

**Association of Washington Public Hospital Districts  
Critical Access Hospital  
Facility Replacement Interviews**

**Final Report  
May, 2003**

**Health Facilities Planning and Development  
Seattle, WA**

## **Introduction/Methodology**

Health Facilities Planning and Development (HFPD) was retained by the Association of Washington Public Hospital Districts (AWPHD) to develop more refined data and information to supplement the Critical Access Hospital (CAH) toolkit the AWPHD sponsored in 2002. The agreement between AWPHD and HFPD delineated a two-phase effort including: 1) The development of a CAH interview and data collection tool with the goal of providing a context and sense of proportion for the national CAH facilities as they are studied by hospital leadership in Washington; and 2) through interviews with model CAH personnel and review of available data, to collect “baseline” or comparative data and information on each. The primary objectives of the interviews were to gather data about, and ascertain the experiences from, CAH’s who had recently undergone or were in the process of facility replacement in order to provide information to assist AWPHD members considering similar options.

The interview tool used in this effort was designed by HFPD, based on direct input from several AWPHD member hospitals. In developing the tool, HFPD reviewed existing data and information about critical access designation and facility replacement. The interviews were conducted by telephone with the administrators of the participating hospitals. Additional demographic and financial data was compiled from the U.S. Census Bureau and the American Hospital Association.

## **Report Cautions**

While HFPD was able to conduct several in-depth interviews, it was much more challenging than originally anticipated to schedule and conduct the needed interviews. Due to the reality of the complex and time consuming position of rural hospital administrator, HFPD was unable to conduct complete interviews with all of the administrators from the AWPHD toolkit hospitals. In addition, these interviews with toolkit hospitals strongly suggest that their financial and demographic circumstances might not be directly relevant to Washington hospitals contemplating facility replacement. Based on these findings, HFPD contacted several additional CAH hospitals. A total of eight hospitals were reached and six interviews were completed, some much more extensive than others. HFPD also gathered additional demographic, financial and utilization data on the applicable hospitals and service areas to supplement the contact and interview data.

Since the interviews conducted varied in completeness and detail, HFPD was not able to gather information on each element covered in the report from every participating hospital and much of the information provided was anecdotal rather than scientific. While HFPD is confident this

information will still prove to be valuable to member hospitals seeking data on CAH replacement, it is important to note that where HFPD discusses overall conclusions, it is reflecting the available information on that particular element. All eight (8) hospitals' experiences are not necessarily reflected in each conclusion. For specific details on each hospital, see Attachments 1-8.

## **Participating Hospitals**

### **FROM CAH TOOLKIT**

- ◆ Bridges Medical Services – Ada, Minnesota
- ◆ Ogallala Community Hospital – Ogallala, Nebraska
- ◆ Crete Area Medical Center – Crete, Nebraska
- ◆ Wray Community District Hospital – Wray, Colorado

### **OTHER HOSPITALS**

- ◆ Bertie Memorial Hospital - Windsor, North Carolina
- ◆ Shoshone Medical Center – Kellogg, Idaho
- ◆ St. Vincent Randolph Hospital – Winchester, Indiana
- ◆ Broaddus Hospital – Phillippi, West Virginia

## **Overall Findings and Conclusions**

Each hospital's unique circumstances and experiences make it challenging to directly compare data among the hospitals. Additionally, it is difficult to assess the independent impacts of facility replacement since many of these hospitals are also undergoing other significant changes in financing, management, and reimbursement. However, the experiences of these hospitals do provide many valuable insights and lessons that can be utilized by Washington's CAHs as they consider facility replacement.

The majority of the hospitals interviewed considered facility replacement to be a very positive experience for their hospital and community. With older facilities they encountered inefficiencies, loss of business, reduction in community confidence, and other negative consequences based on the age, image, condition, and design of their facilities. The replacement (or proposed replacement) of the facility and the acquisition of updated and superior equipment did (or is expected to) result, at a minimum, in improvements in these areas. However, neither

the individual hospitals nor HFPD can (with confidence) quantify the impact of these changes on factors including volume/utilization and financial performance.

The hospitals' experiences also offer valuable details about many elements of facility replacement, including facility design, financing options, and community education. Following is a summary of the information collected from the participating hospitals along with various recommendations and cautions generated from these individual experiences.

## **Utilization and Demographic Characteristics**

The following table summarizes key utilization and demographic characteristics from each hospital. In addition to this information, many of the communities also had other unique characteristics posing additional challenges. For example, Shoshone Medical Center, St. Vincent Randolph Hospital, and Bertie Memorial Hospital all reside in areas with some of the highest unemployment rates in their respective states. Shoshone Medical Center is located in the Silver Valley in Idaho that used to lead the area in mining production. Due to reduced silver prices and the impact of new EPA standards, Shoshone County has become one of the counties with the highest rate of unemployment in the state. St. Vincent Randolph Hospital resides in Randolph County, which is a large farming community, one of the poorest counties in Indiana. Bertie Memorial serves a very poor county in North Carolina, ranked 93<sup>rd</sup> out of 100 North Carolina counties in terms of per capita income. It also has a large minority population (63-70% of its population is black).

**Table 1**  
**Hospital Utilization and Service Area Demographics**  
*Source: American Hospital Association Guide and U.S. Census Bureau<sup>1</sup>*

	Bridges Medical Services	Ogallala Comm. Hospital	Crete Area Medical Center	Wray Comm. District Hospital	Bertie Mem. Hospital	Shoshone Medical Center	St. Vincent Randolph Hospital	Broaddus Hospital
Total Personnel <sup>2</sup>		140	173	61	102	84	219 <sup>3</sup>	165
Total Staffed Beds (Including Babies) <sup>1</sup>	8	41	57	16	6	25	25	72
Admissions <sup>1</sup>			511	501	518	564		422
ADC <sup>1</sup>	2.5 <sup>2</sup>			4	4	6	2.3 <sup>2</sup>	
Outpatient Visits <sup>1</sup>				26,050	18,610	33,867	7,491	23,342
Births <sup>1</sup>		75	436	75	0		129	0
Total Expenses <sup>1</sup>		\$7,100,000 <sup>2</sup>	\$7,409,000	\$5,991,000	\$7,020,000	\$7,667,000	\$6,846,018	\$7,224,000
Payer Mix <sup>2</sup> (Medicare/ Medicaid)	75% Medicare	45%/10%			53%/13%	75%/3%	37%/15%	
Total Capital Costs of Replacement Project	\$24 mil.		\$14 mil.		\$10 mil.	\$18.6 mil.	\$15.6 mil.	\$8 mil.
Total Population – 2000 <sup>4</sup>	7,442	13,709	13,843	9,841	19,773	13,771	2,098	15,557
Population % Change 1990 to 2000 <sup>3</sup>	-6.7%	-3.35%	8.9%	9.9%	-3.0%	-1.1%	-6.2%	-0.9%
Persons Under 18 <sup>3</sup>	25.7%	23.58%	25.1%	28.3%	26.1%	22.9%	23.3%	23.0%
Persons 65 Years old and over <sup>3</sup>	20.9%	20.43%	17.2%	16.3%	16.0%	17.4%	22.9%	15.6%
Persons Below Poverty <sup>3</sup>	10.3%	11.75%	9.4%	12.9%	23.5%	16.4%	9.1%	22.6%
Persons Per Square Mile <sup>3</sup>	8.5	3.8	24.1	4.2	28.3	5.2	4.8	45.7

<sup>1</sup> The data provided in this table was collected through either the AHA or the US Census Bureau and in some instances conflicts with the self-reported information provided by the interviewed hospitals and included in Attachments 1-8.

<sup>2</sup> American Hospital Association Guide, 2003

<sup>3</sup> Information provided by applicable hospital administrator

<sup>4</sup> U.S. Census Bureau

## **Impact on Services Offered**

While a few of the hospitals interviewed did not experience or plan for significant changes in services offered after facility replacement, most of the hospitals did increase services after the facility replacement, many of them due to improved equipment as much as to the facility replacement. The types of increased or enhanced services included:

- ◆ Physical therapy
- ◆ Specialty radiology services, including mobile and fixed CT scanning, in-house and mobile MRIs, mammography, and ultrasound
- ◆ Visiting sub specialists
- ◆ Swing beds
- ◆ Sleep lab
- ◆ Telepsychiatric services
- ◆ Orthopedic surgery
- ◆ Diabetic education program
- ◆ Outpatient surgery
- ◆ Podiatry
- ◆ Rural health clinic services

## **Facility Design**

The facility design of the hospitals that participated in the interviews was as varied as the circumstances and communities in which they reside. Some of the hospitals were built specifically to function as a critical access hospital; others were built prior to applying for or receiving this designation. Following is a summary of the key design recommendations and cautions shared by hospital administrators familiar with the day-to-day operations of these facilities.

### ***Recommendations***

- ◆ Focus design on functionality and cost and energy efficiency, not on appearance.
- ◆ Give a lot of thought to both staff efficiency and ease of patient access and transport.
- ◆ Develop the site to be flexible to allow for any future needed expansions or modifications to departments and/or services offered.
- ◆ Base space on quantitative analysis of future productivity and projected volumes for specific services/departments.
- ◆ Single story facilities allow for greater accessibility to other departments and services and avoid problems with elevators and other issues.

- ◆ Design a central, open public space with the various inpatient and outpatient service entry points clustered around the main public space, providing for minimal inconvenience for patients and the greatest staff efficiency.
- ◆ Locate imaging, laboratory and emergency departments immediately adjacent to physician and specialty clinic spaces.
- ◆ Use the “Convenience Kitchen” model. One person can staff this set-up. Everything is precooked. There are no dishes necessary other than plates, virtually no waste and limited dry storage.
- ◆ Purchase patient meals from a local nursing home or other facility. It is a large capital expense to put in a commercial kitchen in addition to the operating FTE expenses of directly providing food service for a limited number of patients.
- ◆ Evaluate closely the type of automatic exterior doors used for best durability and easiest maintenance.
- ◆ Use as a model the Quorum Health Resource Prototype for a 25-bed rural facility.
- ◆ Establish a biohazard wash down and decontamination structure separate from the main facility.
- ◆ Design some private rooms, if possible.
- ◆ Separate administrative areas from other hospital areas with firewalls. This allows these areas to be built under less stringent codes than the rest of the hospital and can save a significant amount of money. These administrative areas can still be attached and easily accessible to the other areas.
- ◆ Build more office space than you think you will need.

### *Cautions*

- ◆ Don’t overbuild or focus on visual features (sky lights, atrium, etc.).
- ◆ Avoid bi-folding exterior doors. They constantly lock up and need repair.
- ◆ Flat roofs can lead to big problems and expense, particularly for areas with extreme weather conditions.
- ◆ Do not have the ER triage area located by the main lobby. It is important to keep the ER traffic out of the main lobby of the hospital.

## **Financial Impact**

The reported financial impact of facility replacement ranged from a slight reduction in revenue to significant increases. Once again, it was often difficult to determine the distinct benefits of facility replacement since all of these institutions had recently increased their reimbursement through critical access designation, and some had become affiliated with a large health system or made other changes that were also impacting the financial status of the hospital. The following examples further highlight how the unique circumstances of each hospital and community need to be considered when contemplating facility replacement as well as when analyzing the results.

St. Vincent Randolph Hospital was able to provide financial information for the year immediately preceding and the year immediately following the facility replacement. The hospital administrator reported that this information demonstrated a significant positive financial impact, with an average of 150 new patients per month since the facility replacement and an increase in revenue in excess of \$2 million. In contrast, Ogallala Community Hospital has not experienced any financial benefit to date. While Ogallala's administrator does predict eventual positive financial results, he also cautions other hospitals from assuming facility replacement is the panacea for all their problems. For example, Ogallala had a history of problems with some existing medical providers prior to the facility replacement that resulted in reduced community confidence that continues to be an issue. It is now actively recruiting physicians. However, even with the new facility, the challenge to find physicians willing to practice in rural Nebraska remains.

While not directly part of the scope of this project, HFPD recently participated with Harden Financial Services Incorporated in the development of a March 2003 report entitled "Identification and Evaluation of Financing Options" on behalf of several rural, Washington public hospital district hospitals.<sup>5</sup> Each of these hospitals is a CAH. This project verified the ongoing challenge rural hospitals face in maintaining a reasonable level of ongoing financial viability. According to the study:

*breaking even from operations may be a false point of security or comfort when measuring the TOTAL FINANCIAL NEEDS of any hospital's operations. During periods of evaporating cash flow support from programs like Pro-Share and RHAP, CAH won't serve as a long-term "godsend" or cure to basic economic survival. While the pro forma calculation of debt service coverage doesn't look too bad, the overall cash flow positions suggest that the current budget position of each of these three hospitals is grossly inadequate to meet the TOTAL FINANCIAL NEEDS of each hospital. This somewhat contradictory information is a simple function of the underlying simplistic methodology in the debt service coverage calculation, which TOTALLY IGNORES the overall cash flow requirements for working capital and capital expenditures. In other words, CAH payments may be better than PPS, but the CAH payment system does not cover the full financial needs in terms of overall cash flow requirements (page 8).*

In other words, for those Critical Access Hospitals contemplating replacement that can not, with confidence, quantify significant increases in volume and/or revenue, the ability to assume new depreciation and interest expenses must be closely examined.

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<sup>5</sup> Sponsored by AWPHD and the Department of Health Office of Community and Rural Health.

## Financing Options

The financing options used for the various facility replacements were also as unique as the hospitals interviewed. The financing option selected by each hospital was based on many factors including level of community support, relationships with larger health systems, ownership and management of the hospital, and federal and state regulations that applied to each specific situation.

Several hospitals were able to finance facility replacement based on affiliations with larger hospitals or health systems. While some of these hospitals also had community assistance through donations, tax support, and other options; without the leverage of these affiliations, it would have been challenging to finance the replacement. The majority of Washington hospitals contemplating facility replacement do not have these affiliations and will need to pursue other financing options in order to replace their facilities. However, a couple of financing approaches did surface through the interviews that could potentially be considered and evaluated in more depth by Washington CAH hospitals.

For example, Shoshone Medical Center in Kellogg, Idaho is similar to many rural Washington hospitals: It is a small rural public hospital district with very little cash; no commercial bank would have considered funding the replacement; it did not have a large tertiary facility or network to provide the funding; its maximum levy dollars were already being used just to fund operations; and it did not have large private donation funds to put toward the replacement project. The financing option being used by Shoshone is the HUD 242 program<sup>6</sup>. Shoshone reported that this program has been streamlined and redesigned specifically for CAHs. The process used to take up to 2 years and is now designed to take about 6 months. According to Shoshone, it can be a good option for small rural hospitals with very little cash. It allows CAHs to access the bond market at an AAA rating; roll everything into one package (e.g. equipment purchases, renovations, consolidation of debt); and start buying and using equipment as soon as the loan is approved. However, and per the Harden Financial Services Report referenced above, it is a costly financing option, and the hospital has to supply 10% of the total project costs as an asset. Additionally, the application and approval process is lengthy and detailed, with many requirements. For Washington public hospital districts, there may be additional issues and/or requirements with which to contend; most notably the ability to assume a mortgage.

Bertie Memorial was able to replace its facility through a Department of Agriculture (USDA) loan received by Bertie County. The county borrowed the money through that low interest rate loan program, and Bertie Memorial is now leasing the hospital from the county for the amount of the loan payment. When the loan is paid off, the ownership of the hospital will switch back to

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<sup>6</sup> HUD program's requirements are detailed on pages 23-25 of the Harden Report. Also refer to Appendix 3 of the Harden Report. This appendix notes that a \$10 million base project loan from HUD will require \$13.1 million in bonds--\$10 million for construction, \$1.0 million for debt service reserves, \$1.2 million for capitalized interest and \$0.9 million in underwriting and issuance costs.

Bertie Memorial as a private, not-for-profit hospital. The county processed the loan, which took about a year. It is important to note that Bertie Memorial is also part of University Health Systems (North Carolina).

Most of the other hospitals interviewed had the advantage of affiliations with larger facilities that could provide cash or leverage for the replacement projects. However, they did often couple those resources with campaigns to raise additional private donations and pledges, increased economic development taxes, bonds and other options. Details on these financing approaches can be found in the attached summaries.

In summary, the Harden Report evaluated financing options for several rural, Washington public hospital district hospitals. This report's conclusions identify issues and raise cautions that need to be considered prior to seeking any financing, including those referenced in this report. It also recommends considering a multiple source financing approach referred to as the "1-2-3-4 solution" which blends multiple resources from a variety of funding methods—including equity, tax-supported general obligation capacity, grant funding or development and HUD or USDA.

## **Community Education and Response**

The majority of hospitals reported positive community response to the facility replacement, with results ranging from improved community perception, increased daily census, enhanced financial foundation and community support, and better recruitment and retention. Even hospitals that did not report immediate positive impacts via increases in census or net revenues, did predict eventual positive impacts based on the overwhelmingly positive reaction from community members and health care providers. The only exception to this was Bertie Memorial in North Carolina, which has seen a reduction in census since the facility replacement. Several factors have contributed to this which can serve as lessons for other hospitals as they go through this process.

The Bertie Memorial administration focused advertising of the new facility on a new "critical access" hospital. According to Bertie Memorial administration, the community interpreted this to mean that the hospital provided only "critical care", so they did not seek treatment unless they were very ill. The additional focus on critical access "designation" also led the public to assume that they needed to be part of a group in order to be treated. According to Bertie Memorial, the advertising focus when raising funds for a new facility or to market one when complete should be on what this new hospital will do for the community as far as services and accessibility. From Bertie's experience, the term "critical access" has no, or adverse, meaning for the public.

Additionally, neither Bertie Memorial nor the University system had experience or associations with individuals experienced in working with CAHs, the reimbursement system or the design. They would highly recommend working with a consulting architectural firm with experience in

critical access requirements, designation, and design to discuss how to function in a critical access environment and how this impacts space allocation and design.

## **Implications**

These interviews clearly indicate that there are many elements to facility replacement that need to be considered by Washington's CAHs contemplating facility replacement. The decision to seek facility replacement and the process is quite complex, and there is not one solution that fits every community and/or hospital. Care should be taken and expertise sought on each element from financing decisions to future forecasting and facility design, and community education. Many lessons can already be gleaned from other states' experiences and many more can be learned as these facilities continue to operate and the long-term implications of financing options, facility design, and other elements identified.

**Attachment 1**  
**Bridges Medical Services – Ada, Minnesota**  
**Information Summary**

**Bridges Medical Services - Ada, Minnesota**

***Facility Information***

- ◆ Achieved CAH Designation: 2001
- ◆ Facility Replacement: 2000
- ◆ Service area: Norman County, Minnesota
- ◆ Location of Other Hospitals:
  - Network referral hospital: Americare - 45 miles
  - Other hospitals are 50 or more miles from Bridges.
- ◆ 14 total beds, use interchangeably as observation, acute care, and swing beds

***Staffing***

- ◆ Active Medical Staff
  - 1 physician
  - 1 physician assistant
  - 1 nurse practitioner

***Services Offered***

- ◆ PT/OT Unit is part of facility
- ◆ No obstetrics
- ◆ Emergency Department
- ◆ 49 bed nursing home, part of facility
- ◆ Rural health clinic, part of facility
- ◆ Services offered have not been changed significantly since the facility replacement

***Community Information***

- ◆ We are experiencing shortages in physicians, but we have been able to successfully fill the gaps with midlevel practitioners.

***Patient Activity***

- ◆ 1,000 Inpatient Days
- ◆ ADC of 2.5
- ◆ 750 Emergency Visits

### ***Financials***

- ◆ Total Net Revenue: \$5,000,000 (includes hospital, nursing home, rural health clinic, and rehab center)
- ◆ Payer Mix: 75% Medicare
- ◆ Total capital costs for the replacement project: \$24 Million
- ◆ Sources of Financing: Federal Emergency Management Agency (FEMA) funded the replacement due to extensive flood damage.
- ◆ Financing Costs: FEMA funded whole project. There were no financing costs or payback requirements.
- ◆ No overall financial benefits or losses since the facility replacement.

### ***Facility Design***

- ◆ The new facility is way overbuilt.
- ◆ It is a “showcase” with skylights, atrium, etc.
- ◆ If designing specifically for use as critical access hospital (which ours was not), we would build just the basics.
- ◆ The focus of the design should be on functionality and efficiency, not on looks or design.

### ***Key Decision Making Factors***

- ◆ Had to replace because of flood damage.

### ***Demographics*** (From U.S. Census Bureau)

<b>Demographics</b>	<b>Norman County</b>	<b>Minnesota</b>
Total Population – 2000	7,442	4,919,479
Population – Percent Change – 1990 to 2000	-6.7%	12.4%
Persons Under 18 Years Old – 2000	25.7%	26.2%
Persons 65 Years Old and Over – 2000	20.9%	12.1%
Female Persons – 2000	50.3%	50.5%
White Persons – 2000	95.3%	89.4%
Median Value of Owner-Occupied Housing Units – 2000	\$43,600	\$122,400
Median Household Income – 1999	\$32,535	\$47,111
Per Capita Money Income – 1999	\$15,895	\$23,198
Persons Below Poverty – 1999	10.3%	7.9%
Persons Per Square Mile	8.5	61.8

## Attachment 2 Ogallala Community Hospital – Ogallala, Nebraska Information Summary

### Ogallala Community Hospital – Ogallala, Nebraska

#### *Facility Information*

- ◆ Originally Built: 1952
- ◆ Achieved CAH Designation: August 1, 2002
- ◆ Facility Replacement: November, 2000
- ◆ 18 licensed beds
- ◆ Service Area
  - Keith County
  - Arthur County
  - Garden County
  - Duell County
  - Do also provide service further south to Perkins and Chase County, although they are not officially part of service area.
- ◆ Location of Other Hospitals
  - Network referral hospital: North Colorado Medical Center – 200 miles from facility
  - Main Competitors: Great Plains and North Platt Medical Centers –50 miles (much larger hospitals)
  - Other Hospitals within 50 miles: Perkins County Hospital – 20 miles (much smaller hospital).
  - Also refer patients to:
    - Scotts Bluff, Nebraska – 150 miles
    - Karne, Nebraska – 150 miles
    - A number of hospitals in Denver – 220 miles

#### *Staffing*

- ◆ Before Facility Replacement
  - 5 Family Practice Physicians
  - 1 Surgeon
  - 4 Physician Assistants
- ◆ After Facility Replacement
  - 4 Family Practice Physicians
  - 2 Physician Assistants
  - We are currently recruiting practitioners. The reduction in staff is not a result of the facility replacement. The new administration let some of the existing staff go when they took over the hospital.

### ***Services Offered***

- ◆ Outpatient Rehabilitation
- ◆ Inpatient Rehabilitation
- ◆ Outpatient Specialty Clinics
- ◆ Obstetrics
- ◆ Emergency Services
- ◆ General Radiology Services
- ◆ Specialty Radiology Services (e.g. MRIs, CT scans)
- ◆ Laboratory Services
- ◆ Swing Beds
- ◆ Inpatient Surgery
- ◆ Outpatient Surgery
- ◆ Intensive Care
- ◆ Home Health
- ◆ Hospice
- ◆ Long-Term Care

### ***Impact of facility replacement on services offered***

Before the facility replacement, we had only mobile CT Scanning and did not perform bone density MRIs or nuclear medicine. We now can offer fixed-base CT Scanning, mobile MRIs, and nuclear medicine.

## ***Community Information***

- ◆ Health Professional shortages.
  - We are experiencing huge shortages in family practice physicians and general surgeons.
  - The facility replacement has not made a noticeable difference. The new hospital may make it a little more attractive, but the bottom line is that the challenge of finding providers and families that are willing to live in rural Nebraska and are willing to be the only provider (e.g. surgeon) with no back-up will continue regardless. Building a new facility will not address all of the recruiting issues. The facility is just one of the factors providers use in their decision-making.
- ◆ Unique Population Characteristics
  - We experience a lot of tourism. Our facility is close to a large lake, which is the #2 tourist attraction for the state of Nebraska.
  - We are located right off a busy highway, Interstate 80 and get a lot of trauma cases from the interstate.
  - Large farming and agriculture community
- ◆ Physician Recruitment and Retention
  - This is not much easier since the replacement. We have been recruiting for a year for a general surgeon and 2 family practice physicians. We have had had lots of applications. The facility has been a plus, but we still have the issue of finding people willing to live in rural Nebraska, be the only specialist in town, and be on call 24/7. Having a new hospital will help recruit only IF they want this kind of lifestyle.
- ◆ Other Clinical Staff Recruitment and Retention
  - These positions are 100% full. This is not necessarily only because of the new facility.
  - There is a new administration and new culture. There were several issues under the previous administration. Staff is happier now and is wanting to stay. We actually have a waiting list for nurses wanting employment.
- ◆ Hospital Administrator Turnover
  - The previous administrator had been there for 9 years
  - A new administrator was hired and other staff changes were made when we became a member of Banner Health.
- ◆ Data Collection and Analysis Systems
  - Ogallala is now a member of Banner Health. They guide the data collection and analysis decisions.
- ◆ Rural Health Network Development
  - The tertiary hospital for Banner is North Colorado Medical Center. It is definitely not the closest. We do not always refer our patients there. We choose referral hospitals based on patient needs, bed availability and helicopter availability. We do have an agreement with North Colorado Medical Center that requires them to accept our referrals. It is optional for the other hospitals.

### ***Patient Activity***

- ◆ Emergency Visits: 350 per month
- ◆ Obstetrics: 75 per year

### ***Financials***

- ◆ Total Net Revenue: \$7.4 million
- ◆ Total Operating Expenses: \$7.1 million
- ◆ Total Debt: \$6 ½ million plus \$1 million. The community pays this through taxes. Banner is backing those bonds
- ◆ Monthly cost of debt: ½ of the bond payment from Banner.
- ◆ Total FTEs: 100. Total personnel: 140.
- ◆ Payer Mix
  - 45% Medicare
  - 10% Medicaid
  - 30% Insurance
  - Small % worker's compensation and/or self-pay
  - No managed care
- ◆ Had lost money for 15 straight years, probably more.
- ◆ When home care was fee for service, had positive cash flow, but the hospital proper has never made money.
- ◆ Total Capital Costs for Replacement Project: \$6 ½ million, \$1 million for equipment
- ◆ Sources of Financing:
  - “Commitment for Caring” campaign to raise money in the community
  - Majority of funding came from 20-year ¼% economic development sales tax. Banner Health System backed bonds. The hospital will pay half of the funds to pay the debt. The sales tax will cover the other half.
- ◆ Length of Time for Financing:
  - Entire “Commitment for Caring” campaign was a 5-year process of gathering private donations and pledges.
  - We started building the facility as soon as got enough pledges and donations, etc. and were in the new facility at the end of the 5-year process.
- ◆ Financing costs:
  - Banner backed bonds provided a beneficial high bond rating.
- ◆ Financing approach recommendations:
  - Having a large company to provide the backing works well, and there is little risk to the community. The company takes the risk and the community benefits from a hospital that is paid for in 20 years, regardless of its bottom line.

- ◆ Financial Impact of Facility Replacement:
  - A new facility does help and has the potential of increasing business and community perception. However, if the community has confidence issues with providers, a new facility will not resolve those. We had to make some major changes, other than the facility replacement, to build community confidence in the hospital.
- ◆ Other efficiencies achieved through the facility replacement
  - Our previous facility was in 2 different buildings. The new facility is all on one level, which allows for much more efficient staffing and lots of increased efficiencies.

### ***Facility Design***

- ◆ Have both single and double occupancy patient rooms
- ◆ Multi-Purpose rooms
  - Chemotherapy is combined with overflow ER
  - Overflow OB is combined with recovery
  - 2 operating rooms that are also used for trauma
  - Clinic and hospital are connected. Outpatient surgery uses OR rooms and ER exams rooms. 1 big ER with 2 bays and 1 private ER room. Nurse stations can work both inpatient and ER.
  - Emergency room and front door entries.
  - Medical clinics attached to hospital. Home care and durable medical equipment downtown.
- ◆ Design Strengths
  - Positioning OR on one side with ER on the other and diagnostic services in between which allows for staff efficiency and ease of patient movement and transport.
  - Strongly recommend the “convenience kitchen” set-up. Everything is precooked. Can staff the kitchen with one person because there are no dishes other than plates, no waste, and limited dry storage.
  - Having one level is great. Don’t have leaking problems between floors. More accessibility to other departments/services. Inpatient and ER services can be staffed by same nurses.
- ◆ Design Weaknesses
  - The bi-folding exterior doors are horrible, constantly locking up and needing repair. We have had the manufacturer come out numerous times and can’t fix them. Should pursue automatic doors where one slides in front of the other.
  - A flat roof was a huge mistake. Look into slanted roof options that are better able to handle all weather conditions.

**Key Decision Making Factors**

- ◆ Forecasted financial benefits were not an issue for the community. If the hospital makes money, Banner will benefit. If the hospital loses money, Banner will be impacted, not the community.
- ◆ Potential to increase total community viability was a large part of the decision-making. The community decided to put the entire economic development tax increase towards the hospital for 20 years. They felt health care was a very important element to increase community growth, something new businesses and individuals would evaluate in deciding whether to come to the community.

**Demographics** (From U.S. Census Bureau)

<b>Demographics</b>	<b><i>Deuel County</i></b>	<b>Keith County</b>	<b>Arthur County</b>	<b>Garden County</b>	<b>Nebraska</b>
Total Population – 2000	2,098	8,875	444	2,292	1,711,263
Population – Percent Change – 1990 to 2000	-6.2%	3.4%	-3.9%	-6.8%	8.4%
Persons under 18 years old – 2000-	23.3%	25.3%	23.9%	21.8%	26.3%
Persons 65 years old and over, 2000	22.9%	18.4%	16.4%	24.0%	13.6%
Female Persons, 2000	51.3%	50.9%	49.5%	51.3%	50.7%
White Persons –2000	97.3%	96.8%	96.4%	98.3%	89.6%
Median Value of Owner-Occupied Housing Units – 2000	\$48,300	\$69,300	\$44,300	\$44,300	\$88,000
Median Household Income – 1999	\$32,981	\$32,325	\$27,375	\$26,458	\$39,250
Per Capita Money Income – 1999	\$17,891	\$17,421	\$15,810	\$15,414	\$19,613
Persons Below Poverty – 1999	9.1%	9.3%	13.8%	14.8%	9.7%
Persons Per Square Mile	4.8	8.4	0.6	1.3	22.3

**Attachment 3**  
**Crete Area Medical Center – Crete, Nebraska**  
**Information Summary**

**Crete Area Medical Center – Crete Nebraska**

***Facility Information***

- ◆ Facility Replacement: To be completed in 2003
- ◆ Replaced facility will have 25 patient rooms and 26 physician exam rooms.

***Services Offered***

- ◆ Services located within the facility and elsewhere on the site are being developed with planned flexibility to allow any department to be easily expanded or modified without significant interruption or impact on adjacent services.
- ◆ Obstetrics
- ◆ Emergency Services
- ◆ Breast Cancer Screening/Mammography
- ◆ Oncology
- ◆ Social Work
- ◆ Outpatient Surgery
- ◆ Long-Term Care Services
- ◆ Home Health

***Patient Activity***

- ◆ Inpatient Admissions – 511
- ◆ ADC – 22
- ◆ Births – 436

***Financials***

- ◆ Total capital costs for the replacement project: \$14 million
- ◆ Sources of financing: BryanLGH Medical Center, in partnership with Crete Municipal Hospital and the City of Crete, coupled plans to replace their physician's clinic with a plan to address the hospital's needs. An arrangement was reached by which a new separate not-for-profit legal entity was created establishing an integrated hospital and clinic. City of Crete retains the ownership of the current hospital building and Crete Area Medical Center will lease the building that will become a long-term care facility through a contract with the Medical Center.
- ◆ Total Annual Expenses: \$7,409,000
- ◆ Total Personnel: 173

### ***Facility Design***

Which design features in your replacement facility would you recommend?

- ◆ A central open public space filled with natural daylight.
- ◆ Services such as cardiac rehabilitation, physical and occupational therapy, and classrooms for health education will open onto the open public space.
- ◆ Imaging, laboratory and emergency departments are located immediately adjacent to the physicians' clinic and specialty clinic spaces for ease of access and to minimize the movement of our guests.
- ◆ Every window in the private patient rooms will be focused on an adjacent wooded ravine, uninterrupted by parking lots or pavement.
- ◆ Services located within the facility and elsewhere on the site are being developed with planned flexibility to allow any critical department to be easily expanded or modified without significant interruption or impact on adjacent services.

### ***Key Decision Making Factors***

- ◆ To help maintain and enhance the local medical community by providing for new facilities, which will provide a very positive environment for clients and staff, as well as to provide for cost-effective, efficient delivery of care.
- ◆ To serve as a positive consideration for recruitment of new physicians into the area.

### ***Demographics*** (From U.S. Census Bureau)

<b>Demographics</b>	<b>Saline County</b>	<b>Nebraska</b>
Total Population – 2000	13,843	1,711,263
Population – Percent Change – 1990 to 2000	8.9%	8.4%
Persons under 18 years old – 2000	25.1%	26.3%
Persons 65 years old and over – 2000	17.2%	13.6%
Female Persons – 2000	50.6%	50.7%
White Persons – 2000	93.0%	89.6%
Median Value of Owner-Occupied Housing Units – 2000	\$69,000	\$88,000
Median Household Income – 1999	\$35,914	\$39,250
Per Capita Money Income – 1999	\$16,287	\$19,613
Persons Below Poverty – 1999	9.4%	9.7%
Persons Per Square Mile	24.1	22.3

**Attachment 4**  
**Wray Community District Hospital – Wray, Colorado**  
**Information Summary**

**Wray Community District Hospital – Wray, Colorado**

***Services Offered***

- ◆ Obstetrics
- ◆ Breast Cancer Screening/Mammography
- ◆ Oncology
- ◆ Outpatient Surgery
- ◆ Community Outreach
- ◆ CT Scanning and general radiology
- ◆ Geriatric Services
- ◆ Outpatient Care
- ◆ Nutritional Services
- ◆ Outpatient Physical Rehabilitation
- ◆ Certified Trauma Services

***Patient Activity***

- ◆ 16 beds
- ◆ Inpatient Admissions – 501
- ◆ ADC - 4
- ◆ Outpatient Visits – 26,050
- ◆ Births – 75

***Financials***

- ◆ Total Expenses - \$5,991,000
- ◆ Total Personnel – 61

***Demographics*** (From U.S. Census Bureau)

<b>Demographics</b>	<b>Yuma County</b>	<b>Colorado</b>
Total Population – 2000	9,841	4,301,261
Population – Percent Change – 1990 to 2000	9.9%	30.6%
Persons under 18 years old – 2000	28.3%	25.6%
Persons 65 years old and over – 2000	16.3%	9.7%
Female Persons – 2000	50.8%	49.6%
White Persons – 2000	94.2%	82.8%
Median Value of Owner-Occupied Housing Units – 2000	\$77,100	\$166,600
Median Household Income – 1999	\$33,169	\$47,203
Per Capita Money Income – 1999	\$16,005	\$24,049
Persons Below Poverty – 1999	12.9%	9.3%
Persons Per Square Mile	4.2	41.5

**Attachment 5**  
**Bertie Memorial Hospital – Windsor, North Carolina**  
**Information Summary**

**Bertie Memorial Hospital – Windsor, North Carolina**

***Facility Information***

- ◆ 6 bed facility. Current ADC is 2.
- ◆ Achieved CAH Designation: June, 1999
- ◆ Facility Replacement: October 8, 2001
- ◆ Location of Other Hospitals
  - Pitt County Memorial Hospital - Greenville, North Carolina
    - Network Referral Hospital
    - 45 miles from Bertie Memorial
    - Part of University Health System who also manages Bertie Memorial
  - Main Competitors
    - Pitt County Memorial – 45 miles
    - Chowan Hospital – Edenton, North Carolina – 30 miles
  - Other Hospitals within 50 miles
    - Plymouth Hospital – 25 miles – not main competitor
    - Williamston Hospital – Williamston, North Carolina– 15 or 20 – not main competitor

***Staffing***

No staffing changes resulted from the facility replacement. Some staff changes occurred when the management of the hospital changed.

- ◆ Employed by Bertie Memorial
  - 2 full-time physicians employed by Bertie Memorial
  - 1 part-time pathologist, medical director of lab
  - 1 physician assistant
  - 1 nurse practitioner
- ◆ 13 other general surgeons and family practice physicians on active medical staff that practice at Bertie Memorial periodically.
- ◆ Hospital owned practice
  - 2 physician assistants
- ◆ Emergency Department
  - 2 physician assistants
  - 1 nurse practitioner
- ◆ Total Personnel -100

### ***Services Offered***

- ◆ Outpatient Physical Therapy
- ◆ Outpatient Specialty Clinics
- ◆ Gynecology, not deliveries
- ◆ Emergency Services
- ◆ General Radiology
- ◆ Specialty Radiology Services (CT, mammography, ultrasound)
- ◆ Laboratory
- ◆ Applying for Swing Beds
- ◆ Inpatient Surgery
- ◆ Outpatient Surgery
- ◆ Occupational Health Services

### ***Services changed since facility replacement:***

- ◆ Added
  - Outpatient physical therapy
  - Specialty Radiology Services (CT, mammography, ultrasound)
  - Visiting sub specialists
  - Physical medicine
  - Applying for Swing Beds
- ◆ Reduced
  - Inpatient Surgery more limited
- ◆ Enhanced
  - Outpatient Surgery – do more
  - Podiatry

### ***Community Information***

- ◆ Bertie County has a population of about 20,000
- ◆ Bertie Memorial serves about 5,000 of that population
- ◆ Our patient population is very poor. Bertie County is 93<sup>rd</sup> out of 100 North Carolina counties in per capita income.
- ◆ 63-70% of service area is black
- ◆ We are not experiencing provider shortages
- ◆ Voluntary turnover has decreased since facility replacement
- ◆ Some staffing changes have been made that have impacted turnover which were not related to facility replacement.

***Patient Activity***

- ◆ 6 bed facility. Current ADC is 2.
- ◆ Had higher inpatient census before facility replacement
- ◆ Inpatient census has dropped off since facility replacement because:
  - Mild winter.
  - Public confusion
    - Advertising focused on critical access designation. Public interpreted it to mean that the hospital was a “critical care” hospital, so they did not come unless they were very ill.
    - Also misinterpretation that had to be a member of a group to be seen at the hospital
    - Concerns about the 96 hour requirement. The community did not understand it is an average, so they were afraid that they would be discharged after 96 hours, regardless of ongoing health needs.
- ◆ Emergency Visits
  - Have gone up steadily since corporation took over management, over 600 a month now. This is not necessarily related to facility replacement.
- ◆ Outpatient Admissions
  - 19,288. This has increased by 10% since the facility replacement as a result of having a new facility and offering a few more services.

***Financials***

	<b>Before Facility Replacement</b>	<b>After Facility Replacement</b>
Total Net Revenues	Ending October 30 2001 \$7,788,000	Ending October 30, 2002 \$8,566,000
Total Operating Expenses	\$7,873,000	\$9,932,000
Total Debt		\$10,000,000
Monthly Costs of Debt		\$46,000 in interest, \$102,000 of depreciation
Total FTEs	99	102
Payer Mix		23% various commercial
% Medicare		53%
% Medicaid		13% Medicaid
% Charity Care		91/2% self pay

- ◆ Total capital costs for the replacement project: \$10 million
- ◆ Sources of financing: Department of Agriculture Federal Farmers Loan (County borrowed money. Hospital is now leasing from the county, paying in the amount of the county loan payment.
- ◆ When the loan is paid off, the ownership of the hospital will switch back to the corporation, as a private, not-for-profit hospital.
- ◆ Length of financing: County processed loan. Took about a year
- ◆ Would you recommend the financing approach you used? Yes. The interest rate is reasonably low and seems to be working for the county.
  
- ◆ Financial Impact
  - We have experienced financial losses to date. We believe this is because we had a lack of knowledge about operating as a CAH. The average tertiary setting doesn't have CAH experience, and the average CPA doesn't have experience with cost-based reimbursement.
  - Recommend having thorough discussions at the onset with individuals experienced in CAH requirements, design and cost-based reimbursement.
  - We are now working with CAH experts to "fix" some of the problems we have experienced.
  - We have also experienced reduced census. Once again, this is a result of a lack of experience. We focused advertisement of the replacement facility on it being a "Critical Access Hospital" and on receiving "critical access designation". This lead members of the community to think that they had to be critically ill or be a member of a particular "designation" to be treated at the hospital.
  - It is also very important to recruit individuals who have experience with smaller hospitals and realize the importance of thorough billing to the financial viability of a small hospital. The central billing office from the tertiary hospital was writing off \$40 bills without realizing that small hospitals can't survive without collecting these small bills.
  
- ◆ Other efficiencies through the facility replacement
  - Purchase patient meals from a local nursing home. It is a large capital cost to put in a commercial kitchen and to fund the FTEs to run a food service for a limited number of patients. We can now provide meals to our patients for under \$4 a meal.

**Demographics** (From U.S. Census Bureau)

<b>Demographics</b>	<b>Bertie County</b>	<b>North Carolina</b>
Total Population – 2000	19,773	8,049,313
Population – Percent Change – 1990 to 2000	-3.0%	21.4%
Persons Under 18 years old – 2000	26.1%	24.4%
Persons 65 years old and over – 2000	16.0%	12.0%
Female Persons, 2000	53.3%	51.0%
White Persons, 2000	36.3%	72.1%
Black Persons, 2000	62.3%	21.6%
Median Value of Owner – Occupied Housing Units – 2000	\$59,200	\$108,300
Median Household Income – 1999	\$25,177	\$39,184
Per Capita Money Income – 1999	\$14,096	\$20,307
Persons Below Poverty Level – 1999	23.5%	12.3%
Persons Per Square Mile	28.3	165.2

**Attachment 6**  
**Shoshone Medical Center – Kellogg, Idaho**  
**Information Summary**

**Shoshone Medical Center – Kellogg, Idaho**

***Facility Information***

- ◆ Originally Built: 1959
- ◆ Achieved CAH Designation: December, 2001
- ◆ Facility Replacement: Currently working to fund replacement of facility through the HUD 242 Mortgage Insurance Programs for CAHs.
- ◆ Service area: ½ of Shoshone County, including zip code 83837, 83850, 83849, 83873, 83839, 83868, 83867, 83846, 83810, 83874
- ◆ Public Hospital District

***Staffing***

- ◆ Active Medical Staff
  - 14 fulltime physicians
  - 1 anesthesiologist
  - 5 emergency physicians
  - 2 general surgeons
  - 1 orthopedic surgeon
  - 1 radiologists
- ◆ 3 physician assistants and 2 nurse practitioners on staff, but not employed by hospital
- ◆ 1 chiropractor

***Services Offered***

- ◆ Inpatient and Outpatient Physical Therapy
- ◆ No Obstetrics
- ◆ 24/7 Emergency
- ◆ General Radiology and CT Scanner
- ◆ In-House CT and Trailer MRI
- ◆ Laboratory Services
- ◆ Swing Beds
- ◆ Inpatient and Outpatient Surgery in same unit
- ◆ Emergency Services
- ◆ Occupational Health
- ◆ Hospital went “back to the basics” three years ago when hospital signed a contract with Quorum Health Resources to run the hospital.
- ◆ After facility replacement, will have in house MRI and are building to allow for the ability to easily add on an obstetrics wing in design of building if there is a need in the future.

***Community Information***

- ◆ Location of Other Hospitals
  - Network referral hospital - Kootenai Medical Center, Coeur d-Alene, Idaho - 40 miles over a mountain pass
- ◆ Main competitors
  - Not competitors – Deaconess Medical Center and Sacred Heart Medical Center are in excess of 50 miles. Refer all cardiac patients to those facilities.
- ◆ Interesting community because the main industry is mining, but we are also located near a ski resort, bringing in a very different demographic population.
- ◆ No shortages in community providers

***Other Community Factors***

<b>Factors</b>	<b>Before Facility Replacement</b>	<b>After Facility Replacement</b>
Level of Community Support for CAH (Tax dollars or private donations)	\$400,000 a year through taxes \$10,000 private donations	Project donations will increase. Will be interesting to see
Physician Recruitment and Retention	Haven't had in the past too much	Should increase recruitment and retention
Training Programs	Radiology Tech training	Assuming will grow
EMS System and Provision of EMS Services	Private system	
Data Collection and Analysis Systems	Good information system in place	Improve greatly
Rural Health Network Development	Pretty good one	
Quality improvement program and linkages to support those programs (e.g. hospital associations, state departments, PROs, support hospitals)		Improve

### ***Patient Activity***

- ◆ Inpatient Days (2002 YTD Nov)
  - Medicare – 1,406
  - NonMedicare – 471
  - Total – 1,877
- ◆ Emergency Visits
  - 4,973
- ◆ Outpatient Admissions
  - 302 Sugeries
  - 282 Scopes
  - Outpatient Tests – 20,064
  - Inpatient Surgeries – 122
  - Outpatient Surgeries – 302
  - 4,740 Inpatient and Outpatient Respiratory Therapy

### ***Financial Data/Financing Details***

- ◆ Total Net Revenues - \$8.1 million
- ◆ Total Operating - \$8.38 million
- ◆ Total Current Debt \$143,552 long-term debt, \$2.25 million total liabilities
- ◆ Additional Debt for Facility Replacement - \$645,000 for 2002, goes to \$1.5 million per year in 2005.
- ◆ Total FTEs - 78
- ◆ Payer Mix
  - 75% Medicare
  - 3% Medicaid
  - 6% Charity
  
- ◆ ***Capital Costs for Replacement Project***
  - Total Replacement Costs - \$18.639 million
  - Total construction costs – \$8.6 million
  - Equipment and Furnishing – \$4.8 million
  - Other fees – \$1.6 million – architectural design, construction management, etc.
  
- ◆ ***Sources of Financing***
  - HUD 242 critical access loan program
  - Source: HUD 242 Critical Access Loan Program. Our application was deemed complete by HUD on 11/25/02.
  - Application process took a little over a year. This is partially because we are in the middle of an EPA clean-up area. This cost us valuable time. If someone is familiar with the process, it can be completed in 6 to 8 months.
  - Financing Costs: \$2.9 million in carrying and financing charges
  - Financing Timeline: Estimating that it will be a 25-28 year loan at about 6%.

- ▶ Pros
  - HUD 242 Program was redesigned specifically for critical access hospitals. It has been streamlined. The process used to take up to 2 years. It is now designed to take about 6 months. This process has taken over a year for us, partially due to other issues around EPA clean up.
  - Provides options to small rural hospitals with very little cash.
    - No commercial bank would consider financing the project.
    - Don't have large tertiary facility or network to provide the funding.
    - Already use maximum levy dollars for operations.
    - Don't have large private foundation funds.
  - Provides small rural hospitals access to the bond market at an AAA rating.
  - Can roll everything into one package (e.g. buy equipment, renovate, build new, consolidate debt).
  - As soon as loan is approved, can start buying and using new equipment. Don't have to wait until new facility is completed.
- ▶ Cons
  - Have to come up with 10% of the total project costs as an asset. If tearing building down, can't use that as an asset, but can use property. 10% can also come from private foundations, etc.
  - Will not finance infrastructure costs (e.g. sewer).
  - Lengthy, detailed, and bureaucratic application and approval process.
  - Because it is a federally insured program, there are many requirements to meet:
    - Comply with Davis Bacon bill wage rates. This added significant costs to our project.
    - Meet environmental/historical site preservation and other site regulations.
  - Have to have a competitive bid process for every piece of the process. If used one architect when presented plan to HUD, still have to go out for a competitive bid after approval. If a different architect gets the bid, adds time and money to process.
- ▶ Issues to Consider
  - HUD Program requires a feasibility study. This cost about \$50,000. This feasibility study is waived for states that require a Certificate of Need for the replacement.
  - Since Shoshone was a governmental subdivision, the Idaho Financing Authority requires that it can't acquire more than \$100,000 of debt in a year without going through a vote of the people or through the Financing Authority. The Financing Authority deals in long-term leases and HUD deals in mortgages. A lot of legal work was required to address the requirements of both entities.
  - This is not a construction loan. Once the loan is approved, payments start.

- Resources
  - Used Innovative Consultants out of New York. Strongly recommend using expert consultants. There is no way they could have managed the process without them. We spent about \$200,000 just to get through the pre-application process.
  - Quorum Health Resources prototype for a 25 bed rural facility. We used this prototype, and it made the process much more efficient.
  - Gary Moore, Administrator, Shoshone Medical Center, is willing to be a resource to other facilities starting this process. He could help shave several months off the process by sharing their experiences/lessons learned.

### *Facility Design*

- ◆ **Prototype through Quorum Health Resources**
  - Total of 25 beds; 5 double occupancy rooms.
  - Surgical unit that has 2 operating rooms for inpatient and outpatient.
  - 4 single individual private emergency rooms.
  - 2 bed trauma unit.
  - Entrances: Main entrance; emergency/ambulance entrance; staff entrance; materials management supplies entrance.
  - All digital x-ray departments.
  - In-house MRI.
  - Provided a trailer for any kind of portable units.
  - No clinics involved with this structure.
  - 2 bay ambulance.
  - Exterior Biohazard Decontamination Structure.
- ◆ **Recommended Design Features**
  - Used standard rural hospital design.
  - Do future productivity studies and design space on those findings.
  - Recommend biohazard wash down and decontamination structure.
  - Focus on cost-efficiency, not “fluff”.

**Key Decision Making Factors**

- ◆ Building was a time bomb. Boilers needed to be replaced, but manufacturer had quit making parts for them 10 years ago. Pipes were rusty and corroded. Cost for renovation would have been \$14 million and we would still not have had a good design.
- ◆ Community perceptions. Lose 20% of business to Kootenai.
- ◆ To help recruit and retain providers.
- ◆ Improvements to quality of care through new and upgraded equipment.
- ◆ To improve emergency care system through new emergency room and digital diagnostic system.
- ◆ Community Viability.
  - Draw other people/businesses to the community, particularly retirees looking for a small community in which to retire. Quality health care services are a top priority for this population.

**Demographics (From U.S. Census Bureau)**

<b>Demographic Data</b>	<b>Shoshone County</b>	<b>Idaho</b>
Total Population – 2000	13,771	1,293,953
Population – Percent Change – 1990 to 2000	-1.1%	28.5%
Persons Under 18 Years Old – 2000	22.9%	28.5%
Persons 65 Years Old and Over – 2000	17.4%	11.3%
Female Persons – 2000	50.1%	49.9%
White Persons – 2000	95.8%	91.0%
Median Value of Owner-Occupied Housing Units	\$70,200	\$106,300
Median Household Income – 1999	\$28,535	\$37,572
Per Capita Money Income – 1999	\$15,934	\$17,841
Persons Below Poverty – 1999	16.4%	11.8%
Persons Per Square Mile	5.2	15.6

- ◆ The Valley population represents 12 individual communities spread over a 25-mile radius.
- ◆ Beginning in the late 1800's, this area produced over 25% of the nation's silver and other metals such as gold, zinc and lead. During the 1970's most mining operations closed due to reduced silver prices and the increased cost of compliance to new EPA standards. This led to the Shoshone Medical Center service area becoming one of the highest unemployed counties in the state.
- ◆ Younger working families are relocating out of state, resulting in the median age of the Valley growing to 41.8 years.

**Attachment 7**  
**St. Vincent Randolph Hospital – Winchester, Indiana**  
**Information Summary**

**St. Vincent Randolph Hospital – Winchester, Indiana**

***Facility Information***

- ◆ Originally Built: 1915 as a women's home
- ◆ Achieved CAH Designation: September 1, 1999
- ◆ Facility Replacement: November 16, 2001

***Staffing***

- ◆ Active Medical Staff
  - 16 physicians, including 1 full-time and 1 part-time general surgeon and 1 OB/GYN
  - Added 1 orthopedic surgeon after facility replacement

***Services Offered***

- ◆ Outpatient Rehabilitation
- ◆ Inpatient Rehabilitation
- ◆ Outpatient Specialty Clinics
- ◆ Obstetrics
- ◆ Emergency
- ◆ General Radiology Services
- ◆ Specialty Radiology Services (e.g. MRIs, CT scans)
- ◆ Laboratory
- ◆ Swing Beds
- ◆ Inpatient Surgery
- ◆ Outpatient Surgery
- ◆ “Closely Monitored Rooms” (not intensive care, but one step above from general inpatient)
- ◆ New services since facility replacement:
  - Sleep lab
  - Telepsychiatric
  - Orthopedic surgery
  - Diabetic education program

### ***Community Information***

- ◆ Service area - Randolph County
  
- ◆ Location of Other Hospitals
  - Network referral hospital
    - Ball Memorial Hospital in Muncie, Indiana. – 35 miles
    - St. Vincent Hospital in Indianapolis – 90 miles
  
- ◆ Main competitors
  - Reed Hospital, Richmond – 30 miles
  - Ball Memorial – 35 miles
  - Wayne Hospital, Greenville, Ohio – 20 miles
  
- ◆ Provider shortages
  - Shortages have decreased. The new facility and the new relationship with Ascension Health in St. Louis and specifically St. Vincent Hospital in Indianapolis has had a very positive impact.
  
- ◆ Unique Population Characteristics
  - One of the poorest counties in Indiana
  - Farming community
  
- ◆ Level of Community Support
  - Have experienced increased moral and monetary community support.
  - Giving to our private foundation has increased.
  - The community likes what they see and wants to help.
  
- ◆ Physician Recruitment and Retention
  - The new facility has helped. It is much easier to convince physicians to come work at a state of the art facility, then an out-dated and dilapidated building.
  
- ◆ Other Clinical Staff Recruitment and Retention
  - Other employee retention has improved. Staff is much happier now that they have the equipment and space they need to function effectively.

- ◆ Other impacts of facility replacement
  - Training Programs. Have increased part-time clinical educator position to full-time.
  - All clinical areas have completed competency training.
  - All ER nurses have achieved trauma nurse certification.
  - All ER personnel have achieved ACLS certification and Pediatric Advanced Support Certification.
  - EMS System and Provision of EMS Services - Emergency service provision has improved because of the emergency room design. Now have 2 trauma rooms and lots of space.
  - Data Collection and Analysis Systems - In the process of adding to data system.
  - Have already added a new lab data collection system and an automatic time and attendance system.

***Patient Activity***

	<b>Before Facility Replacement</b> <i>12 months, ending October, 2001</i>	<b>After Facility Replacement</b> <i>12 months, ending October, 2002</i>
Inpatient Days	793	834
Emergency Visits	3,054	2,878 (Has decreased because of new program funded through CAP grant. Social worker follow-up with uninsured to connect with primary care physicians, help with Medicaid applications, etc.)
Outpatient Admissions (Excluding ER visits)	6,319 (excluding ER but including surgery)	7,491 (excluding ER but including surgery)
Obstetrics - # of Births	80	129
Surgeries (Inpatient)	43	66
Surgeries (Outpatient)	206	243
PT/OT Visits Inpatient Rehab Outpatient Rehab	291 5,107	366 1,650 (Can't compare outpatient numbers because have split outpatient rehab into a separate corporation. Hospital owns 37%. Anecdotal reports are that the numbers have increased and that the outpatient rehab program is busier than ever.)
Quality Improvements (Patient outcomes/quality improvement process)		Have seen improvements in quality and efficiency. Don't have any hard data. Improvements in design, square footage, technology and increasing services have made it possible to see more patients and to provide care more efficiently and with higher quality.

**Financial Information/Financing Details**

	<b>Before Facility Replacement</b>	<b>After Facility Replacement</b>
	<i>12 months, ending October 2001</i>	<i>12 months, ending October 2002</i>
Total Net Revenues	\$7,282,478	\$9,484,185 (Only had 4% price increase). The increases in revenues are definitely reflective of the new facility and new patients it has brought in.
Total Operating Expenses	\$5,557,477	\$6,846,018 (Expenses have increased a bit to run the bigger facility and operate the new technology, but the majority of costs are related to the increased volume.)
Total Debt	\$14,581,000	\$17,863,000
Monthly Costs of Debt		\$100,000 a month just for the hospital costs
Total FTEs	210	219
Payer Mix		
% Medicare	37%	37%
% Medicaid	15%	15% Medicaid might have gone up slightly, but not substantially
% Charity Care		
	Self-pay – 10%	Self-pay – 10%
	Workers comp – 1.7%	Workers comp – 1.7%
	Blue Cross – 11%	Blue Cross – 11%
	Commercial – 25%	Commercial – 25%

- ◆ Have averaged 150 new patients a month since we have moved into the new facility. It has made a huge positive impact.
- ◆ Replacement Costs
  - \$15.6 million total replacement costs
- ◆ Sources of financing
  - Affiliation with St. Vincent Hospitals and Health Services in Indianapolis (part of Ascension Health System). The affiliation enabled the hospital to secure the necessary loans for the project, but the community chipped in 32 acres of land and a heliport, as well as monetary contributions.
- ◆ Financial Impacts of Facility Replacement
  - Tremendous positive effects
  - Exceeded our budget expectations every month for the entire first year.

- ◆ Other Efficiencies Resulting From Facility Replacement
  - Lay out and design for outpatient care focuses all services around the lobby. The patient/lobby is the wheel and the spokes are the services (e.g. lab, x-ray). It is even more efficient for the patients than the staff. It is a patient driven model.
- ◆ While the facility replacement has resulted in positive impacts, the CAH cost-based reimbursement is definitely key to the hospital's survival and success.

### ***Facility Design***

- ◆ 25-bed, 66,000 square foot facility.
- ◆ All private rooms.
- ◆ All single use rooms.
- ◆ Specialty clinics are part of the main hospital. Rural clinics are separate.
- ◆ Recommended Features
  - Private rooms.
  - Separate administrative areas from other hospital areas with firewalls. This allows these areas to be built under less stringent codes than the rest of the hospital and can save a significant amount of money. They can still be attached to the other areas and still easily accessible.
  - Have all outpatient service entry points clustered around the main lobby. This allows for minimal inconvenience for patients, keeps them from having to run all over the hospital for services (e.g. lab, x-ray).
- ◆ Design Cautions
  - Do not have the ER triage area located by the main lobby. Have a triage area located at the ER point of entry, not off the main lobby. This would keep the ER traffic out of the main lobby of the hospital.
  - Would have built more office space. Should add more than you think you will need. You will need more as you get busier because of the facility replacement.

### ***Key Decision Making Factors***

- ◆ Building was deteriorating and getting more expensive to maintain and operate.
- ◆ Impact quality of, and access to, care through new equipment and technology and increased efficiency.

**Demographics** (From U.S. Census Bureau)

<b>Demographics</b>	<b>Randolph County</b>	<b>Indiana</b>
Total Population – 2000	27,401	6,080,485
Population – Percent Change – 1990 to 2000	0.9%	9.7%
Persons Under 18 years old – 2000	25.2%	25.9%
Persons 65 years old and over – 2000	15.8%	12.4%
Female Persons – 2000	51.0%	51.0%
White Persons – 2000	98.1%	87.5%
Median Value of Owner-Occupied Housing Units – 2000	\$64,600	\$94,300
Median Household Income – 1999	\$34,544	\$41,567
Per Capita Money Income – 1999	\$16,954	\$20,397
Persons Below Poverty – 1999	11.1%	9.5%
Persons Per Square Mile	60.5%	169.5%

**Attachment 8**  
**Broaddus Hospital – Phillipi, West Virginia**  
**Information Summary**

**Broaddus Hospital – Phillipi, West Virginia**

***Facility Information***

- ◆ 12 beds support acute care patients requiring short stay hospitalizations
- ◆ Achieved CAH Designation: 1997
- ◆ Rebuilt as CAH: August, 2000

***Services Offered***

- ◆ Inpatient Services
  - Internal nutrition and nutrition assessments
  - Patient education and patient/family counseling
  - Intake/output monitoring
  - Physical therapy
  - Occupational therapy
  - Speech/swallowing therapy
- ◆ Emergency services
  - 24-hour emergency services
  - Emergency transportation services, including Health Net helicopters

***Financial Information***

- ◆ \$8 Million in total capital costs for the replacement project
- ◆ More than a decade ago, Broaddus Hospital was on the brink of bankruptcy. Turnaround is based on several factors:
  - 1991 Barbour County Healthcare Referendum provided the hospital a \$1.3 million tax levy
  - 1994 – Davis Memorial Hospital took over management
  - 1997 – Received Critical Access Designation
  - 1998 – Became part of the Davis Health System

***Facility Design***

- ◆ 45,000 Square Feet
  - ◆ 12 inpatient beds
  - ◆ 60 bed skilled nursing facility
  - ◆ 24 hour rural health clinic
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