Mark Twain
Health Care District

AGENDA
Regular Meeting of the
Board of Directors
Mark Twain HealthCare District
Wednesday, October 30, 2013
7:30 a.m.
Classroom 2
San Andreas, CA

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1. Call to Order and Roll Call
2. Approval of Agenda

3. Public Comment on matters not listed on the Agenda.
The purpose of this section of the Agenda is to allow comments and input from the public on matters within the jurisdiction of the Mark Twain HealthCare District not listed on the Agenda.
(The public may also comment on any item listed on the Agenda prior to Board action on such item.)

Limit of 3 minutes per speaker.

CONSENT CALENDAR
All items on the Consent Calendar are considered routine and may be approved by the District Board without any discussion by a single roll-call vote. Any Board Member or member of the public may remove any item from the Consent Calendar. If an item is removed, it will be discussed separately following approval of the remainder of the Consent Calendar.

Approval of the September 25, 2013 Minutes
(Pg. 1-5)

UNFINISHED BUSINESS

1. Approval of the Community Health Needs Assessment......................Daymon Doss
(pg. 7-16, Attachment A)
Public Comment

2. Construction Update at Suites 103-105........................Larry Cornish / Daymon Doss
Public Comment

Approval of the August 28, 2013 Minutes

Mr. Campana made a motion to approve the Minutes of August 28, 2013, as amended; the motion was seconded by Mr. McInturf and approved by a vote of 4 in favor, 0 opposed.

UNFINISHED BUSINESS

1. **Presentation at The Cancer Center Regarding the Telehealth Robot**
   (pg. 6, Attachment A)

   The Board began the monthly meeting at The Cancer Center located at 704 Mountain Ranch Road, Suite B. Drs. Smart and Allen provided the Board Members with a demonstration. Members were given the opportunity to ask questions regarding the Robot.

   Public Comment
   None

2. **Site Visit and Construction Review at Suites 103-105**
   (pg. 8, Attachment B)

   Mr. Cornish presented the scope of work for the necessary renovation to expand the current FMC to include suite 105, incorporating 1900 sq ft. The majority of the work is changes to the store front to provide contiguous access and reception to all patients. The expanded space will include three examine rooms and one provider office.

   Public Comment
   None

NEW BUSINESS

3. **Resource Connection**
   (pg. 11, Attachment C)

   Jeanne Hayward, Director of the Resource Connection Food Bank, a non-profit organization, requested a $5,000 donation for purpose of continuing the food program for needy families, on June 26, 2013. In a letter, dated September 17, 2013, the Resource Connection made a formal request to the MTHCD, for a $5,000 donation.
   After discussion the Board agreed that the request may not meet the criteria of "Public Health" as stated in the MTHCD Mission Statement. The Board agreed to table the decision until all Board Members are present.

Mr. McInturf made a motion to table the discussion until the October, 2013 meeting when all of the Board Members are present for the discussion and action; it was seconded by Dr. Smart, and approved by a vote of 4 in favor, 0 opposed.

Public Comment
Mr. Fry questioned the Board Members, if the iPad Scholarship met the criteria for "Public Health".

4. **MTHCD President's Report**

Mr. Doss reported:

- Proposed Holiday Schedule Approval - The Board discussed the upcoming holiday meeting schedule as proposed.

  Upon motion by Dr. Smart the Board agrees to the following holiday schedule:
  - October 30, 2013– Monthly meeting
  - November 13, 2013, ACO meeting at Camps Restaurant
  - December 4, 2013 – Monthly meeting
  - January 22, 2013 – Monthly meeting
  -

  The motion was seconded by Mr. McInturf, and approved by a vote of 4 in favor, 0 opposed.

5. **Real Estate Update**

Dog Town Road:

- Mr. Doss distributed the "Traffic Impact Analysis", as attached (Attachment G). He noted that there is no overwhelming traffic impact for the intersection of Highway 49 and Highway 4. Cal Trans will make a possible recommendation of a right-in, right-out turn. This has not yet determined to be necessary.

- The EIR (Environmental Impact Report), and Air Quality Report (a copy is available for review at the MTHCD office) has been completed on the Dog Town property.

- The planning commission will meet November / December to review and discuss the studies etc. of the property.

- Discussions with the City of Angels continue regarding the building and sewage.

Public Comment
Mr. Fry asked if the General Plan would go to the Planning Commission.

6. Monthly Financial Report

Mr. McInturf reviewed the Narrative included in the Board Agenda materials (pg.12, Attachment D).

- Fixed Income Investment - Mr. McInturf stated that the District has received the funds in the amount of $91,000 for the Prop 1A funds that were borrowed from the District. These funds will be recorded in the September financials.

- Audit Engagement Letter (pg. 18-21, Attachment E) – The Board reviewed the letter attached from TCA.

ACTION:

A motion by Dr. Smart and seconded by Mr. Campana to accept the Financial Report for August, 2013, was approved by a vote of 4 in favor, 0 opposed.

7. ACO in Calaveras County Update

Mr. Doss stated that he has spoken with Lynn Barr from the National Rural ACO. She has agreed to attend the November 13, 2013 ACO meeting to speak on behalf of NRACO.

ACTION:

After discussion, Dr. Oliver made a motion to proceed with the ACO meeting on November 13, 2013 at Camps Restaurant in Angels Camp from 6:00pm-8:00pm with a budget not to exceed $2,000; the motion was seconded by Dr. Smart and approved by a vote of 4 in favor, 0 opposed.

Public Comment
None

8. **MTHCD Executive Director Report**

Mr. Doss reported:

- Prop 1A Securitization – The District received $91,000 from the Prop 1A County borrowed funds.

- ACHD Best Practices for Governance Transparency (pg. 22, Attachment F) – Mr. Doss will complete and submit the documentation for an ACHD approval of "Best Practices". The goal of the Board will be to achieve "*Best Practice*" status.

- Emergency Water System (Plug Ugly) – Mr. Doss met with the county last week regarding the water system that can be used as potable water in the event of an emergency. Unfortunately, the line was not functioning correctly, possibility due to a broken valve. The county will research the cause of the failure.

Public Comment
None

9. **Lease Review Adhoc Committee Update**

Dr. Oliver stated that he met with the Lease committee on September 11, 2013, and had a positive discussion. A consensus was reached on all items on the Lease Amendment. The Amendments will shadow the extension. It is anticipated that the document will be ready to present to the Board in 60-90 days. A thorough report will be presented to the Board in October.

Mr. Marks noted that the September 11, 2013 did not have attorney present for either side.

This item will remain on the Agenda monthly until such time that the Lease is completed.

Public Comment
None

10. **MTMC Board Report**

Mr. Campana distributed the monthly report for the Board to review.

Public Comment
None

11. Board Comments

- Mr. McInturf requested an update on the student iPad. Mr. Doss stated that by the end of the day he will have all the final details, and give a final report in October.
- Mr. McInturf and Dr. Smart will begin to update the criteria for the iPad Scholarships for 2014.
- Mr. Campana complimented Dr. Smart on his work with the Telehealth program.
- Dr. Smart briefly discussed the materials on page 8, Attachment B, included in the Board agenda materials. He requested that a letter from the hospital be submitted to the MTHCD stating that the upgrades made to Suite 105 would be repaid to the District by the Hospital. Mr. Marks agrees that it is a reasonable request.

Dr. Smart made a motion to approve the temporary Lease Agreement with Mark Twain Medical Center, as outlined in Attachment B for Suites 103,104 and 105; the motion was seconded by Mr. McInturf and approved by a vote of 4 in favor, and 0 opposed.

There being no further business, Mr. McInturf made a motion to adjourn the meeting of the Mark Twain HealthCare District at 9:38 a.m., and the motion was seconded by Dr. Smart, and approved by a vote of 4 in favor, and 0 opposed.

Lin Reed, President

Peter Oliver, M.D., Secretary

ATTACHMENT A

Community Health Needs Assessment

Mark Twain Medical Center

October 17, 2013

AGENDA

- *Welcome and Introductions*
- *Community Assessment Cycle*
- *Working Timeline*
- *Community Wellbeing Domains*
- *Indicator Prioritization*
  - » *Selection and Research Criteria*
  - » *Indicator Review*
- *Next Steps*

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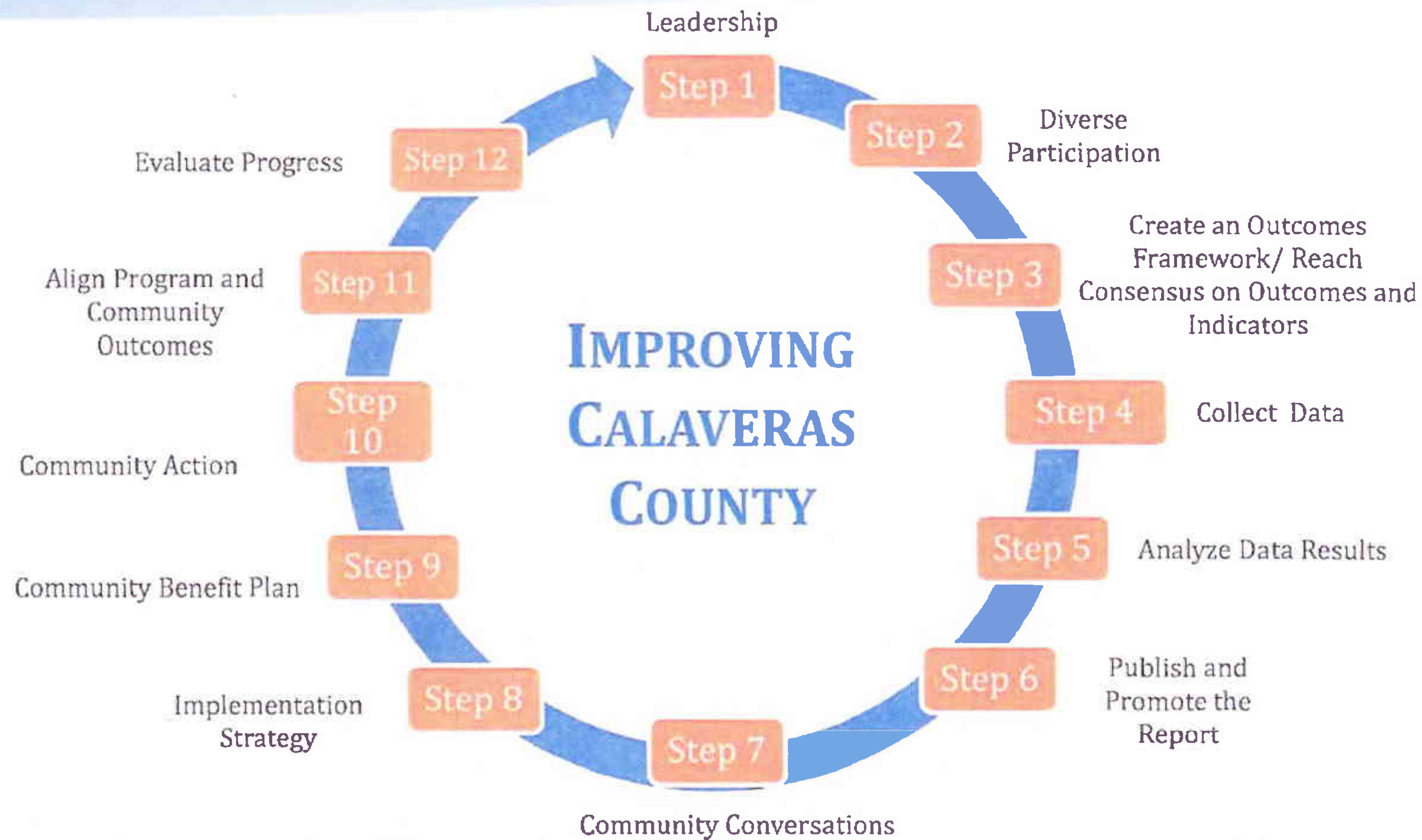
COMMUNITY ASSESSMENT CYCLE



ASR

WORKING TIMELINE

- Develop final quality of life indicators (OCTOBER)
- Key Informant Interviews (NOVEMBER)
- Secondary data collection (NOVEMBER-JANUARY)
- Data report (FEBRUARY)
- Community Summit Meeting (TBD)
- Implementation Plan (TBD)

0 010

COMMUNITY WELLBEING DOMAINS

0 011

INDICATOR PRIORITIZATION

0 012

SELECTION AND RESEARCH CRITERIA

Choosing a Quality of Life Indicator

- Understandable
- Responsive to change
- Has policy relevance
- Comparable to peer counties, state and nation
- Valid
- Available on an on-going basis
- Reliable

0 013

INDICATOR REVIEW

- Review current indicators
  - » Determine whether to keep, delete, or modify
- Recommend new indicators
  - » Only those with a known data source
- Select final indicators

NEXT STEPS

- Finalize list of indicators
- Determine key informants to interview
- Develop key informant interview questions
- Start key informant interviews
- Start data collection

THANK YOU

Abbie Stevens
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831-728-1356

Deanna Zachary
deanna@appliedsurveyresearch.org

0 016

ATTACHMENT B

Open

Lynn Barr, Strategic Advisor

Lynn Barr, Strategic Advisor. An energetic entrepreneur with thirty years of experience in health care, Ms. Barr has shepherded twelve medical inventions and five start-ups through research, the FDA and to worldwide markets. While earning her Master's Degree in Public Health at UC Berkeley, she led the California Health IT and Exchange Strategic Planning Team under California HHS HIT Deputy Secretary Jonah Frohlich, formed the Rural Health Information Technology Consortium and assessed HIT status of California Rural and Critical Access Hospitals. She developed a $20 million rural hospital loan program with United Health Group and is the Executive Director of the CAReHIN network which is HRSA-funded to assist hospitals in technology adoption. Ms. Barr is a member of the National Rural Health Association Government Affairs Council, a 2013 NRHA Fellow, an ORHP Advisor on Health Care Reform, Chair of the National Rural Hospital Innovators Group and policy advocate on behalf of all rural providers.

Georgia Green, Executive Director

Georgia Green, Executive Director. Georgia has a Master's of Science from UC Berkeley's School of Public Health. Her research centered around the health impacts of electronic waste disposal in the developing world, particularly in Abidjan, Cote d'Ivoire (West Africa). She has worked in various research laboratories and high-tech start-up companies, including most recently, an algae biofuel company. A natural systems-thinker, she is responsible for the internal operations of the NRACO, as well as the development and execution of the organization's strategic plans.

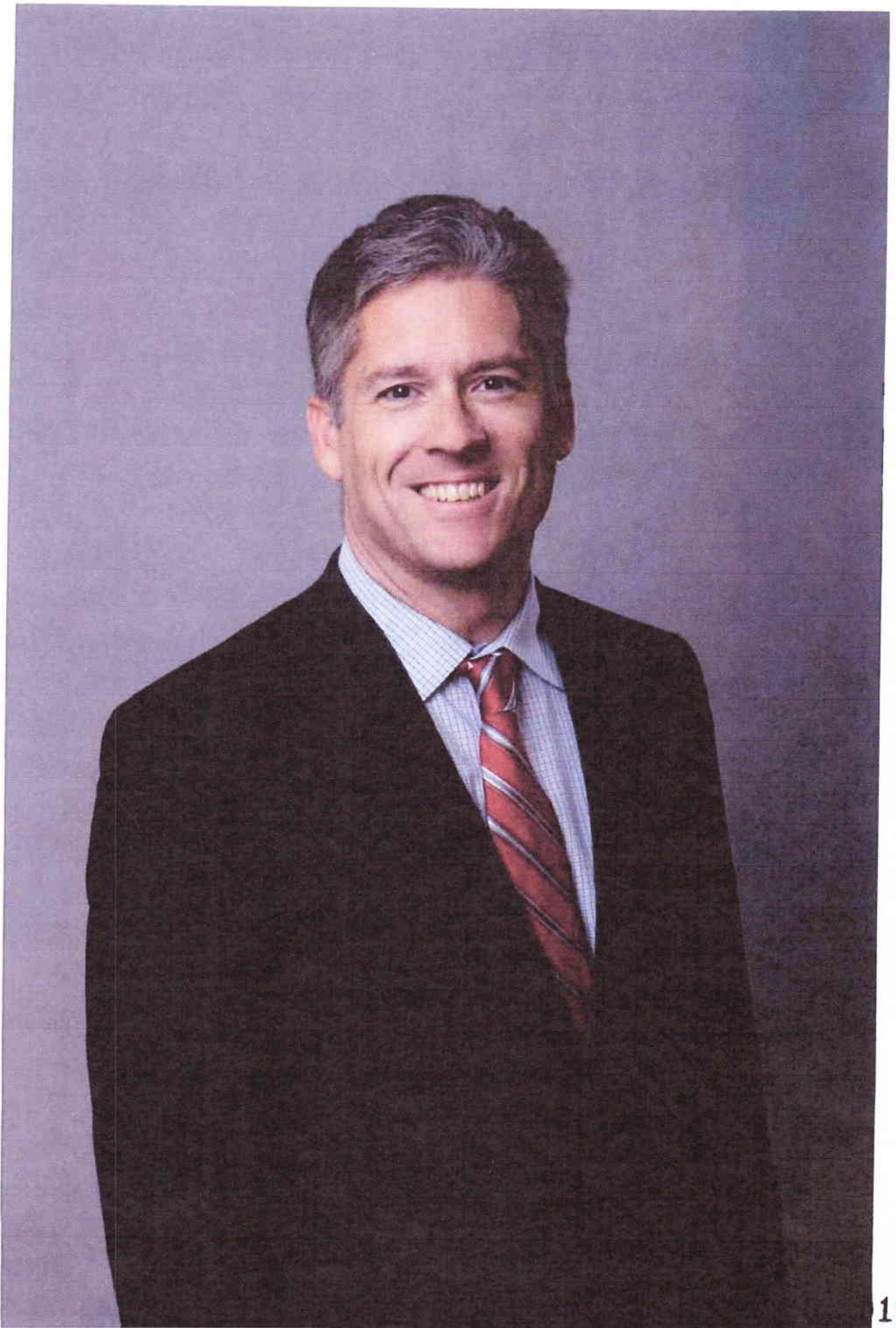
ATTACHMENT C

Stephen Foerster, Vice President, Managed Care, Dignity Health. Steve is responsible for managing Dignity Health's North State, Sacramento/San Joaquin, and Central Valley contract portfolios for Dignity Health Hospitals. In addition, he has responsibility for Medical Foundation and Joint Venture contracting. He is also responsible for leading multi-year state-wide and system-wide negotiations with payers including fee-for-service, commercial and senior capitation.

Steve has 20 years of experience as a health care executive, including strategic planning, business development and revenue management in heavily penetrated managed care markets. His leadership background includes payer negotiations, program development, physician relations and financial analysis.

Prior to joining Dignity Health, Steve spent several years as Senior Director of Contract Services at Washington Hospital Healthcare System in Fremont, California, served on the administrative team at Doctors Medical Center in Modesto and Doctors Hospital Manteca; and also served as executive director at Westshore Health Network in Muskegon, Michigan, which was a joint venture between the Muskegon Area Physicians Association and Trinity Healthcare hospitals.

Steve holds a bachelor of arts degree in economics from the University of Michigan Ann Arbor and a Master's of Business Administration from the University of California at Irvine.



Rural Health *Beth Kutscher*

Shift to coordinated care

Qualifying for ACOs a tough challenge for rurals

The town of Paris, Tenn., population 10,166, boasts a 60-foot replica of the Eiffel Tower and draws visitors with events such as the "World's Biggest Fish Fry."

It's also a community where 19% of the population lives below the poverty line and residents struggle with high rates of diabetes, chronic obstructive pulmonary disease and high cholesterol, plus low health literacy. With the closest major city, Nashville, and its major medical centers two hours away, the job of overseeing population health falls to 101-bed Henry County Medical Center, the only hospital in the county.

"We're a very poor-health community," says Thomas Gee, the hospital's administrator and CEO. "Just being in rural Tennessee, that puts us at ground zero. There's a lot of room for improvement."

The quality-improvement agenda of the Patient Protection and Affordable Care Act is intended to help improve the health of communities like Henry County. While rural healthcare providers say they're doing their part to meet the "Triple Aim" of better care for individuals, better health for populations and reduced healthcare spending, they're facing a bumpy road in the shift from fee-for-service to value-based payment.

Lacking in electronic health records and data analytics expertise, many rural providers are not even being given the chance to participate in risk-based managed-care contracts and accountable care organizations, says Jennifer Lundblad, president and CEO of Stratis Health, a Bloomington, Minn.-based not-for-profit that focuses on healthcare quality and safety issues.

In addition, Medicare ACO programs require a minimum of 5,000 beneficiaries, which by itself could be a barrier in a small community. "They're not offered the opportunity to shift from volume to value," Lundblad says.

But some rural hospitals that are part of larger health systems and have more financial resources than standalone facilities have launched accountable care initiatives. And for smaller independent hospitals, organizations such as the National Rural ACO are working to create a pooled ACO for rural Medicare beneficiaries across the country.

> **"We have a very challenged market."**
> *—Denny DeNarvaez*
> ***President and CEO, Wellmont Health System***

Henry County Medical Center participates in the 17-county Delta Rural Health Initiative, where it works on chronic-disease management and pharmacy assistance programs. It has clinics in the community and offers free cholesterol screenings and diabetes education programs.

It also is investing heavily in technology and is now at Stage 2 in meaningful use of EHRs. "All that stuff is really expensive to do," Gee says. The hospital ended fiscal 2012 with $287,000 in net income on $71.7 million in revenue, according to a financial statement filed with the state.

Gee estimates that the medical center's efforts have saved patients more than $1 million in prescription costs. But whether there will be a financial return on investment for the hospital is still uncertain. "I'm seeing patients benefit, but I'm not seeing it translate to financial benefits for the institution," Gee says. "It hasn't accrued to us—it's accrued to patients."

Meeting the ACA's quality-improvement measures is proving hard for rural providers. The investments needed to meet the goals of care coordination and population health management are likely to shut out some providers from participating in new healthcare payment and delivery models such as ACOs. The two biggest cost barriers they cite are in adding personnel and health information technology.

Preventive care is at the center of keeping people healthy. But 77% of rural counties face a primary-care physician shortage, and 8% don't have a single primary-care provider, according to a 2009 policy brief from the federal Office of Rural Health Policy.

Then there are the infrastructure costs required to track and analyze patient data. While a third of rural hospitals have at least basic EHR capabilities, only 1% can meet a proxy for Stage 2 meaningful use, according to testimony in July by the American Hospital Association before the Senate Finance Committee. Nationwide, 44% of hospitals have at least a basic EHR system, and 5.1% can meet a proxy for Stage 2. For a hospital struggling to stay in the black, the costs of implementing an EHR system can be daunting.

In Georgia, a hospital financial survey from the state Department of Community Health found that 55% of rural hospitals lost money in 2011, compared with 38% of the state's hospitals overall. The difficult operating environment led two rural providers to close their doors this year—Stewart Webster Hospital, Richland, and Calhoun Memorial Hospital, Arlington.

One predominantly rural system that is participating in ACOs is Maine's EMHS, which has seven hospitals, the largest of which is in Ban-

Helping hospitals make it work

Group fits pieces together to form a rural ACO

The design of current Medicare accountable care programs has effectively shut out many smaller providers, particularly in rural areas, that don't have the size, reach or infrastructure to meet the requirements. But one not-for-profit organization is bringing those smaller providers together to achieve the accountable care goals of care coordination and transitioning from volume to value.

The National Rural ACO, a group started four years ago to help rural providers in California adopt electronic health records, has applied to be a pooled accountable care organization for 10 rural health systems across the country. It submitted its application in July to the CMS and will be part of a cohort announced in January.

"The way (the CMS) assigns beneficiaries is kind of prejudicial to rural providers," says Lynn Barr, strategic adviser to the group. "There's no way for us to participate—it's very, very frustrating."

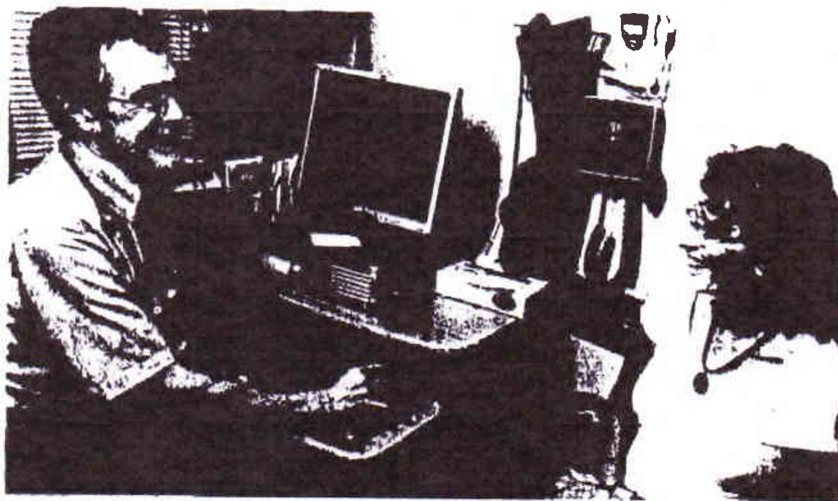
The National Rural ACO will provide centralized services, such as building a data warehouse for participating providers. Participants will not undertake any capitation risk and will continue to be paid on a fee-for-service basis. They will, however, be eligible to share in any Medicare savings, but without penalty if costs exceed the budget targets.

Barr says rural health providers already coordinate care and provide social services for people in their communities. "The strength we have is our relationship with patients," she says.

But resources are the limiting factor.

Terry Hill, executive director of the National Rural Health Resource Center, which has partnered with the National Rural ACO, says

Dr. Frank Bragg practices at Husson Internal Medicine, one of seven primary-care practices with Eastern Maine Medical Center. The hospital is in one of Medicare's Pioneer ACOs and reported some savings.



gor, a city of 32,800 people. The hospital is participating in one of the Medicare Pioneer ACOs.

The biggest investment the group had to make was in analytic tools, says Dr. Iyad Sabbagh, medical director of population health management. "We're a health system, not an insurance company."

Its ACO included 10,000 Medicare beneficiaries in its first year, and 14,500 participants are expected in year two. Although it's still early, Sabbagh says the ACO has seen savings of about 5% in the total costs of care for its assigned Medicare population and scored in the 90th percentile on many of the Medicare Pioneer program's quality metrics.

Although EMHS has a footprint in about two-thirds of the state, there are still challenges, such as physician recruitment. Most physicians train in urban environments and prefer the urban lifestyle and professional environment, Sabbagh says. Out-of-state doctors don't have ties to Maine, and it's a cold place in the winter and a buggy place in summer. That means the system has had to rely on mid-level practitioners such as nurse practitioners and physician assistants to fill in the gaps.

In Kingsport, Tenn., Wellmont Health System is participating in a Medicare Shared Savings ACO, with 10,000 assigned beneficiaries. It plans later to add its own employees to the ACO program. Denny DeNarvaez, the system's president and CEO, says the six-hospital system serves a community with high rates of smoking, diabetes and obesity. "We have a very challenged market."

Some of its care-coordination efforts include a nurse call program, where patients connect with a "navigator" who directs them to the most appropriate care setting so they don't just show up in the emergency department. It also will follow up with a home visit, if that's what a patient needs.

"By far the most significant (investment) is the people piece," DeNarvaez says. High rates of obesity, for instance, are linked to depression and a lack of knowledge about nutrition. "It is by nature something that is more social work, (and) care managers are hard to come by."

Wellmont also has spent $100 million transitioning from McKesson Corp. to Epic Systems Corp. for its EHR system.

The system reported $22.3 million in income on revenue of $789.7 million in fiscal 2012, according to a financial report. While those numbers were an improvement over fiscal 2011, inpatient admissions fell 6.3%, while emergency department visits fell 1.9%.

In October, Wellmont suspended operation of Lee Regional Medical Center, a 58-bed facility in Pennington Gap, Va., citing the federal budget sequestration cuts, other Medicare reimbursement cuts under the ACA and Virginia's decision not to expand Medicaid eligibility under the healthcare reform law.

More than 60% of Wellmont's revenue comes from government payers—and the payment cuts are coming hand-in-hand with efforts to hold down utilization. "The payment mechanism is lagging behind," DeNarvaez says. "Right now it's one foot on the boat, one foot on the dock."

Smaller rural providers such as Wellmont and Henry County Medical Center say they are looking at partnerships with larger organizations to help them transition to a world of alternative payment and delivery systems.

Wellmont, for instance, partnered with wellness company Healthways in October 2012 to prepare its ACO application and coordinate care for the Medicare beneficiaries in the program.

Other rural providers have enough size to do it on their own. At Sanford Health, which has hospitals in North and South Dakota, Minnesota and Iowa, clinicians who practice at the system's urban locations can help fill gaps at rural facilities, including through telemedicine. "I think one of the benefits we have is we've got the scale to be able to meet those challenges," says Ruth Krystopolski, executive vice president of development and research.

Sanford is participating in a number of care-coordination projects. It runs 180 patient-centered medical home practices and last year received a $12 million CMS grant to integrate primary and behavioral healthcare. It also identifies patients who would benefit from close interaction with a nurse health coach to increase treatment compliance.

Lundblad of Stratis Health says rural hospitals do not need to give up their independence to create a care-coordination network. Partnerships with public health agencies or social services such as Meals on Wheels can achieve some of the same results. "We would never tell a rural hospital that their only option is to be part of a larger health system," she says.

Gee of Henry County Medical Center says the hospital sees a merger with a larger system as a last resort. Its financial performance has been "spotty" recently, but in the past 22 years it has lost money only twice.

"We've been able to build a strong balance sheet and that's what's getting us through, but that's not going to last," he says. "We're very concerned about what the future holds for us." «

even more than the expense of purchasing an EHR system, rural providers struggle with a shortage of experienced HIT professionals they can bring on board. In addition, a small hospital can't get the discounts offered to large providers.

And that means rural hospitals need to pool their resources, either formally through a merger or informally through a looser alliance. In Minnesota, for instance, roughly 20 hospitals are tapping into the expertise of a cooperative of 70 IT professionals who work with providers throughout the state. "Collaboration is such a necessary component," Hill says.

Barr concedes it may be a number of years before the National Rural ACO achieves any financial gain for participants. "If we're lucky, we're going to cover our costs," she says, adding that the immediate benefit will be in creating the large data warehouse.

She also acknowledges that some providers have abandoned care-coordination programs because they were losing revenue by holding down utilization.

On the other hand, Barr says providers that can't succeed in the program will need to ask themselves how they plan to survive in the future, which likely will feature a broad shift from fee for service to alternative payment and delivery systems. "That's where the money is," she says. "If we don't coordinate care for our patients, somebody else will." «

—Beth Kutscher

768 Mountain Ranch Road
P.O. Box 668
San Andreas, CA 95249
209 754-4468 Telephone

Mark Twain Health Care District

August, 2013

William Griffin, M.D., Chairman of the Board
Mark Twain Medical Center
768 Mountain Ranch Road
San Andreas, CA 95249

Dr. Griffin:

The Mark Twain Health Care District (MTHCD) in its strategic planning process of July 2012 identified the completion of the Angel's Camp Health Center as one of its primary goals. Over the ensuing year we have worked with the Mark Twain Medical Center (MTMC) and members of the Dignity Health administrative team to develop a project and process to complete this goal.

A parcel was identified by the MTMC as being the appropriate location for a high profile and accessible health center in Angel's Camp. This parcel on Dog Town Road and at the corner of Hwy 4 and 49 reflects what we collectively believe to be the best opportunity to create a quality medical facility that will serve the needs of our community.

MTHCD has entered into an active process with the owners of this property and have through our local real estate advisor reached an agreement on the price of the property at $290,000. This 2.92 acre parcel purchase has also required an extensive application with the City of Angel's Camp for a General Plan Amendment. The MTHCD will spend approximately $60,000 satisfying the requirements for this application.

Planning discussions with the MTMC and Dignity Health administrative team has focused upon a land lease process wherein the MTHCD will purchase the property and the MTMC will lease the property and build the health center. This community partnership will allow a blending of participation between the MTMC and MTHCD.

We also endorse that the Mark Twain Medical Center Foundation has initiated an active capital campaign of $2.3 million dollars in support of this project.

The MTHCD is requesting a formal declaration of intent from the MTMC regarding this understanding. As we move forward towards the Angel's Camp planning commission and city council meetings it is essential that we have documentation of this commitment. We are also requesting a specific timeline for a formal land lease agreement to be developed.

We have an opportunity to serve our community in a way that will significantly improve access and quality of care. The Mark Twain Health Care District is very pleased to be able to partner with the Mark Twain Medical Center in this important decision.

MARK TWAIN HEALTHCARE DISTRICT

By:______________________________
Lin Reed, Chairman

Mark Twain HealthCare District Mission Statement

Through community collaboration, we serve as the stewards of a community health system that ensures our residents have the dignity of access to care that provides competent, professional and compassionate healing.

ATTACHMENT F

Dignity Health.
Mark Twain Medical Center

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marktwainmedicalcenter.org

September 27, 2013

Lin Reed, President
Mark Twain Healthcare District
768 Mountain Ranch Road
P.O. Box 668
San Andreas, CA 95349

Dear Ms. Reed:

Your letter to me, received by Mark Twain Medical Center ("Mark Twain") on August 26, 2013, asked that Mark Twain provide a formal "declaration of intent" regarding the proposed Angel's Camp Health Center. Your letter discusses the purchase by Mark Twain Health Care District ("District") of property on Dogtown Road in Angels Camp, California ("the Property") for the development of a new Mark Twain Family Medical Center ("the Clinic"). Representatives of the District and Mark Twain have been discussing that after the Property is acquired by the District, Mark Twain may acquire the Property from the District or may ground lease the Property from the District, and then construct a Clinic building.

I have reviewed your letter with the Board of Trustees of Mark Twain. The board is excited about the prospect of such a new facility. The board wants to move forward with the development of the Clinic building on the Property, so long as the following items are first addressed and agreed to by the District and Mark Twain, consistent with our recent discussions:

1. Mark Twain and the District need to complete the negotiations and execute the Sixth Amendment to Lease Agreement that they are currently discussing so that both parties have a common understanding as to what would happen in the event the hospital Lease Agreement between the District and Mark Twain is not extended beyond December 31, 2019.

2. Mark Twain and the District need to agree on the basic framework for the proposed long term extension of the hospital Lease Agreement beyond 2019 as we discussed.

3. Consistent with sound business practices and the fiduciary responsibilities of the boards, Mark Twain needs to complete a business plan on the feasibility and financial viability of the Clinic. The District and Mark Twain

share a common interest in seeing that the Clinic building is "right-sized" and can be supported financially over the long term.

4. Mark Twain and the District need to negotiate and execute either a purchase agreement whereby Mark Twain acquires the Property from the District, or a ground lease of the Property from the District to Mark Twain.

Mark Twain is excited and confident that a viable project can and will be developed, one that is financially prudent, aesthetically pleasing and clinically excellent. Obviously, there are important details to be worked out. We trust that this non-binding declaration of intent appropriately responds to your request and that you'll work with us to resolve the above items 1-4 and have each of them approved by our boards as expeditiously as possible.

MARK TWAIN MEDICAL CENTER,
BOARD OF TRUSTEES

By:
William Griffin, M.D., Chairman