MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

HOSPITALS
APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION, ATTACHMENTS AND EXHIBITS SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. MedStar Southern Maryland Hospital Center, Inc.
Legal Name of Project Applicant (ie. Licensee or Proposed Licensee)

b. 7503 Surratts Road
Street

c. Clinton 20735 Prince George's
City Zip County

d. 301-877-4530
Telephone

e. Michael J. Chiaramonte, President
Name of Owner/Chief Executive

2.a. none
Legal Name of Project Co-Applicant (ie. if more than one applicant)

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

e. _____
Name of Owner/Chief Executive

3.a. MedStar Southern Maryland Hospital Center
Name of Facility

b. same
Street (Project Site)

c. same
City Zip County

4. _____
Name of Owner (if different than applicant)

5.a. _____
Representative of Co-Applicant

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

6. Person(s) to whom questions regarding this application should be directed:
(Attach sheets if additional persons are to be contacted)

a. Richard G. McAlee, Hospital Counsel Name and Title	a. Patricia G. Cameron Name and Title
b. 2000 North 15th Street; Suite 302 Street	b. 5565 Sterrett Place Street
c. Arlington, VA 22201 City Zip County	c. Columbia, MD 21044 City Zip County
d. (703) 558-1118 Telephone No.	d. 410-772-6689 Telephone No.
e. (703) 558-1111 Fax No.	e. Fax No.
f. richard.mcalee@medstar.net E-mail Address	f. patricia.cameron@medstar.net E-mail address

7. Brief Project Description (for identification only; see also item #14):
New construction and renovation to modernize and enhance the Intensive Care Unit, the Emergency Department, the operating rooms and associated pre- and post-surgical care units.

8. Legal Structure of Licensee (check one from each column):

a.	b.	c.
Governmental ___	Sole Proprietorship ___	To be Formed ___
Proprietary ___	Partnership ___	Existing √
Nonprofit √	Corporation √	
	Subchapter "S" ___	

9. Current Physical Capacity and Proposed Changes: (Staff will also provide separately a detailed spreadsheet on which the applicant will display current and proposed physical bed capacity by location.)

Service	Current Physical Beds	Beds to be Added or Reduced	Total Beds if Project is Approved
M/S/G/A	230	0	230
Pediatrics	4	0	4
Obstetrics	27	0	30
ICU/CCU Care	18	8	24
Psychiatry	28	0	28
Rehabilitation	0	0	0
Chronic	0	0	0
Other (Sub-Acute)	24	0	24
TOTAL BEDS	331	0	337

10. Project Location and Site Control:

A. Site Size 15.8 acres. The professional buildings are on 19.5 acres for a total of 35.3 acres.

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO X (If NO, describe below the current status and timetable for receiving necessary approvals.)

The subject property is zoned R-R (Rural Residential) and C-O (Commercial Office). The existing Medical Health Campus has been developed over the years through various approved Special Exception Site Plans including SE 3949, SE 3355, SE 3305, SE 2403 & the most recent of 3949-05. The proposed additions to the building and campus will require a new Special Exception Site Plan as well as a Preliminary Plan of Subdivision to obtain the necessary improvements, revisions and expansion to the campus. It is anticipated that these approval processes could take approximately fifteen to eighteen months.
Building Permit will also be obtained.

C. Site Control:

(1) Title held by: MedStar Southern Maryland Hospital Center, Inc.

(2) Options to purchase held by: N/A
(i) Expiration date of option _____
(ii) Is option renewable? _____ If yes, please explain
_____
_____
(iii) Cost of Option _____

(3) Land Lease held by: N/A
(i) Expiration date of lease _____
(ii) Is lease renewable _____ If yes, please explain
_____
_____
(iii) Cost of Lease _____

(4) Option to lease held by: N/A
(i) Expiration date of option _____
(ii) Is option renewable?_____ If yes, please explain
_____
_____
(iii) Cost of option _____

(5) If site is not controlled by ownership, lease, or option, please explain how site control will be obtained_____
_____

(INSTRUCTION: IN COMPLETING ITEMS 11, 12 & 13, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

11. Project Implementation Target Dates (for construction or renovation projects)

This project will require phased construction: _____

A. Obligation of Capital Expenditure _12_ months from approval date.
B. Beginning Construction _4_ months from capital obligation.
C. Pre-Licensure/First Use _48_ months from capital obligation.
D. Full Utilization _12_ months from first use.

12. Project Implementation Target Dates (for projects not involving construction or renovations):

A. Obligation of Capital Expenditure _____ months from approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

13. Project Implementation Target Dates (for new service projects not involving a capital expenditure):

A. Obligation of Capital Expenditure _____ months from approval date.
B. Pre-Licensure/First Use _____ months from capital obligation.
C. Full Utilization _____ months from first use.

14. Project Description:

Describe the project's construction and renovation plan, and all services to be provided following completion of the project.

About MedStar Southern Maryland Hospital Center

Southern Maryland Hospitals Center was founded in 1977 by Francis P. Chiaramonte, M.D. In December 2012 the hospital became part of MedStar Health Inc. and was renamed MedStar Southern Maryland Hospital Center (MSMHC). MSMHC is a full-service acute care hospital serving Southern Maryland: Prince George's County, Charles County, Calvert County, and St. Mary's County. Its primary service area is southern Prince George's County and northern Charles County. MSMHC is located approximately five miles south of the Capitol Beltway, and only a few miles from Joint Base Andrews. MSMHC is licensed for 227 acute care beds for FY 2014.

The hospital is governed by a Board of Directors consisting of eleven members, is accredited by The Joint Commission, and licensed by the Maryland Department of Health & Mental Hygiene. MSMHC is located on a site adjacent to Surratts Road and Branch Avenue (Maryland Route 5) in Prince George's County. The hospital site is approximately 15.8 acres, and is part of a campus of approximately 35.3 acres which includes two medical office buildings. The central hospital building consists of two levels, including diagnostic, treatment and other patients support spaces. Attached to the central building are Bed Towers I and II, where all the nursing units except Critical Care are located. Bed Tower I is a four-story structure and Bed Tower II has three floors (including a lower level).

Scope of Services

MedStar Southern Maryland Hospital Center provides a complete range of services along the entire health delivery continuum. Emergency care services, mental healthcare, outpatient medical services, and a skilled nursing unit (Subacute Care) are also important parts of the MSMHC continuum. The Partial Hospitalization Program for patients with mental illness (1999), Heartburn Center (2001), and Primary Angioplasty under the C-Port protocol (2002) have added new dimensions to the levels of care which are delivered at MSMHC.

Services offered at MedStar Southern Maryland Hospital Center:

- 24-hour Emergency Department
- Imaging (Radiology, Ultrasound, Nuclear Medicine, CT Scan, MRI, Mammography)
- Maternal-Child Health
- Level II Perinatal Program
- Surgical Services
- Ambulatory "Same Day" surgery
- Critical Care-Intensive Care Unit

- Critical Cardiac Care Unit
- Telemetry-Cardiac Observation Unit
- Cardiology, Cardiac Catheterization, Angiography
- Cardio/Pulmonary Rehabilitation
- Chest Pain Evaluation Center
- Medical-Surgical Services
- Orthopedics and Physical Medicine
- Dialysis
- Mental Health Services
- Partial Hospitalization Program
- Pediatrics
- Primary Angioplasty (C-Port)
- Sleep Disorders Laboratory
- Diabetes Program
- Physical, Occupational and Speech Therapy
- Case Management/Social Services
- Nutrition Services
- Respiratory Care
- Laboratory
- Lithotripsy
- Subacute Care Center
- Asthma and Allergy Center
- Heartburn Center
- Abdominal Aortic Aneurysm (AAA) Screening

Since 1977, the hospital has been a medical center that not only treats illnesses and injuries, but also promotes wellness and community health. As a strong supporter of health care education, MSMHC's goal is to help the residents of Southern Maryland achieve the highest possible level of physical and mental health. It has done this through extensive clinical outreach services, support groups, and health education programming. MSMHC has also provided wellness services, including cardiac risk reduction, diabetes self-management, and weight management. MSMHC's affiliates in the MedStar Health system also operate outpatient clinics and physician office practices in local communities in an effort to ensure that the approximately one million residents of southern Maryland have access to a comprehensive array of healthcare services. As a resource center, MSMHC seeks to prevent illness and promote health through education and screening. Lectures, classes, and seminars are offered throughout the year on topics of interest to the community.

In addition to the hospital's services, MSMHC also offers:

- Primary Care Services:
  - Clinton Family Medical Center
  - Fort Washington Family Medical Center
  - Pediatrics after Hours Family Medical Center in Waldorf
  - Upper Marlboro Family Medical Center
  - Waldorf Family Medical Center

- Medical Office Facilities:
  - Lakeside Professional Center
  - Southern Maryland Professional Building
  - Waldorf-St. Charles Professional Center
- Outpatient Imaging Services:
  - Mammography Center of Southern Maryland
  - Southern Maryland Professional Radiology
  - MRI of Maryland
- The Asthma and Allergy Center of Southern Maryland
- Waldorf ENT
- Clinton ENT
- Clinton OB/GYN
- White Plains OB/GYN

Southern Maryland Hospital's Merger with MedStar Health

Since its founding in 1977, Southern Maryland Hospital Center has been guided by its vision, both of becoming a center of excellence in patient care and of being an extraordinary place to work. Then, as now, the people who work here are our greatest asset and it is they who define our patient-first culture. Over the past 36 years, the hospital has been guided by an unwavering vision to provide the highest quality medical and surgical care to the community – and becoming a regional medical center for the one million residents of Prince George's County and the southern Maryland region.

In 2012, SMHC engaged in discussions to partner with a health system as a way of expanding the range of clinical services offered, reconfiguring the facility and campus to address the needs of the service area population, and preparing for a changing health care landscape. The partnership with MedStar Health was finalized on December 11, 2012, which was a watershed moment as Southern Maryland Hospital Center joined the leading provider of health care services in Washington D.C. and Maryland.

Partnering with MedStar Health mirrors a trend in the healthcare industry as many independent hospitals are aligning with larger health systems. It was seen as a way to better position Southern Maryland Hospital Center for the future as the nation's health care systems continues to undergo monumental transformation. Dr. Francis Chiaramonte, founder and then-chairman of the board of the hospital, and Michael Chiaramonte, the hospital's CEO, felt that MedStar Health was the best partner for the hospital's patients, staff and physicians, and the southern Maryland community, and would greatly enhance the hospital's position for the long term.

Through its merger with MedStar Health, the hospital will continue to grow and meet the needs of southern Maryland residents by providing the highest quality clinical care with advanced technology, innovative medical services, and the region's top doctors. Being part of MedStar Health makes it possible for the hospital to rapidly expand the range of clinical programs offered to the community, particularly in oncology, neurosciences, and

cardiology. It also provides access to capital for a building program to improve and modernize key services. The new partnership with MedStar Health helps the hospital realize its vision while maintaining its culture and tradition of service to the community. MedStar Southern Maryland Hospital Center has become a non-profit organization as a result of the merger. It plans to draw on MedStar Health's expertise in charitable fund-raising and to solicit gifts and contributions totaling five million dollars in support of the project described in this application.

About MedStar Health

MedStar Health is a not-for-profit, regional healthcare system based in Columbia Maryland, and is one of the largest employers in the region. It is the largest healthcare provider in the Maryland and Washington, D.C. region, a $4.2 billion enterprise. MedStar's ten hospitals, including seven in Maryland, and 20 other health-related organizations are recognized regionally and nationally for excellence in medical care. Its more than 27,000 associates and 5,600 affiliated physicians all support MedStar's patient-first philosophy that combines care, compassion and clinical excellence with an emphasis on customer service. MedStar Health combines the best aspects of academic medicine, research and innovation with a complete spectrum of clinical services to advance patient care.

In the greater Baltimore-Washington region, MedStar Health serves 1 in 5 patients receiving acute services, with 20% of the market. MedStar has one of the largest graduate medical education programs in the country, training more than 1,100 medical residents annually, and is the medical education and clinical partner of Georgetown University. With a broad network of primary care and hospitals, as well as MedStar Family Choice, our Medicaid HMO, MedStar Health is well positioned to serve those currently uninsured residents who will have insurance coverage beginning January 2014.

Figure 1. Other MedStar Health Statistics

MedStar Health Benchmarks	FY 2012
Admissions and Observation Cases	163,800
Outpatient Visits	3.6 million
Home Health Visits	200,500
Clinical Trials	1,044
Community Benefits – Research	$7.8 million
Community Benefits – Community Services	$43.2 million
Community Benefits – Charity Care/Bad Debt	87.5 million
Community Benefits – Medical Education	$144.7 million
Community Benefits –Total	$283.3 million

Source: MedStar Health 2012 Annual Report

MedStar Health hospitals:

- MedStar Franklin Square Medical Center
- MedStar Georgetown University Hospital
- MedStar Good Samaritan Hospital
- MedStar Harbor Hospital
- MedStar Montgomery Medical Center
- MedStar National Rehabilitation Network
- MedStar St. Mary's Hospital
- MedStar Southern Maryland Hospital Center
- MedStar Union Memorial Hospital
- MedStar Washington Hospital Center

A few of the MedStar Health related organizations:

- MedStar Health Research Institute (MHRI) – in Hyattsville, MD, provides scientific, administrative and regulatory support for research that complements MedStar's clinical services and teaching programs. MHRI conducts clinical, healthcare delivery and outcomes research in hospital and ambulatory settings.
- MedStar Ambulatory Services – as MedStar's philosophy of a distributed care delivery network is implemented, moving away from a hospital-centric model of health care, MAS is focused on developing convenient and accessible locations throughout the community for patients to receive a variety of health services in the neighborhoods where they live and work. This includes large multi-specialty centers that bring together a variety of diagnostic and treatment services to a single location. One of the newest of these is in Mitchellville, in Prince George's County.
- MedStar Medical Group – MedStar's physician network, with more than 5,600 affiliated physicians, includes more than 1,560 employed physicians across the region, in addition to the 1,100+ residents going through their clinical rotations. Major multi-specialty groups within the network are MGUH, MWHC and MedStar Physician Partners, a primary care group of more than 100 physicians.
- MedStar Visiting Nurse Association – a nonprofit in-home healthcare provider offering skilled nursing, rehabilitation and infusion therapy serving the entire Baltimore Washington region.
- MedStar Family Choice – a licensed HMO which services nearly 37,000 Medicaid enrollees in Maryland. MFC has recently added Prince George's County to its service area, and to date has 2,589 members who reside in Prince George's County. MFC already manages care for over 34,000 Medicaid recipients in Washington, D.C. since beginning there in 2012.

Prince George's County

In 2008, the Prince George's County Council contracted with the RAND Corporation to study the changing health care needs of County residents and the capacity of the County's health care system to meet those needs. Key findings included:

- Prince George's County residents are uninsured at relatively high rates – more than twice as many as Howard County and one-third more than in Montgomery County;
- Primary care physicians are in short supply in Prince George's County – a substantially lower per capita number of primary care physicians compared to neighboring jurisdictions;
- Prince George's County residents use hospital emergency department capacity more intensively than residents of other jurisdictions; and
- A substantial proportion of Prince George's County residents leave the County for hospital and emergency care.

These findings were confirmed in the 2012 report issued by the University of Maryland's School of Public Health – *Transforming Health Care in Prince George's, Maryland: A Public Health Impact Study.*

MedStar has identified several opportunities to significantly improve access to care in Prince George's County in a comprehensive manner. MedStar's steps to address these issues include:

- Expanding MedStar's Medicaid managed care organization (MedStar Family Choice) in Prince George's County.
- Developing additional primary care sites in Prince George's County that will expand access to primary and specialty care physicians, and seamlessly link patients to referral services as needed.
- Developing urgent care sites to help alleviate ED use by providing an easily accessible, after-hours option for non-urgent uses as proposed in this project.
- Addressing severe space constraints at MSMHC and providing state-of-the-art facility upgrades.

MedStar Southern Maryland Hospital Center Renovation and Expansion Project

MedStar Southern Maryland Hospital Center ("MSMHC") is proposing a major renovation and expansion for modernizing of its existing facility. The proposed renovation and expansion seeks to address critical space needs, and create the facilities necessary for MSMHC to continue to upgrade its programs and services while also accommodating the growing need for specialty, sub-specialty and general medical care for patients throughout the southern Maryland region. This transformation and modernization will enhance patient care, particularly in relation to emergency services, critical care, surgery and cardiovascular services.

The MSMHC renovation and expansion project is the outgrowth of comprehensive facility master planning work conducted during 2012 and early 2013 that took into account several specific factors including:

1. Anticipated population growth and demographic change in Prince George's County and the southern Maryland region;

2. Collaborative patient care agreements with Malcolm Grow Medical Clinic at Joint Base Andrews;
3. Current outmigration of patients for services such as oncology, orthopedics, and neurosurgery;
4. Development of separate clinical pathways as a part of the MedStar system (e.g. geriatric, pediatric, behavioral health, diabetes, and bariatric programs); and
5. Comprehensive community needs assessment with direct community member involvement.

The overarching goal of the MedStar Southern Maryland Hospital Center renovation & expansion project is to meet the growing and changing needs of its community, the region and the state for providing access to comprehensive, high-quality health care programs and services. The proposed project includes approximately 165,000 square feet of floor area of new construction which would provide the hospital with additional space needed for modernization of the thirty-six year old facility by enhancing existing space and capabilities for the Emergency Department, Surgery Department, Cardiovascular Interventional Services, and Critical Care. Expansion and modernization will allow the facility to greatly improve utilization, efficiency and patient safety in each area. These improvements are essential to have the continued ability to serve the needs of patients in a comprehensive manner.

The key driver of this project is to create a contemporary facility, accommodating the changing needs of the patients services, improving efficiencies and addressing the significant lack of space in most of the hospital's clinical areas. Many critical clinical services are provided in spaces that are significantly undersized to support contemporary practice for both existing and anticipated community need. The restrictive size of these spaces also presents significant challenges for the introduction of both established and emerging advances in diagnostic and therapeutic technology. Departmental square footage is well below national benchmarks of similar size and location in many areas, particularly critical care beds, medical/surgical beds, ED, radiology, surgery, administration, central supply and materials management, dietary and cafeteria, lab, and public lobby space. These areas all lack sufficient staff and physician support space, and often lack of space hinders family members from participating in patient care. Space constraints in the Emergency Department, Surgery and Critical Care restrict operational efficiency. Critical care rooms are very dissimilar to each other, contributing to inefficiencies for staff. ICU space shortages impact multiple service lines. The undersized specialty procedure and diagnostic rooms and operating rooms do not support current or future technology. In addition, with a new level of care being provided, more space is needed for the growing number of observation patients.

The primary objectives of this project are to:

- Right-size the hospital for the current and projected mix of inpatient and outpatient volumes, and expected growth in strategic service lines.
- Provide needed additional space for growing clinical services to enhance the hospital's ability to provide care consistent with current clinical standards.
- Clarify and simplify circulation patterns.

- Improve the patient and visitor experience.
- Provide necessary staff support space.

Based on study of the existing floor plan layouts, projected volumes and benchmark comparison with similar hospitals, key clinical departments will be resized to meet the facility's projected needs through 2017 and beyond. The area covered by this project has been designed with both connectivity and long-term growth in mind, thereby allowing valuable flexibility so that the hospital can continue to grow, as needed, in an efficient and planned manner in future years.

To address these space needs, new construction will be added along the south side of the main building and across the west side of the hospital. The south addition will extend the main floor, Level 01, by 80 feet to allow the southward expansion of the ED, Surgery and Interventional Cardiology. Due to the grade in that area, the basement level, Level 00, will also be extended to support the main floor extension. This will allow future expansion of patient support, business operations, and employee needs such as a renovated cafeteria, and a new central supply area. On the front side, the vertical expansion will change the hospital's main and emergency entrances, allow additional expansion of the ED, and construct three new floors above the ED. The relocated Critical Care Unit will move to the new Level 02. A dedicated observation unit will go into the new Level 03, easing capacity constraints in the ED and inpatient beds. The top floor, Level 04, will be constructed as shell space and will eventually be used to allow conversion of the hospital's semi-private rooms to private rooms. The renovations will then create the public concourse that will help consolidate visitor and outpatient movement and include improved amenities for patients and their families, expand pre- and post-op areas of the Surgery Department, and add much-needed staff office, staff lounge, and private consultations spaces as well as a dedicated waiting area serving the Surgery Department.

Overview of Major Project Components

Emergency Services: One of the preeminent factors driving this proposal involves emergency services. The department is significantly undersized for the current and projected patient volumes, based on best practice programming and comparable facilities. Improving patient flow and reducing length of stay is a critical goal of this project, as is enhancing care for those in need of mental health needs of our community. Minor renovations to the Emergency Department had been undertaken over ten years ago in an attempt to improve patient flow, accommodate increased volumes to better meet code requirements and current health care standards, but there is simply no way to further expand the ED within the existing facility.

The renovated and expanded Emergency Department will enhance efficiency of care and privacy for patients, as well as meet the growing demand for emergency care. This plan has been developed to meet long-term needs by expanding the ED square footage by approximately 150%. Renovation and expansion of the footprint would increase the Emergency Department from its current size of 13,009 square feet to a total of 32,500

square feet, and accommodate 48 treatment bays, 3 triage bays, and 2 resuscitation rooms. Private treatment rooms will be constructed that are larger in size to support advanced monitoring and treatment technology, and encourage family involvement during a patient's emergency visit. The treatment spaces will be designed to accommodate acuity ebb and flow. The plan also includes establishing a separate behavioral health section within the Emergency Department with six dedicated treatment rooms to better serve those with behavioral health needs.

Surgery Department: The surgery, pre-op and post-op areas are undersized based on best practice programming and comparable facilities. There is a significant lack of adequate storage space in the Surgery Department. The ten existing ORs average 416 square feet. Larger operating rooms are essential for the requirements of orthopedic, neurosurgical and spine surgery as well as intra-operatory imaging. The expanded and renovated Surgery Department will have six new large state-of-the-art operating rooms in the new area, and the PACU/Pre/Post area will expand into the space currently occupied by the Critical Care Unit. Six of the existing ORs will become part of the new PACU/Pre/Post area, and four will remain in service, with no addition to the hospital's current count of 10 licensed OR's.

Critical Care: The Critical Care Unit is also significantly undersized based on best practice programming and comparable facilities. The ICU/CCU will be relocated to new construction directly above the ED in the vertical expansion. The new unit will bring the patient rooms into appropriate size and provide adequate space for staff, family and equipment.

Cardiovascular Services: This service also needs more space. The project will extend the current first floor location of the cath labs, EP lab and interventional radiology on the south side of facility for the purpose of providing appropriate space when systems undergo replacement. The additional space will be used to increase the number of holding rooms for patients before and after cardiac and vascular procedures.

Observation Unit: Currently, observation beds are distributed among the inpatient nursing units throughout the hospital. A new dedicated Observation Unit will relieve the patient flow back-up in the ED and integrate new treatment areas within the existing facility for improved flows. Creation of an observation unit will ultimately enable the hospital to convert some of its semi-private rooms into private rooms.

Main Entrance Plaza: Renovation and expansion of the main lobby will create an internal public concourse with public amenities linking the front entrance with the Emergency Department, and waiting areas for key diagnostic and treatment departments. The creation of a primary circulation path east-west along the north face of the Hospital will clarify way-finding for patients and their families. It will also provide a much more visible entrance and a more welcome 'front door' experience for patients and visitors alike. Along the circulation, patients and families will have access to the gift shop, café and chapel amenities. An internal corridor, running east-west, will be a dedicated staff corridor.

Support space: The loading dock will be relocated, and the hospital utilities infrastructure will be upgraded.

Site Work: The helipad will be relocated to allow for more efficient ambulance entry, drop-off and exit. Some employee parking spaces displaced by construction due to expansion on southern most part of hospital will be relocated to space vacated by dismantling a metal storage building behind southeast corner of hospital campus. Existing generators, oxygen tank, below-grade fuel tanks, and other infrastructure will also be replaced or relocated, and existing site utilities will be moved or supplemented to better serve the expanded hospital footprint.

In summary, the MSMHC renovation and expansion project is an $126 million undertaking that will substantially enhance the operational profile of the MSMHC campus by it completion in 2018. The project will increase functional space within the hospital by almost 70% and will position MSMHC to provide for the community's well-being for many years to come. The addition of this space to the hospital will increase privacy, comfort and safety for patients and improve the setting provided for family members and others who visit the hospital every day.

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15. Project Drawings:

Projects involving renovations or new construction should include architectural drawings of the current facility (if applicable), the new facility (if applicable) and the proposed new configuration. These drawings should include, as applicable:

1) the number and location of nursing stations,
2) approximate room sizes,
3) number of beds to a room,
4) number and location of bath rooms,
5) any proposed space for future expansion, and
6) the "footprint" and location of the facility on the proposed or existing site.

Please see Attachment 1, which includes the architectural drawings and area tabulations with approximate room sizes from Perkins + Will.

16. Features of Project Construction:

A. Please Complete **"CHART 1. PROJECT CONSTRUCTION CHARACTERISTICS AND COSTS"** describing the applicable characteristics of the project, if the project involves new construction or renovation.

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.

We have included one floor of shell space above the Critical Care Unit and Observation Unit. This space will share the same footprint as those two units. We anticipate the gradual conversion, as funds allow, of semi-private rooms to private rooms. MSMHC will eventually seek the appropriate level of MHCC approval to finish this shell space.

C. Please discuss the availability of utilities (water, electricity, sewage, etc.) for the proposed project, and the steps that will be necessary to obtain utilities.

The Washington Suburban Sanitary Commission (WSSC) provides ten inch water and eight inch sewer service to the existing buildings and Health Campus. The water and sewer lines for the proposed expansion will be provided from the existing service. Roof drains from the existing hospital consist of underground pipes that connect to an existing storm drain system around the perimeter of the hospital which conveys stormwater runoff to an existing stormwater management pond on the western side of the property. The proposed expansion of the hospital and the proposed improvements adjacent to the hospital will require the relocation of the roof drain and storm drain system. The size of the roof drain pipes are anticipated to be approximately 12" in diameter. The hospital building expansion will require the relocation of existing 24" and 27" diameter reinforced concrete pipe

(RCP) on the east and south sides of the building. An additional 15" RCP will be relocated on the western side of the building to accommodate parking lot improvements. Diversion manholes will be utilized to divert the first floor of stormwater runoff to bio-trenches.

Chart 1. Project Construction Characteristics and Costs		
Base Building Characteristics	Complete if Applicable	
	New Construction	Renovation
Class of Construction		
Class A	X	X
Class B		
Class C		
Class D		
Type of Construction/Renovation		
Low		
Average		
Good	X	X
Excellent		
Number of Stories	5	2
Total Square Footage		
Basement	21,955	575
First Floor	51,812	42,772
Second Floor	30,533	NA
Third Floor	30,533	NA
Fourth Floor	30,533	NA
Perimeter in Linear Feet		
Basement	1,258	0
First Floor	1,389	972
Second Floor	1,008	NA
Third Floor	1,008	NA
Fourth Floor	1,008	NA
Wall Height (floor to eaves)		
Basement	16'-0"	16'-0"
First Floor	16'-0"	16'-0"
Second Floor	15'-0"	NA
Third Floor	15'-0"	NA
Fourth Floor	15'-0"	NA
Elevators		
Type *Passenger* *Freight*	Passenger	NA
Number	4	NA
Sprinklers (Wet or Dry System)	Wet and dry	Wet
Type of HVAC System	Central plant with package air handlers	Central plant with package air handlers
Type of Exterior Walls	Brick w/ CMU or metal stud backup	Brick w/ CMU or metal stud backup

Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs	$	$
Normal Site Preparation*	37,265	
Demolition	312,894	
Storm Drains	150,039	
Rough Grading	879,612	
Hillside Foundation	0	
Terracing	0	
Pilings	3,584,100	
Offsite Costs	$	$
Roads	0	
Utilities	0	
Jurisdictional Hook-up Fees	0	
Signs	$175,00	$
Landscaping	$346,029	$

*As defined by Marshall Valuation Service. Copies of the definitions may be obtained by contacting staff of the Commission.

PART II - PROJECT BUDGET

(INSTRUCTION: All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.)

A. Use of Funds

1. Capital Costs:

a.	New Construction	
(1)	Building	$ 56,846,021
(2)	Fixed Equipment (not included in construction)	8,090,000
(3)	Land Purchase	0
(4)	Site Preparation	7,313,002
(5)	Architect/Engineering Fees	6,135,902
(6)	Permits, (Building, Utilities, Etc)	288,750
SUBTOTAL		$ 78,673,676
b.	Renovations	
(1)	Building	$ 12,480,685
(2)	Fixed Equipment (not included in construction)	4,045,000
(3)	Architect/Engineering Fees	1,248,068
(4)	Permits, (Building, Utilities, Etc.)	96,250
SUBTOTAL		$ 17,870,003
c.	Other Capital Costs	
(1)	Major Movable Equipment	7,225,000
(2)	Minor Movable Equipment	1,850,000
(3)	Contingencies	3,691,985
(4)	Other (Specify)	0
TOTAL CURRENT CAPITAL COSTS (a - c)		$ 109,310,663
d.	Non Current Capital Cost	
(1)	Interest (Gross)	$ 5,580,030
(2)	Inflation (state all assumptions, Including time period and rate)	$ 9,729,969
TOTAL PROPOSED CAPITAL COSTS (a - d)		$ 124,620,662

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$ 1,100,000
b.	Bond Discount	0
c.	Legal Fees (CON Related)	500,000
d.	Legal Fees (Other)	0
e.	Printing	10,000
f.	Consultant Fees	
	CON Application Assistance	150,000
	Other (Specify)	0
g.	Liquidation of Existing Debt	0
h.	Debt Service Reserve Fund	0
i.	Principal Amortization Reserve Fund	0
j.	Other (Specify)	0
	TOTAL (a - j)	$ 1,760,000

3. Working Capital Startup Costs $ _____

TOTAL USES OF FUNDS (1 - 3) **$ 126,380,662**

B. Sources of Funds for Project:

1.	Cash	32,100,188
2.	Pledges: Gross _____, less allowance for uncollectables _____ = Net	0
3.	Gifts, bequests	5,000,000
4.	Interest income (gross)	0
5.	Authorized Bonds	89,280,474
6.	Mortgage	0
7.	Working capital loans	0
8.	Grants or Appropriation	
	(a) Federal	0
	(b) State	0
	(c) Local	0
9.	Other (Specify)	0

TOTAL SOURCES OF FUNDS (1-9) **$ 126,380,662**

Lease Costs:

a. Land	$_____	x _____	= $_____
b. Building	$_____	x _____	= $_____
c. Major Movable Equipment	$_____	x _____	= $_____
d. Minor Movable Equipment	$_____	x _____	= $_____
e. Other (Specify)	$_____	x _____	= $_____

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

(INSTRUCTION: Each applicant must respond to all criteria included in COMAR 10.24.01.08G(3), listed below.)

10.24.01.08G(3)(a). The State Health Plan.

List each applicable standard from each appropriate chapter of the State Health Plan and provide a direct, concise response explaining the project's consistency with that standard. In cases where standards require specific documentation, please include the documentation as a part of the application.

COMAR 10.24.10.04 Acute Inpatient Services Standards

A. General Standards.

The following general standards encompass Commission expectations for the delivery of acute care services by all hospitals in Maryland. Each hospital that seeks a Certificate of Need for a project covered by this Chapter of the State Health Plan must address and document its compliance with each of the following general standards as part of its Certificate of Need application. Each hospital that seeks a Certificate of Need exemption for a project covered by this Chapter of the State Health Plan must address and demonstrate consistency with each of the following general standards as part of its exemption request.

(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.

Response: MSMHC has a policy regarding the provision of information on hospital charges. See Attachment 2. A list of services and charges is posted on the hospital's website. See http://www.medstarsouthernmaryland.org/average_charges.php. The list includes inpatient and outpatient surgical procedures.

(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

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

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

Response: MSMHC complies fully with the HSCRC's regulations on financial assistance policies [COMAR 10.37.10.26], as revised in 2010. See Attachment 3 for MSMHC's financial assistance charity care policy. Notice of the hospital's financial assistance policy is posted in the admissions office, business office, and emergency department.

Prior to its merger with MedStar Health, MSMHC was a for-profit organization, and as such did not fall under the same rules on financial assistance as non-profit organizations. Since the merger, MSMHC converted to a non-profit hospital in the MedStar system. MedStar hospitals provide over 11% of the charity care provided by all Maryland hospitals and three of the hospitals provided more that the state average in charity care in the HSCRC 2012 Community Benefit Report. MSMHC, as a new no-profit hospital is expected to be in line with the MedStar Health hospitals for provision of charity care.

(3) Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

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

Response: MSMHC is properly licensed and accredited by the Joint Commission. Our most recent licensure letter from the Office of Health Care Quality and the most recent certificate of accreditation are included as Attachment 4. The hospital is working with the Office of Licensing and Certification Programs on a Plan of Correction that will put the hospital in full compliance with the CMMS conditions of participation. That Plan has been accepted by OLCP, and full resolution is anticipated. An update will be provided as soon as it is available.

MSMHC scored at the 90% level or above for all but four of the 25 applicable quality indicators in the most recent update of the *Maryland Hospital Performance Evaluation Guide*. As shown in the figure below, three are also ranked in the bottom quartile of all hospitals reported on that measure. The score for pneumococcal immunization, while below 90%, is not in the bottom quartile of reporting hospitals.

Figure 2. MSMHC Quality Indicator Comparison

Quality Indicator	Total Hospitals	MSMHC Rank	MSMHC Score	Beginning of 4th Quartile
Quality of Care for Pneumonia				
Performing the recommended blood test	44	44	88%	95%
Quality of Care for Children's Asthma				
Children and their caregivers who received a home management plan of care document	19	19	58%	86%
Quality of Care for Immunizations				
Pneumococcal Immunization	45	32	88%	85%
Influenza Immunization	45	38	85%	86%

To address the performance in the other three measures, MSMHC has taken the following actions:

Performing the recommended blood test for pneumonia –

- Educated emergency department physicians and nurses on need for blood test prior to antibiotic administration.
- Medication dispenser (Pyxis) has an alert to the nurses reminding them to obtain blood culture prior to administering antibiotic.
- Department feedback provided to individuals that fail to obtain blood culture prior to antibiotic.
- Monthly update to department manager regarding core measure pneumonia compliance.
- Core measure compliance rates provided to emergency department medical director, vice president of medical affairs, and chief nursing officer.
- Educated emergency department staff to document correct time of blood culture and not the time sent to the lab.

Children and their caregivers who received a home management plan of care document for asthma –

- Developed and educated physicians on the Childhood Asthma Discharge Form.
- Educated nursing staff to document asthma patient education on the plan of care.
- Nurse director of the pediatric unit receives a daily report to follow pediatric asthma patients and ensure proper documentation for plan of care.

Influenza immunization –

- Nurses screen all patients upon initial admission to the nursing units
- If immunizations are needed, an order is placed on the patient chart to go to pharmacy.
- Nurse administers the necessary immunization and records it on the medication record.
- Unit secretaries provide oversight of the immunization need and inform nurse to address.
- Chief nursing officer and vice president of medical affairs receive monthly core measure reports
- New-Horizon HEV program monitors on nursing unit alert nursing staff of immunization needs on each patient.
- Daily report from IT to all nursing departments and quality office to follow up on missed immunizations.

B. Project Review Standards

The standards in this section are intended to guide reviews of Certificate of Need applications and exemption requests involving acute hospital facilities and services. An applicant for a Certificate of Need must address, and its proposed projects will be evaluated for compliance with, all applicable review standards. An applicant for a Certificate of Need exemption must address, and its proposed project will be evaluated for consistency with, all applicable 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.

Response: MSMHC is not relocating therefore, this standard does not apply.

(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.

Response: MSMHC does not propose to develop new acute care beds. Therefore, this standard does not apply.

(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.

Response: MSMHC does not propose to establish a new pediatric service.

(4) Adverse Impact.

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

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.

Response: This application does not include an increase in hospital rates to cover the capital cost. Therefore, part (a) does not apply to this project. No reductions in service are proposed, therefore part (b) does not apply to this project.

(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.

Response: The primary objectives of this project are to:

- Right-size the hospital for the current and projected mix of inpatient and outpatient volumes, and expected growth in strategic service lines.
- Provide needed additional space for growing clinical services to enhance the hospital's ability to provide care consistent with current clinical standards.
- Clarify and simplify circulation patterns.
- Improve the patient and visitor experience.
- Provide necessary staff support space.

Facility Master Plan Options

Option 0: Do nothing/ Refurbish only:
This option is not a feasible solution to achieve the stated goals of MSMHC to meet the growing and changing needs of the community. A strategy to only refurbish areas of greatest need has served the hospital center in the past. However, the under-sizing of key departments has reached the point where the quality of patient care will be impacted unless additional clinical space is provided. Further, the physical limitations of the existing buildings and infrastructure make it cost-prohibitive for MSMHC to implement updated patient care practices (i.e. family-based care) and the installation of new medical equipment.

Option 1: Minimal Renovation / Elbow Room
This option, which was ultimately selected as the preferred approach moving forward, is the least costly of the three master plan options. This option minimally improves the visibility and approach for visitors. The location of the primary entries – the main public, the Emergency Department walk-in and ambulance - remain close to their existing locations. However, the creation of a primary circulation path east-west through the center of the Hospital will clarify way-finding for patients and their families. Along this key public corridor are located key amenities and waiting areas for the diagnostic and treatment departments. The orientation and the location of the building expansion, along the south edge of the diagnostic & treatment block, ideally locates the needed renovation and "in-place" expansion of the key departments: the Emergency Department, Imaging and Surgery. While the two existing Bed Towers (BT I & BT II) will remain primarily acute inpatient nursing, a second level of the new expansion will include new replacement patient beds for intensive care and critical care. These will be designed to the most current standards and vertically adjacent to the ED, Imaging and Surgery. By creating a new intensive/critical care core with area designated for vertical expansion, this approach provides flexibility for the future. Further, retaining the land to the south of the site as surface parking keeps MSHMC's options open for future site development. Making the most of the existing facilities while expanding key departments, as well as providing a framework for later-phase expansion, are the most cost-effective ways to address MSMHC's stated goals.

Option 2: Moderate Renovation / Satisfy Best Practice Standards
This option is of moderate cost. While not addressing visibility and approach (similar to Option 1), the proposed arrangement of new on-site parking and entries would separate the outpatient and inpatient traffic flow upon entering the site. This would complement the proposed concentration of outpatient functions at the north end of campus (the SMPB and BT 1) and the inpatient functions at the south end. The relocation of the Main Entry to the south would allow patients and visitors to use a later-phase South Parking Deck. Also, the ED Ambulance traffic would be more clearly separated from the public traffic flow. Similar to Option 1, a new public circulation spine is an organizing element and its location along the south edge of the proposed expansion would feed additional, later-phase expansion. In addition to the new Main Entry and connecting public circulation spine, a new patient tower would be built and would provide an opportunity for MSMHC to create a new, modern image. Despite this, the current problems with the internal flows (e.g. the lack of a direct connection between the diagnostic and treatment areas of the hospital and the new beds; the cross traffic between Public & Patient/ Staff) are not eliminated. Also, the location of the South Parking Deck would reduce future expansion

opportunities. The additional cost and disruption required to implement this approach make it incompatible with MSMHC's key goals of creating a cost-effective solution to enhance patient care.

Option 3: Extensive Renovation / Support Future Growth

This option is the most costly and complex to implement. The idea behind this approach is to create a new outpatient, ambulatory care center which will be highly visible and serve as the main public face of MSMHC from Branch Ave/Highway 5. Similar to Option 2, the arrangement of site parking and entries would separate the outpatient and inpatient flow upon entering the site, thereby reducing the traffic congestion on site. The main Hospital entries would maintain their existing orientation. All outpatient services would be located on the north side of campus, which would create a remote connection between the existing and new outpatient functions. Consolidated parking on the west, Hotel site – either surface or structured, depending on need – is cost effective, but is distant from the main Hospital entry points. The ultimate strategy for future expansion – the development of the adjacent Hotel site – will allow for phased replacement of the entire facility, but this would require significant property acquisition and a timeline not compatible with MSMHC's stated goals and needs.

After extensive review and analysis, Option 1 was identified as the most cost effective option. Three refinements were then developed as a variation of Option 1 to further confirm and refine the effectiveness of both cost and care improvements. The major difference between the three variations of Option 1 is the placement and renovation of Patient Beds on the campus. The following diagnostic and treatment departments remain identical in all three variations of Option 1:

- Emergency Department expansion and dedicated behavioral health area to meet increased demand for ED services;
- Surgery Department expansion to allow for larger ORs, increased Prep and Post bays, improved staff support space;
- Cardiology expansion to right-size patient treatment space and improve circulation for staff and patients.

Public concourse and amenities are likewise unchanged within each of the below options.

Option 1A: Horizontal Expansion at Bed Tower II

The new public concourse conflicted with the existing Critical Care Unit and Intensive Care Unit (CCU/ICU) and would require the department to be relocated. The CCU/ICU was proposed to be moved to the first level of Bed Tower II and maintain a bed count of 18. This move required expansion of the south end of Bed Tower II along two perimeter walls at the main level and the basement level below. The distance between the Emergency Department and CCU/ICU increases in this option while the travel distance between Surgery and CCU/ICU is relatively unchanged. Post-Partum Beds were relocated to Level 02 of Bed Tower II, consolidating the Post-Partum Department and Nursery. Sub-Acute Beds were relocated to a single story addition above the expanded ED with new vertical circulation. A new staff-only elevator was also proposed at Bed Tower II to improve safety and patient privacy. The construction cost of this option was initially estimated to be approximately $78.7 million dollars.

Option 1B: Vertical Expansion at Bed Tower II

Option 1B also relocated CCU/ICU to Level 01 of Bed Tower II; however, in this option, CCU/ICU would take over the entirety of Bed Tower II's Level 01 footprint as compared to Option 1A in which only the south end of Bed Tower II was effected. The number of CCU/ICU beds increased from 18 to 24, the current licensed CCU/ICU bed number. Travel distance between CCU/ICU increased while distances between CCU/ICU and Surgery would remain unchanged. At the time of Bed Tower II's construction, it was designed structurally to accommodate two additional levels. This option required the addition of two floors to Bed Tower II; however, new structural support and infrastructure would be required to meet current structural code requirements. A Consolidated Post-Partum unit and Nursery was placed on the existing Level 02. The new Level 03 housed Labor and Delivery along with shell space for future expansion. Sub-Acute beds were relocated to the new Level 04. A staff-only elevator was added to Bed Tower II to improve safety and patient privacy. The construction cost of this option was initially estimated to be approximately $87.6 million dollars.

Option 1C: No Expansion of Existing Bed Towers

Both Options 1A and 1B proposed extensive renovation at Bed Tower II and subsequent significant phasing to build. In contrast, Option 1C proposes no renovation or expansion within either existing Bed Tower. Instead, Option 1C proposes building vertically over the expanded Emergency Department (ED) to accommodate the new CCU/ICU and a dedicated Observation Bed Unit. Currently, observation beds within the hospital are scattered throughout the existing Bed Towers. The CCU/ICU would be placed on the first level above the ED and would increase from 18 beds to 24 beds. Travel distance between CCU/ICU and ED is reduced, while travel distance between Surgery and CCU/ICU is increased, but not to a significant distance. Both dedicated staff and public elevators would be added and placed remotely, providing segregated Staff and Public flow. A consolidated Observation Unit is placed on Level 02. The vertical expansion also includes one level of shell space above the Observation Unit. This future addition of two nursing floors allows the facility to transition to private beds and potentially decommission and transition the oldest Bed Tower, Bed Tower I, to alternate function. Additionally, the vertical expansion at the front facade will provide significant visual connection from the main thoroughfare, Route 5. This option was selected as the most cost-effective, patient-centered, and staff-supportive, and is described in more detail throughout the remainder of this application. The comparable construction cost of this option was initially estimated to be approximately $77.7 million dollars.

(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.

Response: No new services are proposed with this project, therefore this standard does not apply.

(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.

Response: The Marshall Valuation benchmark for this project is $373.49, compared to the project cost of $393.57. See Attachment 5.

(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.

Response: This project does not involve construction of non-hospital space.

(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.

Response: The Critical Care Unit will be reconstructed in a different location within the existing hospital. The purpose of this renovation is to provide much needed space for critical care to be consistent with state-of-the-art modern practices. In addition to the space reconfiguration, the MSMHC projects an increase in more complex patients being admitted in the future, requiring a higher mix of critical care beds. The proposed new Critical Care Unit will be approximately 27,050 square feet. The patient care rooms will be 372 net square feet, which is consistent with industry standards. The Unit Program Space shown in Figure 3 was prepared according to the State Health Plan definition by Perkins + Will.

Figure 3. Critical Care Units – Proposed Program Space

Critical Care Unit	Program Space	# of Beds	Space per Bed
Current	3,636	18	202
Proposed	15,816	24	659

Please note that although this standard appears to apply one standard to all nursing units, critical care units are not like general medical-surgical nursing units in their size requirements. Higher intensity of patient care required means more equipment and more staff in the unit and in each room. This application is consistent with the standard's policy because the unit is designed to meet the reasonable space standards developed by architects and industry experts over the past few years, consistent with the way critical care is provided today.

(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.

Response: The HSCRC does not have a current measure of Reasonableness of Charges (ROC) report, and is not currently labeling any hospitals as high-cost. The HSCRC has not determined that MSMHC is a high cost hospital, and therefore, this standard does not apply.

(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.

Response: A key goal of the MSMHC Renovation & Expansion Project is to maximize efficiency of its functional space and operations. The master plan, which preceded the Project, identified several areas where inefficiency was impacting the quality of patient care.

For example, the arrival experience for patients and their families to the hospital is affected by traffic congestion on the site, inadequate space for patient drop-off at the main entry points and difficulty finding parking. The project will address this through improved exterior signage which will clarify the arrival paths and entries, expanded drop-off zones and segregation of traffic flow types on campus. The exterior signage will tie into the interior so that the path from entry, through security to treatment area, support area or patient room remains clear. This will improve efficiency by reducing incidents where patients and their families are delayed to their destination because they lost their way.

Another example is the high number of ambulance transport re-routings occurring at the Emergency Department. The master plan identified the lack of open ED exam beds as a key factor causing these diversions. Upon closer study, it was determined that the turnover of patients in the ED exam rooms was slowed due to a combination of non-critical patients who needed observation but not acute care, as well as those more-critical patients waiting for an ICU or CCU bed to become available. In addition, several existing Operating Rooms within Surgery were underutilized due to the lack of modernized services and materials, therefore causing a delay in clearing surgical cases from the ED exam rooms. All three of these conditions create a bottleneck in the throughput that ultimately results in back-ups at the ambulance drop-off area. The project proposes an observation unit above the Emergency Department for the former group and Intensive/Critical Care beds immediately above the ED for the latter group. Additionally, adequate space, protected from the elements, is provided at the ambulance entry for the staging of arriving gurneys.

A third example and overarching strategy to improve efficiency throughout the clinical care areas is the provision of additional equipment and supply storage along primary staff circulation pathways, convenient to its target patient recipients. This will result in the nursing staff spending less time finding, transporting and storing supplies and more time with patients.

These specific examples illustrate how the scope of renovation and new construction takes into account current inefficiencies within the existing facility and addresses them through the programming and design of the new project.

(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.

Response: The MSMHC Renovation & Expansion Project is focused on improving the experience for patients, physicians, staff and visitors. A primary goal of the project is to provide a superior environment of care. Furthermore, as a part of MedStar Health, a partner in the "Healthier Hospitals Initiative," this project will enhance MSMHC's environmental sustainability and improved patient care. This will allow the hospital to recruit and retain the best physicians and staff in the region.

The project will implement overarching strategies which include the following:

- Design following the most recent design guidelines (e.g. FGI) as well as building and life safety codes.
- Improve the patient experience through the creation of defined pathways and improved access to services.
- Create a culture and environment around the immediacy of care.
- Provide areas for staff-patient information exchange to better meet the most recent HIPAA guidelines.

- Provide an information infrastructure (i.e. EMR) that enables the best possible coordination among care providers.
- Standardize fundamentals: space, layout, location, equipment and supplies.
- Create dedicated staff support areas as well as areas of respite.
- Clearly identify future expansion zones and plan for flexible space which anticipates changes in technology.

Many critical clinical services are provided in spaces that are significantly undersized to support contemporary practice for both existing and anticipated community need. The restrictive size of these spaces also presents significant challenges for the introduction of both established and emerging advances in diagnostic and therapeutic technology. This project will right-size these spaces to support the best possible clinical practice.

Department locations have become somewhat fragmented and dissociated due to incremental development within the facility over time. This project will re-establish appropriate departmental adjacencies, based on the optimal flow of patients, clinicians, staff, and supplies. This will promote greater efficiency and safety in the delivery of patient care.

Critical care rooms are very dissimilar to each other, contributing to inefficiencies for staff. This project will standardize the patient rooms in this area promoting greater safety by increasing staff familiarity with the environment and facilitating greater observation of the patient. In the critical care areas, additional, specific steps include the following:

- Support family involvement in the care of the patient by providing both shared and dedicated space.
- Design workstations to foster better staff collaboration and communication.
- Establish immediate accessibility of information, supplies and material in close proximity to the patient, and the caregiver in close proximity to the patient.
- Improve visibility of patient to staff and staff to patient.
- Locate staff work areas to provide visibility to patients, and accessibility for patient to care provider.

In Surgery, additional, specific steps include the following:

- Integrate technology as tools to aid the caregiver. For example, a focus on clinical documentation and communication.
- Design and plan around scalability and flexibility.
- Plan in the context of longer-term master plan strategies.

(13) Financial Feasibility.

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

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

(b) Each applicant must document that:

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

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

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

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

Response: The statistical and financial projections found in Tables 1 and 3, respectively, indicate that the project is financially feasible. Statistical projections are based on estimated capture of additional inpatient and outpatient volumes in the total service area (TSA) and from the Southern Maryland peninsula. FY 2017 represents the largest growth based on project completion and expanded services in neurosciences, cancer, orthopedics and cardiology. Revenue and expenses reflect the following assumptions:

- There is no increase in Revenues or Expenses due to inflation. All values represent current dollars.
- Increases in revenues and expenses are the result of volume growth.
- Interest capitalized during construction has been expensed starting in FY 2018.
- Physician revenues and expenses have been eliminated in an attempt to normalize the fiscal year presentations.
- The interest (financing cost) and depreciation are based on the project budget and are reflected in FY 2018.

(14) Emergency Department Treatment Capacity and Space.

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

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

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

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

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

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

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

Response: MSMHC proposes to expand the hospital's emergency department treatment beds to 53 treatment spaces, and increase square footage from approximately 13,009 to approximately 32,500 square feet. The expansion is needed to accommodate the current and increasing visit volume, and to provide modern state-of-the-art treatment space. The hospital's current and planned emergency department inventory is shown on Figure 4 below.

Figure 4. Emergency Department Inventory, By Room Type, Current and Proposed

Category	Treatment Space?	Monitored?	Current	Proposed
Treatment - General	√	√	24	42
Resuscitation	√	√	4	2
Results Pending/Holding	√		11	0
Dedicated Psych	√	√	0	6
Triage/Intake		√	2	3
Total			41	53
Decontamination Room/Shower			1	1

The Emergency Department is significantly undersized for current and projected patient volumes based on best practice programming and comparable facilities. The ED and/or the critical care beds are often full, resulting in 1,416 total hours on diversion in CY 2012, and over 1,000 hours in the first seven months of CY13. The ED design does not lend itself to optimal ED work flow. For example, line of sight hindrances between staff and the treatment bays and staff flow patterns in the existing ED reduces staff efficiency.

Figure 5 shows the relatively steady increase in ED visits over the past ten years, and the projected increase through 2018. MSMHC projects a 2% annual increase, consistent with this historical trend. Utilization forecasts are based on an examination of emergency department visit trends in the hospital's service area. The projections are based on assumptions of population growth and use rates remaining consistent with current trends, and observations of volume increases at other hospitals that have expanded and upgraded their emergency departments. Medical assistance and self-pay patients make up 38% of ED visits, overall, and from the primary service area. Several urgent care centers have entered the market in the service area,

slowing the growth in ED visits, especially for lower acuity care, but increasing average acuity levels at the hospital.

Figure 5. Historical and Projected ED Visits, FY 2004 – 2018

	FY	ED Visits	Percent Change
Historical	2004	52,427	
	2005	53,057	1.2%
	2006	58,350	10.0%
	2007	64,073	9.8%
	2008	67,547	5.4%
	2009	65,497	-3.0%
	2010	68,333	4.3%
	2011	63,345	-7.3%
	2012	66,423	4.9%
	2013	65,316	-1.7%
Current	2014	65,316	0.0%
Projected	2015	66,622	2.0%
	2016	67,954	2.0%
	2017	72,031	6.0%
	2018	73,472	2.0%

Figure 6 shows the trend in visits over the last three years that resulted in admission compared to those that did not result in admission. This reflects the growing use of observation status.

Figure 7 compares the MSMHC emergency department characteristics with the guidelines from the American College of Emergency Physicians, used to determine the optimal size of an emergency department based on its unique characteristics. Of the 11 categories, MSMHC is consistent with the low range in two categories, and with the high range in seven categories.

Figure 6. MedStar Southern Maryland Hospital Center ER Visits; FY 2011 thru FY 2013

Month	FY 2011			FY 2012			FY 2013		
	IP	OP	Total	IP	OP	Total	IP	OP	Total
Jul	1,115	4,091	5,206	1,030	4,064	5,094	993	4,757	5,750
Aug	1,055	4,332	5,387	1,216	4,545	5,761	950	5,475	6,425
Sep	1,066	4,177	5,243	1,097	4,470	5,567	768	4,078	4,846
Oct	983	3,901	4,884	1,025	4,236	5,261	1,008	4,845	5,853
Nov	1,009	4,099	5,108	991	4,425	5,416	856	4,286	5,142
Dec	1,042	4,104	5,146	1,003	4,340	5,343	838	4,352	5,190
Jan	1,051	4,556	5,607	1,087	4,734	5,821	977	5,124	6,101
Feb	1,049	4,214	5,263	996	4,513	5,509	688	3,799	4,487
Mar	1,063	4,366	5,429	978	4,657	5,635	799	4,499	5,298
Apr	1,013	4,047	5,060	1,020	4,816	5,836	818	4,771	5,589
May	1,091	4,387	5,478	1,020	4,816	5,836	830	4,715	5,545
Jun	1,041	4,493	5,534	962	4,382	5,344	780	4,310	5,090
Totals	12,578	50,767	63,345	12,425	53,998	66,423	10,305	55,011	65,316

Figure 7. Comparison of American College of Emergency Physicians Low and High Range Guidelines and MedStar Southern Maryland Hospital Center's Emergency Department

	Low Range	High Range	MSMHC
ALOS	< 2.5 hrs	> 3.5 hrs	> 6.2 hours, admitted 2.5 hours non-admitted
Location of Observation Beds	Outside ED	Inside ED	Outside ED
Time to admit	< 60 minutes	> 90 minutes	175 minutes
Turnaround time Dx Tests	< 31 minutes	> 60 minutes	71 minutes
% Admitted	< 18%	> 23%	21%
Percent Nonurgent/%Urgent	Nonurgent > Urgent by > 10%	Urgent > Nonurgent by > 10%	Urgent 63%, Nonurgent 36%
Age of Patient	< 20% 65+	> 25% 65+	15.3%
Admin/Teaching Space	Minimal	Extensive	Moderate
Imaging w/in ED	No	Yes	Yes
Specialty components	No	Yes	Yes, Psych
Flight/Trauma Services	No	Yes	Yes

Based on the current recommendations in *Emergency Department Design: A Practical Guide to Planning for the Future*, the current Emergency Department at MedStar Southern Maryland Hospital Center should have over 39,000 square feet and over 50 formal treatment spaces. This is consistent with the benchmarks used by Perkins + Will, MSMHC's architectural consultant, calling for 34,850 square feet for an ED with this volume. The proposed ED with 53 treatment spaces and 32,500 square feet is well within with both guidelines. Careful planning of the new ED configuration allowed an augmented ED program to be accommodated within a footprint smaller than the guidelines

Figure 8. MedStar Southern Maryland Hospital Center's Emergency Department Current and Optimal Size

	MSMHC Current Size	MSMHC Proposed Size	ACEP Guideline at 70,000 Projected Visits/Low Range	ACEP Guideline at 80,000 Projected Visits/High Range
Beds	28+11=39	56/55	40	61
DGSF	13,009	32,600	33,000	50,325

The new Emergency Department will have dedicated space for psychiatric emergencies to provide this needed specialized care in a focused environment. Ambulance flow and accessibility will be improved with a circular one way in and one way out approach. Rather than the current arrangement of physical division between areas in the ED, flexibility in treatment spaces will allow staffing to ebb and flow with census and acuity, with improved visibility staff-to-staff and staff-to-patient throughout. The new dedicated Observation Unit, another component of this project, will relieve the patient flow back-up in the ED. In addition, the new ED will feature:

- Better separation of the higher acuity patient from the lower acuity patient.
- Dedicated bariatric patient rooms and negative pressure rooms.
- A satellite Lab and CT.
- More space and privacy in the intake and registration areas.
- A designated play area for pediatric patients in the lobby
- A bereavement room for family
- Improved presence for Security in the ED Lobby.
- More space for staff documentation and support.
- Medical gases in the Triage lounge for potential overflow or crisis situation.
- More toilets for patients and staff.
- Better separation between ambulance vestibule and patient care areas.
- A Rapid Admission Hold Area
- A fast track unit with dedicated staff

(15) Emergency Department Expansion.

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

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

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

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

Response: All patients that present to the ED are provided a Medical Screening Exam, as required by the Emergency Medical Treatment and Labor Act (EMTALA). Several other steps have been implemented to alleviate the overcrowding in the Emergency Department. All discharged patients are encouraged to follow-up with their primary care provider and/or medical specialists in order to prevent non-emergency use of the ED. A low acuity triage area was designed and implemented, referred to internally as "First Track", to treat non-emergent cases similar to an outpatient clinic environment (such as sore throat, sprained joints). By doing this, patient populations are effectively differentiated as true emergencies vs. non-emergent issues. MedStar Southern Maryland Hospital Center is part of the (202) 877-DOCS physician referral system which is a way for patients to geographically locate a primary care provider or medical specialist after discharge that is close to their home.

Regarding part (b), the Emergency Department is appropriately sized for 20,000 to 40,000 patients per year. Since 2001, we have worked to accommodate over 50,000 patients per year, indicating that the hospital is working to effectively managed its existing treatment capacity to maximum use. Examples of department management efforts include:

- The Director of Emergency Services, Donald Charlson, led a Nursing Centric Patient Flow Group where a faxed report from the ED to the receiving nurse was conceived and implemented. Faxing the Nursing Report with a brief follow-up phone call for hospital documenting non-electronically is considered a clinical 'best practice'. This practice, established two years ago, has now been supplanted by reliance on a fully integrated Electronic Medical Record system that went live in February 2013.
- In the past 18-months, a multidisciplinary team was formed to assess patient throughput in the ED from initial triage and treatment to admission to the nursing unit. This team includes the ED Director, the ED Medical Director, the Associate CNO, the Nursing Supervisor, the Director of Case Management, the Chair of Psychiatry, and the Director of the hospitalist group serving the hospital ED. This team has developed a pre-diversion policy, psychiatric admission criteria and a handoff communication policy.
- An expedited process was also created and implemented for obtaining a bed for critical care patients. The purpose of this effort was to decrease the length of time that admitted critical care patients are in the Emergency Department. Literature has stated that there is a positive correlation between critical care patient's length-of-stay and mortality.
- A Bed Board Flow Coordinator was established in 2011 to rapidly facilitate assignment of patients from the ED to the nursing unit.
- A Bed Board team meets twice daily at 9:00AM and 12:30PM comprised of nursing leaders to discuss clinical needs of individual patients and determine bed availability as well as placement.
- In 2013, the ED implemented a pre-diversion policy that has led to a decrease in the hours of diversion for EMS. Hospitals with higher hours of diversion are not able to effectively

serve their communities and cause patients to be transported to other facilities that are further away from their home.

- Inpatient nursing leadership implemented a Patient Pull Program to help decrease the ED's length-of-stay for admitted patients. Inpatient nursing staff occasionally have the capacity to transport admitted patients from the Emergency Department when the ED staff was busy caring for critical patients. After the bed is assigned, if the ED does not bring the patient to the inpatient Nursing Unit, the receiving staff is to call the ED to see if the patient is ready to go to the inpatient nursing unit. If the patient is ready for transfer but no one in ED is available to transport, then the receiving staff or the Nursing Supervisor transports the patient to the receiving unit.

Regarding part (c), this project is intended to provide an appropriate environment for the current volume of patients and the increase in volume associated with population growth, as well as to improve ED throughput. One related component of this project is the construction of a 32-bed observation unit to be located in new space above the Emergency Department. This dedicated unit will be close to the ED, and will keep observation patients out of ED and inpatient beds, improving ED throughput and easing overcrowding. Finally, if we do not address the critical need for space, we could see a higher Left Without Being Seen ("LWBS") rate, longer lengths-of-stay, and increased hours of diversion.

(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;

(ii) Considers the time frame projected for finishing the space; and

(iii) Demonstrate 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.

Response: Shell space is proposed at three locations within the proposed addition and renovation: below grade at Level 00 adjacent to the existing cafeteria, on grade at Level 00 beneath the proposed south addition, and above grade positioned above the proposed Observation level.

Approximately 5,100 square feet of below-grade shell space is proposed at the west side of Level 00 adjacent to the existing cafeteria. This shell space is intended to allow for future expansion of the cafeteria and kitchen that would be required to adequately accommodate future growth of the facility as a whole. It is most cost-effective to construct this shell space in conjunction with the foundation work for the new Emergency Department, as it would be impractical and very expensive to excavate this space at a later date from beneath the new structure proposed at the west side of the building. Further, this new structure would likely require deep foundations (piles and pile caps) which would greatly hamper a future expansion of the dining facility if not adequately prepared for.

In addition, approximately 3,200 square feet of shell space is proposed at the southwest corner of the same level, although this space will be mostly at-grade at this location. The creation of this shell space is a direct consequence of the southern expansion of the Emergency Department above, and is the most cost-effective method of addressing this expansion on Level 00. It would be possible to leave this area unenclosed, but this would likely result in increased construction and operating costs associated with additional paving; insulation, fireproofing, and architectural treatment of the exposed suspended slab, plumbing, and ductwork; and increased energy consumption associated with a larger area of exposed building envelope.

It is anticipated that this shell space would be used in the near term for storage, but also as additional transitional or "flex" space for other departments with space constraints that are not directly addressed by this project. Over the long term, the space would likely be occupied through full relocation of another department, or by introduction of a new service line. This shell space is also directly connected to the shell space adjacent to the dining facility, so both spaces can be accessed from multiple locations and the division between both functions can remain fluid, allowing for maximum flexibility and efficiency.

In addition to the two shell space locations described above, one full floor of shell space is proposed above the Nursing Observation level (Level 04). This will provide the space necessary to facilitate a gradual future transition to private rooms within the Bed Towers, as well as providing the option of immediately available space for any other future expansion.

It is conceivable that this additional shell space could be constructed at some point in the future, but we believe that constructing it in conjunction with the overall project scope is the most cost-effective option. Doing so would allow contractor mobilization and demobilization costs associated with a separate construction phase to be avoided. Constructing this floor at a future time would also be highly disruptive operationally, as this would require construction staging and congestion directly in front of the main entrance and Emergency Department, and would also likely require the Nursing Observation level to be shut down during construction.

COMAR 10.24.11.05 Surgical Services Standards

A. General Standards.

The following general standards encompass Commission expectations for the delivery of surgical services by all health care facilities in Maryland, as defined in Health General §19-114 (d). Each applicant that seeks a Certificate of Need for a project or an exemption from Certificate of Need review for a project covered by this Chapter shall address and document its compliance with each of the following general standards as part of its application.

(1) Information Regarding Charges.

Information regarding charges for surgical services shall be available to the public. A hospital or an ambulatory surgical facility shall provide to the public, upon inquiry or as required by applicable regulations or law, information concerning charges for the full range of surgical services provided.

Response: See response to standard at COMAR 10.24.10.04A(1). MSMHC is consistent with this standard.

(2) Charity Care Policy.

(a) Each hospital and ambulatory surgical facility shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide ambulatory surgical services on a charitable basis to qualified indigent persons consistent with this policy. The policy shall have the following provisions:

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

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the surgical facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's arrival for surgery, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. Hospitals shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. ASFs, at a minimum, must include the following eligibility criteria in charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of

ASFs described in these regulations.

(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.

(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If an existing ASF has not met the expected level of charity care for the two most recent years reported to MHCC, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the service area population.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a Certificate of Need for a surgical facility project, shall commit to provide charitable services to indigent patients. Charitable services may be surgical or non-surgical and may include charitable programs that subsidize health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by ASFs, measured as a percentage of total ASF expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Response: MSMHC's financial assistance policy is in Attachment 3. See also our response to standard at COMAR 10.24.10.04A(2).

(3) Quality of Care.

A facility providing surgical services shall provide high quality care.

(a) An existing hospital or ambulatory surgical facility shall document that it is licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(b) A hospital shall document that it is accredited by the Joint Commission.

(c) An existing ambulatory surgical facility shall document that it is:

(i) In compliance with the conditions of participation of the Medicare and Medicaid programs; and

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the

Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification.

(d) A person proposing the development of an ambulatory surgical facility shall demonstrate that the proposed facility will:

(i) Meet or exceed the minimum requirements for licensure in Maryland in the areas of administration, personnel, surgical services provision, anesthesia services provision, emergency services, hospitalization, pharmaceutical services, laboratory and radiologic services, medical records, and physical environment.

(ii) Obtain accreditation by the Joint Commission, the Accreditation Association for Ambulatory Health Care, or the American Association for Accreditation of Ambulatory Surgery Facilities within two years of initiating service at the facility or voluntarily suspend operation of the facility.

Response: See response to standard at COMAR 10.24.10.04A(3)(a).

(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.

(c) Each ASF shall have procedures for emergency transfer to a hospital that meet or exceed the minimum requirements in COMAR 10.05.05.09.

Response: MSMHC has written transfer agreements with Washington Adventist Hospital and with MedStar Washington Hospital Center. See attachment 6.

B. Project Review Standards.

The standards in this section govern reviews of Certificate of Need applications and requests for exemption from Certificate of Need review involving surgical facilities and services. An applicant for a Certificate of Need or an exemption from Certificate of Need shall demonstrate consistency with all applicable review standards.

(1) Service Area.

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.

Response: Not applicable.

(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 hospital's 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.

(b) An applicant proposing the establishment of a new ambulatory surgical facility shall submit a needs assessment that includes the following:

(i) Historic trends in the use of surgical facilities for outpatient surgical procedures by the proposed facility's likely service area population;

(ii) The operating room time required for surgical cases projected at the proposed facility by surgical specialty or, if approved by Commission staff, another set of categories; and

(iii) Documentation of the current surgical caseload of each physician likely to perform surgery at the proposed facility.

Response: Not applicable.

(3) Need - Minimum Utilization for Expansion of An Existing Facility.

An applicant proposing to expand the number of operating rooms at an existing hospital or ambulatory surgical facility shall:

(a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;

(b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and

(c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:

(i) Historic trends in the use of surgical facilities at the existing facility;

(ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and

(iii) Projected cases to be performed in each proposed additional operating room.

Response: MSMHC proposes to construct six operating rooms as replacements for six existing rooms. Six existing operating rooms will be removed from service as ORs, and will instead be used for expansion of the prep/recovery area. As no new capacity is proposed, this standard does not apply.

*(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.

(b) An ASF shall meet the requirements in Section 3.7 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.

Response: The floor plans and planned new space are consistent with FGI guidelines, and are developed to meet the requirements of section 2.2 of those guidelines.

*(5) **Support Services.***

Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.

Response: MSMHC provides lab, radiology and pathology services directly.

*(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;

Response: The new space is designed to have more clear circulation, better separation of restricted and semi-restricted corridors, better separation of individual patient spaces and improved nursing visualization, a negative pressure room for isolation patients, more space for storage, equipment and staff, better adjacencies, and to have services and equipment more at hand. See also response to review standard B(12), COMAR 10.24.10.04B.

*(7) **Construction Costs.***

The cost of constructing surgical facilities shall be reasonable and consistent with current industry cost experience.

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities 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.

(ii) 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:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall

Valuation Service® benchmark; and

2. Those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of an ambulatory surgical facility construction or renovation project shall be compared to the benchmark cost of good quality Class A 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.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost by 15% or more, then the applicant's project shall not be approved unless the applicant demonstrates the reasonableness of the construction costs. Additional independent construction cost estimates or information on the actual cost of recently constructed surgical facilities similar to the proposed facility may be provided to support an applicant's analysis of the reasonableness of the construction costs.

Response: The Marshall Valuation benchmark for the surgical component of this project is $610.72, compared to the project cost of $407.54. See Attachment 5.

(8) Financial Feasibility.

A surgical facility project shall be financially feasible. Financial projections filed as part of an application that includes the establishment or expansion of surgical facilities and services shall be accompanied by a statement containing each assumption used to develop the projections.

(a) An applicant shall document that:

(i) Utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility;

(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 facility or, if a new facility, the recent experience of similar facilities;

(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 facility, or, if a new facility, the recent experience of similar facilities; and

(iv) The facility 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 of initiating operations.

(b) A project that does not generate excess revenues over total expenses even if utilization forecasts are achieved for the services affected by the project may be approved upon demonstration that overall facility financial performance will be positive and that the services will benefit the facility's primary service area population.

Response: The financial feasibility analysis presented in response to COMAR 10.24.10.B(13)

demonstrates that the entire project is financially feasible. That analysis includes all assumptions pertaining to surgical services.

(9) Preference in Comparative Reviews.

In the case of a comparative review of CON applications to establish an ambulatory surgical facility or provide surgical services, preference will be given to a project that commits to serve a larger proportion of charity care and Medicaid patients. Applicants' commitment to provide charity care will be evaluated based on their past record of providing such care and their proposed outreach strategies for meeting their projected levels of charity care.

Response: Not applicable.

COMAR 10.24.01.08G(3)(b). Need.

For purposes of evaluating an application under this subsection, 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.

Please discuss the need of the population served or to be served by the Project.

Responses should include a quantitative analysis that, at a minimum, describes the Project's expected service area, population size, characteristics, and projected growth. For applications proposing to address the need of special population groups identified in this criterion, please specifically identify those populations that are underserved and describe how this Project will address their needs.

Service Area and Demographic Analysis

MedStar Southern Maryland Hospital Center defines its service area as the zip code areas that account for 75% of the hospital's inpatient discharges. MSMHC's service area has a population of approximately 376,000 people in 2010, which is slightly younger in comparison to the nation. The service area is projected to see about 0.2% growth through 2015, less than the State average of 2.1%. All growth will occur in the 45 and older age cohorts, especially in the 65+ age group, the age cohort with the highest use of healthcare services, which will see a 23.2% growth.

Significant numbers of service area residents seek care in facilities outside Prince George's County, particularly Montgomery County and the District of Columbia. One goal of this project is to provide the modern, state of the art services that will encourage more county/service area residents to seek care within their home county with modern facilities. By joining the MedStar Health system of care that includes tertiary services at MedStar Washington Hospital Center and MedStar Georgetown University Hospital, MSMHC plans to bring world class services to Prince George's County over time. Modernizing the hospital is the first step in achieving this goal. Conservative assumptions suggest recapturing market share lost over the past several years to Hospitals in Washington, D.C. and other Maryland jurisdictions will result in very modest growth in selected service lines, including orthopedics, cancer, neurology, cardiology and some

additional outpatient surgery expertise.

MedStar Southern Maryland Hospital's service area, as defined by the State Health Plan, is shown in Figure 9.

Figure 9. MSMHC's Service Area by Zip Code and Community, 12 Months Ending 31 August 2013

ZIP CODE	Community	Location	Discharges	Percent of Total	Cumm %	Service Area
20735	CLINTON	MD	2,301	15.75%	15.7%	PSA
20748	TEMPLE HILLS	MD	1,492	10.21%	26.0%	PSA
20744	FORT WASHINGTON	MD	1,209	8.27%	34.2%	PSA
20747	DISRICT HEIGHTS	MD	1,091	7.47%	41.7%	PSA
20772	UPPER MARLBORO	MD	1,071	7.33%	49.0%	PSA
20746	SUITLAND	MD	990	6.78%	55.8%	PSA
20745	OXON HILL	MD	694	4.75%	60.6%	PSA
20613	BRANDYWINE	MD	525	3.59%	64.2%	SSA
20743	CAPITOL HEIGHTS	MD	513	3.51%	67.7%	SSA
20602	WALDORF	MD	507	3.47%	71.1%	SSA
20601	WALDORF	MD	425	2.91%	74.0%	SSA
20603	WALDORF	MD	347	2.37%	76.4%	SSA
20774	UPPER MARLBORO	MD	218	1.49%	77.9%	SSA
20646	LAPLATA	MD	215	1.47%	79.4%	SSA
20607	ACCOKEEK	MD	208	1.42%	80.8%	SSA
20020	WASHINGTON	DC	193	1.32%	82.1%	SSA
20032	WASHINGTON	DC	182	1.25%	83.4%	SSA
20640	INDIAN HEAD	MD	160	1.10%	84.5%	SSA
20019	WASHINGTON	DC	125	0.86%	85.3%	SSA
	All Other		2,145	14.68%	100%	
	Total		14,611			

Volume projections are shown in Table 1. MedStar Health uses a sophisticated forecasting tool, developed by Sg2, to project future need by service line for inpatient and outpatient services. The baseline projections use national and regional trends, market data and institutional data and then account for population, expected changes in epidemiology, economic drivers, payment drivers, changes in innovation and technology and anticipated changes in the care delivery system. The factors are impacted by a rapidly changing market environment, including the emergence of new levels of care and care settings, such as observation and urgent care centers and unique financial drivers in the state of Maryland. As such, these baseline projections are then adjusted using management's knowledge of discrete market dynamics that may impact the baseline forecast. Program volumes are developed using a more detailed understanding of the

market by service lines, opportunities to grow and balance a mix of services needed by the market, with an additional focus on patients who are leaving the county for care who could be cared for closer to home if the expertise was available.

Emergency Department – see analysis at Review Standard B(14), COMAR 10.24.10.04.

Surgery Department

The existing Surgery Department was constructed as part of the original Hospital in the 1970's and few changes to the layout of this unit have been implemented over the past thirty-plus years. At the time the hospital was constructed, most surgeries were performed on an inpatient basis and the design of this unit reflected an inpatient surgery model. Today, approximately two-thirds of surgical procedures are performed on an outpatient basis, significantly changing the spatial requirements of surgical units. Specifically, outpatients need to be prepared for surgery when they arrive at the Hospital and recovered before leaving the same day. At the time this unit was constructed, the majority of patients were prepared for surgery in their inpatient room. The majority of patients now must be prepared within the surgical department as they are not inpatients and therefore have not been transported from a patient room. As a stop-gap measure, a small and very constrained intake/prep area was developed within the Surgery Department, but it is problematic, not meeting most Guideline space requirements. Additionally, the PACU/Pre/Post area is undersized and will not support future growth in surgical procedures. Surgical supply and storage areas are also significantly undersized. Many of the spaces within this unit no longer meet the current FGI Guideline requirements. The department is so short of space that it does not allow for efficient patient flow and work processes, and storage is almost non-existent.

The need for the Surgery Department expansion is driven by inadequate space and antiquated facilities that present daily challenges for staff. The space is badly outdated, and must be consistent with how surgical care is delivered today. Pre-surgical testing and anesthesia evaluations are conducted in two separate areas, the Professional Building and the hospital OR, respectively. The current surgical patient intake area does not allow for efficient patient throughput or workflow. Space that is cramped and poorly lit by modern standards does not accommodate modern medical and EMR equipment related to the pre-surgical patient preparation. The space does not allow for family visitation, or for patient or staff comfort. The workspace is not ergonomically designed. Backup generator/emergency power is limited. There are no dedicated locations for physicians to speak with patients and families privately, to obtain the history & physical, informed consent, operative site marking and answer last minute questions.

The operating room average size is 416 square feet. For the many procedures requiring multiple types of equipment, ORs of this size present significant problems. The storage space is extremely inadequate resulting in cluttered work areas throughout the department. There are no boom arms to house our video towers resulting in inefficiency caused by moving video equipment from room-to-room, case-to-case. The department must use additional storage space on the ground floor, which can result in additional delays and inefficiencies. There are no dedicated ORs for isolation patients. Current finishes, flooring, ceiling and walls are outdated and in need of

regular repair. The locker room space is very small with two bathrooms and one sink on the female side. The male locker room is a bit larger but still inadequate. Surgeons frequently complain about the lack of locker space and privacy. The adjoining surgeon waiting area is extremely cramped with only two computer workstations.

The PACU consists of 13 bays with inadequate space and little provision for privacy. This environment is quite challenging when trying to provide for family visitation. There are no rest rooms immediately available for PACU patient or staff use. There are sometimes delays in the OR related to overcrowding of the PACU related to surgical volume, lack of PACU phase 2, and boarding of patients without a bed assignment.

GI Endoscopy consists of two procedure rooms that are not large enough to accommodate a C-arm or anesthesia ventilator. Intubated patients requiring an endoscopy procedure must go to an OR, or be performed in the ICU. The GI endoscopy recovery space will only accommodate two patients simultaneously, often requiring the unit to recover these patients to the main PACU. Patients may wait in the hallway or procedure room for physician arrival.

Any practical renovation of this department must involve expansion to gain the space necessary to meet current programmatic requirements. Possible expansion of this unit is constrained by its location within the first floor of the main hospital. The surgical core is located to the immediate south of the PACU, and the Critical Care Unit is located immediately to the north. Radiology and the Clinical Lab are located to the immediate west and GI Services is located to the east. The department is essentially landlocked on three sides, with only one possibility for expansion.

The proposed project calls for six new ORs to be built within an expanded footprint and six of the existing ten ORs to be decommissioned to make way for a more appropriately sized PACU and support space. The total number of ORs will remain the same. The number of Prep/PACU/Recovery bays will increase to 34. Two dedicated cystoscopy suites and two GI suites will remain, and will be replaced, enlarged and upgraded. The new construction will alleviate our patient flow issues related to restricted and semi-restricted corridors. Prep/recovery space is expanded in the new plan to alleviate overcrowding and associated delays. The new Prep/Recovery space will also have the ability to flex between Prep and Recovery as volumes change depending on time of day. Support space for staff within Prep and Recovery allows for off-stage support areas and adequate staff toilet rooms as well as meeting guidelines for quantities of patient toilets. The new ORs will have sufficient space to accommodate procedures requiring extra space such as major orthopedic cases, neurosurgery, colo-rectal and vascular surgery. At least one room will be able to change to negative pressure when needed for isolation patients. The plan provides for additional needed storage space in alcoves and storage rooms. The new space will have more staff space and private consultation rooms. Sufficient modernized OR locker rooms as well as staff lounge areas will replace the current overcrowded space.

Industry benchmarks used by MSMHC's architectural consultant, Perkins + Will, suggest the Surgery Department should be 31,050 square feet for the current volume and mix of cases. MSMHC has 13,435 square feet. Current best practice guidelines call for general ORs of 484 square feet, ORs for neurosurgery cases of 676 square feet, and ORs for orthopedics of 621 square feet. Benchmarks for the PACU/Prep/Recovery area call for a range of three to four bays

per operating room of 400 – 500 square feet. At MSMHC this would be a minimum of 12,000 square feet. MSMHC has 2,686 square feet. As a result of the expansion, the surgery area will have approximately 19,183 square feet, and the PACU area will have approximately 9,662 square feet.

Critical Care

The existing Critical Care Unit was constructed as part of the original hospital in the 1970's. It was originally developed as two units, a Coronary Care Unit and a Medical/Surgical Intensive Care Unit, each with nine beds. It has essentially remained in its original configuration, although the two units have, from an operational perspective, been combined into one 18-bed Critical Care Unit. Even more so than the Emergency Department and Surgery Department, the need for more space in the Critical Care Unit is a key factor in this project. The size of critical care rooms restricts advancement or integration of new technology as well as adequate space for family or guests. The current unit cannot support growth in the Surgery or Emergency Departments. Lack of standardization in ICU rooms creates inefficiency for staff. The size of the entire unit is only 5,846 square feet. This equates to less than 315 DGSF per bed.

Limitations in the current environment include:

1. The current patient rooms do not meet existing requirements for room space.
2. Lack of space for a wide variety of supplies and patient support equipment including mechanical ventilation, multiple IV drips, balloon pump support, hyperthermia treatment, etc.
3. Lack of space for other personnel such as respiratory therapy, case management and other ancillary staff who care for critical care patients daily.
4. Clinical support space is severely lacking, which impedes workflow, cannot accommodate equipment or computer needs, and is inadequate for the current volume of patients and activity.
5. Many procedures are performed in the patient rooms including cardioversion, bedside tracheostomy, central line placement, thoracentesis, lumbar puncture, etc., all of which require equipment and personnel.
6. The shortage of space makes these procedures, as well as mobilizing patients, responding to patient arrest, accommodating equipment, etc., a constant daily challenge for the team members.
7. Access to the room is limited by small doorways, which is an issue during emergencies such as Code Blue.
8. All physicians share one computer workstation in the ICU and CCU.
9. A separate private family meeting area is needed for confidential discussions about the patient's condition.

The need for enhancing Critical Care Unit design has its basis in having a larger consolidated unit with standardized patient room size and circulation around the patient for the interdisciplinary teams that render care to the patient appropriately integrated with diagnostic and treatment facilities. The Critical Care Unit in its current configuration and bed capacity will not be able to support anticipated growth of surgical procedures or planned expansion of the Emergency Department that represent two major drivers of critical care admission. The current

18 bed complement will be increased to 24 beds to maintain the ratio of ED treatment bays to critical care beds, and accommodate volume increases in both ED and surgery.

The new Critical Care Unit will be constructed in the vertical expansion because the unit is landlocked on Level 01 of the main building with no room for in-place expansion, and because that space will be used for PACU expansion. The new unit will provide direct sight-lines between staff and patients, private patient toilet rooms per bed, off-stage space for staff and off-stage space for families, outside of patient rooms. To anticipate any needs in the future, the new Critical Care Unit is designed with acuity-adaptable beds in a typical nursing floor layout, allowing for future flexibility. Clinical support areas such as clean, soil, med supply and nourishment are located uniformly through the unit to negate long travel distances for nurses within the increased departmental footprint. Views to daylight are incorporated in family waiting areas, staff lounges, conference areas and at the ends of corridors, where available. The patient care rooms will be 372 NSF, including the toilet room, ample size to meet current code, and to accommodate the complement of equipment required in today's critical care settings. The design also allows space for current technology at the head of the patient, enhanced privacy and safety, defined in-room family space, private patient-staff travel pathway to and from Critical Care and ED or Surgery, separate family/guest travel pathway to the unit, and better adjacency between the ED and the unit. The benchmarks used by Perkins + Will call for at least 22,800 square feet for a 24-bed Critical Care Unit. The proposed new Critical Care Unit will provide approximately 27,050 square feet.

Cardiovascular Services

Within the Interventional Radiology (IR) area, there are three labs with approximately 480 to 612 square feet per lab. MSMHC has one Cardiac Catheterization Lab (CCL), one combo cardiac/peripheral lab, and one Angiography suite within the allotted space for interventional procedures. An additional specialty combo lab with 950 square feet is utilized as an Electrophysiology room in an adjacent hallway. A small three bay preparation and recovery area is also located in the IR corridor, with six beds allotted on one of the nursing units for preparation and recovery of patients.

A variety of procedures are performed in the CCL and CCL/combo labs such as diagnostic cardiac catheterizations and percutaneous coronary interventions (both elective and emergent), diagnostic peripheral procedures and vascular interventions, diagnostic carotid procedures and interventions, insertion of permanent pacemakers, bi-ventricular pacemakers, implantable cardioverter-defibrillators (ICDs); and utilize imaging technologies such as intravascular ultrasound (IVUS) and Fractional Flow Reserve (FFR). At MSMHC approximately 25 procedures per week are performed in the CCL and CCL/combo labs. There are approximately 50 to 60 procedures performed within the angiography suite each week. These procedures are performed by interventional cardiologists, diagnostic cardiologists, vascular surgeons and electrophysiology cardiologists.

As MSMHC continues to evolve into a regional cardiac center, growth in the area of cardiology and electrophysiology will be seen. The addition of new services of stimulation and ablation for cardiac rhythm disturbances will lead to patients being able to have cardiac procedures closer to

their home. The cardiac center is already a SPCP (Society of Chest Pain Centers) accredited Cycle III cardiac center with percutaneous cardiovascular intervention (PCI). MSMHC is also accredited by MIEMSS as a Cardiac Intervention Center to receive patients needing emergent care for ST segment elevation myocardial infarction (STEMI).

The addition of planned services in neurological, vascular, oncology, and general surgical care within the hospital will increase the volume of procedures needed while caring for patients in an angiography suite which is already very busy. These additional procedures include biopsies, tumor ablation, endovascular procedures, for example. The Interventional Radiology, Cardiology and Electrophysiology service lines require space for continued growth of these services and improved patient care experiences.

In order to accommodate this growth, the addition of a combination lab is planned into the space configuration which will allow for cardiac, peripheral vascular and neurovascular procedures as well as electrophysiological studies and interventions. By making this lab multi-functional, it will allow for growth in many areas and help with the overflow from the other interventional labs. A preparation and recovery area will be included to accommodate patients for studies and procedures within close proximity to the labs. A lab to assist in studies for cardiac procedures will be added so that a safe, controlled environment will be available for tilt table and TEE (Trans Esophageal Echocardiography) with cardioversion.

The present Interventional Radiology area is surrounded by other departments in the present location which allows no ability for growth. Hallways are shared with other departments and sterile procedure rooms are accessed from these hallways. There is no space for transition from sterile to clean locations. At present there are no dressing rooms, break room, storage or clean/dirty utility rooms within the IR corridor. No ADA bathroom is available in close vicinity of the IR corridor.

The benchmarks for cardiovascular services with comparable volumes is 17,500 square feet. The department currently has only 6,579 square feet. This project will increase this substantially to approximately 9,580 square feet, thereby better meeting appropriate standard of care practices. The new space increases Prep and Recovery bays to current guideline sizing. In addition, Prep and Recovery include dressing spaces and accessible patient toilets. Prep and Recovery are adjacent to new procedural spaces, with separate entries and exits for the Prep and Recovery suite. The new 'hybrid rooms' will improve utilization. The multi-purpose procedure use room will be available to provide a release valve for procedural busy times. This will move patients through the system much more efficiently. Taking advantage of the adjacencies with the Surgery and Emergency Departments will provide additional relief from the severely cramped conditions. The project will provide additional space for designated clean areas prior to red-lined passage into the procedure rooms. Additionally, the department will include storage space for mobile equipment and sterilization space. Staff will receive dedicated off-stage space with lockers, lounges and dictation space. Staff changing and break areas will allow for staff to change into appropriate hospital-provided clean attire and remain within the designated clean area.

Observation Unit

The concept for establishing Observation Units has evolved over the past several years as a viable solution to pressing problems hospitals face with respect to capacity constraints in the Emergency Department, lack of inpatient beds and the continued movement towards outpatient based services by the Centers for Medicare & Medicaid Services and other payers.

Patients initially coming to the Emergency Department (ED) are referred to such a unit for testing and observation for a minimum of eight hours to a maximum of 48 hours. Observation units function more efficiently when located in close proximity to the ED where the unit can help streamline ED throughput by moving patients presenting with more complex conditions, such as decompensated congestive heart failure, into an area better suited for their treatment, thereby freeing up treatment beds in the ED. Observation units can help mitigate unnecessary and costly inpatient admissions by aggressively diagnosing and treating symptoms, as an effective means for reducing the patient's stay.

The 32-bed dedicated observation unit will allow MSMHC to adapt to this changing environment. The need for the observation unit at MSMHC is driven by the increasing use of observation status. Keeping patients in acute care beds or Emergency Department beds is not an optimal alternative. Like many other hospitals in Maryland, the number of observation patients has been increasing at MSMHC, as shown in Figure 10. The summer of 2013 has seen the biggest increases in the number of observation patients to date. Average daily census is now averaging 24 to 26 patients per day. As this trend is not expected to reverse, MSMHC must be prepared to accommodate this new standard of care with a dedicated observation unit.

Dedicated observation beds allows for improved staffing compared to the current observation beds, which are dispersed throughout the hospital. The dedicated unit also supports the operations within the ED. The most recent data for MedStar Southern Maryland Hospital Center's Emergency Department has 500-hours of yellow alert for the first eight months of the current year (January through August 2013). The new observation unit will help decrease the hours of diversion and contribute to better throughput and improved turnaround time.

The new Observation Unit is designed with acuity-adaptable beds in a typical nursing floor layout, allowing for future flexibility. The move to private Observation Beds with private toilet rooms will assist in infection control, allow for family support space within the room and adequate staff off-stage areas. The unit will include dispersed clinical support areas such as clean, soil, medication supply and nourishment, to negate long travel distances for nurses within the departmental footprint. Views to daylight are incorporated in family waiting areas, staff lounges, and conference areas and at the ends of corridors, where available.

Figure 10. Trends in Observation Status Patients, CY 2011 - CY 2013 (thru August)

Month	CY11	CY12	CY13	% Change CY11-CY12	% Change CY12-CY13
Jan	364	566	467	55.5%	-17.5%
Feb	363	661	591	82.1%	-10.6%
Mar	455	670	696	47.3%	3.9%
Apr	411	453	771	10.2%	70.2%
May	426	516	790	21.1%	53.1%
Jun	420	487	787	16.0%	61.6%
Jul	388	526	749	35.6%	42.4%
Aug	471	588	788	24.8%	34.0%
Sep	505	521		3.2%	
Oct	512	464		-9.4%	
Nov	549	461		-16.0%	
Dec	537	492		-8.4%	
Total	5,401	6,405	5,639	18.6%	

TABLE 1: STATISTICAL PROJECTIONS - ENTIRE FACILITY

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2012	2013	2014	2015	2016	2017	2018
1. Admissions							
a. M/S/G/A	11,761	10,559	10,657	10,864	11,055	12,605	12,668
b. Pediatric	118	106	105	105	104	117	115
c. Obstetric	2,223	1,996	2,014	2,054	2,090	2,383	2,395
d. Intensive Care	1,180	1,059	1,069	1,090	1,109	1,263	1,270
e. Psychiatric	1,162	1,043	1,053	1,073	1,092	1,244	1,250
f. Rehabilitation	-	-	-	-	-	-	-
g. Chronic	453	492	497	506	515	586	589
h. Other (Nursery)	1,973	1,771	1,808	1,842	1,882	1,928	1,938
j. TOTAL (excluding Nursery)	**16,897**	**15,255**	**15,395**	**15,692**	**15,965**	**18,198**	**18,287**
2. Patient Days							
a. M/S/G/A	45,478	42,713	43,161	43,999	44,773	51,050	51,305
b. Pediatric	234	173	171	171	170	191	187
c. Obstetric	6,064	5,348	5,398	5,505	5,601	6,386	6,419
d. Intensive Care	4,633	4,633	4,672	4,742	4,802	5,444	5,448
e. Psychiatric	5,688	4,313	4,359	4,442	4,510	5,138	5,175
f. Rehabilitation	-	-	-	-	-	-	-
g. Chronic	6,710	7,205	7,276	7,418	7,540	8,591	8,623
h. Other (Nursery)	5,582	4,999	5,099	5,194	5,307	5,437	5,465
j. TOTAL (excluding Nursery)	**74,389**	**64,385**	**65,037**	**66,277**	**67,396**	**76,800**	**77,157**
3. Average Length of Stay							
a. M/S/G/A	3.9	4.0	4.1	4.0	4.1	4.0	4.0
b. Pediatric	2.0	1.6	1.6	1.6	1.6	1.6	1.6
c. Obstetric	2.7	2.7	2.7	2.7	2.7	2.7	2.7
d. Intensive Care	3.9	4.4	4.4	4.4	4.3	4.3	4.3
e. Psychiatric	4.9	4.1	4.1	4.1	4.1	4.1	4.1
f. Rehabilitation	-	-	-	-	-	-	-
g. Chronic	14.8	14.6	14.6	14.7	14.6	14.7	14.6
h. Other (Nursery)	2.8	2.8	2.8	2.8	2.8	2.8	2.8
j. TOTAL (excluding Nursery)	**4.4**	**4.2**	**4.2**	**4.2**	**4.2**	**4.2**	**4.2**
4. Occupancy Percentage*							
a. M/S/G/A	80.4%	75.0%	82.1%	84.3%	83.4%	78.1%	78.1%
b. Pediatric	16.0%	11.8%	11.7%	11.7%	11.6%	13.1%	12.8%
c. Obstetric	55.4%	48.8%	49.3%	50.3%	51.2%	58.3%	58.6%
d. Intensive Care	52.9%	52.9%	53.3%	54.1%	54.8%	62.1%	62.2%
e. Psychiatric	62.3%	51.8%	51.8%	52.1%	52.4%	52.6%	52.9%
f. Rehabilitation	-	-	-	-	-	-	-
g. Chronic	76.6%	82.2%	83.1%	84.7%	86.1%	98.1%	98.4%
h. Other (Nursery)	63.7%	57.1%	58.2%	59.3%	60.6%	62.1%	62.4%
j. TOTAL (excluding nursery)	**77.8%**	**67.1%**	**71.0%**	**72.6%**	**72.7%**	**73.6%**	**73.7%**

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2012	2013	2014	2015	2016	2017	2018
5. Number of Licensed Beds							
a. M/S/G/A	155	156	144	143	147	179	180
b. Pediatric	4	4	4	4	4	4	4
c. Obstetric	30	30	30	30	30	30	30
d. Intensive Care	24	24	24	24	24	24	24
e. Psychiatric	25	25	25	25	25	25	25
f. Rehabilitation	-	-	-	-	-	-	-
g. Chronic	24	24	24	24	24	24	24
h. Other (Nursery)	24	24	24	24	24	24	24
j. TOTAL (excluding nursery)	**262**	**263**	**251**	**250**	**254**	**286**	**287**
6. Outpatient Visits							
a. Emergency	66,423	65,316	65,316	66,622	67,954	72,031	73,472
b. Outpatient Dept. (Lab, Rad, PT, STH, OTH)	64,617	66,671	66,671	70,005	73,505	77,180	81,039
c. Other (PDC, CL)	7,199	5,963	5,963	6,202	6,450	6,837	7,247
d. Other (SDS)	5,849	5,252	5,252	5,462	5,680	6,021	6,382
e. Other (observation)	2,883	4,429	4,429	4,872	5,359	5,895	6,485
f. TOTAL	**146,971**	**147,631**	**147,631**	**153,163**	**158,948**	**167,964**	**174,625**

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT

Not applicable.

COMAR 10.24.01.08G(3)(c). Availability of More Cost-Effective Alternatives.
For purposes of evaluating an application under this subsection, the Commission shall compare the cost-effectiveness of providing the proposed service through the proposed project with the cost-effectiveness of providing the service at alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

Please explain the characteristics of the Project which demonstrate why it is a less costly or a more effective alternative for meeting the needs identified.

For applications proposing to demonstrate superior patient care effectiveness, please describe the characteristics of the Project which will assure the quality of care to be provided. These may include, but are not limited to: meeting accreditation standards, personnel qualifications of caregivers, special relationships with public agencies for patient care services affected by the Project, the development of community-based services or other characteristics that the Commission should take into account.

The purpose of this project is to modernize the hospital, and provide sufficient space to provide services in an updated current environment. MSMHC and MedStar considered three options to meet the need for more space.

Option A is the option presented in this application. This includes minimal expansion of the diagnostic and treatment block, expansion of the ED, a new front door, reconfiguration of the public / staff circulation, and the addition of a new outpatient facility across the campus.

Option B included decommissioning Bed Tower I and converting it to an outpatient services building, construction of a new bed tower, minimal expansion of the diagnostic and treatment block, expansion of the ED, a new front door, and reconfiguration of public / staff circulation. This option would have provided significantly more new construction and space for expansion and modernization, located all outpatient functions on the north side of the campus for greater separation as well as convenience, and a revised main entry separate from the ED/ambulance traffic. Option B was not priced, but was clearly more expensive than Option A. This option was rejected due to the higher cost and reduced future flexibility.

Option C involved purchase of the hotel property that lies between the hospital and Branch Avenue for future replacement hospital, and expansion of the ED in the meantime. This would provide the best long term solution, would locate all outpatient activity on the north side of the campus and inpatient activity at the South side, and would result in minimal disruption during construction. This option was not priced, but was clearly more expensive than Option B. Option C was rejected because it did not meet the current pressing needs for more space, and was the most expensive option.

COMAR 10.24.01.08G(3)(d). Viability of the Proposal.
For purposes of evaluating an application under this subsection, the Commission shall consider the availability of financial and non-financial resources, including community support, necessary to implement the project within the time frame set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

Please include in your response:

a. Audited Financial Statements for the past two years. In the absence of audited financial statements, provide documentation of the adequacy of financial resources to fund this project signed by a Certified Public Accountant who is not directly employed by the applicant. The availability of each source of funds listed in Part II, B. Sources of Funds for Project, must be documented.

Audited financial statements for the past two years are attached at Attachment 7. Please note that these statements reflect MSMHC prior to the merger with MedStar.

b. Existing facilities shall provide an analysis of the probable impact of the Project on the costs and charges for services at your facility.

At this time, MSMHC is not requesting a rate increase from the HSCRC to cover costs of this project, therefore, we are not projecting an impact of the project on costs and charges.

c. A discussion of the probable impact of the Project on the cost and charges for

similar services at other facilities in the area.

Regarding potential impact on the cost and charges at other hospitals in the service area, this project is consistent with State and County policy to reduce the outmigration by providing state-of-the-art services within the county. As utilization increases over time, we believe the impact on DC and Montgomery County facilities will be gradual.

d. All applicants shall provide a detailed list of proposed patient charges for affected services.

The latest rate order from the HSCRC is attached at Attachment 8.

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

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2012	2013	2014	2015	2016	2017	2018
1. Revenue**							
a. Inpatient Services	$ 184,149,559	$ 167,004,215	$ 159,806,755	$ 162,269,904	$ 164,599,473	$ 185,241,927	$ 189,595,735
b. Outpatient Services	$ 86,487,262	$ 100,950,594	$ 103,574,125	$ 107,793,625	$ 112,295,725	$ 118,778,625	$ 124,296,325
c. Gross Patient Services	$ 270,636,821	$ 267,954,809	$ 263,380,880	$ 270,063,529	$ 276,895,198	$ 304,020,552	$ 313,892,060
d. Allowance for Bad Debt	$ 14,841,008	$ 15,671,754	$ 14,345,397	$ 15,104,677	$ 15,486,773	$ 17,003,897	$ 17,556,011
e. Contractual Allowance	$ 29,096,276	$ 38,500,483	$ 39,154,132	$ 35,995,228	$ 36,905,782	$ 40,521,166	$ 41,836,883
f. Charity Care	$ 1,038,183	$ 2,463,285	$ 1,208,139	$ 1,585,816	$ 1,625,931	$ 1,785,212	$ 1,843,177
g. Net Patient Services	$ 225,661,354	$ 211,319,287	$ 208,673,212	$ 217,377,808	$ 222,876,712	$ 244,710,277	$ 252,655,989
h. Other Operating Revenues (Specify)	$ 232,482	$ 895,398	$ 1,083,016	$ 1,115,506	$ 1,148,971	$ 1,183,440	$ 1,218,943
i. Net Operating Revenue	$ 225,893,836	$ 212,214,685	$ 209,756,228	$ 218,493,314	$ 224,025,683	$ 245,893,717	$ 253,874,932
2. Expenses*							
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	$ 106,115,073	$ 116,724,246	$ 112,159,923	$ 114,365,198	$ 116,619,648	$ 125,571,015	$ 128,828,613
b. Contractual Services	$ 19,689,858	$ 28,235,612	$ 13,598,032	$ 13,865,338	$ 14,138,605	$ 15,223,619	$ 15,618,479
c. Interest on Current Debt	$ 1,237,744	$ 2,412,769	$ 8,094,955	$ 7,690,207	$ 7,305,697	$ 6,940,412	$ 6,593,391
d. Interest on Project Debt***	$ -	$ -	$ -	$ -	$ -	$ -	$ 5,332,016
e. Current Depreciation	$ 5,566,726	$ 4,599,985	$ 7,830,137	$ 7,830,137	$ 7,830,137	$ 7,830,137	$ 7,830,137
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,950,377
g. Current Amortization	$ -	$ 1,278,012	$ 2,019,054	$ 2,019,054	$ 2,019,054	$ 2,019,054	$ 2,019,054
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ 58,667
i. Supplies	$ 42,849,230	$ 40,409,909	$ 37,990,100	$ 38,858,845	$ 39,746,962	$ 43,273,258	$ 44,556,554
j. Other Expenses (Specify)	$ 37,225,241	$ 32,593,472	$ 28,045,294	$ 29,187,621	$ 30,263,763	$ 34,339,048	$ 35,502,588
k. Total Operating Expenses	$ 212,683,872	$ 226,254,005	$ 209,737,495	$ 213,816,400	$ 217,923,866	$ 235,196,543	$ 251,289,876
3. Income							
a. Income from Operation	$ 13,209,964	$ (14,039,320)	$ 18,733	$ 4,676,914	$ 6,101,817	$ 10,697,174	$ 2,585,056
b. Non-Operating Income	$ 376,895	$ 342,029	$ -	$ -	$ -	$ -	$ -
c. Subtotal	$ 13,586,859	$ (13,697,291)	$ 18,733	$ 4,676,914	$ 6,101,817	$ 10,697,174	$ 2,585,056
d. Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -	$ -
e. Net Income (Loss)	$ 13,586,859	$ (13,697,291)	$ 18,733	$ 4,676,914	$ 6,101,817	$ 10,697,174	$ 2,585,056
4. Patient Mix:							
A. Percent of Total Revenue							
1) Medicare	39.2%	41.1%	41.1%	41.1%	41.1%	41.1%	41.1%
2) Medicaid	4.1%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
3) Blue Cross	16.4%	15.7%	15.7%	15.7%	15.7%	15.7%	15.7%
4) Commercial Insurance	8.7%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%
5) Self-Pay	5.5%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
6) Other (Specify)	26.1%	24.7%	24.7%	24.7%	24.7%	24.7%	24.7%
7) TOTAL	100%	100%	100%	100%	100%	100%	100%
B. Percent of Patient Days\Visits\Procedures (as applicable)							
1) Medicare	39.2%	41.1%	41.1%	41.1%	41.1%	41.1%	41.1%
2) Medicaid	4.1%	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%
3) Blue Cross	16.4%	15.7%	15.7%	15.7%	15.7%	15.7%	15.7%
4) Commercial Insurance	8.7%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%
5) Self-Pay	5.5%	6.1%	6.1%	6.1%	6.1%	6.1%	6.1%
6) Other (Specify)	26.1%	24.7%	24.7%	24.7%	24.7%	24.7%	24.7%
7) TOTAL	100%	100%	100%	100%	100%	100%	100%

*Expenses exclude physicians expense and CRNA expense.

**Income excludes physicians income

***Interest capitalized during construction periods for Fys 2015, 2016, 2017 and expensed starting in FY 2018

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

Not applicable.

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

To meet this subsection, an applicant shall demonstrate compliance with all conditions applied to previous Certificates of Need granted to the applicant.
List all prior Certificates of Need that have been issued to the project applicant by the Commission since 1990, and their status.

MSMHC was granted one CON since 1990. The CON for a 20- bed sub-acute unit (96-16-1792), issued in 1995, has been fully implemented, and there are no unfulfilled conditions.

COMAR 10.24.01.08G(3)(f). Impact on Existing Providers.
For evaluation under this subsection, 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 when there is a risk that this will increase costs to the health care delivery system, and on costs and charges of other providers.
Indicate the positive impact on the health care system of the Project, and why the Project does not duplicate existing health care resources. Describe any special attributes of the project that will demonstrate why the project will have a positive impact on the existing health care system.

Complete Table 5

1. *an assessment of the sources available for recruiting additional personnel;*
2. *recruitment and retention plans for those personnel believed to be in short supply;*
3. *for existing facilities, a report on average vacancy rate and turnover rates for affected positions,*

(INSTRUCTION: FTE data shall be calculated as 2,080 paid hours per year. Indicate the factor to be used in converting paid hours to worked hours.

Regarding potential impact on other providers in the service area, this project is consistent with state and County policy to reduce the outmigration by providing state-of-the-art services within the county. As utilization increases over time, we believe the impact on DC and Montgomery County facilities will be gradual.

This project will have a positive impact on the existing health care system by providing a more modern, efficient hospital, able to attract and provide more Prince George's County residents access to care closer to where they live.

Table 5 reflects the incremental increase in staffing after the project completion from the increase in inpatient and outpatient utilization and square footage of the hospital.

The recruitment sources available for hiring additional Clinical and Non Clinical personnel will consist of the following:

- MSMHC website
- Social Media Outlets
- Newspaper Ads (Local & Regional)
- Website Ads (Focused at Clinical Specialties)
- Job Fairs
- College Career Fairs
- Direct Mailings
- Contingency Firms

TABLE 5. MANPOWER INFORMATION

(INSTRUCTION: List by service the staffing changes (specifying additions and/or deletions and distinguishing between employee and contractual services) required by this project.)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration					
OBs Unit					
Nurse Director		+1	$115,000	Employee	$115,000
Asst. Nurse Dir		+1	90,000	Employee	90,000
Direct Care Staff					
NP	2.0	+ 2.0	$115,000	Employee	$ 230,000
RN	332.0	+51.0	72,800	Employee	3,712,800
CNA	119.0	+12.0	31,200	Employee	374,400
Cardio Cath RN	13.0	+ 7.0	72,800	Employee	509,600
OR RN	10.5	+ 4.0	72,800	Employee	291,200
CRNA	8.0	+ 2.0	162,000	Employee	324,000
SA	8.5	+ 3.0	85,000	Employee	255,000
OR Tech	10.5	+ 3.0	63,000	Employee	189,000
Support Staff					
Phlebotomist	17.0	+ 3	$ 33,000	Employee	$ 99,000
PT/OT	12.0	+ 6	88,000	Employee	528,000
Env. Services	64.0	+15	21,000	Employee	315,000
Security	19.0	+ 6	34,000	Employee	204,000
Maint./Engineering	21.0	+ 5	58,000	Employee	290,000
Bio-Med	3.0	+ 1	59,000	Employee	59,000
Pharmacist	8.0	+ 3	115,000	Employee	345,000
FTEs Sub-Total:		+125	Sub-Total (18%): Benefits		$1,427,580
		Sub-Total Base Hourly Rate			$7,931,000
		Sub-Total: Benefits (18%) & Base Hr Rate			$9,358,580

TABLE 5. MANPOWER INFORMATION (continued)

Position Title	Current No. FTEs	Change in FTEs (+/-)	Average Salary	Employee/ Contractual	TOTAL COST
Administration			$		$
Direct Care Staff			$		$
Support Staff					
Pharmacy Tech	10.0	+ 2	$ 38,000	Employee	$ 76,000
Radiology Tech	22.0	+ 3	69,000	Employee	207,000
Resp. Therapist	20.0	+ 3	67,000	Employee	201,000
Echo Tech	12.4	+ 4	102,098	Employee	204,196
Med Tech	29.0	+ 2	52,000	Employee	104,000
Soc. Worker	8.0	+ 3	69,000	Employee	207,000
Case Managers	19.0	+ 3	97,000	Employee	231,000
Tele Monitor	21.0	+ 3	34,000	Employee	102,000
	Sub Total: +23 FTEs		Sub-Total: Benefits 18%		$ 239,795
			Sub-Total: Base Hr Rate		$1,332,196
			Sub-Total: Benefits (18%) & Base Hr Rate		$1,571,991

(INSTRUCTION: Indicate method of calculating benefits percentage):
+18% of Base Hourly Rate of Pay (Vacation, Holiday, Sick Pay, Float Days, SS and Employee Benefits)

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

1. List names and addresses of all owners and individuals responsible for the proposed project and its implementation.

   MedStar Southern Maryland Hospital Center, Inc.
   7503 Surratts Road
   Clinton, MD20735

2. Are the applicant, owners, or the responsible persons listed above now involved, or have they ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of these facilities, including facility name, address, and dates of involvement.

   MedStar Southern Maryland Hospital Center, Inc. was formed in 2012 and in December 2012 it acquired Southern Maryland Hospital Center. It has not been involved in the ownership, development, or management of any other health care facilities.

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to number 2, above, ever been suspended or revoked, or been subject to any disciplinary action (such as a ban on admissions) in the last 5 years? If yes, provide a written explanation of the circumstances, including the date(s) of the actions and the disposition. If the applicant, owners or individuals responsible for implementation of the Project were not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No.

4. Are any facilities with which the applicant is involved, or have any facilities with which the applicant has in the past been involved (listed in response to Question 2, above) ever been found out of compliance with Maryland or Federal legal requirements for the provision of, payment for, or quality of health care services (other than the licensure or certification actions described in the response to Question 3, above) which have led to actions to suspend the licensure or certification at the applicant's facility or facilities listed in response to Question 2? If yes, provide copies of the findings of non-compliance including, if applicable, reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable governmental authority.

   No.

5. Have the applicant, owners or responsible individuals listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense in any way connected with the ownership, development or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written

No.

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the proposed or existing facility.

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.

10/3/13
Date

Michael J. Chiaramonte
Signature of Owner or
Board-designated Official

List of Attachments

1 – Construction Drawings and Area Tabulations

2 – Average Estimated Charges Policy

3 – Financial Assistance Policy

4 – Licensure and Accreditation

5 – Marshall Valuation Analysis

6 – Transfer Agreements

7 – Audited Financial Statements

8 – Rate Order