STATE OF MARYLAND

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MEMORANDUM

TO: Commissioners

FROM: Paul E. Parker, Chief PEP
Certificate of Need

DATE: April 12, 2012

SUBJECT: Frederick Memorial Hospital
Addition of 10 General Medical/Surgical Beds
Docket No. 12-10-2326

Frederick Memorial Hospital proposes to add 10 MSGA beds, functioning as general medical/surgical beds, through renovation of 7,800 square feet of existing hospital space. The estimated cost of this project is $2,348,587. The hospital proposes to borrow the funds needed for this project through the sale of bonds.

FMH reports that it has the physical capacity to operate 305 beds and is licensed, in the current fiscal year, to operate 309 acute care beds. The project will increase the hospital's physical MSGA bed capacity to 256 beds and its total bed capacity to 315 beds. The State Health Plan projects that Frederick County will need between 222 and 267 MSGA beds by 2018.

This project will complete the transition of all space in the 4A unit of FMH to an 18-bed bed MSGA unit. Partial renovation of the unit, which made eight MSGA beds available for "over-flow" levels of census, has been previously authorized and was not found to require Certificate of Need review and approval because it did not increase the hospital's bed capacity at that time. The unit will consist of all private rooms.

Commission Staff recommends approval of this project.

IN THE MATTER OF	*	**BEFORE THE**
	*	
FREDERICK MEMORIAL HOSPITAL	*	**MARYLAND HEALTH**
	*	
Docket No. 12-10-2326	*	**CARE COMMISSION**
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Staff Report and Recommendation

April 19, 2012

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I. INTRODUCTION

A. Project Description

Frederick Memorial Hospital ("FMH" or "the hospital") is a 305-bed general acute care hospital located at 400 West Seventh Street in Frederick (Frederick County), providing medical/surgical, pediatric, obstetric, and acute psychiatric inpatient services, emergency medical care, and a range of outpatient services It is the center piece of Frederick Memorial Healthcare System, which includes a cancer therapy center adjacent to the hospital campus and several outpatient centers in Frederick, Urbana, and Mt. Airy. FMH is a community hospital organized as a private, not-for-profit corporation unaffiliated with any other hospitals or hospital system. FMH dates its origins in Frederick back to 1902.

FMH proposes to add 10 Medical/Surgical/Gynecological/Addictions ("MSGA") beds, functioning as general medical/surgical beds, through renovation of 7,800 square feet ("SF") of existing hospital space. The hospital operated a 20-bed comprehensive care facility ("CCF") unit until early 2011 on the fourth floor of the hospital's "A" wing. The south wing of this former CCF unit is the area of the hospital to be renovated. The estimated cost of this project is $2,348,587. The hospital proposes to borrow the funds needed for this the project through the sale of bonds.

FMH reports that it has the physical capacity to operate 305 beds, including 246 MSGA beds. The hospital is licensed, in the current fiscal year, to operate 309 acute care beds and has allocated 251 of those beds to the MSGA bed category. This project will increase the hospital's physical MSGA bed capacity to 256 beds and its total bed capacity to 315 beds. The hospital has allocated 58 beds of licensed capacity to the other three inpatient services it provides. Reported physical bed capacity in these bed categories closely mirrors licensed bed capacity; there is only a difference of one bed between licensed and reported actual capacity for these services, combined.

This project will complete the transition of all space in the 4A unit to an 18-bed bed MSGA unit. Partial renovation of the unit, which made eight MSGA beds available for "over-flow" levels of census, has been previously authorized and was not found to require Certificate of Need review and approval because it did not increase the hospital's bed capacity at that time. The unit will consist of all private rooms.

B. Summary of Staff Recommendation

Staff finds that this project complies with the State Health Plan standards for the addition of MSGA beds in Frederick County and that the hospital has demonstrated the need for the project, its cost-effectiveness, and its viability. This modest project will not have a negative impact on cost and charges at FMH or on other hospitals and the hospital has complied with terms and conditions of previous Certificates of Need. Accordingly, staff recommends that the Commission **APPROVE** the Certificate of Need application of Frederick Memorial Hospital to renovate the former CCF unit space to add 10 general medical/surgical beds.

II. PROCEDURAL HISTORY

A. Review of the Record

On October 25, 2011, Frederick Memorial Hospital submitted a letter of intent to the Commission to undertake a renovation project at FMH. The Commission acknowledged the letter of intent through a memorandum dated November 9, 2011. (D.I. #1).

On January 6, 2012, the applicant filed a Certificate of Need application. (D.I. #2). A January 10, 2012 letter acknowledging receipt of the application (D.I. #3) assigned Matter Number 12-10-2326 to the application. Also on this date, MHCC requested that the *Frederick Post* (D.I #4 and the *Maryland Register* (D.I. #5) publish notices of the filing of this application.

Letters of support from elected officials were filed by the applicant on January 10, 2012. (D.I. #6)

The *Frederick Post* provided proof of publication (D.I. #7) that the requested filing notice publication occurred on January 13, 2012.

The Commission sent a letter to FMH on January 24, 2012 noting docketing of the CON application effective February 10, 2012. Additional questions were posed in this letter. (D.I. #8).

Notice of the docketing of the application was requested of the *Frederick Post* (D.I. #9) as well as the *Maryland Register* (D.I. #10) on January 24, 2012.

The Frederick County Health Department was requested to review and comment on the application on January 24, 2012. (D.I. #11).

The *Frederick Post* provided proof of publication (D.I. #12) that the requested docketing notice publication occurred on January 31, 2012.

On February 7, 2012, FMH responded to the request for additional information. (D.I. #13)

B. Interested Parties

There are no interested parties to this review.

C. Local Government Review and Comment

A copy of the application was sent to the Frederick County Health Department for review and comment. The Health Department did not comment on the application.

D. Community Support

FMH provided letters of support for this application. These letters were written by Maryland State Senators David Brinkley and Ronald N. Young, and State Delegates Kathy Afzali, Galen Clagett, Donald Elliott, Patrick Hogan, Michael Hough, and Kelly Schulz.

III. BACKGROUND

A. Hospital Service Area and Demographics

FMH states that its primary service area "is comprised of the majority of zip code s in Frederick County. Home county residents accounted for 87% of its MSGA patient discharges in FY 2011. The balance of its MSGA patients originate from neighboring Carroll, Montgomery, and Washington Counties, bordering areas of Pennsylvania and Virginia and the nearby border areas of West Virginia.

Population growth and aging in Frederick County is profiled in the following table and compared with the State as a whole.

Table 1: Population Projections
Frederick County, State of Maryland

Age Range	2000	2010	2020	2030	Projected Change 2000-2010	Projected Change 2000-2020	Projected Change 2000-2030
FREDERICK							
0-14	45,217	49,205	60,453	72,090	8.8%	33.7%	59.4%
15-44	87,013	91,475	110,505	133,215	5.1%	27.0%	53.1%
45-64	44,211	66,145	72,289	65,271	49.6%	63.5%	47.6%
65-74	10,084	14,111	25,338	34,304	39.9%	151.3%	240.2%
75+	8,752	10,412	14,569	23,670	19.0%	66.5%	170.5%
TOTAL	195,277	231,348	283,154	328,550	18.5%	45.0%	68.3%
STATE OF MARYLAND							
0-14	1,136,846	1,147,314	1,257,913	1,291,496	0.9%	10.7%	13.6%
15-44	2,334,925	2,305,791	2,431,633	2,619,963	-1.3%	4.1%	12.2%
45-64	1,225,408	1,600,200	1,623,028	1,436,835	30.6%	32.5%	17.3%
65-74	321,285	395,172	607,708	733,874	23.0%	89.2%	128.4%
75+	278,022	330,902	419,010	602,088	19.0%	50.7%	116.6%
TOTAL	5,296,486	5,779,379	6,339,292	6,684,256	9.1%	19.7%	26.2%

Source: Maryland Department of Planning, Population Projections, November 2010

The population of Frederick County is younger and growing faster than the overall state population.

B. Hospital Utilization Trends

From 2006 to 2011, MSGA discharge volumes at FMH increased at an average of 5.7% per

year. Average MSGA average daily census increased from 128 to 173 patients over this same period.

Table 2: MSGA Discharges – Frederick Memorial Hospital

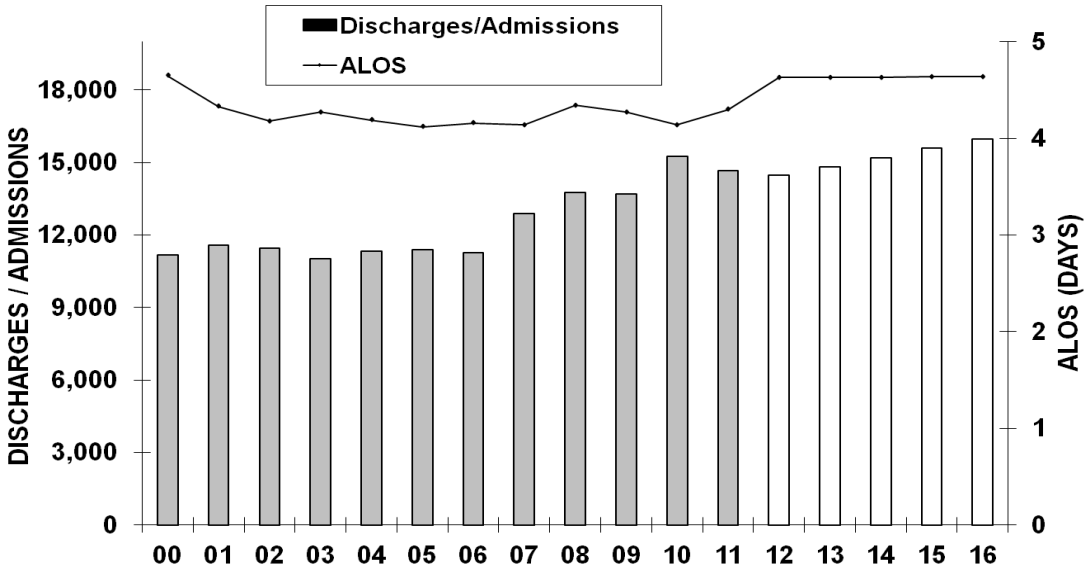
Calendar Year	2006	2007	2008	2009	2010	2011
Discharges	11,261	12,900	13,744	13,688	15,269	14,653
Change		+14.6%	+6.5%	-0.4%	+11.6%	-4.0%
Patient Days	46,847	53,401	59,706	58,452	63,219	63,056
Change		+14.0%	+11.8%	-2.1%	+8.2%	-0.3%
Average Length of Stay (days)	4.2	4.1	4.3	4.3	4.1	4.3

Source: HSCRC Discharge Data Base

The hospital projects that MSGA discharges will increase at an average annual rate of 2.5% between 2012 and 2016 and that MSGA average length of stay will average 4.6 days going forward.

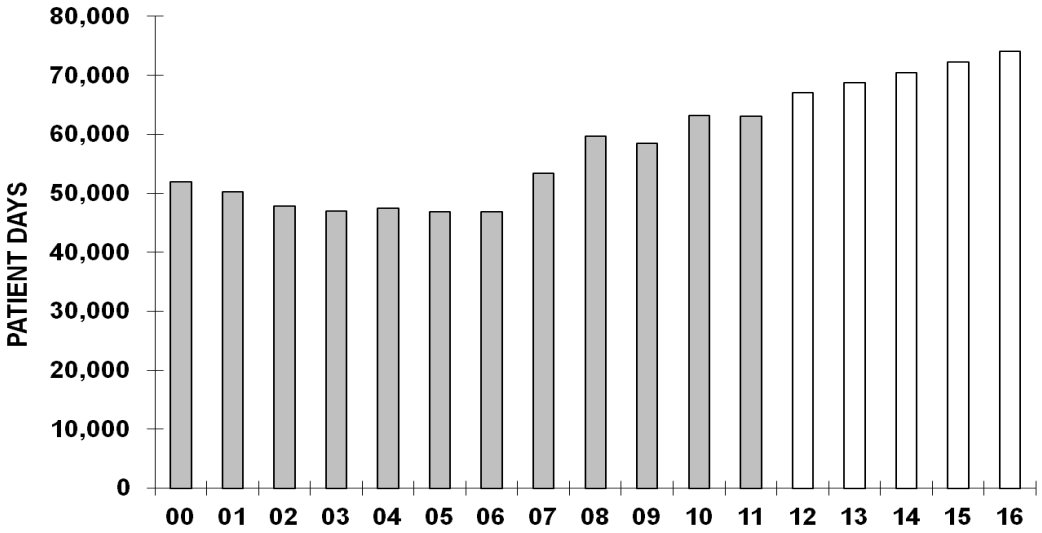
The following charts track recent and projected changes in MSGA discharges/admissions, average length of stay, and patient days at FMH.

HISTORIC MSGA DISCHARGES AND ALOS (CY2000-CY2011, FY2012*) AND PROJECTED MSGA ADMISSIONS AND ALOS (FY2013-FY2016) FREDERICK MEMORIAL HOSPITAL



SOURCE: HSCRC HOSPITAL DISCHARGE DATA BASE AND FMH CON APPLICATION
*Admissions in FY2012

HISTORIC MSGA PATIENT DAYS (CY2000-CY2011) AND PROJECTED MSGA PATIENT DAYS (FY2012-FY2016) FREDERICK MEMORIAL HOSPITAL



SOURCE: HSCRC HOSPITAL DISCHARGE DATA BASE AND FMH CON APPLICATION

IV. STAFF REVIEW AND ANALYSIS

The Commission is required to make its decision in accordance with the general Certificate of Need review criteria at COMAR 10.24.01.08G (3) (a) through (f). The first of these six general criteria require the Commission to consider and evaluate this application according to all relevant State Health Plan ("SHP") standards and policies.

A. The State Health Plan

COMAR 10.24.01.08G(3)(a)State Health Plan.
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

The relevant State Health Plan chapter is COMAR 10.24.10, Acute Inpatient Services.

COMAR 10.24.10.04A — General Standards.

(1) Information Regarding Charges. ***Information regarding hospital charges shall be available to the public. After July 1, 2020, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:***

Information regarding hospital charges shall be available to the public. Each hospital

shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

The applicant states, "Upon request, FMH provides a representative list of services and charges and will readily respond to individual requests for current charges for specific services and procedures." It provided a link to the representative list of services and charges posted on its web site and this posting complies with the standard.

(2) Charity Care Policy ***Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.***

(a) The policy shall provide:

(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

FMH provided the Commission with a copy of its financial assistance policy. The policy complies with the requirements of this standard. The applicant reports that it posts notices in the hospital's admissions and business offices and emergency department.

FMH reports that its level of charity care provision in FY 2010, as reported by HSCRC, was 1.32% of gross patient revenue and fell within the bottom quartile for all Maryland hospitals. The hospital reports a substantial increase in charity care for FY 2011 ($7.8 million) over FY 2010 ($4.1

million) and projects a charity care level (expressed as a percentage of total operating expenses) going forward of 2.7%, very close to the state average reported for FY 2010.

The hospital notes that Frederick County's estimated median household income in 2010 (U.S. Census Bureau) was $80,216 compared to a statewide median household income estimate of $68,933 and a correspondingly lower level of poverty, based on the federal income thresholds, 5.6% of the county's population compared to 9.9% for the overall statewide population. Only Howard County, among the state's jurisdictions, had a lower estimated rate of poverty, for all ages.

The applicant complies with this standard.

(3) Quality of Care

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene;

(ii) Accredited by the Joint Commission; and

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

(b) A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

FMH is licensed in good standing, is accredited by the Joint Commission, and in compliance with the conditions of participation of the Medicare and Medicaid programs.

Of the quality measures published by MHCC on its website, at the time of application filing, FMH's performance fell below 90% for three measures: (1) AMI patients whose time from arrival to primary PCI is 90 minutes, or less (88% performance compared to state average of 89%); (2) Giving full instructions to heart failure patients when they leave the hospital (84% performance compared to state average of 88%); and (3) Asthmatic children and their caregivers who received a home management plan of care document (3% performance compared to state average of 78%).

It provided detailed information on the actions plans being implemented to address these measures and improve the hospital's scores.

This standard is met.

COMAR 10.24.10.04B-Project Review Standards

(1) Geographic Accessibility ***A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general***

medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

This standard is not applicable to this project. No new or replacement hospital facilities are proposed.

(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 State Health Plan identifies a minimum gross bed need of 222 MSGA beds in Frederick County for the year 2018 and a maximum gross bed need of 267. FMH proposes the addition of 10 beds to the hospital's physical MSGA bed capacity, bringing its physical MSGA bed capacity up to 256 beds. This is within the bed need forecast range for Frederick County but above the minimum MSGA bed need forecast.

The hospital believes the completion of the conversion of the former CCF unit to an acute care unit through this renovation project is justified by the growth in demand for MSGA beds it has recently experienced, which has brought census levels to a point where occupancy is at or near 100% during peak census periods, especially in the winter months. It also notes the recent and anticipated growth in physician supply in the area, including surgical practitioners that will increase demand for surgical bed capacity. Finally, like many hospitals, FMH utilizes licensed MSGA bed capacity for extended observation patients, which, in some cases, are the same types of patient previously admitted for short hospital stays. Thus, demand for bed capacity exceeds the official census levels recorded in the discharge data base for this reason.

Staff finds that FMH has reasonably justified the proposed addition of MSGA beds, consistent 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 this project.

(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.

The applicant is not seeking a rate increase in conjunction with this project and will have no negative impact on availability or accessibility of facilities or services. The project complies with this standard.

(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 hospital for each alternative; and
(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives, including, but not limited to, the introduction of a new single service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.
(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:
(i) That it has considered, at a minimum, the two alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);
(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;
(iii) That it has detailed the capital and operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and
(iv) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project sites located within a Priority Funding Area.

The proposed project is considered by Staff to be limited in its objectives, consistent with Part (b) of this standard. It involves expansion of capacity for a single service through renovation of space previously used to provide services no longer offered by the hospital.

Because FMH has demonstrated that the proposed project is the only practical approach to achieving the limited objective of having more MSGA bed capacity available and this is a reasonable reuse for this space, Staff finds that the project is consistent with this standard.

(6) <u>Burden of Proof Regarding Need</u>

A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.

As outlined in the consideration of Project Review Standard (2), Identification of Bed Need and Addition of Beds, the State Health Plan addresses the need for additional MSGA beds in

Frederick County and the applicant has reasonably justified the increase in MSGA bed capacity, that falls within the forecast range of the current State Health Plan need projection.

(7) Construction Cost of Hospital Space

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

This standard has limited utility with respect to evaluating a project of the type proposed, which is limited to construction activity involved in renovating existing building space rather than construction of new building space. The construction cost involved in this project, at $195 per square foot, are far below what the Marshall Valuation Service standards would estimate as the cost for constructing comparable new building space for housing these beds ($306 per square foot).

The project is consistent with this standard.

(8) Construction Cost of Non-Hospital Space

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

This standard is not applicable to this project.

(9) Inpatient Nursing Unit Space

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500

square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

As previously noted, HMH is not proposing to seek a rate adjustment related to the cost of this project. For this reason, this standard will not have a practical impact. FMH has calculated that the completed 18-bed MSGA unit will contain 462 square feet of Inpatient Unit Program Space per bed.

(10) Rate Reduction Agreement

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

This standard is not applicable. FMH is not a high-charge hospital.

(11) Efficiency

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

FMH notes that this project is necessitated by the age and "antiquated layout" of the former CCF unit with patient rooms and other areas undersized relative to contemporary acute care nursing unit design standards. The renovation is intended to reconfigure the unit so that it can operate efficiently as a general medical/surgical unit, with medication and supply areas located to minimize walking distances and keep staff close to patients. The refurbished unit will integrate electronic medical record documentation, consistent with other areas of the hospital. The applicant believes it has designed the renovation with minimizing staffing requirement and length of stay in mind.

The applicant has demonstrated that the project will achieve better operational efficiencies for its intended purpose than the former CCF design could. The project complies with this standard.

(12) Patient Safety

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

The applicant outlined design and operational characteristics incorporated in its proposed project that will have a positive impact on patient safety, as follows:

- Locating patient bathrooms along the headwall, with a handrail from the bed to the bathroom to minimize patient falls;
- Nurse servers and custom-designed support areas to accommodate contact isolation protocols;
- Nurse servers directly outside patient rooms, minimizing need for staff to leave the area of the patient room;
- Incorporating electronic medical record computer stations in each room to maximize staff time with the patient;
- Segregated and adequate countertop and hand washing facilities in the patient room for nursing to administer medications in a well lit and adequately-sized area;
- Properly sized and located medication rooms and equipment storage areas to keep supplies close to the patient; and
- Patient room designs that make it easy to move patient and beds in and out of rooms.

The applicant has demonstrated that design of its project took patient safety into consideration and includes features that enhance and improve patient safety, consistent with this 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.

The application filed by FMH meets the requirements of this standard. Staff's review of the financial and utilization projections found them to be reasonable and internally consistent. Because this is a relatively small renovation project, HSCRC Staff was not asked to provide a financial feasibility opinion. The project complies with this standard.

(14) <u>Emergency Department Treatment Capacity and Space</u>

(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.

This standard is not applicable. The project does not involve ED facilities or services.

(15) Emergency Department Expansion

A hospital proposing expansion of emergency department treatment capacity shall demonstrate that it has made appropriate efforts, consistent with federal and state law, to maximize effective use of existing capacity for emergent medical needs and has appropriately integrated emergency department planning with planning for bed capacity, and diagnostic and treatment service capacity. At a minimum:

(a) The applicant hospital must demonstrate that, in cooperation with its medical staff, it has attempted to reduce use of its emergency department for non-emergency medical care. This demonstration shall, at a minimum, address the feasibility of reducing or redirecting patients with non-emergent illnesses, injuries, and conditions, to lower cost alternative facilities or programs;

(b) The applicant hospital must demonstrate that it has effectively managed its existing emergency department treatment capacity to maximize use; and

(c) The applicant hospital must demonstrate that it has considered the need for bed and other facility and system capacity that will be affected by greater volumes of emergency department patients.

This standard is not applicable. The project does not involve ED facilities or services.

(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.

The proposed project does not involve development of shell space.

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.

As outlined in the consideration of Project Review Standard (2), Identification of Bed Need and Addition of Beds, the State Health Plan addresses the need for additional MSGA beds in Frederick County and this project is consistent with this standard. The proposed project is consistent with the applicable need analysis in the State Health Plan.

C. Availability of More Cost-Effective Alternatives

COMAR 10.24.01.08G(3)© Availability of More Cost-Effective Alternatives.
The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

The proposed project involves completing the transformation of a unit that was most recently operated as a CCF, or skilled nursing facility, unit into a general MSGA unit. There are already eight general MSGA beds functional in this unit and the project will complete it as an 18-bed unit. This application is not a part of a comparative review. Therefore, the Commission's consideration of cost and effectiveness is limited, in this case, to consideration of what alternative approaches exist to reusing this space and gaining additional bed capacity at FMH. As outlined in the discussion of Project Review Standard (5), Cost-Effectiveness, the proposed project has a single patient care objective, greater availability of general MSGA bed capacity. It achieves this objective through a fairly limited renovation project. Consistent with that standard, Staff found that FMH demonstrated that the proposed project is the only practical approach to achieving the limited objective of having more MSGA bed capacity available in a short time frame and at a reasonable cost.

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.

The total estimated project budget for this proposal is shown in Table 3 on the following page. FMH plans to finance the entire project cost with funds generated through the sale of bonds.

FMH's recent financial performance, while below HSCRC target values, does not indicate any significant barriers to successful implementation of a project of this scope. (See Tables 4 and 5.) Within its HSCRC Peer Group, it was found to an average, fully-adjusted charge per case that was 3.51% below the group mean in the most recent Reasonableness of Charges review by the rate setting agency.

Table 3: Project Budget – FMH Addition of 16 MSGA Beds

Capital Costs	
Renovations	
Building	$1,519,112
Architect/Engineering Fees	142,797
Permits	81,667
SUBTOTAL - Renovation	**$1,743,576**
Other Capital Costs	
Major Movable Equipment	$300,000
Contingencies	41,667
Other (furnishings, signage, IT services, miscellaneous)	141,667
SUBTOTAL – Other Capital	**$590,011**
Total Current Capital Costs	**$2,333,587**
TOTAL ESTIMATED CAPITAL COSTS	**$2,333,587**
Financing Cost and Other Cash Requirements	
CON Application Assistance	$15,000
SUBTOTAL – Financing and Other Cash	**$15,000**
TOTAL USES OF FUNDS	**$2,348,587**

Source: CON application, Project budget, pages 11-12

Table 4: Financial Performance, Frederick Memorial Hospital FY2008-FY2010

	Fiscal Year Ending		
	Jun-30-2008	Jun-30-2009	Jun-30-2010
FMH Regulated Operations Only			
Net Operating Revenue	$ 215,569,301	$ 233,970,884	$ 248,531,944
Net Operating Income	$ 10,435,545	$ 12,333,922	$ 16,242,542
Net Operating Margin	4.84%	5.27%	6.54%
FMH Regulated and Unregulated			
Net Operating Revenue	$ 270,843,838	$ 287,888,368	$ 303,017,127
Net Operating Income	$ 1,705,357	$ 1,943,092	$ 4,555,165
Net Operating Margin	0.63%	0.67%	1.50%
Operating Margin – Peer Group 2 Regulated			
Average	5.11%	6.45%	6.04%
Median	4.84%	5.61%	6.42%
Operating Margin – Peer Group 2 Regulated and Unregulated			
Average	1.99%	1.89%	1.79%
Median	2.38%	1.93%	1.66%
Operating Margin – State Wide Regulated and Unregulated			
State Wide Regulated and Unregulated	2.30%	2.60%	2.60%
State Wide Regulated	5.20%	5.90%	6.20%

Source: Report on Financial Conditions, Fiscal Year 2011 issued by the HSCRC.

Table 5: Selected Financial and Operating Indicators
(Regulated and Unregulated)

Maryland Hospitals-Statewide Average		
Year	Operating Margin	Excess Margin
2010	2.60%	3.80%
2009	2.60%	0.01%
2008	2.30%	1.40%
Frederick Memorial Hospital		
Year	Operating Margin	Excess Margin
2010	1.50%	2.69%
2009	0.67%	-4.6%
2008	0.63%	-2.78%
HSCRC Target Values		
	2.75%	**4.00%**

Source: Report on Financial Conditions, Fiscal Year 2011 issued by the HSCRC.

As noted in the consideration of the *Financial Feasibility* project review standard, the application meets the requirements of this standard and financial and utilization projections were found to be reasonable and internally consistent. FMH has demonstrated that it has the necessary financial and nonfinancial resources for implementation of the project and the project is financially feasible, and that FMH will be financially viable following implementation of the project.

E. Compliance with Conditions of Previous Certificates of Need

COMAR 10.24.01.08G(3)(e), Compliance with Conditions of Previous Certificates of Need. An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

FMH has complied with the terms and conditions of the Certificates of Need it has received in the past.

F. Impact on Existing Providers

COMAR 10.24.01.08G(3)(f),)Impact on Existing Providers and the Health Care Delivery System.
An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, 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.

As previously noted, this project, which increases MSGA bed capacity at HMH by 10 beds (a 4.1% increase in physical bed capacity), is justifiable under the current bed need projections in the State Health Plan and the applicable review standard for addition of beds. FMH is the only hospital in Frederick County.

The hospital does not project a rate increase as necessary to recoup the capital cost associated with this modest project.

Because of the nature of this project, there is no basis for finding that it will have any negative impact on access to services or on costs and charges of other providers. Staff recommends that the Commission find that the proposed project will not have a negative impact on service accessibility, cost and charges, or other providers of health care services. Therefore, the project is consistent with this criterion.

V. SUMMARY AND STAFF RECOMMENDATION

Based on its review and analysis of the Certificate of Need application, the Commission staff has determined that the proposed capital project:

- Complies with the applicable State Health Plan standards;
- Is needed;
- Is a cost-effective approach to providing a small increment of additional MSGA bed capacity in Frederick County and reusing space formerly used to provide CCF services;
- Is viable;
- Is proposed by an applicant that has complied with the terms and conditions of previously issued CONs; and
- Will not have a negative impact on service accessibility, cost and charges, or other providers of health care services.

Accordingly, Staff recommends that the Commission **APPROVE** the application of Frederick Memorial Hospital for a Certificate of Need to renovate approximately 7,800 square feet of existing hospital building space to add 10 additional MSGA beds.

IN THE MATTER OF	*	**BEFORE THE**
	*	
FREDERICK MEMORIAL HOSPITAL	*	**MARYLAND HEALTH**
	*	
Docket No. 12-10-2326	*	**CARE COMMISSION**
	*	

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FINAL ORDER

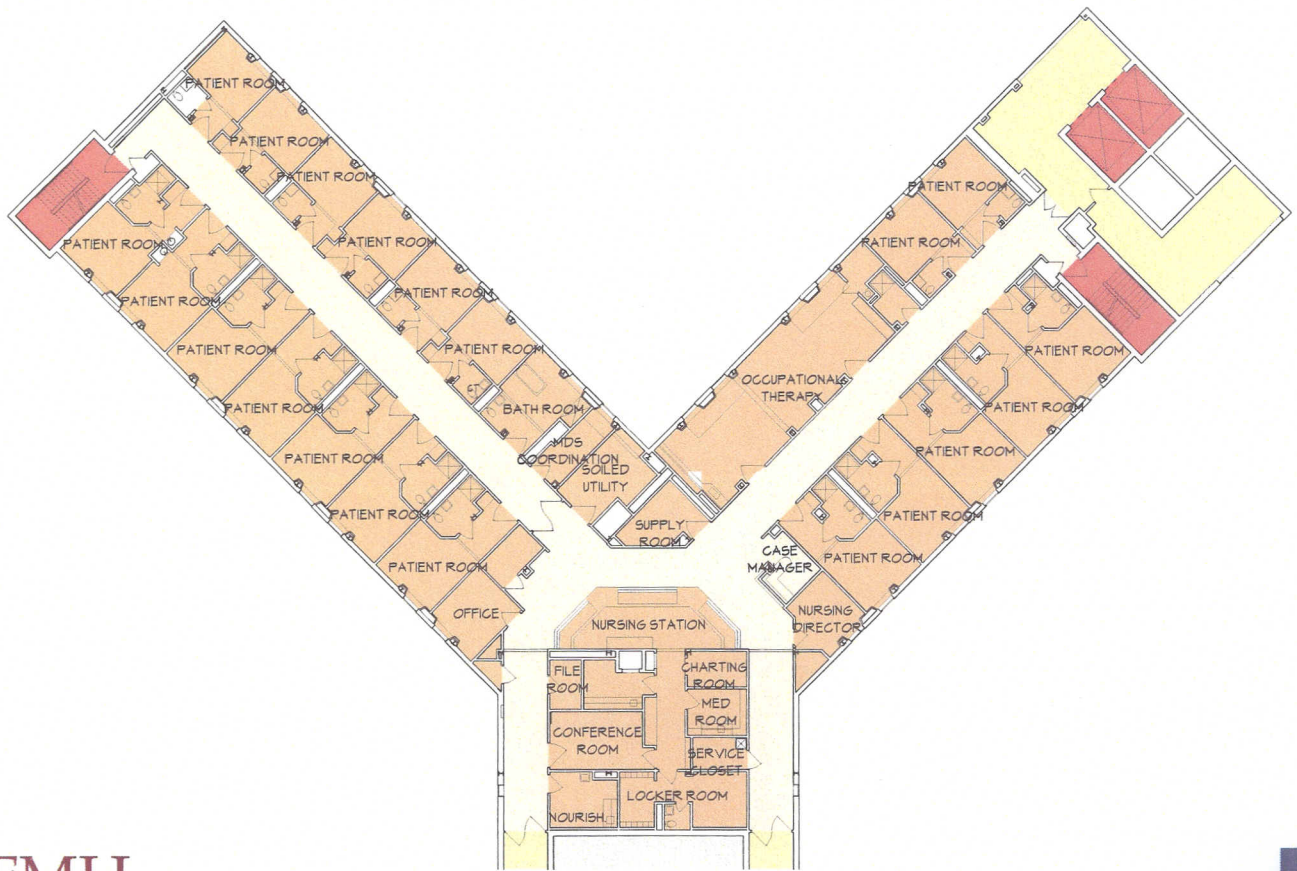
Based on the analysis and findings in the Staff Report and Recommendation, it is this 19th day of April 2012:

ORDERED, that the application for Certificate of Need by Frederick Memorial Hospital, Docket No. 12-10-2326, to add 10 MSGA beds through renovations on the fourth floor "A" unit of the hospital, at a capital cost of $2,348,587 is **APPROVED**.

MARYLAND HEALTH CARE COMMISSION

APPENDIX A

Floor Plans



FMH
FREDERICK REGIONAL HEALTH SYSTEM

INPATIENT RENOVATIONS

4A - Existing Floor Plan

11/08/2011

1/16" = 1'-0"

TRINITY

FMH
FREDERICK REGIONAL HEALTH SYSTEM

INPATIENT RENOVATIONS

4A - Proposed Floor Plan

11/08/2011

1/16" = 1'-0"

TRINITY