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Community Medical Center – Market, Utilization, and Financial Projections – Discussion Draft

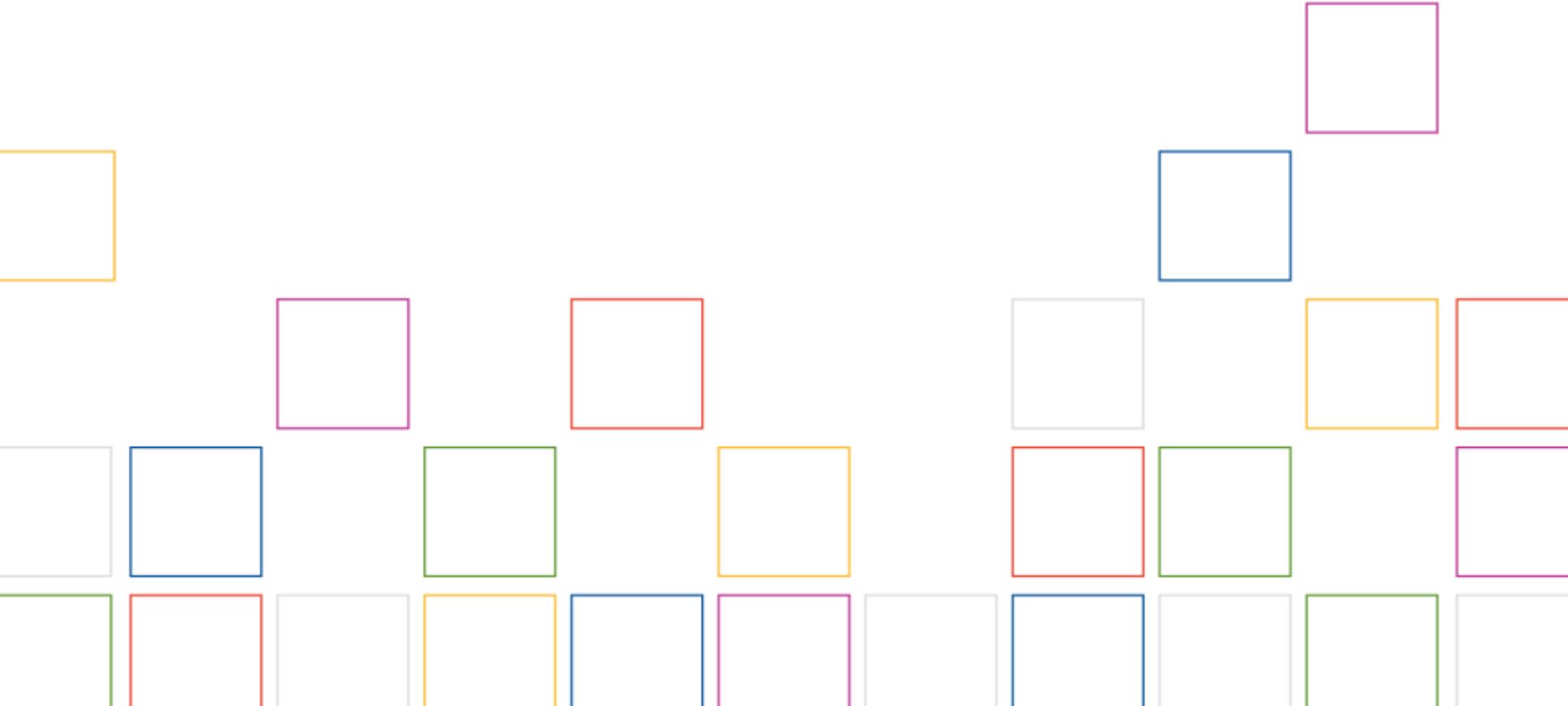
Coast Life Support District
Gualala, California
December 17, 2013



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Background



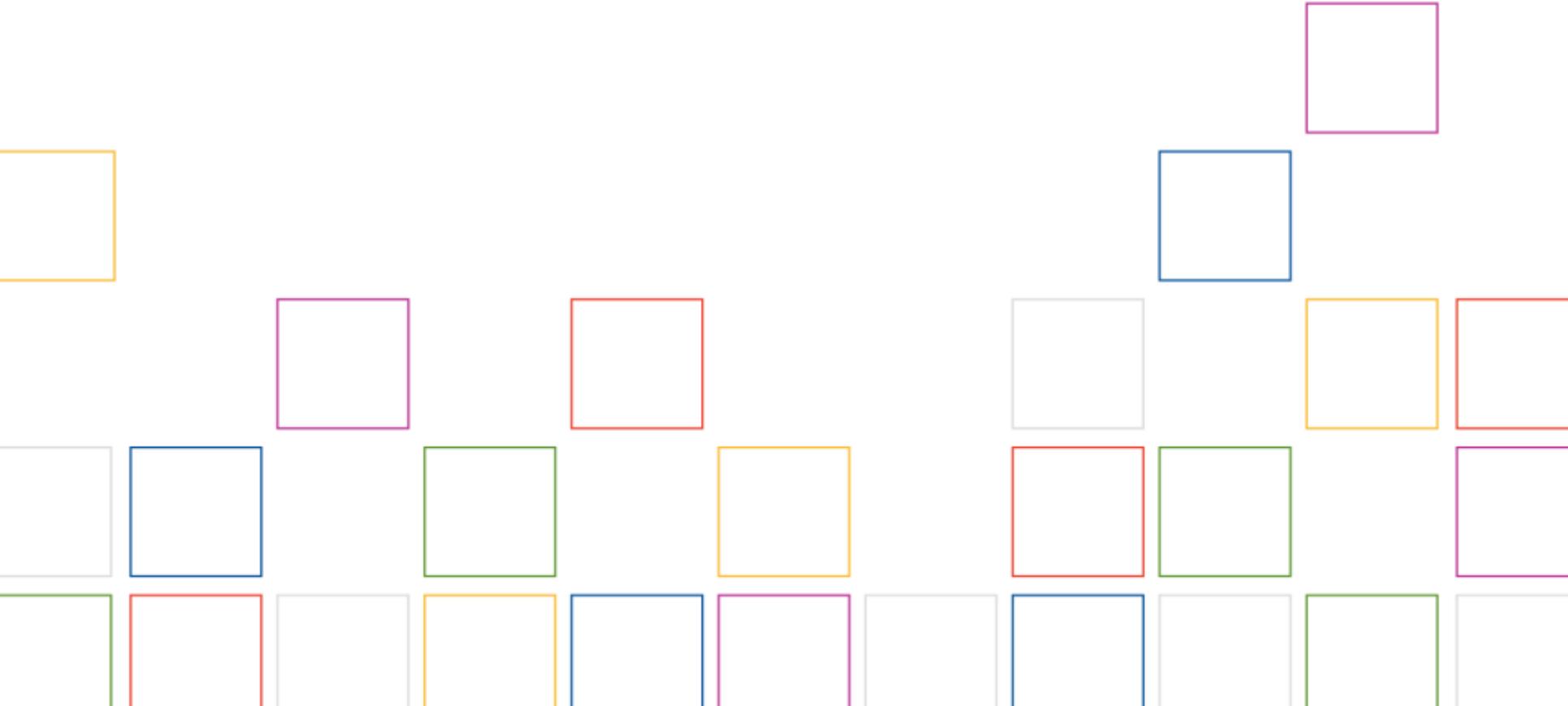
Background

- On October 29 and 30, 2013, The Camden Group met with the Engagement Task Force, which includes members from Coast Life Support District (“CLSD” or “Coast Life”), Redwood Coast Medical Services (“RCMS”), and the community, to review the service area’s Situation Assessment, and to identify options for a financially sustainable healthcare model. At the conclusion of the meeting, the following options were identified to explore further:
 - ▶ Option 1: Expand urgent care hours (a preliminary financial analysis for this option was completed prior to the October 29, 2013 meeting)
 - ▶ Option 2: Build a community medical center (less than 25 beds) with a 24/7 emergency room
 - ▶ Option 3: Develop a robust ambulatory services strategy

Background

This document presents utilization and financial projections associated with building a community medical center (less than 25 beds) with a 24/7 emergency room.

Licensing and Regulatory Requirements



California Licensing Regulations

Community Medical Center Requirements

General acute care hospitals are required to provide eight essential services:

- Medical services
- Nursing
- Surgical
- Anesthesia
- Laboratory
- Radiology
- Pharmacy
- Dietary

Minimum registered nurse (“RN”) staffing ratios:

- Critical care - 1:2
- Emergency department (“ED”) - 1:4
- Medical/Surgical - 1:5
- Post-anesthesia - 1:2
- Step-down – 1:3
- Telemetry – 1:4
- No fewer than two RNs physically present per unit

Hospital must have at least one operating room to support 25 or fewer licensed beds.

Critical Access Designation Requirements

Critical Access Designation Requirements

Be located more than a 35-mile drive from the nearest hospital or more than a 15-mile drive in areas with mountainous terrain or other secondary roads.

Provide no more than 25 inpatient acute care beds.

- Beds can be used as inpatient or swing

Hospital can also operate a distinct part rehabilitation or psychiatric unit, each with up to ten beds.

Furnish 24/7 emergency care services, using on-site or on-call staff.

Have an ALOS of 96 hours or less per patient for acute care.

- Excludes patients in swing beds or beds within a distinct part unit

Medicare pays 101 percent of reasonable patient costs.

Typically takes 12 to 18 months to receive critical access designation from submission of application.

California Licensing Regulations

Distinct Part Skilled Nursing Facility Requirements

To qualify as a distinct part skilled nursing facility (“SNF”), the unit must be physically separated from the rest of the institution (e.g., building, floor, wing).

SNFs are required to operate 24/7 and, as a minimum, provide the following services:

- Medical
- Nursing
- Dietary
- Pharmaceutical services
- An activity program

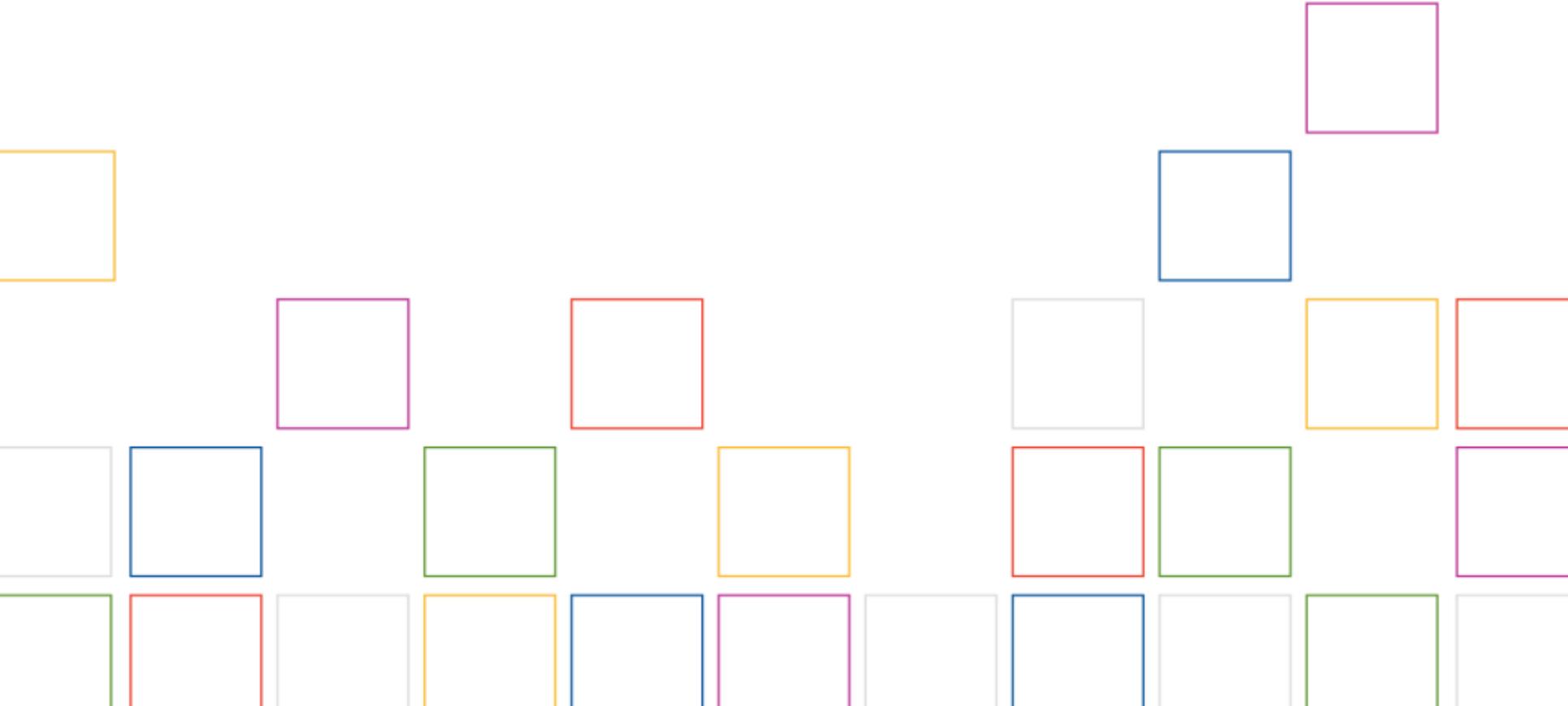
Medicare requires an inpatient hospital stay of at least three consecutive calendar days to be discharged to a SNF. Medicare pays up to 100 days of skilled nursing services per illness.

SNFs with 59 or fewer beds shall have at least one RN/licensed vocational nurse on duty at all times.

Minimum nurse staffing ratios:

- Day shift – 1:5
- Evening shift – 1:8
- Night shift – 1:13

Market and Volume Projections

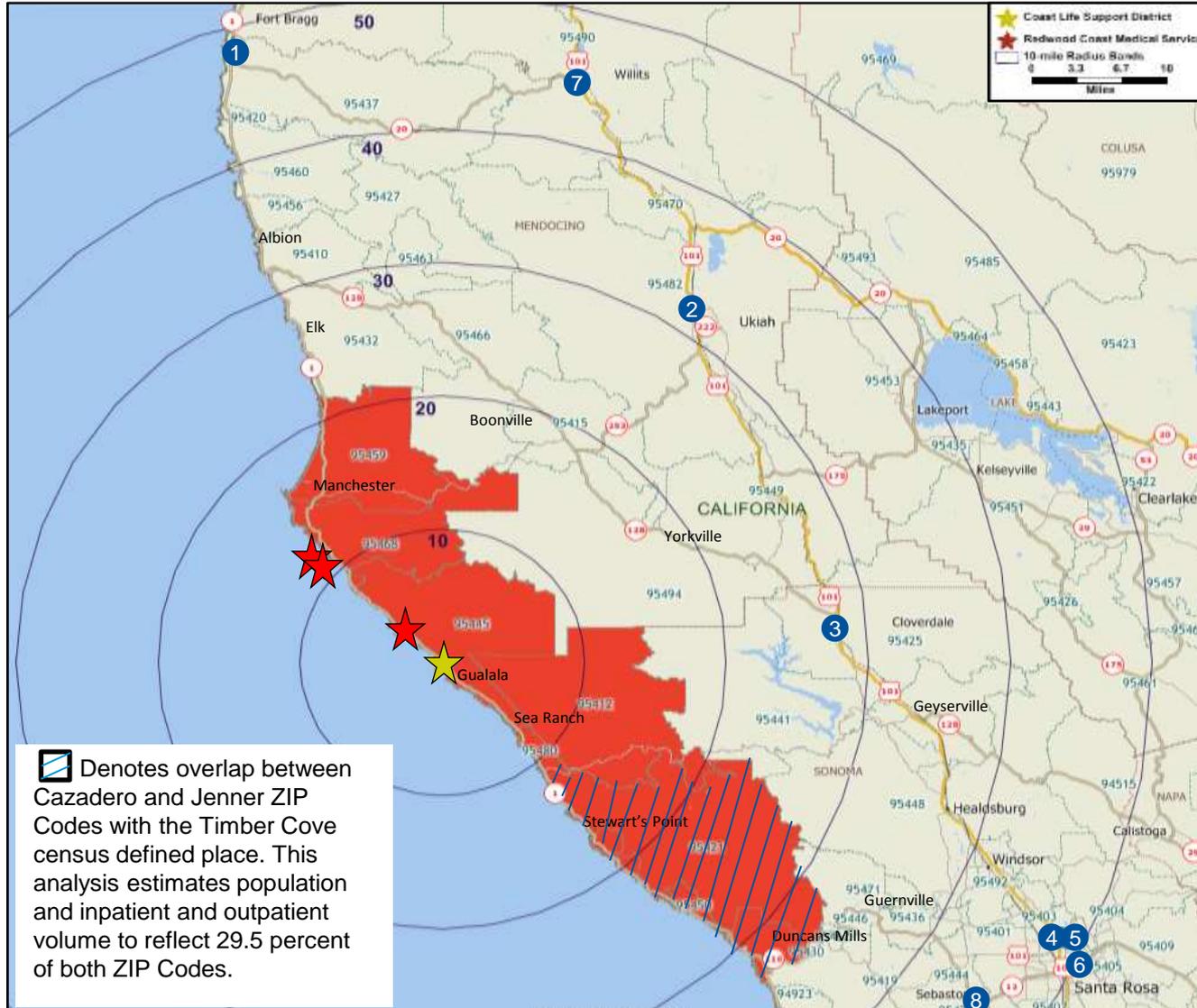


Population and Demographics

The service area (shown on the following page) was defined at the engagement kick-off meeting on September 10, 2013. It was used to develop the utilization and financial projections for the community medical center.

Service Area Map

Area Hospitals



- 1 Mendocino Coast District Hospital (49 beds)**
 59.6 miles driving (98 min. drive time)
 47.6 miles direct
- 2 Ukiah Valley Medical Center (78 beds)**
 65.9 miles driving (122 min. drive time)
 31.5 miles direct
- 3 Healdsburg District Hospital (26 beds)**
 69.9 miles driving (131 min. drive time)
 27.3 miles direct
- 4 Kaiser Foundation Hospital – Santa Rosa (173 beds)**
 79.8 miles driving (140 min. drive time)
 48.1 miles direct
- 5 Sutter Medical Center of Santa Rosa (135 beds)**
 80.8 miles driving (142 min. drive time)
 48.3 miles direct
- 6 Santa Rosa Memorial Hospital – Montgomery (278 beds)**
 82.8 miles driving (144 min. drive time)
 49.7 miles direct
- 7 Frank R. Howard Memorial Hospital (25 beds)**
 87.4 miles driving (143 min. drive time)
 44.4 miles direct
- 8 Palm Drive Hospital (37 beds)**
 75.5 miles driving (138 min. drive time)
 46.0 miles direct

Source: The Camden Group
 Note: Beds represents licensed acute care beds.
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Service Area Population Profile

Coast Life Support District
Service Area versus the State of California - Population by Age Cohort
Calendar Year 2010

Age Cohort (Years)	CAGR ⁽¹⁾	Estimated 2010	
		Number	Percent of Total
Service Area			
0 - 14	0.9%	769	12.4%
15 - 44	0.5%	1,576	25.4%
45 - 64	-0.8%	2,358	38.1%
65 +	4.4%	1,491	24.1%
Total	1.2%	6,194	100.0%
Women 15 - 44	0.6%	727	11.7%
Median Age	0.5%		54.5
California			
0 - 14	0.6%	7,580,558	20.3%
15 - 44	0.1%	16,113,601	43.2%
45 - 64	1.0%	9,380,347	25.2%
65 +	3.3%	4,200,171	11.3%
Total	0.8%	37,274,677	100.0%
Women 15 - 44	0.0%	7,891,481	21.2%
Median Age	0.6%		35.2

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/Claritas/[Pop_by_Age_and_Sex _CLSD.xlsx]Pop Table

Source: Claritas, Inc.

Service Area reflects the total population from Primary Service Area, Secondary Service Area North, and 29.5 percent of the population from Secondary Service Area South.

- Per discussions with the Engagement Task Force, population estimates based on the school districts were determined to be the most accurate. The population will be held flat at 2010 levels as there has not been growth in the area.
- Information provided by CLSD shows seasonal population varies from 760 – 3,000 depending on the time of year. A weighted average was applied to estimate the average increase in the population on an annual basis (~1,400 residents). This incremental population would affect urgent care and ED the most.

Inpatient Utilization Assumptions

The following assumptions were made to determine the community medical center's projected utilization by service line for the five-year projection period:

- Projected population was kept flat at 2010 levels at 6,194 residents; no anticipated growth in population through the projection period.
- Projected use rates by service line were kept flat at 2010 levels; no anticipated change in use rates through the projection period.
- Market capture of inpatient discharges in the service area is assumed to increase through the projection period to retain approximately 40 percent of total discharges by Year 5.
- Critical access hospital designation will be achieved in Year 3 of the projection period.

Inpatient Utilization Assumptions

- The following service lines, shown in more detail on the following two pages, will be offered at the new community medical center:
 - ▶ Cardiology (medical only)
 - ▶ Endocrine
 - ▶ Gastroenterology (medical only)
 - ▶ General Medicine
 - ▶ General Surgery
 - ▶ Neurology
 - ▶ Oncology (medical only)
 - ▶ Orthopedics (medical only)
 - ▶ Pulmonary Medicine
 - ▶ Urology

Inpatient Utilization Assumptions

Coast Life Support District Opportunity for Retained Inpatient Volume Calendar Year 2011

Service Line	Potential to Retain Market Volume ⁽¹⁾	Target Volume				100 Percent Potential Target Volume		
		Mendocino Coast District Hospital	Santa Rosa Hospitals	Ukiah Valley Medical Center	Palm Drive Hospital	Discharges	Patient Days	Average Daily Census
Cardiology - Diagnostic/Interventional	No	0	14	0	0	0	0	0.0
Cardiology - Medical	Potentially	3	21	0	0	24	71	0.2
Cardiology - Surgery	No	0	8	0	0	0	0	0.0
Chemical Dependency	No	1	0	0	1	0	0	0.0
Endocrine	Potentially	2	1	1	0	4	18	0.1
ENT	No	0	2	1	0	0	0	0.0
Gastroenterology	Potentially	8	18	3	2	30	164	0.4
General Medicine	Potentially	3	8	4	2	17	100	0.3
General Surgery	Potentially	9	15	2	2	28	191	0.5
Gynecology	No	3	4	2	0	0	0	0.0
Neonatal Intensive Care	No	1	5	2	0	0	0	0.0
Neurology	Potentially	3	11	2	0	16	54	0.1
Neurosurgery	No	0	3	0	0	0	0	0.0
Obstetrics & Deliveries	No	9	21	12	0	0	0	0.0
Oncology (Medical)	Potentially	4	4	0	0	8	23	0.1
Ophthalmology	No Cases	0	0	0	0	0	0	0.0
Orthopedics	Potentially	8	31	0	1	40	131	0.4
Plastic Surgery	No Cases	0	0	0	0	0	0	0.0
Psychiatry	No Cases	0	0	0	0	0	0	0.0
Pulmonary Medicine	Potentially	15	21	3	1	41	183	0.5
Rehabilitation	No Cases	0	0	0	0	0	0	0.0
Spine Surgery	No	0	1	0	1	0	0	0.0
Thoracic & Vascular Surgery	No	0	9	0	0	0	0	0.0
Transplant	No Cases	0	0	0	0	0	0	0.0
Urology	Potentially	0	7	1	0	8	27	0.1
Total		69	204	33	10	215	962	2.6
<i>Average Length-of-Stay</i>							4.5	

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[CLSD_Assessment_Tables.xlsx]Opportunity

Source: OSHPD Inpatient Discharge Database, 2011

Notes: Service lines defined by The Camden Group; excludes normal new borns (MS-DRG 795). Includes acute care only.

Santa Rosa Hospitals include Santa Rosa Memorial Hospital - Montgomery and Sutter Medical Center of Santa Rosa

(1) "No Cases" indicates no volume in the service area for that service line in calendar year 2011; "No" denotes service line will not be provided at the new community medical center

Inpatient Utilization Assumptions

Coast Life Support District
Service Area Opportunity for Retained Inpatient Volume - Market Share Sensitivity Analysis
Calendar Year 2011

Service Line	Total Service Area Inpatient Discharges	Coast Life Potential Retained Inpatient Discharges	Market Share Range Scenarios			Resultant Discharges		
			Low	Medium	High	Low	Medium	High
Cardiology - Medical	26	24	45.0%	60.0%	75.0%	11	14	18
Endocrine	5	4	35.0%	50.0%	65.0%	2	2	3
Gastroenterology	33	30	40.0%	55.0%	70.0%	12	17	21
General Medicine	24	17	45.0%	60.0%	75.0%	8	10	13
General Surgery	37	28	35.0%	50.0%	65.0%	10	14	18
Neurology	18	16	35.0%	50.0%	65.0%	5	8	10
Oncology (Medical)	16	8	20.0%	35.0%	50.0%	2	3	4
Orthopedics	50	40	25.0%	40.0%	55.0%	10	16	22
Pulmonary Medicine	42	41	50.0%	65.0%	80.0%	20	26	33
Urology	9	8	25.0%	40.0%	55.0%	2	3	4
Volume from other Service Lines	115	0						
Total	374	215				81	114	146
<i>Overall Market Share for Target Areas</i>		<i>57.5%</i>	<i>21.7%</i>	<i>30.5%</i>	<i>39.0%</i>			
Patient Days		962				370	514	658
Average Length-of-Stay		4.5				4.5	4.5	4.5
Average Daily Census		2.6				1.0	1.4	1.8
Bed Need At 80% Occupancy		4.0				2.0	2.0	3.0

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[CLSD_Assessment_Tables.xlsx]Opportunity (2)

Sources: OSHPD Inpatient Discharge Database, 2011, and The Camden Group

Notes: Service lines defined by The Camden Group; excludes normal new borns (MS-DRG 795). Includes acute care only.

Estimated Physician Subsidies

- In order to treat patients locally and have physicians available for emergency consults, significant subsidies would be required to attract and retain physicians in the area, as shown in the table on the following page.
 - ▶ This could be an understatement, as it is assumed that 100 percent of patient volume would not stay in the service area.
 - ▶ Subsidies could take the form of ED on-call, relocation expense, income guarantee, medical directorships or other contractual arrangements.

Estimated Physician Subsidies

Coast Life Support District Estimated Physician Subsidy Analysis Calendar Year 2011

Specialty	Physician Need ⁽¹⁾	MGMA Median Physician Compensation	Assumed Physician Full-Time Equivalents ("FTE")	Estimated Annual Physician Subsidy ⁽²⁾
Cardiology - Medical	0.21	\$432,620	1.0	\$340,966
Endocrine	0.05	232,965	1.0	220,353
Gastroenterology	0.17	494,853	1.0	408,856
General Surgery	0.62	351,509	1.0	133,784
Neurology	0.15	264,469	1.0	225,659
Oncology (Medical)	0.24	385,283	1.0	293,259
Orthopedics	0.40	562,594	1.0	335,723
Pulmonary Medicine	0.10	341,119	1.0	308,402
Urology	0.22	400,000	1.0	313,644
Emergency Medicine ⁽³⁾	0.38	334,398	3.0	620,854
Certified Registered Nurse Anesthetist ⁽⁴⁾	0.62	152,146	1.0	57,907
Total			13.0	\$3,259,407

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[CLSD_Assessment_Tables.xlsx]MD Subsidies

Sources: GMENAC 1990; Merritt, Hawkins & Assoc. 2002; Claritas, Inc., MGMA Physician Compensation and Production Survey: 2013 Based on 2012 Data (Western Geography), and The Camden Group

(1) Based on total service area population of 6,194 residents.

(2) Assuming 1.0 full-time physician available locally (assuming 3.0 full-time physicians specific to emergency medicine).

(3) Physician need reflects a ratio of service area emergency department visits projected by Year 5 to median MGMA emergency medicine hospital encounters.

(4) Service area physician need assumed to be equivalent to general surgery

Inpatient Utilization Assumptions

- The projected payer mix of the community medical center was assumed to include a slightly higher percentage of Medicare and Medi-Cal patients and a lower proportion of private coverage and other payer patients when compared to the market.
 - ▶ It was assumed there would be no change in payer mix distribution through the projection period.

Coast Life Support District
Inpatient Payer Mix - Service Area Market versus the Community Medical Center
Based on Data From Calendar Year 2011

Payer	Patient Days	
	Service Area Market	Community Medical Center
Medicare - FFS	43.8%	48.4%
Medicare - Managed Care	3.7%	4.1%
Total	47.5%	52.5%
Medi-Cal - FFS	16.8%	18.6%
Medi-Cal - Managed Care	6.2%	6.9%
Total	23.0%	25.5%
Private Coverage - FFS	0.4%	0.3%
Private Coverage - Managed Care	20.1%	14.3%
Total	20.6%	14.6%
Other Payers	8.9%	7.4%
Total	100.0%	100.0%

._District/Business_Plan_2013/Planning/CAH_Utilization_Projections/[Bed_Need_and_Volume.xlsx]Payer Mix Table

Source: OSHPD Inpatient Discharge Database 2011 and The Camden Group

Notes: Excludes normal new borns (MS-DRG 795)

Inpatient Utilization Assumptions

- Inpatient acute care ALOS at the community medical center was reduced from the market ALOS of 4.6 days down to 4.0 days to meet Critical Access Hospital designation requirements, and because higher acuity patients, requiring longer stays in a hospital bed, were assumed to continue to migrate outside of the service area for care.
- Inmigration of inpatient hospital services was assumed to be zero.
- Swing bed projections were based on hospital inpatients categorized as skilled nursing type of care. Swing beds can be used for acute care patients or skilled nursing patients. Due to low projected volume of acute care patients, it is assumed that the patient volume utilizing the swing beds will be primarily skilled nursing patients.

Medical/Surgical Bed Need

- Based on an average daily census of 0.9 to 1.6, there is a need for three medical/surgical beds. However, because California RN staffing ratios mandate one nurse to support five medical/surgical beds with a minimum of two RNs per unit, we assumed building five general acute care beds and five swing beds for a total of ten beds in the acute care unit. The two staffed RNs will cover both acute care and swing beds.
- Swing bed detail is available on the following page.

Coast Life Support District
Community Medical Center - Inpatient Medical/Surgical Bed Need
Year 1 - Year 5

Medical/Surgical Beds	Projected Year				
	1	2	3	4	5
Discharges	81	97	123	136	147
Patient Days	324	391	494	546	588
Average Length-of-Stay	4.0	4.0	4.0	4.0	4.0
Average Daily Census	0.9	1.1	1.4	1.5	1.6
Bed Need at 70 Percent Functional Occupancy	2.0	2.0	2.0	3.0	3.0
Assumed Number of Beds ⁽¹⁾	5.0	5.0	5.0	5.0	5.0

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/CAH_Utilization_Projections/[Bed_Need_and_Volume.xlsx]Bed Need Model Report

(1) For minimum staffing requirements

Swing Bed Need

Swing bed utilization is estimated below assuming similar market share capture assumptions.

Coast Life Support District
Community Medical Center - Inpatient Swing Bed Need
Year 1 - Year 5

Swing Beds	Projected Year				
	1	2	3	4	5
Discharges	3	4	5	5	5
Patient Days	35	42	53	59	64
Average Length-of-Stay	11.7	11.7	11.7	11.7	11.7
Average Daily Census	0.1	0.1	0.1	0.2	0.2
Bed Need at 95 Percent Functional Occupancy	1.0	1.0	1.0	1.0	1.0
Assumed Number of Beds ⁽¹⁾	5.0	5.0	5.0	5.0	5.0

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/CAH_Utilization_Projections/[Bed_Need_and_Volume.xlsx]Bed Need Model Report

(1) For minimum staffing requirements

Skilled Nursing Assumptions

- Many smaller hospitals utilize skilled nursing beds to assist with staffing and to expand service offerings to the community.
- We assumed the community medical center will have a five-bed distinct part SNF and would reach capacity within the first three years of the projection period.
- These patients will be predominantly Medi-Cal, as shown in the table on the following page.

Skilled Nursing Assumptions

**Coast Life Support District
Freestanding Skilled Nursing Facility
Payer Mix in Mendocino and Sonoma
Counties ⁽¹⁾
Calendar Year 2012**

Payer	Distribution
Medi-Cal	62.5%
Medicare	12.9%
Managed Care ⁽²⁾	11.5%
Private Insurance	2.0%
Self-Pay	6.4%
All Other	4.7%
Total	100.0%

Source: OSHPD Annual Utilization Report of Long-term Care Facilities, 2012; OSHPD Long-Term Care Facility Annual Financial Data: Report periods ended March 31, 2012 through December 31, 2012

Note: Includes skilled nursing facilities licensed by the State as "open." Excludes inpatient skilled nursing beds and volume attributed to hospital licenses.

(1) Payer Mix is based off of number of patients in the facility on December 31, whose principal source of payment was from each of the above payers.

(2) Includes patients enrolled in Medicare and Medi-Cal managed care plans.

ED Assumptions

- Total ED activity consists of encounters resulting in a hospital admission and encounters that were treated and released.
- Approximately 56 percent of service area inpatients were admitted through an ED in CY 2011. Due to the lower acuity patients assumed to utilize the community medical center and the limited breadth of services offered, it was assumed that a smaller proportion, 28 percent, of the inpatients admitted to the community medical center will come through the ED.
- CLSD was assumed to capture 75 percent of ED visits that were treated and released without a hospital admission.
 - ▶ Current ED service area market share is shown on page 29.

ED Assumptions

- The ED at the community medical center will be designated as standby. Key differences between standby and basic EDs are provided in Appendix B.
- It was assumed that the community medical center could utilize the existing waiver already in place at RCMS regarding 911 transfers.

Service Area ED Market Share

**Coast Life Support District
Service Area Emergency Department Visits Market Share by Hospital
Calendar Year 2011**

Hospital	Service Area							
	Total		Primary		Secondary - North		Secondary - South ⁽¹⁾	
	Visits	Percent of Total	Visits	Percent of Total	Visits	Percent of Total	Visits	Percent of Total
Mendocino Coast District Hospital	333	41.7%	283	43.7%	50	63.3%	0	0.0%
Santa Rosa Memorial Hospital-Montgomery	106	13.3%	95	14.7%	3	3.8%	8	11.2%
Ukiah Valley Medical Center/Hospital Drive	98	12.3%	74	11.4%	24	30.4%	0	0.0%
Sutter Medical Center Of Santa Rosa	84	10.5%	72	11.1%	0	0.0%	12	16.1%
Kaiser Foundation Hospitals	60	7.6%	37	5.7%	0	0.0%	23	32.6%
Palm Drive Hospital	41	5.2%	17	2.6%	0	0.0%	24	33.9%
Healdsburg District Hospital	27	3.4%	25	3.9%	0	0.0%	2	2.5%
Petaluma Valley Hospital	7	0.9%	6	0.9%	0	0.0%	1	1.2%
Sutter Lakeside Hospital	6	0.7%	5	0.8%	0	0.0%	1	0.8%
Sutter Auburn Faith Hospital	4	0.5%	2	0.3%	2	2.5%	0	0.0%
Frank R Howard Memorial Hospital	4	0.5%	4	0.6%	0	0.0%	0	0.0%
Eden Medical Center	4	0.5%	4	0.6%	0	0.0%	0	0.0%
Community Hospital Monterey Peninsula	3	0.4%	3	0.5%	0	0.0%	0	0.0%
Alta Bates Summit Med Ctr-Alta Bates Campus	3	0.4%	3	0.5%	0	0.0%	0	0.0%
Arroyo Grande Community Hospital	2	0.3%	2	0.3%	0	0.0%	0	0.0%
John Muir Medical Center-Walnut Creek Campus	2	0.3%	2	0.3%	0	0.0%	0	0.0%
Grossmont Hospital	2	0.3%	2	0.3%	0	0.0%	0	0.0%
California Pacific Med Ctr-Pacific Campus	2	0.3%	2	0.3%	0	0.0%	0	0.0%
Sutter Roseville Medical Center	2	0.3%	2	0.3%	0	0.0%	0	0.0%
St. Joseph Hospital - Orange	2	0.3%	2	0.3%	0	0.0%	0	0.0%
Valleycare Medical Center	2	0.3%	2	0.3%	0	0.0%	0	0.0%
Marin General Hospital	2	0.3%	2	0.3%	0	0.0%	0	0.0%
Alameda Hospital	2	0.3%	2	0.3%	0	0.0%	0	0.0%
San Joaquin General Hospital	1	0.1%	0	0.0%	0	0.0%	1	0.8%
St. Helena Hospital	1	0.1%	0	0.0%	0	0.0%	1	0.8%
Total	798	100.0%	648	100.0%	79	100.0%	71	100.0%
ED Station Need at 2,000 Visits per Station	0.4		0.3		0.0		0.0	

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/(ED_Tables.xlsx)Market Share

Source: OSHPD Emergency Department Database, 2011

Note: Numbers may not foot due to rounding.

(1) Secondary Service Area - South ED visits were calculated as 29.5 percent of total ED visits

ED Assumptions

Payer mix was assumed to mirror the market

Coast Life Support District
Service Area Emergency Department Visits Payer Mix
Calendar Year 2011

Payer	Service Area							
	Total		Primary		Secondary - North		Secondary - South ⁽¹⁾	
	Visits	Percent of Total	Visits	Percent of Total	Visits	Percent of Total	Visits	Percent of Total
Medicare	169	21.1%	141	21.8%	20	25.3%	8	10.7%
Medicare Managed Care	26	3.3%	20	3.1%	0	0.0%	6	9.1%
<i>Sub total</i>	<i>195</i>	<i>24.4%</i>	<i>161</i>	<i>24.8%</i>	<i>20</i>	<i>25.3%</i>	<i>14</i>	<i>19.8%</i>
Medi-Cal	201	25.2%	169	26.1%	16	20.3%	16	22.3%
Commercial - HMO	57	7.1%	37	5.7%	6	7.6%	14	19.4%
Commercial - PPO	18	2.2%	13	2.0%	3	3.8%	2	2.5%
Commercial - Other	173	21.7%	145	22.4%	22	27.8%	6	8.3%
<i>Sub total</i>	<i>248</i>	<i>31.0%</i>	<i>195</i>	<i>30.1%</i>	<i>31</i>	<i>39.2%</i>	<i>22</i>	<i>30.2%</i>
Self-pay	117	14.7%	96	14.8%	8	10.1%	13	18.6%
Other Payers	37	4.7%	27	4.2%	4	5.1%	6	9.1%
Total	798	100.0%	648	100.0%	79	100.0%	71	100.0%

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ED_Tables.xlsx]Payer Mix

Source: OSHPD Emergency Department Database, 2011

Note: Numbers may not foot due to rounding.

(1) Secondary Service Area - South ED visits were calculated as 29.5 percent of total ED visits

ED Assumptions and Station Need

- To account for the notable volume of tourists visiting the service area each year, an immigration factor of ten percent was applied to the ED visits that were treated and released without a hospital admission.
- Based on a station need benchmark of 1,800 visits per station, there is a need for one ED station in the service area. However, due to the random nature of emergencies, we assumed building two ED stations, one station to serve for back-up purposes.

Coast Life Support District
 Community Medical Center - Emergency Department Station Need
 Year 1 - Year 5

Emergency Department	Projected Year				
	1	2	3	4	5
Visits	555	595	638	677	706
Station Need at 1,800 Visits Per Station	1.0	1.0	1.0	1.0	1.0
Assumed Number of Stations	2.0	2.0	2.0	2.0	2.0

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/CAH_Utilization_Projections/[Bed_Need_and_Volume.xlsx]Bed Need Model Report

Ambulatory Surgery Market Share

**Coast Life Support District
Service Area Ambulatory Surgery Market Share
Calendar Year 2011**

Hospital	Service Area							
	Total		Primary		Secondary - North		Secondary - South ⁽¹⁾	
	Surgeries	Percent of Total	Surgeries	Percent of Total	Surgeries	Percent of Total	Surgeries	Percent of Total
Mendocino Coast District Hospital	119	35.6%	103	37.1%	16	55.2%	0	0.0%
Sutter Medical Center of Santa Rosa	66	19.6%	61	21.9%	0	0.0%	5	17.0%
Santa Rosa Memorial Hospital-Montgomery	43	12.8%	37	13.3%	2	6.9%	4	13.8%
UCSF Medical Center	31	9.2%	28	10.1%	0	0.0%	3	10.6%
Kaiser Foundation Hospital - Santa Rosa	16	4.7%	7	2.5%	0	0.0%	9	31.9%
California Pacific Med Center-Pacific Campus	14	4.2%	14	5.0%	0	0.0%	0	0.0%
PDI Surgery Center	12	3.6%	5	1.8%	7	24.1%	0	0.0%
Palm Drive Hospital	10	3.0%	4	1.4%	0	0.0%	6	21.3%
Ukiah Valley Medical Center	9	2.7%	5	1.8%	4	13.8%	0	0.0%
Healdsburg District Hospital	4	1.2%	3	1.1%	0	0.0%	1	3.2%
Ronald Reagan UCLA Medical Center	3	0.9%	3	1.1%	0	0.0%	0	0.0%
Menlo Park Surgical Hospital	2	0.6%	2	0.7%	0	0.0%	0	0.0%
Presidio Surgery Center	2	0.6%	2	0.7%	0	0.0%	0	0.0%
San Francisco General Hospital	2	0.6%	2	0.7%	0	0.0%	0	0.0%
Surgery Center of Palo Alto	2	0.6%	2	0.7%	0	0.0%	0	0.0%
Sonoma Valley Hospital	1	0.2%	0	0.0%	0	0.0%	1	2.1%
Total	335	100.0%	278	100.0%	29	100.0%	28	100.0%

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[CLSD_Ambulatory_Surgery_Data.xlsx]Market Share

Source: OSHPD Ambulatory Surgery Database, 2011

Note: Numbers may not foot due to rounding.

(1) Secondary Service Area - South surgeries were calculated as 29.5 percent of total surgeries

Surgical Volume Assumptions

Payer mix was assumed to trend similar to the inpatient market.

**Coast Life Support District
Ambulatory Surgery Payer Mix - Service Area Market versus
the Community Medical Center
Based on Data From Calendar Year 2011**

Payer	Surgeries	
	Service Area Market	Community Medical Center
Medicare	43.4%	49.4%
Medicare Managed Care	2.2%	1.2%
Subtotal	45.7%	50.6%
Medi-Cal	20.6%	23.1%
Commercial - HMO	6.2%	4.3%
Commercial - PPO	1.7%	0.9%
Commercial - Other	23.4%	20.1%
Subtotal	31.3%	25.3%
Other Payers	2.4%	0.9%
Total	100.0%	100.0%

Business Plan 2013/Planning/CAH_Utilization_Projections/[Bed_Need_and_Volume.xlsx]Payer Mix AS
Source: OSHPD Ambulatory Surgery Database, 2011 and The Camden Group
Numbers may not foot due to rounding

Surgical Volume Assumptions

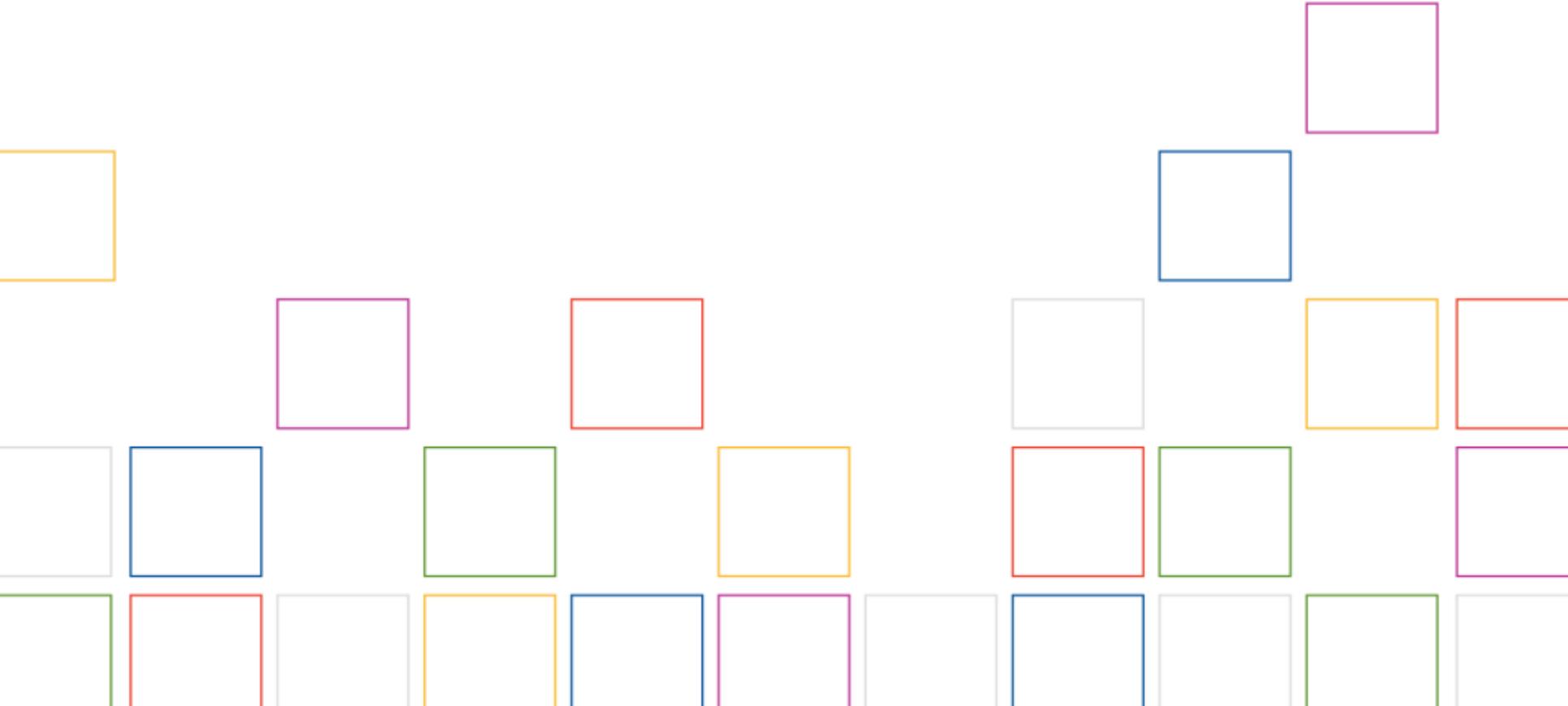
Market share of ambulatory surgeries was assumed to reflect similar capture assumptions as inpatient surgeries, approximately 48 percent of the service area's surgeries.

**Coast Life Support District
Community Medical Center - Summary of Surgical Volume
Year 1 - Year 5**

Surgery	Projected Year				
	1	2	3	4	5
Ambulatory	86	102	126	136	159
Inpatient	10	12	16	17	18
Total	95	114	142	153	177

ss_Plan_2013/Planning/CAH_Utilization_Projections/[Bed_Need_and_Volume.xlsx]Bed Need Model Report

Financial Projection



Financial Projection: Start-up and Five-Years

Assumes Critical Access designation in Year 3 of projected period with an increase in Medicare reimbursement to 101 percent of cost.

Financial Statement	Pre-opening 2-Years	General Acute Care Hospital		Critical Access Hospital		
		Projected Year				
		1	2	3	4	5
Discharges						
Medical/Surgical		81	97	123	136	147
Swing Bed		3	4	5	5	5
Skilled Nursing Facility		8	11	13	13	13
Net Revenue						
Net Revenue	\$0	\$2,953,275	\$3,631,924	\$7,234,404	\$7,576,893	\$7,881,664
Revenue Loss Prior to CMS Approval	0	(728,205)	0	0	0	0
Total	\$0	\$2,225,070	\$3,631,924	\$7,234,404	\$7,576,893	\$7,881,664
Operating Expenses						
Salaries, Wages, Benefits, and Professional Fees	\$6,753,301	\$6,191,886	\$6,377,643	\$6,568,972	\$6,568,972	\$6,568,972
Physician Professional Fees	0	3,259,407	3,259,407	3,259,407	3,259,407	3,259,407
Supplies	0	273,235	325,655	385,874	405,465	424,246
Purchased Services	0	533,450	597,616	669,871	697,150	724,022
Lease and Rentals	0	40,836	47,066	54,156	56,571	58,923
Other Direct Expenses	0	287,657	300,177	313,757	324,066	334,529
Total	\$6,753,301	\$10,586,472	\$10,907,564	\$11,252,038	\$11,311,630	\$11,370,099
EBITDA	(\$6,753,301)	(\$8,361,401)	(\$7,275,640)	(\$4,017,634)	(\$3,734,738)	(\$3,488,435)
Depreciation	0	1,314,232	1,315,008	1,319,125	1,319,516	1,319,865
Interest Expense	0	2,265,818	2,223,718	2,179,974	2,134,520	2,087,289
Net Operating Income	(\$6,753,301)	(\$11,941,451)	(\$10,814,366)	(\$7,516,733)	(\$7,188,774)	(\$6,895,589)
High-level Cash Flow						
Net Income	(\$6,753,301)	(\$11,941,451)	(\$10,814,366)	(\$7,516,733)	(\$7,188,774)	(\$6,895,589)
Add: Depreciation Expense	0	1,314,232	1,315,008	1,319,125	1,319,516	1,319,865
Less: Capital Additions	(45,880,000)	0	0	0	0	0
Less: Working Capital/Other Debt Financing Costs	(11,450,650)	0	0	0	0	0
Less: Routine Capital Expenditures	0	(118,131)	(145,277)	(289,376)	(303,076)	(315,267)
Add: Income from Financing/Funding	64,083,951	0	0	0	0	0
Less: Principal Payments	0	(1,077,169)	(1,119,269)	(1,163,013)	(1,208,467)	(1,255,698)
Estimated Cash Flow	\$0	(\$11,822,519)	(\$10,763,904)	(\$7,649,997)	(\$7,380,801)	(\$7,146,688)
Cumulative Cash Flow	\$0	(\$11,822,519)	(\$22,586,423)	(\$30,236,420)	(\$37,617,221)	(\$44,763,909)

Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[OSHDPD_Financial_Benchmarks.xlsx]CAH_Projections

Financial Projection: Summary of Findings

- Negative net operating income exists in each year of projection and is predominantly impacted by:
 - ▶ Net Revenue is low due to small volumes and general acute care reimbursement in first two years
 - ▶ High operating expenses for salaries, wages, benefits, professional fees, and physician professional fees
- Capital additions, depreciation, working capital, and other debt financing are assumed to be \$64.1 million (Scenario 1) which was assumed to be financed or funded through a parcel tax as shown on pages 40-41.
- Cash flow indicates a \$45 million cumulative cash shortage by Year 5 in projection period. An additional \$12 to \$7 million is needed per year in order for hospital to operate, therefore a greater cushion in funding is required.

Assumptions: Capital and Debt Service

- Two scenarios of project capital costs were reviewed based on a 37,000 square foot building with building, architecture and engineering, equipment, and information technology costs ranging between \$46 and \$57 million, including contingency.
- Ten percent of the project cost is assumed to be raised through funding through a parcel tax.
- Ninety percent of the project cost is assumed to be financed through a loan.
- Working capital requirements includes:
 - Ninety-days of cash for revenue loss during licensing period
 - Three months of start-up salaries, wages, and benefits (“SWB”)
 - Two years of an estimated administrator SWB
 - Estimated consulting and legal fees as 10.0 percent of project cost

Assumptions: Capital and Debt Service

- ▶ 2.5 percent issuance cost
- ▶ 10.0 percent debt reserve fund
- ▶ 30-year term loan with two years capitalized interest and two years principal deferment in the two-year start-up period
- ▶ 3.84 percent government interest rate
- All estimates for inflation are in today's dollars and would need to be adjusted for inflation.

Assumptions: Capital and Debt Service

Sources and Uses Scenario 1

- Multiple scenarios were shown for capital costs.
- Scenario 1 shows lower capital expenditures based on \$800 per square foot and was used in the financial projections.
- Equity contribution from parcel tax equates to \$414 per unit based on 11,069 tax units.

**Coast Life Support District
Community Medical Center - Scenario 1 Sources and Uses
Pre-opening and Year 1 - Year 5**

Sources	Amount	Uses	Amount
Bond proceeds	\$59,495,951	Capital expenditures ⁽¹⁾	\$45,880,000
Equity contribution (Parcel Tax)	4,588,000	Working capital requirement	9,363,664
		Debt service reserve fund	4,557,481
		Cost of issuance	1,032,300
		Capitalized interest	3,250,506
Total	<u><u>\$64,083,951</u></u>	Total	<u><u>\$64,083,951</u></u>

Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[OSHPD_Financial_Benchmarks.xlsx]Sources_Uses

⁽¹⁾ Capital expenditures include building costs, architecture and engineering, equipment, information technology, and contingency

Assumptions: Capital and Debt Service

Sources and Uses Scenario 2

- Scenario 2 shows higher capital expenditures based on \$1,000 per square foot.
- Equity contribution from parcel tax equates to \$518 per unit based on 11,069 tax units.

**Coast Life Support District
Community Medical Center - Scenario 2 Sources and Uses
Pre-opening and Year 1 - Year 5**

Sources	Amount	Uses	Amount
Bond proceeds	\$72,029,023	Capital expenditures ⁽¹⁾	\$57,350,000
Equity contribution (Parcel Tax)	5,735,000	Working capital requirement	9,363,664
		Debt service reserve fund	5,696,851
		Cost of issuance	1,290,375
		Capitalized interest	4,063,133
Total	<u>\$77,764,023</u>	Total	<u>\$77,764,023</u>

Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[OSHPD_Financial_Benchmarks.xlsx]Sources_Uses

⁽¹⁾ Capital expenditures include building costs, architecture and engineering, equipment, information technology, and contingency

Assumptions: Capital and Debt Service

- Total Debt Service in scenarios ranges from \$3.3 to \$4 million.
- Cash available for debt service is based on negative net operating revenue and the debt service coverage ratio is negative.
- Mendocino County's Standard and Poor's credit rating is AA- and a hospital with a similar rating would have a debt service coverage ratio of 5.8. The debt service coverage ratio for speculative grade is 2.1 to 2.6.

Coast Life Support District
Community Medical Center -Projected Capital Costs
Pre-opening and Year 1 - Year 5

Bond		Pre-Opening 2-Years	1	2	3	4	5
Scenario 1: \$59,495,951	Cash Available for Debt Service	\$0	(\$8,361,401)	(\$7,315,676)	(\$4,068,102)	(\$3,790,466)	(\$3,548,503)
	Total Debt Service	\$0	\$3,342,987	\$3,342,987	\$3,342,987	\$3,342,987	\$3,342,987
	Debt Service Coverage Ratio		(2.50)	(2.19)	(1.22)	(1.13)	(1.06)
Scenario 2: \$72,029,023	Cash Available for Debt Service	\$0	(\$8,361,401)	(\$7,315,676)	(\$4,068,102)	(\$3,790,466)	(\$3,548,503)
	Total Debt Service	\$0	\$4,047,201	\$4,047,201	\$4,047,201	\$4,047,201	\$4,047,201
	Debt Service Coverage Ratio		(2.07)	(1.81)	(1.01)	(0.94)	(0.88)

Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[OSHDP_Financial_Benchmarks.xlsx]Sources_Uses

Note 1: 30 year term loan with two years capitalized interest and two years principal deferment for the start-up period

Stroudwater Report Assumptions

A “New Critical Access Hospital Economic Feasibility Analysis” in Gualala, California was completed by Stroudwater Associates (“Stroudwater”) in May 2010. The analysis required a set of assumptions to estimate annual utilization of services, revenue, expenses, profit/loss, and the cost for building and servicing the debt of a new facility. The Stroudwater Report differed from the Camden Group’s assumptions for a community medical center in the following areas, shown on the next five pages.

Stroudwater Report Assumptions

Assumption Category	The Camden Group	Stroudwater
Service Area	Included Timber Cove	Excluded Timber Cove
Population Size/Population Growth	6,194/No Growth	8,000/10 percent growth over 10 years
Historical Utilization	Office of Statewide Health Planning and Development (“OSHDP”)	Truven (formally Thomson-Reuters) healthcare services database
Market Share	39 percent in Year 5	34 percent
Average Daily Census	1.6 days in Year 5 for acute inpatients 0.2 days in Year 5 for swing bed inpatients	2.71 days for acute inpatients 1.0 days for swing beds inpatients
Licensed Bed Number	5 acute care beds 5 swing beds 5 skilled nursing beds	6 swing beds
Critical Access Designation	Year 3	Year 1

Stroudwater Report Assumptions

Assumption Category	The Camden Group	Stroudwater
Operational Losses:	\$11.9 million to \$6.9 million per year in the five year projection	\$519,000 to \$346,000 per year in the five year projection
Inpatient Payer Mix	53 percent Medicare 26 percent Medi-Cal 15 percent Private Coverage 6 percent All Other	83 percent Medicare 7 percent Medi-Cal 7 percent Other Third Party Payers 3 percent All Other and County Indigent
Outpatient Payer Mix	Specific to ED Visits: 24 percent Medicare 25 percent Medi-Cal 31 percent Private Coverage 20 percent All Other	55 percent Medicare 10 percent Medi-Cal 30 percent Other Third Party Payers 5 percent All Other and County Indigent
Staffing and Salaries	California staffing requirements	National database was used to determine salaries

Stroudwater Report Assumptions

Assumption Category	The Camden Group	Stroudwater
Reimbursement	<p>Medicare: 101 percent of reasonable costs with assumption that 10 percent of operating costs non-reasonable</p> <p>Other Third Party Payer: 80 percent gross revenue and 3 percent increase per year in projection period.</p> <p>Medi-Cal: based on APR-DRG rate for rural hospitals; rate remains flat through projection period</p> <p>All Other Payers: 20 percent of gross revenue and rate remains flat through projection period</p>	<p>Medicare: 101 percent cost reimbursement with no loss and 1 percent profit</p> <p>Other Third Party Payer: 60 percent of gross revenue</p> <p>County Indigent: 20 percent of gross revenue while</p> <p>All Other Payers: 40 percent of gross revenue</p>

Stroudwater Report Assumptions

Assumption Category	The Camden Group	Stroudwater
Costs	<p>Facility: ranges from \$45.9 million to \$57.4 million based on cost per square foot</p> <p>Start-up costs: \$6.7million</p> <p>Additional financing: \$18.2 million to \$20.4 million</p> <p>Construction: \$800 to \$1,000 per square foot for a 37,000 square foot facility</p> <p>Loan payments: \$3.3 million to \$4.0 million for a 30 year term loan with two years capitalized interest and two years principal deferment for projection period</p>	<p>Facility: ranges from \$33 million (without primary care clinic) to \$37 million (with primary care clinic)</p> <p>Start-up costs: \$2 million</p> <p>Recruitment and housing: \$200,000</p> <p>Additional Emergency Department staffing: \$100,000 per year</p> <p>Construction: \$600 per square foot for a 38,000 square foot facility</p> <p>Monthly loan payments: \$165,000</p>

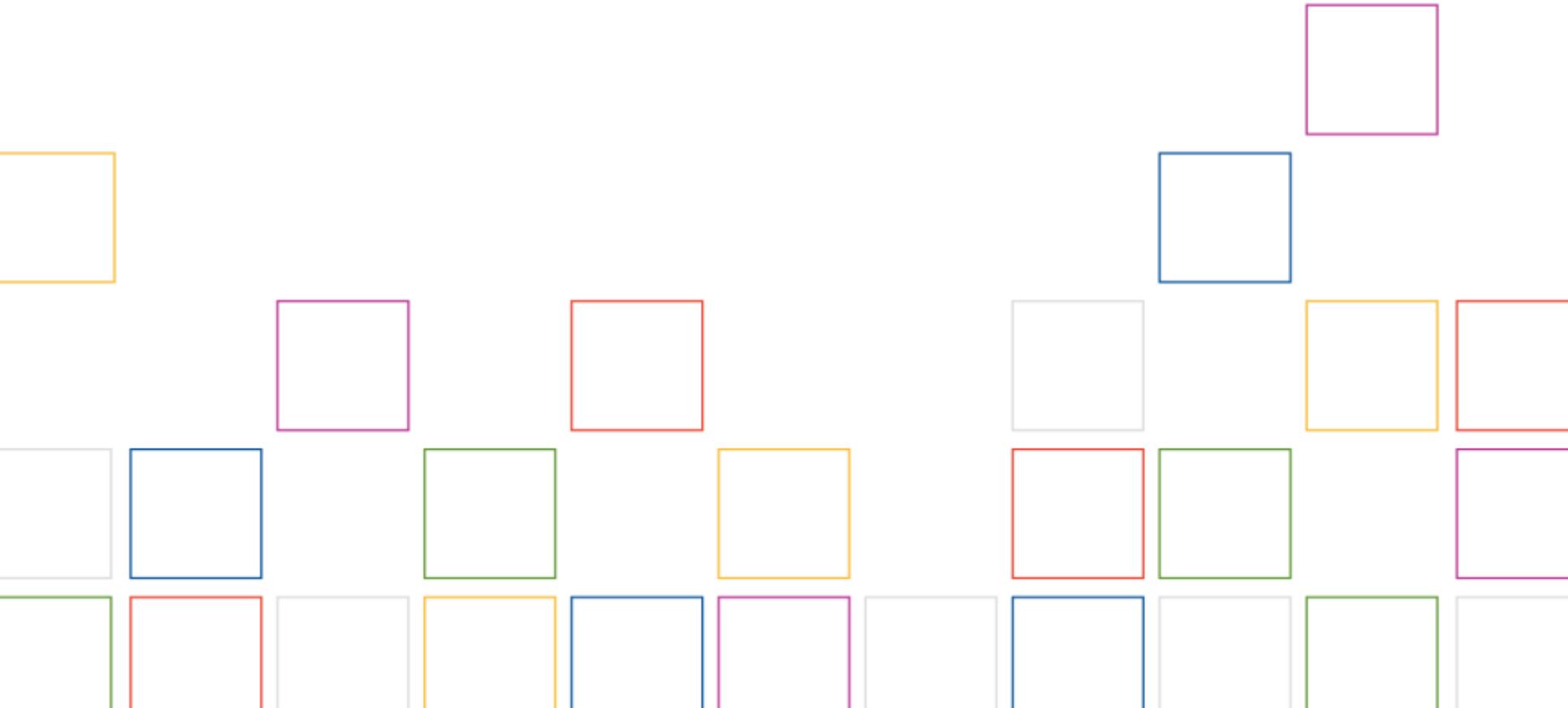
Stroudwater Report Assumptions

Assumption Category	The Camden Group	Stroudwater
Funding and Financing	<p>\$4.6 million to \$5.7 million of local funds raised through parcel tax</p> <p>\$59.5 million to \$72.0 million bond issuance</p> <p>Loan rate for 30 years at 3.84 percent interest</p> <p>Debt service coverage ratio is negative</p>	<p>\$5 million of local funds raised</p> <p>\$34 million bond issuance</p> <p>Loan rate for 40 years at 6.0 percent interest</p> <p>Debt service coverage ratio of 1.46</p>

New Community Medical Center Critical Success Factors

Critical Success Factors	Likelihood
Critical access designation	Probably
Part of System	Potentially
High Medicare payer mix (60+ percent)	Probably not
High occupancy levels and critical mass	No
Adequate physician supply and select specialist coverage	Probably not
Support tax, donations, and other non-operating revenue to support facilities	To Be Determined

Recommendations



Recommendations

- The Camden Group does not believe that building a small community medical center (less than 25 licensed beds) in CLSD's service area would serve as a financially sustainable healthcare model for the community due to the following factors:
 - ▶ High start-up costs to build a new facility due to California's regulatory environment.
 - ▶ Low inpatient occupancy levels hinder the community medical center's ability to provide consistently high quality, keep clinical competencies, and maintain enough critical mass to be financially sustainable.
 - ▶ Delays in cost-based reimbursement methodologies at the new community medical center caused by the 12 to 18 month qualification period for critical access designation will translate into significant financial losses during the initial years of operation.

Recommendations

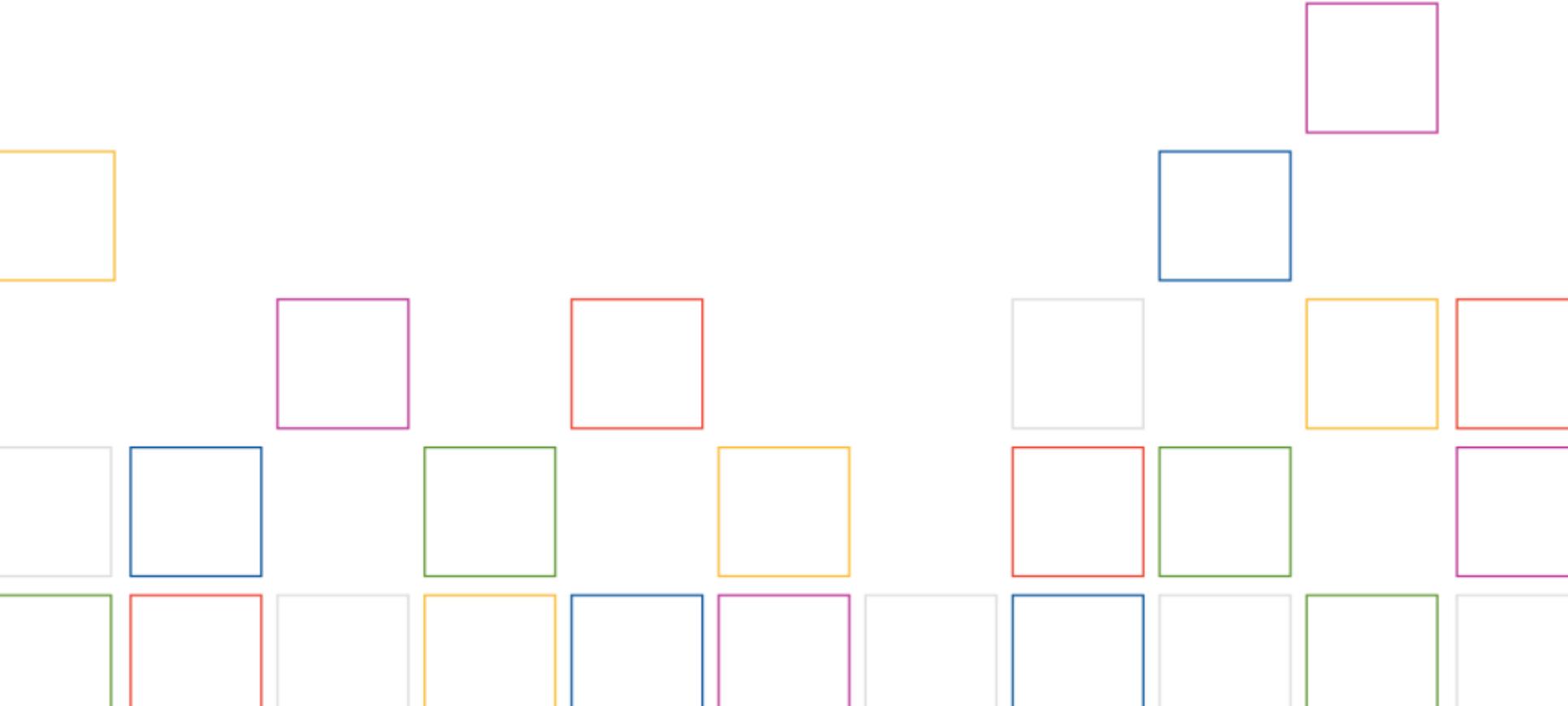
- ▶ The payer mix of the market will most likely not yield a high enough proportion of Medicare patients, which will contribute to the financial unsustainability of the hospital
- ▶ Significant household parcel tax increases to provide start-up and ongoing funds to support a community medical center
- The above listed factors will reduce CLSD's ability to attract a health system partner, which is critical to the success of this new facility.
- In addition, ongoing challenges would persist in the recruitment and retention of physicians, hospital management, and technical staff needed for the community medical center to succeed locally.
 - ▶ Would require subsidies and premiums to attract and retain talent in the service area.

Recommendations

- The anticipated future trends in the healthcare environment (e.g., reimbursement levels, declining inpatient use, physician and clinical shortages) will continue to make it difficult to successfully operate and maintain financially viable hospitals in general, and smaller hospital players in particular.
- The Camden Group believes the use of valuable financial resources and management would be better served to support the expansion of urgent care and outpatient services at this point-in-time.

Appendix A

Terms



Terms

- **General Services** - The non-revenue producing cost centers for those services generally associated with the operation and maintenance of a hospital, including such cost centers as laundry and linen, housekeeping and plant operations, and maintenance.
- **Fiscal Services** - The non-revenue producing cost centers for those services generally associated with the fiscal operations of a hospital, including such cost centers as general accounting, patient accounting, and admitting.
- **Administrative Services** - The non-revenue producing cost centers for those services generally associated with the overall management and administration of a hospital, such as hospital administration, personnel, and medical records.

Terms

- **Salaries and Wages** - The compensation for services performed by an employee payable in cash and the fair market value of service donated to the hospital by persons performing under an employee relationship. Includes compensation only for actual hours worked (productive hours), including overtime and "on-call" premiums.
- **Benefits** - Labor expenses that are not compensation for actual time worked.
- **Physician/Professional Fees** - The professional fees incurred relating to physicians (including subsidies) and the fees paid for professional services provided by therapists, consultants, legal counsel, auditors, and registry nursing personnel.

Terms

- **Supplies** - The cost of various types of supplies used by the hospital, including medical supplies, drugs, food, and office supplies.
- **Purchased Services** - The expenses incurred relating to services purchased from an outside contractor or vendor, such as diagnostic imaging services, equipment repairs and maintenance, and collection services. Also includes fees paid to a related organization for management services and inpatient services purchased from another hospital.
- **Leases and Rentals** - The cost related to the lease and rental of buildings, equipment, and leasehold improvements.

Standby and Basic ED Requirements

Standby and Basic Emergency Medical Services Requirements

Facility Requirements	Emergency Department	
	Standby	Basic
General Space Requirements	Designated emergency room area	Treatment room
Specific Space Requirements:		
Cast room		X
Nursing station		X
Medication room		X
Public toilets		X
Observation room	X	X
Staff support rooms including toilets, showers, and lounge		X
Waiting room		X
Reception area	X	X
Observation beds in the emergency medical service shall not be counted in the total licensed bed capacity of the hospital.	X	X

[https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/\[ER_Requirements.xls\]Matrix](https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ER_Requirements.xls]Matrix)

Sources: California Administrative Code Title 22

Standby and Basic ED Requirements

Standby and Basic Emergency Medical Services Requirements

General Requirements	Emergency Department	
	Standby	Basic
Written policies and procedures developed and maintained by the person responsible for the service in consultation with other appropriate health professionals and administration. Policies shall be approved by the governing body. Procedures shall be approved by the administration and med staff where appropriate.	X	X
The responsibility and the accountability of the emergency medical service to the medical staff and administration shall be defined.	X	X
There shall be a roster of names of physicians and their telephone numbers who are available to provide emergency service.	X	
The emergency medical service shall be so located in the hospital as to have ready access to all necessary services.		X
A communication system employing telephones, radiotelephone or similar means shall be in use to establish and maintain contact with the police department, rescue squads and other emergency services of the community.	X	X
The emergency medical service shall have a defined emergency and mass casualty plan in concert with the hospital's capabilities and the capabilities of the community served.	X	X
The hospital shall require continuing education of all emergency medical service personnel.	X	X
Medical records shall be maintained on all patients presenting themselves for emergency medical care. These shall become part of the patient's hospital medical record. Past hospital records shall be available to the emergency medical service.	X	X

[https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/\[ER_Requirements.xls\]Matrix](https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ER_Requirements.xls]Matrix)

Sources: California Administrative Code Title 22

Standby and Basic ED Requirements

Standby and Basic Emergency Medical Services Requirements

General Requirements	Emergency Department	
	Standby	Basic
An emergency room log shall be maintained and shall contain at certain information relating to the patient.	X	X
Emergency medical services shall be identified to the public by an exterior sign , clearly visible from public thoroughfares. The wording of such signs shall state:	Standby Emergency Medical Service, Physician On Call	Basic Emergency Medical Service, Physician On Duty
All medications furnished to patients through the emergency service shall be provided by a pharmacist or an individual lawfully authorized to prescribe.		X
Standardized emergency nursing procedures shall be developed by an appropriate committee of the medical staff.	X	X
A list of referral services shall be available to include the name, address and telephone number of the following:		
Police department	X	X
Blood Bank	X	
Antivenin service	X	X
Burn center	X	X
Drug abuse center	X	X
Poison control information center	X	X
Suicide prevention center	X	X
Director of the State Dept of Health or designee	X	X
Local health department	X	X
Clergy	X	X
Emergency psychiatric service	X	X
Chronic dialysis service	X	X
Renal transplant center	X	X
Intensive care newborn nursery	X	X
Emergency maternity service	X	X
Radiation accident management service	X	X
Ambulance transport and rescue service	X	X
County coroner or medical examiner	X	X

[https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/\[ER_Requirements.xls\]Matrix](https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ER_Requirements.xls]Matrix)

Sources: California Administrative Code Title 22

Standby and Basic ED Requirements

Standby and Basic Emergency Medical Services Requirements

General Requirements	Emergency Department	
	Standby	Basic
Periodically, an appropriate committee of the medical staff shall evaluate the services provided and make appropriate recommendations to the executive committee of the medical staff and administration.	X	X
The hospital shall have the following service capabilities:		
Intensive care service with adequate monitoring and therapeutic equipment.		X
Laboratory service with the capability of performing blood gas analysis and electrolyte determinations.		X
Radiological service shall be capable of providing the necessary support for the emergency service.		X
Surgical services shall be immediately available for life-threatening situations.		X
Post anesthesia recovery service.		X
The hospital shall have readily available the services of a blood bank containing common types of blood and blood derivatives. Blood storage facilities shall be in or adjacent to the emergency service.		X

[https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/\[ER_Requirements.xls\]Matrix](https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ER_Requirements.xls]Matrix)

Sources: California Administrative Code Title 22

Standby and Basic ED Requirements

Standby and Basic Emergency Medical Services Requirements

Physician Requirements	Emergency Department	
	Standby	Basic
A physician shall have overall responsibility for the service.	No qualifications delineated	Must be trained and experienced in emergency medical services.
Responsibilities include:		
(1) Implementation of established policies and procedures.	X	X
(2) Development of a system for physician coverage on call 24 hours a day to the ED.	X	
(3) Providing physician staffing for the ED 24 hours a day who are experienced in emergency medical care.		X
(3) Assurance that physician coverage is available within a reasonable length of time, relative to the patient's illness or injury.	X	
(4) Development of a roster of specialty physicians available for consultation at all times.	X	X
(5) Assurance of continuing education for the medical and nursing staff.	X	
All physicians, dentists and podiatrists providing services in the emergency room shall be members of the organized medical staff.	X	X
An RN shall be responsible for the nursing care within the service.		X
An RN shall be immediately available within the hospital at all times to provide emergency nursing care.	X	
An RN trained and experienced in emergency nursing care shall be on duty at all times.		X
There shall be sufficient other personnel to support the services offered.	No qualifications delineated	Must be other licensed nurses and skilled personnel.

[https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/\[ER_Requirements.xls\]Matrix](https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ER_Requirements.xls]Matrix)

Sources: California Administrative Code Title 22

Standby and Basic ED Requirements

Standby and Basic Emergency Medical Services Requirements

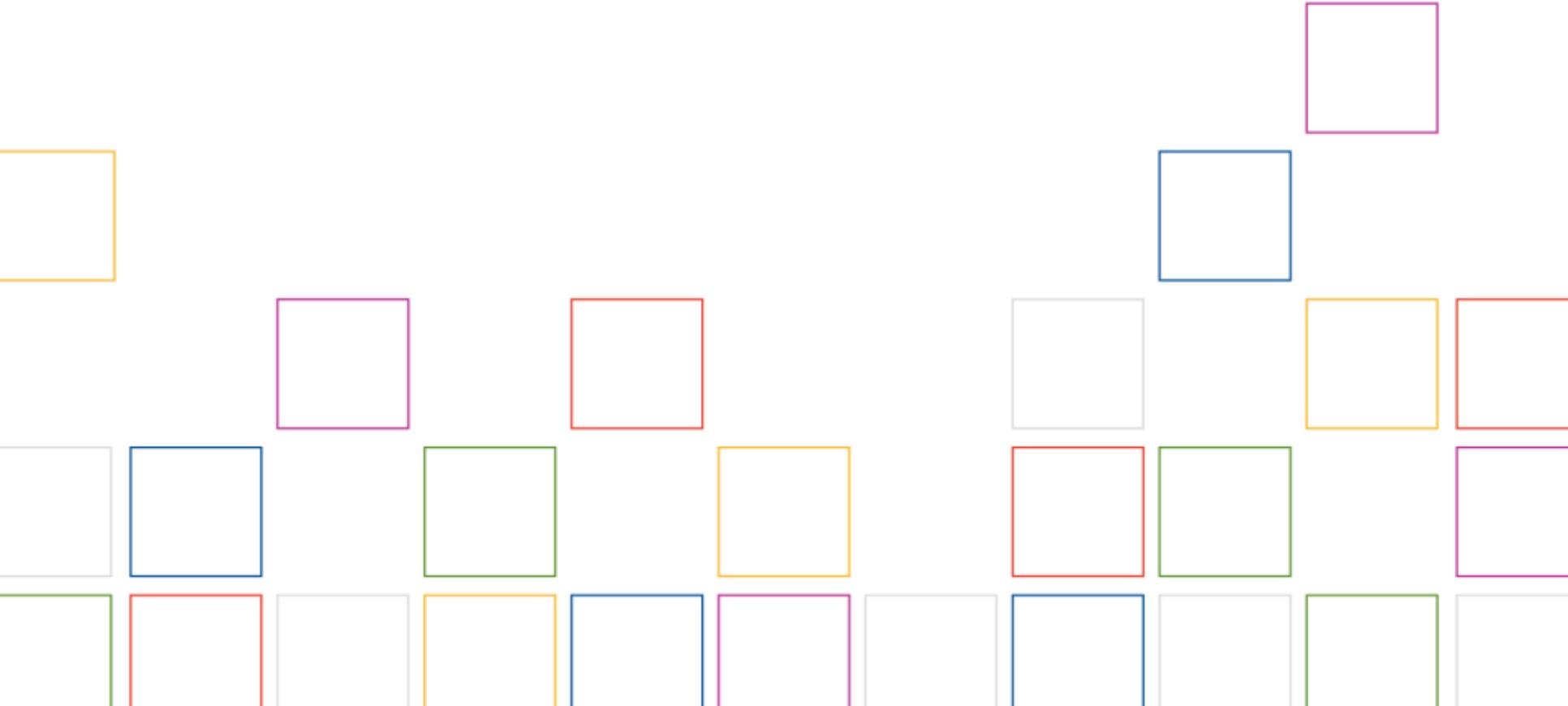
Equipment Requirements	Emergency Department	
	Standby	Basic
All equipment and supplies necessary for life support shall be available, including but not limited to:		
Airway control and ventilation equipment	X	X
Suction devices	X	X
Cardiac monitor defibrillator	X	X
Pacemaker capability		X
Apparatus to est. central venous pressure monitoring		X
IV fluids and administration devices	X	X
Blood expanders	X	X

[https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/\[ER_Requirements.xls\]Matrix](https://sharepoint.thecamden.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ER_Requirements.xls]Matrix)

Sources: California Administrative Code Title 22

Appendix C

Financial Assumption Detail



Financial Assumption Detail

The financial projection baseline was based on the comparable hospitals selected for their related characteristics (e.g., region, size, ownership, critical access status) to the community medical center.

Hospital	Type of Control	County	Beds	Medicare Case Mix Index	Critical Access Status	Eight Essential Services	Emergency Services	Rural Health Clinic
Catalina Island Medical	Non-profit Corporation	Los Angeles	4 Acute 12 Long-term	0.7706	Yes	All except Surgery	Standby	Yes
Community Hospital of San Bernardino	Non-profit Corporation	San Bernardino	26 Intensive 229 Acute 88 Long-term	0.9527	Yes	All	Basic	No
Eastern Plumas District Hospital	District	Plumas	10 Acute 66 Long-term	0.9269	Yes	All	Basic	Yes
Mammoth Hospital	District	Mono	2 Intensive 13 Acute	1.1398	Yes	All	Standby	Yes
Mendocino Coast Hospital	District	Mendocino	4 Intensive 16 Acute 5 Long-term	1.4256	Yes	All	Basic	Yes
Seneca District Hospital	District	Plumas	10 Acute 16 Long-term	0.9842	Yes	All	Standby	Yes
Bear Valley Community Hospital	District	San Bernardino	9 Acute 21 Long-term	1.0881	No	All	Standby	Yes

Financial Assumption Detail

The baseline assumptions for revenue and costs are based on Fiscal Year 2012 OSHPD Annual Financial Disclosure Reports. The baseline assumptions do not include an inflation factor, as the timing of the opening had not been estimated.

Financial Assumption Detail

- Financial projection shows a two-year pre-opening period and five-year operational projection period. The first two years of operations assumed to be general acute care until critical access designation obtained.
- Medicare payment for general acute care hospital is the acute inpatient prospective payment system (“PPS”) and the hospital outpatient PPS. Payment for inpatient services were assumed to be an average Medicare Severity-Diagnosis Related Group (“MS-DRG”) payment for case mix index of 1.0 based on comparable hospitals.
- Medicare payment for critical access hospital for inpatient and outpatient services are assumed at 101 percent of reasonable costs (e.g., lesser of costs or charges, costs for provision of services that exceed average costs of similar hospitals). Ninety percent of total operating expenses on page 36 were assumed to be reasonable costs.

Financial Assumption Detail

- Medi-Cal payment is based on the APR-DRG pricing for remote and rural locations based on the California Department of Health Care Services and the outpatient fee schedules. Medi-Cal rate remains flat through the projection period.
- Commercial reimbursement assumed at 80 percent of gross revenue, and assumed to increase by three percent each year.
- Self-pay and other reimbursement assumed at 20 percent of gross revenue. Self-pay rate remains flat through the projection period.

Financial Assumption Detail

- The costs associated with operating expense include SWB, professional fees, physician professional fees, supplies, purchased services, leases, rentals, and other direct costs.
- Services include the eight essential services as well as respiratory, fiscal, general, and administrative services.
- Operating expense increases by 3.0 percent inflation per year.

Financial Assumption Detail

- FTE projections are based on expected inpatient and outpatient volume and ancillary utilization and on comparable hospitals' staffing. The minimum requirements for staffing units are included.
- SWB are based on FTEs and additional professional fees range from \$6.2 to \$7.0 million in Years 1 to 5 and are included in total operating expense.

Coast Life Support District
Community Medical Center - Full Time Equivalents
Year 1 - Year 5

Department	Projected Year				
	1	2	3	4	5
Medical/Surgical	8.4	8.4	8.4	8.4	8.4
Skilled Nursing	8.4	8.4	8.4	8.4	8.4
Emergency Department	8.4	8.4	8.4	8.4	8.4
Clinical Laboratory	4.2	4.2	4.2	4.2	4.2
Diagnostic Radiology	4.2	4.2	4.2	4.2	4.2
Physical Therapy	2.0	2.0	2.0	2.0	2.0
Respiratory Therapy	4.2	4.2	4.2	4.2	4.2
Surgery and Anesthesia	4.2	4.2	4.2	4.2	4.2
Pharmacy	4.2	4.2	4.2	4.2	4.2
Dietary	1.5	1.5	1.5	1.5	1.5
Fiscal Services	2.0	2.0	2.0	2.0	2.0
General Services	4.0	4.0	4.0	4.0	4.0
Administrative Services	2.0	2.0	2.0	2.0	2.0
Total Productive FTEs	57.8	57.8	57.8	57.8	57.8
Total Paid FTEs	65.3	65.3	65.3	65.3	65.3

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