



Sutter Medical Center of Santa Rosa (SMCSR) Responses to Sonoma County Department of Health Services Questions

Question #1: Please list the medical and specialty services the Hospital will offer. What services currently provided at Sutter Medical Center of Santa Rosa will not be provided at Hospital other than Invasive Cardiology?

SMCSR Response to #1: SMCSR will continue providing the following services as specified in the HCAA:

HCAA Service	Currently at SMCSR	New SMCSR
General acute care	Yes	Yes
Perinatal	Yes	Yes
Intensive Care	Yes	Yes
Intensive Care Newborn Nursery	Yes	Yes
Pediatric	Yes	Yes
Coronary Care	Yes	Yes
Skilled Nursing*	Yes	Yes
Basic Emergency	Yes	Yes
Podiatric Services	Yes	Yes
Cardiac Cath Lab	Yes	Yes
Respiratory Care	Yes	Yes
Physical Therapy	Yes	Yes
Outpatient Services	Yes	Yes
Occupational Therapy	Yes	Yes
Nuclear Medicine	Yes	Yes
* SMCSR will hold any patient requiring a skilled nursing bed that is not available in the community until such time that the patient is able to go home or a bed becomes available.		

SMCSR is simply moving the services currently provided under the HCAA to the new hospital. Other SMCSR services provided at the Chanate Campus not required by the HCAA will continue to be provided if sufficient physician coverage is available. SMCSR does not anticipate eliminating services except for Invasive Cardiac services. However, it is anticipated that Invasive Cardiac services will be provided at the Physicians Medical Center.

Question #2: Will SMCSR continue to provide the full range of Women’s Reproductive Health Services provided at the Chanate campus today?

SMCSR Response to #2: Yes.

Question #3: Will the new SMCSR provide privacy for sexual assault victims?

SMCSR Response to #3: Yes. A dedicated Sexual Assault Response Team (SART) room will be provided within the ED department. It will be locked and only used by the SART team.

Question #4: The Business Plan acknowledges that Sutter is responsible for the continued provision of the outpatient services that were offered at Community Hospital in 1996. These included various specialty clinics. What plans does Sutter have to assure continued access to outpatient specialty care?

SMCSR Response to #4: SMCSR plans to provide continued access to outpatient specialty care through the Affiliation Agreement with Southwest to provide services in specialty care such as Diabetic Education, Dermatology, Endocrinology, Pediatrics, Podiatry, Ophthalmology, Psychiatry, Gynecology etc. SMFNB will contract with Medi-Cal Managed Care and provide specialty care pursuant to that contract. From 1996 to 2004, SMCSR operated the Family Practice Center as an outpatient department of SMCSR’s Chanate campus. In 2004, SMCSR, with the consent of the County, subleased Clinic C of the Family Practice



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Center to the Southwest Community Health Center ("Southwest"). In 2007, SMCSR, with the consent of the County, subleased the remainder of the Family Practice Center to Southwest and entered into an Affiliation Agreement among SMCSR, Southwest and Sutter Medical Foundation North Bay ("SMFNB") pursuant to which Southwest now operates the entire Family Practice Center as a Federally Qualified Health Center. Southwest coordinates the provision of outpatient specialty care. The Sutter Health guaranty in the HCAA remains in effect and will continue to apply to the outpatient services provided by Southwest in accordance with and through the term of the HCAA.

Question #5: If a Kaiser patient presents at the SMCSR Emergency Department (ED) and states they have a Kaiser physician, will they be transferred to Kaiser?

SMCSR Response to #5: Kaiser patients arriving at SMCSR are transferred to Kaiser once they are stable enough to transport, which is the decision of the treating physician at SMCSR. SMCSR notifies Kaiser if one of their patients is unstable and requires admission at SMCSR.

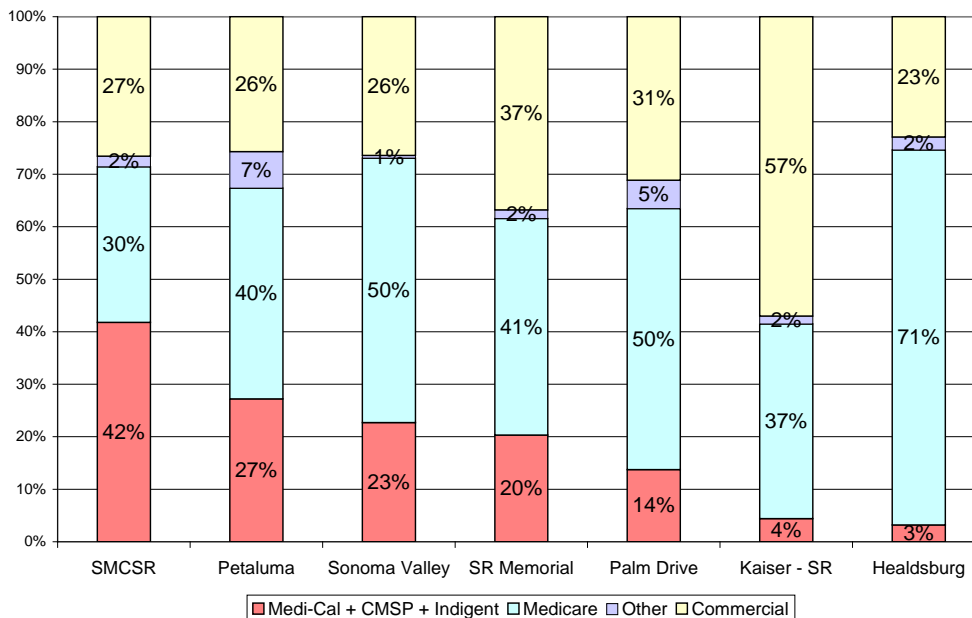
Question #6: How many negative pressure rooms will the new Hospital have for the treatment of tuberculosis?

SMCSR Response to #6: The New SMCSR hospital will have eight (8) negative pressure rooms. The benefit of a negative pressure room is that when a door to a negative pressure room is opened any odors, airborne contaminants or airborne hazardous materials generated in the room tend to stay in the room and are eventually exhausted out of the room by the HVAC (Heating, Ventilating and Air Conditioning) system. This results from the air pressure in the room being slightly lower than the remainder of the building.

Question #7: What is the 2007 payer mix for acute services at SMCSR? How does this compare to other Sonoma County Hospitals? What is SMCSR's payer mix by service line?

SMCSR Response to #7: SMCSR has the greatest percent of acute Medi-Cal (including CMSP and Indigent) patient cases and the smallest percent of acute Medicare and Commercial cases.

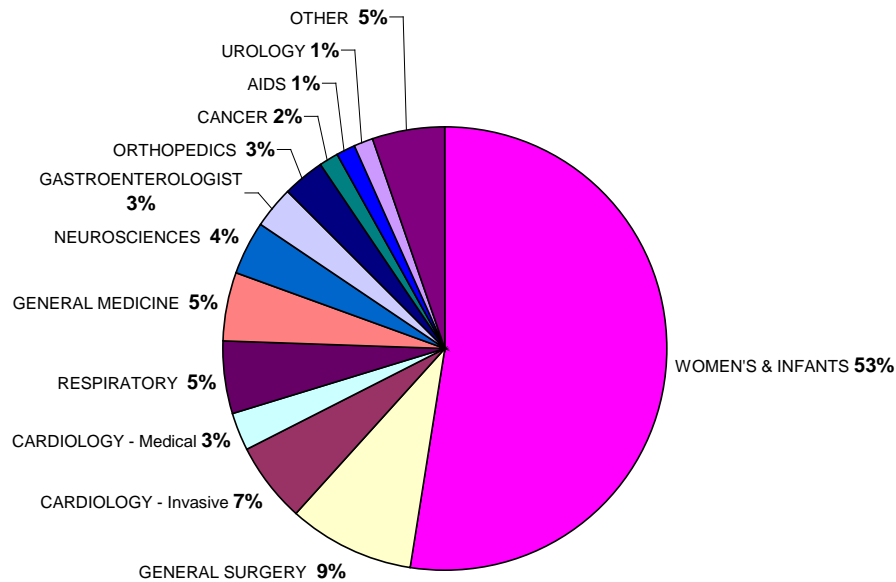
2007 Sonoma County Hospitals Acute Cases Payer Mix



Over 50% of SMCSR's Medi-Cal/CMSP/Indigent Patient Days are in Women's & Infants' Services. See chart below.



**2007 SMCSR Medi-Cal, County Indigent & Other Government*
 Patient Days by Service Line**



Source: 2007 OSHPD Inpatient data

* Other Government excludes Medicare.

Question #8: Will all med/surg and perinatal beds be private rooms?

SMCSR Response to #8: The new hospital plan is to have private rooms in all departments.

Question #9: Please explain how med/surg and perinatal bed needs will be met.

SMCSR Response to #9: Sufficient Med/Surg capacity exists with utilization of perinatal beds in the New SMCSR. The New SMCSR will not have an invasive cardiology program which will reduce the med/surg and ICU bed demand of the new hospital. Perinatal beds will be used as overflow Med/Surg beds as needed. The slight, indicated bed deficit can be accommodated by operational mitigations including utilization of the UCU stations. From 2007 to 2008, med/surg patient days in Sonoma County hospitals declined by 5% which represents a decrease in ADC of 14 patients. One of the factors SMCSR has taken into consideration in determining the number of beds required is that many surgical procedures are being performed using minimally invasive surgical technologies and patients do not require inpatient hospitalization.

Question #10: How will SMCSR address quality of care issues for both med/surg and perinatal patients in the perinatal unit if med/surg patients are regularly placed in the perinatal unit?

SMCSR Response to #10: SMCSR's Patient Placement Guidelines, describe SMCSR's current standard of placing female med-surg patients in the Mother Baby Unit (OB/postpartum) in the event patient volumes overflow med-surg bed capacity. OB staff members already have med-surg nursing skills which they use every day as they care for C-sections as well as high risk patients with other complicating diagnoses. All OB staff is competent to care for med surg patients since OB care has med-surg as a foundational skill. SMCSR will continue to ensure quality care in the same manner as is conducted today.

Question #11: What is the rationale for two operating rooms and one Procedure Room?



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SMCSR Response to #11: The two operating rooms at the New SMCSR will provide sufficient capacity for SMCSR's inpatient surgeries (excluding cardiac surgery) and outpatient surgical volume and will run at a 70% occupancy rate. The New SMCSR with one procedure room will run at 65% occupancy. These occupancy projections are conservative as they do not take into account changes in the marketplace; for example, the shift of outpatient procedures to outpatient surgery and endoscopy centers. Additionally, there will be two C-section rooms in the new SMCSR hospital for c-sections and tubal ligations.

Question #12: How will SMCSR meet ICU bed demand?

SMCSR Response to #12: The New SMCSR will not have an invasive cardiology program which reduces the ADC in the ICU. The 8 ICU beds in the New SMCSR will be more than sufficient to provide care for ICU patients.

Question #13: What will be the license type for the new hospital's Emergency Department (ED)?

SMCSR Response to #13: The New SMCSR will continue to be licensed as a Basic Emergency Department.

Question #14: Will the ED have physicians on-site 24 hours a day? Will Sutter reimburse specialists for being on-call, similar to the system currently used at Sutter?

SMCSR Response to #14: Yes.

Question #15: Please provide a projection of the need for ED treatment bays at the Hospital in 2014 and 2021. Will 12 ED bays (a 20% reduction from the current 15 ED bays) be sufficient to meet demand?

SMCSR Response to #15: SMCSR engaged C&S to review demand and existing capacity of ED services in Sonoma County over the past few years utilizing OSHPD Emergency Department Patient Encounter Data 2005 -2007 and OSHPD ALIRTS data reports from 2002 -2007. The C&S model accounts for current population figures, projected growth and aging of the population to adjust for the growing elderly population who require increased medical care and utilize the ED more frequently. Based on that analysis, C&S projects ED visits in Sonoma County will grow by 8% to 2014, and 19% to 2021, relative to 2007 levels. C&S was aware of changes taking place in the market with Kaiser doubling the size of its ED to 34 bays. Taking this change into account, together with the decrease in 3 bays in the New SMCSR, the number of ED bays in Sonoma County will increase by 15 %, from 81 to 93. This percentage increase does not take into account the positive impacts of the 16 station UCU at SMCSR on increasing ED capacity. A standard used in both academic studies and for planning purposes is 2000 visits per bay per year. In evaluating ED demand, a measure that can indicate if there are capacity problems in a county is if the average number of visits per ED bay station is over 2000. The statistic for Sonoma County in 2007 was 1600, or 80% of capacity. With the expected growth in visits factored in for population growth and aging, the increase in the number of bays, the measure for 2021 will rise slightly to 1662, or 83% of capacity. Thus, this measure demonstrates that even when taking into account the increases expected from an increased aging population, there is ample ED capacity in Sonoma County through 2021. To summarize, C&S concluded the likelihood of capacity problems in Sonoma County over the next 10 to 15 years to be unlikely. Moreover, this analysis only addressed ED and did not take into account the 16 UCU stations at SMCSR which effectively will increase ED capacity at SMCSR and in Sonoma County. Partnership Health Plan of California (PHC) is scheduled to implement Medi-Cal Managed Care in Sonoma County in the fall of 2009. If implemented, PHC is projecting a 50% reduction in Medi-Cal emergency department visits, which translates to an approximate 20% reduction ED visits to SMCSR.

Question #16: Will the new SMCSR provide the same or quicker medical response times located next to Highway 101?

SMCSR Response to #16: The new SMCSR will have a dedicated ambulance exit lane from Highway 101 accessing SMCSR's Emergency entrance. Medical response times are estimated to be quicker from almost all parts of Sonoma County. The current Chanate facility is located in a residential neighborhood with two lane roads in every direction and 1.4 miles off Highway 101 from the hospital.

Question #17: Will any measures be implemented by SMCSR to reduce demand for ED services?



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SMCSR Response to #17: Partnership Health Plan of California (PHC) is scheduled to implement Medi-Cal Managed Care in Sonoma County in the fall of 2009. If implemented, PHC is projecting a 50% reduction in Medi-Cal emergency department visits, which translates to an approximate 20% reduction ED visits to SMCSR. Participation by SMFNB and other providers in the program is expected to further reduce ED service demand.

In addition, SMCSR is planning a 16 station Universal Care Unit (“UCU”). The Universal Care Unit is a valuable new tool for hospitals that provides flexibility and greater access to critical care by expanding capacities of the ED, Surgery and Medical/Surgical operations.

This UCU functions as an observation and extended recovery unit. Many of the patients seen in the ED need observation but are not critical. For example, once a non-critical patient has been evaluated and triaged in the ED, they can be moved to the UCU for observation while awaiting test results or consultation with other specialists. Moving the non-critical patients to the UCU will free up the bays in the ED to be utilized for more critical patients and thereby expanding the ED’s capacity.

Likewise, many outpatient surgery patients are not critical but require extended observation. These patients can be moved to the UCU and free up the Medical/Surgical beds for more critical patients thereby increasing the capacity of the Medical/Surgical operations.

The UCU greatly enhances flexibility in patient care and frees up licensed beds for more critical patients by shifting non-critical observation patients to a unit providing the appropriate level of care. This unit will have beds in stations that are separated with walls and have sliding glass doors so that each station is private and quiet.

The peak times for the medical and surgical departments are the daytime hours while the peak times for the ED are the evening and overnight hours. The UCU will be utilized constantly assisting both the ED and the Surgery/Medical-Surgical departments expanding capacity because the peak times differ for the various departments

Question #18: What is SMCSR’s ED payer mix over the last few years?

SMCSR Response to #18: The following table shows SMCSR’s ED payer mix:

Sutter Medical Center of Santa Rosa
ED Visits by Payer
Includes Sutter Warrack Hospital

Payer	2004	2005	2006	2007	2008
Medi-Cal	44%	40%	42%	43%	44%
Self Pay/Other	17%	17%	17%	18%	18%
PPO	12%	15%	13%	14%	14%
Medicare	13%	16%	15%	13%	13%
HMO	12%	10%	10%	9%	9%
Misc	3%	3%	3%	2%	2%
Total	100%	100%	100%	100%	100%

Source: SMCSR Finance Data - 1/28/09

Question #19: What impact will Managed Medi-Cal have on ED Utilization?



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SMCSR Response to #19: Partnership Health Plan of California (PHC) is scheduled to implement Medi-Cal Managed Care in Sonoma County in the fall of 2009. PHC is projecting a 50% reduction in Medi-Cal emergency department visits, which translates to an approximate 20% reduction in ED visits to SMCSR, reducing the required number of ED bays approximately 2.1 based on 2007 data.

Question #20: Does Sutter have any plans to discontinue providing cardiac surgery at the Chanate facility prior to occupying the new hospital(s) at Wells Fargo?

SMCSR Response to #20: No.

Question #21: What types of imaging services will be provided in the Hospital? Will there be an MRI at the new SMCSR?

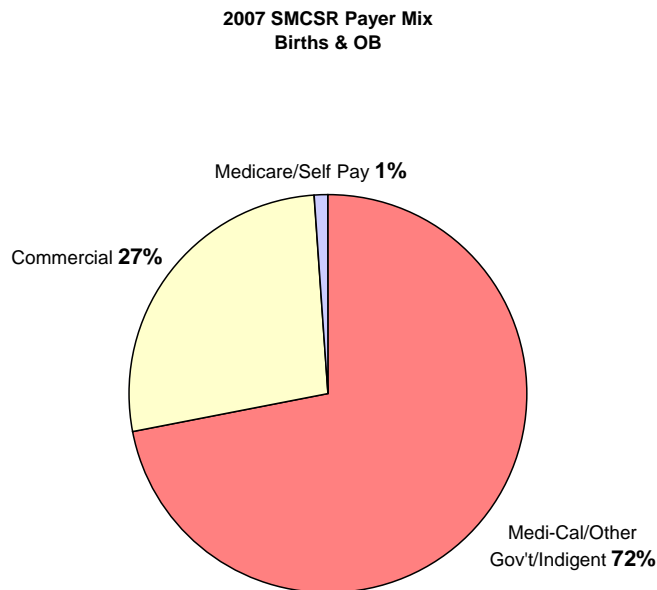
SMCSR Response to #21: The New SMCSR will provide a CT, nuclear medicine, radiology/fluoroscopy, and ultrasound. A mobile docking station will also be included for an MRI and special imaging equipment or new technology such as a PET scan, PET/CT scan, etc.

Question #22: Please describe the current type and volume of perinatal surgeries and related procedures done at Sutter and the plan to accommodate the anticipated volume of services in the new SMCSR facility.

SMCSR Response to #22: SMCSR currently provides C-sections and GYN surgery and will continue to provide these services at the new SMCSR hospital. SMCSR does not currently provide perinatal surgery (surgery in the womb), nor is it planning to do so at the new SMCSR hospital. SMCSR is planning on building two C-section rooms in the new SMCSR hospital. SMCSR will perform tubal ligations in one of the two C-section rooms. The new hospital design with dedicated C-section rooms is anticipated to be an improvement in services with patients staying in the OBGYN Department for these procedures and allowing for quick turnaround of the C-section rooms.

Question #23: What is SMCSR's payer mix for Obstetrical services?

SMCSR Response to #23: Medi-Cal/CMS/Indigent patients account for the majority, 72%, of SMCSR's Obstetrical services.



Source: 2007 OSHPD Inpatient data
Patient Days



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Question #24: Does SMCSR plan to provide antenatal testing?

SMCSR Response to #24: Yes.

Question #25: How will Sutter provide obstetrical services to the increasing numbers of monolingual Spanish speaker?

SMCSR Response to #25: As is the case today, with Spanish speaking staff. SMCSR provides an education benefit of Spanish speaking classes and other education classes and/or training.

Question #26: Please provide information about the types of patients and diagnoses served by the Universal Care Unit stations.

SMCSR Response to #26: The unit will be used primarily for ED overflow outpatients and observation patients (Medicare designation for patients who stay less than 24 hours). With an ED there are often patients with orthopedic injuries who are seen in the ED and discharged home to return in 1 or 2 days for an outpatient surgical repair, so the UCU would be used pre and post op for these types or surgical outpatients. Some ED overflow patients require additional work-up or psychiatric work-up for transfer to out-of-county inpatient psychiatric hospitals. See Answer #13 for more information.

Question #27: Please explain how the use of Universal Care Unit stations will reduce demand for med surg beds.

SMCSR Response to #27: See Answer #13. Any Medicare, Medi-Cal or Surgical patient who does not meet InterQual criteria for inpatient admission, but does meet InterQual Criteria for observation stay and is expected to be discharged in 24 hours or less, may occupy a UCU station. If a medical patient is not ready for discharge within 24 hours, but does not meet InterQual criteria for inpatient admission, the patient may remain on Medicare Observation status in an UCU station for up to 48 hours. This sometimes happens with congestive heart failure patients. In the absence of a UCU, this type of patient would be accommodated in a licensed bed.

Question #28: Will access to hospital services for uninsured and government funded patients be maintained pursuant to the HCAA?

SMCSR Response to #28: Yes, SMCSR will continue to fulfill the HCAA requirements for uninsured and government-funded patients. SMCSR is a community based not for profit providing quality health care to the community regardless of ability to pay.

Question #29: If a physician wants to admit an indigent patient to the hospital for a med-surg procedure but there are no available beds, please provide a detailed description of how Sutter would meet its obligations under the HCAA.

SMCSR Response to #29: If there is no capacity at the New SMCSR, the procedure will be the same as the current procedure: the physician will work with SMCSR to find a hospital with capacity for the patient. Conversely, if there is insufficient capacity at another hospital but there is capacity at SCMSR, that physician could make arrangements for the patient to be treated at SMCSR. Availability of beds, physicians, staffing, and equipment are all resources that community hospitals shift as needed to care for patients today.

Question #30: Will Sutter participate in Medi-Cal Managed Care?

SMCSR Response to #30: SMCSR and Sutter Medical Foundation North Bay will contract with Medi-Cal Managed Care.

Question #31: Will Sutter continue to maintain the Family Residency as required under the HCAA?

SMCSR Response to #31: Yes.

Question #32: Describe how geography, age and socio-economic factors are applied to demand projections for hospital days or discharges.

SMCSR Response to #32: The following chart provides an overview of the inpatient bed demand methodology. As can be seen, data as to payer mix, patient age and residence zip code, are taken into account in several steps of the methodology.



Inpatient Model Methodology Overview

TASK	Step One	Step Two	Step Three	Step Four	Step Five	Step Six	Step Seven
	Define service line and service areas	Prepare assumptions regarding future population levels	Review recent trends and develop assumptions regarding market share levels, inclusive of migration patterns	Review trends in hospital utilization levels. Develop projected discharge use-rates and patient day use-rates.	Forecast use-rates	Calculate bed need requirement based upon projected census levels and assumptions regarding occupancy levels by nursing units	Calculate forecasted volumes and bed needs requirements utilizing sensitivity analyses regarding population, market shares levels and technology diffusion
DATA SOURCES	OSHPD Patient level discharge datasets (OPLDD) (1999-2007)	DOF projections 2007; DHS Medi-Cal enrollment; C&S HMO survey	OPLDD	OPLDD	OPLDD; DOF projections 2007	SMCSR internal data	Sutter Health internal data
LEVEL OF ANALYSIS	Hospital, DRG, zip code detail for all area residents	Age, payor, zip code level	Hospital, area, service lines	Service line level	Incident rates: zone, service line, cohort, payor. Patient day rates: service line, cohort, payor, hospital	Bed type	

Question #33: Describe SMCSR patient volume decreases in recent years and anticipated future patient volumes.

SMCSR Response to #33: SMCSR inpatient volume (ADC) declined 49% from 2002 to 2008. Further, SMCSR’s ADC has declined an additional 19% from 2008 to 2009 (January through April) for a total ADC decline of 53% since 2002. SMCSR anticipates continued future decline in demand due to advances in technology, pharmaceutical treatment options and minimally invasive surgical procedures performed on an outpatient basis which eliminate the need for hospitalization or with shorter hospitalization. Further shifts in the private insurance market to Kaiser will also reduce SMCSR patient demand. In spite of the decreased demand trends, to be conservative, our bed demand projections indicate increases in patient volumes to account for population growth and aging.

Question #34: Describe how staff levels and supply issues impact the cost of health care when beds in hospitals go unused.

SMCSR Response to #34: Hospitals must hire staff and buy supplies in advance of patients arriving to ready the hospital for patients. These are fixed costs that must be spent without knowing if patients will use the hospital. Hospitals need to operate at 70 – 85% of capacity in order to be sustainable due to these high fixed costs. Unused hospital beds increase the cost of health care in communities.

Question #35: Does the new SMCSR hospital plan provide for expansion?



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SMCSR Response to #35: Yes. The plans provide a possible expansion of the hospital by up to 29 beds, as well as an expansion of the Emergency Department.

Question #36: What criteria would be used to determine whether the 70-bed hospital would need to be expanded? What would be the process/timeline for implementing that expansion?

SMCSR Response to #36: Sutter Health evaluates the proposed capital projects of affiliates in many ways including contribution to mission, community need, financial feasibility, available debt and equity for investment, and capital expenditure payback time. If SMCSR determined that the new 70-bed SMCSR should be expanded, it would make a request to Sutter Health for funding. SMCSR would compete with other affiliates for funding. Because any future capital projects will be based upon facts unknown at this time, Sutter Health cannot commit to any capital projects beyond the 70-bed SMCSR.

The process and timeline for expansion is anticipated to be as follows: 1. Design: 10-12 months; 2. OSHPD Review: 12 months; 3. Construction: 12-14 months; Total Time: Approximately 3-3 ½ years.

Question #37: Is SMCSR committed to building a replacement hospital?

SMCSR Response to #37: Yes. SMCSR will use its best efforts to coordinate with the County through the land use process and CEQA review. If Board approval of the proposed Business Plan is obtained, Sutter will implement it.

Question #38: The "project" submitted to OSHPD includes only the 70-bed hospital. If or when the expansion is pursued, will that have to be resubmitted as another project to OSHPD?

SMCSR Response to #38: Yes, it would be a separate project.

Question #39: Is the possible expansion included in the current CEQA project description? Our understanding is that the plans submitted to PRMD include the proposed expansion, so everything will be reviewed at once for purposes of CEQA. Is that correct?

SMCSR Response to #39: Yes. The use permit includes a possible future expansion of the Sutter Medical Center by up to 29 beds. The first two phases of the project include a 70 bed Sutter Medical Center. The third phase, which is included in the use permit and in all of the environmental impact reviews, is a possible future expansion of up to 29 beds.

Question #40: How will the new SMCSR hospital, Physician's Medical Center and Medical Office Building at the same location enhance patient care?

SMCSR Response to #40: Locating compatible medical uses into an integrated medical campus will greatly enhance patient care and convenience. For example, if a pregnant woman visits her obstetrician at the Medical Office Building and an ultrasound is ordered, the patient can walk to the new SMCSR for the ultrasound. The results of the ultrasound would be immediately available for review by her physician on Sutter's electronic medical record system. The patient can then walk back to the physician's office for consultation on the results. For patients with limited transportation options, the integrated medical campus at the Wells Fargo site will enable patients in many instances to avoid multiple trips.

Question #41: Will there be an on-site helistop at SMCSR or on the Wells Fargo site for transfer and transport?

SMCSR Response to #41: Yes. A new helistop is planned for on the Wells Fargo site. The FAA's advisor circular on Heliport Design (AC 150/5390-2B) provides definitions of heliport and helistop as follows:

- Heliport: The area of land, water or a structure used or intended to be used for the landing and takeoff of helicopters, together with appurtenant buildings and facilities.
- Helistop: A minimally developed helicopter facility for boarding and discharging passengers or cargo. The heliport/helistop relationship is comparable to a bus terminal-bus stop relationship with respect to the extent of services provided or expected.



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“Helistop” is as much a functional term as one describing a physical facility. As the definition above indicates, a helistop does not have buildings, fueling capabilities, and other components. Rather, it is where helicopters land, remain briefly, and then depart. Most hospital heliports can be considered to be helistops.

Question #42: Will the new SMCSR hospital be a “Green” hospital? Please explain how the “Green” building, design and construction practices anticipated to be implemented on the New SMCSR hospital:

SMCSR Response to #21:

1. *Reducing Auto Emissions* - The New SMCSR provides for reducing auto emissions through a complete Transportation Management Plan including bike storage, lockers and showers for staff who bike or walk to work, preferred parking for car pools, electric vehicles, and free-of-cost electric charging station.
2. *Green Space* - The New SMCSR maximizes green space and landscaped areas, shades parking and minimizes hard surface areas to reduce heat island effect. SMCSR intends to plant native, drought resistant, water conservative plants, and utilize smart irrigation controllers and low flow emitting irrigation devices. Bioswales will be used in the parking lots to reduce the amount of hydrocarbon run off in storm water. Storm water plans, including retention of storm run off, will be in full compliance with County regulation and will meet or exceed all water quality control standards. The use of treated waste water to irrigate landscaping will be investigated with the County.
3. *Energy Efficient Hospital Design* - The New SMCSR is designed to be highly energy efficient and includes low heat island roofing, energy efficient plant equipment (boilers, chillers, generators), fully controlled lighting and thermal comfort systems, thermally efficient building skin and glazing materials, interior day lighting to reduce energy demand, fluorescent and LED lighting, and site lighting designed to avoid light pollution.
4. *Construction Process and Selection of Materials* - SMCSR will implement a complete construction waste management and recycling plan for all construction components of the New SMCSR. SMCSR will utilize materials with high feasible recycled content and low or no emitting materials such as adhesives, sealants, paints, coatings, carpet and flooring systems. SMCSR intends to purchase materials from sustainable processes. It is anticipated that SMCSR will, when possible, procure building materials locally to reduce green house gases (“GHGs”) in transporting materials to the site. SMCSR plans to use on-site soil to reduce the amount of import or export of materials to/from the site. In addition, SMCSR plans to use the most water efficient toilets, urinals and fully automated faucets throughout the New SMCSR. A major goal of the New SMCSR is to reduce GHGs whenever possible.

Question #43: SMCSR will build and own the new hospital at no cost to taxpayers on land owned by SMCSR. Will SMCSR continue to own the hospital beyond the expiration of the HCAA?

SMCSR Response to #43: Yes

Question #44: What is the anticipated opening date of the hospital?

SMCSR Response to #44: We anticipate the hospital to open in the fall of 2013.

Question #45: Warrack Hospital is no longer has licensed hospital beds. What can the Warrack campus be used for?

SMCSR Response to #45: Construction estimates for the 70-bed SMCSR hospital are \$176 million. To assist in funding the capital requirements, SMCSR plans to sell the Warrack campus sometime in the future. In the short term, SMCSR is utilizing the Warrack campus for various staff office, support services and other operational needs.