Craig P. Tanio, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR

MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

October 23, 2013

VIA Email & U.S. MAIL

Robert Jepson, Vice President
Business Development
Adventist HealthCare, Inc.
820 West Diamond Ave.
Gaithersburg, MD 20878

Re: Adventist Healthcare, Inc. d/b/a Washington Adventist Hospital
Replacement of Washington Adventist Hospital and Reconfiguration of the former Washington Adventist Hospital Campus in Takoma Park or
Establishment of a New General Acute Care Hospital and Reconfiguration of the Existing Washington Adventist Hospital
Matter No. 13-15-2349

Dear Mr. Jepson:

Staff of the Maryland Health Care Commission ("MHCC") has reviewed the Certificate of Need application filed on October 4, 2013. We have the following questions and requests for additional information concerning this application. Please respond to this request, following the rules at COMAR 10.24.01.07. The application will be docketed if the response is complete.

PROJECT DEFINITION

1. The project is described in this application as the replacement of a general hospital. However, it also appears that the application proposes to operate two general hospital campuses in Montgomery County approximately five to six miles apart recognized as a single licensed general hospital by the Department of Health and Mental Hygiene and the Health Services Cost Review Commission. This gives rise to the following questions:

   A. How can the operation of two general hospital campuses as proposed be consistent with hospital licensure regulations at COMAR 10.07.01.06, that state, "Separate licenses are required for institutions on separate premises, even though both institutions are operated under the same management?"

B. How can a hospital campus containing only a special rehabilitation hospital and a free-standing mental health facility be licensed as a general hospital, given the hospital licensure regulations at COMAR 10.07.01.02 that define a "General Hospital" as a hospital that "at least has the facilities and provides the services that are necessary for the general medical and surgical care of patients?"

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. Item 9 requests the current physical capacity in Column 1. The response reports the number of licensed beds. While staff appreciates the comparison between the current number of licensed and the proposed capacity, please report the existing physical capacity as requested. Specify the location and current use of all physical bed capacity as was done in the 2009 CON application for a similar project. Complete the attached bed inventory spreadsheet.

2. The response to Item 11 indicates that the project will be constructed in three phases. Will all phases be constructed under one construction contract or will each phase have its own contract?

3. Regarding the White Oak campus, please specify the outpatient and clinic services that will be provided.

4. Regarding the description of a maternity clinic for low-income women on the Takoma Park campus, will this clinic serve only low-income women? Please describe the services proposed to be provided and the patient population to be served at this clinic.

5. Please cite the source and provide documentation of the statement made on page 8: "Recent hospital constructions considered 'efficient' are typically [between] 2,000 [to] 2,200 [gross square feet per] patient room."

6. Please prepare a table that compares the space, number of diagnostic and treatment rooms, and equipment capacity currently available on the Takoma Park campus and the proposed White Oak facility for the following departments/service lines:

    a. Cancer Treatment (both medical and radiation oncology)
    b. Diagnostic imaging
    c. Cardiac Catheterization and other Angiography
    d. Dialysis (acute and Chronic)
    e. Endoscopy
    f. Observation Units

7. Regarding Item 16, please provide the following additional information and clarifications:

a. Regarding Chart 1, please specify the perimeter of the interior areas on each floor of the Takoma Park campus that will be renovated.

b. The response to subsection C, Availability of Utilities, refers to a number of permitting processes that will take six to nine months (public water connections, site water and sewers, storm drainage, storm water management). Please explain how each one of these permitting processes will proceed in relationship to the project schedule.

PART II – PROJECT BUDGET

8. Explain the land purchase cost of $11 million and why it is included as a source of funds.

9. Please explain how the contingency amounts for Phase 1 and 2 and for Phase 3 were calculated and explain why you think the amounts are reasonable. Also explain the calculation of the contingencies for Options B and C as presented in Exhibits 20 and 21.

10. Describe what is included in the "Takoma Park Capital Facility Upgrades," estimated to cost $14.3 million. Can some of these costs be allocated to the areas that undergo renovations? If yes, please allocate a portion of this amount to the renovation budget line (line 1b2) and explain how these costs were allocated. If a portion of the Capital Facility Upgrade budget cannot be allocated to the renovations, explain why not.

11. Specify what is included in line 1c(4)g, certifications and inspections, of the budget for the proposed project on page 17 and the project budgets for Options B and C.

12. Submit details on the calculation of the gross interest [line A1d(1)] and interest income as a source of funds (line B4) of the budget for the proposed project on page 17 and the project budgets for Options B and C.

13. Please provide a more detailed explanation of how the inflation allowances were calculated for the proposed project on page 17 and the project budgets for Options B and C.

PART III – CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)
Response to State Health Plan for Facilities and Services: Acute Hospital Services, COMAR 10.24.10

14. Regarding COMAR 10.24.10.04A(1), Information Regarding Charges, the standard requires that at a minimum the [applicant's] 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 website; (b) procedures for promptly responding to individual requests for current charges for specific services/procedures, and (c) requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled. This chapter of the SHP also

includes a definition of "Representative list of services and charges" at COMAR 10.24.10.06.B(29). Subsection (b) of this definition states that, "this list should be updated, with respect to DRGs, CPT codes, and charges, at least *quarterly*." The applicant's policy includes the word *regularly*, but does not include a defined period of time. Please update this policy to reflect the required *quarterly* updates.

15. Regarding COMAR 10.24.10.04A(2), Charity Care Policy, please provide a copy of the notice posted in the emergency department, admissions department, and business offices.

16. Regarding COMAR 10.24.10.04B(1), Geographic Accessibility, please provide a travel time analysis that includes population estimates. While Exhibit 13 of the application includes a travel time analysis which lists the travel times from the existing and proposed site for each primary and secondary ZIP code area, this exhibit does not include population estimates for these ZIP code areas and specify whether 90% of the population in these ZIP code areas is within 30 minutes of the proposed site under normal driving conditions.

17. Regarding the response to COMAR 10.24.10.04B(4)(b), please provide the following additional information and clarifications:

    a. Explain how The Traffic Group conducted the travel time analysis. Specify the source of the travel times. If the travel times are based on travel during a particular time of day, specify the time of day.

    b. The second paragraph on page 29 refers to Exhibit 16 and states that, "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". However, only travel time to the proposed White Oak and current Takoma Park locations are compared. Please compare travel times to the locations of the other hospitals whose primary service areas overlap with WAH's, including the travel to the proposed new location of Prince George's Hospital Center. Please add a population component to this travel time analysis, as requested in Question 17 above.

    c. Explain the "Next Bus" system and plans for implementation. Describe how this system would impact the proposed facility's accessibility for patients in WAH's current and expected primary service areas.

18. Regarding the response to COMAR 10.24.10.04B(5), Cost-Effectiveness, please provide the following additional information and clarifications:

    a. Submit complete development schedules for each option similar to the development schedule submitted for Option B on page 127.

    b. Explain how the estimated costs of each option was developed, including assumptions regarding inflation.

c. Regarding Option B, explain why Phase One does not involve the construction of a larger bed tower with more floors to accommodate the relocation of more than the 72 beds on two floors, thus making it easier to accommodate hospital functions in later phases and achieving one of the applicant's major objectives of improving private bed capacity. Similarly why doesn't Phase Two involve construction of a second tower with more floors?

d. Regarding Option C, specify the number of beds by service that would be relocated. How was the smaller number of beds determined? Provide more details with respect to the provision of services compared to the proposed alternative including the provision of community-based services and the amount of charity care services to be provided to non-regulated outpatient services.

e. If it were determined by OHCQ that the freestanding psychiatric hospital facility proposed for operation on the Takoma Park campus would be licensed as a Special Hospital - Psychiatric and HSCRC treated it as such for rate setting purposes, and HSCRC treated the outpatient services provided on the Takoma Park campus as non-regulated services, would Adventist HealthCare pursue implementation of this project as proposed? Would it request CON approval of Option C or a different option? If a different option would be proposed with more beds and services to be relocated to White Oak, how would this alter the project budget estimate and projected revenues and expenses? What assumptions would be used to forecast revenues and expenses?

f. Explain why each objective in the scoring matrix in Exhibit 19 has the same value with a maximum of five points.

19. Regarding the response to COMAR 10.24.10.04(B)(7), Construction Cost of Hospital Space, as presented in Exhibits 24 through 29, please provide the following clarifications:

a. Regarding the statement on Page 38 that the estimated capitalized interest cost of the project for the construction of the hospital has been adjusted from $47,943,000 to $17,764,000, explain the derivation of the $47,973,000 given that the budget estimate for gross interest is $50,288,600.

b. Explain how the hillside foundation adjustment was calculated

c. Report the total cost of bringing utilities to the building broken down by the costs of bringing the utilities from the property line to the building and the cost of bringing the utilities to the property line. Do not include jurisdictional hook-up fees.

20. Regarding COMAR 10.24.10.04B(13), Financial Feasibility, please provide the following additional information and clarifications:

a. Please demonstrate that the utilization projections are consistent with the use rate trends for each service in its service area.

b. Please quantify the staffing reductions (FTEs and dollars by position) currently underway and anticipated in the years prior to the proposed relocation of services to White Oak. Submit a Table 5 that reports the FTEs, salaries and wages, and cost by position (more detailed than the Table 5 submitted with the application) for either 2012 or 2013 (specify which year), which should be consistent with salary and wages and employee benefits on Table 3 and Exhibits 22 and 31. The Table should also report the expected changes between the base year and the opening of the new facility. Finally the table should report the changes attributable to the relocation of the hospital and a total for the first full year of new facility operation (this total should be consistent with Table 3.

21. The Department of Health and Mental Hygiene's "Maryland's All Payer Model," submitted to the Centers for Medicare and Medicaid Innovation on October 11, 2013, anticipates that, "The CON program would support the success of the Maryland All-Payer Model by considering the goals and objectives of the model in its decisions to approve or deny health care facility projects by requiring health care facilities to demonstrate that their projects are viable without reliance on continually growing service volume." Given this expectation:

    a. Can the applicant demonstrate that the proposed project is viable without reliance on continually growing service volume?

    b. Can the applicant demonstrate that the proposed project's utilization forecasts are consistent with a future in which demand for hospital admissions by the hospital's service area population (i.e., the acute hospital use rate of the service area population) is trending down, consistent with the Model's expectations?

22. Regarding COMAR 10.24.10.04B(14),Emergency Department Treatment Capacity and Space, please provide WAH's actual performance regarding: length of stay for all ED patients and the percent of patients age 65 and older.

Response to State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetric Services, COMAR 10.24.12

23. Regarding COMAR 10.24.12.04(2):

    a. For Standard 2.1c., please provide additional information about how this standard changed and how the hospitals addressed the most recent published guidelines.

    b. For Standard 13.7., please provide the hospital's policy to eliminate deliveries by induction of labor or by caesarean section prior to 39 weeks gestation without a medical indication. The application includes data regarding this measure, but does

not explain how the hospital addresses the occurrences and what a plan of action might include.

Response to State Health Plan for Facilities and Services: Psychiatric Services, COMAR 10.24.07

24. Regarding COMAR 10.24.07 AP 6, please confirm whether the applicant has a separate written quality assurance program, evaluations, and treatment protocols for geriatric patients, as the standard stipulates.

25. Regarding COMAR 10.24.07 AP 8, please provide the amount of uncompensated care and percent of total operating expenses of this care that WAH provided for acute psychiatric patients in FY 2012.

Response to State Health Plan for Facilities and Services: General Surgical Services, COMAR 10.24.11

26. Regarding COMAR 10.24.11.05B(6), please provide additional analysis of patient safety features of the proposed surgical facilities that enhance and improve patient safety, especially to the degree that these features are improvements over the existing surgical facilities.

27. Regarding COMAR 10.24.11.05B(8), please provide financial projections and staffing projections for the Surgery Department only.

28. Provide a service area population-based analysis of the need for surgical capacity at the proposed replacement hospital.

Response to Other Criteria

29. Regarding COMAR 10.24.01.08G(3)(b), Need, please provide the following additional information and clarifications:

    a. Explain how physician relationships were taken into account when evaluating the market share changes as a result of the relocation to White Oak (Page 99).

    b. On Page 102, it is stated that, in redefining the hospital's service areas, four zip code areas were dropped from the primary service area and six zip code areas were dropped from the total service area. No reference is made to the addition of zip code areas. Explain why that is?

    c. Please specify the use rate assumptions that were made in projecting the 2022 admissions/discharges from WAH's TSA as they appear in the table on Page 104 for MSGA admissions, Page 111 for psychiatric discharges, and the obstetric and newborn discharges on page 118. Explain the basis for these assumptions.

d. Submit detailed explanations of the projected observation visits and the outpatient department visits. Clearly state all assumptions and show all calculations. What is the assumed average stay (hours) of observation visits?

30. Regarding COMAR 10.24.01.08G(3) (c), Availability of More Cost-effective Alternatives, please provide the following additional information and clarifications:

a. On the bottom of page 127, it is stated that the final activity of Phase 2 of Option B is the construction of a 600 space, above grade parking structure. However, the summary schedule, also on page 127, indicates that the parking garage is part of Phase 3. Please clarify.

b. The first bullet of the narrative under the considerations subheading on page 128 identifies, among the shortcomings, that surgical services would be split between two different locations due to the current location of operating rooms. This is not reflected in Exhibit 56, which only shows surgery on the second level after completion of Phase 2. Please correct or explain this apparent discrepancy.

c. Provide a detailed explanation of the financial projections for each option as presented in Exhibit 22 including volume, rate, charge and expense and inflation assumptions. Submit a detailed calculation of revenue projections. Explain why you think the assumptions are reasonable. Prepare alternative projections (with and without inflation) for each option assuming revised HSCRC rate setting methodologies (from the All Payer Model proposal submitted by DHMH in October, 2013) such as the application of a 50% variable cost factor applied to all regulated services.

d. To what extent do the projections in Exhibit 22, especially Option C, build in increases in the patient population covered by Medicaid and private insurance as a result of the Affordable Care Act? If such changes are not included, make reasonable assumptions about the changes in the percentage of patients with such coverage and account for such changes in the preparation of the projections that include an alternative HSCRC methodology.

31. Regarding COMAR 10.24.01.08G(3)(d), Viability of the Proposal, please provide the following additional information and clarifications:

a. Submit the Amended and Restated Master Trust Indenture dated as of February 1, 2003 as supplemented and amended among Adventist HealthCare, Inc., Adventist Rehabilitation Hospital of Maryland, Inc. and Hackettstown Regional Medical Center (collectively the, "Obligated Group") and Manufacturers and Traders Trust Company (formerly All first Bank).

b. Explain the projected financials and ratios on Page 130 for the Obligated Group. Specify all assumptions and explain why they are reasonable.

d. Specify the source(s) of the $60.5 million in cash and document that it will be available when needed after the project funds from the tax-exempt financing are depleted, as set forth on Page 131.

d. Explain the apparent discrepancy between the statements on Page 11 that Adventist plans to commence as soon as possible following CON award utilizing existing capital funds with the statement on Page 131 that equity contributions will begin in 2017 after the project funds from the tax-exempt financing are depleted.

32. Please provide alternative projections of revenues and expenses for the proposed project that are consistent with a variable cost factor that provides the hospital with 50 percent of revenue for incremental increases in volume above the budgeted amount in the hospital's base for the year, consistent with the Maryland All-Payer Model proposal. Provide this alternative projection in both current year dollars and with inflation assumptions for both revenue and expenses.

33. Regarding Table 3 and the assumptions included as Exhibit 31, please provide the following additional information and clarifications:

a. What is included and will be included in other operating revenues (line 1h) and why are these revenues projected to increase significantly after the opening of the White Oak campus?

b. What is the basis for the increase in bad debt as a percent of gross patient revenues from 7% in 2011 to 10% in 2012 to the projected 11% for the years 2013 through 2023?

c. What is the basis for the increase in contractual allowance as a percent of gross patient revenues from 7% in 2011 to 9.4% in 2012 and the projection that this allowance will decline to 6.5% by the time the White oak campus opens and continue at that rate through the projection period?

d. Submit an amortization table for the bond debt.

e. Explain how both current and project depreciation and amortization were calculated.

f. Identify the components of Other Expenses (Table 3, line 2j) and break down the expenses accordingly.

g. In Exhibit 31, what is included in the overhead allocation?

34. Regarding COMAR 10.24.01.08G(3)(f), Impact on Existing Providers, please provide the following additional information and clarifications:

d. The 2nd paragraph on Page 136 discusses projected population growth from 2012 to 2022 by age group in the White Oak total service area based on data from HSCRC and Nielson Claritas. Please supply the data. If WAH manipulated the data in anyway such as interpolating interim year data between the years provided by HSCRC and Nielson Claritas or projecting years beyond the data provided, explain the methods used to interpolate and/or project the data.

e. Please submit a detailed discussion of how the estimated market share adjustment for each zip code area was derived, as reported for MSGA, on Pages 137 and 138 and as reported for obstetrics on Page 141. Show all calculations necessary to show how these adjustments were derived.

f. Please provide a detailed discussion of the table at the top of Page 140 for MSGA and Page 143 for obstetrics, explaining what each column represents and outlining the assumptions and calculations used in each step of the impact analysis shown.

Please submit ten copies of the responses to completeness questions and the additional information requested in this letter within ten working days of receipt. All information supplementing the applicant must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "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."

Should you have any questions regarding this matter, please contact me at (410)764-3261 or Kevin McDonald at (410)764-5982.

Sincerely,

PE Parker

Paul E. Parker, Director
Center for Health Care Facilities Planning
and Development

Attachment

cc: Joyce Newmeyer
Geoffrey A. Morgan
Howard Sollins, Esquire
Ulder Tillman, MD, MHP, Montgomery County Health Officer
(internal distribution)

ATTACHMENT 1: Actual Physical Bed Capacity Before And After The Project

Hospital: _____ Date:

Location (Floor/Wing)	Before the Project						After Project Completion				
			Room Count			Bed Count		Room Count			Bed Count
	Hospital Service	Licensed July 1, 2012	Total Rooms	Semi-Private	Private	Physical Capacity	Hospital Service	Total Rooms	Semi-Private	Private	Physical Capacity
			0			0		0			0
			0			0		0			0
			0					0			0
			0			0		0			0
			0			0		0			0
SUBTOTAL	Gen. MSGA		0	0	0	0	Gen. MSGA	0	0	0	0
	ICU/CCU		0			0	ICU/CCU	0			0
TOTAL	MSGA	0	0	0	0	0	MSGA	0	0	0	0
	Obstetrics		0			0	Obstetrics	0			0
	Pediatrics		0			0	Pediatrics	0			0
	Psychiatric		0			0	Psychiatric	0			0
ACUTE TOTAL	Acute Care	0	0	0	0	0	Total Acute	0	0	0	0
Non-Acute Beds											
	Rehabilitation										
Hospital Total											

Note: Physical capacity is the total number of beds that could be accommodated without significant renovations. A room with two headwalls and two sets of gasses is a semi-private room, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough, from a square footage perspective, to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain a single headwall, but are used to accommodate more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms is semi-private, and the bed capacity is as applicable.