395

BARNES & THORNBURG

11 South Meridian Street
Indianapolis, Indiana 46204-3535 U.S.A.
(317) 236-1313
Fax (317) 231-7433

www.btlaw.com

J. Michael Grubbs
(317) 231-7224
Email: mgrubbs@btlaw.com

GEO RECLASS
CBSAs

KENLY
JONES
HEFTER
HARTSTEIN

Certified Mail
Return Receipt Requested

June 24, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

RE: Geographic Reclassification (CMS-1500-P)

Dear Sir or Madam:

These comments address the May 4, 2005 proposed rule regarding "Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates." 70 Fed. Reg. 23306 ("Proposed Rule"). These comments are submitted on behalf of Ball Memorial Hospital of Muncie, Indiana (Delaware County, IN 15-0089).

With respect to Geographic Reclassification, in Section III.H of the Proposed Rule, CMS did not specifically invite comments about the "special circumstances of hospitals in single-hospital MSAs and whether their special circumstances should be addressed by revisions to the regulations governing reclassification, or other measures" as it did in last year's proposed rule. 69 Fed. Reg. at 28290-28291. However, during a meeting between my partner, Robert T. Grand, and CMS Administrator McClellan on this subject in early May 2005 to discuss the single-hospital MSA issue on behalf of Ball Memorial, Dr. McClellan suggested that we submit comments on this issue in response to the Proposed Rule.

Ball Memorial Hospital is the only hospital in the Muncie, IN MSA. CMS believes that a single-hospital MSA ("S-H MSA") is problematic because it "reduces the averaging effect of the wage index, lessening some of the efficiency incentive inherent in a system based on the average hourly wages for a large number of hospitals. In labor market areas with a single hospital, high wage costs are passed directly into the wage index with no counterbalancing averaging with lower wages paid at nearby competing hospitals. . . . it creates an arguably inequitable system when so many hospitals have wage indexes based solely on their own wages, while other hospitals' wage indexes are based on an average hourly wage across many hospitals." *Id.*

CMS acknowledges that, due to the 108% test, the only way that hospitals in S-H MSAs can currently qualify for reclassification, even if they meet the relevant distance criteria, is to obtain exemption from the wage threshold requirements based on rural referral center status. 69 Fed. Reg. at 28290. However, the only S-H MSAs that have been able to qualify for reclassification to other urban areas under this exemption are those composed of urban counties that were formerly classified as part of rural areas. Most of the current S-H MSAs (and likely most of the newly proposed S-H MSAs) are composed of counties that have not ever been classified as rural. Ball Memorial Hospital has never been classified as rural.

CMS further acknowledges that S-H MSAs are disadvantaged financially in raising wages to levels of nearby MSAs due to the three year lag in the data used to compute the wage index. *Id.* CMS states that this disadvantage "may only be temporary" because, if hospitals in S-H MSAs were to raise their average hourly wage ("AHW") to the same AHW as the urban MSAs with which they compete, the S-H MSAs could increase their wage indexes to the same level as the wage index of competing MSAs in three years time. *Id.* Even if the delay is characterized as "temporary" - it is nevertheless very significant. Because labor supply shortages tend to fuel wage inflation, the AHWs of competing MSAs have historically also increased from year to year and will likely continue to do so for the foreseeable future. Unless the labor shortage becomes a surplus or the AHW of a competing MSA providentially remains frozen during at least one three year period in the future, this "temporary" disadvantage will continue to be perpetuated permanently.

CMS' observations in the preamble to the FY 2005 IPPS proposed rule are helpful in that they suggest ways to address the S-H MSA issue. It is clear that CMS believes that S-H MSAs are inconsistent with the use of average wages in all other labor areas to determine wage indexes. Therefore, CMS could exercise its discretion to merge every S-H MSA into the closest MSA for wage index purposes to eliminate the problem entirely. This straightforward approach is consistent with CMS policy that the wage index is intended to act as an efficiency incentive but can only do so where a counterbalancing occurs based on the AHW of more than one hospital. This policy would also eliminate the inequity that CMS perceives currently exists regarding S-H MSA wage indexes. CMS is not bound by OMB's new MSA designations where they are not appropriate for funding purposes as CMS acknowledges by deciding not to use Micropolitan areas when determining wage indexes. 69 Fed. Reg. at 28249-51.

Second, based on the foregoing rationale, CMS could merge into the closest MSA only S-H MSAs whose hospitals satisfy the 84% test. This would reduce but not entirely eliminate S-H MSAs.

Third, CMS could exercise its discretion to allow hospitals in S-H MSAs to reclassify to the closest MSA if they satisfy all the rural referral center criteria except the rural location requirement. This would also reduce but not entirely eliminate S-H MSAs. For purposes of applying the current criteria for reclassification to another urban area, this solution would also create parity between S-H MSAs composed of counties that have not ever been classified as rural and S-H MSAs composed of counties that have been reclassified by OMB from rural to urban areas. Parity for all hospitals in S-H MSAs that are in effect "urban rural referral centers" is

consistent with CMS' proposal to use the same AHW threshold for all rural referral centers on the grounds that all rural referral centers play a significant role in treating Medicare beneficiaries from rural areas regardless whether they are located in urban or rural areas and should be treated the same. 69 Fed. Reg. at 28289.

Fourth, CMS could combine the second and third options with other options designed to result in the elimination of all or as many S-H MSAs as possible for the same policy reasons discussed above.

Ball Memorial has an additional issue that makes it different from hospitals in most, if not all, other S-H MSAs. The FY 2005 Inpatient PPS Final Rule adopted the use of Core Based Statistical Areas ("CBSAs") based on the 2000 Census for purposes of determining the wage index. The 1990 Census Metropolitan Statistical Areas ("MSAs") had previously been used to determine the wage index. A county was previously included in an MSA if 15 percent of its residents commuted to the central county of the MSA. However, a county is not included in a CBSA unless 25 percent of its residents commute to the central county of the CBSA. 69 Fed. Reg. at 28249.

This change caused a new Anderson, IN MSA to be spun off from the former Indianapolis, IN MSA into its own MSA (even though it is also in the new Indianapolis CSA). As a result, the Muncie, IN MSA is no longer adjacent to the Indianapolis, IN MSA for purposes of wage index reclassification. Segregation of Anderson, Indiana into its own MSA makes little sense given that the population of Madison County, Indiana, whose principal city is Anderson, increased by only 2,789 residents between the 1990 Census (130,699) and the 2000 Census (133,358).

Although the Anderson, IN MSA has been carved out from the 1990 Census Indianapolis, IN MSA, it is part of the 2000 Census Indianapolis-Anderson-Columbus, IN CSA. CMS has discretion to utilize this CSA in order to determine wage indexes and to apply geographic reclassification criteria. OMB Bulletin No. 04-03 indicates that OMB itself believes the CSA is more appropriate to use than the newly created MSAs:

> "Users making comparisons with areas defined under the 1990 standards should note that when the 2000 standards were applied, the result, in some cases, was to create several areas from an existing Metropolitan Statistical Area. The resulting reconfigured areas may also qualify under the 2000 standards to form a complementary Combined Statistical Area, while retaining their separate designations as Metropolitan or Micropolitan Statistical Areas. In these situations, *the Combined Statistical area may be the approximate geographic equivalent of the previous Metropolitan Statistical Area, and thus may be the more appropriate geographic unit for analytic and program purposes.*"

(emphasis added).

OMB cautions that the new definitions "should not be used to develop and implement Federal, state, and local nonstatistical programs and policies *without full consideration of the effects of using these definitions for such purposes.* These areas are not intended to serve as a general-purpose geographic framework for nonstatistical activities, and they may or may not be suitable for use in program funding formulas." (emphasis added). OMB Bulletin 04-03. CMS is not bound by OMB's new CBSA designations where they are not appropriate for funding purposes as CMS has already acknowledged when it decided not to use Micropolitan areas to determine wage indexes. 69 Fed. Reg. at 28249-51.

OMB's standards for the 1990 Census generally reflected continuity with those adopted for the 1980 Census, and they maintained the basic concepts originally developed in the 1950 Census. However, the increase in the commuting standard from 15% to 25% in the 2000 Census represents a significant modification of the standards employed during the 1990 Census that causes dramatic changes in wage indexes by creating new MSAs between currently contiguous MSAs.

CMS should do as OMB suggests and utilize the Indianapolis-Anderson-Columbus, IN CSA for wage index purposes. CMS can accomplish this either by utilizing CSAs in every case or by utilizing CSAs only in cases where new MSAs have been created that are part of a CSA. Another option would be to "grandfather" any urban county previously designated a part of a 1990 Census MSA into the corresponding 2000 Census CBSA if the urban county is part of the same CSA.

Another measure that would address the problem created by the Anderson, IN MSA, would be to allow reclassification of S-H MSAs to nearby but not contiguous MSAs based on a showing of unique ties to that MSA. The ties between the Muncie, IN MSA and the Indianapolis, IN MSA are unique.

Since 1974, the Indiana University School of Medicine in Indianapolis and Ball State University in Muncie have jointly operated the Muncie Regional Campus of the School of Medicine located at Ball Memorial Hospital which offers first and second year undergraduate medical education programs. Medical students from Muncie thereafter complete their third and fourth years of medical school at the Indianapolis campus. The Muncie Regional Campus also offers a third year rotation in Ambulatory Care, a fourth year sub-internship in Internal Medicine, several fourth year electives for medical students, and 4 residency programs.

Attracting physicians to practice in rural areas is difficult particularly since most medical schools and residency programs are located exclusively in large urban areas. Physicians trained in rural areas are more likely to practice in rural areas. 75% of Ball Memorial Hospital's primary care physicians are graduates of its undergraduate and residency programs. Many other physicians who began their education at the Muncie Regional Campus or who participated in a residency or fellowship program at Ball Memorial Hospital are practicing in other rural areas both in Indiana and elsewhere.

The majority of medical residents at Ball Memorial Hospital commute from the Indianapolis, IN MSA. In order to attract graduates to Primary Care residency programs in Muncie, salaries must be on par with salaries offered at similar programs in nearby Indianapolis. The Family Practice residency program at Ball Memorial Hospital failed to fill all available slots in the current academic year for the first time in over a decade due to the salary differential with Indianapolis hospitals.

CMS could allow hospitals in S-H MSAs to reclassify to a nearby non-contiguous MSA if the hospital in the S-H MSA is part of a multi-campus undergraduate medical education program whose main campus is located in the non-contiguous MSA. This reclassification criterion would recognize the special circumstances faced by hospitals like Ball Memorial Hospital and the valuable contribution they make to the supply of physicians practicing outside large urban areas.

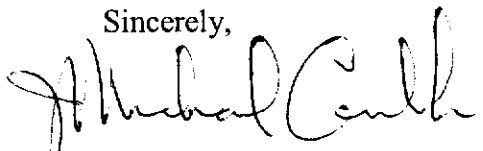
Ball Memorial Hospital is surrounded by labor areas that all receive higher wage indexes or are exempt from the wage index. The 2005 Delaware County wage index (0.8675) is lower than the wage indexes of hospitals in Henry County to its south (1.0102), Madison County to its west (0.8790), a rural referral center in Grant County to its northwest (1.0102), and critical access hospitals in Jay and Randolph Counties to the east and Blackford County to the north who receive 100% of their wage costs. Hospitals in Howard County (0.9038), Allen County (0.9825), and Wayne County (0.9490), all of which are not contiguous but are only two counties away from the Muncie, IN MSA, all receive higher wage indexes as well. Approximately one third of Ball Memorial Hospital's patients come from these surrounding areas.

As a result, Ball Memorial Hospital has already had to eliminate some programs including its rural home care and rural home infusion programs. These were the only such programs available for public assistance beneficiaries in some rural areas formerly served by these programs. Ball Memorial Hospital has also already been forced to substantially reduce its wellness program and its patient and community education programs to offset the effect of the wage index in order to keep salaries competitive. Ball Memorial Hospital also recently eliminated a Sports Medicine Fellowship and reduced staff and capacity in several service lines. These program cuts are no longer enough, however, to offset the effect of its current wage index without the need for layoffs. Consequently, Ball Memorial Hospital has reduced its staff by 328 FTEs in the last 90 days and projects another $900,000 in salary reduction through attrition during the next fiscal year in order to fund the salaries projected in the budget for its remaining staff.

Ball Memorial asks CMS to address the competitive disadvantage it faces in the labor market due to its inability to reclassify to the Indianapolis, IN MSA under the current reclassification criteria. Reclassification to the proposed Anderson, IN MSA would not be a satisfactory result. CMS can use its discretion and adopt the Indianapolis-Anderson-Columbus, IN CSA in lieu of the Anderson, IN MSA for wage index purposes.

Contact me regarding any questions you have regarding these proposals or if you would like further information regarding the special circumstances of these two hospitals.

Sincerely,



J. Michael Grubbs

QHR
QUORUM HEALTH RESOURCES

396

COLLINS
MOREY
SMITH
HEFTER

105 Continental Place Brentwood, Tennessee 37027 615.371.7979

HARTSTEIN

CAH/RELOC

June 22, 2005

Centers for Medicare & Medicaid Services

Department of Health and Human Services
Attention: CMS-1500-P
Box 8011
Baltimore, Maryland 21244-1850

Subject: Medicare Program; Proposed Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2006 Rates: Proposed Rule, Comment Period

File Code: CMS–1500-P

We are providing these comments and questions to the Department of Health and Human Services for consideration in accordance with instructions published in the May 4, 2005, Federal Register. Our questions and comments regarding the proposed regulations affecting Critical Access Hospitals as published on pages 23450 to 23453 of the May 4, 2005, Federal Register. In addition, we are taking this opportunity to comment and ask additional questions for purposes of obtaining clarification of current policies regarding Critical Access Hospital bed counts, observation room services, combined billing, and ancillary services provided by hospital personnel in a critical access hospital. These particular issues have developed during the past year and a half and are being raised since we have seen different interpretations from State agencies and fiscal intermediaries.

QHR is the leading provider of hospital professional management services in the United States. We provide professional management and consulting support services to over 200 not-for-profit acute care hospitals in the United States. We provide management services to a vast majority of the hospitals located in rural communities with populations ranging from 5,000 to 30,000 residents. Rural health issues and policies developed and implemented by Health and Human Services have significant impact upon our affiliated hospitals and the communities they serve on a daily basis.

Within our client base are approximately 70 hospitals that are Medicare designated Critical Access Hospitals or will be by December 31, 2005. Most of these hospitals obtained CAH designation prior to January 1, 2005. Approximately 20 are currently in the process of obtaining CAH designation. These hospitals are now able to qualify for CAH designation due to the revision of the CAH bed count limitation to 25 on January 1, 2004.

Since establishment of the Critical Access Hospital program, QHR managed and affiliated CAHs have been able to continue providing access to care for Medicare population. CAHs have been able to improve operating margins, purchase modern equipment, and improve overall access and quality of services to their communities. The Critical Access Hospital program has been an exceptional program and has helped improve patient access to care in rural to a level not seen since the Hill Burton program. We would be saddened to see this wonderful program curtailed and many of these hospitals eventually close or return to pre-CAH financial status due to inability to meet specific CMS regulations.

BACKGROUND INFORMATION AND COMMENTARY

Medicare initiated the Medicare Limited Service Hospital (Critical Access Hospital) program with passage of the Balanced Budget Act of 1997. An initial criterion for a hospital to participate in the Limited Service Hospital Program was a bed count of 15 and patients had to be discharged or transferred within 96 hours of admission. Subsequently, the Beneficiary Improvement Act of 1999 revised the 96 hours discharge criteria to an average length of stay of four. This was a significant change and allowed numerous hospitals to enter the program.

The Medicare Modernization Act of 2003 further enhanced the ability of acute care hospitals to participate in the program. In particular, CAHs were allowed to operate and maintain 25 acute care beds and also operate a 10 bed psychiatric unit and a 10 bed rehabilitation unit. Industry wide, these changes have allowed more hospital to review the potential to become CAHs without reducing services to Medicare beneficiaries.

For example, a hospital within the QHR system had actively reviewed becoming CAHs prior to MMA changes but also operated inpatient psychiatric units. These hospitals would have converted to CAH status but did not want to close the psychiatric units and cease providing inpatient psychiatric care to their communities.

These changes were made to enhance the accessibility to healthcare for the Medicare beneficiaries in rural areas of the country. QHR is concerned the proposed regulations are not implementing the legislation but making additional rules not intended by the legislation.

Congressional Intent

Similar to other "special providers" and status granted by the Medicare program, the overall intent of creating the CAH program was to ensure Medicare beneficiary access to health care services. For example, the Medicare program created Rural Health Clinic and Federally Qualified Health Centers to promote health care services in underserved areas. Hospitals subject to the prospective payment system can obtain Sole Community Hospital or Medicare Dependent Hospital designations if they meet specific criteria, and in turn qualify for enhanced Medicare payments. This ensures a hospital's financial viability and ability to provide health care services. As such, the CAH program follows a long Medicare program public policy to ensure access to patient care by equalizing payments between rural and urban hospitals.

From a financial and reimbursement perspective, PPS methodology is a volume driven payment methodology. Higher Medicare volumes equate to higher Medicare reimbursements and ensure that the hospital recovers fixed type operating costs: minimum staffing, equipment and plant costs, administrative operating type costs such as billing, collections, and management. In short, higher volumes yield lower fixed costs per case, and improved operating margins and cash flow. In rural settings however, the ability of hospitals to generate patient volumes sufficient to recover fixed overhead costs is limited. Rural communities have a lower population number thus limiting the ability of some rural facilities to generate sufficient volumes to survive under a PPS payment methodology.

BBA transition to PPS for all services provided by rural hospitals created additional financial strain on rural hospitals. Small rural hospitals had no choice but convert to CAH in order to survive financially. Congressional intent, to ensure continual access to patient care in rural communities has been very well served since the Balanced Budget Act of 1997 created the Critical Access Hospital program.

MMA of 2003: Necessary Provider Designation

The ability of the individual States' Departments of Rural Health to designate a hospital as a necessary provider of health services will expire on December 31, 2005. MMA of 2003 contained a statue revoking the ability of State Departments of Rural Health to designate a hospital as a necessary provider of health services. Effective January 1, 2006, a hospital that decides to become a CAH will have to meet federal location requirements of being 35 miles or more away from another hospital and be located in a rural area.

CMS has further clarified that the hospital must actually have already gone through the Medicare certification process and obtained a CAH provider number by December 31, 2005. Hospitals deemed necessary providers by the State in the State Rural Health Plan and are not certified as CAHs on December 31, 2005, cannot obtain a necessary provider designation and thus CAH status at some future date.

MMA also contained language grandfathering certified CAHs. If a hospital is a certified CAH as of December 31, 2005, then such status will continue. Reimbursements will continue to be on a cost basis.

After December 31, 2005, very few hospitals will obtain CAH designation since most hospitals meeting the 35-mile criterion have already obtained CAH. Such hospitals either converted to CAH or obtain significant Medicare reimbursement enhancements as Sole Community Hospitals or Medicare Dependent Hospitals or generate sufficient patient volumes to remain financially viable under the Medicare prospective payment system.

Replacement Facilities

Due to CAH designation and improved Medicare program payments, many CAHs are now considering remodeling or totally replacing their physical plants. Due to historically poor performance, many rural hospitals have not been able to access capital for plant and property improvements. Most CAHs are in old facilities, with many dating to the Hill Burton program. The signs of years of wear and tear are obvious to many facilities and their communities.

In addition, most facilities were designed and built long before the emphasis on healthcare shifted to outpatient-based delivery models from inpatient care. These hospital buildings are inherently inefficient.

Capital financing has become readily available to CAHs due to improved operating performance. For the first time in years, small rural hospitals, CAHs, are moving forward with facility replacement projects and accessing capital via the bond markets, other financing sources and obtaining local tax support to finance replacement facilities. These developments will provide the community with a modern facility, improve patient safety, patient access to inpatient and outpatient care, patient satisfaction while improving the efficiency and cost effectiveness of the hospital.

The United States Department of Urban Development has developed an expedited loan guarantee process specifically for CAHs (HUD 242 Program). It is known that a number of CAHs have obtained HUD loan guarantees in the past few years. In fact, QHR manages one facility that has already obtained a HUD loan guarantee and just recently opened their new facility and 2 other

CAHs that are actively pursuing a HUD loan guarantee. QHR has multiple CAH clients that are in the initial process of financing and planning facility replacement projects and identifying most affordable financing vehicle.

The United States Department of Agriculture (USDA) has also been actively promoting and making either direct loans or loan guarantees to CAHs. QHR manages one facility that just recently qualified for an USDA loan guarantee and anticipates breaking ground on new facility within the next 30 days. Numerous other CAHs are considering USDA program as a viable financing vehicle.

General Policy Questions

Are the proposed regulations in concurrence with Congressional intent to allow State designated necessary providers to be grandfathered as necessary providers effective January 1, 2006?

The Congressional intent to grandfather Critical Access Hospitals would not be served by the regulations as proposed. Under the proposed regulations will only allow a Critical Access Hospital the ability to replace the physical facility if such development plans were under significant progress as of December 6, 2003, or the CAH built either on the same site or with 250 yards of current facility on land adjacent to and owned by the CAH on or before December 6, 2003. As such, all CAHs that do not meet these stringent guidelines must remain in current location or, if they relocate, lose necessary provider designation, critical access hospital designation, and cost based reimbursement.

Under these proposed regulations, CAHs that are in significant need of facility replacement may eventually be forced to close the hospital. As the building continues to deteriorate, patient safety will eventually become an acute issue. At this point in time the CAH will be forced to close for patient safety concerns. State licensure and certification regulations will take effect and the hospital will be forced to close, or the community and hospital will have to seek out purchasers of the hospital facility.

Under these proposed regulations, building a new facility will be impossible for this particular group of hospitals. As proposed, a CAH that relocates and does not meet 35-mile distance requirement will become an acute care hospital subject to the prospective payment system. The hospitals would suffer a significant reimbursement reduction from the Medicare program by moving into a new facility and converting back to a PPS payment methodology will prevent

them relocating and constructing and relocating to a new facility since they will not be able to survive the underlying reduction in profitability and cash flow. The ability to obtain financing from USDA, HUD, or other third party financing sources will evaporate since all these entities require certain levels of profitability and cash flow.

Effectively, the CAHs that need replacement facilities are in a Catch 22: stay on same location and eventually have to close due to building safety concerns, or go through very expensive and time and cost prohibitive renovation projects, or relocate and become a hospital subject to PPS and suffer a large reduction in Medicare payments. This final option is really not an option at all since CAH's revenue base is so small that the reduction in Medicare payments will make any form of new facility unaffordable.

Under these proposed regulations, a large number of these hospitals may eventually close, eliminating access to patient care in numerous rural communities. In some of these communities, local healthcare will not exist or at minimal be reduced in future years.

It would not be Congress' intent to force small rural communities to close their CAHs due to facility issues and inability to replace facility when the MMA of 2003 grandfathered existing CAHs. Instead, we believe the intent was to effectively grandfather all such CAHs for the foreseeable future and prevent existing acute care hospitals from becoming Critical Access Hospitals after December 31, 2005.

It should be pointed out, that MedPAC recently estimated that CAHs cost the federal government approximately $1,000,000 per year per hospital. QHR's internal information and results of various studies in the past 5 years indicates that this is a reasonable amount on average. Our studies have indicated that the reimbursement benefits CAHs enjoy from cost based reimbursement over prospective payment system reimbursements range from $250,000 per year to approximately $1,000,000 per year. During the past 6 months, studies conducted on hospitals with 25 acute care beds have indicated that the reimbursement benefit is higher ranging from $600,000 to $2,000,000 per year. The additional reimbursements are crucial to small rural hospitals.

The typical CAH in the QHR system have net revenues from all payors of less than $20,000,000 per year and operating margins of less then $500,000 per year. If the financial benefit is removed, CAHs would be losing money each year and be unable to obtain financing for a new facility or possibly not even able to service existing debt. The proposed regulations will have the direct effect of causing reduced access to patient care for Medicare beneficiaries residing in the very communities the Critical Access Hospital program was created to assist.

Will the proposed regulations promote cost savings to the Medicare Program in future years and encourage CAHs to make cost effective decisions when considering renovation projects or replacement facilities?

CAHs within 35 miles of another hospital will be forced to renovate existing plants and facilities on current sites. As discussed above, very few, if any, CAHs will be able to absorb the financial loss of losing CAH status, let alone afford the financing and depreciation costs of a new facility. As such, CAHs will have to spend capital funds on current facilities to remain open, stay in compliance with fire and safety codes, ensure patient safety, provide modern medical technology, and ensure long-term patient access to care to patients in their communities.

Often, renovation and improvement of existing aging facilities are as expensive as totally replacing a facility. At 2 QHR managed facilities, facility master plans and engineering and building renovation estimates have approximated or exceeded the costs of replacing the entire facility. The studies are attached for your reference and were compiled and prepared by a subsidiary corporation of QHR: American Health Facilities Development, LLC.(AHFD). AHFD provides construction management and master facility planning services throughout the United States.

Many CAHs were built 40 to 50 years ago as primarily inpatient facilities well before the modern advances in medical technology and treatment. Outpatient services have grown tremendously throughout the United States the past 15 years proving to be effective and much more cost efficient then inpatient care and surgery. This trend will likely continue on into the future as fewer invasive procedures are performed. Facilities built and constructed over 30 years ago are ill suited to provide these services and very expensive to totally renovate.

Major renovation projects can take years to complete. As one section of the hospital is renovated, services must be relocated to another part of the hospital facility. When that area requires renovation, services for that area must be moved elsewhere. Patient access is interrupted, and additional steps have to be taken to ensure patient safety. For an extended period while renovations are taking place, certain services may be limited or not available. Medicare patients would have to travel further distances to obtain healthcare services during the time a hospital would be renovating its existing facility. In effect, the proposed regulations will do the exact opposite of the Congressional intent and CMS standing policy: to ensure Medicare patient access to care.

Piece meal renovations over a number of years are even more inefficient and costly. Replace the roofing system one year, replace the plumbing and HVAC system the following, renovate the

patient rooms the following, expand a wing the following year, add a floor 4 years from now, remove a wall over in another area, and add a few hundred square feet. Many CAHs will be forced to go about renovating facilities in piecemeal fashion.

The cost to the Medicare program is higher in the long term with major building renovations and piece meal facility renovations versus complete facility replacement in a number of areas:

1. Additional costs of building renovation will be reflected in higher depreciation costs on the annual Medicare cost report.

2. Cost of financing will be higher since CAHs may have to resort to piece meal financing approaches at higher interest rates than a single debt issuance.

3. Staffing costs in antiquated facilities are higher than modern facilities due to plant layout and design. The level and type of services offered have expanded significantly the past 20 years, requiring higher levels of patient throughput and a more coordinated approach to patient care. Staffing cannot be optimized and minimized since nurses and other personnel cannot staff or support multiple areas of the hospital. This issue is particularly crucial for smaller hospitals.

4. Maintenance and repair costs increase with the age of a physical plant.

5. Utility expenses such as heating and air conditioning costs are always higher in old hospital facilities than new facilities due to improvements in building and insulation materials.

6. Costs of materials and labor will and always have increased over time. A renovation project taking a 3-5 year period of time to complete will be more costly simply because labor material costs will increase by 3-5% per year. A new facility can be constructed and placed into service within 18 months of construction start up. As such, construction and renovation occurring after 18 months will result in increased costs of materials and labor and likewise costs to the Medicare program.

Comment: Departure from Historical Payment Policy (Is CMS following historical certification and payment policies?)

The proposed regulations are a departure from the historical CMS payment policies in a number of instances. We believe part of this issue is due to the manner in which "certification" as a CAH inherently affects a CAHs reimbursement. Hospitals that have converted to CAH have done so due to the increased reimbursement that results from cost based reimbursement methodology versus a PPS payment methodology. Congressional intent was to provide higher payments to CAHs to ensure their financial survival. We have found no evidence or statements in the Congressional record to indicate that Congress intended to curtail or limit a CAHs ability to modernize or replace existing facilities.

CMS has always treated "certification" issues separately and distinctly from "new providers for payment purposes".

The proposed regulations appear to depart from historical CMS policies and guidelines granted to hospitals by Congress to improve payments to such providers or provide exception payments. We have compiled several examples illustrating historical policy to separate building, relocation and certification issues from underlying payment issues.

Example 1
If a Sole Community Hospital relocates its site, the Sole Community Designation is not automatically reviewed by CMS. Current policy is that the SCH is required to inform CMS if the new location places them within the statutory 25 mileage criteria. Relocating a SCH within 25 miles of another acute care hospital would then trigger a loss in SCH designation for payment purposes.

However, we are unaware of any instance whereby a Sole Community Hospital has relocated the physical facility and then lost Sole Community Hospital Status for payment purposes. We assume, and are requesting commentary and confirmation, based on the proposed regulations for CAHs, that CMS would follow the same methodology: determine whether the hospital has ceased to operate as an ongoing entity and, if so, the hospital would have to go through a survey and obtain a new provider number. Likewise, the SCH would have to reapply for SCH status and would not be paid under previous provider's hospital-specific payment amount. The hospital would qualify for capital cost pass through reimbursement under 42 CFR Section 412.324(b) as a new provider. Any sub providers would also be resurveyed and treated as new providers with the Medicare program for payment purposes.

Example 2
Inpatient PPS exempt units, inpatient psychiatric units, and rehabilitation units are required to notify CMS Regional Offices when such units expand or relocate within the hospital, add additional beds, or relocate to other areas on the main hospital campus. However, CMS historically has not automatically scheduled a survey nor allowed adjustments to TEFRA rates or treated the units/hospitals as new providers. With expansion and relocation of exempt units, these units were not permitted to obtain new TEFRA rates, nor qualify for any other special payments that exempt units qualified for during first year of operations. CMS historical policy has always been that facility relocation or expansion did not trigger a change in base year rates or resetting of such rates or treatment of the provider as a "new provider".

Example 3
Skilled Nursing Facilities, when subject to the per diem reimbursement limitations before 1998, were granted a "new provider" exemption from the per diem limitations for the first three years the Skilled Nursing Facility of operation. CMS did not recognize a new exemption period if the SNF relocated, expanded, or was purchased by another provider. Generally, policy has been that it the SNF relocates but is treating the same general patient population and providing similar services, the SNF was not a "new provider" and therefore did not qualify for the 3-year exemption from the per diem cap limitations.

Example 4
Change in hospital ownership transactions are reviewed from a "certification" standpoint separate and distinct from "payment" issues. The Provider Reimbursement Manual discusses notification requirements and generally has held that a change in ownership resulting in issuance of a tie-in notice or new provider number will not automatically result in changes to Medicare payments. Generally, the new provider will still enjoy payment benefits or "status" as the previous provider had and valuation of assets will not be allowed automatically. Such determination is made separately from the provider number and assignment of the Medicare participation agreement.

Example 5
When the Medicare inpatient PPS system was implemented in the early 80's, hospitals could qualify for an adjustment/revision to their hospital specific payment amount under extraordinary circumstances. If the hospital incurred substantial changes in operating costs from their base period beyond their control or if the hospital was a new provider, the hospital specific payment rate could be adjusted from the base period amount. In a number of PRRB cases and HCFA Administrative decisions, the Secretary held that construction of a new facility did not constitute a new provider nor did it justify revising the hospitals specific payment amount.

In each example above, CMS has historically separated certification issues from underlying payment issues. CMS historical policy has been that facility replacement, expansion or

renovation did not create a "new provider'. CMS historical policy also determined the original provider had not ceased operations causing the need for a new provider number, new participation agreement or assignment of an existing participation agreement. Instead, CMS and the Secretary have based new provider status on basis of patients being served and level of services provided in the new or expanded hospital. Previously, if the "expanded", new facility or beds of the facility are serving the same patient population and generally providing the like services, then a "new provider" did not exist.

The proposed regulations should be revised to reflect this underlying historical payment and certification policy.

Determination should be made on whether relocating a facility will significantly and materially alter the patient population being served and assuring a "new provider" is not being created with a new facility. After affirmative confirming these items, the "necessary provider" designation granted by the State should be applied to the existing CAH provider number and the new building. Having the "necessary provider" designation follow the provider number and participation agreement will be exactly the same as historical payment policy, the same way the policy was established for TEFRA rates, exemptions from caps, relief from cost limitations.

This approach will be in concurrence with long standing Medicare payment and certification policies and satisfy Congressional intent to grandfather the necessary provider designation.

The proposed policy stating that any new CAH facility that is more then 250 yards away from the current facility or the facility did not have development plans significantly completed by December 8, 2003 has ceased operations as a hospital and is now a "new provider" is contrary to historical CMS policies.

Specific Questions and Issues Regarding the Proposed Regulations

Question

Does CMS through State survey agencies have legal and statutory authority to revoke a providers certification upon relocating to another location .If so, what is the statutory authority, regulatory references or and manual references to support such a certification issue.

Comments

We believe CMS has right to review certification of any provider for purposes of managing the Medicare program and ensuring integrity of the Medicare program. CMS also reserves the right to conduct surveys on providers whenever they wish in order to ensure a facility is meeting and complying with Medicare conditions of participation requirements. To clarify CMS should at this time develop clear regulations to address when a provider's certification will be reviewed and under what circumstances. We recommend these regulations be developed for all providers that participate in the Medicare program.

Question

Can CMS review a CAHs "necessary provider" designation after December 31, 2005 and effectively revoke such designation on basis that the original provider no longer exists.

Comments

The statute is clear. CAHs that are certified as such on January 1, 2006 are grand-fathered as necessary providers. It is understood however, that CMS has a responsibility to manage the Medicare program and is obligated issue interpretive regulations. However, public health policy would be better served if revocation of a necessary provider designation should resides with the state agencies provided such designations.

The statue reads:

(2) STATE DESIGNATION OF FACILITIES._

(B) CRITERIA FOR DESINGATION AS CRITICAL ACCESS HOSPITAL- A State may designate a facility as a critical access hospital if the facility –

(II) Is certified before January 1, 2006, by the State as being a necessary provider of health care services to residents in the area:

The statute is clear. If a CAH is certified by the State as being a critical access hospital, then the hospital is a CAH. The statue does not propose that CAHs must remain on same site and relocation of physical plant would negate their necessary provider designation.

CMS has partially justified the proposed regulations on the basis that the necessary provider designations throughout the United States were common in that all were based upon the provider's location. CMS notes on page 23452, paragraph 1:

"Each State's criteria are different, but the criteria share certain similarities and all define a necessary provider related to facilities location"

CMS further justifies the proposed regulation by noting that a CAH that relocates to another location may not be serving the same patients in the same area as when the original necessary provider status was granted by the State. CMS notes on page 23452:

"We have interpreted "services to residents in the area" to mean that the necessary provider designation does not automatically follow the provider if the facility relocates to a different location because it is no longer furnishing "services to patients" in the area determined to need a necessary provider."

CMS should come to some form of process for reviewing the necessary provider designation for relocated facilities. Medicare program integrity could be jeopardized without guiding regulations. For example, if CMS did not review the necessary provider designation, unscrupulous individuals could become very creative in relocating CAHs to the detriment of local communities and other competing hospitals for individual profit. However, this determination should be made on a hospital-by-hospital basis and rest in the hands of the state's departments of rural health since they are more familiar with the local rural health issues and needs than the Regional or Central CMS offices.

CMS should be applauded for developing regulations defining when a CAH has relocated or ceased business as a CAH at one location. These regulations are necessary to protect the Medicare program. However, CMS should avoid strict guidelines such as miles or the "250" yards criterion in the proposed regulations. Instead CMS or preferably state's departments of rural health should rely upon CAHs primary market areas, historical policies on new providers as discussed above and other readily available parameters. Generally, if the new location is in the hospital's primary market area and primary roads exist for providing ease of access from the old

location, the hospital medical staff will not change, then patient access will not be severely hindered and a relocated CAH will still be serving the same "area".

Hospitals improve patient access to the facility when choosing a new hospital location. This is particularly true of CAHs since many plants are so old, community population bases may have moved, State and / or Federal Highways may have been built within the past 20 years that now make the current location difficult to access. Many CAHs are often located in town centers where access is only by city streets and the site is land locked and surrounded by residences. Though such locations may serve the residents of a particular neighborhood very well, other patients in surrounding areas are not so well served. In many cases, these CAHs would be unable to build replacement facilities on their existing site without closing and demolishing all or part of the existing facility temporarily because there is not enough space on which to build. This would obviously have a negative effect on the CAH's ability to meet their community's health care needs.

CAHs are located in rural areas. Primary market areas may cross 15 to 35 miles in a particular county. Relocating a facility a few miles from a current location to a site located on a State highway or in outskirts of the primary town will improve the CAHs access for all residents in the area. We believe that, in most cases, relocating a CAH more than 250 yards will not result in a substantial change in the patient population served by that CAH. This determination should be made by the appropriate State agency.

Additionally, terrain and available land influence a CAH's decision to relocate. Land on current location may be too small to build new facility or other land in general location of current site may not be available for sale or prohibitively expensive. In many areas, new sites are limited due to terrain: mountainous areas, swamps, and other issues that either prevent development of the land site or become very costly to develop.

In many instances, in small communities, rural hospitals are able to obtain land donations for a new building site. The 250-yard criterion will void this opportunity to the CAH. The Medicare program traditionally encourages philanthropy, and the proposed regulation would certainly discourage willing benefactors from making such gifts.

If CMS does insist on using a distance criterion, it should study the trends of hospital relocation in this country and devise quantitative as well as qualitative rulres to determine such criterion. Utilizing rules established for other types of providers may result in poor relocation decisions that ultimately may harm access for the beneficiaries of a certain area. Such an analysis would result in a clearer public policy for the CAHs and the communities they reside in.

If CMS cannot remove the mileage criterion altogether,we would suggest that the distance be at least 3 miles with greater distances upon approval of the regional office. Increasing the distance will be a much more workable public policy for the CAHs and the communities they reside in and one still subject to review by CMS.

SPECIFIC QUESTIONS AND COMMENTS

Deadline of Dec 8, 2003 is unfair to hospitals converting to CAH during 2004 and 2005.

A number of hospitals converted to CAH status after December 8, 2003. A large number of hospitals will be or have converted since January 1, 2004 with revision of the bed count limitation to 25 from previous 15 acute patients and 10 swing bed patients. Hospitals that have converted since Dec 8, 2003 and obtained CAH status on basis of necessary provider designation will not be able to construct new hospital facilities and maintain CAH status and cost based reimbursement unless they construct at current location and site.

The requirement that construction projects be significantly in progress by December 8, 2003 be should be removed from the proposed regulations. Even though December 8, 2003 date is the date of passage of the Medicare Modernization Act, CMS has the obligation to promulgate clear and definitive instructions to the provider community. CMS has clearly established policies with dates that differed from the enactment dates on various pieces of legislation in the past. There is nothing in the statutory language to require CMS to set a date with retroactive consequences.

Can a CAH construct a outpatient ancillary and patient care building in another location, retain some hospital functions at current location and maintain necessary provider designation?

Assuming the proposed regulations become final as proposed, we are seeking clarification on when a CAH will be considered to have "ceased" operations at the existing facility. A number of examples:

Example 1
CAH constructs an outpatient ancillary building including laboratory, diagnostics, surgical suites, therapy services and outpatient clinics 5 miles away from the current location. Such services are transferred to the new outpatient ancillary building and patients are treated at such location. Inpatient services are still provided at the old facility including major diagnostics and

surgical services and emergency room services. New building and operations would all comply with CMS current provider based regulations.

Example 2
Same as above except minimum inpatient services would be provided at existing facility. Only 2-6 beds inpatient beds would be kept in service and only utilized in when patient beds were fully occupied at the new facility. Hospital administration, laundry services, dietary, and miscellaneous other support services would be housed at the old facility.

Example 3
Same as Example 2, except the old facility would also have a separately certified Medicare Skilled Nursing Facility, 10 bed exempt psychiatric unit at the existing facility. No acute care inpatient services would be provided in the old building.

There is not an appeals process established in the proposed regulations for CAHs that do not receive approvals from State Agencies and or Regional Office to relocate facility and retain necessary provider designation.

Since this is such a significant issue for affected CAHs, it is only reasonable that the provider have an opportunity to appeal adverse decisions in accordance with the Administrative Procedures Act.

If a CAH is deemed to ceased operations upon relocating to another physical plant and hospital obtains a new provider number as an acute care hospital, will all Medicare program liabilities from the CAH be assigned to the new provider number? Will liabilities resulting from CMS or other governmental agencies enforcement proceedings resulting from filing of false claims, inaccurate cost reports and other penalties accessed be the responsibility of the new provider?

We assume not since as proposed, the regulations would effectively terminate the existing provider number and participation agreement. If CMS policy is that a "necessary provider" designation cannot follow a facility or plant 251 yards down the road, then benefits associated with the provider agreement should also terminate.

Will CAHs that relocate facility, and obtain a new provider number, qualify for capital pass through payments as a new provider under CFR Section 412.324(b).

CFR Section 42 412.324(b) allows for capital pass through cost reimbursement for new hospital facilities. If a CAH facility replacement is considered a cessation of business for purposes of continuing as a CAH, they should be considered a new provider under Capital PPS.

Will CAHs that relocate facility and obtain new provider number be treated as "new providers" under all CMS and State Medicaid program payment and certification regulations?

Exempt units and other provider based type entities might also be affected by a CAHs that ceases business and becomes a new provider.

Other Issues and questions relating to Critical Access Hospitals: Clarification on bed counting policies;

We have heard conflicting statements from CMS and State survey offices regarding counting of beds. As you are aware, CAHs may only have 25 beds effective January 1, 2005, 10 beds for psychiatric unit and 10 beds for a rehabilitation unit. Licensed Skilled Nursing Facility and nursing facility beds are not counted towards as part of the CAH 25 bed compliment.

Prior to January 1, 2005, CAHs could maintain 25 beds with requirement that only 15 patients could be acute inpatients and 10 patients in swing bed status. The beds, in accordance with Swing Bed regulations, could be used interchangeably.

Current State Operations Manual guidelines define beds for counting purposes and specifically exclude beds used for patients recovering from anesthesia, beds used exclusively for labor and delivery, stretchers and generally beds that are not utilized for inpatient care. However, some CMS representatives and State survey offices state that they would in fact count beds used only for outpatient observation services, patient stretchers, beds and stretchers housed in emergency room for purposes of observation and emergency room care. We ask that CMS clarify its policies regarding bed counts and patient census in Critical Access Hospitals, with particular emphasis on whether patients in observation status are to be included in the count. This issue is extremely important from a certification and compliance standpoint and a hospital operations and staffing standpoint. In addition, as CAHs go through building renovations or construction of new

physical plants, they will want to ensure that the new facility design and lay out will not cause a compliance issue.

We suggest that CMS consider interpreting and implementing the 25 bed count requirement in a manner that promotes patient safety, patient access to care, minimize need to transfer patients and provides the hospital with some level of flexibility. In addition, we would like to remind CMS that the State Departments of Health do have the ability to "waive" the 25 bed requirement when areas are stricken with unusual epidemics. For example, we are aware of 2 instances within the past 2 years where States have allowed CAHs to house more then 25 patients due to pneumonia outbreaks during winter months. In both cases, other hospitals in the region were fully occupied and not accepting patient transfers.

In addition, some specific questions need clarification:

1) If a Critical Access Hospital staffs a distinct observation room department, will such beds be counted for purposes of the 25 bed count rule? The unit would be separately staffed, have distinct designated patient rooms in order to ensure accurate Medicare cost reporting. Inpatients would never be placed in the beds.

2) Can beds be used interchangeably between floors and units? For example, CAH has 6 licensed intensive care unit beds, 25 medical/surgical beds and 6 beds utilized for obstetrics' for a total of 30 beds. All beds are located in separately staffed distinct floors of the hospital. On day at the midnight census count, the CAH has 6 patients in ICU, 6 in obstetrics and 13 patients occupying the medical surgical beds. On the next day, due to patient admissions and discharges, the CAH now has 2 patients in ICU, 2 in obstetric beds, and 21 in the medical /surgical beds. In this example, would the CAH be in violation of the 25 bed count rule? (John, both examples have 25 patients in licensed beds. Did you mean for one of these examples to have more than 25 patients?)

3) Depending on answer to above, for purposes of bed count rule, is the bed count rule directly tied to bed licensure? In other words, in example above, would the CAH be in violation of the 25 bed count rule simply because State bed licensure exceeded 25 beds?

4) Should CAHs rely upon other published regulations and manual sections that define "available" beds for purposes of CAH bed count regulation? Specifically Provider Reimbursement Manual Sections 2405.4(G) and other published commentary regarding

bed counting for purposes of hospitals subject to the inpatient PPS indirect medical education reimbursements.

Billing of ancillary services by nursing personnel

We understand current CMS payment and billing policy to be that when a licensed nurse performs respiratory services for an inpatient while the patient is physically located in a patient bed, that such services cannot be billed to the Medicare program. This policy exists since the CAH is already obtaining reimbursement for nursing service costs through the cost report as inpatient routine service costs. Assuming our interpretation of current policy is accurate, does this policy also apply to other procedures or diagnostics performed by nursing personal? For example, EKGs conducted in the patient room. The nurse would be licensed by appropriate State licensure boards to conduct the service.

Required level of outpatient coding required on outpatient claims submitted to Medicare by CAHs.

Regulation found at CFR 419.20 exempts CAHs from the Medicare outpatient prospective payment system. Medicare Intermediary Manual (CMS Pub. 13-3) Section 3627.8 states that CAHs are not required to report HCPCS codes unless the service is paid under a fee schedule. We are requesting clarification on this issue and assurance that CAH outpatient claims submitted without HCPCS codes will be processed and paid by the fiscal intermediary.

SUMMARY

Like many others in the provider community, QHR respects the efforts CMS has made in devising and developing the CAH program. CAHs are important providers in the country's health care system. Without them, Medicare beneficiaries in rural communities would be without many primary care services. The CAH program needs to have the flexibility so that the CAHs can service their communities and CAHs need to have clear and concise guidelines in planning their capital needs.

Sincerely,

Mr. James J. Free
President, Consulting Division

Experience Leadership Commitment

Planning Design Construction

Falls Memorial Hospital
International Falls, MN
May, 2005

Facility Master Plan

AHFD
American Health Facilities Development, LLC

Introduction

Falls Memorial Hospital (FMH) retained the services of American Health Facilities Development, LLC (AHFD), to evaluate the hospital's existing healthcare systems and develop a Facility Master Plan for the long-term development of the hospital.

Process

Through a series of meetings, interviews and reviews involving key members of the hospital, clinic and medical staff, the AHFD planning team

- Reviewed the strategic direction of the hospital
- Observed functions, relationships and the flow of patients, visitors, staff and materials within the building
- Reviewed the physical plant and systems evaluation performed in 2000 (see **Section 6 – MEP Systems Review**)
- Inventoried and assessed major pieces of equipment and furniture (see **Section 5 – Medical Equipment & Furniture Review**)

AHFD used the results of this review to

- Create a Space Allocation Program (SAP) (see **Section 2 – Space Allocation Program**)
- Develop two options for facility development (see **Section 3 – Architectural Narrative**)
- Create architectural block drawings for the two facility development options (see **Section 4 – Master Plan Drawings**)
- Estimate project budgets for both options (see **Section 7 – Projected Budgets**)

Facility Options

Based on this evaluation, AHFD developed two facility options, with proposed budgets, for meeting the hospital's current and future needs:

Option 1 – Expand/Renovate on the Existing Site

- 75,200 SF New Construction & Renovation
- 3 Phases - 60+ Months to Complete
- $35 Million Estimated Cost

Option 2 – Build a Replacement Facility on a New Site

- 66,280 SF New Construction
- 1 Phase - 28 Months to Complete
- $26 Million Estimated Cost

The following point-by-point comparison summarizes the relative merits of the two Options:

Option 1 – Expand/Renovate	Option 2 - Replace
Meets programmed space	Nearly meets programmed space*
Longer time to complete	Shorter time to complete
More expensive	Less expensive
Limited/sloped site	Spacious/level site
Difficult construction	Easier construction
Less efficient with 2 levels	More efficient with 1 level
No expansion opportunities	Excellent expansion opportunities
Limited parking	Ample/level parking
Poor service access	Good service access
Connected to Nursing Home	Connected to Clinic

* See **Section 2 – Space Allocation Program** for a detailed description of how the hospital can meet its space needs with the smaller square footage in Option 2.

Recommendations

AHFD recommends that the FMH Board take the following next steps:

1. Approve the Facility Master Plan.
2. Decide which Option is in the best interest of the organization and the community.
3. Secure funding for the selected Option.
4. Select the Project Management Team.

This Facility Master Plan presents AHFD's detailed evaluation of Falls Memorial Hospital's existing facility and provides development options for meeting both current and future needs.

Introduction

American Health Facilities Development, LLC (AHFD), prepared the budgets in this section based on the facility development options described in **Section 1 – Space Allocation Plan** and **Section 2 – Architectural Narrative**, and incorporating the review information in **Section 4 – Medical Equipment & Furniture Review** and **Section 5 – MEP Systems Review.**

Summary

This section contains detailed projected budgets for

- Option 1 (Expansion/Renovation – broken down by phases)
- Option 2 (Replacement).

Summary of Option 1 – Expansion/Renovation - All Phases

Code	Budget Item	Amount	% (of 200)
100	Development Costs	659,000	3.01%
200	Building Construction *(23,029 New SF; 52,171 Renovated SF)*	21,868,000	100.00%
300	Professional Fees & Reimbursable Expenses	3,735,000	17.08%
400	Administrative & Legal	103,000	0.47%
500	Medical Equipment	4,205,554	19.23%
600	Furniture & Furnishings (FFE)	561,000	2.57%
700	Telecommunications Systems	1,490,000	6.81%
800	Financing	0	0.00%
900	Project Contingency	2,301,000	10.52%
TOTAL		**$34,922,554**	

There are 3 Phases in Option 1. The estimated project budget for each phase is:

- Phase 1 $ 24,246,000
- Phase 2 $ 9,122,000
- Phase 3 $ 1,554,000

Option 2 would be completed in one phase.

Summary of Option 2 – Replacement - Proposed Budget

Code	Budget Item	Amount	% (of 200)
100	Development Costs	245,000	1.56%
200	Building Construction *(66,280 New SF)*	15,690,800	100.00%
300	Professional Fees & Reimbursable Expenses	2,197,718	14.00%
400	Administrative & Legal	60,000	0.38%
500	Medical Equipment	4,205,554	26.8%
600	Furniture & Furnishings (FFE)	561,000	3.58%
700	Telecommunications Systems	1,545,000	9.85%
800	Financing	0	
900	Project Contingency	1,600,000	10.20%
TOTAL		**$26,105,072**	

Option 1 is more costly than Option 2 for the following reasons:

- More space is being constructed and renovated
- Older buildings are more difficult and costly to renovate
- The existing site limitations will increase construction costs
- It will take longer to complete the construction due to phasing

Because of the high cost to complete Option 1, Phase 1, there is no financial advantage to dividing the project into multiple phases.

Falls Memorial Hospital

International Falls, MN

- Option 1 -

Expansion/Renovation

Estimated Project Budget
(By Phase)

Falls Memorial Hospital - Option 1, Phase 1

International Falls, Minnesota

4/18/2005

PRELIMINARY PROJECT BUDGET

A. Building Construction Costs			$	13,650,000
New Construction	17,979 SF	Cost per SF= 260.30		4,680,000
Renovation	32,010 SF	Cost per SF= 188.00		6,018,000
Asbestos Abatement				Not Included
Allow - MEP Systems Report				2,893,000
Allow - Special Construction				59,000
B. Site Development (Allowance)			$	500,000
Site Grading, Utilities, Paving				Included Above
Landscaping (Allowance)				Included Above
Site Signage (Allowance)				Included Above
C. Total Construction Cost			**$**	**14,150,000**
D. Professional Fees			**$**	**2,586,000**
Project Management				Included Above
Architect/Engineers				Included Above
Interior Designer				Included Above
Equipment Planning				Included Above
Design Reimbursable Expense				Included Above
E. Equipment			**$**	**5,859,000**
Fixed & Movable Equipment				4,206,000
Furnishings & Furniture				561,000
Communications Equip (Allowance)				1,093,000
F. Materials Testing and Survey			**$**	**133,000**
Soil Borings				Included Above
Asbestos Survey				Included Above
Topographical, Boundary and As-Built Survey				Included Above
Soils and Materials Testing				Included Above
G. Other Costs			**$**	**73,000**
C.O.N. Application Fee				N/C
Misc. Fees, Permits and Other Cost				Included Above
Administrative and Legal				Included Above
H. Contingency	10.2% of Total Construction Cost		**$**	**1,445,000**
PRELIMINARY PROJECT BUDGET			**$**	**24,246,000**

Note - Excludes Costs for Financing, Asbestos Consultant and Abatement, CON Consultant, Inflation (beyond 2006) and Land Acquisition.

RANGE

LOW	HIGH
$ 23,800,000	**$ 25,500,000**

Falls Memorial Hospital - Option 1, Phase 2

International Falls, Minnesota

4/18/2005

PRELIMINARY PROJECT BUDGET

A. Building Construction Costs			$	7,009,000
New Construction				-
Renovation	17,181 SF	Cost per SF= 186.02		3,196,000
Asbestos Abatement				Not Included
Allow - MEP Systems Report				3,813,000
Allow - Special Construction				N/C
B. Site Development (Allowance)			$	-
Site Grading, Utilities, Paving				N/C
Landscaping (Allowance)				N/C
Site Signage (Allowance)				N/C
C. Total Construction Cost			**$**	**7,009,000**
D. Professional Fees			**$**	**1,000,000**
Project Management				Included Above
Architect/Engineers				Included Above
Interior Designer				Included Above
Equipment Planning				Phase 1
Design Reimbursable Expense				Included Above
E. Equipment			**$**	**341,000**
Fixed & Movable Equipment				In Phase 1
Furnishings & Furniture				In Phase 1
Communications Equip (Allowance)				341,000
F. Materials Testing and Survey			**$**	**22,000**
Soil Borings				Not Included
Asbestos Survey				In Phase 1
Topographical, Boundary and As-Built Survey				By Owner
Soils and Materials Testing				Included Above
G. Other Costs			**$**	**20,000**
C.O.N. Application Fee				N/C
Misc. Fees, Permits and Other Cost				Included Above
Administrative and Legal				Included Above
H. Contingency	10.4% of Total Construction Cost		**$**	**730,000**
PRELIMINARY PROJECT BUDGET			**$**	**9,122,000**

Note - Excludes Costs for Financing, Asbestos Consultant and Abatement, CON Consultant, Inflation (beyond 2006) and Land Acquisition.

RANGE	LOW	HIGH
	$ 8,900,000	$ 9,600,000

Falls Memorial Hospital - Option 1, Phase 3

International Falls, Minnesota

4/18/2005

PRELIMINARY PROJECT BUDGET

A. Building Construction Costs			$	1,209,000
New Construction				-
Renovation	7,830 SF	Cost per SF= 154.41		1,209,000
Asbestos Abatement				Not Included
Allow - MEP Systems Report				In Phases 1 & 2
Allow - Special Construction				N/C
B. Site Development (Allowance)			$	-
Site Grading, Utilities, Paving				N/C
Landscaping (Allowance)				N/C
Site Signage (Allowance)				N/C
C. Total Construction Cost			**$**	**1,209,000**
D. Professional Fees			**$**	**149,000**
Project Management				Not Included
Architect/Engineers				Included Above
Interior Designer				Included Above
Equipment Planning				In Phase 1
Design Reimbursable Expense				Included Above
E. Equipment			**$**	**56,000**
Fixed & Movable Equipment				In Phase 1
Furnishings & Furniture				In Phase 1
Communications Equip (Allowance)				56,000
F. Materials Testing and Survey			**$**	**4,000**
Soil Borings				Not included
Asbestos Survey				In Phase 1
Topographical, Boundary and As-Built Survey				By Owner
Soils and Materials Testing				Included Above
G. Other Costs			**$**	**10,000**
C.O.N. Application Fee				N/C
Misc. Fees, Permits and Other Cost				Included Above
Administrative and Legal				Included Above
H. Contingency	10.4% of Total Construction Cost		**$**	**126,000**
PRELIMINARY PROJECT BUDGET			**$**	**1,554,000**

Note - Excludes Costs for Financing, Program Management, Asbestos Abatement, CON Consultant, Inflation (beyond 2006) and Land Acquisition.

RANGE

LOW	HIGH
$ 1,500,000	$ 1,600,000

Falls Memorial Hospital

International Falls, MN

- Option 2 -

Replacement

Estimated Project Budget

Falls Memorial Hospital

New Replacement Hospital - 66,280sf

Preliminary Project Budget

April 13, 2005

AHFD

Budg. Code	Item	Preliminary Budget	Budget as a % of Build. Constr.
100	**Development Costs**	**245,000**	**1.56%**
101	Land	200,000	
102	Site Survey	25,000	
103	Environmental Survey	20,000	
200	**Building Construction**	**15,690,800**	**100.00%**
201	Site Work - 66,280sf @ $15 / sf	994,200	
202	Building Construction 66,280sf @ $220 / sf	14,581,600	
203	Builder's Risk Insur.	15,000	
204	Impact Fees (Assumption)	100,000	
300	**Professional Fees & Reimbursursable Expenses**	**2,197,718**	**14.01%**
301	Architectural Design (Fee 7.0% to 7.5%) (Reimbursables & Additional Services 1% to 1.5%) (Total 8.5%)	1,333,718	
302	Project Management	460,000	
303	Medical Equip. Planning Consult.	77,000	
304	Telecomm. Consult.	125,000	
305	Geotechnical Engineering	30,000	
306	Construction Material Testing Sev.	80,000	
307	Dietary Consultant	35,000	
308	Furniture Planning Consultant	27,000	
309	State Plan Review Fee	30,000	
400	**Administrative & Legal**	**60,000**	**0.38%**
401	Legal Expense	25,000	
402	Administrative & Miscellaneous Expense	35,000	

Budg. Code	Item	Preliminary Budget	Budget as a % of Build. Constr.
500	**Medical Equipment**	**4,205,554**	**26.80%**
501	Fixed & Moveable Medical Equipment	3,773,554	
502	Dietary Equipment	432,000	
600	**Furniture and Furnishings (FFE)**	**561,000**	**3.58%**
601	Furniture and Furnishings	546,000	
602	Cubicle Curtains / Window Treatments	In 601	
603	Artwork	In 601	
604	Specialty Items	15,000	
700	**Telecommunications Systems**	**1,545,000**	**9.85%**
701	Telephone System		
702	Nurse Call & Code Blue		
703	Public Address / Intercom System		
704	Structured Cable System		
705	Video Surveillance		
706	Television, Cable TV, Closed Circuit		
707	Radio Systems		
708	Information Systems software & hardware (Allowance of $600,000)		
709	Access Control / Security		
710	Nework Electronics		
711	Time and Attendance		
800	**Financing**	**0**	
900	**Project Contingency**	**1,600,000**	**10.20%**
	Total	**$26,105,072**	

Notes:	1) Financing expense is excluded.		
	2) Relocation cost to move into new faciity is excluded.		
	3) Picture Archieving Commications System (PACS) is included at $621,000 for PACS equipment and CR readers..		
	4) Budget based on utilities existing at the site.		
	5) Consulted with John Davies, Kraus-Anderson Construction Co., on historical hospital cost in the area. For mid-2006 bids, he		
	recommends cost projections between $210 / sf and $220 / sf. Used $220 / sf in budget. For sitework; projected between		
	$12 / building sf and $18 / building sf. Used $15 / building sf in budget.		
	6) Budget excludes demolition of existing facility.		
	7) Project needs to begin construction by June 06' to avoid winter conditions prior to closing in building, if possible.		
	8) Medical Equipment (budget code 500) and furniture (budget code 600) include escalation for 2006 and 2% freight.		
	9) Architect's fee includes mechanical, electrial, plumbing, civil, and interior design.		

Introduction

Kingfisher Regional Hospital (KRH) retained the services of American Health Facilities Development, LLC (AHFD), to evaluate the hospital's existing healthcare systems and develop a Facility Master Plan for the long-term development of the hospital.

Process

Through a series of meetings, interviews and reviews involving key members of the hospital and medical staff, the AHFD planning team

- Reviewed the strategic direction of the hospital
- Observed functions, relationships and the flow of patients, visitors, staff and materials within the building
- Reviewed evaluated the physical plant and systems
  (see **Section 6 – MEP Systems Review**)
- Inventoried and assessed major pieces of equipment and furniture
  (see **Section 5 – Medical Equipment & Furniture Review**)

AHFD used the results of this review to

- Create a Space Allocation Program (SAP)
  (see **Section 2 – Space Allocation Program**)
- Develop two options for facility development
  (see **Section 3 – Architectural Narrative**)
- Create architectural block drawings for the two facility development options
  (see **Section 4 – Master Plan Drawings**)
- Estimate project budgets for both options
  (see **Section 7 – Projected Budgets**)

Facility Options

Based on this evaluation, AHFD developed two facility options, with proposed budgets, for meeting the hospital's current and future needs:

Option 1 – Expand/Renovate on the Existing Site

- 46,696 SF New Construction & Renovation
- 2 Phases - 42+ Months to Complete
- $18.7 Million Estimated Cost

Option 2 – Build a Replacement Facility on a New Site

- 56,745 SF New Construction
- 1 Phase - 28 Months to Complete
- $20.1 Million Estimated Cost

The following point-by-point comparison summarizes the relative merits of the two Options:

Option 1 – Expand/Renovate	Option 2 - Replacement
Meets programmed space	Meets programmed space
Longer time to complete	Shorter time to complete
Less expensive	More expensive
Limited/sloped site	Spacious/level site
Difficult construction	Easier construction
Less efficient	More efficient
Limited expansion opportunities	Multiple expansion opportunities
Limited parking	Ample/level parking
Poor service access	Good service access
No CAH issue	Possible CAH issue

Recommendations

AHFD recommends that the KRH Board take the following next steps:

1. Approve the Facility Master Plan.
2. Decide which Option is in the best interest of the organization and the community.
3. Secure funding for the selected Option.
4. Select the Project Management Team.

This Facility Master Plan presents AHFD's detailed evaluation of Kingfisher Regional Hospital's existing facility and provides development options for meeting both current and future needs.

Introduction

American Health Facilities Development, LLC (AHFD), prepared the budgets in this section based on the facility development options described in **Section 2 – Space Allocation Plan** and **Section 3 – Architectural Narrative**, and incorporating the review information in **Section 5 – Medical Equipment & Furniture Review** and **Section 6 – MEP Systems Review**.

Summary

This section contains detailed projected budgets for

- Option 1 (Expansion/Renovation – broken down by phases)
- Option 2 (Replacement).

Summary of Option 1 – Expansion/Renovation - All Phases

Code	Budget Item	Amount	% of 200
100	Development Costs	51,000	0.44%
200	Building Construction *(32,512 New SF; 14,184 Renovated SF)*	11,689,000	100.00%
300	Professional Fees & Reimbursable Expenses	2,037,000	17.43%
400	Administrative & Legal	52,000	0.44%
500	Medical Equipment	2,760,000	23.61%
600	Furniture & Furnishings (FFE)	370,000	3.17%
700	Telecommunications Systems	545,000	4.66%
800	Financing	0	0.00%
900	Project Contingency	1,208,000	10.33%
TOTAL		**$18,712,000**	

There are 2 Phases in Option 1. The estimated project budget for each phase is:

- Phase 1 $ 15,176,000
- Phase 2 $ 3,536,000

Option 2 would be completed in one phase.

Summary of Option 2 – Replacement - Proposed Budget

Code	Budget Item	Amount	% of 200
100	Development Costs	65,000	0.49%
200	Building Construction *(56,745 New SF)*	13,145,000	100.00%
300	Professional Fees & Reimbursable Expenses	1,776,000	13.51%
400	Administrative & Legal	48,000	0.37%
500	Medical Equipment	2,667,000	20.29%
600	Furniture & Furnishings (FFE)	415,000	3.16%
700	Telecommunications Systems	628,000	4.78%
800	Financing	0	0.00%
900	Project Contingency	1,363,000	10.37%
TOTAL		**$20,107,000**	

Option 1 is nearly as costly as Option 2 for the following reasons:

- The new space is being constructed in Option 1 is more costly than for Option 2 ($231/sf vs. $218/sf) because of the departments being replaced.
- Option 1 includes the system upgrade costs ($1,528,000) from **Section 6 – MEP Systems Review**.
- Older buildings are often more difficult and costly to renovate.
- The existing site limitations will increase construction costs.
- It will take longer to complete the construction due to phasing.

Kingfisher Regional Hospital

Project Cost Estimates

Option 1 - Expansion/Renovation of Existing Building

	Low Range	Estimate	High Range
Phase 1	$14,900,000	$15,176,000	$15,900,000
Phase 2	$3,500,000	$3,536,000	$3,700,000
Total	$18,400,000	$18,712,000	$19,600,000

Note - Excludes Costs for Financing, Asbestos Abatement, CON Consultant, Inflation (beyond 2006) and Land Acquisition.

Option 2 - Replacement Facility on New Site

	Low Range	Estimate	High Range
One Phase	$19,700,000	$20,107,000	$21,100,000
Total	$19,700,000	$20,107,000	$21,100,000

Note - Excludes Costs for Financing, Asbestos Abatement & Demolition of the Existing Buildings, Relocation, CON Consultant, Inflation (beyond 2006) and Land Acquisition.

Kingfisher Regional Hospital - Option 1, Phase 1

Kingfisher, Oklahoma
6/14/2005
PRELIMINARY PROJECT BUDGET

A. Building Construction Costs			$	8,926,000
New Construction	32,512 SF	Cost per SF= 230.78		7,503,000
Renovation	2,049 SF	Cost per SF= 167.89		344,000
Asbestos Abatement				Not Included
Allow - MEP Systems Report				1,069,000
Allow - Special Construction (Demolition)				10,000
B. Site Development (Allowance)			$	481,000
Site Grading, Utilities, Paving				Included Above
Landscaping (Allowance)				Included Above
Site Signage (Allowance)				Included Above
C. Total Construction Cost			**$**	**9,407,000**
D. Professional Fees			**$**	**1,572,000**
Project Management				Included Above
Architect/Engineers				Included Above
Interior Designer				Included Above
Equipment Planning				Included Above
Design Reimbursable Expense				Included Above
E. Equipment			**$**	**3,131,000**
Fixed & Movable Equipment				2,480,000
Furnishings & Furniture				216,000
Communications Equip (Allowance)				434,000
F. Materials Testing and Survey			**$**	**51,000**
Soil Borings				Included Above
Asbestos Survey				Not included
Topographical, Boundary and As-Built Survey				Included Above
Soils and Materials Testing				Included Above
G. Other Costs			**$**	**44,000**
C.O.N. Application Fee				N/C
Misc. Fees, Permits and Other Cost				Included Above
Administrative and Legal				Included Above
H. Contingency	10.3% of Total Construction Cost		**$**	**971,000**
PRELIMINARY PROJECT BUDGET			**$**	**15,176,000**

Note - Excludes Costs for Financing, Asbestos Abatement, CON Consultant, Inflation (beyond 2006) and Land Acquisition.

RANGE

LOW	HIGH
$ 14,900,000	**$ 15,900,000**

Kingfisher Regional Hospital - Option 1, Phase 2

Kingfisher, Oklahoma
6/14/2005
PRELIMINARY PROJECT BUDGET

A. Building Construction Costs			$	2,282,000
New Construction				-
Renovation	12,135 SF	Cost per SF= 150.23		1,823,000
Asbestos Abatement				Not Included
Allow - MEP Systems Report				459,000
Allow - Special Construction				N/C
B. Site Development (Allowance)			$	-
Site Grading, Utilities, Paving				N/C
Landscaping (Allowance)				N/C
Site Signage (Allowance)				N/C
C. Total Construction Cost			**$**	**2,282,000**
D. Professional Fees			**$**	**465,000**
Project Management				Included Above
Architect/Engineers				Included Above
Interior Designer				Included Above
Equipment Planning				Included Above
Design Reimbursable Expense				Included Above
E. Equipment			**$**	**544,000**
Fixed & Movable Equipment				279,000
Furnishings & Furniture				154,000
Communications Equip (Allowance)				111,000
F. Materials Testing and Survey			**$**	-
Soil Borings				N/C
Asbestos Survey				Not included
Topographical, Boundary and As-Built Survey				By Owner
Soils and Materials Testing				N/C
G. Other Costs			**$**	**8,000**
C.O.N. Application Fee				N/C
Misc. Fees, Permits and Other Cost				Included Above
Administrative and Legal				Included Above
H. Contingency	10.4% of Total Construction Cost		**$**	**237,000**
PRELIMINARY PROJECT BUDGET			**$**	**3,536,000**

Note - Excludes Costs for Financing, Asbestos Abatement, CON Consultant, Inflation (beyond 2006) and Land Acquisition.

	RANGE	
	LOW	HIGH
	$ 3,500,000	$ 3,700,000

Kingfisher Regional Hospital - Option 2, Replacement

Kingfisher, Oklahoma
6/14/2005
PRELIMINARY PROJECT BUDGET

A. Building Construction Costs			$	12,396,000
New Construction	56,745 SF	Cost per SF= 218.45		12,396,000
Renovation				N/C
Asbestos Abatement				Not Included
Allow - MEP Systems Report				Not Applicable
Allow - Special Construction				N/C
B. Site Development (Allowance)			$	749,000
Site Grading, Utilities, Paving				Included Above
Landscaping (Allowance)				Included Above
Site Signage (Allowance)				Included Above
C. Total Construction Cost			**$**	**13,145,000**
D. Professional Fees			**$**	**1,776,000**
Project Management				Included Above
Architect/Engineers				Included Above
Interior Designer				Included Above
Equipment Planning				Included Above
Design Reimbursable Expense				Included Above
E. Equipment			**$**	**3,710,000**
Fixed & Movable Equipment				2,667,000
Furnishings & Furniture				415,000
Communications Equip (Allowance)				628,000
F. Materials Testing and Survey			**$**	**65,000**
Soil Borings				Included Above
Asbestos Survey				Not included
Topographical, Boundary and As-Built Survey				By Owner
Soils and Materials Testing				Included Above
G. Other Costs			**$**	**48,000**
C.O.N. Application Fee				N/C
Misc. Fees, Permits and Other Cost				Included Above
Administrative and Legal				Included Above
H. Contingency	10.4% of Total Construction Cost		**$**	**1,363,000**
PRELIMINARY PROJECT BUDGET			**$**	**20,107,000**

Note - Excludes Costs for Financing, Asbestos Abatement, CON Consultant, Inflation (beyond 2006) and Land Acquisition.

RANGE	
LOW	**HIGH**
$ 19,700,000	**$ 21,100,000**

Kingfisher Regional Hospital

OPTION 1 - Equipment & Furniture Budget, by Phase

Option 1, Phase 1 Functions

Department	Equipment	Furniture	Total
Calculation	$2,294,122.89	$199,902.76	$2,494,025.65
Adjusted for Inflation & Freight	***$2,480,405.67***	***$216,134.86***	***$2,696,540.53***

Option 1, Phase 2 Functions

Department	Equipment	Furniture	Total
Administration	$292.12	$61,095.25	$61,387.37
Sleep Lab	$73,392.37	$15,119.44	$88,511.81
OP Specialty Clinic	$85,575.54	$9,453.14	$95,028.68
Laboratory	$37,646.43	$10,238.97	$47,885.40
HIM	$19,900.00	$24,366.00	$44,266.00
Pharmacy	$39,175.73	$2,746.84	$41,922.57
Medical Staff Areas	$822.30	$12,417.13	$13,239.43
Information Technology	$1,113.89	$4,166.59	$5,280.48
Finance & Accounting	$0.00	$2,938.00	$2,938.00
Totals	$257,918.38	$142,541.36	$400,459.74
Adjusted for Inflation & Freight	***$278,861.35***	***$154,115.72***	***$432,977.07***

Functions Not Included in Option 1 Budget

Department	Equipment	Furniture	Total
OP Rehabilitation	$39,604.44	$14,073.00	$53,677.44
Patient Financial Services	$383.76	$50,687.59	$51,071.35
Totals	$39,988.20	$64,760.59	$104,748.79

Total for Option 1 (NOT Adjusted for Inflation or Freight)

Department	Equipment	Furniture	Total
ALL Departments	$2,592,029.47	$407,204.71	$2,999,234.18
ADD Inflation @ 6%	$2,747,551.24	$431,636.99	$3,179,188.23
ADD Freight @ 2%	$2,802,502.26	$440,269.73	$3,242,772.00

Kingfisher Regional Hospital

OPTION 2 - Equipment & Furniture Budget

Option 2 Functions

Department	Equipment	Furniture	Total
Calculation	$2,466,849.49	$383,678.57	$2,850,528.06
Adjusted for Inflation & Freight	***$2,667,157.67***	***$414,833.27***	***$3,081,990.94***

Functions Not Included in Option 2 Budget

Department	Equipment	Furniture	Total
OP Rehabilitation	$39,604.44	$14,073.00	$53,677.44
OP Specialty Clinic	$85,575.54	$9,453.14	$95,028.68
Totals	$125,179.98	$23,526.14	$148,706.12
Adjusted for Inflation & Freight	***$135,344.59***	***$25,436.46***	***$160,781.06***

Total for Option 1 (NOT Adjusted for Inflation or Freight)

Department	Equipment	Furniture	Total
ALL Departments	$2,592,029.47	$407,204.71	$2,999,234.18
ADD Inflation @ 6%	$2,747,551.24	$431,636.99	$3,179,188.23
ADD Freight @ 2%	$2,802,502.26	$440,269.73	$3,242,772.00