Constantino, Mike

From: Vilt, Patt [Patt-Vilt@RiversideHealthCare.net]
Sent: Thursday, March 07, 2013 3:28 PM
To: Constantino, Mike
Cc: Vilt, Patt
Subject: Riverside Medical Center project 12-089 reply to Intent to Deny
Attachments: Riverside Medical Center Project 12-089 reply to Intent to Deny.pdf

Mike,
Attached is Riverside's reply to the Intent to Deny issued for Project 12-089 by the Review Board at the 02/05/2013 meeting.
If any questions, please let me know. Thank you.
Patt

Patricia K. Vilt
Vice President of Finance and Chief Compliance Officer

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March 7, 2013

Mr. Michael Constantino
Supervisor, Project Review Section
Illinois Health Facilities and Services Review Board
525 West Jefferson Street
2nd Floor
Springfield, IL 62761

Re: Response to Intent to Deny and Modification to Application
Project Number 12-089; Riverside Medical Center d/b/a Riverside Medical Center North Campus at Frankfort

Dear Mr. Constantino:

Riverside Medical Center, the applicant in Project No. 12-089, submits this letter and attached materials as supplemental information in response to the Intent-to-Deny issued by the Review Board on February 5, 2013. This information addresses questions raised at the Review Board's February meeting and addresses the three negative findings of the State Agency Report ("SAR").

The two negative findings in the SAR under Part 1110 were based on historical utilization below target levels at existing facilities. In response to the utilization issue, we include the study of our health care consultant, 3d Health, showing that the project is compliant with the criterion on projected utilization in that no provider's utilization will be reduced from current levels within 24 months of project completion.

In addition, we document that there all other emergency services providers within the proposed Geographic Service Area ("GSA") and that providers are outside the northern portion of the GSA and therefore not readily accessible to patients in the central and southern portions of the GSA. **[Attachment A]**

Please note that in order to address the sole negative finding under the financial criteria we are modifying the project to reduce the project cost, including a reduction in the Site Preparation costs which exceeded state standards. Total project costs have been reduced from $10,301,278 to $10,217,061, which is an $84,216 reduction. Costs were specifically reduced for Site Preparation. The costs for Site Preparation were adjusted from $294,157 to $209,941. This cost reduction will remove the one negative finding under those criteria and bring the project into compliance with all the financial criteria. The modified application pages are submitted with this letter.

A. FECs Are A Key Component In Addressing the Changing Landscape Of Healthcare

A question arose at the Board's February meeting as to the need for Freestanding Emergency Centers ("FEC") in general. Among the greatest challenges facing health care providers today is the need to create better approaches for all levels of care: emergency, urgent, acute, chronic, and long-term care. We would like to present the variables that we believe need to be considered and underpin both the need and the important role for FEC's in the care continuum in the targeted service area.

FEC's can be uniquely positioned in geographic areas where rapid access to an acute care hospital is lacking and where access to emergency care can be constrained by drive times, distance, congestion, and challenging infrastructure, such as rural roads. An FEC is not geographically bound to the extensive infrastructure and heavily burdened campus of an acute care hospital. An FEC meets the need for a more geographically dispersed healthcare system than what currently exists.

Analysis of research studies from the Center for Disease Control ("CDC"), Annals of Emergency Medicine and other professional associations indicates that Emergency Department ("ED") care and the utilization parameters within EDs have changed.

The major factors underlying the changes are:

- projected increased utilization of Emergency Departments,
- expanded scope of treatments provided in EDs, and
- increased length of stay (time patient is occupying an ED treatment bay).

Each of these factors is integrally related and will continue to increase pressure on ED throughput.

According to a 2012 research study published in the Annals of Emergency Medicine, since 1992 the number of emergency department visits in the U.S. has increased at roughly twice the rate of population growth (Annals of Emergency Medicine. 2012; 60(6): 679-686).

In May 2012, the CDC released a study of emergency room use. This study highlighted that nearly 80% of adults visited EDs due to the lack of access to other providers (CDC 2012-Emergency Use Among Adults Aged 18-64).

The National Hospital Ambulatory Medical Care Survey (2009 being the most recent data analysis) identified that approximately 60% of patients arrived to an ED after business hours. Though access to care is improving in alternate settings, the need for ED care in today's health care environment is increasing, not diminishing. Contrary to popular literature, the bulk of ED patients are insured, with only 16% of ED patients in the U.S. having no insurance.

The CDC has studied and noted that about 20% of U.S. adults use Emergency Departments ("EDs") with the highest visit rates by those with public insurance and those living outside a metropolitan area. (CDC 2012-Emergency Use Among Adults Aged 18-64) . Even though 300 million additional people in the U.S. are projected to have improved access to health care as a result of insurance coverage provided by the Affordable Care Act, there are some missing links to achieve the intended result. There are not enough primary care physicians to serve the growing population and the newly insured. Individuals who have insurance are the most common recipients of emergency services. Another missing link is the access to services during the hours when they are needed. Even with the proliferation of urgent care centers and retail clinics, those centers do not address the fact that over 60% of ED visits occur after business hours nor do they have the clinical capabilities of an ED.

Emergency Departments have evolved to become a significant and important venue for complex treatments, often serving as a critical step to prevent a hospital admission, thereby decreasing the overall cost of health care in this country.

Inpatient care is recognized as the most costly site for care and efforts by the entire health care system to reduce hospital utilization are making great strides. However, it is important to recognize that the need for complex care has not changed---it is the site where the care is being provided that has changed, care often now provided in the Emergency Department.

Hospital admissions are being heavily scrutinized today and in some cases, readmissions are resulting in financial penalties for hospitals. Emergency Departments have always served as the front door for hospital admissions. Now Emergency Departments are serving as the 'filter' to determine the appropriateness for a hospital admission.

Increasingly often now, an Emergency Department can have a patient in a bay for an extended period of time (4 to 8 hours), treat the patient with appropriate measures, and then have that patient clinically ready to return to their home or residence. This avoids a costly admission, yet significantly decreases the throughput of an ED bay.

As a result of both the increased utilization and the changed scope of treatment being provided in Emergency Departments, the average length of stay (LOS) for an average Emergency Department patient has increased across the country. The ability to cycle patients through each ED bay has changed to such a degree that national standards have been revised and Emergency Departments are being required to report their efficiency measures for benchmarking purposes.

An unfortunate challenge facing hospitals is the shortage of behavioral health services, and particularly, inpatient beds for those in need of a behavioral health admission. That has resulted in an average LOS of 11.5 hours for psychiatric patients (Annals of Emergency Medicine. 2012; 60(2): 162-171).

The Emergency Departments related to this project are reporting ED stays for Medicare patients of 319-240 minutes (5.3 hours to 4.0 hours) for admissions and 182 to 135 minutes (3.0 hours to 2.25 hours) for patients discharged to home. (Hospital Compare, 2012) This reported time does not account for room turn-over, meaning cleaning after one patient and set-up and preparation for another. Typically that turn-over time is 30 minutes. The ED room utilization times then are 5.8 to 4.5 hours for admissions and 3.0 to 2.75 hours for patients discharged to home or residence.

The average length of stay for an ED bay in the U.S., including turnover time for cleaning and set-up and preparation is 5.5 hours (The National Hospital Ambulatory Medical Care Survey (2009).

With an average LOS of 5.5 hours/ ED visit, then the average number of visits per bay would be 1590 ED visits per bay at 100% of target utilization. Given that 100% utilization immediately means that there is no flexibility and not enough capacity, we would suggest that 1500 visits per bay may still be a tight metric, but closer to reflecting the industry experience.

Facilities within 30 minutes of proposed facility

Facility	City	Adjusted Time	Stations	2011 Visits	Number of Stations Justified	Met Standard
Silver Cross Hospital	New Lenox	20.7	38	56,264	29	No
Franciscan St. James – Olympia Fields	Olympia Fields	20.7	24	35,877	18	No
Advocate South Suburban	Hazel Crest	25.3	25	44,104	23	No
Silver Cross Freestanding Emergency Center	Homer Glen	27.6	6	11,230	6	Yes
Franciscan St. James – Chicago Heights	Chicago Heights	28.75	22	43,087	22	Yes
Ingalls Memorial Hospital	Harvey	29.9	31	47,290	24	No
Presence St. Joseph Medical Center	Joliet	32.2	53	66,577	34	No

- Information taken from 2011 IDPH Profile and information requested by the State Board Staff
- Time and Distance from MapQuest and adjusted per 1100.510 d
- Silver Cross Hospital relocated from Joliet to New Lenox in February 2012.

The Emergency Departments listed in the State Agency Report on page 5 and reproduced above had 304,429 total ED visits and 199 ED bays.

Applying the national experience-based metric of 1500 visits/bay to the aforementioned hospital ED visit volumes and existing ED bays, there is not excess ED capacity in this market as detailed below:

[304,429 total visits/ 1500 visits per bay = need for at least 203 bays]

Riverside recognizes that there are many measures needed to face the country's health challenges. Riverside has 3 immediate care centers in Watseka, Monee, and Coal City and one retail health clinic (Fast Care) in the Wal-Mart in Bourbonnais. These sites are proactive measures on Riverside's part to shift care to less expensive sites, yet these sites will never serve as a substitute for the level of care needed by individuals in an FEC nor do they offer the hours to relieve the need for additional EDs.

B. The Proposed Project Is Part Of Riverside's Broader Efforts To Recruit Primary Care Physicians

Riverside is actively employing physicians to be able to increase the core of primary care physicians in the market. Riverside employs primary care, internal medicine, obstetrics/gynecology, pediatrics, psychiatry and a variety of sub-specialties.

By actively employing physicians, Riverside is able to place and assure primary care physician coverage for markets and clinics located where a physician may be reticent to set up an independent practice. There is a serious national shortage of primary physicians and that shortage contributes to limited health care access. Riverside is developing Medical Home practices to more fully coordinate care.

Riverside has a long history of providing a geographically dispersed system of care, irrespective of the demographic of the market. Further, Riverside has an expansive network of facilities throughout our service area intended to bring care to patients.

Riverside's Rural Health Clinic is located in the township of Pembroke, one of the state's most impoverished communities, where 55 percent of the residents live beneath the poverty level and 40 percent live without running water. In 2005, the average income was $9,700 a year. The Riverside Rural Health Clinic is the only medical facility located within this community.

In an area with limited access to care and limited access to transportation, Riverside's New Life Center serves an impoverished area in great need of health services. The Riverside Center provides family planning services, obstetric care, gynecologic care, diagnostic testing, and specialized treatments for HIV/AIDS and STD. These services are not provided by any other practitioner in the immediate area for patients with limited transportation options.

The Riverside Clinic in Momence offers primary care services to an area designated by HRSA as a Health Professional Shortage Areas (HPSAs). Riverside supports communities like Pembroke and Momence by placing primary care practitioners and facilities directly where area residents can easily access the care they need and deserve.

Riverside's commitment to its patients and the communities served is also demonstrated by the level of charity care provided. Riverside bears over 60% of the charity expense to its immediate neighborhoods. The charity care dollars per charity care case that Riverside provides exceed every facility within 30 minutes of the proposed FEC with the exception of Advocate South Suburban Hospital. Providing care to the community it serves is Riverside's mission. In 2011, Riverside provided over $42 million in community benefit which included $5 million in charity care.

Riverside Medical Center also serves a high volume of Medicaid patients and is a disproportionate share hospital. At both the federal and state level, Riverside is designated at the highest level based upon the exceptionally high number of Medicaid patients served.

The attached map **[Attachment B]** displays the comprehensive services Riverside has established in its surrounding communities supported by its multi-specialty physician network. Riverside's facilities extend broadly to the south in Watseka, to the west in Coal City and to the east in Pembroke. Riverside's proposed FEC project located south of Frankfort will allow Riverside to serve patients in the target service area who currently have a shortage of emergency care providers.

Riverside is not proposing an FEC to increase its hospital admissions. Riverside is proposing an FEC because it is a viable alternative to hospitalization and can play a significant role in increasing access to care and decreasing health care costs.

C. Riverside's Proposed FEC Will Not Reduce Utilization At Existing Facilities And The Project Substantially Conforms To The Two Part 1110 Criteria For Which Negative Findings Were Made

The only two negatives under the Part 1110 Criteria were triggered by the same factor: some facilities within 30-minutes travel time of the proposed site were operating below the target utilization area. This resulted in negative findings under Criterion 1110.3230(b) Planning Area Need, and Criterion 1110.3230(c) Unnecessary Duplication/Maldistribution. Both negative findings referenced the Table on page 5 of the SAR which is reproduced below.

Facilities within 30 minutes of proposed facility

Facility	City	Adjusted Time	Stations	2011 Visits	Number of Stations Justified	Met Standard
Silver Cross Hospital	New Lenox	20.7	38	56,264	29	No
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- Information taken from 2011 IDPH Profile and information requested by the State Board Staff
- Time and Distance from MapQuest and adjusted per 1100.510 d
- Silver Cross Hospital relocated from Joliet to New Lenox in February 2012.

Riverside recognizes that historical utilization of existing facilities is a factor to be considered under Criterion 1110.3230(b) and (c). We respectfully note that, given the Review Board's planning function under the Health Facilities Planning Act, future utilization is as important, if not more so, than historical utilization, and the Review Board's criteria specifically focus on projected utilization. Criterion 1110.3230(d)(3) addresses projected utilization of existing facilities as follows:

> "3) The applicant shall document that, within 24 months after project completion, the proposed project:
>
> A) Will not lower the utilization of other GSA providers below the utilization standards specified in 77 Ill. Adm. Code 1100; and

B) Will not lower, to a further extent, the utilization of other GSA hospitals or FECs that are currently (during the latest 12-month period) operating below the utilization standards."

77 Ill. Adm. Code 1110.3230(c)(3).

To address this criterion we retained 3d Health, Inc. to project occupancy rates for the facilities identified in the above Table. 3d Health is a national firm based in Chicago that provides consulting services to hospitals and health systems. They are known for specialized expertise in the complexities of strategic planning, medical staff development, healthcare market assessments and hospital-physician relationships.

Included as **Attachment C** to this letter is the study from 3d Health, Inc. documenting that the project conforms to Criterion 1110.3230(c)(3). First, there are no existing providers of emergency services within the Geographic Service Area ("GSA") to be served by Riverside's proposed FEC. Second, with respect to the facilities identified in the above Table from the SAR, 3d Health has documented that (a) no provider that is currently at or above the target utilization standard will be taken below the standard 24 months after project completion and that (b) no provider that is currently below the target utilization standard will have its utilization further lowered 24 months after project completion. This is attributable to (1) utilization changes; (2) population growth, and (3) the effects of health care reform.

The 3d Health study shows that two providers currently at or above target utilization, namely, Silver Cross Freestanding Emergency Center in Homer Glen and Franciscan St. James in Chicago Heights, will remain above target utilization. The utilization of the five providers currently below target utilization will not be further lowered and, in fact, the utilization of all providers will be increased from current levels within 24 months of project completion for the Riverside FEC. Please see Table 6 of the 3d Health market study.

We also note that all of the existing providers, identified above are located outside of the northern portion of the proposed service area and are more than thirty minutes travel time from patients located in the central and southern portions of the proposed service area. (Attachment A.) Consequently, while these providers may be within 30 minutes of the proposed site, they are not within 30 minutes of most of the geographic region to be served by the project.

D. Riverside's Proposed Project Location is Best Suited for the Intended Market

Riverside's proposed facility is located just over 3 miles south of Frankfort. This location provides quicker and easier access for residents in the south Frankfort area and residents between Frankfort and Manteno. This proposed project is further from any existing hospital than other proposed projects. The proposed site is also closer to the communities intended to be served than other proposed projects.

Riverside's proposal includes not only a Freestanding Emergency Department, but also primary care physicians to serve the market. This project is intended to meet needs of the population on multiple fronts---24 hour a day access to critical services and increased primary care services.

E. Riverside Is Modifying The Application To Reduce The Project Costs And Eliminate The Sole Negative Finding Under Part 1120

The SAR contained three negative findings, one of which was under the financial review criteria of Part 1120. Under Criterion 1120.140 – Reasonableness of Project Costs, the staff found that the Site Survey Soil Investigation and Site Preparation exceeded the State Standard by $45,611. The SAR reported on page 30 that: "These costs total $186,589 and are 6.62% of construction and contingency costs. These costs appear high when compared to the State Board Standard of 5%."

Riverside has reviewed our Project Costs and has reduced expenses for the Site Survey, Soil Investigation and Site Preparation. Total project costs have been reduced from $10,301,278 to $10,217,061, which is an $84,216 reduction. Costs were specifically reduced for Site Preparation. The costs for Site Preparation were adjusted from $294,157 to $209,941. This cost reduction will remove the one negative finding under those criteria and bring the project into compliance with all the financial criteria. The modified application pages are submitted with this letter. Revised charts of Project Costs are attached and are labeled as **Attachment D and E**.

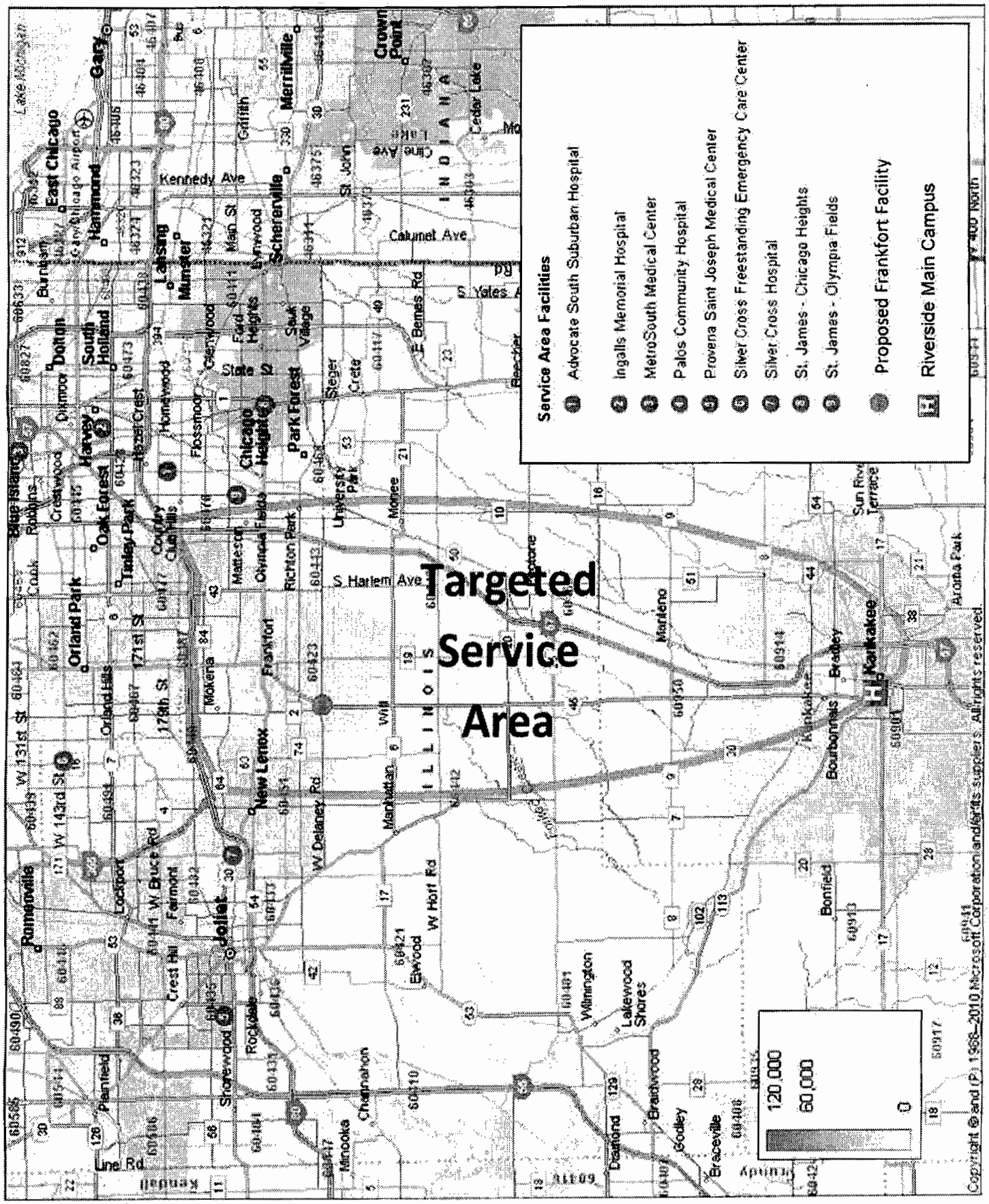
Sincerely,

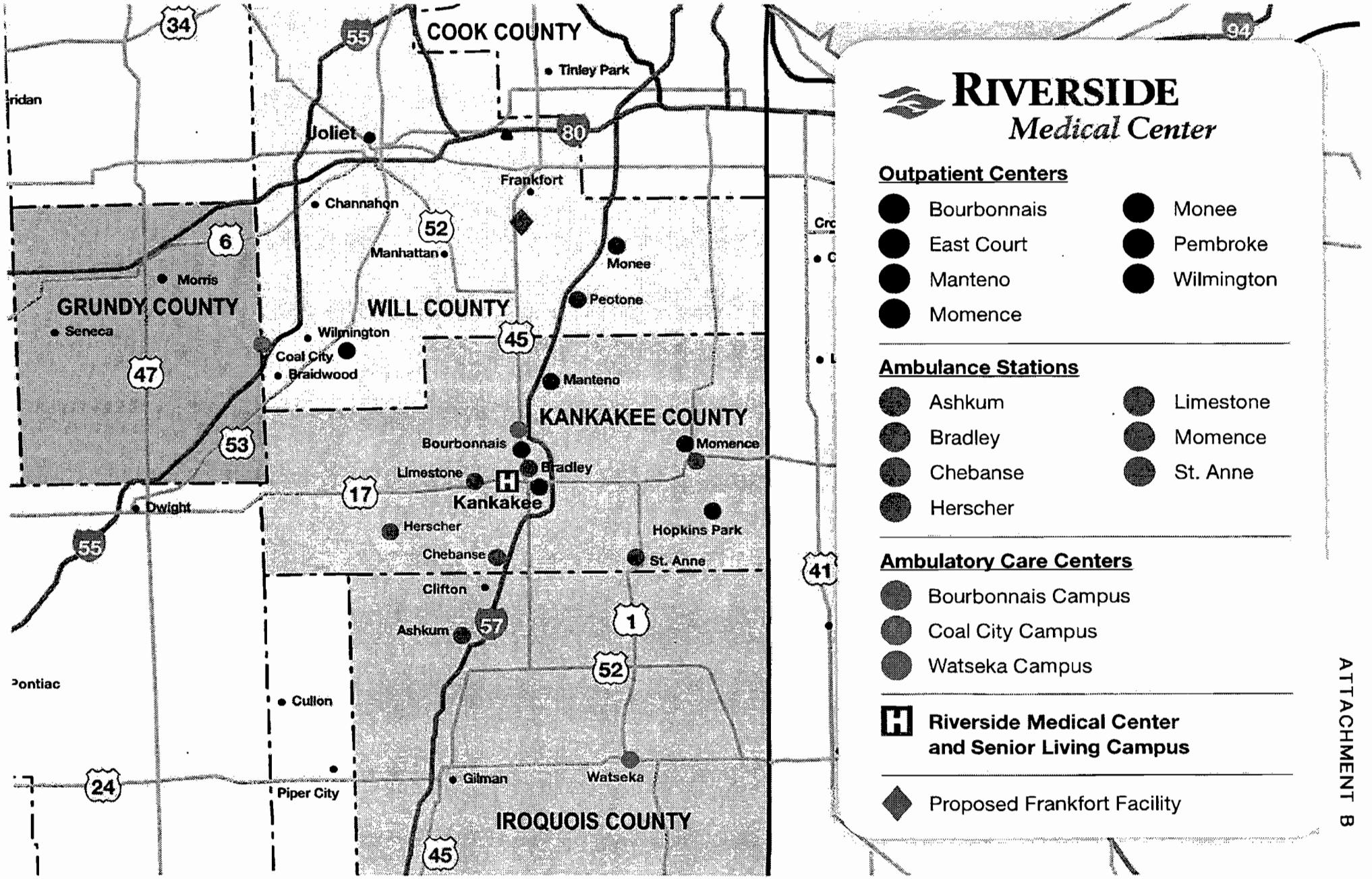
Margaret Frogge

Margaret Frogge
Senior Vice President
Riverside Medical Center

ATTACHMENT A

Service Area





ATTACHMENT B

Service Area

In order to project visit volumes for the proposed Frankfort Freestanding Emergency Department ("ED"), as a first step 3d Health worked with Riverside Medical Center to establish a reasonable service area for the proposed facility. The agreed upon service area includes the 10 ZIP codes south of I-80 that are within a 20-minute drive time of the proposed location.

Market Projections

3d Health used the defined service area to develop market-based projections for total ED visits expected from the population residing in these 10 ZIP codes (regardless of eventual destination hospital/facility for care). The market-based projections were developed as follows:

Baseline Use Rates

- 3d Health used Illinois COMPdata from calendar year 2011 to establish a baseline set of data on the number of ED visits by age, gender, and payer category for the service area.
- COMPdata does not track the facility levels assigned to ED visits across all facilities in the database (i.e. Levels 1 through 5 and Critical Care visits). As such, 3d Health used a combination of blinded client data, national ED visit sample data from the National Center for Health Statistics ("NCHS"), as well as select Illinois data from COMPdata where facility visit levels were reported, to estimate the number of visits by level in the baseline 2011 data.
- These actual historical visits (after adjusting for facility level) were then converted into utilization rates by age, gender, payer, and facility level by applying 2011 population estimates by cohort to the visit data.

Use Rate Adjustments

- In order to project forward and account for changes to the underlying utilization rates, 3d Health evaluated the historic change in use rates from COMPdata from 2009 through 2011 by age, gender, and payer. This historic rate of change in utilization rate per population was then applied to the baseline use rates to model future utilization from 2012 through 2017 (see Table 1.) Initially, expected utilization changes reduce the incremental number of visits in the market, but as the population ages and grows in size, volume increases to almost 1,300 additional visits due to changes in use rates.

Table 1. Incremental Market Visit Impact of Expected Utilization Changes

	Projected						% Change,	CAGR
City	2012	2013	2014	2015	2016	2017	2012-2016	
Frankfort	(84)	(145)	(174)	(184)	(173)	(164)	105.0%	19.7%
Manhattan	(25)	(41)	(47)	(44)	(46)	(44)	80.5%	15.9%
Manteno	46	118	223	348	358	363	683.0%	67.3%
Matteson	40	127	281	485	495	503	1136.1%	87.5%
Mokena	(58)	(100)	(121)	(129)	(119)	(112)	106.2%	19.8%
Monee	(21)	(32)	(31)	(23)	(21)	(18)	(0.0%)	(0.0%)
New Lenox	(107)	(185)	(223)	(238)	(222)	(210)	108.0%	20.1%
Park Forest	58	178	381	625	621	609	963.6%	80.6%
Peotone	(8)	(10)	(3)	9	11	12	(243.1%)	-
Richton Park	23	86	205	350	356	355	1435.5%	98.0%
Total	**(135)**	**(3)**	**491**	**1,199**	**1,262**	**1,295**	**(1034.0%)**	-

Population Projections

- Once the final set of use rates by age, gender, payer, and facility visit level was established, 3d Health applied these use rates to population forecasts by cohort from Claritas and Truven Health for the years 2012 through 2017.
- Based on Claritas projections, the overall population in the service area is expected to increase by 1.5% on an annual basis from 2012 through 2017 (see Table 2.) This is almost twice the current national average of 0.8% annual growth. The population is forecast to increase the most in the towns of Frankfort (3,587 new residents) and New Lenox (3,267 new residents).

Table 2. Service Area Population Projections

	Projected						% Change	CAGR
Payer	2012	2013	2014	2015	2016	2017	2012-2017	
Frankfort	32,277	32,922	33,601	34,316	35,067	35,864	11.1%	2.1%
Manhattan	10,508	10,760	11,023	11,306	11,597	11,906	13.3%	2.5%
Manteno	12,647	12,855	13,074	13,299	13,538	13,785	9.0%	1.7%
Matteson	21,785	22,123	22,478	22,863	23,273	23,709	8.8%	1.7%
Mokena	25,028	25,415	25,825	26,259	26,727	27,215	8.7%	1.7%
Monee	9,803	10,004	10,212	10,429	10,668	10,914	11.3%	2.1%
New Lenox	35,248	35,826	36,445	37,093	37,785	38,515	9.3%	1.8%
Park Forest	21,938	21,865	21,801	21,749	21,701	21,666	(1.2%)	(0.3%)
Peotone	6,152	6,225	6,300	6,382	6,467	6,562	6.7%	1.3%
Richton Park	13,529	13,598	13,675	13,768	13,854	13,958	3.2%	0.6%
Total	**188,915**	**191,593**	**194,434**	**197,464**	**200,677**	**204,094**	**8.0%**	**1.5%**

- Given this rapid population growth, the incremental impact on expected ED visits from population growth and aging is quite substantial. Across the total service area, the number of ED visits is forecast to increase by almost 8,000 visits on an annual basis by 2017 based on forecast population changes alone.

Table 3. Incremental Market Visit Impact from Forecast Population Changes

	Projected						% Change	CAGR
City	2012	2013	2014	2015	2016	2017	2012-2017	
Frankfort	577	743	929	1,117	1,295	1,510	161.7%	22.4%
Manhattan	(58)	1	66	131	184	258	(546.5%)	-
Manteno	501	603	751	855	921	1,050	109.4%	16.4%
Matteson	1,360	1,530	1,791	2,023	2,150	2,401	76.6%	12.1%
Mokena	(244)	(150)	(40)	63	156	279	(214.5%)	-
Monee	80	139	209	274	335	411	414.5%	43.1%
New Lenox	489	654	854	1,034	1,191	1,413	188.7%	24.9%
Park Forest	154	59	70	25	(155)	(194)	(225.7%)	-
Peotone	(167)	(148)	(120)	(102)	(92)	(66)	(60.3%)	(13.9%)
Richton Park	593	615	714	761	724	795	34.0%	5.1%
Total	**3,286**	**4,048**	**5,223**	**6,180**	**6,709**	**7,856**	**139.0%**	**19.5%**

- In addition, upon implementation of health reform Truven Health forecasts an increase in the number of service area residents that enroll in Medicaid and private Insurance through health insurance exchanges that are currently uninsured. Since insured patients – particularly those covered by Medicaid – visit the emergency department more frequently than the uninsured, there is an incremental increase in visits in the market as a result of this shift in coverage (see Tables 3 and 4.)

Table 4. Service Area Population Projections by Payer

	Projected						% Change	CAGR
Payer	2012	2013	2014	2015	2016	2017	2012-2017	
Medicaid	18,782	19,954	21,671	21,944	21,791	21,747	15.8%	3.8%
Medicare	20,514	21,425	22,407	23,647	24,853	26,041	26.9%	4.9%
Private	137,225	138,769	141,254	144,616	148,973	151,177	10.2%	2.1%
Uninsured	12,394	11,445	9,102	7,257	5,060	5,129	(58.6%)	(20.1%)
Total	**188,915**	**191,593**	**194,434**	**197,464**	**200,677**	**204,094**	**8.0%**	**1.5%**

Table 5. Incremental Market Visit Impact from Health Reform Changes

	Projected						% Change	CAGR
City	2012	2013	2014	2015	2016	2017	2012-2017	
Frankfort	6	23	22	4	(12)	(22)	(447.5%)	-
Manhattan	19	38	60	72	85	84	339.6%	45.5%
Manteno	129	268	384	448	505	490	280.9%	40.7%
Matteson	162	342	466	525	566	538	231.3%	36.6%
Mokena	(3)	3	(5)	(28)	(45)	(55)	1646.5%	95.0%
Monee	11	26	33	33	33	30	158.9%	30.4%
New Lenox	13	41	43	17	(3)	(21)	(261.5%)	-
Park Forest	235	486	652	719	749	688	192.7%	33.6%
Peotone	10	23	27	25	25	21	122.8%	26.6%
Richton Park	159	330	453	508	541	508	219.9%	35.9%
Total	**741**	**1,579**	**2,135**	**2,324**	**2,442**	**2,260**	**205.2%**	**34.8%**

- 3d Health further refined the market visits by applying an adjustment factor to exclude visits that would be inappropriate for treatment in a freestanding setting. These factors were developed through an analysis of ED visit data by diagnosis from 3d Health clients, the NCHS sample data, and by visits to Illinois freestanding EDs.
- Upon the conclusion of this analysis, 3d Health had a database of historic and future expected ED visits by age, gender, payer, and facility visit level for each ZIP code in the proposed service area that would be appropriate for a freestanding ED setting of care.

Table 6. Total ED Visit Market Projections

	Baseline	Projected						% Change	CAGR
Visit Type	2011	2012	2013	2014	2015	2016	2017	2012-2017	
Total, All Levels	64,288	68,180	69,910	72,137	73,991	74,701	75,699	17.7%	2.8%
Appropriate for Freestanding	51,561	54,961	56,359	58,162	59,573	59,979	60,655	17.6%	2.7%

In total, the market volume of ED visits is projected to grow from 64,288 in the baseline year to 75,699 by 2017. The projected growth of ED visits results in 11,411 new ED visits on an annual basis within the defined service area by 2017 (Table 1 + Table 3 + Table 5).

The 11,411 ED visits are new to the market and do not impact the existing ED volume at the current providers serving the defined service area. In fact, this represents new market volume for all of the existing providers serving the service area.

Projections Specific to the Proposed Frankfort Facility

Upon completion of the market visit projections, 3d Health worked with Riverside Medical Center to estimate likely capture rates ("market share") at the proposed facility for ED visits. These estimates were made specific to each of the 10 ZIP codes in the service area.

Each ZIP code was evaluated across several criteria when developing the visit projections for the proposed facility:

- Baseline Shift in Visits
  - Based on the location of the proposed facility, some level of existing ED visit volume from other facilities would likely seek care at the new location as opposed to driving to a more distant ED
- Capture of Incremental Growth
  - Within the market, ED visit volume is projected to increase in the aggregate based on the population changes (both in size and age distribution) and the implementation of health reform
  - Riverside made estimates by ZIP code of how much of this incremental new visit volume in the service area would seek care at the proposed facility
- Cannibalization of Existing Riverside Medical Center Visits
  - Riverside Medical Center currently provides ED services to a number of patients in the service area and given the closer proximity of the proposed location to many of these patients, Riverside made assumptions relative to how many of these existing patients would choose to go to the proposed facility in Frankfort rather than continue to come to the main Riverside campus in Kankakee for care

Since the proposed Frankfort facility projections were market-based and focus on a defined geography, 3d Health also built in an additional adjustment to account for inmigration volume to the facility.

For emergency services, inmigrating patients may live far away from the facility but could have a condition or issue that would cause them to present at the proposed freestanding ED while they are passing through the area or visiting residents of the service area.

3d Health made an assumption that 90% of the visits at the proposed Frankfort facility are for residents of the service area and that the remaining 10% of visits would be for these patients that live in other areas.

Riverside North Campus at Frankfort **Attachment D**

Project 12-089 **REVISED**

Facility Square Footage **10,768**

Project Costs and Sources of Funds				
USE OF FUNDS	**CLINICAL**	**NON-CLINICAL**	**TOTAL**	**Cost Per Sq Ft**
Preplanning Costs	$92,446	$56,654	**$ 149,100**	$ 13.85
Site Survey and Soil Investigation	$4,211	$2,581	**$ 6,792**	$ 0.63
Site Preparation	$130,164	$79,778	**$ 209,941**	$ 19.50
Off Site Work	$527,000	$323,000	$ 850,000	$ 78.94
New Construction Contracts	$2,559,514	$1,568,735	**$ 4,128,249**	$ 383.38
Modernization Contracts	$ -	$ -	$ -	$ -
Contingencies	$255,951	$156,873	**$ 412,825**	$ 38.34
Architectural/Engineering Fees	$197,083	$120,793	**$ 317,875**	$ 29.52
Consulting and Other Fees	**$ 248,000**	**$ 152,000**	$ 400,000	$ 37.15
Movable or Other Equipment (not in construction contracts)	**$ 3,632,552**	**$ 109,727**	**$ 3,742,279**	$ 347.54
Bond Issuance Expense (project related)	$ -	$ -	$ -	$ -
Net Interest Expense During Construction (project related)	$ -	$ -	$ -	$ -
Fair Market Value of Leased Space or Equipment	$ -	$ -	$ -	$ -
Other Costs To Be Capitalized	$ -	$ -	$ -	$ -
Acquisition of Building or Other Property (excluding land)	$ -	$ -	$ -	$ -
TOTAL USES OF FUNDS	$ 7,646,921	$ 2,570,140	$ 10,217,061	$ 948.84
SOURCE OF FUNDS	**CLINICAL**	**NONCLINICAL**	**TOTAL**	
Cash and Securities	$7,646,921	$2,570,140	$10,217,061	
Pledges	$ -	$ -	$0	
Gifts and Bequests	$ -	$ -	$0	
Bond Issues (project related)	$ -	$ -	$0	
Mortgages	$ -	$ -	$0	
Leases (fair market value)	$ -	$ -	$0	
Governmental Appropriations	$ -	$ -	$0	
Grants	$ -	$ -	$0	
Other Funds and Sources	$ -	$ -	$0	
TOTAL SOURCES OF FUNDS	$ 7,646,921	$ 2,570,140	$ 10,217,061	

Riverside North Campus at Frankfort
Project 12-089
Detailed Costs

Attachment E
REVISED

Preplanning Costs		**$ 149,100**
Market study	$ 57,983	
Feasibility analysis	$ 47,397	
Legal and document review	$ 43,720	
Site Survey and Soil Investigation		**$ 6,792**
Village engineering expenses	$ 6,792	
Site Preparation		**$ 209,941**
Grading	$ 111,618	
Asphalt	$ 98,323	
Off Site Work		**$ 850,000**
Exterior utilities	$ 294,531	
Landscaping	$ 53,000	
Curb improvements	$ 172,391	
Traffic access configuration	$ 330,078	
Consulting and Other Fees		**$ 400,000**
Development fee	$ 250,000	
Pre development consulting/oversight and Phase 1 project management	$ 150,000	
Movable or Other Equipment (not in construction contracts)		**$ 3,742,279**
CT scanner	$ 1,500,000	
Medical equipment	$ 876,636	
Digital xray unit	$ 350,000	
Ultrasound unit	$ 168,000	
Portable CR xray	$ 100,000	
Furniture	$ 98,229	
ED/Rad reading station	$ 85,000	
Chemistry analyzer	$ 75,000	
Portable ultrasound	$ 60,000	
Signage	$ 60,000	
CT injector	$ 55,000	
Security monitors, cameras and intercom	$ 49,220	
Information services cabling and hardware	$ 41,600	
Call light system	$ 30,000	
Coag analyzer	$ 30,000	
Defibrillator units	$ 30,000	
Hematology unit	$ 30,000	
Computer equipment, printers, scanners	$ 29,594	
EKG units	$ 26,000	
Ventilator	$ 18,000	
Artwork/decorations	$ 15,000	
BiPap machine	$ 15,000	