Advocate Health Care
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May 22, 2017

Ms. Kathryn Olson
Illinois Health Facilities and Services Review Board
525 West Jefferson Street, 2nd floor
Springfield, Illinois 62761

Re: Opposition to Mercy Micro Hospital, #17-002

Dear Ms. Olson,

It is my professional opinion that the proposed Crystal Lake hospital project is significantly oversized for the number of IP beds and volume of outpatient services to be rendered as described in the CON Application. My career spans more than 30 years as an Architect, focused exclusively on healthcare planning, design and construction.

By my analysis of the information contained in the CON Application, other similarly sized hospitals developed by peers in multiple states and my own personal healthcare planning experience, it appears that the chassis (that is the non-clinical space) of the Crystal Lake facility is excessive for the planned clinical service volumes. The non-clinical/support space (e.g., administrative, admitting, pharmacy, dietary, laundry, materials management,) is larger than the clinical space (e.g., inpatient beds, emergency room, imaging department, laboratory and surgical suite). The non-clinical space (68,148 sf) comprises more than 60% of the facility. This high percent of non-clinical space is rarely found in any medical facility: typical hospital, micro hospital or even an ambulatory/outpatient facility. I wonder how this facility can be considered cost effective with such a large amount of non-clinical space. I also wonder if the overly large non-clinical space, the chassis, is being built to be large enough to accommodate more beds (maybe observation beds) and more operating rooms and ancillary services. This size non-clinical space (chassis) would be more than capable of supporting a 60 bed hospital and potentially up to a 74 bed hospital.

A few examples of the seemingly large allocation of non-clinical space are the administration/conference room space at 9,318 sf and the storage at 6,677 sf.

Not only is the large amount of non-clinical space driving up the cost, the medical equipment cost ($28M) for the planned services is much higher than expected. As an example, the $11.5M for the surgical suite with two ORs, two procedure rooms and PACU, prep/recovery bays seems unwarranted, even for a full-service hospital.

A recent article on micro hospitals (which is attached) shows that micro hospitals with 8-10 beds plus operating rooms, emergency services, imaging services (a scope of services similar to that proposed by Mercy) average 15,000 sf to 50,000 sf at a cost of $7M to $30M. The proposed Mercy Hospital is planned to be more than twice the size and more than twice the cost.

At a time when most providers are looking for options to limit unnecessary and excessive costs, I wonder about the design efficiency and future plans for this facility.

Sincerely,

Scott Nelson, AIA, ACHA
Vice President, Planning, Design & Construction

SN/md

Advisory Board

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At the Margins

To grow your hospital, think micro

1:28 PM on May 20, 2016 by **Kalyn Saulsberry**

As hospitals and health systems consider growth opportunities, we've increasingly heard from our members that traditional facility options such as ambulatory centers, urgent care sites, and freestanding EDs are not always sufficient. Most ambulatory centers don't offer a complete breadth of services while full-scale hospitals often offer more than the community needs. Micro-hospitals are emerging as a middle ground.

Micro-hospitals are 24/7, small-scale inpatient facilities—around 15,000 to 50,000 square feet—with between eight and ten inpatient beds for observation and short-stay use. No two micro-hospitals are exactly the same in their design or service mix, but one trend is becoming clear. Most health systems are using them as entry points into markets where demand would not be able to support a full-scale hospital.

Here are answers to questions we get frequently asked about investing in a micro-hospital.

Where should I build a micro-hospital?

Micro-hospitals work best in markets that have service gaps, but do not have enough demand to support a full-service facility. Even though micro-hospitals can treat some high-acuity needs when necessary, locating the micro-hospital within 18 to 20 miles of a full-service hospital is a good rule of thumb to ensure a seamless transfer process for high-acuity needs to a larger facility.

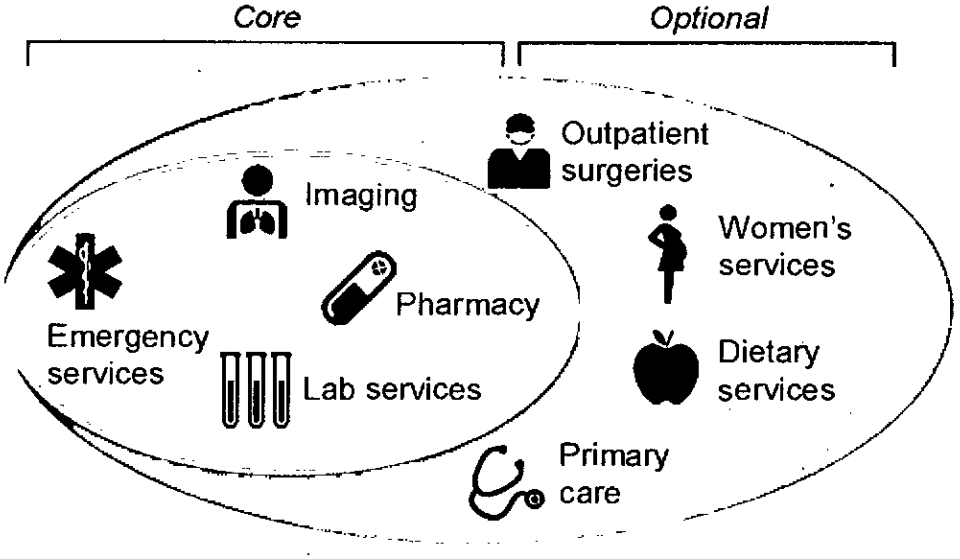
Also, systems should assess the state's certificate of need processes as these can determine whether or not you can build a micro-hospital. At this time, micro-hospitals have only been developed in states without certificate of need laws.

What services should be in a micro-hospital?

The goal of a micro-hospital is not to be "all-things-to-all-people." System leaders implementing these facilities are aiming to meet up to 90% of the care needs of the community it serves. Hospital stays longer than 48 hours are sent to higher-acuity settings. While the ancillary services vary, each micro-hospital has a set of core services including the emergency department, pharmacy, lab, and imaging. The rest of the services depend on the needs of the community, but common examples include primary care, dietary services, women's services, and low-acuity outpatient surgeries.

With such a variety of services, there is no standard way to staff a micro-hospital. In general, micro-hospitals avoid overstaffing the site with high-acuity employees who are more appropriate for larger sites. One of the health systems we spoke with, SCL Health, staffs their micro-hospitals with board-certified emergency physicians and nurses.

Key Features of Micro-hospitals



How much does a micro-hospital cost?

Typically, micro-hospitals are located in retail or similarly easily accessible locations, as they are aimed at providing at a better consumer experience. Land in these spaces can be expensive. Although the cost varies depending on the number and type of ancillary services offered, building a micro-hospital costs between $7M and $30M.

How do I get started?

Providers can either choose to partner with an existing micro-hospital developer or choose to build these using existing internal facility development capabilities. SCL Health, Baylor Scott & White, and Dignity Health have all chosen to work with an external partner. However, independently building a micro-hospital can save capital and give the organization more flexibility to align the micro-hospital with the organization's unique priorities. CHRISTUS Health plans to build a micro-hospital with its own resources to fill service gaps in an area rich in outpatient services, but lacking inpatient facilities.

What the hospital of the future looks like

To achieve acute care sustainability, organizations have to shift their focus to the challenge with the greatest savings potential: fixed costs. This white paper shares tactics for significantly restructuring fixed costs by reallocating services across the system and rightsizing excess inpatient capacity.

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