BEFORE THE DEPARTMENT OF JUSTICE
FOR THE STATE OF MONTANA

In the matter of the application for a certificate of public advantage by the Columbus Hospital and Montana Deaconess Medical Center, Great Falls, Montana.	)))))	**AMENDED FINDINGS OF FACT, CONCLUSIONS OF LAW, AND CERTIFICATE OF PUBLIC ADVANTAGE**

This matter is before the Department of Justice on the application of Columbus Hospital and Montana Deaconess Medical Center ("Applicants") for a Certificate of Public Advantage pursuant to Mont. Code Ann. title 50, chapter 4, part 6, for the proposed consolidation of the two facilities. In accordance with Mont. Admin. R. 23.18.103(4), the Department now issues the following Findings of Fact, Conclusions of Law, and Certificate of Public Advantage ("COPA"), subject to the terms and conditions that follow.

I. DEFINITIONS

1. "Columbus" refers to Columbus Hospital, a general acute-care nonprofit hospital located at 500 Fifteenth Avenue South, Great Falls, Montana.

2. "MDMC" refers to Montana Deaconess Medical Center, a general acute-care nonprofit hospital located at 1101 Twenty-sixth Street South, Great Falls, Montana.

3. "Consolidated Hospital" refers to the entity, by whatever name, existing after the consolidation of MDMC and Columbus, its successors and assigns, and any entity controlling or controlled by the consolidated entity.

4. "Sisters of Providence" means the Sisters of Providence, St. Ignatius Province, and any entity controlling or controlled by that entity.

5. "Department" refers to the Montana Department of Justice.

6. "Applicants" refer to Columbus and MDMC.

7. "Managed care plan" means a health maintenance organization, preferred provider organization, or other health service purchasing program which uses financial or other incentives to prevent unnecessary services and includes some form of utilization review.

8. "Person" means any individual, firm, partnership, association, organization, agency, institution, corporation, trust, estate, or governmental unit, whether organized for profit or not.

9. "Joint Commission on Accreditation of Health Care Organizations" or "JCAHO" means the organization nationally recognized by that name with headquarters in Chicago, Illinois, that surveys health care facilities upon their requests and grants

accreditation status to a health care facility that it finds meets its standards and requirements.

10. "Health plan" means an organized health service purchasing program, including but not limited to managed care plans, offered by third-party payers, health care providers or any other person. "Health Plans" does not include organized health services or purchasing programs provided by the Consolidated Hospital to its employees.

11. "Health care costs" means the amount paid by consumers or third-party payers for health care services or products. Mont. Admin. R. 23.8.101(3).

12. "Health care provider" or "provider" means a person who is licensed, certified, or otherwise authorized by the laws of Montana to provide health care in the ordinary course of business or practice of a profession.

13. "Service area" means the fourteen counties of North Central Montana, including Cascade, Hill, Glacier, Fergus, Valley, Blaine, Pondera, Teton, Chouteau, Phillips, Toole, Liberty, Judith Basin, and Meagher.

14. "Acute care inpatient hospital services" means 24-hour inpatient health care, and related medical, surgical, diagnostic and treatment services, for physically injured or sick persons with short-term or episodic health problems or infirmities.

15. "Ambulatory surgery facility" means a facility that provides surgical treatment to patients not requiring hospitalization. This type of facility may include observation beds for patient recovery from surgery or other treatment.

16. "Master Indenture" refers to the Master Trust Indenture dated as of October 1, 1985, between Sisters of Charity of Providence of Montana and Mellon Bank, N.A., as Master Trustee, as heretofore amended and supplemented and as it may hereafter be amended or supplemented.

II. THE APPLICANTS

Columbus is a general acute-care nonprofit hospital founded in 1892 by the Sisters of Providence, St. Ignatius Province, an affiliate of the Catholic Church. Applicants' Documents at 1046-47.[1] Columbus is licensed to operate 198 beds; it has 145

[1] Citations to the record refer to the following sources: (1) Memorandum in Support of Application for Certificate of Public Advantage for Great Falls Hospital Merger, Oct. 2, 1995 ("Memorandum"); (2) Appendices to Memorandum in Support of Application for Certificate of Public Advantage for Great Falls Hospital Consolidation ("Appendices"); (3) Response of Columbus Hospital and Montana Deaconess Medical Center to Montana State Attorney General's Request for Additional Information submitted Nov. 10, 1995 ("Response"); (4) Documents produced by Applicants in Response to Attorney General's Request for Additional Information ("Applicants' Documents"); (5) Formation Committee Facilities Utilization Statement dated Jan. 4, 1996 ("Formation Committee Statement"); (6) O.R. Surgical Task Force Operating Room Utilization Analysis dated Jan. 4, 1996 ("O.R. Utilization Analysis"); (7) Report prepared by National Economic Research Associates, Inc. ("Economists' Report"); (8) Written comments submitted by the public and interested parties ("Comments"); (9) Interviews conducted by the Department during its investigation of the Application ("Interviews"); (10) Transcript of the Jan. 24, 1996 public hearing

available beds and routinely staffs 80 beds. Comments Response at p. 6. The 1995 average daily census at Columbus was 74. Id. The Sisters of Providence operate five hospitals in Montana and two hospitals in Washington. All of these institutions receive management, financial and consulting services from the Central Provincial Administration located in Spokane, Washington. Applicants' Documents at 1047-48.

MDMC is a general acute-care nonprofit hospital founded in 1898 by members of the Methodist Church. The medical center is now operated as a private community hospital governed by a self-perpetuating volunteer board of nine community leaders. Applicants' Documents at 606. MDMC is licensed to operate 288 beds, with 178 available beds and 140 beds that are routinely staffed. Comments Response at p. 6. The average daily census in 1995 at MDMC was 115. Id.

The traditional health-care service area for the Great Falls hospitals is the fourteen counties of North Central Montana, including Cascade, Hill, Glacier, Fergus, Valley, Blaine, Pondera, Teton, Chouteau, Phillips, Toole, Liberty, Judith Basin and Meagher. Applicants' Documents at 611; Application at (f)(vi). Over the last several years, the market share split of inpatient volume for patients receiving care in Great Falls has approximated 60% for MDMC and 40% for Columbus. Applicants' Documents at 699; Appendices, Ex. H at 29.

The Great Falls hospitals compete to some extent with hospitals in Billings, Missoula and other cities for high-level tertiary services. Applicants' Documents at 615, 700; Memorandum at 4-5; Tr. at 19:15-23, 25:14-19. The Applicants have acknowledged, however, that with respect to at least some general acute inpatient services, the proposed consolidation will "create a monopoly." Laura Goldhahn-Konen Interview, *Great Falls Tribune*, Apr. 24, 1995. The Applicants also concede that "historically there has been very little competition . . . between Columbus and MDMC." Memorandum at 69. Managed care has not yet become a significant force in Great Falls. Id. at 17. In 1994, case mix adjusted costs per case were 6.5% higher in Great Falls than in Billings and up to 20% higher than in other small cities in the western United States. Appendices, Ex. C at 7.

Based on the increase in market concentration resulting from the consolidation, the Department concludes that the proposed consolidation, without a certificate of public advantage, would likely violate state and federal antitrust laws. Pursuant to Mont. Code Ann. § 50-4-601, the Department's supervision and regulation of the proposed consolidation will have "the effect of granting the applicants state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws." Id.

III. BACKGROUND

("Tr."); and (11) Applicants' Jan. 23, 1996 Response to Comments ("Comments Response").

In 1993, the Montana legislature created the Montana Health Care Authority and charged it with, inter alia, reviewing and approving cooperative agreements between health care facilities. The Authority was given power to issue a COPA if it found that the cooperative agreement was "likely to result in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement." 1993 Mont. Laws ch. 606, § 39.

When the Health Care Authority was abolished in 1995, these duties and responsibilities were transferred to the Department of Justice. 1995 Mont. Laws ch. 378, §§ 19, 21. In addition, the statute was extended to cooperative agreements among physicians and was further amended to authorize a COPA for mergers and consolidations among health care facilities or physicians. 1995 Mont. Laws ch. 526, §§ 2-3 (codified at Mont. Code Ann. §§ 50-4-602, -603). The standard for issuance of a COPA also was amended, and the statute now authorizes the granting of a certificate if "the department finds that the [consolidation] is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs." Mont. Code Ann. § 50-4-603(2).

The purpose of the COPA act is to "control[] health care costs and improv[e] the quality of and access to health care" by providing the state, through the Department, "with direct supervision and control over the implementation of cooperative agreements, mergers, and consolidations among health care facilities and physicians . . . for which certificates of public advantage are granted." Mont. Code Ann. § 50-4-601. The COPA process is intended to "substitute regulation of facilities and physicians . . . for competition between facilities and physicians . . . , and . . . this regulation [is meant to] have the effect of granting the parties to the agreements, mergers, or consolidations state action immunity for actions that might otherwise be considered to be in violation of state or federal, or both, antitrust laws." Id.

Montana is among roughly half the states in the country that have adopted "state action immunity" statutes to immunize certain health care collaborations from antitrust scrutiny. General Accounting Office, *Federal and State Antitrust Actions Concerning the Health Care Industry* (Aug. 1994) (GAO Report). Such statutes are designed to contain costs by allowing providers to develop more efficient delivery systems without the "chilling effect" of the threat of antitrust enforcement, responding to the argument that "traditional antitrust analytic methods inappropriately preclude certain types of potentially beneficial arrangements." J. Teevans, *State-Action Immunity: Immunizing Health Care Cooperative Agreements* 3 (Alpha Center Dec. 1995). The objective of Montana's COPA act, like those in other states, is "to make health care more affordable to" the state's residents. Minutes, House Human Servs. & Aging Comm., 2/15/95 at 15 (comments of bill sponsor Rep. Anderson). The measure was intended to provide a mechanism for

health care facilities in the state to adjust to changes in the industry and respond to decreased revenues due to trends such as lower patient census numbers. Minutes, Sen. Pub. Health, Welfare & Safety Comm., 3/22/95 at 2 (testimony of Rep. Wiseman). It was the intent of the legislature that mergers and consolidations, which are subject to the jurisdiction of federal antitrust enforcement authorities, be reviewed at the state level rather than subject to decisions by the federal government affecting the health care of Montanans. Id., 3/24/95 at 7-8 (comments of Sen. Benedict).

Health care mergers and consolidations are sharply rising in the United States, as the industry attempts to respond to lower utilization rates and managed care pressure to bring down costs. More than 200 hospital mergers were announced in 1995, up from 50 in 1990. B. Gruley & L. McGinley, "Rebuke in Dubuque," *Wall Street Journal*, Jan. 4, 1996, at A1. That included a record 43 hospital mergers in the third quarter of 1995, nine of which involved acquisitions by the for-profit Columbia/HCA Healthcare Corp. 14 *Business & Health* No. 1 at 9 (Jan. 1996). The Pew Health Professions Commission recently predicted that market pressures will force the closure of up to half of the nation's hospitals by the year 2000. 7 *Washington CEO* No. 1 at 21 (Jan. 1996).

Although both the Federal Trade Commission and the United States Justice Department have jurisdiction to review mergers and acquisitions, those agencies challenged fewer than 4% of the 397 acute-care hospital mergers they reviewed between fiscal years 1981 and 1993. (GAO Report at 2, 6.) The COPA process is intended to ensure that a hospital merger will be immune from challenge but subject to ongoing supervision by the State of Montana, through the Department. Mont. Code Ann. § 50-4-622; Mont. Admin. R. 23.18.106.

IV. THE APPLICATION PROCESS

In accordance with the COPA act and rules adopted thereunder to implement its provisions (Mont. Admin. R. 23.18.101 to 23.18.108), the Applicants submitted an application with supporting documents to the Department on October 2, 1995. Following its preliminary review, the Department notified the Applicants on October 12, 1995, that additional information was necessary in order to make the application complete. The requested information was submitted to the Department on November 10, 1995, in the form of a narrative response accompanied by approximately 4,000 pages of additional documents. By letter dated November 21, 1995, the Department requested clarification of licensed bed statistics and avoidance of projected capital expenditures. That information was provided on November 28, 1995.

On October 24, 25 and 26, 1995, Department representatives conducted interviews of approximately two dozen Great Falls physicians, as well as ancillary care providers, representatives of Blue Cross and Blue Shield of Montana, the Montana Hospitals Rate Review System, the Montana Department of Public Health and Human Services, the Montana Insurance Commissioner's office, and the medical cost containment representatives of the State Worker's

Compensation Fund program. Interviews were set up by the Department in an effort to gain information about medical markets and practices in Montana, particularly the Great Falls area, and to ascertain the nature of any concerns about the Applicants' proposal. The Department also conducted interviews by telephone with other physicians and with representatives of Intermountain Planned Parenthood.

On November 30, 1995, pursuant to Mont. Admin. R. 23.18.108(1)(c), the Department notified the Applicants of its estimated costs of reviewing the application and the fee that would be required. The fee was remitted to the Department on December 11, 1995.

On December 7, 1995, the Department declared the application to be complete and published notice of its filing in the Montana Administrative Register as required by Mont. Admin. R. 23.18.102(6). MAR Notice No. 23-10-101 (12/7/95). In that notice, the Department also opened a 30-day public comment period and announced that a public hearing would be held on the application on January 24, 1996, in Great Falls, Montana.

In response to publication of the notice, the Department received over 300 letters during the written comment period from members of the public, including physicians, hospital staff, health care consumers, and third-party payers regarding the proposed consolidation. The Department also received dozens of petitions and other preprinted forms signed by individuals opposing the consolidation for unspecified reasons.

On January 11, 1996, the Department received a utilization statement and operating room utilization analysis from the Applicants, in response to which additional information was requested by letter dated January 16, 1996. The Applicants responded with additional information on January 24, 1996. On January 23, 1996, the Applicants submitted a response to the written public comment in accordance with Mont. Admin. R. 23.18.102(7).

The public hearing was held January 24, 1996, between the hours of 2:00 and 5:15 p.m. and again from 6:30 until approximately 9:00 p.m. The Applicants explained the nature of their proposal and the reasons supporting their decision to seek a COPA for the proposed consolidation; comments were then presented by 110 individuals both supporting and opposing the application. In addition, written testimony was received from approximately 60 individuals who did not present oral comments at the hearing.

V. PUBLIC COMMENT SUMMARY AND APPLICANTS' RESPONSE[2]

[2] This section of the findings is intended to summarize the public comment received during the application process. It is not a comprehensive listing of each comment received, and citations are to a representative sample of the comments.

Supporters of the COPA argue that Great Falls is not now and will not in the future be able to support two quality acute-care hospitals. They agree with the Applicants that significant cost savings may be achieved by the consolidation as a result of eliminating costly duplication of services and equipment and suggest that quality of care will improve with an increase in the volume of services and the ability to provide expanded health care services throughout the region. Supporters further argue that competition does not bring about lower prices in the health care industry, that the two Great Falls hospitals are currently underutilized, and that neither hospital now is able to offer tertiary care on a competitive level with other large hospitals in the state. (See, e.g., Tr. of Public Hearing at 22:9-22, 27:1-10, 39:8-15, 55:13-20, 166:5-10; Deborah Hanson Letter (1/5/96); Dr. Paul G. Dolan Letter (1/8/96); Dr. Bill J. Tacke Letter, (1/5/96); Dr. James D. Hinde Letter, (1/5/96); Dr. Thomas C. Key Letter (1/5/96)).

Some supporters also express fear that if the consolidation does not occur the two hospitals will be weakened over time and vulnerable to takeover by out-of-state, for-profit interests, thereby forfeiting all community control of the facility. They take the position that real competition does not now exist between the two Great Falls hospitals and that declining revenues due to lower government reimbursement levels and decreasing patient utilization will only worsen the situation. (Tr. at 43:21-24, 44:2-20, 48:18-25, 50:8-14, 53:24-25, 167:4-8.)

Third-party payers who commented on the application were few in number but without exception support issuance of the COPA. Blue Cross and Blue Shield of Montana, the state's largest third-party payer, submitted a letter in support of the consolidation, agreeing that elimination of duplication and consolidation of resources will lower costs and improve quality and access to health care. (Appl. App. E.) In addition, the consolidation is supported by the Montana Contractors' Association Trusts, a self-insurance entity which insures approximately 1,450 individuals and their dependents; Employee Benefit Management Services, a third-party administration firm that administers benefit programs for over 100 self-insured companies covering approximately 48,000 Montanans; and the Montana Association of Health Care Purchasers, with the proviso that appropriate conditions and guarantees be imposed. (Ex. 6 to Applicants' Response to Public Comment, 1/23/96; Tr. at 56:13 - 60:12.)

Opponents, on the other hand, claim that the consolidation will create a monopoly for acute care services in Great Falls and surrounding areas and will eliminate the choice now enjoyed by Great Falls residents who need hospital care. Opponents fear that local control of a merged entity will be lost and that health care decisions will be subordinated to religious teachings of the sponsoring entity. Some opponents further argue that the consolidation will result in layoffs and limit opportunity for employment in the health care field in Great Falls. They dispute

the Applicants' claims of underutilization and inability of the community to support two full-service hospitals, and argue instead that the community is growing and needs both facilities to handle the demand for services. (See, e.g., Tr. at 72:16-25, 77:15-21, 117:12-15; Dr. Cheryl M. Reichert Letter (12/2/95); Dr. Jake J. Allen Letter (1/8/96); Lawrence Anderson Letter (1/8/96).) With respect to the religious affiliation of the proposed entity, concerns have been raised about the elimination of certain services now available at Deaconess, particularly inpatient abortion services. (Tr. at 78-79, 89:7-22, 110:20 - 112:23, 117:16-23, 203:12 - 205:16.)

A number of physicians have expressed concern that the Applicants have failed to conduct an adequate facilities utilization study and that the proposal for consolidation of acute care services into one facility leaves insufficient operating room capacity and emergency services. (Allen Letter; Dr. Paul Gorsuch Letter (11/21/95); Dr. Dale M. Schaefer Letter (1/7/96); Resolution of Departments of Surgery, Anesthesia, OB-GYN, Jan. 4, 1996; Dr. Terry Jackson Letter (1/5/96).)

Concern also has been raised that health care quality will suffer due to staff cutbacks, lack of competition between the hospitals, and departure from the community of doctors who oppose the consolidation. (Tr. at 92:3-25, 108:12-15, 209:9-16.) A number of opponents question the Applicants' net cost savings estimate on the grounds that they have failed to consider realistic costs of remodeling and new construction. (Allen Letter.) Many opponents have urged the Applicants to consider collaborative activities short of consolidation. Some also raise concern about current differences in quality of care or responsiveness to patient needs between the two facilities, fearing that a single entity will not feel compelled to be responsive to its patients. (Tr. at 87:8 - 88:6, 207:22 - 208:7, 210:16-25.)

The Applicants submitted a response to the written public comment in accordance with Mont. Admin. R. 23.18.102(7). In their response, the Applicants claim that the merged entity will be a community hospital with Catholic sponsorship, having only one of 15 board members appointed by the Sisters of Providence. Regarding access to services in a Catholic hospital, the Applicants point to the commitment of MDMC to arrange for donation of assets to Intermountain Planned Parenthood to enable transportation costs to be paid for women who seek hospital-based abortions. All other services, including tubal ligations, AIDS prevention counseling, and post-coital contraception for rape victims, will remain available in the merged hospital.

The Applicants respond to concerns about facilities planning by committing to retain the assistance of facilities planning and architectural experts to undertake a detailed facilities utilization study if the consolidation is approved. They argue that this costly and time-consuming effort should not be required unless and until the consolidation takes place. The Applicants deny any need for or intention on their part to construct a new

hospital and reaffirm their belief that either existing structure could be modified to house all acute care services. The Applicants also contend that their plan to reduce licensed beds from a combined total of 486 to approximately 300, and routinely staff about 230 inpatient beds, is adequate to cover even the busiest times. They argue that the reduced bed numbers are a prudent response to falling utilization rates and will reduce the "peaks and valleys" now experienced by many services in both facilities.

Finally, the Applicants reiterate that the proposed consolidation will result in significant cost savings; they estimate that the cost of accomplishing the consolidation will amount to roughly one-half of one year's operating savings, and that implementation costs will be almost entirely offset by capital avoidance savings. The Applicants also reaffirm their belief that the consolidation will bring about access and quality improvements, claiming the ability of a merged hospital to meet the standards for becoming a Regional Trauma Center and to become a major competitor for tertiary services. The Applicants also emphasize that significant duplication of services and costs cannot be avoided without a consolidation.

VI. THE PROPOSED TRANSACTION

The Applicants propose to consolidate MDMC and Columbus into a newly created Montana Nonprofit Corporation (the "Consolidated Hospital"), that will be sponsored by the Sisters of Providence. Providence Services, a corporation owned and operated by the Sisters of Providence, will be the sole corporate member of the Consolidated Hospital. Appendices, Ex. H.

The Consolidated Hospital's governing board will be selected equally by the boards of Columbus and MDMC, with the Sisters of Providence having the right to appoint one of the fifteen board members. The board will approve its own budget and initiate all bylaw amendments. Id. Decisions regarding operations and services will be made by the board. Providence Services will retain certain express powers which require its concurrence on issues such as religious restrictions on services offered or the issuance of new debt. Id.

The Consolidated Hospital will continue operating at both existing locations for the near-term future, under the direction of a single board of directors and a single administrative staff. Most critical care services, including emergency care and most surgery, will gradually be shifted to one facility, and other acute care, including oncology and rehabilitation, gradually centralized at the other location. Appendices, Ex. I at p. 2.

The issue of continued corporate affiliation with Providence Services shall be annually evaluated by the Board of Directors of the Consolidated Hospital, based upon benefits to the community and such other criteria as shall be mutually established by the Board of Directors of the Consolidated Hospital and the Board of Providence Services. Id. If, at the conclusion of five years following the consummation of the consolidation, the Board of Directors of the Consolidated Hospital determines by a 60% vote

that such affiliation be discontinued, Providence Services and its parent, The Sisters of Providence, shall initiate and support alienation of the Consolidated Hospital, subject to certain conditions relating to the financial obligations assumed by the Consolidated Hospital at the time of the consolidation. Id.

The Consolidated Hospital will assume or otherwise provide for the payment of all debts of Columbus and MDMC and will become a member of the Montana Corporation obligated group, thereby assuming additional liability for bonded indebtedness of other members of that group under the terms of the Master Trust Indenture. Id.

VII. FINDINGS OF FACT

Pursuant to Mont. Code Ann. § 50-4-603, and Mont. Admin. R. 23.18.103(4), the Department makes the following specific findings based upon the application of Columbus and MDMC, the Memorandum, Appendices, Response, Applicants' Documents, other materials and information submitted by the Applicants in response to the Department's requests for additional information, interviews conducted by the Department, written public comments and the Applicants' responses to those comments, and the information presented at the hearing. See Mont. Admin. R. 23.18.103(2), (3).

A. The Department Finds That the Proposed Consolidation Is Likely to Result in Lower Health Care Costs Than Would Occur in the Absence of a Consolidation.

In evaluating whether the proposed consolidation is likely to result in lower health care costs, the Department has considered the following factors:

(c) gains in the cost efficiency of services provided by the health care facilities or physicians involved;

(d) savings to health care consumers resulting from anticipated cost efficiencies;

(e) improvements in the utilization of health services and equipment; and

(g) avoidance of duplication of health care resources. Mont. Admin. R. 23.18.104(1).

1. Savings to Health Care Consumers

Applicants contend that the proposed consolidation will result in annual operating savings in excess of $10.7 million, annual capital expenditure savings of approximately $2 million and a one-time capital allowance savings of $6.5 million. Memorandum at 48-49; Appendices at Ex. I; Response at 25. These projected savings are based on a plan that would allow the elimination of duplicate emergency rooms, surgical facilities, obstetrics delivery suites and pediatric units, as well as duplicate administrative and support services. Memorandum at 47.

In its October 12, 1995 request for additional information, the Department asked the Applicants to clarify whether the projected savings were net of anticipated costs necessary to achieve those savings. On November 10, 1995, the Applicants submitted a supplemental response outlining the likely cost of achieving the projected operational savings. Response at pp. 22-25. Applicants projected a total estimated consolidation cost of $12.25 million, including renovation costs of $5.95 million, to achieve the projected operational savings.

After analyzing the Applicants' analysis of the projected net savings, the Department asked the Applicants to address physician concerns about the estimated costs of consolidation, the capacity of the Consolidated Hospital to adequately handle anticipated volume, and whether quality of care will suffer as a result of changes in the facilities necessary to achieve the projected savings. Applicants responded by producing a supplemental analysis

that estimated an additional $1 million in renovation costs to achieve the projected savings. See Facilities Utilization Statement; Comments Response at 8.

a. Analysis of savings claimed by Applicants

The Department finds that the proposed consolidation is likely to result in significant cost savings. Of the $10.7 million in merger-specific annual operating savings[3] claimed by the Applicants, the Department finds approximately $7.5 million in actual merger-specific savings is likely to result from the consolidation. See Economist's Report at 4. Approximately $1 million of the $3.2 million difference between the Applicants' claimed merger-specific savings of $10.7 million and the Department's estimate of $7.5 million is savings that could be achieved without the consolidation. The Department finds that the remaining amount of savings claimed by the Applicants either (1) is not likely to be achieved or (2) will be offset by a corresponding reduction in revenues. See Economist's Report at 4-5.

[3] "Merger-specific" savings are those savings that could be achieved only through a merger of the two hospitals.

In addition to the annual operating savings of $8.5 million (the $7.5 million in merger-specific savings plus $1 million in nonmerger-specific savings) the Department finds that the consolidation is likely to result in annual capital cost savings of $1.6 million. At present dollar values, the total cost savings over the next 10 years equals approximately $46 million. Economists' Report at 2. The Department also finds that the Consolidation is likely to result in additional annual Medicare revenues of $6 million.[4] This brings the value of the consolidation over the next 10 years to approximately $86 million. Economist's Report at 2.

Opponents of the consolidation point to a 1990 study of 18 hospital mergers between 1985 and 1987 in which expenses were only reduced "one to two percent annually." Dr. Jake J. Allen Letter (1/7/96), citing Greene, Jay, "Do Mergers Work?", *Modern Health Care*, Mar. 19, 1990, at 24-36. Opponents argue that this undermines the Applicants' claim of $10.7 million in projected annual operating savings. Id. The mergers reviewed in the 1990 study are distinguishable from the proposed Great Falls merger in that they did not involve post-merger state regulation to ensure that projected savings are achieved and passed on to consumers. The granting of a COPA in this case will be contingent upon the Applicants' acceptance of terms and conditions that give the

[4] An additional $6 million in Medicare revenues will be paid to the Consolidated Hospital assuming it qualifies as a "sole community provider" under current Medicare regulations. The Applicants have been advised that the Consolidated Hospital is likely to qualify for this additional Medicare revenue. Comments Response at 8.

Department the ability to ensure that the projected cost savings are achieved.

b. Health care costs in the absence of a consolidation

A finding of significant merger-specific savings alone does not satisfy the statutory standard for a certificate. The Department may not issue a COPA unless it also determines that the consolidation would result in lower health care costs than would occur in the absence of a consolidation. Concl. of Law at 42-43.

While it is impossible to predict with certainty what the costs for hospital services in Great Falls would be in the absence of the consolidation, the Department finds that those costs would likely decrease. Hospital costs in Great Falls are approximately 10% higher than other hospitals considered by Applicants to be in the same "peer group," and 6.5% higher than in Billings, Montana. Appendices, Ex. C at 9. The average cost of inpatient treatment in Great Falls rose 141% from 1988 to 1995 as compared with a statewide increase of 84.3%. Tr. at 31:13-20. Great Falls has not yet felt the effects of significant managed care penetration. Memorandum at 15; *The InterStudy Competitive Edge*, vol. 5, No. 1 at p. 69 (InterStudy Pubs. 1995). As Applicants admit, "the trickle will certainly grow, as it has almost everywhere else in America." Id. at 23. Financial projections prepared by the Applicants predict that "managed care penetration and discounting" will start immediately and will increase to 12.5% in five years. Privileged Document 36 at p. 2.

Managed care penetration has the effect of lowering health care costs. See Cleverly, William O., *The 1995 Almanac of Hospital Financial & Operating Indicators* at 453 (Ctr. for Healthcare Industry Performance Studies). Consolidation, however, may impede the ability of managed care to negotiate price discounts for hospital services. "Merger Monopolies," *Modern Health Care*, at 39 (Dec. 5, 1994). While some of the difference between hospital costs in Great Falls and those in other areas may be explained by factors other than managed care penetration, the Department finds that the gradual increase in managed care penetration in Great Falls that is likely to occur without a consolidation could eventually result in annual cost savings of $3 million to $5 million. See Economist's Report at 6. The Department finds, however, that the consolidation is likely to result in lower health care costs than would occur in the absence of a consolidation, because the merger-specific savings of $7.5 million plus the $1.6 million in annual capital expenditure savings are significantly greater than the $3 million to $5 million in managed care savings that may occur without a consolidation.[5]

c. Passing cost savings and financial benefits on to consumers

[5] As explained in Note 3, supra, the consolidation is also likely to result in an additional $6 million in Medicare revenues. While this significant financial benefit provides additional support for the Department's decision to issue a COPA, that benefit could be eliminated in the future through Medicare reform. That possibility, however, does not preclude the granting of a COPA in this case because the $7.5 million in merger-specific annual operating savings and the $1.6 million in merger-specific annual capital expenditure savings are sufficient to compel the issuance of a COPA on the ground that the proposed consolidation is likely to result in lower health care costs.

A COPA may be issued subject to terms and conditions that the Department determines are appropriate in order to ensure that savings resulting from the consolidation benefit consumers. Mont. Code Ann. § 50-4-603(3). The Department may also establish terms and conditions that are "reasonably necessary to protect against abuses of private economic power . . . or otherwise appropriate to best achieve lower health care costs." Mont. Admin. R. 23.18.104(5).

Applicants suggest that the nonprofit status of the Consolidated Hospital will ensure that the gains from consolidation will be passed on to consumers in the form of lower prices, better quality and more accessible health care in the Great Falls region. Memorandum at 70. While the Department finds that the Consolidated Hospital's nonprofit status may provide some protection against conduct detrimental to consumers, that status alone is not sufficient to ensure that cost savings are passed on to consumers or that economic power resulting from the consolidation is not abused. See, e.g., United States v. Rockford Memorial Corp., 898 F.2d 1278, 1285 (7th Cir. 1990) (rejecting argument that nonprofit status of hospital "removes any concern that [it] might seek to maximize profits through avoidance of price or service competition"). Health care costs in Great Falls have been historically higher than in other similarly situated cities, despite the fact that both hospitals are nonprofit. Appendices, Ex. C at 7. The Department finds that the imposition of terms and

conditions is necessary to ensure that projected cost savings are actually realized and that consumers benefit from those savings. The terms and conditions will also reflect managed care savings in Great Falls that would likely occur in the absence of a consolidation.

After offsetting for the costs of consolidation and the amortization of capital expenditure savings, the net financial benefits resulting from the consolidation approximate $8 million for the first year following the consolidation, increasing to more than $14 million by year four. Economist's Report at Ex. 3. The Department will require that these savings be passed on to consumers in the form of price reductions. See Economist's Report at 8-18 for a description of the regulatory methodology for ensuring that cost savings are passed on to consumers by the Consolidated Hospital. Price reductions of approximately 18-23% will be required in order for the Consolidated Hospital to comply with the patient revenue cap regulation imposed by the Department. Economist's Report at 3; Terms and Conditions Section 1. The Department finds that the proposed consolidation qualifies for a COPA pursuant to Mont. Code Ann. § 50-4-602 on the grounds that it is likely to result in significant health care cost savings.

2. Duplication of Resources

The proposed consolidation will significantly eliminate duplication of health care resources. The plan to shift most critical care services to one facility and locate other acute-care services at the other location will allow the elimination of duplicate emergency rooms, surgical facilities, obstetric delivery suites and pediatric units. Memorandum at 47; Appendices Ex. I at 2-4; Tr. at 55:13-20, 63:5-15, 166:5-10, 180:18-23, 183:12-16. Duplicate administrative, support and clinical support services will also be eliminated to a great extent. Id. The Department finds that the proposed consolidation is likely to result in the elimination of duplication of health care services.

3. Improvements in the Cost Efficiency and Utilization of Health Services and Equipment

Increasing the average daily census in several combined specialty-care units will result in staffing efficiency gains. Combining clinical units will yield efficiencies through better coordination of staff, equipment and facility resources. Tr. at 65:1-11, 66:9-20, 175:4-10. Cost efficiencies will also be achieved through volume purchasing and discounts. Appendices Ex. I at 2-4. The Department finds that the consolidation is likely to result in increased efficiencies and utilization.

4. Applicants' Argument That Costs Will Rise and Services Will Diminish Unless the Hospitals Merge

The Applicants claim that reductions in Medicaid and Medicare reimbursements, increased regional competition, and decreasing inpatient utilization from increased managed care penetration will

cause hospital revenues in Great Falls "to decline faster than [the hospitals] can separately reduce their costs" without significantly reducing the level or scope of services they now offer. Memorandum at 60. According to the Applicants, this would result in "continuing price increases" and "ultimately those services that were not paying their way would begin to be curtailed or eliminated." Memorandum at 60-61. Ultimately, Applicants argue, "as scope and quality of services begin to suffer, regional patients would consider alternative regional hospitals, thereby causing a vicious cycle of cutbacks, quality reductions, and decline in patient census." Id. The Applicants' argument is based on an analysis by Lewin-VHI, Inc., which predicts that the financial condition of both hospitals is likely to deteriorate over the next five years, resulting in negative "total margins" by the year 2000. Memorandum at 23-27.

The evidence suggests that the Applicants' concerns are overstated. An analysis prepared in 1994 for the Applicants by the accounting firm of Arthur Andersen projects steady decreases in operating margins for both hospitals from 1994 through 1998. Appendices, Ex. F at 82. Data produced by the hospitals for 1995, however, indicates strong operating margins far exceeding those projected by Arthur Andersen. Applicants' Privileged Document 14 at p. 1 (12.97% operating margin for MDMC as of September 1995 compared to 3.5% Arthur Andersen projection); id. at 20 (7.8% operating margin for Columbus as of September 1995 compared to 1.4% projected by Arthur Andersen). Neither hospital in Great Falls

requested price increases from the Montana Hospital Rate Review System for 1996. Dr. Jake J. Allen Letter (1/7/96) at 11.

The Applicants' projections also assume that the population in Cascade County will remain "stagnant" and the economy will not grow or expand. Memorandum at 30. A 30% increase in residential and commercial building permits during 1995 and the recent entry of several significant business enterprises into the Great Falls area suggest that this assumption may not be accurate. Dr. Jake J. Allen Letter (1/7/96) at 10-11. Similarly, the Lewin projections of steadily declining margins fail to take into account cost decreases resulting from increased managed care penetration. Oct. 26, 1995 Interview with Robert Mechanic and Allen Dobson. The Appl services will likely diminish without a consolidation. The Department does not rely on this argument as a basis for granting the COPA.

Applicants have demonstrated, however, that only one full-service hospital is likely to survive in Great Falls. Total patient days in Great Falls hospitals have steadily declined from 125,974 in 1972 to 67,853 in 1995. Comments Response, Ex. 4. That decline in utilization is likely to continue as managed care penetration increases. Memorandum at 9. The economic literature suggests "that as competition increases, the firms which survive in an industry will be at least of minimum efficient scale." Frech, H.E. & Mobley, L.R., *Resolving the Impasse on Hospital Scale Economies: A New Approach, Applied Economics* 27, 286-96 (1995). Minimum efficient scale for full-service hospitals is generally

considered to require in excess of 300 beds. Id. With the combined number of staffed beds for both hospitals in Great Falls at approximately 220, it does not appear that two full-service hospitals can efficiently operate in the Great Falls area. While Applicants have not demonstrated when the evolution from two full-service hospitals to one in Great Falls is likely to occur or whether that process will likely result in higher prices and the loss of tertiary services, the Department finds that one of the two full-service hospitals in Great Falls is likely to exit that market in the future. See Economists' Report at 6. The Montana Association of Health Care Purchasers ("MAHCP") agrees with that assessment (see Jan. 19, 1996 letter from MAHCP, Comments Response at Ex. 6) as do other persons familiar with hospital services in Great Falls. Tr. 22:9-15, 27:1-4, 169:10 - 170:16. That finding supports the Department's conclusion that the issuance of a COPA is warranted in this case.

5. Conclusion

The Department finds that the proposed consolidation of Columbus and MDMC, as implemented by the specific terms and conditions adopted by the Department herein, is consistent with and in furtherance of the Montana legislature's express policy of "controlling health care costs and improving the quality of and access to health care" in the Great Falls service area. Mont. Code Ann. § 50-4-601. The specific details of the consolidation are mandated by the terms and conditions adopted by the Department. Competition between Columbus and MDMC will be displaced by the

Department's supervision and control of the Consolidated Hospital.

A0 The Department Finds That the Quality of Health Care Services Will Likely Be Maintained After the Consolidation.

1 Quality Enhancement Claims

Applicants contend that unless consolidation occurs the scope and quality of hospital services will suffer. Memorandum at 60-61. This argument is based primarily on the Lewin projections which the Department concludes are not sufficient to establish that such a result is likely to occur. See supra at 25-26.

The Applicants also contend that consolidation will improve the response time of trauma physicians and enable the creation of a single medical record allowing physicians access to more complete patient information. Memorandum at 56-57. While such benefits are likely to improve the quality of care after the consolidation, the Department finds that these benefits could be achieved through arrangements less restrictive than a consolidation and therefore these benefits alone do not justify the proposed consolidation. Tr. at 35:7-14.

Applicants further contend that consolidation of relatively low volumes in certain medical specialty services will improve quality. Memorandum at 67. There is evidence supporting the assertion that increased volume leads to the delivery of more efficient and higher quality health care. Frech, H.E. & Mobley, L.R., *Applied Economics* 27 at 294; Comments of Steven P. Krautscheid, Dec. 29, 1995; Comments of Dr. Thomas C. Key, Jan. 5,

1996 at 2; Comments of Dr. Richard D. Blevins, Nov. 30, 1995; Tr. at 40:1-5, 174:8-20. Although increased volumes would not be a factor in specialty services that are currently provided at only one of the two hospitals (i.e., cardiac surgery), the Department finds that increased volumes resulting from the consolidation are likely to improve the overall quality of hospital services in Great Falls.

2 Quality Concerns

a. Elimination of competition between the hospitals on service quality

The proposed consolidation, however, could negatively impact quality by eliminating local competition as an incentive for the Consolidated Hospital to respond to physician and patient needs. Several physicians expressed this concern. Dr. Jake J. Allen Letter (1/7/96) at 15; Tr. at 209:9-16, 234:17 - 235:6. The hospitals argue that physicians often "play the hospitals against each other" for reasons unrelated to quality or patient benefit. While there is some evidence that this has occurred (Tr. at 29:1-6), the Department finds that the elimination of competition poses a risk to the quality of hospital services to consumers in Great Falls. The granting of a certificate will also be conditioned on a state-administered program for monitoring the quality of health care at the Consolidated Hospital. The Consolidated Hospital will be required to meet certain quality standards specified in the terms and conditions set forth in Section 2.

b. Bed capacity

Opponents also argue that the proposed consolidation will result in a shortage of beds affecting "quality and access." Dr. Jake J. Allen Letter (1/7/96) at 2. MDMC and Columbus currently operate with 323 available beds and 220 staffed beds. Comments Response at 6. The combined average daily census in 1995 was 189 and the maximum combined census on any day in 1995 was 222. Id. The Consolidated Hospital would have approximately 300 available beds and 230 staffed inpatient beds. Id. The projected number of staffed beds exceeds the 1995 combined average daily census by about 40 beds and would have been sufficient for the busiest day during 1995. Id. Additionally, the Consolidated Hospital plans to staff 15-20 short stay/ambulatory beds and 140 long term/skilled nursing beds. Id. The Department finds that the effect of the proposed consolidation on the availability of beds is not likely to reduce the quality of or access to health care in Great Falls.

c. Inpatient operating room capacity

Merger opponents argue that a new facility or a new wing on one of the existing hospitals would have to be constructed in order to make room for the number of inpatient operating rooms necessary to accommodate anticipated surgical volumes. See Comments of Dr. Jake Allen at 4-5. In fact, some physicians argue that existing operating room capacity is inadequate and that "there is considerable difficulty in getting urgent surgical cases on schedule in a reasonable amount of time." Dr. Dale M. Schaefer Letter (1/7/96). Applicants responded by submitting an analysis

which concluded that only one additional operating room, at a cost of approximately $300,000, would be required if Columbus were selected as the inpatient surgery facility and no additional surgery suites would be necessary if MDMC were selected. See O.R. Utilization Analysis. Applicants' analysis was based on the assumption that all inpatient operating rooms would be scheduled for 10.5 hours per working day and all outpatient operating rooms would run 9.0 hours per working day. Id.

MDMC currently has five general surgery suites, one open heart surgery suite, and three outpatient operating rooms. Columbus operates five general operating suites for a total of 13 general and one open heart operating room in Great Falls. Comments Response at 4. Both facilities could add up to three additional operating rooms at a cost of approximately $300,000 per room. Comments Response at 5.

An independent analysis prepared in conjunction with the Montana Trauma Project Survey suggests that current delays in scheduling urgent surgical cases are not caused by a lack of operating rooms but by the limited availability of anesthesiology coverage and a "lack of agreement about scheduling." See Report of the Montana Trauma Systems Plan at 4, Comments Response Ex. 5. See also Tr. at 29:7-15. That report supports the conclusions of the hospital management expert who analyzed this issue for the Department and concluded that potential operating capacity at either facility is sufficient to adequately handle projected volumes. See Economist's Report at 7. The Department finds that

quality will not be adversely affected by a lack of operating capacity at the Consolidated Hospital.

The Department will require, however, that the Consolidated Hospital add a sufficient number of inpatient operating rooms to handle projected volumes while maintaining an average daily operating schedule consistent with industry norms for similarly situated hospitals as determined by the Department. The Department finds that a schedule requiring 10.5-hour operating days would negatively affect quality of service and the Department will require that the Consolidated Hospital maintain a sufficient number of inpatient operating rooms to accommodate projected volumes at an operating schedule that does not adversely impact quality of care. See Terms and Conditions at ¶ 2.11.

d. Conclusion

Having considered these potential benefits and risks to the quality of health care services, the Department is not persuaded that a COPA should be granted on the ground that the consolidation is likely to result in "higher quality health care" than would occur in the absence of the consolidation. In order to grant a COPA on other statutory grounds, however, the Department must find that the consolidation is not likely to result in reduced quality of health care. See Conclusions of Law, at 42. The Department finds that the quality of hospital services provided in Great Falls will likely be maintained if the Terms and Conditions of the COPA are met.

B0 The Department Finds That the Consolidation Is Likely to Result in Improved Access to Health Care.

1 Financial and Geographic Access

In making determinations as to availability of or access to health care, the Department has considered "the extent to which the proposed agreement or transaction is likely to otherwise make health care services or products more financially or geographically available to persons who need them." Mont. Admin. R. 23.18.104(3)(c).

Applicants contend that consolidation provides the best chance of preserving Great Falls as a regional health care center. Memorandum at 57-58. Without consolidation, Applicants believe that many tertiary services will be curtailed or eliminated as a result of the declining financial conditions of the hospitals. Memorandum at 60-62. This contention is based on the Lewin analysis which the Department has concluded is not sufficient to satisfy the Applicants' burden of justifying a consolidation under the "declining financial condition theory." Supra at 25-26.

The Department finds, however, that the consolidation does not threaten geographic access to hospital services and it is likely to result in improved financial access to health care services in the Great Falls area through the imposition and enforcement of terms and conditions that require Applicants to pass on the savings and financial benefits resulting from the consolidation to consumers of hospital services in Great Falls. Mont. Admin. R. 23.18.104(3)(c). As set forth in these findings, the consolidation will result in

significant cost savings for consumers. Detailed estimates of the anticipated net financial benefits to consumers from the consolidation are presented in Exhibit 4 to the Economist's Report.

2 New Services

In making determinations about the availability of health care, the Department has considered "the extent to which the proposed agreement or transaction is likely to make available a new and needed service or product to a certain geographic area." Mont. Admin. R. 23.18.104 3(b). Applicants have not asked the Department to consider any specific new medical services or products as a justification for granting the requested COPA. Rather, Applicants contend that "only consolidation offers the hope of ***maintaining*** the current level and quality of services and any ***possibility*** of expansion in the future." Memorandum at 66 (emphasis added).

The COPA is granted on the basis of cost reductions, not access to new services. The Consolidated Hospital may, in its discretion, add new services after the consolidation, provided that the terms and conditions of the COPA are satisfied, including the cost and revenue requirements.

3 Maintaining Access

In addition to ensuring that access to health care services is improved through the redeployment of merger-specific savings, the Department finds that terms and conditions are required to ensure that the consolidation does not adversely affect the availability of health care services to consumers in the following areas:

a0 The effect of the Consolidated Hospital's affiliation with the Sisters of Providence on access to medical services

The Department asked the Applicants to state the extent to which any medical services would not be permitted or would be restricted as a result of the Consolidated Hospital's affiliation with the Catholic Church. See Oct. 12, 1995 Request for Additional Information. The Applicants responded by stating that with the exception of abortion services, there would be no restrictions at the Consolidated Hospital on any of the services currently offered by MDMC. See Response at 27-28.

The Department will require as a condition to the issuance of a COPA that the Consolidated Hospital agree to continue providing, without restrictions, the following services as set forth in the Applicants' response: (1) information and counseling on post-coital contraceptives for victims of rape; (2) elective sterilization; and (3) HIV risk reduction counseling. Additionally, with the exception of abortion services, the Consolidated Hospital will be required to maintain the same level and type of services being provided by Columbus and MDMC immediately prior to the consolidation. Any reduction in service must be approved by the Department. See Terms and Conditions at ¶ 4.1.

Abortion services will not be provided at the Consolidated Hospital. Such services are currently provided by MDMC on an elective or therapeutic basis. Response at 28. The application

claims that approximately twelve abortion procedures are performed each year at MDMC. Memorandum at 44. The vast majority of abortions are performed outside the hospital acute care setting. Tr. at 204:9-15. Some procedures, however, particularly late trimester abortions, must be performed in a hospital operating room. Id. Of the 32 abortions performed at MDMC between February 1, 1994, and February 1, 1996, twenty-eight involved a diagnosis of fetal abnormalities or "anomalous fetus." Feb. 27, 1996 Letter from Kirk Wilson to Max Davis. The sole perinatologist in Montana resides in Great Falls. Memorandum at 57. MDMC is currently the only hospital in the state where perinatal genetic counseling and related terminations are performed. Interview with Dr. Thomas Key. Of the 32 abortions performed at MDMC during the period from February 1, 1994, through February 1, 1996, only nine involved patients from Cascade County. The others involved patients from all across the state. Kirk Wilson Letter (2/27/96).

MDMC originally proposed to deed an office condominium to Intermountain Planned Parenthood. The revenue generated by the condominium would be used to cover the nonmedical expenses of any woman who is required to travel to another city to obtain an abortion. Memorandum at 44. The Department finds that, so long as the revenue is sufficient to cover the expenses of both the patients and any physician who will be required to travel in order to continue providing within the state services previously performed at MDMC, this solution to the abortion access problem is adequate.

The Department agrees with the Applicants' contention that the perinatal procedures currently provided in Great Falls are "vital services" that should be preserved in Montana. Memorandum at 57. These procedures now include genetic-related terminations performed for women throughout Montana. The perinatologist has committed to continue to provide these services on a statewide basis at another location or locations in Montana. Dr. Thomas Key Letter (1/5/96). With the continued provision of these services, and on the basis of the perinatologist's willingness to provide the service elsewhere in Montana, the Department finds that there will be no diminution in access to currently available services. In fact, since many patients now travel to Great Falls for this service, the availability of the service in other locations may even enhance access.

The Department will also require that MDMC deed an office condominium to Intermountain Planned Parenthood, the revenue from which shall be used to cover the nonmedical expenses of any patient who is required to travel to another city in Montana to obtain abortion services previously available at MDMC. In addition, the Department will require that the revenue be used to cover the expenses of the perinatologist or any other physician who is required to travel to another city to perform pregnancy terminations previously performed at MDMC which may not be performed in the Consolidated Hospital. Terms and Conditions at ¶ 4.6.

With these conditions, the Department finds that affiliation of the Consolidated Hospital with the Sisters of Providence will not negatively impact access to medical services. Concerns regarding religious restrictions on access to medical services are adequately resolved through terms and conditions set forth in Section 4. To the extent that objections to the Consolidated Hospital's affiliation with the Sisters of Providence relate to concerns other than cost, quality and access, the Department finds that such objections, while made in good faith, are outside the statutory guidelines that set the parameters for evaluating the application.

b0 Effect of the consolidation on competition among health care providers competing with Consolidated Hospital

In evaluating any disadvantages likely to result from the consolidation the Department has considered the "reduction in competition among health care providers or other persons furnishing goods or services to, or in competition with, health care facilities or physicians that is likely to result directly or indirectly from the . . . consolidation." Mont. Admin. R. 23.18.104(2)(c).

Health care providers competing with MDMC and Columbus for the provision of home health care services expressed concerns that the Consolidated Hospital might use its economic power to disadvantage competitors that compete with the hospitals in ancillary service markets. Tr. at 122:24 - 126:12. In response to the Department's

request, the Applicants explained their policies regarding such referrals. Response at 7-8.

Interim Health Care submitted comments disputing the hospitals' claim that they "endeavor to provide patients with objective impartial information regarding the patient's options for any particular service." Patrick E. Melby Letter (8/7/95). The Department will require the Consolidated Hospital to adopt written guidelines regarding patient referrals in accordance with paragraph 13.1 of the Terms and Conditions to ensure that competing health care providers are not unfairly denied access to potential customers.

c0 Effect of the consolidation on health care payers

Mont. Admin. R. 23.18.104(2)(b) allows the Department to consider the adverse impact of the proposed consolidation on the "ability of health care payers to negotiate optimal payment and service arrangements with health care providers." The largest health care payer in Montana supports the consolidation. See Blue Cross and Blue Shield of Montana Letter (8/17/95), Appendices, Ex. E. After reviewing the proposed consolidation, Blue Cross and Blue Shield of Montana stated that the consolidation will "result in elimination of duplication and consolidation of resources, thereby further improving quality and access to care in the region served." Id. The consolidation is also supported by groups representing over 135 self-insured Montana companies and other health care purchasers. See Letters Supporting Consolidation from

Employee Benefit Management Servs., Montana Ass'n of Health Care Purchasers, Montana Contractors Ass'n Trust, Energy West, Buchanan Enters., Smith Equip. Co., Montana Refining Co., and other health care purchasers. Comments Response at Ex. 6; Tr. at 56:13-60, 190:1-18, 191:14 - 192:1.

The Department finds, however, that the increase in economic power and concentration resulting from the consolidation may adversely impact the ability of health care payers to negotiate optimal payment and service arrangements with the Consolidated Hospital. The Montana Association of Health Care Purchasers shares this concern. See MAHCP letter, Comments Response at Ex. 6. The Department will require the Consolidated Hospital to negotiate in good faith with health care payers and will impose other terms and conditions to ensure that the ability of health care payers to negotiate optimal payment and service arrangements is not adversely affected. See Terms and Conditions at Sections 5, 6, and 9.

d0 Effect of the consolidation on other health care providers

The elimination of competition for hospital services in Great Falls also raises concerns about the access of physicians and other health care providers to hospital facilities and services. A COPA will be granted subject to terms and conditions which ensure that economic power resulting from the consolidation will not be used to unfairly discriminate against physicians or other health care providers that require access to hospital services and facilities. See Terms and Conditions at Sections 5, 6, and 8.

C0 Availability of Arrangements Less Restrictive to Competition

Mont. Admin. R. 23.18.104(2)(d) provides that in evaluating an application for a COPA, the Department may consider "the availability of arrangements less restrictive to competition that achieve the same benefits." Opponents of the consolidation contend that duplication could be eliminated and substantial savings achieved through joint ventures between the hospitals that would not require a complete merger. Comments of Dr. F. John Allaire, Oct. 27, 1995.

The Department finds that a large portion of the savings that can be achieved through joint venturing has already been realized through previous cooperative efforts between the hospitals. Memorandum at 36. Cardiac surgery and neonatal intensive care are provided exclusively at MDMC and only Columbus offers radiation oncology and renal dialysis. Dr. Jake J. Allen Letter (1/7/96) at 2. Despite these cooperative efforts, the Department finds that significant additional annual operating savings could be achieved through a consolidation. A substantial portion of those savings results from the elimination of duplicate administrative and support costs that can most effectively be realized through a consolidation. Economist's Report at 5, 6. While further joint venturing might result in some additional savings, the effect would be to further eliminate competition between the hospitals without producing the significant efficiencies that are provided by a complete merger.

D0 Continuing Supervision

Due to the high level of concentration of hospital services in the Great Falls market after the consolidation, and as required by Mont. Code Ann. § 50-4-622, the Department will monitor and supervise the activities of the Consolidated Hospital on a continuing basis. The Consolidated Hospital will submit annual progress reports pursuant to Mont. Admin. R. 23.18.106 that comply with the provisions of Mont. Admin. R. 23.18.106(1)(b) and include the additional information required by the Terms and Conditions.

The Department will use any authorized means necessary to enforce compliance with the terms and conditions including revocation of the certificate (Mont. Code Ann. § 50-4-609), the filing of an action to enforce compliance with the terms and conditions (Mont. Code Ann. § 50-4-621) and the imposition of additional terms and conditions that it determines are necessary to effectuate the objectives of the COPA (Mont. Admin. R. 23.18.106(6)).

VIII. CONCLUSIONS OF LAW

The Department's authority to grant or deny a COPA is governed by the standard set forth in Mont. Code Ann. § 50-4-603(2), which provides in pertinent part:

> The department may not issue a certificate unless the department finds that the agreement is likely to result in lower health care costs or is likely to result in improved access to health care or higher quality health care without any undue increase in health care costs.

The Department may issue a COPA subject to terms and conditions, as the Department determines are appropriate, in order to best achieve

lower health care costs or greater access to or quality of care. Mont. Code Ann. § 50-4-603(3).

This application is the first to be reviewed under Montana's COPA act. The act specifies three factors pertinent to the Department's decision--cost, access and quality. The test to be applied in determining whether the COPA should issue is whether the proposed transaction is: (1) likely to result in lower health care costs, or (2) likely to result in better access to or quality of care without any undue increase in health care costs. The instant application is based primarily on the first prong of the test, although Applicants also claim that access and quality will improve.

While the statutory tests are framed in the alternative, there is nothing in either the plain language of the statute or its legislative history to indicate that lower costs could justify issuance of a COPA if the proposed agreement or transaction would have a material adverse impact on access or quality. Efforts to reduce or contain costs should not be accomplished at the expense of access to or quality of care. Accordingly, a COPA may be issued under the "lower costs" test of Mont. Code Ann. § 50-4-603(2) only if the proposed transaction will not have a material adverse effect on access to health care services and quality of care.

"Health care costs," for the purposes of COPA proceedings, are defined as "the amount paid by consumers or third party payers for health care services or products." Mont. Admin. R. 23.18.101(3). Therefore, an application based on projected cost savings must

show that prices to consumers (or third-party payers) will be lower, i.e., that the savings achieved by the consolidation will be passed on to health care consumers.

In evaluating whether the proposal is likely to bring about lower costs, the relevant inquiry is whether the costs will be lower than they are likely to be if the proposal is not approved. It is an elemental principle of statutory construction that statutes should be construed so as to give effect to all of their provisions. Mont. Code Ann. § 1-2-101; Gibson v. State Fund, 255 Mont. 393, 396, 842 P.2d 338, 340 (1992). Related statutes should be harmonized (Matter of W.J.H., 226 Mont. 479, 483, 736 P.2d 484, 486-87 (1987)), and conflicts avoided unless no other reasonable construction is possible (Continental Oil Co. v. Board of Labor Appeals, 178 Mont. 142, 151, 582 P.2d 1236, 1241 (1978)). Further, the legislature's intent should be determined, if possible, from the plain language of the statute. State ex rel. Neuhausen v. Nachtsheim, 253 Mont. 296, 299, 833 P.2d 201, 204 (1992).

The COPA act contains slightly different phrasing of the legal standard that governs the Department's review. As noted above, Mont. Code Ann. § 50-3-603(2) refers to "lower health care costs" or "improved access to health care or higher quality health care without any undue increase in health care costs." On the other hand, § 50-4-609 provides that the Department

> shall revoke a certificate previously granted by it if the department determines that the cooperative agreement is not resulting in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement.

Interpreting the statutes as a whole, and consistent with the legislature's expressed intent that the COPA process make health care more affordable to Montanans, the Department concludes that a certificate may not be issued unless the Department finds that the proposed consolidation is likely to result in lower health care costs or greater access to or quality of health care than would occur in absence of the agreement. To satisfy this standard, the Applicants must demonstrate that health care costs after the proposed consolidation are likely to be lower than the costs would have been but for the transaction. This conclusion finds support in antitrust law, where damages are measured by taking the difference between what the injured party's profits would have been in a hypothetical free economic market and what the party actually made in spite of the anticompetitive conduct of the defendant. Dolphin Tours v. Pacifico Creative Serv., 773 F.2d 1506, 1517 (9th Cir. 1985). See also II P. Areeda & D. Turner, *Antitrust Law* 231-34 (1978).

Factors to be considered in determining whether the statutory tests have been met are set forth in Mont. Admin. R. 23.18.104. Each of these factors pertains in some way to the Department's determination of whether the transaction is likely to result in lower health care costs or bring about greater access to care or improvements in quality. If, based on those factors, it appears that the transaction will meet the statutory standards, the certificate must be issued.

The standards set forth in § 50-4-603(2) constitute a condition precedent to the issuance of a certificate. Matter of E-Z Supply, 267 Mont. 298, 302, 883 P.2d 833, 836 (1994). There is no statutory basis for denial of the COPA if the condition precedent is satisfied. Administrative agencies enjoy only those powers that are specifically conferred on them by law. Bick v. State Dep't of Justice, 224 Mont. 455, 457, 730 P.2d 418, 420 (1986). See also State ex rel. State Tax Appeal Bd. v. Montana Bd. of Personnel Appeals, 181 Mont. 366, 371, 593 P.2d 747, 750 (1979) ("administrative agencies are bound by the terms of the statutes or regulations granting them their powers and are required to act accordingly"). Further, "[w]here an agency has been charged with administering a law, it may not substitute its own policy for that of the legislature." 3 Sutherland *Statutory Construction* § 65.01, at 309 (5th ed. 1992). The factors set forth in Mont. Code Ann. § 50-4-603(2) are the guideposts for the Department's discretion; if one or both of those factors is satisfied, the Department may not deny the COPA. See also Bascom v. Carpenter, 126 Mont. 129, 136, 246 P.2d 223, 226 (1952) ("It is well settled that, where even the word 'may' is used, and the rights of the public or of a third party are affected, the language is mandatory, and must be strictly obeyed").

In FTC v. Ticor Title Ins. Co., 504 U.S. 621, 112 S. Ct. 2169 (1992), the Supreme Court reaffirmed that in order for private conduct to qualify for state action immunity from the federal antitrust laws, (1) "'the challenged restraint must be one clearly

articulated and affirmatively expressed as state policy,'" and (2) "'the policy must be actively supervised by the state itself.'" 112 S. Ct. at 2176 (quoting California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980)). The Court recognized that states are entitled to displace competition with regulation "if the displacement is both intended by the state and implemented in its specific details." 112 S. Ct. at 2176. Thus, the active supervision test "'requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.'" Id. at 2177 (quoting Patrick v. Burget, 486 U.S. 94, 100-01 (1988)).

The Montana legislature clearly articulated its policy that state regulation of health care facilities and physicians "substitute . . . for competition" between such entities. Mont. Code Ann. § 50-4-601. Additionally, it imposed specific requirements for active supervision of approved cooperative agreements, mergers or consolidations. First, as noted above, the COPA act allows terms and conditions to be imposed to ensure that the objectives of the certificate are met. Mont. Code Ann. § 50-4-603(3). Second, the law requires the submission of reports to the Department at least annually, evaluating whether the agreement approved by the Department has been complied with and whether any terms and conditions have been satisfied. Mont. Code Ann. § 50-4-622. The Department is required to issue findings as to whether the terms and conditions have been satisfied during the

reporting period. Id. The statute provides no termination date for the filing of such reports.

Likewise, under the rules governing supervision of approved transactions, parties to an approved cooperative agreement, merger or consolidation are required to submit progress reports that enable the Department to evaluate the impact of the agreement or transaction on the availability, cost effectiveness, quality, and delivery of health care services. Mont. Admin. R. 23.18.106(1). The Department is entitled to conduct audits, request information, require surveys, and consider public comment in evaluating whether the objectives of the COPA are being met. Mont. Admin. R. 23.18.106(2), (3), (5). Pursuant to subsection (1)(a) of the rule, the first progress report will be due on or before March 6, 1997. These state laws and regulations require the Department to impose and conduct ongoing supervision if a COPA is granted.

Given the complexity of the instant transaction and the fact that the merged facility will be the sole acute-care, full-service hospital in the community of Great Falls, and based on the foregoing Findings of Fact, it is appropriate to impose conditions on the COPA to make sure the objectives of the COPA are achieved and to guard against the potential for abuse of monopoly power. In particular, it is appropriate to impose:

- cost regulation which assures that cost savings resulting from the consolidation will be passed on to health care consumers and third-party payers;

- access regulation which assures that medical services now available in Great Falls are not denied as a result of the consolidation and, to the extent access to hospital-based abortions is limited by the consolidation, to guarantee that patients will not bear the cost of having abortion services performed elsewhere, and that specialized perinatal services will continue to be provided within the State of Montana; and

- quality regulation, including submission of certain internal quality reporting measures including patient outcomes, satisfaction surveys, and other quality indicators to assure that quality of care is not diminished as a result of the consolidation.

IX. ORDER

Based on the foregoing findings of fact and conclusions of law, the Certificate of Public Advantage for the consolidation of the Columbus Hospital and Montana Deaconess Medical Center of Great Falls, Montana, is GRANTED, subject to the following:

X. TERMS AND CONDITIONS

1. Savings and Price Reductions

1.1 The Department will regulate the revenues of the Consolidated Hospital to ensure that cost savings are passed on to consumers while still providing sufficient funding to the Consolidated Hospital to ensure quality care.

1.2 Within 90 days following the issuance of this COPA the Consolidated Hospital and the Department will develop a model to implement the patient revenue cap regulation in accordance with the requirements of this Section. The patient revenue cap methodology

allows the Consolidated Hospital to generate only those revenues sufficient to provide a profit margin approved by the Department. Additional Medicare revenues resulting from the Consolidated Hospital's status as a "sole community provider" will be included in the calculation of the revenue cap to assure that consumers benefit from this increased revenue.

1.3 Within three months after the close of the first fiscal year following the effective date of this COPA and during the same period every year thereafter, the Department will conduct a review of the Consolidated Hospital's audited financial statements to determine whether actual patient revenues for the previous year exceeded the patient revenue cap established by the Department pursuant to the following methodology:

a0 Calculate the Baseline Total Costs

The Department will calculate what costs for the two hospitals would have been in their respective fiscal years immediately preceding the consolidation if the claimed cost savings had been implemented. This provides a baseline cost target that the Department has determined is achievable post-merger. This calculation provides the main benchmark against which all hospital performance will be measured. Using the audited financial statements that most closely correspond to the baseline year, the combined total costs for MDMC and Columbus will be calculated. Any one-time transaction costs that were expended to study and implement this merger will be subtracted from baseline costs. Other significant non-recurring expenses will also be considered in setting the baseline cost measure.

b0 Calculate the Allowable Total Costs

"Allowable Total Costs" are what the total costs would have been for the previous year if the Consolidated Hospital had implemented the planned cost savings program for that year. The Allowable Total Costs are calculated by subtracting the appropriate Expense Reduction Target from the Baseline Total Costs. The Expense Reduction Target represents the projected cost savings, assuming that patient volume, case mix and input costs remain unchanged.

c0 Adjust the Allowable Total Costs for Inflation

Because hospital input costs rise from year to year, the Allowable Total Costs must be adjusted for the amount of inflation that has occurred between the baseline year, 1995, and the year under review. The inflation index that will be applied is the Bureau of Labor Statistics measure called the Producer Price Index (PPI) for all hospital services. The actual inflation index that will be used will be created by taking the PPI for the year under review and dividing it by the PPI for 1995. Once the inflation index is determined, the Allowable Total Costs in current dollars will be calculated by multiplying the Allowable Total Costs in 1995 by the inflation index.

d0 Create the Ratio of Casemix Adjusted Admissions

The ratio of Casemix Adjusted Admissions is calculated by dividing the casemix adjusted admissions for the year under review by the casemix adjusted measure for the baseline year, 1995. If the ratio is less than 1, this indicates that the workload has gone down.

The casemix adjusted admissions is a standard indicator used in the hospital industry to measure a hospital's workload. It controls for both the number of patients and the casemix of the patients. The formula for calculating the casemix adjusted admissions is as follows:

[admissions x(1 + gross outpatient revenues/gross inpatient revenue)] x casemix].

In applying this formula, normal newborns will not be included in the number of admissions. The number of admissions will be based only on the categories of admissions that are currently included in the applicants' audited financial reports. The casemix will be based on the Health Care Financing Administration (HCFA) casemix index in effect as of October 1 of the year in question. The formula for the baseline year, 1995, will be based on whatever HCFA casemix index was in effect as of October 1, 1995. Similarly, the formula for the first post-merger year, will be based on the casemix index in effect as of October 1 of that year.

e0 Determine the Variable Cost Approximation (in current dollars)

Total Allowable Costs (in current dollars) are multiplied by the Ratio of Casemix Adjusted Admissions. The resulting figure will provide an approximation of how much actual costs have changed as a result of the patient volume and/or casemix changing.

f0 Determine the Fixed Cost Correction (in current dollars)

The Fixed Cost Correction is based on the assumption that about 30 percent of hospital costs are fixed and 70 percent are variable. The Fixed Cost Correction is calculated by multiplying the Variable Cost Approximation by 0.3.

g0 Adjust the Allowable Total Costs (in current dollars) for Changes in Volume and/or Casemix to Arrive at the Total Cost Target

The Total Cost Target represents what costs should be if the merged hospital is producing efficiently--even in the face of

changing volume and/or casemix. The Fixed Cost Correction is subtracted from the Variable Cost Approximation. If the casemix adjusted admissions in the year under review are greater than in the baseline year, the resulting number is added to the Allowable Total Costs. If the casemix adjusted admissions have declined relative to the baseline year, the number is subtracted from the Total Allowable Costs.

h0 Calculate the Total Revenue Cap (in current dollars)

The Total Cost Target from Step g is divided by .94, which is equal to 1 minus the allowable net margin of six percent. The resulting figure is the Total Revenue Cap for the year under review. The Total Revenue Cap indicates the maximum revenue the hospital should have collected during the previous year.

i0 Calculate the Patient Revenue Cap (in current dollars)

The Patient Revenue Cap is calculated by subtracting the past year's non-patient related net revenue from the Total Revenue Cap. Non-patient net revenue includes any net revenues earned by the hospital from its investment portfolio, cash and other current assets, or other operating activities not related to patient care. The Patient Revenue Cap indicates the maximum revenue that the hospital will be allowed to earn through the prices it charges for patient care services.

j0 Compare the Actual Patient Revenues (in current dollars) to the Patient Revenue Cap (in current dollars)

To determine if the hospital pricing policies yielded an appropriate level of revenues, the revenue cap must be compared to

the patient revenues brought in during the year under review. If actual revenues are higher than the cap, then patient prices are considered to have been too high. The Department may order the following action:

(1) Any excess revenues above the Patient Revenue Cap that are under $3.5 million will be retained by the Consolidated Hospital and returned to the health care consumer through lower patient prices during the next year. If the hospital fails to lower prices sufficiently to eliminate the surplus from the previous year, the surpluses will accumulate under the regulation until the cumulative surpluses after any given year reach a sum of $3.5 million or more.

(2) If the surplus in any one year or the cumulative surpluses from all previous years exceed $3.5 million, the Department may order that the amounts above $3.5 million be rebated to health care consumers or turned over to the Department as a contribution to health care related programs in the service area. The Department will determine which consumers or agencies will receive the rebates or refunds in any given year and these funds will not be returned to the hospital, even in years of shortfall. For purposes of Sections 1.3(j)(1) and (2), the $3.5 million sum shall be adjusted for inflation pursuant to the formula set forth in paragraph 1.3 of these Terms and Conditions.

In the event that actual patient revenues are less than the Patient Revenue Cap, the Consolidated Hospital will be

allowed to raise its prices to recover that revenue the following year. Any shortfalls in revenues will be cumulative and will be subtracted from any amounts in the surplus fund. In the event that the cumulative revenue shortfalls exceed the revenue surplus the hospital may raise its prices until the deficit is eliminated. Under no condition does the Department guarantee either the financial success or the business survival of the Consolidated Hospital if market conditions evolve toward greater competition.

1.4 The Department reserves the right to request all the necessary and appropriate documents, records and data needed to conduct its review including, but not limited to audited financial statements, casemix, outpatient and admissions data. These documents will be produced in a timely manner. All financial statements provided by the Consolidated Hospital in compliance with the requirements of this Section shall be prepared in a manner that is consistent with the accepted financial practices employed in generating the 1995 audited financial statements used in calculating the baseline cost and volume figures required by this regulation.

1.5 The Consolidated Hospital shall include the following information in the annual report required by Mont. Admin. R. 23.18.106:

(1) A summary comparison by category of the patient-related prices charged by the Consolidated Hospital during the year under review and the preceding year. The categories

shall include medical/surgical rates, obstetric rates, outpatient visit rates, home health care rates, skilled nursing rates, cardiovascular surgical rates, and any other categories specified by the Department or its consultant in conjunction with the annual review;

(2) A summary of the steps taken by Consolidated Hospital to reduce costs and improve efficiency during the year under review;

(3) The changes in full time equivalents (FTEs) that occurred during the year, plus an analysis of the resulting cost savings;

(4) The services or functions that were consolidated during the year and an analysis of the resulting cost savings; and

(5) Significant changes in the volume or availability of any inpatient or outpatient services offered by the Consolidated Hospital.

2. Quality

a. **Reporting to Department of Public Health and Human Services**

2.1 Under terms specified in the interagency agreement to be entered into between the Department and the Montana Department of Public Health and Human Services ("PHHS"), the Consolidated Hospital shall report to PHHS in all matters pertaining to quality monitoring required by these terms and conditions.

2.2 Within 30 days of the effective date of this Certificate, Consolidated Hospital shall contact PHHS and arrange a meeting to begin developing quality of care reporting devices required by this Certificate. Consolidated Hospital shall pay all expenses incurred by PHHS in conducting the quality monitoring functions required by this Certificate, including any expenses for contracted services.

2.3 The quality monitoring portion of the annual report required by Mont. Admin. R. 23.18.106 shall be submitted to PHHS which, under the terms of the interagency agreement, shall report to the Department on compliance with quality terms and conditions imposed by this Certificate.

2.4 The PHHS liaison to the Department is:

Mr. Denzel Davis, Administrator
Quality Assurance Division
Department of Public Health and Human Services
Cogswell Building, Room 211
P.O. Box 202951
Helena, MT 59620-2951

b. JCAHO Accreditation

The Consolidated Hospital shall:

2.5 Become and remain accredited by the Joint Commission on the Accreditation of Hospital Organizations (JCAHO) after the effective date of this Certificate.

2.6 Not become conditionally accredited by the JCAHO after expiration of the one-year transition period following the effective date of this Certificate.

2.7 Correct any deficiencies reflected by scores of noncompliance (5) or marginal compliance (4) for JCAHO surveys

conducted after the effective date of this Certificate within the time provided by JCAHO, or within one year from receipt of the JCAHO survey results if no deadline is stated by the JCAHO.

2.8 Promptly provide to the Department of Public Health and Human Services (PHHS) an explanation of scores of noncompliance (5), marginal compliance (4) or partial compliance (3) received in surveys conducted after the effective date of this Certificate, and submit action plans to improve such scores as part of the annual progress report required by Mont. Admin. R. 23.18.106, and attach copies of any focused survey results received from JCAHO.

2.9 Show no material decrease in the "Summary Grid Score" for JCAHO surveys conducted after the effective date of this Certificate.

2.10 Maintain a three-year JCAHO survey schedule for JCAHO surveys conducted after the effective date of this Certificate.

c. Operating Room Capacity

2.11 The Consolidated Hospital will equip and staff a sufficient number of operating rooms to maintain average daily operating hours in compliance with industry standards for similarly situated hospitals as determined by PHHS. At a minimum, Consolidated Hospital will equip and staff no fewer than six inpatient operating rooms in addition to the operating room dedicated to heart surgery.

d. Quality Monitoring Devices

The Consolidated Hospital shall:

2.12 Continue to collect data for all quality indicators selected by PHHS and set forth in the interagency agreement referred to in Section 2.1, and include a summary of the results in each annual report submitted under Mont. Admin. R. 23.18.106, in a form approved by PHHS. The summary must also include a comparison of the data with other health care facilities of similar size throughout the country.

2.13 Continue to conduct patient satisfaction surveys, measuring quality indicators such as outcomes data, the degree to which a patient received adequate explanation of procedures and care, satisfaction with the care and treatment provided, discharge instruction received, and timeliness of care provided, including waiting times for services received. The form used for patient satisfaction surveys and the frequency with which such surveys are conducted shall be approved by PHHS. The results of these surveys shall be included in each annual report submitted under Mont. Admin. R. 23.18.106.

2.14 Collect and provide in each annual report data concerning staffing ratios, including but not limited to the average number of hours of patient care delivered per patient and the ratio of Registered Nurses to Licensed Professional Nurses and other caregivers such as nurse's aides. The form in which such data are collected and reported must be approved by PHHS. The report must include a comparison of this data to other health care facilities of similar size throughout the country.

2.15 Develop and administer on an annual basis surveys of the hospital's medical, hospital and nursing staffs to be included in the annual report. The survey form must be approved by PHHS.

e. Ombudsman and Complaint Procedure

The Consolidated Hospital shall:

2.16 Within 60 days of the effective date of this Certificate, establish a procedure for review of consumer complaints by the Community Health Council provided for in paragraph 3.3. The Community Health Council will be responsible for receiving consumer complaints and working with hospital management to resolve those complaints. If the Council finds cause to believe that the conduct of which the consumer complains constitutes a violation of Mont. Code Ann. title 50, chapter 5, part 1 or 2, or Mont. Admin. R. title 16, chapter 32, subchapter 3, or a term or condition of this Certificate, and the complaint is not resolved after consultation with hospital management, the Council shall report the alleged violation to PHHS within 30 days of its determination. In its discretion, the Department may forward to the Council any complaints received under Mont. Admin. R. 23.18.106(4), and the Council will report back to the Department the results of its investigation of the complaint.

2.17 Designate a member of its staff who does not hold a management position as Consumer Ombudsman to receive complaints from consumers about quality issues at the hospital. The Ombudsman will be responsible for assisting the consumer in presenting his or

her complaint to the Community Health Council as provided in paragraph 2.16 above.

3. Community Health

3.1 The Consolidated Hospital will continue the charitable services that Columbus and MDMC presently provide at no less than current levels, including annual adjustments for inflation pursuant to the formula set forth in paragraph 1.3 of these Terms and Conditions. This commitment shall include funding for charitable programs and the provision of medical services for low-income persons.

3.2 The Consolidated Hospital shall include the following information in the annual report required by Mont. Admin. R. 23.18.106: (1) a detailed description of the community and charitable services provided by the Consolidated Hospital during the year under review; (2) the amounts expended on each service provided during that year; and (3) a comparison of the amounts expended on community and charity services during the year under review with the combined spending of MDMC and Columbus in their respective fiscal years prior to consolidation.

3.3 The Consolidated Hospital will establish and provide funding for the operation of a Community Health Council ("Council"). The Council will consist of twelve representatives. One permanent member will be appointed to represent each of the following:

a. the hospital;

b. the hospital's medical staff;

c. the city/county health department;

d. health care consumers, to be appointed by the Attorney General;

e. third-party payers, to be appointed by the Attorney General;

f. the Great Falls public school system;

g. the local military community, to be appointed by Malmstrom Air Force Base.

The remaining five representatives will be selected by the seven permanent members from business or community organizations or other social and health agencies serving the service area. The Council members shall serve staggered three-year terms.

The purposes of the Council will be (i) to establish community health goals and strategies, (ii) to coordinate services of various health providers, (iii) to review and comment on the annual report and strategic plan of the hospital, and (iv) to receive and act on consumer complaints as provided in paragraph 2.16. It is understood that the Council shall act solely in an advisory and consultive capacity, except as specifically provided in (iv) of the preceding sentence, and that the Council shall have no separate powers to enforce the provisions of this COPA. Nothing in this Section shall be deemed to preclude or limit the Department's authority to enforce the provisions of this COPA, regardless of whether such enforcement has been suggested, recommended or approved by the Council.

4. Provision of Services

4.1 With the exception of the hospital services referred to in paragraph 4.6, the Consolidated Hospital will continue to provide all hospital services provided by either MDMC or Columbus as of December 31, 1995. The Consolidated Hospital shall not terminate or reduce any services without the prior approval of the Department.

4.2 The Consolidated Hospital will allow elective sterilizations to be performed on its premises.

4.3 The Consolidated Hospital will provide HIV testing and counseling services pursuant to the requirements of Mont. Code Ann. §§ 50-16-1001 to -1013.

4.4 The Consolidated Hospital will continue to follow the national standard protocol for rape victim counseling. Patients at the Consolidated Hospital will be provided the option of utilizing post-coital contraception at the time of treatment, and the pharmacy at the Consolidated Hospital will stock the prescription drug Ovral and other post-coital contraceptives generally available at hospital pharmacies.

4.5 The Consolidated Hospital will comply with the procedures and requirements of the Montana Rights of the Terminally Ill Act and the Federal Patient Self-Determination Act.

4.6 Within 60 days of the issuance of this COPA and prior to commencement of the consolidation, MDMC shall deed an office condominium to Intermountain Planned Parenthood and shall demonstrate to the Department's satisfaction that the revenue

generated from the condominium will be available and sufficient to cover the nonmedical expenses of any patient who is required to travel to another city to obtain abortion services that were available at MDMC prior to the consolidation, and the out-of-pocket expenses of the perinatologist or any other physician required to travel to another city to perform pregnancy terminations performed at MDMC prior to the consolidation.

5. Nonexclusivity

5.1 Consolidated Hospital shall not enter into any provider contract with any Health Plan on terms that prohibit Consolidated Hospital from entering into a provider contract for any services Consolidated Hospital offers with any other health plan.

5.2 Consolidated Hospital shall not require Managed-Care Plans to contract with its employed doctors as a precondition to contracting with Consolidated Hospital.

5.3 Consolidated Hospital shall not restrict an independent physician's ability to provide services or procedures outside the Consolidated Hospital, unless performance of duties outside the Consolidated Hospital would impair or interfere with the safe and effective treatment of a patient.

5.4 Consolidated Hospital shall not prohibit independent physicians who are members in any Consolidated Hospital physician-hospital network from participating in any other physician-hospital networks, Health Plans, or integrated delivery systems.

5.5 Consolidated Hospital shall not enter into any exclusive contracts with any Health-Care Provider by which it requires that

provider to render services only at Consolidated Hospital or by which it requires only one physician or group of physicians to provide particular services at Consolidated Hospital. Consolidated Hospital may enter into exclusive contracts with radiologists, pathologists, emergency-room physicians and radiation oncologists, so long as these contracts do not exceed three years in duration and are reviewed and awarded after consideration of all available options, taking into account issues of quality, access, and cost, and any other factors customarily considered in the award of such provider contracts. Any such exclusive contract must affirmatively require the physician(s) not to refuse unreasonably to participate in any Health Plans that have provider contracts with the Consolidated Hospital. Consolidated Hospital may petition the Department for approval to enter into exclusive contracts with physicians in specialties other than those listed above. The Department shall provide Consolidated Hospital with a response to the petition within ninety (90) days.

6. Nondiscrimination

6.1 Other than as provided in Paragraph 5.5, Consolidated Hospital shall provide an open staff, ensuring equal access to all qualified physicians in the Great Falls Service Area according to the criteria of the JCAHO and the medical staff bylaws.

6.2 Consolidated Hospital shall negotiate in good faith with all Health Plans licensed to provide services in the Great Falls Service Area which approach it seeking a provider contract. This provision, however, shall not be construed to require Consolidated

Hospital to enter into a provider contract with any particular Health Plan.

6.3 Consolidated Hospital shall not enter into provider contracts with any licensed Health Plan operated by Consolidated Hospital or any hospitals owned or operated by the Sisters of Providence, in existence now or which may be created, on terms available to that plan solely because it is sponsored by Consolidated Hospital or the Sisters of Providence, where doing so would place other comparable licensed Health Plans at an unreasonable competitive disadvantage, because of any market power Consolidated Hospital may have rather than from efficiencies resulting from its integration with its Health Plan.

6.4 With respect to any Health Plan affiliated with or proposed by Consolidated Hospital or the Sisters of Providence, Consolidated Hospital will participate in this plan only on nonexclusive terms. Consolidated Hospital will not cross-subsidize such plan through the operating revenues of Consolidated Hospital in a manner that would facilitate predatory pricing or other anticompetitive conduct.

6.5 Consolidated Hospital will not use employment, the location of a physician or group practice, or the location where patients will receive any necessary follow-up care to determine referrals from the emergency room. Consolidated Hospital may consider quality of care and reasonable proximity for patient convenience in determining referrals. The referral policy used to inform unassigned patients of the availability of follow-up care

shall be provided to the Department within thirty (30) days after the execution of this COPA.

6.6 Except as provided in Paragraph 6.1, if Consolidated Hospital establishes or sponsors its own Health Plan, it shall not base credentialing decisions or other decisions affecting a physician's access to, or working conditions at, Consolidated Hospital on whether that physician enters into a provider contract with either Consolidated Hospital's plan or with a competing plan.

6.7 Consolidated Hospital shall attempt, in good faith, to contract with all Health Plans operating in its service area which offer commercially-reasonable terms on a capitated basis, a percentage of premium revenue basis, or on other terms that require Consolidated Hospital to assume risk. Consolidated Hospital shall not refuse to contract with a Health Plan solely because such plan proposes a capitated contractual reimbursement methodology. This provision, however, does not require Consolidated Hospital to enter into a provider contract with any particular Health Plan or with all Health Plans.

7. Employment of Physicians

7.1 Consolidated Hospital shall be prohibited from employing more than 20% of the physicians in Great Falls practicing in any of the following areas: family practice/internal medicine, pediatrics, or obstetrics/gynecology. For purposes of this paragraph, a physician is considered to be "employed" by the Consolidated Hospital if the physician receives more than 25% of his or her annual income for services provided to the Consolidated Hospital.

7.2 Consolidated Hospital shall not solicit the employment of any physician or group practice within Great Falls if such employment would cause Consolidated Hospital to exceed the limitations imposed by Subparagraph 7.1.

8. Agreements with Surgical Facility Providers

8.1 Consolidated Hospital shall not, without the prior approval of the Department, acquire any interest in or enter into joint ventures or agreements with persons providing surgical facilities or access to surgical facilities, including but not limited to, ambulatory surgery facilities and outpatient surgery clinics.

9. "Most-Favored-Nation" Provisions

9.1 Consolidated Hospital shall not enter into any provider contract with any Health Plan on terms which include a most-favored-nation clause to the benefit of Consolidated Hospital or any health-care plan. A most-favored-nation clause is any term in a provider contract that allows the buyer to receive the benefit of any better payment rate, term or condition that the seller gives another provider for the same service.

10. Certificates of Need

10.1 Consolidated Hospital shall not oppose certificates-of-need applications filed by other hospitals or other health-care providers with PHHS unless it notifies the Department in writing, as soon as practicable but at least seven (7) days prior to filing any opposition, and provides a copy of any opposition to the Department when it is filed.

11. Reporting

11.1 Consolidated Hospital shall comply with the requirements of Mont. Admin. R. 23.18.106(1) by submitting progress reports in accordance with the requirements of that Rule.

11.2 In addition to the reporting requirements set forth in Mont. Admin. R. 23.18.106(1), each progress report shall comply with the reporting requirements of these Terms and Conditions.

12. Enforcement

12.1 If the Department believes that there has been a violation of any terms and conditions of the COPA, it shall promptly notify Consolidated Hospital thereof. The Department

shall thereafter permit Consolidated Hospital a reasonable opportunity to cure any alleged violation without instituting legal action. If the alleged violation is not substantially cured by Consolidated Hospital within sixty (60) days of notification, the Department may thereafter undertake any remedial action it deems appropriate. Upon prior written notice by the Department, this time period may be extended or reduced in the sole discretion of the Department where it determines the sixty (60) day period is not sufficient time to cure the alleged violation or that more immediate action is necessary under the circumstances.

12.2 Consolidated Hospital shall reimburse the Department for reasonable expenses, including attorney fees and expert fees, incurred by the Department in any actions filed by nonparties to this proceeding challenging the validity of this COPA or any part or provision thereof.

12.3 In recognition that pecuniary compensation for nonperformance of these Terms and Conditions would not afford adequate relief and that the Department has no plain, adequate and speedy remedy available at law, the Department shall be entitled, in the event of breach of any of these Terms and Conditions, to equitable relief including an injunction or decree for specific performance.

12.4 Nothing herein shall be construed as restraining the Department from pursuing all other remedies available to it for breach. The Department does not waive any remedy it may have for breach of these Terms and Conditions, under state or federal law.

None of the provisions of this COPA shall prohibit the Department from commencing an action under state or federal law based on events that transpire after the date of the consolidation and obtaining appropriate relief therefor.

12.5 These Terms and Conditions shall be governed by, construed, and enforced in accordance with the laws of the State of Montana.

13. Ancillary Services

13.1 Patient referrals for durable medical equipment, home health services, home infusion services, or any other ancillary services made by Consolidated Hospital, its employees, contractors and medical staff shall provide for patient choice among competing providers in the service area and shall be on a nondiscriminatory basis without regard to whether Consolidated Hospital owns or operates the provider of such services.

13.2 Consolidated Hospital shall provide the Department with written guidelines regarding patient referrals within 30 days after the execution of this COPA.

13.3 Consolidated Hospital shall not cross-subsidize any of its affiliated ancillary service providers through operating revenues of Consolidated Hospital in a manner that would facilitate predatory pricing or other anticompetitive conduct.

14. Compliance

To determine or secure compliance with this COPA, any duly authorized representative of the Department, including any expert engaged by it, shall be permitted:

14.1 Upon reasonable notice, access during normal business hours to all nonprivileged books, ledgers, accounts, correspondence, memoranda, reports, accountant's work papers and other records, and documents, in the possession or under the control of Consolidated Hospital or its independent auditors, relating to any matters contained in this COPA.

14.2 Upon reasonable notice, access during normal business hours to interview directors, officers, managers or employees regarding any matters contained in this COPA.

14.3 Upon reasonable notice, to call a special meeting of the board of directors of Consolidated Hospital.

14.4 The Department will endeavor to provide notice to Consolidated Hospital of any concerns raised by the progress reports, or any other information tending to show that Consolidated Hospital may not be in compliance with any of the conditions of this COPA, within a reasonable time after its receipt. Consolidated Hospital, and its board of directors, shall meet with the Department, upon request, to attempt to resolve any such concerns.

15. Change of Legal Status or Sale

15.1 The Consolidated Hospital shall remain a nonprofit hospital with a community-controlled governing board. Any sale or transfer of control of Consolidated Hospital, or all or substantially all of its assets, shall take place only with the prior written approval of the Department. Such approval may be upon conditions.

The foregoing shall not apply to any sale or transfer of control which may be deemed to arise solely by reason of the termination of Providence Services' corporate membership in the Consolidated Hospital or a withdrawal of the Consolidated Hospital from the Obligated Group (as defined in the Master Indenture).

15.2 By entering into this COPA the Consolidated Hospital stipulates and agrees that, in the event of any direct or indirect sale or transfer of control of the Consolidated Hospital, or all or substantially all of its assets, to a parent, subsidiary or other entity otherwise affiliated with Consolidated Hospital, the Department shall have the right to specific performance of the terms and conditions of this COPA.

15.3 The Applicants have represented to the Department that an important element of assuring that the grant of this COPA will be in the public interest is that the Board of Directors of the Consolidated Hospital will be composed of residents of Great Falls and the Service Area. Accordingly, the Consolidated Hospital shall remain a nonprofit hospital governed by such a local board of directors, the initial board to consist of fifteen (15) local members. Five of the initial members shall carry over from the MDMC board, five shall carry over from the Columbus Board, and the remaining five shall be local residents without prior service on the board of either of the Great Falls hospitals. Only one member of the board shall be appointed by Providence Services from a list of nominees submitted by the remaining board members.

15.4 The foregoing provisions of this Section 15 shall not limit in any respect (a) the rights, remedies or powers granted to the Master Trustee, to any holder of indebtedness (whether Master Notes or otherwise), to any lender or to any credit enhancer to enforce any provision of the Master Indenture (or similar debt instrument to which the Consolidated Hospital is a party or by which it is bound), or the rights or powers of any trustee, secured party, lender, credit enhancer, receiver, custodian, liquidator or judicial or regulatory authority to deal with the property or assets of the Consolidated Hospital, upon the occurrence or continuance of an Event of Default, default or similar event under the Master Indenture (or similar debt instrument to which the Consolidated Hospital is a party or by which it is bound) or to effect any sale, transfer or other disposition of any property or assets pursuant to or resulting from any debt or security arrangement or (b) limit the right of the Consolidated Hospital to grant any lien or to transfer any property or assets as security for any indebtedness (whether Master Notes or otherwise).

16. Conflicts with Master Indenture

16.1 Nothing contained in this COPA shall be deemed to require the Consolidated Hospital to take any action or prevent the Consolidated Hospital from taking any action that it shall demonstrate to the reasonable satisfaction of the Department (a) is likely to result in a breach by the Obligated Group of its obligations under Section 5.01, 5.03(f) or 5.06 of the Master Indenture or require the Obligated Group to engage a Consultant pursuant to Section 5.06 of the Master Indenture or, if the Consolidated Hospital should no longer be a party to or bound by the Master Indenture, is likely to result in a breach by the Consolidated Hospital of its obligations under comparable provisions of its master trust indenture or similar debt instrument or require it to engage a consultant pursuant to the rate covenant provisions of such master trust indenture or similar debt instrument or (b) that would result in the occurrence of an Event of Default within the meaning of Section 6.01 of the Master Indenture or a default or event of default under comparable provisions of any master trust indenture or similar debt instrument to which the Consolidated Hospital is a party or by which it is bound.

16.2 The Consolidated Hospital will, prior to taking any action pursuant to Section 16.1, consult with the Department as to the action proposed to be taken, will give due consideration to all actions that can feasibly be taken by the Obligated Group, given the nature and type of breach, Event of Default, default or event of default which is likely to occur and will use all reasonable efforts to comply (as if the exceptions permitted pursuant to Section 16.1 did not exist) with this COPA within the shortest practicable period. In the event the Department determines that the Consolidated Hospital has not used all reasonable efforts to comply with this COPA within the shortest practicable period, the Department may order the Consolidated Hospital to take whatever action the Department determines is reasonably necessary to satisfy the requirements of this COPA subject to the limitations set forth in Section 16.1.

16.3 Notwithstanding Section 16.1, in the event the Consolidated Hospital shall have demonstrated to the reasonable satisfaction of the Department pursuant to Section 16.1 that compliance with the provisions of Section 1.3j(2) of this COPA (a) is likely to result in a breach by the Obligated Group of its obligations under Section 5.06 of the Master Indenture or require the Obligated Group to engage a Consultant pursuant to Section 5.06 of the Master Indenture or (b) if the Consolidated Hospital should no longer be a party to or be bound by the Master Indenture, is likely to result in a breach by Consolidated Hospital of its obligations under the comparable provisions of its master trust

indenture or similar debt instrument or require the Consolidated Hospital to engage a consultant pursuant to the rate covenant provisions of such master trust indenture or similar debt instrument, the provisions of said Section 1.3j(2) shall be deemed to require a rebate or return to the Department of only such amount of surplus as shall not be likely to result in such a breach or to require the engagement of a consultant and, as to the remaining amount of surplus, in lieu of a rebate or return to the Department, such surplus will be retained by the Consolidated Hospital and returned to the health care consumer through lower patient prices or through other benefits approved by the Department, in either case, pursuant to a schedule approved by the Department, recognizing the effects of Section 5.06 of the Master Indenture or the rate covenant provisions of any other such master trust indenture or similar debt instrument, as the case may be.

16.4 So long as the Consolidated Hospital is a Member of the Obligated Group under the Master Indenture or a member of another obligated group (the "Other Obligated Group") pursuant to another master trust indenture or similar debt instrument, no addition to or withdrawal from the Obligated Group or Other Obligated Group, as the case may be, shall be made (except a withdrawal or disassociation of the Consolidated Hospital from or with the Obligated Group or Other Obligated Group, so long as the Consolidated Hospital shall, following such withdrawal or disassociation, remain subject to this COPA), without the prior approval of the Department; provided, however, that no such approval of the Department shall be required if, after giving effect to such addition or withdrawal, the Obligated Group or Other Obligated Group, as the case may be, would comply with either of the following tests:

(a) the historical pro forma debt service coverage ratio (determined in the same manner the Historical Pro Forma Debt Service Coverage Ratio of the Obligated Group is determined under the Master Indenture, as evidenced by a certificate delivered to the Department and signed by an officer of the Consolidated Hospital) of the Obligated Group or the Other Obligated Group, as the case may be, for the most recent Fiscal Year preceding the date of delivery of such certificate to the Department for which financial statements of the Obligated Group or Other Obligated Group reported upon by

independent certified public accountants are available would be 2:1 or greater; or

(b) the projected debt service coverage ratio (determined in the same manner as the Projected Debt Service Coverage Ratio of the Obligated Group is determined under the Master Indenture, as evidenced by a certificate delivered to the Department and signed by an officer of the Consolidated Hospital) of the Obligated Group or the Other Obligated Group, as the case may be, for the full Fiscal Year next following the Fiscal Year during which such certificate is delivered to the Department would be 2:1 or greater.

16.5 Nothing contained in this COPA shall be deemed to create any lien, charge or encumbrance on any property or assets of the Consolidated Hospital, it being understood that any claim or right of the Department for the payment or refund of moneys shall constitute a general, unsecured obligation of the Consolidated Hospital.

l6.6 In preparing, issuing, entering into, executing, exercising their rights and powers and performing their obligations under and pursuant to this COPA, the Department and the State of Montana and their respective officers, agents and employees are exercising regulatory authority pursuant to Montana law and neither the Department or State or any of their respective officers, agents or employees shall be liable or responsible for monetary damages to Columbus, Deaconess or the Consolidated Hospital or any other person as a result of or arising from this COPA, the terms and

provisions hereof, or the exercise or asserted exercise of the rights, powers, authority or responsibilities of the Department or State hereunder or in connection herewith.

17. Modification and Amendment of Terms and Conditions

17.1 Pursuant to Mont. Admin. R. 23.18.106(b), the Department may impose additional terms and conditions or modify existing terms and conditions in order to effectuate the objectives of this COPA if it determines that the terms and conditions upon which the COPA was issued are not being satisfied or that the consolidation is not meeting the objectives of lower health care costs and improved quality of or access to health care services.

17.2 The Consolidated Hospital may request modifications to or the repeal of any terms and conditions in the COPA that it believes are justified by unforeseen circumstances, changed conditions in the marketplace or other reasons. The Department will grant such requests if it determines that the requested modifications are necessary to promote lower costs, improved access to health care or higher quality health care or, in respect of modifications to Section 1.3, 2.11 or 3.1 of these Terms and Conditions, if the Department determines that the requested modifications are necessary to provide sufficient funding to the Consolidated Hospital to ensure quality health care.

17.3 Within ten years following the effective date of this COPA, the Department shall conduct a review to determine the extent to which these Terms and Conditions should be maintained, modified, amended or repealed in order to further the purposes of Mont. Code

Ann. §§ 50-4-601 to -623. Within 90 days following the commencement of that review, the Department shall issue findings of fact supporting its decision to maintain, modify, amend or repeal any of these Terms and Conditions.

17.4 In exercising its authority to impose additional terms and conditions or to modify existing terms and conditions pursuant to Section 17.1 and in granting requests for modifications to or the repeal of any terms and conditions in the COPA pursuant to Section 17.2, the Department shall not take any action if such action would result or would reasonably be likely to result in the occurrence of a default or Event of Default under the Master Indenture or similar debt instrument to which the Consolidated Hospital is a party or by which it is bound. The Department agrees that, in the event of any requests pursuant to Section 17.2, it will use its best efforts to act without unreasonable delay.

18. Legal Exposure

18.1 No provision of this COPA shall be interpreted or construed to require Consolidated Hospital to take any action, or to prohibit Consolidated Hospital from taking any action, if that requirement or prohibition would expose Consolidated Hospital to significant risk of liability for any type of negligence (including negligent credentialing or negligence in making referrals) or malpractice.

19. Averment of Truth

19.1. By consenting to and signing this COPA, Columbus and MDMC aver that the information they have provided to the Department in connection with this COPA, to the best of their knowledge, is true and represents the most recent and comprehensive data available, and that no material information has been withheld.

20. Expenses of Supervision

20.1 Consolidated Hospital agrees to pay the Department reasonable annual expenses, including attorney fees and expert fees, incurred in analyzing and verifying its progress reports and compliance with the terms and conditions of this COPA, to be paid within thirty (30) days of the receipt of the invoices.

21. Binding effect of COPA

21.1 The terms and conditions of this COPA are binding on the Applicants and the Consolidated Hospital, its successors and assigns, directors and officers, and all persons and entities in active concert or participation with Consolidated Hospital. The term "successors and assigns" shall include any entity with which the Consolidated Hospital merges or consolidates or to which it transfers its assets as an entirety or substantially as an entirety. Notwithstanding the foregoing but subject to the provisions of Section 15.2 of this COPA, no other Member of the Obligated Group shall be bound by this COPA solely by reason of its status as a Member of the Obligated Group.

22. Notices

22.1 All notices required by these Terms and Conditions shall be in writing and sent by first-class mail, postage prepaid, or by hand delivery, and shall be addressed as follows:

If to the Department:

Montana Department of Justice
Attn: Elizabeth S. Baker
215 North Sanders
P.O. Box 20401
Helena, MT 59620-1401

If to the Consolidated Hospital:

Maxon R. Davis
Davis, Hatley, Haffeman & Tighe, P.C.
P.O. Box 2103
Great Falls, MT 59403

The persons to be notified may be changed by giving written notice of the change to the other party within ten (10) business days prior to the effective date of the change.

23. Effective Date of COPA

23.1 This COPA shall become effective upon the written acknowledgment of the Applicants' consent to and agreement to be bound by all terms and conditions contained herein, and upon receipt by the Applicants of the Department's written notification that the conditions precedent set forth in paragraphs 1.2 and 4.6 of these Terms and Conditions have been satisfied.

DATED this _____ day of July, 1996.

MONTANA DEPARTMENT OF JUSTICE

By:_____
JOSEPH P. MAZUREK, Attorney General

THE TERMS AND CONDITIONS OF THE FOREGOING CERTIFICATE OF PUBLIC ADVANTAGE ARE AGREED UPON AND CONSENTED TO:

MONTANA DEACONESS MEDICAL CENTER

By:_____

Date:_____

COLUMBUS HOSPITAL

By:_____

Date:_____