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Page

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. Terry Forde
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. Terry Forde, Interim 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. TForde@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. 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 170-bed replacement hospital facility on 48.86 acres in the White Oak area of Silver Spring ("White Oak campus") with inpatient and outpatient services. Behavioral health services, including 40 psychiatric beds, will remain in renovated space inside the current Washington Adventist Hospital building on the Takoma Park campus, but not as part of Washington Adventist Hospital. Rather, behavioral health services in Takoma Park will be delivered under Adventist Behavioral Health. The Takoma Park campus

will house behavioral health, Adventist Rehabilitation Hospital services and other community based services.

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

a. Governmental	___	b. Sole Proprietorship	___	c. 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.)***

See Exhibit 1 Hospital CON Application Tables, Table A: Physical Bed Capacity Before and After Project

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 0ption _____

(3) Land Lease held by: _____

(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.

(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 White Oak Campus

A. Obligation of Capital Expenditure: <1 month from approval date.
B. Beginning Construction: <1 month from approval date.
C. Pre-Licensure/First Use: 6 months from capital obligation
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 Phase I
B. Beginning Construction: <2 months from capital obligation.
C. Pre-Licensure/First Use: 32 months from capital obligation.
D. Full Utilization: 4 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 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 1 will be followed by a three month period encompassing negotiation, award, capital obligation, and schedule and cost planning, and mobilization in preparation for Phase 2 construction activities.

Phase 2 of the project consists of excavation, foundation, core and shell, and fit-out. Phase 2 also includes the 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 427,662 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 32 months from Capital Obligation to Pre-licensure/First Use for Phase 2 of the project.

Each project Phase will be conducted under separate contract.

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(3) (i) "For a multiphase 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." For convenience, a schedule graphic is provided at Exhibit 2.

12. Project Implementation Target Dates *(for projects <u>not</u> 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 <u>not</u> 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 170 bed replacement 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 3 - Priority Funding Area Map). The replacement hospital will include all existing acute care services except for behavioral health services which will stay permanently in Takoma Park and be licensed as part of Adventist Behavioral Health (See Exhibit 4 – Letter from OHCQ). The Takoma Park campus, operated by Adventist HealthCare, will also include other non-acute care services:

- a Federally Qualified Healthcare Center (FQHC) operated by Community Clinic, Inc.,
- the Women's Center, providing prenatal and other services for the community, including low-income women
- a new walk-in primary care clinic
- the existing rehabilitation unit licensed as part of Adventist Rehabilitation Hospital
- physician offices
- Imaging and other ancillary services in support of the clinical care provided on the campus
- 55,000 square feet of space to be leased to Washington Adventist University, a college with an adjoining campus. (See Exhibit 5- 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. (A discussion of the challenges with the current campus location can be found in the response to the Geographic Accessibility standard.)

White Oak Facility Description

The project is the development of a full service acute care facility on the White Oak campus, which will house the current hospital services delivered with the exception of behavioral health services, which will remain on the Takoma Park campus. The White Oak facility will have a 427,662 square foot gross area and be comprised of seven stories above grade and one below grade, cellar level. The hospital will have 170 private inpatient rooms.

The White Oak hospital will include the following components:

1) An Emergency Department with 32 treatment bays

2) 8 Operating Rooms (6 for general surgery, 2 special purpose (primarily cardiac surgery)

3) 2 Endoscopy Rooms

4) 1 Cystoscopy Room

5) 6 Cardiac/Vascular Angiography suites

6) 28 bed Critical Care Unit

7) Maternity Unit (18 post-partum rooms, 4 Medical-Surgical patient rooms dedicated to women's care, 7 Labor and Delivery Rooms, 2 C-Section)

8) 8 dedicated Short Stay Observation Beds in the patient tower and 12 Clinical Decision beds adjacent to the Emergency Department.

9) Approximately 750 surface parking spaces

A central utility plant will be developed by an unrelated third party, selling utility services to the hospital. The utilities costs are an operating expense of the hospital.

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 function 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 a dedicated surface 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 site utility functions such as the medical gas storage facility, electrical transformers, generators, central plant and cooling towers, which are less aesthetic, to be hidden as much as possible from the street view, improving the view to and from the hospital. 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, the White Oak site was selected and planned to allow for logical and feasible future growth as needed. 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 benefit 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 patient tower of 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.

Unit sizes are organized and located to improve efficiency. The Emergency Department is directly below Critical Care and Surgery. Operating rooms are accessible by a 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.

Sustainable features of the building include:

- Energy efficiency: the design has set a goal to be more than 10% 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 served by 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, Adventist HealthCare will re-develop the Takoma Park campus for non-acute health care services more suited to campus conditions.

The Takoma Park campus will be operated by Adventist HealthCare and is not a formal element of this CON application. Exhibit 6 provides narrative of the development plans for repurposing the Takoma Park campus.

Project Cost

The total project cost for the development of the new Washington Adventist Hospital facility in White Oak is $330,829,524 million including interest and an allowance for inflation. The specific breakout for these costs is provided in the “Use of Funds” section of this application.

Project Schedule

The total duration of the project from CON submission through to completion of the final phase is estimated at 62 months, including 24 months of planning, CON review, design, permitting and

financing and 38 months of site and building construction and occupancy. The project itself is divided into two 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.

Clinically Integrated Network

Adventist HealthCare is committed to implementing population health strategies as a method to reduce the per capita cost of health care and improve patient experience (outcomes and satisfaction) for Maryland residents. The Maryland Global Budget Revenue model creates a strong incentive for hospitals to collaborate with community physicians, and Adventist HealthCare, including Washington Adventist Hospital, is developing a clinically integrated physician network in order to align physician and hospital incentives around these goals. Adventist HealthCare is working to ensure physicians are able to continue to care for their patients in the community while collaborating with us toward aligned cost and quality goals through the implementation of a population health-based delivery system, consistent with State objectives.

FDA Memorandum of Understanding

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 7, 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 smaller initiatives regarding major FDA regulatory program areas and the collaborative relationship will expand when the hospital moves to White Oak, a relationship that will benefit public health and health care research.

This collaboration between Washington Adventist Hospital and the FDA is further enhanced by the recent approval by Montgomery County of the White Oak Science Gateway Master Plan (WOSGMP). (See Exhibit 8). This emerging White Oak bioscience corridor will be anchored by the FDA, the proposed new Washington Adventist Hospital, and the Life Sciences Village. White Oak is poised to become one of the most important biotech corridors in the nation. Washington Adventist Hospital already has all the Montgomery County development approvals necessary to build its new facility at White Oak. The new WOSGMP will allow transformational development of the surrounding area that will be a tremendous benefit to Washington Adventist Hospital, the White Oak area, Montgomery County, the State of Maryland, and the nation.

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 9

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 has been replaced by Table C "Construction Characteristics and is attached as Exhibit 1

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

APPLICANT RESPONSE:

There are no current plans for bed expansion subsequent to approval as part of the construction plan. In this modification Shell Space has been provided see COMAR 10.20.10.04B(16).

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 550' of private 10"W is proposed through the hospital site and continues with 870' feet connecting with the County property to connect to the existing public 30"W inside the WSSC parcel, just north of the existing WSSC water tower to provide redundancy service to the site.

A Washington Suburban Sanitary Commission (WSSC) application, plan and profiles were submitted to WSSC for the Public SEP process. The WSSC plans have been reviewed by WSSC multiple times and are ready for approval. The remaining permit process will take approximately 2 to 3 months to complete.

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.

Site Utility (previously referred to as "On-Site") water and sewer is required on site to accommodate the new building demands. A WSSC application, plan, and profiles were submitted to the Regulatory Systems Group to process. The WSSC plans have been reviewed by WSSC multiple times and are ready for approval. The WSSC permits will be issued prior to Hospital Building Permit issuance. The remaining permit process will take approximately 2 to 3 months to complete.

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. An application, plan, and profiles were

submitted to the Montgomery County Department of Permitting Services (MCDPS) for issuance of a construction permit. The storm drain plans have been approved by MCDPS. The permit will require processing which takes approximately 4 weeks.

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.

An application, plan, and profiles, were submitted to Montgomery County Department of Permitting Services (MCDPS) for the construction permit. The Stormwater Management Plans have been approved and the permit has been issued by MCDPS.

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.)

Washington Adventist Hospital - Option 4
New Hospital at White Oak, 170 Licensed Beds
CAPITAL BUDGET

			Phase 1 & 2
A.	Uses of Funds		
1.	Capital Costs		White Oak
	a.	New Construction	
	(1)	Building & Fixed Equipment	135,200,000
	(2)	Fixed Equipment (Included above)	-
	(3)	Land Purchase	11,000,000
	(4)	Site Preparation - Land Improvements	10,400,000
	(5)	Architect/Engineering Fees	13,200,000
	(6)	Permits, (Building, Utilities, Etc.)	700,000
		SUBTOTAL	$ 170,500,000
	b.	Renovations	
	(1)	Building demolition	-
	(2)	Renovations	-
	(3)	Fixed Equipment	-
	(4)	Architect/Engineering Fees	-
	(5)	Permits, (Building, Utilities, Etc.)	-
		SUBTOTAL	$ -
	c.	Other Capital Costs	
	(1)	Major Movable Equipment	20,300,000
	(2)	Minor Movable Equipment	13,500,000
	(3)	Contingencies	11,200,000
	(4)	Other (Specify)	
		a. Furniture	10,100,000
		b. Interior & Exterior Signage	1,400,000
		c. IS/Comm	13,500,000
		d. Security system	2,000,000
		e. Relocation expense	2,700,000
		f. Certifications, inspections, etc.	1,000,000
		g. Takoma Park Capital Facility Upgrades	-
			-
		TOTAL CURRENT CAPITAL COSTS (a - c)	$ 246,200,000

d.	Non Current Capital Cost	
(1)	Interest (Gross)	45,156,375
(2)	Inflation Allowance (2.0% per year to midpoint of each construction phase)	10,100,000
	TOTAL PROPOSED CAPITAL COSTS (a-d)	$ 301,456,375

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	4,898,149
b.	Bond Discount	-
c.	Legal Fees (CON Related)	-
d.	Legal Fees (Other)	-
e.	Printing	-
f.	Consultant Fees	-
	CON Application Assistance	
	Other (Specify)	
g.	Liquidation of Existing Debt	-
h.	Debt Service Reserve Fund	24,475,000
i.	Principal Amortization	-
	Reserve Fund	
j.	Other (Specify)	-
	TOTAL (a - j)	$ 29,373,149

3. Working Capital Startup Costs

	TOTAL USES OF FUNDS (1 - 3)	**$ 330,829,524**

B. Sources of Funds for Project:

		Phase 1 & 2 White Oak
1	Cash	50,575,175
2	Pledges: Gross, less allowance for uncollectables=Net	
3	Gifts, bequests	20,000,000
4	Interest income (gross)	4,504,349
5	Authorized Bonds	244,750,000
6	Mortgage	
7	Working capital loans	

8	Grants or Appropriation	
	(a) Federal	
	(b) State	
	(c) Local	
9	Other (Specify) (Land)	11,000,000
	TOTAL SOURCES OF FUNDS (1-9)	**$ 330,829,524**

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). <u>The State Health Plan</u>.

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") COMAR 10.24.11 General Surgical Services Chapter and unanswered completeness questions regarding COMAR 10.24.17 (the "Specialized Health Care Services — Cardiac Surgery and Percutaneous Coronary Intervention Services Chapter") of the State Health Plan are discussed below.

<u>COMAR 10.24.10 - Acute Hospital Services</u>

.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 10) 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 falls 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 including Washington Adventist Hospital. (Exhibits 11 and 12). 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 9 and 10, 2014 and appeared in all Montgomery County and Prince George's County editions (Exhibit 13). The same notice was posted in Spanish in El Tiempo Latino, a daily newspaper in the Washington metropolitan area on July 11, 2014 (Exhibit 14).

In 2013, Washington Adventist Hospital provided a total community benefit of 15.3% of its total operating expenses, as reported in the August, 2014 Maryland Hospital Community Benefit Report FY 2013 (http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/CommunityBenefits/cb-fy13/HSCRC-FY2013-CB-Data-Report.xlsx). The total net community benefit was 11.12% of operating expense; ranking the hospital as providing the 7th highest amount of community benefit for all hospitals in Maryland, with an average for all hospitals of 6.3%.

(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 21, 2013 through January 21, 2016 (Exhibit 15). Hospital License Number 15369 effective December 30, 2013 through December 30, 2014 was issued by the Health and Human Services Licensure and Regulatory Services of Montgomery County (Exhibit 16).

Washington Adventist Hospital is accredited by the Joint Commission and earned a "Gold Plus Get with the Guidelines – Stroke" quality award in 2013 (Exhibit 17). The last full survey by the Joint Commission successfully concluded on August 16, 2013, and named Washington Adventist Hospital a Top Performer on Key Quality Measures.

Other recent honors and awards conferred upon the Hospital

- Three-Star rating for heart surgery by The Society of Thoracic Surgeons (STS)
- Accredited Chest Pain Center, Level IV with PCI,The Society of Cardiovascular Patient Care (SCPC)
- Designated Cardiac Interventional Center, Maryland Institute for Emergency Services and Systems (MIEMSS)
- Designated Primary Stroke Center, Maryland Institute for Emergency Medical Services Systems(MIEMSS)
- Stroke Gold Plus Quality Achievement Award and the Target: Stroke Honor Roll award from the American Heart Association (AHA)
- Mission: Lifeline Bronze Performance Achievement Award, from the American Heart Association (AHA)

- Accredited Cancer Program with Commendation, The Commission on Cancer (CoC) of the American College of Surgeons (ACoS)
- Accredited Radiation Oncology Program, American College of Radiation Oncology (ACRO)
- Silver Performance Achievement Award from the American College of Cardiology Foundation's NCDR ACTION Registry - Get With the Guidelines Designated Center of Excellence and Center of Distinction.
- Healogics, Inc.; The Center for Advanced Wound Care & Hyperbaric Medicine

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 contracted a consultant, IMA. The consultant was on site at the hospital and worked 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 Primary Service Area (PSA) and a Secondary Service Area (SSA) using zip codes in the Washington region. Exhibits 18 and 19 detail the estimated drive times under normal driving conditions from Washington Adventist Hospital's PSA (highlighted in green) and SSA (highlighted in blue).

The first step in the analysis was to identify, for both the Takoma Park and White Oak locations, the 30 minute travel time boundary in all directions (Exhibits 20, 21 and 22) and overlay this on the identified area in order to identify locations that meet or exceed the 30 minute drive time standard. Distributed Locations within the primary and secondary service area zip codes were identified as a travel time data point. Additionally, a central location within each zip code location was identified. The selected points were individually entered into Google Maps as the "starting location" and the White Oak and Takoma Park campus locations became the "destination locations." Google Maps was utilized for travel time mapping, where trips were calculated under normal conditions. No peak hour or peak direction travel times were selected.

The objective of the analysis was to determine if 90% of the populations in the service area are within 30 minutes of the proposed site under normal traffic conditions. Using the analysis, the average travel time of all of the identified data points was calculated and multiplied by the service area population resulting in the Total Traveled Minutes. The percentage of service area population that was both within the 30 minute travel time standard as well as had travel times greater than the standard was calculated. For service area locations that exceeded the 30 minute standard, travel times were calculated to the closest acute care hospital.

The Travel Time Table (Exhibit 18) 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 19) 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 the 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, a suboptimal 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. 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 Google Maps.

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 Takoma Park and White Oak. 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 up to 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 2022 is 805 MSGA beds, and the maximum jurisdictional bed need is 1,103 MSGA beds. As of July 1, 2014, there were 949 licensed MSGA beds located in the five acute care general hospitals of Montgomery County and 75 beds approved in 2011 at Holy Cross Hospital Germantown, as shown below:

Licensed MSGA Beds in Montgomery County (FY2015)	
Hospital	**Licensed & Approved MSGA Beds**
Holy Cross Hospital of Silver Spring	277
Holy Cross - Germantown	75
MedStar Montgomery Medical Center	87
Shady Grove Adventist Hospital	224
Suburban Hospital	190
Washington Adventist Hospital	171
Total	**1,024**

Source: Maryland Health Care Commission, Acute Care Bed Inventory (Fiscal Year 2015)

The replacement hospital project proposes 152 MSGA beds, a reduction of 19 MSGA beds. All of the 152 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 -200 to 98 beds for Montgomery County in FY2022.

Projected Minimum and Maximum
Bed Need
Montgomery County

	Gross Bed Need (1)	Licensed & Approved Beds (2)	Proposed Beds	Net Bed Need
Date	**FY 2022**	**FY 2015**		**FY2022**
Minimum	805	1,024	1,005	-200
Maximum	1,103	1,024	1,005	98

(1) Estimates from the Maryland Register (Volume 41, Issue 5, p.356-358) dated March 7, 2014
(2) Based on Licensed Acute Care Beds (Fiscal Year 2015) Includes 75 CON approved beds at Holy Cross Hospital - Germantown

(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 publicly available HSCRC annual filing (FY 2013), Washington Adventist Hospital's average age of plant is 23.0 years, second highest average age among 47 hospitals in the State of Maryland.

In response to part (a), Washington Adventist Hospital has assumed a rate increase in the financial projections of $19.7M effective January 1, 2019. The new Global Budget Revenue that Washington Adventist Hospital entered into effective July 1, 2013, with a 50% variable cost factor for increased market share does not provide the hospital with the ability to fund capital through growth but rather incentivizes hospitals to manage utilization in the most effective and efficient manner leading to overall reductions in the cost of care. Under this new program, the hospital project requires capital funding through rates in order to achieve reasonable profitability in the 5th year of the project which in turn will allow the hospital the ability to continue to re-invest in the facility and continue to manage hospital utilization and patient care efficiently. The impact of a one-time permanent increase of $19.7M is far less than the impact to the overall Statewide system than if Washington Adventist Hospital was to seek additional volume growth to fund the 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. All clinical services currently provided by the hospital will continue to be offered for the community. The acute care services in White Oak are within the hospital's existing primary service area and will be augmented by population health services and specialty hospital services on the existing Takoma Park campus, including: a Federally Qualified Healthcare Center (FQHC); the Women's Center, providing prenatal and other services for the community, including low income women; a new walk in primary care clinic; the existing behavioral health unit that will be licensed and operated under Adventist Behavioral Health; the existing rehabilitation unit licensed and operated under Adventist Rehabilitation Hospital; physician offices; and imaging and other ancillary services in support of the clinical care provided on the campus. (The hospital also has a letter of intent to lease 55,000 square feet of space to Washington Adventist University for its education needs).

The hospital is reducing the number of inpatient beds consistent with market changes in inpatient acute care hospital utilization. The volume growth for the new Washington Adventist Hospital approximates population growth, a recognition by Washington Adventist Hospital of the State's concern about paying for new capacity for patients currently served by existing hospital capacity. The 170 bed total for the White Oak facility represents 80% occupancy based upon the hospital's projections for future volume growth. Finally, the hospital is moving from a facility with a significant number of semi-private rooms to one with all private rooms, creating a more efficient clinical operation. 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.

Any analysis of adverse impact must consider the negative impact to the community if Washington Adventist Hospital were not able to build a new, modern facility in a location with more accessible public transportation and more space for clinical services. The existing campus is small, difficult to access and lacks adequate space for physician offices and outpatient services. As demonstrated elsewhere in this application, attempting to rebuild the facility on the existing campus is not the most a cost effective alternative. A Washington Adventist Hospital continually crippled by an aging infrastructure on a small, difficult-to-access campus does not serve the community well.

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 modern 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 9 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 23), 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/senior

s.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;
- In addition to parking on campus, 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 24) 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 25) 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 $17.50

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.

The Next Bus System is a cloud-based solution that provides real-time passenger information to transit agencies and the sponsoring organization. The Next Bus Corporation currently services more than 300 million riders each year and offers a host of options, including a GPS-enabled web site for mobile devices that instantly recognizes the nearest stops in proximity order. Next Bus offers a web site that is compatible with a screen reader that meets the guidelines of the Americans with Disabilities Act. Next Bus information is available in English, French, and Spanish. This system benefits patients by creating better information for riders as they are waiting to leave either the White Oak or Takoma Park campus with a destination to the other campus, or to other transit systems. This system will be installed in a kiosk inside the

hospital in White Oak, in Takoma Park, and at a kiosk in the bus waiting areas along Plum Orchard Road. Basically, this system tells the rider when the next bus will arrive and how long they have to wait. It provides information on the bus route with a bus number so that the rider will have better information.

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 8 is the Montgomery County Planning Department's White Oak Science Gateway Master Plan. It addresses the comprehensive master plan amendment for the southern portion of eastern Montgomery County.

A table comparing travel times to hospitals that will likely overlap with the primary service area projected for the proposed White Oak location of Washington Adventist Hospital was produced from the analyses. The following additional hospitals are included in the analysis which can be found at Exhibit 26: Holy Cross – Silver Spring; Laurel Regional Hospital; Doctors Community Hospital; Prince George's Hospital-Cheverly; proposed Prince George's – Largo. The analysis includes a population component.

Of the seven hospital locations studied, the proposed White Oak location for Washington Adventist Hospital results in the fewest service area population drive time minutes exceeding the 30 minute standard. The average drive time for the population to the proposed White Oak location is 21 minutes, and the average drive time for the population to ANY of the hospitals in the study is 12 minutes. If other hospital locations were included, such as Medstar Southern Maryland Hospital Center, Shady Grove Adventist Hospital or the new Holy Cross Hospital - Germantown, the average drive time is estimated to be less. Therefore, it was concluded that 100% of the likely service area population identified for the White Oak location has normal drive time access to a hospital within 30 minutes or less.

(5) <u>Cost-Effectiveness</u>

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 options for staying on the Takoma Park campus and options for relocating to White Oak on a site within the hospital's existing primary service area.

After filing a CON application in October 2013, the State of Maryland negotiated a new waiver with CMS resulting in a new Global Budget Revenue model for acute care hospitals in Maryland, including Washington Adventist Hospital. This change has a substantial impact on how Maryland hospitals are reimbursed, incentives for hospitals moving forward, and impacts size and scope of future capital projects. Accordingly, Adventist HealthCare felt it was prudent to re-evaluate options for the future of Washington Adventist Hospital based upon this new paradigm.

The options developed and considered are:

Options

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

2. Replacement hospital on the existing Takoma Park campus;

3. Relocation of all existing acute care hospital services, including behavioral health, to a new facility and campus in White Oak.

4. Relocation of all existing acute care hospital services to the new facility in White Oak except for behavioral health, which would stay in Takoma Park as a specialty hospital service.

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 27, identifies the degree to which each option met the 19 objectives established by the Board.

Option 1, the limited capital project in Takoma Park, was removed from consideration 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 initiated for each alternative. The details for option 2 are included below and in the response to the Availability of More Cost Effective Alternatives standard. Information regarding Option 3 is included below. Information for Option 4 is included throughout the application and below.

For option 2, 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 an approach that maximizes what might realistically be accomplished on the Takoma Park campus, even if all 19 objectives were not attained.

Option 2 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 7 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 three 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 4 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. Upon completion of Phase 2, hospital services will be activated over a period of 5 months including survey, relocation and demolition of the existing 1980's West Building to prepare for construction of Phase 3. Phase 3 building construction would follow the demolition and last for a duration of 18 months.

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

- A new cardiac care unit
- New labor and delivery and diagnostics
- New laboratory, pharmacy, and respiratory areas.
- New heart center
- New medical same day unit
- New medical surgical unit
- New lobby
- New central utility plant by third-party developer

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

- New medical surgical unit
- New critical care unit
- New maternity unit
- New surgical suite
- New G.I. endoscopy suite
- New emergency department
- New admitting and radiology areas
- New cafeteria
- New structured parking by third-party developer

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.

Completion of Phase 3 would provide the following programs/departments:

- New medical surgical unit
- Shell space for future bed capacity and/or to accommodate Phase 4 relocation requirements.
- New behavioral health unit and renovation of existing unit
- New surgery to connect to Phase 2 surgery areas to provide contiguous department.
- New radiology
- New central warehouse

The capital expenditure for this project would be $351.2 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.

Option 3, a proposal to build a 210 bed hospital in White Oak, was also considered by Adventist HealthCare. This proposal is very similar to Option 4 except that in Option 3 the 40 behavioral health beds would move to White Oak and be operated as acute hospital beds instead of staying in Takoma Park, licensed and operated as special hospital beds under Adventist Behavioral Health. An array of non-acute care hospital community based services would be provided in Takoma Park. (The Takoma Park campus services in Option 3 would be the same as those in Option 4, except that in Option 3 the behavioral health beds and services would be located in White Oak.) Under Option 3, the White Oak hospital would have all private rooms and the campus would have a 750-car surface parking lot. The construction timeline for this option would be 57 months, including 24 months for planning, CON review, design, and 35 months of building construction and occupancy. The capital expenditure for Option 3 would be $353.2million (Exhibit 28- Project Sources and Uses of Option 3).

Option 4 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 (which will become part of Adventist Behavioral Health), an FQHC, the services of Adventist Rehabilitation Hospital of Maryland/Takoma Park, the Women's Center clinic, a walk in primary care clinic, doctor's offices, 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 White Oak facility in option 4 would have 170 inpatient beds, and a total cost of $330.8 million.

As noted in the options scoring matrix (Exhibit 27), Option 4 received the highest score, followed by Option 3 and then Option 2.

An analysis of the options against one another delineates why Option 4 is the most cost effective choice.

Option 2, the on-campus alternative, creates challenges by encumbering the organization with significant debt without addressing the serious access 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, all on a very small campus. (See Exhibit 29- Sources and Uses Option 2). This is why, for example, Option 2 received the lowest score, a "1," for the objective Improves Access while Option 4 received a "5" for the same objective. In addition, Option 2 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 the quality of care delivered during the construction and renovation periods. Option 2 received a score of "1" for Minimizes Impact on Current Operations versus a "4" for Option 4.

Most significantly, Option 2 does not earn a positive financial margin within 5 years. 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 4 on those objectives.

Option 3 has many positive attributes and is similar to Option 4 in creating a new facility in White Oak on a sizeable, more accessible medical campus within the hospital's existing primary service area. The financial viability and feasibility for Option 3 scored well, a "4" in both cases, but slightly less than "5" received for Option 4 for two reasons. First, the combined margin, including both the gain in White Oak and the loss in Takoma Park, is greater in Option 4 by the fifth year. Second, Option 3 would require an additional $23 million in capital expenditures to build new acute hospital space to accommodate the 40 behavioral health beds on the White Oak campus. Option 4 allows the organization to avoid that capital expense. 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 less comprehensive under Option 3 than Option 4. In Option 3 the 40-bed behavioral health unit would be located in White Oak, leaving the Takoma Park campus without a major anchor. In Option 4 the behavioral health services are in Takoma Park, creating a more robust depth of services and a greater level of health care activity and revenue on that campus. Operating the behavioral health service in Takoma Park also makes the campus more sustainable by increasing revenues by an additional $2 million annually. As a result, Option 3 ranked lower than Option 4 for the Impact on Community objective.

Projected income statements and Adventist Healthcare, Inc. financial ratios for each of the options evaluated can be found at Exhibit 30.

In summary, Option 4 provides the best alternative for ensuring the long term future of Washington Adventist Hospital and is the most cost effective. Option 4 requires the lowest amount of capital of the three possible options and earns the most when factoring both the gain in White Oak and loss in Takoma Park.

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

Comparison of Each Option

OPTION	**CAPITAL EXPENSE**	**COMBINED MARGIN IN FIFTH YEAR**
Option 2	$ 351.2 million	($4.6 million)
Option 3	$ 353.2 million	$4.910 million
Option 4	$ 330.8 million	$4.989 million

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. In 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 31, 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 3).

(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:

Please see COMAR 10.24.01.08G(3)(b) where the need for MSGA 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 32 through 35. The MVS analysis addresses the cost of the new hospital at White Oak.

The construction cost assumptions for this modification are current. In this modification, the cost estimate has been adjusted slightly for revisions to bed count and program space. The expected start of construction has remained the same and the cost estimate is considered current for the planned construction schedule. 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 $45,156,375 to $21,378,750, 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 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 33. 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 $371.37 as shown below and in Exhibit 32.

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

	Unadjusted	**Extraordinary**	**Total Cost**
New Construction, Incl. Fixed Equipment	$135,200,000	$10,400,000	$124,800,000
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	$21,378,750	$2,607,000	$18,771,750
TOTAL	$180,878,750	$ 22,057,000	$158,821,750
	TOTAL SQUARE FEET		427,662
	COST PER SQUARE FOOT		**$371.37**

The project includes a basement and seven upper floors. According to the MVS calculations summarized below, the Washington Adventist Hospital replacement facility of Class A, Good construction quality should cost approximately $374.91/SF. The complete calculations are found at Exhibit 34. Adjustments for construction cost differentials by department have been included in the calculations as found at Exhibit 35.

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

	GSF	$ / GSF	Total Cost
Basement	70,931	$195.80	$ 13,888,008
1st - 2nd Floors	149,016	$435.24	$ 64,857,121
3rd - 4th Floors	111,889	$402.12	$ 44,992,777
5th – 7th Floors	95,826	$381.93	$ 36,598,680
TOTAL	**427,662**	**$374.91**	**$ 160,336,585**

Comparison to MVS Standard – New Construction At White Oak

As the calculations indicate and as reflected in Exhibit 34, the estimated cost of the new hospital construction in White Oak is approximately $3.54/SF or 1% below the applicable MVS standard.

(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 proposed project does not include construction of non-hospital 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	13,680	488.57
Floor 3	Cardiac	32	11,580	361.87
Floor 4	Post Partum/Ante Partum / MSGA	22	9,418	448.48
Floor 5	Med / Surg	32	14,191	443.46
Floor 6	Med / Surg	32	14,191	443.46
Floor 7	Med / Surg	24	11,013	458.87
.	Total =	170		

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	CHARTING STATION	363
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	CASE MGMT, GME	652
LEVEL 2	CRITICAL CARE	DECONTAM	126
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	283
LEVEL 2	CRITICAL CARE	ICU 02	283

LEVEL 2	CRITICAL CARE	ICU 03	283
LEVEL 2	CRITICAL CARE	ICU 04	272
LEVEL 2	CRITICAL CARE	ICU 05	293
LEVEL 2	CRITICAL CARE	ICU 06	311
LEVEL 2	CRITICAL CARE	ICU 07	327
LEVEL 2	CRITICAL CARE	ICU 08	271
LEVEL 2	CRITICAL CARE	ICU 09	283
LEVEL 2	CRITICAL CARE	ICU 10	283
LEVEL 2	CRITICAL CARE	ICU 11	272
LEVEL 2	CRITICAL CARE	ICU 12	293
LEVEL 2	CRITICAL CARE	ICU 13	290
LEVEL 2	CRITICAL CARE	ICU 14	296
LEVEL 2	CRITICAL CARE	ICU 15	290
LEVEL 2	CRITICAL CARE	ICU 16	286
LEVEL 2	CRITICAL CARE	ICU 17	296
LEVEL 2	CRITICAL CARE	ICU 18	290
LEVEL 2	CRITICAL CARE	ICU 19	293
LEVEL 2	CRITICAL CARE	ICU 20	272
LEVEL 2	CRITICAL CARE	ICU 21	283
LEVEL 2	CRITICAL CARE	ICU 22	283
LEVEL 2	CRITICAL CARE	ICU 23	271
LEVEL 2	CRITICAL CARE	ICU 24	327
LEVEL 2	CRITICAL CARE	ICU 25	311
LEVEL 2	CRITICAL CARE	ICU 26	293
LEVEL 2	CRITICAL CARE	ICU 27	272
LEVEL 2	CRITICAL CARE	ICU 28	283
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	PHYSICIAN WORK ROOM	124
LEVEL 2	CRITICAL CARE	TEAM ROOM	220
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)	13,680
		Patient Rooms	28
		Area per Patient Room	488.5714

(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 a new method for determining "high cost" hospitals has not yet been developed under the new waiver and reimbursement methodologies. Furthermore, industry discussions indicate the need for a measure that focuses more on the overall efficiency of hospitals including both cost and quality.

(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 hospital 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 replacement 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.
- 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 clinical decision 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 existing hospital 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 36.

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 have a separate waiting area 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 entry directly adjacent to the ambulance entry door thus minimizing contact with other patient treatment spaces. The decontamination

area has a separate entry from the exterior to isolate and extract potential contaminants before entering the emergency department.

The proposed surgical facilities at White Oak will be a modern, efficient surgical department designed to replace the aging and inefficient existing department at Takoma Park.

The current Surgery Department at Takoma Park has significant impairment in the patient throughput process. Currently patients from Pre- and Post-Op areas must travel through a major public corridor in order to get to and from the Operating Rooms. This is a significant disadvantage in the Takoma Park surgical patient flow which can present risks for infection transmission and patient privacy. The proposed Surgery Department at White Oak will not have this issue; all patient flow is within the defined Surgery Department with a direct connection between the surgery suite and PACU.

Higher floor heights and Modern facilities to comply with current codes and standards and ease of service. The existing facility pre-dates the current HVAC standards (2008 version of ASHRAE Standard 170). The new facility will comply with the current version of ASHRAE Standard 170, Ventilation of Health Care Facilities, referenced by the 2010 FGI Guidelines for Design and Construction of Health Care Facilities. Higher floor-to-floor heights and modern utilities will make servicing and construction easier and safer. In addition to these higher floor heights, the new operating rooms will provide the opportunity to get the majority of equipment cords and gases off of the operating room floor. The current facility does not accommodate surgical booms that will hold the equipment and provide several types of outlets and gases in order to facilitate surgery. The existing facility subjects the staff to many electrical cords and outlets that can become a safety hazard for tripping and falling injuries. In the new operating rooms, gases and outlets will be placed in strategic locations based on room standardization and patient orientation.

Size. Existing operating room sizes do not meet current standards. There is a high potential for surgical field contamination due to the limited space within the existing operating rooms. If a case is complex and involves several surgical disciplines, the room space becomes inadequate. With new instrumentation and technology, such as surgical microscopes and da Vinci® Robots, the current operating rooms present quite a challenge. The largest existing operating room is 493sf. New operating rooms in the proposed replacement hospital are typically 600sf, appropriately sized for state-of-the-art surgical equipment and booms

Standardized design. The existing facility has operating rooms of different sizes and arrangements. With the current design, each room configuration consists of different levels of supply and instrument storage areas. This can cause a delay in patient care since there is no standardized periodic automatic replenishment (PAR) level for all supplies and equipment. The proposed department at White Oak has rooms of standardized sizes and shapes, resulting in better familiarity and orientation of staff. This new design leads to efficiencies based on providing the correct supplies, instruments and equipment at the right time during surgery.

The Pre-Post procedure unit is designed with more than half of the treatment spaces as enclosed private patient treatment spaces which will enhance patient privacy and lower the risk of airborne infections. Each space is accessed through an ICU-style breakaway door

system designed for maximum observation and easy access to patients. This change will ensure patient privacy and confidentiality, which is a challenge in the current space.

Direct Access to Central Sterile The existing department uses elevators outside the surgical department to transport to and from Central Sterile Services. The new White Oak facility will provide a dedicated, direct elevator from Surgery (at the Soiled Holding and Clean Core). This will reduce infection risk to patients and staff and improve department efficiency.

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 White Oak campus, a discrete examination/assessment suite for behavioral health patients is provided within the Emergency Department and is designed to permit segregation of disruptive patients while allowing for visual control by staff. This suite is accessed via a set of doors directly adjacent to the ambulance entrance door, minimizing contact with other E.D. patients.

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) <u>Financial Feasibility.</u>

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 37.

Historical trends in utilization of services in Washington Adventist Hospital's service area have been taken into consideration for the projections of future utilization of the hospital prior to opening of the new facility (See Exhibit 38 (Utilization Trends.xls) for summary utilization trends). Future utilization of the hospital after opening of the new facility have been based on estimated population growth of the service area population as shown in the need and market share projection in 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 for Washington Adventist Hospital. Washington Adventist Hospital entered into a Global Budget Revenue arrangement effective July 1, 2013 and continues to operate under that model. Revenue projections assume a base update factor less shared savings for readmissions. Additionally, in years where there is overall volume growth, 50% of the estimated population growth is applied to the base revenue. Because Washington Adventist Hospital is assuming growth only related to population growth, there are no positive adjustments for market share in any years in the projections. A summary of revenue updates applied in year can be found at Exhibit 37 (Revenue Assumptions.xls). The hospital has also included uncompensated care experience and funding equal to the FY 2015

amount in all years of the projection. It is assumed that any reduction or increase in experience in any given year would have a corresponding increase or decrease in funding, thereby having no impact on the profitability of the hospital.

Staffing and expenditure levels as shown in Exhibit 1 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 Table J, (Exhibit 1) the hospital will generate excess revenues in the first year of the project.

Attached as Exhibit 39 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.

(c) 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.

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

(vi) 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;

(vii) 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;

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

(ix) 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;

(x) 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. 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.

The response to this section 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 32 treatment rooms, 2 Mental Health Evaluation rooms, and an adjacent area with 12 short stay clinical decision rooms.

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. The current design, 32 treatment bays and 12 clinical decision rooms in 22,784 DGSF, is within the high and low range parameters (see table below). In addition, 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 clinical decision 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

Low Range Parameter	Applies to Washington Adventist Hospital
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 follow:

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 CY2013 internal operating data, the current service area for emergency department visits at Washington Adventist Hospital Takoma Park was analyzed.

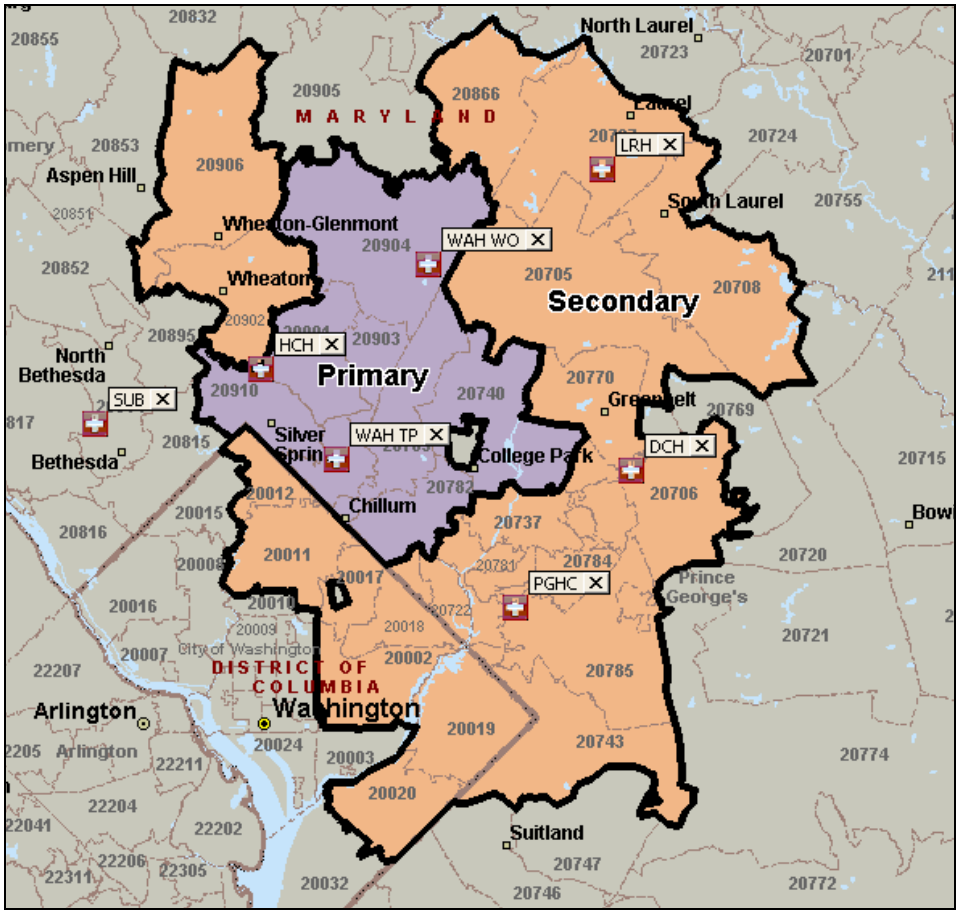
In CY2013, the Washington Adventist Hospital PSA for the Emergency Department consisted of 8 zip codes, 5 located in Montgomery County, and 3 located in Prince George's County, with the primary number of Emergency Department visits coming from zip code 20783 (Hyattsville). Within the Washington Adventist Hospital Takoma Park PSA, Holy Cross Hospital is the only other emergency department service provider.

The Washington Adventist Hospital Takoma Park TSA is comprised of 31 zip codes, 8 located in Montgomery County, 16 located in Prince George's County, and 7 located in the District of Columbia, listed below.

Zip Code	City	Service Area	ED Visits
20783	Hyattsville	Primary	8,523
20912	Takoma Park	Primary	5,630
20782	Hyattsville	Primary	3,955
20903	Silver Spring	Primary	3,793
20901	Silver Spring	Primary	2,236
20904	Silver Spring	Primary	2,050
20910	Silver Spring	Primary	1,926
20740	College Park	Primary	1,218
20011	Washington	Secondary	1,205
20737	Riverdale	Secondary	1,023
20705	Beltsville	Secondary	960
20770	Greenbelt	Secondary	821
20902	Silver Spring	Secondary	803
20781	Hyattsville	Secondary	723
20712	Mount Rainier	Secondary	684
20784	Hyattsville	Secondary	672
20012	Washington	Secondary	666
20906	Silver Spring	Secondary	660
20706	Lanham	Secondary	547
20785	Hyattsville	Secondary	439
20722	Brentwood	Secondary	371
20707	Laurel	Secondary	347
20020	Washington	Secondary	318
20710	Bladensburg	Secondary	270
20002	Washington	Secondary	269
20019	Washington	Secondary	260
20743	Capitol Heights	Secondary	249
20708	Laurel	Secondary	240
20018	Washington	Secondary	229
20017	Washington	Secondary	225
20866	Burtonsville	Secondary	224

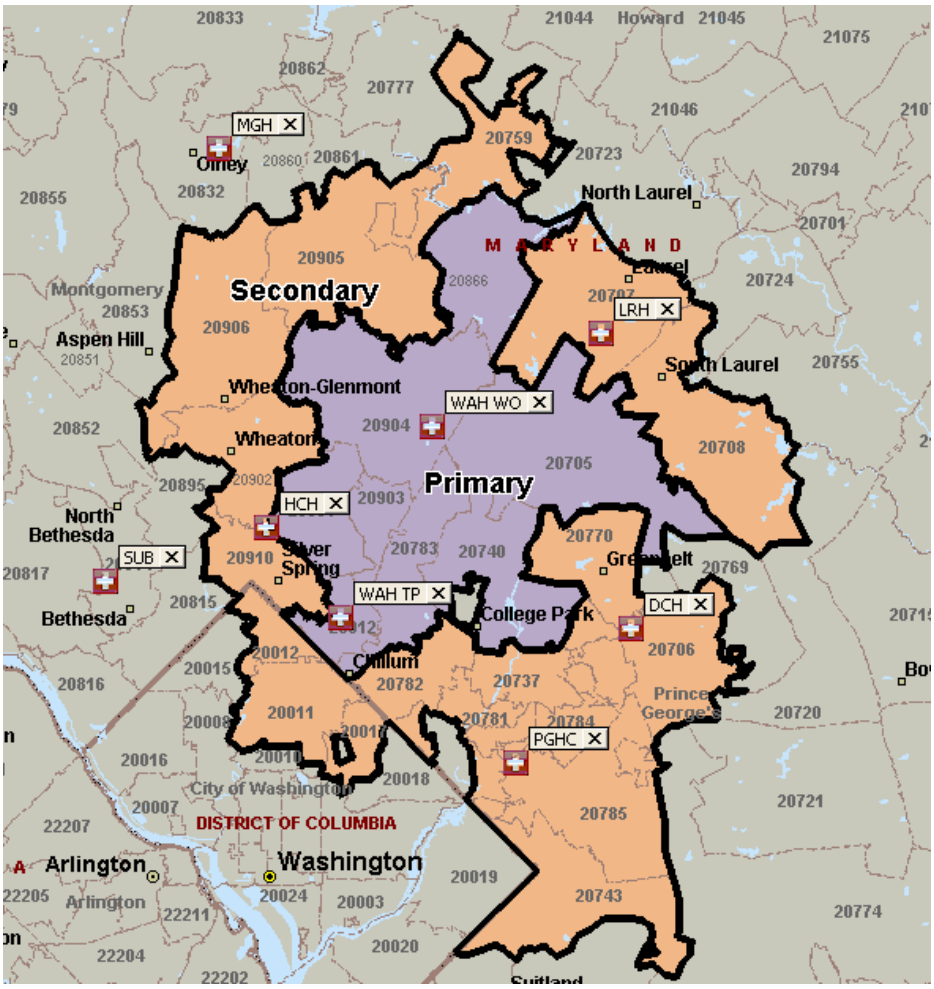
CY2013 Washington Adventist Hospital Takoma Park

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 2009 until CY 2013. Overall emergency department visits declined 3.2% over the last five years. Washington Adventist Hospital experienced emergency room growth of 5.7% since 2009.

ED Visits for Montgomery and Prince George's Hospitals - Calendar Years 2009-2013

ED Visits for Montgomery and Prince George Hospitals - Calendar Year

Provider	2009	2010	2011	2012	2013	5-Year Change
Washington Adventist	46,257	44,823	48,189	50,840	48,902	5.7%
Holy Cross	93,801	86,627	90,582	92,761	88,752	-5.4%
Montgomery General	36,100	36,325	39,091	40,339	38,721	7.3%
Shady Grove Adventist	75,973	71,984	72,113	78,575	72,757	-4.2%
Suburban Hospital Center	44,491	43,063	44,219	45,851	43,956	-1.2%
Laurel Regional Hospital	37,461	35,147	35,268	36,041	35,133	-6.2%
Prince Georges Hospital Ctr	47,761	47,205	51,312	53,126	50,993	6.8%
Fort Washington Hospital	47,302	44,424	44,749	46,366	43,826	-7.3%
Doctors Community Hospital	60,047	59,150	57,116	52,398	50,616	-15.7%
Total	489,193	468,748	482,639	496,297	473,656	-3.2%

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	2009	2010	2011	2012	2013	Change
COMMERCIAL	30.7%	29.1%	27.9%	26.7%	26.8%	-3.9%
MEDICAID	22.2%	30.1%	41.1%	28.0%	25.8%	3.5%
MEDICARE	22.5%	24.8%	21.9%	22.0%	21.6%	-0.9%
OTHER	2.7%	1.5%	1.6%	1.9%	1.5%	-1.2%
SELF PAY	21.9%	14.5%	7.5%	21.4%	24.4%	2.5%

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.

Washington Adventist Hospital has many initiatives to divert non-emergency cases away from the emergency department to more appropriate settings. The response to the next section provides a list of these programs and services.

Answer to Completeness Question: "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."

The following information is provided and is derived from the database of actual patients seen in the Washington Adventist Hospital Emergency Department during the period June 2012 thru May 2013.

Average LOS for All Emergency Department Patients = **261 minutes**
% Emergency Department Patients > 65 y/o = **14.2%**

(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 current Emergency Department is configured to accommodate 30,000 visits per year, however in 2013 just under 49,000 patients were treated. 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 Women's Center clinic. In fact, CCI is currently providing Federally Qualified Health Services on the Takoma Park campus and the Women's Center will continue to provide prenatal and other women's services on the Takoma Park campus. Adventist HealthCare also will develop a primary care walk in clinic in Takoma Park after the hospital moves to White Oak. These efforts taken by the hospital have and will continue to have a favorable impact on preventing unnecessary 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. 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.

- 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 underserved patients discharging from the hospital.

- 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.

- Development of an Emergency Department case management program to identify high volume users in addition to decreasing re-admissions. This case manager will assist with the ED U-turn program in an effort to collaborate with outside facilities to determine appropriateness of patients being admitted.

- Partnership with skilled nursing facilities for enhanced communication and collaboration to identify high risk patients and develop care plans to address those patients' needs. This program will aid in providing better and more cost efficient care to the patient while at their facility. Dr. Andy Catanzaro has initiated a program with Washington Adventist Hospital at St. Thomas Moore that has decreased significantly re-admissions to Washington Adventist Hospital.

- Senior Peer Advocate program in coordination with Washington Adventist University and Adventist Community Services in order to place volunteers over

the age of 50 with peers in the community. This service will allow for senior companions to develop a relationship with a peer that is at high risk due to limited medical knowledge and assist them with health advocacy issues. Data from this program will be reported to Montgomery County.

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 referred 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. It 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 Equity and Wellness addresses disease prevention and management, improves access to quality care, and promotes health equity in the communities we serve to eliminate health disparities. The Center achieves its mission through health services and health disparities research, cultural and linguistic competence education and training, clinical preventive services, community health education outreach, and health ministry.

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, Healthy Kids Campaign 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 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 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 lCBS, 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.

- Partnerships with other clinics for low income, uninsured and underinsured individuals in our community include Spanish Catholic Center, Muslim Community Clinic, Mansfield Kaseman and Pan-Asian Clinics.

- 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.

(16) <u>Shell Space.</u>

(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 project proposes 14,042 square feet of shell space located on the third floor, southwest from the elevator core. Below the shell space on the 2nd floor is the Surgical Suite and adjacent to the shell space on the 3rd floor is Cardiology and the interventional angiography suite for Cardiology and Radiology (includes electrophysiology). Washington Adventist Hospital considers this location optimal as it allows for flexibility of future uses as well as minimizing the impact to the Surgical and Interventional Suites during future construction.

In the event that additional program area is required, the shell space could be used for a variety of programs but the most likely use will be for expansion of medical surgical bed capacity. When finished, the area would be capable of supporting 15 private patient rooms and their associated support spaces (such as equipment rooms, soiled utility rooms, etc.). Other uses will be considered for this space, if the need arises, such as additional program for Cardiology or Radiology (taking advantage of the location adjacent to the Cardiology and the interventional angiography suite) or administration and training. If Washington Adventist Hospital determines that uses other than medical surgical beds are needed, a combination of beds and other uses would be considered.

Washington Adventist Hospital considers this shell space an integral part of the success of the new facility for the following reasons:

- **Program Flexibility**. The hospital has reduced capacity by over 28,000 square feet and 31 patient rooms from its initial application, reflecting recent changes in the Global Budget Revenue payment system for Maryland hospitals and future volume projections. This program reduction is a responsible decision on the part of the hospital but will diminish its ability to respond to potential future service demand.

- **Anticipated Need**. The current projections for the replacement hospital are appropriately conservative in response to utilization assumptions tied to the newly implemented Global Budget Revenue system and do not take into account evidenced-based market influences that a more accessible and newly constructed replacement hospital may experience. It should be noted that once the replacement facility achieves an average occupancy of 78%, the 140% licensing law in conjunction with required Commission approvals would allow for the build-out within the third year of operations. The proposed shell space will allow the hospital to bring new beds on-line in a cost effective manner but only if they are needed.

- **Cost-Effectiveness**. Constructing the proposed shell space at the time of hospital construction is a cost effective method to provide an expansion space.

The construction of the shell space as a part of the CON project provides the ability to fit out an interior project quickly, with minimal disruption, and with minimal risk. As such, the shell space constructed with the hospital and a future interior fit out are less expensive than if the entire space (structure, exterior enclosure, and interior) had to be constructed at a later date after the hospital is functioning.

The initial cost of constructing the 14,042 SF of shell space on Level 3 is estimated to be $2,808,400. As the shell space will be constructed as part of the major project, it will benefit from the efficiencies and economies of scale of the larger project. Furthermore, the initial hospital construction will be unencumbered by the restrictions and requirements of working in and around an existing operating hospital facility.

If construction of the space was deferred for a period of three years, the estimated cost is $4,502,048. Comparing only construction costs, this cost would be 38% more than the initial cost of shell space now. Taking into consideration operating and carrying costs as well as value of money over time (a discount rate), the future cost is 28% more expensive than the initial cost.

The cost differential is attributable to:

- Escalating the cost of construction;
- Need to remove and replace the roofing membrane in order to add space above occupied floors;
- Cost of working off hours and longer period of construction due to existing site operations (shift differential); and
- Additional cost associated with restricted physical access, general conditions, and larger construction fee.

Not included in the calculations above is the impact of service disruptions to the adjacent occupied areas, which includes operating rooms on the floor below. Again, including the shell space in the initial construction avoids these impacts and disruptions.

Refer to the Exhibit 40 for estimate details and Net Present Value calculations which take into account the value of money over time and discount rates.

- **Future Construction and Buffer space**. The shell space provides a "buffer" space between surgery on Level 2 and any future construction over this area (noted in the project drawings as "Future South Wing"). Building over any existing hospital space is difficult and particularly difficult when the proposed addition is the level above the surgical services, as in this case. As such, should the South Wing be built the buffer provided by the shell space will be valuable to mitigate noise, vibration, infection control and other risks to working above a functioning surgery department.

As required in COMAR 10.24.10 section 16, because the most likely use for the shell space is future beds and not considered to support spaces above the shell space, the following information is included in response to the requirements of subsection (b).

- Refer to Exhibit 40 for Net Present Value calculation.

- Most likely use will be additional patient beds. A mix of MSGA and Observation beds are anticipated as the likely use

- The fit out of the shell space will be based on need. As the replacement hospital performs to the volume and occupancy projections, Commission approval of the finishing of the space is expected to be requested within three years of the opening.

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 41 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 41 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 High Risk policy, Policy WWS 9510, attached as Exhibit 42.

b. Fetal monitoring, including internal scalp electrode monitoring, Policy WWS 9509 and WWS 9507 attached as Exhibit 43.

c. Initiating a cesarean delivery within 30 minutes of the decision to deliver, Washington Adventist Hospital follows the ACOG guidelines (Exhibit 44); 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 45).

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 as appropriate. (Exhibit 46- 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 47) 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 48).

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 has 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, 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 49.

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 50- 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 51 - 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 a 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 52-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 53- 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 54-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 55- Policies WWS 9502 and WWS 9152).

13.2 Washington Adventist Hospital has maternal and neonatal resuscitation protocols. (See Exhibit 47- 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 46-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 46-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 56-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 57, 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 11 and 12) 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 9 and 10, 2014 and appeared in the all Montgomery County and Prince George's County editions (Exhibit 13). The same notice was posted in Spanish in El Tiempo Latino, a daily newspaper in the Washington metropolitan area on July 11, 2014 (Exhibit 14).

Section .04(4) <u>Medicaid Access</u>. 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.

<u>APPLICANT RESPONSE:</u>

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 Center. 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 prenatal 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 are 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	82	8.2%	1,688	37.9%
Medicaid	876	87.2%	2,622	58.8%
Medicare	1	0.1%	3	0.1%
Self-Pay	4	0.4%	42	0.9%
Other	42	4.2%	104	2.3%
Total	1,005	100.0%	4,459	100.0%

	White Oak OB Primary Service Area (PSA)			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	64	7.6%	1,575	38.6%
Medicaid	737	87.4%	2,363	58.0%
Medicare	1	0.1%	3	0.1%
Self-Pay	4	0.5%	42	1.0%
Other	37	4.4%	94	2.3%
Total	843	100.0%	4,077	100.0%

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, 21 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 physicians.

2014 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			
Director	1.0				1.0	$ 107,000	$ 107,000
Asst. Nurse Mgr.	1.0			1.0	2.0	$ 89,500	$ 179,000
Lactation Consultant			1.6		1.6	$ 69,000	$ 110,400
Medical Assistant				1.5	1.5	$ 37,500	$ 56,250
Patient Care Tech			7.8		7.8	$ 43,000	$ 335,400
Physician Asst II	3.1				3.1	$ 126,700	$ 386,435
Registered Nurse	18.5	8.8	20.5		47.8	$ 84,300	$ 4,029,540
Registered Nurse Float Pool II			0.2		0.2	$ 97,800	$ 19,625
RN, Unit Based Per Diem	2.0	1.0	0.9		3.9	$ 98,000	$ 382,402
Scrub Tech	6.8				6.8	$ 61,500	$ 418,200
Secretary II	1.0				1.0	$ 46,200	$ 46,200
Unit Support Coord.	1.0		1.0		2.0	$ 40,100	$ 80,200
Patient Rep. II				0.7	0.7	$ 33,700	$ 23,590
Patient Rep. III/Lead				0.7	0.7	$ 45,200	$ 31,640
Total FTE's	**34.4**	**9.8**	**32.0**	**3.9**	**80.1**	**$ 77,522**	**$ 6,205,882**
Physician Coverage							$ 1,030,000.00

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			
Director	1.0				1.0	$ 119,600	$ 119,600
Asst. Nurse Mgr.	1.0				1.0	$ 100,000	$ 100,000
Lactation Consultant			1.6		1.6	$ 77,100	$ 123,360
Medical Assistant					0.0	$ 41,900	$ -
Patient Care Tech			8.0		8.0	$ 48,100	$ 384,800
Physician Asst II	3.1				3.1	$ 141,600	$ 431,880
Registered Nurse	19.0	9.7	20.5		49.2	$ 94,200	$ 4,634,640
Registered Nurse Float Pool II			0.9		0.9	$ 109,300	$ 98,370
RN, Unit Based Per Diem	2.0	1.0	0.9		3.9	$ 109,500	$ 427,276
Scrub Tech	7.3				7.3	$ 68,700	$ 501,510
Secretary II	1.0				1.0	$ 51,600	$ 51,600
Unit Support Coord.	1.0		1.3		2.3	$ 44,800	$ 103,040
Total FTE's	**35.4**	**10.7**	**33.2**	**0.0**	**79.3**	**$ 88,024**	**$ 6,976,076**
Physician Coverage							$ 1,040,000

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			
Director	1.0				1.0	$ 130,700	$ 130,700
Asst. Nurse Mgr.	1.0				1.0	$ 109,300	$ 109,300
Lactation Consultant			1.6		1.6	$ 84,300	$ 134,880
Medical Assistant					0.0	$ 45,800	$ -
Patient Care Tech			8.5		8.5	$ 52,600	$ 447,100
Physician Asst II	3.1				3.1	$ 154,800	$ 479,880
Registered Nurse	19.0	9.9	21.5		50.4	$ 103,000	$ 5,191,200
Registered Nurse Float Pool II			0.2		0.2	$ 119,500	$ 23,979
RN, Unit Based Per Diem	2.7	1.0	1.8		5.5	$ 119,700	$ 658,350
Scrub Tech	7.3				7.3	$ 75,100	$ 548,230
Secretary II	1.0				1.0	$ 56,400	$ 56,400
Unit Support Coord.	1.0		1.0		2.0	$ 49,000	$ 98,000
Total FTE's	**36.1**	**10.9**	**34.6**	**0.0**	**81.6**	**$ 96,544**	**$ 7,878,019**
Physician Coverage							$ 1,082,000

Section .04(6) Physical Plant Design and New Technology. 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:

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 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.

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.

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 Center
- 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.

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 10) 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 11-12). 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. The most recent posting was made on July 9 and 10, 2014 and appeared in the all Montgomery County and Prince George's County editions (Exhibit 13). The same notice was posted in Spanish in El Tiempo Latino, a daily newspaper in the Washington metropolitan area on July 11, 2014 (Exhibit 14).

In 2013, Washington Adventist Hospital provided a total community benefit of 15.3% of its total operating expenses, as reported in the August, 2014 Maryland Hospital Community Benefit

Report FY 2013 (http://www.hscrc.state.md.us/documents/HSCRC_Initiatives/CommunityBenefits/cb-fy13/HSCRC-FY2013-CB-Data-Report.xlsx). The total net community benefit was 11.12% of operating expense; ranking the hospital as providing the 7th highest amount of community benefit for all hospitals in Maryland, with an average for all hospitals of 6.3%.

(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 21, 2013 through January 21, 2016 (Exhibit 15). Hospital License Number 15369 effective December 30, 2013 through December 30, 2014 was issued by the Health and Human Services Licensure and Regulatory Services of Montgomery County (Exhibit 16).

Washington Adventist Hospital is accredited by the Joint Commission and earned a "Gold Plus Get with the Guidelines – Stroke" quality award in 2013 (Exhibit 17). The last full survey by the Joint Commission successfully concluded on August 16, 2013, and named Washington Adventist Hospital a Top Performer on Key Quality Measures.

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 58.

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, 6 general surgery ORs and 2 specialty ORs (2 for cardiac surgery). In addition to the operating rooms, 1 dedicated cystoscopy room, 2 endoscopy rooms, and 2 C-section OR's are proposed. As of CY2013, 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

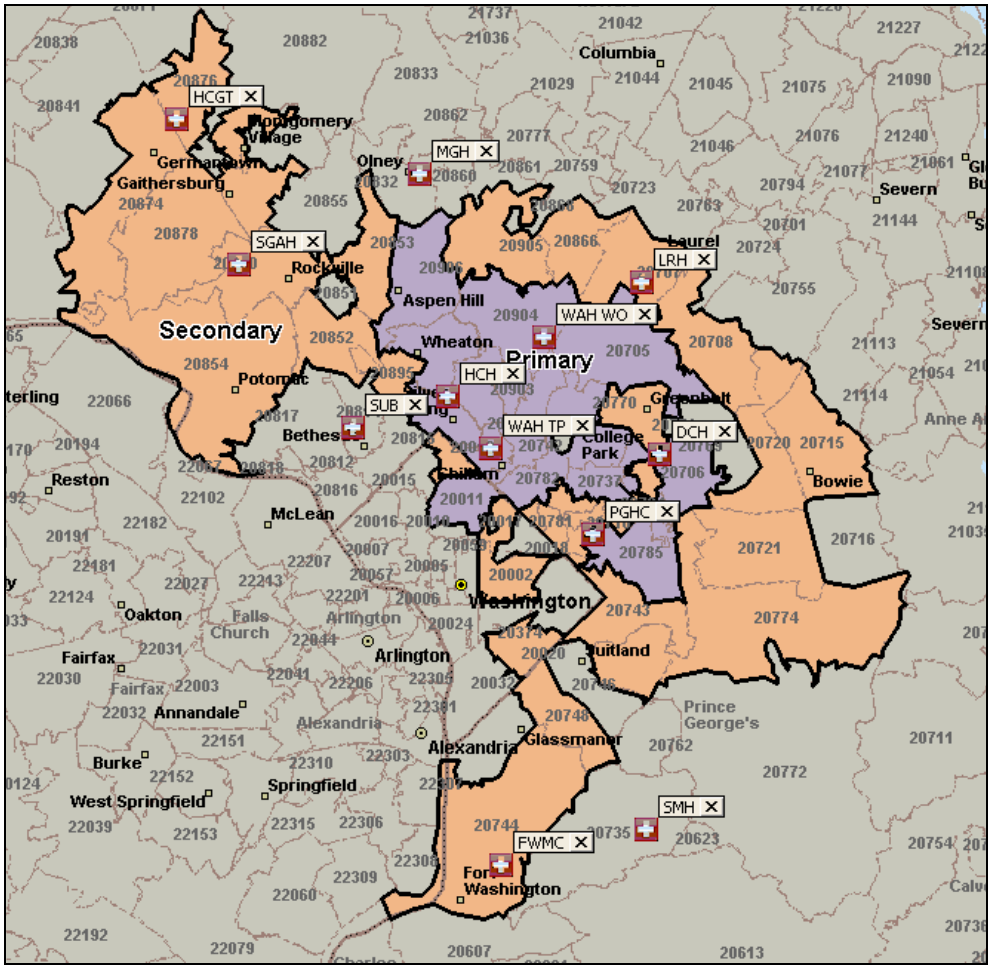
Based on CY2013 internal operating data, we have analyzed the current service area for outpatient surgeries at Washington Adventist Hospital Takoma Park.

In CY2013, the Washington Adventist Hospital PSA for surgeries consisted of 15 zip codes, 7 located in Montgomery County, 7 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 47 zip codes, 19 located in Montgomery County, 23 located in Prince George's County, and 5 located in the District of Columbia listed below.

Zip Code	City	Service Area	Surgeries
20783	Hyattsville	Primary	892
20912	Takoma Park	Primary	557
20904	Silver Spring	Primary	461

Zip Code	City	Service Area	Surgeries
20782	Hyattsville	Primary	457
20901	Silver Spring	Primary	407
20903	Silver Spring	Primary	389
20910	Silver Spring	Primary	311
20902	Silver Spring	Primary	304
20906	Silver Spring	Primary	254
20705	Beltsville	Primary	209
20740	College Park	Primary	182
20011	Washington	Primary	158
20785	Hyattsville	Primary	152
20737	Riverdale	Primary	150
20706	Lanham	Primary	142
20784	Hyattsville	Secondary	121
20707	Laurel	Secondary	115
20770	Greenbelt	Secondary	113
20781	Hyattsville	Secondary	98
20905	Silver Spring	Secondary	92
20708	Laurel	Secondary	87
20712	Mount Rainier	Secondary	86
20774	Upper Marlboro	Secondary	86
20853	Rockville	Secondary	85
20743	Capitol Heights	Secondary	84
20012	Washington	Secondary	74
20722	Brentwood	Secondary	74
20747	District Heights	Secondary	69
20721	Bowie	Secondary	68
20866	Burtonsville	Secondary	67
20852	Rockville	Secondary	60
20878	Gaithersburg	Secondary	55
20710	Bladensburg	Secondary	52
20874	Germantown	Secondary	52
20720	Bowie	Secondary	49
20877	Gaithersburg	Secondary	49
20886	Montgomery Village	Secondary	49
20020	Washington	Secondary	47
20850	Rockville	Secondary	46
20744	Fort Washington	Secondary	44
20002	Washington	Secondary	42
20715	Bowie	Secondary	42
20748	Temple Hills	Secondary	41
20876	Germantown	Secondary	39
20895	Kensington	Secondary	38
20017	Washington	Secondary	36
20854	Potomac	Secondary	36

CY2013 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.

(5) <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 (6 mixed-use surgery ORs and 2 specialty cardiac ORs) in CY2023 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 for both cardiac and non-cardiac services 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 CY2013 are shown below:

CY2013 Utilization Statistics (Mixed Use)

Statistic	Inpatient	Outpatient
Discharges (All)	8,383	N/A
Cases	2,509	3,067
Minutes	213,205	260,583
Case/Admission	29.9%	N/A
Minutes/Case	85	85

CY2013 Utilization Statistics (Cardiac)

Statistic	Inpatient	Outpatient
Discharges (All)	8,383	N/A
Cases	325	N/A
Minutes	86,737	N/A
Case/Admission	3.9%	N/A
Minutes/Case	267	N/A

CY2013 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 its mixed-use 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 for the general surgery ORs. 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 resulting bed need for the mixed-use surgery ORs:

Projected Operating Room Statistics (Mixed Use)

Projected Operating Room Statistics - Mixed Use (non cardiac cases)

Year	Inpatient Cases	Outpatient Cases	Cases Total	Surgery Minutes Inpatient	Surgery Minutes Outpatient	Surgery Minutes Total	Turnaround Time Minutes	Surgery Minutes Total (surgery + turnaround)	Mixed Use ORs Needed at Optimal Capacity
2014	2,402	3,067	5,469	204,142	260,583	464,725	164,080	628,805	5.52
2015	2,366	3,098	5,463	201,027	263,189	464,216	163,901	628,117	5.51
2016	2,330	3,129	5,458	197,958	265,821	463,779	163,747	627,526	5.50
2017	2,287	3,160	5,447	194,376	268,479	462,854	163,420	626,275	5.49
2018	2,246	3,192	5,438	190,875	271,164	462,038	163,132	625,171	5.48
2019	2,269	3,223	5,492	192,783	273,875	466,659	164,764	631,422	5.54
2020	2,291	3,256	5,547	194,711	276,614	471,325	166,411	637,737	5.59
2021	2,314	3,288	5,603	196,658	279,380	476,038	168,075	644,114	5.65
2022	2,337	3,321	5,659	198,625	282,174	480,799	169,756	650,555	5.71
2023	2,361	3,354	5,715	200,611	284,996	485,607	171,454	657,061	5.76

In CY2023, five years after project completion, a need of 6 mixed use operating rooms is estimated.

In addition to the proposed compliment of mixed-use operating rooms for the replacement Washington Adventist Hospital, 2 special purpose operating rooms are proposed to service Washington Adventist Hospital's cardiac surgery program. Capacity for these rooms considered historical utilization and future need projections. Washington Adventist Hospital utilized an estimated turnaround time of 40 minutes per case for the special purpose operating rooms. The optimal capacity of 1,188 hours per year or 71,250 minutes was applied and the following table summarizes the resulting need for the specialty operating rooms:

Projected Operating Room Statistics (Specialty Cardiac)

Projected Operating Room Statistics - Cardiac

Year	Inpatient Cases	Outpatient Cases	Cases Total	Surgery Minutes Inpatient	Surgery Minutes Outpatient	Surgery Minutes Total	Turnaround Time Minutes	Surgery Minutes Total	Cardiac ORs Needed at Optimal Capacity
2014	311	-	311	83,050	-	83,050	12,447	95,497	1.34
2015	306	-	306	81,783	-	81,783	12,257	94,040	1.32
2016	302	-	302	80,534	-	80,534	12,070	92,605	1.30
2017	296	-	296	79,077	-	79,077	11,852	90,929	1.28
2018	291	-	291	77,652	-	77,652	11,638	89,291	1.25
2019	294	-	294	78,429	-	78,429	11,755	90,184	1.27
2020	297	-	297	79,213	-	79,213	11,872	91,086	1.28
2021	300	-	300	80,005	-	80,005	11,991	91,996	1.29
2022	303	-	303	80,805	-	80,805	12,111	92,916	1.30
2023	306	-	306	81,613	-	81,613	12,232	93,846	1.32

In CY2023, five years after project completion, a need for 2 special purpose operating rooms is estimated. Washington Adventist Hospital operates a comprehensive interventional and cardiac surgical program which is regional in nature and serves as cardiac surgery backup to other interventional cardiology hospitals in the area. In order to service the projected special purpose cases and to provide sufficient backup to Washington Adventist Hospital's own interventional cardiology program as well as regional backup, no less than 2 special purpose operating rooms are required and are therefore proposed in this replacement hospital project.

(6) 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.

(7) 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 not include any design features that are at variance with the current FGI Guidelines.

(8) 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.

(9) 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).

(10) 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 is 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 32-35. As described in the above, the projected cost per square foot does not exceed the Marshall Valuation Service® benchmark cost.

(11) 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.

Answers to questions posed by the Maryland Health Care Commission on March 4, 2014 are asked and answered below:

PART III -- CONSISTENCY WITH GENERAL REVIEW CRITERIA

COMAR 10.24.17

3. **As an existing cardiac surgery program, Washington Adventist's cardiac surgery program should be able to document compliance with standards set out in COMAR 10.24.17.06 B. Cardiac Surgery Standards. Please address 10.24.17.06 B.2 Quality Review Program for Cardiac Surgery, which states that:**

   Each applicant proposing cardiac surgery services shall have utilization or peer review and control programs, or both, with regularly scheduled conferences to:

   (a) Establish protocols that govern the referral, admission, and discharge or cardiac surgery patients;
   Please provide a copy of these protocols.

APPLICANT RESPONSE:

Protocols are developed and reviewed by the Cardiac Surgery Quality Collaborative Group which meets bi-monthly in conjunction with the Critical Care Committee of Washington Adventist Hospital. Standard orders are used for preoperative and postoperative care, and the transfer of patients out of the ICU into the Cardiac Telemetry Step Down Unit. (See Exhibits 59-61). These orders are based on the following sections of the Washington Adventist Hospital Patient Care Policy Manual:

a) ADMISSIONS/DISCHARGE/TRANSFER CRITERIA: ICU/CCU (Exhibit 62 Policy WAH 5614)

b) ADMISSIONS/DISCHARGES/TRANSFERS FOR THE CARDIAC TELEMETRY UNITS (Exhibit 63 Policy WAH 5615)

c) ADMISSION/DISCHARGE/TRANSFER CRITERIA FOR THE IMCU (Exhibit 64 Policy WAH 5617)

Inpatient care and discharge planning are governed by the following hospital policies:

a. INTERDISCIPLINARY CARE & DISCHARGE PLANNING (Exhibit Policy 65 WAH 5921)

b. DISCHARGE OF PATIENT (Exhibit 66 Policy WAH 5922)

Quality metrics are measured through the Society of Thoracic Surgeons (STS) Cardiac Surgery Registry. Results are reviewed quarterly with a multidisciplinary team encompassing the entire Cardiac Surgery team. Individual case reviews done through the Physician Professional and Executive Council.

(b) Establish and review a list of indications and contraindications to govern patient selection for cardiac surgery;
Please provide these lists.

APPLICANT RESPONSE:

Indications and contraindications for surgery are based on guidelines established by the American College of Cardiology and the American Heart Association (2011 ACCCF/AHA Guideline for Coronary Artery Bypass Graft Surgery: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines, *Circulation*, 2011; 124:e652-e735; originally published online November 7, 2011; doi: 10.1161/CIR.0b013e31823c074e). Treatment goals are to improve survival and to relieve symptoms. Each patient is evaluated by a cardiologist and the surgeon with the following considerations:

a) Anatomic setting
b) Clinical setting
c) Patient comorbidities
d) STS risk score

Discussion is then carried out with the patient as to the proposed course of treatment.

(c) Establish a program to educate patients about treatment options;
Describe the program that is in place to educate patients about treatment options.

APPLICANT RESPONSE:
Prior to surgery patients are seen, examined and counseled by the surgeon and the Cardiac Nurse Practitioner team on the following:

a) Objectives of and rationale for surgery
b) Alternative treatment options
c) Risks and possible complications
d) Projected postoperative course and recovery

This counseling may occur in the outpatient setting at the hospital and surgeon's office for elective cases and in the inpatient setting at the hospital for urgent/emergent cases.

(d) Establish and review guidelines governing the admission of cardiac surgery patients to the intensive care, coronary care and progressive care units, and of discharge from these units;
Provide a copy of these guidelines.

APPLICANT RESPONSE:

The following guidelines are used in the admission and discharge of patients to and from the ICU/CCU, Progressive Care Unit, and Cardiac Telemetry/Step Down Unit:

a) ADMISSIONS/DISCHARGE/TRANSFER CRITERIA: ICU/CCU (Exhibit 62 Policy WAH 5614)

b) ADMISSIONS/DISCHARGES/TRANSFERS FOR THE CARDIAC TELEMETRY UNITS (Exhibit 63 Policy WAH 5615)

c) ADMISSION/DISCHARGE/TRANSFER CRITERIA FOR THE IMCU (Exhibit 64 Policy WAH 5617)

(e) Review morbidity and mortality rates and other indicators of patient outcomes, and compliance with established processes of care as compared with regional or national averages;
Please provide the morbidity and mortality statistics associated with the WAH cardiac surgery program between 2008 and 2013.

APPLICANT RESPONSE:

Quality metrics are gathered through the STS Cardiac Surgery Data Base and reviewed quarterly by a multidisciplinary group. Data is listed below:

Risk-Adjusted Major Procedures Mortality

In-hospital Mortality	WAH	Like	STS	Number of Cases
2013	**0.8%**	**1.8%**	**1.9%**	**263**
2012	1.0%	1.9%	2.0%	295
2011	2.7%	1.8%	2.0%	294
2010	1.7%	2.0%	2.1%	336
2009	2.6%	2.1%	2.1%	405
2008	3.2%	2.2%	2.2%	415
Operative Mortality	**WAH**	**Like**	**STS**	**Number of Cases**
2013	**1.1%**	**2.2%**	**2.4%**	**263**
2012	1.4%	2.3%	2.4%	295
2011	3.4%	2.3%	2.4%	294
2010	2.3%	2.4%	2.4%	336
2009	2.7%	2.5%	2.5%	405
2008	3.2%	2.6%	2.5%	415

Any Reoperations

Any Reoperations	WAH	Like	STS	Number of Cases
2013	**2.9%**	**3.4%**	**3.7%**	**213**
2012	4.7%	3.9%	4.0%	233
2011	5.6%	4.0%	4.2%	254
2010	9.4%	4.1%	4.2%	305
2009	7.4%	4.6%	4.6%	359
2008	7.7%	4.8%	4.8%	364

Deep Sternal Wound Infections

DSWI	WAH	Like	STS	Number of Cases
2013	**0.0%**	**0.2%**	**0.3%**	**213**
2012	0.0%	0.2%	0.2%	233
2011	0.3%	0.3%	0.3%	254
2010	0.7%	0.3%	0.3%	305
2009	0.2%	0.4%	0.4%	359
2008	0.3%	0.4%	0.4%	364

Cerebrovascular Accident

CVA	WAH	Like	STS	Number of Cases
2013	**1.6%**	**1.2%**	**1.2%**	**213**
2012	1.0%	1.3%	1.3%	233
2011	0.9%	1.2%	1.2%	254
2010	3.8%	1.2%	1.2%	305
2009	1.8%	1.2%	1.2%	359
2008	1.9%	1.2%	1.2%	364

Renal Failure

RF	WAH	Like	STS	Number of Cases
2013	**0.8%**	**1.7%**	**2.1%**	**213**
2012	2.0%	1.9%	1.9%	233
2011	1.2%	3.0%	3.2%	254
2010	2.7%	3.3%	3.5%	305
2009	2.3%	3.7%	3.7%	359
2008	2.8%	3.7%	3.6%	364

Prolonged Ventilator Time

Prolonged Vent	WAH	Like	STS	Number of Cases
2013	**5.3%**	**8.0%**	**8.8%**	**213**
2012	10.0%	9.3%	10.1%	233
2011	11.0%	9.8%	10.5%	254
2010	14.2%	9.3%	10.2%	305
2009	10.5%	10.3%	10.8%	359
2008	12.6%	10.8%	10.9%	364

30 Day Readmission

Readmission 30 Days (N-RA)	WAH	Like	STS	Number of Cases
2013	**3.3%**	**9.4%**	**9.5%**	**213**
2012	8.2%	10.2%	10.1%	233
2011	12.9%	10.0%	10.1%	254
2010	15.0%	9.7%	9.8%	305
2009	13.2%	9.8%	9.8%	359
2008	5.4%	10.0%	9.6%	364

Data is aggregated by the STS into an overall STAR rating which ranges from one star (below average) to three stars (above average). Washington Adventist Hospital currently has a rating of three stars based on elements of this data. Washington Adventist Hospital is also a founding member of the Maryland Cardiac Surgery Quality Initiative (MCSQI) a statewide group recently formed to promote best practices and attainment of highest quality in Cardiac Surgery centers in Maryland.

(f) Establish and review compliance with physician minimum volume guidelines recommended by the American College of Cardiology, the American College of Surgeons, or other appropriate professional organization; and

Please provide data comparing the volume of WAH cardiac surgeons to the minimum volume guidelines promulgated by the American College of Cardiology, the American College of Surgeons, or other appropriate professional organization.

APPLICANT RESPONSE:

At present we cannot identify a definitive published minimum volume guideline for cardiac surgery, however Washington Adventist Hospital through its Department of Surgery, Thoracic and Cardiac Surgery Subsection has defined specific volume standards to perform cardiac surgery at this institution. (See Exhibit 67 Appendix X Washington Adventist Hospital Department of Surgery Rules and Regulations) Minimum volume for those who are on staff four or more years is 40 surgeries per year. Those surgeons falling below this minimum the prior year are sent a letter from the Medical Staff Office and the Chief Medical Officer to provide evidence from Washington Adventist Hospital and other surrounding hospitals where they are privileged that they have performed this minimum. If there is no response within 30 days and/or insufficient evidence of volume, privileges to perform cardiac surgery are suspended.

(g) Establish mechanisms for monitoring long-term outcomes of discharged patients.
Describe the mechanisms that WAH has in place or will be implementing to monitor long term outcomes of discharged cardiac surgery patients.

APPLICANT RESPONSE:

Patients are followed upon discharge with a visit to the surgeon and subsequent follow up by the referring cardiologist. At the appropriate time, patients are also referred to Cardiac Rehabilitation where they are monitored and placed on an individualized reconditioning protocol. In addition, Washington Adventist Hospital is cooperating with the STS in initiatives for a longitudinal follow up study of cardiac surgery patients.

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 residents of 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).

MSGA BED NEED ANALYSIS FOR WASHINGTON ADVENTIST HOSPITAL

Washington Adventist Hospital is currently licensed for 232 beds, of which 171 are MSGA beds. The proposed replacement hospital for Washington Adventist Hospital will have 152 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

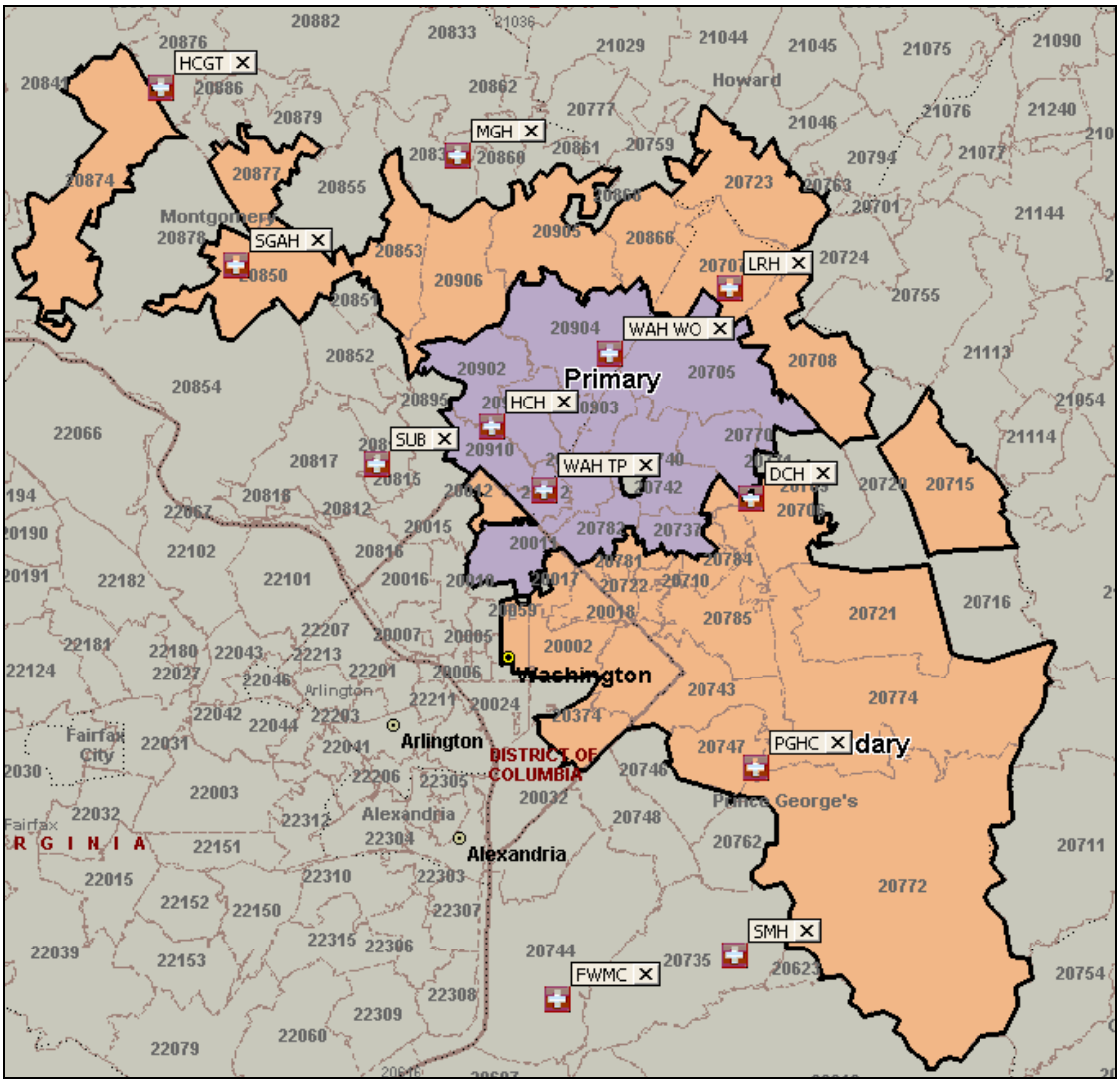
In CY2013, the Washington Adventist Hospital PSA for MSGA discharges consisted of 13 zip codes, 6 located in Montgomery County, 6 located in Prince George's County, and 1 located in the District of Columbia, with the largest number of discharges coming from zip code 20783 (Hyattsville). Washington Adventist Hospital realized 60.1% market share within 20783 (Hyattsville) and 60.6% of market share within its home zip code 20912 (Takoma Park). Washington Adventist Hospital's market share within its PSA for MSGA discharges was 25.4%.

The Washington Adventist Hospital TSA is comprised of 43 zip codes, 13 located in Montgomery County, 21 located in Prince George's County, 1 in Howard County, and 8 located in the District of Columbia, listed below.

CY2013 MSGA WASHINGTON ADVENTIST HOSPITAL TSA

Zip Code	City	Service Area	Discharges	% of Total	Cumulative
20783	Hyattsville	Primary	1,259	14.8%	14.8%
20912	Takoma Park	Primary	716	8.4%	23.3%
20782	Hyattsville	Primary	700	8.2%	31.5%
20903	Silver Spring	Primary	391	4.6%	36.1%
20901	Silver Spring	Primary	336	4.0%	40.1%
20904	Silver Spring	Primary	318	3.7%	43.8%
20740	College Park	Primary	293	3.5%	47.3%
20910	Silver Spring	Primary	267	3.1%	50.4%
20705	Beltsville	Primary	191	2.2%	52.7%
20011	Washington	Primary	184	2.2%	54.8%
20737	Riverdale	Primary	182	2.1%	57.0%
20902	Silver Spring	Primary	162	1.9%	58.9%
20770	Greenbelt	Primary	148	1.7%	60.6%
20784	Hyattsville	Secondary	126	1.5%	62.1%
20706	Lanham	Secondary	125	1.5%	63.6%
20781	Hyattsville	Secondary	124	1.5%	65.0%
20906	Silver Spring	Secondary	118	1.4%	66.4%
20712	Mount Rainier	Secondary	117	1.4%	67.8%
20785	Hyattsville	Secondary	117	1.4%	69.2%
20012	Washington	Secondary	109	1.3%	70.5%
20707	Laurel	Secondary	103	1.2%	71.7%
20708	Laurel	Secondary	78	0.9%	72.6%
20722	Brentwood	Secondary	77	0.9%	73.5%
20743	Capitol Heights	Secondary	77	0.9%	74.4%
20019	Washington	Secondary	65	0.8%	75.2%
20017	Washington	Secondary	64	0.8%	75.9%
20020	Washington	Secondary	63	0.7%	76.7%
20774	Upper Marlboro	Secondary	63	0.7%	77.4%
20002	Washington	Secondary	61	0.7%	78.1%
20747	District Heights	Secondary	59	0.7%	78.8%
20710	Bladensburg	Secondary	56	0.7%	79.5%
20018	Washington	Secondary	54	0.6%	80.1%
20905	Silver Spring	Secondary	52	0.6%	80.8%
20877	Gaithersburg	Secondary	45	0.5%	81.3%
20721	Bowie	Secondary	43	0.5%	81.8%
20772	Upper Marlboro	Secondary	42	0.5%	82.3%
20866	Burtonsville	Secondary	41	0.5%	82.8%
20715	Bowie	Secondary	38	0.4%	83.2%
20874	Germantown	Secondary	38	0.4%	83.7%
20850	Rockville	Secondary	36	0.4%	84.1%
20853	Rockville	Secondary	36	0.4%	84.5%
20723	Laurel	Secondary	34	0.4%	84.9%
20001	Washington	Secondary	31	0.4%	85.3%

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 accessible 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 20866, Burtonsville, is closest to Laurel Regional Hospital yet Laurel has only 11.9% market share while Holy Cross Hospital is ranked 3rd in distance but has the largest market share of 33.3%. MedStar Montgomery is ranked as the second closest hospital but only has 9.4% market share. If Washington Adventist Hospital relocates to White Oak, it is estimated that it will take an additional 15% of the market as a result of its proximity to Burtonsville, 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 20866 – Burtonsville		
	To Washington Adventist Hospital - Takoma Park	To Washington Adventist Hospital - White Oak
Distance	12.1 miles	6.0 miles
Drive time	22.0 minutes	12.0 minutes

Source: Based on Travel Time Study (Exhibit 24)

Hospital	**Market Share**	**Ranked - Closest hospital by proximity**
Laurel Regional Hospital	11.9%	1
MedStar Montgomery	9.4%	2
Holy Cross Hospital	33.3%	3
Washington Adventist Hospital	6.7%	4
Doctors Community Hospital	1.3%	5
Suburban Hospital	4.4%	6
Prince Georges Hospital Center	0.6%	7
Shady Grove Adventist Hospital	2.3%	8
Southern Maryland	0.3%	9
Others	29.9%	-
Total	100.0%	

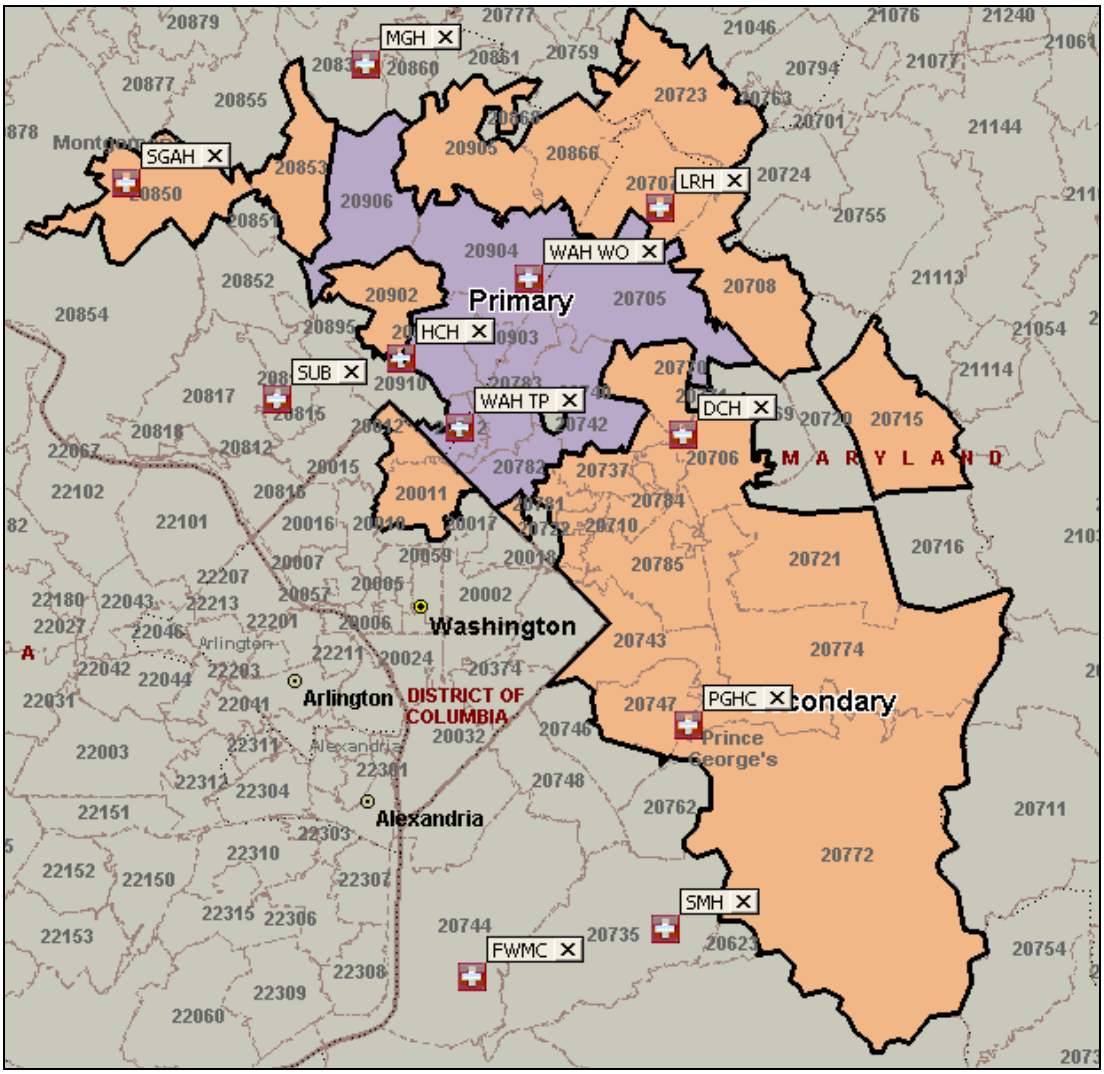
Taking into account all of the factors and methodology listed above, the following adjustments to the Washington Adventist Hospital MSGA TSA were considered:

WASHINGTON ADVENTIST HOSPITAL MSGA TSA Market Share Analysis of Proposed Location

Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	60.1%	-15.0%	45.1%
20912	Takoma Park	60.6%	-15.0%	45.6%
20782	Hyattsville	55.2%	-15.0%	40.2%
20903	Silver Spring	37.5%	3.0%	40.5%
20901	Silver Spring	20.2%	5.0%	25.2%
20904	Silver Spring	9.3%	45.0%	54.3%
20740	College Park	26.3%	-1.0%	25.3%
20910	Silver Spring	15.1%	-15.0%	0.1%
20705	Beltsville	14.8%	10.0%	24.8%
20011	Washington	26.8%	-17.0%	9.8%
20737	Riverdale	18.3%	-15.0%	3.3%
20902	Silver Spring	6.6%	0.0%	6.6%
20770	Greenbelt	11.8%	2.0%	13.8%
20784	Hyattsville	8.1%	-1.0%	7.1%
20706	Lanham	5.1%	-1.0%	4.1%
20781	Hyattsville	22.8%	-15.0%	7.8%
20906	Silver Spring	2.6%	5.0%	7.6%
20712	Mount Rainier	42.2%	-20.0%	22.2%
20785	Hyattsville	4.8%	-1.0%	3.8%
20012	Washington	38.2%	-15.0%	23.2%
20707	Laurel	5.1%	5.0%	10.1%
20708	Laurel	5.7%	1.0%	6.7%
20722	Brentwood	25.1%	-15.0%	10.1%
20743	Capitol Heights	2.9%	-1.0%	1.9%
20019	Washington	6.5%	-6.5%	0.0%
20017	Washington	32.2%	-17.0%	15.2%
20020	Washington	10.1%	-10.1%	0.0%
20774	Upper Marlboro	2.9%	-1.0%	1.9%
20002	Washington	14.1%	-14.1%	0.0%
20747	District Heights	2.7%	0.0%	2.7%
20710	Bladensburg	11.0%	-1.0%	10.0%
20018	Washington	21.5%	-17.0%	4.5%
20905	Silver Spring	5.6%	15.0%	20.6%
20877	Gaithersburg	2.2%	-1.0%	1.2%
20721	Bowie	3.2%	0.0%	3.2%
20772	Upper Marlboro	2.0%	0.0%	2.0%
20866	Burtonsville	6.7%	15.0%	21.7%
20715	Bowie	2.1%	0.0%	2.1%
20874	Germantown	1.5%	-1.5%	0.0%
20850	Rockville	1.4%	0.0%	1.4%
20853	Rockville	2.2%	0.0%	2.2%
20723	Laurel	2.6%	5.0%	7.6%
20001	Washington	14.7%	-14.7%	0.0%
Total Service Area		**11.5%**	**0.8%**	**12.3%**

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 the overall market share of the hospital by approximately 0.8%. 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 10 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 838.6 thousand in CY2010, 862.1 thousand residents in CY2013, and 900.4 thousand residents in CY2018. This implies an overall increase in the population of approximately 2.8% between CY2010 and CY2013.

Demonstrated in the table below, MSGA discharges in the Washington Adventist Hospital/White Oak TSA decreased 10.7% between CY2009 and CY2013. In the Washington Adventist Hospital/White Oak TSA, Medicare[1] discharges have decreased 4.6% since CY2009 and non-Medicare discharges have decreased by 15.7%.

MSGA Discharges within WAH - White Oak TSA

Provider	2009	2010	2011	2012	2013	5-Year Change
Washington Adventist	9,413	8,750	7,884	7,357	6,474	-31.2%
Holy Cross	10,970	11,305	11,328	11,168	10,947	-0.2%
Montgomery General	4,272	4,375	4,072	3,841	3,404	-20.3%
Shady Grove Adventist	2,914	2,966	2,906	3,010	2,801	-3.9%
Suburban Hospital Center	2,664	2,685	2,674	2,757	2,739	2.8%
Laurel Regional Hospital	3,192	2,788	2,392	2,629	2,857	-10.5%
Prince Georges Hospital Ctr	6,830	6,580	5,720	5,047	4,887	-28.4%
Southern Maryland	3,054	3,136	3,208	2,973	2,441	-20.1%
Fort Washington Hospital	169	184	161	159	148	-12.4%
Doctors Community Hospital	9,287	10,166	9,611	8,510	8,096	-12.8%
Other Provider	7,629	8,003	8,544	9,090	9,114	19.5%
Total	60,394	60,938	58,500	56,541	53,908	-10.7%

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 14.2% from 2009 to 2013 or from 72.9 to 62.5 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.

Use Rates within WAH – White Oak TSA

WAH - White Oak TSA	2009	2010	2011	2012	2013	5-Year Change
Population	828,766	838,647	846,115	853,932	862,113	4.0%
Discharges	60,394	60,938	58,500	56,541	53,908	-10.7%
Use Rates	72.9	72.7	69.1	66.2	62.5	-14.2%
YoY Change		***-0.3%***	***-4.8%***	***-4.2%***	***-5.6%***	

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

CY2013 Use Rates by Age cohort and Zip Code within the WAH – White Oak TSA

Zip Code	City	Age 15-44	Age 45-64	Age 65-74	Age 75+	Total
20904	Silver Spring	23.9	57.4	132.2	305.3	74.5
20783	Hyattsville	24.9	73.6	139.7	335.3	57.0
20912	Takoma Park	24.3	55.7	166.7	351.8	59.6
20782	Hyattsville	21.6	56.0	133.1	243.5	50.8
20903	Silver Spring	24.5	71.6	131.9	378.6	60.4
20901	Silver Spring	17.3	54.3	141.2	306.0	56.6
20906	Silver Spring	21.7	59.8	128.0	289.6	83.1
20705	Beltsville	21.0	70.1	150.0	224.5	59.7
20740	College Park	12.6	64.5	160.4	350.3	45.9
20707	Laurel	24.6	87.5	179.9	388.3	75.8
20905	Silver Spring	17.0	47.9	123.6	292.9	59.8
20770	Greenbelt	28.0	69.1	170.3	295.4	61.9
20902	Silver Spring	21.7	59.3	127.6	329.6	61.7
20866	Burtonsville	20.4	61.9	118.6	334.1	55.1
20784	Hyattsville	30.2	89.3	178.2	344.2	71.6
20706	Lanham	34.6	87.3	167.2	360.4	81.2
20723	Laurel	23.6	63.4	148.6	329.6	55.2
20785	Hyattsville	37.1	116.4	180.1	324.7	86.7
20708	Laurel	28.2	84.1	171.0	397.9	68.4
20712	Mount Rainier	11.2	64.5	87.9	183.4	38.2
20747	District Heights	30.5	82.9	171.7	275.4	69.3
20710	Bladensburg	23.9	89.6	182.0	340.5	68.6
20743	Capitol Heights	32.3	99.7	169.1	313.2	84.9
20721	Bowie	22.1	47.1	132.8	360.4	59.9
20781	Hyattsville	24.0	72.7	140.6	336.4	57.7
20772	Upper Marlboro	21.6	58.0	149.5	368.4	60.2
20774	Upper Marlboro	26.6	56.5	122.4	244.1	59.0
20715	Bowie	29.8	71.3	146.8	350.2	85.2
20850	Rockville	16.7	46.3	110.6	378.2	65.1
20853	Rockville	22.1	51.3	108.7	289.9	65.6
20737	Riverdale	29.2	77.6	163.2	389.0	62.5

* Chart excludes Washington DC Zip Codes

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 50-68 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.

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.[2] Having increased access to healthcare for the uninsured and underinsured will result in higher use rates for this population.

While further declines in use rates by shifts to outpatient and observation stays may be offset by an improving economy, an aging population and those populations who would receive improved access to coverage, we have taken a conservative approach in projecting bed need. We have assumed use rates will decline an additional 5% in 2014, 2015, and 2016. Considering use rates declined 5.6% in the Washington Adventist Hospital – White Oak TSA between 2012 and 2013, this assumption will indicate a total use rate change of approximately negative 15% between 2013 and 2016.

Taking into account the estimated population growth and the forecasted declining use rates, a baseline projection was developed, reflecting the changes that will occur based on population size and age composition. Using Nielsen Claritas data, population estimates were calculated by zip code and age cohort (15-44, 45-64, 65-74, and 75+) and estimated usage rates were applied to determine the projected discharges in CY2023.

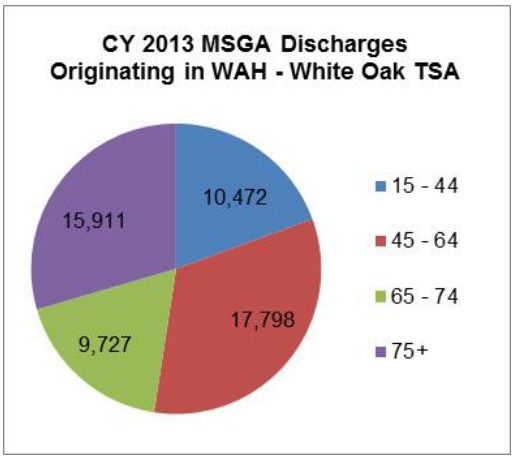
Population Estimates by Age Cohort Originating in WAH's TSA

Ages	2013	2023	Total Change	Annual Change
15 - 44	453,329	441,124	-2.7%	-0.3%
45 - 64	280,666	312,667	11.4%	1.1%
65 - 74	72,949	123,277	69.0%	6.4%
75+	55,269	71,399	29.2%	2.6%
Total	862,113	948,475	10.0%	1.0%

Use Rates by Age Cohort Originating in WAH's TSA

Ages	2013	2023	Total Change	Annual Change
15 - 44	23.1	19.6	-15.0%	-1.6%
45 - 64	63.4	53.9	-15.0%	-1.6%
65 - 74	133.3	113.8	-14.6%	-1.6%
75+	287.9	248.9	-13.6%	-1.4%
Total	62.5	60.4	-3.4%	-0.3%

The table below summarizes the estimated discharges considered over the 10-year period.



Discharge Estimates by Age Cohort Originating in WAH's TSA

Ages	2013	2023	Total Change	Annual Change
15 - 44	10,472	8,662	-17.3%	-1.9%
45 - 64	17,798	16,854	-5.3%	-0.5%
65 - 74	9,727	14,033	44.3%	3.7%
75+	15,911	17,768	11.7%	1.1%
Total	**53,908**	**57,317**	**6.3%**	**0.6%**

Source: HSCRC data base and Nielson Claritas population projections

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

A total of 57,317 discharges in CY2023 was estimated for the Washington Adventist Hospital/White Oak TSA, which indicates absolute growth of approximately 6.3% over the 10-year period, or an increase of 3,409 incremental discharges. Total Medicare discharges (patients 65 and older) are estimated to increase from 25,638 in CY2013 to 31,801 in CY2023, indicating growth of 24.0% and total non-Medicare discharges (patients 15 through 64) are estimated to decrease from 28,270 in CY2013 to 25,516 in CY2023, indicating a decline of 9.7%.

(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 Adventist Hospital/White Oak TSA and increased 12.4% for non-Medicare patients during this time period.

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

Provider	2009	2010	2011	2012	2013	5-Year Change
Washington Adventist	5.4	5.5	5.7	5.9	5.9	7.7%
Holy Cross	4.8	4.6	4.7	4.8	4.8	-0.3%
Montgomery General	4.6	4.7	4.3	4.3	4.2	-9.6%
Shady Grove Adventist	5.2	5.6	5.5	5.6	5.3	1.4%
Suburban Hospital Center	4.4	4.6	4.6	4.8	4.4	-0.3%
Laurel Regional Hospital	5.1	5.2	5.1	4.9	4.2	-16.7%
Prince Georges Hospital Ctr	6.2	6.5	6.2	6.6	6.3	1.6%
Southern Maryland	4.1	4.2	4.4	4.5	4.5	8.4%
Fort Washington Hospital	4.8	3.5	4.4	4.1	4.3	-9.8%
Doctors Community Hospital	4.9	5.2	5.2	5.4	5.4	10.2%
Other Provider	6.2	6.4	6.5	6.2	6.3	0.8%
Total	5.2	5.2	5.2	5.3	5.2	1.5%

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

Provider	2009	2010	2011	2012	2013	5-Year Change
Washington Adventist	4.0	4.3	4.4	4.9	5.2	30.7%
Holy Cross	4.0	3.9	4.0	4.2	4.4	8.7%
Montgomery General	4.0	3.8	3.8	3.7	3.6	-10.2%
Shady Grove Adventist	4.0	3.9	4.2	4.3	4.2	3.8%
Suburban Hospital Center	4.0	3.9	3.9	4.2	3.9	-3.8%
Laurel Regional Hospital	3.7	3.8	3.8	3.7	3.6	-5.1%
Prince Georges Hospital Ctr	4.4	4.6	4.8	5.4	5.3	22.5%
Southern Maryland	3.3	3.3	3.4	3.8	3.8	17.4%
Fort Washington Hospital	3.6	3.2	3.4	2.8	3.3	-9.5%
Doctors Community Hospital	3.5	3.6	3.8	4.3	4.1	16.4%
Other Providers	5.4	5.6	5.5	5.9	5.6	2.2%
Total	4.1	4.2	4.3	4.7	4.6	12.4%

We applied the overall CY2013 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 964 beds. We recognized that historically, 20.2% 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 778 for patients going to acute care facilities within Montgomery and Prince George's County. See calculations below.

	Total Bed Need for Discharges Originating in WAH - White Oak TSA				
	CY2023 Admissions	ALOS	Days	Occupancy	Bed Need
Medicare	31,801	5.2	166,565	80.0%	570
Non-Medicare	25,516	4.6	117,826	80.0%	404
Total	**57,317**	**5.0**	**284,391**	**N/A**	**974**
CY2013 Market Share Leaving Montgomery & Prince George's County				20.2%	196
Beds Needed in Montgomery & Prince George County Hospitals					778

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	FY2015 Total Licensed MSGA Beds	MSGA Beds Serving WAH - WO TSA
Washington Adventist	35,605	46,915	75.9%	171	130
Holy Cross	50,253	77,036	65.2%	277	181
Montgomery General	13,691	25,119	54.5%	87	47
Shady Grove Adventist	13,575	63,723	21.3%	224	48
Suburban Hospital Center	11,379	51,397	22.1%	190	42
Laurel Regional Hospital	11,004	14,148	77.8%	50	39
Prince Georges Hospital Ctr	27,660	40,921	67.6%	141	95
Southern Maryland	10,063	45,870	21.9%	148	32
Fort Washington Hospital	540	8,522	6.3%	31	2
Doctors Community Hospital	37,648	49,165	76.6%	182	139
Total	**211,418**	**447,234**	**N/A**	**1,501**	**756**

Further analysis shows an additional net bed need of 36 for the Washington Adventist Hospital/White Oak TSA. This calculation of additional beds takes into account Washington Adventist Hospital's current licensed beds of 171 as well as the proposed reduction of beds at the replacement hospital. 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.

Net Bed Need for WAH - White Oak TSA	
	Bed Need
Beds Needed at Montgomery & Prince George's County Hospitals	**778**
Beds Available to Serve TSA in M & PG County	(756)
Net Bed Need Considering FY2015 Licensed Beds	**22**
Proposed WAH MSGA Bed Reduction	19
WAH % MSGA Days from WAH - WO TSA	75.9%
Proposed Reduction Serving WAH - White Oak TSA	**14**
Net Bed Need	**36**

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.

OBSTETRIC BED NEED ANALYSIS FOR WASHINGTON ADVENTIST HOSPITAL

Washington Adventist Hospital is currently licensed for 232 beds, of which 21 are licensed for obstetric ("OB") services. The proposed Washington Adventist Hospital replacement facility will include 18 OB beds, indicating a reduction of 3 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.

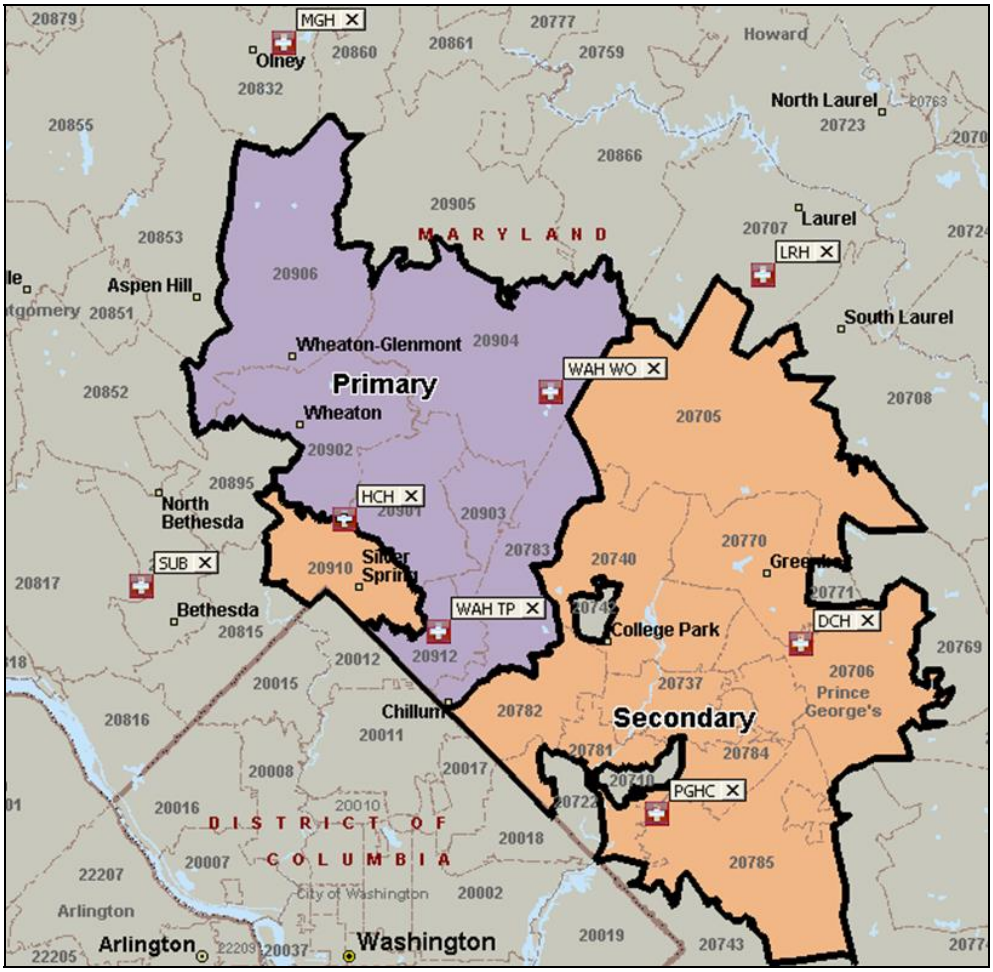
(1) Service Area

Zip Code	City	Service Area	Discharges	% of Total	Cumulative
20783	Hyattsville	Primary	207	12.6%	12.6%
20903	Silver Spring	Primary	190	11.5%	24.1%
20912	Takoma Park	Primary	162	9.8%	34.0%
20902	Silver Spring	Primary	138	8.4%	42.3%
20901	Silver Spring	Primary	114	6.9%	49.3%
20906	Silver Spring	Primary	113	6.9%	56.1%
20904	Silver Spring	Primary	81	4.9%	61.1%
20782	Hyattsville	Secondary	60	3.6%	64.7%
20705	Beltsville	Secondary	48	2.9%	67.6%
20910	Silver Spring	Secondary	47	2.9%	70.5%
20706	Lanham	Secondary	46	2.8%	73.3%
20737	Riverdale	Secondary	45	2.7%	76.0%
20770	Greenbelt	Secondary	34	2.1%	78.1%
20785	Hyattsville	Secondary	28	1.7%	79.8%
20740	College Park	Secondary	26	1.6%	81.3%
20784	Hyattsville	Secondary	24	1.5%	82.8%
20712	Mount Rainier	Secondary	18	1.1%	83.9%
20781	Hyattsville	Secondary	18	1.1%	85.0%

In CY2013, the Washington Adventist Hospital PSA for OB discharges consisted of 7 zip codes, 6 located in Montgomery County and 1 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 38.1% market share within 20783 and 42.4% of market share within its home zip code 20912. Washington Adventist Hospital's market share within its PSA for OB discharges is 22.5%.

The Washington Adventist Hospital TSA is comprised of 18 zip codes, 7 located in Montgomery County and 11 located in Prince George County, listed below.

CY2013 OB Washington Adventist Hospital TSA



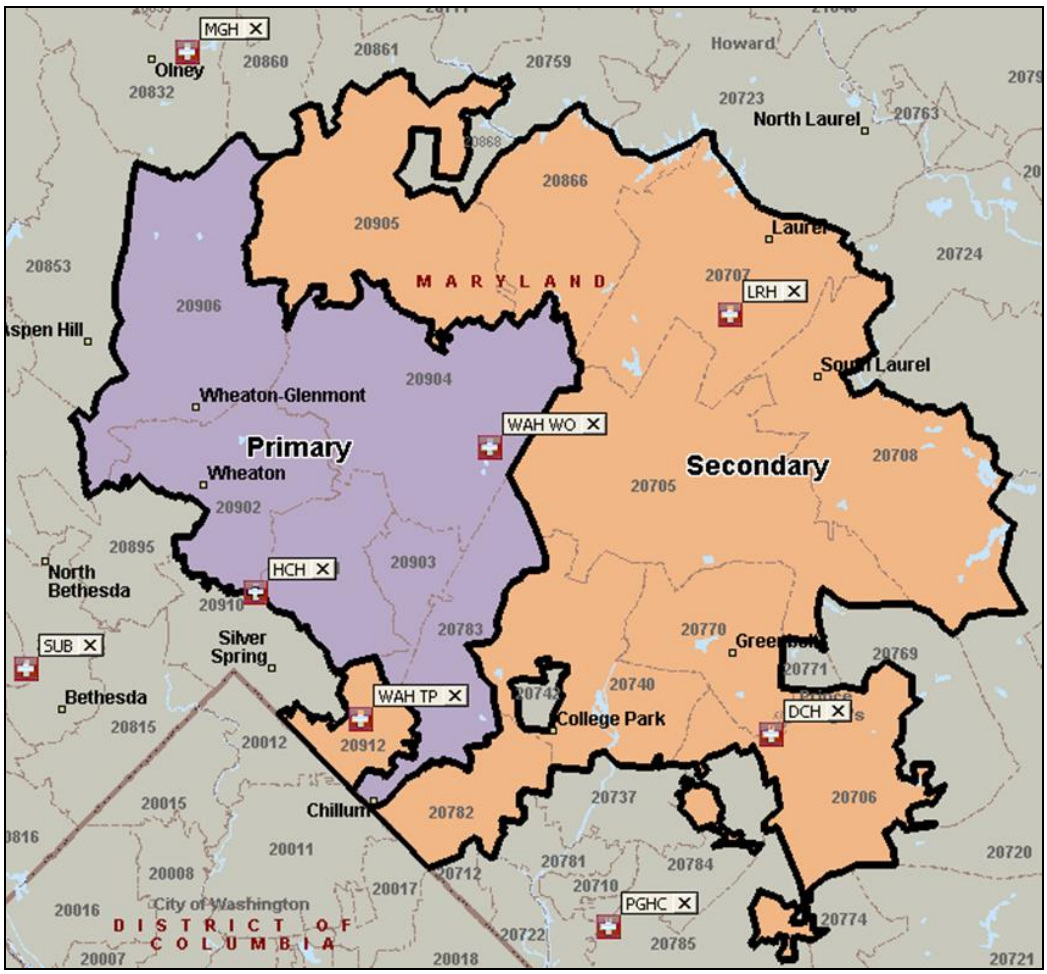
An analysis was performed to understand the expected differences in market share by zip code as a result of the proposed relocation to White Oak. Based on market dynamics that considers location of the new hospital, proximity to other hospitals, drive times, major streets and highways, current market 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	38.1%	0.0%	38.1%
20903	Silver Spring	38.5%	0.0%	38.5%
20912	Takoma Park	42.4%	-15.0%	27.4%
20902	Silver Spring	16.6%	5.0%	21.6%
20901	Silver Spring	20.1%	5.0%	25.1%
20906	Silver Spring	13.0%	5.0%	18.0%
20904	Silver Spring	10.5%	20.0%	30.5%
20782	Hyattsville	19.9%	-10.0%	9.9%
20705	Beltsville	13.6%	5.0%	18.6%
20910	Silver Spring	11.7%	-8.0%	3.7%
20706	Lanham	9.0%	0.0%	9.0%
20737	Riverdale	13.9%	-10.0%	3.9%
20770	Greenbelt	10.3%	0.0%	10.3%
20785	Hyattsville	5.4%	-3.0%	2.4%
20740	College Park	11.1%	0.0%	11.1%
20784	Hyattsville	5.7%	-5.7%	0.0%
20712	Mount Rainier	24.3%	-10.0%	14.3%
20781	Hyattsville	11.1%	-10.0%	1.1%
20707	Laurel	3.5%	5.0%	8.5%
20708	Laurel	3.3%	2.0%	5.3%
20866	Burtonsville	6.7%	5.0%	11.7%
20905	Silver Spring	4.9%	5.0%	9.9%
Total market share		**17.0%**	**1.4%**	**18.3%**

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 1.4% in the identified zip codes.

Primary and secondary service area for Washington Adventist Hospital/White Oak was redefined as follows:

CY2013 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 64 ("Female – Childbearing") within the Washington Adventist Hospital/White Oak TSA was estimated to be 187,300 in CY2010, and 188,638 in CY2013. This implies an overall increase in the population of approximately 0.5% between CY2010 and CY2013.

Demonstrated in the table below, OB discharges in the Washington Adventist Hospital/White Oak TSA decreased 3.0% between CY2010 and CY2011, remained flat between CY2011 and CY2012, and decreased an additional 3.6% between CY2012 and CY2013. The total change over the past five years was 6.7%.

OB Discharges within WAH - White Oak TSA

Provider	2009	2010	2011	2012	2013	5-Year Change
Washington Adventist	1,762	1,617	1,426	1,306	1,269	-28.0%
Holy Cross	4,025	4,009	4,050	4,111	4,026	0.0%
Montgomery General	300	293	293	306	273	-9.0%
Shady Grove Adventist	428	401	442	437	403	-5.8%
Suburban Hospital Center	1	1	2	4	1	0.0%
Laurel Regional Hospital	409	513	478	485	502	22.7%
Prince Georges Hospital Ctr	557	555	455	463	381	-31.6%
Southern Maryland	16	13	20	18	15	-6.3%
Fort Washington Hospital	-	-	-	-	1	0.0%
Doctors Community Hospital	22	24	15	15	10	-54.5%
Other Provider	423	504	509	551	532	25.8%
Total	7,943	7,930	7,690	7,696	7,413	-6.7%

The following table presents the use rates within the Washington Adventist Hospital-White Oak TSA for OB Services.

Use Rates within WAH – White Oak TSA

WAH - White Oak OB - TSA	2009	2010	2011	2012	2013	5-Year Change
Female Population (15-44)	118,181	118,421	117,895	117,374	116,859	-1.1%
OB Discharges (15-44)	7,911	7,904	7,667	7,663	7,383	-6.7%
Use Rates	66.9	66.7	65.0	65.3	63.2	-5.6%
Female Population (45-64)	67,358	69,831	70,797	70,797	71,779	6.6%
OB Discharges (45-64)	32	26	23	33	30	-6.3%
Use Rates	0.5	0.4	0.3	0.5	0.4	-12.0%
Female Population (15-65)	**185,539**	**187,300**	**187,726**	**188,172**	**188,638**	**1.7%**
OB Discharges	**7,943**	**7,930**	**7,690**	**7,696**	**7,413**	**-6.7%**
Use Rates	**42.8**	**42.3**	**41.0**	**40.9**	**39.3**	**-8.2%**

Population estimates, sourced from Nielsen Claritas, for the Female – Childbearing population and newborns within the Washington Adventist Hospital – White Oak TSA were examined. It was found that although the majority of the Female – Childbearing population, women ages 15-44, are estimated to decrease approximately 0.5% annually, newborns are expected to increase 0.5% annually. Therefore, an increase in the use rate of 1.0% was applied each year to consider the expected higher rate of births within the Washington Adventist Hospital – White Oak TSA.

Population Estimates within the WAH - White Oak TSA

Population	2013 Population	2023 Population	Total Change	Annual Change
Females (15 - 44)	116,859	111,462	-4.6%	-0.5%
Females (45 - 64)	71,779	78,382	9.2%	0.9%
Female - Childbearing	**188,638**	**189,844**	0.6%	0.1%
Newborns	**38,884**	**40,884**	5.1%	0.5%

The table below presents the projected OB discharges within the Washington Adventist Hospital – White Oak TSA.

OB Discharge Estimates within the WAH - White Oak TSA

Growth Estimate Based On:	2013 Discharges	2023 Estimated Discharges	Total Change	Annual Change
Female - Childbearing	7,413	7,817	5.4%	0.5%

(3) Estimated Bed Need

OB ALOS within the Washington Adventist Hospital/White Oak TSA decreased 11.0% over the five year period and the ALOS of 2.6 was considered to calculate patient days in CY2023

OB ALOS within WAH - White Oak TSA

Provider	2009	2010	2011	2012	2013	5-Year Change
Washington Adventist	2.8	2.8	2.6	2.5	2.5	-10.7%
Holy Cross	2.9	2.9	2.7	2.6	2.6	-11.1%
Montgomery General	2.7	2.6	2.5	2.5	2.6	-5.0%
Shady Grove Adventist	3.2	3.3	3.3	2.8	2.6	-19.7%
Suburban Hospital Center	3.0	1.0	2.5	3.0	6.0	100.0%
Laurel Regional Hospital	2.4	2.6	2.5	2.4	2.3	-6.1%
Prince Georges Hospital Ctr	2.9	2.8	3.0	2.7	2.8	-5.1%
Southern Maryland	2.6	2.5	2.8	2.7	3.1	19.7%
Doctors Community Hospital	-	-	-	-	1.0	0.0%
Other Provider	3.3	2.8	2.9	3.0	2.8	-17.4%
Total	2.9	2.8	2.7	2.6	2.6	-11.0%

Market Share Based on Days Within WAH - White Oak TSA

Provider	2009	2010	2011	2012	2013	Variance
Washington Adventist	21.6%	20.0%	17.8%	16.2%	16.7%	-3.6%
Holy Cross	50.8%	51.2%	52.1%	52.9%	54.4%	-0.7%
Montgomery General	3.6%	3.3%	3.5%	3.8%	3.8%	0.7%
Shady Grove Adventist	6.0%	5.9%	7.0%	6.1%	5.5%	1.0%
Suburban Hospital Center	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%
Laurel Regional Hospital	4.3%	5.9%	5.8%	5.7%	6.0%	1.9%
Prince Georges Hospital Ctr	7.1%	7.0%	6.4%	6.4%	5.6%	-0.8%
Southern Maryland	0.2%	0.1%	0.3%	0.2%	0.2%	0.0%
Doctors Community Hospital	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other Provider	6.2%	6.3%	7.0%	8.4%	7.7%	1.5%
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 84 beds. Recognizing that historically 7.7% 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 78 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				
	CY2023 Admissions	ALOS	Days	Occupancy	Bed Need
Population Estimates	7,817	2.6	20,019	65.0%	84
CY2013 Market Share Leaving Montgomery & Prince George's County				7.7%	7
Beds Needed in Montgomery & Prince George's County Hospitals					78

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	FY2015 Licensed OB Beds	OB Beds Serving WAH - White Oak TSA
Washington Adventist	3,169	4,275	74.1%	21	16
Holy Cross	10,329	22,840	45.2%	88	40
Montgomery General	712	1,871	38.1%	11	4
Shady Grove Adventist	1,038	13,673	7.6%	56	4
Suburban Hospital Center	6	31	19.4%	-	-
Laurel Regional Hospital	1,135	2,136	53.1%	10	5
Prince Georges Hospital Ctr	1,057	5,863	18.0%	38	7
Southern Maryland	46	4,921	0.9%	30	0
Fort Washington Hospital	1	29	3.4%	-	-
Doctors Community Hospital	24	85	28.2%	-	-
Total	**17,517**	**55,724**	**31.4%**	**254**	**76**

Further analysis shows that there is a net OB bed need of 4 for the Washington Adventist Hospital/White Oak TSA. This calculation of additional beds takes into account Washington

Adventist Hospital's current licensed beds of 21 as well as the proposed reduction of 3 beds at the replacement hospital

CY2023 Net Bed Need for WAH - White Oak TSA	
	Bed Need
Beds Needed at Montgomery & Prince George's County Hospitals	**78**
Beds Available to Serve WAH - White Oak TSA in M & PG County	(76)
Net Bed Need Considering FY2015 Licensed Beds	**2**
Proposed WAH OB Bed Reduction	3
WAH % of OB Days from WAH - WO TSA	74.1%
Proposed Reduction Serving WAH - White Oak TSA	**2**
Net Bed Need	**4**

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 discussed more fully 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 27) in Takoma Park 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 many of the 19 objectives identified by the Board within a shorter timeframe.

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-phase program of demolition and construction at the campus. The resulting hospital at Takoma Park would have a total of 200 beds and the project would take seven years to complete beginning with site preparation and demolition.

The on-campus alternative, known as “option 2,”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. As part of the process to develop this alternative, Washington Adventist Hospital commissioned a Campus Master Plan for the development of the Takoma Park site. The “on-campus alternative” includes the first three phases of the Campus Master Plan and includes two features comparable to the preferred option: all-private patient rooms and shell space for future flexibility. Private rooms are the industry standard and an option that retains semi-private rooms is not a comparable or preferred option.

Limitations of the Site

In looking at the Takoma Park site the first option that comes to mind is for Washington Adventist Hospital to simply construct larger towers to achieve bed capacity. Washington Adventist Hospital has considered this option and deemed it infeasible due to site limitations. The Takoma Park site has existing zoning restrictions that limit the height of new construction. The proposed Option 2 shows a design with modern floor heights that slightly exceeds the legal zoning limit by four feet. The current property is zoned R-60 Residential which requires a Montgomery County Special Exception for Hospital use (S-591). The Special Exception has binding restrictions on any future site development, its approval based on the fact that “proposed additions will not exceed the height of the existing hospital facility.” The belief is that this small dimension would not adversely affect the surrounding residential community and thus may not receive significant opposition. Proposing additional floors, however, would be a major change to the zoning and would be substantially inconsistent with the applicable zoning restriction. As such, the proposed design shows the most logical and cost-effective approach for this site that is reasonably expected to be achievable.

Another approach that was considered for the site was a single seven-story tower at the Takoma Park site. This option is also not feasible. A single, higher tower for the first phase would require matching substandard floor heights which would not work for modern healthcare standards without significant repercussions. Eleven feet floor heights would require more vertical shafts (to reduce or eliminate ducts) which will reduce efficiency and add cost. Even if Washington Adventist Hospital were to undertake such an effort, seven stories is a full story higher than the current buildings, requiring a major variance approval (as noted above). With standard floor heights (14'), a six-story building as proposed in the current Option 2 will still require a minor variance (or no variance with some trade-offs to lower floors). Were Washington Adventist Hospital to construct only one new tower with modern floor heights, the resulting floor transitions would require ramps or additional elevators to make up floor differences which would be an operational hindrance. A single tower scheme would use the only available free space on the site to gain some number of rooms, but the resulting tower would block future growth and effectively eliminate future expansion. Meanwhile, the small increase in bed capacity gained by this scenario would not solve the campus problem on the

existing rooms with low floor heights. Modernizing these rooms becomes more costly than constructing new. After reviewing these factors, Washington Adventist Hospital did not consider this viable.

The site and construction is not only limited by height. The Takoma Park Campus Master Plan (Exhibit 68) and Takoma Park On-Campus Alternative (Exhibit 69) describe the process to provide new space to replace aging existing buildings and note the limited availability, or lack of an "empty chair" for expansion on the campus. The current site restricted areas, including stream buffer setback and environmentally restricted areas, limits future site development. Slide 3 of the Campus Master Plan illustrates these site restrictions; the only available area to construct a new building is the location of Phase 1.

Further, unlike a simple addition to provide additional program space, an on-site replacement project like Option 2 has programmatic limitations; the replacement project must construct new versions of existing program departments before removing the existing departments. In the case of Option 2, Phase 1 is intended to replace patient- and non-patient service programs in the oldest of the buildings (the 1950s building) to allow for future removal of these buildings and greater density. Phase 1 includes three floors of patient service (Cardiac care on level 5, Maternity/OB couplet care on level 4, and Maternity/OB delivery/diagnostics on level 3). The other programs in Phase 1 replace departments in the 1950s building (e.g. laboratory, pharmacy, etc.) and provide parking (at the lower levels) to replace the parking lost to the new building footprint.

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 (Exhibit 68) that would form the basis for any future site redevelopment. This Campus Master Plan 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 68) 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 three Phases of the Campus Master Plan. (Exhibit 68-69).

Washington Adventist Hospital selected this stage in the Campus Master Plan because Phases 1-3 provide suitable program to improve the existing campus while still maintaining a reasonable project cost and schedule.

The Campus Master Plan illustrates 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 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, a building which would, in turn, be replaced in Phase 2.

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

- A new cardiac care unit
- New labor and delivery and diagnostics
- New laboratory, pharmacy, and respiratory areas.
- New heart center
- New medical same day unit
- New medical surgical unit
- New lobby
- New central utility plant by third-party developer

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

- New medical surgical unit
- New critical care unit
- New maternity unit
- New surgical suite
- New G.I. endoscopy suite
- New emergency department
- New admitting and radiology areas

- New cafeteria
- New structured parking by third-party developer

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.

Completion of Phase 3 would provide the following programs/departments:

- New medical surgical unit
- Shell space for future bed capacity and/or to accommodate Phase 4 relocation requirements.
- New behavioral health unit and renovation of existing unit
- New surgery to connect to Phase 2 surgery areas to provide contiguous department.
- New radiology
- New central warehouse

Cost

The total capital budget for the phased Takoma Park hospital construction is $351.2 million dollars including interest and inflation. Total new construction costs are $176.5 million with the balance of costs allocated to renovations, $5.5 million, and building demolition, $4.4 million; furniture, equipment and other capital costs $79.5 million; interest of $33.9 million and an inflation allowance to the mid-point of construction of $20.1 million.

Washington Adventist Hospital - Option 2
Phased Replacement at Takoma Park - Master Plan Phases 1, 2 & 3
CAPITAL BUDGET

			Hospital	Garage	Total
1.	Capital Costs				
	a.	New Construction			
	(1)	Building & Fixed Equipment	$ 150,000,000	$ 7,000,000	$ 157,000,000
	(2)	Fixed Equipment (Not Included in Construction)	3,300,000	-	$ 3,300,000
	(3)	Land Purchase	-	-	$ -
	(4)	Site Preparation - Land Improvements	1,000,000	-	$ 1,000,000
	(5)	Architect/Engineering Fees	13,900,000	500,000	$ 14,400,000
	(6)	Permits, (Building, Utilities, Etc.)	800,000	-	$ 800,000
		SUBTOTAL	$ 169,000,000	$ 7,500,000	$ 176,500,000
	b.	Renovations			
	(1)	Building demolition	$ 4,400,000	$ -	4,400,000
	(2)	Renovations	4,500,000	-	4,500,000
	(3)	Fixed Equipment (Not Included in Construction)	-	-	-
	(4)	Architect/Engineering Fees	1,000,000	-	1,000,000
	(5)	Permits, (Building, Utilities, Etc.)	-	-	-
		SUBTOTAL	$ 9,900,000	$ -	$ 9,900,000
	c.	Other Capital Costs			
	(1)	Major Movable Equipment	20,300,000	-	20,300,000
	(2)	Minor Movable Equipment	13,500,000	-	13,500,000
	(3)	Contingencies	11,200,000	1,100,000	12,300,000
	(4)	Other (Specify)		-	-
		a. Furniture	10,100,000	-	10,100,000
		b. Interior & Exterior Signage	1,400,000	100,000	1,500,000
		c. IS/Comm	13,500,000	-	13,500,000
		d. Security system	2,000,000	200,000	2,200,000
		e. Relocation expense	2,700,000	-	2,700,000
		f. Certifications, inspections, etc.	1,000,000	100,000	1,100,000
		g. Takoma Park Capital Facility Upgrades	2,300,000	-	2,300,000
		TOTAL CURRENT CAPITAL COSTS (a - c)	$ 256,900,000	$ 9,000,000	$ 265,900,000
	d.	Non Current Capital Cost			
	(1)	Interest (Gross)	33,899,250		33,899,250
	(2)	Inflation Allowance (2.0% per year to midpoint of each construction phase)	20,100,000	-	20,100,000
		TOTAL PROPOSED CAPITAL COSTS (a-d)	$ 310,899,250	$ 9,000,000	**$ 319,899,250**
2.	Financing Cost and Other Cash Requirements:				
	a.	Loan Placement Fees	5,234,348		5,234,348.19
	b.	Bond Discount			
	c.	Legal Fees (CON Related)			
	d.	Legal Fees (Other) (zoning)			
	e.	Printing			
	f.	Consultant Fees			
		CON Application Assistance			
		Other (Specify)			
	g.	Liquidation of Existing Debt			
	h.	Debt Service Reserve Fund	26,115,500		26,115,500
	i.	Principal Amortization			-
		Reserve Fund			-
	j.	Other (Specify)			
		TOTAL (a - j)	$ 31,349,848	$ -	$ 31,349,848
3.	Working Capital Startup Costs				
		TOTAL USES OF FUNDS (1 - 3)	**$ 342,249,098**	**$ 9,000,000**	**$ 351,249,098**

B.	Sources of Funds for Project:	Hospital	Garage	Total
1	Cash	73,042,962	9,000,000	82,042,961.50
2	Pledges: Gross, less allowance for uncollectables=Net			
3	Gifts, bequests	5,000,000		5,000,000
4	Interest income (gross)	3,051,137		3,051,136.65
5	Authorized Bonds	261,155,000		261,155,000
6	Mortgage			-
7	Working capital loans			-
8	Grants or Appropriation			-
	(a) Federal			-
	(b) State			-
	(c) Local			-
9	Other (Specify)			-
	TOTAL SOURCES OF FUNDS (1-9)	**$ 342,249,098**	**$ 9,000,000**	**$ 351,249,098**

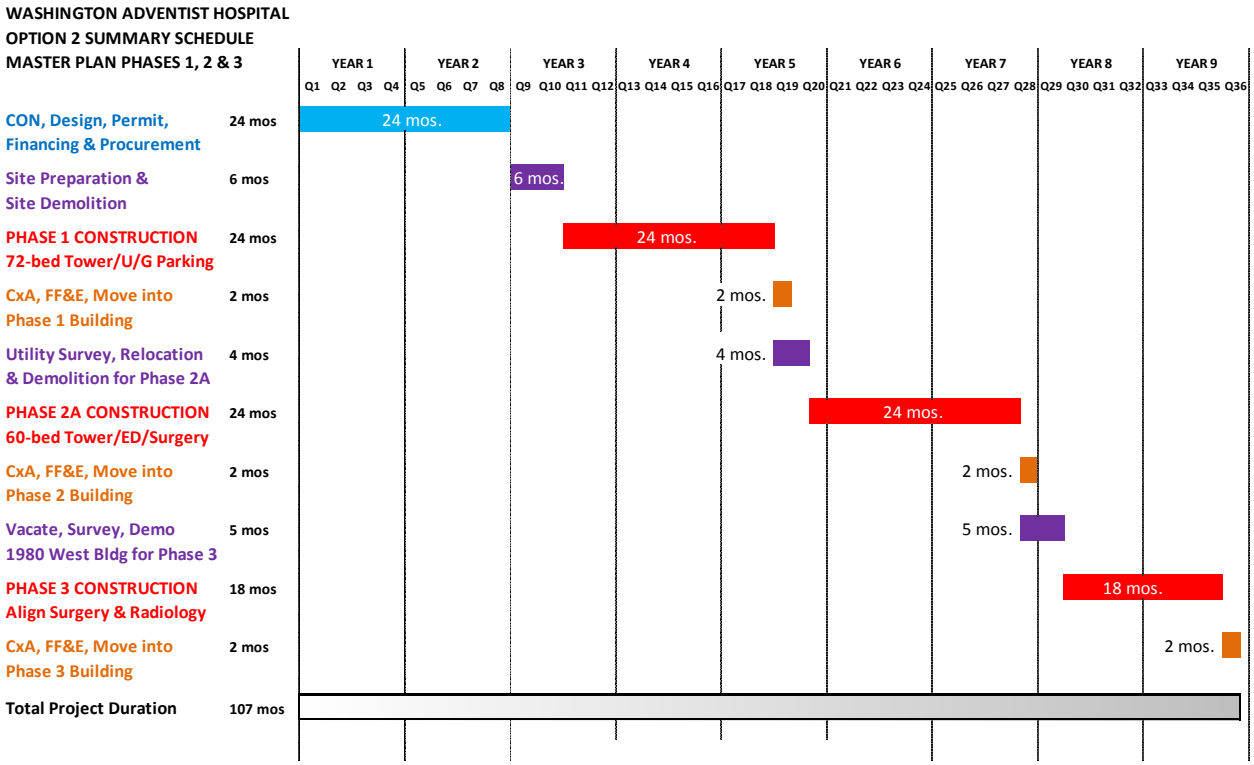
Schedule

To achieve the intent of the on-campus alternative while operating a fully functional hospital, the modernization of the hospital is divided into three separate phases of construction and corresponding phases of demolition. The total construction duration of the multi-phased project is seven years. The current schedule for Option 2 is aggressive, with accelerated parking garage construction and tight phasing and demolition schedules. Extensive schedule contingencies for existing conditions issues were not included to make the "on-campus alternative" as cost-efficient as possible.

The first phase of the project is the development of a new bed tower with below-grade parking and third-party 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 4 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 5 months including survey, relocation and demolition of the existing 1980s West building to prepare for construction of Phase 3.

Phase 3 building construction would follow the demolition. Phase 3 further advances the Campus Master Plan by removing the existing 1980s West building, adding patient beds, rejoining the surgery and radiology departments, replacing support space, and renovating the behavioral health unit.



Considerations

The on-campus alternative ultimately falls short of the White Oak proposal in many respects. 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 or the age of building stock.

In addition:

- Surgical services would initially be split into two different areas due to the location of the current operating rooms. This situation is not able to be addressed until Phase 3 when the new surgery at level 2 is completed.

- 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. The new Central Utility Plan (CUP) would be constructed by a third-party developer (as proposed in Option 4). This does not negate the necessity for two central plants because the outdated plant cannot be demolished until the later phases.

- 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 because of the different floor heights as described above. Connecting these two different floor elevations will require some form of transfer, either a ramp (for minor variation) or a lift or transfer

elevators. These mechanisms are costly to install and maintain and reduce work flow and efficiency.

- 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 70).

Projected income statements and Adventist Healthcare, Inc. financial ratios for each of the options evaluated can be found at Exhibit 30.

Conclusion

This alternative falls significantly short of meeting 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. 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 project addresses some of the issues with the current hospital, 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 Master Plan, adopted by the Montgomery County Council on July 29, 2014. The relocated Washington Adventist Hospital is an important element in the plan given 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 2012 and 2013 can be found in Exhibit 71.

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 assumed issue date for the tax-exempt bonds is February 1, 2016. The financing for the proposed project in the anticipated aggregate principal amount of $244.8 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") (Exhibits 72-84) 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"). Adventist HealthCare reached an agreement earlier this year to sell Hackettstown Regional Medical Center (HRMC). The transaction is currently going through the required regulatory approvals. The anticipated closing of the transaction is late 2014 or early 2015. HRMC operations are included in the data presented below through 2014 and assume the sale takes place as of 12/31/14.

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 as it relates to the construction of the new hospital.

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 4 – Key Financial Indicators (dollars in thousands)

Key Financial Indicators w/ Option 4									
	2012	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Operating Income	$ 12,658	$ 8,704	$ 22,988	$ 27,917	$ 29,478	$ 27,331	$ 28,901	$ 18,194	$ 18,056
Excess of Revenue Over Expenses	$ 15,527	$ 12,143	$ 26,939	$ 37,579	$ 38,587	$ 36,754	$ 38,510	$ 27,955	$ 27,964
Cash	$200,140	$225,947	$211,208	$193,287	$202,020	$204,228	$169,546	$185,068	$202,791
Long Term Debt	$308,239	$321,193	$321,650	$299,236	$523,511	$504,732	$502,689	$482,748	$464,056
Net Assets	$372,969	$396,045	$380,187	$422,367	$466,655	$505,065	$560,546	$573,331	$592,329
Maximum Annual Debt Service	$ 32,142	$ 32,103	$ 32,755	$ 32,755	$ 40,224	$ 40,224	$ 40,224	$ 38,606	$ 35,007
Debt Service Coverage	1.96	1.80	2.30	2.41	2.00	1.97	2.04	2.54	2.85
Days Cash on Hand	111.80	124.58	112.24	115.52	119.58	118.33	96.20	99.75	106.65
Debt to Capitalization	45.2%	44.8%	45.8%	41.5%	52.9%	50.0%	47.3%	45.7%	43.9%
Total Liabilities to Unrestricted Net Assets	1.27	1.23	1.27	1.06	1.43	1.26	1.14	1.10	1.06

Note: *Note that per applicable accounting guidance, the AHC 2013 audited financial statements show HRMC as discontinued operations. Under this guidance, the comparative AHC audited financial statements as of December 31, 2013 and 2012 show the revenue and expenses for HRMC as a net amount below income from continuing operations. For comparison purposes, the financial data presented in the above table includes HRMC's revenue and expenses as part of the total revenue and expenses for the years 2012, 2013 and 2014. In addition, the projections used to compute the ratios above do not reflect cash proceeds from the sale, gain on sale or investment income to be earned on the proceeds. There is no assurance that this transaction will close. It is currently anticipated that if this transaction were to close it would result in further increase 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 $81.6 million in equity. This is comprised of $11.0 million in land, $20 million in fundraising proceeds, and $50.6 million in cash. Equity contributions will begin in 2018 after the project funds from the tax-exempt financing are depleted. The $50.6 million equity contribution will be generated from operations and will be available as needed once the project funds are depleted. In addition to cash generated from operations, there are various Adventist HealthCare assets that are expected to be monetized in the next 5 years, including the sale of HRMC (which is not included in the above ratio calculations) that will contribute to the funds available to cover the $50.6 million. In addition, AHC will continue to invest $25 to $40 million of routine capital annually in the other members of AHC. These capital investments can be deferred if necessary to ensure that cash is available to fund the equity contribution.

The projected financials for the Adventist HealthCare Obligated Group were created using the 2013 audited financials as the base year. Following are assumptions used for 2014-2020.

Table 1 represents the blended assumptions used to prepare the projections for all Obligated Group members. Each entity projection was developed using global assumptions and then adjusted as appropriate based on that entity's historical trends. We believe that the net revenue assumptions are consistent with new reimbursement methodologies for entities covered under Global Budget Revenue arrangements and expense assumptions are consistent with historical performance.

Table 1
Adventist HealthCare Obligated Group Financial Projections

	2014	2015	2016	2017	2018	2019	2020
Net patient revenue	1.65%	1.53%	2.57%	2.08%	2.10%	2.11%	2.01%
Salaries & Wages	1.0%	2.2%	2.1%	2.1%	2.1%	2.2%	2.2%
Employee benefits (% of salaries)	21.95%	21.64%	21.79%	21.95%	22.11%	22.23%	22.42%
Professional Fees	-1.0%	0.2%	0.2%	0.2%	0.2%	0.5%	0.2%
Medical Supplies	3.23%	2.93%	3.43%	3.53%	3.53%	3.53%	3.53%
Purchased Services	1.4%	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%
Investment Income	3.25%	3.25%	3.3%	3.3%	3.3%	3.25%	3.25%

Adventist HealthCare has conducted successful campaigns, raising over $30 million 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 July, 2014 the Washington Adventist Hospital Foundation Capital Campaign in support of the relocation of Washington Adventist Hospital has raised just over $2.1M 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 invites 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. The Washington Adventist Hospital Foundation has contracted with BethGruppAssociates to assist with further development and implementation of the capital campaign.

In addition to the financial resources discussed above, Washington Adventist Hospital has documented support from the medical community (Exhibit 85), state and local government (Exhibit 86), and the community in (Exhibit 87). Letters of support were received from, among others, Gov. Martin O'Malley, Lt. Gov. Anthony Brown, Rep. John P. Sarbanes, House of Delegates Speaker Mike Busch, Montgomery County Executive Isiah Leggett, and the Montgomery County Council.

Washington Adventist Hospital has assumed a rate increase in the financial projections of $19.7M or 7% effective January 1, 2019. The new Global Budget Revenue that Washington Adventist Hospital entered into effective July 1, 2013, with a 50% variable cost factor for increased market share does not provide the hospital with the ability to fund capital through growth but rather incentivizes hospitals to manage utilization in the most effective and efficient manner leading to overall reductions in the cost of care. 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 J. Under this new reimbursement program, the hospital project requires capital funding through rates in order to fund increases in capital and achieve reasonable profitability in the 5th year of the project which in turn will allow the hospital the ability to continue to re-invest in the facility and continue to manage hospital utilization and patient care efficiently.

The assumption of $19.7M for capital funding built into the projections approximates 80% of the annual depreciation, amortization and interest related to the project in the first full year of operations. There are significant efficiencies built into the projections that help to minimize the required capital funding. For example, sustainable design of the building and the mechanical systems results in a 19.9% reduction in Building and Maintenance costs in the new facility as compared to the current outdated facility. In addition to building and maintenance efficiencies, the program of services is optimized in order to provide service adjacencies that result in more efficient use of labor allowing for salary and benefit cost per case mix adjusted equivalent discharge to decline nearly 2% after opening of the new facility. An example of optimizing service adjacency in the new facility is the consolidation of cardiac services into a single location as compared to the six locations on four different floors in the current facility.

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 88 in both English and Spanish.

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.

Washington Adventist Hospital was issued a CON on November 18, 2005 to establish the Washington Adventist Surgery Center. The CON was relinquished on August 18, 2006.

Adventist HealthCare, Inc. has complied with 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, and improved access to outpatient services, improved public transportation and improved parking, among other enhancements. The services that will remain on the Takoma Park campus – the existing behavioral health services; a Federally Qualified Healthcare Center (FQHC) operated by Community Clinic, Inc.; the Women's Center, providing prenatal and other services for the community, including low-income women; a new walk in primary care clinic; the existing, separately licensed rehabilitation unit; physician offices; imaging and other ancillary services in support of the clinical care provided on the campus; 55,000 square feet of space to be leased to Washington Adventist University, a college with an adjoining campus – 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 enhancing the provision of 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 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 2013 – 2023. While the 15-44 age cohort will decline in the TSA for that period, the 65-74 age cohort will grow 44.3% (3.7% annually). Seniors use inpatient health care services at a much higher rate and when accounting for potential declines in use rates due to health care reform and an increased emphasis on alternatives to hospital services, inpatient discharges will grow from 53,908 in 2013 to 57,317 in 2023 within the WOTSA.

Second, 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. The impact of Washington Adventist Hospital's new facility considers the impact from the move as well as growth in cases. The MSGA discharge table on page 108 of this application shows that Holy Cross Hospital had 10,947 discharges from the proposed WOTSA in 2013. If Washington Adventist Hospital was located in White Oak in CY 2013, the impact to Holy Cross would have been 1,102 cases, but with incremental growth and the downsizing of Washington Adventist Hospital, Holy Cross is estimated to have 10,829 discharges in 2023, indicating a total decline of only 1.1% of discharges. Likewise, Medstar Montgomery Medical Center had 3,404 discharges from the WOTSA in CY 2013. The impact of Washington Adventist's relocation is 91 cases, and discharges will be 3,645 in 2023. Prince George's Hospital Center would see an increase in discharges attributable to the relocation of Washington Adventist Hospital.

Market share in individual zip codes within the primary service area will change (see table below), however the overall net effect is that almost all hospitals treating patients from within the WOTSA will see an increase in discharges from 2013 through 2023, even when accounting for the relocation of Washington Adventist Hospital.

Analysis

Washington Adventist Hospital is currently licensed for 232 beds, of which 171 are MSGA beds. The proposed replacement hospital for Washington Adventist Hospital will have 152 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

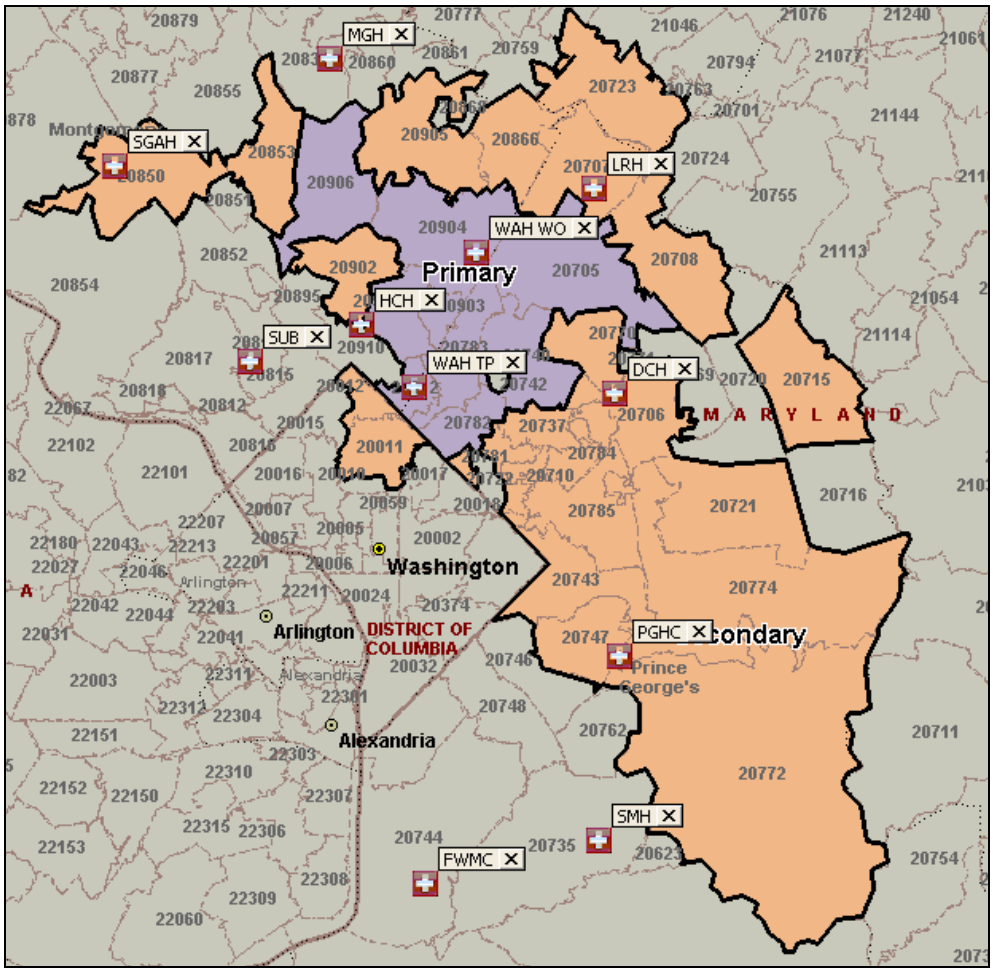
Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	60.1%	-15.0%	45.1%
20912	Takoma Park	60.6%	-15.0%	45.6%
20782	Hyattsville	55.2%	-15.0%	40.2%
20903	Silver Spring	37.5%	3.0%	40.5%
20901	Silver Spring	20.2%	5.0%	25.2%
20904	Silver Spring	9.3%	45.0%	54.3%
20740	College Park	26.3%	-1.0%	25.3%
20910	Silver Spring	15.1%	-15.0%	0.1%
20705	Beltsville	14.8%	10.0%	24.8%
20011	Washington	26.8%	-17.0%	9.8%
20737	Riverdale	18.3%	-15.0%	3.3%
20902	Silver Spring	6.6%	0.0%	6.6%
20770	Greenbelt	11.8%	2.0%	13.8%
20784	Hyattsville	8.1%	-1.0%	7.1%
20706	Lanham	5.1%	-1.0%	4.1%
20781	Hyattsville	22.8%	-15.0%	7.8%
20906	Silver Spring	2.6%	5.0%	7.6%
20712	Mount Rainier	42.2%	-20.0%	22.2%
20785	Hyattsville	4.8%	-1.0%	3.8%
20012	Washington	38.2%	-15.0%	23.2%
20707	Laurel	5.1%	5.0%	10.1%
20708	Laurel	5.7%	1.0%	6.7%
20722	Brentwood	25.1%	-15.0%	10.1%
20743	Capitol Heights	2.9%	-1.0%	1.9%
20019	Washington	6.5%	-6.5%	0.0%
20017	Washington	32.2%	-17.0%	15.2%
20020	Washington	10.1%	-10.1%	0.0%
20774	Upper Marlboro	2.9%	-1.0%	1.9%
20002	Washington	14.1%	-14.1%	0.0%
20747	District Heights	2.7%	0.0%	2.7%
20710	Bladensburg	11.0%	-1.0%	10.0%

Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20018	Washington	21.5%	-17.0%	4.5%
20905	Silver Spring	5.6%	15.0%	20.6%
20877	Gaithersburg	2.2%	-1.0%	1.2%
20721	Bowie	3.2%	0.0%	3.2%
20772	Upper Marlboro	2.0%	0.0%	2.0%
20866	Burtonsville	6.7%	15.0%	21.7%
20715	Bowie	2.1%	0.0%	2.1%
20874	Germantown	1.5%	-1.5%	0.0%
20850	Rockville	1.4%	0.0%	1.4%
20853	Rockville	2.2%	0.0%	2.2%
20723	Laurel	2.6%	5.0%	7.6%
20001	Washington	14.7%	-14.7%	0.0%

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 estimated 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. Refer to our response to 10.24.01.08G (3)(b). Need, in this application for more detailed discussion regarding our MSGA service area analysis.

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 57,317 discharges in CY 2023 was estimated for the Washington Adventist Hospital/White Oak TSA, which indicates absolute growth of approximately 6.3% over the 10 year period, or an increase of 3,409 incremental discharges. The table below represents the estimated discharges by age cohort for the Washington Adventist Hospital/White Oak TSA in CY2023 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 Change	Annual Growth
15 - 44	10,472	8,662	-17.3%	-1.9%
45 - 64	17,798	16,854	-5.3%	-0.5%
65 - 74	9,727	14,033	44.3%	3.7%
75+	15,911	17,768	11.7%	1.1%
Total	**53,908**	**57,317**	**6.3%**	**0.6%**

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 CY2023 there is more than enough MSGA growth to offset 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 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 1,423 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	CY2013 (1)		Adjustments		CY2023 Discharges (4)	
	Discharges	Market Share	Location Adj (2)	Incremental Growth (3)	Discharges	Market Share
Holy Cross	10,947	20.31%	(1,102)	985	10,829	18.89%
Montgomery General	3,404	6.31%	(91)	331	3,645	6.36%
Shady Grove Adventist	2,801	5.20%	0	280	3,081	5.38%
Suburban Hospital Center	2,739	5.08%	(79)	266	2,926	5.10%
Laurel Regional Hospital	2,857	5.30%	(95)	276	3,038	5.30%
Prince Georges Hospital Ctr	4,887	9.07%	63	495	5,445	9.50%
Southern Maryland	2,441	4.53%	0	244	2,685	4.68%
Fort Washington Hospital	148	0.27%	0	15	163	0.28%
Doctors Community Hospital	8,096	15.02%	63	816	8,975	15.66%
Other Providers	9,114	16.91%	(183)	893	9,824	17.14%
Washington Adventist	**6,474**	**12.01%**	**1,423**	**(1,193)**	**6,705**	**11.70%**
Total	53,908	100.00%	-	3,409	57,317	100.00%

Notes:
(1) Actual CY2013 discharges and market share within the WAH - White Oak TSA
(2) Adjustment to market share assuming a relocation to White Oak
(3) Incremental growth by provider indicates slight increases in market share for all providers due to actual projected discharges for WAH.
(4) CY2023 discharges = CY2013 discharges + location adj + 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 offset lost cases resulting from the move. For example, Holy Cross Hospital is expected to lose 1,102 discharges due to the relocation to White Oak and gain approximately 985 MSGA cases due to volume growth, indicating an overall market share decline of approximately 1.42%. Washington Adventist Hospital is estimated to lose market share of approximately 0.31% as a result of losing approximately 10.5% MSGA discharges from CY2013 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 almost all hospitals 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	1,524	21.1%	18,163	28.7%
Medicaid	833	11.5%	7,570	12.0%
Medicare	3,672	50.7%	31,052	49.1%
Self-Pay	1,111	15.3%	5,479	8.7%
Other	99	1.4%	970	1.5%
Total	7,239	100.0%	63,234	100.0%

	White Oak TSA			
	WAH Discharges	% of Total	All Discharges*	% of Total
Commercial	1,361	21.0%	15,288	28.4%
Medicaid	724	11.2%	6,178	11.5%
Medicare	3,284	50.7%	26,961	50.0%
Self-Pay	1,034	16.0%	4,674	8.7%
Other	71	1.1%	818	1.5%
Total	6,474	100.0%	53,919	100.0%

Impact to Other Area Hospitals – Obstetrics

Washington Adventist Hospital is currently licensed for 232 beds, of which 21 are licensed for obstetric ("OB") services. The proposed replacement hospital for Washington Adventist Hospital will include 18 OB beds, indicating a reduction of 3 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:

Washington Adventist Hospital OB TSA Market Share Analysis of Proposed Location

Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20783	Hyattsville	38.1%	0.0%	38.1%
20903	Silver Spring	38.5%	0.0%	38.5%
20912	Takoma Park	42.4%	-15.0%	27.4%
20902	Silver Spring	16.6%	5.0%	21.6%
20901	Silver Spring	20.1%	5.0%	25.1%
20906	Silver Spring	13.0%	5.0%	18.0%
20904	Silver Spring	10.5%	20.0%	30.5%
20782	Hyattsville	19.9%	-10.0%	9.9%

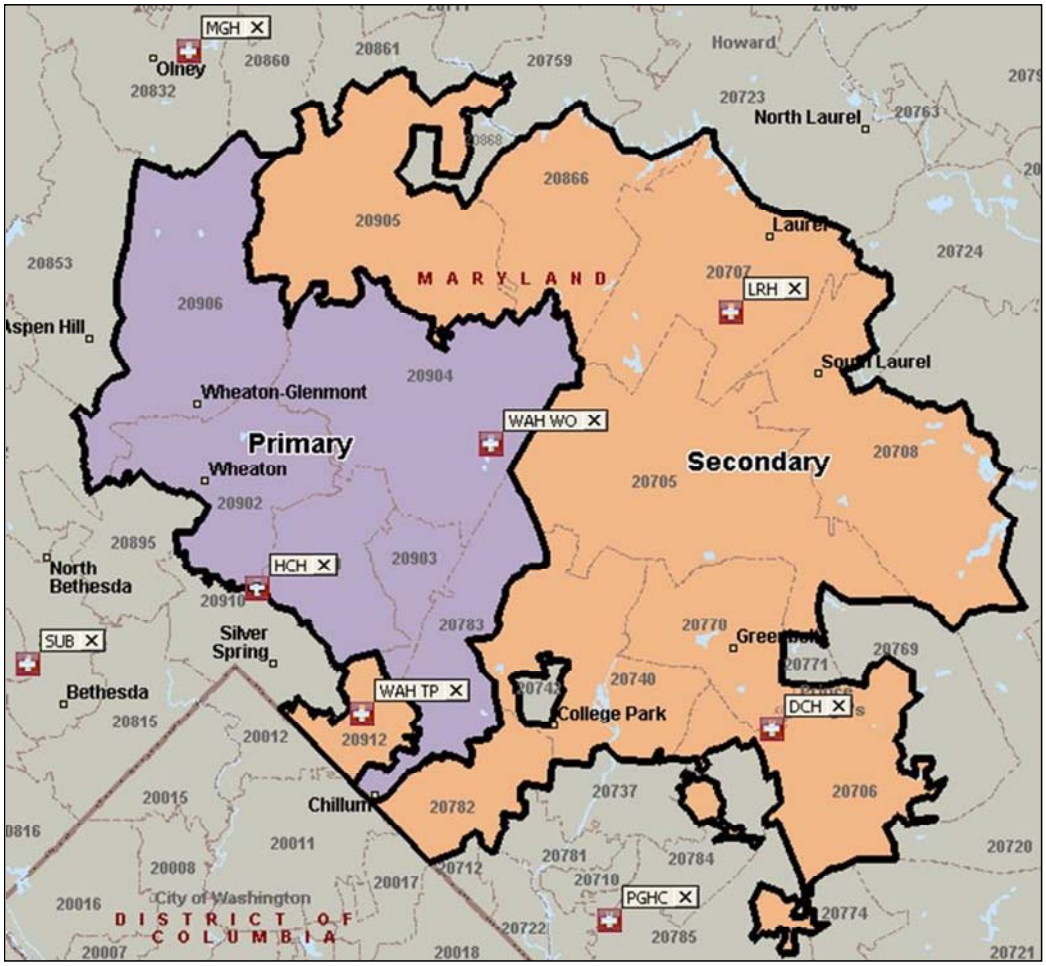
Zip Code	City	Current Market Share at Takoma Park	Adjustment	Estimated Market Share in Proposed Location
20705	Beltsville	13.6%	5.0%	18.6%
20910	Silver Spring	11.7%	-8.0%	3.7%
20706	Lanham	9.0%	0.0%	9.0%
20737	Riverdale	13.9%	-10.0%	3.9%
20770	Greenbelt	10.3%	0.0%	10.3%
20785	Hyattsville	5.4%	-3.0%	2.4%
20740	College Park	11.1%	0.0%	11.1%
20784	Hyattsville	5.7%	-5.7%	0.0%
20712	Mount Rainier	24.3%	-10.0%	14.3%
20781	Hyattsville	11.1%	-10.0%	1.1%
20707	Laurel	3.5%	5.0%	8.5%
20708	Laurel	3.3%	2.0%	5.3%
20866	Burtonsville	6.7%	5.0%	11.7%
20905	Silver Spring	4.9%	5.0%	9.9%

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. Refer to our response to 10.24.01.08G(3)(b). Need, in this application for more detailed discussion regarding our OB service area analysis.

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. The results of our analysis are summarized below.

CY2013 OB Washington Adventist Hospital WO TSA



Population estimates, sourced from Nielsen Claritas, for the Female – Childbearing population and newborns within the Washington Adventist Hospital – White Oak TSA were examined. It was found that although the majority of the Female – Childbearing population, women ages 15-44, are estimated to decrease approximately 0.5% annually, newborns are expected to increase 0.5% annually. Therefore, an increase in the use rate of 1.0% was applied each year to consider the expected higher rate of births.

Population Estimates within the WAH - White Oak TSA

Population	2013 Population	2023 Population	Total Change	Annual Change
Females (15 - 44)	116,859	111,462	-4.6%	-0.5%
Females (45 - 64)	71,779	78,382	9.2%	0.9%
Female - Childbearing	**188,638**	**189,844**	0.6%	0.1%

Newborns	**38,884**	**40,884**	5.1%	0.5%

The table below presents the projected OB discharges within the Washington Adventist Hospital – White Oak TSA.

OB Discharge Estimates within the WAH - White Oak TSA

Growth Estimate Based On:	2013 Discharges	2023 Estimated Discharges	Total Change	Annual Change
Female - Childbearing	7,413	7,817	5.4%	0.5%

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 CY2023 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 118 OB cases that would move to Washington Adventist Hospital. See table below.

Providers	CY2013 (1)		Adjustments		CY2023 Discharges (4)	
	Discharges	Market Share	Location Adj (2)	Incremental Growth (3)	Discharges	Market Share
Holy Cross	4,026	54.31%	(143)	172	4,055	51.88%
Montgomery General	273	3.68%	(26)	11	258	3.30%
Shady Grove Adventist	403	5.44%	(30)	17	389	4.98%
Suburban Hospital Center	1	0.01%	-	0	1	0.01%
Laurel Regional Hospital	502	6.77%	(4)	22	521	6.66%
Prince Georges Hospital Ctr	381	5.14%	84	21	485	6.21%
Southern Maryland	15	0.20%	-	1	16	0.20%
Doctors Community Hospital	10	0.13%	-	0	10	0.13%
Fort Washington Hospital	1	0.01%	-	0	1	0.01%
Other Providers	532	7.18%	1	24	557	7.12%
Washington Adventist	1,269	**17.12%**	**118**	**137**	**1,523**	**19.49%**
Total	7,413	100.00%	-	404	7,817	100.00%

Notes:
(1) Actual CY2013 discharges and market share within the WAH - White Oak TSA
(2) Adjustment to market share assuming a relocation to White Oak
(3) Incremental growth by provider indicates slight increases in market share for all providers due to actual projected discharges for WAH.
(4) CY2023 discharges = CY2013 discharges + location adj + 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 within the TSA will offset the total lost cases resulting from the move. For example, in

CY2013, it is estimated that Holy Cross would lose 143 cases but it will observe an increase of approximately 172 OB cases due to volume growth.

In the case of Medstar Montgomery General Hospital, by CY2023 estimates indicate a loss of approximately 15 OB cases in the Washington Adventist Hospital/White Oak TSA compared to CY2013 levels with a market share decrease of approximately 0.38%. While a loss of cases is identified within the Washington Adventist Hospital/White Oak service area, only 37.2% 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 15 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 2.37%. 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.

Payor Mix Summary

	Takoma Park TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	164	11.7%	3,186	39.4%
Medicaid	1,168	83.5%	4,603	56.9%
Medicare	5	0.4%	22	0.3%
Self-Pay	57	4.1%	209	2.6%
Other	5	0.4%	64	0.8%
Total	1,399	100.0%	8,084	100.0%

	White Oak TSA			
	WAH Discharges	% of Total	All Discharges	% of Total
Commercial	146	11.5%	3,113	42.0%
Medicaid	1,066	84.0%	4,020	54.2%
Medicare	2	0.2%	15	0.2%
Self-Pay	49	3.9%	193	2.6%
Other	6	0.5%	72	1.0%
Total	1,269	100.0%	7,413	100.0%

The Washington Adventist Hospital project has been sized in a way that does not build excess capacity to allow for increasing market share. This in turn minimizes the impact to surrounding providers to a negligible amount. An overall summary of MSGA and OB projected impact for each hospital between 2013 and 2023 can be found at Exhibit 89.

Given the assumption of budget neutrality in market share adjustments under the Global Budget Revenue arrangement, Washington Adventist Hospital has attempted to quantify the potential gross revenue impacts to surrounding hospitals, however Washington Adventist Hospital has not assumed a positive market share shift adjustment in rates for these cases, therefore, the presumption would be that any negative market share impacts to other hospitals are so minimal that they would not warrant any negative adjustment in rates. A high level analysis of potential impact can be found Exhibit 89. In summary, the analysis shows that while there is an impact to other hospitals, there is little to no unwarranted impact and further the impact is more than fully offset by the projected population growth in the White Oak TSA market.

Furthermore, the $19.7M required funding is estimated to be less than 0.11% of the statewide allowable increase of 3.58% plus population growth. The impact of a one-time permanent increase of $19.7M is far less than the impact to others if Washington Adventist Hospital was using increased volume growth to fund the project.

In addition, an analysis of the current payor mix in the Takoma Park TSA and the newly defined White Oak TSA indicates the overall payor mix is not significantly different between the two service areas.

Recruitment and Retention

1. **an assessment of the sources available for recruiting additional personnel**;

APPLICANT RESPONSE:

Candidates for all areas – nursing, allied health, non-Clinical positions – are recruited through various media, both analogue and digital. Media and materials include but are not limited to: print ads; brochures and other collateral; web banners; e-mailings; postings, messaging and other tools on targeted website properties such as WashingtonPost.com, DCJobs.com, Indeed.com, SmartMedia (online banner network targeting active and passive job seekers), and Ziprecruiter (automated candidate job alerts and recruiter candidate sourcing).

The Human Resources Department recently launched a new careers website that features responsive design (the ability to be user friendly on all electronic devices – mobile phones, tablets, desktops, etc.). The website follows best practice functionality at all points to provide candidates with the most optimal user experience, thereby increasing candidate engagement and ultimately the flow of qualified applications. Additionally, the new careers site offers a built-in candidate relationship marketing module, a proactive communication tool that sends branded and relevant messaging to candidates who have opted in by expressing their interest in working for Adventist HealthCare. Branded materials and messaging are also developed on an as-needed basis for special recruiting situations such as hiring events, open houses, trade and industry shows, etc.

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 "Leading Through People" strategy to maintain competitive advantage toward recruitment and retention of personnel in short supply, particularly the shortage of experienced nurses. Washington Adventist Hospital has been closely monitoring its nursing population and considering ways to retain and attract the needed talent. Specifically, we have looked at education, engagement, new graduate/residency program, career ladders, turnover, pay and other indicators of the health of the profession.

Below are a number of initiatives we have put in place to aid in the recruitment and retention of personnel including nurses and other leaders.

- Education: Having well trained professionals delivering care is of paramount importance. As part of our Talent Management system we have developed an online profile for nurses and other healthcare workers that captures education, certifications and other relevant information, reinforcing the importance of these attributes. The data is useful as we design education requirements for our positions and consider ways to recognize their expertise.

- Employee Engagement: An Advisory Board engagement survey that is health care specific is administered each year which provides a basis for action planning around areas of opportunity. The data can be segmented by occupational group to further tailor improvement strategies.

- Mission Engagement: We seek an environment where employees and patients alike can experience Washington Adventist Hospital as a welcoming place of healing. We have focused resources and tailored action plans to win the hearts and minds of our employees. Leaders, managers and employees are held accountable for their team's engagement through various scoring methods. The Leading Through People framework was designed to improve our culture and employee engagement.

- New Graduate/Nurse Residency Program: Washington Adventist Hospital has created a Residency Coordinator resource to facilitate the mentoring of new nurses. This program also includes the development of programs at colleges and universities that reflect the operational priorities and competencies needed at Washington Adventist Hospital.

- Career Ladder: We are in the process of building a revised career ladder for nurses that will be launched in early 2015. The career ladder will highlight factors critical for providing high levels of patient care including training, education and capabilities.

- Turnover: We have successfully used Pegged Software, an algorithm that predicts success to significantly reduce turnover in a number of positions. Pegged Software has become a valuable partner by applying a data solution to help us find the right people that will improve quality of care, increase patient satisfaction and reduce costs related to turnover.

- Succession Planning (Develop Key Talent and Key Roles): Human Resources personnel are engaged in key talent/key roles discussions using assessment tools to identify individuals who have the interest and talent to grow in the organization. This will provide a framework to create professional development plans for key talent and track their progress through our talent management system.

- Total Rewards: We have implemented a "total rewards" compensation approach that encompasses pay, benefits, learning and development and a variety of employee health and wellness programs to ensure our total compensation package always remains competitive.

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 5.24%. The overall turnover rate at Washington Adventist Hospital is 18.7%

Complete Table 5
Table 5 has been replaced by Table M in the Hospital CON Application Tables, Exhibit 1.

***(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:

Terry Forde
President and 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: 2011-Present

Shady Grove Adventist Emergency Center at Germantown
19731 Germantown Road
Germantown, MD 20874
Years: 2011-Present

Washington Adventist Hospital
7600 Carroll Avenue
Takoma Park, MD 20912
Years: 2011-Present

Hackettstown Regional Medical Center
651 Willow Grove Street
Hackettstown, NJ 07840
Years: 2011-Present

Adventist Behavioral Health
14901 Broschart Road
Rockville, MD 20850
Years: 2011-Present

Adventist Rehabilitation Hospital of Maryland
9909 Medical Center Drive
Rockville, MD 20850
Years: 2011-Present

Reginald S. Lourie Center for Infants and Young Children
12301 Academy Way
Rockville, MD 20852
Years: 2011-Present

Capital Choice Pathology
12041 Bournefield Drive
Silver Spring, MD 20904
Years: 2011-Present

Previous involvement:

Adventist Health System/Centura Health
Denver, CO
Years: 2003-2011

Truman Medical Center – Lakewood
Kansas City, MO
Years: 2002-2003

Avera – Holy Family Hospital
Estherville, IA
Years: 1999-2002

HCA – Independence Regional Health Center
Independence, MO
Years: 1997-1999

Shawnee Mission Medical Center
Shawnee Mission, KS
Years: 1992-1997

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.

9-23-2014
Date

Terry Fessle
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.

Tony Forde
Terry Forde
President and Chief Executive Officer
Adventist Healthcare

Interim President
Washington Adventist Hospital

9-23-2014
Date

AFFIRMATION

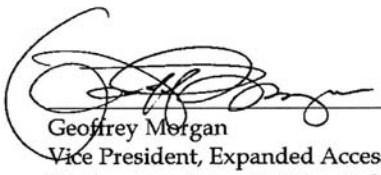
I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

Robert E. Jepson
Vice President, Business Development
Washington Adventist Hospital

9/23/14
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

9/28/14
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 L. Dymond
Vice President, Financial Operations
Adventist Healthcare

9/23/14
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.

Kristen Pulio
Vice President, Revenue Management
Adventist Healthcare

9/23/2014
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.

Diana Rowny
Director of Finance
Washington Adventist Hospital

9/23/14
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.

Linda Beth Berman
Grant Manager
Adventist Healthcare

September 23, 2014
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, LLP

9/23/14
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
Deloitte Financial Advisory Services, LLP

9/23/14
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.

Thad Nicholson, Project Manager Heery	23 SEP 2014 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	September 23, 2014 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.

Greg Stackel, RTKL	September 23, 2014 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

9.23.14
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.

Javorka Saracevic
Senior Manager
AtSite, Inc.

9/23/2014
Date