BEFORE THE IDAHO BOARD OF TAX APPEALS

EASTERN IDAHO HEALTH SERVICES, INC.,	)	
	)	
Appellant,	)	APPEAL NO. 25-A-1027
	)	
v.	)	FINAL DECISION AND ORDER
	)	
BONNEVILLE COUNTY,	)	
	)	
Respondent.	)	
	)	
_____	)	

COMMERCIAL PROPERTY APPEAL

This appeal is taken from a decision of the Bonneville County Board of Equalization denying an appeal of the valuation for taxing purposes on property described by Parcel No. RPA1150001001F. The appeal concerns the 2025 tax year.

This matter came on for hearing November 17, 2025, in Idaho Falls, Idaho, before Board Member Doug Wallis. Attorney Marvin Smith appeared at hearing for Appellant. Bonneville County Assessor Dustin Barron represented Respondent.

Board Members Kenneth Nuhn and Doug Wallis join in issuing this decision.

The issue on appeal concerns the market value of an improved commercial property.

The decision of the Bonneville County Board of Equalization is affirmed.

FINDINGS OF FACT

The assessed land value is $3,981,233, and the improvements' value is $90,546,127, totaling $94,527,360. Appellant contends the correct total value is $65,000,000.

The subject property is a 26.11 acre commercial property located a couple miles southeast of downtown Idaho Falls, Idaho, and operates as a general acute care

hospital. The original hospital building, constructed in 1985, was a 252,829 square foot, six-story building. A 28,552 square foot, two-story women's center was added in 1993. In 2000, the emergency room and intensive care unit, a 52,516 square foot, two-story addition, was completed. The final addition was a 45,300 square foot, two-story neonatal intensive care unit in 2010. In all, the hospital building totals 379,197[1] square feet. The property is further improved with two (2) ancillary support buildings: a 2,304 square foot building constructed in 1985, referred to as the Carpenter Shop, and a 1,326 square foot building constructed in 2021, referred to as the Generator Building.

In support of a lower assessed value for the subject property, Appellant offered an independent fee appraisal report with a retroactive date of valuation of January 1, 2025. The appraisal developed value estimates using the cost and sales comparison approaches. The appraisal's cost model first sought to estimate the value of subject's 26.11 acres. In this regard, the appraisal analyzed four (4) land sales which transpired between September 2019 and May 2024. The sale lots varied in size from 4.4 to 17.3 acres, and sale prices ranged from $900,000 to $2,250,000, or from $2.46 to $7.04 per square foot. Time adjustments were applied to the pre-2024 land sales. Other adjustments were applied for location, size, and entitlements, as one (1) of the sale parcels had already been approved for a 144-unit townhome project. The result was adjusted price rates from $2.71 to $5.04 per square foot. The appraisal determined a value of $4.00 per square foot, or a rounded value of $4,500,000, for the subject lot.

For the hospital building, the appraisal evaluated subject as a Class A – Average General Hospital with a base replacement cost rate of $430 per square foot according

[1] Respondent did not identify individual size figures for each addition, instead reported a total size of 375,295 square feet for the entire hospital building.

to Marshall Valuation Service (MVS). To this, the appraisal added $2.99 per square foot for sprinklers and $15.00 per square foot for site improvements, and calculated a replacement cost new estimate of $447.99 per square foot. After applying current and local modifiers, a number of stories multiplier, and adding a 5% contingency cost factor, the appraisal determined an adjusted base replacement cost of $503.60 per square foot. The appraisal then cited national hospital construction cost data published in an industry magazine, which suggested typical construction costs range from $440 to $460 per square foot for hospital buildings. Based on these indicators, the appraisal concluded a replacement-cost-new rate of $485 per square foot, or $183,910,545, for the subject hospital building.

In its discussion of depreciation, the appraisal was critical of the MVS depreciation table for commercial buildings. According to the appraisal, "[t]his table stems from industrial studies conducted over 80 years ago and lacks any documentation or market evidence to support current methodologies or conclusions, especially for special use properties, such as the subject hospital." The appraisal characterized the use of the MVS depreciation table by appraisers as a mistake. Instead, the appraisal preferred to measure depreciation through data gleaned from the market.

The appraisal also outlined the three (3) basic methods for estimating depreciation. The appraisal regarded the age-life method as the most appropriate method for the valuation of hospitals, and noted the methodology accounts for physical, functional, and economic obsolescence in a single step. Total depreciation under the age-life method is measured by the ratio between the effective age of an improvement and the economic life expectancy of that improvement. To determine an appropriate

economic life for the subject hospital, the appraisal considered information from hospital replacement studies. The data showed a median age of thirty-eight (38) years for the hospitals in the data set at the time those hospitals were replaced.

The appraisal also referenced MVS, which suggested a life expectancy of 35 to 50 years for acute care hospitals. In an effort to narrow the life expectancy range indicated by the different sources, the appraisal discussed recent healthcare trends and the subject hospital's position in the current marketplace. The appraisal explained structural designs for hospitals have changed dramatically over the past 75 years, ". . . shifting from utilitarian, efficiency-focused post-war buildings to adaptable, patient-centered facilities." The appraisal reported the prevailing trend in the acute general hospital space in recent years has been away from inpatient services to more profitable outpatient services.

The appraisal further noted most outpatient surgeries were historically performed at hospitals, but there has been a significant rise in the number of ambulatory surgery centers performing non-hospital outpatient surgeries. The appraisal emphasized subject, with 304 licensed beds, was built to accommodate inpatient services, but the design is outdated and inefficient in today's market, which is geared more toward outpatient services, as evidenced by subject's inpatient occupancy hovering around 60%. In the appraisal's view, the subject hospital suffers some functional obsolescence in today's marketplace. Based on these various factors, the appraisal concluded an economic life of forty (40) years for the subject hospital.

To determine an overall effective age of the subject hospital, the appraisal separately examined each expansion phase. The original hospital building was

constructed in 1985, which equates to an actual age of forty (40) years. The appraisal, however, determined an effective age of thirty (30) years for the original portion of the building because it had been updated throughout the years. The appraisal determined a twenty-eight (28) year effective age for the women's center added in 1993, and effective ages of twenty-two (22) and thirteen (13) years for the emergency room/intensive care unit and neonatal intensive care units, added in 2000 and 2010, respectively. The appraisal concluded an overall actual weighted age of 34.3 years for the subject hospital building and an overall effective age of 26.7 years.

Having identified subject's effective age and economic life expectancy, the appraisal next calculated a specific depreciation factor. Dividing the 26.7 effective age by a 40-year life expectancy, the appraisal calculated a 66.8% depreciation factor. Applying the depreciation factor to the roughly $184,000,000 cost-new estimate, the appraisal determined a depreciated value of $61,058,301 for subject's hospital building. After adding $400,000 for the two (2) ancillary buildings, and $4,500,000 for the land, the appraisal's cost model concluded a total value of $66,000,000 for the subject property.

The appraisal's sales comparison model included six (6) hospital sales which transpired between August 2019 and January 2025, all located outside Idaho. The sale hospitals varied in size from 176,355 to 414,237 square feet. Sale prices ranged from roughly $27,000,000 to $101,000,000. After removing land values and the values of any ancillary buildings included in the sales, the appraisal calculated residual hospital building values from approximately $14,500,000 to $97,500,000, or from $62.38 to $272.55 per square foot. Adjustments were then made to the sales for differences in

location, gross building area, and age/quality/condition compared to subject. The result was adjusted residual price indications from $68.62 to $231.67 per square foot for the sale hospitals. The appraisal determined a rate of $150 per square foot for subject's hospital building. After adding subject's land value and the value of the ancillary buildings determined under its cost approach model, the appraisal calculated a total value of $61,800,000 for the subject property.

In the final reconciliation of value indicators, the appraisal placed roughly 95% weight on its cost approach model, and 5% on the sales comparison approach. The result was a total value conclusion of $65,000,000 for the subject property. Appellant petitioned subject's assessed value be reduced accordingly.

Respondent explained the subject property was reappraised for the 2025 assessment year. During the reappraisal assignment, Respondent discovered several errors in the cost model used to assess the subject property in prior years. In addition to a higher depreciation allowance for floors two (2) through six (6), the subject property had also been receiving a 2% economic adjustment related to COVID since 2023. Respondent further identified 3,525 square feet of shell space that had been finished during 2024. Correcting these errors caused the value of subject's improvements to increase from $73,098,231 in 2024 to $90,546,127 for 2025.

Respondent noted that while preparing for the hearing in this matter, an additional error was discovered regarding subject's story height. Instead of a uniform 10-foot story height across all floors of the subject building, Respondent learned the height actually varies from twelve (12) to fifteen (15) feet, with an overall average story height of 13.5 feet. During this timeframe, Respondent also received updates to its cost

tables. After these adjustments, the replacement cost increased by approximately $15 per square foot in Respondent's updated cost model presented at hearing.

Like Appellant's appraisal, Respondent's cost model started with the value of subject's 26.11 acres. Respondent's analysis included five (5) sales involving vacant parcels larger than ten (10) acres in size. The sale lots varied in size from 10.06 to 36.77 acres, and sale prices ranged from $1,175,000 to $9,581,458, or from $2.62 to $5.98 per square foot, with an average price rate of $3.52 per square foot. Subject's assessed land value is $3,981,233, or $3.50 per square foot.

Respondent's cost model next evaluated subject's improvements using MVS cost data. Because MVS provides for an additional 0.5% multiplier for each story over three (3), Respondent developed separate value estimates for the first lower (3) floors of the subject hospital and the upper three (3) floors. Respondent considered subject a Class A – Average General Hospital building with a base replacement cost of $430 per square foot, the same as Appellant's appraisal report. To this, Respondent added $3.06 per square foot for sprinklers, and a $12.25 per square foot HVAC adjustment because subject's location is considered an "extreme" climate. This calculated to an adjusted base cost of $445.31 per square foot. Respondent next applied current and local cost modifiers, as well as multipliers for number of stories, perimeter, and story height. The result was a replacement cost new rate of $452.75 per square foot for subject's lower three (3) floors, and $455.02 per square foot for the upper three (3) stories, or a total cost of roughly $170,000,000.

Unlike Appellant's appraisal, Respondent regarded the MVS depreciation tables as a reliable tool for estimating depreciation. According to Respondent, the MVS tables

" . . . incorporate effective age, remaining economic life, typical renovation cycles, and the replacement patterns of major structural and mechanical systems. This provides a realistic representation of physical and functional depreciation, especially for complex facilities such as hospitals . . . ." Citing MVS life expectancy tables for a Class A – Average General Hospital, Respondent utilized an economic life of forty-five (45) years for the subject hospital. And based on subject's effective age of twenty-five (25) years, the MVS depreciation table indicated a 33% deprecation factor, which yielded a depreciated replacement cost estimate of nearly $114,000,000 for the subject hospital building.

Respondent then added nearly $70,000 for the two (2) ancillary buildings and roughly $1,000,000 for other improvements. After adding the land value determined earlier, Respondent's updated cost model concluded a total value of $119,037,173 for the subject property.

Respondent next shared details of its sales comparison analysis. It was noted hospitals represent a unique property type, so sales are limited, even on a regional basis. Respondent identified three (3) hospital sales in Utah that were part of a 2024 portfolio purchase, and a hospital sale in Georgia that transpired in 2020. The sale hospitals ranged in gross building area from 306,753 to 416,861 square feet, with prices from roughly $82,000,000 to $184,000,000, or from approximately $267 to $649 per square foot, with an average price rate of $504 per square foot. After removing land values from the respective sale prices, Respondent determined an average adjusted price rate of roughly $493 per square foot. Applying this rate to subject's 375,295 square feet and adding the land value indication from the earlier cost model, a total value of

$189,024,186 was concluded for the subject property in Respondent's sales comparison approach.

Moving to the income approach, Respondent again stressed hospitals are a special-use property and noted they are typically owner-occupied, so estimating market rent is a challenge. Respondent explained there is only one (1) other general hospital in the county, and that hospital had reported its income to the assessor's office in prior years. According to Respondent, the average annual rental rate of the competing hospital was $62.31 per square foot, so the same lease rate was used for subject. Respondent's income model used a 5% vacancy rate and a 30% operating expense rate, which yielded a net operating income figure of roughly $15,500,000. Respondent's 7.13% capitalization rate was derived from a collection of sales involving emergency rooms and other medical facilities. Applying the capitalization to the estimated net operating income resulted in a value indication of $218,103,505 for the subject property.

In its final reconciliation, Respondent placed all weight on the cost approach. In Respondent's view, there were not enough hospital sales to develop a reliable sales comparison model, and there was likewise a shortage of market lease data to produce a credible value indication using the income approach. Respondent's cost model concluded a value of nearly $119,037,173, which was noted to be higher than subject's assessed value of $94,527,360[2].

CONCLUSIONS OF LAW

This Board's goal in its hearings is the acquisition of sufficient, accurate evidence to support a determination of market value in fee simple interest or, as applicable, a

[2] Subject's assessed value was determined prior to updating the MVS cost tables and Respondent's discovery that subject's average story height is 13.5 feet instead of 10.0 feet.

property's exempt status. This Board, giving full opportunity for all arguments and having considered all the testimony and documentary evidence submitted by the parties, hereby enters the following.

Idaho Code § 63-205 requires taxable property be assessed at market value annually on January 1; January 1, 2025, in this case. Market value is always estimated as of a precise point in time. Idaho Code § 63-201 provides the following definition,

> "Market value" means the amount of United States dollars or equivalent for which, in all probability, a property would exchange hands between a willing seller, under no compulsion to sell, and an informed, capable buyer, with a reasonable time allowed to consummate the sale, substantiated by a reasonable down or full cash payment.

Market value is estimated according to recognized appraisal methods and techniques. The three (3) primary approaches for determining value include the sales comparison approach, the cost approach, and the income approach. *Merris v. Ada Cnty.*, 100 Idaho 59, 63, 593 P.2d 394, 398 (1979).

The parties agree the cost approach is the most appropriate methodology for estimating the market value of a special-use property like the subject hospital. The Board concurs. Special-use properties are often owner-occupied, so there are few sales and limited market lease data by which to develop credible sales comparison or income approach models. Though Appellant's appraisal report did assign 5% weight to the sales comparison approach in its final reconciliation, the primary source of the parties' differing value opinions was in their respective cost approach models, so the Board will likewise focus on the cost approach.

The parties' cost models were relatively similar through the first couple steps of the respective analyses. Appellant's appraisal concluded a value of $4.00 per square

foot for subject's 26.11 acres, and Respondent determined a value of $3.50 per square foot. For the subject hospital building, both cost models started with the same $430 per square foot base replacement cost rate. There were some differences in the adjustments and cost multipliers applied to the base rate, but the respective replacement cost new figures were within a reasonable range of each other, with Respondent concluding approximately $170,000,000, or $453 per square foot, and Appellant's appraisal concluding roughly $184,000,000, or $485 per square foot.

The primary source of difference between the parties' cost models was in their approaches for determining an appropriate deprecation factor for the subject hospital building. Respondent relied on the MVS depreciation table for commercial properties. Using the forty-five (45) year economic life expectancy figure for a Class A – Average hospital provided in the MVS life expectancy guideline tables and a twenty-five (25) year effective age for the subject hospital building, a 33% depreciation factor was indicated.

Appellant's appraisal rejected the MVS commercial property depreciation table, stating, "[t]his table stems from industrial studies conducted over 80 years ago and lacks any documentation or market evidence to support current depreciation methodologies or conclusions . . . ." Instead, the appraisal developed its own estimate of subject's economic life expectancy using age and replacement data from other hospitals located across the country. The twenty-two (22) hospitals included in the data set ranged in average age from twenty-three (23) to sixty (60) years at the time those hospitals were replaced. The appraisal reported an overall average age for the hospitals in the data set of 38.3[3] years. After referencing that MVS indicates a life expectancy range from thirty-

[3] It was unclear how the 38.3 age figure was determined, as the actual average age of the hospitals in the data set calculates to 39.1 years.

five[4] (35) to sixty (60) years, the appraisal concluded an economic life expectancy of forty (40) years for subject. Based on this life expectancy and an effective age of 26.7 years for the subject hospital, the appraisal calculated a 66.8% depreciation factor. This equated to nearly $123,000,000 in depreciation and a rounded value conclusion of $61,000,000 for the subject hospital building.

While the Board understands the methodology employed by the appraisal for estimating economic life expectancy and depreciation, we were not convinced it produced a more credible value indication than Respondent's straightforward cost analysis utilizing MVS data and tables. MVS has long been used by appraisal professionals to develop cost approach models. In fact, the prominence of MVS was recognized by Appellant's appraisal report itself, which stated, "The *Marshall Valuation Service* is a nationally recognized authority for providing cost data for determining replacement costs of buildings and other improvements . . . Appraisers, assessors, and others who need access to reliable cost data often use this resource" (emphasis in original).

Despite the wide acceptance of MVS data in developing reliable cost models, Appellant's appraisal effectively abandoned MVS at nearly every step in its analysis, each time in favor of an input into the model that contributed to a lower final value conclusion. Indeed, the appraisal determined a replacement cost new estimate of $503.60 per square foot using MVS cost tables but instead concluded a rate of $485 per square foot after citing national hospital construction cost data published in a trade magazine. Concerning from the Board's perspective, however, was that the

[4] According to MVS, the thirty-five (35) year life expectancy figure is for Class D and Class S general hospitals, not a Class A facility, like the subject hospital.

construction cost data referenced by the appraisal concerned two (2) to three (3) story hospital buildings, whereas the subject hospital is six (6) stories. And because of subject's upper floors, Respondent's cost model included a number of stories multiplier, an adjustment missing in the appraisal report's analysis, which evaluated subject as a three-story hospital.

The appraisal deviated further from MVS in its consideration of depreciation. The appraisal noted the MVS life expectancy range for general hospitals but instead relied on age data from roughly two (2) dozen hospitals that were replaced across the country. Though somewhat unclear in the summary table provided in the appraisal, it appeared the hospital replacement data stretched back to 1996. Using this information, the appraisal report concluded a forty (40) year economic life for the subject hospital. According to MVS, however, a forty (40) year life expectancy is for a Class C hospital building, not a Class A hospital like subject. From the MVS table, the difference in depreciation between a forty (40) year economic life versus a forty-five (45) year life for a commercial building with an effective age of twenty-five (25) years is 10%. And with an effective age of twenty-seven (27) years, as the appraisal concluded for the subject hospital, there is a 12% difference in the depreciation rate between a forty (40) year life expectancy and a forty-five (45) year life expectancy. These are not insignificant differences and underscore the importance of properly classifying an improvement and accurately estimating effective age.

In its criticism of the MVS depreciation schedule for commercial properties, the appraisal asserted, "[t]he use and inclusion of this table assumes that depreciation is the same for every different property type located in any location, which is clearly not

supportable." Despite emphasizing location as a critical consideration, the appraisal relied on age data for hospitals located primarily in the southeastern region of the U.S. In fact, only five (5) of the twenty-two (22) hospitals comprising the data set were located west of the Mississippi River. Interestingly, the only hospital from Idaho included in the group was forty-five (45) years old at the time of replacement, which is the same economic life expectancy for a Class A – Average hospital indicated by MVS, and the same economic life Respondent used in its cost model.

In all, the Board was not satisfied the alternative methodology advocated by Appellant's appraisal report was superior, or more reliable, than a traditional cost methodology guided by MVS, like the cost model offered by Respondent. When properly utilized, MVS cost data and tables have long been recognized by courts and appraisal professionals as reliable for purposes of developing value estimates under the cost approach. And under the circumstances presented here, the Board was not persuaded to adopt the alternative methodology advanced by Appellant's appraisal.

In accordance with Idaho Code § 63-511, the burden is with Appellant to establish subject's valuation is erroneous by a preponderance of the evidence. The Board did not find the burden of proof satisfied. In the Board's view, Respondent's cost model, based on data obtained from MVS, a nationally recognized and widely used cost manual, represented the best indicator of subject's current market value in this instance.

The decision of the Bonneville County Board of Equalization is affirmed.

FINAL ORDER

In accordance with the foregoing Final Decision, IT IS ORDERED that the decision of the Bonneville County Board of Equalization concerning the subject parcel be, and the same hereby is, AFFIRMED.

DATED this 26th day of February, 2026.