MARYLAND HEALTH CARE COMMISSION

MATTER/DOCKET NO.

DATE DOCKETED

OTHER THAN HOSPITAL AND COMPREHENSIVE/ EXTENDED CARE SERVICES APPLICATION FOR CERTIFICATE OF NEED

ALL PAGES THROUGHOUT THE APPLICATION SHOULD BE NUMBERED CONSECUTIVELY.

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1.a. Rockville Eye Surgery, LLC
Legal Name of Project Applicant
(ie. Licensee or Proposed Licensee)

b. 4818 Del Ray Avenue
Street

c. Bethesda 20814 Montgomery
City Zip County

d. 301-657-8200
Telephone No.

e. Paul Kang, MD
Name of Owner/Chief Executive

2.a. _____
Legal Name of Project Co-Applicant
(i.e. if more than one applicant)

b. _____
Street

c. _____
City Zip County

d. _____
Telephone

e. _____
Name of Owner/Chief Executive

3.a. Palisades Eye Surgery Center
Name of Facility

b. 4831 Cordell Avenue
(Project Site)

c. Bethesda 20814 Montgomery
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.	Paul Kang, MD **Name and Title**		**a.**	Penelope Williams **Name and Title**	
b.	2 Wisconsin Circle **Street**		**b.**	4818 Del Ray Avenue **Street**	
c.	Chevy Chase **City**	20815 **Zip**	Montgomery **County**	**c.** Bethesda **City**	20814 **Zip**	Montgomery **County**
d.	301-215-7100 **Telephone**			**d.** 301-657-8200 **Telephone**	
e.	301-215-4144 **Fax No.**			**e.** 301-657-4121 **Fax No.**	
	Email: pkang@edow.com			**Email:** pwilliams@palisadeseye.net	
a.	Howard L. Sollins **Name and Title**		**a.**	Andrew L. Solberg **Name and Title**	
	Ober, Kaler, Grimes, & Shriver			A.L.S. Healthcare Consultant Services	
b.	100 Light Street **Street**		**b.**	5612 Thicket Lane **Street**	
c.	Baltimore **City**	21202 **Zip**	Baltimore City **County**	**c.** Columbia **City**	21044 **Zip**	Howard **County**
d.	410 347-7369 **Telephone**			**d.** 410-730-2664 **Telephone**	
e.	443-263-7569 **Fax No.**			**e.** 410-730-6775 **Fax No.**	
	Email: hlsollins@ober.com			**Email:** asolberg@earthlink.net	

7. Brief Project Description (for identification only; see also item #14):
Relocation of current facility to expand from 1 operating room to 3 operating rooms and maintain two procedure rooms.

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

a.	b.	c.
Governmental ___	Sole Proprietorship ___	To be Formed ___
Proprietary _X_	Partnership ___	Existing _X_
Nonprofit ___	Corporation _X_ (LLC)	
	Subchapter "S" ___	

9. Project Services (check below, if applicable):

Service	Included in Project
ICF-MR	
ICF-C/D	
Home Health Agency	
Residential Treatment Center	
Ambulatory Surgery	X
Other (Specify)	

10. Current Capacity and Proposed Changes:

Service	Unit Description	Currently Licensed/ Certified	Units to be Added or Reduced	Total Units if Project is Approved
ICF-MR	Beds	____/____		
ICF-C/D	Beds	____/____		
Residential Treatment	Beds	____/____		
Ambulatory Surgery	Operating Rooms	1	2	3
	Procedure Rooms	2	0	2
Home Health Agency	Counties	____/____		
Hospice Program	Counties	____/____		
Other (Specify)				
TOTAL		3	2	5

11. Project Location and Site Control:

A. Site Size 9,178 Square Feet

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

_____

_____

_____

C. Site Control:

(1) Title held by: _____

(2) Options to purchase held by: _____
(i) Expiration Date of Option _____
(ii) Is Option Renewable? _____ If yes, Please explain
_____
_____
(iii) Cost of Option _____

3) Land Lease held by: Rockville Eye Surgery Center, LLC
(i) Expiration Date of Lease 192 months from rent commencement date
(ii) Is Lease Renewable yes If yes, please explain
Lease allows to extend the term of the lease for one additional term of 5 years beyond the first option term
_____
(iii) Cost of Lease $2,050,000/year

(4) Option to lease held by: _____
(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 12, 13 & 14, PLEASE NOTE APPLICABLE PERFORMANCE REQUIREMENT TARGET DATES SET FORTH IN COMMISSION REGULATIONS, COMAR 10.24.01.12)

12. Project Implementation Target Dates (for construction or renovation projects):
A. Obligation of Capital Expenditure 1 month from approval date.
B. Beginning Construction 1 month from capital obligation.
C. Pre-Licensure/First Use 5 months from capital obligation.
D. Full Utilization 24 months from first use.

13. 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.

14. Project Implementation Target Dates (for projects not involving capital expenditures):

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.

15. Project Description:
Provide a summary description of the project's construction and renovation plan and all

medical services to be establish, expanded, or otherwise affected if the project receives approval. Please attach this description as a separate sheet or section to your application.

Please see Page 6.

16. Project Drawings:

Projects involving renovations or new construction should include architectural schematic drawings or plans outlining the current facility (if applicable), the new facility (if applicable) and the proposed new configuration for inpatient facilities. These drawings should include:

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.

For free-standing (including office-based) ambulatory surgical facilities, these drawings should include:

1) dimensions of major architectural features and equipment of all operating rooms and procedure rooms, existing and proposed,
2) clear demarcation of restricted sterile corridor,
3) any proposed space for future expansion, and
4) the "footprint" and location of the facility on the proposed or existing site.

Please see Exhibit 1.
Notes to the Drawings:
1. The Procedure Rooms are labeled "Exam/Laser Room" and "Femto Room."
2. The Procedure Rooms are not in the sterile corridor
3. The space labeled "Vacant" is not part of the area that will be leased by PESC.

17. Features of Project Construction:

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

B. Explain any plans for bed expansion subsequent to approval which are incorporated in the project's construction plan.
None

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. All utilities exist.

Project Description

Rockville Eye Surgery, LLC, d.b.a Palisades Eye Surgery Center ("Palisades" or "PESC") was established as a one Operating Room (OR) Ambulatory Surgery Facility ("ASF") with two Procedure Rooms in 2004, with five founding ophthalmologists; Dr. Robert Chu, Dr. Thomas Clinch, Dr. Howard Kane, and Dr. J. Alberto Martinez. In 2007, additional partners joined the practice; Dr. Larry Frank, Dr. Paul Kang and Dr. Daniel Pluznik. For nearly 10 years, the Center and surgeons have provided quality patient care with the following ophthalmic procedures.

Operating Room Procedures

- Cataract,
- Corneal Transplant (PK and DESK),
- Pterygium,
- Procedures for Glaucoma (Diode Transcleral Cyclophotocoagulation, Endoscopic Cyclophotocoagulation, iStent, Express Mini Shunt, Trabeculectomy, Ahmed Valve), and
- Ophthalmic plastic surgeries, not limited to blepharoplasty, blepharoptosis, ectropion, entropion, and lid lesion.

Procedure Room Procedures

- SLT Laser (Selected Laser Trabeculoplasty),
- YAG Laser (Yttrium-Aluminum Garnet Laser),
- Iritotomy Laser, and
- Femtosecond Laser

While the focus of practice has not changed significantly since 2004, the scope of practice has. Several evolving factors influence PESC's demand for additional operating and procedural accommodations. These include advanced technology in the field of ophthalmology, growth of each Principal Partner's physician practice, and an aging population.

Advanced Technology

Evolving technology continues to optimize the ophthalmic industry. PESC is a leader in combining groundbreaking technology, materials, supplies and surgical technique, to improve the patient experience by providing specialized technology equipment, materials, and supplies that allow multiple procedures to be performed during the same visit, at the same facility. For example, PESC was one of the first ASF in the Baltimore - Washington region to have a Femtosecond Laser. At this writing, only one ASF in Montgomery County, (Eye Center of Silver Spring), and two others (Chesapeake Eye Surgery Center in Annapolis, and Dimensions Surgery Center in Bowie) own this specialty equipment. Hence, surgeons from other facilities and around the country visit PESC to observe surgeons use the femtosecond laser, and learn how to integrate the specialized equipment into their personal practice. PESC also uses Optiwave Response Analyzer ("ORA"), a cataract surgery measurement tool which helps customize a patient's vision, even further during cataract surgery, measuring Corneal Hysteresis ("CH"); an indication of the biomechanical properties of a patient's cornea. In addition, PESC has Endoscopic Cyclophotocoagulation ("ECP") equipment, which is a new technique that reduces the amount of fluid (aqueous humor) produced in the eye and thus lowers pressure within the eye (intraocular pressure). Furthermore, PESC has the capability to provide iStent® Trabecular Micro-Bypass, a new treatment option designed for patients suffering from mild-to-moderate open-angle glaucoma to help reduce pressure in the eye and slow the progression of glaucoma.

While several ASFs in the Maryland – D.C. region have been obtaining one or another of these capabilities, none have all of them in the same facility, as indicated in the table below.

Surgery Center	LenSx Femto Second Laser	ORA	ECP	iStent	Alcon Infinity Phaco	Alcon Centurian Phaco	AMO Signature Phaco	Alcon Lenses	AMO Lenses
Ambularory Surgery Centers									
Palisades Eye Surgery Center	x	x	x	x	x	x	x	x	x
Dimensions Surgery Center	x			x	x			x	x
Forbes Surgery Center							x		x
Friendship Heights			x		x		x	x	x
Silver Spring Ophthalmology			x			x		x	x
Eye Center of Silver Spring	x				x			x	x
Northern VA Eye Surgery Center			x		x		x	x	x
Montgomery Surgery Center						x		x	x
University Center for Ambulatory Surgery					x			x	x
Woodburn Surgery Center					x			x	x

In addition to ASFs, PESC understands that this unique combination of equipment and supplies are not available in hospitals within their service area. This is based on phone calls the Center receives from surgeons operating in area hospitals and from their own surgeons who are credentialed at several area hospitals including; Suburban, Sibley, George Washington, Shady Grove and Providence.

As a result of being a facility focused on quality patient care and outcome, through advanced technology equipment and supplies, PESC is capturing the attention and interest of other surgeons. In 2013, PESC credentialed four surgeons not affiliated with any of their Principal Partner practices. At this writing, PESC is in the process of credentialing a fifth surgeon, who approached the Center, with interest in credentialing and training on femtosecond laser.

Expanding Physician Practices

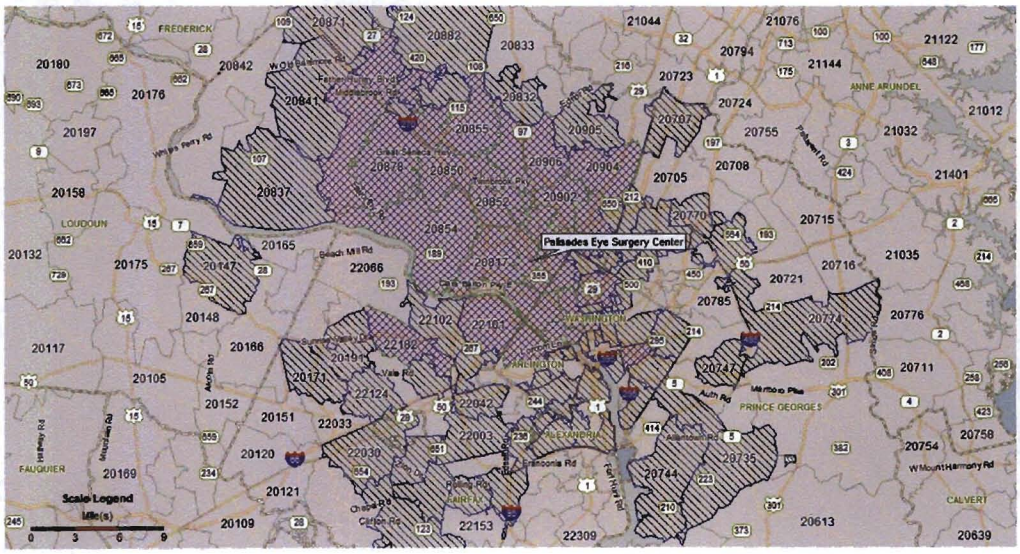
In the process of being responsive to the needs of an ever growing patient population, PESC's team of surgical providers has increased from the five original

ophthalmic surgeons in 2004 to eighteen surgeons, credentialed to perform ophthalmic surgery, in 2013.[1] One of the Principal Partner practices, Eye Doctors of Washington, recently hired two surgeons. One is credentialed and is currently performing surgery at the Center. The other will be starting and credentialed in Spring 2014. PESC's current surgeons are predominantly members of one of six ophthalmic specialty groups serving the Maryland, D.C., and northern Virginia area.

- Eye Doctors of Washington
- Montgomery Eye Center
- Hammerman, Wanicur, Kane, and Zeller
- Visionary Eye Doctors
- Rockville Eye Physicians
- Eye Physicians of Washington

Consequently, PESC's patients come from a wide service area. PESC's Service Area is shown in Figure 1:

Figure 1
Palisades Eye Surgery Center Service Area



Primary Service Area

Secondary Service Area

[1] PESC has 22 surgeons credentialed. However, only 18 currently perform surgery.

The Project

As a result of the growth in surgeons seeking privileges to perform surgery at PESC, the surgical case load has grown considerably. In 2013, PESC saw 3,573 Operating Room (OR) cases. The average OR time is 25 minutes. Palisades estimates that the average clean up time between cases is also 20 minutes. This calculates to the need for 1.46 ORs based on 2013 utilization. (3,573 x 40 = 143,040; 143,060/97,920 = 1.46) Such high utilization has required limitations on additional utilization.

Consequently, Palisades is applying for additional OR capacity. To accommodate future growth, Palisades is seeking approval for two additional ORs.

Also, Palisades is proposing to relocate to another office space in the same building in which it is currently located. Though both the existing suite and the new suite are on the first floor in the same building, they have different addresses because the building has two entrances on different streets, and Palisades will be served by an entrance on Cordell Avenue, rather than the current entrance on Del Ray Avenue.

Chart 1. Project Construction Characteristics and Costs			
Base Building Characteristics		Complete if Applicable	
		New Construction	Renovation
Class of Construction			
Class A			X
Class B			
Class C			
Class D			
Type of Construction/Renovation			
Low			
Average			
Good			X
Excellent			
Number of Stories			
Total Square Footage			9,178
Basement			
First Floor			9,178
Second Floor			
Third Floor			
Fourth Floor			
Perimeter in Linear Feet			
Basement			
First Floor			547'
Second Floor			
Third Floor			
Fourth Floor			
Wall Height (floor to eaves)			
Basement			
First Floor			14'4"
Second Floor			
Third Floor			
Fourth Floor			
Elevators			
Type	*Passenger*	*Freight*	
Number	0	0	
Sprinklers (Wet or Dry System)			Wet (Pre-Existing)
Type of HVAC System			Self-Contained Rooftop Gas Fired Heat with Integral 2 Stage Filtration and Integral Humidification
Type of Exterior Walls			

Chart 1. Project Construction Characteristics and Costs (cont.)		
	Costs	Costs
Site Preparation Costs	$	$
Normal Site Preparation*		
Demolition		
Storm Drains		
Rough Grading		
Hillside Foundation		
Terracing		
Pilings		
Offsite Costs	$	$
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Signs	$	$
Landscaping	$	$

*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.-j., 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	
	(2)	Fixed Equipment (not included in construction	
	(3)	Land Purchase	
	(4)	Site Preparation	
	(5)	Architect/Engineering Fees	
	(6)	Permits (Building, Utilities, Etc.)	
		SUBTOTAL	$0
b.	**Renovations**		
	(1)	Building	$2,050,000
	(2)	Fixed Equipment (not included in construction	
	(3)	Architect/Engineering Fees	$205,000
	(4)	Permits (Building, Utilities, Etc.)	$75,000
		SUBTOTAL	$2,330,000
c.	**Other Capital Costs**		
	(1)	Major Movable Equipment	$964,600
	(2)	Minor Movable Equipment	
	(3)	Contingencies	$174,750
	(4)	Other (Moving)	$25,000
		SUBTOTAL	$1,164,350
		TOTAL CURRENT CAPITAL COSTS (a - c)	$3,494,350
d.	**Non-Current Capital Costs**		
	(1)	Inflation (13.4-14.4, the MHCC Index; 1.5%)	$52,415
	(2)	Capitalized Construction Interest	
	TOTAL PROSOSED CAPITAL COSTS (a - e)		$3,546,765

2. **Financing Cost and Other Cash Requirements:**

a.	Loan Placement Fees	$20,500
b.	Bond Discount	
c.	Legal Fees, Printing, etc.	$50,000
d.	Consultant Fees	
	CON Application Assistance	$20,000
	Other (Purchase bed rights)	
e.	Liquidation of Existing Debt	
f.	Debt Service Reserve Fund	
g.	Principal Amortization Reserve Fund	
h.	Other	
TOTAL (a - h)		$90,500

3. Working Capital Startup Costs

TOTAL USES OF FUNDS (1 - 3) $3,637,265

B. Sources of Funds for Project:

1.	Cash	$260,000
2.	Pledges: Gross less allowance for uncollectable = Net	
3.	Gift, bequests	
4.	Interest income (gross)	
5.	Authorized Bonds	
6.	Mortgage	3,377,265
7.	Working capital loans	
8.	Grants or Appropriation	
	(a) Federal	
	(b) State	
	(c) Local	
9.	Other (Specify)	

TOTAL SOURCES OF FUNDS (1 - 9) $3,637,265

Lease Costs:

a. Land	$	x	= $	
b. Building	$ 223.36	x 9,178	= $	2,050,000
c. Major Movable Equipment	$	x	= $	
d. Minor Movable Equipment	$	x	= $	
e. Other (Specify)	$	x	= $	

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

(INSTRUCTION: Each applicant must respond to all applicable criteria included in COMAR 10.24.01.08G. Each criterion is listed below.)

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

List each standard from the applicable 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. **(Copies of the State Health Plan are available from the Commission. Contact the Staff of the Commission to determine which standards are applicable to the Project being proposed.)**

.05 Standards
A. General Standards.

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(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.

PESC provides to the public upon inquiry information concerning charges for and the range and types of services provided. Exhibit 2, includes PESC's facility fee schedule. Patients are provided with estimates of the actual charges, depending on the procedures they require.

(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 it's 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.

PESC has history of providing charity care (Exhibit 3) to assist uninsured and underinsured patients and families. This is accomplished though partial of full facility fee reductions, physician fee reductions, vendor programs and payment support programs such as Care Credit.

Before the patient is scheduled for surgery, the physician's office is responsible for reviewing a patient's financial status and determines level of coverage. If patient financial concerns arise and assistance is required, the surgery center is contacted. In 2013, PESC provided a total $37,335 in charity care. In addition to charity care for local patients, PESC has two surgeons who volunteer their time on medical mission trips to Central and South America. Annually, PESC donates unused equipment, instruments, and supplies to their medical mission efforts. The value of these donations was approximately $3,500 in 2013. Consequently, PESC's total charity care contribution in 2013 was $40,835. ($37,335 + $3,500 = $40,835) Total expenses for 2013 were $4,032,765. In total, PESC's charity care equaled 1% of total operating costs. ($37,335 + $3,500 = $40,835; $40,835/$4,032,765 = .0101)

According to MHCC Staff (Joel Riklin email to Andrew Solberg, 11/21/13), the statewide charity care percentage for ASFs is 1.2%. 1.2% of PESC's total operating costs in 2013 calculate to $48,393. PESC acknowledges that its 2013 charity care was slightly lower than what it would be at the Statewide average of 1.2%. PESC will

commit to meeting the 1.2% charity care levels and believes that PESC's historical performance is evidence of its ability to achieve it.

Public notice and information regarding the Charity Care Program is provided on the PESC website (http://www.palisadeseye.com/index.html), and to surgical Coordinators. Notices regarding the availability of payment programs are located in the registration area and business office of the center. Exhibit 4 includes a photo of the posted notice.

(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 radiological 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.

PESC is licensed by the Maryland Department of Health and Mental Hygiene and certification is included in Exhibit 5. PESC received certification by the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF) valid

through November 2014. A copy of the certification is included in Exhibit 6. PESC is Medicare certified.

(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.

PESC has a transfer agreement with Suburban Hospital, Bethesda, that has been in effect since 2005. A copy of the transfer agreement is attached as Exhibit 7. Ambulance service is provided by the Emergency Medical System by calling 911.

B. Project Review Standards.

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(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.

The primary service area for the expanded PESC will remain the same. See Exhibit 8 for the zip codes that account for 60% of our ambulatory surgery cases. See Figure 1 above (in the Project Description) for a Service Area Map.

(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 out patient surgical procedures by the new or replacement hospitals likely service area population;

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

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

Please see the response to Standard 2(b)(i) below.

(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;

Nationwide, ambulatory surgery centers continue the trend as examples of quality health care delivery. As compared with hospitals, ASCs are more cost effective (often as much as 61%) and efficient. Studies demonstrate ASCs are often safer for patients in that equipment and skilled staff are tailored to their specialty, and perform more specialty procedures than in hospitals.[2]

In an article published by Ambulatory Surgery Center Coalition, the aging population is a major force in driving demand for ASC growth. By 2020, forecasted growth is 14-47 percent, depending on specialty.[3]

A 2011 statistical profile by Maryland Health Care Commission reported 326 freestanding ambulatory surgery facilities statewide of which 251 are single-specialty-ophthalmology. 53 of these are located in Montgomery County. The number of

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[2] Citations for both findings:
(http://www.asge.org/uploadedFiles/Members_Only/Practice_Management/Ambulatory%20Surgery%20Centers%20–20A%20Positive%20Trend%20in%20Health%20Care.pdf and http://www.ama-assn.org/resources/doc/clrpd/asc-tps.pdf)

[3] http://mhcc.dhmh.maryland.gov/hospital/Documents/hospital/acute/ambulatorysurgery/ambsurg_report_2012.pdf

outpatient ophthalmic surgeries increased 15.2% from 2007 to 2011.

PESC was formed in 2004, as a single-specialty-ophthalmology facility, by four well-established DC Metro area ophthalmologists, each with his or her own physician practice. In 2007, three additional partners joined partnership. One was an affiliated partner with a founding owner, and the other two were independent. Since that time, the ownership of the Center has remained unchanged. Exhibit 9 shows the Principal Partners for PESC.

Since 2007, each Principal Partner practice has grown. Not only has each physician owner increased their number of patients, and surgical caseload, they have added associates to their practices, which adds to the overall case volume and demand for operating room time. Since 2007, PESC operating room cases increased from 2,551 to 3,871, a 67% percent increase.

To date, the center is functioning at maximum capacity and is not able to offer operating room time to the associate surgeons who are currently credentialed at PESC. It is, therefore, necessary for them to schedule their cases at centers not affiliated with PESC or its owners. In 2013, PESC physicians reported that 407 operating room cases were performed outside which they would have performed at PESC had they had the opportunity to schedule them. (In addition, an additional surgeon being credentialed performed 800 cases, which he will bring to PESC when feasible.) These operation room cases were performed at Friendship Ambulatory Surgery Center, and Suburban, Shady Grove, George Washington, and Providence hospitals.

Table A shows the historical volumes by surgeon at PESC from 2011-2013.

Table A
Historical Volumes by Surgeon
PESC
2011-2013

	2011	2012	2013
Chu	311	227	335
Clinch	603	740	694
Frank	258	263	323
Kane	216	252	276
Kang	467	571	534
Martinez	562	530	477
Pluznik	300	345	376
Allen	80	77	107
Fischer	136	164	128
Gupta	30	1	35
Mayer	89	138	173
Vicente	1		
Zeller	21	22	23
Green-Simms		1	36
Nguyen		10	16
Cremers			12
Chaudhary			3
Gess			16
Yin			9
Schor			
Ghafouri			
Totals	3,074	3,341	3,573

Note: Shaded areas denote that the surgeon did not yet have privileges.
Source: PESC

Table B shows the current need for ORs at PESC. I shows that in 2013, PESC operated at well above optimal capacity and needs 1.46 ORs.

Table B
Current Need for ORs at PESC

Total Cases, 2013	3,573
Avg Minutes/Case, 2013	25
Total OR Minutes	89,325
Turn Around Time in Minutes/Case	15
Total TAT in Minutes	53,595
Total OR and TAT Minutes	142,920
Optimal Capacity/OR	97,920
Needed ORs	1.46

Table C shows the projected OR need at PESC. By 2017, PESC will need 2.65 ORs. Projections were based on the compound average annual growth rate ("CAGR") for established surgeons and for modest growth for newer surgeons. Average time per case was based on the average minutes per case shown in CON Formset Table 1 for 2011-2013. Turnaround Time is based on PESC's estimate of average Turnaround Time over the last few years.

Table C
Projected Need for ORs at PESC
2014-2017

	Compound Average Growth Rate	Basis for Projections	2014	2015	2016	2017
Chu	3.79%	CAGR	348	361	375	389
Clinch	7.28%	CAGR	745	799	857	919
Frank	11.89%	CAGR	361	404	452	506
Kane	13.04%	CAGR	312	353	399	451
Kang	6.93%	CAGR	571	611	653	698
Martinez	-7.87%	CAGR	439	405	373	344
Pluznik	11.95%	CAGR	421	471	528	591

Allen	15.65%	CAGR	124	143	166	191
Fischer	-2.99%	CAGR	124	120	117	113
Gupta	8.01%	CAGR	38	41	44	48
Mayer	39.42%	CAGR	241	336	469	654
Vicente	-100.00%	CAGR	-	-	-	-
Zeller	4.65%	CAGR	24	25	26	28
Green-Simms		5%, 15%, 25%, 15%	38	43	54	62
Nguyen		5%, 15%, 25%, 15%	17	19	24	28
Cremers		5%, 15%, 25%, 15%	13	14	18	21
Chaudhary		5%, 15%, 25%, 15%	3	4	5	5
Gess		5%, 15%, 25%, 15%	17	19	24	28
Yin		5%, 15%, 25%, 15%	9	11	14	16
Schor		5%, 15%, 25%, 15%	17	19	24	28
Ghafouri		Phase in of 800 Cases	100	600	800	800
Totals			3,961	4,800	5,421	5,918
Avg Minutes/Case			28.9	28.9	28.9	28.9
Total OR Minutes			114,485	138,710	156,659	171,044
Turn Around Time in Minutes/Case			15	15	15	15
Total TAT in Minutes			59,421	71,995	81,311	88,777
Total OR and TAT Minutes			173,906	210,705	237,970	259,822
Optimal Capacity/OR			97,920	97,920	97,920	97,920
Needed Ors			1.78	2.15	2.43	2.65

(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

CON Formset Table 1 (Statistical Projections) shows the number of operating room cases performed between 2011 – 2013 and the number of operating rooms

minutes. (This does not include the time it takes to turn over the operating room between cases.) Projected minutes are based on the average OR minutes per case in 2011 - 2013.

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

Please see the response to Standard 2(b)(i) above.

(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.

Please see the response to Standard 2(b)(i) above.

(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.

Please see Exhibit 10 which is a letter from the Architectural firm Hardaway Associates attesting that the surgical suite meets FGI Guidelines.

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

There are times when the physician finds it necessary to submit tissue samples for analysis or requests screening tests for their patients. PESC has longstanding agreements with two local lab processing facilities, LabCorp and LabQuest for tissue/specimen analysis. When samples, such as blood glucose is requested or required, PESC maintains CLEA Certification and performs screens such as glucose, on site. A copy of the CLEA Certification is attached. PESC does not have the occasion to refer patients for radiology and, therefore, has no need for radiology contracts.

(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;

Patient safety is a key consideration in this project. The increased number of operating rooms will allow Palisades Eye Surgery Center to minimize the number of surgeries performed in the late afternoons and evenings, times of day when industry studies have documented an increase in the incidence of medical errors. The new larger design of the ORs will also address current patient safety standards.

The ORs will be designed with layout similar to those in the existing center, which will minimize the necessity to train staff and allow staff to move from one suite to another with minimal chance of confusion or retraining, thus improving patient safety.

Architectural features to promote patient safety in Operating Rooms are consistent with the Guidelines for Design and Construction of Healthcare Facilities (2010 edition; adopted by the State of Maryland) and the Maryland Building Code. The proposed project will be built in strict accordance with those requirements. For example, finishes of the floors, walls, etc. are specified to maintain a sterile environment and minimize operative and post-operative infection risk. Similarly, mechanical filtration is designed to maintain optimum levels of air quality.

User input is being actively included in the design process through review of plans and input on equipment and design features of the ORs. Meetings have been held with the medical and nursing staff to discuss flow of sterile supplies and instruments, and patient flow. Specific consideration is being given to the lighting in each room to identify any opportunities to minimize staff and surgeon fatigue from that source while still maintaining the illumination levels necessary to conduct the procedures. PESC's project will also improve patient safety in the following ways:

Visibility of Patients

- Pre-Op/PACU Bays will be arranged around the nurse station with the support spaces off to the side. This provides direct visibility and proximity to each recovery bay.

Standardization

- Pre-Op/PACU bays will have a standardized layout to enhance patient safety.

Automation and Immediate Access to Information

- PESC plans to use an electronic medical information system to facilitate

physician order entry and electronic charting.

Scaleability/Adaptability

- Since this involves renovation of shell space, PESC has the opportunity to design the new space to meet the most current practices.

Noise Reduction

- To support infection control practices, all surfaces will be easily cleanable. Other than the acoustical ceiling tile, monolithic finish materials and easily scrub able fabrics will be used in the patient recovery and treatment areas. Sound absorbing cubicle curtain fabric will provide acoustical absorption for environments that must remain sterile.

Patient Involvement in Care

- PESC plans to use mobile and wireless charting systems which will allow better interaction between the staff and patient or family member directly at the point of care. Nurses and Physicians currently use computers at the nursing station.

Design for Vulnerable Patients

- The circulation within the proposed areas have been arranged to minimize the cross between outpatients, visitors, staff and materials. The OR Waiting space will be easily accessible to the entry/exit points for Prep/Recovery spaces. The OR Waiting space will also have a direct connection to the public elevator that leads to the parking area. PESC has arranged that patient parking spaces be directly adjacent to the elevator.

Efficient Use of Staff Time

- Location of documentation stations and support areas in each of the recovery areas will be centralized to provide close proximity to patient bays. Each nurse station countertop will be constructed for at sitting height to allow the nurse to sit while working.

FMEA (Failure Modes and Effects Analysis)

- PESC has not implemented an analysis tool such as FMEA, instead relying on scheduled design process reviews and interaction between the architect and experienced nurses, physicians, and administrators, relating to infection control, safety, housekeeping, security, information systems, and facilities management.

Design for Precarious Events

- Operative / Post-operative Complications
  - Standardized OR equipment layout
  - Immediate access to supplies
  - Proper HVAC air flow, changes and filtration
  - Sterile air field around OR table
  - Separation of sterile area and materials from and dirty area and materials
  - Patient tracking system

- Patient Falls
  - Patient visibility improved by centralized documentation stations
  - Slip resistant floor surfaces

(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.

The project costs/square foot are below the MVS benchmark for Outpatient Surgery Centers, as demonstrated below.

I. Marshall Valuation Service
Valuation Benchmark

Type		Outpatient (Surgical) Centers
Construction Quality/Class		A-B/Good
Stories		1
Perimeter		547
Height of Ceiling		14.33
Square Feet		9,178
f.1	Average floor Area	9,178
A. Base Costs		
	Basic Structure	358.66
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$358.66
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$358.66
C. Multipliers		
Perimeter Multiplier		1.00144736
	Product	$359.18
Height Multiplier (plus/minus from 12')		1.054
	Product	$378.43
Multi-story Multiplier (0.5%/story above 3)		1

Product	$378.43	
D. Sprinklers		
Sprinkler Amount	-	
Subtotal	$378.43	
E. Update/Location Multipliers		
Update Multiplier	1.02	12/13
Product	$386.00	
Location Multipier	1.07	10/13
Product	$413.02	
Final Square Foot Cost Benchmark	**$413.02**	

Cost of Renovation

II. The Project

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$2,050,000	$223.36
Fixed Equipment	In Building	
Site Preparation	$0	$0.00
Architectual Fees	$205,000	$22.34
Capitalized Construction Interest	$0	$0.00
Permits	$75,000	$8.17
Subtotal	$2,330,000	$253.87

III. Comparison

A. Adjusted Project Cost/Sq. Ft.	$253.87
B. Marshall ValuationService Benchmark	$413.02

(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.

The utilization projections are consistent with observed historic trends in use of the applicable service(s) by the likely service area population of the facility, based on the historical growth of the surgeons' caseloads. 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. 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 PESC.

As can be seen from CON Formset Table 1 (and discussed above), PESC projects that volumes will continue to grow. As CON Formset Table 3 shows, PESC is profitable and is projected to continue to be so.

A statement of assumptions is included in Exhibit 11.

(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.

Not applicable

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.

While the focus of practice has not changed significantly since 2004, the scope of practice has. Several factors influence the Center's demand for additional operating and procedural room accommodations. These include an aging population, organic growth of each Principal Partner's physician practice, and technology.

The primary service area for this facility will continue to include Montgomery County, Washington, D.C., and parts of Prince George's County and Northern Virginia. A 2013 assessment of patient zip codes indicates 64% of patients reside in Maryland, 18% Virginia, 17% Washington, D.C. and 1% resided in other areas.

According to the Claritas, the total population of PESC's Primary Service Area (the Zip Codes that comprise 60% of our patients, Zip Codes 20906, 20854, 20850, 20852, 20878, 20817, 20874, 20853, 20815, 20877, 20007, 20008, 20016, 20902, 20904, 20910, 20895, 20886, 20003, 20009, 20814, 20015, 20851, 20855, 20901, 22101, 20876, 20011, 20816, and 22182) is 1,134,678 and is projected to grow by 6.8% between 2014 and 2019. The population age 65 and older in the Primary Service area is 161,575 and is projected to grow by 22.7% between 2014 and 2019.

Table D
Population
PESC Primary Service Area
2010, 2014, and 2019

	Total Population	% Change	Age 65+	% Change
2010 Census	1,071,198		140,003	
2014 Estimate	1,134,678	5.9%	161,575	15.4%
2019 Projection	1,211,853	6.8%	198,231	22.7%

Source: Claritas

The need to expand the surgery facility is to keep up with health care trends and the demands of an aging population. Ophthalmology has the largest forecasts for surgical specialty (47% growth by 2020) and persons over the age of 65 are 8 times more likely the consumers of cataract surgery.

The expanded facility will provide the opportunity for current owners and their associates to provide cataract and other ophthalmic procedures to this growing population. As indicate previously in this proposal, the current practice has exhausted its ability to serve their current caseload.

Please see the response to Standard 2(b)(i) above.

[(INSTRUCTION: Complete Table 1 for the Entire Facility, including the proposed project, and Table 2 for the proposed project only using the space provided on the following pages. Only existing facility applicants should complete Table 1. All Applicants should complete Table 2. Please indicate on the Table if the reporting period is Calendar Year (CY) or Fiscal Year (FY)]

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)	20___	20___	20___	20___	20___	20___	20___
1. Admissions							
a. ICF-MR							
b. RTC-Residents							
Day Students							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
2. Patient Days							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___	20___	20___	
3. Average Length of Stay							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
4. Occupancy Percentage*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
5. Number of Licensed Beds*							
a. ICF-MR							
b. RTC-Residents							
c. ICF-C/D							
d. Other (Specify)							
e. TOTAL							
6. Home Health Agencies							
a. SN Visits							
b. Home Health Aide							
c. Other Staff							
d.							
e. Total patients srvd.							

Table 1 Cont.	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with first full year at full utilization)			
CY or FY (Circle)	2011	2012	2013	2014	2015	2016	2017
7. Hospice Programs							
a. SN visits							
b. Social work visits							
c. Other staff visits							
d.							
e. Total patients srvd.							
8. Ambulatory Surgical Facilities							
a. Number of operating rooms (ORs)	1	1	1	1	3	3	3
• Total Procedures in ORs	3,657	4,670	5,599	5,866	7,404	7,999	8,734
• Total Cases in ORs	3,074	3,341	3,573	3,961	4,800	5,421	5,918
• Total Surgical Minutes in ORs**	85,151	114,120	89,325	114,485	138,710	156,659	171,044
b. Number of Procedure Rooms (PRs)	1	2	2	2	2	2	2
• Total Procedures in PRs	833	1,693	2,055	2,157	2,697	2,967	3,263
• Total Cases in PRs	717	778	863	906	1,133	1,246	1,370
• Total Minutes in PRs**	8,300	16,960	20,550	17,271	21,598	23,752	26,121

*Number of beds and occupancy percentage should be reported on the basis of licensed beds.
**Do not include turnover time.

TABLE 2: STATISTICAL PROJECTIONS - PROPOSED PROJECT
(INSTRUCTION: All applicants should complete this table.)
Note: PESC is not providing Table 2 (which would be the same as Table 1) based on conversations with CON Staff on other projects. PESC recognizes that CON Staff has the right to request PESC to complete Table 2.

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20	20	20	20
1. Admissions				
a. ICF-MR				
b. RTC-Residents				
Day Students				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
2. Patient Days				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
3. Average Length of Stay				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
4. Occupancy Percentage*				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				

Table 2 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
5. Number of Licensed Beds				
a. ICF-MR				
b. Residential Treatment Ctr				
c. ICF-C/D				
d. Other (Specify)				
e. TOTAL				
6. Home Health Agencies				
a. SN Visits				
b. Home Health Aide				
c.				
d.				
e. Total patients served				
7. Hospice Programs				
a. SN Visits				
b. Social work visits				
c. Other staff visits				
d. Total patients served				
8. Ambulatory Surgical Facilities				
a. Number of operating rooms (ORs)				
• Total Procedures in ORs				
• Total Cases in ORs				
• Total Surgical Minutes in ORs**				
b. Number of Procedure Rooms (PRs)				
• Total Procedures in PRs				
• Total Cases in PRs				
• Total Minutes in PRs**				

*Do no include turnover time

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 that 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 the Commission should take into account.

PESC has four different alternatives.

1. Attempting to purchase a low volume existing single OR ASC in PESC's service area and re-locating it to the PESC site.

The Commission has not allowed single OR freestanding ASCs (which were established through CON exemptions) to merge without obtaining a CON. This option would be the same as the one chosen with the exception that it would have incurred the high cost of acquisition.

2. Attempting to purchase a low volume existing multi-OR ASF in PESC's service area, closing ASF, and re-locating the multi-OR ASC to the PESC site.

This is not a more effective or lower cost alternative for the same reason as above.

3. Do nothing

The alternative of seeking to care for these patients at other facilities is simply unrealistic. It is not cost effective for surgeons to be performing surgery at so many additional sites. As discussed in the Project Description, no other facility has the

breadth of technology that PESC has available. There is a need for familiarity with facility procedures and staff, confidence in recovery protocols and staff, and continuity of patient care. There is a benefit to the involved surgeons being able to collectively have oversight over the center, versus dividing their availability over the current center and other locations over which they have no oversight. It is also more efficient and effective for the multiple surgical practices to continue to collectively support this center versus each practice trying to establish a separate, duplicate center elsewhere. The expansion of this established, commonly owned and operated center is an efficient way to achieve quality results using updated technologies. If a surgical load is split between many facilities, the surgeon is unable to be an active participant in facility protocols, cannot rely on continuity of staff, and cannot be sure of continuity of facility-patient interactions. PESC has excelled in these areas and in patient orientation, which is why the physicians are so supportive and PESC's volumes have increased since it opened.

4. The existing project.

This project has a capital cost which is considerably lower than the MVS benchmark. It was designed to be implemented in the least costly way.

PESC has attempted to compare its charges to those of other facilities. First, charge data for other freestanding ASFs are not generally available. Even if the gross charges were listed on the facilities websites (PESC could not find such information), gross charges are irrelevant, since they are unrelated to what facilities actually are reimbursed. PESC believes that the Medicare reimbursement is the more appropriate measure among facilities, and the same patient obtaining the same procedures would be reimbursed the same at all such facilities in Montgomery County. Private insurance reimbursement is based on a percentage of Medicare reimbursement (for example,

120%) but varies among facilities based on whether the facilities are in insurance companies' networks and the nature of the contract between the insurance company and the facility.

One distinguishing factor, however, is that PESC charges Private Pay patients the Medicare reimbursement rate, a practice which PESC does not believe is the same at other facilities.

PESC has attempted to compare its Medicare Reimbursement/Private Pay charges to those of nearby hospitals. PESC used the charge list for common outpatient procedures that the MHCC requires hospitals to post on their websites. Table E shows the information that PESC was able to compare. Cataract Removal was the only comparable ophthalmic procedure that the hospitals listed in their common procedure lists. As shown in the table, PESC is considerably lower cost for Cataract Removal than both Shady Grove Adventist Hospital and Suburban Hospital.

Table E
Comparable Charges
PESC and Local Hospitals

PESC[4]	Extracapsular Cataract Removal with insertion of IOL	$1,003	Medicare Reimbursement/ Private Pay Charge
Shady Grove Adventist Hospital[5]	Extracapsular cataract removal w/insertion of intraocular lens prosthesis	$3,184	Average Charge
Suburban Hospital[6]	Cateract Removal	$9,271	Average Charge
Holy Cross Hospital[7]	No Comparable Procedure Listed		
Medstar Montgomery General Hospital	Could Not Find Charge List		

[4] Source: PESC Charge List
[5] Source: https://www.adventisthealthcare.com/app/files/public/364/pdf-SGAH-Billing-HospitalCharges.pdf
[6] Source: http://www.suburbanhospital.org/PatientsVisitors/documents/ChargesforSuburbanWebsite.pdf
[7] Source: http://www.holycrosshealth.org/documents/for_patients/HCH_ChargeEstimates_0713.pdf

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.

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

c. A discussion of the probable impact of the Project on the cost and charges for similar services at other facilities in the area.

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

PESC does not have audited financial statements. Exhibit 12 includes a letter from Deniz Unal, Vice President at PNC Bank, with which PESC has a long-standing relationship, attesting that PESC has the financial resources to fund the equity contribution for this project. In addition, Mr. Unal's letter states that PNC is interested in working with PESC to secure the necessary financing.

This project will have no impact on the charges at PESC. Ambulatory surgery reimbursement rates are set by Medicare, and other insurers' reimbursement is based on Medicare reimbursement. No reimbursement rates take into account capital expenditures.

Nor does PESC believe that this project will impact the costs or charges at any other facility, whose rates are also driven by Medicare reimbursement schedules. (See

10.24.01.08G(3)(f) Impact on Existing Providers for a full analysis of the cases to be transferred from existing facilities.)

A list of patient charges is included as Exhibit 2.

Letters of support are included in Exhibit 13.

(INSTRUCTIONS: Table 3, "Revenue and Expenses - Entire Facility (including the proposed project)" is to be completed by existing facility applicants only. Applicants for new facilities should not complete Table 3. Table 4, "Revenues and Expenses - Proposed Project," is to be completed by each applicant for the proposed project only. Table 5, "Revenues and Expenses (for the first full year of utilization", is to be completed by each applicant for each proposed service in the space provided. Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Medicaid revenues for all years should be calculated on the basis of Medicaid rates and ceilings in effect at the time of submission of this application. Specify sources of non-operating income. State the assumptions used in projecting all revenues and expenses.)

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

(INSTRUCTION: ALL EXISTING FACILITY APPLICANTS MUST SUBMIT AUDITED FINANCIAL STATEMENTS)

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)			
Calendar Year	2011	2012	2013	2014	2015	2016	2017
1. Revenue							
a. Inpatient Services							
b. Outpatient Services	6,422,073	7,222,270	8,116,857	8,522,700	10,653,375	11,718,712	12,890,585
c. Gross Patient Services Revenues	6,422,073	7,222,270	8,116,857	8,522,700	10,653,375	11,718,712	12,890,585
d. Allowance for Bad debt	25,351	35,513	35,271	37,035	37,195	50,923	56,015
e. Contractual Allowance	2,157,829	2,495,020	3,207,410	3,367,781	4,209,726	4,630,698	5,093,769
f. Charity Care	16,921	13,324	37,335	52,611	64,795	74,722	81,045
g. Net Patient Services Revenue	4,221,972	4,678,413	4,836,841	5,078,683	6,348,354	6,983,189	7,681,509
h. Other Operating Revenues (Specify)	-	443,475	480,575	504,604	630,755	693,830	763,213
i. Net Operating Revenues	4,221,972	5,121,888	5,317,416	5,583,287	6,979,108	7,677,019	8,444,721

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)			
Calendar Year	2011	2012	2013	2014	2015	2016	2017
2. Expenses							
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	$ 834,731	$ 791,128	$ 919,439	$1,055,622	$1,274,408	$1,699,211	$1,869,132
b. Contractual Services	84,172	123,404	26,754	30,717	37,083	49,444	54,388
c. Interest on Current Debt	10,284	6,657	2,671	-	-	-	-
d. Interest on Project Debt			-	119,454	104,234	88,235	67,306
e. Current Depreciation	107,478	37,411	112,000	112,000	112,000	112,000	112,000
f. Project Depreciation			-	28,115	140,575	140,575	140,575
g. Current Amortization	10,069	10,069	10,069	-	-	-	-
h. Project Amortization			-	129,805	288,630	369,372	389,888
i. Supplies	1,747,149	2,343,367	2,302,359	2,417,477	3,021,846	3,324,031	3,656,434
j. Other Expenses (Specify)	496,816	628,258	659,473	692,447	865,558	952,114	1,047,326
k. Total Operating Expenses	3,290,699	3,940,294	4,032,765	4,384,224	5,399,564	6,226,872	6,753,755
3. Income							
a. Income from Operation	931,273	1,181,594	1,284,651	1,199,063	1,579,544	1,450,147	1,690,966
b. Non-Operating Income							
c. Subtotal	931,273	1,181,594	1,284,651	1,199,063	1,579,544	1,450,147	1,690,966
d. Income Taxes							
e. Net Income (Loss)	$931,273	$1,181,594	$1,284,651	$1,199,063	$1,579,544	$1,450,147	$1,690,966

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)			
Calendar Year	2011	2012	2013	2014	2015	2016	2017
4. Patient Mix: **A. Percent of Total Revenue**							
1) Medicare	37%	34%	41.0%	38.0%	38.0%	39.0%	39.0%
2) Medicaid	2%	3%	2.0%	1.0%	1.0%	1.0%	1.0%
3) Blue Cross	10%	16%	15.0%	16.0%	16.0%	16.0%	16.0%
4) Commercial Insurance	38%	37%	30.0%	33.0%	34.0%	33.0%	33.0%
5) Self Pay	13%	10%	12.0%	12.0%	11.0%	11.0%	11.0%
6) Other (Managed care)	0%	0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)							
1) Medicare	48.0%	19.0%	51.0%	50.0%	50.0%	50.0%	50.0%
2) Medicaid	2.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
3) Blue Cross	7.0%	14.0%	13.0%	14.0%	14.0%	14.0%	14.0%
4) Commercial Insurance	39.0%	31.0%	30.0%	32.0%	32.0%	32.0%	32.0%
5) Self Pay	4.0%	5.0%	5.0%	3.0%	3.0%	3.0%	3.0%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	70.0%	100.0%	100.0%	100.0%	100.0%	100.0%

TABLE 4: REVENUES AND EXPENSES - PROPOSED PROJECT

(INSTRUCTION: Each applicant should complete this table for the proposed project only)

Note: PESC is not providing Table 4 (which would be the same as Table 3) based on conversations with CON Staff on other projects. PESC recognizes that CON Staff has the right to request PESC to complete Table 4.

	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20__	20__	20__	20__
1. Revenues				
a. Inpatient Services				
b. Outpatient Services				
c. Gross Patient Services Revenue				
d. Allowance for Bad Debt				
e. Contractual Allowance				
f. Charity Care				
g. Net Patient Care Service Revenues				
h. Total Net Operating Revenue				
2. Expenses				
a. Salaries, Wages, and Professional Fees, (including fringe benefits)				
b. Contractual Services				
c. Interest on Current Debt				
d. Interest on Project Debt				
e. Current Depreciation				
f. Project Depreciation				
g. Current Amortization				
h. Project Amortization				
i. Supplies				
j. Other Expenses (Specify)				
k. Total Operating Expenses				

Table 4 Cont.	Projected Years (Ending with first full year at full utilization)			
CY or FY (Circle)	20___	20___	20___	20___
3. Income				
a. Income from Operation				
b. Non-Operating Income				
c. Subtotal				
d. Income Taxes				
e. Net Income (Loss)				
4. Patient Mix: A. Percent of Total Revenue				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%
5. Ambulatory Surgical Facilities				
1. Medicare				
2. Medicaid				
3. Blue Cross				
4. Commercial Insurance				
5. Self-Pay				
6. Other (Specify)				
7. TOTAL	100%	100%	100%	100%

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 1995, and their status.

None

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.

Table F shows the cases that surgeons at Palisades performed in 2013 outside the surgical center that would likely be performed at Palisades once Palisades has adequate capacity.

Table F
Cases Performed by PESC Surgeons at Other Facilities
2013

Name	Name of ASF	2013 OR Cases Performed in Outside ASF	Name of Hospital	2013 OR Cases Performed in Outside Hospital	Total
Chu					0
Clinch					0
Frank			Suburban	3	3
Kane					0
Kang					0
Martinez			Shady Grove	11	35
Pluznik					0
Allen					0
Chaudhary	Friendship Ambulatory Surgery Center	39			39
Cremers	NA	9			9
Fischer					0
Gess			George Washington	2	2
Green-Simms	Friendship Ambulatory Surgery Center	27			27
Gupta					0
Mayer	Friendship Ambulatory Surgery Center	70			70
Nguyen					0
Yin					0
Zeller			Shady Grove	260	260
Ghafouri			Providence Hospital	800	800
Totals		145		1,062	1,207

The MHCC Public Use Data for 2011 show that The Friendship Ambulatory Surgery Center, P.C. had 4,880 OR cases. The 136 cases that PESC expects would now occur at Palisades are only 2.8% of Friendship's volume. In the most recent HSCRC Annual Report of Revenue, Expenses and Volume (for FY 2013, downloaded from http://www.hscrc.state.md.us/hsp_Data2.cfm on 12/27/13), Suburban Hospital reported having 6,428 Same Day Surgery ("SDS") Cases. Shady Grove Adventist Hospital reported having 12,090 SDS cases. Palisades does not have data on either

ASFs or hospitals located in Washington, D.C. or Northern Virginia.

PESC believes that these data show that no facility or hospital will be adversely affected by this expansion.

PESC does not usually have any difficulty recruiting staff. PESC uses the following resources in recruitment.

- Positions are posted on the PESC website,
- Employee Referrals,
- Online (Craigslist, CareerBuilder, Indeed),
- Nurse magazines, and
- Newspaper advertisements

In 2013, PESC's Vacancy Rate was 1.5%. Its Turnover Rate was 45%. PESC's high Turnover Rate in 2013 was caused by several nursing staff going on maternity leave and one replacement not passing the probationary period. With only 11 FTEs of nursing staff (see Table 5), a small number of turnovers can result in a high Turnover Rate.

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 FTE	Change FTE	Proposed FTE	Base Salary	Employee/ Contractual	Total Salary
Administration							
	Director	1.0		1.0	$105,000	Employee	$105,000
	Nurse Manager	1.0		1.0	$79,040	Employee	$79,040
	Office Manager		+1.0	1.0	$62,400	Employee	$62,400
Support							
	Receptionist	1.0		1.0	$35,360	Employee	$35,360
	Account Payable	1.0		1.0	$39,520	Employee	$39,520
	Scheduling	1.0		1.0	$37,440	Employee	$37,440
	Medical Assistant I	0.3		0.3	$24,960	Employee	$6,240
Direct Patient							
	Pre Operative RN	1.0	+1.0	2.0	$72,800	Employee	$145,600
	Post Operative RN	1.0	+1.0	2.0	$72,800	Employee	$145,600
	Operating Room RN	1.0	+2.0	3.0	$72,800	Employee	$218,400
	Medical Assistant I	1.0	+1.0	2.0	$24,960	Employee	$49,920
	Medical Assistant II	1.0	+2.0	3.0	$41,600	Employee	$124,800
	Medical Assistant III	1.0		1.0	$45,760	Employee	$45,760
	Medical Assistant III	1.0		1.0	$45,760	Employee	$45,760
	Scrub Technician Lead	1.0		1.0	$72,800	Employee	$72,800
	Scrub Technician	1.0	+1.5	2.5	$52,000	Employee	$130,000
PRN							
	RN	1.0		1.0	$72,800	Employee	$72,800
Contract Labor							
	Temporary RN or Scrub	0.0	1.0	1.0	-		-
Total		15.25	10.5	25.75	$957,800		$1,416,440
Benefits							$244,451
Total							$1,660,891

(INSTRUCTION: Indicate method of calculating benefits percentage):

17.3%

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

1. List the name and address of each owner or other person responsible for the proposed project and its implementation. If the applicant is not a natural person, provide the date the entity was formed, the business address of the entity, the identify and percentage of ownership of all persons having an ownership interest in the entity, and the identification of all entities owned or controlled by each such person.

   Please see Exhibit 9.

2. Is the applicant, or any person listed above now involved, or ever been involved, in the ownership, development, or management of another health care facility? If yes, provide a listing of each facility, including facility name, address, and dates of involvement.

   No

3. Has the Maryland license or certification of the applicant facility, or any of the facilities listed in response to Questions 1 and 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, owner or other person responsible for implementation of the Project was not involved with the facility at the time a suspension, revocation, or disciplinary action took place, indicate in the explanation.

   No

4. Is any facility with which the applicant is involved, or has any facility with which the applicant or other person or entity listed in Questions 1 & 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 an action to suspend, revoke or limit the licensure or certification at any facility. 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 reached by the applicable governmental authority.

No

5. Has the applicant, or other person listed in response to Question 1, above, ever pled guilty to or been convicted of a criminal offense connected in any way with the ownership, development or management of the applicant facility or any health care facility listed in response to Question 1 & 2, above? If yes, provide a written explanation of the circumstances, including the date(s) of conviction(s) or guilty plea(s).

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 authorized agent of the applicant for 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.

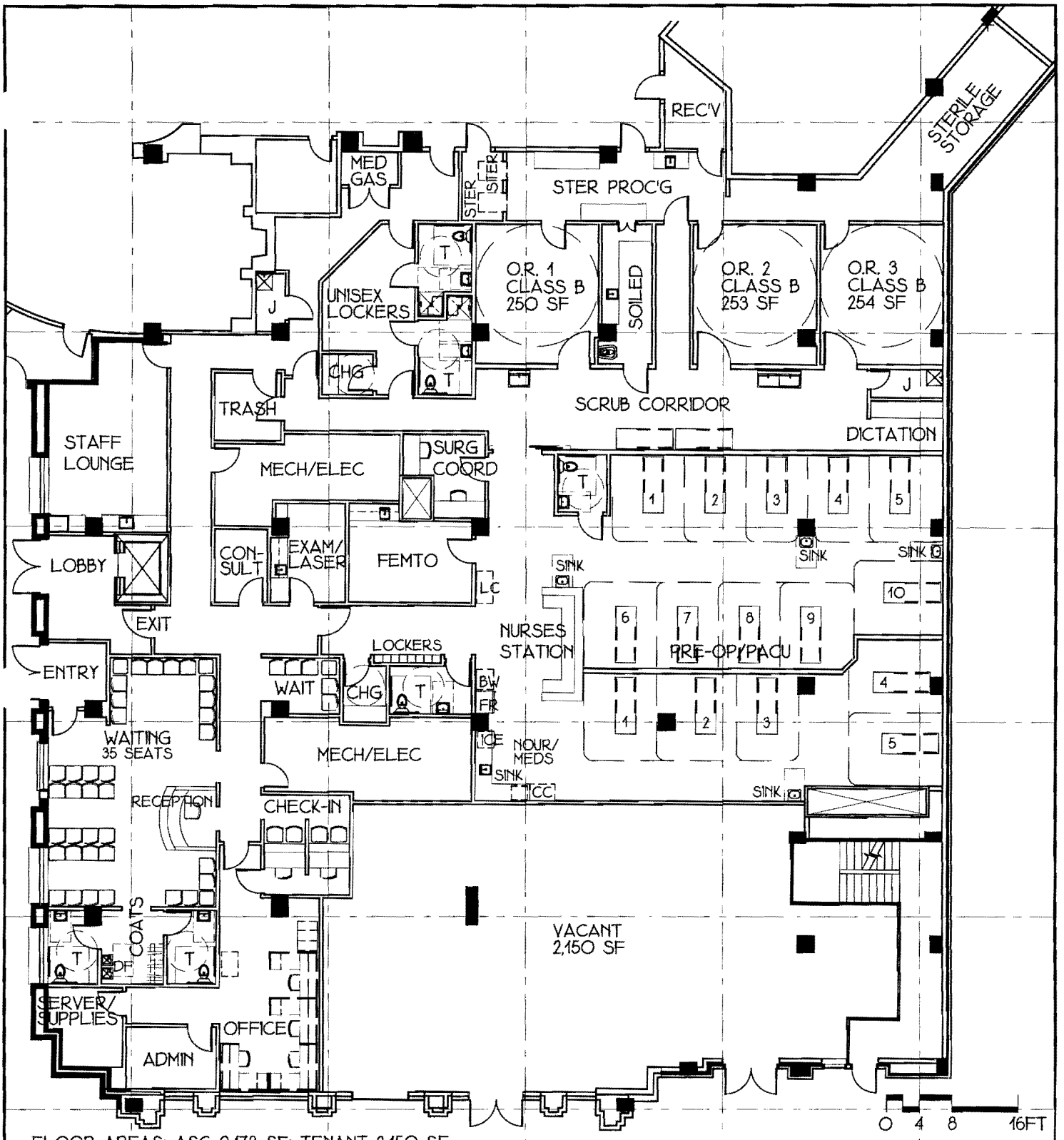
December 30, 2013
Date

Signature of Owner or
Authorized Agent of the Applicant

Exhibits

1. Project Drawings
2. PESC's Facility Fee Schedule
3. Charity Care Policy
4. Photo of Posted Charity Care Notice
5. DHMH License
6. American Association for Accreditation of Ambulatory Surgery Facilities, Inc. Certification
7. Transfer Agreement
8. Service Area Zip Codes
9. PESC Principle Partners List
10. Architectural Letter Regarding FGI Guidelines
11. Statement of Assumptions
12. PNC Bank Letter
13. Letters of Support
14. Affirmations

Exhibit 1
Project Drawings



FLOOR AREAS: ASC 9,178 SF; TENANT 2,150 SF

Hardaway Associates
Architects

47 River Street, Suite 200
Wellesley, Massachusetts
02481

Phone 781-235-5339
FAX 781-235-5329

Project Name: Palisades Eye Surgery Center
BETHESDA, MD

Drawing Title: FLOOR PLAN

Sheet No.: 13.19 010214 PLAN1

Project No.: 13.19
Date: 01/02/14
Scale: 1/16"=1'-0"
Drawn by: MWB
Checked by: RTH
Drawing No.:

Exhibit 2
PESC's Facility Fee Schedule

Palisades Eye Surgery 2013 Fee Schedule

CPT	Description	Self pay Fee	Ins. Charge	Medicare Allowable
11441	Excision, other benign lesion including margains; excosed diam. 0.6 to 1.0cm	$111	$193.97	$110.84
15120	Split Graft	$896	$1,567.51	$895.72
15821	Blepharoplasty, Lower Lid	$896	$1,567.51	$895.72
15823	Blepharoplasty, Upper Lid	$896	$1,567.51	$895.72
65210	Removal of foreign body, external eye; conjunctival embedded	$37	$65.07	$37.18
65285	Repair of laceration; cornea and/or sclera, perforating, with repo. Of uvealtiss	$1,721	$3,011.63	$1,720.93
65286	Repair of laceration; application of tissue glue, wounds of cornea and/ or sclera	$303	$530.37	$303.07
65400	Excision of lesion, cornea(keratectomy,lamellar,partial) except pterygium	$697	$1,220.21	$697.26
65410	Excision of lesion, Biopsy of cornea	$697	$1,220.21	$697.26
65426	Excision Or Transposition of Pterygium; with Graft	$978	$1,710.78	$977.59
65435	Removal of corneal epithelium; with or without chemocauterization	$45	$78.70	$44.97
65730	Keratoplasty(Corneal Transplant);Penetrating	$1,591	$2,784.57	$1,591.18
65750	Keratoplasty(Corneal Transplant);Pentrg. Aphakia	$1,591	$2,784.57	$1,591.18
65755	Keratoplasty(Corneal Transplant);Pentrg. Pseudophakia	$1,591	$2,784.57	$1,591.18
65756	Kerotoplasty(Cornel Transplant);Endothelial	$1,591	$2,784.57	$1,591.18
65772	Limbal Relaxing Incision (LRI)	$697	$1,220.21	$697.26
65779	Placement of Amniotic membrane single layer, sutured	$697	$1,220.21	$697.26
65780	Ocular Surface Reconstruction;Amnio Membrane Trans.	$1,591	$2,784.57	$1,591.18
65850	Trabeculectomyabeterno	$978	$1,710.78	$977.59
65855	Trabeculeoplasty by laser surgery (MLT & SLT)	$188	$328.44	$187.68
65865	Severing adhesions of anterior segment of eye; goniosynechiae	$697	$1,220.21	$697.26
65875	Severing adhesions of anterior segment of eye; posterior synechiae	$978	$1,710.78	$977.59
65920	Removal of implanted material, anterior segment of eye	$978	$1,710.78	$977.59
66170	Fistulization of sclera for glaucoma; Trabeculectomy	$978	$1,710.78	$977.59
66172	Fistulization of sclera for glaucoma; Trabeculectomyabexterno w/scarring	$978	$1,710.78	$977.59

66180	Aqueous Shunt to extraocular reservoir	$1,748	$3,058.65	$1,747.80
66185	Revision of aqueous shunt to extraocular reservoir	$978	$1,710.78	$977.59
66250	Revision or repair of operative wound of anterior segment	$697	$1,220.21	$697.26
66680	Repair of Iris, Ciliary body(as for iridodialysis)	$978	$1,710.78	$977.59
66682	Suture of iris, ciliary body(sperateprocedure)w/ retrieval of suture	$978	$1,710.78	$977.59
66710	Ciliary body destruction; Transcleral cyclophotocoagulation	$697	$1,220.21	$697.26
66711	Ciliary body destruction; Endoscopic cyclophotocoagulation (ECP)			
66761	Iridotomy/iridectomy by laser surgery	$199	$348.27	$199.01
66821	Discission of secondary membranous (YAG LASER)	$227	$397.62	$227.21
66840	Removal of lens material	$697	$1,220.21	$697.26
66850	Removal of lens material;phacofragmentation technique, with aspiration	$1,301	$2,277.31	$1,301.32
66982	Extracapsular Cataract Removal with insertion of IOL	$1,003	$1,754.69	$1,002.68
66984	Cataract Extraction with IOL	$1,003	$1,754.69	$1,002.68
66985	Secondary IOL Exchange	$1,003	$1,754.69	$1,002.68
66986	Exchange Of IOL	$1,003	$1,754.69	$1,002.68
67005	Removal of vitreous, anterior approach; partial removal	$906	$1,585.80	$906.17
67010	Removal of vitreous,anterior approach; subtotal removal with mech. Vitrec	$1,721	$3,011.63	$1,720.93
67036	Vitrectomy, mechanical,parsplana approach	$1,721	$3,011.63	$1,720.93
67120	Removal of implanted material, posterior segment; extraocular	$906	$1,585.80	$906.17
67255	Scleral reinforcement with graft	$906	$1,585.80	$906.17
67311	Strabismus surgery, recession or resection procedure; 1 horizontal muscle	$1,045	$1,828.80	$1,045.03
67314	Strabismus surgery, recession or resection procedure; 1 vertical muscle	$1,045	$1,828.80	$1,045.03
67343	Release of extensive scar tissue without detaching	$1,045	$1,828.80	$1,045.03
67715	Canthotomy	$825	$1,443.61	$824.92
67840	Excision of lesion of eyelid without closure or with simple direct closure	$198	$346.41	$197.95
67880	Construction of intermarginal adhesions	$697	$1,220.21	$697.26
67900	Repair of brow ptosis	$1,143	$2,001.02	$1,143.44
67901	Repair of blepharoptosis; frontalismusle	$825	$1,443.61	$824.92

	technique with suture			
67904	Repair of blepharoptosis;(tarso) levator resection or advancement	$825	$1,443.61	$824.92
67908	Repair of blepharoptosis; conjunctivo-tarso-mullersmuslelevator resection	$825	$1,443.61	$824.92
67911	Correction of lid retraction	$825	$1,443.61	$824.92
67917	Repair of ectropion; extensive	$825	$1,443.61	$824.92
67923	Repair of entropion; excision tarsal wedge	$825	$1,443.61	$824.92
67924	Repair of entropion; extensive	$825	$1,443.61	$824.92
67935	Suture of recent wound, full thickness	$825	$1,443.61	$824.92
67950	Canthoplasty (reconstruction of canthus)	$825	$1,443.61	$824.92
67961	Excision and repair of eyelid 1/4 of lid margin	$825	$1,443.61	$824.92
67966	Excision and repair of eyelid over 1/4 of lid margin	$825	$1,443.61	$824.92
68130	Excision of lesion, conjunctiva; with adjacent sclera	$697	$1,220.21	$697.26
68320	Conjunctivoplasty; with conjuctival graft	$1,143	$2,001.02	$1,143.44
68326	Conjuntivoplasty, reconstruction cul-de-sac; with conjunctival graft	$825	$1,443.61	$824.92
68440	Snip incision of lacrimal punctum	$66	$115.89	$66.22
68840	Probing of lacrimal canaliculi, with or without irrigation	$78	$136.33	$77.90
0191T	Insertion of anterior segment aqueous drainage device (Express glaucoma device) iStent	$1,748	$3,058.65	$1,747.80

Exhibit 3
Charity Care Policy

Section 2-1 Medical Financial Assistance Program

Palisades Eye Surgery Center is committed to improving health care access for medically necessary care, to uninsured and underinsured persons, by waiving or reducing their fees for services provided at the facility. Each applicant for financial assistance or reduced fee must meet criteria as set by PESC Medical Financial Assistance Program and federal guidelines. PESC medical financial assistance is not a substitute for employer-sponsored, public, or individually purchased insurance.

1. PESC Medical Financial Assistance Program shall meet Maryland Health Care Commission's expected level for the population in the service area, measured as 1.2 percent of total expenses, in the most recent year reported.
2. Public notice and information regarding the facility's charity care policy shall be published in the *Montgomery Gazette* on an annual basis. Notices regarding PESC's Medical Financial Assistance policy shall be posted in PESC's registration area and business office and on the company website; www.palisadeseye.com.
3. Individual notice of the availability of medical assistance shall be provided to persons by way of their PESC surgeon's pre-operative education and paperwork.
4. Request for financial assistance must be made at least 5 days prior to service being rendered. To request assistance, persons must complete a PESC Medical Financial Assistance Application (see attached).
5. PESC will address any financial concerns of persons not less than 2 days prior to a person's arrival for surgery.
6. Eligibility is based on federal financial need. These guidelines may be found on the website for the US Department of Health and Human Services: http://aspe.hhs.gov/poverty.
    i. Persons with family income below 100 percent of the current poverty level 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.
    ii. 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.
    iii. Proof of income and verification of the number of dependents based upon the previous year's tax return must be provided. If this is not available, the last two months paycheck stubs will be accepted. Dependents must meet IRS definition of dependents to qualify as household members.
    iv. Proof that Medical Assistance has been applied for and rejected. If the rejection is for non-compliance with all Medical Assistance paperwork requirements, reduced fee or charity will not be granted. If Medical Assistance rejection is based on income, disability, or assets, PESC will review person's Medical Financial Assistance Application. If the person has not yet applied for Medical Assistance, PESC staff will assist the person with the application.

Financial Qualifications

(Assumes a Family of Two)

Family Income	Discount Rate
<$15,510	100%
$15,510-$19,388	30%
$19,389-$23,265	20%
$23,266-$27,143	15%
$27,144-$31,020	10%
>$31,020	0%

Exhibit 4
Photo of Posted Charity Care Notices

Medical Financial Assistance Program (MFAP)

What is the MFAP?

MFAP waives or reduces fees for services provided at PESC for eligible patient.

Who is eligible?

Individuals who have exhausted all other sources of payment including insurance, public assistance, or funds from legal settlements. All insurance benefits must be exhausted before financial assistance approval will be granted.

Who do I contact?

For more information contact your eye physician before your surgery date.

Where do I apply?

To obtain an application you may ask your eye doctor or print one out at www.palisadeseye.com/Forms

Programa de Asistencia Médica Financiera (PAMF)

¿Qué es PAMF?

PAMF renuncia o reduce los pagos por los servicios administrados en PESC a los pacientes que son elegibles.

¿Quién es elegible?

Los pacientes que han extenuado todas otras fuentes de pago, incluyendo seguros de salud, asistencia pública, o los fondos de los establecimientos legales. Todos los beneficios del seguro deben ser agotados antes de que se concede la aprobación de asistencia financiera.

¿A quién contactó para más información?

Para más información póngase en contacto con su oftalmólogo antes de su cirugía.

¿Adónde puedo aplicar?

Para obtener un formulario, pregúntale a su oftalmólogo por una aplicación o imprime una copia en www.palisadeseye.com/Forms.

Exhibit 5
DHMH License

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. A1406

Issued to: PALISAIDES EYE SURGERY CENTER
4818 DEL RAY AVENUE, FIRST FLOOR
BETHESDA, MD 20814

Type of Facility or Community Program: AMBULATORY SURGICAL CENTER

Date Issued: DECEMBER 21, 2013

SPECIALTIES: OPHTHALMOLOGY

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Annotated Code of Maryland, including all applicable rules and regulations promulgated there under. This document is not transferable.

Expiration Date: DECEMBER 21, 2016

Patricia Tomko May, MD
Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

Exhibit 6
American Association for Accreditation of Ambulatory Surgery Facilities, Inc.
Certification

AMERICAN ASSOCIATION FOR ACCREDITATION OF AMBULATORY SURGERY FACILITIES, INC.
ACCREDITATION OFFICE: 5101 Washington Street, Suite 2F • P.O. Box 9500, Gurnee, Illinois 60031 • Toll Free 1-888-545-5222
Phone 847-775-1970 Fax 847-775-1985 • E-mail: info@aaaasf.org • Web Site: www.aaaasf.org

10/10/2012

Final Accreditation Decision Letter

Dear: Robert Chu M.D.

Thank you for participating in this important process, this report contains information relevant to your accreditation. Please note that AAAASF requires that all standards be met in order to achieve accreditation and that 100% compliance must be maintained at all times. Your FinalAccreditation Decision is Full

Survey Details Below

Survey: 4309

Program AAAASF Surgical

Facility Number: 3232

Mailing: Rockville Eye Surgery Center

4818 Del Ray Ave. Attn: Penelope Williams

Survey Type: Full Accreditation Survey

Bethesda, MD 20814

Request Type: Re-Survey

United States

Survey Begin: 10/5/2012

Survey End: 10/5/2012

Accreditation Decision: Full

Expiration Date: 11/11/2014

Plan of Correction Time Frame:

Follow-up Method:

Effective Date of Accreditation: 11/11/2012

Recent Survey History:

Exhibit 7
Transfer Agreement

TRANSFER AGREEMENT

This TRANSFER AGREEMENT is made effective this 20th day of January 2012, by and between SUBURBAN HOSPITAL, INC., a Maryland corporation (hereinafter referred to as the "Hospital"), which owns and operates and acute-care hospital located in Bethesda, Maryland, and PALISADES EYE SURGERY CENTER, a Maryland corporation (hereinafter referred to as the "Facility").

To facilitate continuity of care and the timely transfer of residents/patients between the Hospital and the Facility, the parties do hereby agree as follows:

1. In the event a resident/patient of the Facility requires hospitalization at the Hospital, the Hospital agrees to accept the resident/patient, provided that beds are otherwise available and the Hospital has the appropriate facilities and services requires to treat the resident/patient. Except in the case of emergencies, all decisions to admit resident/patients of the Facility to the Hospital shall be made by the resident/patient's private attending physician. The Facility agrees that at such time as resident/patient's attending physician determines that the resident/patient no longer needs acute in-patient care at the Hospital, thee resident/patient will be transferred back to the Facility, and the Facility will accept the resident/patient back and be responsible for further placement.
2. The transferring institution will send with each resident/patient at the time of transfer, or in the case of emergency, as promptly as possible, all medical records and other information necessary and useful in the care and treatment of such resident/patient transferred between institutions.
3. It shall be the responsibility of the resident/patient's attending physician to determine the safest and most appropriate means of transportation and to determine the type of care to be render during transfer. It shall be the responsibility of the institution initiating the transfer to arrange for safe and appropriate transportation in accordance with the orders of the attending physician.
4. The transferring institution will be responsible for the transfer or other appropriate disposition of personal effects, particularly money and valuables.
5. Each party to the Agreement is solely responsible for all matters pertaining to billing and collecting its own resident/patient charges. Neither party shall have any liability to the other for such charges.
6. Neither party by virtue of this Agreement assumes any liability for any debts or obligations of either a financial or legal nature incurred by the other party to the Agreement.

7. The Facility agrees to reserve space for the resident/patient to return to the Facility upon discharge from the Hospital and to accept the resident/patient back if return to the Facility is determined to be the appropriate placement on discharge.
8. Nothing in this Agreement shall be construed as limiting the rights of either party to affiliate or contract with any other institution while this Agreement is in effect.
9. Neither party shall use the name of the other party in any promotion pr advertising unless prior written approval of the intended use is obtained from the party whose name is to be used.
10. This Agreement supersedes any prior agreements between the parties. This Agreement may be modified or amended from time to time by mutual agreement of the parties and such modifications or amendments shall be in writing and signed by both parties. This Agreement may not be assigned by either party without the prior written consent of the other. This Agreement shall be construed and enforced in accordance with the laws of the State of Maryland.
11. This Agreement shall commence as of the date set forth above and shall continue in effect until terminated. This Agreement may be terminated by either party at any time by providing the other party thirty (30) days' prior written notice of termination. This Agreement shall be automatically terminated if either party shall fail to maintain its license or certification.

Attest:

_____ Jacqueline Sully

Suburban Hospital, Inc.

_____

Palisades Eye Surgery Center

Penelope Williams RN, Director

Exhibit 8
Service Area Zip Codes
(FY 2013)

State	Zip Code	Cases	%	Cumulative %
MD	20906	212	5.3%	5.3%
MD	20854	162	4.1%	9.4%
MD	20850	141	3.5%	12.9%
MD	20852	140	3.5%	16.4%
MD	20878	139	3.5%	19.9%
MD	20817	104	2.6%	22.5%
MD	20874	102	2.6%	25.0%
MD	20853	101	2.5%	27.5%
MD	20815	99	2.5%	30.0%
MD	20877	94	2.4%	32.4%
DC	20007	90	2.3%	34.6%
DC	20008	85	2.1%	36.7%
DC	20016	80	2.0%	38.7%
MD	20902	80	2.0%	40.7%
MD	20904	68	1.7%	42.4%
MD	20910	64	1.6%	44.0%
MD	20895	56	1.4%	45.4%
MD	20886	52	1.3%	46.7%
DC	20003	51	1.3%	48.0%
DC	20009	49	1.2%	49.2%
MD	20814	49	1.2%	50.5%
DC	20015	47	1.2%	51.6%
MD	20851	46	1.2%	52.8%
MD	20855	45	1.1%	53.9%
MD	20901	45	1.1%	55.0%
VA	22101	44	1.1%	56.1%
MD	20876	42	1.1%	57.2%
DC	20011	39	1.0%	58.2%
MD	20816	36	0.9%	59.1%
VA	22182	36	0.9%	60.0%
VA	22207	35	0.9%	60.8%
DC	20037	34	0.9%	61.7%
MD	20832	34	0.9%	62.5%
VA	22003	33	0.8%	63.4%
DC	20002	32	0.8%	64.2%
MD	20879	32	0.8%	65.0%
VA	22201	30	0.8%	65.7%
MD	20912	29	0.7%	66.4%
MD	20783	28	0.7%	67.1%
VA	22304	27	0.7%	67.8%

MD	20903	26	0.7%	68.5%
VA	22314	25	0.6%	69.1%
VA	22102	23	0.6%	69.7%
DC	20010	21	0.5%	70.2%
MD	20837	21	0.5%	70.7%
DC	20001	20	0.5%	71.2%
DC	20020	20	0.5%	71.7%
VA	22043	20	0.5%	72.2%
MD	20774	19	0.5%	72.7%
MD	20706	18	0.5%	73.1%
MD	20882	18	0.5%	73.6%
MD	20871	17	0.4%	74.0%
VA	22015	16	0.4%	74.4%
DC	20012	15	0.4%	74.8%
MD	20841	15	0.4%	75.2%
VA	22030	15	0.4%	75.5%
MD	20707	14	0.4%	75.9%
MD	20740	14	0.4%	76.2%
MD	20905	14	0.4%	76.6%
VA	22032	14	0.4%	76.9%
DC	20005	13	0.3%	77.3%
MD	20747	13	0.3%	77.6%
MD	20748	13	0.3%	77.9%
MD	20782	13	0.3%	78.2%
VA	20171	13	0.3%	78.6%
VA	20191	13	0.3%	78.9%
DC	20017	12	0.3%	79.2%
DC	20019	12	0.3%	79.5%
VA	22180	12	0.3%	79.8%
VA	22204	12	0.3%	80.1%
DC	20024	11	0.3%	80.4%
VA	20190	11	0.3%	80.6%
VA	22042	11	0.3%	80.9%
VA	22150	11	0.3%	81.2%
VA	22202	11	0.3%	81.5%
VA	22203	11	0.3%	81.7%
MD	20735	10	0.3%	82.0%
MD	20744	10	0.3%	82.2%
MD	21701	10	0.3%	82.5%
VA	22039	10	0.3%	82.7%
VA	22152	10	0.3%	83.0%
VA	22302	10	0.3%	83.2%
DC	20032	9	0.2%	83.5%

MD	20770	9	0.2%	83.7%
MD	21771	9	0.2%	83.9%
VA	20147	9	0.2%	84.1%
VA	22124	9	0.2%	84.4%
VA	22206	9	0.2%	84.6%
VA	22209	9	0.2%	84.8%
VA	22311	9	0.2%	85.0%
VA	22312	9	0.2%	85.3%
	235 other Zips	589	14.7%	
Total		3,999		

Exhibit 9
Principal Partners

Principal Partners

Robert Chu, MD (Medical Director)
6333 Executive Blvd
Rockville, MD 20852
phone: (301) 770-2020
fax: (301) 770-9038
drrobchu@hotmail.com

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2 Wisconsin Circle, Suite 230
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fax: (301) 215-4144
tclinch@edow.com

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lfrankmd@gmail.com

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jalbertom@comcast.net

Daniel Pluznik, MD
1133 20th St NW, Suite B-150
Washington, DC 20036
phone: (202) 296-4900
fax: (202) 293-3409
dpluznik@gmail.com

Exhibit 10
Architectural Letter Regarding FGI Guidelines

Hardaway
Associates Inc.
Architects

47 River Street
Suite 200
Wellesley, MA
02481

31 December 2013

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

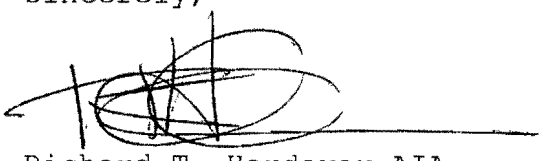
RE: Palisades Eye Surgery Center

Dear Madam/Sir:

This architectural firm prepared the preliminary floor plan for the Palisades Eye Surgery Center, Bethesda, MD, dated 23 December 2013. I hereby attest that, to the best of my knowledge, information, and belief, the design meets the requirements of the 2010 FGI *Guidelines for Design and Construction of Health Care Facilities*.

Thank you for your attention.

Sincerely,



Richard T. Hardaway AIA
Architect

781-235-5339
781-235-5329 (Fax)

3.7 Specific Requirements for Outpatient Surgical Facilities

Appendix material, which appears in shaded boxes at the bottom of the page, is advisory only

3.7-1 General

3.7-1.1 Application

3.7-1.1.1 This chapter of the Guidelines applies to outpatient facilities (see 3.1-1.1) where surgery is performed.

3.7-1.1.2 The general requirements set forth in Chapter 3.1, Common Elements for Outpatient Facilities, shall apply to outpatient surgical facilities with the modifications set forth in this chapter.

*3.7-1.2 Functional Program

*3.7-1.2.1 Facility Requirements

The extent (number and type) of the diagnostic, clinical, and administrative facilities to be provided will be determined by the services contemplated and the estimated patient load as described in the functional program. Provisions shall be made for medical and nursing assessment, nursing care, preoperative testing, and physical examination for outpatient surgeries.

3.7-1.2.2 Patient Privacy

Visual and acoustical privacy shall be provided by design and include the registration, preparation, examination, treatment, and recovery areas.

3.7-1.2.3 Shared Services

3.7-1.2.3.1 If the outpatient surgical facility is part of an acute care hospital or other medical facility, services may be shared to minimize duplication as appropriate and acceptable to authorities having jurisdiction.

3.7-1.2.3.2 Where outpatient surgical services are provided within the same area or suite as inpatient surgery, additional space shall be provided as needed.

3.7-1.2.3.3 If inpatient and outpatient procedures are performed in the same room(s), the functional program shall describe in detail scheduling and techniques used to separate inpatients from outpatients.

3.7-1.3 Site

3.7-1.3.1 Reserved

3.7-1.3.2 Parking

Comply with the general requirements of Section 1.3-3.3 and the following specific requirements:

3.7-1.3.2.1 Four spaces shall be provided for each room routinely used for surgical procedures plus one space for each staff member.

3.7-1.3.2.2 Additional parking spaces convenient to the entrance for pickup of patients after recovery shall be provided.

APPENDIX

A3.7-1.2 The functional program describes in detail staffing, patient types, hours of operation, function and space relationships, transfer provisions, and availability of off-site services.

A3.7-1.2.1 Outpatient surgery is performed without anticipation of overnight patient care, and most outpatient procedures do not require an overnight stay. However, some require extended patient observation for up to "23 hours and 59 minutes" of care.

a. This extended care possibility should be addressed in a recovery care center that provides facilities for adequate sleeping, bathroom, and nutrition services for the patient.
b. Recovery care centers should have adequate waiting areas for family, including children and adolescents, and privacy (noise barriers and sight barriers) for meetings between physicians and other professionals with family. The areas should be large enough for translators or have available translation equipment.
c. A key element to housing patients is the communication system and the ability to obtain additional assistance as necessary.

3.7-1.3.3 Facility Access

The outpatient surgical facility shall be designed to facilitate movement of patients and personnel into, through, and out of defined areas within the surgical suite. Signs shall be provided at all entrances to restricted areas and shall clearly indicate the surgical attire required.

3.7-1.3.4 Layout

3.7-1.3.4.1 General. The outpatient surgical facility shall be divided into three designated areas—unrestricted, semi-restricted, and restricted—that are defined by the physical activities performed in each area.

(1) Unrestricted area. The unrestricted area shall include a central control point established to monitor the entrance of patients, personnel, and materials into the restricted areas. (Street clothes are permitted in this area, and traffic is not limited.)

(2) Semi-restricted area. The semi-restricted area shall include the peripheral support areas of the surgical suite, including those listed here. (Personnel in the semi-restricted area are required to wear surgical attire and cover head and facial hair. Traffic in this area is limited to authorized personnel and patients.)

(a) Storage areas for clean and sterile supplies
(b) Work areas for storage and processing of instruments
(c) Corridors leading to the restricted areas of the surgical suite
(d) Scrub sink areas

(3) Restricted area. The restricted area shall include those listed here. (Surgical attire and hair coverings are required. Masks are required where open sterile supplies or scrubbed persons may be located.)

(a) Operating and other procedure rooms
(b) The clean core (if required by the functional program)

3.7-2 Reserved

*3.7-3 Diagnostic and Treatment Locations

3.7-3.1 General

Facilities for diagnostic services shall be provided on or off site for pre-admission tests as required by the functional program.

*3.7-3.2 Examination Room

At least one room, ensuring both visual and acoustical privacy, shall be provided for examination of patients, private medical consultations, and confidential communication with patients and their families/legal guardians.

3.7-3.2.1 This room(s) may be an examination room or a treatment room as described in 3.1-3.2.2 (General Purpose Examination/Observation Room) or 3.1-3.2.4 (Treatment Room).

3.7-3.2.2 Use of a multifunctional room for examinations shall be permitted if additional uses do not eliminate the ability of the room to support an examination of the patient.

*3.7-3.3 Ambulatory Operating Rooms

APPENDIX

A3.7-3 Provisions should be made to separate pediatric from adult patients. Separate areas should include pre- and postoperative care areas and should allow for parental presence.

A3.7-3.2 An examination room used as a multifunctional space can accommodate both clinical and administrative functions. For example, if the area is used as a changing area, it must provide enough room for the exam table/recliner/stretcher and the ability to secure medical supplies. Another example would be using the room as a private interview space for the business area (to discuss insurance and billing). For this use, the space would require a way to secure supplies and equipment, access from both clinical and public areas as well as the ability to restrict/lock doors.

A3.7-3.3 When invasive procedures need to be performed on persons who are known or suspected of having airborne infectious disease, these procedures are ideally performed in a room meeting airborne infection isolation (AII) ventilation requirements or in a space using local exhaust ventilation. If the procedure must be performed in the operating suite, follow recommendations outlined in the CDC "Guidelines for Environmental Infection Control in Health-Care Facilities" or the CDC "Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Facilities."

3.7-3.3.1 General

3.7-3.3.1.1 The size and location of the operating rooms shall depend on the level of care and equipment specified in the functional program.

*3.7-3.3.1.2 Operating rooms shall be as defined by the American College of Surgeons and designed in accordance with the levels of sedation/analgesia defined by the American Society of Anesthesiologists' Continuum of Depth of Sedation.

3.7-3.3.1.3 Facilities that meet the guidelines for a particular category of procedure (Class A, B, and C) automatically qualify for procedures in all less restrictive categories. For example, facilities that meet the guidelines for Class C procedures automatically qualify for Class A and Class B procedures.

3.7-3.3.2 Class A Operating Room

These operating rooms are for surgery and other procedures that require "minimal" sedation.

3.7-3.3.2.1 Space requirements. Class A operating rooms shall have a minimum clear floor area of 150 square feet (45.72 square meters) with a minimum clear dimension of 12 feet (3.65 meters).

3.7-3.3.2.2 Clearances. There shall be a minimum clear distance of 3 feet 6 inches (1.07 meters) at each side, the head, and the foot of the operating table.

3.7-3.3.2.3 Location. Class A operating rooms may be accessed from the semi-restricted corridors of the surgical suite or from an unrestricted corridor adjacent to the surgical suite.

3.7-3.3.3 Class B Operating Room

These operating rooms are for surgery and other procedures that require "moderate" sedation.

APPENDIX

A3.7-3.3.1.2 Operating room definitions

a. American College of Surgeons Surgical Facility Classes

The following definitions are adapted from the American College of Surgeons publication 04GR-0001: *Guidelines for Optimal Ambulatory Surgical Care and Office-Based Surgery*, which was developed by the Board of Governors Committee on Ambulatory Surgical Care and published in May 2000.

Class A: Provides for minor surgical procedures performed under topical and local infiltration blocks with or without oral or intramuscular preoperative sedation. (Excluded are procedures that involve use of spinal, epidural anthesia, and stellate ganglion blocks; regional blocks [e.g., interscalene] and supraclavicular, infraclavicular, and intravenous regional anesthesia.) These procedures are also appropriately performed in Class B and C facilities.

Class B: Provides for minor or major surgical procedures performed in conjunction with oral, parenteral, or intravenous sedation or under analgesic or dissociative drugs. These procedures are also appropriately performed in Class C facilities.

Class C: Provides for major surgical procedures that require general or regional block anesthesia and support of vital bodily functions.

b. American Society of Anesthesiologists Continuum of Depth of Sedation

The level of sedation/analgesia is defined by the American Society of Anesthesiologists in "Continuum of Depth of Sedation, Definition of General Anesthesia and Levels of Sedation/Analgesia," which was approved by the ASA House of Delegates on October 13, 1999, and amended on October 17, 2004.

General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Deep sedation/analgesia is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. (Reflex withdrawal from a painful stimulus is not considered a purposeful response.) The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

Moderate sedation/analgesia ("conscious sedation") is a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

Minimal sedation (anxiolysis) is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

3.7-3.3.3.1 Space requirements. Class B operating rooms shall have a minimum clear floor area of 250 square feet (23.23 square meters) with a minimum clear dimension of 15 feet (4.57 meters).

3.7-3.3.3.2 Clearances. Room arrangement shall permit a minimum clear dimension of 3 feet 6 inches (1.07 meters) at each side, the head, and the foot of the operating table.

3.7-3.3.3.3 Location. Class B operating rooms shall be accessed from the semi-restricted corridors of the surgical suite.

3.7-3.3.4 Class C Operating Room

These operating rooms are for surgery and procedures that require general anesthesia or "deep" sedation.

3.7-3.3.4.1 Space requirements. These operating rooms shall have a minimum clear floor area of 400 square feet (37.16 square meters) and a minimum clear dimension of 18 feet (5.49 meters).

3.7-3.3.4.2 Clearances. Room arrangement shall permit a minimum clear dimension of 4 feet (1.22 meters) at each side, the head, and the foot of the operating table.

3.7-3.3.4.3 Location. Class C operating rooms shall be accessed from the semi-restricted corridors of the surgical suite.

3.7-3.3.4 Emergency Communication System

All operating rooms shall be equipped with an emergency communication system designed and installed to effectively summon additional qualified staff support with no more than push activation of an emergency call switch.

*3.7-3.3.5 Image Viewer

Each operating room shall have access to at least one medical image viewer located as required by the functional program.

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A3.7-3.3.5 For surgeries dependent upon medical imaging, such as many orthopedic procedures, medical image viewers should be provided in each operating room.

3.7-3.3.6 Special Design Elements

3.7-3.3.6.1 For mechanical system requirements, see 3.1-8.2 (HVAC Systems) and Part 6 (ASHRAE 170).

3.7-3.3.6.2 For medical gas requirements, see Table 3.1-1 (Station Outlets for Oxygen, Vacuum, and Medical Air in Outpatient Facilities).

3.7-3.4 Pre- and Post-operative Holding Areas

3.7-3.4.1 Preoperative Patient Holding Areas

3.7-3.4.1.1 General

(1) Location. Preoperative holding areas shall be under direct visual control of the nursing staff.

(2) Number. The minimum number of patient stations within the preoperative holding areas shall be as follows:

(a) Class A operating room

(i) At least one patient station per Class A operating room shall be required if the operating room is accessed from the semi-restricted area.

(ii) If the operating room is accessed from an unrestricted area and the functional program allows for preoperative care to be carried out within the operating room, no patient station shall be required for the Class A operating room.

(b) At least one patient station per Class B operating room shall be provided.

(c) At least one patient station per Class C operating room shall be provided.

(3) In facilities with Class B and C operating rooms, area shall be provided to accommodate stretcher patients and/or seating space.

3.7-3.4.1.2 Space requirements

(1) Area. Each preoperative holding area shall provide a minimum clear floor area of 80 square feet (7.43 square meters) for each patient station.

*(2) Clearances. Each preoperative holding area shall have a minimum clear dimension of 5 feet (1.52 meters) between patient stretchers and 4 feet (1.22 meters) between patient stretchers and adjacent walls (at the stretcher's sides and foot).

(3) If the functional program requires other uses for the preoperative holding area, such as an overflow post-anesthesia recovery area or a holding area at the end of the day, see Section 3.7-3.4.2.2 (2), Space Requirements for Post-Anesthesia Recovery Positions, for area and clearance requirements.

3.7-3.4.1.3 Reserved

3.7-3.4.1.4 Patient privacy. Provisions such as cubicle curtains shall be made for patient privacy.

3.7-3.4.1.5 Hand-washing station

(1) Hand-washing stations with hands-free or wrist blade-operable controls shall be available, with at least one station for every four positions or fewer and for each major fraction thereof.

(2) Hand-washing stations shall be uniformly distributed to provide convenient access from each patient position.

3.7-3.4.1.6 Reserved

3.7-3.4.1.7 Documentation space. A counter, table, area for a desk, or storage for a movable table shall be provided.

3.7-3.4.2 Recovery Areas

3.7-3.4.2.1 General

(1) When determining the number of recovery positions required, recovery area design shall, at minimum, take into consideration the types of surgery and procedures performed in the facility, the types of anesthesia used, average recovery periods, and anticipated staffing levels.

(2) Recovery areas shall be accessible directly from the semi-restricted area. If both are required by the functional program, preoperative holding areas and recovery areas shall be permitted to share the same space if all patient positions meet the most restrictive requirements of both areas.

*(3) Clearances noted around gurneys are between the normal use position of the gurney and any adjacent fixed surface or between adjacent gurneys.

(4) Staff shall have direct sightlines to patients in acute recovery stations.

(5) If pediatric surgery is part of the program, the following requirements shall be met:

(a) Pediatric recovery stations shall be separate from adult stations.
(b) Pediatric stations shall provide space for parents.
(c) Sound attenuation shall be required.
(d) The ability to view the patient from the nursing station shall be required.

3.7-3.4.2.2 Post-anesthesia recovery positions. Room(s) for post-anesthesia recovery in outpatient surgical facilities shall be provided in accordance with the functional program.

(1) Number

(a) A minimum of one recovery station per operating room shall be provided. A recovery area analysis shall determine the need for additional recovery stations.
(b) In the absence of a recovery area analysis approved by the authority having jurisdiction, the minimum number of post-anesthesia recovery positions shall be as follows:

(i) Three recovery positions for each Class C operating room
(ii) Two recovery positions for each Class B operating room
(iii) One recovery position for each Class A operating room

(2) Space requirements

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A3.7-3.4.1.2 (2) Clearances do not include any area that would have to be shared to meet the standard.

A3.7-3.4.2.1 (3) Clearances do not include any area that would have to be shared to meet the standard.

(a) Area

(i) When a patient cubicle is used for each patient care station, a minimum clear floor area of 80 square feet (7.43 square meters) shall be provided.
(ii) Space shall also be provided for additional equipment described in the functional program.

(b) Clearances. Each post-anesthesia recovery area shall provide a minimum clear dimension of 5 feet (1.52 meters) between patient stretchers or beds, 4 feet (1.22 meters) between patient stretchers or beds and adjacent walls (at the stretcher's sides and foot), and at least 3 feet (91.44 centimeters) from the foot of the stretcher or bed to the closed cubicle curtain.

(3) Reserved

(4) Patient privacy. Provisions for patient privacy such as cubicle curtains shall be made.

(5) Hand-washing stations. For requirements, see 3.7-3.4.1.5.

(6) Support areas for post-anesthesia recovery rooms. Support areas listed below shall be provided in accordance with the requirements for such areas in 3.7-3.6 (Support Areas for Surgical Service Areas). If the post-anesthesia recovery room(s) is located immediately adjacent to the surgical suite, sharing of these support areas shall be permitted.

(a) Supply storage
(b) Provisions for soiled linen and waste holding
(c) Documentation space
(d) Drug distribution station
(e) Equipment storage

3.7-3.4.2.3 Phase II recovery

(1) General

(a) A Phase II recovery area shall be provided if required by the functional program.
(b) Location of the Phase II recovery area within the post-anesthesia recovery area shall be permitted, but the Phase II area shall be an identifiably separate and distinct part of the post-anesthesia recovery area.

(2) Space requirements

(a) Area. When a patient cubicle is used for each patient care station, the design shall provide a minimum of 50 square feet (4.65 square meters) for each patient in a lounge chair with space for additional equipment described in the functional program.

(b) Clearances

(i) The design shall provide a minimum clear dimension of 4 feet (1.22 meters) between the sides of adjacent lounge chairs and between the foot of the lounge chairs and the nearest obstruction.
(ii) When permanent partitions (full or partial height or width) are used to partially define the patient care station (rather than cubicle curtains), a minimum clear dimension of 3 feet (91.44 centimeters) shall be provided on the sides of the lounge chair.

(3) Reserved

(4) Patient privacy. Provisions for patient privacy such as cubicle curtains shall be made.

(5) Hand-washing station. If a Phase II recovery area is provided, see 3.7-3.4.1.5 for hand-washing station requirements.

(6) Patient toilet room(s)

(a) In facilities with three or more operating rooms, a dedicated patient toilet room shall be provided in the Phase II recovery area.
(b) In facilities with two or fewer operating rooms, a patient toilet room shall be provided in or adjacent to the Phase II recovery area.

(7) Support areas for Phase II recovery areas. If a Phase II recovery area is provided, it shall contain the following with exceptions as described:

(a) Nurse control. In Phase II recovery areas, a dedicated nurse utility/control station with a view of patients is not required. If the Phase II recovery area is designed as a separate unit, sightlines and easy access from the post-anesthesia recovery area nurse control station shall be provided.
(b) Storage space for supplies and equipment
(c) Documentation space. A counter, table, area for a desk, or storage for a movable table shall be provided.

(d) Space for family members
(e) Nourishment facilities

3.7-3.5 Support Areas for Patient Care—General

For requirements, see 3.1-3.5.

3.7-3.6 Support Areas for Surgical Service Areas

The following shall be provided in surgical service areas:

3.7-3.6.1 Nurse or Control Station

A nurse or control station(s) shall be located to permit visual surveillance of patients in post-anesthesia recovery positions and all traffic entering the semi-restricted corridor (the passage used to access operating rooms and ancillary semi-restricted areas).

3.7-3.6.2 Documentation Area

A counter, table, area for a desk, or storage for a movable table shall be provided.

3.7-3.6.3 Reserved

3.7-3.6.4 Reserved

3.7-3.6.5 Scrub Facilities

3.7-3.6.5.1 Scrub station(s) shall be provided directly adjacent to the entrance to each operating room.

3.7-3.6.5.2 A scrub station may serve two operating rooms if it is located directly adjacent to the entrances to both.

3.7-3.6.5.3 Scrub stations shall be arranged to minimize splatter on nearby personnel or supply carts.

3.7-3.6.6 Medication Distribution Station

A medication distribution station shall be provided.

3.7-3.6.6.1 Provisions shall be made for storage and preparation of medications administered to patients.

3.7-3.6.6.2 A refrigerator for pharmaceuticals and double-locked storage for controlled substances shall be provided if required by the functional program.

3.7-3.6.6.3 Convenient access to hand-washing stations shall be provided.

3.7-3.6.7 through 3.7-3.6.9 Reserved

3.7-3.6.10 Soiled Workroom

(1) A soiled workroom shall be provided. This may be the same workroom as that described in 3.7-5.1.2.1 (Soiled workroom).

(2) The soiled workroom shall contain a clinical sink or equivalent flushing-type fixture, a work counter, a hand-washing station, and waste receptacle(s).

(3) The soiled workroom shall be located within the semi-restricted area.

3.7-3.6.11 Equipment and Supply Storage

3.7-3.6.11.1 General equipment and supply storage. Equipment storage room(s) shall be provided for equipment and supplies used in the surgical suite.

(1) Area. The combined area of equipment and clean clinical supply storage room(s) shall have a minimum floor area of 50 square feet (15.24 square meters) for each operating room(s) up to two and an additional 25 square feet (7.62 square meters) per additional operating room.

(2) Location. Equipment storage room(s) shall be located within the semi-restricted area.

3.7-3.6.11.2 Anesthesia equipment and supply storage. Provisions shall be provided for cleaning, testing, and storing anesthesia equipment and supplies, as defined by the functional program. This space shall be located within the semi-restricted area.

3.7-3.6.11.3 Medical gas storage. Provisions shall be made for the medical gas(es) used in the facility. Adequate space for supply and storage, including space for reserve cylinders, shall be provided and protected per NFPA 99 standards.

3.7-3.6.11.4 Stretcher storage area. In facilities that provide Class B and C operating rooms, a stretcher storage area for at least one stretcher shall be provided. This storage area shall be convenient for use and located outside the required width of the exit access corridor.

3.7-3.6.11.5 Wheelchair storage space. Wheelchair storage space shall be provided. See Section 3.1-3.6.11.5 for requirements.

3.7-3.6.11.6 Emergency equipment/supply storage. Provisions shall be made for convenient access to and use of emergency resuscitation equipment and supplies (crash cart(s) and/or anesthesia carts) at both the surgical and recovery areas.

3.7-3.6.12 Environmental Services Room

An environmental services room shall be provided exclusively for the surgical suite. This room shall contain a floor receptor or service sink and storage space for housekeeping supplies and equipment.

3.7-3.6.13 Reserved

3.7-3.6.14 Sterilization Facilities

Space shall be provided for a high-speed sterilizer or other sterilizing equipment for immediate or emergency use, as required by the functional program.

(1) This space shall be located in the semi-restricted area.

(2) The space shall include a separate area for cleaning and decontamination of instruments prior to sterilization.

3.7-3.6.15 Fluid Waste Disposal Facilities

3.7-3.6.15.1 Fluid waste disposal facilities shall be convenient to the general operating rooms and post-anesthesia recovery positions.

3.7-3.6.15.2 A clinical sink or equivalent equipment in a soiled workroom shall meet this requirement in the operating room area, and a toilet equipped with a bedpan-cleaning device or a separate clinical sink shall meet the requirement in the recovery area.

3.7-3.7 Support Areas for Staff

3.7-3.7.1 Staff Lounge and Toilet Facilities

Staff lounge and toilet facilities shall be provided in facilities with three or more operating rooms. The toilet room shall be near the recovery area.

3.7-3.7.2 Staff Clothing Change Area

Appropriate change area(s) shall be provided for male and female staff working within the surgical suite (a unisex locker area with one or more private changing rooms shall be permitted).

3.7-3.7.2.1 The area(s) shall contain lockers, toilet(s), hand-washing station(s), and space for donning scrub attire.

3.7-3.7.2.2 For facilities that provide Class B and C surgical services, this area(s) shall be designed to effect a one-way traffic pattern so that personnel entering from outside the surgical suite can change and move directly into the suite's semi-restricted corridor.

3.7-3.7.3 Staff Shower

At least one staff shower shall be provided that is conveniently accessible to the surgical suite and recovery areas.

3.7-3.8 Support Areas for Patients

3.7-3.8.1 Outpatient Surgery Change Area

3.7-3.8.1.1 A separate area(s) shall be provided for outpatients to change from street clothing into hospital gowns and to prepare for surgery. This area shall include the following:

(1) Lockers

(2) Toilet(s)

(3) Clothing change or gowning area(s)

(4) Space for administering medications

3.7-3.8.1.2 Provisions shall be made for securing patients' personal effects.

3.7-3.8.2 Toilet Room

3.7-3.8.2.1 A toilet room(s) shall be provided for patient use.

3.7-3.8.2.2 The patient toilet room(s) shall be separate from public use toilet(s) and located to permit access from pre- and postoperative holding areas. For specific requirements for the patient toilet room in Phase II recovery areas, see 3.7-3.4.2.3 (6).

■ 3.7-4 Reserved

3.7-5 General Support Services and Facilities

3.7-5.1 Sterilization Facilities

A system for sterilizing equipment and supplies shall be provided.

3.7-5.1.1 General

3.7-5.1.1.1 When sterilization is provided off site, a room for the adequate handling (receiving and distribution) and on-site storage of sterile supplies that meets the requirements of 3.7-5.1.2.3 shall be provided.

3.7-5.1.1.2 Provisions shall be made for sanitizing clean and soiled carts and/or vehicles consistent with the needs of the particular transportation system.

3.7-5.1.2 On-Site Facilities

If on-site processing facilities are provided, they shall include the following:

3.7-5.1.2.1 **Soiled workroom.** Soiled and clean workrooms or holding rooms shall be separated. A self closing door or pass-through opening for decontaminated instruments is permitted between soiled and clean workrooms.

(1) The soiled workroom (or a soiled holding room that is part of a system for the collection and disposal of soiled material) is for the exclusive use of the surgical suite.

(2) The soiled workroom shall be located in the semirestricted area and shall not have direct connection with operating rooms.

(3) The soiled workroom shall contain the following:

(a) Flushing-rim clinical sink or equivalent flushing-rim fixture
(b) Hand-washing station
(c) Work counter
(d) Space for waste receptacles and soiled linen receptacles

(4) Omission of the flushing-rim clinical sink and work counters shall be permitted in rooms used only for temporary holding of soiled material. However, if the flushing-rim clinical sink is omitted, other provisions for disposal of liquid waste shall be provided.

*3.7-5.1.2.2 **Clean assembly/workroom.** Clean and soiled work areas shall be physically separated.

(1) The clean assembly room shall have adequate space for the designated number of work areas as defined in the functional program as well as space for storage of clean supplies, steriliner carriages (if used), and instrumentation.

(2) Access to this room shall be restricted.

(3) This room shall contain the following:

(a) Hand-washing station
(b) Workspace
(c) Equipment for terminal sterilizing of medical and surgical equipment and supplies

3.7-5.1.2.3 **Storage for sterile supplies**

(1) Storage for packs, etc., shall include provisions for ventilation, humidity, and temperature control.

(2) The sterile supply room shall have a minimum floor area of 70 square feet (21.3 square meters) or 50 square feet (15.24 square meters) per operating room, whichever is greater.

(3) Location of this clean and sterile supply storage in an area within the clean assembly/workroom described in 3.7-5.1.2.2 shall be permitted if it is a permanently designated area and meets the space requirements in 3.7-5.1.2.3 (2).

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A3.7-5.1.2.2 This room is exclusively for the inspection, assembly, and packaging of medical/surgical supplies and equipment for sterilization. The area should contain worktables or counters and storage facilities for backup supplies and instrumentation. An area for a drying cabinet or equipment may be required. The area should be spacious enough to hold sterilizer carts, if used, for loading or prepared supplies for sterilization.

3.7-5.2 Linen Services

Designated space in the post-anesthesia recovery area(s) shall be provided for clean and soiled linen.

3.7-5.3 Reserved

3.7-5.4 Reserved

3.7-5.5 Environmental Services

3.7-5.5.1 Environmental Services Rooms

See 3.1-5.5.1.1 (Number), including the corresponding appendix, to determine the number of housekeeping carts/environmental services rooms required.

3.7-6 Public and Administrative Areas

The following shall be provided:

3.7-6.1 Public Areas

*3.7-6.1.1 Entrance

A covered entrance shall be provided for pickup of patients after surgery. The entrance covering shall not be required to cover the driveway or street areas but only the patient entrance of the building.

3.7-6.2 Administrative Areas

3.7-6.2.1 Reserved

3.7-6.2.2 Interview Space

Space(s) for private interviews relating to admission shall be provided separate from public and patient areas. Use of a multipurpose or consultation room for this purpose shall be permitted.

3.7-6.2.3 Office Space

At a minimum, designated office space shall be provided for general and individual office(s) for business transactions.

3.7-6.2.4 Multipurpose or Consultation Room(s)

At least one private multipurpose or consultation room shall be provided as part of the unrestricted area.

3.7-6.2.5 Medical Records

For requirements regarding paper or electronic medical records, see Section 3.1-6.2.5.

3.7-6.2.6 General Storage

General administrative storage facilities shall be provided.

3.7-6.3 Support Areas for Staff

Special storage, including locking drawers and/or cabinets, for the personal effects of administrative staff, shall be provided.

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A3.7-6.1.1 Such roof overhang or canopy should extend as far as practicable to the face of the driveway or curb of the passenger access door of the transport vehicle. Vehicles in the loading area should not block or restrict movement of other vehicles in the drive or parking areas immediately adjacent to the facility.

3.7-7 Design and Construction Requirements

3.7-7.1 Building Codes and Standards

3.7-7.1.1 The outpatient surgical facility, whether freestanding or adjacent to a separate occupancy, shall comply with the New Ambulatory Health Care Occupancies section of NFPA 101 and with the requirements herein.

3.7-7.1.2 Separation for hazardous areas and smoke separation shall conform to NFPA 101.

3.7-7.1.3 Flammable anesthetics shall not be used in outpatient surgical facilities.

3.7-7.1.4 Outpatient surgical facility exits shall conform to NFPA 101 or equivalent building, fire, and safety codes where adopted and enforced by the authority having jurisdiction.

3.7-7.2 Architectural Details, Surfaces, and Furnishings

In addition to the requirements in 3.1-7.2, the requirements in this section shall be met.

3.7-7.2.1 Reserved

3.7-7.2.2 Architectural Details

3.7-7.2.2.1 Corridor width

(1) Public corridors shall have a minimum width of 5 feet (1.52 meters), except that corridors connecting the operating room section and the PACU and at least one (ambulance transfer) exit, where patients are transported on stretchers or beds, shall have a minimum width of 6 feet (1.83 meters).

(2) The semi-restricted corridor shall have a minimum width of 8 feet (2.44 meters) in areas used to transport patients on gurneys between preoperative, procedure, and post-anesthesia recovery areas.

(3) Passages and corridors used exclusively for staff access shall be a minimum of 3 feet 8 inches (1.12 meters) in clear width.

3.7-7.2.2.2 Reserved

3.7-7.2.2.3 Doors and door hardware

(1) Door openings

(a) Door openings serving occupiable spaces shall have a minimum clear width of 2 feet 10 inches (86.36 centimeters).

(b) Door openings requiring gurney/stretcher access shall have a minimum clear width of 3 feet 8 inches (1.12 meters).

(2) Toilet rooms. Toilet rooms for patient use in surgery and recovery areas shall comply with the following:

(a) These toilet rooms shall be equipped with doors and hardware that permit access from the outside in emergencies.

(b) When such rooms have only one opening or are small, the doors shall open outward or be otherwise designed to open without pressing against a patient who may have collapsed within the room.

3.7-7.2.3 Surfaces

3.7-7.2.3.1 General. Surfaces shall comply with NFPA 101.

3.7-7.2.3.2 Flooring. Floor finishes shall be appropriate for the areas in which they are located and shall be as follows:

(1) Floor finishes shall be cleanable.

(2) Floor finishes in areas such as clean corridors, central sterile supply spaces, specialized radiographic rooms, and Class A operating rooms shall be washable, smooth, and able to withstand chemical cleaning.

(3) Floor finishes in areas such as operating rooms, delivery rooms, and trauma rooms shall be scrubbable, able to withstand chemical cleaning, and monolithic, with an integral base.

(4) All floor surfaces in clinical areas shall be constructed of materials that allow the easy movement of all required wheeled equipment.

3.7-7.2.3.3 Walls. Wall finishes shall be appropriate for the areas in which they are located and shall be as follows:

(1) Wall finishes shall be cleanable.

(2) Wall finishes in areas such as clean corridors, central sterile supply spaces, specialized radiographic rooms, and minor surgical procedure rooms shall be washable, smooth, and able to withstand chemical cleaning.

(3) Wall finishes in areas such as operating rooms, delivery rooms, and trauma rooms shall be scrubbable, able to withstand chemical cleaning, and monolithic.

3.7-7.2.3.4 Ceilings. Ceiling finishes shall be appropriate for the areas in which they are located and shall be as follows:

*(1) Semi-restricted areas

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A3.7-7.2.3.4 (1) Ceilings in semi-restricted areas. If a lay-in ceiling is provided, it should be gasketed or each ceiling tile should weigh 1 pound per square foot to prevent the passage of particles from the cavity above the ceiling plane into the semi-restricted environment.

(a) Ceiling finishes in semi-restricted areas such as clean corridors, central sterile supply spaces, specialized radiographic rooms, and Class A operating rooms shall be smooth, scrubbable, nonabsorptive, nonperforated, capable of withstanding cleaning with chemicals, and without crevices that can harbor mold and bacteria growth.

(b) Perforated, tegular, serrated, or highly textured tiles shall not be used.

(2) Restricted areas

(a) Ceilings in restricted areas such as operating rooms shall be monolithic, scrubbable, and capable of withstanding chemicals. Cracks or perforations in these ceilings are not allowed.

(b) All access openings in ceilings in restricted areas shall be gasketed.

(3) Mechanical and electrical rooms. Suspended ceilings may be omitted in mechanical and electrical rooms/spaces unless required for fire safety purposes.

3.7-8 Building Systems

3.7-8.1 Reserved

3.7-8.2 Heating, Ventilation, and Air-Conditioning (HVAC) Systems

HVAC systems shall be as described for similar areas in 3.1-8.2 and in Part 6.

3.7-8.3 Electrical Systems

For requirements, see 3.1-8.3.

3.7-8.4 Plumbing Systems

For requirements, see 3.1-8.4.

3.7-8.4.1 Medical Gas Systems

Flammable anesthetics shall not be used in outpatient surgical facilities.

3.7-8.5 Communications Systems

See Section 3.1-8.5.

3.7-8.6 Electronic Safety and Security Systems

3.7-8.6.1 Fire Alarm System

A manually operated, electrically supervised fire alarm system shall be installed in each facility as described in NFPA 101.

3.9-6.2.4 Multipurpose Room

At least one private multipurpose or consultation room(s) shall be provided.

3.9-6.2.5 Medical Records Storage

See Section 3.1-6.2.5 for medical records (paper or electronic) storage requirements.

3.9-6.3 Support Areas for Staff

3.9-6.3.1 Staff Storage Facilities

Special storage, including locking drawers and/or cabinets, for the personal effects of administrative staff shall be provided.

3.9-7 Design and Construction Requirements

3.9-7.1 Building Codes and Standards

3.9-7.1.1 The separate endoscopy facility or section shall comply with the "New Ambulatory Health Care Occupancies" section of NFPA 101 and requirements described herein.

3.9-7.1.2 Flammable anesthetics shall not be used in outpatient endoscopy facilities.

3.9-7.2 Architectural Details, Surfaces, and Furnishings

3.9-7.2.1 Reserved

3.9-7.2.2 Architectural Details

3.9-7.2.2.1 **Corridor width**

(1) Minimum public corridor width shall be 5 feet (1.52 meters), except that corridors where patients are transported on stretchers or beds shall be 8 feet (2.44 meters) wide.

(2) Passages and corridors used exclusively for staff access may be 3 feet 8 inches (1.12 meters) in clear width.

3.9-7.2.2.2 **Reserved**

3.9-7.2.2.3 **Door openings**

(1) Door opening width

(a) Door openings serving occupiable spaces shall have a minimum clear width of 2 feet 10 inches (86.36 centimeters).
(b) Door openings requiring gurney/stretcher access shall have a minimum clear width of 3 feet 8 inches (1.12 meters).

(2) Toilet room doors

(a) Toilet rooms in procedure and recovery areas for patient use shall be equipped with doors and hardware that permit access from the outside in emergencies.
(b) When such rooms have only one opening or are small, the doors shall open outward or be otherwise designed to open without pressing against a patient who may have collapsed within the room.

3.9-7.2.3 Surfaces

3.9-7.2.3.1 **Reserved**

3.9-7.2.3.2 **Flooring**

(1) Floor finishes. Floor finishes in the gastrointestinal endoscopy facility shall be appropriate for the areas in which they are located and shall be as follows:

(a) Floor finishes shall be cleanable.
(b) Floor finishes in areas such as clean corridors and patient care areas shall be washable, smooth, and capable of withstanding chemical cleaning.
(c) Floor finishes in areas such as procedure rooms and the decontamination room shall be scrubbable, capable of withstanding chemical cleaning, and monolithic with an integral base.

(2) Procedure room floor. Floor covering in the procedure suite shall be monolithic and joint free.

(3) Instrument processing room floor. Floor covering in the instrument processing room shall be monolithic and joint free with 6-inch (15.24-centimeter) integral cove base.

3.9-7.2.3.3 **Walls.** Wall finishes shall be appropriate for the areas in which they are located and shall be as follows:

(1) Wall finishes shall be cleanable.

(2) Wall finishes in areas such as clean corridors, central sterile supply spaces, specialized radiographic rooms, and endoscopic procedure rooms shall be washable, smooth, and capable of withstanding chemical cleaning.

(3) Wall finishes in areas such as procedure rooms shall be scrubbable, capable of withstanding chemical cleaning, and monolithic.

3.9-7.2.3.4 **Ceilings.** Ceiling finishes shall be appropriate for the areas in which they are located and shall be as follows:

(1) Ceiling finishes in general areas are optional and may be omitted in mechanical and electrical rooms/spaces unless required for fire-resistive purposes.

(2) Ceiling finishes in procedure rooms, the decontamination room, and other semirestricted areas shall be capable of withstanding cleaning with chemicals and without crevices that can harbor mold and bacteria growth. If a lay-in ceiling is provided, it shall be gasketed or clipped down to prevent the passage of particles from the cavity above the ceiling plane into the semirestricted environment. Perforated, regular, serrated, cut, or highly textured tiles shall not be used.

3.9-8 Building Systems

3.9-8.1 Reserved

3.9-8.2 Heating, Ventilation, and Air-Conditioning (HVAC) Systems

3.9-8.2.1 General

Heating, ventilation, and air conditioning shall be as described for similar areas in 3.1-8.2.

*3.9-8.2.2 Instrument Processing Room and Decontamination Facilities

See Table 3.1-1 (Stations Outlets for Oxygen, Vacuum [Suction], and Medical Air Systems in Hospitals) for ventilation requirements for this area.

3.9-8.3 Reserved

3.9-8.4 Plumbing Systems

3.9-8.4.1 Medical Gas and Vacuum Requirements

3.9-8.4.1.1 **Medical gas requirements.** Provisions shall be made for the medical gases used in the facility. See Part 6 (ASHRAE 170) for mechanical system requirements and Table 3.1-1 (Station Outlets for Oxygen, Vacuum, and Medical Air in Outpatient Facilities) for medical gas requirements.

3.9-8.4.1.2 **Requirements for specific locations**

(1) Post-procedure recovery positions. Oxygen and suction per Table 3.1-1 shall be provided for each patient cubicle.

(2) Procedure room. Station outlets for oxygen and vacuum (suction) shall be available in the procedure room.

(3) Instrument processing room and decontamination area. Provision for vacuum and/or non-medical compressed air shall be provided as appropriate to cleaning methods used.

3.9-8.5 Electronic Safety and Security Systems

3.9-8.5.1 Fire Alarm System

A manually operated, electrically supervised fire alarm system shall be installed in each facility as described in NFPA 101.

APPENDIX

A3.9-8.2.2 Instrument processing room and decontamination facilities. Additional local exhaust ventilation systems may be provided to control disinfectant or detergent vapors at their source.

Exhibit 11
Statement of Assumptions

Revenue	Reference	Assumptions
Outpatient Services	1 b.	Estimated based on the projected OR cases for proposed project in Table 1
Allowance fro Bad Debt	1 d.	Estimated as a percentage of Gross Outpatient Revenue based on C.Y. 2013 actual Bad Debt.
Contractual Allowances	1 e.	Estimated as a percentage of Gross Outpatient Revenue based on C.Y. 2013 actual Contractual Allowances
Charity Care	1 f.	Estimated at 5 cases per year at PESC current average charges per case.
Expenses:		
Salaries and Wages	2 a.	Estimated based on the Manpower information in Table 5
Depreciation	2 e.	Estimated using current deprecation and estimated useful life of assets.
Supplies	2i	Estimated using the historical percentage from CY 2013 of supplies to revenue
Other Expenses	Line J	
Advertising		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Automobile Expense		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Bank Service Charges		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Billing Expenses		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Billing Services		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Cable		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Credit Card Discount Fees		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Dues and Subscriptions		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Education		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Equipment Rental		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Insurance		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Licenses and Permits		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Maintenance		Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Marketing and Promotion		Estimated as a percentage of Net Operating Revenue based on C.Y 2013

Medical Records	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Medical Waste	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Miscellaneous	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Office Supplies	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Postage and Delivery	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Printing and Reproduction	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Professional Development	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Professional Fees	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Promotion	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Rent	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Repairs	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Retirement Contribution	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Security Services	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Taxes	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Telephone	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Transcription	Estimated as a percentage of Net Operating Revenue based on C.Y 2013
Travel & Ent	Estimated as a percentage of Net Operating Revenue based on C.Y 2013

Exhibit 12
PNC Bank Letter

PNC BANK

Md Health Care Commission
Mr. Ben Steffen, Executive Dir
4160 Patterson Ave.
Baltimore, MD 21215

December 31, 2013

Dear Mr. Steffen:

This letter is regarding the client of PNC Bank, Rockville Eye Surgery Center LLC. Rockville Eye Surgery

Center currently maintains both deposit and credit accounts, that are very satisfactory with healthy balances. This relationship has been with PNC Bank since 2007. We hold this relationship in high regards and are interested in working with them to secure the anticipated financing needed for expansion. While loan details are in discussion, we are confident, based on account history and average cash balance, that Rockville Eye Surgery is a viable candidate to receive funding and will be able to apply at least $260,000 as cash contribution.

If you have any questions regarding Rockville Eye Surgery, LLC, please do not hesitate calling me at 202-577-7107.

Deniz Unal
Vice President

Exhibit 13
Letters of Support

SOUTHERN'S
COMMERCIAL PROPERTIES DIVISION

1950 Old Gallows Road • Suite 600 • Vienna, VA 22182 • T: 703.902.9400 • F: 703.902.9401

October 15, 2013

Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
Attention: Mr. Ben Steffen
Executive Director

Dear Mr. Steffen,

I am very pleased to write this testimonial letter for Palisades Eye Surgery Center ("PESC").

Southern Management Corporation whole heartedly supports the Certificate of Need application for their expansion and relocation. PESC has been an exemplary tenant in our building for ten (10) years and provides a high quality surgery center which fulfills an important community need. I know they have experienced increased growth over the past few years and their project moving forward is well thought out and seems very cost effective.

I completely support this project and recommend that the Commission approves PESC's CON application.

Sincerely,

Edward Dosik
Director
Southern Management Corporation

cc: Penelope Williams, Director

I:\Palisades-Bethesda\Correspondence\Rockville Eye Surgery\Letter of Support

Thomas J. Murray
5116 Sangamore Road
Bethesda, MD 20816

December 13, 2013

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Ave
Baltimore, MD 21215-2299

Re: Rockville Eye Surgery Center, dba Palisades Eye Surgery Center

Dear Mr. Steffen,

I recently had the opportunity to undergo surgery at Palisades Eye Surgery Center and was quite impressed with the level of professionalism in all stages of care, from reception through pre-op, anesthesia, surgery and post-op. The staff was efficient yet rendered individualized attention to my needs. The location was convenient for me and the total procedure flowed seamlessly.

Given my favorable experiences (two surgeries) at Palisades Eye Surgery Center and the excellent medical care I received from my surgeon and his staff, when asked to express my opinion regarding their proposal to expand, I readily agreed. I am enthusiastically endorsing expansion of this Ambulatory Surgery Center. Certainly, given the number of patients I witnessed in the physician's reception area and the growing number of baby boomers who may soon be needing cataract surgery, there is a demonstrated need for this type of multiple-OR ophthalmic facility in our community.

Sincerely,

Thomas J. Murray

Thomas J. Murray

Cc: Penelope Williams, Director

Exhibit 14
Affirmations

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.

Signature

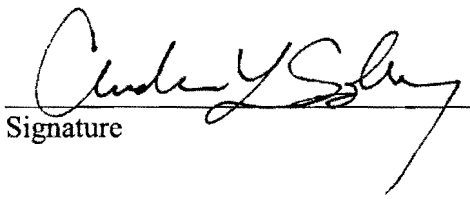
Date

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.

Signature

Date 1/2/14

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.



Signature

12/30//2013

Date