

STATE OF MARYLAND

Craig P. Tanio, M.D.
CHAIR



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MARYLAND HEALTH CARE COMMISSION

4160 PATTERSON AVENUE – BALTIMORE, MARYLAND 21215
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October 23, 2013

VIA Email & U.S. MAIL

Richard G. McAlee, Hospital Counsel
MedStar Southern Maryland Hospital Center, Inc.
2000 North 15th Street; Suite 302
Arlington, VA 22201

Re: MedStar Southern Maryland Hospital Center
New Construction and Renovations
Matter No. 13-16-2350

Dear Mr. McAlee:

Staff of the Maryland Health Care Commission (“MHCC”) has reviewed the Certificate of Need application filed on October 4, 2013. We have the following questions and requests for additional information concerning this application. Please respond to this request, following the rules at COMAR 10.24.01.07. The application will be docketed if the response is complete.

PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. Regarding Item 9, please provide the following clarifications and additional information and revise the table accordingly:
 - a. The response reports a total current physical bed capacity of 331 including 24 sub-acute and 307 acute care beds. However, the MHCC Report on Selected Maryland Acute Care and Special Services, FY 2013, reported a total acute care physical bed capacity of 324 beds based on information provided by the hospital. Survey data for FY 2014 reported by the hospital indicates a total acute care physical bed capacity of 322 beds. Please reconcile the physical bed capacity numbers reported in this application with the physical bed capacity numbers reported on the MHCC surveys during the past two years. Please complete the attached bed inventory form. For information purposes, I have also attached a bed inventory form from 2007 that shows a capacity of 350 beds established by MHCC and Southern Maryland Hospital Center staff as part of a prior CON review. Note the definition of physical capacity at the bottom of the spreadsheet.
 - b. The response to Item 9 indicates a current capacity of 18 ICU/CCU beds and a proposed capacity of 24 such beds but an increase of eight (8) beds. However the sum of 18 and 8 is 26. What is the current ICU/CCU bed capacity? What is the

proposed capacity? Note that the FY 2014 Acute General Hospital Licensed Bed Designation sheet indicates 12 licensed Medical Surgical Intensive Care beds and 12 licensed Medical Cardiac Critical Care beds. Also note that the 2007 inventory indicated a total CCU capacity of 30 beds in 24 rooms.

- c. The response to Item 9 also indicates a current capacity of 27 obstetric beds and a proposed capacity of 30 beds, but the table reports zero in the change column. Please reconcile the current capacity, the change column and the proposed capacity. Note that the Hospital designated 30 OB beds for licensure for FY 2013 and FY 2014 on MHCC surveys. Note also that the results from the work in 2007 indicated that the OB capacity was 34 beds in 18 rooms.
 - d. The "Total" row of the table reports a total current capacity of 331 beds including the 24 sub-acute beds and a proposed total of 337 beds, which would suggest an increase in capacity of 6 beds. However, the total number in the change column is zero. The "Proposed" column actually totals 340 beds suggesting an increase in capacity of 9 beds. Please reconcile these numbers.
2. Regarding the response to Item 10, submit detailed time tables for receiving Special Exception Site Plan approval and Preliminary Plan of Subdivision approval including submission of applications, anticipated dates of public hearings and dates of expected action by granting authorities.
 3. Regarding Item 11, please provide the following clarifications and additional information:
 - a. Given the response to Item 10 that obtaining approval of Special Exception Site Plan and Preliminary Plan of Subdivision could take approximately 15 to 18 months, explain how MSMHC will be able to obligate at least 51% of the approved capital expenditure within 12 months of CON approval.
 - b. The response to Item 11 indicates that the project will be developed in phases over 48 months. Please identify the phases and the scope of each phase keeping in mind the performance requirements set forth in the MHCC regulations at COMAR 10.24.0.12. Will all phases be constructed under a single construction contract? If not, specify the number of construction contracts and identify the phase to be constructed under each contract.
 4. Regarding Item 14, Project Description, please provide the following clarifications and additional information:
 - a. On page 11 it states that departmental square footage is well below national benchmarks. Submit national benchmarks for the departments affected by this project and identify the source of the benchmarks.

- b. Page 12 (1st paragraph), refers to a study of existing floor plan layouts, projected volumes and benchmark comparisons with similar hospitals. Please submit this study.
 - c. Regarding the Surgery Department, identify the size of the operating rooms that will be replaced.
 - d. Describe the nature and extent of the rough grading that is estimated to cost \$879,612 and the need for the pilings that are estimated to cost \$3,584,100.
 - e. Describe the nature and the extent of the renovations by department.
5. Regarding Item 15, Project Drawings, please provide drawings that more clearly show the departmental space to be added through new construction and the departments and other areas to be altered by renovations. Clearly identify the areas that will be shell space when the project is complete.
 6. Regarding Chart 1, please identify the perimeter of the space that will be renovated in the basement.

PART II – PROJECT BUDGET

7. Please respond to the following:
 - a. A reconciliation of the estimated site preparation cost of \$7,313,002 on page 18 with the total cost reported on page 17 of \$5,484,939.
 - b. An explanation of how the contingency estimate of \$3,691,985 was calculated.
 - c. An explanation of how the interest cost estimate of \$5,580,030 was calculated.
 - d. An explanation of how the inflation allowance of \$9,729,969 was calculated.
 - e. An explanation of how the loan placement fee estimate of \$1.1 million were calculated.

PART III – CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)

Response to State Health Plan for Facilities and Services: Acute Care Hospital Services, COMAR 10.24.10

8. Regarding COMAR 10.24.10.04(A)(1), the submitted policy lacks specific procedures for promptly responding to individual requests for charge information for specific services/procedures as required by the standard. Please revise and resubmit the policy accordingly.

9. Regarding COMAR 10.24.10.04(A)(2)(a)(ii), please provide the following additional information and documentation:
 - a. The policy at Attachment 3 provides for probable eligibility determination within two business days only upon receipt of all requested and necessary documentation. Specify the requested and necessary documentation that is required for a determination of probable eligibility. Explain how this is consistent with the purpose of this standard which is to give a potential patient seeking charity care an idea fairly quickly as to whether the patient will be able to obtain services. The standard's required two-day turnaround for a determination of *probable* eligibility permits a patient to know their likely eligibility for charity care, if the underlying required documentation bears out what the patient represented in a request for charity care or an application for medical assistance. It can take a patient days or weeks to get all the required documentation needed for a *complete* application. This standard requires a determination of probable eligibility; a final determination of eligibility can be made after the application is complete and has required supporting documentation.
 - b. MedStar Health's financial assistance program exclusions include insured patients who may be underinsured (e.g., a patient with high deductible/coinsurance). How is it determined who is underinsured?
 - c. The policy does not address the requirement that public notice of information regarding the hospital's charity care shall be distributed through methods designed to best reach the target population and in a format understandable by the target population. Please revise the policy accordingly addressing how notice will be distributed and submit copies of the public notice in the languages understandable by significant segments of the target population. The notices should include clear instructions to the public on how to apply for charity care.
 - d. Submit copies of the notices posted in each major registration area. Specify where in MSMHC such notices are posted.
 - e. Submit a copy of Maryland Patient Information/MedStar's Patient Information Sheet that is provided to inpatients on admission and at the time of final account billing. How is such information provided to each patient who seeks outpatient services?
10. Regarding COMAR 10.24.10.04(A)(3)(a), Quality of Care, please provide a copy of the deficiency(ies) cited by the Office of Licensing and Certification Programs and the applicant's plan of correction, and provide a timeline on when you expect to receive a final resolution of this matter.
11. Regarding COMAR 10.24.10.04(A)(3)(b), concerning the actions taken to improve the performance for the three Quality Measures that fell below the 90% level and in the bottom quartile for all hospitals, please discuss the progress made in terms of staff

compliance and improved performance for blood tests for Pneumonia, Influenza Immunizations, and preparing a home management plan of care for Children with Asthma.

12. Regarding the response to COMAR 10.24.10.04(B)(5), Cost-Effectiveness, on page 27 (2nd paragraph) of the response it states that after extensive review and analysis Option 1 was identified as the most cost effective option. With respect to this review and analysis and the response to this standard in general, please provide the following additional information and clarification:
 - a. Provide a detailed description of this extensive review and analysis.
 - b. Did the review and analysis quantify the level of effectiveness of each alternative in achieving each alternative including the three variations of Option 1? If yes, submit the quantification of each alternative except Option 0, the do nothing/refurbish alternative.
 - c. The standard also requires the hospital to develop capital estimates and projections for each alternative. While the application includes the estimated capital cost for each variation of Option C, no capital cost estimates were presented for Options 2 and 3. Submit capital cost estimates for Options 2 and 3 comparable to the capital cost estimate for Option 1C.
 - d. The capital cost estimate for Option 1C of \$77.7 million does not appear to be consistent with the cost estimate for the proposed project which is \$78.6 million for new construction and \$17.9 million for renovations, both amounts excluding movable equipment, contingencies, interest during construction, inflation and financing fees. Please explain or revise accordingly and insure that the estimates for Option 1A and B and Options 2 and 3 are consistent in terms of project components and time frame .
 - e. The standard also requires the applicant to develop operational cost estimates for each alternative, please submit such estimates for each alternative.
13. Regarding the response to COMAR 10.24.10.04(B)(7), Construction Cost of Hospital Space, as presented in Attachment 5, please provide the following clarifications with respect to the cost adjustments
 - a. Do the calculations of the MVS benchmark for new construction and renovations include the expansion and renovation of the surgery department? If no, please submit alternative calculations of the MVS benchmark for new construction and for renovations including the work proposed for the surgery department. Note that the State Health Plan Chapter for General Surgical Services provides that a hospital is not required to address standards in the chapter that are completely addressed in its response to the standards in COMAR 10.24.10. MHCC Staff believes that the application of the Construction Cost of Hospital Space standard

from that chapter to projects that make physical plant changes to Surgery Departments as well as other departments is likely to be more appropriate than applying the Construction cost standard from the General Surgical Services chapter separately.

- b. Explain the reason for the two columns under the cost adjustment section of the calculation of the benchmark for both new construction and renovations and for the surgery department.
 - c. Explain why there are adjustments for phasing/temporary work under both new construction and renovation and for surgery department and how each was calculated.
 - d. Explain the escalation on each page and how it was calculated. Is this escalation related to the project budget estimate for inflation on page 18?
 - e. Explain the need for the piled foundation system and how the cost adjustment for this item was calculated for the new construction.
 - f. Describe the major earthworks and explain the need and how the cost adjustment was calculated. Differentiate this line item adjustment from the adjustment for site earthworks (demolition, rough grading).
 - g. Explain the need for the underpinning listed under renovations and explain how the cost adjustment for this item was calculated for the renovations.
 - h. Regarding the site utilities demolition and relocation, describe the work that will be done and how this adjustment was calculated differentiating the demolition from the relocation. Justify the reasonableness of taking an adjustment for the cost of the relocation given that the calculator cost section of the Marshall Valuation Service includes utilities from the structure to the lot line in the hospital base cost (\$336.71 per sq. ft.).
 - i. What are the markups in the adjustment for each component and explain how it is calculated.
14. Regarding COMAR 10.24.10.04(B)(9), Inpatient Nursing Unit Space, please provide documents that support your position that higher intensity of patient care requires more space in patient rooms for equipment and staff, and that 659 square feet per critical care bed complies with the space standards used by architects and industry experts.
15. Regarding COMAR 10.24.10.04(B)(11), Efficiency, please provide a copy of the sections of the master plan discussed on p. 30-31 of your application that address the inefficiencies in the existing hospital and how the project will improve operational efficiencies for the Emergency Department, Surgery Department, Critical Care Unit, Cardiovascular Services, Observation Unit, and the Main Entrance Plaza. If not

addressed by the master plan, please provide (a) an analysis of each change in operational efficiency projected for each treatment service, and document the manner in which the planning and design of the project took efficiency improvements into account; and demonstrate how the proposed project will improve operational efficiency when the expanded treatment service experiences an increase in the volume of services delivered, or why improvements in operational efficiency cannot be achieved.

16. Regarding COMAR 10.24.10.04(b)(12), please provide the following:

- a. The manner in which the proposed project incorporates patient safety in the changes and design to: the Emergency Department; Surgery Department; Critical Care Services; Cardiovascular Services; Observation Unit; and the Main Entrance Plaza. Include how each of the bulleted items on pages 31-32 are implemented and address how each improves patient safety for each of these patient services.
- b. Provide information on the EMR system incorporated with this project. Provide the name of the software system, how physicians and staff will utilize this system, such as computerized physician order entry, electronic medication administration records, barcode medication administration, electronic data exchange with providers, etc. Will providers at MSMHC have the ability to exchange data on the HIE?
- c. How right sizing the clinical services will “support the best possible clinical practice” as discussed in paragraph one on page 32.
- d. Which departments have been fragmented and dissociated within the facility, and how the project will create “optimal flow of patients, clinicians, staff, and supplies.”
- e. Provide details and identify the problems associated with the dissimilarity of critical care rooms. How will the project address each of the bulleted items listed on page 32?
- f. For the Surgery Department, identify the integrated technology that will be used as a tool to aid the caregiver. What design changes and plans in the proposed project will promote scalability and flexibility? What are the long term strategies in the master plan for the Surgery Department?

17. COMAR 10.24.10.04(B)(13), Financial Feasibility, requires each applicant to demonstrate that utilization projections are consistent with observed historic trends. Please respond as required.

18. Regarding COMAR 10.24.10.04(B)(14), please provide the following information:

- a. The number of uninsured, underinsured, indigent, and otherwise underserved patients residing in MSMHC’s primary service area and the impact these groups have on emergency department utilization.

- b. Identify efforts by MSMHC to divert non-emergency cases from the emergency department to more appropriate primary care or urgent care settings and quantify the impact of such efforts.
 - c. Explain how the projected ED visits as shown in Figure 5 support the need for the increase in treatment rooms from the current 41 to the proposed 53.
19. Regarding COMAR 10.24.10.04(B)(15), please respond to the following:
- a. Where does MSMHC refer non-emergent cases for primary care and alternative facilities or programs?
 - b. Besides the Medical Screening Exam, how does MSMHC educate or inform people regarding alternatives to utilizing emergency rooms for care.
20. Regarding COMAR 10.24.10.04(B)(16), please respond to the following:
- a. Present an analysis that demonstrates that the fourth floor (Level 04) shelled space area will have a positive net present value for MSMHC as required by subpart (b) of the standard.
 - b. When is it anticipated that the 5,100 square feet (SF) of shell space on the Westside will be used for expansion of the cafeteria and kitchen?
 - c. When does MSMHC anticipate a decision on the use and the finishing of the shell space in the Southwest corner?
 - d. Please provide the cost of constructing each of the shell space areas separately, which includes those portions of contingency allowance, inflation allowance, and capitalized construction interest related to each shell space area. Explain how each of these costs was derived.

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

21. Regarding COMAR 10.24.11.05(B)(1 and 2), please provide a service area population based analysis of the need for the 10 operating rooms that MSMHC is proposing to maintain and replace. This demonstration of need shall use the operating room capacity assumptions and other guidance included in Regulation .06 of the General Surgical Services plan chapter.
22. Regarding COMAR 10.24.11.05(B) (8), please provide Tables 2 and 4 for the 10 licensed operating rooms at MSMHC for FY 2015 through FY 2020, and provide the assumptions used in the utilization and revenue and expense statements for the surgery department.

Need, 10.24.01.08G(3)(b)

23. Please provide a detailed description of the forecasting tool used by Sg2 to project future need by service line.
24. The Department of Health and Mental Hygiene's "Maryland's All Payer Model," submitted to the Centers for Medicare and Medicaid Innovation on October 11, 2013, anticipates that, "The CON program would support the success of the Maryland All-Payer Model by considering the goals and objectives of the model in its decisions to approve or deny health care facility projects by requiring health care facilities to demonstrate that their projects are viable without reliance on continually growing service volume." Given this expectation, can the applicant demonstrate that the proposed project's utilization forecasts are consistent with a future in which demand for hospital admissions by the hospital's service area population (i.e., the acute hospital use rate of the service area population) is trending down, consistent with the Model's expectations?
25. Demonstrate that the proposed project's utilization projections are consistent with a future in which the demand for hospital admissions by the hospital's service area population (i.e., the acute hospital use rate of the service area population) is trending down.
26. Please specify the market share changes referred to on page 47.
27. Demonstrate the need for the 24 ICU/CCU beds proposed.
28. Please demonstrate the need to establish a 32-bed Observation Unit.
29. Please identify, under Table 1, Patient Mix, the source of the Revenue and Patient Days identified as Other. Reconcile the difference in Patient Mix reported in Table 1 with the Sources of Net Patient Service Revenue reported for year ending December 9, 2012 in Attachment 7, Audited Financial Statements, addressing the difference in payer source for Medicaid, Commercial Insurance, and Other. What assumptions does MSMHC use to support a patient mix of only 4.3% Medicaid population from FY 2014 through 2018, especially since the audited financial statements indicate the hospital received 18% of revenue from Medicaid as of December 9, 2012?

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

30. Are Option B and Option C, discussed in the response to this criterion, the same as Option 2 and Option 3 in the response to the Cost-Effectiveness standard of the SHP for Acute Care Hospital Services, COMAR 10.24.10.04(B)(5)? Is Option A, as described in the response to this criterion, the same as the Option 1 referred to in the response to the Cost Effectiveness standard of the SHP? If not, please explain the options referenced in the response to this criterion in relationship to the options referred to in the response to the SHP standard.

31. Please explain why the additional service volumes to be accommodated in the proposed facility and service expansions included in this project cannot be provided more cost effectively at alternative existing facilities.

Viability of the Proposal, COMAR 10.24.08G(3)(d)

32. Identify the source(s) of the cash contribution of \$32,100,188 that will be used to fund the project.
33. Please provide audited financial statements for the past two years for MedStar Health System.
34. Please identify the anticipated debt-financing vehicle and specify the terms of such financing (interest rate and the length of the loan). Submit an amortization table.
35. Regarding Tables 1 and 3, please project the utilization and the expected revenue and expenses through FY 2020.
36. With respect to Table 3, please provide the following additional information and clarifications:
 - a. Please specify the assumptions regarding hospital rates and charges and submit detail on the calculation of revenue projections, both inpatient and outpatient.
 - b. What is included and will be included in other operating revenues (line 1h) and explain why it increases so much from 2012 to 2013 (285%) and why it is expected to increase another 21% from 2013 to 2014.
 - c. Specify your assumptions with respect to the variability of expenses with volume and explain why you think they are reasonable.
 - d. Provide further explanation of why physician revenues and expenses have been eliminated
 - e. Submit a Table 5 that ties into the Table 3 (the total from Table 5 should equal the salaries, wages and professional fees (line 2a) of Table 5) and should show the change in staffing as a result of this project. It may be necessary to add a column to account for other expected staff increases.
 - f. Explain the large increase in contractual services from 2012 to 2013 (43.4%) and large decrease from 2013 to 2014 (51.8%).
 - g. Explain the large increase in interest on current debt from 2012 to 2013 (94%) and the still larger increase from 2013 to 2014 (235%).

- h. Identify the components of Other Expenses (Table 3 line 2j) and breakdown the expenses accordingly. Explain why these expenses decreased by 12% from 2012 to 2013 and are expected to decrease another 14% from 2013 to 2014.
 - i. Explain the increase in current depreciation from 2013 to 2014 of 70%.
37. Submit an alternative Table 3 with inflation along with a statement of all assumptions and explanations of why you think they are reasonable.
38. The Department of Health and Mental Hygiene's "Maryland's All Payer Model," submitted to the Centers for Medicare and Medicaid Innovation on October 11, 2013, anticipates that, "The CON program would support the success of the Maryland All-Payer Model by considering the goals and objectives of the model in its decisions to approve or deny health care facility projects by requiring health care facilities to demonstrate that their projects are viable without reliance on continually growing service volume." Given this expectation, can the applicant demonstrate that the proposed project is viable without reliance on continually growing service volume?
39. Demonstrate that the proposed project is viable without reliance on continually growing service volumes.
40. Please provide alternative projections of revenues and expenses for the proposed project that are consistent with a variable cost factor that provides the hospital with 50 percent of revenue for incremental increases in volume above the budgeted amount in the hospital's base for the year, consistent with the Maryland All-Payer Model proposal. Provide this alternative projection in both current year dollars and with inflation assumptions for both revenue and expenses.

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

41. This criterion requires applicants to provide information and analysis with respect to the impact of the proposed project on existing health care providers. The response does not provide any analysis. Please provide an analysis of the likely impact of the proposed improvements at MSMHC on other area hospitals, quantifying impact on case volume, days, or outpatient case load at these other hospitals.

Please submit ten copies of the responses to completeness questions and the additional information requested in this letter within ten working days of receipt. All information supplementing the applicant must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Richard C. McAlee, Esquire
October 23, 2013
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Should you have any questions regarding this matter, please contact me at (410)764-3261 or Kevin McDonald at (410)764-5982.

Sincerely,

A handwritten signature in black ink that reads "PE Parker". The letters are stylized and connected.

Paul E. Parker, Director
Center for Health Care Facilities Planning
and Development

Attachments

cc: Patricia G. Cameron , MedStar Health
Pamela Creekmur, Prince George's County Health Officer
(internal distribution)

Hospital Name: Southern Maryland Hospital Center

Date:

Location (Floor/Wing)	Existing Physical Capacity				Proposed Physical Bed Capacity				Notes	
	Hospital Service	Room Count			Hospital Service	Room Count				Licensed Beds Jul-13
		Total Rooms	Four Bed Rms	Semi- Private		Physical Capacity	Total Rooms	Four Bed Rms		
INPATIENT										
Tower I 1st Fl. West	General M/S	0			0				0	
Tower I 1st Fl. East	General M/S	0			0				0	
Tower I 2nd Fl. West	General M/S	0			0				0	
Tower I 2nd Fl. East	General M/S	0			0				0	
Tower I 3rd Fl. West	General M/S	0			0				0	
Tower I 3rd Fl. East	General M/S	0			0				0	
Tower I 4th Fl. East	General M/S	0			0				0	
Sub-total	General MSGA	0	0	0	0	0	0	0	0	
Tower I 1st Fl. East	CCU	0			0				0	
Main Bldg., 1st Fl.	CCU	0			0				0	
Sub-total	CCU	0	0	0	0	0	0	0	0	
TOTAL	MSGA	0	0	0	0	0	0	0	168	
Tower II 1st Fl. South	Obstetrics	0			0				30	
Tower I 2nd Fl. East	Pediatric	0			0				4	
Tower I 4th Fl. West	Psychiatric	0			0				25	
TOTAL INPATIENT		0	0	0	0	0	0	0	227	

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

Table B-1

Hospital Name: Southern Maryland Hospital Center

Date: 2/13/2007

Location (Floor/Wing)	Existing Physical Capacity				After Project Completion				Notes	
	Hospital Service	Room Count			Hospital Service	Room Count				Bed Count Physical Capacity
		Total Rooms	Four Bed Rm	Semi-Private		Total Rooms	Four Bed Rm	Semi-Private		
INPATIENT										
Tower I 1st Fl. West	General M/S	15	2	13	General M/S	15	2	13	34	
Tower I 1st Fl. East	General M/S	10	2	8	General M/S	11	2	9	26	
Tower I 2nd Fl. West	General M/S	17	2	15	General M/S	17	2	15	38	
Tower I 2nd Fl. East	General M/S	15	2	13	Gen. M/S	15	2	13	34	
Tower I 3rd Fl. West	General M/S	17	2	15	General M/S	17	0	17	34	
Tower I 3rd Fl. East	General M/S	17	2	15	General M/S	17	0	17	34	
Tower I 4th Fl. East	General M/S	17	2	15	General M/S	17	2	15	38	
Tower II 3rd Fl.					GYN	6	0	0	6	
Sub-total	General MSGA	108	14	94	General MSGA	115	10	99	244	
Tower I 1st Fl. East	CCU	6	0	6	CCU	5	0	5	10	
Main Bldg., 1st Fl.	CCU	18	0	0	Surgery	0	0	0	0	
Tower II, 1st Fl.					CCU	20	0	0	20	
Sub-total	CCU	24	0	6	CCU	25	0	5	30	
TOTAL	MSGA	132	14	100	Total MSGA	140	10	104	274	
Tower II 1st Fl. South	Obstetrics	18	0	16	Obstetrics	27	0	3	30	
Tower II 3rd Fl.										
Tower I 2nd Fl. East	Pediatric	2	0	2	Pediatric	2	0	2	4	
Tower I 4th Fl. West	Psychiatric	17	2	15	Psychiatric	17	2	15	38	
TOTAL INPATIENT		169	16	133	TOTAL INPATIENT	186	12	124	346	

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