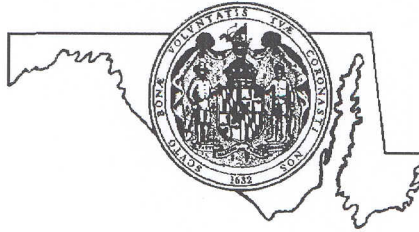


Craig P. Tanio, M.D.
CHAIR

STATE OF MARYLAND

Ben Steffen
EXECUTIVE DIRECTOR



MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
TELEPHONE: 410-764-3460 FAX: 410-358-1236

Memorandum

To: Commissioners
From: Joel Riklin, Acting Chief
Certificate of Need *JR*
Date: February 21, 2013
Re: Garrett County Memorial Hospital
Docket No. 12-11-2337

Garrett County Memorial Hospital (“GCMH”) proposes the construction of a new four-story wing, adding approximately 20,300 square feet of space and the renovation of approximately 42,000 square feet of existing space. The project will provide eight additional private patient rooms for general medical/surgical patients, increasing the total number of patient rooms at the hospital for acute care patients to 38. Given that the hospital’s current licensed acute care bed capacity is 29, the project will have the practical effect of eliminating most of the need for semi-private room accommodation. The project will also expand and renovate the hospital’s Maternity Suite, Intensive Care Unit, and Comprehensive Care Facility unit, used as a sub-acute rehabilitation unit. There will be no change in GCMH’s physical bed capacity.

The project has an estimated cost of \$23,539,350. GCMH anticipates funding the project with \$15,000,000 of bond debt, \$7,5 million in cash, and \$1 million from fundraising. The hospital sought and obtained approval from the Health Services Cost Review Commission for an adjustment in its Total Patient Revenue cap to provide revenue to support the increase in debt service expenses and depreciation that this project will entail.

Staff recommends approval of this project with one condition. The project meets an institutional need for facility expansion and modernization, it is a cost-effective alternative for meeting this need, it is viable, and will have no substantive impact on other facilities. The recommended condition responds to changes that occurred in the performance of the hospital on Quality Measures reported by MHCC on the Hospital Performance and Evaluation Guide during the review of this project.

IN THE MATTER OF

GARRETT COUNTY

MEMORIAL HOSPITAL

Docket No. 12-11-2337

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BEFORE THE

MARYLAND

HEALTH CARE

COMMISSION

Staff Report and Recommendation

February 21, 2013

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STAFF REPORT AND RECOMMENDATION

I. INTRODUCTION

A. Applicant

Garrett County Memorial Hospital (“GCMH” or “the Hospital”) is a general hospital licensed to operate 29 acute care beds in the current fiscal year and ten comprehensive care (nursing home) beds. It is located in Garrett County at 251 North Fourth Street, in Oakland. GCMH is organized as a nonprofit corporation, with its land held by the Commissioners of Garrett County and its buildings owned by GCMH’s Board of Governors.

B. Project Description

The project involves the construction of a new four-story wing (basement plus three stories above ground) which will add 20,286 square feet and the renovation of 41,954 square feet of existing space. The additional wing will provide eight inpatient private rooms on a single general medical/surgical/gynecological/addiction (“MSGA”) unit, which will allow for the conversion of eight existing semi-private rooms to private rooms. As a result, the Hospital will achieve a bed capacity of 26 private rooms, accommodating approximately 80 percent of the physical general MSGA bed capacity. Additionally, the project will provide for expansion and renovation of GCMH’s Maternity Suite, its four-bed Intensive Care Unit, and its 10-bed Comprehensive Care Facility (“CCF”) unit, used as a sub-acute rehabilitation unit. GCMH is not proposing a change in its physical bed capacity, as detailed in Table 1 below and in Appendix B, Physical Bed Capacity Before and After the Project. The Hospital is proposing to increase the number of private rooms, construct larger more modern patient rooms, and renovate existing nursing unit space.

**Table 1
Garrett County Memorial Hospital
Current and Proposed Physical Bed Capacity by Service**

Service	Current Licens ed Beds	Physical Capacity					
		Existing Beds/Rooms		After Project Beds/Rooms		Change	
		Beds	Rooms	Beds	Rooms	Beds	Rooms
	FY 2013						
General Medical/Surgical		31	20	31	28	0	8
Intensive Care		4	4	4	4	0	0
Total MSGA	24	35	24	35	32	0	8
Obstetric	4	9	5	9	5	0	0
Pediatric	1	1	1	1	1	0	0
Total Acute Care	29	45	30	45	38	0	8
CCF (Sub-Acute)	10	10	7	10	8	0	1
Total Beds	39	55	37	55	46	0	9

Source: GCMH August 29, 2012 response to July 23rd completeness letter (DI #11, Exhibit 1) and GCMH October 5th response to additional information questions (DI #17, p. 1)

The proposed project also includes expansion of the Surgery Department to provide additional storage for equipment and supplies, and the expansion and renovation of Pharmacy, Cafeteria/Dining, Education and Administrative areas of the Hospital.

**Table 2
Components of the Garrett County Memorial Hospital Project**

Location	Gross SF		Project Components
	New	Renovations	
Basement	5,428	2,098	Multipurpose Room/ Education all in new space and Dietary and mechanical/electrical space in new and renovated space
First Floor	5,090	5,751	Administration & accounting in new space and pharmacy, cardiology, registration, patient financial services and mechanical/electrical in renovated space
Second Floor	5,215	17,000	Family centered maternity services and sub-acute care in a mix of new and renovated space, and ICU, surgical services, dialysis and mechanical/electrical in renovated space
Third Floor	4,553	17,105	Medical/surgical nursing unit in new and renovated space and administrative offices, shared support space and mechanical/electrical in renovated space
Total	20,286	41,954	

Source: GCMH August 29, 2012 response to July 23rd completeness letter (DI #11, Exhibit 4)

All construction will occur on the approximately eight-acre current hospital site. Construction is expected to begin six months after CON approval and take 36 to 38 months to complete. Phase I, which will include construction of the new wing and renovation of the medical/surgical unit, is expected to take 18 months. Renovations and completion of the fit out of the new wing will begin during Phase I and continue through three additional phases before the project is complete. All construction work will be completed under one construction contract.

As detailed in the table below, the total estimated cost of the project is \$23,539,350. This includes \$21,869,806 in current capital costs, \$1,599,180 in inflation allowance, and \$70,364 in financing cost and other cash requirements. GCMH proposes to fund this project with \$15,000,000 raised through the sale of county-authorized bonds, \$7,539,350 in cash, and \$1,000,000 in pledges. The annual interest expense rate on these new bonds is expected to be 5.3 percent. The sum of interest expense incurred during the construction period is estimated at \$460,348. This amount will be capitalized and added to the cost of the project. Because the amount that is borrowed each month is spent on project costs, there is no material balance of cash on which investment income would be earned. (DI #2, pp. 8-9, DI #11, p.4)

Table 3: Project Costs

New Construction	
Building	\$6,366,582
Fixed Equipment (not included in construction)	40,000
Site Preparation	342,000
Architect/Engineering Fees	539,887
Permits, (Building, Utilities, Etc)	316,638
SUBTOTAL (New Construction)	\$7,605,107
Renovations	
Building	\$8,097,789
Architect/Engineering Fees	1,395,121
SUBTOTAL (Renovations)	\$ 9,492,910
Other Capital	
Major Movable Equipment	\$1,759,098
Contingencies	1,625,204
Other (Specify)—Const. Manager, Inspections, County Fees, etc.	927,139
Interest (Gross)	\$ 460,348
TOTAL CURRENT CAPITAL COSTS	\$ 21,869,806
Non Current Capital Cost	
Inflation (1% per month; High value due to anticipated rise in inflation and increasing cost of materials and labor)	1,599,180
TOTAL PROPOSED CAPITAL COSTS	\$ 23,468,986
FINANCING COSTS	
Legal Fees (CON Related)	\$52,773
Other – Bank Fees	17,591
SUBTOTAL	\$70,364
TOTAL USES OF FUNDS	\$23,539,350
SOURCE OF FUNDS	
Cash	\$7,539,350
Gifts/Bequests	1,000,000
Authorized Bonds (County Bonds/Loan)	15,000,000
TOTAL SOURCES OF FUNDS	\$23,539,350

Source: Garrett County Memorial Hospital, DI #2, pp.8-9.

C. Summary of Staff Recommendation

Staff finds that the proposed project complies with the applicable State Health Plan standards for this project and that consideration of the project in the light of the required review criteria support approval of the project. A summary of the Commission Staff’s analysis of the proposed project is provided below.

Bed Capacity

- GCMH is not proposing a change in bed capacity. The project will involve adding patient rooms to the hospital so that its current physical bed capacity will be distributed over mostly private rooms.

Cost-Effectiveness

- GCMH conducted a reasonable assessment of alternatives and selected the best overall option for meeting its objectives.

Construction Cost

- The estimated new construction costs for the project are below the Marshall Valuation Service (“MVS”) benchmark costs for a similar project.

Need

- GCMH has demonstrated the needs of the population it serves for the facility modernization contemplated by the proposed project.

Financial Feasibility and Viability

- GCMH has demonstrated the availability of resources to implement the project, and with the HSCRC approval of the Hospital’s rate request, it will have the resources to sustain the project and the Hospital’s on going operations.

Impact

- As the sole provider of inpatient services in Garrett County and a hospital that is located at some distance from any other general hospitals, this GCMH project, given its limitation to modernizing the existing facilities and services of the hospital, will not have an adverse impact on other providers in the service area or a negative impact on geographic and demographic access to service. It will require higher charges but the increase is acceptable, given the need for the modernization and the hospital’s relatively low current charge level.

Staff recommends approval of this project with a condition. Because levels of performance on quality measures reported on the MHCC Hospital Performance Evaluation Guide changed over the course of this review, the project complies with the General Standard for Quality of Care but it is appropriate to obtain additional information on the actions being taken by GCMH to improve performance on measures for which scores declined after application filing.

II. PROCEDURAL HISTORY

A. Review of the Record

On May 3, 2012, FWMC submitted a Letter of Intent to apply for a Certificate of Need (“CON”) for this project. This letter was received by MHCC on May 3, 2012 and acknowledged by Commission staff on May 9, 2012. [Docket Item (“DI”) #1]

The Hospital filed a CON application on July 6, 2012. (DI #2)

Commission staff acknowledged receipt of the application for the project (DI #3) on July 9, 2012 and requested publication of a notice of receipt of the application in the next issue of *The Republican* (DI #4) and *Maryland Register* (DI #5) on the same date.

On July 6, 2012, staff received a letter of acknowledgement of receipt for the Copy of the Certificate of Need Application delivered to the Garrett County Health Department. (DI #6)

On July 19, 2012, *The Republican* provided proof of publication of the application notice. (DI #7).

On July 23, 2012, staff requested completeness information from GCMH within ten working days (DI #8). Staff followed up with an additional set of questions regarding the completeness of the application on July 26, 2012. (DI #9)

On July 26, 2012, staff emailed GCMH regarding an additional completeness question. GCMH requested an extension to the deadline date for responses to the completeness information questions. Commission staff granted an extension of the submission date to August 30, 2012, as requested by GCMH. (DI #10)

On August 29, 2012, GCMH submitted responses to the completeness information questions (DI #11).

On September 18, 2012, staff notified the applicant of docketing for formal review on October 5, 2012 and requested additional information. (DI#12) Staff requested publication of notice in the next issue of *The Republican* (DI #13) and the *Maryland Register* (DI #14) on the same date.

On September 18, 2012, staff requested a review and comment on the CON application from the Garrett County Health Officer. (DI #15)

On September 27, 2012, *The Republican* provided proof of publication of the docketing notice. (DI #16)

On October 5, 2012, GCMH submitted responses to staff's additional information questions. Staff received this response on October 9, 2012. (DI #17)

On November 30, 2012, staff requested an opinion on the financial feasibility of the proposed project from The Health Services Costs Review Commission (HSCRC). (DI #18)

On December 5, 2012, staff requested additional information from GCMH. (DI #19)

On December 18, 2012, GCMH submitted responses to the additional information questions. (DI #20)

On January 17, 2013, staff requested a copy of GCMH's current license and Joint Commission Accreditation, which were submitted by GCMH on January 18, 2013 (DI #21)

On February 6, 2013 the HSCRC submitted its review and comments on the financial feasibility of the proposed project (DI #22)

On February 8, 2013, staff requested a revision to GCMH's charity care policy and the posting of updated charge information on the Hospital's website (DI #23)

On February 12, 2013, staff requested clarification of GCMH's bed capacity before and after the project, which was provided on February 12th (DI #24)

B. Interested Parties

There are no interested parties to this review.

C. Local Government Review and Comment

The Garrett County Health Department and local government officials are among those who provided letters supporting this project. These are listed in the following section.

D. Community Support

GCMH provided nine letters of support for this application. (DI #2, Exhibit 16) These letters were written by local elected and appointed officials, GCMH staff, and community business leaders.

Senator George C. Edwards, 1st Legislative District, Maryland
Delegate Wendell R. Beitzel, 1A Legislative District, Maryland
Gregan T. Crawford, Robert G. Gatto, and James M. Raley, Garrett County Commissioners
R. Lamont Pagenhardt, County Administrator, Garrett County
Rodney B. Glotfelty, RS, MPH, Health Officer, Garrett County Health Department
James Hinebaugh, Director, Garrett County Maryland Economic Development
Peggy Jamison, Mayor of Oakland
Dr. Charles A. Walch, Chair of GCMH Department of Surgery & Garrett Surgical Group, P.A.
William B. Grant, Chairman of the Board, President and CEO, First United Bank & Trust

III. BACKGROUND

A. Hospital Service Area and Demographics

COMAR 10.24.10.06(25) defines "primary service area" as "The Maryland postal zip codes from which the first 60 percent of a hospital's patient discharges originate during the most recent twelve month period..." GCMH identifies its service area as including Garrett and Allegany counties in western Maryland and Grant, Mineral, Preston, and Tucker counties in northeastern West Virginia. As presented below by the applicant, approximately 70 to 75 percent of GCMH's inpatient and outpatient volumes come from western Maryland with more than 60

percent coming from Garrett County. An additional 20 to 25 percent of GCMH’s volumes originate from West Virginia.

**Table 4: Garrett County Memorial Hospital
Hospital Volumes by County
October 1, 2010 – September 30, 2011**

	Inpatient		Outpatient	
	Volume	% of Total	Volume	% of Total
Maryland				
Garrett	2,122	67.8%	52,782	73.6%
Allegany	82	2.6%	956	1.3%
Subtotal	2,204	70.5%	53,738	75.0%
West Virginia				
Grant	98	3.1%	2,154	3.0%
Mineral	89	2.8%	1,401	2.0%
Preston	430	13.7%	8,815	12.3%
Tucker	157	5.0%	2,351	3.3%
Subtotal	774	24.7%	14,721	20.5%
Other	150	4.8%	3,222	4.5%
Total	3,128	100%	71,681	100%

Source: GCMH CON Application, DI #2, p. 23.

As illustrated in the table below, the population of Garrett County is projected to increase only two percent from 2010 to 2020, compared to anticipated statewide growth of almost eight percent and more than 10 percent for the four county Western Maryland region. Most of Western Maryland’s growth is expected in Frederick and Washington Counties, the eastern most half of the region which is exurban to the Washington, D.C. metropolitan area and affected by the growth patterns of that urban center.

**Table 5: Estimated & Projected Population by County
Western Maryland & State**

Region	2010	2015	2020	% Change	
				2010-15	2015-20
Maryland	5,773,552	5,962,014	6,216,156	3.3%	4.3%
Western MD Region	485,999	506,694	537,097	4.3%	6.0%
Allegany County	75,087	75,148	75,647	0.1%	0.7%
Frederick County	233,385	247,350	267,646	6.0%	8.2%
Garrett County	30,097	30,200	30,704	0.3%	1.7%
Washington County	147,430	153,996	163,100	4.5%	5.9%

Source: MD Department of Planning; March 2012 Update.

B. Selected GCMH and Regional Utilization Trends

Medical/Surgical/Gynecological/Addictions (MSGA) Utilization

Each of the four counties in Western Maryland has a single general hospital. As illustrated in the table below, every hospital in Western Maryland experienced a decrease in MSGA discharges between 2010 and 2011 while Frederick Memorial was the only Western Maryland hospital to experience growth in MSGA discharges since 2005, likely due to the ongoing population growth in its County and surrounding communities. All hospitals in the region, except GCMH, also experienced a drop in patient days from 2010 to 2011 while

Frederick Memorial was the only hospital to see growth in patient days since 2005. The implementation of state and national initiatives to reduce readmissions and to shift one day inpatient stays to outpatient observation status, combined with the recession and weak economic recovery post-recession are the most important factors in the recent softening of demand for acute care hospital beds.

**Table 6: MSGA Discharges and Patient Days,
Selected Maryland Hospitals, Calendar Year 2005-2011**

Hospital	MSGA Discharges								% Change	
	2005	2006	2007	2008	2009	2010	2011	2010-11	2005-11	
	Frederick Memorial	11,389	11,261	12,900	13,744	13,688	15,269	14,653	-4.2%	28.7%
Garrett Co Memorial	2,096	2,224	2,314	2,200	2,200	2,053	1,859	-10.4%	-11.3%	
Meritus	11,906	12,239	12,292	12,266	12,360	12,318	11,899	-3.5%	-0.1%	
Western MD Regional	14,513	14,458	13,925	14,212	13,834	12,854	11,708	-9.8%	-19.3%	
Total Western MD Hospitals	39,904	40,182	41,431	42,422	42,082	42,494	40,119	-5.9%	0.5%	
	MSGA Patient Days									
Frederick Memorial	46,871	46,847	53,401	59,706	58,452	63,219	63,056	-0.3%	34.5%	
Garrett Co Memorial	7,340	7,602	8,256	7,581	7,365	6,780	6,999	3.1%	-4.6%	
Meritus	54,122	56,313	57,087	56,900	58,381	55,594	53,931	-3.1%	-0.4%	
Western MD Regional	62,594	61,158	60,469	61,672	58,404	56,632	53,700	-5.5%	-14.2%	
Total Western MD Hospitals	170,927	171,920	179,213	185,859	182,602	182,225	177,686	-2.6%	4.0%	

Source: MHCC analysis of HSCRC discharge abstract data, Calendar Years 2005-2011.

GCMH's average length of stay (ALOS) performance for MSGA discharges has been positive in recent years. GCMH's 2011 LOS for MSGA discharges was 5.3 percent below its case mix-adjusted LOS, i.e., the LOS that would be expected based on its patients' diagnoses.

Acute Care Utilization by Service

As shown in the following table, MSGA discharges represented more than 79 percent of all discharges and almost 84 percent of all discharge days in Western Maryland hospitals in 2011. As expected, obstetrics (OB) and pediatrics (PEDS) discharge days were about half the percentage of their respective total discharges.

Table 7: Western Maryland Hospitals, Discharges and Days, CY 2011

	Discharges					Total Days				
	OB	PSYCH	PEDS	MSGA	Total	OB	PSYCH	PEDS	MSGA	Total
Frederick Memorial	2,485	1,295	402	14,653	18,835	6,780	7,386	780	63,056	78,002
Garrett Co Memorial	312	13	88	1,859	2,272	526	36	178	6,999	7,739
Meritus Medical Center	2,032	998	392	11,899	15,321	4,671	4,796	797	53,931	64,195
Western MD Health System	1,103	1,196	283	11,708	14,290	2,614	5,084	560	53,700	61,958
Total Western Maryland Hospitals	5,932	3,502	1,165	40,119	50,718	14,591	17,302	2,315	177,686	211,894
	Percentage of Discharges					Percentage of Total Days				
	OB	PSYCH	PEDS	MSGA	Total	OB	PSYCH	PEDS	MSGA	Total
Frederick Memorial	13.20%	6.90%	2.10%	77.80%	100%	8.70%	9.50%	1.00%	80.80%	100%
Garrett Co Memorial	13.70%	0.60%	3.90%	81.80%	100%	6.80%	0.50%	2.30%	90.40%	100%
Meritus Medical Center	13.30%	6.50%	2.60%	77.70%	100%	7.30%	7.50%	1.20%	84.00%	100%
Western MD Health System	7.70%	8.40%	2.00%	81.90%	100%	4.20%	8.20%	0.90%	86.70%	100%
Total Western Maryland Hospitals	11.70%	6.90%	2.30%	79.10%	100%	6.90%	8.20%	1.10%	83.90%	100%

Source: MHCC analysis of HSCRC discharge abstract data, Calendar Year 2011.

GCMH’s application projects that approximately 1,600 general MSGA discharges in 2012, 244 intensive care discharges, 262 OB discharges, and 46 pediatric discharges. GCMH projects a 10.1 percent decline over the next six years.

IV. STAFF REVIEW AND ANALYSIS

The Commission is required to make decisions on CON applications in accordance with the general Certificate of Need review criteria at COMAR 10.24.01.08G (3) (a) through (f).

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 chapters are COMAR 10.24.10, Acute Inpatient Services, and COMAR 10.24.12, Acute Hospital Inpatient Obstetric 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, 2010, 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.*

GCMH provided an updated Estimated Average Charges for Frequent Procedures listing as contained in the Notification of Charges Policy. Moreover, GCMH states that, "(T)he charge information available in written form at the Hospital and on the charge information on the Hospital's website has been updated to include all the categories specified."

GCMH's policy states that this information will be updated quarterly. The Patient Financial Services Department is responsible for maintaining accurate charges and its staff is to respond to patient or designated payer requests for charge estimates. Staff training is to occur during initial training and during annual competency training. Commission staff has confirmed that these charges are posted on the patient information section of the Hospital's website and that they have been update quarterly during the project review period.

GCMH complies with this 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.

GCMH reports that it “has a ‘Caring Program’ that enables the hospital to offer financial assistance for the healthcare services rendered to underprivileged, underemployed, and/or underinsured patients who have difficulty providing themselves with food, clothing, shelter, and healthcare.” GCMH provided its written policy for the provision of charity care for indigent patients, which includes a determination of probably eligibility within two business days of a request. While the entire policy doesn’t appear to be posted on its website, its “Caring Program” is mentioned and contact persons and phone numbers are provided for patients to inquire about eligibility. The Hospital’s policy states that notification of charity care availability is posted in all patient registration areas and is in the Patient Handbook.

Based on the Maryland Hospital Community Benefits Report for FY2011, dated June 6, 2012, GCMH’s total community benefits were equivalent to nine percent of its total operating expense and charity care was equivalent to 7.8 percent. The Hospital’s charity care level ranked it 4th among Maryland’s 46 general hospitals. In FY2010, GCMH was ranked 3rd in the State but provided charity care equivalent to 6.5 percent of total operating expense and community benefits equivalent to 7.1 percent, reflecting increased levels of charity care in the State overall from FY2010 to FY2011.

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.

GCMH documented its current licensure with the Maryland Department of Health and Mental Hygiene (expiration date of August 3, 2015) and accreditation status. It is accredited by the Joint Commission (accredited on May 3, 2012 for 39 months). GCMH is in compliance with the conditions of participation of the Medicare and Medicaid programs, using provider numbers 210017 for acute services and 215310 for sub-acute services.

As identified in the Maryland Hospital Performance Evaluation Guide for the period from October 2010 to September 2011, GCMH noted in its application that it has quality measure values equal to or greater than 90 percent for the majority of quality measures. However, four measures were identified as being in the bottom quartile with measure values less than 90 percent, as identified in the table below.

Table 8: Maryland Hospital Performance Evaluation Guide Garret County Community Hospital

Quality Measure	Hospital Performance 10/10-9/11	Hospital Performance 7/11-6/12	State Average 7/11-6/12
Heart Failure Measures			
<i>Giving full instructions at discharge</i>	71%	81%	92%
Performing LVF health function test	97%	100%	99%
<i>Giving the recommended ACE inhibitor</i>	NA	73%	97%
Giving smoking cessation counseling	NA	Discontinued	-
Immunization Measures			
Vaccination against pneumonia	New measure	97%	91%
Vaccination against influenza	New measure	94%	91%
Pneumonia Measures			
Giving vaccination against pneumonia	100%	Replaced	-
Performing emergency room blood culture	94%	98%	96%
Giving smoking cessation counseling	100%	Discontinued	-
Giving initial antibiotic within 6 hours	97%	95%	96%
Giving most appropriate antibiotic	94%	Discontinued	-
Giving influenza vaccine	98%	Discontinued	-
Surgical Care Improvement Project (SCIP)			
Received antibiotics 1 hour before incision	98%	99%	98%
Prophylactic Antibiotic Selection for surgical patients	100%	96%	98%
Antibiotic discontinued 24 hours after surgery	87%	86%	97%
Cardiac surgery 6am postoperative blood glucose	NA	NA	94%
Appropriate hair removal	100%	100%	100%
Urinary catheter removed on POD 1 or POD 2	New measure	78%	95%
Perioperative temperature management	New measure	99%	100%
Received beta-blocker during perioperative period	100%	97%	97%
Doctor-ordered treatments to prevent blood clots	89%	92%	98%
Blood clot prevention within 24 hours	89%	92%	97%

Source: MHCC Hospital Performance Evaluation Guide, July 2011-June 2012. Hospitals that reported 20 or fewer cases are shown as N/A.

At the time GCMH's application was submitted, GCMH fell within the bottom quartile and below a 90 percent level of compliance with four quality measures: (1) Heart Failure Quality Measure – Giving full instructions when you leave the hospital (71 percent); (2) SCIP Quality Measure – Prophylactic antibiotic discontinued within 24 hrs after surgery end time (87 percent); (3) SCIP Quality Measure – Surgical patients who received treatment at the appropriate time to help prevent blood clots (89 percent); and (4) SCIP Quality Measure – Surgery patients whose doctors ordered treatments to prevent blood clots (89 percent). GCMH submitted a list of actions it took to improve performance for these quality measure, listed below. (DI #2, Exhibit 8)

Heart Failure Quality Measure – Giving full instructions when you leave the hospital

- 1) Jan 2012-HF discharge instructions were reinforced at MSGA and ICU staff meetings with educational board, Core Measures results, documentation requirements, use of

Interdisciplinary Patient Education Record for HF, computerized HF discharge instructions, need to provide HF packet, updated cheat sheet titled Nurses Critical Reminder- Your Core Measures

2) Jan 2012-Updated cheat sheet placed on all in-patients charts titled- Physicians Critical Reminder-Your Core Measures.

3) Jan 2012-a laminated written guidelines for HF discharge instructions given to each nurse on MSGA and ICU.

4) Jan 2012-Utilization Management began concurrent paper reviews on HF patients

5) The discharging nurse is counseled when all discharge instructions for HF have not been completed.

SCIP Quality Measure - Prophylactic antibiotic discontinued within 24 hrs after surgery

1) Each fall out goes to physician peer review (surgical)

2) % is discussed at quality and medical staff committees

3) Jan 2012-Updated cheat sheet placed on all in-patients charts titled- Physicians Critical Reminder-Your Core Measures.

4) We have one surgeon that does not agree with this indicator and has not changed his practice of ordering antibiotics totally.

SCIP Quality Measure – Doctor-ordered treatments to prevent blood clots

1) Each fall out goes to physician peer review (surgical)

2) % is discussed at quality and medical staff committees

3) Jan 2012-Updated cheat sheet placed on all in-patients charts titled- Physicians Critical Reminder-Your Core Measures.

4) We do utilize a preprinted order form for VTE prophylaxis

5) The plan is for Utilization Management to begin concurrent paper abstraction of SCIP patients

SCIP Quality Measure – Surgical patients who received treatment at the appropriate time to help prevent blood clots

1) Each fall out goes to physician peer review (surgical)

2) % is discussed at quality and medical staff committees

3) Jan 2012-Updated cheat sheet placed on all in-patients charts titled- Physicians Critical Reminder-Your Core Measures.

4) We do utilize a preprinted order form for VTE prophylaxis

5) If the order was written, but not followed through, we investigate to see where the breakdown occurred and complete counseling appropriately.

6) The plan is for Utilization Management to begin concurrent paper abstraction of SCIP patients

For the latest year (ending June 2012) GCMH has improved to over 90% compliance on two of the measures for which it was in the bottom quartile for the year ending September 2011. It remains below 90% and in the bottom quartile for the other two measures for which it was in the bottom quartile at the time the application was filed. For one of these measures the Hospital improved from 71% compliant to 81% compliant. For the other measure it remained essentially the same with compliance in 86% to 87% range. In addition, GCMH is below 90% and in the

bottom quartile for two additional measures one of which it did not have enough reported cases during the prior reporting period, giving the recommended ACE inhibitor, and the other that is a new measure, urinary catheter removed POD 1 or POD 2.

GCMH has complied with this standard because it documented its efforts to improve performance. However, it needs to evaluate the effectiveness of the actions it took to improve performance on the two measures that did not improve to above 90% and to document actions to improve in the two new measures for which it was below 90% on the most recent update of the Maryland Hospital Performance Evaluation Guide. Therefore, staff recommends that the application be approved with the following condition.

At the time of its first quarterly report, Garrett County Memorial Hospital shall document any changes in the actions it is taking to improve performance on the two quality measures for which its performance was below 90% and in the bottom quartile for both the year ending September 2011 and June 2012 and it shall document the actions it is taking to improve performance on the two additional measures for which its performance was in the bottom quartile and below 90% in the most recent Maryland Hospital Performance Guide for the year ending June 2012.

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 is 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.

This standard does not apply to this project. No change in MSGA or pediatric beds are being requested by the applicant. This project will involve adding patient rooms to the hospital so that its current physical bed capacity will be distributed over a room inventory of mostly private rooms.

- (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. A new pediatric service is not being established.

- (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.

As for the requirements found in paragraph (b), this project doesn't involve reduction in the availability or accessibility of a facility or service.

With respect to paragraph (a), on July 6, 2012, GCMH submitted a request to increase its revenue cap to the Health Services Cost Review Commission ("HSCRC"). GCMH requested an increase in rates to account for the increase in capital costs associated with the proposed project. As detailed in Section I.B. of this report, the total cost of the project is approximately \$23.5 million of which \$15.0 million will be funded through debt. Depreciation and interest expense (i.e. capital costs) related to the Project are projected to equal \$2.2 million by FY2017. This cost will be phased in over three years as components of the project become operational in 2015, 2016, and 2017. After adjusting for unregulated Sub-Acute related costs of \$109,000, the total depreciation and interest for the project will equal \$2,112,803. As presented in GCMH's application to HSCRC, GCMH is requesting full funding of these costs. Applying GCMH's mark-up of 1.1256 results in gross revenue related to the project of \$2,378,171. The HSCRC approved the full request on February 6, 2013 as detailed in Appendix C.

GCMH's fully-adjusted Charge Per Case does not exceed the fully adjusted average Charge Per Case for its peer group, therefore, it is not required to document that its Debt to Capitalization ratio is below that of its peer group or that the age of the physical plant assets exceeds the average age of plant for its peer group. GCMH's charges compared to other non-urban, non-teaching hospitals in the State in 2011 were -6.58 percent, next to the lowest of its peer group statewide. Regarding the average age of the physical plant assets, the HSCRC no longer calculates this measure. However, it is worth noting that GCMH's response to this portion of this standard indicates that the majority of the physical plant to be renovated has been largely unchanged for thirty-two years, exceeding the standard capital depreciation period for health care facilities.

Based on the above, the proposed capital project will not have an unwarranted adverse impact on hospital charges, availability of services, or access to services.

(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.

Only paragraph (a) applies to this CON application as it is neither limited in scope nor intended to result in the establishment of a new hospital or relocation of an existing hospital to a new site.

According to GCMH, the primary objectives of the proposed project are to:

- update the Hospital's inpatient facilities, including MSGA and Intensive Care beds, to current best practice standards;
- address the ongoing challenges of the Surgical Suite overcrowding;
- improve workflow throughout the facility,
- maintain operations during construction, and
- minimize construction costs.

Secondary objectives to be addressed include:

- Family Centered Maternity Suite workflow challenges of managing laboring mothers and perinatal outpatient services,
- Information Systems Department centralization,
- Patient Financial Services overcrowding,
- Pharmacy expansion needs,
- Cafeteria/Dining Service efficiency enhancements, and
- Addition of an Assembly Area for education/meetings.

In the design phase of the project, three alternative approaches were considered by GCMH.

The first approach was to address only the MSGA Unit expansion within the current building, resulting in major renovations and the displacement of support services staff. This alternative would achieve six additional private rooms, allowing the conversion of six more semi-private rooms. The current building's space is fully occupied, therefore, the displacement of support services staff would require the moving of some staff offsite resulting in the need to build additional space at an alternate location. This alternative was "abandoned because the goal achievement was too limited and the logistical management of offsite support staff was undesirable given already existing challenges of minimized support staff needing to serve multiple functions in the small hospital setting." Additionally, the cost, detailed in the table below and roughly estimated at more than \$5 million, was deemed to be "extremely expensive" for a "limited solution" by the applicant. Moreover, GCMH notes that there would be additional costs for demolition of an existing house and preparation of the grounds for a support staff building on an alternate land site owned by the Hospital.

The second approach considered was to build a new hospital on an alternate site owned by GCMH. While this alternative would address all primary and secondary goals, a new hospital was estimated to cost approximately \$100 million and, therefore, not considered cost-effective.

The third alternative considered and the one chosen by GCMH is the additional wing expansion and major renovations to address all primary and secondary goals. This project "will make significant enhancements to the modernization of the inpatient facilities," allowing patient placement concerns including enhancing patient privacy, improving infection control management, and increasing patient satisfaction. This approach proposes major enhancements to the facility's inpatient units which have not been substantially improved for 32 years. The cost of this project at \$23.5 million is much more reasonable than the cost of a complete relocation of the Hospital.

GCMH has met the basic requirements of this standard by assessing the effectiveness of each alternative, comparing the capital cost of each alternative and explaining the basis for selecting the proposed alternative.

(6) Burden of Proof Regarding Need

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.

It should be noted that this project does not propose any new services not currently offered by the Hospital and no increase in the capacity of any existing service is proposed. The need to maintain the existing MSGA and pediatric capacities is covered by Regulation .05 of this Chapter and is addressed under standard B(2), Identification of Bed Need and Addition of Beds, COMAR 10.24.10.04B(2). The need for the proposed maintenance of the existing Obstetric capacity is addressed under the Review Standards for Obstetric Services, COMAR 10.24.12.04(1). GCMH is not proposing any changes to its Emergency Department and the

changes to the Surgery Department do not affect the operating rooms.

(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 requires a comparison of the project's estimated construction cost with an index cost derived from the Marshall Valuation Service ("MVS"). For comparison, the MVS cost index is based on the relevant construction characteristics of the proposed project. The MVS includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses including hospitals. Separate base costs are specified for basements and mechanical penthouses. The MVS guide also includes a variety of adjustment factors, including adjustments of the base costs to the costs for the latest month, the locality of constructions, as well as factors for the number of stories, height per story, shape of the building (such as relationship of floor size to perimeter), and department use of space.

GCMH developed an MVS benchmark cost for the new construction portion of the project (\$386.26 per SF). This benchmark included adjustments to account for the sprinkler system and the specific departments affected by the new construction (departmental differential cost factor), the shape of the building addition (relationship of floor size to perimeter), average floor height, current cost, and local costs. GCMH did not factor in a separate and lower basement square foot cost for the lowest level of the addition because the Hospital does not consider this floor to be basement space since significant portions of the floor will not be below ground and the floor will not be fit out like a basement with the space primarily used for a public dining room and public meeting space. GCMH then compared its estimated cost for construction adjusted for costs that the Hospital believes are not included in MVS costs or are higher do to extenuating circumstances, and determined that its estimated costs are less than the MVS benchmark for both renovations and new construction (\$367.15 per SF).

With respect to the renovation portion of the project, MVS cost figures in the calculator section typically used to develop the benchmarks are for new construction only. Therefore, the MVS benchmarks are typically much higher than the costs estimated by applicants for the renovation portion of projects. GCMH developed an MVS benchmark for the renovation portion of the project based on new construction with a comparable anticipated mix of departments in a building of comparable size and shape as the proposed renovations. In developing this

benchmark, GCMH first developed separate benchmarks for the basement and for the upper floors before combining them to calculate a single benchmark for comparison purposes. As expected, this benchmark, \$402.09 per SF, is much higher than the estimated costs, \$233.50 per SF.

Commission Staff has reviewed and recalculated the MVS benchmark for both the renovation and new construction. As expected, the benchmark for the renovation portion is much higher than the estimated costs.

With respect to the benchmark for the new construction, staff has accepted GCMH's point that a lower level that is substantially above ground should not be treated as a basement in the calculation of the MVS benchmark. Staff's recalculation resulted in some slight differences in adjustment factors and staff has updated the benchmark to February 2013. The result is a slightly higher benchmark of \$387.88 per SF, as calculated in the table below.

Table 9: Calculation of Marshall Valuation Service Benchmark for Garrett County Memorial Hospital Modernization Project

Construction Class/Quality	Class A/Good Quality
Number of Stories	4
Square Feet	20,286
Average Floor Areas (SF)	15,103
Average Perimeter (F)	578.38
Average Floor to Floor Height (F)	13.33
Base Cost per SF (Nov. 2011)	\$336.71
Adjustment for Dept. Cost Differences	1.059
Adjusted Base Cost per SF	\$356.58
Multipliers	
Perimeter Multiplier	1.017
Story Height Multiplier	0.965
Multi-story Multiplier*	1.005
Refined Cost per SF	\$351.70
Add-ons (Sprinkler System)	3.50
Refined Cost per SF plus add-ons	\$355.20
Update/Location Multipliers	
Update Multiplier (Feb. 2013)	1.05
Location Multiplier (Cumberland, Jan., 2013)	1.04
Final Benchmark MVS Cost per SF	\$387.88

Data Sources: CHC CON Application Chart 1 and Response to Completeness Questions, August 30, 2012 and Marshall Valuation Service®, published by Marshall & Swift/Boeckh, LLC

*Multi-story multiplier is .5% (.005) per floor for each floor more than three floors above the ground.

In comparing its estimated costs to the MVS benchmark, GCMH made adjustments for costs such as demolition, storm drains, rough grading, hillside foundation, paving, signs and landscaping that are explicitly excluded from the MVS calculator section costs. GCMH made adjustments for extraordinary costs that the Hospitals experts considered to be over and above

the costs captured by MVS calculator costs. These adjustments were for infection control attributable to the connection of the addition to the existing building, and a premium for the constricted site. Commission staff considers most of these adjustments to be reasonable. Staff did not accept the adjustment for paving because no such costs were identified on the application's Chart 1 and Staff also reduced the adjustment for demolition from the \$67,000 taken by the Hospital to the \$17,000 identified on Chart 1.

A comparison of GCMH's estimated cost for constructing the addition with adjustment described above to the MVS benchmark calculated by Commission staff is detailed in the following table.

Table 10: Comparison of Garret County Memorial Hospital's New Construction Budget to Marshall Valuation Service Benchmark

Project Budget Item	
Building	\$6,366,582
Fixed Equipment	40,000
Site Preparation	342,000
Architectural Fees	539,887
Permits	316,638
Capitalized Construction Interest	147,126
Total	\$7,752,233
Total Adjustments to Cost	505,997
Adjusted Total for MVS Comparison	\$7,246,237
Adjusted Project Cost Per SF	\$357.20
MVS Benchmark Cost Per SF.	\$387.88
Total Over (Under) MVS Benchmark	(\$30.68)

Data Sources: GCMH Response to Completeness Questions, August 30, 2012 and Commission Staff calculations

The standard requires that any rate increase proposed by the applicant hospital related to the capital cost of the project shall not include the amount of project construction costs that exceeds the MVS benchmark and those portions of the contingency allowance, inflation allowance and capital construction interest that are based on the excess construction cost. The construction cost is below the MVS benchmark. Therefore no adjustment to the construction costs for purposes of any rate increase request submitted to the HSCRC is necessary. HSCRC's approval of the rate request on February 6, 2013 included a provision that the approved adjustment to the Hospital's revenue cap is contingent on MHCC approval of the CON without material changes.

(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. Construction of non-hospital space is not proposed by GCMH.

(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 reported by GCMH, this project will extend the hospital's current MSGA space on the third floor of the existing building into the third floor of the new building. The total space for the newly built and renovated combined MSGA/pediatric unit with 32 beds will be 14,843 square feet, resulting in 464 square feet per bed. Thus, the project is consistent with this standard.

(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. GCMH is not a high-charge hospital, as discussed previously in COMAR 10.24.10.04B (4).

(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.

GCMH listed operational efficiencies for diagnostics and services at the facility. Two key objectives of GCMH's proposed construction and renovation project are to increase the amount of space available for providing patient care and improve patient privacy.

MSG A Unit

The proposed increase in private rooms in the Third Floor MSGA/pediatric unit from the current 10 rooms to 26 rooms will make patient placement easier and significantly decrease the amount of time and resources utilized in moving patients from one room to another. GCMH's MSGA/pediatric unit is a 32-bed unit with a current mix of ten private rooms and eleven semiprivate rooms. Patients admitted to this unit range in age from pediatric to geriatric. Six of the 32 beds are for progressive care, typically ICU step down or MSGA patients that require closer monitoring. The need for clinical isolation drives the occupancy of private rooms. Patients are admitted to isolation rooms due to an identified or suspected MDRO, suspected or confirmed influenza, suspected or known infectious diseases, or because they are immune-compromised. Appropriate patient room placement must also take gender, diagnosis, and nursing care needs into consideration, so nursing staff frequently have to move patients from one patient room to another to accommodate new admissions. When near capacity, GCMH reports that it is not uncommon to move three patients for one new admission.

Since more than 65 percent of GCMH's patient admissions originate in the Emergency Department, difficulties and logistics associated with moving patients to accommodate new admissions on the third floor impacts patient flow in the Emergency Department (ED). While the nursing staff are working to find clinically and gender-specific compatible roommates for existing patients, newly admitted patients coming from the ED must remain in that department until their bed is ready for occupancy. Moving patients creates increased workloads for nursing, housekeeping, registration, and the pharmacy departments and is an inconvenience for the patient and their family.

The addition of a third nurses' station will improve efficiencies in staffing and patient assignments. The current nurse staffing plan for the unit utilizes three teams. One of the three teams has a split room assignment with patient rooms located geographically in-between the two existing nurses stations. The addition of a third nurses' station improves the geographic layout of the unit so that each nursing team can work from their own decentralized nurses' station and in closer proximity to the patient rooms. The additional nurses' station will improve medication administration and medication cart security by providing a specifically designed and dedicated space to store the medication carts and will remove them from being stored in the unit's corridor. It will also reduce the amount of congestion in these areas eliminating the need for the staff to work out of two medication carts. The renovation of the Third Floor nursing unit will improve existing linen, and supply storage; decrease the need for off-unit storage of essential patient care equipment; and re-locate the existing nutrition station and ice machine out of the open corridor and into an enclosed area away from the public. The proposed renovation of the two existing nurses' stations will provide an opportunity to re-design the space to more adequately address the increased number of computer monitors and new (existing) nurse call system.

Intensive Care Unit

The renovation and expansion of the ICU will increase the overall square footage of the unit from 1,667 SF to 3,676 SF, facilitating a number of improvements that will have a positive impact on efficiency. By enlarging the unit, GCMH will be able to increase storage space, consolidate like-use supplies into one area, and improve the control of par levels and the ability to maintain an accurate accounting and adequate level of supplies. This will lessen the amount of time nurses spend traveling in and out of the unit to get equipment and supplies and allow them more time for patient care.

The enlarged unit will include larger patient rooms to enhance bedside care and facilitate workflow including patient transfers and responses to emergencies. Today, ICU nurses must provide bedside care while working across and around cords, wires, tubing, and equipment while trying to do their best to avoid disconnecting an essential piece of equipment or tripping over a misplaced cord on the floor. When the ICU patients are transferred, all equipment must be moved in order to get a transfer cart in and out. When there is a “code blue” (i.e. cardiac arrest, respiratory arrest) in the ICU, the small patient rooms become even more limiting because the existing rooms do not allow for more than a few caregivers to be at the bedside. This forces other members of the resuscitation team to stand at the patient’s doorway and around the area. This overflow of additional staff into the unit causes congestion and noise, effects patient privacy, and can impede access to visitors of the other ICU patients.

The larger ICU will also have larger patient bathrooms. The existing ICU patient bathrooms are extremely small and do not include patient showers or a sink. Often patients opt to use bedside commodes rather than attempting to ambulate to the bathroom through the myriad of equipment situated between the bed and bathroom doorway.

The existing configuration of the ICU nurses station accommodates only two people. Its redesign will improve workflow by increasing the space available for nursing and physician documentation, improving the space dedicated to medication storage and preparation. As the hospital moves forward to computerized physician order entry, it becomes even more imperative that we have adequate space for the medical staff to facilitate compliance.

Surgery Storage Space

The Surgery Department will be expanded by approximately 2,700 SF primarily involving additional storage space with the goal of eliminating the need to travel to storage locations outside the surgical suite. The existing surgical suite was constructed in 1980. Since that time there have been significant advances in surgical technology and its associated equipment, outgrowing the original storage space. Alternative locations are currently used for storage outside of the surgical unit. In addition, the amount of specialized surgical supplies has proliferated so that closets and small work rooms have to be used for storage within the clean core. Frequently utilized equipment, such as the fracture table, surgical case carts, and the emergency resuscitation carts are stored along one side of the clean corridors because regulations require that surgical supplies be stored in areas that are temperature and humidity controlled.

Renovating existing hospital space to expand surgical storage will improve efficiency through consolidation of equipment and eliminate the need to travel to the storage locations out of the surgical suite. An increase in storage space will decrease the likelihood of having to discard costly supplies because the hospital was unable to guarantee that they had been maintained in temperatures and humidity as required. Being able to store equipment directly adjacent to the operating rooms will decrease the amount of time nurses spend transporting equipment between the two areas.

Obstetrical Unit

Within the OB unit, in addition to the LDRP rooms, the Hospital has one post partum semi-private patient room. This room is small and shares many of the problems related to space as the semiprivate MSGA rooms. Because GCMH's standard practice is to encourage rooming-in, there are additional limits and concerns related to keeping a basinet in the room during open visiting hours. When two post-partum patients occupy this room, there is not adequate space to accommodate a side chair for each patient along with two bassinets.

The nursing staff struggles to maintain privacy for each patient. The presence of visitors for either or both patients makes the situation worse. Maintaining privacy is a challenge when mothers breastfeed because of the narrow space between beds. When mothers assigned to this room go to the bathroom, the nursing staff must ask visitors to step outside to help protect patient privacy. Moreover, the bathroom does not have a shower. Therefore, patients must be escorted to a shower located outside of their room. This practice is not in compliance with the most recent standards of the American College of Obstetrics and Gynecology. The additional space will provide a safer environment for the patient and staff.

On the OB unit, semi-private patient rooms also impact patient placement. OB has the same issues as the MSGA unit in relation to moving patients, room turnover, patient flow, increased workload, laundry usage, and patient inconvenience. In OB, the family waiting area is located directly across from a patient room and can be an area of increased activity and noise and makes it difficult for the patient to rest. As noise levels and activity increase so does the nursing staff time involved in trying to control noisy visitors, reducing time for patient care.

There is also no dedicated space within the unit to serve OB outpatients' scheduled or unscheduled procedures such as non-stress tests. If there are no empty patient rooms available, the nursing staff looks for alternative locations to accommodate the patient.

Sub-Acute Unit

The increase in private rooms will decrease the amount of time and resources spent transferring patients between rooms to accommodate isolation patients and compatible roommates. Currently, one patient room is equipped with a private shower. Patients in the remaining rooms must shower in a centralized shower room. The new design will provide a patient shower for each room. This will decrease the amount of time the staff spends transporting patients to the central shower as well the amount of staff time and supplies utilized to clean the shower between patients.

The doors on the existing bathrooms are narrow. They will accommodate a wheelchair but not the patient recliners used on this unit. Most of the patients require assistance in getting to the bathroom. This results in the staff transferring patients from the recliner to a wheelchair and reversing the process for toileting activities. The new bathrooms will be larger in size and the doorways will be increased to provide an easy exit from the recliner to the bathroom, saving nursing time.

The current nursing station is small and has no separate medication room. The dining room and activities room are located at one end of the unit, and the physical therapy gym is outside of the unit. The renovation plan will reconfigure and group the nursing station, the dining room, activities room, and physical therapy gym to a more centralized location. This improves efficiency by consolidating these services within close proximity and makes sharing staff between these functions easier. The design of the new nurses' station will be open and have a separate medication room. The addition of a separate, lockable medication room will allow the nurse to prepare for medication administration without interruptions.

The current unit design requires that equipment is stored off the unit. The proposed renovation of this area will increase storage space and will decrease the amount of time spent traveling in and off the unit to get needed supplies.

Regarding sustainable building practices, the improvements across many departments in this project are done with the idea of sustaining the existing hospital facility. GCMH intends to utilize best practices for incorporating sustainable elements into the project.

While Commission staff would have preferred that GCMH quantify some of its project's operational efficiencies, the applicant has demonstrated that the project will achieve reasonable operational efficiencies. The applicant is consistent 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.

GCMH states that the National Patient Safety Goals (NPSG) serve as the foundation for its Patient Safety Program. The 2012 NPSG include improving staff communication, medication safety, and prevention of infections. In addition, GCMH implements rules to ensure correct patient identification and reduce patient falls. The Hospital's proposed plans for renovation and expansion address these elements.

The elimination of semi-private rooming or a significant increase in the number of private patient rooms reduces the risks of misidentifying patient that relocation creates. Because of the lack of private rooms, especially on Third Floor, GCMH must move patients from one room to another to accommodate new admissions. A change in patient placement requires

notification or changes in processes related to registration, patient care assignments, medication administration, and documentation. A failure to carry out proper notification of all parties could potentially result in medication errors, transcription errors, and/or wrong patient events.

Poor communication is a major cause of medical errors. Patient room changes can generate a change in nursing assignments. A misstep or failure to pass along critical test results, medication history, or outcomes of treatments could result in gaps in patient care and failures in patient safety. An increase in the number of private patient rooms will help to reduce the number of patients that need to be moved, improve patient placement, and reduce communication errors.

Regarding patient falls, the Center for Health Design categorized four environmental factors that have an impact on patient falls: spatial organization, interior characteristics, sensory attributes, and use of the environment. The study identified ways to mitigate the risk of patient falls, including increasing visual access to patients, locating high risk patients near the nurses' station, and using decentralized nurses' stations. GCMH's proposed plan for new construction and renovation of existing space will increase the number of nurses' stations on the third floor and relocate and redesign the nurses' stations to improve patient visualization in OB. The increased number of nurses' stations on third floor will also result in a corresponding increase in the number of patients rooms located in close proximity to a nurses station. The existing nursing station on OB is enclosed and does not provide good visualization of the patient rooms. The relocation and redesign of the OB nurses' station will create an open nursing station that is centrally located, and will improve the visibility of the patients and visitors.

The Center for Health Design also cited poorly designed bathrooms as a risk factor for increased patient falls. GCMH plans to evaluate its existing patient bathrooms in terms of adequate space and interior characteristics such as floor surfaces, transitions between floor surfaces, lighting, and visual contrast. The location of patients' room furniture, an unobstructed pathway to the bathroom, the use of night lights, and uncluttered floor space will be considered. The Hospital has a small number of patient rooms that are not equipped with a sink for the bathroom and separate hand washing sink and not all patient rooms have night lights. Newly constructed patient rooms and renovated patient rooms will be configured with the goal of optimizing the placement of patient room furniture so that it is in close proximity to bathrooms and provides adequate space around the patient's bed for delivering care.

Furniture placement in GCMH's semi-private rooms makes it difficult to have a clear pathway because numerous, but necessary pieces of treatment equipment clutter limited floor space. This puts the patients, visitors, and staff at an increased risk for falls. The Hospital plans to do an assessment of sensory attributes such as patient room lighting levels, noise levels, color schemes, and surface finishes. The Hospital will investigate new measures such as incorporating a video surveillance system for patients at high risks, night lights, and acuity adaptable patient rooms to further reduce the need for intra-unit room transfers.

Regarding preventing infection, the primary source of hospital acquired infections is personnel who move from patient to patient, often carrying medical equipment. The proposed increase in the number of single-bed patient rooms makes the spread of infection less likely

because patients and their visitors do not share space with other patients. The most effective way to reduce risk of transmission is by increasing the functional distance between patients.

Hand washing is the single most important measure to reduce the risk of transmission of infectious microorganisms from one person to another. New guidelines call for a separate sink for hand washing and toilet facilities. With this project, a dedicated hand washing sink will become a standard for each patient room. With the new patient unit designs, the Hospital's Infection Control Practitioner, hospital staff, and physicians will be asked to provide input into the location for new alcohol-based hand cleaner dispensers.

In order to minimize risk to our patients, staff, and visitors, GCMH will maintain an Infection Control Risk Assessment Plan (ICRA) during all phases of the construction project, developed by a multi-disciplinary team led by our infection control practitioner. The group will develop specific recommendations for the containment and control of transmission of air and waterborne biological contaminants. The ICRA will also include input from the infection control practitioner in regard to the design of certain aspects of the project such as hand washing sinks, isolation rooms, and selection of materials for ability to clean and resistance to bacterial and fungal growth.

Regarding medication safety, the Agency for Healthcare Research and Quality has found that noise can be a serious health hazard and threat to patient safety and performance. The World Health Organization found noise interferes with communication, creates distractions, affects cognitive performance and concentration, and causes stress and fatigue in patients and healthcare workers. Mental activities that demand concentration are particularly sensitive to noise and lead to a degradation of performance. Other studies have determined that medication administration is negatively affected by noise and distractions. GCMH will address noise by choosing building materials such as sound absorbing ceiling tiles, the use of carpeting, increased insulation between patient rooms, and quiet engineered mechanical systems.

Regarding medication errors, the process of transferring patients between rooms or units could cause delays in timely medication administration, miscommunication, discontinuities between staff, and a loss of crucial information. An increased number of single bed rooms will significantly decrease room-to-room transfers. Moreover, active participation by patients and their families or significant others in the patient's care can improve medication safety. The increase in single-patient rooms with more space will assist in making this available. (DI #11, pp. 12-15)

The applicant has demonstrated that design of its project took patient safety into consideration and that it 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.

With respect to subsection (i), MSGA utilization projections are consistent with historic use trends. MSGA discharges from GCMH have declined at an average annual rate of 1.8 percent since 2005. GCMH is projecting an annual rate of decline of 1.9 percent from 2012 to 2018. GCMH is projecting a decline in OB patients at an average annual rate of 1.9% compared to an historic growth rate of 4.0% from 2005 through 2011. While a decline in OB admissions is consistent with projected changes in the female population 15 to 44, the projected rate of decline is faster than that suggested by the projected decline in the female population 15 to 44. The Maryland Department of Planning is projecting this population group in Garrett County to decline at an annual rate of 0.5% from 2010 through 2020. Given these facts, the utilization projections may be conservative.

With respect to subsection (ii), revenue estimates are consistent with utilization projections and are based on current charge levels and rates of reimbursement adjusted for the rate request filed and approved by the HSCRC (see Appendix C), contractual adjustments and discounts, bad debt, and charity care provision, as experienced by GCMH.

With respect to subsection (iii), staffing and overall expense projections are consistent with utilization projections and are based on current GCMH expenditure levels and reasonably anticipated future staffing. GCMH projects that a net change of 0.3 additional full time equivalent employees (FTEs) will be needed, with increases in plant operations and housekeeping staff due to the increase in the size of the physical plant, and decreases in medical staff due to lower patient volumes by 2018. (DI #11, p. 69)

With respect to subsection (iv), GCMH can reasonably project an ability to generate

excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), at the projected utilization, which appear conservative, given the increase in rates approved by the HSCRC.

Financial viability of the project is addressed under the Financial Viability review criterion, COMAR 10.24.01.08G(3).

The proposed project is consistent 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.

This standard is not applicable because the project does not propose to expand ED services at GCMH.

(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 because the project does not propose to expand ED services at GCMH.

(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.

This standard is not applicable. The project does not propose construction of permanent shell space. GCMH explained that some areas are designated as temporary shell space during the construction phase to allow for phasing of the project.

COMAR 10.24.12.04 – Review Standards for Obstetric Services

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. This chapter of the State health Plan applies to this application because GCMH is proposing to relocate some of its OB service to newly constructed space and to locate the remainder of its OB service in renovated space. Standards (1) through (6) apply to all applicants. Standards (7) through (14) apply only to applicants for a new perinatal service. Standard (15) only applies to applicants with an existing service. Since this application includes the location of an existing serve in new and renovated

space, standards (7) through (14) are not applicable. Standards (1) through (6) and standard (15) are applicable.

(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 hospital inpatient obstetric services states that the burden of proof for demonstrating need for additional obstetric program capacity 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 that 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. The State Health Plan chapter for acute hospital inpatient obstetric services does not include a bed need methodology.

GCMH does not propose an addition to obstetric program capacity. The proposed departmental changes are based on a need to modernize facilities to enhance patient quality and experience. The additions and renovations to this department will improve patient and family safety, privacy, and comfort. The proposed project includes relocating two semi-private patient rooms to new larger rooms on the second floor of the addition; renovating and reconfiguring spaces in the existing unit to coordinate with the new addition; repurposing current unit functions into different unit functions; and expanding departmental space into existing sub-acute unit space, which is unneeded. (DI # 20, p. 1)

Staff reviewed Garrett County’s projected population estimates and GCMH’s historical discharge trends. The population of women most likely to bear children has declined since 2000 and is not projected to reach 2010 levels by 2030, hovering around a population of 5,000.

Table 11: Garrett County Population Estimates, Females 20-44, 2010-2040

Year	2000	2005	2010	2015	2020	2025	2030
Females 15-44	5,934	5,512	5,243	5,026	4,972	5,076	5,106
Five-year % change		-7.1%	-4.9%	-4.1%	-1.1%	2.1%	0.6%

Source: Maryland Department of Planning.

As shown below, Staff also reviewed GCMH’s historical OB use and found that the average daily census since 2005 has been 2 patients or fewer. However, Staff also found that in 2011 the hospital had a maximum daily census of five patients on one day and four patients on several other days, according to HSCRC’s discharge abstract data. This does not include any patients who stayed for less than one day.

**Table 12: Garrett County Memorial Hospital OB Discharges,
Patients Days and Average Length of Stay, 2005-2011**

Year	2005	2006	2007	2008	2009	2010	2011	Average annual growth rate since 2005
Discharges	257	304	338	296	333	297	312	
% Change from Prev Yr		18.3%	11.2%	-12.4%	12.5%	-10.8%	5.1%	4.0%
Total Days	514	633	741	589	668	522	526	
% Change from Prev Yr		23.2%	17.1%	-20.5%	13.4%	-21.9%	0.8%	2.0%
ALOS	2.0	2.1	2.2	2.0	2.0	1.8	1.7	
Average Daily Census	1.4	1.7	2.0	1.6	1.8	1.4	1.4	

Source: MHCC analysis of HSCRC discharge abstract data, Calendar Year 2005-2011.

While the proposed nine bed capacity does not appear to be justified by recent and projected utilization, the proposed capacity equals the current capacity and the five patient rooms enable GCMH to generally accommodate all OB patients in private rooms. In addition, GCMH pointed out that given its location with the nearest hospital one hour or more away, it must be able to accommodate all laboring mothers that present¹ and that, on occasion, this has required the placement of two mothers in one room. The Hospital has also pointed out that there is no dedicated space for OB outpatient visits. For these reasons Staff concludes that it is reasonable for GCMH to maintain the nine-bed OB capacity, considering that the inventory includes only five patient rooms, one private room and four semi-private rooms, and no changes in bed capacity have been proposed in this project.

(2) The Maryland Perinatal System Standards

Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center .

GCMH has a Level I perinatal center. The Hospital submitted a self assessment tool used by Dr. Lee Woods of the Maryland Department of Health and Mental Hygiene on October 24, 2012. The self assessment tool demonstrates that GCMH is in compliance with all essential requirements of a Level I program. The applicant complies with this standard.

(3) Charity Care Policy

Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

- (i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);*
- (ii) posted notices in the admissions office, business office and emergency areas within the hospital,*
- (iii) individual notice provided to each person who seeks services in the hospital at the*

¹ Laboring mothers are not counted in the discharge abstract data until admitted

time of community outreach efforts, prenatal services, preadmission, or admission, and

(iv) within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the facility must make a determination of probable eligibility.

(b) Public notice and information regarding a hospital's charity care policy shall be in a format understandable by the target population.

GCMH reports that it “has a ‘Caring Program’ that enables the hospital to offer financial assistance for the healthcare services rendered to underprivileged, underemployed, and/or underinsured patients who have difficulty providing themselves with food, clothing, shelter, and healthcare.” GCMH provided its written policy for the provision of charity care for indigent patients.

GCMH's policy states that it posts an ad in the local newspaper informing residents of the availability of its financial assistance program and that it posts signs in all registration areas and in the reception area of the Patients Financial Services Department. (DI # 20, Exhibit 2, p. 29) Contact persons and phone numbers are provided for patients to inquire about eligibility. The Hospital's policy states that notification of charity care availability is posted in all patient registration areas and is in the Patient Handbook and that probable eligibility determination will be given to the applicant within two business days of the patient's request. (DI #23, p. 8)

(4) Medicaid Access

Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service area, and

(b) the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

GCMH's financial assistance program requires an assessment of Medicaid eligibility is for all patients, including obstetric patients, who are in need of financial assistance. There are approximately 6,500 medical assistance recipients in Garrett County. There are seven family medicine physicians with admitting privileges at GCMH that serve obstetric patients.

The applicant complies with this standard.

(5) Staffing

Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post-partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes.

GCMH provided the number and type of FTEs and expenses for the existing and proposed obstetric unit. The application materials state that the family medicine physicians with

obstetric privileges at GCMH belong to two independent practitioner groups and are employees of GCMH. GCMH projects a slight decrease in staffing for the obstetric unit. (DI #20, p. 2)

**Table 13: Existing and Projected Staffing,
Garrett County Memorial Hospital's Obstetric Unit**

	Existing FTEs	2017 FTEs Projected
Nursing/nursing assistants	14.1	13.8
Labor cost	\$738,481	\$727,510
Benefits	279,146	\$283,089
Total	1,017,627	\$1,010,599

Source: Based on information provided by Garrett County Memorial Hospital, DI #20, p. 2.

The applicant complies with this standard.

(6) Physical Plant Design and New Technology

All applicants must describe the features of new construction or renovations that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

GCMH states that the National Patient Safety Goals (NPSG) serve as the foundation for the hospital's Patient Safety Program. The 2012 NPSG include improving staff communication, medication safety, and prevention of infections. In addition, GCMH implements rules to ensure correct patient identification and reduce patient falls.

The proposed project will relocate and redesign the nurses' stations to improve visualization of patients' rooms, create a new open nursing station that is centrally located, and improve the visibility of entry of visitors. Renovations will help resolve issues due to poor furniture and equipment placement. The facility will assess room lighting and noise levels. Patient safety will be a consideration in color scheme and surface finish choices, as well as the possibility of video surveillance, night lights, and adaptable patient rooms.

The applicant complies with this standard.

(7) Outreach Program

Each applicant with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B.

GCMH's Family Centered Maternity Suite staff operate a 24/7 Parent Hot Line. This hotline is available to parents-to-be and new parents to provide guidance with questions or concerns related to pregnancy, delivery, recovery, children, and breastfeeding. The FCMS staff works with physicians to determine appropriate advice and when to direct a caller to a physician or emergency room for immediate attention. (DI #20, p. 5)

GCMH also collaborates with the Garrett County Health Department on outreach

programs that target the uninsured, underinsured, and indigent patients in the community. Much of the content of these programs is geared toward proper prenatal care, prevention of low birth weights, and infant mortality. (DI #20, p. 32)

The applicant complies with this standard.

B. 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 need criterion requires the Commission to consider the applicable need analysis in the State Health Plan (“SHP”). Where there is no need analysis, the Commission is required to consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs. Staff has already considered the applicable bed need analysis in the SHP applicable to MSGA beds and Pediatric beds under standard B(2), Identification of Bed Need and Addition of Beds, COMAR 10.24.10.04B(2). The need for the proposed maintenance of the existing Obstetric capacity is addressed under the Review Standards for Obstetric Services, COMAR 10.24.12.04(1). GCMH is not proposing any changes to its Emergency Department and the changes to the Surgery Department do not affect the operating rooms.

While this criterion has primarily been applied to the need for increases in bed capacity and specific service capacities such as ED treatment rooms and space and operating rooms, as detailed above, Commission staff interprets this need criterion more broadly to include the need to expand and modernize health care facilities such as GCMH. In the case of the proposed project this includes the need to modernize the Obstetrics unit, the ICU, and the need to modernize the MSGA nursing unit including the need to increase the number of private patient rooms.

The SHP does not include a specific analysis of the need to modernize nursing units or for that matter a specific analysis of the need for private patient rooms. However, the SHP does state that “CON regulation should assure that facility designs reflect the state-of-the-art in facilitating safer patient care, improving patient outcomes, and minimizing negative environmental impacts.”² The SHP also recognizes that hospitals continue to reconfigure themselves and that this reconfiguration often includes a “strong emphasis on meeting the perceived market demand for private patient rooms and more technologically sophisticated space for the delivery of inpatient services to a patient population that is, on average more acutely ill.”³ Beyond the SHP’s recognition of the strong emphasis on private rooms, the Facility Guidelines Institute (“FGI”) guidelines⁴ call for private rooms in new construction unless the functional program demonstrates the value of a multiple-bed arrangement.

² State Health Plan for Facilities and Services: Acute Care Hospital Services, page 7

³ Ibid, page 7

⁴ Facility Guidelines Institute, Guidelines for Design and Construction of Health Care Facilities, 2010 edition

The need to modernize GCMH is especially critical because of its age and its role as the center for health care in the community. The Hospital states that there are no free standing health care facilities, such as surgical, urgent care, or freestanding laboratory or imaging centers, in Garrett County. Therefore, the Hospital continues to “physically contain many of the services that more urban hospitals have either lost or relocated to off campus outpatient settings over time.” As a result of how health care delivery has changed since the Hospital was built more than thirty years ago, the following have occurred:

- Inpatient care delivery has changed, including more demand for patient privacy and safety. Private inpatient rooms help solve the problems of limited privacy and cross contamination associated with semi-private rooms. Currently, GCMH’s only inpatient general MSGA and Pediatric unit currently contains 32 total beds, only ten of which are private rooms. Semi-private rooms can inhibit physician/patient candor and clinical discussions and create infection cross contamination risks, not to mention interrupted patient rest and recovery. Finally, semi-private rooms can make patient placement difficult, particularly given patient gender and age differences, particularly in a facility, such as GCMH, with a relatively small number of licensed beds.
- According to the applicant, GCMH operates two-bed semi-private inpatient rooms built in the 1960’s consisting of 237 square feet. Today’s industry standard for a single bed inpatient room is 230 square feet, which is nearly the same size as the old semiprivate room. This becomes particularly problematic when the patient requires postoperative traction equipment, has multiple IV infusion pumps or monitoring equipment devices. The Hospital notes that it has purchased shorter patient beds and moved patients to new rooms when their condition exceeds the room’s physical capacity, stressing the patient, their family, and the Hospital staff.
- Additionally, the improvements will rid the hospital of an overflow hallway bed in the obstetrics department, and enlarge the Intensive Care Unit patient rooms to avoid having to move the bedside toilet out of the room in order to access equipment and other unacceptable care delivery inefficiencies.
- Upgraded health care facilities often enhance patient care and outcomes, improve efficiencies and increase staff satisfaction and retention.

Patients can choose to travel to Cumberland, Maryland or Morgantown, West Virginia to seek inpatient care in a more “modern” facility. However, the potential private vehicle or ambulance transport alone for the approximate one-hour trip to either location would add significant unnecessary private transportation costs or charges to the patient’s healthcare bills, which may be cost prohibitive for area lower-income residents. Additionally, in terms of charge to patient, Garrett County Memorial Hospital has historically remained one of the lowest cost hospitals in the state. GCMH’s cost will increase somewhat, but the applicant states that the enhanced benefits to the patient quality and experience will be of greater significance. Commission staff agrees with GCMH’s assessment of the need for this project.

Staff finds that the GCMH has demonstrated the needs of the population it serves for the facility modernization contemplated by the proposed project.

C. COMAR 10.24.01.08G(3)(c) 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.

GCMH is the sole provider of inpatient services in Garrett County and surrounding areas. There are no alternative existing facilities at which the services described in the application could be provided, and there were no competitive applications submitted. GCMH is a significant distance from the nearest regional health facilities in Cumberland, Maryland and Morgantown, West Virginia, which are approximately 60 miles and 60 minutes away.

As previously outlined in the discussion of COMAR 10.24.10.04(B) (5), the Project Review Standard for Cost-Effectiveness, the applicant described its operational objectives and the project alternatives considered, including the reasons for their rejection in favor of the proposed project. The criteria used to assess alternatives included factors affecting capital cost and ability to address facility needs. Commission Staff concluded that the applicant conducted a reasonable assessment of alternatives and selected the best overall option for meeting its key objectives.

Based on the above staff finds that there are no cost effective alternatives to the proposed project.

D. 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.

Availability of Financial Resources

GCMH provided audited financial statements for the Hospital and its Subsidiary for June 30, 2011 and 2010, including not only GCMH but also its subsidiary, Professional Emergency Physician Services, LLC. There are combining statements near the end of the audited financial statements that present GCMH separately, but for FY 2011 the Subsidiary had a relatively small negative impact on the overall corporate entity. No consolidating statements were included for FY 2010.

As presented in Part I.B. of this report, the most significant source of funding for the project costs is \$15 million of debt issued through Garrett County. GCMH states that it has obtained tax-exempt bond funding through the County government in the past. (DI #2, p. 31) A bond bill (Senate Bill 369) was introduced by Senator George Edwards on January 25, 2013 to permit Garrett County to issue bonds of up to \$15 million to finance the cost of hospital improvements in Garrett County.

The other sources of funding for the project are \$7.5 million of GCMH’s cash reserves and \$1 million in fundraising. As presented in GCMH’s 2011 audited financial statements, GCMH has over \$24 million of cash, short-term investments, and long-term investments to provide this funding. While GCMH does have some short-term investments and long-term investments whose use is limited, the project funding of \$7.5 million – or potentially \$8.5 million due to timing delays of fundraising efforts if pledges are made over a multi-year period – will come out of GCMH’s short-term Certificates of Deposit, with a current value of approximately \$14 million, according to the applicant. These funds reportedly are not limited by donor or by the Board of Governors, which is substantiated by the financial statements. Current long-term debt less the current portion is about \$3.7 million and its pension liabilities are \$6.2 million.

Recent Financial Performance

Recent operational results for GCMH and its HSCRC Peer Group 2 are summarized below:

Table 14: Financial Performance, Garrett County Memorial Hospital, FY 2009 – FY 2011

	Fiscal Year		
	2011	2010	2009
Garrett County Memorial Hospital			
<i>REGULATED OPERATIONS</i>			
Net Operating Revenue	\$32,531,219	\$32,921,208	\$31,369,000
Net Operating Profit	\$2,237,587	\$3,800,143	\$1,581,406
Operating Margin	6.88%	11.54%	5.04%
<i>REGULATED AND UNREGULATED OPERATIONS</i>			
Net Operating Revenue	\$37,945,816	\$39,084,669	\$37,539,024
Net Operating Profit	\$1,892,131	\$4,474,553	\$1,911,618
Operating Margin	4.99%	11.45%	5.09%
PEER GROUP COMPARISON			
<i>REGULATED OPERATIONS</i>			
Average Operating Profit Margin	7.09%	5.96%	5.89%
Median Operating Profit Margin	6.86%	5.97%	5.61%
<i>REGULATED AND UNREGULATED OPERATIONS</i>			
Average Operating Profit Margin	2.72%	1.86%	2.15%
Median Operating Profit Margin	2.85%	1.75%	2.17%

Source: MHCC analysis of HSCRC’s Disclosure of Hospital Financial and Statistical Data, Fiscal Years 2011-2009.

As indicated in the above table, net operating revenues of regulated operations were between \$31 million and \$33 million for GCMH between 2009 and 2011. In 2011, GCMH’s regulated and unregulated net operating margins were above its peer group averages medians, and the hospital’s regulated net operating margin for 2011 is in line with its Peer Group median.

**Table 15: Selected Financial and Operating Indicators
(Regulated and Unregulated)**

Maryland Hospitals – Statewide Average			
Year	Regulated Operating Margin	Regulated & Unregulated Operating Margin	Excess Margin
2011	6.94%	2.45%	4.81%
2010	5.29%	1.56%	2.89%
2009	4.38%	0.75%	-0.80%
Peer Group Average			
Year	Regulated Operating Margin	Regulated & Unregulated Operating Margin	Excess Margin
2011	7.09%	2.72%	5.06%
2010	5.96%	1.86%	3.13%
2009	5.89%	2.15%	0.91%
Garrett County Memorial Hospital			
Year	Regulated Operating Margin	Regulated & Unregulated Operating Margin	Excess Margin
2011	6.88%	4.99%	7.25%
2010	11.54%	11.45%	12.53%
2009	5.04%	5.09%	4.36%

Source: MHCC analysis of HSCRC's Disclosure of Hospital Financial and Statistical Data, Fiscal Years 2011-2009.

The table above profiles the financial performance of the Hospital as reported in audited financial statements. In 2011, GCMH reported a healthy operating margin of 6.9 percent, exceeding the HSCRC target value of 2.75 percent. In the same year the excess margin (5.1 percent) also exceeded HSCRC's target of 4 percent.

Projected Financial Performance

The applicant has provided projected financial results through 2018 that assumed HSCRC approval of its requested revenue cap increase:

**Table 16: Projected Financial Performance (\$000s)
Garrett County Memorial Hospital**

	Actual		Current Projected	Projected					
	2010	2011	2012	2013	2014	2015	2016	2017	2018
Gross Patient Revenue*	\$45,793	\$45,819	\$47,616	\$48,281	\$48,288	\$49,109	\$49,904	\$50,743	\$50,755
Allowance For Bad Debt	\$1,468	\$1,273	\$1,833	\$1,858	\$1,858	\$1,890	\$1,921	\$1,953	\$1,953
Contractual	\$5,218	\$6,249	\$6,069	\$5,411	\$5,414	\$5,497	\$5,578	\$5,657	\$5,661
Charity Care	\$2,260	\$2,766	\$2,875	\$2,915	\$2,915	\$2,965	\$3,013	\$3,063	\$3,064
Other Revenue	\$782	\$777	\$778	\$778	\$778	\$778	\$778	\$778	\$778
Net Operating Revenue	\$37,629	\$36,308	\$37,617	\$38,875	\$38,879	\$39,535	\$40,170	\$40,848	\$40,855
Operating Expenses	\$33,114	\$34,333	\$36,642	\$36,663	\$37,162	\$38,442	\$39,193	\$40,059	\$39,944
Income from Operation	\$4,515	\$1,975	\$975	2,212	\$1,717	\$1,093	\$977	\$789	\$911
Operating Margin	12.25%	5.56%	2.65%	5.81%	4.51%	2.82%	2.48%	1.97%	2.27%

Source: Garrett County Memorial Hospital, DI #2, Exhibit 18.

*Inpatient and outpatient revenue combined.

Project related interest, depreciation and amortization are projected to be \$2,225,000 in FY 2017. GCMH's operating margins are expected to remain positive throughout this project.

On February 6, 2013, HSCRC approved GCMH's request for a revenue cap increase, increasing the hospital's rate charging capacity to cover the capital expense impact of this project. The approval will provide the Hospital with a total increase in its revenue cap of \$2,378,171 in three annual installments beginning July 1, 2014 provided the assets are available for use at that time. With the approval of this rate increase request, HSCRC Staff believes the project is financially feasible. (See AppendixC)

The proposed project is considered to be financially feasible and GCMH is considered financially viable.

E. 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.

GCMH received a CON in July 1996 to establish a 10 bed sub-acute care unit within existing hospital space. Commission staff has not identified any instances of non-compliance with CON terms or conditions by this applicant in our records. GCMH is compliant with this standard.

F. 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 the only hospital in the county, GCMH's rural location is physically isolated from the nearest regional healthcare facilities in Cumberland, Maryland or Morgantown, West Virginia, which are approximately 60 miles/60 minutes away. Requiring patients to access care in those communities to receive the standard of care proposed would generally cause area residents to travel excess distances in potentially dangerous timeframes, especially in adverse winter weather conditions. Moreover, these facilities do not largely serve the same population served by GCMH.

Additionally, Garrett County's population is aging, and there is no public transportation available for them which compounds the challenges faced by working families with older family members or limited financial resources. Therefore, when inpatient care is necessary, separation of patients from the support of their families would thwart recovery and positive outcomes.

GCMH reports that the physicians based in the County currently refer patients to GCMH and will continue to do so after this project is complete. Moreover, it collaborates closely with the Garrett County Health Department, Social Service Agencies, County Commissioners, Community Action Agency, local Emergency Management Boards, and other agencies to create a health care delivery system which is accessible, inclusive and makes efficient use of each organization's potential.

Located within Garrett County, Deep Creek Lake, WISP Ski Resort and the Adventure Sports Center International all serve as attractions which make Garrett County a world class tourism destination. Hosting visitors from all over the state/country/world means that GCMH serves numerous four-season, second home owners, tourists, and visitors not native to the area. GCMH notes that it has a responsibility to maintain state-of-the-art trauma, diagnostic, clinical and emergency care services so the visiting public is not shortchanged should they experience a serious health crisis while they are visiting the area. This responsibility to serve both the local populace and the visiting public significantly impacts the need for GCMH to have a high level of clinical, technological and manpower readiness, as well as adequate physical plant and facilities at all times.

Because GCMH will continue to serve similar, if not decreased, patient volumes, there is no additional staffing anticipated for direct patient care or administrative functions. However, with the additional physical space to be maintained with this project, GCMH is projecting positions to be added in Environmental Services and Plant Operations. Three Housekeepers and one Maintenance Mechanic will be added to GCMH's FTE requirements. The 2011 Environmental Services Department vacancy rate was two percent, with a turnover rate of 16 percent. The 2011 Plant Operations Department vacancy rate was three percent, with a turnover rate of 10 percent. While there is some competition in the local market place for these types of jobs, particularly in the local tourist industry, the Hospital reports that it is generally able to recruit these positions due to the benefits package offered.

As the sole provider of inpatient services to Garrett County, this project likely will have no adverse impact on other health care providers in the service area. Therefore, all components of this standard have been met by the applicant.

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 meeting Garrett County Memorial Hospital's objectives, 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 Garrett County Memorial Hospital for a Certificate of Need, with a condition, to modernize GCMH's inpatient facilities, including the conversion of 8 semi-private rooms to 16 private

rooms and involving the construction of a new four story wing, as well as the renovation of existing space, at a total estimated cost of \$23,539,350.

**IN THE MATTER OF
GARRETT COUNTY
MEMORIAL HOSPITAL
Docket No. 12-11-2337**

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*

**BEFORE THE
MARYLAND
HEALTH CARE
COMMISSION**

FINAL ORDER

Based on Commission Staff's analysis and findings, it is this 21st day of February 2013, **ORDERED** that the application for a Certificate of Need, submitted by Garret County Memorial Hospital to construct a new four-story wing, which will add 20,286 square feet, and to renovate 41,954 square feet of existing space, at an estimated cost of \$23,539,350, Docket No. 12-11-2337, be **APPROVED**, subject to the following condition:

At the time of its first quarterly report, Garrett County Memorial Hospital shall document any changes in the actions it is taking to improve performance on the two quality measures for which its performance was below 90% and in the bottom quartile for both the year ending September 2011 and June 2012 and it shall document the actions it is taking to improve performance on the two additional measures for which its performance was in the bottom quartile and below 90% in the most recent Maryland Hospital Performance Guide for the year ending June 2012.

APPENDIX A

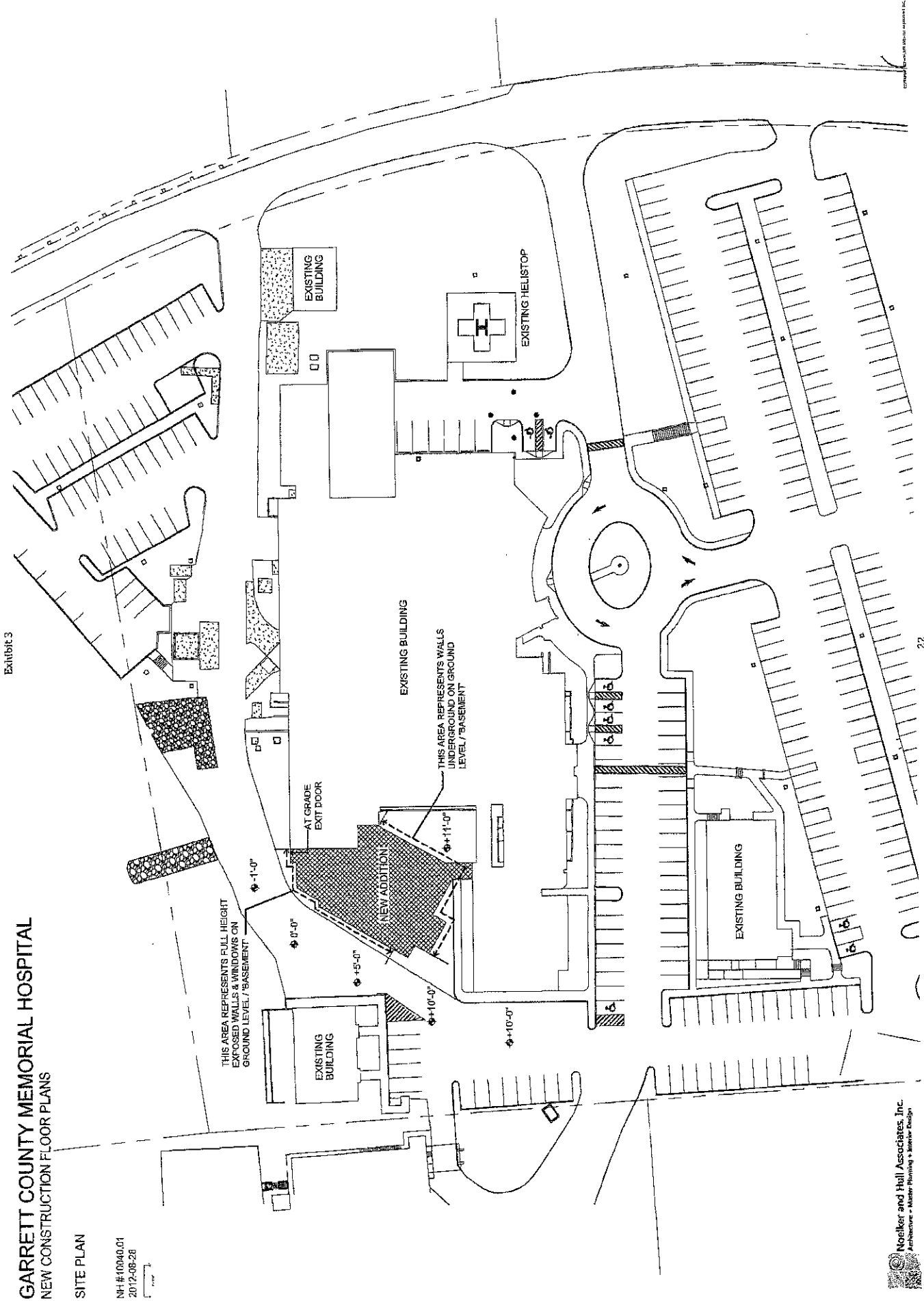
Floor Plans

GARRETT COUNTY MEMORIAL HOSPITAL
NEW CONSTRUCTION FLOOR PLANS

Exhibit 3

SITE PLAN

NH # 10040.01
 2012-08-28



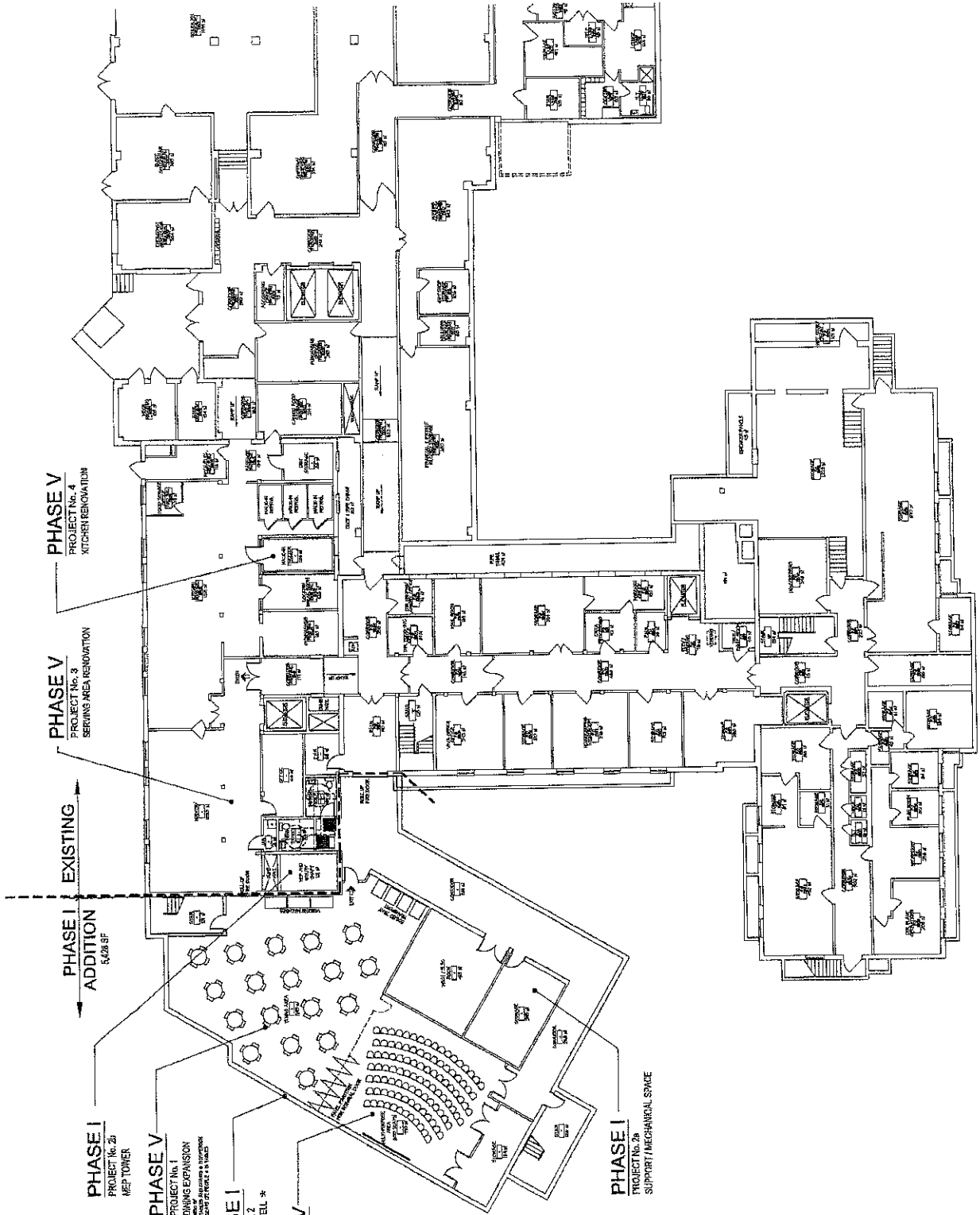
GARRETT COUNTY MEMORIAL HOSPITAL NEW CONSTRUCTION FLOOR PLANS

BASEMENT LEVEL PLAN

NH #10040.01
2012-09-28



Exhibit 3



KEY

- ★ = NURSES STATION
- ⊙ = BATHING
- ⊕ = PATIENT ROOM RESTROOM
- ⊞ = NON-PATIENT ROOM RESTROOM

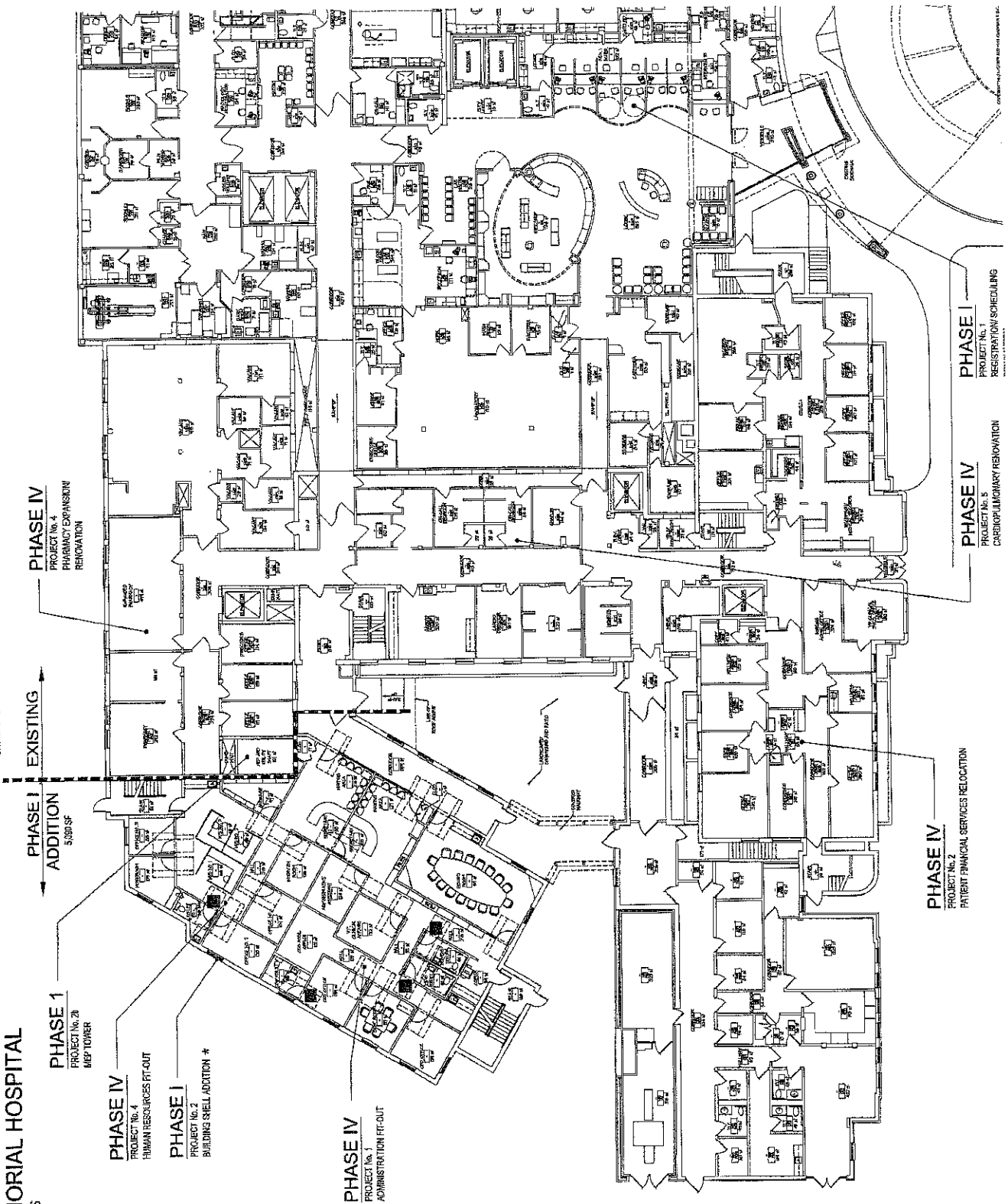
*** NOTE:**
THE REFERENCE TO BUILDING SHELL RELATES TO PHASING SEQUENCES ONLY. UPON COMPLETION OF THE ENTIRE PROJECT, THERE WILL BE NO SHELL SPACE.

GARRETT COUNTY MEMORIAL HOSPITAL NEW CONSTRUCTION FLOOR PLANS

FIRST FLOOR PLAN

NH #: 10040.01
2012-08-28

Exhibit 3



PHASE IV
PROJECT No. 4
PHARMACY EXPANSION
RENOVATION

PHASE I EXISTING
PHASE I ADDITION
5,300 SF

PHASE 1
PROJECT No. 20
MFP TOWER

PHASE IV
PROJECT No. 4
HUMAN RESOURCES FIT-OUT

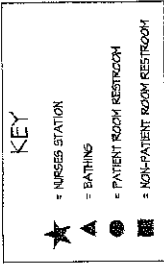
PHASE I
PROJECT No. 2
BUILDING SHELL ADDITION *

PHASE IV
PROJECT No. 1
ADMINISTRATION FIT-OUT

PHASE IV
PROJECT No. 2
PATIENT FINANCIAL SERVICES RELOCATION

PHASE IV
PROJECT No. 5
CARDIOPULMONARY RENOVATION

PHASE I
PROJECT No. 1
REGISTRATION/SCHEDULING

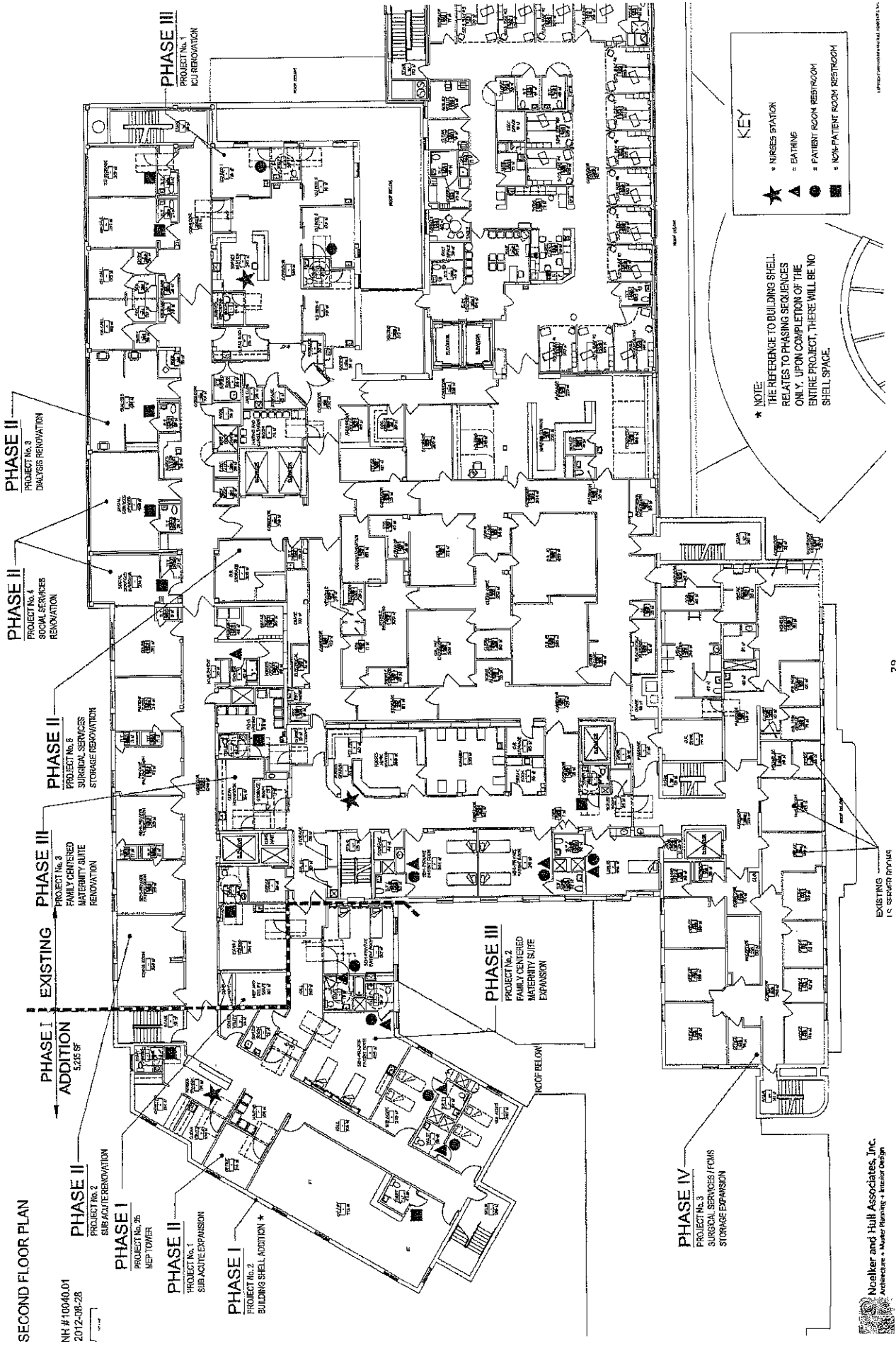


* **NOTE:**
THE REFERENCE TO BUILDING SHELL
RELATES TO PHASING SEQUENCES
ONLY. UPON COMPLETION OF THE
ENTIRE PROJECT, THERE WILL BE NO
SHELL SPACE.

GARRETT COUNTY MEMORIAL HOSPITAL NEW CONSTRUCTION FLOOR PLANS

SECOND FLOOR PLAN

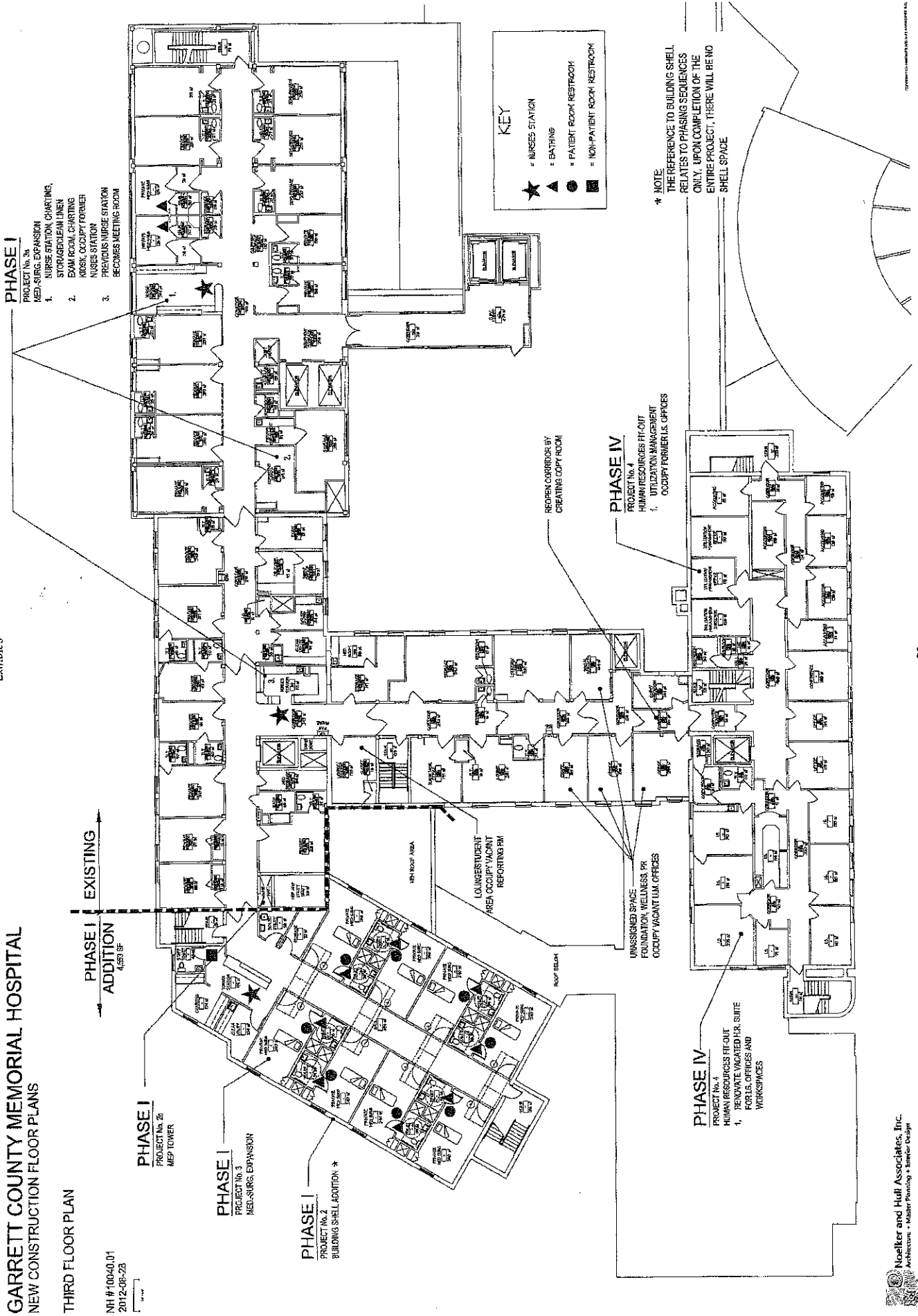
NH # 10040.01
2012-08-28



GARRETT COUNTY MEMORIAL HOSPITAL NEW CONSTRUCTION FLOOR PLANS

THIRD FLOOR PLAN

NH # 10040.01
2012-08-28



APPENDIX B

Physical Bed Capacity Before and After the Project

APPENDIX B: Physical Bed Capacity Before And After The Project

Hospital: Garrett County Memorial Hospital Date: October 5, 2012

Location (Floor/Wing)	Before the Project				After Project Completion						
	Hospital Service	Licensed July 1, 2012	Room Count		Hospital Service	Room Count		Bed Count			
			Total Rooms	Semi-Private		Private	Physical Capacity		Total Rooms	Semi-Private	Private
Third Floor	MSGa		20	11	9	31		28	3	25	31
			0			0		0			0
			0			0		0			0
			0			0		0			0
			0			0		0			0
SUBTOTAL	Gen. MSGa		20	11	9	31		28	3	25	31
	ICU/CCU		4	0	4	4		4	0	4	4
TOTAL	MSGa	24	24	11	13	35		32	3	29	35
Second Floor	Obstetrics	4	5	4	1	9		5	4	1	9
Third Floor	Pediatrics	1	1	0	1	1		1	0	1	1
	Psychiatric	0	0			0		0			0
ACUTE TOTAL	Acute Care	29	30	15	15	45		38	7	31	45
Non-Acute Beds											
Second Floor	Sub-Acute	10	7	3	4	10		8	2	6	10
Hospital Total		39	37	18	19	55		46	9	37	55

Note: Physical capacity is the total number of beds that could be accommodated without significant renovations. A room with two headwalls and two sets of gasses is a semi-private room, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough, from a square footage perspective, to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain a single headwall, but are used to accommodate more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms is semi-private, and the bed capacity is as applicable.

APPENDIX C

HSCRC Memorandum

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

22

February 8, 2013
John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

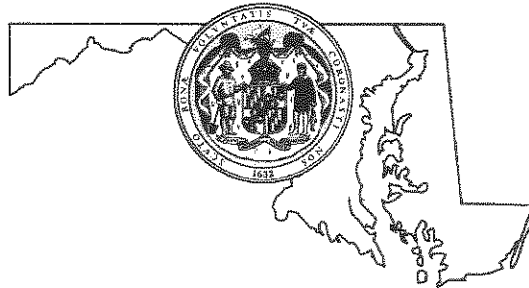
George H. Bone, M.D.

Stephen F. Jencks, M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen



Patrick Redmon, Ph.D.
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Mary Beth Pohl
Deputy Director
Research and Methodology

HEALTH SERVICES COST REVIEW COMMISSION

4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

MEMO

To: Joel Riklin, Maryland Health Care Commission
From: Gerard J. Schmith
Subject: Garret County Memorial Hospital ("GCMH" or "Hospital") - CON Request, #12-11-2337, Expansion and renovation Project
Date: February 6, 2012

On November 30, 2012 you requested that we review and comment on the financial feasibility of GCMH's proposed capital project. The Hospital is seeking approval to construct 19,504 sq. ft of new space and renovate 41,538 sq. ft. of existing space. The cost of this project, including financing cost, is estimated at \$23,539,350. The Hospital intends to finance the cost of the project through a combination of cash from operations (\$7,468,986), fund raising (\$1,000,000), and a tax exempt bond offering (\$15,000,000) through Garret County.

On July 6, 2012, GCMH submitted a full rate application to the Health Services Cost Review Commission (HSCRC) requesting increases to revenue of \$789,019 at July 1, 2014, \$761,429 at July 1, 2015, and \$827,723 at July 1, 2016 to cover the cost of borrowing the \$15,000,000. The total amount requested over the three year period is \$2,378,171.

On February 6, 2013, the HSCRC approved the staff's recommendation to grant GCMH's requested revenue increases. A copy of the Staff Recommendation is attached for your review.

With the approval of this recommendation, the HSCRC staff believes that the project is financially feasible.

RECEIVED

FEB 06 2013

MARYLAND HEALTH
CARE COMMISSION

Toll Free 1-877-4MD-DHMH · TTY for the Disabled Maryland Relay Service 1-800-735-2258

IN RE: THE FULL

* BEFORE THE HEALTH SERVICES

RATE REVIEW OF

* COST REVIEW COMMISSION

GARRETT COUNTY

* DOCKET: 2012

MEMORIAL HOSPITAL

* FOLIO: 1958

OAKLAND, MARYLAND

* PROCEEDING: 2168R

* * * * *

STAFF RECOMMENDATION

February 6, 2013

I. INTRODUCTION

On July 6, 2012 Garrett County Memorial Hospital (“Hospital,” or “GCMH”) submitted a full rate application to the Health Services Cost Review Commission (“HSCRC,” or “Commission”). GCMH is a 55-bed acute care community hospital located in Oakland, Maryland.

GCMH has operated under the HSCRC’s Total Patient Revenue (TPR) System since the early 1980’s. Under the TPR System, the Hospital is provided a fixed revenue (CAP) amount under which it must operate each year. The CAP is updated each year for inflation based on the same inflation factor applied to all other hospitals. The CAP is also adjusted each year for a change in the Hospital’s payer mix and approved uncompensated care (mark-up), as is the case with all other hospitals. However, the Hospital does not receive an adjustment for actual case mix change or an adjustment for actual volume changes as do other hospitals. Instead, the CAP is increased based on a fixed adjustment for volume changes each year. The volume adjustment provides the Hospital with the lesser of 25% of the percentage change in the population of the County, or a flat 1% increase, whichever is less. The TPR System attempts to deter unnecessary admissions by providing the Hospital with an incentive to control both the charge per inpatient case and the number of cases.

II. THE HOSPITAL REQUEST AND JUSTIFICATION

The Hospital has requested combined overall rate increases, exclusively for capital, of \$789,019 at July 1, 2014, \$761,429 at July 1, 2015, and \$827,723 at July 1, 2016. The total amount requested over the three year period is \$2,378,171. The capital costs are related to a \$23.5 million project for a New Wing Expansion and Renovations. GCMH expects to receive

Certificate of Need (CON) approval from the Maryland Health Care Commission (MHCC) for the Project.

III. HOSPITAL RATE HISTORY

As stated above, GCMH has operated under the TPR system since the early 1980's, and for years was the only hospital utilizing this fixed revenue methodology. GCMH continues to be unique even with the new TPR group, which consists primarily of hospitals in larger and more suburban areas.

Under the TPR rate setting structure, a hospital's unit rates may change significantly throughout a given year depending on fluctuations in volumes. The revenue CAP places pressure on hospitals to control costs during periods of rising volumes and acts as a safety net during periods of declining volumes. While the TPR structure does provide for a predictable operating revenue stream, the TPR system does not readily address the funding of infrequent large capital building projects.

Since 2008, GCMH has applied for and received two full rate adjustments – in 2008 and 2009. In 2008, the Hospital received a \$2.1 million (6%) increase of which nearly one-third was related to West Virginia Medicaid, which refused to pay HSCRC-approved rates. The other two-thirds were used to hire additional staffing and for certain technological advances.

In 2009, GCMH received a \$1.9 million (5%) increase to its TPR, which was used for additional staffing and increased group health benefits.

Both the 2008 and 2009 applications were predicated on GCMH's favorable Reasonableness Of Charges (ROC) position.

IV. HOSPITAL FINANCIAL SITUATION

The Hospital's fiscal year end is June 30. For the past three fiscal years, the Hospital has reported the following audited operating results:

Garrett County Memorial	Net Operating Revenue (Regulated)	Net Operating Profit/(Loss) (Regulated)	Operating Margin (Regulated)	Net Profits
FYE June 2012	\$33,733,500	\$1,755,400	5.20%	\$1,621,900
FYE June 2011	\$32,531,200	\$2,237,600	6.90%	\$2,815,100
FYE June 2010	\$32,921,200	\$3,800,100	11.5%	\$4,973,000

V. STAFF ANALYSIS

a. Timing of Rate Request

The total costs of the Wing Expansion and Renovation Project are \$23.5 million. The Hospital plans to fund 32%, or \$7.5 million, through equity and \$1.0 million through contributions. Project debt is expected to equal \$15.0 million at 5.25% interest over 20 years. GCMH has requested a phased-in approach for the rate adjustment. The requested effective dates of July 1, 2014, 2015, and 2016 are reflective of when the depreciation and interest expense related to the Project are projected to be realized.

b. Baseline ICC Calculation

The HSCRC's ICC methodology for full rate reviews was applied to GCMH's rate request. While the ICC methodology produced a 0.46% rate increase, GCMH's 3-year phased-in revenue request of \$2,378,171 results in a 5.88% rate increase when applied to GCMH's current revenue base. In its application, GCMH requests that the difference between the 5.88% and 0.46% (or 5.42%) be provided as a special adjustment to rates.

c. Rate Methodology for Capital

The current HSCRC policy for funding capital in rates (either through a full or partial application^[1]) limits the amount of funding to the lesser of 50% of the project capital costs or the peer group average capital costs. Hospitals are expected to generate the shortfall in capital funding through increased volumes related to the Project. Prior to this application, GCMH has never requested HSCRC funding for a major capital project.

TPR vs. Non-TPR Hospitals

While it is equitable for many HSCRC policies to be applied across-the-board to all Maryland hospitals, certain criteria should be considered when evaluating capital cost requests from hospitals with extreme circumstances such as GCMH.

A hospital's rate methodology and the related incentives of that methodology should be considered in addition to the reasonableness of costs and charges with respect to the request.

While non-TPR hospitals are able to generate additional revenue with increased volumes as a result of capital expenditures, there is no opportunity for GCMH, as a TPR hospital, to generate necessary revenues to fund capital shortfalls through volume increases.

Lack of TPR Transition Adjustment

While GCMH has been on the TPR rate system since the early 1980's, eight of the current ten TPR hospitals entered into their TPR agreements during fiscal 2011, at a time when rate adjustments were given ("Transition Adjustments") to hospitals that transitioned from the Charge Per Case ("CPC") rate methodology to TPR. These adjustments ranged between \$1.1 million and \$10.6 million and averaged \$6.5 million per TPR hospital spread over 2 years.

[1] A partial application using the relaxed ICC (ICC adding back 2% productivity) would have resulted in funding of \$978,000, or 41% of GCMH capital costs.

GCMH has no Transition Adjustment to assist with the funding of the capital project which could be used to offset a portion of this rate request. With no Transition Adjustment, GCMH has to rely on its TPR revenue and prudent spending to maintain a viable bottom line.

Reasonable Charges

A hospital’s existing charge structure should be taken into account prior to the HSCRC's granting capital funding, whether it is a TPR hospital or not. There should be some offset to capital funding for TPR hospitals above the peer average on the ROC methodology. On the last published ROC in the spring of 2011, GCMH was 6.58% below its peers and had been consistently well below the average on previous ROCs.

Reasonable Cost Structure

In addition to a review of charges, staff analyzed GCMH’s cost structure compared to its ROC peer group as well as the other TPR hospitals. A comparison of capital costs per EIPA and non-capital costs per case mix adjusted EIPA resulted in GCMH’s costs being significantly below its peers as follows:

	<u>GCMH (Below) Peers</u>	
	<u>v. TPR</u>	<u>v. ROC Group</u>
Capital per EIPA	(47.8%)	(31.9%)
Non-capital per CMAEIPA	<u>(5.7%)</u>	<u>(3.5%)</u>
Combined	<u>(9.5%)</u>	<u>(6.1%)</u>

Adding the \$2.1 million in Project costs to GCMH’s capital costs results in GCMH remaining 6.0% below the TPR hospitals’ combined average and at the ROC peer group average.

VI. FINAL RATES SUMMARIZED

Based on the analysis outlined in Section V and the unique circumstances of GCMH, the staff recommends the following:

1. That the Hospital's CAP be adjusted by \$2,378,171 as follows, provided that the assets are available for use at that time:

July 1, 2014 \$789,019

July 1, 2015 \$761,429

July 1, 2016 \$827,723

If the assets are not available for use at the times stated above, the staff recommends that the adjustments be made when the assets become available for use.

2. That these adjustments be contingent on the approval of the CON before the MHCC without any material changes.

3. That any material difference between the Hospital's assumed interest rate and the actual interest rate secured be appropriately adjusted for at the time this adjustment is to be made.