

IN THE MATTER OF \* BEFORE THE  
PROPOSED NEW HOSPITALS \* MARYLAND HEALTH CARE  
IN MONTGOMERY COUNTY \* COMMISSION  
Holy Cross Hospital of Silver Spring \*  
Docket No. 08-15-2286 \*  
Clarksburg Community Hospital \*  
Docket No. 09-15-2294 \*  
\* \* \* \* \*

**EXHIBITS TO**  
**ADVENTIST'S EXCEPTIONS TO THE**  
**RECOMMENDED SUPPLEMENTAL DECISION**

May 23, 2012

## EXHIBIT LIST

1. Excerpts of 2011 CON Final Decision
2. Excerpts of Adventist's January, 2011 Exceptions
3. Judge Pierson's Memorandum Opinion
4. March 2, 2012 Letter from Marilyn Moon, Ph.D. to Diane Festino Schmitt, Esquire and Jack C. Tranter, Esquire
5. March 7, 2012 Letter from Diane Festino Schmitt, Esquire to Marilyn Moon, Ph.D.
6. March 28, 2012 E-mail from Suellen Wideman to Diane Schmitt
7. Adventist Healthcare, Inc.'s Comments on Additional Evidence Entered Into the Record
8. Holy Cross Hospital's Response to Comments Filed by Clarksburg Community Hospital and Adventist Healthcare, Inc.
9. May 11, 2012 Letter from Marilyn Moon, Ph.D. to Diane Festino Schmitt, Esquire and Jack C. Tranter, Esquire
10. May 15, 2012 Recommended Supplemental Decision from Marilyn Moon, Ph.D. to Commissioners, Maryland Health Care Commission

# Exhibit 1

**IN THE MATTER OF**

**PROPOSED NEW HOSPITALS**

**IN MONTGOMERY COUNTY**

**Holy Cross Hospital of Silver Spring  
Docket No. 08-15-2286**

**Clarksburg Community Hospital  
Docket No. 09-15-2294**

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**BEFORE THE  
MARYLAND HEALTH  
CARE COMMISSION**

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**Final Decision**

**January 20, 2011**

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that the HCH-G site, because of its nearness to more densely populated areas of Montgomery County, has a greater potential than the CCH site to reduce the overall travel time to a hospital experienced by Montgomery County residents.

**(2) Identification of Bed Need and Addition of Beds**

*Only medical/surgical/gynecological/addictions (“MSGA”) beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.*

*(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.*

*(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.*

*(c) Additional MSGA or pediatric beds may be developed or put into operation only if:*

*(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or*

*(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or*

*(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or*

*(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.*

**Background**

This standard requires that a proposal to increase capacity of either MSGA beds or pediatric beds must be justified in one of four ways. First, the applicant may demonstrate that the proposed bed increase will result in actual bed capacity at the hospital that is equal to or less than its current licensed acute care bed capacity. Second, a proposal may be consistent with the State Health Plan’s current minimum jurisdictional bed need projection for the jurisdiction in which the hospital is located. The jurisdictional need projection consists of a range between a minimum gross bed need and a maximum gross bed need for MSGA beds and pediatric beds. The third approach is for the applicant to demonstrate that the additional beds are consistent with the maximum bed need for the jurisdiction and that there is a need for the additional beds at the applicant hospital. The final approach outlined in the standard is for the applicant to propose a service area analysis modeled on the jurisdictional bed need projection methodology.

Holy Cross Hospital is proposing to construct a new hospital in Germantown that will include 75 MSGA beds, and CCH is proposing to construct a new hospital in Clarksburg that

will include 70 MSGA beds. Neither applicant is proposing pediatric beds for its new hospital. Given that each of these proposals is for a new hospital, Part (c)(i) of this standard is inapplicable.

When these applications were filed, the Commission was projecting a 2016 minimum gross MSGA bed need of 1,007 and a maximum gross MSGA bed need of 1,289. The updated MSGA bed need projections for 2018 (March, 2010) show a gross minimum of 995 beds needed by that forecast year and a maximum of 1,193 beds. The number of licensed MSGA beds in Montgomery County, effective July 1, 2010, is 1,076. The number of licensed MSGA beds by hospital and the calculation of the minimum and maximum projected need for MSGA beds, net of licensed and approved beds, for the last two iterations of bed need, are as follows:

**Table 22: Licensed MSGA Beds in Montgomery County (July 1, 2010)**

Hospital	Licensed MSGA Beds
Holy Cross	288
Montgomery General	121
Shady Grove	255
Suburban	192
Washington Adventist	220
<b>Total</b>	<b>1,076</b>

**Table 23: Projected 2016 and 2018 Minimum and Maximum MSGA Bed Need for Montgomery County**

	Gross Bed Need		Licensed & Approved* Beds		Net Bed Need	
	2016	2018	Feb 2009	March 2010	2016	2018
Minimum	1,007	995	1,068	1,094	-61	-99
Maximum	1,289	1,193	1,068	1,094	221	99

\*There are no outstanding CON-approved MSGA beds in Montgomery County.

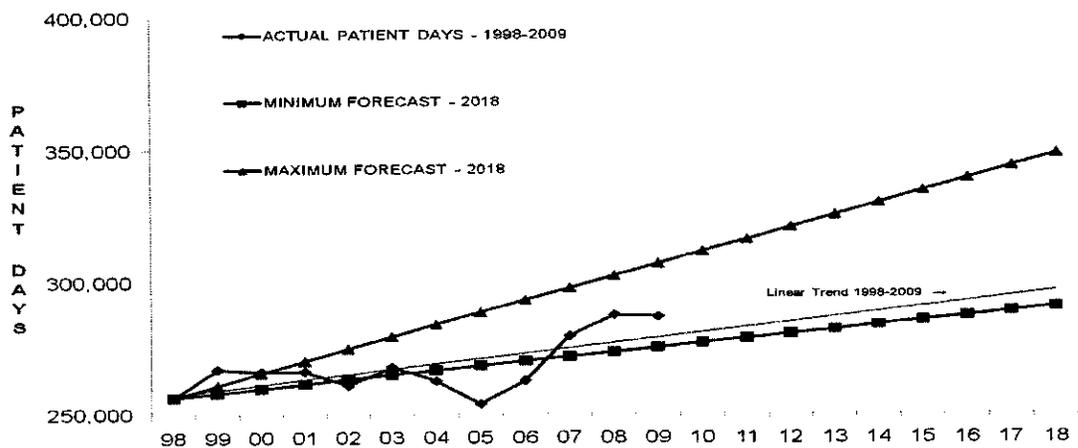
Two hospitals in Montgomery County, HCH-SS and SGAH have reported less patient room space in which to license acute care beds than their licenses would allow in the last two years; an average of 25 beds in Silver Spring, and 32 beds in Rockville. Two other hospitals, Montgomery General and Washington Adventist, have reported excess physical bed capacity for acute care patients in 2009 and 2010: an average of 40 beds and 20 beds, respectively. The fifth hospital, Suburban, reports no discrepancy between acute licensed and acute physical bed capacity over this period, but the accuracy of this self-report has not been determined. (Annual Report on Selected Maryland Acute Care and Special Hospital Services: FY 2011, MHCC.)

This bed need projection is developed by first establishing a baseline forecast of MSGA discharges and average length of stay (“ALOS”) for Medicare and non-Medicare patients for the five hospitals in the jurisdiction, assuming that the per capita rate of discharges and the ALOS, age-adjusted, is static and that each hospital will maintain its same market share of MSGA discharges in the future. Thus, the baseline forecast predicts changes in demand for MSGA beds related solely to population growth or decline in the service area and the aging of the population. This baseline forecast is then adjusted, based on predictions of how the MSGA discharge rate and ALOS, by the two payer groups, are likely to change in the future. Observed trends in the

statewide MSGA discharge rate and ALOS during both the last five years and the last ten years are used as a basis for this prediction. The “minimum” forecast is produced by using the lowest observed rate of positive change when the average annual rate of change in the discharge rate and in ALOS for the five-year and ten-year period are compared or the highest observed rate of negative change in these variables. The “maximum” forecast is produced by using the highest observed rate of positive change when the average annual rate of change in the discharge rate and in ALOS for the five-year and ten-year period are compared or the lowest observed trends of negative change in these variables. Thus, when trends in discharge rates and ALOS are relatively stable in the decade preceding a base year used for forecasting, the range of minimum and maximum utilization forecasts, and, thus, the bed need forecast, will have a relatively narrow range. Conversely, if trends in discharge rates and ALOS have a sharper degree of slope or change in the preceding years, the range between the maximum and minimum forecast is larger, which should be expected, given that the more rapid pace of change occurring in population demand for beds and/or length of hospital stay, usually implies more uncertainty about future demand.

An occupancy rate scale is used to translate the utilization forecast into a bed need projection. Each hospital in Montgomery County is large enough that the SHP assumes that the average daily census can be managed at an annual average occupancy rate of 80%, approximately 9% higher than the occupancy rate assumption used annually to translate observed acute care hospital census into a maximum licensed bed capacity. The following Chart graphs the linear trends in predicted MSGA patient days implied by the 2018 SHP forecast and reported MSGA days in 1998 and the chart also shows the trend in actual MSGA patient days reported by the five hospitals from FY1998 to 2009.

**CHART 1: HISTORIC and PROJECTED MSGA PATIENT DAYS (CY1998-CY2018)  
MONTGOMERY COUNTY ACUTE CARE GENERAL HOSPITALS**



SOURCE: HSCRC HOSPITAL DISCHARGE DATA BASE AND MHCC BED NEED FORECAST

If the most “conservative” positive trends and the most “robust” negative trends observed statewide in the Medicare and non-Medicare MSGA discharge rates and MSGA ALOS are used

to adjust the Montgomery County baseline forecast, the State Health Plan methodology (using a base year of 2008) predicts that no addition to the current licensed bed inventory will be needed in the County through 2018. And, if the most robust positive trends and the most conservative negative trends observed statewide in the Medicare and non-Medicare MSGA discharge rates and MSGA ALOS are used to adjust the Montgomery County baseline, the State Health Plan methodology predicts that approximately 120 MSGA beds more than the current licensed bed inventory will be needed in the County by 2018 to meet demand without experiencing an average annual occupancy rate that compromises bed availability during most days of the year. So, the SHP forecast range indicates that consideration of authorizing additional bed capacity for MSGA patients within the scope of one of these proposed projects is warranted.

Since the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need methodology in Regulation .05 is negative, there is no need for additional MSGA beds in the County at the minimum projection and the additional beds cannot be developed based on part (c)(ii).

The case made by each applicant with respect to the need for MSGA beds in its project and the relationship to the minimum jurisdictional bed need projection, which, of necessity, addresses Parts (c)(iii) and (c)(iv) of the standard, is summarized as follows:

#### Applicants' Responses

##### Clarksburg Community Hospital

CCH seeks to demonstrate a need for MSGA beds above the minimum jurisdictional bed need projection in accordance with part (c)(iii) by examining the annual change in patient days reported by Montgomery County hospitals from 2004 through 2009, using actual data for the period 2004 through 2008 and annualized 2009 data, based on two quarters. CCH calculated an average annual change of 3.37% over this time period and projected continued growth in patient days at this rate through 2016. The result was a projected gross need for 1,267 beds in the County by 2016 at 80% average annual occupancy, which is more than the minimum gross need of 1,007 beds previously projected by the Commission for 2016 but less than the maximum gross need of 1,289 beds.

CCH has since updated its projections based on a complete 2009 year. The average annual change in MSGA patient days for all Montgomery County hospitals for years 2004 through 2009 was 1.99%. CCH applied this growth to the years 2010 through 2018. The result is a projected gross bed need of 1,172 beds in 2018 at an 80% average annual occupancy rate. This is also more than the Commission's updated 2018 minimum gross bed need of 995 but less than the maximum projected gross bed need of 1,193, and would suggest a net need for 96 additional beds based on the current 1,076 licensed bed figure.

To determine the need for, and project the future utilization of the 70 MSGA beds proposed for its hospital, CCH examined the utilization patterns of the residents of its 13-zip code area ESA and the average annual changes in discharge rates and in ALOS over a five and ten year period for the two age groups used in the SHP jurisdictional projections (15-64 and

65+). The average annual changes over the five-year period from 2004 to 2009 (annualized) were applied to the projected 2015 population. The result is a projected need for 170 beds compared to the estimated 140 beds that currently serve the area. Therefore, according to CCH's analysis, there would be a need for 30 additional MSGA beds to meet the needs of the service area. CCH then examined the discharge data from the proposed service area to determine what proportion of its total discharges would have likely gone to CCH had it been operating in FY 2008. CCH projects that it will capture a 34.5% market share of its service area's patient days in 2015 (CCH #39, p. 86). CCH is also projecting that SGAH's market share of patient days will decrease from 47.6% in 2009 to 19.2%, a decrease of 34 beds in the number of SGAH beds serving CCH's ESA, and that Frederick Memorial Hospital's ("FMH") market share will decline from 16.1% in 2009 to 10% in 2015, a decrease of six beds in the number of FMH beds serving the area. CCH projects that the market shares of the other Montgomery County hospitals (HCH, Suburban Hospital, and Montgomery General Hospital) and all other Maryland hospitals will remain the same as in 2009, and, if they remain the same, the number of MSGA beds at these hospitals that would be serving the expected ESA of the proposed hospital will increase slightly (two beds each for Suburban and MGH, one bed for HCH-SS, and 6 beds for all Maryland hospitals outside Montgomery County). The 34.5% market share would be equivalent to 59 of the 170-bed need in the service area. CCH assumes that the proposed service area would account for 85% of its utilization, which would mean that the new hospital would need the 70 MSGA beds proposed.

#### Holy Cross Hospital-Germantown

HCH-G takes the position that it only has to demonstrate the need for 36 additional MSGA beds at the proposed Germantown hospital because it is proposing to relocate 39 licensed MSGA beds from the existing HCH-Silver Spring campus, 29 of which are "paper" beds, i.e., licensed beds in excess of the physical capacity of the Silver Spring campus, based on 408 licensed beds as of July 1, 2008 and a physical bed capacity for 379 beds.

HCH-G attempts to demonstrate the need for the MSGA bed capacity at the proposed hospital in Germantown, which would bring the total number of MSGA beds in the County further above the minimum projected need but not above the maximum projected need, pursuant to part (c)(iii) by two methods. The two methods used the same basic methodology for projecting the bed need for the 18-zip code area ESA with one significant variation; the first method used FY 2009 MSGA discharges and patient days from all Maryland hospitals and the second method used FY 2009 MSGA discharges and patient days from the five Montgomery County hospitals. Both methods involved multiplying the fiscal year 2009 hospital discharge rates by age group (15-64 and 65+)<sup>8</sup> for the population residing in each zip code area in the new hospital's ESA by the projected 2018 population by age (15-64 and 65+) for each ESA zip code area<sup>9</sup> and the FY 2009 ALOS for each age group for each of these zip code areas to arrive at the

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<sup>8</sup> In the first method, the discharge rate was derived by dividing the discharges from all Maryland hospitals by the 2009 population estimates and in the second method by dividing the discharges from the five Montgomery County hospitals by the 2009 population estimates.

<sup>9</sup> The 2018 population projections by age group by zip code were prepared by Holy Cross by extrapolating based on the growth rate from the 2009 estimated population to the 2014 projected population (both the 2009 estimates and the 2014 projections were prepared by Claritas).

projected MSGA 2018 patient days from each zip code area. The results was summed and divided by 365 to arrive at a projected FY 2018 average daily census (“ADC”) of patients from the ESA zip code areas. Only discharges of Maryland hospitals were considered in this analysis.

The bottom line result of this method by HCH-G is a forecast that 395 MSGA beds will be needed to serve the service area in 2018 and, with 296 MSGA beds having served the areas in 2009, 99 additional beds would be needed by 2018. The second approach used by HCH-G, limited in scope to the five Montgomery County hospitals rather than to all Maryland hospitals, results in a forecast for 353 beds by 2018 in an area served by 262 beds, suggesting a need for 91 additional beds.

HCH-G also applies a bed need methodology to the ESA of the proposed hospital based on the Commission’s jurisdictional bed need methodology in accordance with part (c)(iv). Using this methodology, HCH-G calculated average annual change in use rate (discharge rate) and the change in ALOS over five- and 10-year periods from 1998 through 2008 for the ESA based on actual discharges and patient days for those zip code areas and population by age (15-64 and 65+) from the 1990 and 2000 US Census and 2009 estimates by Claritas. Using this methodology and a target occupancy rate of 75%, HCH-G calculated an additional minimum need for 60 MSGA beds by 2018 and a maximum additional need for 117 MSGA beds. Again, only Maryland hospital discharges were considered.

HCH-G updated this methodology in pre-filed testimony for the evidentiary hearing using actual calendar year 2009 discharges and ALOS, 2010 estimated population, and 2015 projected population data, obtained from Claritas. With the additional year of utilization data, HCH-G calculated the average annual change in discharge rate and the change in ALOS over the five-year period from 2005 through 2009 and the ten-year period 2000 through 2009. Applying these rates of change to the actual 2009 data and to population, as estimated for 2010 and projected for the years 2011 through 2019<sup>10</sup>, HCH-G projected an additional minimum need of 63 MSGA beds and a maximum additional need of 147 MSGA beds in 2019 for the ESA. HCH-G now anticipates that the Germantown hospital would open in 2014 and would reach full utilization in 2017. The projection methodology for the service area described above projects a minimum need for 49 beds in 2017 and a maximum need for 112 beds. HCH-G states that the number of MSGA beds proposed for the Germantown hospital is justified even at the minimum projected bed need because HCH-G is only proposing to add 36 beds (75 MSGA beds minus 39 licensed beds not in operation at the Silver Spring campus and, thus, “relocated” from the Silver Spring campus).

### Interested Party Comments

#### HCH-G Comments on the CCH Application

Although HCH-G did not specifically comment on the consistency of the Clarksburg proposal with this standard, the pre-filed testimony of Annice Cody, Vice President of Strategic

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<sup>10</sup> The 2011 through 2014 populations were calculated by interpolating between the 2010 population as estimated by Claritas and the 2015 population projected by Claritas. The 2016 through 2019 populations were extrapolated based on the growth rate from the 2010 population estimate to the 2015 projections.

Planning at HCH, addressed the reasonableness of the market share assumption. Ms. Cody analyzed CCH projections of cases and CCH market share for the expected ESA. Ms. Cody pointed to CCH's projection of 6,343 cases (5,143 MSGA and 1,200 obstetrics discharges) in 2015 (projected 3<sup>rd</sup> year of operation), of which 85% (5,392) are expected to come from the ESA, and CCH's projection of total discharges from the ESA of 13,843 (11,443 MSGA and 2,400 OB discharges) (CCH #39, p. 93 & Att. 8). Ms. Cody concluded that CCH is projecting that it will capture 39% of the total MSGA and obstetric cases from the service area, and compared this to the market share achieved by other hospitals of similar size and distance from their closest competitors, excluding hospitals that are the sole provider in their county. The comparison is as follows:

**Table 24: HCH-G Analysis of Market Share Capture by Existing Hospitals and CCH Proposed Capture**

Hospital	Laurel	Harford Memorial	Montgomery General	Proposed Clarksburg
<b>FY 10 Licensed Beds or Proposed Beds</b>	95	105	170	86 Proposed
<b>Market Share in 85% Service Area</b>	6%	23%	13%	39% Projected
<b>Closest Hospital</b>	Holy Cross	Union of Cecil	Holy Cross	Shady Grove
<b>Time/Distance to Closest Hospital</b>	20 min./14 mi.	24 min./17 mi.	21 min./11 mi.	15 min./12 mi.
<b>Second Closest Hospital</b>	Howard County	Upper Chesapeake	Laurel	Frederick
<b>Time/Distance to 2<sup>nd</sup> Closest Hospital</b>	21 min./14 mi.	26 min./20 mi.	26 min./13 mi.	19 min./18 mi.

Source: Annice Cody pre-filed testimony, (GF #92, p. 3)

Comments of Adventist Entities on the HCH-G Application

The Adventist Entities state that HCH-G has failed to demonstrate how the applicable law permits the movement of beds licensed at Holy Cross's Silver Spring campus, based on its utilization, to a new, separately licensed hospital in Germantown. (HCH #87, p. 2) Of the 75 MSGA beds proposed for HCH-G, Holy Cross proposes to relocate 39 beds from its Silver Spring campus, which was the difference between the number of beds licensed at the Silver Spring campus as of July 1, 2008 (408 beds) and proposed capacity of the Silver Spring campus after completion of its proposed modernization project (369 beds). The Adventist Entities state that "these licensed beds are based on the past utilization of Holy Cross Hospital in Silver Spring, in lower Montgomery County, not on the need for additional beds upcounty."<sup>11</sup>

These comments were amplified in the pre-filed testimony of Richard J. Coughlan, a consultant to CCH. Coughlan pointed out that, at the time of HCH-G's original application, HCH was licensed for 294 MSGA beds, which was 31 beds, not 39 beds, more than the 263 bed capacity proposed in the Silver Spring modernization project CON (Docket No. 08-15-2287). Mr. Coughlan testified that there is no way of forecasting the actual number of MSGA beds a hospital will be designating to license as MSGA beds at some future time (such as when the proposed Germantown hospital would open, if approved). He further stated that "the future number of licensed beds will not be determined until actual utilization of HCH-SS takes place,

<sup>11</sup> March 25, 2009 Adventist Entities' comments on the original HCH-G application. (HCH #52, pp. 10-11)

and HCH-SS determines how many of its total licensed beds will be assigned to MSGA....”<sup>12</sup> Mr. Coughlan argues that future licensure status, through the annual licensure process, does not make such beds available for relocation elsewhere.

#### Applicants’ Responses to Comments

##### Clarksburg Community Hospital

CCH did not specifically reply to comments on this standard.

##### Holy Cross Hospital-Germantown

HCH-G maintains that the transfer of unavailable licensed bed capacity from Holy Cross Hospital in Silver Spring to a new hospital in Germantown is both legal and an efficient way to manage available capacity. HCH-G also argues that, even if the transfer of licensed beds from its existing hospital in Silver Spring to the proposed hospital in Germantown is not permitted, the 75 MSGA beds proposed for Germantown is justified by both the HCH-G and CCH need methodologies. (HCH #91, pp. 2-3)

#### Analysis and Findings

The Commission finds that the service area-level analysis should serve as the basis of its consideration of this standard. The multi-hospital nature of Montgomery County provides initial support for this approach. Review of the analyses presented by the applicants, and further examination of existing hospital service areas and the expected services areas of the applicants and future bed need likely in these areas, strengthen the Commission’s views in this regard. These analyses indicate that a service-area level evaluation for Montgomery County is appropriate [the alternative outlined at Part (c)(iv) of the standard] and that the HCH-G plan for a hospital serving the northern sections of the County is supported by this alternative approach to consideration of bed need.

The proposed projects would add MSGA beds equivalent to between 6 and 7% of current licensed acute care capacity, if only one is implemented; approximately 13.5% if both were implemented. As noted in the introduction to this standard, the jurisdictional level need projection has a range of 198 beds, which is approximately 18% of the licensed MSGA bed capacity in Montgomery County. At a minimum, the forecast predicts that Montgomery County hospitals would be adequately supplied with beds in 2018 if real capacity in that year were approximately 7.5% less than current licensed bed capacity. At the high end, the forecast suggests that more bed capacity than that currently licensed should be put in place by 2018: just under 11% more. Part (c)(iii) of the standard is not an alternative that allows for the context in which to best consider competing new hospital proposals; it tends to, at best, serve as an elaboration of the jurisdictional bed need projection.

HCH-G, using Part (c)(iv) of the Standard, applied a use-rate based projection methodology and employed assumptions and targets derived from the methodology outlined in

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<sup>12</sup> August 9, 2010 prefiled testimony of Richard J. Coughlan.

Regulation .05, projecting future patient days and bed need based on discharge rate and ALOS trends for the 18-zip code area ESA that support its proposed project.

CCH's analysis only applied the average annual change in the discharge rate and ALOS over the last five years in its service area-based bed need analysis. The methodology used does not select the lowest and highest rate of change from the five and ten-year average annual rates of change to produce a minimum and maximum bed need, as outlined in regulation. The CCH methodology only demonstrates the need for 30 additional MSGA beds to serve the ESA in 2015. If this methodology were simply applied to the projected 2018 population used by CCH (the last year of population projections by CCH), the result would be the need for an additional 52 beds, not the 70 beds proposed.

Each applicant claims that the proposed beds are needed even at the projected minimum need because some patients currently served by other hospitals will receive treatment at the new hospitals. HCH-G states that it is only adding 36 MSGA beds because it is relocating 39 beds already licensed at HCH-SS (75 beds minus 39 beds equals 36 beds). CCH argues that such beds are not available to be relocated from HCH-SS to a new hospital site.

The Commission notes that this use of "paper" licensed bed capacity is not explicitly envisioned in the State Health Plan as a basis for justifying new bed capacity at locations other than the hospital that experienced the use that generated the licensed bed calculation for that hospital.<sup>13</sup> However, the existence of such paper beds does unquestionably alter the manner in which the net need calculation produced by the SHP methodology must be interpreted, given that this final step expresses net need based on the licensed rather than the actual existing bed inventory. There is some logic, given the way in which licensed bed totals are generated in Maryland, in the general theme of the argument made by Holy Cross. HCH-SS is generating licensed bed capacity from demand expressed at Silver Spring that, to some extent, arises in HCH-G's expected service area. HCH has not developed all of this licensed bed capacity at its Silver Spring campus and has demonstrated that doing so, in a way that creates modern and functional bed capacity is not something that can be easily accomplished with the current HCH-SS physical plant and is not the best geographic approach to deploying additional bed capacity for the future population distribution of Montgomery County. Under existing law, HCH-SS could add this additional bed capacity and, from a regulatory standpoint, need considerations would not be a basis for denying the hospital that opportunity. A hospital with more licensed beds than physical bed capacity has a basis for claiming that a proposal to develop a satellite hospital can embody, to some extent and under certain circumstances, a preferable alternative to putting this licensed capacity into operation at its existing campus, given that development of a new hospital can reasonably be projected to involve some transfer of demand to the new location and putting all of the licensed beds into operation at the existing campus may be difficult, for a variety of reasons. As noted above, HCH-G makes this argument, which will be further discussed later in this report. A similar situation can also be inferred between Shady Grove Adventist Hospital, which has recently modernized its bed capacity and has physical capacity operating at the facility below its licensed bed capacity and the proposed CCH project.

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<sup>13</sup> The number of licensed beds effective July 1<sup>st</sup> is calculated based on 140% of the ADC for the 12 month period ending the prior March 31<sup>st</sup> (71.4% occupancy) and the number of beds for each service are designated by each hospital to equal the total number of licensed beds.

However, unlike HCH-SS, SGAH has the ability to return some areas of its hospital that are still configured as patient room space back into service with fairly modest renovations, an alternative it has indicated to MHCC that it wants to undertake.

Under Maryland hospital bed licensure law, the number of licensed beds in the future will be based on the actual utilization of those beds in future years, whether or not a decision on the HCH-G application takes into account the difference between the current number of licensed MSGA beds on the Silver Spring campus and the current and proposed (Docket No. 08-15-2287) physical capacity of that campus,. The number of such beds is unknown and subject to change on an annual basis based on both changes in utilization of the hospital by inpatients (total patient days) and by the hospital's decision on the number of beds to designate for each service. Since 2008, the number of licensed beds at HCH-SS has declined slightly as a result of Maryland's dynamic licensure law which establishes the number of licensed beds for each hospital effective for the year beginning each July 1 at 140% of each hospital's average daily census ("ADC") for the 12-month period ending the prior March 31. As a result of this calculation, HCH-SS's licensed beds have declined from 408 beds effective July 1, 2008 to 404 licensed beds as of July 1, 2009 and to 402 licensed beds as of July 1, 2010. Therefore, the number of licensed beds in excess of the proposed physical capacity has declined from 39 beds to 33 (402 minus 369). Under HCH-G's reasoning, the number of MSGA beds that HCH-G would have to justify as needed by the proposed hospital is currently 42 instead of the original request for 36. The number of licensed beds in excess of HCH-SS's physical capacity in three to five years when the Germantown hospital would be ready to open is, of course, not known.

Notably, HCH-G did not project bed need based on the number of licensed beds and the 71.4% occupancy rate (140% of ADC) used to calculate licensed beds under the dynamic licensure law, but projected bed need based on the actual number of MSGA beds used in Maryland hospitals by residents of the ESA in calendar year 2009 and the number of beds needed assuming an average occupancy of 75% or 80% (occupancy targets from the SHP).

HCH-G estimated that 74% of the 1,475 HCH-SS MSGA inpatients from the ESA in FY 2008 would have gone to HCH-G if it were available. (HCH #30, p. 114R) For calendar year 2009, HCH-SS reported a total of 74,185 MSGA patient days, of which 6,516 were from residents of HCH-G's ESA. If 74% of these patient days would have occurred at the Germantown hospital if it had been available, a total of 4,821 days would have shifted, which is an ADC of 13.2. At 80% occupancy, this volume would have needed 16.5 beds.

Regarding CCH's application of a service area MSGA bed need analysis under Part (c)(iv), after examining the discharge data from CCH's proposed service area, CCH concluded that it will capture 34.5% of the patient days in 2015, which will decrease SGAH's market share of CCH's ESA from 47.6% in 2009 to 19.2% of patient days in 2015, reducing the number of SGAH MSGA beds serving the ESA by 34 from 67 to 33. CCH also concluded that FMH's market share of patient days from CCH's ESA would decrease from 16.1% in 2009 to 10.1% in 2015, reducing the number of FMH MSGA beds serving the ESA by six from 23 to 17. However, it does not appear that Adventist HealthCare is taking into account this projected shift in bed utilization in its plans for SGAH and, further, there is no indication of how this projected shift in beds from FMH will affect the bed capacity of that hospital. In the case of SGAH, a

determination has been requested concerning the applicability of CON regulations to an increase in its physical capacity to 255 MSGA beds to match the number of its designated licensed MSGA beds. SGAH has submitted a CON application to increase its MSGA physical bed capacity to 263 beds.

In order to give full consideration to this standard, which is based on a bed need projection method that, of necessity for a jurisdiction with multiple hospitals like Montgomery County, aggregates multiple hospital forecasts, the Commission also analyzed hospital service areas and the applicants' ESAs that were used as a basis for replicating the SHP's bed need projection methodology. This analysis employs the County, rather than the entire State, as the basis for adjusting baseline forecasts derived from the service areas.

Hospital service areas were defined for seven hospitals, the five in Montgomery and two border county hospitals with substantial overlap with existing Montgomery County hospital service areas and/or a new hospital site's ESA. The service areas were constructed from zip code areas with the goal of accounting for 90% of each hospital's discharges in 2008 from contiguous zip code areas. The result is service areas that ranged from 35 zip code areas to 89 zip code areas. Maps of these areas are shown in Appendix C.

**Table 25: Contiguous "90%" Hospital MSGA Service Areas**

Hospital	Number of Zip Code Areas in the Service Area	Total MSGA Discharges Originating in the Service Area	Market Share of MSGA Discharges* Originating in the Service Area
<b>Frederick Memorial</b>	35	91.7%	42.11%
<b>HCH-SS</b>	68	90.1%	8.68%
<b>Laurel Regional</b>	52	91.0%	3.95%
<b>Montgomery General</b>	48	91.3%	10.22%
<b>Shady Grove Adventist</b>	37	90.6%	20.73%
<b>Suburban</b>	67	90.1%	9.52%
<b>Washington Adventist</b>	89	89.8%	6.20%

\*Discharges from Maryland and D.C. Hospitals only  
 Source: HSCRC Discharge Data Base and D.C. Hospital Discharge Data Set

The ESAs identified by the applicants are both identified as "85% service areas," i.e., the ESA is projected to provide 85% of the proposed new hospital's total discharges. HCH-G specified an ESA of 18 zip code areas, all in Montgomery County. CCH specified an ESA of 13 zip code areas, four of which are in Frederick County.

Historical population data (1990 and 2000), current population estimates (2009), and projected population for 2014 prepared by Applied Geographic Solutions, Inc. ("AGS") were used in the service area analysis. The populations for intervening years (1998 and 1999 and 2001 through 2008) were interpolated in order to calculate discharge rate trends, with the 2019 population for each zip code area projected by applying a change factor (to account for mortality and migration) to each 5-year 2014 age cohort. The change factor was derived from the change in each 5-year age cohort from the 2009 estimate as it aged to the next 5-year age cohort in the projected 2014 population. For example, the projected 2014 population 65 to 69 was compared to the 2009 population estimate for the 60 to 64 age cohort and the change factor was calculated. Then this change factor was applied to projected 2014 population 60 to 64 to derive the 2019

projected population age 65 to 69. The projected population by age and zip code area were proportionately adjusted for the projected total 2019 population by zip code area prepared by AGS. A 2018 population projection was then derived through an interpolation of the 2014 and 2019 projections.

A projection methodology was used that aligns with the SHP’s projection methodology as much as possible, given that actual service areas are established as a basis for the analysis. A comparison of the change in population from 2000 to 2008 for all Montgomery County zip code areas, for each hospital’s service areas, and for the ESAs of each of the proposed new hospitals is detailed in the following table.

**Table 26: Historic Population Change 2000 to 2008**

Service Area	Number of Zip Codes	Population 15 - 64			Population 65 & Older		
		2008 Est. Pop.	Change from 2000	Percent Change	2008 Est. Pop.	Change from 2000	Percent Change
Montgomery County	42	623,577	32,303	5.5	117,023	18,782	19.1
Frederick Memorial	35	247,788	30,628	14.1	43,131	6,911	19.1
HCH-SS	68	1,368,142	33,853	2.5	231,585	33,093	16.7
Laurel Regional	52	972,138	27,945	3.0	150,611	28,997	23.8
Montgomery General	48	757,030	48,104	6.8	130,032	25,225	24.1
Shady Grove Adventist	37	649,569	48,162	8.0	116,230	20,970	22.0
Suburban	67	1,236,942	60,931	5.2	212,381	32,133	17.8
Washington Adventist	89	1,656,898	64,660	4.1	265,440	42,463	19.0
HCH-Germantown	18	255,730	23,539	10.1	34,333	9,129	36.2
Clarksburg Community	13	102,082	18,537	22.2	11,247	4,943	78.4

Source: Spatial Insights projections, as interpolated.

The 2018 population for each zip code in the service area of at least one of the subject hospitals for at least one service was projected, and the projections for the hospitals’ service areas are displayed on the following table.

**Table 27: Projected 2018 Population for Hospital Service Areas**

Service Area	Number of Zip Codes	Population 15 - 64			Population 65 & Older		
		2018 Projected Pop.	Change from 2008	Percent Change	2018 Projected Pop.	Change from 2008	Percent Change
Montgomery County	42	605,968	-17,609	-2.8	160,789	43,766	37.4
Frederick Memorial	35	271,766	23,978	9.7	62,143	19,012	44.1
HCH-SS	68	1,267,145	-100,997	-7.4	309,431	77,846	33.6
Laurel Regional	52	902,713	-69,425	-7.1	210,211	59,600	39.6
Montgomery General	48	747,571	-9,459	-1.3	186,860	56,648	43.6
Shady Grove Adventist	37	635,792	-13,777	-2.1	146,230	30,000	25.8
Suburban	67	1,212,552	-24,390	-2.0	295,246	82,865	39.0
Washington Adventist	89	1,567,680	-89,218	-5.4	364,211	98,771	37.2
HCH-Germantown	18	257,014	1,284	0.5	53,680	19,347	56.4
Clarksburg Community	13	114,339	12,257	12.0	21,555	10,308	91.7

Source: Spatial Insights projections, as interpolated.

Baseline projected MSGA utilization for 2018 was projected for each hospital, based on actual 2008 discharges and patient days and estimated 2008 population by age (15-64 and 65+) for each zip code area in the defined hospital service area, and on projected 2018 population for each zip code area. The results were adjusted, consistent with the SHP methodology, using

historic discharge rate (discharges per 1000 population) and average length of stay (“ALOS”) trends for all discharges for all 42 Montgomery County zip code areas from all Maryland and District of Columbia hospitals. As previously noted, this replicates the SHP methodology with the exception that Montgomery County experience serves as the basis for adjustment of the baseline rather than statewide trends. The Commission concludes that this is an appropriate way to assess need for MSGA beds in Montgomery County, consistent with both the State Health Plan methodology and underlying principles. The discharge rate and ALOS trends are as follows:

**Table 28  
Average Annual Changes in Discharge Rates and Average Length  
Montgomery County 1998 to 2008**

	Medicare (Age 65 and older)		Non-Medicare (Age 15 – 64)	
	Discharge Rate	ALOS	Discharge Rate	ALOS
<b>Five Year Trend (2003-2008)</b>	-0.47%	-1.65%	-0.34%	-1.13%
<b>Ten Year Trend (1998-2008)</b>	0.63%	-2.03%	0.69%	-0.73%

Source: MHCC data.

As previously noted, the baseline forecast projects how demand in the service areas would change over time, if market share experienced in 2008 is maintained, population use rates and average length of stay, adjusted for age, do not change, and population projections used in this analysis accurately reflect the changes that will occur in population size and age composition. As a first step, a target year 2018 baseline forecast of discharges and patient days was developed for each hospital service area and the two new hospital ESAs. Target values for adjusting the baseline forecast were derived by examining use rate and average length of stay trends for Montgomery County residents, as shown in the immediately preceding table. Average annual rates of change observed over the last five years and the last ten years were used to create the minimum and maximum forecast values shown in the following table.

**Table 29: Montgomery County Target Values**

	2008	2018	
		Minimum	Maximum
Medicare Discharge Rate	252.45	240.8	268.8
Non-Medicare Discharge Rate	66.51	64.3	71.2
Medicare ALOS	5.17	4.21	4.38
Non-Medicare ALOS	4.07	3.63	3.78

Source: MHCC data.

An additional ALOS adjustment is made for each hospital with actual MSGA ALOS in the base year that exceeded its case mix-adjusted ALOS. This adjustment occurred for all of the Montgomery County hospital service areas, for both Medicare and non-Medicare patients, with the exception of Suburban Hospital. This means that the other four hospitals each had an actual MSGA ALOS in 2008 that was too long, when compared with overall statewide experience for the types of inpatient cases each hospital handled. The recent record of length of stay efficiency for the study hospitals is shown in chart form in Appendix D. (See remarks on this issue in Section III.C, *Hospital Utilization Trends*, of this Final Decision.) No case mix adjustment was warranted for non-Medicare patients in the case of the two non-Montgomery County hospitals considered, Frederick Memorial and Laurel Regional.

This approach to alternative analysis of MSGA bed need under Part (c)(iv) produced the following bed need forecast for the hospital service areas. The gross bed need figures shown reflect a final adjustment, in the approximate range of 10% since these are approximate “90%” service areas, to account for the proportion of discharges originating outside of the defined service area.

**Table 30: Gross MSGA Bed Need, MSGA Bed Capacity, and Net MSGA Bed Need  
Seven Selected Hospitals**

	2018 Gross MSGA Bed Need		MSGA Beds		2018 Net MSGA Bed Need			
	Minimum	Maximum	Physical Bed Capacity	Licensed Bed Capacity	Net of Physical Bed Capacity		Net of Licensed Bed Capacity	
					Min	Max	Min	Max
Frederick Memorial	251	312	203	219	48	109	32	93
HCH-SS	271	338	265	288	6	73	-17	50
Laurel Regional	92	114	NA	63	NA		29	51
Montgomery General	153	179	150	121	3	29	32	58
Shady Grove Adventist	340	423	263*	255	77	160	85	168
Suburban	316	394	NA	192	NA		124	202
Washington Adventist	206	257	241	220	-35	16	-14	37

Source: Service areas derived from Maryland HSCRC and DC discharge data bases; population data provided by Spatial Insights; bed inventory data from MHCC records  
\*Reachable with some renovation expense

This approach, when applied to the projects’ ESAs, produces a forecast of MSGA bed demand projected to originate from these areas in 2018. If I accept the applicants’ assumption that these are “85%” expected service areas, it produces the following total MSGA bed need demand forecast for the CCH and HCH-G ESAs. The 85% ESA assumption was not challenged by either applicant or any interested party and is plausible when one compares these ESAs and the “90%” service areas defined by MHCC.

**Table 31: Gross MSGA Bed Need and Implied Bed Need at the New Hospitals at Selected Levels  
of Market Share Capture of Bed Demand  
Two New Hospital Expected Service Areas**

	2018 Gross Bed Need		Demand for Bed Capacity at the New Hospital At Various Levels of Market (Bed Need) Capture			
	Minimum	Maximum	10%	20%	30%	40%
Clarksburg Community ESA	227	282	23 to 28	45 to 56	68 to 85	91 to 113
Holy Cross-Germantown ESA	527	657	53 to 66	105 to 131	158 to 197	211 to 263

Source: MHCC data.

As shown above, the historic service areas of HCH-SS and WAH, located in the southeast quadrant of Montgomery County, near Washington, D.C. are not projected to generate demand for MSGA beds that would require substantial additions to the hospitals’ current physical or licensed bed capacity, a combined range of -31 MSGA beds to 89 MSGA beds, equivalent to 6% fewer physical beds or 18% more physical beds. Growth in demand is more likely to generate a need for more MSGA bed capacity in the service area of Shady Grove

Adventist Hospital, the dominant hospital in upper Montgomery County, which would be tapped by the proposed new hospitals for most of their patients. This service area is projected to need an additional 77 to 160 beds, equal to 29 to 61% of SGAH bed capacity. Suburban Hospital's service area is also expected to generate growth, but the implications are less certain without more knowledge concerning actual physical bed capacity at Suburban. Montgomery General is predicted to need modest growth in physical bed capacity, 3 to 19%. It has been approved to develop more private rooms and also has approved shell space that will allow it meet growth in demand over time with only space finishing expenses.

With respect to the new hospitals' proposed ESAs, this analysis reflects the much larger service area population expected for the HCH-G project when compared with the CCH ESA and the ability of the proposed 75 MSGA beds at HCH-G to be highly occupied with a market penetration of MSGA patients originating in the service area of 10% while the CCH project would need to achieve market penetration in excess of 20% in its expected service area to fill its proposed 70 beds at similar levels. As shown in the preceding table, market share observed to be achieved by Montgomery County hospitals in "90%" service areas ranged from 7 to 21 percent, but only one of the five, SGAH, achieved a market share above 10% in a service area representing this level of importance for a hospital. This strongly suggests that the proposed HCH-G project would be likely to achieve efficient utilization of its proposed MSGA beds by penetrating its expected service area at a level that existing hospital experience indicates is realistic.

The Commission concludes that Part (c)(iv) of the standard is the only option under which the number of beds proposed by either applicant can be shown as needed and that HCH-G has shown under this standard that its proposed new hospital MSGA beds are needed.

The Commission further concludes that, considering MSGA bed need at the hospital service area and new hospital expected service area level, and incorporating the State Health Plan bed need forecasting methodology steps and Montgomery County trends in MSGA bed use, rather than the overall State experience, as a basis for establishing target discharge rate and ALOS values: (1) a redistribution of MSGA bed capacity from the southeastern area of the County, dominated by HCH-SS and Washington Adventist Hospital to the north and central regions of the County, dominated by Shady Grove Adventist Hospital and Suburban Hospital, is consistent with service area patterns and trends; (2) the HCH-G project has a service area that makes it possible and very likely, given the experience of most hospitals, to achieve market penetration that can fully support the MSGA beds proposed over the coming decade; and (3) the service area of the CCH project is such that it is possible but not likely, given the experience of most hospitals, to achieve market penetration that can fully support the MSGA beds proposed for its project over the coming decade.

A service area-based analysis, based on Part (c)(iv) of the standard, establishes that the MSGA beds sought for the HCH-G project are needed, and that the redistribution of the utilization of bed capacity from the southeastern to the north and central areas of the County is both appropriate and expected. Regarding CCH, the Commission concludes that, given its expected service area and the experience of most hospitals, it is not likely to achieve market penetration that can fully support the MSGA beds proposed for its project over the coming

decade. For these reasons, the Commission finds that HCH-G has demonstrated consistency with this standard, and that CCH has not demonstrated consistency with this standard

**(3) Minimum Average Daily Census for Establishment of a Pediatric Unit**

*An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:*

- (a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or*
- (b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.*

This standard does not apply to these projects. Neither applicant proposes pediatric beds at its new hospital.

**(4) Adverse Impact**

*A capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The Commission will grant a Certificate of Need only if the hospital documents the following:*

- (a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and*
- (b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.*

This standard, which can only be applied to consideration of projects proposed by existing hospitals, does not apply to these projects.

**(5) Cost-Effectiveness**

*A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.*

- (a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:*
  - (i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;*
  - (ii) Detail the capital and operational cost estimates and projections developed by the*

## Holy Cross Hospital-Germantown

HCH-G cites the following design features as “enhancing patient safety:” (1) all private rooms, eliminating “room-mate” transmission of infections; (2) nursing unit design ensuring proximity of key services and reduced travel time, from the ED to imaging, from the surgical suite to the intensive care unit, from the ED to the intensive care unit, and from labor and delivery rooms to post-partum OB beds; (3) standardized nursing unit designs that enhance visibility, reduce noise, integrate computerized medical record-keeping capabilities, including computerized physician order entry, protocol-based ordering, and automatic drug interaction analysis. (HCH #30, p.53)

### Interested Party Comments

No comments were received regarding either applicant’s compliance with this standard.

### Analysis and Findings

The specific examples noted by each applicant will likely enhance patient safety at its proposed hospital. The Commission finds that CCH and HCH-G have each met the patient safety standard.

### **(13) Financial Feasibility**

*A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.*

*(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.*

*(b) Each applicant must document that:*

*(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;*

*(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;*

*(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and*

*(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital’s primary service area population.*

## Applicants' Responses

### Clarksburg Community Hospital

CCH states that its proposal is financially feasible based on the utilization and financial projections presented in its CON application. It supports the reasonableness of its assumptions based on the reasonableness of the service area it defined for CCH, which served as the basis for its utilization projections, the reasonableness of assuming a hospital opening in January 2013, and the achievement of full occupancy within three years.

In its third year of operation, CCH projects that its proposed primary service area will need 119 to 146 MSGA beds. The hospital anticipates a 58% market share of MSGA patients in its primary service area (the area from which 60% of total MSGA and obstetric discharges are anticipated). It assumes that 16% of emergency department patients will be admitted and that this group will comprise 59% of total admissions. It states that the assumptions concerning the ALOS and the acuity, or case mix intensity ("CMI"), of the projected patient population were based on the relative paucity of more highly specialized services available at CCH when compared with SGAH or Frederick Memorial Hospital.

Key financial assumptions made by CCH included: (1) an assumed standard charge per case ("CPC") of \$9,800 and, based on adjustments, an FY 2015 case mix-adjusted ("CMA") CPC of \$8,563; (2) an assumed outpatient charge ("OP") of \$510 for ED visits, \$2,500 for ambulatory surgery cases, and \$1,000 for endoscopy cases (note: imaging charges and other OP service charges were not listed.); (3) bad debt, contractual allowance, and charity care were projected at 4.0%, 7.0% and 3.0% of gross patient service revenue, respectively; (4) salaries per FTE were stated to be based on SGAH historical experience; (5) other operating expenses were stated to be based on historical experience at SGAH; (6) depreciation of building and fixed equipment at 22 years, depreciation of major moveable equipment at 8 years; (7) debt financing for project through a tax exempt bond issue of \$135,885,000 with a term of 33.5 years and a 5.75% interest rate; (8) a 18-month construction period; (9) a debt service fund at 3%, construction fund of 1.5% and capitalized interest fund at 1.5%; (10) a 10 year level debt service working capital loan at \$20,000,000 and 4.0% interest; and (11) interest earnings of 4% on cash balances greater than, \$5,000,000 and 2% below \$5,000,000.

CCH provided audited financial statements for Adventist HealthCare, Inc. and stated that future patient charges will remain consistent with the rates approved for the hospital by HSCRC.

### Holy Cross Hospital-Germantown

HCH-G states that its utilization projections are "consistent with existing utilization adjusted for population growth and aging" and also cites the projected 22% market share of HCH-G in the ESA as comparable to the market share of the five existing Montgomery County hospitals in the areas from which they draw 85 percent of their patients, which it states range from 11% to 27%. With respect to obstetric utilization, HCH-G states that it anticipates that the new hospital will result in a shift of patients who live within the ESA who are currently drawn

from this area to HCH-SS. It states that it can utilize the proposed OB beds at HCH-G by “shifting” only 63% of the ESA patients currently using HCH-SS. It states that its six psychiatric beds can be supported by drawing 5% of the County’s total adult psychiatric admissions and that utilizing the proposed HCH-G emergency department capacity will require a market share of 13.7% of the ED demand in the ESA. The applicant states that it arrived at its ED use projections by stratifying its projected discharges at HCH-G by 30 service lines and applying a percentage of “ED admits” for each line, which results in a projection that 3,985 of its projected 6,396 discharges in FY 2015 will be patients first encountered in the ED. It then assumed that this ED admit total of 3,985 will represent 18% of total ED visits, based on recent experience at HCH-SS. It states that it used national outpatient surgery use rates, adjusted for Montgomery County’s age mix, to project demand for outpatient surgery volume and that its utilization projections imply capturing 15% of the ESA’s total projected hospital-based outpatient surgery volume.

HCH-G states that its revenue estimates for the new hospital are consistent with HSCRC’s methodology for similar hospitals and with the experience of HCH-SS. For inpatient revenue, it took a statewide charge per case and adjusted it for the SGAH payer mix, payer service mix projected for the new hospital, the labor market (assumed to be the same confronted by HCH-SS), medical education (no teaching programs at HCH-G), and capital costs, consistent with HSCRC’s methodology. Outpatient charges were projected on the basis of FY 2009 service line experience at HCH-SS.

The experience of HCH-SS is also cited as the basis for the HCH-G assumptions concerning contractual allowances, charity care, bad debt, other uncompensated care, as well as staffing, salary, benefit expense, and supply expense projections.

With respect to revenue, HCH-G established a statewide charge per case using an inpatient statewide Reasonableness of Charges calculation, and this was adjusted for: (1) payer mix (using SGAH as the most pertinent model); (2) the labor market (same as HCH-SS); (3) medical education (assumed no teaching program at the new hospital); and (4) capital (50% hospital specific and 50% hospital statewide average), consistent with contemporary HSCRC practice. The FY 2010 target for the new hospital was determined to be \$9,940 at a case mix of 1.0 (increased 4.2% in FY 09 for HSCRC approved rate increase).

HCH-G’s average outpatient charges were derived from HCH-SS experience applied to forecasted volumes (increased 4.2% in FY 09 for HSCRC-approved rate increase). Contractual allowance and charity care were projected based on HCH-SS experience at, respectively, 9.36% and 4.2% of gross patient service revenue. Bad debt was estimated at 2.3% based on the experience of SGAH. Staffing levels were forecasted as 4.8 FTEs per adjusted occupied bed. Expenses were forecasted based on expenses per adjusted patient day ratios experienced at HCH-SS.

HCH-G projects profitability by the third year of operation.

## Interested Party Comments

### Comments of HCH-G on the CCH Application

HCH-G states that CCH failed to demonstrate that its proposed project is financially feasible because financial feasibility is dependent upon achieving projected volumes. HCH-G believes that CCH's utilization projections are unrealistic because they rely on achieving a level of market share in the CCH service area that is too high and lacks any "analytical foundation." HCH-G presents a market share analysis of what it considers to be comparable hospitals to CCH; Laurel Regional, Harford Memorial, and Montgomery General. It concludes that these hospitals achieved total inpatient market share in "85%" service areas ranging from 6% to 23% and contrasts this with the 39% projected by CCH. It also notes what it sees as an "inconsistency" in the inpatient market share and surgical market share projections developed by CCH.

Secondly, HCH-G states that CCH fails to demonstrate that its proposed project is financially feasible because it does not have the financial resources to implement the project. It relies on an analysis by Navigant Consulting that concludes that AHC will not be able to borrow the funds necessary or generate the additional funding necessary to implement the CCH project and the replacement of WAH simultaneously. According to HCH-G, AHC has bond covenants that will present obstacles to funding the projects, it has very weak financial ratios, and a poor "outlook" from the credit rating agency, Moody's. HCH-G concludes that, even if CCH is able to overcome these obstacles, AHC's circumstances will result in high borrowing cost for AHC, higher than the "unrealistic" interest rates that the applicant has assumed.

HCH-G provided a new critique of CCH's utilization projections, as modified in the course of the review, while continuing to state that they are unrealistic and, thus, do not provide support for a finding of financial feasibility. It claims that CCH is projecting that 95% of its MSGA cases will be admitted following emergency room care, in Clarksburg or at the Germantown Emergency Center and that this is unrealistic, noting that CCH has reduced projected intensive care volume but left the number of intensive care beds the same, leading to an unacceptably low projection of bed occupancy. HCH-G states that, in modifying its projected number of MSGA discharges, CCH has assumed that the assumptions about the patient discharges reduced are inconsistent with CCH's high reliance on ED patients for admissions. HCH-G reiterates its position that CCH, while now assuming a lower level of market share, is still projecting a share that is too high, relative to the experience of comparable hospitals. HCH-G also reiterates its statement that AHC cannot financially support the two capital projects it currently plans, referencing new analyses done by Navigant and adding analysis done by another consultant, Hal Cohen, Ph.D. Dr. Cohen's analysis is described by HCH-G as identifying faulty financial assumptions used by CCH and AHC.

### Comments of Adventist Entities on the HCH-G Application

CCH states that the HCH-G proposal is "inordinately expensive" and not financially feasible for that reason. (CCH cites three SHP standards, including this one, and two general review criteria, as a basis for this comment, so some repetition between this standard and the viability criterion is inevitable. The comments that seem most applicable to this standard are

summarized.) CCH notes that the HCH-G cost estimate is much higher, on a per bed basis, than the costs approved for the Washington County Hospital replacement (which was completed this year) and the replacement general hospital completed in Allegany County in 2009. It provides an analysis by John Cook, D.Phil., which claims that to break-even under HSCRC rate setting system and HCH-G assumed "Standard Rate," the new hospital would have to achieve non-capital costs in its operation so far below the Maryland experience that it will be unachievable and the hospital will be insolvent. Cook also concludes that HCH-G is overstating projected revenue by assuming a case mix index for medical/surgical patients, 1.12, which is too high for a hospital of the proposed type and size. Cook also points out what he views as errors or unexplained anomalies in the HCH-G financial projections and claims that, revised to correct for the unreasonable case-mix and non-capital cost assumptions, HCH-G would lose \$13.4 million.

After HCH-G's application was modified, CCH provided an additional report from Cook and another from David Cohen, C.P.A., attacking HCH-G's assumptions. Mr. Cohen claims that HCH-G has overstated outpatient revenue, focusing on the ways in which projections of revenue and volume for radiology and respiratory therapy services developed by HCH-G differ from experience at "competing" hospitals and also states that capital costs have been understated, specifically with respect to capitalized interest and construction period inflation. He also says that HCH-G has failed to count as an expense, excess revenue transferred to its parent, Trinity. Cook's comments constitute a rebuttal of the critique of his earlier comments by Cohen and Cross. He reiterates his conclusion that HCH-G is projecting costs for medical/surgical services that cannot be attained and an excessive length of stay, using "peer" hospitals as a base for his analysis. Other material filed by CCH at this time was stricken from the record, after consideration of a motion from HCH-G.

### Applicants' Responses to Comments

#### Clarksburg Community Hospital

CCH stated that HCH-G's comments regarding AHC's inability to fund its two major capital projects, the WAH replacement and CCH, reflects a "mischaracterization" of CCH's method of financing, which will not have a negative effect on AHC given that AHC assets will not secure the bond debt. CCH provided a letter from Don Carlson of Zeigler Capital Markets that reviewed the funding plans for CCH and WAH, which involve obtaining "credit enhanced debt" through the U.S. Department of Housing and Urban Development's Federal Housing Administration ("FHA") 242 program. Carlson gives a positive assessment of that plan being successfully implemented by CCH and WAH on a stand-alone basis, without reliance on other AHC assets to support the financing and also disputes HCH-G's claim that interest rates achievable will be unattractively high.

In responding to later comments, after submission of modified applications, CCH reiterates its refutation that AHC will be unable to fund both CCH and WAH simultaneously, providing a updated critique from Carlson of the Navigant analysis relied on by HCH-G which

also provides an example of an FHA 242 financing from November, 2009 that enabled the New Hampshire Health and Education Facilities Authority to sell bonds with a maximum yield of 5.75%.

### Holy Cross Hospital-Germantown

HCH-G responds that CCH overstates the cost differences between HCH-G and two recent replacement hospitals. As a new hospital, HCH-G will not be able to relocate existing equipment and save on equipment expenses, as can replacement hospitals; it also notes the two examples cited by CCH are much larger hospitals, of 267-275 beds, which obviously allows for a lower per bed cost than the 91-bed HCH-G project, and they are located in Western Maryland, a lower cost region of the state for construction.

HCH-G responds to the Cook analysis with reports by Hal Cohen, Ph.D. and Jeanette Cross, of Navigant Consulting. Dr. Cohen refutes Cook's claim that the money available to HCH-G for non-capital costs is equal to its Standard Rate less its capital cost or that the non-capital cost implied is unachievable. He states that Cook also errs in taking capital cost directly from Table 4, which reflects Generally Accepted Account Principles ("GAAP") in identifying capital costs. However, Dr. Cohen states that financial feasibility does not require generating sufficient revenue to cover GAAP-defined capital costs, as implied by Cook. A hospital is financially feasible if it can obtain rates that allow the hospital to fund interest expenses, principle, and equipment purchases. Depreciation and amortization are "paper costs that do not have to be covered for solvency to be achieved." Dr. Cohen states that HCH-G has this coverage using well-supported assumptions with respect to revenues and expenses.

Cross refutes the validity of the Cook critique of HCH-G cost relative to the peer group employed by Cook. She says that Cook incorrectly used the "HSCRC approved mark-up" to adjust the HCH-G Standard Rate to connect charges to costs and incorrectly assumed that HCH-G will have the same operating margin as the Cook peer group. Cross, adjusting for what she characterizes as Cook's flawed assumptions, calculates a non-capital cost per adjusted equivalent inpatient day for FY 2015 that is 4% above the Cook peer group average rather than 25% below, as Cook concluded. She defends the case mix assumption used by HCH-G, noting that it is based on an assumed increase in case mix index ("CMI") of 0.5% per year, within recently observed trends in CMI.

In responding to the later Cook analyses and the David Cohen analysis, HCG-G provided a second report from Cross, in which she criticizes David Cohen for using a large hospital peer group in his analysis (the Montgomery County hospitals and Frederick Memorial), an inadequate set of radiology charge categories, an arithmetic error, and his focus on a "subset" of outpatient services rather than outpatient services, overall. She presents an analysis that, using what is viewed as a more appropriate peer group of hospitals, shows that HCH-G has outpatient revenue projections that are in line with other hospitals' experience. She also responds to Cook's claim that HCH-G's projections are based on an overstated case mix index by noting that the HCH-G assumption is very close to the CMI of Montgomery General Hospital and below that of Memorial Hospital at Easton and notes that CCH has a higher projected CMI in 2015. She provides a "corrected" version of Cook's peer group analysis of LOS, to support HCH-G's

projection, and also refutes CCH's claims that non-capital costs and capital costs of HCH-G are understated.

HCH-G also provided an affidavit from James W. Bosscher, Senior Vice President and Treasurer of Trinity, which responds to the Adventist Entities' comments concerning understatement of capital cost, asserting that the comments are based on a misunderstanding of how Trinity funds capital projects of its member institutions.

### Analysis and Findings

Both applicants provided responses to this standard that address its requirements. The standard has served as a basis for vigorous comment and response. HCH-G has focused on what it views as a poor case for CCH's "market feasibility" (Part (b)(i) of the standard) and AHC's financial weakness (a concern more directly addressed under the "Viability" criterion, later in this Final Decision). CCH counters, questioning HCH-G's assumptions concerning operational (non-capital) cost projections, case mix and length of stay (which have an impact on revenue projections) and a number of less central points of HCH-G's project performance forecasting and project funding plan. Interestingly, CCH's main analysis suggests the impossibility or high improbability of any new hospital project of modest size, including CCH itself, to comply with this standard, i.e., the requirement in Part (b)(iv) of the standard that hospitals should be able to reasonably project an "accounting profit" and not just positive cash flow within a reasonable time following implementation of a capital project.

On balance, the Commission concludes that HCH-G has made a strong case for its financial feasibility, which rests on a relatively conservative set of assumptions with respect to market feasibility. The HCH-G project is more likely to meet or exceed its utilization projections at the site proposed through a combination of: (1) the shift in patient demand from the Gaithersburg/Germantown area, the core of the expected service area, that currently expresses itself at HCH-SS to HCH-G; and (2) the larger nominal growth in population concentrated in this Gaithersburg/Germantown core and the larger ESA. As previously outlined under the MSGA Bed Need Standard, COMAR 10.24.10.04(B)(2), CCH's utilization projections rest on an assumption of achieving substantially higher market share within its expected service area than HCH-G must achieve in its comparable service area. HCH-G has directly responded to the Adventist Entities' comments with analysis and explanations of the foundations of its assumptions and projections that rely on sound evidence from hospitals that are realistic "peers" of HCH-G and support the reasonableness of HCH-G's assumptions and projections.

On the other hand, HCH-G's more focused critique of CCH does, on balance, hold up. The same market feasibility indicators that undergird the feasibility analysis of HCH-G raise doubts about the ability of CCH to establish the market strength in Clarksburg needed to generate projected patient service volumes and revenues. Furthermore, HCH-G has correctly identified the difficulties faced by AHC in advancing the CCH and WAH replacement projects simultaneously, from the perspective of borrowing the needed funds and generating the needed cash (this latter problem is addressed, in more detail, under the "Viability" criterion). CCH has not effectively countered these points.

The Commission finds that the CCH project is not consistent with this standard because it has employed assumptions concerning market share that are not consistent with historic trends. HCH-G has demonstrated consistency with this standard.

**(14) Emergency Department Treatment Capacity and Space**

*(a) An applicant proposing a new or expanded emergency department shall classify service as low range or high range based on the parameters in the most recent edition of Emergency Department Design: A Practical Guide to Planning for the Future from the American College of Emergency Physicians. The number of emergency department treatment spaces and the departmental space proposed by the applicant shall be consistent with the range set forth in the most recent edition of the American College of Emergency Physicians Emergency Department Design: A Practical Guide to Planning for the Future, given the classification of the emergency department as low or high range and the projected emergency department visit volume.*

*(b) In developing projections of emergency department visit volume, the applicant shall consider, at a minimum:*

*(i) The existing and projected primary service areas of the hospital, historic trends in emergency department utilization at the hospital, and the number of hospital emergency department service providers in the applicant hospital's primary service areas;*

*(ii) The number of uninsured, underinsured, indigent, and otherwise underserved patients in the applicant's primary service area and the impact of these patient groups on emergency department use;*

*(iii) Any demographic or health service utilization data and/or analyses that support the need for the proposed project;*

*(iv) The impact of efforts the applicant has made or will make to divert non-emergency cases from its emergency department to more appropriate primary care or urgent care settings; and*

*(v) Any other relevant information on the unmet need for emergency department or urgent care services in the service area.*

Applicants' Responses

Clarksburg Community Hospital

CCH plans to include 17 patient treatment rooms/bays in the design of its Emergency Department. The following table provides a detailed description of the treatment spaces in the Emergency Department.

efficiently. In FY2008, there were 82,376 visits in 45 treatment spaces or 1,831 visits per treatment space. According to Holy Cross, this ratio of visits per treatment bay is much higher than the 2007 statewide average, 1,336. (HCH #30, p.71)

#### Interested Party Comments

No comments were received regarding either applicant's compliance with this standard.

#### Analysis and Findings

This standard is not applicable to either CCH or HCH-G.

#### **(16) Shell Space**

*Unfinished hospital space for which there is no immediate need or use, known as "shell space," shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective. If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that considers the most likely use identified by the hospital for the unfinished space and the time frame projected for finishing the space. The applicant shall demonstrate that the hospital is likely to need the space for the most likely identified use in the projected time frame. Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space. The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Service Cost Review Commission.*

#### Applicant's Response

HCH-G states that its new hospital is designed with a full floor of shell space in its "patient tower," the top fifth floor, which can be finished to add 30 beds to the hospital. It does not support finished building space above. (HCH #77, Tab 6)

HCH-G projects needing to finish half of the fifth floor shell space, for general medical/surgical beds, by FY 2018, the fourth year of operation, based on annual growth in demand for MSGA beds of three percent in the first four years of hospital operation (HCH #77, Tab 6). It projects needing to completely finish the fifth floor shell space four years later, in FY 2022, probably for additional critical and intermediate care beds (HCH #77, Tab 6). The two methods to calculate the projected need for MSGA beds at HCH-G, are described previously under COMAR 10.24.10.04(B)(2).

For the net present value analysis, HCH-G explains that building shell space now is a better alternative than building on top of the existing structure because it will require relocation of infrastructure on the roof; additional infection control measures will be needed; it would be

disruptive for patients and staff below; and the expense is greater. A construction management source provided cost estimates for the shell construction in current dollars (\$152 per square foot) and vertical expansion (\$225 per square foot). The fit-out costs are estimated to be the same whether the shell space is fit-out immediately or fit-out in new space built in 2018 (\$203 per square foot). HCH-G states that it assumed the discount rate is the same as the inflation rate for construction. Based on HCH-G's assumptions, it concludes that the net present value of the shell space is 32 percent below the net present value of the vertical expansion option (HCH #77, Tab 6)

### Interested Party Comments

#### Comments of Adventist Entities on the HCH-G Application

The Adventist Entities expressed concern that HCH-G describes the proposed Germantown hospital as a small hospital, but plans to build a much larger one, as evidenced by the amount of shell space planned. (HCH#52, p. 15)

### Response to Comments

HCH-G states that the Adventist Entities failed to explain how the potential for expansion would have an untoward impact or threaten an existing provider. (HCH#60, p. 25)

### Analysis and Findings

HCH-G's projections for the need for MSGA beds by residents in its expected service area are very similar to the projections generated from the method used for official State projections of MSGA bed need. The average annual growth rate assumed by HCH-G, 1.9%, is higher than the 1.4% predicted by the SHP.

The need for beds at HCH-G highly depends on the market share HCH-G is expected to capture. At the low-end of the MSGA bed need range that Holy Cross projects under one of two methods that it uses to calculate bed need and assuming higher annual growth from 2015 to 2018 (3.0 percent instead of 1.9 percent), HCH-G would need to capture a 25 percent market share. With a 25 percent market share, HCH-G would need 90 MSGA beds in 2018. However, if HCH-G has a market share of only 20 percent, then only 79 beds would be needed in 2018. Projections greater than ten years out are highly speculative. Nonetheless, similarly, if the market share for HCH-G is assumed to be 25 percent and average annual growth in MSGA days continues to be three percent between 2018 and 2022, the Commission concludes that in 2023 HCH-G will need 105 beds, the remainder of the shell space.

The Commission concludes that net present value analysis demonstrates that building shell space at HCH-G is more cost-effective than a vertical expansion in 2018. Although the net present value analysis of the applicant fails to include the interest cost of borrowing funds for constructing shell space, constructing additional space through vertical expansion in 2018, and fitting out the space in 2018 and 2022, the inclusion of this cost does not change the

Commission’s conclusion that building shell space now is more cost-effective than constructing an additional floor in 2018, when additional space is expected to be needed. The following tables show the net present value for the two alternative approaches, building shell space now or waiting to build until new space is needed.

**Table 51: Costs to Build Shell Space and Fit-out in 2018 and 2022.**

<b>Category</b>	<b>PV2010</b>
Cost of Shell Space	\$3,400,696
Interest Paid Through 2022 on Loan for Shell Space	1,257,411
Cost of Fitting Out Half the Shell Space	2,270,860
Interest Paid Through 2022 on Loan to Fit Out Half the Shell Space in 2018	323,609
Interest Paid on Loan to Fit Out Remaining Shell Space in 2022	-
<b>Total</b>	<b>\$7,252,575</b>

Sources: HCH #77, Tab 11; <http://www.bretwhissel.net/cgi-bin/amortize>

**Table 52: Costs to Build and Fit-out New Space in 2018 and Fit-out Additional Space in 2022.**

<b>Category</b>	<b>PV2010</b>
Cost of Vertical Expansion	\$5,033,925
Interest Paid Through 2022 on Loan for Vertical Expansion	716,737
Cost of Fitting Out Half the New Space	2,270,860
Interest Paid Through 2022 on Loan to Fit Out Half the New Space in 2018	323,609
Interest Paid on Loan to Fit Out Remaining New Space in 2022	-
<b>Total</b>	<b>\$8,345,130</b>

Sources: HCH #77, Tab 11; <http://www.bretwhissel.net/cgi-bin/amortize>

HCH-G identified the use of the proposed shell space, identified the time frame for needing the space, and demonstrated that the space will likely be used within the projected time frame. The net present value analysis also favors building shell space. Therefore, HCH-G has met this standard. Although the Adventist Entities expressed concern about the amount of shell space planned, HCH-G reduced the amount of shell space considerably in the course of this review. It is now limited to space that would have little use other than as additional bed capacity and would be unlikely to be finished (or approved for finishing by MHCC) unless HCH-G’s projected patient census volumes were realized. Any approval of the HCG-G project should include the following conditions, which are standard conditions for CONs involving projects that include shell space:

1. Holy Cross Hospital of Germantown will not finish the shell space without giving notice to the Commission and obtaining all required Commission approvals.
2. Holy Cross Hospital of Germantown will not obtain or request an adjustment in rates by the Health Services Cost Review Commission (“HSCRC”) that includes depreciation or interest costs associated with construction of the proposed shell space until and unless Holy Cross Hospital of Germantown has filed a CON application involving the finishing of the shell space, has obtained CON approval for finishing the shell space, or has obtained a determination of coverage from the Maryland Health Care Commission that CON approval for finishing the shell space is not required.
3. The HSCRC, in calculating an initial rate or any future rates for Holy Cross Hospital of Germantown and its peer group, shall exclude the capital costs associated with the shell space until such time as the space is finished and put to use in a rate-regulated activity. In calculating any rate that includes an accounting for capital costs associated with the shell space, HSCRC shall exclude any depreciation of the shell space that has occurred between the construction of the shell space and the time of the rate calculation (i.e., the rate should only account for depreciation going forward through the remaining useful life of the space). Allowable interest expense shall also be based on the interest expenses going forward through the remaining useful life of the space.

<p style="text-align: center;"><b>COMAR 10.24.12 - State Health Plan for Facilities and Services: Acute Hospital Inpatient Obstetric Services</b></p>
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The policies and review standards in the Acute Hospital Inpatient Obstetric Service Chapter guide Certificate of Need reviews involving new acute hospital inpatient obstetric (“OB”) services, existing services proposed to be relocated to newly constructed space, and existing services proposed to be located in renovated space.

CCH proposes the development of a 16-bed obstetric unit and a Level IIB perinatal service for normal and intermediate specialty newborn care (not neonatal intensive care).

HCH-Germantown proposes the development of a 12-bed obstetric unit and a Level IIB perinatal service for normal and specialty neonatal care.

Consistency of the respective projects with the applicable Review Standards is considered below.

**(1) Need**

*All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.*

Policy 4.1 of this Plan chapter governing inpatient hospital obstetric services states that the burden of proof for demonstrating need for the number of obstetric service beds proposed rests with the applicant, and outlines the type of information the Commission shall consider. That information includes: historical and projected service area; utilization forecasts; obstetric service providers in the service area anticipated to use the service; data on the number of uninsured, underinsured, indigent and underserved obstetric patients in the service area; expected improvements in the delivery of obstetric services as a result of the new service; any demographic or utilization data which is significantly different from that found in the MHCC's forecast of obstetric service utilization; and any other information on the unmet needs for obstetric services in the service area.

### Background

Four of the five general hospitals in Montgomery County provide organized obstetric ("OB") and perinatal programs, Suburban Hospital being the exception. Recent discharge abstract data for postpartum OB bed use is shown in the table on the following page. As can be seen, HCH-SS accounts for a little over half of the total OB discharges from Montgomery County hospitals. Also, unlike other acute inpatient care services at hospitals, the average length of stay for postpartum obstetric patients has been increasing in recent years. The State Health Plan chapter for acute hospital inpatient obstetric services does not include a bed need methodology.

Both of the proposed new hospitals propose OB and normal newborn perinatal programs (i.e., neither project proposes the provision of specialized or intensive care to neonates).

## F. Impact on Existing Providers

### *COMAR 10.24.01.08G(3)(f)*

*"An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system."*

### Applicants' Responses

#### Clarksburg Community Hospital

Clarksburg Community Hospital states that it will have no negative impact on other providers. CCH points out that the new hospital was conceived as a way of expanding the health and hospital system of the State in a complementary and cooperative manner building on the capabilities of SGAH and FMH. CCH asserts that the new hospital will have no impact on the costs and charges of other providers, and that it will improve patient access to hospital services without increasing costs, lowering occupancy, or duplicating existing resources. (CCH #39, p. 105)

Pointing to the SHP projection of maximum MSGA bed need, CCH states that the two major providers of hospital care to the Clarksburg ESA, SGAH and FMH, do not have sufficient capacity to meet future need. (CCH #39, p. 106)

Regarding the impact on costs to the health care delivery system, CCH points to its plans to have all private rooms and sees three related advantages as follows: (1) promote efficiency by allowing the hospital to operate at a higher occupancy with fewer beds; (2) promote clinical effectiveness by providing a safer environment for both patients and staff; and (3) promoting more patient and family centered care. (CCH # 39, p. 106)

#### Holy Cross Hospital-Germantown

HCH-G states that it can achieve full occupancy without reducing volume at any existing hospital, pointing out that approximately 40% of its volume, including 100% of obstetric volume, will be upcounty residents who currently receive care at HCH-SS. The applicant notes that this shift in volume will make capacity available at HCH-SS to accommodate the growth projected for that hospital's service area. HCH-G believes that the balance of its volume will come from the growth and aging of the population in its ESA (HCH #77, Tab 8, p. 3).

HCH-G projected an additional 3,906 MSGA cases in FY 2015 compared to FY 2008 for the Germantown ESA, and an additional 397 psychiatric cases countywide. HCH-G expects to absorb much, but not all, of this increase. HCH-G projects an excess growth of 172 MSGA cases and 104 psychiatric cases that will be available for other hospitals to absorb assuming that it achieves its target volumes. HCH-G concludes that, due to the shift in cases from Silver Spring to Germantown and the growth in the Germantown market, it will cause no loss in of MSGA,

obstetric, or psychiatric volume from other hospitals. (HCH #30, p. 115R<sup>33</sup>)

With respect to the impact on costs and charges of other providers, HCH-G points to the HSCRC’s adoption of an 85 percent variable cost assumption relative to changes in volume. Holy Cross’s asserts that this means that even if other hospitals lose volume, they will not suffer financial harm as long as they reduce costs by 85%. Thus, if there is any reduction in volume, both lost revenue and avoided cost are expected to be 85 percent. Therefore, there is no financial impact on existing health care providers. (HCH #4, p. 117)

Regarding the impact on costs to the health care delivery system, HCH-G points to the benefits of the proposed hospital in meeting the growing demand for services of the growing upcounty population in a more convenient facility. The new hospital would improve convenience for patients that travel from the upcounty area to Silver Spring, especially the poor and uninsured who are more likely to face transportation challenges in traveling to Silver Spring. (HCH #4, p. 117)

Regarding the impact on demographic access to services, in responding to the cost-effectiveness criterion, HCH-G claims that while there is substantial overlap of service areas, the demographic characteristics of the unique zip codes of each hospital are quite different as detailed in the following table.

**Table 102**  
**HCH-G’s Comparison of Demographic Characteristics**  
**Unique Germantown Zip Codes to Unique Clarksburg Zip Codes**

<b>Characteristic</b>	<b>Zip Codes Unique to Germantown ESA</b>	<b>Zip Codes Unique to Clarksburg ESA</b>
<b>White, non-Hispanic</b>	51.6%	88.3%
<b>Hispanic</b>	16.3%	3.2%
<b>Black, non-Hispanic</b>	12.0%	4.5%
<b>Asian non-Hispanic</b>	17.0%	2.1%
<b>Other</b>	3.0%	1.8%
<b>% who speak English less than very well</b>	14.8%	0.9%

Source: Holy Cross Hospital-Germantown October 28, 2010 modification (HCH #77, Tab 8, p 6)

Interested Party Comments

Comments of HCH-G on the CCH Application

HCH-G states that the volume projection for MSGA cases and obstetric cases contained in CCH’s October 28, 2009 modification demonstrate that approval of the CCH application will have a significant effect on existing providers. It notes that, according CCH’s own projections, 44% of CCH’s MSGA volume and 92% of its obstetric volume from its 13 zip code service area primary service area will be redirected from existing hospitals. HCH-G points to CCH’s modification response to Obstetric Standard .04(1), concluding that SGAH would need 11 fewer obstetric beds and FMH would need one fewer obstetric bed if the 16 bed obstetric unit proposed

<sup>33</sup> Replacement page labeled as 115R in HCH-G’s February 27, 2009 submission actually replaces page 116 of original application

by CCH is operational in 2015. Similarly, CCH's modified response to the need criterion projects a reallocation of 34 MSGA beds to CCH from SGAH and six MSGA beds from FMH. (CCH #46, pp. 17-18)

HCH-G believes that CCH does not address the impact of redirecting this MSGA and obstetric volume from existing hospitals to the proposed new hospital as required by Criterion .08G(3)(f). For this reason, HCH-G states that CCH's proposal cannot, as a matter of law, be approved. (CCH #46, p. 18)

#### Comments of Adventist Entities on the HCH-G Application

The Adventist Entities state that the proposal to construct HCH-G will increase the market share of a competitor in the heart of SGAH's primary service area. (HCH #52, p. 12) They also contend that approval of HCH-G will jeopardize the nearby Germantown Emergency Center ("GEC"), an affiliate of SGAH, and will inevitably reduce the future volume of ED visits at SGAH. The commenters estimate that if HCH-G had been in operation during 2008, approximately 60% of the 33,019 visits to GEC would have gone to HCH-G. This would have been almost 70% of the visits to GEC from the HCH-G's proposed service area (20,000/29,043). AHC projects that the visit impact would increase from 20,000 in 2008 to 25,000 in 2016. AHC also estimates that 13,500 of the 74,300 visits to SGAH's Emergency Department would have gone to HCH-G. This would have been over 27% of the 48,863 visits to SGAH's ED from HCH-G's proposed service area. (HCH #52, pp. 17-18)

Finally, the Adventist Entities state that HCH-G will be a much larger hospital threatening the existing health care system because ED observation rooms could be converted to ED treatment rooms. They also point to various shell (unfinished) spaces throughout the original design of the new hospital.<sup>34</sup> (HCH #52, p. 15)

#### Applicants' Responses to Comments

##### Clarksburg Community Hospital

Clarksburg's October 5, 2009 response to HCH-G's comments on its application addresses the SHP financial feasibility standard and viability criterion, but does not address the impact criterion. (CCH #36, pp. 10-11)

##### Holy Cross Hospital-Germantown

HCH-G points out that only seven of 19 zip code areas in its proposed ESA are in SGAH's primary service area. (HCH #60, p. 19) HCH-G states that the Adventist Entities' comments do not identify any untoward impact on MSGA or obstetric care. Regarding psychiatric care, HCH-G again states that the commenters have failed to identify or quantify any negative impacts resulting from any change in referral patterns.

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<sup>34</sup>In its modified application, HCH-G eliminated all of these shell spaces except for one full floor (5<sup>th</sup> floor) that has been included for growth in the general MSGA patient population. (HCH #77, Tab 6)

HCH-G also states that, while the commenters argue that inclusion of shell space for future expansion at HCH-G threatens the existence of the existing health care system, they fail to explain how the potential for expansion, which would only be brought on-line in response to increased demand, threatens the survival of any existing provider. (HCH #60, pp. 24-25)

### Findings and Analysis

The impact of the projects under review on geographic accessibility is addressed under the geographic accessibility project review standard, COMAR 10.24.10.04(B)(1). The Commission's review of that standard concludes that both of the proposed new acute care general hospital sites are located so that their likely service area population will have optimal travel time accessibility, as defined in that standard. The vast majority of the population of Montgomery County, greater than 90%, currently enjoy a travel time for general medical/surgical, intensive/critical care and pediatric services of 30 minutes or less, under normal driving conditions. More than 90% of the total County population, including the population of the upcounty region, which will see travel time reductions if one or both of these new hospitals is developed, will continue to have this level of access through the coming decade even if no new hospital sites are developed. On that basis, the letter of that standard does not provide a strong basis for preferring one of these competing projects over the other.

However, with respect to the issue of travel time accessibility in general, the Commission found that the HCH-G site, because of its nearness to more densely populated areas of Montgomery County, has a greater potential than the CCH site to reduce the overall travel time to a hospital experienced by Montgomery County residents. Thus, with respect to this criterion, HCH-G, if developed, will have a greater potential positive impact on geographic access to hospital services than CCH, because its location will have the potential to reduce the greatest amount of time required by persons to travel to the nearest hospital and more persons will have a reduced travel time to the nearest hospital.

The Commission also finds that the HCH-G has a greater potential for positive impact on "demographic access to services" because of the substantial number of residents from the HCH-G ESA that currently travel to HCH-SS for services, especially the participants in the Montgomery County Maternity Partnership, and the more diverse population of the unique zip code areas of the HCH-Germantown ESA, when compared to the CCH ESA. However, the importance of this distinction is muted by the fact that of the nine zip code areas in HCH-G's ESA that are not in Clarksburg's ESA, six are zip code areas that meet the Commission's definition for inclusion in SGAH's primary service area, even when including discharges originating in Washington, DC hospitals. Of these six zip code areas, three are closer to SGAH than they would be to the new Germantown hospital and one is roughly equidistant.

If a new hospital is built in Clarksburg, there would be some negative impact on volume and bed occupancy at SGAH and Frederick Memorial Hospital. CCH provided an analysis of the impact of the shifts in volumes on hospital revenue in its May 29, 2009 response to the first set of completeness questions. This analysis was based on shifts in volume at FMH and all Montgomery County hospitals. A similar analysis was not submitted with the modified application that limited the volume impacts to SGAH and FMH. AHC and SGAH did not

submit volume projections and revenue expense projections that reflect the anticipated shifts in MSGA and obstetric volumes. Therefore, the Commission concludes that Clarksburg Community Hospital has not provided as complete an analysis of impact in responding to this criterion as it could have, with respect to the impact of the proposed project on existing health care providers in the service area including the impact on occupancy and on costs and charges (revenues) of other providers.

Regarding the impact on occupancy and costs and charges of other providers, AHC raises concerns about the threatening impact of HCH-G on the GEC and SGAH's obstetric, MSGA and emergency department services. However, AHC does not explain how it arrived at its projected ED volume impacts and does not quantify the impact of losses in volume in any of these services on occupancy, costs, or charges (revenue) at SGAH or GEC.

It appears likely that Holy Cross's conclusion that Holy Cross Hospital-Germantown can achieve full occupancy within a reasonable amount of time without reducing volume at existing hospitals, other than Holy Cross Hospital of Silver Spring, is valid because the projected additional need for MSGA beds in Germantown's ESA plus the shift in volume from HCH-SS is sufficient to support the number of beds proposed. Holy Cross has accounted for the shift in volume and the impact on revenues and costs at HCH-SS and projects a healthy operating margin.

In terms of market share assuming each of the proposed hospitals' ESAs would account for 85% of discharges, HCH-G would have to achieve a market share in its ESA of about 10%, which is reasonable, given the observed experience of existing hospitals (see earlier consideration of MSGA bed need in this report). CCH would have to achieve a substantially higher market share in its ESA.

Finally, the Commission would like to reiterate, under this criterion, the view expressed earlier in this report with respect to the issue of services not provided by hospitals affiliated with the Roman Catholic Church. The Commission believes that this would be a serious impact concern if a hospital like HCH-G were being proposed for an area that lacks available and accessible options for obtaining these services. Montgomery County is not such an area. The Commission does not find that approval of HCH-G would have a substantive negative impact on the availability or accessibility of the services that HCH-G will not provide, because it will be a hospital adhering to the doctrines of the Roman Catholic Church.

In summary, the Commission finds that each of the proposed projects is unlikely to have a negative impact on access, costs, or charges that would warrant denial.

## **V. SUMMARY**

The Commission approves the Certificate of Need application, Docket No. 08-15-2286, of Holy Cross Hospital of Silver Spring to establish a new 93-bed general acute care hospital in Germantown.

The Commission denies the Certificate of Need application of Clarksburg Community

Hospital, Docket No. 09-15-2294, to establish a new 86-bed general acute care hospital in Clarksburg.

The Commission believes that the proposal for a new acute general hospital in Germantown embodies a reasonable approach to improving access to hospital services for northern Montgomery County and providing adequate bed capacity for the future that is close to the area of the County that will experience the highest levels of population growth, at a reasonable cost. It is also a project that, as a “satellite” hospital of HCH-SS, has the advantage of creating a more direct opportunity for shifting hospital bed and service capacity from an area of the County that will experience relatively less demand for hospital services in coming years and a project that will make it possible for HCH-SS to more readily modernize and rationalize its aging Silver Spring campus, by relieving demand pressure at this existing site. It is also a timely project that has a sponsor who is well positioned, financially, to undertake its implementation.

In contrast, while the Clarksburg hospital proposal would also improve access for the upcounty area and provide beds for the future, it is a riskier approach, given the lower population density that exists in that part of the County. It does not meet a need on the part of SGAH to modernize or reduce demand for services at its campus that cannot be fulfilled through expansion and renovation. It is not a timely project, in that AHC needs to focus its limited resources on improving the long-term viability of Washington Adventist Hospital, a much larger project that will be difficult for AHC to absorb alone and, over the long-term, is critical to restoring AHC to robust financial health.

Beyond these broad and longer-term considerations, HCH-SS has made a strong case in the record of this review that it has a record with respect to the following performance characteristics that is as good or superior to that achieved by the AHC hospitals in Montgomery County:

- Quality care, in terms of the measures currently in use for evaluation of quality;
- Providing access to care for the indigent and providing broader community benefits;
- Managing its hospital operations to achieve a desirable cost position and strong performance indicators relative to its peer hospitals;
- Making information on cost and charges available to the public; and
- Facility design for patient safety.

The Commission’s review of the applicable State Health Plan standards and general review criteria summarize the basis for its decision, as outlined in detail in the preceding body of this Final Decision. See Appendix F for a chart summarizing the Commission’s findings.

## A. COMPLIANCE WITH APPLICABLE STATE HEALTH PLAN STANDARDS

### COMAR 10.24.10, Acute Inpatient Services

#### *General Standards for Acute Inpatient Services*

- 1. Information Regarding Charges*
- 2. Charity Care Policy*
- 3. Quality of Care*

Both applicants complied with these general standards.

#### *Project Review Standards for Acute Inpatient Services*

##### *1. Geographic Accessibility*

With respect to the issue of travel time accessibility in general, the Commission finds that the HCH-G site, because of its nearness to more densely populated areas of Montgomery County, has a greater potential than the CCH site to reduce the overall travel time to a hospital experienced by Montgomery County residents. The issue of geographic accessibility, as addressed in this standard, shows that both of the proposed new acute care general hospital sites are located so that their likely service area population will have optimal travel time accessibility, as defined in this standard. More than 90% of the total County population, including the population of the upcounty region, which will see travel time reductions if one or both of these new hospitals is developed, will continue to have this level of access through the coming decade even if neither new hospital is developed.

Each applicant is consistent with this standard.

##### *2. Identification of Bed Need and Addition of Beds*

The Commission finds that HCH-G has demonstrated a need for its project, based on a bed need analysis at the hospital service area level. It has the potential for achieving market penetration in its ESA that can fully support its planned MSGA bed capacity. CCH is unlikely to achieve market penetration in its expected service area that can fully support the MSGA beds proposed for its project over the coming decade. The Commission also finds that a redistribution of MSGA bed capacity from the southeastern area of the County to the north and central regions of the County is consistent with an analysis of overall MSGA bed need in the County that replicates the State Health Plan's bed need forecasting methodology at the hospital service area level. For these reasons, the Commission finds that HCH-G is consistent with this standard, and that CCH is not consistent with this standard.

##### *5. Cost-Effectiveness*

CCH has failed to identify two alternatives to its proposed project, as required by the standard, and has also failed to quantify the level of effectiveness of alternatives in meeting its

objectives. Therefore, the Commission finds that Clarksburg Community Hospital's application has failed to comply with the requirements of this standard.

HCH-G identified three distinct primary objectives of its proposed project to develop a new hospital in Germantown and two alternative approaches that it considered for achieving the objectives including the alternative of only expanding HCH-SS. It provided detailed reasoning, including a minimum capital cost estimate for accommodating all HCH-G ESA volume on the Silver Spring campus, an explanation of why the alternatives would not be as effective as the proposed project in meeting the objectives, and an explanation of why the proposed project was selected. Therefore, the Commission finds that HCH-G is consistent with this standard.

#### ***6. Burden of Proof Regarding Need***

Each applicant acknowledged its burden of proof under this standard and provided information on how it assessed the need for the facilities and services proposed. The Commission's overall assessment of the quality of the applicants' demonstrations leads it to find that HCH-G has carried the burden of proof for its proposed project's facilities and services and that CCH has not.

#### ***7. Construction Cost of Hospital Space***

CCH's construction cost estimate, as appropriately adjusted for comparison with a Marshall Valuation Service ("MVS") benchmark cost, is \$452.21. The MVS benchmark cost is \$371.56. Therefore, in establishing a rate for CCH, if it was approved, the Health Services Cost Review Commission would need to exclude \$16,902,900 of the project cost to account for excess construction cost and the amounts of capitalized construction interest, budgeted contingency, and budgeted inflation allowance attributable to the excess construction cost.

HCH-G's construction cost estimate, as appropriately adjusted for comparison with a MVS benchmark cost, is \$376.71. It is within the MVS benchmark cost of \$380.33.

#### ***9. Inpatient Nursing Unit Space***

Each applicant's nursing unit designs meets this maximum size standard.

#### ***11. Efficiency***

Both applicants claim that their designs will result in operational efficiency. While CCH cites the economy of its budget estimate under this standard, consideration of COMAR 10.24.10.04(B)(6) indicates that the construction cost estimate for CCH is not in line with the index of hospital construction cost used by MHCC. In contrast to CCH, only HCH-G quantified its projections of operational efficiency in the form of a comparison of staffing ratios per unit of activity projected for the HCH-G facility and the same efficiency measure as achieved by HCH-SS. HCH-G is consistent with this standard and CCH is not.

## ***12. Patient Safety***

The Commission finds that both HCH-G and CCH have complied with this standard. Each has incorporated state-of-the-art patient safety enhancement features in its hospital designs.

## ***13. Financial Feasibility***

While both applicants have provided the information required under this standard, the Commission finds that the HCH-G case for financial feasibility is more plausible because it has made a stronger case with respect to market feasibility and has the resources to implement the project.

The Commission finds that the CCH project is not consistent with this standard because it has employed assumptions concerning market share that are not consistent with historic trends.

## ***14. Emergency Department Treatment Capacity and Space***

Both CCH's and HCH-G's projections of ED demand are based on a realistic predictive range for ED market share, based on the market share that the GEC facility captured during its first two years of operation.

HCH-G projects a very high level of utilization for its emergency department bays. While the level of projected capacity use by HCH-G is concerning, the Commission does not believe it warrants a recommendation to enlarge the design of its proposed ED. If HCH-G finds that its treatment bay capacity is inadequate, it appears to have sufficient space planned to permit some reconfiguration and adjustment to address such a problem.

The Commission finds that CCH's projections with respect to the large negative impact of HCH-G on GEC and the SGAH ED are highly speculative and not supported by reliable and quantitative analysis. The Commission does not believe the potential negative impact on GEC should be a major determining factor in considering the best location for a sixth hospital in Montgomery County. GEC is not a hospital, but is a freestanding medical facility that can continue to serve as a significant alternative source of unscheduled and urgent medical care that reduces the overall need for hospital ED capacity at SGAH and any other hospital that would be developed north and west of Rockville.

## ***16. Shell Space***

HCH-G identified the use of the proposed shell space, the time frame for needing the space, and demonstrates that the space will likely be used within the projected time frame. The net present value analysis also favors building shell space. Therefore, the applicant has met this standard. Standard conditions with respect to hospital shell space are recommended.

## Appendix A

**Appendix A:  
Review of Record-General File**

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the financial feasibility of the other application. A chart listing attached documents regarding each application was enclosed with the letter. (GF #34)

In a letter dated April 9, 2010, Dr. Moon wrote counsel and Dr. Tillman, regarding pending requests for an evidentiary hearing in the comparative review to establish new hospitals in Montgomery County. Based on her review of the record in the comparative review, Dr. Moon requested testimony on the following issue areas: Access [COMAR 10.24.10.04B(1)]; Need/Cost Effectiveness of Alternatives [COMAR 10.24.01.08G(3)(b) & (c)]; and, Viability [COMAR 10.24.01.08G(3)(d)]. Dr. Moon instructed counsel for the applicants and interested party to submit, in writing, at 4:30 p.m. on May 13, 2010, a list of issues on which they seek to introduce evidence, as a proffer of the testimony that would be presented relevant to these issues. (GF #35)

In a letter dated April 9, 2010, from Jack C. Tranter, Esquire to Howard L. Sollins, Esquire, Mr. Tranter advised that Mr. Sexton, CEO of Holy Cross Hospital, Inc. had: (1) published a letter in the *Gazette* newspaper; (2) mailed a brochure with a detachable response card to Montgomery County residents; (3) canvassed at shopping centers, churches and other places where Montgomery County residents gather; and, (4) used social media networks. (GF #36)

In a letter dated April 29, 2010 to Dr. Moon, Jack C. Tranter, Esquire requested that Adventist HealthCare, Inc. be directed to produce certain financial documents (along with any amendments or supplements). (GF #37)

In a letter dated May 3, 2010, Howard L. Sollins, Esquire wrote Dr. Moon in opposition to Holy Cross Hospital-Germantown's April 29<sup>th</sup> letter urging that Clarksburg Community Hospital provide information Holy Cross Hospital/Germantown (HCH/G) wishes to obtain, according to a deadline HCH/G sets. (GF #38)

In a letter dated May 4, 2010, Dr. Moon wrote Jack C. Tranter, Esquire and Howard L. Sollins, Esquire, responding to the request filed by Holy Cross Hospital-Germantown for certain financial documents regarding Adventist HealthCare, Inc., which Holy Cross views as necessary in order to file a list of issues and proffers by the May 13, 2010 deadline. Holy Cross Hospital-Germantown requested that AHC be required to produce the following documents (along with any amendments or supplements):

1. Amended and Restated Master Trust Indenture dated as of February 1, 2003 between AHC and certain subsidiaries and Manufacturers and Traders Trust Company, as trustee (the "Master Trust Indenture"), identified in the December 16, 2009 Memorandum from Ziegler Capital Markets (attached as Exhibit 2 to the Response to Comments filed by AHC on December 17, 2009) and in the Official Statement relating to the Series 2005A and 2005B Bond Issue (the "2005 Official Statement") by the Maryland Health and Higher Educational Facilities Authority ("MHHEFA");

**Appendix A:  
Review of Record-General File**

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In a letter dated June 17, 2010 to Dr. Moon, Loretta E. Shapero entered her appearance as counsel for the Montgomery County Department of Health and Human Services. Ms. Shapero reserved the option to cross-examine witnesses at the evidentiary hearing. (GF #66)

Ms. Loretta E. Shapero, Associate County Attorney, entered her appearance on behalf of the Montgomery County Department of Health and Human Services, also referred to in these matters as the Montgomery County Health Department. (GF #67)

In a letter dated June 17, 2010 to Dr. Moon, Howard L. Sollins, Esquire provided a supplemental summary of witness background and areas of testimony. (GF #68)

In a letter dated June 18, 2010 to counsel, Dr. Moon provided a list of issues for the evidentiary hearing:

Issue Area 1: Access

Dr. Moon stated that she wished to receive testimony regarding access, as follows:

- A. Project Planning. Testimony that details the history of the planning of these projects by the respective applicants, limited in focus to the specific consideration that was given to issues of access in choosing the locations of the proposed projects. The testimony must be limited to historic information relating to issues of access that was developed and considered by each applicant up to the point that a decision to establish a new hospital at the proposed site was made. Each applicant should provide pertinent exhibits to the written testimony that documents its planning processes regarding issues of access. Testimony should not include statements about the advantages of a proposed project in making facilities and services generally accessible or accessible to specific subgroups of the population.
- B. Travel Time. Testimony that: (1) quantifies the number and proportion of persons or households in the service area identified by the applicant as the expected or projected service area of the proposed hospital who will experience a reduction in travel time to a general acute care hospital if the hospital is established;<sup>1</sup> and (2) quantifies the reduction in travel time to a general acute care hospital that will be achieved if the proposed hospital is established (e.g., the number of persons or households that will experience a reduction in travel time of one to five minutes, the number that will experience a reduction of six to ten minutes, etc.)

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<sup>1</sup> The service area identified for CCH includes the following zip code areas; 20838, 20839, 20841, 20842, 20871, 20872, 20874, 20876, 20882, 21704, 21710, 21754, and 21770. The service area identified for HCGH includes the following zip code areas; 20837, 20838, 20839, 20841, 20842, 20850, 20851, 20853, 20855, 20871, 20872, 20874, 20876, 20877, 20878, 20879, 20882, and 20886.

**Appendix A:  
Review of Record-General File**

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Issue Area 2: Need and the Cost-Effectiveness of Alternatives

With respect to the need and cost effectiveness, Dr. Moon stated that she would receive testimony as follows: Testimony regarding the need, at this time (i.e., construction beginning in 2011-2012 with project completion in 2013-2014), for a hospital of the size, scope, and location proposed. Testimony should be aimed at demonstrating the inability to effectively meet the need for hospital facilities and services in Montgomery County without the proposed project, and should include testimony that specifies and quantifies the limitations for expansion of the facilities and services at Shady Grove Adventist Hospital (“SGAH”), HCHSS, and other Montgomery County hospitals, as relevant. Testimony may address both the potential for raw service capacity expansion and how expansion potential of the existing hospitals compares to the proposed new hospital projects, in terms of design features and implications for optimal patient care. This testimony should not repeat the bed need analyses already available in the record.

Issue Area 3: Viability

Dr. Moon requested testimony regarding viability that is limited to the plans for funding the proposed projects. First, this includes testimony that details each of the financing plan assumptions that bear on the applicant’s determination that it can fund both of its proposed hospital capital projects and adequately service the debt associated with both projects. Second, testimony should be provided that details the applicant’s specific consideration (in establishing the specific financing plan assumptions detailed in the first area of testimony) of the impact of current disruption in the market for tax-exempt bond financing and the outlook for such financing over the next three years during which the proposed project will need to be obligated. Testimony should identify the sources of information and/or expert opinion reviewed and used to establish each financing plan assumption. Testimony should also include detailed data on the overall financial condition of the applicant hospital and all other hospitals, health care facilities, and health programs owned and/or operated by the applicant hospital’s parent (Adventist HealthCare in the case of CCH and Trinity Health, in the case of HCHSS) including: (1) all planned capital spending; (2) current and projected debt obligations, including detail on current financing terms and assumptions concerning future debt financing terms; and (3) recent and projected overall financial performance of these parent organizations and their subsidiaries. (GF#69)

In a letter dated June 22, 2010 to Dr. Moon, Howard L. Sollins, Esquire wrote in opposition to Holy Cross Hospital’s June 14, 2010 request that Dr. Moon reconsider the Pre-hearing Conference ruling that SGAH and SGAEC may, represented by separate counsel, cross-examine witnesses. (GF #70)

In a letter dated June 23, 2010 to Dr. Moon, Howard L. Sollins, Esquire submitted a Response to the Health Services Cost Review Commission memorandum. (GF #71)

In an e-mail dated June 24, 2010 to counsel and Commission staff, Jack Tranter, Esquire noted that he had filed a Motion to Strike and a Response to the HSCRC Staff Memorandum on

**Appendix A:**  
**Review of Record-Holy Cross Hospital-Germantown**

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On August 1, 2008, Jack C. Tranter, Esquire filed a letter of intent on behalf of Holy Cross Hospital, Inc., to construct a new 93-bed hospital in Germantown, Maryland, to be known as Holy Cross Hospital – Germantown, consisting of 75 MSGA, 12 obstetric, and 6 psychiatric beds. Of the 75 MSGA beds, 19 will be new beds projected as needed under the *Acute Care Chapter of the State Health Plan* and 56 beds will be relocated from Holy Cross Hospital - Silver Spring, a 408-bed acute care facility. On August 4, 2008, Ruby Potter, Health Facilities Coordinator, acknowledged receipt of the Letter of Intent for the construction of the 93-bed hospital to be known as Holy Cross Hospital – Germantown. In that letter, Ms. Potter noted that the submission date for the Certificate of Need application is October 3, 2008 and a pre-application conference has been scheduled for August 13, 2008. (HCH #1)

On September 10, 2008, Ms. Potter acknowledged a request from Howard Sollins, Esquire, dated September 5, 2008, for receipt of notification and informed him that in order to become an interested party, he must make written comments within 30 days of the docketing of the application. (HCH #2)

On October 2, 2008, Jack C. Tranter, Esquire, Counsel to Holy Cross Hospital – Germantown filed a modified Letter of Intent. The total bed complement of the new hospital is to be comprised of 75 MSGA, 12 obstetric and 6 psychiatric beds. The source of the 75 MSGA beds has now changed. Instead of 19 new beds and 56 beds to be relocated from Holy Cross Hospital – Silver Spring, the new MSGA bed complement will consist of 36 new beds and 39 beds to be relocated from Holy Cross Hospital – Silver Spring. (HCH #3)

On October 3, 2008, Holy Cross Hospital-Germantown filed the Certificate of Need Application (HCH #4)

On October 4, 2008, Brian Hepburn from Mental Hygiene Administration filed a letter of support for Holy Cross Hospital-Germantown to Pamela Barclay, Director, Center for Hospital Services. (HCH #5)

On October 6, 2008, Ruby Potter sent a letter to Annice Cody, Vice President, Strategic Planning at Holy Cross Hospital, acknowledging the receipt of application for completeness review. (HCH #6)

On October 6, 2008, Ruby Potter sent a request to *The Washington Examiner* to publish notice of receipt of the application. (HCH #7a)

On October 6, 2008, Ruby Potter submitted request to the *Maryland Register* to request publication notice of receipt of application. (HCH #7b)

On October 13, 2008, notice of receipt of application was published in *The Washington Examiner*. (HCH #8)

# Exhibit 2

**IN THE MATTER OF**

\*

**BEFORE THE**

**PROPOSED NEW HOSPITALS IN**

\*

**MARYLAND HEALTH**

**MONTGOMERY COUNTY**

\*

**CARE COMMISSION**

**Clarksburg Community Hospital  
Docket No. 09-15-2294**

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**Holy Cross Hospital of Silver Spring  
Docket No. 08-15-2286**

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**CLARKSBURG COMMUNITY HOSPITAL, SHADY GROVE ADVENTIST HOSPITAL AND SHADY GROVE ADVENTIST GERMANTOWN EMERGENCY CENTER**

**EXCEPTIONS TO THE RECOMMENDED DECISION**

January 6, 2011

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## B. SUMMARY OF EXCEPTIONS

1. **The Commission should not rule on the above-captioned CON applications at its January 20, 2011 meeting because the Recommended Decision is based on information and data not yet in the record, and is therefore not yet ripe for consideration. The final decision should not be based on extra record evidence.**

While the Recommended Decision reflects the significant information that has been supplied to the Commission in this comparative review, it is not ripe for consideration by the full Commission at its January 20, 2011 meeting in a manner that comports with the Commission's regulations and due process requirements applicable to such contested case proceedings. It is based on information that is not in the record, fails to consider relevant information in the record and draws conclusions for which a basis has not been identified. The conclusions reached have broad, statewide implications beyond AHC, HCH or Montgomery County.

We urge the Commission to defer action until the applicants have had full disclosure, access to and an ability to respond to all information, calculations and determinations on which the Recommended Decision is based, and all procedural and substantive defects have been remedied.

Page 147 of the Recommended Decision on the HCH-G application links the approval of the HCH-G project to the favorable outcome on the WAH application, Docket No. 09-15-2295, a decision on which the Commission has yet to act. Because of this, the HCH-G application should be held in abeyance pending the confirmation of that WAH CON application.

As detailed in Exception 1 below, the Recommended Decision relies on information that is extra-record evidence, i.e. information that is outside the record of this proceeding and to which advance notice was not given to the applicants. Even if the information is in the public domain and even if it might be information of which the Reviewer may wish to take administrative notice and thus accept its validity as a source of information without the need for a sponsoring witness or other evidence of its reliability, parties to the proceeding are still entitled to advance notice of any information of which the Reviewer intends to take administrative notice, so that the information can be evaluated, a response generated, and any additional information presented, if this is needed to respond to such evidence. That has not been done here.

The problem is exacerbated where the Recommended Decision relied on information that is not in the public domain. For example, described in Exception 1 below, the Recommended Decision relies on information from the DC Discharge Database to develop its own service area analysis based on MSGA discharges from Maryland and District of Columbia hospitals to certain Montgomery County zip codes. That DC Discharge Database is not available in the public domain and is only available upon request to the Commission's Institutional Review Board under COMAR 10.25.11. Even if disclosed, it must be held according to strict non-disclosure requirements in a mandatory agreement governing the disclosure and in accordance with COMAR 10.25.11. By relying on data which is both outside the record and to which parties cannot respond in the public Exceptions process as a result of the Commission's nondisclosure requirements, the Recommended Decision is based on nonpublic

information not in the record. There may be a way the Commission can accomplish its objective of using these data in the pending review. But, until that process is developed and the information is made available in a way that the parties may use and respond to it in the record, the Recommended Decision should not be considered.

The Recommended Decision relies on extra-record information that post-dates the closing of the record in this proceeding. The full Commission is the finder of fact and will render the final agency decision in this review. Thus, the full Commission has the opportunity and obligation to determine if it has all of the information it needs to render its decision. If more recent information was considered by the Reviewer, the parties are entitled to advance disclosure of that information and an opportunity to respond to it.<sup>3</sup>

2. **There are procedural and evidentiary defects in the record that should be addressed and cured before the Commission rules, to ensure that the agency's decision is both fair and legally sound.**

In Exceptions 3 through 10 below, we identify rulings that were made during the course of this CON review, the effect of which was to exclude from the record relevant, material and important information that bears directly on the manner in which both applicants met their respective burdens to address CON requirements. We urge the Commission to review and reverse these rulings where indicated in the Exceptions

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<sup>3</sup> This is not just a due process obligation, it is an opportunity as well. For example, the Recommended Decision refers to AHC's sale of its nursing home affiliates. Thus, AHC is no longer, as it had been, the only Maryland hospital system responsible for a chain of nursing homes. That transaction substantially improved Adventist's cash position and debt structure. Reopening the record to consider some new information, affords a further opportunity for up-to-date information to be considered before a final agency decision were rendered.

## C. DETAILED EXCEPTIONS

1. CCH takes exception to the Recommended Decision's use of, and reliance on evidence not in the record.

The Recommended Decision relies on evidence not in the record, as is apparent from the citations identified and relied upon. In some instances the references to such evidence are readily apparent. In others, the Recommended Decision provides either no or vague citations to the evidence on which it is based. There is a process for the Commission, as may other administrative agencies, to take "administrative notice" of information in the public record that is readily available to the general public and the reliability of which is undisputed. State Government Article §10-213(h). But, the taking of administrative notice is simply a method by which evidence may be introduced into the record without the need for a sponsoring witness or stipulation. For the Commission's process to comport with due process requirements and accord the parties with an opportunity to respond, the Commission is requested to direct the Staff to identify with particularity the sources of information used and to provide the parties with the calculations or methodology used in reaching a stated conclusion.

Specific examples of this recurring problem with the Recommended Decision are as follows:

- On Table 7, in the narrative on page 10 in the first paragraph, in the second line on page 40, in Table 37 on page 41 and in the last paragraph on that page, in the second to last paragraph on page 168 and elsewhere there are references in the Recommended Decision to District of Columbia data and the

“DC Discharge database.” Because of this, Richard Coughlan, a CCH consultant, made an Institutional Review Board request to the Commission after the Recommended Decision was issued, seeking the 2008 and 2009 DC Discharge Databases. It was provided but under strict confidentiality requirements under COMAR 10.25.11. This confidential access after the Recommended Decision is issued does not provide the parties with sufficient time nor opportunity to consider this information as part of the record and to respond to it. The Recommended Decision should be deferred until a solution is identified that enables the data to be used in the public record and the parties have been provided with an explanation of how it was used.

- Tables 8, 9 and 10 refer to data from Spatial Insights. There is no information in the record about Spatial Insights, the source of its data, the validity of its data, how the data was accessed nor how the data was used. This information should be provided to the parties and with sufficient time to allow the parties to evaluate and comment on the use of the data.
- A footnote to TABLE 14 states “Accurate information on the utilization of this facility prior to 2009 is not available.” The basis for this statement is unstated and the Table is therefore questionable.
- Table 15 refers to data from the St. Paul Group. This data should be provided, along with the calculations supporting the Table.
- Table 21 refers to a Source that is blank.

- Table 24 is followed by Table 32. We have been advised by the Staff that there are no missing tables and this is a numbering issue. We accept this statement and if for any reason this is not the case we wish to obtain any additional charts.
- On page 29, the second paragraph commencing "Two hospitals in Montgomery County, . . .": refers to reports of patient room space. There is no citation to the source of these data in the record and we are therefore unable to effectively review it.
- On page 30, in the second paragraph carrying over to Page 31 there are no citations to the data and calculations leading to the statement that there will be a need for 120 MSGA beds by 2018.
- On page 33 there is no citation to where in the record HCH-G amended its application to project an opening in 2014. (For convenience we use 2014 in these Exceptions, but the change in the opening of the hospital refer to a January 2013 date).
- On page 35, in the second and third paragraphs, there are no citations to the calculations of bed need, definitions of "real capacity," or bed ranges.
- On page 36, there are no citations or calculations leading to the bed need for CCH.
- Table 32 includes asserted descriptions of market share but no calculations are provided.

- Pages 38 and 39 refer to data from Applied Geographic Solutions. There is no description of where these data are available in the record.
- Tables 35, 36 and 37 refer generically to "MHCC data," but there are not more detailed descriptions to data that is in the record that was used for these charts.
- In Tables 69, 73, 74, 75, 84, and 85 and on pages 47, 124 and 125 there are references to HSCRC data being used including data or reports that were issued after the evidentiary hearing. But, there is no description of where in the record these data from another commission appear in the record in this proceeding. CCH should be advised of any HSCRC information that was used in the preparation of the Recommended Decision other than that which was in the record when closed and be afforded an opportunity to evaluate and respond to it if necessary.
- The maps at Appendix C are based on data from a private company and have not been made available to the applicants. These maps wrongly rely on extra-record evidence. The reasons for this cannot be identified without access to the data on which they were based, but, for example, the location of SGAEC in relation to the HCH-G site is clearly misidentified, since they are located one mile from each other and the maps identify them as more distant. (HCH#87, p. 16;<sup>4</sup> Exhibit 2). Likewise CCH is located just off I-270 but HCH-

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<sup>4</sup> Throughout these exceptions we utilize the Commission's Docket item numbers when citing to documents in the record in the Upcounty CON review.

G is on a college campus with significant surface street access challenges, yet the map identified them both as just off the highway.

Also, the most current data is not always used as required. For example, the Recommended Decision states on page 10: "As part of this review, MSGA service areas for the five Montgomery County hospitals were defined using 2008 patient origin data at the zip code level." However, COMAR 10.24.10.06B(30) states that "service area means the contiguous area comprised of the postal zip code areas from which the first 85% of a hospital's discharged patients originated during the most recent 12-month period." The 2008 patient origin data is not the most recent 12 month period.

On page 10, the Recommended Decision states; "These service areas were constructed by accumulating contiguous zip code areas from highest to lowest relevance for each hospital until the list of zip code areas was assembled that come closest to accounting, cumulatively, for 90% of total MSGA discharges from either a Maryland or District of Columbia hospital." The Recommended Decision did not use accurate information since the COMAR standard cited above stops at 85%, not 90%.

- 2. CCH takes exception to the use of, and reliance on tables to evaluate the viability of the proposals that are replete with errors. CCH also takes exception to the errors in the description of the positions taken by the parties concerning financial feasibility.**

Attached as Exhibit 1 is a description of these errors.

- 3. CCH takes exception to the Reviewer's May 4, 2010 ruling requiring the production of AHC financial documents, as irrelevant to CCH's financing since AHC is not the applicant, borrower or guarantor of this FHA federally insured CCH debt.**

# Exhibit 3

**IN THE MATTER OF THE  
PETITION OF  
CLARKSBURG COMMUNITY  
HOSPITAL, INC.**

\*  
\*  
\*  
\*

**IN THE  
CIRCUIT COURT  
FOR BALTIMORE CITY  
Case No.: 24-C-11-001046**

\* \* \* \* \*

**MEMORANDUM**

Before the court is a petition for judicial review of a decision of the Maryland Health Care Commission relating to proposed new hospitals in Montgomery County. The decision in question is the Commission's Final Decision of January 20, 2011 approving the application of Holy Cross Hospital of Silver Spring for a Certificate of Need to establish a new 93 bed acute care general hospital in Germantown, Maryland and denying the application of Clarksburg Community Hospital, Inc. for a Certificate of Need to establish a new 86 bed acute care general hospital in Clarksburg, Maryland. The petitioners are Clarksburg Community Hospital, Inc. and Adventist Healthcare, Inc. d/b/a Shady Grove Adventist Hospital.<sup>1</sup>

Participating in the proceedings before this court were the petitioners, as well as the Maryland Health Care Commission and Holy Cross Hospital. The parties all filed memoranda in accordance with Rule 7-207. In addition, the Commission filed a Motion to Correct Administrative Record, seeking to supplement the administrative record with certain documents that were not included in the record transmitted to this court. This motion was opposed by petitioners.

Petitioners present three questions. First, they argue that the Commission violated the

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<sup>1</sup> CCH was an applicant before the Commission; it is a wholly owned affiliate of the other petitioners, who were interested parties.

Administrative Procedure Act and the parties' right to due process by relying on extra-record evidence to support its decision. Second, they assert that the Commission misapplied the law by disregarding the State Health Plan in determining to issue a Certificate of Need to Holy Cross. Finally, they contend that the Commission exceeded its statutory authority by approving the Holy Cross project without required input from the Health Services Cost Review Commission. Each of these arguments will be addressed in turn.

### **1. Reliance on Extra-Record Evidence**

Marilyn Moon, Ph.D., the Chair of the Commission, acted as the Reviewer on the applications. Between October 2009 and August 23, 2010, an extensive administrative record was compiled, and numerous procedural rulings were made. The Reviewer determined that the record would be closed to further submissions on August 27, 2010, and that an evidentiary hearing would be held on certain specified issues. An evidentiary hearing was held from August 30, 2010 through September 16, 2010, culminating in closing arguments.

A Recommended Decision was issued by the Reviewer on December 17, 2010. In the Recommended Decision, the Reviewer relied upon several sources of data that are the subject of petitioners' argument. She cited population data from Spatial Insights, Inc.; historical population data, current population estimates and projected population for 2014 prepared by Applied Geographic Solutions, Inc.; and the "D.C. Discharge databases/Data Set."

The significance of this information relates to the bed need standard. That standard permits an applicant to justify an increase in beds by application of projection methodology, assumptions and targets. Data employed for this purpose include zip code population data sets. Each of the

applicants used zip code level data provided by Claritas in presenting their analysis of a need for their proposed hospitals in estimating the projected market share of the hospital. The Reviewer used zip code area population estimates and projections provided by another vendor. There is no dispute that the population data used by the Reviewer was not part of the administrative record compiled before September 16, 2010.

Petitioners filed exceptions to the Recommended Decision on January 6, 2011, the deadline imposed at the time the Recommended Decision was issued. In their exceptions petitioners protested the use of the data in question. An exceptions hearing was conducted on January 20, 2011, at which time the full Commission voted to adopt the Recommended Decision.

Petitioners rely on the provisions of the Administrative Procedure Act, specifically State Government Article § 10-213(h). That section states:

- (1) The agency . . . may take official notice of a fact that is:
  - (i) judicially noticeable; or
  - (ii) general, technical, or scientific and within the specialized knowledge of the agency.
  
- (2) Before taking official notice of a fact, the presiding officer:
  - (i) before or during the hearing, by reference in a preliminary report, or otherwise, shall notify each party; and
  - (ii) shall give each party an opportunity to contest the fact.

Section 10-214(a) provides that “[f]indings of fact must be based exclusively on the evidence of record in the contested case proceeding and on matters officially noticed in that proceeding.”

Petitioners contend that the Commission’s action contravened the express terms of the statute.

Respondents make several arguments in response. They suggest that the Commission complied with the terms of the statute because it afforded an opportunity to contest the facts. To

support this suggestion they cite a statement from A. Rochvarg, Principles and Practice of Maryland Administrative Law (2011) at 89: "Official notice may even be taken for the first time in the proposed decision as long as the opportunity for objection is provided." They claim that petitioners were not surprised by the use of the data in the Recommended Decision and dispute the argument that petitioners had no meaningful opportunity to challenge the data. They also state that petitioners have failed to establish that any prejudice occurred as a result of the supposed violation.

In support of their position, respondents state that petitioners could have addressed any disparities in the data in their exceptions to the Recommended Decision or in a later filed request for reconsideration. They note that on December 21, 2010 counsel for petitioners informed counsel for the Commission that he would be requesting data used in the decision that was not in the record.<sup>2</sup> However, petitioners' counsel waited until January 26, 2011, after the exceptions hearing had taken place, to request the data. Commission staff sent the requested data in a series of e-mails, ten of which were sent on January 28 and the eleventh on January 31, 2011.

Respondents point to COMAR § 10.24.01.19, which permits the filing of a motion for reconsideration of a Commission decision. They state that petitioners could have sought reconsideration based on an allegation that the data presented significant and relevant information which was not previously presented to the Commission or that the data demonstrated that there had been significant change in factors or circumstances relied upon by the Commission in reaching its

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<sup>2</sup> This information is contained in the Motion to Correct Administrative Record. While the court is not convinced that this material properly forms a part of the administrative record as such, it deems it expeditious to grant the motion in order to consider the impact of this information on the contention that petitioners had an opportunity to contest the use of these facts.

decision.

As to prejudice, the Commission states that while CCH used zip code area population data sets “that could be expected to differ to some degree from that used by the Reviewer, given that the data were supplied by different vendors[,] . . . [i]t is common sense that all zip code area population data sets will contain very similar estimates and projections because the universe of inputs and techniques used to develop these data sets is limited.” The Commission argues that petitioners fail to allege any harm or substantive error in the use of the data by the Reviewer.

The court concludes that petitioners’ position has merit. The explicit terms of the statute mandate that before an agency takes official notice of a fact it shall give each party an opportunity to contest that fact. Contrary to respondents’ arguments, the court’s review of the record convinces it that petitioners were not presented with a meaningful opportunity to contest the data relied upon by the reviewer. The issues presented in this case are of great complexity, and the record, as the Commission notes, is measured in feet rather than inches.<sup>3</sup> The Reviewer’s analysis of the data required a 180 page decision. Following the service of the Recommended Decision, petitioners had twenty days to file exceptions, and were allotted twenty minutes at the exceptions hearing to present all of their objections to the Recommended Decision. It is unrealistic to state that petitioners had a meaningful opportunity to contest the use of this information. And given the circumstances, the failure of petitioners’ counsel to secure the data prior to the exceptions hearing does not militate against this conclusion. Finally, in the court’s view, the right to file a request for reconsideration of a final decision is not an opportunity to contest a fact that the agency proposes to notice within

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<sup>3</sup> It probably could more readily be measured in yards.

the contemplation of section 10-213.

Respondents also argue that the case should not be remanded because petitioners have failed to establish that any prejudice occurred as a result of the violation. The court believes that this argument is misplaced. Whether petitioners were prejudiced by use of the information is ineluctably linked to an analysis of what part that information plays in the findings that were the foundation of the decision. To determine whether the data used by the Commission was equivalent to the data otherwise in the record and what part that information played in the Decision would require the court to undertake the weighing of the data. In seeking to place upon petitioners the burden to demonstrate to this court how the use of this data prejudiced them, respondents would have this court take on the functions of the administrative agency, whose role is to determine the weight to be accorded to evidence.

For this reason, the Decision must be reversed to permit petitioners the opportunity to contest the facts noticed by the Commission after the closing of the record. The Commission must comply with the provisions of section 10-213 by giving the parties a meaningful opportunity to contest the facts of which it took official notice.

## **2. Misapplication of the law**

Petitioners' second argument asserts that the Commission disregarded the bed need standard embodied in the 2009 Acute Care Hospital State Health Plan, COMAR § 10.24.10.04B(2), by the manner in which it determined that Holy Cross had established a bed need at its new proposed location. Petitioners contend that the Commission allowed Holy Cross to relocate 39 beds currently licensed for use at its existing hospital to the new location. Petitioners argue that this contravenes

the provisions of the Plan because the Plan does not permit the shifting of licensed beds in order to make a showing of need.

This argument is founded entirely upon comments made on page 36 of the Decision. After careful consideration of those statements in the context of the entire passage relating to the analysis of the showing of bed need under section (c)(i)(iv), the court does not believe that petitioners' characterization is accurate. The Decision finds that there was an adequate demonstration of bed need based on a service area analysis. The comments on page 36 are not necessary to this analysis. Notably, petitioners seize upon a single statement and do not consider its relation to the entire text of the lengthy and closely-reasoned discussion of the bed need showing. Furthermore, if there were a showing of need, Holy Cross's decision not to use licensed beds at its existing location would not amount to a "shifting" of beds (although it might look like it). The court is convinced that this is an illusory issue.

### **3. Disregard of Health Services Cost Review Commission**

The third argument is based on the provisions of Health-General Article §19-103(d), which provides that the Commission shall coordinate the exercise of its functions with the Health Services Cost Review Commission to ensure an integrated, effective health care policy for the State. Petitioners argue that in awarding a Certificate of Need to Holy Cross, the Commission disregarded the requirements of this section. They rely upon a memorandum from HRCRC provided in response to a request for that agency's input. That memorandum expressed the opinion of HRCRC staff that "neither [applicant] can prudently and successfully undertake the financing, construction and successful operation of a new facility at this time."

In its Decision, the Commission undertook a detailed discussion of the viability of each proposal, which review included the availability of resources necessary to sustain the project. (Final Decision at 148 - 163). Within that discussion, the Decision acknowledges the conclusions of the Health Services Cost Review Commission. After that acknowledgement, the Decision integrates that input with its findings on viability. In the court's view, the Commission's treatment of the HSCRC input complies with the requirements of section 19-103(d).

The statute requires coordination of the Commission's functions with HRCRC. The language does not vest HRCRC with veto power over the Commission decisions. Given the deference that the court must extend to the agency, the weight to be given to HRCRC input should be measured by the Commission, as long as it is cognizant of its statutory obligation to coordinate its function. The Decision of the Commission adequately documents its compliance with this standard.

#### 4. Conclusion

Because the court has concluded that the only defect in the proceedings below was the use of extra-record information in the Decision, that defect may be rectified by a remand for the purpose of enabling petitioner to respond to the information in question. Accordingly, the decision will be reversed and remanded for the purpose of permitting petitioner to comment on the information employed in the Decision.

Dated: February 21, 2012

**W. MICHEL PIERSON, Judge**  
Judge's signature appears on original document  
Judge W. Michel Pierson

IN THE MATTER OF THE  
PETITION OF  
CLARKSBURG COMMUNITY  
HOSPITAL, INC.

\* IN THE  
\* CIRCUIT COURT  
\* FOR BALTIMORE CITY  
\* Case No.: 24-C-11-001046

\* \* \* \* \*

**ORDER**

The court having read and considered the Motion to Correct Administrative Record (No. 12), along with the opposition and reply, it is, this 21<sup>st</sup> day of February, 2012,

ORDERED that the motion is GRANTED, and further

ORDERED that the documents attached to the motion shall be included in the record before this court.

**W. MICHEL PIERSON, Judge**  
Judge's signature appears on original document  
Judge W. Michel Pierson

**IN THE MATTER OF THE  
PETITION OF  
CLARKSBURG COMMUNITY  
HOSPITAL, INC.**

\*  
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\*  
\*  
\*

**IN THE  
CIRCUIT COURT  
FOR BALTIMORE CITY  
Case No.: 24-C-11-001046**

\* \* \* \* \*

**ORDER**

For the reasons set forth in a Memorandum of even date, it is, this 21<sup>st</sup> day of February, 2012,

ORDERED that the Final Decision of the Maryland Health Care Commission in Docket Nos. 08-15-2286 and 09-15-2294 is reversed and the case remanded to the Commission with direction to comply with Md. Ann. Code State Government Article § 10-213(h)(2) as set forth in the Memorandum.

**W. MICHEL PIERSON, Judge**  
Judge's signature appears on original document

Judge W. Michel Pierson

# Exhibit 4

STATE OF MARYLAND

Marilyn Moon, Ph.D.  
CHAIR



Ben Steffen  
ACTING EXECUTIVE DIRECTOR

**MARYLAND HEALTH CARE COMMISSION**

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215  
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March 2, 2012

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Re: **Remand from the Circuit Court for Baltimore City**  
Case No. 24-C-11-001046  
**Montgomery County New Hospitals Review**  
Holy Cross Hospital-Germantown (Docket No. 08-15-2286)  
Clarksburg Community Hospital (Docket No. 09-15-2294)

Dear Counsel:

In his February 21, 2012 Memorandum and Order, W. Michel Pierson, Judge of the Circuit Court for Baltimore City, sustained the Commission on two out of the three issues raised by petitioners Clarksburg Community Hospital and Adventist HealthCare, Inc d/b/a Shady Grove Adventist Hospital and Shady Grove Adventist Germantown Emergency Center (collectively, "Adventist Entities"). The Court remanded the matter to the Commission to give the Adventist Entities an opportunity "to comment on the information employed in the Decision."

On remand, the Adventist Entities have the opportunity to file comments specific to the use of "extra-record" data in the Decision. Specifically, at issue on remand, are "several sources of data that are the subject of petitioners' argument ... population data from Spatial Insights, Inc.; historical population data, current population estimates and projected population for 2014 prepared by Applied Geographic Solutions, Inc; and the 'D.C. Discharge databases/Data Set.'" The record in this matter indicates that the Adventist Entities have had access to the above-referenced data for over one year.

Diane Festino Schmitt, Esquire  
Jack C. Tranter, Esquire  
March 2, 2012  
Page 2

I suggest that, on or before April 2, 2012, the Adventist Entities file their comments on the use of the data, pointing out with specificity how use of the data affected the analysis supporting the Decision. Holy Cross Hospital may respond to the Adventist Entities' filing on or before April 17, 2012. I believe that this time frame will be adequate; if not, counsel for the parties should seek to agree upon different dates and so advise Suellen Wideman, Assistant Attorney General.

I want to note that the issue on remand is limited to the use of specific data in the Commission's decision. Parties are cautioned not to attempt to raise other issues that were or could have been raised in earlier filings before the Commission or the Circuit Court. For instance, Clarksburg Community Hospital did not contend in its petition to the Circuit Court for Baltimore City that its application to establish a new hospital should have been approved by the Commission; thus, it cannot argue that position on remand.

After reviewing the parties' filings, I will determine whether additional filings or oral argument will be helpful to me. I will issue a Recommended Supplement to the Commission's Decision. Parties will then have the opportunity to file exceptions and responses regarding the Recommended Supplement to the Decision, and can present oral argument before the full Commission.

Sincerely,



Marilyn Moon, Ph.D.  
Chair, Commissioner/Reviewer

cc: Loretta Shapero, Esquire  
Ulder Tillman, M.D., M.P.H.  
John J. Eller, Esquire  
Paul E. Parker  
Joel Riklin  
Suellen Wideman, AAG

# Exhibit 5

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March 7, 2012

Offices in  
Maryland  
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Virginia

**VIA E-MAIL AND FIRST CLASS MAIL**

Marilyn Moon, Ph.D.  
Chair, Commissioner/Reviewer  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Md. 21215

Re: Reversal and Remand of Circuit Court for Baltimore City  
Case No. 24-C-11-001046  
Montgomery County New Hospitals Review  
Holy Cross Hospital-Germantown (Docket No 08-15-2286)  
Clarksburg Community Hospital (Docket No. 09-15-2294)

Dear Dr. Moon:

I am writing of on behalf of Clarksburg Community Hospital and Adventist HealthCare, Inc. d/b/a Shady Grove Adventist Hospital and Shady Grove Adventist Germantown Emergency Center (collectively the "Adventist Entities") in response to your letter of March 2, 2012 to counsel in the above-referenced matter (the "March 2 Letter"). The March 2 Letter follows Judge Michel Pierson's February, 2012 Memorandum and Order (the "Pierson Ruling") reversing the Maryland Health Care Commission's January 20, 2011 Decision awarding Holy Cross Hospital a CON for a new 93 bed acute care hospital in Germantown, Maryland and denying Clarksburg Community Hospital's CON application for a new 86 bed acute care hospital in Clarksburg (the "Decision"). In addition to reversing the Decision, the Pierson Ruling also remanded the matter to the Commission "with direction to comply with the Md. Ann. Code State Government Article §10-213(h)(2)." For your convenience, a copy of the Pierson Ruling is attached hereto.

The March 2 Letter states that "on remand, the Adventist Entities have the opportunity to file comments specific to the use of 'extra-record' data in the Decision . . . The record in this matter indicates that the Adventist Entities have had access to the above-referenced data for over one year." The March 2 letter further proposes that "on or before April 2, 2012, the Adventist Entities file their comments on the use of the data, pointing out with specificity how use of the

Marilyn Moon, Ph.D.  
March 7, 2012  
Page 2

data affected the analysis supporting the Decision.” A response time for Holy Cross of April 17, 2012 is also proposed, with the caveat that you “believe that this time frame will be adequate.” The March 2 Letter concludes by noting that “After reviewing the parties’ filings, I will determine whether additional filings or oral argument will be helpful to me. I will issue a Recommended Supplement to the Commission’s Decision.”

The Adventist Entities take this opportunity to respond to the proposed schedule and procedure described in the March 2 Letter.

First, the Adventist Entities would like to point out that the Pierson Ruling constitutes a final Circuit Court Decision that may be appealed to the Court of Special Appeals pursuant to Md. Code Ann. State Gov’t §10-223(b). An appeal to the Court of Special Appeals must be filed within “30 days after entry of the judgment or order from which the appeal is taken.” Md. Rule 8-202(a). The Pierson Ruling was entered by the Circuit Court for Baltimore City on February 28, 2012, giving the parties until March 29, 2012 to note an appeal. Because it is possible that the Adventist Entities or Holy Cross may appeal, the Adventist Entities respectfully assert that the remand schedule and procedure set forth in the March 2 Letter is premature.

Second, the Adventist Entities believe that a rushed process and schedule that requires them to “file their comments” on April 2, 2012, before all of the extra record evidence is even officially noticed by the Commission and formally admitted into the record will not provide the sort of “meaningful opportunity to respond” to the extra record evidence that the Pierson Ruling and the Maryland Administrative Procedure Act contemplates. The Pierson Ruling states that

The explicit terms of the statute mandate that before an agency takes judicial notice of a fact it shall give each party an opportunity to contest that fact. Contrary to [the Commission and Holy Cross’] arguments, the court’s review of the record convinced it that [the Adventist Entities] were not presented with a meaningful opportunity to contest the data relied upon by the reviewer. The issues presented in this case are of great complexity, and the record, as the Commission notes, is measured in feet rather than inches. The Reviewer’s analysis of the data required a 180 page decision.... Whether [the Adventist Entities] were prejudiced by use of the information is ineluctably linked to an analysis of what part that information plays in the findings that were the foundation of the decision.... For this reason, the Decision must be reversed to permit [the Adventist Entities] the opportunity to contest the facts noticed by the Commission after the closing of the record. The Commission must comply with the provisions of section 10-213 by

Marilyn Moon, Ph.D.  
March 7, 2012  
Page 3

giving the parties a meaningful opportunity to contest the facts of which it took official notice. (See Pierson Ruling at pp. 5-6).

Thus, the Pierson Ruling squarely holds that the Adventist Entities must have a "meaningful opportunity to contest the facts of which [the Commission] took official notice." The official notice statutes and regulations require that the agency "notify each party" of facts it may use in its decision (see St. Gov't Art. §10-213(h)) and incorporate facts by reference into the record "upon notice to the parties and an opportunity to object." COMAR 10.24.11A(3). To date, the Adventist Entities have still not been so notified of the extra record evidence under §10-213(h) or COMAR 10.24.11.A(3). Furthermore, the totality of the extra record evidence has not even been formally entered into the administrative record.

Pursuant to §10-213(h), in order for the Adventist Entities to have a meaningful opportunity to respond, they must know precisely WHICH extra-record data the Commission used, reviewed and considered, the format in which the Commission reviewed it, the direct source of the information, and they must know which assumptions outside vendors may have used to generate the data put before the Reviewer in preparing the Decision.

The Adventist Entities cannot ask for precisely what that extra record evidence/data is, because only the Commission knows which extra record evidence it used, reviewed and considered in preparing the Decision. Put simply, all extra record data – and not just compilations from it or staff analysis of it – that "plays in the findings that were the foundation of the decision" (see Pierson Ruling at p. 5) should be both formally made a part of the record and provided to the Adventist Entities and Holy Cross. The Adventist Entities, therefore, propose that all extra-record data that was used in, mentioned in, considered by or relied upon by the Reviewer in the preparation of the Decision be provided to both the Adventist Entities and to Holy Cross Hospital, in the same format that it was presented to and considered by the Reviewer. The data can be transmitted to those parties, and, at the same time, officially made a part of the administrative record as required by the Maryland Administrative Procedure Act.

Once that information is compiled, formally made a part of the administrative record and provided to the Adventist Entities and Holy Cross, we can discuss further a process for how the Adventist Entities can respond to/contest that data. After all, the Pierson Ruling did reverse the Decision because there were deficiencies in the process used for noting and including evidence in the agency record. The process on remand should accordingly be crafted to correct those deficiencies and should ensure that all parties are formally notified of and provided with the additional evidence.

Marilyn Moon, Ph.D.  
March 7, 2012  
Page 4

In order for the Adventist Entities to have the type of meaningful opportunity to respond to the extra record evidence that the Pierson Ruling and the Maryland Administrative Procedure Act contemplates, the Adventist Entities respectfully request that you:

- (1) withhold issuing a schedule/process for the remand until after the appeal period passes (with no appeal having been filed);
- (2) formally place into the administrative record the full data set of extra record evidence that the Commission reviewed, and considered in reaching the Decision; and
- (3) notify the Adventist Entities and Holy Cross of that evidence by providing them with the full data set referenced in point two.

Thank you very much for your attention to this matter.

Sincerely



Diane Festino Schmitt

DFS/pad  
Attachment

cc: Howard L. Sollins, Esquire  
Lisa D. Stevenson, Esquire  
John J. Eller, Esquire  
Jack C. Tranter, Esquire  
Philip F. Diamond, Esquire  
Loretta Shapero, Esquire  
Ulder Tillman, M.D., M.P.H.  
Mr. Paul E. Parker  
Mr. Joel Riklin  
Suellen Wideman, AAG

# Exhibit 6

**Schmitt, Diane**

---

**From:** Suellen Wideman [swideman@mhcc.state.md.us]  
**Sent:** Wednesday, March 28, 2012 2:54 PM  
**To:** Schmitt, Diane  
**Cc:** Stevenson, Lisa D.; Jack Tranter; pdiamond@gejlaw.com; Eller, John; Paul Parker; Joel Riklin; Ruby Potter  
**Subject:** RE: Remand from the Circuit Court for Baltimore City, Case No. 24-C-11-001046, Montgomery County New Hospitals Review, Holy Cross Hospital-Germantown (Docket No. 08-15-2286), Clarksburg Community Hospital (Docket No. 09-15-2294)

Diane,

Jack Tranter has informed me that he will filing a response to your letter.

Dr. Moon will be sending you and other counsel a letter (of course, after she reviews Mr. Tranter's expected letter). The short answer is that the data that Ober Kaler received in January of 2011 is all the extra record data. There are no additional data, assumptions, documents, etc. There simply is nothing else. These documents will be downloaded to a thumb drive and placed in the record. I think it is reasonable to consider them in the record. Would you like me to forward the emails to you again? All this will be detailed in a letter, but be assured that Ober Kaler has had all the extra record information since the last week in January 2011.

I'm sorry that I've been so hard to reach. As I understand that Rob Jepson has told you, I've been spending a whole lot of time in Annapolis.

Suellen

Suellen Wideman  
Assistant Attorney General  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215  
410-764-3326  
[swideman@mhcc.state.md.us](mailto:swideman@mhcc.state.md.us)

---

**From:** Stevenson, Lisa D. [mailto:ldstevenson@ober.com]  
**Sent:** Tuesday, March 27, 2012 2:10 PM  
**To:** Paul Parker; 'Jack Tranter'; 'pdiamond@gejlaw.com'; Suellen Wideman; Joel Riklin; Ben Steffen; Ruby Potter  
**Cc:** Schmitt, Diane; Eller, John  
**Subject:** Remand from the Circuit Court for Baltimore City, Case No. 24-C-11-001046, Montgomery County New Hospitals Review, Holy Cross Hospital-Germantown (Docket No. 08-15-2286), Clarksburg Community Hospital (Docket No. 09-15-2294)

Please see attached.

Regards,

4/23/2012

Lisa

**Lisa D. Stevenson, DPM, JD**

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# Exhibit 7

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May 4, 2012

Offices in  
Maryland  
Washington, D.C.  
Virginia

**VIA E-MAIL AND HAND DELIVERY**

Suellen Wideman, Esquire  
Assistant Attorney General  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Md. 21215-2299

Re: In the Matter of Proposed New Hospital in Montgomery County  
Holy Cross Hospital of Silver Spring (Docket No 08-15-2286)  
Clarksburg Community Hospital (Docket No. 09-15-2294)  
Before The Maryland Health Care commission

Dear Suellen:

In accordance with the schedule established for these remand proceedings, enclosed please find an original and six copies of Adventist's Comments On Additional Evidence Entered Into The Record.

Very truly yours,



Diane Festino Schmitt

DFS/pad  
Attachment

cc: Howard L. Sollins, Esquire  
Lisa D. Stevenson, Esquire  
John J. Eller, Esquire  
Jack C. Tranter, Esquire  
Loretta Shapero, Esquire

IN THE MATTER OF	*	BEFORE THE
PROPOSED NEW HOSPITALS	*	MARYLAND HEALTH CARE
IN MONTGOMERY COUNTY	*	COMMISSION
Holy Cross Hospital of Silver Spring	*	
Docket No. 08-15-2286	*	
Clarksburg Community Hospital	*	
Docket No. 09-15-2294	*	
* * * * *		

**ADVENTIST’S COMMENTS  
ON ADDITIONAL  
EVIDENCE ENTERED INTO THE RECORD**

Clarksburg Community Hospital, Inc. (“CCH”) and Adventist HealthCare, Inc. (“AHC”) d/b/a Shady Grove Adventist Hospital (“SGAH”), which is also the owner and operator of Shady Grove Adventist Germantown Emergency Center (“GEC”) (collectively “Adventist”), through undersigned counsel, hereby submits these comments on the additional information placed into the record by the Maryland Health Care Commission (“MHCC”) on March 29, 2012 (the “Additional Evidence”).

**I. INTRODUCTION**

The Additional Evidence significantly changes the landscape of this remand in which Holy Cross Hospital of Silver Spring, Inc. (“Holy Cross”) attempts to revive its presently revoked certificate of need (“CON”) to construct a new hospital in Germantown. Because the Additional Evidence erases Holy Cross’s ability to show “need for the hospital beds sought” and because the Additional Evidence demonstrates that the proposed project is not “financially feasible,” Holy Cross’ efforts to revive its defunct CON must be denied. See COMAR 10.24.01.08G(3)(b) (requiring a finding of need for the beds Holy Cross seeks based on the

prescribed need analysis); see also 10.24.10.04(B), (2) (6) and (13) (requiring that “need” for and financial feasibility of the project be satisfied under the State Health Plan Acute Care Chapter).

The decades old CON process exists to “to assure that health care resources, which are expensive to create and maintain, are sufficient to meet the public need but not excessive.” Medstar Health v. Maryland Health Care Comm’n, 391 Md. 427, 431 (2006). Any CON decision should be based on sound, and accurate information and must be consistent with the State Health Plan (SHP). See HEALTH-GEN §19-126(c). If the CON Holy Cross now seeks to revive is flawed – which Adventist establishes in these comments – the MHCC should not approve it. Given that this would be Maryland’s first CON approved hospital in over 32 years, and given its impact for decades to come, it is crucial for the MHCC to “get the process right” in applying its standards. A mistake has far-reaching and long term consequences to the delivery of health care services in Maryland. Maryland’s citizens are entitled no less than a full, fair and open process.

## **II. PROCEDURAL POSTURE**

### **A. The Original MHCC Decision Awarding Holy Cross A CON And Reversal By The Circuit Court For Baltimore City.**

This CON review was initially a comparative one with Holy Cross seeking to construct a new hospital in Germantown and Adventist to construct a new hospital in Clarksburg.<sup>1</sup> Although

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<sup>1</sup> The record in this case documents that Adventist has been engaged for years in a careful, deliberate and public process leading to the development of a new hospital on a medical campus in Clarksburg, the fastest growing area in Montgomery County. It included: acquiring a site in the town center planned as the focus of Montgomery County’s development along the I-270 corridor toward Frederick County; obtaining support from and collaboration with Frederick Memorial Hospital for the development of that campus; securing all land use and environmental regulatory approvals; obtaining support from the upcounty medical community; and establishing a process for broad community input and coordination with consumers and business leaders. Holy Cross, using a different and more secretive planning process, announced its plans for a new hospital in Germantown, at a site already served by numerous other hospitals and located only one mile from the emergency services offered by GEC.

Holy Cross initially resisted comparative review, Holy Cross ultimately acquiesced to that process. After a 2+ year MHCC proceeding, and despite the urging of the Health Services Cost Review Commission to the MHCC that neither CON be approved, in December, 2010, Dr. Moon, as Reviewer, issued a Recommended Decision in favor of Holy Cross.

Adventist timely filed Exceptions in January 2011 in keeping with the CON regulations. The very first of these Exceptions was a plea that the MHCC delay considering and voting on the Recommended Decision because it improperly relied on "extra-record" evidence that appeared for the first time in the December 2010 Recommended Decision itself.

Within its Exceptions, Adventist reasonably asked that the "extra-record" evidence be entered into the record and that Adventist receive an opportunity to respond to that evidence before a final decision was rendered. Had that been done, this issue would have been addressed a year ago.

Instead of agreeing with Adventist's legally sound and procedurally correct request, Holy Cross chose to fight, insisting that the MHCC press ahead, claiming in its Response that Adventist's Exceptions were "foolish," "ridiculous" and a form of "quibbling." The MHCC rejected Adventist's Exceptions, and decided on January 20, 2011 to award Holy Cross a CON and deny CCH a CON (the "CON Decision").

As was its absolute right under Maryland law, Adventist appealed the CON Decision to the Circuit Court for Baltimore City.<sup>2</sup> Therein, Adventist raised the CON Decision's improper reliance on the "extra-record" evidence. Because this evidence was neither provided nor made part of the MHCC record before the CON Decision was reached, the Adventist Entities never

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<sup>2</sup> Adventist did not appeal the MHCC's denial of the CCH CON. Adventist's decision in this regard does not equate to either its' acquiescence to the CON Decision, or to Adventist's belief that these ongoing remand proceedings are somehow a mere procedural "speed bump" on the road to development of any proposed Holy Cross Germantown Hospital.

had any meaningful opportunity to ask questions about it, rebut it or otherwise respond to it. This, they argued, denied them due process and was grounds to reverse the CON. Holy Cross strenuously opposed the appeal, persistently asserting that there was no problem with the process, the CON should stay just as is, and that Adventist could not possibly be prejudiced by the "extra-record" data Adventist had never had a chance to comment on to the MHCC.

On appeal, Baltimore City Circuit Court Judge J. Michel Pierson did not find Adventist's arguments to be "foolish" or "quibbling." Far from it. Instead, Judge Pierson independently concluded that Adventist was right and that the CON Decision violated the governing Maryland Administrative Procedures Act.<sup>3</sup> Judge Pierson voided the CON, ruled further that Adventist **MUST** be afforded a meaningful opportunity to respond to the data not entered into the record, and ordered that the case be sent back the MHCC for that to happen. Thus, by fighting about whether Adventist should receive the legally mandated opportunity to respond to information used in the CON Decision, and by refusing to collaborate on an important point of applicable administrative law, Holy Cross lost its CON.

**B. The Proceedings On Remand – Adventist Responded In A Timely, Procedurally Proper Way To The Information On Which These Comments Are Based.**

Once Judge Pierson ruled, Adventist was in frequent contact with the MHCC about the process for commenting on the Additional Evidence. Initially, on March 2, 2012, Dr. Moon suggested that Adventist file its comments on the extra record evidence by April 2, 2012. Adventist responded on March 7, 2012, that it could not file comments by April 2, 2012 because

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<sup>3</sup> Judge Pierson did not agree with two other issues Adventist raised on appeal, and those issues are therefore not presently before the MHCC. Since the Holy Cross CON was voided and the case remanded back to the MHCC, those additional issues are not yet ripe for further judicial appeal. Under applicable Maryland law, however, those issues remain preserved for potential judicial review down the road. See Singley v. County Commissioners of Frederick County, 178 Md. App. 658, 666-74 (2008).

Adventist still did not know which extra record data the MHCC “used, reviewed and considered.” Adventist further stated it could not guess or speculate about what constituted the universe of the extra record data, since the evidence had not yet been entered into the record and only the MHCC knew what data it had used, reviewed and considered.

Having heard nothing further on what constituted the complete extra record data, or when that data would be entered into the MHCC administrative record, Adventist wrote to MHCC counsel on March 27, 2012. On March 28, 2012, counsel for MHCC sent an e-mail, which stated, for the first time, that “the data Ober[Kaler received in January of 2011 is all the extra record data. There are no additional data, assumptions, documents, etc. There simply is nothing else.”<sup>4</sup> That e-mail further said that the documents “will be downloaded to a thumb drive and placed in the record.” On March 29, 2012, that occurred, Adventist picked up the thumb drive – which contained 152 megabytes of data – and MHCC counsel asked to talk about “what Adventist has in mind as a reasonable time” for filing comments.<sup>5</sup>

Once Adventist received what has been characterized as the complete universe of extra record data, and that data had been entered into the record in accordance with Judge Pierson’s ruling, Adventist could and did begin to evaluate the data in earnest. After preliminary review,

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<sup>4</sup> This refers to certain data the MHCC made available to Adventist in late January 2011, after the Decision was issued. On appeal, Holy Cross and the MHCC argued to Judge Pierson that giving data to Adventist after the record closed satisfied the law. Judge Pierson did not agree, and held instead that the case must be remanded to afford Adventist a meaningful opportunity to respond to the MHCC about the extra record data. (See Pierson Ruling at pp. 4-6).

<sup>5</sup> The MHCC supplemented the Additional Evidence contained on the thumb drive on April 3, 2012, and also corrected some table data errors in the CON Decision.

Adventist proposed in an April 11, 2012 letter to Dr. Moon that Adventist could file its comments by May 7, 2012. Adventist subsequently agreed to advance its filing to May 4, 2012.<sup>6</sup>

Following Adventist's April 11, 2012 letter, Holy Cross filed an "emergency" motion, on April 18, 2012, asking the MHCC to permit Holy Cross to continue project development – without CON approval – because Holy Cross wished to follow its prearranged construction schedule. Adventist strongly opposed the Motion, arguing in part that the emergency was of Holy Cross's own making. The MHCC then heard argument on the Motion on April 25<sup>th</sup>. During the hearing, a Commissioner asked specifically about whether the MHCC had ever granted such request before. All parties agreed the answer is no. Indeed, approval of the Holy Cross Motion would have established a new precedent with far-reaching implications for the CON process across the board for all health care providers. Accordingly, the MHCC rightly did not grant the Holy Cross Motion and tabled it instead.<sup>7</sup>

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<sup>6</sup> Throughout the remand, the MHCC and Dr. Moon in particular have commented that Adventist has had the data for 15 months. We appreciate that Dr. Moon may not share Adventist's perspective on this, but it is important that Adventist share its perspective for the full MHCC. Put simply, it would have been a fruitless waste of resources for Adventist to review any data Adventist received UNTIL Judge Pierson revoked the Holy Cross CON in late February, 2012. Until that ruling, data review would have been a purely academic exercise because: the MHCC would and could not have considered any Adventist submission about the data, and Holy Cross would not have responded to it. Once Judge Pierson revoked the CON and remanded the case to the MHCC, Adventist was given the right to comment on the extra record data to the MHCC.

Similarly, UNTIL the MHCC delineated the complete universe of the Additional Evidence on March 28, 2012, entered it into the record on March 29, and then augmented it on April 3, Adventist would have been engaging in a guessing game and supposition about the Additional Evidence. This is all the more so because the MHCC and Holy Cross both claimed – during the Exceptions process and appeal—that the CON Decision must be upheld without any further Adventist comment. Thus, Adventist respectfully and strongly disputes any suggestion that Adventist delayed the process by not commenting sooner than today.

<sup>7</sup> At the hearing, Holy Cross attempted to engage in a "name-calling" exercise, claiming that Adventist was delaying the process for the sake of delay and claiming further that Adventist is motivated by forcing Holy Cross to "lose money" while the remand proceeds. Adventist did not

At this point, Adventist is confident that the MHCC will give Adventist's Comments full and fair consideration under the applicable rules. As will be described next, the Additional Evidence shows that the earlier (now revoked) 2011 Holy Cross CON should not be revived.

### **III. ADVENTIST'S COMMENTS**

#### **A. The Additional Evidence Makes Clear That The Invalid Holy Cross CON Should Not Be Revived.**

As the Circuit Court explained in its Ruling remanding the case to the MHCC, the Additional Evidence relates to the vital CON question of whether Holy Cross established a need for its project. Unfortunately for Holy Cross – which seeks to treat this remand proceeding as a merely pro forma step in the further development of its project – the Additional Evidence does not support reviving the Germantown CON. Quite the opposite. Instead, the Additional Evidence shows that: Holy Cross has not demonstrated a need for its Germantown facility; and that Holy Cross's project is not financially feasible.

HEALTH-GEN §19-126(c), titled "Required [A]pprovals," provides that: [a]ll decisions of the Commission on an application for a certificate of need. . . shall be consistent with the State Health Plan and the standards of review established by the Commission." The burden to establish both need and financial feasibility lies squarely on Holy Cross as applicant. COMAR 10.24.10.04(B)(6). Indeed, the CON Decision previously determined that "the MSGA beds proposed for the HCH-G project were consistent with COMAR 10.24.10.04(B)(2)" (at p. 120).

The Additional Evidence negates the CON Decision's finding that Holy Cross established bed need and negates the CON Decision's finding that the Holy Cross project is financially feasible. (CON Decision at p. 74). Absent a showing of need and financial

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take the bait, responding instead with the facts of the case, the facts of Judge Pierson's ruling, and the long standing CON law, all of which support Adventist's position every step of the way.

feasibility, the MHCC cannot revive the Holy Cross CON. Holy Cross's inability to show both need for its proposed bed complement and financial feasibility in light of the Additional Evidence will be separately discussed.

1. **The Additional Evidence Shows That There is No "Need" For The Proposed Holy Cross Germantown Facility.**

The SHP project review standards require that an applicant prove the hospital beds it seeks are needed. See COMAR 10.24.10.04B(2) and (6). The CON Decision's analysis of the need for the Holy Cross beds begins on page 35. Richard J. Coughlan – an expert witness in this and many other CON reviews since 1995 – considered the CON Decision's need analysis and sought to replicate and test the CON Decision's analysis and conclusions in light of the Additional Evidence. He analyzed the Additional Evidence in full reliance on the MHCC's assurance that it had provided all information it considered in reaching the CON Decision as part of the Additional Evidence.<sup>8</sup>

As described in the Coughlan Affidavit, the MHCC included two types of data on the thumb drive that defined the Additional Evidence. The first data were population estimates and projections for Montgomery County residents generally, as well as population estimates and projections for the seven existing hospital and two proposed hospital service areas. These data are referenced and included in CON Decision page 39, Table 26, called the "Historic Population Change 2000 to 2008." Table 26 also includes population changes for the proposed CCH and Holy Cross Germantown hospital Expected Service Areas.

The CON Decision states on page 39 that Table 26 was prepared using zip code areas. It was possible to identify the zip codes assigned to the Table 26 service areas because, on April 3, 2012, the MHCC gave Adventist and Holy Cross, as part of the Additional Evidence, the service

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<sup>8</sup> As the Affidavit of Richard P. Coughlan ("Coughlan Affidavit"), attached hereto as Exhibit A describes, Mr. Coughlan is the former director of Maryland's CON program.

area zip codes for the 7 existing hospitals listed on Table 26. The zip codes assigned to the CCH and Holy Cross applications were found in CCH and Holy Cross's respective applications. Mr. Coughlan identified the 42 zip codes that comprise Montgomery County. These are listed on Attachment 1, to the Coughlan Affidavit.

Analyzing the population data the MHCC identified and entered into the record as part of the Additional Evidence, along with another document the MHCC provided called "Population Estimates and Projections Shown in Tables 26 and 27 of the Final Decision" (also labeled as Item 2 031111.pdf), Mr. Coughlan could match, with close proximity, the population estimates and projections appearing in Tables 26 and 27 of the CON Decision. (See Coughlan Affidavit).

The second type of Additional Evidence data Mr. Coughlan evaluated consists of hospital inpatient utilization data for the Maryland and District of Columbia hospitals for the ten-year period 1998-2008. Analyzing this Additional Evidence data, Mr. Coughlan could also match, with close proximity, the 2008 Medicare Discharge Rate of 252.45 shown on Table 29, called "Montgomery County Target Values" found on page 40 of the CON Decision.

Mr. Coughlan conducted this analysis as follows: In the Maryland Hospital database, there were 26,538 Medicare Medical/Surgical/Gynecological/Addictions ("MSGA") bed discharges reported in 2008. From the District of Columbia Hospital data base, there were 3,555 Medicare MSGA discharges. Together, these Medicare discharges total 30,093. After dividing this total by the 2008 estimated population of Montgomery County residents aged 65 and older (taken directly from Table 26 in the CON Decision) and multiplying the result by 1,000, a 2008 Medicare discharge rate of 257.16 was determined. This 257.16 figure is less than a 2% difference from the 252.45 Montgomery County Medicare Discharge Rate the MHCC used and discussed on page 40, Table 29 of the CON Decision. The fact that Mr. Coughlan's Montgomery County Medicare MSGA discharge rate calculations approximates the 252.45 value

shown on the MHCC's Table 29, validates the approach he used to test the CON Decision's identification of the discharge rate.

Mr. Coughlan then followed the same approach to test the p. 40 CON Decision's Table 29 published 2008 Non-Medicare discharge rate of 66.51 in light of the Additional Evidence. This time though, he obtained strikingly different results.

Based on the Additional Evidence, in 2008, there were 24,889 non-Medicare MSGA cases discharged from a Maryland hospital among Montgomery County residents. That same year, there were 4,600 non-Medicare MSGA discharges from a District of Columbia hospital. 24,889 plus 4,600 equals 29,489. These 29,489 MSGA discharges were then divided by the 2008 Montgomery County population age 15-64 taken from Table 29 (CON Decision p. 39), and multiplied by 1,000. The result is a non-Medicare discharge rate for the Montgomery County population age 15-64 of 47.29, which is 28% lower than the 66.51 published rate on Table 26.

Even though the same approach closely approximated the 2008 Medicare MSGA discharge rate, the approach yielded – a much lower Non-Medicare Discharge Rate than the MHCC Table 29 CON Decision published rate. Table 29 shows a 66.51 discharge rate for the non-Medicare population, not a 47.29 rate. Clearly, this is a significant discrepancy between the two figures that cannot be reconciled from the actual data.

Next, as yet another test, Mr. Coughlan considered the Montgomery County Non-Medicare Discharge Rate for the 10 years of actual MSGA discharge data from 1998-2008, provided by the MHCC. See, Attachment 2 to Coughlan Affidavit. For the periods 1998-2008, none of the Montgomery County Non-Medicare Rates in any year come close to the 66.51 2008 Non-Medicare Discharge Rate shown on CON Decision Table 29. In fact, all the Non-Medicare Discharge Rates Mr. Coughlan calculated for the 1998 through 2008 period much more closely approximate the lower discharge rate Mr. Coughlan calculated for 2008 using the Additional

Evidence the MHCC provided. That is, Mr. Coughlan's Discharge Rates for the 10 year period range between 43 and 48 MSGA discharges per 1,000 population age 15-64, is much closer to Mr. Coughlan's calculated 47.29 rate than to the MHCC's published 66.51 rate. (See Attachment 2 to Coughlan Affidavit).

Interestingly, during the same 1998 to 2008 10-year period, the Medicare discharge rate for the Montgomery County age 65+ population ranged between 232.10 and 259.29 per 1,000, which approximates the 252.45 2008 discharge rate obtained for the Montgomery County resident Medicare population as shown for 2008 in CON Decision Table 29. Thus, it is reasonable to conclude that if Table 29's 2008 Medicare discharge rate is accurate as calculated and tested for the preceding 10 years, then Table 29's non-Medicare discharge rate must be wrong.

The discrepancy Mr. Coughlan identified in the Non-Medicare discharge rates for 1998-2008 leads to a further conclusion. This further conclusion is that the CON Decision's forecast of MSGA bed need in 2018 for the seven existing hospital and two proposed hospital service areas (see CON Decision Tables 30 and 31) relied upon incorrectly calculated non-Medicare discharge rates which means those forecasts are likewise wrong. This is a logical conclusion since discharge rates are an integral factor and flow through in the computations required to generate the Non-Medicare trend values found on Table 28 – "Average Annual Changes in Discharge Rates and Average Length, Montgomery County 1998-2008," Table 30 – "Gross MSGA Bed Need, MSGA Bed Capacity and Net MSGA Bed Need, Seven Selected Hospitals," and found on Table 31 – "Gross MSGA Bed Need and Implied Bed Need at the New Hospitals at Selected Levels of Market Share Capture of Bed Demand, Two New Hospital Expected Service Areas."

These differences are very significant because the entire premise of approving the Holy Cross CON application in 2011 was the MHCC's projections of MSGA bed need in 2018 among future adult residents of an 18 zip code area of Montgomery County. The year 2018 is obviously 10 years after the 2008 discharge hospital data used in the CON Decision and is 20 years from the earliest (1998) data used. Consequently, the Additional Evidence, when accurately analyzed, shows that an integral numerical factor in the CON Decision's 2018 MSGA need projections are indeed very far off, and without correction, do not result in accurate 2018 MSGA bed need projections for Montgomery County residents. Put simply, the CON Decision's 2018 MSGA bed need projections do not support a finding of need for the 75 MSGA and ICU beds proposed for the Holy Cross Germantown project.<sup>9</sup>

In addition to considering the population and inpatient hospital utilization data the MHCC included as part of the Additional Evidence, Mr. Coughlan also considered the additional Average Length of Stay ("ALOS") adjustment that is made for each hospital with actual MSGA ALOS in the base year that exceeded its case mix-adjusted ("CMA") ALOS. Mr. Coughlan further considered the CMA ALOS analysis – CMA by Diagnostic Related Group ("DRG") reports provided for Maryland hospitals, 2005-2009. (This adjustment is described by the MHCC at the bottom of page 40 of the CON Decision).

After reviewing the CMA by DRG reports and the CON Decision's description of how the additional adjustment was made to the ALOS for each hospital, or more importantly, to the existing and expected hospital service areas, it was impossible for Mr. Coughlan to determine the case-mix adjusted computations used by the MHCC to forecast the 2018 MSGA Gross Bed Need for the hospital services shown on Tables 30 and 31 of the CON Decision. The MHCC, having

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<sup>9</sup> Adult critical care beds, including Intensive Care beds, are part of the larger MSGA inventory. (See, p. 9, *Annual Report on Selected Maryland Acute Care and Special Hospital Services: Fiscal Year 2012*.)

represented that it has provided all Additional Evidence used in the CON Decision, has not included information or calculations that indicate how this CON Decision adjustment to ALOS was made.

Nonetheless, Mr. Coughlan reviewed the actual 2008 MSGA Discharge and Patient Day data indicating which Maryland hospitals provided MSGA services to patients who were residents of the Holy Cross Germantown Expected Service Area. He determined that eight Maryland Hospitals provided 86% of those discharges. He then reviewed the MHCC's report, provided as part of the Additional Evidence, titled, "CMA LOS analysis – CMA by DRG, 01/2008 to 12/2008, and determined that seven of the eight hospitals had actual ALOS for all of their MSGA cases that exceeded their case mix-adjusted ALOS.

With these data, Mr. Coughlan then reduced the actual MSGA patient days and ALOS reported by the seven hospitals for their 2008 discharges of MSGA patient days and ALOS reported by the seven hospitals for their 2008 discharges of MSGA patients among residents of the Holy Cross Germantown Expected Service Area for purposes of projecting the MSGA bed need in 2018. With the lowered case mix-adjusted ALOS for 2008, Mr. Coughlan attempted to test the CON Decision's MSGA 2018 bed need calculations, minimum and maximum, for the Holy Cross Expected Service Area.

An accurate and reliable projection of bed need is a core component of the CON process, which means that a CON based on inaccurate and unreliable projections cannot be supported under the law and regulations. See HEALTH-GEN §19-126(c)(1) (mandating that all CONs "shall be consistent with the [SHP] and the standards for review established by the Commission"); see also Adventist Healthcare Midatlantic, Inc. v. Suburban Hosp. Inc., 350 Md. 104, 121 (1998) (applications that are inconsistent with the governing SHP and CON review criteria are facially "unapprovable"); COMAR 10.24.04(b)(2).

Because these analyses are so critical, Mr. Coughlan recalculated the MSGA Gross Bed Need for the residents of the Holy Cross Germantown Expected Service Area for 2018 using a more accurate non-Medicare discharge rate (described above). This more accurate 2008 Non-Medicare discharge rate is based on the Additional Evidence provided and is consistent with the 1998-2008 data. In doing this calculation, Mr. Coughlan used the MHCC-endorsed 10% market share for the Holy Cross Expected Service Area, and the expected 85% service area adjustment used in Table 31, page 41 of the CON Decision.

Below is a correcting chart, using Mr. Coughlan's more reliable non-Medicare MSGA discharge rate for 2008 and trending it forward to 2018, consistent with the published values shown on CON Decision Table 28. These calculations involved the substitution of corrected minimum and maximum Medicare and Non-Medicare discharge rate and ALOS targets (not corrected for CMA ALOS) in 2018 to project demand for MSGA bed need for the Holy Cross Germantown Expected Service Area as well as the needed MSGA bed capacity at Holy Cross. Mr. Coughlan's calculations give Holy Cross' project the benefit of a higher Medicare MSGA discharge rate (derived from use of the actual 1998-2008 MSGA Non-Medicare and Medicare discharges from Maryland or District of Columbia hospitals, among residents of the Holy Cross Germantown Expected Service Area, as trended at the MHCC rates for Montgomery County published on CON Decision Table 28) than the MHCC used in Table 29.

After interpolating the 2015-2017 Additional Evidence the MHCC added to the record, Mr. Coughlan derived the following minimum and maximum 2018 MSGA discharge rates:

	2008	2018 Minimum	2018 Maximum
MHCC Non-Medicare Rate (Mo.Co.) (From Table 29, p. 40 of the CON Decision)	66.51	64.3	71.2
Corrected Non-Medicare Rate (Mo.Co.)	47.29	45.11	50.36
Corrected Non-Medicare Rate (HCH-G ESA)	47.43	45.84	50.81
MHCC Medicare Rate (Mo.Co.) (From Table 29, p. 40 of the CON Decision)	252.45	240.8	268.8
Corrected Medicare Rate (Mo.Co.)	257.16	245.32	273.82
Corrected Medicare Rate (HCH-G ESA)	252.64	241.02	269.02

The discharge rate values were then used to compute a corrected MSGA bed need forecast for the Holy Cross Expected Service Area for 2015, 2017 and 2018, again, giving the Holy Cross the benefit of the 10% market share the CON Decision embraced, and ALOS projections that adjust for CMA ALOS.<sup>10</sup> The results of this computation are shown on Attachment 3 to the Coughlan Affidavit.

As Attachment 3 establishes, in 2015, Holy Cross will need between 42 and 47 MSGA beds at 70% occupancy, serving between 2,748 and 2,961 MSGA inpatients with a forecasted ALOS of between 3.91 days and 4.02 days. By 2018, that need will increase but only to between 42 and 49 MSGA beds, with forecasted ALOS between 3.71 days and 3.85 days. This finding is significantly below the 75 MSGA beds Holy Cross proposed for its 93 bed hospital. This finding is also in marked contrast to the approval of the CON Decision for Holy Cross on the basis of a need for 75 MSGA beds at an ALOS of 4.56 days, since it is nearly one-half day higher per MSGA case than is reasonably forecasted to be needed.

<sup>10</sup> The CON Decision embraced this 10% market share even though multiple hospitals already serve the Holy Cross Germantown Expected Service Area population.

This discrepancy suggests that projections of MSGA utilization found in the Holy Cross application and CON Decision are not “consistent with observed historic trends in use of the applicable service by the service area population of the hospital or State Health Plan need projections, if relevant.” See COMAR 10.24.10.04B(13)(b)(i). The difference is dramatic. Holy Cross and the MHCC in the Decision find that the need for Holy Cross is consistent with the observed market share performance of 10% (based on the historic MSGA market share performance of the existing Montgomery County hospitals of between 7 and 21%, see p. 42), but miscalculates both the observed historic discharge rates, and ALOS trends of MSGA patients residing in the area Holy Cross expects to serve.

**2. Holy Cross Fails To Present A Financially Feasible CON Application Once The Necessary Corrections To The Holy Cross MSGA Bed Need And Related Changes To Revenues And Expenses Are Taken Into Account.**

Not only is the MSGA bed need calculation wrong, but that error has a major and consequential impact on the financial feasibility of the proposed Holy Cross Germantown hospital. The SHP project review standards require that a hospital capital project be financially feasible within 5 years of initiating operations or less. COMAR 10.24.10.04(B)(13). The CON Decision’s financial feasibility analysis commences on page 67 and states that a hospital capital project “shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.”

On page 69 of the CON Decision, the MHCC relies on Holy Cross’s assurance that it will be profitable by the third year of operation: “HCH-G projects profitability by the third year of operation.” On page 73, the CON Decision equally relies on what it characterized as the Holy Cross “relatively conservative” assumptions. These assumptions included, in part, the “nominal growth in population” in area to be served. However, as explained in the previous section, the

non-Medicare MSGA discharge rate for the Holy Cross Expected Service Area population is substantially lower, even using the CON Decision's assumed Holy Cross 10% market share. Critically for these remand proceedings, this in turn means that Holy Cross will simply not have the revenues it needs to be financially feasible.

On pages 67-74 of the CON Decision, the MHCC briefly summarized, the parties' respective positions, including Adventist's position that Holy Cross was championing a very expensive, small hospital. Different positions on this point were taken during the comparative review, including the MHCC's rejection of Adventist's evidence that Holy Cross' presented a financially infeasible project.

Holy Cross submitted on October 28, 2009 a modification to its CON Application information to address the financial feasibility standard. The October 28, 2009 CON Application modification explained "Because this standard requires that the new hospital 'generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved ... within five years or less of initiating operations,' a table relating expected performance in 2017 – the fifth year of the new hospital, is attached as Exhibit B. This table unlike Table 4 [of the CON standard form set] includes inflation in both rates and costs."

Adventist's expert witness, David Cohen, CPA, then evaluated the financial implications of the corrections Mr. Coughlan made to address the errors in the non-Medicare discharges necessitated by the Additional Evidence. Mr. Cohen reviewed Mr. Coughlan's corrected projections of MSGA discharges (see previous section) to analyze the financial impact of those

converted projections, and to determine if the Holy Cross project can be financially feasible with fewer projected MSGA admissions to a significantly smaller number of beds.<sup>11</sup>

As noted above, based on Mr. Coughlan's more accurate, corrected service area bed need analysis, in 2015, Holy Cross's maximum MSGA discharges will be 2,961. This maximum discharge figure assumes that 85% of Holy Cross's MSGA discharges in that year are residents of its Expected Service Area, and that 10% of the Expected Service Area's total MSGA's discharges would occur at Holy Cross. Mr. Cohen then considered these corrected projections for 2015 (the third year of operations as shown in Holy Cross's CON application Table 4) and 2017 (the fifth year of operations as shown in Holy Cross's CON modification filing as discussed in the previous paragraph). Financial feasibility by the 5<sup>th</sup> year of operation is mandated by the State Health Plan's financial feasibility standard under Regulation 10.24.10.04(B)(13)(b)(iv). As described next, Holy Cross fails to meet this standard.<sup>12</sup>

Mr. Cohen reviewed the projections of MSGA admissions (including Intensive Care admissions) from Table 1, page 95R (submitted on 11/11/09 by Holy Cross (See, Exhibit 3 to Cohen Affidavit)). He also reviewed financial projections submitted as part of the Holy Cross CON application modification filed on October 28, 2009 (See attachments to Cohen Affidavit Exhibit 4). These documents Holy Cross filed with the MHCC set forth the financial projections (without inflation) for Holy Cross in 2015 and with inflation for 2017. Holy Cross itself projected that, in 2015, it would have 4,790 MSGA and Intensive Care admissions. Comparing Holy Cross's projections to the more accurate and corrected Coughlan projections, it is apparent

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<sup>11</sup> The Affidavit of David Cohen, CPA (the "Cohen Affidavit") is attached hereto as Exhibit B.

<sup>12</sup> As proposed, Holy Cross's fifth year of operation is 2017.

that Holy Cross will have 1,829 fewer admissions in 2015, and 1,651 fewer admissions in 2017.<sup>13</sup> (see Exhibits 1 and 2 to the Cohen Affidavit).

Mr. Cohen also evaluated the impact of a reduction in MSGA admissions on the Holy Cross projected revenues and operating expenses for Projection Year 2015 (without inflation), and for Projection Year 2017 (with inflation). Mr. Cohen's changes to the Holy Cross projections used the assumptions found in Holy Cross's own financial projections, including the projected charge per case, the projected case mix, and the projected deductions from Gross Patient Service Revenue ("GPSR") used to derive Net Patient Service Revenue ("NPSR").

For 2015 (and without inflated projections), Holy Cross will have 1,829 fewer MSGA admissions than projected in its CON application. Each fewer admission removes \$10,549 from Holy Cross's projected GPSR, and \$8,883 from the Holy Cross NPSR. For the entire projection year, this NPSR reduction is \$16,246,000.

Mr. Cohen then estimated the reduction in operating expenses attributable to fewer admissions based on Holy Cross's own "variability with volume" assumptions. He determined that, based on Holy Cross's assumptions, its new hospital operating expenses would be reduced by \$12,659,000 in four categories: salaries, contractual services, supplies and other expenses. Mr. Cohen noted that Holy Cross assumed 100% variability with volume for Salaries, Wages, and Professional Fees (including Fringes) and for Supplies and used these same percentages. Mr. Cohen also noted that Holy Cross's assumptions used a 25% variability with volume factor for

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<sup>13</sup> Holy Cross did not provide projections of MSGA admissions for 2017, but its projected average daily census ("ADC") of 59.8 and its occupancy rate for both MSGA and ICU beds in 2015 is 80%, suggesting that any projected increase in MSGA admissions in 2017 could be constrained by the high occupancy of the 75 MSGA beds proposed. For example, the State Health Plan requires that only hospitals with an MSGA ADC in excess of 100 are required to meet an 80% occupancy standard to meet jurisdictional bed need. (see COMAR 10.24.10.05 D.(4)(a)).

year 2014 to year 2015 volume increases for Contractual Services and Other Expenses, but used a 75% variability with volume factor for year 2013 to year 2014 volume increases for Contractual Services and Other Expenses.

Using extreme conservatism, Mr. Cohen removed Contractual Services and Other Expenses using 75% variability with volume for all reduced inpatient cases. This would result in a \$3,587,000 adjustment to the projected net income. Mr. Cohen then removed this \$3,587,000 from the without inflation net income figure of \$1,920,000 projected by Holy Cross (see Cohen Affidavit Exhibit 1, and see attachments to Cohen Affidavit Exhibit 4 consisting of information Holy Cross itself submitted to the MHCC in 2009). This calculation results in an adjusted net loss of \$1,667,000 for Projection Year 2015. Had Mr. Cohen used a 50% variability with volume factor for Contractual Services and Other Expenses reductions to account for the reduced inpatient cases, the without inflation net income as adjusted would be a loss for 2015 of \$2,279,000.

These levels of income loss – which results directly from correcting the projected admissions based on the Additional Evidence now in the record – means that the new Holy Cross hospital is not financially feasible in 2015. This is true even without taking into account the fact that Holy Cross has already self-identified its project as more expensive in its January, 2012 quarterly report filed with the MHCC.

Mr. Cohen's second analysis is for Projection Year 2017 (with inflation). Exhibit B of the attached information submitted in 2009 by Holy Cross indicates that Holy Cross' projected net income would be \$5,062,000 for the 5<sup>th</sup> year of operations (the Holy Cross 2009 document also explains that this with inflation projection was submitted to support Holy Cross' assertion that the project is financially feasible).

This second analysis begins with a reduction in 1,651 MSGA admissions for the reasons already explained above, i.e., to correct MSGA cases based on the Additional Evidence in the record. This calculation achieves a NPSR reduction of \$18,871,000 (\$11,430 NPSR per admission), accompanied by a \$12,810,000 operating expense reduction.

The upshot of these mathematical calculations reduces 2017 net income (with inflation) by \$6,061,000. Once this \$6,061,000 is subtracted from the previously projected \$5,062,000 net income, the 2017 with inflation projections result in a loss of \$990,000. This \$999,000 loss assumed the very favorable treatment of using 75% variability with volume factor for Contractual Services and Other Expenses (see discussion at the top of page 18). Mr. Cohen again noted that use of a 50% variability with volume factor would indicate a with inflation loss for 2017 of \$1,578,000.

Consequently, Mr. Cohen's analysis shows that once the Additional Evidence is considered in light of the CON Decision, and in light of the very projections Holy Cross itself submitted to the MHCC, the Holy Cross Germantown project is not financially feasible by the fifth year of operations. According to the MHCC's regulations, a project that is not financially feasible may not be awarded a revived CON. Thus, the Holy Cross Germantown Hospital must be denied. See, COMAR 10.24.10.04(b)(13).

#### **IV. CONCLUSION**

In summary, the Additional Evidence the MHCC made available and entered into the record following the remand by Judge Pierson shows that errors were made in calculating critical data in the Decision. These errors establish that the proposed Holy Cross Germantown hospital is neither needed --because it is too big and because it is inefficient-- nor financially feasible. The absence of these two vital elements of a new hospital CON -- need and financial viability -- dictates that the Holy Cross push to revive its CON must be, under the law, denied.

Respectfully submitted,



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**CERTIFICATE OF SERVICE**

I HEREBY CERTIFY that on this 4th day of May, 2012, a copy of the foregoing Adventist's Comments On Additional Evidence Entered Into The Record was e-mailed and hand-delivered to:

Suellen Wideman, Esquire  
Assistant Attorney General  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215-2299

Jack C. Tranter, Esquire  
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Baltimore, Maryland 21201

And e-mailed and mailed, first-class, postage prepaid to:

Loretta E. Shapero, Esquire  
Associate County Attorney  
1301 Piccard Drive, 4<sup>th</sup> Floor  
Rockville, Maryland 20850



Diane Festino Schmitt

IN THE MATTER OF  
PROPOSED NEW HOSPITALS  
IN MONTGOMERY COUNTY

Holy Cross Hospital of Silver Spring  
Docket No. 08-15-2286

Clarksburg Community Hospital  
Docket No. 09-15-2294

\* BEFORE THE  
\* MARYLAND HEALTH CARE  
\* COMMISSION  
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**AFFIDAVIT OF RICHARD J. COUGHLAN**

I, Richard J. Coughlan being over 18 years of age and competent to testify as to the matters stated in this Affidavit, and upon my own personal knowledge, testify as follows:

1. I am a health planning consultant with the firm of Cohen Rutherford and Knight, P.C., and have been with the firm since 1995. From 1985 to 1995, I was Director of the Maryland Certificate of Need Program.

2. I am responsible for providing consultation and advisory services to the clients of the firm on matters pertaining to health planning and marketing, including the preparation of Certificate of Need ("CON") applications and I have provided expert witness testimony at CON hearings on multiple occasions and testified as an expert witness in this CON review.

3. I provided professional health planning assistance to Adventist HealthCare in the preparation of the Clarksburg Community Hospital ("CCH") CON application and in evaluating the HCH-G CON application.

4. Now that additional evidence has been added to the record and the Circuit Court for Baltimore City ordered that Adventist have an opportunity to comment on it, Adventist asked me to review the data to analyze the service area-level bed need analysis found at pp. 35-41 of

the Maryland Health Care Commission's (the "MHCC") January 20, 2011 final decision awarding HCH-G a certificate of need to construct a new hospital in Germantown, Maryland (the "CON Decision").

5. The purpose of this review was to determine if the MHCC's State Health Plan need analysis and findings in the CON Decision were supported by the data and evidence.

6. MHCC provided two types of data, as part of the additional evidence ("Additional Evidence").

7. The first data set were the population estimates and projections for the residents of Montgomery County, Maryland and for the 9 hospital service areas which appear on TABLE 26 of the Decision, including 7 existing hospital service areas and the expected service areas of the proposed new hospitals in this review: HCH-Germantown ("HCH-G") and CCH.

8. I reviewed the zip code assignments for the service areas also shown on TABLE 26, and was able to identify the 42 zip codes which comprise Montgomery County. True and correct copies are shown on Attachment 1 hereto.

9. The service area zip codes for the seven existing hospitals were provided to me by the MHCC on April 3, 2012, as part of the Additional Evidence. The zip codes assigned to the service areas for HCH-G and CCH were found in the CON applications of each.

10. I next reviewed the population data that was supplied by the MHCC as part of the Additional Evidence, and applied the methodology discussed in the paper, "Population Estimates and Projections Shown in Tables 26 and 27 of the Final Decision," to that population data.

11. I was able to match, with close proximity, the population estimates and projections appearing in TABLES 26 and 27.

12. The second data set I reviewed was the hospital inpatient utilization data for the Maryland and District of Columbia hospitals provided as part of the Additional Evidence for the ten-year period 1998-2008.

13. For Montgomery County, I found in the Maryland Hospital database that there were 26,538 Medicare MSGA bed discharge cases reported in 2008. From the District of Columbia Hospital database, I found that there were 3,555 Medicare MSGA discharges reported in 2008, for a total of 30,093 Medicare discharges. I then divided the total by the 2008 estimated population of Montgomery County residents age 65 and older (from TABLE 26) and multiplied the result by 1,000 to obtain a Medicare Discharge Rate in 2008 of 257.16.

14. I was therefore able to match, with close proximity, the 2008 Medicare Discharge Rate of 252.45 shown on TABLE 29.

15. I then calculated the 2008 Montgomery County Non-Medicare Discharge Rate by adding the 24,889 Non-Medicare MSGA discharges from a Maryland hospital among Montgomery County residents to the 4,600 Non-Medicare discharges from a District of Columbia hospital, for a total of 29,489 Non-Medicare cases. I divided the total by the estimated 2008 population of Montgomery County age 15-64 (from TABLE 26) and multiplied the result by 1,000 to obtain a Non-Medicare Discharge Rate of 47.29. This is 28% lower than the published rate from the TABLE 26 figure of 66.51.

16. I was therefore unable to confirm or even approximate the published rate used by MHCC with the Maryland and D.C. Additional Evidence obtained from the MHCC for 2008.

17. I then compared the Montgomery County Non-Medicare Discharge Rates for the 10 years of data provided by the MHCC, from 1998 through 2008. Attachment 2 hereto is a true and correct copy of this comparison.

18. For the period from 1998 to 2008, none of the Montgomery County Non-Medicare Discharge rates approximate the 2008 Non-Medicare Discharge Rate of 66.51 shown on TABLE 29. In fact, all the discharge rates more closely approximate the lower rate calculated from the actual data provided, and range from between 43 and 48 MSGA discharges per 1,000 population age 15-64 over the ten year period. For the same period, the Medicare discharge rates for the Montgomery County age 65 and over population range from 232.10 and 259.29 per 1,000, which approximates the 252.45 2008 discharge rate shown on TABLE 29.

19. The discrepancy in the Non-Medicare Discharge Rates for Montgomery County causes me to believe the MHCC's forecasted MSGA bed need for Montgomery County, the seven existing hospital service areas, and the two expected service areas for HCH-G and CCH, is incorrect, as these Non-Medicare Discharge Rates are an integral factor in the computations required to generate the Non-Medicare trend values found on TABLE 28 – "Average Annual Changes in Discharge Rates and Average Length, Montgomery County 1998-2008," TABLE 30 – "Gross MSGA Bed Need, MSGA Bed Capacity and Net MSGA Bed Need, Seven Selected Hospitals," and TABLE 31 – "Gross MSGA Bed Need and Implied Bed Need at the New Hospitals at Selected Levels of Market Share Capture of Bed Demand, Two New Hospital Expected Service Areas."

20. I also reviewed the explanation of the additional ALOS adjustment that is made for each hospital with actual MSGA ALOS in the base year that exceeded its case mix-adjusted ALOS, and the CMA LOS analysis – CMA by DRG reports provided for the Maryland hospitals, 2005-2009. After reviewing the CMA by DRG reports and the CON Decision's description of how the additional adjustment was made to the ALOS for each hospital, or more importantly, to the existing and expected hospital service areas, I was able to adjust the 2008 MSGA ALOS for

the eight Maryland hospitals that discharged 86% of the MSGA patients from the Holy Cross service area. This adjustment was made by estimating the number of "excess" MSGA days associated with those 17,943 discharges. This estimate was made by comparing the total actual MSGA ALOS for the eight Maryland hospitals to the Case Mix-Adjusted ALOS found on the Table entitled, "CMA LOS analysis – CMA by DRG, 01/2008 to 12/2008," that was part of the Additional Evidence. For the seven hospitals with a Case Mix-Adjusted ALOS lower than the actual ALOS, I made an adjustment. For the eighth, Suburban Hospital, whose actual ALOS was lower than the Case Mix-Adjusted ALOS, I made no adjustment. For the adjustment, I applied the difference between the two values, and lowered each hospital's patient days and ALOS for the MSGA cases discharged from each hospital among residents of the Holy Cross Germantown's expected service area in 2008. These computations are shown on Attachment 4. I estimated that 3,290 of the 95,561 MSGA days were "excess" days in 2008. I subtracted 1,614 Medicare MSGA days, and 1,676 non-Medicare MSGA days to adjust the actual 2008 MSGA ALOS to reflect the estimated case-mix adjustment.

2008				
	Medicare ALOS	Non-Medicare ALOS	Medicare Patient Days	Non-Medicare Patient Days
Unadjusted	5.27	4.11	45,695	49,866
Adjusted	5.08	3.97	44,081	48,190
Difference	-.19	-.14	-1,614	-1,676

21. Adventist HealthCare asked me to approximate and to re-compute the minimum and maximum 2018 bed need calculations from the HCH-G Expected Service Area ("ESA"), as shown on TABLE 31, with an adjustment for case-mix based on the data provided, and to project the MSGA bed need at HCH-G in 2018, using a 10% market share for that ESA and the expected 85% service area adjustment used in TABLE 31.

22. I substituted the corrected minimum and maximum Medicare and Non-Medicare discharge rates and ALOS targets in 2018 to project demand for MSGA bed capacity at HCH-G. These values are based on the actual 1998 – 2008 MSGA Non-Medicare and Medicare discharges from any MD or DC hospitals, as trended at the MHCC's rates for Montgomery County. The 2008 and 2018 population estimates and projections provided by the MHCC were used to make the computations, with my interpolation for the 2015 and 2017 projections.

23. These values were used to compute a corrected MSGA bed need forecast for the HCH-G service area, and the imputed bed need for HCH-G in 2015, 2017, and 2018 at 10% market share. I used 10% market share because this is the market share for HCH-G the MHCC used. Attachment 3 hereto is a true and correct copy of these computations.

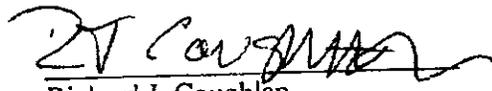
24. It is my opinion that based on the 10% market share penetration used by the MHCC as a reasonable target for this proposed hospital in 2018, that it needs to reduce its projections of future MSGA utilization and MSGA bed capacity accordingly for the HCH-G expected service area, as the projected demand for MSGA services among adult residents of that area was inflated due to errors in the calculations made from the Maryland and D.C. hospital data provided to me.

25. These computations show that in 2015, HCH-G will need between 42-47 MSGA beds at 70% occupancy to meet the needs of between 2,748 and 2,961 MSGA inpatients with a forecasted ALOS of between 3.91 days and 4.02 days. By 2018, the need will increase to need between 42 and 49 MSGA beds, with forecasted ALOS between 3.71 days and 3.85 days.

26. This is in marked contrast to the approval of the CON Decision for Holy Cross on the basis of a need for 75 MSGA beds at an ALOS of 4.56 days, nearly one-half day higher per MSGA case than is reasonably forecasted to be needed. This discrepancy suggests that projections of MSGA utilization found in the Holy Cross application and CON Decision are not "consistent with observed historic trends in use of the applicable service by the service area population of the hospital or State Health Plan need projections, if relevant." (See COMAR 10.24.10.04B(13)(b)(i)).

27. Holy Cross and the MHCC find that the need for Holy Cross is consistent with the observed market share performance of 10% (based on the historic MSGA market share performance of the existing Montgomery County hospitals of between 7 and 21%), but miscalculates both the observed historic discharge rates, and ALOS trends of MSGA patients residing in the area Holy Cross expects to serve.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.

  
Richard J. Coughlan

MSGA Case

Moco Zips

tag yes  
Name MSGA

SERV 2008 MD

Zip Code	Sum of Med-Case	Sum of Med-Day	Sum of NonM-Case	Sum of NonM-Days
20812	5	37	10	44
20814	1,103	5,720	509	2,128
20815	916	5,086	390	1,453
20816	172	714	128	386
20817	869	4,360	606	2,240
20818	20	105	25	70
20832	579	3,056	756	2,541
20833	135	778	254	1,034
20837	118	584	199	732
20838	12	93	5	13
20839	11	41	17	38
20841	102	415	249	928
20842	73	330	60	227
20850	1,539	7,930	1,097	4,792
20851	308	1,855	388	1,424
20852	1,547	7,977	757	3,360
20853	1,050	5,035	777	3,193
20854	1,500	7,650	964	3,420
20855	349	1,720	381	1,380
20860	176	947	64	243
20861	44	218	70	387
20862	11	33	14	89
20866	258	1,205	413	1,684
20868	18	69	27	96
20871	120	631	268	991
20872	309	1,491	415	1,632
20874	702	3,814	1,740	6,685
20876	285	1,572	658	2,751
20877	970	4,767	1,040	4,364
20878	904	4,821	1,419	5,518
20879	370	1,794	794	3,120
20882	277	1,459	403	1,584
20886	577	3,194	921	3,575
20895	632	3,261	372	1,478
20901	900	5,445	936	3,831
20902	1,256	6,874	1,269	5,584
20903	431	2,551	671	2,614
20904	2,190	10,433	1,532	6,250
20905	418	2,195	588	2,312
20906	3,748	18,832	1,891	7,540
20910	927	5,436	870	3,922
20912	607	3,475	942	4,249
Grand Total	26,538	138,003	24,889	99,904



tag            yes  
 Name        MSGA

SERV 2008 DC

Zip Code	Sum of Med-Case	Sum of Med-Day	Sum of NonM-Case	Sum of NonM-Days
20812	5	44	4	9
20814	171	828	159	673
20815	616	3,397	301	1,264
20816	311	1,652	215	935
20817	292	1,735	274	1,041
20818	22	121	21	81
20832	34	215	103	371
20833	11	82	27	75
20837	19	100	27	105
20838	.	.	1	20
20839	.	.	2	21
20841	8	23	30	156
20842	4	95	.	.
20850	115	725	153	779
20851	18	153	34	153
20852	161	1,255	183	1,152
20853	98	580	135	778
20854	226	1,312	303	1,257
20855	32	179	59	376
20860	5	13	5	21
20861	7	35	9	36
20862	1	4	1	3
20866	18	86	54	335
20868	3	47	10	41
20871	8	43	27	170
20872	16	158	40	231
20874	45	431	160	791
20876	11	86	75	336
20877	62	532	99	754
20878	85	564	231	1,122
20879	21	129	86	421
20882	14	74	50	251
20886	42	277	89	455
20895	91	518	82	288
20901	71	490	157	808
20902	122	856	195	971
20903	50	391	115	832
20904	228	1,592	260	1,497
20905	38	179	100	606
20906	255	1,714	297	1,692
20910	162	1,158	265	1,309
20912	57	336	162	1,046
Grand Total	3,555	22,209	4,600	23,263

tag yes  
 Name MSGA

TOTAL

Zip Code	Sum of Med-Case	Sum of Med-Day	Sum of NonM-Case	Sum of NonM-Days
20812	10	81	14	53
20814	1,274	6,548	668	2,801
20815	1,532	8,483	691	2,717
20816	483	2,366	343	1,321
20817	1,161	6,095	880	2,281
20818	42	226	46	151
20832	613	3,271	859	2,912
20833	146	860	281	1,109
20837	137	684	226	837
20838	12	93	6	33
20839	11	41	19	59
20841	110	438	279	1,084
20842	77	425	60	227
20850	1,654	8,655	1,250	5,571
20851	326	2,008	422	1,577
20852	1,708	9,232	940	4,513
20853	1,148	5,615	912	3,971
20854	1,726	8,962	1,267	4,677
20855	381	1,899	440	1,756
20860	181	960	69	264
20861	51	253	79	423
20862	12	37	15	92
20866	276	1,291	467	2,019
20868	21	116	37	135
20871	128	674	295	1,161
20872	325	1,649	455	1,863
20874	747	4,245	1,900	7,476
20876	296	1,658	733	3,087
20877	1,032	5,299	1,139	5,118
20878	989	5,385	1,650	6,640
20879	391	1,923	880	3,541
20882	291	1,533	453	1,835
20886	619	3,471	1,010	4,030
20895	723	3,779	454	1,766
20901	971	5,935	1,093	4,639
20902	1,378	7,730	1,464	6,555
20903	481	2,942	786	3,446
20904	2,418	12,025	1,792	7,747
20905	456	2,374	686	2,918
20906	4,003	20,546	2,188	9,232
20910	1,089	6,594	1,135	5,231
20912	664	3,811	1,104	5,295
Grand Total	30,093	160,212	29,489	123,167

**MSGA Discharges from MD and DC Hospitals: Montgomery County Residents**

YEAR	Med Cases		Med Days		Med ALOS		Non-Med Days		Non-Med ALOS		POPULATION		Discharge Rates	
	Med Cases	Non Med Cases	Med Days	Non Med Days	Med ALOS	Non Med Days	Non-Med ALOS	15-64	65	Medicare	Non-Medicare			
1998	22,257	25,349	141,758	111,295	6.37	4.39	583,198	93,546	237.93	43.47				
1999	22,257	25,912	146,603	117,705	6.59	4.54	587,236	95,893	232.10	44.13				
2000	23,727	26,287	146,600	115,475	6.18	4.39	591,274	98,241	241.52	44.46				
2001	25,392	26,252	149,443	114,447	5.89	4.36	595,312	100,589	252.43	44.10				
2002	25,808	27,868	146,900	118,315	5.69	4.25	599,350	102,937	250.72	46.50				
2003	27,034	28,686	152,292	123,614	5.63	4.31	603,388	105,284	256.77	47.54				
2004	27,908	28,723	153,313	119,704	5.49	4.17	607,426	107,632	259.29	47.29				
2005	28,570	28,661	150,678	116,540	5.27	4.07	611,463	109,980	259.78	46.87				
2006	28,455	28,799	143,161	114,793	5.03	3.99	615,501	112,328	253.32	46.79				
2007	29,008	29,255	151,824	117,183	5.23	4.01	619,539	114,675	252.96	47.22				
2008	30,093	29,489	160,212	123,167	5.32	4.18	623,577	117,023	257.15	47.29				



ATTACHMENT 3  
2015

Corrected Calculations: Non-Medicare				10% Market		10% Market		10% Market		FOR HXGerm @ 85% Service Area		Beds Needed @ 70% Occ.	
Discharge Rate	Population	Discharges	Share Assumption	Patient Days	Share Assumption	Discharges	Patient Days	ADC	Discharges	Patient Days	ADC	Discharges	Patient Days
46.31	256,626	11,884	1,188	40,882	4,088	3.44	40,882	3.44	1,398	4,810	13	1,398	4,810
49.77	256,626	12,772	1,277	45,214	4,521	3.54	45,214	3.54	1,503	5,219	15	1,503	5,219
Corrected Calculations: Medicare				10% Market		10% Market		10% Market		FOR HXGerm @ 85% Service Area		Beds Needed @ 70% Occ.	
Discharge Rate	Population	Discharges	Share Assumption	Patient Days	Share Assumption	Discharges	Patient Days	ADC	Discharges	Patient Days	ADC	Discharges	Patient Days
244.45	46,945	11,476	1,148	50,493	5,049	4.40	50,493	4.40	1,350	5,940	16	1,350	5,940
264	46,945	12,393	1,239	56,019	5,602	4.52	56,019	4.52	1,458	6,590	18	1,458	6,590
Corrected Calculations: TOTAL				10% Market		10% Market		10% Market		FOR HXGerm @ 85% Service Area		Beds Needed @ 70% Occ.	
Discharge Rate	Population	Discharges	Share Assumption	Patient Days	Share Assumption	ALOS	Patient Days	Share Assumption	Discharges	Patient Days	ADC	Discharges	Patient Days
46.31	256,626	11,884	1,188	40,882	4,088	3.91	91,375	9,138	2,748	10,750	29	2,748	10,750
49.77	256,626	12,772	1,277	45,214	4,521	4.02	101,232	10,123	2,961	11,910	33	2,961	11,910
244.45	46,945	11,476	1,148	50,493	5,049				1,350	5,940	16	1,350	5,940
264	46,945	12,393	1,239	56,019	5,602				1,458	6,590	18	1,458	6,590
46.31	256,626	11,884	1,188	40,882	4,088				1,398	4,810	13	1,398	4,810
49.77	256,626	12,772	1,277	45,214	4,521				1,503	5,219	15	1,503	5,219
244.45	46,945	11,476	1,148	50,493	5,049				1,350	5,940	16	1,350	5,940
264	46,945	12,393	1,239	56,019	5,602				1,458	6,590	18	1,458	6,590
46.31	256,626	11,884	1,188	40,882	4,088				1,398	4,810	13	1,398	4,810
49.77	256,626	12,772	1,277	45,214	4,521				1,503	5,219	15	1,503	5,219
244.45	46,945	11,476	1,148	50,493	5,049				1,350	5,940	16	1,350	5,940
264	46,945	12,393	1,239	56,019	5,602				1,458	6,590	18	1,458	6,590
46.31	256,626	11,884	1,188	40,882	4,088				1,398	4,810	13	1,398	4,810
49.77	256,626	12,772	1,277	45,214	4,521				1,503	5,219	15	1,503	5,219
244.45	46,945	11,476	1,148	50,493	5,049				1,350	5,940	16	1,350	5,940
264	46,945	12,393	1,239	56,019	5,602				1,458	6,590	18	1,458	6,590





ATTACHMENT 3  
2018

Corrected Calculations: Non-Medicare				10% Market		10% Market		10% Market		FOR HKGerm @ 85% Service Area		Beds Needed @ 70% Occ.	
Discharge Rate	Population	Discharges	Share Assumption	ALOS	Patient Days	Share Assumption	Discharges	Patient Days	ADC	Patient Days	ADC	Patient Days	Beds Needed @ 70% Occ.
45.84	257,014	11,782	1,178	3.24	38,172	3,817	1,386	4,491	32	4,491	32	4,491	18
50.81	257,014	13,059	1,306	3.36	43,878	4,388	1,536	5,162	14	5,162	14	5,162	20

Corrected Calculations: Medicare				10% Market		10% Market		10% Market		FOR HKGerm @ 85% Service Area		Beds Needed @ 70% Occ.	
Discharge Rate	Population	Discharges	Share Assumption	ALOS	Patient Days	Share Assumption	Discharges	Patient Days	ADC	Patient Days	ADC	Patient Days	Beds Needed @ 70% Occ.
241.02	53,680	12,938	1,294	4.14	53,563	5,356	1,522	6,302	17	6,302	17	6,302	25
269.02	53,680	14,441	1,444	4.30	62,096	6,210	1,669	7,305	20	7,305	20	7,305	29

Corrected Calculations: TOTAL				10% Market		10% Market		10% Market		FOR HKGerm @ 85% Service Area		Beds Needed @ 70% Occ.	
Discharge Rate	Population	Discharges	Share Assumption	ALOS	Patient Days	Share Assumption	Discharges	Patient Days	ADC	Patient Days	ADC	Patient Days	Beds Needed @ 70% Occ.
		24,719	2,472	3.71	91,735	9,174	2,908	10,792	30	10,792	30	10,792	42
		27,500	2,750	3.85	105,974	10,597	3,235	12,468	34	12,468	34	12,468	49



# Exhibit B

IN THE MATTER OF	*	BEFORE THE
PROPOSED NEW HOSPITALS	*	MARYLAND HEALTH CARE
IN MONTGOMERY COUNTY	*	COMMISSION
Holy Cross Hospital of Silver Spring	*	
Docket No. 08-15-2286	*	
Clarksburg Community Hospital	*	
Docket No. 09-15-2294	*	
* * * * *		

**AFFIDAVIT OF DAVID S. COHEN, CPA**

I, David S. Cohen, being over 18 years of age and competent to testify as to the matters stated in this Affidavit, and upon my own personal knowledge, testify as follows:

1. I am a certified public accountant, licensed by the Maryland State Board of Public Accountancy.
2. I am President of Cohen Rutherford & Knight, P.C. ("CRK"), a certified public accounting firm located in Bethesda, Maryland.
3. I have client responsibilities associated with the attest, tax and business advisory services provided to firm clients and I am expert in health care financial and payment matters. I have been accepted as an expert witness in this case.
4. I provided assistance to Adventist HealthCare in the preparation of the Clarksburg Community Hospital ("CCH") certificate of need ("CON") application.
5. Now that additional evidence has been added to the record and the Circuit Court for Baltimore City ordered that Adventist have an opportunity to comment on it, Adventist asked me to review the analysis and corrected projections of MSGA discharges at HCH-Germantown

("HCH-G") prepared by Richard J. Coughlan, of CRK, to analyze the financial impact, and determine if the HCH-G project is financially feasible with fewer MSGA admissions.

6. To prepare my analysis, I reviewed the projections of MSGA admissions (including Intensive Care Admissions) from TABLE 1, page 95R (submitted by HCH-G on 11/11/09) and financial projections submitted by HCH-G on 10/28/09, which set forth assumptions and financial projections (without inflation) for HCH-G for 2013, 2014 and 2015 (the first 3 years of operations) and financial projections including inflation for 2017 (the 5<sup>th</sup> year of operations). The 11/11/09 submission is attached in its entirety as Exhibit 3 and the applicable portions of the 10/28/09 submission is attached as Exhibit 4.

7. HCH-G projected that in 2015, it would have 4,790 MSGA and Intensive Care Admissions. HGH-G did not provide projections of MSGA admissions for 2017, but its projected ADC of 59.8 and its occupancy rate for both MSGA and ICU beds in 2015 is 80%, suggesting that any projected increase in MSGA admissions in 2017 could be constrained by the high occupancy of the 75 MSGA beds proposed.

8. I used 2017, the 5<sup>th</sup> year of operations, because pursuant to the State Health Plan Acute Care Chapter, COMAR 10.24.10.04B(13)(b)(iv) – "Financial Feasibility" an application must document that "the hospital will generate excess revenues over total expenses . . . , if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses . . . when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population."

9. I compared HCH-G's projections to Mr. Coughlan's, and found that HCH-G would have 1,829 fewer MSGA and Intensive Care admissions in 2015, and 1,651 fewer admissions in 2017. True and correct copies of my comparisons for 2015 and 2017 are attached to my Comments as Exhibit 1 and 2 hereto respectively.

10. I analyzed the impact of a reduction in MSGA admissions on the projected revenues and operating expenses of HCH-G in Projection Year 2015 (without inflation), and in Projection Year 2017 (with inflation).

11. My analysis incorporated the assumptions found in HCH-G's own financial projections. True and correct copies of my analysis for 2015 and 2017 are contained in Exhibits 1 and 2 hereto respectively.

12. For 2015 (without inflation), HCH-G would have 1,829 fewer MSGA admissions than projected in its CON application, and each reduced admission would remove \$10,549 from HCH-G's projected GPSR, and \$8,883 from its NPSR. For the entire projection year, this NPSR reduction is \$16,246,000. See Exhibit 1 hereto.

13. I then estimated the reduction in operating expenses due to fewer admissions based on HCH-G's own "variability with volume" assumptions, and determined that based on HCH-G's assumptions operating expenses would be reduced by \$12,659,000 in four categories: salaries, contractual services, supplies and other expenses. I noted that Holy Cross assumed 100% variability with volume for Salaries, Wages, and Professional Fees (including Fringes) and for Supplies and used these same percentages. I also noted that Holy Cross's assumptions used a 25% variability with volume factor for year 2014 to year 2015 volume increases for Contractual Services and Other Expenses, but used a 75% variability with volume factor for year 2013 to year 2014 volume increases for Contractual Services and Other Expenses. Using extreme

conservatism I removed Contractual Services and Other Expenses using 75% variability with volume for all reduced inpatient cases.

14. This would result in a \$3,587,000 adjustment to the projected net income. I then removed this \$3,587,000 from the "without inflation" net income projected by HCH-G of \$1,920,000. See Exhibit 1 and Exhibit A to the October 28, 2009 letter from HCH-G's counsel to the Maryland Health Care Commission, a true and correct copy of which is attached as Exhibit 4 hereto.

15. This results in an adjusted net loss of \$1,667,000 for Projection Year 2015. See Exhibit 1. Had I used a 50% variability with volume factor for Contractual Services and Other Expenses reductions to account for the reduced inpatient cases, the without inflation net income as adjusted would be a loss for 2015 of \$2,279,000.

16. At these levels of income loss, the hospital is not financially feasible.

17. My second analysis was for Projection Year 2017 (with inflation). See Exhibit 2 hereto.

18. My second analysis begins with a reduction in 1,651 MSGA admissions. This requires a NPSR reduction of \$18,871,000 (\$11,430 NPSR per admission), accompanied by a \$12,810,000 operating expense reduction. The result is reduction to with inflation net income for 2017 of \$6,061,000.

19. Once this \$6,061,000 is reduced from the previously projected \$5,062,000 net income (Exhibit B to Exhibit 4 hereto), the 2017 with inflation projections result in a loss of \$999,000. See Exhibit 2. This \$999,000 assumed the very favorable treatment of using 75% variability with volume factor for Contractual Services and Other Expenses. I noted that use of a 50% variability with volume factor would indicate a with inflation loss for 2017 of \$1,578,000.

20. My conclusion is that the hospital is not financially feasible.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND  
CORRECT.

*David S. Cohen*

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David S. Cohen

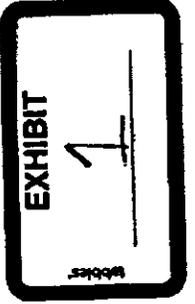
**REVISED HCHG FINANCIAL INFORMATION  
CORRECTING FOR ERROR IN COMPUTING DISCHARGE USE RATES  
PROJECTION YEAR 2015 - NOT INFLATED**

(Rounded to closest 1,000)

	<u>AMOUNTS</u>	<u>COMMENTS</u>
HCHG Total MSGA (including ICU) Discharges	2,961	This is the corrected MSGA discharges for HCHG's ESA as determined by Rich Coughlan. See HCHG CON (page 95R; HCHG 11/11/09 filing).
HCHG Total MSGA and ICU Discharges Per CON	4,790	
Difference	<u>1,829</u>	
HCHG GPCR/MSGA Discharge	\$ 10,549	HCHG CON assumed \$9,940 charge per case at a case mix index (CMI) of 1.0 (HCHG 10/28/09 CON Modification); HCHG CON also assumed an overall CMI of .9041 for 2015 and provided CMIs for OB and Newborn cases, but did not provide a CMI for Pstch. Assuming a .9041 CMI for Psych, the MSGA CMI for 2015 is 1.0613.
HCHG NPSR/MSGA Discharge	\$ 8,883	HCHG CON assumed 84.2% of GPCR for NPSR for 2015 (HCHG 10/28/09 CON Modification).

	\$ (16,246,000)		
Excess Projected NPSR			
Salaries	\$ 42,996,000	CON	CON included the amounts and variability with volume (HCHG 10/28/09 CON Modification).
Contractual Services	\$ 9,803,000	CON	CON included the amounts and variability with volume (HCHG 10/28/09 CON Modification). See Note Below.
Supplies	\$ 15,725,000	CON	CON included the amounts and variability with volume (HCHG 10/28/09 CON Modification).
Other Expenses	\$ 3,474,000	CON	CON included the amounts and variability with volume (HCHG 10/28/09 CON Modification). See Note Below.
Expense Reduction Associated with Volume Reduction	\$ 480,000		
Impact on (Reduction to) Projected Net Income	\$ 12,659,000		
HCHG CON Projected Net Income	\$ (3,587,000)		
Adjusted CON Projected Net Income (Loss)	\$ 1,920,000		
	\$ (1,667,000)		

Note: The Assumptions information provided by HCHG as part of the 10/28/09 CON Modification indicated that the variability with volume for Contractual Services and Other Expenses was 25% for volume increases from 2014 to 2015 and 75% for volume increases from 2013 to 2014. The computations shown above assume 75% for the removal of expenses for Contractual Services and Other Expenses even though a much lower percentage could be used. If 50% had been used, Adjusted CON Projected Net Loss for 2015 would be (\$2,279,000) instead of (\$1,667,000) as shown above.



**REVISED HCHG FINANCIAL INFORMATION  
CORRECTING FOR ERROR IN COMPUTING DISCHARGE USE RATES  
PROJECTION YEAR 2017 - WITH INFLATION**  
(Rounded to closest 1,000)

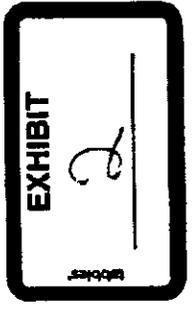
	<u>AMOUNTS</u>	<u>COMMENTS</u>
HCHG Total MSGA (Including ICU) Discharges	3,139	This is the corrected MSGA discharges for HCHG's ESA as determined by Rich Coughlan.
HCHG Total MSGA and ICU Discharges Per CON Difference	<u>4,790</u> <u>1,651</u>	See HCHG CON (page 95R); HCHG 11/11/09 filing). Not increased from 2015 since 80% occupancy was assumed by HCHG to be achieved in 2015.
HCHG GPSR/MSGA Discharge	\$ 13,575	Exhibit B of the HCHG document submitted on 10/28/09 included with inflation projections for 2017 (the 5th year of operations). The inpatient GPSR was \$88,292,000 which was divided by the 7,635 total admissions, including Newborn cases (per CON). This resulting \$11,564 is assumed at a CMI of .904). Adjusting for the 1.06133 MSGA CMI results in \$13,575 as the inflated average charge per MSGA discharge.
HCHG NPSR/MSGA Discharge	<u>\$ 11,430</u>	CON assumed 84.2% of GPSR for NPSR

**Excess Projected NPSR**

	\$ (18,871,000)	
SALARIES	8,162,000	CON included the amounts and variability with volume (HCHG 10/28/09 CON Modification).
Contractual Services	1,270,000	CON included the amounts and variability with volume (HCHG 10/28/09 CON Modification). See Note Below.
Supplies	2,912,000	CON included the amounts and variability with volume (HCHG 10/28/09 CON Modification).
Other Expenses	466,000	CON included the amounts and variability with volume (HCHG 10/28/09 CON Modification). See Note Below.
<b>Expense Reduction Associated with Volume Reduction</b>	<b>12,810,000</b>	
<b>Impact on (Reduction to) Projected Net Income</b>	<b>\$ (6,061,000)</b>	
<b>Exhibit B Projected Net Income</b>	<b>\$ 5,062,000</b>	
<b>Adjusted Inflated Projected Net Income (Loss)</b>	<b>\$ (999,000)</b>	

HCHG 10/28/09 CON Modification  
**CONCLUSION - PROJECT IS NOT FEASIBLE**

Note: The Assumptions information provided by HCHG as part of the 10/28/09 CON Modification indicated that the variability with volume for Contractual Services and Other Expenses was 25%, for volume increases from 2014 to 2015 and 75% for volume increases from 2013 to 2014. The computations shown above assume 75% for the removal of expenses for Contractual Services and Other Expenses even though a much lower percentage could be used. If 50% had been used, Adjusted CON Projected Net Loss for 2017 would be (\$1,578,000) instead of (\$999,000) as shown above.



IN THE MATTER OF HOLY CROSS \* BEFORE THE  
HOSPITAL - NEW HOSPITAL IN \* MARYLAND HEALTH  
GERMANTOWN \* CARE COMMISSION  
Matter No. 08-15-2286 \*

\* \* \* \* \*

**HOLY CROSS HOSPITAL OF SILVER SPRING'S  
RESPONSE TO REQUEST FOR LIST AND  
BRIEF DESCRIPTION OF PROJECT CHANGES**

Holy Cross Hospital of Silver Spring, Inc. ("Holy Cross"), by its undersigned counsel,  
files this response to the Maryland Health Care Commission's request that Holy Cross identify  
and briefly describe the modifications made on October 28, 2009.

**PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION**

1. Legal Name of Project Applicant, Address, Phone Number, Name of Owner/Chief Executive  
 Change  No Change
2. Legal Name of Project Co-Applicant, Address, Phone Number, Name of Owner/Chief Executive  
 Change  No Change
3. Name of Facility, Street (Project Site), City, Zip, County  
 Change  No Change
4. Name of Owner (if different than applicant)  
 Change  No Change
5. Representative of Co-Applicant, Address, Phone Number  
 Change  No Change



6. Person(s) to whom questions regarding this application should be directed

Change  No Change

7. Brief Project Description

Change  No Change

8. Legal Structure of License

Change  No Change

9. Current Physical Capacity and Proposed Changes

Change  No Change

10. Project Location and Site Control

Change  No Change

**Brief Description of Change:**

The site size has been corrected to 24.5 acres; the sublease of the project site to Holy Cross has been signed. See October 28, 2008 Letter from Jack C. Tranter to Ms. Ruby Potter (the "Holy Cross Modification Letter") at Tab 13, pages 3R(10/28/09) and 4R (10/28/09).

11. Project Implementation Target Dates

Change  No Change

**Brief Description of Change:**

Originally, Holy Cross projected that it would obligate 51% of the approved capital expenditure in three months, begin construction one month thereafter, apply for prelicensure/first use 35 months after obligating capital, and achieve full utilization 22 months after first use. Those benchmarks are now, respectively seven, two, 27 and 24 months. See Holy Cross Modification Letter at Tab 13, page 4R (10/28/09)

12. NA

13. NA

14. Project Description

Change  No Change

**Brief Description of Change:**

The new design, configuration and description of the proposed new hospital are related on revised CON Application pages 19R (10/28/09) to 21R (10/28/09), filed on October 28, 2009. See Holy Cross Modification Letter at Tab 13. Pages 22 and 23 of the CON Application should be deleted. As related on pages 19R(10/28/09) to 21R(10/28/09), and in revised Chart 1 also filed on October 28, 2009, the total square footage of the proposed new hospital is smaller, the project cost is lower, and the new hospital's design is no longer based on the "separate structures concept." More detail is related on the revised pages noted above.

15. Project Drawings

Change  No Change

**Brief Description of Change:**

New drawings were submitted as part of the modifications filed on October 28, 2009. See Holy Cross Modification Letter at Tab 14.

16. Features of Project Construction

Change  No Change

CHART 1. Project Construction Characteristics and Costs

Change  No Change

**Brief Description of Change:**

A new Chart 1 was filed on October 28, 2009. As noted there, the proposed new hospital is now smaller than originally proposed. See Holy Cross Modification Letter at Tab 10.

**PART II - PROJECT BUDGET**

Change  No Change

**Brief Description of Change:**

A revised Project Budget, relating a lower project cost, was included as part of the modifications filed on October 28, 2009. See Holy Cross Modification Letter at Tab 9.

**PART III - CONSISTENCY WITH GENERAL REVIEW  
CRITERIA AT COMAR 10.24.01.08G(3):**

10.24.01.10 - The State Health Plan. Acute Care Hospital Services

General Standards

1. Information regarding Charges  
 Change  No Change
2. Charity Care Policy  
 Change  No Change
3. Quality of Care  
 Change  No Change

Project Review Standards

1. Geographic Accessibility  
 Change  No Change
2. Identification of Bed Need and Addition of Beds  
 Change  No Change

**Brief Description of Change:**

Holy Cross updated the discussion of MSGA bed need to reflect the number of MSGA beds licensed in Montgomery County as of July 1, 2009. The Holy Cross analyses were also

updated to include more recent population and discharge data. A change in the way approved beds at Shady Grove Adventist Hospital are considered was also made based on the availability of more recent data. See Holy Cross Modification Letter at Tab 1.

3. Minimum Average Daily Census for Establishment of a Pediatric Unit

Change  No Change

4. Adverse Impact

Change  No Change

5. Cost Effectiveness

Change  No Change

6. Burden of Proof Regarding Need

Change  No Change

7. Construction Cost of Hospital Space

Change  No Change

**Brief Description of Change:**

A new MVS analysis was performed based on the revised design and lower project cost. The new MVS benchmark is \$356.09/sf. The comparable project cost is \$371.77, i.e., \$15.68 greater than the MVS standard. Originally, the project exceeded the MVS standard by \$63.20 (\$375.71-\$312.51). See Holy Cross Modification Letter at Tabs 2 and 15.

8. Construction Cost of Non-Hospital Space

Change  No Change

9. Inpatient Nursing Unit Space

Change  No Change

**Brief Description of Change:**

As a result of the redesign of the proposed new hospital, the Inpatient Nursing Unit Space per bed in the psychiatric unit no longer exceeds 500 square feet per bed. While impacted by the redesign, the Inpatient Nursing Unit Space per bed in the MSGA units and CCU are still below 500 square feet/bed standard. See Holy Cross Modification Letter at Tab 3.

10. Rate Reduction Agreement

Change  No Change

11. Efficiency

Change  No Change

12. Patient Safety

Change  No Change

13. Financial Feasibility

Change  No Change

**Brief Description of Change:**

The response to Standard .04B(13)(a) and (b)(i) has been changed to include a reference to "Revised Table 4, attached as Exhibit A" rather than "Table 4" in the second line of the response. In terms of Standard .04B(13)(b)(ii), the language "the FY 2008 target for the new hospital was estimated to be \$9,840, at a case mix of 1.0 (increased 4.2% in FY 2009 for HSCRC-approved rate increase)" has been replaced with "the FY10 target for the new hospital was estimated to be \$9,940, at a case mix of 1.0 (increased 1.77% in FY10 for the HSCRC-approved rate increase)." The reference to and computation of outpatient charges being increased by 4.2% in FY09, based on the HSCRC-approved rate increase for Holy Cross Hospital of Silver Spring, has been replaced by the 1.77% HSCRC-approved rate increase for FY10. In

terms of Standard .04B(13)(iii), the reference to FTEs pre AOB has been changed from "approximately 4.6-4.7" to "approximately 4.8." Finally, the response to Standard .04B(13)(iv) has been changed to replace the reference to "Table 4" with "Revised Table 4A, attached as Exhibit A." Additional commentary was also added addressing operating performance in the fifth year of the new hospital's operation. See Holy Cross Modification Letter at Tab 4.

14. Emergency Department Treatment Capacity and Space

Change  No Change

**Brief Description of Change:**

The only change is a correction to a number in the third line on page 60 of the Response to New Acute Care Chapter Standards filed on February 7, 2009. See Holy Cross Modification Letter at Tab 5.

15. Emergency Department Expansion

Change  No Change

16. Shell Space

Change  No Change

**Brief Description of Change:**

The redesigned project still includes a floor of shell space as the top floor of the patient tower. Shell space on other floors, however, has been eliminated. See Holy Cross Modification Letter at Tab 6.

10.24.01.08G(3)(b). Need

Change  No Change

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

Change  No Change

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT

Change  No Change

10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives

Change  No Change

**Brief Description of Change:**

A supplement to the prior response to Review Criterion .08G(3)(c), in the CON Application and related filings was submitted, performing a comparative analysis of the proposed project with the competing new hospital proposal filed by Adventist HealthCare, Inc. Holy Cross's original responses did not perform this analysis because this was a single-applicant review when those responses were filed. See Holy Cross Modification Letter at Tab 8.

10.24.01.08G(3)(d). Viability of the Proposal

Change  No Change

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

Change  No Change

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

Change  No Change

**Brief Description of Change:**

Holy Cross revised the financial projections for the proposed new hospital based on the new project cost, a change in the assumed date of initiation of services, i.e., from September 2012 (FY13) to January 2013 (FY13), an updated charge per case estimate, a reduction in the interest on long-term debt estimate (from 5.25% to 5.0%), and a change in the variable cost FTE assumption in FY15 from 100% to 95%. See Holy Cross Modification Letter at Tab 11.

10.24.01.08G(3)(e). Compliance with Conditions of Previous Certificates of Need

Change  No Change

10.24.01.08G(3)(f). Impact on Existing Providers

Change  No Change

TABLE 5. MANPOWER INFORMATION

Change  No Change

**Brief Description of Change:**

Table 5 was revised to reflect a slight increase in staffing for the proposed new hospital, i.e., from 569.9 FTEs to 572.8 FTEs. The projected salaries and benefits have been updated to reflect the FY10 salaries and benefits at Holy Cross Hospital of Silver Spring. See Holy Cross Modification Letter at Tab 12.

**PART IV – APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY,  
AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE**

Change  No Change

**OTHER CHANGES**

In addition to the changes noted above, Holy Cross modified the response to Standard .04(13), Financial Feasibility, in COMAR 10.24.12, the Acute Hospital Inpatient Obstetric Services Chapter of the State Health Plan. As a result of using more recent data and financial information, charges for obstetric care at the new hospital will be 7.8% below the state-wide case-mix adjusted average for both obstetric and perinatal discharges from Level I and II hospitals. See Holy Cross Modification Letter at Tab 7. Holy Cross also filed updated audited financial statements, the currently applicable rate order and a new bed capacity chart on October 28, 2009. See Holy Cross Modification Letter at Tabs 16, 17 and 18.

Finally, in reviewing the materials filed on October 28, 2008 and in preparing this response, Holy Cross realized that it did not update Table 1, Statistical Projections, to respond to the new date when Holy Cross expects the new hospital will begin providing care, i.e., in January 2013 (FY13) rather than September 2012 (FY13). An updated Table 1, accordingly, is attached as Exhibit 1. As related there, the projections for FY15, the new hospitals first full year of operation are unchanged.

Respectfully submitted,



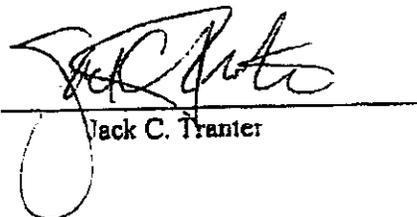
Jack C. Tranter  
Gallagher Evelius & Jones LLP  
218 North Charles Street, Suite 400  
Baltimore MD 21201  
(410) 727-7702

*Attorneys for Holy Cross Hospital of  
Silver Spring, Inc.*

November 12, 2009

### CERTIFICATE OF SERVICE

I certify that on this 12th day of November, 2009, a copy of the foregoing was sent via email to: Paul Parker (pparker@mhcc.state.md.us); Ruby Potter (rpotter@mhcc.state.md.us) for Marilyn Moon, Ph.D.; Pamela Barclay (pbarclay@mhcc.state.md.us); Joel Riklin (jriklin@mhcc.state.md.us); Suellen Wideman (swideman@mhcc.state.md.us); Christopher Hall (CHall@adventisthealthcare.com); Howard Sollins (hsollins@ober.com); Ulder Tillman (ulder.tillman@montgomerycountymd.gov); and Clarksburg Civic Association (baines2005@verizon.net).



Jack C. Tranter

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

**TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY**

CY or FY (Circle)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20	20		2013	2014	2015	20
<b>1. Admissions</b>							
a. MS/G/A				1,359	3,419	4,119	
b. Pediatric							
c. Obstetric				406	1,027	1,237	
d. Intensive Care				221	557	671	
e. Coronary Care							
f. Psychiatric				122	305	369	
g. Rehabilitation							
h. Chronic							
i. Other (Specify)							
J. TOTAL				2,111	5,309	6,396	
<b>2. Patient Days</b>							
a. MS/G/A				5,907	14,858	17,901	
b. Pediatric							
c. Obstetric				1,179	2,965	3,572	
d. Intensive Care				1,297	3,262	3,930	
e. Coronary Care							
f. Psychiatric				618	1,550	1,868	
g. Rehabilitation							
h. Chronic							
i. Other (Specify)							
J. TOTAL				8,999	22,635	27,271	

95R (11/11/09)



Table 1 cont. CY or FY (Circle)	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20	20	20	2013	2014	2015	20
<b>3. Average Length of Stay</b>							
a. MIS/G/A				4.35	4.35	4.35	
b. Pediatric							
c. Obstetric				2.89	2.89	2.89	
d. Intensive Care				5.86	5.86	5.86	
e. Coronary Care							
f. Psychiatric				5.06	5.06	5.06	
g. Rehabilitation							
h. Chronic							
i. Other (Specify)							
J. TOTAL				4.26	4.26	4.26	
<b>4. Occupancy Percentage*</b>							
a. MIS/G/A				32	68	82	
b. Pediatric							
c. Obstetric				32	68	82	
d. Intensive Care				29	60	72	
e. Coronary Care							
f. Psychiatric				34	71	85	
g. Rehabilitation							
h. Chronic							
i. Other (Specify)							
J. TOTAL				32	67	80	

Table 1 cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
	20	20		2013	2014	2015	20
<b>5. Number of Licensed Beds</b>							
a. MIS/GIA				60	60	60	
b. Pediatric							
c. Obstetric				12	12	12	
d. Intensive Care				15	15	15	
e. Coronary Care							
f. Psychiatric				6	6	6	
g. Rehabilitation							
h. Chronic							
i. Other (Specify)							
<b>J. TOTAL</b>				<b>93</b>	<b>93</b>	<b>93</b>	
<b>6. Outpatient Visits</b>							
a. Emergency				7,295	19,779	22,107	
b. Outpatient Dept. (Surgery)				1,302	3,628	3,944	
c. Other (Specify)				12,434	34,867	37,679	
<b>d. TOTAL</b>				<b>21,031</b>	<b>58,274</b>	<b>63,730</b>	

\*Other includes services such as medical imaging, endoscopy, ob/gyn clinics.

Finally, in reviewing the materials filed on October 28, 2008 and in preparing this response, Holy Cross realized that it did not update Table 1, Statistical Projections, to respond to the new date when Holy Cross expects the new hospital will begin providing care, i.e., in January 2013 (FY13) rather than September 2012 (FY13). An updated Table 1, accordingly, is attached as Exhibit 1. As related there, the projections for FY15, the new hospitals first full year of operation are unchanged.

Respectfully submitted,



Jack C. Tranter  
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218 North Charles Street, Suite 400  
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(410) 727-7702

*Attorneys for Holy Cross Hospital of  
Silver Spring, Inc.*

November 12, 2009

### CERTIFICATE OF SERVICE

I certify that on this 12th day of November, 2009, a copy of the foregoing was sent via email to: Paul Parker (pparker@mhcc.state.md.us); Ruby Potter (rpotter@mhcc.state.md.us) for Marilyn Moon, Ph.D.; Pamela Barclay (pbarclay@mhcc.state.md.us); Joel Riklin (jriklin@mhcc.state.md.us); Suellen Wideman (swideman@mhcc.state.md.us); Christopher Hall (CHall@adventisthealthcare.com); Howard Sollins (hsollins@ober.com); Ulder Tillman (ulder.tillman@montgomerycountymd.gov); and Clarksburg Civic Association (baines2005@verizon.net).



Jack C. Tranter

GALLAGHER  
EVELIUS & JONES LLP  
ATTORNEYS AT LAW

JACK C. TRANTER  
jtranter@gejlaw.com  
direct dial: 410 347 1370  
fax: 410 468 2786

October 28, 2009

**VIA HAND DELIVERY**

Ms. Ruby Potter  
Health Facilities Coordination Officer  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215-2299

Re: *In the Matter of Holy Cross Hospital – Establish a New  
Hospital in Germantown - Docket No. 08-05-2286*

Dear Ms. Potter:

I write to submit modifications to the above-referenced project. The enclosed changes involve the standards, review criterion, and other items listed below.

1. Standard .04B(2) – Bed Need - new
2. Standard .04B(7) – MVS Analysis - new
3. Standard .04B(9) – Inpatient Nursing Unit Space - new
4. Standard .04B(13) – Financial Feasibility - new
5. Standard .04B(14) – Emergency Department - (only change is a correction to a number in the third line on page 60 of the Responses to New Acute Care Chapter Standards filed on February 27, 2009).
6. Standard .04B(16) – Shell Space - new
7. OB Standard .04(13) – Financial Feasibility – new
8. Review Criterion .08G(3)(c) – Cost Effectiveness - new
9. Project Budget – new
10. Chart 1 – new
11. Table 4 and assumptions - new

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009849-0018



GALLAGHER  
EVELIUS & JONES LLP  
ATTORNEYS AT LAW

Ruby Potter  
October 28, 2009  
Page 2

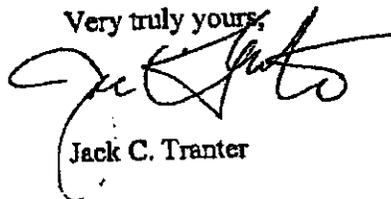
12. Table 5 – new
13. CON application replacement pages 3-5, 19-21, and 68
14. CON Exhibit – new drawings
15. CON Exhibit 5 – new detailed MVS analysis
16. CON Exhibit 8 – updated Audited Financial Statements
17. CON Exhibit 9 - rate orders effective 12/1/08
18. Bed Capacity Chart – new

As you can see, most of the enclosed modifications result from a change in the proposed new hospital's design. Other changes involve an update to the MSGA bed need analysis (Standard .04B(2)) and the analysis required under COMAR Review Criterion .08G(3)(c) because this is now a comparative review. While the enclosed materials are not marked as replacement pages, copies with replacement page designations will be filed later.

If you have questions about this matter, please contact me at your convenience.

Best regards.

Very truly yours,



Jack C. Tranter

cc: Ms. Annice Cody  
Andrew L. Solberg  
Hal Cohen, Ph.D.  
Howard Sollins, Esq.

**Standard .04B(13) – Financial Feasibility.**

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

This new hospital project is financially viable. The required assumptions are included as part of Revised Table 4, attached as Exhibit A, and are addressed below. As explained below, the utilization projections set forth in Table 1: Statistical Projections are consistent with existing utilization adjusted for population growth and aging.

As described in response to Project Review Standard .04B(2) above, the MSGA bed need projected for the new hospital's ESA is consistent with current utilization and population trends. The new hospital's volume projections, developed in conjunction with Navigant Consulting, are described on page 37 in the response to Question 28 in the Responses to Completeness Questions: First Set. Assuming all of the new hospital's cases are drawn from its relatively compact (18 ZIP code) ESA, the new hospital's market share in 2015 will be 22%, which is comparable to the market share of the five existing Montgomery County hospitals in the areas from which they draw 85 percent of their patients. Those market shares range from 11% to 27%. See, Response to Question 2(c) in the Responses to Completeness Questions: First Set (page 3).

The obstetric volume was projected based on the anticipated shift of existing patients (particularly Maternity Partnership and Kaiser Permanente patients) from Holy Cross Hospital in Silver Spring. The projected volume is only 65 percent of Holy Cross Hospital in Silver Spring's current patients from the ESA.

Psychiatric volume was projected on a county-wide basis. The market for psychiatric cases in Montgomery County was based on the 2008 use rate/1000 population (age 18+, in hospitals with psychiatric units) applied to the projected 2015 population, adjusted for in and outmigration. Holy Cross estimates that the new hospital will serve 5% of the adults needing inpatient psychiatric care in 2015 ( $369/7341 = 5\%$ ).

Emergency department volume was projected based on the number of discharges projected for the new hospital, the percent of discharges in the core market that entered hospitals through an emergency department, and the assumed emergency visit admit rate. See, Response to Question 29 in the Responses to Completeness Questions, First Set. The 22,107 emergency visits projected for FY15 represent a market share of only 13 percent in the new hospital's ESA.

Outpatient surgery volumes were developed using national use rates adjusted for the projected Montgomery County age mix, as described in the response to Question 13(a) in the Responses to Completeness Questions, Second Set. The outpatient surgery volume projected for the new hospital is 15% of ESA's total projected hospital-based outpatient surgery volume. See, Response to Question 31(f) on pages 47-49 in the Responses to Completeness Questions, First Set.

**(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision as experienced by the**

applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

Revenue estimates for the new hospital are consistent with the HSCRC's methodology for similar Maryland hospitals and with current operations at Holy Cross Hospital in Silver Spring. An inpatient Charge per Case ("CPC") target was developed based on the following methodology:

A statewide CPC, based on an Inpatient Statewide Reasonableness of Charges ("ROC") calculation, was established and then adjusted for the following factors:

Payer mix –same payer mix as SGAH, adjusted for patient service mix at the new hospital

Labor market –same labor market index as Holy Cross Hospital

Medical education – no teaching program at the new hospital

Capital –capital costs have been included in rates in accordance with the HSCRC methodology of 50% hospital specific and 50% statewide average. The hospital specific capital costs were based on the third full year of operations, excluding capital costs related to parking, shell space and costs above the MVS standard.

Based on current methodology, the FY10 target for the new hospital was estimated to be \$9,940 at a case mix of 1.0 (increased 1.77% in FY 10 for the HSCRC-approved rate increase).

Average charges per outpatient visit were developed by service line based on FY 2009 experience at Holy Cross Hospital in Silver Spring, applied to the forecasted outpatient volumes in the financial model (increased 1.77% in FY10 for HSCRC-approved rate increase). To ensure that the outpatient revenue was reasonable, charges were compared to State-wide median rates and revenue and appeared consistent with current HSCRC methodology.

Contractual allowances were forecasted to be 9.36% of gross patient revenues each year, based on current experience at Holy Cross Hospital in Silver Spring. Charity care was forecasted to be 2.3% of gross patient revenues each year, based on current experience at Holy Cross Hospital of Silver Spring. Bad debt expense was forecast to be 4.2% of gross patient revenues each year, based on current experience at Holy Cross Hospital in Silver Spring and expectations at the new facility.

Uncompensated care (charity care plus bad debt expense) for the new hospital was based on the experience at Holy Cross Hospital in Silver Spring. The projected level of uncompensated care is comparable to the uncompensated care predicted for SGAH.

**(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and**

Staffing levels were forecasted based on "Full Time Equivalents per Adjusted Occupied Bed" targets ("FTEs per AOB") with the volumes expected at the new site. FTEs per AOB targets were approximately 4.6 – 4.7 for the forecast periods based on prior experience at Holy Cross Hospital in Silver Spring, limited efficiencies for certain administrative duties, and comparisons to national benchmarks for similar facilities.

Average salaries per full time equivalents were estimated based on current experience at Holy Cross Hospital in Silver Spring by job category. Benefits were estimated as a percentage of salary based on the ratios at Holy Cross Hospital in Silver Spring.

Other operating costs, i.e., supplies, purchased services and related expenses, were forecast based on expenses per adjusted patient day ratios at Holy Cross Hospital in Silver Spring, adjusted for variability by volumes and case mix index

(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations, with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.

The financial forecast, based on reasonable volume, revenue and expense assumptions, estimates profitability in the third year of operations for the new hospital in Germantown. See, Revised Table 4, attached as Exhibit A.

Because this standard requires that the new hospital "generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved ... within five years or less of initiating operations," a table relating expected performance in 2017 - the fifth year of the new hospital, is attached as Exhibit B. . This table, unlike Table 4, includes inflation in both rates and costs. Not only does the table show net income of approximately \$5 million, but it also shows that capital cost, in the fifth year, will be 15.2% of total operating expenses ( $\$6,493 + \$11,257 / \$116,872 = .152$ ) and 14.6% of net operating revenue ( $(\$6,493 + \$11,257 / \$121,425 = .146)$ ). Given HCH's history of operational efficiency, as discussed under Section .08G(3)(c), Availability of More Cost-Effective Alternatives, it is clear that the Germantown facility's projection of profitability by the fifth year is very

credible.

These data refute Dr. Cook's claim (*See October 5, CCH Reply to Comments Submitted by HCH, Exhibit 4*) that the Germantown facility would not generate profits in 2017. Additionally, it is important to note what Dr. Cook did not dispute regarding Holy Cross's arguments in its Comments on AHC's Clarksburg proposal.. He did not dispute that the original rates for SGAH were set using a methodology that included SGAH's principal payments and that such a methodology resulted in less in rates for capital than the current HSCRC methodology. Dr. Cook also did not dispute that the SGAH rates included a very substantial reduction for efficiencies that SGAH promised during the CON process – a percentage reduction less than embodied in the current methodology for setting the rates of new hospitals. Finally, Dr. Cook noted that SGAH actually made profits in its fifth year despite this very restrictive initial rate setting. Holy Cross's position is that if SGAH could make profits in the fifth year under a more restrictive initial rate order, then HCH could certainly make profits in the fifth year at the proposed Germantown facility.

# EXHIBIT A

**Holy Cross Health - Germantown**  
**Table 4: Revenue and Expenses - Project**  
**For the Fiscal Years 2010 - 2015**

	Projected (Beginning with first full year of utilization)					
	Budget 2010	2011	2012	2013	2014	2015
<b>Fiscal Year Ended June 30,</b>						
<b>1. Revenue</b>						
a. Inpatient Services	\$ -	\$ -	\$ -	\$ 22,417	\$ 56,665	\$ 68,611
b. Outpatient Services	-	-	-	11,948	33,107	36,066
c. Gross Patient Services Revenues	-	-	-	34,365	89,772	104,677
d. Allowance for Bad Debt	-	-	-	(1,443)	(3,770)	(4,396)
e. Contractual Allowance	-	-	-	(3,217)	(8,405)	(9,739)
f. Charity Care	-	-	-	(790)	(2,065)	(2,408)
g. Net Patient Services Revenue	-	-	-	28,915	75,532	88,135
h. Other Operating Revenues	-	-	-	934	2,441	2,848
<b>i. Net Operating Revenue</b>	-	-	-	29,850	77,973	90,983
<b>2. Expenses</b>						
a. Salaries, Wages, and Professional Fees (Including fringes)	-	-	-	14,111	36,877	42,996
b. Contractual Services	-	-	-	4,260	9,412	9,803
c. Interest on Current Debt	-	-	-	-	-	-
d. Interest on Project Debt	-	-	-	2,564	6,839	6,730
e. Current Depreciation	-	-	-	-	-	-
f. Project Depreciation	-	-	-	5,054	10,257	10,557
g. Current Amortization - Included in Depreciation	-	-	-	-	-	-
h. Project Amortization - Included in Depreciation	-	-	-	-	-	-
i. Supplies	-	-	-	-	-	-
j. Other Expenses (Pre-opening recruiting, training and other related costs in 2013 - Insurance, Utilities, Repairs)	-	-	-	5,167	13,562	15,725
<b>k. Total Operating Expenses</b>	-	-	-	29,932	79,648	91,111
<b>3. Income</b>						
a. Income from Operations	-	-	-	(9,266)	(2,311)	1,698
b. Non-Operating Income	-	-	-	-	69	272
c. Subtotal	-	-	-	(9,266)	(2,242)	1,970
d. Income Taxes	-	-	-	-	-	-
<b>e. Net Income (Loss)</b>	-	-	-	\$ (9,266)	\$ (2,242)	\$ 1,920

*Note: Dollars in Thousands and in Current FY 2010 Dollars*

**Holy Cross Hospital - Germantown  
Table 4: Patient Mix  
For the Fiscal Years 2010 - 2015**

Fiscal Year	Projected Years (ending with first full year utilization)				
	2010	2011	2012	2013	2014

Fiscal Year

**2. Patient Mix**

**A. Percent of Net Patient Service Revenues\***

- 1) Medicare
- 2) Medicaid
- 3) Blue Cross
- 4) Commercial Insurance
- 5) Self-Pay
- 6) Other
- 7) Total

n/a	n/a	n/a	n/a	34.8%	35.3%	35.8%
n/a	n/a	n/a	n/a	12.4%	12.3%	12.2%
n/a	n/a	n/a	n/a	12.9%	12.8%	12.7%
n/a	n/a	n/a	n/a	31.8%	31.5%	31.3%
n/a	n/a	n/a	n/a	5.1%	5.1%	5.1%
n/a	n/a	n/a	n/a	3.0%	3.0%	3.0%
n/a	n/a	n/a	n/a	100.0%	100.0%	100.0%

**B. Percent of Patient Days/Visits/Procedures (as applicable)**

- 1) Medicare
- 2) Medicaid
- 3) Blue Cross
- 4) Commercial Insurance
- 5) Self-Pay
- 6) Other
- 7) Total

n/a	n/a	n/a	n/a	33.5%	36.2%	36.8%
n/a	n/a	n/a	n/a	12.8%	12.3%	12.2%
n/a	n/a	n/a	n/a	12.9%	12.3%	12.2%
n/a	n/a	n/a	n/a	32.1%	31.0%	30.8%
n/a	n/a	n/a	n/a	5.4%	5.2%	5.2%
n/a	n/a	n/a	n/a	3.0%	2.9%	2.8%
n/a	n/a	n/a	n/a	100.0%	100.0%	100.0%

\* Gross patient charges

Note: Commercial Insurance includes Managed Care



**Holy Cross - Germantown**  
**Inpatient ICC Buildup**  
**Statewide Peer Group Excluding UMMC & JHH**

\$9,105

Statewide Stripped CPC excl. JHH and UMMMS

Buildup:		
<i>Non-Teaching IME</i>	(701)	
<i>DSH</i>	(0.98%)	
Capital	2.93%	
Labor Market	1.0239	
Direct Strips	\$0	
Markup	1.1146 (1)	
<b>Modified ICC Result</b>	<b>\$9,767</b>	

1.77% (2)

FY 2010 Statewide Rate Increase

\$9,940

**Modified ICC Result**

Note 1: Calculation of Markup based on CON Payer Mix

Ratio of Medicare & Medicaid Changes	A	Germantown
Ratio of Blue Cross sp Changes	B1	0.4720 per CON 2012
Ratio of Blue Cross CP Changes	B2	0.0964 per CON 2013
Ratio of MCO Medicare, Medicaid Changes	C	0.0426 per CON 2013
Reductions Paid by Medicaid & Blue Cross	D	0.0000 per CON 2013
Proportion for Unreimbursable Accounts:	EP - Prospective	0.0650 per CON 2013
Proportion for Other Payers:	FP = 1 - (A + B1 + B2 + C + EP)	0.3340
Approved Markup:	GP = GP (UBA) * 0.0225(1) + 0.0225 * DMC * D70 * EP + 0.02FP * H	1.1146

Note 2: Effective July 1, 2009 the HSCRC approved a final update factor of 1.77%.

# EXHIBIT B

## Holy Cross Health - Germantown Revenue and Expenses - Project For the Fiscal Years 2017 (with Inflation)

*Note: Dollars in Thousands and in FY 2017 Forecasted Dollars*

	Projected 2017
<b>Fiscal Year Ended June 30,</b>	
<b>1. Revenue</b>	\$ 88,292
a. Inpatient Services	51,416
b. Outpatient Services	139,708
c. Gross Patient Services Revenues	(5,868)
d. Allowance for Bad Debt	(13,003)
e. Contractual Allowance	(3,213)
f. Charity Care	117,624
<b>g. Net Patient Services Revenue</b>	<b>3,801</b>
h. Other Operating Revenues	121,425
i. Net Operating Revenue	
<b>2. Expenses</b>	60,423
a. Salaries, Wages, and Professional Fees (including fringes)	12,539
b. Contractual Services	-
c. Interest on Current Debt	6,493
d. Interest on Project Debt	-
e. Current Depreciation	11,257
f. Project Depreciation	-
g. Current Amortization - included in Depreciation	-
h. Project Amortization - included in Depreciation	21,556
i. Supplies	4,604
j. Other Expenses (Insurance, Utilities, Repairs)	116,872
k. Total Operating Expenses	
<b>3. Income</b>	4,553
a. Income from Operations	509
b. Non-Operating Income	5,062
c. Subtotal	-
d. Income Taxes	\$ 5,062
e. Net Income (Loss)	

# Exhibit 8

**GALLAGHER  
EVELIUS & JONES LLP**  
ATTORNEYS AT LAW

JACK C. TRANTER  
jtranter@gejlaw.com  
direct dial: 410 347 1370  
fax: 410 468 2786

May 10, 2012

**VIA EMAIL AND HAND DELIVERY**

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~~Ms. Ruby Potter~~  
Health Facilities Coordination Officer  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215-2299

Re: Holy Cross Hospital of Silver Spring, Inc. – New Hospital in Germantown, MD,  
Docket No. 08-15-2286

Dear Ruby:

Enclosed are six copies of Holy Cross Hospital's Response to Comments Filed By Clarksburg Community Hospital, Inc. and Adventist Healthcare, Inc. These comments were emailed to all parties yesterday.

One change has been made to the filing—Jack Tranter's signature page has been substituted, at page 13.

Very truly yours,



Jack C. Tranter

JCT/cmc

Enclosures

cc: Ben Steffen  
Pamela Barclay  
Paul Parker  
Joel Riklin  
Suellen Wideman, Esq.  
Ulder J. Tillman, M.D., MPH  
Kevin J. Sexton  
Annice Cody  
John J. Eller, Esq.  
John F. Morkan, III, Esq.  
Howard Sollins, Esq.  
Kathie Hulley

#445141  
9849-20

IN THE MATTER OF HOLY CROSS	*	BEFORE THE
HOSPITAL NEW HOSPITAL IN	*	MARYLAND HEALTH
GERMANTOWN	*	CARE COMMISSION
Matter No. 08-15-2286	*	
* * * * *		

**HOLY CROSS HOSPITAL'S RESPONSE TO COMMENTS  
FILED BY CLARKSBURG COMMUNITY HOSPITAL, INC.  
AND ADVENTIST HEALTHCARE, INC.**

Holy Cross Hospital of Silver Spring, Inc. ("Holy Cross"), by its undersigned counsel, files this Response to the Comments on Additional Evidence submitted by Clarksburg Community Hospital, Inc. and Adventist HealthCare, Inc. (collectively "AHC"). In this filing, Holy Cross will address and refute AHC's claims that the Maryland Health Care Commission ("Commission") should have denied the Holy Cross new hospital application because: (1) there is no need for a new hospital in Germantown; and (2) the Holy Cross project ("HCH-G") is not financially viable.

**INTRODUCTION**

AHC maintains that "the entire premise of approving the Holy Cross CON application in 2011 was the MHCC's projections of MSGA bed need in 2018 among future adult residents of an 18 zip code area of Montgomery County" (*See Comments at 12*). This is an egregious misrepresentation of the Commission's 180-page Decision. Bed need was just one issue among the 48 applicable State Health Plan Standards and CON Review Criteria that Holy Cross met.

In fact, the sole issue raised by AHC in its Comments is whether an alleged mistake in the 2008 non-Medicare MSGA discharge rate for Montgomery County

impacts the Commission's determinations that there was need for a new hospital in Germantown and that the HCH-G project is financially viable. Instead of focusing on the non-Medicare discharge rate that AHC claims is erroneous and relating the impact on the five- and ten- year trend adjustments in the Commission's need methodology, where this alleged mistake could have impacted the MHCC's need determination, AHC does now what it should have done in its Exceptions, i.e., challenge the Commission's determination that a new hospital is needed in upper Montgomery County.

As will be shown in this filing, even accepting AHC's critique of the need methodology, the market share penetration rates necessary for Holy Cross's new hospital to be highly utilized are realistic and support the Commission's finding of need and financial feasibility. More detail regarding these projections is related below and in the Affidavit of Annice Cody attached as **Exhibit 1**.

#### ARGUMENT

**I. AHC'S CLAIM THAT THERE IS NO NEED FOR THE NEW HOSPITAL THAT HOLY CROSS PROPOSES TO CONSTRUCT IN GERMANTOWN SHOULD BE REJECTED.**

After spending more than two years seeking approval to build a new hospital in Clarksburg, including seeking legislative intervention in the CON review process, AHC now maintains there is no need for a new hospital in upper Montgomery County. Indeed during this review, AHC consistently argued that there was need for a new hospital in upper Montgomery County and that its proposal to build a new hospital in Clarksburg (with a service area population projected in 2018 to be less than half the population projected the HCH-G service area) was the appropriate location for the new hospital.

The Commission is best able to assess the information related in the Coughlan Affidavit. The Commission and Staff must determine first if there was a mistake in the use rate for non-Medicare MSGA discharges for residents of Montgomery County, as AHC alleges. The Commission and its Staff must next determine the materiality of any such mistake on the five and ten-year trend adjustment in the Commission's need

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methodology, if the discharge rate in question that appears in Table 29 on page 40 of the Decision is erroneous.

However, even assuming *arguendo* that AHC is correct, the impact of the alleged mistake in the 2008 non-Medicare use rate for Montgomery County error is not material and does not impact or change the Commission's determination that there is need for a new hospital in Germantown. Indeed, it is important to remember that the Montgomery County non-Medicare use rate that Mr. Coughlan asserts is wrong is not the use rate utilized to project bed need for the HCH-G Expected Service Area ("ESA") in 2018. Rather, the discharge rate in question is used only in the second part of the Commission's need methodology, i.e., to adjust the MSGA bed need projection for 2018 by the five and ten year trends in discharges and ALOS to establish minimum and maximum MSGA bed need projections.

In the Decision, the Commission found that need had been shown because Holy Cross would achieve the necessary MSGA volumes if its market share penetration in its expected service area ("ESA") was just 10%. For many reasons, the Decision considered a ten percent market penetration for the HCH-G ESA to be "realistic." However, the Commission did not hold, as AHC claims, that a 10% market share in a hospital's service

area was a maximum achievable level of market penetration or some kind of ceiling to be used in assessing whether there was need for a new hospital.

As is demonstrated below, accepting and using the data related in the Coughlan Affidavit shows that HCH-G must achieve a market penetration of between 14.5% (at the maximum bed need projection) and 16.5% (at the minimum bed need projection). These levels of market penetration are “realistic” and achievable for the very same reasons that the Commission found that a somewhat lower market share demonstrated need for the new hospital proposed by Holy Cross. Holy Cross will address why these levels of market penetration are realistic after relating the need methodology and performing the calculations that produced these values.

Annice Cody, Vice President of Strategic Planning at Holy Cross, calculated MSGA bed need for the HCH-G 18-zip code service area using: (1) the DC and Maryland 2008 discharge databases, and (2) data from Exhibit 2 to the Coughlan Affidavit, titled, “MSGA Discharges from MD and DC Hospitals: Montgomery County Residents.”<sup>1</sup> As previously noted, Ms. Cody’s methodology is attached as Exhibit 1.

In brief, Ms. Cody calculated the 2008 use rate and ALOS for Medicare and non-Medicare cases as the baseline. She adjusted those values based on the five-year and ten-year Montgomery County trends calculated by using the data provided by Mr. Coughlan. She then applied the adjusted use rate and ALOS to the 2018 population for the HCH-G service area from Table 27 of the Decision that Mr. Coughlan had verified as matching the extra-record data.

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<sup>1</sup> Exhibit 2 relates the use rates and average length of stay (“ALOS”) for Montgomery County residents for 1998 through 2008.

As shown below, Ms. Cody used these data and the Commission's service area need methodology set forth in the Decision resulting in an average daily census ("ADC") of between 290 and 329 MSGA patients in the HCH-G ESA in 2018, and a corresponding bed need, assuming 75% occupancy of between 386 and 439 MSGA beds.<sup>2</sup>

2018 HCH-G ESA Bed Need	15-64	65+	Total	ADC	Bed Need
2018 pop HCH-G ESA	257,014	53,680	310,694		
Minimum use rate	46.2	251.0			
Minimum ALOS	3.90	4.41			
Minimum days	46,311	59,432	105,743	290	386
Maximum use rate	50.9	270.9			
Maximum ALOS	3.95	4.71			
Maximum days	51,908	68,588	120,166	329	439

Adjusting for the expectation that 85% of MSGA patients will be generated from the ESA, the market share necessary for HCH-G's 75 MSGA beds to be highly utilized is between 14.5% and 16.5%.

Market share requirement	Min	Max
HCH-G beds	75	75
85% of HCH-G beds	64	64
Bed Need	386	439
Market share to meet bed need	16.5%	14.5%

<sup>2</sup> The bed need methodology in the Acute Care Hospital Services Chapter of the State Health Plan identifies the minimum occupancy rate for hospitals with between 50 and 99 MSGA beds as 75%

AHC's Comments state, "it was impossible for Mr. Coughlan to determine the case-mix adjusted computations used by the MHCC to forecast the 2018 MSGA Gross Bed Need for the hospital service areas shown on Tables 30 and 31 of the CON Decision." *See* Comments at 12. Despite the fact that he did not know how this was done, Mr. Coughlan developed a methodology that resulted in reducing need by 3,290

patient days. To give Mr. Coughlan's analysis the benefit of the doubt, Holy Cross deducted these days from the 2008 baseline and found the impact was negligible; i.e., the necessary market share to demonstrate need increased by approximately half a percent to between 15.0% and 17.1%. *See* Table 4 of the Cody Affidavit.

The test established in the Decision as to whether either of the new hospital projects is needed is whether the market share necessary to meet the MSGA volume projections is "realistic." Decision at 42. AHC, however, distorts the test established by the Commission, arguing that the Decision "embraced" a 10% market share as the target market share for HCH-G. *See* Comments at 15. This is simply not true.

As part of the need analysis in the Decision, the Commission notes "the much larger service area population expected for the HCH-G project when compared with the CCH ESA and the ability of the proposed 75 MSGA beds at HCH-G to be highly occupied with a market penetration of MSGA patients originating in the service area of 10%." Decision at 42. The Commission next noted the consistency of the HCH-G market share projection with those of existing Montgomery County hospitals, concluding that the 10% market share projected for HCH-G's 85% ESA was "realistic."

However, the Commission did not establish a 10% market share as some sort of benchmark or achievable market share ceiling that had to be demonstrated for the

Commission to find need under its methodology. The Decision simply noted that a 10% market share was "realistic" for HCH-G to achieve in its 85% service area, given the experience of the five existing Montgomery County hospitals in their 90% service areas.

In the Decision, the 10% market share was the market penetration at which HCH-G would be highly utilized. AHC has turned this comment on its head and interpreted it as a ceiling for what a new hospital's market share can be.

In terms of whether the somewhat higher market shares computed by Ms. Cody are "realistic," the Decision noted that the existing Montgomery County hospitals' Maryland MSGA market shares in their 85% service areas ranged from 11% to 27%. *See* Decision at 68. These market shares are consistent with the range computed by Ms. Cody.

The 90% service area market share figures are much lower because each additional ZIP code that is added contributes all of its population to the denominator of the market share calculation, but only a few cases to the numerator. The table below replicates data regarding the 90% service areas of Montgomery County hospitals from Table 25 and compares it to data regarding the 85% service areas of Montgomery County's hospitals from Ms. Cody's Pre-Filed Direct Testimony (*see* Cody PFT at 7). For Montgomery County hospitals, the 85% service area market share is 30% to 110% higher than the 90% service area market shares. The market share required for HCH-G to be highly utilized is well within the range of the other Montgomery County hospitals.

	90% MSGA Service Area		85% MSGA Service Area		Percent Variance Between 85% and 90% Service Areas	
	Number of ZIPs	Market Share	Number of ZIPs	Market Share	Number of ZIPs	Market Share
Hospital						
Holy Cross	68	8.68%	52	15%	-24%	73%
Montgomery General	48	10.22%	30	15%	-38%	47%
Shady Grove	37	20.73%	26	27%	-30%	30%
Suburban	67	9.52%	39	20%	-42%	110%
Washington Adventist	89	6.20%	58	11%	-35%	77%

A finding that the market share values for HCH-G computed by Ms. Cody are “realistic” and demonstrate need under the Commission’s methodology is also supported by the market shares of three similarly sized hospitals that Holy Cross identified in its testimony, all in multi-hospital jurisdictions, with similar distances from their closest competitors. The total market shares for those hospitals in their 85% service areas ranged from 6% to 23%. These values support a finding that HCH-G can achieve a MSGA market share in its 85% ESA ranging from 14.5 to 16.5%. See Decision at 34.

The market share range Ms. Cody calculated for HCH-G is achievable and realistic for the many reasons set forth in her affidavit and in this filing. The minimum and maximum market shares she calculated (14.5% to 16.5%) are also below the 22% market share identified in the Holy Cross application and the 39% market share AHC projected for the proposed Clarksburg hospital. Indeed, AHC’s claim in its Comments that 10% is the maximum realistic market share that can be achieved is inconsistent with: (1) its failure to challenge the higher market share in the Holy Cross application (22%); and (2) its assertion that a 39% MSGA market share in the proposed Clarksburg hospital’s ESA was reasonable and achievable.

In its Decision the Commission also identified two aspects that are unique to the Holy Cross new hospital proposal that further support a finding that a 14.5% - 16.5%

market share penetration is realistic and probably conservative. Both features of the HCH-G project are discussed below.

First, the Commission found that “[t]he HCH-G project is more likely to meet or exceed its utilization projections at the site proposed [due to a] shift in patient demand from the Gaithersburg/Germantown area, the core of the expected service area, that currently expresses itself at HCH-SS to HCH-G.” *See* Decision at 73. As the evidence in this case showed, in 2008, 1,475 MSGA residents of the HCH-G ESA received inpatient care at Holy Cross Hospital in Silver Spring (“HCH-SS”). Holy Cross estimated that nearly three quarters of these patients (74%) would have gone to HCH-G had it been available. Just this shift alone generates an ADC of 13.2 or a bed need at 80% of 16.5 beds. This phenomenon supports a finding that the market share penetration computed by Ms. Cody is “realistic.” *See* Decision at 37.

In addition to the expectation that HCH-G will serve patients who would have otherwise have gone to HCH-SS, the tremendous growth projected for the 65+ population in the HCH-G service area also demonstrates that the market share penetration computed by Ms. Cody is achievable. As shown in Table 27 of the Decision, the 65+ population in Montgomery County is projected to grow 37.4% between 2008 and 2018. In the HCH-G ESA, however, the growth will be 50% higher at 56.4%.

For all of these reasons, even if the non-Medicare use rate for Montgomery County is lower than identified in the Decision, the size and growth of the HCH-G ESA easily supports the need for a new hospital.

**II. AHC's CLAIMS THAT THERE IS NO NEED FOR A NEW HOSPITAL IN MONTGOMERY COUNTY IS AT ODDS WITH THE POSITIONS TAKEN AND ARGUMENTS MADE BY AHC IN ITS EXCEPTIONS AND EXCEEDS THE SCOPE OF THE REMAND ORDER.**

It is important to note that AHC's attack on the finding of need for a new hospital is at odds with the positions taken and arguments made in its Exceptions. AHC did not challenge the Commission's need methodology until *after* the Commission issued the Final Decision, approving HCH-G and rejecting the AHC new hospital proposal. Indeed, the AHC Exceptions repeatedly argue that the market share penetration necessary to achieve the MSGA volumes projected for the new hospital proposed by AHC (39%) was achievable. *See* Exceptions at 14, 47, 49-55 and 67.

All of the arguments made by AHC in its Comments could and should have been made in its Exceptions. At the latest, AHC should have made these arguments before the Circuit Court. To make them now, for the first time, exceeds the scope of Judge Pierson's remand order and memorandum. Otherwise stated, AHC may not make arguments now that are inconsistent with the claims made in its Exceptions, its pleadings before the Circuit Court and Judge Pierson's remand order. AHC does not, as a matter of law, get a second substantive "bite" at the Exceptions apple because this matter was remanded so AHC can review certain data not included as part of the record in this case. Unless an argument can be connected to the data in question, it cannot be made now.

Specifically, AHC's Comments challenge the five and ten-year trend adjustments in the Commission's need methodology. However, AHC should have raised this issue in its Exceptions, relating its concern that it did not have all of the data necessary to "test" the validity of this aspect of the need methodology.

Similarly, AHC failed to challenge the third step in the Commission's need methodology, i.e. the case-mix ALOS adjustment. Again, if AHC thought this or any other aspect of the Commission's methodology was problematic, this claim should have been made in AHC's Exceptions or before the Circuit Court, not "after the fact," as is occurring now. Moreover, all of the data necessary to assess the case-mix adjustment component of the Commission's methodology were available at the time AHC filed Exceptions. A claim that should have been included in the Exceptions or in pleadings before the Circuit Court, as a matter of law, cannot be made now.

However, AHC's failure to challenge the finding of need in its Exceptions is not surprising, as AHC maintained that it could achieve the 39% MSGA market share penetration necessary for a finding of need for a new hospital in Clarksburg. Put simply, AHC should not be permitted to raise issues and arguments in this remanded proceeding that should have been made as part of the Exceptions and that were not raised before the Circuit Court. As noted above, AHC's Exceptions argue that need had been demonstrated for a new hospital in Clarksburg. Now, after the Commission has approved the Holy Cross new hospital proposal, AHC abandons its claim that need for the Clarksburg hospital had been demonstrated and now claims that there is not need for a new hospital in upper Montgomery County.

**III. THE AHC ARGUMENT THAT HOLY CROSS FAILS TO MEET THE FINANCIAL FEASIBILITY STANDARD SHOULD BE REJECTED BECAUSE IT IS BASED ON THE FAULTY ASSUMPTION THAT HCH-G WILL NOT MEET ITS VOLUME PROJECTIONS.**

AHC's claim that HCH-G is not financially feasible is based entirely on its notion that HCH-G cannot achieve the volumes necessary to generate sufficient revenue to be

financially feasible. This view is inconsistent with the Decision's finding that "on balance the Commission concludes that HCH-G has made a strong case for its financial feasibility, which rests on a relatively conservative set of assumptions with respect to market feasibility." See Decision at 73.

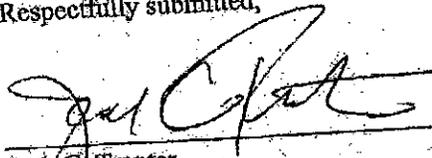
As described in detail above, HCH-G will serve a large and rapidly growing market. At only 14.5% - 16.5% market share, MSGA beds at HCH-G will be highly utilized, particularly since part of the population served by HCH-G will be ESA residents who currently travel to HCH-SS to receive inpatient care. Put simply, as demonstrated above, the market share penetration necessary for a financially feasible hospital is achievable and realistic, as Ms Cody demonstrated by assessing need based on the Commission's methodology.

Indeed, AHC never previously challenged HCH-G's volume projections. It does so now solely on the baseless claim that HCH-G cannot achieve a market share above 10% in its ESA. As demonstrated above and in Ms. Cody's Affidavit, the market share penetration necessary for HCH-G to demonstrate need is realistic and achievable. Because those volumes can be achieved, HCH-G has demonstrated consistency with the financial feasibility standard and review criterion.

### **CONCLUSION**

For the reasons related above and in Ms. Cody's Affidavit, the arguments made in the Comments should be rejected and the Commission should reaffirm its determination that there is need for a new hospital to serve upper Montgomery County and that the Holy Cross Germantown proposal should be approved.

Respectfully submitted,



Jack C. Tranter  
Philip F. Diamond  
Gallagher Evelius & Jones LLP  
218 North Charles Street, Suite 400  
Baltimore MD 21201  
(410) 727-7792

*Attorneys for Holy Cross Hospital of  
Silver Spring, Inc.*

May 9, 2012

#444993  
009849-0020

**CERTIFICATE OF SERVICE**

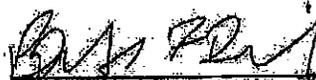
I hereby certify that on the 9<sup>th</sup> day of May, 2012, a copy of the foregoing Response to Comments was sent via email and first-class mail to:

Diane Festino Schmitt, Esq.  
Howard L. Sollins, Esq.

-----  
Lisa D. Stevenson  
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Assistant Attorney General  
Maryland Health Care Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

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Associate County Attorney  
1301 Piccard Drive, 4<sup>th</sup> floor  
Rockville, Maryland 20850



Philip F. Diamond

---

# EXHIBIT

1

IN THE MATTER OF HOLY CROSS \* BEFORE THE  
HOSPITAL NEW HOSPITAL IN \* MARYLAND HEALTH  
GERMANTOWN \* CARE COMMISSION  
Matter No. 08-15-2286 \*

\* \* \* \* \*

**AFFIDAVIT OF ANNICE CODY**

1. My name is Annice Cody. I am over 21 years of age and am competent to provide this Affidavit. I am the Vice President of Strategic Planning for Holy Cross Hospital of Silver Spring (“Holy Cross”). I have previously provided testimony regarding market feasibility for a new hospital during the evidentiary hearing held on this matter.

2. I am providing this Affidavit to describe how I calculated bed need for the Germantown hospital’s Expected Service Area (“ESA”) using the Maryland Health Care Commission’s (“Commission”) methodology.

3. For the purpose of this analysis, I have accepted data from Mr. Richard Coughlan’s Affidavit that was included in Adventist’s Comments on Additional Evidence Entered into the Record (“Comments”) in order to ascertain what bed need the data generate when applied to the Commission methodology.

4. Mr. Coughlan did not show the baseline 2008 MSGA discharge use rate and ALOS for Medicare and non-Medicare MSGA patients from the Germantown hospital (“HCH-G”) ESA that he used. Therefore, I calculated this baseline by identifying the HCH-G ESA discharges and patient days from the 2008 DC and Maryland hospital databases and the 2008 HCH-G ESA population from Table 26 of the

Montgomery County Hospital CON Decision (“Decision”). The results are shown in the attached Table 1.

5. The Commission bed need methodology adjusts the base year use rate and ALOS based on the average annual change of the previous five and ten year periods. For both use rate and ALOS, it uses the more negative of either the five or ten year average to calculate the minimum need and the more positive of the five or ten year average to calculate the maximum need. Exhibit 2 “MSGAs Discharges from MD and DC Hospitals: Montgomery County Residents” of Mr. Coughlan’s Affidavit has the data necessary to calculate these averages, however he did not include either the annual percent change for each year or the average change for the previous five or ten years for use rate or ALOS. I used Mr. Coughlan’s data to make those calculations which are shown in the attached Table 2.

6. To calculate bed need in 2018, I applied the appropriate average annual change to each year from the base year (2008) to the target year (2018) using the formula:  $\text{base year} \times (1 + \text{average annual change})^{10} = \text{target year}$ . I used the 2018 population for the Germantown ESA that was identified in Table 27 of the Decision because Mr. Coughlan reported in his Affidavit that he “was able to match, with close proximity, the population estimates and projections appearing in Tables 26 and 27.” See Coughlan Affidavit at 2.

7. The results of this analysis are shown in Table 3. Based on my baseline calculation adjusted using Mr. Coughlan’s data, the Germantown ESA will have a minimum MSGA average daily census (“ADC”) of 290 and a maximum of 329 in 2018.

8. The Acute Care Hospital Services Chapter of the State Health Plan identifies that the minimum occupancy rate for hospitals with between 50 and 99 MSGA beds as 75%. Therefore I applied 75% occupancy to the ADC to determine the bed need would be a minimum of 386 and a maximum of 439.

9. To determine the market share necessary for Holy Cross's proposed Germantown hospital ("HCH-G") to be highly utilized, I divided the 75 MSGA beds by 0.85 to reflect the assumption that 85% of HCH-G's cases would be generated from the ESA. I then divided the resulting 64 beds by the 386 and 439 bed need to determine that the market share necessary would be 14.5% for the maximum bed need and 16.5% for the minimum bed need.

10. In the Comments at 12, AHC noted that "it was impossible for Mr. Coughlan to determine the case-mix adjusted computations" that the Commission used to adjust for actual ALOS that exceeds case-mix adjusted ALOS. In my own review of the Decision, I could not tell if any adjustment was made to the applicant hospital service area bed need projections or only to the existing hospitals. I also could not determine how the adjustment was made. Nevertheless, I used the results of Mr. Coughlan's calculation from Exhibit 4 of his Affidavit that shows the 1,614 excess Medicare days and 1,676 excess non-Medicare days to reduce the 2008 baseline patient days and resultant ALOS. The results of this analysis are shown in Table 4. The increase in market share necessary to meet the bed need is negligible. With this adjustment, the market share necessary would be 15.0% to 17.1%.

11. This market share range is below the 22% MSGA market share that Holy Cross identified in its application and which AHC never challenged. It is well below the 39% MSGA market share that AHC projected for its proposed Clarksburg hospital.

12. This market share is well within the range of the existing Montgomery County hospitals' MSGA market shares in their 85% service areas that I identified on page 3 of my Pre-Filed Testimony for the Evidentiary Hearing in this matter. As shown below, those Maryland discharge market shares ranged from 11% to 27%. For these hospitals, the 85% service area market share is 30% to 110% higher than the 90% service area market shares identified in Table 25 of the Decision.

Hospital	90% MSGA Service Area		85% MSGA Service Area		Percent Variance Between 85% and 90% Service Areas	
	Number of ZIPs	Market Share	Number of ZIPs	Market Share	Number of ZIPs	Market Share
Holy Cross	68	8.68%	52	15%	-24%	73%
Montgomery General	48	10.22%	30	15%	-38%	47%
Shady Grove	37	20.73%	26	27%	-30%	30%
Suburban	67	9.52%	39	20%	-42%	110%
Washington Adventist	89	6.20%	58	11%	-35%	77%

13. This 14.5% - 16.5% market share is also within the range of total (all services) Maryland discharge market share for three similarly sized hospitals located in multi-hospital jurisdictions with similar distances to their closest competitors that I identified in my Pre-Filed Testimony at page 7.

	<u>Laurel Hospital</u>	<u>Harford Memorial</u>	<u>Montgomery General</u>
FY10 Licensed beds	95	105	170
Market Share in 85% Area	6%	23%	13%
Closest hospital	Holy Cross	Union	Holy Cross
Time/distance to closest hospital	20 min. / 14 miles	24 min. / 17 miles	21 min. / 11 miles
Second closest hospital	Howard County	Upper Chesapeake	Laurel
Time/distance to 2nd closest hospital	21 min. / 14 miles	26 min. / 20 miles	26 min. / 13 miles

14. In my opinion, the possible error identified by Mr. Coughlan does not change the bed need for the Germantown ESA sufficiently to alter the finding that there is need for the HCH-G hospital and that the market share it must achieve is realistic.

I solemnly affirm under the penalties of perjury that the contents of the foregoing Affidavit are true and correct to the best of my knowledge, information, and belief.

5/9/12  
Date

  
Annice Cody

**Table 1****2008 MSGA Discharges from MD and DC Hospitals: HCH-G ESA Residents**

	Medicare Cases	Non-Med Cases	Total Cases	Medicare Days	Non-Med Days	Total Days
Maryland	7,985	10,645	18,630	40,936	42,378	83,314
DC	598	1,298	1,896	4,149	6,919	11,068
Total	8,583	11,943	20,526	45,085	49,297	94,382

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	15-64	65+
Population	255,730	34,333
Use Rate	46.7	250.0
ALOS	4.13	5.25

**Table 2**  
**MSGAs Discharges from MID and DC Hospitals: Montgomery County Residents**

	Population										Discharge Rates	
	Non-Medicare					Medicare					Non-Medicare	Medicare
	Cases	Days	ALOS	Annual change	Non-Med Days	Non-Med ALOS	Non-Med Annual change	15-64	65+	Medicare Annual change	Annual change	
1998	22,257	25,349	141,758	6.37	111,285	4.39	3.42%	583,198	93,546	237.93	43.47	
1999	22,257	25,912	146,603	6.59	117,705	4.54	3.42%	587,236	95,893	232.10	44.13	
2000	23,727	26,287	146,600	6.18	115,475	4.39	-3.30%	591,274	98,241	241.52	44.46	
2001	25,392	26,252	149,443	5.89	114,447	4.36	-0.68%	595,312	100,589	252.43	44.10	
2002	25,808	27,868	146,900	5.69	118,315	4.25	-2.52%	599,350	102,937	250.72	46.50	
2003	27,034	28,686	152,292	5.63	123,614	4.31	1.41%	603,388	105,284	256.77	47.54	
2004	27,908	28,723	153,313	5.49	119,704	4.17	-3.25%	607,426	107,632	259.29	47.29	
2005	28,570	28,661	150,678	5.27	116,540	4.07	-2.40%	611,463	109,980	259.77	46.87	
2006	28,455	28,799	143,161	5.03	114,793	3.99	-1.97%	615,501	112,328	253.32	46.79	
2007	29,008	29,255	151,824	5.23	117,163	4.01	0.50%	619,538	114,675	252.86	47.22	
2008	30,093	29,489	160,212	5.32	123,167	4.18	4.24%	623,577	117,023	257.15	47.29	
5 year average (2003-2008)							-1.07%					-0.10%
10 year average (1998-2008)							-1.73%					0.86%

	Medicare	Non-Medicare
5 year trend	Disch 0.04%	Disch -0.10%
10 year trend	ALOS -1.07%	ALOS -0.57%
	0.81%	0.86%

Note: These data are from Exhibit 2 of the Coughlin Affidavit with the addition of the annual change columns and the 5 year and 10 year average calculations

**Table 3: 2018 Bed Need and Market Share Requirement for HCH-G ESA**

HCH-G ESA	Use rate	Use rate	ALOS	ALOS
	15-64	65+	15-64	65+
2008 Actual	46.7	250.0	4.13	5.25

Montgomery County Residents, 1998	Annual change			
	Use rate	Use rate	ALOS	ALOS
	15-64	65+	15-64	65+
Average Annual change (5 year)	-0.10%	0.04%	-0.57%	-1.07%
Average Annual change (10 years)	0.86%	0.81%	-0.46%	-1.73%

2018 HCH-G ESA Bed Need	15-64	65+	Total	ADC	Bed Need
2018 pop HCH-G ESA	257,014	53,680	310,694		
Minimum use rate	46.2	251.0			
Minimum ALOS	3.90	4.41			
Minimum days	46,311	59,432	105,743	290	386
Maximum use rate	50.9	270.9			
Maximum ALOS	3.95	4.71			
Maximum days	51,608	68,558	120,166	329	439

Market share requirement	Min	Max
HCH-G beds	75	75
85% of HCH-G beds	64	64
Bed Need	386	439
Market share to meet bed need	16.5%	14.5%

**Table 4: 2018 Bed Need and Market Share Requirement for HCH-G ESA with Coughlan Case Mix Adjustment**

<b>2008 HCH-G ESA</b>	<b>15-64</b>	<b>65+</b>		
Population	255,730	34,333		
Cases	11,943	8,583		
Unadjusted Days	49,297	45,085		
Adjusted days	47,621	43,471		
<b>HCH-G ESA</b>	<b>Use rate</b>	<b>Use rate</b>	<b>ALOS</b>	<b>ALOS</b>
	<b>15-64</b>	<b>65+</b>	<b>15-64</b>	<b>65+</b>
2008 Actual	46.7	250.0	4.13	5.25
2008 Adjusted	46.7	250.0	3.99	5.06

<b>Montgomery County Residents, 1998-2008</b>	<b>Annual change</b>			
	<b>Use rate</b>	<b>Use rate</b>	<b>ALOS</b>	<b>ALOS</b>
	<b>15-64</b>	<b>65+</b>	<b>15-64</b>	<b>65+</b>
Average Annual change (5 year)	-0.10%	0.04%	-0.57%	-1.07%
Average Annual change (10 years)	0.86%	0.81%	-0.46%	-1.73%

<b>2018 HCH-G ESA Bed Need</b>	<b>15-64</b>	<b>65+</b>	<b>Total</b>	<b>ADC</b>	<b>Bed Need</b>
2018 pop HCH-G ESA	257,014	53,680	310,694		
Minimum use rate	46.2	251.0			
Minimum ALOS	3.76	4.26			
Minimum days	44,713	57,333	102,047	280	373
Maximum use rate	50.9	270.9			
Maximum ALOS	3.81	4.55			
Maximum days	49,827	66,137	115,965	318	424

<b>Market share requirement</b>	<b>Min</b>	<b>Max</b>
HCH-G beds	75	75
85% of HCH-G beds	64	64
Bed Need	373	424
Market share to meet bed need	17.1%	15.0%

# Exhibit 9

Marilyn Moon, Ph.D.  
CHAIR

STATE OF MARYLAND



Ben Steffen  
ACTING EXECUTIVE DIRECTOR

**MARYLAND HEALTH CARE COMMISSION**

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215  
TELEPHONE: 410-764-3460 FAX: 410-358-1236

**CORRECTED**

May 11, 2012

By E-Mail

Diane Festino Schmitt, Esquire  
Howard L. Sollins, Esquire  
Lisa D. Stevenson, Esquire  
Ober, Kaler, Grimes & Shriver, P.C.  
100 Light Street  
Baltimore, Maryland 21202

Jack C. Tranter, Esquire  
Philip F. Diamond, Esquire  
Gallagher Evelius & Jones  
218 North Charles Street, Suite 400  
Baltimore, Maryland 21201

Re: **Remand from the Circuit Court for Baltimore City**  
Case No. 24-C-11-001046  
**Montgomery County New Hospitals Review**  
Holy Cross Hospital-Germantown (Docket No. 08-15-2286)  
Clarksburg Community Hospital (Docket No. 09-15-2294)

Dear Counsel:

I have reviewed the parties' filings, and have determined that I do not desire additional filings, evidence, or oral argument in this matter. I anticipate that, by the middle of next week, I will issue a Recommended Supplemental Decision. As provided in COMAR 10.24.01.B, a party taking exceptions to the Recommended Supplemental Decision will then have seven days to file exceptions, and a party filing a response to exceptions will have five days to file its response. Oral argument on the exceptions will be heard on May 31, 2012.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Moon".

Marilyn Moon, Ph.D.  
Chair, Commissioner/Reviewer

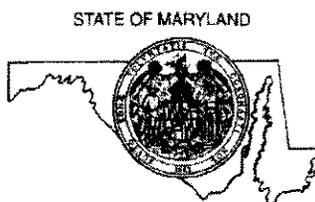
cc: Loretta Shapero, Esquire  
Ulder Tillman, M.D., M.P.H.  
John J. Eller, Esquire  
Paul E. Parker  
Joel Riklin  
Suellen Wideman, AAG

TOLL FREE  
1-877-245-1762

TDD FOR DISABLED  
MARYLAND RELAY SERVICE  
1-800-735-2258

# Exhibit 10

Marilyn Moon, Ph.D.  
CHAIR



Ben Steffen  
ACTING EXECUTIVE DIRECTOR

## MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215  
TELEPHONE: 410-764-3460 FAX: 410-358-1236

### MEMORANDUM

**TO:** Commissioners, Maryland Health Care Commission

Holy Cross Hospital of Silver Spring  
Clarksburg Community Hospital  
Montgomery County Department of Health and Human Services  
Shady Grove Adventist Hospital  
Shady Grove Adventist Emergency Center at Germantown

**FROM:** Marilyn Moon, Ph.D. *MM/REP*  
Chair/Reviewer

**RE:** Recommended Supplemental Decision in the Matter of  
Proposed New Hospitals in Montgomery County  
Holy Cross Hospital of Silver Spring, Docket No. 08-15-2286

**DATE:** May 15, 2012

---

Enclosed is my Recommended Supplemental Decision regarding my review on remand from the Circuit Court for Baltimore City. The remand was ordered by the Court to give the Adventist Entities (former applicant Clarksburg Community Hospital, interested party Shady Grove Adventist Hospital, and interested party Shady Grove Emergency Center at Germantown) an opportunity to comment on certain data that was not included in the record of the review of the applications to establish new hospitals in upper Montgomery County. That review resulted in a 180-page Commission decision, dated January 20, 2012 (the "Decision") that approved the application of Holy Cross Hospital of Silver Spring ("Holy Cross Hospital") for a Certificate of Need to establish a 93-bed general acute care hospital in Germantown ("HCH-G") and denied the application of Clarksburg Community Hospital ("CCH") to establish an 86-bed general acute care hospital in Clarksburg.

I have carefully considered the comments filed by the Adventist Entities, the response of Holy Cross Hospital, and have again looked at bed need, as well as HCH-G's expected service area and market penetration. I recommend that the Commission

**APPROVE** the application of **Holy Cross Hospital of Silver Spring** for a Certificate of Need to establish a 93-bed general acute care hospital in Germantown, with the conditions that are standard for a project involving shell space. The proposed hospital will contain 60 general medical/surgical beds, a 15-bed intensive care unit, 12 obstetric beds, six acute psychiatric beds, five operating rooms, and an emergency department with 14 treatment spaces.<sup>1</sup>

I recommend that Holy Cross Hospital of Silver Spring be awarded a Certificate of Need because I again conclude that its proposal for a new general acute care hospital in Germantown will supply upper Montgomery County with hospital bed capacity that the current and growing population of this region needs and that the new hospital will improve access to hospital services at a reasonable cost. Holy Cross and its parent, Trinity Health, are financially well positioned to implement this project.

While the 2011 Decision contained miscalculations of MSGA bed need for HCH-G's expected service area, these miscalculations do not warrant any alteration in the Commission's conclusions with respect to the need for or the viability of the new hospital, as argued by the Adventist Entities. The 2011 Decision indicated that the proposed hospital could fill its beds and be feasible if it captured 10 percent of the MSGA demand generated in its expected service area. However, the Decision indicated that a 10%-20% market penetration range was achievable. My Recommended Supplemental Decision makes it clear that a market share of 10% was not put forward as a ceiling in the 2011 Decision and supports the 2011 Decision's use of a 10-20% market share range as constituting the critical range for market share in an analysis of this proposed hospital's expected service area demand levels as they relate to proposed bed capacity. I have analyzed the corrected need forecast for HCH-G's proposed MSGA beds using a 15% market share assumption, which is demonstrably reasonable and achievable based on the market shares achieved by Maryland hospitals in their comparable service areas. I find that HCH-G is likely to capture this share of the market and note that Holy Cross's campus in Silver Spring already captures slightly less than 7% of the MSGA market share in the proposed Germantown hospital's expected service area.

Holy Cross Hospital of Silver Spring has a strong record in providing quality care, access to care for the indigent, broad community benefits, and efficient and effective management of its hospital operations. I recommend that the Commission re-issue a Certificate of Need for the proposed Holy Cross Hospital in Germantown.

---

<sup>1</sup> Holy Cross Hospital has notified the Commission that further refinement of its physical plant design has resulted in an Emergency Department with 14 (rather than 12) treatment spaces, but with no additional square footage. This is not a significant change in physical plant design that requires Commission approval.

**REVIEW SCHEDULE AND FURTHER PROCEEDINGS**

This matter will be placed on the agenda for a meeting of the Maryland Health Care Commission on May 31, 2012, beginning at 11:00 a.m., at 4160 Patterson Avenue. The Commission will issue a final decision based on the record of the proceeding.

As provided under COMAR 10.24.01.09B, a party may submit written exceptions to the enclosed Recommended Supplemental Decision and Order. Exceptions should be filed by email no later than noon on Wednesday, May 23, 2012. Copies of exceptions will be distributed electronically to the Commissioners; thus, paper copies may be filed the following day. Written exceptions and argument must identify specifically those findings or conclusions to which exception is taken, citing the portions of the record on which each exception is based. A party must submit 30 copies of their written exceptions and responses to exceptions. Responses to exceptions should be filed no later than 5:00 p.m. on Monday, May 28.

Oral argument during the exceptions hearing before the Commission is limited to 15 minutes per applicant and 10 minutes per interested party, unless extended by the Vice Chair or the Vice-Chair's designated presiding officer. I will not be chairing the meeting when this Recommended Supplemental Decision is considered by the Commission. The schedule for the submission of exceptions and responses is as follows:

Submission of exceptions	Wednesday, May 23, 2012 No later than noon
Submission of responses	Monday, May 28, 2012 No later than 5:00 pm
Exceptions hearing	May 31, 2012 11:00 a.m.

IN THE MATTER OF \* BEFORE THE  
\*  
PROPOSED NEW HOSPITALS \* MARYLAND HEALTH  
\*  
IN MONTGOMERY COUNTY \* CARE COMMISSION  
\*  
Holy Cross Hospital of Silver Spring \*  
Docket No. 08-15-2286 \*  
\*  
Clarksburg Community Hospital \*  
Docket No. 09-15-2294 \*  
\*\*\*\*\*

**Recommended Supplemental Decision**

**May 31, 2012**

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## I. INTRODUCTION

This matter is back before the Commission upon remand from the Circuit Court for Baltimore City. The review came before the Commission as a review of two applications to establish new hospitals in upper Montgomery County, Maryland. On January 20, 2011, the Commission granted a Certificate of Need to Holy Cross Hospital of Silver Spring to establish a new hospital, Holy Cross Hospital-Germantown (“HCH-G”), in Germantown, Maryland. On the same day, the Commission denied the application of Clarksburg Community Hospital, Inc., a corporation formed by Adventist HealthCare, Inc., that sought to establish a new hospital to be known as Clarksburg Community Hospital (“CCH”) in Clarksburg, Maryland. The Commission found that the CCH project was inconsistent with six applicable State Health Plan standards and two Certificate of Need (“CON”) review criteria. The Commission analysis of the two applications is contained in a 180-page decision dated January 20, 2011 (the “Decision”).

The “Adventist Entities”, consisting of CCH, interested party Shady Grove Adventist Hospital, and interested party Shady Grove Adventist Emergency Center at Germantown, appealed the Commission’s grant of a CON for HCH-G on three grounds; they did not allege that the CCH application should have been approved. By a February 21, 2012 Memorandum and Order (“Mem. Opinion”), W. Michel Pierson, Judge of the Circuit Court for Baltimore City, sustained the Commission on two<sup>1</sup> out of the three issues raised by the Adventist Entities, but remanded the matter to the Commission to give the Adventist Entities an opportunity “to comment on the information employed in the Decision” that was not contained in the record. (Mem. Opinion at 8).

On remand, the Adventist Entities had the opportunity to file comments specific to the use of “extra-record” data in the Decision. Specifically, at issue on remand, were “several sources of data that are the subject of [the Adventist Entities’] argument ... population data from Spatial Insights, Inc.; historical population data, current population estimates and projected population for 2014 prepared by Applied Geographic Solutions, Inc; and the ‘D.C. Discharge databases/Data Set.’” (Mem. Opinion at 2). The Adventist Entities have had access to the above-referenced data since January of 2011.

This remand is limited in scope to the use of specific data in the Decision. On May 4, 2012, the Adventist Entities filed comments on the data. On May 9, 2012, HCH-G filed a response to those comments.

### **Reviewer’s Recommendation**

I recommend that the Commission re-issue a Certificate of Need, approving the application, Docket No. 08-15-2286, of Holy Cross Hospital of Silver Spring to establish a new

---

<sup>1</sup> The Circuit Court found that the Commission had properly considered input from the Health Services Cost Review Commission, rejecting the Adventist Entities’ argument that statutory language requiring coordination with HSCRC “vest[s] HSCRC with veto power over the Commission decisions.” (Mem. Opinion at 8). The Court noted that the second issue raised by the Adventist Entities was an “illusory issue” because the Commission had not permitted the “shifting” of beds from Holy Cross Hospital in Silver Spring to the proposed new hospital and, thus, that the Commission had not violated the bed need standard in the Acute Care Chapter of the State Health Plan. (Mem. Opinion at 7).

93-bed general acute care hospital in Germantown, with the same standard conditions as in the 2011 Certificate of Need. Although the Adventist Entities have correctly pointed out calculation errors in the Commission's January 20, 2011 decision, Holy Cross Hospital-Germantown has satisfied all State Health Plan Standards and Certificate of Need review criteria and should be re-issued a Certificate of Need.

## II. REVIEW AND ANALYSIS OF ADVENTIST ENTITIES' COMMENTS

The Adventist Entities found errors in the projection of bed need in the Decision. The applicable State Health Plan standard, shown below, requires that a proposal to increase capacity of either MSGA beds or pediatric beds must be justified in one of four ways. The fourth approach outlined in (c)(iv) of the standard permits a service area analysis modeled on the jurisdictional bed need projection methodology. Analysis at the service area-level was used by the applicants in the review, was used in the Decision, and is used in this Recommended Supplement to the Decision.

### **10.24.10.04B(2) Identification of Bed Need and Addition of Beds**

*Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.*

- (a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.*
- (b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.*
- (c) Additional MSGA or pediatric beds may be developed or put into operation only if:
  - (i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or*
  - (ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter; or*
  - (iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or*
  - (iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.**

The Adventist Entities correctly pointed out two errors that occurred in the analysis of service area bed need in the Decision. The first was in the projected range of use rates of MSGA beds by the adult population aged 15 to 64 in the expected service area of HCH-G in the forecast

year of 2018. The range used for this rate, usually referenced as the “non-Medicare MSGA discharge rate” occurred because the wrong use rate for the base year of 2008 was inadvertently inserted in the bed demand forecast calculations. The overstated base year use rate affected the range of use rates employed in projecting demand in the target year, ten years after the base year.

The Decision used a range of projected 2018 use rates for the HCH-G expected service area, unadjusted, of 64.3 to 71.2 discharges per thousand population aged 15 to 64. The correct range of projected 2018 use rates for this age group in the HCH-G expected service area, which should have been used in the Decision, prior to any adjustment, was 46.6 to 52.3 discharges per thousand population.<sup>2</sup> Thus, for the entire adult population aged 15 and older, this translates into the Decision’s overstated use rate range for MSGA beds of 92.0 to 106.2 discharges per thousand; the correct range would be 77.4 to 90.5 discharges per thousand.

In their comments, the Adventist Entities calculated the (apparently unadjusted) range of projected 2018 use rates for the 15-64 age group to be 45.8 to 50.8. They use this range of 45.8 to 50.8 in their 2018 projection of bed demand for HCH-G’s expected service area. As noted in the table below, I have recalculated the range for this age group and find that the correct unadjusted 2018 range is 46.6 to 52.3; as one can see, this rate is relatively close to that calculated by the Adventist Entities. The differences are not large enough to be significant. I arrived at the unadjusted rate by trending the 2008 use rate to 2018 based on the average annual rate of change over the immediately preceding five-year period (2003-2008) and the immediately preceding ten-year period (1998-2008).

The Decision replicated the State Health Plan methodology, as much as possible, in developing the applicants’ service area forecasts “with the exception that Montgomery County experience serves as the basis for adjustment” rather than the state as a whole. Decision at 40. I followed this method because I conclude that it is the best method to use in a jurisdiction with multiple existing acute care general hospitals with overlapping service areas.

The following table summarizes the MSGA discharge rate for the 15-64 age group used in the 2011 decision and the corrected discharge rates, unadjusted, and the final corrected discharge rate range, adjusted for county-wide proportional change in discharges, which serves as the range used in the service area bed demand forecast.

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<sup>2</sup> The overall statewide MSGA discharge rate for the population aged 15-64 in 2008 (Maryland and DC hospital discharges only) was 70.8 discharges per thousand population. Montgomery County and subregions of the County, such as the HCH-G expected service area have a much lower use rate for this age group, which is probably why this error was not readily apparent.

**MSGA Discharge Rate Range  
Population Aged 15-64**

	<b>Minimum MSGA Discharge Rate</b>	<b>Maximum MSGA Discharge Rate</b>
<b>2011 Decision (adjusted)</b>	<b>64.3</b>	<b>71.2</b>
<b>Corrected Rates (unadjusted)</b>	<b>46.6</b>	<b>52.3</b>
<b>Corrected Rates (adjusted)</b>	<b>45.3</b>	<b>56.4</b>

The second error in the Decision involves the projection of the average length of stay (“ALOS”) used in MSGA bed need projection. The Decision’s missteps in adapting the SHP methodology to adjust ALOS resulted in an inappropriately high range of ALOS for both the Medicare and non-Medicare patient population. I find that the Decision should have used a 2018 projected range for the 65 and older population (the “Medicare” population) in HCH-G’s expected service of 3.99 to 4.15 days; for the 15 to 64 year old population, the projected 2018 range should have been 3.27 to 3.42 days. For the entire adult population, this equates to a 2018 range of 3.63 to 3.80 days (instead of the range of 4.60 to 4.74 days that was used in the Decision), as shown in the following table.

**MSGA Average Length of Stay Range  
All Adults**

	<b>Minimum</b>	<b>Maximum</b>
<b>2011 Decision (adjusted)</b>	<b>4.60</b>	<b>4.74</b>
<b>Corrected ALOS (adjusted)</b>	<b>3.63</b>	<b>3.80</b>

The Decision identified a projected 2018 range of MSGA average daily census (“ADC”) generated by the population of HCH-G’s expected service area (“ESA”) of 358 to 447 patients. When I alter the demand projection to reflect the correct discharge rate and ALOS values, the projected 2018 range for the expected service area’s MSGA ADC is 230 to 314 patients. This is a 2018 MSGA ADC projection for an expected service area (“ESA”) that is an “85% service area,” i.e., a geographic area expected to generate 85% of the demand for MSGA patient days at the proposed Germantown hospital. Thus, in order to project the full level of MSGA bed demand in 2018 available to the prospective hospital, the projected ADC is adjusted accordingly. I note that HCH-G and CCH each used an 85% service area in their analyses of their projected ESA in their respective applications. (Decision at 38).

The following table compares the correct projected MSGA ADC for HCH-G’s expected service area with the projection used in the Decision, as outlined above. The table also makes the same comparison for HCH-G’s MSGA ADC at two levels of market capture (or market share), ten percent and fifteen percent.

**Projected 2018 MSGA Average Daily Census Generated from HCH-G Expected Service Area Population and**

**Projected 2018 MSGA Average Daily Census at HCH-G at Two Levels of Market Capture**

	Projected MSGA ADC HCH-G Expected Service Area		Projected ADC Adjusted for "85%" Service Area		Projected HCH-G ADC at 10% Market Share Capture		Projected HCH-G ADC at 15% Market Share Capture	
	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum	Minimum	Maximum
2011 Decision	358	447	421	526	42	53	63	79
Corrected Projection	230	314	271	370	27	37	41	56

The following table identifies the projected MSGA bed need at HCH-G, both in the Decision and as corrected, for the same range of market capture, utilizing the target average annual occupancy rates of the State Health Plan, which are scaled to average daily census. Two target occupancy rates come into play here. For an MSGA ADC of 1-49 patients, the State Health Plan target occupancy rate is 70 percent. (COMAR 10.24.10.05(d)(4)). For MSGA ADC of 50 to 99 patients, the State Health Plan target occupancy rate is 75 percent. (*Id.*). The numbers shown for the 10% market share capture in the Decision are different from those shown in Table 31 of the Decision (a minimum of 53 and a maximum of 66) because, for all the bed need values shown in that table, a conservative target occupancy rate of 80% was used<sup>3</sup> rather than the 70 to 75% targets actually applicable to the projected ADC.

**Projected Bed Need at HCH-G at Two Levels of Market Capture and the State Health Plan Target Occupancy Rate**

	Projected HCHG Bed Need at 10% Market Share Capture and SHP Target Occupancy Rate		Projected HCHG Bed Need at 15% Market Share Capture and SHP Target Occupancy Rate	
	Minimum	Maximum	Minimum	Maximum
2011 Decision	60	71	84	105
Corrected Projection	39	53	59	75

It will be noted that, when a market capture share assumption of fifteen percent is applied to HCH-G's expected service area, the range of corrected bed need projected for HCH-G, 59 to 75 beds, is almost identical to the overstated bed need projection in the Decision at the ten percent market capture rate for this 75-MSGA bed hospital (60-71).

It is true that my Recommended Decision and the Decision identified utilization projections at the proposed hospital level at a market share rate of ten percent in comparing the two hospitals' applications. A market share capture assumption of ten percent is a very conservative benchmark. This is illustrated by the fact that nearly seven percent of MSGA patients in HCH-G's ESA traveled to Holy Cross Hospital in Silver Spring for their hospital care in 2008. (See Appendix 2). Statewide, the 47 general acute care hospitals in Maryland operating in 2008, on average, had a market share of 28.8% in their "85%" service areas. Because the hospitals that are the only hospitals in their jurisdictions tend to have the largest market shares in their service areas, I examined the 32 hospitals that operated in multi-hospital jurisdictions in

<sup>3</sup> The State Health Plan uses an 80% target occupancy rate for hospitals with an ADC greater than 100 patients.

2008, to get a better sense of what a reasonable benchmark would be for HCH-G. Excluding the extreme outlier of James Lawrence Kernan Hospital in Baltimore City (this specialty rehabilitation hospital had a market share of only 0.2% in its 85% service area in 2008 and only 11 acute care beds), the remaining 31 general hospitals in multi-hospital markets had an average market share of 17.8% in their 85% service areas in 2008. Maryland's two academic medical centers and other large hospitals with tertiary services, such as cardiac surgery, tend to have large and diffuse service areas in which they command the lowest levels of market share. I note that, after eliminating these hospitals from consideration to get a better "peer group" for HCH-G, the remaining 23 community hospitals in Maryland without cardiac surgery services that are located in multi-hospital jurisdictions, commanded an average 21.1% market share in their 85% service areas in 2008.

Additionally, as noted in the Decision, of the women who participate in the Montgomery County Maternity Partnership at Holy Cross Hospital in Silver Spring, 75% come from HCH-G's ESA.<sup>4</sup> (Decision at 46, 101, 170). Because many of these women depend on public transportation to travel past closer available hospitals to go to Holy Cross Hospital's Silver Spring campus, it is reasonable to assume that more Maternity Partnership patients in HCH-G's ESA may access Holy Cross services if such services are more convenient.

The Adventist Entities conduct their analysis using only a ten percent market share for HCH-G. This assumption serves as the constant in their analyses, and forms the basis for their belief that "the CON Decision's 2018 MSGA bed need projections do not support a finding of need for the 75 MSGA and ICU beds proposed for the Holy Cross Germantown project." (Comments at 12).

Despite the miscalculations in the Decision's MSGA bed need projection that were noted by the Adventist Entities, the corrected bed need projection still supports a finding of need for the complement of 75 MSGA beds proposed for the HCH-G project. The Adventist Entities' conclusion solely focuses on the bed demand that HCH-G would be projected to achieve in 2018 if it captured only ten percent of the projected demand for MSGA beds in its expected service in that year. This focus has been selected because of the following findings and conclusions made in the Decision (at 42):

With respect to the new hospitals' proposed ESAs, this analysis reflects the much larger service area population expected for the HCH-G project when compared with the CCH ESA and the ability of the proposed 75 MSGA beds at HCH-G to be highly occupied with a market penetration of MSGA patients originating in the service area of 10% while the CCH project would need to achieve market penetration in excess of 20% in its expected service area to fill its proposed 70 beds at similar levels. ... [M]arket share observed to be achieved by Montgomery County hospitals in "90%" service areas ranged from 7 to 21

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<sup>4</sup> This information played an important part in the Commission's finding that that "HCH-G has a greater potential for positive impact on 'demographic access to services' because of the substantial number of residents from the HCH-G ESA that currently travel to [Silver Spring] for services, especially the participants in the Montgomery County Maternity Partnership, and the more diverse population of the unique zip code areas of the HCH-Germantown ESA...." (Decision at 180-181).

percent, but only one of the five, SGAH, achieved a market share above 10% in a service area representing this level of importance for a hospital. This strongly suggests that the proposed HCH-G project would be likely to achieve efficient utilization of its proposed MSGA beds by penetrating its expected service area at a level that existing hospital experience indicates is realistic.

The Commission further concludes that, considering MSGA bed need at the hospital service area and new hospital expected service area level, and incorporating the State Health Plan bed need forecasting methodology steps and Montgomery County trends in MSGA bed use, rather than the overall State experience, as a basis for establishing target discharge rate and ALOS values: (1) a redistribution of MSGA bed capacity from the southeastern area of the County, dominated by HCH-SS and Washington Adventist Hospital to the north and central regions of the County, dominated by Shady Grove Adventist Hospital and Suburban Hospital, is consistent with service area patterns and trends; (2) the HCH-G project has a service area that makes it possible and very likely, given the experience of most hospitals, to achieve market penetration that can fully support the MSGA beds proposed over the coming decade; and (3) the service area of the CCH project is such that it is possible but not likely, given the experience of most hospitals, to achieve market penetration that can fully support the MSGA beds proposed for its project over the coming decade.

I believe that, as noted at the end of the first paragraph of the preceding excerpt, the key conclusion regarding market capture in the Decision was “that the proposed HCH-G project would be likely to achieve efficient utilization of its proposed MSGA beds by penetrating its expected service area at a level that existing hospital experience indicates is realistic.” This is still true. I note that the Decision found that the 75 MSGA beds at HCH-G would be “highly occupied” with a market penetration level of ten percent, in contrast to the market penetration needed by CCH. I explicitly find that, as indicated in the first sentence of the excerpt, 10 to 20 percent constitutes a critical range of market share for consideration in an analysis of expected service area demand levels of this type and their relevance to proposed bed capacity.

The Decision did not conclude that either CCH or HCH-G would have to achieve a high level of bed occupancy in 2018 at a ten percent level of market share in order for a proposed hospital to be found to be needed. Rather, the Commission found that HCH-G would experience a level of demand in its expected service area that would warrant the availability of 53 to 66 MSGA beds operating at an annual average occupancy rate of 80% if it were successful in capturing 10 percent of the demand for MSGA beds in its expected service area; this is equivalent to 59 to 75 beds at the more appropriate 70% to 75% occupancy rate target identified in the State Health Plan, as shown in the preceding table. The Decision also found that the proposed Clarksburg Community Hospital project would only need 23 to 28 beds operating at an annual average occupancy rate of 80% (26 to 32 beds at the more appropriate 70% occupancy rate target) if it were successful in achieving the same level of market share in its expected service area. Thus, an important conclusion from the Decision with respect to HCH-G was simply that the proposed hospital would have “a service area that makes it possible and very likely, given the experience of most hospitals, to achieve market penetration that can fully

support the MSGA beds proposed over the coming decade.” (Decision at 42). This conclusion remains true for HCH-G.

I want to point out that the Decision’s overstatement of the 2018 demand for MSGA beds applied not only to the HCH-G expected service area, but to all of the other hospital service areas examined, including the proposed Clarksburg Community Hospital. However, as shown in the preceding tables, correcting for this overstatement indicates that HCH-G would still achieve approximately the same level of bed use in 2018 by capturing a 15 percent share of the MSGA demand in its expected service area, i.e., a level of market share that is approximately eight percentage points higher than its parent hospital, located in Silver Spring, has already achieved in the Germantown market. (See Appendix 2). And, as previously noted, the 23 non-cardiac surgery hospitals operating in multi-hospital jurisdictions in 2008 achieved an average MSGA market share of 21.1 percent in their 85% MSGA service areas.

As previously noted, the State Health Plan permits a determination of bed need to be made at the service area level, and requires that such an analysis hew to the approach outlined in the Plan’s methodology for forecasting bed need at the jurisdictional level. The consideration of market share implications for filling proposed hospital beds at given levels of forecasted demand in a service area is an obvious and conventional analytic approach. The Decision’s use of a 10 to 20 percent market share as the critical range emerged from the context of the following information on MSGA market share levels achieved by existing hospitals in Montgomery County, as shown in Table 25 of the Decision. (Decision at 38).

**2008 MSGA Market Share of Discharges – “90% MSGA Service Areas”  
Montgomery County Hospitals**

Hospital	Number of Zip Code Areas in the Service Area	Market Share of MSGA Discharges* Originating in the Service Area
Washington Adventist	89	6.2%
HCH-SS	68	8.7%
Suburban	67	9.5%
Montgomery General	48	10.2%
Shady Grove Adventist	37	20.7%
<b>Average</b>	<b>62</b>	<b>11.1%</b>

The Commission noted that the “90%” service areas used in the Decision were not directly comparable to the “85%” expected service areas used by CCH and HCH-G in their applications. (Decision at 38). For a more directly comparable perspective, the following table shows the 85% service areas and market share for existing Montgomery County hospitals.

**2008 MSGA Market Share of Discharges – “85% MSGA Service Areas”  
Montgomery County Hospitals<sup>5</sup>**

Hospital	Number of Zip Code Areas in the Service Area	Market Share of MSGA Discharges* Originating in the Service Area
Washington Adventist	62	7.5%
HCH-SS	51	10.3%
Suburban	37	15.3%
Montgomery General	25	15.9%
Shady Grove Adventist	22	28.5%
<b>Average</b>	39	15.5%

For the five Montgomery County hospitals in 2008, MSGA market share in each hospital’s 85% service area ranged from 7.5% to 28.5%, with an average of 15.5% and a median of 15.3%. The Montgomery County hospital that is closest in size and range of services to HCH-G is Montgomery General Hospital (“MGH”; now known as MedStar Montgomery Medical Center). MGH currently has 120 licensed MSGA beds; the number of licensed MSGA beds for the other Montgomery County hospitals currently ranges from 203 (Suburban Hospital) to 295 (HCH-SS).

The range of market shares reflects the nature of the individual hospitals and the level of competition in their service areas. As shown in the above table, MGH’s market share in 2008 in its 85% service area was 15.9%. Washington Adventist Hospital (“WAH”) and HCH-SS have large, diffuse service areas (as illustrated by the larger number of zip code areas in their 85% service areas) and lower average overall market shares in these service areas because they compete against each other as well as Prince George’s County and District of Columbia hospitals. Specialized service offerings, such as cardiac surgery at WAH and special relationships, such as the relationship between HCH-SS and Kaiser Permanente also contribute to larger and less concentrated service areas with lower overall market share. SGAH has limited competition; and, therefore, its 85% service area has the smallest number of zip code areas and the highest level of MSGA market share. The limited competition in the area as well as HCH-G’s relationship with HCH-SS should make it easier for HCH-G to achieve the volume needed to support its proposed 75 MSGA beds.

The Adventist Entities incorrectly elevated the Decision’s finding with respect to the level of use that HCH-G could achieve at a quite conservative market share level of 10 percent to the status of a threshold standard for approval.<sup>6</sup> The Decision does not support their position. I have used a corrected bed need projection and a reasonable market share in considering the

<sup>5</sup>Holy Cross Hospital of Silver Spring, in its response to the Adventist Entities comments, also includes an examination of MSGA market share for Montgomery County hospitals at the “85% service area level”. However, that examination started with a definition of the 85% service area based on all acute care discharges, with the exception of neonates. My examination in this footnoted table defines the 85% service area as the zip code areas from which 85% of MSGA discharges alone are derived.

<sup>6</sup>Interestingly, in the Montgomery County new hospital review, the bed demand projections of Clarksburg Community Hospital implied an ability for that hospital to achieve much higher levels of MSGA market share in its expected service area. (Decision at 34).

comments filed by the Adventist Entities and the record in this review. I find that HCH-G's 75 MSGA beds are likely to be well-utilized within a few years after the completion of the project.

**(13) Financial Feasibility**

*A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.*

*(a) Financial projections filed as part of a hospital Certificate of Need application must be accompanied by a statement containing each assumption used to develop the projections.*

*(b) Each applicant must document that:*

*(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;*

*(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;*

*(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or, if a new hospital, the recent experience of other similar hospitals; and*

*(iv) The hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital may receive a Certificate of Need for a project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project when the hospital can demonstrate that overall hospital financial performance will be positive and that the services will benefit the hospital's primary service area population.*

The Adventist Entities "piggy-back" on their analysis of bed need, exclusively focusing on the bed need for HCH-G at the ten percent market share level, to develop a totally derivative analysis of financial performance for HCH-G. The Adventist Entities' analysis concludes, not unexpectedly, that, at lower projected utilization levels, HCH-G will generate less revenue and that bottom-line performance cannot be maintained because hospitals cannot reduce their variable expenses on a dollar for dollar basis when revenue targets are not met. They do not undertake any analysis of the financial feasibility of the HCH-G project that is based on HCH-G capturing more than ten percent of the total MSGA demand in its expected service area.

As previously noted in this Recommended Supplemental Decision, the incorrect bed need calculation used in the Decision does not change the Commission's findings and conclusions with respect to the need for the HCH-G project. There is sufficient bed need in HCH-G's expected service area for this new hospital to support a revenue base that will result in the profitable operation of the hospital. I find that, using the corrected bed need, the proposed HCH-G hospital is financially feasible.

## **B. Need**

### ***COMAR 10.24.01.08G(3)(b) Need.***

***The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.***

The only need issue addressed by the Adventist Entities in their comments is the MSGA bed need projection. As discussed above, the MSGA bed need standard of COMAR 10.24.10, is satisfied by the HCH-G project. In considering this review criterion, the Commission found that HCH-G also demonstrated a need for the obstetric and acute psychiatric bed capacity proposed for the new hospital and the surgical facilities proposed. That has not changed. I find that need for the new hospital in Germantown has been established.

## **D. Viability of the Proposal**

### ***COMAR 10.24.01.08G(3)(d) Viability of the Proposal.***

***The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.***

In considering this review criterion, the Commission found that both the HCH-G project and the Clarksburg Community Hospital project would be well accepted by the medical community and general population in their respective service areas. (Decision at 149-165). The Commission found that the sponsor of the HCH-G project had adequately demonstrated, with a high degree of certainty, that resources are available for its project planning and for the execution of its plans, which included both HCH-G and the expansion and renovation of the existing Holy Cross Hospital in Silver Spring. The plans of Holy Cross Hospital of Silver Spring and its parent, Trinity Health, were found to have substantially lower risk than those of the Adventist Entities based on the former organizations' superior creditworthiness, liquidity, capital structure, and profitability. Nothing in the comments of the Adventist Entities addresses or alters these findings.

The Commission also found in its Decision that, from the perspective of market feasibility, HCH-G had demonstrated that it can achieve utilization levels consistent with its projections. Cognizant that no forecast can be established with perfect confidence, the Decision also found that the HCH-G project "is backed by resources, in the form of Holy Cross Hospital of Silver Spring and Trinity Health, that can weather difficulties." (Decision at 163). The Adventist Entities have argued in their comments that the HCH-G project is not viable because it cannot demonstrate that it can achieve its projected use levels, which are consistent with a viable level of financial performance. As previously noted, the sole focus of the Adventist Entities is on projected service area demand at the lowest level of market share considered in the Decision. I find that HCH-G continues to be a viable project.

### III. SUMMARY

In January, 2011, the Commission issued a Certificate of Need authorizing Holy Cross Hospital of Silver Spring to establish a 93-bed acute care general hospital in Germantown. Appendix 3 summarizes the basis for the Commission's decision, detailing its review of the applicable State Health Plan standards and Certificate of Need general review criteria.

I have fully considered the comments provided by the Adventist Entities based on their review of the extra-record data that was in the Decision. The Adventist Entities have correctly identified two errors that occurred in the Decision's analysis of bed need, at the proposed hospital expected service area level. They assert that the Commission would not have granted a CON for HCH-G if the errors in the analysis of service area bed need had not occurred, positing that the Commission would have found that the project was not needed and not financially feasible.

I have considered the Decision's miscalculation of the bed need projection for the expected service area of the Germantown hospital, and applied a reasonable and achievable market share for the hospital. I conclude, as I did in my 2010 Recommended Decision, that the hospital is needed and is financially feasible. The market share that the Germantown hospital would need to achieve in its expected service area by 2018, the target year used in the bed need analysis, to attain the same levels of bed occupancy found in the Decision, while five percentage points higher than the level used in the Decision, is within the range of market penetration that can be attained by this new hospital, as demonstrated by Maryland general acute care hospital experience. It is important to note that, in 2008, Holy Cross Hospital of Silver Spring, the sponsor of the Germantown hospital project, captured 6.7% of the MSGA market share generated in the expected service area of the Germantown hospital. The Decision found that the project would need to capture only ten percent of the projected range of MSGA market demand in 2018 to occupy its proposed MSGA bed capacity of 75 beds at a level that would comply with the State Health Plan's bed need standard. Based on my review of the corrected bed need projection, this same level of bed use will be attained in 2018 if the new hospital captures 15 percent of the range of projected MSGA market demand. In 2008, three of the five existing Montgomery County hospitals captured 15 percent or more of the MSGA market in their respective "85% MSGA service areas," directly comparable, in terms of accounting for MSGA discharges, to the expected service area of HCH-G. I note that the 23 Maryland hospitals most comparable to HCH-G (non-cardiac surgery community hospitals operating in multi-hospital jurisdictions) achieved an average MSGA market share of 21.1 percent in their 85% MSGA service areas in 2008.

Because the Adventist Entities' assessment of financial feasibility is based upon an unrealistic assumption that a ten percent market share is the highest level of market penetration that HCH-G can achieve and that this represents a static condition, their conclusions with respect to financial feasibility lack a firm foundation. The Holy Cross Hospital in Germantown has demonstrated financial feasibility.

I conclude that the proposed new hospital in Germantown is needed. I believe that residents of upper Montgomery County, including patients who currently travel to Holy Cross

Hospital in Silver Spring for their medical care, will benefit from having this new hospital in Germantown. As I noted in 2011, Holy Cross Hospital is well-positioned, financially, to build the Germantown hospital; the Germantown hospital is well-positioned, geographically and demographically, to make the hospital succeed

For these reasons, I recommend that the Commission approve the Certificate of Need application, Docket No. 08-15-2286, of Holy Cross Hospital of Silver Spring to establish a new 93-bed general acute care hospital in Germantown, with the standard conditions for a project that contains shell space.

IN THE MATTER OF	*	BEFORE THE
	*	
PROPOSED NEW HOSPITALS	*	MARYLAND HEALTH
	*	
IN MONTGOMERY COUNTY	*	CARE COMMISSION
	*	
Holy Cross Hospital of Silver Spring	*	
Docket No. 08-15-2286	*	
	*	

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**FINAL ORDER**

Based on the analysis and findings in the Commission's Final Decision, it is this 31<sup>st</sup> day of May, 2012,

**ORDERED**, by a majority of the Maryland Health Care Commission, that the application of Holy Cross Hospital of Silver Spring for a Certificate of Need to establish a 93-bed acute care general hospital at Observation Drive and Middlebrook Road, on the Germantown campus of Montgomery College, in Montgomery County, containing 75 MSGA beds, 12 obstetric beds, 6 acute psychiatric beds, five operating rooms, and 14 emergency department treatment bays,<sup>1</sup> at a total project cost of \$201,983,857, consisting of a total current capital cost of \$169,191,969, including capitalized interest, an inflation allowance of \$1,409,242, financing and other cash requirements of \$6,382,646, and working capital of \$25,000,000, is **APPROVED** subject to the following conditions:

1. Holy Cross Hospital-Germantown will not finish the shell space without giving notice to the Commission and obtaining all required Commission approvals.
2. Holy Cross Hospital-Germantown will not obtain or request an adjustment in rates by the Health Services Cost Review Commission ("HSCRC") that includes depreciation or interest costs associated with construction of the proposed shell space until and unless Holy Cross Hospital of Germantown has filed a CON application involving the finishing of the shell space, has obtained CON approval for finishing the shell space, or has obtained a determination of coverage from the Maryland Health Care Commission that CON approval for finishing the shell space is not required.
3. The HSCRC, in calculating an initial rate or any future rates for Holy Cross Hospital of Germantown and its peer group, shall exclude the capital costs

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<sup>1</sup> Holy Cross Hospital has notified the Commission that further refinement of its physical plant design has resulted in an Emergency Department with 14 (rather than 12) treatment spaces, but with no additional square footage. This is not a significant change in physical plant design that requires Commission approval.

associated with the shell space until such time as the space is finished and put to use in a rate-regulated activity. In calculating any rate that includes an accounting for capital costs associated with the shell space, HSCRC shall exclude any depreciation of the shell space that has occurred between the construction of the shell space and the time of the rate calculation (i.e., the rate should only account for depreciation going forward through the remaining useful life of the space). Allowable interest expense shall also be based on the interest expenses going forward through the remaining useful life of the space.

**MARYLAND HEALTH CARE COMMISSION**

## Appendix 1

## **Record of the Review on Remand**

On February 21, 2012, W. Michel Pierson, Judge of the Circuit Court for Baltimore City, sustained the Commission on two of three issues raised by petitioners Clarksburg Community Hospital, Inc. and Adventist Healthcare, Inc., d/b/a Shady Grove Adventist Hospital (collectively, the “Adventist Entities”) and remanded the matter to the Commission to give the Adventist Entities an opportunity “to comment on the information employed in the Decision.” (R-1)

On March 2, 2012, Marilyn Moon, Ph.D., the reviewer in this matter, notified counsel of record Diane Festino Schmitt and Jack Tranter that the project was remanded back to MHCC and requested that Adventist file comments regarding the use of “extra-record” data in the Decision. (R-2)

On behalf of the Adventist Entities, Diane Festino Schmitt, by letter to Dr. Moon on March 7, 2012, requested that she withhold issuing a schedule/process for the remand until after the appeal period passed and formally make all extra-record data a part of the administrative record in this matter (R-3)

On March 9, 2012, Jack Tranter, counsel to Holy Cross Hospital—Germantown (“Holy Cross”) notified Dr. Moon that it did not object to the Commission providing to the Adventist Entities the three data bases in question in this matter; and argued that the Adventist Entities have no standing to appeal this matter. (R-4)

On March 27, 2012, Diane Festino Schmitt notified Suellen Wideman, AAG, counsel for MHCC in this matter, that the Adventist Entities would not pursue an appeal to the Court of Special Appeals at that time and requested the extra-record data in the format in which the Reviewer reviewed it. (R-5)

On March 28, 2012, Ms. Wideman notified the parties by email correspondence that the Adventist Entities had all of the extra-record data since January of 2011 and that Dr. Moon would respond to the parties’ requests by letter. (R-6)

On behalf of Holy Cross, Mr. Tranter replied to the Adventist Entities’ request for additional time to file comments by letter to Dr. Moon on March 28, 2012. (R-7)

On March 29, 2012, Ms. Wideman requested that counsel for the parties consider and discuss the date for filing comments on the extra-record data. (R-8)

On March 29, 2012, Ms. Wideman re-sent to the Adventist Entities thirteen original emails and attached data provided by Paul Parker, the Commission’s Director of Hospital Services, in January of 2011 (R-9) and provided a copy of the correspondence and data originally

sent to the Adventist Entities on January 28, 2011 and January 31, 2011 to Ms. Schmitt on March 30, 2012. (R-10)

Holy Cross agreed to an extension of time for filing comments, with conditions, on March 30, 2012. (R-11)

Ms. Wideman wrote to counsel for the parties on April 3, 2012, providing a list of the zip code areas comprising the defined MSGA service areas in this matter. (R-12)

The Adventist Entities requested clarification of zip code area data by email correspondence on April 5, 2012. (R-13) Also on April 5, 2012, Holy Cross requested that this matter be considered by the Commission on April 19, 2012 as the Adventist Entities did not file comments by the deadline of April 2, 2012. (R-14) Ms. Wideman provided additional clarification of the zip code data to the parties herein on April 5, 2012. (R-15)

On April 11, 2012, the Adventist Entities argued against the Holy Cross request for the MHCC to consider this matter on April 19, 2012 and proposed that the Adventist Entities file its comments by May 7, 2012. (R-16)

Ms. Wideman proposed revised filing deadlines for comments and the Recommended Supplement to the Decision in this matter on April 16, 2012 (R-17) in response to Holy Cross' letter of that same date setting forth the unnecessary cost estimates for every month of delay to completion of site work at its location. (R-18) The Adventist Entities agreed to work with Holy Cross to establish the filing dates for comments and responses on April 18, 2012 (R-19)

Holy Cross filed a Motion Seeking Issuance of an Interlocutory Non-Final Determination Authorizing Holy Cross Hospital to Continue Construction of a New Hospital In Germantown on April 18, 2012. (R-20)

Ms. Wideman provided preliminary notice to counsel for the parties on April 20, 2012 via email correspondence regarding the possibility of scheduling a hearing in this matter during the last week of April. (R-21) Ms. Wideman requested additional clarification of the Adventist Entities schedule for filing comments and responses on April 24, 2012. (R-22)

On April 24, 2012, the Adventist Entities filed its Opposition to HCH's Motion Seeking Issuance of an Interlocutory Non-Final Determination. (R-23) On that same date, the Commission's Vice-Chair, provided notice to the parties that he would chair a hearing on April 25, 2012, giving each party ten minutes to present oral argument on the Motion Seeking Issuance of an Interlocutory Non-Final Determination Authorizing Holy Cross Hospital to Continue Construction of a New Hospital in Germantown filed by Holy Cross on April 18, 2012. (R-24)

On April 25, 2012, the Commission received documentation that Judge W. Michel Pierson denied the Motion to Revise Judgment (Pleading No. 22), along with the opposition, on April 16, 2012. (R-25)

The transcript of the motions hearing held on April 25, 2012 In the Matter of Proposed New Hospitals in Montgomery County, Holy Cross Hospital Silver Spring, Docket No. 08-15-2289; Clarksburg Community Hospital, Docket Number 09-15-2294 was received by the Commission on May 3, 2012. (R-26)

On May 4, 2012, the Adventist Entities filed Adventist's Comments on Additional Evidence Entered Into The Record. (R-27) and on May 7, 2012, the Adventist Entities filed original signature pages for Richard J. Coughlan and David S. Cohen's Affidavits A and B to its Comments. (R-28)

On May 10, 2012, Holy Cross filed its Response to Comments Filed By the Adventist Entities. (R-29)

On May 11, 2012, Dr.Moon notified the parties via email letter dated April 11, 2012 that she did not desire additional filings, evidence, or oral argument in this matter, that she expected to issue a Recommended Supplemental Decision on or about May 16, 2012; a party taking exceptions would have seven days to file them with the Commission and a party filing responses to exceptions would have five dates to file its reponse; and that oral argument on the exceptions will be heard on May 31, 2012. (R-30) On May 14, 2012, another email was sent to the parties from Dr.Moon revising the date of document R-30 to May 11, 2012. (R-31)

## Appendix 2

**2008 MSGA MARKET SHARE DISCHARGES to  
Germantown Expected Service Area (ESA) Zip Codes**

ESA Zip Codes	2008 MSGA MARKET SHARE						TOTAL	Total Discharges MD & DC Hospitals
	FREDERICK	HOLY CROSS	MGH	SGAH	SUBURBAN	WAH		
20837	3.7%	2.3%	2.5%	59.7%	9.3%	2.8%	80.28%	355
20838	22.2%	0.0%	0.0%	50.0%	11.1%	0.0%	83.33%	18
20839	0.0%	0.0%	0.0%	55.2%	6.9%	17.2%	79.31%	29
20841	2.3%	6.0%	1.0%	60.3%	9.1%	3.1%	81.82%	385
20842	24.6%	1.5%	0.7%	50.7%	5.2%	6.0%	88.81%	134
20850	0.3%	4.8%	3.0%	55.4%	18.9%	3.0%	85.48%	2858
20851	0.3%	14.2%	5.1%	32.4%	30.0%	4.2%	86.18%	731
20853	0.1%	17.8%	31.2%	16.3%	14.2%	3.7%	83.33%	2021
20855	0.4%	4.7%	16.8%	46.5%	10.6%	2.7%	81.73%	810
20871	8.0%	7.1%	5.6%	51.3%	7.8%	3.2%	82.97%	411
20872	9.1%	2.9%	21.4%	38.1%	4.7%	3.5%	79.61%	770
20874	0.5%	5.4%	3.1%	63.4%	9.1%	3.4%	84.97%	2628
20876	0.7%	6.2%	3.9%	61.1%	8.8%	4.3%	84.88%	1005
20877	0.3%	5.5%	3.7%	63.6%	11.3%	2.8%	87.31%	2198
20878	0.4%	4.1%	1.8%	58.2%	12.6%	3.4%	80.43%	2586
20879	0.3%	6.1%	8.2%	56.6%	12.0%	1.9%	85.18%	1255
20882	1.1%	4.0%	31.7%	36.5%	6.6%	2.9%	82.65%	732
20886	0.3%	7.8%	6.1%	58.4%	9.6%	3.1%	85.35%	1597
<b>Total for Above</b>								
<b>Zip Codes</b>	234	1385	1772	10661	2536	664	17252	20523
<b>Percent of Total</b>	1.1%	6.7%	8.6%	51.9%	12.4%	3.2%	84.1%	

Source: HSCRC (Maryland) Hospital and DC Hospital Discharge Data Bases, CY 2008

## Appendix 3

## Summary of Analysis and Findings – 2011 Commission Decision

Evaluation Criteria	Page	Clarksburg Community Hospital	Holy Cross Hospital - Germantown
<b>I. THE STATE HEALTH PLAN COMAR 10.24.01.08G(3)(a)</b>			
<b>State Health Plan: Acute Care Hospital Services-General Standards COMAR 10.24.10.04A-</b>			
(1) Information Regarding Changes	15	Meets Standard	Meets Standard
(2) Charity Care Policy	17	Meets Standard	Meets Standard
(3) Quality of Care	21	Meets Standard	Meets Standard
<b>Project Review Standards</b>			
(1) Geographic Accessibility	26	Meets Standard	Meets Standard
(2) Identification of Bed Need and Addition of Beds	35	Does Not Meet Standard	Meets Standard
(3) Minimum Average Daily Census for Establishment of a Pediatric Unit	43	Not Applicable	Not Applicable
(4) Adverse Impact	43	Not Applicable	Not Applicable
(5) Cost-Effectiveness	50	Does Not Meet Standard	Meets Standard
(6) Burden of Proof Regarding Need	52	Does Not Meet Standard	Meets Standard
(7) Construction Cost of Hospital Space	58	Meets Standard	Meets Standard
(8) Construction Cost of Non-Hospital Space	63	Not Applicable	Not Applicable
(9) Inpatient Nursing Unit Space	64	Meets Standard	Meets Standard
(10) Rate Reduction Agreement	64	Not Applicable	Not Applicable
(11) Efficiency	66	Does Not Meet Standard	Meets Standard
(12) Patient Safety	67	Meets Standard	Meets Standard
(13) Financial Feasibility	73	Does Not Meet Standard	Meets Standard
(14) Emergency Department Treatment Capacity and Space	80	Meets Standard	Meets Standard
(15) Emergency Department Expansion	83	Not Applicable	Not Applicable
(16) Shell Space	84	Not Applicable	Meets Standard
<b>State Health Plan: Acute Hospital Inpatient Obstetric Services-Review Standards COMAR 10.24.12.04</b>			
(1) Need	95	Meets Standard	Meets Standard
(2) The Maryland Perinatal System Standards	97	Meets Standard	Meets Standard

Evaluation Criteria	Page	Clarksburg Community Hospital	Holy Cross Hospital - Germantown
(3) Charity Care Policy	99	Meets Standard	Meets Standard
(4) Medicaid Access	101	Meets Standard	Meets Standard
(5) Staffing	103	Meets Standard	Meets Standard
(6) Physical Plant Design and New Technology	104	Meets Standard	Meets Standard
(7) Nursery	105	Meets Standard	Meets Standard
(8) Community Benefit Plan	108	Does Not Meet Standard	Meets Standard
(9) Source of Patients	109	Meets Standard	Meets Standard
(10) Non-Metropolitan Jurisdictions	109	Not Applicable	Not Applicable
(11) Designated Bed Capacity	109	Not Applicable	Not Applicable
(12) Minimum Volume	111	Meets Standard	Meets Standard
(13) Impact on the Health Care System	112	Meets Standard	Meets Standard
(14) Financial Feasibility	112	See COMAR 10.24.10 and Viability Review Criterion	See COMAR 10.24.10 and Viability Review Criterion
(15) Outreach Program	113	Meets Standard	Meets Standard
<b>State Health Plan: Overview, Psychiatric Services, and EMS-Standards for Psychiatric Services COMAR 10.24.07 Availability</b>			
(AP1a) Bed Need	113		See COMAR 10.24.01.08G
(AP1b) Delicensing Requirements	114		Not Applicable
(AP1c) State Hospital Conversion Bed Need	114		Not Applicable
(AP1d) Preference	114		Not Applicable
(AP2a) Procedures for Psychiatric Emergency Inpatient Treatment	114		Meets Standard
(AP2b) Emergency Facilities	115		Meets Standard
(AP2c) Emergency Holding Beds	115		Meets Standard
(AP3a) Array of Services	115		Meets Standard
(AP3b) Required Services for Child & Adolescent Psychiatric Services	116		Not Applicable
(AP3c) Psychiatric Consultation Services	116		Meets Standard
(AP4a) Separate CONs for Each Age Group	116		Meets Standard
(AP4b) Physical Separation and Distinct Programs for Each Age Group	116		Meets Standard

Evaluation Criteria	Page	Clarksburg Community Hospital	Holy Cross Hospital - Germantown
<b>Accessibility</b>			
(AP5) Required Services	116		Meets Standard
(AP6) Quality Assurances	117		Meets Standard
(AP7) Denial of Admission Based on Legal Status	117		Meets Standard
(AP8) Uncompensated Care	117		Meets Standard
(AP9) Admission of Acute Child Psychiatric Patients to General Pediatric Beds	118		Not Applicable
<b>Accessibility-Variant LHPA Standard Cost</b>			
(AP10) Occupancy	118		Not Applicable
(AP11) Age-Adjusted Average Total Cost	118		Not Applicable
<b>Quality</b>			
(AP12a) Clinical Supervision	119		Meets Standard
(AP12b) Staffing	119		Meets Standard
(AP12c) Staffing of Child and/or Adolescent Acute Psychiatric Units	119		Not Applicable
<b>Continuity</b>			
(AP13) Discharge Planning and Referrals	119		Meets Standard
<b>Acceptability</b>			
(AP14) Letters of Acknowledgement	120		Meets Standard
<b>II. COMAR 10.24.01.08G(3)(b) NEED</b>	124, 130	CCH has not adequately justified need for MSGA beds and ED treatment capacity. Its case for OB bed capacity is weaker than that of HCH-G. CCH has adequately justified need for surgical facilities.	HCH-G has adequately justified need for MSGA, OB, and acute psychiatric beds, surgical facilities, and ED treatment space.
<b>III. COMAR 10.24.01.08G(3)(c) AVAILABILITY OF MORE COST EFFECTIVE ALTERNATIVES</b>	146	CCH has not made the case that it is a more cost effective alternative to expanding Shady Grove Adventist Hospital or to establishing HCH-G.	HCH-G will be more cost effective than CCH at meeting the needs for additional beds in its upcounty extended service area; HCH-G will provide improved accessibility in terms of travel time for more residents than the Clarksburg location; when considering resources in the County as a whole, HCH-G is the most cost-effective alternative.

Evaluation Criteria	Page	Clarksburg Community Hospital	Holy Cross Hospital - Germantown
IV. COMAR 10.24.01.08G(3)(d) VIABILITY OF THE PROPOSAL	154	Although it is less than certain, CCH/WAH may be able to obtain resources needed to undertake both the development of CCH and the replacement of WAH, if approved; however, ability to sustain CCH has not been shown due to problems with market feasibility.	Project Financially Viable
V. COMAR 10.24.01.08G(3)(e) COMPLIANCE WITH CONDITIONS OF PREVIOUS CERTIFICATES OF NEED	164	Hospital in compliance	Hospital in compliance although historic track record not as strong as AHC
VI. COMAR 10.24.01.08G(3)(f) IMPACT ON EXISTING PROVIDERS	168	No undue negative impact.	No undue negative impact. The HCH-G project has a greater potential for positive impact on demographic access to services.