PROJECT DEFINITION

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

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

APPLICANT RESPONSE:

The question pertains to a hospital licensing regulation. Discussions are currently underway with the Office of Health Care Quality regarding the hospital services on the respective White Oak and Takoma Park campuses. A more detailed response will be provided soon.

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

APPLICANT RESPONSE:

The question pertains to a hospital licensing regulation. Discussions with the Office of Health Care Quality regarding the hospital services on the respective White Oak and Takoma Park campuses are currently underway. A more detailed response will be provided soon.

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

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

APPLICANT RESPONSE:

Please see Exhibit 65 attached Bed Inventory Spreadsheet

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

APPLICANT RESPONSE:

Each of the three project phases will have its own construction contract.

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

APPLICANT RESPONSE:

The following is a list of outpatient and clinic services that will be provided at the White Oak campus of Washington Adventist Hospital.

Name of OP Service	**Description of Services Provided**
Emergency Department	Emergency Room Services (Diagnostics)
Clinic Services	
Infusion Center	Clinical Chemotherapy and Other Infusion
Cardiac Rehabilitation Services	Outpatient Cardiac Rehab Clinic
Women's Center Clinic	Maternity Care Clinic
Nutrition Counseling	Clinical Nutrition Education & Therapy by a Registered Dietician
Short Stay Clinic	Short Stay Clinic & Blood Transfusions
Same Day Surgery	Outpatient Surgery Services - Recovery
Labor and Delivery Services	Outpatient Labor & Delivery Services
Outpatient Surgery	Outpatient Same Day Surgery Services
Operating Room Clinic Services	
Wound Care Clinic	Clinical Services and ORC
Anesthesiology	Outpatient Surgery Services - Anesthesiology
Laboratory	
Lab and Blood Bank	Blood Therapy & Diagnostic Laboratory Services
Laboratory (Chemistry, Histology, Microbiology, and Point of Care)	Outreach Diagnostic Laboratory Services
Electrocardiography	Cardiovascular Services & Diagnostics
Neurodiagnostics	
Electroencephalography	Diagnostic EEG
Sleep Therapy	Sleep Lab
Radiology-Diagnostic	
Radiology	Imaging Services
Ultrasound	Ultrasound Diagnostic Imaging Services

Name of OP Service	Description of Services Provided
Mammography	Women's Diagnostic Imaging Services
Radiation Oncology	Radiation Therapy
Nuclear Medicine	
Nuclear Medicine Services	Diagnostic Imaging Services
Positron Emission Tomography (PET)	Diagnostic PET Imaging Services
Computed Tomography (CT)	Diagnostic CT Imaging Services
Respiratory Therapy	Respiratory Therapy Services
Pulmonary Function	Pulmonary Function Therapy & Diagnostic Services
Physical Therapy	Physical Therapy Services
Occupational Therapy	Occupational Therapy Services
Speech Therapy	Speech Diagnostic & Therapy Services
Magnetic Resonance Imaging (MRI)	Diagnostic MRI Services
Interventional Radiology Cardiology	
Radiology	Imaging Services & Interventional Diagnostics
Cardiology Services	Cardiovascular Services (Diagnostics)
Catheterization Lab Services	Catheterization Lab Cardiovascular Services & Procedures
Electrophysiology Services	EP Lab Cardiovascular Services & Procedures
Observation Services	Observation Care Services (Diagnostics)
Hyperbaric Chamber	Clinical Hyperbaric Services
Needs Assessment Counselor	Clinical Needs Assessment Evaluation by licensed practitioner

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

APPLICANT RESPONSE:

The Women's Center, located on the campus of Washington Adventist Hospital, provides prenatal, postpartum and related gynecological services to the community served by the 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 Montgomery County Maternity Partnership Program. These include women of limited means and who are not eligible for Medical Assistance. Washington Adventist Hospital anticipates the ability to accept and provide care for 500 Maternity Partnership Program patients per year. While most of the clinic clients are low-income women, the services are available to all women.

Maternity Partnership Program participants who are referred by Montgomery County will receive 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, STD screens, 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 Washington Adventist Hospital chair of Obstetrics and Gynecology, Dr. Kimberly Campbell, and her associates, Dr. Yolande Hackney and Dr. Leslie Simmons, all members of the Metropolitan Women's Group, provide direct clinical care for patients and all are board-certified obstetricians.

The manager of the Women's Center, a Registered Nurse, is responsible for the overall planning and organization of program services. The Assistant Nurse Manager, also a Registered Nurse, is responsible for the day-to-day operations.

The Metropolitan Women's Group is responsible for ensuring 24-hour on-call coverage for the patients at the Women's Center directly themselves or through arrangements made and agreed upon with another obstetrician with staff privileges at Washington Adventist Hospital.

Patients who develop conditions which place them in a "high-risk" category will be referred to the Maternal Fetal Medicine practice located at 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 and non-stress tests will be performed on the labor and delivery unit of Washington Adventist Hospital in White Oak. 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 in White Oak for the delivery of her baby, unless circumstances, such as extreme prematurity, require her to deliver at another facility.

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

APPLICANT RESPONSE:

This is a standard that the architects, RTKL, use based upon past experience with hospitals of this size and complexity, and is considered an industry standard. RTKL is not the only organization that uses these parameters. Below is an extract from a recent Kaiser document:

"Typically the Kaiser Template Hospital, based on 150 bed capacity would result in about 2,000 building gross square feet (BGSF) per bed. " (p.5 Exhibit 66) Source: Kaiser Permanente, "Connect to Total Health, Supporting Data"

In addition, benchmarking hospital construction metrics has been important to the development of the proposed relocation facility. As such, Washington Adventist Hospital and Heery conducted a survey of various new hospitals of similar scale and program in order to establish a framework of metrics to determine design efficiency. This analysis (Exhibit 67) reinforced RTKL's standard of efficiency.

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

    a. **Cancer Treatment (both medical and radiation oncology)**

    b. **Diagnostic imaging**

    c. **Cardiac Catheterization and other Angiography**

    d. **Dialysis (acute and Chronic)**

    e. **Endoscopy**

    f. **Observation Units**

APPLICANT RESPONSE:

Exhibit 68 contains the table requested.

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

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

APPLICANT RESPONSE:

Chart 1. Project Construction Characteristics and Costs		
Base Building Characteristics	Complete if Applicable	
	New Construction	Renovation
Class of Construction		
Class A	A	Not Applicable
Class B	Not Applicable	B
Class C	Not Applicable	Not Applicable

Class D	Not Applicable	Not Applicable
Type of Construction/Renovation		
Low	Not Applicable	Not Applicable
Average	Not Applicable	Average
Good	Good	Not Applicable
Excellent	Not Applicable	Not Applicable
Number of Stories	8	4[2]
Total Square Footage	428,412	125,306[1]
Basement	70,836	42,240
First Floor	81,794	55,005
Second Floor	64,430	28,061
Third Floor	51,948	0
Fourth Floor	43,142	0
Fifth Floor	28,289	0
Sixth Floor	28,289	0
Seventh Floor	28,289	Not Applicable
Eighth Floor	28,289	Not Applicable
Penthouse Floor	3,105	Not Applicable
Perimeter in Linear Feet		
Basement	1482	2068[4]
First Floor	1581	1932
Second Floor	1510	1154
Third Floor	1297	0
Fourth Floor	1159	0
Fifth Floor	913	0
Sixth Floor	913	0

Seventh Floor			913	Not Applicable
Eighth Floor			913	Not Applicable
Penthouse Floor			438	Not Applicable
Wall Height (floor to eaves)				Varies by bldg.
Basement			21	11 (Typical)[3]
First Floor			18	11 (Typical)[3]
Second Floor			18	11 (Typical)[3]
Third Floor			15	11 (Typical)[3]
Fourth Floor			15	
Fifth Floor			15	
Sixth Floor			15	
Seventh Floor			15	
Eighth Floor			15	
Elevators				
Type	*Passenger*	*Freight*		
Number	6	6	6 for public 6 service for hospital transport	Not Applicable Existing to Remain
Sprinklers (Wet or Dry System)			Wet	Wet
Type of HVAC System			Mechanically Ventilated	Mechanically Ventilated
Type of Exterior Walls			Precast Concrete Panel, CMU, Curtainwall, Unitized metal panels	Not Applicable Existing to Remain

NOTES:

1. Total Square Footage values for renovation work include only renovated floors and areas of existing building. Floors and areas designated as existing to remain are excluded.
2. Number of Stories at the existing Takoma Park campus varies by building. Number of Stories, indicated for “Renovation” work indicates the typical condition.

3. Wall heights at the existing hospital on the Takoma Park campus vary. Wall Height for "Renovation" indicates the typical condition at Takoma Park.
4. "Basement" in Takoma Park is the Lower Level.

Chart 1. Project Construction Characteristics and Costs (cont.)

	Costs	Costs
Site Preparation Costs	**$10,400,000**	**$0**
Normal Site Preparation*	$1,350,000	
Demolition	$100,000	
Storm Drains	$1,500,000	
Rough Grading	$1,200,000	
Hillside Foundation	$300,000	
Terracing	$0	
Pilings	$0	
Offsite Costs	**$3,850,000**	**$0**
Roads	$2,500,000	
Utilities	$600,000	
Jurisdictional Hook-up Fees	$750,000	
Signs	**$150,000**	**$0**
Landscaping	**$1,000,000**	**$0**

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

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

APPLICANT RESPONSE:

All of the referenced permitting processes are under way and are in various stages of approval by the applicable permitting entities as described below.

Public Water and Sewer: 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 and Sewer: 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 the site. Currently, the proposal is to relocate these 3 existing public storm drain lines to accommodate the new layout. In addition, an on-site private storm drain to safely convey runoff conditions created by the new layout has been proposed. 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.

Stormwater Management: 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.

PART II – PROJECT BUDGET

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

APPLICANT RESPONSE:

The land located in White Oak was purchased by Adventist HealthCare in July 2006. This land is considered part of Adventist HealthCare's equity contribution. It was included in the sources and uses in an attempt to provide a comprehensive summary of the project costs.

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

APPLICANT RESPONSE:

The contingency amount for Phase 1 and 2 is calculated at 5% of the sum of the Capital Costs for New Construction (Building & Fixed Equipment + Site Preparation + Architect/Engineering Fees + Permits), plus Other Capital Costs (Major Movable Equipment + Minor Movable Equipment + Other) rounded to the nearest $100,000 for budgeting purposes.

The contingency amount for Phase 3 is also calculated at 5% of the sum of the Capital Costs for Renovations (Building Demolition + Renovations + Architect/Engineering Fees + Permits), plus Other Capital Costs (Major Movable Equipment + Minor Movable Equipment + Other) rounded to the nearest $100,000 for budgeting purposes.

Project factors such as size, complexity, nature of construction (new versus renovation) and nature of site (from "greenfield" to moderate on-site grading and utility work to major site demolition or "brownfield" redevelopment and remediation) determine the appropriate level of budgeted contingency. Contingency amounts of 0% to 3% would generally be appropriate for a large, simple, new construction project on a greenfield site. For large new construction projects with higher complexity and/or site development a contingency of 3% to 5% is appropriate. For smaller interior fit-up type renovation projects without modifications to the structure, base mechanical systems or building envelope, a range of contingency from 5% to 10% is generally applied. Contingencies for small, phased, occupied renovation projects with extensive modification of base building systems and/or structure and/or exterior envelope would be estimated at more than 10%.

Since the contingency for the new construction project was calculated conservatively at the upper end of the range for large, complex, new construction (5%), the renovation was carried at a lower end of the renovation scale (also 5%) for ease of calculation.

The contingency for Option B was calculated at 6% of Capital Cost to account for the greater complexity associated with phased occupied renovation. The contingency for Option C was calculated at 5% of Capital Cost, using the same methodology as Option D.

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

APPLICANT RESPONSE:

The $14.3 million in Capital Facility Upgrades are upgrades which have been identified through a Facility Condition Assessment (FCA) which was undertaken in late 2012 through early 2013. The FCA identified elements of building infrastructure which required modernization or replacement to allow for the

continued operation of the facility. The infrastructure items included elements related to building structure, façade, mechanical, electrical and plumbing systems, as well as fire protection systems.

The capital facility upgrades are planned for throughout the campus and are not specifically related to or targeted to support areas which are undergoing renovations. Rather the upgrades will promote the long term viability of the campus for its continued use.

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

APPLICANT RESPONSE:

Line 1c(4)g, Certifications and Inspections of the budget for the proposed project on page 17 and the project budgets for Options B and C include:

1. Code-required independent third-party site and building inspections including as-built documentation of site utilities required prior to acceptance and placement into service by Montgomery County
2. Soil compaction tests
3. Concrete strength tests
4. Structural steel and welding tests and inspections
5. Roofing tests and inspections
6. Piping and mechanical pressure testing
7. Electrical coordination studies and arc-flash testing
8. Inspection and certification of medical equipment is not included in Line 1c(4)g,it is included in the budget for medical equipment.

12. **Submit details on the calculation of the gross interest [lineA1d(1)] and interest income as a source of funds (line B4) of the budget for the proposed project on page 17 and the project budgets for Options B and C.**

APPLICANT RESPONSE:

The details of the capitalized interest fund [lineA1d(a)] and interest income [line B4] are attached as Exhibit 69.

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

APPLICANT RESPONSE:

Projected annual inflation was calculated by performing a linear regression of recent construction cost escalation figures as reported by Engineering New Record (ENR) for Baltimore, Maryland, which is the

closest jurisdiction for which ENR publishes monthly cost escalation statistics. Based upon this analysis, a figure of 2.0% annual inflation was determined.

In every case, the 2.0% annual inflation was applied from the date of analysis to the mid-point of the respective project phase or activity. As an example, for the new hospital construction portion of the project, an adjustment factor was added to the current estimated construction cost equal to 2.0% compounded monthly from the current date to the mid-point of the new hospital construction period, 39 months from the date of CON submission in this example. This is a more conservative approach than applying inflation only to the date of contract award, in that it captures expected material and labor escalation during the term of the contract, which may be reflected in general contractor and subcontractor pricing.

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

14. **Regarding COMAR 10.24.10.04A(1), Information Regarding Charges, the standard requires that at a minimum the [applicant's] policy shall include: (a) maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet website; (b) procedures for promptly responding to individual requests for current charges for specific services/procedures, and (c) requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled. This chapter of the SHP also includes a definition of "Representative list of services and charges" at COMAR 10.24.10.06B(29). Subsection (b) of this definition states that, "this list should be updated, with respect to DRGs, CPT codes, and charges, at least *quarterly*." The applicant's policy includes the word *regularly*, but does not include a defined period of time. Please update this policy to reflect the required *quarterly* updates.**

APPLICANT RESPONSE:

Adventist HealthCare Policy 3.19.2 Public Disclosure of Charges, revised November 1, 2013, is Exhibit 70.

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

APPLICANT RESPONSE:

Washington Adventist Hospital Public Notice of Financial Assistance and Charity Care is Exhibit 71.

16. **Regarding COMAR 10.24.10.04B(1), Geographic Accessibility, please provide a travel time analysis that includes population estimates. While Exhibit 13 of the application includes a travel time analysis which lists the travel times from the existing and proposed site for each primary and secondary ZIP code area, this exhibit does not include population estimates for**

these ZIP code areas and specify whether 90% of the population in these ZIP code areas is within 30 minutes of the proposed site under normal driving conditions.

APPLICANT RESPONSE:

The travel time analysis has been revised to reflect travel time estimates for general medical services for the likely service area population as requested. Results for the analysis can be found at Exhibit 72. In summary, 95% of the population in the likely service area is within 30 minutes of the proposed White Oak location under normal driving conditions which is an improvement compared to the Takoma Park location. The average travel time to the existing Takoma Park location is 22 minutes, where the average travel time to the White Oak location is 21 minutes. This improvement results in a travel time savings estimated to be 1,133,019 minutes. Further, the broader analysis in support of the response to completeness question #17.b. demonstrates that 100% of the likely service area population identified for the White Oak location has a travel time of <30 minutes to ANY hospital.

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

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

APPLICANT RESPONSE:

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 73 and 74) 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.

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

APPLICANT RESPONSE:

As requested, a new table has been produced to compare travel times to hospitals that will likely overlap with the primary service area projected for the proposed White Oak location of Washington Adventist Hospital. The following additional hospitals are included in the analysis which can be found at Exhibit 75: Holy Cross – Silver Spring; Laurel Regional Hospital; Doctors Community Hospital; Prince George's Hospital-Cheverly; proposed Prince George's – Largo. Also, as requested, the analysis includes the requested population component.

In summary, 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.

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

APPLICANT RESPONSE:

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..

18. **Regarding the response to COMAR 10.14.10.04B(5), Cost-Effectiveness, please provide the following additional information and clarifications:**

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

APPLICANT RESPONSE:

Exhibit 76 presents the summary schedules for each option.

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

APPLICANT RESPONSE:

The estimated cost for Option A was derived from a detailed Facility Condition Assessment completed in 2013. Estimated costs to complete the identified capital facility upgrades were prepared based upon commercially available construction cost data which took into account building type and projections for CPI increases. The capital facility upgrade program was projected to be completed over a six year time frame, with the most urgent needs addressed in the early years and more discretionary upgrades completed in out years.

Estimated costs for Options B, C and D were developed by an independent construction management firm who provided construction cost estimates based upon program and planning documentation prepared by Washington Adventist Hospital and RTKL. Consistent assumptions were utilized in each option with regard to: new construction cost per square foot; surface parking cost per space; structured parking cost per space; A/E and permit fees as a percentage of construction cost; proportion of new versus reused equipment (approximately 50% new and 50% reused); and other expenses (including contingency) as a percentage of construction cost.

For Options B, C and D, a 2.0% annual inflation factor was applied from the date of analysis to the mid-point of the respective project phase or activity. As an example, for the new hospital construction portion of Option D, an adjustment factor was added to the current estimated construction cost equal to 2.0% compounded monthly from the current date to the mid-point of the new hospital construction period, 39 months from the date of CON submission in this example. This is a more conservative approach than applying inflation only to the date of contract award, in that it captures expected material and labor escalation during the term of the contract, which may be reflected in general contractor and subcontractor pricing.

The assumptions for site work at Takoma Park are the same in Options C and Option D as to level and cost of site development, except that the total size of the Option C project is a 180-bed hospital with proportionally allocated parking.

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

APPLICANT RESPONSE:

The Takoma Park site has existing zoning restrictions that limit the height of new construction. The proposed Option B shows a design with modern floor heights that slightly exceeds the legal zoning limit by 4 feet. The current property is zoned R-60 Residential which required 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.

The site and construction is not only limited by height. The Takoma Park Campus Master Plan and Takoma Park On-Campus Alternative 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 which can provide additional program space, an on-site replacement project like Option B has programmatic limitations; the replacement project must construct new versions of existing program departments before removing the existing departments. In the case of Option B, Phase 1 is intended to replace the 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.

Finally, any project considered for replacement or modernization of Washington Adventist Hospital must be financially feasible and operationally viable. As a result, the scope and budget for Option B were limited to Phases 1 and 2 to provide a more realistic, cost-effective option that would serve as a practical alternative to Option D. Rather than submit a 15-year comprehensive replacement of the entire Takoma Park facility, Option B strikes a balance by providing modern beds and replacing facilities within 8-10 years.

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

APPLICANT RESPONSE:

For Option C, the number of beds by service to be relocated are as follows:

96	Medical-Surgical
32	Psychiatry
24	Maternity (Post-Partum)
28	Intensive Care
180	Total

As indicated in the application, the Adventist HealthCare Board of Trustees directed the executive team to evaluate two options of varying size and scope on the Takoma Park campus, and two options of varying size and scope in White Oak. The smaller number of beds for Option C represents approximately 75% of existing capacity. This option was an attempt to balance a potentially lower capital cost in White Oak while continuing existing hospital-based services consistent with our mission as a community-based hospital also offering regional services such as cardiac surgery and behavioral health services in acute

hospital beds. Option C would not have general acute care inpatient or outpatient services on the Takoma Park campus. Reimbursement for any services provided on that campus would have no provision for indigent care through the hospital rate setting system. As a result, charity care would be significantly limited in comparison to hospital-based outpatient services. Because of significant financial feasibility and viability concerns, Option C was eliminated and a final determination of services on the Takoma Park campus has not been made. However, it's likely that the Takoma Park campus in Option C would include physician offices, a primary care center, the women's center, the Adventist Rehabilitation Hospital of Maryland unit, and leased space. Option C would result in a negative adverse impact to the community given the smaller capacity in White Oak combined with fewer health care services and the limited amount of charity care that could be provided in Takoma Park. Option C does not earn a positive margin within 5 years despite what turned out to be a capital expense similar to the preferred alternative, Option D. Retiring the debt service on the Takoma Park campus would be difficult and Option C would require an ongoing subsidy from Adventist HealthCare.

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

APPLICANT RESPONSE:

As noted in the response to questions 1a and 1b, this pertains to a hospital licensing regulation. Discussions are currently underway with the Office of Health Care Quality regarding the hospital services on the respective White Oak and Takoma Park campuses. A more detailed response will be provided soon.

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

APPLICANT RESPONSE:

Adventist HealthCare sought to be as objective as possible in scoring each criterion in the matrix. Introducing a greater or lesser "weight" to each objective would have introduced a more subjective, pre-determined bias to the outcome. Instead, the organization felt it was more appropriate to list the objectives that were derived from a meeting of its Board of Trustees and then assign a score based upon how successfully each campus option met that individual criterion.

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

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

APPLICANT RESPONSE:

The statement on Page 38 should read that the estimated capitalized interest cost of the project has been adjusted from $50,288,600 to $17,764,000. The $47,973,000 interest figure did not include interest associated with the cost of land purchase, which is part of the budget for the new hospital but not a part of the MVS interest calculation.

b. **Explain how the hillside foundation adjustment was calculated.**

APPLICANT RESPONSE:

The hillside foundation adjustment represents the increased cost of the uphill/retaining wall at a height of 21 feet, as required, due to the steep slope of the site versus 15 feet, as required, for the programmatic requirements of the space. The adjustment captures the difference in cost of a 16 inch wide versus 12 inch wide concrete foundation due to the higher lateral pressure resulting from the steep site. The additional height of the three non-retaining walls, columns, exterior wall finish, vertical utility distribution and other costs associated with the higher basement story is not carried in the hillside foundation adjustment, but rather in the floor height adjustment factor of the MVS calculation.

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

APPLICANT RESPONSE:

With the exception of a single redundant 900 feet by 10 inch diameter water line which is fed across the corner of an adjacent property, all required utilities are available at the property line and estimated costs are for on-site distribution. The redundant water line is estimated at $180,000.

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

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

APPLICANT RESPONSE:

Inpatient MSGA growth rates for the proposed project during the period covering calendar years 2013 through 2018 are projected to continue to decline partially due to the continued shift of short stay cases to observation (as shown in the response to completeness question 29d). In 2019, after the opening of

the new facility growth rates are projected to increase due in small part to the increase in population as well as recapture of lost market share due to the aging facility. The average annual growth rate in MSGA admissions is 0.6% for the projection period, which is well below projected population growth, adjusted for use rates for the service area, of 2.2% indicating some further compression in utilization rates at Washington Adventist Hospital. Additionally, as shown on page 140 of the original CON submission, even with the growth in Washington Adventist Hospital MSGA discharges projected, Washington Adventist is projecting that its market share in calendar year 2022 (10.93%) will be less than it was in 2012 (11.51%).

Utilization projections for outpatient services, with the exception of Observation visits which is explained in the response to completeness question 29d, are consistent with current utilizations trends for the hospital and its service area.

Over the past three years at Washington Adventist Hospital and Montgomery County and Prince George's County hospitals, Emergency Department visits have grown annually by an average of 5.87% and 6.28%, respectively, as shown in Exhibit 32 of the original submission. In the interim years before the opening of the hospital, Washington Adventist Hospital believes that increased volumes in the Emergency Department will be challenging due to capacity issues and therefore has projected no growth in this area. Subsequent to the opening of the new hospital, Washington Adventist projects annual average growth in Emergency Department visits of 5.5%, consistent with current trends.

While Montgomery County and Prince George's County hospitals have seen a slight decrease in outpatient surgeries over the past three years, Washington Adventist has seen more substantial growth in this area. This is partially attributable to the conversion of inpatient cardiac stent cases to outpatient. The hospital expects for this trend to continue but not to the same magnitude as in previous years as many of these volumes have already converted. As a result, before 2019 the hospital has estimated growth below population projections. After the relocated hospital opens, outpatient surgeries are projected to grow at a rate higher than population assuming recapture of the volume lost between 2009 and 2018. It should be noted that increase in outpatient surgery minutes in 2023 over 2009 is 9.9% or an average annual growth of 0.71%.

Outpatient department visits, which are mainly comprised of clinic visits, is projected to grow around population for the period covering calendar year 2013 through 2018. Despite substantial growth in clinic visits in the Montgomery County and Prince George's County region over past three years, Washington Adventist Hospital's footprint designated for outpatient services is extremely constrained as previously discussed in other sections of the CON application. As a result, the capacity for increased outpatient services is limited to population growth in the period of the projection covering calendar year 2013 through 2018.

In 2019, subsequent to the completion of the proposed project, the hospital will have significantly expanded capacity for outpatient services at the White Oak location as well as the retention of some outpatient services at Takoma Park and the expansion of a primary care clinic at the Takoma Park location. Over the past three years, fiscal year 2010 through 2013, Montgomery County and Prince George's County hospitals grew from 173,315 to 250,848 clinic visits or 44.7% [1] (see table below). Upon opening of the newly relocated facility and the expanded capacity for outpatient services, Washington

[1] Source: Maryland Hospital Experience Reports found at: http//www.hscrc.state.md.us/hsp_Data2.cfm

Adventist would expect to see growth rates similar to what has been experienced by the region in most recent history.

Summary of Outpatient Clinic Trends
Maryland Acute Care Hospitals
FY 2010 - FY 2013

		2010	2011	2012	2013	3 Year Average Growth
Statewide						
CL	RVUs	11,615,159	12,175,339	13,652,692	13,745,238	
			4.82%	*12.13%*	*0.68%*	***5.88%***
CL	Visits	1,935,280	2,607,439	2,168,968	2,151,979	
			34.73%	*-16.82%*	*-0.78%*	***5.71%***
Montgomery & Prince George's County Hospitals						
CL	RVUs	955,735	1,077,693	1,577,684	1,641,981	
			12.76%	*46.39%*	*4.08%*	***21.08%***
CL	Visits	173,315	217,171	265,594	250,848	
			25.30%	*22.30%*	*-5.55%*	***14.02%***
Washington Adventist Hospital						
CL	RVUs	123,763	119,491	109,926	122,141	
			-3.45%	*-8.00%*	*11.11%*	***-0.11%***
CL	Visits	18,603	17,210	14,564	14,862	
			-7.49%	*-15.37%*	*2.05%*	***-6.94%***

Source: Maryland Hospital Experience Reports found at:
http://www.hscrc.state.md.us/hsp_Data2.cfm

b. Please quantify the staffing reductions (FTEs and dollars by position) currently underway and anticipated in the years prior to the proposed relocation of services to White Oak. Submit a Table 5 that reports the FTEs, salaries and wages, and cost by position (more detailed than the Table 5 submitted with the application) for either 2012

or 2013 (specify which year), which should be consistent with salary and wages and employee benefits on Table 3 and Exhibits 22 and 31. The Table should also report the expected changes between the base year and the opening of the new facility. Finally the table should report the changes attributable to the relocation of the hospital and a total for the first full year of new facility operation (this total should be consistent with Table 3.

APPLICANT RESPONSE:

Washington Adventist Hospital is currently engaged in reducing full-time equivalents and plans to reduce a total of 47 full-time equivalents between 2013 and 2018, as follows:

Ancillary Services	-4.9 FTE
Facility Services	+1.4 FTE
Financial Services	-3.1 FTE
Patient Care Services	-19.4 FTE
Support & Overhead	-23.1 FTE
Surgical and Cardiovascular	+1.9 FTE

Table 5 below notes the changes in full-time equivalents by position.

Washington Adventist Hospital

Table 5. Manpower Information

Cost Centers	2013 FTEs	2018 FTEs	Change in FTEs	2019 FTEs	Avg Salary per FTE	2019 Total Cost
WAH Outpatient Wound Care	4.1	4.0	(0.1)	8.0	$ 63,600	$ 508,800
WAH Radiology	21.6	21.3	(0.3)	25.6	$ 71,100	$ 1,820,160
WAH Mammography	2.0	2.1	0.1	2.1	$ 82,300	$ 172,830
WAH CT Scan	8.5	8.6	0.1	8.6	$ 85,100	$ 731,860
WAH MRI Scanner	2.7	2.9	0.2	2.9	$ 61,400	$ 178,060
WAH Nuclear Medicine	3.6	3.5	(0.1)	3.5	$ 104,000	$ 364,000
WAH Interventional Radiology	2.0	2.0	-	2.0	$ 85,000	$ 170,000
WAH Ultrasound	6.1	6.2	0.1	6.2	$ 89,500	$ 554,900
WAH Radiation Oncology	4.6	4.9	0.3	-	$ 58,300	$ -
WAH Pharmacy	38.1	35.6	(2.5)	38.5	$ 81,300	$ 3,130,050
WAH Physical Therapy	11.7	11.3	(0.4)	11.8	$ 79,900	$ 942,820
WAH Occupational Therapy	5.1	5.0	(0.1)	5.2	$ 95,600	$ 497,120
WAH Speech Therapy	2.8	2.9	0.1	3.0	$ 69,200	$ 207,600
WAH Nutrition Services	44.6	42.3	(2.3)	48.2	$ 29,200	$ 1,407,440
Ancillary Services Total	**157.5**	**152.6**	**(4.9)**	**165.6**		**$ 10,685,640**
WAH Plant Operations and Services	18.6	19.6	1.0	24.6	$ 62,000	$ 1,525,200
WAH BioMed Engineering	4.3	4.4	0.1	4.4	$ 93,300	$ 410,520
WAH Security	16.3	16.0	(0.3)	21.0	$ 39,100	$ 821,100
WAH Safety Emergency Preparedness	1.0	1.0	-	1.0	$ 90,200	$ 90,200
WAH Environmental Services	15.3	16.0	0.7	22.0	$ 27,900	$ 613,800
WAH Laundry	2.0	2.0	-	3.0	$ 33,500	$ 100,500
WAH Telecommunications	5.8	5.7	(0.1)	5.7	$ 33,700	$ 192,090
Facility Services Total	**63.3**	**64.7**	**1.4**	**81.7**		**$ 3,753,410**
WAH Patient Access	39.3	37.0	(2.3)	38.0	$ 42,100	$ 1,599,800
WAH Medical Records	15.8	15.0	(0.8)	15.0	$ 38,100	$ 571,500
WAH Tumor Registry	1.0	1.0	-	1.0	$ 89,500	$ 89,500
WAH Case Management	21.3	21.0	(0.3)	21.0	$ 72,000	$ 1,512,000
WAH Population Health	3.0	3.3	0.3	3.3	$ 73,000	$ 240,900

Washington Adventist Hospital

Table 5. Manpower Information

Cost Centers	2013 FTEs	2018 FTEs	Change in FTEs	2019 FTEs	Avg Salary per FTE	2019 Total Cost
WAH Materials Management	10.0	10.0	-	10.0	$ 37,700	$ 377,000
WAH Utilization Management	3.0	3.0	-	3.0	$ 77,800	$ 233,400
Financial Services Total	**93.4**	**90.3**	**(3.1)**	**91.3**		**$ 4,624,100**
WAH Emergency Department	59.1	63.1	4.0	65.6	$ 60,500	$ 3,968,800
WAH Nursing Administration	11.3	9.2	(2.1)	9.9	$ 82,200	$ 813,780
WAH Nursing Grant-MD	1.8	1.8	-	1.8	$ 41,000	$ 73,800
WAH Patient Sitters	6.0	5.9	(0.1)	6.4	$ 33,800	$ 216,320
WAH Graduate Internship	8.9	8.2	(0.7)	8.9	$ 64,100	$ 570,490
WAH Float Pool	2.1	1.7	(0.4)	1.8	$ 55,200	$ 99,360
WAH Monitor Tech	-	9.6	9.6	9.8	$ 38,800	$ 380,240
WAH Medical Surgical Unit 2200	46.1	43.2	(2.9)	46.6	$ 62,700	$ 2,921,820
WAH Medical Surgical Unit 3200	34.6	35.6	1.0	38.5	$ 65,200	$ 2,510,200
WAH Medical Surgical Unit 4200	37.6	36.5	(1.1)	39.4	$ 63,100	$ 2,486,140
WAH Joint Center	3.7	3.7	-	-	$ 70,200	$ -
WAH Behavioral Health Unit 2100	46.7	53.8	7.1	55.5	$ 65,300	$ 3,624,150
WAH Labor and Delivery	33.0	34.5	1.5	35.9	$ 80,100	$ 2,875,590
WAH Special Care Nursery	9.8	9.8	-	9.8	$ 93,000	$ 911,400
WAH Maternal Child	31.4	31.1	(0.3)	32.3	$ 70,100	$ 2,264,230
WAH Women's Center	3.3	4.5	1.2	4.5	$ 48,100	$ 216,450
WAH Intensive Care Unit 4300	28.4	28.4	-	-	$ 79,900	$ -
WAH Intensive Care Unit 1500	40.3	39.9	(0.4)	-	$ 80,800	$ -
WAH NEW ICU	-	-	-	64.2	$ 79,500	$ 5,103,900
WAH CV Step Down Unit 2500	48.8	53.4	4.6	57.7	$ 65,300	$ 3,767,810
WAH Cardiac Telemetry Unit 5100	47.0	-	(47.0)	-	$ -	$ -
WAH Intermediate Care Unit 4100	46.9	53.3	6.4	57.6	$ 65,100	$ 3,749,760
WAH Inpatient Wound Care	1.5	1.5	-	1.5	$ 95,600	$ 143,400
WAH EKG	3.7	3.6	(0.1)	3.9	$ 31,000	$ 120,900
WAH Electroencephalography	1.3	1.2	(0.1)	1.2	$ 41,400	$ 49,680

Washington Adventist Hospital

Table 5. Manpower Information

Cost Centers	2013 FTEs	2018 FTEs	Change in FTEs	2019 FTEs	Avg Salary per FTE	2019 Total Cost
WAH Infusion Center	1.7	2.5	0.8	2.5	$ 62,300	$ 155,750
WAH Respiratory Therapy	28.6	25.8	(2.8)	27.9	$ 70,100	$ 1,955,790
WAH Pulmonary Function	2.3	2.5	0.2	2.5	$ 60,700	$ 151,750
WAH Outpatient Behavioral Health	1.2	2.0	0.8	3.0	$ 56,700	$ 170,100
WAH Behavioral Day Treatment	3.6	3.6	-	3.6	$ 59,000	$ 212,400
WAH Needs Assessment	4.5	4.6	0.1	4.6	$ 72,700	$ 334,420
WAH TP NEW Clinic	-	-	-	7.2	$ 56,000	$ 403,200
WAH Clinical Leadership	3.0	3.0	-	3.0	$ 155,300	$ 465,900
WAH Clinical Practice	2.0	2.0	-	2.0	$ 96,900	$ 193,800
WAH Cancer Care Services	2.0	2.0	-	2.0	$ 69,200	$ 138,400
WAH Education	5.6	5.8	0.2	5.8	$ 91,900	$ 533,020
WAH Quality and Patient Safety	6.0	6.9	0.9	6.9	$ 88,300	$ 609,270
WAH Infection Control	1.6	1.6	-	1.6	$ 83,800	$ 134,080
WAH Risk Management	1.8	2.0	0.2	2.0	$ 92,800	$ 185,600
Patient Care Services Total	**617.2**	**597.8**	**(19.4)**	**627.4**		**$ 42,511,700**
WAH Care Excellence	21.3	3.0	(18.3)	3.0	$ 56,800	$ 170,400
WAH Clinical Informatics	4.0	3.0	(1.0)	3.0	$ 96,700	$ 290,100
WAH Executive Services	10.0	10.0	-	10.0	$ 169,000	$ 1,690,000
WAH Strategic Project Management	0.4	0.4	-	-	$ 58,000	$ -
WAH Patient Relations	2.0	2.0	-	2.0	$ 62,400	$ 124,800
WAH Guest Services	2.2	2.1	(0.1)	2.1	$ 31,300	$ 65,730
WAH Internal Transporters	13.8	11.0	(2.8)	7.5	$ 24,300	$ 182,250
WAH Human Resources	4.0	4.0	-	4.0	$ 75,400	$ 301,600
WAH Occupational Health Services	0.6	-	(0.6)	-	$ 75,400	$ -
WAH Medical Staff	4.0	4.5	0.5	4.5	$ 76,500	$ 344,250
WAH Foundation Office	2.4	2.0	(0.4)	2.0	$ 84,200	$ 168,400
WAH Volunteers	1.9	2.0	0.1	2.0	$ 58,800	$ 117,600
WAH Gift Shop	1.3	1.1	(0.2)	1.1	$ 28,700	$ 31,570

Washington Adventist Hospital

Table 5. Manpower Information

Cost Centers	2013 FTEs	2018 FTEs	Change in FTEs	2019 FTEs	Avg Salary per FTE	2019 Total Cost
WAH Pastoral Care	3.8	3.5	(0.3)	3.5	$ 70,900	$ 248,150
Shared Corporate Services	-	-	-	-	$ -	$ 6,420,000
Support & Overhead Total	**71.7**	**48.6**	**(23.1)**	**44.7**		**$ 10,154,850**
WAH Nurse Practitioner Cardiac	9.1	9.7	0.6	10.5	$ 104,100	$ 1,093,050
WAH Transcare	16.3	19.5	3.2	20.2	$ 77,500	$ 1,565,500
WAH Surgical Services OR	37.4	39.3	1.9	42.5	$ 75,600	$ 3,213,000
WAH Surgical Services PACU	8.3	7.4	(0.9)	7.9	$ 87,400	$ 690,460
WAH Surgical Services PAs	8.6	7.7	(0.9)	8.3	$ 136,900	$ 1,136,270
WAH Surgical Services Endo	0.2	1.1	0.9	1.0	$ 43,500	$ 43,500
WAH Surgical Services Short Stay	10.6	11.5	0.9	12.4	$ 76,000	$ 942,400
WAH Anesthesiology	2.5	2.0	(0.5)	2.0	$ 41,300	$ 82,600
WAH Central & Sterile Processing	10.7	11.1	0.4	10.0	$ 47,600	$ 476,000
WAH Cardiology	7.4	6.8	(0.6)	7.4	$ 75,700	$ 560,180
WAH Cardiac Data Management	3.0	3.0	-	3.0	$ 89,000	$ 267,000
WAH Cardiology - Research	4.2	3.7	(0.5)	3.7	$ 82,100	$ 303,770
WAH Cardiac Cath Lab	19.7	18.0	(1.7)	19.4	$ 88,700	$ 1,720,780
WAH Electrophysiology	9.7	9.0	(0.7)	9.7	$ 80,700	$ 782,790
WAH Cardiac Rehab	2.3	2.1	(0.2)	2.3	$ 67,400	$ 155,020
Surgical & CV Services Total	**150.0**	**151.9**	**1.9**	**160.3**		**$ 13,032,320**
Total Salaries	**1,153.1**	**1,105.9**	**(47.2)**	**1,171.0**		**$ 84,762,020**
Benefits at 21% of Salaries, based on historical experience						**$ 17,800,000**
Total Salaries and Benefits						**$ 102,562,000**

21. The Department of Health and Mental Hygiene's "Maryland's All Payer Model," submitted to the Centers for Medicare and Medicaid Innovation on October 11, 2013, anticipates that, "The CON program would support the success of the Maryland All-Payer Model by considering the goals and objectives of the model in its decisions to approve or deny health

care facility projects by requiring health care facilities to demonstrate that their projects are viable without reliance on continually growing service volume." Given this expectation:

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

APPLICANT RESPONSE:

As demonstrated in the utilization discussion, Washington Adventist Hospital has projected average annual growth rates for MSGA admissions and outpatient visits well below the estimated population growth for the service area which suggests that the per capita growth is expected to decline. This is consistent with the Maryland All Payor Model proposal and also demonstrates that the hospital is not relying on continually growing service volume. Additionally, the hospital projects ramping up of service volumes as a function of population growth and market share recapture beginning to taper off and stabilize in 2023. As shown in exhibit 31 of the original CON, the hospital reaches a point of profitability in the fourth year following the opening of the relocated hospital and would not require additional volumes at that point in order to remain viable.

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

APPLICANT RESPONSE:

The hospital believes that its forecasts are consistent with a future in which demand for hospital admissions is trending down. The hospital has projected continued declines in MSGA admissions, even before the shift of more short stay admissions to the outpatient setting, of 2.2% annually prior to the opening of the relocated hospital. It is also important to note that the MSGA admissions in 2023 are below the MSGA admissions at Washington Adventist in 2009 of 13,079.

Washington Adventist Hospital
Summary of MSGA Admission Projections
Calendar Year 2012 through 2023

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Baseline MSGA Admission Projection	9,694	8,691	8,500	8,313	8,130	7,951	7,776	8,398	9,154	10,161	11,075	11,850
% Change		*-10.3%*	*-2.2%*	*-2.2%*	*-2.2%*	*-2.2%*	*-2.2%*	*8.0%*	*9.0%*	*11.0%*	*9.0%*	*7.0%*
Reclass to Observation		(127)	(784)	(917)	(1,042)	(1,051)	(989)	(1,060)	(1,157)	(1,278)	(1,405)	(1,513)
Revised MSGA Admissions	9,694	8,564	7,716	7,396	7,088	6,900	6,787	7,338	7,997	8,883	9,670	10,337
%Change		*-11.7%*	*-9.9%*	*-4.1%*	*-4.2%*	*-2.7%*	*-1.6%*	*8.1%*	*9.0%*	*11.1%*	*8.9%*	*6.9%*

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

APPLICANT RESPONSE:

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%**

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

23. **Regarding COMAR 10.24.12.04(2):**

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

APPLICANT RESPONSE:

According to the Guidelines for Perinatal Care, 7th Edition (October 2012).

Under the Cesarean Delivery heading: "*Historically, the consensus has been that hospitals should have the capability of beginning a cesarean delivery within 30 minutes of the decision to operate. However, the scientific evidence to support this threshold is lacking. The decision-to-incision interval should be based on the timing that best incorporates maternal and fetal risks and benefits. For instance many of these clinical scenarios will include high-risk conditions or pregnancy complications (eg, morbid obesity, eclampsia, cardiopulmonary compromise, or hemorrhage), which may require maternal stabilization or additional surgical preparation before performance of emergent cesarean delivery. Conversely, examples of indications that may mandate more expeditious delivery include hemorrhage from placenta previa, abruption placentae, prolapse of the umbilical cord, and uterine rupture. Therefore, it is reasonable to tailor the time to delivery to local circumstances and logistics." Page 192*

Washington Adventist Hospital has the following personnel available 24 hours per day, 7 days per week in the event that a cesarean delivery is required: in house anesthesiologists, obstetricians, labor and delivery nurses, nursery nurses, as well as neonatologists and pediatricians.

    b. **For Standard 13.7., please provide the hospital's policy to eliminate deliveries by induction of labor or by caesarean section prior to 39 weeks gestation without a medical**

indication. The application includes data regarding this measure, but does not explain how the hospital addresses the occurrences and what a plan of action might include.

APPLICANT RESPONSE:

Washington Adventist Hospital Policy WWS.9518 Scheduled Procedures in Labor and Delivery is attached as Exhibit 77.

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

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

APPLICANT RESPONSE:

Policy LD-38, Performance Improvement Plan is attached as Exhibit 78.

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

APPLICANT RESPONSE:

In fiscal year 2012, Washington Adventist Hospital provided $3.3M, 10.09%, uncompensated care to its psychiatric patient population as compared to the overall uncompensated care provided by Montgomery County hospitals of 8.27%, and the state of 6.68%, as reported in the FY 2012 HSCRC Annual Filing reports.

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

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

APPLICANT RESPONSE:

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 current state subjects the staff to many cords and electrical 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. With the existing size of the operating rooms, there is a high potential for surgical field contamination due to the limited space. 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 of existing operating rooms 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 facilities have 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 without standardized periodic automatic replenishment (PAR) levels with 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.

~~**27. Regarding COMAR 10.24.11.05B(8), please provide financial projections and staffing projections for the Surgery Department only.**~~ ***Question Withdrawn 11/5/13***

~~**28. Provide a service area population-based analysis of the need for surgical capacity at the proposed replacement hospital.**~~ ***Revised 11/5/13:***

28. Please explain the reasons behind the real and projected decline of surgical volume at Washington Adventist Hospital between 2009 and 2018. Also explain the assumptions leading to a volume rebound of well over 30% between 2018 and 2023. Also provide a detailed explanation of the statements in the first paragraph of page 92, specifically explaining how service area population was used in projecting total inpatient and outpatient cases. Please cite any information you have that documents the service area use rate of surgical services.

APPLICANT RESPONSE:

Inpatient and outpatient cases declined between 2009 and 2012 due to a shift in cases to outpatient surgery centers and a loss of surgeons at the hospital.

Between 2013 and 2018, outpatient surgery cases are estimated to grow at about the same rate as population growth considering the MSGA service area as a proxy for surgeries. Washington Adventist Hospital considered the five-year average outpatient minutes/outpatient case of 60 minutes and applied that to the projected outpatient cases to estimate outpatient surgery minutes. The drop in outpatient minutes between 2012 and 2013 is due to lower average outpatient minutes per outpatient case compared to what was observed in 2012. Inpatient surgery cases were estimated considering projected inpatient MSGA admissions (including observation visits) and the historical relationship of inpatient surgery cases/MSGA admission and inpatient surgery minutes/inpatient surgery cases. MSGA admissions were estimated to decline between 2013 and 2018 based on historical performance and patient/physician patterns that have been experienced over the past few years.

Before 2019, both inpatient and outpatient volume was estimated to grow below population projections. After the relocated hospital opens, both inpatient and outpatient cases are projected to grow at a rate higher than population assuming recapture of the volume lost between 2009 and 2018. Total estimated surgery minutes of 673,765 in 2023 is below total surgery minutes of 719,835 in 2009.

Average utilization statistics applied to estimated outpatient cases and to MSGA admissions to determine total minutes can be found on page 91 of the CON application.

Response to Other Criteria:

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

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

APPLICANT RESPONSE:

Many factors were taken into account when evaluating the market share changes as a result of the relocation to White Oak, of which existing physician relationships was one. These factors include the location of the new hospital, proximity to other hospitals, drive times, major streets and highways, current market share of other providers, along with existing physician relationships. With respect to physician relationships, our calculation considered that the specific White Oak location was a net positive from an access standpoint for physicians for whom the hospital has a current relationship.

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

APPLICANT RESPONSE:

Both increases in market share for zip codes closer to the White Oak location, as well as decreases in market share for zip codes further from the White Oak location, were considered in redefining the new service area. Market share within each zip code was analyzed independently, discharges by zip code were recalculated based on the newly estimated market share and the total service area was then redefined based on those zip codes that now comprised 85% of total estimated discharges. A number of factors were observed that contributed to the reduction of zip codes without inclusion, overall demonstrating a tightening of the service area:

- Washington Adventist Hospital will move closer to the northern zip codes already being served and farther from zip codes in Washington, D.C. and along the beltway. In the analysis, consideration was made to add the northern zip codes, 20868, 20777, 20759, and 20723 not currently in the Washington Adventist Hospital Takoma Park service area, but they did not meet the definition of primary and secondary service area for White Oak.
- The number of patients originating from the proposed home zip code of 20904 and 20906 are the largest patient populations observed from all the zip codes within the current Washington Adventist Hospital Takoma Park primary service area. Although historically Washington Adventist Hospital only held 11.3% market share in the proposed White Oak home zip code of 20904, it was the 5th highest in patient origination. Increases in market share in these more populated zip codes within the primary service area resulted in a shift of zip codes from the primary service area to the secondary service area.
- Relocation away from Washington, D.C. resulted in certain zip codes within the secondary service area to shift out of the total service area.

c. Please specify the use rate assumptions that were made in projecting the 2022 admissions/discharges from WAH's TSA as they appear in the table on Page 104 for

MSGA admissions, Page 111 for psychiatric discharges, and the obstetric and newborn discharges on page 118. Explain the basis for these assumptions.

APPLICANT RESPONSE:

Population growth rates estimated by age cohort (15-44, 45-64, 65-74, 75+) and zip code were applied to the respective CY2012 discharge cohorts to determine discharges in 2022 within the White Oak service area. It is assumed that use rates will remain constant.

Based on an analysis performed by Kaufman Hall, Maryland has experienced a large decline in inpatient use rates from 2006-2011 of almost 10%.[2] Use rates for 2012 were estimated by taking total admissions in the Washington Adventist Hospital – White Oak Total Service Area, excluding Washington, D.C. zip codes, and determined based on population that the inpatient use rate for MSGA was approximately 68.4 per 1,000 in population. Assuming a 20% – 25% outmigration factor would adjust that use rate to 85.5 to 91.2 per 1,000 in population.

A study conducted in 2011 by Milliman for Kaufman Hall estimates an average inpatient use rate of 89 per 1,000 for 2021, down from 103 per 1,000 in 2011. Even with estimating a high 20%-25% outmigration factor with 2012 use rates, Washington Adventist Hospital is still approximating the average inpatient use rate to be in the range of Milliman's estimate of 89 per 1000 in 2021. Based on this analysis the hospital believes that current use rates are appropriate for the projections as Maryland is already below inpatient use rates at a national level.

In addition to other factors such as an improving economy and an aging population, independent studies expect a one-time impact on expanded insurance coverage on utilization to be small but significant. In a study by McKinsey[3], it is estimated that inpatient utilization will likely increase by 30%-35% for the uninsured population newly obtaining coverage. This increase in utilization could result in all discharges increasing up to 100 basis points nationally. This increase was not reflected in the Washington Adventist Hospital projections but is additional support of why current use rates were used in the projections.

Psychiatric, obstetric and newborn use rates were kept at current levels and specific population growth rates by age cohort were applied to current discharges in 2012 to project 2022 discharges.

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

APPLICANT RESPONSE:

In determining inpatient MSGA admissions and outpatient observations volume projections for this application, the hospital has taken into account the anticipated impact of the two midnight rule within the most recent Final Rule effective October 1, 2013. The hospital anticipates that this will cause even

[2] "Decline in Utilization Rates Signals A Change In The Inpatient Business Model", Mark Grube, Kenneth Kaufman, and Robert York of Kaufman Hall, March 8, 2013.
[3] "The impact of coverage shifts on hospital utilization", Edward Levine, MD; Noam Bauman; and Bowen Garrett, PhD; of McKinsey & Co., May 2013.

further shift of short stay inpatient cases (those not crossing two midnights) to outpatient observation. As a result, the baseline inpatient MSGA volume projections are offset by the shift in a significant number of these short stay cases to the outpatient setting leading to significant decreases in Washington Adventist Hospital inpatient utilization during the calendar year period 2013 to 2018. This causes a corresponding spike in outpatient observation volumes in the early years of the projection until the effects of this shift stabilize in 2016. After 2016, the model assumes that only 70% of the current short stay case rate will be considered outpatient in the future as there will still be a portion of the population that will remain true short stay inpatient cases. The average length of stay for observation cases is assumed constant at 24.6 hours per visit for the projection period. The movement of short stay cases from inpatient to outpatient causes a corresponding increase in MSGA ALOS despite a 7.4% ALOS reduction effort from calendar year 2013 to 2014.

Washington Adventist Hospital
Analysis of Moving ODS to OBV
Calendar Years 2012 - 2023

	Volumes											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Original MSGA Admissions	9,694	8,691	8,500	8,313	8,130	7,951	7,776	8,398	9,154	10,161	11,075	11,850
ODS Adjustment		(183)	(895)	(1,051)	(1,199)	(1,172)	(1,147)	(1,238)	(1,350)	(1,498)	(1,633)	(1,747)
>48 Hour Adjustment		56	111	134	157	157	158	178	193	220	228	234
Revised MSGA Admissions	9,694	8,564	7,716	7,396	7,088	6,936	6,787	7,338	7,997	8,883	9,670	10,337
		-11.7%	*-9.9%*	*-4.1%*	*-4.2%*	*-2.1%*	*-2.1%*	*8.1%*	*9.0%*	*11.1%*	*8.9%*	*6.9%*
Original OP Observation Visits	1,300	2,151	2,158	2,165	2,172	2,178	2,185	2,464	2,672	3,041	3,162	3,241
Additional Observation Visits		127	784	917	1,042	1,015	989	1,060	1,157	1,278	1,405	1,513
Revised Observation Visits	1,300	2,278	2,942	3,082	3,214	3,193	3,174	3,524	3,829	4,319	4,567	4,754
		75.2%	*29.1%*	*4.8%*	*4.3%*	*-0.7%*	*-0.6%*	*11.0%*	*8.7%*	*12.8%*	*5.7%*	*4.1%*
Total cases requiring a bed (MSGA + OBV)	10,994	10,842	10,658	10,478	10,302	10,129	9,961	10,862	11,826	13,202	14,237	15,091
		-1.4%	*-1.7%*	*-1.7%*	*-1.7%*	*-1.7%*	*-1.7%*	*9.0%*	*8.9%*	*11.6%*	*7.8%*	*6.0%*

	ALOS											
	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Original MSGA Days (includes ALOS reduction from 5.4 to 5.0 by 2014)	52,348	46,931	42,500	41,565	40,650	39,755	38,880	41,990	45,770	50,805	55,375	59,250
Convert ODS to OBV Days		(183)	(895)	(1,051)	(1,199)	(1,172)	(1,147)	(1,238)	(1,350)	(1,498)	(1,633)	(1,747)
Convert >48 hr OBV to IP Days		142	281	339	398	398	400	451	489	557	577	593
Revised MSGA Days	52,348	46,890	41,886	40,853	39,849	38,981	38,133	41,203	44,909	49,864	54,319	58,096
Revised ALOS	5.4	5.5	5.4	5.5	5.6	5.6	5.6	5.6	5.6	5.6	5.6	5.6
Observation Hours		56,130	72,491	75,940	79,193	78,676	78,207	86,831	94,347	106,420	112,531	117,139
Average Hours/Visit		24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6	24.6

Outpatient Department Visits:

In Table 1, Outpatient Department visits include clinic visits and ancillary only visits. Services captured in this category would be mostly clinic visits with minimal laboratory only visits, diagnostic imaging only visits, and outpatient therapies. One of the challenges within the current Washington Adventist campus is that the footprint of the hospital designated for outpatient services is extremely constrained. As a result, the capacity for increased outpatient services is limited in the period of the projection covering calendar year 2013 through 2018. The hospital, therefore, limited the projected growth in this period to approximately the projected population growth for the service area.

In 2019, subsequent to the completion of the proposed project, the hospital will have significantly expanded capacity for outpatient services at the White Oak location as well as the retention of some outpatient services at Takoma Park and the expansion of a primary care clinic at the Takoma Park location. The majority of the growth in outpatient department visits is attributable to the primary care clinic that will be established at the Takoma Park location. As shown below, the majority of outpatient department growth is due to the primary care clinic visits. While the percent growth in visits may seem substantial, it is important to note that the incremental visits are on a relatively low volume base to begin with and the average revenue per visit for the primary care clinic is much lower than the overall average outpatient revenue per visit. This service is required to ensure that the underinsured population in Takoma Park has access to primary care services in an attempt to reduce unnecessary emergency department visits and admissions at both the proposed hospital location in White Oak as well as other area hospitals.

Washington Adventist Hospital
Summary of Outpatient Department Growth
CY 2012 - CY 2023

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Total OP Department Visits	16,048	16,289	16,475	16,664	16,855	17,049	17,243	22,382	28,600	30,888	32,123	32,927
Growth in Visits		*241*	*186*	*189*	*191*	*194*	*194*	*5,139*	*6,218*	*2,288*	*1,235*	*804*
Primary Care Clinic Visit Growth	-	-	-	-	-	-	-	4,602	5,154	781	421	274
% of Overall OP Dept Growth		*0%*	*0%*	*0%*	*0%*	*0%*	*0%*	*90%*	*83%*	*34%*	*34%*	*34%*

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

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

APPLICANT RESPONSE:

Exhibit 79 is the Summary Schedule Master Plan Phases 1 and 2 for Option B.

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

APPLICANT RESPONSE:

The existing surgery, In-Patient and Same-Day-Surgery (SDS), is currently located on Level 1 of the 1970-80s building with relatively low floor-to-floor heights and small operating rooms. In the long range Campus Master Plan for Takoma Park, the intent is to relocate all surgical services to Level 2 in new spaces. The scope of the Cost-Effective Alternative is limited to Phase 1 and 2 which address the major issues of patient beds, older existing buildings and infrastructure, and parking. Work on the existing 1970-80s buildings on the Takoma Park campus are not included in Option B, but are shown on the longrange Campus Master Plan.

After Phase 2, the inpatient surgery facilities will be split between two different areas on Level 1 (SDS in the 1970-80s building) and new facilities on Level 2 of the new construction. In a future phase when the 1970-80s building is replaced the surgery department will be expanded and united on Level 2.

This condition is shown in Exhibit 56 on page 17 (Phase 1 Detail, Level 01), Surgery remaining on Level 1 in Phase 1. In Phase 2, Exhibit 56 shows the Surgery facilities on two levels: on page 27 (Phase 2 Detail, Level 01) shows SDS on Level 1 and page 28 (Phase 2 Detail, Level 02) shows SDS, Surgery, and PACU on Level 2.

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

APPLICANT RESPONSE:

Please refer to Exhibit 80, which includes financial projections and corresponding assumptions for Options B, C, and D in both inflated and in current dollars with both a 50% and 85% variable cost factor. Following each financial projection is a detailed list of volume, rate and expense inflation assumptions. The inflated projections also include assumptions for revenue update factor and expense inflation by category.

With respect to the projections under a 50% variable cost factor, the hospital does not believe that it is appropriate to rely on projections where only the variable cost factor is adjusted. The projections that were initially provided in the original CON application are consistent with current HSCRC methodologies for rate setting which include an 85% variable cost factor. If the HSCRC were to adopt a 50% variable cost factor, adjustments to other rate setting methodologies and assumptions would likely need to be made. These may include but are not limited to, increased annual update factor amount, adjustments for market share shifts, adjustments for improvements in avoidable volumes, and alternative avenues for access to capital, to name a few.

The hospital believes that the assumptions made in preparing the financial projections originally submitted as part of the CON are both reasonable and consistent with the current HSCRC methodologies for revenue.

Revenues were projected using the current HSCRC annual rate update methodology. This includes an approved charge per episode adjusted for case-mix changes and outpatient revenues as fee for service. Unit rates and the charge per episode were adjusted for the following: reversal of prior year adjustments, update factor, efficiency offset, case-mix index, and a prospective volume adjustment (50% or 85% as labeled on each projection sensitivity). All assumptions with the exception of volumes and case-mix which are listed in the assumptions section of each projection were held constant throughout Options B, C, and D. A summary of the components of the revenue build up can be seen below for the proposed option with an 85% variable cost factor.

Washington Adventist Hospital
Option D - Proposed Project - With Inflation @ 85% VCF
Calendar Year 2013 - 2023

Gross Revenues:		CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	CY 2023
Reversal of One-Time Adjustments (1)		**1.17%**	**1.17%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**	**0.00%**
Annual Update Factor		0.75%	1.50%	1.50%	2.00%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%	2.50%
Less: Efficiency scaling		0.00%	-0.25%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%	-0.50%
Subtotal Update Factor		**0.75%**	**1.25%**	**1.00%**	**1.50%**	**2.00%**	**2.00%**	**2.00%**	**2.00%**	**2.00%**	**2.00%**	**2.00%**
Aggregate raw volume change		-2.94%	-0.38%	0.31%	-0.14%	-0.12%	-0.08%	7.93%	8.68%	8.00%	5.71%	4.13%
IP CMI Change		-0.97%	-0.68%	0.32%	0.33%	-0.71%	-0.72%	0.90%	1.02%	1.23%	0.98%	0.75%
IP Included Revenue %		58.45%	58.04%	57.71%	57.25%	56.85%	56.47%	50.28%	49.90%	50.62%	51.64%	52.51%
Subtotal CMI Impact on Volume		-0.57%	-0.40%	0.19%	0.19%	-0.41%	-0.40%	0.45%	0.51%	0.62%	0.51%	0.40%
Total Volume change		**-3.51%**	**-0.78%**	**0.50%**	**0.05%**	**-0.52%**	**-0.49%**	**8.38%**	**9.19%**	**8.63%**	**6.22%**	**4.53%**
Less: Volume Adjustment from PY state fiscal years		0.50%	0.35%	0.07%	-0.01%	0.03%	0.07%	-0.34%	-1.09%	-1.40%	-1.22%	-0.91%
Total Impact of Volume on Revenue		**-2.44%**	**-0.42%**	**0.57%**	**0.04%**	**-0.49%**	**-0.42%**	**8.04%**	**8.10%**	**7.23%**	**5.00%**	**3.62%**
Overall Gross Patient Revenue Change		**-1.09%**	**1.99%**	**1.57%**	**1.54%**	**1.51%**	**1.58%**	**10.04%**	**10.10%**	**9.23%**	**7.00%**	**5.62%**
Expenses (Not including Capital):												
Aggregate Base Operating Expense Inflation		1.19%	1.88%	1.88%	2.15%	2.16%	2.16%	2.17%	2.18%	2.20%	2.22%	2.23%
Expense Increase/Decrease above inflation	B	-0.79%	-1.81%	-1.38%	-0.99%	-0.83%	-0.17%	5.39%	5.28%	5.32%	4.01%	3.16%
Overall Expense Growth		**-0.10%**	**0.06%**	**0.50%**	**1.16%**	**1.32%**	**1.99%**	**7.56%**	**7.46%**	**7.52%**	**6.23%**	**5.39%**

(1) Includes:
- Reversal of large FY 2012 overcharge of $4.7M reflected in FY2013 rates. Half impact in CY 2013, half in CY 2014.
- Reversal of MHIP negative performance in FY 2012 Rates ($2.4M)
- Addition of one time impact of MHIP/QBR positive performance in FY 2014 rates ($564K)

As shown in the assumptions for each of the uninflated projections at Exhibit 80, the assumptions used in the projections lead to both the inpatient revenue per admission and the outpatient revenue per outpatient volume to decline. The hospital believes that this is reasonable as healthcare transitions to a model that shifts focus from a system that rewards for volumes to a system that rewards for quality and more efficient use of healthcare dollars.

As demonstrated in the response to completeness question 33b and 33c, both the bad debt, charity and contractual allowances as a percent of gross patient revenues is held constant in all options. The hospital believes that these assumptions are reasonable as the current HSCRC methodologies in place take into consideration shifts in payor mix as well as increases and decreases in uncompensated care;

therefore changes in these assumptions would have corresponding and offset changes in the revenue thus leading to minimal impacts on profitability.

With the exception of expense reductions already planned and underway and capital expenses related to the project, the projections hold the base expenses per unit relatively flat throughout projection as shown in each projection, without inflation at Exhibit 80. In today's economic environment, there is no option but to reduce costs. The hospital is currently experiencing significant cost reductions and has budgeted for continued expense reductions in calendar years 2014 and 2015. Continuous and significant cost reductions will not be sustainable; therefore the Hospital believes that holding expense per unit flat beyond 2015 is a reasonable assumption. In the projections at Exhibit 80 that include expense inflation, the aggregate inflation in 2016 through 2023 is approximately 2.2% which is consistent with estimates for market basket. Assumptions for expense inflation are consistent throughout all options.

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

APPLICANT RESPONSE:

The current projections do not specifically take into account any adjustments for increases in coverage due as a result of the Affordable Care Act. While it is likely that the Affordable Care Act will lead to increased coverage, the current HSCRC methodologies already in place take into consideration shifts in payor mix as well as increases and decreases in uncompensated care. For example, as a hospital's uncompensated care decreases, the current methodologies also reduce the amount of funding built into rates for uncompensated care. The hospital fully anticipates that these policies will remain in place regardless of what transpires with the Maryland All-Payor Model proposal and therefore any impact of increased coverage on the financial projections will be minimal.

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

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

APPLICANT RESPONSE:

The Master Trust Indenture and amendments are contained in Exhibits 81-91.

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

APPLICANT RESPONSE:

The projected financials for the Adventist HealthCare Obligated Group were created using the 2012 audited financials as the base year. Following are assumptions used for 2013-2020. 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 assumptions are reasonable since they are consistent with historical performance. Note that the detail assumptions for Option D were included in the original application as part of exhibit 31.

Table 1

Adventist HealthCare Obligated Group Financial Projections

	2013	2014	2015	2016	2017	2018	2019	2020
Net patient revenue	-2.40%	1.93%	2.26%	2.04%	2.03%	2.06%	4.50%	4.64%
Salaries & Wages	1.2%	0.4%	1.3%	2.2%	2.3%	2.3%	3.8%	4.0%
Employee benefits (% of salaries)	21.30%	21.30%	21.30%	21.30%	21.30%	21.30%	21.30%	21.30%
Professional Fees	9.7%	5.1%	2.2%	2.2%	2.3%	2.3%	-0.3%	2.3%
Medical Supplies	-3.15%	2.43%	2.45%	3.32%	3.43%	3.40%	6.33%	6.77%
Purchased Services	7.1%	1.3%	1.5%	1.6%	1.6%	1.6%	2.9%	3.1%
Building & Maintenance	3.5%	1.9%	1.9%	2.0%	2.0%	2.0%	6.8%	2.0%
Insurance	-5.3%	0.8%	0.8%	0.9%	0.8%	0.9%	0.8%	0.9%
Investment Income	4.00%	5.80%	6.10%	4.7%	4.5%	4.9%	7.10%	8.30%

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

APPLICANT RESPONSE:

The $60.5 million in funds will be generated from operations and will be available as needed once the project funds are depleted. The projections on page 130 of the original CON application show financial indicators that assume the $60.5 million is generated from operations. In addition to cash generated from operations, there are various Adventist HealthCare assets that are expected to be monetized in the next 5 years that will contribute to the funds available to cover the $60.5 million.

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

APPLICANT RESPONSE:

As noted on page 11 of the application, Adventist HealthCare plans to commence Phase I of the project as soon as possible following the CON award, utilizing existing capital funds. This section also indicates that these funds will be reimbursed from the bond proceeds at the closing of the construction financing. Since the funds will be reimbursed, they are not considered to be part of the Adventist HealthCare equity contribution, but are simply fronting these expenses in the early stages of the project. As noted on page 131 on the CON application, equity contributions will begin in 2017, after the project funds from the financing are depleted.

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

APPLICANT RESPONSE:

Please refer to the projections provided in response to completeness question 30c at Exhibit 16. As previously explained, the hospital does not believe that it is appropriate to rely on projections where only the variable cost factor is adjusted. The projections that were initially provided are consistent with current HSCRC methodologies for rate setting which include an 85% variable cost factor. If the HSCRC were to adopt a 50% variable cost factor, adjustments to other rate setting methodologies and assumptions would likely also be made that may include but are not limited to increases in annual update factor, adjustments for market share shifts, adjustments for improvements in avoidable volumes, and alternative avenues for access to Capital, to name a few.

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

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

APPLICANT RESPONSE:

Other Operating Revenue	2013	2014	2015	2016	2017	2018	2019	2020	Notes
Other Operating Revenue	3,917	3,917	3,917	3,917	3,917	3,917	3,917	3,917	[1]
Meaningful Use	1,005	1,444	889	-	-	-	-	-	
Urgent Care Revenue	-	-	-	200	400	900	1,200	1,321	
Rent Revenue	-	-	-	-	-	-	2,128	2,128	[2]
Total	**4,922**	**5,361**	**4,806**	**4,117**	**4,317**	**4,817**	**7,245**	**7,365**	

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[1] Includes cafeteria sales, cardiology research, and other sources.

[2] Rental Income for lease of the following spaces in the Takoma Park facility, once the hospital opens in White Oak: (i) 55,021 square feet to Washington Adventist University for library, learning center, and clinical education space and (ii) 23,314 square feet for physician offices; considers a lease rate of $27.16 per square foot.

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

APPLICANT RESPONSE:

Total actual uncompensated care (bad debt plus charity care) for Washington Adventist Hospital has been steadily increasing over the past years. In calendar year 2011 and 2012, actual audited uncompensated care was 11.35% and 13.27% respectively. For purposes of this projection, Washington Adventist Hospital has assumed that the uncompensated care levels will remain consistent with the experience in 2012 for the duration of the projection (see table below). The hospital feels that this assumption is fair as any change in uncompensated care, increase or decrease, will be offset by a corresponding change in the amount funded in rates.

Washington Adventist Hospital
Summary of Uncompensated Care Trends
CY 2011 - CY 2023

	Actual		Projected										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Bad Debt %	7.57%	11.03%	11.00%	11.00%	11.00%	11.00%	11.00%	11.00%	11.00%	11.00%	11.00%	11.00%	11.00%
Charity %	3.78%	2.23%	2.25%	2.25%	2.25%	2.25%	2.25%	2.25%	2.25%	2.25%	2.25%	2.25%	2.25%
Total UCC %	11.35%	13.27%	13.25%	13.25%	13.25%	13.25%	13.25%	13.25%	13.25%	13.25%	13.25%	13.25%	13.25%

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

APPLICANT RESPONSE:

The contractual allowance line on the summary financial projections includes numerous assumptions detailed in the second table below. While it appears that overall contractual allowances are declining in the projected years from 2012 actual experience, this is not the case. Contractual allowances, as shown below, remain constant as a percentage of gross patient revenue throughout the projection, as do the regular HSCRC Assessments that are built into rates and subsequently paid out. The appearance of a reduction in overall contractual allowances is due to the expected increase in UCC pool payments in the last quarter of calendar year 2013, and calendar years 2014 and 2015. The UCC methodology incorporates a 3-year average actual in the determination of the amount that is funded for each hospital in rates. The 3-year average actual is lagged behind the current year. For example, the fiscal year 2013 policy uses data from calendar year 2009, 2010 and 2011 for Washington Adventist Hospital. The hospital has updated the three-year average in the methodology to reflect updated actual UCC for each year of the projection (see computation in the first table below). Because Washington Adventist Hospital is funded at a level greater than the statewide average UCC that is built into its rate structure, the hospital receives funding from the pool. This amount is reflected as a reduction in deductions from revenue.

Washington Adventist Hospital
Proforma UCC in Rates
FY 2013 - FY 2014

Annual Filing Year (CY)		SFY 2013	SFY 2014	SFY 2015	SFY 2016
2009	A	8.64%			
2010	B	9.34%	9.34%		
2011	C	11.35%	11.35%	11.35%	
2012			13.27%	13.27%	13.27%
2013				13.27%	13.27%
2014					13.27%
3-year avg.	D = (A+B+C)/3	9.78%	11.32%	12.63%	13.27%
Predicted Value	E = Held constant from 2013 policy	8.84%	8.84%	8.84%	8.84%
50/50 Blend		9.31%	10.08%	10.74%	11.06%
Charity Care Impact	F = Held constant from 2013 policy		-0.30%	-0.30%	-0.30%
Averted BD offset	G = Eliminated in 2014 methodology	-1.03%	0.00%	0.00%	0.00%
Total UCC Funding	H = (D+E)/2 + F + G	8.28%	9.78%	10.44%	10.76%
In Rates	I = 2013 Statewide Avg.	6.85%	6.85%	6.85%	6.85%
Fiscal Year Pool funding	H - I	1.43%	2.93%	3.59%	3.91%

		CY 2013	CY 2014	CY 2015
Calendar year Pool Receipts	**3/4*Prior SFY+1/4*Current SFY**	**1.81%**	**3.09%**	**3.67%**

Note: New funding levels usually begin in September so this analysis assumes that the last quarter of the calendar year will be at the new funding levels.

d. Submit an amortization table for the bond debt.

APPLICANT RESPONSE:

The bond debt amortization table is contained in Exhibit 92.

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

APPLICANT RESPONSE:

Depreciation on Existing Fixed Assets
Depreciation on existing fixed assets was calculated assuming a straight-line methodology and a remaining useful life of approximately 9 years.

Existing Amortization
Costs incurred in connection with the issuance of long-term debt obligations at Adventist HealthCare are amortized and charged to Washington Adventist Hospital. Amortization schedules are created at the time of the debt issuance considering the same life as the respective debt term.

Depreciation on Project Expenditures
Project expenditures and interest were capitalized until 2019 when the relocated hospital opens. Beginning in 2019, depreciation on the total project expenditures was calculated assuming a straight-

line methodology and a blended depreciable life of approximately 28 years. The depreciable life was estimated based on projected spending by asset category, with the following assumptions for the most significant asset categories:

- Buildings & Fixed Equipment – 40 years
- Land Improvements – 25 years
- Major & Minor Moveable Equipment – 15 years

Depreciation on Future Routine/Maintenance Expenditures

Routine/maintenance expenditures were also included in financial pro forma to address the capital needed to support continuing operations. Depreciation was calculated assuming a straight-line methodology and depreciable life of 15 years for a mix of assets.

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

APPLICANT RESPONSE:

Other Expenses	2013	2014	2015	2016	2017	2018	2019	2020	Notes
General & Administrative	13,400	13,266	13,133	13,002	12,872	12,743	12,616	12,490	
Building and Maintenance	8,500	8,500	8,500	8,500	8,500	8,500	10,509	10,509	[1]
Insurance	1,660	1,660	1,660	1,660	1,660	1,660	1,660	1,660	
Corporate Overhead	16,921	16,667	16,417	16,171	15,928	15,689	15,454	15,222	
IT Depreciation	2,105	3,215	3,215	3,215	3,215	3,215	3,215	3,215	
Expense Deductions	-	-	(1,872)	(3,276)	(4,680)	(4,680)	(4,680)	(4,680)	
Total	**42,586**	**43,308**	**41,053**	**39,272**	**37,495**	**37,127**	**38,774**	**38,416**	

[1] Increase in 2019 due to the operation of both the Takoma Park and White Oak campuses and estimated based on square footage.

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

APPLICANT RESPONSE:

The overhead allocation includes management fees and shared services expenses from the Adventist HealthCare corporate office as well as an allocation for IT services.

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

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

Claritas or projecting years beyond the data provided, explain the methods used to interpolate and/or project the data.

APPLICANT RESPONSE:

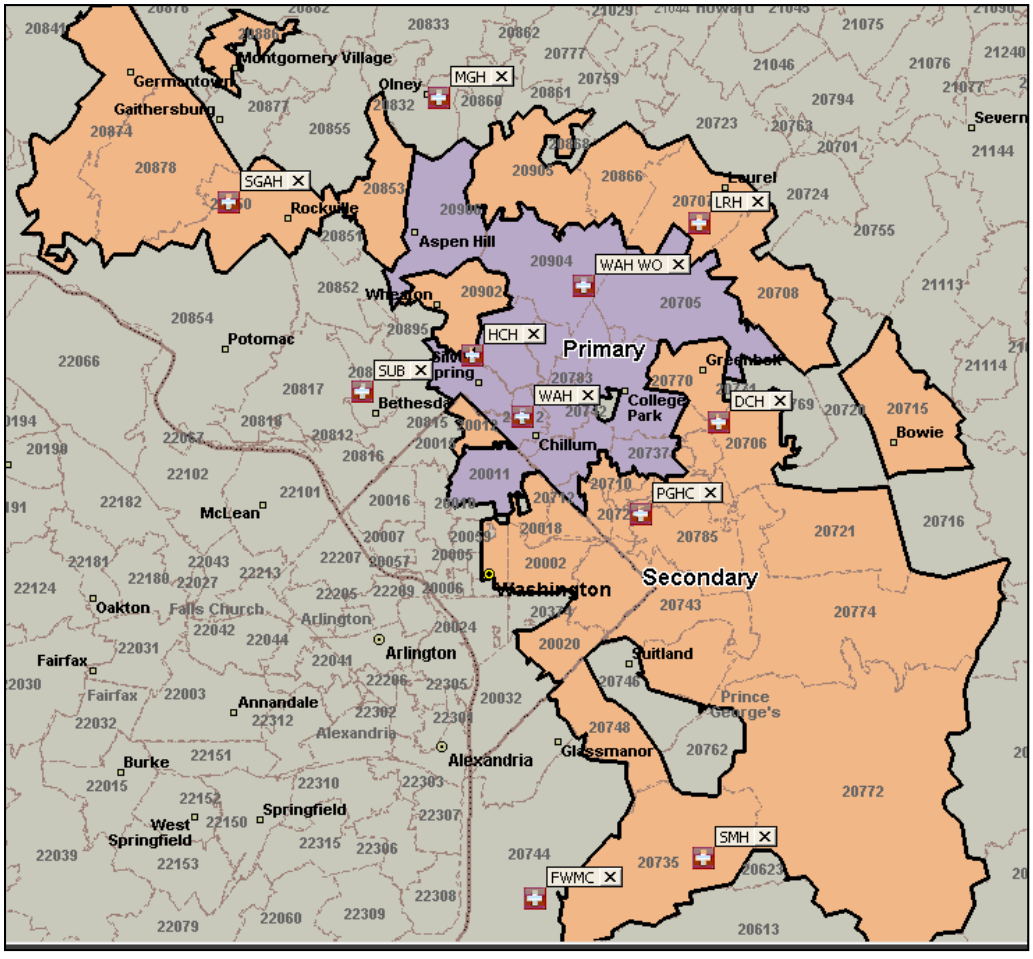
This was a typo in the application as population growth rates were based solely on data from Nielson Claritas. Nielson Claritas provided population projections by various cohorts and zip code for CY2012, CY2013, and CY2018. The same compound annual growth rate was applied by the selected demographic cohort for projections past CY2019. See Exhibit 93 for a summary of data used.

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

APPLICANT RESPONSE:

Overall market share adjustment methodology that was used in redefining the service area for both MSGA and obstetrics was described on pages 99 -100 and is replicated here:

Current WASHINGTON ADVENTIST HOSPITAL MSGA Primary and Secondary Service Area



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

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

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

- Identification of proximity of zip code to all acute care hospital providers including drive time and distance
- Analysis of current market share for acute care hospital providers relative to their location to the zip code
- Approximation of the shift in market share as a result of the proposed replacement hospital recognizing both the distance and current market presence within each zip code.

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

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

Source: Based on Travel Time Study (Exhibit 16)

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

Taking into account all of the factors and methodology listed above, we applied market share adjustments as noted on pages 137-138 of the CON application.

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

APPLICANT RESPONSE:

The tables present the steps considered to project CY2022 discharges and market share by hospital provider in Montgomery County and Prince George's County. The changes in market share due to the relocation and population growth in estimating impact to other providers were both considered. The columns are described below:

- Column 1 – Presented actual CY2012 discharges originating from the Washington Adventist Hospital-White Oak TSA by hospital and their respective market share. Discussions on how the

Washington Adventist Hospital-White Oak TSA was defined can be located on page 97 –101 for MSGA and page 114 – 116 for obstetrics. The total discharges reconciles to the bed need analysis on page 103 – 104 for MSGA and page 118 for obstetrics.

- Column 2 – Demonstrated the estimated change in discharges as a result of the Washington Adventist Hospital relocation to White Oak. The impact to all providers within each zip code was analyzed individually and presented the total net effect by provider in column 2 of the table. Further, it was estimated that Washington Adventist Hospital would witness an increase of 1,002 discharges based solely on the relocation and the other hospitals would experience the increases or decreases identified in the table. The "other providers" label represents out-migration in which patients originating from the Washington Adventist Hospital-White Oak TSA went to hospitals outside of Montgomery County and Prince George's County.
- Column 3 – Calculated adjusted CY2012 discharges by adding base CY2012 discharges in Column 1 to the estimated adjustment from the relocation in Column 2. The market share % was recalculated based on the total discharges.
- Column 4 – Represents the estimated additional cases that will come from population growth over the next 10 years. The total incremental growth for MSGA discharges reconciles to the bed need analysis on page 104 (86,110 – 69,054 = 17,056) and to page 118 for obstetric discharges (9,720 – 9,278 = 442).

  Washington Adventist Hospital incremental discharges were based on estimated volume and capacity constraints at the new hospital after considering the additional discharges as a result of the move (Column 2). The remaining discharges from population growth were distributed to the other providers based on their adjusted CY2012 market share.
- Column 5 – Equaled the adjusted CY2012 discharges (Column 3) plus the discharges from volume growth (Column 4) to determine total discharges. The market share % was recalculated based on the total discharges.

The table illustrates that every hospital will experience increased MSGA cases with only slight changes in overall market share from where they are today.