VIRGINIA DEPARTMENT OF HEALTH

Office of Licensure and Certification

Division of Certificate of Public Need

Staff Analysis

October 19, 2020

RE: COPN Request No. VA-8519
Virginia Hospital Center
Arlington, Virginia
Add 43 Medical-Surgical Beds at Virginia Hospital Center

Applicant

Virginia Hospital Center (VHC) is a 501(c)(3) Virginia non-stock corporation located in Arlington (Arlington County), Virginia. The hospital is owned and operated by Virginia Hospital Center Arlington Health System, a 501(c)(3) non-profit organization also located in Arlington. The applicant has numerous subsidiaries including Virginia Hospital Center Physician Group, LLC, Arlington Pediatric Center, South Arlington, LLC, AHV, and the Virginia Hospital Center Foundation. VHC is located in Planning District (PD) 8, within Health Planning Region (HPR) II.

VHC has been providing care to residents of Arlington and nearby communities since 1944. In late 2004, VHC completed major renovations to the hospital, including renovations to the medical-surgical department. Today, VHC is a 530,000-square foot, 350-bed academic medical center offering comprehensive and highly specialized health care services, including inpatient medical-surgical, adult intensive care, pediatric, psychiatric, obstetric, newborn, and medical rehabilitation services as well as other complementary services. As a tertiary-level facility, VHC offers open-heart surgery service and neonatal intensive care services and is in the process of seeking designation as a Level 2 Trauma Center.

Background

As demonstrated in **Table 1** below, the current PD 8 medical-surgical bed inventory consists of 2,679 beds. In 2018, the most recent year for which Virginia Health Information (VHI) data is available, the PD 8 medical-surgical inventory operated at a collective utilization of 59.7%[1]. More specifically, the medical-surgical beds at VHC operated at a collective utilization of 70.2% for the

[1] DCOPN notes that the available days reported by VHI appear to be in error. Specifically, available days were calculated using the number of staffed beds for some facilities, while using the number of licensed beds for others. In the interest of uniformity, throughout this staff analysis report, DCOPN has corrected this error where necessary. All available days, and likewise, occupancy data found in this staff analysis report was calculated by DCOPN using the number of licensed beds at a given facility.

same period. DCOPN notes that medical-surgical beds added to the PD 8 inventory subsequent to 2018 are not included in DCOPN's calculations for occupancy, as the beds were not yet operational and utilization data is not available.

DCOPN also notes that nearly all acute care hospital beds in Virginia are licensed as "medical-surgical" beds. The exceptions are psychiatric, substance abuse treatment, and rehabilitation beds, which are licensed separately. Licensed medical-surgical beds may be used as hospital management wishes, e.g., as adult medical-surgical, obstetrics, pediatric, or intensive care beds. As long as the total licensed bed complement is not exceeded, hospitals may configure and use "medical-surgical" beds as circumstances require.[2] For this reason, DCOPN has included obstetric, pediatric, and intensive care beds in the total count of licensed medical-surgical beds in **Table 1**, below.

[2] Health Systems Agency of Northern Virginia (HSANV) report on COPN Request No. VA-8519, at 1.

Table 1. PD 8 Medical-Surgical Inventory[3] and Occupancy: 2018

Facility	Licensed Beds	Available Patient Days	Actual Patient Days	% Occupancy
Inova Alexandria Hospital*	302	116,070	56,594	48.8%
Inova Fair Oaks Hospital*	174	66,430	34,448	51.9%
Inova Fairfax Medical Campus*	822	307,330	209,907	68.3%
Inova Loudoun Hospital*	189	52,925	39,770	75.1%
Inova Mount Vernon Hospital	140	51,100	21,642	42.4%
Novant Health UVA Health System Prince William Medical Center	158	57,670	29,465	51.1%
Reston Hospital Center**	209	71,905	48,044	66.8%
Sentara Northern Virginia Medical Center	183	66,795	41,323	61.9%
Stone Springs Hospital Center[4]	124	45,260	4,713	10.4%
Virginia Hospital Center[5]***	378	121,910	85,598	70.2%
TOTAL/Average	**2,679[6]**	**957,395**	**571,504**	**59.7%**

Source: VHI (2018) and DCOPN Records

*Pursuant to the conditions associated with COPN No. VA-04658, 44 medical-surgical beds were added at Inova Loudoun Hospital through the transfer of existing capacity within the Inova Health System. Phase One involved the relocation of 16 inpatient beds from Inova Alexandra and was operationalized on July 3, 2019. Phase Two involved the relocation of 20 medical-surgical beds from Inova Fairfax Hospital and eight medical-surgical beds from Inova Fair Oaks Hospital and was complete in April 2020.

**COPN No. VA-04514 authorized the addition of 12 adult intensive care unit beds at Reston Hospital Center. The beds became operational in February 2019.

***COPN No. VA-04563 authorized the addition of 44 medical-surgical beds at VHC and is expected to become operational by December 31, 2022.

[3] The Adjudication Officer's case decision for COPN No. VA-04682 held that DCOPN was in error by including obstetric, intensive care and pediatric patient days in its calculations for medical-surgical bed need, despite those beds being fungible and accordingly, able to convert to medical-surgical beds without COPN authorization. However, because obstetric, intensive care and pediatric beds can be easily converted to medical-surgical beds, thereby changing the medical-surgical inventory without first obtaining COPN authorization, DCOPN maintains that obstetric, intensive care and pediatric beds should be included in the medical-surgical inventory and the corresponding patient days used for medical-surgical bed need calculations.

[4] 2018 was the second year of operation for Stone Springs Hospital Center, arguably contributing to its low utilization.

[5] Again, the number of available patient days reported by VHI for 2018 appears to be in error. DCOPN has calculated PD 8 occupancy using a corrected number of available patient days, derived by multiplying the number of licensed beds by 365, or in the event of a leap year, 366.

[6] Though not included in the overall calculations for utilization, the total number of licensed beds reflects the 44 medical-surgical beds added pursuant to COPN No. VA-04563 and the 12 ICU beds added pursuant to COPN No. VA-04563.

According to historical VHI data, VHC's total medical-surgical inventory (including pediatric, ICU, and obstetric) has increased from 282 licensed beds with a collective annual occupancy of 72.6% in 2014 to 344 bed with a collective annual occupancy of 70.2% in 2018 (**Table 2**). DCOPN notes that in 2018, 44 of VHC's existing beds were not staffed. However, the applicant assures DCOPN that currently, all existing medical-surgical beds are fully staffed.

Table 2. Historic VHC Total Medical-Surgical Inventory[7] and Occupancy: 2014-2018

Year	Licensed Beds	Available Patient Days	Actual Patient Days	% Occupancy
2018*	378	121,910	85,598	70.2%
2017	334	121,910	81,777	67.1%
2016	290	106,140	77,751	73.3%
2015	282	102,930	75,684	73.5%
2014	282	102,930	74,746	72.6%

Source: VHI (2014-2018)
*Though not included in the occupancy data for 2018, the number of licensed beds includes the 44 medical-surgical beds added pursuant to COPN No. VA-04563.

Proposed Project

VHC seeks to add 43 adult inpatient medical-surgical beds to its total licensed bed inventory. The project involves the renovation and conversion of 29,977 square feet of space (34,575 gross square feet) located on the third floor of VHC's existing bed tower that is currently used for outpatient services. The new until will be developed similarly to the 44-bed medical-surgical unit currently under development on the fourth floor. Specifically, there will be two sub-units on the floor, each with a central team area and adjacent support space to accommodate team huddles, medication management, medical records and charting, nourishment, and clean and soil supply spaces. All rooms will be private rooms. The location of the proposed 43 beds on the third floor of the bed tower is directly above VHC's surgical and critical care departments.

The applicant states that recent experience in the wake of the COVID-19 pandemic has illustrated the importance of Airborne Infection Isolation (AII) rooms and fully-exhausted patient rooms. Based on that experience, VHC is developing some of the rooms on the fourth floor (to house approved, but not-yet-operational beds) as AII rooms. VHC is also planning to develop some of the rooms proposed in this application to be added on the third floor as AII rooms. All patient rooms on the third floor will be fully exhausted, allowing VHC to turn positive pressure rooms into negative pressure rooms with the flip of a switch. All rooms will be designed to allow the addition of temporary vestibules at each patient entrance, as necessary. These isolation-driven design features will allow VHC to manage demand surges by patients with conditions requiring isolation, such as those experienced in the spring of 2020.

[7] For reasons previously discussed, inventory counts include obstetric, pediatric, and intensive care beds and available days have been corrected, where necessary.

The applicant anticipates construction for the proposed project to commence in April 2022 and to be complete by March 2023. The applicant anticipates a March 2023 date of opening. If approved, schedule allowances may need to be made in order to accommodate the applicant's response to the COVID-19 pandemic.

The projected capital costs for the proposed project total $18,554,791 (**Table 3**), the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with the proposed project.

Table 3. Projected Capital Costs

Direct Construction Costs	$13,124,500
Equipment Not Included in Construction Contract	$4,340,800
Architectural and Engineering Fees	$964,991
Other Consultant Fees	$124,500
Total Capital Costs	**$18,554,791**

Source: COPN Request No. VA-8519

The proposed project would result in a net increase of 43 licensed medical-surgical beds in PD 8. As will be discussed later in this staff analysis report, DCOPN has calculated a large surplus of medical-surgical beds in PD 8, however the applicant cites an institutional specific need as justification to add the requested medical-surgical beds.

Project Definition

§32.1-102.1:3 of the Code of Virginia (The Code) defines a project, in part, as "An increase in the total number of beds…in an existing medical care facility described in subsection A." A medical care facility is defined, in part, as "Any facility licensed as a hospital, as defined in § 32.1-123."

Required Considerations -- § 32.1-102.3 of the Code of Virginia

In determining whether a public need exists for a proposed project, the following factors shall be taken into account when applicable.

1. **The extent to which the proposed project will provide or increase access to health care services for people in the area to be served and the effects that the proposed project will have on access to health care services in areas having distinct and unique geographic socioeconomic, cultural, transportation, and other barriers to access to health care;**

VHC is centrally located in Arlington County, a suburb of Washington, D.C., making it readily accessible to residents of PD 8. The surrounding area is a mix of single-family residential communities, large multi-family housing developments, and commercial development around the Orange Line of the Metrorail transit system. Major highway access is provided by Routes 66 and 29 (east and west) and by N. George Mason Drive and Glebe Road, two four-lane cross-country connectors that travel primarily north/south. Emergency vehicles primarily use Glebe Road and Washington Boulevard to access the hospital.

Public transportation, including Metrorail and bus services, adds to VHC's accessibility. Metrorail patrons can use the Arlington Connector to access the hospital from the local metro transit stations. There are two bus stops adjacent to the hospital campus. One stop is at the hospital's main entrance at N. George Mason Drive, and the other stop is at the hospital's entrance off 16th Street. Additionally, Washington Metropolitan Area Transportation provides handicapped para-transit, and several cab companies service the hospital with direct dial company phones located in the hospital lobbies and emergency department.

As will be discussed in more detail later in this staff analysis report, DCOPN concludes that at least 95% of the population of PD 8 is within 30 minutes' drive time, one way, under normal driving conditions of existing inpatient bed services. Furthermore, the applicant is a current provider of this service. Accordingly, DCOPN concludes that the proposed project would not improve geographic access to inpatient bed services in any meaningful way.

Regarding socioeconomic barriers to access to services, the applicant has provided assurances that it would accept all patients in need of care without regard to ability to pay or payment source. Additionally, the Pro Forma Income Statement provided by the applicant proffered a charity care contribution equal to 3.0% of gross patient services revenue (reflected in the "Deductions from Revenue" line) (**Table 4**). While this amount is lower than the 4.1% HPR II charity care average (**Table 5**), it is consistent with the Virginia Hospital Center Arlington Health System's system-wide charity care condition currently in place[8]. Accordingly, should the Commissioner approve the proposed project, DCOPN contends that the 3.0% system-wide charity care condition should apply.

Table 4. VHC Pro Forma Income Statement (in $000's)

	Year 1	**Year 2**
Gross Revenue	$503,470	$526,126
Deductions from Revenue	($309,684)	($326,250)
Net Revenue	**$193,785**	**$199,875**
Total Direct Expenses	$117,869	$119,222
Indirect Expenses	$62,470	$61,995
Net Income	**$13,447**	**$18,658**

Source: COPN Request No. VA-8519

[8] 3.0% System-wide condition established pursuant to COPN No. VA-04447/04447 in 2014.

Table 5. HPR II Charity Care Contributions: 2018

Health Planning Region II			
2018 Charity Care Contributions at or below 200% of Federal Poverty Level			
Hospital	**Gross Patient Revenues**	**Adjusted Charity Care Contribution**	**Percent of Gross Patient Revenue:**
Novant Health UVA Health System Prince William Medical Center	$495,433,432	$44,647,076	9.01%
Sentara Northern Virginia Medical Center	$789,301,159	$56,962,621	7.22%
Inova Mount Vernon Hospital	$479,308,693	$25,072,214	5.23%
Inova Alexandria Hospital	$924,056,506	$46,277,537	5.01%
Inova Fairfax Hospital	$3,422,077,165	$157,062,195	4.70%
Inova Loudoun Hospital	$730,947,536	$26,227,153	3.59%
Novant Health UVA Health System Haymarket Medical Center	$255,870,637	$8,844,583	3.46%
Inova Fair Oaks Hospital	$672,995,830	$22,827,171	3.39%
Virginia Hospital Center	$1,361,001,590	$32,175,893	2.36%
StoneSprings Hospital Center	$204,255,017	$2,703,533	1.32%
Reston Hospital Center	$1,323,668,487	$14,710,834	1.20%
Total Facilities			11
Median			3.6%
Total $ & Mean %	**$10,658,916,052**	**$437,510,810**	**4.1%**

Source: VHI (2018)

The most recent Weldon-Cooper data projects a total PD 8 population of 2,937,128 persons by 2030 (**Table 6**). This represents an approximate 31.7% increase in total population from 2010 to 2030. Comparatively, Weldon-Cooper projects the population of Virginia as a whole to increase by only 16.6% for the same period. With regard to Arlington specifically, Weldon-Cooper projects a total population increase of approximately 32.1% from 2010-2030. With regard to the 65 and older age cohort, Weldon-Cooper projects a much more rapid increase (**Table 7**). Specifically, Weldon-Cooper projects an increase of approximately 114.6% among PD 8's collective 65 and older age cohort, while an increase of approximately 49.3% is expected among this cohort in Arlington. This is important as this age group uses medical care resources, including inpatient treatment beds, at a rate much higher than the rest of the population.

Table 6. Statewide and PD 8 Total Population Projections, 2010-2030

Locality	2010	2020	% Change	2030	% Change	2010-2030 % Change
Virginia	8,001,024	8,655,021	8.17%	9,331,666	7.8%	16.6%
Arlington	207,627	249,298	20.1%	274,339	10.0%	32.1%
Fairfax County	1,081,726	1,162,504	7.5%	1,244,025	7.0%	15.0%
Loudoun	312,311	430,584	37.9%	554,808	28.9%	77.7%
Prince William	402,002	478,134	18.9%	571,844	19.6%	42.3%
Alexandria City	139,966	166,261	18.8%	182,067	9.5%	30.1%
Fairfax City	22,565	25,047	11.0%	26,397	5.4%	17.0%
Falls Church City	12,332	12,332	0.00%	17,032	38.1%	38.1%
Manassas City	37,821	43,099	14.0%	46,332	7.5%	22.5%
Manassas Park City	14,273	17,086	19.7%	20,284	18.7%	42.1%
TOTAL PD 8	**2,230,623**	**2,584,345**	**15.9%**	**2,937,128**	**13.7%**	**31.7%**

Source: U.S. Census, Weldon Cooper Center Projections (August 2019) and DCOPN (interpolations)

Table 7. PD 8 Population Projections for 65+ Age Cohort, 2010-2030

Locality	2010	2020	% Change	2030	% Change	2010-2030 % Change
Arlington	18,054	22,515	24.7%	26,951	19.7%	49.3%
Fairfax County	106,290	151,585	42.6%	184,218	21.5%	73.3%
Loudoun	20,425	45,314	121.9%	84,522	86.5%	313.8%
Prince William	27,220	52,698	93.6%	80,830	53.4%	197.0%
Alexandria City	12,806	17,359	35.6%	22,175	27.7%	73.2%
Fairfax City	3,088	3,754	21.6%	4,611	22.8%	49.3%
Falls Church City	1,293	1,908	47.5%	2,317	21.5%	79.2%
Manassas City	2,607	3,930	50.8%	5,387	37.1%	106.7%
Manassas Park City	806	1,426	76.9%	2,258	58.4%	180.2%
TOTAL PD 8	**192,589**	**300,491**	56.0%	**413,269**	37.5%	114.6%

Source: U.S. Census, Weldon Cooper Center Projections (August 2019) and DCOPN (interpolations)

DCOPN did not identify any other unique geographic, socioeconomic, cultural, transportation, or other barriers to care in the planning district.

2. The extent to which the project will meet the needs of the people in the area to be served, as demonstrated by each of the following:

(i) The level of community support for the proposed project demonstrated by people, businesses, and governmental leaders representing the area to be served;

The applicant provided numerous letters of support for the proposed project from elected officials, medical professionals associated with VHC, and Kaiser Permanente. Collectively, these letters addressed the following:

- VHC is the only acute care inpatient hospital in Arlington County and the only independent community hospital in the entire Northern Virginia Planning Region. Its high and continually growing utilization attests to the vital role VHC has historically played in the community and the excellent quality of care it provides.

- In 2018, VHC's operational [medical-surgical] beds exceeded 95% occupancy, and the hospital operates at 100% occupancy with increasing frequency. The 44-bed expansion approved in 2017 will, once operational, provide VHC and its patients with some reprieve from these high occupancy rates, but even with those beds, VHC's 2019 patient days exceed the applicable occupancy threshold for expansion.

- By simply expanding the scope of the work currently in progress, as opposed to finishing the approved project only to then start on another, VHC can capitalize on numerous efficiencies of scale, reduce the project's costs, and mitigate the impact of construction on ongoing hospital operations.

- Approval of the proposed project will ensure that VHC has sufficient bed capacity available to provide timely access to necessary care for the growing patient population of inpatients and trauma patients and will ensure it is well equipped to address surging demand.

- With VHC's current inventory, clinicians must continuously engage in bed management efforts, diverting valuable time and resources away from clinical care delivery. Patients waiting for a medical-surgical bed to become available must currently be boarded in other areas of the hospital (such as the emergency room or the hospital's post-anesthesia care unit). This impairs timely access to care for all of VHC's patients—inpatients, emergency department patients, and even outpatients. Although VHC is currently implementing additional recently approved beds, those beds are insufficient to provide lasting relief to VHC's over utilized medical-surgical department.

- VHC's incremental addition of 43 medical-surgical beds is well justified by the hospital's historical and current demand and conservative utilization projections which indicate continuing growth in patient days at VHC.

- VHC's bed capacity issue becomes even more problematic when the population growth of the Northern Virginia region is considered.

DCOPN received no letters in opposition to the proposed project.

The Health Systems Agency of Northern Virginia (HSANV) conducted a public hearing via teleconference on September 14, 2020. There was no public comment on the proposal other than the statements submitted with the application. All of this comment, which was distributed to all parties before the meeting, endorsed or otherwise supported the project.

(ii) The availability of reasonable alternatives to the proposed project that would meet the needs of the people in the area to be served in a less costly, more efficient, or more effective manner;

As stated above, the most recently published VHI data (2018) demonstrates a 59.7% collective occupancy rate among all existing medical-surgical beds (including obstetric, pediatric, and ICU) within PD 8 (**Table 1**). More specifically, VHC reported a 70.2% occupancy rate among its 334 authorized beds for 2018. However, DCOPN nonetheless contends that no better alternative to the proposed project exists.

First, while 70.2% occupancy falls well beneath the 80% State Medical Facilities Plan (SMFP) threshold for expansion, as will be discussed in more detail later in this staff analysis report, DCOPN concludes that converting existing ICU, pediatric, or obstetric beds would be ill advised as doing so would likely result in the overutilization of those services at VHC. Furthermore, when the occupancy of beds labeled strictly as medical-surgical is assessed, the need for expansion becomes more evident. For example, as **Table 8** below demonstrates, data provided by the applicant shows that VHC's existing medical-surgical inventory operated at 103% in 2019[9], a substantial increase from the year prior. As also will be discussed in more detail later in this staff analysis report, the applicant attributes this to the increased population growth of the Northern Virginia Region and VHC's designation as Kaiser Permanente's leading Virginia premier hospital. Additional discussion in this staff analysis report will elaborate as to why DCOPN agrees with the applicant's assessment and accordingly, why DCOPN finds the applicant's projections for 2023 and 2024 to be reasonable.

The applicant projects that if the requested 43 beds are approved, along with the 44 beds not yet in operation, the resulting VHC medical-surgical inventory will reach only 68.7% utilization in 2024, well beneath the 80% SMFP threshold for expansion. However, DCOPN notes that denial of the proposed project would result in occupancy of approximately 77.8% among VHC's medical-surgical inventory (including the 44 beds not yet in operation), only marginally beneath the expansion threshold. Furthermore, DCOPN acknowledges HSANV's findings that during the past several decades, Northern Virginia has shifted from a net exporter of hospital patients, largely to District of Columbia hospitals, to a net importer of patients, largely from bordering Virginia jurisdictions and that these patterns are now well established and not likely to change soon.[10] For these reasons, DCOPN concludes that Northern Virginia hospitals, and particularly

[9] While DCOPN cannot quantifiably confirm this data, it notes that the applicant is required to release such data to VHI, and therefore has included it in the analysis for this project.

[10] HSANV staff analysis report, at 4.

VHC due to its contract with Kaiser Permanente, are likely to continue to see an increase in utilization.

Finally, DCOPN notes that by integrating the proposed bed addition with the pending construction necessary to implement the 44 additional beds already approved at VHC, the applicant will be able to capitalize on efficiencies of scale, thereby reducing the overall cost of the project while minimizing the duration of construction. For these reasons, DCOPN maintains that the proposed project is more favorable than maintaining the status quo.

Table 8. VHC Historical and Projected Medical-Surgical Inventory and Occupancy[11]

Year	Licensed Beds	Staffed Beds	Available Days	Actual Patient Days	% Utilization
2024 (projected)	318	--	116,070	79,008	68.7%
2023 (projected)	318	--	116,070	78,008	67.2%
2019	231	231	84,315	--	103.0%
2018	231	187	84,315	65,011	77.1%
2017	231	187	84,315	61,923	73.4%
2016	187	187	68,442	57,126	83.5%

Source: VHI (2016-2018) and COPN Request No. VA-8519

(iii) Any recommendation or report of the regional health planning agency regarding an application for a certificate that is required to be submitted to the Commissioner pursuant to subsection B of § 32.1-102.6;

At its September 14, 2020 meeting, the HSANV Board of Directors reviewed the COPN application filed by VHC. The Board voted unanimously (eleven in favor, with one abstention) to recommend approval of the application.

The Board based the recommendation on its review of the application, on the HSANV staff report on the proposal, on the testimony and evidence presented at the September 14, 2020 public hearing and Board of Directors meeting held on the application, and on several basic findings and conclusions, including:

1. There are hundreds of unused medical-surgical beds in Northern Virginia hospitals. The medical surgical bed need formula specified in the Virginia SMFP indicates that there is likely to be more than 250 surplus medical-surgical beds in the region over the next five years. There is no regional need for additional medical-surgical beds now or within the next five years.

2. Despite the modest demand region-wide, medical-surgical caseloads at VHC are high and growing, exceeding projections over the last three years.

[11] Again, DCOPN notes that the number of available days and the resulting occupancy, as reported by VHI has been corrected, where necessary.

3. With the shift of substantial numbers of Kaiser Foundation Health Plan patients to Virginia Hospital Center over the last decade, medical-surgical bed occupancy is higher at VHC than elsewhere.

4. Net increase in demand at VHC over the last decade, and its recent gains in market share, result from the shift of Kaiser Permanente Health Plan patients to VHC.

5. Projected capital costs are reasonable for the space to be renovated and the number of beds proposed.

6. Current and projected medical-surgical service volumes, and related operational considerations, qualify VHC for consideration to add capacity in accordance with the institutional need provision of the Virginia SMFP.

(iv) Any costs and benefits of the proposed project;

As illustrated in **Table 3**, the total projected capital cost of the proposed project is $18,554,791 (or $431,507 per bed), the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with this project. DCOPN concludes that the costs for the proposed project are reasonable and consistent with previously approved projects similar in scope.[12]

The applicant cited the following benefits of the proposed project:

- The project would improve timely access to medical-surgical beds and care for the growing patient population seeking care at VHC;

- The project would minimize the need to board inpatients in the emergency department and other areas of the hospital, thus enhancing those patients' access to care and improving overall efficiency of care; and

- The project would equip VHC with adequate capacity to manage projected growth and short-term surges in inpatient demand.

(v) The financial accessibility of the proposed project to people in the area to be served, including indigent people; and

As already discussed, the applicant has provided assurances that inpatient bed services at VHC will be accessible to all patients, regardless of financial considerations. However, recent changes to § 32.1-102.4B of the Code of Virginia now require DCOPN to place a charity care condition on every applicant seeking a COPN. Furthermore, DCOPN again notes that if approved, the

[12] COPN No. VA-04706 authorized the addition of 44 beds at Bon Scours Memorial Regional and had a capital cost of $52,738,157; COPN No. VA-04682 authorized the addition of 55 beds at Bon Secours St. Francis Medical Center and had a capital cost of $155,764,458; COPN No. VA-04658 authorized the addition of 44 beds at Inova Loudoun Hospital Center and had a capital cost of $22,301,950; COPN No. VA-04649 authorized the addition of 40 beds at Winchester Medical Center and had a capital cost of $18,800,000.

proposed project should be subject to the 3.0% Virginia Hospital Center Arlington Health System system-wide charity care condition currently in place, in addition to any new requirements as found in the revised § 32.1-102.4B of the Code of Virginia.

(vi) At the discretion of the Commissioner, any other factors as may be relevant to the determination of public need for a proposed project.

On March 12, 2020, Governor Ralph Northam declared a state of emergency throughout Virginia in response to the coronavirus pandemic. Subsequent to this declared state of emergency, on March 20, 2020, Governor Northam signed Executive Order 52 (EO 52) providing that notwithstanding the provisions of Article 1.1 of Chapter 4 of Title 32.1 of the Code of Virginia, the State Health Commissioner (Commissioner), at his discretion, may authorize any general hospital or nursing home to increase licensed bed capacity as determined necessary by the Commissioner to respond to increased demand for beds resulting from COVID-19. Such beds authorized by the Commissioner under EO 52 would, notwithstanding Virginia Code § 32.1-132, constitute licensed beds that do not require further approval or the issuance of a new license. VHC received authorization under EO 52 to add up to 232 licensed beds for the duration of the declared emergency. As of June 23, 2020, VHC has opened 32 of the 232 additional authorized beds.

Section 32.1-102:1 of the Code of Virginia calls for the State Health Services Plan Task Force to develop, by November 1, 2022, recommendations for a comprehensive State Health Services Plan (SHSP). In the interim, DCOPN will consider the consistency of the proposed project with the predecessor of the SHSP, the SMFP.

3. The extent to which the application is consistent with the State Health Services Plan;

Part VI of the SMFP contains criteria/standards for the addition of medical-surgical beds. They are as follows:

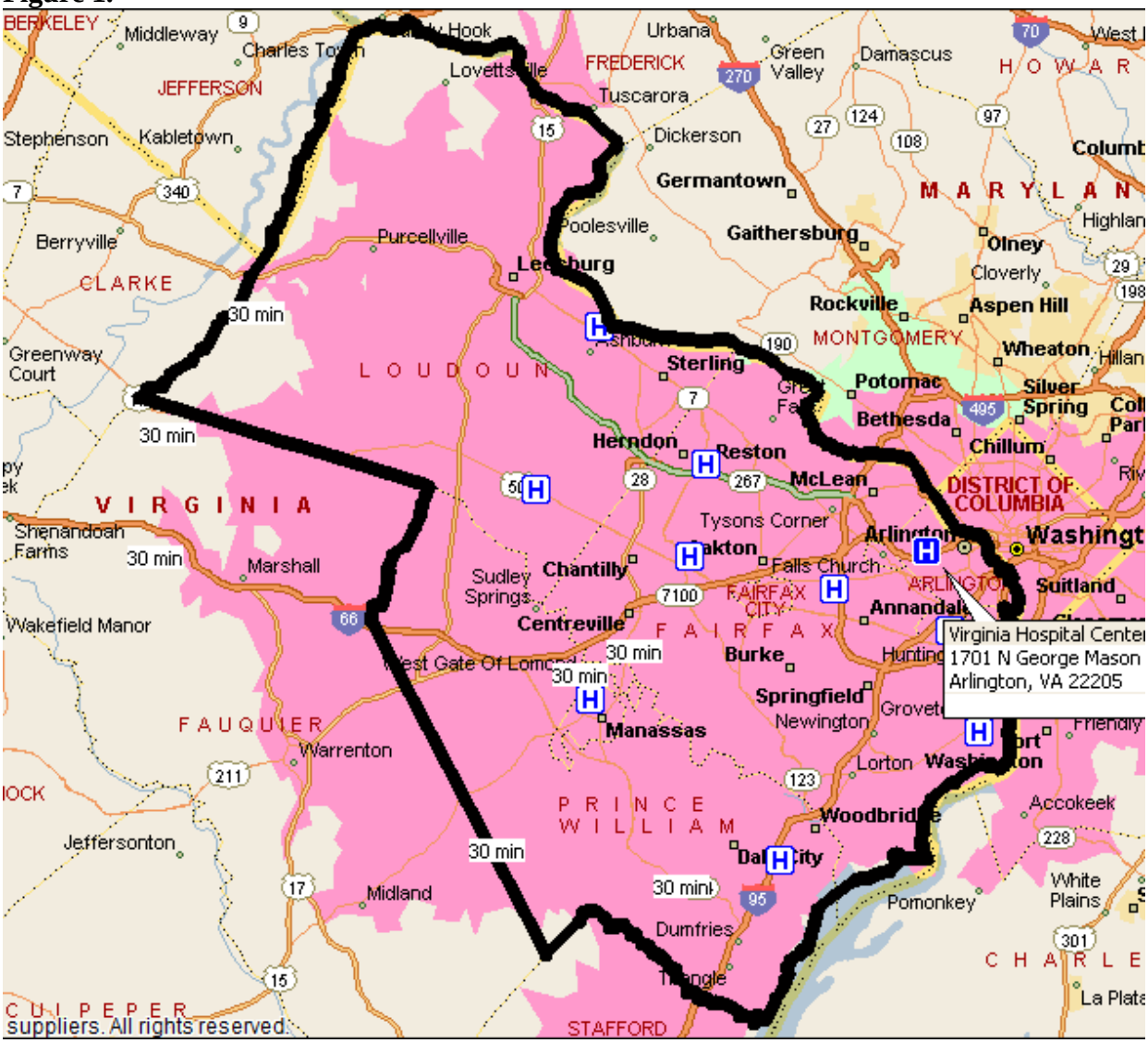
Part VI
Inpatient Bed Requirements

12VAC5-230-520. Travel Time.
Inpatient beds should be available within 30 minutes driving time one way under normal conditions of 95% of the population of a health planning district using mapping software as determined by the commissioner.

The heavy black line in **Figure 1** represents the boundary of PD 8. The blue "H" symbol marks the location of VHC. The white "H" symbols mark the locations of all other existing inpatient bed services in PD 8. The pink shaded area represents the area of PD 8 and surrounding areas that are within 30 minutes' drive time of existing inpatient bed services. There is no area within 30 minutes of VHC that is not also with 30 minutes of another existing provider. Given the amount of shaded area, it is evident that inpatient bed services currently existing within a 30-minute drive for a least 95% of the population of PD 8. Furthermore, DCOPN again notes that the applicant is a current provider of inpatient bed services. Accordingly, DCOPN concludes that approval of the proposed

project would not improve geographical access to inpatient bed services for persons in PD 8 in any meaningful way. DCOPN further notes that because the applicant cites an institutional need for the requested beds, geographic access is not what prevents patients from receiving timely access to care.

Figure 1.



12VAC5-230-530. Need for New Service.

A. No new inpatient beds should be approved in any health planning district unless:
   1. **The resulting number of beds for each bed category contained in this article does not exceed the number of beds to be needed for that health planning district for the fifth planning horizon year; and**
   2. **The average annual occupancy based on the number of beds in the health planning district for the relevant reporting period is:**
      a. **80% at midnight census for medical-surgical and pediatric beds;**
      b. **65% at midnight census for intensive care beds.**

B. For proposals to convert under-utilized beds that require a capital expenditure of $15 million or more, consideration may be given to such proposals if:
   1. **There is a projected need in the applicable category of inpatient beds; and**
   2. **The applicant can demonstrate that the average annual occupancy of the converted beds would meet the utilization standard for the applicable bed category by the first year of operation.**

For purposes of this part, "utilization" means less than 80% average annual occupancy for medical-surgical or pediatric beds, when the relocation involves such beds and less than 65% average annual occupancy for intensive care beds when the relocation involves such beds.

C. The capital expenditure threshold referenced in subsection B of this section shall be adjusted annually using the percentage increase listed in the Consumer Price Index for All Urban Consumers (CPI-U) for the most recent year as follows:

$$A \times (1 + B)$$

Where:
A = the capital expenditure threshold amount for the previous year; and
B = the percent increase for the expense category "Medical Care" listed in the most recent year available of the CPI-U of the U.S. Bureau of Labor Statistics.

As the applicant is not proposing to establish a new service, this section is not applicable to the review at hand. However, in the interest of completeness, the following calculation demonstrates that there is a projected surplus of 467 medical-surgical beds in PD 8 for the five-year planning horizon. The proposed project would add an additional 43 beds to this existing surplus. However, as the applicant relies upon the assertion of a unique institutional need for expansion, DCOPN contends that an existing PD 8 surplus should not alone serve as the basis for the denial of the proposed project.

12VAC5-230-540. Need for Medical-surgical Beds.
The number of medical-surgical beds projected to be needed in a health planning district shall be computed as follows:

1. **Determine the use rate for medical-surgical beds for the health planning district using the formula:**

$$BUR = (IPD/PoP)$$

Where:

BUR = the bed use rate for the health planning district.
IPD = the sum of the total inpatient days in the health planning district for the most recent five years for which inpatient day data has been reported to VHI; and
PoP= the sum of the total population 18 years of age and older in the health planning district for the same five years used to determine IPD as reported by a demographic program as determined by the commissioner.

Step 1. PD 8 – SMFP Medical-Surgical Bed Use Rate

IPD 2014-2018 Sum Patient Days Last 5 Years	PoP 2014-2018 Sum Population Age 15+ Last 5 Years	BUR 2012-2016 Bed Use Rate
2,850,361	9,714,850	0.2934

Table 8. PD 8 Inpatient Utilization of General Medical-surgical Services[13] (2014-2018)

	2014	2015	2016	2017	2018	TOTAL/Average
Beds	2,410	2,410	2,585	2,613	2,679	12,641
Available Days	879,650	879,650	946,110	953,745	957,395	4,616,550
Patient Days	549,590	567,608	587,157	574,502	571,504	2,850,361
Occupancy	62.5%	64.5%	62.1%	60.2%	59.7%	61.7%

Source: VHI (2014-2018)

Table 9. PD 8 Historical and Projected Population (Ages 18+)

	2014	2015	2016	2017	2018	TOTAL 2014-2018	2025 (Projected)
Pop.	1,883,730	1,913,350	1,942,970	1,972,590	2,002,210	**9,714,850**	2,201,176

Source: Weldon Cooper
Note: While the SMFP requires population data for persons aged 18 and older**,** the Weldon Cooper Center for Public Service projects Virginia population on an annual basis by county/city broken down by age in 5-year increments. As such, the calculations above include data for those persons aged 15 -17.

[13] DCOPN again notes that the number of available days and accordingly, the resulting occupancy has been corrected by DCOPN, where necessary.

The medical-surgical bed use rate for 2014-2018 in PD 8 was 0.29 patient days per capita for the population age 15 and over.

2. Determine the total number of medical-surgical beds needed for the health planning district in five years from the current year using the formula:

$$\textbf{ProBed} = \frac{\textbf{((BUR x ProPop) / 365}}{\textbf{0.80}}$$

Where:

ProBed = the projected number of medical-surgical beds needed in the health planning district for five years from the current year.

BUR = the bed use rate for the health planning district determined in subdivision 1 of this section.

ProPop = the projected population 18 years of age and older of the health planning district five years from the current year as reported by a demographic program as determined by the commissioner.

$$\text{ProBed} = \frac{((0.2934 \times 2{,}201{,}176) / 365)}{0.80}$$

ProBed = 2,211.7

At a medical-surgical average utilization of 80%, there is a need for 2,211.7 (2,212) medical-surgical beds in PD 8 for five years from the current year.

3. Determine the number of medical-surgical beds that are needed in the health planning district for the five year planning horizon year as follows:

NewBed = ProBed – CurrentBed

Where:

NewBed = the number of new medical-surgical beds that can be established in a Health planning district, if the number is positive. If NewBed is negative, No additional medical-surgical beds should be authorized in the health Planning district.

ProBed = the projected number of medical-surgical beds needed in the health Planning district for five years from the current year as determined in Subdivision 2 of this section.

CurrentBed = the current inventory of licensed and authorized medical-surgical Beds in the health planning district.

New Bed = 2,211.7 – 2,679

New Bed = (-) 467.3

At a medical-surgical average utilization of 80%, there is a current calculated surplus of 467.3 (467) medical-surgical beds in PD 8.

12VAC5-230-550. Need for Pediatric Beds.

In the interest of brevity, this calculation has been omitted from this DCOPN staff analysis report as the applicant is not proposing to add pediatric beds at VHC. However, DCOPN notes that VHC's pediatric beds were underutilized in 2018, operating at a collective occupancy of only 54% (**Table 10**). However, DCOPN contends that converting existing pediatric beds to medical-surgical beds would be ill advised, as converting only three pediatric beds would result in a collective utilization of 70.2% among the remaining 10 pediatric beds, thereby potentially overwhelming the pediatric service at VHC.

Table 10. VHC Pediatric Bed Occupancy: 2018

Licensed Pediatric Beds	Staffed Beds	Available Days	Patient Days	Occupancy
13	13	4,745	2,564	54.0%

Source: VHI (2018)

12VAC5-230-560. Need for Intensive Care Beds.

In the interest of brevity, this calculation has been omitted from this DCOPN staff analysis report as the applicant is not proposing to add intensive care beds at VHC. However, DCOPN notes that VHC's adult ICU beds were underutilized in 2018, operating at a collective occupancy of only 50.3% (**Table 11**). However, as is the case with pediatric beds at VHC, DCOPN contends that converting existing ICU beds to medical-surgical beds would be ill advised, as converting only ten ICU beds would result in a collective utilization of 73.1% among the remaining 22 ICU beds, thereby potentially overwhelming the ICU service at VHC.

Table 11. VHC ICU Bed Occupancy: 2018

Licensed ICU Beds	Staffed Beds	Available Days	Patient Days	Occupancy
32	32	11,680	5,870	50.3%

Source: VHI (2018)

12VAC5-230-570. Expansion or Relocation of Services.

A. Proposals to relocate beds to a location not contiguous to the existing site should be approved only when:
   1. **Off-site replacement is necessary to correct life safety or building code deficiencies;**
   2. **The population currently served by the beds to be moved will have reasonable access to the beds at the new site, or to neighboring inpatient facilities;**
   3. **The number of beds to be moved off-site is taken out of service at the existing facility;**
   4. **The off-site replacement of beds results in:**
      a. **A decrease in the licensed bed capacity;**
      b. **A substantial cost savings; cost avoidance, or consolidation of underutilized facilities; or**
      c. **Generally improved efficiency in the applicant's facility or facilities; and**
   5. **The relocation results in improved distribution of existing resources to meet community needs.**

B. Proposals to relocate beds within a health planning district where underutilized beds are within 30 minutes driving time one way under normal conditions of the proposed relocation should be approved only when the applicant can demonstrate that the proposed relocation will not materially harm existing providers.

VHC is proposing to add 43 new medical-surgical beds to its existing inventory. Accordingly, this standard is not applicable to the proposed project.

12VAC5-230-580. Long-Term Acute Care Hospitals (LTACHs)

In the interest of brevity, this standard has been omitted from this DCOPN staff analysis report as the applicant is not proposing to add LTACH beds or to convert existing beds to LTACH beds.

12VAC5-230-590. Staffing.
Inpatient beds should be under the direction of one or more qualified physicians.

The applicant is an established provider of inpatient care beds and services and the applicant provided assurances that the existing and proposed inpatient beds will be under the direction of one or more qualified physicians.

The SMFP also contains criteria/standards when institutional expansion is needed. They are as follows:

Part 1
Definitions and General Information

12VAC5-230-80. When Institutional Expansion is Needed.

A. Notwithstanding any other provisions of this chapter, the commissioner may grant approval for the expansion of services at an existing medical facility in a health planning district with an excess supply of such services when the proposed expansion can be justified on the basis of a facility's need having exceeded its current service capacity to provide such service or on the geographic remoteness of the facility.

As discussed, converting existing ICU or pediatric beds at VHC to medical-surgical beds would be ill advised, as doing so would likely result in the overutilization of those services. Accordingly, DCOPN has assessed this standard using only the utilization of those beds designated as "medical-surgical" within VHI.

Data provided by the applicant demonstrates that VHC's medical-surgical inventory operated at a collective occupancy of 103% in 2019, a substantial increase from the prior year. DCOPN also notes that this occupancy level surpasses the projections made in VHC's 2016 application for additional medical-surgical beds. While DCOPN cannot quantifiably confirm this data, it again notes that for reasons briefly discussed in this staff analysis report, the data appears to be reasonable. DCOPN will elaborate on this at more length later in this staff analysis report.

Furthermore, with the approval of the requested 43 beds, the applicant projects its medical-surgical inventory to operate at 68.7% by 2024. While this occupancy is below the 80% threshold required for expansion under the SMFP, DCOPN again notes that failure to implement the requested 43 beds would result in occupancy of approximately 77.8% among VHC's medical-surgical inventory (including the 44 beds not yet in operation), only marginally beneath the expansion threshold. As briefly discussed already, DCOPN concludes that the applicant's projections are reasonable. Furthermore, DCOPN concludes that the applicant is likely to see continued growth in inpatient utilization for the next several years, and that additional capacity at the hospital is necessary to allow it to meet existing and growing demand and to accommodate future grown and utilization surges. DCOPN will elaborate on this at more length in following sections of this staff report.

B. If a facility with an institutional need to expand is part of a health system, the underutilized services at other facilities within the health system should be reallocated, when appropriate, to the facility with the institutional need to expand before additional services are approved for the applicant. However, underutilized services located at a health system's geographically remote facility may be disregarded when determining institutional need for the proposed project.

Not applicable. VHC is not part of a health system and there are no VHC-affiliated facilities from which underutilized beds could be reallocated.

C. This section is not applicable to nursing facilities pursuant to §32.1-102.3:2 of the Code of Virginia.

Not applicable. The applicant is not a nursing facility seeking to utilize this section for the purpose of adding beds pursuant to §32.1-102.3:2 of the Code of Virginia.

D. Applicants shall not use this section to justify a need to establish new services.

Not applicable. The applicant is not seeking to utilize this section to justify a need to establish a new service.

Eight Required Considerations Continued

4. The extent to which the proposed service or facility fosters institutional competition that benefits the area to be served while improving access to essential health care services for all people in the area to be served;

VHC is PD 8's only independent hospital as well as its lowest-cost provider, with its 2018 net revenue per adjusted admission (i.e., the average dollar amount expected to be collected per adjusted admission) below that of any other existing PD 8 acute care hospital (**Table 12**). VHC currently operates 378 medical-surgical beds (including obstetric, ICU, and pediatric), accounting for approximately 14% of the total PD 8 inventory. In 2018, VHC's reported patient days accounted for approximately 13% of total PD 8 medical-surgical utilization.

Table 12. PD 8 Net Revenue per Adjusted Admission: 2018

Facilty	Net Revenue per Adjusted Admission
Reston Hospital Center	$11,678.09
Inova Fairfax Hospital	$11,652.29
Stone Springs Hospital Center	$11,576.54
Inova Fair Oaks Hospital	$11,027.58
Inova Mount Vernon Hospital	$10,515.54
Inova Alexandria Hospital	$9,840.22
Inova Loudoun Hospital	$9,648.53
Sentara Northern Virginia Medical Center	$8,039.70
Novant Helath UVA Health System Prince William Medical Center	$7,817.01
Virginia Hospital Center	$7,163.76

Source: VHI Industry Report (2018)

Recognizing that the current application is intended to meet a unique institutional need, DCOPN does not find that the proposal is intended to foster institutional competition, but rather is intended to ensure VHC's patients access to needed inpatient bed services. Furthermore, DCOPN notes that VHC is the largest of three hospitals in Virginia designated by Kaiser Health

Plan as premier hospitals and receives the majority of Kaiser's referrals in Virginia.[14] Kaiser's referral arrangement with VHC, which began in 2010, has resulted in most of Kaiser's Northern Virginia patients being directed to VHC for impatient care[15]. DCOPN also notes that Kaiser enrollment in Northern Virginia has grown steadily in recent years, and now serves approximately 275,000 residents, more than 10% of the regional population, and is growing at a compound annual growth rate of more than 6%.[16] Kaiser expects to enroll approximately 375,000 Northern Virginia residents by 2026. DCOPN contends that Kaiser growth and use of VHC services is a critical element of VHC's growth and market share gain over the last decade. DCOPN also notes that should VHC's contract with Kaiser fail to be renewed in the future, approval of the proposed project would result in a surplus of medical-surgical beds at VHC. However, because the nonrenewal of the Kaiser contract is speculative, DCOPN contends that the additional beds are needed to fulfill VHC and Kaiser's current contractual obligations. Furthermore, because residents enrolled with a Kaiser health plan are unlikely to receive care at a facility other than VHC, DCOPN does not expect any potential negative impact on neighboring facilities to be destabilizing. DCOPN additionally notes that no letters of opposition were received with regard to this project.

5. The relationship of the proposed project to the existing health care system of the area to be served, including the utilization and efficiency of existing services or facilities;

Table 1, as well as the calculated surplus, demonstrates that there is arguably ample capacity within the existing PD 8 medical-surgical inventory to provide care for PD 8 patients. However, DCOPN maintains that the applicant has adequately demonstrated a unique institutional need for the additional 43 beds. To reiterate, VHC is the only hospital in Arlington County and serves as the core Kaiser Permanente hospital for medical-surgical services in Northern Virginia, undoubtedly contributing to its sharp increase in utilization in recent years. Furthermore, even with the 44 beds recently authorized, failure to implement the requested beds would result in a medical-surgical occupancy of approximately 78% by 2024, only marginally beneath the SMFP threshold for expansion. Finally, for reasons already discussed in this staff analysis report, DCOPN maintains that no reasonable alternatives to the project exist, as converting existing pediatric or ICU beds would ultimately result in the overutilization of those services. Because the proposed project hinges upon a unique institutional need, DCOPN contends that while approval of the proposed project is likely to have some impact on neighboring facilities, that impact is not likely to be significant.

6. The feasibility of the project, the financial benefits of the project to the applicant, the cost of construction, the availability of financial and human resources, and the cost of capital;

The Pro Forma Income Statement (**Table 4**) provided by the applicant anticipates retained earnings net profit of $13,447,000 in year one and $18,658,000 in year two, illustrating that the

[14] The other premier Virginia hospitals are Reston Hospital Center and Stafford Hospital.

[15] In 2018, 67.2% of Kaiser discharges from Northern Virginia hospitals were at VHC.

[16] HSANV staff analysis report, at 11.

proposed 43 additional beds would be financially feasible in the immediate and the long-term. When consolidated with the projected earnings for COPN Request No. VA-8276, which projected retained earnings of $13,401,000 in year one and $11,748,000 in year two, DCOPN calculated a combined net retained earnings of $6,910,000. As already discussed, DCOPN contends that the projected capital costs for the proposed project are reasonable when compared to previously authorized projects similar in scope. The applicant will fund the project entirely using accumulated reserves. Accordingly, there are no financing costs associated with this project.

With regard to staffing, the applicant anticipates the need to hire 150 additional full-time employees (FTEs) in order to staff the current bed addition proposed here as well as the 44 new beds currently being implemented at the hospital. DCOPN notes that this is *in addition to* the 216 positions currently vacant at VHC, 132 of which are registered nurse positions. The applicant states that it does not anticipate an issue with recruiting the staff necessary to operationalize the project given its role as a teaching hospital and its close affiliation with many of the training and educational facilities in Northern Virginia and the District of Columbia. DCOPN notes that the applicant is an established provider of inpatient bed services with a robust employee retention plan. However, DCOPN contends that 366 employees is a large number of FTEs to recruit and retain, even when considering the large employee pool present in Northern Virginia. Accordingly, DCOPN does have some reservations about the applicant's ability to staff the proposed project without negatively impacting the staffing of existing PD 8 facilities. The applicant states that personnel will be recruited through customary channels, including the internet and print advertising, and the many schools with which VHC is affiliated.

7. The extent to which the proposed project provides improvements or innovations in the financing and delivery of health care services, as demonstrated by (i) the introduction of new technology that promotes quality, cost effectiveness, or both in the delivery of health care services, (ii) the potential for provision of health care services on an outpatient basis; (iii) any cooperative efforts to meet regional health care needs; and (iv) at the discretion of the Commissioner, any other factors as may be appropriate;

DCOPN notes that the design of the proposed addition incorporates numerous features that enhance the quality of health-care services. For example, based on its recent experience in the wake of the COVID-19 pandemic, VHC is developing some of the rooms to house the proposed beds as AII rooms. VHC is also planning to develop all patient rooms to be fully exhausted, allowing their conversion from positive pressure rooms into negative pressure rooms with the flip of a switch. All rooms will be designed to allow the addition of temporary vestibules at each patient entrance, as necessary. These and many other infection isolation-driven design features will allow VHC to efficiently and effectively manage demand surges by patients with conditions requiring isolation, such as those experienced in the spring of 2020.

While VHC's proposal seeks the addition of medical-surgical beds to address its patients' growing inpatient needs, the project will also enhance opportunities for the provision of services on an outpatient basis by transferring patients that currently must be boarded in the emergency department, thereby ensuring timely access to care for VHC's emergency department patients.

Regarding cooperative efforts to meet regional health care needs, since 2012, VHC has collaborated with Children's National Medical Center for the management of the hospital's NICU and neonatology team of physicians. In addition to the medical management of the NICU, VHC has a transfer agreement with Children's National Medical Center if infants need to be moved to a higher level of specialty care after stabilization. VHC has also been a member of the Mayo Clinic Network since 2015, allowing its physicians to complement their patient treatment by using May Clinic's point-of-care best practices on disease management, care guidelines, and treatment recommendations. Furthermore, VHC also has affiliations with many of the training and educational facilities in Northern Virginia and the District of Columbia.

8. In the case of a project proposed by or affecting a teaching hospital associated with a public institution of higher education or a medical school in the area to be served, (i) the unique research, training, and clinical mission of the teaching hospital or medical school and (ii) any contribution the teaching hospital or medical school may provide in the delivery, innovation, and improvement of health care services for citizens of the Commonwealth, including indigent or underserved populations.

VHC is an academic medical center that began its affiliation with Georgetown University over 50 years ago. Since then, VHC has also partnered with many other training and educational facilities in Northern Virginia and the District of Columbia, including Marymount University, Northern Virginia Community College, George Mason University, Stratford University, and Chamberlain University. Under various programs, VHC regularly receives students and residents for hands-on training at the hospital and received the Leapfrog Top Teaching Hospital Award in 2019. The applicant states that sufficient medical-surgical capacity is necessary to ensure efficient operation of the hospital and efficient care delivery, and to permit the commitment of appropriate resources toward VHC's teaching and education mission—rather than diverting those resources toward bed management efforts.

DCOPN Staff Findings and Conclusions

VHC is requesting authorization to add 43 medical-surgical beds to its total licensed bed count. The total projected capital cost of the proposed project is $18,554,791, the entirety of which will be funded using the accumulated reserves of the applicant. Accordingly, there are no financing costs associated with this project. DCOPN concludes that this cost is reasonable when compared to previously approved projects similar in scope.

VHI data for 2018 indicates that the total medical-surgical inventory at VHC operated at a collective utilization of 70.2%, beneath the 80% SMFP threshold for expansion. However, when beds specifically classified as medical-surgical within VHI are considered, occupancy increases to 77.1%, only marginally beneath the 80% expansion threshold. DCOPN notes that this is important, because converting existing ICU or pediatric beds (included in the total medical-surgical inventory) would likely result in the overutilization of those services. More importantly, data provided by the applicant demonstrates that for 2019, VHC's medical-surgical inventory operated at 103%, far surpassing the applicant's projections for that year listed in its 2016 application for additional beds. DCOPN attributes this sharp increase to VHC's designation as a Kaiser Permanente premier hospital as well as continued population growth in the area. For this

reason, DCOPN contends that the applicant's projections for 2023 and 2024 are reasonable. DCOPN concludes that even with the 44 beds recently authorized at VHC, failure to approve the requested 43 additional beds would result in a medical surgical occupancy of approximately 78% in 2024, only marginally beneath the SMFP expansion threshold.

Based on the Pro Forma profit and loss statement provided by the applicant, the addition of the 43 new medical-surgical beds would add to the hospital's overall profitability. The Pro Forma projects a net income of $13,447,000 in the first year of operation and $18,658,000 in year two.

The applicant proffered a charity care contribution equal to 3.0% of gross patient services revenue. While this amount is lower than the 4.1% HPR II charity care average, it is consistent with the Virginia Hospital Center Arlington Health System system-wide charity care condition currently in place. Accordingly, should the Commissioner approve the propose project, DCOPN maintains that the 3.0% system-wide charity care condition should apply.

DCOPN maintains that while there is a large calculated surplus of medical-surgical beds in PD 8, the applicant has adequately demonstrated a unique institutional need for the requested 43 beds.

DCOPN Staff Recommendation

The Division of Certificate of Public Need recommends **conditional approval** of Virginia Hospital Center's request to add 43 licensed medical-surgical beds to its existing inventory for the following reasons:

1. The proposed project is generally consistent with the applicable criteria and standards of the State Medical Facilities Plan and the Eight Required Considerations of the Code of Virginia.

2. The capital costs are reasonable.

3. The proposed project appears economically viable both in the immediate and in the long-term.

4. There is no known opposition to the proposed project.

5. The project is more favorable than maintaining the status quo.

6. The applicant has adequately demonstrated a unique institutional need for the addition of the requested 43 medical-surgical beds.

7. The Health Systems Agency of Northern Virginia recommended approval of the proposed project.

DCOPN's recommendation is contingent upon Virginia Hospital Center's agreement to the following:

Virginia Hospital Center will provide inpatient medical-surgical services to all persons in need of this service, regardless of their ability to pay, and will facilitate the development and operation of primary medical care services to medically underserved persons in PD 8 in an aggregate amount equal to at least 3% of Virginia Hospital Center's gross patient revenue derived from medical-surgical services, consistent with the Virginia Hospital Center Arlington Health System system-wide charity care condition agreed to in 2014. Compliance with this condition will be documented to the Division of Certificate of Public Need annually by providing audited or otherwise appropriately certified financial statements documenting compliance with the preceding requirement. Virginia Hospital Center will accept a revised percentage based on the regional average after such time regional charity care data valued under the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. is available from Virginia Health Information. The value of charity care provided individuals pursuant to this condition shall be based on the provider reimbursement methodology utilized by the Centers for Medicare and Medicaid Services for reimbursement under Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq.

Virginia Hospital Center will provide inpatient medical-surgical services to individuals who are eligible for benefits under Title XVIII of the Social Security Act (42 U.S.C. § 1395 et seq.), Title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.), and 10 U.S.C. § 1071 et seq. Additionally Virginia Hospital Center will facilitate the development and operation of primary and specialty medical care services in designated medically underserved areas of the applicant's service area.