovis.
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> Source: *Saint Agnes Medical Center - Community Health Needs Assessment, 2019*; https://www.samc.com/assets/documents/2019-samc-central-valley-chna.pdf.

Services Provided by St. Agnes Medical Center – Outpatient and Inpatient

In their Community Needs Assessment Report (2019) St. Agnes Medical Center lists the services provided, as follows:

Our Services

Outpatient Care Service – Outreach Programs

- Breast Care Center
- Holy Cross Center for Women
- Holy Cross Clinic at Poverello House
- Home Health and Hospice
- Outpatient Surgery North
- Pathways Cancer Support Services
- Saint Agnes Physician Residency Clinics
- Saint Agnes Health Hub
- Saint Agnes Wound Care
  Hyperbaric Medicine and Amputation Prevention

Saint Agnes Care

- Advanced Laparoscopic & Robotic Surgery
- Cardiology
- Family Practice
- General Surgery
- Internal Medicine
- Metabolic & Bariatric Surgery
- Neurosurgery
- Sports Medicine
- Obstetrics & Gynecology
- Occupational Health
- Orthopedic Surgery
- Pain Management

Source: ***Saint Agnes Medical Center - Community Health Needs Assessment, 2019***; https://www.samc.com/assets/documents/2019-samc-central-valley-chna.pdf.

Community Health Needs Identified by St. Agnes Medical Center

In addition, St. Agnes Medical Center identified a number of prioritized health needs for their community, as follows:

IDENTIFIED HEALTH NEEDS

Prioritization Process and Identified Needs

Saint Agnes Medical Center, in collaboration with Community Medical Centers and Valley Children's Healthcare, invited leaders representing public health and community-based sectors from Fresno, Kings, Madera and Tulare counties to participate in a CHNA-identified health needs ranking process. The majority of these participants were surveyed in the primary data gathering phase of the 2019 CHNA report process. Public health and community leaders were tasked with ranking the needs that were most pressing in their respective counties —based on health issues previously identified in our 2019 primary data collection phase. Participants in our collaborative health ranking session, held Friday, March 29, 2019 in Fresno, California were tasked with ranking the identified health needs based on the following criteria:

- Severity, magnitude, urgency
- Feasibility and effectiveness of possible interventions
- Potential impact on greatest number of people
- Potential health need score (which included community stakeholder and resident feedback - *see page 44-47*)
- Outcomes are measurable and achievable in a 3-year span
- Existing resources/programs

Prioritized Needs

1. Access to Care
2. Obesity/HEAL/Diabetes
3. Maternal and Infant Health
4. Mental Health
5. Economic Security
6. Oral Health
7. Substance Use/Tobacco
8. Violence and Injury Prevention
9. Climate and Health
10. CVD/Stroke
11. Asthma
12. HIV/AIDS/STIs
13. Cancer

Source: ***Saint Agnes Medical Center - Community Health Needs Assessment, 2019***; https://www.samc.com/assets/documents/2019-samc-central-valley-chna.pdf.

Summary Statistics – St. Agnes Medical Center

The following set of tables provide detailed data on the capacity, available services, utilization, operations, and financial performance of St. Agnes Medical Center for the most current available three years (2018 – 2020), based on the Hospital's Annual Financial Disclosure reports to HCAI. In general, these data paint a picture of a much larger hospital, with a wider range of available services, and more stable financial position relative to Madera Community Hospital.

Overall, the data indicate the ability of St. Agnes Medical Center to provide administrative, clinical, and financial resources to stabilize and maintain the solvency and operations of Madera Community Hospital. It is important to note that this analysis does not include data for the Trinity Health system.

Beds and Utilization

The Table below summarizes licensed bed and utilization statistics for St. Agnes Medical Center for three years, 2018 – 2020.

Beds and Utilization Statistics	St. Agnes FYE 6/30/2020	St. Agnes FYE 6/30/2019	St. Agnes FYE 6/30/2018
General Acute Care Beds			
Licensed Beds	436	436	436
Licensed Bed Occ. Rate	61.19%	70.76%	66.58%
Available Beds	436	436	436
Available Bed Occ. Rate	61.19%	70.76%	66.58%
Summary Utilization Statistics			
Patient Days (excl. nursery)	97,650	112,601	105,952
Discharges (excl. nursery)	22,243	24,572	23,542
Average Length of Stay (est.)	4.39	4.58	4.5
Adjusted Patient Days	161,680	182,901	170,844
ER Visits	78,361	85,850	87,361
Referred O/P Visits	89,734	100,721	103,619
I/P Surgeries	4,028	4,529	4,373
O/P Surgeries	7,065	7,510	7,241
Nursery Days	7,038	6,681	6,496
Nursery Discharges	3,908	3,761	3,550
Natural Births	2,528	2,340	2,239
Cesarean Sections	1,344	1,354	1,294

Source: HCAI PIVOT Data, Selected Years.

Income Statement

The Table below summarizes income statement data for St. Agnes Medical Center for three years, 2018 – 2020.

Income Statement - Total	St. Agnes FYE 6/30/2020	St. Agnes FYE 6/30/2019	St. Agnes FYE 6/30/2018
Gross Patient Revenue	$ 1,836,400,905	$ 1,924,865,392	$ 1,843,225,783
- Deductions from Revenue	1,354,135,168	1,419,054,509	1,317,136,232
+ Capitation Premium Rev.	0	0	0
Net Patient Revenue	$ 482,265,737	$ 505,810,883	$ 526,089,551
+ Other Operating Revenue	20,346,622	7,494,210	7,986,679
Total Operating Revenue	$ 502,612,359	$ 513,305,093	$ 534,076,230
- Operating Expenses	521,930,076	501,775,183	476,436,848
Net from Operations	($19,317,717)	$ 11,529,910	$ 57,639,382
+ Non-Operating Revenue	15,878,972	23,650,106	26,595,677
- Non-Operating Expense	5,309,713	5,791,418	11,055
- Income Taxes	0	0	0
- Extraordinary Items	0	0	0
Net Income	($8,748,458)	$ 29,388,598	$ 84,224,004
Uncompensated Care Costs			
Charity-Other	$ 4,038,982	$ 4,228,419	$ 2,772,482
Charity-Other + Bad Debt	6,918,942	6,220,957	4,635,690
Charity-Other + Bad Debt + CIP Cont. Adj.	6,918,942	6,220,957	4,635,690
Uncompensated Care Costs % of Operating Expenses			
Charity % of Operating Expenses	0.81%	0.86%	0.59%
Charity + Bad Debt % Operating Expenses	1.38%	1.26%	0.99%
Charity+Bad Debt+CIP Cont Adj % of Op. Exp.	1.38%	1.26%	0.99%

Source: HCAI PIVOT Data, Selected Years.

Income Statement per Adjusted Day

The Table below summarizes income statement data per day for St. Agnes Medical Center for three years, 2018 – 2020.

Income Statement - Per Adjusted Day	St. Agnes FYE 6/30/2020	St. Agnes FYE 6/30/2019	St. Agnes FYE 6/30/2018
Gross Patient Revenue	$ 11,358.26	$ 10,524.08	$ 10,788.97
- Deductions from Revenue	8,375.42	7,758.59	7,709.60
+ Capitation Premium Rev.	0.00	0.00	0.00
Net Patient Revenue	$ 2,982.85	$ 2,765.49	$ 3,079.36
+ Other Operating Revenue	125.85	40.97	46.75
Total Operating Revenue	$ 3,108.69	$ 2,806.46	$ 3,126.11
- Operating Expenses	3,228.17	2,743.43	2,788.73
Net from Operations	($119.48)	$ 63.04	$ 337.38
+ Non-Operating Revenue	98.21	129.31	155.67
- Non-Operating Expense	32.84	31.66	0.06
- Income Taxes	0.00	0.00	0.00
- Extraordinary Items	0.00	0.00	0.00
Net Income	($54.11)	$ 160.68	$ 492.99

Source: HCAI PIVOT Data, Selected Years.

Deductions from Revenue

The Table below summarizes deductions from revenue data by payor for St. Agnes Medical Center for three years, 2018 – 2020.

Deductions from Revenue	St. Agnes FYE 6/30/2020	St. Agnes FYE 6/30/2019	St. Agnes FYE 6/30/2018
Medicare Cont Adj-Trad	$ 525,740,468	$ 584,448,629	$ 555,664,781
Medicare Cont Adj-Mng Care	160,320,799	164,293,538	137,259,037
Medi-Cal Cont Adj-Trad	67,425,115	82,298,198	65,919,316
Medi-Cal Cont Adj-Mng Care	339,021,306	326,295,019	303,824,936
DSH (SB 855) Funds Rec'd	0	0	0
Co Indigent Cont Adj	0	0	0
Other 3rd Cont Adj-Trad.	131,321,305	125,554,949	10,851,476
Other 3rd Cont Adj-Mng Care	104,974,495	111,938,065	225,376,488
Provision for Bad Debts	10,544,129	7,759,489	7,331,224
Charity-Hill-Burton	0	0	0
Charity-Other	14,787,551	16,466,622	10,908,974
Total Deductions from Rev.	$ 1,354,135,168	$ 1,419,054,509	$ 1,317,136,232

Source: HCAI PIVOT Data, Selected Years.

Financial and Utilization – All Payors

The Table below summarizes financial and utilization data for all payors for St. Agnes Medical Center for three years, 2018 – 2020.

Financial and Utilization - Total	St. Agnes FYE 6/30/2020	St. Agnes FYE 6/30/2019	St. Agnes FYE 6/30/2018
Patient Days (excl. nursery)	97,650	112,601	105,952
Discharges (excl. nursery)	22,243	24,572	23,542
Average Length of Stay (est.)	4.39	4.58	4.50
Outpatient Visits	163,797	178,739	183,728
Gross Inpatient Revenue	$ 1,109,134,341	$ 1,185,022,331	$ 1,143,112,670
Gross Outpatient Revenue	727,266,564	739,843,061	700,113,113
Gross Patient Revenue	$ 1,836,400,905	$ 1,924,865,392	$ 1,843,225,783
- Deductions from Rev	1,354,135,168	1,419,054,509	1,317,136,232
+ Capitation Premium Rev	0	0	0
Net Patient Revenue	$ 482,265,737	$ 505,810,883	$ 526,089,551
Percent of Gross Revenue	26.26%	26.28%	28.54%
Expenses (est.)	$ 501,583,454	$ 494,280,973	$ 468,450,169
Payment Shortfall	($19,317,717)	$ 11,529,910	$ 57,639,382
Adjusted Patient Days	161,680	182,901	170,844

Source: HCAI PIVOT Data, Selected Years.

Financial and Utilization – Medicare

The Table below summarizes financial and utilization data for Medicare for St. Agnes Medical Center for three years, 2018 – 2020.

Financial and Utilization - Medicare	St. Agnes FYE 6/30/2020	St. Agnes FYE 6/30/2019	St. Agnes FYE 6/30/2018
Patient Days (excl. nursery)	55,934	65,427	58,693
Discharges (excl. nursery)	12,741	14,277	11,568
Average Length of Stay (est.)	4.39	4.58	5.10
Outpatient Visits	61,337	66,336	72,028
Gross Inpatient Revenue	617,175,322	667,369,690	612,087,177
Gross Outpatient Revenue	294,891,366	297,807,187	282,297,170
Gross Patient Revenue	912,066,688	965,176,877	894,384,347
- Deductions from Rev	687,281,180	750,254,367	693,691,813
+ Capitation Premium Rev	0	0	0
Net Patient Revenue	224,785,508	214,922,510	200,692,534
Percent of Gross Revenue	24.65%	22.27%	22.44%
Expenses (est.)	249,116,388	247,845,157	227,305,034
Payment Shortfall	(24,330,880)	(32,922,647)	(26,612,500)
Adjusted Patient Days	82,659	94,602	85,716
Gross I/P Rev Per Day	22,075.84	20,568.73	21,632.47
Gross I/P Rev Per Discharge	96,912.18	94,261.23	110,435.37
Gross O/P Rev Per Visit	9,629.29	9,056.32	7,817.48
Net I/P Rev Per Day	5,382.58	4,430.63	4,755.12
Net I/P Rev Per Discharge	23,629.38	20,304.41	24,268.71
Net O/P Rev Per Visit	2,347.74	1,950.57	1,721.60

Source: HCAI PIVOT Data, Selected Years.

Financial and Utilization – Medi-Cal

The Table below summarizes financial and utilization data for Medi-Cal for St. Agnes Medical Center for three years, 2018 – 2020.

Financial and Utilization - Medi-Cal	St. Agnes FYE 6/30/2020	St. Agnes FYE 6/30/2019	St. Agnes FYE 6/30/2018
Patient Days (excl. nursery)	27,830	31,698	31,701
Discharges (excl. nursery)	6,338	6,918	7,784
Average Length of Stay (est.)	4.39	4.58	4.10
Outpatient Visits	57,562	64,528	64,453
Gross Inpatient Revenue	290,628,734	310,646,670	325,558,246
Gross Outpatient Revenue	228,285,973	240,570,754	228,980,741
Gross Patient Revenue	518,914,707	551,217,424	554,538,987
- Deductions from Rev	407,521,618	409,609,795	369,982,500
+ Capitation Premium Rev	0	0	0
Net Patient Revenue	111,393,089	141,607,629	184,556,487
Percent of Gross Revenue	21.47%	25.69%	33.28%
Expenses (est.)	141,733,230	141,545,630	140,934,380
Payment Shortfall	(30,340,141)	61,999	43,622,107
Adjusted Patient Days	49,648	56,194	53,690
Gross I/P Rev Per Day	20,720.21	19,440.60	20,007.26
Gross I/P Rev Per Discharge	90,975.73	89,073.56	81,968.53
Gross O/P Rev Per Visit	7,802.41	7,357.96	6,893.33
Net I/P Rev Per Day	6,252.15	6,021.18	6,745.46
Net I/P Rev Per Discharge	27,448.22	27,587.30	27,643.79
Net O/P Rev Per Visit	2,334.63	2,273.71	2,324.80

Source: HCAI PIVOT Data, Selected Years

Financial and Utilization – Other Third Party (Commercial/Private)

The Table below summarizes financial and utilization data for commercial/private payors for St. Agnes Medical Center for three years, 2018 – 2020.

Financial and Utilization - Other Third Party	St. Agnes FYE 6/30/2020	St. Agnes FYE 6/30/2019	St. Agnes FYE 6/30/2018
Patient Days (excl. nursery)	13,402	14,929	14,823
Discharges (excl. nursery)	3,053	3,258	3,961
Average Length of Stay (est.)	4.39	4.58	3.98
Outpatient Visits	40,985	44,769	43,805
Gross Inpatient Revenue	195,825,573	200,864,237	200,430,494
Gross Outpatient Revenue	189,394,780	190,093,911	176,803,845
Gross Patient Revenue	385,220,353	390,958,148	377,234,339
- Deductions from Rev	242,633,544	242,812,915	241,086,424
+ Capitation Premium Rev	0	0	0
Net Patient Revenue	142,586,809	148,145,233	136,147,915
Percent of Gross Revenue	37.01%	37.89%	36.09%
Expenses (est.)	105,216,761	100,393,084	95,872,948
Payment Shortfall	37,370,048	47,752,149	40,274,967
Adjusted Patient Days	26,400	28,920	29,123
Gross I/P Rev Per Day	29,172.67	27,774.53	17,781.19
Gross I/P Rev Per Discharge	128,061.46	127,269.36	67,723.47
Gross O/P Rev Per Visit	9,242.65	8,526.12	7,447.07
Net I/P Rev Per Day	10,808.78	10,282.48	5,832.03
Net I/P Rev Per Discharge	47,447.14	47,116.80	21,885.33
Net O/P Rev Per Visit	3,439.62	3,191.50	2,025.46

Source: HCAI PIVOT Data, Selected Years.

Inpatient Service Mix - Top 25 DRGs - St. Agnes Medical Center

The Table below summarizes discharge and charge data for the Top 25 DRGs or Diagnosis-related group codes for all payors for St. Agnes Medical Center for three years, 2018 – 2020.

MS-DRG Code	MS-DRG Description	Number of Discharges	Total Charges	Mean Charge Per Day	Mean Length Of Stay
795	NORMAL NEWBORN	2,504	$ 7,475,296	$ 1,652	1.81
807	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	2,184	$ 25,266,238	$ 5,709	2.03
788	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	955	$ 21,117,079	$ 7,635	2.90
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	759	$ 47,498,161	$ 8,480	7.38
794	NEONATE W OTHER SIGNIFICANT PROBLEMS	748	$ 2,425,737	$ 1,664	1.95
291	HEART FAILURE & SHOCK W MCC	734	$ 28,410,943	$ 7,870	4.92
177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	516	$ 24,497,949	$ 6,803	6.98
789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	379	$ 507,521	$ 1,442	1.06
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	363	$ 8,628,088	$ 7,337	3.24
470	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	361	$ 25,135,765	$ 33,876	2.06
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	330	$ 11,503,573	$ 8,300	4.20
392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	323	$ 9,325,583	$ 8,950	3.23
193	SIMPLE PNEUMONIA & PLEURISY W MCC	310	$ 12,018,991	$ 7,082	5.47
378	G.I. HEMORRHAGE W CC	303	$ 10,331,923	$ 10,363	3.29
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	288	$ 8,754,083	$ 7,476	4.07
194	SIMPLE PNEUMONIA & PLEURISY W CC	278	$ 7,339,759	$ 7,490	3.53
641	MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS/ELECTROLYTES W/O MCC	271	$ 6,538,037	$ 8,569	2.82
292	HEART FAILURE & SHOCK W CC	228	$ 6,339,558	$ 8,191	3.39

683	RENAL FAILURE W CC	224	$ 6,633,958	$ 7,156	4.14
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	213	$ 18,488,414	$ 41,829	2.08
603	CELLULITIS W/O MCC	209	$ 4,972,648	$ 6,897	3.45
065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	179	$ 6,690,866	$ 10,740	3.48
743	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	175	$ 5,966,142	$ 20,293	1.68
853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	172	$ 28,616,884	$ 10,914	15.24
638	DIABETES W CC	167	$ 3,978,343	$ 7,651	3.11

Source: HCAI Top 25 DRGs Report (2020).

Profile of Acquired Hospital – Madera Community Hospital

Licensure Status

Madera Community Hospital is a general acute care hospital, fully accredited by the American Osteopathic Association Healthcare Facilities Accreditation Program and licensed by the California Department of Public Health. Madera Community Hospital is a member of the Hospital Council of Northern and Central California and the California Hospital Association.

History, Capacity, and Services

Madera Community Hospital opened on October 1, 1971 as a 63-bed community hospital. Today, it provides an array of diagnostic and treatment services from a 106-bed hospital and various clinics and outpatient facilities. As a private, not for profit community hospital (501(c)(3)), incorporated in the State of California, Madera Community Hospital is dedicated to providing quality health care services to Madera County and the surrounding communities. Growing to meet the needs of the community, Madera Community Hospital opened a new 16-bed Emergency Department (ED) and 10-bed Intensive Care Unit (ICU) in December of 2000 in a 15,000 square foot addition to the original building. The facility has a separate ambulance entrance and elevator to transport patients directly from ER to ICU. In 2012, the hospital completed construction of and opened a 13,000 square foot Central Utility Plant to support the buildings and services provided on the main campus. Services at Madera Community Hospital include surgery (both inpatient and outpatient), 24-hour emergency services, specialized intensive care unit, cardiac care, medical and surgical care, maternity care (including private birthing suites), diagnostic imaging, laboratory, physical therapy, respiratory therapy, speech therapy, health education and support groups. Madera Community Hospital operates rural

health clinics and other non-hospital-based services. The hospital employs over 700 people in 46 departments.

Affiliated Providers and Entities: The Family Health Services Madera (FHS) Clinic (a rural health clinic), located on the Hospital campus, is open from 8:30 a.m. to 6:00 p.m. seven days per week (closed some holidays). Appointments may be made in advance, and walk-ins are seen on a first come/first served basis. The FHS Clinic is staffed with Family Nurse Practitioners and Physician Assistants. A separate Specialty Clinic is also operated in which contracted physicians see patients with certain special health needs.

Madera Community Hospital expanded to provide services at the Chowchilla Medical Center (a rural health clinic) in 2007. The Chowchilla Medical Center, located at 285 Hospital Drive in Chowchilla, is staffed with a full-time Nurse Practitioner or Physician Assistant, Monday through Saturday. Appointments may be made in advance, and walk-ins are seen on a first come/first served basis. The Madera Community Hospital medical staff consists of a number of active and courtesy staff, practicing in primary care and internal medicine and a broad range of specialties.

Madera Community Hospital operates Family Health Services (FHS) Mendota, a third rural health clinic of the hospital, and also provides other outpatient service locations that offer mammography and x-ray services in Madera County.[15]

Madera Community Hospital – Existing Service Inventory

The Table below summarizes service inventory and service availability data for Madera Community Hospital for 2020. This list is limited to Madera Community Hospital hospital-based services as reported to HCAI on their hospital level report. Madera Community Hospital may offer additional services, either through their non-hospital-based clinics and programs or at the hospital but not explicitly listed below.

Daily Hospital Services	(1) Code	Laboratory Services (Continued)	(2) Code	Clinic Services	(3) Code
		Microbiology	1	Dental	3
Burn	3	Necropsy	2	Dermatology	4
Coronary	1	Serology	1	Diabetes	4
Medical	1	Surgical Pathology	2	Drug Abuse	3
Neonatal	3	**Diagnostic Imaging Services**		Family Therapy	3

[15] Source: Madera Community Hospitals - 2018-Community-Benefits-and-Social-Accountability-Report.pdf; www.maderahospital.org/documents/content/2018-Community-Benefits-and-Social-Accountability-Report.pdf.

Neurosurgical	3	Computed Tomography	1	Group Therapy	3
Pediatric	3	Cystoscopy	1	Hypertension	4
Pulmonary	1	Magnetic Resonance Imaging	1	Metabolic	3
Surgical	1	Positron Emission Tomography	3	Neurology	4
Definitive Observation Care	1	Ultrasonography	1	Neonatal	3
		X-Ray - Radiology	1	Obesity	3
Alternate Birthing Center (Licensed Beds)	3	**Diagnostic/Therapeutic Services**		Obstetrics	3
Geriatric	1	Audiology	3	Ophthalmology	4
Medical	1	Biofeedback Therapy	3	Orthopedic	4
Neonatal	3	Cardiac Catheterization	2	Otolaryngology	3
Oncology	3	Cobalt Therapy	3	Pediatric	4
Orthopedic	1	Diagnostic Radioisotope	1	Pediatric Surgery	4
Pediatric	3	Echocardiology	1	Podiatry	4
Physical Rehabilitation	3	Electrocardiology	1	Psychiatric	3
Post-Partum	1	Electroencephalography	1	Renal	3
Surgical	1	Electromyography	2	Rheumatic	3
Transitional Inpatient Care (Acute Beds)	1				
		Endoscopy	1	Rural Health	1
Developmentally Disabled Nursery Care	3	Gastro-Intestinal Laboratory	1	Surgery	1
Newborn Nursery Care	1	Hyperbaric Chamber Services	3		
Premature Nursery Care	3	Lithotripsy	2	**Home Care Services**	
Hospice Care	3	Nuclear Medicine	1	Home Health Aide Services	3
Inpatient Care Under Custody (Jail)	1	Occupational Therapy	1	Home Nursing Care (Visiting Nurse)	3
		Physical Therapy	1	Home Physical Medicine Care	3
Behavioral Disorder Care	3	Peripheral Vascular Laboratory	3	Home Social Service Care	3
Developmentally Disabled Care	3	Pulmonary Function Services	2	Home Dialysis Training	3
Intermediate Care	3	Radiation Therapy	3	Home Hospice Care	3

Residential/Self Care	3	Radium Therapy	3	Home I.V. Therapy Services	3
Self Care	3	Radioactive Implants	3	Jail Care	3
Skilled Nursing Care	3	Recreational Therapy	3	Psychiatric Foster Home Care	3
Sub-Acute Care	3	Respiratory Therapy Services	1		
Sub-Acute Care - Pediatric	3				
Transitional Inpatient Care (SNF Beds)	3				
Chemical Dependency - Detox		Speech-Language Pathology	1	**Ambulatory Services**	
Alcohol	3	Sports Care Medicine	3	Adult Day Health Care Center	3
Drug	3	Stress Testing	1	Ambulatory Surgery Services	1
		Therapeutic Radioisotope	3	Comprehensive Outpatient Rehab Facility	3
Alcohol	3	X-Ray Radiology Therapy	3	Observation (Short Stay) Care	1
		Psychiatric Services		**Ambulatory Services**	
		Clinic Psychologist Services	3	Satellite Clinic Services	3
Psychiatric Acute - Adult	3	Child Care Services	3		
Psychiatric - Adolescent and Child	3	Electroconvulsive Therapy (Shock)	3		
Psychiatric Intensive (Isolation) Care	3	Milieu Therapy	3	Diabetic Training Class	1
Psychiatric Long-Term Care	3	Night Care	3	Diabetic Counseling	1
		Psychiatric Therapy	3	Drug Reaction Information	2
Obstetric Services		Psychopharmacological Therapy	3	Family Planning	3
Abortion Services	3	Sheltered Workshop	3	Genetic Counseling	3
Combined Labor/Delivery Birthing Room	1	**Renal Dialysis**		Medical Research	3
Delivery Room Services	1	Hemodialysis	1	Parent Training Class	1
Infertility Services	3	Home Dialysis Support Services	3	Patient Representative	1
Labor Room Services	1	Peritoneal	3	Public Health Class	3
		Self-Dialysis Training	3	Social Work Services	1

Dental	3	Organ Acquisition	2	Toxicology/Antidote Information	2
General	1	Blood Bank	2	Vocational Services	3
Gynecological	1	Extracorporeal Membrane Oxygenation	3		
Heart	3	Pharmacy	1		
Kidney	1			Approved Residency	3
Neurosurgical	3			Approved Fellowship	3
Open Heart	3	Emergency Communications Systems	1	Non-Approved Residency	3
Ophthalmologic	3	Emergency Helicopter Service	2	Associate Records Technician	3
Organ Transplant	3	Emergency Observation Service	1	Diagnostic Radiologic Technologist	3
Orthopedic	1	Emergency Room Service	1	Dietetic Intern Program	3
Otolaryngolic	1	Heliport	3	Emergency Medical Technician	3
Pediatric	3	Medical Transportation	2	Hospital Administration Program	3
Plastic	3	Mobile Cardiac Care Services	2	Licensed Vocational Nurse	3
Podiatry	1	Orthopedic Emergency Services	1	Medical Technologist Program	3
Thoracic	1	Psychiatric Emergency Services	3	Medical Records Administrator	3
Urologic	3	Radioisotope Decontamination Room	3	Nurse Anesthetist	3
Anesthesia Services	1	Trauma Treatment E.R.	3	Nurse Practitioner	3
				Nurse Midwife	3
Laboratory Services		**Clinic Services**		Occupational Therapist	3
Anatomical Pathology	2	AIDS	3	Pharmacy Intern	3
Chemistry	1	Alcoholism	3	Physician Assistant	3
Clinical Pathology	1	Allergy	3	Physical Therapist	3
Cytogenetics	2	Cardiology	4	Registered Nurse	3
Cytology	2	Chest Medical	4	Respiratory Therapist	3
Hematology	1	Child Diagnosis	4	Social Worker Program	3
Histocompatibility	3	Child Treatment	4		
Immunology	1	Communicable Disease	3		

Service Availability Codes: 1 - Service is available at the hospital. 2 - Service is available through arrangement at another health care entity. 3 - Service not available. 4 - Clinic services are commonly provided in the emergency suite to non-emergency outpatients by hospital-based physicians or residents. *Code 4 used only for Clinic services. Source: HCAI, Hospital Annual Disclosure Report, 2020.

Top 25 DRGS for Madera Community Hospital

The Table below summarizes discharge and charge data for the Top 25 DRGs for all payors for Madera Community Hospital, 2020.

MS-DRG Code	MS-DRG Description	Number of Disch.	Total Charges	Mean Charge Per Stay	Mean Charge Per Day	Mean Length Of Stay
795	NORMAL NEWBORN	2,504	$7,475,296	$2,989	$1,652	1.81
807	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	2,184	$25,266,238	$11,574	$5,709	2.03
788	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	955	$21,117,079	$22,112	$7,635	2.90
871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W MCC	759	$47,498,161	$62,580	$8,480	7.38
794	NEONATE W OTHER SIGNIFICANT PROBLEMS	748	$2,425,737	$3,243	$1,664	1.95
291	HEART FAILURE & SHOCK W MCC	734	$28,410,943	$38,707	$7,870	4.92
177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	516	$24,497,949	$47,477	$6,803	6.98
789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	379	$507,521	$1,538	$1,442	1.06
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	363	$8,628,088	$23,769	$7,337	3.24
470	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	361	$25,135,765	$69,628	$33,876	2.06
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	330	$11,503,573	$34,859	$8,300	4.20
392	ESOPHAGITIS, GASTROENT & MISC	323	$9,325,583	$28,872	$8,950	3.23

	DIGEST DISORDERS W/O MCC					
193	SIMPLE PNEUMONIA & PLEURISY W MCC	310	$12,018,991	$38,771	$7,082	5.47
378	G.I. HEMORRHAGE W CC	303	$10,331,923	$34,099	$10,363	3.29
872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	288	$8,754,083	$30,396	$7,476	4.07
194	SIMPLE PNEUMONIA & PLEURISY W CC	278	$7,339,759	$26,402	$7,490	3.53
641	MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS/ELECTROLYTES W/O MCC	271	$6,538,037	$24,126	$8,569	2.82
292	HEART FAILURE & SHOCK W CC	228	$6,339,558	$27,805	$8,191	3.39
683	RENAL FAILURE W CC	224	$6,633,958	$29,616	$7,156	4.14
247	PERC CARDIOVASC PROC W DRUG-ELUTING STENT W/O MCC	213	$18,488,414	$86,800	$41,829	2.08
603	CELLULITIS W/O MCC	209	$4,972,648	$23,793	$6,897	3.45
065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	179	$6,690,866	$37,379	$10,740	3.48
743	UTERINE & ADNEXA PROC FOR NON-MALIGNANCY W/O CC/MCC	175	$5,966,142	$34,092	$20,293	1.68
853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	172	$28,616,884	$166,377	$10,914	15.24
638	DIABETES W CC	167	$3,978,343	$23,822	$7,651	3.11

Source: HCAI Top 25 DRG Report, 2020.

Economic Impact of Madera Community Hospital on Broader Local Economy

A recent report commissioned by the Hospital Council of Northern & Central California documents that Madera Community Hospital provides important economic benefits to Madera County beyond providing needed health care services to Madera County residents. According to the report (see summary data in Table below), Madera Community Hospital has an economic "ripple effect" that creates additional employment (beyond direct employment and income within the Hospital) and increases the size of the local economy and household incomes in the region. Major beneficiaries of hospital spending are industries of employment services, real estate, restaurants, financial investment firms, and wholesale trade. Research has shown that household income levels are important predictors of the health status of a population. The study produced the following findings:

Table 5.3. Hospital Spending Economic Impact

Effect	Employment Impact	Labor Income Impact	Output Impact
Direct	997	$89,841,999	$172,360,443
Indirect	382	$16,770,830	$46,892,876
Induced	534	$22,900,791	$69,368,669
Total	**1,913**	**$129,513,620**	**$288,621,988**

Source: Economic Impact Report, commissioned by the Hospital Council of Northern & Central California, estimates the economic impact of hospital spending in the Central Valley (Fresno, Kings, Madera, and Tulare Counties). Financial data used for this report was collected from HCAI for 2014–2015. Analysis was conducted by: Abbas P. Grammy, Ph.D. Professor of Economics California State University, Bakersfield 9001 Stockdale Highway, Bakersfield, CA 93311 (661) 654-2466, agrammy@csub.edu.

In addition, the study estimated additional tax revenue generated by the economic activity of Madera Community Hospital, as follows:

> Spending of Madera Community delivers $41.0 million in tax revenues. State and local governments take $12.1 million (30 percent) and the federal government collects $28.9 million (70 percent). States and local government taxes are collected from various sources, including $521,300 from employees' compensation, $6.3 million from production and imports, $4.9 million from personal income, and $452,500 from corporate profit. Distribution of federal government taxes includes $13.8 million from employees' compensation, $421,700 from proprietors' income, $1.2 million from production and imports, $10.9 million from personal income, and $2.6 million from corporate profit.

Madera Community Hospital – Summary Statistics based on Annual Financial Data

The following set of tables provide detailed data on the capacity, available services, utilization, operations, and financial performance of Madera Community Hospital for the most current available three years (2018-2020), based on the Hospital's Annual Financial reports to HCAI.

In addition to this set of Tables covering CY, 2018-2020, the Report incorporates data covering all of CY 2020 and 2021 as reported to HCAI by Madera Community Hospital via the quarterly reporting system. The quarterly data represent the most recent, publicly reported and available data for Madera Community Hospital. The quarterly data are reported to HCAI within 90 days of the close of each quarter. The quarterly data provides the most up-to-date picture of the Hospital's performance. Tables are based on quarterly data and additional details on the interpretation and use of the quarterly data are provided below.

Beds and Utilization

The Table below summarizes licensed beds and utilization statistics for Madera Community Hospital based on Annual PIVOT Data, 2018-2020.

	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018
General Acute Care Beds			
Licensed Beds	106	106	106
Licensed Bed Occ. Rate	34.06%	36.28%	38.43%
Available Beds	106	106	106
Available Bed Occ. Rate	34.06%	36.28%	38.43%
Summary Utilization Statistics			
Patient Days (excl. nursery)	13,214	14,036	14,870
Discharges (excl. nursery)	3,251	3,658	3,885
Average Length of Stay (est.)	4.06	3.84	3.83
Adjusted Patient Days	30,165	31,809	32,676
ER Visits	31,588	33,820	34,626
Clinic Visits	51,141	56,487	60,020
Home Health Visits	0	0	0
Referred O/P Visits	44,939	53,952	56,258
I/P Surgeries	1,307	1,379	1,387
O/P Surgeries	1,743	1,817	1,750

Purchased I/P Days	0	0	0
Nursery Days	1,541	1,683	1,961
Nursery Discharges	786	806	888
Natural Births	547	607	658
Cesarean Sections	232	234	250

Source: HCAI Hospital PIVOT Data, Selected Years.

Income Statement, Uncompensated Care Costs and Uncompensated Care Costs Percent of Operating Expenses

The Table below summarizes income statement data for all payors for Madera Community Hospital based on Annual PIVOT Data, 2018-2020.

	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018
Gross Patient Revenue	201,922,700	205,807,554	202,639,935
- Deductions from Revenue	116,930,552	113,036,047	111,641,574
Net Patient Revenue	84,992,148	92,771,507	90,998,361
+ Other Operating Revenue	4,145,353	1,787,711	1,590,168
Total Operating Revenue	89,137,501	94,559,218	92,588,529
- Operating Expenses	91,301,309	93,635,532	90,032,246
Net from Operations	(2,163,808)	923,686	2,556,283
+ Non-Operating Revenue	1,132,263	920,353	713,512
- Non-Operating Expense	35,864	27,528	0
- Income Taxes	0	0	0
- Extraordinary Items	0	0	0
Net Income	(1,067,409)	1,816,511	3,269,795
Uncompensated Care Costs			
Charity-Other	780,209	1,011,002	785,552
Charity-Other + Bad Debt	2,315,905	2,502,417	2,118,529
Charity-Other + Bad Debt + CIP Cont. Adj.	2,339,396	2,515,454	2,127,330
Uncompensated Care Costs % of Operating Expenses			
Charity % of Operating Expenses	0.90%	1.10%	0.89%
Charity + Bad Debt % Operating Expenses	2.66%	2.72%	2.40%
Charity+Bad Debt+CIP Cont Adj % of Op. Exp.	2.68%	2.74%	2.41%

Source: HCAI Hospital PIVOT Data, Selected Years.

Income Statement - Per Adjusted Day

The Table below summarizes income statement data per day for all payors for Madera Community Hospital based on Annual PIVOT Data, 2018 – 2020.

Income Statement - Per Adjusted Day	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018
Gross Patient Revenue	6,693.98	6,470.20	6,201.54
- Deductions from Revenue	3,876.39	3,553.64	3,416.65
+ Capitation Premium Rev.	0.00	0.00	0.00
Net Patient Revenue	2,817.59	2,916.56	2,784.89
+ Other Operating Revenue	137.42	56.20	48.67
Total Operating Revenue	2,955.02	2,972.76	2,833.56
- Operating Expenses	3,026.75	2,943.73	2,755.32
Net from Operations	(71.73)	29.04	78.23
+ Non-Operating Revenue	37.54	28.93	21.84
- Non-Operating Expense	1.19	0.87	0.00
- Income Taxes	0.00	0.00	0.00
- Extraordinary Items	0.00	0.00	0.00
Net Income	(35.39)	57.11	100.07

Source: HCAI Hospital PIVOT Data, Selected Years.

Deductions from Revenue

The Table below summarizes deductions from revenue by payor for Madera Community Hospital based on Annual PIVOT Data, 2018 – 2020.

Deductions from Revenue	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018
Medicare Cont Adj-Trad	28,158,503	38,294,325	35,622,764
Medicare Cont Adj-Mng Care	8,782,607	7,340,967	6,791,409
Medi-Cal Cont Adj-Trad	5,002,801	5,665,600	3,244,591
Medi-Cal Cont Adj-Mng Care	48,945,627	38,766,779	47,260,292
DSH (SB 855) Funds 'ec'd	(3,880,059)	(4,450,135)	(2,838,579)
Co Indigent Cont Adj	54,424	29,213	20,165
Othe[r] 3rd Cont Adj-Trad.	8,675,673	7,601,303	7,588,980
Othe[r] 3rd Cont Adj-Mng Care	15,734,641	14,068,181	9,012,566
Provision for Bad Debts	3,557,896	3,341,881	3,054,139
Charity-Hill-Burton	0	0	0
Charity-Other	1,807,586	2,265,398	1,799,869
Gifts & Subs. Indigent Care	0	0	0
All Other Deductions	90,853	112,535	85,378
Total Deductions from Rev.	116,930,552	113,036,047	111,641,574

Source: HCAI Hospital PIVOT Data, Selected Years.

Financial and Utilization – Total, All Payors, Annual PIVOT Data

The Table below summarizes financial and utilization data for all payors for Madera Community Hospital based on Annual PIVOT Data, 2018-2020.

Financial and Utilization - Total	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018
Patient Days (excl. nursery)	13,214	14,036	14,870
Discharges (excl. nursery)	3,251	3,658	3,885
Average Length of Stay (est.)	4.06	3.84	3.83
Outpatient Visits	128,665	144,862	148,081
Gross Inpatient Revenue	88,454,275	90,815,768	92,216,934
Gross Outpatient Revenue	113,468,425	114,991,786	110,423,001
Gross Patient Revenue	201,922,700	205,807,554	202,639,935
- Deductions from Rev	116,930,552	113,036,047	111,641,574
+ Capitation Premium Rev	0	0	0
Net Patient Revenue	84,992,148	92,771,507	90,998,361
Percent of Gross Revenue	42.09%	45.08%	44.91%
Expenses (est.)	87,155,956	91,847,821	88,442,078
Payment Shortfall	(2,163,808)	923,686	2,556,283
Adjusted Patient Days	30,165	31,809	32,676

Source: HCAI Hospital PIVOT Data, Selected Years.

Financial and Utilization – Medicare, Annual PIVOT Data

The Table below summarizes income statement data for Medicare for Madera Community Hospital based on Annual PIVOT Data, 2018 – 2020.

Financial and Utilization - Medicare	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018
Patient Days (excl. nursery)	5,242	6,199	6,109
Discharges (excl. nursery)	1,083	1,318	1,355
Average Length of Stay (est.)	4.84	4.63	4.63
Outpatient Visits	24,349	29,053	29,889
Gross Inpatient Revenue	35,424,450	40,829,586	37,973,786
Gross Outpatient Revenue	26,615,365	28,062,716	25,186,878
Gross Patient Revenue	62,039,815	68,892,302	63,160,664
- Deductions from Rev	37,538,137	46,199,718	42,933,537
Net Patient Revenue	24,501,678	22,692,584	20,227,127
Percent of Gross Revenue	39%	32.94%	32.02%
Expenses (est.)	26,778,264	30,745,265	27,566,434
Payment Shortfall	(2,276,586)	(8,052,681)	(7,339,307)
Adjusted Patient Days	9,176	10,462	10,160
Gross I/P Rev Per Day	6,757.81	13,020.96	12,271.18
Gross I/P Rev Per Discharge	32,709.56	60,266.96	56,823.63
Gross O/P Rev Per Visit	1,093.08	1,871.44	1,608.83
Net I/P Rev Per Day	2,668.89	4,710.92	4,070.05
Net I/P Rev Per Discharge	12,918.14	21,714.72	18,888.83
Net O/P Rev Per Visit	431.69	673.25	531.98

Source: HCAI Hospital PIVOT Data, Selected Years.

Financial and Utilization – Medi-Cal

The Table below summarizes income statement data for Medi-Cal for Madera Community Hospital based on Annual PIVOT Data, 2018 – 2020.

Financial and Utilization - Medi-Cal	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018
Patient Days (excl. nursery)	6,079	5,993	6,862
Discharges (excl. nursery)	1,665	1,788	1,984
Average Length of Stay (est.)	3.65	3.35	3.45
Outpatient Visits	72,618	81,237	85,597
Gross Inpatient Revenue	40,372,991	39,047,660	41,878,321
Gross Outpatient Revenue	61,270,310	61,636,575	61,686,577
Gross Patient Revenue	101,643,301	100,684,235	103,564,898
- Deductions from Rev	50,161,120	40,179,493	47,829,089
Net Patient Revenue	51,482,181	60,504,742	55,735,809
Percent of Gross Revenue	51%	60.09%	53.82%
Expenses (est.)	43,872,329	44,933,373	45,200,838
Payment Shortfall	7,609,852	15,571,369	10,534,971
Adjusted Patient Days	15,253	15,491	16,878
Gross I/P Rev Per Day	6,641.39	13,142.98	12,036.18
Gross I/P Rev Per Discharge	24,248.04	44,009.93	41,540.59
Gross O/P Rev Per Visit	843.73	1,651.07	1,511.55
Net I/P Rev Per Day	3,363.85	8,935.03	7,712.86
Net I/P Rev Per Discharge	12,281.60	29,901.04	26,518.07
Net O/P Rev Per Visit	427.35	1,152.54	1,020.47

Source: HCAI Hospital PIVOT Data, Selected Years.

Financial and Utilization – Other Third Party (Private/Commercially Insured)

The Table below summarizes income statement data for commercial/private payors for Madera Community Hospital based on Annual PIVOT Data, 2018 – 2020.

Financial and Utilization - Other Third Party	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018
Patient Days (excl. nursery)	1,751	1,736	1,756
Discharges (excl. nursery)	463	519	514
Average Length of Stay (est.)	3.78	3.31	3.43
Outpatient Visits	24,918	27,962	26,321
Gross Inpatient Revenue	11,830,529	10,286,055	11,675,520
Gross Outpatient Revenue	21,097,713	20,946,729	19,886,800
Gross Patient Revenue	32,928,242	31,232,784	31,562,320
- Deductions from Rev	25,856,931	23,086,520	17,844,436
+ Capitation Premium Rev	0	0	0
Net Patient Revenue	7,071,311	8,146,264	13,717,884
Percent of Gross Revenue	21%	26.08%	43.46%
Expenses (est.)	14,212,827	13,938,571	13,775,356
Payment Shortfall	-7,141,516	(5,792,307)	(57,472)
Adjusted Patient Days	4,883	5,233	4,751
Gross I/P Rev Per Day	2,256.87	12,083.18	13,344.71
Gross I/P Rev Per Discharge	25,551.90	39,898.99	45,893.82
Gross O/P Rev Per Visit	846.69	1,571.82	1,584.51
Net I/P Rev Per Day	891.32	3,405.73	5,758.25
Net I/P Rev Per Discharge	10,091.33	11,040.76	19,762.80
Net O/P Rev Per Visit	334.39	466.21	678.70

Source: HCAI Hospital PIVOT Data, Selected Years.

Madera Community Hospital – Summary Statistics based on Quarterly Financial Data

The following series of Tables summarizes capacity, utilization and financial indicators using HCAI Quarterly data, covering Q4 of 2018 through and including Q4 of 2021. These data represent the most recent, publicly reported and available data for Madera Community Hospital. The data are reported to HCAI within 90 days of the close of each quarter. These data provide the most up-to-date picture of the Hospital's performance. However, given that they are filed so quickly following the close of each quarter, they are subject to revision with the passage of time and may not match the data reported by the Hospital in their Annual Disclosure Reports and PIVOT profiles, filed later and covering the same time periods. However, previous analyses that compared previously filed quarterly data to Annual Reports filed later (and subject to audit) indicated that the quarterly data were generally consistent with each other. The integration and use of the most current quarterly data for this project are important since, as the data below show, the financial performance of Madera Community Hospital has recently deteriorated substantially, and this trend is not reflected in the most recent HCAI Annual Disclosure reports available to the public.

At the same time, it is important to note, the quarterly data covering 2020 and 2021 also include the effects of the COVID-19 pandemic. Research has shown that the pandemic has had a disruptive effect on the utilization of and financial performance of U.S. hospitals, including hospitals in California. It is not known at this time how long these pandemic driven effects will continue. It is likely, however, that the observed adjustments in hospital cost structures, where annual total operating expenses have increased substantially during the pandemic, are likely to persist.

Beds – Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Beds													
25. Licensed Beds (end of report period excluding bassinets and	106	106	106	106	106	106	106	106	106	106	106	106	106
30. Available Beds (average for report period excluding	106	106	106	106	106	106	106	106	106	106	106	106	106
35. Staffed Beds (average for report	43	42	42	40	41	44	35	60	53	52	41	52	60

Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Discharges – Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Hospital Discharges (excluding nursery													
50. Medicare -	273	269	271	246	218	253	153	237	191	194	181	171	183
55. Medicare - Managed	77	56	69	38	58	58	59	60	72	65	71	75	83
60. Medi-Cal -	121	147	143	142	163	139	119	191	125	89	109	147	143
65. Medi-Cal - Managed	322	272	264	289	302	264	250	296	270	204	234	294	315
80. Other Third Parties -	51	36	49	54	44	47	46	50	57	68	34	55	36
85. Other Third Parties -	74	79	84	71	79	80	41	85	72	82	64	66	72
90. Other Indigent	1	1	1	2	1	1	1	1	1	1	1	1	1
95. Other Payors	8	8	8	13	7	7	6	8	6	5	5	5	6
100. Total Hospital Discharges (sum of Lns	927	868	889	855	872	849	675	928	794	708	699	814	839

Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Patient Days – Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Patient (Census) Days (excluding nursery													
150. Medicare -	1,293	1,423	1,227	1,206	1,016	1,230	769	1,711	1,318	1,319	1,094	1,064	1,370
155. Medicare -	379	212	321	193	257	300	271	354	474	553	477	529	538
160. Medi-Cal -	409	450	458	470	603	524	495	988	483	444	351	723	670
165. Medi-Cal - Managed	1,072	920	991	1,007	1,085	1,023	877	1,232	1,323	1,040	1,012	1,280	1,685
180. Other Third Parties -	151	113	154	182	172	168	235	278	346	412	176	350	233
185. Other Third Parties -	216	284	346	211	248	330	206	388	468	421	237	361	503
190. Other Indigent	3	4	4	5	3	4	4	6	4	4	4	5	6
195. Other Payors	32	33	27	34	29	32	25	44	24	20	10	21	23
200. Total Patient (Census) Days (sum of	3,555	3,439	3,528	3,308	3,413	3,611	2,882	5,001	4,440	4,213	3,361	4,333	5,028

Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Outpatient Visits – Quarterly Report Data (Q4 2018 – Q4 2021)

	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Outpatient Visits	4	1	2	3	4	1	2	3	4	1	2	3	4
250. Medicare - Traditiona	5,116	5,242	5,231	5,121	4,700	4,612	3,461	3,854	3,731	5,573	3,920	4,282	4,140
255. Medicare - Managed	1,169	1,365	1,372	1,267	1,251	1,412	1,072	1,144	1,246	1,261	1,461	1,442	1,382
260. Medi-Cal - Traditiona	3,469	3,659	3,195	2,915	2,957	3,468	2,528	2,843	2,693	2,656	3,075	3,171	2,989
265. Medi-Cal - Managed	16,261	16,331	16,156	16,032	14,620	15,881	12,376	14,085	13,608	13,248	14,153	15,330	14,174
270. County Indigent Prog	8	11	2	10	29	10	11	16	41	29	20	19	45
280. Other Third Parties -	2,247	1,846	2,193	2,140	2,536	1,871	1,612	1,761	1,683	1,778	1,827	2,120	1,636
285. Other Third Parties -	5,011	4,822	4,518	4,323	4,561	4,752	4,251	4,561	4,026	4,796	3,930	4,308	4,248
290. Other Indigent	50	52	64	68	63	65	44	60	45	51	32	40	35
295. Other Payors	1,383	1,624	1,926	1,968	1,773	1,673	1,594	1,814	1,029	2,175	1,540	1,432	1,463
300. Total Outpatient Visi	34,714	34,952	34,657	33,844	32,490	33,744	26,949	30,138	28,102	31,567	29,958	32,144	30,112

Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Gross Inpatient Revenue – Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Gross Inpatient Revenue (including PPC charges)													
350. Medicare - Traditional	8,059,557	10,181,083	8,140,435	7,877,614	6,961,926	8,035,846	5,276,387	10,390,159	8,801,771	8,408,068	7,582,696	6,982,933	8,933,992
355. Medicare - Managed Care	2,175,477	1,525,922	2,084,420	1,331,769	1,783,330	2,245,841	1,911,736	2,035,474	2,618,382	3,135,314	3,186,215	3,381,092	2,880,976
360. Medi-Cal - Traditional	2,619,770	2,758,587	2,899,931	2,821,435	3,786,075	3,157,818	3,110,625	5,908,919	3,375,596	3,163,402	2,048,725	4,434,406	4,016,366
365. Medi-Cal - Managed Care	6,930,107	6,456,158	6,179,271	6,709,970	7,372,835	6,997,111	5,886,554	8,215,304	9,161,866	7,348,128	6,939,008	9,050,775	11,655,266
370. County Indigent Programs - Traditional	0	0	0	0	0	0	0	0	0	0	0	0	0
375. County Indigent Programs - Managed Care	0	0	0	0	0	0	0	0	0	0	0	0	0
380. Other Third Parties - Traditional	1,061,798	720,781	1,081,812	1,407,095	925,178	1,096,912	1,467,653	1,478,168	2,047,368	3,020,881	1,003,400	2,070,530	1,359,215
385. Other Third Parties - Managed	1,521,551	1,865,671	2,316,469	1,603,936	1,921,512	2,473,167	1,428,078	2,653,643	3,100,888	3,490,482	1,734,849	2,395,080	3,522,030
390. Other Indigent	25,760	26,252	26,077	41,221	24,711	24,726	21,645	40,193	29,418	31,974	23,768	27,989	35,244
395. Other Payors	172,392	175,683	174,515	275,865	165,376	165,475	144,853	318,982	196,872	156,109	134,062	133,468	175,091
400. Total Gross Inpatient Revenue (sum of Lns 350 thru 395)	22,566,412	23,710,137	22,902,930	22,068,905	22,940,943	24,196,896	19,247,531	31,040,842	29,332,161	28,754,358	22,652,723	28,476,273	32,578,180

Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Gross Outpatient Revenue – Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Gross Outpatient Revenue (including PPC charges)													
450. Medicare - Traditional	5,259,584	5,680,446	6,127,673	6,304,722	5,382,213	5,482,873	3,474,322	4,102,550	3,622,202	2,869,318	3,691,853	4,479,818	4,532,940
455. Medicare - Managed Care	1,186,110	1,564,879	1,567,348	1,377,536	1,484,869	1,883,139	1,225,693	1,298,454	1,095,462	1,105,802	1,852,952	2,008,267	2,049,784
460. Medi-Cal - Traditional	2,137,065	2,587,907	2,525,676	2,364,501	2,512,967	2,651,231	1,792,807	2,071,806	1,959,397	1,701,763	2,071,782	2,118,546	2,078,231
465. Medi-Cal - Managed Care	11,522,077	11,509,494	12,171,062	12,861,957	12,810,088	12,588,375	8,715,205	11,330,826	11,295,941	7,507,411	12,093,022	13,524,254	12,293,369
470. County Indigent Programs - Traditional	6,849	14,069	1,862	9,465	29,697	10,716	10,048	15,725	39,611	19,836	58,349	16,898	42,378
475. County Indigent Programs - Managed Care	0	0	0	0	0	0	0	0	0	0	0	0	0
480. Other Third Parties - Traditional	2,629,446	2,275,019	2,509,189	2,463,963	2,963,283	2,303,992	1,398,869	1,540,649	1,456,039	1,227,842	1,840,058	2,413,304	2,286,212
485. Other Third Parties - Managed Care	3,853,907	4,047,745	4,552,324	4,325,861	4,530,990	4,231,707	2,895,168	3,536,405	3,196,146	2,298,057	3,256,317	3,664,508	3,908,258
490. Other Indigent	41,607	34,452	44,053	59,736	56,261	60,404	38,885	53,822	43,646	24,987	36,202	36,734	30,614
495. Other Payors	998,561	976,838	1,290,889	1,433,665	1,350,273	1,449,698	933,245	1,291,718	1,047,515	807,907	868,844	1,187,730	1,234,734
500. Total Gross Outpatient Revenue (sum of Lns 450 thru 495)	27,635,206	28,690,849	30,790,076	31,201,406	31,120,641	30,662,135	20,484,242	25,241,955	23,755,959	17,562,923	25,769,379	29,450,059	28,456,520

Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Deductions from Revenue – Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Deductions from Revenue													
545. Provision for Bad Debts	665,322	776,493	752,581	1,053,305	856,835	1,007,001	586,844	1,018,582	822,218	648,043	671,612	775,609	869,532
550. Medicare - Traditional Contractual Adj	10,022,065	10,208,908	9,009,759	7,541,803	9,107,917	8,368,253	2,948,862	10,462,867	6,043,948	3,959,322	10,461,299	8,994,507	9,996,131
555. Medicare - Managed Care Contractual Adj	1,306,328	1,838,226	1,876,016	2,423,100	1,749,874	1,955,972	2,653,662	2,721,014	2,275,314	2,228,766	2,431,447	2,954,995	2,437,186
560. Medi-Cal - Traditional Contractual Adj	1,330,473	1,826,737	2,042,045	2,076,946	2,375,278	2,221,923	1,148,644	3,620,667	3,035,705	2,707,629	1,984,423	3,789,026	3,484,968
565. Medi-Cal - Managed Care Contractual Ad	9,965,335	10,185,453	11,904,308	12,577,430	12,210,038	13,770,848	8,575,233	9,960,751	13,192,791	9,649,443	7,134,744	12,749,943	12,596,609
566. Disproportionate Share Payments for Medi-Cal (SB 855) (credit balance)	-787,500	-787,500	-787,500	-912,500	-912,500	-912,500	-912,500	-934,817	-912,500	-912,500	-912,500	-826,596	-826,596
580. Other Third Parties - Traditional Contractual Adj	1,582,267	2,188,879	1,866,805	2,504,319	2,139,441	2,304,930	1,742,037	1,462,876	1,351,951	1,987,984	2,462,565	2,340,009	2,536,754
585. Other Third Parties - Managed Care Contractual Ad	3,170,691	3,221,692	3,703,064	2,994,288	3,748,177	3,342,085	3,285,733	3,898,465	3,246,134	3,622,360	2,433,173	2,938,464	3,753,782
595. Charity - Other	317,800	291,255	581,403	597,570	537,941	524,646	424,599	512,761	410,295	312,962	277,407	467,036	459,968
620. Total Deductions from Revenue	27,626,823	29,784,050	30,967,051	30,887,340	31,860,062	32,602,396	20,496,472	32,745,185	29,524,448	24,235,922	26,990,509	34,201,054	35,364,666

Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Net Patient Revenue – Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Net Patient Revenue													
750. Medicare - Traditional	3,297,076	5,652,621	5,258,349	6,640,533	3,236,222	5,150,466	5,801,847	4,029,842	6,380,025	7,318,064	813,250	2,468,244	3,470,801
755. Medicare - Managed Care	2,055,259	1,252,575	1,775,752	286,205	1,518,325	2,173,008	483,767	612,914	1,438,530	2,012,350	2,607,720	2,434,364	2,493,574
760. Medi-Cal - Traditional	4,213,862	4,307,257	4,171,062	4,021,490	4,836,264	4,499,626	4,667,288	5,294,875	3,211,788	3,070,036	3,048,584	3,590,522	3,436,225
765. Medi-Cal - Managed Care	8,486,849	7,780,199	6,446,026	6,994,497	7,972,885	5,814,638	6,026,526	9,585,379	7,265,016	5,206,096	11,897,286	9,825,086	11,352,026
780. Other Third Parties - Traditional	2,108,977	806,921	1,724,196	1,366,739	1,749,020	1,095,974	1,124,485	1,555,941	2,151,456	2,260,739	380,893	2,143,825	1,108,673
785. Other Third Parties - Managed Care	2,204,767	2,691,724	3,165,729	2,935,509	2,704,325	3,362,789	1,037,513	2,291,583	3,050,900	2,166,179	2,557,993	3,121,124	3,676,506
795. Other Payors	205,525	64,040	169,593	86,062	128,894	67,569	79,916	101,066	24,652	13,496	44,253	66,862	52,763
800. Total Net Patient Revenue	22,574,795	22,616,936	22,725,955	22,382,971	22,201,522	22,256,635	19,235,301	23,537,612	23,563,672	22,081,359	21,431,593	23,725,278	25,670,034

Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Other Revenue and Expenses – Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Other Revenue and Expenses													
810. Other Operating Revenue	363,411	554,383	353,229	562,085	397,461	440,966	2,730,426	1,614,469	739,964	967,953	599,257	239,268	3,398,620
830. Total Operating Expenses	23,064,807	23,259,624	23,347,405	23,689,228	23,920,601	24,238,210	22,885,579	25,641,389	27,084,320	26,217,270	25,531,098	27,351,440	30,083,556
835. Physician Professional Component (PPC) Expenses (optional)	1,638,745	1,672,279	1,714,720	1,603,914	1,764,215	1,958,252	2,038,065	2,192,186	2,241,368	2,181,758	2,090,726	2,182,431	2,439,292
840. Nonoperating Revenue Net of Nonoperating Expenses	207,562	231,362	221,519	224,053	272,667	328,420	271,965	799,840	481,718	157,903	105,475	100,288	103,644
880. Total Capital Expenditures (excluding disposal of assets)	279,497	145,310	397,562	694,440	198,910	1,294,185	209,081	1,087,945	347,935	431,104	1,037,470	638,710	428,868
885. Fixed Assets Net of Accumulated Depreciation	27,759,340	27,173,557	26,877,134	26,922,741	26,541,910	27,252,999	26,869,438	27,383,969	27,160,361	27,027,502	27,471,874	27,532,092	27,395,059
2000. Quality Assurance Fees	2,356,095	2,356,095	2,356,095	2,356,095	2,356,095	2,356,095	2,356,095	1,538,392	1,538,392	1,538,392	1,538,392	1,533,641	1,533,641
2005. Fee-For-Service Quality Assurance Supplemental Payments	2,818,875	2,818,875	2,818,875	2,818,875	2,818,875	2,818,875	2,818,875	1,872,303	1,872,303	1,872,303	1,872,303	1,852,896	1,852,896

The Tables and Exhibits below summarize trends in revenue, expenses, and margins (excess of revenue over expenses) for Madera Community Hospital using HCAI Quarterly data, covering Q4 of 2018 through and including Q4 of 2021. As discussed above, these data are the most current available data reflecting operations and financial performance of the Hospital.

As can be seen, the financial status of the Hospital has deteriorated over time and especially in the last two years. Madera Community Hospital has incurred accumulated losses of almost $20 million over the period covering 13 quarters of operation beginning in the last quarter of 2018.

Revenue and Expenses and Total Margin – Quarterly Report Data (Q4 2018 – Q4 2021)

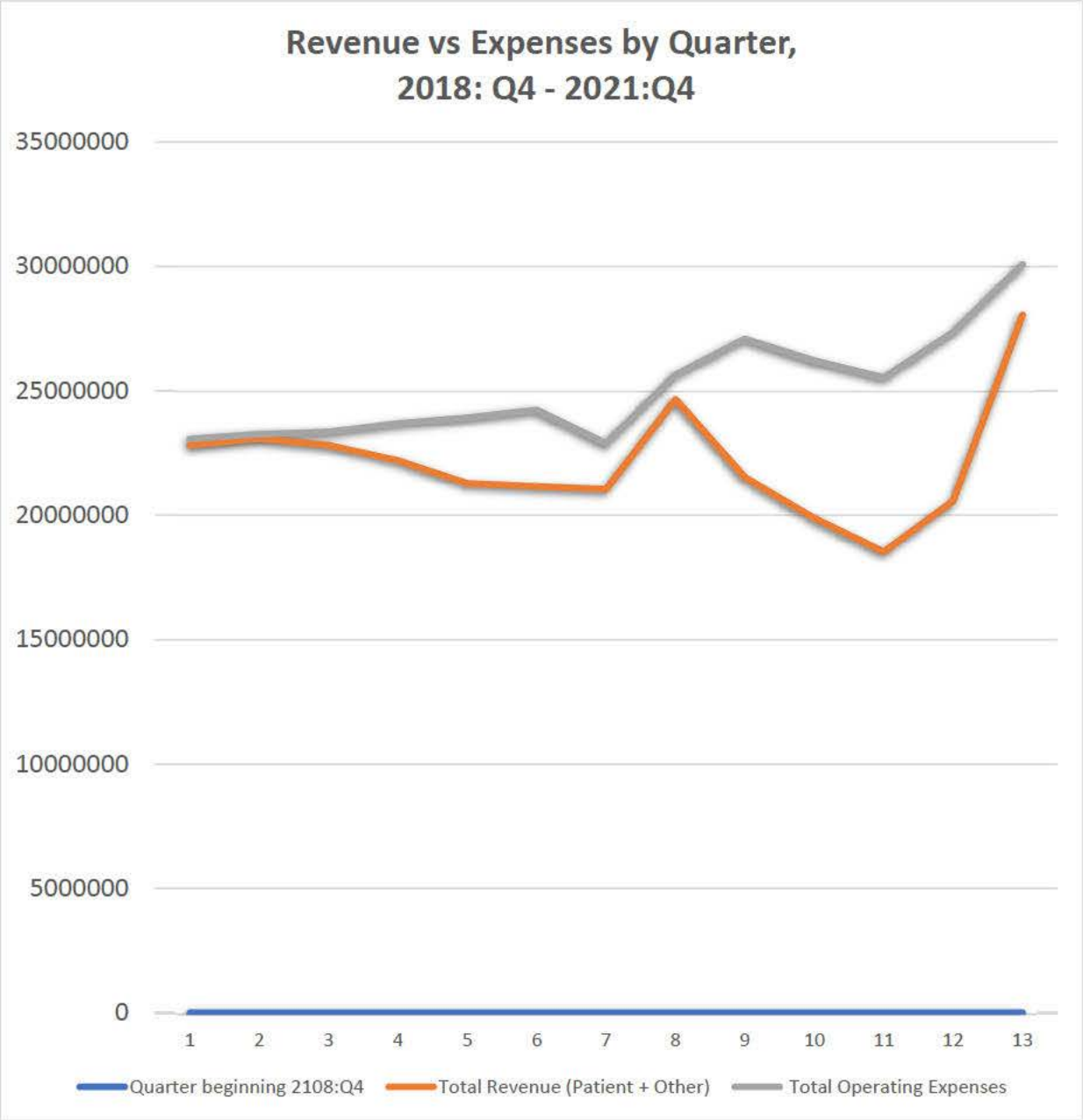
Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Total Revenue (Patient + Other)	22,938,206	23,171,319	23,079,184	22,945,056	22,598,983	22,697,601	21,965,727	25,152,081	24,303,636	23,049,312	22,030,850	23,964,546	29,068,654
830. Total Operating Expenses	23,064,807	23,259,624	23,347,405	23,689,228	23,920,601	24,238,210	22,885,579	25,641,389	27,084,320	26,217,270	25,531,098	27,351,440	30,083,556
Total Margin (Revenue Less Expenses)	-126,601	-88,305	-268,221	-744,172	-1,321,618	-1,540,609	-919,852	-489,308	-2,780,684	-3,167,958	-3,500,248	-3,386,894	-1,014,902

Cumulative Margin - Quarterly Report Data (Q4 2018 – Q4 2021)

Year	2018	2019	2019	2019	2019	2020	2020	2020	2020	2021	2021	2021	2021
Quarter	4	1	2	3	4	1	2	3	4	1	2	3	4
Cumulative Margin	-126,601	-214,906	-483,127	-1,227,299	-2,548,917	-4,089,526	-5,009,378	-5,498,686	-8,279,370	-11,447,328	-14,947,576	-18,334,470	-19,349,372

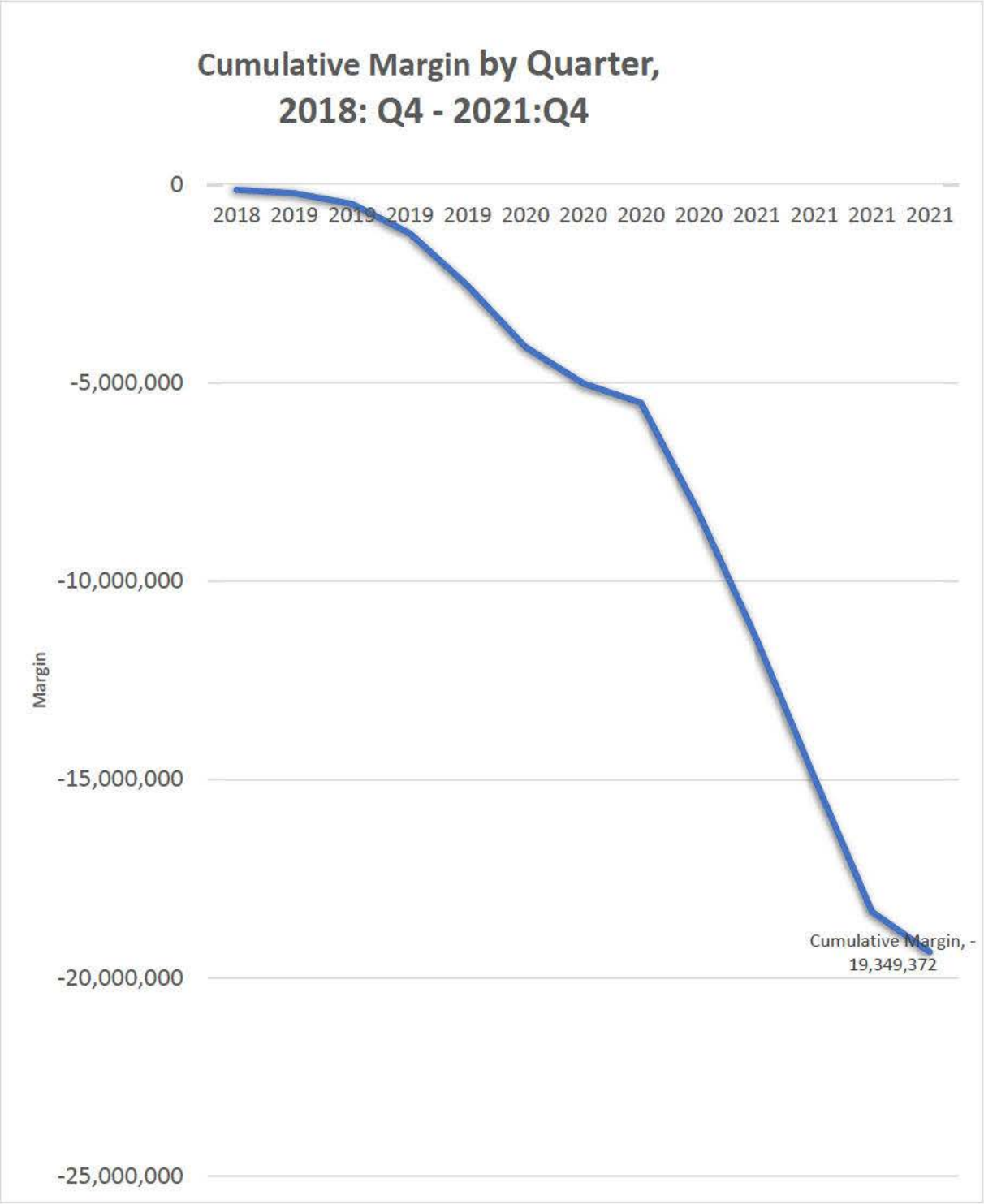
Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Revenue vs Expenses over Time, by Quarter, 2018: Q4 - 2021:Q4



Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

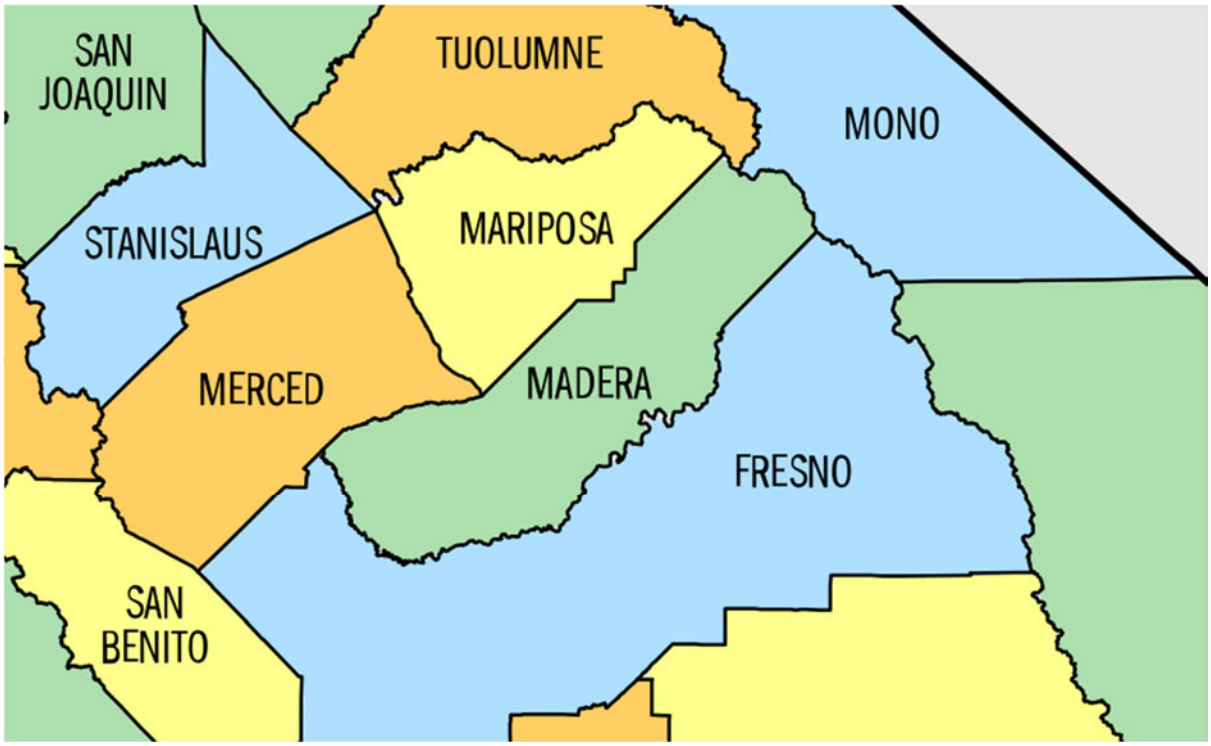
Cumulative Margin over Time, by Quarter, 2018: Q4 - 2021:Q4



Source: Hospital Quarterly Financial and Utilization Report, Selected Years.

Map of Madera County and Surrounding Counties

Madera County is located in the exact center of California, in the heart of the Central San Joaquin Valley and the Central Sierras. Madera County is adjacent to five of California's counties.



Demographic and Economic Indicators

The Tables below summarize population counts and population characteristics based on current data.

Population	Madera County, California
Population Estimates, July 1 2021, (V2021)	159,410
Population estimates base, April 1, 2020, (V2021)	156,255
Population, percent change - April 1, 2020 (estimates base) to July 1, 2021, (V2021)	2.00%
Population, Census, April 1, 2020	156,255
Population, Census, April 1, 2010	150,865
Age and Sex	
Persons under 5 years, percent	7.30%
Persons under 18 years, percent	27.40%
Persons 65 years and over, percent	14.30%
Female persons, percent	51.80%
Race and Hispanic Origin	
Black or African American alone, percent	4.20%
American Indian and Alaska Native alone, percent	4.40%
Asian alone, percent	2.60%
Two or More Races, percent	2.60%
Hispanic or Latino, percent	58.80%

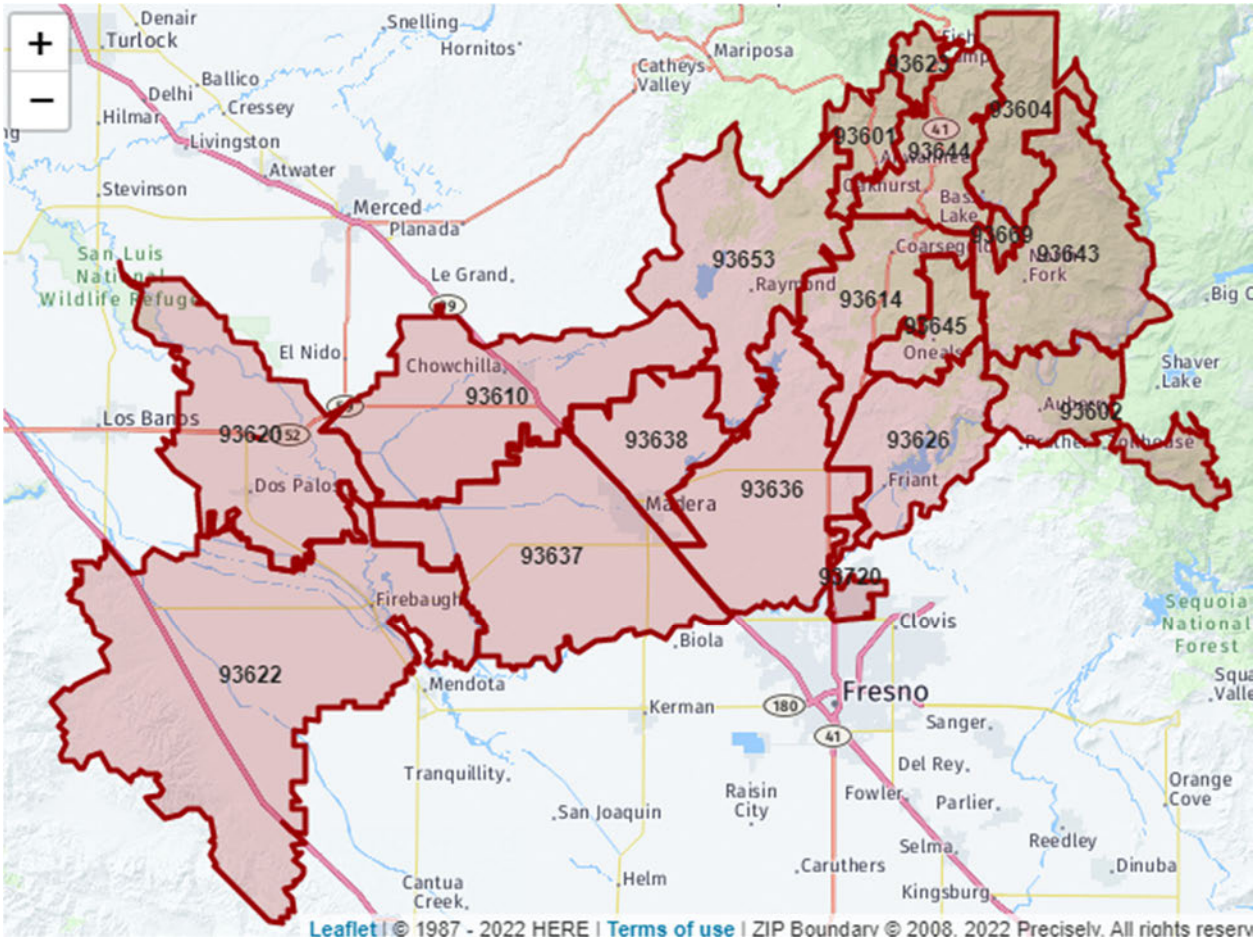
Sources: U.S. Census Bureau, Population Estimates Program (PEP). Updated annually. Population and Housing Unit Estimates; U.S. Census Bureau, American Community Survey (ACS). Updated annually. American Community Survey.

Housing	Madera County, California
Housing units, July 1, 2019, (V2019)	51,438
Owner-occupied housing unit rate, 2016-2020	65.80%
Median value of owner-occupied housing units, 2016-2020	$268,500
Median selected monthly owner costs -with a mortgage, 2016-2020	$1,578
Median selected monthly owner costs -without a mortgage, 2016-2020	$490
Median gross rent, 2016-2020	$1,068
Building permits, 2020	852
Families & Living Arrangements	
Households, 2016-2020	44,479
Persons per household, 2016-2020	3.32
Living in same house 1 year ago, percent of persons age 1 year+, 2016-2020	87.30%
Language other than English spoken at home, percent of persons age 5 years+, 2016-2020	45.20%
Education	
High school graduate or higher, percent of persons age 25 years+, 2016-2020	72.00%
Bachelor's degree or higher, percent of persons age 25 years+, 2016-2020	15.20%
Health	
With a disability, under age 65 years, percent, 2016-2020	9.00%
Persons without health insurance, under age 65 years, percent	11.00%

Sources: U.S. Census Bureau, Population Estimates Program (PEP). Updated annually. Population and Housing Unit Estimates; U.S. Census Bureau, American Community Survey (ACS). Updated annually. American Community Survey.

Madera County Zip Codes – Map and Population Counts

The Map and Table below summarize the number of zip codes in Madera County and the population distribution within the county by zip code.



Population Counts and Distribution by Zip Code

#	Zip Code	ZIP Code Name	Percent Total County Population	Population
1	93638	Madera	32%	49,068
2	93637	Madera	25%	37,743
3	93610	Chowchilla	16%	23,833
4	93636	Madera	8%	11,908
5	93614	Coarsegold	8%	11,661
6	93644	Oakhurst	6%	8,637
7	93643	North Fork	2%	3,171
8	93601	Ahwahnee	1%	1,909
9	93626	Friant	1%	1,359
10	93653	Raymond	1%	1,229
11	93604	Bass Lake	0%	674
12	93645	O'Neals	0%	318
TOTAL			100%	151,510

Health Care Impact Assessment – Availability and Accessibility of Health Care Services

Published Literature

There is an extensive and growing literature on the potential short and long-term effects of the closure of small, rural hospitals similar to Madera Community Hospital.[16] This literature is important as it provides important background and input into the assessment of the circumstances surrounding the proposed transaction, with one alternative outcome that the transaction is ***not*** completed and, that as a result, Madera Community Hospital is forced to close and cease operations. Similarly, there is a growing literature on the observed and potential effects when rural hospitals merge with a larger health system, as is proposed in this transaction.

Effects of Hospital Closures on Availability of and Access to Health Care Services and Other Community Effects

Physician Supply and Long-Term Access to Physician Services: A 2019 study demonstrated that in the years following a rural hospital closure the community faced an 8.2 percent annual decrease in primary care physicians.[17] This study focused on community-based physicians (excludes physicians working for federal hospitals and other federal agencies), and found that following a closure, not only did these counties retain fewer primary care physicians, but also fewer obstetrician-gynecologists. They concluded that closure of a rural hospital significantly

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[16]Miller, Katherine EM, et al. "Access to outpatient services in rural communities changes after hospital closure." Health services research (2021): *Published 25 June 2021;* Germack, Hayley Drew, et al. "Relationship between rural hospital closures and the supply of nurse practitioners and certified registered nurse anesthetists." Nursing Outlook (2021); Gujral, Kritee and Anirban Basu. "Impact of Rural and Urban Hospital Closures on Inpatient Mortality." Nature & Society eJournal (2019); *T*roske, S, Davis, A (2019). Do hospital closures affect patient time in an ambulance? Rural and Underserved Research Center. Retrieved from Rural & Underserved Health Research Center Policy Brief February 2019; Kozhimannil, K., et al. (2018). Association between loss of hospital-based obstetric services and birth outcomes in rural counties in the United States. JAMA, 319, 1239–1247; United States Government Accountability Office. (2018). Rural Hospital Closures: Number and characteristics of affected hospitals and contributing factors. (Retrieved from GAO Report to Congressional Requesters Rural Hospital Closures August 2018).

[17]Germack, H., et al. (2019). When rural hospitals close, the physician workforce goes. *Health Affairs*, *38*(12), 2086–2094. https://doi.org/10.1377/hlthaff.2019.00916; Goodfellow, et al. (2016). Predictors of primary care physician practice location in underserved urban and rural areas in the United States: A systematic literature review. Academic Medicine, 91, 1313-1321.

limits local access to essential health care services such as routine surgical procedures, primary care checkups and appointments, and maternal and reproductive health care. A more recent study examined the relationship between hospital closures and the supply and availability of physician services over time following hospital closure. The study found that rural hospital closures were associated with persistent and gradual reductions in the supply of physicians in the years following a closure including statistically significant declines in the supply of all physicians as long as the fourth year after a closure. Declines were even greater by the sixth year after a closure and beyond, specifically for primary care physicians, surgical specialists, and medical specialists. The findings from this study of the relationship between hospital closures and the supply of all physicians post closure are consistent with a similar study involving 132 rural hospitals that closed. That study found an average decrease of 12.4 percent total physicians comparing the two years before and the two years after a closure.

Barriers to Accessing Other Services: Rural residents face the prospect that closure of their hospital creates barriers to accessing not only hospital care but other essential non-hospital services. Several studies have documented that rural hospital closure results in increased barriers to receiving diagnostic tests and scans, and decreased access to emergency care.[18]

Reduced Access to Emergency Services: With the closure of their hospital, rural residents face reduced access to timely emergency medical care. Studies have shown that ambulance services to the nearest hospital, following hospital closure, are spread over a larger geographic area, leading to longer emergency response times and poorer overall community health. Studies of the impact of reduced access to emergency services have found that increased travel time to the nearest Emergency Department is associated with higher mortality rates. In one study looking directly at closure of Emergency Departments in California, the study found worse impacts of rural closures for Medicaid patients and racial minorities.[19] Other studies have found that these effects are disproportionately felt in rural minority communities as these communities tend to have higher percentages of minority residents.[20] Data in this report

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[18]Jane Wishner and others, "A Look at Rural Hospital Closures and Implications for Access to Care: Three Case Studies," (Washington: Kaiser Family Foundation, 2016), available at http://files.kff.org/attachment/issue-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care; Thomas, Sharita R., et al. "A Comparison of closed rural hospitals and perceived impact." *Findings Brief. NC Rural Health Research Program* (2015).

[19]Gujral, Kritee and Basu, Anirban, Impact of Rural and Urban Hospital Closures on Inpatient Mortality-National Bureau of Economic Research Working Paper Series, No. 26182, August 2019, www.nber.org/papers/w26182.

[20]Nicholl J., et al. The relationship between distance to hospital and patient mortality in emergencies: an observational study. Emerg Med J. 2007 Sep 24 (9): 665-8. doi: 10.1136/emj.2007.047654. PMID: 17711952; PMCID: PMC2464671.

confirm that a large fraction of Madera County residents are low income and are dependent on Medi-Cal for their insurance coverage.

Economic Impacts: Rural hospital closures can also have impacts on a community's economic health. Often rural hospitals are the largest employers in their communities, and the loss of rural hospital jobs has a multiplier effect on the surrounding community. One study estimates that for every 100 hospital jobs lost in a rural community, an additional 35 jobs are lost in the surrounding community.[21] Studies have shown that the economic health of the community is correlated with the health status of the population. Data below shows that Madera Community Hospital is a large employer in Madera County and, as such, the operation of the hospital in the County has economic ripple effects that extend outside of the hospital.

Effects on Service Availability and Community Benefits After Hospitals Are Acquired by Health Systems

While, in general, studies have shown that ownership by a health system is associated with stronger financial performance of rural or remote hospitals, other studies have suggested potential downsides of affiliation such as loss of local services and/or reductions in community benefits by non-profit hospitals.[22]

Risk of Reductions in Specific Services: Studies have shown that following a merger with a system, rural hospitals reduce their capacity related to on-site access to imaging, obstetric services, and primary care departments, and they have fewer hospital employees. These reductions may be attributed to reduction of duplicative services or equipment that resulted in cost efficiencies. However, researchers caution that this is not always the case and that even if there are internal cost efficiencies, patients may still see meaningful and potentially harmful reductions in access to needed services and, further, that depending on the competitive conditions post-merger, may see higher prices despite internal efficiency gains.

Risk of Reduction in Community Benefits: Research has shown that community benefit spending on non-clinically related services, especially community health improvement activities, decreased after independent hospitals were acquired by not-for-profit hospital systems but that there was not a significant change in either total community benefit spending or clinical services[23]. The study also found mergers with out-of-market systems may lead to greater reductions in total community benefit spending and population health spending,

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[21]Doeksen, G., et al. "The Economic Impacts of 26-50 Bed PPS Hospitals & 51-100 Bed PPS Hospitals on the Local Economies." (2015); Eilrich, F., et al. "The economic impact of recent hospital closures on rural communities." *National Center for Rural Health Works.[www. ruralhealthworks. org (August 2015)]* (2015).

[22]Oyeka, O., et al. (2018). *The Rural Hospital and Health System Affiliation Landscape-A Brief Review*. Retrieved from http://www.public-health.uiowa.edu/.

[23]Oyeka, O., et al. *The Rural Hospital and Health System Affiliation Landscape-A Brief Review*. Retrieved from http://www.public-health.uiowa.edu/.

suggesting that discretionary community benefit spending, such as community health improvement activities, is at risk of reduction following an acquisition. The authors recommend that regulators should be skeptical of claims suggesting that hospital consolidations will lead to improvements in community health investment or an increase in services provided to underserved populations. The study authors also argue that not-for-profit hospital tax exemption should hold hospitals accountable to providing community benefits consistent with their stated charitable mission. They caution that even if acquisitions lead to efficiency gains, social welfare could suffer if such gains are not shared in the form of lower prices, increased quality, or increased community benefit spending. Thus, regulators and antitrust enforcement of not-for-profit mergers and acquisitions should consider potential reductions in community benefit spending among the other outcomes and offer that regulatory oversight by states could ensure that community benefit spending reflects hospital profitability accordingly.

Importance of Madera Community Hospital to the Community

Madera Community Hospital is the only general acute care hospital in Madera County serving both adult and pediatric patients, with a population in excess of 150,000. As such, Madera Community Hospital is a critically important provider and resource for a wide range of health care services to the residents of Madera County. The Hospital is essential for its direct provision of emergency, inpatient, obstetrics, and mental health services to residents within Madera Community Hospital's service area. In addition, Madera Community Hospital owns and operates several non-hospital-based outpatient units in Madera County. The importance of Madera Community Hospital to Madera County residents and patients is underscored in many in-person interviews with health plans and other providers and community members. Health plans noted that it is important to payors to create provider networks that meet "network adequacy" requirements under Centers for Medicare and Medicaid Services (CMS) or Department of Managed Health Care (DMHC) standards. Madera Community Hospital is considered particularly important by health plans because it serves Madera County's large Medi-Cal population. Both CMS and DMHC have maximum time and distance requirements to ensure network adequacy and Madera Community Hospital helps provide the adequacy needed for payor networks, including Medi-Cal managed care. Additionally, multiple payors noted that Madera Community Hospital is also important for Madera County elderly residents and for patients who need local obstetrics care.[24]

Anchor for Availability of Other Health Care Providers

Importantly, as the only general acute care hospital in the county providing services to both adult and pediatric patients, Madera Community Hospital serves as the anchor for the broader health care delivery system including the maintenance and availability of many other essential health care services and providers in the county. The presence and operation of Madera

[24] See Appendix for additional input from interviews regarding importance of Madera Community Hospital to the community.

Community Hospital in the county serves to attract and retain other health care providers to meet the health care needs of Madera County residents. Research has shown that when the only hospital in the county closes, the availability of many other non-acute care based medical services in the community also declines over time. It becomes harder to attract new physicians and to retain existing physicians. Other health care provider organizations are also less likely to locate in the area while existing ones are more likely to relocate. As can be seen in the Table below summarizing data reported by Madera Community Hospital to HCAI, the hospital serves as an essential service to many physicians serving Madera County patients and residents.

Madera Community Hospital: Active Medical Staff Profile - MDs, DOs, Podiatrists and Dentists

The Table below summarizes the active Medical Staff at Madera Community Hospital. It is anticipated that the Hospital will continue to maintain active medical staffing at or above current levels.

	Hospital Based			Non-Hospital Based	
Clinical Specialty	**(1) Board Certified**	**(2) Board Eligible**	**(3) Other**	**(4) Board Certified**	**(5) Other**
Anesthesiology	1		1		
Cardiovascular Diseases				2	1
Diagnostic Radiology				5	
Gastroenterology				3	1
General Surgery				4	2
Internal Medicine	6	5		7	10
Neurology				6	1
Nuclear Medicine				1	
Obstetrics and Gynecology				4	
Oncology				2	1
Ophthalmology				4	1
Oral Surgery (Dentists Only)				1	
Orthopedic Surgery				3	
Other Specialties				10	7
Otolaryngology				1	
Pathology				9	6
Pediatric Medicine				23	6
Pediatric-Allergy				1	

Podiatry				3	2
Pulmonary Disease				1	1
Radiology				12	1
Thoracic Surgery				1	1

Source: https://sieraarchiveexternal-oshpd-web-prd.azurewebsites.net/.

Emergency Services

The Hospital is an important, if not the essential, provider of emergency services to the residents of Madera County. Madera Community Hospital reported 29,615 emergency visits/patients in their Annual Hospital Utilization Report for 2020. The next closest source for hospital-based emergency services is in Fresno County (20+ miles from Madera Community Hospital). Many of the emergency department patients are low-income patients with limited transportation options. As can be seen in the Tables below, the emergency department within Madera Community Hospital maintains capacity for essential services to provide timely emergency care to its patients, including for acute medical surgical patients as well as those requiring immediate care, such as heart attack patients and those requiring intensive care.[25] Health plans, during in-person interviews, noted that while both St. Agnes Medical Center and Community Regional Medical Center are bigger and provide emergency services, they are both located in Fresno County and as such access is more difficult as travel time can be as much as 2.5 hours by public transport and at least 30–40-minutes by private transportation.[26] As previously noted, low-income populations including the sizeable Medi-Cal population in Madera County have more challenges with transportation.

Availability of Services and Physicians on Site for ED Patients

Services Available on Premises (ED)	(1) 24 Hour	(2) On-Call
Anesthesiologist		X
Laboratory Services	X	
Operating Room		X
Pharmacist		X
Physician	X	
Psychiatric ER	X	
Radiology Services	X	

Source: Hospital Utilization Profile Report – 2020, HCAI.

[25]Buchmueller, T., et al., How far to the hospital?: The effect of hospital closures on access to care, Journal of Health Economics, Volume 25, Issue 4, 2006, Pages 740-761, www.sciencedirect.com/science/article/pii/S0167629605001116

[26]Travel time calculated using Google Maps.

Ensuring that Madera's emergency department remains open following the transaction and at its current level of emergency treatment capacity is critical to providing timely and accessible emergency services to residents of Madera County, as they have no other local option.

Should Madera Community Hospital cease to operate, and its emergency services are no longer available to Madera County residents, St. Agnes Medical Center in Fresno is the closest alternative general acute care hospital. The travel distance from Madera Community Hospital to St. Agnes Medical Center is 22+ miles, and driving time is approximately 30-40 minutes. The travel distances and times are even longer to St. Agnes Medical Center for residents living in two of Madera's most populated zip codes. Zip code 93638 has 32 percent of the county population and is 29 miles from St. Agnes Medical Center and zip code 93610 has 16 percent of the county population and is 44 miles from St. Agnes Medical Center. Should emergency care, as in the case of a miscarriage or complications following an abortion implicate the ERDs, the nearest emergency department outside of the Trinity system is Community Regional Hospital (driving distance per Google Maps, 26+ miles).

Medical/Surgical Services, Intensive Care Services, and Obstetrics/Perinatal Services

Madera Community Hospital reported the following in their Annual Hospital Utilization Report for 2020. As can be seen in the Table below, the Hospital reported: 73 licensed medical/surgical beds with 2,879 patient discharges and 12,985 inpatient days, 23 licensed perinatal beds with 1,206 patient discharges and 1,207 inpatient days, and 10 licensed intensive care beds with 296 patient discharges and 6,121 inpatient days.

As can be seen in the Table below, the hospital provides an important source for a range of needed inpatient services to the community. Maintaining the Hospital's bed capacity and availability for these services is important to meeting the health care needs of the population in the Hospital's service area. The importance of having ICU bed availability at the Hospital was highlighted by the needs in the community that were created by the COVID-19 pandemic.

Licensed Bed Classification / Designation	Beds	Patient Days	Discharges
Medical/Surgical Acute (includes GYN/DOU)	73	12,985	2,879
Perinatal (includes LDRP, excludes nursery)	23	1,207	1,206
Intensive Care	10	6,121	296
Total - General Acute Care	106	20,313	4,381

Source: Hospital Utilization Profile Report – 2020, HCAI.

Obstetric Services

The Hospital is also a very important provider of obstetrics services to the local community. This is highlighted in the Table below. The Hospital reported 787 deliveries in their 2020 Annual Utilization Report. Many of these births are for low-income and Medi-Cal patients with limited transportation options to alternative hospitals. The importance of having locally provided

obstetric services at Madera Community Hospital was frequently underscored during in-person interviews with health plans and other interviewees with knowledge of the local market.

Birth Data	Number of Births	% of Total
Live Births, C-Section - Inpatient	201	25.54%
All Other Live Births – Inpatient vaginal birth	586	74.46%
Total Live Births	**787**	**100%**

Source: Hospital Utilization Profile Report – 2020, HCAI.

Reproductive Health Services

The Hospital is an important provider of a range of reproductive health care services including services for women and other sub-populations. The Table below, based on the most recent patient discharge data for the Hospital, documents the availability of these services and highlights their importance to the community. Also, though not listed in the Table below, based on data provided by Madera Community Hospital, the Hospital also currently provides a wide range of reproductive services on an outpatient basis including hormone therapy, contraception, and fertility services.

It will be important for the Hospital to carefully consider any limitations on historically needed and provided services and ensure that providers, staff, and the community are fully and properly informed of any reductions as a result of the transaction and that the Hospital has an explicit and transparent plan to ensure and maintain access to these services by accessing other (non-Madera Community Hospital and non-St. Agnes Medical Center) providers.

Service	Diagnosis Code
Gender identity disorder, unspecified	F649
Missed abortion	O021
Genital tract and pelvic infection following incomplete spontaneous abortion	O030
Delayed or excessive hemorrhage following incomplete spontaneous abortion	O031
Shock following incomplete spontaneous abortion	O0331
Incomplete spontaneous abortion without complication	O034
Genital tract and pelvic infection following complete or unspecified spontaneous abortion	O035
Renal failure following complete or unspecified spontaneous abortion	O0382
Metabolic disorder following complete or unspecified spontaneous abortion	O0383
Sepsis following complete or unspecified spontaneous abortion	O0387
Urinary tract infection following complete or unspecified spontaneous abortion	O0388

Complete or unspecified spontaneous abortion without complication	O039
Delayed or excessive hemorrhage following failed attempted termination of pregnancy	O071
Displacement of intrauterine contraceptive device, initial encounter	T8332XA
Encounter for sterilization	Z302
Encounter for removal of intrauterine contraceptive device	Z30432
Encounter for surveillance of implantable subdermal contraceptive	Z3046
Encounter for prophylactic removal of ovary(s)	Z4002
Other sex counseling	Z708
Long term (current) use of selective estrogen receptor modulators (SERMs)	Z79810
Long term (current) use of other agents affecting estrogen receptors and estrogen lev	Z79818
Hormone replacement therapy	Z79890
Tubal ligation status	Z9851
Vasectomy status	Z9852

Source: Madera Hospital Patient Discharge Data, 2019.

Community and provider interviews identified potential limitations and or reductions of existing and essential services currently provided by Madera Community Hospital given the policies of Trinity Health regarding Ethical and Religious Directives for Catholic Health Care Services (ERDs).

The issue of ERDs is the subject of a growing literature that increasingly supports the concern that limitations on the availability of services can result in reduced health outcomes in affected communities.[27] It is important to note in this matter that St. Agnes Medical Center is the closest alternative to Madera Community Hospital and St. Agnes is also part of Trinity Health. As such, should the transaction be approved and some ERD limitations imposed on Madera Community Hospital, it could result in Madera patients having substantially reduced access to some needed services. The next closest non-Trinity Health hospital is in Fresno County. Travel distance from Madera Community Hospital to Community Regional Hospital in Fresno (via CA-145 S and CA-99 S) is 26+ miles. This reduction in access would disproportionately negatively impact low-income

[27]Wicclair, M. (2011). Conscientious Refusals by Hospitals and Emergency Contraception. *Cambridge Quarterly of Healthcare Ethics,* 20(1), 130-138. doi:10.1017/S0963180110000691; Wendy C., et al., Conscientious Objection and Refusal to Provide Reproductive Health care: A White Paper Examining Prevalence, Health Consequences' and Policy Responses, 123 Int'l J. Gynecol. & Obstet. 3 (2013), S41-S56; Stulberg D., et al. Referrals for Services Prohibited In Catholic Health Care Facilities. Perspect Sex Reprod Health. 2016 Sep; 48(3):111-7. doi: 10.1363/48e10216. Epub 2016 Jul 28. PMID: 27467888.

patients with limited transportation options.[28] These points were frequently made during our interviews with providers and community organizations with knowledge of local market conditions, patient populations, and their utilization patterns.

Interviews identified concerns that if ERD based limitations are applied to some existing reproductive and other potentially ERD prohibited services at Madera Community Hospital as a result of the transaction with St. Agnes Medical Center/Trinity Health, some essential emergency and/or reproductive services might be limited resulting in potentially negative patient outcomes.

For example, in cases where pregnancies should be terminated for medical necessity or in an emergency, where certain reproductive sterilization procedures are needed in an emergency or for medical necessity, or in cases of sexual assault where emergency contraception services should be provided, implementation of ERDs may have a detrimental impact on patient access and outcomes. These negative outcomes could come from either the delays in care from turning away patients at Madera Community Hospital or their affiliated clinics or due to burdening the patient who must be referred to and travel to alternative providers or health care settings for medically necessary services, and outside the service area depending on the nature of the procedure or treatment.

Furthermore, if contraception and family planning services are discontinued at Madera Community Hospital's rural health clinics as a result of ERD implementation, a significant number of financially disadvantaged patients in the service area will be disproportionately negatively impacted for lack of available nearby resources.

Interviewees did indicate that alternative providers of medicinal as well as surgical abortions and some gender affirming and reproductive health services and surgical treatments are available and provided in other hospitals, surgery centers or clinics and outpatient settings. However, in most cases the closest alternatives would be in Fresno. They noted that many financially disadvantaged or low-income patients located in Madera may have significant difficulty arranging or obtaining transportation to these Fresno locations.

Continuation as a Licensed General Acute Care Hospital

It is not anticipated that there will be a change in the status of the hospital or its license as a general acute care hospital following completion of the transaction. It is anticipated that the hospital will continue its license for both inpatient and emergency services and that the hospital will maintain its existing services following completion of the transaction. Except as may be impacted by the implementation of the ERDs, the hospital will operate as a general acute care

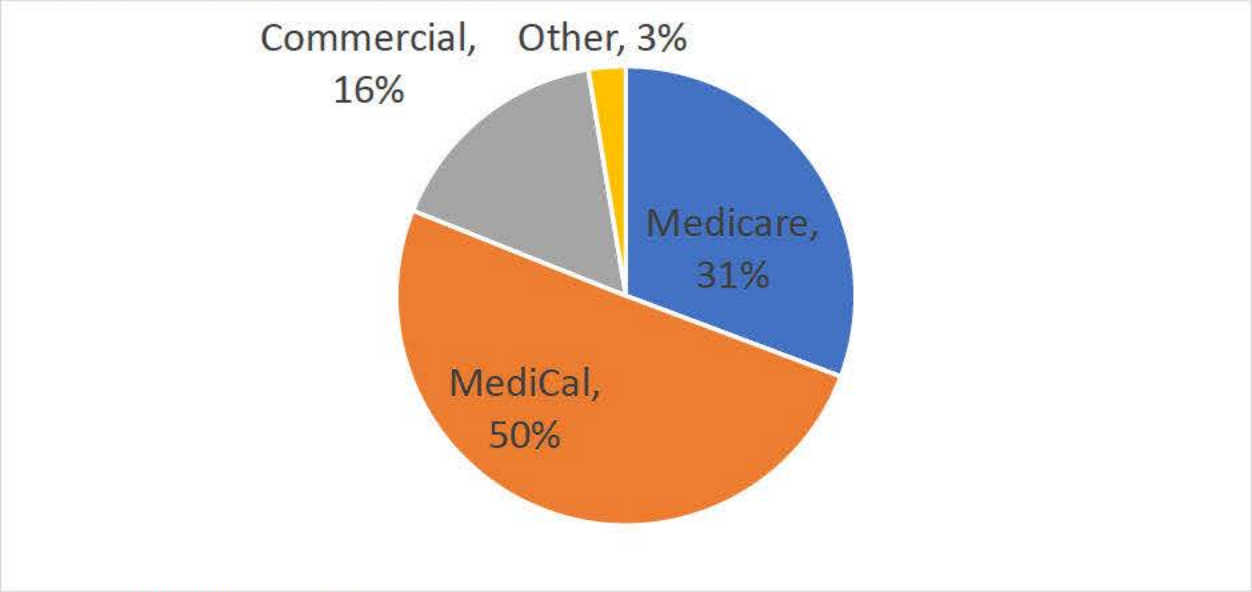
[28] Arcury, T., et al. (2005). The Effects of Geography and Spatial Behavior on Health Care Utilization among the Residents of a Rural Region, 40 Health Serv. Research, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1361130/.

hospital maintaining all of the same types and levels of services as currently provided including those reported in the hospital's most recent filing of their Annual Disclosure Report to HCAI and/or listed on the Hospital's website.

Availability and Provision of Services to Different Groups of Patients Based on Insurance (Payor) Status

Madera Community Hospital currently serves a wide range of patients with different sources of health insurance coverage (as well as uninsured patients).

Madera Community Hospital – Payor Mix



Source: HCAI PIVOT Data, 2020.

Approximately one-third (31 percent) of the Hospital's total charges are for Medicare patients and charges for Medi-Cal (low income) patients account for 50 percent of total charges at Madera Community Hospital. The Hospital currently participates in the Medicare and Medi-Cal programs through both fee-for-service contracts as well as managed care contracts. Under existing regulations, patients enrolled in the traditional Medicare and Medi-Cal fee-for-service programs have assured access to hospitals in their community regardless of the contract status of the hospital. However, if, post-transaction, Madera Community Hospital chose to discontinue its contracts for the managed care plans with the Medicare and Medi-Cal programs, eligible patients could be denied access to non-emergency health care services, thus creating a negative impact on availability or accessibility for these patient populations.

Uncompensated and Charity Care

While the expansion of health insurance coverage following the implementation of the Patient Protection and Affordable Care Act has expanded the covered population in California, many uninsured and under-insured individuals in the community rely on the Hospital for health care services. Per the pie chart above, approximately 3 percent of total charges were for patients in the Other (uninsured) group. The Table below documents the level of uncompensated care as reported by the Hospital to HCAI for FYE 2020.

Uncompensated Care Costs	**Amount**
Charity-Other	$ 780,209
Charity-Other + Bad Debt	$ 2,315,905
Charity-Other + Bad Debt + CIP Cont. Adj.	$ 2,339,396
Uncompensated Care Costs % of Operating Expenses	**Percent**
Charity % of Operating Expenses	0.9%
Charity + Bad Debt % Operating Expenses	2.7%
Charity+Bad Debt+CIP Cont Adj % of Op. Exp.	2.7%

Source: HCAI PIVOT Data, 2020.

Per the Table, the current level of charity provided by the Hospital is similar to the statewide average (0.9% of operating expenses) and documents the importance of providing uncompensated care to the community. It will be important for Madera Community Hospital to continue to provide needed services to the uninsured and underinsured.

Preferred Language Spoken by Madera Community Hospital Patients

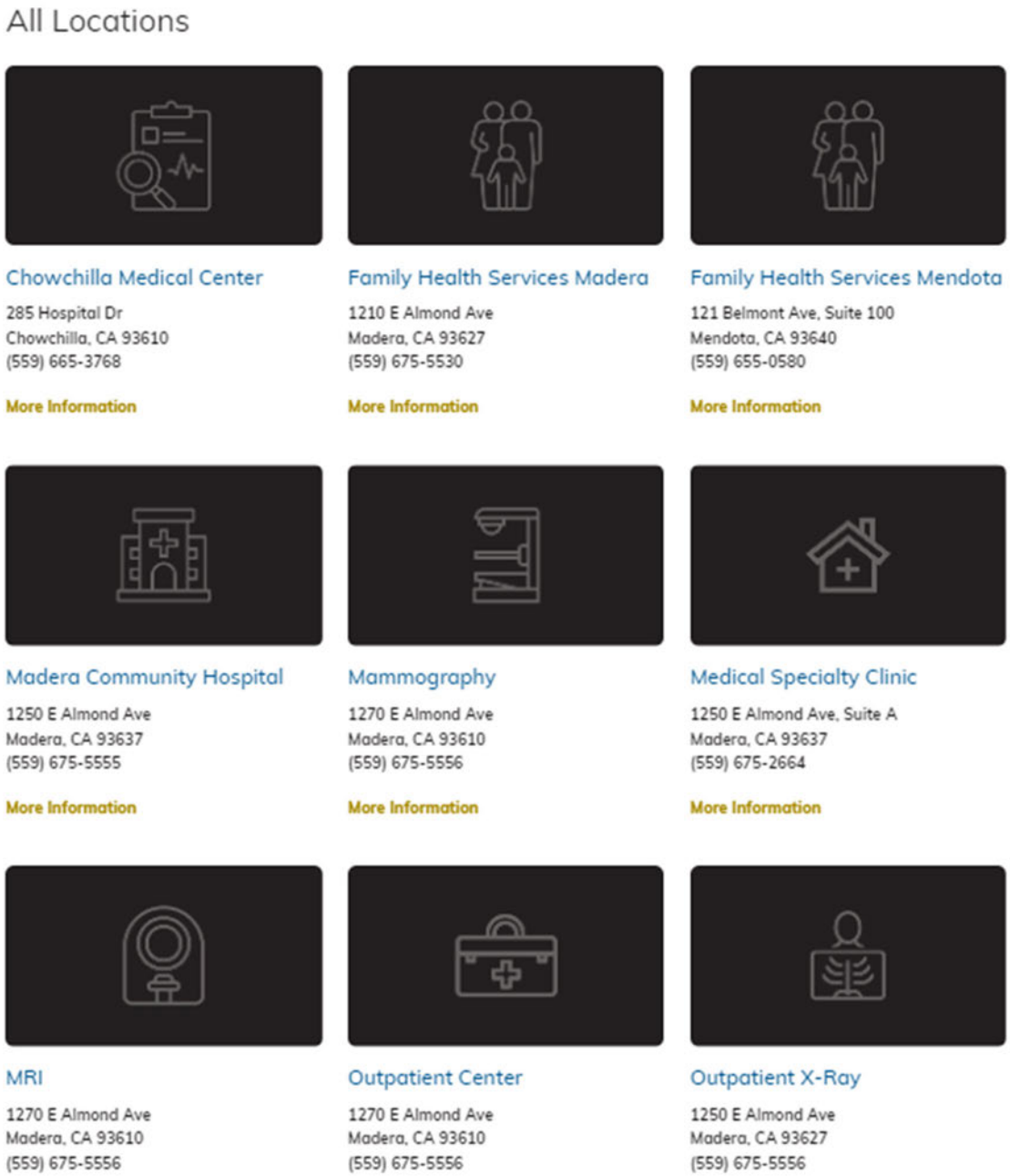
The Table below lists the preferred languages spoken by Madera Community Hospital patients. As can be seen, a large portion of Madera Community Hospital patients are Spanish speaking. It will be important for the Hospital to continue to offer language assistance services to these patients.

PREFERRED LANGUAGE SPOKEN	ED Encounters
Arabic	37
English	19,439
Panjabi; Punjabi	81
Sign Language	40
Spanish	8,623
TOTAL	28,244

Source: HCAI, Emergency Department Encounters Data, 2021.

Madera's Non-Hospital-Based Outpatient Services

Per the exhibit below from the Madera Community Hospital website, the Hospital currently owns and/or operates multiple non-hospital-based outpatient facilities and services: clinics, MRI services, mammography, and x-ray services. It will be important for the Hospital to maintain these services following the transaction to ensure continued availability of needed services and to minimize disruption to patient care patterns in the County.



Madera Community Hospital – Community Benefits

The Hospital has historically provided a significant amount of community benefit services. According to the data provided in the Hospital's recent Community Benefit Report (see Table below), the Hospital provided approximately $35 million in community benefits (largely as a result of reimbursement below operating expenses for Government programs). These data document the important role of the Hospital in providing community benefits both as the only acute care hospital in the county and as a non-profit hospital. As can be seen, more than $30+ million of the Hospital's community benefits are tied to unpaid costs of Medicare and Medi-Cal.

Community Benefit Service Categories Executive Summary July 1, 2020 - June 30, 2021	
Community Health Improvement Services (A)	
Community Health Education (A1)	$1,061,944
Health Care Support Services (A3)	$53,530
Other (A4)	$656
**** Community Health Improvement Services	**$1,116,130**
Health Professions Education (B)	
Nurses/Nursing Students (B2)	$25,531
Other Health Professional Education (B3)	$42,218
Scholarships/Funding for Professional Education (B4)	$1,850
Other (B5)	$183
**** Health Professions Education	**$69,782**
Financial and In-Kind Contributions (E)	
Financial Contributions (E1)	
In-kind Donations (E3)	$194
Cost of Fundraising for Community Programs (E4)	
**** Financial and In-Kind Contributions	**$194**
Community Building Activities (F)	
Community Support (F3)	$82,890
Community Health Improvement Advocacy (F7)	$3,757
Workforce Development (F8)	$0
**** Community Building Activities	**$86,647**
Community Benefit Operations (G)	
Community Needs/Health Needs Assessment (G2)	$3,684
Other Resource (G3)	
**** Community Benefit Operations	$3,684
Total Community Benefit Programs	**$1,276,437**
Traditional Charity Care	**$849,991**
Government Sponsored Health Care	
Unpaid Cost of Medicaid	$22,249,789
Means-Tested Programs	$2,944,958
**** Government Sponsored Health Care	**$25,194,747**
Unpaid Costs of the Medicare Program	**$7,376,489**
Total Community Benefit Costs	**$34,697,664**

Source: Community Benefits & Social Accountability Report (2021) https://www.maderahospital.org/about-us/community-benefits/.

Hospital Staffing and Employee Rights

Should the transaction be approved, it will be important to maintain continuity of existing patient and health provider relationships and, to the extent possible, maintain and retain staff that have an understanding and appreciation of the Madera Community Hospital patient population and the Madera County community as a whole.[29] These factors have been shown to be important inputs into cultural competency in provided health services.[30] For this reason, it will also be important, post transaction, to maintain privileges for current medical staff including clinical and other support staff at Madera Community Hospital who are in good standing as of the closing date. According to the parties, the closing of the Affiliation Agreement shall not change the medical staff officers, committee chairs, or independence of the medical staff, and such persons shall remain in good standing for the remainder of their tenure as medical staff officers or committee chairs at Madera Community Hospital.

Community Physicians and Hospital Medical Staff

As discussed, Madera Community Hospital is an essential centerpiece to the health care delivery system within Madera County. Further, access to the Hospital by community physicians (after credentialing) is essential to effective access for patients and overall community health status. As such, it is important that community physicians (both existing and future) have appropriate access and admitting privileges to the Hospital. In addition, it will be important to assure that existing physicians, IPAs, and Medical Groups that access and refer to Madera Community Hospital will continue to have access to the hospital and that future contracts do not limit their access or the access of their patients to Madera Community Hospital services and/or their controlled entities.

Alternatives

If the proposed Affiliation Agreement is not approved, it is expected that the Hospital would evaluate alternative proposals from other health systems for a transaction and/or alternatively would be forced to cease operating as a licensed general acute care hospital.

Summary and Conclusions

Our Health Impact analysis finds that Madera Community Hospital is an essential component of the health care delivery system to ensure access to needed health care services for Madera County residents.

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[29]Ngo-Metzger, Q., et al., Cultural Competency and Quality of Care Obtaining the Patient's Perspective, The Commonwealth Fund, October 2006.

[30]Blewett, L., et al. Patient perspectives on the cultural competence of US health care professionals. *JAMA Netw Open.* 2019; 2(11):e1916105. doi:10.1001/jamanetworkopen.2019.16105.

Further, we find that the proposed transaction can benefit both Madera Community Hospital and Madera County residents and current and future Madera Community Hospital patients by ensuring the continued and sustained operation of the Hospital, and as such, maintain access to needed health care services in Madera County.[31] Individuals that participated in the interviews as part of this project also agreed the transaction could provide the hospital with support needed to continue and sustain its operation and that the community would benefit from the transaction by providing a solid foundation for the Hospital to continue to operate and provide needed services to the community.

It is concluded that a series of recommended post-transaction conditions are needed to ensure that the transaction maximizes the benefits to the community.[32]

It is important to note that the Health Impact analysis is only part of the overall assessment of the proposed transaction. The Competitive Impact analysis is described in detail below along with proposed conditions related to the competitive impacts of the proposed transaction. The Competitive Impact analysis reveals that this transaction has significant anti-competitive concerns that, all other factors equal, would likely generate a recommendation to block the proposed transaction.

However, the Health Impact analysis summarized above clearly identifies that there are significant potential access and availability benefits associated with the transaction that might be lost if the transaction were disapproved.

As such, it will be important to consider both analyses and both sets of recommended conditions together and in their entirety in determining whether to approve the proposed transaction.

Recommended Conditions Related to Health Care Impacts for Transaction Approval by the California Attorney General

If the California Attorney General approves the proposed transaction, it is recommended that the following conditions be considered/required in order to minimize any potential disruptions to access to needed health care services and community benefits historically provided by Madera Community Hospital and in so doing minimize negative and/or adverse health care impacts that might result from the transaction.

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[31]The benefits of continued access and availability to hospital services provided by Madera Community Hospital that might derive from the proposed transaction are unrelated to any potential merger specific economic efficiencies that may occur as a result of the transaction.
[32]The benefits of the transaction referenced here are related to access and availability of services to the community and are not due to any specific economic efficiencies that may occur as a result of the merger.

Maintain Availability of Existing Services[33]

For at least ten years from the closing date:

1. The Hospital shall continue to operate as a general acute care hospital, shall maintain 24-hour emergency and inpatient medical services at no less than current licensure and designation with the same types and/or levels of services as reported to HCAI, and shall provide the following:

    (a) basic emergency medical beds and basic emergency medical services providing services 24 hours a day, 7 days a week, including: maintaining the unit's necessary and required nursing staff, physicians, emergency medical personnel and necessary and required equipment, supplies, services and space, in order to provide prompt and safe care for any patients presenting with urgent and emergency medical conditions;

    (b) 73 unspecified general acute care medical/surgical beds;

    (c) 23 perinatal beds;

    (d) 10 intensive care beds;

    (e) Labor & Delivery services, including four Labor and Delivery Recovery Suites, operating rooms, lactation consultants, maternity care, and education;

    (f) Primary Care and Specialty Care services;

    (g) Specialty Surgical services including Orthopedic, Interventional, Thoracic, Endoscopic, Gynecological, Podiatric, Otolaryngological, and, Urological surgeries;

    (h) General Surgical services; and

    (i) Outpatient services, including Telemedicine, and Outpatient Imaging and X-ray services.

2. The Hospital shall maintain all health care services provided at the current locations or at similar locations with equivalent services, including but not limited to:

    - Rural Health Clinics located at 285 Hospital Drive, Chowchilla, California, 93610; 1210 E. Almond Avenue, Suite A & B, Madera, California 93627; and 121 Belmont Avenue, Suite 100, Mendota, California, 93640;

[33]At the discretion of the Attorney General, it is reasonable to extend the maintenance of availability and access for an additional five years beyond the minimum ten-year time-periods recommended here.

- Medical Specialty Clinic at 1250 E. Almond Avenue, Suite A, Madera, California, 93637;
- Outpatient Center at 1270 E. Almond Avenue, Madera, California, 93610;
- MRI and Mammography at 1270 E. Almond Avenue, Madera, California, 93610; and
- Outpatient X-Ray, at 1250 E. Almond Avenue, Madera, California, 93627.

3. The Hospital shall maintain language and communications services currently available, as no cost to the patient, including:

    a. Hospital website with English and Spanish pages as needed;
    b. Financial Assistance Program applications written in English and Spanish;
    c. Languages spoken at the Hospital, either as a primary language or through translation services, as needed; and
    d. Deaf and Hearing-Impaired interpreter services and communication aids during the provision of health services or treatment.

4. The Hospital shall maintain a charity care policy that is no less favorable than its current charity care policy, historical performance and in compliance with California and Federal law. An example would be to require a commitment based on a three-year rolling average of the most recent available data. The Minimum Charity Care Amount will be increased on an annual basis by the rate of inflation as measured by the Consumer Price Index for the Western Census Region as measured and reported by U.S. Bureau of Labor Statistics.[34] For purposes herein, the term "Charity Care" shall mean the amount of charity care costs (not charges) incurred by the Hospital in connection with the operation and provision of services at the Hospital. The definition and methodology for calculating "Charity Care" and the methodology for calculating "cost" shall be the same as that used by HCAI for annual hospital reporting purposes. Additionally, the Hospital Fair Pricing Policies, Health and Safety Code section 127405, gives the Hospital the flexibility to adjust eligibility for its discount payment and charity care policies. The Attorney General may consider imposing other charity care protections such as improving the charity care policy and disclosure requirements.[35]

5. The Hospital shall continue to expend no less than historical levels in relation to their overall operating budget, averaged over the previous three years, in community benefit services as defined, calculated and reported by Madera Community Hospital in their annual Community Benefits & Social Accountability Report filed with the State. The

[34]www.bls.gov/regions/west/summary/blssummary_fresno.pdf.

[35]This condition is similar to one that was required for the Dignity Health (now Common Spirit Health) transaction issued on November 21, 2018.

Table below summarizes the most recent three years of data, as reported by Madera Community Hospital and the 3-year average of $31,095,296.

	2020	**2019**	**2018**	**Average (3 Year)**
Total Community Benefit Costs (including Traditional Charity Care)	$ 33,858,755	$ 31,614,951	$ 27,812,181	$ 31,095,296

The Minimum Community Benefit Amount will be increased on an annual basis by the rate of inflation as measured by the Consumer Price Index for the Western Census Region as measured and reported by the U.S. Bureau of Labor Statistics.[36] If the Hospital receives any grant funds for community benefit services, those grant funds may not be applied to the Minimum Community Benefit Amount. In addition, the aforementioned community benefit programs shall continue to be offered and/or supported for at least five years from the closing date

Maintain Access to Hospital Services for Medicare and Medi-Cal Patients

For at least ten years from the closing date:

6. The Hospital shall maintain its participation in the Medicare (Traditional FFS) program, by maintaining a Medicare Provider Number and providing the same types and/or levels of emergency and non-emergency services to Medicare beneficiaries, on the same terms and conditions as other similarly situated hospitals.

7. The Hospital shall be certified to participate in the Traditional Medi-Cal program, providing the same type, and/or levels of emergency and non-emergency services to Medi-Cal beneficiaries.

8. The Hospital shall maintain its participation in Medicare and Medi-Cal Managed Care programs, providing the same types and/or levels of emergency and non-emergency services to Medicare and Medi-Cal Managed Care enrollees, on the same terms and conditions as other similarly situated hospitals offering substantially the same services, without any loss, interruption of service, or decrease of quality, or gap in contracted hospital coverage.

[36] www.bls.gov/regions/west/summary/blssummary_fresno.pdf.

Seismic Compliance and Capital Expenditures

9. St. Agnes and the Hospital shall commit the necessary investments required to maintain HCAI seismic compliance requirements at the Hospital through 2030 under the Alfred Alquist Hospital Facilities Seismic Safety Act of 1983, as amended by the California Hospital Facilities Seismic Safety Act (Health & Safety. Code, § 129675- 130070).

10. St. Agnes and Trinity Health will provide funds to adequately support Madera Community Hospital's long-range strategic capital plan. Saint Agnes and Trinity Health anticipate providing additional allocations for capital improvements at Madera Community Hospital, estimated at $3,000,000 per year, to support its annual capital plan for routine replacement of equipment and strategic growth projects. Additional capital funding opportunities include major projects, clinical equipment/infrastructure, technology information systems, contingency replacement, physician alignment/ business development and innovation grants. Any such allocations shall be subject to and determined in accordance with Trinity Health's due diligence and capital budget process and procedures.

11. No later than one year after the closing date, Saint Agnes and Trinity Health will install the Epic electronic health records system at Madera Community Hospital and train Hospital employees on system use. Saint Agnes and Trinity Health will install the Epic electronic health records system at Madera Community Hospital and train its employees to use the EHR. The EHR installation and training for Madera Community Hospital are estimated to cost approximately $30,000,000.

Non-Discrimination Policies

12. Madera Community Hospital shall prohibit discrimination on the basis of any protected personal characteristic identified in state and federal civil rights laws, including section 51 of the California Civil Code and title 42, section 18116 of the United States Code. Categories of protected personal characteristics include:

    a) Gender, including sex, gender, gender identity, and gender expression;

    b) Intimate relationships, including sexual orientation and marital status;

    c) Ethnicity, including race, color, ancestry, national origin, citizenship, primary language, and immigration status;

    d) Religion;

    e) Age; and

    f) Disability, including disability, protected medical condition, and protected genetic information.

Health Care Impacted by the Ethical and Religious Directives (ERDs)

13. Emergency reproductive and other health care: Madera Community Hospital shall continue to provide inpatient emergency reproductive and other health services by permitting medical personnel to (i) make clinical decisions consistent with the standard of care and their independent professional judgment, respecting the needs and wishes of each individual patient; (ii) inform patients of all of their health care options; (iii) prescribe any interventions that are medically necessary and appropriate; (iv) transfer or refer patients to other facilities whenever they determine it is in the patient's interests; and (v) provide any item or service they deem in their professional judgment to be necessary and appropriate without restriction, and without seeking approval from any non-provider, including any items or services where referral or transfer to another facility would, in their sole professional judgment, risk material deterioration to the patient's condition. Madera Community Hospital shall revise their written policies, tools, procedures, guidelines, and training materials and shall train existing medical staff to ensure compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. §§ 1395cc, 1395dd; Health & Safety Code § 1317; and 42 C.F.R § 489.24.

14. Treatment of Sexual Assault Survivors: Madera Community Hospital shall comply with Health & Safety Code section 1281 and Penal Code Sections 13823.11 and 13823.5.

15. Women's Health Services: For at least 10 years from the closing date, the Hospital shall maintain the following women's health care services at Madera Community Hospital's general acute care hospital, rural clinics, and other outpatient settings:

    i. Mammography and Breast Health Services;

    ii. Preventative Health care, including Pap Smears;

    iii. Labor and Delivery Department, including Maternity Services such as Breastfeeding Support;

    iv. Gynecology and Gynecological Surgery to treat common female reproductive health conditions, including Hysterectomy, Salpingo-oophorectomy, D/C, Diagnostic laparoscopy, Endometrial Ablation, LEEP procedure, Cystocele repair, Anterior/Posterior Repair, Myomectomy, and Ovarian Cystectomy; and

    v. Contraception, including oral, implantable, injectable and IUD insertion.

16. Notice of Policy-Based Restrictions: Madera Community Hospital shall inform members of the public and current and prospective patients of any health care services that will either not be available, that will be discontinued, or that might otherwise be subject to policy-based restrictions or limitations from the ERDs. The hospital shall also make

publicly available on the hospital website, in both English and Spanish and to the patient in person, the process and criteria to determine whether the service will be provided.

17. Madera Community Hospital shall provide referral and transportation assistance to current or presenting patients who are in need of or are otherwise seeking restricted services, to another health care provider or location where the services may be provided.

Competitive Impact Assessment

Potential Issues Associated with the Competitive Impact of the Proposed Transaction

Published Literature on Hospital Mergers and Acquisitions

There is extensive health economic literature containing many empirical studies of the economic effects of hospital mergers and acquisitions. The studies examine data for a wide sample of mergers occurring different places and during different time periods and, in general, find that there can be substantial increases in prices resulting from mergers in concentrated markets (e.g., Town and Vistnes, 2001; Krishnan, 2001; Vita and Sacher, 2001; Gaynor and Vogt, 2003; Capps et al., 2003; Capps and Dranove, 2004; Dafny, 2009; Haas-Wilson and Garmon, 2011; Tenn, 2011; Thompson, 2011; Gowrisankaran et al., 2015).[37] Price increases on the order of 20 or 30 percent are common, with some increases as high as 65 percent.

[37] Town, R. and Vistnes, G. (2001). Hospital competition in HMO networks. *Journal of Health Economics*, 20(5):733–752; Krishnan, R. (2001). Market restructuring and pricing in the hospital industry. *Journal of Health Economics*, 20:213–237; Vita, M. and Sacher, S. (2001). The competitive effects of not-for-profit hospital mergers: A case study. *Journal of Industrial Economics*, 49(1):63–84; Gaynor, M. and Vogt, W. (2003). Competition among hospitals. *RAND Journal of Economics*, 34:764–785; Capps, C., et al. (2003). Competition and market power in option demand markets. *RAND Journal of Economics*, 34(4):737–63; Capps, C. and Dranove, D. (2004). Hospital consolidation and negotiated PPO prices. *Health Affairs*, 23(2):175–181.; Dafny, L. (2009). Estimation and identification of merger effects: An application to hospital mergers. *Journal of Law and Economics*, 52(3):pp. 523–550; Haas-Wilson, D. and Garmon, C. (2011). Hospital mergers and competitive effects: Two retrospective analyses. *International Journal of the Economics of Business*, 18(1):17–32; Town, R. and Vistnes, G. (2001). Hospital competition in HMO networks. *Journal of Health Economics*, 20(5):733–75; Thompson, E. (2011). The effect of hospital mergers on inpatient prices: A case study of the New Hanover-Cape Fear transaction. *International Journal of the Economics of Business*, 18(1):91–101; Gowrisankaran, G., et al. (2015). Mergers when prices are negotiated: Evidence from the hospital industry. *American Economic Review*, 105(1):172–203.

Recent testimony by Professor Martin Gaynor to the US Senate summarized the empirical literature on the price increasing effects of hospital mergers as follows:[38]

> These studies consistently show that when hospital consolidation is between close competitors it raises prices, and by substantial amounts. Consolidated hospitals that are able to charge higher prices due to reduced competition are able to do so on an ongoing basis, making this a permanent rather than a transitory problem. Moreover, there is no difference between not-for-profit and for-profit hospitals in the extent to which they raise prices due to increased market power… Price increases on the order of 20 or 30 percent are common, with some increases as high as 65 percent.

The underlying structure of hospital markets and the competitive dynamics that flow from different market structures help to explain these findings. In general, negotiations between hospitals and insurers determine whether a hospital is included in an insurer's provider network and the resulting negotiated price terms of the contract.[39] Insurers compete in the insurance market and as such their goal is to construct provider networks that employers (and consumers) will value. In addition, there are also government regulations such as network adequacy requirements that can affect this process and outcome. However, in general, if two hospitals are viewed as good alternatives to each other by consumers and/or their employers (close substitutes), then the insurer can substitute one for the other with little loss to the value of their product, and therefore each hospital's bargaining leverage is limited. If one hospital declines to join or is not included in the network, customers of the insurance company will still have access to needed services from a similar substitute hospital. As such their product is still attractive and is still valuable. If the two competing hospitals merge, the insurer now has limited options. The health plan can no longer benefit from price competition between two independent hospitals competing to be in the plan's network and at the same time the plan's insurance product will lose value if they offer a plan and a network without either of the merged entities--especially if it is a concentrated market with limited other hospitals viewed as good alternatives by consumers. In sum, a merger in a concentrated market that results in greater concentration results in increased market power by the merged entities which can be used to negotiate above market price increases. Overall, studies consistently show that when hospital consolidation is between close competitors it raises prices, and by substantial amounts.

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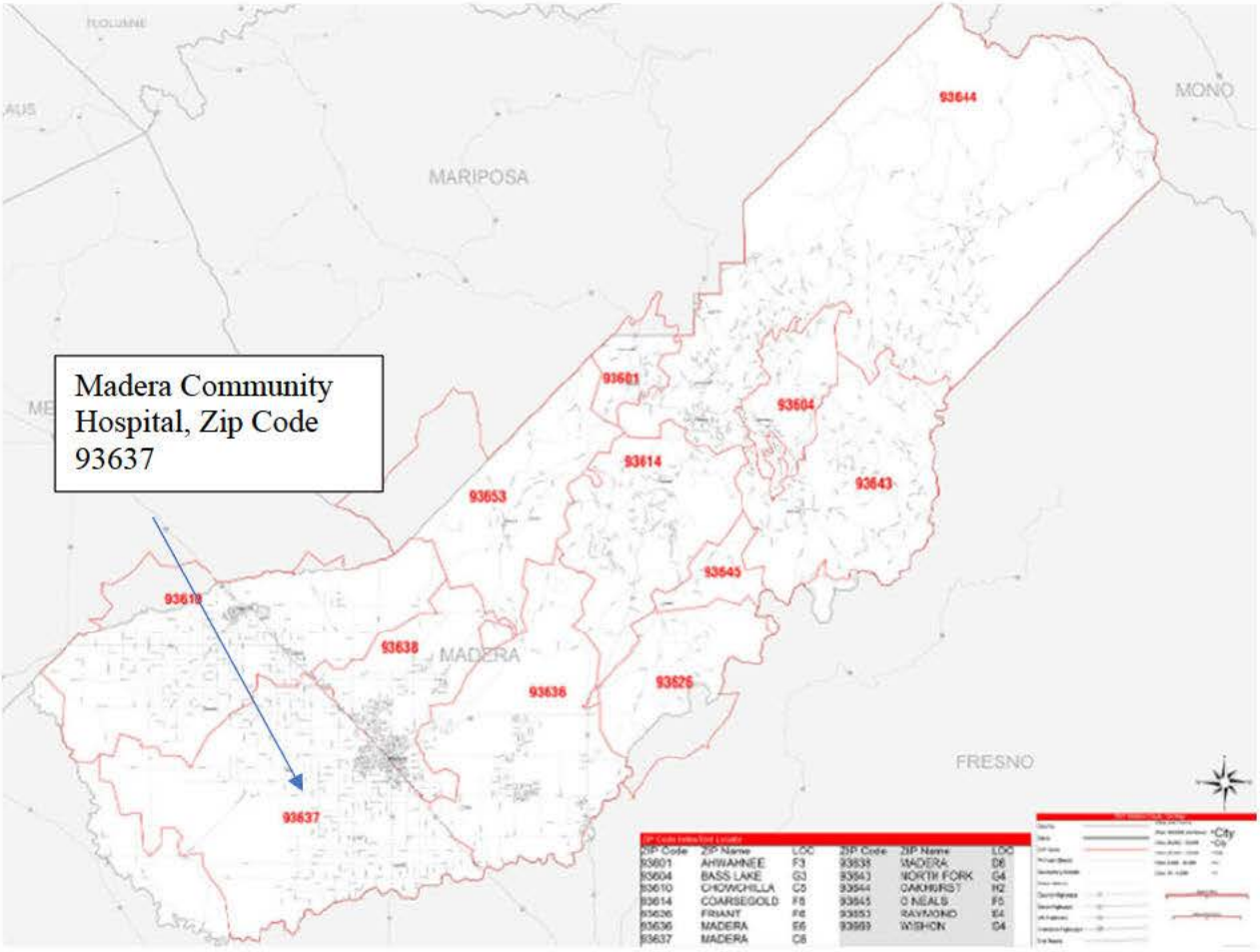
[38]https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf

[39]Medicare FFS and Medi-Cal FFS plans/products are not subject to these same market forces as the price terms are not negotiated but rather determined unilaterally by the plans when contracting with hospitals. However, Medicare and Medi-Cal managed care plans are subject to market forces and price terms are determined through contract negotiation processes.

Also, and importantly, consolidated hospitals that are able to charge higher prices due to reduced competition are able to do so on an ongoing basis, making this a permanent rather than a transitory problem.

Importance of Madera Community Hospital to the Community

Madera Community Hospital is the only general acute care hospital in Madera County. The County covers 2,153 square miles, with a population in excess of 150,000+. Madera Community Hospital is located in zip code 93637.

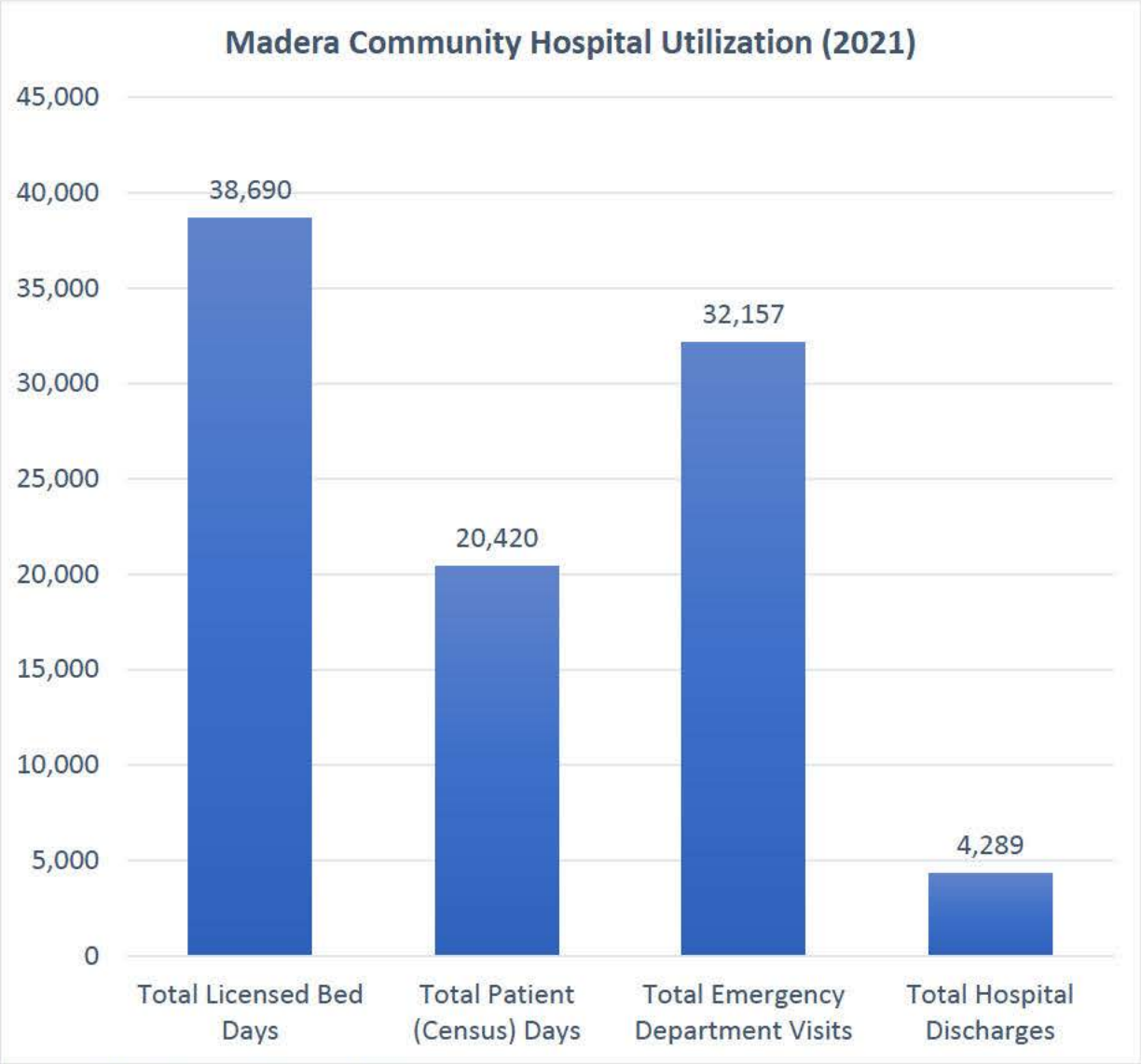


Madera Community Hospital: Capacity and Utilization, 2016-2020

Again, Madera Community Hospital is a critically important provider and resource for a wide range of health care services to the residents of Madera County. The Hospital is essential for its direct provision of emergency, inpatient, obstetrics, and mental health services to residents within its service area. In addition, Madera Community Hospital owns and operates several non-hospital-based outpatient units in Madera County.

Summary Utilization Statistics	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018	Madera FYE 6/30/2017	Madera FYE 6/30/2016
Licensed Beds	106	106	106	106	106
Patient Days (excl. nursery)	13,214	14,036	14,870	13,970	13,313
Discharges (excl. nursery)	3,251	3,658	3,885	3,758	3,644
Average Length of Stay (est.)	4.06	3.84	3.83	3.72	3.65
Adjusted Patient Days	30,165	31,809	32,676	32,232	33,048
ER Visits	31,588	33,820	34,626	35,798	38,392
Clinic Visits	51,141	56,487	60,020	55,064	51,036
Home Health Visits	0	0	0	0	0
Referred O/P Visits	44,939	53,952	56,258	50,462	46,119
I/P Surgeries	1,307	1,379	1,387	1,346	1,228
O/P Surgeries	1,743	1,817	1,750	1,709	1,361
Purchased I/P Days	0	0	0	0	0
Nursery Days	1,541	1,683	1,961	2,185	2,322
Nursery Discharges	786	806	888	942	1,006
Natural Births	547	607	658	715	728
Cesarean Sections	232	234	250	301	314

Madera Community Hospital Utilization, 2021



Source: HCAI Utilization Report, 2021.

Madera Community Hospital Emergency Department Utilization – 2021

EDS Visit Type	CPT Codes	ED Visits not Resulting in Admission*	Inpatients Admitted from ED
Minor	99281	746	5
Low/Moderate	99282	6,311	231
Moderate	99283	15,249	923
Severe without threat	99284	5,484	640
Severe with threat	99285	1,637	931
Total		**29,427**	**2,730**

Source: HCAI Utilization Report, 2021. Note: May not equal annual total due to missing CPT Codes.

Madera County Residents Reliance on Madera Community Hospital, 2020

As can be seen in the two Tables below, Madera County residents are highly dependent on Madera Community Hospital for their emergency care.

Madera County Residents ED Utilization, 2020

Hospital	ED Visits/Patients from Madera County
MADERA COMMUNITY HOSPITAL	22,445
ST. AGNES MEDICAL CENTER	4,057
CLOVIS COMMUNITY MEDICAL CENTER	1,729
COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	1,694
MERCY MEDICAL CENTER - MERCED	1,004
JOHN C FREMONT HEALTH CARE DISTRICT	530
ADVENTIST HEALTH HANFORD	95
MEMORIAL HOSPITAL LOS BANOS	66

Source: HCAI Hospital Market Share Report, 2020. Medi-Cal. Includes only ED visit patients and hospitals with at least 50 ED visits. Excludes specialty hospitals (children's hospitals, surgical hospitals, rehabilitation hospitals) and Kaiser hospitals. These hospitals are excluded for competitive analysis because they are not considered substitutes by health plans for Madera Community Hospital as part of negotiations with commercial health plans for contracting purposes.

Madera County Residents ED + Inpatient Utilization, 2020

FACILITY NAME	All ED Patients and Inpatients 2020
MADERA COMMUNITY HOSPITAL	26,026
ST. AGNES MEDICAL CENTER	7,123
COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	3,607
CLOVIS COMMUNITY MEDICAL CENTER	2,737
MERCY MEDICAL CENTER - MERCED	1,432
JOHN C FREMONT HEALTH CARE DISTRICT	558
FRESNO SURGICAL HOSPITAL	154
STANFORD HEALTH CARE	139
SAN JOAQUIN VALLEY REHABILITATION HOSPITAL	138
ADVENTIST HEALTH HANFORD	120
UCSF MEDICAL CENTER	111
DOCTORS MEDICAL CENTER	108
MEMORIAL MEDICAL CENTER - MODESTO	89
MEMORIAL HOSPITAL LOS BANOS	79
EMANUEL MEDICAL CENTER	79

Source: HCAI Hospital Market Share Report, 2020. Includes all patients (IP + ED, excludes ASC patients) and hospitals with at least 60 patients. Excludes Children's and Kaiser Hospitals.

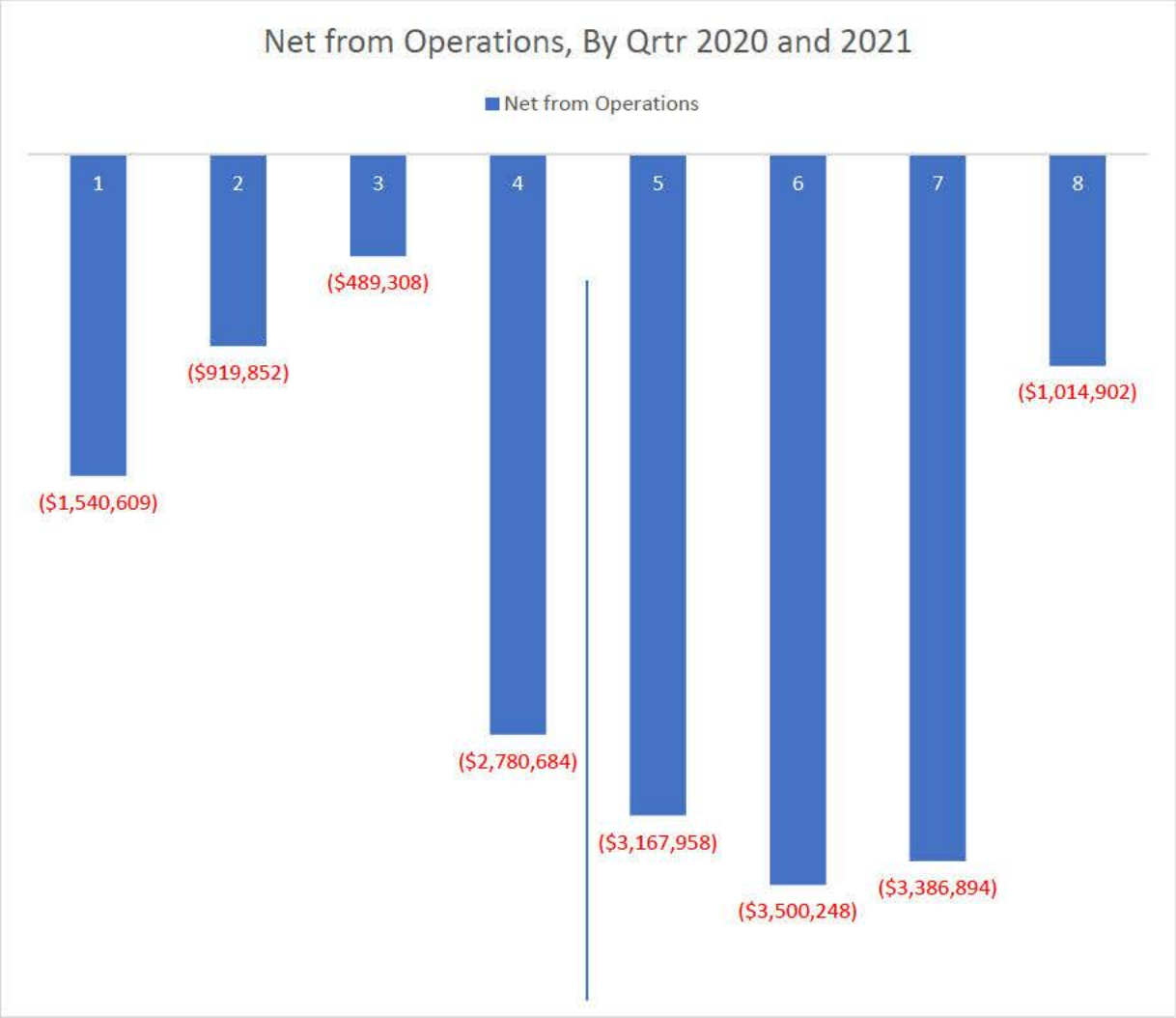
Financial Performance of Madera Community Hospital

Madera Community Hospital Financial Performance, Selected Measures, PIVOT Data, (2016- 2020)

	Madera FYE 6/30/2020	Madera FYE 6/30/2019	Madera FYE 6/30/2018	Madera FYE 6/30/2017	Madera FYE 6/30/2016	Cumulative –2016 - 2020
Total Operating Revenue	89,137,501	94,559,218	92,588,529	77,081,854	82,911,123	436,278,225
- Operating Expenses	91,301,309	93,635,532	90,032,246	84,979,023	82,065,189	442,013,299
Net from Operations	-2,163,808	923,686	2,556,283	-7,897,169	845,934	-5,735,074
+ Non-Operating Revenue	1,132,263	920,353	713,512	1,133,553	589,190	4,488,871
- Non-Operating Expense	35,864	27,528	0	0	0	63,392
- Income Taxes	0	0	0	0	0	0
- Extraordinary Items	0	0	0	0	0	0
Net Income	-1,067,409	1,816,511	3,269,795	-6,763,616	1,435,124	-1,309,595

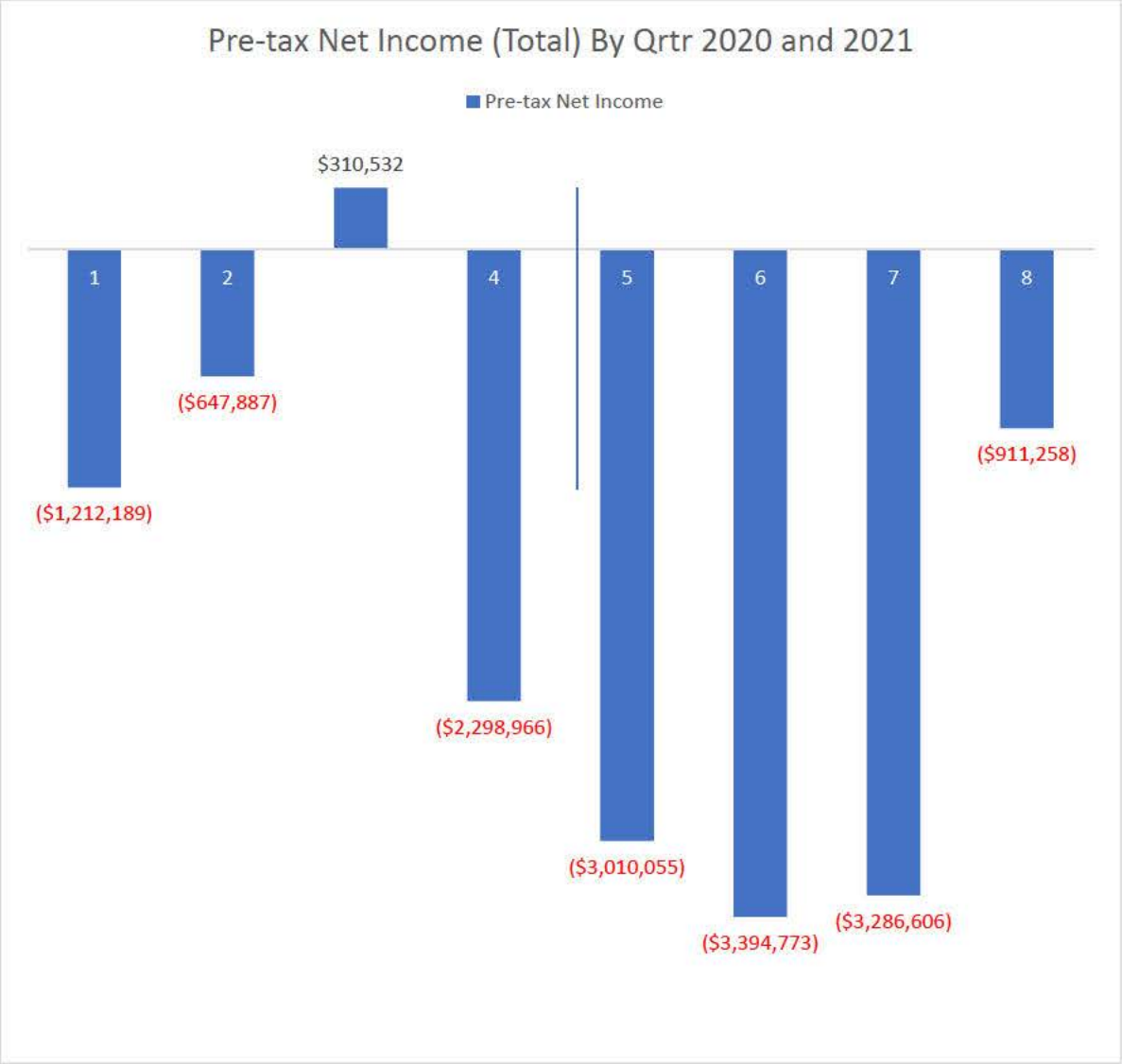
Source: HCAI Hospital PIVOT Data. Selected Years.

Madera Community Hospital Financial Performance, Net from Operations, Quarterly Data, (2020 and 2021)



Source: HCAI Hospital Quarterly Data, 2020 and 2021.

Madera Community Hospital Financial Performance, Pre-Tax Net Income, Quarterly Data, (2020 and 2021)



Source: HCAI Hospital Quarterly Data, 2020 and 2021.

Madera Community Hospital Financial Performance, Net Income from Operations and Pre-Tax Net Income, Quarterly Data, by Year and Cumulatively (2020 and 2021)

Net Income Measure	2021	2020	Cumulative, 2020-2021
	–Total - 4 Quarters	–Total - 4 Quarters	–Total - 8 Quarters
Net from Operations	($11,070,002)	($5,730,453)	($16,800,455)
Pre-tax Net Income	($10,602,692)	($3,848,510)	($14,451,202)

Source: HCAI Hospital Quarterly Data, 2020 and 2021.

Summary and Conclusions – Importance of Madera Community Hospital to the Community

As shown above, Madera County residents are highly dependent on Madera Community Hospital for access to needed health care services. This includes not only hospital-based services but other non-hospital-based outpatient services owned and operated by Madera Community Hospital. Madera County residents also rely on and benefit from the availability of other health care services provided by non-Madera Community Hospital providers that are located in Madera County. As the research literature documents, the presence of general acute care hospitals, such as Madera Community Hospital, is valuable in attracting other health care providers to a remote geographic area and the closure of such "anchor" hospitals is often followed by a long-term decline of the availability of a wide range of health services to local residents.

It is anticipated that following completion of the transaction, Madera Community Hospital will continue to operate with no change in the status of the hospital or its license as a general acute care hospital. It is further anticipated that the hospital will continue its license for both inpatient and emergency services and that the hospital will maintain its existing services following completion of the transaction. The hospital will operate as a general acute care hospital maintaining each of the following with generally the same types and levels of services as currently provided as reported in the hospital's most recent filing of their Annual Disclosure Report HCAI.

This report includes a series of recommended conditions to assure that Madera Community Hospital can and does, should the transaction be approved, continue to maintain its commitment and capacity to provide needed services to Madera County residents while at the same time accounting for and limiting the negative effects on competition that would occur, should the transaction be approved.

Competitive Impact Effects and Factors

It is essential to consider the potential anti-competitive effects of the acquisition of Madera Community Hospital by St. Agnes Medical Center (and the Trinity Health System).

While the access and availability benefits of the proposed transaction appear to be quite positive and valuable, it is, however, important to consider the potential effects of the transaction on the competitive structure of the hospital market and how changes in the structure of the market could affect competition and competitive dynamics including hospital prices, contracting practices by the parties to the transaction and possible broader effects on

the health care market as a result of increased consolidation, should the transaction be approved.[40]

Alternatively, should the proposed transaction be denied, a related question concerns the alternatives that may be available for assuring continued operation of and availability of services at Madera Community Hospital given its importance to the community and its declining financial condition.

For example, Madera Community Hospital might seek other alternative hospitals or health systems that might consider partnering with Madera Community Hospital to stabilize the Hospital's financial status. This report does not address these alternative scenarios as doing so would require detailed information and analyses of specific alternatives and their likely feasibility and effects.

Alternatively, should the transaction not be approved, Madera Community Hospital could be in a position where it is either forced to cease operations or request further consideration from regulators that in the absence of approval of this transaction the hospital would be forced to close down its operations. This is generally referred to as a "failing-firm" situation under federal antitrust law. This report does not address the legal question of whether a "failing-firm" approach should be applied here.

Geographic and Product Overlap between Madera Community Hospital and St. Agnes Medical Center

Both hospitals are licensed as general acute care hospitals with a range of inpatient and outpatient services. As can be seen in the Table below, St. Agnes Medical Center is larger, has a higher patient volume, and operates at a higher occupancy rate. Also, though not shown here, data reported by St. Agnes Medical Center to HCAI show that St. Agnes has a much wider range of available services than Madera Community Hospital.

Madera Community Hospital and St. Agnes Medical Center: Bed Capacity and Utilization, 2020

Data by Type of Care	St. Agnes	Madera
Licensed Beds	436	106
Licensed Bed Occ. Rate	61.19%	34.06%

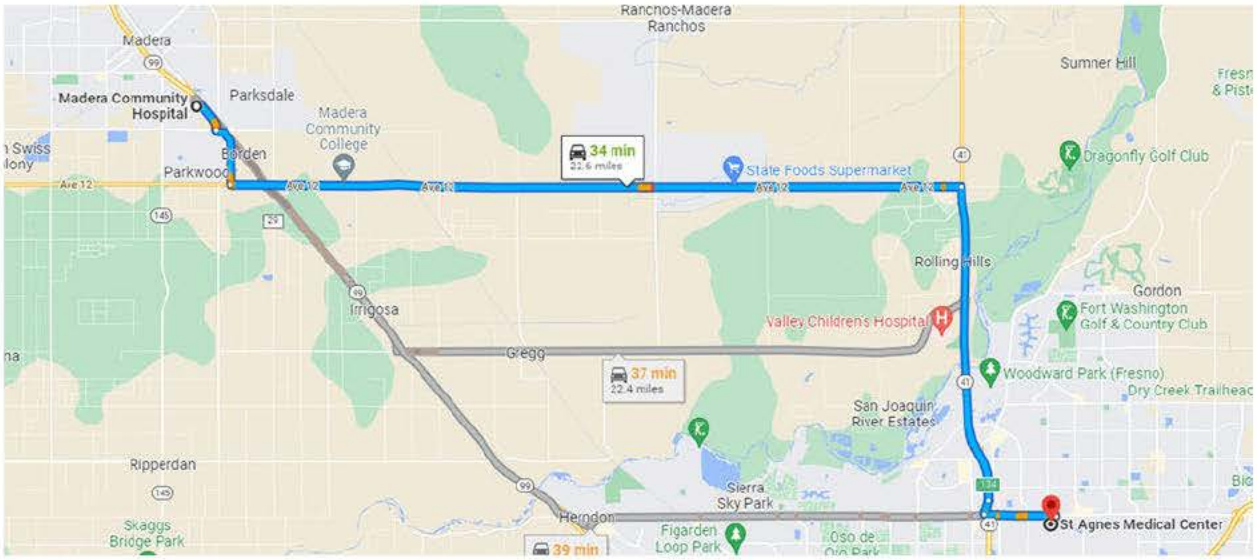
[40] The benefits of the transaction referenced here are related to maintaining access and availability of services to the community and are not due to any specific economic efficiencies that may occur as a result of the transaction.

Patient Days (excl. nursery)	97,650	13,214
Discharges (excl. nursery)	22,243	3,251
Average Length of Stay (est.)	4.39	4.06

Source: HCAI PIVOT Data, 2020.

Madera Community Hospital is located in Madera County and St. Agnes Medical Center is located in neighboring Fresno County. According to Google Maps, the driving distance from one facility to the other is approximately 22+ miles and the driving time is approximately 30-40 minutes.

Locations of Madera Community Hospital and St. Agnes Medical Center



Geographic Overlap of Madera Community Hospital and St. Agnes Medical Center Service Areas

As a result of their geographic proximity, there is substantial geographic overlap of the service areas of the two hospitals. As can be seen in the two Tables below, Madera Community Hospital ranks #1 in the number of Madera County patients served for both ED and Inpatient Care in 2020 and St. Agnes Medical Center ranks #2 in serving Madera County residents.

As a result, St. Agnes is the most direct general acute care hospital competitor to Madera Community Hospital in terms of overlapping geographic market.

The third Table below shows the overlap between the two hospitals at a more disaggregated (zip code) level. As can be seen, there is substantial overlap between the two hospitals for the 15 highest volume zip codes for Madera Community Hospital.

Rank	Hospital	ED Patients from Madera County, 2020
1	MADERA COMMUNITY HOSPITAL	22,445
2	ST. AGNES MEDICAL CENTER	4,057
3	CLOVIS COMMUNITY MEDICAL CENTER	1,729
4	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	1,694
5	MERCY MEDICAL CENTER - MERCED	1,004

Source: Source: HCAI Hospital Market Share Report, 2020. Excludes Children's and Kaiser Hospitals.

Rank	Hospital	All Patients (ED + Inpatients) From Madera County, 2020
1	MADERA COMMUNITY HOSPITAL	26,026
2	ST. AGNES MEDICAL CENTER	7,123
3	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	3,607
4	CLOVIS COMMUNITY MEDICAL CENTER	2,737
5	MERCY MEDICAL CENTER - MERCED	1,432

Source: Source: HCAI Hospital Market Share Report, 2020. Note: Table excludes children's hospitals and Kaiser hospitals that provide ED services to Madera County residents. These hospitals are excluded for competitive analysis because they are not considered substitutes by health plans for Madera Community Hospital as part of negotiations with commercial health plans for contracting purposes. This was confirmed during interviews with health plans.

Madera Community Hospital Service Area

The data in the Table below shows the Service Area for Madera Community Hospital at the zip code level. As can be seen, Madera Community Hospital's service area is highly concentrated. More than 90 percent of Madera Community Hospital patients reside in one of the 15 zip codes in Madera County (listed in this Table). Further, the top five zip codes within Madera County account for 85 percent of all of the patients served by Madera Community Hospital.

#	Zip Code	Total Patients from Zip Code to Madera Community Hospital	% Total Madera Community Hospital Patients	Cumulative % Madera Community Hospital Patients
1	93638	13,562	42%	42%
2	93637	8,776	27%	69%
3	93610	3,644	11%	80%
4	93622	794	2%	83%
5	93630	734	2%	85%
6	93640	714	2%	87%
7	93636	644	2%	89%
8	93722	393	1%	90%
9	93614	192	1%	91%
10	93705	164	1%	91%
11	93706	158	0%	92%
12	93644	136	0%	92%
13	93702	117	0%	93%
14	93727	102	0%	93%
15	93660	101	0%	93%

Geographic Overlap of Madera Community Hospital and St. Agnes Medical Center

The Table below shows the number of patients from each of the 15 zip codes in Madera County that utilize either Madera Community Hospital or St. Agnes Medical Center. As can be seen, the overlap is quite substantial. St. Agnes Medical Center draws patients from all of the zip codes in Madera County and draws significant numbers of patients from the top zip codes in the Madera Community Hospital Service Area.

#	Zip Code	Total Patients from Zip Code Going to Madera Community Hospital	Total Patients from Zip Code Going to St. Agnes Medical Center
1	93638	13,562	2,500
2	93637	8,776	2,139
3	93610	3,644	747
4	93622	794	517
5	93630	734	1,309
6	93640	714	530
7	93636	644	1,047
8	93722	393	9,563
9	93614	192	968
10	93705	164	5,533
11	93706	158	3,705
12	93644	136	723
13	93702	117	4,584
14	93727	102	5,438
15	93660	101	277

Source: HCAI Patient Origin Data, 2020. Note: Includes top 15 highest volume zip codes for Madera Community Hospital for all patient services.

Service Overlap between Madera Community Hospital and St. Agnes Medical Center

An important aspect of competitive structure of hospital markets relates to the product market and service mix available at different hospitals. To the extent that two hospitals are located near each other but do not offer overlapping services, they are less likely to be direct or meaningful competitors. The Tables below summarize basic data on the capacity and services at both hospitals. As can be seen, both hospitals have medical/surgical beds, perinatal beds, and intensive care beds. Similarly, both hospitals offer obstetric services, emergency care, and have surgical (OR) capacity.

Madera Community Hospital	Beds	Licensed Bed Days	Discharges	Patient Days
Medical / Surgical (include GYN)	73	26,645	2,738	16,123
Perinatal (exclude Newborn / GYN)	23	8,395	1,132	1,132
Intensive Care	10	3,650	413	3,158
Sub–total - GAC	106	38,690	4,289	20,420
St. Agnes Medical Center	**Beds**	**Licensed Bed Days**	**Discharges**	**Patient Days**
Medical / Surgical (include GYN)	343	125,195	17,079	87,312
Perinatal (exclude Newborn / GYN)	32	11,680	3,973	9,071
Intensive Care	35	12,775	403	7,121
Coronary Care	26	9,490	414	5,393
Subtotal - GAC	436	159,140	21,869	108,897

Source: HCAI Annual Utilization Report, 2021.

Services	Madera Community Hospital	St. Agnes Medical Center
Obstetrics		
Total Live Births (counts multiple births separately)*	694	4,000
Live Births with Birth Weight Less Than 2500 grams (5 lbs 8 oz)	48	350
Live Births with Birth Weight Less Than 1500 grams (3 lbs 5 oz)	10	80
ED Stations	16	48
Operating Room Minutes		
Inpatient	98,130	515,397
Outpatient	148,942	559,604
Operating–Room - Surgeries		
Inpatient	1,170	3,866
Outpatient	2,359	7,673

Source: HCAI Annual Utilization Report, 2021.

The Table below summarizes the service overlap between Madera Community Hospital and St. Agnes Medical Center based on their Top 25 DRGs (highest volume) in 2020. They share 17 DRGs among their top 25 high volume DRGs, representing greater than 80 percent overlap.

#	MS-DRG Code	MS-DRG Description	Number of Discharges - Madera	Number of Discharges - St. Agnes
1	795	NORMAL NEWBORN	653	2,504
2	807	VAGINAL DELIVERY W/O STERILIZATION/D&C W/O CC/MCC	440	2,184
3	871	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W	252	759
4	177	RESPIRATORY INFECTIONS & INFLAMMATIONS W MCC	152	516
5	788	CESAREAN SECTION W/O STERILIZATION W/O CC/MCC	120	955
6	291	HEART FAILURE & SHOCK W MCC	119	734
7	794	NEONATE W OTHER SIGNIFICANT PROBLEMS	91	748
8	872	SEPTICEMIA OR SEVERE SEPSIS W/O MV >96 HOURS W/O MCC	74	288
9	789	NEONATES, DIED OR TRANSFERRED TO ANOTHER ACUTE CARE FACILITY	53	379
10	683	RENAL FAILURE W CC	50	224
11	190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	44	330
12	641	MISC DISORDERS OF NUTRITION, METABOLISM, FLUIDS/ELECTROLYTES W/O MCC	42	271
13	853	INFECTIOUS & PARASITIC DISEASES W O.R. PROCEDURE W MCC	40	172
14	193	SIMPLE PNEUMONIA & PLEURISY W MCC	39	310
15	065	INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC OR TPA IN 24 HRS	36	179
16	470	MAJOR HIP AND KNEE JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	36	361
17	392	ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	35	323
		Total - Top 25	**2,623**	**13,173**
		Total in Overlapping DRGs	**2,276**	**11,237**
		Percent of Total Top 25 in Overlapping DRGs	**87%**	**85%**

Source: HCAI Hospital Top 25 DRG Report, 2020.

Payor Overlap between Madera Community Hospital and St. Agnes Medical Center

Another important aspect of the competitive structure of hospital markets concerns the different payor or health plans in the market and whether a particular provider serves patients covered by different payors. To the extent that providers do not overlap in serving similar payors, they may be less likely to substitute for one another and therefore the potential competitive effect may be reduced. The Table below shows that there is substantial overlap between Madera Community Hospital and St. Agnes Medical Center in terms of their patients and the different payors in the local market. This overlap increases the potential for anti-competitive effects of the proposed transaction.

Madera Community Hospital and St. Agnes Medical Center Payor-Mix:

ED Utilization, 2021

Payor	St. Agnes – Number of ED Patients	Madera – Number of ED Patients
Medicaid (Medi-Cal)	31,328	16,520
Medicare Part B	7,818	4,537
Preferred Provider Organization (PPO)	646	2,528
Self Pay	2,508	2,083
Workers' Compensation Health Claim	855	448
Blue Cross/Blue Shield	7,236	365
Health Maintenance Organization	142	364
CHAMPUS (TRICARE)	215	77
Other federal program	93	14

Source: HCAI Annual Utilization Report (ED), 2021.

A more detailed listing of the different health plans and the different health plan products that each hospital contracts for is provided in the Tables below. As can be seen there is substantial overlap between the two hospitals at this level as well. This indicates that the two hospitals likely participate in the same market with regard to different health plans and specific/different health plan products. This overlap raises the risk of reduced competition following the transaction and increases the risk of anti-competitive effects.

Commercial Health Plans Listed on Hospital's Websites

Health Plans Listed on Madera Community Hospital Website
AETNA HEALTH
AETNA MEDICARE
BLUE CROSS
BLUE CROSS MEDI-CAL
BLUE CROSS MEDICARE
BLUESHIELD HMO/POS
BLUESHIELD PPO
CIGNA
HEALTH NET
HEALTH NET MEDI-CAL
HEALTH NET MEDICARE
UNITED HEALTH CARE
UNITED HEALTH CARE MEDICARE

Source: www.maderahospital.org/patients-visitors/price-transparency/.

Health Plans Listed on St. Agnes Website
Aetna
Beech Street
Blue Cross
Blue Shield
CIGNA (PPO and Open Access Plus)
Coventry Health Care / First Health
Great West Health care
Health Net
Health Smart
Lyons Magnus
Multi-Plan
Networks by Design
Private Health care Systems
United Health care

Source www.samc.com/for-patients/billing-and-financial-information/health-plans.

Calculation of HHI Concentration Measure, Pre and Post Transaction

Definition and Calculation of HHI Concentration Index[41]

The term "HHI" means the Herfindahl–Hirschman Index, a commonly accepted measure of market concentration. The HHI takes into account both the number and the relative size distribution of the firms in a market. It approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 points when a market is controlled by a single firm. The HHI increases both as the number of firms in the market decreases and as the disparity in size between those firms increases.

The HHI is calculated by first calculating the market share of each hospital in the relevant geographic market and then squaring the market share of each hospital and then summing the resulting numbers. For example, for a market consisting of four firms with shares of 30, 30, 20, and 20 percent, the HHI is 2,600 (302 + 302 + 202 + 202 = 2,600).

As a framework, federal government antitrust agencies in the past have generally considered markets in which the HHI is between 1,500 and 2,500 points to be moderately concentrated and consider markets in which the HHI is in excess of 2,500 points to be highly concentrated (see U.S. Department of Justice & FTC, Horizontal Merger Guidelines § 5.3 (2010)). Transactions that increase the HHI by more than 200 points in highly concentrated markets are presumed likely to enhance market power under the Horizontal Merger Guidelines issued by the Department of Justice and the Federal Trade Commission.[42] The literature reports that prices tend to be higher in more concentrated markets, all other factors being equal. Transactions that occur in already concentrated markets and that increase concentration further have been found to result in greater price increases, due to the increased market power of the remaining participants in the market.

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[41]Excludes specialty hospitals (children's hospitals, surgical hospitals, rehabilitation hospitals) and Kaiser hospitals. These hospitals are excluded for competitive analysis because they are not considered substitutes by health plans for Madera Community Hospital as part of negotiations with commercial health plans for contracting purposes. This was confirmed during interviews with health plans.

[42]The Federal Horizontal Merger Guidelines are presented here to provide a framework for understanding calculation and use of HHIs in measuring concentration. My analyses and conclusions do not rely on the specific thresholds outlined in the guidelines but rather depend on my prior experience and review of the literature. It is also expected that the guidelines will be updated in the near future. At the same time, the guidelines do provide a source of confirmation for this matter that both the pre-transaction and post-transaction HHI values are high (highly concentrated) and that the transaction raises the HHI value for the relevant market quite substantially.

The Tables below summarize two sets of HHI calculations pre and post transaction using different samples of Madera County patients: 1) All patients (including inpatient discharges + ED visits) at each hospital and 2) inpatient discharges only.

The first set of Tables below shows the calculations for All Patients. As can be seen, and consistent with previous Tables:

- Madera Community Hospital is the largest provider of hospital services to Madera County patients at 26,026 in 2020.
- St. Agnes is the next largest hospital provider to Madera County patients, serving 7,123 patients in 2020.

The next largest provider is the combined entity of Community Regional Medical Center and Clovis Community Medical Center, serving 6,344 patients in 2020. As can be seen, the transaction would result in the two highest market share hospitals consolidating, resulting in an increase in the market share for the combined entities and an increase in the concentration of the market.

The calculated HHI values and change in HHI, pre and post transaction, are as follows:

HHI Pre-Post-Change (All Patients)	HHI Value
HHI- Pre-Transaction:	4,378
HHI- Post-Transaction:	6,484
Change in HHI Value– Pre - Post Transaction:	2,106

Calculation of HHI, Pre-Post: All Patients

Facility County	Hospital	Total Patients (IP + ED) from Madera County	Total Patients - Adjusted for Common Ownership	Market Share	Market Share
		PRE	PRE	PRE	POST
Madera	MADERA COMMUNITY HOSPITAL	26,026	26,026	62%	
Fresno	ST. AGNES MEDICAL CENTER	7,123	7,123	17%	
	MADERA COMMUNITY HOSPITAL + ST. AGNES MEDICAL CENTER				79%
Fresno	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	3,607			

Fresno	CLOVIS COMMUNITY MEDICAL CENTER	2,737			
	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO + CLOVIS COMMUNITY MEDICAL CENTER		6,344	15%	15%
Merced	MERCY MEDICAL CENTER - MERCED	1,432	1,432	3%	3%
Mariposa	JOHN C FREMONT HEALTH CARE DISTRICT	558	558	1%	1%
Kings	ADVENTIST HEALTH HANFORD	120	120	0%	0%
Stanislaus	DOCTORS MEDICAL CENTER	108	108	0%	0%
Stanislaus	MEMORIAL MEDICAL CENTER - MODESTO	89	89	0%	0%
Merced	MEMORIAL HOSPITAL LOS BANOS	79	79	0%	0%
Stanislaus	EMANUEL MEDICAL CENTER	79	79	0%	0%
TOTAL		***41,958***	***41,958***	***100%***	***100%***

Source: HCAI Hospital Patient Origin Data, 2020. Some numbers may not total due to rounding.

Notes:

1) Excludes alternative hospital settings and models of care (children's hospitals, surgical clinics, rehabilitation hospitals) and Kaiser hospitals. Kaiser hospitals are excluded for competitive analysis because they are not considered substitutes by health plans for Madera Community Hospital as part of negotiations with commercial health plans for contracting purposes.

2) Includes all hospitals located in Madera County and neighboring counties (Fresno, Merced, Mariposa, Stanislaus and Kings counties) that treated at least 50 patients during the year. This includes hospitals that are well beyond Madera's service area and market. The non-Madera County, non-Fresno County hospitals, are included to provide a broad picture of Madera's market and a very conservative test of the effects of the transaction on market concentration for Madera Community Hospital.

Facility County	Hospital	Market Share	Market Share - Squared	Market Share - Squared, Cum	Market Share	Market Share - Squared	Market Share - Squared, Cum
		PRE	PRE	PRE	POST	POST	POST
Madera	MADERA COMMUNITY HOSPITAL	62%	38%	38%			
Fresno	ST. AGNES MEDICAL CENTER	17%	3%	41%			
	MADERA COMMUNITY HOSPITAL + ST. AGNES MEDICAL CENTER				79%	62%	62%
Fresno	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO						
Fresno	CLOVIS COMMUNITY MEDICAL CENTER						
	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO + CLOVIS COMMUNITY MEDICAL CENTER	15%	2%	44%	15%	2%	65%
Merced	MERCY MEDICAL CENTER - MERCED	3%	0%	44%	3%	0%	65%
Mariposa	JOHN C FREMONT HEALTH CARE DISTRICT	1%	0%	44%	1%	0%	65%
Kings	ADVENTIST HEALTH HANFORD	0%	0%	44%	0%	0%	65%
Stanislaus	DOCTORS MEDICAL CENTER	0%	0%	44%	0%	0%	65%
Stanislaus	MEMORIAL MEDICAL CENTER - MODESTO	0%	0%	44%	0%	0%	65%
Merced	MEMORIAL HOSPITAL LOS BANOS	0%	0%	44%	0%	0%	65%
Stanislaus	EMANUEL MEDICAL CENTER	0%	0%	44%	0%	0%	65%
TOTAL		100%	44%	44%	100%	65%	65%

Notes:

1) Some numbers may not total due to rounding.

2) Excludes specialty hospitals (children's hospitals, surgical hospitals, rehabilitation hospitals) and Kaiser hospitals. These hospitals are excluded for competitive analysis because they are not considered substitutes by health plans for Madera Community Hospital as part of negotiations with commercial health plans for contracting purposes.

3) Includes all hospitals located in Madera County and neighboring counties (Fresno, Merced, Mariposa, Stanislaus and Kings counties) that treated at least 50 patients during the year. This includes hospitals that are well beyond Madera's service area and market. The non-Madera County, non-Fresno County hospitals, are included to provide a broad picture of Madera's market and a very conservative test of the effects of the transaction on market concentration for Madera Community Hospital.

The set of Tables below shows the calculations for inpatients. As can be seen, and consistent with previous Tables, Madera Community Hospital is the largest provider of hospital services to Madera County patients at 3,581 in 2020. St. Agnes is the next largest hospital provider to Madera County patients, serving 3,066 patients in 2020. The next largest provider is the combined entity of Community Regional Medical Center and Clovis Community Medical Center, serving 2,921 patients in 2020. As can be seen, the transaction would result in the two highest market share hospitals consolidating, resulting in an increase in the market share for the combined entities and an increase in the concentration of the market. The calculated HHI values and change in HHI, pre and post are as follows:

Summary Change in HHI (All Patients), Pre – Post Transaction

HHI Pre-Post-Change - Inpatients	HHI Value
HHI- Pre-Transaction:	4,378
HHI- Post-Transaction:	6,484
Change in HHI Value– Pre - Post Transaction:	2,106

Calculation of HHI, Pre-Post: Inpatients

Facility County	Hospital	Total Patients (IP + ED) from Madera County	Adjusted for Common Ownership	Market Share	Market –hare - Squared	Adjusted for Common Ownership	Market Share	Market –hare - Squared
		PRE	PRE	PRE	PRE	POST	POST	POST
Madera	MADERA COMMUNITY HOSPITAL	3,581	3,581	35%	12%			
Fresno	ST. AGNES MEDICAL CENTER	3,066	3,066	30%	9%			
	MADERA COMMUNITY HOSPITAL + ST. AGNES MEDICAL CENTER					6,647	65%	42%
Fresno	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO	1,913						
Fresno	CLOVIS COMMUNITY MEDICAL CENTER	1,008						
	COMMUNITY REGIONAL MEDICAL CENTER-FRESNO + CLOVIS COMMUNITY MEDICAL CENTER		2,921	29%	8%	2,921	29%	8%
Merced	MERCY MEDICAL - MERCED	428	428	4%	0%	428	4%	0%
Mariposa	JOHN C FREMONT HEALTH CARE DISTRICT	54	54	1%	0%	54	1%	0%
Kings	ADVENTIST HEALTH HANFORD	25	25	0%	0%	25	0%	0%

Stanislaus	DOCTORS MEDICAL CENTER	60	60	1%	0%	60	1%	0%
Stanislaus	MEMORIAL MEDICAL - MODESTO	45	45	0%	0%	45	0%	0%
Merced	MEMORIAL HOSPITAL LOS BANOS	13	13	0%	0%	13	0%	0%
Stanislaus	EMANUEL MEDICAL CENTER	31	31	0%	0%	31	0%	0%
TOTAL		***10,224***	***10,224***	**100%**	**30%**	**10,224**	**100%**	**51%**

Notes:

1) Excludes alternative hospital settings and models of care (children's hospitals, surgical clinics, rehabilitation hospitals) and Kaiser hospitals. These hospitals are excluded for competitive analysis because they are not considered substitutes by health plans for Madera Community Hospital as part of negotiations with commercial health plans for contracting purposes.

2) Includes all hospitals located in Madera County and neighboring counties (Fresno, Merced, Mariposa, Stanislaus and Kings counties) that treated at least 50 patients during the year. This includes hospitals that are well beyond Madera's service area and market. The non-Madera County, non-Fresno County, hospitals are included to provide a broad picture of Madera's market and a conservative test of the effects of the transaction on market concentration for Madera Community Hospital.

Summary Change in HHI (Inpatients), Pre – Post Transaction

HHI Pre-Post-C–ange - Inpatients	HHI Value
HHI- Pre-Transaction:	2,961
HHI- Post-Transaction:	5,062
Change in HHI Value– Pre - Post Transaction:	2,101

Summary and Conclusions – Impact of Transaction on Market Concentration and the Need for Protection from Increased Concentration from Transaction

Increased Concentration Following Transaction

As shown in the Tables above, Madera Community Hospital is the largest provider of hospital services to Madera County and St. Agnes is the next largest hospital provider to Madera County patients. Both hospitals have significant market shares prior to the transaction. The transaction would consolidate and merge the two highest market share hospitals, resulting in an increase in the market share for the combined entities and a substantial increase in the concentration of the market. This finding is consistent for both samples (inpatient only, all patients).

The Federal Anti-Trust Guidelines, provided as a framework for interpreting an HHI analysis, are summarized in the Table below. These guidelines illustrate and provide some perspective on the potential competitive effects of the transaction. My opinion does not rely on these guidelines but rather is based on my experience and the extensive economic empirical literature documenting the relationship between hospital market concentration and hospital prices. This literature includes both cross-sectional studies as well as time-series studies including studies before and after mergers that result in increased concentration.

Federal Anti-Trust Guidelines[43]

Federal Anti-Trust Thresholds	Guidelines
HHI: 1,500 to 2,500	Moderately Concentrated
HHI: Above 2,500	Highly Concentrated
Change in HHI Value: 200 or above	Likely to Enhance Market Power

According to the federal framework, the HHI values pre transaction are in the highest category (above 2500) and are considered to be highly concentrated. The change in HHIs, when comparing pre values to and post transaction values, would increase substantially. This is not surprising, given that the two largest providers in the market would be consolidating into a single entity. The change in HHI values for both HHI calculations is well above the 200 point

[43] Please see footnote above regarding application of Federal Merger Guidelines for this matter.

threshold (both 2100+ increases), indicating that the transaction is likely to enhance market power.

While the Federal Merger Guidelines are useful for context, my analysis does not rely on them directly. Rather, my prior work in this area as well as the extensive published literature provide a firm basis for concluding that the proposed transaction would lead to a substantial increase in concentration of an already concentrated market and, if approved, would create anticompetitive conditions that would support above market price increases, post-transaction.[44]

As discussed above, there is extensive scientific empirical literature on the price increasing effects of hospital mergers. Studies in this literature consistently show that when hospital consolidation is between close competitors (as is the case in this proposed transaction) it raises prices, and by substantial amounts. Consolidated hospitals that are able to charge higher prices due to reduced competition are able to do so on an ongoing basis, making this a permanent rather than a transitory problem.[45] That is, the excess price differential due to reduced competition and the ability of the merged hospitals to negotiate supra-competitive prices is not just for one year, but continues over time, unless the competitive dynamics change and market power is negated. Also, as noted above, there is extensive literature that shows that with regard to market power and pricing,[46] there is no difference between not-for-profit and for-profit hospitals in the extent to which they raise prices due to increased market power.

The Need for Protection from Anti-Competitive Effects from Increased Concentration from Transaction

As documented in this report, Madera Community Hospital is the only licensed general acute care hospital serving both adult and pediatric patients in Madera County which covers over 2,000 square miles and is home to 150,000 people. Madera Community Hospital provides essential hospital services, is the most important provider of hospital services to Madera County residents, and is the anchor to the broader health delivery system in Madera County, including outpatient care and other non-hospital-based health care services.

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[44]www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf.

[45]https://www.judiciary.senate.gov/imo/media/doc/Gaynor_Senate_Judiciary_Hospital_Consolidation_May_19_2021.pdf

[46]Melnick, G., et al. "Market Power and Hospital Pricing: Are Nonprofits Different? New evidence suggests that in a consolidated market, market share may be what drives hospitals' pricing behavior." *Health Affairs* 18.3 (1999): 167-173; Capps, C., et al. "Antitrust treatment of nonprofits: Should hospitals receive special care?" *Economic Inquiry* 58.3 (2020): 1183-1199.; Gudikson, K., et al. "Markets or Monopolies? Considerations for Addressing Health Care Consolidation in California." (2021).

Madera Community Hospital's financial data paint a mixed but troubling picture. Historically, the hospital has generally been able to generate sufficient revenue to cover its costs each year. However, it appears that not unlike many other small rural hospitals serving low income and disadvantaged populations, the COVID-19 pandemic has negatively affected the financial status of Madera Community Hospital and possibly threatens the long-term survival and sustainability of the hospital. Recent filings by Madera Community Hospital with HCAI show substantial losses for several quarters in a row in the last several years. While it not possible to be certain or to predict the future, it appears that COVID-19 driven factors have negatively impacted the hospital's underlying cost structure and operating costs. Should these trends continue, the long-term sustainability of the Hospital would continue to be at significant risk.

The proposed transaction would combine two hospitals of different sizes and differing financial situations. One goal of the transaction would be to allow Madera Community Hospital to join with St. Agnes to ensure the on-going financial sustainability of Madera Community Hospital and, in so doing, continue to provide needed services to Madera County residents. At the same time, the proposed transaction between the two highest market share hospitals serving Madera County substantially raises the likelihood for negative effects of enhanced market power by the two Hospitals. As such, it is necessary to consider the threats to competition that would result from the transaction and to develop conditions that would limit the negative effects of the transaction while allowing the positive benefits to be generated.

Recommended Conditions and Adjustments to Conditions Related to Competitive Impacts for Transaction Approval by the California Attorney General

If the California Attorney General approves the proposed transaction, it is recommended that the Attorney General impose conditions to limit the anti-competitive effects and in so doing minimize the negative and/or adverse health care impacts that might result from the transaction while at the same time allowing for a transaction that will help to sustain the long-term operation of Madera Community Hospital.

This section of the Report summarizes conclusions related to the competitive impact of the proposed transactions as well as presenting two sets of recommendations related to the proposed conditions regarding the competitive impacts for the transaction. Included is an initial set of recommended conditions for approval of the transaction. In addition, following further recent issues raised by the parties to the transaction[47] and further analysis on rural hospitals, Madera's financial condition, and Madera's contracting cycle with payors, a second set of proposed adjustments to the initial set of recommended conditions are included.

[47] Letter from [redacted] and [redacted] to Emilio Varanini (June 8, 2022).

Competitive Impact Conclusion and Conditions

Overall, we conclude that the risk to horizontal competition created by the proposed transaction is likely to be negative and substantial. The conditions we recommend that the OCAG attach to approval of the transaction are constructed to reduce the risk of anticompetitive effects arising from the transaction.[48] The proposed conditions are written broadly and allow for the details of how the conditions would be implemented and enforced which are to be determined by the OCAG.

The conditions are intended to prevent the merged parties from leveraging their increased market power following the transaction to obtain above competitive market price terms from health plans in their negotiated contracts with Madera Community Hospital. One set of conditions relates to the increased market power in contract negotiations by tying the merged entities together for contracting purposes. By preventing the tying of the two merging hospitals together in their contract negotiations, the threat of excluding both hospitals from health plan networks is reduced and the ability of the hospitals to leverage their increased market power to obtain above competitive market prices from the transaction is reduced.

While this condition may help to reduce the potential for above competitive market prices following the transaction, a second set of conditions is recommended to ensure that prices are not increased above competitive market levels following the transaction. The second set of conditions applies specific limits to price increases following the transaction for different payors.

Initial Recommended Conditions[49]

Limit Post-Transaction Anti-Competitive Contract Negotiating Behavior and Price Increases to Limit Negative Effects of Increased Concentration

Per data and analyses presented above, approval of the transaction would result in a substantial increase in market concentration and reduced competition and enhance market power for the merging hospitals in their negotiations with health plans. At the same time, analysis of the Madera Community Hospital data and findings from the in-person interviews indicated approval of the transaction would be beneficial to the community if appropriate limits on anti-competitive behavior were included in approving the transaction. Detailed analysis of Madera Community Hospital financial data, commercial contracts, and other data sources combined with findings from in-person interviews with health plans allows for the construction

[48]These proposed conditions align with conditions in previously approved transactions by the OCAG: https://oag.ca.gov/system/files/media/nhft-huntington-ag-decision-071921.pdf; USC Health System, Methodist Hospital of Southern California.

[49]The proposed conditions are written broadly and allow for the details of how the conditions would be implemented and enforced to be determined by the OCAG.

of conditions and empirical thresholds that permit controlled price increases (post-transaction) as part of future contract negotiations with health plans. These conditions allow for normal market-based negotiations while at the same time protecting consumers from excessive price increases that might arise either due to Madera's own use of its market power or due to the increased market power of the combined hospitals, post-transaction—should it be approved.

Following approval of the transaction, St. Agnes Medical Center and/or the Trinity System and or Madera Community Hospital shall:

Limit Anti-Competitive Contract Negotiating Behavior

1. Not condition the participation of one of its controlled hospitals on the participation of any of its other controlled hospitals in contracts with payers. This includes:

    a. Engaging a payer in "all-or-nothing" contracting whereby it explicitly or implicitly requires the payer to contract with all controlled hospitals.

    b. Penalizing a payor for contracting with individual controlled hospitals, including setting significantly higher than existing contract prices or out-of-network fees for any or all controlled hospitals.

    c. Interfering with the introduction or promotion of new narrow, tiered, steering, or value-based benefit designs for commercial or government-sponsored products.

Limit Post-Transaction Price Increases to Limit Negative Effects of Increased Concentration

2. Limit price increases in renewed contracts with Medi-Cal managed care plans to no more than 110 percent of prevailing Medi-Cal FFS prices for similar patients.

3. Limit price increases in renewed contracts with Medicare managed care plans to no more than 110 percent of prevailing Medicare FFS prices for similar patients.

Limit Prices for Out-of-Network Emergency Services

4. In the event that Madera Community Hospital cannot reach agreement with a commercial health plan and becomes out-of-network with respect to any of the health plan's products, Madera Community Hospital will limit prices for out of network emergency services rendered to patients covered by this plan/product to no more than 150 percent of the prevailing Medicare FFS prices for similar patients.

Adjustment of Recommended Conditions

The proposed adjusted conditions for approval of the transaction, recognizing the issues raised by the parties[50] and involving further consideration of rural hospitals, Madera's financial condition, and Madera's contracting cycles, are structured recognizing that:

- Madera Community Hospital is an essential provider of hospital services to Madera County residents.

- Madera Community Hospital is operating at financial loss for several major segments of its patient population resulting in substantial and on-going financial deficits.

- Continuing disruptions from COVID-19 in health care labor markets, especially in rural areas such as Madera County, resulting on-going staffing challenges and rising input costs

- The proposed transaction will result in increased market consolidation.

- And as a result of the transaction and affiliation with St. Agnes Medical Center and Trinity Health system, Madera Community Hospital will be in a better position to negotiate more favorable rates with payors for selected products in order to stabilize their financial position

Under the proposed transaction, St. Agnes Medical Center and Trinity Health system will gain control of all operational processes and decisions including contracting with third party payors. Research has shown small and/or rural hospital's prices rise following affiliation and/or mergers with larger hospitals and health systems. This research supports the finding that smaller, rural hospitals can benefit from the third party contracting and negotiating expertise and experience of larger hospitals and/or systems to achieve prices that are higher and closer to market prices without necessarily needing to rely on the increased combined market power from the transaction.

The proposed transaction and proposed conditions allow for this possibility. At the same time, the proposed conditions recognize the proposed transaction generates significant competitive and market power concerns as the two merging hospitals are direct competitors. As a result, the proposed conditions are designed to limit the ability of the merging hospitals to exploit their increased market power, mainly by limiting various forms of anti-competitive negotiating behavior, while at the same time allowing for price adjustments, post transaction. The question is what happens if Madera Community Hospital cannot achieve higher prices on its own, post-transaction in negotiations with payors.

[50] Letter from [redacted] and [redacted] to Emilio Varanini (June 8, 2022).

Threshold for Adjustment of Contract Negotiating Behavior Conditions

The two hospitals operate in a dynamic environment with changing market conditions and changing responses to market changes by market participants. In addition, the proposed transaction will take place in a dynamic market where the ability to predict final outcomes of the transaction (with small margins of error) is limited.

One possibility is that post-transaction, Madera Community Hospital will not be able to negotiate price increases with third party payors that will allow the hospital to maintain a stable financial position. This would increase the risk that Madera Community Hospital could be lost to the community.

Should Madera Community Hospital, post-transaction, continue to sustain financial losses over an extended period, it may be necessary to relax some of the limits on various forms of anti-competitive negotiating behavior in order for Madera Community Hospital to negotiate those higher prices necessary to sustain operation of the hospital.

Under this scenario, the Attorney General could consider monitoring the financial operation of Madera Community Hospital post transaction to allow for the possibility of removing the limits on various forms of anti-competitive negotiating behavior.

Specifically, Madera Community Hospital would report its financial performance at the end of each year, post transaction, which the Monitor would review and report on to the Attorney General.[51] If the financial condition of Madera Community Hospital did not improve and reach a break-even point[52] in the aggregate across all of its inpatient and outpatient services within a 3-year window from the close of the transaction, Madera Community Hospital would be

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[51]While the break-even point is defined below as being based on the HCAI reports to ensure an objective basis for its calculation, the Monitor could examine both HCAI reports and Madera Community's Hospitals required reports on its financial performance, as supplemented by any requests the Monitor may make of Madera Community Hospital or of St. Agnes/Trinity for additional information, to determine if in fact that point has been reached.

[52]Break-even is defined as the Total Margin as defined and calculated by HCAI Hospital Annual Pivot Reports where: Total Margin = Total Operating Revenue + (Non-Operating Revenue minus Non-Operating Expense) -Total Operating Expenses. The break-even point is the point at which there is "zero or positive shortfall" as defined and reported via HCAI Reports. Operating revenue, as calculated, will include supplemental payments such as Disproportionate Share Hospital (DSH) payments and Quality Assurance Fee (QAF) payments (See Disproportionate Share Hospital (ca.gov) and Hospital Quality Assurance Fee (ca.gov). These types of payments/revenues are included as they constitute ongoing sources of revenue or support rather than a one-time payment. However, one time, exceptional or special purpose payments, such as were paid during the COVID-19 pandemic, are not considered or counted as routine operating revenues when calculating Total Margin for the purpose outlined here.

allowed to undertake this previously prohibited contracting behavior.[53] Once Madera Community Hospital determines that it has not reached a break-even point at the end of the 3-year window, the Monitor would review that determination and issue a recommendation to the Attorney General as to whether Madera Community Hospital has or has not reached at least a break-even point. In determining whether Madera Community Hospital has reached that break-even point in the aggregate, the Monitor would review Madera Community Hospital's financial performance to ensure that Madera Community Hospital's cost structure did not appreciably change post transaction, except for needed capital and other improvements, and to ensure that any expenses allocated to Madera Community Hospital from St. Agnes Medical Center and/or Trinity System were appropriate and reasonable.[54]

If this threshold were met, such that Madera Community Hospital's financial condition did not achieve break-even status in the aggregate across all of its inpatient and outpatient services, then limits on anti-competitive negotiating behavior would be removed. However, recognizing that the use of market power can result in excessive price increases as detailed in the report, the prices caps would be kept in place and extended for 5-8 years.[55]

Adjustment of Price Caps

Upon the parties complaining that the price caps were not high enough, we compared further St. Agnes to Madera, also compared Madera to rural hospitals throughout the state, and examined updated information as to Madera's financial condition. The key takeaways, as set out in the next set of tables, are as follows:

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[53]The 3-year window allows for negotiation of new contracts for contracts of varying lengths and renegotiation/renewal dates given my review of Madera Community Hospital's contracting cycles.

[54]Limiting the criteria to what is appropriate and reasonable, without attempting to further define those criteria, provides the Monitor with flexibility on the consideration of the allocation of multistate system-wide expenses to Madera Community Hospital over what will be a 3-year window. The appropriateness and reasonableness of the allocation of those system-wide expenses will be highly dependent on the facts. For example, it may not be appropriate, or reasonable, to allocate expenses from the system's acquisition of a future indebted hospital located elsewhere in the county in whole or in part to Madera Community Hospital in calculating the break-even point.

[55]I have considered and rejected St. Agnes' suggestion that these conditions with respect to contracting behavior not be imposed unless or until Madera Community Hospital has reached a 3 percent margin. This suggestion is rejected based on at least three reasons: (1) Allowing Madera Community Hospital to use the enhanced market power from its combining with St. Agnes should be a last resort, not a first resort; (2) Defining and calculating an appropriate margin that is based on what is appropriate for a competitive market under the specific market circumstances present here is complicated; and (3) Any cost-based benchmark that includes guaranteed margins is likely inflationary as it is subject to moral hazard by rewarding higher costs with higher payments.

There are some similarities between Madera Community Hospital and St. Agnes Medical Center:

- Both are licensed as general acute care hospitals in California.
- Both hospitals serve government sponsored and commercially insured patients.
- There is geographic overlap of the service areas of the two hospitals.

However, St. Agnes is much larger, provides many more services, has a more complex case mix, and has much higher charges compared to Madera Community Hospital.

- Madera has 39 staffed beds vs 294 at St Agnes.
- Madera's Case Management Index (CMI) is 1.19 vs 1.48 at St Agnes.
- Madera's charge per day is $6,694 vs $11,358 at St. Agnes.

While Madera Community Hospital is much smaller and is not comparable to St. Agnes for purposes of the price cap, Madera Community Hospital is similar to small, rural hospitals in California.

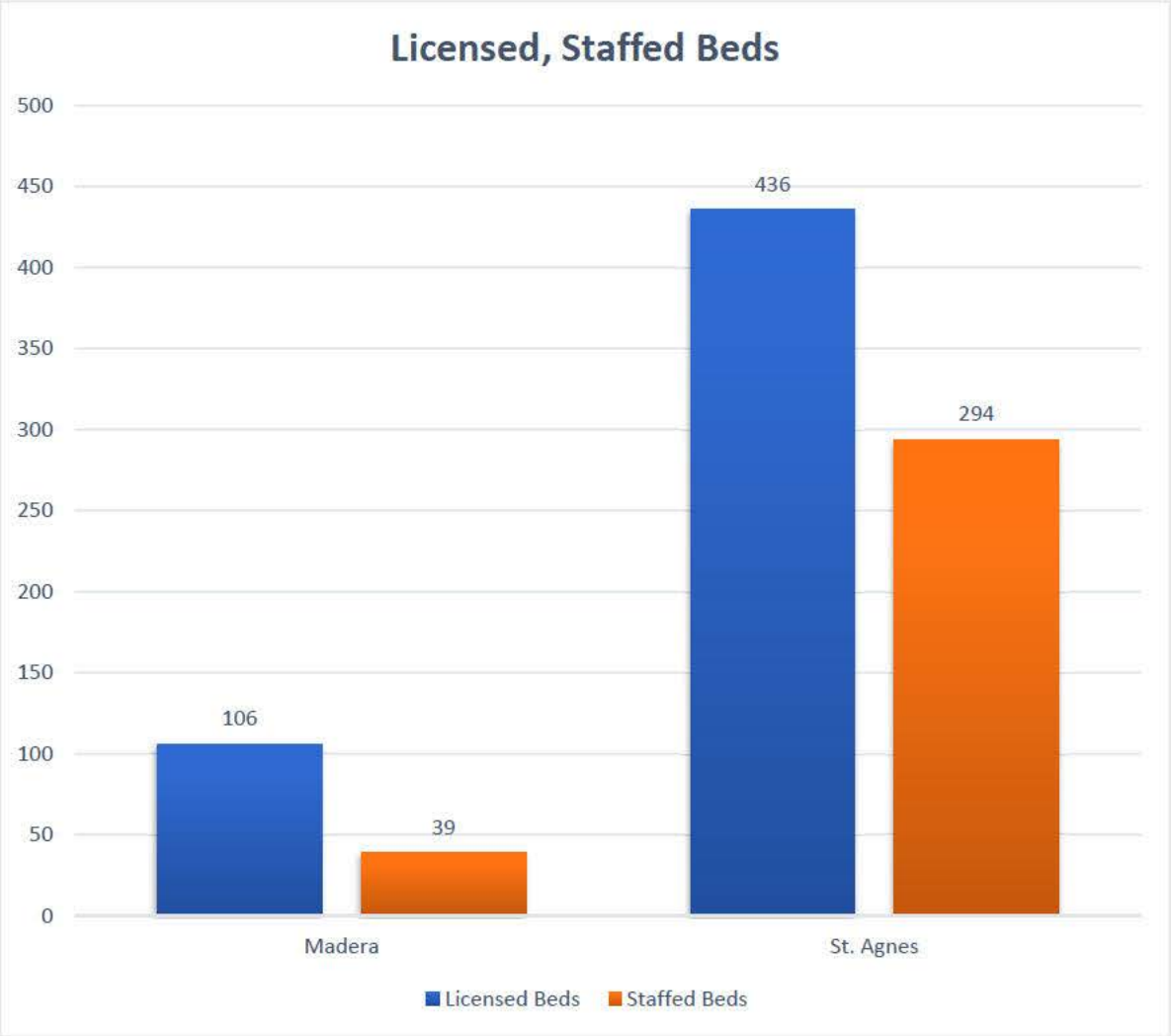
As set out in the next set of tables, Madera is comparable to small rural hospitals. Those tables also show where Madera fits in as being comparable to small rural hospitals in CA. Key takeaway points are as follows:

- Madera has a similar size in terms of staffed beds to rural hospitals;
- Madera is at the lower end of distribution of CMI vis-a-vis rural hospitals;
- Madera has a slightly more favorable commercial insurance payor mix in terms of percentage of volume than other rural hospitals; but
- Unlike other small, rural hospitals Madera's commercial population does not contribute positively to hospital margin
    - Small rural hospital's commercial payors pay 141 percent of costs
    - Madera collects only 51 percent of expenses allocated to commercial patients

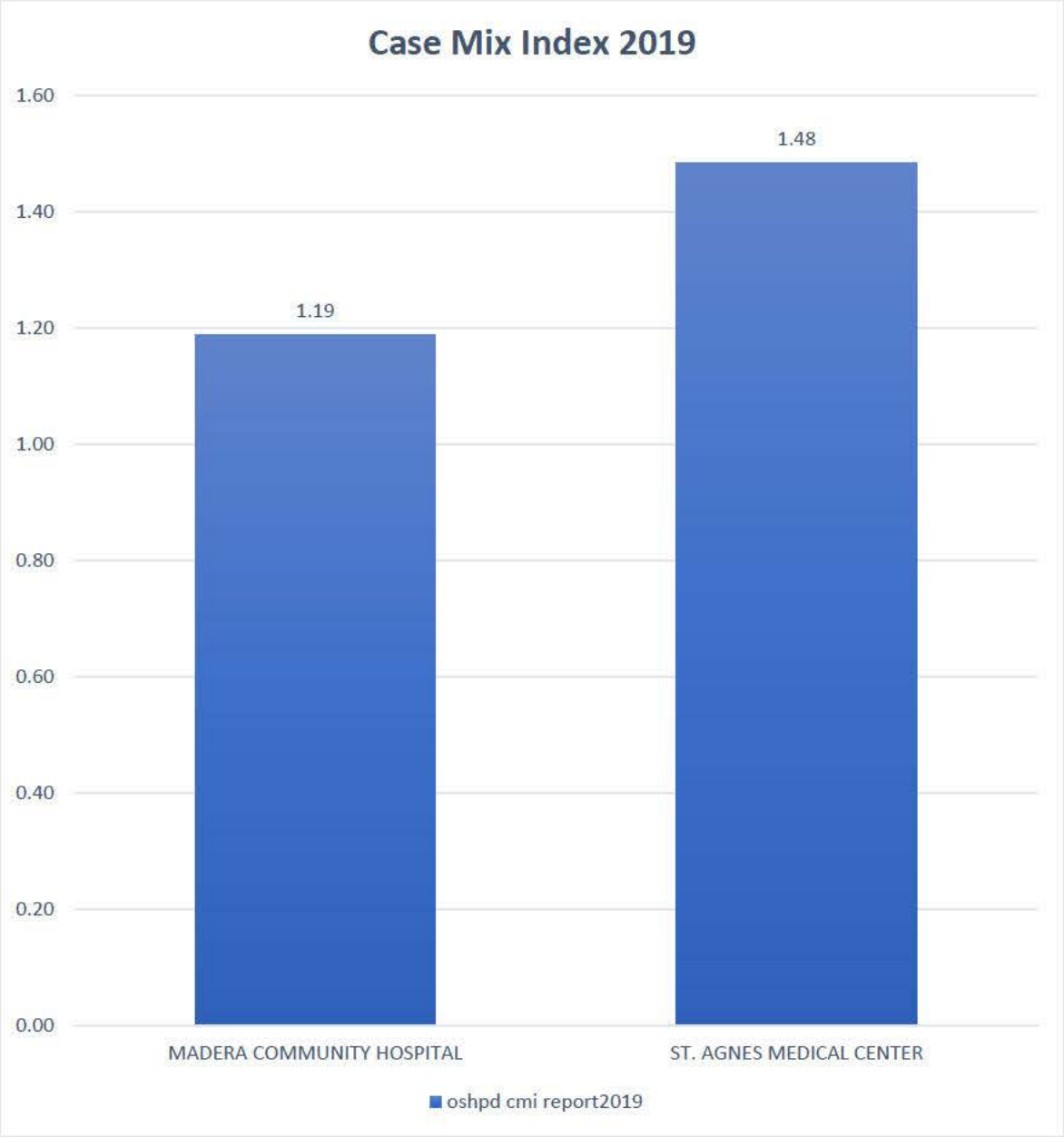
In sum, St. Agnes and the prices it receives is thus not an appropriate point of reference for price caps for Madera as confirmed by payor interviews. Rather, other rural hospitals are. These points are elaborated on by the Tables below.

Tables: Madera Community Hospital and St. Agnes Medical Center

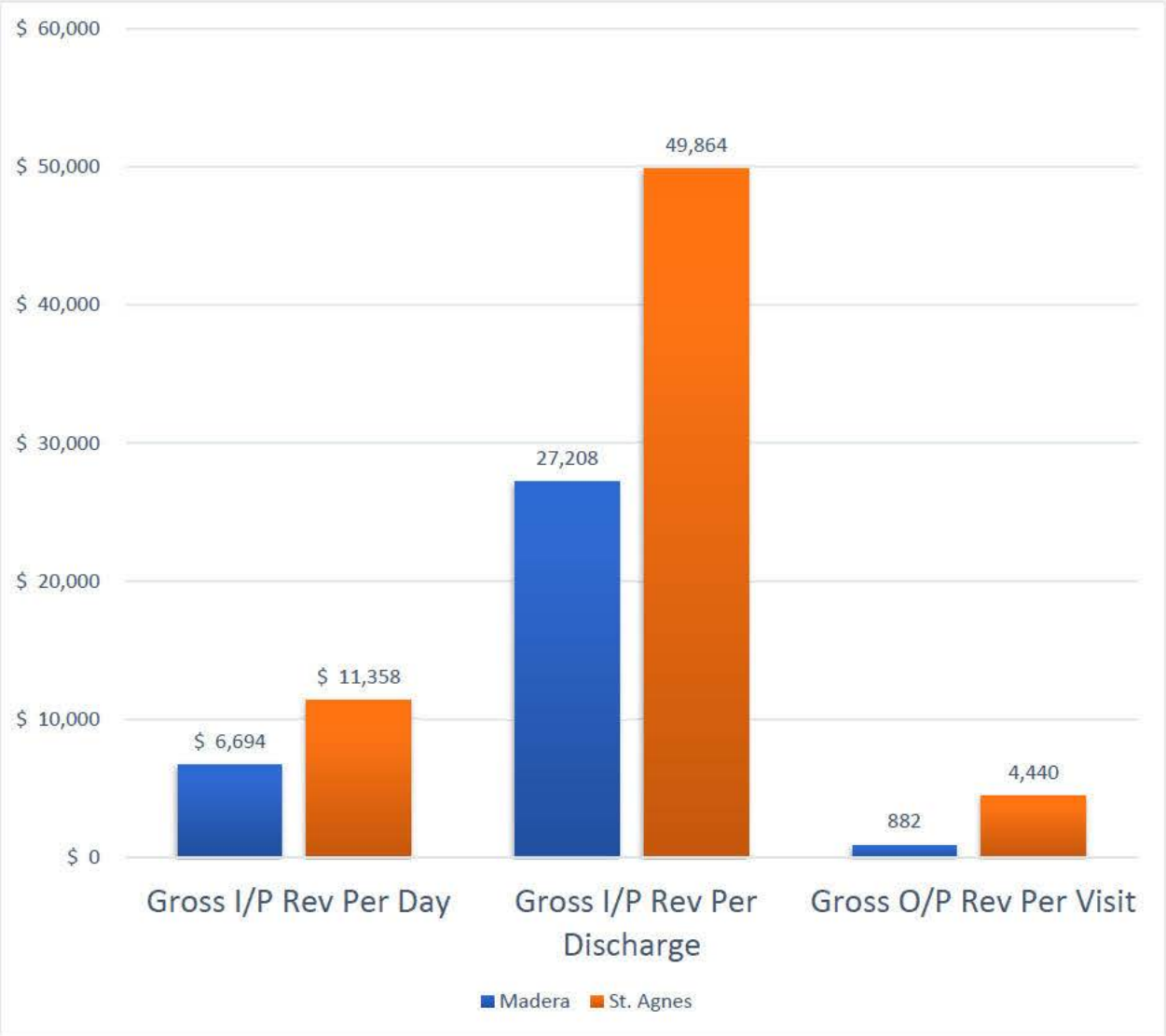
Both hospitals operate with staffed beds below licensed beds (as do most CA hospitals). Madera Community Hospital is much smaller in terms of bed size: Madera 39 staffed beds vs 294 at St Agnes.



The Case Mix Index at St. Agnes Medical Center is much higher than the case mix at Madera Community Hospital. This reflects the more narrow, limited range of services at Madera compared to St. Agnes Medical Center.

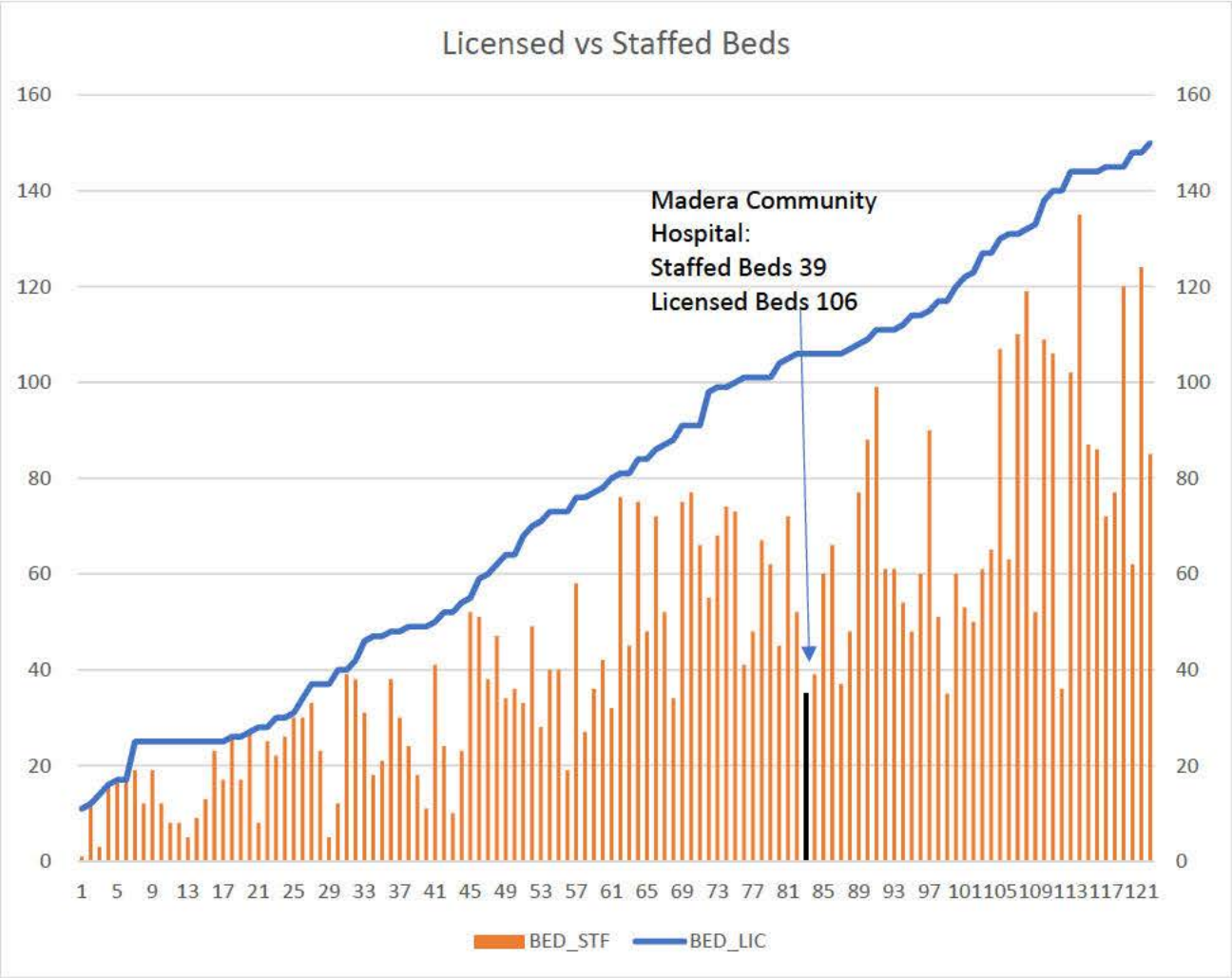


Charges art St. Agnes Medical Center are much higher than Madera Community Hospital – reflecting the differences in service availability and patient acuity.

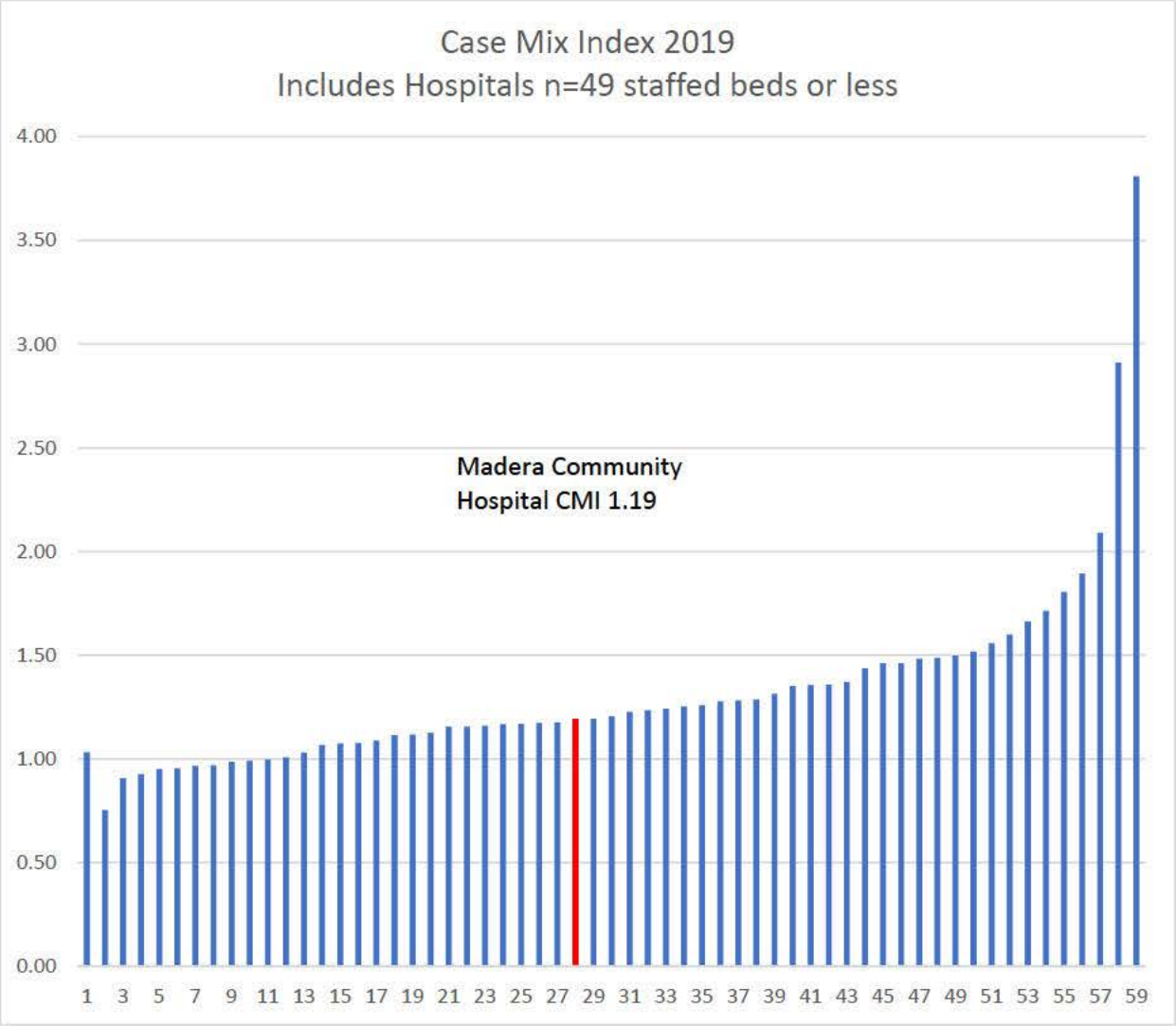


Comparison of Madera Community Hospital and Small Rural Hospitals in CA

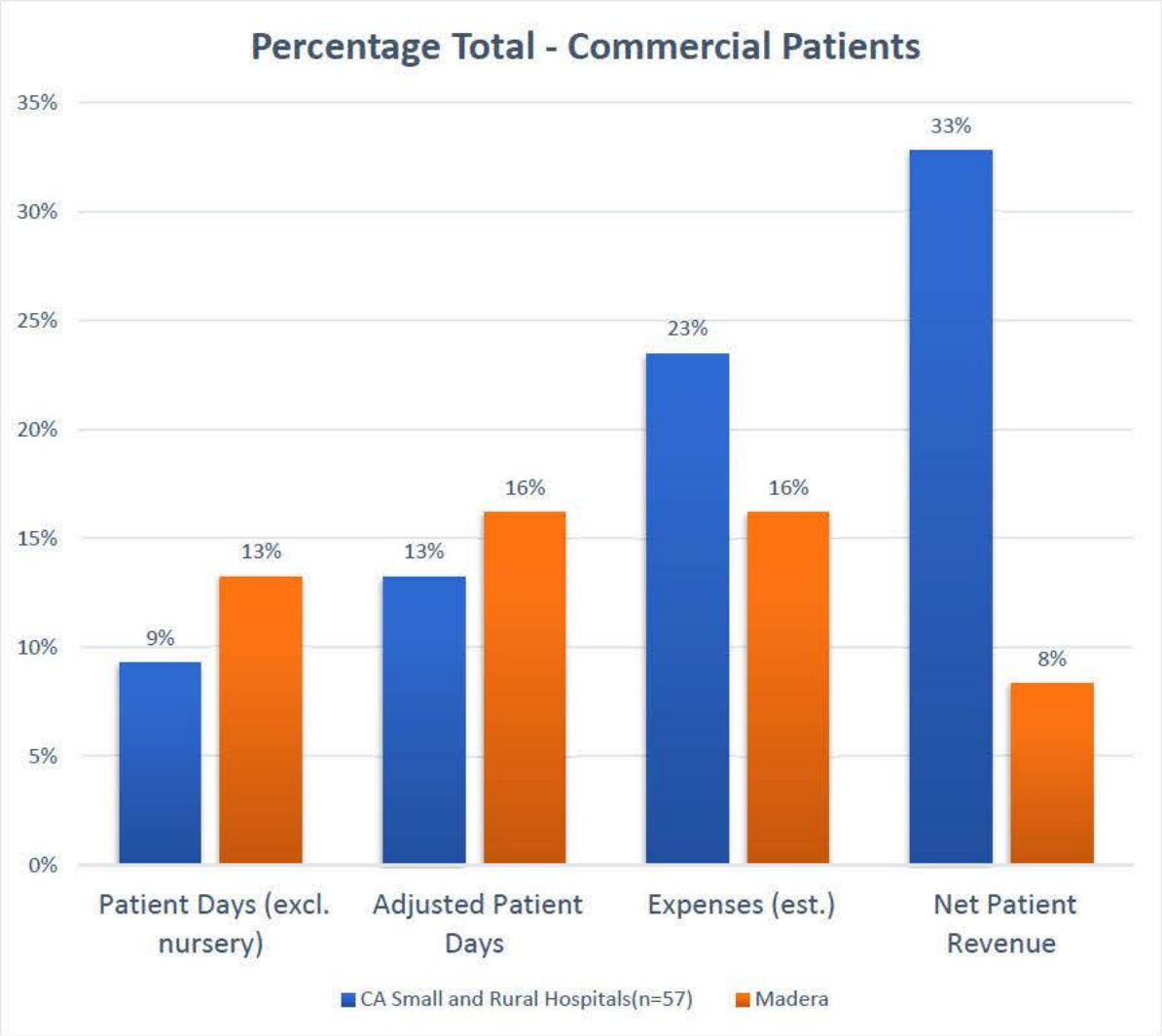
Madera Community Hospital is similar to other small rural hospitals in CA, both in terms of licensed and staffed beds.



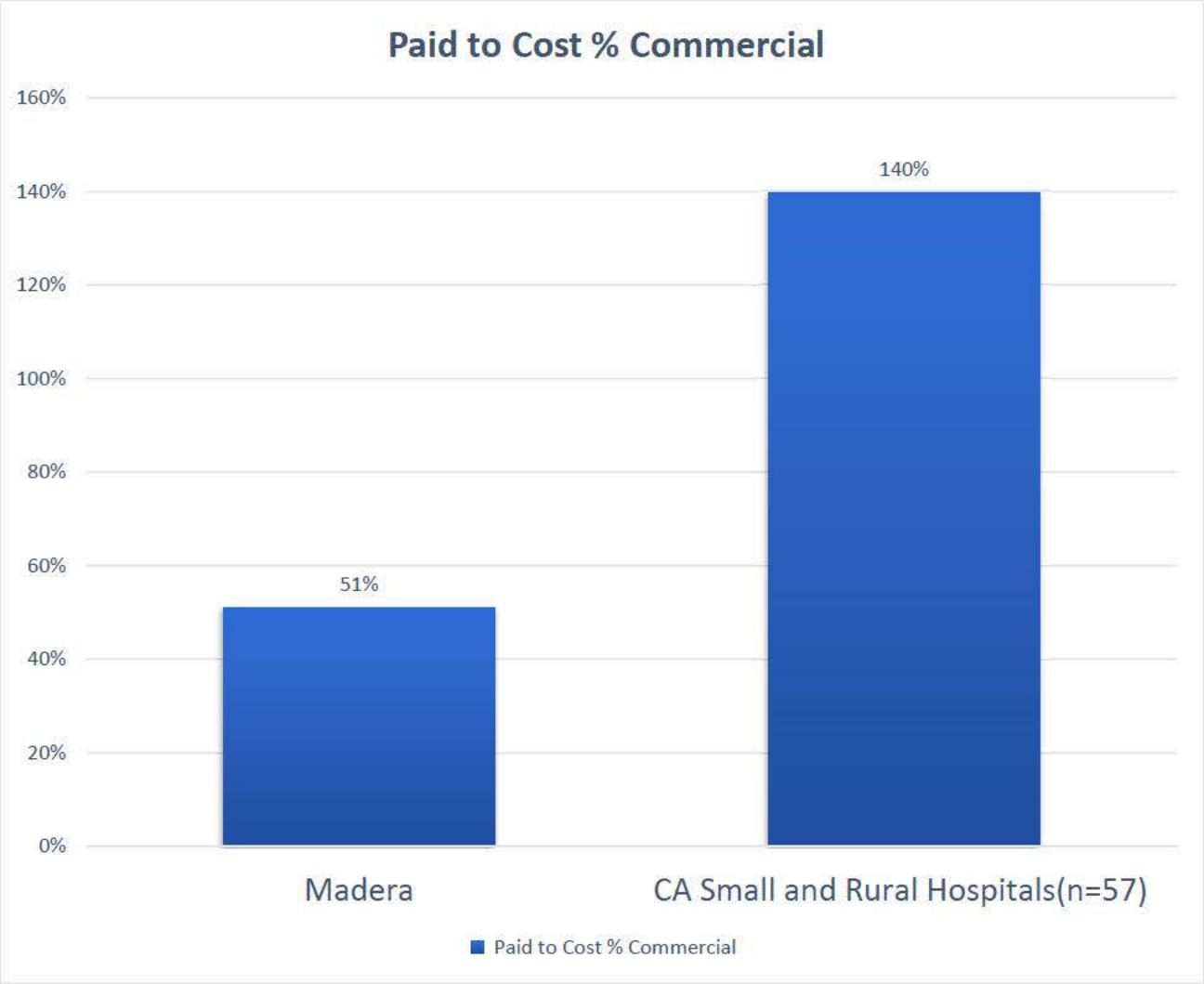
Madera Community Hospital is similar to other small rural hospitals in CA in terms of case mix index. CMI values of small rural hospitals tend to be lower given their limited set/mix of services.



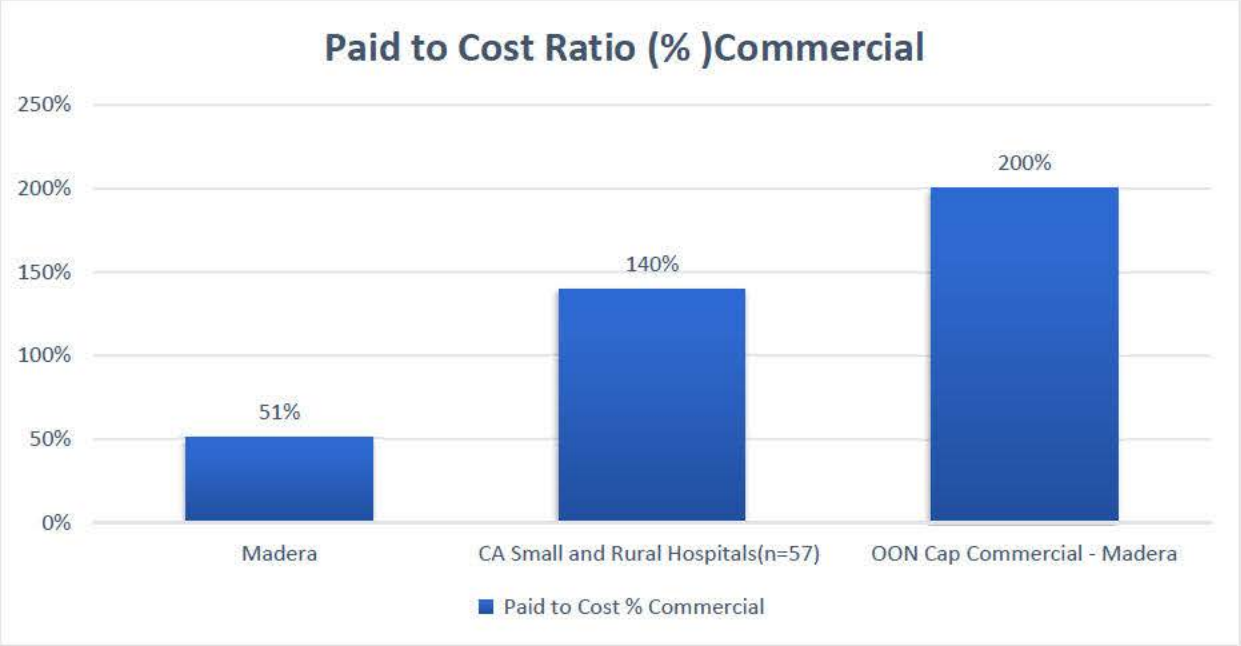
Madera Community Hospital is similar to small rural hospitals in California in terms of payor mix. More specifically, small rural hospitals generally serve mostly government program sponsored patients, including Madera Community Hospital. Madera Community Hospital, however, has a slightly higher commercial payor mix than the average small rural hospital.



Most hospitals negotiate prices with commercial payors that more than cover the costs of their commercially insured patient population. The average for small rural hospitals in CA is 140 percent of costs. Madera Community Hospital is well below the average for comparable rural hospitals and actually incurs a loss from this patient population – covering only 51 percent of expenses.



Potential OON Cap – 200% of Medicare FFS/Costs



Typical small rural hospitals collect 140 percent of costs from commercial payors. This includes emergency and non-emergency patients.

Raising the OON Cap to 200 percent for Medicare FFS would thus guarantee Madera 200 percent of their costs for emergency OON patients.

This is above the 140 percent average for small rural hospitals for commercially insured patients but adjusts for potentially higher costs of ED (excluding non-elective, lower CMI patients) only for commercial patients plus it makes a contribution to fixed costs to maintain emergency room over a smaller number of commercial patients should the hospital go out of network.

Based on the immediately following Table, Medicare FFS is assumed to cover approximately 100 percent of allocated costs and thus is an appropriate benchmark here (as opposed to costs).

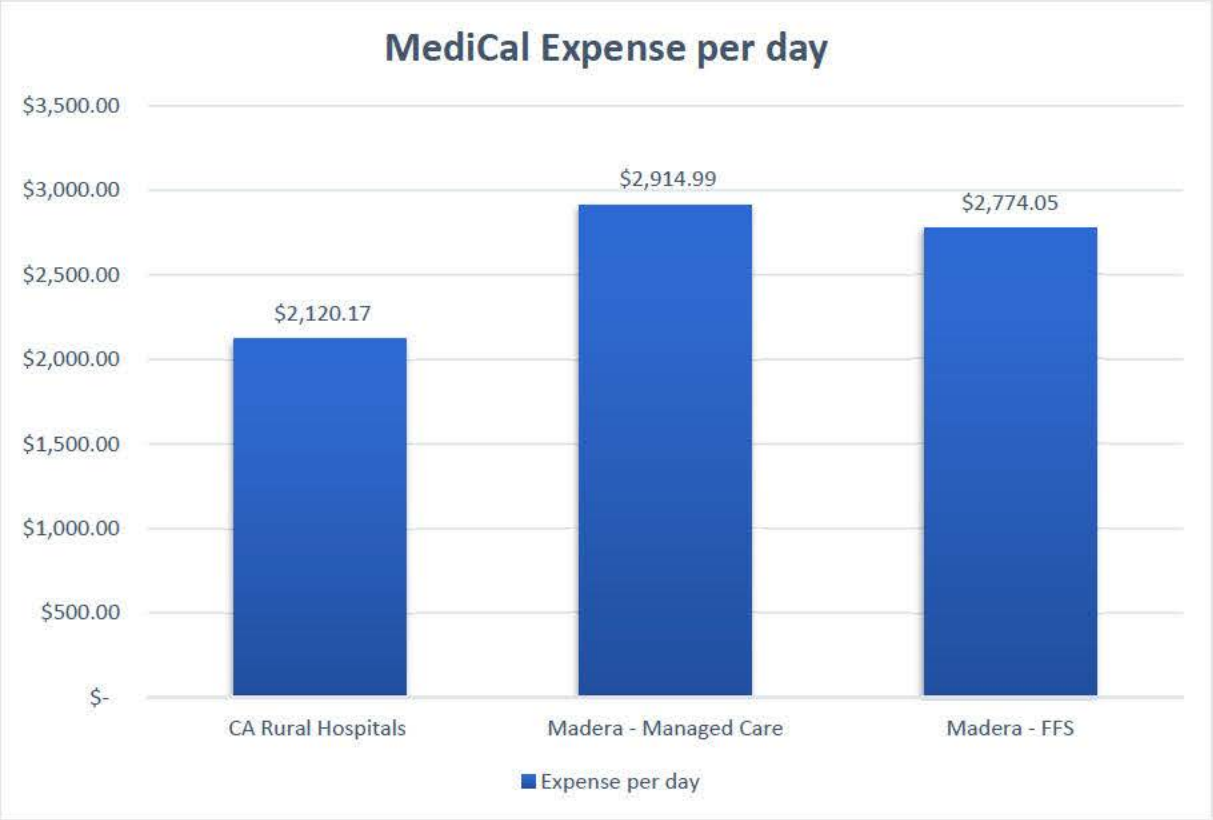
Medicare FFS at Madera Covers 97% of Allocated Costs

Madera 2020 Pivot Data	Medicare FFS
FFS Gross Patient Revenue	$ 48,795,900
FFS Net Patient Revenue	$ 20,337,618
FFS Paid - Percent of Gross Revenue	41.68%
FFS Expenses (est.)	$ 21,061,789
Ratio: FFS Revenue to FFS Expenses	97%

Medi-Cal Managed Care

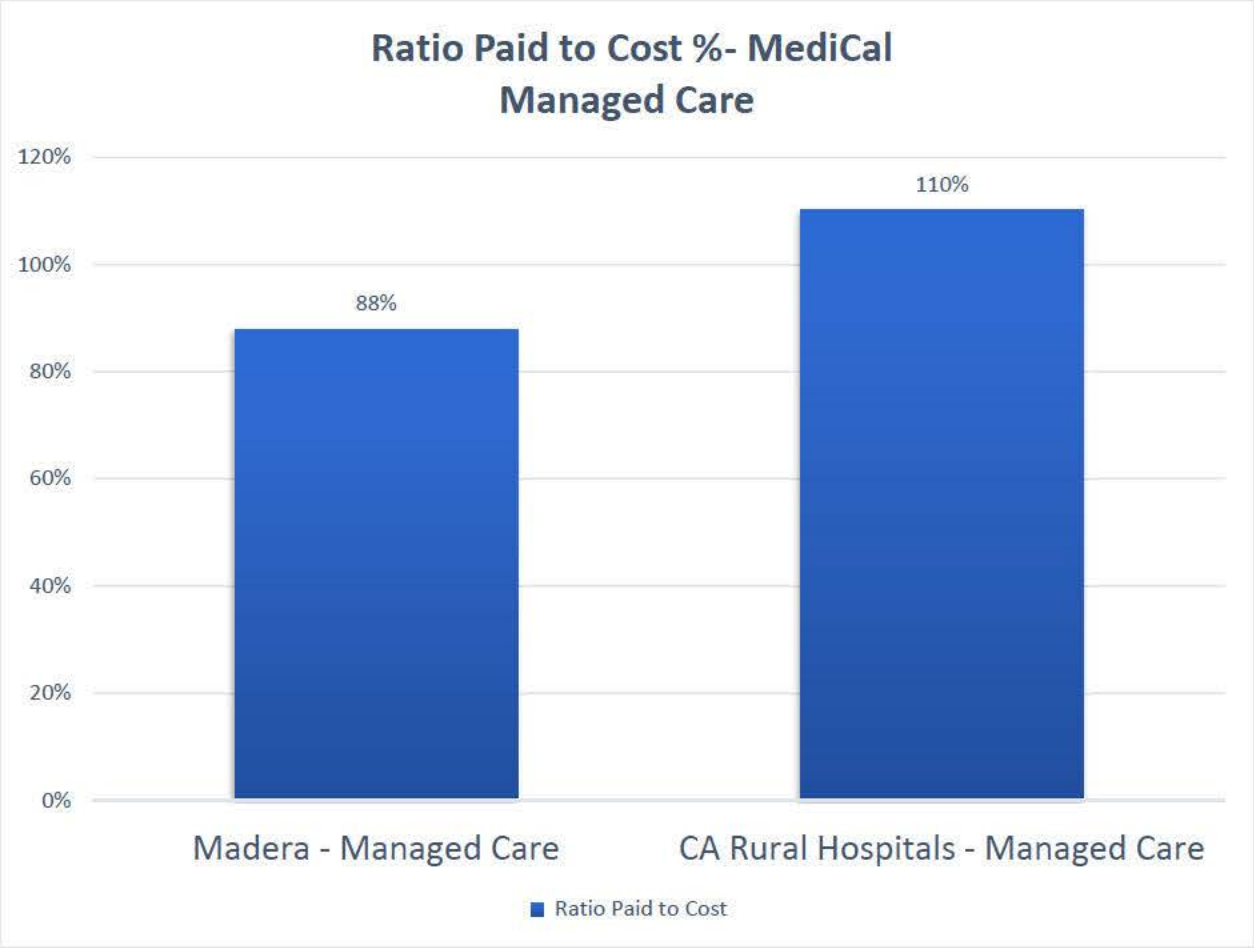
Madera Community Hospital provides care to Medi-Cal patients covered by both the traditional Fee-for-Service program and managed care programs. Approximately half of Madera Community Hospital patients are covered by Medi-Cal and as such Madera Community Hospital is an essential provider of hospital services to low-income Madera County residents covered by Medi-Cal.

The table below shows that Madera Community Hospital incurs higher costs per day for Medi-Cal patients compared to Medi-Cal managed care patients served by all rural hospitals in California.[56]

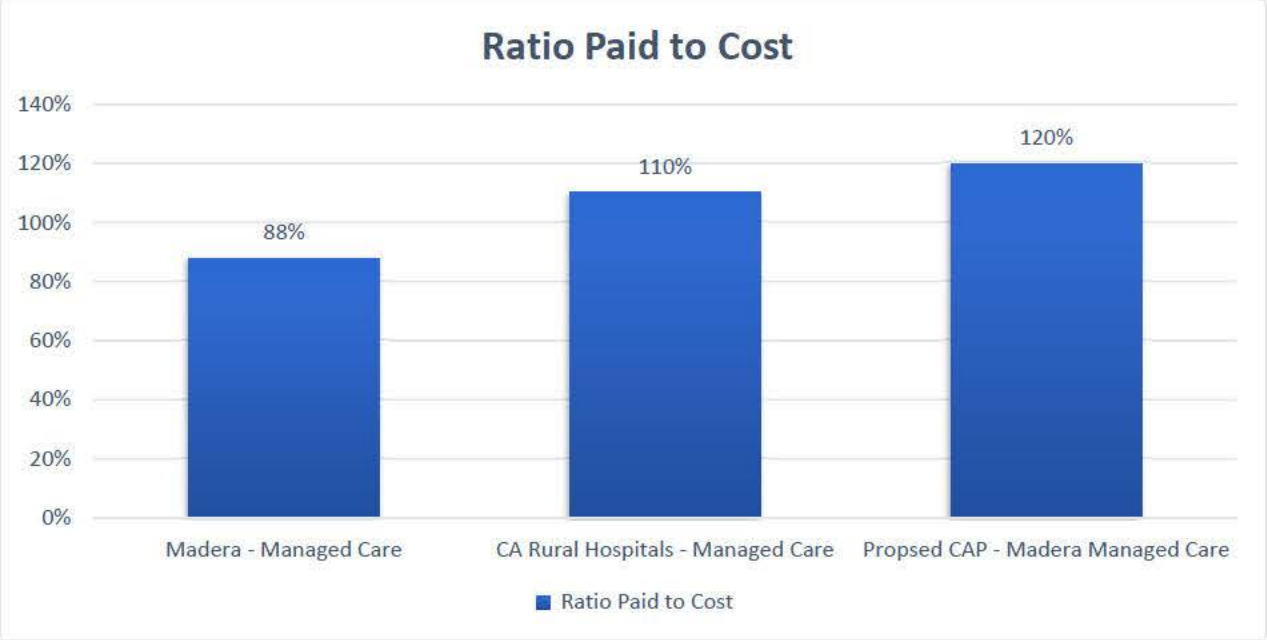


[56] The amounts are not adjusted for Medicare Wage Index or CMI. Most rural hospitals have the same Medicare Wage Index value and Madera's CMI is approximately average.

The table below shows that reimbursement under the Medi-Cal managed care program to Madera Community Hospital is below the cost of treating these patients. This is compared to the average rural hospital, where reimbursement under the Medi-Cal managed care program covers 110 percent of the costs of treating these patients.



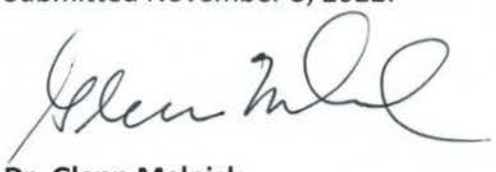
Given the importance of Madera Community Hospital to the Medi-Cal population in Madera County and the need for Madera Community Hospital to increase prices to cover their costs and remain viable, the COAG could consider approving the transaction but, given the increased market consolidation that would occur, limit the price increase to no more than 120 percent of Medi-Cal FFS prices. Typically, Medi-Cal managed care contracts are linked to Medi-Cal FFS rates and are in the range of 105-110 percent of Medi-Cal FFS rates. The CAP proposed here allows for the differential between Madera's operating costs and the average for all CA rural hospitals as set out in the next tables, as well as the importance of Madera Community Hospital, as the only hospital in the County, to Madera County residents. It also fits with Madera's worsening financial position as set out in recently updated quarterly data for 2022 in the next tables.



Madera Updated Quarterly Data thru Q1 2022 (compared to same quarter in 2021)

	Quarter	Quarter
	01/01/2022	1/1/2021
	03/31/2022	3/31/2021
800. Total Net Patient Revenue	22,220,747	22,081,359
Other Revenue and Expenses		
830. Total Operating Expenses	29,382,266	26,217,270
840. Nonoperating Revenue Net of Nonoperating Expenses	187,609	157,903
Operating Loss	-7,161,519	-4,135,911
Total Loss	-6,973,910	-3,978,008

Submitted November 3, 2022:



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APPENDIX - SUPPLEMENTAL INFORMATION AND DATA

Summary of Payor and Stakeholder Interviews

A series of videoconferences and phone interviews was conducted with local health care providers to assess the impact on the community from the sale of Madera Community Hospital to St. Agnes Medical Center regarding the quality and accessibility of health care services, as well as the impact of Ethical or Religious Directives (ERDs) on reproductive health and gender affirming services.

Several health plans that conduct business in Madera County were also interviewed to understand the market dynamics of the area and potential impact of the proposed transaction on payors and enrollees.

Below are summaries of the interviews as they relate to access, availability, and affordability of health care services.

Madera Community Hospital Service Area: Quality and Accessibility of Health Services

a. Importance of Madera Community Hospital's basic and emergency inpatient services at the hospital, and primary care services at rural health clinics and outpatient settings.

According to interviewees, Madera Community Hospital maintains an important role for community members who depend on the hospital for immediate and critical inpatient general acute care basic and emergency services, as well as outpatient primary care services. In addition to providing acute care services in a primarily rural area where the next available inpatient facility is located over 20 miles away in Fresno, interviewees noted that Madera Community Hospital provides important preventative and primary care medical services to the community with its diagnostic, maternal, family, and mental health services at three rural health clinics and other specialty services at outpatient settings. It also serves as a provider of care for Native American tribal communities in the service area. Further, the hospital provides inpatient and emergency services to inmate patients located in nearby state correctional facilities. Finally, interviewees indicated that many of the community's indigent or low income residents need access to both Madera's rural health clinics and general acute care hospital services as a first line of access to treat acute or chronic health conditions.

b. Economic and cultural indicators for recipients of care in the service area.

Providers discussed both cultural and economic considerations of residents living in the Madera Community Hospital service area and how those factors may impact access and availability to health services. Many recipients of care in the service area include individuals with income below the Federal Poverty Level (FPL). In 2021, many were recipients of Family PACT Medicaid, Medicaid managed care, and Medicare. Also, a significant number of recipients do not have ability to drive over 20 miles to the nearest town for health services (Fresno) and there are limited transportation services between Madera and Fresno. Consequently, Madera Community Hospital is the only general acute care hospital where many county residents can receive both inpatient, emergency, and outpatient services.

Many recipients in the service area that have income below the FPL include persons of color and are predominantly Latinx. There are translation services available to patients receiving care at Madera Community Hospital's locations, but staff are not always bilingual and these services are not offered 24 hours a day. Further, Madera also has a large Sikh community, so linguistic issues might be a factor for these residents receiving access to care.

Madera Community Hospital Service Area: Access to Reproductive Health and Gender Affirming Services

a. Limited number of providers of reproductive health and gender affirming services in the service area.

There are a limited number of outpatient health care settings in the Madera Community Hospital service area where reproductive health, including abortion services, or gender affirming services are provided. However, it is the only hospital setting in the service area where inpatient surgical reproductive health services and gynecological surgeries can occur, such as tubal ligation, hysterectomy, or surgical abortion. Madera Community Hospital's three rural health clinics in Madera, Chowchilla, and Mendota currently provide outpatient family planning services, including birth control and fertility treatment; obstetrical and gynecological health services; hormone therapy; and gender identity services.

Alternative outpatient providers in the service area offer reproductive health services, contraception and family planning (and). However, neither reproductive nor gender affirming surgical procedures are provided at these alternative settings. Other alternative outpatient locations in the service area include several private physician offices and Federally Qualified Health Centers ("FQHC"). However reproductive health or gender affirming providers based in Madera may not be privileged to admit patients at the nearest hospitals located outside of Madera Community Hospital's service area. Interviewees did indicate that alternative providers of medical as well as surgical abortions and some gender affirming and reproductive health services and surgical treatments are available and provided in some hospitals, surgery centers or clinics and outpatient settings in Fresno, 22 miles away from Madera Community Hospital. However, many financially disadvantaged or low-income patients located in Madera or its rural communities may have significant difficulty arranging or obtaining transportation to these Fresno locations.

b. Impact on reproductive health and gender affirming care from the application of ERDs.

Providers interviewed believe that if ERDs are applied to services of Madera Community Hospital as a result of the transaction with St. Agnes Medical Center, some necessary emergency reproductive services might be limited resulting in potentially negative patient outcomes. For example, in cases where pregnancies should be terminated for medical necessity or in an emergency, where certain reproductive sterilization procedures are needed in an emergency or for medical necessity, or in cases of sexual assault where emergency contraception services should be provided, implementation of ERDs may have a detrimental impact on patient access and outcomes. These negative outcomes could come from either the

delays in care from turning away patients or due to burdening the patient who must be referred to and travel to alternative providers or health care settings for medically necessary services, and outside the service area depending on the nature of procedure or treatment.

Furthermore, if contraception and family planning services are discontinued at Madera Community Hospital's rural health clinics as a result of ERD implementation, a significant number of financially disadvantaged patients in the service area will be disproportionately impacted for lack of available nearby resources.

ERDs may also have a negative impact on patients seeking gender affirming care at Madera Community Hospital in that these patients might be turned away. Interviewees also expressed there is a lack of training among providers in the service area regarding the transgender community's need for access to health care.

c. Potential future growth in demand for reproductive health services in California could impact the resources and availability of alternative reproductive health providers in the Madera Community Hospital service area.

Interviewees expect that many (over one million) out-of-state consumers will likely travel to California seeking access to abortion care from other states expected to or already partially or fully banning abortions. Local reproductive health providers interviewed believe they could likely be impacted by the surge of patients seeking care.

Payor Insight on Madera County, Madera Community Hospital and the Proposed Transaction

a. Payors in the Market.

There are a number of health plans with products in the region, including [redacted], [redacted] and [redacted]. Product lines range from commercial, HMO, PPO, EPO, Medicare and Medi-Cal, Medicare Advantage, and Medi-Cal managed care. Madera County's Medi-Cal and Medicare contracts are especially desirable to payors. [redacted] and at least one other payor plans to rebid for one of two Madera County Medi-Cal contracts, starting in 2024.

b. Payor Opinions on the Madera County Region.

Generally, for residents in Madera, the only alternatives are Community Regional Medical Center and St. Agnes Medical Center as other hospitals are too far a distance to drive. Community Regional Hospital and St. Agnes Medical Center are the only two alternatives and Community Regional Hospital is already a dominant player. Because of the dearth of alternatives to Madera Community Hospital, there would be marketability concerns that would be raised as to any network that lacked both Madera Community Hospital and St. Agnes Medical Center. And a network without Madera Community Hospital and St. Agnes Medical Center would be less competitive. Fifty percent (50%) of Madera and Fresno counties are covered by Medi-Cal, and many patients have difficulty traveling long distances for care. All health plans are challenged in this region due to lack of options and difficulty recruiting providers, making Madera Community Hospital particularly important.

c. Importance of Madera Community Hospital.

Payors believe Madera Community Hospital has a good reputation in the community. Though their equipment and technology is out of date and it is not considered a first choice hospital, Madera Community Hospital is the only general acute care hospital in the county, with no other options for outpatient acute care. It is also important to payors for creating a network that is adequate under Centers for Medicare and Medicaid Services (CMS) or Department of Managed Health Care (DMHC) standards. It is particularly important because it serves the county's sizeable Medi-Cal population. Both CMS and DMHC have time and distance requirements to ensure network adequacy and Madera Community Hospital helps provide the adequacy needed for payor networks, including Medi-Cal managed care. Though plans note Community Regional Medical Center is bigger and provides all services, it is 2.5 hours by public transport and a 30–40-minute drive.[57] As previously noted, the Medi-Cal population has more challenges with transportation. Additionally, multiple payors noted that losing Madera Community Hospital would be especially challenging for the elderly and for those who need local obstetrics care.

Madera Community Hospital is also important for Medicare Advantage plans because plan revenue is based off the Medicare Advantage Star Rating system which contemplates user experience with respect to factors like access. Losing Madera Community Hospital from the Medicare network would likely adversely impact any plan's star rating in the county.

Further, Madera Community Hospital has rural health clinics in remote areas of the county which are critical for the Medi-Cal population due to a primary care shortage in the area. Finally, [redacted] notes that if Madera Community Hospital were to close, patients could still access emergency services at Community Regional Medical Center. However, if for whatever reason, Community Regional Medical Center were inaccessible to Madera residents, patient wait times could go from 3 hours to 10 hours at other area hospital emergency rooms.

d. Payor Views on St. Agnes Medical Center.

Payors generally have favorable views of St. Agnes Medical Center, noting it has reasonable rates for Fresno though they are higher than Madera Community Hospital. Due to Trinity's headquarters being located in Michigan, St. Agnes Medical Center takes a long time to respond to payors in contracting negotiations. One payor states Trinity has little understanding of the California market, specifically with respect to its delegated IPAs, since St. Agnes Medical Center's negotiations are done from Trinity's headquarters in Michigan.

[redacted] notes certain reproductive services may be pulled back due to St. Agnes Medical Center's religious affiliation. However, it also notes that St. Agnes Medical Center and Madera Community Hospital are priced much more competitively than Community Regional Medical Center. It likes the idea of keeping prices down, but not at the expense of losing Madera Community Hospital. St. Agnes Medical Center has been reasonable in the past and while [redacted] knows they have to prop up Madera Community Hospital, it doesn't see them asking for a 100% increase and the health plans would push back on that.

[57] Travel time calculated using Google Maps.

e. Rate Increases.

[redacted] could withstand some rate increase by St. Agnes Medical Center and would have to in order to maintain access standards required by [redacted] Basically, [redacted] would have to agree to rate increases due to lack of other options in the area. Other payors spoke of the challenges of having a marketable or viable network that would be competitive in the area without Madera Community Hospital and St. Agnes Medical Center.

f. Opinion on Fresno/Madera Duopoly.

Payors understand that the Fresno area is already a duopoly. Having only Community Regional Medical Center and St. Agnes Medical Center in the area is concerning from a network affordability perspective. Most payors interviewed were not aware Madera Community Hospital was having financial issues or heard only vague rumors. However, payors would prefer that Madera Community Hospital stay open and operational instead of closing.

[redacted]

g. If Madera Community Hospital Closed or Was No Longer a Care Option.

The closest options for people in Madera County would be Community Regional Medical Center and St. Agnes Medical Center. Community Medical Center seems to be the most dominant provider, with a large geographical footprint. Both [redacted] and [redacted] note that Community Regional Medical Center is a challenging negotiator due to its market dominance and because it rents networks resulting in multiple layers of collaboration. Due to Community Regional Medical Center's market dominance, closing Madera Community Hospital could result in higher prices in the area. Payors state that Madera Community Hospital is important for network adequacy requirements; however, they would be able to meet requirements by having Community Regional Medical Center and either St. Agnes or Madera Community Hospital—so if they lost one, they could manage—from a network adequacy standpoint.

Trinity owns St. Agnes Medical Center and Fresno Surgical Hospital that also offer a wide range of acute care services at a lower cost than Community Regional Medical Center.

h. Conditions to Address Price Hikes.

To address concerns about potential price increases, payors would want to limit the amount of price increases that could be imposed after the potential acquisition. For example, [redacted] said that such price increases could be a significant hit to the population in Madera. This is because [redacted] business is highly self-funded, meaning employer groups pay directly for the care of their employees. [redacted] suggested that anti-bundling and price cap conditions would be appropriate to address the acquisition of Madera Community Hospital by St. Agnes Medical Center and expressed a concern about quick and significant price increases.

Legal criteria for definition of Rural Hospital in California

Health and Safety Code section 124800. The Legislature finds and declares all of the following:

(a) Rural hospitals serve as the "hub of health," and through that role attract and retain in their communities physicians, nurses, and other primary care providers. Because of economies of scale compounded by reimbursement reforms, many rural hospitals will close before the end of this decade. This will result in the departure of primary care providers and the loss of emergency medical services both to residents and persons traveling through the area. The smallest and most remote facilities are at highest risk.

(b) The rural hospital is often one of the largest employers in the community. The closure of such a hospital means the loss of a source of employment. This has an economic impact beyond the health sector. Further, economic development of a rural area is, in part, tied to the existence of a hospital. People, for example, tend not to retire to areas where there is not reasonable access to physician and hospital-based services.

(c) Rural hospitals, especially the smaller facilities, lack access to the sophisticated expertise necessary to deal with current reimbursement regulations and the associated bureaucracy.

(d) Most rural hospitals are unable to participate in programs that provide access to short- and long-term financing due to lender requirements for credit enhancement.

(e) Because of economies of scale compounded by regulations under Title 22 of the California Code of Regulations and other regulations, rural hospitals have high, fixed costs that, in the present reimbursement environment, cannot be offset by revenues generated from serving a relatively small population base. Further, in an economically depressed rural area, community contributions are not sufficient to offset deficits.

(f) Rural hospitals are an important link in the Medi-Cal program, and without special consideration that takes into account their unique circumstances, rural hospitals will be unable to continue providing services to Medi-Cal patients. This is especially true for outpatient services that are reimbursed at less than 60 percent of costs.

(g) While only a very small percentage of the Medi-Cal budget for inpatient and outpatient services is spent for services rendered by rural hospitals, their participation is essential to preserve the integrity of the entire Medi-Cal program.

Madera Community Hospital – 2019 Community Health Needs Assessment: Social and Economic Factor Indicators

Social and Economic Factors Indicators	Fresno County		Madera County		State Estimate
Children Below 100% Federal Poverty Level, Percent	38.70%		32.10%		21.90%
Head Start Programs, Rate (Per 10,000 Children)	4.81		9.18		5.9
Mortality-Drug-Induced Death Rate per 100,000	15.9		15.6		12.2
Mortality-Motor Vehicle Traffic Crash Death Rate per 100,000 Population	14.7		17.1		8.8
Population Age 16-19 Not in School and Not Employed, Percent	9.70%		8.40%		7.70%
Population Age 25+ with Bachelor's Degree or Higher, Percent	19.70%		13.10%		32.00%
Population Age 25+ with No High School Diploma, Percent	26.20%		28.30%		17.90%
Population Below 100% Federal Poverty Level , Percent	26.90%		22.10%		15.80%
Population Receiving Public Assistance Income, Percent	8.40%		5.60%		3.80%
Population Receiving SNAP Benefits, Percent	23.10%		18.90%		11.20%
Students Scoring ' 'Not Proficient' or Worse on 4th Grade Reading Test,	68.90%		77.30%		60.50%
Percent					
Students Scoring 'Proficient' or Better on 4th Grade Reading Test, Percent	31.10%		22.70%		39.50%
Substantiated Child Abuse Cases per 1,000, 2015	8.6		9		8
Total Homeless Population, 2018	2,144		2,144		N/A
Unemployment Rate, Percent	6.60%		6.20%		4.30%
Violent Crimes, Raw Count, 2017	5,745		891		N/A

Madera Community Hospital – 2019 Community Health Needs Assessment: Health Status Indicators

Health System	Fresno County	Madera County	State Estimate
Active Asthma Prevalence, Percent	11.30%	10.30%	8.70%
Ambulatory Care Sensitive Condition Discharge Rate	41.3	44.7	36.2
Asthma ED Visits, Rate per 100,000	67.4	60.2	45.8
Asthma Hospitalizations, Rate per 100,000	7.4	6	4.8
Breastfeeding Initiation, Percent	87.70%	90.90%	93.80%
Dentists, Rate per 100,000 Population	59.3	43.3	82.3
Depression Among Medicare Recipients, Percent	13.00%	13.30%	14.30%
Infant Mortality Rate (Per 1,000 Live Births)	6.3	5.2	5
Lifetime Asthma Prevalence, Percent	16.30%	17.10%	14.80%
Low Weight Births (Under 2500g) , Percent	7.50%	6.30%	6.80%
Mental Health Care Provider, Rate per 100,000 Population	293.2	142.9	280.6
Mortality - All Cancers, Age-Adjusted Death Rate per 100,000 Population	141.9	140.6	140.2
Mortality- Diabetes, Age-Adjusted Death Rate per 100,000 Population	26.4	20.8	20.7
Mortality - Alzheimer's Disease, Age-Adjusted Death Rate per 100,000 Population	37.6	41.5	34.2
Mortality - Coronary Heart Disease, Age-Adjusted Death Rate per 100,000 Population	108.1	91.7	89.1
Mortality - Stroke, Age-Adjusted Death Rate per 100,000 Population	44.7	41.1	35.3
Mortality - Influenza/Pneumonia, Age-Adjusted Death Rate per 100,000 Population	18.6	13.7	14.3
Mortality- Chronic Lower Respiratory Disease, Age-Adjusted Death Rate per 100,000 Population	33.8	37.3	32.1
Mortality- Chronic Liver Disease and Cirrhosis, Age-Adjusted Death Rate	16.4	20.7	12.2
per 100,000 Population			
Mortality- Accidents (Unintentional Injuries), Age-Adjusted Death Rate per 100,000 Population	43.8	45.8	30.3
Mortality- Motor Vehicle Traffic Crashes, Age-Adjusted Death Rate per 100,000 Population	14.7	17.1	8.8

Mortality- Drug-Induced Deaths, Age-Adjusted Death Rate per 100,000 Population	15.9		15.6		12.2
Primary Care Physicians, Rate Per 100,000 Population	65.2		40		78
Population Receiving Medicaid, Percent	41.60%		43.90%		26.60%
Rate of Federally Qualified Health Centers per 100,000 Population	2.58		4.64		2.74
Teen Births (per 1,000 female population aged 15 to 19 years old)	29.5		35.4		17.6
Uninsured Population, Percent	14.20%		14.30%		12.60%
Women who Received Adequate or Adequate Plus Prenatal Care , Percent	88.80%		70.20%		77.90%
Women who Received Prenatal Care in the First Trimester, Percent	87.90%		74.90%		83.30%

Madera Community Hospital – 2019 Community Health Needs Assessment: Public Health and Prevention Indicators

Public Health and Prevention	Fresno County		Madera County		State Estimate
Access to Exercise Opportunities, Percent	79.40%		74.20%		89.60%
Adults who are Current Smokers, Percent	14.20%		14.30%		11.00%
Diabetes (Medicare Population), Percent	30.90%		30.70%		25.30%
Excessive Drinking, Percent	16.10%		17.10%		17.80%
High Blood Pressure (Medicare Population), Percent	55.90%		57.10%		49.60%
Heart Disease (Medicare Population), Percent	26.50%		27.90%		23.60%
Poor Fair Health (Age-Adjusted), Percent	23.60%		22.10%		16.60%
Poor Physical Health Days, 30 Day Period	4.2		3.7		3.5
Poor Mental Health Days, 30 Day Period	3.8		4.2		3.4
Population with no Leisure Time Physical Activity, Percent	20.60%		18.80%		17.20%
Obesity, Percent	28.50%		26.10%		22.50%
STI--Chlamydia Incidence, per 100,000 Population	664		495.5		506.2
STI--HIV Prevalence, per 100,000 Population	215.4		133.7		376.4
STI--Gonorrhea Incidence, per 100,000 Population	204.8		114.8		164.9

Madera Community Hospital – 2019 Community Health Needs Assessment: Physical Environment Indicators

Physical Environment	Fresno County		Madera County		State Estimate
Broadband Access, Percent	86.20%		67.50%		95.40%
Cost Burdened Households, Percent	42.00%		38.80%		42.80%
Fast Food Restaurant Rate, per 100.000 Population	68.14		51.7		80.51
Food Insecurity--Children, Percent	26.20%		23.80%		19.00%
Food Insecurity--Overall, Percent	14.50%		11.40%		11.70%
Grocery Store Rate, per 100,000 Population	27.62		25.19		21.14
Housing Units with One or More Substandard Conditions, Percent	45.50%		43.00%		45.60%
Liquor Store Rate per 100,000 Population	10.32		6.63		10.73
Recreation and Fitness Facility Access, per 100,000 Population	6.66		5.3		10.75
SNAP-Authorized Retailers, Rate per 100,000 Population	10.75		10.14		6.81

Madera Community Hospital – 2019 Community Health Needs Assessment: Social and Economic Factor Indicators

Maternal and Child Health	Fresno County		Madera County		State Estimate
Adverse Childhood Experiences	17.90%		18.00%		16.40%
Asthma Diagnoses, Children	19.30%		18.20%		15.20%
Asthma Hospitalizations, Age 0-4, Rate per 10,000	38.1		31.9		19.6
Asthma Hospitalizations, Age 5-17, Rate per 10,000	16		9.6		7.7
Children Below 100% Federal Poverty Level, Percent	38.70%		32.10%		21.90%
Fitnessgram Healthy Zone Percentage, Grade 5	44.30%		31.40%		40.70%
Fitnessgram Healthy Zone Percentage, Grade 7	44.00%		33.40%		38.70%
Fitnessgram Healthy Zone Percentage, Grade 9	43.20%		39.30%		37.20%
Food Insecurity--Children, Percent	26.20%		23.80%		19.00%
Immunizations, Kindergartners	96.20%		95.90%		92.80%
Infant Mortality Rate (Per 1,000 Live Births)	6.3		5.2		5
Students Scoring ' 'Not Proficient' or Worse on 4th Grade Reading Test, Percent	68.90%		77.30%		60.50%
Students Scoring 'Proficient' or Better on 4th Grade Reading Test, Percent	31.10%		22.70%		39.50%
Students Who Experienced Depression in the Past Year, 9th Grade	N/A		30.50%		31.50%
Students Who Experienced Suicidal Ideation in the Past Year, 9th Grade	N/A		20.30%		19.00%
Substantiated Child Abuse Cases per 1,000, 2015	8.6		9		8
Teen Births (per 1,000 female population aged 15 to 19 years old)	29.5		35.4		17.6
Unintentional Injury Hospitalizations per 100,000 Children, ages 5-12	138.8		165.1		118.1
Women who Received Adequate or Adequate Plus Prenatal Care , Percent	88.80%		70.20%		77.90%
Women who Received Prenatal Care in the First Trimester, Percent	87.90%		74.90%		83.30%

Information Provided by Madera