

**OPTIONS FOR
LAGUNA HONDA HOSPITAL
WHITE PAPER**

**Mitchell H. Katz, M.D., Director
Department of Public Health
December 10, 1998**

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PRESENTED TO MAYOR WILLIE L. BROWN

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Executive Summary

This White Paper discusses the current situation at Laguna Honda Hospital and presents the options for rebuilding the institution.

Laguna Honda Hospital is a 1200 bed San Francisco county-run skilled nursing facility (SNF) in the Forest Hills neighborhood. Most Laguna Honda residents require intensive nursing assistance for the activities of daily living: eating, bathing, relieving themselves and dressing. The current average age of a Laguna Honda resident is 72.

The need for long-term care (both community-based and hospital-based) will grow over the next two decades. An estimated 6% of San Franciscans aged 18 – 64 and 23% of San Franciscans over the age of 65 have mobility problems or limitations in caring for themselves. This translates to approximately 57,000 lives in the year 2000. Some of these individuals can be cared for in their homes or in less intensive settings while others will require skilled nursing in institutions such as LHH. By the year 2000 there will be a shortage of 271 SNF beds in San Francisco. Estimates are that this shortage will increase to 2,380 beds by the year 2020 assuming that SNF beds continue to be used at the same rate (i.e., 33 SNF beds for every 1000 persons aged 65 and older). LHH is a critical component of San Francisco's long-term care delivery system.

Although LHH has a well-deserved reputation for providing excellent medical and nursing care, it has been criticized by federal regulators due to the limitations of its physical plant, specifically:

- the principal patient care buildings are 70 to 90 years old and have outlived their useful life,
- LHH's open ward configuration, which accommodates 30 patients in a single room, is not within current federal guidelines which call for housing no more than 4 patients in a single room,
- LHH does not conform to seismic safety standards for hospital construction and was not designed to withstand major earthquakes, and
- needed maintenance has been deferred or under-funded for several years.

The Department has explored several options to ensure that residents have access to needed skilled nursing services. The options are not mutually exclusive and include:

Options Considered

1. Decrease the number of residents (the census) at LHH.
2. Refurbish existing LHH to conform with 4 bed wards and dining/activity areas.
3. Utilize existing beds at acute care institutions.
4. Build several smaller facilities throughout the City.

5. Sell the land of LHH and locate the facility elsewhere in the City where property values are lower.
6. Sell or rent a portion of the land of LHH to obtain additional revenue.
7. Increase use of community-based long-term care options.
8. Place residents who need long-term care out of county.
9. City phases itself out of the institutional long-term care business.
10. Build a new Laguna Honda Hospital at the current Forest Hills site.
 - 10a. Build a 1200 bed replacement facility.
 - 10b. Build an 800 bed replacement facility.
11. Pursue State and Federal financing to help rebuild LHH.
12. Use Tobacco Settlement Funding to finance rebuilding of LHH.

The advantages and disadvantages of each option are assessed. As outlined in the briefing paper, many of these options are not advantageous because they might result in an unacceptable reduction in the number of skilled nursing beds or are more costly. Based on the projected need for institutional-based long-term care services and the Department's assessment of each option, the following recommendations are made:

Departmental Recommendations

1. Rebuild LHH on the existing Forest Hills site.
2. Delay seismic upgrade of administrative space until the next city-wide seismic upgrade bond – saving \$38 million from original LHH rebuild scenario.
3. Work collaboratively with City's Long Term Care Pilot Project Task Force to increase home and community-based long-term care services and decrease reliance on institutional placements.
4. Use Tobacco Settlement Funding to rebuild LHH.
5. Pursue Federal & State to help cover the rebuilding costs.
6. Begin to build a consensus on the right size for a new LHH, by arranging a series of input meetings with interested parties including elders and disabled persons, their advocates and service providers, union leaders, members of the business community, and civic leaders. Feedback will be brought to the Health Commission.

Options for Laguna Honda Hospital White Paper

Following the decision not to pursue a ballot measure on rebuilding Laguna Honda Hospital (LHH) for November 1998, we have a window of time to reconsider the various options for LHH.

The purpose of this document is to 1) review our current situation with regard to LHH, 2) consider all available options for LHH, and 3) critically review the pros and cons of different options.

The current situation of LHH

LHH is a 1200 bed San Francisco county-run skilled nursing facility (SNF) in the Forest Hills neighborhood. Although it has a well-deserved reputation for providing excellent medical and nursing care to indigent and working class residents of San Francisco, it has been under attack from Federal regulators, specifically the Health Care Financing Administration (HCFA) and the Department of Justice (DOJ) due to the limitations of its physical plant.

Physical Plant of LHH

Laguna Honda Hospital consists of a main building with various wings that house patient care wards and support services, several utility buildings and Clarendon Hall. The principal patient care buildings are 70 to 90 years old. They have outlived their useful lives and cannot cost-effectively accommodate modern health care technologies. Most buildings have not had major upgrades in the last 35 years, although almost all other health care institutions in the Bay Area have undergone several expansions and remodeling projects.

The Hospital's main building is designed with open wards which accommodate 30 patients in a single room. LHH is the last skilled nursing facility in the United States to operate open wards of this size. Current HCFA guidelines call for no more than 4 persons in a room. Thus, to continue the operation of LHH, the Department of Public Health requires a waiver from HCFA. This waiver can be revoked at any time. In the absence of the waiver, we would be unable to bill Medicaid and Medicare, resulting in the loss of \$91 million dollars and making it impossible to continue operation of LHH. HCFA surveyors have been extremely critical of the open ward design of LHH during the 1998 inspections. In their opinion, the open wards deny residents their rights to privacy and dignity. DOJ has also been critical of the large, open wards for failing to afford privacy and for being too noisy such that ill patients cannot get sufficient rest.

In addition to the open wards, there are other important ways that LHH is not in compliance with existing long-term care standards. These standards call for dining halls for residents. Given that most LHH residents are in wheel chairs, such dining halls need to be available on or near the ward where the resident resides. Because LHH was built as an acute care hospital, it was envisioned that residents would be eating at their beds. While there are several large rooms that could be used as dining halls at LHH, the amount of time necessary to move non-ambulatory residents to these large halls is prohibitive. The floor plan at LHH with its long distances between buildings and few elevators, which run slowly, all work against having sufficient staff to move residents to existing halls. HCFA has wanted us to further reduce the census at LHH so as to accommodate dining halls on the wards.

The HCFA surveyors have also criticized LHH for its lack of separate activity areas. This is closely related to the dining hall issues, as most SNF's are built with multipurpose rooms next to the wards that can be used for both dining and therapeutic activities.

Seismic issues at LHH

The main hospital building and Clarendon Hall were not designed to withstand earthquakes and do not conform to seismic safety standards for hospital construction.

The most recent reports on the structural integrity and seismic safety of LHH were produced in 1992 by the Department of Public Works (The Seismic Assessment of Various City Owned Buildings Report). The main hospital building and Clarendon Hall were assigned a seismic hazard rating of "3". A "3" rating is defined as major damage/poor performance – during a major earthquake (Appendix 1). The definition of a "3" rated building also includes "structural and non-structural damages are anticipated which would pose appreciable life hazards to occupants". The building has to be vacated during repairs or possibly cannot be repaired due to the extent and/or economic considerations.

The seismic assessment of the Laguna Honda Hospital patient care buildings describe significant structural deficiencies with sheer walls, roofs and flooring systems, sanitary and elevator towers, partitions made of hollow clay tiles and lack of bracing for ceilings, light fixtures and fire suppression systems.

During the Loma Prieta earthquake, Clarendon Hall sustained major damage in the south wing which required retrofitting for continued safe operation. The main building sustained cracked plaster walls and ceilings, cracked flooring tiles and windows.

Maintenance issues at LHH

The LHH facility shows signs of suffering from decades of deferred maintenance and under funding of maintenance. Laguna Honda has 11 buildings on campus totaling

785,000 square feet. The annual maintenance and repair budget is \$500,000 which is insufficient for a large aging facility with a stockpile of deferred maintenance items.

The Capital Improvement Advisory Committee (CIAC) has provided funding for the highest priority capital improvement projects at Laguna Honda. They currently include a \$1.9 million project for partial replacement of the original roof of the main building and \$356,000 for phase II of the fire safety system replacement. Both of these projects are essential in maintaining the facility adequately to retain licensure.

For the next 5 to 10 years there is a need for an additional \$10 to \$15 million to fund maintenance and repair as well as capital improvement projects for the existing building (6 year capital plan attached as Appendix 2). The required work includes completion of roof replacement and fire safety systems, interior and exterior painting, flooring replacement or repair, upgrades or replacement of elevators, upgrade to mechanical and electrical systems, ADA compliance, and a number of other projects.

The Department of Public Health has also intentionally deferred all major capital improvement projects except those that are essential to the life safety, health and comfort of residents with the intention of advancing the general obligation bond to replace the facility. Unless the facility is replaced an increasing portion of the deferred maintenance items must be funded.

Patient Population at LHH

Most Laguna Honda residents require intensive nursing assistance for the simplest activities of daily living: eating, bathing, relieving themselves (i.e. using the toilet) and dressing. As such, Laguna Honda Hospital is a critical component of San Francisco's long-term care delivery system.

The current average age of a Laguna Honda resident is 72. The average length of stay for individuals residing in the Hospital for less than one year is 75 days; for those remaining in the facility over one year the average length of stay is 5 years. Three-fourths (\$91.5 million) of the Hospital's annual reimbursement comes from Medi-Cal and Medicare which funds institutional long-term care. The remaining reimbursement (\$20 million) comes from private insurance, State Realignment and City and County General Fund.

LHH is a "distinct part" SNF. To be a distinct part SNF, a facility must have either a few acute care beds or operate under the license of an acute care facility.

As a distinct part SNF, LHH receives a higher daily rate from Medicaid (\$234.00) than free-standing SNFs, which receive approximately \$86.00 a day. In exchange for this higher rate, distinct part SNFs are meant to admit "heavy care" patients. These are patients who not only meet the minimum SNF criteria but also have other needs which complicate their care (e.g., substance abuse, mental illness, severe cognitive impairment, behavioral problems, neurological impairment).

The state requires that distinct part SNFs attempt to discharge new patients to lower cost free-standing SNFs during the first 25 days of the patient's placement at Laguna Honda (the Hudman Regulations). Since 1990, after thousands of calls, only one patient has been successfully placed at a free-standing SNF. The reason is that free-standing SNFs do not have sufficient resources to care for complicated patients. In fact, patients are often transferred from these free-standing SNFs to LHH when their care needs become too great to be met at a free-standing facility.

LHH is licensed for a maximum census of 1214 Distinct Part Skilled beds (total census of 1457 including acute care beds). It contains one-third of all skilled nursing beds in San Francisco. The maximum census in fiscal year 1997-98 was 1193. Of Laguna Honda Hospital's operational beds, the vast majority (1027) are devoted to long-term skilled nursing beds. The remainder are distributed as follows: 104 skilled nursing facility beds for hospice/AIDS care and Alzheimer's and related diseases; 20 beds for acute general medicine; 15 for acute rehabilitation.

The census is being gradually lowered from 1192 to approximately 1065 as part of a negotiated settlement with HCFA in order to reduce the occupancy of the open wards, and to create space for separate dining and activity areas. This reduction in census has had a negative impact on institutional long-term care placement in San Francisco. To achieve this reduction in census LHH is currently accepting admissions only from San Francisco General Hospital of patients who have been refused by all other institutions. Since July 1998, we have not been able to admit frail elders who are failing at home or patients from other acute care institutions who need the services of LHH.

Even at its full census, there was a waiting list for entry of patients into LHH. Availability of SNF beds is tight at all institutions in San Francisco. The average occupancy rate of SNF beds in San Francisco is 94%.

Finance issues at LHH

Ninety-five percent of LHH's resident days have Medicaid as their source of reimbursement. Medicaid pays \$234 dollars a day for LHH. The City's cost for LHH is approximately \$280 dollars a day. Thus the Department patches the Medicaid rate by \$46 dollars a day per resident.

Projections of need for long term care in San Francisco

The need for long term care in San Francisco will unquestionably increase in the next three decades. The aging of the "baby boom" generation will markedly increase the numbers of persons over the age of 65, the population most likely to need long term care. According to the State Department of Finance, San Francisco's 65 and over population is expected to increase from 116,080 in 2000 to 129,787 in 2010, and to 181,981 in 2020—

an increase of 57%. Similarly, San Francisco's population of persons 75 and over will increase from 59,523 in 2000 to 66,483 in 2010, and to 75,346 in 2020--an increase of 26%. Our population of persons 85 and over will increase from 17,718 in 2000 to 23,958 in 2010 to 26,832 in 2020--an increase of 50%.

Not all older persons will need long term care. Conversely, some persons under the age of 65 require long term care because of disabilities. The precise number of persons that will require long-term care in San Francisco is difficult to predict. One indicator of demand is the number of persons with mobility or self-care limitations. The U.S. Census Bureau estimates 6% of persons 18 to 64 and 22.9% of persons 65 and over have mobility or self-care limitations. These percentages can be used to project the future mobility or self-care limitations that will be experienced by younger and older adults in the City (Table 1).

TABLE 1
PROJECTIONS OF MOBILITY OR SELF CARE LIMITATIONS IN
SAN FRANCISCO

YEAR	Persons 18 to 64	Persons 18 to 64 with mobility or self-care limitations	Persons 65 & Over	Persons 65 & Over with mobility or self-care limitations	TOTAL
2000	506,588	30,395 (6.0%)	116,080	26,582 (22.9%)	56,977
2010	494,877	29,693 (6.0%)	129,787	29,721 (22.9%)	59,414
2020	464,962	27,898 (6.0%)	181,981	41,673 (22.9%)	69,571

Source: U.S. Census Bureau

The Demand for Skilled Nursing Facility (SNF) Beds

SNF beds, such as those provided by LHH, are only one component of long-term care. They are best reserved only for those people who cannot be supported by less institutional care. Persons who can be sustained in their homes or in less intensive settings (e.g., assisted living, service enriched housing, or residential care facilities) should be supported in those settings. Nonetheless, there is a group of individuals who can only be cared for humanely in an institutional setting such as LHH.

DPH recently assessed residents at LHH for the possibility that a sizable proportion could be discharged to a less institutional setting. Assessment teams included experts in community placements. The teams found that there are only approximately 100 residents at LHH who would be appropriate for a less institutional placement. Even for these 100 persons, many of the alternative community placements are not currently available (e.g., psychiatric board and care). It should be noted that the best time to arrange a community placement is prior to placement in a facility like LHH. Once patients are in an institution and have lost their home and/or their ability to cope in a less restrictive environment, community placement becomes significantly more difficult. Nonetheless, this assessment

indicates that the vast majority of residents at LHH need the level of care provided at a skilled nursing facility.

Currently, there are 3,625 SNF beds in San Francisco. Our SNF bed rate in 1995 (the most recent year for which we have calculated this index) was 33 Nursing Facility beds per 1,000 persons over age 65. If we were to continue to use SNF beds at the same rate and maintain LHH at its existing 1200 beds, Table 2, shows, that we will experience an acute and growing shortage of SNF beds in the coming years.

TABLE 2
PROJECTED SUPPLY AND DEMAND FOR SNF BEDS

YEAR	2000	2010	2020
Rate per 1000 persons 65 & older	33 SNF beds per 1000	33 SNF beds per 1000	33 SNF beds per 1000
Projected Demand For SNF Beds	3,831	4,282	6,005
Projected Supply	3,625	3,625	3,625
Shortage of Beds	- 271	- 657	- 2,380

However, it should be the goal of the Public Health Department to reduce our reliance on SNF beds. The State of Oregon which has very progressive policies on community placements, has a SNF bed rate of only 27 SNF beds per 1,000 persons over the age of 65 years. (For comparison, the State of Washington has a SNF bed rate of 45 beds per 1,000 persons over the age of 65). However, even if we are successful in decreasing the proportion of persons with long-term care needs who require SNF beds, the absolute numbers of persons who will need SNF beds will increase due to the aging of the population. This is shown in Table 3. By the year 2020, we will have a shortage of SNF beds of 1,288, even if we have reduced our use of ANF beds to only 27 SNF beds per 1000 persons 65 and older.

TABLE 3
PROJECTED SUPPLY AND DEMAND FOR SNF BEDS
(Based on Oregon's experience)

YEAR	2000	2010	2020
Rate per 1000 persons 65 & older	33 SNF beds per 1000	30 SNF beds per 1000	27 SNF beds per 1000
Projected Demand For SNF Beds	3,831	3,894	4,913
Projected Supply	3,625	3,625	3,625
Shortage of Beds	- 271	- 269	-1,288

Thus, the health care needs for San Francisco dictate an increase in SNF beds in the near future.

Available options for LHH

Below are a list of possible options available for LHH. Some of the options can be pursued jointly (e.g., increase the use of community-based alternatives, rebuild LHH, pursue SB 1732 revenue).

1. Decrease the number of residents (the census) at LHH.

This is the option that is being pursued by HCFA. HCFA staff is not confident that San Francisco will succeed in passing a bond measure. Regardless, they are aware that a new building will take seven years to build and they do not wish to wait for a new facility for us to improve the quality of life of LHH residents.

Unless the City is able to demonstrate that it will be rebuilding LHH, it is likely that HCFA will attempt to force the City to further reduce the size of LHH. Their goal would be to restrict us to a census that would increase the distance between the patient beds on the open ward to satisfy their concern regarding privacy. Markedly decreasing the census at LHH would enable us to provide dining halls and activity areas on the wards.

HCFA has the ability to deny the Public Health Department reimbursement for patient care at LHH. It is very unlikely that HCFA would completely terminate LHH's provider agreement because of the political and ethical ramifications. Moreover, if HCFA were to terminate our provider agreement they state would have to find alternate beds for our residents. Since this would be impossible, it is very unlikely that they will pursue this remedy. On the other hand, HCFA has threatened to cut-off payment for any new admissions. This is a credible threat. If they pursued this, they wouldn't be obligated to identify alternative beds for residents. They would be able to argue that they had not evicted anyone from Laguna.

Pros:

- 1) A decrease in census may satisfy HCFA & DOJ on this issue.
- 2) Would not require a general obligation bond for LHH.

Cons:

- 1) Would cause a severe shortage of SNF beds in San Francisco. Would likely result in acute care hospitals being unable to discharge patients who should be transferred to a more appropriate subacute setting. Would result in patients failing at home with no alternative placements available.
- 2) Although a substantial decrease in the LHH census would likely satisfy HCFA and DOJ on this issue, the LHH buildings cannot stand forever. We run the risk of spending large amounts of money to maintain facilities that have outlived their usefulness.

- 3) As we decrease the number of residents at LHH, the operating cost per resident will increase because of the fixed costs of running LHH.
- 4) Would result in a substantial reduction in revenue which could only be compensated through lay-offs or attrition of staff.

2. Refurbish existing LHH to conform with four bed wards with dining/activity areas.

A plan was considered in 1992 to perform an interior renovation of existing patient care wings. Essentially the open wards would be remodeled to 4 bed wards. Because this would be a less economical use of space, the census at LHH would need to be reduced to 720 beds. The cost was \$160 million dollars (when determined in 1992). However, our architects are doubtful that this option is still viable, given new retrofit standards. These standards call for verification of quality and type of steel framework, specific compression strength for concrete, and a variety of other code requirements.

Pros:

- 1) Would satisfy HCFA.
- 2) Would cost substantially less than a new building.

Cons:

- 1) Would cause a severe shortage of SNF beds in SF. Would likely result in acute care hospitals having to keep patients who should be transferred to a more appropriate subacute setting. Would result in patients failing at home with no alternative placements available.
- 2) LHH buildings cannot stand forever. We run the risk of spending a large sum for an interior renovation of facilities that have outlived their usefulness.
- 3) As we decrease the number of residents at LHH, the operating cost per resident increases because of the fixed costs of running LHH.
- 4) Would result in reduction in revenue of \$25-30 million which could only be compensated through lay-offs or attrition of staff.
- 5) Unclear if this option is still viable given new retrofit standards.

3. Utilize existing beds at acute care institutions.

Although there is insufficient acute care bed capacity in San Francisco to completely solve the need for SNF beds in San Francisco, this may be a viable option for a portion of our needs.

A 1997 study by The San Francisco Nursing Facility Bed Study, commissioned by the San Francisco Section of the West Bay Hospital Conference, estimated a total of 271 acute care beds available for potential conversion to SNF as of June 1996. These beds are listed below in Table 4.

TABLE 4
TOTAL ESTIMATED ACUTE BEDS AVAILABLE FOR CONVERSION TO SNF BEDS
JUNE, 1996

Hospital Name	
Chinese Hospital	None
California Pacific Medical Center	None
Kaiser Medical Center	None
Davies Medical Center	80 Beds
San Francisco General Hospital	None
Saint Francis Memorial Hospital	40 Beds
St. Luke's Hospital	40 Beds
St. Mary's Medical Center	32 Beds
UCSF Medical Center/Mount Zion	21 Beds
VA Medical Center	None
Pacific Coast Hospital	18 Beds
Seton Medical Center	36 Beds
TOTALS:	271 Beds

Although we have not formally resurveyed the hospitals, there is reason to believe that there are fewer beds available now than at the time this survey was conducted. Hospitals are running closer to capacity in 1998 than they were in June of 1996. Many hospitals have used existing space for research or physician offices. The largest congregation of beds for conversion was at Davies, which was recently purchased by CPMC. CPMC purchased Davies specifically because it needed more space for its operations.

There are two potential models for using existing acute care beds. The facilities could administer the beds themselves (i.e., hire labor, develop programs) or the Public Health Department could lease the space and staff the beds with city employees, purchasing only "hotel" services (dietary, housekeeping, laundry, supplies).

In terms of the facilities administering the beds themselves, any of these acute care facilities who wished to open SNF beds could have chosen to do so. They would have been able to bill Medicaid at the same distinct part SNF rate of \$234 that the City receives. These facilities have not pursued using their empty beds in this way because they cannot meet their expenses at this rate. Acute care hospitals typically bill private insurers between \$1200-\$1500 a day for their acute care beds (Medicaid rates are lower), so a rate of \$234 is unattractive.

If the City were willing to provide a patch to the Medicaid rate it is likely that other hospitals would become interested in delivering this service, depending on how large the patch is. However, it is unlikely that the existing patch (approximately \$46.00) that the City pays to make up the difference between Medicaid reimbursement and the cost of doing business at LHH would be sufficient.

We have approached several San Francisco hospitals about the possibility of utilizing empty beds at their facility. One San Francisco hospital estimated that its cost of administering SNF beds is approximately \$295.00 dollars a day. Thus they would require a Medicaid patch of \$61 dollars, rather than the current \$46 dollar patch we are using for LHH.

Providing a patch for non-profit hospitals may violate existing City MOU agreements with some of its unions, which have clauses prohibiting contracting out with existing general fund dollars.

Of the \$295 cost per day estimated by this hospital, approximately \$100 dollars represents their cost of “hotel” services. If the hospital were willing to allow us to rent wards within their facility, we could maintain our existing work force (hospital within a hospital model). However, we would incur additional expense. Because of the economies of scale at LHH, we would save very little per person at LHH for each resident relocated to St. Lukes or another facility. While the exact amount that would be saved is difficult to calculate we know it would be markedly less than \$100 per day. Thus, we would need additional revenue to pursue this option. Purchasing only the “hotel” services would likely not violate any City MOU agreements with labor unions.

Assuming that we can identify a group of beds for conversion at acute care hospitals and cover the additional operating costs, we still face the challenge of covering construction costs. The standards for acute care beds are different from the standards for SNF beds. Thus, there are construction costs in converting from acute care to SNF beds. For example, acute care wards generally do not have dining areas on ward, a requirement for SNF beds. When San Francisco General Hospital converted one ward from acute care to SNF, the cost was \$400,000 for converting 30 beds.

Pros:

- 1) Purchasing hotel services (hospital in a hospital model) may be a viable option for obtaining a portion of the needed SNF beds.

Cons:

- 1) Construction costs may be prohibitive. Also, unless the facility can guarantee the City a long lease, it would be unwise to invest City funds in construction of non-city owned facilities.
- 2) Operating costs would be significantly higher because of the loss of economies of scale of running 1200 beds at LHH.
- 3) Would still require rebuilding of LHH, albeit at a smaller size.
- 4) Patching Medicaid rates to use a contractual staffing model may violate existing City MOU agreements with some of its Unions.

4. Build several smaller facilities throughout the City.

There is no question that the trend for long term care is away from single site institutions. Thus, it would be sensible to consider building multiple facilities (for example, building

six two hundred bed institutions throughout the county. This option could allow for residents to be cared for in a setting closer to their own community.

While these are strong programmatic reasons for building several smaller facilities, this option is markedly more expensive. The 1994 Bond report projected the cost of building 12 ninety-nine bed institutions (with location of one facility on the existing site of LHH and including land purchase for the other facilities) was \$653 million dollars in 1994 dollars (compared to \$482 million in 1994 dollars for building a single 1200 bed facility).

The City would also face difficulties in identifying available land for construction. The operating costs of running several smaller facilities would be greater. Finally, it is unclear whether the State would be willing to grant us the higher distinct part SNF rate for 6-12 facilities, each of which may have to maintain some acute beds to qualify for the distinct part SNF rate.

Pros:

- 1) Several community-sited facilities is a better programmatic model.
- 2) There would probably be greater support for this option in the community than building a single site facility.

Cons:

- 1) Markedly higher constructions cost than building one single site. City may also face obstacles identifying land for the facilities.
- 2) Higher operating costs.
- 3) May not be able to qualify each of the facilities for distinct part SNF rates, thus reducing revenue.

5. Sell the land of LHH and locate the facility elsewhere in the City where property values are lower.

LHH sits on a 62 acre parcel in a very desirable residential area of Forest Hills. This raises the question of whether the land could be sold and the revenue used to locate LHH in another area in San Francisco where property values are lower.

In considering the value of LHH land, it is important to note that 50% of the site is zoned as a “greenbelt” and therefore cannot be developed without a zoning variance. Applications for variances to greenbelts have experienced strong opposition from environmental groups and surrounding neighbors.

Assuming that no zoning variance is requested or granted, City Planning staff projected that approximately 400 to 500 units could be built on 50% of the LHH parcel. City Planning estimated that the value of the land assuming no variance was \$20-\$30 million in 1994 dollars.

Although there are areas of the City where property values are lower, this option would result in significant delays in rebuilding LHH. A new site would need to be identified, we

would need to obtain planning approval, develop environmental impact reports, conduct hazardous material abatement, etc. The delay is problematic for two reasons. It would be harder to hold State and Federal regulators at bay, if we are adding two years to the timing of a new building. Also, the construction costs for a new LHH are very sensitive to cost escalations (i.e. inflation) due to delays in building the project. One idea which has been advanced by the architect, Derek Parker, is to relocate the new facilities on top of City owned parking garages. This would save the dollars incurred by having to purchase new land. It is unknown, however, if the existing structures are seismically strong enough to build on and still meet the SNF standards.

Pros:

- 1) Selling the land and acquiring a new site for LHH in a neighborhood with lower property values could potentially provide a revenue source for the project. If we prevailed on City Planning to remove the greenbelt determination, the value of the LHH land would be even higher.

Cons:

- 1) Identifying a new site and obtaining the necessary approvals to rebuild LHH could result in significant delays to the project
- 2) There would likely be significant neighborhood opposition to selling the LHH land and allowing 400 to 500 units to be developed on the site. Neighborhood opposition would undoubtedly increase if we propose removing the greenbelt designation and building a larger number of units.

6. Sell or rent a portion of the land of LHH to obtain additional revenue.

One option, closely related to option 5, is to rebuild LHH at its current site but sell or rent the remaining land. However, with the greenbelt designation, very little land would be available for sale or rent if we rebuilt LHH at the site. The acreage which currently houses Clarendon Hall would be available and could be sold. Potentially, the land of Clarendon Hall could be sold or rented for the sake of providing market rate senior housing or assisted living. This could provide a potential revenue source of LHH. However, at best the available land at LHH could only generate a small portion of the total cost of rebuilding LHH. As discussed in option 5, if we were to pursue revoking the greenbelt designation of LHH, this would increase available land, but at the cost of generating significant neighborhood and environmental opposition.

Pros:

- 1) Source of revenue to offset cost of rebuilding LHH.

Cons:

- 1) Any large sale or rent of LHH land would likely yield strong neighborhood and environmental opposition.
- 2) Small amount of land would be available for sale and level of revenue from selling land would be marginal unless greenbelt designation is removed.

7. Increase use of community-based long-term care options.

Many persons who need long-term care can be maintained in their homes or in a less institutional setting than LHH. Alternatives to institutionalization include home care, assisted living, board and care, psychiatric board and care, adult day health care, full-continuum program of all-inclusive care for the elderly (PACE model, such as On Lok). Persons who can stay in the community generally prefer to do so. This is especially true of younger disabled persons. Our ability to provide sufficient supports for persons to stay in their homes or community settings depends on available resources as well as creativity in using these resources.

One limitation to community placements has traditionally been the lack of sufficient State and Federal reimbursements for this type of service. For example, Medicaid will pay LHH for a person with skilled nursing needs, but will usually deny paying for a sufficient number of home care hours to allow the person to stay at home. A second problem has been the reluctance of Medicaid to pay for housing, even though loss of housing or lack of handicapped accessible housing often leads to institutionalization (e.g., an elder living at home has a stroke, lives in a third floor walkup without an elevator and, therefore, requires admission to LHH).

It has been suggested by community-based providers that there might be a substantial number of LHH residents who could be cared for at a less institutional facility than LHH. To answer this question, the Department comprehensively evaluated over 700 of the highest functioning residents of LHH. The evaluation team included community-based service providers, so as to broadly consider alternative options for LHH residents. Less than 100 residents were considered candidates for discharge. Among these, the largest group (35) were further assessed to be at the appropriate level of care. Other residents (25) were felt to be candidates for a PACE model. However, none of the residents for whom this was an option wished this placement. Another group of residents (35) were felt to be candidates for medical or psychiatric board and care facilities, which are in extremely short supply. At the conclusion of this process, of all of the patients evaluated, only five were discharged. One important limitation of this evaluation was that the best time for community placement is prior to individuals spending substantial time in a long-term care institution. Once residents have lost their home, community ties and survival skills for living independently, alternative placement is substantially more difficult. Residents at LHH are now and will continue to be assessed for their appropriate level of care prior to and after admission.

To address the need for more community-based long-term care options, San Francisco has been actively planning a Long-term Care Integration Pilot Project as envisioned by AB 1040, signed into law in 1995. The Pilot Project is intended to provide counties with greater flexibility in the design and financing of long-term care services so as to facilitate a greater emphasis on in-home and community-based program models. AB 1040 is based on the assumption that there is a portion of the population currently utilizing institutional long-term care services (such as skilled nursing facilities) that could be cared for in less intensive, non-institutional settings. For some percentage of this population, restrictions

associated with Medi-Cal reimbursement requirements have been identified as obstacles in providing care in these alternative settings. Through AB 1040, San Francisco is seeking waivers so that it may be reimbursed for providing care to some Medi-Cal recipients in non-institutional settings. The Public Health Department is the lead agency for 1040 planning. The members of the Long-Term Care Pilot Project Task Force were appointed by the Board of Supervisors and the Mayor.

San Francisco's long-term care integration plan will improve access to home and community-based long-term care services while simultaneously maintaining access to skilled nursing facilities. Under the plan, persons who need long-term care services will select from a network of providers to receive services. The provider network will be responsible for making sure that clients receive case management, long-term care and acute care services. Under the dictates of AB 1040, San Francisco will designate (or create) a long-term care agency to oversee this new long-term care delivery system. In addition to proposing a new service delivery model, the long-term care integration plan also defines the continuum of home, community and institutional services needed for this population. The success of this plan is dependent upon the availability of supportive housing to keep long-term care consumers in their communities for as long as appropriate. As envisioned, San Francisco will create a capitated managed care system for long-term care services. The Task Force believes that the proposed model will resolve long-standing deficiencies and overlaps in the current long-term care system. The Task Force anticipates that it will take six (6) years to implement this plan.

While the AB 1040 planning shows great promise of creating alternatives to institutionalization, it is clear that there will always be a need for SNF beds. The question is how far can we reduce the need for institutional placements.

In 1995, our use of SNF beds was 33 beds per 1000 persons over the age of 65. If we rebuild Laguna Honda to its current size (1,200 beds) and maintain the same number of total SNF beds in San Francisco (3,625) our use of SNF beds in San Francisco will markedly decrease as the population ages as shown in Table 5.

**TABLE 5
NUMBER OF SNF BEDS IN SAN FRANCISCO
BASED ON LHH BED CAPACITY**

YEAR	PERSONS 65 OR OVER	NO. OF SNF BEDS PER 1000 PERSONS ASSUMING A 1200 BED LHH (3,625 SNF BEDS CITYWIDE)	NO. OF SNF BEDS PER 1000 PERSONS ASSUMING AN 800 BED LHH (3,625 SNF BEDS CITYWIDE)
1995	109,848	33	29
2000	116,080	32	28
2010	129,787	28	25
2020	181,981	20	18

Column 4 shows what our use of SNF beds would be if we lowered our SNF beds at LHH to only 800 beds (for a total of 3,225 beds in San Francisco). It seems unlikely that San Francisco can decrease our SNF bed use from 33 beds per 1000 to only 18 beds per 1000 in the next 20 year period.

Although the data convincingly show the need for SNF beds in the future, it is certainly true that funding for long-term care is scarce. While San Francisco currently has almost enough SNF beds, we are woefully under capacity for community alternatives. Thus, one could consider reprioritizing our resources such that in the future we would be under capacity for SNF beds and have sufficient capacity for community placements. One advantage of this strategy is that since community placements may be cheaper, a reprioritization may result in serving more people.

In the AB 1040 process, one of the major concerns has been that rebuilding all 1200 beds at LHH will deplete all of the City's resources for long-term care. The concern is fueled by the fact that Medicaid rates for SNF's have been frozen for many years. Since the City's costs increase every year, the lack of increase of reimbursement means that the City's contribution to LHH increases every year. Alternatively, if the City were to rebuild only 800 beds, community advocates hope the operating funds (both Medicaid and local funds) for running the additional 400 beds would be used for community placements.

On the other hand, the Public Health Department has traditionally prioritized those at greatest need when funding is scarce. The residents of LHH are the most vulnerable of the population needing long-term care (e.g., those with substance abuse, mental illness, or severe cognitive impairment). Failing to provide for them could lead to unnecessary emergency room visits, unnecessary acute hospital stays, unnecessarily prolonged hospital stays (because of an inability to discharge patients) and an increased number of severely impaired persons living on the streets, in shelters and single room occupancy hotels. When hospitals cannot discharge patients to SNFs, they are unable to admit new patients, resulting in a dangerous shortage of acute care beds. The City also receives markedly less reimbursement when a Medicaid patient who can be discharged is left in an acute hospital bed (@ \$234 a day) compared to the reimbursement for an acute patient (@ \$800 a day for Medicaid; higher for Medicare or private insurance).

In this regard it is important to note that whereas LHH is a more restrictive environment than home care or assisted living, it is a less restrictive environment than acute hospitals, which have no activities, no social dining, etc. Thus it is important to recognize the unique role of LHH in providing rehabilitative and convalescent services.

Pros:

- 1) Community-based alternatives are overwhelmingly preferred by persons who can thrive in non-institutional settings.
- 2) Community-based alternatives may be less expensive and thus a larger number of persons may be served for the same amount of money.

Cons:

- 1) Community-based alternatives are not as successful for the most vulnerably ill persons with long-term care needs.

8. Place residents who need long-term care out of county.

Because of the high property values in San Francisco, it is less profitable to build SNF beds within the City than outside the City. However, the number of SNF beds available even outside our county is small.

Medical Social Services at San Francisco General Hospital does a daily computerized search for SNF beds in the 9 bay area counties (Alameda, Contra Costa, Santa Clara, San Mateo, Napa, Sonoma, San Francisco, Solano, Marin) through the PRN system. It searches 166 SNF facilities.

On 9/3/98, 110 SNFs had a total of 279 beds available. When queried on availability of MediCal beds the number was reduced to 49 facilities with 62 beds. When queried on availability of MediCal beds for patients with behavioral problems there were no beds available.

San Francisco General Hospital was trying to place 19 patients on 9/3/98. The system matches beds to patients' medical, psychiatric, behavioral and financial criteria. For these 19 patients, the system came up with the following:

- 7 patients did not match and could not be placed in any of the facilities.
- 12 patients could be evaluated for 11 available slots.

A follow-up of these 12 patients, one week later, revealed:

- 2 were admitted to LHH.
- 2 became medically unstable and are still at SFGH.
- 1 improved and was discharged home.
- 1 was discharged to an AIDS residence.
- 1 was discharged to a free-standing nursing home in San Francisco.
- 5 were awaiting beds to become available in a SNF or other facility.

Overall the City cannot depend on facilities in other counties to house many potential LHH residents.

Pros:

- 1) To the extent that beds are available, we can place San Francisco residents who need long-term care outside of county at no cost to the City.

Cons:

- 1) Few beds are available.

- 2) The goal of maintaining family involvement is hampered when long-term care residents are placed in SNF out-of-county placements.

9. City phases itself out of the institutional long-term care business.

Although San Francisco has a proud tradition of providing long-term care, not all counties provide institutional long-term care. Therefore, it is worth asking whether the county should continue running an institution like Laguna Honda Hospital (LHH).

In counties of California that do not have SNFs like LHH, patients needing institutional care are provided for at free standing SNFs or at acute hospital based distinct-part SNFs.

As discussed in Option 3, other acute hospitals in San Francisco could have developed distinct part SNFs and received the same level of reimbursement as the Department of Public Health does. However, hospitals have not pursued this option because Medicaid revenues do not adequately reimburse the costs of institutional care given the cost of doing business in San Francisco.

It is possible that if the City were willing to provide a patch to Medicaid rates other institutions would become interested. However, as was discussed in Option 3, there are few acute beds available for transition to SNF care. It is unlikely non-profit hospitals would be interested in building new facilities for the City unless the City would guarantee multi-year operating costs. Generally, the City does not guarantee operating costs beyond a single fiscal year. A private developer unassociated with a hospital would be unable to bill Medicaid at a distinct-part SNF level, and would therefore receive only about \$90 per resident day. A private developer would also likely want the City to make a long-term commitment to providing an operating subsidy.

It should also be noted that contracting out long-term care services would be a violation of some of our existing labor MOUs.

San Francisco's need for a SNF facility like LHH is also greater than that of other counties. San Francisco has on average an older population than that of other California counties. San Francisco also has a larger population affected by substance abuse, mental illness, and homelessness. When persons with these problems develop medical illness they cannot usually be handled by free-standing SNF and instead require a facility like LHH.

For these reasons, the Department does not recommend this option.

Pros:

- 1) Would take advantage of the ingenuity of private non-profit providers and private developers.

Cons:

- 1) Would require a City patch to Medicaid rates.

- 2) Unlikely that non-profit hospitals or private developers would be willing to invest in building new facilities unless the City guaranteed multi-year subsidies.
- 3) Would violate some of the City's MOU agreements with labor.

10. Build a new Laguna Honda Hospital at the current Forest Hills site.

Thus far, we have primarily explored two options for rebuilding LHH: a 1200 and an 800 bed replacement facility. These options are discussed individually.

10a. Build a 1200 bed replacement facility.

LHH is currently licensed at 1457 beds, including 1214 Distinct-part SNF beds. Our peak census in 1997-98 fiscal year was 1193. As of November 1, 1998 we are at a census of 1080, due to the moratorium we instituted as a compromise with HCFA. The current moratorium has created hardship for individuals who have not been able to enter LHH (e.g., seniors failing at home). The moratorium has also created problems for acute care hospitals who have had patients for whom they have had no site of discharge.

The projections for long term care in San Francisco discussed above indicate that San Francisco is likely to experience increased demand for SNF beds in the next twenty years. Even assuming we fully rebuild the 1200 beds at LHH we are still likely to experience a shortage in SNF beds.

The bond measure for LHH that was proposed for November 1998 was to cost a total of \$503 million. If this same plan were to go forward in a June 1999 ballot, the cost would be \$529 million because of cost escalation (i.e., inflation) and because there would be a delay due not being able to start excavation in winter (Appendix 3, Option A).

The Department of Public Health has worked with the Bureau of Architecture to decrease the total cost of the program. We have developed two recommendations to decrease the cost of rebuilding the 1200 bed facility from \$529 million to \$434 million: delay seismic upgrade of the administrative space and involve a private developer in demolishing Clarendon Hall and building elder housing or assisted living (Appendix 3, Option B).

We are not required by Federal or State regulations to seismically upgrade the administrative space of LHH. While ultimately this upgrade needs to be performed, we could delay the upgrade until the City pursues a bond measure for seismic upgrading of other City buildings. This would save \$38 million.

In the bond plan for November 1998 we envisioned the City renovating Clarendon Hall. However, it would likely be more cost effective to engage a private developer to demolish and rebuild or renovate the existing facility. This would save \$56 million.

At a total cost of \$434 million, the cost per bed is \$362K. However, to make comparisons with the construction costs at other facilities, the Bureau of Architecture has developed unit costs per square foot. This allows for "apples-to-apples" comparisons. As shown in

Appendix 4, the range of costs per square foot was \$250-\$276. The cost per square foot for the \$503 million LHH rebuild proposed for November 1998 was \$261.00. This clearly falls within the established range. We have not yet recalculated the costs per square footage for this less expensive 1200 bed facility, but we are certain it will fall within the same range.

As the last decade of planning for rebuilding LHH has shown, it is extremely difficult to plan and finance building a facility like LHH. We will likely have only one shot at rebuilding LHH. Whatever facility we choose will have to meet our needs for the next 60 years.

Operating costs must also be figured in to our decision on how large a LHH facility to build. In recent years the size of the gap between Medicaid reimbursement and our expenses, which is the cost to the City General Fund, has grown. The reason the gap has grown is that our expenses have increased both due to inflation and increased staffing requirements of HCFA, while Medicaid reimbursement rates have been flat for five years. This trend is likely to continue.

In this fiscal year LHH is projecting a new \$7 million revenue shortfall. The revenue is decreased because of the moratorium on new admissions. We cannot decrease our staff to compensate for the smaller number of patients because HCFA requires that we provide increased supervision of residents, increased social activities (necessitating hiring additional activity therapists) and social dining experiences for all our residents. Social dining is very labor intensive because it requires getting patients out of bed, transporting them to the dining areas several times a day and then back to their beds or activity areas. Whereas our expenses are increasing, prospects of an increase in reimbursements are not good. The State of California, as well as the Federal government are looking for ways to decrease Medicaid expenses.

Pros:

- 1) The projections show that San Francisco will need at least 1200 NF beds at LHH.
- 2) Because there are fixed capital costs in building a new LHH (e.g., power plant, excavation of site), the cost per bed for 1200 beds is less (\$362K) than if we build 800 beds (\$474K).

Cons:

- 1) The capital costs of building 1200 beds is high (434 million).
- 2) Maintenance of the 1200 beds at LHH would mean that there would be fewer operating dollars that could be used for community-based alternatives.
- 3) If current trends continue, LHH will need steadily increasing general fund to meet its expenses.

10b. Build an 800 bed replacement facility.

Although there is nothing magic about the number 800, we have used this figure in projecting the implications of building a smaller LHH. An 800 bed facility would cost \$379 million dollars (Appendix 3, Option C). The cost per bed (including all costs) would be \$473K.

Pros:

- 1) The capital costs of constructing an 800 bed facility are significantly lower than for a 1200 bed facility.
- 2) A decrease in the number of LHH beds would increase the amount of money that could be used for non-institutional community placements (e.g., assisted living which formerly were used for institutional care for alternative community programs
- 3) A decrease in the number of LHH beds would decrease the funding needed from the general fund.

Cons:

- 1) An 800 bed facility would not meet the City's needs for SNF beds over the next two decades.
- 2) The cost per bed is higher with an 800 bed facility because of the fixed costs of construction.

11. Pursue State and Federal financing to help rebuild LHH.

We believe it may be possible to obtain State or Federal funding to help rebuild LHH. For example, SB 1732 (Welfare and Institutions Code 14085.5) allows disproportionate share hospitals to finance all or a portion of their capital projects with federal disproportionate share funds (DSH). The funds are above and beyond DSH dollars that the hospital would receive for clinical care. The Department used SB 1732 to finance a portion of the garage for San Francisco General Hospital.

Several counties have used SB 1732 to fund hospital construction (i.e., Contra Costa, Alameda, San Joaquin, San Mateo, etc.) The legislation indicates that the projects coming under SB 1732 must have been approved by the State prior to June 30, 1994. Nonetheless, it is possible to petition the State Legislature to reopen SB 1732.

SB 1732 funding is only available to DSH hospitals. LHH is not a DSH hospital because of the small number of acute care days at LHH. SFGH is a DSH hospital. Therefore, we would need to apply on behalf of SFGH to build a new SNF that would operate under the license of SFGH. We would demonstrate the need for SFGH to build such a facility by explaining that LHH would be closing when construction is complete for the new facility.

The mechanism of reimbursement for DSH would be for the county to float a revenue bond to pay for the construction of the facility. SB 1732 then can be used to pay up to the percentage of the amortized rate (over the 30 year period of the bond) equal to the percentage of Medicaid clients in the institution. At the current time, over 60% of the clients of SFGH have Medicaid. In addition, we are working with the San Francisco

delegation to determine if a specific State appropriation can be made to assist in rebuilding LHH.

Also, Senator Feinstein and Congresswoman Pelosi were successful in adding language to 1999 omnibus appropriation agreement asking the Federal Department of Health and Human Services to assist San Francisco in finding funds to rebuild LHH>.

Pros:

- 1) Provides a potential additional revenue source for rebuilding LHH.

Cons:

- 1) SB 1732 has expired and State legislative action will be required to allow the City to use this option.
- 2) It may be difficult to obtain a specific appropriation for San Francisco.

12. Use Tobacco Settlement Funding to finance rebuilding LHH.

A settlement between the tobacco companies and the State Attorneys General will bring substantial funding to San Francisco. San Francisco was the first local government to sue the tobacco companies. Because of this, our City Attorney, Louise Renne successfully negotiated for the State of California to share the proceeds of the Brown settlement with local counties. One purpose of the suit was for State and local Health Departments to recoup the cost of health care provided to persons suffering ill health due to tobacco consumption. Recognizing this purpose and the tremendous need to rebuild LHH, City Attorney Renne recommended to Mayor Brown that the settlement be used towards rebuilding LHH. He has agreed to this proposal and with the support of the Board of Supervisors, the funding could be used for this purpose.

The funding itself has no restrictions. It will be a yearly payment to the City commencing in the year 2000. Because the amount of the yearly payment is keyed to tobacco sales as well as inflation, we do not know the exact amount of the payment. Currently the tobacco industry projects that tobacco sales will decline by 3%. However, the settlement also provides for increased payments annually by the CPI or 3%, whichever is greater. These assumptions would yield an approximate payment of \$20-22 million per year in 1999 dollars (appendix 5). However, if tobacco sales decline further due to the increased cost of cigarettes (the tobacco companies are increasing the price of cigarettes to pay for the settlement) the size of the award will shrink. We are currently attempting to estimate the correct asset value of the settlement.

PUBLIC HEALTH DEPARTMENT RECOMMENDATIONS:

1. Rebuild LHH on the existing Forest Hills site.
2. Delay seismic upgrade of administrative space until the next city-wide seismic upgrade bond – saving \$38 million from original LHH rebuild scenario.

3. Work collaboratively with City's Long Term Care Pilot Project Task Force to increase home and community-based long-term care services and decrease reliance on institutional placements.
4. Use Tobacco Settlement Funding to rebuild LHH.
5. Pursue Federal & State to help cover the the rebuilding costs.
6. Begin to build a consensus on the right size for a new LHH, by arranging a series of input meetings with interested parties including elders and disabled persons, their advocates and service providers, union leaders, members of the business community, and civic leaders. Feedback will be brought to the Health Commission.

APPENDIX 3

COST OF VARIOUS OPTIONS FOR REBUILDING LAGUNA HONDA HOSPITAL**OPTION A**

**(As proposed for November, 1998 Bond Measure & updated to reflect delay in implementation)
1200 BEDS, CLARENDON HALL & ADMINISTRATION RETROFIT**

1. Demolish power plant and build new Central Plant/Laundry	\$ 37,204,859
2. New 1200 bed hospital & support services	347,346,568
3. Renovate 160 bed Clarendon Hall	56,164,000
4. Seismically upgrade office space in Former hospital	46,248,231
5. Abate & demolish former hospital wards site work	<u>37,058,050</u>
	\$ 524,021,708
 Estimate public financing at 1%	 <u>5,240,217</u>
	\$ 529,261,295

OPTION B

**1200 BEDS, NO RETROFIT OF CLARENDON HALL, UPGRADE ONLY ELECTRICAL
SYSTEMS AND COMPUTER HOOK-UPS OF ADMINISTRATION BUILDING**

1. Demolish power plant and build new Central Plant/Laundry	\$ 37,204,859
2. New 1200 bed hospital & support services	347,346,568
3. Upgrade of Administration area	7,882,875
4. Abate & demolish former hospital wards site work	<u>37,058,050</u>
	\$429,492,352
 Estimate public financing at 1%	 <u>4,294,924</u>
	\$ 433,787,276

OPTION C
800 BEDS, REST IS SAME AS OPTION B

1. Demolish power plant and build new Central Plant/Laundry	\$ 37,204,859
2. New 800 bed hospital & support services	293,356,732
3. Upgrade of Administration area	7,882,875
4. Abate & demolish former hospital wards site work	<u>37,058,050</u>
	\$ 375,502,516
Estimate public financing at 1%	<u>3,755,025</u>
	\$ 379,257,541

Each element includes associated soft cost and escalation to midpoint of construction (4.5% per year). Costs are broad estimates and included as an order of magnitude comparison with other options only.

APPENDIX 2

**COMMUNITY HEALTH NETWORK
LAGUNA HONDA HOSPITAL**

**FY 98-99 CAPITAL IMPROVEMENT REQUESTS
(Includes all 6 Year Capital Plan Projects)**

	Project	*Estimated Costs	
		<u>Subtotal</u>	<u>Total</u>
1.	Replace Roof on Main Hospital Bldgs Phase I – Patient Service Wings Phase I – Support Service Wings Project Total:	\$ 1,901,325 1,279,129	\$ 3,180,454
2.	Replace Fire Safety System (HCFA Waiver) Phase I – Infrastructure Phase II – System Installation Phase III – System Installation Project Total:	\$ 356,425 1,049,452 992,684	\$ 2,398,561
3.	Miscellaneous Facilities Maintenance		950,000
4.	Interior Renovations in Patient wards (6) (DOJ Issue)		600,000
5.	Upgrade Existing Telephone Switch		500,000
6.	ADA Toilet for Adult Day Health Center		100,000
7.	Resident Smoking Pavilions		275,000
8.	Replace Kitchen Waste Lines		110,000
9.	Patient Ward Interior Painting		190,000
10.	Patient Ward Flooring Replacement		65,000
11.	Main Building Elevator Repairs		522,500
12.	Adult Day Care Renovation		125,000
13.	Remodel & Equip Radiology Department		450,000
14.	Exterior Repair & Painting of Main Building (Phase I) (Total for this project is \$3,715,000)		575,000
15.	Misc. ADA Improvements to Main Building		100,000
16.	Clarendon Hall Window Sash Repair & Painting		225,000
17.	Clarendon Hall Ward Flooring		760,000
18.	Patient Tubs/Shower Installation		125,000
19.	Woodside Access Road Expansion		100,000
20.	Exterior Preservation – Service Buildings		140,000
21.	Resurfacing Campus Roadways		300,000
22.	Patient Activity Center Remodeling		400,000
	Total:		\$12,191,515

* To be verified/updated by DPW