STATE OF MARYLAND

MARYLAND HEALTH CARE COMMISSION
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MEMORANDUM

TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: May 19, 2016

SUBJECT: Suburban Hospital
Docket No. 15-152368

Enclosed is the staff report and recommendation for a Certificate of Need ("CON") application filed by Suburban Hospital .

Suburban proposes to construct a 300,000 square foot building addition as part of a larger campus enhancement effort that includes the addition of a 1,112 space parking garage and associated site work (not elements of this CON application). The primary objective of the proposed building addition is to replace outdated patient and clinical service facilities and will require approximately 18,000 square feet of renovation to the existing facility to address connections and retro-fitting of a small number of existing spaces. The project will create private patient rooms and modernize the hospital's surgical facilities It is also intended to create improved circulation and departmental adjacencies. The project is anticipated to take 39 months to complete.

The total project cost is estimated to be $200,550,831. Suburban anticipates funding the project with $90,827,121 in cash; $38,333,129 in philanthropic gifts, $69,782,482 in debt financing through the sale of authorized bonds and $1,608,099 in interest income from bond proceeds. The hospital does not anticipated a need to seek an expansion of its global budget revenue in order to undertake this project.

Commission staff analyzed the proposed project's compliance with the applicable State Health Plan standards and the other applicable CON review criteria at COMAR 10.24.01.08 and recommends that the project be APPROVED with the following conditions:

1. That Suburban Hospital will not routinely use any room on an MSGA nursing unit including the ICU and CCU units for more than one patient without the approval of MHCC.

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $2,361,291. This figure includes the estimated new construction costs that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

3. Suburban Hospital will not finish the third floor shell space without giving notice to the Commission and obtaining all required Commission approvals, nor shall it finish space on the second floor for rate regulated uses without giving notice to the Commission and obtaining all required Commission approvals.

4. Suburban Hospital will not request an adjustment in rates from the Health Services Cost Review Commission ("HSCRC") that includes depreciation or interest costs associated with construction of the proposed shell space unless and until Suburban Hospital has obtained CON approval for finishing the shell space, or has obtained a determination of coverage from the Maryland Health Care Commission that CON approval for finishing the shell space is not required.

5. In calculating any future rates for Suburban Hospital the HSCRC shall exclude the capital costs associated with the shell space until such time as the space is finished and put to use in a rate-regulated activity. In calculating any rate that includes an accounting for capital costs associated with the shell space, the rate should only account for depreciation going forward through the remaining useful life of the space (i.e., the HSCRC shall exclude any depreciation of the shell space that has occurred between the construction of the shell space and the time of the rate calculation. Likewise, allowable interest expense shall also be based on the interest expenses going forward through the remaining useful life of the space.

IN THE MATTER OF	*	**BEFORE THE**
	*	
SUBURBAN HOSPITAL	*	**MARYLAND HEALTH**
	*	
DOCKET NO. 15-15-2368	*	**CARE COMMISSION**
	*	

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Staff Report and Recommendation

May 19, 2016

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I. INTRODUCTION

A. Background

Suburban Hospital ("Suburban" or "the Hospital") is a 236-bed general hospital located at 8600 Old Georgetown Road in Bethesda (Montgomery County). that was established in 1943. It provides acute inpatient services for medical/surgical, pediatric, and acute psychiatric patients and is one of ten hospitals in Maryland offering cardiac surgery. It is a designated Level II Trauma Center, annually treating between 1,500 and 1,600 trauma patients and is Maryland's newest cardiac surgery hospital, inititating this service in 2005. Suburban became a member of Johns Hopkins Medicine in 2009, and has various other strategic partnerships with local and national health care organizations, including the National Institutes of Health, which is located adjacent to Suburban Hospital across Old Georgetown Road

B. Project Description

Suburban proposes to construct a 300,000 square foot building addition as part of a larger campus enhancement effort that includes the addition of a 1,112 space parking garage and associated site work (not elements of this CON application). The primary objective of the proposed building addition is to replace outdated patient and clinical service facilities and will require approximately 18,000 square feet of renovation to the existing facility to address connections and retro-fitting of a small number of existing spaces. The project will create private patient rooms and modernize the hospital's surgical facilities It is also intended to create improved circulation and departmental adjacencies. The proposed building addition will include:

- Two new nursing units providing a total of 54 private patient rooms, allowing Suburban to accommodate all medical/surgical patients in private rooms;A new operating suite replacing existing operating rooms with larger rooms, and modernizing the heating, ventilation, and air conditioning systems and lighting in the surgical suite;
- Relocation of the entire surgical department from the 5th floor of the existing building to the first floor of the proposed addition, with immediate adjacency to the Emergency/Trauma Center;
- Relocation of central sterile services from the basement of the existing hospital to a level immediately below the new surgical suite in the proposed building addition.
- Creation of a satellite compounding pharmacy in the building addition to support the clinical operations in the building addition;
- Medical office space for approximately 30 physicians;
- Relocation of the clinical decision unit (observation beds) from the 6th floor to an existing second floor nursing unit;
- A new main entrance separate from the emergency room entrance and helipad;
- A dedicated driveway for emergency vehicles with direct access to the Emergency/Trauma Center;
- Improvements in the existing loading dock;

- Connections to the existing building on three floors; and
- One shelled floor with the same floor plate as the built-out nursing unit floor. providing future flexibility.

The proposed project will require multiple phases due to the constraints of the site and the need to operate the hospital during construction. The multiple phases will be included in a single construction contract. Phase I will involve construction of a temporary loading dock, renovation and upgrading of the existing loading dock, and construction of an underground connector and above-grade connector. Phase II will include the building addition and related site work. Phase III will complete the building-to-building connections and will also include renovations to existing building space.

The total project cost is estimated to be $200,550,831. Suburban anticpates funding the project with $90,827,121 in cash; $38,333,129 in philanthropic gifts, $69,782,482 in debt financing through the sale of authorized bonds and $1,608,099 in interest income from bond proceeds. The hospital does not anticipated a need to seek an expansion of its global budget revenue in order to undertake this project. Suburban anticipates an obligation of funds for the project four months after CON approval, and initiation of construction within three months from the effective date of the binding construction contract. The project is anticipated to be available for first use 39 months from that date.

C. Summary of Recommendation

Staff recommends approval of the project based on its finding that the proposed project complies with the applicable State Health Plan standards and that the need for the project, its cost effectiveness, and its viability have been demonstrated. Staff also finds that the impact of the project is positive. A summary of the basis for this recommendation is as follows:

Criteria/Standard	Conclusions
Need and Capacity	The project will not add operational bed capacity to the hospital or health system, but will modernize it by adding 54 private MSGA patient rooms in new nursing units, allowing existing semi-private rooms to be used as private rooms at all times. This will result in increased physical bed capacity. Any CON approval should be conditioned to prohibit use of the semi-private rooms for more than one patient. Surgical facilities will be modernized and the number of operating rooms will be reduced from 15 to 14 rooms.
Cost Effectiveness	The applicant demonstrated ample consideration of alternatives and concluded that the selected alternative -- expansion on site -- best addresses the need to upgrade hospital facilities and improve campus circulation and is the most cost effective alternative for meeting project objectives.
Efficiency	The project's design will improve adjacencies and work flow. Single rooms will allow for more efficient use of the hospital's bed capacity. The project will result in reduced staffing hours per unit of service if at the service volumes projected.
Financial Feasibility and Viability	Equity and philanthropy will cover about 65% of the total project cost. Suburban has demonstrated that it has the equity, fund-raising capability, and debt capacity to fund the project as proposed. Its utilization projections and revenue and expense assumptions are reasonable. HSCRC staff concluded that the overall assumptions regarding the financial viability of the project are reasonable and achievable.
Construction Cost	Estimated cost exceeded the MVS benchmark by 2.18%. Although the applicant stated that it will not request a rate adjustment to cover the interest or depreciation costs associated with the project, this necessitates attaching a condition to an approval that any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $2,361,291.
Impact	The proposed project is a modernization of the existing facility which will make the facility safer and better align with contemporary patient expectations. It will marginally improve the ability of the hospital to run at higher bed occupancy. Without any service reconfiguration, there should be no direct or short-term impact on other hospitals as a result of the project although it should position Suburban as a more attractive hospital. Inclusion of physician office space in the project is likely to improve the public's access to services and improve the ability of physicians to make efficient use of their time. Suburban does not project a need to increase charges directly related to the increase in depreciation and interest cost associated with this project.

Staff is recommending approval with conditions related to the use of the converted semi-private rooms; future use of and reimbursement for shell space; and reimbursement of excess construction costs. These recommended conditions are specified in Part V, SUMMARY AND STAFF RECOMMENDATION of this report.

III. PROCEDURAL HISTORY

A. Review of the Record

Please see Appendix 1, Record of the Review.

B. Interested Party

There are no interested parties in this review.

C. Local Government Review and Comment

The Montgomery County Department of Health and Human Services sent a letter of support for this project. (DI # 3)

D. Community Support

MHCC received letters of support for the project from Kimberly Horn, Regional President of Kaiser-Permanente Mid-Atlantic Medical Group; seven members of Suburban Hospital's medical staff leadership; Peter Lowet, the executive director of Mobile Medical Care; Uma Ahluwalia, Director of the Montgomery County Department of Health and Human Services; Roger Berliner of the Montgomery County Council; Alan Butsch, Battalion Chief for Emergency Medical Services of the Montgomery County Fire and Rescue Service; Georgette Godwin, President of the Montgomery County Chamber of Commerce; Mark Bergel, Ph.D., Founder and Executive Director of A Wider Circle; Susan Kirk, Executive Director of Bethesda Cares; Carla Larrick, Vice President of Operations, YMCA of Metropolitan Washington; and Warren R. Slavin, President and CEO of the Charles E. Smith Life Communities. MHCC also received 12 letters supporting the project from community members who were patients and/or members of Suburban's Patient & Family Advisory Committee. (DI#2, Exhibit 34) The applicant also noted the substantial support the project received during a lengthy process of obtaining local government approvals.

III. BACKGROUND

A. Population Change, Race, and Income

Population Projections

Suburban Hospital is located in the southwestern corner of Montgomery County and about 80% of its patients come from that jurisdiction. Montgomery is the most populous jurisdiction in Maryland. As shown in the summary tables below, Montgomery County's population is growing

more rapidly than that projected for the State overall; population projections for 2020 show its age distribution to be very similar to that of the State.

Table III-1: 2010 Population and Population Growth Rate Projections Montgomery County and Maryland

	Population		Growth Rates at 5 Year Intervals	
	Montgomery	Maryland	Montgomery	Maryland
2010	971,777	5,773,552	--	--
2015	1,036,002	6,010,141	6.6%	4.1%
2020	1,067,001	6,224,511	3.0%	3.6%
2025	1,110,004	6,429,749	4.0%	3.3%
2030	1,153,900	6,612,191	4.0%	2.8%
2035	1,186,601	6,762,303	2.8%	2.3%
2040	1,206,802	6,889,692	1.7%	1.9%
Change 2010-2040	235,025	1,116,140	24.2%	19.3%

Source: Maryland Department of Planning, 2014 Total Population Projections by Age, Sex and Race

Table III-2: Age Distribution: 2010 Actual and Three Out-Year Projections Montgomery County and Maryland

	Jurisdiction	0-14	15-44	45-64	65-74	75+
2010	Montgomery	19.8%	39.8%	28.0%	6.4%	5.9%
	Maryland	19.2%	40.8%	27.7%	6.7%	5.6%
2020	Montgomery	18.7%	39.1%	26.4%	9.2%	6.6%
	Maryland	18.0%	40.0%	26.2%	9.4%	6.4%
2030	Montgomery	18.9%	37.7%	24.3%	10.2%	9.0%
	Maryland	17.9%	39.3%	23.1%	11.0%	9.0%
2040	Montgomery	18.6%	36.4%	24.8%	9.1%	11.1%
	Maryland	17.4%	38.4%	23.8%	9.3%	11.2%

Source: Maryland Department of Planning, 2014 Total Population Projections by Age, Sex and Race

Racial Composition

Montgomery County's population is majority white (61.8%). While Montgomery County has a lower percentage of African Americans than does Maryland, both the Asian American and the Hispanic/Latino populations are represented at more than twice their statewide proportions.[1]

[1] Source: 2014 U.S. Census of Population: http://quickfacts.census.gov/qfd/states/24/24033.html

Table III-3: Population by Race/Ethnicity
Montgomery County and Maryland, 2014

Jurisdiction	White	Black or African American	Hispanic or Latino	Asian	Other*	Two or More Races
Montgomery	61.8%	18.8%	19.7%	15.2%	0.8%	2.2%
Maryland	60.1%	30.3%	9.3%	6.4%	0.7%	2.6%

Source: 2014 U.S. Census of Populationhttp://quickfacts.census.gov/qfd/states/24/24033.html
Note: All racial categories, with the exception of "two or more," reported as "alone."
*Other includes American Indian and Alaskan Native, Native Hawaiian and other Pacific Islander.

Economic Status

Montgomery County is one of the most affluent jurisdictions in the State, with an estimated median household income in 2010 of $88,559,[2] second only to Howard County's $100,992 median, and about 29% higher than the statewide median. 7.5% of Montgomery County residents were living in poverty in 2010, ranking it 16th among the state's 24 jurisdictions for this measure of poverty. Table III-4 below shows the poverty rates for various segments of the population in Montgomery County.

Table III-4: Proportion (%) of Total Residents Living in Poverty, 2010*

	Montgomery	Maryland[3]
Residents living in poverty	7.5%	9.9%
Under age 18 in Poverty	9.4%	13.1%
Ages 5-17 in impoverished families	9.1%	11.8%
Under age 5 in Poverty	NA	15.6%
Median Household Income	$88,559	$68,933

*Based on Federal Poverty Guidelines.

Between each decennial census, the U.S. Census Bureau provides a variety of estimates based on community surveys; often these results are compiled and reported for a time period (rather than for one point in time) to reduce sampling error. Economic indicators drawn from this source and shown in Table III-5 below provide a more recent snapshot of the region's economic well-being, and do not indicate major shifts since the 2010 census.

Table III-5: Indicators of Economic Well-Being *

	Montgomery	Maryland
Persons below poverty level, 2009-2013	6.7%	9.8%
Homeownership rate, 2009-2013	67.3%	67.6%
Median value of owner-occupied housing units, 2009-2013	$446,300	$292,700
Per capita money income, past 12 months (2013 dollars), 2009-2013	$49,038	$36,354
Median Household Income, 2009-2013	$98,221	$73,538

*From US Census Bureau State & County Quickfacts, which reports data collected by the US Census Bureau for time frames between each 10 year census. http://quickfacts.census.gov/qfd/index.html

[2] Available at: http://www.census.gov/cgi-bin/saipe/saipe.cgi.
[3] Available at: http://www.census.gov/cgi-bin/saipe/saipe.cgi.

B. General Acute Care Hospitals

Montgomery County has six general acute care hospitals. Demand for hospital bed capacityhas been broadly declining throughout the state in recent years. The number of licensed acute care beds in Maryland, which directly reflects this decline in patient census, dropped from 10,880 in FY2010 to 9,800 in FY2016, a 9.9% decline. The decline in Montgomery County has been more modest; 1.9% since 2010.

Table III-6: Montgomery General Acute Care Hospitals
Licensed Acute Care Bed Inventories, FY 2016 (effective July 1, 2015)
[MSGA= medical/surgical/gynecological/addictions/ OB=obstetric/Peds=pediatric/Psych=acute psychiatric]

Hospital	Location	MSGA	OB	Peds	Psych	Total
Holy Cross Germantown	Germantown	75	12	0	6	93
Holy Cross	Silver Spring	317	84	22	0	423
MedStar Montgomery	Olney	89	11	2	20	122
AHC Shady Grove	Rockville	209	56	25	0	290
Suburban	Bethesda	209	0	3	24	236
AHC Washington Adventist	Takoma Park	169	21	0	40	230
Total Montgomery		1,068	184	52	90	1,394

Source: Maryland Health Care Commission

Table III-7: Change in Acute Care Bed Inventories, Montgomery County General Hospitals FY2010-FY2016

	Licensed Beds FY 2010	Licensed Beds FY 2016	Change FY 2010-16	Reported Physical Bed Capacity
Holy Cross Germantown	--	93	--	93
Holy Cross	404	423	+4.7%	379
MedStar Montgomery	170	122	-28.2%	187
AHC Shady Grove	320	290	-9.4%	326
Suburban	239	236	-1.0%	247
AHC Washington	288	230	-20.1%	304
Total Montgomery	1,421	1,394	-1.9%	1,536

Source: Maryland Health Care Commission

C. Hospital Utilization Trends

The tables below profile demand for acute hospital services in Montgomery County from 2009-2014. Some noteworthy facts and trends for the period 2009-2014 include:

Acute care discharges are falling

- Total acute care discharges declined by 11.5% in Montgomery County hospitals, while declining by 19.5% statewide. Every hospital in the county except Holy Cross of Silver Spring experienced a decline in discharges.

- The average daily census (ADC) at Montgomery County hospitals fell 8% between 2009 and 2014, from 1,007 in 2009 to 925. Statewide, the decline in ADC was 13.5% during this period. This decline in inpatient activity followed a ten-year period (1998-2008) in which ADC had risen by 10% in Montgomery County.

Length of stay is increasing

- MSGA average length of stay (ALOS) is increasing. In 2015 it was 4.79 days in Montgomery County acute care hospitals, virtually the same as the statewide average of 4.78. This represented a 10.6% increase over 2009 in Montgomery, and 11.2% statewide.

- This reversal of a long term trend began almost imperceptibly in 2006 and accelerated in 2011.

- Suburban's MSGA ALOS was lower than the county and state average, at 4.27 in 2014.

Surveying long term trends, demand for acute care hospital beds in Maryland has resumed a downward trend that had been interrupted by growth between 1998 and 2008, following about 20 years of decline.

The three tables that follow provide detail regarding total acute care discharges, discharge days, and average length of stay for general acute care hospitals in Montgomery County from 2009-2014. Appendix 2 provides similar detail for MSGA and psychiatric beds.

Table III-8a: Total Acute Care Discharges
Montgomery County Hospitals, CY 2009 – 2015

ACUTE CARE DISCHARGES							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
Holy Cross Germantown						638	4,099
Holy Cross Silver Spring	27,569	28,069	27,676	27,012	26,523	28,132	26,526
Medstar Montgomery	9,912	9,866	9,232	9,003	8,232	8,208	7,616
AHC Shady Grove	21,974	21,603	20,910	20,911	20,186	19,297	16,452
SUBURBAN	14,164	13,874	14,033	13,622	13,156	13,589	13,365
Ahc Washington Adventist	17,588	16,031	14,328	13,189	11,698	11,455	10,455
MONTGOMERY Co. TOTAL	91,207	89,443	86,179	83,737	79,795	81,319	78,513
All Maryland Hospitals	701,185	660,928	636,575	615,161	588,718	564,733	547,602

Source: HSCRC Discharge Database

Table III-8b: Total Acute Care Discharge Days,
Montgomery County Hospitals, CY 2009 – 2015

ACUTE CARE DISCHARGE DAYS							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
HOLY CROSS GERMANTOWN						2,532	15,716
HOLY CROSS SILVER SPRING	104,485	104,126	104,076	101,590	101,454	108,659	107,777
MEDSTAR MONTGOMERY	42,008	41,012	36,400	35,188	31,106	31,759	30,213
AHC SHADY GROVE	87,347	84,999	86,162	82,054	78,840	76,734	67,708
SUBURBAN	59,303	58,504	58,600	61,863	58,034	60,099	58,922
AHC WASHINGTON ADVENTIST	74,523	70,945	66,236	65,973	59,880	60,500	56,401
Total	367,666	359,586	351,474	346,668	329,314	340,283	336,737
All Maryland Hospitals	2,919,904	2,719,672	2,715,091	2,649,410	2,559,400	2,527,350	2,494,948

Source: HSCRC Discharge Database

Table III-8c: Total Acute Care Average Length of Stay
Montgomery County Hospitals, CY 2009 – 2015

ACUTE CARE AVERAGE LENGTH OF STAY							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
HOLY CROSS GERMANTOWN						3.97	3.83
HOLY CROSS OF SILVER SPRING	3.79	3.71	3.76	3.76	3.83	3.86	4.06
MEDSTAR MONTGOMERY	4.24	4.16	3.94	3.91	3.78	3.87	3.97
AHC SHADY GROVE	3.98	3.93	4.12	3.92	3.91	3.98	4.12
SUBURBAN	4.19	4.22	4.18	4.54	4.41	4.42	4.41
AHC WASHINGTON ADVENTIST	4.24	4.43	4.62	5.00	5.12	5.28	5.39
Total	4.09	4.09	4.12	4.23	4.21	4.28	4.29
All Maryland Hospitals	4.16	4.11	4.27	4.31	4.35	4.48	4.56

Source: HSCRC Discharge Database

IV. REVIEW AND ANALYSIS

The Commission is required to make its decision in accordance with the general Certificate of Need review criteria at COMAR 10.24.01.08G (3) (a) through (f). The first of these six general criteria requires the Commission to consider and evaluate this application according to all relevant State Health Plan ("SHP") standards and policies. The State Health Plan chapters that apply are COMAR 10.24.10, Acute Inpatient Services and COMAR 10.24.11, General Surgical Services.

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.

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:*

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;
(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and
(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

The applicant stated that it provides a copy of the list of charges upon request of the Financial Counseling staff. It also stated that the Hospital provides estimated charges on its website. These estimates of charges are updated quarterly and are based on patients' actual charges incurred over the previous twelve months. Staff are trained to respond appropriately to requests for information regarding charges. They are educated about the criteria for building a charge report and updating the list of representative charges. The Hospital's website includes telephone numbers for inquiries about charges and a list of charges for common inpatient and outpatient procedures and services.

Staff has verified that Suburban Hospital 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.

Suburban stated that it provides care to all patients regardless of their ability to pay, and that it offers free care, sliding fee scales, and extended payment plans to eligible patients. Approval for charity care, sliding fee scales, or payment plans is based on submission of a financial assistance application which is available upon request at each of the Hospital's registration points and on the Hospital's website.

Suburban responded to section (a)(i) of the standard by quoting relevant sections from the Johns Hopkins Health System Financial Assistance Policy, which applies to Suburban Hospital. Those excerpts state:

> A preliminary application stating family size and family income (as defined by Medicaid regulations) will be accepted and a determination of probable eligibility will be made within two business days of receipt....Each affiliate will determine final eligibility for Financial Assistance within thirty (30) business days of the day when the application was satisfactorily completed and submitted. The Financial Counselor will issue the final eligibility determination. (DI#26)

Suburban stated that in actual practice, a final determination is provided within two days of receipt of a complete application, and often on the same day.

The Hospital states that it communicates the availability of financial assistance in a number of ways, including:

- The policy is published annually in the Washington Post;
- Notice of the policy is posted in English and Spanish in the Emergency Department Lobby, inside the Emergency Department, both ED registration bays, the Front Registration Desk, Catheterization Lab, and Financial Counseling Department;
- Notice of the policy and the financial assistance application is given to every self-pay patient with instructions on how to apply and contact information. The same information is provided to all other patients upon request; and
- Each patient registered is provided with a copy of its Financial Assistance Information Sheet.

These communication vehicles were documented in materials presented by the applicant. (DI#26)

The applicant complies with part (a) of this standard.

(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.

The applicant stated that in 2013, Suburban Hospital's level of charity care, defined as a percentage of total operating expenses, was 2.37% ($5,177,296) and did indeed fall within the

bottom quartile of Maryland Hospitals. Suburban attributed this to "unique geographic location of Suburban and the population demographics of the primary service area." (DI# 2, p.25) Factors cited by the applicant were:

- A significantly higher median household income within the community benefit service area (CBSA) ($136,945, compared to $98,935 for Montgomery County and $74,567 for the State of Maryland);
- Fewer Montgomery County households had incomes below the federal poverty guidelines (6.3% compared to 7.1% for Maryland);
- A smaller uninsured population in the CBSA (7.75% compared to 9.6% in Montgomery County and 9.4% in Maryland); and
- A lower percentage of Medicaid recipients in the CBSA population (11.3% compared to 13.4% for Montgomery County and 18.1% for Maryland).

In addition, there are six hospitals within Montgomery County among which the smaller proportion of disadvantaged residents are spread.

To demonstrate that its level of charity care is appropriate, Suburban pointed to its level of total community benefit, which was of 10.41% of operating expenses, compared to a statewide average of 6.3%. Speaking to the requirement that it demonstrate that its level of charity care is appropriate, Suburban, wrote:

> In addition to charity care contributions, Suburban Hospital is committed and dedicated to long standing community partnerships that combine deliberate and planned community benefit operations to meet identified health needs for our most vulnerable residents. Health initiatives include ongoing one-on-one counseling, disease prevention and management sessions, small and large group educational programs, and assistance with health insurance applications.

The applicant cited specific examples, including: vaccinations for uninsured and homeless residents; financial and in-kind support of two Montgomery County safety net clinics, *Clinica Proyecto Salud*-Wheaton and the Holy Cross Hospital Health Center-Gaithersburg, which provide primary health services to low income, uninsured residents; support of the Mobile Med/NIH Heart Clinic at Suburban Hospital, which provides specific cardiovascular specialty care, from diagnostic testing to open heart surgery to rehabilitation, at little or no cost to the patient. (DI# 2, p. 25,26)

As updated information became available, MHCC staff consulted the Maryland Hospital Community Benefit Report for 2014. Suburban's level of charity care was 2.0% of operating expenses, and was again in the fourth quartile (2.09%). However, once again Suburban's total net community benefit for 2014 also exceeded the statewide average, at 7.3% of operating expense, more than the State average for all hospitals at 6.2%.

Staff concludes that the applicant meets part (b) of the charity care 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.

The applicant provided a copy of its DHMH license and Joint Commission accreditation and stated that it is in compliance with all Medicaid and Medicare conditions of participation.

(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.

Staff notes that subpart (b) of this standard is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland HPEG. MHCC recently expanded its reporting of performance measures on an updated Maryland Health Care Quality Reports website. In its quality reports, MHCC now focuses on two priority areas: (1) patient experience, as reported by the Centers for Medicare and Medicaid Services (CMS) in its Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey; and (2) healthcare associated infections, as tracked by CDC's National Healthcare Safety Network ("NHSN"). Staff will recommend amendments to the Acute Care Hospital Services chapter of the State Health Plan to reflect these changes when that chapter is updated.

Suburban also noted in its response that the Maryland HPEG is outdated but also reported that it scored at the 96% level or above for all but one core measure. The Hospital was below average on heart failure discharge instructions and reports that:

> The discharge instructions process for heart failure was completely transformed since the Hospital Performance Evaluation Guide was published. A focused team approach has improved compliance. Frontline staff provide critical information to patients. Transition guide nurses thoroughly explain to patients in a way they can understand. Teach-back method is used to ensure that patients comprehend the instructions. Information on heart failure is provided through pamphlets to patients and their families as a guide. Since the transformation, compliance for discharge instructions has been maintained at or above 96%. (DI#2 ,p.27)

The applicant meets the standard.

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.***

The proposed project does not propose a new acute care general hospital or the replacement of an acute care general hospital on a new site. This standard is not applicable to this proposed project. Nevertheless, the Hospital did respond, and stated that the identified services are within thirty minutes under normal driving conditions for 90% of the residents in its service area.

(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 requires that a proposal to increase capacity of either MSGA beds or pediatric beds must be justified in one of four ways.

- The applicant may demonstrate that the proposed bed increase will result in actual bed capacity at the hospital that is equal to or less than its current licensed acute care bed capacity;
- The proposal is consistent with the State Health Plan's current minimum jurisdictional bed need projection for the jurisdiction in which the hospital is

located;[4]

- The applicant demonstrates that the additional beds are consistent with the maximum bed need for the jurisdiction and that there is a need for the additional beds at the applicant hospital;or
- The applicant proposes a service area analysis modeled on the jurisdictional bed need projection methodology contained in COMAR 10.24.10: State Health Plan for Facilities and Services - Acute Care Hospital Services.

Effective July 1, 2015 Suburban Hospital was licensed for a total of 236 acute care beds including 209 MSGA beds and three pediatric bedsSuburban reports a current physical bed capacity of 247 beds.

This project would construct 54 single-bed patient rooms for MSGA patients in the building addition It would convert an 8-bed MSGA nursing unit into a 17-bed unit by repurposing rooms currently dedicated for observation patients into private rooms for inpatients. It would convert an existing 23-bed MSGA nursing unit to an observation unit. These changes result in a hospital that would have 202 MSGA beds designed to accomododate, physically, 250 beds. However, operationally, the hospital intends to operate all of these rooms as private rooms.The hospital has three pediatric rooms with a designed capacity for four beds. It intends to operate all three rooms as private rooms, yielding a maximum of three beds. The hospital will continue to have 24 psychiatric beds located in 12 semi-private rooms. There would also be a 23-bed observation unit with 9 private rooms and 7 semi-private rooms. A comparison of the hospital's current room and bed inventory and the changes resulting from this projet is shown in the following table.

Table IV-1: Current and Proposed Patient Rooms, Physical Bed Capacity, and Operational Bed Capacity - Suburban Hospital

	Current Physical Bed Capacity		Physical Bed Capacity After Project Completion		Operational Bed Capacity After Project Completion	
	Rooms	**Beds**	**Rooms**	**Beds**	**Rooms**	**Beds**
General Medical/Surgical	112	155	160	206	160	160
ICU/CCU	42	44	42	44	42	42
Total MSGA	**154**	**199**	**202**	**250**	***202***	***202***
Pediatric	3	4	3	4	3	3
Psychiatric	12	24	12	24	12	24
Total Acute Care Beds	**169**	**227**	**217**	**278**	**217**	**229**
Observation	10	20	16	23	16	23
Total	179	247	233	301	233	252

. Source: DI# 2 -Suburban Application, Exhibit 1Aand Annual Report on selected Maryland General and Special Hospital Services, FY 2016

[4] The jurisdictional need projection consists of a range between a minimum gross bed need and a maximum gross need for MSGA beds and pediatric beds.

Private hospital rooms have been the design standard of the Facility Guidelines Institute[5] for the past ten years and has been linked to improved patient safety. The industry has moved to this standard to such a great extent that private room accommodation is now a widespread patient expectation.. MHCC has established a precedent of allowing Maryland general hospitals to expand in order to operate their licensed bed capacity in private rooms without forcing the expense of physically converting semi-private room designs so that the rooms could not actually function with two beds (e.g., by requiring the hospitals to pull out headwalls and gaslines).

Staff recommends that this project be found to comply with this standard, on the basis that the project does not have the objective of increasing MSGA or pediatric bed capacity but, rather, operating its licensed bed capacity in private patient rooms. As with other projects of this type, staff recommends that the project approval come with *the condition that the Hospital will not routinely use any room on an MSGA nursing unit including the ICU and CCU units for more than one patient without the approval of MHCC.*

(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.

The applicant is not seeking to establish a new pediatric unit. This standard is not applicable.

(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

[5] Guidelines for Design and Construction of Hospitals and Outpatient Facilities– The Facilities Guidelines Institute, 2014 edition,p.122

indigent and/or uninsured.

Addressing part (a) of this standard, the Hospital stated that it does not plan to seek a rate increase in conjunction with this project. Addressing part (b), Suburban noted that the goal of the proposed project is rightsizing and modernizing its facilities to position it to continue to provide its current mix and quality of services.. It does not seek to eliminate any services and no changes in the hospital resulting from this proposed project will have an impact on access for indigent and/or uninsured patients.

Staff concludes that the proposed project complies with this standard and will not have an adverse impact on the charges for, or availability of, 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.

The hospital described alternatives it considered and ranked the ability of each alternative to satisfy objectives used in its decision criteria. Alternatives considered included replacement of the hospital at a new site; renovation of the existing building, which would entail a reduction in its scope of services; and expansion of the existing hospital.[6]

Project objectives and prioritization of objectives was described as emerging from a comprehensive facility master planning process that included physical inspections of existing conditions, interviews with various user groups, surveys of staff and a review of existing and projected volumes. Suburban's consultant then looked at the facility through the prism of industry space planning benchmarks (incorporating current codes and industry standards) and found significant facility-wide space deficiencies. The study suggested that Suburban's entire building should be expanded by about 130,000 square feet (approximately one third) to handle the workloads, as of the 2005 assessment. Examples of severe deficiencies included: a surgery department that was sized at just 60% of the benchmark; inpatient units that were sized at just 50% of benchmark, and interventional radiology, sized at just 75% of benchmark. (DI#2,p.34) The priorities were:

- Private patient rooms;
- "State of the Art" operating rooms;
- Adequate parking for patients, physicians, employees, visitors, and vendors;
- Improved campus circulation;
- Providing for future flexibility on a unified campus;
- Predictability for, and compatibility with, Suburban's surrounding neighborhood; and
- Providing physician office space.

These priorities, along with the cost considerations and phasing implications became the primary factors used in considering alternatives.

Limited consideration was given to the alternative of relocating the hospital to an alternative site because:

- Suburban found that there was limited property available that would allow it to continue to serve its existing service area, the cost of any available properties was prohibitive, and few developers were interested in a hospital being located on their land.
- Suburban's unique location across from NIH has fostered a research partnership that no other community hospital can provide. The role that the hospital can play in giving the community access to this partnershipis a benefit that is difficult to quantify but was considered important to maintain.

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[6] The second and third alternatives also included building a new parking garage, a project that was determined not to require a CON and is underway.

The second alternative – renovating its existing facility without expansion would require Suburban to reduce the scope of services it provides because the existing facility's infrastructure and grid would not be able to accommodate advances in technology. Thus this alternative was deemed to be only a short term solution because it would restrict Suburban's ability to provide high quality care in the future.

Suburban concluded that the selected alternative of expansion on site best addresses the campus deficiencies identified in the master planning process by upgrading hospital facilities and improving campus circulation. It was determined to be the most cost effective alternative, allowing Suburban to provide high quality, cost effective care for decades to come, while providing flexibility to adjust to future changes without significant additional expansion. See Appendix 3 for Suburban's Decision Matrix for Evaluating Alternative Solutions.

The applicant has met the standard.

(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.

Suburban responded to this standard with a statement that the purpose of the project is to address space deficiencies and structural grid limitations that restrict its ability to meet current architectural standards and evolving healthcare delivery needs. Suburban stated that it is proposing no new services, additional bed capacity, and is reducing licensed operating rooms by one, and referred readers to its response to the Need criterion at 10.24.01.08G(3)(b).

Staff addresses the need demonstration made for this project in its review of the Need criterion and in its analysis of need-related SHP standards, elsewhere in this report. In summary, staff concluded that Suburban carried its burden of proof regarding need.

(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, adjusted for specific construction characteristics of the proposed project, with an index cost (i.e., essentially, an "expected cost") derived from the Marshall Valuation Service ("MVS"). The MVS methodology allows for a variety of adjustment factors related to the specific circumstances of the project, e.g., timing of the project, the locality, the number of stories, height per story, shape of the building (e.g., the relationship of floor size to perimeter), and departmental use of space. For a more complete explanation of MVS, see Appendix 4.

For this project Suburban developed an MVS benchmark cost for the new construction portion of the project ($325.37 per SF). Suburban adjusted the base costs for factors such as the sprinkler system for each component, the specific departments included (departmental differential cost factor), the shape of the building addition, average wall height, current cost, and local costs. Adjustments were also made for additional elevator stops in the basement and penthouse.

In comparing its estimated costs to the MVS benchmark, Suburban made adjustments to its estimated costs for demolition, storm drains, rough grading, hillside foundation, paving, signs and landscaping, that are explicitly excluded from the MVS calculator costs. Suburban also made adjustments for extraordinary costs that it considered to be over and above the costs captured by the MVS calculator. These adjustments included the additional cost of constructing on a restricted site, of constructing so that additional floors can be added in the future, and of meeting Leadership in Energy and Environment Design ("LEED") Silver Premium standards. After these adjustments, Suburban calculated an adjusted cost of $329.94 per SF, $4.57 above the MVS benchmark for comparable hospital construction in Bethesda, Maryland.

The MVS methodology does not offer data for renovation projects; thus any effort to compare proposed renovation costs to a benchmark can only be made to the benchmarks for new construction. (Therefore, the MVS benchmarks are typically much higher than the costs estimated by applicants for the renovation portion of projects.) Thus the benchmark Suburban developed for the renovation portion of the project was much higher than Suburban's estimated costs of $284.81 per SF for the proposed renovations

Commission Staff did its own MVS calculation (detailed in Appendix 4) and arrived at a benchmark of $324.95 per square foot for the new construction, slightly lower than Suburban's calculation. The table below shows Suburban's estimated cost for constructing the addition (with the adjustments described above) and Commission staff's allocation of interest and financing costs to the MVS benchmark calculated by Commission staff. It shows construction costs to be $2,137,633 ($7.10 per SF times 301,075 SF) above the benchmark.

Table IV-2: Comparison of Suburban Hospital's New Construction Budget to Commission's Staff Marshall Valuation Service Benchmark

Project Budget Item	Suburban Estimate
Building	$89,816,065
Fixed Equipment	10,507,670
Site Preparation	13,372,894
Architectural Fees	5,537,540
Permits	1,049,400
New Construction Subtotal	**$120,283,569**
Adjustments to Budget for Comparison to MVS Benchmark	
Adjustments to Site & Building Costs	24,986,258
Proportional Adjustment to A & E fees	1,327,366
Total Adjustments	**$26,313,624**
Adjusted New Construction Cost	**$93,969,945**
MHCC Addition of Allocated Const. Period Interest & Processing Fee	6,001,944
Adjusted Total for MVS Comparison	**$99,971,889**
Total Additional Square Footage	301,075
Adjusted Project Cost Per SF	**$332.05**
MHCC-calculated MVS Benchmark Cost Per SF.	**$324.95**
Total Over (Under) MVS Benchmark	**$7.10**

Data Sources: Suburban Hospital April 10, 2015 Application pages 40 through 50 and Commission Staff calculations

This standard requires that any rate increase proposed by the 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."

Since the MVS costs already include capital construction interest, the excess construction cost only needs to be adjusted for the contingency and inflation allowances. Staff has apportioned these costs by the percentage that Suburban's estimates exceed the MVS benchmark (1.2%) calculated by staff. The resulting exclusion is shown in the following table.

Table IV-3: Calculation of excess cost

Construction cost exceeding benchmark ($7.10 x 301,075 SF)	$2,137,633
The portion of future inflation that should be excluded ($10,104,821 x 1.2%)	$121,258
The portion of the contingencies that should be excluded ($8,533,323 x 1.2%)	$102,400
Total to be excluded from any rate increase proposed by the hospital related to the capital cost of the project	**$2,361,291**

Based on this analysis, staff recommends that approval of the project should be accompanied by the following condition:

Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $2,361,291. This

figure includes the estimated new construction costs that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

(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.

There is no non-hospital space proposed.

(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.

Suburban submitted documentation that the two new nursing units proposed would be sized at :

- 12,740 net square feet (SF), yielding 425 SF per bed for the 30-bed unit, and ;
- 11,434 net SF, yielding 476 SF per bed for the 24-bed unit.

The proposed space for the nursing units is below the 500 SF per bed threshold, and thus meets the 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.

Suburban stated that this standard is not applicable because it has not been designated a high charge hospital by the Health Services Cost Review Commission, which has been confirmed by MHCC staff.

(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.

Suburban provided a description of the ways in which the design of the proposed project will upgrade efficiency. Those features are: (DI#3, p. 56)

- Optimally locating supply and medication rooms on nursing units to minimize nurse travel
- Relocating the clinical decision unit from 6th floor to 2nd floor, reducing the time required for patient transport;
- Relocating central transport to an area accessible to both the existing facility and the proposed building addition, making for shorter patient transports from nursing units to diagnostic and treatment services or from the emergency department/ trauma center to a patient room;
- Relocating and renovating the receiving department to provide optimal access to the loading dock;
- Creating a consolidated conference room area which will allow media services to be more efficient rather than having conference rooms located in multiple locations throughout the hospital;
- Designing the new nursing units to allow the sharing of a family area rather than dedicating separate space to each unit;
- Converting to all private medical/surgical rooms, providing the ability to achieve high occupancy because beds in semi-private rooms will not have to be blocked for isolation patients. Additionally, multiple patient transfers between rooms due to roommate conflicts such as noise which requires nursing time to effect the moves will be eliminated; and
- Including separate elevator banks segregating patients, service and the public will provide more efficient vertical transport through the building addition.

Suburban also identified efficiencies specific to the surgical suite:

- Relocation of the surgical suite to be adjacent to the emergency department/trauma center rather than five floors away will reduce the time required for patient transport between the two departments;
- Due to space limitations, Suburban currently performs minor procedures, such as endoscopy, on a separate floor with separate pre-op and recovery staff. This service will be co-located within the surgical suite. This physical adjacency will provide for efficient staffing of pre and post procedure care rather than requiring maintainance of separate staffs complements;
- Co-locating pre-operative holding and secondary recovery allows for economies of scale because one can overflow to another at high demand times. The adjacency provides the ability for both areas to flex; each area has a distinctly different high time of demand. The adjacency also provides for staff to be efficiently shifted between the areas as needed;
- Relocating central sterile to one floor below the operating room with dedicated lifts for clean and dirty transport will allow more efficient delivery and removal of supplies and instruments. Currently central sterile is six floors away from the operating rooms and relies on an outdated dumbwaiter system to move materials;
- The design includes two consultation rooms located near the waiting room for families to receive patient statusupdates. While Suburban currently has one consultation space, it is not in a convenient location, making it inefficient for surgeons to use. The planned location will increase physician efficiency as well as enhance communication and increase patient confidentiality;
- Surgical Pathology will be relocated to the operating room suite. Currently it is located six floors away from surgery. Locating the service within the suite will eliminate the need for runners to transport the specimens and will foster greater and more timely communication between surgeon and pathologist.
- The design of the operating room includes efficient and effective sterile cores strategically located between two pods of operating rooms. This will allow for better organized and readily accessible storage of supplies. The design also allows for more efficient turnover of operating rooms;
- In addition to the sterile core, the operating room will have sufficient storage for equipment and less frequently used supplies. Currently there is inadequate storage requiring equipment to be stored elsewhere in the hospital;
- The operating rooms sizes and shapes will allow for adequate storage of critical stock within the operating room minimizing the need for staff to leave while a case is being performed;
- The operating rooms size and shapes will allow for flexibility in the types of cases that can be performed. Suburban's flexibility is currently limited due to the small sizes and awkward shapes of many existing operating rooms. This flexibility allows Suburban to reduce its licensed capacity from 15 to 14 operating rooms. This will not result in a savings in staff as staff currently shift between rooms; it will end up generating a higher utilization rate of operating room capacity; and.
- The nursing units located within the proposed building addition will be designated primarily for surgical patients. With patient-only designated elevators in the proposed

project, this will provide for more efficient transfer from the operating room to the patient room.

In response to staff's request to quantify productivity gains that would accrue from these design efficiencies, Suburban stated that it projects an occupancy rate in 2022 that is higher than in any of the previous years, and that each nursing unit has fixed staff including nurse managers, assistant nurse managers, educators, social workers, s and a unit secretary. Suburban said that none of these positions will need to flex up to accommodate a higher census. This naturally results in a lower FTE per occupied bed on the nursing units. However, the substantial expansionof the facility will require an increase of 4.6 pharmacy staff (13%) and 49.2 (3.5%) support staff (e.g., housekeeping, security, maintenance). (DI#26)

Suburban also compared overall FTE levels in 2015 with the projected FTEs in 2022 arrayed against the projected volumes for the key measures of the hospital's core services as shown below. (Note: Suburban defined each of the volume measures listed below as a "unit.")

	2015	2022
Inpatient Days	59,624	64,261
Observation Days	3,900	4,709
ED Visits	34,858	38,227
Outpatient Surgery Visits	6,593	6,853
Total	104,975	114,050
Total Hospital FTEs	1,400	1,471
Units/FTE	74.96	77.54

Aggregated productivity per unit of service is expected to increase to 77.54 units/FTE from 74.96 units/FTE, a 3.4% gain in productivity.

Suburban also presented information specific to the surgical department showing no FTE changes as projected volume increases, resulting in a 6.8% productivity gain.

	2015	2022
Total Cases	8,338	8,906
OR FTEs	142.5	142.5
Cases/FTE	58.5	62.5

The applicant has provided a credible narrative description of features of the proposed project that would be expected to improve efficiency. In projecting the impact on staffing that the project might produce, however, Suburban did not translate these design efficiencies into staffing economies. Instead, core clinical staff in the affected areas remained constant, while additional pharmacy and support staff are projected to be needed. The applicant's estimates of productivity gains is premised on relatively modest volume increases.

Staff concludes that the applicant has met 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.

Suburban stated that in establishing project priorities and subsequent design of the project it gave significant weight to patient safety. All user groups include multi-disciplinary participation including clinicians, support services and advocates from Suburban's Patient and Family Advisory Committee. Suburban identified the new nursing units, the new operating room suite and the new main entrance of the hospital as key areas to improve patient safety.

Nursing Units

Suburban states that features in the new nursing units that will improve patient safety include:

- Reduced number of trips between the patient room and the nurse station
- Reduced time spent gathering supplies
- Increased ability to do data entry in the patient room or at touch-down stations
- Better visibility and access to the patient

Surgery

Suburban notes that patient safety features included in the operating room suite are described under the surgical service standards of the application (10.24.11.05.B.(6)).

Main entrance

The application states that the creation of a new main entrance allows for the segregation of the majority of patient pedestrian traffic from the circulation of emergency vehicles and helicopters. The new main entrance is also much closer to the parking garage being built, providing easier and safer movement from parking to the hospital facility.

Suburban meets 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.

Suburban projected that staffing would vary with changes in volume and would increase for the additional staffing required in the general services departments for the additional square feet

associated with the project. Suburban also stated that it made no assumptions regarding potential productivity improvements to staffing. Suburban projected non-salary expenses utilizing reasonable inflation factors. However, Suburban also made other adjustments to expenses to reflect planned programmatic changes. For example, supplies and other expenses were projected to change by 6.4% between 2016 and 2017, (2.3%) between 2017 and 2018, 4.9% between 2018 and 2019, .2% between 2019 and 2020, 3.7% between 2020 and 2021, and 4.5% between 2021 and 2022. These annual percentage changes incorporate the 2% to 3% inflation factor assumed for non-salary expenses. 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.

(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;

In regard to (b)(i), the applicant's utilization projections are consistent with historical utilization trends.

(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;

Regarding (b)(ii), Suburban stated that the assumptions utilized in preparing the revenue projections in the CON application were based upon current Health Services Cost Review Commission (HSCRC) methodologies. The methodologies utilized by Suburban in projecting revenues were based upon the methodologies utilized when the HSCRC granted rate increases effective July 1, 2015 for the year ended June 30, 2016 and are reasonable, as confirmed by HSCRC staff (See Appendix 6).

(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

Suburban projected that staffing would vary with changes in volume and would increase for the additional staffing required in the general services departments for the additional square feet associated with the project. Suburban also stated that it made no assumptions regarding potential productivity improvements to staffing. Suburban's overall salaries and benefits for Registered Nurses and Total Employees appear reasonable when compared to the other hospitals in Montgomery County.

(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.

Based on projected utilization, revenues, and expenses, which are based on reasonable assumptions, Suburban has projected the ability to generate excess revenue ranging from 101.6% to 104.8% of expenses over the time period of 2016-2022 which covers construction and the first 2 years of operation of the expanded and renovated hospital. Based on this analysis, the project complies with this standard.

(14) Emergency Department Treatment Capacity and Space
(15) Emergency Department Expansion

Neither of these standards is applicable. Suburban's emergency department is not touched by this project.

(16) Shell Space

(a) 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.
(b) 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
(i) considers the most likely use identified by the hospital for the unfinished space and
(ii) considers the time frame projected for finishing the space and
(iii) demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.
(c) 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.
(d) 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.

Suburban proposes to construct shell space on both the second and third floors of the new building addition, with finished nursing units on the fourth, and top floor. Since the shell space would be supporting finished space, Suburban is not required to present a net present value analysis, but is required to provide information concerning the most likely use and time frame for finishing the space, as well as a cost estimate.

The second-floor space is intended for physician offices and anticipated first use is within a year of opening the building addition. This 35,212 gross square foot ("GSF") space is unregulated space, with respect to rate regulation and its intended use. It is estimated to cost $6,197,312 (35,212 GSF x $176/SF) to construct. An additional allowance of $1,400,000 was included in the project budget to fit out the physician office space, bringing the total cost attributed to this component of the project to $7,597,312.

The third floor will have the same footprint as the fourth floor, and Suburban anticipates that the most likely use of the third floor space will be the relocation of two additional nursing units from the existing building to the new building. Thet decision on when this will occur is anticipated to be made within the next five years. Suburban expects to finish thespace within the next 10 years, as capital is available. The estimated current cost of shelling this space is $6,192,384 (35,184 GSF x $176/SF).

Suburban cited the two benefits associated with including this shell space in the project:

(1) Building as part of this project will avoiding the lengthy and arduous zoning review process, which consumed six years for the current project and cost $5,713,867; and
(2) There will be cost saving and convenience associated with having vacant space to use for staging during the renovation process following new construction. With the completion of this project, Suburban does not anticipate making any substantial changes to the hospital campus for decades (DI#2, p.103)

The applicant has provided the required information concerning the most likely use and timeframe for finishing the space, as well as the cost to construct the shelled space as part of this project. Suburban has made a reasonable case for the cost effectiveness of constructing the shell space now rather than adding space later.

Staff concludes that Suburban has met the requirements of this standard. However, subpart (d) of the standard requires that "the cost of the shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest associated with such construction be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission until such time as the space is put into for rate regulated activities." Thus the amount that would be excluded from any future rate adjustment request includes:

- $12,389, 696 for the cost of constructing the shell space;
- $942,000 in contingency costs (7.6%);
- $681,000 (5.5%) for future inflation;
- $1,152,000 in estimated capitalized construction interest (9.3%); and
- $1,400,000 for the fit out of the physician space.

Thus, any requested adjustment in budgeted revenue related to this project, must exclude this $16,565,000. As previously noted, Suburban does not anticipate seeking such an adjustment.

Any approval of this project should include the following conditions on the CON, as is standard for hospital projects containing shell space:

- *Suburban Hospital will not finish the third floor shell space without giving notice to the Commission and obtaining all required Commission approvals, nor shall it finish space on the second floor for rate regulated uses without giving notice to the Commission and obtaining all required Commission approvals.*

- *Suburban Hospital will not request an adjustment in rates from the Health Services Cost Review Commission ("HSCRC") that includes depreciation or interest costs associated with construction of the proposed shell space unless and until Suburban Hospital has obtained CON approval for finishing the shell space, or has obtained a determination of coverage from the Maryland Health Care Commission that CON approval for finishing the shell space is not required.*

- *In calculating any future rates for Suburban Hospital the HSCRC shall exclude the capital costs associated with the shell space until such time as the space is finished and put to use in a rate-regulated activity. In calculating any rate that includes an accounting for capital costs associated with the shell space, the rate should only account for depreciation going forward through the remaining useful life of the space (i.e., the HSCRC shall exclude any depreciation of the shell space that has occurred between the construction of the shell space and the time of the rate calculation. Likewise, allowable interest expense shall also be based on the interest expenses going forward through the remaining useful life of the space.*

COMAR 10.24.11 State Health Plan for Facilities and Services: General Surgical Services

.05A. General Standards.

The General Surgical Services chapter of the SHP, COMAR 10.24.11, guides CON reviews involving surgical facilities. In the review of general hospital projects which involve expenditures for surgical facilities, this chapter supplements COMAR 10.24.10, *Acute Care Hospital Services.*

Hospital applicants are required to address all standards applicable to its proposed project in both the acute care hospital services and the general surgical services chapters of the SHP; however, COMAR 10.24.11 states that: "A hospital is not required to address standards in this Chapter that are completely addressed in its responses to the standards in COMAR 10.24.10."

Suburban Hospital has 15 operating rooms ("ORs"), 12 mixed-use general purpose ORs, two inpatient special purpose ORs (for cardiac surgery), and one outpatient special purpose OR. The proposed project would relocate the surgical suite from the fifth floor of the existing building to the

first floor of the new addition. The suite would consist of 14 ORs -- 12 mixed-use general purpose ORs and two inpatient special purpose ORs.

The standards in the *General Surgical Services* chapter that duplicate standards from the *Acute Care Hospital Services* chapter, and are addressed in the preceding section of this report, are COMAR 10.24.11:

- **.05A (1)** ***Information Regarding Charges***
- **.05A(2),** ***Charity Care Policy***
- **.05A(3)** ***Quality of Care***
- **.05B(7)** ***Construction Costs***
- **.05B(8)** ***Financial Feasibility.***

Analysis of these standards will not be repeated here.

Among the remaining applicable standards are several that prescribe policies, facility features, and staffing and/or service requirements that an applicant must meet, or agree to meet prior to first use. Staff has reviewed the CON application and confirmed that the applicant provided information and affirmations that demonstrate the proposed relocation and replacement of Suburban Hospital complies with Standards:

.05A(4), Transfer Agreements;
.05B(4), Design Requirements; and
.05B(5), Support Services.

Staff has concluded that the replacement and relocation of the surgical suite at Suburban Hospital meets the requirements of these standards. The hospital has written transfer and referral agreements with hospitals capable of managing cases that exceed its capabilities.The project meets the design requirements in Section 2.2 of the FGI Guidelines. Suburban provides the required support services (laboratory, radiology, and pathology). The text of these standards, as well as the location within the application where compliance is documented, is attached as Appendix 5.

.05B. Project Review Standards.

(1) <u>Service Area.</u>
An applicant proposing to establish a new hospital providing surgical services or a new ambulatory surgical facility shall identify its projected service area. An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall document its existing service area, based on the origin of patients served.

Since the applicant proposes to reduce the total number of operating rooms from 15 to 14, this application is neither a proposal to *establish a new hospital providing surgical services* nor a proposal *to expand the number of operating rooms at an existing hospital,* and thus is not applicable. Suburban did identify its service area.

Suburban provided a map of the service area and a list of the zip code areas included in the primary and secondary service area for the hospital's inpatient and outpatient surgical discharges for FY 2014. (DI #2, Exhibit 21) The service area described represents 85% of the hospital's 2014 inpatient and outpatient surgical cases.[7] The primary service area consists of 31 Montgomery County zip code areas; the secondary service area consists of 53 zip code areas covering the remainder of Montgomery County, parts of Prince George's and Frederick Counties and the District of Columbia. (DI #2, Exhibit 21)

The applicant does not anticipate the primary or secondary service area will change as a result of this project.

(2) Need - Minimum Utilization for Establishment of a New or Replacement Facility.

An applicant proposing to establish or replace a hospital or ambulatory surgical facility shall demonstrate the need for the number of operating rooms proposed for the facility. This need demonstration shall utilize the operating room capacity assumptions and other guidance included in Regulation .06 of this Chapter. This needs assessment shall demonstrate that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the initiation of surgical services at the proposed facility.

(a) An applicant proposing the establishment or replacement of a hospital shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for inpatient and outpatient surgical procedures by the new or replacement hospitals likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed new or replacement hospital by surgical specialty or operating room category; and

(iii) In the case of a replacement hospital project involving relocation to a new site, an analysis of how surgical case volume is likely to change as a result of changes in the surgical practitioners using the hospital.

Background

Currently Suburban Hospital has 15 licensed ORs, of which three are designated special purpose ORs (two for cardiac surgery and one dedicated for outpatient surgical cases); the remaining 12 ORs are designated mixed-use general purpose and handle non-cardiac inpatient and outpatient surgical cases. With regard to the trauma program, Suburban Hospital accommodates these

[7] The applicant states the source for the FY 2014 data is JHM Datamart: Inpatient – HSCIMAIN, Outpatient HSCRCOMAIN; (HSCRC data extract).

procedures based on operating room availability and does not dedicate a particular OR for these cases.

This project will reduce the OR complement by one room. The table below shows the current and proposed OR and Procedure Room complements.

Table IV-4: Proposed Changes to Operating Room and Procedure Room Inventory
Suburban Hospital

Room Type	Current Inventory*	Proposed Inventory**
Mixed-use General Purpose OR	12	12
Inpatient Special Purpose OR	2	2
Outpatient Special Purpose OR	1	0
Dedicated Cesarean Section OR	0	0
Dedicated Cystoscopy Procedure Room	1	1
Dedicated Endoscopy Procedure Room	1	1
Other Procedure Room	1	1

*Source: MHCC Supplemental Survey: Surgery Capacity, 2015
** DI #2, Exhibit 10

Suburban Hospital describes the following deficiencies in its surgical suite that led to the proposal to replace and relocate. (DI #2, p. 77)

- The inability of the building's existing structural grid to support technology-intensive space needs, such as intra-operative imaging;
- The ORs are too small and awkwardly shaped. The makes them inflexible. Some rooms cannot be used for some types of procedures. This reduces the efficiency at which the room complement can be used.;
- The existing surgical suite is located on four separate wings, making the layout ineffective and causing inadequate adjacencies; and
- The ORs are currently located five floors away from the emergency department and trauma center, and six floors from sterile processing.

Needs Assessment

The table immediately below provides FY2014 and projected OR utilization for the mixed-use general purpose operating rooms, excluding the utilization for cardiac surgery. In developing its calculation of the need for ORs, the applicant followed the guidelines in 10.24.11.06A which specify: that the calculations should assume that the average clean-up and turnaround time for an OR is 25 minutes, and; the optimal capacity for a mixed-use OR is 80 percent of full capacity, or 1,900 hours (114,000 minutes) per year.

Suburban projected future (non-cardiac) inpatient surgical utilization as a function of MSGA discharges. That ratio in 2014 ws 36.9% (11,599 MSGA discharges and 4,276 non-cardiac

inpatient surgeries), and that assumption was applied to Suburban's projected MSGA discharges to arrive at projected (non-cardiac) inpatient surgical cases in future years. Similarly, Suburban projected outpatient surgery case volume as a function of inpatient surgeries; i.e., in 2014 outpatient surgical volume was 3,675, 86% of the inpatient total. Suburban assumed that same relationship between inpatient and outpatient surgical volume will apply in the future. The mnutes per case were also derived from 2014 experience. The average OR time for an inpatient case in 2014 was 152 minutes and, for outpatient cases, 100 minutes.

Calculations using these variables and assumptions were used to generate a need projection for 10.7 non-cardiac rooms in 2014 and 12 rooms in 2022. (See the following table.)

Table IV-5: Suburban Hospital's Historic and Projected Utilization Mixed-Use General Purpose Operating Rooms (excludes Cardiac Surgery), FY 2014 – FY 2022

Fiscal Year	IP Cases	OP Cases	Total Cases	IP Surgery Mins.	OP Surgery Mins.	Total Surgery Mins.	Turnaround Time Mins.	Total Surgery Minutes	No. ORs Needed @ Optimal Capacity
2014	4,276	3,675	7,951	650,333	369,532	1,019,865	198,775	1,218,640	10.7
2015	4,484	3,854	8,338	682,025	387,540	1,069,564	208,462	1,278,026	11.2
2016	4,475	3,846	8,321	680,535	386,693	1,067,228	208,006	1,275,234	11.2
2017	4,519	3,884	8,403	687,366	390,575	1,077,941	210,094	1,288,035	11.3
2018	4,531	3,894	8,425	689,152	391,590	1,080,742	210,640	1,291,382	11.3
2019	4,560	3,919	8,479	693,471	394,044	1,087,516	211,960	1,299,476	11.4
2020	4,636	3,985	8,621	705,133	400,670	1,105,802	215,525	1,321,327	11.6
2021	4,713	4,051	8,764	716,794	407,296	1,124,090	219,089	1,343,179	11.8
2022	4,790	4,116	8,906	728,455	413,923	1,142,378	222,653	1,365,031	12.0

Source: CON application, DI#2

Suburban is also proposing to replace its two special purpose (cardiac surgery) ORs. The SHP is less prescriptive in defining assumptions and parameters for special purpose ORs, providing, at COMAR 10.24.12. :

> (c) Special Purpose Operating Room.
>
> Optimal capacity for a special purpose operating room is best determined on a case-by-case basis, using information provided by an applicant regarding the population and/or facility need for each such operating room, the documented demand for each such operating room, and any unique operational requirements related to the special purpose for which the operating room will be used.

Table IV-7 immediately below reflects Suburban's 2014 utilization of its special purpose ORs for cardiac cases (266) in FY 2014. The applicant calculated the need for rooms using the same

average turnaround time assumption (25 minutes) and optimal utilization targets (1,900 hours per room per year) as it did for general purpose, mixed-use rooms.

Table IV-7: Suburban Hospital
FY 2014 Cardiac Surgery Operating Room Utilization

Fiscal Year	Cardiac Cases a	Surgery Minutes - Cardiac b	Cardiac Minutes/ Case c = a*b	Turnaround Time Minutes[1] d = 25 * b	Total Surgery Minutes e = b + d	No. ORs Needed @ Optimal Capacity f=e/ (1,900[2]*60)
2014	266	84,124	316.3	6,650	90,774	0.8

Source: DI #2, p. 78.
[1]Average turnaround time of 25 minutes/case
[2]Optimal capacity of mixed-use operating rooms at 80 percent of full capacity (1,900 hours/ year), as provided in COMAR 10.24.11.06A(1)(a)(ii).

Given that the average time for a cardiac surgery case was 316.3 minutes, the 2014 volume could be accommodated in a single room, as shown in the table However, the applicant will designate two ORs for special purpose cardiac surgery, with one used for open heart procedures and the other as standby for emergent cases. As previously noted, Suburban is a designated hospital for trauma cases.

Staff has reviewed the utilization assumptions and the capacity assumptions used in the applicant's need assessment and find that they are reasonable and consistent with the SHP. The proposed project is consistent with this standard.

(6) Patient Safety.

The design of surgical facilities or changes to existing surgical facilities shall include features that enhance and improve patient safety. An applicant shall:

(a) Document the manner in which the planning of the project took patient safety into account; and

(b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities;

Suburban stated that a multi-disciplinary team including nurses, physicians, laboratory and imaging staff, clinical engineering, environmental services, materials management, and the Patient & Family Advisory Council advocate participated in the design of the operating room suite. (DI #2, pp. 83-84) The following patient safety features were included in the final design of the for the surgical suite (DI #2, p. 9):

- The relocated operating rooms will be larger than the existing rooms and configured in a square shape to promote better access to the patient for medical staff and technology;

- Standardization of the operating room configuration (i.e., size, shape and layout) will improve patient safety through consistent placement of critical supplies and equipment;
- The space to accommodate the appropriate stock of supplies in the operating room will eliminate the need for a staff person to leave the room for supplies and equipment during a procedure;
- Each OR will be equipped with video/digital equipment to facilitate safe conditions and standardization;
- Monitoring equipment will be located within the OR for proper access and visibility by both the surgical nurse staff and anesthesiologist;
- A case cart system will be implemented with a clean core design and dedicated travel paths to improve access to supplies and reduce cross traffic with patient transfer;
- Having the correct ratio and location of prep and recovery areas will improve patient flow and access to the appropriate level of nursing care;
- Air filtration with a minimum of 25 air changes per hour will provide for better infection control;
- Installing durable monolithic flooring will reduce opportunities for contamination that come with damaged or degraded surfaces in traditional sheet flooring;
- Communication errors that can be a cause of wrong site surgeries will be reduced by maintaining visual connections among staff work areas;
- Implementation of current FGI Guidelines for Healthcare Construction and using antimicrobial surfaces where appropriate will limit acquired infections;
- Computerized physician order entry will be utilized to reduce medication errors.
- Surgical pathology will be located within the surgery suite to encourage timely communication between surgeons and the pathologist, and will minimize the risk of lost specimens as the need to transfer specimen via "runners" will no longer be necessary; and
- Including a hybrid OR will allow certain cases currently performed in the interventional radiology or catheterization labs to be performed in the OR suite, minimizing the need to transfer a patient with a negative outcome from another floor.

The applicant has provided evidence that indicates patient safety issues have been considered in the design of the new surgical services department. Staff finds that the applicant meets 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. 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. 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 Suburban. In the case of the proposed project this includes the need to increase the number of private rooms, the need to relocate the surgery department, the need to improve campus circulation and the need to construct space for physician offices within the building addition, as well as the need for the number of MSGA beds proposed.

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) and recommended a finding of consistency provided that the project be approved with a condition restricting the routine use of most patient rooms to single occupancy. The project does increase the physical bed capacity of the hospital because new private patient rooms are being built to accommodate hospital beds currently operated at the hospital in semi-private rooms. Those semi-private rooms will remain in operation and their physical capacity for two beds will not change. The only change with respect to these rooms is that the hospital will set up and staff only one bed in these rooms. While Staff has concluded that the proposed project should be considered as one that does not involve an increase in MSGA bed capacity, which is not needed in Montgomery County, with the proposed condition, the need for the proposed capacity and the construction of additional space to accommodate the increase in private rooms will be discussed below.

The need for the number of operating rooms to be replaced in the newly constructed surgery department has also been considered previously in this report under COMAR 10.24.11.05B(2), the General Surgical Services Chapter. The analysis there found the proposed replacement of 14 operating rooms (a reduction of one) to be consistent with the standard. In this section we will limit discussion of this component of the project to the need to *relocate* the department.

Need to Modernize

Regarding the overall need to modernize the hospital, staff notes that Suburban Hospital is the only Montgomery County hospital that since 2000 that has not constructed or been approved to undertake a major modernization project. In fact the last construction of hospital space on the Suburban Hospital campus was in 1992 and the last major clinical addition was constructed in 1979.

Need for Private Rooms

As for the need for more private patient rooms, the SHP does not include a specific analysis of such need, but 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."[8] 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."[9] More importantly,

[8] State Health Plan for Facilities and Services: Acute Care Hospital Services, page 7
[9] Ibid, page 7

the Facility Guidelines Institute ("FGI") guidelines[10] call for private rooms on medical surgical nursing units in new construction unless the functional program demonstrates the value of a multiple-bed arrangement. Beyond the SHP's and FGI's recognition of private patient rooms as the design standard, staff finds that Suburban makes a strong case for the benefits of private rooms in terms of patient safety and patient satisfaction.

Need to Modernize and Relocate Surgical Facilities

Addressing the need to relocate its surgery department to the new building addition, Suburban points out that the department is spread over four wings of the hospital's fifth floor, and cites the following specific deficiencies of the current location and layout:

- The location of the surgery department on the fifth floor is distant from both the emergency department/trauma center on the first floor and central processing in the basement. This distance creates inefficiencies and, in the case of distance from the ED, increased transport time that can affect outcomes;
- The operating rooms are undersized, typically 380 square Feet, compared to an industry standard of 650 SF. and lack consistent configurations in part due to their construction over the past 50 years;
- The current facility does not provide the necessary ceiling space to accommodate current mechanical, communication and electrical systems and the structural needs of equipment to be hung from the ceiling;
- The location of support functions, such as pre-procedure and recovery space, on separate wings creates logistical inefficiencies which negatively impact patient flow and staff and physician efficiencies; andOther components of the surgery department are undersized including family waiting, pre-procedure and recovery and storage.

A review of the FGI guidelines for hospital surgical services indicates that operating rooms should have a minimum clear floor area of 400 SF. and operating rooms for image guided surgery or surgical procedures that require additional personnel or large equipment should have a minimum clear floor area of 600 SF. Most of Suburban's ORs do not meet the 400 square foot minimum, let alone the 600 square foot minimum for more complicated surgeries. The proposed project will bring the hospital's ORs to the minimum standard for operating room space. The proposed relocation of the surgery department to the first floor of the addition will place it adjacent to the Emergency Department and on the same level as radiology. Central Processing will be relocated to the basement of the addition, one level below the Surgery Department. All adjacency problems within the Surgery Department will be addressed and all components will be right-sized from the waiting room through recovery. The wall height of the proposed addition will be 15 feet compared to 10 feet in the current buildings in order to provide the necessary space for mechanical, communication and electrical systems and the structural needs of equipment to be hung from the ceiling.

[10] *The Facility Guideline Institutes*, 2014 Guidelines for Design and Construction of Hospitals and Outpatient Facilities

Need to Improve Campus Circulation

Construction of the addition will also eliminate the existing conflicts between pedestrian and vehicular traffic that result from the current location of the main entrance that is directly next to the walk in emergency department entrance and the ambulance bays and directly below the helipad. The proposed building addition will provide a new main entry that will serve to segregate private pedestrian traffic from emergency vehicles, both by land and air.

Need for Physician Office Space

Suburban is the only hospital in Montgomery County that does not have a medical office building or physician offices easily accessible to the hospital. The proposed project includes 35,000 square feet for this purpose on the second floor of the addition. While medical office space on hospital campuses in Maryland are typically located in separate buildings designed and constructed to less expensive standards than hospital space, space on the Suburban Hospital campus is limited and obtaining approval of the current project plan took a long time and involved compromises. Staff did question Suburban about the alternative of converted space that will be vacated as a result of the relocation of activity to the building addition. Suburban stated that consideration was given to converting the fifth floor that currently houses the surgery department to physician office space but this was rejected because the narrow wings would not provide the depth required for an efficient layout of medical office space and the existing elevators would not have the capacity for the foot traffic generated by such offices.

Bed Need

This criterion requires the Commission to consider the applicable need analysis in the State Health Plan ("SHP"). The latest SHP bed need analysis for MSGA and pediatric beds indicates the following 2022 bed need range for Montgomery County.

Table IV-8: Bed Need Projections, Montgomery County

	2022 Gross Bed Need		FY 2016 Licensed & Approved Beds	2022 Ned Bed Need	
	Minimum	Maximum		Minimum	Maximum
MSGA	805	1,103	1,072	-267	+31
Pediatric	20	24	48	-28	-24

Source: Maryland Register, Volume 41, Issue 5, March 7, 2014 and MHCC Annual Report on Selected General and Special Hospital Services, Fiscal year 2016

In evaluating the application, staff considered this need analysis as well as bed need projections submitted by Suburban.Staff notes that to achieve the minimum MSGA bed need each Montgomery County hospital could reduce its beds by 25%. That would mean Suburban would operate 157 MSGA beds, 52 fewer beds than its current license of 209 and 45 fewer beds than it proposes to operate upon completion of the project. It would imply operating at an annual average occupancy rate of 90.1% based on 2015 MSGA ADC, a rate that is too high based on SHP guidance. Clearly, an aggregated jurisdictional bed need projection has limitations in evaluating a bed need for a specific hospitals when the hospital is one of six operating in the jurisdiction.

In making its projection, Suburban assumed no change in its service area because it is already a well-established provider in the market and is not relocating. Thus,it projected discharges for the service area from which it drew 85% of its patients in 2014.[11] To calculate bed need of this service area, Suburban relied on projections prepared by Truven Health Analytics. The projected discharges reflect population, demographic and use rate changes

Truven used 2010 and 2011 discharge data to develop inpatient discharge rates by zip code area, age group, gender, payer, and DRG ("baseline use rates"). Truven then multiplied those rates by population projections by zip code area to estimate inpatient discharges for each of the projected years. Truven also developed a second set of projected discharges that took into account the DRG forecast trends, adjustments for CMS readmission penalties, and the effects of healthcare reform, which included changes in insurance coverage. Suburban used the Truven adjusted and trended discharges because they are more conservative than Truven baseline projections.

Suburban assumed no change in market share over the projection period. Market share percentages for psychiatric discharges and non-psychiatric discharges were applied to primary and secondary service area discharge projections for 2019 and 2024 provided by Truven. The results was then summed and divided by 85% to reflect non-service area discharges. Total Suburban discharges for the years 2020 through 2023 were calculated assuming straight line growth from 2019 to 2024.

Projected Suburban psychiatric discharges from its service areas for years 2019 and 2024 were calculated by multiplying the service area discharges projected by Truven by Suburban's 2014 market share for the primary service area and the secondary service area. The projected discharges for the intervening years (2020 through 2023) were again calculated using a straight line growth model. To account for out of area psychiatric discharges, Suburban divided the projected discharges from the service area by 95% instead of 85% because Suburban determined that its service area for psychiatric services was more concentrated.

For pediatric discharges, Suburban assumed that that their proportion of 2015 discharges would continue through the projection period.

Projected MSGA discharges were calculated by subtracting projected psychiatric and pediatric discharges from projected total discharges.

Patient days were projected by multiplying projected discharges by Suburban's 2014 average length of stay and the projected inpatient utilization by service for FY 2022 is detailed in the following table.

[11] The zip code areas that contributed the top 85% of Suburban's total discharges for MSGA, psychiatric, and pediatric patients plus adjacent zip code areas where Suburban's market share was 50% or greater.

Table IV-9: Suburban Hospital Inpatient Utilization By Service
Fiscal Year 2014 Actual and 2022 Projected

	MSGA	Pediatrics	Psychiatric	Total
Discharges				
Actual FY 2014	11,599	113	1,484	13,196
Projected 2022	12,992	81	1,613	14,686
Patient Days				
Actual FY 2014	50,424	205	7,144	57,773
Projected 2022	56,517	147	7,597	64,261
Avg. Length of Stay	4.35	1.81	4.71	4.38
Projected 2022 Avg. Daily Census	154.8	0.4	20.8	176
Beds in Operation-2022	202	3	24	229
Projected Occupancy Rate	76.6%	13.3%	86.7%	76.9%

Source: Suburban Hospital CON Application, Exhibit 1F

Staff considered Suburban's projections of increases in MSGA discharges and patient days and the bed need analysis in the SHP. The bed need methodology of the SHP calls for projections to be based on five year and ten year discharge rate trends; these trends, especially the five year trend have been negative, resulting in discharge rates that are projected to decrease over the ten year planning horizon.

Given Maryland's emphasis on population health and efforts and incentives to reduce potentially avoidable utilization, it is reasonable to expect a continuation of the downward trend in discharge rates. While Suburban's description of Truven's methodology indicates that Truven took some of these factors into account in its projection of discharges, it could not define Truven's approach in detail, making it impossible for staff to discern their impact on discharge projections. Specifically, the 2019 and 2024 discharge rates used by Truven to project service area discharges are not identified.

Therefore, staff undertook its own MSGA bed need projections using two methods, both based on discharge rate trends.

- The first method projected the 2024 minimum and maximum discharge rates for each zip code area in Suburban's 85% relevance service area by payer group (Medicare and Non-Medicare) based on the minimum rate trend, which was the five year trend from 2009 through 2014, and the maximum rate trend, which was the 10 year trend from 2004 through 2014.

- The second method projected 2024 discharge rates at the 85% relevance service area level for each payer group by extending the linear trend line for the period 2004 through 2014 through 2024.

Both methods used discharge data for DC hospitals as well as Maryland hospitals. The discharge rates were then applied to the projected 2024 population for the service area by age group to derive the total number of discharges for the service area.

Table IV-10: Staff's Comparison of Projected 2024 MSGA Discharges for Suburban Service Area

Projected 2024 Population					
		65+		15 - 64	
		324,615		1,181,975	
Projected CY 2024 Discharge Rate by Payer Group and Projected Discharges					
		Medicare		Non-Medicare	
Method 2: Linear prediction based on service area use rate trends (10 years)	Discharge Rate per 1,000 Pop.	160		33	
	Discharges	51,938		39,005	
		Min	Max	Min	Max
Method 1: Linear prediction based on 10 year and 5 year average annual change in use rate within each zip code area	Discharge Rate Per 1,000 Pop.	143	173	26	33
	Discharges	46,565	56,111	30,422	39,394

In Method 1, staff calculated Suburban's projected discharges using Suburban's market share by payor for each zip code area. In Method 2, staff projected Suburban's discharges by multiplying the service area total discharges by Suburban's 2014 market share for each payer group (13.18% for Medicare and 9.08% for Non-Medicare).[12] Because average lengths of stay have generally been increasing, especially for the non-Medicare population, staff used a logarithmic model to project Suburban's 2024 average length of stay by payer group. The resultant bed need projections at the minimum occupancy rate specified in the SHP for a hospital with an average daily census ranging from 100 to 299 are detailed in the following table.

Table IV-11: Comparison of Suburban Hospital Actual 2014 MSGA Utilization to MHCC Projected 2024 Utilization and Bed Need

		Base Year, CY2014	CY2024 (Method 1)		CY2024 (Method 2)
		Actual	Minimum	Maximum	Projection
Service Area Discharges	**Medicare**	6,200	5,507	6,574	6,846
	Non-Medicare	4,108	2,809	3,509	3,541
Total Discharges	**Medicare**	7,012	6,228	7,435	7,743
	Non-Medicare	5,185	3,545	4,429	4,469
Predicted Suburban ALOS, 2024	**Medicare**	4.65	4.47	4.47	4.47
	Non-Medicare	3.98	4.08	4.08	4.08
Patient Days		53,220	42,304	51,304	52,844
Average Daily Census		146	116	141	145
Bed Need	**at Occupancy Rate, 80%**	182	145	176	181

Staff's analysis indicates that it possible that Suburban will not achieve the utilization of MSGA beds that it has projected and will not need all the beds that it has proposed to operate. If

[12] 2014 market shares were used because staff analyzed Suburban's market share by payer for years 2004 through 2014 and determined that there was little change.

Suburban were proposing to replace all of its bed in new construction, staff would recommend that a condition be placed on the Commission's approval of the project. However, Suburban is proposing to leave 148 of the MSGA beds in an older building constructed before 1980. Even if Suburban eventually finishes the proposed shell space on the third floor of the building addition for MSGA nursing units, only 108 of the MSGA beds would be located in new space, significantly fewer than the 145 beds projected under the most conservative scenario detailed above. While consideration was given to adding a condition that Suburban vacate one or more of the older nursing units upon opening of the addition, such a condition was rejected as unnecessary under the current hospital rate setting system. It was concluded that if future utilization is in line with the numbers projected by staff, Suburban would logically respond by not staffing some of the older nursing units.

In summary, Suburban Hospital has demonstrated the needs of the population it serves for a larger and more modern hospital because of the age of its physical plant, pedestrian and vehicle conflicts at the hospital entrance, its limited number of private rooms and surgical facilities that no longer meet contemporary design standards. The proposed project will enable the operation of all MSGA beds in private rooms consistent with current guidelines and patient expectations. This type of room accommodation has already been achieved by its chief competitors. Relocation of the surgery department will correct the department's deficiencies in operating room and other spaces and ceiling heights. Adjacencies both within the department and to other departments, which are currently inefficient, will be addressed. The conflict between vehicle and pedestrian traffic arriving at the hospital for emergency services and patients and visitors arriving for other purposes will be corrected.

The applicant has demonstrated the need for the project.

C. Availability of More Cost-Effective Alternatives

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.

Please see the discussion under the cost-effectiveness standard in COMAR 10.24.10.04B(5) earlier in this report. A brief synopsis of the information found there is offered here.

Suburban described alternatives it considered and ranked the ability of each alternative to satisfy its stated objectives. These objectives emerged from a comprehensive master planning process that included an audit of existing conditions, interviews with user groups, staff surveys, comparison of Suburban's space with department by department industry benchmarks, and a review of existing and projected volumes. The priority objectives were:

- Private patient rooms;
- StateoftheArt operating rooms;
- Adequate parking for patients, physicians, employees, visitors, and vendors;
- Improved campus circulation;

- Providing for future flexibility on a unified campus; and
- Predictability for, and compatibility with, Suburban's surrounding neighborhood;
- Providing physician office space.

These priorities, along with the cost considerations and phasing implications became the primary screening factors in considering alternatives. Alternatives considered included replacement at a new site; renovation of the existing building, which would entail a reduction of its scope of services at its current site; and expanding the existing hospital.

Suburban stated that it did not perform detailed analyses regarding the potential to move to an alternative site because when the Hospital researched this alternative in the late 1990's there was limited property available that would allow the Hospital to continue to serve its existing service area, and the cost of what land was available would have been prohibitive. In addition, Suburban's current location across the street from the National Institutes of Health (NIH) provides numerous opportunities for the Hospital to collaborate with NIH which would diminish if Suburban moved to an alternative site.

The second alternative – renovating its existing facility without expansion -- would require Suburban to reduce the scope of services it provides because the existing facility's infrastructure and grid would not be able to accommodate advances in technology. Thus this alternative was deemed to be only a short term solution because it would restrict Suburban's ability to provide high quality care in the future.

Suburban concluded that the selected alternative -- expansion on site -- best addresses the need to upgrade hospital facilities and improve campus circulation; Suburban also considers it to be the most cost effective alternative, allowing Suburban to meet future needs and challenges.

The applicant has reasonably demonstrated that the project is a cost effective approach to modernizing the hospital in the most important ways needed at this time.

D. Viability of the Proposal

COMAR 10.24.01.08G(3)(d) Viability of the Proposal.
The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

The applicant identified the following sources of project funds:

• Cash:	$90,827,121
• Philanthropy:	$38,333,129
• Bonds:	$ 69,782,482
• Interest income on bond proceeds:	$1,608,099
	$200,550,831

As of the submission of the application, Suburban had raised $36 million in cash for the proposed project and has an additional $3 million in pledges. The total goal for philanthropic funding of Suburban's Campus Enhancement effort is approximately $75,000,000, of which approximately $38,000,000 is designated for the proposed project. Suburban's debt will be part of a larger debt offering by Johns Hopkins Healthcare System with $69,782,482 earmarked for the proposed project.

Suburban also states in the application that the Hospital and its non-hospital services affiliate had combined assets whose use is limited by the Board of Trustees of over $262 million that will be the source for the approximate $91 million in cash required for the project.

Suburban did not discuss in its response to this criterion whether it had evaluated alternative financing mechanisms. However, the financing mechanism proposed, i.e., philanthropy, cash and debt equivalent to 35% of total required funds is reasonable.

Due to the nature of the project – essentially a modernization and not an expansion of services -- staffing changes required as a result of the project will be concentrated in the general service areas to staff the additional square feet proposed for the project; of the additional 49.2 FTEs attributable to the project, 24.5 are housekeeping employees, 10.6 maintenance, 6.2 security, 3.0 central transport, 1.5 food service. There would also be 4.6 pharmacists added. Suburban stated that it does not anticipate any difficulties with recruiting these additional staff.

Finally, HSCRC provided a positive review of the financial feasibility of the project.

The applicant has demonstrated that it has the resources to implement this project and the utilization and financial projections made in planning the project are reasonable. It has demonstrated project viability.

E. Compliance with Conditions of Previous Certificates of Need

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

Suburban responded that it has been issued only one Certificate of Need since 2000, to establishment a cardiac surgery and percutaneous coronary intervention program in 2005 Suburban stated that it has been compliant with the conditions of that CON, which staff has confirmed.

The hospital complies with this criterion.

F. Impact on Existing Providers and the Health Care Delivery System

COMAR 10.24.01.08G(3)(f): "An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system."

Impact On Existing Providers

Suburban stated that since the proposed project is a modernization of the of the existing facility, with no changes to its service configuration, it will not have an impact on other providers. In calculating future volume projections, Suburban assumed no change in its market share.

Impact On Geographic And Demographic Access To Services

Suburban's proposed project includes physician office space, which is unregulated by HSCRC, within the building addition. Suburban states that it is one of the rare hospitals without a medical office building on campus, or even physician offices easily accessible to the hospital. Suburban states that providing physician office space[13] will have a positive impact on access to physicians' services. Suburban noted that, at present, specialists supporting its emergency department have private offices offsite. Traveling to the hospital from physician offices only a few miles from the hospital can often take considerable time, given the frequent road congestion in the D.C. area.Physicians with offices on the hospital campus can see more hospitalized patients and decision regarding admission or discharge can be made more quickly.

The applicant also stated that providing on-campus physician office space could increase availability of specialty services to the underserved by providing shared space to support specialty clinics. For example, Suburban coordinates and sponsors an endocrine clinic for underserved patients that must be organized offsite. The service is staffed by volunteer physicians, many of who work at NIH (across the street from Suburban Hospital). Clinics like this would be relocated to the hospital campus when physician space is available, making it easier to recruit volunteer physicians to support this program and others like it. It also will be more accessible for Suburban employees who volunteer their time in these clinics.

The availability of private rooms will increase overall access to hospital services because private rooms will obviate the need to block beds to accommodate isolation needs and gender differences, as must be done with semi-private rooms. The applicant states that this will reduce the number of times Suburban's emergency department will need to go on ambulance diversion (Suburban was on diversion for 519.6 hours in FY 2015).

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[13] The physician office space willbe utilized by specialists; Suburban is precluded by zoning conditions to lease space to family practice and primary care physicians and pediatricians. Additionally, zoning conditions require that only physicians with privileges to practice at Suburban may occupy the physician office space.(DI#2, p.102)

Impact On Costs To The Health Care Delivery System

Suburban has included no increase in patient charges related to the proposed project, and states that it expects to have a positive impact on reducing overall costs to the health care system by providing a safer and more efficient facility in which to deliver health care. Suburban also stated that it included "limited" savings related to staffing, the elimination of offsite lease expenses and the elimination of the shuttle bus service for offsite parking in its financial projections.

Finally, Suburban posited that there is also a long term cost savings associated with the proposed project because both the shelled space and the vacated space in the existing facility will provide long term flexibility to meet future needs, and provide a hedge against the zoning environment in which Suburban exists, and "will help avoid or postpone the need for future expansions requiring lengthy and costly zoning approval efforts." (DI#2, p.103)

Staff recommends that the Commission find that Suburban's proposed project will not have a direct or short-term negative impact on existing providers;. The project should allow the hospital to operate more efficiently and make the hospital more accessible and is not likely to have a negative impact (i.e., a rate adjustment impact) on charges of Suburban or on health care delivery system costs.

V. SUMMARY AND STAFF RECOMMENDATION

Based on its review and analysis of the Certificate of Need application, the Commission staff recommends that the Commission find that the proposed capital project complies with the applicable State Health Plan standards, is needed, is a cost-effective approach to meeting Suburban'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 the Suburban Hospital for a Certificate of Need for a building addition and modernization project to provide for all-private rooms in MSGA units, replace surgical facilities, through construction of a 300,000 square foot addition and renovation of approximately 18,000 square feet of existing facilities, at a cost of $200,550,831, with the following conditions:

1. *Upon completion of this project Suburban Hospital will not place any of the 45 semi-private MSGA patient rooms being converted to private rooms into service for more than one patient without the approval of MHCC.*

2. *Suburban Hospital will not finish the third floor shell space without giving notice to the Commission and obtaining all required Commission approvals, nor shall it finish space on the second floor for rate regulated uses without giving notice to the Commission and obtaining all required Commission approvals.*

3. *Suburban Hospital will not request an adjustment in rates from the Health Services Cost Review Commission ("HSCRC") that includes depreciation or interest costs associated with construction of the proposed shell space unless and until Suburban Hospital has obtained CON approval for finishing the shell space, or has obtained a determination of coverage from the Maryland Health Care Commission that CON approval for finishing the shell space is not required.*

4. *In calculating any future rates for Suburban Hospital the HSCRC shall exclude the capital costs associated with the shell space until such time as the space is finished and put to use in a rate-regulated activity. In calculating any rate that includes an accounting for capital costs associated with the shell space, the rate should only account for depreciation going forward through the remaining useful life of the space (i.e., the HSCRC shall exclude any depreciation of the shell space that has occurred between the construction of the shell space and the time of the rate calculation. Likewise, allowable interest expense shall also be based on the interest expenses going forward through the remaining useful life of the space.*

5. *Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $2,361,291. This figure includes the estimated new construction costs that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.*

IN THE MATTER OF	*	**BEFORE THE**
	*	
Suburban Hospital	*	**MARYLAND HEALTH**
	*	
Docket No. 15-15-2368	*	**CARE COMMISSION**
	*	

* *

FINAL ORDER

Based on the analysis and findings in the Staff Report and Recommendation, it is this 19th day of May 2016:

ORDERED, that the application for Certificate of Need by Suburban Hospital, Docket No. 15-15-2368, for a project that will build a 300,000 square foot addition and renovate approximately 18,000 square feet of existing facilities, and will enable Suburban to provide all-private rooms in MSGA units and replace its surgical facilities, at an estimated project cost of $200,550,831, be **APPROVED,** subject to the following conditions:

1. That Suburban Hospital will not routinely use any room on an MSGA nursing unit including the ICU and CCU units for more than one patient without the approval of MHCC.

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $2,361,291. This figure includes the estimated new construction costs that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

3. Suburban Hospital will not finish the third floor shell space without giving notice to the Commission and obtaining all required Commission approvals, nor shall it finish space on the second floor for rate regulated uses without giving notice to the Commission and obtaining all required Commission approvals.

4. Suburban Hospital will not request an adjustment in rates from the Health Services Cost Review Commission ("HSCRC") that includes depreciation or interest costs associated with construction of the proposed shell space unless and until Suburban Hospital has obtained CON approval for finishing the shell space, or has obtained a determination of coverage from the Maryland Health Care Commission that CON approval for finishing the shell space is not required.

5. In calculating any future rates for Suburban Hospital the HSCRC shall exclude the capital costs associated with the shell space until such time as the space is finished and put to use in a rate-regulated activity. In calculating any rate that includes an accounting for capital costs associated with the shell space, the rate should only account for depreciation going forward through the remaining useful life of the space (i.e., the HSCRC shall exclude any

depreciation of the shell space that has occurred between the construction of the shell space and the time of the rate calculation. Likewise, allowable interest expense shall also be based on the interest expenses going forward through the remaining useful life of the space.

APPENDIX 1

RECORD OF THE REVIEW

RECORD OF THE REVIEW

Docket Item #	Description	Date
1	MHCC staff acknowledged receipt of the LOI on February 9, 2015.	2/9/2015
2	Anne Langley submits a Certificate of Need (CON) application on behalf of the applicant for its Hospital Addition project.	4/10/2015
3	The applicant submits letters of support from various people on various dates	4/10/2015
4	MHCC acknowledges receipt of this application by letter.	4/14/2015
5	Staff requests that *The Washington Times* to publish notice of receipt of the CON application for Montgomery County.	4/14/2015
6	Staff requests that the *Maryland Register* publish notice of receipt of the CON application.	4/14/2015
7	*The Washington Times* sent confirmation that a Notice of Receipt of the CON Application was published on April 24, 2015.	4/24/2015
8	Following completeness review, Commission staff requests additional information before a formal review of the CON application can begin.	5/4/2015
9	Margaret Fitzwilliam requested an extension to file responses to completeness questions.	5/28/2015
10	Suburban response to the May 4, 2015 request for additional information.	5/13/2015
11	Commission staff requests additional information before a formal review of the CON application can begin.	6/15/15
12	Applicant submits updated Project Budget	8/10/15
13	Commission receives responses to the June 15, 2015 request for additional information.	8/5/15
14	Commission informed the applicant regarding notification of docketing for the application in the *Maryland Register* on September 4, 2015.	8/21/2015
15	Commission requests publication of notification for the formal start of review in *The Washington Times.*	8/21/2015
16	Commission requests publication of notification for the formal start of review in the *Maryland Register.*	8/21/2015
17	Staff sends a copy of the CON application to the Montgomery County Health Department for review and comment.	8/21/2015
18	Notice of formal start of review is published in the *Washington Times*	9/42015
19	Montgomery County Health Department chose not to comment on this project.	9/9/2015
20	Commission staff requested review and comment from the Health Services Cost Review Commission on the project.	3/3/16
21	Commission staff requested additional information from the applicant	3/11/16
22	Anne Langley responded to MHCC staff request of 3/11/16	3/22/16
23	HSCRC provides comments on the project.	3/25/16
24	MHCC emails request clarification of Suburban's implementation of its charity care policy.	4/18/16 and 4/21/16
25	MHCC letter requests additional information re: projection methodology and other issues.	4/28/16
26	Suburban responds to MHCC letter of 4/28.	5/5/16

APPENDIX 2

Acute Care Hospital Data for Montgomery County, 2009-2015:

MSGA and PSYCHIATRY

- **DISCHARGES**
- **DISCHARGE DAYS**
- **AVERAGE LENGTH OF STAY**

MSGA Discharges: Montgomery County 2009-2015

MEDICAL/SURGICAL/GYNECOLOGICAL/ADDICTIONS (MSGA) DISCHARGES							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
HOLY CROSS GERMANTOWN HOSPITAL						475	3,045
HOLY CROSS OF SILVER SPRING	17,160	17,554	17,465	17,037	16,834	18,242	17,078
MEDSTAR MONTGOMERY	7,751	7,741	7,148	6,977	6,367	6,292	5,715
AHC SHADY GROVE	14,960	15,081	14,773	14,833	14,249	13,600	11,270
SUBURBAN	12,956	12,535	12,519	12,199	11,806	12,197	12,103
AHC WASHINGTON ADVENTIST	13,143	11,988	10,613	9,699	8,453	8,089	7,091
MONTGOMERY CO. TOTAL	65,970	64,899	62,518	60,745	57,709	58,895	56,302
ALL Maryland Hospitals	565,607	528,189	505,764	487,361	465,538	442,751	**428,984**

Source: HSCRC Discharge Database.

MSGA Discharge Days: Montgomery County 2009-2015

MSGA DISCHARGE DAYS							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
HOLY CROSS GERMANTOWN HOSPITAL						2,031	12,552
HOLY CROSS OF SILVER SPRING	74,669	74,291	77,091	76,118	76,659	82,928	83,380
MEDSTAR MONTGOMERY	33,270	32,892	28,732	27,893	25,090	25,750	24,219
AHC SHADY GROVE	67,522	66,987	68,425	66,133	63,652	62,363	54,681
SUBURBAN	53,369	51,771	51,480	54,916	51,321	53,220	51,662
AHC WASHINGTON ADVENTIST	57,733	55,572	52,173	51,701	46,681	46,792	43,042
MONTGOMERYCO. TOTAL	286,563	281,513	277,901	276,761	263,403	273,084	269,536
All Maryland Hospitals	2,432,669	2,242,671	2,238,951	2,188,470	2,111,259	2,079,349	2,048,936

Source: HSCRC Discharge Database.

MSGA Discharge Average Length of Stay: Montgomery County 20092015

MSGA AVERAGE LENGTH OF STAY (ALOS) (DAYS)							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
HOLY CROSS GERMANTOWN HOSPITAL						4.28	4.12
HOLY CROSS OF SILVER SPRING	4.35	4.23	4.41	4.47	4.55	4.55	4.88
MEDSTAR MONTGOMERY	4.29	4.25	4.02	4.00	3.94	4.09	4.24
AHC SHADY GROVE	4.51	4.44	4.63	4.46	4.47	4.59	4.85
SUBURBAN	4.12	4.13	4.11	4.5	4.35	4.36	4.27
AHC WASHINGTON ADVENTIST	4.39	4.64	4.92	5.33	5.52	5.78	6.07
MONTGOMERY CO. TOTAL	4.34	4.34	4.45	4.56	4.56	4.64	4.79
All Maryland Hospitals	4.30	4.25	4.43	4.49	4.54	4.70	4.78

Source: HSCRC Discharge Database.

Psychiatric Discharges: Montgomery County 2009-2015*

PSYCHIATRIC DISCHARGES							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
HOLY CROSS GERMANTOWN HOSPITAL						67	333
HOLY CROSS OF SILVER SPRING	43	146	137	117	105	116	79
MEDSTAR MONTGOMERY	1,257	1,306	1,285	1,196	1,098	1,090	1,117
AHC SHADY GROVE	39	61	34	59	46	49	34
SUBURBAN	1,077	1,212	1,407	1,302	1,269	1,322	1,205
AHC WASHINGTON ADVENTIST	1,979	1,778	1,727	1,693	1,581	1,569	1,516
MONTGOMERY CO. TOTAL	4,395	4,503	4,590	4,367	4,099	4,213	4,284
All Maryland Hospitals	33,569	35,243	36,134	34,990	34,428	34,183	32,705

Source: HSCRC Discharge Database.

Psychiatric Discharge Days: Montgomery County 2009-2015*

PSYCHIATRIC DISCHARGE DAYS							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
HOLY CROSS GERMANTOWN HOSPITAL						282	1,533
HOLY CROSS OF SILVER SPRING	195	505	568	410	562	634	357
MEDSTAR MONTGOMERY	6,282	6,056	5,698	5,282	4,088	4,014	4,118
AHC SHADY GROVE	126	239	109	251	199	194	218
SUBURBAN	5,722	6,537	6,948	6,713	6,548	6,749	7,131
AHC WASHINGTON ADVENTIST	9,814	9,104	8,953	9,807	8,890	9,130	8,726
MONTGOMERY CO. TOTAL	22,139	22,441	22,276	22,463	20,287	21,003	22,083
All Maryland Hospitals	186,716	197,597	205,348	203,971	200,374	207,881	205,460

Source: HSCRC Discharge Database.

Psychiatric Discharges - Average Length of Stay: Montgomery County 2009-2015*

PSYCHIATRIC ALOS (DAYS)							
	2009	2010	2011	2012	2013	2014	2015
	Montgomery County General Hospitals						
HOLY CROSS GERMANTOWN HOSPITAL						4.21	4.60
HOLY CROSS OF SILVER SPRING	4.53	3.46	4.15	3.50	5.35	5.47	4.52
MEDSTAR MONTGOMERY	5.00	4.64	4.43	4.42	3.72	3.68	3.69
AHC SHADY GROVE	3.23	3.92	3.21	4.25	4.33	3.96	6.41
SUBURBAN	5.31	5.39	4.94	5.16	5.16	5.11	5.92
AHC WASHINGTON ADVENTIST	4.96	5.12	5.18	5.79	5.62	5.82	5.76
MONTGOMERY CO. TOTAL	5.03	4.98	4.85	5.14	4.95	4.99	5.15
All Maryland Hospitals	5.56	5.61	5.68	5.83	5.82	6.08	6.28

Source: HSCRC Discharge Database.

* Holy Cross Hospital, AHC Shady Grove Medical Center do not operate an organized psychiatric service, nor do they have licensed psychiatric beds. Adventist Behavioral Health & Wellness is a freestanding acute psychiatric hospital operated by AHC and located in Rockville near the AHC Shady Grove Medical Center campus.

Appendix 3

Decision Matrix for Evaluating Alternative Solutions

Appendix 3 Decision Matrix for Evaluating Alternative Solutions

Decision Criteria	Alternative Solution A Relocating Hospital	Alternative Solution B Renovate Existing Building to Meet Industry Standards & Build New Garage	Alternative Solution C Expand Existing Hospital & Build New Garage
Mandatory Requirements			
Private Patient Rooms	5	3	3
State-of-the-Art Operating Rooms	5	1	5
Adequate Parking	5	5	5
Improve Campus Circulation	5	1	5
Flexibility for the Future	5	1	5
Predictability for and Compatibility with Suburban's Surrounding Neighborhood	5	3	5
Availability of Physician Office Space	5	1	3
Other Considerations			
Maintain Operations During Construction	5	3	5
Land Availability	1	5	5
Costs	1	3	3
Maintenance of NIH Relationship	3	3	5
Continue to Serve Existing PSA & SSA	3	5	5
Zoning & Political Complications	3	3	3
Maintain Access to Services	5	1	5
Total	**56**	**38**	**62**

Key:
5 = Solution fully meets decision criterion.
3 = Solution partially meets decision criterion.
1 = Solution fails to meet decision criterion.

Appendix 4

Marshall Valuation Service Review

The Marshall Valuation System – What It Is and How It Works

In order to compare the cost of a proposed construction project to that of similar projects, fundamental to an examination of costs and effectiveness, a benchmark cost is typically developed using the Marshall Valuation Service ("MVS"). MVS cost data 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.

The base cost reported in the MVS guide are based on the actual final costs to the owner and include all material and labor costs, contractor overhead and profit, average architect and engineering fees, nominal building permit costs, and processing fees or service charges and normal interest on building funds during construction. It also includes: normal site preparation costs including grading and excavation for foundations and backfill for the structure; and utilities from the lot line to the structure figured for typical setbacks.

The MVS costs do not include costs of buying or assembling land, piling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, or general contingency set asides for some unknown future event such as anticipated labor and material cost increases. Also not included in the base MVS costs are site improvements such as signs, landscaping, paving, walls, and site lighting. Offsite costs such as roads, utilities, and jurisdictional hook-up fees are also excluded from the base costs.[14]

MVS allows staff to develop a benchmark cost using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide.

In developing the MVS benchmark costs for a particular project the base costs are adjusted for a variety of factors using MVS adjustments such as including an add-on for sprinkler systems, the presence or absence of elevators, the number of building stories, the height per story, and the shape of the building (the relationship of floor area to perimeter). The base cost is also adjusted to the latest month and the locality of the construction project.

Applying MVS to this project

MHCC staff has calculated its own MVS benchmark of $324.95 per square foot for the building addition proposed by Suburban Hospital based on the information submitted in Suburban's CON Application (Docket Number 15-15-2368). Staff used separate MVS November 2015 Class A, "Good" quality construction base costs for floors one through four, Class A-B construction for the basement, and Class A-B Good quality construction for the mechanical penthouse.[15] The base cost for floors one through four were adjusted for the departmental uses proposed by Suburban as detailed in the application. (DI #2, pgs. 44-45) While Suburban also adjusted the basement base costs by 0.86 to account for proposed departmental uses, staff did not make such an adjustment because a lower base cost was used. Suburban used a basement base cost that was characterized by MVS as

[14] Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2014).

[15] Suburban used November 2013 base costs, the most current at the time of application preparation and initial submission. These base cost were replace in November 2015.

having "outpatient finishes, heavy shielding, imaging and radiation, some offices." Since the proposed uses of the basement do not include any outpatient, imaging or office spaces, it was determined that the lower basement base costs for Class A-B basement space should be used. This base cost is characterized by MVS as being for "administrative and technical facilities and services" The proposed uses of the basement are for central sterile processing, compounding pharmacy, and electrical and mechanical spaces. Since the basement base costs used is already for these types of space, it was determined that no departmental adjustment was appropriate. Therefore, a factor of 1.0 was used.

The basement base cost was adjusted for elevator stops, as was done by Suburban, because the MVS basement base costs do not include the cost of basement elevator stops. The cost of an additional stop for each patient elevator ($8,300 each for type good construction) and for the service elevator ($17,400) was added and the total was divided by basement square footage (64,432 SF) to arrive at the additional cost of $3.23 per square foot. This is significantly higher than the elevator add on used by Suburban because Suburban only added on the costs of one stop, not one stop for each of the three elevators. Suburban also added costs for an extra penthouse elevator stop. However, subsequent information from Suburban indicated that there will not be any elevator stops for the mechanical penthouse. Therefore, the staff calculation does not include any such add on for the penthouse.

Staff and Suburban's calculation of the adjustments for the shape of each building component (relationship of floor size to perimeter) are almost exactly the same. The calculation of wall height multipliers are also very similar with the exception of the penthouse multiplier where staff determined that the appropriate multiplier should be 1.069 (MVS Section 15, p. 18) and Suburban used a multiplier of 1.413. Staff also agreed with Suburban's identification of the multi-story multiplier for floors more than three stories above the ground (1.005 for the main floors and 1.01 for the penthouse. However, staff used a lower add on for the sprinkler system than used by Suburban. The MVS add on for sprinkler systems is based on the amount of space covered by such system. While Suburban selected this add on based on the square footage of each component (64,432 SF for the basement, 235,597 SF for floors one through four, and 1,046 SF for the mechanical penthouse), staff selected this add on based on total square footage for the three components combined (301,075 SF).

The resultant cost after adjustment for the specific building characteristics described above were then adjusted by applying the appropriate current cost and local multiplier to bring the MVS benchmark up to date for April 2016 in Bethesda, Maryland. Selected building characteristics and staffs calculation of the MVS benchmark are detailed in the following table

Calculation of Marshall Valuation Service Benchmark for Suburban Hospital Building Addition

	Main Floors	Basement	Penthouse	Total
Construction Class/Quality	Class A/Good Quality	Class A-B		
Number of Stories	4	1	1	6
Square Feet	235,597	64,432	1,046	301,075
Average Floor Areas (square feet)	58,899	64,432	1,046	
Average Perimeter (ft.)	1,316	1,101	1784	
Average Floor to Floor Height (feet)	15	19	15	
Base Cost per SF (Nov. 2015)	**$365.78**	**$157.36**	**$80.77**	
Elevator Add-on	Inc. above	3.23	0	
Adjusted Base Cost per SF	**$365.78**	**$160.59**	**$80.77**	
Adjustment for Dept. Cost Differences	0.929	1.0	1.0	
Gross Base Cost per SF	**$339.92**	**$160.59**	**$80.77**	
Multipliers				
Perimeter Multiplier	.908	0.891	1.2605	
Story Height Multiplier	1.069	1.161	1.292	
Multi-story Multiplier*	1.005	1.0	1.010	
Combined Multiplier	**0.975**	**1.034**	**1.396**	
Refined Cost per SF	**$331.47**	**$166.07**	**$112.71**	
Sprinkler Add-on	2.43	2.43	2.43	
Adjusted Refine Square Foot Cost	$333.90	$168.5	$115.14	
Update/Location Multipliers				
Current Cost Multiplier (April 2016)	1.02	1.02	1.01	
Location Multiplier (Bethesda, April 2016)	1.07	1.07	1.07	
Final Benchmark MVS Cost per SF	**$364.41**	**$183.90**	**$125.67**	
Total Building SF	**235,597**	**64,432**	**1,046**	**301,075**
MVS Building Cost	**$85,854,663**	**$11,849,152**	**$131,450**	**$97,835,285**
Final MVS Cost Per SF				**$324.95**

Source: Suburban Hospital CON Application and Marshall Valuation Service®, published by Core Logic and Commission Staff Calculations

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

APPENDIX 5

Excerpted CON standards for General Surgical Services From State Health Plan Chapter 10.24.11

Excerpted CON standards for General Surgical Services
From State Health Plan Chapter 10.24.11

Each of these standards prescribes policies, services, staffing, or facility features necessary for CON approval that MHCC staff have determined the applicant has met. Bolding added for emphasis. Also included are references to where in the application or completeness correspondence the documentation can be found.

STANDARD	**APPLICATION REFERENCE (Docket Item #)**
(4) Transfer Agreements. (a) Each ASF and hospital **shall have written transfer and referral agreements** with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital. (b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2.	DI #2, p. 74
(4) Design Requirements. Floor plans submitted by an applicant **must be consistent with the current FGI Guidelines.** (a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines. (c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.	DI #2, Exhibit 22
(5) Support Services. Each applicant **shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.**	DI #2, p. 82

APPENDIX 6: HSCRC Opinion Letter

Memorandum

Date: March 25, 2016

To: Kevin McDonald, Chief- CON, MHCC

From: Gerard J. Schmith
Deputy Director, Hospital Rate Setting, HSCRC

Subject: Suburban Hospital Proposed Addition and Renovation Project
Docket No. 15-15-2368

On March 3, 2016, you requested that we review and comment on the financial feasibility and underlying assumptions of the proposed $200.6 million building addition and renovation projectof Suburban Hospital ("Suburban," or "the Hospital') atits existing location inBethesda. Suburban Hospital (Suburban) submitted a CON application on April 10, 2015 with additional supplemental information filed on June 15, 2015. The proposal is a modernization and replacement project that will allow the hospital to convert all MSGA beds to private rooms as well as replace the existing operating suite. The project does not increase the number of beds and would reduce the number of operating rooms from 15 to 14.

This memorandum provides our general comments and addresses your specific questions regarding the project.

General Comments on Financial Feasibility

Data Reviewed

We reviewed the financial information submitted in the CON application as well asother pertinent supplemental information associated with the CON process provided by Suburban. The information submitted included audited financial data for the fiscal years ending June 30, 2013 and 2014 and projected data for the fiscal years ending 2015 through 2022 (the second full year after the completion of the project.) Along with these financial projections, we have also reviewed Suburban's audited financial statements for the year ended June 30, 2014 and the expected financing plan for this project.

Sources and Uses of Funds

The total cost of the project is $199,853,006. Suburban is budgeting $120,283,569 for new construction costs, $2,538,938 in renovation costs, $66,925,678 in other capital costs including movable equipment, construction period interest, contingencies, and other miscellaneous capital costs, and $10,104,821 for an inflation allowance.

Suburban intends to finance the total project costs by incurring $69,782,482 in debt, fund raising $38,333,129, contributing cash of $90,129,296, and earning $1,608,099 in interest income during construction. All of the $199,853,006 project costs are related to capital costs with no allowance made for working capital costs or transition costs.

Revenue Projections

We have reviewed the assumptions regarding the projections of operating revenue. The assumed annual HSCRC approved revenue increases listed in the CONapplication supplemental information assumptions provided by Suburban for In-State and Out of State patients areas follows:

Table 1 - Summary of Projected HSCRC Approved Revenue Increases
Suburban Hospital-In State Revenue
Suburban Hospital CON Projections

	Years Ending June 30,						
	2016	2017	2018	2019	2020	2021	2022
Update Factor	2.40%	2.40%	2.40%	2.40%	2.40%	2.40%	2.40%
Population Adjust.	1.07%	1.07%	1.07%	1.07%	1.07%	1.07%	1.07%
Market Shift	.30%					.32%	.31%
Other	(.81%)						
Total	2.96%	3.47%	3.47%	3.47%	3.47%	3.79%	3.78%

Source: Financial information and projections submitted by Suburban in the CON application.

Table 2 - Summary of Projected HSCRC Approved Revenue Increases
Suburban Hospital-Out of State Revenue
Suburban Hospital CON Projections

	Years Ending June 30,						
	2016	2017	2018	2019	2020	2021	2022
Update Factor	1.71%	1.71%	1.71%	1.71%	1.71%	1.71%	1.71%
Other	(.30%)	.80%	.79%	.79%	1.71%	1.69%	1.66%
Total	1.41%	2.51%	2.50%	2.50%	3.42%	3.40%	3.37%

Source: Financial information and projections submitted by Suburban in the CON application.

In-State revenue comprised 88.8% of Suburban's gross patient revenue in the July 1, 2015 approved rate order, with Out-of-State revenue comprising the remaining 11.2%.
Staff believes that the assumed increases are reasonable in light of the projected changes in population and approved revenue.

Suburban projected that charity write offs would equal 1.4% of gross patient revenue from 2016 through 2022, a decrease of .1% from the 2014 actual of 1.5%. Suburban projected that its bad debt expenses would equal 2.8% of gross patient revenue from 2016 to 2022. This amount is equal to the actual bad debt percentage experienced from 2014.

Suburban's actual other deductions from revenue equaled 14.3% of gross patient revenue in 2014. Suburban projected that its other deductions from revenue would decrease to11.6% of gross patient from 2016 to 2020. A portion of this reduction may be due tothe reduction in HSCRC assessments due to the elimination of the Maryland Health Insurance Program (MHIP)

The Staff also reviewed Suburban's projections of other operating revenue. The projected other operating revenue is considered reasonable and achievable. Suburban did not project any non-operating revenue associated with this project.

Expense Projections

Staff reviewed the assumptions regarding the projection of expenses. Suburban stated that it applied the following variable expense change assumptions in the CONprojected financial statements

Table 3 - Summary of Assumed Expense Increases
Suburban Hospital CON Projections

	Years Ending June 30,						
	2016	2017	2018	2019	2020	2021	2022
Salaries:							
Inflation	2.0%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
Other	.2%	-.1%	3.4%	-.3%	.9%	1.0%	1.0%
Contractual Services:							
Inflation	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Other	9.4%	-5.4%	1.5%	.3%	.2%	.6%	.4%
Supplies:							
Inflation	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Other	-1.1%	-.6%	1.0%	.5%	1.1%	1.1%	1.1%
Other:							
Inflation	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Other	-19.7%	22.4%	-29.8%	9.7%	-22.8%	-1.9%	4.0%

Source: Financial information and projections submitted by Suburban in the CON application

Suburban is projecting that its number of FTE's per Average Equivalent Occupied Beds (AEOB) will decrease from an actual 5.45 in 2014 to a projected 5.31 in 2022. The 2014 FTE's per AEOB for other neighboring Montgomery and Prince Georges County hospitals range from 5.0 at Montgomery General Hospital to 5.8 at Prince Georges General Hospital.

Staff calculated the projected overall annual expense percentage variability with volume based on the percentage change in uninflated revenue compared to the annual change in total expenses including depreciation and interest depreciation and interest. The results of staff'sanalyses were as follows:

Table 4 – Projected Expenses Percent Variability with Volume
Suburban Hospital CON Projections

	Years Ending June 30,						
	2016	2017	2018	2019	2020	2021	2022
Including Depreciation and Interest	113.7%	-26.6%	247.8%	2.2%	504.6%	68.7%	49.3%
Excluding Depreciation and Interest	100.0%	-112.5%	272.8%	56.3%	91.0%	83.8%	78.6%

Source: Financial information and projections submitted by Suburban in the CON application.

In the supplemental information submitted, Suburban explained that it would be implementing program changes to information services and other departments over the next several years, which account for the annual swings in overall variable cost factors.The average variable cost change excluding depreciation and interest expense averages approximately 80% over the 7 year period. However, since the overall volume change is very small during this period, any change to the variable cost percentage would have little impact on the overall projection of expenses. Staff believes that the assumptions used in the projections of ongoing annual expenses are reasonable and achievable.

Financial Ratios

Suburban provided projected income statements only as part of its CON application without providing projected balance sheets. Therefore, our ratio analysis is limited to projected income statement ratios and does not include analysis of balance sheet ratios

Listed below are the projected key Income Statement financialratios for Suburban:

Table 5 – Suburban Hospital Key Financial Information and Ratios
Suburban Hospital CON Projections (in thousands)

	Years Ending June 30, (in Thousands)						
	2016	2017	2018	2019	2020	2021	2022
Operating Income	$12,099.0	$12,429.0	$13,419.0	$14,688.0	$5,017.0	$6,748.0	$8,548.0
Operating Margin	4.5%	4.5%	4.7%	5.0%	1.6%	2.1%	2.6%
Excess of Revenue Over Expense	$12,099.0	$12,429.0	$13,419.0	$14,688.0	$5,017.0	$6,748.0	$8,548.0
Excess Margin	4.5%	4.5%	4.7%	5.0%	1.6%	2.1%	2.6%
Debt Service Coverage Ratio	3.7x	4.6x	5.6x	7.3x	2.5x	2.7x	2.5x
Cash and Equivalents	$119,408.0	$187,216.0	$110,631.0	$54,094.0	$68,784.0	$86,503.0	$101,811.0
Days Cash on Hand	173	264	151	72	88	106	121
Long Term Debt	$53,275.0	$143,255.0	$140,947.0	$138,557.0	$134,612.0	$130,495.0	$124,761.0
Net Assets	$239,385.0	$262,413.0	$286,881.0	$311,773.0	$326,233.0	$342,245.0	$358,087.0
Debt to Capitalization	18.2%	35.3%	32.9%	30.8%	29.2%	27.6%	25.8%

Source: Inflated financial information and projections submitted by Suburban during the CON process

Based upon these projected ratios, Staff believes thatSuburban would be able to obtain financing for the project on terms that are consistent with those assumed in the finance plan.

Summary

Staff believes that the overall assumptions regarding the financial viability of theproposed building and renovation project are reasonable and achievable, assuming that Suburban attains the volumes projected in the CON application. The current environment of change in health care financing and delivery, however, increases the probability that inpatient volumes will decline. Suburbanand the surrounding hospitals in the area currently have substantial volumes ofPAUs. Staff recommends conservatism in evaluating need.If Suburban does not attain the projected volumes inits CON application, its overall rate and revenue structure may be viewed as inefficient, thereby affecting the overall financial viability of the project. Further, if the Hospital subsequently determines that it needs additional revenue, any such request before the HSCRC would necessitate a full rate application. The HSCRC expects that Suburban will maintain its overall financial viability in a manner consistent with Maryland's evolving health care finance and delivery system.

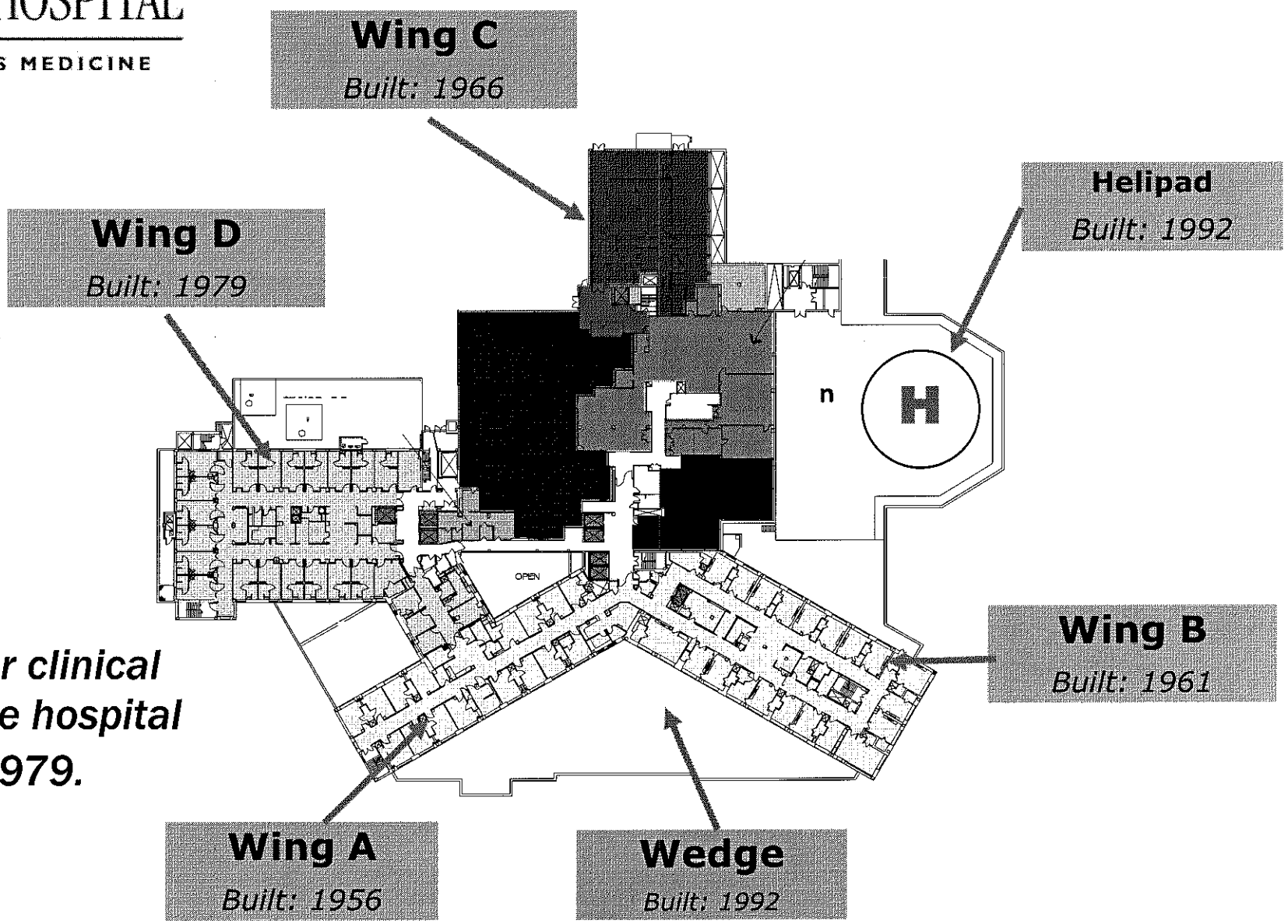
Appendix 7

Site Plan

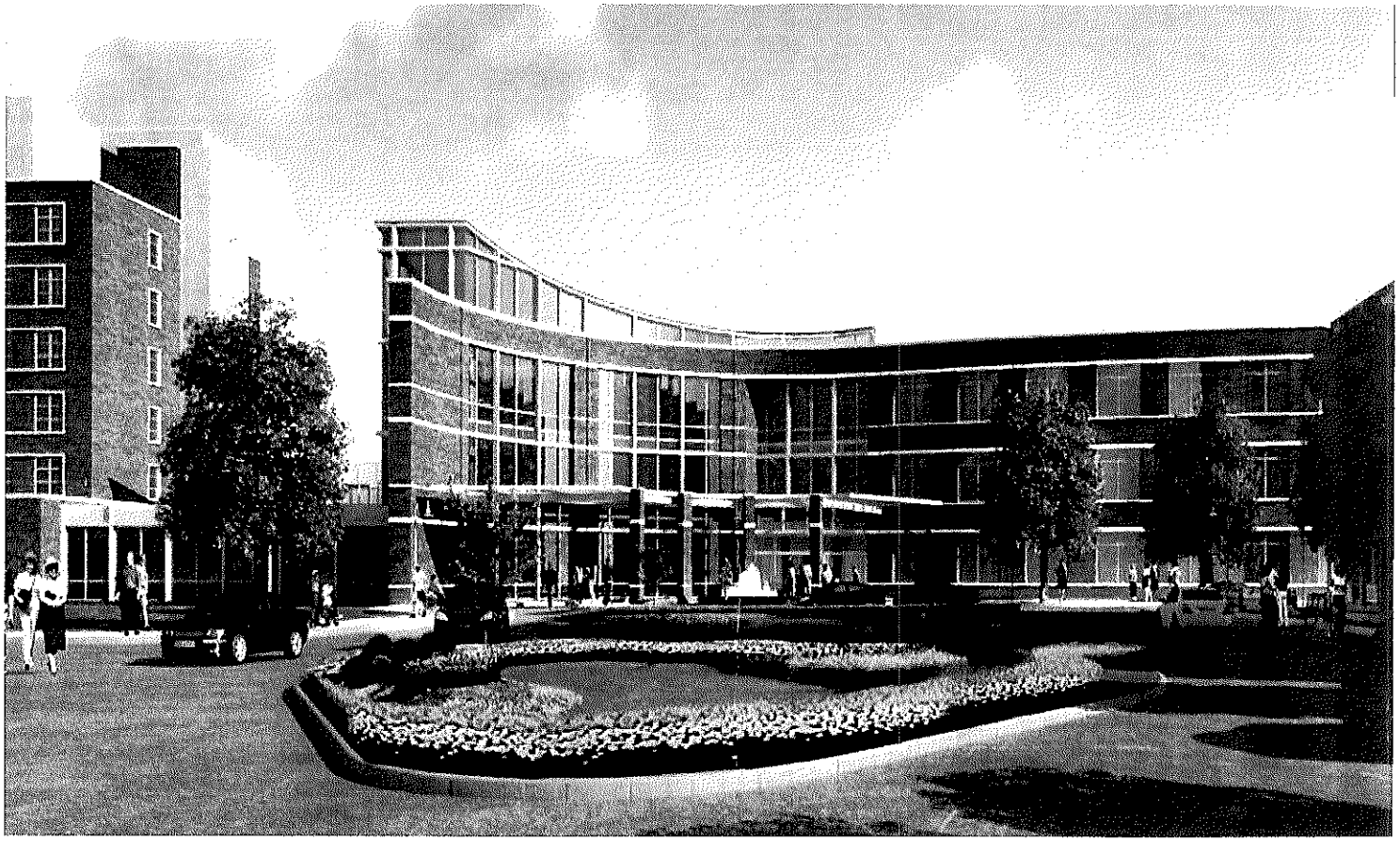
SUBURBAN HOSPITAL

JOHNS HOPKINS MEDICINE

Hospital Challenges: Suburban's Aging Facility



The last major clinical addition to the hospital was built in 1979.



Johns Hopkins Medicine Suburban Hospital

Bethesda MD, 20814

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL

APRIL 10, 2015

Architects/Planners
- **Wilmot/Sanz, Inc.**
  Gaithersburg, Maryland

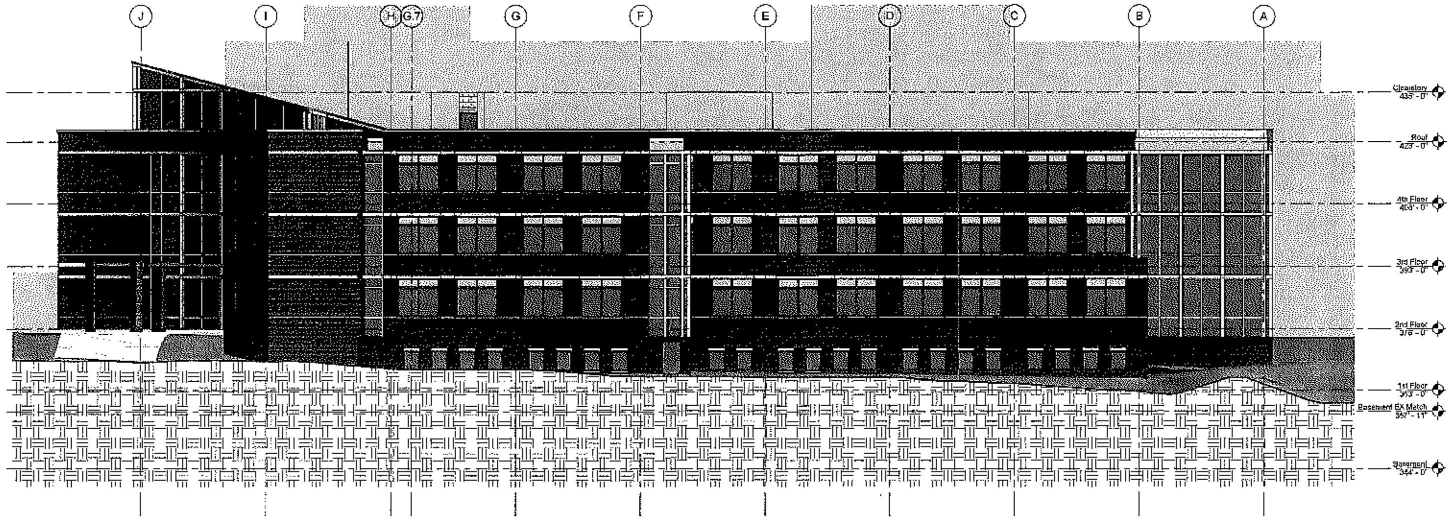
Structural Engineer
- **Cagley & Associates**
  Rockville, Maryland

MEP Engineer
- **Leach Wallace Associates, Inc**
  Elkridge, Maryland

Civil Engineer
- **Rodgers Consulting**
  Germantown, Maryland

DRAWING LIST

ARCHITECTURAL	
Sheet Number	Sheet Name
0	COVER SHEET
A101	EXTERIOR ELEVATIONS
A102	EXTERIOR ELEVATIONS
EXS-1	SITE PLAN
A111	BUILDING SECTION
A200	GROSS DEPT AREA - CELLAR FLOOR PLAN
A201	GROSS DEPT AREA - FIRST FLOOR PLAN
A202	GROSS DEPT AREA - SECOND FLOOR PLAN
A203	GROSS DEPT AREA - THIRD FLOOR PLAN
A204	GROSS DEPT AREA - FOURTH FLOOR PLAN
A205	GROSS DEPT AREA - ROOF PLAN



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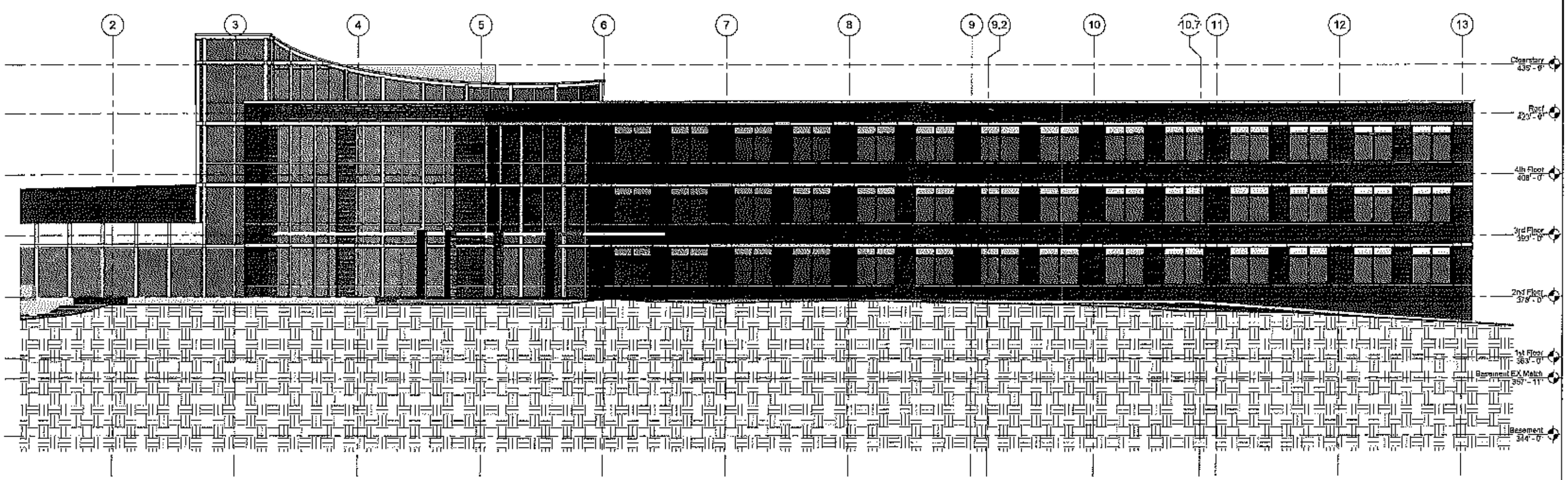


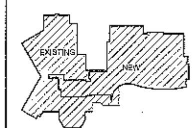
2 EAST EXTERIOR ELEVATION
SCALE: 3/32" = 1'-0"

Revisions	Date	No.

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Johns Hopkins Medicine
Bethesda MD, 20814

SUBURBAN HOSPITAL



KEY PLAN

WILMOT SANZ
ARCHITECTURE
PLANNING
18310 Montgomery Village Avenue
Gaithersburg, Maryland 20879
301-590-2900 (Fax) 301-590-8150

EXTERIOR ELEVATIONS

Project Number	8602.37
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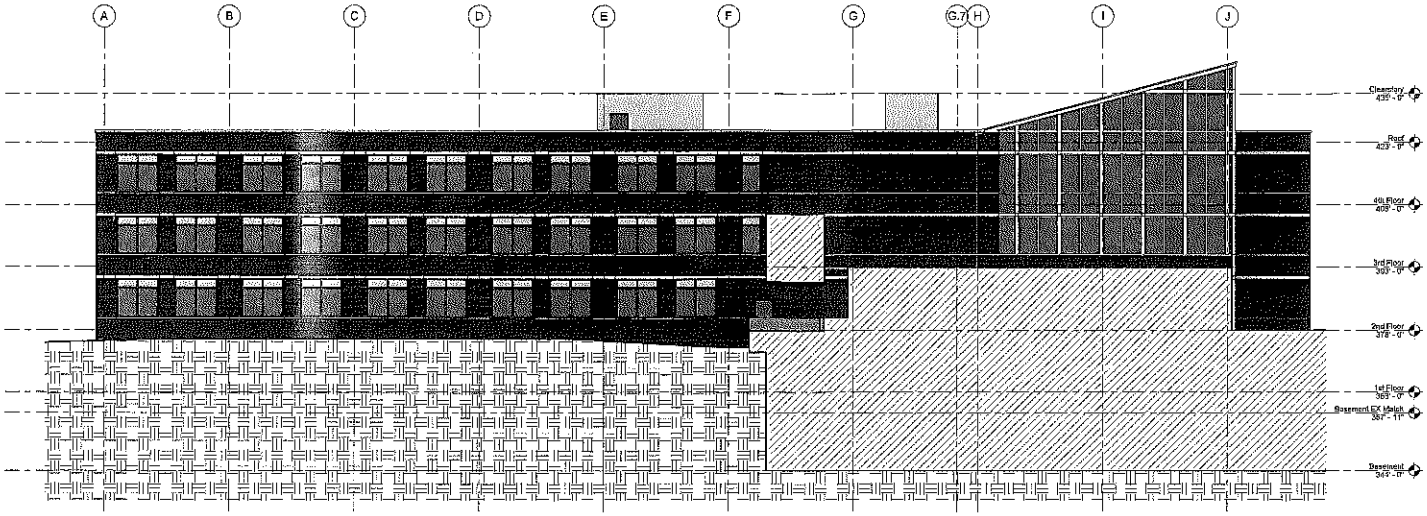
Print Date/Stamp	4/8/2015 5:46:00 PM

Drawing No.: A101

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL



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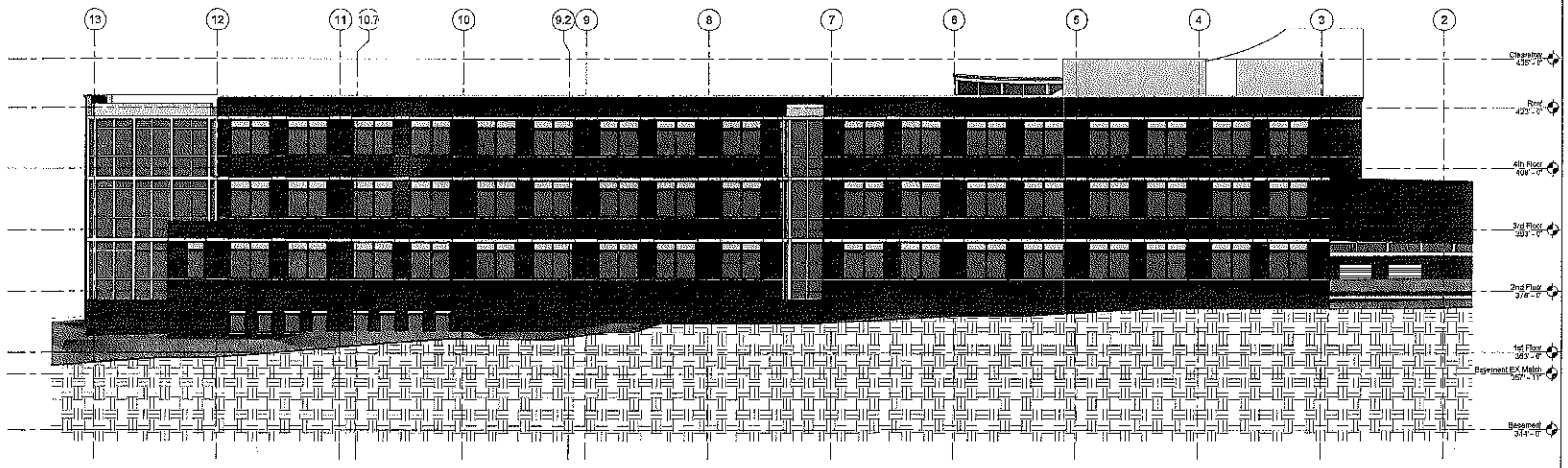

2 WEST EXTERIOR ELEVATION
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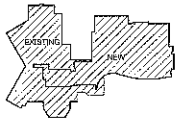
Revisions	Date	No.

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Johns Hopkins Medicine
Bethesda MD, 20814

SUBURBAN HOSPITAL



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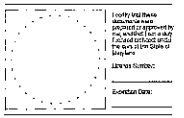

I certify that these documents were prepared or approved by me, and that I am a duly licensed professional engineer under the laws of the State of Maryland.

License Number:

Expiration Date:

WILMOT SANZ
ARCHITECTURE
PLANNING
10310 Montgomery Village Avenue
Gaithersburg, Maryland 20879
301-670-2900 [Fax] 301-590-8130

EXTERIOR ELEVATIONS

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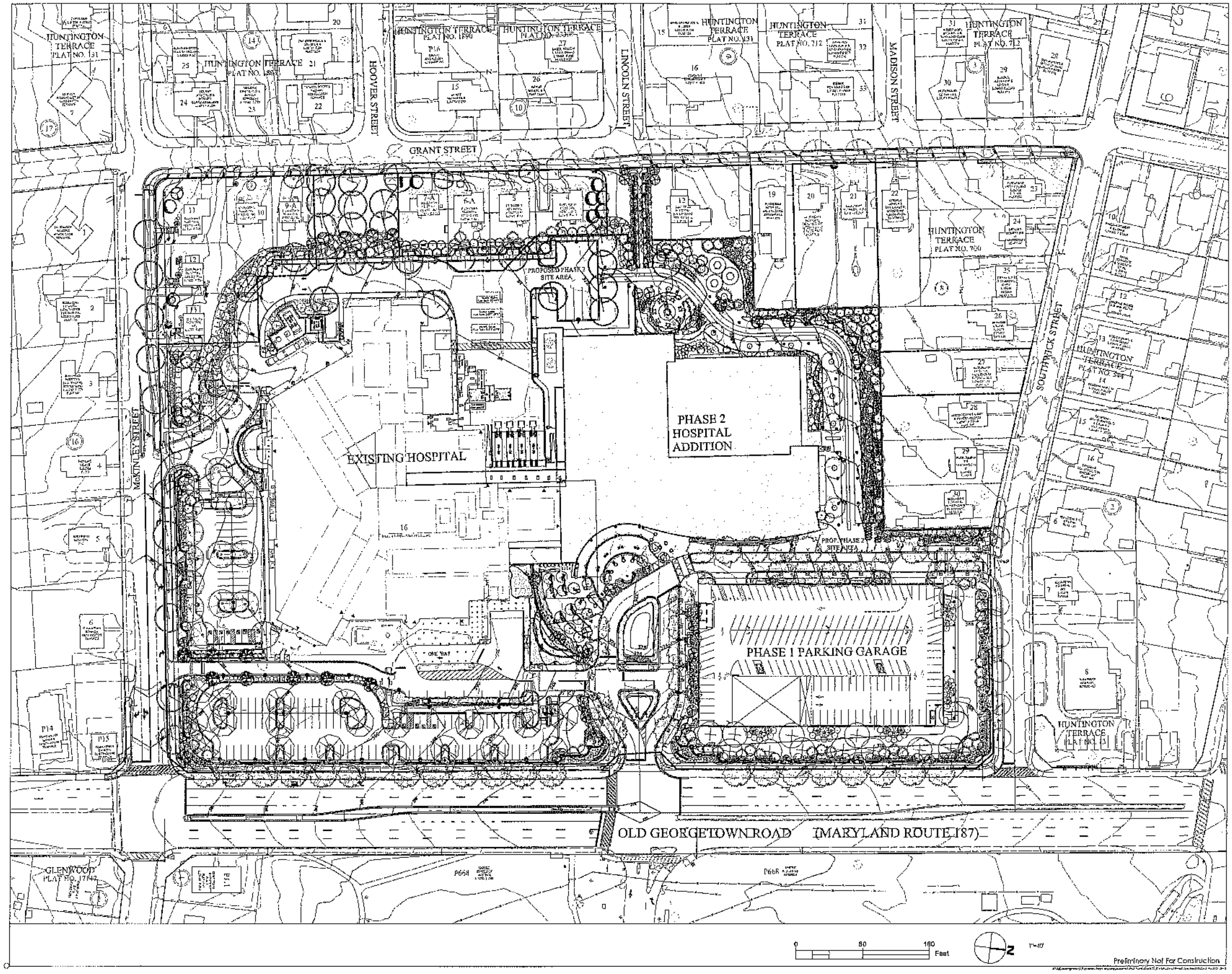


SUBURBAN HOSPITAL

RODGERS CONSULTING

Suburban Hospital
Johns Hopkins Medicine

Linowes and Blocher, LLP

WILMOT SANZ

Rodgers Consulting, Inc.

Wells + Associates

Lewis Wallace Associates, Inc.

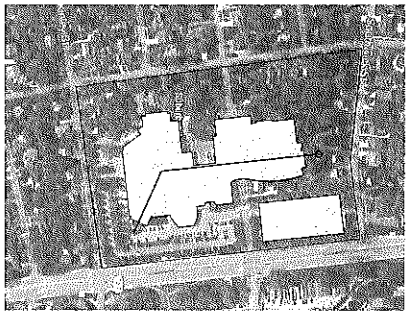
SUBURBAN HOSPITAL
Certificate Of Need

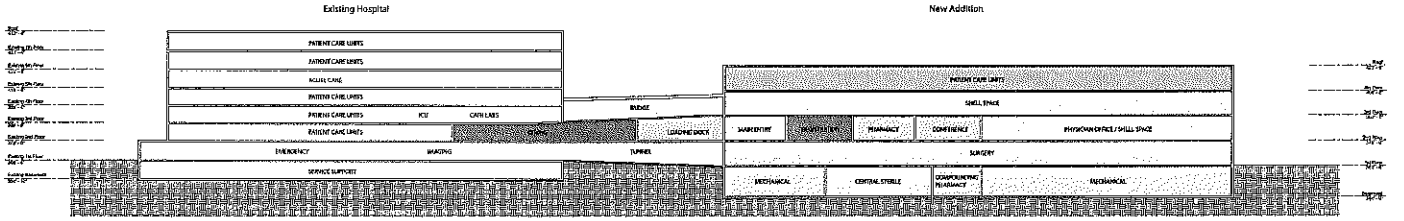
Lots 16, Block 15
Election District (No.7) Montgomery County, Maryland

809-A3
April 2015
1"=40'

SITE AREA PHASE 2 ADDITION

EXB-1





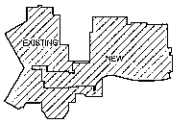
BUILDING SECTION – HOSPITAL

Revisions	Date	No.

SUBURBAN HOSPITAL
JOHNS HOPKINS MEDICINE

Johns Hopkins Medicine
Bethesda MD, 20814

SUBURBAN HOSPITAL



KEY PLAN

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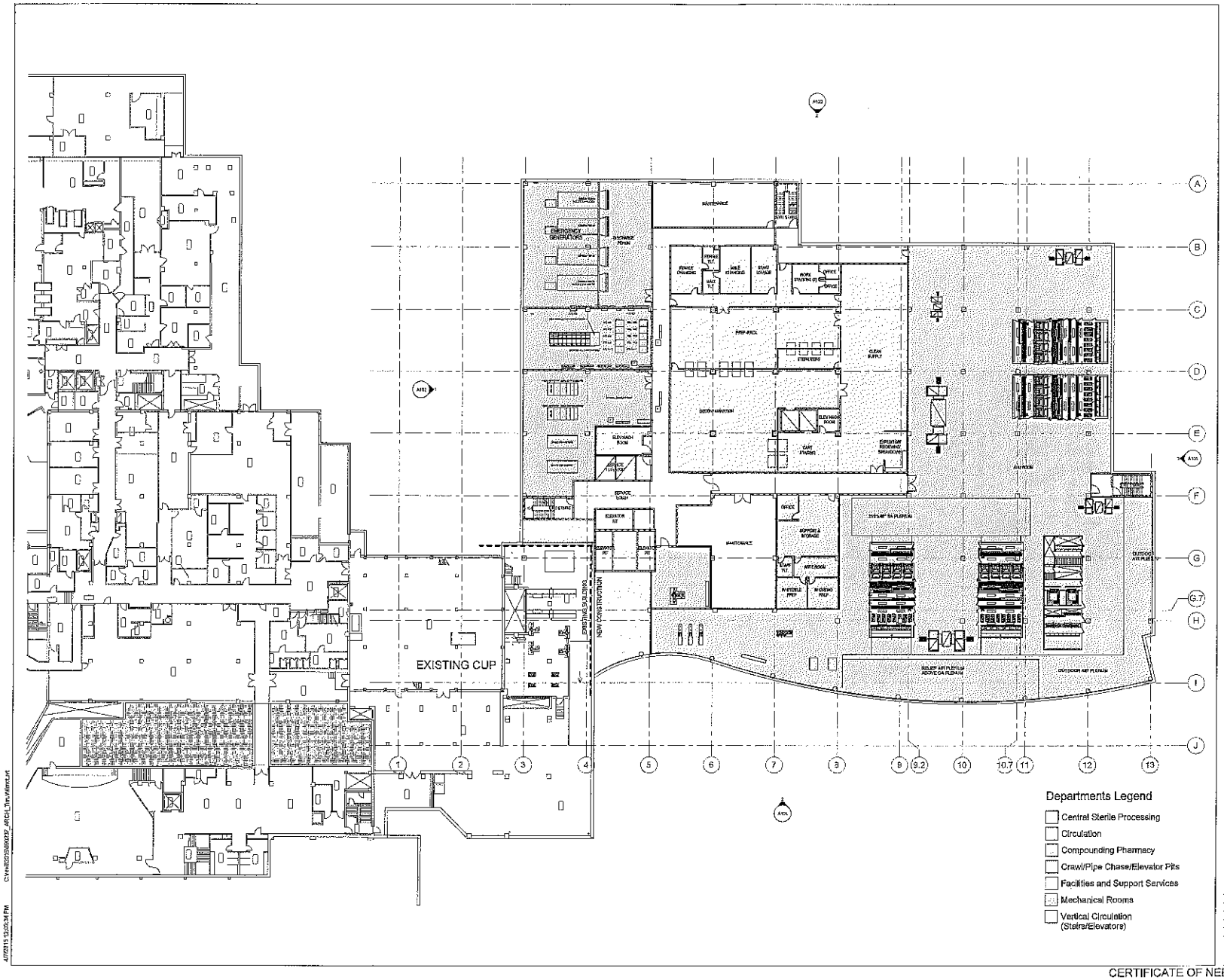
ARCHITECTURE
PLANNING
10310 Montgomery Village Avenue
Gaithersburg, Maryland 20879
301-590-2900 (Fax) 301-590-2150

BUILDING SECTION

Project Number	8902.97
Scale	
Date	APRIL 10, 2015

Drawing No.: A111

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL



Revisions	Date	No.

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Johns Hopkins Medicine
Bethesda MD, 20814

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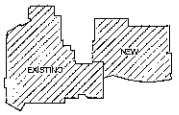
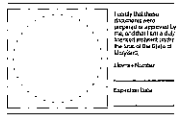


KEY PLAN



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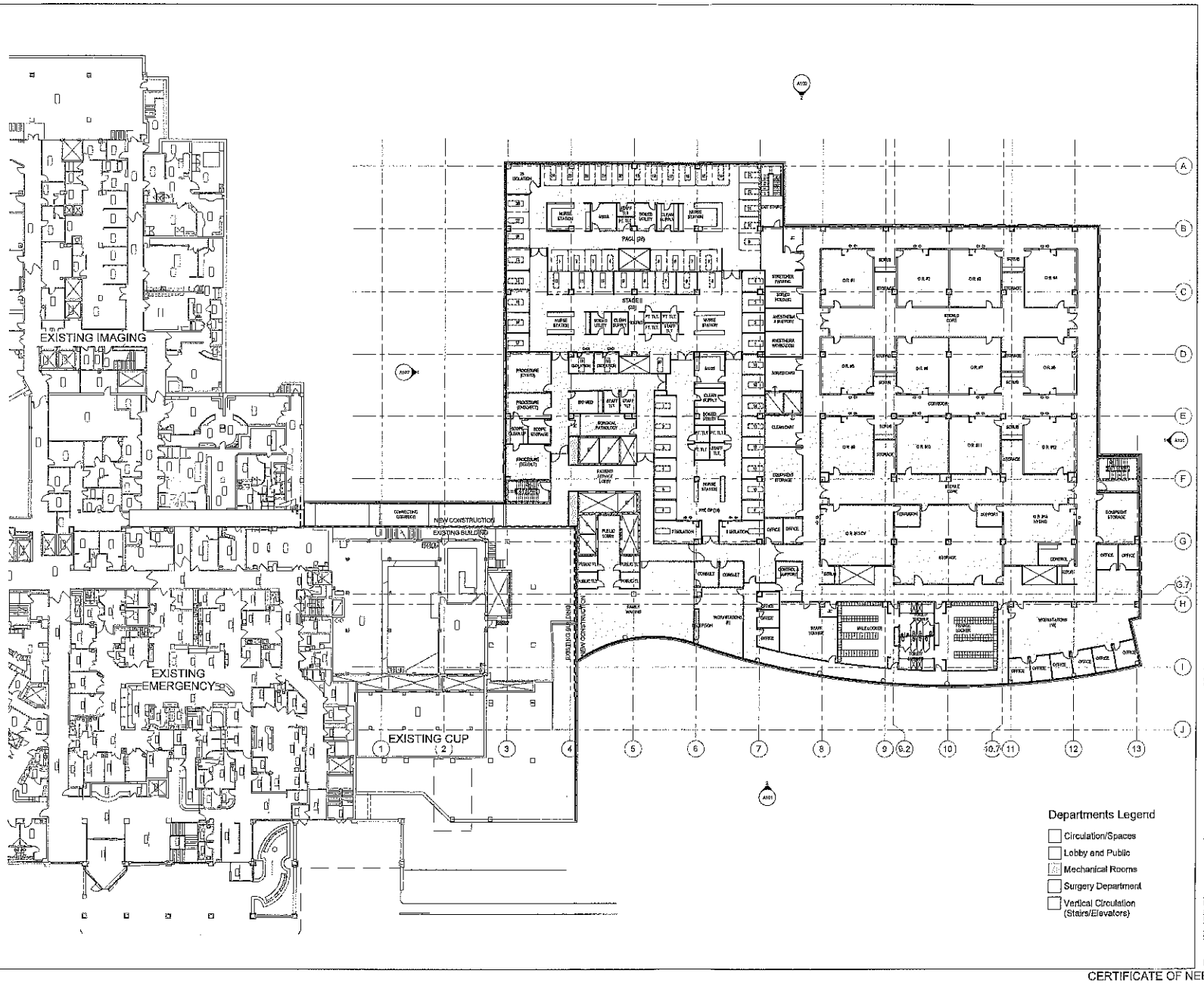
GROSS DEPT AREA - CELLAR FLOOR PLAN

Project Number	6900.07
Scale	1/16" = 1'-0"
Date	APRIL 10, 2015
Plot Date/Stamp	4/9/2015 12:34:24 PM

Drawing No.: A200

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL

4/7/2015 10:00:34 PM C:\Revit2015\6900.07_ARCH_Tim.Willett.rvt



Revisions	Date	No.

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KEY PLAN

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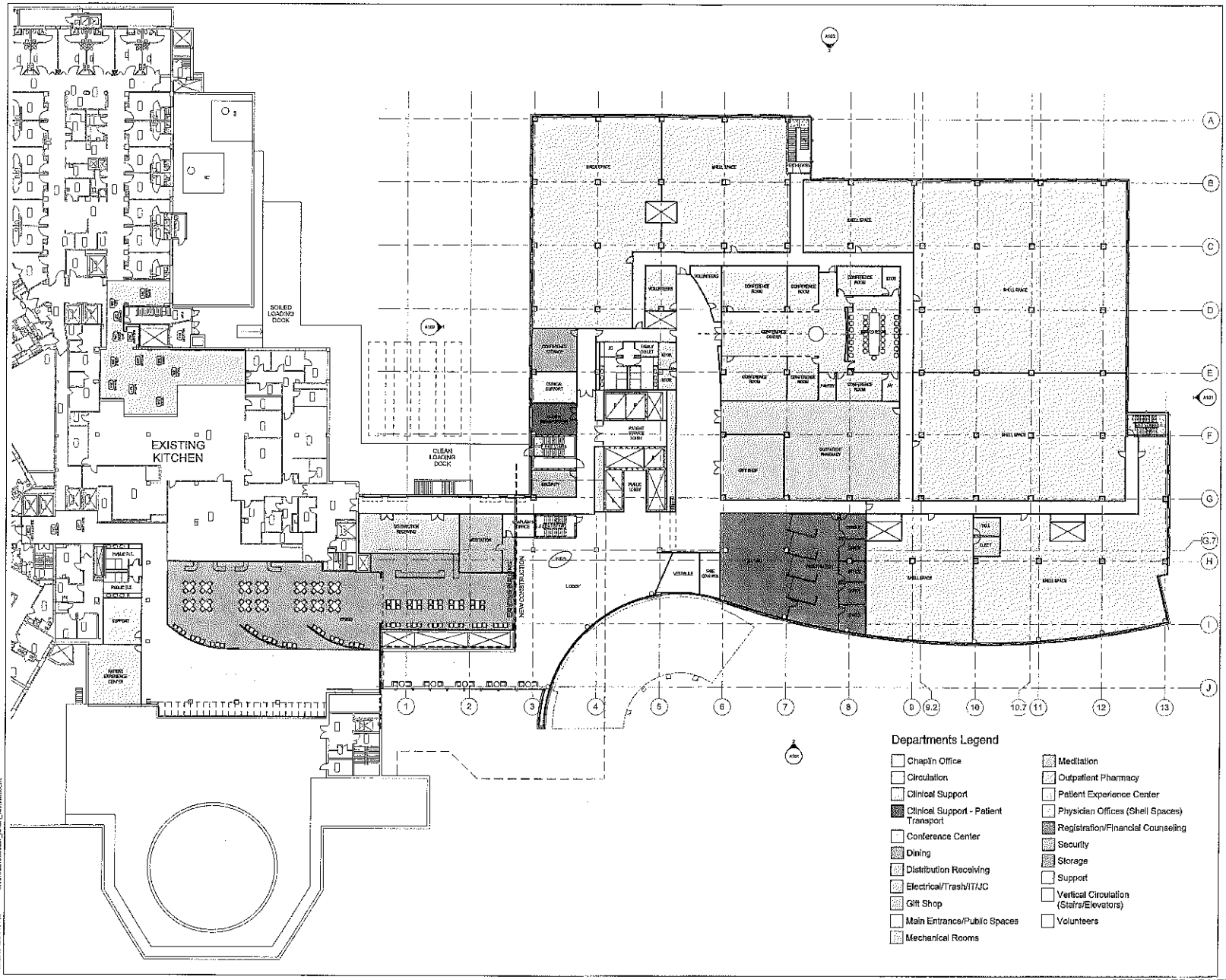
GROSS DEPT AREA - FIRST FLOOR PLAN

Project Number 8012.17
Scale 1/16" = 1'-0"
Date APRIL 10, 2015
Plot Date/Time 4/7/2015 12:04:55 PM

Drawing No.: A201

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL

4/7/2015 12:04:55 PM C:\Revit\CON\8012017_ARCH_Tim.Wilmot.rvt



Revisions	Date	No.

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KEY PLAN

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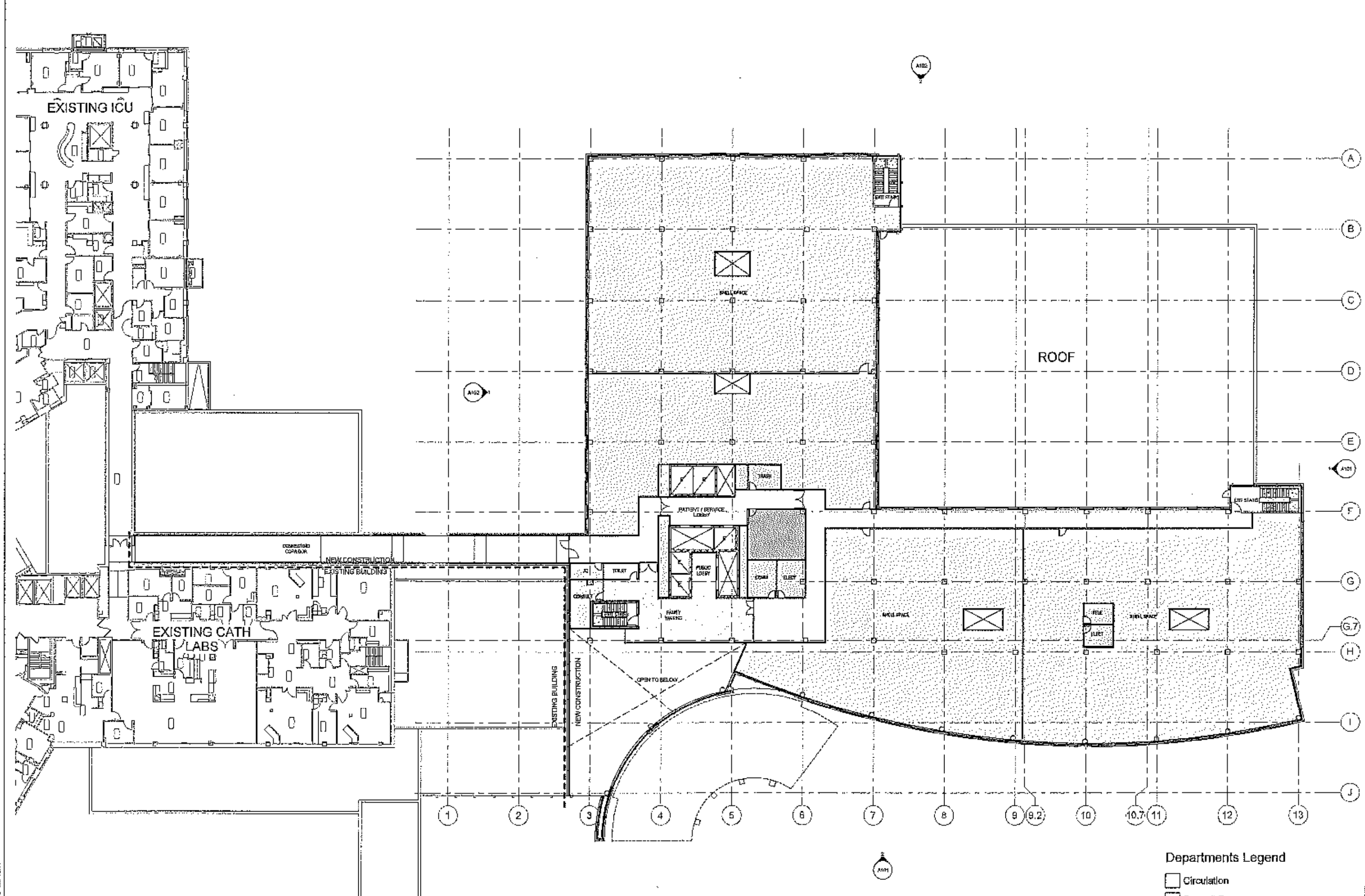
GROSS DEPT AREA - SECOND FLOOR PLAN

Project Number	6902.07
Scale	1/16" = 1'-0"
Date	APRIL 10, 2015

Drawing No.: A202

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL



Departments Legend

- Circulation
- Consult Rooms
- Electrical/Trash/IT/JC
- Mechanical Rooms
- Public Circulation/Space
- Shell Spaces
- Storage
- Vertical Circulation (Stairs/Elevators)

Revisions	Date	No.

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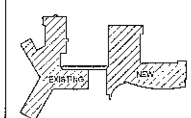
KEY PLAN



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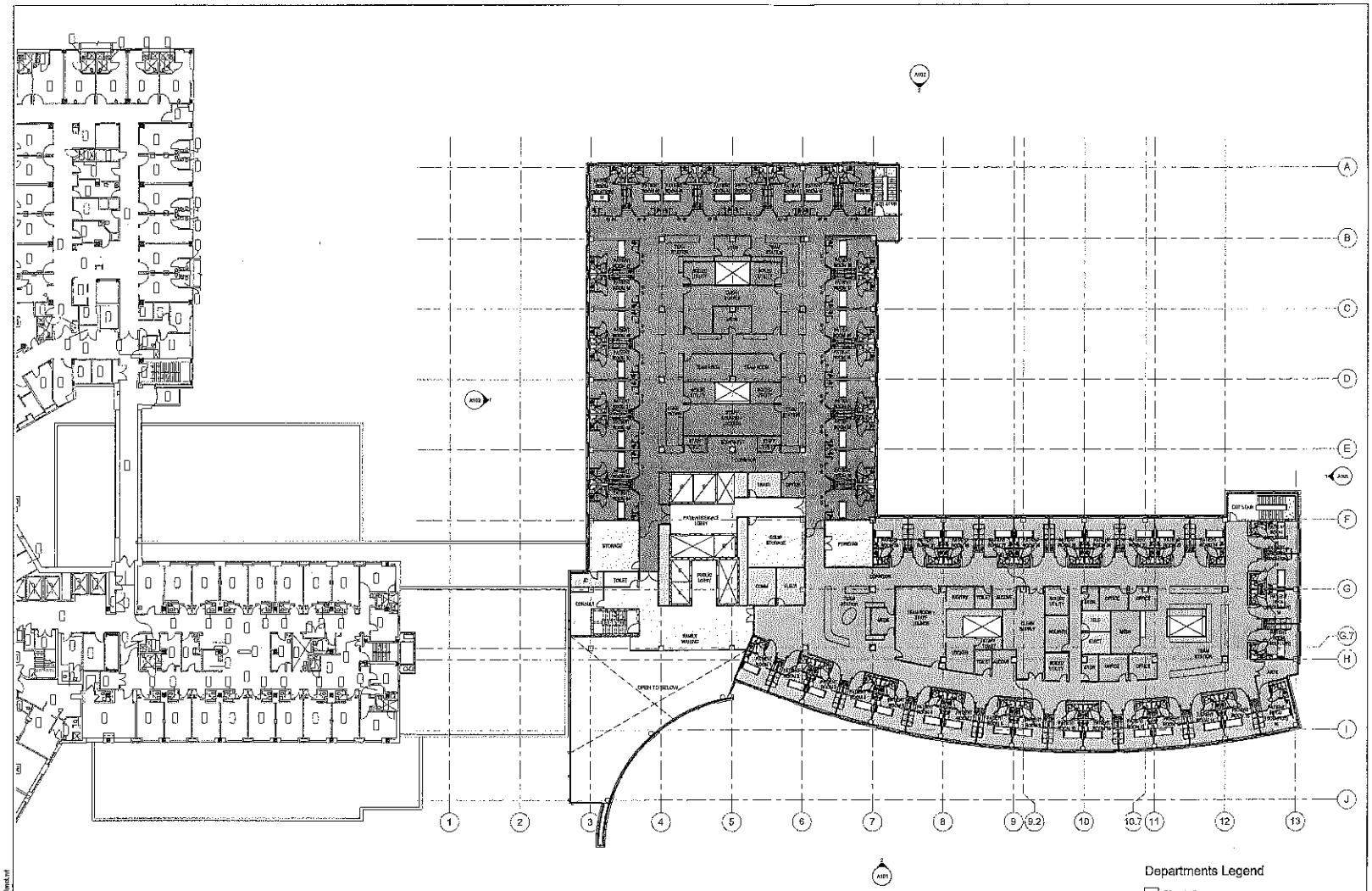
GROSS DEPT AREA - THIRD FLOOR PLAN

Project Number	6902.37
Scale	1/16" = 1'-0"
Date	APRIL 10, 2015
Print Date/Stamp	4/7/2015 12:05:03 PM

Drawing No.: A203

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL



Revisions	Date	No.

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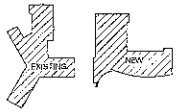

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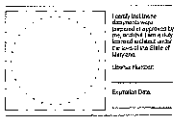

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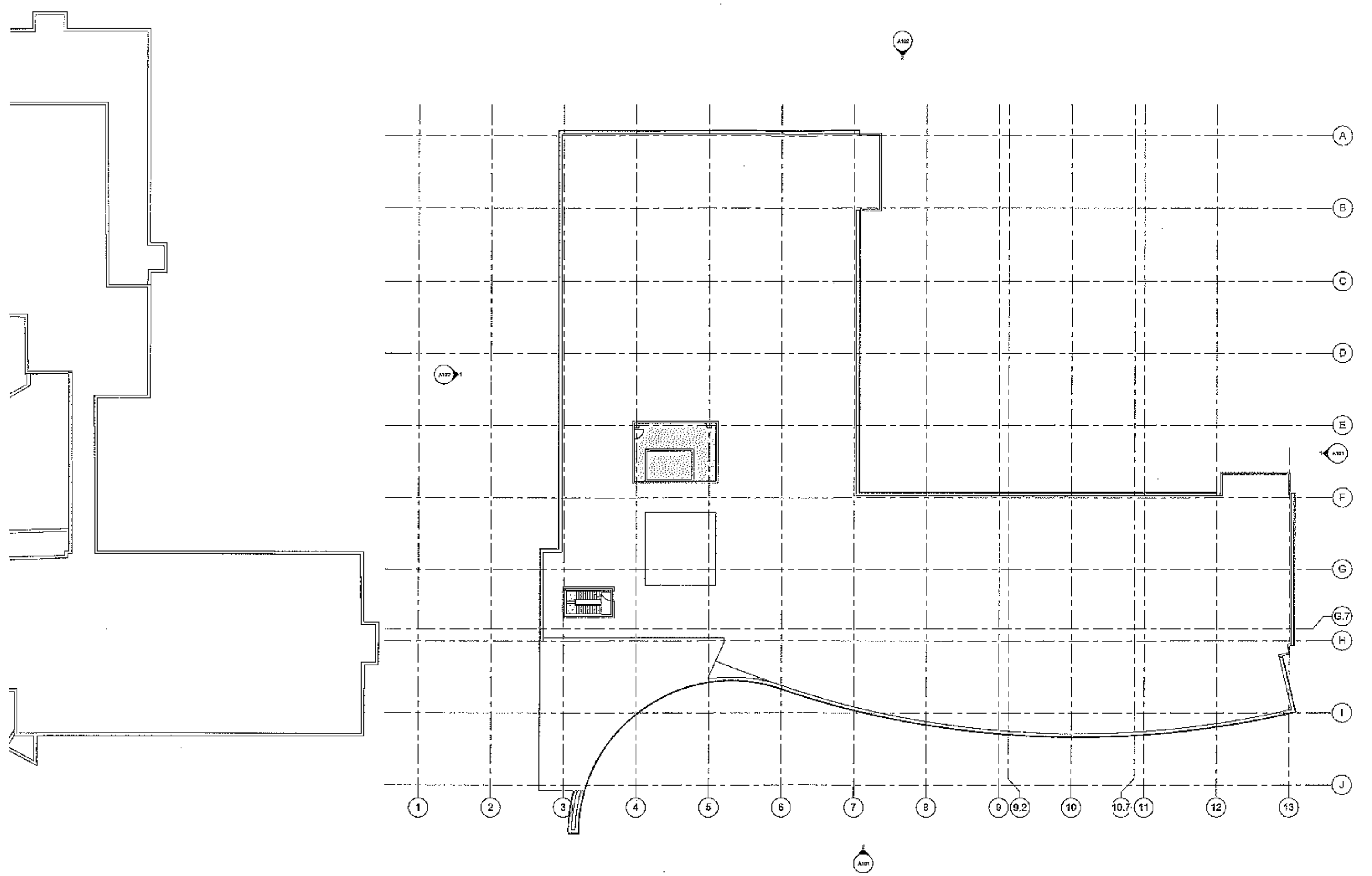
GROSS DEPT AREA - FOURTH FLOOR PLAN

Project Number	8002.37
Scale	1/16" = 1'-0"
Date	April 10, 2015
Plot Date/Time	4/7/2015 10:42:12 AM

Drawing No.: A204

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL



Departments Legend

- Mechanical Rooms
- Vertical Circulation (Stairs/Elevators)

Revisions	Date	No.

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GROSS DEPT AREA - ROOF PLAN

Project Number 8602.37
Scale 1/16" = 1'-0"
Date APRIL 10, 2015

Drawing No.: A205

CERTIFICATE OF NEED (C.O.N.) SUBMITTAL