CPMC Development Agreement
Planning Commission

Commission Questions & Staff Responses

Monitoring and Enforcement of the Development Agreement

E.1. How will the Development Agreement be monitored and enforced, and are there specific provisions for housing, workforce, and healthcare? (Borden; Wu)

Like all development agreements, the CPMC DA has provisions that outline the monitoring and enforcement for the DA generally as well as specific monitoring and enforcement mechanisms for the community benefits including healthcare and workforce. While monitoring responsibilities cross several departments, the Office of the City Attorney is charged with legal enforcement for alleged violations of the agreement. Any finding of non-compliance, whether by the Planning Department, Department of Public Health, or Office of Economic and Workforce Development, will be addressed through the City Attorney's Office. [See D.A. § 8]

Planning: The obligations in the DA as a whole are monitored by the Director of the Planning Department. The DA requires that CPMC submit an annual report to the Planning Director, outlining their compliance with the DA's obligations, including the Hospital Commitment (which requires that St. Luke's Hospital is constructed before the Cathedral Hill Hospital), the community benefits, and the reimbursement of City Costs. The Planning Director must review the submitted information and issue a Certificate of Compliance if CPMC is meeting their obligations. [See, D.A. § 8.2]

Healthcare: CPMC's healthcare obligations, including maintaining the baseline healthcare commitment, providing care for the 10,000 new Medi-Cal Managed Care Beneficiaries and the service provided at St. Luke's, will be monitored by the Director of the Department of Public Health. CPMC will provide an annual report to the DPH Director, who will review the information for compliance with the DA. The results of the Director's findings will be presented annually at the Health Commission. [See, D.A. § 8.2; Exhibit F § 14]

Workforce: CPMC's workforce provisions will be enforced through the existing First Source Hiring Program. CPMC's contractors and sub-contractors will submit hiring records to the Office of Economic & Workforce Development. Non-compliance with the hiring goals will result either in CPMC filling additional positions or in an enforcement action under First Source Hiring Program, section 83 of the Administrative Code. [See, Exhibit E § E]

Healthcare

HC.1. How was the $86 million in annual baseline healthcare determined? How does the amount of services provided under the baseline compare to the $100 million CPMC provided in 2010? (Borden; Antonini)

The $86 million baseline is a maintenance of effort by CPMC to continue to provide at least the same level of services to the poor and underserved in the future that they are providing currently. The $86 million baseline was determined by averaging the level of service CPMC

provided to the poor and underserved over the last three years ($76,928,000 in 2008; $80,294,000 in 2009 and $101,080,000 in 2010). These services are reported annually by CPMC, as required by state law in their "Community Benefit Report." Components of services to the poor and underserved include: 1) unreimbursed Medi-Cal expenses; 2) Charity Care (medical services provided to low-income patients at no-cost to the patient, including Healthy San Francisco participants); and 3) "Other Services to the Poor and Underserved." This last category includes unreimbursed costs for providing services to vulnerable populations, community wellness programs and health promotion and prevention services. CPMC also has the most control over spending for the third category of community benefits; both Medi-Cal and Charity Care are largely driven by patients seeking emergency care. [See, Exhibit F § 1(c)]

This baseline was created to ensure that all of the new commitments included in the CPMC DA would be provided in addition to (and not instead of) the services CPMC is already providing for low-income San Franciscans. As a result, almost all of the healthcare commitments described in the Healthcare Exhibit (Exhibit F) of the DA are in addition to providing this maintenance of effort.

It is also important to note that pursuant to federal law, CPMC will continue to accept all patients who come through their Emergency Rooms regardless of either the patient's ability to pay or whether CPMC has already fulfilled its obligation to provide $86 million of care.

HC.2. What is the relationship between CPMC's participation in Healthy San Francisco and their Charity Care obligations? (Sugaya)

Healthy San Francisco is not health insurance, but rather a program that provides affordable healthcare to uninsured San Francisco residents. Healthy San Francisco links primary care homes with hospitals to create a provider network. The provider network relies on the charity care obligations of hospitals to fulfill the hospital services component of that provider network.

As a condition of licensure in California, hospitals are required to provide free and discounted care to uninsured and underinsured patients with income at or below 350 percent of the federal poverty level, and CPMC provides free service to patients with incomes at or below 400 percent of the federal poverty level. State law does not set a minimum level of charity care that hospitals must provide. One way that hospitals in San Francisco meet their obligation to provide free care is by providing it within the coordinated care structure of the Healthy San Francisco program.

San Francisco hospitals provide charity care both within and outside of the Healthy San Francisco program. Within Healthy San Francisco, the hospitals' charity care commitments are leveraged in coordination with a primary care medical home to provide comprehensive health care services for participating uninsured San Franciscans. In addition, hospitals provide charity care to uninsured San Franciscans not participating in Healthy San Francisco. CPMC continues to be an active participant in Healthy San Francisco, providing hospital services to patients that select either North East Medical Services (NEMS) or Brown & Toland as their medical home. Under the terms of the Development Agreement, CPMC's

continued participation in Healthy San Francisco would contribute to the Baseline Charity Care Commitment.

HC.3. Why are there specific references to the Tenderloin in regards to clinics and other community benefits and not other communities? (Sugaya)

The Development Agreement would require CPMC to care for 10,000 of the 30,000 new Medi-Cal beneficiaries that are anticipated to be eligible in January 2014 as a result of Health Reform. Of the 10,000 new beneficiaries that CPMC will serve, at least 1,500 must be patients from a Tenderloin Medi-Cal managed care program.

The Tenderloin neighborhood is a neighborhood with significant health care needs and health disparities. When the Cathedral Hill campus opens, CPMC will be a new neighbor of this high need community. However, there are several reasons, beyond simply proximity, why the Tenderloin neighborhood is highlighted as a partner for CPMC in the care for a portion of the 10,000 new Medi-Cal beneficiaries CPMC will serve:

- CPMC's already has an existing partnership with North East Medical Services (NEMS) to care for Medi-Cal patients. And, under the Development Agreement, it is anticipated that 8,500 of the additional 10,000 new Medi-Cal beneficiaries that CPMC will serve will be through its existing partnership with NEMS.
- St. Luke's already provides care to a significant Medi-Cal population, many of whom reside in low-income neighborhoods closer to St. Luke's. The provision that requires CPMC to care for the 10,000 new Medi-Cal beneficiaries at Cathedral Hill was specifically designed with the intent to increase care for Medi-Cal patients at a hospital where their access is currently limited.
- Many of the individuals who will be newly eligible for Medi-Cal under Health Reform reside in the Tenderloin. Currently, low-income single adults who are between the ages of 18 and 64 are generally ineligible for Medi-Cal. To be eligible in this age category, individuals must also have children, be disabled, or have extraordinary health care costs. Health Reform will change this significantly. Beginning in 2014, all adult citizens and legal residents with incomes below 133% of the federal poverty level (which is about $14,500 annually for an individual or $24,700 annually for a family of 3) will be eligible for Medi-Cal regardless of their family or health status. Many of these low-income single adults reside in the Tenderloin neighborhood, in large part due to the prevalence of single room occupancy hotels (SROs), shelters, and other social services located in this neighborhood. As a result, the residents of this neighborhood will need access to Medi-Cal services beginning in 2014.
- There are a number of primary care clinics in the Tenderloin that participate in Medi-Cal. However, they need to form new and different partnerships in order to participate in the Medi-Cal managed care model once Health Reform is implemented. The Community Care Innovation Fund established under the Development Agreement allows for these clinic providers to build the capacity necessary to partner with CPMC to serve approximately 1,500 Tenderloin residents and a portion of the

remaining 20,000 new Medi-Cal patients that are expected under Health Reform but will not be cared for under this Development Agreement.

It is also important to note that other low-income San Francisco neighborhoods are specifically identified within the Community Care Innovation Fund and other parts of the CPMC DA. Specifically, the Innovation Fund designates funding to provide infrastructure support for community-based health and human service providers, with a specific focus on Tenderloin, Mission, Western Addition, South of Market, Bayview and Chinatown neighborhoods. Further, the DA requires that CPMC's Community Benefits Plan focus on low-income, underserved communities in these neighborhoods.

HC.4. How can the provisions of the Development Agreement change over time? (e.g., what is the process if Federal Healthcare Reform is repealed?) (Antonini)

In the event that there is a federal or state law that materially affects the City's ability to receive the public benefits described in the Development Agreement, the parties have agreed in the DA to a process that will substitute an alternative method to achieve the benefit. For example, if the Supreme Court overturns all or part of federal Health Reform in a ruling that makes it impossible for CPMC to provide care for 10,000 new Medi-Cal Managed Care Beneficiaries, the City and CPMC would meet to discuss alternative obligations for providing healthcare to that underserved population. [See D.A. § 5.6.4]

HC.5. Do the Centers of Excellence in Community and Senior Health require providing medical specialties? (Borden)

The Development Agreement specifies that CPMC shall open St. Luke's with the following medical specialties:

- Inpatient: cancer, cardiology, endocrinology, respiratory, neurology, gastroenterology, orthopedics, infectious disease, urology, general and vascular surgery, intensive care unit, labor & delivery, gynecology, special care nursery, telemedicine;
- Outpatient: internal medicine, ambulatory surgery, cardiology, diagnostic imaging, gastroenterology, laboratory services, obstetrics, orthopedics, hepatology, neurology, oncology, orthopedics, respiratory therapy, child development, retail pharmacy, lab services; and
- Urgent care.

CPMC will also continue to operate the St. Luke's Health Care Center, which provides outpatient OB-GYN, internal medicine and pediatric services to patients, many of whom are low income and are publicly-insured by Medi-Cal or Medicare.

CPMC will operate two new Centers of Excellence at the St. Luke's campus, as recommended by the Blue Ribbon Panel on St. Luke's. The Center of Excellence in Community Health will build on CPMC's existing HealthFirst Program and annually offer approximately 800 patients from St. Luke's Health Care Center access to a primary care medical home to support self-management of chronic illness. The Center will recruit and

train health workers from the community to work in an interdisciplinary care team setting, providing culturally competent and linguistically appropriate services. This Center will focus on outpatient services, will be responsive to community need, and will have a community advisory board to provide input into the operation of the Center.

The Center of Excellence in Senior Health will be based upon the Hospital Elder Life Program ("HELP") and annually provide care to approximately 600 seniors over age 70. HELP, which focuses on inpatient services, is a targeted program of care for hospitalized older adults designed to prevent or decrease the severity of delirium and increase or maintain function, improve hospital care, maximize the patient's independence at discharge, assist the patient with transition from hospital to home, prevent unplanned readmission, and prevent the hazards of hospitalization that sometimes lead to a cascade in decline. The Center will also provide culturally competent and linguistically appropriate services.

HC.6. Is a 20 year commitment on St. Luke's appropriate? (Miguel; Sugaya)

The City's top priority in negotiating the Development Agreement was ensuring the long-term viability of St. Luke's. The City addressed this concern through several provisions of the Development Agreement. In addition to the commitment to operate St. Luke's for 20 years from the opening of the new hospital, CPMC has also committed to several obligations related to operating the hospital. These provisions include providing specific medical specialties and operating Centers of Excellence in Community and Senior Health. It is the intention and expectation of both CPMC and the City that with a new, state of the art facility and changes to the services provided, St. Luke's will become increasingly financially secure, and CPMC will continue to operate the hospital well beyond the agreed upon 20 years.

The 20 year operating commitment included in the Development Agreement is consistent with the recommendations of the both the Blue Ribbon Panel and with the Health Commission's Resolution 02-10 on CPMC's Institutional Master Plan (IMP).

CPMC's agreement to operate St. Luke's for 20 years is an unprecedented commitment by a medical institution in any development agreement. Previous development agreements entered into by the City have not included obligations that the project sponsor commit to operate facilities, unless the City owned the property. In addition, the Stanford University Medical Center Development Agreement did not include any operational obligations. In the proposed CPMC DA, CPMC has not only agreed to construct a new, $270 million hospital on the St. Luke's Campus, but they have also made an unprecedented commitment to operate the new hospital, regardless of its individual financial performance, for 20 years.

HC.7. What has CPMC's Operating Margin been for the last 10 years? How did the parties come to agreement on this issue? Which entities are included in calculating the Op. Margin? (Borden)

Staff offered to include a "catastrophic out" in some form in return for a 20-year operating commitment for St. Luke's. After discussions with outside consultants to the City as well as with CPMC, both parties agreed that operating margin was the appropriate metric to use.

CPMC's Operating Margin is used in the Development Agreement as a threshold for determining whether CPMC has the contractual obligation to continue to operate St. Luke's Hospital. If CPMC's financial position deteriorates but remains above the threshold, CPMC would be forced to look first at improving performance at their other campuses, including Cathedral Hill, before closing St. Luke's.

The CPMC DA specifically requires that CPMC maintain operating St. Luke's Hospital for 20 years unless their Operating Margin falls below 1% at the close of two consecutive fiscal years. Operating Margin is a metric used in financial accounting to describe the financial health of an organization. The relationship between Operating Margin and credit ratings is illustrated by the median levels indicated in Moody's August 2011 Health Medians Report. The report notes that the fiscal year 2010 median Operating Margin for Freestanding Hospitals and Single State Healthcare Systems rated in the "Aa" category was 4.5%, and was 1% for entities in the Baa category. An organization's credit rating is important because a higher rated organization can access capital more easily and with lower interest rates than a lower rated organization.

The Operating Margin, as defined in the Development Agreement, is calculated by including all of CPMC's operations in San Francisco. It is important to keep in mind that the financial viability of St. Luke's is not the test for the operating obligation, but rather the test examines the financial performance of the entire, integrated CPMC system. This includes all of CPMC's hospitals (Davies, Pacific, California, St. Luke's, and when open, Cathedral Hill). It also includes the CPMC Research Institute, CPMC Foundation, Presidio Surgery Center, California Pacific Advanced Imaging, and San Francisco Endoscopy Center. [See, Exhibit F § 1.c]

CPMC's Operating Margin for the last 10 years is reported below. Please note, St. Luke's joined the CPMC system in 2007, and it not included in the calculations for 2001 to 2006. Operating Margin is calculated by dividing "Operating Revenue" by "Total Operating Revenue."

	2001	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**	**2010**
Total Operating Revenue	$592	$694	$750	$835	$900	$959	$1,154	$1,224	$1,290	$1,311
Operating Income	$81	$135	$120	$137	$99	$140	$103	$106	$144	$168
Operating Margin	**13.7%**	**19.5%**	**16.0%**	**16.4%**	**11.0%**	**14.6%**	**8.9%**	**8.7%**	**11.2%**	**12.8%**

After consulting with outside expertise, staff is confident that operating margin is the appropriate measure to use here and is also confident that the adverse financial consequences to CPMC of a falling Operating Margin, including the reduced ability to access capital, mean that CPMC would not purposefully alter their Operating Margin for the sole purpose of being able to close St. Luke's Hospital.

HC.8. Can St. Luke's achieve operational efficiency and profitability with 80 beds? (Moore)

St. Luke's will operate not on its own, but as part of an overall system of care provided by CPMC on three campuses in San Francisco. Many of the proposals within the development agreement are aimed at integrating these campuses to provide patients at every campus with access to the services they need no matter on which campus it is best provided. By making St. Luke's an integral part of CPMC, the City does not have to worry if it is financially viable on its own. As Dr. Mitchell Katz, the former Director of Health, noted in a December 28, 2010 letter to the Planning Commission,

> "Highly specialized services cannot exist in all areas of a city because there are not enough specialists and because to be very good at something you have to do a lot of it. The delivery of babies is a good example. Healthy women can give birth safely without a lot of special equipment and specialized physicians. They can give birth at small community hospitals or even at home. But some women who are pregnant have or develop during pregnancy serious medical complications. In cases like this, it is critical to have highly trained specialists with the appropriate equipment. This might mean not only an obstetrician experienced in high-risk deliveries but also a NICU for the sickest of babies. There are not enough high-risk deliveries in San Francisco for every hospital to maintain competence in high-risk deliveries and in the NICU's capable of caring for the sickest babies.
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> The answer to this question often leads to another sensible question. If you need to maintain high volumes of specialized services in order to maintain competence in a particular field, why not develop specialized fields of care at different hospitals? For example, why not place a specialized high-risk obstetrical service at the St. Luke's campus with NICU and not put it at the Van Ness campus. The answer is that when people are very sick they may need services from people who have different skills than those in the service line. To continue with the example of a pregnant woman, in a case where a mother's life might be in danger, you would want not only the best high-risk obstetrician and neonatologist for the child, but also the anesthesiologist who knows best how to intubate a woman with a particular condition (e.g., heart disease), or a specialist internist (e.g., cardiologist). This is the reason that across the nation large hospitals (e.g., Mayo Clinic) have developed a broad range of specialty services all in one place. It is also why the consensus of hospital planners is that you should have community hospitals that are widely accessible and connected to a single specialty hospital where people who are too sick to be cared for at the community hospital can be rapidly transferred to."

For more detailed responses regarding the adequacy of the number of proposed single-patient room beds please see Health Care Major Response HC-1. Information regarding the location, size and scope of services at St. Luke's, Cathedral Hill and Davies campus HC-2 may be found in Healthcare Major Response HC-2.

HC.9. What are St. Luke's historic bed occupancy rates and the results of the Camden Report?

Currently, St. Luke's is licensed for 229 beds in 133 "rooms." Most rooms are licensed for more than one bed, of the 229 total licensed beds, 150 beds are general acute care and 79 are skilled nursing or subacute beds. The 80-beds planned for the new St. Luke's Hospital will all be general acute care beds.

General Acute Beds. The 80 general acute beds proposed to be provided at the St. Luke's Hospital would provide sufficient capacity to meet the current demand as well as projected growth. The Camden Study, prepared at the request of the Blue Ribbon Panel, estimated a patient volume of 69 patients in 2020.

Skilled Nursing Beds. Currently, there are 79 licensed SNF/Subacute beds at the St. Luke's Campus (19 are SNF and 60 are subacute). The average daily census for SNF and subacute patients was 76 in 2002, is currently 58. In accordance with the Blue Ribbon Panel recommendations, neither SNF nor subacute care is proposed within the new St. Luke's Hospital. The Development Agreement requires that CPMC maintain a SNF bed capacity of 100 beds. CPMC will be meet this obligation by continuing to provide the 38 licensed SNF beds at the Davies Campus, and providing at least 62 licensed SNF beds at other on or off campus locations within San Francisco.

Subacute. The subacute census at St. Luke's is currently 46 patients. CPMC has committed to working with the Department of Public Health and other hospital operators to develop specific proposals for providing sub-acute care services in San Francisco, which will be presented to the Health Commission by June 30, 2013.

The occupancy rate for St. Luke's 150 general acute care beds has been at approximately 33.5% for the last four years. This is an average of between 50 and 57 patients per day. The table below shows the occupancy rate and average daily census, as reported to the State for the last 15 years – both before and after Sutter acquired St. Luke's in 2007. As you can see, the average daily census over those 15 years was 59 acute patients per day.

St. Luke's General Acute Care - Occupancy Rate History			
Year	**Licensed Beds**	**Occupancy Rate**	**Average Daily Census**
2010	150	33.21%	50
2009	150	33.99%	51
2008	150	33.19%	50
2007 (St. Luke's joins CPMC)	150	37.75%	57
2006	150	41.45%	62
2005	150	38.28%	57
2004	150	41.63%	62
2003	150	47.22%	71
2002	150	53.03%	80

2001 (Sutter acquires St. Luke's)	152	45.57%	69
2000	152	36.59%	56
1999	152	33.08%	50
1998	152	34.34%	52
1997	162	35.18%	57
1996	162	35.46%	57
15-year Average			**59**

HC.10. Could the California Campus be reused to provide for Psychiatric or Skilled Nursing Facility (SNF) Beds? (Miguel)

The proposed Development Agreement only addresses the Near Term Projects, Cathedral Hill Hospital and Medical Office Building (MOB), St. Luke's Hospital and MOB, and the Davies Neuroscience Institute. CPMC intends to transfer substantially all of the functions of the California Campus to the Pacific Campus in approximately 2021. Beyond this transfer of services, the future uses for the California Campus are unknown. CPMC has committed to participating in a process with the California Campus Visioning Advisory Committee (Cal VAC) to ensure that future uses are compatible with the surrounding neighborhood.

Exhibit I of the DA provides brief descriptions about CPMC's Long-Term Projects for Davies, Pacific and the California Campuses. The Exhibit also establishes Community Advisory Groups (CAGs) for neighbors and other interested parties to engage in a planning process.

The CPMC DA requires that CPMC provide 100 SNF beds in San Francisco. The obligation permits CPMC to provide the beds at a campus or community location (however, existing community beds do not count towards fulfilling this obligation). CPMC intends to retain 38 SNF beds at the Davies Campus. The remaining 62 beds will be provided at St. Luke's Hospital (until the new hospital is opened), the California Campus, or a site in the community.

HC.11. Does the Development Agreement provide for Psychiatric Care at either the Cathedral Hill or St. Luke's Campuses? (Borden; Moore; Sugaya)

CPMC currently supports a continuum of services in mental health for San Francisco residents. Consultation and liaison psychiatry services are available at all 4 campuses and there is a low fee outpatient clinic on the Pacific campus. Specialty consultation for pediatrics, women's mental health and health psychology exist. In addition, CPMC operates 18 licensed inpatient psychiatric beds, located at the Pacific Campus to serve all four of its campuses. No change is proposed as a part of the Project in the operations of these 18 beds once the new hospitals are built.

Many referrals to the inpatient psychiatric unit come from the CPMC emergency rooms. Currently, the CPMC emergency rooms (Pacific, California, Davies, and St. Luke's) provide psychiatric evaluation and consultation services. These services will be offered in the new

hospitals. Patients needing inpatient psychiatric services are referred and admitted to the psychiatric unit at the Pacific Campus. The inpatient unit accepts Medicare and Medi-Cal patients and also admits city uninsured patients triaged from one of the four Emergency Departments when needed. The current average patient census for the inpatient unit is about 11 patients per day.

For pediatric patients, CPMC offers through its Child Life Program, patient assessment and referral to treatment at CPMC's Child Development Center. There is a Child Development Center located on the St. Luke's Campus with mental health professional available to treat pediatric patients.

For the adult patients who present in the emergency room needing mental health services and crisis intervention but do not need to be admitted to an inpatient psychiatric unit, CPMC will partner with Progress Foundation's Dore Street Urgent Care Center to provide 24/7 psychiatric assessment, triage, and coordination services onsite at St. Luke's emergency room. All appropriate, patients will be referred and treated at the Dore Clinic or Dore House. This partnership leverages a community-based program designed to support the City's emergency rooms, is supportive of patients' social/psycho needs by employing a rehabilitation model to crisis intervention, and is less costly than inpatient care.

HC.12. Will the Development Agreement create Community Advisory Groups for St. Luke's and Cathedral Hill Campuses? (Borden; Moore)

The CPMC DA specifically addresses the creation of Community Advisory Groups (CAG) and Visioning Advisory Committees (VAC) for campuses with long-term projects (Davies, Pacific, and California Campuses). The purpose of these groups is to advise CPMC as future uses of the campuses are proposed. [See, Exhibit I].

The CPMC DA does not address similar requirements for the St. Luke's or Cathedral Hill Campuses, because there are no long-term projects proposed at either campus. However, as a condition of approval, CPMC is required to have a Community Liaison. The Community Liaison will convene a community advisory group (CAG) at both the Cathedral Hill and St. Luke's Campus with the purpose of conveying input to the project sponsor on its operations and providing a forum for community comment and concern. The CAG shall consist of approximately ten (10) members representing diverse neighborhood interests such as health care providers, established neighborhood groups, resident homeowners and local merchants, and its membership is expected to change over time. Once the CAG is established, the community liaison and CAG members will agree to a regular meeting schedule, with a frequency of not less than quarterly or more than monthly.

HC.13. Does the City have a contingency plan in place in the event that CPMC closes St. Luke's within, or after, 20 years? (Moore)

There are two scenarios under which CPMC can close St. Luke's before the conclusion of its 20-year commitment:

1) If CPMC breaks the Operating Commitment and impermissibly closes St. Luke's Hospital, the DA requires payment of $30 million annually in liquidated damages for the remainder of the 20 year term. The City would expect to use these funds to compensate for the loss of hospital and other medical services for the poor and underserved provided at St. Luke's Hospital. The base amount of liquidated damages, $30 million, will increase annually from the Effective Date of the DA by the medical rate of inflation; or (See, DA § 9.4.4)

2) If the operating margin for all of CPMC (not just St. Luke's) falls below 1% for two consecutive fiscal years, then the City will have ample notice of the potential for changes in operation or closure. CPMC is required to notify the City when an accounting from the close of their fiscal year shows that CPMC's operating margin fell below the 1% threshold. During the following fiscal year, CPMC must meet and confer in good faith with the DPH Director and other City staff to consider any proposed adjustment, modification, reduction, elimination, closing, sale, lease or transfer of St. Luke's Hospital services.

   If, even after these efforts, CPMC falls below the 1% operating margin threshold the second, consecutive fiscal year, CPMC must provide the City with at least 30 days notice before closing St. Luke's. If the City disagrees that CPMC fell below the 1% threshold for two consecutive fiscal years, the City may commence arbitration and St. Luke's Hospital must remain open for at least 6 months, or until an arbitrator finds in CPMC's favor, whichever is earlier. If CPMC closes St. Luke's before the arbitrator makes a decision and the arbitrator finds that CPMC did not fall below the 1% Operating Margin threshold two years in a row, then CPMC will be liable for liquidated damages, as outlined above. (See, Exhibit F § 7(a)).

Regardless of the circumstances, should CPMC choose to modify operations at St. Luke's Hospital (whether before or after conclusion of the 20 year operating commitment), the Department of Public Health would work closely with CPMC to identify another appropriate provider, to transition the facility to that provider, and to ensure that the hospital maintains the set of services necessary to serve its community. Other appropriate providers could be other hospital systems operating in or outside of San Francisco or the Department of Public Health.

It is important to note, however, that if CPMC is closing St. Luke's Hospital because the CPMC system has fallen below the 1% Operating Margin threshold, it is likely that the rest of the health care delivery system – both public and private – in San Francisco would also be impacted. In that event, the Department of Public Health would have to assess the state of the health care delivery system overall.

HC.14. Does CPMC have an emergency plan?

There is an existing emergency response plan in place for the existing CPMC medical campuses, and each of these plans will be modified as a result of the near term projects. A similar plan will be developed for the Cathedral Hill Hospital and must be in place prior to the opening of that hospital.

The emergency operations plan for the Cathedral Hill Hospital will include provisions for "surge capacity," which is essentially the ability of a health care facility to expand its operations to treat an influx of patients in response to a major disaster. At the Cathedral Hill Hospital, the Emergency Department drop-off area will serve as a triage point. The space around the Cathedral Hill Hospital will be controlled to ensure that people needing medical attention receive assistance, while those not needing medical attention will be sent to an area for the "worried well." In the new Cathedral Hill Hospital Emergency Operations Plan, areas have been designated to accommodate patient family members and "worried well" who may arrive at the Cathedral Hill Hospital after a major disaster.

CPMC regularly meets with the City's Emergency Medical Services department, the San Francisco Fire Department (including the Neighborhood Emergency Response Team), and the Hospital Council Emergency Preparedness Partnership to maintain citywide readiness in the event of disaster. CPMC conducts regular, ongoing readiness drills across all campuses and non-clinical buildings in its role within the city's overall Emergency Response Plan.

HC.15. Is it appropriate for the Development Agreement to address Health System Services rates for City employee and retiree medical care? (Sugaya)

The City's Health System Services (HSS) contracts through Blue Shield with CPMC to provide health and hospital care for a significant portion of the City's employees and retirees. Early in negotiating the Development Agreement, Mayor's office staff approached HSS, which is charged with maintaining the cost of City employee and retiree's healthcare, with a concern that CPMC would pass through the cost of this capital project onto rate payers, including the City. To address this concern, CPMC has agreed to limit rate increases for City HSS contracts for the term of the Development Agreement.

It is appropriate for the Development Agreement to address limits on the healthcare rates paid by the City's HSS. The purpose of development agreements, generally, is to achieve benefits to the City that are beyond those that could be obtained through land-use controls. The proposed CPMC DA addresses topics commonly found in development agreements, for example, pedestrian safety, transportation and housing. However, since the CPMC project is a hospital, it also includes some areas that have not been included previously in development agreements, such as healthcare. The inclusion of these provisions is a direct response to the characteristics of the proposed project, and may appropriately be included in the Development Agreement.

HC.16. What is the status of the Healthcare Master Plan? (Sugaya)

Since Ordinance No. 300-10 took effect in January 2011, the Departments of Public Health (DPH) and Planning have partnered to launch an extensive research and community engagement campaign to inform the Health Care Services Master Plan (HCSMP). The Department of Public Health, with the assistance of consultant Harder+Company, is compiling and analyzing demographic and health-related data, researching health policy, and conducting focus groups together primary data. In addition, the participation of stakeholders and the public is informing this process through the HCSMP Task Force.

Beginning in July 2011, DPH convened a 41-member HCSMP Task Force comprising a range of community stakeholders representing hospitals and clinics, the education sector, small business, community-based organizations, health care consumers, and more. By the close of May 2012, the Task Force will have met 10 times -- including four meetings in the community -- to formulate a series of recommendations for DPH and Planning consideration. In addition to the Task Force members, over 150 participants have participated in Task Force meetings.

DPH and Planning anticipate completing the HCSMP in accordance with the following timeline:

- June 2012: HCMSP Task Force Report to DPH and Planning
- August 2012: Full HCSMP draft with recommendations
- September 2012: HCSMP review by San Francisco Health Commission
- October 2012: Per Ordinance No. 300-10, 30-day public comment period
- November 2012 - January 2013: Draft consideration by Health and Planning Commissions
- June 2013: Final approval by Board of Supervisors
- Every Three Years: HCSMP updated

Transportation

T.1. What is the BRT schedule and funding on Van Ness and Geary (Miguel; Borden)

The San Francisco County Transportation Authority (SFCTA) is leading the proposed Van Ness BRT and Geary Corridor BRT projects, in partnership with the San Francisco Municipal Transportation Agency (SFMTA). The proposed Van Ness Avenue BRT project team circulated the project's Draft EIS/EIR from November 4, 2011 to December 23, 2011, and is currently in the process of responding to comments. The SFCTA and SFMTA will be selecting a locally preferred alternative (LPA) from one of the three build alternatives analyzed in the Draft EIS/EIR in Spring 2012. Project staff will present an informational update to the Planning Commission once SFCTA and SFMTA have made a recommendation on the LPA. The Van Ness BRT project has secured $55M in funding from the Federal Transit Administration Small Starts program. The proposed Van Ness BRT project costs range by alternative from $90M to $130M. Additional planned funding sources for the project include $20M in programmed Prop K transportation sales tax funds and other

regional and State grant programs. The project schedule anticipates start of construction in mid-2015 and an opening date in late 2016.

The proposed Geary BRT project team is in the midst of environmental studies and technical studies to refine the project design. The Draft EIS/EIR for the proposed Geary Corridor BRT is scheduled to be circulated in late 2013. The project's estimated cost is $248M and funding planned to date includes $75M from FTA Small Starts program, $30M in programmed Prop K transportation sales tax funds, and other potential local, regional, federal and private sources. Construction of the proposed Geary Corridor BRT is expected to begin in 2017 and end near 2019. The CPMC LRDP FEIR analysis includes both with and without the proposed BRT scenarios.

Workforce

W.1. How many new jobs will the project create? How many jobs will stay in San Francisco as a result of the project? (Antonini)

The CPMC project will create both construction and end-use jobs.

For construction, the projects at Cathedral Hill, St. Luke's and Davies are anticipated to create 1,500 construction jobs. The workforce provisions in the DA require that 30% of the construction jobs are local hire, including 50% of new apprentice positions.

End-use jobs are permanent positions at CPMC's San Francisco campuses (Cathedral Hill, St. Luke's, California, Pacific and Davies). It is projected that the project will create 1,500 new, permanent positions over 10 years in addition to keeping CPMC's existing 6,200 employees in San Francisco. CPMC's workforce has consistently been comprised of approximately 50% San Francisco residents. Currently, CPMC employs over 3,000 San Franciscans. It is expected that as CPMC undertakes this project and creates jobs, that this hiring pattern will continue.

W.2. Why does the CPMC DA express CPMC's end-use hiring requirement as a hard number (40) instead of a percentage of open, entry-level positions? (Borden)

End-use jobs are permanent positions at CPMC's San Francisco campuses (Cathedral Hill, St. Luke's, California, Pacific and Davies). For the last four years, CPMC has filled approximately 600-700 positions annually that are vacated through attrition, promotions, and retirements, of which approximately 100 annually are considered "entry level" or available to someone with a 2-year degree or less. Under the proposed DA, CPMC is required to fill at least 40 of the 100 vacant entry-level positions with San Francisco residents, just less than half of all existing entry-level positions.

In addition to the above, CPMC estimates that approximately 220 of the 1500 projected new end-use jobs would similarly be "entry level," meaning that up to an additional 22 entry level jobs per year over ten years could be produced. Including newly created positions, CPMC would have a total of 122 entry level positions to fill annually(100 from attrition plus 22 new jobs).

The Office of Economic and Workforce Development elected a hard number, 40 jobs, instead of a percentage of CPMC's available jobs. A hard number provides the advantage of setting clear and predictable hiring obligations for CPMC to meet every year as well as providing certainty to Community Benefit Organizations and students participating in the Healthcare Academy regarding the number of jobs available. In addition to administrative difficulties, a percentage based commitment creates a moving target, which could result in more or less than the negotiated 40 positions.

W.3. Why does the CPMC DA define a "San Francisco Resident" for fulfillment of the construction and end use hiring as a person who has lived in the City for 7 days? (Borden)

The Workforce Exhibit of the Development Agreement includes the commitment by CPMC to hire local residents for both end-use and construction jobs. The terms of the Workforce agreement in the DA mirror San Francisco's Local Hire Ordinance. [See, SF Admin. Code § 6.22(G)]. Accordingly, both the DA and the Local Hire Ordinance define a "Local Resident" as "an individual who is domiciled, as defined by Section 349(b) of the California Election Code, within the City at least seven (7) days prior to commencing work on the project." [See, SF Admin. Code § 6.22(G)(2)(j); CPMC DA Ex. E § A(2)(l).

Affordable Housing

AH.1. How does current CPMC DA compare to the Mayor's request on May 16th, 2011 for $73 million for affordable housing? (Antonini; Wu)

The Mayor's "Ask" on May 16, 2011 set a goal of fulfilling the requirements of the Van Ness SUD. Unless modified through a Conditional Use permit, the Van Ness SUD requires that for every square foot of net new occupied commercial space, there must be three square feet of residential. Since development of market rate housing does not require a financial subsidy, the May 16th Ask focused on the portion of the SUD's residential requirement that would be dedicated to affordable housing under the City's Inclusionary Housing Program.

An analysis by the Mayor's Office of Housing and the Planning Department determined that the inclusionary housing requirement under the Van Ness SUD for a project the size of the Cathedral Hill Campus was 220 BMR units. This requirement could be satisfied by providing the units on-site or paying an in-lieu fee of $73 million.

The housing benefits in the Development Agreement exceed the goal of creating 220 affordable units. CPMC must provide $29 million directly to the Mayor's Office of Housing for permanently affordable housing and another $29M to fund a CPMC employee Down Payment Assistance Program (DALP). Upon the first resale of a unit purchased through the DALP program, the borrower must repay MOH 100% of the initial loan plus a portion of the appreciation on the unit. MOH will then use this recaptured DALP revenue to create permanently affordable housing. MOH projects that it will recapture at least $35 million after the DALP loans are repaid. The $64M aggregate amount to MOH for affordable

housing is equivalent to an in lieu fee payment for 191 two bedroom below market rate units. But in reality, MOH will be able to create approximately 320 new permanently affordable units. This unit projection is based on the City's current average subsidy of $200,000 per unit, which local affordable developers leverage on a 2:1 basis against state, federal, and private financing sources.

AH.2. Why does the DALP program created in the CPMC DA limit participation to CPMC employees? (Miguel; Wu)

The CPMC Downpayment Loan Assistance Program (DALP) is patterned on an existing program operated by the Mayor's Office of Housing (MOH). The program's goal is to support first-time homebuyers in San Francisco purchase a single-family home. The additional goal here is to encourage and enable CPMC employees to live where they work, promoting the city's long term commitment to greater environmental sustainability and bring us one step closer to fulfillment of SB 375 goals.

The CPMC DALP program is available to first time homebuyers that are CPMC employees with a household income between 100 and 60 percent of the Area Median Income (AMI) (for a single person 100% AMI is $ 72,100 and 60% AMI is $ 43,250 annually; for a family of four, 100% AMI is $103,000 and 60% AMI is $ 61,800).

With the DALP program, middle- to low-income CPMC employees options for accessing ownership opportunities in San Francisco are significantly expanded. The borrower can use the DALP as a down payment against the purchase price but does not have to pay monthly debt service on the DALP. As a result, the DALP is effectively "silent" for the duration of the borrower's occupancy and only has to be repaid at resale. At resale, the borrower must repay 100% of the loan proceeds plus a portion of the home appreciation equal to the ratio of the DALP to the original purchase price.

AH.3. How are a homeowner's monthly mortgage payments affected by their participation in the CPMC DALP program? (Wu)

The CPMC DALP does not increase a borrower's monthly mortgage payment. It does, however, increase the "buying power" of a 100% AMI household at the point of purchase. The maximum CPMC DALP payment is the lesser of $200,000 or 45% of the home purchase price (the 45% cap is a typical primary lender requirement). A 100% AMI household, with a 5% self-funded down payment contribution, can afford a home costing up to $357,000. According to the Mayor's Office of Housing recent report on middle income housing, this price point constitutes approximately 15% of the homes on the San Francisco housing resale market. A $200,000 DALP payment will increase that household's "buying power" up to $557,000, which constitutes 39% of homes currently on the San Francisco resale market.

The homebuyer must borrow the maximum loan based upon their income and the program minimum housing payment. But because the borrower will not have make mortgage payments on the DALP, the DALP program does not increase a borrower's monthly housing expenses.

AH.4. Are home loans available to people at 100% AMI, and which lending institutions participate in the existing MOH DALP program? (Sugaya)

Yes, in part because of the long history and strong track record of the program. MOH has administered a similar DALP program since 1998 and provided over 500 loans. From January 2005 to August 2011, MOH has provided 239 DALP payments. As part of the program, MOH has established a relationship with three major banks to ensure primary loans for DALP recipients. The program has been so popular, that MOH recently reduced the DALP maximum from $100,000 to $70,000 so that it can increase the number of households per year that the program serves. Currently, the Bank of America, Chase, Citi, First Republic, Redwood Credit Union, SF Credit Union, Union Bank, US Bank, and Wells Fargo participate in MOH's DALP program.

AH.5. What happens if a CPMC DALP participant defaults? (Sugaya)

A DALP payment will be secured against the property much like a primary mortgage would be. However, primary lenders require that the DALP payment be subordinated against the primary mortgage. This means that upon a default sale, the primary lender will recoup the remaining mortgage premium before the City recoup's the DALP.

The track record of default in the existing city DALP program, however, is stellar. The default record is 1%. This low default record can be attributed to the significant level of pre-purchase housing counseling that a DALP applicant is required to attend before applying for a loan. After applying, both the City and primary lender remain significantly involved in the loan processing and home purchase process to monitor for irregularities. The City will require similar pre-purchase housing counseling for CPMC DALP borrowers.

AH.6. What are the statistics on the resale and holding period participants in the existing Mayor's Office of Housing (MOH) DALP program? (Moore)

Based on data collected from the start of the DALP program in January 2005 until August 2011, we know that the average purchase price of a home in the DALP program has been $402,000 ($460,000 over the past three years), the average DALP payment has been $82,000, the average holding period for a DALP home has been 8.6 years, and the average total appreciation has been 38%. The average DALP program household is 2.4 persons and 82% AMI. The average size of a DALP home is 2 bedrooms.

AH.7. What are the appreciation projections for the CPMC DALP recapture? (Moore)

The DALP appreciation projections presented to the Commission were calculated using an average purchase price of $450,000, an average holding period of 8 years and an average annual appreciation of 3.0%. Using these calculations, MOH would recoup $35.9M for affordable rental housing production within 13 years of the beginning of construction. Based on a $200,000 per unit cost to MOH, this is sufficient to fund an additional 179 permanently affordable rental units. Note that if we use the actual DALP program data, these projections would be even more robust. Based on total appreciation of 38% over an 8.6 year

holding period, the return to MOH over 13.6 years would be over $40M. This would be sufficient to fund 199 permanently affordable rental units.

AH.8. Are participants in the CPMC DALP program required to be existing residents of San Francisco? (Borden)

There is no current requirement for a DALP applicant to be a San Francisco resident. All DALP loans, however, must be for a home within San Francisco. With that said, Mayor's Office of Housing would support a San Francisco resident preference for applicants of the CPMC DALP program. A San Francisco residency preference is consistent with MOH and the City's ongoing policy to promote sustainable live/work land use policies. Central to such a policy is the retention of low income and workforce households presently living in San Francisco who also work in San Francisco.

AH.9. Why use Area (verses local) Median Income for determining the affordability level? (Miguel)

The CPMC DALP program uses the San Francisco Metropolitan Statistical Area AMI calculations to determine eligibility for the program. This is the same average used for MOH's existing DALP program. Several other organizations publish data on San Francisco's AMI. The SFMSA AMI was selected for the DALP program because it tends to establish the middle ground (not the high or low end) of the published AMI indexes.

Development Agreement

DA.1. Comparison to other hospital rebuild projects in the Bay Area, including a comparison to the Stanford University Medical Center Development Agreement with the City of Palo Alto. (Antonini)

In San Francisco, the University of California, San Francisco and San Francisco General Hospital have undertaken hospital projects. Neither organization entered into a development agreement.

In 2011, the City of Palo Alto entered into a Development Agreement with Stanford Hospital and Lucille Salter Packard Children's Hospital. In total, the projects included in the Stanford University Medical Center Development Agreement comprise 1.6 million square feet of hospital space. In comparison, the new St. Luke's and Cathedral Hill Hospitals considered in the CPMC Development Agreement will create 1 million square feet of hospital use; two-thirds the size of the Palo Alto hospitals.

A comparison of this DA against the proposed CPMC DA:

	Stanford/Lucile Packard	**CPMC**
Operating Commitment	**N/A**	**20 years (St. Luke's)**
Charity Care	$ 3 million (one-time)	$ 86 million baseline (annually)

	Stanford/Lucile Packard	**CPMC**
Community Based Health/Wellness Programs	$ 4 million (one-time)	$ 20 million (one-time)
Medi-Cal Participation	N/A	Hospital treatment to 10,000 additional Medi-Cal beneficiaries; Up to $9.5 million (annually)
Transportation – Annual*	$ 1.8 million (Caltrain Transit Passes) $ 46,000 (Menlo Park Shuttle program) $ 50,000 (AC Transit) $ 45,000 (Park & Ride Lot) $ 450,000 (Marguerite Shuttle) $175,000 (TDM Coordination)	$ 500,000 (Garage parking) $ 1.5 million (Transit Passes) $ 175,000 (TDM Coordination)
Transportation – Capital*	$ 500,000 (AC Transit) $ 2 million (Marguerite Shuttles)	$ 5 million (Van Ness & Geary BRT) $ 10.5 million (TIDF in-lieu) $ 400,000 (bike study) $ 1 million (Signalization Improvements)
Pedestrian Safety & Streetscape	$ 4.1 million	$13 million
Affordable Housing	$ 23.2 million (may also be used for infrastructure & sustainable neighborhoods and communities)	$ 62 million
Climate Change	$12 million	N/A
Workforce	N/A	$ 2 million (Workforce Training Payment) Local hire requirements for construction and end-use jobs.
Total – Annual	$ 2.6 million (51 years)	$ 97.7 million (10 years)
Total – Capital	$ 48.8 million	$ 113.9 million

Other CPMC Obligations, not itemized, include the commitment to construct and operate St. Luke's Hospital with Centers of Excellence in both Community and Senior Health, limits to HSS rates, maintenance of 100 SNF beds, continued support for Chinese Hospital, and support to the Bayview and St. Luke's Healthcare Centers.

* Includes transportation contributions required at mitigation measures.