STATE OF MARYLAND

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MARYLAND HEALTH CARE COMMISSION

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INSTRUCTIONS FOR APPLICATION FOR CERTIFICATE OF NEED HOSPITAL PROJECTS

ALL APPLICATIONS MUST FOLLOW THE FORMATTING REQUIREMENTS DESCRIBED IMMEDIATELY BELOW. NOT FOLLOWING THESE FORMATTING INSTRUCTIONS WILL RESULT IN THE APPLICATION BEING RETURNED.

REQUIRED FORMAT:

Table of Contents. The application must include a Table of Contents referencing the location of application materials. Each section in the hard copy submission should be separated with tabbed dividers. Any exhibits, attachments, etc. should be similarly tabbed, and pages within each should be numbered independently and consecutively. **The Table of Contents must include:**

- **Responses to PARTS I, II, and III of this application form**
- **Responses to PART IV**
  COMAR 10.24.10: Acute Care Hospital Services
  Other applicable facility-specific State Health Plan chapters
  Review Criteria listed at 10.24.01.08G(3)(b) through(f)
- **Attachments, Exhibits, or Supplements**
  Identification of each attachment, exhibit, and supplement

Application pages must be consecutively numbered at the bottom of each page. Exhibits attached to subsequent correspondence during the completeness review process shall use a consecutive numbering scheme, continuing the sequencing from the original application. (For example, if the last exhibit in the application is Exhibit 5, any exhibits used in subsequent responses should begin with Exhibit 6. However, a replacement exhibit that merely replaces an exhibit to the application should have the same number as the exhibit it is replacing, noted as a replacement.

SUBMISSION FORMATS:

We require submission of application materials in three forms: hard copy; searchable PDF; and in Microsoft Word.

- **Hard copy:** Applicants must submit six (6) hard copies of the application to:
  Ruby Potter
  Health Facilities Coordinator
  Maryland Health Care Commission
  4160 Patterson Avenue
  Baltimore, Maryland 21215

- **PDF:** Applicants must also submit *searchable* PDF files of the application, supplements, attachments, and exhibits.[1] All subsequent correspondence should also be submitted both by paper copy and as *searchable PDFs*.

- **Microsoft Word:** Responses to the questions in the application and the applicant's responses to completeness questions should also be electronically submitted in Word. Applicants are strongly encouraged to submit any spreadsheets or other files used to create the original tables (the native format). This will expedite the review process.

PDFs and spreadsheets should be submitted to ruby.potter@maryland.gov and kevin.mcdonald@maryland.gov.

Note that there are certain actions that may be taken regarding either a health care facility or an entity that does not meet the definition of a health care facility where CON review and approval are not required. Most such instances are found in the Commission's procedural regulations at COMAR 10.24.01.03, .04, and .05. Instances listed in those regulations require the submission of specified information to the Commission and may require approval by the full Commission. Contact CON staff at (410) 764-3276 for more information.

[1] PDFs may be created by saving the original document directly to PDF on a computer or by using advanced scanning technology

CALVERT MEMORIAL HOSPITAL

APPLICATION FOR CERTIFICATE OF NEED

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EXHIBITS

Exhibit #	Title
1	Complete Project Description
2	Project Drawings
3	Hospital license and JCAHO Accreditation
4	CMH Quality Report
5	CON TABLE Package
6	TPR Agreement
7	Daily Census Dataset
8	Calvert County SNF Occupancy Statistics
9	MHCC Comp Care Bed Need Forecast
10	Nursing Square Footage Chart
11	Volume Projections and Assumptions
12	Service Area Maps
13	FY 2014 Audited Financial Statements
14	Letters of Support
15	Affirmations

For internal staff use

MARYLAND HEALTH CARE COMMISSION

_____
MATTER/DOCKET NO.

_____
DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Calvert Memorial Hospital**

Address:

100 Hospital Road	**Prince Frederick**	**20678**	**Calvert**
Street	City	Zip	County

Name of Owner (if differs from applicant):

2. OWNER

Name of owner: **Calvert Memorial Hospital of Calvert County**

3. APPLICANT. *If the application has co-applicants, provide the detail regarding each co-applicant in sections 3, 4, and 5 as an attachment.*

Legal Name of Project Applicant
Calvert Memorial Hospital of Calvert County

Address:

100 Hospital Road	**Prince Frederick**	**20678**	**Maryland**	**Calvert**
Street	City	Zip	State	County

Telephone: **410-535-4000**

Name of Owner/Chief Executive: **Dean A. Teague**

4. Name of Licensee or Proposed Licensee, **if different from applicant:**

N/A

5. LEGAL STRUCTURE OF APPLICANT **(and LICENSEE, if different from applicant).**

Check ☑ or fill in applicable information below and attach an organizational chart showing the owners of applicant (and licensee, if different).

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	XX	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation Maryland; 2-15-1916
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	XX	

6. PERSON(S) TO WHOM QUESTIONS REGARDING THIS APPLICATION SHOULD BE DIRECTED

A. Lead or primary contact:

Name and Title: Dean A. Teague
Mailing Address:

100 Hospital Road	**Prince Frederick**	**20678**	**MD**
Street	City	Zip	State

Telephone: **410-535-8238**
E-mail Address (required): **dteague@cmhlink.org**
Fax: **410-535-8403**

B. Additional or alternate contact:

Name and Title: John J. Eller
Mailing Address:

100 Light Street	**Baltimore**	**21202**	**MD**
Street	City	Zip	State

Telephone: **410-347-7362**
E-mail Address (required): **jjeller@ober.com**

Fax: **410-263-7562**

7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1)	A new health care facility built, developed, or established	☐
(2)	An existing health care facility moved to another site	☐
(3)	A change in the bed capacity of a health care facility	☐
(4)	A change in the type or scope of any health care service offered by a health care facility	☐
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	X

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

Calvert Memorial Hospital ("CMH") seeks approval for the capital expenditures related to construction of a 43,575 DGSF three story addition to the existing hospital's physical plant. The two main objectives of the project are to expand the number of private patient rooms in the hospital from 61 to 101, and to create an 18-room dedicated outpatient observation unit by renovating an existing 31-bed MSGA nursing unit. The proposed building addition is replacement in nature as the acute inpatient physical bed capacity of CMH's 120 beds will not increase. The project also involves 32,910 DGSF of renovations to the existing facility to address connections to the new addition, and reprogramming existing MSGA patient rooms to alternative uses, e.g., staff support, administration, and outpatient services.

The proposed new tower building will house: Elevators and Lobby (Ground Floor), Outpatient Services and Medical Staff/Administration Offices (First Floor), and two new 20-bed inpatient medical/surgical units (Second and Third Floors).

The Project has been proposed in order to expand the number of private patient rooms in the hospital for both MSGA inpatients and for Observation

Outpatients. The current number and distribution of private patient rooms in CMH and the absence of a dedicated unit for Observation services is considered suboptimal.

Alternatives to the proposed project were considered and rejected, including the relocation of CMH's TCU, and the construction and operation of a complete all private patient room replacement hospital. Master Facility Plans for the CMH campus do not contemplate any additional new construction beyond that proposed in this Application.

In making the investments noted above to expand and improve its physical plant on its current site, CMH will incur capital expenditures in excess of the statutory threshold for CON review. In addition, CMH reserves the right to seek from the Health Services Cost Review Commission future additional rate charging authority to help fund this project, and therefore, is not taking the "pledge" as set forth at COMAR 10.24.01.03 J.36 Therefore, a CON is required for the capital expenditures associated with this project, totaling $**51,654,138.**

B. Comprehensive Project Description: The description must include details, as applicable, regarding:

(1) Construction, renovation, and demolition plans;
(2) Changes in square footage of departments and units;
(3) Physical plant or location changes;
(4) Changes to affected services following completion of the project; and
(5) If the project is a multi-phase project, describe the work that will be done in each phase. If the phases will be constructed under more than one construction contract, describe the phases and work that will be done under each contract.

See Exhibit 1. Complete Project Description

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

Complete the Bed Capacity (Table A) worksheet in the CON Table Package if the proposed project impacts any nursing units.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: **102** acres
B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO __**X**___ (If NO, describe below the current status and timetable for receiving necessary approvals.)

Anticipated Dates	Action
September 2015 -January 2016	Site Plan Design Completed
January, 2016	Site Plan Submittal to the Calvert

	County Planning Commission
April, 2016	Site Plan Approval Obtained
April 2016 - December 2016	Construction Drawings Will Be Prepared and Submitted to Calvert County for Building Permit
January, 2017	Building Permit Issued
June, 2017	Commence Construction

C. Form of Site Control (Respond to the one that applies. If more than one, explain.):

(1) Owned by: Calvert Memorial Hospital of Calvert County
Please provide a copy of the deed.

(2) Options to purchase held by: N/A
Please provide a copy of the purchase option as an attachment.

(3) Land Lease held by: N/A
Please provide a copy of the land lease as an attachment.

(4) Option to lease held by: N/A
Please provide a copy of the option to lease as an attachment.

(5) Other: N/A
Explain and provide legal documents as an attachment.

11. PROJECT SCHEDULE

In completing this section, please note applicable performance requirement time frames set forth at COMAR 10.24.01.12B & C. Ensure that the information presented in the following table reflects information presented in Application Item 7 (Project Description).

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date		months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project		months
Completion of project from capital obligation or purchase order, as applicable		months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract	44	months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.	5	months
Initiation of Construction within 4 months of the effective date of the binding construction contract.	1	Months
Completion of 1st Phase of Construction (Demolition) within 24 months of the effective date of the binding construction contract	4	Months
Fill out the following section for each phase. (Add rows as needed)		
Completion of 2nd phase (Construction of New Tower) within 24 months of completion of each previous phase	19	Months
Completion of 3rd phase (Renovations) within 24 months of completion	15	Months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date		months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1		months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.		months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase		months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase		months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase		months

12. PROJECT DRAWINGS

A project involving new construction and/or renovations must include scalable schematic drawings of the facility at least a 1/16” scale. Drawings should be completely legible and include dates.

Project drawings must include the following before (existing) and after (proposed) components, as applicable:

A. Floor plans for each floor affected with all rooms labeled by purpose or function, room sizes, number of beds, location of bathrooms, nursing stations, and any proposed space for future expansion to be constructed, but not finished at the completion of the project, labeled as “shell space”.

B. For a project involving new construction and/or site work a Plot Plan, showing the "footprint" and location of the facility before and after the project.

C. For a project involving site work schematic drawings showing entrances, roads, parking, sidewalks and other significant site structures before and after the proposed project.

D. Exterior elevation drawings and stacking diagrams that show the location and relationship of functions for each floor affected.

See Exhibit 2. Project Drawings

13. FEATURES OF PROJECT CONSTRUCTION

A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C) and Onsite and Offsite Costs (Table D) worksheets in the CON Table Package.

B. Discuss the availability and adequacy of utilities (water, electricity, sewage, natural gas, etc.) for the proposed project, and the steps necessary to obtain utilities. Please either provide documentation that adequate utilities are available or explain the plan(s) and anticipated timeframe(s) to obtain them.

All needed utilities are in place on the existing CMH campus to support the project.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E) worksheet in the CON Table Package.

Note: Applicant must include a list of all assumptions and specify what is included in all costs, as well the source of cost estimates and the manner in which all cost estimates are derived.

Applicant Response:

CMH has relied upon the expertise of Wilmot Sanz with the preparation of the Project Drawings and Construction Budget for this Application. Wilmot Sanz has extensive experience in the budgeting, design, construction of a variety of health care facilities, especially in Maryland.

The Project Cost Estimates include six categories for which the following assumptions were applied:

Category	Cost	Assumptions (% of Current Project Costs)	Assumptions (Interest Rates/Year)
Pre-Construction Costs	**$160,000**	**0.32%**	
Construction Costs	**$29,261,895**	**58.97%**	
Equipment and Furnishings	**$8,739,931**	**17.61%**	
Consultants	**$2,704,824**	**5.45%**	
Inspections/Permits	**$1,034,163**	**2.08%**	
Contingencies	**$7,721,966**	**15.56%**	
TOTAL Current Project Costs	***$49,622,779***	***100%***	
Escalation	**$1,960,387**	**N/A**	**2015: 3%; 2016: 3%**
TOTAL Project Costs (Escalated)	***$51,583,166***		

Source: Wilmot-Sanz.

The Project Budget assumes that the entire project will be financed out of the existing cash resources of CMH, supplemented by contributions.

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

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

   Dean A. Teague, President and CEO, Calvert Memorial Hospital

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

   VP of Operations, Washington Adventist Hospital, 11/01/2005 – 07/01/2012; Calvert Entities: Calvert Urgent Care Centers & Calvert Surgery Center, COO, 07/09/2012 – 03/01/2015.

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

   NO

4. Other than the licensure or certification actions described in the response to Question 3, above, has any facility with which any applicant is involved, or has any facility with which any applicant has in the past been involved (listed in response to Question 2, above) ever received inquiries from a federal or any state authority, the Joint Commission, or other regulatory body regarding possible non-compliance with Maryland, another state, federal, or Joint Commission requirements for the provision of, the quality of, or the payment for health care services that have resulted in actions leading to the possibility of penalties, admission bans, probationary status, or other sanctions at the applicant facility or at any facility listed in response to Question 2? If yes, provide, for each such instance, copies of any settlement reached, proposed findings or final findings of non-compliance and related documentation including reports of non-compliance, responses of the facility, and any final disposition or conclusions reached by the applicable authority.

   NO

5. Has any applicant, owner, or responsible individual listed in response to Question 1, above, ever pled guilty to, received any type of diversionary disposition, or been convicted of a criminal offense in any way connected with the ownership, development, or management of the applicant facility or any of the health care facilities listed in response to Question 2, above? If yes, provide a written explanation of the circumstances, including as applicable the court, the date(s) of conviction(s), diversionary disposition(s) of any type, 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 Board-designated official of the applicant regarding the project proposed in the application.

I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief.

10/7/2015
Date

Signature of Owner or Board-designated Official

President and CEO
Position/Title

Dean A. Teague
Printed Name

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

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

An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards and other review criteria.

If a particular standard or criteria is covered in the response to a previous standard or criteria, the applicant may cite the specific location of those discussions in order to avoid duplication. When doing so, the applicant should ensure that the previous material directly pertains to the requirement and the directions included in this application form. Incomplete responses to any requirement will result in an information request from Commission Staff to ensure adequacy of the response, which will prolong the application's review period.

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

To respond adequately to this criterion, the applicant must address each applicable standard from each chapter of the State Health Plan that governs the services being proposed or affected, and provide a direct, concise response explaining the project's consistency with each standard. In cases where demonstrating compliance with a standard requires the provision of specific documentation, documentation must be included as a part of the application.

Every acute care hospital applicant must address the standards in **COMAR 10.24.10: Acute Care Hospital Services**. A Microsoft Word version is available for the applicant's convenience on the Commission's website. Use of the *CON Project Review Checklist for Acute Care Hospitals General Standards* is encouraged. This document can be provided by staff.

Other State Health Plan chapters that may apply to a project proposed by an acute care hospital are listed in the table below. A pre-application conference will be scheduled by Commission Staff to cover this and other topics. It is highly advisable to discuss with Staff which State Health Plan chapters and standards will apply to a proposed project before application submission. Applicants are encouraged to contact Staff with any questions regarding an application.

Copies of all applicable State Health Plan chapters are available from the Commission and are available on the Commission's web site here:
http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_shp/hcfs_shp

10.24. 07	**State Health Plan: an overview** o **Psychiatric services** o **EMS**
10.24. 09	**Specialized Health Care Services - Acute Inpatient Rehab Services**
10.24. 11	**General Surgical Services**
10.24. 12	**Inpatient Obstetrical Services**
10.24. 14	**Alcoholism and Drug Abuse Intermediate Care Facility Treatment Services**
10.24. 15	**Organ Transplant Services**
10.24. 17	**Cardiac Surgery and Percutaneous Coronary Artery Intervention Services**
10.24. 18	**Neonatal Intensive Care Services**
Capital Projects Exceeding the CON Threshold for Capital Expenditures	**Hospital Capital Projects Exceeding the CON Threshold for Capital Expenditures** Hospital projects that require CON review because the capital expenditure exceeds the CON threshold for capital expenditures but do not involve changes in bed capacity, the addition of new services, and otherwise have no elements that are categorically regulated should address all applicable standards in **COMAR 10.24.10: Acute Care Hospital Services** in their CON application. Applicants should consult with staff in a pre-application conference about any other SHP chapters containing standards that should be addressed, based on the nature of the project.

COMAR 10.24.10 ACUTE CARE CHAPTER
COMAR 10.24.10.04A. GENERAL STANDARDS

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

Standard .04A (1) – Information Regarding Charges.

Information regarding hospital charges shall be available to the public. After July 1, 2010, each hospital shall have a written policy for the provision of information to the public concerning charges for its services. At a minimum, this policy shall include:

(a) Maintenance of a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site;

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

Applicant Response:

The Hospital has reviewed the State Health Plan requirements for maintaining a representative list of services and charges, procedures for promptly responding to individual requests for current charges for specific services/procedures, and for staff training to ensure that inquiries regarding charges for its services are appropriately handled, and is preparing a process and policy to assure compliance. When this policy process is completed and approved, CMH will submit the necessary documentation.

Standard .04A(2) – Charity Care Policy.

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay.

(a) The policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

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

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

Applicant Response:

(a) When CMH last obtained CON approval for a project more than 10 years ago, its charity care policy was determined to be in compliance with the applicable State Health Plan standards. Since that time, the State Health Plan standard has changed. As a result, the current CMH charity care policy needs to be updated. A revised policy to conform to present requirements is being reviewed in the internal Hospital approvals process, and will be provided to the Commission upon approval.

(b) **CMH's level of charity care does not fall within the bottom quartile of all hospitals. To the contrary, for FY 2014, the most recent Health Service Cost Review Commission Community Benefit Report shows that CMH provided total Community Benefits as 16.65% of its Total Operating Expenses, and is appropriate to the needs of its service area population. This compares highly favorably with the Statewide average of 10.47%.**

Standard .04A (3) – Quality of Care.

An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

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

Applicant Response:

CMH complies with all applicable federal, state and local health and safety regulations. CMH is licensed by the Maryland Department of Health and Mental Hygiene, is accredited by the Joint Commission, and is in compliance with the conditions of participation of the Medicare and Medicaid programs. (See Exhibit 3 for a copy of the Hospital's current license and JCAHO Accreditation.

CMH has reviewed the measure values for the Quality Measures included in the most recent update of the Maryland Hospital Performance Guide. None of the measure values fell within the bottom quartile of all hospitals' reported performance measured for any Quality Measures, nor have any fallen below a 90% level of compliance with the Quality Measure. To the contrary, CMH excels in the regulatory required process and outcomes measures, meeting or exceeding the 95th percentile. As further examples: CMH has demonstrated sustained reductions in Maryland Hospital Acquired Conditions significantly over the last 2 report years decreasing patient harm by 32%. CMH has consistently

outperformed the State in readmission reduction maintaining all cause readmissions below the HSCRC expected rates. CMH has maintained a position in the top decile statewide for readmission reduction. CMH has also maintained mortality rates below the HSCRC expected rates ranking in one of the highest survival rates in the State. These and other achievements have resulted in a number of prestigious awards related to quality outcomes and patient safety, of which CMH is justifiably proud: See page 4 for the listing at Exhibit 4, a copy of the Hospital's most recent Performance Improvement Quality and Safety Annual Report.

Our greatest challenge has been related to significant improvement in our HCAHPS (consumer experience) scores which are related to such factors as the lack of privacy and quietness due to double occupancy rooms. The community expectation has changed over the last decade and private rooms with amenities to support the home caregiver engagement and support in the patient's care are the norm in this region. Additionally, concerns for infection prevention make sharing rooms and bathroom facilities undesirable. The CMH Project is needed to directly address these issues.

COMAR 10.24.10 ACUTE CARE CHAPTER
COMAR 10.24.10.04B. PROJECT REVIEW STANDARDS
Standard .04B(1) – Geographic Accessibility.

> **A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.**

Applicant Response:

The proposed project does not involve a new hospital or an existing hospital being relocated to a new site. Also, all of the identified services are already within 30 minutes under normal driving conditions for 90% of the residents of Suburban's service area. This Standard is not applicable.

Standard .04B(2) – Identification of Bed Need and Addition of Beds.

Only medical/surgical/gynecological/addictions ("MSGA") beds and pediatric beds identified as needed and/or currently licensed shall be developed at acute care general hospitals.

(a) Minimum and maximum need for MSGA and pediatric beds are determined using the need projection methodologies in Regulation .05 of this Chapter.

(b) Projected need for trauma unit, intensive care unit, critical care unit, progressive care unit, and care for AIDS patients is included in the MSGA need projection.

(c) Additional MSGA or pediatric beds may be developed or put into operation only if:

(i) The proposed additional beds will not cause the total bed capacity of the hospital to exceed the most recent annual calculation of licensed bed capacity for the hospital made pursuant to Health-General §19-307.2; or

(ii) The proposed additional beds do not exceed the minimum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter.

(iii) The proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection; or

(iv) The number of proposed additional MSGA or pediatric beds may be derived through application of the projection methodology, assumptions, and targets contained in Regulation .05 of this Chapter, as applied to the service area of the hospital.

Applicant Response:

There are currently (FY 2016) seventy-seven licensed MSGA beds located at CMH, the only acute general hospital located in Calvert County. The minimum jurisdictional bed need projections adopted by the Commission for 2022 is 77; the maximum is 101.

CMH is not proposing to add MSGA beds as part of this project. Therefore, the project is consistent with Standard (c) (i) above.

Standard .04B(3) – Minimum Average Daily Census for Establishment of a Pediatric Unit.

An acute care general hospital may establish a new pediatric service only if the projected average daily census of pediatric patients to be served by the hospital is at least five patients, unless:

> **(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or**
>
> **(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.**

Applicant Response:

This standard is inapplicable because the Project does not involve establishment of a new pediatric service.

Standard .04B(4) – Adverse Impact.

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

> **(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and**
>
> **(b) If the project reduces the potential availability or accessibility of a facility or service by eliminating, downsizing, or otherwise modifying a facility or service, the applicant shall document that each proposed change will not inappropriately diminish, for the population in the primary service area, the availability or accessibility to care, including access for the indigent and/or uninsured.**

Applicant Response:

The proposed capital project to be undertaken by CMH will not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The financial assumptions supporting TABLE G. at Exhibit 5 assume no rate increase related to the capital costs of the proposed project, consistent with the terms of the Total Patient Revenue Agreement between CMH and the HSCRC. See Exhibit 6.

The proposed project is to expand and renovate CMH's physical plant in order to increase the number of private patient rooms. Thus it will increase the potential availability and accessibility to care for residents of CMH's service area population.

The project does not eliminate any services; none of the proposed changes will impact access for indigent and or uninsured patients. The project will likely have no impact on the costs and charges at other Maryland hospitals.

Standard .04B (5) – Cost-Effectiveness.

A proposed hospital capital project should represent the most cost effective approach to meeting the needs that the project seeks to address.

(a) To demonstrate cost effectiveness, an applicant shall identify each primary objective of its proposed project and shall identify at least two alternative approaches that it considered for achieving these primary objectives. For each approach, the hospital must:

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;

(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and

(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

(b) An applicant proposing a project involving limited objectives, including but not limited to, the introductions of a single new service, the expansion of capacity for a single service, or a project limited to renovation of an existing facility for the purposes of modernization, may address the cost-effectiveness of the project without undertaking the analysis outlined in (a) above, by demonstrating that there is only one practical approach to achieving the project's objectives.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site that is not within a Priority Funding Area as defined under Title 5, Subtitle 7B of the State Finance and Procurement Article of the Annotated Code of Maryland shall demonstrate:

(i) That is has considered, at a minimum, an alternative project site located within a Priority Funding Area that provides the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);

(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site.

(iii) That it has detailed the capital and operating costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost

associated with transportation system and other public utility infrastructure costs; and

(iv)That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project site or sites located with a Priority Funding Area.

Applicant Response:

CMH is not proposing the establishment of a new hospital or the relocation of CMH to a new site.

The principal need identified by the leadership of CMH that the project seeks to address is an insufficient number of available private beds for the care of future adult, general medical/surgical inpatients and outpatient observation patients in the current hospital facility[2]. Because CMH does not have a "dedicated" observation unit, these outpatients are provided services among the available patient rooms located in the existing general medical/surgical nursing units located in the Hospital.

Currently, CMH operates two general medical/surgical nursing units on the second and third floors of its facility. The second floor unit comprises of 33 patient rooms with a physical bed capacity of 50 beds. Sixteen of the 33 patient rooms on that unit are private rooms, and 17 are semi-private rooms. The third floor unit comprises of 20 patient rooms with a physical bed capacity of 31 beds. Nine of the 20 patient rooms are private rooms, and 11 are semi-private rooms. (See TABLE A., Exhibit 5)

However, given the geometry of the existing nursing units with single loaded corridors and remote nursing stations, the hospital is currently using 5 of the existing 53 general medical/surgical patient rooms for required nursing unit

2 In addition to providing general medical/surgical services to adult patients, CMH currently operates a 10-bed Intensive Care Unit ("ICU"). All ten of the patient rooms in the ICU are private patient rooms, and are not impacted by the proposed project. General Medical/Surgical inpatients are not treated in the ICU.

support services. Three of these five "unavailable" patient rooms are private rooms and two are semi-private rooms. Thus, on any given day, the maximum number of general medical/surgical inpatients and outpatient observation patients that can be provided a private room in the Hospital is 483. When the patient census exceeds 48, some of these patients will be "doubled-up" in one or more semi-private rooms, a suboptimal result that this Project seeks to address and correct.

At CMH, an "observation patient" is any outpatient for which a physician has placed an order of "observation status." Two kinds of patients are designated for "observation status" at CMH: medical observation patients and surgical observation patients. Currently, both medical and surgical observation patients are cared for in the available rooms and beds located in the existing general medical/surgical inpatient units. For the two year time period of FY 2014 - FY 2015, the average percentage of medical observation patients who are converted from "observation status" to an inpatient admission was 18.3%. The average observation length of stay for medical observation patients who remained in observation status and were not admitted was 24.7 hours; for an observation patient who was admitted, the average length of stay in "observation status" was 29.9 hours. For surgical observation patients, because no additional charges are incurred for surgical patients for whom "observation status" has been ordered, there is no record of the average length of stay for the small number of surgical observation patients. Nevertheless, we have estimated that the average surgical observation patient will spend up to 23 hours in "observation status," and have included 23 hours in our assumption of future utilization. In the future, following the completion of the proposed dedicated observation unit, only the medical observation patients will be cared for in the dedicated unit. Surgical observation patients will continue to be cared for in the general medical/surgical inpatient units.

3 We make a distinction between the "physical capacity" of CMH and the "available capacity" of CMH to accommodate general medical/surgical inpatients. The "physical capacity" (as shown on TABLE A) is a maximum number of patient rooms (53) that could be set up in space without significant renovations; the "available capacity" of CMH does not include 5 of the 53 patient rooms that are currently in use for other purposes, that could be set up without significant renovations, but are not staffed and available for patient occupancy.

In FY 2015, of the 2,678 outpatient observation patients treated at CMH, 2,339 (87%) were medical observation patients, and 339 (13%) were surgical observation patients.4

For purposes of projecting the utilization of the proposed dedicated 18 bed observation unit, which will be available for future CMH patients while in "observation status," we have assumed an average length of stay of one day, consistent with the FY 2015 utilization statistics for medical observation patients. Additional discussion on the need for the 18-bed dedicated outpatient observation unit is found in the response to COMAR 10.24.01.08G(3)(b) Need.

During FY 2015, the average daily census of all observation patients was 7.34 and the average daily census of general medical/surgical inpatients was 36.16, for a combined census of 43.50. Based on this average, the occupancy of the 48 available rooms in the Hospital was 90.63%.

In order to assure the statistical availability of a private room for the number of observation and general medical/surgical patients at CMH at FY 2015 levels, 99% of the time, approximately 59 rooms would have been required, 11 more than are available currently.5 This statistical estimate is consistent with the actual utilization of CMH for these services in FY 2015, as shown on the tables below. For the complete dataset on the daily census of CMH in FY 2015, please see Exhibit 7).

The project proposes no change in the number of inpatient general medical/surgical beds and the renovation of existing space for the proposed 18 bed observation unit.

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4 The 2,678 outpatient observation patients treated in FY 2015 is slightly larger than the 2,662 outpatient observation visits reported in FY 2015 on TABLE F. Visits are recorded in the financial database of the Hospital based on each patient's encounter billing record, while patient counts are recorded in the operations database of the Hospital based on dates of actual service utilization.

5 To estimate the need for private rooms during the FY 2015 period, we assumed that patient utilization was randomly distributed on a daily basis, and approximated the mathematical model represented by the Poisson distribution: # of beds needed @ 99% Availability = ADC + 2.33 * (Sq.Root ADC).

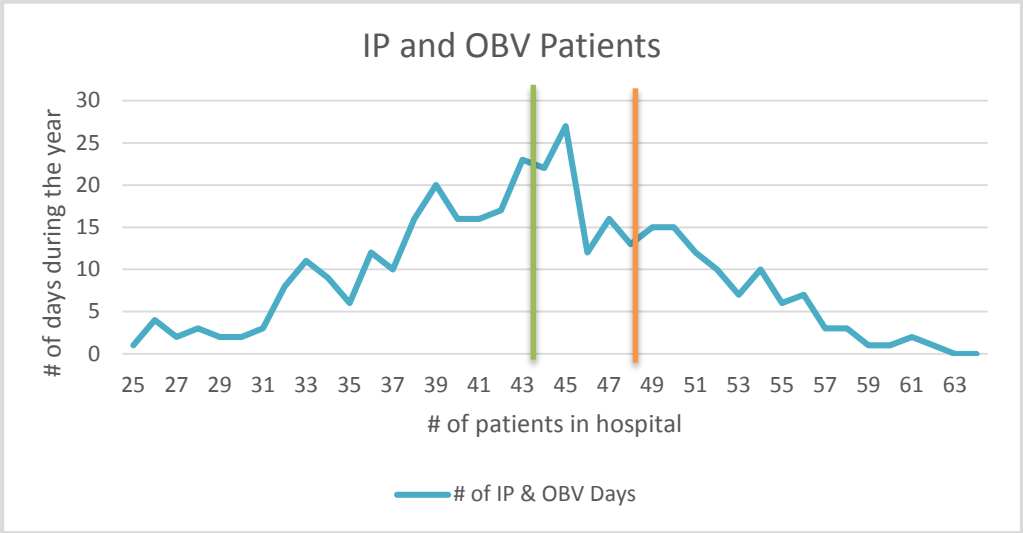
As shown on TABLE F. of this Application, to make use of the resulting bed capacity, we are assuming continued growth in demand for inpatient general medical/surgical patient days and observation patients through FY 2022.

Based on the actual inpatient census of adult medical/surgical inpatients and outpatient observation patients in FY 2015, on 26% (94/365) of total available days, the number of patients exceeded 48. On weekdays, excluding holidays and weekends, the percentage increased to 33% (84/255 days). Shown on below are the census counts in comparison to the 48 available patient rooms.

M/S + Outpt. Observ. Patient. Census	***All Days***	***Weekdays* Only (M-F)***
<48	258	161
48	13	10
49	15	14
50	15	13
51	12	9
52	10	10
53	7	6
54	10	8
55	6	5
56	7	7
57	3	3
58	3	3
59	1	1
60	1	1
61	2	2
>61	2	2
Days When Demand Exceeded 48 Available Private Beds: FY 2015	***94***	***84***
TOTAL	***365***	***255***

****Does not include: Saturdays, Sundays or Holidays.***
Source: CMH.

On the chart shown below, the mean census count (43.5 inpatient general medical/surgical and outpatient observation patients) for the FY 2015 is shown by the green vertical line, and the maximum number of available private beds (48) is shown by the orange vertical line:



Source: CMH.

To address this need for additional private patient rooms, four proposed projects were evaluated for cost-effectiveness.

First, the closure of the Comprehensive Care/Transitional Care Unit ("TCU") and its relocation to a freestanding comprehensive care/SNF facility in Calvert County was considered. The leadership of CMH is committed to assuring continuous access to comprehensive care/SNF services in the community, and closing the TCU and converting the space to a general medical/surgical unit to increase the availability of private rooms was not considered a reasonable alternative unless access to comprehensive care/SNF services provided to patients in the CMH TCU could also be preserved in another location.

Currently, the CMH Comprehensive Care/Transitional Care Unit ("TCU") is located on the fourth floor of the facility, and comprises of 15 patient rooms with a physical capacity of 20 beds6. See TABLE A. Exhibit 5.

In order to free up the 20 patient rooms on this unit to provide additional private beds for general medical/surgical inpatients, future TCU patients would need to be accommodated outside the CMH facility in an alternative location. Shown below are the utilization statistics for this unit:

Fiscal Year	*TCU Unit Average Daily Census*	*Licensed Beds*	*% Occupancy*
Actual			
2012	***12.7***	***18***	***69%***
2013	***13.7***	***18***	***71%***
2014	***14.4***	***18***	***71%***
2015	***14.0***	***18***	***69%***
Projected			
2016	***14.3***	***18***	***72%***
2017	***14.3***	***18***	***72%***
2018	***14.3***	***18***	***72%***

Source: CMH

Currently, there are three such facilities located in Calvert County that provide comprehensive care/SNF services, in addition to CMH:

Facility Name	*Location*	*# Licensed Beds*	*% Occupancy*
Asbury Solomons Island	*Solomons*	*48*	*89%*
Calvert County Nursing Center	*Prince Frederick*	*149*	*84%*
Solomons Nursing Center	*Solomons*	*87*	*93%*

Sources: Asbury Solomon's IRS Form 990, 2013; http://www.ucomparehealthcare.com/nhs/calvert_county_nursing_center/.;http://nursinghomerating.org/MD/solomons+nursing+center/215270/

According to the most recent published statistics from the MHCC, the 302 licensed comprehensive care beds in Calvert County were occupied at 84.64% rate in FY 2013, indicating no possibility of accommodating the patient days of

6 The CMH TCU unit is licensed for 18 comprehensive care beds.

care provided at the existing CMH TCU in the three other existing facilities at their current bed capacity. (See Exhibit 8). Some type of bed expansion at one or more facilities would be necessary to assure continued access.

In addition, the forecast of comprehensive care bed need for Calvert County for 2016 indicates that no additional beds are needed there, meaning that a planned bed expansion at one or more existing facilities would have to be limited to the relocation of the existing 18 TCU beds licensed at CMH. (See Exhibit 9)

This "relocation and expansion" alternative was considered and rejected by CMH due to the difficulties of coordinating such a plan that would assure continued access to needed SNF services in the immediate Prince Frederick area. Under the most likely scenarios, such a plan would also have required at least a five-year process of collaboration with one or more independent providers of SNF services in the County. Such a process would have taken CMH well beyond the timetable for implementing the proposed project, which maintains the operation of the TCU in its current location in the CMH facility.

Second, we considered the possibility of replacing all of the general medical/surgical beds in new construction on-site. This alternative was explored but rejected after preliminary analysis revealed that very significant costs would be incurred for which no return on that investment could be assured under the Hospital's TPR agreement, and the lack of an acceptable location that would provide the adjacencies to existing hospital ancillary and support services needed to achieve and maintain efficient operations. A variant of this alternative, to build an entire replacement hospital, was also considered and rejected as being too costly to accomplish the very limited objective of the project.

Finally, we considered the proposed project. This alternative could be implemented relatively quickly, would increase the square footage of the CMH facility at a reasonable cost, would maintain necessary adjacencies to existing hospital ancillary and support services for all services, would free up patient rooms for alternative non-inpatient uses, such as the dedicated outpatient observation unit, would provide additional and more patient-centered space for

the existing outpatient infusion services unit, and could be implemented without an increase in patient rates or charges. Most importantly, it would deliver on the principle objective of providing additional private patient rooms to a growing number of general medical/surgical inpatients and outpatient observation patients at the Hospital.

For these reasons, we believe the proposed project is the most cost-effective alternative for achieving CMH's objective, and therefore meets the standard.

Standard .04B (6) – Burden of Proof Regarding Need.

> **A hospital project shall be approved only if there is demonstrable need. The burden of demonstrating need for a service not covered by Regulation .05 of this Chapter or by another chapter of the State Health Plan, including a service for which need is not separately projected, rests with the applicant.**

Applicant Response:

The purpose of the proposed project is to increase the number and availability of private patient rooms at CMH. CMH is proposing no new services or additional inpatient bed capacity, and will be re-programming the existing space of the hospital to expand needed outpatient services, including infusion therapy services.

1. **<u>Outpatient Observation Services</u>**

As discussed in the response to Standard .04B (5) – Cost-Effectiveness, the current need for outpatient observation services is addressed through the utilization of unoccupied beds located in CMH general medical/surgical nursing units. Between FY 2014 and FY 2015, the utilization of outpatient observation visits has increased from 1,915 visits to 2,662 visits, a 39% increase. While CMH has not projected significant additional growth in outpatient observation visits through FY 2022, the need to provide a dedicated space has emerged as a planning priority. This space will be created in this Project by renovating the existing general medical/surgical nursing unit on the third floor of the Hospital for medical observation patients. A total of 18 private patient rooms will be provided in the dedicated unit. Surgical observation patients will continue to be provided outpatient services in unoccupied beds located in the Hospital's general medical/surgical nursing units.

In order to provide a sufficient number of private patient rooms for medical observation outpatients in the dedicated unit, CMH reviewed the average daily census and determined that if 99% percent of these medical observation patients were to be provided a private room, between 15 and 16 private rooms would be necessary to meet the projected need in FY 2022. This assumes that current

patterns of demand will continue: that patients identified by CMH physicians for medical observation in the Hospital's Emergency Department will be transferred to the 18-bed dedicated observation unit on the Hospital's third floor. This unit will occupy 11,245 DGSF as shown on TABLE B. The projected average occupancy of that unit is projected be approximately 46%. Given that the average daily census of medical observation patients at CMH ranged from 0 to 14 in FY 20157, that the average length of stay is approximately one day, that demand for observation services is not scheduled, and is projected to grow 3.8% annually through FY 2022, we believe that the projected 46% occupancy for the 18-bed dedicated observation unit is reasonable.

Projections of outpatient observation visits have been provided on TABLE F.

2. <u>Outpatient Infusion Services</u>

CMH currently operates a small outpatient infusion therapy service located on the first floor of the Hospital. Approximately 5,000 infusion therapy visits are projected in FY 2016, largely for the administration of chemotherapy to cancer patients. The current location of the Hospital's Infusion Center is sub-optimal, as it does not provide sufficient space for patients, visitors, and clinical staff during periods of high utilization. In addition, the space is not provided with natural light. CMH is projecting that the number of outpatient visits to the Center will increase to 5,887 in FY 2022. To address the needs of the current Center, and to provide additional space, it will be relocated to a larger space on the Hospital's first floor in the new patient tower proposed for this Project. The specific square footage will increase from 2.990 to 5,000 DGSF is shown on TABLE B. This additional space, which will overlook the Hospital's outdoor Healing Garden, will provide patients and their families with a more comfortable and comforting setting for successful therapies.

Projections of outpatient infusion therapy visits have been provided on TABLE F.

7 See Exhibit 7.

Standard .04B(7) – Construction Cost of Hospital Space.

(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation (MVS) Quarterly, updated to the nearest quarter using the Marshall and Swift update multipliers, and adjusted as shown in the Marshall and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift Guide must demonstrate that the higher costs are reasonable.

(c) If the projected cost per square foot exceeds the MVS benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the proposed construction cost that exceeds the MVS benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response:

The new construction at CMH will include a three story patient tower and is estimated to cost approximately $23.9 Million. Shown below are the computations of the Marshall and Swift Valuation Quarterly (MVS) factors as applied to this project, which total $17.7 Million. When adjusted for the "extraordinary" costs that will be incurred to implement this project (approximately $6,4 Million), the adjusted CMH new construction budget is shown to be slightly lower that the MVS standard for new construction by approximately $4.33/square foot.

New Construction			
Type	Hospital	Computations	
Construction Quality/Class	Good/A		
Stories	3		
Perimeter	644		
Average Floor to Floor Height	13.16		
Square Feet	43,575		
Base Costs (11/13)		$354.99	
Adjustment for Diff Cost Factors	0.989049	$351.10	
Additions			
Elevator	0		
Other	0		
Perimeter Multiplier	1.011952	$355.30	
Height Multiplier	1.0368	$368.37	
Multi Story	0		
Sprinkler Amount	4.16212	$372.54	
Update Location Multipliers			
Update Multiplier (9/2015)	1.05	$391.16	
Location Multiplier	1.04	$406.81	
MVS Cost Standard		**$406.81**	**$17,726,711.66**
Current Construction Costs (TABLE E.)		**$548.39**	**$23,896,092.00**
Extraordinary Costs (TABLE D.)		**$145.91**	**$6,357,982.00**
Adjusted Current Const. Costs		**$402.48**	**$17,538,110.00**
Above/(Below) MVS Standard		**-$4.33**	**($188,601.66)**

In making the computations for the MVS standard, and because the Project will house particular hospital departments and functions at CMH, an adjustment is made to the computations of the MVS standard of .9890, as shown below:

Department/Function	DGSF	MVS Name	MVS Cost Factor	CF X DGSF
FIRST FLOOR				
Medical Oncology/Infusion	5,100	Outpatient Dept	0.96	4,896
Administration/Medical Staff	3,405	Offices	0.96	3,269
Gift Shop/Chapel	1,120	Public Space	0.8	896
Lobby	4,050	Public Space	0.8	3,240
Stairs/Elevator Shafts	650	Shafts and Exterior Wall	0.6	390
SECOND FLOOR				
Nursing Unit	13,900	Inpatient Unit	1.06	14,734
Stairs/Elevator Shafts	650	Shafts and Exterior Wall	0.6	390
THIRD FLOOR				
Nursing Unit	14,050	Inpatient Unit	1.06	14,893
Stairs/Elevator Shafts	650	Shafts and Exterior Wall	0.6	390
TOTAL	**43,575**		**Adjustment Factor: 0.9890**	**43,098**

Because the Project involves a unique plan for demolition and new construction in the space currently occupied by the existing hospital facility, certain costs have been identified as "extraordinary," and are excluded from the comparison to the applicable MVS standard. These extraordinary construction costs, totaling approximately $6.4 Million and are included in the CMH construction budget, are shown on TABLE D. Excluding these extraordinary costs reduces the estimated project costs that are comparable to the MVS applicable calculated standard.

An explanation of these extraordinary costs include the following:

1. **Site/Building Demolition Costs – a portion of the existing Hospital facility will be demolished to make room for the new patient tower;**
2. **Rough Grading – these costs are specifically excluded from the MVS estimates;**

3. **Paving - these costs are specifically excluded from the MVS estimates**
4. **Exterior Signs - these costs are specifically excluded from the MVS estimates;**
5. **Landscaping - these costs are specifically excluded from the MVS estimates;**
6. **Sitework associated with poor soil conditions – these costs are not included in the MVS estimates;**
7. **Temporary Construction for Access – interim entrances during construction period are not included in the MVS estimates;**
8. **Two Elevators – Additional Costs of Building Two Shafts and Installing Elevators**
9. **Flat Plate Concrete in Lieu of Composite Steel – building material not specifically mentioned in the MVS for Class A, Good General Hospitals;**
10. **AHU Capacity for Heat Pump Conversion – Additional Costs for future changes to the CMH HVAC system overall;**
11. **Special foundations and construction adjacent to existing construction – these costs are related to fitting the new tower into the location where the demolished hospital space was located;**
12. **Yard Lighting and Security Devices - these costs are not included in the MVS estimates;**
13. **Pneumatic tube system – The costs for the pneumatic tube system are included in the construction cost estimate as an element of fixed equipment. These costs are not included in the MVS estimates;**
14. **Canopy - these costs are not included in the MVS estimates;**
15. **Extended General conditions associated with Phased Construction – the project will involve three phases: Demolition, New Construction and Renovation. During these phases temporary structures and relocations will be necessary before final completion of the Project. Such conditions are not included in the MVS estimates;**
16. **Escalation to midpoint of construction – Approximately 40% of the total escalation costs ($1.9 M) are attributed to the extraordinary costs, and are excluded from the MVS computations;**

17. **Allocation of A&E fees – Approximately 25% of the A&E fees ($1.5 Million) allocated to the New Construction budget are attributed to extraordinary costs, and are excluded from the MVS computations.**

In addition to the new construction proposed for the CMH project, approximately 33,000 DGSF of renovations are planned in the existing hospital facility. The estimated cost of renovations is approximately $9.5 Million. Shown below are the computations of the Marshall and Swift Valuation Quarterly (MVS) factors as applied to this portions of the Project, which total $11.9 Million. No adjustment for extraordinary costs were applied to the estimated costs of the CMH renovations. The comparison shows that the renovation costs are well below the MVS standard by $58/square foot.

Renovations			
Type	Hospital		
Construction Quality/Class	Good/A		
Stories	3		
Perimeter	648		
Average Floor to Floor Height	13.16		
Square Feet	32,910		
Base Costs		$354.99	
Adjustment for Diff Cost Factors	0		
Additions			
Elevator	0		
Other	0		
Perimeter Multiplier	0.897	$318.43	
Height Multiplier	1.0368	$330.14	
Multi Story	0		
Sprinkler Amount	3.438	$333.58	
Update Location Multipliers			
Update Multiplier	1.05	$350.26	
Location Multiplier	1.04	$364.27	
MVS Cost Standard		**$364.27**	**$11,988,180.39**
Current Construction Costs (TABLE E.)		**$287.39**	**$9,458,150.00**
Extraordinary Costs			**$0.00**
Adjusted Current Const. Costs		**$287.39**	**$9,458,150.00**
Above/(Below) MVS Standard		**-$58.06**	**($2,530,030.39)**

The Hospital is not proposing a rate increase related to the capital costs of the Project. Therefore, even if the Project's construction costs were to exceed the MVS standard benchmark, portion (c) of the Standard does not apply.

In light of the computations shown above, the costs per square foot for both the new construction and renovation portions of the project, as adjusted, are

below the limitations set forth in the MVS Guide. The Project is consistent with this Standard.

Standard .04B(8) – Construction Cost of Non-Hospital Space.

> **The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience. The projected cost per square foot of non-hospital space shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide for the appropriate structure. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the nonhospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.**

Applicant Response:

This standard is inapplicable because the Project does not involve the construction of non-Hospital space.

Standard .04B(9) – Inpatient Nursing Unit Space.

Space built or renovated for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. If the Inpatient Unit Program Space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed square footage limitation in this standard, or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Applicant Response:

The space to be built in new construction and space to be renovated for the three inpatient general medical/surgical nursing units in this Project are shown below:

Room/Function	Net SF	Beds	SF/Bed
Second Floor - Existing Med Surgical Unit (To Be Renovated)	10,021	26	385.42
Second Floor - New Gen. Med/Surgical Unit	7,935	20	396.75
Third Floor - New Gen Med/Surgical Unit	7,935	20	396.75

Source: CMH.

The breakdown of the nursing unit spaces is shown in Exhibit 10.

The space planned for the general medical/surgical nursing units to be addressed in this project is less than 500 square feet per bed. In addition, CMH has not proposed that any of the costs of renovation or new construction of these units be recognized in a rate adjustment. Therefore, the project is consistent with Standard (c) (i) above.

Standard .04B(10) – Rate Reduction Agreement.

A high-charge hospital will not be granted a Certificate of Need to establish a new acute care service, or to construct, renovate, upgrade, expand, or modernize acute care facilities, including support and ancillary facilities, unless it has first agreed to enter into a rate reduction agreement with the Health Services Cost Review Commission, or the Health Services Cost Review Commission has determined that a rate reduction agreement is not necessary.

Applicant Response:

CMH is not a high-charge hospital, and therefore, does not need to agree to a rate reduction agreement with the Health Services Cost Review Commission.

Standard .04B(11) – Efficiency.

A hospital shall be designed to operate efficiently. Hospitals proposing to replace or expand diagnostic or treatment facilities and services shall:

(a) Provide an analysis of each change in operational efficiency projected for each diagnostic or treatment facility and service being replaced or expanded, and document the manner in which the planning and design of the project took efficiency improvements into account; and

(b) Demonstrate that the proposed project will improve operational efficiency when the proposed replacement or expanded diagnostic or treatment facilities and services are projected to experience increases in the volume of services delivered; or

(c) Demonstrate why improvements in operational efficiency cannot be achieved.

Applicant Response:

CMH is currently an efficient hospital and will remain an efficient hospital following completion of the project. To the extent possible, the planning and design of the project took potential efficiency improvements into account, but these cannot be quantified in a manner that would clearly demonstrate significant cost savings, when the operational costs of the additional square footage proposed for the hospital is taken into account as well.

Because CMH will become a larger hospital, with additional available square footage in its physical plant for patient care, CMH's operational expenses will increase marginally with respect to heating and cooling, maintenance, housekeeping, and other "overhead" expenses.

At the same time, the current shortage of private patient rooms and related operational costs of the hospital reflect a lack of flexibility for efficiently managing patient transfers and admissions. For example, the current ALOS of outpatient observation patients at CMH is approximately one day. It is

possible that the availability and utilization of the proposed dedicated 18-bed Outpatient Observation Unit will reduce the ALOS of future observation patients, as transfers from the CMH ED to the Unit may be made more quickly and efficiently than is possible today. The same reductions in transfer time for future admitted MSGA patients may also take place as the availability of additional private patient rooms should shorten the duration of time patients might spend in the ED before being admitted.

In our view, incurring the additional expenses associated with supporting the increased number of private inpatient rooms and the availability of a dedicated outpatient observation unit may be balanced with the possible improvements in operational efficiency and improvements in the overall patient care experience at CMH.

Standard 04B(12) – Patient Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety. A hospital proposing to replace or expand its physical plant shall provide an analysis of patient safety features included for each facility or service being replaced or expanded, and document the manner in which the planning and design of the project took patient safety into account.

Applicant Response:

Research has shown that the most common and costly medical errors that affect patient safety include:

- **Communication Errors**
- **Hospital Acquired Infections**
- **Patient Falls**
- **Medication Errors**
- **Transfers and Hand-offs**

Fortunately, the majority of these medical errors are preventable with proper planning and designing. The proposed project addresses these common medical errors in the following way.

COMMUNICATION ERRORS

Communication failures have been identified as the leading cause of medication errors, delays in treatment, and wrong-site surgeries8. Communication Errors will be minimized in the proposed design as a result of the following:

- **The plan utilizes multi-disciplinary work spaces and visual connections among staff work areas to promote regular communication and discussion.**
- **The proposed Nursing Unit design is based on a planning module to reduce travel distances for access to supplies and medications.**

8Source: Joint Commission on Accreditation of Health Organizations

HOSPITAL ACQUIRED INFECTIONS

The prevalence of Hospital Acquired Infections increases with the duration of hospitalization, and more than 1/3 of all nosocomial infections involve airborne transmissions, which are associated with Staph, Tuberculosis, Legionella, SARS, Clostridium Baumenei and Immuno-compromised Patients, as well as a variety of less virulent pathogens. Hospital Acquired Infections will be reduced in the proposed design as a result of the following:

- **Readily accessible positioning of sinks and hand disinfectants.**
- **Separation of patients into private patient rooms**
- **Use of finishes that are easily cleaned and maintained.**

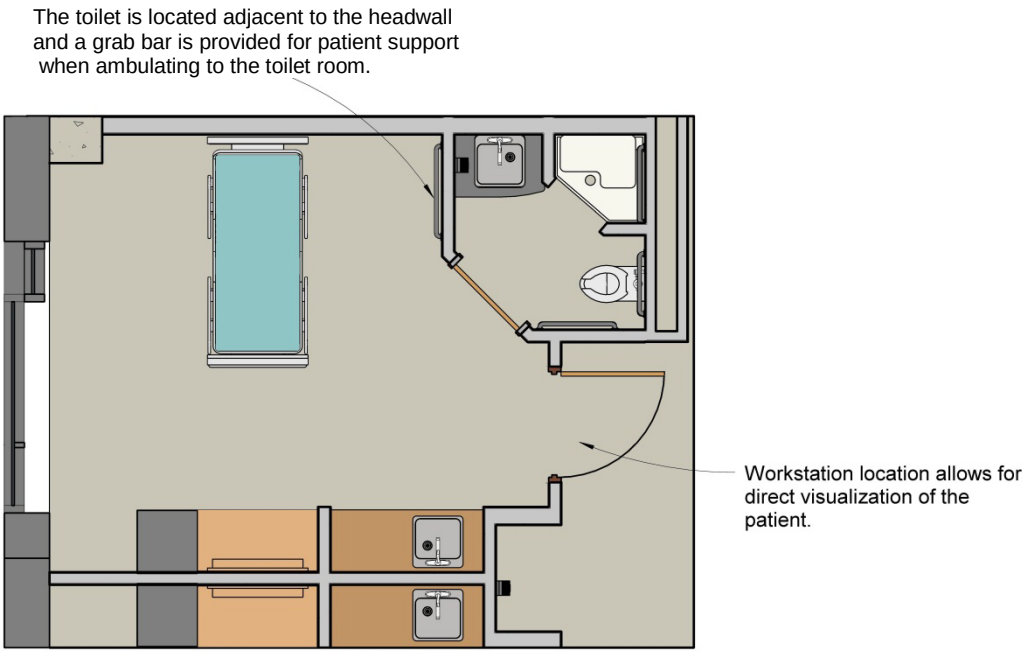
PATIENT FALLS

Studies have shown that the majority of patient falls are either toilet related or occur during transitions from beds to chairs. The risk of falls and resulting injury in patient rooms will be reduced as a result of the following design features:

- **The Patient Room Toilet is placed close as possible to the patient.**
- **The Patient has access to a grab-bar from bed to toilet with no interference of fixed medical equipment.**
- **Staff charting areas located at the Patient Room Entry allow direct visualization of the patient by staff.**
- **The Nursing Unit configuration provides decentralized nursing and clear lines of sight into patient rooms. This will allow greater visibility of the patient that may be attempting to transition from the bed or chair on their own, enable quicker preventative assistance by nursing staff, and in the event of a fall, provide for faster post fall care.**

Refer to Figure 1: Patient Room and Figure 2: Nursing Unit Design

Figure 1
PATIENT ROOM



Bathroom Location and Design

- **Easier bathroom transfers result in fewer falls.**

Bedside Documentation

- **Provisions for charting at bedside will help decrease patient falls**

Nursing Unit Design

- **The nursing units have been designed to maximize staffing efficiency. Reducing the number of trips between the patient room and the team**

station and other support rooms will increase the time staff is available to care for patients. This will help decrease patient falls

MEDICATION ERRORS

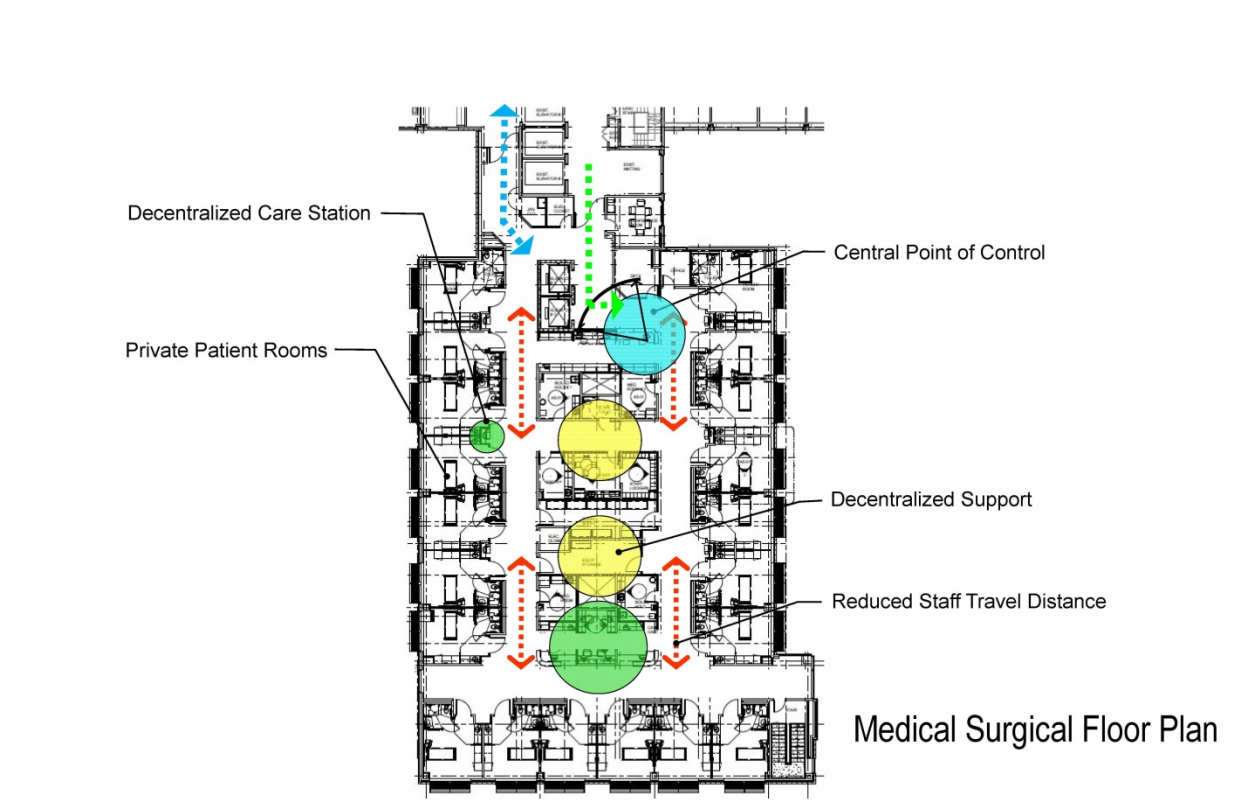
Adverse Drug Events will be reduced thru the use of CPOE and EMAR Technology. This technology will reduce the risk of medication errors. Specific anticipated results and features include:

- **Elimination of confusion among drug names that sound alike**
- **Prompts for drug interaction, allergy, or overdose to reduce prescribing errors**

TRANSFERS AND HAND-OFFS

Serious medical errors result from miscommunication when a patient is transferred from one caregiver to another. Dangerous errors and oversights can occur in the gap when a patient is moved to another unit or turned over to a new nurse or doctor during a shift change. The solution proposed at Calvert Memorial Hospital follows utilizes flexible multidisciplinary work spaces to provide areas for team collaboration during shift changes.

Figure 2
NURSING UNIT DESIGN



Standard .04B(13) – Financial Feasibility.

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

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

(b) Each applicant must document that:

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

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

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

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

Applicant Response:

(a) The following assumptions have been used to develop the financial projections shown in G., and H.:

Table G. Entire Facility – Uninflated

FY 2016 Patient Revenue:

Inpatient Regulated and Outpatient Regulated revenue equals the current final rate order received from the HSCRC of $146,902,750.

Transitional Care Unit and De-Regulated Outpatient revenue equals the FY 2016 Budget

FY 2016 Adjustments to Revenue:

Allowance for Bad Debt, Contractual Allowance, and Charity Care equals the FY 2016 Budget Adjustments as a % of Total FY 2016 Revenue

FY 2016 Other Operating Revenue equals FY 2016 Budget

FY 2016 Expenses equal FY 2016 Budget

FY 2017 – FY 2022 Revenue:

Inpatient Regulated and Outpatient Regulated revenue increase by the demographic adjustment of .52% each year.

Transitional Care Unit and De-Regulated Outpatient revenue equals the FY 2016

Allowance for Bad Debt, Contractual Allowance, and Charity Care remain the same ratio to Revenue as the FY 2016 value using the projected Revenues.

Other Operating Revenue equals FY 2016

FY 2017 – FY 2021 Expenses:

Salary and Wages (including Benefits) equals FY 2016

Contractual Services equals FY 2016

Interest on Current Debt equals 96% of each prior year total Interest on Current Debt

Current Depreciation equals each prior year total Interest on Current Debt plus $600,000

Supplies equals each prior year Supply Expenses plus a % increase based on MSG patient days plus Medical Observation cases volume increase for each of the given year

Other Operating Expenses equal FY 2016

FY 2022 Expenses:

Salary and Wages (including Benefits) equals FY 2021 plus additional staffing for Medical Observation Unit Nursing Manager, and staff for EVS, Plant, and Security for New Tower

Contractual Services equals FY 2021

Interest on Current Debt equals 96% of FY 2021 total Interest on Current Debt

Current Depreciation equals FY 2021 total Interest on Current Debt plus $600,000

Project Depreciation equals total Capital of Project depreciated over 30 years

Supplies equals FY 2021 Supply Expenses plus a % increase based on MSG patient days plus Medical Observation cases volume increase for the given year

Other Operating Expenses equal FY 2016

FY 2017 – FY 2022 Non-Operating Income: Equals FY 2016 Budget

Table H. Entire Facility – Inflated

FY 2016 Revenue and Expenses: Equals Uninflated assumptions

FY 2017 – FY 2022 Revenue:

Inpatient Regulated, Outpatient Regulated, Transitional Care Unit, and De-Regulated revenue are the Uninflated values inflated by 2.34% (based on most current HSCRC Rate Order)

Allowance for Bad Debt, Contractual Allowance, and Charity Care remain the same ratio to Revenue as the FY 2016 value using the projected Revenues.

Other Operating Revenue equals FY 2016 value inflated by 2.34%

FY 2017 – FY 2021 Expenses:

Salary and Wages (including Benefits) equals each prior year plus a 3% increase

Contractual Services equals each prior year plus a 3% increase

Interest on Current Debt equals Uninflated assumptions

Current Depreciation equals Uninflated assumptions

Supplies equals Uninflated assumptions plus a 2% inflator

Other Operating Expenses equals each prior year plus a 2.5% inflator

FY 2022 Expenses:

Salary and Wages (including Benefits) equals Work Force Information Table L. Projected Changes

Contractual Services equals Work Force Information Table L. Projected Changes

Interest on Current Debt equals Uninflated assumptions

Current Depreciation equals Uninflated assumptions

Project Depreciation equals Uninflated assumptions

Supplies equals Uninflated assumptions plus a 2% inflator

Other Operating Expenses equals FY 2021 plus a 2.5% inflator

FY 2017 – FY 2022 Non-Operating Income: Equals FY 2016 Budget

(b) (i) The assumptions used to make the Projections of CMH utilization shown on TABLE F. through FY 2022 are found at Exhibit 11. These assumptions address the service population of CMH, its projected growth between 2015 and 2022, and its utilization of CMH for services. The service area is defined by 21 zipcode areas comprising the geographic areas from which 85% of the MSGA discharges at CMH in FY 2015 were service area residents. See Exhibit 12 for map of the location of CMH and its service area.

Because the proposed project addresses the need to provide additional private patient rooms for adult medical/surgical patients, CMH considered two main factors to project inpatient MSGA and psych discharges: population growth and a reduction in unnecessary care. By applying the FY 2015 MSGA and Psych use rates to the projected populations in the service area, we estimated an annual growth rate of 2.6% for MSGA and Psychiatric discharges through FY 2022. Projected ALOS for both services is assumed to remain constant.

However, we also considered it necessary to incorporate a future reduction in potentially avoidable utilization (PAU's) at CMH. The HSCRC defines PAU as hospital care that is unplanned and can be prevented through improved care, care coordination, or effective community-based care or care cost increases that result from a potentially preventable complications occurring in a hospital.

In Maryland, PAU is calculated using the readmission rate and a prevention quality indicator (PQI) composite measure. Maryland hospitals on GBR/TPR are expected to reduce PAU in upcoming years. There are Statewide and hospital-specific targets for reductions in readmissions required by the CMS Waiver and under the HSCRC's implementation of the waiver, Maryland hospitals are not compensated for PQIs. Consistent with local and regional initiatives for population health, CMH is working to reduce PAU through participation in the Southern Maryland Regional Partnership for Health System Transformation and through the operation of its own outpatient clinic for adults at-risk for unnecessary hospital utilization. The purpose of this clinic is to reduce future unnecessary acute episodes through ongoing care coordination, patient and family education, and chronic disease management.

CMH believes that Inpatient bed capacity should not be planned for providing potentially avoidable care; thus we have made the elimination of all PAUs a challenging goal and a reasonable target for CMH through FY

2022. To be consistent with this target over the next six years, the projections assume an overall reduction in MSGA and Psych discharges from their historic levels by 2% each year. Taking both factors into account, population growth and PAU reduction, both inpatient MSGA and Psych discharges are projected to increase by 0.6% each year.

For the projections of Obstetric and Pediatric inpatient services, changes in utilization were assumed to maintain FY 2015 discharge rates and projected changes in the service area population.

For the projections of Medical Observation volumes, we considered the historical growth in the number of observation visits at CMH, particularly as it relates to the intended reduction of inpatient MSGA and Psychiatric discharges as discussed above.

For projections of Emergency Department , Infusion Therapy and Outpatient Surgical Observation visits, we assumed a growth rate that approximated 66% of the CAGR for residents of the CMH services area age >55.

(ii) Revenue estimates are based on current allowable charge levels and incorporate the current reimbursement methodologies employed by the HSCRC.

(iii) Staffing and overall expense projections are based on current expenditure levels but take into account projected changes in utilization and the necessary increases that are responsive to the additional square footage of the facility, and the operation of a dedicated outpatient observation unit.

(iv) As shown on TABLE G., the Hospital will generate excess revenues over expenses through FY 2022, following the completion of the Project.

Standard .04B(14) – Emergency Department Treatment Capacity and Space.

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

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

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

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

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

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

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

Applicant Response:

This standard is inapplicable because the Project does not involve a new or expanded emergency department.

Standard .04B(15) – Emergency Department Expansion.

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

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

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

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

Applicant Response:

This standard is inapplicable because the Project does not involve an expanded emergency department.

Standard .04B(16) – Shell Space.

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

(i) Considers the most likely use identified by the hospital for the unfinished space;

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

(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

(c) Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants shall provide information on the cost, the most likely uses, and the likely time frame for using such shell space.

(d) The cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the Health Services Cost Review Commission.

Applicant Response:

This standard is inapplicable because the Project does not involve the creation of any shell space at CMH.

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

The Commission shall consider the applicable need analysis in the State Health Plan. If no State Health Plan need analysis is applicable, the Commission shall consider whether the applicant has demonstrated unmet needs of the population to be served, and established that the proposed project meets those needs.

INSTRUCTIONS: Please identify the need that will be addressed by the proposed project, quantifying the need, to the extent possible, for each facility and service capacity proposed for development, relocation, or renovation in the project. The analysis of need for the project should be population-based, applying utilization rates based on historic trends and expected future changes to those trends. This need analysis should be aimed at demonstrating needs of the population served or to be served by the hospital. The existing and/or intended service area population of the applicant should be clearly defined.

Fully address the way in which the proposed project is consistent with each applicable need standard or need projection methodology in the State Health Plan.

If the project involves modernization of an existing facility through renovation and/or expansion, provide a detailed explanation of why such modernization is needed by the service area population of the hospital. Identify and discuss relevant building or life safety code issues, age of physical plant issues, or standard of care issues that support the need for the proposed modernization.

Please assure that all sources of information used in the need analysis are identified. Fully explain all assumptions made in the need analysis with respect to demand for services, the projected utilization rate(s), the relevant population considered in the analysis, and the service capacity of buildings and equipment included in the project, with information that supports the validity of these assumptions.

Explain how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed. Detail the applicant's consideration of the provision of services in non-hospital settings and/or through population-based health activities in determining the need for the project.

Complete the Statistical Projections (Tables F and I, as applicable) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package.

Applicant Response:

The need for this project is described in the response to Standard .04B (5) – Cost-Effectiveness, which proposes a cost-effective phased project of new construction and renovation. While the principal objective of this Project is to expand the availability of private beds for adult medical/surgical inpatients, the project also incorporates adapting the existing facility and expanding the capacity of CMH to address the growing demand for outpatient services. This

Project will provide CMH with the opportunity to address multiple demands for updated and upgraded nursing units in the facility for both inpatients and outpatients. These proposed changes will enhance patient and staff safety, while providing flexibility in the health care system for addressing the transformation initiatives for improving population health. Specifically, CMH is requesting no additional inpatient bed capacity in this Project.

The utilization plan for providing observation services anticipates the availability of the 18-bed dedicated unit only for medical observation patients in FY 2022, as well as the availability of unoccupied beds in the Hospital's general medical/surgical nursing units for surgical observation patients.

As shown on TABLE F., CMH has projected both general medical/surgical inpatient discharges and days and outpatient observation visits and hours. Both observation and admitted inpatients will continue to be cared for in the general medical/surgical inpatient units of CMH, its current practice, through the FY 2021 target year.

In FY 2022, when the renovation phase of the Project is completed, a dedicated outpatient observation unit will open for medical observation outpatients only; surgical observation outpatients will continue to be cared for in the general medical/surgical nursing units.

Because the Hospital does not bill for the actual number of hours spent in "observation status" by outpatient surgical patients, we have assumed that each stay is less than 24 hours, but that during any given day, only one such patient would occupy an available bed. Hence one outpatient visit yields one patient day.

In summary, shown below is the projected utilization of general medical/surgical beds for admitted inpatients, surgical observation outpatients, and medical observation patients, with the 18-bed dedicated observation unit becoming operational in FY 2022 at the conclusion of the renovation phase of the Project.

FY	Admitted M/S Pt. Days	Surgical Outpt. Obs. Days	Medical Outpt. Obs. Days	ADC	Beds	% Occupancy
2016	14,673	360	2,435	47.9	58	82.51%
2017	14,649	369	2,527	48.1	57	84.33%
2018	14,733	379	2,624	48.6	57	85.25%
2019	14,818	389	2,723	49.1	57	86.18%
2020	14,903	399	2,827	49.7	57	87.14%
2021	14,988	409	2,934	50.2	57	88.11%
2022	15,074	419		42.4	57	74.47%
2022*			3,046	8.3	18	46.36%

Source: CMH.
*Dedicated 18-bed Observation Unit Becomes Operational

Currently, the general medical/surgical inpatient rooms of the Hospital are not sufficient to provide access to two groups of patients: admitted MSGA patients and Medical Observation Outpatients. The data presented in this application show a need for additional private patient rooms to assure sufficient access through FY 2022. The patient rooms of CMH do not meet the current expectations and practices for excellent patient care, as well as preferences for larger room size, privacy and patient education. Current codes for new hospital construction all but require patient rooms to be private, adequately sized, and family friendly.

While CMH is located in a service area with a rapidly growing population, between 2015 and 2022, the greatest growth will be among the service area residents age >55. And despite this projected population increase, CMH believes that recent reductions in general medical/surgical discharge rates will be sustained over the forecast period. The population health initiatives of CMH will continue to significantly reduce unneeded hospital utilization.

Nevertheless, the Hospital's services will still be needed in the community, particularly outpatient services. Hence, the floor plan for this Project, anticipates

growing needs for local outpatient infusion therapy for cancer treatment and outpatient observation for patients formerly admitted or re-admitted for short-stays. To provide to some additional surge capacity when needed, some semi-private rooms in the existing MSGA nursing units will maintain the headwall infrastructure to permit additional inpatient admissions when needed without additional renovations.

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

The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or through an alternative facility that has submitted a competitive application as part of a comparative review.

INSTRUCTIONS: Please describe the planning process that was used to develop the proposed project. This should include a full explanation of the primary goals or objectives of the project or the problem(s) being addressed by the proposed project. The applicant should identify the alternative approaches to achieving those goals or objectives or solving those problem(s) that were considered during the project planning process, including:

a) the alternative of the services being provided through existing facilities;

b) or through population-health initiatives that would avoid or lessen hospital admissions.

Describe the hospital's population health initiatives and explain how the projections and proposed capacities take these initiatives into account.

For all alternative approaches, provide information on the level of effectiveness in goal or objective achievement or problem resolution that each alternative would be likely to achieve and the costs of each alternative. The cost analysis should go beyond development costs to consider life cycle costs of project alternatives. This narrative should clearly convey the analytical findings and reasoning that supported the project choices made. It should demonstrate why the proposed project provides the most effective method to reach stated goal(s) and objective(s) or the most effective solution to the identified problem(s) for the level of costs required to implement the project, when compared to the effectiveness and costs of alternatives, including the alternative of providing the service through existing facilities, including outpatient facilities or population-based planning activities or resources that may lessen hospital admissions, or through an alternative facility that has submitted a competitive application as part of a comparative review.

Applicant Response:

As described in the response to Standard .04B (5) – Cost-Effectiveness, the hospital considered and rejected more costly alternatives to the proposed project. In addition, one alternative, to provide skilled nursing services in an alternative non-hospital setting was considered and rejected largely due to timing issues, i.e., the ability to relocate the existing CMH Transitional Care Unit (TCU) within a reasonable period of time. As it stands, there is no available facility in Calvert County that can accommodate the existing demand that the TCU does. The leadership of CMH is committed to continue to provide skilled nursing services until such time additional bed capacity can be developed in an accessible and high quality community based facility.

Moreover, the proposed project can be implemented within the current rate structure of CMH, as defined in its TPR Agreement with the HSCRC. (See Exhibit 6)

As an alternative to building additional inpatient bed capacity to meet the needs of its growing and aging population, CMH has continued to lead population health initiatives in the community to reduce unnecessary inpatient admissions.

COMAR 10.24.01.08G(3)(d). Viability of the Proposal.

The Commission shall consider the availability of financial and nonfinancial resources, including community support, necessary to implement the project within the time frames set forth in the Commission's performance requirements, as well as the availability of resources necessary to sustain the project.

INSTRUCTIONS: Please provide a complete description of the funding plan for the project, documenting the availability of equity, grant(s), or philanthropic sources of funds and demonstrating, to the extent possible, the ability of the applicant to obtain the debt financing proposed. Describe the alternative financing mechanisms considered in project planning and provide an explanation of why the proposed mix of funding sources was chosen.

- Complete applicable Revenues & Expenses (Tables G, H, J and K as applicable), and the Work Force information (Table L) worksheets in the CON Table Package, as required. Instructions are provided in the cover sheet of the CON package. Explain how these tables demonstrate that the proposed project is sustainable and provide a description of the sources and methods for recruitment of needed staff resources for the proposed project, if applicable.

- Describe and document relevant community support for the proposed project.

- Identify the performance requirements applicable to the proposed project and explain how the applicant will be able to implement the project in compliance with those performance requirements. Explain the process for completing the project design, contracting and obtaining and obligating the funds within the prescribed time frame. Describe the construction process or refer to a description elsewhere in the application that demonstrates that the project can be completed within the applicable time frame.

- Audited financial statements for the past two years should be provided by all applicant entities and parent companies.

Applicant Response:

CMH intends to fund this project without incurring debt, and without a rate increase. The Project Budget is found at TABLE E. in the CON Table Package. The Hospital has been advised that its plans to solicit $5 Million in charitable contributions from the community to help fund the project are reasonable and achievable. CMH's most recent audited financial statements (FY 2014) show that CMH had $27 million in cash, $41,000 in short term investments and $98 million in investments. This results in $126.9 million in cash and investments were available to help fund this project. See Exhibit 13.

FY 2015 audited financial statements will be provided to the MHCC when they become available, and will also show the availability of sufficient funds to implement the Project.

Letters of Support for the Project are found at Exhibit 14.

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

An applicant shall demonstrate compliance with all terms and conditions of each previous Certificate of Need granted to the applicant, and with all commitments made that earned preferences in obtaining each previous Certificate of Need, or provide the Commission with a written notice and explanation as to why the conditions or commitments were not met.

INSTRUCTIONS: List all of the Certificates of Need that have been issued to the applicant or related entities, affiliates, or subsidiaries since 2000, including their terms and conditions, and any changes to approved CONs that were approved. Document that these projects were or are being implemented in compliance with all of their terms and conditions or explain why this was not the case.

Applicant Response:

CMH received CON approval, with no conditions, in 2004 for an expansion and renovation project (Docket #03-04-2125). That project was successfully completed and implemented as approved, in accordance with all terms of the CON. There have been no other projects since that time that have required CON approval.

COMAR 10.24.01.08G(3)(f). Impact on Existing Providers and the Health Care Delivery System.

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

INSTRUCTIONS: Please provide an analysis of the impact of the proposed project:

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[9];

b) On access to health care services for the service area population that will be served by the project. (state and support the assumptions used in this analysis of the impact on access);

c) On costs to the health care delivery system.

If the applicant is an existing hospital, provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the Project Budget, the projections of revenues and expenses, and the work force information.

Applicant Response:

Because CMH's proposed project is expanding the square footage of its existing facility, but not increasing its bed capacity, there should be no impact on the volumes of any other existing providers. In calculating future volume projections, CMH assumed no change in market share related to the availability of 13 additional private patient rooms for MSGA inpatients.

CMH's proposed project includes the renovation of existing space to provide additional flexibility in patient assignment for both inpatient and outpatient services, and to provide additional space for existing services. The availability of this additional space will have a positive impact on the process of care, particularly in the transfer of patients from the hospital ED to the inpatient MSGA

[9] **Please assure that all sources of information used in the impact analysis are identified and identify all the assumptions made in the impact analysis with respect to demand for services, the relevant populations considered in the analysis, and changes in market share, with information that supports the validity of these assumptions.**

units, and from the ED to the proposed dedicated outpatient observation unit. The availability of these additional inpatient and outpatient private rooms should have a positive impact on the efficiency and accessibility of the hospital's ED.

In our view, the overall access to health care services for the service area population will improve as a result of the increased number of private rooms at CMH. CMH's current percentage of private rooms available for inpatient hospital services is 62%; this will increase to 80% when the proposed project is completed. In practice, the utilization of semi-private rooms for single patient occupancy will continue, particularly for MSGA patients, which will increase their effective availability to 100% when the project is completed.

The availability of a larger complement of private rooms will reduce the number of times the Hospital's ED will need to "hold" a patient awaiting admission to an MSGA bed or transfer for observation services. In addition to the increase in the number and percentage of private rooms that will become available

The availability of additional private patient rooms will reduce or eliminate the need to "block" beds located in semi-private rooms for various reasons such as isolation needs and gender differences.

CMH has assumed no increase in patient charges in Table G. (Exhibit 4) related to the proposed project consistent with its TPR agreement with the HSCRC.

Finally, CMH believes that there is a long-term cost saving to the proposed project insofar as the efficient use of renovated existing space has been programmed into the project, which will provide long-term flexibility to meet future patient needs, without incurring the high costs of additional new hospital construction.

Given the market environment in which CMH operates, the ability to make use of its existing plant as a platform for a modest addition, and related renovations, increases its operational flexibility. This flexibility will help postpone the need for

either future expansions on its existing campus, or the need for a high-cost project to replace the Hospital in its entirety on a new site.

For Affirmations, see Exhibit 15.