MARYLAND HEALTH CARE COMMISSION

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October 25, 2018

VIA E-MAIL AND REGULAR MAIL

Robert Jepson
Vice President of Business Development
Adventist HealthCare, Inc.
7600 Carroll Avenue
Takoma Park, Maryland 21801

Re: Relocation of a Special Rehabilitation Hospital
Matter No. 18-15-2428

Dear Mr. Jepson:

Commission staff has reviewed the above-referenced application for the Certificate of Need ("CON") application to relocate the 42-bed special rehabilitation hospital. Staff requests that you provide the additional information on this project requested below and responses to questions posed on the CON application.

Project Budget, Table E

1. Please provide a revised Table E showing the sources of funding for this project, which appear to be cash, based on the narrative on page 59.

COMAR 10.24.09: State Health Plan for Facilities and Services: Acute Inpatient Rehabilitation Services

General Review Standard (1), Charity Care

2. The charity care policy states that probable eligibility is communicated to patients within two business days of the submission of an application. Please provide a copy of the application form, and indicate any documentation that is required to accompany it.

General Review Standard (2), Quality of Care

3. At the pre-application conference, staff informed the applicant that the proposed facility must be licensed separately from the special rehabilitation hospital facilities operated on separate premises in Rockville, consistent with Maryland Department of Health regulations. Has Adventist HealthCare ("AHC") initiated any action to correct the single license issued for separate premises?

4. Exhibit 11 includes a license issued by Montgomery County to operate Adventist Rehabilitation Hospital of Maryland as an "Acute General Hospital." This license only includes the Rockville address. Please explain the significance of this license, if any, in consideration of this application.

5. Does the acute rehabilitation program at WAH provide all four types of "specialty" programming, i.e., stroke, brain injury, spinal cord injury, and amputee programming under the CARF certification noted on pages 15-16? What proportion of the total patients served at the WAH program fall within these specialty categories?

Project Review Standard (2), Need

6. Page 23 indicates that the Takoma Park facility experienced 706 discharges in CY 2015. Page 31 indicates 687 discharges in that same year. Please clarify.

7. It appears that the demand forecast for this project is based on an acute rehabilitation discharge use rate calculation for Montgomery County's population in 2016.
   A. Is this use rate calculation based on all adult rehabilitation discharges of Montgomery County residents from any Maryland or D.C. hospital?
   B. Why is a use rate for Montgomery County used rather than a use rate for the actual service area of the program operating in Takoma Park? (We note that the 85% relevance service area definition included on pages 27 and 28 indicate that only 47% of the program's discharges in CY 2017 from that service area originated in Montgomery County.) How would the forecast change if one used the use rate for the service area population?

8. The data on page 23 shows that case volume at the Takoma Park program grew 35% between CY 2013 and CY 2014 and, in the following four year period, CY 2014 to CY 2017, there was no growth in case volume, indicating that the service area use rate declined over this period if the adult population of the service area increased, which we assume to be the case.
   A. Given this recent experience, why did AHC feel a need to add ten beds, a 31% increase in bed capacity, in 2018?
   B. Can AHC identify any factors underlying the spike in demand from 2013 to 2014 and the plateau experienced since 2014?
   C. Given this plateau of no increase in case volume from 2014 to 2017, can AHC provide a credible basis for its expectation that case volume will increase over 30% in the three year period of CY 2017 to CY 2020? How can this projection be credible given the decline in service area population use that the recent plateau implies?

9. The average length of stay ("ALOS") for AHC's acute rehabilitation patients is longer than the statewide average. Page 23 of the application indicates that acute rehabilitation average length of stay in Takoma Park increased by almost a full day between 2013 and 2017. (In contrast, ALOS

at the Rockville facility dropped by over a full day over the same time period.) Can AHC justify this based on data indicating that AHC has a higher case mix intensity of adult rehabilitation patients than the overall statewide patient census? Can AHC justify the recent increase in ALOS at the Takoma Park facility based on an increase in case mix intensity?

10. Please provide further explanation of the "DC Impact" adjustment to AHC's demand forecast. Can AHC provide any tangible evidence that patients would prefer to use AHC facilities but, instead, use D.C. facilities because Takoma Park is not accessible to Montgomery County patients? Identify the more attractive facility features and amenities of D.C. rehabilitation hospital facilities that are luring Montgomery County patients to use these facilities rather than the Takoma Park facility.

11. As noted in the State Health Plan, "to some extent, skilled nursing facilities may substitute for acute inpatient rehabilitation services." What evidence can AHC provide that all of the patients using its rehabilitation hospital facilities require the more costly intensive rehabilitation setting of a hospital rather than the lower cost skilled nursing facility setting?

Project Review Standard (3), Impact

12. AHC projects a shift in patient demand from D.C. hospitals to the proposed hospital. As required by this standard, specifically address this impact, by facility, in terms of care volume, average length of stay, and case mix.

Project Review Standard (6), Financial Feasibility

13. Table J, "Rehab Takoma Park Current -UNINFLATED," appears to be a financial schedule showing historic, current year, and projected year revenues and expenses for a scenario in which AHC operates a special rehabilitation hospital in Takoma Park, as currently authorized.
    A. Why does "interest on current debt" increase from $45,475 in the current year to $654,160 in 2019 and $1,262,845 in 2020? What borrowing is assumed to be undertaken under this scenario and what are these borrowed funds used to buy?
    B. Why does "current depreciation" increase from $417,526 in the current year to $1,214,794 in 2019 and $2,012,514 in 2020? What facility improvements will occur under this scenario that will quintuple the value of this asset?
    C. Why is there a contractual services expense on this schedule but no contract employees or expense shown in Table H?

14. These same questions are applicable to Table K, "Rehab in TP – INFLATED," which appears to be a financial schedule showing historic, current year, and projected year revenues and expenses for a scenario in which AHC operates a special rehabilitation hospital in Takoma Park, as currently authorized.

15. Did AHC consider the operation of a special rehabilitation hospital in Takoma Park unsustainable in 2015? If not, please explain the error in the assumptions employed by AHC at that time and how these errors came to light. If so, please explain why AHC put forward the project plan approved in 2015 to MHCC as viable. As an example, the application states that it is not financially feasible for AHR to remain at the Takoma Park location because its current ability to share ancillary services with Washington Adventist Hospital would no longer exist. This fact was

obviously known during AHC's initial planning for the general hospital relocation. Why is it an important factor now when it apparently was not an important factor then?

16. Table J, "Rehab Takoma Park in White Oak - UNINFLATED," appears to be a financial schedule showing historic, current year, and projected year revenues and expenses for a scenario in which AHC operates a special rehabilitation hospital in Takoma Park until sometime in 2019 and operates a replacement special rehabilitation hospital in White Oak thereafter.
    A. This schedule shows no "project depreciation." Please clarify.
    B. Why does "current depreciation" increase from $417,526 in the current year to $1,214,794 in 2019? What is the $832,526 in "current depreciation" shown for 2020 to 2022 and why is it "current depreciation?"
    C. This schedule shows "interest on current debt" increasing by a factor of 14 from 2018 to 2019 and returning to 2016-17 levels in 2020 to 2022. Please explain.
    D. This schedule shows no "interest on project debt." Does this mean that none of the proposed project expense will be financed? (See Question 1.) Please clarify.
    E. Why is there a contractual services expense on this schedule but no contract employees or expense shown in Table H? Why isn't the "Salaries & Wages" figure consistent with Table H.

17. These same questions are applicable to Table K, "Rehab Takoma Park in White Oak – INFLATED," which appears to be a financial schedule showing historic, current year, and projected year revenues and expenses for a scenario in which AHC operates a special rehabilitation hospital in Takoma Park until sometime in 2019 and operates a replacement special rehabilitation hospital in White Oak thereafter.

18. Given the number of issues we feel exist with the table set provided, please submit a revised Exhibit 4 that addresses the anomalies described in the immediately preceding questions. Explain, in detail, the assumptions employed in developing the expense projections for the alternative scenarios, line by line.

19. What is the outstanding debt on the existing special hospital? Explain how this is treated going forward.

Project Review Standard (8), Transfer and Referral Agreements

20. Your application states, "[you] have relationships with skilled nursing facilities, long-term acute care hospitals, home health agencies, and other providers to allow patients to transition to the most appropriate level of care." How many "transitions" from the special rehabilitation hospital in Takoma Park to a skilled nursing facility occurred in 2017? Please identify the skilled nursing facilities to which patients are referred.

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

Project Review Standard (6), Cost Effectiveness

21. Please respond to the requirements of this standard for the alternative of consolidating special rehabilitation hospital facilities in Rockville, establishing a single hospital on one premise. For this alternative:
    A. Quantify the level of effectiveness of this alternative as an effective treatment setting. The stated objective of maximizing the sharing of resources between AHR and WAH is not a project objective that allows for consideration of any alternative to this project with the exception of operating one special rehabilitation hospital at one location in Montgomery County, which would be the White Oak campus. For this reason, MHCC staff rejects this delimiting objective as a useful basis for analysis of the costs and effectiveness of the only meaningful alternative, which is consolidation of rehabilitation facilities in Rockville.
    B. Detail the capital and operational cost estimates and projections developed for the alternative. Merely stating that the estimated cost of the most "cost-efficient" approach is $40 million does not meet the requirements of this standard. If operating a 97-bed hospital is more efficient than operating two separate hospitals with the same number of beds, which seems likely, the operational savings could make this option the most cost-effective alternative over the life of the project. It is this analysis that is the fundamental point of this standard and the application provides no meaningful information on this point.
    C. Explain the basis for choosing the proposed project over this alternative, as supported by the information provided in (A) and (B).

Please submit four copies of the responses to completeness questions and the additional information requested in this letter within ten working day of receipt. Also submit response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov).

All information supplementing the application must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Should you have any questions regarding this matter, feel free to contact me at (410) 764-5982.

Sincerely,

Kevin McDonald
Chief of Certificate of Need

cc: Travis Gayles, M.D., Montgomery County Health Officer
Patricia Nay, M.D., Executive Director, Office of Health Care Quality
Howard Sollins, Esquire, Baker, Donelson, Bearman, Caldwell & Berkowitz, P.C.