



Prince George's County Ambulatory Surgery Facility

Certificate of Need Completeness Question Responses

Submitted to the Maryland Health Care Commission

March 22, 2018





March 22, 2018

Via Email and U.S. Mail
(ruby.potter@maryland.gov)

Ms. Ruby Potter
Health Facilities Coordinator
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Children's National of Prince George's County, Matter No. 18-16-2413

Dear Ms. Potter:

On behalf of Children's Hospital, a subsidiary of Children's National Medical Center, Inc., enclosed please find four copies of responses to completeness questions, supporting exhibits, and a letter of attestation, as requested in correspondence dated March 1, 2018.

Please contact me if you have any further questions or require additional information.

Sincerely,

A handwritten signature in dark ink, appearing to read "Michael Rovinsky".

Michael Rovinsky, MBA
Director

Enclosures

cc: Kevin McDonald, Maryland Health Care Commission
Charles Weinstein, Children's National Medical Center, Inc.

PART 1 – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. So that staff may provide the Commission with a more descriptive background regarding Children’s Hospital’s initiative to establish a regional outpatient center (“ROC”) with a two operating room ambulatory surgery facility, please provide the following:
 - a. A brief description of the current state of the 6.9 acre Glenarden site, e.g., whether the property is developed or not and whether utility connections are available or will need to be installed; the accessibility of the location relative to Washington, DC and Prince George’s County, including access via public transportation, etc.
 - b. Describe what the applicant will do with the ROCs in Laurel and Upper Marlboro after project completion.
 - c. The age range of the patients to be served by the two operating rooms in the ASF.

Applicant Response

- (a) The site for the proposed ASF is a 6.9 acre property located within the Woodmore Town Centre (“WTC”), a multi-use commercial and residential planned development. WTC is located within the city of Glenarden, MD, in Prince George’s County, on the northeast corner of the intersection of the Capital Beltway, Interstate 95, and Maryland Route 202 (Landover Road). The proposed site is approximately 11 miles from Children’s National Medical Center’s primary campus, located at 111 Michigan Avenue N.W., Washington, D.C. Estimated vehicle travel time is 33 minutes. The site has direct connection to WTC’s internal ring road, connecting to WTC’s vehicle entrances located on St. Joseph Drive and Campus Way North, leading to MD 202 – Landover Road.

WTC is served by Prince George’s County “THEBUS” transit service. THEBUS Route 28 (<https://www.princegeorgescountymd.gov/DocumentCenter/View/20019>) connects WTC with the Washington Metropolitan Area Transit Authority’s (“WMATA”) Landover Town Center (“LTC”) Blue and Silver Lines Metrorail Station. THEBUS operates Monday through Friday, every 45 minutes between 5:30am and 8:00pm. THEBUS routes 21 & 26 serve LTC, providing additional connections to Route 28. Route 21 connects WMATA’s Orange Line New Carrollton Metrorail station and the city of Upper Marlboro, MD. The New Carrollton Station provides additional transit access to the Maryland Department of Transportation’s Maryland Area Regional Commuter (“MARC”) rail lines, serving the Washington, D.C. and Baltimore, MD areas. Route 26 connects WMATA’s Morgan Boulevard Station, Ritchie Marlboro Road area, and LTC station.

The proposed site was rough-graded during the initial development of WTC in 2009-2010. At present, the site is generally level, with ground cover vegetation and second growth woods. Existing underground utility easements are located along the northern property line and do not infringe on the proposed structure or parking. Primary utility connections for the site are available immediately adjacent to the property within WTC, including electricity, potable water, sanitary sewer, and storm water sewer. Utility line installation will be limited in scope to connect the proposed building with these existing services.

- (b) The clinics located at Laurel Lakes and Upper Marlboro will move and consolidate their operations to the new PGC ROC at the Woodmore Town Centre. The existing Laurel Lakes and Upper Marlboro clinics occupy leased space. These leases will be terminated at the time the PGC MOB becomes available.
- (c) The age range of patients to be served by the two operating rooms in the proposed ASF is two months eighteen years of age.

PART 1 – CONTINUED

2. Please go into more detail as to your statement on p. 10 that “Children’s anticipates substantial growth in surgical cases for patients residing closer to the main hospital campus.” What proportion of the 58% of the outpatient surgeries performed at the main DC hospital location will relocate with the establishment of the PG ROC? How will Children’s mitigate the financial impact of the loss of surgical volume resulting by relocating outpatient surgical cases from the main campus to the PG ROC?

Applicant Response

The anticipated growth in surgical cases for patients residing in the service areas adjacent to the main hospital campus is based on pediatric population growth assumptions coupled with Children’s current proportion of cases from these areas. In FY17, 40% of Children’s ambulatory surgical cases at the main Washington, DC hospital campus were for patients residing in the Washington, D.C. and Northern Virginia areas. Pediatric population 5-year growth estimates, obtained from Claritas, are 12% for Washington, D.C. and 5% for Northern Virginia. In Northern Virginia, however, the pediatric population in the Alexandria and Arlington areas (adjacent to Washington, D.C.) is expected to grow by 16% over the next 5 years. In all, it is expected that there will be close to 60,000 more children in the service area served by Children’s main campus in the next 5 years.

The 58% figure referenced on page 10 refers to the percentage of total outpatient surgeries at the main campus that are performed on Maryland patients. Of that 58% of patients, we anticipate about 18% will migrate to the proposed facility in the first year and approximately 35% will migrate to the proposed facility by year three. Based on these assumptions, it is estimated that approximately 10% of total Children’s outpatient surgical cases will migrate from the main campus to the proposed facility in year 1 and approximately 20% will migrate to the proposed facility by year 3.

Children’s believes the financial impact of the migration of these cases to the health system as a whole will be minimal, if not positive in the long term. The expected growth in the Washington, D.C. and Northern Virginia communities is expected to generate additional demand for ambulatory surgery to replace cases that migrate to the new facility in Prince George’s County.

While Children’s expects continued growth in ambulatory surgery cases at the main campus, there are other considerations that mitigate any possible financial impact. The proposed project is part of Children’s overall strategy to provide as much ambulatory care as possible in the communities we serve. Children’s envisions the main hospital campus as an inpatient facility at its core, while also providing capacity for more complex ambulatory services that require additional specialty back up. Migrating less complex cases to the proposed facility allows Children’s to provide ambulatory surgery closer to where patients live while also supporting more appropriate utilization of Children’s main campus.

PART 1 – CONTINUED

3. Regarding Exhibit 1, please show or explain how Children's regional outpatient centers fit within Children's National Medical Center's organizational structure.

Applicant Response

Children's National Medical Center is the sole corporate member of Children's Hospital. Children's Hospital operates the Regional Outpatient Centers as part of Children's Hospital's business.

PART II – PROJECT BUDGET

4. It is not immediately clear to MHCC staff who is responsible for the construction of the facility, and who will own it. Exhibit 3 is a copy of the lease between WTC LOT 17, LLC (landlord) and Children's Hospital (tenant). Please discuss which party is responsible for the construction and development of the building that will be located on Lot 17 at the Woodmore Towne Center. Is Children's Hospital responsible for the total cost of constructing the 60,000 sq. ft. ROC, or just for the cost of constructing the ASF?

Applicant Response

The Landlord, WTC Lot 17 LLC, is responsible for the construction and development of the building and will continue to own it after completion. Children's will lease all of the space in the building from the Landlord, including, but not limited to the ASF space. The Landlord has provided a work allowance for the base building of \$155 per square foot and a tenant improvement allowance for all tenant improvements (including, but not limited to the ASF space) of \$60 per square foot. Children's will be responsible for any cost to construct the base building in excess of the work allowance, either through a payment to the Landlord once the amount is determined or, potentially, through an increase in the lease payment amount if the excess cost is amortized as part of the lease payment. Similarly, Children's will be responsible for any cost to construct the tenant improvements for the building, including, but not limited to the ASF space, in excess of the tenant improvement allowance, either through a payment to the Landlord once the amount is determined or, potentially, through an increase in the lease payment amount if the excess cost is amortized as part of the lease payment. In direct payment, Children's is responsible for costs in excess of the respective allowances for the 60,000 sq. ft. ROC and the ASF. See below for additional detail.

Pursuant to Exhibit 3, Section 3.3 ("Improvements") and "Exhibit C – Work Agreement," WTC Lot 17 LLC (the "Landlord") is responsible for the design and construction of the entire facility. The delineation of responsibility for certain activities related to the construction and development of the proposed facility is outlined below.

- *Landlord Work - Base Building Improvements:* Landlord is responsible for the design, permitting, and construction of the base building structures, systems, and core, based on approved plans and specifications and subject to a Landlord work allowance of \$155 per square foot for a total of 55,200 rentable square feet (RSF, as calculated on 60,000 gross square feet). After the Landlord work allowance has been expended, the tenant is responsible for any base building improvements desired or required to support the functionality of the building. The base building structures, systems and core are intended to be completed by landlord as a "warm shell" with demising walls ready to receive paint, and floors level and ready to receive floor coverings.
- *Landlord Work – Exterior Improvements:* Landlord is responsible for the design, permitting and construction of all improvements to the land and all on-site and off-site improvements necessary or appropriate for the use of the premises. These include (but are not limited to): exterior entrance features, landscaping, utilities, retention, culverts, sidewalks, parking lots, exterior lighting, exterior pavilion signage, wayfinding signage, exterior building signage and roadway improvements and, environmental mitigation and enhancement necessary for construction of the building, at its sole cost and expense, per approved plans and specifications.
- *Tenant Improvements:* Landlord will permit and construct tenant's interior improvements of the premises based on the approved tenant improvement plans, at tenant's sole cost and expense, subject to the application of the tenant improvement allowance of \$60 per square

foot for for 55,200 RSF. The tenant improvements include the build-out of the ASC within the building.

It is intended that the Landlord will enter into a contract with a single design firm for the complete scope of design for base building, exterior improvements, and tenant improvements. Similarly, it is intended that the Landlord will enter into a contract with one or more general contractor(s) to construct the base building, exterior, and tenant improvements.

**PART IV – CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR
10.24.01.08G(3)**

Information Regarding Charges

5. Please discuss how the existing Montgomery ROC currently provides information regarding ambulatory surgical service charges to the public. Does the applicant currently provide this information on the facility's website, and if so, please provide a link or show the location of this information.

Applicant Response

The Montgomery ROC does not publish a list of charges for surgical services on its website, as charges often do not correspond to what each patient may actually pay. Rather, Children's works with each patient individually to determine the estimated cost for services, including copays and deductibles, based on their unique coverage. Children's Hospital, including the existing Montgomery ROC, currently provides estimated charges for specific pediatric outpatient surgical services to any member of the public that inquires, or as required by applicable regulations or laws.

PART IV – CONTINUED

Charity Care Policy

6. The statement on p. 24 that “Children’s will make **reasonable efforts** to make an initial determination of probable eligibility for charity care within two business days of a patient’s request for charity care services...” does not comply with COMAR 10.24.11.05A(2)(a)(i). You describe Children’s policy as making a “Financial Assistance determination within two business days of receiving a completed application, including all required documentation.” (Emphasis mine.) Requiring a completed application with considerable documentation clearly does not comply with the intent of this standard, which is to ensure that a procedure is in place to inform a potential charity care recipient of his/her probable eligibility *within two business days of initial inquiry* based on a simple and expeditious process.

A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible. But the policy must include the more easily navigated determination of probable eligibility. Please remedy this portion of the policy and resubmit.

Applicant Response

A revised charity care policy is included as Exhibit 22. Children’s will make an initial determination of probable eligibility for charity care within two business days of a patient’s request for charity care services, as noted on page 4 of the attached policy. The policy will be in effect and apply to the proposed ASF.

PART IV – CONTINUED

Transfer Agreements

7. Please provide a signed transfer agreement between Children's Hospital and PG ROC that delineates the roles and responsibilities between the two organizations in the event an emergency case should arise and a patient needs to be transferred to the hospital in Washington, DC. An agreement similar to the one presented in Exhibit 13 in your CON application would be sufficient.

Applicant Response

A signed transfer agreement between Children's Hospital and the PGC ROC that delineates the roles and responsibilities between the two organizations in the event an emergency case should arise and a patient needs to be transferred to the hospital in Washington, DC. is included as Exhibit 23.

PART IV – CONTINUED

Service Area

8. The MHCC defines a primary service area as consisting of the first 60% of a facility's patient discharges that originate during a 12 month period. Please identify the zip codes that would meet this definition for PG ROC's primary service area and define which zip codes would fall into your secondary service area.

Applicant Response

The zip codes for the primary service area (PSA) and secondary service area (SSA), based on MHCC's definitions of same, are identified in the table below:

Zip Code	County, State	City	ServiceArea
20783	Prince George's, MD	Hyattsville	PSA
20784	Prince George's, MD	Hyattsville	PSA
20706	Prince George's, MD	Lanham	PSA
20737	Prince George's, MD	Riverdale	PSA
20785	Prince George's, MD	Hyattsville	PSA
20743	Prince George's, MD	Capitol Heights	PSA
20782	Prince George's, MD	Hyattsville	PSA
20747	Prince George's, MD	District Heights	PSA
20774	Prince George's, MD	Upper Marlboro	PSA
20744	Prince George's, MD	Fort Washington	PSA
20602	Charles, MD	Waldorf	PSA
20748	Prince George's, MD	Temple Hills	PSA
20746	Prince George's, MD	Suitland	PSA
20772	Prince George's, MD	Upper Marlboro	PSA
20735	Prince George's, MD	Clinton	PSA
20708	Prince George's, MD	Laurel	PSA
20745	Prince George's, MD	Oxon Hill	PSA
20601	Charles, MD	Waldorf	PSA
20705	Prince George's, MD	Beltsville	PSA
20707	Prince George's, MD	Laurel	PSA
20646	Charles, MD	La Plata	PSA
20011	District of Columbia, DC	Washington	PSA
20019	District of Columbia, DC	Washington	PSA
20770	Prince George's, MD	Greenbelt	PSA
20659	St. Mary's, MD	Mechanicsville	PSA
20721	Prince George's, MD	Bowie	PSA
20603	Charles, MD	Waldorf	PSA
20020	District of Columbia, DC	Washington	PSA
20653	St. Mary's, MD	Lexington Park	PSA
20724	Anne Arundel, MD	Laurel	PSA

20710	Prince George's, MD	Bladensburg	SSA
20740	Prince George's, MD	College Park	SSA
20720	Prince George's, MD	Bowie	SSA
20032	District of Columbia, DC	Washington	SSA
20781	Prince George's, MD	Hyattsville	SSA
20657	Calvert, MD	Lusby	SSA
21403	Anne Arundel, MD	Annapolis	SSA
20716	Prince George's, MD	Bowie	SSA
20613	Prince George's, MD	Brandywine	SSA
21114	Anne Arundel, MD	Crofton	SSA
20002	District of Columbia, DC	Washington	SSA
20715	Prince George's, MD	Bowie	SSA
20640	Charles, MD	Indian Head	SSA
21401	Anne Arundel, MD	Annapolis	SSA
20650	St. Mary's, MD	Leonardtown	SSA
20010	District of Columbia, DC	Washington	SSA
20009	District of Columbia, DC	Washington	SSA

PART IV – CONTINUED

Need – Minimum Utilization for Establishment of a New or Replacement Facility

9. Please complete the two attached tables:
 - a. *Table 1* for each individual surgeon who will perform surgical cases at PG ROC; and
 - b. *Table 2*, an aggregate of the individual surgeon utilization data summarized in one table.
 - c. When do you anticipate the newly recruited surgeons will start performing surgical cases at PG ROC?
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Applicant Response

- (a) Table 1 is provided as Exhibit 24.
- (b) Table 2 is provided as Exhibit 25.
- (c) Newly recruited surgeons are anticipated to begin performing cases at PGC ROC according to the schedule outlined below:
 - *Year 1*: Urology (month 1)
 - *Year 2*: Otolaryngology (first surgeon – month 1)
 - *Year 3*: General Surgery (month 3), Orthopedic Surgery (month 3), Otolaryngology (second surgeon – month 3)

PART IV – CONTINUED

10. Regarding the table on p. 35, please provide all of the assumptions and factors used by Truven Health Analytics, Inc. in projecting the pediatric ambulatory surgery procedures that will be performed in the proposed ambulatory surgery center. Please define what time period is represented by Current, 5-year, and 10-year projections.

Applicant Response

Comprehensive, timely and accurate ambulatory volume data are very difficult to obtain. This is even more true as it pertains to pediatric data. To assist in long range planning, Children's has contracted with Truven Health Analytics for many years to provide health care planning data to assist with projecting future pediatric patient demand. Truven is a nationally recognized provider of health care planning data.

For this analysis and, specifically, the table on page 35, Children's used Truven's Outpatient Procedure Estimates tool. This tool allows for geography, service line, site of care and age specific estimates on most outpatient procedures. In the projection provided in the table on page 35, the tool was filtered on the counties in the primary service area defined in the original application. It was further filtered on patients aged 0-17 for the expected surgical procedure categories to be performed at the proposed PGC ASF. The final filter limited the site of care to ambulatory surgery facilities and hospital outpatient departments. The time periods indicated on this table correspond to 2017 for the current year and 2022 and 2027 for the 5-year and 10-year projections.

Truven's outpatient procedure estimate methodology is very detailed, however, it is essentially a use rate model. Using various data sources for claims data, Truven creates a national use rate model at the procedure code level for specific age, sex, and insurance classes. These use rates are then further adjusted to local markets at the county level, and then extrapolated to the zip code level based on the specific population characteristics of that zip code. A download of the Truven Health Analytics methodology is attached as Exhibit 26 to provide further detail.

To be clear, Truven Health Analytics, Inc. did not project pediatric ambulatory surgery procedures that will be performed in the proposed ambulatory surgery center. The data provided in the Table on Page 35 of the original application pertain to the primary service area, as defined in the application, of the proposed ambulatory surgery center. Those data support the projected volumes for the proposed ambulatory surgery center by demonstrating substantial projected growth in pediatric outpatient surgical procedures in the market to be served by the proposed ambulatory surgery center, some of which Children's anticipates it will capture, while leaving sufficient additional market growth to mitigate any possible adverse impact on other existing providers.

PART IV – CONTINUED

Patient Safety

11. Please provide documentation or evidence that corroborates your statement on p. 43 that CNMC is “one of the nation’s top performing children’s hospitals for patient safety.”
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Applicant Response

Children’s standing as one of the nation’s top performing children’s hospitals for patient safety is supported by recognition earned from numerous national sources, as summarized below:

- *American Nurses Credentialing Center (ANCC)*: Since 2010, Children’s has been an ANCC-designated Magnet organization, a status awarded to those hospitals and health systems demonstrating excellence in nursing practice and clinical care. As of 2011, only 6.61% of registered U.S. hospitals had attained Magnet recognition¹.
- *The Leapfrog Group*: Since 2006, Children’s has been named a Top Children’s Hospital by the Leapfrog Group, an independent non-profit patient safety organization, nine times – more than any other children’s hospital in the United States.
- *U.S. News and World Reports*: Children’s was named to the 2017-2018 U.S. News and World Reports Best Children’s Hospitals Honor Roll, the members of which are selected based upon performance against numerous criteria, including patient safety.

Children’s is the only pediatric hospital to concurrently hold the above-listed designations. Additionally, Children’s is an active member of Children’s Hospitals’ Solutions for Patient Safety National Children’s Network, a network of more than 130 pediatric hospitals across the U.S. whose mission is to “work together to eliminate serious harm across all children’s hospitals².”

¹ American Nurses Credentialing Center, 2018. “History.”

<http://www.nursecredentialing.org/Magnet/ProgramOverview/HistoryoftheMagnetProgram>.

² Children’s Hospitals’ Solutions for Patient Safety, 2018. “Our Mission.” <http://www.solutionsforpatientsafety.org/about-us/our-mission/>.

PART IV – CONTINUED

Construction Costs

12. Please respond to the following:

- a. Exhibit 5, Table C indicates the total square footage in new construction is 10,550 sq. ft. and the perimeter is 492 ft, 3 in., whereas you report on p. 46 that the total square footage is 10,700 sq. ft. and the perimeter is 492 sq. ft. Please confirm the correct square footage and perimeter for the ASF.
- b. Regarding the MVS Benchmark Table on p. 46, the Total Benchmark Basic Structure Cost includes a base cost plus an adjustment for Exterior Walls; Heating & Cooling; and Sprinklers. Please discuss whether these three adjustments are for the 10,700 sq. ft. ambulatory surgery center only, or for the construction of the entire 60,000 sq. ft. ROC. If the former, then the Basic Structure Cost reported in Exhibit 18 states the cost for the ASF is \$4,724,799, which disagrees with the Building Cost of \$3,210,000 reported in your Project Budget, Table E in Exhibit 6. Please clarify this discrepancy in new construction costs for the ASF.
- c. Exhibit 18 indicates you used CoreLogic – SwiftEstimator Commercial Estimator in responding to this criteria. Please state who performed this MVS analysis and include all the assumptions and factors used to arrive at the MVS Benchmark value of \$441.57/sq. ft.
- d. MHCC staff calculates an MVS benchmark of \$301.37/sq. ft. for the project, and an adjusted total project cost of \$406.00/sq. ft., \$104.63/sq. ft. (34.7%) above the benchmark. The standard (COMAR 10.24.11B(7)(b)(ii) states that a “project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs,” and suggests that “[a]dditional independent construction costs estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant’s analysis of the reasonableness of the construction costs.” Please demonstrate that the cost of constructing the two OR ASF is reasonable, and supports the additional cost.

Applicant Response

- (a) The calculated square footage of the ASF is 10,700 sq. ft. Table C (included as Exhibit 27) has been revised to reflect the correct square footage. The calculated perimeter of 492 ft., 3 in. as indicated in the originally submitted Table C reflects the actual perimeter; however, the Marshall & Swift Valuation Service (MVS) CoreLogic software does not allow the inclusion of partial square footage values. In order to maintain consistency, the calculated perimeter in Table C has been revised to a rounded-off value of 492 ft.
- (b) The building cost of \$3,210,000 indicated in the originally submitted Table E includes costs to build-out an ASF in a base building delivered as a warm shell, designed and constructed to suit fit-out of a medical office building (MOB). The fixed equipment costs included under “1.a. (2) Fixed Equipment” in that Table E are the base building related infrastructure equipment costs, which would otherwise be required to fit-out an MOB. These costs were added to the Project Budget, to match the MVS methodology of calculating total cost of setting up an Outpatient Surgical Center.

In an attempt to clarify project budgeting assumptions and maintain consistency with the MVS benchmarking comparison, a revised MVS benchmarking methodology is discussed below. In addition, Table E (included as Exhibit 28) has been revised to only include the ASC fit-out costs.

- (c) The MVS analysis was performed using the CoreLogic Swift Estimator Commercial Estimator software package by Jones Lang LaSalle Incorporated (JLL), acting as project manager on behalf of Children's Construction Department. The assumptions and factors used to arrive at the MVS Benchmark value of \$441.57/sq. ft. are indicated under Exhibit 18 in the original application. In response to sub-section (d) below, this calculation has been revised and included as Exhibit 29.
- (d) PG ROC ASF will be located in a leased building that is otherwise being constructed as an MOB. The cost of constructing the proposed PGC ASF is, therefore, assumed to be similar to that of renovating shell space in an existing MOB. Children's has devised a methodology to evaluate whether the renovation costs of shell space are reasonable, given that the MVS cost per square foot benchmark for "Outpatient Surgical Centers" (OSCs) represents new construction of a complete building.

In addition to a cost per square foot benchmark for OSCs, MVS also has a benchmark for MOBs. The table below presents a calculation of the MVS benchmark for a generic OSC in comparison to that of a generic MOB, under parallel assumptions. For the purposes of this analysis, Children's assumed the following:

- Perimeter Multiplier: Perimeter Multiplier for both the OSC and the MOB benchmark values is assumed to be one (1), since the calculated perimeter values were utilized for both the proposed PGC ASF and MOB.
- Height Multiplier (plus/minus from 12'): Floor-to-floor height of both the proposed PGC ASF and the MOB is 16.6 feet and, therefore, the MVS multiplier of one (1) is assumed.
- Multi-Story Multiplier (0.5%/story above 3): Both the proposed PGC ASF and MOB are no higher than three (3) stories and, therefore, the multiplier is one (1).
- Sprinklers: Since the cost of sprinklers is included in both the ASC building and MOB building construction, no addition for sprinklers is necessary.
- Update and Local Multipliers: Children's has provided the project location zip code for MVS calculated local multiplier of 1.06 to be added automatically in the calculation, both for the proposed PGC ASF and MOB.

A. Marshall Valuation Service Benchmark Comparison		
1. Benchmark Information		
Construction Type	Outpatient Surgical Center	Medical Office Building
Construction Class	A	
Stories in Building	3	
Perimeter	492 sq. ft.	
Height of Ceiling	16.6	
Square Feet	10,700	
2. Benchmark Basic Structure Cost (Per Square Foot)		
	Outpatient Surgical Center	Medical Office Building
Base Cost	\$ 355.14	\$ 187.50
Adjustment: Exterior Walls	\$ 39.04	\$ 43.17
Adjustment: Heating & Cooling	\$ 47.18	\$ 33.49
Adjustment: Elevator	\$ 0.00	\$ 0.00
Adjustment: Sprinklers	\$ 0.00	\$ 0.00
Adjustment: Other	\$ 0.00	\$ 0.00
Total Benchmark Basic Structure Cost	\$ 441.36	\$ 264.16
3. Multipliers		
Perimeter Multiplier	1.0	1.0
Height Multiplier	1.0	1.0
Multi-Story Multiplier	1.0	1.0
Update Multiplier	1.0	1.0
Location Multiplier	1.0	1.0
Product	\$ 441.36	\$ 264.16

In Section 87, page 8, of the Marshall Valuation Service Manual, MVS shows the “Budget Differential Costs by Department” for Hospitals (the only type of structure for which MVS supplies these factors). The area of the MOB in which the proposed PGC ASF will be located would otherwise be considered shell space (or, as MVS terms it on page 8, “Unassigned Space”). MVS estimates that the Departmental Cost Differential Factor for this kind of space is 0.5. Childrens Hospital assumed that the Departmental Cost Differentiation factor of 0.5 should be applied to the MVS benchmark for an MOB of \$264.16 (calculated above) to reflect the cost of constructing the shell of the MOB. If all of the building was shell space (and not fitted out in any way), applying the MVS Departmental Cost Differential Factor to the entire building would suggest that the benchmark for the entire MOB would be half of the full benchmark. Hence, the cost of building the shell of the MOB is half the cost of the MVS benchmark for an MOB.

$$\$264.16 \times 0.50 = \$132.08$$

Therefore, the cost of building the MOB shell is estimated to be \$132.08

In order to calculate a benchmark for only the fitting out of shell space in an MOB into a surgery center, Children’s hospital subtracted the \$132.08 from the benchmark for OSCs of \$441.36, as calculated in the table above to obtain the benchmark for the fitting out of the MOB as a surgery center.

$$\$441.36 - \$132.08 = \$309.28$$

The table below indicated the difference of MVS benchmark as calculated above from proposed project capital costs.

B. Proposed Project Capital Costs	
<i>1. New Construction Costs (Per Square Foot)</i>	
Building	\$ 300.00
Fixed Equipment	\$ 0.00
Site and Infrastructure	\$ 0.00
Architect/Engineering Fee	\$ 14.95
Permits (Building, Utilities, etc.)	\$ 0.90
Total	\$ 315.85
C. Summary	
1. Proposed Project Capital Costs Comparison to Benchmarks	
Total Benchmark Basic Structure Cost	\$ 315.85
Total Proposed Project Capital Costs	\$ 309.28
Difference	\$ 6.57

Proposed project capital costs, have been adjusted to exclude the base building infrastructure equipment components and associated design and permitting fee. These costs now calculate to be only 2.13% higher than the MVS benchmark.

Schedule of Exhibits

Exhibit	Description
22	Financial Assistance Policy
23	Transfer Agreement
24	Completeness Questions, Table 1
25	Completeness Questions, Table 2
26	Truven Health Analytics Methodology
27	Hospital CON Application, Table C
28	Hospital CON Application, Table E
29	CoreLogic MVS Benchmark Report