

Office of the Mayor

SUPPLEMENTAL AGENDA MATERIAL for Supplemental Packet 1

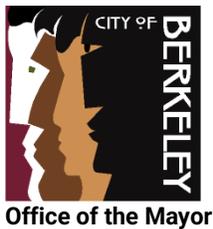
Meeting Date: November 19, 2024

Item Number: 25

Item Description: Exploring the Formation of Joint Powers Authority (JPA) or other entity to Publicly Finance the Development of a Hospital to Meet Regional Healthcare Needs

Submitted by: Mayor Jesse Arreguín

There are typographical edits to the item to ensure consistency and clarity. Additionally, one new attachment has been referenced and submitted: Memorandum of Findings: Briefing on Berkeley Hospital Financing Options, Manatt (August 23,2024).



CONSENT CALENDAR

November 19, 2024

To: Honorable Members of the Berkeley City Council

From: Mayor Jesse Arreguín and Councilmember Sophie Hahn (Authors)

Subject: Exploring the Formation of Joint Powers ~~Association~~-Authority (JPA) or other entity to Publicly Finance the Development of a Hospital to Meet Regional Healthcare Needs

RECOMMENDATION

1. Direct the City Manager and City Attorney to explore establishing ~~necessary~~-legal and financial structures, such as a Joint Powers Authority (JPA) or Hospital District, with relevant East Bay jurisdictions, to facilitate public financing for a full service public acute and emergency care hospital serving Berkeley and the greater East Bay.
2. Authorize the City Manager and City Attorney to engage staff or consultants as needed, and submit further budget requests if additional resources are required.

BACKGROUND

In 2016, Sutter Health announced its intention to close Alta Bates hospital, the only full-service acute and emergency care hospital between Berkeley and the northernmost communities of Contra Costa County, by 2030. Alta Bates has a capacity of 347 beds, and is the third largest general acute care facility in the region. Its service area includes almost 850,000 residents, of whom 44% are people of color and 36% are below 200% of the federal poverty level.

On July 12, 2016, City Council passed Resolution No, 67,615–N.S, opposing Sutter’s plans to close the hospital. The Resolution further resolved that the Mayor, City Council and City Departments pledged to cooperate fully to facilitate this process (Attachment 1). The Mayor’s Office convened the Alta Bates Regional Task Force composed of officials from Alameda and Contra Costa Counties, and the cities of Alameda, Albany, El Cerrito, Emeryville, Oakland, San Pablo and Richmond, as a venue to share information and explore policy alternatives.

Subsequently, a formal request was sent to Sutter Health on February 7, 2019

requesting that Sutter provide a plan, in writing, for the retrofitting/rebuild of Alta Bates Hospital or share their future plans for the property. To date, Sutter has not provided such a plan to the City Council or the public and has not indicated in any forum that it plans to continue operating Alta Bates as a full service acute and emergency care hospital after the 2030 deadline.

According to the City's 2018 Health Status Report, significant health disparities persist in Berkeley, particularly impacting the African American community. Despite comprising only 8% of the population, African Americans accounted for nearly 30% of the Years of Potential Life Lost (YPLL), indicating a higher rate of premature death compared to other racial/ethnic groups. This disparity extends to various health conditions: African Americans were 2.3 times more likely to die prematurely from any condition compared to Whites and faced inequitably high rates of hospitalization due to uncontrolled diabetes and its long-term complications. Moreover, the rate of hospitalization due to hypertension among African Americans sharply increased, being over five times that of the total population.

These troubling health trends, coupled with the potential closure of Alta Bates hospital, could further strain the healthcare system, exacerbating the challenges faced by vulnerable populations in Berkeley and intensifying the need for comprehensive and accessible healthcare solutions across the city.

In December 2018, a Rapid Health Impact Assessment Report (RHIA) was commissioned by the Task Force and delivered by a research team at the UC Berkeley Institute of Urban and Regional Development, led by professor Jason Corburn. The RHIA report identified potential health impacts of the closure of Alta Bates. With the hospital serving as a regional hub for pregnancy and birthing, there will be reduced high quality prenatal, birthing & neonatal care accessible to Berkeley and other East Bay residents. Closure will disproportionately impact people of color and low-income/uninsured residents, many of whom are already at a higher risk of having health complications. Emergency departments in hospitals throughout the region will see increased crowding, leading to longer wait times, longer travel times, and placing additional strains on ambulances, negatively impacting both the Berkeley Fire and Police Departments. Closure also places the entire I-80 corridor at additional risk in the event of a disaster such as an earthquake, wildfire - or pandemic, with victims having less access to emergency services.

In addition to these disparate impacts across the region, the report identified a particularly acute impact to Berkeley's elderly and student populations. Approximately, 13% of the population in the Alta Bates Hospital Service Area is over the age of 65, with an additional 12% between the ages of 55-64. Notably, in three Berkeley ZIP codes (94705, 94707, and 94708), the elderly population (over 65) constitutes 20-30% of the

residents, indicating a significant portion of the population that might require more healthcare services, particularly in the context of emergency services and age-related health issues. Moreover, UC Berkeley students rely heavily on Alta Bates services, with an estimated 4,000 emergency visits per day. Student health and mental health would be impacted by the loss of Alta Bates, where between 2,500-3,000 students per year are referred to from the student health center (Tang Center).

While securing the healthcare needs of Berkeley residents and understanding and addressing the impacts of closure of Alta Bates have been topics of interest and concern to the City Council for many years, evidenced by resolutions, letters, and studies, the COVID pandemic paused progress at a critical moment - and put enormous stress on health care facilities region-wide, including Alta Bates, which heroically cared for (and continues to care for) victims of this unprecedented pandemic. With the Pandemic now largely under control - and 2030 just six years away - the need to pick up the pace to understand and explore options for the people of Berkeley - and in neighboring communities - to have their healthcare needs met is more urgent than ever.

This year, the Mayor and City Council continued their advocacy to ensure healthcare needs are met. Mayor Arreguín and Councilmember Hahn presented the findings of the 2018 Rapid Health Impact Assessment Report at meetings of the City Councils of Richmond and Albany and did outreach to other nearby jurisdictions to ensure neighboring jurisdictions are educated and aware of the potential impacts of Alta Bates' closure. Each of these jurisdictions expressed their enthusiastic support and appreciation for Berkeley's advocacy efforts, as well as an interest in joining together in future efforts to retain or otherwise obtain access to a full service acute and emergency care hospital serving our communities.

In February 2024, the City Council allocated \$300,000 to support the City Attorney's office in engaging technical and legal experts to develop strategies to meet the healthcare needs of Berkeley and the region in the event of Alta Bates' closure. Initial research identified the potential for Berkeley to collaborate with neighboring jurisdictions to publicly finance the construction of a new public hospital to serve the East Bay. (See Attachment 4).

The purpose of this item is to direct staff to continue this work, conducting the necessary financial, technical and other relevant analyses to assess the viability of this approach, or to consider other approaches. This action will provide explicit Council direction for the City Attorney and City Manager to work together on an accelerated schedule to bring this exploration to the next step. Any further formal action, such as authorizing additional funding or formally establishing a partnership of any kind, would still require Council approval.

FINANCIAL IMPLICATIONS

Staff Time

ENVIRONMENTAL SUSTAINABILITY AND CLIMATE IMPACTS

Not Applicable

CONTACT PERSON

Mayor Jesse Arreguín 510-981-7100

Councilmember Sophie Hahn 510-981-7150

Attachments:

1. Resolution 67,615
2. [City of Berkeley 2018 Health Status Summary Report](#)
3. [2018 Rapid Health Impact Assessment: Proposed Closure of Alta Bates Campus](#)
4. [Memorandum of Findings: Briefing on Berkeley Hospital Financing Options, Manatt \(August 23, 2024\)](#)



Briefing on Berkeley Hospital Financing Options
Memorandum of Findings

Updated 11.4.2024



Executive Summary

The City of Berkeley is exploring options to finance the construction of a new 100-200 bed hospital to replace the Alta Bates Medical Center following Sutter Health’s announcement that it will cease inpatient hospital operations in 2030 due to the cost of seismic retrofit. The cost to develop a new facility has been estimated to be up to \$2 billion. The City of Berkeley is not interested in operating the hospital.

This initial assessment considered strategic and financial options related to paying for and structuring this new hospital, yielding the following conclusions:

1. The hospital’s revenues are not projected to support all of the debt service cost of financing the acquisition and construction of the hospital. Municipal tax supported debt — specifically, a general obligation (GO) bond secured by ad valorem property taxes— offers the lowest cost of capital to finance the construction of a new facility with current rates between 3-5%.^{1,2}

2. The City of Berkeley should seek to mitigate municipal tax supported debt and local tax burden by spreading the property tax base to reflect the expected service area, lowering overall project costs, identifying additional capital and/or future revenue sources to subsidize and service the debt, and over the long term, take advantage of opportunities to refinance a portion of the municipal tax supported debt with revenue supported debt once the hospital has fully ramped up operations. Executing all of these mitigation tactics could result in a tax burden of a tenth of what would be experienced if the City were to issue a GO bond for the full \$2 billion.

Debt/Tax Minimization Levers and Impact (Illustrative)

	Annual Property Tax Impact per \$100k in Taxable Assessed Value
Base Case City led GO Bond of \$2 billion (4% rate, 30 yr. term)	\$429
Tax Impact Lever 1 Spread Property Tax Base (3x base)	\$143
Tax Impact Lever 2 Reduce Sticker Price/Debt to \$1B	\$71
Tax Impact Lever 3 Abate using Lease Revenue (Assumes \$20M/yr lease)	\$47
Tax Impact Lever 4 Refinance in Future to 3.5%	\$42

3. The City of Berkeley should prioritize exploring the establishment of a new healthcare district or joint powers agreement (JPA) to offer the debt and spread the tax responsibility across a geography that reflects where expected patients reside. This is the most impactful lever to lower the local tax burden. For example, by expanding the tax base to three times the City’s total property value, the tax increase would drop from \$429 to \$143 per \$100,000 in assessed property value if \$2 billion in GO bond debt financing were required. As confirmed by the City’s bond counsel, a JPA offers a faster and more flexible alternative to a healthcare district, and a JPA may issue a GO bond directly in support of the hospital project.

4. For a hospital opening by 2030 to be possible, planning and feasibility activities should begin in earnest immediately. In a best case scenario, it will take between five to six years to complete all the necessary steps.

¹ Assumes entire hospital project will be eligible for tax exempt municipal financing
² It would be possible to support the tax supported debt with another special tax (most likely a non-ad valorem based property tax), but the required voter approval would be the same and this memorandum assumes the use of GO bonds.



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Introduction

This memorandum describes initial findings following a strategic and financial assessment of a range of available options to establish and fund the development of a new acute care inpatient hospital facility in the City of Berkeley.

In 2016, Sutter Health announced plans to close Alta Bates Summit Medical Center (Alta Bates), a 339-bed acute inpatient facility located in Berkeley, CA, by 2030, citing the costs of seismic retrofit.³ Closure of the facility without some replacement is expected to result in significantly reduced access to acute care and emergency services for residents of Berkeley and the surrounding communities. To mitigate the potential loss, the City of Berkeley is exploring options to retain access to acute inpatient services.

Project Assumptions

This assessment focuses on scenarios related to financing the construction of a new hospital to replace the Alta Bates facility. The inpatient facility being contemplated would have up to 200 inpatient beds and provide a service mix similar to that of Alta Bates for both inpatient and outpatient services. The capital required is estimated to be up to \$2 billion. Additionally, assuming Sutter's exit from inpatient operations, the City of Berkeley will need to find an experienced partner to operate the new or retrofitted hospital once complete, and potentially to take facility ownership in the future.

Assumptions:

- The new inpatient hospital will be between 100-200 beds in size.
- The project timeline should seek to eliminate, if at all possible, time duration between closing of Alta Bates and the opening of the new hospital.
- Partnerships will be pursued across the hospital catchment area to support the financial commitments of building the hospital.
- The project will be funded primarily through debt financing. Other sources will be pursued to subsidize and are anticipated to represent minority contribution (e.g., philanthropy, appropriation, grant).
- Although the hospital's revenues are not projected to support all of the debt service cost of financing the acquisition and construction of the hospital, the financing approach selected should consider all opportunities to minimize taxpayer burden.
- The City of Berkeley will seek an experienced California based operator to manage and oversee all aspects of hospital operations. The City of Berkeley is not interested in operating the hospital.
- The new facility will maintain a service mix that at a minimum includes emergency services, obstetrics and gynecology, medical-surgical, psychiatric and intensive care, consistent with the specialty mix currently offered at Alta Bates.
- The new facility will either be newly constructed (scenario 1) or developed through the retrofit of an existing facility (scenario 2). This memorandum focuses on scenario 1. Scenario 2 may be funded through similar mechanisms, but was not evaluated thoroughly due to a lack of capital estimate.

³ Berkeley's Only Hospital, Alta Bates, to Close by 2030, San Francisco Chronicle July 2, 2016



Scenario 1: Build a New Hospital	Scenario 2: Retrofit of an Existing Facility
a. Capital construction cost: Up to \$2B b. Land acquisition cost: \$50M for city block, not at Sutter location	a. Capital renovation (\$): TBD pending feasibility study b. Facility for Retrofit: Existing facility in Berkeley previously developed to support life science research (retrofit is not being contemplated for existing Alta Bates location)

**Note: \$1.853M per bed was estimated in 2019 for seismic retrofits at 95% cost percentile before accounting for additional facility improvements, capital equipment, and if not previously an inpatient facility, costs to retrofit building to meet regulatory planning requirements.⁴*

Approach

Manatt performed a series of analyses leveraging publicly available information to develop a detailed understanding of the options and related considerations available to the City of Berkeley. This included reviews of California municipal finance, healthcare district and joint powers authority regulations; current and historical financing arrangements for new healthcare facilities across California; healthcare district and joint powers authority context in the Bay Area, and ratings and financial information for the City of Berkeley.

Additionally, Manatt conducted interviews with leaders in the public finance and healthcare divisions of four investment banks.

⁴ Source: *Updating the costs of compliance for California’s Hospital Seismic Safety Standards*, RAND Corporation report for California Hospital Association, 2019



Summary Findings

This memo considers four critical questions that the City of Berkeley faces prior to moving forward with the hospital project:

1: What type of financing is best suited to fund the hospital construction?

A tax-exempt revenue bond secured by the hospital’s revenues generally has a higher interest rate than a GO bond and would be untenable without public tax support. The annual debt service requirements for a \$2 billion revenue bond offering, even at GO level interest rates, would command a majority share of the hospital’s net patient service revenues (NPSR) on an annual basis.⁵ This means that the hospital could not be financed on a revenue-only basis; therefore, whether a hospital district is involved or not, voter approval for tax-secured financing will be needed.

	Amount	% of NPSR
Average NPSR for a 100-250 bed hospital (US)	\$228,000,000	
Annual Debt Service: \$2 billion GO 4% fixed interest rate, 30 year term	\$114,580,000	50%
Annual Debt Service: \$1 billion GO 4% fixed interest rate, 30 year term	\$57,290,000	25%

See Section A in the memo below for additional details regarding this question.

Municipal tax supported debt — specifically, a tax-exempt general obligation (GO) bond secured by ad valorem property taxes — offers the lowest cost of capital to finance the construction of a new facility and a resilient revenue source for debt service. A bond secured through a special tax, such as a non-ad valorem parcel tax, offers more flexibility in its uses (e.g., for operating support). However, it would have less flexibility for annual adjustment or abatement, and if a parcel tax, the revenue would be limited by the number of taxable parcels in the given geography.⁶

	Ad Valorem Property Tax	Parcel Tax
Summary Description	Tax imposed and based on the value of a property.	Tax imposed on property but not directly based on the value of the property.
Considerations	<ul style="list-style-type: none"> • Base ad valorem property tax rate is constitutionally capped at 1% of assessed value (Proposition 13) <ul style="list-style-type: none"> ○ The assessed property value is based on the most recent purchase price ○ The assessed value can only increase by up to 2% annually ○ County administers and distributes base ad valorem property tax revenue based on CA State formula • Additional ad valorem property tax can be levied to pay for voter-approved debt, such as for a GO bond to finance a new hospital. (Proposition 42) <ul style="list-style-type: none"> ○ 2/3 voter approval required to issue the debt ○ Bond proceeds cannot fund operating expenses ○ Voters do not approve a fixed ad valorem property tax rate, rather the rate adjusts annually to service the voter approved debt 	<ul style="list-style-type: none"> • Parcel taxes in CA can be applied in two ways: <ul style="list-style-type: none"> ○ Flat amount: Tax amount applied uniformly on a per parcel basis regardless of parcel characteristics (e.g., \$100/parcel) ○ Variable amount: Tax amount varies based on parcel characteristics such as size or use (e.g., \$100/retail parcel and \$200/commercial parcel) • Parcel taxes are considered a “special tax” in CA and can be levied to pay for voter approved purposes (Proposition 218) <ul style="list-style-type: none"> ○ 2/3 voter approval required ○ Uses can include the funding of capital infrastructure and to provide operating support • Parcel tax revenue is limited by the number of taxable parcels in the taxing authority’s jurisdiction

⁵ Definitive Healthcare Hospital View as Sourced from Medicare Cost Report as of June 2024

⁶ While GO bonds can only finance the acquisition and improvement of real property, a special tax (most likely a non-ad valorem based property tax, often referred to as a “parcel tax”) could finance these and ongoing operations. Because the required voter approval would be the same for GO bonds and parcel taxes and the City has not expressed an interest in establishing an ongoing tax to support operations of the hospital, this memorandum assumes the use of GO bonds for the limited purposes of financing acquisition and construction of the hospital.



The market for tax exempt GO municipal debt is favorable, with interest rates in the 3-5% range for credit worthy issuers, like the City of Berkeley.⁷ The interest cost of any such GO bonds would primarily reflect the property tax base on which the ad valorem taxes are levied. However, issuers with lower credit ratings or without history, such as a newly formed healthcare district, may receive a higher rate.

2: What is the estimated tax impact and how can it be minimized?

The City should mitigate debt and local tax burden by seeking to distribute tax responsibility across the expected service area, accessing other sources of capital, lowering overall project costs, and over the long term, take advantage of opportunities to refinance a portion of the tax supported debt with revenue supported debt once the hospital has fully ramped up operations.

- **Shape taxed geography to reflect expected service area:** By establishing a new healthcare district or joint powers authority, Berkeley can distribute the construction costs across the municipalities expected to use the hospital, as demonstrated in the following table.

Tax Impact Comparison: City led vs Regionally led Offering

	Scenario 1	Scenario 2	Scenario 3
	HCD/JPA led GO Bond(s) of \$1 billion	HCD/JPA led GO Bond(s) of \$1.5 billion	HCD/JPA led GO Bond(s) of \$2 billion
Annual Debt Service	\$57,290,000	\$85,935,000	\$114,580,000
Annual Property Tax Impact per \$100k in Taxable Assessed Value			
City of Berkeley Only: <i>Assumes \$26.712 billion in estimated taxable property value (source FY2023 Annual Report)</i>	\$214	\$322	\$429
HCD or JPA w/3x Tax Base: <i>Assumes HCD/JPA has property tax base 3x that of City of Berkeley ~\$80.137 billion</i>	\$71	\$107	\$143

- **Reduce the sticker price:** The current construction estimate of \$2B is on the high end for a 100-200 bed hospital.⁸ The City should evaluate the potential to construct for less and/or the potential for its hospital operator to make in-kind contributions that would lower associated capital requirements.
- **Secure non-debt-based capital to subsidize project costs:** Including other non-debt based capital contributions to partially fund the project will lower the amount of debt financing required, lower interest payments to service the debt, and heighten investor interest. Similar to a mortgage, investors will view a funding approach that includes a “down payment” from other sources as lower risk. This also aligns with the City’s interest in mitigating local tax burden. Other non-debt based capital contributions to fund the project may include grants, philanthropy, and direct contribution by issuer and/or operator. It is not likely that any such capital sources would be sufficient to eliminate the need for tax supported debt.
- **Identify non-tax based revenue sources to abate the property tax burden, such as through a leasing agreement with the operator:** Under a scenario where property taxes (ad valorem GO taxes and/or parcel taxes) secure the debt, those taxes may be reduced on an annual basis in the

⁷ City of Berkeley currently maintains a AA rating with Moody’s and an Aa1 with S&P. Bloomberg Market Data (as of July 29, 2024)
⁸ Source: Updating the costs of compliance for California’s Hospital Seismic Safety Standards, RAND Corporation report for California Hospital Association, 2019

future as facility or lease revenues are used to offset the tax burden. Further assessment is required to ensure applicability of the lease revenue model.

- Structure the GO bond to allow for refinancing with revenue bonds, in whole or in part, in the future:** GO bonds typically are structured to include a redemption date 10 years following issuance at which point they may be refinanced to achieve savings, but shorter lock out periods are possible. The California Health Facilities Financing Authority (CHFFA) offers revenue-based bond refinancing for facilities with an operating history tied to the State’s GO bond rating, which may be better than what is received if the refunding revenue bonds are issued by a new healthcare district or a JPA.

The below table describes the impact these initiatives could have in combination:

Debt/Tax Minimization Levers and Impact (Illustrative)

	Annual Property Tax Impact per \$100k in Taxable Assessed Value
Base Case City led GO Bond of \$2 billion (4% rate, 30 yr. term)	\$429
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Tax Impact Lever 4 Refinance in Future to 3.5%	\$42

See Section B in the memo below for additional details regarding this question.

3: How can the estimated tax impact be shared across the hospital’s expected service area?

Berkeley property owners would face a heavy tax burden if debt were not distributed across other municipalities expected to be in the hospital’s service area. The City should first explore establishing a new healthcare district or joint powers authority to offer the debt.

- A healthcare district (HCD) or joint powers authority (JPA) would enable tax support to be spread across a larger base that reflects the new hospital’s expected service area.** The closure of the existing Alta Bates facility will impact access for patients beyond just those within Berkeley city limits, including Emeryville, Albany and other communities across north Alameda and Contra Costa Counties. An offering structure that is inclusive of other affected stakeholders should be pursued.
- Healthcare facility financing linked to a healthcare district is generally viewed favorably by investors due to its dedicated purpose, public engagement, and ability to levy taxes across a broader geography than the City alone.** However, existing districts have encountered significant

financial issues, and without special legislation at the State level, establishing a new district can significantly extend the development timeline because they require voter approval.

- **A JPA offers a faster and more flexible alternative to a healthcare district, including liability protection. Also, as confirmed by the City's bond counsel, a JPA may issue a GO bond directly in support of the hospital project.** The benefit of a JPA is that it would allow multiple cities to jointly seek voter approval and issue general obligation bonds. The JPA offers no benefit if the City is the only public agency financing the hospital.

4: What are next steps and under what timeframe?

For a hospital opening by 2030 to be possible, planning and feasibility activities should begin in earnest immediately since under a best case scenario it will take approximately five years to complete all the necessary steps.

- **Perform Feasibility Study and Facility Planning (1-2+ years):** The immediate next step is to conduct a feasibility study and begin detailed facility planning. This step is highly involved and is the primary organizing step in the process including assessment of the local healthcare market and community health needs, defining the clinical service need and inpatient bed mix, initial facility schematic design, preferred structure and partners, and hospital operating partner assessment and selection. Many of these activities can occur concurrently, and in total could take two years to complete.
 - **Stakeholder Engagement and Preparing for Public Announcement:** The financing and development of a new hospital will involve the engagement of multiple stakeholders, including but not limited to the intended operator of the new hospital, Sutter Health, professional services firms, and the intended municipal and/or county partners and their respective local communities. To ensure a successful outcome, a stakeholder engagement and communications plan will need to be developed early in the process. Engagement considerations for key partners are described below.



Stakeholder	Relationship to Project	Engagement Priorities	Engagement Timing
Operating Partner	Experienced hospital operator to oversee and manage operations for the new hospital	<ol style="list-style-type: none"> 1. Clinical enterprise planning and feasibility: <ol style="list-style-type: none"> a. Define clinical enterprise and facility plan to meet service area inpatient and outpatient access needs b. Develop financial model and related assumptions to be operationally sustainable 2. Negotiate operating and lease agreement: <ol style="list-style-type: none"> a. Align on vision and goals of operating partnership b. Define operating agreement and lease and potential future sale terms to execute 	Immediately
Public Financing Partners	Regional municipalities and/or territories that: <ul style="list-style-type: none"> • Will be impacted by the closure of Alta Bates; • Will be served by the new hospital; and/or • Are willing to support a voter approved debt offering and related tax to construct the new hospital 	<ol style="list-style-type: none"> 1. Consider priority partners and engage sequentially (wave 1, wave 2, etc...) 2. Solicitation of Interest: Determine interest and willingness to participate in development of new hospital and identify issues to address 3. Commitment and Active Coordination: Engage in planning and feasibility activities for facility and separately, public initiative and ballot coordination 	Late 2024 – early 2025 to solicit interest and pursue commitments, ideally with more detailed data with rationale for participation and description of local debt and tax impact
State Legislators	Legislature can vote to rapidly establish healthcare district (if pursued) and/or provide public leadership support/influence to improve project feasibility	Advocacy related to: <ol style="list-style-type: none"> a. Project need/criticality b. Introducing special legislation to either provide clarity on JPA ability to issue a GO bond or to rapidly establish a healthcare district 	Late 2024 – early 2025 once project concept, financing and collaboration model are more clearly defined
County and Related Authorities	County is responsible for <ul style="list-style-type: none"> • Levy and collection of any property tax associated with debt repayment for project costs • Approving HCD formation plan prior to vote (if not establishing via special legislation) • Assigning initial HCD Board of Directors 	<ol style="list-style-type: none"> 1. Support for debt offering and related tax 2. Healthcare district planning and feasibility <ol style="list-style-type: none"> 1. Documented support for HCD formation 2. Approval of HCD formation analysis (LAFCO) 3. Support with forwarding of ballot measure and related voter communications 	Once structural pathway is decided upon and required financing amount and tax impact is more precisely modeled
Sutter Health	As owner and operator of Alta Bates, Sutter Health has decisional authority over nature and timing of hospital closure.	<ol style="list-style-type: none"> 1. Clarity on closure timeline: Clarify timeline and seek to mitigate any gaps in access to care 2. Relationship management: Maintain positive relationship and mitigate action that could adversely affect project feasibility 	Once a more detailed need assessment is completed that confirms need for replacement hospital and public and operating partner commitment and support to pursue

- **Gain Necessary Approvals (4-18 months):** Issuing a GO bond will require majority voter approval and local legislative approval. The exact steps for this process will ultimately be determined by the structure selected to issue the debt and oversee the hospital assets and related operations. For example, establishing a healthcare district will require the engagement of all municipalities and territories to be included within the healthcare district as well as the agencies overseeing them, and local voter approval via a single vote. A JPA-issued GO bond will also require a public vote that is inclusive of all geographies supporting the hospital financing through the JPA, though a vote to form the JPA will not be required. Public resistance to either of these options could result in a timeline at the higher end of the range as it could extend the process prior to holding the vote. Local and legislative engagement, advocacy, and related planning activities in this step may begin during the feasibility and planning phase.
- **Issue Debt (4-9 months):** Debt issuance could take anywhere from 4-9 months once approvals are received and a feasibility study has been submitted. This step involves engaging a municipal advisor and investment bank(s) to underwrite the debt. This can occur in parallel during the planning and approval phase. Issuance activities cannot begin until the feasibility study, planning, and approvals are completed.
- **Complete Permitting and Construction (3-5+ years):** Facility development can take anywhere from 3-5+ years once funding has been secured. This step includes securing any necessary land, entitlements, and permits which can occur concurrently with the bond design and issuance step. This is the longest step timewise. Selecting a developer with a demonstrated ability to complete new hospital projects on time and on budget is critical.

- **Open Hospital:** New facility opens for operations under management of selected operator. Lease payments begin. Each year, the district can assess the extent to which lease payments can reduce the need for the ad valorem tax levy.



City of Berkeley
Briefing on Berkeley Hospital Financing Options
Memorandum of Findings

Roadmap (Illustrative): Path to Open by 2030 (Best Case Scenario)

Step	Key Activities	2024		2025		2026		2027		2028		2029		2030	
		H1	H2												
Step 0: Assess Financing Options and Estimate Tax Impact	Define and Narrow Range of Financing Options Available to Construct New Hospital														
	Assess Structures to Fund and Oversee Hospital Assets and Operations														
	Estimate Taxpayer Impact and Identify Ways to Mitigate														
Step 1: Perform Feasibility Study and Planning	Engage Possible Operating Partner(s)														
	Initiate Feasibility Study														
	Define Market and Clinical Service Needs														
	Define Operating Model and Select Operating Partner														
	Determine Oversight and Financing Structure and Engage Public Financing Partners to Execute (JPA or HCD)														
	Prepare Capital Funding Requirements and Financing Approach														
	Finalize Feasibility Assessment and Move to Approvals and Issuance														
Step 2: Gain Necessary Public Approvals	Finalize Facility Location and Plan (Design, Phasing)														
	Prepare for Public Announcement of Project and Related Funding Need and Tax to Support														
	Engage Legislative Advocacy Process for Healthcare District Formation*														
	Execute Agency Review Process for Healthcare District Formation (if pursued)														
	Initiate Local Processes for Debt Issuance														
	Develop Community (Voter) Engagement Plan and Execute														
Step 3: Issue Debt	Organize Voter Initiative(s)														
	Hold Public Vote to Approve (bond issuance, district formation as needed)														
	Engage Municipal Finance Advisor														
	Engage Underwriter(s) for Bond (Competitive Bid)														
	Plan and Structure Bond														
	Authorize Bond (Public and Agency Approvals)														
Step 4: Complete Permitting and Construction	Market and Issue Bond														
	Close Bond (Funding Received)														
	Apply for and Receive Necessary Permits														
Step 5: Open Hospital	Break Ground														
	Construct Hospital and Complete Licensing														
Step 5: Open Hospital	Hospital Welcomes First Patient														

*if seeking legislative action to rapidly establish

See Section D in the memo below for additional details regarding next steps and timeframe.

Detailed Assessment

As the City of Berkeley contemplates the major investment to fund a new hospital – potentially totaling up to \$2B, it faces decisions related to how to fund as well as which entity (or entities) should offer any required debt. The following sections consider:

- A. Approaches for funding hospital construction
- B. Mechanisms to minimize debt financing
- C. Structural options for distributing tax impact across potential service area
- D. Next steps and timing

Section A: Approaches for Funding Hospital Construction

New hospitals are typically paid for through a combination of funding (capital that does not need to be repaid) and financing (debt). Based on project assumptions and available grant opportunities, direct funding opportunities are limited. Therefore, with an estimated capital need of up to \$2B, debt financing is required for Berkeley's hospital construction.

As a local government with taxing authority, the City of Berkeley has the ability to incur tax exempt debt directly via a tax or revenue backed municipal bond offering. Under either arrangement, the City can also utilize regional measures such as establishing a new, or joining an existing, health care district, entering into a JPA, or a combination of the two, through which debt can be issued (further explored in Section C). General obligation (GO) bonds are serviced from ad valorem property taxes while revenue bonds can be secured by project or other revenue sources. Each option has unique elements to consider, as outlined in Table A below.

The hospital's revenues are not projected to support all of the debt service cost of financing the acquisition and construction of the hospital because debt service on a revenue bond to finance all of the acquisition and construction costs could be as high as 50% of the hospital's revenue.

Therefore, public tax support would be needed to cover a significant portion of the debt service. As the financing will be for the limited purpose of acquiring land for and constructing the new hospital, a GO bond secured by ad valorem property taxes offers the City the lowest cost of capital to finance the construction of a new facility. The market for tax-exempt GO municipal debt is favorable, with interest rates in the 3-5% range for issuers with the tax base to support. Taxable debt —whether revenue bonds or GO bonds -- would bear a higher interest rate than tax-exempt debt.



Table A: Bond Funding Options

Funding Option	General Obligation (GO) Bonds	Revenue Bonds
Summary Description	In California, municipal bond issued by local agencies and secured by ad valorem property taxes	Municipal bond secured by revenue from a specific project that the bond is funding
Financing Type	Debt	Debt
Available to	<ul style="list-style-type: none"> • City • County • Healthcare district • JPA⁹ 	<ul style="list-style-type: none"> • City • County • Healthcare district • JPA
Source of Repayment	Voter approved ad valorem property taxes	Revenues from hospital operations and/or Revenues from special taxes (e.g., parcel, gas, cigarettes, sales, etc.)
Voter Approval Required	Yes, 2/3 voter approval	No, unless revenue bond is being secured by a “special tax” requiring 2/3 voter approval.
Obligated Party	Issuer	Issuer
Current Market Interest Rate	3-5%	4- 12%* depending on project risk and issuer credit rating (subject to 12% cap for public issuers)
Interest Rate Cap	12%	12%
Typical Term	30 years	20-30 years
Option to be Tax Exempt¹⁰	Yes	Yes
Advantages	<ul style="list-style-type: none"> • Generally viewed as lower risk as backed by unlimited ad valorem taxing authority of issuer rather than revenue from a discrete project, allowing for a lower interest rate • Can abate the ad valorem tax over time with hospital or lease revenues • Lower cost to issue 	<ul style="list-style-type: none"> • No voter approval required unless debt service reliant on new special tax • Revenues from hospital operations can mitigate local tax burden to service debt, however certain “special taxes” (e.g., sales, tobacco) once established are difficult to abate • Typically faster to issue if no voter approval required (however, this factor is less relevant in this scenario as revenue-only financing is not a viable option)
Disadvantages	<ul style="list-style-type: none"> • Voter approval required • Limited use – can only be used to acquire and improve real property 	<ul style="list-style-type: none"> • Cost of capital higher than GO bonds due to market view of being riskier as tied to project revenues • Higher fees to issue compared to GO bonds • Typically fund up to 80% of project costs requiring capital contribution from other sources akin to a “down payment” • Voter approval required if levying new “special tax” such as a non-ad valorem parcel tax
Examples of Use in Recent Projects	Pajero Valley Health Care District Watsonville Community Hospital renovation 106 bed hospital Amount: \$116M (\$24 per \$100k assessed property tax increase to fund); Passed 4/2/2024 by a vote of 68.5% to 31.5%	LA County MLK Jr. Community Hospital renovation 131 bed hospital Amount: \$260M in Tax Exempt Lease Revenue Bonds; 5% interest (AA Rated) Issued 2021

⁹ As confirmed by the City’s bond counsel.

¹⁰ Interest on bonds not subject to Federal or State of California income tax.

Other funding sources may be available to support the capital need, including direct State support, either through appropriation or grant, contribution(s) from the intended operator, and philanthropy. Gaining contribution from one or several of these sources is viewed favorably, improving bond ratings, overall investor interest, and most importantly, lowering the debt financing requirement and any related tax impact. With the current California State budget shortfall, the likelihood for significant State contribution is low;¹¹ however, targeted capital grant opportunities for behavioral health services are available and are further described in the next section. However, it is not expected that these other funding sources could eliminate the need for tax supported debt.

Alternative financing techniques that do not involve the City of Berkeley or a regionally created structure taking on debt exist, including public private partnerships (P3). Under a P3 arrangement, a private developer finances and constructs the hospital for the public partner and passes along the debt service to the public partner via a long term lease. The public partner, in this case the City, health care district, or JPA, avoids debt exposure, the need for voter approval, and passes the project risk (e.g., potential for cost overruns) to the private developer. The primary disadvantage is the cost of capital to the private developer will almost always be higher and they will want an additional return which will be passed to the public partner in the form of high lease payments. The public partner will also have limited, if any, ownership equity in the hospital. Due to the limited examples of recent California inpatient hospital projects having been advanced with this approach, a P3 arrangement was excluded from further evaluation.

Will the debt offering require tax support?

Hospitals in the United States with 100-250 beds receive an average of \$228 million in NPSR a year.¹² As shown in the table below, this is not enough to independently support the debt service requirements for a \$2 billion bond offering, **eliminating the possibility of a revenue bond secured by hospital revenues to independently fund the hospital**. Tax or other revenue support will be required and, therefore, the project is not viable without voter approval for taxes that finance the hospital.

Exhibit: Patient Revenue to Debt Service Ratio Comparison

Annual Debt Service Obligation Under GO and Revenue Bond Offering Scenarios

	Amount	% of NPSR
Average NPSR for a 100-250 bed hospital (US)	\$228,000,000	
Annual Debt Service: \$2 billion GO 4% fixed interest rate, 30 year term	\$114,580,000	50%
Annual Debt Service: \$1 billion GO 4% fixed interest rate, 30 year term	\$57,290,000	25%
Annual Debt Service: \$2 billion Revenue Bond 6% fixed interest rate, 30 year term	\$143,892,000	63%
Annual Debt Service: \$1 billion Revenue Bond 6% fixed interest rate, 30 year term	\$71,946,000	32%

A GO bond will provide the lowest cost of capital and require ad valorem tax support via a new levy on taxable property in the City or the service area, depending on the structure. While a GO bond may only be used to finance land acquisition and facility construction, once the debt is approved by voters, the ad valorem tax support provides a resilient tax revenue stream in the event of catastrophic loss to property

¹¹ LAO FY24-25 California Fiscal Budget Outlook

¹² Definitive Healthcare Hospital View as Sourced from Medicare Cost Report as of June 2024



values within the taxable geography. With a hospital cost of \$2 billion, this GO bond debt service would result in \$429 in additional property tax burden per \$100k in assessed property value if applied only to the City of Berkeley.¹³ Assuming an average assessed property value of \$1,000,000,¹⁴ property owners' bills would increase by \$4,290 per year on average.

A bond secured through a special tax, such as a non-ad valorem parcel tax, offers more flexibility in its uses (e.g., for operating support). However, it would have less flexibility for annual adjustment or abatement, and if a parcel tax, the revenue would be limited by the number of taxable parcels in the given geography. As the City has not expressed interest in securing financing to support ongoing operations, a GO bond is the preferred option for the limited use of acquiring the land for and constructing the hospital.

Section B: Mechanisms to Minimize Debt Financing

With a guiding principle for the project to minimize taxpayer burden, the City should seek to minimize the level of debt financing required to execute the project and has several levers to do so both before construction and following it. The following table illustrates the combined impact of these levers, which are then further described below.

Debt/Tax Minimization Levers and Impact (Illustrative)

	Annual Property Tax Impact per \$100k in Taxable Assessed Value
Base Case City led GO Bond of \$2 billion (4% rate, 30 yr. term)	\$429
Tax Impact Level 1 Spread Property Tax Base (3x base)	\$143
Tax Impact Level 2 Reduce Sticker Price/Debt to \$1B	\$71
Tax Impact Level 3 Abate using Lease Revenue (Assumes \$20M/yr lease)	\$47
Tax Impact Level 4 Refinance in Future to 3.5%	\$42

Tax Impact Level 1 - Expand Taxable Geography: Financing through the establishment of a new healthcare district or a JPA can allow for an expanded geography over which to assess the tax securing the bond. This can lower the tax burden on individual property owners significantly, as illustrated in the table below.

Exhibit: Impact of Debt Minimization and Property Tax Base Expansion on Tax Impact

¹³ Based on 2023 estimated taxable property value for City of Berkeley - [FY2023 Annual Comprehensive Financial Report Schedule V](#)
¹⁴ [Median sale price for a home in Berkeley was \\$1.24 million as of Dec 2023; City of Berkeley Office of Economic Development](#)



		Bond Scenario A	Bond Scenario B	Bond Scenario C
		GO Bond of \$1 billion	GO Bond of \$1.5 billion	GO Bond of \$2 billion
	Annual Debt Service	\$57,290,000	\$85,935,000	\$114,580,000
	Term (years)	30	30	30
	Interest Rate	4%	4%	4%
Scenario	Estimated Taxable Assessed Property Value (in thousands)	Tax Impact per \$100k in Assesed Property Value		
Scenario 1: City led	\$26,712,286	\$214	\$322	\$429
Scenario 2: Healthcare District or JPA led: 2x property tax base	\$53,424,572	\$107	\$161	\$214
Scenario 3: Healthcare District or JPA led: 3x property tax base	\$80,136,858	\$71	\$107	\$143
Scenario 4: Healthcare District or JPA led: 4x property tax base	\$106,849,144	\$54	\$80	\$107

Tax Impact Lever 2 – Reduce Sticker Price / Debt Requirement: Before it seeks financing, the City can aim to reduce its total financing requirement by lowering the price to construct and identifying additional sources of capital:

- Lowering the price to construct** - Constructing a hospital in California is more expensive than doing so in other parts of the United States, and in a metropolitan area, such as Berkeley, even more so.¹⁵ However, the current estimate of \$1.5-2 billion for a 100-200 bed hospital is particularly high and on a cost per bed basis, it would be one of the more expensive to be built.^{16,17} Prior to securing any non-debt based capital contributions, the City of Berkeley should work with its hospital planning collaborators to thoroughly assess and identify opportunities for cost savings to lower the total construction bill. A meaningful reduction has potential to lower the debt and associated tax burden significantly.

Price to Construct a New Seismically Compliant Hospital in California on a Per Bed Basis (in millions)		
	Average	95th Percentile
Price per Bed	\$4.4	\$9.8
Estimated Cost: 100 Beds	\$440	\$980
Estimated Cost 200 Beds	\$880	\$1,960

Source: Updating the costs of compliance for California’s Hospital Seismic Safety Standards, RAND Corporation report for California Hospital Association, 2019
Assumes cumulative inflation of 36% for new hospital construction since 2019 report; Federal Reserve of St. Louis Economic Data accessed August 2024

- Securing non-debt based capital contributions** - Of particular attraction to revenue bond investors is having the selected operator contribute capital, directly or in kind. This helps assure investors that the relationship will be durable, since the operator will be less likely to exit in a financial downturn. In instances where the operator is not willing to put up capital funding directly, a philanthropy agreement, whereby the operator agrees to raise a certain amount of capital from philanthropic sources to support the project, or the provision of capital equipment and/or infrastructure, such as an electronic health records license, can be effective to reduce the up-front debt load.

¹⁵ [The High Cost of Building California Hospitals, Scripps Health, April 2023](#)
¹⁶ Source: Updating the costs of compliance for California’s Hospital Seismic Safety Standards, RAND Corporation report for California Hospital Association, 2019
¹⁷ Assumes cumulative inflation of 36% for new hospital construction since 2019 report; Federal Reserve of St. Louis Economic Data accessed August 2024



Another option is to generate grant funding through the State for discrete aspects of the facility. One such option currently available is through the bond program recently approved under the California Behavioral Health Services Act. Through this program, the state’s Department of Health Care Services is administering \$6.4 billion in grant funding through a competitive bidding process for the development of behavioral health inpatient treatment beds and residential settings, \$1.5 billion of which being awarded to solely to counties, cities and tribal entities. Considering Berkeley’s community health needs and the desire to maintain the service mix of Alta Bates which includes inpatient behavioral health beds, these grants present a compelling opportunity to reduce the overall debt financing required.¹⁸

After construction and following the first few years of hospital operations, the City may apply several levers to further mitigate the long-term cost of capital and/or tax burden. However, it is unlikely that any such non-debt based capital contributions could eliminate the need for tax supported debt.

Tax Impact Lever 3 – Identify non-tax based revenue sources to abate the property tax burden: With general obligation bonds, the taxing entity can assess each year the extent of ad valorem property taxes needed. Specifically, the taxing entity can use lease revenue from the operator to fund the debt service, reducing the taxes needed considerably. This would be achieved through a long-term lease agreement with fixed and predictable lease payments and term assurances. An abatement may be instituted annually or for a predetermined period across multiple years. Certain conditions may apply, and the opportunity should be thoroughly analyzed with bond counsel prior to execution. The impact of a lease revenue subsidy towards debt service is demonstrated in the exhibit below.

Exhibit: Potential Impact of Hospital Lease Revenues in Reducing Local Tax Burden

Term = 30 Years		Annual Property Tax Impact per \$100k in Assesed Property Value					
Interest Rate = 4%		Bond Scenario A		Bond Scenario B		Bond Scenario C	
		GO Bond of \$1 billion		GO Bond of \$1.5 billion		GO Bond of \$2 billion	
		\$57,290,000		\$85,935,000		\$114,580,000	
Annual Debt Service							
Scenario	Annual Lease Revenue	w/Lease Revenue	w/o Lease Revenue	w/Lease Revenue	w/o Lease Revenue	w/Lease Revenue	w/o Lease Revenue
Scenario 1: City led	\$20,000,000	\$140	\$214	\$247	\$322	\$354	\$429
Scenario 2: Healthcare District or JPA led: 2x property tax base	\$20,000,000	\$70	\$107	\$123	\$161	\$177	\$214
Scenario 3: Healthcare District or JPA led: 3x property tax base	\$20,000,000	\$47	\$71	\$82	\$107	\$118	\$143
Scenario 4: Healthcare District or JPA led: 4x property tax base	\$20,000,000	\$35	\$54	\$62	\$80	\$89	\$107

Tax Impact Lever 4 – Refinance to a lower interest rate in the future: An additional lever to reduce tax impact is through refinancing a portion of the initial GO bonds with revenue bonds in the future. GO bonds typically are structured to include a redemption date ten years following issuance, though shorter lock-out periods are possible, at which point they may be refinanced with revenue bonds. The CHFFA bond financing program offers access to low interest rate tax exempt financing tied to the State of California’s credit rating, and it supports debt issuance at a lower than market fee structure.¹⁹ This program is available for refinancing existing debt; however, refinancing would be available only to revenue bonds. The eligibility requirements for participation are narrow; only public and non-profit health facilities that have been operating for at least three years and have either the revenue or collateral to cover the debt service are eligible. The CHFFA has supported bond offerings of the scale

¹⁸ [California Behavioral Health Transformation Behavioral Health Bond Program](#)

¹⁹ [California Health Facilities Financing Authority Bond Financing Program](#)



being contemplated with a recent example being the Cedars Sinai Marina Del Ray Hospital which received \$1.03 billion in debt financing in 2021. The City should further assess this option with its bond counsel.²⁰

Section C: Structural Options for Distributing Tax Impact across Potential Service Area

Financing through the establishment of a new healthcare district or a JPA can allow for an expanded geography over which to assess the tax securing the bond. As demonstrated, this option offers the greatest potential for reducing the tax impact across the hospital service area.

Healthcare facility financing linked to a healthcare district is generally viewed favorably by investors due to its dedicated purpose, public engagement, and ability to levy taxes across a broader geography. However, existing districts have encountered significant financial issues, and without special legislation at the State level, establishing a new district can significantly extend the development timeline because they require voter approval. As confirmed by the City's bond counsel, a JPA offers a faster and more flexible alternative to a healthcare district, including liability protection, and has the ability to issue GO bonds in support of a JPA project. The benefit of a JPA is that it would allow multiple cities to jointly seek voter approval and issue general obligation bonds; the JPA offers no benefit if the City is the only public agency financing the hospital. The following table describes each structural option and the tradeoffs between the two.

Table B: Structural Options

²⁰ In possible future circumstances where CHFFA is not available or does not offer more favorable rates, it may still, however, be politically necessary to utilize this lever regardless of whether the refunding revenue bonds will bear a lower interest rate than the refunded GO bonds.

Structural Options	Healthcare District	Joint Powers Authority ²¹
Summary Description	<ul style="list-style-type: none"> Independent public entities established under California law²² to address the unique healthcare needs of specific geographic regions Responsible for planning, funding and delivering healthcare services for their defined district²³ May own and operate hospitals and other healthcare facilities, directly or indirectly,^{24,25} Some districts no longer operate any facilities and support healthcare services through grantmaking and other activities 	<ul style="list-style-type: none"> Independent entities established by two or more governmental entities to fulfill a common objective, effectively a public joint venture Support pooling of public resources by public entities Coordinate efforts and support efficiencies across governmental agencies/entities to save taxpayers money If authorized by their legislative or other governing bodies, two or more public agencies by agreement may jointly exercise any power common to the contracting parties, including, but not limited to, levying a fee, assessment, or tax²⁶ Non-governmental entities may participate in JPAs (such as through agreement with non-profit hospital to provide services)
Financing	<ul style="list-style-type: none"> Patient service revenue Taxes and assessments:²⁷ Special taxes or assessments on real and personal property within the district, subject to voter approval (taxes and assessments made up 6% of non-debt healthcare district revenue in 2021)²⁸ Debt financing: Districts may issue general obligation bonds (with 2/3 voter approval to raise property taxes to repay the bonds) and revenue bonds (do not require separate voter approval, paid using revenues from the district) Other sources: Including revenue from capital assets, state and federal funds and grants 	<ul style="list-style-type: none"> Patient service revenue Taxes and assessments: Can charge fees, make assessments and levy taxes via taxing authority of member(s) Debt financing: Flexibilities provided to JPAs in bond issuance include: <ul style="list-style-type: none"> Revenue bonds can be issued without voter approval A JPA may issue GO bonds leveraging the powers of its members so long as 2/3 voter approval is received across all participating member jurisdictions²⁹ Other sources: Including revenue from capital assets, state and federal funds and grants
Governance	<ul style="list-style-type: none"> Board of Directors comprised of five registered voters in the district, with four-year terms Initial Board is appointed by county Board of Supervisors, with subsequent vacancies filled by election³⁰ Sessions of the Board of Directors must be open to the public, with limited exceptions³¹ 	<ul style="list-style-type: none"> Formed via agreement between member entities (must be filed within 30 days with Secretary of State and State Controller) JPA formation and revenue-only bond issuance are not subject to voter approval Board of Directors: Must be identified (flexibility in design as positions could be ex officio or appointed by city councils) and in most cases include a treasurer and auditor

²¹ Nevada County, CA Grand Jury Report: Joint Powers Authority: What You Need to Know, 2021

²² [Cal. Health & Safety Code § 32001](#)

²³ "About Healthcare Districts", [Association of California Healthcare Districts](#)

²⁴ [Cal. Health & Safety Code § 32121](#)

²⁵ [Cal. Health & Safety Code § 32129](#)

²⁶ Cal. Govt code § 6502

²⁷ [Cal. Health & Safety Code § 32200-32205, 32221-32223, 32240-32243](#)

²⁸ [California State Controller's Office, Special District Data, 2021](#)

²⁹ 4 As confirmed by the City's bond counsel

³⁰ [Cal. Government Code § 1780](#)

³¹ [Cal. Health & Safety Code § 32106](#)

		<ul style="list-style-type: none"> • Governance model determined during formation of JPA, with horizontal structure allowing a group of distinct and separate member entities to form JPA and provide oversight for activities • Sessions of the Board of Directors must be open to the public, with limited exceptions
<p>Advantages</p>	<ul style="list-style-type: none"> • Clear purpose: Healthcare districts, unlike Cities or counties, are focused on the delivery of health services to the community and can tailor those based on community need. Although, in this case, the City is interested in <u>financing</u> the hospital, not on <u>delivering</u> health services to the community • Transparency and accountability: Districts are publicly governed with an elected Board and financial reporting requirements allowing tax base to clearly see how district revenues are being spent on public healthcare services. Open meetings allow for public involvement and influence • Spread tax base: District limits can extend beyond city limits limiting per capita tax impact 	<ul style="list-style-type: none"> • Liability Protection: As a legally separate public entity, individual JPA members are typically not liable for JPA debts. This protection does not extend to liabilities independently held by the JPA members. • Flexibility: Broad latitude in JPA design and purpose so long as the situation can benefit from having collaboration between public agencies • Ease of Formation: Voter approval is not required to establish or issue revenue-only bonds; however, 2/3 voter approval is still required to issue debt secured by a new tax (e.g., a GO bond or special tax revenue bond). • Agility/Nimbleness: JPAs can move quickly and can incorporate as private organizations with member appointed governing bodies, allowing for delegated decision making without requirement for public review. • Transparency and Accountability: Board meetings are open to the public with limited exceptions and financial reporting requirements allow tax base to clearly see how district revenues are being spent (it is expected the revenues would primarily or exclusively pay for debt service). Open meetings allow for public involvement.
<p>Disadvantages</p>	<ul style="list-style-type: none"> • Cost of Capital: While having taxing authority and the ability to issue GO bonds, a new healthcare district without credit history or rating will likely receive a higher interest rate than GO bonds issued by municipalities with strong credit history. • Time to Establish: Healthcare district formation is multi-step requiring the engagement of all governments and territories with land within district boundaries, extensive planning and agency review, and a public vote. • Inefficient/Duplication of Service: Healthcare districts often extend across multiple jurisdictions and provide similar services to those already provided by or to the City or County if another healthcare district overlaps their borders • Regional Planning: Can lead to discoordination of efforts as independent board not connected to other local governing bodies and their related health efforts 	<ul style="list-style-type: none"> • Bond Process: Due to the complexities of the laws and rules around GO bonds and JPAs, there may be additional procedural and legal steps required before the JPA could issue a GO bond. •



Establishing or Joining an Existing Healthcare District

If pursued, healthcare districts can be formed through public process or legislative action.

The process for healthcare district formation is defined in the California Health and Safety Code³² and subject to review by the California Local Agency Formation Commission (LAFCO). The process includes:

1. **Define health care district geography and purpose (§ 32001):** District geography may include any territory, incorporated and/or unincorporated, in one or any more counties, and does not need to be contiguous. Municipalities within district boundaries must be fully included and may not be divided. Petitions for district establishment must demonstrate need, feasibility, and public support.
2. **Public and Agency Review (§ 32002):** Prior to petition going to hearing and public vote, it will be subject to agency and public review. Stakeholders with formal review duties include each health planning agency with territory in the district, and the Office of Statewide Health Planning and Development. A public review and comment period of 54 days is also required where comments for or against can be submitted. If comments against district formation are submitted, they must be published and distributed along with election date notifications at least 10 days prior to the election date.
3. **Public Vote and Approval (§ 32003):** Following review, the petition may be presented at any meeting of the supervising authority of the county with the greatest portion of the land proposed for the district resides. The petition must have signatures from at least 12% of the registered votes within the proposed district boundaries. A vote may then be scheduled and held. If the majority of votes cast are in favor of the district, it may form immediately.

There is also precedent for legislative action to rapidly establish a new healthcare district in urgent circumstance. For example, Pajaro Valley Health Care was established with the 2022 passage of Senate Bill 418 to acquire and ensure the ongoing operation of Watsonville Community Hospital following bankruptcy (see appendix for case profile). Recent precedent for fast tracking district formation in urgent circumstance seems to be driven by the goal to avoid healthcare deserts, which would not likely apply to the East Bay market.³³ However, if the City were to explore the potential for this, the next opportunity for review and action will be in 2025’s legislative session.

Additional detail for this process can be found in Appendix B.

Establishing Joint Powers Authority

JPAs can be established relatively rapidly through written contractual agreement between two or more public agencies. This includes public health systems. A joint powers authority does not require voter approval but is subject to public review like other public agencies. While able to bypass the voter approval required for health care district formation, the JPA will still need to include a public member

³² [California Health and Safety Code Division 23 Sec 32000-32003](#)

³³ Pajaro Valley Health Care District was established by legislative action under SB 418 in February 2022 to purchase and maintain operations of Watsonville Hospital following Chapter 11 bankruptcy.



with taxing authority in addition to the City to allow for tax support from a broader geographic base and require 2/3 voter approval across the participating jurisdictions to issue a GO bond.

Bay Area Healthcare District Context

The Bay Area is home to multiple healthcare districts with two adjacent to Berkeley, Alameda Health Care District and the West Contra Costa Health Care District, which is currently being overseen by the Contra Costa County Board of Supervisors following District bankruptcy in 2016. Other Bay area healthcare districts include El Camino Health, Marin Healthcare District, Peninsula Healthcare District, and Sequoia Healthcare District.

Each healthcare district has unique features informed by the scope of services and population base to whom those services are provided. The below table describes the features and key differences between three of the most proximate healthcare districts to Berkeley.

Healthcare District	City of Alameda Healthcare District	West Contra Costa Healthcare District	Marin Healthcare District
Overview	District is the steward for Alameda Hospital and its associated facilities, which are operated by Alameda Health System (AHS), formerly Alameda County Medical Center and currently a public hospital authority, under a JPA formed in 2012 between the District and AHS. District is responsible for collection of parcel tax to support hospital and facilities in the City of Alameda	Currently dormant following 2016 bankruptcy (exited in 2021). District was formed to build Doctors Medical Center (formerly Brookside) and oversaw health planning for West Contra Costa County. Following District bankruptcy, Governor passed Senate Bill 522 in 2018 placing the Contra Costa County Board of Supervisors as governing body for District.	Owns and is steward for Marin General Hospital, an independent non-profit hospital, the only acute care facility in Marin County. District ensures countywide access to care and that hospital facility is in compliance with seismic standards.
Population Served	City of Alameda	West Contra Costa County	Marin County, excluding Novato
District Facilities	<ul style="list-style-type: none"> • Alameda Hospital • South Shore Rehabilitation • Park Ridge Rehabilitation • Kate Creedon Wound Center 	<ul style="list-style-type: none"> • Doctors Medical Center (closed 2015) 	Marin General Hospital dba MarinHealth Medical Center
Tax Levied through District	Yes, annual parcel tax of \$298 on every parcel and possessory interest within district boundaries (\$5.9M received annually) to support operating and capital funding needs of Alameda Hospital and related facilities	Yes, parcel tax levied in 2004 to support struggling Doctors Medical Center Facility and a second parcel tax in 2011 to further subsidize facility losses. Collectively, parcel taxes brought in \$11.3 million in FY23. ³⁴ Parcel taxes support ~\$3M in annual debt service on Doctors Medical Center related bonds set to mature in 2042	Yes, property tax of \$22.3 per \$100k in assessed property value approved by Marin Health Care District voters in 2013 to fund \$394M GO bond to finance rebuild of Marin General Hospital

³⁴ [West Contra Costa Healthcare District FY23 Audited Financials](#)



		with remainder funding other liabilities and district services.	
Existing Financing Arrangements and Purpose	Certificate of Participation secured by statutory lien on parcel taxes to fund capital improvements necessary to meet seismic standards (Amount TBD)	None; Doctors Medical Center (sole acute care facility) closed 2015	General Obligation Bond of \$394M to fund rebuild of Marin General Hospital facilities (30-year term)
Finance Issues to Note	<ul style="list-style-type: none"> JPA Compliance: Alameda Hospital has experienced ongoing financial distress despite parcel tax revenue subsidy due to mismanagement of facility by AHS. Resulted in \$200M in debt owed to Alameda County.³⁵ Financial Shortfall: High governmental payer mix coupled with service mix has resulted in ongoing operating deficit 	Current tax is financing repayment of existing debt and some local health services that remain.	<ul style="list-style-type: none"> No financial issues of note \$394 million for bonds outstanding to finance Oak Pavilion Hospital Building. Receives \$16 million in property tax revenue to service annual debt requirement

Section D: Next Steps and Timing

The City of Berkeley faces many upcoming steps and decisions as it considers options for financing a new hospital. Each structural and financing option carries implication for the time required to execute. Given that a guiding principle is to eliminate the time between the new facility opening and the closure of Alta Bates, and that the assumed closure is to occur in 2030, expediency is a leading consideration. The following represent the major steps in the process and the estimated timeframe to complete.

Step 1: Feasibility and Planning (12-24+ months): Prior to the debt offering, a detailed feasibility study will need to be conducted and presented for investor and public scrutiny. This phase also involves planning and stakeholder engagement to align partner and community interest. This extends to identification and engagement of the future operating partner. This step can take anywhere from 1-2+ years depending on the stakeholders and project scale, amongst other factors.

The feasibility study will evaluate the need for and long term financial sustainability of the proposed hospital project. This is an investor requirement necessary to set bond terms to the extent revenue bonds are utilized, but is politically necessary for GO bonds. The planning process includes partner and vendor selection for financing, constructing and operating the hospital. These activities can occur concurrently.

Elements assessed by investors will include, but are not limited to:

- Geography and Related Community Need:** What is the geography of service? What is the socioeconomic, health, and coverage status of the population to be served? How competitive is

³⁵ [Alameda County Grand Jury Report 2014-15](#)

the local market and do gaps in care exist currently? Does local service demand/needs support the need for a facility of this size and with the proposed service mix?

- **Facility Payer Mix and Reimbursement:** What are the projected financials for the hospital? What assumptions drive that projection and what are the sensitivities (e.g., volume, payer mix, contracted reimbursement rates, etc.)? For example, in a scenario where the facility has a high governmental payer mix, ongoing or additional tax support may be required to offset operating losses if the operator were to require it either through agreement or in the event of a crisis.
- **Performance of Existing Facility:** What is the operating performance of the facility to be replaced? Financial performance of the current inpatient facility will be used to assess likelihood of future performance for the planned facility.
- **Oversight and Funding Structure:** Under what structure will the hospital be organized and how will it be funded? If a health care district and/or JPA is to be formed, the public partners necessary to enable will need to be engaged during this step to develop the plan for establishment, financing and funds flow. Healthcare districts receive independent credit ratings from the municipalities and territories that comprise them. The structure and “what is in” will have implication for credit terms.
- **Operating Partner:** Who is chosen to be the operator will be one of the most, if not the most, important factors investors will look at. Considerations will include:
 - Experience - Investors want an experienced operator. For example, a new healthcare district with no prior operational experience running the hospital would be considered higher risk.
 - Financial interest - Investors in revenue bonds want to see that a third-party operator has some “skin in the game” to give confidence in the durability of the relationship so in the event of financial downturn, the operator has incentive to improve performance rather than exiting the operating or lease agreement. Contribution can take many forms, including capital, philanthropy commitment and/or infrastructure.
 - Well-regarded brand presence in the market - Respected healthcare brands (e.g., UCs, Kaiser) are attractive to patients and are more likely to capture and maintain market share.
 - History of strong financial performance - Particularly important if debt service tied to operating revenues or lease.
- **Timing Between Closing of Old and Opening of New:** Ideally, there should be no gap between the closing of the old and the opening of the new facility. Gaps in access, even short ones, can risk loss of local market share before the new facility opens.
- **Project Team:** All vendors and professionals participating in project will be scrutinized (engineers, architects, etc.) There is a need to select a highly qualified team with demonstrated experience in developing projects of this scale on time and on budget.

Step 2a: Establish Healthcare District *if pursued* (4-9 months): If choosing to establish a new healthcare district, or join and expand the boundaries and scope of service for an existing one, California state law requires planning and submission of a petition for formation, review and comment by the CA Office of Statewide Health Planning and Development and by each health

planning agency with territory within the proposed district (60 days), notification of election to LAFCO and response (10 days), posting of proposal for formation and public comment (54 days), distribution of notice for public vote prior to election (10 days minimum), and finally a public vote with at least 12% of registered voters within proposed district boundaries participating and recording majority approval.³⁶

Step 2b: Establish Joint Powers Authority *if pursued (4-6 months)*: If choosing to establish a JPA, a vote will not be required. Once authorized by their legislative or governing bodies, the public agencies may enter into an agreement. The agreements shall state the purpose of the agreement or the power to be exercised and provide for the method by which the purpose will be accomplished or the manner in which the power will be exercised. Once executed, the agreement must be filed with the Secretary of State within 30 days of the effective date with an additional copy to be sent to the Controller. Once successfully filed, the JPA may issue bonds and finance projects.³⁷

Step 2c: Gain Voter Approval of Additional Debt and Associated Tax to Secure (4-9 months): If debt is to be secured by new tax revenues, ad valorem or special tax, voter approval will be required. Organizing, publicizing, and holding the vote may take anywhere from 4-9 months. (If establishing a healthcare district, the vote can occur at same time as district formation vote.)

Step 3: Issue Debt (4-9 months): Once approval to offer debt is received, the issuing entity will work with investment banks and advisors to develop offering(s) and then make them available to investors. Generally, this can take 4-9 months, though complex circumstances could result in longer timelines extending up to 12-18 months.

Step 4: Complete Permitting and Construction (3-5+ years): Once funded, project construction will begin. The construction timeline has several dependencies, such as permitting, land acquisition, and regulatory review, which may be initiated in parallel with the prior steps. As the most time-intensive step, choosing a developer in the planning and feasibility stage with demonstrated experience executing a hospital project of similar scale in the same or similar geography is essential.

³⁶ California Healthcare District Law 32000-32003

³⁷ California Government Code - Section 6500-6536 :: Article 1. Joint Powers Agreements

Appendices

Appendix A: Special District GO Bond Rating Criteria (Moody's)

Appendix B: California Healthcare District Formation Regulations (32000-32003)

Appendix C: Summary of Regional Municipalities and Current District Participation Status

Appendix D: Case Profile – Pajero Valley Health Care District Formation via Legislation

Appendix A: Moody's Special District GO Bond Rating Criteria

EXHIBIT 1

US Special Purpose District General Obligation Debt Scorecard Overview

Factor	Factor Weighting	Sub-factor	Sub-factor Weighting
Economy / Tax Base	30%	Tax Base Size (full value)	10%
		Full Value Per Capita	10%
		Wealth (median family income)	10%
Finances	30%	Fund Balance (% of revenues)	10%
		Fund Balance Trend (5-year change)	5%
		Cash Balance (% of revenues)	10%
		Cash Balance Trend (5-year change)	5%
Management	20%	Institutional Framework	10%
		Operating History	10%
Debt / Pensions	20%	Debt to Full Value	5%
		Debt to Revenue	5%
		Moody's-adjusted Net Pension Liability (3-year average) to Full Value	5%
		Moody's-adjusted Net Pension Liability (3-year average) to Revenue	5%

Source: Moody's Investors Service



Appendix B: California Health and Safety Codes: Division 23 – Hospital Districts

Division 23, Chapter 1: Formation of District

Section	Policy
§ 32001	<p>A local hospital district may be organized, incorporated and managed, as provided in this division and may exercise the powers herein granted or necessarily implied. Such a district may include incorporated or unincorporated territory, or both, or territory in any one or more counties. The territory comprising this district need not be contiguous but the territory of a municipal corporation shall not be divided; provided, that land either in a municipal corporation or in unincorporated territory which the supervising authority finds will not be benefited shall not be included.</p> <p>(Amended by Stats. 1965, Ch. 2043.)</p>
§ 32002	<p>The manner of formation of local hospital districts, and the conducting of all hospital district elections, unless otherwise provided in this division shall be as in the manner provided, respectively, by Chapter 1 (commencing with Section 58000) of Division 2 of Title 6 of the Government Code, and Part 3 (commencing with Section 10400) and Part 4 (commencing with Section 10500) of Division 10 of the Elections Code. Except as provided in this division, these provisions are hereby incorporated in this division by reference and shall have the same effect and force as if fully set forth herein. In addition to all other requirements regarding formation of hospital districts, no hearing upon the petition to form a hospital district shall be held until comments and recommendations of the Office of Statewide Health Planning and Development and each area health planning agency having territory within the proposed district, concerning the need for new or additional health facilities in the area to be served by the proposed district have been filed with the supervising authority. The Office of Statewide Health Planning and Development and the area health planning agency or agencies shall submit these comments and recommendations to the supervising authority within 60 days after receiving a request therefor from the proponents. Failure to submit these comments to the supervising body within 60 days shall be deemed to constitute a “no comment” response.</p> <p>(Amended by Stats. 1994, Ch. 923, Sec. 145. Effective January 1, 1995.)</p>
§ 32002.31	<p>Within five days after the district formation election has been called, the legislative body which has called the election shall transmit, by registered mail, a written notification of the election call to the executive officer of the local agency formation commission of the county or principal county in which the territory or major portion of the territory of the proposed district is located. Such written notice shall include the name and a description of the proposed district, and may be in the form of a certified copy of the resolution adopted by the legislative body calling the district formation election.</p> <p>The executive officer, within five days after being notified that a district formation election has been called, shall submit to the commission, for its approval or modification, an impartial analysis of the proposed district formation.</p> <p>The impartial analysis shall not exceed 500 words in length and shall include a specific description of the boundaries of the district proposed to be formed.</p> <p>The local agency formation commission, within five days after the receipt of the executive officer’s analysis, shall approve or modify the analysis and submit it to the officials in charge of conducting the district formation election.</p> <p>(Added by Stats. 1970, Ch. 736.)</p>
§ 32002.32	<p>The board of supervisors or any member or members of the board authorized by the board, or any individual voter or bona fide association of citizens entitled to vote on the district formation proposition, or any combination of such voters and associations of citizens, may file a written argument for or a written argument against the proposed district formation.</p>



	<p>Arguments shall not exceed 300 words in length and shall be filed with the officials in charge of conducting the election not less than 54 days prior to the date of the district formation election. (Added by Stats. 1970, Ch. 736.)</p>
<p>§ 32002.33</p>	<p>If more than one argument for or more than one argument against the proposed district formation is filed with the election officials within the time prescribed, such election officials shall select one of the arguments for printing and distribution to the voters. In selecting the arguments, the election officials shall give preference and priority in the order named to the arguments of the following:</p> <ul style="list-style-type: none"> (a) The board of supervisors or any member or members of the board authorized by the board. (b) Individual voters or bona fide associations of citizens or a combination of such voters and associations. <p>(Added by Stats. 1970, Ch. 736.)</p>
<p>§ 32002.34</p>	<p>The elections officials in charge of conducting the election shall cause a ballot pamphlet concerning the district formation proposition to be voted on to be printed and mailed to each voter entitled to vote on the district formation question. The ballot pamphlet shall contain the following, in the order prescribed:</p> <ul style="list-style-type: none"> (a) The complete text of the proposition. (b) The impartial analysis of the proposition, prepared by the local agency formation commission. (c) The argument for the proposed district formation. (d) The argument against the proposed district formation. <p>The elections officials shall mail a ballot pamphlet to each voter entitled to vote in the district formation election at least 10 days prior to the date of the election. The ballot pamphlet is “official matter” within the meaning of Section 13303 of the Elections Code. (Amended by Stats. 1994, Ch. 923, Sec. 146. Effective January 1, 1995.)</p>
<p>§ 32003</p>	<p>Whenever the formation of a local hospital district is desired, a petition may be presented at a regular meeting of the supervising authority of the county in which the land, or a greater portion of the land, in the proposed district is situated, said petition to be signed by the registered voters residing within the boundaries of the proposed district, equal in number to at least 12 percent of the voters registered within the boundaries of the proposed district 30 days prior to the date the petition is filed. The number of written protests required to terminate the proceedings shall be a majority of the registered voters residing in the proposed district. If a majority of all the votes cast in the proposed district are in favor of organization, the supervising authority by resolution entered on its minutes shall declare the district duly organized under this act, shall give the name of the district as theretofore designated and shall describe the boundaries of such district. The county whose supervising authority declares the district organized shall be designated the “organizing county.” (Amended by Stats. 1963, Ch. 1232.)</p>

Appendix C: Summary of Nearby Municipalities in Service Area Geography and Current District Participation Status

Municipality / Territory	Distance from Alta Bates Summit Medical Center (miles)	Currently in/Contains a Health Care District (Y/N)	Health Care District	Health Care District Tax	Net Assessed Value of Taxable Property (in billions) ³⁸
Berkeley	0.0	No	N/A	No	\$26.712
Emeryville	2.3	No	N/A	No	\$7.190
Piedmont	3.6	No	N/A	No	\$4.700 ³⁹
Oakland	3.7	No	N/A	No	\$79.755
Albany	4.2	No	N/A	No	\$3.409
Kensington	4.4	Yes	West Contra Costa	\$52 per parcel tax + tiered parcel tax based on property type*	Not Available
El Cerrito	6.1	Yes	West Contra Costa	\$52 per parcel tax + tiered parcel tax based on property type*	\$5.478
Orinda	6.7	No	N/A	No	\$8.874
Richmond	8.8	Yes	West Contra Costa	\$52 per parcel tax + tiered parcel tax based on property type*	\$13.649
Moraga	11	No	N/A	No	\$5.237
Lafayette	11.2	No*	N/A	No	\$10.524
San Pablo	11.7	Yes	West Contra Costa	\$52 per parcel tax + tiered parcel tax based on property type*	\$2.622
Walnut Creek	14.3	No	N/A	No	\$22.555
Alameda County	N/A	Yes	City of Alameda	District specific	\$379.140
Contra Costa County	N/A	Yes	Los Medanos; Concord/Pleasant Hill; West Contra Costa	District specific	\$256.266

*Tiered parcel tax approved in November 2011 (Measure J): \$47/single family home; \$94/small multi-unit residential; \$282/small commercial or industrial property; \$470/medium commercial or industrial property; \$940/large commercial or industrial property.
Source: Contra Costa County Public Records

³⁸ Net Assessed Value of Taxable Property sourced from FY23 Audited Comprehensive Annual Financial Reports respective municipalities and county.

³⁹ Piedmont does not report net assessed value in annual audited financials and relies on Alameda County for annual estimate. \$4.7 billion value as of June 2020 from Report of the Piedmont Budget Advisory and Financial Planning Committee.

Appendix D: Case Profile

Profile: Pajaro Valley Health Care District Formation via Legislation

Case Profile: Pajaro Valley Health Care District Formation via Legislation

- In 2022, the Pajaro Valley Health Care District (Pajaro Valley) was formed through special legislation (Senate Bill 418) to acquire the operations of Watsonville Community Hospital (Watsonville), a 106-bed inpatient hospital, to ensure its ongoing operation.
 - SB 418 allowed for expedited formation of district, bypassing the voting process and fast-tracking aspects of the planning process
 - Watsonville was in bankruptcy under the prior for-profit operator
 - Watsonville served a lower income community that would experience a significant reduction in access to care should the hospital close.
 - Effort had significant community support and engagement
- The hospital was transitioned from a for-profit to a non-profit entity under the control of Pajaro Valley.
- On March 2, 2024, voters approved Measure N, allowing Pajaro Valley to purchase, renovate and modernize Watsonville.
 - Measure N allowed for the levy an ad valorem property tax estimated at \$24 per \$100k in assessed property value to secure a \$116M general obligation bond
 - Bond is funding the purchase and renovation of Watsonville. Purchasing the facility will save Pajaro Valley \$3M annually in lease payments.
 - Measure passed 68% to 32%

