

PROJECT I SUMMARY

In 2000, 83% of the District voters approved a \$5.5 million hospital general obligation bond, Measure I, for new construction and related plant equipment for the hospital.

This general obligation bond was needed because additional space was needed to house services and medical procedures that have been added since the hospital was built in 1971. Also there were many elements of depreciated infrastructure that did not meet code, that were unsafe or that simply did not meet the requirements for which they were designed. This work was badly needed to update the 34-year-old building and its systems.

The existing acute care hospital was built in 1971. Added requirements for space crowded it to the absolute limit. Since 1971 the hospital has changed from a primarily in-patient service provider to a primarily outpatient service provider. Since 1971 new services have been added such as cardiology, computerized tomography, nuclear medicine, physical therapy, audiology, speech therapy, chemotherapy, outpatient surgery, information technology, and others. Other ongoing services such as emergency room, laboratory, pharmacy, radiology, medical records, finance and billing, have all increased tremendously in activity and requirements for space. All of those services, and others, have been crowded into a building that was designed for 1971 medical knowledge, 1971 medical procedures and technology, 1971 patient volume, 1971 staffing requirements, and 1971 government regulatory requirements. In addition to the strictly medical reasons for need of space need for additional office space and required the rental of off-site office space for all of the financial services, Home Health and Hospices that was both costly and operationally inefficient. Off-site storage space for storage of necessary equipment and records was both inefficient and problematic.

After approval of the bond measure, the Board of Directors formed an ad-hoc committee, the Project I Oversight Committee. This committee, composed of community members, board members, and management staff, was charged with monitoring the progress of the work as recommended by the Planning Committee and approved by the Board of Directors. The primary charge of the Oversight Committee was to assure that the bond funds were being appropriately used for capital expenditures and not for operating expenses. The Project I Oversight Committee has met on the second Tuesday of each month in meetings open to the public and appropriately posted. Occasionally a meeting would not be held because there were no significant changes in scheduled activity that needed to be reviewed. Regular reports were made to the public at the board meeting following the Project I meetings.

To fully understand how this project has developed, it is important to know how a public entity project like Project I is put together and what the obligations are in its execution. It may be helpful to illustrate the course of events in the development of a government involved project like this.

First—as in the case of Project I—there were lengthy discussions by employees, managers, and the Planning Committee of what the problems and needs were and what could be done to resolve them. When the rough scope of the project was determined, a recommendation was made to the Board of Directors for the next step.

Second, after the scope of the project was understood and Board approval was received, an architectural and engineering firm was contacted to develop a preliminary plan for addressing the issues identified. This required a nominal use of funds provided by the operating budget of the hospital.

The firm was carefully chosen, based on the best information available, as one that understood the unique and demanding requirements of healthcare facilities. That firm reviewed the needs, interviewed hospital personnel, developed preliminary rough drawings and estimated potential costs based on the known marketplace, the scope of work to be done, and potential timing.

At that time, the full and exact scope of the work needed, the cost of detailed drawings, the pricing of replacement equipment, and the timelines that were needed for the extensive government reviews and permitting were estimates at best. It was at this stage that the best estimate to be had for the work needed for the additional space, the remodeling of the 34-year-old facility, replacement of fully-depreciated and inadequate equipment, and correcting deficiencies of the existing facilities, was \$5.5 million.

It is unfortunate that at this very preliminary stage of project development, and with only preliminary estimates to go on, a public institution must go to the public to ask for funds to continue the project.

That was the basis for the bond measure. That estimate had to be arrived at, and the bond measure had to be passed, before expenditures could be made for more precise estimates.

Third, when the bond measure was approved by 83% of the District voters, the architectural and engineering firm was awarded a contract to develop detailed specifications, drawings and timelines for the work and to prepare bid packets for the bidding process. They used the amount of the bond issue and their best estimates of cost as the basis for this preparation of the project. It was at this point that charges to Project I began to be recorded.

At this stage, the cost of the work to be done fell within the \$5.5 million available, with a cushion to be provided by the interest earnings of the bond revenues. The initial costs were predicated on liberal estimates made by the architectural firm and confirmed by and outside independent construction estimator. These estimates were about \$162 per square foot for new construction (a similar building was just being completed nearby at a cost of about \$120 per square foot.), on going costs of materials and equipment with reasonable escalation added, and on timing based on the best estimates of approvals, on permitting and on local contractor availability and interest in the project.

Fourth, the bid packets for the Patient Services Center, the Materials Handling Building, and the central plant renovation went out and the first real setback was encountered. The general contractor bids came back at \$240 per square foot, amounting to almost \$1.5 million more than the architect's estimates for that work. An attempt was made to bid another major part of the project, the site work, and no bids were received for this work.

At that time, the entire project had to be re-evaluated. Three courses of action were available. One was to reduce the scope of the project and not complete all of the work planned, or two, to look at re-engineering and hope for more realistic bid responses by the contractors, or three to look at a whole new way of managing the project to reduce the cost while completing the major and most pressing parts of the project.

Because the entire project was seen as needed by the District, an attempt was made to work with the bidders to reduce the bids by re-engineering the designs. When it became clear that this would not bring the bids into line with the budget, the bids were rejected. It appeared that the reluctance to bid, and the excessively high bids, by contractors was because of the nature of healthcare construction, bonding requirements necessary for a public entity contract, our location, and other work to be had.

This brought us to the third remedy—a new way to approach the project. An experienced construction management firm was contacted. When the project was reviewed, they felt it could be completed within the budgeted amount by making changes in the construction that would be cosmetic but that would not impair the functionality of the needed buildings and building modifications. They also had the contacts that would give the bidding process a wider range of potential bidders. A decision was made—and all of these decisions were made in open, posted, public meetings—to go with the construction manager concept so that we could get as much of the project completed as possible. This new approach to managing the project, and the contract with the construction management firm, were fully and carefully reviewed by legal counsel before award of a contract.

Based on all of the oral and written representations of the construction management firm, counsel deemed this to be a legal and appropriate method of construction management for the project.

At the monthly meetings of the Project I Oversight Committee project progress and financial impact of that progress were monitored to assure that the bond proceeds were being appropriately used for Project I capital expenditures.

The campaign material used in Project I, and all of the minutes of Project I Oversight Committee meetings have been carefully reviewed. All of the decisions made that materially affected the project and the monthly financials that have been developed since the Project I inception in 2001 have also been carefully reviewed. Based on all of the information available at the time decisions were made they were the right decisions.

Yes. There have been timing setbacks and there have been cost overruns, and yes, the reach of the project has had to be modified to accommodate these factors. In spite of these setbacks and overruns the most appropriate use has been made of the funds expended considering the events that have taken place.

The needs of the hospital that were presented to the public at the time of the passage of the bond measure consisted of four elements. They were:

1. Construction of a Patient Service Center
2. Construction of a Materials Handling Building
3. Remodel of parts of the Acute Care Building, the A. J. Gray Building and the current Materials/Housekeeping Building
4. Update of the infrastructure of the Acute Care Building

It was estimated that the proceeds of the bond issue would be enough to cover all of these needs but, realistically, it could not be committed to as an exact number. The only commitment that could be made was that the funds would be properly spent for the project and only for the project. It was for this assurance that the Oversight Committee was formed. At no time in the Measure I campaign was a statement made, nor is it realistic to assume, that the only funds required to fill the needs or to correct the deficiencies of the hospital would be those provided by the bond issue.

The increases in Project I expenditures above the original estimates can be largely attributed to:

1. Initial contractual bids that were extremely high and unreasonable. This required redesign and re-bidding. (The bid cost per square foot was about \$240 versus the architect's, and independent contractual estimator's, estimate of \$161. Nearby similar construction, for comparison, was about \$120 per square foot. This made it necessary to rethink the entire project.)
2. Time delays in obtaining reasonable bids through redesign and re-bidding.
3. Delays due to the over-long approval process by various government agencies.
4. Weather and resultant timing shifts due to items 1, 2, 3, above.
5. Extreme escalation of the cost of steel, concrete, and almost every construction material after the project was originally planned. This alone has amounted to a 30% to 45% increase in the cost of new construction.
6. Reluctance of contractors to bid on highly regulated, healthcare construction that requires complex government approval process and high bonding requirements.
7. Problems with systems of the 34- year-old infrastructure have been revealed—as the work has progressed—that were unknown at the time of the start of the project. These absolutely had to be repaired or replaced. Some of these were directly related to Project I and some were appropriately depreciated assets.
8. Interest rates fell significantly over the past five years and this reduced the funds available.

All of these factors have delayed the completion of the project by, conservatively, 18 to 24 months. Consequently, the cost of Project I has increased even though the redesign has provided equally serviceable facilities that cost less than the first bids.

The major parts of the original concept have been completed. Including:

1. The new Patient Services Center is essentially complete and relieves much of the crowding of the acute care building. The registration activities now meet new stringent privacy requirements. Space has been provided for expansion of services such as oncology infusion, diabetic and nutritional counseling, etc. The Billing Department has been moved back to the hospital campus from leased off-site offices. Visiting physician examination and treatment rooms have been provided. Space and facilities for the new and vital Information Technology service has also been provided by relocation of Human Resources and Finance.
2. The materials handling and engineering building has provided relief of extremely inadequate and crowded space for engineering and housekeeping, including the ability to have on-site storage of critical medical supplies and records formally stored in costly rented storage space.
3. Much of the Central Plant upgrading has been completed. The most critical element is the fire protection system of fire doors and complete fire alarm installation which has been upgraded to meet current code requirements.
4. Parts of the Acute Care remodel have been completed as necessary to accommodate relocation of services.

In the accomplishment of these major, and most critical, parts of the project all of the funds provided by the bond issue and the accumulated interest have been expended. The entire amount of the bond proceeds and the accumulated interest has been appropriately used for Project I. This is very well substantiated by the financial statements covering Project I and by the tracking of the Project I Oversight Committee.

Therefore, I recommend that the Oversight Committee that was formed to track use of the bond funds be dissolved. I further recommend that further capital needs and structural requirements of the hospital be planned, approved and executed using normal administrative and operating procedures, with appropriate Board of Directors approval, as the overall financial condition of the hospital allows.

Don Tucker
Project "I" Oversight Committee Chair
November 17, 2005