

Urgent Care Centers Business Plan

ORIGINATING DEPARTMENT:

Business Development and Strategic Planning

I. Executive Summary

An eastern and western Urgent Care Centres (UCC) will be developed to complement the existing acute care hospital (KEMH) located in the central portion of the island to provide direct access to care for all Bermudians. Urgent care is the delivery of ambulatory care in a facility dedicated to the delivery of unscheduled, walk-in care outside of a hospital emergency department. Development of the two facilities will facilitate access to care providers through extended service hours within closer geographic proximity for to patients, families, and caregivers.

Under the leadership of the Bermuda Hospitals Board (BHB), the linkage between the UCCs and KEMH will limit the duplication of services that would lead to unnecessary medical spending without discernible quality or service advantages by providing administrative and medical oversight. Organizing the UCC's under BHB minimizes the operating costs by leveraging the existing infrastructure provided by BHB. The Director of Emergency Services will provide clinical monitoring to ensure quality service provisions..

The UCCs will integrate into the emergent care system for Bermuda. The UCCs will act to alleviate demand for ED services by shifting lower acute patients to a less resource-intensive environment. Emergent patients entering the UCCs will be triaged and stabilized. Ambulance service will be located at each UCC to transfer emergent patients to the KEMH ED. Additionally, locating ambulances at each UCC provides superior response times to the far ends of the island.

Project Team

BHB has collaborated with Lahey Clinic and with support from Kurrion, including, but not limited to the following:

Organization	Individuals
Bermuda Hospital Board	David Hill, CEO Neil Rolfes, Chief Business Development Officer Dr. Donald Thomas, III, Chief of Staff
Kurrion	Corbett Price Devin Price Andrew Cameron

II. Program Overview

UCCs provide treatment to patients suffering from non-life-threatening conditions that require quick attention, including bone fractures, pneumonia and flu, and minor lacerations. Since the late 1980s and early 1990s, hospitals have looked to UCCs as a means to reduce rates of inappropriate ED utilization by triaging non-emergent patients to less acute settings. The ED is not the most appropriate care setting for many ED patients. Non-urgent patients account for well over 10 percent of the average ED's caseload, and semi-urgent cases account for another 20 percent (refer to Figure I)¹. At the other end of the acuity spectrum, most emergent patients would be better served in an inpatient unit, but many are forced to board in the ED because beds are unavailable.

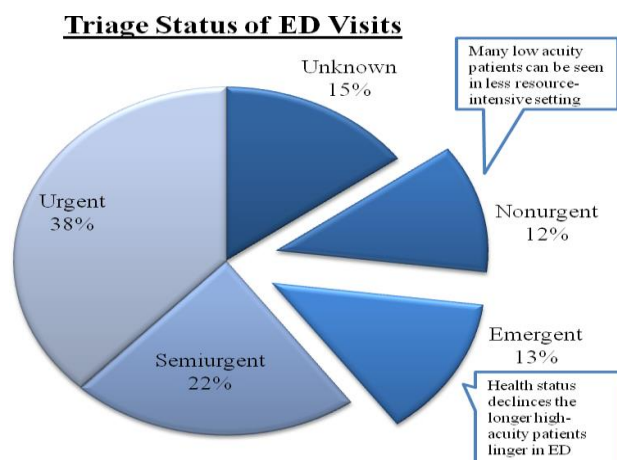
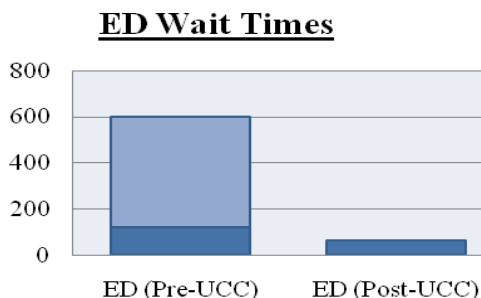


Figure I

Triaging patients to appropriate site of care properly allocates resources to meet patient acuity and result in better clinical outcomes. UCC staffing and treatment approaches are fundamentally different from those in an ED; Patients get more abbreviated and pointed clinical work-ups, which provides care more efficiently done by clinicians who are oriented to less intense discovery and intervention.

UCCs also address community needs for convenient, reliable access to care. Current alternatives to UCCs include the ED, which like other comparable US and UK EDs, has long waiting times and potentially stressful patient environments. Transportation to the KEMH ED can also potentially add considerable time to receiving care, which is exacerbated during periods of inclement weather. Previous research suggests non-emergent patients waited anywhere from 2 to 8 hours in one medical center ED, but after opening an urgent care center the wait is an average of 64 minutes in the ED (see Figure II)². Decreasing waiting times is positively correlated with better outcomes.



¹ Centers for Disease Control, National Hospital Ambulatory Care Survey. Advisory Board Company. Washington DC.

² Ginger Shepherd "Urgent care clinics utilized to decrease wait times, patients". Journal Record, The (Oklahoma City). Jun 13, 2007.

Figure II

The other alternative to care remains the General Practitioner (GP) market, which offers services largely only by appointment and confined to normal business hours. An inability to see GPs after normal operating hours can lead to acuity convergence which occurs when people wait to be treated because of limited access, then go to the ED with more severe conditions. Research suggests that differential access to care to populations with lesser supply of physician is one contributor to health care disparities³. The UCCs fill the gap, acting as mid-level service provider in between that of the ED and GPs.

Location

Current healthcare services are largely concentrated near or within the city of Hamilton suggesting that the ends of the Island are left disadvantaged from those living and working in the central region. Disaster planning also must be reflected in site selection for the East. The potential for bridge outages during hurricanes requires placement to ensure healthcare services are available when access is limited.

Site selection focused on increasing the access to care and facilitating better emergency and disaster response. Best practice would also suggest stationing ambulance services at each UCC. Currently ambulances are based at KEMH which doubles response times for emergent events at the ends of the island. Positioning of the ambulance services also factors into the physical placement of each UCC. The UCC locations are both adjacent to existing Fire Services facilities providing opportunities for coordination of emergency services between the UCCs and Fire Services.



Figure III

The West UCC will be located in Southampton adjacent to the Port Royal Fire Station (see Figure IV). The East UCC will be located in St. George's on St. David's (see Figure V). See Appendix for additional maps.

³ Nicole Lurie, MD, MSPH; Tamara Dubowitz, MSc, SM, ScD. "Health Disparities and Access to Health" JAMA. 2007;297:1118-1121.

West UCC Site

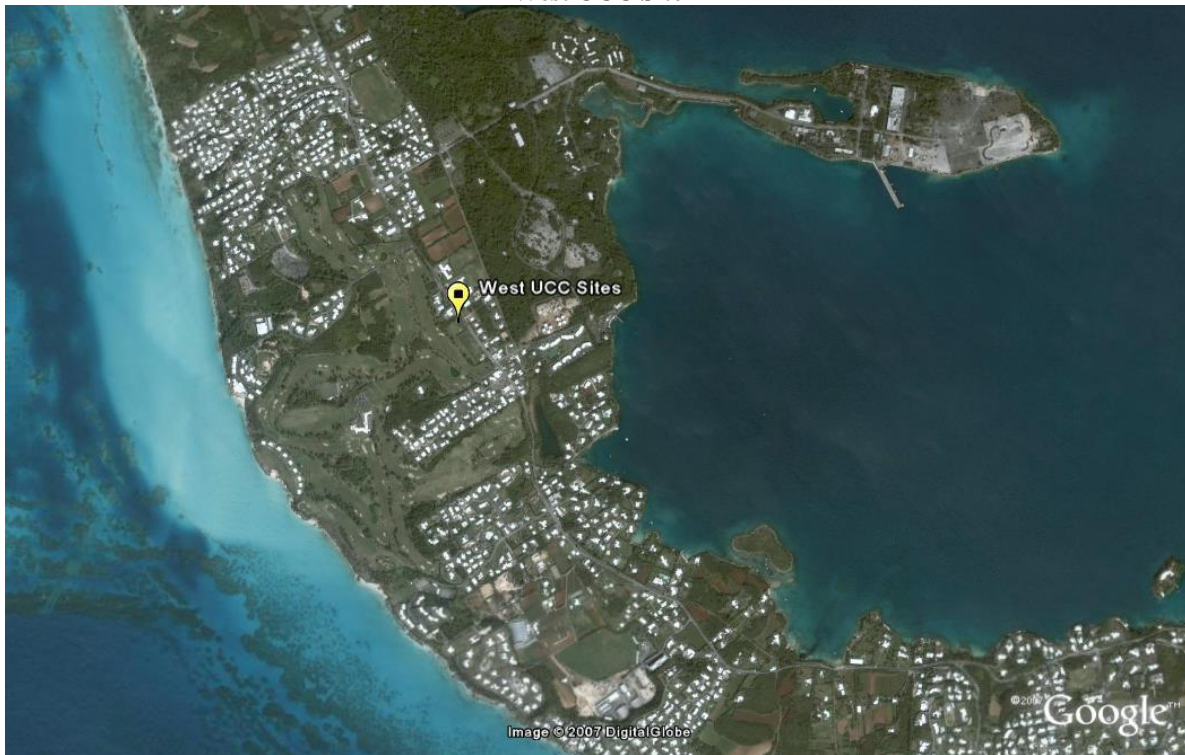


Figure IV

East UCC Site

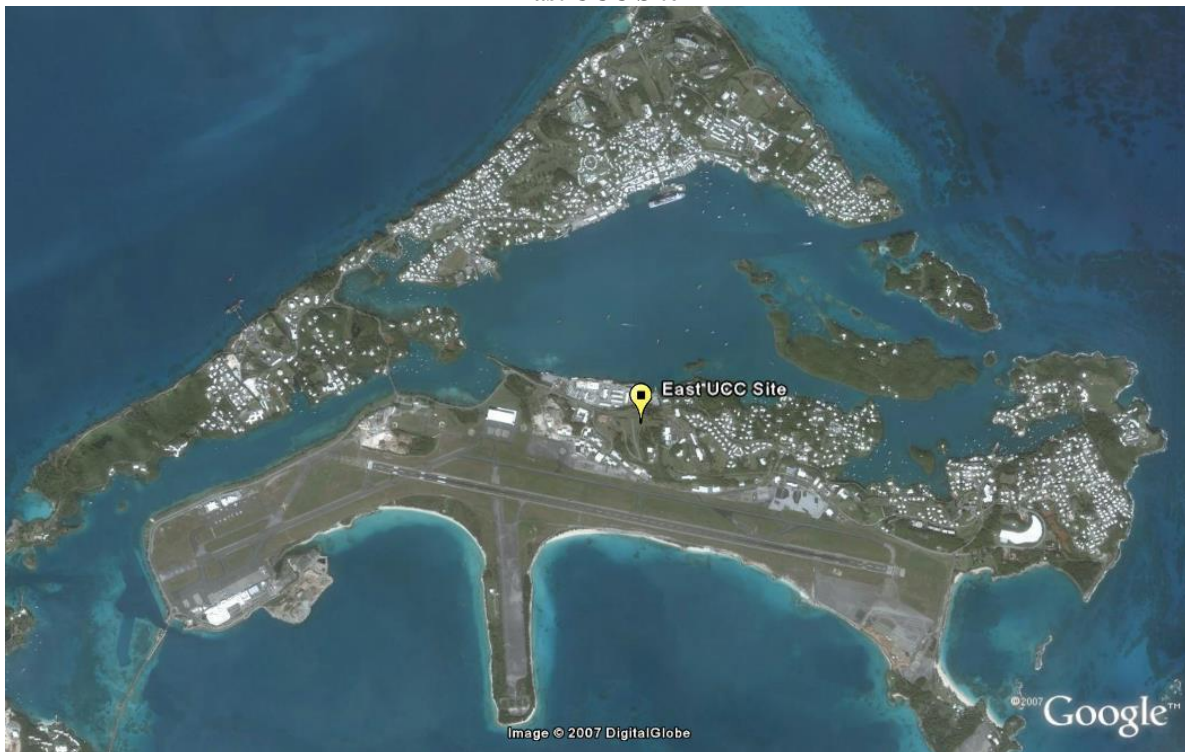


Figure V

The goal of each UCC is to provide greater access to care to the majority of the populace, thus a review of the population density provides insight into locating the UCCs in position to provide maximal value. Population densities also will reflect future demand and ability of the UCCs to generate requisite revenues.

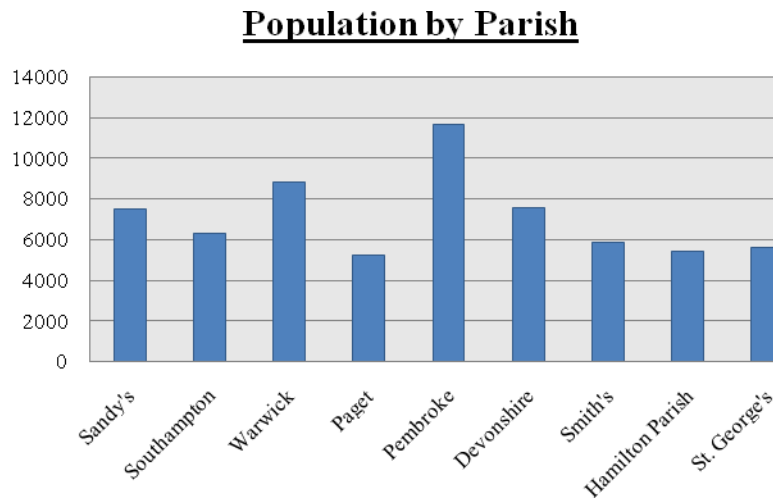


Figure VI

Central Bermuda currently is already home to KEMH and the majority of Private Practice Physicians providing multiple access points for care. The inclusion of both the East and West UCC's provides direct access to care for the outlying parishes.

Services

To meet the needs of the community and provide the appropriate level of care without unnecessary duplication of a resource intensive Emergency Department, each UCC will provide basic emergent procedures, diagnoses and treatments. Care must be taken to inform the community about the limitations of the UCCs and to maintain the KEMH ED as the focal point for high-acuity patients. The following is basic list of services (see Appendix for a more detailed list).

- Nursing triage
- Physician Assessments
- Minor procedures
- Basic Lab Services
- Basic Diagnostic Imaging
- Vital signs
- IV Therapy
- EKG
- Wound care

The potential to house ambulance services out of each UCC provides additional requirements and opportunities. To accommodate the needs of the EMS crew multiple waiting room / bunk rooms will be added to the facility as well as a separate entry point for the ambulance service. Supplies will also be warehoused at the UCC's for easy resupply by the ambulances. These supplies can also be part of the disaster planning strategy for the island to provide closer access to needed equipment and supplies during emergencies.

In addition to providing better coverage for the island's EMS service, the EMS will also provide benefits to the UCCs. The ambulances will provide immediate transport for mis-triaged patients. EMT's can also work in the

UCCs during down time; however, they cannot be counted on as part of UCC staffing due to the variability of their work.

Other Potential Offerings

The UCCs offer additional revenue opportunities to leverage the convenient retail setting to provide clinical services. Occupational Safety Testing could be provided utilizing a secure bathroom to provide basic drug testing at a pre-packaged price. Currently the service is offered at the hospital, but is much better suited for a freestanding center.

The diagnostic lab and x-ray services available for UCC patients could also be offered as a diagnostic referral site for local GPs. Providing a more convenient location for these services than the hospital and creating greater access to care.

Staffing Mix

Staffing for the UCCs will entail supporting the overall emergent system for Bermuda. Multiple options exist for the clinical leads at UCC the potential options are: Emergency Department Physicians, Family Practice/General Practice Physicians with significant outpatient clinic experience and Nurse Practitioners with UCC experience. UCC Clinical Leads will be required to manage emergent cases that may “walk-in” to urgent care centres and stabilize these patients until transport to KEMH is available. The following table overviews the clinical lead staffing options:

	Model #1	Model #2	Model #3
Clinical Lead	ED Physicians	Locum Tenens Physicians	Nurse Practitioner (NP)
Summary	<ul style="list-style-type: none"> Emergency Department physicians who rotate between KEMH ED and UCCs Employed through KEMH 	<ul style="list-style-type: none"> Temporary, hourly-rate physicians with UCC or ED experience Recruited through agency 	<ul style="list-style-type: none"> NPs with significant outpatient clinic experience Employed through KEMH
Finances	<ul style="list-style-type: none"> Employed physicians - \$200K salary / year + benefits + housing allowance Significant Recruitment Costs 	<ul style="list-style-type: none"> \$120/hour + housing + travel allowances Locum Tenens Recruiter Fees 	<ul style="list-style-type: none"> Employed NPs - \$100K salary / year Recruitment Costs
Analysis	<ul style="list-style-type: none"> Difficulty recruiting ED physicians for UCCs Retention concerns Superior ability to treat emergent patients Additional service offerings possible Standardized emergency care throughout system Increase the ability of KEMH ED to cope with volume peaks/troughs High Costs 	<ul style="list-style-type: none"> High skill levels Pre-existing UCC experience Continual rotation of physicians may result in divergent care quality Recurrent recruiting/placement required Limitation of service offerings (variance of physician skill levels) Moderate Costs 	<ul style="list-style-type: none"> Reduced clinical skills available Concerns about clinical quality without full-time physician oversight Inability to provide emergent level care Limitation of potential service offerings Lowest cost

Table I

Yearly Staffing Costs by Clinical Lead Model

STAFFING			
	FTE	Salary	Total
ED Physicians	2.0	\$ 200,000	\$ 400,000
Subtotal		\$	400,000
Benefits as Percentage of Salary			20%
Housing Allowance		\$	48,000
Total Wage and Salary Cost		\$	528,000
	Hourly Rate	Total Hours	Total
Locum Tenens Physicians	\$ 120	60	\$ 374,400
Subtotal		\$	374,400
Travel Allowance		\$	24,000
Housing Allowance		\$	96,000
Total Wage and Salary Cost		\$	470,400
	FTE	Salary	Total
Nurse Practitioners	2.0	\$ 100,000	\$ 200,000
Subtotal		\$	200,000
Benefits as Percentage of Salary			20%
Total Wage and Salary Cost		\$	240,000

Table II

Model #1, utilizing ED physicians, is the preferred staffing model. ED Physicians will rotate between the main KEMH ED and the UCCs to maintain clinical skill levels and to provide cross-coverage at each site. This model supports creating a cohesive team of emergency physicians with consistent clinical quality at each UCC. However, the challenge to recruit and retain ED physicians to staff each UCCs suggests the alternative models, using Locum Tenens and Nurse Practitioners, will provide ample ability to remain properly staffed and maintain clinical quality standards in the face of an ED physician shortage. Staffing will also consist of inviting local physicians to “moonlight,” in which physicians with their own practices or who work in the ED work at the UCC to supplement their existing salary with hourly income and potentially build a patient base (further financial analysis is based on using Model #1, ED physicians).

Medical oversight will be provided by the Urgent Care Medical Director who will be under the Director of Emergency services at KEMH. The medical director will manage the physicians as part of the Emergency care strategy at KEMH.

In order to manage large volumes while maintaining a lean staffing ratio, nursing and ancillary staff will be required to be cross trained to perform multiple duties. Physicians will also be expected to manage a large volume of patients in a rapid fashion to meet the wait time limitations of the community.

Staffing Model per Shift

Position	FTEs
Clinical Lead	1.0

Nurse	1.0
Physicians Assistant	1.0
Radiology Technician	1.0
Medical Assistants / Receptionists	1.0

Table III

Facility

Facility design must meet the needs of clinicians and consumers. Consumers invariably associate the quality of healthcare services with the aesthetics of the site of care. The facility will be designed to blend into the local architecture to be a part of each the eastern and western communities.

Design will also focus on clinical efficiency and safety. The UCCs will be designed to accommodate urgent patients who must be continually monitored by UCC staff. The waiting area will remain in the line of sight to a receptionist to quickly respond to patient needs. Exam room will be situated around the central nursing/physician station to allow for continual monitoring. Additionally, the central workstation will provide UCC staff the opportunity to remain in constant contact, promoting communication and teamwork.

A single entry point will be available at the front of the facility with a separate exit point. An ambulance entrance will also be provided for quick exit by the EMTs located onsite.

Replicating design plans for both UCCs is most cost efficient when you incorporate architectural and planning fees, thus both UCCs will have the same basic space layout as follows:

Facility Description

Space Description	Quantity	Square Feet Per Room	Total Space
Central Nursing / Physician Station	1	500	500
Exam Rooms	5	100	500
Treatment Room	1	150	150
Radiology Room	1	200	200
Staff Offices	2	100	200
Reception/waiting area	1	400	400
Employee Break Room	1	250	250
Medical Records	1	250	250
Laboratory	1	200	200
Restroom	3	50	150
EMS Facilities	2	80	160
Utility Room	2	150	300
Subtotal Usable Sq. Ft.			3260
Circulation, Mechanical, Telecom/IT, Other Space			915

Total Facility Size	4,175
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Table IV

Operating Model

The UCC will open after the normal working hours of local physicians. Operating during these limited hours will reduce the potential for “triplification” of services between KEMH, GPs, and the UCCs. These operating hours also align with the peak ED visit times that significantly trail off after midnight.

Operating Hours

Hours of Operation	
Monday – Friday Hours	8
Saturday & Sunday Hours	10
Hours of Operation per Week	5 PM- 1AM (M-F) & 10AM – 8 PM (Sat. & Sun)
Total Operating Hours	60

Table V

Based on demand for service and the ability to recruit and train staff, each UCC will take a phased approach to increasing hours of operation (See Appendix for Phased Model).

Patients will initially be received by the receptionist and then triaged by a nurse or physician’s assistant. Each patient will be assessed by a physician. Patient visit times will be approximately 15 minute per visit with a potentially large range explained by various levels of acuity and service intensity required for each patient.

Oversight

Operational management of each UCC will rest within BHB and utilize managerial staff that is spread across UCCs to ensure standardization of services effective implementation of best practices. Billing and records management will be centralized to KEMH to benefit from the existing infrastructure. Medical oversight will integrate the UCCs into the emergency system for Bermuda and be provided by the Director of Emergency Medicine at KEMH.

III. Market Profile

Market Overview

Based on the breakdown of health service requirements for Bermuda, the geographic area can be subdivided into three sections. The central market, encompassing the city of Hamilton and where KEMH is located, houses the majority of Bermuda's population (54%). Furthermore, the central region is the primary commercial area where most Bermudians are employed and thus many spend a majority of their day within Hamilton. Moving to the poles, the East (19.6%) and West (26.4) primary service areas are home to the rest of the population. Table VI describes the current population breakdown by parish and aggregates the populations into primary service areas.

UCC Service Areas ⁴

Area	Parish	Percent	2007	2008	2009
East	St. George's	100%	5,622	5,640	5,656
	Hamilton Parish	100%	5,436	5,453	5,468
	Smith's	25%	5,836	5,854	5,871
	Total	19.6%	12,517	12,556	12,592
Central	Smith's	75%	5,836	5,854	5,871
	Devonshire	100%	7,537	7,560	7,582
	Pembroke	100%	11,661	11,698	11,732
	Paget	100%	5,248	5,264	5,280
	Warwick	65%	8,857	8,884	8,910
	Total	54.0%	34,579	34,688	34,788
West	Warwick	35%	8,857	8,884	8,910
	Southampton	100%	6,309	6,329	6,347
	Sandy's	100%	7,504	7,527	7,549
	Total	26.4%	16,913	16,966	17,015
		Total	64,009	64,209	64,395

Table VI

Demand Forecasting

The methodology to define the scope and potential size of each market is to analyze the current markets where potential UCC patients receive their healthcare services. The current landscape on Bermuda for low acuity, time sensitive healthcare can be broken up into the emergency department population at KEMH and into the primary care physician market.

ED volume data at KEMH was analyzed to review for low acuity patients to determine the rate at which those patients could be diverted from the ED to a UCC. Based on historical ED utilization rates by population and reviewing financial data indicating the service level intensity required for patients forecasts have been generated to estimate the volume of cases that can be safely diverged from the ED to a UCC.

⁴ Growth rate based on historical government statistics using a .67% annual population growth.

Unadjusted Demand Forecasting

UCC ED Divergence Demand	West	East	Description/Explanation
Primary Market Population Size	16,913	12,517	Target geographic market
Secondary Market Population Size	34,579	34,579	Secondary geographic market where potential spillover volume may occur
ED Utilization Rate	0	0	Historic ED visits translates to 490 ED Visits / 1,000 Population (KEMH Data).
Primary Market ED Volume	8,287	6,133	
Secondary Market ED Volume	16,944	16,944	
% of Level 1 ED Visits	7%	7%	KEMH Data
% of Level 2 ED Visits	40%	40%	KEMH Data
% of Level 3 ED Visits	37%	37%	KEMH Data
% of Level 1 Cases Transferable to UCC	100%	100%	Low acuity cases that can be averted from ED setting to UCC
% of Level 2 Cases Transferable to UCC	100%	100%	Low acuity cases that can be averted from ED setting to UCC
% of Level 3 Cases Transferable to UCC	40%	40%	Low acuity cases that can be averted from ED setting to UCC
Primary Market Potential Volume from ED	5,156	3,816	
Secondary Market Potential Volume from ED	10,541	10,541	
Primary Market Penetration Rate	95%	95%	Market share inside of primary market (presents leakage of volume to other entities)
Secondary Market Penetration Rate	5%	5%	Potential volume attracted from outside of primary market
Primary Market Demand Forecast	4,898	3,625	
Secondary Market Demand Forecast	527	527	
UCC ED Divergence Demand Forecast	5,425	4,152	

Table VII

The Primary Care market was analyzed using US benchmarks from the Centers for Disease Control that defines utilization rates of physician office visits by population. Applicable visit types were then determined to calculate which visits could be handled within a UCC environment (e.g. new symptoms, injury, etc.) and which would not be appropriate (e.g. chronic conditions, follow-ups, etc.).

Current Primary Care Market

Primary Care Utilization Rate	West	East	
Physician Office Visit Utilization Rate	331%	331%	Benchmark from CDC
Physician Office Visits	55,982	41,431	Potential Physician office visits
Primary Care Visit Rate	60%	60%	Benchmark from CDC
Primary Care Visits	33,309	24,652	Potential PCP visits
Visit Reason - New Symptom Module	47%	47%	Benchmark from CDC
Visits for New Symptoms	15,489	11,463	Potential visit types applicable for UCC
Primary Market Penetration Rate	10%	10%	Penetration rate for UCC of potential PCP market
Primary Market Demand Forecast	1,549	1,146	Penetration rate for UCC of potential PCP secondary market
Total (EC & PC) Demand Forecast	6,974	5,298	

Table VIII

ED Cannibalization Concerns

The potential for a significant volume of ED patients to be offloaded to the UCCs suggests the ED may see its volumes significantly decline and have to make significant staffing and budget cuts. However, analysis proves that the majority of treatment time within ED's are spent on high acuity patients, even though the majority of patients are low acuity.

Acuity Level	Nursing / Physician Time (min) per Case	Average Yearly ED Visits by Acuity	Treatment Time (min)	% of Total Treatment Time
5	300	3,858	1,157,403	37%
4	180	1,555	279,904	9%
3	90	13,484	1,213,530	39%
2	30	14,450	433,509	14%
1	15	2,653	39,795	1%
Total Treatment Time			3,124,141	

Table IX

Because of the high resource consumption of high acuity patients, the ED will need to maintain current staffing and budget levels because only 17% of treatment time will be shifted to UCCs. Ultimately this provides a better use of resources –high acuity patients cared for in high acuity setting with low acuity patients in lower acuity setting.

	Visits by Site (after UCC Implemented)	High Acuity Treatment Time	Low Acuity Treatment Time	Treatment Time (min)	% of Total Treatment Time
ED	24,251	2,044,073	551,365	2,595,438	83%
UCC	11,749	0	528,704	528,704	17%
Total	36,000	2,044,073	1,080,069	3,124,142	

Table X

Adjusted Demand Forecast

The divergent ED market and Primary Care Markets were added together and a growth factor applied. The current population is growing at a rate of .67% indicating a stable market, but adjustments must be made to provide for increased demands of an aging population. Table V presents the potential market for services:

Unadjusted Demand Forecast

Service Area	2007	2008	2009	2010	2011
West	6,974	7,020	7,066	7,113	7,160
East	5,298	5,333	5,369	5,404	5,440

Table XI

The potential market size calculations, however, does not account for a number of external factors. Customer needs and motivation, as well as the influence the physician population and competitive factors also must be factored into the model. Table VI provides adjustment factors that will affect demand for services at the UCC.

External Adjustment Factors

Service Area	Consumer Influence	Physician Influence	Impact of Competitive Position	Hours of Operation	Total Adjustment
West	10.00%	-25.00%	-5.00%	-10.00%	-30.00%
East	10.00%	-25.00%	5.00%	-10.00%	-20.00%

Table XII

Aggregating all the available data and external adjustment factors produces Table XIII which is adjusted demand forecast for each UCC. Please note that limited data and benchmarking resources specific to Bermuda suggests the demand forecast cannot be made as precise as liked.

Adjusted Demand Forecast

Service Area	Visits	2007	2008	2009	2010	2011
West	Year	4,882	4,914	4,946	4,979	5,012
	Month	407	410	412	415	418
	Week	94	95	95	96	96
	Day	13.4	13.5	13.6	13.6	13.7
East	Year	4,239	4,267	4,295	4,323	4,352
	Month	353	356	358	360	363
	Week	82	82	83	83	84
	Day	11.6	11.7	11.8	11.8	11.9

Table XIII

IV. Financial Analysis

Capital Requirements

To estimate the total funds required for launch prior to commencement of operations, BHB has developed the following assessment (Table XIV) of anticipated expenses related to the building of a single UCC with 3,260 sq. ft. of usable space and 4,175 gross sq. ft. as described in an earlier section relating to facility design and a basic review of expected equipment costs.

Capital Requirements per UCC Site

Total Construction Cost	\$	3,246,605
Contingencies, Professional Fees, Management & Overhead, Equipment	\$	2,216,341
Total Project Costs		\$ 5,462,946
Construction Costs per Square Foot	\$	777.63
Project Costs per Square Foot	\$	1,308.49
Square Footage		4,175

Table XIV

Reimbursement Model

The reimbursement of the UCC's will use a flat fee charge based on similar ED visit charges. Based on existing hospital ED reimbursement charges a derived fee of \$262 is proposed as a per visit fee (this averages the costs of Level 1 – Level 3 visits) with expected fee growth of 5%. The reimbursement would remain consistent with similar visits at the KEMH ED, thus local payers should be willing to accommodate the fee.

Breakeven Analysis per UCC Site

Revenue per Case	\$	262.01
Cost per Case	\$	13.47
Contribution Margin	\$	248.54
Direct Costs	\$	1,914,607
Indirect Costs	\$	118,840
Total Costs	\$	1,976,647
Breakeven Quantity (Visits)		8,182

Table XV

Due to high fixed costs this reimbursement level will not cover the operating costs of each UCC. A breakeven analysis shows that each site must maintain 8,182 visits during which the demand forecast does not predict. The

lower volumes produced because of the small population in Bermuda does not produce the requisite revenue to support operating the UCCs. Based on the forecasted demand the cost per visit will greatly exceed the expected reimbursement per visit.

Cost per Patient Visit

Cost per Patient Visit	
West UCC	\$ 430
East UCC	\$ 493

Table XVI

A proposed government grant will cover the shortfall. The size of the grant is based on the expected operational shortfall with the expectation to of a break even cash flow for each UCC. The government grant will cover the operational loss, but ultimately serve to provide the community with greater access to care and improved clinical services.

Government Grant

	Year 1	Year 2	Year 3	Year 4	Year 5
West UCC	\$ 820,155	\$ 836,538	\$ 853,111	\$ 869,867	\$ 886,801
East UCC	\$ 979,434	\$ 979,434	\$ 979,434	\$ 979,434	\$ 979,434

Table XVII

Pro Forma

A Pro Forma has been generated for each UCC based on proposed Phase I operating hours (both revenue and expenses will change significantly for additional phases). A more detailed view of the revenue and expenses is available in the Appendix.

West UCC Pro Forma

WEST UCC	NET CASH FLOW ANALYSIS				
Line Item	Year 1	Year 2	Year 3	Year 4	Year 5
Patient Revenue					
Gross Revenue	\$1,279,043	\$1,326,109	\$1,374,907	\$1,425,501	\$1,477,956
Government Grant	\$820,155	\$836,538	\$853,111	\$869,867	\$886,801
Net Operating Revenue ¹	\$2,099,197	\$2,162,647	\$2,228,018	\$2,295,368	\$2,364,757
Operating Expense					
Salaries and Benefits	\$1,273,200	\$1,311,396	\$1,350,738	\$1,391,260	\$1,432,998
Variable Care Related Expenses	\$65,767	\$68,187	\$70,697	\$73,298	\$75,995
Other Non-Personnel Costs	\$95,351	\$98,212	\$101,158	\$104,193	\$107,319
Occupancy Costs	\$208,750	\$215,013	\$221,463	\$228,107	\$234,950
Repairs & Maintenance	\$40,500	\$41,715	\$42,966	\$44,255	\$45,583
Housekeeping	\$20,000	\$20,600	\$21,218	\$21,855	\$22,510

Communications	\$256,806	\$264,510	\$272,445	\$280,619	\$289,037
Miscellaneous	\$20,000	\$20,600	\$21,218	\$21,855	\$22,510
<i>Direct Operating Expense²</i>	\$1,980,375	\$2,040,233	\$2,101,904	\$2,165,441	\$2,230,903
Income from Operations³	\$118,822	\$122,414	\$126,114	\$129,926	\$133,854
<i>Indirect Expense⁴</i>	\$118,822	\$122,414	\$126,114	\$129,926	\$133,854
Total Expense⁵	\$2,099,197	\$2,162,647	\$2,228,018	\$2,295,368	\$2,364,757
Net Cash Flow⁶	\$0	\$0	\$0	\$0	\$0

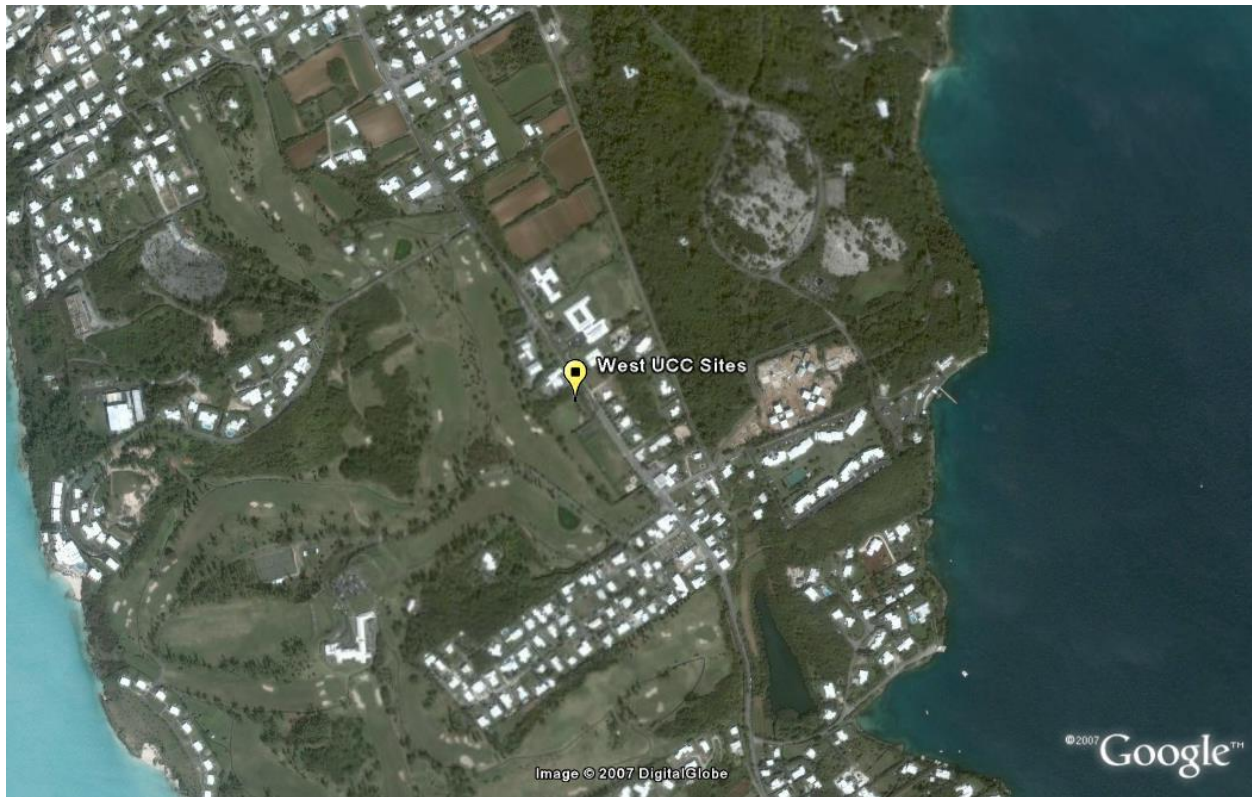
Table XVIII

East UCC Pro Forma

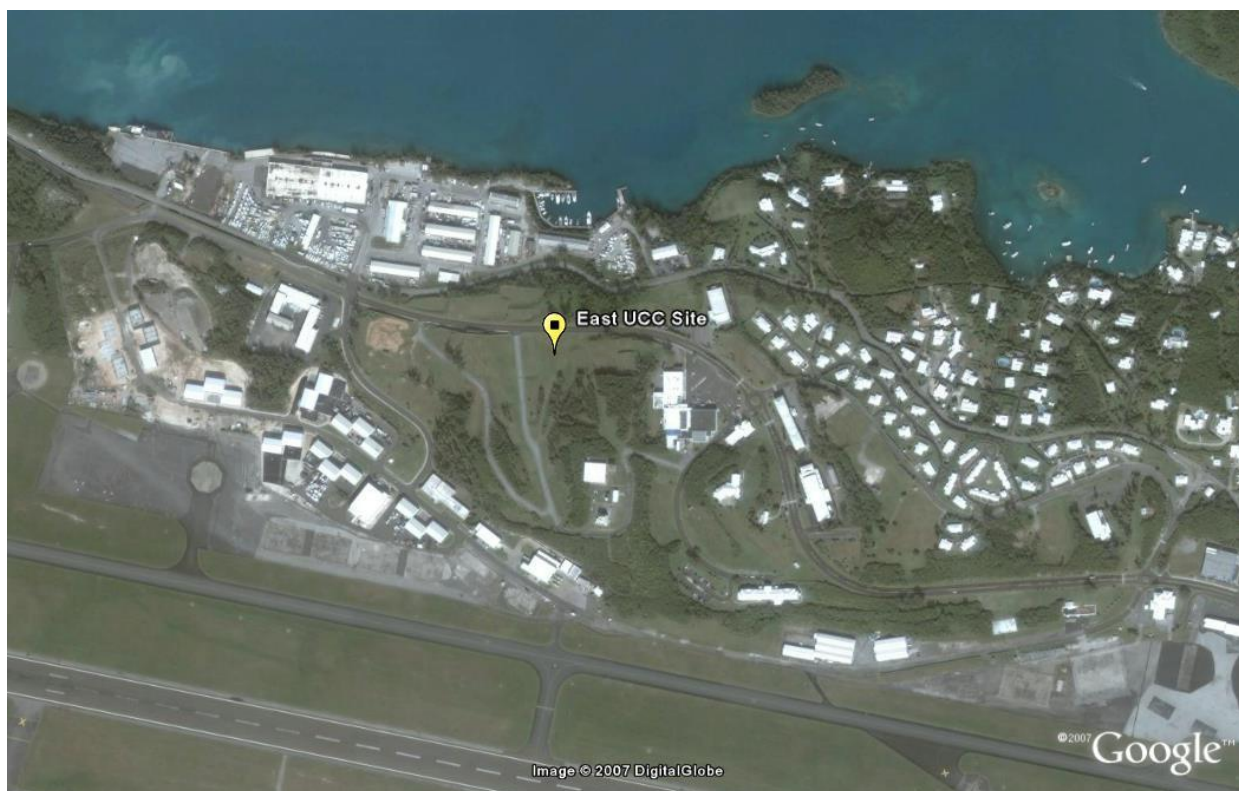
EAST UCC		NET CASH FLOW ANALYSIS				
Line Item	Year 1	Year 2	Year 3	Year 4	Year 5	
Revenue						
Patient Revenue	\$1,110,579	\$1,173,805	\$1,240,629	\$1,311,258	\$1,385,908	
Government Grant	\$979,434	\$979,320	\$977,516	\$973,874	\$968,236	
Net Operating Revenue ¹	\$2,090,013	\$2,153,125	\$2,218,145	\$2,285,132	\$2,354,144	
Operating Expense						
Salaries and Benefits	\$1,273,200	\$1,311,396	\$1,350,738	\$1,391,260	\$1,432,998	
Variable Care Related Expenses	\$57,103	\$59,204	\$61,383	\$63,642	\$65,983	
Other Non-Personnel Costs	\$95,351	\$98,212	\$101,158	\$104,193	\$107,319	
Occupancy Costs	\$208,750	\$215,013	\$221,463	\$228,107	\$234,950	
Repairs & Maintenance	\$40,500	\$41,715	\$42,966	\$44,255	\$45,583	
Housekeeping	\$20,000	\$20,600	\$21,218	\$21,855	\$22,510	
Communications	\$256,806	\$264,510	\$272,445	\$280,619	\$289,037	
Miscellaneous	\$20,000	\$20,600	\$21,218	\$21,855	\$22,510	
Direct Operating Expense ²	\$1,971,710	\$2,031,250	\$2,092,590	\$2,155,785	\$2,220,891	
Income from Operations ³	\$118,303	\$121,875	\$125,555	\$129,347	\$133,253	
Indirect Expense ⁴	\$118,303	\$121,875	\$125,555	\$129,347	\$133,253	
Total Expense ⁵	\$2,090,013	\$2,153,125	\$2,218,145	\$2,285,132	\$2,354,144	
Net Cash Flow ⁶	\$0	\$0	\$0	\$0	\$0	

V. Appendices

West UCC Site



East UCC Site



Services Offered

<p>Nursing Triage Physician Assessments</p>	<p>Potential Diagnoses</p> <ul style="list-style-type: none"> • Common illness • Respiratory illness • Allergies • Bladder infections • Eye/ear/sinus infection • Strep throat • Mononucleosis • Pregnancy testing • Skin rashes • Sport Injuries/sprains/strains Stabilization of
<p>Services</p>	<ul style="list-style-type: none"> • Emergency transfer to KEMH • Vital signs • IV Therapy (Antibiotic, Hydration) • EKG • Wound care • Immunizations, TD, Pneumovax, Flu Vaccines
	<p>Minor procedures</p> <ul style="list-style-type: none"> • Incision and draining of abscess • Excision of skin • Aspiration of cyst • Sutures

	Lab Services <ul style="list-style-type: none"> • Blood • Urine • Other
	Diagnostic Imaging <ul style="list-style-type: none"> • Ultrasound • X-ray

Operating Model - Phased Operating Hours

	Phase I	Phase II	Phase III	Phase IV
Monday – Friday Hours	8	16	20	24
Saturday & Sunday Hours	10	16	20	24
Hours of Operation per Week	5 PM- 1AM (M-F) 10AM – 8 PM (Sat. & Sun)			
Total Operating Hours	60	112	140	168

Financial Analysis - Detailed

	West UCC	East UCC
OPERATING HOURS		
Monday - Friday Hours	8	8
Saturday & Sunday Hours	10	10
Hours of Operation per Week	5PM - 1AM M-F 10AM-8PM Sat. & Sunday	5PM - 1AM M-F 10AM-8PM Sat. & Sunday
Total Operating Hours	60	60
REVENUE		
FORECASTED VOLUME		
Adjusted Demand Forecast	4,881.84	4,238.69
Visits per Month	406.82	353.22
Visits per Week	93.88	81.51
Visits per Day	13.37	11.61
PATIENT REVENUE		
Payer Reimbursement	\$ 1,279,043	\$ 1,110,579
Fee per Visit	\$ 262	\$ 262
ADJUSTMENTS		
Government Grant	\$ 820,155	\$ 979,434
Total Revenue	\$ 2,099,197	\$ 2,090,013

	West UCC			East UCC		
OPERATING EXPENSES						
STAFFING						
	FTE	Salary	Total	FTE	Salary	Total
Physicians	2.0	\$ 200,000	\$ 400,000	2.0	\$ 200,000	\$ 400,000
Nurses	2.0	\$ 80,000	\$ 160,000	2.0	\$ 80,000	\$ 160,000
Physicians Assistant	2.0	\$ 80,000	\$ 160,000	2.0	\$ 80,000	\$ 160,000
Radiology Technician	2.0	\$ 63,000	\$ 126,000	2.0	\$ 63,000	\$ 126,000
Medical Assistant/Receptionist	2.0	\$ 55,000	\$ 110,000	2.0	\$ 55,000	\$ 110,000
Medical Director	1.0	\$ 25,000	\$ 25,000	1.0	\$ 25,000	\$ 25,000
IT Support	0.5	\$ 80,000	\$ 40,000	0.5	\$ 80,000	\$ 40,000
Subtotal	\$		1,021,000	\$		1,021,000
Benefits as Percentage of Salary			20%			20%
Housing Allowance	\$		48,000	\$		48,000
Total Wage and Salary Cost	\$		1,273,200	\$		1,273,200
OCCUPANCY COSTS						
Utility Costs	\$		208,750	\$		208,750
Repair & Maintenance	\$		40,500	\$		40,500
Housekeeping	\$		20,000	\$		20,000
Communication						
Internet	\$		240,000	\$		240,000
Phone Service	\$		16,806	\$		16,806
Miscellaneous / Other	\$		20,000	\$		20,000
Total Occupancy Costs	\$		546,056	\$		546,056
SUPPLIES						
Variable Medical Supply Costs	\$		65,767	\$		57,103
Other Non-Personnel Costs	\$		95,351	\$		95,351
Total Supply	\$		161,119	\$		152,454
Direct Operating Expense	\$		1,980,375	\$		1,971,710
				Phase I		
INDIRECT EXPENSE						
Management Overhead	\$		118,822.49	\$		118,303
Total Expense	\$		2,099,197	\$		2,090,013
Costs per Visit	\$		430	\$		493
PROFITABILITY						

Operating Income	\$	-	\$	s	-
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