CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

THE HOSPITAL BASED MEDICAL OFFICE BUILDING

A graduate project submitted in partial satisfaction of the requirements for the degree of Master of Science in Health Science, Health Administration

by

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ABSTRACT

THE HOSPITAL BASED
MEDICAL OFFICE BUILDING

By

Steven Miles Courtier

Master of Science Degree in Health Science
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The purpose of this project is to determine the need for a medical office building in close proximity to a hospital. The project attempts to measure and determine the need by examining the following:

A) If the need exists for additional medical office space in the service area
B) If there are enough physicians interested in leasing or ownership alternatives in the medical office building
C) Determination of ownership alternatives available to the hospital
D) How to insure interest from the physicians in the project

The paper clearly specifies that the hospital desires to enhance the financial situation of the organization. This can be accomplished by encouraging additional
physicians to admit more of their patients to the hospital, and to increase the use and, thus, the revenues of the hospital's ancillary services. The author believes that a positive approach towards this objective is the hospital based medical office building.

The following surveys were developed to obtain the necessary information for the feasibility study:

A) Physician Survey - to quantify interest level in the project, either ownership or lease arrangements. Seventy-five physicians were interviewed and asked their opinions about the M.O.B. project.

B) Medical Office Building Survey - to quantify all properties, year built, number of stories, square footage, distance to the nearest hospital, average square footage per physician, special facilities, elevators, occupancy, and lease rates and terms. This survey covered approximately twenty-three square miles, containing approximately 614,000 square feet of gross area in medical-dental space.

The two surveys were designed to assist in the entire M.O.B. process. Information obtained in the surveys, in addition to the above will be necessary for the formulation of the gross square footage required, and economic feasibility of the entire building project.

The general findings of the project may be described as follows:

A) The physicians were interested in leasing or ownership alternatives.

B) The majority of physicians preferred the office space in close proximity to the hospital.
C) The overall vacancy factor in the area surveyed is estimated to be between 3% and 5% for completed buildings.

D) The most advantageous time frame to complete the proposed project was determined to be in the summer of 1980 (July or August). This was determined from the survey of lease expirations falling due during this period. (A majority of leases would expire within 18 months)

E) Physician ownership was determined to be approximately 78% of the physicians. The remainder did not want the investment because of a variety of reasons, including investment interests in other areas, poor investment, financially tied to one hospital in one location.
CHAPTER 1

INTRODUCTION TO THE PROJECT
I. Introduction - Rationale For The Project

Many hospital administrators and physicians are rethinking the conventional treatment settings. With increasing frequency, hospitals find they are playing a pivotal role in implementing the transition from single physician office to a modern outpatient facility. Recently in the past few years, hospitals have begun to make available office and support facilities that are necessary to the medical practices of the attending medical staffs. The most recent estimation is that about 80% of all current construction activity on medical office buildings is being done by hospitals. 1

In 1975, the American Hospital Association completed an inquiry regarding the availability of private physician offices located on or adjacent to the hospital site. Fifty-eight percent of all community hospitals reported that individual practices were located on the hospital campus.2

There are considerable geographic variations in the patterns of hospital leasing activity across the country. The largest number of hospitals that offered space for physician offices were clustered in the New England and


Middle Atlantic states. Least involved in leasing activity were hospitals in the West North Central states. The largest number of hospitals with associated private office facilities can be found in the East North Central states where approximately 300, or 35 percent, of hospitals reported leasing activity in 1977.¹

In general, the smaller hospitals have a higher ratio of physicians leasing space. Conversely, in large hospitals, much smaller percentages of the staff occupy hospital-associated offices. Small hospitals, especially those in rural or changing urban areas, consider adjacent medical office facilities to be an asset in their efforts to recruit physicians to the community and to promote physician loyalty to the institution. Middle-sized and large hospitals enter these arrangements with somewhat different constraints and objectives that usually preclude accommodating large percentages of staff.²

The American Hospital Association's survey suggests that one-third of the nation's community hospitals regard the concept of hospital-sponsored private office space favorably. These results should be of interest to others who are concerned with improving the organization of health services delivery. Shortell, S.M. realized ten


² Ibid.
years ago that "the hospital-based medical office serves as a prototype of a more systematized approach to health care."\(^1\)

This concept was recently supported by D.A. Toland when he stated, "Another very important reason for hospital ownership and operation is that no other party in the community is more aware of or more capable of meeting community health care needs, of conducting long-range planning, and of making temporary sacrifices for the long-range good than is the hospital."\(^2\)

Members of hospital boards, administrators, medical staffs, physicians and surgeons in private practice, and many others involved, keenly recognize the current need for new medical office facilities located immediately adjacent to hospitals and health care centers.

The population and industrial growth of many states has generated numerous opportunities to bring this concept to fruition. New hospitals (and expansion of existing hospitals) now under construction or being planned in growing western communities are making it feasible for many more doctors to set up their practices in close proximity to hospitals. These arrangements, it is


suggested, result in considerable advantages for doctors, hospitals, and patients.

Discerning professionals will readily recognize that the success of such projects depends largely upon the ability of all concerned to identify, understand and coordinate the varied objectives of hospital boards, doctors, and others whose needs must be considered. There is a further need to translate those objectives into definite plans which will be followed in a professional, effective, and economical manner.¹

The trend over the past several years has been toward locating medical office buildings on or near the hospital campus. There are several possible beneficial results of this trend: the patient receives better care; the physician's practice is made more efficient; and the hospital benefits from more stable usage of its services through enhanced physician loyalty.²

With the hospital increasingly becoming the central focus for health care services in the community, and considering the benefits of a hospital-based medical office building, it is incumbent upon the hospital and physicians


together to plan a facility that will result in improved medical care for the community.¹

A closer look at the situation reveals that there are many advantages to a hospital-based medical office building, such as:

A) Advantages to the Patient
   1) Improved patient care.
   2) Convenience of all facilities on one campus.
   3) Less waiting time in the physician's office.
   4) Potential for reduced hospital length of stay.²

B) Advantages to the Physician
   1) More efficient practice. Physicians find many of the positive features of group practice in these arrangements, such as possibilities for sharing resources, developing professional contacts and ease of referral. The drawbacks of major personal or financial commitments are eliminated.


2) Continuity of care is improved.
3) Potential for greater gross revenues.
4) Referrals more assured.
5) Greater opportunity for informal consults, other physician interaction.

C) Advantages to the Hospital
1) Improved patient care.
2) Greater physician participation in hospital activities.
3) Assured source of patient admissions.
4) Increased ancillary services usage.
5) Physician practice locations are stabilized.
   The MOB stabilizes the office location of staff physicians (who otherwise might opt for the suburbs) and thus, protects the hospital's assets, for which the board is accountable. A MOB also affords an excellent and vital attraction for recruiting new physicians to the community and to the hospital.
6) Recruitment of new physicians.
   Physician recruitment and other objectives of the hospital will be met.

1 Seminar by the American Hospital Association. Subject: Institute On The Hospital-Based Medical Office Building, February, 1978.
7) Patient care costs will not increase. The initial investment and ongoing costs of carrying the building will come from bottom line dollars. Hence, the decision is to allocate hospital reserves among available investment alternatives, not to raise rates.

8) The presence of the building on the campus will stabilize hospital utilization. In fact, ancillary services usage may increase because patients may use the radiology department rather than travel across town to a different radiology practice. From the change in utilization patterns, distinct financial benefits will accrue to the hospital.¹

Physician Investor Approach

Possible increased utilization lies in the physician investor approach to the office space proposed. The physicians have ownership in the project. By investor, it is suggested to recruit physicians or physician groups as members of a partnership or corporation which would not fall under the purview of Certificate of Need Legislation. A lease arrangement of the real property will be established with the physicians. The construction of the

structure and maintenance and upkeep costs will be incurred by the physicians. The hospital maintains control of the real property. Such a plan provides a sound marketing tool for attracting new physicians. This plan provides a long term investment for physicians including a tax shelter and an incentive for increased physician activity.¹

If the physicians are interested in ownership in the medical office building, then the most common acceptable forms of ownership that apply to the hospital-based building must be explored.

**Major Areas of Examination**

This project will attempt to measure and determine the need for a medical office building in close proximity to a hospital in the West San Fernando Valley. The major areas to examine are:

1) If the need exists for additional medical office space in the service area.

2) If there are enough physicians interested in leasing or ownership alternatives in the medical office building.

3) To determine what ownership alternatives are available to the hospital.

4) To determine how to insure interest from the physicians in the building project.

This will be accomplished with the use of personal interviews and questionnaires to determine the interest level.

This feasibility study will determine if there is the apparent shortage of office space in the hospital's service area. In addition, many "key" physicians on the active medical staff have requested that the medical office building be in close proximity to the hospital. Thus, a feasibility study will be the most logical step to quantify the need for such a project in the service area and the desired location.

The physician interest in the project must be carefully analyzed to determine why a physician is interested in "breaking roots" in the present location of medical practice and relocating in a new facility. The personal interviews and questionnaires will attempt to determine the needs of the physician and their motives to take an active interest in the project. A physician questionnaire sent to the physicians will be helpful in determining their level of interest. An architect can answer most of the questions with respect to the site, and potential legal problems can be identified quickly by an experienced attorney.

All physicians will be interviewed who express an interest in the project. They will be asked candid and direct questions on the acceptability of the project and
their interest in owning the facility.

In conclusion, it is advantageous to the hospital to have its active staff physicians located in the MOB so that they will be more inclined to admit patients to the hospital and to support its programs and services. However, the physicians will not be attracted from their current offices unless the facilities in the MOB are of the highest quality and the rental rates are competitive.

This is the "key" to a successful project, to determine through a feasibility study the basic necessities as outlined above and determine that magic formula to assemble the project in harmony with the physicians so the entire process is a reality. Without a careful analysis of the physician needs from a medical, financial, ease of practice and future security perspective, the goals and objectives of both the hospital and the physician will not reach a common denominator. This common denominator will hinge on the physician's vested financial interest. Will the physician be interested in a financial commitment to the hospital, corporation or developer? If this area will be pursued by the hospital, then it is important to examine the different types of ownership alternatives available.
Ownership Alternatives for the MOB

The most common forms of ownership that apply to the hospital-based medical office building are the following:

A) Hospital Ownership

The traditional approach where the hospital develops (or has developed) a building and then manages it, guarantees maximum hospital control. This arrangement results in a building that is nontaxable for income tax purposes, but most often taxable for property taxes. Physicians receive no tax benefits and the hospital financial commitment is maximized. Hospital ownership probably will continue to be the predominant method for organizing such projects, but it is not the only one possible, and there are some cases in which it is the wrong choice.

Does the hospital want complete control over the project? One of the major concerns of many hospitals is the ability to control the long-term disposition of hospital land, the administration of the project, the type of medicine practiced in the MOB, the activities that might compete with hospital services, and the projects adaptability to future health care systems. Hospital ownership is the only way to retain complete control over a hospital-based project. However, substantial control can be maintained in some other approaches. If the land or the building is leased to a third party or to the
physicians, the lease can contain many rules and conditions covering the project. Even if the land or the building is sold, restrictions can be set forth in the deed.

Is the hospital able and willing to finance the project? There are no third-party reimbursements for MOB project costs, and there are many hospitals that cannot afford to or that prefer not to finance such a project. However, a third-party investor or staff physicians often will be interested in providing the necessary financing. If the hospital has surplus land that it is willing to sell to the owners of the project, there is even the possibility of making some money on the transaction.1

B) Hospital-Physician Partnership

The hospital is the general partner with the participating physicians as individual limited partners. The hospital still retains control through the partnership agreement. Income tax depreciation deductions are apportioned to limited partners on a pro-rata basis. The initial hospital financial commitment is reduced by partners' contribution. Physicians are often uneasy with this alliance.2

1 Seminar by the American Hospital Association. Subject: Institute on the Hospital-Based Medical Office Building, February, 1978.

2 Ibid.
C) Sale to Physician Partnership

A common approach in which physician ownership is the important objective. The hospital may lease land or, alternatively, develop and sell the building to a partnership of physicians which owns and manages the project. Depreciation deduction for tax purposes flows to individual partners. Hospital control is limited to the land lease. The hospital's financial commitment is minimal, and flexibility is built in through resale rights to partners.\(^1\)

D) Sale to Physician Condominium

Each physician owns title to his suite as well as joint ownership of the common areas. Hospital control is difficult, minimal except through initial condominium declaration. Physician receives depreciation deduction for tax purposes and capital gains treatment upon sale. Hospital has initial financial commitment as developer, which is reduced as suites are sold. It is difficult to put together a total financial package for a lender under this type of arrangement.\(^2\)

E) Sale to Private Investor and Lease Back

The hospital develops a building, then sells to a third party investor. The investor leases the building

\(^1\) Seminar by the American Hospital Association, Subject: Institute on the Hospital-Based Medical Office Building, February, 1978.

\(^2\) Ibid.
back to the hospital, who subleases it to doctors and assumes management responsibility. This arrangement minimizes hospital financial commitment after the initial development. Third-party profits are built into lease rates, but the hospital control is weakened through loss of ownership in the building project.  

F) Sale to Private Investor  

The hospital leases land to a private investor who develops and operates the building. Alternatively, the hospital may first develop the building, then sell to an investor who operates the project. The hospital control is limited to a land lease, and third-party profits are built into the lease rates. There is minimum hospital financial commitment, and the third-party investor becomes a landlord to all the physicians involved.  

G) Sale to Outside Developer  

Alternative 1  

The developer leases or purchases property from the hospital or present owners, with restrictive covenants protecting the hospital in areas that include architectural compatibility, building quality, limitation to hospital staff privileged physicians, and non-competing services.

1 Seminar by the American Hospital Association, Subject: Institute on the Hospital-Based Medical Office Building, February, 1978.

2 Ibid.
provided by the hospital.

The developer assumes total responsibility for the development, design, financing, construction, and management of the medical office building and is responsible for physician recruitment, and assumes all financial risks. Under this alternative, the Physician/Lessees may have an option to participate in the ownership of the completed building as Limited Partners.¹

**Alternative 2**

The developer assumes total responsibility for the development, design, location of acceptable financing, and construction of the medical office building owned by Physician/Tenants with the Physician/Tenants assuming the financial risks. The developer assists in recruitment if desired, and will deliver the building to the owners at an agreed upon guaranteed fixed price.²

**Alternative 3**

The developer assumes total responsibility for the development, design, location of acceptable financing, and construction of the medical office building owned by Hospital/Tenants, with the Hospital/Tenants assuming the financial risks. The developer assists in recruitment if desired, and will deliver the building to the owners at an

¹ Seminar by the American Hospital Association, Subject: Institute on the Hospital-Based Medical Office Building, February, 1978.

² Ibid.
agreed upon guaranteed fixed price.¹

**Alternative 4**

The developer is retained on a consulting basis by either the hospital and/or physicians to assist as needed.²

**Summary of Ownership Alternatives**

The major pitfalls of third-party ownership lie in not selecting a developer who understands the unique aspects of hospital-related buildings. The entire project can be scuttled by one lease condition that is unacceptable to physicians, the wrong approach to a group of physicians, or a decision to keep the project books closed.

Retaining ownership of the building and site, but selecting a developer to lease, to finance, and to build the project can lead to the same problems. A premature agreement with a third-party developer, before all of the issues of ownership and financing are explored, may preclude some attractive options, such as physician ownership.

In order to keep the greatest number of options open until the project is well underway, the best choice for a project team leader is a MOB consultant, in the authors opinion. He may be retained to assist the owner during the phases of organization, market feasibility study, and

1 Seminar by the American Hospital Association, Subject: Institute on the Hospital-Based Medical Office Building, February, 1978.

2 Ibid.
presentations to lenders. A knowledgeable consultant without a vested interest in ownership, financing commissions, architectural design fees, or construction profits is an excellent position to review each alternative for organization and financing with the hospital's administration, board, and medical staff. The consultant also can play an important role in comparing the merits of different methods of project delivery and in analyzing proposals submitted by interested architects, contractors, and development firms.

Choosing an Ownership Alternative

The determination of ownership alternatives must be viewed from the standpoint of many perspectives, among which the following should be taken into consideration:

A) **Hospital Control**

1) Medical staff membership as a requirement could possibly secure physicians that are active members of the medical staff.

2) Tenant selection and specialty balance can possibly assure that there can be a concentrated effort. The hospital has a need to exercise some influence over who locates in the building. The building must include among its tenants a balanced mix of specialists so that referrals and consultations are made easily.
3) Overbuild space for recruiting provides for the future growth of the hospital census.

4) Design compatibility and upkeep quality for the overall aesthetics of the medical complex.

5) Restricted ancillary services for the individual practitioners to assure there does not exist any duplication of services.

6) Option on medically-related space for the development of laboratory, radiology, pharmacy, etc.

B) Income Tax Consequences and Capital Gains

Physicians' feelings about price, about investing, and about making tax-sheltered uses of their money vary considerably. The financial and tax characteristics of the various approaches to development of a MOB are different, so the hospital should try to match those characteristics with the aims of its physicians.

C) Property Tax Consequences

D) Flexibility for Expansion or Contraction of Doctors

E) Financing Consequences

F) **Physician Attitudes Toward a Landlord**

Physicians in various communities have different attitudes toward their landlords and toward a hospital landlord in particular. It is very common for MOB's to be organized with the wrong landlord and to fail as a result. Occasionally, a third-party investor will have all the qualities to be an ideal landlord. More commonly, the only landlord that is completely satisfactory to the physicians is themselves.¹

**Developmental Stages of the Project**

This project is formulated with the following fundamental areas of concern:

1) **Is an adequate site available?** An especially troublesome problem arises if there is enough space for a building but not enough for surface parking. Although hospitals in urban areas successfully have developed and paid for parking structures, hospitals in suburban or rural areas almost always have difficulties with them.²

2) **Are there any substantial legal impediments?**


² Ibid.
As with other real estate projects, MOB's can be subject to legal complications. For example, public hospitals may find the laws regulating the manner in which they let contracts and construct facilities to be too restrictive. Other hospitals may discover that all of their property is encumbered by a lender and that there is no acceptable way to renegotiate the loan. Some states may have licensing requirements that impose impossible construction standards on a hospital-based MOB.  

The developmental stages of this project will start with personal interviews with: hospital administrators; hospital board of trustees; physicians in private practice; and developers that are presently working on projects. This, coupled with research compiled from literature that is available will assist in determining a need for a hospital-based medical office building. The results of this research will identify problem areas and provide useful perspective for future research.

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II. Statement of the Problem

The problem which is the subject of this project, is to enhance the financial situation of the hospital, by encouraging physicians to admit more of their patients to the hospital, and to increase the use, and thus, the revenues of the hospital's ancillary services.

The hospital is dependent on physicians to fill empty beds. The physician admits patients to the hospital, and orders laboratory and X-ray tests. The physician is the primary "consumer" of hospital services. To build the census you must encourage maximum utilization of the hospital by the physicians.¹

Most hospitals with new medical office buildings have experienced a sharp census increase and markedly better utilization of outpatient services. Without new medical office buildings, many hospitals are unable to attract new doctors. In today's competitive health care environment, most hospitals must develop new medical office buildings to fill empty beds and better utilize outpatient services.²

The occupancy rate in America's hospitals decreased from 86 percent in 1950 to 76 percent at present. The occupancy at one out of every two hospitals is now less than 65 percent.³

² Ibid.
³ Ibid.
According to the American Hospital Association, most doctors hospitalize their patients in hospitals near their practices. Most doctors refer their patients to laboratories and X-ray departments located in nearby hospitals.

Hundreds of hospitals have constructed new medical office buildings since 1970. Thousands of doctors practice in these new buildings. Most hospitals with new medical office buildings have experienced a sharp census increase and markedly better utilization of outpatient services.
III. Organization of the Paper

The organization of this paper is based on the criteria required by the Health Science Department at California State University, Northridge. The sequence is, somewhat, a reflection of the manner in which the project was undertaken.

Chapter 1 indicates the trend over the past several years and the beneficial results of this trend. The physician investor approach to the project is introduced along with major areas for examination, including:

A) If the need exists for additional medical office space.
B) If there are a significant number of physicians interested in leasing or ownership alternatives in the medical office building.
C) To determine what ownership alternatives are available to the hospital.
D) To determine how to insure interest from the physicians in the building project.

The Statement of the Problem clearly defines the situation that the acute care facility must resolve to remain a comprehensive health care organization and insure continuity of care to the patients.

Chapter 2 identifies the characteristics of the facility that the feasibility study was based on, including:
A) Description of Hospital  
B) Number of Adjacent Medical Office Buildings  
C) Defined Service Area  
D) Specialties  
E) Medical Staff  
F) Ancillary Services Provided  
G) Community Affairs  
H) Transportation  
I) Service Area Statistics  
J) Patient Mix  

Chapter 3 comprises the actual research involved, which includes the following:  

A) Factors to consider in determination of a need for a hospital based medical office building.  
B) The objectives of the building project.  
C) The definition of certain specialized terminology utilized in the discussion of this project.  
D) Sources of data and their measurement. This included a physician survey to measure the interest level in ownership or lease arrangements and a medical office building survey to measure all properties in the service area. The two surveys assist in the formulation of the gross square footage, and the economic feasibility of the entire building project.  

The Physician Survey identifies the percentage of
physicians interested in office space in close proximity to the hospital, and the physicians that expressed interest in ownership alternatives. These two areas are necessary for the feasibility element of the project.

The Medical Office Building Survey was directed towards identifying the total inventory of medical-dental space (excluding hospitals in the service area of the hospital - the West San Fernando Valley). This survey determines the overall vacancy in the area surveyed, the physician preferences to be located in close proximity to the hospital, and the preference to own the space which is occupied, for the tax advantages which accompany ownership.

The study expresses the limitations of the survey results, thus, the researcher will clearly understand the limitations of this study and identify similar types of projects that are relevant to this research.

Chapter 4 states the findings and the direct relationship with each objective expressed in Chapter 3. The chapter introduces the reader to the Certificate of Need Legislation that effects all acute care facilities. Four different circumstances for certificate of need approval of a medical office building are cited. This includes:

A) Hospital ownership and financing
B) Physician ownership and financing with the loan secured by the hospital
C) Physician or private developer ownership and financing in which the hospital's only involvement was to lease the land

D) Physician or private developer ownership and financing.

Chapter 5 develops the conclusions and summary for the project. This area develops the concepts expressed throughout the project that the MOB is another part of the hospital that is necessary to complete the total spectrum of services available to the patient. The chapter concludes with the areas that require further study to complete the economic feasibility and construction phases of the project.
CHAPTER 2

BACKGROUND FOR THE PROJECT
I. Review of Pertinent Literature

This section discusses the available literature on the subject of this project. A literature search was conducted by reviewing the Cumulative Index of Hospital Literature, published by the American Hospital Association, selected references compiled from the Library of the American Hospital Association, researching references cited in journals or books on the subject, seminars and personal interviews with building consultants.

A lack of literature relevant to the project was apparent after extensive research was completed. The available references did not assist in the determination of the need for a medical office building in the service area or if the physicians in our hospital were interested in leasing or ownership alternatives. The material that was available basically assumed that the marketplace was in need of an additional medical office building and that there was significant physician interest in the project. The author was responsible to the hospital executive director, to analyze the extent to which these conditions existed in our situation. If these conditions were not quantified and a favorable conclusion was not reached, there was no need to pursue the project any further.

The underlying questions, therefore, that required answering were:

1) Was there a need for a medical office building
in the service area?

2) Were the staff physicians interested in leasing or ownership alternatives?

These two basic questions resulted in the formulation of a Medical Building Survey, and a Medical Office Building Questionnaire to measure these unknown areas. The Medical Office Building Questionnaire was modeled after the sample provided at the seminar: The Hospital Based Medical Office Building.

Once it had been established that the service area was in need of a MOB and there was substantial physician interest, the available literature was very useful in the development of ideas, concepts and the formulation of the necessary strategy. These areas included the following:

1) Ownership alternatives for the hospital to evaluate.

2) Review of Certificate of Need literature.

3) Establishment of the economic feasibility of the project.

The economic feasibility moves beyond the intent of this study, but has been outlined in Chapter 5, Areas for Future Study. The chapter outlines all additional considerations for the development process.

A reasonable body of literature exists both in book and journal form relating, generally, to the subjects of ownership alternatives, and the review of the Certificate
of Need Laws. A substantial amount of information is also available which is descriptive of economic feasibility of MOB projects, inventories of health care resources, vital statistics, construction and financing.

In conclusion, the feasibility aspects as mentioned earlier, are extremely limited in volume. A guide or manual to assist hospitals through the compilation and analysis of building surveys and physician interest needs to be developed.

Most Useful Sources

Seminars - Sponsored by the American Hospital Association. (Two workshops, 6 hours each). The subject was Hospital-Based Medical Office Buildings.

The development of advantages to the physician was clarified. The efficiency of the physicians' practice was elaborated on, identifying positive features of a group practice in these arrangements with other physicians. This concept shared with the physicians, explored the possibilities for sharing resources, developing professional contacts and ease of referrals.

The advantages to the hospital were predominant in the area of hospital utilization. The major concept of increased patients and ancillary service usage was

developed, accenting the change in utilization patterns and the distinct financial benefits that will accrue to the hospital.

This seminar clearly identified the **Statement of the Problem** for this project. How to enhance the financial situation of the hospital, by encouraging physicians to admit more of their patients to the hospital, and to increase the use and, thus, the revenues of the hospital's ancillary services.

The outline issued during the seminar on factors to consider in determination of a need for a hospital-based medical office building, was instrumental for the formulation of the author's objectives. Only with this planned methodology, was the author able to clearly define the needs of the study. This included the following:

1) Inventory of existing medical office space in the community.
2) A review of the medical staff characteristics.
3) The determination of interest with the medical staff.
4) The exploration of ownership alternatives.

The most common forms of ownership that apply to the hospital-based MOB were introduced. The ownership options were listed in this study followed by a determination of the variables that must be taken into consideration. This was formulated, based on different
points of view. Toland\(^1\) believed that the hospital should own and operate its on-site MOB. The physicians would be totally under the control of the hospital administrator. Carpenter\(^2\) and Steinle\(^3\) took a more modest approach to the ownership question and emphasized that the important factor was hospital control without the day-to-day operation problems. The control could be solidified with the lease of the land and the restrictions included with each involved party to the MOB.

The review of the Certificate of Need Law was covered in Health Planning Chapter 854 Assembly Bill 4001 (Keene).\(^4\) This bill substantially revises the past provisions of law relating to health planning. This law makes the determination that area health planning agencies only are advisory, with the actual decision making power vested in the State Department of Health.

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4. Health Planning Chapter 854 Assembly Bill 4001 (Keene), approved by the Governor, September 9, 1976.
Section 437.10 Projects requiring Certificate of Need. Title 22 Health Planning and Facility Construction,\(^1\) determines the applications that support specific criteria. The State must be assured that the project has identified clearly that there is a need and desirability for the project proposed, based upon the statewide and area plans adopted.

\(^1\) Section 437.10 Projects Requiring Certificate of Need, Title 22 Health Planning and Facility Construction, pp. 2471, 2472.1, 2472.2.
II. Setting for the Feasibility Study

The setting for the feasibility study includes the following:

Description of Existing Hospital: 236 licensed beds, acute care hospital.

Number of Adjacent Medical Office Buildings: two.

Service Area: West San Fernando Valley, Calabasas-Agoura, Conejo Valley, Simi Valley.

Specialties: Anesthesiology, Dentistry, Dermatology, Emergency Medicine, Gastroenterology, General Practice, General Surgery, Internal Medicine, Neurosurgery, Obstetrics and Gynecology, Oncology, Ophthalmology, Orthopedics, Otolaryngology, Otology, Patient Teaching Programs, Pathology, Pediatrics, Plastic and Reconstructive Surgery, Radiation Therapy, Radiology, Thoracic and Cardiovascular Surgery, Urology.

Medical Staff: Over 400 physicians and dentists.

Facilities: Electromyography, Emergency Department, Paramedic Network, Intensive-Coronary-Post Coronary Telemetry and Definitive Observation Units, Medical-Surgical Units, Specialty Laboratories - Pathology, Histology, Cytology - Clinical, Cardio-Pulmonary, Gastrointestinal, Invasive Catheterization, Non-invasive Cardiology, Uro-dynamic Laboratory, Peripheral Vascular Laboratory, Pathology, Nuclear
Medicine - Large Field of View System, CT/T Full Body Scanner, Obstetrical Unit, Occupational and Physical Therapy Units, Oncology Unit, Pediatric Unit, Radiology Department - Radiation Therapy - Linear Accelerator, Respiratory Therapy Unit, Ultra Sonography, Laminar-flow Surgery, Continuing Medical Education and Meeting Rooms.

Community Affairs: Community Advisory Council, Adult and Teen Volunteers, Auxillary Annual Pool Safety Lecture, Monthly Community Health Education Lectures, Monthly Community Health Education Lectures, Guidelines for Babysitters, Health Screening and Immunization clinics, Hospital Tours for children, Medical Explorers, affiliation with the Vocational Nurses School of California, recipient of El Camino Adult School Community Service Award.

Transportation: Canoga Park and Woodland Hills are conveniently located near freeway service or by public transportation to Los Angeles, Orange County or Santa Barbara.

Service Area Statistics: Total Population 665,500 persons, 8% population is 65 or older, nine physicians per 1,000 pop.. Primary care physicians - 122.

Patient Mix: Medical Surgical 67.5%
            OB 6.8%
            Pediatrics 6.9%
| Emergency | 18.8% |
CHAPTER 3

PROJECT METHODOLOGY
I. **Project Objectives**

The following outline was utilized for the formulation of the authors' objectives. Only with a planned methodology was the author able to clearly define the objectives of the study.

**Factors To Consider in Determination of a Need for a Hospital Based Medical Office Building**

**A**) Inventory existing medical office space in the community. (This will be done with a survey.)

1) Determine number of medical office buildings; location; ownership; rentable space; rental rates; occupancy; length of existing leases; condition of building, etc.

B) Review medical staff characteristics. The Medical Staff Statistical Records will achieve this.

1) Establish specialty mix, age distribution, and admissions activity of the active medical staff.

2) Determine the need for additional medical
staff by specialty area based on existing shortages and areas where staff is aging.

3) Review recruiting efforts to date and present status.

C) Establish interest level of present medical staff.

1) Using interviews or the MOB Questionnaire, determine existing office situation of medical staff in terms of form of ownership; square feet occupied; rental rate; lease expiration; present difficulties.

2) Establish level of interest in hospital-based MOB including ownership alternatives; space required; occupancy date; commercial and allied health space; willingness to share space; other. This will be accomplished with the physician survey. (see MOB Questionnaire)¹

Objectives of the Building Project

The objectives of this project are, in order of significance, as follows:

*1) To determine if the active medical staff is interested in a medical office building.

*2) To determine the number of physicians interested in a MOB in close proximity to the hospital.

¹ Seminar: Institute on the Hospital-Based Medical Office Building, American Hospital Association, February, 1978.
*3) To determine the physician interest in ownership of the medical office building.

*4) To determine the overall vacancy factor in all medical office buildings in the service area.

5) To quantify the required size of the new medical office building.

6) To determine the desired average space required for each physician office in the new building.

7) To quantify the maximum rental rate the new medical office building can maintain.

8) To determine the most advantageous time for completion of the medical office building.

9) To evaluate the most typical lease terms arranged by the owners of the surrounding medical office buildings.

10) To evaluate how the Certificate of Need Program effects the hospital.

*All items were crucial for determining if there was a need in the community for a medical office building and if the physicians were interested in leasing or ownership.
II. Definitions

Having introduced the project and the use of many professional terms, it is necessary to define certain specialized terminology utilized in this discussion of this project.

1) Hospital Based Medical Office Building - Physicians' offices located in close proximity and affiliated with the hospital to complete the total spectrum of services available to the patient.

2) Hospital Census - the number of patients in the hospital (inpatients) at one specific time of a 24 hour period.

3) Medical Staff Specialty Mix - the percentage of General Practice, Internal Medicine, OB-Gyn, Pediatrics, Family Practice, Surgery, etc. specialties with Board Certification that comprise the total medical staff.

4) Active Medical Staff - physicians that have applied for privileges, have been accepted by the Executive Committee and Board of Trustees, and utilize the hospital on a regular basis.

5) Referral Network - the establishment of Board Certified specialties to assist the general medicine groups.

6) Utilization - the physician's useage of inpatient
and outpatient services.

7) **Ancillary Services** - the service departments in the hospital that support inpatient and outpatient medical needs. Examples would include the Pharmacy, Laboratory, Radiology and Cardiology.

8) **Ease of Practice** - the convenient arrangement provided to the physician by the hospital to have all medical care treatment facilities located in close proximity to the physician's practice.

9) **Third-Party Reimbursement** - reimbursement of patient costs to the hospital for all medical services rendered to inpatients and outpatients. This would include: Medicare; Medical; Blue Cross; and private insurance companies.

10) **Physician Consultations** - patients for which the doctor provided consultation to the attending physician.

11) **Patient Days** - the average daily census multiplied by 365 days.

12) **Percent of Occupancy** - actual patient days divided by available bed, multiplied by 365 days.

13) **Available Beds** - includes those which are staffed and not under construction or in suspension, and is always a smaller number than
licensed beds.

14) **Service Area** - the hospital's geographic region surrounding the hospital in which the patients served by the hospital live.
III. Sources of Data and Their Measurement

The following surveys were developed to obtain the necessary information for the feasibility study.

1) Medical Office Building Questionnaire - to quantify interest level of physicians in the project, either ownership or lease arrangement. Seventy-five physicians were interviewed and asked their opinions about the medical office building project that would be constructed in close proximity to the hospital.¹

2) Medical Building Survey - to quantify all properties, year built, number of stories, square footage, distance to the nearest hospital, average square footage per physician, special facilities, elevators, occupancy, and lease rates and terms. This survey covered approximately 23 square miles, containing approximately 614,000 square feet of gross area in medical-dental space.²

The two surveys were designed to assist in the entire MOB process. Information obtained in the surveys,

¹ Seminar: Institute on the Hospital-Based Medical Office Building, American Hospital Association, February, 1978.
² Ibid.
in addition to the above will be necessary for the formulation of the gross square footage required, and economic feasibility of the entire building project.
MEDICAL OFFICE BUILDING QUESTIONNAIRE

Physician Name: ________________________________
Specialty: ________________________________
Solo, Partnership, or Group Practice. If group, name of group: ________________________________

Will additional physicians join your practice in the next two - three years? If so, how many and in what specialty areas?

Present Office Situation
1) Present office address: ________________________________
2) How many square feet do you occupy? ________________________________
3) Do you own or rent? ________________________________
4) If you rent:
   a) When does your lease expire? ________________________________
   b) What is your rental rate? ________________________________ ($/sq.ft./mo.)
   c) Does your rent include utilities? Janitorial? Linen?
   d) If not, how much additional do you pay per year for these services? ________________________________
   e) Who owns your building? ________________________________
5) Are you satisfied with your present office situation?
Are you dissatisfied with any aspects of your present office situation? ________________________________
Prospective Medical Office Building

1) Would you have an interest in office space in such a building? ________________________________

2) If so, how much space would you occupy? (Same as now, less, more) (approx. sq. ft.)

3) Under what conditions would you have an interest in office space in such a building?
   a) Own or rent? ________________________________
   b) Maximum rental rate willing to pay in today's dollars? ________________________________
   c) Possible occupancy date? ________________________________

4) Would you be willing to sign a letter of interest stating that you would support development of such a building? ________________________________

5) Other? ______________________________________
       ______________________________________
       ______________________________________
       ______________________________________
MEDICAL BUILDING SURVEY

Property address: ________________________________

Building Name: ________________________________

Ownership: ________________________________

Year Built: _____ No. Stories: _____ Construc. Class: __

Distance to Nearest Hospital: ________________________________

Related to Hospital (ownership, etc.) ________________________________

Number of Suites: ________________________________

Gross Building Area: _____ Sq. Ft. Average per Suite: __

Percent Non-Medical: ________________________________

Special Facilities: Pharmacy _____ Med. Lab. ______

Opt. Lab. _____ Other: ________________________________

Elevator: _____ Building Quality _____ Condition: _____

No. of Parking Spaces: Open _________ Covered _________

Parking Fees: _____ Tenant: _________ Public: _________

*Occupancy %: ___________ * Occupancy Trend: ___________

*Tenant "Mix": ________________________________

_____________________________________________________

Lease Rates and Terms: ________________________________

_____________________________________________________

*These questions were crucial for the success of the project.
Sale Price, Date, Terms: ____________________________

Gross Income, Operating Expenses, Net Operating Income:

Other Information, Comments: ____________________________

Photographs:
IV. Analysis of Survey Results

A) Analysis - The Medical Office Building Questionnaire (75 physicians)

1) Square feet occupied by the physician - average is 1200 sq. ft.

2) 100% of the physicians rent their office space.

3) Lease Term - majority - 5 years (95%).

4) Rental Rate - 80¢/sq.ft./mo. - average

5) Rental Rates include parking, utilities and janitorial services for the present medical office building.

6) 86% of the physicians are not satisfied with their present office situation.

7) 97% of the physicians are interested in office space in close proximity to the hospital. 3% of the physicians are not interested in office space close to the hospital. (This is not an important factor due to the usage of more than one hospital by the physicians).

8) 91% of the interested physicians would require more office space than they have presently.

9) 1700 square feet of office space required (average) for those physicians that desire
additional space in the medical office building.

10) 78% of the physicians that expressed interest in the building are interested in ownership in the medical office building. 22% are interested in renting the medical office building.

11) $95/sq.ft./mo. is the average maximum rental rate the physician is willing to pay in today's dollars, for occupancy in the medical office building.

12) Requested occupancy date - at the termination of the established leases. (Varied from one physician or medical group to another, was dependent on individual circumstances.)

13) 86% of the physicians interviewed are interested in the medical office building.

14) 96% of the interested physicians were willing to sign a letter of interest stating that they would support the development of such a building.
B) Analysis - Medical Building Survey

Research was directed toward identifying the total inventory of medical-dental space (excluding hospitals in the service area of the hospital - the West San Fernando Valley).

The most typical lease terms encountered provide for full service, including janitorial, to be paid by the landlord, with the lease containing real estate tax and expense protection "stops" and a CPI clause. The most typical term is five years. The longest lease term is ten years. Only one property has a parking charge for customers and this building is experiencing difficulty in achieving full occupancy.

The most typical charge for janitorial service appears to be $.05, but higher in some cases.

The survey area, about 23 square miles, contains approximately 614,000 square feet of gross area in medical-dental space, including commercial space such as pharmacies. This includes the subject building and an additional overall allowance of 15% for space not specifically inventoried herein. The actual inventory total, excluding the subject, is 514,204 gross square feet. Of this total, 69,500 square feet is contained in buildings of less than 10,000 square feet of gross area. Thus, 86% of the total is in buildings larger than 10,000 square feet.
Two buildings, containing a total of 79,009 square feet of gross area, are adjacent to hospitals and are under common ownership with the hospitals. Four buildings, containing 187,612 gross square feet, are located across a street from a hospital, but are not under common ownership with a hospital. Twenty-three buildings, containing 247,583 square feet are not adjacent to a hospital.

Approximately 50% of the buildings are ten years old or less, or have been extensively remodeled during this period.

The overall vacancy in the area surveyed is estimated to be between 3% and 5% for completed buildings. Only one building, of about 65,000 gross square feet, is actually under construction.

The data reviewed indicates a very broad rental range for medical space of from $.55 to $1.08 per net square foot, on a full service basis, in two to seven story buildings having adequate parking. The (unverified) highest rate reported is $1.08 for the seven story, high quality, building which is under construction adjacent to the hospital and which has enclosed "bridges" at upper building levels directly to the hospital.

The lower rates, from $.55 to about $.60, are for generally older and smaller buildings not adjacent to a hospital. The newer and better buildings, not adjacent
to a hospital, range up to $.90 to $.96, but a more typical range for this category appears to be from $.60 to $.85.

The market rental of the subject is $.95 per net square foot for the medical suites and $1.00 plus coverage for a pharmacy, if such is included. This rental assumes a full service basis, including janitorial, an adequate tenant improvement allowance and no parking charge. It also assumes that such other convenience items will be provided as may be desirable to attract physicians who practice or wish to practice at the adjacent hospital.

Full occupancy may be slow to develop because of the potential tenants' need to permit existing leases in other locations to expire. Some concession in this respect by the landlord may help to accelerate occupancy.

For hospital staff physicians, a private, direct "hot line" to the hospital communications center may be such an item. A covered walkway to a private entrance at the hospital would also be such an item, but may not be practical for the subject building.

There appears to be a strong preference by physicians and other medical professionals to be located very near the hospital at which they practice. Ideally, within a short, protected walking distance.

There also appears to be a preference to own the space which is occupied, for the tax advantages which accompany ownership.
Medical buildings which do not have one or both of these factors are at a definite market disadvantage relative to those which do have them. This is often reflected in lower rental rates, and sometimes in higher vacancies.¹

A possible alternative program for hospital-owned medical buildings is to sell the improvements to staff or potential staff physicians, but to retain ownership of the land under a suitable land lease arrangement.

V. Limitations of Survey Results

1) The survey was limited to approximately 23 square miles, containing approximately 614,000 square feet of gross area in medical-dental space.

2) Data reviewed indicated a very broad rental range for medical space from $.55 to $1.08 per net square foot, therefore, information may not be useful on a "weighted" average basis.

3) The results could possibly be represented of the San Fernando Valley area only and should not be assumed to be an accurate indication of other geographical areas inside or outside California.

4) The limited number of doctors interviewed may not express the normal attitudes towards a hospital based medical office building.

5) Attitude of physicians could possibly be influenced by the area of the country the survey analysis is taken.

6) Survey's formulation was developed on special circumstances at the 236 bed hospital and should be revised to meet any important considerations for the medical complex involved.

In conclusion, this writer expresses the desire that all information available in this feasibility study is helpful with similar types of projects.
CHAPTER 4

FINDINGS
Summary of General Findings

Objective 1 - To determine if the active medical staff is interested in a medical office building.

Findings: The physicians of the active medical staff were very interested in a medical office building. Approximately 86% would be interested in the project. (Either to lease 22% or to have ownership 78%)

Objective 2 - To determine the number of physicians interested in a medical office building in close proximity to the hospital.

Findings: The physicians are very interested in office space in close proximity to the hospital. This was 97% of the 75 physicians interviewed. The building survey also indicates this is a trend in the West Valley.

Objective 3 - To determine the physician interest in ownership of the medical office building.

Findings: Physician ownership was determined to be approximately 78% of the physicians. The remainder did not want the investment because of a variety of reasons, including investment interests in other areas, poor investment, financially tied to one hospital in one location, did not desire to at this time, and financial interests in other
Objective 4 - To determine the overall vacancy factor in all medical office buildings in the service area.

Findings: The overall vacancy factor in the area surveyed is estimated to be between 3% and 5% for completed buildings.

Objective 5 - To quantify the required size of the new medical office building.

Findings: The size of the medical office building was determined by space requirements for each physician. 73,000 gross square feet was determined a conservative estimate of required space to accommodate the physicians.

Objective 6 - To determine the desired average space required for each physician office in the new building.

Findings: The average square footage requirements by each physician or medical group was approximately 1700.

Objective 7 - To quantify the maximum rental rate the new medical office building can maintain.

Findings: The maximum rental rate the new medical office building could maintain was determined in the following manner: The data collected indicated the rental range for medical space
from $.55 to $1.00 per net square foot, on a full service basis, in two to seven story buildings having adequate parking. The Medical Office Building Questionnaire indicated that $.95 per square foot per month was the maximum rental rate the physician was willing to pay in today's dollars. Thus, based on the findings, if the building was rented to the physicians, the cost in today's dollars would be $.95 to $1.00 per net square foot per month. All calculations assume a full service building. (parking, utilities and janitorial)

**Objective 8** - To determine the most advantageous time for completion of the medical office building.

**Findings:** The most advantageous time frame to complete the proposed project was determined to be in the summer of 1980 (July or August). This was determined from the survey of lease expirations falling due during this period. (A majority of leases would expire within 18 months.)

**Objective 9** - To evaluate the most typical lease terms arranged by the owners of the surrounding medical office buildings.

**Findings:** The most typical lease terms encountered by
the owners of the surrounding medical office buildings was to provide for a full service, including janitorial, to be paid by the landlord, with the lease containing real estate tax and expense protection "stops" and a Consumer Price Index clause. The most typical term is five years.

Objective 10 - To evaluate how the Certificate of Need Program affects the hospital.

Findings:

At the federal level Public Law 93-641, the National Health Planning and Resources Development Act, creates a network of local and state agencies responsible for health planning and development in California. On September 9, 1976 the Governor signed into law a measure known as AB 4001 which provided the state with its first Certificate of Need law. According to the American Hospital Association data, California has joined about thirty-five other states that have already adopted similar measures to control the future planning, development and cost of health care.

Although AB 4001, the California Certificate of Need law, substantially revises the state law relating to planning for health facilities, and does require a Certificate of Need for most major capital expenditures, the scope of projects subject to the act does not conform
to the provisions of P. L. 93-641. Some areas of non-conformity are: (1) no coverage for HMO's; (2) unsatisfactory review procedures; and (3) insufficient review criteria.

On October 6, 1977 Governor Brown signed into law AB 245, a measure that will with certain exceptions, require reductions of licensed bed capacity as a condition for granting exemptions for remodeling or replacement. This new law tightens the requirements of AB 4001 and brings them closer to compliance with P.L. 93-641.

However, California is still in an uncertain transitional period between the creation of state controls on planning (AB 4001) and the need for compliance with Federal requirements. Before some time in 1980, steps will need to be taken to either amend the existing state certificate of need law or the Federal law itself. It is possible that, one of the various evolving federal cost containment measures including Talmadge (S 1475), Carter (H. R. 6575, S. 1391) and others, may further change the regulatory system.

In the larger perspective, proposed measures to control capital expenditures are in a state of flux. However, the present state law (AB 4001) is in effect and health care institutions must become conversant of its provisions and processes; and develop strategies for accommodating the law's requirements.
In conclusion, a Certificate of Need is a permit issued by the Office of Statewide Health Planning and Development, authorizing approval to construct or modify a health care facility. Through Certificate of Need review, the State regulates expenditures for major health care facility construction and equipment purchases.

The State will approve a Certificate of Need if the applicant can demonstrate several factors including:

1) a need exists for the project
2) less costly alternatives have been evaluated
3) the applicant has sufficient resources and management skills to implement the project, and
4) There is community support for the project.

If the commitment of the hospital dollars to the project is deemed appropriate, the board must prepare its presentation for a certificate of need (CON) and for Health Systems Agency (HSA) approval.

In May 1978, a survey to determine where and under what circumstances CON applies to a hospital based medical office building was conducted. The findings indicate that, at the time, 35 states and the District of Columbia had such laws. (Several responses indicate "subject to determination" on an individual project basis because no relevant review guidelines exist.)

Four different circumstances for certificate of need approval of a medical office building were cited. The
first circumstance was outright hospital ownership and financing of the medical office building. The second was physician ownership and financing of the MOB, with the loan to be secured by the hospital. The third was physician or private developer ownership and financing in which the hospital's only involvement was to lease the land. The fourth was physician or private developer ownership and financing in which the hospital leases space in the building from the physician group or developer.

Clearly, most CON laws do apply to a MOB where there is hospital ownership of financing. Most CON laws do not apply to a MOB when the hospital only leases the land. The responses to the other two circumstances fall in between these two extremes.

It is important to note that in the fourth circumstance (the hospital leasing space in a MOB for hospital purposes), CON applies for those states responding "yes" only when a licensable activity occurs in that space or when the effective acquisition price of the leased space exceeds the state's capital expenditure threshold amount, such as $150,000.

If the hospital makes a financial commitment to the project CON will apply in a great many instances. However, there are exceptions, such as in Florida and Minnesota, both of which have CON.
In preparing a CON application, what approach will demonstrate the need for and feasibility of the project? In discussing the MOB project, the following points must be made:

1) Location of the MOB on the hospital campus means better patient care.
2) The hospital now will be in the position of attracting physicians more easily.
3) The MOB will initially be capitalized from bottom-line dollars and, after a start-up period, will be operated at the break-even point. Hospital rates will not be raised.
4) Because there will be no subsidy, no special benefits will inure to physicians, and the community at large will benefit.
5) The hospital's financial involvement means a lower cost project and, thus, lower health care costs to the community.

**Applicability of Certificate of Need**

California requires the following:

1) Hospital owned or hospital financed  

2) Physician owned: hospital secures loan  

3) Physician/Developer owned: leases hospital land  

4) Physician/Developer owned: hospital leases space in the building
**PERCENTAGE DISTRIBUTION OF STATES INCLUDING MEDICAL OFFICE BUILDINGS IN CERTIFICATION-OF-NEED LEGISLATION**

<table>
<thead>
<tr>
<th>Responses</th>
<th>Hospital-owned or hospital-financed</th>
<th>Physician-owned hospital secures loan</th>
<th>Physician/developer owned leases hospital land</th>
<th>Physician/developer owned hospital leases space</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;Yes&quot; Responses</td>
<td>75.0%</td>
<td>36.1%</td>
<td>8.3%</td>
<td>55.6%</td>
</tr>
<tr>
<td>&quot;No&quot; Responses</td>
<td>16.7</td>
<td>22.2</td>
<td>66.7</td>
<td>0.0</td>
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<td>8.8</td>
<td>41.7</td>
<td>25.0</td>
<td>44.4</td>
</tr>
</tbody>
</table>

In conclusion, many architects, developers, and consultants see certificate of need review as a possible problem, but most admit that at least for the time being, the situation differs so greatly from state to state that no generalizations are possible.¹

**Review of Federal and State Laws**

The proposed construction of the building containing doctors' offices and perhaps a pharmacy (but no 24-hour inpatient care) is considered here in relation to federal and state laws concerning health planning. Only the state laws will be relevant.

**State Laws**

The basic California health planning law is contained in California Health and Safety Code §437 et seq. Among other things these sections require the obtaining of a Certificate of Need from the State Department of Health (the "Department") prior to the commencement of certain projects. The general statement of those projects requiring such a certificate is found in §437.10 and the regulations issued pursuant thereto, 17 Cal. Admin. Code §90401(c). Though the list of such projects is quite extensive, generally the construction of new health facilities, changes in bed capacity of licensed

facilities, establishment of clinics or special service centers, and acquisition of expensive medical equipment or capital expenditures by health facilities require such authorization.

The key point is that the requirements only apply to "health facilities". The term is defined in Health and Safety Code §1250 and at various places in the Administrative Code. A part of the definition of a health facility requires that the facility provide "24-hour inpatient care". Health facilities fall into five general categories:

1) General acute hospitals;
2) Acute psychiatric hospitals;
3) Skilled nursing facilities;
4) Intermediate care facilities; and
5) Special hospitals.

The proposed medical office building would not appear to be within the ambit of any of these categories. Thus, in general, the Health and Safety Code and Administrative Code sections do not apply.

However, it should be noted that if the hospital staff were to undertake the project, a Certificate of Need would be required. This is because any large capital expenditure by a health facility must be preceded by the issuance of a certificate. Health and Safety Code §437.10(e); 17 California Administrative Code §90401(c)(11).
As the project is proposed there will be no problem. This is true for two reasons: (1) there will be no expenditure by, for, or on behalf of the hospital, and (2) by the terms of the Administrative Code, a capital expenditure requires an increase in depreciable assets of or owned by a health facility. It should make no difference whether the land is purchased or leased from the hospital.¹

The Federal Law

The National Health Planning and Resource Development Act of 1974, P.L. 93-641, 42 U.S.C. 300k et seq., is a response by the Congress to what it calls the rising cost and maldistribution of health care facilities. The law breaks down into two general areas: (1) the requirement of the establishment of various federal and state health planning and development bodies, and (2) authorization of financial assistance to public and non-profit corporations.

The second area, financial assistance, does not impinge on this project directly since no federal aid in financing, etc. is sought. The establishment of state agencies is, however, more directly related to the proposed construction. 42 U.S.C. 300m-2(a)(4) requires that each state have a health planning and development ¹

¹ 437.10 Projects Requiring Certificate of Need, Title 22 Health Planning and Facility Construction, p. 2471, 2472.1, 2472.2.
agency which, among many other things, administers a Certificate of Need program. However, as we have shown above, the proposed project does not require such a certificate and, hence, the federal law is not relevant to the project.¹

¹ 437.10 Projects Requiring Certificate of Need, Title 22 Health Planning and Facility Construction, p. 2471, 2472.1, 2472.2.
CHAPTER 5

CONCLUSIONS AND SUMMARY
Conclusions

The medical office building is another part of the hospital that is necessary to complete the total spectrum of services available to the patient. It is an administrative aid to expand outpatient utilization, to upgrade care, and to stabilize inpatient occupancy.

It is a reasonable conclusion that X-ray, laboratory, surgery, intensive care, and all other diagnostic and therapeutic facilities should be grouped within one geographic area. Furthermore, it is even more reasonable, if not mandatory, to include the private physician within the same geographic area. Without the physician, the healthcare wheels cannot be kept in motion.

The doctor with offices in the on-campus medical office building has: (1) time and energy conserved, (2) increased annual gross income, (3) practice assured, (4) closer supervision of patients, (5) improved communication with hospital employees, (6) expensive equipment available for the physician's use, and (7) referrals from other specialists.

The hospital with an on-campus medical office building has: (1) improved patient care, (2) all facilities under one roof for the patient, (3) source of admissions, (4) prestige to the hospital, (5) more efficient staff, (6) increased number of patients, and (7) greater bed utilization.
The patient, the doctor, and the hospital experience only advantages with a medical office building located on-campus with the hospital. Disadvantages are negligible in the cohesive organization. Therefore, hospitals must have the foresight to plan and provide an on-campus medical office building - a vital contributor to ultimate patient care.

However, not all hospitals can be ready at any given time to immediately provide a medical office building on campus. Many things have to be taken into consideration before an influential group of physicians are placed within the everyday management process and patient administration. The hospital must be prepared to share the authorities, as well as the responsibilities, with the equivalent of a full-time geographic medical staff in all matters relating to patient care. Consequently, if the administrative team is not sufficiently capable to add this strength to its efforts, care should be taken to correct this weakness before bringing the physicians on board. All motives for providing and operating should be well planned, clearly established, and permanently adopted before the hospital should provide an on-campus office building.

One of the most frequent pitfalls for hospitals in providing medical office buildings has been the hospital's insistence that physicians be "signed up" before
beginning the project. This is grossly unfair to the physician, since he is being asked to make decisions even before the hospital is willing to make a decision as to what it wants to do and will do for him. In particular, this is asking a physician to change his method of practice, his place of practice, even possible making a decision to change a partnership or group arrangement, before the hospital can guarantee him that such an event will take place. This is one of the most frequent delays to any project and, in most instances, kills the project outright.

If hospitals are truly the "health centers of the community", they can no longer delude the public into believing they provide all of the facilities, equipment, and manpower necessary to care for the sick without having the physician immediately available to manage the entire process. If hospitals are serious about providing better health care at lower cost to the consumer, they can no longer "leave the physician off the team" and force him to scramble to the rescue at a time of crisis.

With a greater emphasis now being placed on health care delivered through the outpatient medium, welding the hospital, outpatient services, and the physician into a cohesive unit becomes more important. The development of this cohesive unit can be accomplished, most practically, through an all-encompassing medical office building.
Consequently, regardless of the path of the future of health care, the hospital with a full spectrum of ancillary services available to both inpatients and outpatients and with its own supportive medical office building will be a viable component of the system.

Summary

The section on areas for further study attempts to develop the structure of the project beyond the feasibility elements. The marketplace has clearly defined a need for another MOB. The physicians have expressed interest in the project, ownership alternatives have been reviewed and the Certificate of Need Problems have been investigated.

The Medical Building Survey and the Medical Office Building Questionnaire are complete to advance to the economic feasibility of the project. At this point a decision must be made as to ownership alternatives. The survey clearly indicates that a majority of physicians are interested in ownership of the building. The hospital's needs are clearly identified and the complete ownership of the building is not necessary to achieve these needs. In fact, physician ownership could possibly tie the physician to the hospital with a vested financial interest. It is the opinion of the writer that an ideal arrangement for ownership would be the following: A developer leases from the hospital the land, with restrictive covenants
protecting the hospital in areas that include architectural compatibility, building quality, limitation to hospital staff privileged physicians, and non-competing services provided by the hospital.

The developer assumes total responsibility for the development, design, financing, construction, and management of the MOB and is responsible for physician recruitment, and assumes all financial risks. The physician will have the option to participate in the ownership of the completed building as limited partners, the developer would be the general partner.

If this is not acceptable to the physicians, the developer could assume total responsibility for the development, design, location of acceptable financing, and construction of the medical office building owned by Physicians/Tenants with the Physician/Tenants assuming the financial risks. The developer will assist in recruitment if desired, and will deliver the building to the owners at an agreed upon guaranteed fixed price.

A developer should be retained on a consulting basis by the hospital to determine the feasibility of the above arrangements. If resources are limited (manpower and dollars) this is an ideal position to pursue. Many developers will do the "ground" work to establish if there is physician interest in the project. The developer can meet with the Board of Trustees to promote the project,
the developer can meet with the physician steering committee that has been developed to formulate the needs of the project. Much of what has been mentioned in the feasibility study can be accomplished by the developer on a consultation basis. This can be accomplished with a retainer agreed upon by both the hospital and the developer, with no obligations to pursue any actual construction of the project.

The considerations for State approval of any project exceeding $150,000 via the Certificate of Need process can be avoided using this strategy also. The arrangement is "subject to interpretation" by the State of California for individual hospitals involved.

In conclusion, the needs of the hospital can be accomplished. Physicians are gravitated to your facility with a vested financial interest, ease of practice is established, and Certificate of Need is avoided.

Areas for Further Study

Determination of the Economic Feasibility of the Medical Office Building

1) Project financial performance for four to five years, including project schedule, capital budget; amount to be financed, operating costs and financing costs.

Sources: Architects; general contractors; real estate managers; tax assessor; local bankers;
financial advisor; published reports; and many other sources.

2) Based on steady-state occupancy, determine rental rate required to break even and hospital/physician requirements.

3) Perform complete pro-forma projection of revenues and expenses.

4) Assess economic feasibility of the project, including:
   a) Is rental rate competitive?
   b) What is magnitude of start-up costs?
   c) Will future cash flow be positive; enough to off-set start-up costs?¹

Key Assumption Used in Economic Feasibility

1) Example used is representative of several projects recently done in various sections of the country. Example is for illustrative purposes and should not be used for project planning purposes without a careful review of the numbers used and assumptions made.

2) Permanent financing is assumed to be in the form of a conventional mortgage with a loan to value ratio (including land) of 75 percent, a term of 25 years, and a 9½ percent interest rate.

¹ Seminar: Institute on the Hospital-Based Medical Office Building, American Hospital Association, February, 1978.
The financing terms yield an annual mortgage constant of 10.48 percent.

3) Construction financing terms are assumed to include a loan to value ratio of 75 percent, interest at 3 percent over prime, loan fees of 3/4 percent, and an outstanding loan period of 12 months.

4) The operating costs per square foot analysis is based upon a projected steady-state occupancy level of 95 percent. Thus, rental rates and the equity contribution by individual physicians are factored upward to cover costs of unoccupied space.

5) The financial projections for the building assume a break-even operation once the 95 percent occupancy level is reached and, thereafter, dictated by competitive rental rates for office space in the area. Thus, the cumulative cash flow loss through the start-up years must be financed by the project developer. Moreover, it is assumed that the land is contributed by the hospital, reducing the cash equity required for the project.

6) No return on invested equity is assumed in the financial projections or built into the rate structure. This is a common practice where the
developer would require a higher rental rate or sale than projected here to justify his equity investment.

7) Calculations of after-tax savings to physicians assume a 50 percent tax bracket for the physician and use an average of the first ten years depreciation as an annual deduction, using the 150 percent declining balance method.¹

TABLE 2

The Capital Budget And Financing Requirements. (Example)

### Capital Budget

<table>
<thead>
<tr>
<th>Cost Category</th>
<th>Total Cost</th>
<th>Cost Per Gross Square Feet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Land</td>
<td>$66.1M</td>
<td>$1.87</td>
</tr>
<tr>
<td>Building And Equipment</td>
<td>1,627.9</td>
<td>46.14</td>
</tr>
<tr>
<td>Architect And Engineering</td>
<td>105.8</td>
<td>3.00</td>
</tr>
<tr>
<td>Other Professional Fees</td>
<td>18.6</td>
<td>0.53</td>
</tr>
<tr>
<td>Interim Construction Interest</td>
<td>100.4</td>
<td>2.85</td>
</tr>
<tr>
<td>Permanent Financing Fees</td>
<td>42.4</td>
<td>1.20</td>
</tr>
<tr>
<td><strong>Total Capital Budget</strong></td>
<td><strong>$1,961.2M</strong></td>
<td><strong>$55.69</strong></td>
</tr>
</tbody>
</table>

### Financing Requirements

<table>
<thead>
<tr>
<th>Funding Requirement</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Contribution - Land</td>
<td>$66.1M</td>
</tr>
<tr>
<td>Equity Financing Required</td>
<td>424.2</td>
</tr>
<tr>
<td>Debt Financing Required</td>
<td>1,470.9</td>
</tr>
<tr>
<td><strong>Total Fund Sources</strong></td>
<td><strong>$1,961.2M</strong></td>
</tr>
</tbody>
</table>
# TABLE 3

## Occupancy And Operating Cost Projections. (Example)

### Occupancy

<table>
<thead>
<tr>
<th>Space</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Square Feet</td>
<td>35,300</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rentable Square Feet</td>
<td></td>
<td>28,600</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net To Gross Ratio</td>
<td></td>
<td>0.81</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Area Rented:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physicians</td>
<td>14,960</td>
<td>19,800</td>
<td>22,600</td>
<td>24,970</td>
</tr>
<tr>
<td>Commercial</td>
<td>2,200</td>
<td>2,200</td>
<td>2,200</td>
<td>2,200</td>
</tr>
<tr>
<td>Total</td>
<td>17,160</td>
<td>22,000</td>
<td>24,800</td>
<td>27,170</td>
</tr>
<tr>
<td>Percent Occupied</td>
<td>60%</td>
<td>77%</td>
<td>87%</td>
<td>95%</td>
</tr>
</tbody>
</table>

### Operating Costs

<table>
<thead>
<tr>
<th>Operating Expenses</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Janitorial Services</td>
<td>14.8</td>
<td>18.8</td>
<td>21.2</td>
<td>22.9</td>
</tr>
<tr>
<td>Utilities</td>
<td>28.3</td>
<td>28.6</td>
<td>28.8</td>
<td>26.9</td>
</tr>
<tr>
<td>Other - Admin., etc.</td>
<td>42.5</td>
<td>45.4</td>
<td>47.2</td>
<td>48.5</td>
</tr>
<tr>
<td>Property Taxes</td>
<td>34.4</td>
<td>39.7</td>
<td>44.9</td>
<td>48.8</td>
</tr>
<tr>
<td>Subtotal</td>
<td>120.1</td>
<td>132.5</td>
<td>142.1</td>
<td>149.1</td>
</tr>
</tbody>
</table>

| Year 4                  |        |        |        |        |
| Cost Per Net Square Foot|        |        |        |        |
| Janitorial Services     | $0.84  |        |        |        |
| Utilities               | 1.06   |        |        |        |
| Other - Admin., etc.    | 1.79   |        |        |        |
| Property Taxes          | 1.81   |        |        |        |
| Subtotal                | $5.50  |        |        |        |

### Debt Service Requirements

<table>
<thead>
<tr>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Principal Repayment And Interest</td>
<td>153.6</td>
<td>153.6</td>
<td>153.6</td>
</tr>
<tr>
<td>Total Operating Costs</td>
<td>273.7</td>
<td>286.1</td>
<td>295.7</td>
</tr>
</tbody>
</table>
### Debt Service Requirements

#### Year 4

<table>
<thead>
<tr>
<th>Cost Per Net Square Foot</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.65</td>
</tr>
</tbody>
</table>

#### Principal Repayment And Interest

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost Per Net Square Foot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4</td>
<td>5.65</td>
</tr>
</tbody>
</table>

#### Total Operating Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Cost Per Net Square Foot</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 4</td>
<td>11.15</td>
</tr>
</tbody>
</table>

### Pro-Forma Projection Of Revenues And Expenses. (Example)

<table>
<thead>
<tr>
<th>Operating Revenues</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>166.8</td>
<td>220.8</td>
<td>252.9</td>
<td>278.2</td>
</tr>
<tr>
<td>Commercial</td>
<td>24.5</td>
<td>24.5</td>
<td>24.5</td>
<td>24.5</td>
</tr>
<tr>
<td><strong>Total Revenues</strong></td>
<td>191.3</td>
<td>245.3</td>
<td>277.4</td>
<td>302.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Costs</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>From Previous Page</td>
<td>273.7</td>
<td>285.1</td>
<td>295.7</td>
<td>302.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Operating Revenues Less Operating Costs</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>(82.4)</td>
<td>(40.8)</td>
<td>(18.3)</td>
<td>--</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cumulative Cash Flow</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>(82.4)</td>
<td>(123.2)</td>
<td>(141.5)</td>
<td>(141.5)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Developed And Owned</td>
<td>Hospital Developed, Physician Owned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>-----------------------------</td>
<td>-------------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rent Per Square Foot Per Year</td>
<td>$11.15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tax Savings From Deductions</td>
<td>5.58</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Annual After-Tax Cost</td>
<td>$ 5.57</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Initial Investment Cost - for 1,000 sq. ft.
   
   - Equity Contribution: $15,610
   - Tax Savings From Constr. Period Interest, Other: $(2,630)
   
   Effective Investment Cost: $12,980

2. Annual Cost - Per Square Foot
   
   - Rental Payment To Owner: $11.15
   - Tax Savings From Deductible Portion Of Operating Expenses: $(5.10)
   - Tax Savings From Depreciation: $(1.87)

   Net Annual After-Tax Costs: $ 4.18
Determination of the Financial Benefit to the Hospital from a Hospital Based Medical Office Building

A hospital-based building will mean:

1) Incremental admissions
2) Incremental usage of ancillary services
3) Potential revenues for hospital-operated or franchised services in MGB

Per physician projections of incremental revenues to the hospital range from $5,000 to $10,000 annually.¹

Evaluation of Financial Alternatives

Types of Financing Available:

1) Non-taxable hospital-owned office building.

2) Privately owned office building.
   a. Private placements.
   b. Public offerings (very limited potential)
   c. Sale-leaseback.

Advantages of Hospital Backing

1) Greater flexibility in method; terms.
2) Higher loan to equity ratio.

3) Lower interest rate.
Disadvantage: impairs hospital credit line.

Factors Considered by Lenders
1) Market survey and physician commitment.
2) Proposed rental rates compared to similar quality buildings in the area.
3) Project cost and loan to project value.
4) Ability of the project to service the debt.
6) Quality of management.

Factors to be Considered by the Owner/Developer
1) Gross amount of the loan.
2) Net effective interest cost.
3) Flexibility of loan terms and conditions.¹

<table>
<thead>
<tr>
<th>Loan Term</th>
<th>Conventional Mortgage 20 to 25 years</th>
<th>Taxable Bonds 15 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing Fees</td>
<td>1 - 2%</td>
<td>3½ - 4%</td>
</tr>
<tr>
<td>Interest Rate</td>
<td>9½ - 10½%</td>
<td>9½ - 10½%</td>
</tr>
<tr>
<td>Maximum Loan To Building Value</td>
<td>75%</td>
<td>50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tax-Exempt Bonds 20 to 30 years</th>
<th>FHA Insured Loan 25 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financing Fees</td>
<td>2½ - 3%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest Rate</td>
<td>7 - 7½%</td>
</tr>
<tr>
<td>Maximum Loan To Building Value</td>
<td>100%</td>
</tr>
</tbody>
</table>

**Note:** Interest rates and other terms will vary over time and by specific project depending upon money market conditions and other factors.
Establishment of the Physician-Hospital Relations

Building Development Phase

Independent of ownership, a physicians' advisory committee should be established to represent the medical staff in all matters relative to the building.

1) Review operational policies.
2) Make recommendations as regards the distribution of medical specialties in building.
3) Review lease conditions.
4) Review design parameters.
5) May ultimately serve as a tenant committee.¹

Operational Phase

Independent of ownership, principles of operation should be promulgated at an early stage that provide clear direction to all concerned.

1) Purpose of the building is improvement of patient care.
2) Space made available to all members of the medical staff on a first-come, first-serve basis.

3) Conditions of occupancy include continued membership on hospital medical staff, adherence to the ethical practice procedures acceptable to the medical staff, and the continued full-time practice of medicine in the building.

4) Hospital should have right to participate in tenant selection process, including initial selection and assignment of space to subtenants.

5) Hospital should have right to supervise quality of maintenance to the exterior and common areas of the building interior.

6) Hospital must not permit favoritism to tenants (admissions, surgery schedules, etc.)

7) Hospital should restrict certain ancillary services which might otherwise be provided by tenant practitioners.

8) Tenancy should not be contingent upon financial contribution, assessment, legal structure of tenant's practice, or personal financial guarantee.

9) If hospital is not building owner, must have right to cure default on the underlying mortgage.¹

Determining the Services Offered within a Medical Office Building

Shared by Physician Tenants

1) Reception and waiting areas.
2) Supply and storage space.
3) Business office, including centralized billing, cashier, bookkeeping, patient accounts.
4) Centralized medical records.
5) Examination and consultation rooms.
6) Centralized minor surgical suite.

Physician Amenities

1) Lounge.
2) Recreational facilities.
3) Dining area.

Commercial Services

1) Pharmacy.
2) Laboratory: satellite or drawing station.
3) Centralized radiology room.
4) Brace and limb shop.
5) Optical shop.
6) Medical supplies.
7) Flower Shop.
8) Coffee shop.

---

9) Bank.

10) Barber shop.¹

Services Provided by Hospital

1) Housekeeping and maintenance.

2) Purchasing and supplies.

3) Laundry and linen.

4) Secretarial help.

5) Management.

6) Centralized communications through hospital switchboard and pneumatic tube system.²

Other Services

1) Medical education: auditorium; conference rooms; residents offices; audiovisual equipment area; library.

2) Outpatient clinics: eye; stoma; general medicine; etc.

3) Other outpatient programs: physiological testing; executive physical program.

4) Hospital administrative space.³


² Ibid.

³ Ibid.
Construction of a Project Director's Development Schedule

1) Objectives formulated
2) Project Development Director appointed
3) Market research completed
4) Feasibility study completed
5) Need for facility established
6) Project memorandum drafted
7) Land selected
8) Land sale (or lease) negotiations begun
9) Architect retained
10) Engineer retained
11) Lawyer retained
12) Project financing applications begun
   - Construction
   - Permanent
13) Land survey completed
14) Local zoning cleared
15) Other local approvals obtained
16) County approvals received
17) State approvals received
18) Federal approvals received
19) Land purchased or leased
20) Cost analysis prepared
21) 10-year Pro Forma Economic Analysis for potential lessees/owners prepared
22) Site plan developed
23) Project sketches prepared
24) One-page promotion summary prepared
25) Legal documents drafted
   - Letter of Intent
   - Lease
   - Limited Partnership Agreement
   - Pre-organization subscription letter
26) Lessee information package prepared
27) Lessee information package delivered
28) Architectural renderings prepared
29) Letter of intent signed
30) List of proposed building materials prepared
31) Construction financing commitment received
32) Construction contract signed
33) Performance bonds and payment bonds received from general contractor
34) Leases signed
35) Permanent financing commitment received
36) Closing documents assembled
37) Accountant retained
38) Tenants closing documents signed
39) Permanent financing closing documents signed
40) Construction begun
41) Building management agreements completed
42) Construction completed
43) Building maintenance arrangements completed
44) Premises occupied by lessees
45) Rents received

Phase I

Developer meets with hospital administration to establish scope and direction of the project:

- Which sites are available?
- What parking is available?
- What is the hospital's master plan?
- What is the initial estimate of project size?
- Will the hospital lease space in the building?
- What controls will be placed on competing services?
- To what extent will the hospital support vacant space so that it may be made available to future tenants?
- What are the hospital's relationships with local lending institutions?
- What special development problems exist for this project?

Architect meets with hospital administration. He inspects the alternative sites and orders any surveys or other technical data which may be required. He also examines the architectural character of the hospital and neighboring buildings.

Mortgage broker makes initial contracts with lenders to determine which lenders are most likely to grant interim and long-term financing.\textsuperscript{1}

Developer meets with city officials to determine zoning status of each site. If rezoning is required, he determines all actions necessary and time required to achieve rezoning approval. \textbf{Any rezoning costs not covered.}\textsuperscript{2}

The architect prepares a complete site utilization analysis. Each available site is analyzed by the following criteria:

- Size of building which the site can accommodate
- Zoning status
- Procedure for rezoning, if required
- Accessibility to parking
- Accessibility to the hospital, especially outpatient services
- Accessibility for patients arriving by automobile or public transit
- Suitability for building construction
- Cost implications

Developer conducts a survey of all members of the medical staff to evaluate physician interest in the project.


\textsuperscript{2} Ibid.
The developer prepares a report analyzing the results of the Medical Office Building Questionnaire. The physician responses are categorized in four groups:

1) Highly interested and likely to participate in the building.
2) Undecided, but leaning toward participation.
3) Undecided, but will probably not participate.
4) Not interested.

The developer conducts a rental survey of the community. Information gathered in this survey is used to determine salable rental rates for the new building. This information will later be used as documentation for loan submissions.

Hospital preparation of a ground lease agreement and partnership agreement with attorneys.¹

**Phase II**

The developer prepares economic analyses of potential building sizes.

The developer and architect present a complete project report to the hospital. This report includes:

- Rental rate survey
- Medical staff survey
- Site utilization analysis
- Economic models of potential building sizes

Based upon the report from the developer and architect, the hospital determines the size of building to be developed and selects the site to be used. The developer and architect are directed to continue project development in accordance with these decisions.

The architect orders any additional survey data required for the site selected by the hospital.

The architect designs the building at the size decided upon by the hospital. *(Skematics only)*

After the building has been designed, a construction cost estimate is obtained. The design/build firm will provide a guaranteed construction cost.

Mortgage broker prepares a complete lenders' package. The developer and architect prepare package of materials to be used in soliciting physician tenants. The package includes:

- Architectural drawings of the building
- Exterior perspective
- Lease form to be executed by tenants
- Ground lease and partnership agreement
- Rental rate
- Analysis of cash investment required, tax benefits and return on investment
- The amount of money available for suite improvements and the quantity of doors, partitions, sinks, cabinets, carpeting, etc., which this sum will buy
The developer, architect, attorney and mortgage broker meet with the hospital to present full project package:

- Analysis of total risk to the hospital

The developer schedules the presentation of the project at a hospital medical staff meeting.

The mortgage broker presents lenders' packages to those lenders who have been identified as most likely to provide interim and long-term financing.

The developer, architect, attorney and leasing agent present project information at a medical staff meeting. Physicians are provided with individual packets containing exhibits which were approved by the hospital.¹

*Note: Retainer will be set up to read, "There is no obligation to progress any further with the project."

Evaluation of the Increase in Hospital Census
Evaluation of the Improvement in the Medical Staff Mix

The development and improvement of the Hospital's medical staff. A program to fully develop this building as a physicians office complex as a technique for attracting large medical groups to develop better utilization of inpatient and outpatient services. This

should assure continued improvement and development of the size and scope of the hospital multi-disciplinary medical staff.  

Encouraging the Formulation of Physician Marketing Strategies

In the areas of multi-specialty internal medicine groups, and family practitioner groups, the physician marketing program and physician staff relations should be enhanced by the building project.  

Evaluating the Convenience for the Medical Staff

To provide necessary convenience (located close to the hospital) to the medical staff, should produce higher utilization of the hospital. The need based on a highly competitive physician market should not be discounted. 

---


2 Ibid.

3 Ibid.
### TABLE 5

Number of Outpatient Visits at U.S. Hospitals (in thousands).

<table>
<thead>
<tr>
<th>Year</th>
<th>Visits (in thousands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>'62</td>
<td>30,382</td>
</tr>
<tr>
<td>'63</td>
<td>23,793</td>
</tr>
<tr>
<td>'70</td>
<td>51,370</td>
</tr>
<tr>
<td>'71</td>
<td>99,725</td>
</tr>
<tr>
<td>'72</td>
<td>199,183</td>
</tr>
<tr>
<td>'73</td>
<td>335,555</td>
</tr>
<tr>
<td>'74</td>
<td>50,481</td>
</tr>
<tr>
<td>'75</td>
<td>254,844</td>
</tr>
</tbody>
</table>

Source: American Hospital Association.

---

Outpatient Revenues Generated By Physicians

<table>
<thead>
<tr>
<th>Medical Specialty</th>
<th>Annual Laboratory Revenue</th>
<th>Annual X-ray Revenue</th>
<th>Annual Pharmacy Revenue</th>
<th>Total Annual Revenue</th>
</tr>
</thead>
<tbody>
<tr>
<td>General and Family Practice</td>
<td>$4,690</td>
<td>$7,436</td>
<td>$29,920</td>
<td>$42,046</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>5,550</td>
<td>12,662</td>
<td>17,255</td>
<td>35,467</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>4,350</td>
<td>3,484</td>
<td>19,035</td>
<td>26,869</td>
</tr>
<tr>
<td>General Surgery</td>
<td>1,625</td>
<td>5,070</td>
<td>7,010</td>
<td>13,705</td>
</tr>
<tr>
<td>OB/GYN</td>
<td>7,210</td>
<td>1,534</td>
<td>13,580</td>
<td>22,324</td>
</tr>
<tr>
<td>Other Surgical Specialties</td>
<td>2,120</td>
<td>14,170</td>
<td>13,985</td>
<td>30,275</td>
</tr>
<tr>
<td>Average all doctors</td>
<td>$4,460</td>
<td>$8,398</td>
<td>$21,220</td>
<td>$34,078</td>
</tr>
</tbody>
</table>

Source: National Center for Health Statistics.

---

Number of Hours Spent in Hospitals by Physicians

<table>
<thead>
<tr>
<th>Physician Age</th>
<th>Gen Prac</th>
<th>Int Med</th>
<th>Surg</th>
<th>Ped</th>
<th>Ob Gyn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 50 yrs.</td>
<td>11.2</td>
<td>18.9</td>
<td>30.6</td>
<td>7.3</td>
<td>21.3</td>
</tr>
<tr>
<td>50 yrs. &amp; over</td>
<td>9.9</td>
<td>13.4</td>
<td>24.8</td>
<td>7.0</td>
<td>17.5</td>
</tr>
</tbody>
</table>

Percentage of Total Hours Spent in Hospitals by Physicians

<table>
<thead>
<tr>
<th>Physician Age</th>
<th>Gen Prac</th>
<th>Int Med</th>
<th>Surg</th>
<th>Ped</th>
<th>Ob Gyn</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 50 yrs.</td>
<td>22</td>
<td>37</td>
<td>59</td>
<td>16</td>
<td>42</td>
</tr>
<tr>
<td>50 yrs. &amp; over</td>
<td>20</td>
<td>27</td>
<td>51</td>
<td>14</td>
<td>35</td>
</tr>
</tbody>
</table>

Source: American Medical Association.
TABLE 6

SURVEY OF HOSPITAL/PROFESSIONAL OFFICE BUILDINGS

May 13, 1974

(Use the last complete fiscal year's figures for requested data)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Averages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>a. Number of physicians on staff admitting majority of practice to hospital</td>
<td>144</td>
</tr>
<tr>
<td></td>
<td>b. Number of physicians officeing on hospital campus</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>c. Total square feet of space rented to staff physicians for office</td>
<td>50,500</td>
</tr>
<tr>
<td></td>
<td>d. Average annual per square foot cost to physicians</td>
<td>7.10</td>
</tr>
<tr>
<td>2.</td>
<td>a. Annual costs per square foot for utilities</td>
<td>7.71</td>
</tr>
<tr>
<td></td>
<td>b. Annual costs per square foot for housekeeping</td>
<td>1.23</td>
</tr>
<tr>
<td></td>
<td>c. Annual costs per square foot for maintenance</td>
<td>0.92</td>
</tr>
<tr>
<td></td>
<td>d. Annual costs per square foot for real estate taxes</td>
<td>0.99</td>
</tr>
<tr>
<td></td>
<td>e. Estimated hours per week administrative staff spends in managing</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Professional Office Building</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Annual number of patients in hospital</td>
<td>18,935</td>
</tr>
<tr>
<td></td>
<td>a. of tenant physicians</td>
<td>7,645</td>
</tr>
<tr>
<td></td>
<td>b. of non-tenant physicians</td>
<td>9,570</td>
</tr>
<tr>
<td>4.</td>
<td>Average per patient day stay in hospital:</td>
<td>6.95</td>
</tr>
<tr>
<td></td>
<td>a. of tenant physicians</td>
<td>7.94</td>
</tr>
<tr>
<td></td>
<td>b. of non-tenant physicians</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Compared to other staff physicians do doctors officeing adjacent to hospital:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>a. Spend more time in hospital?</td>
<td>yes 100%</td>
</tr>
<tr>
<td></td>
<td>b. Make rounds more frequently?</td>
<td>100%</td>
</tr>
<tr>
<td></td>
<td>c. Complete charts more promptly?</td>
<td>70%</td>
</tr>
<tr>
<td></td>
<td>d. More cooperative with hospital administration?</td>
<td>75%</td>
</tr>
<tr>
<td></td>
<td>e. Receive more consultations and referrals?</td>
<td>75%</td>
</tr>
<tr>
<td>6.</td>
<td>Estimated annual average-per-tenant net income from outpatient pharmacy, lab, X-ray, and other hospital ancillary services by on-campus tenant physicians:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$1,000.00 per year per tenant</td>
<td>11.1%</td>
</tr>
<tr>
<td></td>
<td>2,000.00 per year per tenant</td>
<td>11.1%</td>
</tr>
<tr>
<td></td>
<td>3,000.00 per year per tenant</td>
<td>11.1%</td>
</tr>
<tr>
<td></td>
<td>Average - $4,556</td>
<td></td>
</tr>
<tr>
<td></td>
<td>4,000.00 per year per tenant</td>
<td>11.2%</td>
</tr>
<tr>
<td></td>
<td>or 56.6% average $5,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5,000.00 per year per tenant</td>
<td>33.3%</td>
</tr>
<tr>
<td></td>
<td>or more per tenant</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6,000.00 per year per tenant or more</td>
<td>33.3%</td>
</tr>
</tbody>
</table>
Source: City of Los Angeles Planning Department (all L.A. City Areas)
Coopers and Lybrand (other areas)
PERCENT INCREASE IN POPULATION
1975 - 1985

NEWIALL
27.9%

SIHI
26.7%

CHATSWORTH
15.0%

GRANADA
5.7%

SYLMAR
4.8%

NORTHRIDGE
7.7%

SEP.
4.5%

PACOIMA
3.7%

T. OAK
59.9%

RESEDA
7.6%

M. H.

CANOGA/WOODLAND HILLS
7.1%

VAN HUYS
7.5%

EUCALYPTUS/TARZANA
11.8%

N. HOLLYWOOD
4.8%

SHERMAN OAKS
5.7%
### Table 1—Clinical office space, 1973

<table>
<thead>
<tr>
<th>Hospital bed size</th>
<th>Total (N=2,418)</th>
<th>Teaching (N=677)</th>
<th>Nonteaching (N=1,741)</th>
<th>Percentage change on number of hospitals leasing space, 1972-77*</th>
</tr>
</thead>
<tbody>
<tr>
<td>6-99 beds</td>
<td>421</td>
<td>21</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>526</td>
<td>37</td>
<td>16</td>
<td>27</td>
</tr>
<tr>
<td>200-399 beds</td>
<td>416</td>
<td>60</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>400 or more beds</td>
<td>227</td>
<td>45</td>
<td>23</td>
<td>13</td>
</tr>
<tr>
<td>All hospitals reporting</td>
<td>1,449</td>
<td>94</td>
<td>63</td>
<td>28</td>
</tr>
</tbody>
</table>

*Nonfederal, short-term, general

Source: Survey of Medical Staff Organizations, 1973

### Table 2—Hospitals leasing office space for medical staff, 1975 and 1977

<table>
<thead>
<tr>
<th>Selected hospital categories</th>
<th>1977</th>
<th>Percentage change on number of hospitals leasing space, 1972-77*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total respondents</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>4,346</td>
<td>13</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>2,219</td>
<td>7</td>
</tr>
<tr>
<td>200-399 beds</td>
<td>968</td>
<td>21</td>
</tr>
<tr>
<td>400-499 beds</td>
<td>222</td>
<td>14</td>
</tr>
<tr>
<td>500 or more beds</td>
<td>970</td>
<td>-13</td>
</tr>
<tr>
<td>Teaching</td>
<td>712</td>
<td>-9</td>
</tr>
<tr>
<td>6-199 beds</td>
<td>107</td>
<td>0</td>
</tr>
<tr>
<td>200-399 beds</td>
<td>274</td>
<td>-8</td>
</tr>
<tr>
<td>400-499 beds</td>
<td>153</td>
<td>-5</td>
</tr>
<tr>
<td>500 or more beds</td>
<td>228</td>
<td>-18</td>
</tr>
<tr>
<td>Nonteaching</td>
<td>4,074</td>
<td>21</td>
</tr>
<tr>
<td>6-99 beds</td>
<td>2,181</td>
<td>7</td>
</tr>
<tr>
<td>100-199 beds</td>
<td>1,088</td>
<td>7</td>
</tr>
<tr>
<td>200-399 beds</td>
<td>964</td>
<td>42</td>
</tr>
<tr>
<td>400 or more beds</td>
<td>101</td>
<td>61</td>
</tr>
<tr>
<td>Nonmetropolitan</td>
<td>2,418</td>
<td>19</td>
</tr>
</tbody>
</table>

*Nonfederal, short-term, general

REFERENCES

The following bibliography of selected references was partially compiled from the Library of the American Hospital Association. The following citations refer to journal articles or monographs that were available in most Health Science and/or academic libraries. To expedite service, material was requested from local and regional sources, rather than directly from the library of the American Hospital Association.


Section 437.10 Projects Requiring Certificate of Need. Title 22 Health Planning and Facility Construction, pp. 2471, 2472.1, 2472.2.

Citation,"Hospital's Small Medical Office Building: Baja, California, Progressive Architecture, 58:58, January, 1977.


REFERENCES (Continued)

Kessler, M.S., "Hospital Office Leasing is on the Rise," Hospitals, July 1, 1979.

Naidus, R.S., "Your Office - Make It an Investment," Medical Economics, April 29, 1974, p. 69.


Seminars - Sponsored by the American Hospital Association, Subject: Institute on the Hospital-Based Medical Office Building.

Personal Interviews: Jud Perkins Development Company, Stayner Development Company. These organizations specialize in the planning, organizing, and financing of medical office buildings.
APPENDICES
APPENDIX A

The following is a sample Pro Forma and Financial Analysis for a M.O.B. Project:

A. Assumptions and Calculations
B. Old and Revised Budget
C. Depreciation - Building
D. Depreciation - Equipment
E. Liability on Premise
F. Insurance
G. Taxes
H. Operating Expenses
I. Interest Computation
J. Cash Flow Analysis - Years 1 - 10
K. Rental Revenue from the M.O.B.
L. Summary A which contains Pro Forma for a medical office building containing 79,000 gross square feet at a projected cost of $5,977,100.
M. Summary B which contains the anticipated effect upon hospital patient days and profit for years 1 - 4.
MEDICAL CENTER

ASSUMPTIONS AND CALCULATIONS FOR THE M.O.B. PROJECT

Average suite contains 1,640 sq. ft. (based on physician survey)

* Average physician admits 58 patients annually.

** Length of stay is 6.0 days.

Number of physicians per suite ratio is 1.35 (1214.8 sq.ft./
each physician).

Revenue per patient day is $600.

Number of suites available:

61,930 net rentable
1640 sq.ft. = 38 suites

Expected number of physicians:

38 suites x 1.35 physician/suite = 51.3 physicians

Expected number of admissions:

51.3 physicians x 58 admissions/physician = 2,975 admissions.

Total patient days:

2,975 admissions x 6.0 L.O.S. = 17,850 patient days anticipated.

Anticipated additional revenue: (@ 100% occupancy)

17,850 patient days x $600/day = $10,710,000
10% increase for year 2-10 on $600/day

*Average physician admits = 5,680 Y.T.D. patient days ÷
10 months = 568 x 12 months = 6816 ÷ 118 active staff =
58 patients annually.

** The oncology patient days were excluded to avoid an
over statement of average length of stay.
**NEW BUDGET**

California
MEDICAL CENTER
Medical Office Building
Project No. 30504-272

Total Project Budget Summary
July 5, 1979

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td></td>
</tr>
<tr>
<td>Off-site Work</td>
<td>11,700</td>
</tr>
<tr>
<td>Demolition</td>
<td>65,700</td>
</tr>
<tr>
<td>Construction</td>
<td>3,398,700</td>
</tr>
<tr>
<td>Landscaping</td>
<td>30,000</td>
</tr>
<tr>
<td>Contingency</td>
<td>175,300</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>3,581,400</td>
</tr>
<tr>
<td>Tenant Improvement Allowance -</td>
<td>1,145,705</td>
</tr>
<tr>
<td>61,930 SF @ 18.50</td>
<td></td>
</tr>
<tr>
<td>Tenant Design Cost</td>
<td>92,895</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>1,238,600</td>
</tr>
<tr>
<td>Equipment Cost</td>
<td>36,700</td>
</tr>
<tr>
<td>Group IV</td>
<td></td>
</tr>
<tr>
<td>Professional Fees</td>
<td></td>
</tr>
<tr>
<td>Arch./Eng. Fee</td>
<td>184,000</td>
</tr>
<tr>
<td>Changes &amp; Reimbursables</td>
<td>21,000</td>
</tr>
<tr>
<td>Other Professional Fees</td>
<td>33,500</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>238,500</td>
</tr>
<tr>
<td>Land Acquisition Cost (Excluded)</td>
<td></td>
</tr>
<tr>
<td>(Estimated @ 891,200 SF @ 6.00)</td>
<td>891,200</td>
</tr>
<tr>
<td>Interim Costs</td>
<td></td>
</tr>
<tr>
<td>Property Taxes &amp; Insurance</td>
<td>85,700</td>
</tr>
<tr>
<td>Interim Interests - Bldg.</td>
<td>364,000</td>
</tr>
<tr>
<td>Interim Interests - Ten.Imp.</td>
<td>61,500</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>511,200</td>
</tr>
<tr>
<td>Misc. Development Costs</td>
<td></td>
</tr>
<tr>
<td>Legal Fees</td>
<td>22,000</td>
</tr>
<tr>
<td>Overhead Allocation - Bldg.</td>
<td>160,000</td>
</tr>
<tr>
<td>Overhead Allocation - Ten.Imp.</td>
<td>60,700</td>
</tr>
<tr>
<td>Direct Costs</td>
<td>28,000</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>270,700</td>
</tr>
<tr>
<td><strong>TOTAL BUDGET</strong></td>
<td>5,977,100</td>
</tr>
</tbody>
</table>

Anticipated Construction Start: 1/80
Construction Duration: Building - 12 months; Tenant Improvements - 24 months
Project Area: New Construction - 79,000 SF*
Net Rentable - 61,930 SF

*Includes approximately 6,000 SF in basement for mechanical and hospital storage
<table>
<thead>
<tr>
<th>Category</th>
<th>OLD BUDGET</th>
<th>NEW BUDGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Construction</td>
<td>3,681,400</td>
<td></td>
</tr>
<tr>
<td>Tenant Improvement Allowance -</td>
<td></td>
<td></td>
</tr>
<tr>
<td>61,930 SF @ 26.50</td>
<td>1,641,200</td>
<td></td>
</tr>
<tr>
<td>Tenant Design Cost -</td>
<td>92,900</td>
<td></td>
</tr>
<tr>
<td>61,930 SF @ 1.50</td>
<td>92,900</td>
<td></td>
</tr>
<tr>
<td>Equipment Cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group IV</td>
<td>36,700</td>
<td></td>
</tr>
<tr>
<td>Professional Fees</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arch./Eng. Fee</td>
<td>184,000</td>
<td></td>
</tr>
<tr>
<td>Changes &amp; Reimbursables</td>
<td>21,000</td>
<td></td>
</tr>
<tr>
<td>Other Professional Fees</td>
<td>33,500</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>238,500</td>
<td></td>
</tr>
<tr>
<td>Land Acquisition Cost -</td>
<td>891,200</td>
<td></td>
</tr>
<tr>
<td>(Estimated @ 891,200 SF @ 6.00)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interim Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property Taxes &amp; Insurance</td>
<td>85,700</td>
<td></td>
</tr>
<tr>
<td>Interim Interests - Bldg.</td>
<td>364,000</td>
<td></td>
</tr>
<tr>
<td>Interim Interests - Ten. Imp.</td>
<td>61,500</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>511,200</td>
<td></td>
</tr>
<tr>
<td>Misc. Development Costs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal Fees</td>
<td>22,000</td>
<td></td>
</tr>
<tr>
<td>Overhead Allocation - Bldg.</td>
<td>160,000</td>
<td></td>
</tr>
<tr>
<td>Overhead Allocation - Ten. Imp.</td>
<td>60,700</td>
<td></td>
</tr>
<tr>
<td>Direct Costs</td>
<td>28,000</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td>270,700</td>
<td></td>
</tr>
<tr>
<td>TOTAL BUDGET</td>
<td>7,363,800</td>
<td></td>
</tr>
</tbody>
</table>

Anticipated Construction Start: 1/80
Construction Duration: Building - 12 months; Tenant Improvements - 24 months
Project Area: New Construction - 79,000 SF*
Net Rentable - 61,930 SF

*Includes approximately 6,000 SF in basement for mechanical and hospital storage
Schedule A

MEDICAL CENTER

PROFESSIONAL BUILDING

DEPRECIATION-BUILDING

Total depreciable cost of building = $5,940,400
(Assume 150% declining balance depreciation over 45 years)

A. $5,940,400
   ____________
   45         = $132,009

B. $132,009
   ____________
   $5,940,400     = .0222

C. .0222 x 1.5  = .0333


Year 1  .0333 x $5,940,400 = $197,815
  2  .0333 x $5,742,585 = $191,228
  3  .0333 x $5,551,357 = $184,860
  4  .0333 x $5,366,497 = $178,704
  5  .0333 x $5,187,793 = $172,754
  6  .0333 x $5,015,039 = $167,001
  7  .0333 x $4,848,038 = $161,440
  8  .0333 x $4,686,598 = $156,064
  9  .0333 x $4,530,534 = $150,867
 10  .0333 x $4,379,667 = $145,843
MEDICAL CENTER
PROFESSIONAL BUILDING

DEPRECIATION-EQUIPMENT

Total cost = $36,700
(Assume 10 year life)

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
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<td>2</td>
<td>$3,670</td>
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<tr>
<td>3</td>
<td>$3,670</td>
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<tr>
<td>4</td>
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<td>$3,670</td>
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<tr>
<td>9</td>
<td>$3,670</td>
</tr>
<tr>
<td>10</td>
<td>$3,670</td>
</tr>
</tbody>
</table>
Schedule B

MEDICAL CENTER

PROFESSIONAL BUILDING

LIABILITY ON PREMISE

Assume $3.00/100 square feet.
Assume total square feet to equal 79,000 gross square feet.
Assume year-to-date increase of 10%.

<table>
<thead>
<tr>
<th>Year</th>
<th>Liability</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$2,370</td>
</tr>
<tr>
<td>2</td>
<td>$2,607</td>
</tr>
<tr>
<td>3</td>
<td>$2,868</td>
</tr>
<tr>
<td>4</td>
<td>$3,155</td>
</tr>
<tr>
<td>5</td>
<td>$3,471</td>
</tr>
<tr>
<td>6</td>
<td>$3,818</td>
</tr>
<tr>
<td>7</td>
<td>$4,200</td>
</tr>
<tr>
<td>8</td>
<td>$4,620</td>
</tr>
<tr>
<td>9</td>
<td>$5,082</td>
</tr>
<tr>
<td>10</td>
<td>$5,590</td>
</tr>
</tbody>
</table>

TOTAL $37,781
MEDICAL CENTER
PROFESSIONAL BUILDING

INSURANCE (PER BILL FraLEY)

Fire-assume .10/$100 value (assume 10% per year property inflation).

Property value (construction price + equipment) = $5,977,100

<table>
<thead>
<tr>
<th>Year</th>
<th>Value</th>
<th>Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$5,977,100</td>
<td>$5,977</td>
</tr>
<tr>
<td>2</td>
<td>$6,574,810</td>
<td>$6,575</td>
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<tr>
<td>3</td>
<td>$7,232,291</td>
<td>$7,232</td>
</tr>
<tr>
<td>4</td>
<td>$7,955,520</td>
<td>$7,956</td>
</tr>
<tr>
<td>5</td>
<td>$8,751,072</td>
<td>$8,751</td>
</tr>
<tr>
<td>6</td>
<td>$9,626,179</td>
<td>$9,626</td>
</tr>
<tr>
<td>7</td>
<td>$10,588,796</td>
<td>$10,589</td>
</tr>
<tr>
<td>8</td>
<td>$11,647,675</td>
<td>$11,648</td>
</tr>
<tr>
<td>9</td>
<td>$12,812,442</td>
<td>$12,812</td>
</tr>
<tr>
<td>10</td>
<td>$14,093,686</td>
<td>$14,094</td>
</tr>
</tbody>
</table>

**TOTAL** $95,260
<table>
<thead>
<tr>
<th>Year</th>
<th>Taxes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$24,484</td>
</tr>
<tr>
<td>2</td>
<td>$69,920</td>
</tr>
<tr>
<td>3</td>
<td>$85,616</td>
</tr>
<tr>
<td>4</td>
<td>$87,328</td>
</tr>
<tr>
<td>5</td>
<td>$89,075</td>
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<tr>
<td>6</td>
<td>$90,857</td>
</tr>
<tr>
<td>7</td>
<td>$92,674</td>
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<td>8</td>
<td>$94,527</td>
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<tr>
<td>9</td>
<td>$96,418</td>
</tr>
<tr>
<td>10</td>
<td>$98,346</td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong> $829,245</td>
</tr>
</tbody>
</table>
Schedule D

MEDICAL CENTER
PROFESSIONAL BUILDING

OPERATING EXPENSES (PER DAVE MEDLEY)

Assume $2.75/rentable square foot (Humana professional building average). This includes housekeeping, maintenance, utilities, and other operating expenses.

Assume a yearly increase of 8%.

Assume rentable square feet equals 61,930.

<table>
<thead>
<tr>
<th>Year</th>
<th>Operating Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$170,308</td>
</tr>
<tr>
<td>2</td>
<td>$183,933</td>
</tr>
<tr>
<td>3</td>
<td>$198,648</td>
</tr>
<tr>
<td>4</td>
<td>$214,540</td>
</tr>
<tr>
<td>5</td>
<td>$231,703</td>
</tr>
<tr>
<td>6</td>
<td>$250,239</td>
</tr>
<tr>
<td>7</td>
<td>$270,258</td>
</tr>
<tr>
<td>8</td>
<td>$291,879</td>
</tr>
<tr>
<td>9</td>
<td>$315,229</td>
</tr>
<tr>
<td>10</td>
<td>$340,447</td>
</tr>
</tbody>
</table>
MEDICAL CENTER

PROFESSIONAL BUILDING

INTEREST COMPUTATION

Assume amount of loan is $5,977,100

Assume Humana will acquire 20% equity in the project

Assume 80% Financing

Assume life of loan will be for 20 years at an interest rate of 11% to be repaid in quarterly payments

Assume that the quarterly payments will be $148,471.64

<table>
<thead>
<tr>
<th>Year</th>
<th>Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$523,132</td>
</tr>
<tr>
<td>2</td>
<td>$515,021</td>
</tr>
<tr>
<td>3</td>
<td>$505,983</td>
</tr>
<tr>
<td>4</td>
<td>$495,906</td>
</tr>
<tr>
<td>5</td>
<td>$484,676</td>
</tr>
<tr>
<td>6</td>
<td>$472,157</td>
</tr>
<tr>
<td>7</td>
<td>$458,206</td>
</tr>
<tr>
<td>8</td>
<td>$442,652</td>
</tr>
<tr>
<td>9</td>
<td>$425,316</td>
</tr>
<tr>
<td>10</td>
<td>$404,687</td>
</tr>
</tbody>
</table>
## Medical Center Professional Building

### Cash Flow

<table>
<thead>
<tr>
<th>Year</th>
<th>Cash Outflow</th>
<th>Principle Repayment</th>
<th>Interest Payment</th>
<th>Total Cash Outflow</th>
<th>Total Cash Inflow</th>
<th>Yearly Cash Loss</th>
<th>Accumulated Cash Flow</th>
<th>Interest Expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 203,139</td>
<td>$ 70,756</td>
<td>$ 523,132</td>
<td>$ 797,027</td>
<td>$ 390,159</td>
<td>$(406,868)</td>
<td>$(406,868)</td>
<td>$ 44,755</td>
</tr>
<tr>
<td>2</td>
<td>263,035</td>
<td>78,867</td>
<td>515,021</td>
<td>856,923</td>
<td>546,226</td>
<td>(310,697)</td>
<td>(717,565)</td>
<td>78,932</td>
</tr>
<tr>
<td>3</td>
<td>294,364</td>
<td>87,904</td>
<td>505,983</td>
<td>888,281</td>
<td>702,286</td>
<td>(185,965)</td>
<td>(903,530)</td>
<td>99,388</td>
</tr>
<tr>
<td>4</td>
<td>312,979</td>
<td>97,982</td>
<td>495,906</td>
<td>906,867</td>
<td>780,318</td>
<td>(126,549)</td>
<td>(1,030,079)</td>
<td>113,309</td>
</tr>
<tr>
<td>5</td>
<td>332,999</td>
<td>109,212</td>
<td>484,676</td>
<td>926,887</td>
<td>780,318</td>
<td>(146,569)</td>
<td>(1,176,648)</td>
<td>129,431</td>
</tr>
<tr>
<td>6</td>
<td>354,539</td>
<td>121,731</td>
<td>472,157</td>
<td>948,427</td>
<td>936,382</td>
<td>(12,045)</td>
<td>(1,188,693)</td>
<td>130,756</td>
</tr>
<tr>
<td>7</td>
<td>377,720</td>
<td>135,682</td>
<td>450,206</td>
<td>971,608</td>
<td>936,382</td>
<td>(35,226)</td>
<td>(1,223,919)</td>
<td>134,631</td>
</tr>
<tr>
<td>8</td>
<td>402,672</td>
<td>151,236</td>
<td>442,652</td>
<td>996,560</td>
<td>936,382</td>
<td>(60,178)</td>
<td>(1,284,097)</td>
<td>141,251</td>
</tr>
<tr>
<td>9</td>
<td>429,539</td>
<td>168,572</td>
<td>425,316</td>
<td>1,023,427</td>
<td>936,382</td>
<td>(87,045)</td>
<td>(1,371,142)</td>
<td>150,826</td>
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<tr>
<td>10</td>
<td>458,475</td>
<td>189,201</td>
<td>404,687</td>
<td>1,052,363</td>
<td>936,382</td>
<td>(115,981)</td>
<td>(1,487,123)</td>
<td>163,584</td>
</tr>
</tbody>
</table>

**Total** $3,429,461 $1,211,143 $4,727,736 $9,368,340 $7,881,217 $(1,487,123) $(10,789,664) $1,186,863
Schedule G

MEDICAL CENTER

PROFESSIONAL BUILDING

RENTAL REVENUE

Assume a rental rate of $12.60/square foot for years 1-5.
Assume a rental rate of $15.12/square foot for years 6-10.
Assume rental rate includes utilities and tenant improvement.
Assume total rentable square feet equals 61,930 and contains approximately 51 physicians.

<table>
<thead>
<tr>
<th>Year</th>
<th>Rent Revenue</th>
<th>Percent of Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$390,159*</td>
<td>50%</td>
</tr>
<tr>
<td>2</td>
<td>$546,226</td>
<td>70%</td>
</tr>
<tr>
<td>3</td>
<td>$702,286</td>
<td>90%</td>
</tr>
<tr>
<td>4</td>
<td>$780,318</td>
<td>100%</td>
</tr>
<tr>
<td>5</td>
<td>$780,318</td>
<td>100%</td>
</tr>
<tr>
<td>6</td>
<td>$936,382</td>
<td>100%</td>
</tr>
<tr>
<td>7</td>
<td>$936,382</td>
<td>100%</td>
</tr>
<tr>
<td>8</td>
<td>$936,382</td>
<td>100%</td>
</tr>
<tr>
<td>9</td>
<td>$936,382</td>
<td>100%</td>
</tr>
<tr>
<td>10</td>
<td>$936,382</td>
<td>100%</td>
</tr>
</tbody>
</table>

* Construction completed, tenant improvements 50% completed, based on anticipated construction duration of building 12 months, tenant improvements 24 months.

** Rental rate was based on the surrounding competitive market place in close proximity to the medical center.
## MEDICAL CENTER
### PROFESSIONAL BUILDING
#### TEN YEAR PRO FORMA
(Assume no Pharmacy)

<table>
<thead>
<tr>
<th>Year</th>
<th>Schedule G Rental Revenue</th>
<th>Schedule B Insurance</th>
<th>Schedule C Taxes</th>
<th>Schedule D Operating Expenses</th>
<th>Schedule E Interest On Loan</th>
<th>Schedule A Depreciation Bldg.-Equip.</th>
<th>Schedule F Inter-Co Interest</th>
<th>Total Expenses</th>
<th>Gain (Loss)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>390,159</td>
<td>8,347</td>
<td>24,484</td>
<td>170,308</td>
<td>523,132</td>
<td>201,485</td>
<td>44,755</td>
<td>972,511</td>
<td>582,352</td>
</tr>
<tr>
<td>2</td>
<td>546,226</td>
<td>9,182</td>
<td>69,920</td>
<td>183,933</td>
<td>515,021</td>
<td>194,898</td>
<td>78,932</td>
<td>1,051,886</td>
<td>505,660</td>
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<tr>
<td>3</td>
<td>702,286</td>
<td>10,100</td>
<td>85,616</td>
<td>198,648</td>
<td>505,983</td>
<td>188,530</td>
<td>99,388</td>
<td>1,088,265</td>
<td>385,979</td>
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<tr>
<td>4</td>
<td>780,318</td>
<td>11,111</td>
<td>87,328</td>
<td>214,540</td>
<td>495,906</td>
<td>182,374</td>
<td>113,309</td>
<td>1,104,568</td>
<td>24,250</td>
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<td>89,075</td>
<td>231,703</td>
<td>484,676</td>
<td>176,424</td>
<td>129,431</td>
<td>1,123,530</td>
<td>343,212</td>
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<td>13,443</td>
<td>90,857</td>
<td>250,239</td>
<td>472,157</td>
<td>170,671</td>
<td>130,756</td>
<td>1,128,123</td>
<td>91,741</td>
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<tr>
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<td>14,788</td>
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<td>270,258</td>
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<td>165,110</td>
<td>134,631</td>
<td>1,135,667</td>
<td>99,286</td>
</tr>
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<td>16,266</td>
<td>94,527</td>
<td>291,879</td>
<td>442,652</td>
<td>159,734</td>
<td>141,251</td>
<td>1,146,309</td>
<td>209,927</td>
</tr>
<tr>
<td>9</td>
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<td>17,892</td>
<td>96,418</td>
<td>315,229</td>
<td>425,316</td>
<td>154,537</td>
<td>150,826</td>
<td>1,160,218</td>
<td>223,836</td>
</tr>
<tr>
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<td>19,682</td>
<td>98,346</td>
<td>340,447</td>
<td>404,687</td>
<td>149,513</td>
<td>163,584</td>
<td>1,176,259</td>
<td>239,877</td>
</tr>
<tr>
<td>Total</td>
<td>7,881,217</td>
<td>133,032</td>
<td>829,245</td>
<td>2,467,184</td>
<td>4,727,736</td>
<td>743,276</td>
<td>1,186,863</td>
<td>11,087,336</td>
<td>3,206,119</td>
</tr>
</tbody>
</table>
MEDICAL CENTER

PROFESSIONAL BUILDING

CHANGES TO HOSPITAL INCOME STATEMENT PER INCREASES IN PATIENT DAYS GENERATED FROM THE PROFESSIONAL BUILDING

<table>
<thead>
<tr>
<th>Year</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Patient Revenue</td>
<td>5,355,000</td>
<td>8,246,700</td>
<td>11,663,190</td>
<td>14,262,150</td>
</tr>
<tr>
<td>2 Contractual Adjustments</td>
<td>803,250</td>
<td>1,237,005</td>
<td>1,749,479</td>
<td>2,139,323</td>
</tr>
<tr>
<td>3 Bad Debts (2.2%)</td>
<td>117,810</td>
<td>181,427</td>
<td>256,590</td>
<td>313,767</td>
</tr>
</tbody>
</table>

Other Income:

<table>
<thead>
<tr>
<th>Year</th>
<th>Patient Revenue</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net Revenue</td>
<td>4,433,940</td>
<td>6,828,268</td>
<td>9,657,121</td>
<td>11,809,060</td>
<td></td>
</tr>
</tbody>
</table>

Expenses:

<table>
<thead>
<tr>
<th>Year</th>
<th>Payroll</th>
<th>Benefits</th>
<th>Supplies</th>
<th>Total Operating Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>1,725,381</td>
<td>293,454</td>
<td>655,898</td>
<td>3,606,325</td>
</tr>
<tr>
<td>Year 2</td>
<td>2,620,826</td>
<td>445,697</td>
<td>1,028,464</td>
<td>5,539,659</td>
</tr>
<tr>
<td>Year 3</td>
<td>3,656,073</td>
<td>621,716</td>
<td>1,481,032</td>
<td>7,815,462</td>
</tr>
<tr>
<td>Year 4</td>
<td>4,407,522</td>
<td>749,522</td>
<td>1,843,013</td>
<td>9,532,793</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Year</th>
<th>Management Fee</th>
<th>Depreciation &amp; Amortization</th>
<th>Interest</th>
<th>Total Fixed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>267,750</td>
<td>-</td>
<td>-</td>
<td>267,750</td>
</tr>
<tr>
<td>Year 2</td>
<td>412,335</td>
<td>-</td>
<td>-</td>
<td>412,335</td>
</tr>
<tr>
<td>Year 3</td>
<td>583,160</td>
<td>-</td>
<td>-</td>
<td>583,160</td>
</tr>
<tr>
<td>Year 4</td>
<td>713,108</td>
<td>-</td>
<td>-</td>
<td>713,108</td>
</tr>
</tbody>
</table>

Profit:

<table>
<thead>
<tr>
<th>Year</th>
<th>Profit</th>
<th>M.O.B. Patient Days</th>
<th>Hospital Projected Patient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>559,865</td>
<td>8,925</td>
<td>42,340</td>
</tr>
<tr>
<td>Year 2</td>
<td>876,274</td>
<td>12,495</td>
<td>43,270</td>
</tr>
<tr>
<td>Year 3</td>
<td>1,258,499</td>
<td>16,065</td>
<td>43,600</td>
</tr>
<tr>
<td>Year 4</td>
<td>1,563,159</td>
<td>17,850</td>
<td>44,900</td>
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</tbody>
</table>

Occupancy - % Increase:

<table>
<thead>
<tr>
<th>Year</th>
<th>50% yr. 1, 70% yr. 2, 90% yr. 3, 100% yr. 4 of 17,850</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year 1</td>
<td>21.1%</td>
</tr>
<tr>
<td>Year 2</td>
<td>28.9%</td>
</tr>
<tr>
<td>Year 3</td>
<td>36.9%</td>
</tr>
<tr>
<td>Year 4</td>
<td>39.4%</td>
</tr>
</tbody>
</table>

1) 50% yr. 1, 70% yr. 2, 90% yr. 3, 100% yr. 4 of 17,850
2) Contractual 15% of gross revenue
3) Bad Debts 2.2% of gross revenue
4) Management Fee, 5% of gross revenue

* The occupancy percentages are predicated on the time schedule of 24 months for completion of all tenant improvements and careful selectivity of dedicated admitting physicians to the hospital.
HEALTH PLANNING

CHAPTER 854

ASSEMBLY BILL 4001 (KEENE)

An act to amend Sections 437, 437.1, 437.2, 437.3, 437.5, 437.7, 437.8, 1203, 1250, 1251, 1255, and 1265 of, to add Sections 437.6, 437.9, 437.10, 437.11, 437.12, 438.1, 438.2, 438.3, 438.4, 438.5, 438.6, 438.8, 438.9, 438.10, 438.11, 438.12, 438.13, 439, 439.5, and 1250.1 to, to add and repeal Section 437.13 of, and to repeal Sections 437.6, 437.9, 437.10, 437.11, 437.12, 438.1, 438.2, 438.3, 438.4, 438.5, 438.6, 438.8, 438.9, 438.10, 438.11, 438.12, 438.13, 439, 439.5, and 1265.7 of, the Health and Safety Code, and to amend Section 14105.5 of, and to add Section 14105.6 to, the Welfare and Institutions Code, relating to health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

Approved by the Governor September 9, 1976
Filed with Secretary of State September 9, 1976

LEGISLATIVE COUNSEL'S DIGEST

AB 4001, Keene. Health planning.

Under present law relating to health planning, the State Department of Health is prohibited from licensing new health facilities or increases or conversion of bed capacity to different license categories, except outpatient or emergency care, unless the proposal has first been approved by the voluntary area health planning agency or on appeal therefrom, or the voluntary area health planning agency failed to act within the time prescribed by law, or 12 months have expired since the decision of the voluntary area health planning agency. Under present law, payment for services pursuant to the Medi-Cal Act may not be made to health facilities which have been constructed or which have added bed capacity or converted bed capacity to a different category of licensure without the approval of the voluntary area health planning agency or approval on appeal from a decision thereof.

This bill would substantially revise existing provisions of law relating to health planning to, among other things, make the decisions of area health planning agencies only advisory, with the actual decisionmaking power vested in the State Department of Health. The bill would provide for appeal of decisions of the department to the Advisory Health Council.

The scope of projects subject to health planning would also be expanded and such projects could not be undertaken without a certificate of need issued by the department, except for projects or portions of projects which are given an express exemption. The undertaking of such
a project without a certificate of need would be grounds for denial or revocation of licensure, prescribed civil penalties, and would require denial of Medi-Cal reimbursement for services.

This bill would require health facilities to be licensed for bed capacity and categories prescribed by the license.

This bill would prescribe fees for licensed health facilities to pay for prescribed health-planning costs, and would appropriate $500,000 to the department for funding contracts with voluntary area health planning agencies pursuant to the bill.

The above changes would not become operative until the department adopts regulations for their implementation and such regulations become effective.

This bill would appropriate $75,000 to the State Controller for allocation and disbursement to local agencies for costs incurred by them pursuant to this bill, and would provide that if federal funds are not available to offset such allocations and disbursements, then the local agencies would not be subject to prescribed fees.

This bill would take effect immediately, as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 437 of the Health and Safety Code is amended to read:

437. There is hereby created the Advisory Health Council, to be composed of 21 members.

The Governor shall appoint 13 members, one of whom shall be a state government official concerned with health, one of whom shall be a representative of nongovernmental organizations or groups concerned with the operation, construction, or utilization of hospitals or other health care facilities, one of whom shall be a representative of a public agency concerned with the operation, construction, or utilization of nongovernmental facilities or services for the retarded, one of whom shall be representative of nongovernmental organizations or groups concerned with the operation, construction, or utilization of mental health services. one of whom shall be a provider of health care, one of whom shall be a representative of consumers of services for the mentally retarded, one of whom shall be a representative of consumers of mental health services, one of whom shall be a representative of local government, and four of whom shall be representatives of the general consumer public, as defined.

The Senate Committee on Rules shall appoint three members, one of whom shall be a Member of the Senate, one of whom shall be a provider of health care, and one of whom shall be a representative of the general consumer public.

The Speaker of the Assembly shall appoint three members, one of whom shall be a Member of the Assembly, one of whom shall be a provider of health care, and one of whom shall be a representative of the general consumer public.

Appeals Body

The Advisory Health Council is to serve as appeals body for decisions of the Health Department on certificates of need. There are 21 members, 13 appointed by the governor. The Senate Committee on Rules and the Speaker of the Assembly each appoints three members. The California Committee on Regional Medical Programs and the Administrator of Veterans' Affairs appoint one member each.
The California Committee on Regional Medical Programs shall appoint one member.

The Administrator of Veterans' Affairs shall appoint one ex officio member.

The chairperson and vice chairperson of the council shall be selected by the council from among the members of the council who are the representatives of the general consumer public or public officials, except for Members of the Legislature and for representatives of major purchasers of health care services.

The representatives of the general consumer public shall be bona fide public representatives whose occupations are neither the administration of health activities nor the performance of health services, who personally have no fiduciary obligation, and have no immediate family member who has a fiduciary obligation, to a hospital or other health agency, and who have no material financial interest in the rendering of health services.

The Member, or Members, of the Senate, appointed by the Senate Committee on Rules, and the Member, or Members, of the Assembly, appointed by the Speaker, shall meet with and participate in the work of the council to the extent that such participation is not incompatible with their positions as Members of the Legislature. The Members of the Legislature appointed to the council shall serve at the pleasure of the appointing power. For purposes of this part, such Members of the Legislature shall constitute a joint legislative committee on the subject of this part and shall have the powers and duties imposed upon such committee by the Joint Rules of the Senate and Assembly.

SEC. 2. Section 437.1 of the Health and Safety Code is amended to read:

437.1. Of the members first appointed by the Governor, two shall hold office for four years, four shall hold office for three years, and two shall hold office for two years. Of the members first appointed by the Senate Committee on Rules, one shall hold office for four years and one shall hold office for two years. Of the members first appointed by the Speaker of the Assembly, one shall hold office for four years and one shall hold office for two years.

The members first appointed to the additional offices created by the amendments to this part effective November 10, 1969 and those enacted at the 1971 Regular Session of the Legislature shall hold office for four-year terms, except that members appointed by the California Committee on Regional Medical Programs and the Administrator of Veterans' Affairs shall serve at the pleasure of the appointing power.

Thereafter, each member, except a member appointed by the California Committee on Regional Medical Programs or the Administrator of Veterans' Affairs, shall hold office for four years. No appointing authority specified in Section 437 shall appoint any person to alternate membership on the Advisory Health Council, unless to fill the vacant term of an appointment.

The terms of Members of the Legislature appointed to the council shall be figured as indicated above, but the
members shall serve at the pleasure of the appointing power and in no event after they cease to be Members of the Legislature.

SEC. 2.5. Section 437.2 of the Health and Safety Code is amended to read:

437.2. The Advisory Health Council shall meet at least bimonthly and as often as necessary to fulfill its duties. Except as provided in Section 437.10, all decisions of the council shall be decided by a majority of the voting members.

SEC. 2.7. Section 437.3 of the Health and Safety Code is amended to read:

437.3. The members of the Advisory Health Council shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the council, except that the members shall receive per diem of one hundred dollars ($100) for each day actually spent in the discharge of official duties pursuant to Section 438.8. Such per diem shall not exceed three hundred dollars ($300) in any one calendar month.

SEC. 3. Section 437.5 of the Health and Safety Code is amended to read:

437.5. (a) The Advisory Health Council, with the recommendation of the state department, shall approve the statewide health facility and services plan adopted pursuant to subdivision (b) of Section 437.7.

(b) The Advisory Health Council shall advise the state department in the conduct of its health planning activities and in the setting of priorities in accordance with the statewide health facility and services plan adopted pursuant to subdivision (b) of Section 437.7.

(c) Public agencies shall furnish to the Advisory Health Council, upon request, data on health programs pertinent to effective planning and coordination.

(d) The Advisory Health Council shall act as the appeals body pursuant to Section 438.8 regarding applications for a certificate of need filed pursuant to this part.

SEC. 3.5. Section 437.6 of the Health and Safety Code is repealed.

SEC. 3.7. Section 437.5 is added to the Health and Safety Code, to read:

437.5. The director shall adopt emergency regulations for the implementation of the provisions of this part, as amended during the 1975-76 Regular Session of the Legislature by the act adding this section, within 90 days after the effective date of such act.

SEC. 4. Section 437.7 of the Health and Safety Code is amended to read:

437.7. In order to assure availability of objective and impartial review by planning groups (referred to as area health planning agencies) of proposals for health facility projects as set forth in Section 437.10, the Advisory Health Council shall evaluate and shall designate annually no more than one area health planning agency for any area of the state designated by the council, provided such agency shall be incorporated as a nonprofit corporation and be controlled by a board of directors consisting of a majority representing the public and local government as consumers of health services with the balance being broadly representative of the providers of health services.

Statewide Plan

The Advisory Health Council shall approve the statewide health facility and services plan upon recommendations of the Department of Health and determine when area plans conform with regulations.

Area Health Planning Agencies

The Advisory Health Council shall annually designate area health planning agencies. The function of the agencies is to review information on utilization of health facilities; develop area plans for determining community need and desirability of projects; conduct public meetings; review applications for certificates of need, and make written findings of fact and recommendations for the applicant and the Department of Health.
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and the health professions, or alternatively be a health systems agency established pursuant to Public Law 93-641. The functions of area health planning agencies shall be the following:

(a) To review information on utilization of hospitals and related health facilities.

(b) To develop area plans to be used for the determination of community need and desirability of projects specified in Section 437.10, consistent with the regulations adopted by the state department pursuant to Section 437.8. Each such plan shall become effective upon a determination by the council that the plan is in conformance with regulations adopted pursuant to Section 437.8. The council shall integrate all such area plans into a single Statewide Health Facilities and Services Plan, which shall become effective upon formal adoption by the council.

(c) To conduct public meetings in which providers of health care and consumers will be encouraged to participate.

(d) To review applications for certificates of need as required by Section 437.10 and make recommendations to the state department as to the need and desirability for the project proposed in the application, based upon the statewide and area plans adopted pursuant to subdivision (b) or, prior to the adoption of such plans, based upon the existing plans specified in Section 437.9.

(e) To make written findings of fact and recommendations to be delivered to applicant and filed with the State Department of Health as a public record.

Area health planning agencies shall comply with the following requirements:

1. The governing body of such agency shall, to the extent feasible, be composed of individuals representative of the major social, economic, linguistic, and racial populations, and geographic areas, within the area served by the agency.

2. The agency shall hold public meetings and hearings only after reasonable public notice. Such notice shall, to the extent feasible, be publicized directly to those who, as determined by the director, are medically underserved and are in other ways denied equal access to good medical care.

3. The agency shall file with the Advisory Health Council an affirmative action employment plan approved by the state department.

Area health planning agencies may divide their areas into local areas for purposes of more effective health facility planning, with the approval of the Advisory Health Council. Such local areas shall be of a geographic size and contain adequate population to insure a broad base for planning decisions. Each local area shall contain a local health planning agency which shall meet the requirements of this section.

An organization which meets the requirements of this section may make application to its area health planning agency for designation as a local health planning agency for a designated area. Within 45 days after a complete application for designation has been received, the area agency shall reach a decision concerning the application. Each area health planning agency existing on the
operative date of amendments to this section enacted during the 1976 portion of the 1975-76 Regular Session of the Legislature shall continue to function as an area planning agency pursuant to this part, and shall provide review and recommendations on applications for certificates of need until such time as one or more designated health systems agencies are fully operational, as determined by the Advisory Health Council in the area served, or formerly served, by the respective area health planning agency.

If the Advisory Health Council determines that an area health planning agency approved under this section is dissolved or unable to carry out the functions required by this part, the state department shall fulfill the responsibilities of an area health planning agency pursuant to this part in the area until such time as another area health planning agency is designated by the Advisory Health Council for such area and becomes fully operational.

Adoption of regulations setting forth administrative procedures for area and local area health planning agencies shall be made by the state department pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 5. Section 437.8 of the Health and Safety Code is amended to read:

437.8. The state department shall promulgate regulations setting forth statewide policies for area health planning agencies in the performance of their responsibilities under Section 437.7.

In adopting such regulations, the department shall, with the advice of the Advisory Health Council, consider the following factors, and may consider other factors not inconsistent with the following:

(a) The need for health care services in the area and the requirements of the population to be served, including evaluation of current utilization patterns;

(b) The availability and adequacy of health care services in the area's existing facilities which currently conform to federal and state standards;

(c) The availability and adequacy of services in the area such as preadmission, ambulatory or home care services which may serve as alternatives or substitutes for care in health facilities;

(d) The possible economies and improvement in service that may be derived from the following:

1. Operation of joint, cooperative, or shared health care resources;

2. Maximum utilization of health facilities consistent with the appropriate levels of care, including but not limited to intensive care, acute general care, and skilled nursing care;

3. Development of medical group practices, especially those providing services appropriately coordinated or integrated with institutional health service, and development of health maintenance organizations;

(e) The development of comprehensive services for the community to be served. Such services may be either direct or indirect through formal affiliation with other health programs in the area, and include preventive.
diagnostic, treatment and rehabilitation services. Preference shall be given to health facilities which will provide the most comprehensive health services and include outpatient and other integrated services useful and convenient to the operation of the facility and the community.

(f) The needs or reasonably anticipated needs of special populations, including members of a comprehensive group practice prepaid health care service plan, members of a religious body or denomination who desire to receive care and treatment in accordance with their religious conviction, or persons otherwise contracted or enrolled under extended health care arrangements, including life-care agreements pursuant to Chapter 4 (commencing with Section 16300) of Part 4 of Division 9 of the Welfare and Institutions Code.

(g) The special needs and circumstances of those entities which provide a substantial portion of their services or resources, or both, to individuals not residing in the health service areas in which the entities are located. Such entities may include medical and other health professional schools, multidisciplinary clinics, and specialty centers.

SEC. 6. Section 437.10 of the Health and Safety Code is repealed.

SEC. 6.5. Section 437.10 is added to the Health and Safety Code, to read:

437.10. The basis for decisions by the state department on applications for certificates of need filed pursuant to this part shall be:

(a) The Statewide Health Facilities and Services Plan specified in subdivision (b) of Section 437.7. Until the statewide plan is adopted by the council pursuant to subdivision (b) of Section 437.7:

(1) Existing area plans developed pursuant to subdivision (b) of Section 437.7, as it existed prior to its amendment by enactment of this section, shall continue in effect, and shall be the basis for decisions on projects requiring a certificate of need pursuant to subdivision (a) of Section 437.10.

(2) Review and approval of projects requiring a certificate of need pursuant to subdivision (b), (c), (d), or (e) of Section 437.10 shall be governed by regulations which shall be adopted by the state department pursuant to Section 437.8.

(b) The statewide policies developed pursuant to Section 437.8.

SEC. 7. Section 437.10 of the Health and Safety Code is repealed.

SEC. 8. Section 437.10 is added to the Health and Safety Code, to read:

437.10. Except as otherwise exempted by Sections 437.11., 437.13, or this section, projects requiring a certificate of need issued by the State Department of Health are the following:

(a) Construction of a new health facility, the increase of bed capacity in an existing health facility, the conversion of an existing health facility from one license category to another, or, on or after January 1, 1977, the conversion of a health facility's existing beds in one bed

Certificate of Need

Projects requiring a certificate of need are: Construction of a new facility, increase in bed capacity; conversion of a license category; conversion to a different bed classification; new clinic or change in clinic class; purchase of lease of diagnostic or therapeutic equipment over $150,000 or a project requiring a capital expenditure over $150,000; and new special services, including
classification to a different bed classification. As used in this section, “license category” means any category of health facility set forth in Section 1250, and “bed classification” means any classification set forth in Section 1250. A facility may use beds in one bed classification when, pursuant to the facility’s license, have been designated in another bed classification, if all such bed classification changes do not at any point in time exceed 5 percent of the total number of the facility’s beds as set forth by the facility’s license and if such use meets the requirements of Chapter 2, (commencing with Section 1250) of Division 2.

In addition, a facility may use an additional 5 percent of its beds in such manner if the director finds that seasonal fluctuations justify it.

(b) A new clinic or change in clinic class, as defined in subdivision (e) or (f) of Section 1203.

(c) The establishment of a new special service delineated in subdivision (a), (b), (d), (e), (f), (g), or (h) of Section 1255, or the establishment, pursuant to subdivision (c) of Section 1255, of an emergency center which provides basic or comprehensive emergency medical services, as defined by regulation of the state department.

(d) The initial purchase or lease by a facility of diagnostic or therapeutic equipment with a value in excess of one hundred fifty thousand dollars ($150,000) in a single fiscal year, or for which the cumulative cost exceeds such amount in more than one fiscal year. For purposes of this subdivision, the purchase or lease of one or more articles of functionally related diagnostic or therapeutic equipment, as determined by the state department, shall be considered together.

(e) Any project requiring a capital expenditure for a health facility, or for a clinic licensed pursuant to subdivisions (e) or (f) of Section 1203, or for the services, equipment or modernization of such facility or clinic in excess of one hundred fifty thousand dollars ($150,000) in the current fiscal year or cumulative to an expenditure of one hundred fifty thousand dollars ($150,000) in the same fiscal year or subsequent fiscal years for a single project.

For the purposes of this subdivision, a “capital expenditure” shall mean any of the following:

(1) An expenditure, including an expenditure for a construction project undertaken by the facility as its own contractor, which under generally accepted accounting principles is not properly chargeable as an expense of operation and maintenance and which exceeds one hundred fifty thousand dollars ($150,000). The cost of studies, surveys, legal fees, land, offsite improvements, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion, or replacement of the physical plant and equipment with respect to which such expenditure is made shall be included in determining whether such cost exceeds one hundred fifty thousand dollars ($150,000). Where the estimated cost of a proposed project, including cost escalation factors appropriate to the area in which the project is located, is, within 60 days of the date on which the obligation for such expenditure is incurred, certified by a licensed architect or engineer to
be one hundred fifty thousand dollars ($150,000) or less, such expenditure shall be deemed not to exceed one hundred fifty thousand dollars ($150,000) regardless of the actual cost of such project. However, in any such case where the actual cost of the project exceeds one hundred fifty thousand dollars ($150,000); the health facility on whose behalf such expenditure is made shall provide written notification of such cost to the state department not more than 30 days after the date on which such expenditure is incurred. Such notification shall include a copy of the certified estimate.

(2) The acquisition, under lease or comparable arrangement, or through donation, of any facility or part thereof, or equipment for a facility, the expenditure for which would have been considered a capital expenditure if the person had acquired it by purchase. For the purposes of this paragraph, "donation" shall not include a bequest.

(3) Any change in a proposed capital expenditure which itself meets the criteria set forth in this subdivision. A "capital expenditure" shall include the total cost of the proposed project as certified by a licensed architect or engineer based on preliminary plans or specifications and concurred in by the state department. For the purposes of this subdivision, "project" shall not include the purchase of real property for future use or the transfer of ownership, in whole or part, of an existing health facility or the acquisition of all or substantially all of the assets or stock thereof.

For the purposes of this subdivision, "modernization" means the alteration, expansion, repair, remodeling, replacement, or renovation of existing buildings, including initial equipment thereof, and the replacement of equipment of existing buildings.

The state department shall annually adjust the capital expenditure thresholds set forth in subdivision (d) and (e) of this section to reflect changes in the cost of living, as determined by the Department of Finance, using 1976 as the base year.

SEC. 9. Section 437.11 is added to the Health and Safety Code, to read:

437.11. (a) The state department shall exempt from the provisions of Sections 438 to 438.13, inclusive, and shall issue a certificate of exemption for those projects which were not previously subject to review under Section 437.7 prior to the effective date of this section where the applicant has shown and the director has found that:

(1) The applicant has, prior to the effective date of this section, committed or incurred a financial obligation, including any obligation payable by force account, which is certified by a licensed architect or engineer to be 10 percent of the cost of the total project, or seventy-five thousand dollars ($75,000), whichever is less; and

(2) The project cannot be terminated without substantial economic loss to the applicant; and

(3) Except with respect to projects set forth in subdivision (d) of Section 437.10, the project was commenced prior to the effective date of this section and is being diligently pursued to completion; and

(4) The applicant has filed a notice of such project...
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Individual Cases
Certificates of need may be granted in individual cases when one of the following conditions applies: Applicant proves the project meets the needs of a special population including members of a religious body desiring care in accord with religious beliefs; applicant proves project is necessary to meet needs of adult residents of defined nonprofit community care facility; applicant proves health facility has developed community support for services provided for at least five years; applicant proves for new facility or increase in beds that there will be an equal or greater reduction in bed capacity in other health facilities in the area.

with the state department on forms supplied by the state department within 60 days of the effective date of this section.

For the purposes of this subdivision, "project" shall mean any project set forth in Section 437.10, and the term "financial obligation" shall include cost factors set forth in the definition of "capital expenditure" in Section 437.10.

Within 120 days of the effective date of this section, the state department shall determine in public hearing which applications are entitled to an exemption under this subdivision.

(b) In addition, the state department shall exempt from the provisions of Sections 438 to 439.13, inclusive, and shall issue a certificate of need for those projects where the applicant has shown and the director has found that:

(1) The project is necessary solely to replace health care services that are no longer available at the facility because of a disaster or other emergency; or

(2) The project is solely for the purpose of complying with requirements of law or regulations; or

(3) The project was the subject of an application submitted to an area health planning agency prior to the effective date of this section. Such applications shall be processed and decided in the manner prescribed by this part as it existed immediately prior to the operative date of this section, except that any petition for appeal of a decision or lack of decision of such an area health planning agency rendered after the effective date of this section shall be made directly to the Advisory Health Council.

(c) A certificate of exemption issued pursuant to this section or Section 1268 shall for all purposes have the same effect as a certificate of need issued pursuant to this part.

SEC. 10. Section 437.12 is added to the Health and Safety Code, to read:

437.12. Taking into consideration the basis for decision set forth in Section 437.9:

(a) The state department may in individual cases, grant certificates of need for projects with respect to which it determines that one of the following is applicable:

(1) The applicant has provided evidence that the project will meet the needs or reasonably anticipated needs of a special population including members of a religious body or denomination who desire to receive care and treatment in accordance with their religious convictions.

(2) The applicant has provided evidence that the project is or will be necessary to meet the health needs or reasonably anticipated health needs of adult residents of a nonprofit community care facility, as defined by subdivision (a) of Section 1502, which is owned by the applicant.

(3) The applicant has provided evidence that, as a health facility, it has developed community support for its services as indicated by its current utilization patterns, and has provided health care services for at least five years.

(4) The applicant has provided evidence, when the
Prepaid Plans

A certificate of need shall be granted where an applicant shows and the director of health finds that the predominant use of a comprehensive group practice prepayment health care service plan if beds or services are not available from nonplan providers and if the project will not result in a substantial increase in community health care costs.

Existing Facilities

Remodeling or replacement of existing facilities is exempted unless: There is an increase in beds; license category is converted; conversion of any beds to another classification (except for the five percent allowances); significant expansion of diagnostic or therapeutic capability or services; location of the facility on a different or non-adjacent site; remodeling or replacement of defined specialty services which exceeds $150,000.

Nothing in this subdivision shall require the state department to grant certificates of need as authorized by this section in any of the above categories.

(b) The state department shall grant certificates of need for projects where the applicant has shown and the director has found that the predominant use of the project is, or will be, by members of a comprehensive group practice prepayment health care service plan, such that the project will meet the needs or reasonably anticipated needs of such members, and the beds or services to be provided are not available to the applicant from nonplan providers, provided, that the director shall not issue a certificate of need pursuant to this subdivision if he finds that the project will result in a substantial increase in health care costs in the community.

For the purposes of subdivision (b), health facility beds or services shall not be considered available if they are dispersed in several facilities, not available on a long-term contractual basis, not available under circumstances which would grant full and equal staff privileges to an adequate number of plan physicians in appropriate specialties, or, in general, where the state department determines the beds or services are not available in a manner which is economically and clinically feasible to the plan.

In order to qualify under this section, a project shall be for or be at a health facility which accommodates at least 50 physicians located therein, or immediately adjacent thereto. Such physicians shall be in group practice and provide at least 75 percent of the medical services they deliver to members of the comprehensive group practice prepayment health care service plan. Such plan shall provide or arrange for both inpatient and outpatient health care services on a prepaid basis.

The state department shall establish uniform procedures and criteria for approving applications under this section.

SEC. 10.5. Section 437.13 is added to the Health and Safety Code, to read:

W 437.13. Notwithstanding any other provision of law, no proposal for the remodeling of any health facility licensed on the effective date of this section or the construction of any new health facility to replace in whole or in part any existing health facility licensed on the effective date of this section, or for the replacement of the equipment or services of any health facility licensed on the effective date of this section, shall be required to be approved as provided in this part, unless the proposal involves one of the following:

(a) An increase in bed capacity.

(b) The conversion of a facility in one category of licensure to a different category of licensure.

(c) The conversion of any of a health facility's existing beds from one classification set forth in Section 1250.1 to another classification, except as authorized by Section 437.10.

(d) A significant expansion or addition of diagnostic or
grandfather clause
defined existing facilities and projects in progress exempted; clause effective 10 years.

application criteria
applications to be submitted on official forms provided by the department of health. information includes at least: site of facility in geographic area served; current and projected population to be served categorized by age, income, sex; anticipated demand for services; utilization of similar programs in area; benefit to community and impact on other institutions with similar services; commencement and completion schedule; reasonable assurance of financing.

therapeutic capability, or a significant expansion or addition of services.
(e) Location of the health facility on a site which is not the same site or adjacent thereto.
(f) The remodeling or replacement of any special service set forth in subdivision (a), (b), (c), (d), (e), (f), (g), or (h) of section 1255, which exceeds a cost of one hundred fifty thousand dollars ($150,000), unless a certificate of need has been obtained for such remodeling or replacement of such special service.

for all purposes, including those specified in section 14105.5 of the welfare and institutions code and in section 1268 of this code it shall be deemed that a certificate of need has been issued for such a proposal.

health facilities desiring an exemption under this section shall, pursuant to regulations of the state department, submit an application and plans to the state department. the state department shall inform the applicant in writing of its determination as to eligibility of the applicant's proposal for such exemption within 60 calendar days of receipt of the application. if the state department determines that the proposal is not eligible for such exemption, the applicant may reapply for a certificate of need as provided in section 438 or seek judicial review.
this section shall remain in effect only for 10 years from the effective date of this section, and as of such date is repealed, unless a later enacted statute, which is chaptered before july 1, 1986, deletes or extends such date.

sec. 11. section 438 of the health and safety code is repealed.
sec. 12. section 438 is added to the health and safety code, to read:
438. applicants for a certificate of need for a project specified in section 437.10 shall submit an application to the state department on the official forms provided by the state department, which may include, but need not be limited to, the following information:
(a) The site of the facility in the geographic area to be served.
(b) The population to be served, categorized by age, income, and sex, as well as projections of population growth, by age, income, and sex.
(c) The anticipated demand for the health care service or services to be provided.
(d) A description of the service or services to be provided.
(e) Utilization of existing programs within the area to be served offering the same or similar health care services.
(f) The benefit to the community which will result from the development of the project as well as the anticipated impact on other institutions offering the same or similar services in the area.
(g) A schedule for the commencement and completion of the project.
(h) Reasonable assurance that adequate financing is available for the completion of the project within the time period stated in the application.
APPENDIX C

AMENDED IN SENATE AUGUST 30, 1977
AMENDED IN SENATE AUGUST 17, 1977
AMENDED IN SENATE AUGUST 5, 1977
AMENDED IN SENATE JUNE 24, 1977
AMENDED IN ASSEMBLY MAY 4, 1977
AMENDED IN ASSEMBLY APRIL 25, 1977
CALIFORNIA LEGISLATURE—1977-78 REGULAR SESSION

ASSEMBLY BILL No. 245

Introduced by Assemblymen Berman and Miller

January 19, 1977

An act to amend Section 437.13 of, and to add Section 437.14 to, the Business and Professions Code; and to amend Section 437.13 of, and to add Section 437.14 to, the Health and Safety Code, relating to health.

LEGISLATIVE COUNSEL'S DIGEST


Under existing law, the State Board of Public Health regulates the limited laboratory activities in which unlicensed laboratory personnel working in clinical laboratories may engage.

This bill would specifically include histocompatibility technicians within such class of unlicensed laboratory personnel. The bill would require the director of a histocompatibility laboratory to meet specified education and experience requirements.

Existing law generally requires that a certificate of need be obtained for construction of new health facilities, or for services, equipment, or modernization costing in excess of $150,-
However, certain remodeling and projects involving the replacement of health facilities are exempt from the requirement of the issuance of a certificate of need. This bill would, with certain exceptions, require reductions of licensed bed capacity as a condition to granting such an exemption for remodeling or replacing patient rooms and nursing stations at a cost of over $250,000.

The bill would, with certain exceptions, limit other such exemptions to replacement or remodeling costing not more than the lesser of $1,500,000 or $4,000 multiplied by the facility's bed capacity.

The bill would also specify time limitations for commencing and completion of remodeling or replacement projects receiving such exemptions.


The people of the State of California do enact as follows:

SECTION 1. Section 1099-1 is added to the Business and Professions Code, to read:

1099-1. As used in this chapter "histocompatibility laboratory director" means any person who is either (a) a duly licensed physician; or (b) a bioclinical; or (c) a person who has earned a doctoral degree in a biological science and has completed subsequent to graduation four years of experience in immunology, two of which have been in histocompatibility testing; He or she shall direct only those laboratories whose clinical function is limited histocompatibility testing; and he or she shall have the same responsibilities for administering such a laboratory under this act as does a laboratory director.

SECTION 2. Section 1069 of the Business and Professions Code is amended to read:

1069. The board shall establish by regulation the limited laboratory activities in which unlicensed laboratory personnel including, but not limited to, laboratory aides, histocompatibility technicians, cardiovascular technicians, and isotope technicians, working in clinical laboratories may engage and shall
establish the extent of supervision required and the minimum qualifications to be met by such persons. Persons engaged in such activities shall do so only under the supervision of a licensed technologist, or person duly authorized to direct a laboratory, who is functioning as a technologist. Before such persons are permitted to perform tests, they shall satisfactorily demonstrate their ability to do so in accordance with procedures prescribed by the department.

SEC. 2. Section 437.13 of the Health and Safety Code is amended to read:

437.13. (a) Notwithstanding any other provision of law, no proposal for the remodeling of any health facility licensed on or before September 9, 1976, or for the construction of any new health facility to replace in whole or in part any existing health facility licensed on or before September 9, 1976, or for the replacement of the equipment or services of any health facility licensed on or before September 9, 1976, shall be required to be approved as provided in this part, unless the proposal involves one of the following:

(1) An increase in bed capacity.
(2) The conversion of a facility in one category of licensure to a different category of licensure.
(3) The conversion of any of a health facility’s existing beds from one classification set forth in Section 1250.1 to another classification, except as authorized by Section 437.10.
(4) A significant expansion or addition of diagnostic or therapeutic capability, or a significant expansion or addition of services.
(5) Location of the health facility on a site which is not the same site or immediately adjacent thereto.
(6) The remodeling or replacement of any special service set forth in subdivision (a), (b), (c), (d), (e), (f), (g), or (h) of Section 1255, which exceeds a cost of one hundred fifty thousand dollars ($150,000), unless a certificate of need has been obtained for such remodeling or replacement of such special service.
(7) The replacement of any diagnostic or therapeutic...
equipment at a cost in excess of one hundred fifty thousand dollars ($150,000), when such equipment has been in operation for five years or less. For the purposes of this paragraph, the purchase or lease of one or more articles of functionally related diagnostic or therapeutic equipment, as determined by the state department, shall be considered together.

(8) The replacement or remodeling of patient rooms and nursing stations costing in excess of two hundred fifty thousand dollars ($250,000), unless such replacement or remodeling meets the requirements of subdivision (b).

(9) Except as provided in subdivision (c), a project for the remodeling or replacement of all or any portion of a health facility or equipment thereof which is not limited to a project specified in paragraph (6), (7), or (8) of this subdivision and the cost of which exceeds the lesser of one million five hundred thousand dollars ($1,500,000) or four thousand dollars ($4,000) multiplied by the health facility's total authorized bed capacity, excluding the cost of projects covered in paragraphs (6), (7), or (8).

(b) Any project specified in paragraph (8) of subdivision (a) which is not otherwise rendered ineligible for exemption by paragraphs (1) to (7), inclusive, of such subdivision, shall be entitled to an exemption under this section if any of the following conditions are met:

(1) Where the health facility has over the previous three years experienced an average licensed bed occupancy rate of over 80 percent, the licensed bed capacity shall not be required to be reduced by a remodeling or replacement proposal.

(2) Except as provided in paragraph (6) of this subdivision, where the health facility has over the previous three years experienced an average licensed bed occupancy rate of not less than 76 nor more than 80 percent, the licensed bed capacity of the health facility upon completion of the remodeling or replacement proposal shall not exceed 95 percent of the licensed bed capacity prior to the project.

(3) Except as provided in paragraph (6) of this subdivision.
subdivision, where the health facility has over the previous three years experienced an average licensed bed occupancy rate of not less than 71 nor more than 75 percent, the licensed bed capacity of the health facility upon completion of the remodeling or replacement proposal shall not exceed 90 percent of the licensed bed capacity prior to the project.

(4) Except as provided in paragraph (6) of this subdivision, where the health facility has over the previous three years experienced an average licensed bed occupancy rate of not less than 66 nor more than 70 percent, the licensed bed capacity of the health facility upon completion of the remodeling or replacement proposal shall not exceed 85 percent of the licensed bed capacity prior to the project.

(5) Except as provided in paragraph (6) of this subdivision, where the health facility has over the previous three years experienced an average licensed bed occupancy rate of not more than 65 percent, the licensed bed capacity of the facility upon completion of the remodeling or replacement proposal shall not exceed 80 percent of the licensed bed capacity prior to the project.

(6) Where the health facility serves a medically underserved population in a medically underserved area as determined by the Health Manpower Policy Commission and the facility's average bed occupancy rate over the previous three years was in excess of 65 percent, the licensed bed capacity shall not be required to be reduced. Where the health facility serves a medically underserved population in a medically underserved area as determined by the Health Manpower Policy Commission and the health facility's average bed occupancy rate is below 65 percent over the previous three years, the licensed bed capacity of the facility upon completion of the remodeling or replacement proposal shall not exceed 90 percent of the facility's licensed bed capacity prior to the project.

(c) Any project specified in paragraph (9) of subdivision (a) which is not otherwise rendered
ineligible for exemption by paragraphs (1) to (7), inclusive, of such subdivision, shall be entitled to an exemption under this section if the applicant demonstrates to the satisfaction of the director that the project is necessary in order for the facility to be able to continue the provision of service in a manner consistent with current standards of practice, and that the project meets all of the following criteria:

1. The proposed space in square feet for the project, upon completion, is not more than 5 percent net above the statewide average number of square feet per licensed bed in services or departments of comparably sized facilities approved in California during the previous two years pursuant to Chapter 1 (commencing with Section 15000) of Division 12.5 unless the applicant demonstrates to the satisfaction of the director special requirements for additional space.

2. Financial resources exist to successfully complete and implement the project, and the financing will not result in an undesirable increase in patient charges in the facility.

3. The project promotes fiscal economies through measures that assure efficiency and effectiveness, which may include the operation of joint cooperative or shared facilities health resources and maximum utilization of facilities.

4. Less costly alternatives for the project were evaluated by the applicant and found not to be as desirable as the proposed project.

5. The cost of equipment and construction is within reasonable limits and range for the area, type of project, and projected operational cost.

6. The size of the project is based on historical or reasonably projected utilization of the service, equipment, or facility.

The state department shall adopt regulations further defining the specifics of the criteria set forth in this subdivision.

For (d) For all purposes, including those specified in Section 14105.5 of the Welfare and Institutions Code and
in Section 1268 of this code, it shall be deemed that a certificate of need has been issued for any proposal approved for issued a certificate of exemption under this section.

Health facilities desiring an exemption under this section shall, pursuant to regulations of the state department, submit an application and plans to the state department. The state department shall inform the applicant in writing of its determination as to eligibility of the applicant's proposal for such exemption within 60 calendar days of receipt of the application. If the state department determines that the proposal is not eligible for such exemption, the applicant may reapply for a certificate of need as provided in Section 438 or seek judicial review.

This section shall remain in effect only until July 1, 1986, and as of such date is repealed, unless a later enacted statute, which is chaptered before July 1, 1986, deletes or extends such date.

SEC. 2. Section 437.14 is added to the Health and Safety Code, to read:

437.14. (a) The state department shall not accept an application for an exemption under paragraph (8) or (9) of subdivision (a) of Section 437.13 if a certificate of exemption has been granted pursuant to such section within the two-year period immediately preceding submission of the new application, unless the applicant shows to the director's satisfaction that the new application is necessitated by emergency conditions which could not reasonably have been foreseen at the time the prior application was submitted.

(b) Except as provided in subdivision (c), a certificate of exemption issued pursuant to Section 437.13 shall expire upon failure to commence or complete the project authorized thereby within the time specified in this subdivision. Any project involving only the acquisition and installation of equipment shall be completed within two years of issuance of the certificate of exemption. Any other project issued a certificate of exemption under Section 437.13 shall be commenced within two years and...
completed within five years of issuance of the certificate of exemption. A project shall be deemed commenced for purposes of this subdivision if both of the following have occurred:

(1) Submission to the state department of an internal commitment of funds through a force account or the submission to the state department of a written agreement executed between the applicant and a licensed general contractor to construct and complete the project within a designated time schedule in accordance with final architectural plans and specifications, which, if required, have been approved pursuant to Chapter 1 (commencing with Section 15000) of Division 12.5.

(2) Completion of construction work on the project to such a degree as to justify and require a progress payment by the applicant to the general contractor under terms of the construction agreement. If the construction agreement does not require progress payments, then completion of construction shall be at that stage where an initial progress payment would otherwise be required in accordance with the usual and customary practices of the building industry.

(c) The director may extend the time for commencement or completion of a project exempted pursuant to Section 437.13 if the holder of the certificate of exemption satisfies the director that the delay is the result of an unpreventable or unexpected occurrence such as an emergency, strike, disaster, unforeseen shortage of materials, or other unforeseen event.

(d) Any project for which an exemption has been approved pursuant to Section 437.13 prior to January 1, 1978, shall not be subject to revocation of such exemption by reason of failure to meet new criteria or requirements effective on or after such date. However, the time limitations specified in subdivision (b) and (c) of this section for commencement and completion shall be applicable to such projects.