DESERT HEALTHCARE DISTRICT
PLAN OF SERVICES

I. INTRODUCTION AND BACKGROUND

This Plan of Services (Plan) is submitted by the Desert Healthcare District (District) as part of the Application to the Riverside County Local Agency Formation Commission (LAFCO) pursuant to AB 2414 (Garcia) Chapter 416 (2016) (AB 2414) for the annexation of approximately 1,760 square miles of the Eastern Coachella Valley into the District's current service area of the Western Coachella Valley that encompasses approximately 515 square miles. The District currently includes the cities of Palm Springs, Desert Hot Springs, Cathedral City, Rancho Mirage, part of Palm Desert, and unincorporated areas within the current District boundaries. The Annexation proposed by AB 2414 includes the remainder of Palm Desert, Indian Wells, La Quinta, Indio and Coachella, the communities of Bermuda Dunes, Mecca, Thermal, Oasis, North Shore and Vista Santa Rosa as well as unincorporated areas of the County of Riverside (Annexed Area).

1.1. AB 2414

AB 2414, authored by Assemblymember Eduardo Garcia, was signed by the Governor on September 21, 2016. This special legislation is unique to Desert Healthcare District and would exempt the proposed annexation from a number of the requirements that govern the usual process under LAFCO for "district annexations." Among other mandates, AB 2414 requires:

- the District to file the proposed annexation Application with LAFCO by January 5, 2107;
- that LAFCO approve the Application within 150 days;
- the Application be exempt from a protest hearing;
- LAFCO to direct the Riverside County Board of Supervisors to place approval of the expansion of the District on the ballot at the next countywide election (November 2018);
- the expansion of the District upon voter approval, if a funding source sufficient to support the operations of the expanded District is also approved as specified.

As noted by the author, the clear intent of AB 2414 is to maximize and enhance the assets of the District, to address the significant barriers preventing access to health care providers and services for residents in the Eastern Coachella Valley. Expanding the District will help address these needs if sufficient revenue sources are included and the expansion is modeled after the success of the District in addressing various critical health needs of its current constituency.

A copy of the complete text of AB 2414 is attached as **Exhibit 1.1** to this Application.

1.2. Desert Healthcare District and Foundation

In 1948, the Desert Hospital District was formed with the mission to build a hospital to meet the healthcare needs of local residents in Palm Springs and surrounding areas. Since its inception, the District has been governed by a five-member board elected by the residents of the communities within its boundaries.

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A diagram of the existing District Boundaries is attached as **Exhibit 1.2** to this Application.

Originally, Desert Hospital was constructed as a single building with 33 beds on 8 acres on the grounds of the El Mirador Hotel. The District purchased the entire hotel property in the early 1970s and over the next few decades transformed the hotel site into a modern, comprehensive healthcare facility - Desert Hospital, now known as Desert Regional Medical Center.

In 1986, the hospital was leased to Desert Hospital Corporation, a not-for-profit organization formed by local residents to operate the hospital. The Desert Hospital Foundation, founded in 1967, became a subsidiary of Desert Hospital Corporation and was governed by a community board. The Foundation operated a number of important local healthcare services including Hospice, Desert Health Car (free door-to-door transportation service to and from non-emergency medical and health appointments) and The Smile Factory (a mobile dental clinic offering free dental screenings and treatment to elementary schoolchildren), which were developed in 1997 after the hospital lease with Tenet.

In the 1990s, the hospital struggled financially in an increasingly complex and competitive healthcare environment. In 1997, after careful consideration and a lengthy public process, the District Board voted unanimously to enter into a lease of the hospital to Tenet Health Systems (Tenet) for 30 years. Desert Hospital District subsequently became Desert Healthcare District. Desert Healthcare Foundation was absorbed by the District and its programs were spun off in 2005 into existing community-based organizations.

Today, with an annual operating budget of roughly $7.21 million, the District Board pursues its mission to promote good health for the District's residents through community health initiatives, providing grants of over $3 million annually, and by serving as good stewards in protecting and enhancing the District's assets. The District's grant funding is linked to the fulfillment of a comprehensive strategic plan, which focuses on enhancing and optimizing the health of District residents. Additional income is derived from property taxes, medical office building leases, interest on investments, and grants and contributions from other public and private sources.

Oversight of the 1997 lease with Tenet of Desert Regional in Palm Springs is an essential component of the District's mission to protect and enhance its assets. Over the last 20 years, Tenet has invested over $200 million in the hospital, including capital upgrades and improvements in technology and equipment. Because Tenet is a for-profit corporation, Desert Regional has paid over $44 million in property and sales tax and invested $7 million in sponsorships to various community organizations.

As a 385-bed, acute-care hospital, Desert Regional provides comprehensive medical care to residents throughout the Coachella Valley. The hospital has the only designated trauma center serving patients across an 8,000-square-mile region from the San Gorgonio Pass to the Arizona border, as well as the Coachella Valley's only neonatal intensive care unit. The Institute of Clinical Orthopedics and Neurosciences at Desert Regional features advanced brain and spine

care treatment and rehabilitation. Also housed at Desert Regional is an expanded, Comprehensive Stroke Center, which includes new technology and a new medical fellowship program. Desert Regional also recently opened a new state-of the-art Linear Accelerator for Radiation Therapy in Cancer Treatment and has the Coachella Valley's only Joint Commission-certified program in hip and knee replacement. Desert Regional's Advanced Congestive Heart Failure Program is the only robotic system for the treatment of atrial fibrillation and other heart disorders in the Coachella Valley.

Other serious health illnesses are addressed at Desert Regional through the Comprehensive Cancer Center, El Mirador Imaging Center, Pulmonary Laboratory and Center for Weight Management, as well as inpatient and outpatient rehabilitation services. An outpatient Surgery Center is also housed in the El Mirador Medical Plaza.

II. ANNEXED AREA, DEMOGRAPHICS, AND GROWTH PROJECTIONS

In accordance with AB 2414, the area proposed to be annexed to the District (Annexed Area) includes the cities of Palm Desert, Indian Wells, La Quinta, Indio and Coachella, the communities of Bermuda Dunes, Mecca, Thermal, Oasis, North Shore and Vista Santa Rosa and unincorporated County areas. The District's Application proposes a 1,760 square-mile area that would extend the eastern boundary of the District. For simplicity, the Annexation Application is based on the boundaries of Desert Sands Unified School District and Coachella Valley Unified School District to the border between Riverside and Imperial Counties to the south. These currently existing and known geographic divides encompass all of the communities required by AB 2414 and provide an appropriate basis for the expanded District.

A diagram of the proposed Annexed Area, which includes the school district boundaries, is attached as **Exhibits 2.1 & 2.2** to this Application.

A legal description of the proposed Annexed Area was prepared by MSA Consultants, Inc. on November 21, 2016, and has been converted to a PDF file for transmittal with this application.

2.1 Demographics

The Annexed Area has a population of approximately 240,000 residents, many of whom are low-income; some are undocumented. They face serious environmental hazards, such as drinking water contamination, pesticide exposure, inferior housing and poor air quality. The health disparities in the Eastern Coachella Valley compared to the Western area are significant, particularly when it comes to access to healthcare. The doctor-to-resident ratio is more than four times below the federally recommended level. Some Eastern Coachella Valley residents must travel 30 minutes for emergency medical care. Residents of this area are more likely to be uninsured compared with the rest of the state, have a higher incidence of obesity, diabetes and childhood asthma, and are less likely to receive dental care and routine medical screenings than those in the Western part of the Valley. A primary goal of AB 2414 in expanding the District is

to improve access to health care programs and services in the Eastern Coachella Valley by narrowing the disparities that exist between the Eastern and Western sides of the Valley.

Demographic information relating to the current District territory and the proposed Annexed Area, which was generated from the GIS boundaries of the two areas prepared by the District's civil engineering consultant, is attached as **Exhibit 2.3** to this Application. The information is divided into Population and Households (Figure 1), Age Comparisons (Figure 2) and Income Bracket Comparisons (Figure 3). The source for this data is ESRI Business Analyst Online. The data reflects estimates of the 2010 Census, and estimates of the 2016 and 2021 resident population.

Figure 1 presents estimates of the permanent population and households in the two areas. Of particular note, despite having approximately 8 percent <u>fewer</u> households, the population of the Annexed Area is nearly 17 percent <u>greater</u> than the District territory due to larger household sizes.

Figure 2 illustrates that Annexed Area households are not only larger but significantly younger, with a median age of 35.6 compared to 47 in the current District boundaries, making the median age more than 24 percent lower than the current District territory. The Annexed Area includes significantly more residents under the age of 30.

Finally, the demographic data indicates that the Annexed Area is somewhat poorer than the current District resident population. As shown in Figure 3, the larger household sizes do indicate that the Annexed Area residents have higher wealth per household, but once adjusted for household size, the per capita income of Annexation Area residents is approximately 12 percent lower than the District territory. Still, the percentage of the population without medical insurance is nearly identical in the District territory and in the Annexed Area.

2.2 Growth Projections in the Annexed Area

The population for the District's proposed service area is projected to experience moderate growth over the next 10 years.

The Annexed Area's population age cohort 65 years and older is projected to grow at a rapid compound annual rate (2.4 percent). As the population ages, the community and its provider organizations are likely to experience an increased demand for services such as internal medicine, cardiovascular services, gastroenterology, neurosciences, oncology, orthopedics, pulmonary medicine and urology, and see a greater need for chronic disease management.

The population age cohort 15 to 44 years overall, and for those who are female, is projected to grow at moderate rates over the next 10 years. This implies that the demand for elective sub-specialty care and obstetrics will continue to grow in the Annexed Area for the duration of the projection period.

The population age cohort 0 to 14 is projected to increase slowly over the next 10 years. As a result, demand for inpatient and outpatient pediatric services will continue to exist in the Annexed Area over the 10-year projection period.

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

A large proportion of household incomes in the Annexed Area are estimated to be below $50,000 in CY 2016 (52.6 percent). During this same time period, the service area is expected to have lower median and average household incomes compared to the State. It is likely that a large portion of the service area population is covered by Medi-Cal or the Affordable Care Act, providing free or subsidized health insurance for individuals and families earning up to 400 percent of the Federal Poverty Level.

The entire service area is located in Riverside County. In general, this geographic region has higher mortality rates from cancer, Alzheimer's disease, coronary heart disease, unintentional injuries, stroke, suicide, motor vehicle accidents, and for infants when compared to the State overall. Further, the service area also has higher rates of cancer (e.g. colorectal, lung and bronchus, prostate), obesity, diabetes, high blood pressure, smoking and low-birth- weight infants.

This implies an increased demand for services such as primary care, cardiovascular, neurosciences, oncology, general surgery, orthopedics, pulmonary medicine, urology, obstetrics and perinatology, neonatology, pediatrics and chronic disease management.

The Health Assessment Resource Center's 2013 "Coachella Valley Community Health Monitor Report" further illustrates that portions of the District's service area population are underserved, and opportunities exist to improve the overall health of the community with a focus on wellness and prevention through increased access to coordinated primary and specialty care services.

III. CURRENT FINANCIAL RESOURCES

3.1 Annual Revenue

The District's operating revenue was $7.21 million in fiscal year 2015-16. Based on an estimated district population of 206,311, this equals approximately $35 per capita.

District revenue is generally comprised of:

- Property taxes received from the County of Riverside for the fiscal year ended June 30, 2016, were $5,794,197. The property taxes are comprised of property taxes received

from District residents and Redevelopment Apportionment Funds. Of the $5,794,197 for the year ended June 30, 2016, the Redevelopment Apportionment Funds were $2,121,562. It is presently unknown how long the Redevelopment Apportionment will continue.

- Rental income from the Las Palmas Medical Plaza, which is owned and managed by the District, generated $1,141,312 for the fiscal year ended June 30, 2016.

- Other income from investments totaled $278,566.

Total revenue for the fiscal year ended June 30, 2016, is $7,214,075.

3.2. Assets

The following facilities are owned by the District:

- Desert Regional Medical Center (including El Mirador Medical Plaza, with imaging, outpatient surgery and cancer centers)
- Las Palmas Medical Plaza
- Desert Healthcare District Wellness Park

3.3. Reserves

Through the stewardship of the District Board, the District has been able to establish a Facility Replacement Reserve Fund with a current balance of almost $58 million. This fund is committed to insuring that the District can meet its legal obligations to Tenet upon the expiration or earlier termination of the 1997 lease or in the event the District needs to take over operations of Desert Regional.

While the District is no longer responsible for operating the hospital, the hospital is still owned by the District, and is its most important asset serving the community. Pursuant to the 1997 lease, the District Board retains significant oversight responsibilities. In fact, two District Board members sit on the hospital's Governing Board. Further, the District must ensure that Tenet maintains the hospital in good condition and that the hospital has appropriate accreditations, valid licenses and adequate insurance. Keeping the hospital in good condition includes compliance with California's Hospital Seismic Safety Law (SB 1953).

Pursuant to the terms of the 1997 lease, Tenet has a number of options to terminate or abandon the Lease prior to expiration, including an option (Section 3.2 of the Lease) to terminate if seismic upgrades exceed $12.5 million. In the event that Tenet elects to terminate or abandon the Lease, the District would be legally obligated to reimburse Tenet for prepaid rent (estimated to be $12.2 million as of January 2017) and pay the fair market value of unamortized improvements that Tenet has made to the hospital, which are estimated to be $47.7 million. To continue operations of Desert Regional, the District would need to finance a

minimum of 90 days working capital (approximately $90 million). In addition, significant capital improvements would be needed to comply with the 2030 seismic requirements. The hospital's North Wing and East Tower have been re-evaluated under HAZUS to SPC-2 ratings – giving the hospital until January 1, 2030, to be brought into compliance. It has been estimated that seismic compliance costs could exceed $100 million.

Consequently, while the Replacement Facility Reserve Fund provides a significant and important safeguard, it would provide only a portion of the funds and financing needed if Tenant abandons or terminates the Lease.

IV. HEALTH CARE RELATED SERVICES, INITIATIVES AND PROGRAMS SUPPORTED BY THE DISTRICT AND FOUNDATION

The District's primary mission and responsibility is to ensure that safe, high-quality hospital services are available and accessible to its residents. For the last year, the District has worked with Desert Regional to review its assessment of potential community need strategies and future facility plans. While the current hospital facility is compliant with seismic statutory requirements, by the end of the lease term in 2027, major renovations and/or replacement of some or all of the existing facilities may be required. Estimates have exceeded $100 million.

As part of its strategic and facility planning process, the District is working with Desert Regional to complete a Facilities Conditions Assessment (FCA), which will provide the foundation from which to develop corresponding infrastructure recommendations. Concurrent with the FCA investigation, the District will conduct an assessment of the hospital's existing conditions and facility operations, and potential scenarios to address seismic retrofit requirements, facility repairs, renovation and potential for expansion.

In addition to working to ensure access to direct healthcare services, the District and Foundation also focus on addressing community health and wellness through initiatives, grants and partnerships with other health care providers. The District and Foundation work with local non-profit and community-based organizations, schools, government agencies and foundations to improve the health and wellness of individuals, families, neighborhoods and communities throughout the service area. The District has taken a leadership role in efforts to address access to healthcare, medically underserved populations, a shortage of healthcare workers, health disparities, socioeconomic determinants of health and other public health issues.

Since 1998, the District has invested more than $66 million in initiatives, grants and programs serving and benefiting its residents.

One of the largest District initiatives in recent years has focused on improving access to primary care, particularly in underserved areas. The District was instrumental in helping make the UCR Medical School and Family Residency Program possible. The first group of family practice residents arrived at Desert Regional Medical Center in 2014.

Today there are residency programs in Internal Medicine, Neurosurgery and Emergency Medicine, with more in development. Ten family medicine physicians are now in place. Sixteen medical students are serving clinical rotations through their rotations at hospitals and community health centers. And, thanks to the District, a new 13,000-square foot UCR primary care clinic is open with physicians seeing hundreds of patients, regardless of ability to pay.

District funding has also helped create a number of new and expanded clinics to increase access to care, including dental and family care clinics in Desert Hot Springs, Cathedral City and Palm Springs. The number of dental providers who accept Medi-Cal and new patients has doubled. The District has also provided funding to more than double the size of the Borrego family care clinic in Cathedral City and add mobile clinic outreach to remote areas to serve those most in need.

The Desert Healthcare Foundation is an important partner in implementing programs to promote access to care. The Foundation has been particularly successful in identifying gaps and working with community partners to develop programs and services to address community health needs and leverage resources to increase both reach and impact.

More than three decades ago, the Foundation launched a free breast screening program, now operated by the Desert Cancer Foundation. The Foundation also created the Smile Factory mobile dental clinic that visits local schools to provide free and reduced-cost dental screening and treatment, now operated by Borrego Health. With funding from The California Wellness Foundation, the Foundation created the Health Assessment Resource Center (HARC) to launch the triennial community health survey to identify health status and priority needs. The District continues as its major funder.

An overview of District- and Foundation-sponsored health initiatives and programs are included on the attached **Exhibit 4.1,** Community Investment in Health and Well Being.

V. POTENTIAL PROGRAM AND SERVICES TO BE PROVIDED

While AB 2414 does not specify which types of services the District is to provide, the Local Health Care District Law allows significant flexibility for healthcare districts to provide and support a variety of health-related facilities, services and programs.

Exhibit 5.1 features a series of maps including: portions of the geographic region that are designated by the Federal Government as a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA), and healthcare facilities located within the region by facility type (e.g. hospitals, skilled nursing facilities, ambulatory surgery centers, imaging centers, health clinics and urgent care centers).

Going forward, these baseline impressions from strategic, facilities, operational, demographic, and market analysis perspectives will continue to be reviewed and considered. Ongoing analysis, including utilization projections, will inform decisions regarding future facility needs and Strategic Facility Master Plan options and projects. As options are developed, high-level schedules and cost estimates will be prepared to assist in the evaluation of the options relative to capital availability. Determining the right size, location and configuration of future hospital services will be a key focus of District planning efforts.

Developing scenarios to ensure the right number and mix of medical/surgical beds, the number, type and location of outpatient clinics, and other facilities needed to serve District residents in the future will be critically important from a capital, efficiency and community need perspective. With healthcare reform impacting reimbursement models and overall incentive structures, the District must also plan for a greater number of non-urgent services located outside of the hospital for a more cost-effective environment.

In implementing the intent of AB 2414 to address the significant barriers preventing access to healthcare providers and services for the residents in the Eastern Coachella Valley, the District, with sufficient funding, could provide grants, programs and services to the residents in the Annexed Areas that are comparable to those being provided to the residents in its current boundaries.

Key components to making decisions for specific services for the annexation area will be assessment, planning, implementation and evaluation.

As a part of the District's ongoing strategic planning efforts, the District regularly reviews and utilizes a wide range of information about the communities it serves. The District is currently involved in a due diligence process which will include a series of workshops to review data, information and market analysis reports to assess, evaluate and plan for future health needs, including accommodating the Annexed Area in the assessment phase.

As a starting point in assessing needs for the Annexed Area, the District will review existing demographic, market and health needs assessment reports which have been conducted for the area. A sample of recent studies is included as **Exhibit 5.2** to this Application. These recent studies will help inform the process for the District, working in consultation with providers and community stakeholders, to identify the precise scope, nature and level of healthcare services that may be provided in the Annexation Area.

Engaging the broader community in the process will be essential. Community input will help to determine the needs of the community and the community assets available to address those needs. Collecting community input on an ongoing basis will also allow the District to directly connect with specific populations in the Annexed Area, including disenfranchised, disadvantaged or minority and special needs populations. Community outreach and public engagement will not only inform and improve eventual plans and strategies, but will also lead to successful collaborations in implementation.

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Because services change depending on the finances available and priorities identified by the community and District Board, it is not possible to list exactly which programs and services will be available in the Annexed Area. However, in accordance with AB 2414, a successful annexation will have a newly constituted board including representatives from the Eastern Coachella Valley who will set priorities and oversee the District's budget. Development of a comprehensive needs analysis and priority setting with public input and participation will ensure resources are allocated for services and programs similar to those described in Article IV above. A few examples of future programs and services (pursuant to the California Health & Safety Code Section 32121) include, but are not limited to, the following:

- Strategic plan for health and wellness initiatives
- Free and low-cost medical and dental clinics
- Mental health counseling and related services
- Drug and alcohol treatment
- Food distribution programs
- Financial support and case management for families with special needs children
- Free rehabilitation for stroke patients
- Health assessment surveys that inform future programs and services
- New and expanded inpatient and outpatient facilities

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

VI. FINANCING OPPORTUNITIES AND CONSTRAINTS

This fiscal section explores the full extent of financing options and constraints that await an expanded district as it works to address future health needs for the entire district. None of the financing options are mutually exclusive and a combination of funding could be considered (e.g. some negotiated share of the current property tax in the expansion area redirected to the District, plus a parcel tax to make up the difference). The potential tax levels are generally based on the amount of funding which would be needed to and would be comparable to the programs and services provided in the current District boundaries.

Figure 6.1 (below) presents a forecast of Annexed Area revenue based on a presumption of 1.37 percent annual population growth rate and a 2.5 percent annual increase in costs. Based on the same per-capita rate in the current District boundaries of approximately $35 per person, the District would need approximately $9 million in operating revenues in fiscal year 2018-2019 from the Annexed Area to generate a comparable level of services given a population of 240,000 residents.

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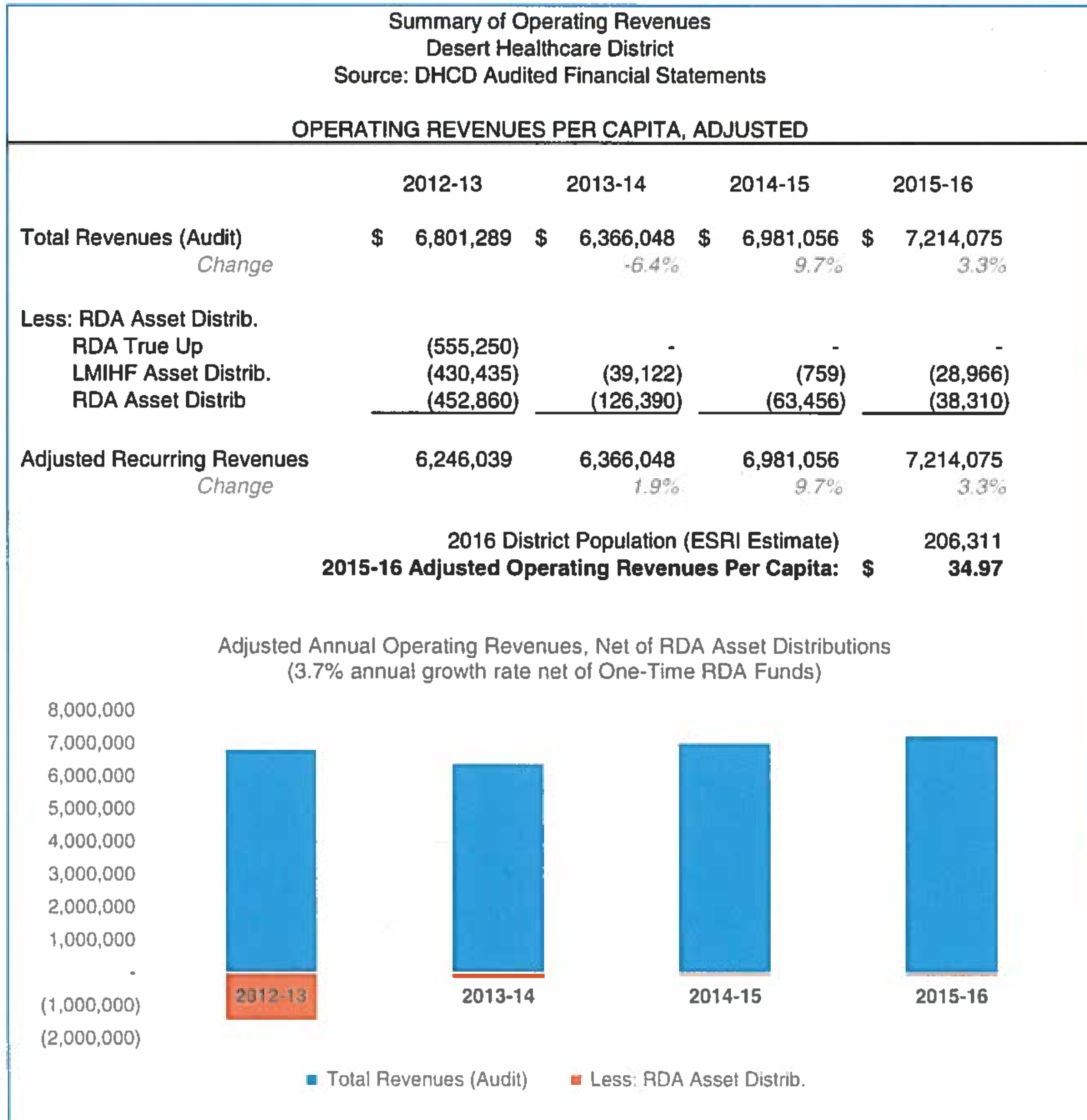
Figure 6.1: Projected Annexation Area Healthcare Revenue Needs



Summary of Operating Revenues
Desert Healthcare District
Source: DHCD Audited Financial Statements

OPERATING REVENUES PER CAPITA, ADJUSTED

	2012-13	2013-14	2014-15	2015-16
Total Revenues (Audit)	$ 6,801,289	$ 6,366,048	$ 6,981,056	$ 7,214,075
Change		-6.4%	9.7%	3.3%
Less: RDA Asset Distrib.				
RDA True Up	(555,250)	-	-	-
LMIHF Asset Distrib.	(430,435)	(39,122)	(759)	(28,966)
RDA Asset Distrib	(452,860)	(126,390)	(63,456)	(38,310)
Adjusted Recurring Revenues	6,246,039	6,366,048	6,981,056	7,214,075
Change		1.9%	9.7%	3.3%

2016 District Population (ESRI Estimate)	206,311
2015-16 Adjusted Operating Revenues Per Capita:	**$ 34.97**

At this time, the District is evaluating all options, consistent with AB 2414. As such, the operational revenue financing options considered, include, but are not limited to, the following:

- Voluntary Dedication of Existing General Fund Taxes by City/County, With Possible Voter Advisory Measure
- Community Facilities District (CFD)
- Joint Powers Authority (JPA)

- Parcel Tax
- Tenet Hospital Lease Income

6.1 Voluntary Dedication of Existing General Fund Taxes by City/County, Including a Voter Advisory Measure

The District currently receives approximately 80 percent of its operating revenues from property taxes collected within the District territory. There is no such levy in place in the Annexed Area.

To estimate the approximate amount of the general (1 percent) tax levy that would be necessary to generate approximately the same amount of revenue per capita in the Annexation Area compared to the current District territory. **Figure 6.2** (below) illustrates that roughly 2.26 percent of the general property tax levy would need to be collected by the District to yield sufficient revenues based on the current $37 billion net assessed value of the Annexation Area. Because assessed values can grow at rates different than population and District healthcare costs, Figure 6.2 also shows a potential shortfall of revenues if assessed values grow by 2 percent annually compared to the projected population and inflation growth rate of nearly 3.8 percent.

The purpose of the annexation proposed by AB 2414 and the District is an extension of new services, rather than an assumption of existing services by the District. This could be accomplished by a voluntary dedication/negotiation of a property tax transfer from the County and/or the affected cities in the Annexation Area (Indian Wells, La Quinta, Indio and Coachella, as well as possibly portions of Palm Desert). Should the District favor this approach, in order to capture and clearly communicate the support of the Annexed Area and the residents' dedication of property taxes, the annexation could be conditioned upon a favorable vote for an advisory measure to dedicate some of their taxes currently allocated to affected local agencies and the County to fund District-provided healthcare services in the Annexed Area.

In this instance, should negotiations on the voluntary contribution of taxes from these entities to the District for healthcare services in the Annexation Area not be successful, the District could pursue mediation with the cities and County to attempt a resolution and meet the conditions of expansion.

Figure 6.2: Share of Annexation Area Property Taxes for Extending Services

Annexation Area Fiscal Model
Desert Healthcare District

POSSIBLE SHARE OF PROPERTY TAX LEVY

2016-17 Assessed Value (AV) of Annexation Area	$	37,139,267,453
2016-17 Revenue Need of Annexation Area (if Annexed)		8,410,000
Derived Share of 1% Property Tax Levy		2.26445%

Projected Property Tax Revenues if Part of Basic 1% Levy

	Year	Projected AV @ 2%	1% General Levy	Revenue 2.26445% Tax Share	Costs Projected Needs (Costs)	Favorable/ (Unfavorable)
	2016-17	$ 37,139,267,453	$ 371,392,675			
	2017-18	37,882,052,802	378,820,528			
1	2018-19	38,639,693,858	386,396,939	$ 8,749,764	$ 9,080,000	$ (330,236)
2	2019-20	39,412,487,735	394,124,877	8,924,759	9,430,000	(505,241)
3	2020-21	40,200,737,490	402,007,375	9,103,254	9,800,000	(696,746)
4	2021-22	41,004,752,240	410,047,522	9,285,320	10,190,000	(904,680)
5	2022-23	41,824,847,285	418,248,473	9,471,026	10,580,000	(1,108,974)
6	2023-24	42,661,344,230	426,613,442	9,660,446	11,000,000	(1,339,554)
7	2024-25	43,514,571,115	435,145,711	9,853,655	11,430,000	(1,576,345)
8	2025-26	44,384,862,537	443,848,625	10,050,729	11,870,000	(1,819,271)
9	2026-27	45,272,559,788	452,725,598	10,251,743	12,330,000	(2,078,257)
10	2027-28	46,178,010,984	461,780,110	10,456,778	12,820,000	(2,363,222)

6.2 Community Facilities Districts (CFD)

Community facilities districts (also known as Mello-Roos districts) are a financing tool that allows for facilities and some services to be financed by the district. However, the law does not currently allow the provision of healthcare services, aside from ambulatory or paramedic services, to be financed with CFDs.

6.3 Joint Powers Authority (JPA)

Some healthcare districts have formed JPAs with other public agencies to expand or enhance services. In 1996, the City of Calexico and Heffernan Memorial Healthcare District created a joint powers authority which was funded by a portion of the city's sales tax revenues for a 10-year period. From a fiscal perspective, this sharing enhanced the funding available to Heffernan MHD for several years, but in 2006 the city's financial obligations terminated and the JPA was dissolved in 2016.

Under a JPA model, the District could provide services throughout the Coachella Valley either by:

1) Creating a JPA with the Annexation Area member cities and County, or
2) Dissolving and reorganizing as a Valley-wide JPA with all Coachella Valley cities and the local unincorporated communities.
3) Partnering with an existing JPA (e.g., Coachella Valley Association of Governments), including the participation of tribal nations.

Under the first option, the District projected the approximate amount of additional revenue that would need to be raised, assuming a sales tax increase among only the four cities wholly within the Annexed Area[1] (Indian Wells, La Quinta, Indio and Coachella). The District would continue to collect property taxes from its existing share of the general tax levy within the District territory. It is noted that two of the four cities (La Quinta and Indio) just this November approved 1 percent increases in their local sales taxes for general purposes. A second approach would be more complex, wherein the JPA would replace the District, with all member cities (and the County) either agreeing to increase the sales tax rate at an overall lower rate and the District's share of the existing property tax levy being reapportioned to the respective cities and County within the District territory.

Both approaches may have several legal, governance and practical challenges which would need to be evaluated by the District. Setting aside these challenges, the District has estimated that a 0.50 increase in the Annexed Area may be necessary to reach sufficient funding for comparable health care services or a 0.25 increase in Valley-wide sales taxes if the entire District reorganized as a JPA reliant on these new taxes. **Figure 6.3** (below) illustrates a hypothetical sales tax increase to extend services into the Annexed Area.

[1] The unincorporated county areas were left out of our analysis because such taxable sales data for the Eastern Coachella Valley was not available.

Figure 6.3: Hypothetical Sales Tax Increase to Extend Services into Annexed Area

Annexation Area Fiscal Model
Desert Healthcare District

POSSIBLE SALES TAX RATE WITH JOINT POWERS AUTHORITY

Jurisdiction	2014 Taxable Sales (000's) /	Current Tax Rate /2	Illustrative Increase for JPA	Total Potential Rate w/ JPA	Increase in Rate
Cathedral City	753,153	9.000%	0.000%	9.000%	0%
Coachella	**330,324**	**9.000%**	**0.500%**	**9.500%**	**6%**
Desert Hot Springs	133,906	8.000%	0.000%	8.000%	0%
Indian Wells	**98,669**	**8.000%**	**0.500%**	**8.500%**	**6%**
Indio	**882,079**	**9.000%**	**0.500%**	**9.500%**	**6%**
La Quinta	**744,038**	**9.000%**	**0.500%**	**9.500%**	**6%**
Palm Desert	1,594,753	8.000%	0.000%	8.000%	0%
Palm Springs	1,036,541	9.000%	0.000%	9.000%	0%
Rancho Mirage	423,095	8.000%	0.000%	8.000%	0%
Unincorporated /3	n/a	n/a	n/a	n/a	n/a

Total with 0.50% Rate Increase in East Valley Cities	$ 10,275,550
Total with 0.25% Rate Increas in All Valley Cities /4	$ 14,991,395

1/ Source: State Board of Equalization, 2014
2/ Source: State Board of Equalization, Preliminary November 2016 election results
3/ Data for unincorporated areas of Coachella Valley not published by State Board of Equalization and is excluded from this forecast for illustrative purposes.
4/ Assumes District dissolved and forms JPA in entire Valley, with property taxes reverting to member cities/county in exchange for share of sales tax increase of 0.25% Valley-wide.

6.4 Parcel Tax

A number of healthcare districts rely on parcel taxes to generate funds when they do not collect sufficient property taxes and operating revenues. Parcel taxes are a type of special tax which require 2/3 voter approval and are then assessed on the property tax bills. Typically, tax exempt properties do not pay these taxes, but the measures can often create multiple types of exemptions and tiers based on land use and other factors.

Parcel taxes are levied by at least 12 healthcare districts in California to augment local funding, including the Palo Verde Healthcare District in Blythe (Riverside County) which levies a parcel tax of $32 per parcel in perpetuity. Rates and terms can vary, as shown in some of the examples listed below in **Figure 6.4**.

Figure 6.4: Select Parcel Taxes Levied by Other Health Care Districts

District	Bear Valley Community Healthcare District (San Bern. Co.)	San Bernardino Mountains Community Hospital District (San Bern. Co.)	Southern Humboldt Community Hospital District (Humboldt Co.)
Effective Date	July 1, 2015	1989	July 1, 2007
Sunset Date	June 30, 2025		June 30, 2018
Levy Rate(s)	$20/ unimproved $45/ improved	$80 per home $40 per vacant lot $200 per business	$125 per parcel

To illustrate the potential level of a parcel tax that could be assessed within the Annexed Area, the District prepared the following hypothetical estimate of a parcel tax in **Figure 6.5** (below). The levy rate and term should be evaluated further to consider potential exemptions, but based on the estimated 117,932 parcels located within the Annexation Area, a parcel tax of approximately $77 per parcel would be needed to meet initial operating revenue goals by 2018-19.

Figure 6.5: Possible Parcel Tax Rates in Annexation Area

Annexation Area Fiscal Model
Desert Healthcare District

POSSIBLE PARCEL TAX REVENUES

	Parcels	Potential Parcel Tax Rate/Parcel	Potential Parcel Tax Total Taxes
Parcels by Land Use Category /1			
Improved			
Agriculture	58	$ -	$ -
Commercial	4,066	100	406,600
Residential	81,174	100	8,117,400
Miscellaneous	2,626	25	65,650
Subtotal	87,924	98	8,589,650
Unimproved			
Agriculture	4,099	-	-
Commercial	1,357	25	33,925
Residential	18,309	25	457,725
Miscellaneous	1,993	-	-
Subtotal	25,758	19	491,650
Unknown	4,250	-	-
Total	117,932	$ 77	$ 9,081,300

1/ Source: Riverside County Assessment Roll

Parcel taxes are generally not designed with automatic inflationary adjustments, something that would need to be evaluated if the District were concerned about the ability to meet the increasing costs for services in the Annexation Area.

6.5 Tenet Hospital Lease Income

The District has an existing 30-year lease with Tenet Health Systems (Tenet) of Desert Regional, which expires in May 2027. In 1997, Tenet paid the District prepaid rent of approximately $110 million, which consisted of approximately $95 million to defease and pay off outstanding hospital indebtedness and approximately $15 million in cash.

While it could raise legal issues to use the existing Facilities Replacement Reserve Fund for health related programs and services in the Annexed Area, Tenet has recently expressed interest in entering into a new lease that would extend the term of the public/private partnership relationship for an additional 30 years. In such event, and depending upon the timing, the new lease would likely require a favorable vote of residents in the existing District and residents in the Annexed Area if the annexation is completed. Moreover, a new lease with Tenet could open a number of scenarios to address acute care needs in the entire Valley, including the possibility of building a new hospital facility that would be more convenient to serve the entire expanded District.

6.6 Other Options for Capital Improvements and Facilities

This fiscal analysis was prepared for the purposes of determining how the District may fund immediate and recurring operational costs associated with providing grants for programs and services, and the administration of health care to the Annexed Area. Separate from these revenue needs, the District expects that annexation may impact Desert Regional Medical Center as well as trigger the need for additional healthcare facilities serving the Annexed Area. The revenue options outlined above focus primarily on potential means for funding recurring services. But there are additional options that could be available to the District, often in collaboration with other local agencies, to raise capital for expanded or new facilities both inside the District territory and serving the Annexation Area. In addition to the above financing tools for capital projects, other possible financing options include:

- General Obligation (GO) bonds - a type of capital financing issued by a government agency secured by any and all tax revenues.
- Enhanced Infrastructure Financing Districts and/or Community Revitalization Investment Areas - are two property tax increment financing tools to finance capital improvements by certain consenting public agencies, differing by where they may be employed.

- Public lease revenue bonds - differ from GO bonds in that they are secured by a specific revenue pledge and therefore do not expose the entire revenue stream of the government agency at risk. Lease revenue bonds are one such type of specific revenue pledge, but there may be others, including tax allocation bonds.
- Financing leases and certificates of participation - are alternatives to bond financing for public agencies. Under a lease financing, a public agency enters into a lease-leaseback with another agency who provides a lump sum lease payment in exchange for recurring leaseback payments from the public agency. A COP is generally a type of lease financing, though often involving multiple investors who share in the lease income.
- Conduit revenue bonds - a type of pass through financing issued by a government agency but secured by revenues from another nongovernmental source, such as project-based income for an economic development project.
- User fees - With a 2/3 voter approval, local agencies can impose user fees or taxes which may in turn be pledged as security for a revenue bond or pay for services.
- Grants and donations – grants and donations received from external sources.

The District does not anticipate any changes to its capital needs with the application for annexation, so we have not explored the feasibility of these financing options in this fiscal analysis.

VII. FORMATION, GOVERNANCE, NEXT STEPS AND PROCESS

Pursuant to AB 2414, governance for the entire expanded district is phased in if voters approve to expand the District. The interim phase will span 2018-2020. The permanent governance structure would become effective in 2020.

7.1. Formation

The District is required to file an annexation application with LAFCO on or before January 5, 2017. LAFCO is required to approve this application within 150 days. Thereafter, the funding for annexation will be presented to the voters of the Annexed Area at the next County-wide general election, which will be November 2018

7.2 Interim Governance – 2018-2020

If the voters approve expanding the District, 30 days after the expansion of the District (approximately December 2018), the then-existing Board of Directors of the District shall adopt a resolution to expand its board from five to seven members. This will be done without a petition or voter approval. The five-member Board of Directors is required to appoint two new

board members. Both new board members are required to be registered voters within the Annexed Area.

7.3 Permanent Governance – 2020 and Beyond

If the District is expanded, the District shall be divided into seven voting districts with representation in accordance with demographic, including population, and geographic factors of the entire area. The first district elections shall occur at the first election after January 1, 2020, which would be November 3, 2020.

7.4 Transition Considerations

As Desert Healthcare District expands its service area, connecting with new communities and serving new constituents, the District is committed to proactively planning to ensure that its communications goals, public engagement mechanisms and outreach strategies align with its evolving identity. The District will undertake comprehensive transition planning to build a foundation of inclusion that encourages broad public involvement across and throughout the expanded service area.

Residents throughout the District, both in the original and annexed areas, will be presented with fair and proportionate outreach, engagement and representation. Efforts will be undertaken to provide effective community education, program support and public participation throughout the expanded District boundaries. Communication will be provided in a culturally and linguistically competent manner, with consideration given to the language, cultural and other needs of all residents so that no group or demographic is left behind. All the communities served will be able to see themselves represented in the District's identity and engagement methods.

Desert Healthcare District welcomes this transition because it offers the opportunity to inform residents within the Annexed Area of the programs and services newly available to support their overall health and wellness, while also increasing the visibility, participation and involvement of residents in the area currently being served by the District.

7.5 District Outreach

The District benefits from an image that reflects its unique history of service, built and strengthened over nearly 70 years supporting health and wellness in the Coachella Valley. While the District's roles, responsibilities and assets have evolved over that time, its central commitment to promoting the good health of residents has not changed. The proposed annexation will be one of the most significant steps in the District's continued evolution, incorporating new communities with unique identities, strengths and needs.

To promote inclusion and involvement throughout the expanded service area, the District will develop a process that allows ongoing outreach to evolve to more completely represent its entire constituency, both new and old.

Outreach evolution will accomplish the following objectives:

- Increased awareness, ensuring that the District is widely recognized and its services understood among those it serves and regional stakeholders.
- Broad inclusiveness, aligning the District more completely with all the communities it serves, allowing residents of all types to see themselves in the District's identity and connect with the benefits it provides.
- Internal guidance, using the District brand and what it represents as a set of guiding principles to connect staff and program partners with the District mission and guide positive and successful interaction with the public.

The outreach evolution, which would take place immediately following approval of expansion, will consist of an ongoing public process to incorporate wide-ranging community input and priorities, and channel them into a representative identity that embodies aspects of the entire service area.

An inclusive outreach process is the platform from which all successful communication will launch.

7.6 Communication Plan

The District will develop and implement a strategic plan to align communications with the new identity of the District, the expanded communities it serves, and its providers and grantees. This plan will capitalize on the District's long legacy of success and further increase public awareness of its services, quality and value. The District recognizes the importance of lining up the communications strategy with the District's mission of promoting and improving health, ensuring that outreach efforts dovetail with and support broader District goals. The plan will focus and prioritize resource allocation by evaluating communication tools and efforts to maximize outreach efficiency and effectiveness.

A communications plan will include:

- Communication goals
- Key message identification
- Stakeholder analysis
- Brand deployment
- Internal communications strategies

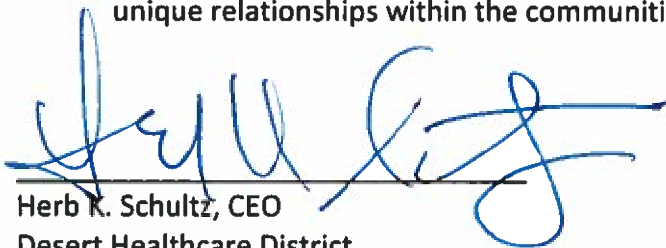
- External communications strategies
- Strategic resource allocation
- Long-term planning

7.7 Public Engagement

The District recognizes the importance of strong communication in meeting and exceeding expectations set by customers, community members and other stakeholders. The District is committed to proactively identifying and connecting with stakeholders and community groups. This is best done in presentations and forums that offer face-to-face communication with various groups and encourage feedback, in addition to other ways.

Other considerations:

- Ensure that messaging is presented in appropriate languages and tone for the audience. Inclusivity of all District residents should be the goal.
- Develop an annual advertising program and budget to support key initiatives and the District's role as a community partner.
- Create and strengthen partnerships with agencies that mutually support the District's goals, and ensure that these stories of shared success reach the general public and other partners.
- Design and implement targeted messaging strategies for the organization's many unique relationships within the communities it serves.



Herb K. Schultz, CEO
Desert Healthcare District

1/5/17
Date