Washington
Adventist Hospital
A Member of Adventist HealthCare

Application for Certificate of Need

October 4, 2013

Washington Adventist Hospital

7600 Carroll Ave.

Takoma Park, MD 20912

301-891-7600

www.AdventistHealthCare.com

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MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITALS
APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION, ATTACHMENTS AND EXHIBITS SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. a. Adventist HealthCare, Inc. d/b/a Washington Adventist Hospital
Legal Name of Project Applicant (ie. Licensee or Proposed Licensee)

   b. 820 West Diamond Avenue
Street

   c. Gaithersburg 20878 Montgomery
City Zip County

   d. 301-315-3030
Telephone

   e. William G. "Bill" Robertson
Name of Owner/Chief Executive

2. a. _____
Legal Name of Project Co-Applicant (ie. if more than one applicant)

   b. _____
Street

   c. _____
City Zip County

   d. _____
Telephone

   e. _____
Name of Owner/Chief Executive

3. a. Washington Adventist Hospital
Name of Facility

   b. 12100 Plum Orchard Drive
Street (Project Site)

   c. Silver Spring 20904 Montgomery
City Zip County

4. _____
Name of Owner (if different than applicant)

5. a. _____
Representative of Co-Applicant

   b. _____
Street

   c. _____
City Zip County

   d. _____
Telephone

6. **Person(s) to whom questions regarding this application should be directed:**
(Attach sheets if additional persons are to be contacted)

a. Robert Jepson, Vice President
Business Development
Name and Title

b. 820 West Diamond Avenue
Street

c. Gaithersburg 20878 Montgomery
City Zip County

d. 301-315-3042
Telephone No.

e. 301-315-3043
Fax No.

f. RJepson@adventisthealthcare.com
E-mail Address

a. Geoffrey A. Morgan, Vice President
Washington Adventist Hospital
Name and Title

b. 12041 Bournefield Way
Street

c. Silver Spring 20904 Montgomery
City Zip County

d. 301-592-4458 or 301-891-6214
Telephone No.

e. 301-891-5991
Fax No.

f. GMorgan@adventisthealthcare.com
E-mail Address

a. Joyce Newmyer, President
Washington Adventist Hospital
Name and Title

b. 7600 Carroll Avenue
Street

c. Takoma Park 20912 Montgomery
City Zip County

d. 301-891-5651
Telephone No.

e. 301-891-5991
Fax No.

f. JNewmyer@adventisthealthcare.com
E-mail address

a. Howard Sollins, Attorney
Ober|Kaler
Name and Title

b. 100 Light Street
Street

c. Baltimore 21202-1643 Baltimore City
City Zip County

d. 410-347-7369
Telephone No.

e. 443-263-7569
Fax No.

f. hlsollins@ober.com
E-mail address

7. **Brief Project Description** ***(for identification only; see also item #14)*:**

APPLICANT RESPONSE:

Adventist HealthCare proposes the construction of a 201-bed replacement hospital facility on 48.86 acres in the White Oak area of Silver Spring ("White Oak campus"). Behavioral health services, including 40 acute psychiatric beds, will remain in renovated space inside the current Washington Adventist Hospital facility on the Takoma Park campus ("Takoma Park campus"). Outpatient services will be available on both the White Oak campus and the Takoma Park campus.

8. **Legal Structure of Licensee** ***(check one from each column):***

a.		b.		c.	
Governmental	___	Sole Proprietorship	___	To be Formed	___
Proprietary	___	Partnership	___	Existing	X
Nonprofit	X	Corporation	X		
		Subchapter "S"	___		

9. **Current Physical Capacity and Proposed Changes:** ***(Staff will also provide separately a detailed spreadsheet on which the applicant will display current and proposed physical bed capacity by location.)***

Service	Current Physical Beds	Beds to be Added or Reduced	Total Beds if Project is Approved	Comments (WO = White Oak, TP = Takoma Park)
M/S/G/A	157 Beds	-5	152	WO
Pediatrics	0 Beds	n/a	n/a	
Obstetrics	21 Beds	0	21	WO
ICU/CCU Care	34 Beds	-6	28	WO
Psychiatry	40 Beds	0	40	TP
Rehabilitation	n/a Beds	n/a	n/a	n/a
Chronic	0 Beds	n/a	n/a	n/a
Other (Specify	n/a Beds	n/a	n/a	n/a
TOTAL BEDS	252	-11	241	WO + TP

10. **Project Location and Site Control:**

A. **Site Size** 48.86 acres

B. **Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained?** YES **XXX** NO _____ ***(If NO, describe below the current status and timetable for receiving necessary approvals.)***

C. Site Control:

(1) Title held by: Adventist HealthCare, Inc.

(2) Options to purchase held by: _____

(i) Expiration date of option _____

(ii) Is option renewable? _____ **If yes, please explain**

_____

_____

(iii) Cost of Option _____

(3) Land Lease held by: Adventist HealthCare, Inc.

(i) Expiration date of lease _____

(ii) Is lease renewable _____ **If yes, please explain**

_____

_____

(iii) Cost of Lease _____

(4) Option to lease held by: _____

(i) Expiration date of option _____

(ii) Is option renewable? _____ **If yes, please explain**

_____

_____

(iii) Cost of option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained _____

_____

APPLICANT RESPONSE:

The proposed replacement hospital will be built in White Oak on a 48.86 acre parcel of land that is wholly owned by Adventist HealthCare Holdings 1, LLC where Adventist HealthCare, Inc. (AHC) is the sole member. Renovations will occur in Takoma Park, on the existing campus of Washington Adventist Hospital, also wholly owned by Adventist HealthCare, Inc.

(INSTRUCTION: IN COMPLETING ITEMS 11, 12 & 13, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

11. Project Implementation Target Dates (for construction or renovation projects):

APPLICANT RESPONSE:

PHASE 1 – Early Site Work at Washington Adventist Hospital at White Oak Campus

A. Obligation of Capital Expenditure: <1 month from approval date.
B. Beginning Construction: <1 month from capital obligation.
C. Pre-Licensure/First Use: 6 months
D. Full Utilization: N/A

PHASE 2 – Base Building and Fit-out at Washington Adventist Hospital White Oak Campus

A. Obligation of Capital Expenditure: <1 month from completion of immediately preceding phase of construction
B. Beginning Construction: 2 months from capital obligation.
C. Pre-Licensure/First Use: 29 months from capital obligation.
D. Full Utilization: 4 months from First Use.

PHASE 3 – Renovations at Takoma Park Campus

A. Obligation of Capital Expenditure: 2 months from completion of immediately preceding phase of construction
B. Beginning Construction: 2 months from capital obligation.
C. Pre-Licensure/First Use: 20 months from capital obligation.
D. Full Utilization: 3 months from First Use.

Phase 1 of the proposed project consists of the early site work on the White Oak campus that is required for commencement of the replacement building foundations and footings. This includes clearing and grubbing, relocation of existing utilities, site access roads and staging areas. In order to deliver a cost-effective project in as short a time frame as possible, Adventist HealthCare will begin Phase 1 construction as soon as possible following award of the CON utilizing existing capital funds (cash) to be reimbursed from the bond proceeds after placement of the construction financing. The design for this work has already been completed and permitted.

Phase 2 of the project consists of fit-out and remainder of site work not required for commencement of the building construction on the White Oak campus, such as final grading, paving, landscaping and site lighting. Because phase 2 will include 428,400 square feet of base building construction, full interior fit-out and equipment installation on a site with complex on-site utilities, extensive on-site circulation and complicated hillside construction, Washington Adventist Hospital is requesting that the Commission authorize 29 months from Capital Obligation to Pre-licensure/First Use for Phase 2 of the project.

This request is respectfully made in recognition that the size and complexity of Phase 2 is equal to or greater than all but the largest single-phase projects approved by the Commission, as well as supported by COMAR 10.24.01.12C. (i) "For a multiphased plan of construction, the Commission, upon a showing of good cause by an applicant, may authorize: (i) Obligation for each approved phase of construction of a specified portion of the capital expenditure that is less than 51 % of the

approved capital expenditure for the entire project; and (ii) Up to 36 months to complete each approved phase.

Phase 3 consists of renovations at the existing Takoma Park campus including a renovated behavioral health unit, new and renovated outpatient clinics, renovation to the Emergency Department and demolition of certain existing interior construction to create leasable space for physician offices and instructional use space by Washington Adventist University.

12. Project Implementation Target Dates *(for projects not involving construction or renovations)*:

A. Obligation of Capital Expenditure ___n/a___ months from approval date.
B. Pre-Licensure/First Use __n/a____ months from capital obligation.
C. Full Utilization _n/a_____ months from first use.

13. Project Implementation Target Dates (for new service projects not involving a capital expenditure):

A. Obligation of Capital Expenditure __n/a____ months from approval date.
B. Pre-Licensure/First Use __n/a____ months from capital obligation.
C. Full Utilization __n/a___ months from first use.

14. Project Description:

Describe the project's construction and renovation plan, and all services to be provided following completion of the project.

APPLICANT RESPONSE:

PROPOSED PROJECT

Washington Adventist Hospital proposes building a replacement inpatient facility on a 48.86 acre site in the White Oak area of Silver Spring, Maryland. The new campus at 12100 Plum Orchard Drive, ("White Oak campus") is located in the existing primary service area for Washington Adventist Hospital and is within a Maryland state priority funding area. (See Exhibit 1 - Priority Funding Area Map). The replacement hospital would include all existing services except for behavioral health services and Adventist Rehabilitation Hospital of Maryland/Takoma Park, both of which will stay permanently in Takoma Park ("Takoma Park campus"). The Takoma Park campus will also retain a Federally Qualified Healthcare Center (FQHC) operated by Community Clinic, Inc., the maternity clinic for low-income women physician offices, diagnostic services (laboratory and imaging), wound care services, various clinics and office space for administrative staff of Adventist HealthCare. The Takoma Park campus would also include more than 55,000 square feet of space to be leased to Washington Adventist University, a growing college with an adjoining campus. (See Exhibit 2- Letter of Intent with Washington Adventist University).

This plan addresses the need for new facilities in an accessible location, continued health care services for the community around the existing Takoma Park campus, and reflects the changing dynamics of health care.

White Oak Facility Description

The project will begin with the development of a full service acute care facility on the White Oak campus, which will then house the current hospital units at Takoma Park with the exception of behavioral health services, which will remain on the Takoma Park campus. The White Oak facility will have a 428,400 square foot gross area and be comprised of eight stories above grade and one below grade, cellar level. The hospital will include 201 private patient rooms.

The White Oak hospital will include the following components:

1) An Emergency Department with 35 treatment bays

2) 8 Operating Rooms (5 for general surgery, 2 for cardiac surgery, 1 hybrid/specialty surgery)

3) 2 Endoscopy Rooms

4) 1 Cystoscopy Room

5) 6 Cardiac/Vascular Angiography suites

6) 32 bed Telemetry Unit

7) 28 bed Critical Care Unit

8) Maternity Unit (21 post-partum rooms, 7 Labor and Delivery Rooms, 2 C-Section)

9) 20 Short Stay Observation Beds (8 in a dedicated unit in the patient tower, 12 adjacent to the ED)

10) Approximately 750 surface parking spaces

The development of the central plant for the facility will be out-sourced to a third party that will provide services to the facility on an ongoing basis.

Once the White Oak hospital opens the existing Takoma Park campus will be partially renovated and modified. In addition, portions of the hospital that will be vacant once services are moved to the White Oak campus will be renovated, mothballed, or leased for alternate uses.

Site Layout and Organization

The White Oak site is oriented generally north-south and slopes from east down to west toward the retention pond. The plan design considered characteristics of the site to incorporate and maximize access, feasibility of future growth and aesthetics.

The building axis is aligned with the site to permit multiple entry points. Site circulation is separated by functions with separate entrances for emergency vehicles, and for the public to access the Emergency Department, the main hospital and the main parking area. This site arrangement improves circulation and access by allowing vehicles to be separated by type of visit. Parking is distributed over the site with multiple points of ingress and egress. Parking functions are also separated according to their associated hospital services with is a dedicated lot for visitors directly in front of the Emergency Department.

The site slope is used to best advantage in the site planning of the campus from both a practical and aesthetic approach. The difference in height is used to expose a back-of-house loading area at the cellar level with a separate entrance and limited visibility and access from patient and public areas. In addition, because the aesthetics of the hospital location and site are criteria in the Washington Adventist Hospital selection process, the sloping site permits less aesthetic site utility functions such as the medical gas storage facility, electrical transformers, generators, central plant and cooling towers to be hidden as much as possible from the street view, improving the view of the hospital from the street. A retaining wall along the west side of the hospital provides additional opportunity for utility functions behind the hospital and an "overlook" south of the hospital.

The sloping site permits access to the lower service level with less excavation than if the entire site were flat and the cellar required major site excavation and manipulation. The intent of the site development will be to balance the excavation and fill required so there is minimal requirement for export or import of soil. This reduces waste and cost and aligns with the project's concept of sustainable development.

Given the constriction and difficulty of expansion at the existing Takoma Park campus, this White Oak site was selected and planned to allow for logical and feasible future growth. The main hospital facility is located in the center of the site with sufficient space for expansion, if necessary, to the north, south, and west. The site plan shows these expansion areas.

The site plan also considers the view of the woods and pond to maximize the aesthetics of the property for the enjoyment of the maximum number of staff, patients, family and visitors. For example, whenever possible, patient rooms will have windows that look out over the pond and woods. The landscape design will include a path around the pond for the use of patients, visitors and staff, with the woodlands retained to the fullest extent possible.

Building Organization, Efficiency and Patient Safety

The hospital is organized to maximize patient safety and efficiency with a patient tower of five Medical-Surgical floors on a "base" with Emergency, Radiology, Surgery, Cardiac, and Maternity services. A cellar level will house support spaces such as Lab, Central Sterile Processing, Dietary, Maintenance, Information Technology and Mechanical-Electrical.

Because the elevators are critical to hospital circulation for patients, visitors, and staff, they form the primary organizing vertical element that also helps differential horizontal functions. Elevator functions are segregated with one bank for the public and a separate bank for service/patients. Both banks are located in the center of the building, to maximize efficiency and provide easy access to all floors and functions. As an organizing element, the central elevator cores provide a functional separation between the patient areas (bed units) north of the elevators and clinical services such as Surgery and Obstetrics which are located south of the elevators.

The hospital design is compact and efficient. The current design has a ratio of 2,031 (GSF) per patient room. Recent hospital constructions considered "efficient" are typically 2,000-2,200 GSF/patient room, making this design on the low (more efficient) end of the spectrum. Efficient buildings are less costly to construct and operate, easier for visitors and staff to navigate, and retain more site for future expansion.

Unit sizes are organized and located to improve efficiency. The Emergency Department is directly below Critical Care and Surgery. Operating rooms are accessible by corridor (Critical Care) or patient transfer elevator (Emergency Department). Maternity and Obstetrics are on one floor. Patient floors are stacked and each patient floor has a similar layout for building function and to simplify construction by stacking services and utilities. Patient rooms are located along the

perimeter for access to natural light and views. Exterior windows will also be provided in the public areas of the unit at the corridors to bring natural light into the unit for staff and visitors. Patient bathrooms are located against the exterior wall to improve staff access to and visibility of patients and minimize travel distance for nurses. The patient rooms are designed around the "family care" model and will contain dedicated areas for family members in each room.

Performance Characteristics and Sustainable Features

Washington Adventist Hospital has set a priority to exceed the minimum threshold of LEED certification that is set as a Montgomery County requirement for a LEED Certified Project. In response, the project design meets a higher standard than that necessary for LEED certification.

Sustainable features of the building include:

- Energy efficiency: the design has set a goal to be more than 14% better than code requirements.
- Envelope efficiency: the design will incorporate an efficient envelope to maximize light while minimizing heat gain.
- Efficient lighting will reduce energy use and improve interior environment quality.
- The project will be commissioned and will employ sophisticated control systems and measuring sensors to ensure the operation meets the design intent.
- Site selection: the site is close to public transportation.
- Stormwater design: the project will control for both quality and quantity within the site.
- Light roofs will reduce the heat island effect.
- Shielded lights will reduce light pollution.
- Water-efficiency will include efficient landscaping with native and low water-use planting and low-flow plumbing fixtures to reduce domestic water use.
- Construction waste will be diverted from landfill, and materials will use recycled content and regional materials to reduce transportation and related environment impact.
- Low-emitting materials, sealants, and finishes will provide a clean interior environment.

Takoma Park Campus

After the completion of the White Oak hospital, the next phase will be the re-development of the Takoma Park campus. As most of the hospital services move to White Oak, the Takoma Park site will change its focus to lower-intensive services more suited to the community and campus conditions.

In this respect, the proposed project makes the best use of an aging campus by changing some functions from clinical to non-clinical uses. Replacing high-intensity clinical services with low-

intensity occupancies will reduce the strain on the infrastructure and utilities so that areas such as behavioral health can remain at Takoma Park with only moderate upgrades and expansions. As explained in the Availability of More Cost Effective Alternatives section the existing infrastructure is not capable of supporting a full building program of modern, high-intensity clinical spaces.

The re-development of the Takoma Park campus includes:

- Behavioral health services will remain in place at Takoma Park and form the core of the inpatient services on that campus. As part of the modernization of this department, a portion of the existing 1990s building will be renovated to accommodate the conversion of semi-private rooms to private, fulfilling one of Washington Adventist Hospital's primary objectives. This will connect to the existing unit via the existing corridor, making one larger behavioral health department. The existing patient rooms will then be converted from semi-private rooms to private rooms.

- The existing Emergency Department will be converted into outpatient clinic space providing a community service and most logical re-use of the existing space. In response to the Takoma Park community, some clinic services will initially operate 24/7 and future hours of operation will depend upon how much the service is utilized by the community. The layout of the clinic space is similar to an emergency department, except that the required infrastructure (including utilities such as air flow) is not as demanding. The ingress and egress of the Emergency Department along with the close proximity of the existing parking make this program change from Emergency Department to clinic space straightforward and logical.

- Existing hospital support functions such as Laboratory, Dietary, Storage, Plant Operations, Pharmacy, and Radiology will remain in their current configuration. They will continue to support the new programs at Takoma Park and the most cost-effective utilization of these spaces is to retain them as is.

- A Federally Qualified Healthcare Center.

- The maternity clinic serving low income women.

- Adventist Rehabilitation Hospital of Maryland/Takoma Park

The balance of the Takoma Park campus will be re-purposed for occupancies and services that make the most sense given the building condition and constraints. Building space will be renovated to house offices for physicians, and Washington Adventist Hospital will lease space to the adjacent Washington Adventist University. Adventist Rehabilitation Hospital of Maryland/Takoma Park will remain in its current space. The reasons for this are as follows:

- These occupancies have less stringent mechanical and plumbing requirements and have lower Energy Use Intensity so they will result in a net reduction of energy use and heating/cooling for the campus. This will in turn free up capacity in the existing utilities to upgrade services to the existing inpatient services which will remain.

- The ceiling heights in the existing Takoma Park buildings are low by current health care standards (refer to "Takoma Park On-Campus Alternative" (Option B). Building new inpatient units in these buildings would be tremendously challenging. It is more

logical to change the occupancies in these areas to uses that will not be as challenging for the building. Commercial office spaces do not have the same ductwork density or sizes that health care occupancies require. As a result, the ceiling height issues are mitigated.

The services in Takoma Park will meet the needs of the community while at the same time making the best use of the existing buildings. The combination of a new facility in White Oak, complete with inpatient and outpatient services within the hospital's primary service area, along with behavioral health services, an FQHC, outpatient clinics, doctor's offices and other services in Takoma Park, provide additional points of access to care for the community.

Project Cost

The total project cost for the development of the White Oak facility and renovations to the Takoma Park campus is $373 million including interest and an allowance for inflation. This includes $294.1M for the construction, and capital costs related to construction of the White Oak hospital facility and $31.787M for the renovations and capital costs related to facilities/services on the Takoma Park campus.

Project Schedule

The total duration of the project from CON submission through to completion of the final phase is estimated at 78 months, including 24 months of planning, CON review, design, permitting and financing and 54 months of site and building construction and occupancy. The project itself is divided into three main phases.

Phase 1 consists of the early site work required for commencement of the building foundations and footings such as clearing and grubbing, relocation of existing utilities, site access roads and staging areas. In order to deliver a cost-effective project in as short a time frame as possible, Adventist HealthCare plans to begin phase 1 as soon as possible following award of the CON utilizing existing capital funds to be reimbursed from the bond proceeds after placement of the construction financing. The design for this work has already been completed and permitted and the site contractor will be selected prior to award of the CON.

Phase 2 will immediately follow phase 1 and consists of the new hospital building construction, fit-out and remainder of site work not required for commencement of the building construction such as final grading, paving, landscaping and site lighting.

Phase 3 is the renovation of the existing Takoma Park hospital including an enhanced behavioral health unit, clinic space and demolition of certain existing interior construction to create leasable space for physician offices and for instructional use by Washington Adventist University. Design, permitting, financing and procurement will begin as the White Oak hospital approaches completion with a target of beginning the construction portion of phase 3 within four months after the White Oak facility construction is completed.

FDA Memorandum of Understanding

Finally, it is important to note that Washington Adventist Hospital has a signed Memorandum of Understanding (MOU) with the Federal Food and Drug Administration, located adjacent to the proposed Washington Adventist Hospital campus in White Oak. The MOU, attached as Exhibit 3, outlines a collaborative relationship between the two entities. "By sharing resources and talents, the two organizations can open up new areas of discovery, funding and cooperation that are critically important for keeping both organizations on the leading edge and for protecting and

promoting our nation's public health." Washington Adventist Hospital and the FDA have already begun collaborating on several initiatives regarding major FDA regulatory program areas and the collaborative relationship will grow when the hospital moves to White Oak.

15. Project Drawings:

Projects involving renovations or new construction should include architectural drawings of the current facility (if applicable), the new facility (if applicable) and the proposed new configuration. These drawings should include, as applicable:

1) the number and location of nursing stations,

2) approximate room sizes,

3) number of beds to a room,

4) **number and location of bath rooms,**

5) any proposed space for future expansion, and

6) the "footprint" and location of the facility on the proposed or existing site.

APPLICANT RESPONSE:

Project drawings are attached as Exhibit 4 (White Oak Campus) and Exhibit 5 (Takoma Park Campus.

16. Features of Project Construction:

A. Please Complete "CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS AND COSTS" describing the applicable characteristics of the project, if the project involves new construction or renovation.

(Chart 1 begins on following page).

Chart 1. Project Construction Characteristics and Costs		
Base Building Characteristics	Complete if Applicable	
	New Construction	Renovation
Class of Construction		
Class A	A	n/a
Class B	n/a	B
Class C	n/a	n/a
Class D	n/a	n/a
Type of Construction/Renovation	n/a	n/a
Low	n/a	n/a
Average	n/a	Average
Good	Good	n/a
Excellent	n/a	n/a
Number of Stories	8	4[1]
Total Square Footage	428,412	126,910[2]
Basement	70,836	42,240
First Floor	81,794	67,770
Second Floor	64,430	15,900
Third Floor	51,948	1,000
Fourth Floor	43142	n/a
Fifth Floor	28,289	n/a
Sixth Floor	28,289	n/a
Seventh Floor	28,289	n/a
Eighth Floor	28,289	n/a
Penthouse Floor	3,105	n/a
Perimeter in Linear Feet		n/a, Interior Renovation
Basement	1482	n/a
First Floor	1581	n/a
Second Floor	1510	n/a
Third Floor	1297	n/a
Fourth Floor	1159	n/a
Fifth Floor	913	n/a
Sixth Floor	913	n/a
Seventh Floor	913	n/a
Eighth Floor	913	n/a
Penthouse Floor	438	n/a
Wall Height (floor to eaves)		Varies by bldg.[3]
Basement	21	11 (Typical)
First Floor	18	11 (Typical)
Second Floor	18	11 (Typical)
Third Floor	15	11 (Typical)
Fourth Floor	15	n/a
Fifth Floor	15	n/a
Sixth Floor	15	n/a
Seventh Floor	15	n/a
Eighth Floor	15	n/a
Elevators		
Type *Passenger* *Freight*		
Number 6 6	6 for public 6 service for hospital transport	n/a, Existing to Remain
Sprinklers (Wet or Dry System)	Wet	Wet
Type of HVAC System	Mechanically Ventilated	Mechanically Ventilated
Type of Exterior Walls	Precast Concrete Panel, CMU, Curtainwall, Unitized metal panels	n/a, Existing to Remain

NOTES: Values for renovation work include only renovated floors and areas of existing building. Floors and areas designated as existing to remain are excluded

1 Number of stories for renovation work at Takoma Park includes only floors on which renovations are taking place. Floors designated as existing to remain are excluded.

2 Total square footage values for renovation work at Takoma Park includes only renovated areas of the existing building. Areas designated as existing to remain are excluded

3 Wall heights at the existing Takoma Park campus vary. Wall height for renovation indicates the typical condition.

Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs	$10,400,000	$0
Normal Site Preparation	1,350,000	n/a
Demolition	100,000	n/a
Storm Drains	1,500,000	n/a
Rough Grading	1,200,000	n/a
Hillside Foundation	300,000	n/a
Terracing	0	n/a
Pilings	0	n/a
Offsite Costs	$3,850,000	$0
Roads	2,500,000	n/a
Utilities	600,000	n/a
Jurisdictional Hook-up Fees	750,000	n/a
Signs	$150,000	$0
Landscaping	$1,000,000	$0

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

There are no current plans for bed expansion subsequent to approval as part of the construction plan.

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

APPLICANT RESPONSE:

C. Availability of Utilities

Water, electricity, sewage and other utilities for the proposed project are available or will be obtained as follows:

Public Water & Sewer:

Water service is available via an existing 10" WSSC main on Plum Orchard Drive (SEP Contract # 83-5831- A).

Sewer service is available via an existing 12" WSSC main on Plum Orchard Drive (SEP Contract #83-5831-A).

Currently, Washington Adventist Hospital is proposing 3 new public water connections and 2 new public sewer connections to service the site. In addition, an existing public sewer line crossing the site will be relocated to create two public connections that will accommodate the new site layout. A WSSC application, plan and profiles, will be required for the Public SEP process; taking approximately 9 months from initial submission to permitting.

Approximately 2,111 ft. of public 12" S and approximately 1257ft. of public 10" W is being proposed to service the site.

Additionally, approximately 1,315 ft. of public 10" W is proposed through the site to connect to public 10" W in Bournefield Way to provide redundancy service to the site.

Site Utility Water & Sewer:

Site Utility (previously referred to as "On-Site") water & sewer is required on site to accommodate the new building demands. A WSSC application, plan, and profiles will be required for the Regulatory Systems Group process; taking approximately 6 months from initial submission to permitting.

Approximately 3,230 ft of private 10" W and approximately 920 ft. of private 8"S is being proposed to service this site.

Storm Drain

All existing and proposed drainage is conveyed to a regional SWM pond located on the site. There are 3 existing public storm drain lines running through our site. Currently, Washington Adventist Hospital is proposing to relocate these 3 existing public storm drain lines to accommodate the new layout as well as an on-site private storm drain to safely convey runoff conditions created by the new layout. A MCDPS application, plan, and profiles, will be required for processing. This will take approximately 6 months from initial submission to permitting.

Approximately 2,410 ft. of public Storm Drain is being proposed to service the site.

Stormwater Management

The existing site is mainly wooded and drains entirely to a regional SWM pond located on our site. Currently, a waiver has been received for recharge, quantity and roof top quality requirements for the proposed condition with an active Sediment Control Permit (covering SWM requirements) for the project site. The current Sediment Control Permit requires quality control for the remaining site provided via underground SWM structural devices. Due to recent changes in SWM regulation, the quality and quantity control must be provided to Environmental Site Design (ESD) facilities. A MCDPS application, plan, and profiles, will be required for processing. This will take approximately 6 months from initial submission to permitting.

Natural Gas

Washington Gas has existing gas lines located in Plum Orchard Drive that will be extended onto the proposed hospital campus to service the proposed hospital building. Gas service will enter the hospital near the Boiler Room.

Electric Power

Based upon the proposed loads of the hospital that have been submitted to PEPCO, the utility service has proposed a plan to provide the required electrical service from the existing Fairland utility substation. Under this plan PEPCO will provide two sources of electricity from existing feeders 15,899 and 15,900 out of the Fairland substation. Both feeds are required to meet the proposed hospital electric

requirements. The PEPCO feeds will be extended from the Fairland substation approximately 3/4 of a mile in a combination of overhead cable along Calverton Road and buried cable in conduit along Broadbirch Road and Plum Orchard Drive. Once on the site, the electrical feeders will be installed in buried conduit from the property line to the utility substation room in the basement of the hospital.

Telephone and Data

Telephone and data services will be extended through the existing cable plant along Plum Orchard Drive to Broadbirch Drive. Redundant services can also be routed in the opposite direction along Plum Orchard Drive to Cherry Hill Road. Alternately, existing fiber on Bournefield Way can be tapped which could provide connection to several data service providers. These services will be extended onto the hospital campus to the entrance facility in the hospital cellar.

PART II - PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

		Phase 1 & 2 White Oak	Phase 3 Takoma Park	Total
1.	Capital Costs			
a.	New Construction			
(1)	Building & Fixed Equipment	$ 136,300,000	-	$ 136,300,000
(2)	Fixed Equipment (Included above)	-	-	$ -
(3)	Land Purchase	11,000,000	-	$ 11,000,000
(4)	Site Preparation - Land Improvements	10,400,000	-	$ 10,400,000
(5)	Architect/Engineering Fees	13,200,000	-	$ 13,200,000
(6)	Permits, (Building, Utilities, Etc.)	700,000	-	$ 700,000
	SUBTOTAL	$ 171,600,000	$ -	$ 171,600,000
b.	Renovations			
(1)	Building demolition	$ -	$ 1,200,000	$ 1,200,000
(2)	Renovations	-	10,100,000	$ 10,100,000
(3)	Fixed Equipment (Not included in Construction)	-	-	$ -
(4)	Architect/Engineering Fees	-	1,100,000	$ 1,100,000
(5)	Permits, (Building, Utilities, Etc.)	-	100,000	$ 100,000
	SUBTOTAL	$ -	$ 12,500,000	$ 12,500,000
c.	Other Capital Costs			
(1)	Major Movable Equipment	20,400,000	400,000	$ 20,800,000
(2)	Minor Movable Equipment	13,600,000	200,000	$ 13,800,000
(3)	Contingencies	11,300,000	700,000	$ 12,000,000
(4)	Other (Specify)			$ -
	a. Furniture	10,200,000	200,000	$ 10,400,000
	b. Interior & Exterior Signage	1,400,000	-	$ 1,400,000
	c. IS/Comm	13,600,000	300,000	$ 13,900,000
	d. Security system	2,000,000	-	$ 2,000,000
	e. Relocation expense	2,700,000	100,000	$ 2,800,000
	f. Certifications, inspections, etc.	1,000,000	100,000	$ 1,100,000
	g. Takoma Park Capital Facility Upgrades	-	14,300,000	$ 14,300,000
		-	-	-
	TOTAL CURRENT CAPITAL COSTS (a - c)	$ 247,800,000	$ 28,800,000	$ 276,600,000
d.	Non Current Capital Cost			
(1)	Interest (Gross)	50,288,600	1,691,800	51,980,400
(2)	Inflation Allowance (2.0% per year to midpoint of each construction phase)	9,400,000	1,300,000	10,700,000
	TOTAL PROPOSED CAPITAL COSTS (a-d)	$ 307,488,600	$ 31,791,800	$ 339,280,400
2.	Financing Cost and Other Cash Requirements:			
a.	Loan Placement Fees	5,260,600	299,600	5,560,200
b.	Bond Discount			
c.	Legal Fees (CON Related)	223,970	26,030	250,000
d.	Legal Fees (Other)			
e.	Printing			
f.	Consultant Fees	129,280	15,020	144,300
	CON Application Assistance			
	Other (Specify)			
g.	Liquidation of Existing Debt			
h.	Debt Service Reserve Fund	26,303,000	1,498,000	27,801,000
i.	Principal Amortization Reserve Fund			
j.	Other (Specify)			
	TOTAL (a - j)	$ 31,916,850	$ 1,838,650	$ 33,755,500
3.	Working Capital Startup Costs			
	TOTAL USES OF FUNDS (1 - 3)	**$ 339,405,450**	**$ 33,630,450**	**$ 373,035,900**

B. Sources of Funds for Project:

		Phase 1 & 2 White Oak	Phase 3 Takoma Park	Total
1	Cash	53,366,656	7,094,044	60,460,700
2	Pledges: Gross, less allowance for uncollectables=Net			
3	Gifts, bequests	20,000,000		20,000,000
4	Interest income (gross)	3,334,935	230,265	3,565,200
5	Authorized Bonds	251,703,859	26,306,141	278,010,000
6	Mortgage			
7	Working capital loans			
8	Grants or Appropriation			
	(a) Federal			
	(b) State			
	(c) Local			
9	Other (Specify) (Land)	11,000,000		11,000,000
	TOTAL SOURCES OF FUNDS (1-9)	**$ 339,405,450**	**$ 33,630,450**	**$ 373,035,900**

PART III - CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3):

(INSTRUCTION: Each applicant must respond to all criteria included in COMAR 10.24.01.08G(3), listed below.)

10.24.01.08G(3)(a). The State Health Plan.

List each applicable standard from each appropriate chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application. *(Copies of the State Health Plan are available from the Commission. Contact the Staff of the Commission to determine which standards are applicable to the Project being proposed.)*

COMAR 10.24.10, the Acute Inpatient Services Chapter (the "Acute Care Chapter"), COMAR 10.24.12, the Acute Hospital Inpatient Obstetric Services Chapter (the "OB Chapter") and COMAR 10.24.07 (the "Psychiatric Services Chapter") of the State Health Plan are discussed below.

COMAR 10.24.10 - Acute Hospital Services

.04 Standards

A. General Standards

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a

Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

(1) Information Regarding Charges.

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;
(b) Procedures for promptly responding to individual requests for current charges for specific/ procedures; and
(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

APPLICANT RESPONSE:

Policy 3.19.2 Public Disclosure of Charges (Exhibit 6) details the Adventist HealthCare, Inc. policy and procedure for the provision of information regarding hospital services and policies to the public. Quarterly updates to the Representative List of Services and Charges are made and posted to the hospital internet web site (http://www.washingtonadventisthospital.com/app/files/public/467/pdf-WAH-Billing-HospitalCharges.pdf) and are available on request to the public. The Patient Access Department of Washington Adventist Hospital ensures that requests made for current charges for specific procedures are provided in a timely manner. The Patient Access Department provides staff training on this and other policies on a regular basis.

(2) Charity Care Policy

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) This policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

1. **Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;**
2. **Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas with the hospital; and**
3. **Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.**

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

APPLICANT RESPONSE:

Adventist HealthCare, Inc. maintains written policies in English and Spanish pertaining to the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. Policy number AHC 3.19 Charity Care Policy, and Policy 3.19.1 Charity Care Policy, Spanish Language Version apply to all Adventist HealthCare-affiliated facilities in Maryland which include Washington Adventist Hospital. (Exhibits 7 and 8). These policies are summarized and included on the website of Adventist HealthCare, Inc. and Washington Adventist Hospital (http://www.washingtonadventisthospital.com/WAH/patientsvisitors/patients/billing/charity-care/).

Notices of the availability of financial assistance are prominently posted in English and Spanish in the Washington Adventist Hospital Emergency Department, 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 nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Gazette Newspapers. The most recent posting was made on July 10 and 11, 2013 and appeared in the following Montgomery County editions: Gaithersburg, Germantown, Damascus, Rockville, Bethesda, Potomac, Silver Spring, and Olney; and in both the Northern and Southern Prince George's County editions (Exhibit 9).

In 2012, Washington Adventist Hospital provided a total community benefit of 15.08% of its total operating expenses, as reported in the July 10, 2013 Maryland Hospital Community Benefit Report FY 2012 (http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/CommunityBenefits/cb-fy12/hscrc-fy-12-cbr-final.pdf) is 15.08%. This ranks the hospital as providing the 7th highest amount of community benefit for all hospitals in Maryland, with an average for all hospitals of 10.19%.

(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.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospital's reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

APPLICANT RESPONSE:

Washington Adventist Hospital is in possession of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality License Number 15-031 issued on October 1, 2010 through January 1, 2014 (Exhibit 10). Hospital License Number 15369 effective December 30, 2012 through December 30, 2013 was issued by the Health and Human Services Licensure and Regulatory Services of Montgomery County (Exhibit 11). Applications for renewal of the licenses are in process.

Washington Adventist Hospital is accredited by the Joint Commission and earned a "Gold Plus Get with the Guidelines – Stroke" quality award in 2013 (Exhibit 12). The last full survey by the Joint Commission successfully concluded on August 16, 2013.

The hospital is in compliance with the conditions of participation of the Medicare and Medicaid programs.

According to the Maryland Hospital Performance Evaluation Guide posted on June 28, 2013, of 23 applicable measures, Washington Adventist Hospital ranked at or above average on 21 measures. The hospital achieved 100% in 8 of the measures. For the measure, "Surgery patients who received treatment at the appropriate time to help prevent blood clots" Washington Adventist Hospital achieved a 97% rating compared to a 98% state average. Washington Adventist Hospital was above the 90% level of compliance on all measures.

Washington Adventist was 47 minutes beyond the standard for the measure, "Median Time from Emergency Department Arrival to Emergency Department Departure for Admitted Patients," and 33 minutes beyond the standard for "Admission Decision Time to Emergency Department Departure Time for Admitted Emergency Department Patients."

When considering emergency department measures, it is important to note that Washington Adventist Hospital's Emergency Department is configured to accommodate 30,000 visits annually. However, more than 50,000 patients were treated in 2012, a 12.5% increase over the prior year.

Throughput times are also negatively affected by the low number of private rooms available since most of the hospital was built with semi-private rooms. As a result, the second bed in a semi-private room is unavailable for admissions if the first bed is a patient with a communicable disease. Similar limitations occur to avoid placing male and female patients in the same room. Delays in throughput times may also be attributed to an overall rise in hospital diversions times throughout Montgomery County.

Washington Adventist Hospital is working to improve performance on the measure Admission Decision Time to Emergency Department Departure Time for Admitted Emergency Department Patients.

Implementation of this improvement plan begins by identifying when an inpatient bed is available. At that notification, patients immediately are moved from the Emergency Department to an inpatient bed. The admitting physician (typically the hospitalist) assesses the patient and orders diagnostic testing after the patient is on the inpatient unit. In the past, the assessment and testing was performed in the Emergency Department contributing to the delays in the time to admission.

The hospital length of stay is on average 10% greater than the state average, contributing to a lack of beds for admitted patients. To address this, Washington Adventist Hospital has contracted a consultant, IMA. The consultant is on site at the hospital and is working with physicians and staff to improve the length of stay. When length of stay reaches the state average, there will be an average of 15-20 beds open and available each day. This will allow a timely movement of admitted patients.

Lastly, the Emergency Department has been working to improve staffing and turnaround times for testing. These changes will allow for quicker assessment and treatment of patients leading up to the decision to admit.

B. Project Review Standards.

(1) Geographic Accessibility

A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive /critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

APPLICANT RESPONSE:

Washington Adventist Hospital is proposing an acute care general hospital to be replaced on a new site that will optimize accessibility and travel time for its likely service area population. This includes optimal travel time for general medical/surgical and intensive/critical care services within 30 minutes under normal driving conditions for 90 % of the population in its likely service area; inpatient pediatric services are not part of the current or new hospital services.

Washington Adventist Hospital analyzed travel times for Zip codes within its likely service area to the current Takoma Park location and to the proposed White Oak location. The result of the analysis, outlined below, indicates that travel time for general medical/surgical, intensive/critical care services will be within 30 minutes under normal driving conditions for more than 90% of the population in the likely service area.

Process and Results Used

Washington Adventist Hospital established the PSA and a Secondary Service Area (SSA) using Zip codes in the Washington region. Exhibits 13 and 14 detail the estimated drive times under normal driving conditions from Washington Adventist Hospital's PSA (highlighted in green) and SSA (highlighted in blue).

The Travel Time Table (Exhibit 13) shows the normal drive time distances from various areas within the Zip codes that represent PSA and SSA for the hospital with following detail:

a) Zip codes

b) Distance from Takoma Park campus and distance from White Oak campus

c) Travel time from various locations within the PSA

The Service Area Map (Exhibit 14) details the location of both the existing Takoma Park facility and the proposed White Oak hospital.

Travel points located within the Zip codes were selected both on the perimeter of the Zip code and in the centroid area of the Zip code. Due to size, some zip codes contain more travel points than others.

Overall, the optimal travel time for general medical/surgical and intensive/critical care services are within 30 minutes under normal driving conditions for more than 90% of the population in Washington Adventist Hospital's likely service area.

Additional Accessibility Considerations

As previously noted, health care services will be maintained on the Takoma Park campus. The White Oak site addresses serious accessibility issues that exist at the current campus. The hospital is presently located in a residential area and is only accessible by narrow, two-lane residential streets, making it difficult for ambulances, patients, physicians, employees and others to access the hospital. Public transportation options are limited as regional Metrobus system does not access the Takoma Park campus, creating a hardship for residents who rely on this mode of travel.

Access challenges continue once on the narrow, linear campus squeezed between Washington Adventist University and Sligo Creek. Ambulances, cars, pedestrians and buses all compete for right-of-way on the main campus roadway, which also serves as a parking area and walkway, an unsafe confluence of traffic that delays ambulances.

An important objective supporting the proposed relocation is site accessibility. Core medical/surgical services will be relocated to a site located on a 48.86 acre parcel on the west side of Plum Orchard Drive, west of its intersection with Cherry Hill Road in the Fairland/White Oak section of Montgomery County and in the center of its service area. This site is located approximately 6.6 miles from the existing Takoma Park campus of Washington Adventist Hospital. Drive time between the two campuses is approximately 16 minutes according to MAPQUEST©.

Additionally, the site is accessible to major interconnecting roadways, such as I-95, New Hampshire Avenue (MD 650), US 29 and Cherry Hill Road. Metrobus provides access to the new site and Montgomery County plans to extend its Ride-On bus service (Montgomery County operated transit system) to the White Oak campus. Hospital representatives are working with

Metrobus to enhance service connections to existing routes originating in Prince George's County. The Maryland Intercounty Connector (ICC) has a major interchange just one mile north of the proposed White Oak campus located along US 29 and I-95.

Washington Adventist Hospital, through its Montgomery County Special Exception and Site Plan approvals, will also provide an employee shuttle bus service between the Takoma Park and White Oak campuses. Washington Adventist Hospital has agreed to make this shuttle bus service available to hospital patients, visitors and others for a modest fee. The "Shuttle Program" will consist of two buses that will operate from 6:00 a.m. until 6:00 p.m. Monday through Friday. The Shuttle Program will operate for a minimum of 10 years, allowing for the development and enhancement of regional public transportation systems.

(2) Identification of Bed Need and Addition of Beds.

Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients included in the MSGA projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General § 19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

APPLICANT RESPONSE:

The minimum jurisdictional gross bed need projection for Montgomery County, in 2018 is 995 MSGA beds. The maximum jurisdictional bed need is 1,193 MSGA beds. As of July 1, 2013, there were 1,022 licensed MSGA beds located in the five acute care general hospitals of Montgomery County and 75 beds approved in 2011 at Holy Cross Germantown, as shown below:

Licensed MSGA Beds in Montgomery County (FY2013)	
Hospital	**Licensed & Approved MSGA Beds**
Holy Cross Hospital of Silver Spring	282
Holy Cross - Germantown	75
MedStar Montgomery Medical Center	100
Shady Grove Adventist Hospital	250
Suburban Hospital	199
Washington Adventist Hospital	191
Total	**1,097**

Source: Maryland Health Care Commission, Acute Care Bed Inventory (Fiscal Year 2013)

The replacement hospital project proposes 180 MSGA beds, a reduction of 11 MSGA beds. All 180 of the MSGA beds will be located in private rooms. There are no additional MSGA beds proposed in the replacement project for Washington Adventist Hospital. The table below demonstrates that the proposed beds indicate a net bed need from -91 to 107 beds for Montgomery County.

Projected Minimum and Maximum
Bed Need
Montgomery County

	Gross Bed Need (1)	Licensed & Approved Beds (2)	Proposed Beds	Net Bed Need
Date	**2018**	**FY 2013**		2018
Minimum	995	1,097	1,086	-91
Maximum	1,193	1,097	1,086	107

(1) Estimates from the Maryland Register (Volume 37, Issue 7, p.589-591) dated March 26, 2010
(2) Based on Licensed Acute Care Beds (Fiscal Year 2013) Includes 75 CON approved beds at Holy Cross Hospital - Germantown

The Washington Adventist Hospital project is well within the bed need projection for Montgomery County.

(3) **Minimum Average Daily Census for Establishment of a Pediatric Unit.**

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

(a) The hospital is located more that 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in the jurisdiction.

APPLICANT RESPONSE:

This standard is not applicable to the proposed project.

(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 full 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 the 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.

APPLICANT RESPONSE:

Part (a) of the standard references Average Age of Plant. According to the most recent HSCRC annual filing, Washington Adventist Hospital's average age of plant is 22.7 years, second highest among 47 hospitals in the State of Maryland.

In response to part (a), Washington Adventist Hospital did not assume a rate increase in the financial projections included in the application. Therefore, there is no unwarranted impact on hospital charges related to this project.

In response to part (b), Washington Adventist Hospital has developed a project that enhances its facilities and services while ensuring continued access to health care for all in its service area. While the hospital is reducing 11 MSGA beds, the efficiency gained by moving to all private rooms offsets the loss of those beds. The prevalence of semi-private rooms in the current facility creates capacity limitations with infectious disease patients and the sharing of rooms by male and female patients.

More importantly, this project improves the availability of, and access to, services in the Washington Adventist Hospital service area and especially to low-income patients for whom public transportation may be the only option. Patients will have access to a 21st century facility on a comprehensive medical campus of inpatient and outpatient services in White Oak in addition to substantial health care services in Takoma Park including the existing 40-bed behavioral health unit; an FQHC; physician offices; imaging and other ancillary services; the maternity clinic for low income patients; a wound care clinic; and outpatient primary care clinic and other health care services. The Adventist Rehabilitation Hospital of Maryland/Takoma Park will remain on the Takoma Park campus. The services in White Oak and Takoma Park provide additional points of access for the community.

Takoma Park Campus Access

The current Takoma Park hospital campus is challenging from both an access standpoint and for the delivery of care. From access to the campus, to traffic flow and parking on campus, to limited space, to an aging infrastructure, to small room sizes, to a limited number of private rooms, the challenges are many. The proposed project is designed to remove barriers to accessing care and enhance access to facilities and services.

Washington Adventist Hospital's current campus is surrounded by narrow, two-lane residential streets on which traffic backups occur regularly. Emergency vehicles must compete with normal vehicular and bus traffic for access to the hospital campus. The main hospital entrance off of Carroll Avenue is located near an aging arched bridge, scheduled for State Highway Administration repair in the next few years. The back entrance to the hospital is at the confluence of three small roads, Maple Avenue, Maplewood Avenue and Sligo Creek Parkway.

Public transportation options are limited. MetroBus, the region-wide bus system in the Washington metropolitan area, does not travel to the hospital campus. The only bus access is from the local Montgomery County RideOn system, creating an additional hurdle for residents who seek and receive care at the hospital.

Access challenges continue once on campus where ambulances, automobiles, pedestrians and buses compete for right-of-way. The facility sits on a 13-acre campus of which only nine acres are buildable. Parking is severely limited with only 645 spaces on campus for patients, visitors, employees, volunteers and physicians.

The proposed project seeks to address these and other barriers to care.

Site Accessibility and the Level of Impact in Relocation

To determine the level of impact from the relocation, it is important to understand how people currently access the campus and what options are available in the future. A Campus Arrival Study completed by The Traffic Group (Exhibit 15), demonstrated that 98% of people arrive to the current Takoma Park campus by private automobile or taxi. The data collected in 2013 confirms previous studies performed in 2007 and 2011.

For others, the following means are used:

(a) Emergency Medical Services ambulance after a 911 call;

(b) Private, nonemergency ambulance such as from area nursing homes;

(c) Helicopter transport (the hospital is a designated back up for other hospitals providing emergency and nonemergency cardiac interventions including primary and non-primary PCI but without an onsite cardiac surgery program),

(d) Metro Access which "provides services for disabled persons who are unable to use the regular transit systems and have been certified eligible to use Special Transportations service";

(e) The Montgomery County "Call 'N' Ride Program. http://www.montgomerycountymd.gov/tsvtmpl.asp?url=/content/dot/transit/seniors.asp#call, which provides subsidized taxi trips for low-income persons with disabilities and seniors;" and

(f) The Montgomery County Ride On bus system.

Each of these options remains available with the relocation of the main hospital facility to White Oak.

The Traffic Group gathered its data by counting automobiles and placing observers where Ride-On buses stopped and noted the direction in which individuals walked. It counted individuals coming to and leaving from the hospital. It did not have a basis to distinguish between patients, visitors, physicians or other clinicians or staff. It was not able to identify which of these individuals arrived and left during the same 12-hour period and therefore might be double-counted in the tally. Neither did it have a basis to know the point of origin for each individual whether arriving by car or the starting point from which a bus traveler departed from home or elsewhere. The Traffic Group campus arrival study confirms 98% of persons coming to the Takoma Park campus travel by automobile.

White Oak Campus Access

The proposed White Oak campus enhances transportation access in a number of important ways:

- The White Oak hospital facility will be directly accessible to individuals using MetroBus. The White Oak campus will also be accessible by the Montgomery Ride-On bus system;

- Emergency ambulances will have direct access to the Emergency Department without competing with all other traffic to and on the campus;

- Nonemergency ambulances will have more convenient access to both the hospital and medical office building on the new campus;

- Helicopter access will be available to a site that is not located in a residential neighborhood, enhancing Washington Adventist Hospital's own emergency access as well as supporting its role as a cardiac surgery PCI backup hospital;

- MetroAccess will continue to be available;

- Call N' Ride taxi access will continue to be available;

- Staff will have additional access via a shuttle from an existing hospital satellite parking lot that will travel to the White Oak campus. This shuttle will be available for the general public as well for a modest fee.

Private automobile access to the Washington Adventist Hospital campus in White Oak will improve significantly with access from multiple major roads and highways.

To further assess the impact of proposed relocation, The Traffic Group also conducted a travel time analysis (Exhibit 16) of where residents live within Washington Adventist Hospital's existing primary and secondary service areas. Most residents electing to travel to a particular hospital will have a shorter travel time to the hospital in White Oak than to other hospitals. (A number of other hospitals are located within, near or overlap Washington Adventist Hospital's service areas).

The report identifies the point beyond which the White Oak campus is a shorter or longer drive time than the Takoma Park campus. The same process was completed for several other hospitals including Holy Cross Hospital, Laurel Regional Hospital, Medstar Montgomery Medical Center, Shady Grove Adventist Hospital, Prince George's Hospital Center, Doctor's Community Hospital and Medstar Southern Maryland Hospital Center. Separate maps were created identifying those dividing lines based on travel for residents in Washington Adventist Hospital's service area.

The Travel Time Proximity Map (Exhibit 17) uses this data to outline in a consolidated manner the area within which it is a shorter distance to White Oak than to another hospital. The Travel Time Proximity Map shows the area within Washington Adventist Hospital's service area where residents would find a shorter drive time to White Oak than to any one of multiple other hospitals. This same consolidated map shows the area within Washington Adventist Hospital's service area where it is a shorter drive time to another hospital than to the proposed facility in White Oak.

The Traffic Group further identifies the load capacities of the roads to and from Takoma Park and White Oak. The roads to White Oak and the driving times demonstrate that White Oak is a superior site for automotive accessibility than Takoma Park. The combination of improved automobile access, better public transportation options, and health care services at two locations significantly improves access to health care services for residents in the hospital's service area.

The only individuals who would experience a longer non-automotive transportation trip to White Oak are those who currently live along a Ride-On route that travels directly to the Washington Adventist Hospital campus in Takoma Park, and who would need to take Ride-On and transfer either to another Ride-On route or to MetroBus to get to the replacement hospital campus in White Oak.

From the survey referenced above, the total number of persons who use Ride-On to access the current Washington Adventist Hospital campus is very small in relation to the total number of individuals coming to the campus, and only a subset of those presumably would not have access to a direct bus route to the White Oak campus. This number of individuals is smaller than the population who lives in the Washington Adventist Hospital service area, both now and after the relocation to White Oak, who will have convenient MetroBus access to Washington Adventist Hospital for the first time.

The travel time for those in the service area who currently must travel by MetroBus and transfer to Ride-On to get to the residential community where Washington Adventist Hospital is located will be diminished. The attached Traffic Group report and associated maps show the far greater access to MetroBus associated with communities in the Washington Adventist Hospital service area in White Oak. This provides shorter non-automotive access for a greater population than the individuals who currently live along a Ride-On route going to the Takoma Park campus, lack proximity to MetroBus and may need to transfer from Ride-On to another bus route to get to the White Oak location.

The availability of health services at the Takoma Park campus means that a portion of the population who currently take Ride-On to that campus for certain services will continue to do so.

From a cost perspective, Ride On monthly passes are available for $45 at current rates. Disabled persons have access for free Monday through Friday from 9:30 a.m. to 3 p.m. and pay half fare all other times. Ride On offers free rides for Metro Access certified riders and one companion traveling with the disabled person. A one-week MetroBus pass is $16.

There is no additional cost for transfers if the rider uses a Smart Trip card and transfers within 2 hours between buses.

Travel options are also improved for Washington Adventist Hospital employees. Those who drive will be able to park at the White Oak campus while other travel options include MetroBus and Ride-On services. The hospital will provide a shuttle bus for employees from the current satellite lot near the Takoma Park campus to the White Oak facility.

To assist bus service to the White Oak campus, Washington Adventist will construct a special bus layover facility at the main entrance to the hospital along Plum Orchard Road as part of its site preparation work. There will be a dedicated bus pull off area that will service three buses at the same time with a 100 foot long bus shelter for staff and patients arriving from throughout the Montgomery County and Prince George's County region. Additionally, there will be dedicated bus stops along Plum Orchard Road and a dedicated bus stop at the medical office building at the north end of the White Oak campus.

The Montgomery County Department of Transportation Transit Division has recognized that bus service to the White Oak Campus is extremely important and, as a result, the hospital has worked with the department to ensure that all of the amenities for bus passengers will exist along Plum Orchard Road. When the Department of Transportation is prepared to install a "Next Bus" system, the hospital will install the system inside the facility for patients and staff and also inside the bus shelters along Plum Orchard Road. The transit service and accessibility to transit will be dramatically enhanced at the White Oak campus as compared to the existing options at the Takoma Park campus. Due to limited right-of-way and other private property, the area around the Takoma Park campus does not allow for the pull-off and layover area that will exist in White Oak.

As further support for The Traffic Group's conclusions about greater accessibility presented by the White Oak campus than exists at the Takoma Park campus, attached as Exhibit 18 is the Montgomery County Planning Department's White Oak Science Gateway recommended draft Master Plan update. It addresses the comprehensive master plan amendment for the southern portion of eastern Montgomery County.

(5) Cost-Effectiveness

A proposal 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.

(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:

(i) That it has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) **That his had quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed site;**

(iii) **That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and**

(iv) **That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project site or sites located within a Priority Funding Area.**

APPLICANT RESPONSE:

The Board of Trustees for Adventist HealthCare held a special meeting regarding Washington Adventist Hospital and developed 19 objectives to consider in selecting the best option for the hospital's future. The 19 objectives, which board members identified as critical to making an informed decision, are divided into the 7 categories listed below:

Financial Considerations

1. Financial feasibility
2. Financial viability

Facility: Size, Scope and Description

3. Improves Access
4. Sufficient Parking
5. Improve Campus and Building Aesthetics
6. Improve Effectiveness and Efficiency of Building Utility Systems

Regulatory Implications

7. Improve Patient Flow/Staff Efficiency
8. Improve Private Bed Capacity
9. Ability to Achieve Regulatory Approval

Clinical Experience

10. Opportunity for Future Inpatient Capacity
11. Increases Outpatient Capacity/Accessibility
12. Increases Physician Recruitment Opportunities

Community Implications

13. Impact on Community

Adventist HealthCare Impacts

14. Minimizes Impact on Current Operations
15. Ability to Achieve Project Completion
16. Impact on AHC and its Services
17. Ensures Long Term Future of Washington Adventist Hospital

Adaptability to Market Changes

18. Potential to Expand
19. Provides Flexibility for a Dynamic Market, Now and in the Future

Using these objectives, the board further directed the executive team to evaluate options for the future of Washington Adventist Hospital that included two options for staying on the Takoma Park campus and two for relocating to White Oak on a site within the hospital's existing primary service area.

The four options considered are as follows:

Options

A. Limited capital project on the existing Takoma Park campus, maintaining the current buildings;

B. More significant capital project on the existing Takoma Park campus;

C. Smaller facility in White Oak with non-rate regulated health care services in Takoma Park;

D. Similar sized facility in White Oak with some rate regulated acute care services in Takoma Park.

Adventist HealthCare then began working to develop the scope and viability of the various options, and a scoring matrix was developed to aid in the decision making process. The scoring matrix, included as Exhibit 19, identifies the degree to which each option met the 19 objectives established by the Board.

Option A, the limited capital project in Takoma Park, was removed from consideration early in the decision making process because it failed to materially address pressing facility infrastructure challenges or access issues. It maintained the status quo including the current, outdated buildings, providing no opportunity to enhance facilities and services for the community, and did not ensure the long term future of Washington Adventist Hospital. This plan represented what amounted to a do nothing approach with the hospital and the campus.

For the remaining three options, scope, programming, budget, and development schedule were developed for each alternative. The details for option B are included below and in the response to the Availability of More Cost Effective Alternatives standard. Information regarding Option C is included below. Information for Option D is included throughout the application and below.

For option B, an effort to try and fully achieve all of the 19 objectives identified by the Adventist HealthCare Board would be an immense challenge given the characteristics of the campus, the aging infrastructure, disruption of ongoing operations during construction, and other issues. Fully re-developing the Takoma Park site consistent with the 19 objectives and what could be

accomplished with a new full sized replacement facility at a new site in White Oak would take 12-15 years of intense construction and demolition and would be cost prohibitive.

Accordingly, Adventist HealthCare evaluated a more reasonable option that meets some of the 19 objectives identified by the Board. Option B would involve a significant reinvestment in the existing hospital with a multi-phased program of demolition and construction at the Takoma Park campus. The resulting hospital in Takoma Park would take six and one half years to complete beginning with site preparation and demolition, instead of 12-15 years. It also would involve replacing portions of the buildings on campus and have a realistic end point. To achieve the objectives of this option while operating a fully functional hospital, the modernization of the hospital is divided into two separate phases of construction and corresponding phases of demolition.

The first phase of the project is the development of a new bed tower, garage and central plant on an existing parking lot to the south of the existing hospital. Phase 1 of construction would take 24 months. With the completion of Phase 1 of construction, services from the oldest portion of the existing hospital will be moved to the new tower and the vacated portion of the hospital will be demolished to make way for Phase 2 of construction. The transition period will last 6 months including survey, relocation and demolition to prepare for Phase 2. Phase 2 will immediately follow the demolition of the existing building and will have an expected duration of 24 months.

Completion of Phase 1 of this project would provide the following programs/departments:

- A new cardiac care unit
- New maternity unit, including postpartum, labor and delivery and diagnostics
- New laboratory, pharmacy, and respiratory areas.
- New heart center
- New medical same day unit
- New central utility plant
- New lobby

Completion of Phase 2 would provide the following programs/departments:

- New 36-bed medical surgical unit
- New 32-bed medical surgical unit
- New surgical suite
- New G.I. endoscopy suite
- New emergency department
- New admitting and radiology areas
- New cafeteria

Upon the completion of the construction of Phase 2, Washington Adventist Hospital will relocate the existing physician's offices in the MOB at the north end of the site into the body of the hospital and construct a 600-car parking structure on the location of the existing MOB. The capital expenditure for this project would be $339.7 million. (See the Capital Budget chart in the response to the COMAR 10.24.01.08G(3)(c)-Availability of More Cost Effective Alternatives standard on page 125 of this application).

Option C, a proposal to build a smaller facility in White Oak, was also considered by Adventist HealthCare. This proposal would downsize the hospital from 252 inpatient beds to 180 beds while developing a more limited range of non-hospital, non-rate regulated community based services in Takoma Park. All existing acute care hospital services would relocate to White Oak but some

services would be downsized. Under Option C, the White Oak hospital would have all private rooms except for a few semi-private rooms in the behavioral health unit. The White Oak campus would have a 750-car surface parking lot. The Takoma Park campus in this option would include non-acute, community-based services. The construction timeline for this option would be 69 months, including 24 months for planning, CON review, design, and 45 months of building construction and occupancy. The capital expenditure for Option C would be $349.4 million (Exhibit 20- Project Sources and Uses of Option C).

Option D is the development of a replacement facility with all private rooms on a 48.86-acre campus in White Oak while retaining the existing Takoma Park campus for various health care services including the hospital's behavioral health services, an FQHC, the services of Adventist Rehabilitation Hospital of Maryland/Takoma Park, the maternity partnership prenatal clinic and other outpatient clinics, as well as lab, radiology and other ancillary services. Washington Adventist University has signed a letter of intent to lease more than 55,000 square feet of space on the Washington Adventist Hospital Takoma Park campus. The new facility in option D would have 11 fewer inpatient beds and a total cost for option D, including renovations on the Takoma Park campus, is $373 million.

As noted in the options scoring matrix (Exhibit 19), Option D received the highest score, followed by Option C and then Option B.

An analysis of the options against one another makes delineates why Option D is the most cost effective choice.

Option B, the on campus alternative, creates challenges by encumbering the organization with significant debt without addressing the serious challenges patients, physicians and others have in negotiating narrow residential streets to get to the hospital or the more limited public transportation options that exist. (See Exhibit 21- Sources and Uses Option B). This is why, for example, Option B received the lowest score, a "1", for the objective Improves Access while Option D received a "5" for the same objective. Although the project delivers an effective modernization of many patient care spaces, Option B does not modernize the entire facility and significant portions of older structures, such as portions of the 1970s, 1980s and 1990s buildings, remain. Thus, Option B received a score of "3" on the scoring grid for both Improve Campus and Building Aesthetics and Improve Effectiveness and Efficiency of Building Utility Systems, in contrast to a higher score for Option D. In addition, Option B is implemented in the midst of current hospital operations and presents a series of major disruptions that endure over a prolonged period of time, presenting a host of unfavorable impacts and challenges to financial viability and to the quality of care delivered during the construction and renovation periods. Option B received a score of "2" Impact on Current Operations versus a "4" for Option D.

Most significantly, Option B does not earn a positive financial margin within 5 years and thus would require a substantial, ongoing subsidy from Adventist HealthCare. This project would not ensure the long term future of Washington Adventist Hospital and would negatively impact the entire Adventist HealthCare organization. Note the ratings of a "1" for the objectives Financial Viability, Impact On Adventist HealthCare and Ensures Long Term Future of Washington Adventist Hospital as opposed to much higher marks for Option D on those objectives.

Like Option B, Option C does have some positive attributes including a new facility in White Oak on a sizeable, more accessible medical campus within the hospital's existing primary service area. However, the financial viability of Option C is weak. Option C does not earn a positive financial margin five years after opening. Option C earned a "3" on Financial Viability due to its loss in year 5 versus a higher mark for Option D. (Option B scored the lowest on Financial Viability given its much more significant losses by year 5). Substantive, accessible and viable health care services on the

Takoma Park campus are important to the community. Yet, the services on the Takoma Park campus are far less comprehensive under Option C than Option D. Since the entire hospital is moved in Option C, hospital-based behavioral and outpatient services in HSCRC rate-regulated clinics would not be available in Takoma Park. This would limit the scope of services and the amount of charity care available to the local community since the services there would not be hospital based. This also means that these health care services on the Takoma Park campus would contribute significantly less to the financial pro forma for the Takoma Park campus with a resulting negative impact on Adventist HealthCare. Hence, Option C rated a "2" for the Impact on Community objective.

The point about impact to Adventist HealthCare is an important one. Projected income statements and Adventist Healthcare, Inc. financial ratios for each of the options evaluated can be found at Exhibit 22. While meeting the current bond covenants required for the Adventist HealthCare Obligated Group, Option B loses money and would require an ongoing subsidy, placing a tremendous strain on the resources on Adventist HealthCare. Likewise, Option C meets the current bond covenants required for the Obligated Group but loses money, would require an ongoing subsidy and would strain the resources of Adventist HealthCare

Option D provides the best alternative for ensuring the long term future of Washington Adventist Hospital and is the most cost effective. Option D is the only option that earns a positive financial margin by the fifth year and would not require ongoing subsidy by Adventist HealthCare. Further, Option D provides a new facility in White Oak and significant health care services on the Takoma Park campus where hospital-based outpatient services would be rate regulated, ensuring the viability of the campus and an ability to provide charity care for the community. Thus, Option D is more financial viable and financially feasible than the other two alternatives.

Finally, Option D positions the organization well for emerging changes in health care with an expansion of outpatient services, more accessible care for the community at two campuses and, as a result, ensures Washington Adventist Hospital is best positioned to meet the needs of patients well into the future.

The table below summarizes the capital expense and the margin in the fifth year after opening each option.

Comparison of Each Option

OPTION	CAPITAL EXPENSE	MARGIN IN FIFTH YEAR
Option B	$ 339.7 million	-3.1%
Option C	$ 349.4 million	-0.7%
Option D	$ 373 million	1.9%

Site Selection Process

Along with real estate consulting assistance, the Washington Adventist Hospital and Adventist HealthCare leadership teams worked through a thorough process to evaluate potential sites for the replacement of the hospital. n total, five possible sites were evaluated according to specific criteria and were scored against a variety of characteristics. Of the five potential sites:

- All but one were located in Silver Spring
- Only one was within a mile of the existing site
- Only one was available for purchase and full ownership
- Only one was available through private ownership

Although five potential sites were identified for the relocation and replacement of Washington Adventist Hospital, they were carefully evaluated and scored against the following twelve criteria:

1. Accessibility/Location (major interconnecting roadways)
2. Available Acreage (to accommodate full master plan & associated structures)
3. Purchase to Own (site control)
4. Zoning (proper zoning and entitlements)
5. Existing Public Transportation (bus, train)
6. Feasibility (ease of transaction)
7. Within Existing Primary Service Area
8. Within Montgomery County
9. Area Compatibility (harmony with surrounding development)
10. Ease of Development (site or other constraints)
11. Natural Setting for Healing Environment (close adjacency to natural elements (trees, water, gardens)
12. Access to Science and Technology Organizations(s) (proximity to FDA, University of Maryland, science and technology affiliates)

As demonstrated by the "Site Selection Decision Grid," Exhibit 23, the selected location (Site #5) scored well above the other four options and is the only property that allowed for complete site control through purchase and full ownership.

Priority Funding Area

Part (c) of this standard makes reference to a Priority Funding Area. The White Oak campus of Washington Adventist Hospital is located in a Priority Funding Area as identified in the map. (See Exhibit 1).

(6) Burden of Proof Regarding Need

A hospital project shall be approved only if there is demonstrable need. The burden of proof of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

APPLICANT RESPONSE:

Washington Adventist Hospital acknowledges that it has the burden of proof regarding need. Please see COMAR 10.24.01.08G(3)(b) where the need for MSGA beds, psychiatric beds,

obstetrical beds and emergency department space are discussed. Please see COMAR 10.24.11.05B(2) where the need for operating rooms is discussed.

(7) **Construction Cost of Hospital Space**

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. 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, update using the Marshall Valuation Service© update multipliers, and adjusted as shown in the Marshall Valuation Service© guile 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 include 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.

APPLICANT RESPONSE:

The proposed cost of the hospital construction project is reasonable and consistent with current industry cost experience in Maryland, evidenced by the Marshall Valuation Service (MVS) analysis of construction costs for this project set forth in Exhibits 24 through 29. The MVS analysis addresses the cost of the new hospital at White Oak and the cost of renovation work at Takoma Park. All construction costs are expressed in current (October 2013) dollars and only those costs applicable to the MVS definitions of construction costs for a standard acute care general hospital are included.

Construction Interest and Other Capital Costs – New Construction at White Oak

MVS states that the costs contain "normal interest on only the building funds during the period of construction and processing fee." For this reason, the estimated capitalized interest costs on the project for the construction of the hospital has been adjusted from $47,943,000 to $17,764,000, which reflects the allocation of interest costs to "only the building funds" and to include equity contribution. In other words, no interest cost is carried on the portion of funding to be provided from Adventist HealthCare equity.

The estimated costs of major and minor moveable equipment and other capital cost items that are not specifically included in the design and construction contracts for the new hospital have been excluded, as has the cost of construction interest on these line items. Cost items that are excluded from the MVS calculation are as follows:

- Interest related to above-MVS site development, such as relocation of existing utilities
- Interest related to off-site improvements
- Interest related to Montgomery County land use costs

- Interest related to other extraordinary above-MVS adjustments
- Interest related to major and minor medical equipment
- Interest related to furniture and signage costs
- Interest related to IT and security costs
- Interest related to relocation costs
- Interest related to infrastructure improvements at Takoma Park
- Interest related to renovations at Takoma Park is not carried in the MVS cost for new hospital construction, but it is carried in the MVS analysis of renovation cost described below
- Interest related to Adventist HealthCare's equity contribution

Extraordinary Above-MVS Costs – New Construction at White Oak

Where certain costs to prepare the White Oak site and build the replacement facility for Washington Adventist Hospital are not included in the MVS standard, these are noted and explanations are provided in Exhibit 24. Among the extraordinary cost items excluded from the analysis are: Montgomery County land use costs; off-site road improvements; relocation of existing utility mains and new storm drains; site retaining walls; landscaping, surface parking and construction interest on these line items.

Adjusted Project Cost – New Construction at White Oak

As adjusted, the estimated cost per square foot of building the replacement facility for Washington Adventist is approximately $365.92 as shown below and in Exhibit 25.

MVS Calculations to Build a Good Quality Class A Hospital in Montgomery County
October 2013

	Unadjusted	Extraordinary	Total Cost
New Construction, Incl. Fixed Equipment	$136,300,000	$10,400,000	$132,600,000
Site Preparation	$10,400,000	$9,050,000	$1,350,000
A/E & Consultant Fees	$13,200,000	n/a	$13,200,000
Permits	$700,000	n/a	$700,000
Capitalized Construction Interest	$17,764,000	$2,152,000	$15,612,000
TOTAL	$178,364,000	$ 21,602,000	$156,762,000
	TOTAL SQUARE FEET		428,400
	COST PER SQUARE FOOT		**$365.92**

The project includes a basement and 8 upper floors. According to the MVS calculations summarized below, the Washington Adventist Hospital replacement facility of Class A, Good construction quality should cost approximately $384.64/SF in October 2013 dollars. The complete calculations are found at Exhibit 26. Adjustments for construction cost differentials by department have been included in the calculations as found at Exhibit 27.

MVS Cost Estimate for Construction of the Washington Adventist Hospital at White Oak

	GSF	$ / GSF	Total Cost
Basement	70,836	$191.28	$ 13,549,268
1st - 2nd Floors	146,224	$445.99	$ 65,149,530
3rd - 4th Floors	95,090	$430.39	$ 42,946,078
5th – 8th Floors	116,250	$371.16	$ 43,129,089
TOTAL	**428,400**	**$380.11**	**$164,778,506**

Comparison to MVS Standard – New Construction At White Oak

As the calculations indicate and as reflected in Exhibit 25, the estimated cost of the new hospital construction in White Oak is approximately $18.71/SF or 4.9% below the applicable MVS standard. In addition, the cost of renovations at Takoma Park reduces the net cost per square foot substantially as described below.

MVS Analysis For Renovations At Takoma Park

The existing hospital at Takoma Park is being renovated to provide a portion of the regulated services under this CON as well as clinic services, physician offices and leased space for Washington Adventist University. The physician offices and leased space for Washington Adventist University are addressed under Construction Cost of Non-Hospital Space. Medical equipment, furniture, signage, IT, communication and security are included in Other Capital Costs. For budgeting purposes, various levels of renovations have been identified, ranging from $250/SF to $100/SF. These are construction costs only. The renovation categories include:

- Full clinical renovation for a new use (i.e. tenant space is gutted, all new interior construction and branch utility lines, core and shell features to remain include structure, building envelope and central utility services) - $250/SF;
- Full clinical renovation for the same or similar use (similar to renovation for new use except that major utility distribution and some clinical areas may remain) - $200/SF;
- Moderate clinical renovation or non-clinical renovation for new use (most walls and branch utility distribution remain) - $150/SF; and
- Minor clinical renovation or non-clinical renovation for same use (minor wall changes if any, lighting, floor, wall and ceiling finishes replaced) - $100/SF.

Cost Estimate for Renovation of Washington Adventist Hospital In Takoma Park

FUNCTION	TOTAL AREA	RENO AREA	LEVEL OF RENOVATION	COST
Outpatient Clinic Space	6,400 SF	6,400 SF	Full Clinical, Similar Use	$1,300,000
Psychiatric Unit	30,600 SF[1]	12,500 SF	Moderate Clinical Renovation	$1,860,000
Psychiatric Unit		2,400 SF	Minor Clinical Renovation	$240,000
AREA	37,000 SF	21,300 SF	CONSTRUCTION COST	$3,400,000
Site Prep, Design Fees, Permits, Interest (See Exhibit 28)				$ 727,000
RENOVATED AREA		**21,300 SF**	**TOTAL PROJECT COST**	**$4,127,000**
PROJECT COST PER SF				**$193.76**

NOTES

1. The 30,600 SF Psychiatric Unit includes 15,700 SF of existing space to remain and 14,900 SF of renovated space.

The renovations at Takoma Park include work on the Lower Level and 2nd floor. According to the MVS calculations summarized below, the renovations at Washington Adventist Hospital/ Takoma Park of Class B, Average construction quality should cost approximately $315.62/SF in October 2013 dollars. The complete calculations are found at Exhibit 29.

MVS Cost Estimate for Renovation of Washington Adventist Hospital at Takoma Park

	GSF	$ / GSF	Total Cost
Lower Level 1	6,400	$236.08	$ 1,510,887
2nd Floor	14,900	$349.78	$ 5,211,785
TOTAL	**21,300**	**$315.62**	**$ 6,772,672**

Comparison To MVS Standard – Renovations At Takoma Park

As the calculations indicate and as reflected in Exhibit 28, the estimated cost for the renovation of Washington Adventist Hospital/Takoma Park is approximately $121.86/SF or 38.6% below the applicable MVS standard.

Net Cost Of Construction For Washington Adventist Hospital - Including Existing Space To Remain, Renovations And New Construction

Many of the existing support spaces at Washington Adventist Hospital/Takoma Park are being re-used or re-purposed with no required renovations as shown below. This increases the cost-effectiveness of the project and reduces the net cost per square foot as compared to a project including new construction only.

Renovation of Washington Adventist Hospital In Takoma Park

FUNCTION	TOTAL AREA	RENO AREA	LEVEL OF RENOVATION
Outpatient Clinics	6,400 SF	6,400 SF	Full Clinical, Similar Use
Plant Operations	1,200 SF	N/A	Existing Space to Remain
Building Engineering	4,500 SF	N/A	Existing Space to Remain
Housekeeping	1,000 SF	N/A	Existing Space to Remain
Dietary	9,200 SF	N/A	Existing Space to Remain
Biomed Engineering	600 SF	N/A	Existing Space to Remain
Morgue	200 SF	N/A	Existing Space to Remain
Materials Mgmt.	2,800 SF	N/A	Existing Space to Remain
Laboratory	3,700 SF	N/A	Existing Space to Remain
Wound Care	1,500 SF	N/A	Existing Space to Remain
Radiology	4,800 SF	N/A	Existing Space to Remain
Pharmacy	1,700 SF	N/A	Existing Space to Remain
Central Registration	1,000 SF	N/A	Existing Space to Remain
Psychiatric Unit	30,600 SF	12,500 SF	Moderate Clinical Renovation
Psychiatric Health Unit	2,400 SF		Minor Clinical Renovation
TOTAL AREA	**69,200 SF**	**21,300 SF**	

Including the renovation cost for services to remain at Takoma Park, the cost for new hospital construction and renovation is $160,162,000. Total program area is 497,600, resulting in an effective cost per square foot of $321.87 for the combined program at White Oak and Takoma Park. This is approximately $62.77 or 16.3% below the MVS standard for new construction only.

(8) Construction Cost of Non-Hospital Space.

The proposed construction cost of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service© guide for the appropriate structure. 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 non-hospital space shall not include 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. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

APPLICANT RESPONSE:

The budget for the Washington Adventist Hospital replacement project includes allowances for demolition of the areas in Takoma Park which are to be converted to leased space for physician offices and Washington Adventist University, for work in the public corridors to create accessible, demisable tenant spaces within the existing hospital and for fit-up of the leased spaces. These are the only non-hospital spaces included in the project.

Values for the fit-up allowances were determined based upon comparison to recent leases executed by Adventist HealthCare for comparable spaces. The allowance values, including escalation, are as follows:

Fit-up allowance for Washington Adventist University space (i.e. renovate to leasable condition) - $84/SF;

Demolition allowance for Washington Adventist University space (i.e. demolish walls, ceilings, lighting, and branch MEP distribution, including demolition of existing OR's to create a leasable space) - $17/SF;

Fit-up allowance for physician office space (i.e. renovate to leasable condition) - $50/SF;

Demolition allowance for physician office space (i.e. demolish walls, ceilings, lighting, and branch mechanical, electrical, plumbing, (MEP) distribution to create a leasable space) - $11/SF;

Allowance for finishes, zoning and security in public corridors (i.e. new finishes, lighting and demising walls as required to create tenant space) - $84/SF.

Cost Budget for Non-Hospital Spaces In Takoma Park

TENANT SPACE	LEASE AREA	ALLOWANCE	COST
Washington Adventist University	56,770 SF	Demolition/Prep	$970,000
Washington Adventist University	Same	Fit-up	$4,770,000
Physician Offices	28,840 SF	Demolition/Prep	$320,000
Physician Offices	Same	Fit-up	$1,440,000
Public Corridors	14,000 SF	Finishes, zoning and security	$1,180,000
TOTAL NON-HOSPITAL SPACE	**99,610 SF**		**$8,680,000**
AVERAGE CONSTRUCTION COST PER SQUARE FOOT, INCL. DEMOLITION			$87.14

As stated, these costs are consistent with fit-out allowances included in recent leases for medical office and related space.

(9) Inpatient Nursing Unit Space.

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

APPLICANT RESPONSE:

None of the space for inpatient units in the project exceeds 500 square feet per bed.

Square Feet/Bed built for inpatient nursing units in the Project is shown below:

Proposed Bed Distribution (White Oak)

Unit Name	Unit Description	No. Beds in the Project	Unit Size (SF)	Square Feet / Bed
Floor 2	ICU / CCU	28	13,766	491.64
Floor 3	Cardiac	32	11,778	368.06
Floor 4	Post Partum/Ante Partum / MSGA	21	9,418	448.48
Floor 5	Med / Surg	32	11,061	345.66
Floor 6	Med / Surg	32	11,061	345.66
Floor 7	Med / Surg	32	11,061	345.66
Floor 8	Med / Surg	24	8,296[4]	345.66
.	Total =	201		

4 This floor contains observation beds which are excluded from the calculation.

Proposed Bed Distribution (Takoma Park)

Unit Name	Unit Description	No. Beds in the Project	Unit Size (SF)	Square Feet / Bed
Floor 2 (Takoma Park)	Behavioral Health / Psych (Takoma Park)	40	19,214	480.35

The department area was determined by summing the interior room areas for each departmental unit, including all patient rooms, support spaces and family support rooms within that department. The tabulation excluded corridor circulation, stairs, elevators, shafts, utility rooms, structural columns, shear walls and exterior wall enclosure. As an example, below is the summary table for the 2North ICU/CCU Unit:

ROOM SCHEDULE BY DEPARTMENT - ICU / CCU

Level	Department	Room Name	Area (sf)
LEVEL 2	CRITICAL CARE	ALCOVE	12
LEVEL 2	CRITICAL CARE	ALCOVE	12
LEVEL 2	CRITICAL CARE	ALCOVE	14
LEVEL 2	CRITICAL CARE	ALCOVE	14
LEVEL 2	CRITICAL CARE	ANTE ROOM	129
LEVEL 2	CRITICAL CARE	ANTE ROOM	129
LEVEL 2	CRITICAL CARE	CHARTING	318
LEVEL 2	CRITICAL CARE	CHARTING STATION	319
LEVEL 2	CRITICAL CARE	CLEAN EQUIPMENT HOLD	453
LEVEL 2	CRITICAL CARE	CLEAN SUPPLY	144
LEVEL 2	CRITICAL CARE	CLEAN SUPPLY	169
LEVEL 2	CRITICAL CARE	CORRIDOR	1,107
LEVEL 2	CRITICAL CARE	DECONTAM	126
LEVEL 2	CRITICAL CARE	EQUIPMENT STORAGE	219
LEVEL 2	CRITICAL CARE	EQUIPMENT STORAGE	297
LEVEL 2	CRITICAL CARE	FAMILY WAITING	253
LEVEL 2	CRITICAL CARE	HK	34
LEVEL 2	CRITICAL CARE	ICU 01	293
LEVEL 2	CRITICAL CARE	ICU 02	272
LEVEL 2	CRITICAL CARE	ICU 03	283
LEVEL 2	CRITICAL CARE	ICU 04	283
LEVEL 2	CRITICAL CARE	ICU 05	272
LEVEL 2	CRITICAL CARE	ICU 06	293
LEVEL 2	CRITICAL CARE	ICU 07	311
LEVEL 2	CRITICAL CARE	ICU 08	327
LEVEL 2	CRITICAL CARE	ICU 09	271
LEVEL 2	CRITICAL CARE	ICU 10	283
LEVEL 2	CRITICAL CARE	ICU 11	283
LEVEL 2	CRITICAL CARE	ICU 12	272
LEVEL 2	CRITICAL CARE	ICU 13	293
LEVEL 2	CRITICAL CARE	ICU 14	290
LEVEL 2	CRITICAL CARE	ICU 15	296
LEVEL 2	CRITICAL CARE	ICU 16	293

Level	Department	Room Name	Area (sf)
LEVEL 2	CRITICAL CARE	ICU 17	272
LEVEL 2	CRITICAL CARE	ICU 18	283
LEVEL 2	CRITICAL CARE	ICU 19	283
LEVEL 2	CRITICAL CARE	ICU 20	271
LEVEL 2	CRITICAL CARE	ICU 21	327
LEVEL 2	CRITICAL CARE	ICU 22	311
LEVEL 2	CRITICAL CARE	ICU 23	293
LEVEL 2	CRITICAL CARE	ICU 24	272
LEVEL 2	CRITICAL CARE	ICU 25	283
LEVEL 2	CRITICAL CARE	ICU 26	283
LEVEL 2	CRITICAL CARE	ICU 27	272
LEVEL 2	CRITICAL CARE	ICU 28	297
LEVEL 2	CRITICAL CARE	LEAD THERAPIST	162
LEVEL 2	CRITICAL CARE	LOCKERS	56
LEVEL 2	CRITICAL CARE	MED	81
LEVEL 2	CRITICAL CARE	MEDICATION	76
LEVEL 2	CRITICAL CARE	NOURISH	59
LEVEL 2	CRITICAL CARE	NOURISH	61
LEVEL 2	CRITICAL CARE	OFFICE	70
LEVEL 2	CRITICAL CARE	OFFICE	71
LEVEL 2	CRITICAL CARE	OFFICE	84
LEVEL 2	CRITICAL CARE	OFFICE	84
LEVEL 2	CRITICAL CARE	PAT TLT	23
LEVEL 2	CRITICAL CARE	PHYSICIAN WORK ROOM	124
LEVEL 2	CRITICAL CARE	SOILED UTILITY	135
LEVEL 2	CRITICAL CARE	SOILED UTILITY	124
LEVEL 2	CRITICAL CARE	STAFF LOUNGE / LOCKERS	401
LEVEL 2	CRITICAL CARE	STAFF ROOM	111
LEVEL 2	CRITICAL CARE	STF TLT	56
LEVEL 2	CRITICAL CARE	STF TLT	42
LEVEL 2	CRITICAL CARE	TEAM ROOM	135
		Total Area (SF)	13,766
		Patient Rooms	28
		Area per Patient Room	491.6

(10) Rate Reduction Agreement.

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission had determined that a rate reduction agreement is not necessary.

APPLICANT RESPONSE:

This standard is inapplicable because the rate reduction agreements contemplated by the standard have been replaced by automatic rate reductions.

(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 volume of services delivered; or

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

APPLICANT RESPONSE:

The Washington Adventist Hospital design team has consistently incorporated performance features into the design of the replacement proposed for the White Oak site in order to perform efficiently. The current design for the proposed replacement hospital retains the following efficiencies in an efficient building footprint.

- Centrally located supply rooms on the patient floors to minimize nurse travel distances.
- Optimized movements between patient care departments and critical support amenities or services will result in greater efficiency for staff providing care and patients receiving care.
- On the cellar level, several key support departments are located with easy access to both the clean dock and the staff/service elevators.
- The main public and staff elevator banks are centrally located.
- Pharmacy is located on the cellar level in close proximity to service elevator core.
- Information Services and Health Information are adjacent to provide better dock access for support service departments with daily dock use.
- Relocation of Patient Care Equipment adjacent to Central Sterile Processing for more efficient circulation and cleaning of equipment.
- Complementing departments are located adjacent to each other, such as Nursing Administration/Public Access and Occupational Health/Human Resources.

- The building has only one patient tower so the vertical circulation is more direct and the distances between matching services such Labor and Delivery adjacent to the Post-Partum Unit is shorter.

- Maternity layout minimizes the distance from the service elevators to the C-Section suites and places the Nursery within the Post-Partum Unit suite.

- Optimal elevator quantity and configuration of elevator banks for better building circulation.

- Centralize public access areas to improve wayfinding and security.

- Include line-of-sight wayfinding from main public entrance to public areas such as gift shop, retail pharmacy, cafeteria, elevators.

Washington Adventist Hospital, along with its architect and engineers, will continue this effort in the design phases to provide the best value for the associated design and/or construction costs. Additional energy-saving suggestions (LED lighting. more-efficient equipment. etc.,) will also be explored in later phases of design.

Efficiencies in Staffing

As described in this proposal to relocate Washington Adventist Hospital, full time equivalents (FTEs) per Adjusted Occupied Bed (AOB) will improve in the replacement facility and will continue to improve as volumes grow as projected. Specifically, in Year 1 in the new facility, FTEs/AOB ratios will improve to 4.20 from 4.34 projected for 2014 in the existing facility. As volume grows according to the projection, FTEs/AOB will further reduce to 3.93 by 2023. The increases in efficiency are related to the programmed improvements in patient flow and management built into the design of the replacement Hospital facility. Specific improvements in efficiency are the result of: 1) consolidating the critical care service into one nursing unit, 2) reduction in patient transport positions due to better adjacencies between departments, 3) improvements in the patient admissions function, and 4) overall reductions in average length of stay. Without these gains in efficiencies, the hospital would incur additional manpower expenses above those associated with the modest increases in volumes forecasted for the proposed relocation of Washington Adventist Hospital.

Building

The overall organization of the new hospital will also improve operations. Unlike the existing facility which requires multiple elevator locations that serve specific areas of the hospital and often mix public, staff, and service traffic, the new design is organized around centrally located, segregated public and staff/service elevator cores that service the entire building thereby reducing confusion, congestion and travel time. A Patient Transfer elevator will allow for the movement of patients from the Emergency Department to Critical Care, Maternity, and Intermediate Care units.

Departments

- Hospital Administration - All functions co-located on a single floor

- Nursing Units - All private rooms increase utilization, reduces moves. Nursing workstations are located outside of patient rooms.

- Critical Care - Co-located in 7-bed zones to allow for fluctuation in census as well as sharing support services. Co-located with Respiratory Therapy.

- Surgical Suite - Central Clean Core with direct elevator access to Central Processing. Designed for switch to case cart system.

- Endoscopy - Co-located with Surgery for shared support.

- Cardiology - All Cardiology (invasive and non-invasive) co-located on one floor with adjacent telemetry unit.

- Maternity - Unlike the current department, a distinct Triage Suite and C-section prep/recovery suite is provided to preclude the need to use LDR's for this purpose.

- Nursery - Respite Nursery co-located with Intermediate Care Nursery for shared support.

- Behavioral Health Unit - To remain in Takoma Park and will undergo renovations to increase private beds and capacity and increase staff efficiency by developing units based on acuity.

- Emergency - Universal enclosed exam/treatment rooms and zoned configuration to allow flexibility in use and adjustments with changes in census. CT and Radiographic rooms in close proximity to Diagnostic Imaging. Satellite Collections Lab provided. Additionally, the 12 adjacent observation beds will facilitate cohorting short-stay patients where care will be managed more efficiently, avoiding inefficient transfers.

- Dialysis - Dialysis Unit located on Nursing Unit Floor

- Rehab - Rehab Suite located on Nursing Unit Floor

- Throughput at the current site is hampered by the number of semi-private rooms. Rooms are blocked when a patient has isolation restrictions due to infection. The replacement facility will have all private rooms improving patient flow and treatment.

Summary

The proposed replacement Washington Adventist Hospital is designed to operate efficiently and, as described above, has incorporated many design features that explicitly address this objective.

(12) Patient Safety.

The design of a hospital project shall take into account patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included in each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

APPLICANT RESPONSE:

Evidence-based architectural methods have been employed in the hospital design to improve patient outcomes, safety, and satisfaction. Additionally, these design methods also improve staff efficiency, satisfaction, and staff retention. The design is consistent with national or jurisdictional codes and guidelines established for hospital design and construction and include those found at Exhibit 30.

All patient rooms will be private, including all of the rooms for Maternity, Medical/Surgical and Intensive Care Unit patients. Therefore, the replacement hospital will eliminate infection risks inherent in semi-private rooms occupied by two patients. In addition, hand washing stations will be located both directly inside the entry door to each patient room as well as along the corridor to further reduce the risk of infection.

Within each patient room, the risk of patient falls is reduced due to the close proximity of the washroom door to the patient's bed and the amount of light provided. Family space is also provided in the room to encourage patient and family involvement in care. Individual computer access is provided in each room to facilitate the communication of concerns that patients or family members might have.

Computer stations are included in both the alcoves and at the patient bedside for staff access to electronic medical records and medication bar coding, potentially reducing errors.

In the Emergency Department, the Triage and Fast Track areas both have separate waiting areas from the main Emergency Department waiting room and all exam spaces are private enclosed rooms, reducing the risk of infection. Within the Emergency Department, the Behavioral Health Assessment Area has a secured suite of rooms with an outside entry for patients.

Upon analysis of its patient population, Washington Adventist Hospital will identify and designate locations where ceiling mounted patient lifts will be placed in order to provide for the safe transfer of bariatric and other similarly incapacitated patients. These areas will also incorporate other safety features to include floor mounted toilets, wider doors, as well as furniture and equipment designed for this population.

At the Washington Adventist Hospital-Takoma Park campus the behavioral health unit will be expanded to provide all private beds and safer conditions. T he current configuration of Behavioral Health at Takoma Park comprises only 5 private rooms. This will be revised to 40 private beds in 2 units: a high-functioning unit and a low-functioning unit. The 2nd floor of the existing 1990's era building (known as building 2500 on the Takoma Park campus) will be renovated to a the low-functioning 20-bed unit with a corridor connection to the existing unit. In addition, renovations to the existing unit will provide better visibility and larger common areas.

At the White Oak campus, a discrete examination/assessment suite is provided within the Emergency Department and is designed to permit segregation of disruptive patients while allowing for visual control by staff. This suite can be accessed directly from the ambulance entrance area.

Where appropriate, various radio frequency identification systems will be utilized to track patient flow during their treatment. Such systems will particularly enhance the safety of patients being treated in the Surgical Suite and the Emergency Department as their progress through the department will be constantly monitored. Infants on the maternity floor will also be protected through the use of these systems which will include automatic alarm and lock down. Tracking of critical equipment through these systems will also be reviewed and implemented to ensure that they are located and available when urgently needed for patient care.

Consistent with its heritage, Washington Adventist Hospital seeks to create a hospital that holistically serves its future patients and staff. Through evidence-based design methods and principles, the replacement hospital is designed to promote healing in a safe and effective physical environment.

(13) 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 Certificate of Need 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 use of the applicable services(s) by the service area population of the hospital or State Health Plan need projections, if relevant;**

(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 provisions, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;**

(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**

(iv) **The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.**

APPLICANT RESPONSE:

A comprehensive table of the revenue and expense assumptions that were used in the financial projections can be found in Exhibit 31.

All of the projections of future utilization of the hospital prior to the opening of the new facility have been based on historical trends in the utilization of these services by the service area population of the hospital. (Exhibit 32). Future utilization of the hospital after opening of the new facility have been based on the utilization of those services by the service area population need projections as shown in the need and market share projection on pages 140 and 143 of this application under COMAR 10.24.01.08G(3)(f)(Impact on Existing Providers).

Revenue estimates are based on current allowable charge levels and incorporate the current reimbursement methodologies employed by the HSCRC (i.e. Charge per Episode methodology for inpatient cases and outpatient fee for service with an 85% variable cost factor for all services except clinic which is subject to 50%). However, Washington Adventist Hospital has entered into discussions with the HSCRC staff to evaluate a new reimbursement mechanism with a probable effective date of January 1, 2014 that will serve to help stabilize Washington Adventist Hospital during the transition period to build a new and efficient hospital which will allow the hospital to meet the objectives of the evolving healthcare delivery model.

Staffing and expenditure levels as shown in Exhibit 31 are based on current expenditure levels but take into account the necessary reductions currently underway that are responsive to the current volume levels and reimbursement/financial challenges.

As shown in Exhibit 31, the hospital will generate excess revenues over expense in the fourth year following the opening of the new facility.

Attached as Exhibit 33 is a letter from Adventist Health Care's investment banker, Ziegler Capital Markets, which endorses the feasibility of the project.

(14) Emergency Department Treatment Capacity and Space.

(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of *Emergency Department Design: A Practical Guide to Planning for the Future* from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians *Emergency Department Design: A Practical Guide to Planning for the Future*, given the classification of the emergency department as low or high range and the projected emergency department visit volume.

(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:

(i) **The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant's primary service areas;**

(ii) **The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;**

(iii) **Any demographic or health service utilization data and/or analyses that support the need for the project;**

(iv) **The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings;**

(v) **Any other relevant information on the unmet need for emergency department or urgent care services in the service area.**

APPLICANT RESPONSE:

Washington Adventist Hospital proposes an emergency department to be located within the replacement hospital on the White Oak campus, and clinic space to be located on the Takoma Park campus. Together, this approach reflects the dynamics of moving an existing emergency department to an adjusted service area and the projected effect of providing clinic services on the existing campus. The plan reflects Washington Adventist Hospital's analysis and projections based on the projected changes to the adjusted service area and changes to market share, current utilization rates and trends in the relocated hospital's service area, the projected population for the new service area, and the existing hospital's utilization trends.

As referenced above, this response addresses the program and design characteristics for the emergency department proposed for the White Oak campus, and, as stated previously, assume the presence of clinic service availability on the Takoma Park campus. The White Oak campus is easier for emergency vehicles to reach and provides safer landing access for helicopters. It is located in an area with a large senior population and is accessible for low income residents in Hyattsville, Langley Park and other communities. The current hospital emergency department on the Takoma Park campus houses 26 treatment bays, which do not provide a desirable level of privacy or dignity for patients and caregivers. The emergency department in White Oak will contain 35 treatment rooms, 2 Mental Health Evaluation rooms, and an adjacent area with 12 short stay observation beds.

Comparing the proposed design at White Oak with the ACEP standards and parameters, the proposed emergency department program and space comfortably meets the projected volumes and provides a plan for expansion should volumes increase as projected. The current design, 35 treatment bays and 12 observation beds in 24,987 DGSF, is within the high and low range parameters (see table below). In addition, Washington Adventist Hospital believes that the current design is appropriately sized to the projected volumes with some ability to expand yearly visits with improvements in efficiency or minor changes in room mix. Further, the 12-bed observation unit

provides flexibility in the emergency department program to meet anticipated future needs. Finally, should future volumes increase beyond the projections, the hospital design includes emergency department expansion capability directly to the north. The DGSF area for the current design is smaller than the ranges noted in the ACEP guidelines because these ranges usually include a radiology program. The current design shows the Radiology Department immediately adjacent to the emergency department with direct access to Radiology and quick access to the CT and MRI. As a result, that program area is included in the overall Radiology Services DGSF.

Washington Adventist Hospital considered the ACEP guidelines for determining the number of treatment spaces and the total program area for the design of the emergency department on the White Oak campus. The table below provides Washington Adventist Hospital's responses to the ACEP parameters.

Parameters Determining Size for Emergency Department

Low Range Parameter	**Applies to Washington Adventist Hospital**
ALOS for all ED patients <2.5 hours	NO
Observation /Evaluation Beds located outside ED	YES
Time to admit <60 minutes after disposition	YES
Average turnaround time for diagnostic test results <30 minutes	NO
Less than 18% of patients are admitted to the Hospital	NO
Non-urgent patients outnumber urgent patients by more than 10 %	NO
Less than 20% of patients are age 65+	NO
Minimal Need for offices or teaching spaces	NO
Imaging studies are not performed within the department	NO
No specialty components or departments	NO
Flight/trauma services support areas not included	YES
ALOS for all ED patients >3.5 hours	YES
Observation/evaluation beds will be located within the ED	YES
Time to admit >90 minutes after disposition	NO
Average turnaround time for diagnostic test results in >60 minutes	YES
More than 23% of patients are admitted to the Hospital	NO
Need for offices or teaching spaces, such as a university teaching hospital	NO
Imaging studies are performed within the department	YES
Specialty components or departments (pediatric ED, large number of psychiatric patients)	YES – psychiatric Patients, geriatric
Flight/trauma services support areas included	NO

Shown below are the low ranges and high ranges of emergency department areas and bed quantities, including patient spaces for observation/clinical decision. The high range includes beds for "observation/clinical decision." These estimates are shown below:

Projected Annual Visits	Departmental Gross Area		Bed Quantities					
	Low Range	High Range	Low Range	Low Range Visits/bed	High Range	High Range Visits/Bed	Area/Bed	Estimated Observation/ Clinical Decision
20,000	13,500	17,100	15	1,333	19	1,053	900	3-4 spaces
30,000	17,500	22,750	20	1,500	26	1,154	875	4-6 spaces
40,000	21,875	28,875	25	1,600	33	1,212	875	6-8 spaces
50,000	25,500	34,000	30	1,677	40	1,277	850	8-10 spaces
60,000	29,750	39,950	35	1,714	47	1,296	850	9-12 spaces
70,000	33,000	44,550	40	1,750	54	1,296	825	11-14 spaces

Source: Emergency Department Design, A Practical Guide to Planning for the Future

Service Area

Based on CY2012 internal operating data, the current service area for emergency department visits at Washington Adventist Hospital Takoma Park was analyzed.

In CY2012, the Washington Adventist Hospital PSA for the Emergency Department consisted of 8 zip codes, 5 located in Montgomery County, and 3 located in Prince George's County, with the primary number of Emergency Department visits coming from zip code 20783 (Hyattsville). Within the Washington Adventist Hospital Takoma Park PSA, Holy Cross Hospital is the only other emergency department service provider.

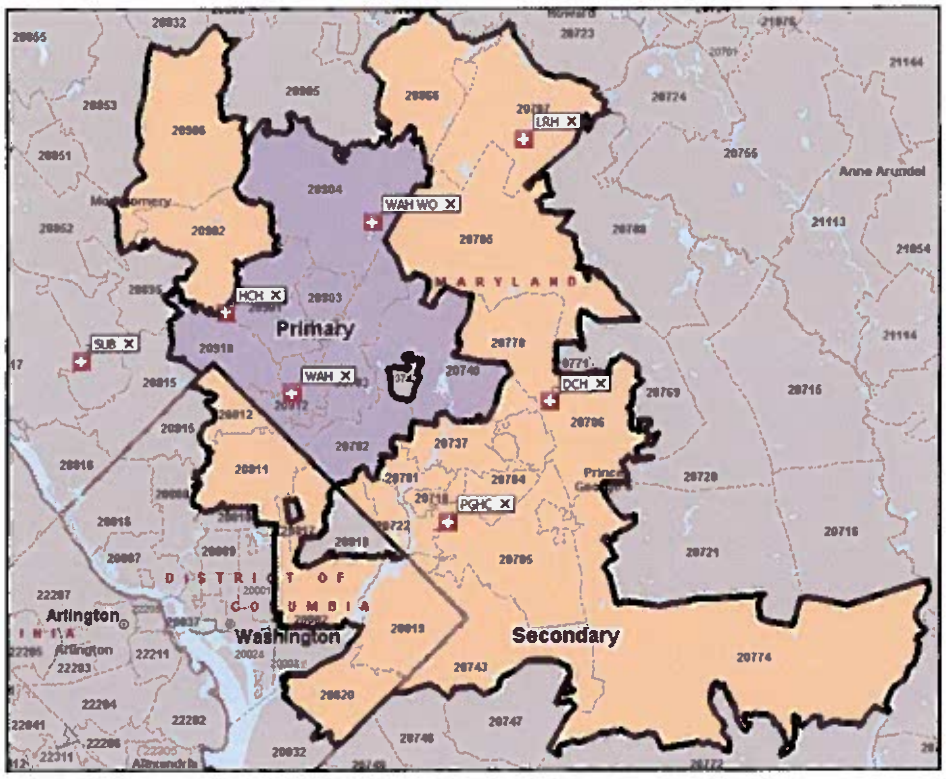
The Washington Adventist Hospital Takoma Park PSA is comprised of 30 zip codes, 8 located in Montgomery County, 16 located in Prince George's County, and 6 located in the District of Columbia, listed below.

Zip Code	City	Service Area	ED Visits
20783	Hyattsville	Primary	9,107
20912	Takoma Park	Primary	5,840
20782	Hyattsville	Primary	4,268
20903	Silver Spring	Primary	3,667
20901	Silver Spring	Primary	2,445
20904	Silver Spring	Primary	2,170
20910	Silver Spring	Primary	2,070
20740	College Park	Primary	1,315
20011	Washington, D.C.	Secondary	1,245
20737	Riverdale	Secondary	1,095
20705	Beltsville	Secondary	964
20902	Silver Spring	Secondary	911
20770	Greenbelt	Secondary	852
20781	Hyattsville	Secondary	778
20906	Silver Spring	Secondary	768
20712	Mount Rainier	Secondary	740
20012	Washington, D.C.	Secondary	630
20706	Lanham	Secondary	612
20784	Hyattsville	Secondary	600

Zip Code	City	Service Area	ED Visits
20722	Brentwood	Secondary	442
20785	Hyattsville	Secondary	426
20707	Laurel	Secondary	323
20019	Washington, D.C.	Secondary	281
20002	Washington, D.C.	Secondary	273
20743	Capitol Heights	Secondary	272
20866	Burtonsville	Secondary	263
20774	Upper Marlboro	Secondary	260
20020	Washington, D.C.	Secondary	257
20017	Washington, D.C.	Secondary	247
20710	Bladensburg	Secondary	245

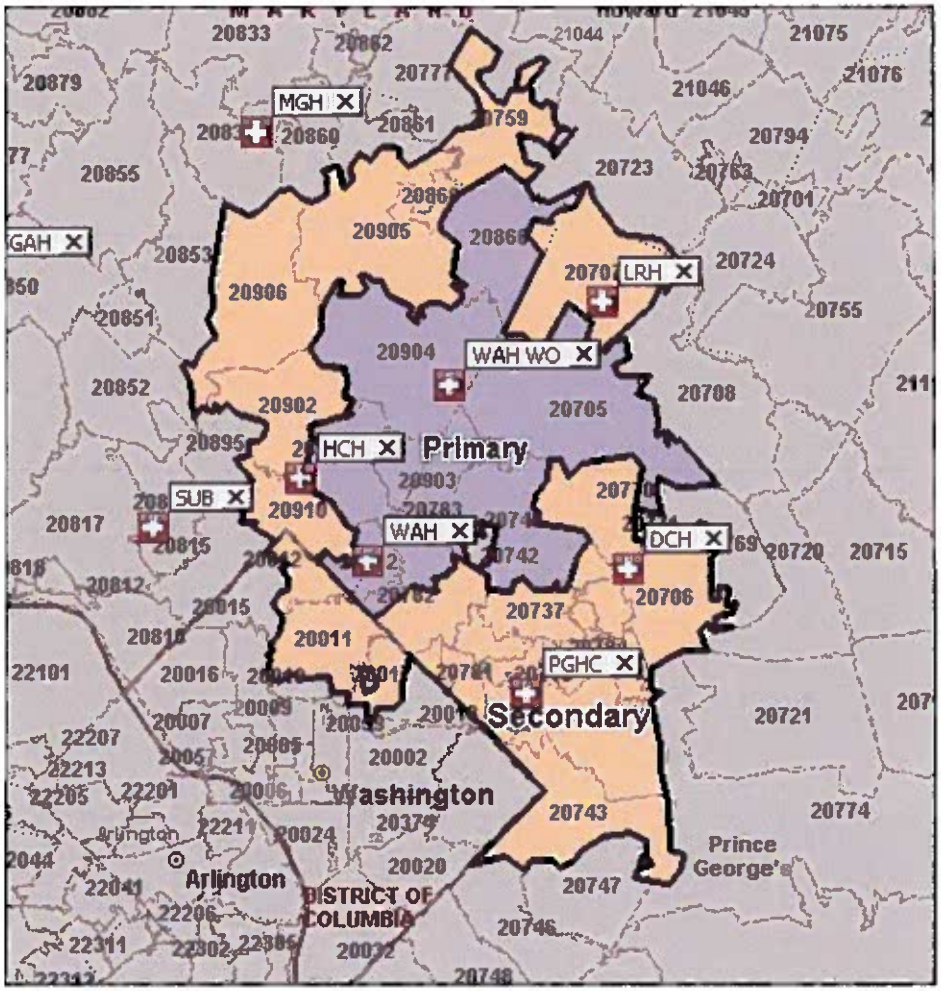
CY2012 Washington Adventist Hospital Takoma Park

Primary and Secondary Service Area for ED Visits



The White Oak TSA was identified based on Emergency Department admissions from contiguous zip codes to the proposed White Oak location because convenience and/or proximity is a critical factor in emergency department use. Travel times of less than 15 minutes to both the proposed White Oak location and the current Takoma Park campus were analyzed to identify the primary service area and secondary service area. The Takoma Park campus is considered relevant in this analysis defining the TSA because primary care clinics will be providing services at that campus to reduce the number of low acuity visits and unnecessary emergency level visits at Washington Adventist Hospital White Oak and surrounding hospital emergency departments. See the map below.

Proposed Washington Adventist Hospital White Oak Primary and Secondary Service Area for Emergency Department



The following chart shows the emergency room visits for all hospitals in Montgomery and Prince George's counties from CY 2008 until CY 2012. Overall emergency department visits grew 9% over the last five years. Washington Adventist Hospital experienced higher than average emergency room growth of 12.6% since 2008.

ED Visits for Montgomery and Prince George Hospitals - Calendar Years 2008-2012

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	45,167	46,257	44,823	48,189	50,840	12.6%
Holy Cross	84,998	93,801	86,627	90,582	92,761	9.1%
Montgomery General	34,200	36,100	36,325	39,091	40,339	18.0%
Shady Grove Adventist	74,457	75,973	71,984	72,113	78,575	5.5%
Suburban Hospital Center	43,138	44,491	43,063	44,219	45,851	6.3%
Laurel Regional Hospital	35,444	37,461	35,147	35,268	36,041	1.7%
Prince Georges Hospital Ctr	43,753	47,761	47,205	51,312	53,126	21.4%
Southern Maryland	-	-	-	-	6,953	N/A
Fort Washington Hospital	43,507	47,302	44,424	44,749	46,366	6.6%
Doctors Community Hospital	57,007	60,047	59,150	57,116	52,398	-8.1%
Total	461,671	489,193	468,748	482,639	503,250	9.0%

The following tables identify current utilization for the Emergency Department at Washington Adventist Hospital Takoma Park.

Emergency Department Payor Mix at Washington Adventist Hospital Takoma Park based on Gross Charges

Payor	2008	2009	2010	2011	2012	Change
COMMERCIAL	31.2%	30.7%	29.1%	27.9%	26.7%	-4.5%
MEDICAID	15.9%	21.6%	23.2%	24.6%	26.1%	10.2%
MEDICARE	22.8%	22.5%	24.8%	21.9%	22.0%	-0.8%
CHARITY	0.2%	0.1%	0.0%	0.0%	0.1%	-0.1%
OTHER	3.1%	2.7%	1.5%	1.6%	1.9%	-1.3%
SELF PAY	26.7%	22.5%	21.3%	23.9%	23.3%	-3.4%

Additionally, the percentage of uninsured population is higher in Montgomery County and Prince George's counties compared to the state of Maryland. Further, representative of the current payor mix at Washington Adventist Hospital, it serves a disproportionate number of the uninsured and underinsured population compared to other area providers.

Insurance Coverage Amongst Civilian Noninstitutionalized Population - CY2012

	No Health Insurance	
Montgomery County	118,148	11.9%
Prince George's County	135,901	15.6%
Maryland	597,554	10.3%

Source: 2012 American Community Survey

The Washington Adventist Hospital emergency department and acute care staff and physicians have been intentionally focused on appropriate utilization and the placement of patients to more appropriate settings for care. The model of care proposed by this plan is informed by and responds to current efforts and the existence of various partnerships directed at caring for the populations Washington Adventist Hospital serves in the best and most appropriate setting. Although the emergency department to be located in White Oak will continue to see a variety of patients from the identified service area, the complement of services to be located in Takoma Park will be available to current populations seeking care for lesser acuity conditions.

The complement of services in Takoma Park will be comprised of clinic services to be provided by the hospital or in affiliation with the hospital, such as CCI, Inc. and the maternity clinic. In fact, CCI will commence with providing Federally Qualified Health Services on the Takoma Park campus by the end of 2013 and the maternity clinic will continue to provide antenatal services as it has for many years at the Takoma Park campus. These efforts taken by the hospital have and will continue to have a favorable impact on the utilization of emergency services. Along with the plan to relocate the emergency department to White Oak, the plan for clinic based services to remain in Takoma Park is focused on ensuring that populations in the adjusted service area have access to the appropriate level of service when it is needed.

In addition to the emergency department and clinic services proposed in this application, population health programs have been implemented during the past two years to lower the rate of non-acute emergency room use and readmissions to the hospital. During the first 24 months of operation of these programs, the readmission rate (excluding one-day stays) has ranged from a high of 9.39%

early in the program to record lows of 6.2% achieved twice in the past 10 months. The program components are:

- A partnership with Walgreens to provide Bedside Prescription Delivery Service to patients ensuring that they have all required medications in hand before leaving the hospital, regardless of their ability to pay. Patients discuss their medications with pharmacists before discharge and again within 48-72 hours post discharge. This program has increased the level of medication compliance and as a result, improved health status and fewer emergent needs among hospital patients.

- WellTransitions Program also in partnership with Walgreens is in place for patients identified as high risk for readmission. Pharmacists make follow-up calls to these patients three times during the 30-day post discharge period. Home medications and prescribed hospital medications, side effects, dosing and other health questions are discussed during these calls.

- 340B Drug Pricing Program, one year after beginning the Bedside Prescription Delivery Service, the hospital and Walgreens initiated this program to ensure funding for prescription medications for the underserved patients discharging from the hospital.

- Early in 2013, the hospital added two Transitional Care positions within the Case Management Department to implement My Health Place® at Washington Adventist Hospital. This program in collaboration with Conifer Health Solutions identifies high risk patients before they leave the hospital and make sure they have follow-up appointments with a physician. Follow-up calls are also made to patients in the program who receive a My Health Place® Passport booklet. The booklet lists their physician name and appointment time, as well as phone numbers to call if they have questions. The Passport is issued in the patient's preferred language, and at present is available in Spanish, French and Amharic in addition to English.

- Washington Adventist Hospital has developed programs in conjunction with other community resources at two housing facilities to provide care for patients before a health condition becomes more serious and requires hospitalization. Programs at Victory Towers in Takoma Park and Holly Hall in Silver Spring are respectively serving seniors living on fixed incomes and seniors and disabled individuals who are aging in place with inadequate resources.

Washington Adventist Hospital, in cooperation with Adventist HealthCare's health and wellness activities, currently collaborates with multiple organizations to improve the health and wellbeing of the communities served by Washington Adventist Hospital. These partnerships support the initiatives described above and further enhance Washington Adventist Hospital's efforts to ensure appropriate utilization of ED services and improved access to the appropriate level of care. These partnerships include:

- Partnering with Mary's Center for Maternal and Child Care at its primary care center in the Long Branch area of Montgomery County. Mary's Center, with 20 years of experience in serving the indigent in Washington, demonstrates how improved access to family medical care, coupled with sensitivity to culture and language, lead to healthy families and safer communities.

- Partnering with MobileMed in the operation of mobile clinic sites and the development and recent fixed-site clinics. Currently MobileMed provides clinic services at: Arcola Towers, Wheaton; Casa de Maryland, Silver Spring; Community Vision at Progress Place, Silver Spring; Crusader Church, Rockville, East Montgomery County Regional Services Center, Silver Spring; Elizabeth House, Silver Spring; Gaithersburg/Ascension House, Gaithersburg; Gude Drive Men's Shelter, Rockville; Holly Hall, Silver Spring; Ibn Sina Clinic, Potomac; Kammsa Clinic, Gaithersburg; La Clinique L'A.M.I., Silver Spring; Lincoln Park Community Center, Rockville; Long Branch Community Center, Silver Spring; Pan Asian Volunteer Health Clinic, Silver Spring; Rockville Senior Center, Rockville; Shepherd's Table, Silver Spring; and Sophia House Women's Shelter.

- Providing ancillary and other support services, including comprehensive health screenings, for patients treated at Mercy Health Clinic in Gaithersburg. Mercy Health Clinic is a free, non-profit, non-sectarian, community-based, primary healthcare provider serving uninsured, low-income adult residents of Montgomery County.

- Maternity clinics at Washington Adventist Hospital and Shady Grove Adventist Hospital as part of the Montgomery County Maternity Partnership Program, providing prenatal health services and education for the low-income and uninsured population.

- Adventist HealthCare partners with Casa de Maryland to provide health care and community services for the immigrant communities in Montgomery County and Prince George's County. The partnership includes the provision of primary medical care for uninsured residents, collaboration on ways to encourage immigrants to pursue a career in health care and a variety of other community services including language assistance and job training.

- Adventist HealthCare's Health Ministry Outreach works with more than 19 faith-based community organizations and some 140 congregations of all faiths, helping them through classes and health events to train and support Faith Community (Parish) Nurses who will directly provide support and care at the local community level.

(15) Emergency Department Expansion.

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses,

injuries, and conditions, to lower cost alternative facilities or programs;

(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility system capacity that will be affected by greater volumes of emergency department patients.

APPLICANT RESPONSE:

Washington Adventist Hospital is proposing an emergency department design for its White Oak hospital that effectively sizes the program to meet the demand of the projected population it will serve in the new location (see response to "Emergency Department Treatment Capacity and Space and the response provided to standard 10.24.01.08G(3)(b). Need). The program and design for the White Oak emergency department is informed by ACEP guidelines as evidenced in the response to the previous standard. Additionally, the design and program reflect the projected volume of patients that will require hospital based emergency services, which assumes a portion of lower acuity visits that will occur in the clinics on the Takoma Park campus. Together, the proposal for emergency services and clinic services in Takoma Park will result in accessible and appropriate medical services for the populations identified in the service area.

The Washington Adventist Hospital emergency department and acute care staff and physicians have been intentionally focused on appropriate utilization and the placement of patients to more appropriate settings for care. The model of care proposed by this plan is informed by and responds to current efforts and the existence of various partnerships directed at caring for the populations Washington Adventist Hospital serves in the best and most appropriate setting. Although the emergency department to be located in White Oak will continue to see a variety of patients from the identified service area, the complement of services to be located in Takoma Park will be available to current populations seeking care for lesser acuity conditions.

The complement of services in Takoma Park will be comprised of clinic services to be provided by the hospital or in affiliation with the hospital, such as CCI, Inc. and the maternity clinic. In fact, CCI will commence with providing Federally Qualified Health Services on the Takoma Park campus by the end of 2013 and the maternity clinic will continue to provide antenatal services as it has for many years at the Takoma Park campus. These efforts taken by the hospital have and will continue to have a favorable impact on the utilization of emergency services. Along with the plan to relocate the emergency department to White Oak, the plan for robust clinic based-services to remain in Takoma Park is focused on ensuring that populations in the adjusted service area have access to the appropriate level of service when it is needed.

In addition, Washington Adventist Hospital will continue to promote and provide a wide array of health and wellness programs in the community designed to help individuals lead healthy lives. These additional community focused services are available today and will continue to be provided by the hospital and Adventist HealthCare.

Following are examples of the extensive offering of health programs offered by Washington Adventist Hospital and Adventist HealthCare:

- The low-income breast cancer program provides free mammography and education to more than 2,500 women annually. The Breast Cancer Screening Program at Washington Adventist Hospital helps low-income, uninsured women ages 40 and older in Montgomery and Prince George's counties fight and defeat breast cancer. In partnership with the Montgomery County Women's Cancer Control Program and the State of Maryland Breast and Cervical Diagnosis and Treatment Program, the Breast Cancer Screening Program offers a continuum of care to patients including screenings and individual patient education, instruction on breast self-examinations and access to treatment. All patients diagnosed with breast cancer are case managed from diagnosis through treatment and beyond. Diagnosed patients are also recommended to the support group at Washington Adventist Hospital as well as the Look Good Feel Better Program.

- The Cardiac & Vascular Outreach program is committed to supporting Washington Adventist Hospital's mission by providing programming and screenings that will both educate, enable, and empower individuals to better understand and manage their risk factors and to make lifestyle changes with the goal of lowering their risk of heart disease. Cardiac outreach has touched many lives through Washington Adventist Hospital and Adventist HealthCare's Heart Healthy Screening Programs by striving to help eliminate the health disparities that exist among populations in our community.

- The Colorectal Cancer Screening Program, supported by the Cigarette Restitution Fund, provides education, outreach, and free screenings to eligible men and women residing in Montgomery County. The goal of the Colorectal Cancer Screening Program is to target men and women who are considered to be "at-risk" for colorectal cancer. This includes individuals who are aged 50 and over, medically uninsured or underinsured, and who are low income. African Americans and Hispanic/Latinos have been identified as target populations as data reveal high colorectal cancer diagnosis rates for these groups. Program Coordinators for the screening program are continually out in the community promoting the program and providing outreach in faith-based settings (churches and synagogues), soup kitchens, area shelters, community centers, and work sites. t is our goal to increase awareness within the community of the cancer risk and the benefits of early detection and screening.

- Community Health Education uses a variety of strategies to improve the health status of the community by providing classes and programs that are both educational and fun. This includes an array of classes such as nutrition and self-improvement, as well as fitness classes, which include land and water activities. Also offered are CPR and First Aid classes. In addition to providing community health classes, we actively participate in health fairs where health screenings and flu shot clinics are held.

Adventist HealthCare's pioneering Center for Health Disparities, assisted by its Blue Ribbon Advisory Panel of community leaders, has three areas of focus: increased services for underserved populations; a research program to identify and promote best practices of healthcare for the underserved; and an education initiative to improve the ability of caregivers to provide culturally competent care. Progress continues on a number of the panel's recommendations including an annual health disparities report card, a Maternal Services Center, a Patient Advocacy Program/Linguistic Access and Disparities Awareness Program, and cultural training programs for physicians and staff.

Washington Adventist Hospital and Adventist HealthCare continue to effectively engage the community by providing extensive educational and clinical opportunities through partnerships with 29 universities and specialty schools. Of special note is the relationship with Montgomery College for nursing students to do their clinical rotations. Many of the Adventist HealthCare facilities (Washington Adventist Hospital, Shady Grove Adventist Hospital, Adventist Rehabilitation Hospital of Maryland and Adventist Behavioral Health) provide clinical rotations for nursing students.

Adventist Healthcare also collaborates with multiple organizations including Adventist Community Services, American Cancer Society, American Heart Association, American Lung Association, Avon Foundation, Susan G. Komen Foundation, Montgomery County Health and Human Services, Montgomery County Fire and Rescue, Healthy Kids Campaign, Sister to Sister Foundation and GROWS (Grass Roots Organizations for Well-being of Seniors).

Other specific partnership examples which further extend care into the community, and seek to prevent illness and disease, as well as reduce unnecessary emergency department utilization,

- Partnering with Mary's Center for Maternal and Child Care at its primary care center in the Long Branch area of Montgomery County. Mary's Center, with 20 years of experience in serving the indigent in Washington, demonstrates how improved access to family medical care, coupled with sensitivity to culture and language, lead to healthy families and safer communities.

- Partnering with MobileMed in the operation of mobile clinic sites and fixed-site clinics. Currently MobileMed provides clinic services at: Arcola Towers, Wheaton; Casa de Maryland, Silver Spring; Community Vision at Progress Place, Silver Spring; Crusader Church, Rockville, Eastern Montgomery County Regional Services Center, Silver Spring; Elizabeth House, Silver Spring; Gaithersburg/Ascension House, Gaithersburg; Gude Drive Men's Shelter, Rockville; Holly Hall, Silver Spring; Ibn Sina Clinic, Potomac; Kammsa Clinic, Gaithersburg; La Clinique L'A.M.I., Silver Spring; Lincoln Park Community Center, Rockville; Long Branch Community Center, Silver Spring; Pan Asian Volunteer Health Clinic, Silver Spring; Rockville Senior Center, Rockville; Shepherd's Table, Silver Spring; and Sophia House Women's Shelter ICBS, Rockville.

- Providing ancillary and other support services, including comprehensive health screenings, for patients treated at Mercy Health Clinic in Gaithersburg. Mercy Health Clinic is a free, non-profit, non-sectarian, community-based, primary healthcare provider serving uninsured, low-income adult residents of Montgomery County.

- Maternity clinics at Washington Adventist Hospital as part of the Montgomery County Maternity Partnership Program, providing prenatal health services and education for the low-income and uninsured population.

- Adventist HealthCare partners with Casa de Maryland to provide health care and community services for immigrant communities in Montgomery County and Prince George's County. The partnership includes the provision of primary medical care for uninsured residents, collaboration on ways to encourage immigrants to pursue a career in health care and a variety of other community services including language assistance and job training.

- Adventist HealthCare Health Ministry Outreach works with more than 19 faith-based community organizations and more than 140 congregations of all faiths, helping them with classes and health events to train and support Faith Community (Parish) Nurses who will directly provide support and care at the local community level.

Washington Adventist Hospital is and will continue to be a valuable community asset and a major healthcare provider in the region, committed to fulfilling its mission and serving the general community. In addition to these partnerships and as mentioned, Washington Adventist Hospital proposes to continue providing care in Takoma Park with services directed to meet community needs.

(16) Shell Space.

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

(i) Considers the most likely use identified by the hospital for the unfinished space;

(ii) Considers the time frame projected for finishing the space; and

(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

APPLICANT RESPONSE:

The current design does not include shell space.

COMAR 10.24.12—Acute Hospital Inpatient Obstetric Services Standards

Section .04 Review Standards – The standards in this section are intended to guide Certificate of Need and CON exemption reviews involving acute hospital inpatient obstetric services, existing services proposed to be relocated to newly constructed space, and existing services proposed to be located in renovated space. Standards (1) through (6) apply to all applicants. Standards (7) through (14) apply only to applicants for a new perinatal service. Standard (15) applies only to applicants with an existing obstetric service.

Section .04(1) Need. All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.

APPLICANT RESPONSE:

Please see response to COMAR 10.24.01.08G(3)(b)(Need) where the need for obstetrical beds is discussed.

Since Washington Adventist Hospital is not proposing to establish a new perinatal service, Policy 4.1 does not apply.

Section .04(2) The Maryland Perinatal System Standards. Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center.

APPLICANT RESPONSE:

Washington Adventist Hospital is committed to the Level IIB Perinatal Center that is currently serving our community and intends to maintain or exceed the Maryland Perinatal System Standards on the White Oak campus. A site visit conducted by the Maryland Department of Health and Mental Hygiene in November 2012 found Washington Adventist Hospital in compliance with all Level IIB Perinatal System Standards.

1.1 Organization

a. Exhibit 34 documents the Board resolution on September 10, 2013 agreeing to meet the Maryland Perinatal System Standards as a Level IIB Center.

b. Washington Adventist Hospital participates in the Maryland Perinatal System and submits patient care data to the Maryland Department of Health and Mental Hygiene and the Maryland Institute for Emergency Medical Services Systems, as appropriate for system and quality management.

c. All perinatal patients at Washington Adventist Hospital receive the medical care commensurate with a Level IIB Perinatal Program.

d. Exhibit 34 documents the Board resolution, bylaws, contracts, budgets specific to the perinatal program committing the appropriate physical resources and infrastructure necessary to support the Level IIB Perinatal Program.

1.2 Washington Adventist Hospital holds license number 15-031 as an acute general hospital from the Maryland Department of Health and Mental Hygiene, and license number 15369 from Montgomery County.

1.3. Washington Adventist Hospital is accredited by the Joint Commission and completed a successful survey August 16, 2013.

1.4 Washington Adventist Hospital does not currently have, nor is it pursuing the creation of a NICU.

1.5 Washington Adventist Hospital owns and maintains current equipment and technology to support optimal perinatal care for the Level IIB designation.

1.6 Washington Adventist Hospital does not accept neonatal or maternal transports other than transports of patients who were referred elsewhere and now returning to the hospital (back transports).

1.7. As a Level IIB Neonatal Program, Washington Adventist Hospital is not governed by this standard.

2.1 Obstetrical Unit Capabilities

Washington Adventist Hospital is capable of providing uncomplicated and complicated obstetrical care and has the following written standards, protocols and guidelines:

a. Unexpected obstetrical care problems policy High Risk policy, Policy WWS 9510, attached as Exhibit 35.

b. Fetal monitoring, including internal scalp electrode monitoring, Policy WWS 9509 and WWS 9507 attached as Exhibit 36.

c. Initiating a cesarean delivery within 30 minutes of the decision to deliver, Washington Adventist Hospital follows the ACOG guidelines (Exhibit 37); however this standard has changed, according to the Guidelines for Perinatal Care, 7th Edition (October 2012).

d. Selection and management of obstetrical patients at a maternal risk level appropriate to its capability, is covered under Policy WWS 9534. (Exhibit 38).

2.2 Washington Adventist Hospital is capable of providing critical care services appropriate for obstetrical patients as demonstrated by having a critical care unit and a board-certified critical care specialist as an active member of the medical staff.

2.3. Washington Adventist Hospital has written plans for initiating maternal transports to an appropriate level at Shady Grove Adventist Hospital. (Exhibit 39- Policy WWS 9170).

2.4 Washington Adventist Hospital does not accept maternal transports from other institutions.

3.1 Neonatal Capabilities

a. Washington Adventist Hospital Policy WAH 5736 (Exhibit 40) includes sections on the resuscitation and stabilization of unexpected neonatal problems all nursing personnel in the L&D and Nursery must be certified by the Neonatal Resuscitation Program.

b. Selection and management of neonatal patients at a neonatal risk level appropriate to its capability is demonstrated in WWS 9302. (Exhibit 41).

c. Because Washington Adventist Hospital is a Level IIB Neonatal Program, this standard does not apply.

4. Obstetric Personnel

4.1 As a Level IIB Neonatal Program, Washington Adventist Hospital is not governed by this standard.

4.2 Washington Adventist Hospital has obstetrics/gynecology board certified physician(s) as members of the medical staff who have responsibility for programmatic management of obstetrical services.

4.3 Washington Adventist Hospital has maternal-fetal medicine board-certified physicians who are members of the medical staff and have responsibility for programmatic management of high-risk obstetrical services.

4.5 Washington Adventist Hospital has a maternal-fetal medicine physician on the medical staff, in active practice and available 24 hours a day seven days per week.

4.6 Washington Adventist Hospital does not accept maternal transports, therefore this standard is not applicable.

4.7 As a Level IIB Neonatal Program, Washington Adventist Hospital meets the higher standard 4.8.

4.8 Washington Adventist Hospital has a physician board-certified or an active candidate for board-certification in obstetrics/gynecology or family medicine (with obstetrical privileges) readily available to the delivery area when a patient is in active labor.

4.9 A physician board-certified or an active candidate for board-certification in obstetrics/gynecology is present in-house 24 hours a day and immediately available to the delivery area when a patient is in active labor.

4.10 Washington Adventist Hospital has a physician present at all deliveries.

4.11 Washington Adventist Hospital has a physician board-certified (or active candidate for board-certification) in anesthesiology as a member of the medical staff who is responsible for programmatic management of obstetrical anesthesia services.

5. Pediatric Personnel

5.1 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.2 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.3 Washington Adventist Hospital has physician(s) board-certified or active candidate for board-certification in neonatal-perinatal medicine on the medical staff who have full-time responsibility for neonatal special care or intensive care unit services.

5.4 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.5 Neonatal Resuscitation Program (NRP) trained professional(s) with experience in acute care of the depressed newborn and skilled in neonatal endotracheal intubation and resuscitation are immediately available to the delivery and neonatal units at Washington Adventist Hospital.

5.6 Washington Adventist Hospital has a physician who has completed postgraduate pediatric training, with privileges for neonatal care appropriate to the level of the nursery (Level IIB) shall be immediately available when an infant requires Level II neonatal services such as FiO2>40%, assisted ventilation, or cardiovascular support.

5.7 Washington Adventist Hospital has a physician who has completed postgraduate pediatric training appropriate to the Level IIB nursery immediately available 24 hours a day.

5.8 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.9 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

Neonatal Subspecialty Care

5.10 Washington Adventist Hospital has written consultation and referral agreements in place with pediatric cardiology, pediatric surgery, and ophthalmology with experience and expertise in neonatal retinal examination.

5.11 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.12 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.13 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

5.14 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

6. Other Personnel

6.1 Washington Adventist Hospital has a physician board-certified or an active candidate in anesthesiology available so that cesarean delivery may be initiated per hospital protocol as stated in Standard 2.1c.

6.2 Washington Adventist Hospital has a physician board-certified or an active candidate in anesthesiology readily available to the delivery area when a patient is in active labor.

6.3 Washington Adventist Hospital has a physician board-certified or an active candidate for board certification in anesthesiology present in-house 24 hours a day, readily available to the delivery area.

6.4 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

6.5 Washington Adventist Hospital has a physician on the medical staff with privileges for providing critical interventional radiology services for obstetrical patients, and neonatal patients. The hours for this service are Monday through Friday from 8:00 a.m. to 5:00 p.m.

6.6 Washington Adventist Hospital has obstetric and neonatal diagnostic imaging available 24 hours a day, with interpretation by physicians with experience in maternal and neonatal disease and its complications.

6.7 Washington Adventist Hospital has a registered dietician with knowledge of and experience in adult and neonatal parenteral/enteral high—risk management on staff.

6.8 Washington Adventist Hospital has an International Board Certified Lactation Consultant on full-time staff who has programmatic responsibility for lactation support services which include education and training of additional hospital staff members in order to ensure availability seven days per week of dedicated lactation support.

6.9 As a Level IIB Neonatal Program, Washington Adventist Hospital meets standard 6.10.

6.10 Washington Adventist Hospital has a licensed social worker with a master's degree a Licensed Certified Social Worker (LCSW) and experience in psychosocial assessment and intervention with women and their families dedicated to the perinatal service.

6.11 As a Level IIB Neonatal Program, Washington Adventist Hospital meets standard 6.10.

6.12 Washington Adventist Hospital has respiratory therapists skilled in neonatal ventilator management who are available when an infant is receiving assisted ventilation and present in-house 24-hours a day.

6.13 Washington Adventist Hospital has an agreement with Maternal and Fetal Medicine to provide genetic diagnostic and counseling.

6.14 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

6.15 Washington Adventist Hospital's perinatal program has on its administrative staff a registered nurse with a master's degree in nursing and experience in high-risk obstetric and neonatal nursing who shall have programmatic responsibility for the obstetrical and neonatal nursing services.

6.16 Washington Adventist Hospital's perinatal program has nurses with special expertise in obstetrical and neonatal nursing identified for staff education.

6.17 The Level IIB Perinatal Program at Washington Adventist Hospital has:

a. A registered nurse skilled in the recognition and nursing management of complications of labor and delivery readily available if needed to the labor and delivery unit 24 hours a day.

b. A registered nurse skilled in the recognition and management of complications in women and newborns readily available to the obstetrical unit 24 hours a day.

c. A registered nurse with demonstrated training and experience in the assessment, evaluation and care of patients in labor present at all deliveries.

d. A registered nurse with demonstrated training and experience in the assessment, evaluation, and care of newborns readily available to the neonatal unit 24 hours a day.

6.18 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

6.19 Washington Adventist Hospital has a written plan which assures registered nurse/patient ratios as per current *Guidelines for Perinatal Care*. The AWHOON Guidelines are presented in Exhibit 42.

7. Laboratory

7.1 The programmatic leaders of the Washington Adventist Hospital perinatal service in conjunction with the hospital laboratory have established laboratory processing and reporting times to ensure that these are appropriate for samples drawn from obstetric and neonatal patients with specific consideration for the acuity of the patient and the integrity of the samples. As a practice all laboratory specimens sent from the obstetrical service or newborn nursery are sent STAT. (Exhibit 43- Policy LAB.L2-1).

7.2 Washington Adventist Hospital's laboratory is capable of immediately receiving, processing, and reporting urgent/emergent obstetric and neonatal laboratory requests.

7.3 Washington Adventist Hospital's laboratory has a process to report critical results to the obstetric and neonatal services. (See Exhibit 44- Policy 5204).

7.4 Laboratory results from standard maternal antepartum testing are available to the providers caring for the mother and the neonate prior to discharge from Washington Adventist Hospital. If test results are not available or if testing was not performed prior to admission, such testing shall be performed during the hospitalization of the mother and results available prior to discharge of the newborn.

7.5 Washington Adventist Hospital has the capacity to conduct rapid HIV testing 24 hours a day.

7.6 Washington Adventist Hospital has a laboratory capable of performing the following tests 24 hours a day:

a) fetal scalp blood pH is not considered standard of care and is not used at Washington Adventist Hospital

b) fetal lung maturity tests

7.7 Washington Adventist Hospital has available the equipment and trained personnel to perform newborn hearing screening prior to discharge on all infants born at the hospital as required by the Universal Newborn Hearing Screening, Diagnosis, and Intervention Guidelines.

7.8 Blood bank technicians are present in-house at Washington Adventist Hospital 24 hours a day.

7.9 As a Level IIB Neonatal Program, Washington Adventist Hospital is not required to meet this standard.

8. Diagnostic Imaging Capabilities

8.1 Washington Adventist Hospital has portable obstetric ultrasound equipment, with the services of appropriate staff, present in the delivery area.

8.2 As a Level IIB Neonatal Program, Washington Adventist Hospital meets standard 8.1.

8.3 Washington Adventist Hospital has portable x-ray equipment with the services of appropriate staff, available to the neonatal units.

8.4 Washington Adventist Hospital has portable head ultrasound for newborns, with the services of appropriate staff, available to the neonatal units.

8.5 Washington Adventist Hospital has computerized tomography (CT) capability, with the services of appropriate staff, available on campus.

8.6 Washington Adventist Hospital has magnetic resonance imaging (MRI) capability, with the services of appropriate staff, available on campus.

8.7 Washington Adventist Hospital has neonatal echocardiography equipment and an experienced technician available on campus as needed with interpretation by pediatric cardiologist.

8.9 Washington Adventist Hospital has equipment for performing interventional radiology services for obstetrical patients

9. Equipment

9.1 Washington Adventist Hospital has all of the following equipment and supplies immediately available for existing patients and for the next potential patient:

a) O2 analyzer, stethoscope, intravenous infusion pumps

b) radiant heated bed in delivery room and available in the neonatal units

c) oxygen hood with humidity

d) bag and masks capable of delivering a controlled concentration of oxygen to the infant

e) orotracheal tubes

f) aspiration equipment

g) laryngoscope

h) umbilical vessel catheters and insertion tray

i) cardiac monitor

j) pulse oximeter

k) phototherapy unit

l) Doppler blood pressure for neonates

m) cardioversion/defibrillation capability for mothers and neonates

n) resuscitation equipment for mothers and neonates

o) individual oxygen, air, and suction outlets for mothers and neonates

p) emergency call system

9.2 Washington Adventist Hospital has a neonatal intensive care unit bed set up and equipment available at all times for an emergency admission.

9.3 Washington Adventist Hospital has fetal diagnostic testing and monitoring equipment for:

a) non-stress and stress testing

b) ultrasound examinations

c) amniocentesis

9.4 Washington Adventist Hospital has the capability to monitor neonatal intra-arterial pressure.

9.5 As a Level IIB Perinatal Program Washington Adventist Hospital is not required to meet this standard.

9.6 Washington Adventist Hospital has a full range of invasive maternal monitoring available to the delivery area, including equipment for central venous pressure and arterial pressure monitoring.

9.7 Washington Adventist Hospital has appropriate equipment (including back-up equipment) for neonatal respiratory care as well as protocols for the use and maintenance of the equipment as required by the Level IIB status. (Exhibit 45-Policies 5736, 219, 901, 601, 903 and Appendix R).

10. Medications

10.1 Washington Adventist Hospital has Emergency medications, as listed in the *Neonatal Resuscitation Program* of the American Academy of Pediatrics/American Heart Association (AAP/AHA), present in the delivery area and neonatal units.

10.2 Washington Adventist Hospital has the following medications immediately available to the neonatal units:

a) Antibiotics, anticonvulsants, and emergency cardiovascular drugs

b) Surfactant, prostaglandin E1

10.3 All emergency resuscitation medications to initiate and maintain resuscitation, in accordance with Advanced Cardiac Life Support (ACLS) guidelines, are present in the delivery area of Washington Adventist Hospital.

10.4 The following medications are in the delivery area of Washington Adventist Hospital:

a) Oxytocin (Pitocin)

b) Methylergonovine (Methergine)

c) 15-methyl prostaglandin F2 (Prostin)

d) Misoprostol (Cytotec)

e) Carboprost tromethamine (Hemabate)

11. Education Programs

11.1 Washington Adventist Hospital has identified minimum competencies for perinatal clinical staff, not otherwise credentialed, that are assessed prior to independent practice and on a regular basis thereafter. The competencies for clinical staff are done as part of their onboarding orientation at the hospital, nursing, and unit orientation. Following orientation, competencies are done on an annual basis based on regulatory requirements and also unit specific during skills days. If other competencies arise during the year, a plan is developed to address the specific new need. (Exhibit 46- Policy WAH.2184).

11.2 Washington Adventist Hospital provides continuing education programs for physicians, nurses, and allied health personnel on staff concerning the treatment and care of obstetrical and neonatal patients. (See Exhibit 47-examples of CME programs)

12. Performance Improvement

12.1 Washington Adventist Hospital has a multi-disciplinary continuous quality improvement program for improving maternal and neonatal health outcomes that includes initiatives to promote patient safety including safe medication practices, Universal Protocol to prevent surgical error, and educational programs to improve communication and team work.

12.2 Washington Adventist Hospital conducts internal perinatal case reviews which include all maternal, intrapartum fetal, and neonatal deaths, as well as all maternal and neonatal transports.

12.3 Washington Adventist Hospital uses multidisciplinary forums to conduct quarterly performance reviews of perinatal programs. This review includes a review of trends, all deaths, all transfers, all very low birth weight infants, problem identification and solution, issues identified from the quality management process and systems issues.

12.4 Washington Adventist Hospital participates with the Department of Health and Mental Hygiene and Montgomery County health department Fetal and Infant Mortality Review and Maternal Mortality Review programs.

12.5 Washington Adventist Hospital participates in the collaborative collection and assessment of data with the Department of Health and Mental Hygiene and the Maryland Institute for Emergency Medical Services Systems for the purpose of improving perinatal health outcomes.

13. Policies and Protocols

13.1 Washington Adventist Hospital has written policies and protocols for the initial stabilization and continuing care of all obstetrical and neonatal patients appropriate to Level IIB care rendered at the hospital. (Exhibit 48- Policies WWS 9502 and WWS 9152).

13.2 Washington Adventist Hospital has maternal and neonatal resuscitation protocols. (See Exhibit 40- Policy WAH 5736).

13.3 Washington Adventist Hospital medical staff credentialing process includes documentation of competency to perform obstetrical and neonatal invasive procedures appropriate to a Level IIB program.

13.4 Washington Adventist Hospital has written guidelines for accepting or transferring mothers or neonates as "back transports" including criteria for accepting the patient and patient information on the required care. (See Exhibit 39-Policy WWS.9170).

13.5 Washington Adventist Hospital has a licensed neonatal transport service or written agreement with a licensed neonatal transport service. (See Exhibit 39-Policy WWS.9170).

13.6 Washington Adventist Hospital has policies that allow families (including siblings) to be together in the hospital following the birth of an infant and that promote parental involvement in the care of the neonate. (Exhibit 49-Policy WWS.9454).

13.7 Washington Adventist Hospital has a policy to eliminate deliveries by induction of labor or by cesarean section prior to 39 weeks gestation without a medical indication. The hospital has a systematic internal review process that evaluates any occurrences and a plan for corrective action. Data on <39 week deliveries is attached as Exhibit 50, Policy 9518.

Section .04(3) Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

(i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(ii) posted notices in the admissions office, business office and emergency areas within the hospital;

(iii) **individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and**

(iv) **within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination of probable eligibility.**

(b) **Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.**

APPLICANT RESPONSE:

Adventist HealthCare, Inc. maintains written policies in English and Spanish pertaining to the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. Policy number AHC 3.19 Charity Care Policy, and Policy 3.19.1 Charity Care Policy, Spanish Language Version (Exhibits 7 and 8) apply to all Adventist HealthCare-affiliated facilities in Maryland which include Washington Adventist Hospital. These policies are summarized and included on the website of Adventist HealthCare, Inc. and Washington Adventist Hospital (http://www.washingtonadventisthospital.com/WAH/patientsvisitors/patients/billing/charity-care/). Determination of probable eligibility is made within two business days and is stated as such in the policy.

Notices of the availability of financial assistance are prominently posted in English and Spanish in the Washington Adventist Hospital Emergency Department, Registration/Admissions Department and business offices and are provided to patients at the time of preregistration and/or registration, at prenatal visits, and at outreach events.

Public notice of nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Gazette Newspapers. The most recent posting was made on July 10 and 11, 2013 and appeared in the following Montgomery County editions: Gaithersburg, Germantown, Damascus, Rockville, Bethesda, Potomac, Silver Spring and Olney; and in both the Northern and Southern Prince George's County editions. (See Exhibit 9).

Section .04(4) Medicaid Access. Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) **an estimate of the number of Medical Assistance enrollees in its primary service area, and**

(b) **the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.**

APPLICANT RESPONSE:

Washington Adventist Hospital has active partnerships with several community based organizations and health care clinics that provide improved access to care for low-income

residents of Montgomery and Prince George's counties. Many of these residents have limited proficiency in English and/or are from racial and ethnic minority groups. Partnerships include Mary's Center for Maternal and Child Care, Mobile Medical Care (MobileMed), the Primary Care Coalition of Montgomery County and Community Clinic, Inc. (CCI), a Federally Qualified Health Clinic. Women receive prenatal care through these programs and deliver their babies at the hospital.

Since 2006, Washington Adventist Hospital has partnered with the Montgomery County Department of Health and Human Services. Maternity Partnership Program to provide obstetric and gynecologic services to uninsured women in Montgomery County. This program will continue and the antenatal clinic portion will be part of the services at the Takoma Park campus while deliveries will be at the White Oak campus.

Over the past seven years, Maternity Partnership Program participants have been cared for at the Women's Center at Washington Adventist Hospital and serve as a testament to the hospital's continued commitment to offer quality care for the entire community served.

The Women's Center provides prenatal, postpartum and related gynecological services to the community served by Washington Adventist Hospital. The center is located on the Takoma Park campus and is fully equipped and supplied to handle different aspects of prenatal and gynecological care. The program was designed to meet the needs of women who meet the criteria for Maryland Medical Assistance as well as those who are participants in the Maternity Partnership Program. Washington Adventist Hospital anticipates the ability to accept and provide care for 500 Maternity Partnership Program patients per year.

Maternity Partnership Program participants who are referred by Montgomery County will be assured of receiving comprehensive, routine, standard clinical and laboratory services, including postpartum services, in accordance with accepted medical standards for perinatal care, as approved by the American College of Obstetricians and Gynecologists. This care will include all necessary prenatal visits, related routine laboratory services including Pap smears, screenings for sexually transmitted diseases, urine cultures and HIV screening, counseling and appropriate treatment. All clinic supplies and Rhogam supplies will be provided as a part of the routine care and at no extra cost to the patient.

Obstetric ultrasound is offered at the recommended discounted rate and no patient will be refused an ultrasound due to an inability to pay. The ultrasound will be performed by Community Radiology Associates which has multiple locations throughout Montgomery County. Most program participants are referred to the White Oak imaging location as it is the closest to their homes.

Patients who develop conditions that place them in a "high risk" category will be referred to the Maternal Fetal Medicine practice located on the Takoma Park campus. The patient will be followed by both Maternal Fetal Medicine and the obstetrician in the Women's Center for management of her pregnancy.

The advanced ultrasounds will be performed by Maternal Fetal Medicine at its offices and non-stress tests will be performed on the labor and delivery unit of the hospital. The patient experiences convenience and continuity of care with the presence of both Maternal Fetal Medicine and the hospital on one campus; the obstetric hospitalist will deliver the patient's baby in consult with Maternal Fetal Medicine. The Maternity Partnership Program participant will be pre-admitted to Washington Adventist Hospital for the delivery of her baby, unless circumstances, such as extreme prematurity, require delivery at another facility.

As part of the needs assessment, the current Washington Adventist Hospital obstetric services payor mix in the Takoma Park primary service area (PSA) and the newly defined White Oak PSA were analyzed. The assessment indicates that the overall payor mix is similar between the two service areas and in fact, there is a greater proportion of the hospital's Medicaid patients residing in the White Oak PSA. Washington Adventist Hospital expects to retain the same payor mix for OB patients due to the fact that the hospital will retain the OB clinic services at the Takoma Park campus and as noted above, serves a significant number of low-income and high risk patients.

OB Payor Mix Summary

Takoma Park OB Primary Service Area (PSA)

	WAH Discharges	% of Total		All Discharges	% of Total
Commercial	131	12.1%	Commercial	1,870	37.9%
Medicaid	905	83.9%	Medicaid	2,897	58.7%
Medicare	2	0.2%	Medicare	15	0.3%
Self-pay	41	3.8%	Self-pay	132	2.7%
Other	-	0.0%	Other	21	0.4%
Total	1,079	100%	Total	4,935	100%

White Oak OB Primary Service Area (PSA)

	WAH Discharges	% of Total		All Discharges	% of Total
Commercial	88	10.3%	Commercial	1,617	38.5%
Medicaid	735	86.2%	Medicaid	2,439	58.1%
Medicare	1	0.1%	Medicare	13	0.3%
Self-pay	29	3.4%	Self-pay	108	2.6%
Other	-	0.0%	Other	20	0.5%
Total	853	100%	Total	4,197	100%

Currently, of the 23 maternal fetal medicine or obstetrics and gynecology physicians on staff or employed by Washington Adventist Hospital, with admitting privileges to provide obstetric or pediatric services for women and infants, 19 participate in the Medical Assistance program.

Section .04(5) Staffing. Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expanses, for labor and delivery, post partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

APPLICANT RESPONSE:

Staffing at Washington Adventist Hospital for Obstetrics and Nursery services will grow in proportion to the projected increase in patient volume (see Table on following page). Physician coverage in the replacement hospital will be provided by private practice community physicians consistent with current arrangements.

2013 Clinical Staffing Budget

FTE Category	Clinical FTE's by Unit				Total FTE's	Average Salary Per Paid FTE	Total Expense
	Labor & Delivery	Nursery	OB	OB Clinic			
Asst. Nurse Mgr.	1.0		1.0		2.0	$ 95,368	$ 190,736
Lactation Consultant			1.0		1.0	$ 79,706	$ 79,706
Medical Assistant				1.5	1.5	$ 33,342	$ 48,739
Nurse Director	0.8	0.2	0.8	0.2	2.0	$ 97,947	$ 195,894
Patient Care Tech			7.7		7.7	$ 37,336	$ 285,643
Physician Asst II	1.3				1.3	$ 120,910	$ 159,603
Registered Nurse	20.0	8.7	19.7	1.1	49.5	$ 83,710	$ 4,161,741
Registered Nurse Float Pool	1.2		0.1		1.3	$ 94,744	$ 119,584
Registered Nurse Float Pool II			0.2		0.2	$ 96,117	$ 19,453
RN, Unit Based Per Diem	1.6	0.7	1.0		3.3	$ 96,110	$ 324,704
Scrub Tech	5.5			0.2	5.7	$ 59,124	$ 350,507
Secretary II	1.0				1.0	$ 64,750	$ 64,750
Surgical Asst.	1.0				1.0	$ 84,698	$ 84,867
Unit Support Coord.	3.2		3.2		6.4	$ 38,210	$ 244,541
Total FTE's	**36.6**	**9.6**	**34.6**	**2.9**	**83.8**		**$ 6,330,468**
Physician Coverage							**$ 1,512,000**

2019 Clinical Staffing Budget

FTE Category	Clinical FTE's by Unit				Total FTE's	Average Salary Per Paid FTE	Total Expense
	Labor & Delivery	Nursery	OB	OB Clinic			
Asst. Nurse Mgr.	1.0		1.0		2.0	$ 95,368	$ 190,736
Lactation Consultant			1.0		1.0	$ 79,706	$ 79,706
Medical Assistant				1.5	1.5	$ 33,342	$ 48,739
Nurse Director	0.8	0.2	0.8	0.2	2.0	$ 97,947	$ 195,894
Patient Care Tech			8.6		8.6	$ 37,336	$ 322,776
Physician Asst II	1.3				1.3	$ 120,910	$ 159,603
Registered Nurse	22.6	9.8	22.2	1.3	55.9	$ 83,710	$ 4,679,416
Registered Nurse Float Pool	1.3		0.3		1.6	$ 94,744	$ 152,848
Registered Nurse Float Pool II					-		$ -
RN, Unit Based Per Diem	1.8	0.8	1.1		3.8	$ 96,110	$ 360,997
Scrub Tech	6.2			0.3	6.5	$ 59,124	$ 386,717
Secretary II	1.0				1.0	$ 64,750	$ 64,750
Surgical Asst.	1.0				1.0	$ 84,698	$ 84,867
Unit Support Coord.	3.2		3.2		6.4	$ 38,210	$ 244,541
Total FTE's	**40.3**	**10.8**	**38.3**	**3.2**	**92.6**		**$ 6,971,591**
Physician Coverage							**$ 1,512,000**

2023 Clinical Staffing Budget

FTE Category	Clinical FTE's by Unit				Total FTE's	Average Salary Per Paid FTE	Total Expense
	Labor & Delivery	Nursery	OB	OB Clinic			
Asst. Nurse Mgr.	1.0		1.0		2.0	$ 95,368	$ 190,736
Lactation Consultant			1.0		1.0	$ 79,706	$ 79,706
Medical Assistant				1.5	1.5	$ 33,342	$ 48,739
Nurse Director	0.8	0.2	0.8	0.2	2.0	$ 97,947	$ 195,894
Patient Care Tech			8.8		8.8	$ 37,336	$ 329,232
Physician Asst II	1.3				1.3	$ 120,910	$ 159,603
Registered Nurse	23.0	9.8	22.7	1.3	56.8	$ 83,710	$ 4,756,547
Registered Nurse Float Pool	1.3		0.3		1.6	$ 94,744	$ 152,848
Registered Nurse Float Pool II					-		$ -
RN, Unit Based Per Diem	2.0	0.8	1.2		3.9	$ 96,110	$ 377,067
Scrub Tech	6.4			0.3	6.7	$ 59,124	$ 394,097
Secretary II	1.0				1.0	$ 64,750	$ 64,750
Surgical Asst.	1.0				1.0	$ 84,698	$ 84,867
Unit Support Coord.	3.2		3.2		6.4	$ 38,210	$ 244,541
Total FTE's	**41.0**	**10.8**	**38.9**	**3.2**	**94.0**		**$ 7,078,627**
Physician Coverage							**$ 1,512,000**

Section .04(6) <u>Physical Plant Design and New Technology.</u> All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

APPLICANT RESPONSE:

When obstetric services relocates from Takoma Park to White Oak, the replacement facility for Washington Adventist Hospital will include all of the existing birthing and inpatient services currently provided at the Takoma Park facility. This includes labor/delivery/recovery (LDR) rooms, private inpatient post-partum/GYN patient rooms, antepartum procedure rooms, triage non-stress test, 2 C-section Rooms, and related support services and functions. The replacement facility will house a special care nursery, consistent with the requirements of the Level IIB Neonatal Program at currently at Washington Adventist Hospital. The special care nursery has been designed to provide newborns with a full range of services where the level of care is adjusted to their developmental needs. A feature of the unit design will permit control over noise and temperature, access to natural light, and lighting controls.

The construction design of the obstetrics service in the replacement facility will include the following features that are expected to contribute to improvements in patient safety and/or quality of care.

- All private patient rooms
- Electronic medical record access in all rooms and conveniently located in charting alcove between patient rooms
- Advanced physical security systems for infant protection and patient safety
- Standardized room set-up and design
- Strategically located hand washing stations to promote infection control and cross contamination control
- Ample space for family accommodation and support
- LDR's sized to include an isolette zone with appropriate support area
- Post partum rooms sized to accommodate couplet care

The expected benefits include a high degree of patient satisfaction and optimum patient outcomes.

Washington Adventist Hospital is compliant with this Standard.

Section .04(15) Outreach Program. Each applicant with an existing perinatal service shall document an outreach program for obstetrics patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, underinsured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.B.

APPLICANT RESPONSE:

The Women's Center provides prenatal, postpartum and related gynecological services to the community served by Washington Adventist Hospital. The program was designed to meet the

needs of both women who meet the criteria for Maryland Medical Assistance as well as women who are participants in the Maternity Partnerships Program. Washington Adventist Hospital anticipates the ability to accept and provide care for 500 Maternity Partnership Program patients per year.

As indicated above, Washington Adventist Hospital has active partnerships with

- Mary's Center for Maternal and Child Care,
- Mobile Medical Care (MobileMed),
- the Primary Care Coalition of Montgomery County,
- Community Clinic, Inc. (CCI), a Federally Qualified Health Clinic, and participates in the Montgomery County Department of Health and Human Services Maternity Partnership Program

to provide obstetric and gynecologic services to uninsured women in Montgomery County. The patients receive their antenatal and postnatal care in the clinic and deliver their babies at the hospital. Participation in this program is expected to continue and expand with the new and renovated facilities.

COMAR 10.24.07- PSYCHIATRIC SERVICES

The Acute Psychiatric Section has eleven standards applicable to this review. These are addressed below.

Availability

Standard AP 1a. The projected maximum bed need for child, adolescent, and adult acute psychiatric bed is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

APPLICANT RESPONSE:

Please see 10.24.01.08G(3)(b)(Need) where the need for psychiatric beds is discussed.

Standard AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 day a week with no special limitation for weekdays or late night shifts.

APPLICANT RESPONSE:

Washington Adventist Hospital's Psychiatric Unit provides inpatient treatment 24 hours a day, seven days a week with no special limitation for weekdays or late night shifts. The Plan for Delivery

of Care and On-call Policies address program services and physician coverage. (Exhibit 51 at p. 24)

Standard AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

APPLICANT RESPONSE:

Licensed mental health professionals at Washington Adventist Hospital in Takoma Park perform face to face assessments 24 hours a day, seven days a week with no special time limitations. Patients believed to have a mental disorder and brought in on emergency petition will be assessed by (1) two physicians or doctors of osteopathy or (2) one physician or doctor of osteopathic medicine and a nationally licensed psychologist to determine whether the patient meets commitment criteria within no later than six hours of presenting to the emergency department. A Needs Assessment clinician performs the Initial Needs Assessment in the Emergency Department and presents medical, psychosocial, and medication information to the assigned attending or on-call physician for determination of whether the patient can be admitted onto the Washington Adventist Hospital Psychiatric Unit following EMTALA requirements. (Exhibit 52- Policy WAH ED 5026 and Policy WAH ED 5030).

Washington Adventist Hospital has been named a Designated Emergency Psychiatric Facility for 2013 by the Maryland Department of Health and Mental Hygiene. (See Exhibit 53)

Standard AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

APPLICANT RESPONSE:

The Washington Adventist Hospital Psychiatric Unit has emergency holding beds and two seclusion rooms used in emergency psychiatric situations where the patient is deemed to be an imminent danger to self or others. Staff are trained in CMS regulations and behavior management techniques to minimize the use and/or duration of said interventions through development of therapeutic milieu and rapport with patients.

Standard AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

APPLICANT RESPONSE:

Washington Adventist Hospital's psychiatric programs are tailored to each patient's needs. Chemotherapy, individual psychotherapy, group therapy, family therapy, social services and expressive therapies are available to patients in the programs. These modalities are designed to assist patients in the development of interpersonal skills within a group setting, restoration of family functioning and provision of any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family.

Standard AP 3b. **In addition to the services mandated in Standard 3a, inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psycho educational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.**

APPLICANT RESPONSE:

Washington Adventist Hospital does not provide inpatient psychiatric services for children and adolescents.

Standard AP 3c. **All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.**

APPLICANT RESPONSE:

Washington Adventist Hospital provides psychiatric consultation services through full time and part time staff psychiatrists.

Standard AP 4a. **A certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.**

APPLICANT RESPONSE:

Washington Adventist Hospital does not wish to change the bed capacity or configuration for the Psychiatric Unit. It is currently licensed as a 40 bed acute adult psychiatric unit serving patients 18 and older.

Standard AP 4b. **Certificate of need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.**

APPLICANT RESPONSE:

As stated in AP4a, the patient population of the Psychiatric Unit is acute adult patients.

Accessibility

Standard AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

(i) intake screening and admission;

(ii) arrangements for transfer to a more appropriate facility for care if medically indicated;

(iii) necessary evaluation to define the patient's psychiatric problem and/or

(iv) emergency treatment.

APPLICANT RESPONSE:

Washington Adventist Hospital's Behavioral Health Needs Assessment department clinical staff provides the face-to-face evaluation to determine psychiatric criteria and most appropriate level of care. The Emergency Department physician will evaluate and determine that the individual is medically stable to participate in psychiatric care. The Needs Assessment staff will arrange for an appropriate transfer only if needed services are not available.

Standard AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations, including children, adolescents, patients with a secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment of through referral.

APPLICANT RESPONSE:

The Washington Adventist Hospital Psychiatric Unit has a quality assurance program based upon Adventist Behavioral Health's performance improvement program. Specific metrics are identified based upon behavioral health patient population needs as well as accrediting and licensing body standards. Central to the program are the Hospital Based Inpatient Psychiatric Services core measures, readmissions, seclusion, restraint, outcomes and other CMS requirements. Protocols and programming for co-occurring disorders such as substance abuse are in place.

Standard AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

APPLICANT RESPONSE:

Although Washington Adventist Hospital is not proposing new or expanded psychiatric services no individual will be denied psychiatric services based on legal status. Washington Adventist Hospital is the only hospital in Montgomery County that has a psychiatric program accepting adult involuntary admissions.

Standard AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the HSCRC for the most recent 12-month period.

APPLICANT RESPONSE:

During FY 2011, the last year for which data have been posted on the HSCRC web site, Washington Adventist Hospital provided 10.09% in uncompensated care for acute psychiatric patients. The average level of uncompensated care provided by all acute general hospitals located in Montgomery County during that period was 7.43% and the state average was 7.79%.

Standard AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

APPLICANT RESPONSE:

Washington Adventist Hospital does not serve children as inpatients. They would instead be admitted to the child and adolescent unit of Adventist Behavioral Health in Rockville, which is less than a 45-minute drive under normal road conditions.

Quality

Standard AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

APPLICANT RESPONSE:

All psychiatric care at Washington Adventist Hospital is directed by a board-certified psychiatrist who is the head of a multidisciplinary team of mental health professionals. All staff psychiatrists are evaluated by the Washington Adventist Hospital Medical Director and Chair of the Washington Adventist Hospital Psychiatric Department, and recommendations are reviewed and approved by the Medical Director of Washington Adventist Hospital.

Standard AP 12b. Staffing of acute psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven-day per week treatment program.

APPLICANT RESPONSE:

Patients in the Psychiatric Unit at Washington Adventist Hospital receive therapeutic programming which provides active treatment in compliance with standards of practice, 7 days per week. The individual's therapist is responsible for coordinating aftercare planning to promote continuity

of care. In addition to making appointments and referrals to outpatient providers, the therapist ensures that an aftercare plan with recommendations is transmitted to the patient's next level of care provider.

Continuity

Standard AP 13: Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

APPLICANT RESPONSE:

The Washington Adventist Hospital Psychiatric Unit follows the discharge planning and referral policies to ensure the patient next level of care needs are met through a variety of services including inpatient, outpatient, partial hospitalization, aftercare treatment programs and other alternative treatment programs. The policies are available for review by appropriate licensing and certifying bodies.

Care management staff are a part of the treatment team at Washington Adventist Hospital and assist with arranging the needed services at discharge to enhance the successful treatment of the individual.

Standard AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);

(ii) the local community mental health center(s);

(iii) the Department of Health and Mental Hygiene; and

(iv) the city/county mental health department(s).

Letter from other consumer organizations are encouraged.

APPLICANT RESPONSE:

Washington Adventist Hospital is not seeking to expand its Psychiatric program.

COMAR 10.24.11 - General Surgical Services

.05 Standards

A. General Standards

The following general standards encompass Commission expectations for the delivery of surgical services by all health care facilities in Maryland, as defined in

Health General §19-114 (d). Each applicant that seeks a Certificate of Need for a project or an exemption from Certificate of Need review for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application.

(1) Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

APPLICANT RESPONSE:

Policy 3.19.2 Public Disclosure of Charges (Exhibit 6) details the Adventist HealthCare policy and procedure for the provision of information regarding hospital services and policies to the public. Quarterly updates to the Representative List of Services and Charges are made and posted to the hospital internet web site (http://www.washingtonadventisthospital.com/app/files/public/467/pdf-WAH-Billing-HospitalCharges.pdf) and are available on request to the public. The Patient Access Department of Washington Adventist Hospital ensures that requests made for current charges for specific procedures are provided in a timely manner. The Patient Access Department provides staff training on this and other policies on a regular basis

(2) Charity Care Policy.

(a) Each hospital and ambulatory surgical facility 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 ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

(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.

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

(iii) Criteria for Eligibility. Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASFs, at a minimum, must include the following eligibility criteria in 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. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of ASFs described in these regulations.

(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 Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

APPLICANT RESPONSE:

Adventist HealthCare, Inc. maintains written policies in English and Spanish pertaining to the General Standards on Information Regarding Charges: Policy 3.19 Charity Care Policy, and Policy 3.19.1 Charity Care Policy, Spanish Language Version (Exhibits 7-8). These policies are summarized and included on the website of Adventist HealthCare, Inc. and Washington Adventist Hospital. http://www.adventisthealthcare.com/WAH/patientsvisitors/patients/billing/charity-care/. Notices of the availability of financial assistance in English and Spanish are prominently posted in the hospital emergency department, 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 nondiscrimination policy and access to care regardless of ability to pay is posted annually in The Gazette Newspapers (Exhibit 9). The most recent posting was made on July 10 and 11, 2013 and appeared in the following editions: Gaithersburg, Germantown, Damascus, Rockville, Bethesda, Potomac, Silver Spring and Olney in Montgomery County; and both the Northern and Southern Prince George's County editions.

The percentage of total operating expenses for Washington Adventist Hospital as reported in the July 10, 2013 Maryland Hospital Community Benefit Report FY 2012 is 15.08% which ranks the hospital as 7th highest for all hospitals in Maryland, with an average for all hospitals of 10.19%.

(3) **Quality of Care.**

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

APPLICANT RESPONSE:

Washington Adventist Hospital is in possession of Maryland Department of Health and Mental Hygiene, Office of Health Care Quality License Number 15-031 issued on October 1, 2010 through January 1, 2014. (See Exhibit 10). Hospital License Number 15369 effective December 30, 2012 through December 30, 2013 was issued by the Health and Human Services Licensure and Regulatory Services of Montgomery County. (See Exhibit 11). Applications for renewal of the licenses are in process.

Washington Adventist Hospital is accredited by the Joint Commission and earned a "Gold Plus Get with the Guidelines – Stroke" quality award in 2013. The last full survey by the Joint Commission successfully concluded on August 16, 2013. (See Exhibit 12).

The hospital is in compliance with the conditions of participation of the Medicare and Medicaid programs.

(4) **Transfer Agreements.**

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2

APPLICANT RESPONSE:

Washington Adventist Hospital transfer policies WAH 5778 and WAH 5908 are attached as Exhibit 54.

B. Project Review Standards

The standards in this section govern reviews of Certificate of Need applications and requests for exemption from Certificate of Need review involving surgical facilities

and services. An applicant for a Certificate of Need or an exemption from Certificate of Need shall demonstrate consistency with all applicable review standards.

(1) Service Area.

An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

APPLICANT RESPONSE:

Washington Adventist Hospital proposes to construct 8 operating rooms (ORs) in its replacement hospital, 5 general surgery ORs and 3 specialty ORs (2 for cardiac surgery, 1 hybrid). In addition to the operating rooms, 1 dedicated cystoscopy room, 2 endoscopy rooms, and 2 C-section OR's are proposed. As of FY2012, Washington Adventist Hospital has 11 operating rooms (mixed use + specialty), 1 dedicated cystoscopy, 1 dedicated endoscopy and 2 C-section rooms.

In the existing Takoma Park facility, all 13 rooms (less C-section) are used to manage the surgical schedule. This is the case because the existing rooms are outdated and much smaller than current design standards, so that ORs are scheduled based on case types and room size requirements. Additionally, the rooms do not provide the current technology or safety features such as lack of intuitive placement of gases, IP, vacuum and electrical outlets which decreases the available square footage that is conducive to optimal patient care. When this square footage is decreased, the risk of contamination of surgical fields increases. Contamination may lead to surgical site infections, which is a national patient safety initiative. All operating rooms proposed for the replacement facility will meet current codes and standards, including storage requirements and proper sizing and placement of technology.

Service Area

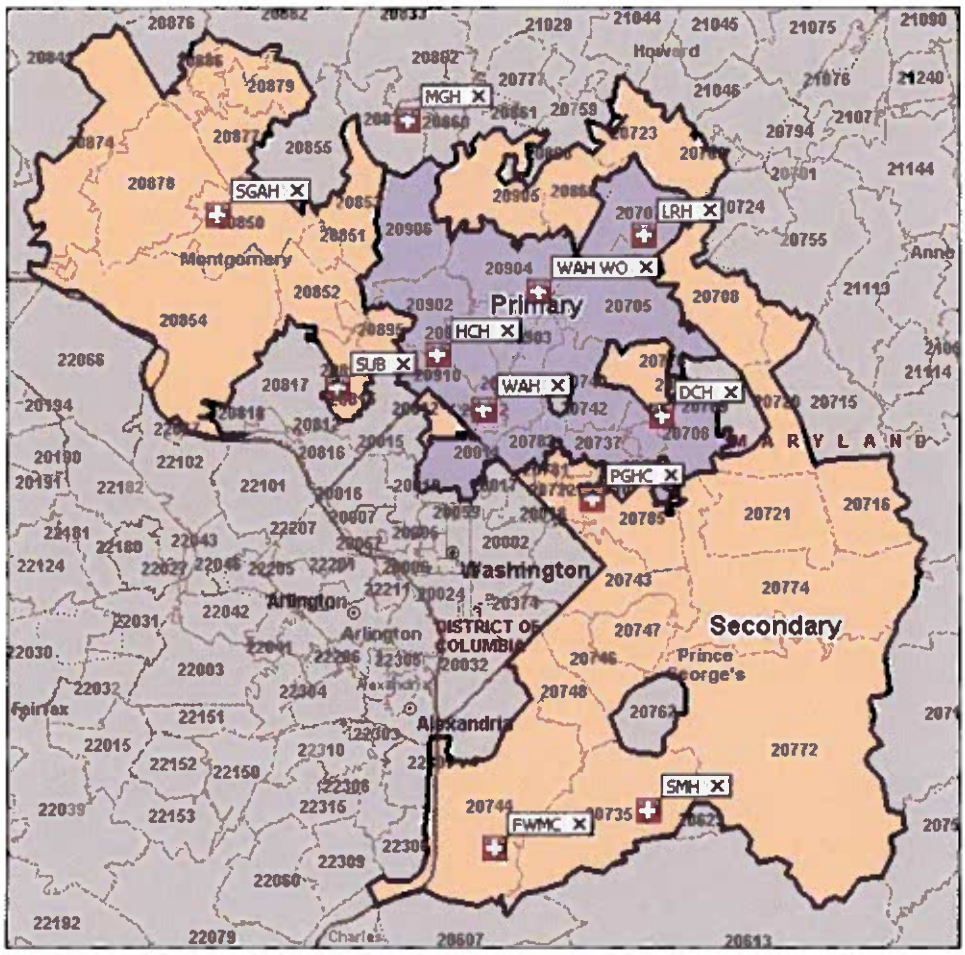
Based on FY2012 internal operating data, we have analyzed the current service area for outpatient surgeries at Washington Adventist Hospital Takoma Park.

In CY2012, the Washington Adventist Hospital PSA for surgeries consisted of 16 zip codes, 7 located in Montgomery County, 8 located in Prince George's County, and 1 located in the District of Columbia, with the primary number of discharges coming from zip code 20783 (Hyattsville). The Washington Adventist Hospital TSA for surgeries is comprised of 50 zip codes, 21 located in Montgomery County, 26 located in Prince George's County, 2 located in the District of Columbia, and 1 located in Howard County listed below.

Zip Code	City	Service Area	Surgeries
20783	Hyattsville	Primary	597
20912	Takoma Park	Primary	403
20904	Silver Spring	Primary	356
20782	Hyattsville	Primary	293
20901	Silver Spring	Primary	251
20903	Silver Spring	Primary	234
20906	Silver Spring	Primary	233

Zip Code	City	Service Area	Surgeries
20902	Silver Spring	Primary	192
20910	Silver Spring	Primary	184
20705	Beltsville	Primary	161
20740	College Park	Primary	129
20737	Riverdale	Primary	103
20784	Hyattsville	Primary	97
20011	Washington	Primary	95
20706	Lanham	Primary	92
20707	Laurel	Primary	87
20905	Silver Spring	Secondary	78
20781	Hyattsville	Secondary	77
20770	Greenbelt	Secondary	76
20785	Hyattsville	Secondary	70
20853	Rockville	Secondary	70
20774	Upper Marlboro	Secondary	68
20708	Laurel	Secondary	65
20712	Mount Rainier	Secondary	65
20743	Capitol Heights	Secondary	55
20772	Upper Marlboro	Secondary	55
20866	Burtonsville	Secondary	54
20850	Rockville	Secondary	52
20874	Germantown	Secondary	44
20012	Washington, D.C.	Secondary	41
20722	Brentwood	Secondary	41
20895	Kensington	Secondary	41
20878	Gaithersburg	Secondary	39
20723	Laurel	Secondary	38
20886	Montgomery Village	Secondary	36
20721	Bowie	Secondary	32
20852	Rockville	Secondary	32
20720	Bowie	Secondary	30
20735	Clinton	Secondary	30
20710	Bladensburg	Secondary	29
20747	District Heights	Secondary	29
20854	Potomac	Secondary	29
20879	Gaithersburg	Secondary	29
20716	Bowie	Secondary	28
20746	Suitland	Secondary	28
20748	Temple Hills	Secondary	28
20744	Fort Washington	Secondary	25
20877	Gaithersburg	Secondary	25
20814	Bethesda	Secondary	24
20851	Rockville	Secondary	24

CY2012 Washington Adventist Hospital Primary and Secondary Service Area for Surgeries



The resulting service area for surgery patients at Washington Adventist Hospital was analyzed and it was determined that it did not differ materially from inpatient MSGA services (identified in the MSGA bed need response under COMAR 10.24.01.08G(3)(b)(Need)). Therefore, we consider the new service area for surgeries to reflect what was considered for MSGA services at White Oak.

(2) <u>Need -Minimum Utilization for Establishment of a New or Replacement Facility</u>.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospital's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

APPLICANT RESPONSE:

The proposed need for 8 operating rooms in 2022 was based upon the current utilization of the Washington Adventist Hospital operating rooms for both inpatient and outpatient surgery for the most current periods, as well as forecasts of future volumes at the replacement hospital for its first five years of operation. The forecasted growth in volumes reflects both the anticipated growth in inpatient surgical volumes, as well as future outpatient surgical volumes. The actual operating room utilization statistics for the existing Hospital for CY2008 through CY2012 are shown below:

CY2008 – CY2012 OR Data

Calendar Year	Surgery Minutes - Inpatient	Surgery Minutes - Outpatient	Surgery Minutes - Total	Inpatient Cases	Outpatient Cases	MSGA Admission
2008	473,230	260,366	733,596	3,881	4,458	12,982
2009	471,456	248,379	719,835	3,948	4,522	13,079
2010	365,746	210,413	576,159	3,311	3,789	12,116
2011	338,470	201,520	539,990	3,032	3,359	10,647
2012	337,518	230,967	568,485	2,879	3,291	9,694

CY2008 – CY2012 OR Utilization Statistics

	Inpatient		Outpatient
Year	Cases/Admission	Minutes/Case	Minutes/Cases
2008	29.9%	122	58
2009	30.2%	119	55
2010	27.3%	110	56
2011	28.5%	112	60
2012	29.7%	117	70
Average	**29.1%**	**116**	**60**

Historical average utilization statistics were applied to projected inpatient and outpatient volume to estimate future surgery minutes. Specifically, inpatient surgery minutes were calculated considering projected MSGA admissions and historical cases/admission and minutes/case. Future outpatient minutes were estimated considering projected outpatient surgeries.

Washington Adventist Hospital currently operates it's ORs with 15 minutes for room prep and 15 minutes for clean-up. Therefore an estimated turnaround time of 30 minutes per case was considered. The optimal capacity of 1,900 hours per year or 114,000 minutes was applied as defined on page 14 of COMAR 10.24.11, State Health Plan for Facilities and Services: General Surgical Services . The following table summarizes the results of the analysis:

Projected Operating Room Statistics

Calendar Year	Surgery Minutes - Inpatient	Surgery Minutes - Outpatient	Surgery Minutes - Total	Total Cases	Estimated Turnaround Time	Total Minutes	ORs Needed at Optimal Capacity
2013	293,890	204,701	498,590	5,953	178,596	677,186	5.9
2014	287,431	206,748	494,179	5,932	177,954	672,133	5.9
2015	281,108	208,815	489,923	5,912	177,358	667,281	5.9
2016	274,919	210,903	485,823	5,894	176,807	662,629	5.8
2017	268,866	213,012	481,879	5,877	176,301	658,180	5.8
2018	262,949	215,142	478,091	5,861	175,841	653,932	5.7
2019	283,982	223,748	507,730	6,186	185,591	693,321	6.1
2020	309,546	237,173	546,719	6,631	198,929	745,648	6.5
2021	343,598	256,147	599,745	7,241	217,242	816,988	7.2
2022	374,506	266,393	640,898	7,679	230,365	871,264	7.6
2023	400,713	273,053	673,765	8,016	240,476	914,241	8.0

In CY2021, three years after project completion a need of 7.2 operating rooms and 8.0 operating rooms is estimated by the end of CY2023.

(3) Need -Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

APPLICANT RESPONSE:

Washington Adventist Hospital is not planning an expansion of operating room capacity in the replacement facility.

(4) **Design Requirements.**

Floor plans submitted by an applicant must be consistent with the current FGI Guidelines.

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.

(b) An ASF shall meet the requirements in Section 3.7 of the FGI Guidelines.

(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

APPLICANT RESPONSE:

The design will be consistent with FGI guidelines.

(a) Section 2.2 of the "Guidelines for Design and Construction of Health Care Facilities" by the Facilities Guidelines Institute (FGI), formerly known as the "AIA Guidelines for Healthcare," addressed Specific Requirements for General Hospitals. The Architect has designed the project in the current state to comply with the FGI Guidelines.

(b) This standard is not applicable.

(c) The current design does include any design features that are at variance with the current FGI Guidelines.

(5) Support Services.

Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.

APPLICANT RESPONSE:

Washington Adventist Hospital provides in house services for laboratory, radiology and pathology 24 hours per day.

(6) Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities;

APPLICANT RESPONSE:

See response under section COMAR 10.24.10.04(12)(Patient Safety).

(7) Construction Costs.

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities 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.

(ii) 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 include:

1. **The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and**

2. **Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.**

APPLICANT RESPONSE:

The cost of constructing the surgical facilities at the Washington Adventist Hospital White Oak campus are reasonable and consistent with current industry cost experience. The projected cost per square foot of the project has been 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.

The details of this analysis are contained in Part IIB-Project Review Standards – COMAR 10.24.10.04B (7) Construction Cost of Hospital Space, including Exhibits 24-29. As described in the above, the projected cost per square foot does not exceed the Marshall Valuation Service® benchmark cost.

(8) Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

(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 facility or, if a new facility, the recent experience of similar facilities;

(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 facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

APPLICANT RESPONSE:

Please see financial feasibility section, COMAR 10.24.10.04B(13), for complete details.

10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, 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.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

APPLICANT RESPONSE:

Both White Oak and Takoma Park are located in southeastern Montgomery County, Maryland, very close to the border between Montgomery County and Prince George's County, Maryland. The White Oak site is 6.6 miles from the Takoma Park site, and located within the primary service area of the existing hospital.

The hospital serves a broad population and service area, including Maryland residents of Montgomery and Prince George's counties, and the District of Columbia. As defined in the State Health Plan, at COMAR 10.24.10.06B.(30), the "service area" means the contiguous area comprised of the postal zip code areas from which the first 85% of a hospital's patients originated during the most recent 12-month period. (This is identified as the Total Service Area or "TSA").

Further, the first 60% represents the primary service area (PSA) and the following 25% represents the secondary service area (SSA). (While the Chapter requires use of 60% of Maryland zip codes in the definition of primary service area, there is no such reference in the definition of "service area." For consistency and since this is both logical and accurate, District of Columbia zip codes that are part of the primary service area in the 60% are included.

MSGA BED NEED ANALYSIS FOR WASHINGTON ADVENTIST HOSPITAL

Washington Adventist Hospital is currently licensed for 252 beds, of which 191 are MSGA beds. The proposed replacement hospital for Washington Adventist Hospital will have 180 MSGA beds. The following steps were applied to determine bed need for MSGA beds:

(1) Defined the new service area

(2) Estimated total discharges and patient days considering population growth, usage rates, and other relevant patient utilization factors

(3) Calculated bed need within the Washington Adventist Hospital/White Oak TSA

(1) Service Area

In CY2012, the Washington Adventist Hospital PSA for MSGA discharges consisted of 13 zip codes, 6 located in Montgomery County, 6 located in Prince George's County, and 1 located in the District of Columbia, with the primary number of discharges coming from zip code 20783 (Hyattsville). Washington Adventist Hospital realized 62.0% market share within 20783 (Hyattsville) and 62.7% of market share within its home zip code 20912 (Takoma Park). Washington Adventist Hospital's market share within its PSA for MSGA discharges was 26.0%.

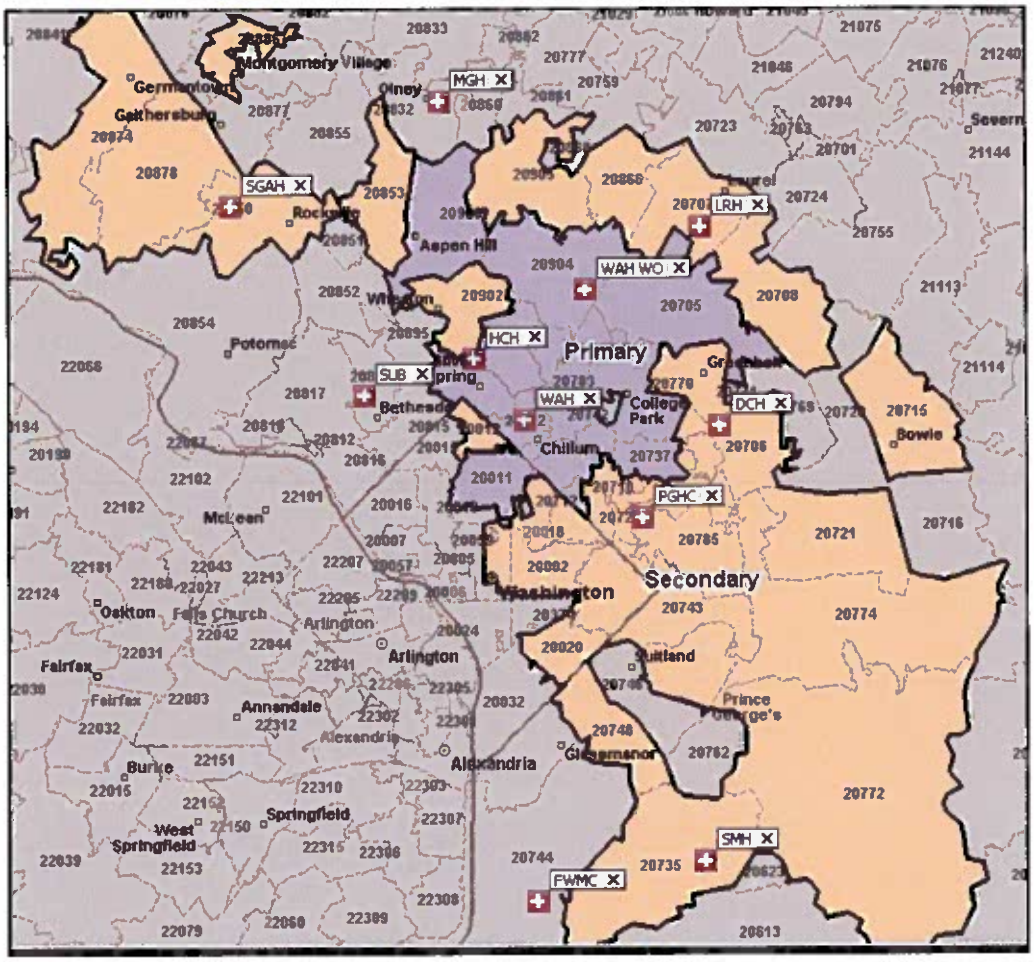
The Washington Adventist Hospital TSA is comprised of 45 zip codes, 14 located in Montgomery County, 23 located in Prince George's County, and 8 located in the District of Columbia, listed below.

CY2012 MSGA WASHINGTON ADVENTIST HOSPITAL TSA

Zip Code	City	Service Area	Discharges	% of Total	Cumulative
20783	Hyattsville	Primary	1,386	14.2%	14.2%
20912	Takoma Park	Primary	801	8.2%	22.4%
20782	Hyattsville	Primary	799	8.2%	30.7%
20903	Silver Spring	Primary	475	4.9%	35.5%
20904	Silver Spring	Primary	421	4.3%	39.8%
20901	Silver Spring	Primary	374	3.8%	43.7%
20910	Silver Spring	Primary	350	3.6%	47.3%
20740	College Park	Primary	327	3.4%	50.6%
20011	Washington, D.C.	Primary	236	2.4%	53.1%
20737	Riverdale	Primary	212	2.2%	55.2%
20705	Beltsville	Primary	202	2.1%	57.3%
20712	Mount Rainier	Primary	177	1.8%	59.1%
20906	Silver Spring	Primary	160	1.6%	60.8%

Zip Code	City	Service Area	Discharges	% of Total	Cumulative
20781	Hyattsville	Secondary	153	1.6%	62.3%
20706	Lanham	Secondary	149	1.5%	63.9%
20770	Greenbelt	Secondary	138	1.4%	65.3%
20902	Silver Spring	Secondary	137	1.4%	66.7%
20785	Hyattsville	Secondary	136	1.4%	68.1%
20784	Hyattsville	Secondary	118	1.2%	69.3%
20012	Washington, D.C.	Secondary	109	1.1%	70.4%
20707	Laurel	Secondary	101	1.0%	71.5%
20774	Upper Marlboro	Secondary	97	1.0%	72.4%
20722	Brentwood	Secondary	87	0.9%	73.3%
20743	Capitol Heights	Secondary	82	0.8%	74.2%
20708	Laurel	Secondary	78	0.8%	75.0%
20002	Washington, D.C.	Secondary	70	0.7%	75.7%
20710	Bladensburg	Secondary	65	0.7%	76.4%
20905	Silver Spring	Secondary	62	0.6%	77.0%
20017	Washington, D.C.	Secondary	60	0.6%	77.6%
20019	Washington, D.C.	Secondary	58	0.6%	78.2%
20020	Washington, D.C.	Secondary	58	0.6%	78.8%
20748	Temple Hills	Secondary	57	0.6%	79.4%
20772	Upper Marlboro	Secondary	56	0.6%	80.0%
20747	District Heights	Secondary	54	0.6%	80.5%
20715	Bowie	Secondary	52	0.5%	81.1%
20850	Rockville	Secondary	50	0.5%	81.6%
20866	Burtonsville	Secondary	46	0.5%	82.0%
20853	Rockville	Secondary	43	0.4%	82.5%
20874	Germantown	Secondary	42	0.4%	82.9%
20878	Gaithersburg	Secondary	41	0.4%	83.3%
20018	Washington, D.C.	Secondary	41	0.4%	83.8%
20721	Bowie	Secondary	39	0.4%	84.2%
20001	Washington, D.C.	Secondary	36	0.4%	84.5%
20886	Montgomery Village	Secondary	32	0.3%	84.9%
20735	Clinton	Secondary	32	0.3%	85.2%

Current WASHINGTON ADVENTIST HOSPITAL MSGA Primary and Secondary Service Area



Washington Adventist Hospital is currently located on the southern part of its PSA. Relocation to White Oak, located in zip code 20904 (Silver Spring) will allow for a more central location within its existing PSA. An analysis was performed to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak recognizing that even a short move of approximately six miles will have an impact on the current TSA.

Market dynamics that consider location of the replacement hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, and physician relationships were taken into consideration when evaluating market share changes as a result of the relocation to White Oak.

Specifically, the following steps were performed to estimate the market share adjustments applied to each zip code:

- Identification of proximity of zip code to all acute care hospital providers including drive time and distance
- Analysis of current market share for acute care hospital providers relative to their location to the zip code

- Approximation of the shift in market share as a result of the proposed replacement hospital recognizing both the distance and current market presence within each zip code.

The example below demonstrates the methodology showing that not any single market dynamic can be used to estimate a change in market share but that all market dynamics need to be considered to best estimate changes in market share from the proposed relocation to White Oak. For example, zip code 20705, Beltsville, is closest to Laurel Regional Hospital yet Laurel has only 22.5% market share while Holy Cross Hospital is ranked 4th in distance but has the largest market share of 26.1%. Doctors Hospital is ranked as the second closest hospital but only has 7.7% market share. Washington Adventist Hospital currently has a 16.1% market share in Beltsville and is ranked 3rd in distance. If Washington Adventist Hospital relocates to White Oak, it is estimated that it will take an additional 10% of the market as a result of its proximity to Beltsville, drive times, current market share, the proximity to other area hospitals but not ignoring the fact that Holy Cross has a strong market presence and most likely strong physician relationships in the zip code.

Zip Code 20705 – Beltsville		
	To Washington Adventist Hospital - Takoma Park	To Washington Adventist Hospital - White Oak
Distance	9.4 miles	4.7 miles
Drive time	21.2 minutes	10.7 minutes

Source: Based on Travel Time Study (Exhibit 16)

Hospital	Market Share	Ranked - Closest hospital by proximity
Laurel Regional Hospital	22.5%	1
Doctors Community Hospital	7.7%	2
Washington Adventist Hospital	16.1%	3
Holy Cross Hospital	26.1%	4
Prince Georges Hospital Center	2.7%	5
Suburban Hospital	2.3%	6
Medstar Montgomery Hospital Center	1.7%	7
Shady Grove Adventist Hospital	1.8%	8
Others	19.1%	-
Total	100.0%	

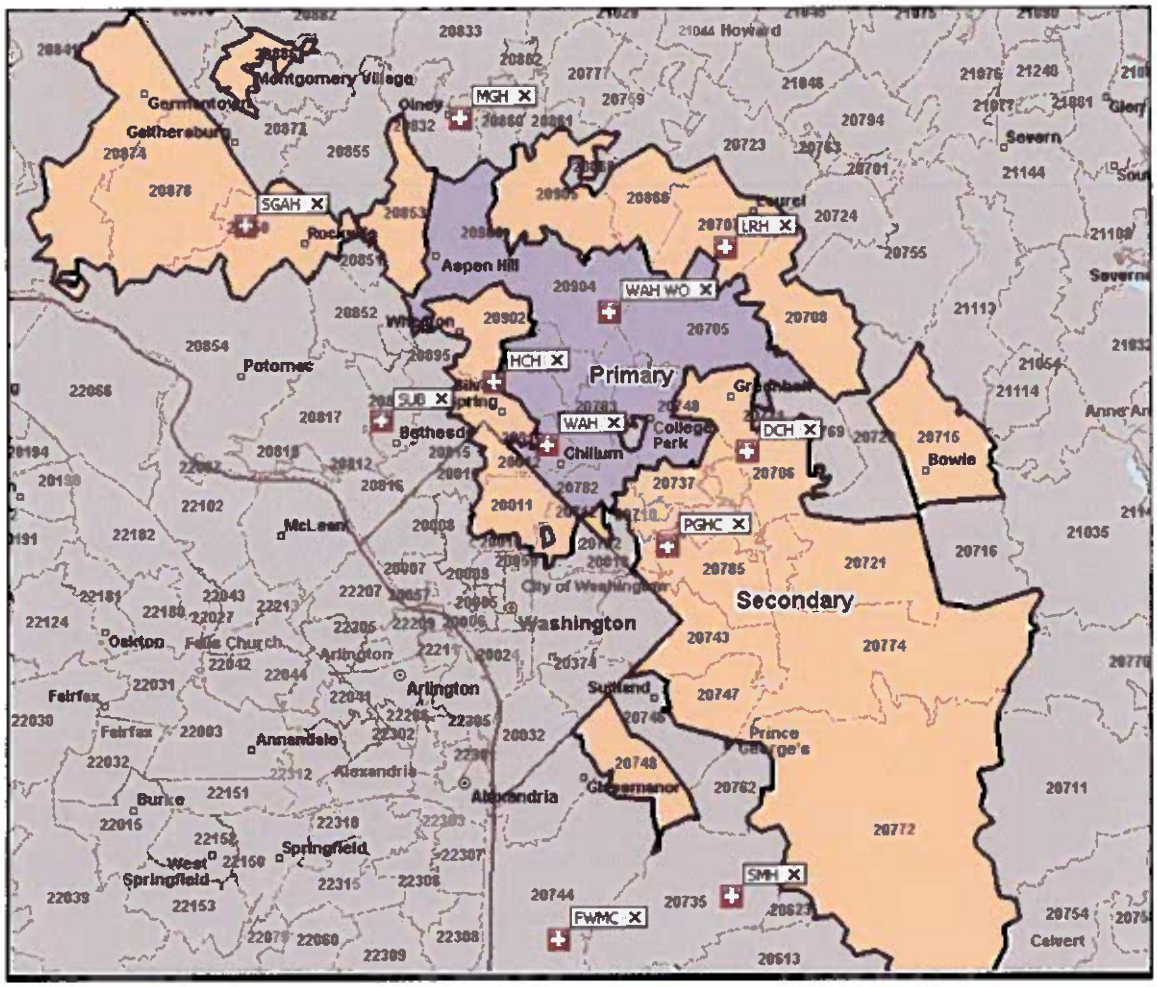
Taking into account all of the factors and methodology listed above, the following adjustments to the Washington Adventist Hospital MSGA TSA were considered:

WASHINGTON ADVENTIST HOSPITAL MSGA TSA Market Share Analysis of Proposed Location

Zip Code	City	Current Market Share at Takoma Park	Estimated Market Share Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	62.0%	-15.0%	47.0%
20912	Takoma Park	62.7%	-15.0%	47.7%
20782	Hyattsville	59.6%	-15.0%	44.6%
20903	Silver Spring	41.7%	0.0%	41.7%
20904	Silver Spring	11.3%	45.0%	56.3%
20901	Silver Spring	21.8%	5.0%	26.8%
20910	Silver Spring	17.8%	-15.0%	2.8%
20740	College Park	29.1%	-1.0%	28.1%
20011	Washington, D.C.	33.4%	-15.0%	18.4%
20737	Riverdale	19.8%	-15.0%	4.8%
20705	Beltsville	16.1%	10.0%	26.1%
20712	Mount Rainier	54.6%	-20.0%	34.6%
20906	Silver Spring	3.2%	5.0%	8.2%
20781	Hyattsville	28.5%	-15.0%	13.5%
20706	Lanham	5.9%	-1.0%	4.9%
20770	Greenbelt	10.7%	5.0%	15.7%
20902	Silver Spring	5.3%	0.0%	5.3%
20785	Hyattsville	5.3%	-1.0%	4.3%
20784	Hyattsville	7.4%	-1.0%	6.4%
20012	Washington, D.C.	34.9%	-15.0%	19.9%
20707	Laurel	5.2%	10.0%	15.2%
20774	Upper Marlboro	4.2%	-1.0%	3.2%
20722	Brentwood	26.8%	-20.0%	6.8%
20743	Capitol Heights	2.9%	-1.0%	1.9%
20708	Laurel	5.4%	1.0%	6.4%
20002	Washington, D.C.	16.6%	-15.0%	1.6%
20710	Bladensburg	11.5%	-1.0%	10.5%
20905	Silver Spring	6.3%	15.0%	21.3%
20017	Washington, D.C.	32.3%	-15.0%	17.3%
20019	Washington, D.C.	6.6%	-5.0%	1.6%
20020	Washington, D.C.	9.7%	-8.0%	1.7%
20748	Temple Hills	2.7%	0.0%	2.7%
20772	Upper Marlboro	2.5%	0.0%	2.5%
20747	District Heights	2.4%	0.0%	2.4%
20715	Bowie	2.8%	0.0%	2.8%
20850	Rockville	1.7%	0.0%	1.7%
20866	Burtonsville	7.2%	15.0%	22.2%
20853	Rockville	2.6%	0.0%	2.6%
20874	Germantown	1.6%	0.0%	1.6%
20878	Gaithersburg	1.7%	0.0%	1.7%
20018	Washington, D.C.	16.9%	-15.0%	1.9%
20721	Bowie	3.0%	0.0%	3.0%
20001	Washington, D.C.	17.6%	-15.0%	2.6%
20886	Montgomery Village	2.0%	0.0%	2.0%
20735	Clinton	1.1%	0.0%	1.1%
Total Market Share		**11.6%**	**1.0%**	**12.6%**

As demonstrated above, individual adjustments were considered to each Zip code. Total discharges at Washington Adventist Hospital/White Oak were then calculated, considering the estimated market share by Zip code. The conclusion is that moving to the White Oak location will increase overall market share within the Takoma Park TSA approximately 1%. Finally, the primary and secondary service for Washington Adventist Hospital/White Oak was redefined based on the estimate total discharges. It was determined that moving to the White Oak location will tighten the current service area as 4 Zip codes will drop out of the primary service area and 6 will drop out of the total service area.

Washington Adventist Hospital - White Oak MSGA Primary and Secondary Service Area



The redefined Washington Adventist Hospital/White Oak TSA was considered to perform the bed need analysis.

(2) Estimated Discharges

Overall adult population within the Washington Adventist Hospital - White Oak TSA was estimated to be 1.042 million in CY2010, 1.07 million residents in CY2013, and 1.12 million residents in CY2018. This implies an overall increase in the population of approximately 2.9% between CY2010 and CY2013.

Demonstrated in the table below, MSGA discharges in the Washington Adventist Hospital/ White Oak TSA decreased 6.5% between CY2010 and CY2012. In the Washington Adventist Hospital/White Oak TSA, Medicare[5] discharges have decreased 0.8% since CY2008 and non-Medicare discharges have decreased by 4.7%, indicating a total decrease of 2.9%.

MSGA Discharges within WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	9,947	10,141	9,488	8,540	7,948	-20.1%
Holy Cross	11,570	12,619	13,109	13,180	12,890	11.4%
Montgomery General	4,699	4,508	4,578	4,330	4,091	-12.9%
Shady Grove Adventist	6,923	7,317	7,547	7,446	7,547	9.0%
Suburban Hospital Center	3,650	3,555	3,529	3,592	3,771	3.3%
Laurel Regional Hospital	3,218	2,979	2,623	2,250	2,498	-22.4%
Prince Georges Hospital Ctr	6,748	7,109	6,805	5,949	5,238	-22.4%
Southern Maryland	7,407	6,986	6,926	6,914	6,417	-13.4%
Fort Washington Hospital	517	511	511	420	398	-23.0%
Doctors Community Hospital	8,945	9,535	10,407	9,857	8,736	-2.3%
Other Provider	7,511	8,026	8,295	8,880	9,520	26.7%
Total	71,135	73,286	73,818	71,358	69,054	-2.9%

The declining discharges during periods with population growth indicate historical declines in usage rates that are likely due to a number of factors, including:

- National shift from inpatient to outpatient services
- Increases in observation and decreases in one-day stays
- Loss of insurance coverage due to economic conditions
- Increased emphasis on reduction of readmissions

In fact, MSGA use rates in the White Oak TSA declined 8.2% from 2010 to 2012 or from 70.8 to 65.0 per 1,000 in population. This significant decline recognizes the weak economy, decreases in one-day stays and readmissions, and the shift to outpatient and observation stays that have already had a significant impact on volumes and use rates. With the magnitude of this decline experienced in the White Oak TSA, there are more contributing factors than just shifts from inpatient to outpatient services.

In addition to recognizing historical trends, given the potential for changes due to the Affordable Care Act, and related health care reform legislation, history-graded influences, most specifically the baby boomer cohort, were also considered. The term baby boomers is generally described as the generation of Americans born between 1946 and 1964. This population boom cohort is now aged 67-49 with 10,000 baby boomers reaching age 65 at a rate of 10,000 each day. In 2010 this demographic represented 13% of the U.S. population but is expected to grow to represent 18% of the U.S. population by 2030.

In spite of greater access to healthcare advancements than previous generations, baby boomers actually have more chronic health problems. For example, with almost 40% of baby boomers diagnosed as obese, obesity-related conditions such as hypertension, high cholesterol and heart disease are more common – which means a greater need for healthcare services as this population ages.

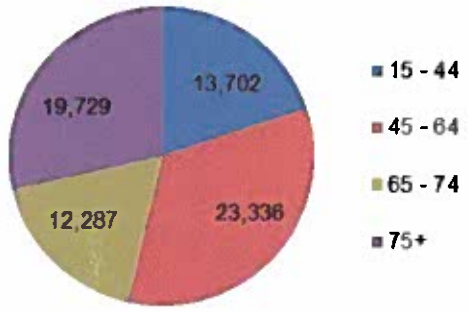
[5] For purposes of this analysis, we have grouped MSGA patients over 65 into Medicare and patients aged 15-64 into Non-Medicare.

Health insurance enrollment projections estimated the uninsured population will decline from 48.6 million in 2013 to 23.1 million in 2021 because of health exchanges or Medicaid expansion.[6] Having increased access to healthcare for the uninsured and underinsured will result in higher use rates for this population.

As a result, further declines in use rates by shifts to outpatient and observations stays would be offset by an improving economy, an aging population and those populations who would receive improved access to coverage.

Based on these factors, usage rates were maintained at 2012 levels recognizing a historical decrease in usage rates. Taking into account the estimated population growth, a baseline projection was developed using the 2012 population use rates, reflecting the changes that will occur based on population size and age composition. Using Nielsen Claritas data, population growth rates to CY2012 discharges by Zip code and age cohort (15-44, 45-64, 65-74, and 75+) were applied. The table below summarizes the growth rates considered over the 10-year period.

CY 2012 MSGA Discharges Originating in WAH - White Oak TSA



Admission Estimates by Age Cohort Originating in WAH's TSA

Ages	2012	2022	Total Change	Annual Change
15 - 44	13,702	13,224	-3.5%	-0.4%
45 - 64	23,336	25,826	10.7%	1.0%
65 - 74	12,287	21,073	71.5%	5.5%
75+	19,729	25,987	31.7%	2.8%
Total	**69,054**	**86,110**	**24.7%**	**2.2%**

Source: HSCRC data base and Nielson Claritas population projections

A total of 86,110 discharges in CY2022 was estimated for the Washington Adventist Hospital/ White Oak TSA, which indicates absolute growth of approximately 24.7% over the 10-year period, or an increase of 17,056 incremental discharges. Total Medicare discharges (patients 65 and older) are estimated to increase from 32,016 in CY2012 to 47,060 in CY2022, indicating growth of 47.0% and total non-Medicare discharges (patients 15 through 64) are estimated to increase from 37,038 in CY2012 to 39,050 in CY2022, indicating growth of 5.4%.

Washington Adventist Hospital projects further declines in volumes until the replacement hospital opens in White Oak. As a result, the improvement in volume once the new facility opens is a recapture of lost market share. In fact, market share for Washington Adventist Hospital in 2022 will be less than what it is in 2012.

(3) Estimated Bed Need

The historical average length of stay (ALOS) for patients originating in the Washington Adventist Hospital/White Oak TSA for the past five calendar years was examined. As indicated in the tables below, overall ALOS for Medicare patients has remained relatively flat within the Washington

[6] Standard & Poor's Industry Survey, Healthcare: Facilities, June 2013.

Adventist Hospital/White Oak TSA and increased 10.3% for non-Medicare patients during this time period.

MSGA ALOS within WAH - White Oak TSA (Medicare 65+)

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	5.4	5.4	5.5	5.7	5.9	8.3%
Holy Cross	5.2	4.9	4.7	4.8	4.9	-6.3%
Montgomery General	4.7	4.7	4.7	4.3	4.3	-8.9%
Shady Grove Adventist	5.1	5.4	5.3	5.5	5.4	4.0%
Suburban Hospital Center	4.4	4.4	4.5	4.5	4.7	8.1%
Laurel Regional Hospital	4.8	5.1	5.1	5.1	4.9	3.7%
Prince Georges Hospital Ctr	6.8	6.2	6.5	6.2	6.6	-2.4%
Southern Maryland	4.5	4.6	4.4	4.9	4.8	6.3%
Fort Washington Hospital	4.5	4.0	4.1	4.6	4.5	1.5%
Doctors Community Hospital	5.1	4.9	5.2	5.2	5.4	5.5%
Other Provider	6.9	6.5	6.7	6.9	6.5	-4.9%
Total	5.3	5.2	5.2	5.3	5.3	0.8%

MSGA ALOS within WAH - White Oak TSA (Non - Medicare 15 - 64)

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	4.1	4.0	4.2	4.4	4.9	19.8%
Holy Cross	4.2	4.0	3.9	4.1	4.2	-0.6%
Montgomery General	4.0	4.0	3.8	3.8	3.7	-8.0%
Shady Grove Adventist	3.8	3.8	3.8	4.0	3.8	1.1%
Suburban Hospital Center	3.5	3.9	3.8	3.7	4.2	20.3%
Laurel Regional Hospital	3.7	3.8	3.8	3.7	3.8	1.7%
Prince Georges Hospital Ctr	4.6	4.4	4.6	4.8	5.5	19.9%
Southern Maryland	3.3	3.4	3.4	3.6	4.0	19.1%
Fort Washington Hospital	3.5	3.4	3.0	3.3	3.2	-8.3%
Doctors Community Hospital	3.7	3.5	3.7	3.8	4.2	14.8%
Other Providers	6.1	5.9	6.1	5.9	6.2	2.2%
Total	4.2	4.1	4.2	4.3	4.6	10.3%

Market Share Based on Patient Days in WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	Variance
Washington Adventist	14.1%	14.0%	13.3%	12.6%	12.4%	-1.7%
Holy Cross	16.3%	16.6%	16.3%	17.2%	17.1%	0.8%
Montgomery General	6.4%	6.0%	5.9%	5.3%	4.9%	-1.4%
Shady Grove Adventist	9.1%	9.9%	9.8%	10.3%	10.0%	0.9%
Suburban Hospital Center	4.3%	4.4%	4.3%	4.3%	4.9%	0.6%
Laurel Regional Hospital	4.1%	3.9%	3.4%	2.9%	3.1%	-1.0%
Prince Georges Hospital Ctr	10.6%	10.4%	10.3%	9.3%	9.0%	-1.6%
Southern Maryland	8.6%	8.2%	7.8%	8.6%	8.2%	-0.4%
Fort Washington Hospital	0.6%	0.5%	0.5%	0.5%	0.4%	-0.2%
Doctors Community Hospital	11.5%	11.5%	12.9%	12.7%	12.1%	0.6%
Other Provider	14.4%	14.6%	15.2%	16.4%	17.6%	3.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	N/A

We applied the overall CY2012 ALOS for patients originating in the Washington Adventist Hospital/White Oak TSA by patient grouping to determine the overall estimated patient days. We assumed occupancy rates of 80% based on guidance indicated in COMAR10.24.10.05.D(4) for both Medicare and Non-Medicare patients to arrive at a total need of 1,475 beds. We recognized that historically, 17.6% of the days associated with patients originating in the Washington Adventist Hospital/White Oak TSA went to other providers outside Montgomery County and Prince George's County and therefore adjusted the total bed need to reflect only the beds needed to serve the patients who remain in those counties at the identified acute care hospitals. We calculated a total bed need of 1,215 for patients going to acute care facilities within Montgomery and Prince George's County. See calculations below:

Historically, 17.6% of the days associated with patients originating in the Washington Adventist Hospital/White Oak TSA went to other providers outside Montgomery County and Prince George's County so that the total bed need was adjusted to reflect only the beds needed to serve the patients who remain in those counties at the identified acute care hospitals. A total bed need of 1,215 for patients going to acute care facilities within Montgomery and Prince George's counties was calculated:

	Total Bed Need for Discharges Originating in WAH - White Oak TSA				
	CY2022 Admissions	**ALOS**	**Days**	**Occupancy**	**Bed Need**
Medicare	47,060	5.3	250,898	80.0%	859
Non-Medicare	39,050	4.6	179,935	80.0%	616
Total	**86,110**	**5.0**	**430,833**	**N/A**	**1,475**
CY2012 Market Share Leaving Montgomery & Prince George's County				17.6%	260
Beds Needed in Montgomery & Prince George County Hospitals					1,215

The same methodology was considered in calculating the licensed beds at the Montgomery and Prince George's hospitals currently serving this selected population.

Analysis of Beds Serving the Washington Adventist Hospital – White Oak TSA

Provider	MSGA Days Originating in WAH - WO TSA	Total MSGA Days	% MSGA Days from WAH - WO TSA	FY2013 Licensed MSGA Beds	MSGA Beds Serving WAH - WO TSA
Washington Adventist	42,423	51,796	81.9%	191	156
Holy Cross	58,448	76,245	76.7%	282	216
Montgomery General	16,893	28,007	60.3%	100	60
Shady Grove Adventist	34,304	66,234	51.8%	250	129
Suburban Hospital Center	16,781	55,074	30.5%	199	61
Laurel Regional Hospital	10,713	14,485	74.0%	53	39
Prince Georges Hospital Ctr	30,715	42,340	72.5%	152	110
Southern Maryland	28,067	50,027	56.1%	180	101
Fort Washington Hospital	1,525	7,701	19.8%	31	6
Doctors Community Hospital	41,302	51,610	80.0%	207	166
Total	**281,171**	**443,519**	**N/A**	**1,645**	**1,045**

Further analysis shows an additional net bed need of 170 for the Washington Adventist Hospital/White Oak TSA. This calculation of additional beds takes into account Washington Adventist Hospital's current licensed beds of 191 and does not consider the proposed replacement hospital will have 180 MSGA beds. While 75 MSGA beds have already been approved for Holy Cross Hospital in Germantown, those beds are not included in the analysis due to the lack of related historical data. This does not affect the bed need calculation supporting the application. Assuming 100% of those beds would support the Washington Adventist Hospital/White Oak TSA, implying direct overlap of service areas, a need is still indicated for 95 (170 – 75) MSGA beds in the Washington Adventist Hospital/White Oak TSA.

Net Bed Need for WAH - White Oak TSA	
	Bed Need
Beds Needed at Montgomery & Prince George's County Hospitals	1,215
Beds Available to Serve TSA in M & PG County	(1,045)
Net Bed Need	170

The analysis also focused on the bed need within the Washington Adventist Hospital /White Oak TSA and therefore did not consider growth in admissions from patients outside the service area. If the rest of Maryland was also expected to experience increases in its adult population, there would be further support for additional bed need.

PSYCHIATRIC BED NEED ANALYSIS FOR WASHINGTON ADVENTIST HOSPITAL

In FY2013, Washington Adventist Hospital was licensed for 252 beds, of which 40 are licensed for psychiatric services. Washington Adventist Hospital intends to continue offering psychiatric services at the Takoma Park location with no adjustment to the number of beds in service. Psychiatric services are regional and include involuntary patients.

(1) Service Area

In CY2012, the Washington Adventist Hospital PSA for psychiatric discharges consisted of 20 zip codes, 12 located in Montgomery County and 8 located in Prince George's County with the primary number of discharges coming from zip code 20910 (Silver Spring) and 20912 (Takoma Park). Washington Adventist Hospital observed 52.3% market share within 20910 and 79.9% market

share within its home zip code 20912. Washington Adventist Hospital's market share within its PSA for psychiatric discharges is 37.4%.

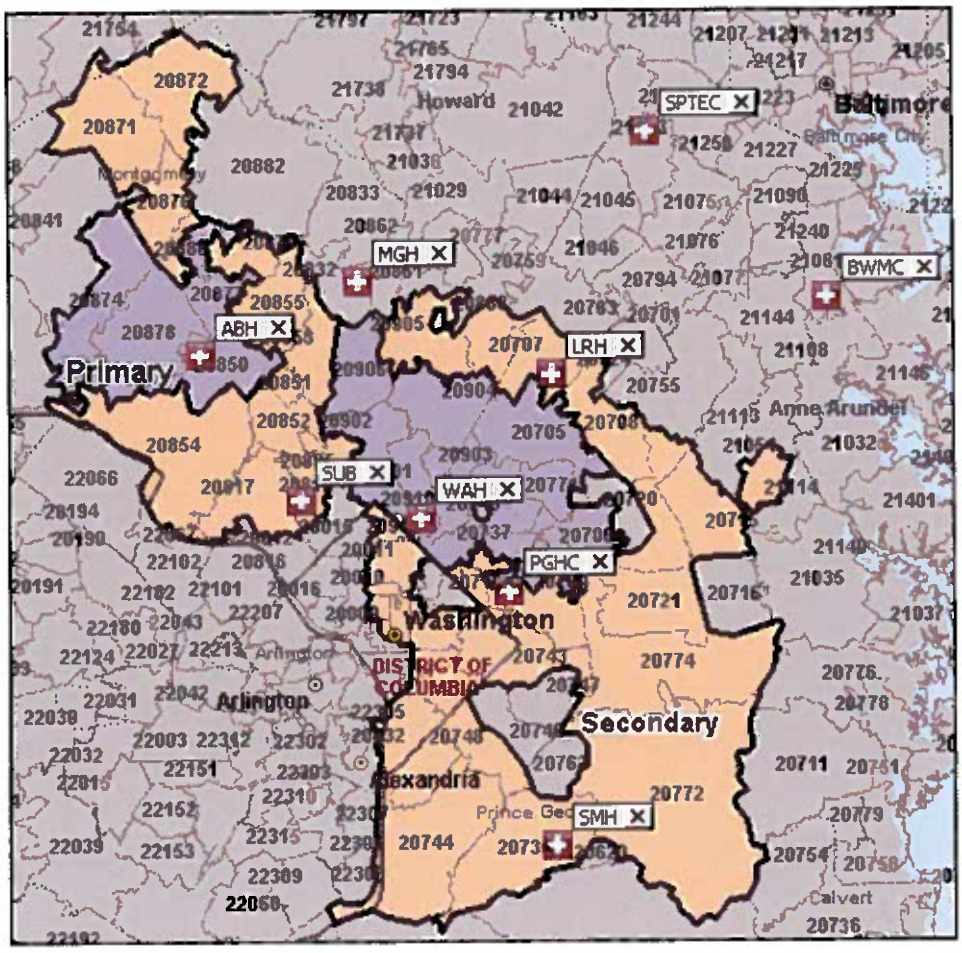
The Washington Adventist Hospital TSA is comprised of 63 zip codes, 26 located in Montgomery County, 24 located in Prince George's County, 12 located in the District of Columbia, and 1 located in Anne Arundel County, listed below.

CY2012 Psychiatric Washington Adventist Hospital TSA

Zip Code	City	Service Area	Discharges	% of Total	Cumulative %	Market Share
20910	Silver Spring	Primary	113	6.8%	6.8%	52.3%
20912	Takoma Park	Primary	107	6.4%	13.2%	79.9%
20783	Hyattsville	Primary	84	5.0%	18.2%	63.2%
20904	Silver Spring	Primary	76	4.6%	22.8%	34.5%
20901	Silver Spring	Primary	75	4.5%	27.2%	52.1%
20782	Hyattsville	Primary	69	4.1%	31.4%	67.6%
20902	Silver Spring	Primary	61	3.7%	35.0%	36.1%
20850	Rockville	Primary	58	3.5%	38.5%	34.5%
20906	Silver Spring	Primary	53	3.2%	41.7%	15.0%
20903	Silver Spring	Primary	51	3.1%	44.7%	76.1%
20737	Riverdale	Primary	30	1.8%	46.5%	33.0%
20784	Hyattsville	Primary	29	1.7%	48.3%	22.8%
20878	Gaithersburg	Primary	29	1.7%	50.0%	31.5%
20877	Gaithersburg	Primary	29	1.7%	51.7%	43.9%
20770	Greenbelt	Primary	26	1.6%	53.3%	26.5%
20740	College Park	Primary	24	1.4%	54.7%	32.9%
20874	Germantown	Primary	24	1.4%	56.2%	21.6%
20886	Montgomery Village	Primary	22	1.3%	57.5%	26.8%
20705	Beltsville	Primary	21	1.3%	58.7%	23.1%
20706	Lanham	Primary	21	1.3%	60.0%	14.9%
20002	Washington, D.C.	Secondary	21	1.3%	61.3%	46.7%
20707	Laurel	Secondary	19	1.1%	62.4%	10.9%
20011	Washington, D.C.	Secondary	18	1.1%	63.5%	38.3%
20879	Gaithersburg	Secondary	18	1.1%	64.6%	26.9%
20712	Mount Rainier	Secondary	16	1.0%	65.5%	50.0%
20781	Hyattsville	Secondary	16	1.0%	66.5%	32.7%
20876	Germantown	Secondary	16	1.0%	67.4%	27.6%
20774	Upper Marlboro	Secondary	15	0.9%	68.3%	11.5%
20814	Bethesda	Secondary	14	0.8%	69.2%	9.8%
20010	Washington, D.C.	Secondary	13	0.8%	69.9%	39.4%
20785	Hyattsville	Secondary	12	0.7%	70.7%	6.5%
20721	Bowie	Secondary	12	0.7%	71.4%	19.7%
20853	Rockville	Secondary	12	0.7%	72.1%	11.0%
20032	Washington, D.C.	Secondary	12	0.7%	72.8%	16.9%

Zip Code	City	Service Area	Discharges	% of Total	Cumulative %	Market Share
20012	Washington, D.C.	Secondary	11	0.7%	73.5%	52.4%
20743	Capitol Heights	Secondary	10	0.6%	74.1%	5.1%
20866	Burtonsville	Secondary	10	0.6%	74.7%	21.3%
20895	Kensington	Secondary	10	0.6%	75.3%	12.7%
20009	Washington, D.C.	Secondary	10	0.6%	75.9%	30.3%
20851	Rockville	Secondary	10	0.6%	76.5%	21.3%
20001	Washington, D.C.	Secondary	9	0.5%	77.0%	40.9%
20852	Rockville	Secondary	9	0.5%	77.5%	6.7%
20019	Washington, D.C.	Secondary	8	0.5%	78.0%	14.3%
20855	Derwood	Secondary	8	0.5%	78.5%	27.6%
20708	Laurel	Secondary	7	0.4%	78.9%	7.9%
20905	Silver Spring	Secondary	7	0.4%	79.3%	11.1%
20020	Washington, D.C.	Secondary	7	0.4%	79.8%	23.3%
20817	Bethesda	Secondary	7	0.4%	80.2%	7.0%
20854	Potomac	Secondary	7	0.4%	80.6%	9.7%
20003	Washington, D.C.	Secondary	7	0.4%	81.0%	28.0%
20013	Washington, D.C.	Secondary	7	0.4%	81.4%	77.8%
20772	Upper Marlboro	Secondary	6	0.4%	81.8%	4.3%
20720	Bowie	Secondary	6	0.4%	82.2%	12.2%
20744	Fort Washington	Secondary	6	0.4%	82.5%	4.0%
20872	Damascus	Secondary	6	0.4%	82.9%	16.2%
20735	Clinton	Secondary	5	0.3%	83.2%	4.1%
20871	Clarksburg	Secondary	5	0.3%	83.5%	20.8%
21114	Crofton	Secondary	5	0.3%	83.8%	9.8%
20005	Washington, D.C.	Secondary	5	0.3%	84.1%	62.5%
20722	Brentwood	Secondary	4	0.2%	84.3%	33.3%
20748	Temple Hills	Secondary	4	0.2%	84.6%	2.6%
20715	Bowie	Secondary	4	0.2%	84.8%	5.1%
20745	Oxon Hill	Secondary	4	0.2%	85.0%	3.0%

CY2012 Psychiatric Washington Adventist Hospital TSA



Because psychiatric services will remain in Takoma Park, a bed need analysis was conducted based upon the CY2012 Washington Adventist Hospital Psych TSA since there will no adjustment in the market service area.

(2) Estimated Discharges

The overall adult population within the Washington Adventist Hospital psychiatric TSA was estimated to be 1.64 million in CY2010, 1.7 million in CY2013, and 1.8 million in CY2018. This implies an overall increase in the population of approximately 3.7% between CY2010 and CY2013.

As indicated in the table below, psychiatric discharges in the Washington Adventist Hospital TSA have decreased 2.3% between CY2010 and CY2012, although they have increased 12.2% over the past 5 years. The greatest annual increase in discharges occurred between CY2008 and CY2009 with 13.5% growth. Between CY2011 and CY2012, total psychiatric discharges at Montgomery Count and Prince George's County hospitals declined 8.3% while psychiatric discharges within the Washington Adventist Hospital TSA experienced a less significant decline of 4.4%.

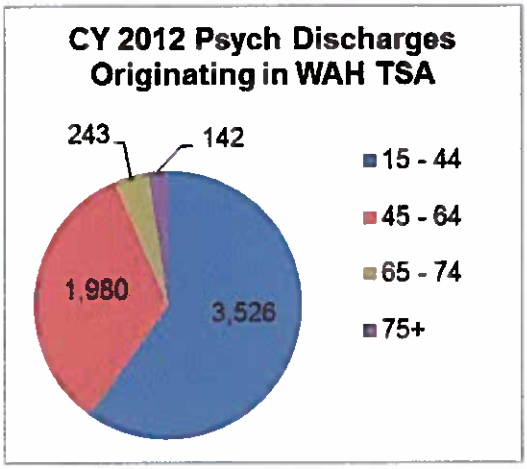
Psych Discharges in WAH TSA

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	1,491	1,671	1,444	1,397	1,420	-4.8%
Holy Cross	44	40	78	78	73	65.9%
Montgomery General	829	850	898	881	814	-1.8%
Shady Grove Adventist	47	32	38	23	36	-23.4%
Suburban Hospital Center	721	819	945	1,062	976	35.4%
Laurel Regional Hospital	311	367	337	407	384	23.5%
Prince Georges Hospital Ctr	762	1,036	1,112	1,120	1,083	42.1%
Southern Maryland	736	736	764	719	626	-14.9%
Fort Washington Hospital	4	4	3	6	3	-25.0%
Doctors Community Hospital	11	13	12	10	6	-45.5%
Other Provider	294	392	401	457	470	59.9%
Total	5,250	5,960	6,032	6,160	5,891	12.2%
Annual Change	*N/A*	*13.5%*	*1.2%*	*2.1%*	*-4.4%*	

Psych Total Discharges

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	1,798	1,972	1,757	1,703	1,670	-7.1%
Holy Cross	47	43	85	96	82	74.5%
Montgomery General	1,145	1,213	1,234	1,223	1,123	-1.9%
Shady Grove Adventist	56	38	42	29	38	-32.1%
Suburban Hospital Center	914	1,075	1,189	1,376	1,254	37.2%
Laurel Regional Hospital	646	764	800	892	719	11.3%
Prince Georges Hospital Ctr	918	1,266	1,341	1,400	1,349	46.9%
Southern Maryland	1,294	1,280	1,289	1,221	1,057	-18.3%
Fort Washington Hospital	7	7	6	8	4	-42.9%
Doctors Community Hospital	14	15	16	13	6	-57.1%
Total	6,839	7,673	7,759	7,961	7,302	6.8%
Annual Change	*N/A*	*12.2%*	*1.1%*	*2.6%*	*-8.3%*	

Based on Nielsen Claritas data, population growth rates to CY2012 discharges by zip code and age cohort (15-44, 45-64, 65-74, and 75+) were applied. The table below summarizes the growth rates considered over the 10-year period.



Discharge Estimates by Age Cohort Originating in WASHINGTON ADVENTIST HOSPITAL TSA

Ages	2012	2022	Total Change	Annual Change
15 - 44	3,526	3,475	-1.4%	-0.1%
45 - 64	1,980	2,228	12.5%	1.2%
65 - 74	243	416	71.2%	5.5%
75+	142	178	25.2%	2.3%
Total	5,891	6,297	6.9%	0.7%

Source: HSCRC data base and Nielsen Claritas population projections

Under this methodology, a baseline projection was developed that maintains population use rates and reflects the changes that will occur based on population size and age composition. A 10%

increase in non-Medicare discharges based on changes in Maryland's coverage for psychiatric services was also included.

A total of 6,297 discharges in CY2022 for the Washington Adventist Hospital TSA was estimated based on population growth and an increase of 570 discharges, or 10% growth, due to increased access and demand for psychiatric services. The adjusted CY2022 discharges, including population growth and usage adjustments, indicated absolute growth of approximately 16.6% over the 10-year period, or annual growth of 1.5%.

(3) Estimated Bed Need

The historical ALOS for patients originating in the Washington Adventist Hospital TSA for the past five calendar years was analyzed. As indicated in the tables below, overall ALOS for Medicare patients has declined 6.2% and 1.5% for non-Medicare patients during this time period.

Psych ALOS within WAH TSA (Medicare)

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	6.8	7.4	7.0	6.7	9.3	36.3%
Holy Cross	7.9	6.6	4.4	3.3	4.3	-46.0%
Montgomery General	8.9	7.3	8.1	7.8	6.7	-24.6%
Shady Grove Adventist	1.9	5.7	4.9	2.4	3.5	88.5%
Suburban Hospital Center	7.0	8.5	7.6	7.6	6.4	-7.8%
Laurel Regional Hospital	7.8	8.1	4.6	6.4	5.5	-29.8%
Prince Georges Hospital Ctr	9.7	7.1	8.1	9.7	7.8	-20.0%
Southern Maryland	6.5	8.0	6.1	7.5	7.5	15.3%
Fort Washington Hospital	2.0	3.0	-	3.7	3.0	50.0%
Doctors Community Hospital	4.3	2.3	2.0	1.3	2.5	-42.3%
Other Providers	20.8	13.1	14.8	18.1	17.6	-15.7%
Total	8.7	8.2	7.8	8.4	8.1	-6.2%

Psych ALOS within WAH TSA (Non - Medicare)

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	5.2	4.8	5.0	5.2	5.8	11.2%
Holy Cross	5.2	3.7	2.6	5.3	3.1	-39.9%
Montgomery General	5.2	5.0	4.5	4.3	4.3	-17.2%
Shady Grove Adventist	2.6	4.1	2.9	3.2	3.0	16.5%
Suburban Hospital Center	5.5	5.0	5.0	4.6	4.9	-10.4%
Laurel Regional Hospital	6.0	4.0	3.3	4.0	4.4	-26.0%
Prince Georges Hospital Ctr	5.5	5.5	5.7	5.3	5.2	-5.4%
Southern Maryland	4.9	4.9	4.3	5.0	4.5	-8.8%
Fort Washington Hospital	1.7	1.7	1.3	2.3	2.0	20.0%
Doctors Community Hospital	3.5	3.7	2.2	1.5	1.5	-57.1%
Other Providers	7.1	7.8	7.9	10.4	8.7	22.9%
Total	5.4	5.1	5.0	5.2	5.3	-1.5%

Market Share Based on Days in WAH TSA

Provider	2008	2009	2010	2011	2012	Variance
Washington Adventist	26.8%	25.9%	23.5%	21.8%	25.9%	-0.8%
Holy Cross	0.9%	0.6%	0.8%	1.1%	0.8%	-0.1%
Montgomery General	15.5%	13.9%	13.6%	12.0%	11.3%	-4.2%
Shady Grove Adventist	0.4%	0.4%	0.4%	0.2%	0.3%	0.0%
Suburban Hospital Center	13.6%	13.7%	15.7%	15.2%	15.3%	1.6%
Laurel Regional Hospital	6.4%	4.9%	3.6%	5.0%	5.3%	-1.1%
Prince Georges Hospital Ctr	14.9%	18.2%	20.7%	18.3%	18.0%	3.1%
Southern Maryland	12.6%	11.9%	10.8%	11.1%	9.0%	-3.6%
Fort Washington Hospital	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
Doctors Community Hospital	0.1%	0.1%	0.1%	0.0%	0.0%	-0.1%
Other Provider	8.7%	10.3%	10.9%	15.1%	13.9%	5.3%
	100.0%	100.0%	100.0%	100.0%	100.0%	N/A

To determine the overall estimated patient days, the overall CY2012 ALOS from patients originating from the Washington Adventist Hospital TSA was applied by patient grouping. Occupancy rates of 70% were assumed for both Medicare and non-Medicare patients to arrive at a total need of 149 beds.

Historically, 13.9% of days originating from patients in the Washington Adventist Hospital TSA went to other providers outside Montgomery County and Prince George's County. As a result, total bed need was adjusted to reflect only the beds needed to serve the patients who remain in those counties at the identified acute care hospitals. A total bed need of 128 for patients going to acute care facilities within Montgomery and Prince George's County was calculated:

	Total Bed Need for Discharges Originating in WAH TSA						
	CY2022 Discharges	Increase in Access	Adjusted CY2022 Discharges	ALOS	Days	Occupancy	Bed Need
Medicare	594	0.0%	594	8.1	4,827	70.0%	19
Non-Medicare	5,703	10.0%	6,273	5.3	33,234	70.0%	130
Total	**6,297**	N/A	**6,867**	**6.0**	**38,061**	**N/A**	**149**
CY2012 Market Share Leaving Montgomery & Prince George's County						13.9%	21
Beds Needed In Montgomery & Prince George's County Hospitals							128

The same methodology was used to calculate the licensed beds currently serving this selected population.

Provider	Psych Days From WAH TSA	Total Psych Days	% Psych Days from WAH TSA	FY2013 Licensed Psych Beds	Psych Beds Serving TSA
Washington Adventist	8,377	9,652	86.8%	40	35
Holy Cross	259	291	89.0%	-	-
Montgomery General	3,644	4,916	74.1%	25	19
Shady Grove Adventist	112	113	99.1%	-	-
Suburban Hospital Center	4,934	6,440	76.6%	24	18
Laurel Regional Hospital	1,718	3,308	51.9%	14	7
Prince Georges Hospital Ctr	5,824	7,310	79.7%	28	22
Southern Maryland	2,906	4,833	60.1%	25	15
Fort Washington Hospital	7	11	63.6%	-	-
Doctors Community Hospital	13	13	100.0%	-	-
Total	**27,794**	**36,887**	**N/A**	**156**	**116**

Further analysis shows that there is a net psychiatric bed need of 12 for the Washington Adventist Hospital TSA.

Net Bed Need for WAH - White Oak TSA	
	Bed Need
Beds Needed at Montgomery & Prince George's County Hospitals	128
Beds Available to Serve WAH TSA in M & PG County	(116)
Net Bed Need	12

In addition, the analysis focused on the bed need within the Washington Adventist Hospital TSA and therefore did not consider growth in admissions from those patients outside the service area. If the rest of Maryland was also expected to experience increases in its adult population, there would be further support for additional bed need.

OBSTETRIC BED NEED ANALYSIS FOR WASHINGTON ADVENTIST HOSPITAL

Washington Adventist Hospital is currently licensed for 252 beds, of which 21 are licensed for obstetric ("OB") services. The proposed Washington Adventist Hospital replacement facility will include 21 OB beds, indicating no addition of OB beds.

Washington Adventist Hospital plans to continue its participation in the Maternity Partnership Program in Montgomery County and will also continue to offer prenatal services in Takoma Park. This program provides prenatal care, routine laboratory tests, prenatal classes, and dental screening for pregnant women without insurance or with low income.

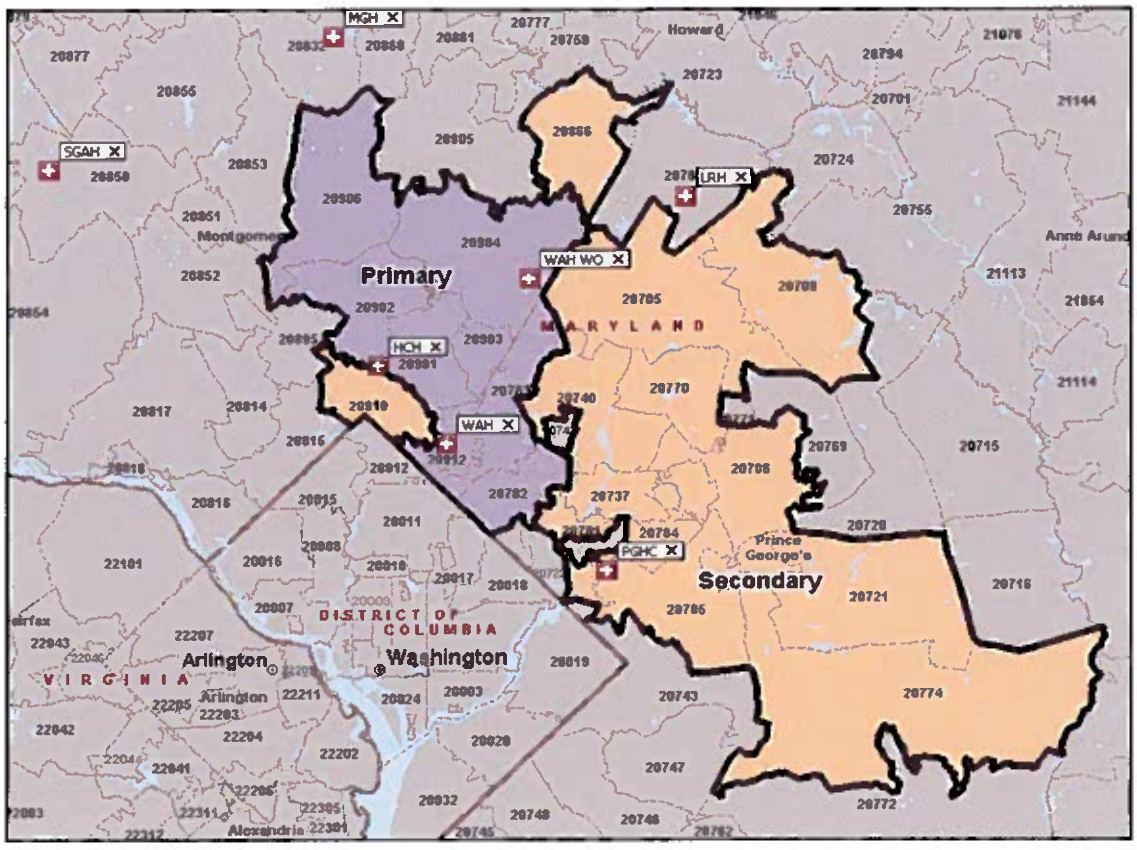
(1) Service Area

In CY2012, the Washington Adventist Hospital PSA for OB discharges consisted of 8 zip codes, 6 located in Montgomery County and 2 located in Prince George's County with the primary number of discharges coming from zip code 20783 (Hyattsville) and 20903 (Silver Spring). Washington Adventist Hospital observed 36.6% market share within 20783 and 36.5% of market share within its home zip code 20912. Washington Adventist Hospital's market share within its PSA for OB discharges is 15.5%.

The Washington Adventist Hospital TSA is comprised of 21 zip codes, 8 located in Montgomery County and 13 located in Prince George County, listed below.

Zip Code	City	Service Area	Washington Adventist Hospital	% of Total	Cumulative
20783	Hyattsville	Primary	214	12.1%	12.1%
20903	Silver Spring	Primary	184	10.4%	22.4%
20912	Takoma Park	Primary	140	7.9%	30.3%
20906	Silver Spring	Primary	131	7.4%	37.7%
20902	Silver Spring	Primary	119	6.7%	44.4%
20901	Silver Spring	Primary	114	6.4%	50.9%
20904	Silver Spring	Primary	91	5.1%	56.0%
20782	Hyattsville	Primary	86	4.9%	60.9%
20910	Silver Spring	Secondary	60	3.4%	64.2%
20706	Lanham	Secondary	57	3.2%	67.5%
20705	Beltsville	Secondary	52	2.9%	70.4%
20737	Riverdale	Secondary	45	2.5%	72.9%
20784	Hyattsville	Secondary	38	2.1%	75.1%
20770	Greenbelt	Secondary	37	2.1%	77.2%
20740	College Park	Secondary	29	1.6%	78.8%
20785	Hyattsville	Secondary	27	1.5%	80.3%
20781	Hyattsville	Secondary	20	1.1%	81.4%
20866	Burtonsville	Secondary	19	1.1%	82.5%
20708	Laurel	Secondary	17	1.0%	83.5%
20721	Bowie	Secondary	14	0.8%	84.3%
20774	Upper Marlboro	Secondary	13	0.7%	85.0%

CY2012 OB Washington Adventist Hospital TSA



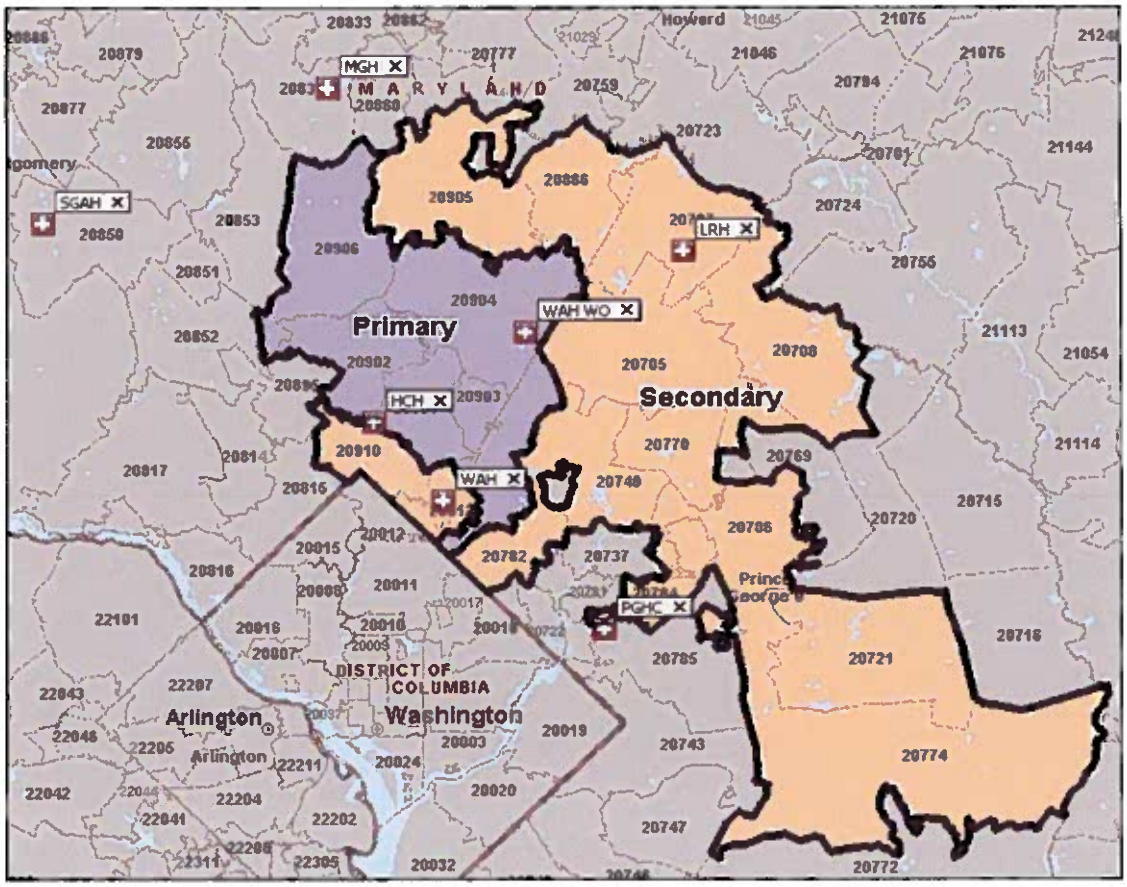
An analysis was performed to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak. Based on market dynamics that considers location of the new hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, and physician relationships, the following adjustments to the Washington Adventist Hospital OB TSA were considered:

Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	36.6%	0.0%	36.6%
20903	Silver Spring	36.5%	0.0%	36.5%
20912	Takoma Park	37.9%	-15.0%	22.9%
20906	Silver Spring	14.4%	5.0%	19.4%
20902	Silver Spring	14.0%	5.0%	19.0%
20901	Silver Spring	19.5%	5.0%	24.5%
20904	Silver Spring	11.9%	20.0%	31.9%
20782	Hyattsville	23.3%	-15.0%	8.3%
20910	Silver Spring	12.4%	-8.0%	4.4%
20706	Lanham	10.5%	0.0%	10.5%
20705	Beltsville	13.1%	5.0%	18.1%
20737	Riverdale	13.0%	-10.0%	3.0%
20784	Hyattsville	8.8%	-6.0%	2.8%
20770	Greenbelt	10.5%	0.0%	10.5%
20740	College Park	11.8%	0.0%	11.8%
20785	Hyattsville	5.2%	-3.0%	2.2%
20781	Hyattsville	12.3%	-10.0%	2.3%
20866	Burtonsville	10.5%	5.0%	15.5%
20708	Laurel	3.8%	2.0%	5.8%
20721	Bowie	5.5%	0.0%	5.5%
20774	Upper Marlboro	3.2%	0.0%	3.2%
20707	Laurel	2.4%	5.0%	7.4%
20905	Silver Spring	5.6%	5.0%	10.6%
Total Market Share		**14.8%**	**0.9%**	**15.7%**

As demonstrated above, individual adjustments to each zip code were considered, then discharges were calculated, considering the estimated market share by zip code in White Oak to determine total discharges at Washington Adventist Hospital/White Oak. Conclusion: moving to the White Oak location will increase overall market share approximately 0.9% in the identified Zip codes.

Primary and secondary service area for Washington Adventist Hospital/White Oak was redefined as follows:

CY2012 OB Washington Adventist Hospital TSA



Bed analysis was conducted based upon the redefined Washington Adventist Hospital/White Oak TSA.

(2) Estimated Discharges

Female population between the ages of 15 through 44 ("Female – Childbearing") within the Washington Adventist Hospital/White Oak TSA was estimated to be 299,551 in CY2010, 297,117 in CY2013, and 291,850 in CY2018. This implies an overall decrease in the population of approximately 0.8% between CY2010 and CY2013.

Demonstrated in the table below, OB discharges in the Washington Adventist Hospital/White Oak TSA decreased 3.4% between CY2010 and CY2012 and 2.1% over the past five years.

OB Discharges within WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	1,801	1,943	1,783	1,560	1,434	-20.4%
Holy Cross	4,852	4,756	4,765	4,750	4,816	-0.7%
Montgomery General	259	318	311	306	318	22.8%
Shady Grove Adventist	463	485	460	495	497	7.3%
Suburban Hospital Center	3	3	1	4	5	66.7%
Laurel Regional Hospital	422	472	594	555	581	37.7%
Prince Georges Hospital Ctr	932	874	900	756	759	-18.6%
Southern Maryland	59	46	66	52	62	5.1%
Doctors Community Hospital	30	30	41	24	17	-43.3%
Other Provider	658	617	679	736	789	19.9%
Total	9,479	9,544	9,600	9,238	9,278	-2.1%

Population estimates, sourced from Nielsen Claritas, for the Female – Childbearing population and newborns within the Washington Adventist Hospital TSA were examined. It was found that although the Female – Childbearing population is estimated to decline approximately 0.3% annually, newborns are expected to increase 0.4% annually.

OB Discharge Estimates within the WAH - White Oak TSA

Growth Estimate Based On:	2012 Discharges	2022 Estimated Discharges	Total Change	Annual Change
Female - Childbearing	9,278	8,959	-3.4%	-0.3%
Newborn Estimates	9,278	9,720	4.8%	0.4%

Source: HSCRC data base and Nielson Claritas population projections

Growth rates indicated by newborn projections were considered as a more appropriate measure of future OB volume.

(3) Estimated Bed Need

OB ALOS within the Washington Adventist Hospital TSA decreased 10.4% over the five year period and the ALOS of 2.6 was considered to calculate patient days in CY2022

OB ALOS within WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	5-Year Change
Washington Adventist	2.8	2.8	2.8	2.6	2.5	-11.8%
Holy Cross	3.0	2.9	2.9	2.7	2.6	-13.7%
Montgomery General	2.8	2.7	2.6	2.5	2.5	-12.2%
Shady Grove Adventist	2.8	3.2	3.4	3.3	2.8	-1.0%
Suburban Hospital Center	3.0	1.7	1.0	2.8	2.8	-6.7%
Laurel Regional Hospital	2.3	2.4	2.6	2.5	2.3	2.7%
Prince Georges Hospital Ctr	2.9	3.0	2.8	2.9	2.8	-1.8%
Southern Maryland	2.6	2.6	2.7	2.7	2.7	6.4%
Doctors Community Hospital	2.1	1.6	2.0	2.1	1.8	-13.2%
Other Provider	3.3	3.3	2.9	2.8	3.0	-9.5%
Total	2.9	2.9	2.8	2.7	2.6	-10.4%

Market Share Based on Days Within WAH - White Oak TSA

Provider	2008	2009	2010	2011	2012	Variance
Washington Adventist	18.3%	19.9%	18.2%	16.2%	14.7%	-3.6%
Holy Cross	52.4%	49.8%	50.2%	50.9%	51.1%	-1.2%
Montgomery General	2.7%	3.2%	2.9%	3.1%	3.3%	0.6%
Shady Grove Adventist	4.8%	5.7%	5.6%	6.5%	5.8%	1.0%
Suburban Hospital Center	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%
Laurel Regional Hospital	3.5%	4.1%	5.6%	5.6%	5.6%	2.1%
Prince Georges Hospital Ctr	9.7%	9.4%	9.2%	8.7%	8.9%	-0.9%
Southern Maryland	0.6%	0.4%	0.6%	0.6%	0.7%	0.2%
Doctors Community Hospital	0.2%	0.2%	0.3%	0.2%	0.1%	-0.1%
Other Provider	7.9%	7.3%	7.3%	8.3%	9.8%	1.9%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	N/A

An occupancy rate of 65% was assumed to arrive at a total need of 107 beds. Recognizing that historically, 9.8% of days associated with patients originating in the Washington Adventist Hospital/White Oak TSA went to other providers outside Montgomery and Prince George's counties total bed need was adjusted to reflect only the beds needed to serve the patients who remain in those counties at the identified acute care hospitals. A total bed need of 96 was calculated for patients going to hospitals within Montgomery and Prince George's counties. See calculations below:

	Total Bed Need for Discharges Originating in WAH - White Oak TSA				
	CY2022 Admissions	ALOS	Days	Occupancy	Bed Need
Population Estimates	9,720	2.6	25,362	65.0%	107
CY2012 Market Share Leaving Montgomery & Prince George's County				9.8%	10
Beds Needed in Montgomery & Prince George's County Hospitals					96

The same methodology was considered to calculate the licensed beds currently serving this selected population.

Provider	OB Days From WAH - White Oak TSA	Total OB Days	% OB Days from WAH - White Oak TSA	FY2013 Licensed OB Beds	OB Beds Serving WAH - White Oak TSA
Washington Adventist	3,558	4,437	80.2%	21	17
Holy Cross	12,379	23,404	52.9%	88	47
Montgomery General	792	1,902	41.6%	11	5
Shady Grove Adventist	1,396	14,074	9.9%	56	6
Suburban Hospital Center	14	43	32.6%	-	-
Laurel Regional Hospital	1,361	2,428	56.1%	10	6
Prince Georges Hospital Ctr	2,147	6,495	33.1%	36	12
Southern Maryland	170	5,983	2.8%	30	1
Doctors Community Hospital	31	69	44.9%	-	-
Total	**21,848**	**58,835**	**37.1%**	**252**	**92**

Further analysis shows that there is a net OB bed need of 4 for the Washington Adventist Hospital/White Oak TSA.

CY2022 Net Bed Need for WAH - White Oak TSA	
	Bed Need
Beds Needed at Montgomery & Prince George's County Hospitals	96
Beds Available to Serve WAH - White Oak TSA in M & PG County	(92)
Net Bed Need	4

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1. Admissions										
a. M/S/G/A	9,108	8,268	7,100	6,397	6,132	5,876	5,750	5,627	6,084	6,630
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	1,902	1,712	1,609	1,617	1,625	1,634	1,642	1,650	1,716	1,802
d. Intensive Care	1,539	1,426	1,464	1,319	1,264	1,212	1,186	1,160	1,254	1,367
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	1,779	1,706	1,791	1,850	1,911	1,974	2,039	2,106	2,176	2,187
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	14,328	13,112	11,964	11,184	10,933	10,696	10,617	10,543	11,230	11,986
2. Patient Days										
a. M/S/G/A	45,038	44,929	40,163	35,825	35,044	34,281	33,532	32,802	35,438	38,627
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	4,786	4,165	3,915	3,935	3,954	3,974	3,994	4,014	4,175	4,383
d. Intensive Care	7,807	7,218	6,727	6,061	5,810	5,568	5,448	5,331	5,764	6,282
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	9,114	9,954	10,452	10,796	11,152	11,519	11,898	12,289	12,697	12,761
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	66,745	66,266	61,257	56,617	55,959	55,342	54,873	54,436	58,074	62,053

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
3. Average Length of Stay										
a. M/S/G/A	4.9	5.4	5.7	5.6	5.7	5.8	5.8	5.8	5.8	5.8
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	2.5	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4	2.4
d. Intensive Care	5.1	5.1	4.6	4.6	4.6	4.6	4.6	4.6	4.6	4.6
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	5.1	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8	5.8
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	4.7	5.1	5.1	5.1	5.1	5.2	5.2	5.2	5.2	5.2
4. Occupancy										
a. M\S/G/A	66.3%	69.5%	70.1%	62.5%	61.2%	59.8%	58.5%	57.2%	66.5%	72.5%
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	62.4%	54.3%	51.1%	51.3%	51.6%	51.8%	52.1%	52.4%	54.5%	57.2%
d. Intensive Care	62.9%	58.2%	54.2%	48.8%	46.8%	44.9%	43.9%	43.0%	46.4%	50.6%
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	62.4%	68.2%	71.6%	73.9%	76.4%	78.9%	81.5%	84.2%	87.0%	87.4%
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	65.1%	66.7%	66.6%	61.6%	60.8%	60.2%	59.7%	59.2%	66.0%	70.5%
5. Number of Licensed Beds										
a. M\S/G/A	186	177	157	157	157	157	157	157	146	146
b. Pediatric	-	-	-	-	-	-	-	-	-	-
c. Obstetric	21	21	21	21	21	21	21	21	21	21
d. Intensive Care	34	34	34	34	34	34	34	34	34	34
e. Coronary Care	-	-	-	-	-	-	-	-	-	-
f. Psychiatric	40	40	40	40	40	40	40	40	40	40
g. Rehabilitation	-	-	-	-	-	-	-	-	-	-
h. Chronic	-	-	-	-	-	-	-	-	-	-
i. Other (Specify)	-	-	-	-	-	-	-	-	-	-
j. TOTAL	281	272	252	252	252	252	252	252	241	241

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
6. Outpatient Visits										
a. Emergency	38,189	40,906	44,253	44,253	44,253	44,253	44,253	44,253	46,023	48,785
b. Outpatient Department	16,341	16,048	16,289	16,475	16,664	16,855	17,049	17,243	22,382	28,599
c. Other (OP Surgery & Interventional Radiology)	4,156	4,199	4,367	4,411	4,455	4,499	4,544	4,590	4,773	5,060
d. Other (Observation Visits)	1,226	1,300	2,278	2,942	3,082	3,214	3,193	3,174	3,524	3,829
e. TOTAL	59,912	62,453	67,187	68,081	68,454	68,821	69,039	69,260	76,702	86,273

Note 1: ICU and CCU admissions are combined in Intensive care category
Note 2: LOS for ICU only includes time spent in those beds. It does not include the time spent in step down beds as this time is included in the MSGA days.
Note 3: Increase in MSGA LOS is due to movement of short stay inpatient cases to OP Observation

* Number of beds and occupancy percentage should be reported on the basis of licensed beds.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT

Not Applicable.

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.

For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project which will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics that the Commission should take into account.

APPLICANT RESPONSE:

As referenced in the response to the Cost Effectiveness standard, Adventist HealthCare considered multiple options for the future of Washington Adventist Hospital including a re-development on the existing Takoma Park campus. An effort to try and fully achieve the 19 objectives identified by the Adventist Health Care Board of Trustees (Exhibit 19) would be an immense challenge given the characteristics of the campus, the aging infrastructure, the lack of an "empty chair" during construction, and other issues. Fully re-developing the site consistent with what is achieved with the proposed White Oak facility would take 12-15 years of intense construction and demolition, would be disruptive to the residential community and would be cost prohibitive.

Instead, the organization evaluated a reasonable alternative to the White Oak project, not attempting to duplicate exactly what White Oak achieves, but a project that meets some of the 19 objectives identified by the Board.

The "on-campus alternative" to the development of a new hospital in White Oak involves a significant reinvestment in the existing hospital with a multi-phased program of demolition and construction at the campus. The resulting hospital at Takoma Park would have the equivalent number of beds to the existing hospital (252) and the project would take six and one half years to complete beginning with site preparation and demolition.

The on-campus alternative would modernize the existing hospital by demolishing buildings that are approaching the end of their useful life and provide new and renovated facilities that meet modern operational standards such as floor to ceiling heights and ADA requirements.

Program

After a careful review of the existing hospital conditions, Washington Adventist Hospital and its design team arrived at the conclusion that if the facility were to remain at Takoma Park, the entire site inventory would need to be replaced. As a result, Washington Adventist Hospital engaged the design team to produce a total Campus Master Plan, that would form the basis for any future site redevelopment. This Campus Master Plan (Exhibit 55) is a comprehensive blueprint to replace the current hospital with a new, modern, code-compliant hospital on the existing campus, albeit without correcting limitations on the campus that would have to remain.

The reason the Takoma Park site requires complete replacement of its spaces is described in the attached Campus Master Plan (Exhibit 55) in the description of "Critical Planning Issues" on page 2 of the document and is summarized below:

- Available site building area does not support retaining existing low-rise buildings

  Current site restricted areas, including stream buffer setback and legacy community related development restrictions, limits site future development potential. To provide available site building area for medical office and structured parking facilities, future site development will require higher-density building footprints.

- Limited building floor to floor heights

  10'-9" and 11'-0" floor to floor heights do not support high-acuity services, limiting future repositioning for contemporary acute care healthcare services.

- Aging facilities limit asset value of existing facilities

  The 1950s era building is over 60 years old with substantial deferred maintenance and building upgrade issues, providing diminished asset value going forward.

  The 1970s era building is approaching 50 years old with substantial deferred maintenance and building upgrade issues, providing diminished asset value going forward.

Given these constraints, the long-term vision for the hospital to remain at Takoma Park must start with the thesis that the campus must be completely re-developed. As noted previously, the Campus Master Plan, if implemented fully, would be a multi-phase effort over 12 to 15 years. This is the comprehensive planning design for the site to produce a hospital comparable to the proposed hospital at White Oak. This, however, would not be a realistic option. Instead, Washington Adventist Hospital considered an on-campus alternative that uses the comprehensive campus redevelopment master plan as a guide but seeks to achieve a reasonable alternative that while less than what is accomplished in White Oak still accomplishes some objectives and is possible. Therefore, the alternative described here defines an on-campus alternative that implements the first Phases of the Campus Master Plan. (Exhibit 56).

Washington Adventist Hospital selected this stage in the Campus Master Plan because Phase 2 provided sufficient additional program to improve the existing campus while still maintaining a reasonable project cost and schedule.

The Campus Master Plan reveals the new site layout and organization. In general, the existing parking lot directly south of the hospital will be the site in Phase 1 to build new space, upon which

the existing facilities will begin to be replaced. Phase 1 of the Master Plan (a single tower addition) provides some additional capacity, but this step is primarily used to replace programs in the oldest portion of the hospital, the 1950s building, so that it can be replaced in Step 2.

Completion of Phase 1 of this project would provide the following programs/departments:

- A new cardiac care unit
- New maternity unit, including postpartum, labor and delivery and diagnostics
- New laboratory, pharmacy, and respiratory areas.
- New heart center
- New medical same day unit
- New central utility plant
- New lobby

Completion of Phase 2 would provide the following programs/departments:

- New 36-bed medical surgical unit
- New 32 bed medical surgical unit
- New surgical suite
- New gastrointestinal endoscopy suite
- New emergency department
- New admitting and radiology areas
- New cafeteria

Upon the completion of Phase 2 construction, Washington Adventist Hospital will relocate the existing physician offices in the MOB at the north end of the site into the body of the hospital and construct a 600-car parking structure on the location of the existing MOB.

Cost

The total capital budget for the phased Takoma Park hospital renovations is $339.7 million dollars including interest and inflation. Total new construction costs are $155.6 million with the balance of costs allocated to renovations (primarily building demolition) $3.7 million; furniture, equipment and other capital costs $88.3 million; interest of $45.1 million and an inflation allowance to the mid-point of construction $15.4 million.

Washington Adventist Hospital - Option B

Phased Replacement at Takoma Park - Master Plan Phases 1, 2 & Garage

CAPITAL BUDGET

		Hospital	Garage	Total
1.	Capital Costs			
	a. New Construction			
(1)	Building & Fixed Equipment	$118,100,000	$ 20,500,000	$138,600,000
(2)	Fixed Equipment (Not Included in Construction)	2,900,000	-	2,900,000
(3)	Land Purchase	-	-	-
(4)	Site Preparation - Land Improvements	1,000,000	-	1,000,000
(5)	Architect/Engineering Fees	11,000,000	1,400,000	12,400,000
(6)	Permits, (Building, Utilities, Etc.)	600,000	100,000	700,000
	SUBTOTAL	$133,600,000	$ 22,000,000	$155,600,000

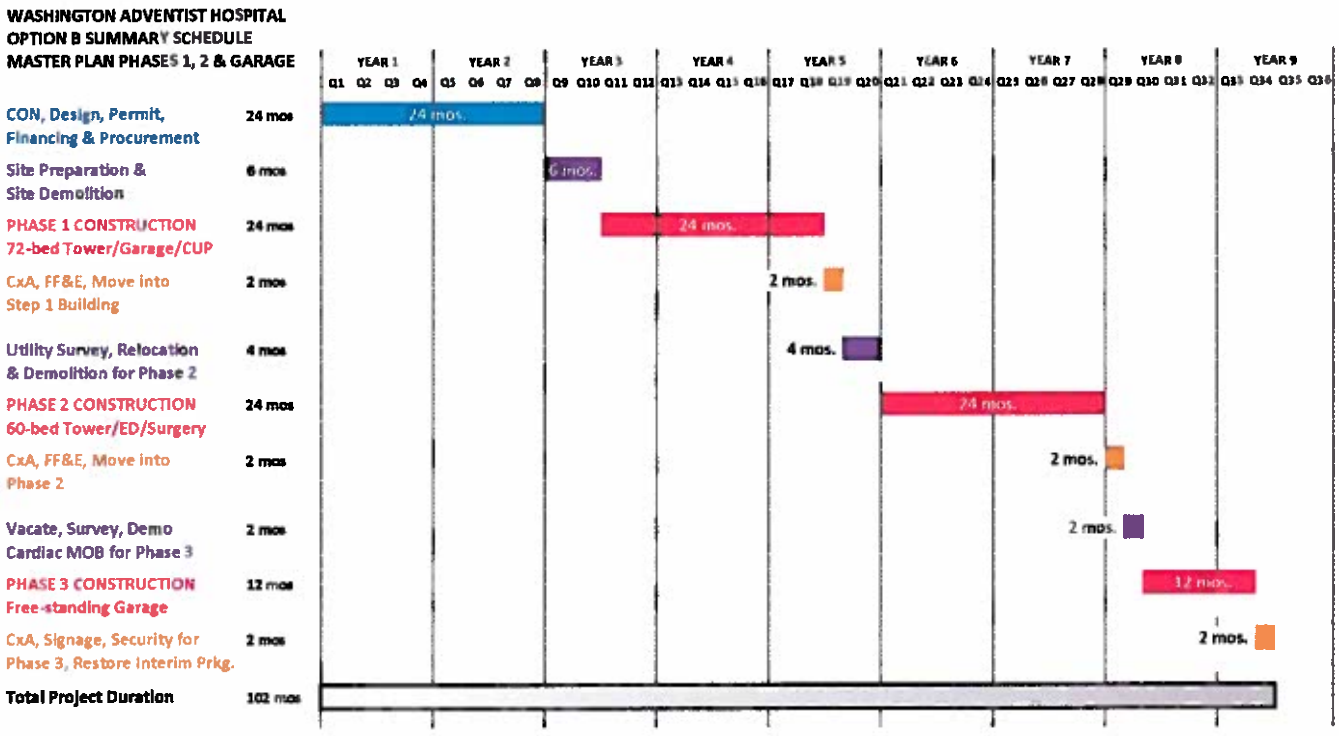
b.	Renovations			
(1)	Building demolition	$ 3,300,000	$ -	3,300,000
(2)	Renovations	-	-	-
(3)	Fixed Equipment (Not Included in Construction)	-	-	-
(4)	Architect/Engineering Fees	400,000	-	400,000
(5)	Permits, (Building, Utilities, Etc.)	-	-	-
	SUBTOTAL	$ 3,700,000	$ -	$ 3,700,000
c.	Other Capital Costs			
(1)	Major Movable Equipment	18,300,000	-	18,300,000
(2)	Minor Movable Equipment	8,800,000	-	8,800,000
(3)	Contingencies	12,000,000	1,200,000	13,200,000
(4)	Other (Specify)		-	-
	a. Furniture	10,900,000	-	10,900,000
	b. Interior & Exterior Signage	1,500,000	200,000	1,700,000
	c. IS/Comm	14,600,000	-	14,600,000
	d. Security system	2,100,000	200,000	2,300,000
	e. Relocation expense	2,900,000	-	2,900,000
	f. Certifications, inspections, etc.	1,200,000	100,000	1,300,000
	g. Takoma Park Capital Facility Upgrades	14,300,000	-	14,300,000
	TOTAL CURRENT CAPITAL COSTS (a - c)	$223,900,000	$ 23,700,000	$247,600,000
d.	Non Current Capital Cost			
(1)	Interest (Gross)	41,059,350	4,346,170	45,405,520
(2)	Inflation Allowance (2.0% per year to midpoint of each construction phase)	13,100,000	2,300,000	15,400,000
	TOTAL PROPOSED CAPITAL COSTS (a-d)	$278,059,350	$ 30,346,170	$308,405,520
2.	Financing Cost and Other Cash Requirements:			
a.	Loan Placement Fees	4,570,327	483,773	5,054,100
b.	Bond Discount			-
c.	Legal Fees (CON Related)	226,070	23,930	250,000
d.	Legal Fees (Other) (zoning)	226,070	23,930	250,000
e.	Printing			-
f.	Consultant Fees	452,140	47,860	500,000
	CON Application Assistance			-
	Other (Specify)			-
g.	Liquidation of Existing Debt			-
h.	Debt Service Reserve Fund	22,851,636	2,418,864	25,270,500
i.	Principal Amortization			-
	Reserve Fund			-
j.	Other (Specify)			-

TOTAL (a - j)	$ 28,326,243	$ 2,998,357	$ 31,324,600
3. Working Capital Startup Costs			
TOTAL USES OF FUNDS (1 - 3)	**$306,385,592**	**$ 33,344,528**	**$339,730,120**

Schedule

To achieve the intent of the on-campus alternative while operating a fully functional hospital, the modernization of the hospital is divided into two separate phases of construction and corresponding phases of demolition. The total construction duration of the multi-phased project is 6.5 years which is similar in duration to the proposed White Oak project.

The first phase of the project is the development of a new bed tower, garage and central plant on an existing parking lot to the south of the existing hospital. Phase 1 of construction will take 24 months. With the completion of the first phase of construction, existing services from the oldest portion of the existing hospital will be moved to the new tower and the vacated portion of the hospital will be demolished to make way for Phase 2 of construction. The transition period will last 6 months including survey, relocation and demolition to prepare for Phase 2.



Phase 2 will immediately follow the demolition of the existing building and will have an expected duration of 24 months. During Phase 2 an additional 60-unit bed tower, Emergency Department and Surgical Unit will be constructed. Upon completion of Phase 2, hospital services will be activated over a period of 4 months including survey, relocation and demolition of the existing cardiac MOB to prepare for construction of the new above-grade parking structure. The final activity of Phase 2 is the construction of a 600-space above-grade parking structure

on the former MOB site. The parking development will have duration of 12 months and a transition period of 2 months.

Considerations

While there are some attractive features to this on-campus alternative, it ultimately falls short of the White Oak proposal in many respects. First and foremost, this alternative does not, address the inherent challenges in accessing a small campus that is surrounded by narrow residential streets with limited public transportation options. Furthermore, Phase 1 does not substantially improve any of the long-term problems on the Takoma Park campus, including, access and circulation on the campus, the age of building stock, and it does not move the hospital to all private rooms.

In addition:

- Surgical services would be split into two different areas due to the location of the current operating rooms. This is functional but not efficient.

- There would be two central plants. The new central plant is needed for the new construction and would be sized to accommodate all future campus growth in the Campus Master Plan. The existing, outdated central plant must remain in place until the existing buildings are replaced.

- Transfer elevators would be required to move people and material from existing building levels because many of the existing buildings would remain. These are not desirable but necessary in this scheme.

- Construction and demolition will be disruptive to patients and staff. It is difficult to overstate the effect of a construction project like this on a site like Takoma Park. Noise, vibration, dust, construction vehicles, and service interruptions would all make this project challenging. It is likely that this project would adversely affect patient and staff satisfaction and inpatient visits and staff retention. It is likely many people would simply avoid the hospital for the period of the construction. The attached exhibit summarizes the risks and impacts inherent in an on-site hospital replacement of this magnitude. (See Exhibit 57).

The attached table further reviews the two options, the on-campus alternative against the proposed project. (See Exhibit 58). In each case, the proposed White Oak hospital is the superior option.

Projected income statements and Adventist Healthcare, Inc. financial ratios for each of the options evaluated can be found at Exhibit 22. While meeting the current bond covenants required for the Adventist HealthCare Obligated Group, Option B, the Washington Adventist Hospital on campus alternative, loses money and would require an ongoing subsidy, placing a tremendous strain on the resources on Adventist HealthCare. (Likewise, Option C, another alternative considered, meets the current bond covenants required for the Obligated Group but loses money, would require an ongoing subsidy and would strain the resources of Adventist HealthCare).

Conclusion

This alternative falls significantly short of meeting a "majority" of the objectives set forth by the Adventist HealthCare Board. Although the project delivers an effective modernization of most patient care spaces, it does not modernize the entire facility and significant portions of older structures remain. (See Exhibit 58). In addition, the project is implemented in the midst of current

operations presenting a series of major disruptions that endure over a significantly prolonged period of time. This in turn, presents a host of unfavorable impacts and challenges to financial viability and to the quality of care delivered during the prolonged construction and renovation periods.

The on-campus alternative is inferior to the proposal to relocate to White Oak. Although this on-campus alternative is considered Washington Adventist Hospital's best alternative to the proposed relocation, the challenge of on-campus modernization along with the disruption to operations and uncertainty of project financing render this option less cost effective than the relocation proposal.

In addition to inferior cost effectiveness, there are the effects on the neighborhood from the disruption caused by the extensive demolition, construction traffic and rebuilding. The on-campus alternative does not solve the problems of inferior access to the campus and the availability of parking. Additionally, the land use approval process in Montgomery County is complex and lengthy, requiring a special exception for this campus with an uncertain outcome. This contrasts with the White Oak campus where land use approvals have already been secured.

Further, the on-campus alternative to the proposed relocation to White Oak is inferior in terms of broader accessibility to the populations that will be served by the relocation plan. The White Oak site is more central to the service area populations, and combined with the services to remain on campus, is far superior in terms of overall accessibility. Finally, the White Oak site is located within the area defined by Montgomery County in its Master Planning Process as the White Oak Science Gateway. The five-member Montgomery County Planning Board unanimously approved a land-use blueprint on September 19, 2013 to send the White Oak Science Gateway Master Plan to the County Council and County Executive Isiah Leggett for review. The relocated Washington Adventist Hospital is an important element in the plan and references the synergy with the FDA and the planned Life Sciences Village, both on adjacent or nearby properties. This area is planned and designated as an important hub for medical and biotech development.

10.24.01.08G(3)(d). Viability of the Proposal.

For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. **Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.**

b. **Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.**

c. **A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.**

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

APPLICANT RESPONSE:

Audited financial statements for calendar years 2011 and 2012 can be found in Exhibit 59.

Description of Project Sources:

Adventist Healthcare, Inc. intends to pursue traditional tax-exempt bond financing for this project on behalf of Washington Adventist Hospital. The financing for the proposed project in the anticipated aggregate principal amount of $278.0 million will be secured pursuant to the Amended and Restated Master Trust Indenture dated as of February 1, 2003, as supplemented and amended (the "Master Indenture") among Adventist Healthcare Inc., Adventist Rehabilitation Hospital of Maryland, Inc. ("Adventist Rehab") and Hackettstown Regional Medical Center (collectively, the "Obligated Group") and Manufacturers and Traders Trust Company (formerly Allfirst Bank), as master trustee (the "Master Trustee"). The ratios of the Obligated Group including the proposed project, presented in the table below, indicate that the Obligated Group will continue to meet the bond covenants, listed below, as required by the Master Indenture and by certain agreements between one or more members of the Obligated Group and financial institutions providing credit support (the" Bank Agreements"). Based on the proposed structure, Adventist HealthCare, Inc. does not anticipate that any bondholder consents would be required.

Debt service coverage: Not less than 1.25
Days cash on hand: Not less than 70 days
Total Liabilities to Unrestricted Net Assets: Not greater than 2.5

Adventist HealthCare Obligated Group with Option D – Key Financial Indicators (dollars in thousands)

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Operating Income	$ 26,408	$ 12,658	$ 12,552	$ 17,891	$ 22,658	$ 21,339	$ 21,147	$ 21,131	$ 3,074	$ 10,638
Excess of Revenue Over Expenses	$ 22,729	$ 15,527	$ 14,161	$ 22,241	$ 27,315	$ 26,256	$ 26,326	$ 26,605	$ 8,943	$ 16,993
Cash	$ 193,842	$ 200,140	$ 187,309	$ 194,034	$ 225,035	$ 241,231	$ 258,850	$ 278,080	$ 299,102	$ 326,338
Long Term Debt	$ 323,061	$ 308,239	$ 291,255	$ 271,603	$ 510,857	$ 487,750	$ 467,810	$ 449,223	$ 451,047	$ 442,206
Net Assets	$ 352,608	$ 372,968	$ 382,710	$ 404,954	$ 432,944	$ 461,309	$ 504,440	$ 593,290	$ 602,641	$ 619,727
Maximum Annual Debt Service	$ 28,069	$ 32,142	$ 31,678	$ 31,678	$ 43,170	$ 36,894	$ 35,882	$ 35,837	$ 36,597	$ 33,137
Debt Service Coverage	2.69	1.96	1.99	2.31	1.86	2.19	2.28	2.30	2.52	3.06
Days Cash on Hand	**100.36**	**103.84**	**98.90**	**101.61**	**116.51**	**122.65**	**129.16**	**135.87**	**138.04**	**145.01**
Debt to Capitalization	47.8%	45.2%	43.2%	40.1%	54.1%	51.4%	48.1%	43.1%	42.8%	41.6%
Total Liabilities to Unrestricted Net Assets	1.40	1.27	1.20	1.12	1.62	1.48	1.32	1.09	1.08	1.04

Note: These ratios do not assume the impending sale of Hackettstown Regional Medical Center. It is currently anticipated that a signed agreement for such sale may be executed prior to the close of the calendar year. There is no assurance that such an agreement will be executed and if so, when or what the exact terms will be. It is currently anticipated that if this transaction were to close it would likely result in significant improvement to the Obligated Group's days cash on hand.

In addition to the amount financed by tax-exempt debt for the Washington Adventist Hospital project, Adventist Healthcare Inc. will contribute $91.5 million in equity. This is comprised of $11.0 million in land, $20 million in fundraising proceeds, and $60.5 million in cash. Equity contributions will begin in 2017 after the project funds from the tax-exempt financing are depleted.

Adventist Healthcare, has conducted successful campaigns, raising over $30 million system wide over the last 10 years. The projects include the following:

Project	Amount Raised
-"Building Greater Care Together" (Tower Expansion Campaign)	$15.25M (Exceeding target goal of $12M)
-Barbara Truland Butz Healing Garden	$1.5M (Exceeding target goal of $1.25M)
-Jerome & Edna Goldberg Cardiac, Vascular and Interventional Radiology (CVIR) Suite	$5.2M (Initial target goal of $5.0M)
-Aquilino Cancer Center & Life Beyond Cancer Programs	$6.0M (Target goal of $10M) *Currently in Progress

As of October, 2013 the Washington Adventist Hospital Foundation, Next Century Health Capital Campaign in support of the relocation of Washington Adventist Hospital has raised just over $1.9M toward a total goal of $20M. The capital campaign provides the opportunity for donors to make a philanthropic commitment in support of a new state-of-the-art acute care facility for Washington Adventist Hospital. The campaign messaging is focused on inviting donors to participate in ensuring Washington Adventist Hospital's ability to continue our legacy of compassionate excellence in healthcare and our leadership in service of a healthy community today and for the next 100 years. Concurrent with the submission of the CON the hospital foundation will engage a professional fundraising firm to conduct a feasibility study. This study will allow us to gather the most up-to-date information on our donors' and potential donors' propensity to give to the campaign. In turn, this information will be used to assess and inform our goal and to fine-tune our strategy to raise $20M.

Non-Financial Resources:

In addition to the financial resources discussed above, Washington Adventist Hospital has documented support from the medical community (Exhibit 60), state and local government (Exhibit 61), and the community in (Exhibit 62).

Washington Adventist Hospital did not assume a rate increase in the financial projections in this application. However, the Hospital does reserve the right to request future rate increases based on the HSCRC rate setting system methodology and criteria. Due to the capital investment and financing related to the project, capital costs at the Hospital will increase. Project related depreciation, amortization, and interest expenses are identified in TABLE 3.

The Hospital does not anticipate an impact on costs and charges for hospital services at other hospitals located in the area as a result of this project.

Current average patient charges for the top 10 APR-DRGs, Outpatient procedures, Diagnostic Imaging tests and laboratory tests can be found on the Hospital's website at: http://www.washingtonadventisthospital.com/WAH/patientsvisitors/patients/billing/ as well in Exhibit 63 in both English and Spanish.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility (including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.) Table 4, "Revenues and Expenses - Proposed Project," is to be completed by each applicant for the proposed project only, using the same instructions outlined above for Table 3.

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
1. Revenue										
a. Inpatient Services	*$196,858*	*$178,355*	*$162,345*	*$157,340*	*$155,896*	*$153,146*	*$150,322*	*$147,842*	*$156,626*	*$165,322*
b. Outpatient Services	70,377	81,403	95,518	103,698	105,336	106,917	107,225	107,418	117,690	129,652
c. Gross Patient Services Revenues	267,235	259,758	257,863	261,038	261,232	260,063	257,547	255,260	274,316	294,974
d. Allowance for Bad Debt	18,627	26,076	28,365	28,714	28,736	28,607	28,330	28,079	30,175	$ 32,447
e. Contractual Allowance	19,383	24,427	19,876	18,331	16,853	16,778	16,616	16,468	17,697	19,030
f. Charity Care	9,191	4,672	5,802	5,873	5,878	5,851	5,795	5,743	6,172	6,637
g. Net Patient Services Revenue	220,034	204,583	203,821	208,119	209,766	208,827	206,807	204,970	220,272	236,860
h. Other Operating Revenues (Specify)	4,966	5,696	4,922	5,361	4,806	4,117	4,317	4,817	7,245	7,365
i. Net Operating Revenue	$225,000	$210,279	$208,743	$213,480	$214,571	$212,944	$211,124	$209,787	$227,516	$244,225
2. Expenses										
a. Salaries, Wages, and Professional Fees (including fringe benefits)	$103,090	$101,808	$101,488	$ 98,223	$ 97,696	$ 97,408	$ 97,341	$ 97,232	$ 102,562	$ 108,759
b. Contractual Services	24,817	25,895	27,381	26,224	26,007	25,797	25,594	25,395	25,993	26,915
c. Interest on Current Debt	2,732	2,474	2,466	2,198	2,024	1,842	1,706	1,563	1,374	1,194
d. Interest on Project Debt			-	-	-	-	-	-	15,782	16,675
e. Current Depreciation	6,646	6,713	6,047	6,365	6,681	6,999	7,314	7,626	8,124	8,480
f. Project Depreciation			-	-	-	-	-	-	11,477	11,467

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)						
CY or FY (Circle)	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
g. Current Amortization	218	265	242	242	242	242	242	242	242	242
h. Project Amortization	-	-	-	-	-	175	175	175	175	185
I. Supplies	42,586	39,987	36,860	36,423	35,678	35,593	35,613	35,608	38,476	41,881
j. Other Expenses (Specify)	42,424	39,521	42,586	43,308	41,053	39,272	37,495	37,127	38,774	38,416
k. Total Operating Expenses	$222,513	$216,662	$ 217,068	$212,982	$ 209,381	$207,326	$ 205,480	$204,967	$ 242,979	$ 254,214
3. Income										
a. Income from Operation	$2,487	$(6,383)	$ (8,326)	$ 498	$ 5,191	$ 5,618	$ 5,644	$ 4,820	$(15,462)	$ (9,989)
b. Non-Operating Income	(428)	(1,012)	(1,138)	-	-	-	-	-	-	-
c. Subtotal	2,059	(7,396)	(9,464)	498	5,191	5,618	5,644	4,820	(15,462)	(9,989)
d. Income Taxes	-	-	-	-	-	-	-	-	-	-
e. Net Income (Loss)	$ 2,059	$ (7,396)	$ (9,464)	$ 498	$ 5,191	$ 5,618	$ 5,644	$ 4,820	$(15,462)	$ (9,989)
4. Patient Mix: **A. Percent of Total Revenue**										
1. Medicare	41.3%	42.5%	43.3%	44.1%	45.0%	45.8%	46.6%	47.4%	48.3%	49.1%
2. Medicaid	18.7%	19.3%	19.1%	18.8%	18.5%	18.2%	18.0%	17.7%	17.4%	17.1%
3. Blue Cross	13.2%	12.3%	12.1%	11.9%	11.7%	11.6%	11.4%	11.2%	11.0%	10.8%
4. Commercial Insurance	15.1%	14.6%	14.4%	14.2%	14.0%	13.8%	13.6%	13.4%	13.2%	13.0%
5. Self-Pay	10.9%	10.0%	9.9%	9.7%	9.6%	9.4%	9.3%	9.2%	9.0%	8.9%
6. Other (Specify)	0.8%	1.3%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.1%	1.1%
7. TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)										
1. Medicare	38.8%	41.2%	42.3%	43.1%	44.0%	44.8%	45.6%	46.4%	47.3%	48.1%
2. Medicaid	25.4%	25.1%	22.4%	22.1%	21.8%	21.4%	21.1%	20.8%	20.5%	20.2%
3. Blue Cross	7.0%	6.6%	6.6%	6.5%	6.4%	6.3%	6.2%	6.1%	6.0%	5.9%
4. Commercial Insurance	12.8%	11.4%	13.0%	12.8%	12.6%	12.4%	12.2%	12.1%	11.9%	11.7%
5. Self-Pay	15.9%	15.5%	15.4%	15.2%	15.0%	14.8%	14.6%	14.3%	14.1%	13.9%
6. Other (Specify)	0.1%	0.1%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%	0.2%
7. TOTAL	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Note: Payor mix and patient day percentages take into account the growth in the Medicare population due to the aging population. Assumes an annual increase in Medicare beneficiaries of 3.93% versus 0.52% growth in other beneficiaries.

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

Not Applicable.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need.

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.

List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1990, and their status.

APPLICANT RESPONSE:

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.

Adventist HealthCare, Inc. has complied with all conditions applicable to all previously issued Certificates of Need.

10.24.01.08G(3)(f). Impact on Existing Providers.

For evaluation under this subsection, an applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.

Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special

attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

APPLICANT RESPONSE:

Washington Adventist Hospital's relocation plans, which include building a new facility in White Oak while retaining the campus in Takoma Park for health care services, will have a positive impact on the health care system. Patients benefit from private rooms, more efficient clinical space, improved access to outpatient services, additional public transportation options and improved parking, among other enhancements. The services that will remain on the Takoma Park campus – the hospital's acute behavioral health services, an FQHC, physician offices, the maternity clinic for low income patients, ancillary services, various outpatient clinics, plus the Adventist Rehabilitation Hospital of Maryland/Takoma Park services – provide continued health care to patients in the immediate area. The hospital's proposal positively impacts the health care delivery system also through alignment with the new realities of health care including downsizing inpatient bed capacity, increasing access to outpatient services, and building the infrastructure for population based care.

There are several main points to highlight with respect to Washington Adventist Hospital's initiative and the impact to other providers.

First, data from the HSCRC and Nielsen Claritas population projections show significant aging of the population will occur in the hospital's proposed White Oak Total Service Area (WOTSA) over a 10 year period from 2012 – 2022. While the 15-44 age cohort will decline in the TSA for that period, the 65-74 age cohort will grow 71.5% (5.5% annually). Seniors use inpatient health care services at a much higher rate and even when accounting for health care reform and an increased emphasis on alternatives to hospital services, inpatient discharges will grow from 69,054 in 2012 to 86,110 in 2022 within the WOTSA.

The second major point regarding this standard is that all individual hospitals that treat patients living in zip codes within the WOTSA will experience some growth in discharges during the 10-year period from 2012 to 2022. No hospital will experience a decline in discharges from the WOTSA, even when accounting for the development of a new hospital facility in White Oak. The impact of Washington Adventist Hospital's new facility is from the growth in cases, not on baseline volume.

Third, the impact to other providers caused by Washington Adventist Hospital's relocation is not substantial and in some cases other hospitals will see an increase in discharges related to Washington Adventist's relocation. As the MSGA discharge table on page 103 of this application shows, Holy Cross Hospital had 12,890 discharges from the proposed WOTSA in 2012. If Washington Adventist Hospital was located in White Oak in CY 2012, the impact to Holy Cross would have been 1,120 cases, a market share impact of less than 2%, and the hospital will have 15,019 discharges in 2022. Likewise, Medstar Montgomery Medical Center had 4,091 discharges from the WOTSA in CY 2012. The impact of Washington Adventist's relocation is 121 cases, a market share impact of less than 1% and discharges will be 5,066 in 2022. Prince George's Hospital Center would see an increase in discharges attributable to the relocation of Washington Adventist Hospital, a market share increase of .38% from the WOTSA.

Market share in individual zip codes with the primary service area will change (see table below), however the overall net effect is that all hospitals treating patients from within the WOTSA will see an increase in discharges from 2012 through 2022, even when accounting for the relocation of Washington Adventist Hospital.

Analysis

Washington Adventist Hospital is currently licensed for 252 beds, of which 191 are MSGA beds. The proposed replacement hospital for Washington Adventist Hospital will have 180 MSGA beds.

Washington Adventist Hospital is currently located on the southern part of their PSA. Relocation to White Oak, located in zip code 20904 (Silver Spring) will allow for a more central location within its existing PSA. We performed an analysis to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak recognizing that even a short move of approximately six miles will have an impact on the current TSA. Based on market dynamics that considers location of the new hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, and physician relationships, we considered the following adjustments to the Washington Adventist Hospital MSGA TSA:

Washington Adventist Hospital MSGA TSA Market Share Analysis of Proposed Location

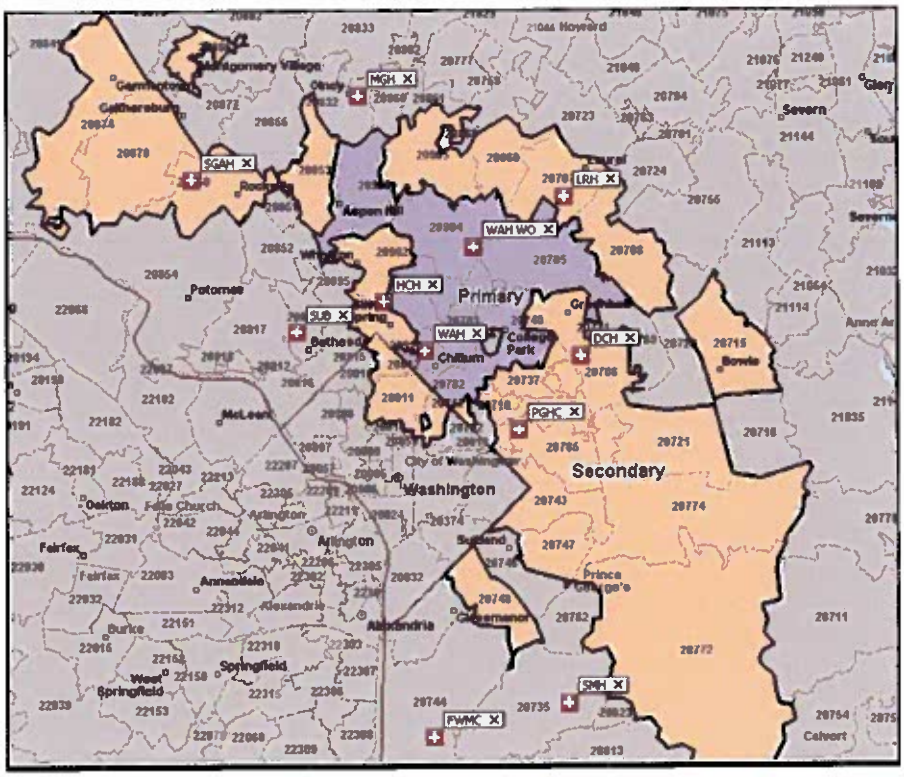
Zip Code	City	Current Market Share at Takoma Park	Estimated Market Share Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	62.0%	-15.0%	47.0%
20912	Takoma Park	62.7%	-15.0%	47.7%
20782	Hyattsville	59.6%	-15.0%	44.6%
20903	Silver Spring	41.7%	0.0%	41.7%
20904	Silver Spring	11.3%	45.0%	56.3%
20901	Silver Spring	21.8%	5.0%	26.8%
20910	Silver Spring	17.8%	-15.0%	2.8%
20740	College Park	29.1%	-1.0%	28.1%
20011	Washington	33.4%	-15.0%	18.4%
20737	Riverdale	19.8%	-15.0%	4.8%
20705	Beltsville	16.1%	10.0%	26.1%
20712	Mount Rainier	54.6%	-20.0%	34.6%
20906	Silver Spring	3.2%	5.0%	8.2%
20781	Hyattsville	28.5%	-15.0%	13.5%
20706	Lanham	5.9%	-1.0%	4.9%
20770	Greenbelt	10.7%	5.0%	15.7%
20902	Silver Spring	5.3%	0.0%	5.3%
20785	Hyattsville	5.3%	-1.0%	4.3%
20784	Hyattsville	7.4%	-1.0%	6.4%
20012	Washington	34.9%	-15.0%	19.9%
20707	Laurel	5.2%	10.0%	15.2%
20774	Upper Marlboro	4.2%	-1.0%	3.2%
20722	Brentwood	26.8%	-20.0%	6.8%
20743	Capitol Heights	2.9%	-1.0%	1.9%
20708	Laurel	5.4%	1.0%	6.4%
20002	Washington	16.6%	-15.0%	1.6%
20710	Bladensburg	11.5%	-1.0%	10.5%
20905	Silver Spring	6.3%	15.0%	21.3%
20017	Washington	32.3%	-15.0%	17.3%
20019	Washington	6.6%	-5.0%	1.6%
20020	Washington	9.7%	-8.0%	1.7%
20748	Temple Hills	2.7%	0.0%	2.7%
20772	Upper Marlboro	2.5%	0.0%	2.5%
20747	District Heights	2.4%	0.0%	2.4%

Zip Code	City	Current Market Share at Takoma Park	Estimated Market Share Adjustment	Estimated Market Share in Proposed Location
20715	Bowie	2.8%	0.0%	2.8%
20850	Rockville	1.7%	0.0%	1.7%
20866	Burtonsville	7.2%	15.0%	22.2%
20853	Rockville	2.6%	0.0%	2.6%
20874	Germantown	1.6%	0.0%	1.6%
20878	Gaithersburg	1.7%	0.0%	1.7%
20018	Washington	16.9%	-15.0%	1.9%
20721	Bowie	3.0%	0.0%	3.0%
20001	Washington	17.6%	-15.0%	2.6%
20886	Montgomery Village	2.0%	0.0%	2.0%
20735	Clinton	1.1%	0.0%	1.1%

As demonstrated above, we first considered individual adjustments to each zip code. We then calculated total discharges at Washington Adventist Hospital/White Oak, considering the estimated market share by zip code. Finally, we redefined the primary and secondary service area for Washington Adventist Hospital/White Oak based on the estimate total discharges. We determined that moving to the location will tighten the current service area as four zip codes will shift from the primary service area to the secondary service area and six will drop out of the total service area.

Considering the same market dynamics identified above, we estimated, by zip code, the market share reduction or increase other providers in Montgomery & Prince George's counties would experience from the relocation of Washington Adventist Hospital to White Oak. The results of our analysis are summarized below.

Washington Adventist Hospital - White Oak MSGA Primary and Secondary Service Area (based on move to White Oak)



Based on the estimates for the bed need analysis a total of 86,110 discharges in CY 2022 was estimated for the Washington Adventist Hospital/White Oak TSA, which indicates absolute growth of approximately 24.7% over the 10 year period, or an increase of 17,056 incremental discharges. The table below represents the estimated discharges by age cohort for the Washington Adventist Hospital/White Oak TSA in CY2022 based on the analysis detailed in the response to bed need.

Admission Estimates by Age Cohort Originating in Washington Adventist Hospital – White Oak's TSA

Ages	2012	2022	Total Growth	Annual Growth
15 - 44	13,702	13,224	-3.5%	-0.4%
45 - 64	23,336	25,826	10.7%	1.0%
65 - 74	12,287	21,073	71.5%	5.5%
75+	19,729	25,987	31.7%	2.8%
Total	**69,054**	**86,110**	**24.7%**	**2.2%**

Source: HSCRC data base and Nielson Claritas population projections

Changes in market share by zip code and the fact that the TSA changes with a move of approximately six miles will result in some redistribution of cases among hospitals serving the TSA.

The analysis shows that between now and CY2022 there is more than enough MSGA growth to offset any lost volume. The estimate of the impact is based upon the volumes that area hospitals would gain or lose to Washington Adventist Hospital if the replacement hospital were to open in White Oak today. The analysis shows that if the replacement hospital were open today, Washington Adventist Hospital White Oak would gain MSGA cases from other area hospitals such as Holy Cross Hospital, Medstar Montgomery Medical Center, Suburban Hospital and Laurel Regional Hospital. Other area providers such as Prince George's Hospital and Doctors Community Hospital would also gain cases from the move.

Based upon the analysis, if Washington Adventist Hospital were to open a replacement hospital in White Oak today, there would be a total 1,002 cases within the redefined Washington Adventist Hospital/White Oak TSA that would move to the hospital with the majority of those cases coming from Holy Cross Hospital. See table below.

Providers	CY2012 (1)		Location Adjustment (2)		Adjusted CY2012 (3)		Incremental Growth (4)		CY2022 Discharges (5)	
	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
Holy Cross	12,890	18.67%	(1,120)	-1.62%	11,770	17.04%	3,249	19.05%	15,019	17.44%
Montgomery General	4,091	5.92%	(121)	-0.18%	3,970	5.75%	1,096	6.43%	5,066	5.88%
Shady Grove Adventist	7,547	10.93%	0	0.00%	7,547	10.93%	2,083	12.22%	9,630	11.18%
Suburban Hospital Center	3,771	5.46%	(5)	-0.01%	3,766	5.45%	1,040	6.10%	4,806	5.58%
Laurel Regional Hospital	2,498	3.62%	(102)	-0.15%	2,397	3.47%	662	3.88%	3,058	3.55%
Prince Georges Hospital Ctr	5,238	7.59%	259	0.38%	5,497	7.96%	1,518	8.90%	7,015	8.15%
Southern Maryland	6,417	9.29%	0	0.00%	6,417	9.29%	1,771	10.39%	8,188	9.51%
Fort Washington Hospital	398	0.58%	0	0.00%	398	0.58%	110	0.64%	508	0.59%
Doctors Community Hospital	8,736	12.65%	244	0.35%	8,980	13.00%	2,479	14.53%	11,459	13.31%
Other Providers	9,520	13.79%	(157)	-0.23%	9,363	13.56%	2,585	15.15%	11,948	13.88%
Washington Adventist	**7,948**	**11.51%**	**1,002**	**1.45%**	**8,950**	**12.96%**	**464**	**2.72%**	**9,414**	**10.93%**
Total	69,054	100.00%	-	0.00%	69,054	100.00%	17,056	100.00%	86,110	100.00%

Notes:
(1) Actual CY2012 discharges and market share within the WAH - White Oak TSA
(2) Adjustment to market share assuming a relocation to White Oak
(3) Adjusted CY2012 market share, applied to the incremental growth calculated in the bed need section of the CON.
(4) Incremental growth by provider indicates slight increases over Adjusted CY2012 market share for all providers due to actual projected discharges for WAH.
(5) CY2022 discharges = adjusted CY2012 discharges + calculated incremental growth.

The location adjustment represents what would happen today if Washington Adventist Hospital would relocate to White Oak. The incremental growth takes into account the estimated additional cases that will come from population growth over the next 10 years. This growth will more than offset any lost cases resulting from the move. For example, in CY2012, Holy Cross Hospital market share is estimated to decrease approximately 1.23% although it will observe an increase of approximately 2,129 more MSGA cases due to volume growth. Washington Adventist Hospital is estimated to lose market share of approximately 0.58% as a result of losing approximately 19.8% MSGA discharges from CY2012 to CY2018 until the new hospital opens. When the new hospital would open in late CY2018, Washington Adventist Hospital will expect to maintain its market share going forward. The table above shows that every hospital will experience increased MSGA cases with only slight changes in overall market share from where they are today.

In addition, an analysis of the current payor mix in the Takoma Park TSA and the newly defined White Oak TSA indicates that the overall payor mix is not significantly different between the two service areas.

Payor Summary for Both Service Areas

	Takoma Park TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	1,818	21.9%	22,270	30.4%
Medicaid	1,148	13.8%	9,044	12.3%
Medicare	4,164	50.1%	34,790	47.5%
Self-Pay	1,140	13.7%	5,654	7.7%
Other	36	0.4%	1,279	1.7%
Total	8,306	100.0%	73,313	100.0%

	White Oak TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	1,758	22.1%	21,506	30.5%
Medicaid	1,102	13.9%	8,409	11.9%
Medicare	3,936	49.5%	33,638	47.6%
Self-Pay	1,124	14.1%	5,525	7.8%
Other	36	0.5%	1,259	1.8%
Total	7,956	100.0%	70,613	100.0%

Impact to Other Area Hospitals – Obstetrics

Washington Adventist Hospital is currently licensed for 252 beds, of which 21 are licensed for obstetric ("OB") services. The proposed replacement hospital for Washington Adventist Hospital will include 21 OB beds, indicating no addition of OB beds.

An analysis was performed to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak. Based on market dynamics that considers location of the new hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, and physician relationships, the following adjustments to the Washington Adventist Hospital OB TSA were considered:

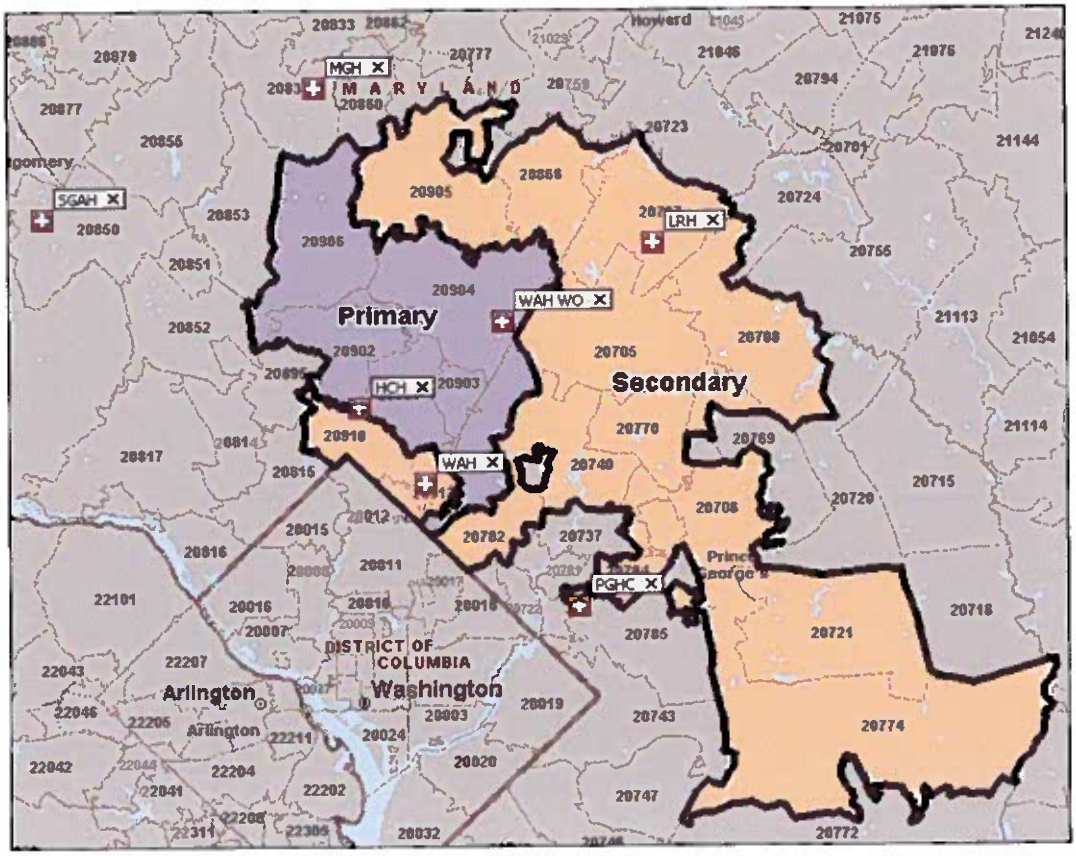
Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	36.6%	0.0%	36.6%
20903	Silver Spring	36.5%	0.0%	36.5%
20912	Takoma Park	37.9%	-15.0%	22.9%
20906	Silver Spring	14.4%	5.0%	19.4%
20902	Silver Spring	14.0%	5.0%	19.0%
20901	Silver Spring	19.5%	5.0%	24.5%
20904	Silver Spring	11.9%	20.0%	31.9%
20782	Hyattsville	23.3%	-15.0%	8.3%
20910	Silver Spring	12.4%	-8.0%	4.4%
20706	Lanham	10.5%	0.0%	10.5%
20705	Beltsville	13.1%	5.0%	18.1%
20737	Riverdale	13.0%	-10.0%	3.0%
20784	Hyattsville	8.8%	-6.0%	2.8%
20770	Greenbelt	10.5%	0.0%	10.5%
20740	College Park	11.8%	0.0%	11.8%
20785	Hyattsville	5.2%	-3.0%	2.2%
20781	Hyattsville	12.3%	-10.0%	2.3%
20866	Burtonsville	10.5%	5.0%	15.5%
20708	Laurel	3.8%	2.0%	5.8%
20721	Bowie	5.5%	0.0%	5.5%
20774	Upper Marlboro	3.2%	0.0%	3.2%
20707	Laurel	2.4%	5.0%	7.4%
20905	Silver Spring	5.6%	5.0%	10.6%

As demonstrated above, individual adjustments to each Zip code were first considered. Discharges were then calculated, considering the estimated market share by Zip code in White Oak to determine total discharges at Washington Adventist Hospital/White Oak.

Finally, primary and secondary service area was redefined for Washington Adventist Hospital/White Oak.

Considering the same market dynamics identified above, we estimated, by zip code, the market share reduction or increase other providers in Montgomery & Prince George's County would experience from the relocation of Washington Adventist Hospital to White Oak today. The results of our analysis are summarized below.

CY2012 OB Washington Adventist Hospital TSA



Population estimates, sourced from Nielsen Claritas, for the Female – Childbearing population and newborns within the Washington Adventist Hospital TSA were estimated with the finding that although the Female – Childbearing population is estimated to decline approximately 0.3% annually, newborns are expected to increase 0.4% annually.

OB Discharge Estimates within the WAH - White Oak TSA

Growth Estimate Based On:	2012 Discharges	2022 Estimated Discharges	Total Change	Annual Change
Female - Childbearing	9,278	8,959	-3.4%	-0.3%
Newborn Estimates	9,278	9,720	4.8%	0.4%

Source: HSCRC data base and Nielson Claritas population projections

Growth rates are indicated by newborn projections, which measure future OB volume more appropriately.

Again, changes in market share by zip code and the fact that the TSA changes with a move of approximately six miles will result in some redistribution of cases among hospitals serving the TSA. The analysis shows that between now and CY2022 there is OB growth that will offset most, if not all, lost volume. The estimate of the impact is based on the volumes that area hospitals would gain or lose to Washington Adventist Hospital if the replacement hospital were to open today. The

analysis shows that if the new replacement hospital were open today, Washington Adventist Hospital White Oak would gain OB cases from other area hospitals such as Holy Cross, Medstar Montgomery Medical Center, Shady Grove Adventist Hospital and Laurel Regional Hospital. Prince George's Hospital would gain cases from the move.

Based on the analysis if Washington Adventist Hospital was to open its new replacement hospital in White Oak today there would be a total 163 OB cases that would move to Washington Adventist Hospital. See table below.

Providers	CY2012 (1)		Location Adjustment (2)		Adjusted CY2012 (3)		Incremental Growth (4)		CY2022 Discharges (5)	
	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share	Discharges	Market Share
Holy Cross	4,816	51.91%	(151)	-1.63%	4,665	50.28%	203	46.03%	4,868	50.09%
Montgomery General	318	3.43%	(26)	-0.28%	292	3.15%	13	2.88%	305	3.14%
Shady Grove Adventist	497	5.36%	(31)	-0.34%	466	5.02%	20	4.60%	486	5.00%
Suburban Hospital Center	5	0.05%	0	0.00%	5	0.05%	0	0.05%	5	0.05%
Laurel Regional Hospital	581	6.26%	(4)	-0.04%	577	6.22%	25	5.69%	602	6.20%
Prince Georges Hospital Ctr	759	8.18%	51	0.55%	810	8.73%	35	7.99%	845	8.70%
Southern Maryland	62	0.67%	0	0.00%	62	0.67%	3	0.61%	65	0.67%
Doctors Community Hospital	17	0.18%	0	0.00%	17	0.18%	1	0.17%	18	0.18%
Other Providers	789	8.50%	(2)	-0.02%	787	8.49%	34	7.77%	822	8.45%
Washington Adventist	1,434	**15.46%**	**163**	**1.76%**	**1,597**	**17.21%**	**107**	**24.20%**	**1,704**	**17.53%**
Total	9,278	100.00%	-	0.00%	9,278	100.00%	442	100.00%	9,720	100.00%

Notes:
(1) Actual CY2012 discharges and market share within the WAH - White Oak TSA
(2) Adjustment to market share assuming a relocation to White Oak
(3) Adjusted CY2012 market share, applied to the incremental growth calculated in the bed need section of the CON.
(4) Incremental growth by provider indicates slight increases over Adjusted CY2012 market share for all providers due to actual projected discharges for WAH.
(5) CY2022 discharges = adjusted CY2012 discharges + calculated incremental growth.

The location adjustment represents what would happen today if Washington Adventist Hospital would relocate to White Oak and the incremental growth takes into account the estimated additional cases that will come from population growth over the next 10 years. Volume growth in total will offset the total lost cases resulting from the move. For example, in CY2012, it is estimated that Holy Cross market share will decrease approximately 1.82% although it will observe an increase of approximately 52 OB cases due to volume growth. It should be noted that Holy Cross is scheduled to open a new hospital in Germantown in 2014. This new hospital is in a growing area and further offsets any impact to its Silver Spring campus.

In the case of Medstar Montgomery General Hospital, by CY2022 estimates indicate a loss of approximately 13 OB cases in the Washington Adventist Hospital/White Oak TSA compared to CY2012 levels with a market share decrease of approximately 0.29%. While a loss of cases is identified within the Washington Adventist Hospital/White Oak service area, only 42.1% of total discharges going to Medstar Montgomery Medical Center originate in the Washington Adventist Hospital/White Oak TSA. Therefore, it is expected that Medstar Montgomery Medical Center will gain more than 13 OB cases from zip codes within its service area that are not included in the Washington Adventist Hospital/White Oak TSA. Washington Adventist Hospital is estimated to increase its market share by approximately 2.07%. The table above shows that every hospital will experience limited effects on its OB cases with only slight changes in overall market share from where they are today.

In addition, an analysis of the current payor mix in the Takoma Park TSA and the newly defined White Oak TSA which indicates the overall payor mix is not significantly different between the two service areas.

Payor Mix Summary

	Takoma Park TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	238	15.8%	4,048	41.7%
Medicaid	1,209	80.2%	5,305	54.7%
Medicare	6	0.4%	39	0.4%
Self-Pay	54	3.6%	251	2.6%
Other	-	0.0%	56	0.6%
Total	1,507	100.0%	9,699	100.0%

	White Oak TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	229	16.0%	4,131	44.5%
Medicaid	1,150	80.2%	4,811	51.9%
Medicare	3	0.2%	29	0.3%
Self-Pay	52	3.6%	250	2.7%
Other	-	0.0%	57	0.6%
Total	1,434	100.0%	9,278	100.0%

Washington Adventist Hospital has attempted to quantify the gross revenue impacts to surrounding hospitals. In this analysis, the Hospital attempts to quantify the net change in gross MSGA and OB revenues (at 2013 charge levels) by 2022 due to the relocation of Washington Adventist Hospital and projected population growth. A detailed step by step analysis can be found in Exhibit 64. In summary, the analysis shows that while there is an impact to other hospitals due to market share shifts, there is no unwarranted impact and further the impact is more than fully offset by the projected population growth in the White Oak TSA market.

Recruitment and Retention

1. an assessment of the sources available for recruiting additional personnel;

APPLICANT RESPONSE:

To recruit additional personnel, the Human Resources Department utilizes the expertise of a recruitment media and advertising agency to guide a national recruitment strategy. The department advertises employment opportunities through a wide variety of electronic and print resources including digital media, job postings, banners, email blasts, search engines and job aggregators to target a widespread audience. Candidates for all areas -- nursing, allied health and non-clinical care positions -- are recruited through various web sites such as WashingtonPost.com, AdvanceWeb.com. DCJobs.com, Indeed.com, LinkUp.com, Nurse.com and ZipRecruiter.com. In addition, DCJobs.com automatically delivers hospital job postings to the appropriate state workforce agencies through cross-posting or email.

Washington Adventist Hospital is an Equal Employment Opportunity employer.

2. **recruitment and retention plans for those personnel believed to be in short supply;**

APPLICANT RESPONSE:

Washington Adventist Hospital has developed a number of initiatives under its "People Strategy to Maintain Competitive Advantage" toward recruitment and retention of those personnel believed to be in short supply. From the very start, the hospital applies an enhanced recruiting and onboarding strategy toward its candidate selection screening process.

Learning opportunities and career ladders available to help employees maintain and enhance their skill level include:

- Enhanced courses through a learning management system that delivers convenient e-learning education courses
- Emphasized training, certifications and performance enhancement strategies
- Development of career ladders
- Identification of key talent for succession planning

The hospital has implemented an enhanced leadership development strategy to:

- Train managers on providing meaningful performance feedback and coaching to direct reports
- Increase leadership presence throughout the hospital
- Incorporate regular employee engagement surveys and follow-up action plans in response to feedback

The hospital also continuously monitors regional career changes in the health care arena to ensure that its employees continue to receive a competitive employment compensation package. These efforts include:

- Developing a "total rewards" approach that encompasses pay, benefits, learning and development, in addition to a wide variety of employee health and wellness programs.
- Tracking competitor sign-on and retention bonuses to adopt if needed
- Continuously examining market pay and behavior to quickly respond with market adjustments and other retention initiatives

3. **for existing facilities, a report on average vacancy rate and turnover rates for affected positions,**

APPLICANT RESPONSE:

The Vacancy rate for Washington Adventist Hospital presently is 6%. The overall turnover rate at Washington Adventist Hospital is 20.6%

Complete Table 5

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

TABLE 5. MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration	54.6	0.0	$116,838	Employee	$ -
Direct Care Staff	864.3	54.0	$71,179	Employee	$3,843,665
Support Staff	234.3	-15.0	$40,693	Employee	$(610,402)
				Benefits	$ 678,985
Total staffing changes required by this project			39.0	TOTAL	$3,912,248

(INSTRUCTION: Indicate method of calculating benefits percentage):_
Benefits are calculated using a historical 21% of salary expenses

PART IV - APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. **List names and addresses of all owners and individuals responsible for the proposed project and its implementation.**

APPLICANT RESPONSE:

William G. "Bill" Robertson
President & Chief Executive Officer
Adventist Healthcare, Inc.
820 W. Diamond Avenue, 6th Floor
Gaithersburg, MD 20878

2. Are the applicant, owners, or the responsible persons listed above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

APPLICANT RESPONSE:

Yes, current involvement comprises:

Shady Grove Adventist Hospital
9901 Medical Center Drive
Rockville, MD 20850
Years: 2000-Present

Shady Grove Adventist Emergency Center at Germantown
19731 Germantown Road
Germantown, MD 20874
Years: 2000-Present

Adventist Behavioral Health
14901 Broschart Road
Rockville, MD 20850
Years: 2000-Present

Adventist Rehabilitation Hospital of Maryland
9909 Medical Center Drive
Rockville, MD 20850
Years: 2001-Present

Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912
Years: 2000-Present

Hackettstown Regional Medical Center
651 Willow Grove Street
Hackettstown, NJ 07840
Years: 2000-Present

Reginald S. Lourie Center for Infants and Young Children
12301 Academy Way
Rockville, MD 20852
Years: 2006-Present

Capital Choice Pathology
12041 Bournefield Drive
Silver Spring, MD 20904
Years: 2000-Present

Previous involvement:

Adventist Senior Living Services, Inc.
Rockville, MD 20850
Years: 2000- 2010

Bradford Oaks Nursing and Rehabilitation Center
Clinton, MD
Years: 2000-2010

Glade Valley Nursing and Rehabilitation Center
Walkersville, MD
Years: 2000-2010

Sligo Creek Nursing and Rehabilitation Center
Takoma Park, MD
Years: 2000-2010

Shady Grove Nursing and Rehabilitation Center
Rockville, MD
Years: 2000-2010

Fairland Nursing and Rehabilitation Center
Silver Spring, MD
Years: 2000-2010

Kingshire Manor Assisted Living
Rockville, MD
Years: 2000-2010

Springbrook Nursing and Rehabilitation Center
Silver Spring, MD
Years: 2000-2010

Shawnee Mission Medical Center
Shawnee Mission, KS
Years: 1996-2000

St. Luke's Shawnee Mission Health System
Shawnee Mission, KS
Years: 1997-2000

Adventist Health Systems
Southwest Cluster
Years: 1988-1996

Rollins Brook Community Hospital
Lampasas, TX
Years: 1992-1996

Willow Creek Psychiatric Hospital
Arlington, TX
Years: 1992-1996

St. Luke's South
Overland Park, KS
Years: 1999-2000

Huguley Health System
Fort Worth, TX
Years: 1988-1996

Metroplex Hospital
Killeen, TX
Years: 1988-1996

Central Texas Medical Center
San Marcos, TX
Years: 1988-1996

East Pasco Medical Center
Zephyrhills, FL
Years: 1986-1988

3. **Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to number 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.**

APPLICANT RESPONSE:

No

4. **Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2? If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable governmental authority.**

APPLICANT RESPONSE:

No

5. **Have the applicant, owners or responsible individuals listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).**

APPLICANT RESPONSE:

No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization
shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information and belief.

10-3-2013
Date

Signature of Owner or Board-designated Official

AFFIRMATION

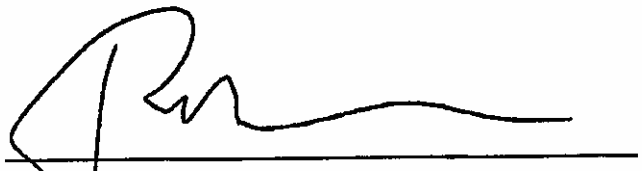
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Linda Berman
Grants Manager
Adventist Healthcare

10/1/13
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



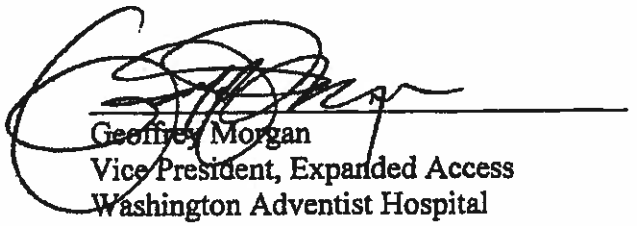
10/1/13

Robert Jepson
Vice President of Business Development
Adventist Healthcare

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

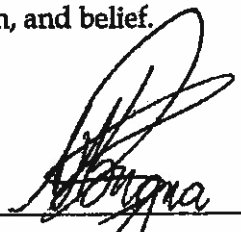


Geoffrey Morgan
Vice President, Expanded Access
Washington Adventist Hospital

10/21/13
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



10/2/2013

Peter Mbugua
Manager, Planning & Market Analysis
Adventist Healthcare

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

10/2/13

Kristen Pulio
Associate Vice President Reimbursement
Adventist Healthcare

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Maureen Dymond
Vice President, Financial Operations
Adventist HealthCare

10/2/13
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Joyce Newmyer — October 2, 2013

Joyce Newmyer
President
Washington Adventist Hospital

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Pippa Laundy

Pippa Laundy
Deloitte Financial Advisory Services LLP

10/2/2013

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

R. Lee Piekarz
Deloitte Financial Advisory Services

10/2/13
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Scott Martin, Heery

OCT. 3, 2013

Date

AFFIRMATION

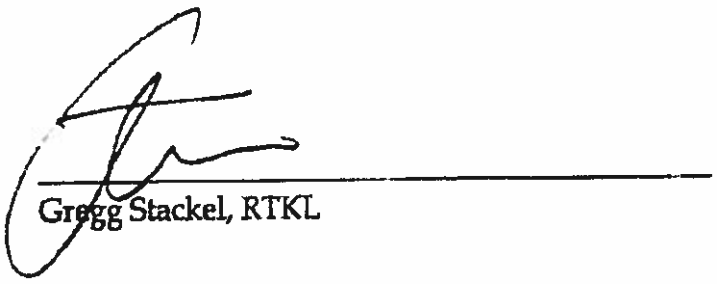
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Ray Brower, RTKL

10/2/2013
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



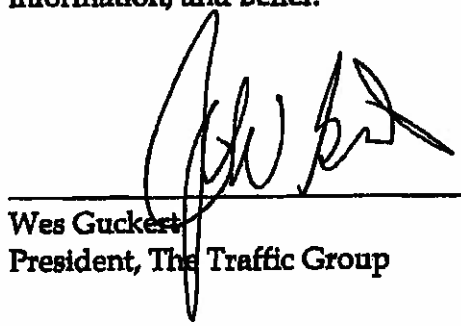
Gregg Stackel, RTKL

10/2/2013

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.



Wes Guckert
President, The Traffic Group

10/3/2013
Date