

Salinas Valley Memorial Healthcare System

Increased Transparency and Stronger Controls
Are Necessary as It Focuses on Improving Its
Financial Situation

March 2012 Report 2011-113



Independent NONPARTISAN
TRANSPARENT Accountability

The first five copies of each California State Auditor report are free. Additional copies are \$3 each, payable by check or money order. You can obtain reports by contacting the Bureau of State Audits at the following address:

California State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, California 95814
916.445.0255 or TTY 916.445.0033

OR

This report is also available on the World Wide Web <http://www.bsa.ca.gov>

The California State Auditor is pleased to announce the availability of an on-line subscription service. For information on how to subscribe, please contact the Information Technology Unit at 916.445.0255, ext. 456, or visit our Web site at www.bsa.ca.gov.

Alternate format reports available upon request.

Permission is granted to reproduce reports.

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

Elaine M. Howle
State Auditor
Doug Cordiner
Chief Deputy

CALIFORNIA STATE AUDITOR

Bureau of State Audits

555 Capitol Mall, Suite 300

Sacramento, CA 95814

916.445.0255

916.327.0019 fax

www.bsa.ca.gov

March 8, 2012

2011-113

The Governor of California
President pro Tempore of the Senate
Speaker of the Assembly
State Capitol
Sacramento, California 95814

Dear Governor and Legislative Leaders:

As requested by the Joint Legislative Audit Committee, the California State Auditor presents this audit report concerning the fiscal management of the Salinas Valley Memorial Healthcare System (Health Care System). This report concludes that the Health Care System's board of directors (board), when making decisions regarding executive compensation, violated the Ralph M. Brown Act, which requires legislative bodies of local public agencies to conduct their meetings in an open manner. In an environment characterized by a lack of an executive compensation policy and limited transparency, the Health Care System granted compensation for its executives at the upper end of the range for the health care industry. In addition, the former chief executive officer (CEO) received generous retirement and severance benefits totaling \$4.9 million between 2008 and 2011, most of which were paid to him before he retired.

Our review also noted weaknesses in controls in several areas. We identified 11 instances in which the Health Care System had business relationships between 2006 and 2010 with entities in which its executives or board members had economic interests. In the two relationships we reviewed, the former CEO may have violated conflict-of-interest laws in one instance, and the board may have violated conflict-of-interest laws in the other instance. Also, the Health Care System did not ensure that many of the individuals its conflict-of-interest code identified as needing to submit statements of economic interests did so. Further, it does not have a written policy and procedures to demonstrate that its community funding furthers its public purposes, thereby risking questions about whether this funding violates the constitutional prohibition against public agencies making gifts of public funds. Additionally, for contracts we reviewed for which it was not required by state law to use a competitive process, the Health Care System generally did not document how it selected contractors in a way that demonstrated that it obtained the best value when procuring goods and services.

Finally, we noted that the Health Care System has undertaken several initiatives to improve its financial situation, including reducing its staff by 341 positions between July 2010 and October 2011. Even though it reduced its staffing, there is no indication that this decrease affected patient quality of care, as reflected by complaints and similar measures.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

Contents

Summary	1
Introduction	7
Chapter 1	
The Salinas Valley Memorial Healthcare System Needs More Transparency in Its Executive Compensation Practices	15
Recommendations	29
Chapter 2	
Stronger Controls Are Needed in the Salinas Valley Memorial Healthcare System's Oversight of Conflicts of Interest and Other Areas	31
Recommendations	47
Chapter 3	
Fiscal Challenges Are Affecting the Salinas Valley Memorial Healthcare System's Operations	49
Appendix	
Compensation for Vice Presidents of the Salinas Valley Memorial Healthcare System	59
Response to the Audit	
Salinas Valley Memorial Healthcare System	63
California State Auditor's Comments on the Response From the Salinas Valley Memorial Healthcare System	73

Summary

Results in Brief

The Salinas Valley Memorial Healthcare System (Health Care System) is an independent special health care district with an elected five-member board of directors (board) that governs its activities. At the core of the Health Care System is the Salinas Valley Memorial Hospital, which employed more than 1,700 employees as of June 30, 2011, and maintains 269 beds. Although as a public agency the Health Care System's decisions regarding compensation for its top executives should be transparent, this has not been the case for such board decisions. Even though compensation policies are very common in the health care industry and can support the transparency of an organization's compensation decisions, the Health Care System does not have a formal policy for compensating its chief executive officer (CEO) and other executives. When the board was making decisions regarding executive compensation, it also violated the Ralph M. Brown Act (Brown Act), which requires legislative bodies of local public agencies, such as boards, to conduct meetings in an open manner to keep the public informed of their actions. On several occasions since 2005, the board discussed proposed compensation for the Health Care System's executives in closed session, and neither the open- nor closed-session agendas listed executive compensation as a discussion topic, which the Brown Act prohibits, except in certain limited circumstances for closed-session discussions that do not apply here.

In an environment characterized by the lack of an executive compensation policy and limited transparency in executive compensation matters, the Health Care System's executives were granted compensation at the upper level of industry practices. The former CEO, who retired in April 2011, received \$4.9 million in retirement and severance benefits between 2008 and 2011, most of which were paid to him before he retired. The majority of these benefits came from multiple retirement investment plans that the Health Care System provided him as part of his overall retirement benefits package. Examples of the level of compensation granted by the board include the salaries of the Health Care System's vice presidents employed as of August 2011, which ranged from \$272,000 to \$341,000, and the salary of the former CEO, which was \$668,000 in 2011. The Health Care System also provides abundant health care benefits, including medical, dental, and vision coverage at no cost for all of its employees.

As a public entity, the Health Care System is required to have a conflict-of-interest code and should take steps to ensure that its employees are not involved in business relationships that could result in personal financial gain or the appearance of personal

Audit Highlights . . .

Our audit of the fiscal management of the Salinas Valley Memorial Healthcare System (Health Care System) highlighted the following:

- » *The Health Care System does not have a formal policy for compensating its chief executive officer (CEO) and other executives.*
- » *The board of directors (board) has made decisions regarding executive compensation in violation of the Ralph M. Brown Act, which requires conducting meetings in an open manner to keep the public informed of its actions.*
- » *The Health Care System's executives were granted compensation at the upper level of industry practices.*
 - *The former CEO, who retired in April 2011, received \$4.9 million in retirement and severance benefits over four years.*
 - *The salaries of the vice presidents employed as of August 2011 ranged from \$272,000 to \$341,000, and the former CEO's salary was \$668,000 in 2011.*
- » *We identified two instances in which conflict-of-interest laws may have been violated.*
- » *About 25 percent of the Health Care System's employees and consultants that it identified as needing to file statements of economic interests for 2010 had not filed them as of September 2011—more than five months after the filing deadline.*

continued on next page . . .

- » *The Health Care System did not consistently document how it selected contractors in cases for which it was not required by law to use a competitive process.*
- » *The Health Care System reported operating losses during fiscal years 2009–10 and 2010–11, sustaining an operating loss of \$7.4 million in the latter fiscal year alone.*
- » *By offering incentives to resign and imposing involuntary separations, the Health Care System reported reducing staffing by 341 positions from July 2010 through October 2011.*

financial gain. However, we identified 11 instances between 2006 and 2010 in which Health Care System executives or board members had economic interests in entities with which the Health Care System had business relationships. In the two relationships we reviewed, the former CEO may have violated conflict-of-interest laws in one, and the board may have violated conflict-of-interest laws in the other. For example, the former CEO disclosed that he had an investment in 2008 with 1st Capital Bank, a business with which the Health Care System agreed to deposit up to \$1 million in March 2008. We believe this action may have violated California's Political Reform Act, which states that no public officials at any level of state or local government shall make, participate in making, or in any way attempt to use their official positions to influence governmental decisions in which they have a financial interest. The Health Care System updated its conflict-of-interest policy in December 2011 to require that board members, medical staff, consultants, and employees disclose potential conflict-of-interest situations to their supervisors and the Health Care System's ethics and compliance officer, who is required to make a determination on the appropriate resolution.

The Health Care System also has not ensured that its employees and consultants file statements of economic interests (statements), as required. Our testing found that of the 99 individuals that we identified as needing to file statements for 2010, 25 had not filed them as of September 2011, more than five months after the filing deadline of April 1. We informed the Health Care System of our testing results, and according to the ethics and compliance officer, it subsequently obtained the statements from these individuals.

The Health Care System could also better oversee the support it provides to the local community, which it does in part by funding community events and programs. It does not have a policy and written procedures to demonstrate that its community funding furthers its public purposes, and it thereby risks questions about whether this funding violates the constitutional prohibition against public agencies making gifts of public funds. We reviewed 14 recipients of its community funding between 2008 and 2010 and found that in only three instances did it demonstrate that all of the disbursements related to these recipients furthered its public purposes. For example, it disbursed nearly \$54,000 to the California Rodeo during 2009 for its 2009 and 2010 sponsorships of the event, but was unable to provide any evidence that it considered how this funding furthered its public purposes. According to the Health Care System's interim CEO, the California Rodeo provides an optimum means to market the Health Care System's services and positions it as the local expert in health care through sponsorship of the rodeo's first aid area. However, without a policy and procedures

to ensure that the Health Care System's community funding furthers its public purposes, it risks making or appearing to make gifts of public funds.

Yet another area in which the Health Care System could provide better control is the awarding of certain contracts. Although it used a competitive process to award contracts when required for the contracts we tested, it did not consistently document how it selected contractors in cases for which it was not required by law to use a competitive process. Of the eight such cases that we reviewed, the Health Care System was able to demonstrate for only one contract that it went through some type of process to ensure that it received the best value from the contractor it selected. Although Health Care System officials were able to explain how they believed they received the best value from the selected contractor for four of the remaining seven contracts, they could not provide documentation of the process. Thus, the approach it used for awarding seven of the eight contracts we reviewed leaves the Health Care System at risk of not being able to demonstrate that it is obtaining the best value when procuring goods and services using public funds.

Stronger oversight and controls will be even more important as the Health Care System continues to focus on improving its financial situation. After a period of strong financial growth—its operating revenues increased by almost \$79 million between fiscal years 2005–06 and 2008–09—the Health Care System reported operating losses during fiscal years 2009–10 and 2010–11, sustaining an operating loss of \$7.4 million in fiscal year 2010–11 alone. Some of the reasons for its declining financial situation are, according to Health Care System management, high unemployment rates that resulted in fewer people seeking medical care, decreases in insurance reimbursements, and increases in the amount of income lost due to providing charity care.

The Health Care System hired a consultant in 2010 to review its operations and make recommendations for improvement. Subsequently, by offering incentives to resign and imposing involuntary separations, the Health Care System reported reducing staffing by 341 positions from July 2010 through October 2011. The Health Care System also reported estimated labor savings of nearly \$44 million annually as of December 2011 and the implementation of 93 other cost-saving initiatives valued at \$7.4 million as of September 2011, some of which are expected to be recurring. Our analysis of data for patient complaints and other measures of quality of care filed with either the Health Care System or the California Department of Public Health found no indication that the Health Care System's staffing reductions affected patient quality of care as reflected by such measures.

Recommendations

To provide members of the public with opportunities to meaningfully participate in board meetings regarding executive compensation matters, and to hold the board accountable for its decisions on these matters, the Health Care System should take the following actions:

- Develop a formal policy that establishes a process for determining executive compensation, including retirement benefits, that clearly documents all executive compensation decisions.
- Clearly indicate compensation matters on the agendas for its board meetings.
- Discuss executive compensation matters only in open sessions of board meetings, except in the limited circumstances that allow for discussion in closed sessions.

To ensure that the Health Care System, its board members, medical staff, employees, and consultants are engaged only in appropriate business relationships with respect to their economic interests, the Health Care System should take the following steps:

- Engage an independent investigator to review the Health Care System's business relationships with entities that we identified as being among the economic interests of its board members and executives to determine whether any of the relationships violate applicable legal prohibitions and take appropriate corrective action if they do.
- Implement the requirement in the Health Care System's recently updated conflict-of-interest policy that board members, medical staff, employees, and consultants disclose potential conflict-of-interest situations to their supervisors and to the ethics and compliance officer.

To help ensure that individuals designated by the Health Care System as needing to file statements of economic interests do so, the Health Care System should amend its conflict-of-interest policy to specify the steps the filing officer should take to ensure that this requirement is met.

To ensure that it is not making gifts of public funds, the Health Care System should develop and implement a policy and written procedures to demonstrate how funds it provides to support entities and programs in the community further the Health Care System's public purposes.

To increase the transparency of its processes for awarding contracts that are not required by law to be selected using a competitive process, the Health Care System should require its employees to fully document the steps they take in selecting contractors and to describe how the selections result in the best value to the Health Care System.

Agency Comments

The Health Care System disagreed with some of our conclusions but indicated it plans to implement all of our recommendations.

Blank page inserted for reproduction purposes only.

Introduction

Background

The Salinas Valley Memorial Healthcare System (Health Care System) was founded in 1947 under the provisions of the State's Local Hospital District Law, with the formation of the Salinas Valley Memorial Hospital District. The Health Care System has undergone two name changes by its board of directors (board) since its inception, first to the Salinas Valley Memorial Health Care District in 1995 and then to its current name in 1997. The mission of the Health Care System is to improve the health of residents in its geographical health care district and beyond. At the core of the Health Care System, the Salinas Valley Memorial Hospital employed more than 1,700 employees as of June 30, 2011, and maintains 269 beds. For the fiscal year ending June 30, 2011, the Health Care System had total operating revenues of \$353.2 million and total operating expenses of \$360.6 million.

The Health Care System is an independent special district that is required by state law to have an elected board made up of five registered voters residing in the district who serve four-year terms; the board is thus accountable to the voters. It is responsible for the operation of all health care facilities owned or leased by the Health Care System and for making and enforcing all rules, regulations, and bylaws necessary for the administration, governance, protection, and maintenance of the health care facilities under its management and all property belonging to the Health Care System. State law gives districts such as the Health Care System various powers, including the power to do the following:

- Obtain, hold, lease, or use property of every kind and description.
- Employ any officers and employees, architects, consultants, and legal counsel the board deems necessary to carry on properly the business of the Health Care System.
- Establish the compensation of all officers and employees of the Health Care System. Compensation for board members is limited by law to no more than \$100 per meeting, in addition to reimbursement for expenses they incur in performing official business.

State and County Oversight of Local Health Care Districts' Reporting of Financial and Quality-of-Care Data

The California State Controller's Office (State Controller), the Office of Statewide Health Planning and Development (OSHPD), and county auditors are responsible for overseeing certain aspects of the

operations of special health care districts. Mainly, these oversight duties include the collection of the special districts' financial and quality-of-care data. At the state level, the State Controller and OSHPD collect and publish special health care districts' financial information. Likewise, county auditors collect special districts' audited financial statements.

In accordance with the California Government Code, the State Controller gathers and publishes special districts' financial data in the *Special Districts Annual Report*, which is a compilation of financial data provided by county auditors and special district officials. The report presents a high-level view of the special districts' operating revenues and expenses. The Government Code also mandates that special districts file independently audited financial statements with the State Controller and county auditors.

The State Controller also requires that independent special districts file salary and compensation data for each of their positions.¹ In fiscal year 2010–11, the State Controller began a new reporting program to compile and publish compensation information beginning with 2009. For example, the State Controller publishes minimum and maximum salary ranges and total wages subject to Medicare for all positions of independent special districts. The compensation information and the *Special Districts Annual Report* are available on the State Controller's Web site.

Similarly, OSHPD compiles and publishes on its Web site financial information for all California hospitals, as well as patient care data such as the annual number of patient discharges for heart surgeries performed. Other information OSHPD requires from hospitals includes data related to quality of care and treatment outcomes, as well as fair pricing policies. In addition to its data reporting requirements, OSHPD maintains the *Accounting and Reporting Manual* for California Hospitals and ensures that California hospitals have adopted and implemented the accounting system set forth in the manual.

Role of the California Department of Public Health

The California Department of Public Health (Public Health) oversees hospitals through various inspections, also known as surveys, of facilities and investigations of complaints and incidents that are self-reported by hospitals. Public Health is the designated agency to ensure compliance with federal laws as well as regulations

¹ An independent special district has a legislative body such as a board of directors that is elected by the district's community or is appointed to fixed terms.

prescribed by the Centers for Medicare and Medicaid Services (CMS). As part of its CMS monitoring responsibilities, Public Health performs initial licensing surveys for new hospitals. These surveys verify whether a provider meets applicable requirements for participation in the Medicare and/or Medicaid programs and evaluate quality of care.

California hospitals, such as the Salinas Valley Memorial Hospital at the center of the Health Care System, undergo periodic recertification by either Public Health or an accrediting organization such as the Joint Commission—an independent, nonprofit organization that accredits and certifies health care organizations and programs. The Health Care System is accredited by the Joint Commission. According to the CMS Web site, accredited hospitals are deemed to have met the Medicare requirements, and recertification surveyors assess compliance with the conditions of participation for the Medicare program. The Health Care System received accreditation in 2005 and has since maintained its accreditation status. The last Joint Commission full survey of the Health Care System's hospital was in November 2011.

Public Health also investigates complaints related to alleged violations of state and federal laws and regulations. According to Public Health, complaints can originate from the public, from facility employees, or as referrals from government agencies such as CMS. Public Health's complaint investigations may result in the discovery of deficiencies, which are violations of state and federal laws or regulations. Deficiencies can be discovered any time Public Health visits a hospital. Corrective action is required for each deficiency, and CMS guidelines state that the hospital must submit a plan of corrective action to Public Health within 10 calendar days following Public Health's notification of the deficiency. According to Public Health, it can accept the written plan of corrective action as evidence of compliance or it can make an on-site visit to determine whether the plan was implemented.

In recent years state law has mandated two new significant hospital reporting requirements, included in a category known as entity-reported incidents, for adverse events and for unauthorized access to or disclosure of patient medical information (privacy breach). The adverse event reporting requirement took effect in July 2007, and the privacy breach requirement took effect in January 2009. Hospitals must report these incidents to Public Health or face monetary penalties. An adverse event includes, for example, surgery performed on the wrong body part or person and retention of a foreign object in a patient after surgery or other procedure.

Penalties for Health Care Districts That Do Not Comply With Reporting Requirements

The State Controller, OSHPD, and Public Health have the ability to penalize health care districts if they do not comply with reporting requirements. The State Controller can require a district to forfeit up to \$5,000 if it does not submit required financial data. Likewise, OSHPD can impose a civil penalty of \$100 a day for failure to file certain required reports. Hospitals face tough penalties for failure to report certain events. State law grants Public Health the authority to financially penalize hospitals for failure to communicate required entity-reported incidents. Public Health may assess a penalty of up to \$100 for each day that a hospital does not report an adverse event, and privacy breaches can result in total penalties of up to \$250,000 per breach. Specifically, following a period of five business days after a privacy breach, Public Health can assess a \$100 penalty for each day the breach is not reported. Public Health can also assess an administrative penalty of up to \$25,000 per patient and \$17,500 for each subsequent privacy breach. As of mid-December 2011 the Health Care System has had five instances in which it failed to inform Public Health of entity-reported incidents since the respective requirements were enacted. Four failures to report involved privacy breaches, and the penalties totaled \$6,600. The fifth situation involved the hospital's failure to report the retention of a foreign object in a patient, for which the Health Care System was assessed a penalty of \$52,800 in 2008. The Health Care System has appealed this penalty, and it remained unresolved as of mid-December 2011.

In addition, Public Health can issue penalties for situations involving immediate jeopardy. These situations are ones in which a hospital's noncompliance with one or more requirements of licensure has caused, or is likely to cause, serious injury or death to a patient. Such a situation would occur, for example, if hospital staff failed to monitor a patient who was experiencing a potentially fatal heart condition that resulted in death. Immediate jeopardy penalties are up to \$50,000 for the first violation, up to \$75,000 for the second, and up to \$100,000 for each subsequent violation within three years of the last immediate jeopardy violation. The Health Care System has not received an immediate jeopardy deficiency.

Scope and Methodology

The Joint Legislative Audit Committee (audit committee) directed the California State Auditor to perform an audit of the fiscal management of the Health Care System. The analysis the audit committee approved contained 10 separate objectives. We list the objectives and the methods we used to address them in Table 1.

Table 1
Methods of Addressing Audit Objectives

AUDIT OBJECTIVES	METHOD
1. Understand criteria related to local health care systems.	Reviewed relevant laws, regulations, and other background materials.
2. Identify and assess the roles and responsibilities of the various departments and agencies involved with special health care districts. Determine which agency, if any, is authorized to oversee and monitor these health care districts.	Interviewed officials at oversight entities and reviewed records and data related to monitoring activities. We focused our review on entities that oversee financial reporting and quality of care.
3. Identify what mechanisms are in place at the oversight entities to ensure corrective action is taken by health care districts on any improper processes that may be noted during their oversight monitoring activities.	Interviewed officials at oversight entities and reviewed documentation related to corrective actions.
4. Review the policies of the Salinas Valley Memorial Healthcare System (Health Care System) related to establishing business relationships and determine whether such policies and practices—particularly as they relate to the Health Care System's relationship with Rabobank—comply with laws, rules, and regulations.*	Reviewed relevant policies and interviewed Health Care System officials. Determined during our analysis whether its practices complied with applicable laws and regulations. Reviewed statements of economic interests filed by Health Care System executives and board of directors (board) members to identify economic interests. Identified instances where the Health Care System had business relationships with entities with which its board members and executives had economic interests and reviewed the relevant facts associated with the relationships for two such instances. Reviewed a cross-section of contracts to determine whether the Health Care System was following requirements for selecting contractors using competitive means, when required, or similar means when not required.
5. If any inappropriate relationships or activities are identified, to the extent possible, determine the impact on the Health Care System's operations and services.	For the selected relationships we reviewed, we identified certain consequences, but did not note any specific negative impact on the Health Care System's operations and services.
6. Review the Health Care System's compensation policies and practices, including those for setting and disclosing compensation, pensions, living allowances, and other benefits offered to high-level executives and administrators. Determine whether such policies comply with relevant laws, rules, and regulations, and, to the extent possible, whether they are comparable with industry practices. Determine if the Health Care System's practices comply with its policies.	Determined whether the Health Care System has a formal policy for compensating its executives. Reviewed board meeting agendas and meeting minutes, payroll records, retirement plans, and a report by the Internal Revenue Service (IRS) that discusses industry practices. We also reviewed compensation studies prepared for the Health Care System by private consultants. We noted that the Health Care System does not reimburse the executives it employs for their living expenses.
7. To the extent possible, determine the total compensation for the Health Care System's high-level executives and administrators over the past three years and compare the compensation to public and private sector hospital executives and administrators.	Used Health Care System's payroll records to determine total compensation for the former chief executive officer and management employees at the vice president level. We presented compensation beginning with 2005 as that was the year during which the executives received their last major compensation increase. Used the IRS and private consultant studies mentioned above for comparative purposes.
8. Identify to what entities or to whom the Health Care System has made donations or offered sponsorships and determine whether the recipient has a relationship or connection with any of the board members or executives. To the extent possible, determine whether such donations or sponsorships are permitted by law and comparable to industry practices.	Used Health Care System accounting records to identify entities receiving donations and sponsorships. In our review of selected donations and sponsorships, we considered whether the Health Care System's donations and sponsorships complied with applicable legal restrictions. We also compared the aggregate level of the Health Care System's donations and sponsorships with comparable levels for nonprofit hospitals of similar size as indicated in the IRS report mentioned above.

AUDIT OBJECTIVES	METHOD
<p>9. Identify critical indicators for the Health Care System. Using data from the past five years, trend the data for the indicators and, to the extent possible, determine reasons for significant or unusual fluctuations. At a minimum, trend data for the following indicators:</p> <ul style="list-style-type: none"> a. Revenues and expenses b. Staffing levels c. Number of patients treated d. Number of complaints received 	<p>We reviewed revenue and expense data included in the Health Care System's audited financial statements for fiscal years 2005–06 through 2010–11.</p> <p>We identified the Health Care System's quarterly staffing levels for fiscal years 2006–07 through 2010–11 using automated payroll records. We also reviewed the Health Care System's memoranda regarding staffing reductions.</p> <p>We used data in the Management Discussion and Analysis Section of the Health Care System's financial statements for fiscal years 2005–06 through 2010–11 regarding patient days, which reflects the number of patients staying overnight and the duration of their stay.</p> <p>We reviewed complaint data maintained by the Health Care System for January 2007 through September 2011 and also reviewed deficiencies identified by the California Department of Public Health for January 2006 through mid-October 2011.</p>
<p>10. Review and assess any other issues that are significant to the Health Care System.</p>	<p>No other issues came to our attention.</p>

Sources: California State Auditor's analysis of Joint Legislative Audit Committee audit request number 2011-113, planning documents, and analysis of information and documentation identified in the column titled Method.

* Rabobank is a bank with branch offices in Salinas with which the Health Care System has a business relationship.

To address several of the audit committee's objectives, we relied on the data the Health Care System provided. The U.S. Government Accountability Office (GAO), whose standards we follow, requires us to assess the sufficiency and appropriateness of computer-processed information. To comply with this standard, we assessed each system separately according to the purpose for which we used the data in this report.

We assessed the reliability of its Meditech data for the period of January 2005 through March 2008 and of its API data for the period of April 2008 through August 2011 for the purposes of quantifying staffing levels by union type and determining total compensation for the Health Care System's former chief executive officer (CEO) and vice presidents. We also assessed the reliability of the Meditech data for the period January 2006 through December 2010 for the purpose of comparing the Health Care System's disbursements to businesses identified as economic interests of its board members and executives. We assessed the reliability of an extract of the hospital's general ledger from the Meditech system for the period July 2006 through June 2011 for the purpose of identifying donations or sponsorships made by the Health Care System.

Specifically, to assess the reliability of Meditech and API payroll data to quantify staffing levels by union type and fiscal year, and to determine the total compensation for the Health Care System's former CEO and vice presidents, we reviewed documentation and interviewed appropriate Health Care System staff. In addition, we

performed data-set verification procedures and electronic testing of key data elements and did not identify any issues. We did not perform accuracy and completeness testing of the Meditech or API payroll data, because these payroll systems are paperless and hard-copy source documentation was not available for review. Alternatively, following GAO guidelines, we could have reviewed the adequacy of selected system controls that include general and application controls. However, we did not conduct these reviews because this audit is a one-time review of a local health care system and we determined that it did not warrant the same level of resource investment as a state agency whose system produces data that may be used during numerous future audit engagements. Consequently, the Meditech and API payroll data are of undetermined reliability for the purposes of quantifying staffing levels by union type and fiscal year and of calculating total compensation for the Health Care System's former CEO and vice presidents. Nevertheless, we present these data, as they represent the best available source of payroll information.

To assess the reliability of the Meditech data for the purpose of comparing the Health Care System's disbursements to businesses identified as economic interests of its board members and executives, we interviewed appropriate Health Care System staff. In addition, we performed data-set verification procedures and electronic testing of key data elements. We also tested the accuracy and completeness of the data by tracing samples of records to and from supporting documentation.

We identified no issues when performing data-set verification procedures, nor did we identify any illogical information in the key fields used in our analysis. For accuracy testing, we selected a random sample of 29 transactions and found no errors. We tested the completeness of the Meditech data by selecting 29 vendor payment records and ensuring that they were included in its accounts payable data. In all instances we were able to find the data record associated with each payment record sampled. We found, based on the above testing and review, that the Meditech data were sufficiently reliable for the purposes of comparing the Health Care System's disbursements to businesses identified as economic interests of its board members and executives for the period January 2006 through December 2010.

To assess the reliability of an extract of the hospital's general ledger from the Meditech system for the purpose of identifying donations or sponsorships made by the Health Care System, we interviewed appropriate Health Care System staff. In addition, we performed data-set verification procedures and electronic testing of key data elements, as well as accuracy and completeness testing. We identified no issues when performing the data-set verification

procedures, nor did we identify any illogical information in the key fields used in our analysis. To assess the accuracy of the extract, we reviewed the independent audit reports for the period of July 2006 through June 2011. In each report, the independent auditor concluded that the financial statements present fairly, in all material respects, the financial position of the Health Care System and subsidiaries in conformity with accounting principles generally accepted in the United States. Further, to assess the completeness of the general ledger extract, we reviewed the source code used by the Health Care System to create the extract. We found that the source code did not exclude any records pertaining to donations or sponsorships made by the Health Care System. Based on the above testing and review, we found the extract of the Health Care System's Meditech general ledger to be sufficiently reliable for the purpose of identifying donations or sponsorships made by the Health Care System for the period of July 2006 through June 2011.

Chapter 1

THE SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM NEEDS MORE TRANSPARENCY IN ITS EXECUTIVE COMPENSATION PRACTICES

Chapter Summary

When the Salinas Valley Memorial Healthcare System (Health Care System) board of directors (board) was making decisions regarding executive compensation, on several occasions it violated the Ralph M. Brown Act (Brown Act), which requires legislative bodies of local public agencies such as the board to conduct their meetings in an open manner, thereby keeping the public informed of their actions. In addition, agendas for the board meetings held in open or closed sessions did not indicate, as they should have to comply with the Brown Act, that the board was planning to discuss proposed compensation, such as additional retirement benefits for the former chief executive officer (CEO). According to two board members we spoke with, they did not clearly understand at times what compensation the former CEO had received or was entitled to because of changes in board membership during the former CEO's tenure and the enactment of various compensation agreements and retirement plans over the years.² One reason the board was unsure about the former CEO's compensation was that it did not have anything in writing, such as a written employment contract, that detailed all of the compensation, including retirement benefits, to which the former CEO was entitled.

The Health Care System targeted compensation for its former CEO and vice presidents at the upper end of the range for the industry (the 75th percentile) in an effort to be a leader in the health care industry and to retain talented executives.³ In addition, the former CEO received generous retirement and severance benefits totaling \$4.9 million between 2008 and 2011, most of which were paid to him before he retired. These benefits were in addition to the annual pension of \$115,000 he is entitled to receive during retirement. The Health Care System was also generous to all of its employees in certain benefits it awarded them, particularly health care benefits and paid time off.

² We spoke with two current board members regarding the former CEO's compensation and other matters of the Health Care System. These board members were the current board president and its treasurer during our audit; the treasurer served as board president in 2005, the time period during which the executives received their last major compensation increase discussed in this chapter. We refer to these two board members throughout the report.

³ The 75th percentile is the value below which 75 percent of the comparable executive compensation in the health care market falls.

The board did not adequately disclose its planned discussions of proposed executive compensation increases and discussed such increases for executives in closed sessions in violation of the Brown Act.

The Health Care System Lacks a Compensation Policy and Transparency in Its Compensation Decisions

The Health Care System does not have a formal policy for compensating its CEO and other executives, and the board's decisions about executive compensation, including retirement benefits, lacked transparency. Compensation policies are not required by law but, according to one survey we reviewed, are very common in the health care industry and can support the transparency of an organization's decision making regarding compensation. The Brown Act includes provisions to ensure the transparency of local public agency decisions; however, the board violated the Brown Act when it did not adequately disclose its planned discussions of proposed executive compensation increases and when it discussed such increases for the Health Care System's executives in closed sessions.

Although not required by state law, compensation policies can aid organizations in using consistent, justifiable, well-documented approaches for compensation-related decisions. However, the Health Care System does not have such a policy. A 2009 Internal Revenue Service (IRS) study of nonprofit hospitals reported that 87 percent of hospitals with annual revenues of \$250 million to \$500 million—the category that applies to the Health Care System—had a written compensation policy. The study further indicated that executive compensation can be considered reasonable if the process used to establish that compensation includes approval of executive compensation by an authorized body free from conflicts of interest, the use of comparison information, and contemporaneous documentation of the basis for its compensation decisions.⁴ Recently, the Health Care System has faced public criticism over the former CEO's level of compensation, including retirement plan benefits. Clear policies and processes could lend clarity and transparency to executive compensation matters and aid the Health Care System in allaying public concern.

The last major pay increase for the Health Care System's executives occurred in August 2005. According to the two board members we spoke with, the board was informed of the 2005 executive salary increases in closed session, but a formal vote on the increase did not subsequently occur. However, meeting agendas failed to announce that executive salary increases would be discussed in either open or closed session. As a result, the board violated the Brown Act, which requires legislative bodies of local public agencies such as the board to conduct their meetings in an open manner to keep the public

⁴ The 2009 IRS report titled *IRS Exempt Organizations (TE/GE) Hospital Compliance Project Final Report* examined, primarily by survey, nonprofit hospitals' practices and reporting of community benefit expenditures and executive compensation.

informed of its actions. Specifically, the Brown Act allows closed sessions to consider certain personnel matters, but it prohibits closed-session discussion of or action on proposed compensation except in cases involving a possible reduction in pay due to discipline. Further, the Brown Act requires that meeting agendas for local public agencies contain a brief general description of each item of business to be transacted or discussed at the meeting, including items to be discussed in closed session, and generally prohibits action or discussion on matters that are not on the agenda.

We discovered other Brown Act violations that were due to the board's failure to adequately disclose retirement compensation items on its agendas and because it discussed the items in closed session. In 2006 and 2009 the board restructured or adopted retirement plans for the Health Care System's executives. In 2006 the closed-session agenda described the discussion item only as a performance evaluation of "administration." Although the administration's performance may have been part of the discussion, the ultimate product of that item was approval for the restructure of the supplemental executive retirement plan discussed later in the chapter.

Also in 2009, when the board adopted enhancements to the former CEO's retirement package, the closed-session agenda stated that the board would discuss the performance evaluation of the former CEO. In addition, the open-session agenda item related to the enhancements described the item as being related to the consideration of a board resolution on employee benefit plans' compliance with the Internal Revenue Code rather than a specific decision to be made regarding increases to the retirement benefits of the former CEO in an effort to ensure that his total compensation remained competitive.

Additionally, we noted Brown Act violations related to the handling of a special item for the former CEO's compensation. In March 2008 the board discussed in closed session the payment of a severance obligation granted to the former CEO in 2000. The discussion resulted in a board resolution that changed the payment terms of the severance obligation so significantly that it constituted discussion of proposed compensation rather than simply authorizing payment of a previously approved item. Consequently, this discussion of the severance obligation violated the section of the Brown Act that prohibits closed-session discussions about proposed compensation. In addition, neither the resolution that approved the payment nor the fact that the board was to discuss the payment of the former CEO's severance obligation was listed on the open- or closed-session agendas posted for this meeting. Instead, the closed-session agenda indicated that the board was to discuss the former CEO's performance evaluation. Board minutes indicated that during the open session the board retroactively

A March 2008 discussion of the severance obligation violated the section of the Brown Act that prohibits closed-session discussions about proposed compensation.

added this resolution to the agenda, citing the section of the Brown Act that allows it to take action on business items not on the agenda if it determines a need to take immediate action and if the need for action came to its attention subsequent to the agenda being posted at least 72 hours before the meeting. However, we saw no indication that immediate action was needed. In fact, as we note later in this chapter where we discuss the severance obligation further, the board made its payment decision based only on a risk that onerous tax consequences could occur for the former CEO. In addition, two years before the 2008 action, the former CEO sent a memo to board members reminding them of the severance obligation granted by the board in 2000, further calling into question the board's determination that immediate action was necessary.

The Health Care System, through these actions by its board, deprived members of the public of information they needed to offer comments and recommendations to the board regarding compensation decisions. In addition, the Brown Act authorizes the district attorney or an interested party to demand that the board correct the violations and, if it fails to do so, to bring a lawsuit to have a court void the compensation decisions that violated the Brown Act. However, the demand must be made within 30 days for violations that occurred in open session and within 90 days for violations that occurred in closed session. Consequently, the statute of limitations has expired for each of the Brown Act violations we discovered. Nevertheless, our concerns about the transparency of the Health Care System's practices remain.

According to the two board members we spoke with, executive compensation, including retirement items, was always discussed in closed session, although the board did not vote on compensation items in closed session.

According to the two board members we spoke with, executive compensation, including retirement items, was always discussed in closed session, although the board did not vote on compensation items in closed session. The board members contended that when the board did vote on a compensation matter, such as changes in retirement benefits, a board resolution was produced. This was the case when the board approved executive retirement changes in 2006 and 2009. In contrast, the board did not approve any items at the August 2005 meeting, when it discussed increases in executive compensation. According to the two board members, the former CEO was responsible for approving executive pay increases, except for his own. However, Health Care System documents do not clearly indicate who approved the pay increases in 2005 for the former CEO and the other executives.

We asked the two board members why the board thought it could discuss proposed compensation in closed session. They responded that a section of the Brown Act provides an exception that allows the board to deliberate in closed session regarding the design of a compensation package for unrepresented employees such as the former CEO. They stated that this section provides that a legislative body, such as the board, could hold closed sessions with designated

representatives regarding compensation matters for represented and unrepresented employees. We disagree that this section allowed these closed sessions, based on a commonsense reading of the Brown Act. This section provides that a legislative body may meet in closed session with its designated representatives to review its position and to instruct the body's designated representatives regarding the compensation of represented and unrepresented employees. It does not allow the legislative body to consider the proposed compensation of employees in closed session.

The Board's Oversight of the Former CEO's Total Compensation Could Have Been Stronger

According to the two board members we spoke with, the board was unclear at times about the former CEO's total compensation.⁵ The board members indicated that changes in board membership over the years and the restructuring of the former CEO's compensation and retirement package made it unclear exactly what the former CEO had received and to what he was entitled. They stated that over the years, various CEO retirement plans and other compensation agreements had been made between the board and the former CEO. We did note that before approving increases to the former CEO's retirement benefits in 2009, the board received a consultant study that compared his compensation and retirement benefits to those of other CEOs in the industry. The two board members indicated that this was done in response to a request by the former CEO that his compensation package be reviewed to determine whether it was competitive. We discuss this study and the former CEO's retirement increases further in the next section.

Total compensation for the executive team, including the former CEO, was difficult to determine. We expected the Health Care System's human resources division to have documentation that clearly indicated each executive's base pay, retirement, and other employment benefits as a standard business practice. This was not the case. The identification and compilation of the executives' total compensation required significant help from the Health Care System's human resources, accounting, and administration departments, as well as its outside legal counsel and retirement benefit contractors. Consequently, the board members' assertion that the CEO's total compensation was unclear to the board is understandable.

During the former CEO's 26 years as the top administrator for the Health Care System, he was not party to a written employment contract that could have helped to provide clarity

Total compensation for the executive team was difficult to determine and its compilation required significant help from the Health Care System's human resources, accounting, and administration departments, as well as its outside legal counsel and retirement benefit contractors.

⁵ Total compensation refers to salary, retirement plans, and employee benefits.

as to his compensation. According to the two board members we spoke with, the former CEO chose employment with the Health Care System without a written contract, but they did not know why. State law allows local health care districts to enter into a renewable employment contract of up to four years with a hospital administrator, but it does not specify that such contracts be in writing. A 2006 survey of executive compensation by a recognized compensation consulting firm noted that 53 percent of the health care systems that provided data on employment contracts engage one or more of their executives in employment contracts and that the CEO is the position most likely to be engaged in such a contract.⁶ The two board members stated that the board will engage the next permanent CEO in an employment contract because they believe this will provide clarity and transparency to the CEO's terms of employment. Also, since the board was unclear about the former CEO's total compensation, a written employment contract would strengthen its oversight of this area.

Our review of appraisals delivered since 2004 indicates that despite the lack of a written employment contract, the board president generally appraised the former CEO's performance every two years. The former CEO's last appraisal was through December 2010, and it included ratings for quality of work, productivity, teamwork, and professional accountability. Overall, his performance appraisals from 2004 to 2010 indicate that the former CEO most often exceeded the board's expectations.

The Board Set Compensation at High Market Levels and Allowed Generous Employee Benefits

In an environment characterized by the lack of an executive compensation policy and limited transparency in executive compensation matters, the Health Care System's executives were granted compensation that was positioned at the upper level of industry practices, and the former CEO received \$4.9 million in supplemental retirement and severance benefits between 2008 and 2011. Included in the supplemental retirement benefits were enhancements acknowledged to be at the high end of health care CEO retirement plans. In addition, the Health Care System grants all of its employees premium health care and paid time off benefits, which a consultant for the Health Care System indicated were in the upper end of those in the California region.

The Health Care System's executives were granted compensation that was positioned at the upper level of industry practices, and the former CEO received \$4.9 million in supplemental retirement and severance benefits between 2008 and 2011.

⁶ This survey was produced by Sullivan, Cotter and Associates, Inc. in 2006 and surveyed manager and executive compensation of health systems and hospitals. Sullivan, Cotter and Associates, Inc., is an independent consulting firm specializing, in part, in executive compensation in the tax-exempt not-for-profit industry with a specific focus within health care. This survey contains aggregate compensation-related responses of health systems and hospital executives nationwide. We refer to this report as the 2006 health system salary survey throughout our report.

The Former CEO Received Multiple Retirement Benefits and Severance Pay

From December 2006 until his retirement in April 2011, the Health Care System's board granted the former CEO an overall retirement package comprising seven separate investment plans in addition to the Health Care System's standard employee pension plan and approved payment of a severance package that was 18 times his average monthly salary.⁷ The board approved three of the seven additional investment plans for the former CEO in 2006; other executives received two of the investment plans that were approved. The remaining four investment plans were established by the board in 2009 solely for the former CEO. The Health Care System used multiple investment plans to achieve the desired level of retirement benefits for the former CEO without exceeding Internal Revenue Code limitations on pension plans.

In 2006 the Health Care System restructured the existing supplemental executive retirement plan that was established in 1988 for the Health Care System's executive team, including the CEO. The board resolution that approved the restructuring indicated that the IRS had enacted regulations and guidance that required compliance by December 31, 2007, and that it was in the best interests of the Health Care System to be in full compliance with the Internal Revenue Code. This restructuring resulted in three investment plans collectively known as a qualified supplemental executive retirement plan (2006 supplemental retirement plan). Organizations commonly use such plans to provide monetary benefits to their executives that are greater than the distribution ceilings in regular retirement plans. The 2006 supplemental retirement plan was designed for executives to receive a benefit equivalent to 60 percent of their average base compensation during the final five years prior to reaching age 65 (salary income replacement level). The 60 percent took into account benefits from the standard employee pension plan. The 2006 health system salary survey we previously discussed reported that the median salary income replacement level of the 18 respondents for health care management retirement benefits was 60 percent in that year. Similarly, another survey published in 2011 reported that the median targeted income replacement of CEOs surveyed was 60 percent.⁸

From December 2006 until his retirement in April 2011, the board granted the former CEO an overall retirement package comprising seven separate investment plans in addition to the standard employee pension plan and approved payment of a severance package that was 18 times his average monthly salary.

⁷ We use the term *investment plan* to mean the various components used to build a total retirement package. For example, a 403(b) contribution plan was one of the former CEO's seven additional investment plans in his overall retirement package.

⁸ Yaffe and Company, Inc. conducted a survey of CEO retirement benefits at nonprofit hospitals and systems. Yaffe and Company, Inc. is an independent consulting firm that specializes in governance services to not-for-profit boards and committees. This survey was conducted in April 2011 and contained responses from 134 organizations from 18 states.

The former CEO reached age 65 in 2009 and was paid benefits under the 2006 supplemental retirement plan, even though he had not yet retired from the Health Care System. The investment plans allowed the former CEO, at his option, to receive the benefits at age 65 while he was still employed. The former CEO chose this option. His payment for the 2006 supplemental retirement plan totaled \$3 million. In December 2009 he received a \$2.1 million gross payment, and \$917,000 was rolled into a personal individual retirement account.

Earlier in 2009 the board had enhanced the former CEO's retirement package further by granting him another four investment plans for benefits earned after age 65 (post-65 benefits). According to the two board members we spoke with, the Health Care System, at the request of the former CEO, hired a consultant to review the former CEO's total compensation package. The consultant was the same firm that performed the 2006 health system salary survey. The 2009 consultant study (CEO study) centered on proposed increases to the former CEO's retirement benefits and included an analysis of his total compensation. This study was provided to the board two days before it approved the post-65 benefits. Overall, the CEO study concluded that the former CEO's proposed post-65 benefits were consistent with typical market practice, albeit at the upper end. The CEO study further reviewed the proposed post-65 benefits in the context of his total compensation and concluded that they were within market practice; however, it did not assess the manner in which the benefits were to be delivered, such as the use of multiple investment plans. Although the study found that the former CEO's proposed retirement benefits were within typical market practice, it advised the board to carefully review the proposed action. Specifically, it warned of the estimated \$1.2 million cost and the potential scrutiny that might ensue if the board enhanced the former CEO's retirement benefits immediately before he was to receive payment for his 2006 supplemental retirement plan.

The board approved the proposed post-65 benefit increases in November 2009. This action increased the former CEO's target retirement benefit from 60 percent to 70 percent of his average base compensation over his final five years of employment and provided an annual retirement contribution equal to 15 percent of his annual salary until he retired. This increase cost the Health Care System less than the \$1.2 million estimated in the study because the former CEO retired earlier than age 70, the age anticipated by the study. The former CEO received \$835,000 in cash a few months after he retired in 2011, and \$123,000 was rolled into his individual retirement account, for a total of \$958,000. Details on the former CEO's compensation and retirement plans are included in Figure 1.

The former CEO received \$835,000 in cash a few months after he retired in 2011, and \$123,000 was rolled into his individual retirement account, for a total of \$958,000.

Figure 1
Compensation Paid to Salinas Valley Memorial Healthcare System’s Former Chief Executive Officer From 2005 Through 2011

Compensation							
By Calendar Year	2005	2006	2007	2008	2009	2010*	2011†
Salaries and Wages							
Base pay	\$599,547	\$649,914	\$624,657	\$649,504	\$668,431	\$694,663	\$223,667
Other wages‡	6,189	0	35,654	50,429	115,690	0	120,306
Total Salaries and Wages	605,736	649,914	660,311	699,933	784,121	694,663	343,973
Retirement and Severance Compensation§							
Cash retirement payment					2,099,716		754,877
Cash withdrawal from investment plan							79,808
Cash severance payment				947,595			
Other compensation for retirement benefits#					916,540		122,961
Total Compensation	\$605,736	\$649,914	\$660,311	\$1,647,528	\$3,800,377	\$694,663	\$1,301,619

Employer-Provided Retirement and Severance Benefits	
1	Standard employee pension plan, a defined benefit plan, valued at approximately \$115,000 annually**
2	Qualified supplemental executive retirement plan approved December 2006 (2006 supplemental retirement plan) Supplemental Pension Plan—a defined benefit pension plan Qualified Governmental Excess Benefit Arrangement Defined Contribution Retirement Plan
3	Severance payment that granted 18 times his average monthly salary for the last 12 months of employment
4	Post-65 benefits approved November 2009 403(b) Nonelective Contribution Plan 457(b) Nonelective Deferred Compensation Plan Defined Contribution Retirement Plan Qualified Governmental Excess Benefit Arrangement

Other Fringe Benefit							
	2005	2006	2007	2008	2009	2010	2011
Automobile††	\$6,600	\$7,848	\$12,750	\$12,750	\$2,040	0	0

Sources: California State Auditor’s analysis of data obtained from Salinas Valley Memorial Healthcare System’s (Health Care System) Meditec and API systems, pension and retirement plans, and information from the accounting and administration departments. See the Introduction’s Scope and Methodology regarding the reliability of the data.

- * Base pay in 2010 reflects an additional pay period; therefore, the amount is higher than the previous year.
- † The former chief executive officer (CEO) retired in April 2011. His last payroll payment in the data we analyzed was for retirement benefits on July 14, 2011.
- ‡ Other wages include cash for accrued paid time off and retroactive pay. Because the Health Care System did not separately classify payments for accrued paid time off in 2005 and 2006, such payments in those years are included in base pay.
- § Retirement payments, a severance payment, and compensation for retirement benefits total \$4.9 million.
- || Descriptions of the former CEO’s investment plans and severance obligation related to these payments are listed in the Employer-Provided Retirement and Severance Benefits section of this figure.
- # Other compensation for retirement benefits was rolled into a personal individual retirement account.
- ** The former CEO was previously projected to receive a defined benefit from his standard employee pension plan worth \$148,000 annually. However, because of Internal Revenue Code limits on the amount individuals can receive from such pension plans and the former CEO having received benefits from another such plan in 2009, the former CEO’s defined benefit from the standard employee pension plan was reduced to \$115,000 annually.
- †† According to the accounting department, the amounts shown here are the lease value of the former CEO’s company automobile. Documentation also indicates that the former CEO received a monthly gas allowance of \$400 through June 2010.

When the board approved the former CEO’s post-65 benefits, it decided to fully vest the CEO in one of the four investment plans used to provide the benefits. As discussed earlier, this investment plan provided the former CEO with an increase in his target benefit from 60 percent to 70 percent. According to the two board members we spoke with, this increase was originally

Shortly after the March 2008 board approval of the payment, the Health Care System paid the former CEO \$948,000 to meet its severance obligation, even though he did not retire until April 2011.

proposed to have the former CEO earn or vest in the benefit over five years as an incentive to retain him. They further stated that during the meeting in which the board decided to approve the post-65 benefits, a discussion ensued in open session about the former CEO's vesting. The two board members noted that some board members thought the former CEO was entitled to the retirement benefit regardless of the timing of his departure from the Health Care System. Ultimately, the board decided to fully vest and make payable this amount upon the former CEO's separation. The resolution that approved his post-65 benefits stated that the board approved the enhancements because it wanted to ensure that the former CEO's total compensation would remain competitive.

In 2008—approximately three years before he retired from the Health Care System—the board approved a severance payment to the former CEO. The board had adopted a resolution in 2000 specifying that in the event of a CEO's termination or retirement after serving at least 15 years in that position, the Health Care System's severance obligation shall be 18 times the CEO's average monthly salary for the immediately preceding 12-month period. However, shortly after the March 2008 board approval of the payment, the Health Care System paid the former CEO \$948,000 to meet its severance obligation, even though he did not retire until April 2011. To do so, the board created a new resolution that changed the payment terms of the severance obligation created in 2000, making it no longer contingent upon the former CEO's termination or retirement. As documented in the board resolution, based on advice from its consultant, the board was concerned that not paying the CEO his severance payment at that time would create onerous tax consequences for the former CEO under the Internal Revenue Code, Section 457(f), if that section was deemed to be applicable.⁹ An arrangement subject to the Internal Revenue Code, Section 457(f), requires that deferred compensation be included in the participant's gross income in the first taxable year in which the participant has rights to the compensation.

Further, the 2008 resolution stated that the board did not intend for the original 2000 action to result in any tax consequences to the former CEO prior to the actual payment of the benefit. The resolution went on to state that in the Health Care System's best interest, paying the benefit at that time so the former CEO could pay the taxes due would relieve the board of its obligation to remit the severance pay in the future. However, we note that the resolution itself acknowledged only a risk that the tax consequences the board was concerned about would occur at that time. In total,

⁹ The consultant was Sullivan, Cotter and Associates, Inc., a consulting firm we describe earlier in the report.

the former CEO received \$4.9 million in retirement and severance benefits, of which \$3.9 million was cash compensation and \$1 million was rolled into a personal individual retirement account.

In September 2010 the Health Care System's board froze participation in the standard employee pension plan for all nonunion employees. The board expressed concern about the long-term viability and sustainability of the standard employee pension plan. Further, the board believed that freezing the existing plan and implementing a new one was in the Health Care System's best interest. The freeze was effective March 31, 2011, and a new Internal Revenue Code, Section 403(b), plan was implemented on June 1, 2011. Under this plan, the Health Care System provides nonunion employees an automatic 5 percent contribution. Additionally, the new plan allows nonunion employees to receive matching amounts of 3 percent to 8 percent from the Health Care System based on individual employee contributions. The standard employee pension plan remains in place for employees of the two unions that are eligible, according to the Health Care System's legal counsel, and any changes to union employee retirement benefits are subject to union agreement.

In November 2011 the Health Care System's board also decided to freeze participation in the supplemental retirement plan for its executives, effective at the end of December 2011. In addition, the board directed the personnel and pension committee to examine, by June 30, 2012, the possibility of paying out all of the remaining benefits and terminating the plan completely. In its resolution, the board indicated that the rationale for the benefits can no longer be sustained in the Health Care System's current economic climate. The interim CEO stated that this action is in response to the expressed public concern about the Health Care System's executive benefits.

The Health Care System's Executives Had Compensation Set at the Higher End of the Market

The board hired consultants to study executive compensation before increases in these levels were finalized, and in doing so set levels at the higher end of the market. In 2005 a consultant produced two compensation reports for the Health Care System, one for the former CEO's compensation and the other for the vice presidents' compensation.¹⁰ As directed, the consultant reports focused on establishing compensation in a range within

The former CEO received \$4.9 million in retirement and severance benefits, of which \$3.9 million was cash compensation and \$1 million was rolled into a personal individual retirement account.

¹⁰ The consultant studies were produced by Moss Adams, LLP, a specialized consulting firm, and considered data from other compensation studies.

The Health Care System was clearly targeting generous salary levels for its executives when 10 of its 11 executives received base compensation increases in 2005.

the 75th percentile of market practices for executives because the Health Care System had made what it considered to be a strategic decision to do so in alignment with its business focus on being a leader in the industry. Both reports compared executives' total cash compensation and base salaries. However, only the vice president compensation study made recommendations for salary adjustments to raise compensation to the 75th percentile.¹¹ The consultant report that focused on the former CEO noted that he was already compensated within the 75th percentile range. Also, both consultant reports noted that of the 82 percent of hospitals and health systems with executive compensation strategies in 2004, only 5 percent targeted the 75th percentile for their executives' base salaries and 19 percent targeted this percentile for total cash compensation. Similarly, the 2006 health system salary survey we discussed previously revealed that 8 percent of survey respondents targeted the 75th percentile for their executives' base salaries and 25 percent targeted it for total cash compensation. Thus, the Health Care System was clearly targeting generous salary levels for its executives.

Subsequent to the completion of the consultant reports, 10 of the Health Care System's 11 executives received base compensation increases; the other executive was newly hired and did not require an adjustment. These increases varied by position, ranging from 32 percent to 65 percent for senior vice presidents, 4 percent to 25 percent for vice presidents, and 10 percent for the former CEO. Even though the former CEO received a salary increase despite his compensation already being within the 75th percentile range, his increased salary remained within this range. Generally, most Health Care System executives had not received any increases in base compensation since 2005, but all received annual cost-of-living adjustments of 3 percent to 4 percent for several years, with the last adjustment awarded in August 2008. The controller/treasurer and the vice president of strategic management and planning each received base compensation increases after 2005, but their salaries are still below the salaries several other Health Care System executives receive. The annual base salary for vice presidents employed in August 2011 ranged from \$272,000 to \$341,000. See the Appendix for further information on the compensation the vice presidents received from 2005 through 2011.

The two board members we spoke with stated that compensation levels for the former CEO and vice presidents were targeted at the 75th percentile because at the time the hospital was successful financially, with strong revenue and cash reserves. In addition, the

¹¹ The 2005 consultant studies considered total cash compensation to include base pay and bonuses. The Health Care System does not offer bonuses to its executives.

Health Care System had a desire to retain the talent of the executive team and to be sure that executive salaries were competitive. Further, the two board members commented that at the time of the 2005 compensation increases, the employment environment in the health care market was very competitive, and some members of the executive team had received employment offers from other hospitals.

A comparison of the former CEO's compensation to that of other health care systems' CEOs reveals that his base salary was within the range of other CEOs in the industry. At the time of the CEO study in 2009 and prior to his retirement in 2011, the former CEO received an annual base salary of \$668,000.¹² A 2009 IRS report on executive compensation revealed that for nonprofit hospitals with revenue similar to that of the Health Care System, average annual total compensation of the top executive was about \$790,000, and the median total compensation was \$642,000. Nonetheless, the former CEO's compensation level and his extensive retirement package have led to an unfavorable public perception of the Health Care System.

Although the former CEO's salary was within the range of comparable data, the Health Care System's paid time off policy allowed the CEO to receive a substantial amount of additional cash compensation. For example, he received about \$116,000 in additional cash compensation in 2009 by cashing out his paid time off. A Health Care System policy allows employees to cash out accrued paid time off, subject to approvals and provisions of the policy. We discuss the paid time off policy for all employees in the next section.

Benefits for Health Care System Employees and Executives Are Generous

The Health Care System provides all of its employees with generous health care and paid time off benefits. Employees are granted medical, dental, and vision coverage at no cost. Health Care System employees also have the option of receiving 100 percent free coverage for inpatient and outpatient medical services provided at the Health Care System hospital and urgent care clinic. In addition, employees' prescriptions are covered at 80 percent of the cost. According to a consultant's assessment of its operations in May 2010, the Health Care System's costs for its employees' health insurance are above the 75th percentile compared to other

According to a consultant's assessment of its operations in May 2010, the Health Care System's cost for its employees' health insurance are above the 75th percentile compared to other health care providers in California.

¹² The former CEO voluntarily reduced his base pay by 10 percent one month prior to his retirement. We have presented his base pay as it was prior to the voluntary reduction in an effort to adequately disclose his base pay during the later years of his tenure as CEO.

Paid time off benefits for nonunion employees range from 27 days per year for new employees to 56 days per year for employees with 30 or more years of service.

health care providers in California, and its employees' contributions are estimated to be only 3 percent of health plan costs.¹³ In addition, the majority of employees' medical claims are reimbursed at 100 percent of billed charges, and pharmacy benefit costs are above the national benchmark. The consultant's assessment included several recommendations to restructure the Health Care System's employee medical coverage. These recommendations included modifying the employee contribution strategy toward health and prescription plan costs and reviewing health plan designs for employees, such as vendor options for health care coverage.

The Health Care System also provides its employees generous amounts of paid time off. For example, paid time off benefits for nonunion employees range from 27 days per year for new employees to 56 days per year for employees with 30 or more years of service.¹⁴ In addition, many employees are eligible to receive an additional day of paid time off each quarter if they do not use sick leave, or leave that is otherwise unscheduled. Further, the Health Care System's paid time off policy grants employees the ability to cash out their paid time off. The policy also establishes a two-year maximum limit for employees' paid time off balances and mandates payment for paid time off that exceeds policy limits. This policy has resulted in considerable additional compensation for Health Care System executives. For example, in 2010 the vice president of strategic management and planning received \$46,000 by cashing out his paid time off, and three other vice presidents received more than \$20,000 each in additional compensation because they exceeded the paid time off limit. The consultant's assessment noted that employee paid time off appeared to be above what is common for the Northern California region. The assessment recommended that the Health Care System review its paid time off practices and align them with standard industry practices. According to the interim CEO, the Health Care System proposed to its two largest employee organizations a reduction in paid time off, but was not successful in achieving such reductions. The interim CEO also indicated that he did not pursue adjusting paid time off benefits for nonunion employees because he wanted to address the issue in an across-the-board manner.

¹³ The consultant, Wellspring + Stockamp Huron Healthcare, provided assessments of the Health Care System's total operations in 2010 and 2011. The consultant delivered a series of assessments focused on labor and nonlabor operations and provided recommendations to the Health Care System.

¹⁴ Paid time off includes vacation, sick leave, and seven holidays.

Recommendations

To provide members of the public with opportunities to meaningfully participate in board meetings regarding executive compensation matters, and to hold the board accountable for its decisions on these matters, the Health Care System should take the following actions:

- Develop a formal policy that establishes a process for determining executive compensation, including retirement benefits, that clearly documents all executive compensation decisions.
- Clearly indicate compensation matters on the agendas for its board meetings.
- Discuss executive compensation matters only in open sessions of board meetings, except in the limited circumstances that allow for discussion in closed sessions.

To ensure that the terms of its CEO's employment and compensation are clear, and to aid the board in its oversight role, the Health Care System should engage its next permanent CEO in a written employment contract.

To help reduce its operating costs and improve its overall financial situation, the Health Care System should continue to try to modify its employee benefits, such as paid time off, so they are aligned with industry practice.

Blank page inserted for reproduction purposes only.

Chapter 2

STRONGER CONTROLS ARE NEEDED IN THE SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM'S OVERSIGHT OF CONFLICTS OF INTEREST AND OTHER AREAS

Chapter Summary

As a public entity, the Salinas Valley Memorial Healthcare System (Health Care System) is required to have a conflict-of-interest code and should take steps to ensure that its employees are not involved in business relationships that could result in personal financial gain or the appearance of personal financial gain. We identified 11 instances between 2006 and 2010 in which Health Care System executives or members of the board of directors (board) had economic interests in entities with which the Health Care System had business relationships. In the two relationships we reviewed, the former chief executive officer (CEO) may have violated conflict-of-interest laws in one instance, and the board may have violated conflict-of-interest laws in the other instance. Also, the Health Care System did not ensure that many of the individuals its conflict-of-interest code identified as needing to submit statements of economic interests (statements) did so.

The Health Care System supports the local community in part by funding community events and programs. However, it does not have a written policy and procedures to demonstrate that its community funding furthers its public purposes, thereby risking questions about whether this funding violates the constitutional prohibition against public agencies making gifts of public funds. The interim CEO acknowledged that the former CEO made community funding decisions without following any formalized process. Similarly, for contracts we reviewed for which state law did not require a competitive process, the Health Care System generally did not document the process it used to select contractors in a way that demonstrated that it obtained the best value when procuring goods and services.

The Health Care System's Policy and Practices for Conflicts of Interest Need Strengthening

The Health Care System has a conflict-of-interest policy that indicates its employees should avoid situations that constitute or appear to constitute conflicts of interest. However, we found one instance in which the board may have violated conflict-of-interest laws and another instance in which the former CEO may have violated conflict-of-interest laws. In addition, while its conflict-of-interest code specifies the employees who must file statements, the Health Care System does not ensure that these

employees file statements or that filed statements are complete. Finally, we determined that before the Health Care System's conflict-of-interest code was approved in December 2011, it had not been approved for 10 years, and therefore, for an extended period of time the code did not have the force of law.

The Health Care System Has Made Payments to or Deposits With Entities Identified as Economic Interests of Board Members and Executives

Despite prohibitions in state law and in its conflict-of-interest policy against its employees and board members engaging in activities that may result in an apparent or real conflict of interest, the Health Care System's safeguards in this area are insufficient. As a result, it lacks assurance that it acts appropriately under state law, that its board members and executives do not experience personal financial gain from its transactions with businesses, and that these transactions do not appear to be influenced by personal economic interests.

The Political Reform Act of 1974 (Political Reform Act) prohibits public officials at any level of state or local government from making, from participating in making, or from attempting to use their official position to influence a governmental decision in which they know or have reason to know they have a financial interest. Regulations implementing this prohibition generally specify that a public official has a conflict of interest if a decision will have a reasonably foreseeable material financial effect on an economic interest of the public official. Another state conflict-of-interest law, California Government Code, Section 1090 (Section 1090), prohibits officers and employees of special districts, among others, from being financially interested in any contract made by them in their official capacity, or by any body or board of which they are members, subject to some exceptions for statutorily defined remote interests and noninterests.¹⁵ In addition to the provisions in state law, the Health Care System's conflict-of-interest policy states that a conflict of interest may exist when an obligation or situation resulting from an individual's personal activities or financial interests may influence, or be perceived as influencing, the individual's judgment in his or her performance of duties for the Health Care System.

The Political Reform Act requires public officials who manage public investments to complete—annually, upon assuming office, and upon leaving office—statements in which they are to disclose their economic interests. An agency's own conflict-of-interest code may require statements from other positions in the agency.

¹⁵ An example of a noninterest would be a case in which an official owns less than 3 percent of the shares of a corporation with which the official's agency had a business relationship, and payments from the corporation do not exceed 5 percent of the official's total annual income.

For example, if a member of a governmental board of directors receives income of \$500 or more from a business, that board member should report this interest on his or her statement and generally must refrain from making decisions that would have a material financial effect on that business. Reportable interests include investments, interests in real property, income, and business positions.

Using information provided by the Health Care System’s board members and executives in their statements for filing years 2006 through 2010, we compared the economic interests they identified to the Health Care System’s disbursements for the same years. The relationships we identified are in Table 2.

Table 2
Disbursements Made to Businesses That Board Members and Executives of the Salinas Valley Memorial Healthcare System Reported as Economic Interests in 2006 Through 2010

BUSINESS	NATURE OF ECONOMIC INTEREST	HEALTH CARE SYSTEM DISBURSEMENTS*
1 st Capital Bank	Investment stock [†]	\$1,000,000
California International Airshow	Salary	112,200
Doctors on Duty Medical Group	Reportable source of income for business entity or trust, salary	50,380
First National Bank of Central California	Reportable source of rental income for real property	7,070,483
Kasavan Architects	Reportable source of income for business entity or trust	860,367
Medtronic USA, Inc.	Investment stock	3,327,951
Ottone Leach Olsen and Ray, LLP	Reportable source of income for business entity or trust	2,120,778
Rabobank	Personal loan, salary	5,625,663
Spectranetics Corporation	Investment stock	488,240
Staff Care, Inc.	Salary	398,278
Starbucks Coffee Company	Investment stock	577,376
Total		\$21,631,716

Source: Salinas Valley Memorial Healthcare System’s (Health Care System) statements of economic interests (statements) and the California State Auditor’s analysis of data obtained from the Health Care System’s Meditech System. See the Introduction’s Scope and Methodology regarding the reliability of the data.

* Disbursements reflect amounts paid by the Health Care System to the specified business for years in which a board member or executive reported an economic interest. We also included disbursements made to the California International Airshow, an entity in which a board member should have reported an economic interest, but did not. We discuss this issue later in the chapter.

† Type of investment not specified in the statements. Subsequent discussion with the former chief executive officer indicated that it was stock.

As shown in Table 2, the Health Care System disbursed \$21.6 million between 2006 and 2010 to businesses that board members and executives reported as economic interests. Although it may legally enter into business relationships with individuals or businesses that have been identified by its employees and board members as economic interests, the Health Care System must ensure that these employees and board members comply with the

We reviewed two of the 11 business relationships—for disbursements made to businesses that board members and executives of the Health Care System disclosed as economic interests—and found that it may have violated conflict-of-interest laws.

prohibitions in state conflict-of-interest laws. We reviewed two of the 11 relationships identified in Table 2—one involving the former CEO and one involving a business that we were requested to review as part of this audit—and found that the Health Care System may have violated conflict-of-interest laws. We believe, based on the problems we noted in the two relationships, that the Health Care System has a responsibility to ensure that all payments it made to businesses that board members and executives disclosed as economic interests for the business relationships we identified are in compliance with applicable legal restrictions.

The Former CEO Had \$50,000 Invested in 1st Capital Bank

The former CEO disclosed on his 2008 and 2009 statements a \$50,000 investment relationship with 1st Capital Bank, a bank with which the Health Care System agreed to deposit up to \$1 million in March 2008. Our review found that the Health Care System's former CEO signed the contract to deposit these funds after being authorized to do so by a board resolution in February 2008. In addition, the former CEO signed a waiver of security, which was executed under a state law that gives local agencies the discretion to waive the security for a portion of a deposit that is federally insured, further demonstrating that the former CEO made a discretionary decision related to an entity in which he had an economic interest. According to our legal counsel, these actions may have violated the Political Reform Act.

The Health Care System's legal counsel stated that the former CEO's investment would be considered *de minimis*, which means that it was so minor as to merit disregard. State law provides an exception to the prohibition in Section 1090 against public officials being financially interested in a contract made by them in their official capacity by defining certain financial interests as noninterests, such as when an official who owns less than 3 percent of the shares of a corporation and other conditions are met. According to our legal counsel, the former CEO's stock ownership likely met this exception. However, under the Political Reform Act, a public official has a financial interest in a decision if it is reasonably foreseeable that the decision will have a material financial effect, distinguishable from its effect on the public generally, on any business entity in which the public official has a direct or indirect investment worth \$2,000 or more. State regulations specify that the financial effects of a governmental decision on a business entity that is directly involved in the governmental decision are presumed to be material, unless the investment is worth \$25,000 or less.

Further, the Health Care System's legal counsel stated that its board authorized the establishment of an account with 1st Capital Bank and that the former CEO was designated by board resolution, along with a senior vice president, as an authorized representative of the Health Care System. However, according to our legal counsel, the former CEO may have made or participated in making a governmental decision when he entered into the Health Care System's contract and executed a discretionary waiver in connection with this contract. State regulations implementing the Political Reform Act specify that a public official makes a governmental decision when the official, acting within the authority of his or her office or position, among other things, enters into any contractual agreement on behalf of his or her agency or obligates or commits his or her agency to any course of action. The former CEO's actions, according to our legal counsel, arguably meet these regulatory specifications, and while the Political Reform Act does not prohibit a public official from participating in a governmental decision when that participation is legally required, our legal counsel believes it is unlikely that this exception would apply, because the resolution empowered both the former CEO and a senior vice president at that time to perform the duties related to the contract. Violations of the Political Reform Act may carry criminal, civil, and administrative penalties. For example, the Political Reform Act states that any knowing and willful violation of provisions within the Political Reform Act is a misdemeanor.

A Board Member Is a Salaried Regional President of Rabobank

In the second business relationship we reviewed, a board member of the Health Care System is a salaried regional president of a bank, Rabobank, to which the Health Care System made \$5.6 million in disbursements during the filing years we reviewed. We reviewed one agreement with Rabobank pertaining to the financing of an equipment lease of up to \$2.5 million. When the board voted in 2008 to enter into the agreement with Rabobank, the board member abstained from voting on the decision. However, according to our legal counsel, although it appears that by abstaining the board member did not violate the Political Reform Act's prohibition against participating in a decision, the board itself may have violated Section 1090 by entering into an agreement with an entity in which one of its members had a financial interest.

According to the Health Care System's legal counsel, the Health Care System has a business relationship with Rabobank or its predecessor that predates the appointment of the board member to the Health Care System's board. He further stated that the board member has always fully disclosed his employment with the bank and has not participated in any discussion or board vote related

One of the business relationships we reviewed—in which a board member is a salaried regional president of a bank—disclosed that the Health Care System made \$5.6 million in disbursements to the bank during the filing years we reviewed.

The Health Care System's legal counsel informed us that he believes the board felt at the time that the board member's withdrawal from any participation in the matter satisfied the requirements of the law.

to any transaction between the Health Care System and the bank. However, regulations implementing the Political Reform Act require the board member to orally identify his financial interest in the contract and require this identification to be made part of the official public record. The Political Reform Act requires this public identification to be done immediately prior to the consideration of the matter. The minutes for the meeting in which the board approved this contract did not indicate that the board member did this. Also, as previously stated, even though the board member abstained from the decision, our legal counsel believes that, in approving a resolution authorizing the execution of the contract, the board itself may have violated Section 1090 because one of its members arguably is financially interested in the contract, in that he receives a salary from the bank, and because the bank likely received a financial benefit as a result of its contract with the Health Care System.

The Health Care System's legal counsel informed us that he believes the board felt at the time that the board member's withdrawal from any participation in the matter satisfied the requirements of the law and that, on its face, certain exceptions to Section 1090 would appear to allow the transaction. These exceptions state that a director, an officer, or an employee of a bank with which a party to the contract has a relationship of borrower, depositor, debtor, or creditor has a remote interest or a noninterest in the contract; thus, the contract can be made without violating Section 1090. However, according to the 2010 version of the California Attorney General's Office's *Conflicts of Interest Guide*, these exceptions address the circumstance wherein a customer of a bank is preparing to enter into a contract with a government agency, and a bank director, officer, employee, or owner is a member of the government board or works for the government agency.¹⁶ According to this guide, these exceptions do not address the circumstance in which the bank itself wishes to contract with a government agency, such as the situation involving Rabobank and the Health Care System.

Unlike the prohibition in the Political Reform Act, which applies specifically to public officials with economic interests, Section 1090 also applies to any body or board on which these officials serve. Contracts made in violation of this section are void, even contracts entered into without the participation of the financially interested public official. Further, willful violations of Section 1090 are criminal acts punishable by a fine or imprisonment, and the public officials committing these violations are forever disqualified from holding any office in the State. Because of our concerns

¹⁶ The previous version of the *Conflicts of Interest Guide* issued in 2004 did not provide this guidance for these exceptions, but the underlying law was not substantively changed between 2004 and 2010.

regarding possible violations, we referred this matter, as well as the one involving the former CEO, to the Monterey County District Attorney.

The Health Care System's Conflict-of-Interest Code Was Not Enforceable by Law

To help ensure that its employees do not enter into business relationships with entities they identify as economic interests, and to thereby avoid making decisions that could result in personal financial gain or the appearance of personal financial gain, the Health Care System needs a strongly enforced conflict-of-interest code. However, previous conflict-of-interest codes it had been using before its current code was approved in December 2011 were not legally enforceable because they had not been approved by the Monterey County Board of Supervisors (board of supervisors).

State law requires every state or local government agency to adopt and make public a conflict-of-interest code; these codes have the force of law. Further, the law requires that agencies submit their codes to a reviewing body for approval and specifies that a code is not effective until approved by the code-reviewing body. Additionally, state law requires agencies to biennially report to the reviewing bodies regarding changes to their conflict-of-interest codes.¹⁷ State law also provides that if six months have elapsed following the deadline for an agency's submission of a proposed conflict-of-interest code to the reviewing body, and no code has been adopted and made public, the superior court, in an action filed by the agency, among others, may prepare a code and order its adoption.

The board of supervisors is the reviewing body for the Health Care System's conflict-of-interest code. The Health Care System filed biennial updates and amended codes with the clerk of the board of supervisors between 2000 and 2010. However, the last time the board of supervisors had approved an update was in 2001, when it approved the code the Health Care System had adopted in 2000.¹⁸ According to the current clerk of the board of supervisors, no records have been located showing that updates and amended codes submitted by the Health Care System were provided by the

The Health Care System needs a strongly enforced conflict-of-interest code.

¹⁷ Agencies are also required by law to amend their conflict-of-interest codes when necessitated by changed circumstances, and these amendments or revisions shall be submitted to the code-reviewing body within 90 days. We focused our review on the biennial requirement.

¹⁸ In January 2003 the Monterey County Office of the County Counsel (county counsel) sent a letter to the Health Care System's legal counsel stating that the county counsel was recommending a revision of the revised conflict-of-interest code submitted by the Health Care System in December 2002 and indicating that it would hold the submitted code until it had been contacted regarding further revision of the code. We did not note any further communication between the Health Care System and the county counsel regarding this matter.

The board of supervisors had not approved a Health Care System conflict-of-interest code in 10 years.

clerk's office to the board of supervisors for its review. The Health Care System's most recent submission of a biennial update occurred in December 2010. Following questions we posed to the clerk of the board of supervisors regarding the status of the Health Care System's conflict-of-interest code and various communications between the county and the Health Care System as part of the county's review process, the board of supervisors approved the Health Care System's current code in December 2011. The consequence of the Health Care System's conflict-of-interest code not being approved was that the code, along with its requirements, was not legally in effect and therefore not enforceable by law. For example, without an approved code, the Health Care System could not legally compel the employees designated in its code to file statements of economic interest (statements).

Since the board of supervisors had not approved a Health Care System conflict-of-interest code in 10 years, we asked the Health Care System's legal counsel whether it had filed an action in superior court for the adoption of a code. The legal counsel told us the Health Care System had neither filed such an action nor contemplated it. In fact, according to its legal counsel, the Health Care System operates under the assumption that unless the board of supervisors notifies it otherwise, changes in the conflict-of-interest code it submitted are approved. Nonetheless, staff within the Health Care System's legal counsel's firm have contacted the clerk of the board of supervisors on a few occasions over the last few years inquiring about approval of the Health Care System's code. Legal counsel also informed us that the Health Care System has always had a conflict-of-interest code, and that amendments submitted to the board of supervisors particularly have been to update the list of employees designated to file statements. However, as stated earlier, if the conflict-of-interest code is not approved, it does not have the force of law and cannot be enforced.

The Health Care System Does Little to Ensure That Individuals File Statements

The Health Care System has not ensured that its employees and consultants file statements as required and has done little to ensure that submitted statements are complete. As a result, staff who should be filing statements do not always do so, thereby increasing the possibility of these staff making decisions resulting in personal financial gain or giving the appearance of realizing such gain. To prevent such occurrences, government agencies need to have mechanisms in place to ensure that individuals designated by law or in the agencies' conflict-of-interest codes as needing to file statements do so.

We reviewed the Health Care System's method of ensuring that the individuals identified in its current conflict-of-interest code as being in designated filing positions do file their statements. The Health Care System maintains the statements submitted by designated filers in its accounting office. The accounting office uses a spreadsheet to identify the individuals in designated filing positions and to track whether these individuals submit their statements. Our testing found that 25 of the 99 designated filers identified in the tracking spreadsheet for the 2010 filing year had not filed as of September 2011, more than five months after the annual filing deadline of April 1. Although the assistant controller sent a reminder e-mail to designated filers shortly before the 2010 statements were due, no follow-up efforts occurred until we informed the Health Care System of our testing results. According to its ethics and compliance officer, the Health Care System subsequently obtained the late statements from the individuals.

By law, the Health Care System is required to indicate in its conflict-of-interest code whether it will file statements for those in designated filing positions within its own agency or with its code-reviewing body. According to state law, the person responsible for obtaining and maintaining these statements is the filing officer. The law allows for the filing officer to impose financial penalties of \$10 per day, up to a maximum of \$100 or the cumulative amount stated in the late statement, whichever is greater, on designated filers who fail to file on time. According to its ethics and compliance officer, the Health Care System has not historically identified one individual as being responsible for ensuring that designated filers submit annual statements. However, according to Fair Political Practices Commission guidelines, each agency must designate an individual or individuals as a filing officer. The Health Care System's conflict-of-interest code designates only the Health Care System itself as the filing officer for designated filers. Further, the conflict-of-interest policy in place during our testing designated *accounting* as the filing officer.

In December 2011 the Health Care System revised its policy, which continues to designate accounting rather than an individual as the filing officer. The revised policy includes new provisions specifying the Health Care System's ethics and compliance officer as the individual responsible for reviewing the statements annually for "completion compliance." Additionally, the revised policy requires board members, medical staff, consultants, and employees to disclose potential conflict-of-interest situations to their direct supervisor and the ethics and compliance officer, who shall review the situation and make a determination as to the appropriate resolution. Although this new process is a step in the right direction, the Health Care System should, in addition to designating an individual as a filing officer, ensure that its conflict-of-interest

Our testing found that 25 of the 99 designated filers identified for the 2010 filing year had not filed as of September 2011, more than five months after the deadline.

policy and practices include certain measures described below that are required by state regulations and that help ensure submitted statements are complete and accurate.

According to state regulations, the responsibilities of filing officers include conducting reviews of all submitted statements to verify that the cover sheets for the statements are complete and conducting a more comprehensive review of all statement attachments on at least 20 percent of submitted statements. The comprehensive review comprises determining whether filers submit applicable schedules, including all required descriptive information, and determining whether the information that filers provide suggests that other information is omitted on a schedule. Our testing of the statements for the 2010 filing year found that 10 of the 74 submitted forms included omissions that may have been identified by the mandatory cover sheet review.

We also noted that the Health Care System failed to obtain a statement from its interim CEO, with whom the Health Care System contracted in April 2011, upon assuming office (assuming office statement). State law requires public officials who manage public investments to file statements disclosing investments, interests in real property, and income received upon assuming office, annually thereafter while in office, and upon leaving office. The Health Care System's CEO, or a consultant working as the CEO, as a high-level officer or employee of a public agency exercising primary responsibility for the management of public investments, is by legal definition such a public official. Our testing revealed that the Health Care System obtained the applicable statements from its board members and former CEO during the 2006 to 2010 filing years. However, it did not obtain an assuming office statement from its interim CEO, which he was required by law to provide within 30 days of his appointment in April 2011, until we brought the matter up in October 2011.

Further, we found that the statements the Health Care System properly collected from the board members and from its former CEO were not always accurate. For example, the former CEO failed to report for the 2007 filing year his acquisition of investment stock in 1st Capital Bank—a bank with which the Health Care System entered into a banking relationship, as discussed previously. Although the former CEO subsequently included this investment in the 2008 and 2009 filing year statements, he also failed to include it in his 2010 annual statement and in his statement upon leaving office in 2011. In addition, one of the Health Care System's current board members informed us during the audit that he did not report on his annual statements the \$1,000 per month salary he received from his position as executive director of the California International Airshow because, due to the small amount, he did

The former CEO failed to report for the 2007 filing year his acquisition of investment stock in 1st Capital Bank—a bank with which the Health Care System entered into a banking relationship.

not think he was required to report it. However, the law states that public officials who manage public investments must disclose in their statements any business positions held and must include in their statements the name and address of each source of income totaling \$500 or more.

The Health Care System Lacks a Policy and Procedures to Ensure That It Does Not Make Gifts of Public Funds

Despite a prohibition in the California Constitution against public agencies making gifts of public funds, the Health Care System does not have a policy or written procedures to ensure that it complies with this requirement when making decisions about providing funds to community programs. As a public agency managing public funds, the Health Care System must ensure that its donations and sponsorships (community funding) further the specific public purposes for which it was created.¹⁹ Without a policy and procedures to ensure that the Health Care System's community funding furthers its public purposes, it risks making or appearing to make gifts of public funds.

The Health Care System's community funding has declined dramatically over the past few years, going from almost \$2.5 million during 2008 to roughly \$1 million during 2010. Information as of mid-2011 indicated that the Health Care System's community funding expenses for 2011 were on track to be at a level similar to those in 2010. According to the interim CEO, this decline is due mainly to the Health Care System's concerted effort to reduce its expenses in all areas since the recession began in Salinas in 2008. We observed that a substantial portion of its community funding went to Monterey County for the Natividad Medical Center, which received \$1.7 million in 2008 and \$1.2 million in 2009, but no funding from the Health Care System after that. The extension through July 2009 for the original 2006 agreement stated that this funding was for the sole purpose of assisting the county in operating, maintaining, and improving Natividad Medical Center. The board resolution authorizing the 2006 agreement included a finding by the board that the agreement would, among other things, further the efficient delivery of health care services. According to the Health Care System's legal counsel, Natividad, which is the "safety net" hospital for the region, is now very successful.

Using data in the 2009 report by the IRS mentioned previously, we found that the Health Care System's expenses for community funding seem roughly comparable to those of nonprofit hospitals

The Health Care System's community funding has declined dramatically over the past few years, going from almost \$2.5 million during 2008 to roughly \$1 million during 2010.

¹⁹ The Health Care System's mission statement is, "To improve the healthcare of our geographical healthcare district and beyond."

Of the 14 recipients of the Health Care System's community funding between 2008 and 2010 that we reviewed, the Health Care System demonstrated for only three recipients that all of the disbursements were made after considering whether they furthered its public purposes.

of similar size, although caution is needed in making such comparisons, due to differences in what hospitals may categorize as community funding. According to the IRS report, 61 hospitals with revenues similar to those of the Health Care System spent an average of \$1.87 million on community program expenditures during their most recent tax period.²⁰

We reviewed 14 recipients of the Health Care System's community funding between 2008 and 2010 to determine whether anyone had considered whether the funding of these recipients furthered its public purposes. The Health Care System demonstrated for only three of the recipients we reviewed that all of the disbursements made furthered its public purposes. For example, we reviewed a \$100,000 payment it made to the Central Coast YMCA in 2008. This payment was authorized in 2005 by the board as part of a multiyear funding commitment the Health Care System made to the Central Coast YMCA capital development program. The Health Care System documented in its meeting minutes that the board agreed funding for this project fit its mission statement and operating guidelines, following a presentation on the project and its health benefits.

However, while able to provide explanations for the funding of the 11 other recipients, the Health Care System could not demonstrate, for all or some portion of the disbursements, that it made its decisions after considering whether the funding furthered its public purposes. For instance, the Health Care System disbursed nearly \$54,000 to the California Rodeo during 2009 for its 2009 and 2010 sponsorships of the event, general admission tickets, and box seating. In return for its sponsorships, the Health Care System received several rodeo-related benefits, including in 2010 tickets to the event's sponsor hospitality area for food and beverages, main grandstand tickets, a flag presented during each rodeo performance, and an ad in the rodeo souvenir program. The Health Care System was unable to provide any evidence that it considered how this funding furthered its public purposes, but according to the interim CEO, the California Rodeo provides an optimum means to market the Health Care System's services to its residents and positions the Health Care System as the local expert in health care through sponsorship of the rodeo's first aid area.

In another example, the Health Care System spent \$1,250 of its 2008 community funding for attendance at a fundraiser benefiting elephants housed in a sanctuary, which was promoted as including an evening of fine food, spirits, live music, and dancing. According

²⁰ The report listed expenditures for items such as improving access to health care, medical screening, studies of a community's unmet health care needs, and other health care promotion as community program expenditures.

to the Health Care System's interim CEO, this event provided exposure to an important audience, such as community leaders who can and have benefited the hospital, allowed interaction with key potential patients, served as informal marketing for its services, and served as an opportunity to discuss its latest achievements with key community leaders. Given the absence of a policy or written procedures to ensure that its community funding decisions further its public purposes, the Health Care System leaves itself open to having its decisions questioned.

According to the Health Care System's interim CEO, the former CEO made community funding decisions without following any formalized process. He stated that the board would provide the former CEO with a budget for community funding every fiscal year, and major funding decisions would be discussed in board meetings. The interim CEO stated that since late April 2011, the Health Care System's process has been for its executive leadership group to review all funding requests. Before approving a request, the group is to require written justification, which must contain the name of the community organization, the activity to be financially supported, how such support benefits the mission of the Health Care System, and the amount requested. We were unable to include community funding commitments made under this new process in our testing, though, because as of mid-October 2011, according to the interim CEO, the Health Care System had made no new community funding commitments since his arrival in late April 2011.

In addition, we found that the Health Care System does not have a policy and procedures for tracking the disposition to its employees of event tickets it receives from entities to which it provides community funding, so that it can meet applicable state reporting requirements. For example, the Health Care System received tickets to events at the California International Airshow and the rodeo after providing financial sponsorship support for these events in 2010. According to Health Care System officials, the tickets for these events were distributed to employees, but the Health Care System did not keep track of who received the tickets. When public officials receive tickets to events such as the airshow and the rodeo from their agencies, the tickets could be considered either income or gifts. State regulations require the agencies to publicly disclose who received the tickets. If the tickets are considered gifts, they may also be economic interests that could prohibit the officials receiving them from making decisions involving the entities that provided the gifts, as discussed earlier in this chapter. The Health Care System's failure to track the recipients of event tickets could result in its or its employees' noncompliance with applicable disclosure laws, thus depriving the public of information that would allow informed public comments to the board on the Health Care System's community funding and other business relationships.

The Health Care System spent \$1,250 of its 2008 community funding for attendance at a fundraiser benefiting elephants housed in a sanctuary, which was promoted as including an evening of fine food, spirits, live music, and dancing.

The Health Care System Needs to Improve Its Processes for Awarding Certain Types of Contracts

Although the Health Care System used a competitive process to award contracts when required for those contracts we tested, it did not consistently document how it selected contractors in cases for which it was not required to use a competitive process. When it does not document its decision-making approach, the Health Care System is at risk of not being able to demonstrate to the public that the business relationships it has established are in its best interests and that it is making sound contracting decisions that result in obtaining the best value when procuring goods and services.

Only Some Health Care System Contracts Are Required by State Law to Follow a Competitive Process

State law generally requires the board to award contracts involving an expenditure of more than \$25,000 for materials and supplies to be furnished, sold, or leased to the Health Care System, and for work to be done amounting to a contract of over \$25,000 to the lowest responsible bidder. Additionally, according to state law, the board must use competitive means to purchase electronic data processing and telecommunications goods and services with a cost of more than \$25,000, unless the items are the only ones that can meet the Health Care System's needs or are needed for an emergency. State law defines *competitive means* as including any appropriate means specified by the board, including the preparation and circulation of a request for proposals to an adequate number of qualified sources. When the board awards a contract through competitive means, the law requires the contract award to be based on the proposal that provides the most cost-effective solution to the Health Care System's requirements, as determined by the evaluation criteria specified by the board. The evaluation criteria may provide for the selection of a vendor on an objective basis other than cost alone.

We reviewed five contracts for which the Health Care System had to either follow competitive bidding requirements or use competitive means in selecting the contractors. For four construction contracts we reviewed, the Health Care System collected bids from multiple bidders and appropriately awarded the contract to the lowest responsible bidder in all instances. We also reviewed a contract for an information technology software system and found that the Health Care System issued a request for information for this project to three firms, established predetermined criteria for selecting the firm with the most cost-effective solution, and awarded the contract to the firm that provided the lowest cost for the services that the Health Care

System required. We did note that although the board ultimately approved the contract, the Health Care System was unable to provide evidence showing that the board specified the evaluation criteria for the selection of this firm, as required by law. However, according to the Health Care System's official charged with leading this selection, the board set the stage by making a formal decision to move to a new information technology system and approved the budget prior to contractor selection. Further, before awarding the contract, a presentation was provided to a board committee that included information regarding the process the Health Care System followed to select this firm.

The Health Care System Needs to Better Document Its Processes for Contracts Exempt From Competitive Requirements

Instead of requiring documented processes for awarding contracts that are not required by law to follow a competitive process, the Health Care System relies on the discretion of its management personnel to document their decision-making process for establishing business relationships through contracts. This approach leaves the Health Care System at risk of not being able to demonstrate to the public that the business relationships it has established are in its best interests and that it is making sound contracting decisions that result in obtaining the best value when procuring goods and services. As a result, we believe it would be a good business practice and would benefit the Health Care System to maintain documentation demonstrating why it selected certain vendors or contractors.

State law permits the Health Care System to acquire medical or surgical equipment or supplies and professional services such as consultant contracts without using a bidding process or other competitive means. The Health Care System has policies and procedures that cover various types of purchases. For example, it uses a signing matrix that delegates signing authority for purchases of a predetermined amount to department directors and Health Care System executives.²¹ However, we were unable to find any specific policies or procedures that outline how the Health Care System ensures that its contract and vendor selection results in the best value for the Health Care System. In fact, the Health Care System's ethics and compliance officer acknowledged a lack of consistent guidelines or practices for its process of selecting contracts and vendors. According to the ethics and compliance officer, department directors are typically responsible for researching, comparing, and selecting contracts and vendors.

The Health Care System relies on the discretion of its management personnel to document their decision-making process for establishing business relationships through contracts.

²¹ In the Health Care System, department directors report to the executives.

We found that the Health Care System was able to demonstrate for only one of the eight contracts we tested that the responsible party followed some type of process to ensure that the Health Care System received the best value.

The Health Care System's executives are then responsible for approving those decisions by signature, with the expectation that the directors performed adequate research and selected the most appropriate vendor.²²

We reviewed eight contracts that were not specifically required by law to have a competitive process, to determine whether the parties responsible for making the contract decision went through a process to ensure that their selection represented the best value for the Health Care System. We found that the Health Care System was able to demonstrate for only one of the eight contracts that the responsible party followed some type of process to ensure that the Health Care System received the best value from the selected contractor. Specifically, for its selection of parking and shuttle services, the Health Care System obtained proposals from various bidders and documented in a spreadsheet what each bidder offered, along with itemized costs for services.

Health Care System officials were able to explain how they believed they received the best value from the selected contractor for four of the remaining seven contracts, although they could not provide documentation of the process they used. The officials claim to have compared multiple vendors against criteria such as costs or vendor experience and knowledge prior to awarding three of these contracts, but we were unable to verify these assertions. In another example, an official informed us that he based his selection for a maintenance contract on the fact that the contractor he selected was the original equipment manufacturer and that the selection of original equipment manufacturers for maintenance is typical because they have the best product knowledge of their systems, provide original parts, and do not place blame when things go incorrectly, which, he stated, occurs when maintenance is outsourced. However, other maintenance providers could also have the necessary attributes. In addition, the Health Care System does not have a policy or procedure specifying that original equipment manufacturers should be selected to provide maintenance on their equipment for the purpose of providing the best value, which we would expect to find if it is a common practice.

Health Care System officials could not sufficiently explain how they believed they obtained the best value for three of the seven contracts. For one contract, an official explained that a consultant was selected based on that consultant's reputation and past performance of services it provided to the Health Care System and that no other businesses were considered. For the other

²² The ethics and compliance officer also informed us that, in some cases, vendor and contract selection may take place at the executive level or within a committee such as the Electronic Health Record Devices/Software Needs Assessment Committee.

two contracts, the Health Care System officials listed as the primary responsible parties for the contracts were unable to provide an explanation as to how the Health Care System received the best value with its selections. We believe our testing results underscore the importance of having policies and procedures to guide the selection process for contracts not required by law to go through some type of competitive process, including documenting the basis for the contractors that are ultimately selected.

Recommendations

To ensure that the Health Care System, its board members, medical staff, employees, and consultants are engaged only in appropriate business relationships with respect to their economic interests, the Health Care System should take the following steps:

- Engage an independent investigator to review the Health Care System's business relationships with entities that we identified as being economic interests of its board members and executives to determine whether any of the relationships violate applicable legal prohibitions and take appropriate corrective action if they do.
- Implement the requirement in the Health Care System's recently updated conflict-of-interest policy that board members, medical staff, employees, and consultants disclose potential conflict-of-interest situations to their supervisors and the ethics and compliance officer, who shall review each situation and make a determination on the appropriate resolution.
- To ensure that it has an up-to-date, approved conflict-of-interest code, the Health Care System should develop a protocol to file an action through the superior court to adopt a code if, in the future, the board of supervisors does not approve a code within six months of one being submitted to it by the Health Care System and if follow-up efforts with the board of supervisors prove unsuccessful.

To help ensure that individuals designated by the Health Care System as needing to file statements of economic interests do so, the Health Care System should amend its conflict-of-interest policy to address the following:

- Specify an individual as its filing officer, in accordance with guidelines of the Fair Political Practices Commission.

- Delineate the steps its filing officer should take to ensure that all Health Care System board members, medical staff, employees, and consultants who are required to file statements of economic interests do so.
- Specify penalties for failure to file.

To help ensure the accuracy and completeness of filed statements of economic interests, the Health Care System's filing officer should follow state regulations for reviewing submitted statements, including verifying the cover sheet for completeness for all submitted statements.

To ensure that it is not making gifts of public funds, the Health Care System should develop and implement a policy and written procedures to demonstrate how funds it provides to support entities and programs in the community further the Health Care System's public purposes.

To help ensure that the Health Care System has the information it needs to comply with state regulations regarding public disclosure of the disposition of event tickets, the Health Care System should develop and implement a policy and written procedures for tracking its distribution of event tickets. The procedures should ensure that the Health Care System follows state requirements for making pertinent public disclosures.

To increase the transparency of its processes for awarding contracts that are not required by law to be selected using a competitive process, the Health Care System should require its employees to fully document the steps they take in selecting contractors and to describe how the selections result in the best value to the Health Care System.

Chapter 3

FISCAL CHALLENGES ARE AFFECTING THE SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM'S OPERATIONS

Chapter Summary

Between fiscal years 2005–06 and 2008–09, the Salinas Valley Memorial Healthcare System (Health Care System) was profitable financially. However, high unemployment rates that led to fewer patients and decreases in insurance reimbursements were two key reasons that subsequently lowered operating revenues. In fiscal year 2010–11, the Health Care System experienced an operating loss of \$7.4 million. To help improve its financial situation, the Health Care System hired a consultant in 2010 to review and make recommendations for improving its operations. Subsequently, by offering incentives to resign and imposing involuntary separations, the Health Care System reported cutting its staffing by 341 positions. The Health Care System reported estimated annual labor savings of nearly \$44 million as of December 2011 and reported implementing a number of other cost-saving initiatives valued at \$7.4 million. Even though the Health Care System reduced its staffing, there is no indication that this decrease affected patient quality of care, as reflected by complaints and similar indicators.

The Health Care System Has Reduced Staff and Taken Other Measures to Strengthen Its Financial Condition

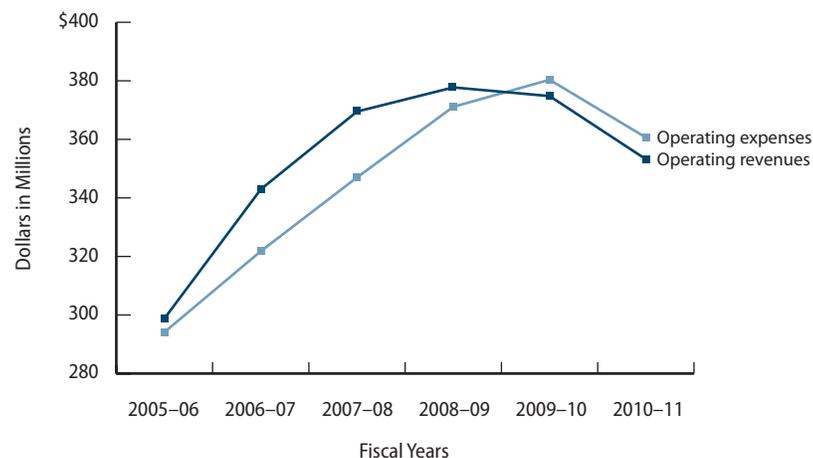
In an effort to improve its financial condition, the Health Care System has undertaken numerous cost-saving initiatives. Primary among these are its staff reduction efforts. In addition, the Health Care System reported successfully completing 93 of 109 other cost-saving strategies as of September 2011, such as reducing costs for cardiac rhythm management devices. Two members of the board of directors (board) we spoke with indicated that the Health Care System is focused on achieving efficiencies and increasing its revenue from operations while maintaining quality of care.

The Health Care System Started Reporting Operating Losses in Fiscal Year 2009–10

During fiscal years 2005–06 through 2008–09, the Health Care System's operating revenues increased by nearly \$79 million, but beginning in fiscal year 2009–10, operating expenses exceeded operating revenue. Although the Health Care System managed to decrease its operating expenses for fiscal year 2010–11, it still

reported an operating loss of \$7.4 million. Figure 2 shows the Health Care System's operating expenses and revenues for fiscal years 2005–06 through 2010–11. Although it has reported operating losses during the last two fiscal years, the Health Care System also receives nonoperating revenues, such as property taxes and investment income, which have acted to offset its operating losses. Specifically, when its nonoperating revenues, which ranged between \$7.1 million and \$11.2 million during the six fiscal years we reviewed, are taken into consideration, the Health Care System continued to experience gains, even though its operating expenses have exceeded its operating revenues for the last two fiscal years. Recently, however, the Health Care System's annual overall gains have decreased substantially, from a high of \$35.6 million in fiscal year 2007–08 to only \$1.3 million in fiscal year 2010–11.

Figure 2
Salinas Valley Memorial Healthcare System Operating Revenues and Expenses
Fiscal Years 2005–06 Through 2010–11

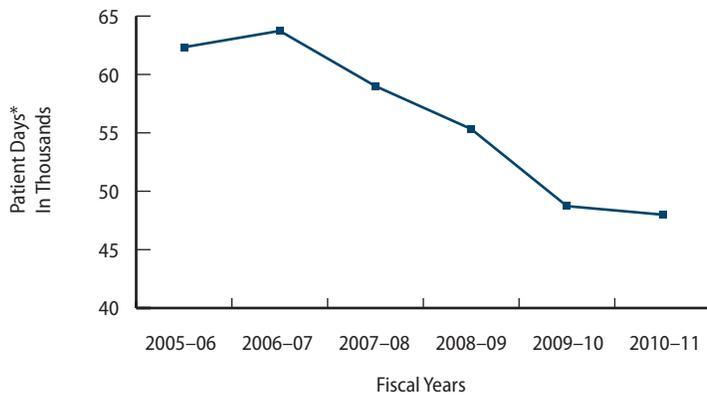


Source: Salinas Valley Memorial Healthcare System's audited financial statements.

The Health Care System cited several reasons for the decreases in its operating revenue, which is based primarily on fees for patient services. For example, according to its vice president of strategic management and planning, high unemployment rates have negatively affected the Health Care System because fewer people are insured and people are not as likely to seek medical care. This is in line with an American Hospital Association analysis of 2010 survey data from 572 nonfederal, short-term acute care hospitals that found patients continue to delay or forego care as family budgets remain tight, and noted that 70 percent of hospitals reported lower patient volume. The vice president of strategic

management and planning also commented that the recent press coverage the Health Care System received has lowered patient volume because patients are reluctant to go to a hospital that receives negative press. As shown in Figure 3, after an initial small increase, patient days dropped significantly between fiscal years 2005–06 and 2010–11.

Figure 3
Salinas Valley Memorial Healthcare System Patient Days
Fiscal Years 2005–06 Through 2010–11



Source: Unaudited data in the Management’s Discussion and Analysis section of the Salinas Valley Memorial Healthcare System’s financial statements for the years indicated.

* The Office of Statewide Health Planning and Development defines patient day as a unit of measure denoting lodging facilities provided and services rendered to one inpatient between the census-taking hour on one day to the same hour on the next day.

The vice president of strategic management and planning also informed us that decreases in insurance reimbursements and increases in the amount of income lost due to the provision of charity care have negatively affected the financial condition of the Health Care System.²³ According to the American Hospital Association analysis, 87 percent of the 572 hospitals surveyed in 2010 reported increased bad debt and charity care. The two board members we spoke with expanded on the vice president’s comments regarding insurance reimbursements by explaining that Anthem Blue Cross negotiations resulted in a change in the reimbursement plan for the Health Care System that significantly decreased its reimbursements. Although we found that the Health Care System agreed to decreases in reimbursement rates for charges for inpatient services from 90 percent to 83 percent and for outpatient services from 90 percent

²³ The Health Care System provides care without charge or at less than its established rates (charity care) for emergency inpatient or outpatient hospital services for individuals with assets below a set percentage of the federal poverty level.

to 82 percent for patients covered by Anthem Blue Cross, these changes did not take effect until January 1, 2011. The two board members also indicated that the Health Care System faced significant costs to meet the State's seismic safety requirements for its facilities. In fact, the Health Care System reported spending \$33 million in fiscal years 2009–10 and 2010–11 to retrofit its facilities and indicated that it expected to spend \$9 million more in fiscal year 2011–12 to complete its seismic retrofitting efforts.

The Health Care System Has Undertaken Several Initiatives to Improve Its Financial Condition

The Health Care System reported that it has implemented measures that have resulted in substantial cost savings, with most of the savings attributable to staff reductions. In early 2010 the board hired a consultant to aid the Health Care System in reducing costs in order to adapt to financial challenges.²⁴ The consultant evaluated the Health Care System's operations to identify areas for process improvement and cost savings, including possible labor reductions. The Health Care System reported that it subsequently reduced its staff by 341 positions over the period from July 2010 through October 2011. The Health Care System reported annual labor savings of nearly \$44 million as of December 2011. A few months earlier, it reported implementing other cost-saving initiatives valued at \$7.4 million, some of which are expected to be recurring.

The consultant produced a series of reports for the Health Care System's consideration in 2010 and 2011 that contained key observations. For example, the consultant indicated in its May 2010 update report that the Health Care System was above the 95th percentile in terms of staffing compared to a peer group of California hospitals.²⁵ Also, the consultant noted that the number of nurses in most of the Health Care System's units was significantly above California hospital benchmarks and required California nurse-to-patient ratios. Over the course of this evaluation, the consultant made recommendations for financial improvements to the Health Care System, such as the need to reduce labor costs by adjusting the staff levels to reflect demand.

The Health Care System reduced its staff levels in an effort to align its workforce with patient volume and revenue constraints. In June and July 2010, the former CEO sent memos to staff that contained information about incentives for nonunion employees

The Health Care System reported annual labor savings of nearly \$44 million as of December 2011. A few months earlier, it reported implementing other cost-saving initiatives valued at \$7.4 million, some of which are expected to be recurring.

²⁴ We mention this consultant, Wellspring + Stockamp Huron Healthcare, in our discussion of employee benefits in Chapter 1.

²⁵ This statistic indicates that the Health Care System had more staff than 95 percent of comparable California hospitals.

to voluntarily resign. This was followed by a similar offer made to union employees in October 2010. The Health Care System includes employees from the following three unions: the California Nurses Association, the National Union of Healthcare Workers, and the International Union of Operating Engineers (known as Local 39). Initially, employees were offered incentive packages that ranged from five to 18 weeks of pay, depending on years of service. Subsequently, in the fall of 2010, employees were offered incentive packages of from two to 13 weeks, based on years of service. This was followed by cash incentives offered to union and nonunion employees in the spring of 2011 in the amount of \$3,000 to \$7,000. The Health Care System estimated that implemented staff reductions have resulted in decreased labor costs of nearly \$44 million annually as of December 2011.

According to Health Care System human resources staff, in fiscal year 2010–11, 202 employees accepted incentive packages. Of these, 71 were represented by the National Union of Healthcare Workers, 27 were represented by the California Nurses Association, one was from Local 39, and 103 were not affiliated with a union. In addition, 125 employees were involuntarily separated in fiscal year 2010–11 and 14 more through October 2011, resulting in a total decrease of 341 employees. Included in the 341 employees was one vice president who the Health Care System does not plan to replace.²⁶ In a letter published on its Web site in August 2011, the board president acknowledged that the workforce was close to the needed size and that the Health Care System did not anticipate future staff layoffs in addition to those already announced. Table 3 on the following page shows the decrease in the number of Health Care System employees during fiscal year 2010–11 by union affiliation, and Figure 4 on the following page shows the Health Care System's staff trends over the last five years.

The consultant and the Health Care System also identified 109 nonlabor opportunities with potential savings of \$8.1 million. According to the consultant's final nonlabor report in September 2011, the Health Care System had implemented 93 of the initiatives, worth \$7.4 million. Examples include initiatives to reduce the Health Care System's costs for transcription services and cardiac rhythm management devices. We reviewed documentation related to these two initiatives and found that the Health Care System's estimates that it should annually save \$287,000 for transcription services and \$416,000 for cardiac rhythm management devices by renegotiating contracts appear reasonable.

Employees accepting incentive packages accounted for 202 of the total staff reduction of 341; the remainder were involuntarily separated.

²⁶ Unrelated to the staff reduction effort, as of February 2012, six vice presidents had separated from the Health Care System. Two resigned and two retired in January 2012; one retired in February 2012; and another vice president retired in June 2010. The interim CEO stated that he will fill one of these positions and that will be on a part-time basis.

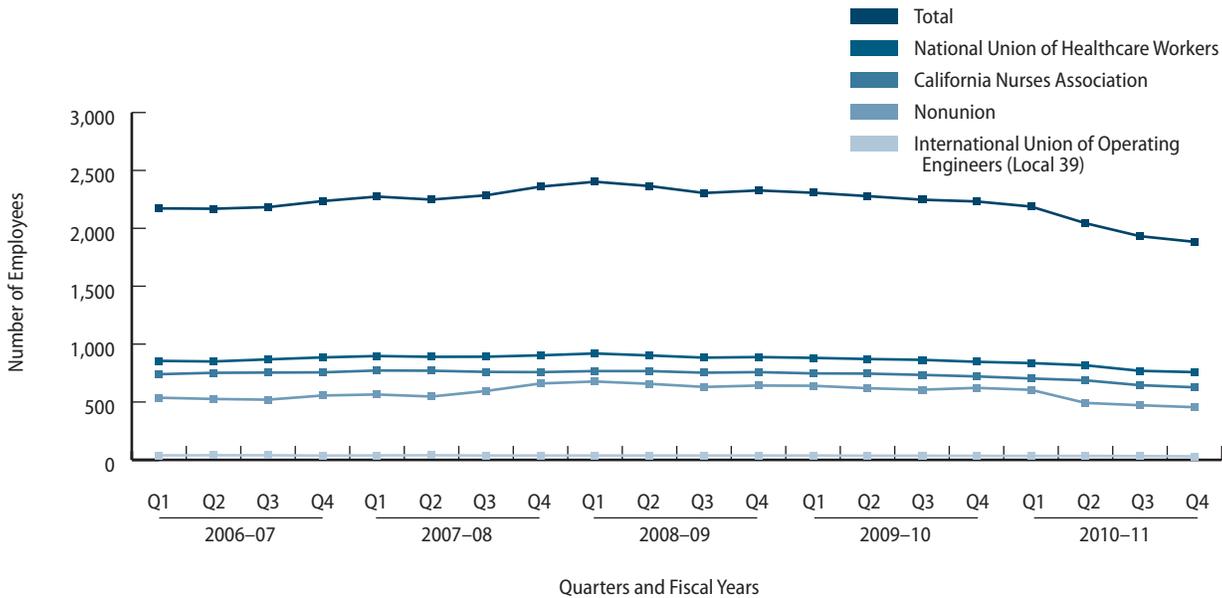
Table 3
Staffing Levels in the Salinas Valley Memorial Healthcare System
During Fiscal Year 2010–11

UNION AFFILIATION	FIRST QUARTER OF FISCAL YEAR 2010–11*	FOURTH QUARTER OF FISCAL YEAR 2010–11*	DECREASE	PERCENTAGE DECREASE
Nonunion	605	455	150	25%
National Union of Healthcare Workers	836	758	78	9
California Nurses Association	703	627	76	11
International Union of Operating Engineers (Local 39)	34	31	3	9
Totals	2,178	1,871	307	14%

Source: California State Auditor’s analysis of data obtained from the Salinas Valley Memorial Healthcare System’s (Health Care System) Meditech and API systems. See the Introduction’s Scope and Methodology regarding the reliability of the data.

* The employees captured in this data worked for the Health Care System at least one day during the quarter specified. In addition, the numbers in the table include staffing changes unrelated to the Health Care System’s staff reduction efforts discussed in this section. The total number of employees shown in the fourth quarter of fiscal year 2010–11 in this table differs from the more than 1,700 employees mentioned in the Introduction because that number is a point-in-time value at the end of the fourth quarter.

Figure 4
Salinas Valley Memorial Healthcare System Quarterly Staffing Levels
Fiscal Years 2006–07 Through 2010–11



Source: California State Auditor’s analysis of data obtained from the Salinas Valley Memorial Healthcare System’s (Health Care System) Meditech and API systems. See the Introduction’s Scope and Methodology regarding the reliability of the data.

Note: The employees captured in this data worked for the Health Care System at least one day during the quarter specified.

According to the two board members we spoke with, the Health Care System realizes that it could have acted sooner to implement cost-cutting measures based on the changing economic climate. They added that the Health Care System does not have an excess of revenues over expenses from its current operations and is focused on achieving efficiencies and improving its revenue from operations while maintaining quality of care. Further, the two board members indicated that the Health Care System will explore adding or augmenting hospital services and expanding its affiliations. The board members also commented that, as part of its fiduciary duty, the board will also explore opportunities for new affiliations and the possibility of a partnership or merger with a larger health care system.

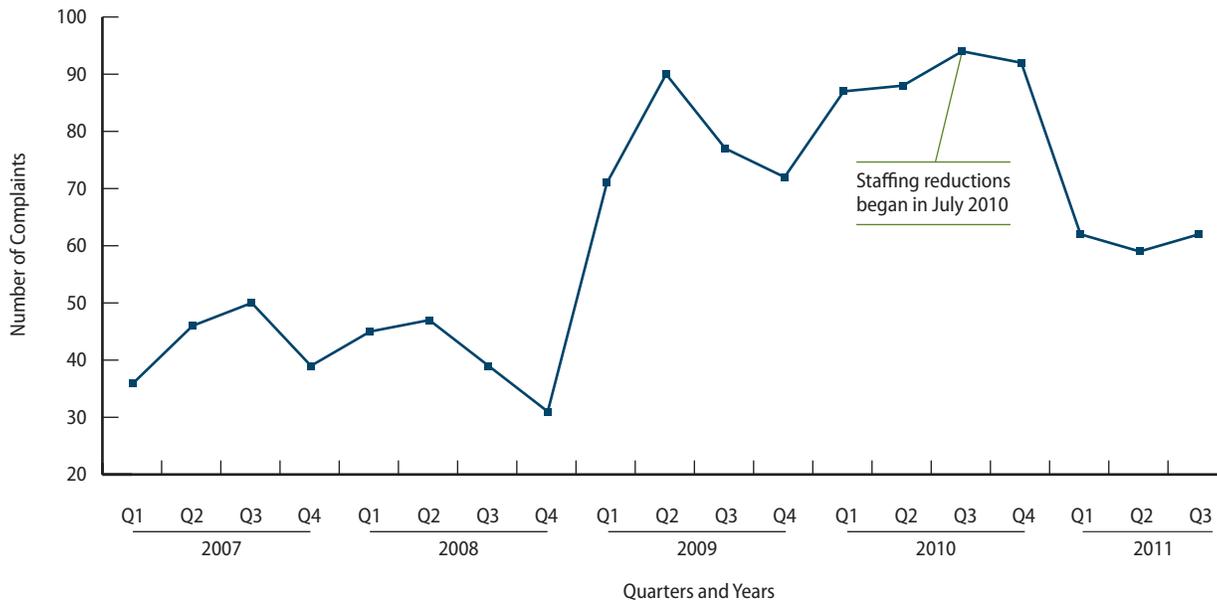
The Health Care System Has Not Experienced Significant Increases in Patient Complaints Following Decreases in Staffing

Although patient complaints and other indicators of quality of care—such as the number of deficiencies cited—have in some cases increased over the last several years, nothing indicates that the Health Care System’s staff reductions have caused an increase in such indicators in the limited time since they were made. The number of patient complaints the Health Care System tracks pertaining to issues such as confidentiality and quality of care has fluctuated substantially over the past several years, which is most likely attributable to the Health Care System’s method for tracking them. For example, the increases in complaints during the first and second quarters of 2009 were likely due to the implementation of the Health Care System’s online tracking system, according to the former senior administrative director of quality and risk management (former senior director).²⁷ The new online system features data entry points at various locations around the hospital that potentially make it easier for Health Care System employees to register complaints. As shown in Figure 5 on the following page, the number of patient complaints dropped significantly during the time period in which the Health Care System made its staffing reductions and then generally stayed at this level. This decrease, according to the former senior director, may have been due to normal patterns of variation or to a decrease in patient volume, or it could have been affected by nursing staff and managers being requested to address and resolve as many complaints in “real time” as possible, and therefore not entering them into the online tracking system. Although the various factors involved preclude any precise conclusion regarding the effect of staffing reductions on complaints, the decreased level of complaints suggests that the reductions had little, if any, effect on them.

The number of patient complaints dropped significantly during the time period in which the Health Care System made its staffing reductions and then generally stayed at this level.

²⁷ According to the former senior director, the Health Care System does not always track complaints that are resolved to the patient’s satisfaction when patients make them. Complaints that are not resolved prior to the patient’s departure from the hospital, or any complaints patients lodge after they leave the hospital, are entered into the Health Care System’s online tracking system as grievances. To avoid confusion, we refer to both complaints and grievances as complaints in this report.

Figure 5
Complaints Reported to the Salinas Valley Memorial Healthcare System
First Quarter 2007 Through the Third Quarter of 2011



Sources: Salinas Valley Memorial Healthcare System's complaint reports to the board of directors and the Quality and Safety Committee, as well as the California State Auditor's analysis of staff reduction data.

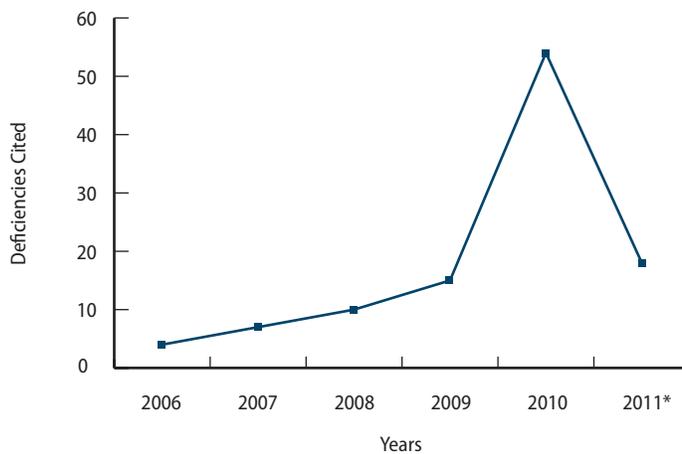
To keep the board apprised of complaint trends, according to the former senior director, the Quality and Risk Management Office presents patient complaint information to the board and the Health Care System's Quality and Safety Committee, which includes a board member. We reviewed quarterly reports presented to the board and the committee and found that they included information such as total patient complaints by type and department, quarterly data related to patient perception of care, and comments related to improvement opportunities. Also, as indicated on its Web site, the Health Care System participates in quality reporting programs such as Hospital Compare, Cal Hospital Compare, and patient experience surveys.

The California Department of Public Health (Public Health) also receives complaints about hospitals throughout California, including the Health Care System. Complaints include issues such as medication errors, patient rights or abuse, and billing. The number of complaints concerning the Health Care System submitted to Public Health between January 2006 and July 2011 generally increased over this time period; however, they never exceeded 12 in one year. Similarly, the number of entity-reported incidents reported to Public Health regarding the Health Care System increased between 2008 and 2010, but only from six to 19, and then decreased in 2011.

Public Health officials informed us that all hospitals generally experienced a change in volume of entity-reported incidents during this time due to new reporting requirements.²⁸

Public Health also tracks deficiencies, which are violations of state and federal laws and regulations. Public Health identifies deficiencies during various events, such as when it investigates complaints or entity-reported incidents, or conducts a survey, and can be discovered any time Public Health visits a hospital, as discussed in the Introduction. As indicated in Figure 6, deficiencies for the Health Care System increased substantially in 2010 and then appeared to be declining in 2011. According to Public Health officials, the increase in deficiencies in 2010 was the result of two surveys conducted at the Health Care System, which typically lead to more deficiencies cited than complaint or entity-reported incident investigations.

Figure 6
Salinas Valley Memorial Healthcare System Deficiencies, as Cited by the California Department of Public Health January 2006 Through Mid-October 2011



Source: California Department of Public Health deficiencies cited files for 2006 through October 19, 2011.

* The value for 2011 represents deficiencies through October 19, 2011.

Finally, we considered the trends in the various data that Public Health maintains, to determine whether they indicated that the Health Care System’s staffing reductions in fiscal year 2010–11 affected quality of care. We noticed increases in 2010 for complaints and entity-reported incidents, but these increases were minimal.

²⁸ Entity-reported incidents include adverse events and privacy breaches. We discuss these incidents and the new reporting requirements in the Introduction.

Although the increases we saw for deficiencies in 2010 were higher than for the other two measures, we would not have expected to see a declining trend in deficiencies for 2011 if they were the result of staffing reductions. Consequently, we have no reason to believe that recent staff reductions affected these measures.

We conducted this audit under the authority vested in the California State Auditor by Section 8543 et seq. of the California Government Code and according to generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives specified in the scope section of the report. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Respectfully submitted,



ELAINE M. HOWLE, CPA
State Auditor

Date: March 8, 2012

Staff: Karen L. McKenna, CPA, Audit Principal
John Billington
Jamahl A. Hill
Angela C. Owens, MPPA
Katie Tully

Legal Counsel: Scott A. Baxter, JD

IT Audit Support: Michelle J. Baur, CISA, Audit Principal
Ryan P. Coe, MBA
Benjamin Ward, CISA

For questions regarding the contents of this report, please contact Margarita Fernández, Chief of Public Affairs, at 916.445.0255.

Appendix

COMPENSATION FOR VICE PRESIDENTS OF THE SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

The information in Table A contains the total compensation, including retirement benefits, for nine executives, other than the former chief executive officer (CEO), who were employed by the Salinas Valley Memorial Healthcare System (Health Care System) in a vice president position at some point between January 2009 and August 2011. Table A reflects the most current titles for the positions.²⁹

Table A shows compensation for the vice presidents from 2005 through 2011. The annual base salary for vice presidents employed with the Health Care System in August 2011 ranged from \$272,000 to \$341,000. Table A also depicts the retirement plans for the vice presidents as of August 2011, which consist of the standard employee pension plan, the 2006 supplemental retirement plan, and a new 403(b) plan.

We did not include in Table A compensation information for the current interim CEO and interim chief financial officer (CFO), who are employed on a contract basis with the Health Care System. The interim CEO's contract stipulates that he shall receive \$10,000 a week plus reasonable reimbursement for food, air travel, automobile allowance, housing, and other travel expenses. The interim CFO's contract specifies a weekly payment of \$8,750, but his reimbursements are limited to business expenses consistent with the Health Care System's policy. Both contracts are scheduled to end in December 2012.

Table A
Compensation for Salinas Valley Memorial Healthcare System's Vice Presidents From 2005 Through 2011

SALARIES AND WAGES BY CALENDAR YEAR	2005	2006	2007	2008	2009	2010*	2011†
Vice President of Patient Care and Cardiovascular Services							
Base pay	\$244,541	\$314,767	\$318,572	\$333,585	\$340,897	\$352,035	\$340,897
Other wages‡	18,924	0	0	24,275	0	22,420	\$
Total Salaries and Wages	\$263,465	\$314,767	\$318,572	\$357,860	\$340,897	\$374,455	\$
Vice President Chief Medical Officer							
Base pay	\$273,862	\$307,411	\$318,572	\$332,324	\$340,897	\$354,009	\$340,897
Other wages‡	8,579	0	0	0	30,323	27,885	\$
Total Salaries and Wages	\$282,441	\$307,411	\$318,572	\$332,324	\$371,220	\$381,894	\$

continued on next page . . .

²⁹ Comparable information for the former CEO is included in Chapter 1.

SALARIES AND WAGES BY CALENDAR YEAR	2005	2006	2007	2008	2009	2010*	2011†
Controller/Treasurer^{ll #}							
Base pay	\$79,615	\$186,308	\$217,179	\$251,490	\$272,051	\$282,515	\$272,051
Other wages [‡]	13,677	0	7,923	16,006	10,464	26,159	\$
Total Salaries and Wages	\$93,292	\$186,308	\$225,102	\$267,496	\$282,515	\$308,674	\$
Vice President of Finance and Information Technology^{ll}							
Base pay	\$276,346	\$307,411	\$318,572	\$332,324	\$340,897	\$354,009	\$340,897
Other wages [‡]	13,475	17,627	0	0	7,864	21,286	\$
Total Salaries and Wages	\$289,821	\$325,038	\$318,572	\$332,324	\$348,761	\$375,295	\$
Director of Marketing^{# **}							
Base pay	\$136,538	\$155,715	\$161,370	\$168,335	\$172,677	\$179,319	\$104,385
Other wages [‡]	3,258	0	0	0	0	21,590	10,598
Total Salaries and Wages	\$139,796	\$155,715	\$161,370	\$168,335	\$172,677	\$200,909	\$114,983
Vice President of Operations^{ll}							
Base pay	\$274,826	\$366,257	\$318,572	\$332,324	\$340,897	\$354,009	\$340,897
Other wages [‡]	10,919	0	31,518	32,274	26,223	39,334	\$
Total Salaries and Wages	\$285,745	\$366,257	\$350,090	\$364,598	\$367,120	\$393,343	\$
Vice President of Physician Integration and Business Development^{ll}							
Base pay	\$245,106	\$314,767	\$318,572	\$344,931	\$340,897	\$354,009	\$340,897
Other wages [‡]	13,971	0	27,275	31,140	27,042	40,154	\$
Total Salaries and Wages	\$259,077	\$314,767	\$345,847	\$376,071	\$367,939	\$394,163	\$
Vice President of Professional Services^{**}							
Base pay	\$177,852	\$155,715	\$161,369	\$167,288	\$172,677	\$82,956	\$0
Other wages [‡]	664	0	14,688	27,396	0	5,375	0
Total Salaries and Wages	\$178,516	\$155,715	\$176,057	\$194,684	\$172,677	\$88,331	\$0
Vice President of Strategic Management and Planning							
Base pay	\$140,944	\$192,337	\$217,179	\$252,327	\$301,434	\$323,199	\$311,228
Other wages [‡]	3,534	0	31,699	20,122	45,705	46,385	\$
Total Salaries and Wages	\$144,478	\$192,337	\$248,878	\$272,449	\$347,139	\$369,584	\$

Vice President Pension and Retirement Benefits

1. Standard employee pension plan, a defined benefit plan.^{†† ##}
2. Qualified supplemental executive retirement plan approved December 2006 (2006 supplemental retirement plan).^{§§ ||||}
Supplemental Pension Plan—a defined benefit pension plan ^{##}
Defined Contribution Retirement Plan
3. 403(b) retirement plan—A defined contribution plan.

Sources: California State Auditor's analysis of data obtained from the Salinas Valley Memorial Healthcare System's (Health Care System) Meditech and API systems, the Health Care System's pension and retirement plans, resolutions from the board of directors (board), and documentation from the Health Care System's human resources department regarding those executives employed in a vice president position between January 2009 and August 2011. See the Introduction's Scope and Methodology regarding the reliability of the data.

* Base pay in 2010 reflects an additional pay period; therefore, amounts are higher than the previous year.

† Base pay is projected through 2011, except for the director of marketing and the vice president of professional services because they separated from the Health Care System prior to August 2011.

- ‡ Other wages may include the following: cash for accrued paid time off, retroactive pay, educational assistance, and certification bonuses. Because the Health Care System did not separately classify payments for accrued paid time off in 2005 and 2006, such payments in those years are included in base pay.
- § We did not project other wages in 2011 due to the variability of the amounts paid under the paid time off policy.
- || Between August 2011 and February 2012, employees in the following executive management positions separated from the Health Care System: vice president chief medical officer, controller/treasurer, vice president of operations, and vice president of physician integration and business development. The vice president of finance and information technology left his executive position on June 30, 2011, but he remained employed with the Health Care System until he officially retired in January 2012.
- # Prior to August 2010 the controller/treasurer and the director of marketing had titles that reflected vice president positions.
- ** The vice president of professional services and the director of marketing received payments through severance agreements after they separated from the Health Care System, in June 2010 and April 2011, respectively. These agreements specified that the director of marketing would receive \$130,000 in 2011, equal to nine months' salary, and the vice president of professional services would receive 17 and a half months' salary, or about \$259,000 in 2010 and 2011.
- †† As we describe in Chapter 1, the Health Care System froze participation in the standard employee pension plan effective March 2011 for nonunion employees, which includes vice presidents. The board approved the 403(b) plan listed above for nonunion employees effective June 2011. All vice presidents except for the controller/treasurer are eligible to participate in the new 403(b) plan.
- ‡‡ The controller/treasurer did not meet the service requirements to be eligible for the standard employee pension plan.
- §§ At the board's November 2011 meeting, the board approved a freeze on the 2006 supplemental retirement plan effective December 2011. In addition, the board directed the personnel and pension committee to examine, by June 30, 2012, whether it would be economically advantageous to the Health Care System to terminate and pay out all remaining benefits under the 2006 supplemental retirement plan.
- ||| The vice president of professional services did not participate in the 2006 supplemental retirement plan.
- ### The vice president of strategic management and planning and the director of marketing did not require participation in the Supplemental Pension Plan because they were forecasted to have achieved 60 percent of their average base compensation over their final five years of employment without participation in the plan.

Blank page inserted for reproduction purposes only.

(Agency response provided as text only.)

Salinas Valley Memorial Healthcare System
450 E. Romie Lane
Salinas, CA 93901

February 16, 2012

Elaine M. Howle*
State Auditor
Bureau of State Audits
555 Capitol Mall, Suite 300
Sacramento, CA 95814

Dear Ms. Howle:

For the past eight months, Salinas Valley Memorial Healthcare System (SVMHS) has fully and willingly cooperated with auditors from the Bureau of State Audits (BSA). Thousands of employee hours were spent in researching and responding to auditors' requests concerning the period of January 1, 2005 through December 31, 2011. SVMHS advised the auditors that it would make available those persons with whom the BSA desired to meet to complete its investigation. At the auditors' request and selection, SVMHS staff representatives, consultants and two members of the Board participated in extensive meetings with the auditors. SVMHS provided more than 425 documents totaling more than 6,000 pages of information, in addition to six years' worth of accounts payable and payroll data, access to our intranet and contracts database, as well as all policies and procedures. ①

The SVMHS Board of Directors welcomed the scrutiny of state auditors as an opportunity to carefully examine business and operational practices, and to explore areas of potential improvement. The BSA report contains valuable conclusions and recommendations that have already been or will be acted upon. The report also reaches conclusions and raises questions regarding which legal experts, including those who have advised SVMHS, may disagree. These will be addressed in more detail in this document.

It is important to note that the BSA did not express any concern with the quality of patient care at Salinas Valley Memorial Healthcare System.

Summary of SVMHS Response

The BSA report focuses on the following four categories:

- Executive Compensation & Transparency
- Conflict of Interest
- Community Funding & Contracting
- SVMHS Financial Status

The BSA offered recommendations only in the first three categories. We briefly comment here on the overall tenor of the audit report, the findings in the four categories, and the BSA recommendations.

In some cases, we find that the audit report focuses more on form than substance, ignoring relevant context and discounting SVMHS actions that reflect a commitment to meeting the spirit of government ethics laws. ②

* California State Auditor's comments begin on page 73.

- ② In others, the audit report alleges misconduct or insinuates troublesome findings while overlooking key details that refute these same allegations. That said, as a reflection of the desire of the SVMHS Board and management to operate our agency beyond reproach, the BSA's recommendations will be followed.
1. **Executive Compensation and Transparency:** SVMHS appreciates the BSA's recognition that, though the subject of intense media and political scrutiny, in fact, the base salary of the former CEO was within the range of compensation for executives of peer institutions. SVMHS also wishes to clarify that the particularly controversial – though legal – pension programs provided for our executive staff have been frozen and will soon be eliminated. In addition, we appreciate the BSA's recommendations aimed at improving transparency in agency practices, and we look forward to bolstering public trust in the effective leadership and management of the SVMHS in all appropriate ways without jeopardizing its position in the competitive market-place.
 - ② 2. **Conflict of Interest:** The audit report distorts executive and board actions, pointing out the potential for conflicts in a range of circumstances without accurately reporting or analyzing readily-available details that provide a more complete picture of the realities in any of them. In addition, the audit report irresponsibly alleges serious violations of conflict of interest rules without conducting a thorough consideration of the laws and how they might apply. Finally, the BSA mischaracterizes the importance of Monterey County's failure to re-adopt the SVMHS Conflict of Interest Code every time it was updated by SVMHS, particularly as SVMHS has always appropriately treated its Code as binding, regardless of County inaction. Despite these failings, the BSA's recommendations will be pursued to enhance the Healthcare System's protection against conflicts in the future.
 - ③
 - ④
 - ⑤ 3. **Community Funding and Contracting:** The BSA appears not to understand the role for and benefit of community outreach activities and marketing initiatives in the pursuit of SVMHS' public health mission. Though SVMHS has necessarily curtailed such activities as a result of the current economic environment, SVMHS will henceforth formalize its policies for evaluating and reporting on these appropriate expenditures when they do occur. In addition, though the BSA found no fault with the outcomes of SVMHS procurements, SVMHS will take recommended and other prophylactic steps to strengthen certain contracting procedures for future procurements.
 - ⑥
 4. **SVMHS Financial Status:** SVMHS appreciates the global review of SVMHS financial environment, including the challenges we face and our effective responses in addressing them. We are especially gratified by the BSA's finding that the quality of SVMHS services as experienced by our patients has not suffered from or been diminished by SVMHS initiatives to maintain economic viability during these difficult times.

SVMHS Response to BSA Audit Report

We now turn to a more comprehensive analysis of the issues raised in the audit report.

1. *Executive Compensation & Transparency*

The BSA has enumerated five recommendations at the conclusion of Chapter 1. The SVMHS Board of Directors agrees with each of these recommendations and will move expeditiously to comply with each one by developing a formal policy that establishes a process for determining executive compensation; clearly indicating compensation matters on agendas for board meetings; and discussing executive compensation matters only in open sessions of board meetings, except in the limited circumstances that allow for discussion in closed sessions.

Substantial commentary is devoted in Chapter 1 to the former CEO's total compensation. Significantly, on page 33 of the BSA report, it should be noted the report reaches the conclusion that, *"A comparison of the former CEO's compensation to that of other health care system's CEOs reveals his base salary was within the range of other CEOs in the industry."*

⑦

The SVMHS Board has already taken significant actions to address supplemental pension plan policy that led to the pension received by the former CEO and two additional long-term senior executives. In November of 2011, prior to receiving the audit report, the Board froze the supplemental pension plan so that no executives in the organization receive any type of supplemental pension, and the Board plans to terminate the plan before the end of this fiscal year in June 2012.

Turning to the second aspect of Chapter 1, SVMHS disagrees with certain conclusions of the BSA regarding application of, and alleged violations of, the Brown Act.

②

⑧

Legal Context:

SVMHS found the BSA's discussion of the law of the Brown Act in the draft audit lacked context; accordingly, we seek to set forth what we expect would be a common understanding of relevant portions of the Brown Act here.

⑧

The Brown Act, codified at California Government Code sections 54950-54962, details requirements for meetings of quorums of local government legislative bodies, such as the SVMHS Board. Covered meetings must, by default, be held with proper public notice, public access and an opportunity for the public to comment on agenda items. However, the law also recognizes that some topics should not be discussed in the open and, thus, closed sessions may be held on those issues. The Brown Act, at Government Code section 54957(b), permits closed sessions for consideration of "the appointment, employment, evaluation of performance, discipline, or dismissal of a public employee or to hear complaints or charges brought against the employee by another person or employee unless the employee requests a public session." In addition, Government Code section 54957.6 sets forth the procedures for "closed sessions with the local agency's designated representatives regarding the salaries, salary schedules, or compensation paid in the form of fringe benefits of its represented and unrepresented employees..." "Safe harbor" language provided in Government Code section 54954.5 provides guidance on how to properly agendaize closed session discussions, including performance evaluations and compensation discussions.

We understand that (i) any general discussion of compensation programs; (ii) compensation negotiations between a quorum of the Board and an employee, and (iii) Board action to award compensation or approve an employment agreement, must occur in open session, and thus there is no "safe harbor" for a closed session on these discussions. We also understand that only certain aspects of performance evaluations and compensation discussions may be held in closed session, and any actions must be reported in subsequent open session.

In the case of an employee's performance review, the law permits discussion by the Board regarding their evaluation of the employee, and associated conversation between the Board and the executive, to be held in closed session, to protect the employee's privacy. In addition, discussions between the Board and its compensation negotiator(s)—which may be an individual Board member, a committee of the Board, the full Board or a non-Board member negotiator—concerning the agency's negotiating position may also be held in closed session. In practice, if the full Board, or a quorum thereof, serves as the agency's negotiator, the Board can discuss its strategy for a certain negotiation in closed session, but the Board must go into open session to carry out compensation negotiations with the employee, as well as to discuss or act on more general compensation programs.

All of the closed sessions addressed above must be limited only to the agenda item, such as an employee's performance in his/her role. Furthermore, if an employee is present during a closed-session performance evaluation, once the discussion turns from a performance evaluation to the Board's position for compensation negotiations, the employee must leave/not enter the room so that the Board may determine its negotiating position and direct its negotiator(s) accordingly. As stated above, actual compensation negotiations, if carried out by a quorum of the Board, must be held in open session, and the Board must vote on the final agreed-upon compensation award in open session.

Compliance with the Brown Act in this arena is like a tight-rope walk. As an agency, SVMHS endeavors to create an environment that is conducive to Brown Act compliance by Board and management, alike. However, every agency seeking to comply with the Brown Act is inherently challenged by the close relationship between employee evaluations and negotiations for related compensation.

Moving Forward:

Historically, legal counsel has been present at every SVMHS Board meeting, during both open and closed sessions, and has been available to advise the Board on all actions with a legal implication, including Brown Act compliance. Because compliance with the Brown Act is, and always has been, of utmost importance to the SVMHS Board, effective as of the March 22, 2012 meeting, the Board will retain additional outside counsel with Brown Act expertise to review and approve all Board agendas and provide guidance as to the appropriate scope of closed session discussions that are noticed on an agenda. Such counsel will also provide periodic Brown Act refresher trainings.

2. *Conflict of Interest Matters*

- ② SVMHS also disagrees with the BSA's characterization of agency and director actions as set forth in Chapter 2 related to alleged conflicts of interest. These matters demand a more rigorous analysis and attention to detail which was sorely lacking in the BSA report.

- ⑨ First, Chapter 2 of the draft audit report includes a list of 11 District disbursements to business entities in which board members or executives appropriately reported having a financial interest. In nine of these 11 transactions, the auditors identified no legal concerns. Given the auditors' lack of negative findings, the District objects to inclusion of a table listing these disbursements in the final report. The attention focused on them is misleading to the public, implying that SVMHS and its Board members or executives acted inappropriately when no such evidence has been identified. For example, highlighting the fact that an officer or employee of SVMHS holds a small number of shares of Starbucks stock - equating to a truly negligible interest in the company - implies that SVMHS should not ask or allow the popular, ubiquitous café to serve refreshments to patients, visitors and staff at District facilities. Listing such an investment in the report unfairly raises suspicions without any valid basis for even a parenthetical mention, much less inclusion in one of the report's few graphically-highlighted charts.

- ⑩ Second, turning to the two disbursements which the auditors conclude *might* have been impermissible under State laws, the auditors' discussion of the transactions lacks some relevant context, as illustrated in the discussion below.

Disbursement 1: The District's investment of \$1,000,000 in a Certificate of Deposit (CD) held by 1st Capital Bank

The former CEO of the District invested \$50,000 when 1st Capital Bank opened to provide financial services specifically in the Monterey-Salinas community. The former CEO's investment represents just 1/15th of 1% of the \$32 million in capital raised at the time. When the District opened its account with 1st Capital, the

former CEO's proportional stake in the bank had been further diluted. As a result, we agree with the BSA that Government Code Section 1090 clearly is not implicated.

The auditors correctly stated that any direct financial interaction between the District and 1st Capital is presumed to result in a material financial effect for the former CEO under the Fair Political Practices Commission regulations implementing the Political Reform Act given that the former CEO's investment exceeded \$25,000. However, that presumption can be rebutted if it is not reasonably foreseeable that the governmental decision will have any financial effect on the business entity. ⑪

In this case, actions taken by the former CEO were delegated acts to implement specific direction set forth by the Board in publicly-adopted resolutions numbered 2008-2, 2008-9 and 2008-10, and by the District Treasurer pursuant to the same. Further, minutes of Board meetings related to the transaction indicate that the former CEO had no role in the Board's discussion, and did not present any information or opinions to guide its decision. Accordingly, even if he had a disqualifying interest – based on a potentially rebuttable presumption – *the actions of the former CEO do not equate to making or participating in making a governmental decision. In contrast, he was carrying out the ministerial duties delegated to him by the Board authorization.* ⑫

Disbursement 2: The District's lease arrangement involving \$2.5 million from Rabobank

The BSA alleges that the District's use of \$2.5 million in lease financing from Rabobank equates to a violation of Government Code Section 1090 based on an SVMHS director's title as "Regional President" of Rabobank. Regrettably, despite two meetings with this Board member on other aspects of their audit, the auditors did not ask any questions about this particular transaction or his position with the bank. We believe that if they had taken the time to seek out more complete information, the BSA would have reached an entirely different conclusion. ⑬

Rabobank is the 24th largest bank in the world with \$870 Billion in assets across 37 countries. The California bank within Rabobank has \$10 Billion in assets and is managed by a five-member executive officer team in Roseville. Not part of the executive officer team, the SVMHS board member serves as one of eight "Regional Presidents" responsible for Rabobank's local retail and commercial lending accounts – but not leasing. His region covers four counties. All leasing arrangements – such as the one at issue here – are handled in their entirety by either a different division of Rabobank located in Southern California or a related subsidiary in Pennsylvania. **Regional Presidents are employees of the bank; they are not directors or officers of the bank.** They receive a salary and have the potential to earn a bonus based on performance measures not tied in any way to deals managed by other divisions, such as the subject lease financing. Rabobank is a cooperative bank owned by 150 community banks in the Netherlands. There is no stock ownership of the bank and thus no dividend payouts made to any stock-holders or employees. Bank earnings are simply reinvested in the company. The individual in question worked for Rabobank (or its pre-merger predecessor bank) for seven years before joining the SVMHS Board and was not involved in the bank or the District's making of this contract. ⑭

This information on the bank and the employer-employee relationship between the bank and the SVMHS Director should serve as the basis for any analysis of the potential for conflicts under Government Code Section 1090.

As the BSA explains, Government Code Section 1090, et seq. prohibits the making of contracts between public entities and parties in which officers or employees of the public entities have one or more financial interests. As applied at the board level, this law prohibits the making of contracts between the District and another party if any member of the SVMHS Board has a financial interest in the contract, or in the other party to the contract, unless a specified exception applies.

⑭ *SVMHS lease financing contract with Rabobank does not violate Section 1090.*

As stated above, Section 1090, et seq. includes numerous exceptions to allow a public entity to enter into a contract with another party despite the existence of a public official's potential conflict of interest. These exceptions are referred to as "remote interests" (Sections 1091 and 1091.4) and non-interests (Section 1091.5). In case of a remote interest, the public official must disclose the interest and may not vote on the contract involved or attempt to influence the public entity's decision(s) on the contract.

Remote Interests:

Government Code Section 1091 provides:

(a) An officer **shall not be deemed to be interested** in a contract entered into by a body or board of which the officer is a member within the meaning of this article **if the officer has only a remote interest** in the contract and if the fact of that interest is disclosed to the body or board of which the officer is a member and noted in its official records, and thereafter the body or board authorizes, approves, or ratifies the contract in good faith by a vote of its membership sufficient for the purpose without counting the vote or votes of the officer or member with the remote interest.

Paragraph (b) goes on to define 15 specific remote interests, several of which might apply. Section 15(b)(2) is the clearest choice:

(2) That of an **employee** or agent of the contracting party, if the contracting party has 10 or more other employees and if the officer was an employee or agent of that contracting party **for at least three years** prior to the officer initially accepting his or her office and the officer **owns less than 3 percent of the shares** of stock of the contracting party; and the employee or agent is **not an officer or director** of the contracting party and **did not directly participate** in formulating the bid of the contracting party....

Note that the Government Code does not include definitions of "officer" or "director" for these purposes. However, the Corporations Code defines "officers" of corporations to include a chairman and/or president of the board, a secretary, a chief financial officer, and other officers stated in the bylaws or determined by the board as necessary for the corporation to sign instruments and share certificates. See Corporations Code section 312. Further, Corporations Code section 164 provides that "directors" includes persons designated in the articles or elected by the incorporators, and persons designated, elected or appointed to act as directors. Based on these definitions, *the SVMHS Director is quite clearly an employee – and not a director or owner – of Rabobank.*

⑭ *of Rabobank.*

Applying this rule to the facts set forth above, the SVMHS Director has – at most - a remote interest in the transaction at issue.

The BSA also discusses in its report the remote interest set forth in (b)(10), which reads as follows:

(10) Except as provided in subdivision (b) of Section 1091.5, that of a director of, or a person having an ownership interest of, 10 percent or more in a bank, bank holding company, or savings and loan association with which a party to the contract has a relationship of borrower or depositor, debtor or creditor....

Again, the SVMHS Director is neither a director nor owner of Rabobank, and appears to have an even narrower, lower-level interest than that explored in this Section 1091(b)(10).

Non-Interests:

In addition to remote interests, Government Code Section 1091.5 sets forth NON-interests as follows:

- (a) An officer or employee **shall not be deemed to be interested** in a contract if his or her interest is any of the following...

Paragraph (b) goes on to list 13 specific non-interests, including:

- (b) (11) Except as provided in subdivision (b), that of an officer or employee of, or a person having less than a 10-percent ownership interest in, a bank, bank holding company, or savings and loan association with which a party to the contract has a relationship of borrower, depositor, debtor, or creditor...

As set forth above, the SVMHS director who is employed by Rabobank is an employee – not an “officer” of the bank – and has a zero-percent ownership interest in the bank. Accordingly, we further conclude that his employment relationship could also be construed as a “non-interest” under the law.

⑭

We acknowledge that, as the BSA has pointed out, the 2010 edition of the Conflict of Interest guide published by the Attorney General indicates that the exceptions discussed above in Sections 1091(b)(10) and 1091.5(b) are meant to apply to relationships between (a) the service provider/bank and (b) the party which is contracting with (c) the public entity, as opposed to a direct relationship between (a) the service provider/bank and (c) the public entity. **However, the prior edition of this guide, on which the District relied at the time of this transaction in 2008, did not include such advice so as to clarify the application of the rules.**

⑮

Moving forward:

In light of the clarification set forth in the 2010 Conflict of Interest Guide, SVMHS will take a fresh look at the application of Government Code Section 1090 in the banking area. However, in reviewing actions taken in prior years, we believe the Board acted in full accordance with the law in connection with this transaction. Furthermore, there is no public interest served in pursuing a different outcome.

⑮

In addition, to the extent the BSA intended to indicate that members of the Board who participated in the questioned decision (which did not include the Rabobank employee, who clearly disclosed his interest and did not participate in the decision in any fashion) should themselves be investigated for Section 1090 violations, we recommend that BSA counsel review *D’Amato v. Superior Court* (2008) 167, Cal. App. 4th 861. The court in *D’Amato*, stated at page 867: “Because the Legislature did not intend to criminalize legislative acts taken by public officials who hold no personal financial interest in a contract made in violation of section 1090, petitioner’s legislative activity may not serve as a basis for the indictment.” **In light of this case law authority, we submit that any suggestion that the other four Board members are accountable for a Section 1090 violation is clearly misguided and an overreach under current law.**

⑯

Conflict of Interest Code:

Finally, the BSA indicates – incorrectly in our view - that SVMHS did not have a legally-binding Conflict of Interest Code for the time period covered by most of the audit. The SVMHS Board adopted and has regularly updated its Conflict of Interest Code in compliance with and on the schedule set forth in State law and FPPC regulations. This Code, despite the County Board of Supervisor’s failure to perform its approval obligation, has been enforced and given the effect of law by the District since it was first adopted. Moreover, each year, as required, SVMHS has instructed all statutorily-required and agency-designated officers and employees to file their statements of economic interest in accordance with its Code.

⑰

- ①7 We also note with some concern the BSA's insinuating that the District should have sought injunctive relief for the County's failure to approve the District's Code. Such action might be appropriate in a more extreme case, but as long as the District gave effect to its own Code – as it did – SVMHS views the BSA's suggestion of such an inter-governmental attack to be an extreme example of form over substance and an invitation for agency and judicial waste.

Moving forward:

At the conclusion of Chapter 2, the BSA makes six recommendations concerning the SVMHS conflict of interest policies in general. Setting our concerns aside, the SVMHS Board will immediately act on these recommendations, including increased oversight of the current requirement in the SVMHS conflict of interest policy that board members, medical staff, employees, and consultants must disclose potential conflict of interest situations; retaining outside expertise to thoroughly investigate and analyze all eleven disbursements enumerated in Table 2 of Chapter 2 of the draft report; developing a protocol to pursue adoption of the agency's code by Monterey County, the agency's code-reviewing body, within six months of the code being adopted by the SVMHS Board and submitted to the County; publically specifying an individual as filing officer for Form 700 statements of economic interests; delineating steps for the filing officer to take to ensure that statements of economic interest are collected by each designated and statutorily-required officer or employee; setting forth penalties for failure to file a statement of economic interest; and establishing a protocol for verifying submission of completed statements by all statutorily-required and agency-designated filers.

3. *Community Funding & Contracting*

Community Support Funding:

- ①8 Unlike cities, counties and other special districts, such as water or transit providers, district hospitals, like SVMHS, operate in a uniquely competitive marketplace. In recognition of the health care industry's market structure and pressures, the Hospital District Law includes an exemption to the Brown Act not available to other public entities. Similarly, the subject of gifts of public funds must be analyzed in a more expansive manner than may typically apply to other public agencies, taking into account the industry context in which SVMHS functions. Clearly, SVMHS' substantial financial and managerial assistance to support the Natividad Medical Center was for the purpose of improving the delivery of health care services in the County. Other appropriate expenditures for SVMHS, as a district hospital surviving in a highly competitive market, include marketing and promotional expenditures, such as SVMHS' marketing efforts at the California Rodeo. These promotional initiatives ensure that SVMHS is viewed as a top-notch provider of health services and a supportive neighbor in the community.

- ⑤ In the BSA report, the auditors indicated some concern over those SVMHS expenditures that were made for purposes of marketing, promotion and community visibility. In light of the mission of SVMHS and the reality that this mission must be executed in a highly competitive environment, such expenditures are indisputably justified as furthering the public purpose of strengthening the market position and public awareness of SVMHS. For these reasons, we are confident that all of the expenditures reviewed by the auditor and made by SVMHS in this category pass muster under the standard appropriately applied for gifts of public funds to a district hospital.

Moving Forward:

Nevertheless SVMHS agrees that policies are helpful tools. In point of fact, with the change in administration at the Healthcare System last April, the Salinas Valley Memorial Executive Leadership Group (ELG) implemented a standardized procedure concerning donation of SVMHS funds to community organizations.

Every request is presented to the ELG, where it is evaluated for its potential to further the public purpose of SVMHS. This procedure will be formalized to become a part of the SVMHS written policies and procedures.

In addition, SVMHS will more clearly delineate marketing activities from community benefit activities, going forward. In the upcoming fiscal year budget commencing July 1, 2012, funding for these activities will be delineated in two separate budgets—one for marketing and the other to address community needs funding. (19)

Furthermore, in recognition of the potential for even an appearance of impropriety, SVMHS will not make event tickets available to any agency Board members, management or employees for less than face value. If this approach changes in the future, SVMHS will first adopt a ticket distribution policy and commits to reporting on its activities in full compliance with the Political Reform Act and implementing regulations adopted by the Fair Political Practices Commission.

Contracting:

SVMHS employees are fully compliant with documenting actions taken and following the applicable rules in the selection of contractors both where bidding is and is not required. Procedures currently in place result in obtaining the best value for the District when procuring goods and services. Recently renewed attention to strong fiscal management has resulted in exceptional value-based purchasing. (20)

SVMHS utilizes its Group Purchasing Organization (Amerinet) and its distributor partner (Owens & Minor) to ensure the District is receiving the best price possible for purchased goods and services. SVMHS uses group purchasing to receive a guaranteed lowest price for 96% - 97% of the items purchased by SVMHS. This is much better than the 85% - 87% rate typical for most hospitals utilizing group-purchasing agreements. SVMHS also recently participated in a procurement audit that demonstrated exceptional performance relative to procurement price integrity.

Moving Forward:

Management will re-emphasize to all employees who are involved in contracting activities their responsibilities in entering into contractual relationships. Management will also work with an outside expert to review all procurement practices and policies, review and update a procurement manual for staff use, and conduct educational sessions for all employees involved in purchasing to ensure total compliance with state regulations and agency policies. Procedures will be reviewed to ensure proper documentation that demonstrates contractual and business relationships are in the best interests of the District and that the District employees are making sound contracting decisions that result in obtaining the best value when procuring goods and services.

4. SVMHS Financial Status

Chapter 3 outlines action taken by SVMHS to improve the operating performance from 2010 through the present. The BSA makes no recommendations in this activity. ***SVMHS is gratified by the observation in the BSA report that no negative consequences could be observed in patient quality as a result of these initiatives.***

In the appendix, the BSA enumerates the compensation of the executive leadership group. SVMHS wants to point out that the only executive still employed by SVMHS as of March 8, 2012 is the current Vice President/Chief Operating Officer (formerly VP/Strategic Management and Planning). The increase in salary level reflects a change in position from a director level to administrative director, to vice president to senior vice president, with an increase in the scope of responsibility at each step.

Conclusion

While we welcome the recommendations of BSA, we believe SVMHS and the Board have acted prudently and responsibly at all times, acting within all boundaries of the law and in the best interest of the people of this District, guided by an unswerving commitment to provide the community with high quality health care.

Very truly yours,

Salinas Valley Memorial Healthcare System Board of Directors

Jim Gattis, President

Deborah Nelson, MS, RN, Vice President

Patrick Egan, Secretary

Harry Wardwell, Treasurer

Nathan J. Olivas, Assistant Treasurer

Comments

CALIFORNIA STATE AUDITOR'S COMMENTS ON THE RESPONSE FROM THE SALINAS VALLEY MEMORIAL HEALTHCARE SYSTEM

To provide clarity and perspective, we are commenting on the Salinas Valley Memorial Healthcare System's (Health Care System) response to our audit. The numbers below correspond to the numbers we have placed in the margin of the Health Care System's response.

The Health Care System's comments about the considerable effort it undertook to research and respond to our requests during the audit underscore the importance of having strong controls, including documented processes. We noted a lack of sufficient documentation in several areas, as we discuss in the report. For example, on page 19, we report that because of a lack of clear documentation, the identification and compilation of the executives' total compensation required significant help from various Health Care System departments, as well as its outside legal counsel and retirement benefit consultants.

①

We stand by our audit conclusions and recommendations. We conducted our audit of the Health Care System in accordance with generally accepted government auditing standards, which require that we obtain sufficient and appropriate evidence to support our audit conclusions.

②

The Health Care System is incorrect when it asserts that our audit report irresponsibly alleges serious violations of conflict-of-interest rules without conducting a thorough consideration of the laws and how they might apply. As detailed on pages 31 through 37, our legal counsel thoroughly considered applicable laws and guidance from the California Attorney General's Office in concluding not only that the Health Care System may have violated these laws, but that the potential violations were significant enough to warrant referral to the Monterey County District Attorney.

③

We do not mischaracterize the importance of the Health Care System lacking a conflict-of-interest code that had been approved by the Monterey County Board of Supervisors (board of supervisors). California Government Code, Section 87303, states that "no conflict-of-interest code shall be effective until it has been approved by the code reviewing body," which in this case is the board of supervisors. At the time of our review, the last code that the board of supervisors approved was in 2001, 10 years earlier. Although subsequently, the board of supervisors approved

④

the Health Care System's current code in December 2011, any unapproved codes before that time were not legally in effect and therefore not enforceable by law, as we indicate on page 38.

- ⑤ The Health Care System misses the point of our concern in this area. As a public agency, its expenditures must further the specific public purposes for which it was created. However, as we discuss on page 42, for 11 of the 14 recipients of community funding we reviewed, the Health Care System could not demonstrate that before making its funding decisions that it considered whether all or some portion of the funding furthered its public purposes.
- ⑥ Regarding the Health Care System's comment that we found no fault with the outcomes of its procurements, it is important to point out that our review of this area did not focus on outcomes. Rather, our review of a cross-section of contracts focused on the process by which the Health Care System selected contractors. Further, part of our role as auditors is to identify weaknesses in controls, that if not addressed, could lead to fraud, violations of laws or regulations, or abuse—whether or not any such actions actually occurred. Our finding regarding the Health Care System's lack of documentation for selecting certain contractors is an example of such weak controls.
- ⑦ While preparing our draft audit report for publication, page numbers shifted. Therefore, the page number that the Health Care System cites in its response does not correspond to the page number in our final report.
- ⑧ Although the Health Care System states that it disagrees with certain of our conclusions regarding its violations of the Ralph M. Brown Act (Brown Act), it does not specify which conclusions. Similarly, it does not explain its statement that our discussion of the Brown Act lacked context.
- ⑨ The Health Care System's objection to the inclusion of Table 2 in the report is without merit. We clearly state on page 33 that the businesses in Table 2 are the businesses to which the Health Care System made disbursements between 2006 and 2010 and that were listed as economic interests by its executives and members of its board of directors (board) on the statements of economic interests they filed for those years. We also state on pages 33 and 34 that the Health Care System may legally enter into business relationships with individuals or businesses that have been identified by its employees and board members as economic interests, but that it must ensure that these employees and board members comply with the prohibitions in state conflict-of-interest laws. Further, the Health Care System's statement that we identified no legal concerns in nine of the 11 transactions is misleading. Our report

clearly indicates that we reviewed the two business relationships we discuss in detail in the report, not all 11. In the two relationships we reviewed, we found that the Health Care System may have violated conflict-of-interest laws, which is why we referred these matters to the Monterey County District Attorney. Further, on page 47 we recommended that the Health Care System engage an independent investigator to determine whether any violations may have occurred for the various business relationships that we identified.

The Health Care System is mistaken. We provide ample context on pages 34 through 37 about the two business relationships we reviewed that indicated the former chief executive officer (CEO) and the board may have violated conflict-of-interest laws.

⑩

The Health Care System does not indicate whether it believes it was reasonably foreseeable that the financial interaction between it and 1st Capital Bank would have any financial effect on the bank. We believe most people would conclude that a deposit of up to \$1 million would have a financial effect on a bank.

⑪

The Health Care System claims that the former CEO's involvement in the transaction with 1st Capital Bank was carrying out "ministerial duties." Black's Law Dictionary defines a ministerial act as an act that is done under the authority of a superior and involves the obedience to instructions, but demands no special discretion, judgment, or skill. As we indicate on pages 34 and 35, the former CEO signed a discretionary waiver related to this transaction that demonstrated he made a discretionary decision related to an entity in which he had an economic interest.

⑫

In mid-November 2011, our legal counsel informed the Health Care System's legal counsel that we were concerned that the agreement with Rabobank was prohibited under California Government Code, Section 1090 (Section 1090), and asked the legal counsel to explain why the agreement was not prohibited under that law. In his response at the end of November, the Health Care System's legal counsel stated that he would be meeting with the applicable board member the next day to discuss the agreement and indicated that he would inform our legal counsel if the board member had information relevant to this agreement other than what the legal counsel had already shared with us. The Health Care System's legal counsel did not provide us with any information from his meeting with the board member.

⑬

In disagreeing with our conclusion that the board may have violated Section 1090 when it entered into an agreement with Rabobank, the Health Care System cited certain statutory exceptions for remote interests and noninterests that it thought could apply

⑭

to allow the agreement. In making its argument as to how the exceptions could apply, the Health Care System contends that the board member, who is a salaried regional president of Rabobank, is an employee of the bank, rather than a director or officer. We were surprised to hear this as, during the audit, our legal counsel specifically questioned the Health Care System's legal counsel whether any exceptions to Section 1090 were applicable and the remote interest exception for certain employees was not raised by the Health Care System as a relevant exception until we received its response to our draft audit report. Further, we discussed this issue at the exit conference at which both the legal counsel and the applicable board member were present and this exception was not discussed. Moreover, that exception only applies if the fact of the official's financial interest is disclosed and noted in the board's official records. Our review of the board minutes indicates that no such notation was made. In fact, as we state on page 36, although the board member abstained from the decision regarding the contract, the pertinent board meeting minutes did not indicate that he identified his financial interest. Moreover, we question whether a regional president of a bank would be considered to be simply an employee. Regarding the other exceptions described in the Health Care System's response, they do not apply to this situation according to guidance provided by the California Attorney General's Office as we explain on page 36. Finally, our report acknowledges that this specific guidance from the California Attorney General's Office was not in the previous guide that was issued, but we also state that the underlying law was not substantively changed since the time the previous guide was issued.

⑮ We disagree. As we indicate on page 36, willful violations of Section 1090 are criminal acts punishable by a fine or imprisonment, and the public officials committing these violations are forever disqualified from holding any office in the State. Additionally, contracts made in violation of Section 1090 are void. Thus, we believe the public interest is served by referring any potential violations to the Monterey County District Attorney for possible prosecution, which we did.

⑯ Our legal counsel was familiar with the *D'Amato* decision when we prepared our report and advised us that the *Conflicts of Interest Guide* interpreted the decision as not precluding the prosecution of a public official who does not have a financial interest in a contract, but who facilitates a Section 1090 violation related to the contract. Moreover, the state law that provides that contracts made in violation of Section 1090 are void applies when either the financially interested officer or the officer's board makes the contract. Similarly, the state law that criminalizes willful violations of Section 1090 applies both to those who are prohibited from making contracts

and those who are prohibited from being financially interested in the contracts. Therefore, we do not believe it is misguided or an overreach to conclude that the board may have violated Section 1090.

We find the Health Care System's comments regarding "an intergovernmental attack" to be puzzling as seeking action through a superior court for the adoption of its conflict-of-interest code is the process that state law authorizes if no code has been adopted by the code-reviewing body, which in this case is the board of supervisors, within six months of the deadline for submission. Further, our recommendation on page 47 for the Health Care System to develop a protocol to do so is only when its follow-up efforts with the board of supervisors prove unsuccessful.

⑰

The Health Care System provides no legal basis for its contention that in analyzing gifts of public funds different criteria should be used for health care systems as compared to other public agencies.

⑱

The Health Care System's comments suggest it may believe that funds it designates for marketing activities are exempt from the constitutional prohibition on making gifts of public funds. That is incorrect. As a public entity, all of its expenditures must further its public purposes.

⑲

The Health Care System is incorrect. As we indicate on page 46, for only one of the eight contracts we reviewed that were not specifically required by law to have a competitive process could the Health Care System document it followed a process to ensure it received best value from the selected contractor.

⑳

cc: Members of the Legislature
Office of the Lieutenant Governor
Little Hoover Commission
Department of Finance
Attorney General
State Controller
State Treasurer
Legislative Analyst
Senate Office of Research
California Research Bureau
Capitol Press