STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION

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TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: March 21, 2019

SUBJECT: Adventist Rehabilitation Hospital of Maryland
Docket No. 18-15- 2428

Enclosed is the staff report and recommendation for a Certificate of Need ("CON") application filed by Adventist Rehabilitation Hospital of Maryland, Inc. d/b/a Adventist HealthCare Rehabilitation ("Adventist Rehabilitation Hospital" or "ARH"), a special rehabilitation hospital, and Adventist HealthCare Washington Adventist Hospital ("WAH"), a general hospital located in Takoma Park (Montgomery County).

ARH operates at two locations, a 55-bed facility in Rockville, MD and a 42-bed facility located within Washington Adventist Hospital ("WAH") in Takoma Park. It provides inpatient and outpatient rehabilitation services, including comprehensive rehabilitation programs for traumatic brain injury, spinal cord injury, stroke, amputation, orthopedic injury and post-surgical rehabilitation, and sports and work-related injury.

It proposes the relocation of the Takoma Park ARH operation to a new hospital campus under development in the White Oak area of Silver Spring. A general hospital replacing WAH was approved in 2015 and is under construction at this campus. ARH is seeking authorization to relocate 42 rehabilitation beds to two floors of new building space atop a wing of the replacement general hospital. The proposed additional floors would total almost 39,000 SF would be added to a five-level south building wing of the general hospital. Each floor would accommodate 21 private patient rooms and hold the appropriate support spaces required for acute rehabilitation programs.

The estimated cost for construction of the two floors is $19,547,323 and would be funded with cash.

Staff concludes that the proposed project complies with the applicable State Health Plan standards and that the need for the project, its cost effectiveness, and its viability have been demonstrated, and therefore recommends **APPROVAL** of the project, subject to a condition designed to bring ARH into conformance with Maryland hospital licensure regulations and will conform data reporting and regulatory oversight of this hospital to the actual nature of its operation as two distinct hospitals operating on separate campuses located miles apart. The recommended condition is:

> **Prior to first use approval, Adventist Health Care will obtain two separate special hospital licenses for the ARH rehabilitation hospital facilities in Rockville and the ARH rehabilitation hospital facilities in Takoma Park.**

IN THE MATTER OF	*	**BEFORE THE**
ADVENTIST REHABILITATION	*	**MARYLAND**
HOSPITAL OF MARYLAND, INC.	*	**HEALTH CARE**
Docket No. 18-15-2428	*	**COMMISSION**

* *

Staff Report and Recommendation

March 21, 2019

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I. INTRODUCTION

The Applicants

The applicants in this review are Adventist Rehabilitation Hospital of Maryland, Inc. d/b/a Adventist HealthCare Rehabilitation ("Adventist Rehabilitation Hospital" or "ARH"), a special rehabilitation hospital located in Rockville, Maryland (Montgomery County), and Adventist HealthCare Washington Adventist Hospital ("WAH" or "AHC"), a general hospital located in Takoma Park, Maryland (Montgomery County). Both of these entities are subsidiaries of Adventist HealthCare, Inc. ("Adventist"). In addition to ARH and WAH, Adventist operates a second general hospital, AHC Shady Grove Medical Center, in Rockville, a freestanding medical facility, AHC Germantown Emergency Center, in Germantown, and a home health agency, AHC Home Health. It also operates a variety of outpatient diagnostic and treatment centers and physician groups.

ARH operates on two premises with a single license, contrary to Maryland Department of Health licensure regulations.[1] ARH operates at two locations, a 55-bed facility in Rockville and a 42-bed facility located within Washington Adventist Hospital ("WAH") in Takoma Park.

ARH provides inpatient and outpatient rehabilitation services, including comprehensive rehabilitation programs for traumatic brain injury, spinal cord injury, stroke, amputation, orthopedic injury and post-surgical rehabilitation, and sports and work-related injury.

The Project

The project is the relocation of the Takoma Park ARH operation to a new hospital campus under development in the White Oak area of Silver Spring. A general hospital replacing WAH was approved in 2015 and is under construction at this campus. ARH is seeking authorization to relocate 42 rehabilitation beds to two floors of new building space atop a wing of the replacement general hospital. The proposed additional floors would each be 19,432 square feet ("SF") in size and would be added to a five-level south building wing of the general hospital. This building component has been designed for this type of vertical expansion and has the structural, mechanical, electrical, and plumbing systems needed for the proposed project.

Each floor would accommodate 21 private patient rooms and hold the appropriate support spaces required for acute rehabilitation programs. The estimated cost for construction of the two floors is $19,547,323 and would be funded with cash. (DI#2, pp. 3-5 and p.19; DI#9, Table E).

Project Budget

Capital Costs		
New Construction	$13,448,000	

[1] COMAR 10.07.01.06 states that separate licenses are required for institutions maintained on separate premises, even though both institutions are operated under the same management.

Building		
Fixed Equipment		
Site and Infrastructure		
Architect/Engineering Fees	$1,626,480	
Permits (Building, Utilities, Etc.)	$289,152	
SUBTOTAL	**$15,363,632**	
Other Capital Costs		
Movable Equipment		
Contingency Allowance	$984,641	
Gross interest during construction period		
Other (Specify/add rows if needed)		
Inspections & Certifications	$250,000	
Security / IT / Comm / Signage, etc	$2,197,050	
SUBTOTAL	**$3,431,691**	
TOTAL CURRENT CAPITAL COSTS	**$18,795,323**	
Land Purchase		
Inflation Allowance	$752,000	
TOTAL CAPITAL COSTS	**$19,547,323**	
TOTAL USES OF FUNDS	**$19,547,323**	
Source of Funds		
Cash	$19,547,323	

Background

Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital received a Certificate of Need ("CON") in December of 2015 to construct a replacement hospital in the White Oak area of Silver Spring. That CON authorized Adventist HealthCare, Inc. ("AHC" or "Adventist") to relocate and replace WAH, with the exception of acute psychiatric inpatient services. It also did not include relocation of the separately licensed AHR medical rehabilitation facility. The new hospital campus is approximately 6.6 miles from the existing Takoma Park campus. As originally approved, WAH's acute inpatient psychiatric beds were to remain in the WAH building and become a special psychiatric hospital and ARH, a tenant in WAH, was to remain in that location as well. The approved total project cost was $336,053,030 and included $5,223,506 for the renovation/expansion of the existing inpatient psychiatric unit.

Subsequently, WAH requested and received approval of two requests for a Project Change after CON Approval ("modification").

The first modification in September 2017 authorized WAH to expand the project to include a central utility plant ("CUP") and parking garage.[2] These changes increased the approved cost of the project by approximately $64 million, to $400,198,988.

[2] The original plan did not include construction by WAH of a CUP to provide heating and cooling for the hospital facilities on the relocated hospital campus, but instead assumed that the CUP would be developed and operated by a third party from whom WAH would purchase the utility services needed.

The second modification authorized Adventist to relocate ten of the acute psychiatric beds to the replacement WAH,[3] and was accompanied by an Exemption-from- CON Review request to consolidate the balance of Adventist's psychiatric hospital facilities within Shady Grove Medical Center in Rockville. Adventist characterized these moves as part of a larger strategy to ensure the stability and viability of its behavioral health service operations.

These changes would leave ARH as the lone tenant in the current WAH facility, with the exception of an urgent care center that is to be established as a condition of the CON authorizing the relocation of WAH. ARH maintains that it "cannot sustain its infrastructure with the carrying costs of an aging building on the Takoma Park campus once WAH moves to its new location in White Oak." (DI#2, p.4).

Staff Recommendation

Staff recommends conditional approval of the project. This recommendation is based on its finding that the proposed project complies with the applicable State Health Plan standards and general CON review criteria, that the need for the project, its cost effectiveness, and its viability have been demonstrated. Staff also concludes that the impact of the project is positive. A summary of the basis for this recommendation is outlined in the following table.

The condition recommended for this CON approval is that Adventist HealthCare, Inc. will obtain two separate special hospital licenses for the ARH facilities at Rockville and the ARH facilities at Takoma Park, prior to first use approval of this project. This will bring licensure of the rehabilitation hospital facilities into conformance with Maryland hospital licensure regulations and will conform data reporting and regulatory oversight of this hospital to the actual nature of its operation as two distinct hospitals operating on separate campuses located miles apart.

Criteria/Standard	Conclusions
Need and Capacity	The driver of the project is the applicant's need to reduce the overhead costs that would fall on ARH when it becomes the sole occupant of the facility in which it currently resides. ARH seeks to relocate its current 42 beds, and would not add capacity. Its need projection for its 42 inpatient rehabilitation beds is based on reasonable assumptions, is consistent with the need methodology in the State Health Plan, and is aligned with the bed need projections promulgated by the Maryland Health Care Commission in April 2018. Access will be enhanced by the all-private bed configuration, which eliminates the need to delay or re-route rehabilitation patients due to incompatible clinical conditions, infection risk, or gender matching.

[3] This modification authorized the relocation of 10 adult psychiatric beds from Takoma Park to White Oak, into shell space that was authorized as a component of the replacement hospital in 2015. The estimated cost for finishing that shell space was approximately $3.3 million, and utilized the $5.2 million that was approved as an element of the 2015 CON.

Cost Effectiveness	ARH provided an analysis comparing the selected alternative – adding two floors to the new WAH – to two alternatives: remaining in Takoma Park in its current location; and consolidating all of its beds at its other campus in Rockville. The applicants' analysis found both of these alternatives to be considerably more costly.
Financial Feasibility and Viability	The applicant has provided reasonable assumptions and utilization assumptions that are consistent with historic trends, and revenue projections that are consistent with its current experience. Its plan to move its operation to WAH at White Oak projects to continue profitable operation. However, if ARH were to remain on the Takoma Park campus after other services vacate, ARH's costs for ancillary services would increase and it would have to assume all campus depreciation costs, leading to multi-million dollar losses. The net swing between staying in Takoma Park and moving to the new WAH is more than $5 million.
Impact	The project is not expected to have a significant impact on other acute inpatient rehabilitation providers. ARH expects its referrals to come from the same sources that have historically referred patients to ARH, and does not assume significant shifts in market share from other existing rehabilitation providers to ARH. At the same time it is expected that the proposed relocation will enhance access to services because the White Oak facility would be considerably easier to access for those traveling by both private and public transportation. In addition, its all-private-room design will eliminate its need to deny some admissions because of incompatible clinical conditions, infection risk, or gender matching. It should be able to operate at a marginally higher bed occupancy rate. The proposed project should have a positive impact on access and ARH operational efficiency without having any significant negative impact on other providers of the service.

II. PROCEDURAL HISTORY

A. Review of the Record

See Appendix 1.

B. Interested Parties in the Review

There are no interested parties in the review.

C. Local Government Review and Comment

No comments on this application were received from the Montgomery County Health Department.

D. Community Support

Letters supporting the project were submitted by the Executive Director of the Brain Injury Association of Maryland, the Chair of the LabQuest Partnership (described by the Chair as "the lead coordinating body and information clearinghouse for all interested parties in support of the development of the Federal research Center at White Oak"), the Executive Director of CASA, an advocacy group described on its website as "working to organize, advocate for, and expand opportunities for Latino and immigrant people in the state of Maryland," as well as a social worker from Suburban Hospital and a physiatrist from Holy Cross Hospital.

III. REVIEW AND ANALYSIS

The Commission is required to make its decisions in accordance with the general CON review criteria at COMAR 10.24.01.08G(3)(a) through (f). The first of these six general criteria require the Commission to consider and evaluate this application according to all relevant State Health Plan standards and policies.

A. STATE HEALTH PLAN

COMAR 10.24.01.08G(3)(a) State Health Plan.
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant chapter of the State Health Plan is COMAR 10.24.09: State Health Plan for Facilities and Services: Specialized Health Care Services – Acute Inpatient Rehabilitation Services ("Rehabilitation Services Chapter"). Adventist Rehabilitation Hospital was also asked to respond to applicable standards in the State Health Plan Chapter for Facilities and Services: Acute Care Hospital Services ("Acute Care Chapter") in COMAR 10.24.10 because space for this special hospital is proposed to be added to the general hospital that is currently under construction as a replacement for WAH. ARH would essentially be a tenant of WAH, an affiliated hospital. The applicant responded only to those standards from the Acute Care Hospital Services Chapter that were considered relevant and not redundant with similar or identical standards in COMAR 10.24.09.

COMAR 10.24.10 - State Health Plan for Facilities and Services: Acute Care Hospital Services

A. General Standards

(3) Quality of Care.
An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

WAH provided documentation of being licensed in good standing and accredited by the Joint Commission. It also stated that it is in compliance with the conditions of participation of the Medicare and Medicaid programs. (DI #2, p.48 and Exh. 18 and 19).

Staff concludes that the standard has been met.

B. Project Review Standards

(4) Adverse Impact.
A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

The applicant states that this proposed project will not have an unwarranted adverse impact on hospital charges, while enhancing the availability and accessibility of acute inpatient rehabilitation services, as well as the continuity of care for patients requiring acute rehabilitation following an acute care stay at WAH. The applicant asserts that geographic accessibility will be improved over the current Takoma Park location given its proximity to major roadways and access to public transportation. (DI #2, p. 50).

Staff concludes that the standard has been met.

(5) Cost-Effectiveness.

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

In its application the applicants identified the primary objectives of this project as the creation of the most effective treatment setting for ARH to provide acute rehabilitation services and maximization of its ability to share resources between WAH and ARH.[4] The alternatives considered were: (1) maintaining ARH's services on the Takoma Park campus; or (2) relocating and consolidating all of ARH's beds on the Rockville campus, adding to the 55 beds in operation there.

The applicants stated that maintaining ARH's operations on the Takoma Park campus would be difficult because it would be left as the only inpatient service remaining on that campus. This was identified as a problem because ARH depends on a number of clinical and ancillary services (such as medical consults, pharmacy, laboratory, housekeeping, and dietary, among others) provided by WAH that would not be available after WAH moves to White Oak. In this

[4] MHCC staff notes that the stated objective of *maximizing the sharing off resources between ARH and WAH* is not a project objective that allows for consideration of any alternative to this project with the exception of operating one special rehabilitation hospital at one location in Montgomery County which would be the White Oak campus. Therefore staff has discounted this objective as a basis for evaluating the costs and effectiveness of alternatives. Staff does believe that the applicant has fairly evaluated its selected alternative against the alternative of consolidating all of its rehabilitation facilities in Rockville.

scenario, ARH claims that it would have to contract for these services at a higher cost; conversely, moving ARH to White Oak would allow it to contract with WAH for those services more cost effectively. Staff notes that the separation of ARH and WAH was not identified as creating any insurmountable or particularly costly problems in 2015 when AHC proposed this separation. In 2015, AHC was proposing to operate two special hospitals on the Takoma Park campus, ARH and a special psychiatric hospital and this plan for a second special hospital has already been abandoned by AHC, in favor of creating a small adult psychiatric unit in the replacement hospital and consolidating all of the remaining psychiatric hospital facilities of AHC at its Rockville general hospital campus.

Another consideration is that continuing to operate this service in Takoma Park would substantially decrease the options for the future use or disposition of the Takoma Park campus. (DI #2, p. 50).

ARH also considered the alternative of consolidating all of its acute rehabilitation beds on the Rockville campus. In response to staff completeness questions seeking a more detailed description of its analysis of this option, the applicants conceded that there indeed might be operational efficiencies associated with relocating the Takoma Park beds to the Rockville campus where all staff are combined at one site rather than two locations. They stated, however, that this potential is outweighed by several "major drawbacks to relocating the Takoma Park beds to Rockville," including:

- Consolidating at the Rockville location would move the rehabilitation beds entirely out of the Takoma Park facility's service area, which the applicants maintain would be a significant issue given the mobility issues that many patients must contend with;
- Construction of additional space on the Rockville campus is problematic. Structural limitations of the existing building prevent adding additional floors on top of the facility, and given the space limitations of the campus, "significant expansion would require construction of three, three-story towers yielding approximately 60,000 square feet of new construction on space currently used as parking for patients, visitors and staff. This would leave the facility with no on-site parking."
- The estimated cost for such a project is estimated at $40 million, double the cost estimate of adding the beds at WAH, and does not include additional costs to renovate the existing Rockville facility to expand the gymnasium to accommodate the additional patients, nor does it include the cost of finding a new parking solution. Necessary renovation of the existing ARH Rockville facility would add an estimated $14.1 million. (DI #9, pp. 23, 24).

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

WAH states that the project is located within a Priority Funding Area.

Staff concludes that the applicants have presented a credible examination of alternatives and selected the one that is most cost effective.

(11) Efficiency.

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

The applicants gave several examples of how the proposed relocation of their inpatient rehabilitation facility has been designed for efficiency, including:

- The patient units are designed with a central nurse station that can serve both corridors, allowing physicians, nutritionists, pharmacists and others to support both sides of the all-private room unit with relatively short walking distances;
- Having an entirely private room facility will allow private consultations between patients and clinicians to occur in the patient's room, eliminating the need to move to a private space in which to hold such a conversation;
- Unit design supports electronic health records (EHR) systems implementation throughout the unit, and provides clinicians with easy access to computers; and
- Overhead patient lift tracks will be installed in patient bedrooms, significantly reducing the need for staff to retrieve a mobile patient lift when such needs arise.

Staff concludes that the applicants have met the efficiency standard.

COMAR 10.24.09 — State Health Plan for Facilities and Services: Specialized Health Care Services – Acute Inpatient Rehabilitation Services

10.24.09.04 Standards.

A. General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient

rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

AHC provided a copy of its financial assistance policy. (DI # 2, Exh. 7). Its alignment with the subparts of this standard is addressed in order, below.

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

AHC's policy states that "Probable eligibility will be communicated to the patient within 2 business days of the submission of an application." (DI # 2, exh. 7 at section 3.3.1). Responding to questions from staff, AHC described its procedure for accepting and acting on an "application" with submission of the document inserted below. (DI #18).

Determination of Probable Financial Assistance Eligibility Workflow
Adventist HealthCare, Inc.
(Shady Grove Medical Center, Washington Adventist Hospital, Adventist HealthCare Rehabilitation, Germantown Emergency Center)

When pre-determining probable Financial Assistance Program (FAP) Eligibility, our Patient Access team does the following:

1) For Self-proclaimed financial need:
   - Request family size and family income from the patient or patient family member
     - If there is no income, determine how patient pays living expenses
     - If homeless, utilize appropriate program
     - Medicaid linkage
       - If Medicaid approved, assume Medicaid coverage
       - If Medicaid denied, check for FAP linkage
   - Compare family size and income to FAP financial eligibility criteria
   - Inform patient of probable financial assistance coverage based on financial assistance sliding scale (see below) at the time request is made.

2) For Patients demonstrating financial need (inability to pay patient liability), the full FAP process is utilized to determine final eligibility:
   - Inform of AHC FAP process
   - If patient shows interest and consents, begin final FAP eligibility process according to AHC Policy 3.19.
   - If patient declines, begin financial counseling process to determine payment plan options.

Staff concludes that AHC's approach to determining probable eligibility complies with this subpart of the standard.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's

charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

ARH states that Notices of the availability of financial assistance are posted in English and Spanish at prominent locations in the ARH Registration/Admissions Department and business offices. The charity care policy is made available to patients during the preadmission and/or admission process. Public notice of a nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Washington Post and El Tiempo Latino, a daily Spanish-language newspaper circulated in the Washington metropolitan area. (DI#2, p.15).

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands.

AHC's criteria for eligibility provides for families with up to 200% of the federal poverty guideline to receive services at no cost. At 225% of the federal poverty guideline families are responsible for 10% of the cost. Discounts continue up to 600% of the of the federal poverty guideline, at which point the family is responsible for 95%.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Citing the May 1, 2018 *Maryland Hospital Community Benefit Report FY 2017,* The applicant responded that WAH provided a total net community benefit of 12.13% of operating expenses – the 6th highest amount of net community benefit for all hospitals in Maryland.

Staff notes that this standard measures a hospital's performance on charity care rather than on total community benefit. The same HSCRC report shows WAH ranking as the sixth highest in charity care as a per cent of operating expenses.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy,

which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

This section of the standard is not applicable, as ARH is proposing to relocate its acute inpatient rehabilitation hospital, not to establish or expand one.

Staff concludes that the applicant complies with the charity care policy standard.

(2) Quality of Care.
A provider of acute inpatient rehabilitation services shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(ii) Accredited by the Commission for Accreditation of Rehabilitation Facilities.

(iii)In compliance with the conditions of participation of the Medicare and Medicaid programs.

AHR documented compliance with Parts (a)(i) and (iii) of this standard, as noted earlier in this report, with respect to the identical General Standard found in COMAR 10.24.10. It documented that it is accredited by the Commission for Accreditation of Rehabilitation Facilities ("CARF"). (DI # 2, pp.15,16 and Exh. 11 and 12).

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

This standard does not appear to be directly applicable to the proposed project. ARH is not proposing to establish a new facility at a new location. It is proposing to relocate its existing facility and the facility will have the same bed capacity that ARH currently operates.

ARH reported that over the twenty-four month period ending on September 30, 2017 its 30-day post-discharge readmission rate was 3.75% compared to a 6.01% national average for

inpatient rehabilitation facilities. It also reported that its rate of "falls with injury" and it incidence rate for two hospital-acquired infections, methicillin resistant staphylococcus aureus and clostridium-difficile were lower than both the weighted regional and weighted national averages. (DI #15).

Staff concludes that the quality standard is met.

B. Project Review Standards.

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access.

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

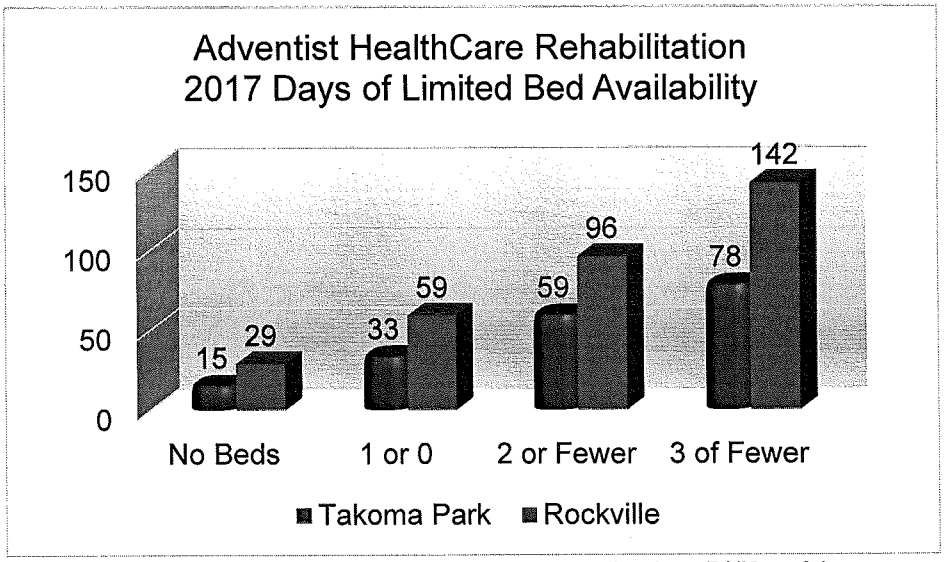
ARH points out that the proposed project is the relocation of an existing facility to a site about 6.6 miles from its current location. ARH posits that the project would enhance access to the population that ARH currently serves. Its new location is easier to access, stating that the current Takoma Park site is located in a residential area that is accessible only via "narrow, two-lane residential streets...[that are] difficult for patients and employees to access [while] ...the WAH replacement hospital site is ... accessible to major interconnecting roadways, such as, Interstate 95, New Hampshire Avenue, Route 29 and Cherry Hill Road." Further, ARH states that the Inter County Connector "has a major connecting intersection just 1 mile north of the proposed White Oak campus located along Route 29 and Interstate 95... [and]...is serviced by Metrobus and Montgomery County plans to extend its Ride-On bus #10 to service the new site." (DI #2, p.20).

ARH also notes that the relocated hospital will have 42 private rooms, while the current facility includes mostly semi-private rooms.[5] The effective capacity of the Takoma Park facility is reduced by the inability to always use both beds in a semi-private room when there is demand for bed capacity due to incompatible clinical conditions, infection risk, or gender matching. ARH states that when a patient bed is 'blocked' in this way, a rehabilitation admission must sometimes be delayed or the patient referred to a more distant facility.

[5] The existing facility has 10 private rooms and 16 semi-private rooms.

ARH states that it "closely coordinates" services between its Rockville and Takoma Park facilities, so that if a patient requiring acute rehabilitation cannot be accommodated on one campus, an effort is made to accommodate admission at the other campus. There is often limited flexibility to accommodate patients on either campus because the Rockville facility has just one private room. The applicant provided a graphic on the number of days in 2017 on which it had limited bed availability (see Figure 1 below).

Figure 1: Adventist HealthCare Rehabilitation - Days of Limited Bed Availability in 2017



Source: AHR internal records as shown in CON application, DI#2, p.21.

ARH also provided information on the number of admissions that were denied for lack of an available bed, as shown in Table III-1.

Table III-1 Adventist HealthCare rehabilitation Denials of Admission Due to Lack of Beds

	2015	2016	2017	2018*
Rockville	79	63	42	53
Takoma Park	18	32	16	5
Total	97	95	58	58

*Includes four and a half months of FY2018.
Source: AHR internal records as submitted in CON application, DI#2, p. 21

Staff concludes that this project will enhance access to inpatient rehabilitation services. It would replace a longstanding program with one housed in a more modern facility, meeting the current design standard for patient rooms. Its private room configuration will eliminate the need to delay or re-route rehabilitation patients because of difficulty in fully utilizing semi-private rooms.

(2) Need.

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health

planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

Part (a) is not applicable. AHR is not proposing to establish or expand an adult acute inpatient rehabilitation service.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

ARH assumes that out-migration from Montgomery County will be reduced as a result of relocating the Takoma Park component of ARH to a more accessible location for Montgomery County residents and building a more efficiently configured physical plant that will eliminate the use of semi-private beds and have expanded gym space. ARH does not anticipate that in-migration will change substantially as a result of the move. The vast majority of ARH patients come from Montgomery and Prince George's counties. ARH expects to continue to serve patients from Prince George's County after relocation and that other in-migration is expected to remain at historical proportions. (DI #2, p. 34).

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

Part (c) is not applicable. The bed need projection for Montgomery County does not include an adjustment to account for out-migration exceeding 50 percent of acute rehabilitation discharges for residents of the health planning region.

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

Part (d) is not applicable. This project is not seeking to establish or expand adult acute rehabilitation beds in the health planning region.

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

ARH stated that it does not propose a specialized program for pediatric patients and is already accredited to offer specialized programs for patients with brain and spinal cord injuries.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

Part (f) is not applicable. ARH does not propose to add acute rehabilitation beds or establish a new facility. It proposes to relocate the existing ARH facility in Takoma Park to the site of the replacement WAH in Silver Spring.

Staff believes that the proposed project is consistent with the applicable parts of the Need standard.

(3) Impact.

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

ARH states that it does not anticipate that the project will have a significant impact on other acute inpatient rehabilitation providers. ARH explains that it expects its referrals to come from the same sources that have historically referred patients to ARH does not assume significant shifts in market share from other existing rehabilitation providers to ARH. (DI #2, p. 36). ARH projects that 50, 60, and 70 additional patients would be drawn to AHR at White Oak in 2020, 2012, and 2022 respectively. For those three years, it projected that a total of 180 discharges out of 2,704 total discharges (6.7%) would come from District of Columbia hospitals. (DI #2, p. 33).

Referring to the inpatient rehabilitation programs at George Washington University Hospital and MedStar National Rehabilitation Hospital, AHR cited the number of patients these hospitals served from its defined service area in 2016 and projected the number of those patients it expected would have been "redirected" to its proposed White Oak facility if it had been in operation. (See Table: III- 2).

Table: III- 2: D.C. Providers' Acute Rehabilitation Discharges from the Takoma Park Service Area, and the Projected Impact on these Providers of Redirection to White Oak, 2016 Data

Facility	Total Discharges Age 18+	Discharges from Takoma Park ARH Service Area	Discharges Redirected to White Oak	% Impact
MedStar National Rehabilitation	2,104	1,069	69	3.3%
George Washington University	366	11	1	0.3%
Total	2,470	1,080	70	2.8%

Source: MHCC DC Hospital Discharge Data. (DI #9, pp. 11, 12).

ARH concluded that George Washington University Hospital would lose just one of the 11 patients it attracted from the Takoma Park service area, and that MedStar National Rehabilitation Hospital would have lost 69 of its 1,069 Takoma Park service area patients.

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;

ARH does not believe the project will result in any reduction in availability of or accessibility to acute rehabilitation hospital services, including access for patients who are indigent or uninsured or who are eligible for charity care, and asserts that this project will enhance the availability and accessibility of services for all patients. (DI #2, p. 37).

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

ARH maintains that this proposed relocation of its existing program to a site not far from its current location would have no impact on the quality of care or ability to hire specialized staff because it seeks to serve patients in the same service area, not draw patients away from other programs, and it expects that its existing staff will relocate with the facility to the White Oak location. (DI #2, pp. 36, 37).

In summary, with respect to this standard, staff concludes that the proposed move of the Takoma Park component of ARH's rehabilitation services to the new White Oak hospital campus under development by its owner, Adventist Health Care, Inc., in Silver Spring would not have a detrimental impact on the cost of services, the financial viability of any existing provider of acute

inpatient rehabilitation hospital services, the ability of other providers to maintain specialized staff, or the quality of other providers. At the same time, it is likely to enhance the availability of and access to inpatient rehabilitation services and will improve the patient experience of care, through its facilities modernization and the increase in the supply of private patient rooms.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, the projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not included the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

This standard requires a comparison of the project's estimated construction cost with an index cost derived from the Marshall Valuation Service ("MVS") guide. To complete this comparison, an MVS benchmark cost is developed for new construction based on the relevant construction characteristics of the proposed project. The MVS cost data includes the base cost-per-square-foot for new construction by type and quality of construction for a wide variety of building uses including a general hospital. The MVS guide also includes a variety of adjustment factors, including adjustments of the base costs to the costs for the latest month, the locality of the construction project, as well as factors for the number of building stories, the height per story, the shape of the building (such as the relationship of floor area to perimeter), and departmental use of space. The MVS guide also identifies costs that should not be included in the MVS calculations. These exclusions include costs for buying or assembling land, making improvements to the land, costs related to land planning, discounts or bonuses paid for through financing, yard improvements, costs for off-site work, furnishings and fixtures, marketing costs, and funds set aside for general contingency reserves.[6]

Both ARH and MHCC staff performed independent analyses comparing the applicant's estimated project cost to the MVS benchmark calculated for the proposed project. (See Appendix 2). The applicant proposes the construction of two additional floors on a wing of the general hospital being developed in White Oak. The cost of constructing the two floors is estimated at approximately $19.5 million.

[6] Marshall Valuation Service Guidelines, Section 1, p. 3 (February 2018).

Using the project costs allowable for MVS comparison, MHCC staff calculated the adjusted project cost per SF to be $395.32. Using a different approach, Adventist Rehabilitation aggregated the adjusted total project cost for (1) the original CON approved replacement hospital relocated from Takoma Park to White Oak; (2) the modification approval for the construction of the central utility plant ("CUP"); and (3) the construction cost for the two-floor addition. Totaling $200,718,387 in allowable adjusted costs, the applicant divided this amount by the total building square footage for these three projects (511,811 SF) to calculate an adjusted project cost of $392.17 per SF.

ARH used the MVS benchmark of $398.51 per SF calculated by MHCC staff with the original November 18, 2015 approval for the replacement hospital. Conversely, MHCC staff utilized the costs of constructing the two-story addition, and the current MVS values for the construction of a "Good" quality Class A general hospital. MHCC staff calculated the MVS benchmark to be $433.91 per SF. The difference between the MVS benchmark values calculated by the applicant and MHCC staff is $35.40 per SF, about an 8.2% difference.

The applicant used the MVS values that were in effect on November 18, 2015 for the aggregate costs of construction for not only the replacement hospital, but also the inclusion of the costs for constructing the CUP and the proposed two-story rehabilitation addition. With respect to the MHCC staff's calculations, these calculations focused on the costs for the two-story addition only and used the values reported by MVS currently for the multipliers and adjustments, which is consistent with the SHP standard with regard to using *"current industry cost experience in Maryland"* and the updated use of *"Marshall Valuation Service® update multipliers"* and adjustments.

ARH calculated the adjusted project cost per SF of $392.17 per SF, which is about $6.34 below the applicant's MVS benchmark of $398.51 per SF (about 1.6% lower). MHCC staff's adjusted project cost of $395.32 per SF is around $38.59 below the calculated MVS benchmark of $433.91 per SF (approximately 8.9% lower). As previously noted, the difference between Adventist Rehabilitation's and MHCC's values is about 8.2%. In both scenarios, the projected cost of constructing the two-story addition does not exceed the calculated MVS benchmark value by more than 15%. Thus, the project complies with this standard.

(5) Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

ARH states that the facility will be designed to current codes and standards. Evidence-based architectural methods have been employed in the design of the rehabilitation floors at the WAH replacement hospital to improve patient outcomes, safety, and satisfaction. ARH asserts that this design will also boost staff efficiency, satisfaction, and retention.

All of the acute rehabilitation rooms in the new facility will be private, in contrast to the existing Takoma Park facility, which has few. This will reduce infection risks and help patients rest. Other features the applicants highlighted include:

- Bathrooms will have curbless showers, which will help reduce falls by patients and staff while bathing patients;
- Doors to the patient bathrooms will be 42" wide, which allows staff members to walk alongside patients to help them navigate between rooms;
- The gym and other patient treatment areas are significantly larger than the current facility at Takoma Park, which provides more maneuvering space around equipment;
- The location of patient beds in new construction allows for overhead patient lifts to be included in the construction of the new facility, assisting both patients and staff;
- Support spaces (clean supply room, equipment room, soiled rooms, main nurse station) along with the day/dining room are accessed directly from both major corridors on the unit. Reducing the travel distance will allow staff to spend more time with patients which will increase both patient and staff safety; and
- Hand washing sinks will be located both directly inside the entry door to each patient room and along the corridor to further reduce the risk of infection. (DI#2, pp. 38, 39, and pp. 55, 56).

Staff concludes that the proposed project includes design features that enhance and improve patient safety.

(6) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital CON application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

ARH projected utilization for the project based on historical trends in acute inpatient rehabilitation in its service area and its experience at the Takoma Park facility. Projected growth in utilization is based primarily on population growth by age cohort. ARH assumes that:

- Existing referral relationships and intensity of services provided will not change, nor will ARH's market share in Montgomery County and Prince George's County;
- Discharges will increase at the same rate as the population by age cohort, i.e, a constant use rate;
- Length of stay will decrease slightly (from 13.9 days to 13.5);
- In-migration from areas outside of Montgomery County, Prince George's County, and the District of Columbia will remain constant;
- 70 (35%) of the approximately 200 residents of Montgomery County who received inpatient rehabilitation hospital services at a provider located in D.C. will shift to ARH in White Oak by 2022. (DI #2, p.40).

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

ARH's projected revenues increase in proportion to projected increases in utilization, and ARH states that these projections are based on actual performance and experience in the current facility. Revenue is assumed to increase 0.4% annually due to annual updates and payor escalators. (DI #2, p.41).

(iii)Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or if a new hospital, the recent experience of other similar hospitals; and

The staffing and overall expense projections submitted by ARH are based on its historical operating experience at Takoma Park and grow in proportion to its volume projections. The ratio of full time-equivalent staff per bed at Takoma Park has averaged is 3.4:1 and is expected to continue at the level with the proposed facility relocation. (DI #2, p.41).

(iv)The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

Table III-3 below shows actual and projected patient volume and financial results for ARH at Takoma Park and its proposed replacement at White Oak. In reviewing this data, staff notes that 2019 volume increases are related to ARH's addition of ten "waiver" beds in 2018[7] and the $3+ million increase in expenses in 2019 is related to ARH assuming all of the ancillary costs of the campus, as it becomes the sole tenant in the hospital building.[8]

Table III-3: Actual and Projected Volume, Revenue, and Expenses, ARH at Takoma Park (and White Oak)

		Actual			Projected			
		CY16	CY17	CY18	CY19	CY20	CY21	CY22
Scenario 1: ARH remains at	Discharges	635	678	714	849	886	901	917
	Patient-days	8,968	9,538	9,580	11,498	11,955	12,165	12,379

[7] An increment of up to 10 beds that MHCC law and regulation allow health care facilities other than hospitals to periodically add without CON approval.

[8] The financial tables for the current scenario at Takoma Park assume that starting in July 2019, ARH will be the only hospital occupant. Therefore, AHR will be charged with campus-related costs associated with the campus depreciation.

Takoma Park	Net revenue	$13,893,251	$14,379,427	$15,237,779	$17,310,481	$17,994,817	$18,308,938	$18,629,043
	Operating Expense	$10,994,791	$11,750,919	$11,643,910	$17,484,792	$21,229,244	$21,442,761	$21,632,372
	Net Income	$ 2,898,460	$ 2,628,508	$ 3,593,869	$ (174,312)	$(3,234,427)	$(3,133,823)	$(3,003,329)
Scenario 2: ARH Moves to WAH at White Oak beginning in 2020	Discharges	635	678	714	849	886	901	917
	Patient-days	8,968	9,538	9,580	11,498	11,955	12,165	12,379
	Net revenue	$13,893,251	$14,379,427	$15,237,779	$17,310,481	$17,994,817	$18,308,938	$18,629,043
	Operating Expense	$10,994,791	$11,750,919	$11,643,910	$16,951,484	$16,065,159	$16,278,677	$16,468,288
	Net Income	$ 2,898,460	$ 2,628,508	$ 3,593,869	$ 358,997	$ 1,929,658	$ 2,030,262	$ 2,160,756

Source: DI#9, corrected Tables F,G ,H, and I.

In Scenario 2, which assumes that ARH moves its operation to WAH at White Oak during 2020, ARH projects an ability to continue profitable operation. In Scenario 1 it begins to lose money in 2019 when other services vacate the Takoma Park campus, increasing ARH's costs for ancillary services as well as saddling it with all campus depreciation costs.

Staff believes that the proposed project meets the requirements of the financial feasibility standard and that the proposed project will offer Adventist HealthCare a more positive financial outlook than the plan established in 2015 to continue operation at the sole existing hospital facility operation on the Takoma Park campus.

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

Part (a) of this standard is not applicable. The proposed project does not involve creation of an inpatient unit in a hospital. Regarding Part (b) of the standard, the 42 acute inpatient rehabilitation beds AHR proposes to relocate will be operated as a separately licensed rehabilitation hospital, consistent with the minimum size requirement of the standard. AHR's projected average daily census within three years of implementation would imply an average annual occupancy rate of 80%, the State Health Plan's target occupancy rate for a facility of up to 49 beds. (DI#2, p.42).

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

ARH states that it can accommodate most patients with the exception of ventilator dependent patients. It states that, prior to admission, it "carefully evaluates patients to the acute rehabilitation service to be certain the patient meets clinical criteria and has the ability to tolerate the intensive rehabilitation services provided," and that if a patient's condition changes during the course of a stay, "AHR has relationships with skilled nursing facilities, long-term acute care hospitals, [and] home health agencies." (DI#2, p.43). In its response to MHCC staff completeness questions, ARH disclosed that in 2017 it discharged 78 patients to 23 different skilled nursing facilities (11.5%). DI#9, p. 21).

Staff concludes that the Transfer and Referral Agreement standard has been satisfied.

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that offers the best balance between program effectiveness and costs to the health care system as a whole.

This is not a comparative review.

B. Need

COMAR 10.24.01.08G(3)(b) Need. The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

Referencing the need analysis in the State Health Plan, ARH submitted the data in Table III-4 below. The last column in the table points out that factoring in the additional 10 waiver beds that ARH - Takoma Park added in September of 2018 results in a net need of between -18 (at the minimum need projection) and +22 beds (at the maximum need projection) by 2021 to meet Montgomery County's need for acute rehabilitation beds in 2021. ARH noted that it was seeking to relocate beds – not add any beds to the present bed count in the jurisdiction. (DI#2, p. 46).

Table III-4: Gross and Net Bed Need Projections for Acute Rehabilitation Beds in Montgomery County, 2021

Health Planning Region	Minimum Occupancy Standard	Range	Total Days Projected	Current Licensed Bed Capacity	Available Bed Days	Gross Bed Need Range		Net Bed Need Range	Net Bed Need Range adjusted for ARH-TP addition of 10 waiver beds
Montgomery	80%	Minimum	22,947	87	31,775	Min.	79	(8)	(18)
		Maximum	34,665			Max.	119	32	22

Source: Gross and Net 2021 Bed Need Projections for Acute Rehabilitation Beds by Health Planning Region, by MHCC, published in the Maryland Register, April 13, 2018.

ARH projected its utilization will grow by 28% between 2018 at the current Takoma Park location and 2022 at White Oak (Table III-5). Its assumptions are relatively conservative.[9] The projected growth is primarily a function of population growth in its service area (primarily Montgomery and Prince George's Counties) and an aging population. Montgomery County's population is projected to grow by 6% between 2015 and 2025, and that of Prince George's by 5%. The combined growth rate of the 65-and-over population, the cohort with the highest utilization by far of acute rehabilitation hospital services, in the two counties is 39%.[10] For example, the inpatient rehabilitation use rate for Montgomery County residents aged 65+ for the five years 2012 – 2016 averaged 6.68 per thousand population; over that same period the use rate of the population aged 45 – 64 was 1.32. (DI #2, p. 32; Source Maryland Health Care Commission).

Table III-5: ARH Historical and Projected Utilization

	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022
Discharges	501	678	706	635	678	714	849	886	901	917
Patient days	6,591	8,569	9,561	8,968	9,538	9,580	11,498	11,955	12,166	12,380
Beds	22	32	32	32	32	32	42	42	42	42
Average Annual Occupancy Rate	82.3%	73.4%	81.9%	76.6%	81.7%	72.9%	75%	78%	79.4%	80.8%

Source: DI#2, Table F and DI#16).

ARH supplemented the information in Table III-5 with more up-to-date data that shows utilization just before and after its addition of 10 waiver beds. While it is not advisable to draw conclusions from a very limited sample size, as beds were added in 2018, patient census rose and bed occupancy in February 2019 was in a range defined as optimal for 42 beds by the SHP.

Table III-6: ARH Occupancy Since Adding 10 Waiver Beds

	Oct 2018	Nov 2018	Dec 2018	Jan 2019	Feb 2019
Beds	32	42	42	42	42

[9] ARH Assumptions:

- Existing referral relationships and intensity of services provided will remain unchanged.
- Age-specific rates of acute rehabilitation discharges per 1,000 population remain constant at 2016 levels.
- AHR's historical combined market shares for the Takoma Park and Rockville facilities in Montgomery County and Prince George's County will remain at current levels. (Assumes a small shift in market share from Rockville to White Oak in Montgomery County to reflect the 10 new beds being added to Takoma Park in 2018 and the move to all private rooms at White Oak.)
- Discharges increase at the same rate as the population in each relevant portion of the service area and age cohort.
- Length of stay remains constant at current levels.
- The portion of in-migration attributable to areas outside of Montgomery County, Prince George's County, and the District of Columbia remains constant.
- About 70 (of about 200) Montgomery County residents currently traveling to DC will choose instead to go to AHR in White Oak by 2022.

[10] Source: Maryland Department of Planning, Projections and State Data Center (January 2018) (DI #2, p.30).

Average Daily Census	29.0	26.9	28.4	30.4	35.4
Average Monthly Occupancy Rate	91%	64%	68%	72%	84%

Source: Email from Robert Jepson of Adventist HealthCare conveying utilization data for AHR-TP for Oct. 2018 through February 2019. (DI#17).

Staff concludes that the relocation of the current ARH bed inventory is consistent with the applicable need analysis in the State Health Plan and a reasonable demonstration has been made to authorize relocation of all 42 beds based on recent demand experienced by the ARH facility in Takoma Park. The other aspects of project need bearing on the modernization of the facility and the most effective and efficient configuration of the Adventist hospital facilities operated in eastern Montgomery County were addressed earlier in this report.

C. AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

COMAR 10.24.01.08G(3)(c) Availability of More Cost-Effective Alternatives. The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

The applicants provided an analysis comparing the relocation proposal with the alternative of consolidating Adventist rehabilitation hospital facilities in response to COMAR 10.24.09.04B(5), as outlined earlier in this report. Staff concluded that the applicants have presented a credible examination of the chief alternative and demonstrated the cost effectiveness of co-locating the Adventist general hospital under development and the special rehabilitation hospital on the same campus.

D. VIABILITY OF THE PROPOSAL

COMAR 10.24.01.08G(3)(d) Viability of the Proposal. The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Availability of Resources to Implement the Proposed Project

The estimated capital cost for adding two additional floors to accommodate ARH at the White Oak hospital project is $19,547,323. The applicants state that a large part of the additional cost for the two floors will be covered in the current budget for the WAH relocation project, in which savings of about $14 million have been identified, primarily from efficiencies achieved in the development of the parking garage and the CUP. The balance of the $19.5 million increase will come from AHC routine capital budget, which is currently averaging approximately $50 million per year. The applicants state that "AHC continues a trend of strong financial performance, which has resulted in improved cash balances, which will easily cover the additional dollars needed to complete the two additional floors," and presented the table below illustrating a positive trend in operating results and cash. (DI #2, pp. 59, 60).

Table III-4: Adventist HealthCare Depiction of its Operating Results and Cash Position

AHC Consolidated (in thousands)	2012	2013	2014	2015	2016	2017	YTD 3/31/2018
Net Income	$ 5,369	$ 4,046	$ 14,675	$ 24,018	$ 21,615	$ 26,502	$ 5,240
Cash	$ 175,383	$ 187,334	$ 195,677	$ 184,057	$ 218,792	$ 238,518	$ 235,351

ARH's audited financial statements show current assets to be 226% of current liabilities; the ratio of total assets to total liabilities is about 1.53.

Availability of Resources to Sustain the Proposed Project

In staff's review of the financial feasibility standard, COMAR 10.24.09.04B(6), staff concluded that the applicants had demonstrated the likelihood of being able to profitably operate the relocated special hospital. Under Maryland's rate regulation model for hospitals, special rehabilitation hospitals are not rate regulated in the same manner applied to general hospitals. A special hospital like ARH, with a high level of Medicare use, is funded like other dedicated rehabilitation hospitals in the U.S., receiving the reimbursement for hospital services established by Medicare, under it prospective payment system for acute hospital rehabilitation services.

Staff recommends that the Commission find that this project is viable. The applicants have cash on hand to develop the facility and have an established base of patients and the necessary program elements in place such that relocating to new facilities within seven miles of the existing facility should not present any significant challenge to sustainability of the hospital program.

E. COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED

COMAR 10.24.01.08G(3)(e) Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

The applicants provided the following list of CONs issued to it or Adventist HealthCare, Inc.

- Adventist HealthCare Inc. was issued a CON by the Commission to build a rehabilitation hospital on April 14, 1995.
- Adventist Health Care, Inc. was issued a CON by the Commission on September 10, 1996 to create the Shady Grove Adventist Hospital Neonatal Intensive Care Unit (NICU).
- Adventist HealthCare, Inc. was issued a CON by the Commission on November 12, 1996 to establish a 20-bed hospital-based subacute care unit. This unit operated as Care-Link at Washington Adventist Hospital.
- Adventist HealthCare, Inc. was issued a CON by the Commission on February 20, 2003 for 15 of the 20 comprehensive care beds operated at Care-Link at Washington Adventist Hospital to be consolidated and relocated with the existing 82 bed complement at Fairland

Nursing and Rehabilitation Center, expanding its bed capacity to 97 beds. The remaining five beds were relinquished.

- Adventist HealthCare, Inc. was issued a CON by the Commission on June 19, 2003 for 22 rehabilitation beds.
- Adventist HealthCare, Inc. was issued a CON on February 16, 2005 to expand the patient tower at Shady Grove Adventist Hospital.
- Washington Adventist Hospital was issued a CON on November 18, 2005 to establish the Washington Adventist Surgery Center. The CON was relinquished on August 18, 2006.

Adventist HealthCare, Inc. has complied with the terms and conditions of these CONs. The most recent CON issued to Adventist Health Care, Inc. and the changes authorized to that CON were reviewed at the beginning of this report. The relocation and replacement of WAH appears to be on schedule and within authorized spending levels. (DI#2, p. 60).

The applicants have an acceptable track record in implementing authorized project.

F. IMPACT ON EXISTING PROVIDERS AND THE HEALTH CARE DELIVERY SYSTEM

COMAR 10.24.01.08G(3)(f)Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

As described previously in this report, at COMAR 10.24.09.04B(3) Impact, AHR maintains that the project will not have a significant impact on other acute inpatient rehabilitation providers.

AHR explains that it expects its referrals to come from the same sources that have historically referred patients to AHR. It assumes some shifts in market share from D.C. hospitals. (DI#2, p. 36). Specifically, AHR projects that, in its first three years of operation in White Oak, a cumulative total of 180 discharges will shift from two hospitals in D.C. that provide acute rehabilitation hospital services to adults. This case volume is a relatively small proportion of the service provided by MedStar National Rehabilitation Hospital, the hospital that is projected to experience the highest level of impact. ARH projects capturing about 6.5% of the patients originating from the ARH Takoma Park service area that use the D.C. hospitals.[11] (DI#2, p. 33 and DI#9, pp. 11, 12).

As reviewed at COMAR 10.24.09.04(1) – Access, ARH projects that its proposed relocation will enhance access to services because the White Oak location is easier to reach from most parts of its service area. The replacement hospital itself, with all private rooms, will be designed to allow for greater levels of use.

[11] In 2016, 1,080 rehabilitation hospital patients from the ARH Takoma Park service area were discharged from two D.C. hospitals. ARH projects shifting about 70 of these cases as a result of its proposed relocation.

Staff concludes that the impact of the project will be positive.

IV. SUMMARY OF RECOMMENDATION

Based on its review and analysis of the Certificate of Need application, MHCC staff recommends that the Commission approve the proposed project with a condition that ARH be licensed in conformance with the Maryland Department of Health regulations concerning the licensure of hospitals located on separate premises.

Staff recommends that the proposed project be found to comply with the applicable State Health Plan standards and general CON review criteria. Modernizing the hospital is needed and continuing to operate the hospital on the same campus as the replacement general hospital is the most cost effective approach to meeting that need. The project is viable and its impact will be positive. It can be implemented without a substantial increase in the spending levels already authorized for the new hospital under development in the White Oak area of Silver Spring, Maryland.

Accordingly, Staff recommends that the Commission conditionally **APPROVE** the relocation of the Takoma Park facilities of Adventist HealthCare Rehabilitation to the White Oak campus through the addition of two floors to the general hospital building currently under construction, at an estimated cost of $19, 547,323.

The condition recommended for this CON approval is that Adventist Health Care, Inc. will obtain two separate special hospital licenses for the ARH facilities at Rockville and the ARH facilities at Takoma Park, prior to first use approval of this project.

IN THE MATTER OF	*	**BEFORE THE**
	*	
ADVENTIST REHABILITATION *		**MARYLAND**
	*	
HOSPITAL OF MARYLAND, INC.	*	**HEALTH CARE**
	*	
Docket No. 18-15-2428	*	**COMMISSION**

* *

FINAL ORDER

Based on the analysis and findings in the Staff Report and Recommendation, it is this 21st day of March 2019:

ORDERED, that the application of Adventist Rehabilitation Hospital of Maryland, Inc. for a Certificate of Need to relocate its 42 inpatient rehabilitation beds to expanded building space within the general hospital being constructed in Silver Spring, Maryland as a replacement of AHC Washington Adventist Hospital, at a cost of $19,547,323 be **APPROVED,** with the following condition:

> Prior to first use approval, Adventist Health Care will obtain two separate special hospital licenses for the ARH rehabilitation hospital facilities in Rockville and the ARH rehabilitation hospital facilities in Takoma Park.

APPENDIX 1

RECORD OF THE REVIEW

RECORD OF THE REVIEW

Docket Item #	Description	Date
1	Letter of Intent received and acknowledged.	5/15/18
2	Certificate of Need Application received.	7/11/18
3	Receipt Certificate of Need Application acknowledged.	7/12/18
4	MHCC Staff requests publication of notice of receipt of application in the Washington Times.	7/12/18
5	MHCC Staff requests the Maryland Register to publish notice of receipt of application.	7/12/18
6	Notice of receipt of application published in the Washington Times.	7/23/18
7	MHCC Staff requests completeness information.	10/25/18
8	Extension to file completeness until 11/15/18 requested and granted.	11/6/18
9	Completeness Information received by MHCC.	11/13/18
10	MHCC informs Coastal Hospice that the formal start of review will be 10/13/17; includes request for additional information.	1/4/19
11	MHCC Staff requests that Washington Times publish notice of formal start of review.	1/4/19
12	MHCC Staff requests the Maryland Register to publish notice of formal start of review as of 10/13/17.	1/4/19
13	FORM – Request local health planning comments	1/4/19
14	Notice of formal start of review published in the Washington Times.	1/28/19
15	Email exchanges between Kevin McDonald of MHCC and Robert Jepson of Adventist HealthCare regarding quality measures.	2/27/19-3/1/19
16	Email from Robert Jepson of Adventist HealthCare conveying utilization and financial data for AHR-TP for 2018, updating the projection that was in the application with actual.	3/8/19
17	Email from Robert Jepson of Adventist HealthCare conveying utilization data for AHR-TP for Oct. 2018 through February 2019.	3/11/19
18	Additional information regarding applicant's *Determination of Probable Financial Assistance Eligibility Workflow* submitted via email.	3/12/19

Appendix 2

Marshall Valuation Service Review

Marshall Valuation Service Review

The Marshall Valuation System – what it is, how it works

In order to compare the cost of a proposed construction project to that of similar projects as part of a cost-effectiveness analysis, a benchmark cost is typically developed using the Marshall Valuation Service ("MVS"). MVS cost data includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses.

The base cost reported in the MVS guide are based on the actual final costs to the owner and include all material and labor costs, contractor overhead and profit, average architect and engineering fees, nominal building permit costs, and processing fees or service charges and normal interest on building funds during construction. It also includes: normal site preparation costs including grading and excavation for foundations and backfill for the structure; and utilities from the lot line to the structure figured for typical setbacks.

The MVS costs *do not include* costs of buying or assembling land, piling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, general contingency set aside for some unknown future event such as anticipated labor and material cost increases. Also not included in the base MVS costs are site improvements such as signs, landscaping, paving, walls, and site lighting. Offsite costs such as roads, utilities, and jurisdictional hook-up fees are also excluded from the base costs.[12]

MVS allows staff to develop a benchmark cost using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide. In developing the MVS benchmark costs, the base costs are adjusted for a variety of factors (e.g., an add-on for sprinkler systems, the presence or absence of elevators, number of building stories, the height per story, and the shape of the building. The base cost is also adjusted to the latest month and the locality of the construction project.)

Calculating the Adjusted Project Cost in this Application

Adventist Rehabilitation states that the proposed 42 rehabilitation beds will be located on two newly constructed floors built on top of the new WAH facility presently under construction in White Oak. Each of the two floors will have 19,432 SF, for a total of 38,864 SF, with the two floors constructed on top of the south portion of the newly constructed five story building. (CON application, p. 4). The applicant states this section of the building is the best location for the addition, designed "to accept two additional floors from a structural and mechanical, electrical, and plumbing perspective." The cost of constructing the two floors is a little over $19.5 million. Staff's MVS calculations assumes the entire project is composed of new construction for the two floors.

Adventist Rehabilitation and MHCC staff used two different approaches in calculating the adjusted project cost per SF for the two floors. Table A below illustrates how MHCC staff calculated this value.

[12] Marshall Valuation Service Guidelines, Section 1, p. 3 (February 2018).

Table A: Respective Adjusted Project Cost Developed by MHCC Staff

Cost of New Addition	
New Construction	
Building	$ 13,448,000
Architect/Engineering	1,626,480
Permits	289,152
Total Project Costs	$ 15,363,632
Cost Adjustments - Off-site and On-site Costs*	
Total Adjustments*	$ 0
Project Costs for MVS Comparison	$ 15,363,632
Square Feet of Construction	38,864
Adjusted Project Cost per SF	$ 395.32
MHCC calculated MVS Cost/SF	$ 433.91
Over(Under)	$ (38.59)

Source: CON Application, Exhibit 4, Tables C & D, and 10/25/2018 Completeness Response, Exhibit 23, Table E.

There are no off-site and on-site costs[13] reported with this project. Therefore, the only costs included in the MVS calculations by MHCC staff are the additional costs for constructing the two floors for the rehabilitation program. **MHCC staff** arrived at an adjusted project cost of $395.32 per SF.

Adventist Rehabilitation utilized a different method for calculating the adjusted project cost per SF. (CON Application, Exhibit 15, please see attached table). The applicant aggregated the Adjusted Total Project Cost for MVS Comparison[14] (a total of $200,718,387) awarded with: (1) the original CON approval to relocate WAH from Takoma Park to White Oak on November 18, 2015; (2) the modification approval for the construction of the central utility plant ("CUP") granted on September 19, 2017; and (3) the construction costs for the proposed two-floor addition for the 42 rehabilitation beds. Dividing the Adjusted Total Project Cost of $200,718,387 by the total building square footage for these three projects (511,811 SF), the applicant calculated an adjusted project cost of $392.17 per SF.

Developing an MVS Benchmark for This Project

Adventist Rehabilitation used the MHCC's calculated MVS benchmark of $398.51 per SF calculated by MHCC staff with the original November 18, 2015 approval for the WAH replacement. This MVS benchmark used the Marshall Valuation Service to calculate a base cost for a *Good* quality Class A construction for a general hospital.

[13] These costs are for site preparation such as demolition, storm drains, and rough grading, and for costs of site improvements such as paving, signs, landscaping, walls, yard lighting, roads, utilities, and jurisdictional hook-up fees.

[14] Which includes adding the costs for constructing the building; site preparation; architectural, engineering & consultant fees; building permits; and capitalized construction interest, minus the adjustments for off-site and on-site costs.

MHCC staff only included the costs for constructing the two-story addition, and calculated an MVS benchmark for the construction of a Good quality Class A construction for the two-story addition of $433.91 per SF by adjusting the MVS base cost ($374.00 per sq. ft. as of November 2017) for a general hospital, using the following multipliers and factors:

1. Use of a departmental cost factor of 1.06 for the nursing units where the rehabilitation program will operate.
2. Since the rehabilitation will construct a two story addition with an average area per floor of 19,432 SF and an average perimeter of 581 linear feet, MVS calculates the Perimeter Multiplier is 0.923.
3. With the height for each of the two floors at 14 ft., MVS indicates the Height Multiplier is 1.046.
4. The cost of installing a wet sprinkler system for the 38,864 SF addition is estimated at $3.55 per SF.
5. Staff used the Current Cost Multiplier of 1.08 for a Class A general hospital, as reported by MVS for February 2019.
6. Staff then adjusted the cost to the location of the project by applying the MVS Local Multiplier for Silver Spring (1.04) as of January 2019 (the most current available) to arrive at an initial benchmark square foot cost of $433.91 per SF.

The following table identifies the select building characteristics, the MVS base cost and the adjustments and calculations made by MHCC staff for this analysis:

Table B: Marshall Valuation Services Benchmark - Adventist Healthcare Rehabilitation and MHCC Staff's Calculations

	Adv. Rehab	MHCC
Class	A	A
Type	Good	Good
Ave. Perimeter (ft.)	581	581
Ave. Wall Height (ft.)	14'	14'
Stories	2	2
Average Area Per Floor (sq. ft.)	19,432	19,432
	Adv. Rehab	MHCC
Net Base Cost		$374.00
Elevator Add-on		0
Adjusted Base Cost		$ 374.00
Departmental Cost Diff.		1.06
Gross Base Cost		$ 396.44
Perimeter Multiplier		0.923
Story Height Multiplier		1.046
Multi-story Multiplier		1
Multipliers		0.965

Refined Square Foot Cost		**$ 382.76**
Sprinkler Add-on (wet)		**3.55**
Adjusted Refined Square Foot cost		**$ 386.31**
Current Cost Modifier		**1.08**
Local Multiplier		**1.04**
CC & Local Multipliers		**1.123**
MVS Building Cost Per Square Foot	**$ 398.51**	**$ 433.91**

Source: CON Application, Exhibit 4, Tables C and D, and Exhibit 15.

The difference in the MVS Benchmark values calculated by the applicant and MHCC staff is $35.40 per SF, about 8.2% difference.

Adventist Rehabilitation's MVS calculator value of $398.51 per SF used the MHCC's calculated MVS benchmark value for the replacement hospital in November 2015. The applicant aggregated the total adjusted construction costs to include the costs for construction of the CUP and the proposed two-story rehabilitation addition for MVS comparison. The applicant bases its review on the total cost of construction for the White Oak hospital on the MVS values that were in use as of November 2015, and not updating the multipliers and adjustments using the current values reported with the Marshall Valuation Service.

Conversely, MHCC staff used the currently available MVS base costs and adjustments in calculating the MVS benchmark. With regard to the total cost of construction, MHCC staff only reviewed the costs for constructing the two story addition. As a result, the MVS benchmark values calculated by Adventist Rehabilitation differ by 8.9% from the MHCC value. Differences due to the timeframes used for the multipliers and adjustments as well as staff's focus only on the cost of adding two-floors for this MVS analysis play a part in the different findings between the applicant and staff.

Comparing Estimated Project to the MVS Benchmark

MHCC staff's analysis found the adjusted project cost to be $38.59 per sq. ft. (about 8.9%) below the calculated MVS benchmark, while Adventist Rehabilitation calculated the adjusted project costs to be $6.34 per sq. ft. (about 1.6%) under the MVS benchmark. In both situations, the applicant and MHCC indicate the cost of constructing two floors above the newly constructed WAH complies with this standard.

Table C: Comparison of Adjusted Project Cost as Calculated with the MVS Benchmark

	Adv. Rehab Calculation	MHCC Staff Calculation
Adjusted Project Cost per SF	$392.17	$ 395.32
Adv. Rehab and MHCC calculated MVS Benchmark Cost per SF	$398.51	$ 433.91

Total Over (Under) MVS Benchmark	($6.34)	($38.59)
Over(Under) %	-1.6%	-8.9%

Source: CON Application, Exhibit 15 and MHCC Staff calculations.

Washington Adventist Hospital Replacement Project Construction Costs Compared to Marshall Valuation Service Benchmark - WASHINGTON ADVENTIST REPLACEMENT HOSPITAL

A	B	C	D	E	F	G	H
MVS Adjusted for Final Design Area, Actual Capitalized Interest, and Addition of CUP Costs	MVS as per MHCC REVIEW	FINAL DESIGN & CAPITALIZED INTEREST	ADD CENTRAL PLANT COSTS	FINAL DESIGN & CENTRAL PLANT (Note 5)	ADJUSTED MVS (B + E)	ADD Level 6 & Level 7	ADJUSTED MVS (F + G)
Project Budget Item	Cost	Adjust	Adjust	Adjust	Cost	Adjust	Cost
Building	$ 135,200,000	$ -	$ 26,750,000	$ 25,300,000	$ 160,500,000	$ 13,566,680	$ 174,066,680
Fixed Equipment	Incl above		Incl above		Incl above	Incl above	Incl above
Site Preparation	$ 10,400,000		$ 1,380,000	$ 1,382,000	$ 11,782,000	$ -	$ 11,782,000
Architectural, Engineering & Consultant Fees	$ 13,200,000		$ 1,675,000		$ 14,875,000	$ 1,626,480	$ 16,501,480
Permits	$ 700,000		$ 110,000	$ 280,000	$ 980,000	$ 289,152	$ 1,269,152
Capitalized Construction Interest (Notes 1, 2 & 6)	$ 28,248,645	$ 21,051,531	$ 1,614,744		$ 22,666,275	$ -	$ 22,666,275
Total	$ 187,748,645				$ 210,803,275		$ 226,285,587
Adjustments (Note 3)	$ 19,450,000		$ 6,117,200		$ 25,567,200	$ -	$ 25,567,200
Adjusted Total for MVS Comparison	$ 168,198,645				$ 185,236,075		$ 200,718,387
Building Square Footage (Note 4)	427,662	28,765	16,520		472,947	38,864	511,811
Adjusted Project Cost Per Square Foot	$ 393.53				$ 391.66		$ 392.17
MVS Benchmark Cost Per Square Foot	$ 398.51				$ 398.51		$ 398.51
Total Over (Under) MVS Benchmark	$ (4.98)				$ (6.85)		$ (6.34)

Note 1: *CON application estimated Capitalized Interest to be $45M. MHCC calculated $28M out of $45M Capitalized Interest (56.8%) attributable to Project + same proportion of $4.5M Placement Fee. Actual capitalized interest at bond issue was $34M + $2.8M Placement Fee. Applying MHCC apportionment to actual transaction costs results in $21M for original project capitalized interest and placement fee, plus the entire* ***actual*** *CUP financing costs of $2.03M. This incorporates the* ***actual*** *finance costs of $21M in lieu of the $28M* ***estimate****.*

Note 2: *Total for* ***actual*** *CUP Capitalized Interest and Placement Fee is $2,028,572.49. Extraordinary Items are $6.1M of the $29.9M Project Costs, or 20.4%. Capitalized Interest and Placement Fee have been reduced proportionately for the Capitalized Interest attributable to the Extraordinary Items. $2,028572.49 less $413,828.79 (20.4%) = $1,614,743.70.*

Note 3: *See attached table for Extraordinary Items deducted from CUP budget. For the ARH 6th & 7th Level add,* ***no additional*** *Extraordinary items identified.*

Note 4: *CON application estimated building area at 427,662 SF prior to Schematic Design. Design Development refinements added 28,765 SF. The Central Utility Plant adds 16,520 SF for a current total of 472,947 SF. See AHC "Notification of Change" to MHCC, dated June 15, 2017, for details. MHCC replied via letter, dated June 23, 2017, confirming permissibility of space. The 6th & 7th Level adds 38,864 SF for a total of 511,811 SF*

Note 5: *Incorporated the Final CUP Designs and Costs.*

Note 6: *The 6th & 7th Floor Addition will not be financed and will be funded with available AHC capital/cash. For this calculation the building cost includes an allotted portion of the contingency.*