THE CAMDEN GROUP

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Healthcare Options

Coast Life Support District
Gualala, California
February 24, 2014

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Executive Summary

Executive Summary

- The Camden Group was hired by Coast Life Support District ("CLSD" or "Coast Life") to identify a financially sustainable healthcare model that will serve as a road-map for local delivery of medical services in conjunction with the Redwood Coast Medical Service ("RCMS") to the residents of the coastal communities located in southern Mendocino and northern Sonoma counties.
- On October 29 and 30, 2013, The Camden Group met with the Engagement Task Force, which includes members from CLSD, RCMS, and the community, to review the service area's Situation Assessment, and to identify options for a financially sustainable healthcare model.

Executive Summary

- The Situation Assessment included a review of current services and capabilities, market analysis, physician needs, and comparison of similar markets. The following conclusions were drawn from the Situation Assessment report:
  - CLSD and RCMS have been innovative and resourceful in their ability to increase access of healthcare services to the population.
  - Access to urgent/emergency care continues to be a critical issue due to distance, weather, and road conditions.
  - The population of CLSD is small (~6,200 people) which affects the level of healthcare services that can be provided in the community without outside funding or support.

Executive Summary

- Portions of CLSD's service area are designated either as a Health Professional Shortage Area ("HPSA") or a Medically Underserved Area ("MUA") indicating a state and federally recognized shortage of primary care resources. Benefits of practicing in shortage-designated areas can include: physician recruitment assistance, and physician financial incentive programs/payments.
- There were approximately 374 inpatient discharges from CLSD's service area in calendar year ("CY") 2011 generating an average census of 4.7 patients per-day in a hospital bed, assuming 100 percent market retention of volume (no outmigration).
- Expansion of after-hours urgent care is a viable extension of current services given it leverages existing infrastructure and capabilities if a sustained funding source can be secured.

Executive Summary

- Given the service area's population size, there is the potential for some increase in specialty rotation on a part-time basis (e.g., one to three days per week) and/or coverage through tele-health:
  - Cardiology*
  - Dermatology
  - Gastroenterology
  - General Surgery
  - Hematology and Oncology
  - Neurology
  - OB/GYN
  - Ophthalmology*
  - Orthopedics*
  - Otolaryngology
  - Pediatrics
  - Psychiatry
  - Urology

* Indicates specialties with partial physician coverage currently

Executive Summary

- Partnership with other care providers to increase access through tele-health is a potential solution if grant/funding sources can be identified.
- Other innovative programs are being piloted in California or elsewhere that may eventually provide increased access for rural providers, although they are not currently allowed under California regulation.

- Additionally, The Camden Group completed a review of the scope of services provided by California healthcare districts and counties with comparable populations and geographic characteristics to CLSD's service area. Data collected from the comparison was used to identify solutions and key characteristics that lead to successful healthcare models in other markets.

Executive Summary

- At the conclusion of the October 29 and 30, 2013 meetings, 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 new ambulatory care center (“ACC”) to house expanded outpatient services
- The Camden Group recommends Option 1, the expansion of the urgent care hours, as the near-term strategy. Expansion of urgent care was consistently stated as the highest need by community members. RCMS’ existing infrastructure is the most financially viable, cost-effective, consistent model to expand healthcare services to the community.

Executive Summary

- For a longer-term solution, The Camden Group recommends CLSD and/or RCMS pursue grants and fundraising for Option 3 to develop a new ACC to house expanded outpatient services. The ACC could include space to house technology that will expand access to services through tele-health and remote monitoring. More planning should be conducted to see if the building could be constructed for a cost more in line with medical buildings built throughout California and the reasonableness of rental rates.
  - Grants and fundraising will be critical to the financial viability of the new ACC, given current market conditions.
- CLSD and RCMS should continue to explore grants to fund innovations in tele-health that will expand access to healthcare locally.

Executive Summary

- Partnerships and collaborations were identified as a key element to expanding healthcare services to the population such as:
  - Partnership to provide urgent care services and clinical staffing
  - Specialists/Residents rotate to community physically or remotely
  - Expand other outpatient/ancillary services to community needed by new specialists rotating to the community
  - Establish electronic linkages to clinically integrate with other providers
  - In order to work collaboratively on providing additional healthcare services to the community, CLSD, RCMS, and other partners as applicable, should consider establishing a Joint Operating Committee (“JOC”) equally composed of CLSD and RCMS/other partner members.

Executive Summary

- CLSD and RCMS should continue to explore grants to fund innovations in tele-health/remote access that will expand healthcare locally.
- Partner with others to increase access to age-in-place, wellness, preventative, chronic care management, and other relevant services
- Partner to increase broadband to ensure reliable connections to support remote access to healthcare services

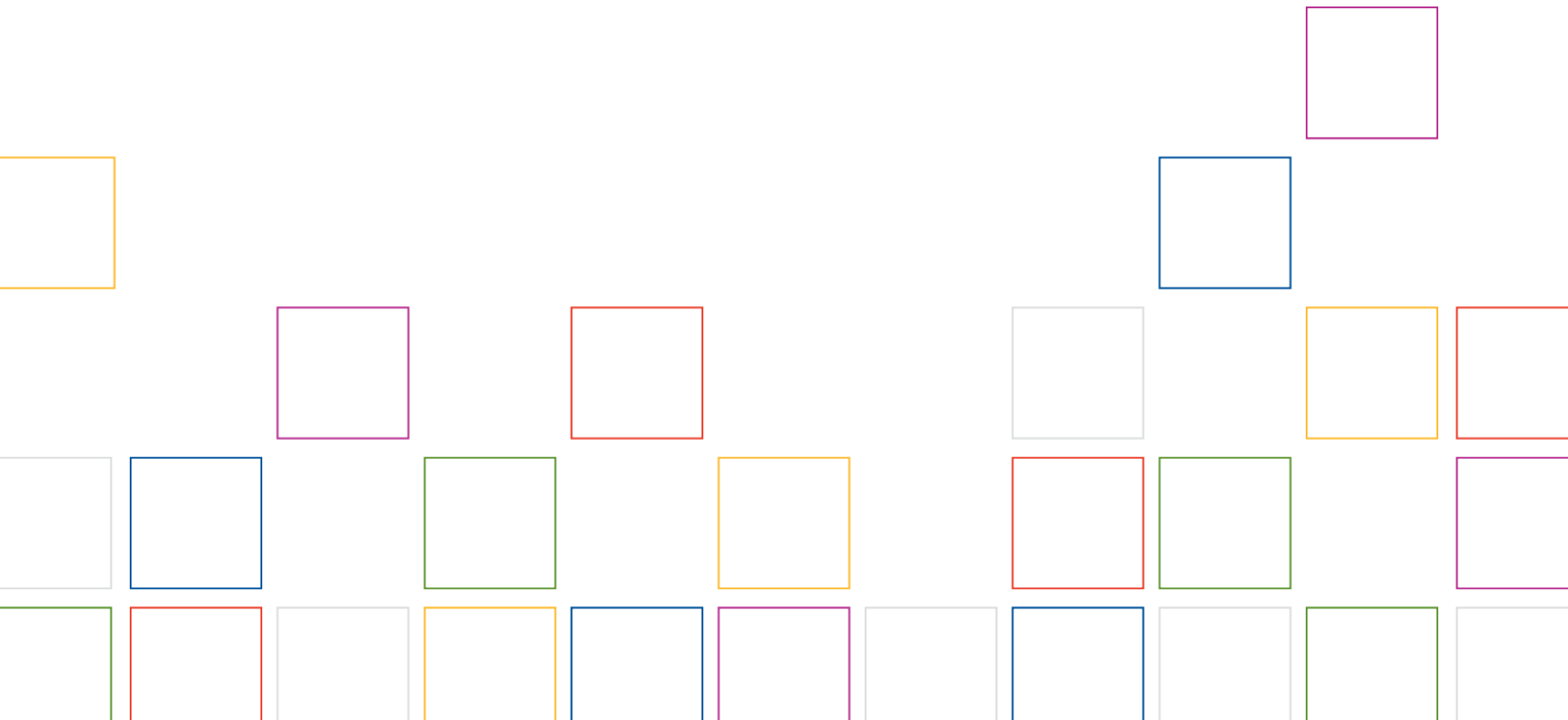
Executive Summary

- As part of this analysis, The Camden Group considered a series of other potential options, but determined they were not optimal solutions for a financially sustainable healthcare model for the community.
  - Community Medical Center (Option 2 listed on page 37)
    - The Camden Group recommends CLSD not pursue this option due to an amalgamation of high start-up costs to build the facility, low patient occupancy levels, poor payer mix, anticipated challenges recruiting and retaining clinical providers, and required ongoing needed financial support.
  - Development of Community Paramedicine (“CP”) program
    - Not currently allowed in California, although use of paramedics was modeled into the after-hours urgent care expansion as a staffing option
  - Free-standing Emergency Department (“ED”)
    - Not currently allowed in California

Executive Summary

- Hospital at Home (“HAH”)
  - Distance from acute care hospital, considerable start-up costs, and staff requirements
- Development of a district clinic
  - Duplication of resources and less financially viable model
- Development of a hospital clinic
  - Outside of distance requirements
- Addition of other full-time specialists and related services (e.g., surgery, advanced imaging/diagnostics)
  - Not supported by population
- Build larger ACC to include rental space for other community healthcare providers.
  - It was noted that due to the presence of commercial real estate vacancy rates in the service area currently, and estimated cost of new construction, that building additional space in the ACC to be leased would not be financially viable.

Engagement Objectives



Engagement Objectives

- The objectives of the Coast Life business plan are as follows:
  - Create a financially sustainable healthcare model that will serve as a road-map for local delivery of medical services in conjunction with RCMS to the residents of the coastal communities located in southern Mendocino and northern Sonoma counties.
  - Evaluate the community benefit of reinstating some level of after-hours urgent care.
  - Develop a long-term fiscally responsible plan to expand other local medical services and facilities; in order to reduce time wasting, stressful transportation and road trips, and enable more community members to age-in-place.
  - Enable a course for the future to anticipate advances in medical services and delivery.

California Healthcare Trends

California Healthcare Trends

- **Continued downward pressure on revenue rates: healthcare operating expenses will outpace payment increases**. There will be continued pressure to minimize rate increases from payers, especially governmental payers. Cost per unit will rise unless an organization increases throughput, clinically integrates, and reduces resource consumption. Strategy must focus on attracting/capturing a larger population. This means increasing market share in an environment of no per capita growth in volume. Cost reduction must be at the forefront to assure that these new volumes are profitable.

California Healthcare Trends

- **Continual movement away from pay-for-procedure payments to pay-for-performance (value) payments:** economic incentives and new payment models (e.g., value-based purchasing, shared savings) are being put into place to reward improved quality, reduced costs, and top patient service satisfaction. There will be greater transparency of quality scores of hospitals and physicians (e.g., HCAHPS surveys). Penalties to occur if quality standards are not met. Consistent high quality is difficult to achieve for low volume services/providers.
- **New care models are here, and still evolving.** The new models will either target managing a population or treating episodes of care (resource consumption per case). Expect greater use of information technology ("IT"), including telemedicine, wireless devices, and population and utilization analytics. New models include those mentioned above, as well as global payments and mini PCMHs targeted to specific major chronic diseases.

California Healthcare Trends

- **Just as efforts to reduce readmissions and length-of-stay are achieving the desired results for purposes of succeeding in new payment models, there will be a need to replace this "unwanted" volume with "new" volume.** There will be an all-out effort to consolidate markets (hospital-to-hospital, medical group to medical group, medical groups/physicians to hospitals, and health plan to health plan) as hospitals seek to gain scale, reduce costs, and capture a greater portion of the healthcare continuum. Health systems will focus on geographic markets where they can concentrate resources and better utilize assets. Medical groups and IPAs will consolidate as well, given that many physician organizations will not have the capital to invest in the necessary infrastructure (e.g., IT, care models, protocols, human resources to manage the "new" delivery system).

California Healthcare Trends

- **Keep an eye on the government**. With state budgets still reeling from the recession and a disappointingly slow economic recovery, state governments will need to find solutions to their problems, which include Medi-Cal expansion, Covered California, state employee costs (health and retirement), and infrastructure costs to manage all of the changes underway. This will put continued economic pressure on the programs funded by the state.
- **Covered California** will continue to play a pivotal role in the state's changing healthcare landscape, but the impact on healthcare utilization (ED use increase), physician shortages (increase), and insurance premiums (go up for the same benefits) is still to be determined.

California Healthcare Trends

- **IT will continue to consume a greater portion of a health system's budget.** Health systems must invest in IT in order to be ready for healthcare reform's new delivery models and payment systems. The necessary investment includes those that should be completed now such as picture archiving and communications system ("PACS"), results reporting, electronic medical records ("EMR") for the inpatient and outpatient setting, and computerized physician order entry ("CPOE"). In 2013 and 2014, the focus has and will continue to be on data warehousing and health information exchanges in which to participate or interface, and finally moving to population analytics and web portals for patients and physicians.

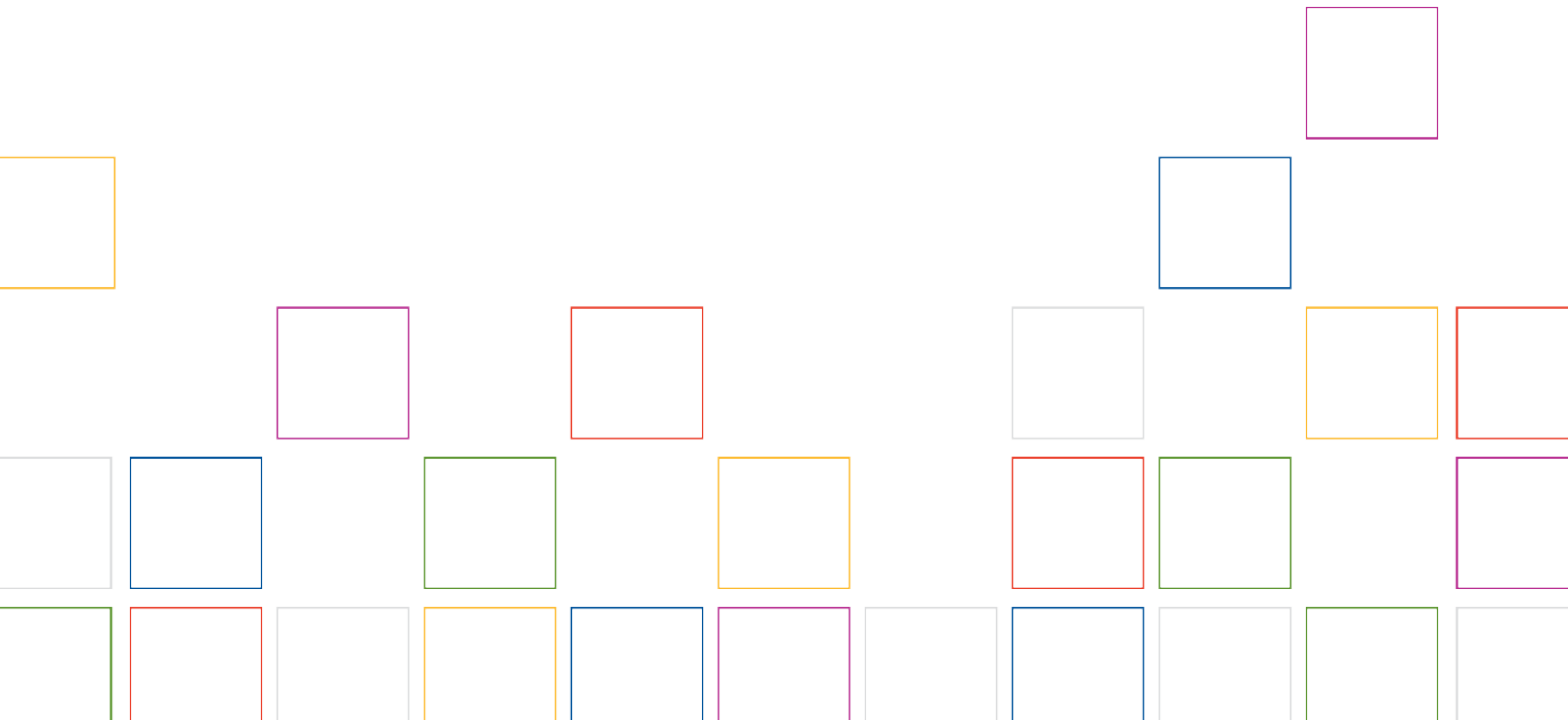
California Healthcare Trends

- **Continued physician economic alignment.** Hospitals and physicians will pursue a variety of models: patient-centered medical homes (“PCMHs”), bundled payments, ACOs, clinical integration, co-management, and joint ventures. A significant focus of health system resources will be setting economic incentives that reward improved quality, reduced costs, and top patient service satisfaction.
- **Continued development of the continuum of care**: As Medicare and other major payers continue to modify payment methodologies that penalize preventable readmissions, use case rates and focus on population health, providers will focus on outpatient and lower levels of care, decreasing inpatient and emergency use.

California Healthcare Trends

- **Academic medical centers ("AMCs") are aggressively expanding their networks and marketing their "brand"** to steer more volume into their system and retain patients. AMCs are continuing to buy up primary care physician practices, expand their urgent care presence, and acquire small community hospitals as a strategy to stay operational and profitable as a tertiary/quaternary care center in the new era of population health.
- **Physician shortages are looming.** The already anticipated physician shortages are likely to be exacerbated as additional Californians gain insurance coverage in January 2014 due to Covered California and Medi-Cal eligibility coverage expansion.

Discussion of Healthcare Models: Context



Discussion of Healthcare Models: The Context

The diagram on the following page illustrates the process The Camden Group went through to help determine three healthcare models to evaluate.

Discussion of Healthcare Models: The Context

Review of Current Market Services	Review of Healthcare Districts in Other Rural Areas	State and National Trends	Interviews and Community Input	Determine Community Need
■ Services offered in service area today ■ Demographics ■ Inpatient, ED, ambulatory surgery, skilled nursing use rates, and market share ■ Payer Mix ■ Clinical staff in service area	■ Services offered ■ Profitability of hospital (if applicable) ■ Payer mix and other financial indicators ■ Criteria needed for success	■ Review of key trends and their impact on future delivery of healthcare services	■ Interview selected members of CLSD and RCMS Boards ■ Community feedback to understand the area's health service needs	■ Projected use of inpatient, ED, ambulatory surgery, skilled nursing services ■ Physicians to support population ■ Projected change in payer mix ■ Identification of needed services

Three Healthcare Models

1) Expand Urgent Care Hours

3) Develop a New Ambulatory Care Center

2) Build Community Medical Center

Discussion of Healthcare Models: Option 1 – Expand Urgent Care Hours

Option 1 – Expand Urgent Care Hours

- The Camden Group completed the expanded urgent care financial analysis and issued the assessment, findings, and conclusions as a separate document dated November 6, 2013.
- In the urgent care analysis document, The Camden Group made efforts to assess the reasonableness of the following aspects of RCMS' analysis:
  - The fiscal year ("FY") 2014 budgeted cost estimates
  - The incremental costs associated with extending the urgent care clinic's on-call coverage to supplement its current operating hours
  - The reasonableness of RCMS's current revenue per visit
  - If another model could be more appropriate to meeting the urgent care needs of the community outside a federally qualified health center ("FQHC")

Option 1 – Expand Urgent Care Hours

- The analysis compared RCMS' operating expenses to industry benchmarks and data from similar organizations and found that the projected incremental expenses associated with the expanded hours were reasonable in the 10 hours per day/7 days per week ("10/7") option, and more costly in the other options than the RCMS prepared projection. We recommended a 15 percent annual cost contingency be added.
- The table on the following page shows the estimated incremental impact by urgent care option.

Option 1 – Expand Urgent Care Hours

Redwood Coast Medical Services
The Camden Group's Estimated Incremental Impact
Fiscal Year Ending June 30, 2014

	Options (Hours per Day/Days per Week)				
	10/5 **	10/7	12/7	16/7	24/7
Additional Annual Staffing Cost					
Additional Operating Hours Per Year	0	1,040	1,768	3,224	6,136
Physician	$0.00	$136.40	$136.40	$136.40	$136.40
Paramedic	0.00	23.53	23.53	23.53	23.53
Total Hourly Cost [(1)]	**$0.00**	**$159.93**	**$159.93**	**$159.93**	**$159.93**
Total	**$0**	**$166,323**	**$282,750**	**$515,602**	**$981,307**
Incremental Annual Costs					
Additional Annual Staffing Cost	$0	$166,323	$282,750	$515,602	$981,307
15% Contingency	0	24,948	42,412	77,340	147,196
Total Incremental Annual Cost	**$0**	**$191,272**	**$325,162**	**$592,942**	**$1,128,503**
Existing Budgeted Costs					
Current Budgeted Operating Expense	$704,917	$704,917	$704,917	$704,917	$704,917
Allocation of Administration	171,925	171,925	171,925	171,925	171,925
Total	**$876,842**	**$876,842**	**$876,842**	**$876,842**	**$876,842**
TCG Projected Loss	**($239,344)**	**($430,616)**	**($564,506)**	**($832,286)**	**($1,367,847)**
RCMS Project Loss	**($239,344)**	**($433,744)**	**($550,224)**	**($783,184)**	**($1,249,104)**
Difference in Incremental Cost Between RCMS and TGC Projection	**$0**	**$3,128**	**($14,282)**	**($49,102)**	**($118,743)**
Percentage Variance from RCMS	**0%**	**2%**	**-5%**	**-10%**	**-12%**

/Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[CLSD_RCMS_Urgent_Care_Financial_Analysis.xlsx]TCG_Est_Cost

** Denotes current option

[(1)] It was assumed that no existing non-provider staff will be needed during additional hours of operation.

Note: Sources for all rate estimates are displayed in the appendix near the end of the report

Option 1 – Expand Urgent Care Hours

- The Camden Group reviewed various provider staffing models.
- Model A assumed the same staffing level proposed by RCMS.
  - A blended MGMA median and 75th percentile hourly staffing rate was used for the physician assistant to account for the remoteness of the area and the associated difficulty of retaining competent staff, while the other rates reflect median.
- Model B assumed that the additional hours would be staffed by a physician and a paramedic.
  - The MGMA Western Region Median Urgent Care physician annual compensation plus 11 percent benefits was used for the physician.
  - For the paramedic, RCMS's current paramedic Step-6 hourly rate plus 25 percent benefits was used.
- If urgent care were staffed by emergency medicine physicians, the physician coverage expense would be significantly higher.

Option 1 – Expand Urgent Care Hours

The differences between RCMS and The Camden Group's hourly rates by physician are shown in the table below.

Redwood Coast Medical Services
Estimated Hourly Staffing Rates
Fiscal Year Ending June 30, 2014

Hourly Staffing Rates	RCMS Estimate	The Camden Group Estimates	
		Model A	Model B
Physician Support On-Call	$30.00	$37.00	
Physician Assistant	$100.00	$73.30	
Radiology Technician	$30.00	$44.01	
Physician			$136.40
Paramedic			$23.53
Total Hourly Rates	**$160.00**	**$154.30**	**$159.93**

/Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[CLSD_RCMS_Urgent_Care_Financial_Analysis.xlsx]Comparison

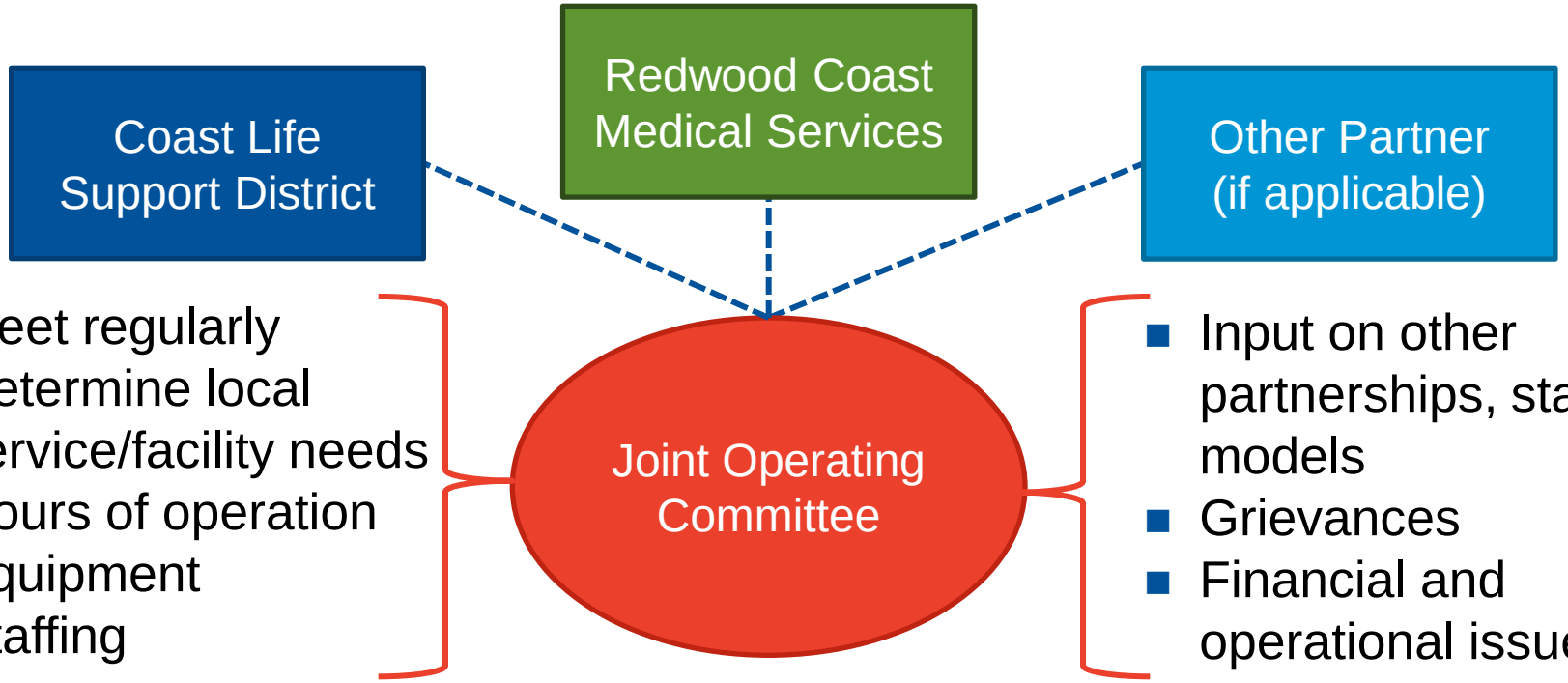
Sources: Coast Life Support District, Redwood Coast Medical Services, MGMA Compensation and Production Survey, The Bureau of Labor Statistics, and The Camden Group

Option 1 – Expand Urgent Care Hours

- The Camden Group compared RCMS' model to other organizational models and determined that utilizing RCMS' current structure is the most cost-effective and best reimbursement model given the community's payer mix.
  - Recommendation: Expansion of urgent care was consistently stated as the highest need by community members. RCMS' existing infrastructure is the most financially viable, cost-effective, and consistent model to expand healthcare services to the community.
  - The Camden Group recommends CLSD and RCSM continue to work together to expand urgent care services to the community.

Option 1 – Expand Urgent Care Hours

- In order to work collaboratively on providing urgent care services to the community, CLSD, RCMS, and other partners as applicable, should consider establishing a JOC equally composed of CLSD and RCMS/other partner members.

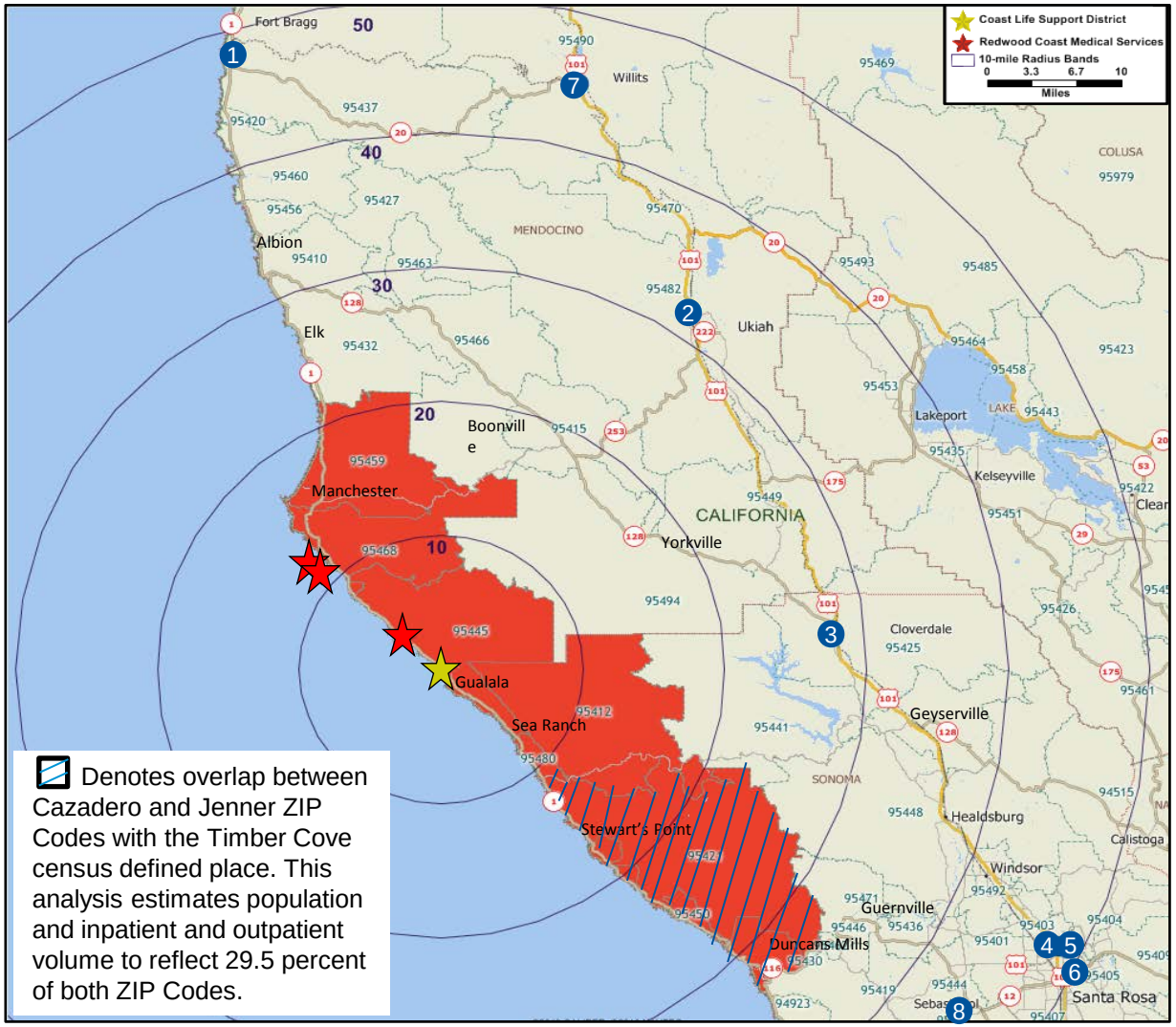


Discussion of Healthcare Models:
Option 2 – Build Community Medical Center

Option 2 – Build Community Medical Center

- The Camden Group completed utilization and financial projections associated with building a community medical center (less than 25 beds: qualifies for critical access designation) with a 24/7 emergency room and issued the assessment, findings, and conclusions as a separate document dated December 17, 2013.
- 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.

Option 2 – Build Community Medical Center



Source: The Camden Group
Note: Beds represents licensed acute care beds.

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

Option 2 – Build Community Medical Center

The following list includes a series of critical success factors for the community medical center, and the likelihood of accomplishment.

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

Option 2 – Build Community Medical Center

- **Recommendation**: 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 an amalgamation of high start-up costs to build the facility, low patient occupancy levels, undesirable payer mix, anticipated challenges recruiting and retaining clinical providers, and required ongoing needed financial support.
- In addition, 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.

Discussion of Healthcare Models: Option 3 – Develop a New Ambulatory Care Center

Option 3 – Develop a New ACC

- The ACC includes a new building that could house new/expanded outpatient services.
- The site of the ACC would be located adjacent to the current RCMS clinic in Gualala, on land currently owned by RCMS.
- The new/expanded ambulatory services are assumed to include:
  - Urgent care center with current capability, and dedicated additional space with tele-health capabilities.
  - Primary care services, to include space for four primary care providers (one geriatric provider).
  - Specialty care services, to include space for rotating specialists (existing and new), as well as space dedicated for telemedicine visits/consults. To determine and prioritize specialty expansion to the community (in-person and/or through telemedicine), community need to support specialists should be considered (see table on following page).

Option 3 – Develop a New ACC

- At a 2010 population size of 6,194, the service area could support the following specialists on a part-time, rotating basis:
  - Cardiology*
  - Dermatology
  - Gastroenterology
  - General surgery
  - Hematology and oncology
  - Neurology
  - OB/GYN
  - Ophthalmology*
  - Orthopedics*
  - Otolaryngology
  - Pediatrics
  - Urology
- Based on discussions with CLSD, population was held flat at 2010 levels.

* Indicates specialties with partial physician coverage currently

Coast Life Support District
Physician Full-Time Equivalents Required to Support Population
Calendar Year 2013

Specialty	Physician Demand	Physician Supply (2)
Primary Care (1)	**3.62**	5.75
Allergy and Immunology	0.05	
Cardiology	0.21	0.05
Cardiovascular Surgery	0.05	
Dermatology	0.18	
Endocrinology	0.05	
Gastroenterology	0.17	
General Surgery	0.62	
Hematology and Oncology	0.24	
Infectious Disease	0.06	
Neonatology	0.03	
Nephrology	0.07	
Neurology	0.15	
Neurosurgery	0.06	
Obstetrics and Gynecology	0.65	
Ophthalmology	0.29	0.10
Oral and Maxillofacial Surgery	0.07	
Orthopedics	0.40	0.05
Otolaryngology	0.21	
Pediatrics	0.97	
Physical Medicine and Rehab	0.11	
Plastic Surgery	0.07	
Pulmonary Disease	0.10	
Radiation Oncology	0.07	
Rheumatology	0.04	
Thoracic Surgery	0.05	
Urology	0.22	
Population	**6,194**	

Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[Physician_Ratios.xlsx]Sheet1

Sources: Redwood Coast Medical Services, GMENAC 1990; Merritt, Hawkins & Assoc. 2002; Claritas, Inc., and The Camden Group

Denotes FTE demand greater than or equal to 1.0.

(1) Primary care providers inclusive of family practice, internal medicine, and mid-level providers (e.g., physician assistants, nurse practitioners).

(2) MD/DO providers are considered 1.0 FTE per 40 hours worked per week. Mid-level providers are assigned an FTE of 0.75.

Option 3 – Develop a ACC

The proposed sizing for the new ACC is shown in the table below.

Coast Life Support District
Square Footage Summary of Proposed New Ambulatory Care Center

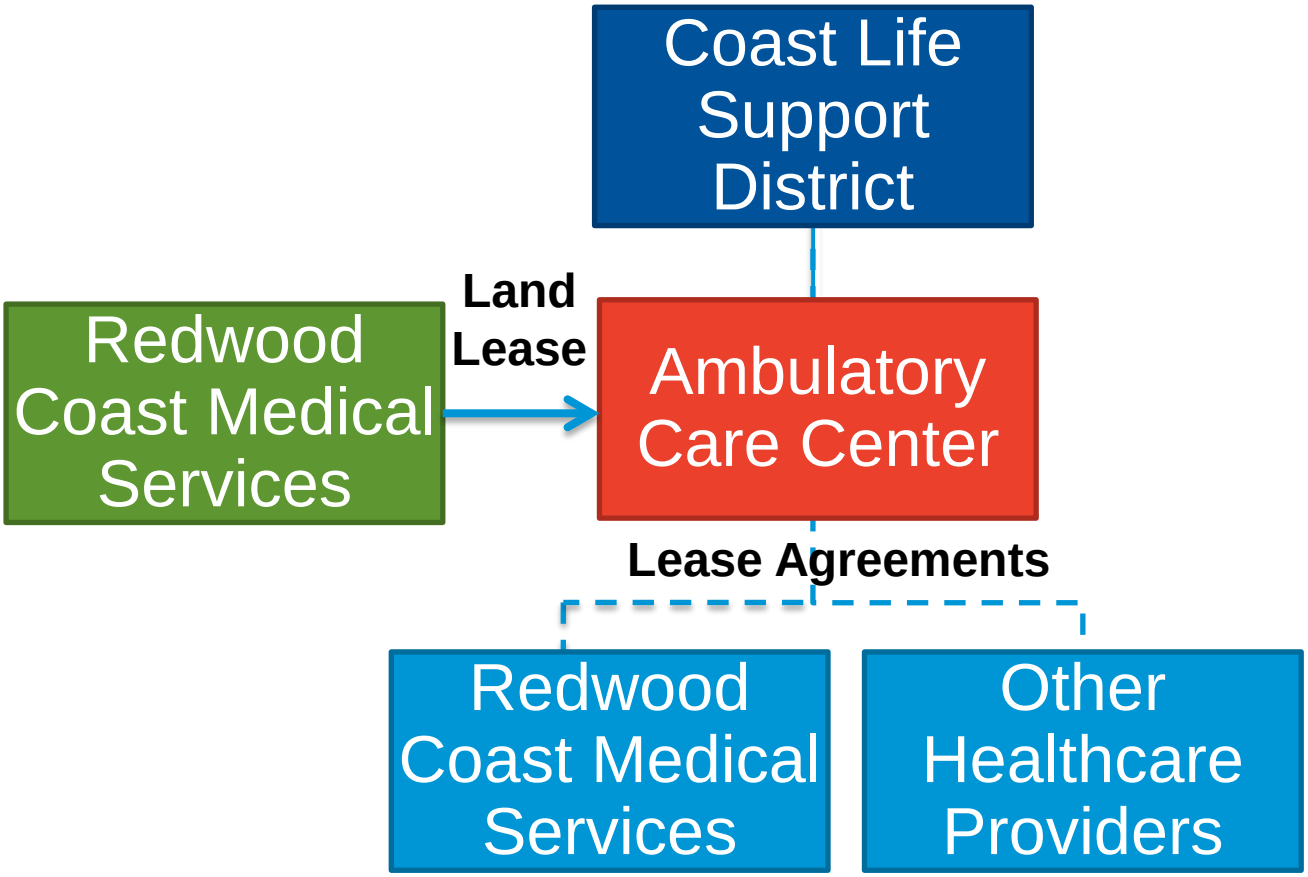
Proposed Service	Square Footage Range per Physician		Square Feet Needed	Comments
	Low	High		
Primary Care	1,500	1,750	7,000	Four physicians; higher square footage per physician for medical home model
Urgent Care	1,000	1,200	1,200	Three Rooms
Specialty Care	1,200	1,500	1,500	
Total Space of Building [(1)]			**10,000**	

(1) Rounded to nearest '000

https://sharepoint.thecamdengroup.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Planning/[ACC_Square_Footage.xlsx]Sizing Table

Option 3 – Develop a ACC

Owned by Coast Life Support District

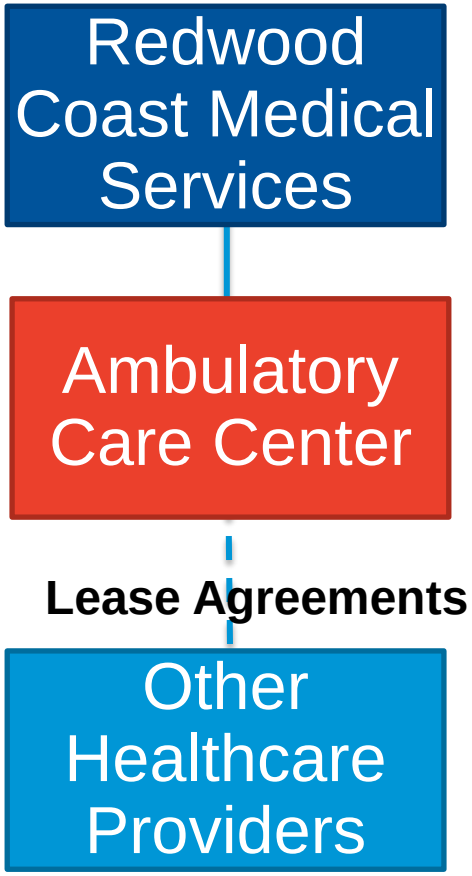


Description

- CLSD raises funds and/or borrows money to finance the construction of a new ACC.
- CLSD pays a fee for the land (upfront, annual) to RCMS.
- CLSD rents space to local healthcare providers.
- Potential to offer ownership.

Option 3 – Develop a ACC

Owned by Redwood Coast Medical Services



Description

- RCMS raises funds and/or incurs debt to build the new ACC
- Applies for grants, coordinates fundraising, and/or obtains loan to finance
- May rent space to other healthcare providers

Financial Projections of New Ambulatory Care Center

Assumptions

- The ACC was assumed to be 10,000 square feet and constructed at a cost of $800 per square foot for a total cost of $8.4 million ($8.0 million in planned capital, with an additional $400,000 for contingency). This is based on local knowledge of recent non-medical construction. Similar medical buildings are built for significantly less cost in other parts of the State.
  - The costs above include the construction of the building, architecture, engineering, and furniture for the lobby.
  - All other costs such as equipment, tenant furniture, software and costs were excluded.

Assumptions

- In order to make the building feasible, 100 percent of the project cost was assumed to be funded through contributions.
- Preopening expenses of $420,000 for legal, consulting, and other related expenses.
- As the District would be the landlord of the ACC, it was assumed that management and maintenance of the building would be outsourced to a management company therefore limiting the working capital need for the actual operation of the ACC.
  - Working capital was assumed to be six months of rental income ($120,000) which would cover required deposits and provide cash reserves upon opening.

Assumptions

The table below summarizes the sources and uses of funds in the development of the ACC.

Coast Life Support District
Ambulatory Care Center: Sources and Uses of Funds
Pre-opening and Years 1 - 5

Sources	Amount	Uses	Amount
Loan proceeds	$0	Capital expenditures [1]	$8,000,000
Equity contribution	8,940,000	Project Contigency of 5 percent	400,000
		Pre-opening expenses	420,000
		Working Capital	120,000
Total	**$8,940,000**	**Total**	**$8,940,000**

https://sharepoint.thecamdengroup.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[Coast_ACC_Finance_012114.xlsx]Sources_Uses

[1] Capital expenditures include building costs, architecture, engineering, and some furniture

Assumptions

- Renter occupancy assumed that RCMS would move into the ACC immediately in Year 1 with the specialty space occupied by Year 2
- Rental income was assumed to be $2.00 per square foot (“PSF”) per month Operating costs were estimated to be $1.10 PSF
  - Excludes potential costs of a land lease.
  - A deposit equal to three months of operating costs assumed to required by management company.
- An additional cost of $0.20 PSF was included starting Year 2 to begin a reserve fund
- Rental income and operating expenses were assumed to inflate at rate of 2.5 percent each year
- The ACC was assumed to be depreciated over 30 years

Financial Projection: Pre-opening and Five-years

The table below summarizes the estimated financial performance of the ACC during the pre-opening period and the first five-years of operation.

Coast Life Support District
Ambulatory Care Center: Operating Financial Performance
Pre-opening and Years 1 - 5

		Projected Year				
Category	**Pre-opening**	**1**	**2**	**3**	**4**	**5**
Revenue (Rental Income)	**$0**	**$204,000**	**$246,000**	**$252,150**	**$258,454**	**$264,915**
Operating Expense [(1)]	**$420,000**	**$132,000**	**$159,900**	**$159,900**	**$159,900**	**$159,900**
EBITDA	**($420,000)**	**$72,000**	**$86,100**	**$92,250**	**$98,554**	**$105,015**
Depreciation	$0	$298,000	$298,000	$298,000	$298,000	$298,000
Interest on Debt		-	-	-	-	-
Net Operating Income	**($420,000)**	**($226,000)**	**($211,900)**	**($205,750)**	**($199,446)**	**($192,985)**

https://sharepoint.thecamdengroup.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[Coast_ACC_Finance_012114.xlsx]PandL_1

(1) Does not include potential land lease expense

Financial Projection: Cash Flow

The table below highlights the estimated cash flow of the ACC during the pre-opening period and first five-years of operation assuming it project is not financed.

Coast Life Support District
Ambulatory Care Center: Cash Flow
Pre-opening and Years 1 - 5

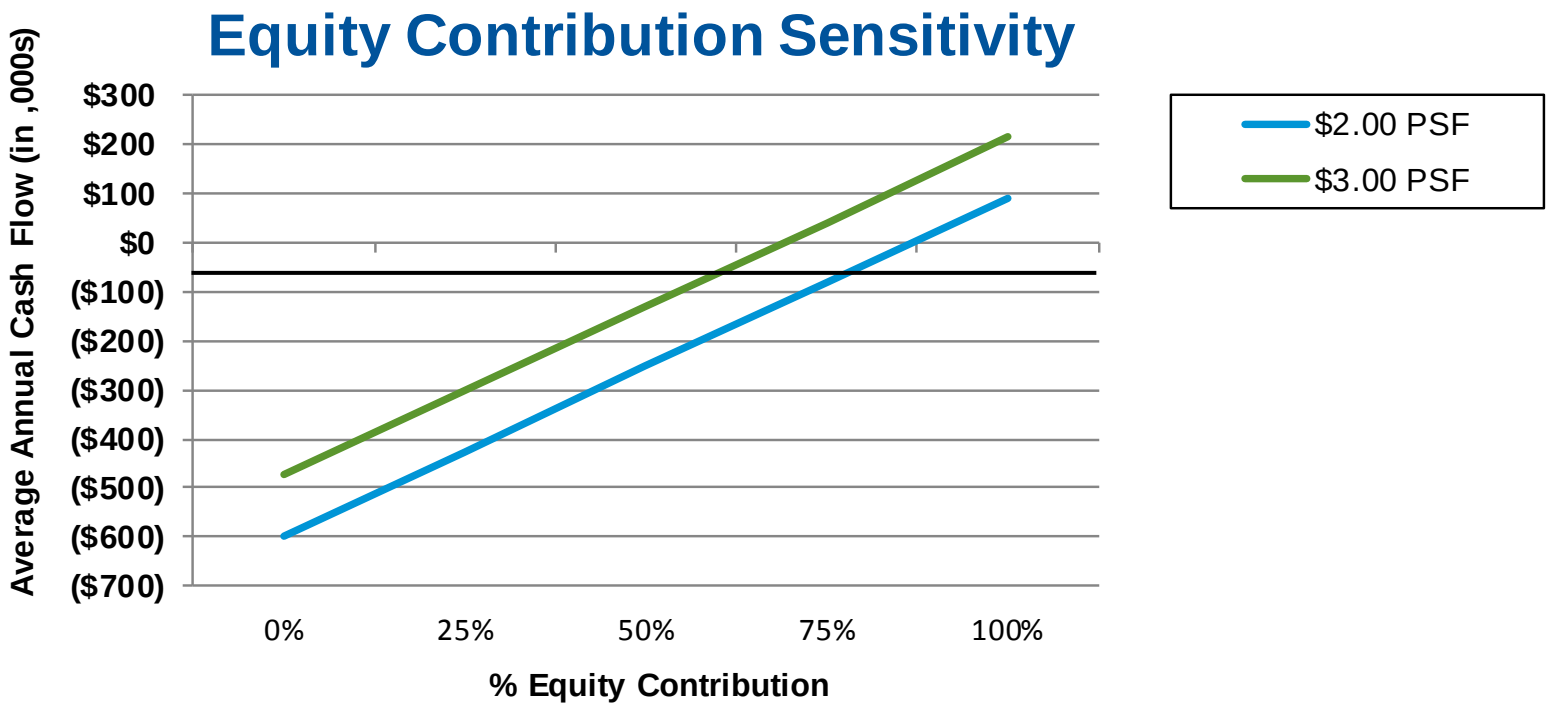
Category	Pre-opening	Projected Year 1	2	3	4	5
High-level Cash Flow						
Net Operating Income	**($420,000)**	**($226,000)**	**($211,900)**	**($205,750)**	**($199,446)**	**($192,985)**
Add: Depreciation	0	298,000	298,000	298,000	298,000	298,000
Less: Capital Additions	(8,400,000)	0	0	0	0	0
Less: Deposits	(39,000)	0	0	0	0	0
Add: Contribution	8,940,000	0	0	0	0	0
Estimated Cash Flow	**$81,000**	**$72,000**	**$86,100**	**$92,250**	**$98,554**	**$105,015**
Cumulative Cash Flow	**$81,000**	**$153,000**	**$239,100**	**$331,350**	**$429,904**	**$534,919**

https://sharepoint.thecamdengroup.com/Clients/Coast_Life_Support_District/Business_Plan_2013/Financial/[Coast_ACC_Finance_012114.xlsx]PandL_1

Note: Contribution includes funds for construction, lobby furniture, pre-opening expenses and working capital

Equity Contribution Sensitivity

The table below highlights the sensitivity of the average annual cash flow of the ACC (over the first five-years) to the initial equity contribution and rental rate.



Note: Loan terms were assumed to a be 5.0 percent interest rate over a 25 year period. These assumptions are estimates only and have been used to help understand the order of magnitude should the District decide to finance a portion of the ACC.

Summary of Findings

- Given the high cost of construction in the District and the current conditions of the rental market:
  - The District or RCMS would likely have to fund most, if not the entire, project through existing cash reserves or grants.
  - The District or RCMS may have trouble finding a developer to invest in the ACC as returns would likely be below investors' expectations.
    - If an investor would take a lower return, the District or RCMS would need to lease the facility and provide a master guarantee.

Existing RCMS Gualala Building

- The existing RCMS building in Gualala is proposed to be repurposed as an administrative building. The proposed services to be put into the existing RCMS building are:
  - Billing/Finance
  - Grants/Resource Development Staff
  - EMR/IT staff
  - Management Staff
  - More storage space
  - Sleeping quarters for on-call providers/staff
  - Other miscellaneous non-clinical activities
- Remodeling the existing RCMS building may cost an estimated $1 million.

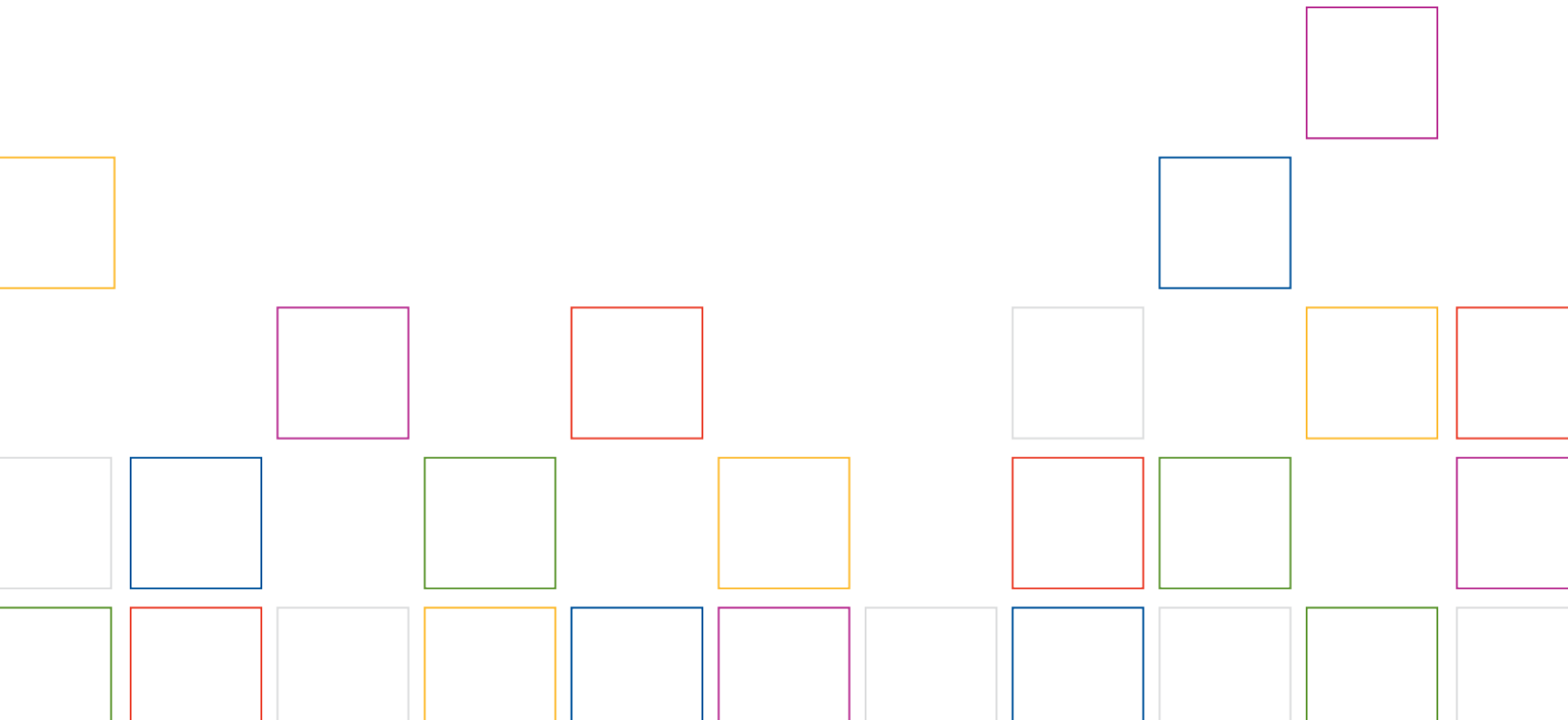
Estimated Telehealth Costs

- Start-up and ongoing costs associated with a higher-quality tele-health unit are approximately $40,000. This would include audiovisual equipment and compatible diagnostics, digital stethoscope, and the vital diagnostics.
  - There are several software programs to purchase ranging in cost from $1,000 to $2,000. Training and support will vary.
- Alternatives to tele-health units exist such as a dedicated codec (teleconferencing) or Internet-based programs. Set-up would include a high-quality webcam and computer monitor, internet-based software, and traditional diagnostics. The alternative method to tele-health is assumed to cost an estimated $5,000.
- Each of these systems require adequate broadband infrastructure to ensure reliable connections.

Potential Funding Options

- Local donations
- Grants (e.g., Kaiser, rural health, HRSA's Health Center Capital Development Programs, California Healthcare Foundation)
- Partnerships with other adjacent health systems
- Partnership with local Indian health services
- New market tax credits – difficult to get (see Appendix B)
- District tax
- Debt (if coupled with tax base or guarantees to support ACC)
- Joint venture with a real estate developer (probably not feasible, given economics)
- Others

Partnerships



Partnership with Health Systems and Community Providers

- CLSD and RCMS should consider partnering with hospital/health system to provide expanded access to healthcare services in the community (e.g., specialists, tele-health).
  - Partnership to provide urgent care services and clinical staffing
  - Specialists/Residents rotate to community physically or remotely
  - Expand other outpatient/ancillary services to community needed by new specialists rotating to the community
- Establish electronic linkages to clinically integrate with other providers:
  - Share patient information: hospitals, physicians, labs, other services

Partnership

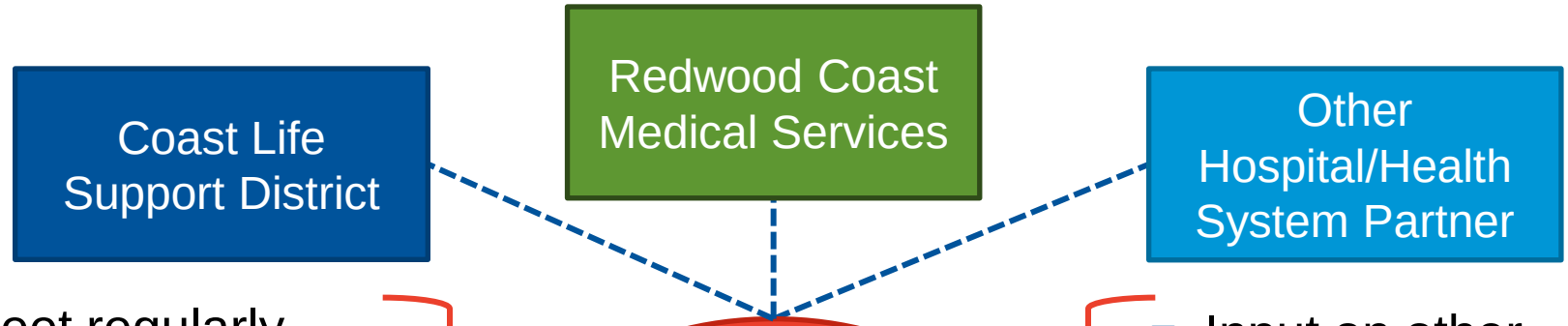
Health Systems and Community Providers

- Advice/Consults in real time: emergency rooms, specialty physicians, tele-health
- Manage patient care: identify high-risk patients, patient monitoring at home or remote setting

- CLSD and RCMS should continue to explore grants to fund innovations in tele-health/remote access that will expand healthcare locally.
- Partner with others to increase access to services;
  - Use of “smart” technology, home health, tele-health
  - Expanded senior programs and age-in-place services (e.g., Village Model) (see Appendix A)
  - Expanded wellness/preventative and chronic care management services to manage the population's health
  - Increased broadband to ensure reliable connections

Partnership

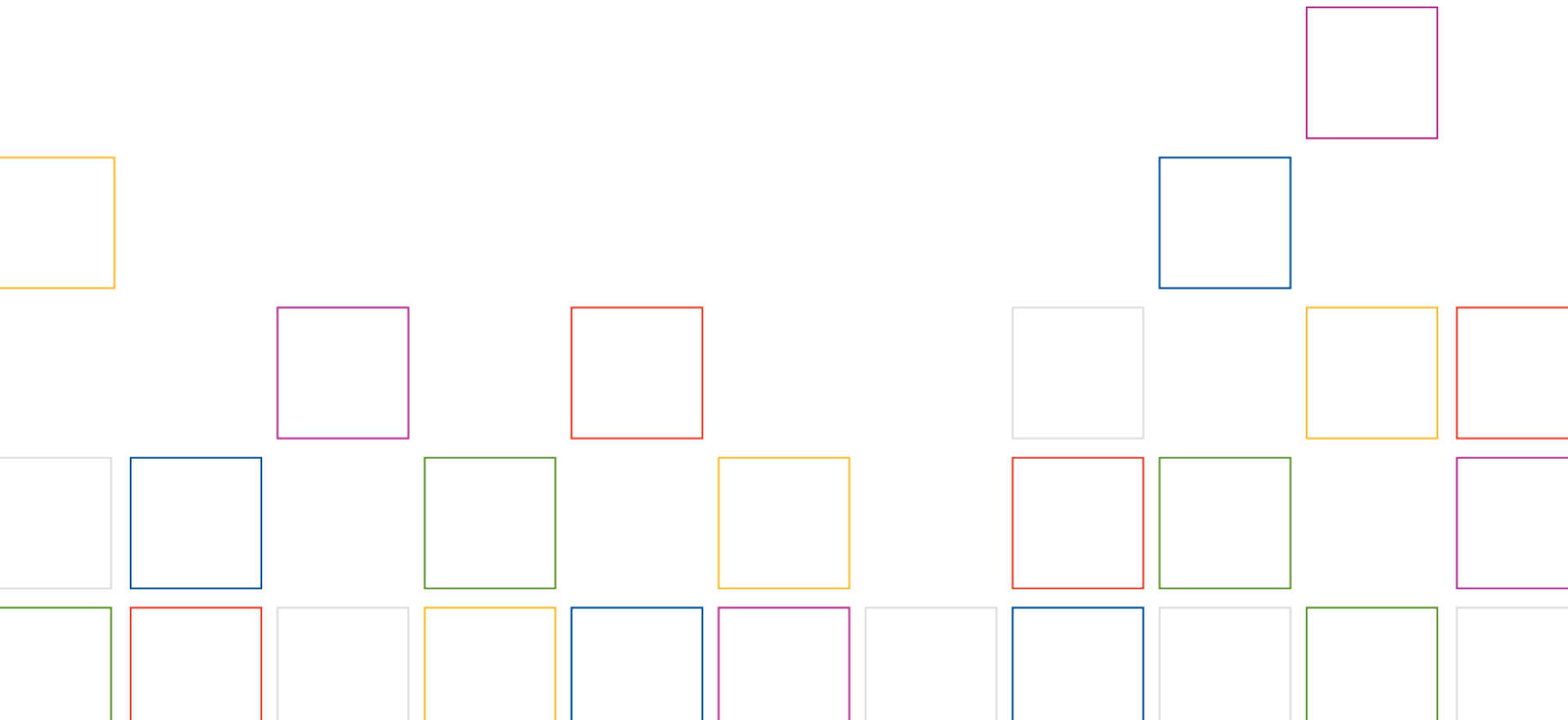
Health Systems and Community Providers



- Meet regularly
- Determine local community needs
- Outpatient service needs
- Equipment
- Electronic linkages

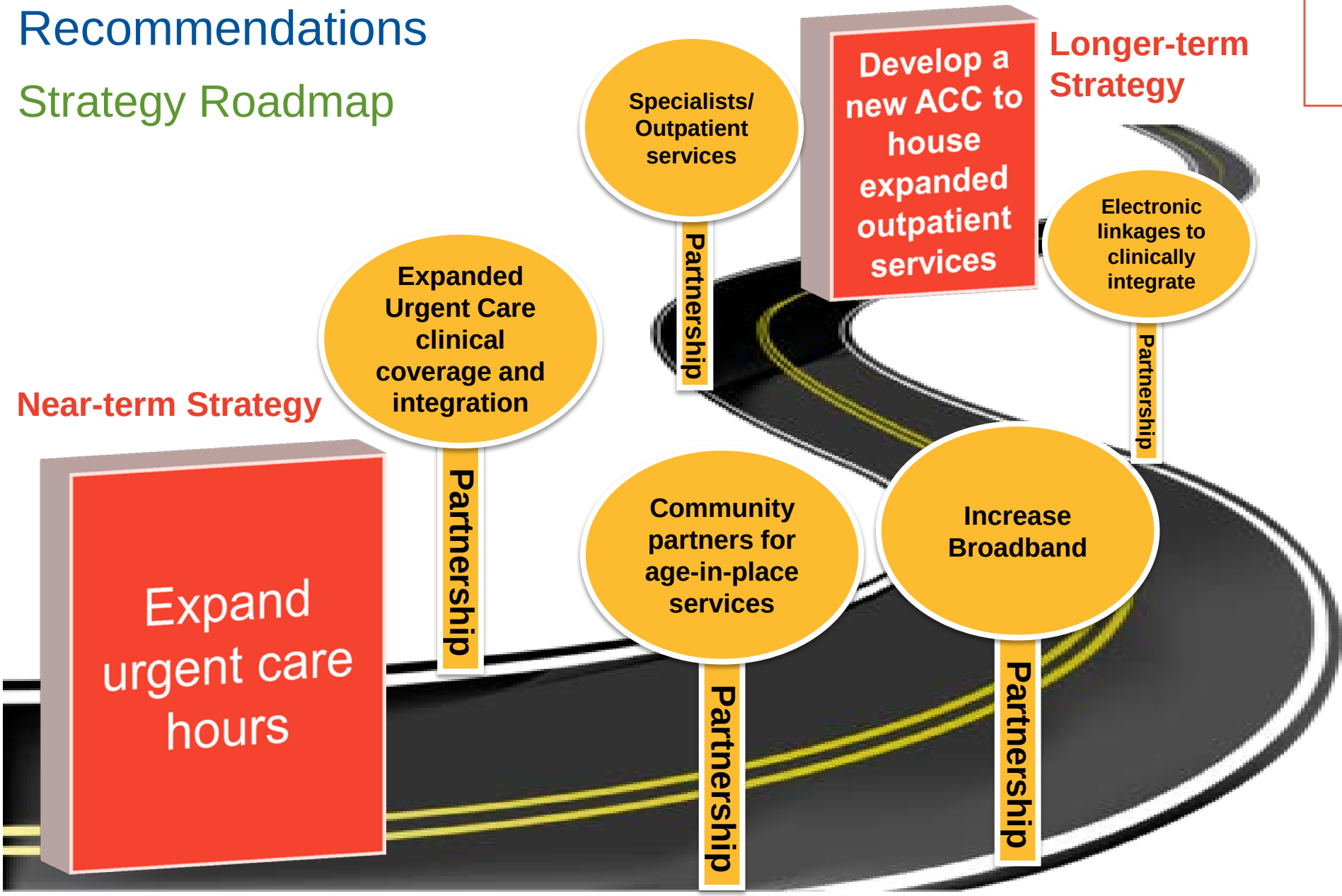
- Input on other partnerships, clinical staffing
- Grievances
- Financial and operational issues

Recommendations



Recommendations

Strategy Roadmap



Recommendations

Strategy Roadmap

Near-term Strategy

- Expand urgent care hours which were consistently stated as the highest need by community members. RCMS' existing infrastructure is the most financially viable, cost-effective, consistent model to expand healthcare services to the community.
- Consider partnering with another health system to assist with clinical coverage, tele-health, referrals, and clinical integration.
- Utilize the urgent care as a first step for a larger and more long-term solution.

Recommendations

Strategy Roadmap

- Partnership with hospital/health system to provide expanded urgent care coverage and clinical integration.
- Engage community partners to assist in the expansion of senior programs and age-in-place services (e.g., Village Model). Look to staff an age-in-place expansion coordinator, and fund through grant opportunities.
- Enhance broadband capacity to ensure reliable connections.
- Establish electronic linkages to clinically integrate with other potential partners.
- Partnership with hospital/health system/residency program to provide expanded specialty services.

Recommendations

Strategy Roadmap

Longer-term Strategy

- Pursue grants and fundraising to support new infrastructure and investment in tele-health that will expand access to healthcare locally.
- Include space and technology to expand access to services on-site, through tele-health and remote monitoring.
- Work with health plans to establish payment methodologies for e-visits.
- More planning and due diligence should be conducted to see if the building could be constructed for less cost.
- Either fundraising, grants, or tax support will be needed to make the new building feasible.

Next Steps

1. Expansion of urgent care services
2. Form building planning group/develop plan/needs
3. Identify and obtain planning grant/funding
4. Pursue partnerships/affiliations (urgent care, other needs)
5. Grant funding for age-in-place coordinator position

Options Considered and Excluded

Additional Options Considered and Excluded

- Development of a community medical center (less than 25 licensed beds)
  - Low volume
  - Difficulty recruiting and retaining physician support
  - Difficulty maintaining consistently high quality and clinical competencies
  - Significant financial support needed
- Development of Community Paramedicine program
  - Community Paramedicine is currently not practiced in California due to strict paramedic scope-of-practice specifications, and restrictions placed on where paramedics may treat patients. However, OSHPD and California Emergency Medical Services Authority (“EMSA”) are beginning demonstration CP programs.
  - Although, use of paramedics to staff after-hours urgent care could be a viable staffing alternative

Additional Options Considered and Excluded

- Development of a free-standing ED
  - Not currently allowed in California
- HAH
  - Distance from acute care hospital, considerable start-up costs, and staff requirements
- Development of a district clinic
  - Duplication of resources and less financially viable model
- Development of a hospital clinic
  - Outside of distance requirements
- Addition of other full-time specialists and related services (e.g., surgery, advanced imaging/diagnostics)
  - Not supported by population

Additional Options Considered and Excluded

- Build larger ACC to include rental space for other community healthcare providers.
  - It was noted that due to the presence of commercial real estate vacancy rates in the service area currently, and estimated cost of new construction, that building additional space in the ACC to be leased would not be financially viable.

Appendix A
Age-in-Place Services

Age-in-Place Services

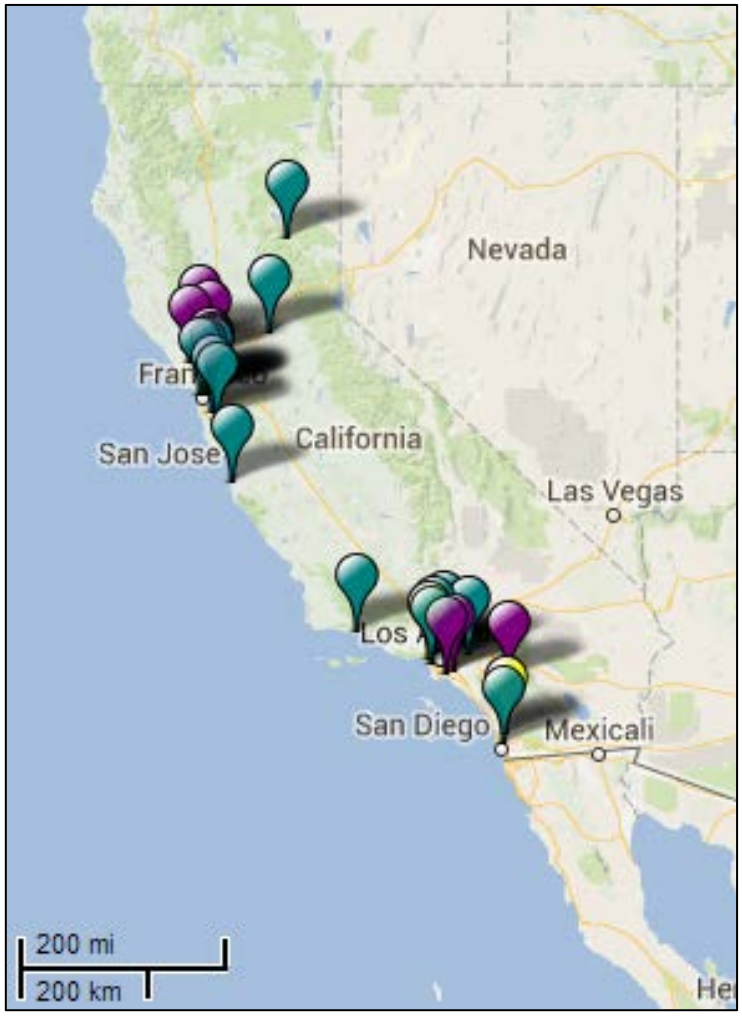
- Key trends in age-in-place services for future aging generations:
  - Maintaining resident independence: use of “smart” technology, home health, tele-health in senior living facilities
  - Expanding senior programs and services outside of senior living communities: home health, adult day care, the Village Model
  - Wellness and continuing education programs for seniors
- Community-based membership organization that empowers elderly adults to remain active and engaged in their communities as they age.

The Village Model

- Villages facilitate access to community services and provide connections to ongoing civic engagements by providing three core services to its members:
  - Concierge or referral to providers/volunteers for anything
    - Transportation is the most common requested service
    - Home maintenance is the second most common requested service
  - Health and wellness programs and services (i.e., exercise programs, home health care, meals and groceries delivered)
  - Social and community building programs, including seminars, wellness and prevention activities developed and administered by the members themselves.

The Village Model

- 22 Villages open in California
- 17 Villages in development in California
  - Three Villages in development closest to Gualala located in Petaluma, St. Helena, and Napa.
- Village model relies heavily on volunteerism to provide member services
- Fostering friendships and social connections are a key component of the Villages model



= Member/Open

= Member/In Development

= Non-Member/Open

Appendix B
New Markets Tax Credit Program

New Markets Tax Credit Program

- Established by Congress in 2000 to spur new or increased investments into operating businesses and real estate projects located in low-income communities. (See next page for low-income definition.)
- Helps economically distressed communities attract private investment capital by providing investors with a federal tax credit.
- Investments are used to finance businesses and real estate projects.
- Communities wishing to receive funds must be a certified Community Development Entity and must proceed with a competitive application process.
- Communities benefit from added jobs as well as greater access to public facilities, goods, and services.

New Markets Tax Credit Program

- Low-income Communities (“LIC”) are defined as:
  - High out-migration rural county census tracts:
    - Population census tract which, during the 20-year period ending with the year in which the most recent census was conducted, has a net out-migration of inhabitants from the county of at least ten percent, if the median family income for the census tract does not exceed 85 percent of statewide median family income (at 82 percent)
  - Low population/empowerment zone census tracts:
    - Population census tract with a population of less than 2,000 if the tract is within an empowerment zone, and is contiguous to one or more LICs (not including other LICs in this category)
  - Targeted Populations:
    - Certain individuals, or an identifiable group of individuals, including an Indian tribe, who (A) Are low-income persons [median family income at or below 120 percent of the applicable median family income]; or (B) Otherwise lack adequate access to loans or equity investments

CDFI Fund, New Markets Tax Credit Program Fact Sheet