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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

Johns Hopkins Health System Application for Certificate of Need Suburban Hospital

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**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: Suburban Hospital

Address: 8600 Old Georgetown Rd	Bethesda	20814	Montgomery
Street	City	Zip	County

Name of Owner (if differs from applicant):
N/A

2. OWNER

Name of owner: Suburban Hospital, Inc.

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
Suburban Hospital, Inc.

Address: Above				
Street	City	Zip	State	County

Telephone: 301-896-3100

Name of Owner/Chief Executive: Gene Green, MD.

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 ☒
- (2) For-profit ☐
- (3) Close ☐ State & date of incorporation
Maryland; May 22, 1942
- C. Partnership ☐
- General ☐
- Limited ☐
- Limited liability partnership ☐
- Limited liability limited partnership ☐
- Other (Specify): _____
- D. Limited Liability Company ☐
- E. Other (Specify): _____
- To be formed: ☐
- Existing: ☒

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

A. Lead or primary contact:

Name and Title: Margaret Fitzwilliam, Director Capital Renovation Planning

Mailing Address:

8600 Old Georgetown Rd. Bethesda MD 20814
Street City Zip State

Telephone: 301-896-3806

E-mail Address (required): Mfitzwi1@jhmi.edu

Fax: 301-493-5583

B. Additional or alternate contact:

Name and Title: Anne Langley, Sr. Director, Health Planning & Community Engagement

Mailing Address:

3910 Keswick Road, Suite N-2200 Baltimore MD 21211
Street City Zip State

Telephone: 443-997-0727

E-mail Address (required): alangl2@jhmi.edu

Fax: 443-614-9709

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 | <input type="checkbox"/> |
| (2) An existing health care facility moved to another site | <input type="checkbox"/> |
| (3) A change in the bed capacity of a health care facility | <input type="checkbox"/> |
| (4) A change in the type or scope of any health care service offered by a health care facility | <input type="checkbox"/> |
| (5) A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: | X |

http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf

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.

Suburban Hospital seeks approval for the capital expenditures related to a 300,000 square foot building addition. The building addition is part of a larger campus enhancement effort that also involves the addition of a 1,112 space parking garage and associated site work. The campus enhancement effort is the result of a master facility and campus plan completed in 2005 by AECOM, an international architectural firm specializing in healthcare. Among many findings, the master facility plan process noted two critical issues related to Suburban's existing facility. Suburban is significantly undersized based on current building codes and industry standards and existing volumes, and Suburban's existing facility footprint and infrastructure (column grid and floor to floor heights) are inadequate to address the needs of current and emerging technologies. The proposed building addition is replacement in nature. The project will also require approximately 18,000 square feet of renovation to the existing facility to address connections and retro-fitting a small number of existing spaces impacted by connections.

The proposed building addition will include:

- Replacement of the existing operating room suite
- A floor of nursing units accommodating 54 beds to decant existing semiprivate rooms and create more private patient rooms
- New main entrance lobby and supporting patient and visitor retail services
- Medical office space (38,000 square feet) which is not regulated by the Health Services Cost Review Commission (HSCRC)
- Underground floor to accommodate new central sterile, satellite pharmacy and mechanical equipment to serve the building addition
- One floor of shell space to provide flexibility for future replacement needs.

Suburban is requesting no additional capacity of patient beds and proposes to reduce the number of licensed operating rooms from 15 to 14.

In making the aforementioned investments in its physical plant, Suburban will incur capital expenditures in excess of the statutory exception threshold (see Md. Health General Code Ann. 19-120(k)(1)(i)(1)). Further, Suburban may in the future seek from the Health Services Cost Review Commission (“HSCRC”) additional rate charging authority to help fund this project, and therefore, is unable to take the “pledge” pursuant to Md. Health General Code Ann. 19-120(k)(6)(viii). Therefore, a CON is required for the capital expenditures associated with the project, totaling \$ 200,550,831.

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.

Suburban Hospital

Suburban Hospital (“Suburban”), is a 220 licensed -bed not-for-profit community hospital located in Bethesda, Maryland, a suburb of Washington, DC. Suburban has been dedicated to maintaining and improving the health and well-being of the people of Montgomery County and surrounding areas since 1943. On June 30, 2009, Suburban became a member of Johns Hopkins Medicine. Suburban has various other strategic partnerships with local and national healthcare providers including the National Institutes of Health.

Located in the southwest portion of Montgomery County, approximately three miles from Washington, D.C., Suburban is across the street to the National Institutes of Health (“NIH”) campus and two blocks from Walter Reed National Military Medical Center (“WRNMMC”) (Exhibit 2). Suburban’s service area includes most of Montgomery County as well as nearby portions of the District of Columbia and extends into Prince George’s County. Suburban’s primary and secondary service areas for inpatient admissions and surgery services are shown in Exhibit 3 and Exhibit 4. Suburban is fully accredited by The Joint Commission (“TJC”) and offers a comprehensive range of acute, ambulatory and ancillary services with the exception of obstetrics. Suburban is Montgomery County’s only Level II Trauma Center designated by the Maryland Institute for Emergency Medical Services Systems (“MIEMSS”). Suburban is best known for clinical excellence in stroke care, cardiology, cardiovascular

surgery, emergency/trauma services, neurosurgery, orthopedics and physical medicine, behavioral health and addiction treatment. Due to our unique partnership with NIH in cardiac imaging, cardiovascular surgery, and cardiac and stroke care, Suburban is able to offer patients specialized procedures and participation in research protocols that would otherwise be inaccessible to the residents in its service area.

Suburban obtained its MIEMSS designation as the Level II Trauma Center for Montgomery County in 1976. As one of only nine regional trauma centers in Maryland, Suburban treats between 1,500 to 1,600 trauma patients each year. Given Suburban's unique geographic location, a nationally recognized model to provide coordinated emergency response during disasters has been established with NIH's Clinical Center ("NIHCC"), WRNMMC and the National Library of Medicine. The partnership focuses on accommodating as many patients as possible in an emergency situation and includes systems of mutual assistance such as transferring patients from Suburban to NIHCC and WRNMMC to accommodate more trauma cases at Suburban, cross-privileged physicians that can deliver care in partnered facilities and the sharing of critical supplies between hospitals.

Suburban has served Montgomery County at its current location on Old Georgetown Road since 1943. The existing hospital facility is located on a 7.1 acre parcel south of Lincoln Street and was built in five phases, with the last major clinical addition built in 1979 (Exhibit 5). The current parking structure and a two-story office building are located on a 2.9 acre parcel to the north of Lincoln Street.



Suburban also owns numerous residential properties surrounding the land on which the hospital currently operates. Based on a comprehensive facility master planning process performed in 2005 by AECOM, an international architecture firm specializing in healthcare, the campus enhancement effort addresses significant campus deficiencies identified in the master planning process by upgrading hospital facilities and improving campus circulation. Campus deficiencies identified in the campus master planning process include:

- Insufficient size of the existing hospital, for 2005 volumes, by approximately 130,000 square feet impacting the organization's ability to meet current and future needs
- No options for major demolition or renovation without sacrificing existing patient care services; all space in the existing facility is currently being utilized
- The inability of the existing structural grid to support technology-intensive space needs, such as intra-operative imaging
- A significant lack of private patient rooms
- Operating rooms that are too small and awkwardly shaped; the existing surgical suite, located on 4 separate wings, has an ineffective layout and inadequate adjacencies
- A critical parking shortage
- A poor campus circulation pattern that impacts safety because there is a single point of access for emergency vehicles, pedestrians, cars and helicopters
- A lack of medical office space

To complement the AECOM study, in 2005, Suburban engaged a community panel to provide input into Suburban's planning process to help ensure that the hospital's clinical services, outreach programs and physical facilities will be responsive to the future healthcare needs of the communities served by Suburban. The input identified considerations and highlighted priorities as Suburban began development of a long-range plan. The complement of the community panel was designed to gather input from the broad community that Suburban serves and included representatives from several local citizens associations, fire and rescue, business people, clergy, patients and other local healthcare professionals. Exhibit 6 includes a listing of participants. The community panel met for two years and reviewed various plans and provided valuable input as Suburban began to refine its campus enhancement effort.

Based on the identified deficiencies and input from the community panel, Suburban's management and Board of Trustees identified the following priorities for the campus enhancement efforts:

- Private patient rooms
- Operating Rooms
- Adequate parking for patients, physicians, employees, visitors and vendors
- Improved campus circulation
- Flexibility for the future provided by a unified campus
- Predictability for and compatibility with Suburban's surrounding neighborhood

Suburban Hospital's land is zoned residential and is a permitted use by special exception. This zoning designation significantly limits what can be performed on the site and any physical modifications to the campus. To meet the ever-changing medical needs of the community it serves, keep the facility in good repair, and comply with new laws and regulations governing how healthcare is delivered, Suburban has sought and secured many special exception modifications over the years. As Suburban embarked on this campus enhancement effort, zoning requirements and the strict zoning process served as a framework for development of a plan. Prior to submitting the necessary

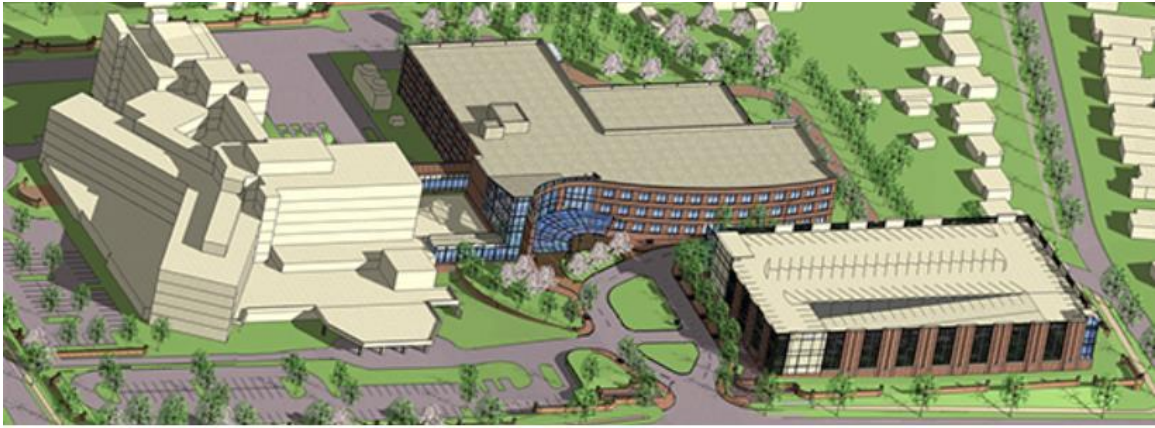
zoning applications, various campus alternatives were considered. However, given the constrained site, few alternatives addressed all project priorities.

On March 26, 2008, Suburban filed a petition with the Board of Appeals for Montgomery County (the “Board”) to modify its special exception use (the “Modification”) and expand the hospital. In September 2008, the Modification was recommended for approval by both the Technical Staff of the Maryland-National Capital Park and Planning Commission (“Technical Staff”) and the Montgomery County Planning Board (“Planning Board”). After extensive review, the Modification was approved by the Board, which issued an opinion (the “Opinion”), effective December 9, 2010, granting, with conditions, the Modification and concluding that the Modification satisfied all applicable statutory requirements and standards of the Montgomery County Code. Upon appeal, the Board’s decision was affirmed by the circuit court and the intermediate appellate court. A Motion for Reconsideration filed by opponents of the Modification was denied by the Court of Special Appeals by Order dated October 31, 2013. The Court of Appeals declined to hear any further appeal on January 27, 2014.

The final campus enhancement effort approved by the Montgomery County Board of Appeals consists of closing one block of a road to allow the consolidation of multiple parcels of land (including two parcels on which Suburban currently operates) and demolition of existing structures to create a contiguous campus of just under 13 acres. In addition to the proposed building addition and renovations (the focus of this CON), the campus enhancement project includes a new 1,112 space parking garage and substantial site work to accommodate a change in flow on the campus.² Once completed, campus safety will be significantly enhanced by the new circulation pattern for the campus that permits the segregation of delivery, emergency and private vehicles from each other and further minimizes pedestrian and vehicular conflicts.

The footprint of the proposed addition was determined by the contiguous square footage required to accommodate the replacement of the operating room suite, while the overall mass of the proposed addition was determined by space deficiencies and project priorities. The location of the building on the site was driven by zoning limitations such as set-backs and coverage ratios. The proposed building addition connects with the existing facility on 3 levels and includes current design elements that are critical to the effectiveness of hospital operations in the new building addition as well as the existing facility. The proposed addition includes selected construction features that will accommodate future vertical expansion such as increased support in the foundation and space for expanded elevator capacity.

² Construction of the parking garage and the associated substantial site work were determined by the Maryland Health Care Commission not to require a Certificate of Need. See the letter of determination dated September 27, 2013 and the related correspondence at Exhibit 7.



The proposed five-level building addition totaling approximately 300,000 square feet and the limited renovations of the existing facility include the following features:

- A new main entrance separate from the emergency room entrance and helipad. Emergency vehicles will also have a dedicated driveway with direct access to the Emergency / Trauma Center.
- Relocation of the entire surgical department from the 5th floor of the existing building to the first floor of the proposed addition, with immediate adjacency to the Emergency/ Trauma Center.
- New operating suite replacing existing operating rooms with appropriate floor-to-floor heights, HVAC, lighting and square footage to accommodate modern standards of surgical care.
- Relocation of central sterile services from the basement of the existing hospital to a level immediately below the new surgical suite in the proposed building addition.
- One floor of the addition will have two new nursing units providing a total of 54 private patient rooms, thus increasing Suburban's percentage of medical/surgical private rooms from 50% to 100%.
- Creation of a satellite compounding pharmacy in the building addition to support the clinical operations in the building addition.
- Improved functionality of the existing loading dock.
- Medical office space for approximately 30 physicians.
- Connections to the existing building on three floors.
- One shell floor with the same floor plate as the built-out nursing unit floor providing future flexibility
- Relocation of the clinical decision unit (observations services) from 6th floor to an existing second floor nursing unit

Project Phasing - Due to a very constrained site and the need to maintain operations of the existing facility during construction, the campus enhancement project requires an extended implementation and sequencing plan. The building addition project will also require multiple phases as outlined below:

- Phase I: Temporary loading dock, renovation to upgrade the existing loading dock and build an underground connector and an above grade connector.
- Phase II: Building addition and related sitework.
- Phase III: Building to building connections with limited renovation to the existing facility.

Table B (Exhibit 1B) summarizes the changes in square feet for the areas of the existing hospital being affected. In addition to the new shell space provided in the building addition, vacating the 5th floor and other smaller areas of the existing facility provides flexibility for the future - a key priority of the project. Given the tremendous zoning restrictions with which Suburban is faced as well as the protracted zoning review timeline, and the significant legal and consulting costs involved with zoning efforts, modifications to the Suburban campus are undertaken infrequently. Flexibility will provide the opportunity to relocate selected departments that are currently offsite, such as human resources, back on campus and, most importantly, the ability to then begin to consider rightsizing various other departments in the hospital that are not addressed in the building addition. Larger departments identified as undersized in the 2005 study include radiology, the emergency department and behavioral health. Suburban's volumes have increased since 2005. Given that vacated space will not be available until FY20 and that healthcare is undergoing changes, limited consideration has been given to prioritize future rightsizing priorities and capital investments. Accordingly, these areas are not included in the CON application. Suburban anticipates repurposing vacated space and completing the shell space within the next 10 years. Applicable regulatory approval will be sought as appropriate for future repurposing efforts.

Complete the DEPARTMENTAL GROSS SQUARE FEET WORKSHEET (Table B, Exhibit 1B) in the CON TABLE PACKAGE for the departments and functional areas to be affected.

See Exhibit 1B.

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.

See Exhibit 1A.

10. REQUIRED APPROVALS AND SITE CONTROL

- A. Site size: 12.8868 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.)

Suburban Hospital began the process of gaining necessary zoning approval in March 2008. The following approvals were received on the dates indicated:

- Approval for a Modification to Suburban Hospital's Special Exception from the Montgomery County Board of Appeals (BOA) in October 2010. This decision was appealed by opposition to the Montgomery County Circuit Court which affirmed the decision of the BOA. The decision was appealed by the opposition to the Maryland Court of Special Appeals which upheld the findings of the lower court in a written decision issued in September 2013. The Court of Appeals declined to hear any further appeal on January 27, 2014.
- Suburban received approval for the road closure of one block of Lincoln Street by the Montgomery County Council in July 2011 contingent on the Modification to Suburban Hospital's Special Exception approval becoming final with no further appeals.
- Suburban received the necessary zoning variances required from the BOA in July 2012.
- Suburban received approval of its Preliminary Plan and Site Plan from the Montgomery County Planning Board in May 2013.

As this project involves the consolidation of multiple parcels of lands, one of which is currently one block of a roadway, Suburban Hospital must obtain approval of a record plat to consolidate the parcels into a single lot. Suburban has filed the necessary paperwork with Maryland-National Capital Park and Planning Commission (MNCPPC) and anticipates record plat approval in April or May 2015.

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

- (1) Owned by: Suburban Hospital, Inc.
Please provide a copy of the deed. See Exhibit 8 and Exhibit 9 for copies of the deeds to the properties involved in this project.
- (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

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	
<u>Single Phase Project</u>		
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
<u>Multi-Phase Project</u> for an existing health care facility (Add rows as needed under this section)		
<u>One Construction Contract</u>		
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.	39	months
Initiation of Construction within 4 months of the effective date of the binding construction contract.	4	months
Completion of 1 st Phase of Construction within 24 months of the effective date of the binding construction contract	3	months
	8	months
Fill out the following section for each phase. (Add rows as needed)		
Completion of 2nd phase of construction within 24 months of completion of 1st phase of construction	20	months
Completion of 3rd phase of construction within 24 months of completion of 2nd phase of construction	4	months
<u>Multiple Construction Contracts</u> for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1 st 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
<u>To Be Completed for each subsequent Phase of Construction</u>		
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 10.

13. FEATURES OF PROJECT CONSTRUCTION

- A. If the project involves new construction or renovation, complete the Construction Characteristics (Table C, Exhibit 1C) and Onsite and Offsite Costs (Table D, Exhibit 1D) 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.

Through its engineers, working with the various jurisdictions and public service agencies, Suburban has established that all necessary utilities required for the building addition will be available and adequate and will have formal documentation in hand before July 2015. One compromise to this statement concerns offsite sanitary sewer mains for which there is a construction solution included in the Total Capital Costs. The Washington Suburban Sanitary Commission (WSSC) has identified approximately 5,000 linear feet of offsite sanitary sewer mains that might be undersized to handle the added flow that will result from the Suburban building addition. Suburban has already established with WSSC that it will be permitted to connect to the sanitary sewer provided that Suburban corrects the undersized mains. The Total Capital Costs contemplates as much as \$5,000,000 will be needed to accomplish this. Our engineers have identified conflicting as-built information that WSSC has used in raising this point and an agreement has been made that the final determination on the final scope of any sanitary sewer main upgrades will be the result of measuring the actual sanitary flow over time using strategically positioned meters installed by WSSC. The results of the metering and analysis is anticipated to be completed early July 2015 and final documentation will require an additional three (3) months to complete.

PART II - PROJECT BUDGET

Complete the Project Budget (Table E, Exhibit 1E) 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.

Suburban is being supported in part by Johns Hopkins Health System's Facilities Design and Construction Division ("FD+C") with the preparation of this application and have played the principal role in assembling the project budget. FD+C fields extensive experience in the budgeting, design, construction, and activation of a variety of healthcare facilities especially in the Maryland markets.

Construction aspects of the budget have been supported with professionally prepared conceptual designs allowing quantity surveys to be performed and current market costs applied to arrive at a construction value. In turn working to limit the scale of any assumptions. The vast majority of consultant costs are based on actual proposals and agreements with the balance predicted from research and prior experience. Permits and jurisdictional fees are based on research of published regulations. Moveable equipment has been budgeted using Attainia data base which is a purchased service is subscribed to by JHHS that focuses on health care equipment and current costs.

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.

Suburban Hospital is a non-stock not-for-profit corporation. Suburban's sole corporate member is The Johns Hopkins Health System Corporation. Gene Green, MD, President and Chief Executive Officer of Suburban Hospital is responsible for the proposed project (Exhibit 11).

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.

Prior to becoming a member of The Johns Hopkins Health System Corporation, Suburban Hospital was wholly owned by Suburban Hospital Healthcare System, Inc. (SHHS). Since the 1980s, various members of Suburban Hospital Inc.'s (SHI) executive and management team were involved in the development and oversight of various wholly owned subsidiaries and joint ventures of Suburban Hospital and Suburban Hospital Healthcare System. Exhibit 12 includes a listing of all of such facilities for which SHI and SHHS still have an ownership interest. Additionally, Dr. Gene Green, prior to joining Suburban as President & CEO, participated in the development of primary care physician practices when employed by Johns Hopkins Community Physicians.

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.

In May of 2012, the Joint Commission (TJC) triennial survey at Suburban Hospital resulted in an adverse accreditation decision – Accreditation With Follow-Up Survey. Suburban Hospital submitted corrective action plans on 7/9/12 and 7/24/12, which were accepted on 9/18/12 and TJC then granted an accreditation decision of Accredited with an effective date of 7/24/12. See Exhibit 13 for a copy of the final letter from TJC.

On 6/1/12, DHMH Office of Health Care Quality (OHCQ) conducted a complaint survey on behalf of CMS, which resulted in a condition-level deficiency. Suburban Hospital submitted a corrective action plan on 7/19/12. OHCQ re-surveyed on behalf of CMS on 8/15/12 – 8/16/12 and cited the hospital for a different condition-level deficiency due to Life Safety Code deficiencies, and removed the hospital's deemed status. Suburban Hospital submitted a corrective action plan on 10/4/12. OHCQ conducted a hospital revisit survey on behalf of CMS on 11/9/12. On 3/14/13, Suburban Hospital received a letter from OHCQ, on behalf of CMS, restoring the hospital's deemed status as of 11/9/12. See Exhibit 14 for a copy of the letter.

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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).

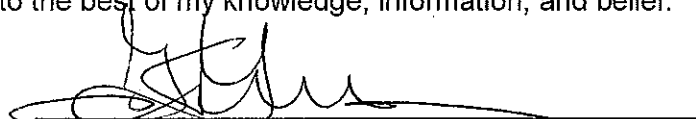
No.

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.

4/9/2015

Date


Signature of Owner or Board-designated Official

President and CEO

Position/Title

Gene E. Green, M.D., M.B.A.

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 0.24.01.08G(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.

COMAR 10.24.10 ACUTE CARE CHAPTER

.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:

A copy of Suburban's policy regarding the provision of information about charges is attached as Exhibit 15 Suburban provides estimated charges on our website, www.suburbanhospital.org. Written copies of the charges are also provided to staff in registration and financial counseling offices. Patients can receive a copy of the list of charges upon request.

Estimates of charges for most frequently occurring services and procedures are updated quarterly. Upon request, patients are provided with written estimates for hospital services by our Financial Counseling staff. Patients with inquiries related to hospital charges prior to or on the day of service can contact Financial Counseling for a copy of the list of charges, or request current charges for specific service/procedure(s). A copy of the charges is also mailed upon request.

Staff is trained regularly to respond appropriately to the requests for information regarding charges and is aware of the location of the information. Financial staff is educated about the criteria to build the charge report and how to update the list of representative charges quarterly on our website.

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.

Applicant Response:

Suburban Hospital provides quality care to all patients regardless of their ability to pay. The charity care policy is attached as Exhibit 16. Free care, sliding fee scales and extended payment plans are offered to eligible patients. Approval for charity care, sliding fee scales or payment plans are based on submission of a financial assistance application available upon request at each of our registration points of entry and our website, www.suburbanhospital.org.

Suburban Hospital provides each patient registered for emergency care, same day care, or inpatient care a copy of our Financial Assistance Information Sheet. Signs are also posted in English and Spanish explaining the availability of financial assistance and contact information in the Emergency Department Lobby, inside the Emergency Department, both ED Registration Bays, the Front Registration Desk, Cath Lab, and Financial Counseling Department. The financial assistance application is given to every self-pay patient with instructions on how to apply and contact information. The same information is provided to all other patients upon request. This information is also available in Spanish.

In addition, our Financial Counselors and Social Workers are trained through staff meetings on how to answer patient questions regarding financial assistance and linkage to other community assistance resources prior to discharge. Registration staff is trained to answer questions regarding financial assistance and who to contact with billing questions or other financial questions. Patient Financial Services staff is also trained to answer questions and provide information to patients regarding financial

assistance and billing. Suburban Hospital uses contractors from Financial Health Services and Deco who assist patients in applying for Maryland Medical Assistance. The Financial Health Services and Deco contractors interview all self-pay patients upon admission and provide them with information and referral for financial assistance.

Patients interested in applying for financial assistance are instructed to submit their application and supporting documentation to the JHHS Patient Financial Services central business office for processing. Contact information for Financial Assistance Unit is provided in the application instructions. The Financial Assistance Unit provides each applicant a preliminary approval indicating probable eligibility within two business days of receipt of a complete application.

Suburban Hospital's financial assistance policy is posted on the website, www.suburbanhospital.org for public view and available for review upon request. A notice of the Hospital's policy on charity and financial assistance is published in the Washington Post on an annual basis and was last published in November 2014.

(a) 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:

Based on the FY13 Health Services Cost Review Commission (HSCRC) Community Benefit Report, Suburban Hospital's total charity care as a percentage of total operating expenses falls within the bottom quartile of all non-profit hospitals. Suburban provided 2.37% (\$5,177,296) of its total operating expenses for charity care in FY13. However, the total community benefit as a percentage of total operating expenses was 10.41% (which is in the second quartile of all Maryland hospitals). The low charity care expense percentage is due to the unique geographic location of Suburban and the population demographics of the primary service area.

In FY13, the median household income within the community benefit service area (CBSA) was \$136,945, compared to \$98,935 for Montgomery County and \$74,567 for the State of Maryland. Only 6.3% of households in Montgomery County had incomes below the federal poverty guidelines, compared to 7.1% for Maryland. The uninsured population was 7.75% (compared to 9.6% in Montgomery County and 9.4% in Maryland). 11.3% of the CBSA population comprised Medicaid recipients (compared to 13.4% for Montgomery County and 18.1% for Maryland). Many acute care hospitals are also within close proximity to Suburban. Overall, the small number of low-income or uninsured patient population has six hospitals within the Montgomery County to access care.

In addition to charity care contributions, Suburban Hospital is committed and dedicated to long standing community partnerships that combine deliberate and

planned community benefit operations to meet identified health needs for our most vulnerable residents. Health initiatives include on-going one-on-one counseling, disease prevention and management sessions, small and large group educational programs, and assistance with health insurance applications. For example, targeted to uninsured and homeless residents who may otherwise avoid a lifesaving vaccination for reasons of mistrust, the *Knots for Shots* program provides free hats, scarves and blankets in exchange for a flu shot. In total, 600 residents received free vaccinations, giving them greater access to staying healthy, safe and the opportunity to experience an improved quality of life.

Another important health initiative to support increased access to care is Suburban Hospital's financial and in-kind support of two Montgomery County safety net clinics: *Clinica Proyecto Salud*-Wheaton and the Holy Cross Hospital Health Center-Gaithersburg which provides primary health services to low income, uninsured residents. For the past seven years, free specialty health care services are provided in support of the Mobile Med/NIH Heart Clinic at Suburban Hospital. This heart clinic provides specific cardiovascular specialty care, from diagnostic testing to open heart surgery to rehabilitation, at little or no cost to the patient.

Although the dollar amount of charity care Suburban Hospital provided in FY13 was lower than other Maryland hospitals, Suburban Hospital is proactive, diligent, committed and dedicated to supporting low-income and uninsured residents through daily charitable health improvement initiatives, programs, screenings, classes and health services that benefit our most vulnerable and hard to reach community members every day.

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.**

Applicant Response:

Suburban complies with all applicable federal, state and local health and safety regulations. A copy of license to operate as an acute general hospital facility in Montgomery County is attached as Exhibit 17. The Maryland Department of Health and Mental Hygiene has also given Suburban authority to operate (Exhibit 17). A copy of Suburban's Joint Commission on Accreditation of Healthcare Organizations ("TJC") accreditation for a three-year period beginning May 17, 2012 is attached as (Exhibit 17). There is a pending survey by the Joint Commission in the spring of 2015. Upon its completion, The Joint Commission will renew Suburban's accreditation for another three years.

Suburban Hospital provides high quality patient care. Most core measures have achieved compliance at or above 96%. However, according to the data that are in the most recent Maryland Hospital Performance Evaluation Guide, Suburban Hospital was below average on heart failure discharge instructions. It must be noted that this information is outdated (October 1, 2012-September 30, 2013). Since then, Suburban staff worked diligently and collaboratively to improve this core measure.

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

COMAR 10.24.10 ACUTE CARE CHAPTER
.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.

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:

Per the Maryland Register, volume 41, Issue 5, Friday, March 7, 2014, the minimal jurisdictional gross bed need projections for Montgomery County in 2022 is 805 MSGA beds; the maximum jurisdictional bed need is 1,103 MSGA.

As of July 1, 2014 there were

Licensed MSGA Beds in Montgomery County			
Hospital	Licensed & Approved MSGA Beds FY15 (1)	Additional Beds on line after 7/1/14 (2)	Total
Holy Cross Silver Spring	277		277
MedStar Montgomery Medical Center	87		87
Shady Grove Adventist Hospital	224		224
Suburban Hospital	190		190
Washington Adventist Hospital	171		171
Holy Cross Germantown		75	75
Total	949	75	1,024

(1) Source: Maryland Health Care Commission, Acute Care Bed Inventory Update (Fiscal Year 2015)

(2) Source: Holy Cross Germantown Approved Certificate of Need

Based on 11 months of patient days through February 2015, below is a projection of Suburban's licensed and approved Med/Surg beds for FY16:

Total Patient Days April 2014 through February 2014 = 56,007
Average Daily Census 167.69

ADC flexed 140% for licensed beds 235
Less licensed psychiatric beds (24)
Less licensed pediatric beds (3) (*)
Projected FY16 MSGA beds 208

(*) Suburban's FY15 license includes 6 licensed pediatric beds. In FY16, Suburban plans to allocate only 3 beds of the total licensed beds to pediatrics, due to limited physical bed capacity in pediatrics.

Based on projected admissions and average length of stay provided in Table F (Exhibit 1F), the 202 beds of MSGA physical capacity will accommodate the patient days, however will be a few beds short of the licensure calculation of 217 beds. (56,517 patient days in 2022/365 = 154.8; 154.8 x 1.4 = 216.7)

Given no proposed change in psychiatric and pediatric beds, Suburban is not increasing its licensed MSGA above projected FY16. Table A (Exhibit 1A) captures the physical beds before and after the proposed project is completed.

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 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

Applicant Response:

The proposed project does not have an adverse impact on hospital charges. Financial assumptions supporting Table G (Exhibit 1G) assume no rate increase related to the proposed project. The proposed project, which is rightsizing Suburban's facilities and does not eliminate any services, positions Suburban for the long term to continue to provide access for its service area to high quality services. Furthermore, none of the proposed changes will impact access for indigent and/or uninsured patients.

Suburban's FY14 average age of plant ratio is 9.5; while Standard & Poor's rating service reports the median ratio for hospitals is 10.7 in CY13. Adjusted only to include buildings and land, Suburban's average age of plant ratio increases to 13.4. The proposed project is a building addition to rightsize Suburban's existing facility. Exhibit 5 is a plan of the existing facility and the years different additions were built. The last major clinical addition was in 1979, almost 40 years ago; and Suburban continues to utilize a wing built in the 1950s. Recognizing that Suburban's existing facility will continue to be used for decades, the maintenance, upgrading and renovations of all aspects of the facility have been an ongoing effort. However, as documented in sections 10.24.01.08G(3)(b) Need and 10.24.01.08G3(c) Availability of More Cost Effective Alternatives, it is impractical to upgrade the current facility to achieve contemporary standards given the limits in the structural grid and other space deficiencies.

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.

Applicant Response:

As described in the project description, Suburban used a comprehensive approach to develop the proposed project. In 2005, Suburban engaged AECOM (Ellerbe Becket at the time), an international architecture firm specializing in healthcare, to perform a comprehensive facility master planning process. The discovery phase of the process included a thorough review including physical inspections of existing conditions, interviews with various user groups, surveys of staff and a data review of existing and projected volumes. Discovery also considered previous efforts to make space available on campus including administrative and clinical services already moved off campus, services closed because of space constraints and consideration of additional services that might be accommodated off campus. As of 2005, the following administrative and clinical services were relocated offsite from the hospital campus in ventures wholly owned or owned through a joint venture:

- Outpatient Addiction Treatment Services, including intensive day treatment
- Outpatient Imaging Services
- Radiation Oncology
- Outpatient surgery, including a freestanding surgery center and freestanding endoscopy center
- Oncology research and community services
- Laboratory draw stations
- Outpatient physical medicine
- Accounting and Patient Accounting

- Offsite parking for approximately 150 hospital employees who then take a shuttle to Suburban

As space planning benchmarks, AECOM utilized industry benchmarks that accommodate current codes and industry standards. Space deficiencies identified in the facility master planning process suggested that Suburban's entire building should be expanded by about 130,000 square feet (approximately by one third) to handle the 2005 workloads. Examples of severe deficiencies include: surgery department 60%, inpatient units 50%, interventional radiology 75%. In addition to space deficiencies, infrastructure, adjacency, and service delivery deficiencies were identified including:

- A significant lack of private patient rooms (50% of medical/surgical beds are in semi-private rooms)
- Operating rooms that are too small and awkwardly shaped; the existing surgical suite, located on 4 separate wings, has an ineffective layout and inadequate adjacencies
- A critical parking shortage
- A poor campus circulation pattern that impacts safety because there is a single point of access for emergency vehicles, pedestrians, cars and helicopters
- A lack of medical office space

Understanding that every issue cannot be resolved without relocating to a different site, AECOM established 3 categories by which to evaluate needs: Departmental/Service needs, Building Wide Component needs and Engineering Systems. Exhibit 18 includes a summary of this evaluation. Based on the evaluation AECOM determined that new construction rather than renovation, was required for the following reasons:

- The existing structural grid will not support technology-intensive spaces, such as intra-operative imaging.
- Diagnostic and Treatment spaces require large, square footprints that are not available in the existing building's geometry.
- Modern, efficient inpatient units need a larger footprint than is available in the existing wings.
- All space in the existing facility is currently being utilized. There are no additional services that could move off campus and provide sufficient space in which to accommodate renovations without sacrificing existing patient care services.

Benchmarks were then applied to projected workloads to create long term space need projections. Based on the results, AECOM performed massing studies to create options for expansion. Various design alternatives were evaluated.

To complement the AECOM study, in 2005, Suburban engaged a community panel, to provide input into Suburban's planning process to help ensure that the hospital's clinical services, outreach programs and physical facilities will be responsive to the future healthcare needs of the communities served by Suburban. The panel

identified key considerations and highlighted priorities as Suburban began development of a long-range plan. The complement of the community panel was designed to gather input from the broad community that Suburban serves and included representatives from several local citizens associations, fire and rescue, business people, clergy, patients and other local healthcare professionals. Exhibit 6 includes a listing of participants. The community panel met for two years, reviewed various plans and provided valuable input as Suburban began to refine our campus enhancement effort.

Based on the deficiencies identified by AECOM and input from the community panel, Suburban's management and Board of Trustees identified the following priorities for the campus enhancement efforts:

- Private patient rooms
- State of the Art Operating Rooms
- Adequate parking for patients, physicians, employees, visitors and vendors
- Improved campus circulation
- Flexibility for the future provided by a unified campus
- Predictability for and compatibility with Suburban's surrounding neighborhood

The above priorities, along with the ability to provide physician office space, estimated project costs, phasing implications, and other factors were used to evaluate various alternatives. Table 1 provides a comparison of three alternatives considered and the evaluation of each based on the identified priorities and other criteria.

Table 1
Decision Matrix for Evaluating Alternative Solutions

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

Key:

5 = Solution fully meets decision criterion.

3 = Solution partially meets decision criterion.

1 = Solution fails to meet decision criterion.

Limited consideration was given to the potential for total relocation of the hospital to an alternative site for the following reasons:

- An assessment performed in the late 1990s found that there was limited property available that would allow Suburban to continue to serve its existing service area. The costs associated with any available properties were prohibitive and few developers were interested in the concept of a hospital being located on their land.
- Suburban's existing unique location across from NIH has fostered a research partnership that no other community hospital can provide. Providing our community access to such research is a benefit that is difficult to quantify but important for us to maintain.

Consideration was given to reducing the services Suburban provides in order to continue to provide services in the existing facility without expansion, other than the replacement of the garage. However, it was determined this alternative was only a short term solution. With the existing facility's infrastructure and grid, Suburban will not be able to incorporate advances in technology, which would impact its ability to provide high quality care in the future.

The final campus enhancement effort addresses significant campus deficiencies identified in the master planning process by upgrading hospital facilities and improving campus circulation. The proposed project is the most cost effective alternative that will allow the facility to provide high quality, cost effective care for decades to come, and also allow for flexibility to incorporate future changes without further needing significant physical expansion.

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

Applicant Response:

Inapplicable.

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

(i) That it has considered, at a minimum, 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 operational costs associated with implementing the project at each alternative project site and at the proposed project site, with a full accounting of the cost associated with transportation system and other public utility infrastructure costs; and

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

Applicant Response:

Inapplicable.

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 proposed project is rightsizing in nature. The purpose is to address space deficiencies and structural grid limitations that restrict Suburban's ability to meet current architectural standards and evolving healthcare delivery needs. Suburban is proposing no new services or additional capacity in beds and is reducing licensed operating rooms by one operating room. The need is fully addressed in section 10.24.01.08G(3)(b).

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 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.

Applicant Response:

The new construction at Suburban will include a hospital basement, a tower, and a rooftop mechanical penthouse. Below is the comparison of Suburban's proposed costs to the MVS benchmark. A complete MVS analysis is attached as Exhibit 19.

I. Marshall Valuation Service

Valuation Benchmark– New Construction – Hospital Basement

Type	Hospital Basement
Construction Quality/Class	Good/A
Stories	1
Perimeter	-
Average Floor to Floor Height	19.0
Square Feet	64,432
f.1	Average floor Area
	64,432

A. Base Costs

Basic Structure	\$180.52
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
Total Base Cost	\$180.52

Adjustment for Departmental Differential Cost Factors	0.86
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Adjusted Total Base Cost	\$155.85
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B. Additions

	Elevator (If not in base)	\$9.37
	Other	\$0.00
Subtotal		\$9.37

Total	\$165.22
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C. Multipliers

Perimeter Multiplier	0.890706328
Product	\$147.16

Height Multiplier	1.16
Product	\$170.86

Multi-story Multiplier	1.000
Product	\$170.86

D. Sprinklers

	Sprinkler Amount	\$3.07
Subtotal		\$173.93

E. Update/Location Multipliers

Update Multiplier	1.05	3/15
Product	\$182.62	

Location Multiplier

1.07 1/15

Product

\$195.41

Calculated Square Foot Cost Benchmark**\$195.41**

The MVS benchmark for this component of the project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
Cellar				
CENTRAL STERILE PROCESSING 12,057 12,057	12,057	Central Sterile Supply	1.54	18,567.8
MECHANICAL ROOMS 29,549 29,549	29,549	Mechanical Equipment and Shops	0.7	20,684.3
ELECTRICAL ROOMS 8,336 8,336	8,336	Mechanical Equipment and Shops	0.7	5,835.2
COMPOUNDING PHARMACY 1,659 1,659	1,659	Pharmacy	1.33	2,206.5
MAINTENANCE 3,351 3,351	3,351	Mechanical Equipment and Shops	0.7	2,345.7
CRAWL/PIPE CHASE/ELEVATORS PIT 2,534 2,534	2,534	Mechanical Equipment and Shops	0.7	1,773.8
PUBLIC CIRCULATION/SPACES 3,981 3,981	3,981	Internal Circulation, Corridors	0.6	2,388.6
VERTICAL CIRCULATION (STAIRS/ELEVATORS) 1,089 1,089	1,089	Shafts and Exterior wall	0.6	653.4
ELEVATOR MACHINE ROOM 471 471	471	Mechanical Equipment and Shops	0.7	329.7
EXTERIOR WALL THICKNESS 1,406 1,406	1,406	Shafts and Exterior wall	0.6	843.6
Total	64,433		0.86	55,628.6

II. Marshall Valuation Service**Valuation Benchmark– New Construction – Hospital**

Type
Construction Quality/Class

Hospital
Good/A

Stories	4
Perimeter	1,376
Average Floor to Floor Height	15.0
Square Feet	235,597
f.1	Average floor Area
	58,899

A. Base Costs

Basic Structure	\$354.99
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0

Total Base Cost \$354.99

Adjustment for Departmental Differential Cost Factors 0.93

Adjusted Total Base Cost \$330.14

B. Additions

Elevator (If not in base)	\$0.00
Other	\$0.00

Subtotal \$0.00

Total \$330.14

C. Multipliers

Perimeter Multiplier 0.907650599
Product \$299.65

Height Multiplier 1.07
Product \$320.32

Multi-story Multiplier 1.005
Product \$321.92

D. Sprinklers

Sprinkler Amount \$2.46

Subtotal \$324.38

E. Update/Location Multipliers

Update Multiplier 3/1
1.05 5
Product \$340.60

Location Multiplier 1/1
1.07 5
Product \$364.44

Calculated Square Foot Cost Benchmark \$364.44

The MVS estimate for this component of the project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
First Floor				
SURGERY DEPARTMENT	56,276	Operating Suite, Total	1.59	89,478.8
LOBBY AND PUBLIC	2,408	Public Space	0.8	1,926.4
CIRCULATION/SPACES	2,433	Internal Circulation, Corridors	0.6	1,459.8
VERTICAL CIRCULATION (STAIRS/ELEVATORS/SHAFTS)	2,750	Shafts and Exterior wall	0.6	1,650.0
MECHANICAL ROOMS	148	Mechanical Equipment and Shops	0.7	103.6
EXTERIOR WALL THICKNESS	1,590	Shafts and Exterior wall	0.6	954.0
Second Floor				
PHYSICIAN OFFICES (SHELL SPACES)	35,212	Unassigned Areas	0.5	17,606.0
CONFERENCE CENTER	5,478	Public Space	0.8	4,382.4
OUTPATIENT PHARMACY	3,062	Pharmacy	1.33	4,072.5
GIFT SHOP	944	Public Space	0.8	755.2
REGISTRATION FINANCIAL COUNSELING	3,511	Offices	0.96	3,370.6
VOLUNTEERS	572	Volunteer Areas	0.8	457.6
CONFERENCE STORAGE	422	Offices	0.96	405.1
CLINICAL SUPPORT	323	Offices	0.96	310.1
PATIENT TRANSPORTERS	323	Public Space	0.8	258.4
CHAPLAIN OFFICE	88	Offices	0.96	84.5
MECHANICAL ROOMS	800	Offices	0.96	768.0
SECURITY	385	Offices	0.96	369.6
CIRCULATION (include MAIN LOBBY)	12,950	Public Space	0.8	10,360.0

MAIN ENTRANCE/PUBLIC SPACES	1,182	Public Space	0.8	945.6
VERTICAL CIRCULATION (STAIRS/ELEVATORS)	2,765	Shafts and Exterior wall	0.6	1,659.0
EXTERIOR WALL THICKNESS	1,206	Shafts and Exterior wall	0.6	723.6
Third Floor				
SHELL SPACE	35,184	Unassigned Areas	0.5	17,592.0
CONSULT ROOMS	230	Offices	0.96	220.8
MECHANICAL ROOMS	320	Mechanical Equipment and Shops	0.7	224.0
STORAGE	545	Housekeeping	1.31	714.0
ELECTRICAL/TRASH/ IT /JC	717	Mechanical Equipment and Shops	0.7	501.9
CIRCULATION/PUBLIC SPACES	7,467	Public Space	0.8	5,973.6
VERTICAL CIRCULATION (STAIRS/ELEVATORS)	2,423	Shafts and Exterior wall	0.6	1,453.8
EXTERIOR WALL THICKNESS	4,829	Shafts and Exterior wall	0.6	2,897.4
Fourth Floor				
PATIENT CARE UNIT - 24 Beds (3/500)	17,244	Inpatient Units	1.06	18,278.6
PATIENT CARE UNIT - 30 Beds (3/600)	19,605	Inpatient Units	1.06	20,781.3
PT/REHAB	427	Physical Medicine	1.09	465.4
SHARED CLINICAL SUPPORT	1,019	Offices	0.96	978.2
MECHANICAL ROOMS	331	Mechanical Equipment and Shops	0.7	231.7
TRASH/IT/ELE/JC ROOMS	847	Mechanical Equipment and Shops	0.7	592.9
PUBLIC SPACES	1,728	Public Space	0.8	1,382.4
CIRCULATION	878	Internal Circulation, Corridors	0.6	526.8
VERTICAL CIRCULATION (STAIRS/ELEVATORS)	2,480	Shafts and Exterior wall	0.6	1,488.0
EXTERIOR WALL THICKNESS FOURTH FLOOR	4,492	Shafts and Exterior wall	0.6	2,695.2
Total	235,594		0.93	219,099

III. Marshall Valuation Service

Valuation Benchmark– New Construction – Mechanical Penthouse

Type
Construction Quality/Class
Stories
Perimeter

Mechanical
Penthouse
Excellent A
7
178

Average Floor to Floor Height	15.00
Square Feet	1,046
Average floor Area	1,046

A. Base Costs

Basic Structure	\$78.55
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
Total Base Cost	\$78.55

B. Additions

Elevator (If not in base)	\$9.37
Other	\$0.00
Subtotal	\$9.37
Total	\$87.92

C. Multipliers

Perimeter Multiplier	1.2925032
Product	\$113.64
Height Multiplier	1.413
Product	\$160.57
Multi-story Multiplier	1.035
Product	\$166.19

D. Sprinklers

Sprinkler Amount	\$5.82
Subtotal	\$172.01

E. Update/Location Multipliers

Update Multiplier	1.05	3/1 5
Product	\$180.61	
Location Multiplier	1.07	1/1 5
Product	\$193.25	

Calculated Square Foot Cost Benchmark	\$193.25
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IV. Consolidated MVS Benchmark

	MVS Benchmark	Sq. Ft.	Total Cost Based on MVS
Standard			
			\$
<u>"Tower" Component</u>	\$364.44	235,597	85,862,129.23
			\$
<u>Basement</u>	\$195.41	64,432	12,590,416.39
<u>Mechanical</u>			\$
<u>Penthouse</u>	\$193.25	1,046	202,139.34
	\$		\$
<u>Consolidated</u>	327.67	301,075	98,654,684.95

V. Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	\$89,816,065	\$298.32
Fixed Equipment	\$8,253,670	\$0.00
Site Preparation	\$13,372,894	\$44.42
Architectural Fees	\$5,537,540	\$18.39
Permits	\$1,049,400	\$3.49
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	\$118,029,569	\$392.03

However, as related below, this project includes expenditures for items not included in the MVS average.

Site Demolition Costs	\$566,484	Site
Storm Drains	\$40,030	Site
Rough Grading	\$50,133	Site
Paving	\$1,075,149	Site
Exterior Signs	\$6,250	Site
Landscaping	\$168,072	Site
Walls	\$29,546	Site
Yard Lighting	\$17,156	Site
Site Furnishings	\$114,372	Site
Sheet and Shore Basement Excavation	\$2,845,215	Site
Fire Pump Water Storage Tank (20,000 gal)	\$285,863	Site

Security Devices	\$50,000	Site
Utilities	\$5,000,000	Site
Jurisdictional Hook-up Fees	\$500,000	Site
Restricted Site	\$3,248,000	Building
Backfill Premium	\$721,520	Building
Select building demolition	\$281,880	Building
Provisions for vertical addition	\$2,900,000	Building
Pneumatic tube system	\$440,800	Building
Permanent dewatering system	\$174,000	Building
LEED Silver Premium	\$3,922,789	Building+Fixed
Canopy	\$489,520	Building
Premium for Concrete Frame Construction	\$730,351	Building
Overhead Bridge	\$1,329,128	Building
Total Cost Adjustments	\$24,986,258	

Explanation of Extraordinary Costs

- Signs, Canopy, Jurisdictional Hook-up Fees, Paving and Roads, Storm Drains, Rough Grading, Landscaping (including Walls to set the hospital off from the neighbors and Site Furnishings), Yard Lighting (and Security Devices), and Demolition – These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.
- Restricted Site – As noted previously, Suburban is on a very restricted site. Therefore, because of the congestion of the site and the necessity to build within limited footprints surrounded by existing buildings, the construction will be restricted. It will also have a lack of onsite, storage, parking and laydown space. This will add costs to onsite labor and equipment as well as add costs to materials resulting from added storage and handling costs over and above the average construction costs. In order to maintain our presence at the current site, these additional costs are unavoidable.
- LEED Silver Premium – Suburban has included a 4% premium (based on Building Costs only) due to constructing this building to LEED Silver standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.
- Permanent Dewatering – Since only Normal Site Preparation is included in the benchmark (see Section 1, page 3 of the Marshall Valuation Service), the need for dewatering is not included.
- Utilities – This item is discussed in paragraph 13.B of the Application and involves the replacement of existing offsite sanitary mains. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A – Good General Hospital per Section 1, page 3 of the Marshall Valuation Service. They are both included in the site preparation costs.

- Overhead Bridge – This project includes an overhead bridge, not usual in the average hospital project. While a pedestrian bridge is necessary in this project, these costs are specifically excluded from the MVS base square foot cost for a Class A – Good General Hospital per Section 15, page 25 of the Marshall Valuation Service.
- Sheet and Shore Basement Excavation and Backfill Premium - Mass excavation to building subgrade and backfill is included in MVS, but it does not recognize the limited area of the site. In the normal case the excavation would be sloped back, earth materials would be retained on site and then these stockpiled materials would be used for backfill. With limited site area these direct construction activities are affected requiring the sloped back excavation to be replaced by a structural system of sheeting and shoring such that the excavation is a vertical cut. With insufficient work space earth backfill materials cannot be stockpiled on site but instead need to be hauled and disposed of offsite. Backfill materials will then have to be purchased and hauled to the site.
- Fire Pump Water Storage Tank - Building codes anticipated to be adopted July 2015 will require a fire pump water storage tank to be installed. As a new code requirement, this would not be included in MVS.
- Select building demolition - At various points where the building addition interfaces with the existing building there is a need to perform select building demolition. MSV does not consider any demolition.
- Provisions for vertical addition - The building structure and certain utility elements have been increased in size and capacity to support a future four (4) story vertical building addition. MVS does not consider such provisions.
- Pneumatic tube systems - The costs for the pneumatic tube system are included in the construction cost estimate and not in the Owner's equipment costs. These costs are excluded from the Marshall & Swift Valuation base square foot cost for a Class A - Good General Hospital.
- Premium for Concrete Frame Construction – Concrete frame construction is significantly more costly than steel frame. Only the Premium has been considered an extraordinary cost. Suburban estimated it to be \$3.10/square foot.
- Capitalized Construction Interest and Financing Costs on Extraordinary Costs – \$10,467,372 in capitalized interest shown on the project budget sheet is for the entire costs of the project. We have allocated it between new construction and renovation. However, because the Capitalized Construction Interest only associate with the costs in the “Building” budget line are considered in the MVS analysis, it is appropriate to adjust the cost of each of the above items that are in the Building costs to include the associated capitalized construction interest.
- Architectural and Engineering Fees Related to Extraordinary Costs – A&E Fees are typically a percentage of the total cost of Building, Fixed Equipment, and Site Preparation, including extraordinary costs. Consequently, like Capitalized Interest, if the extraordinary costs are removed from the comparison, their related A&E Fees should also be removed. This was accomplished by calculating the percent that the original A&E Fees comprised of the Building and Site Prep costs, multiplying

that percentage times the sum of the extraordinary costs, and subtracting that number from the original A&E fees.

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS estimate to \$329.94. As noted below, the project's cost per square foot is consistent with the MVS benchmark.

C. Adjusted Project Cost		Per Square Foot
Building	\$75,578,077	\$251.03
Fixed Equipment	\$8,253,670	\$27.41
Site Preparation	\$2,624,624	\$8.72
Architectural Fees (adjusted for Extraordinary Cost allocation)	\$4,210,174	\$13.98
Permits	\$1,049,400	\$3.49
Subtotal	\$91,715,945	\$304.63
Capitalized Construction Interest	\$7,620,737	\$25.31
Total	\$99,336,682	\$329.94

VI. Comparison to the MVS Benchmark

MVS Benchmark	\$327.67
The Project	\$329.94
Difference	\$2.27
	0.69%

VII. Marshall Valuation Service Valuation Benchmark – Renovation

Type	Hospital
Construction Quality/Class	Good/A
Stories	3
Perimeter	475
Average Floor to Floor Height	11.3
Square Feet	17,587
f.1 Average floor Area	5,862

A. Base Costs

Basic Structure	\$354.99
Elimination of HVAC cost for adjustment	0
HVAC Add-on for Mild Climate	0
HVAC Add-on for Extreme Climate	0
Total Base Cost	\$354.99

B. Additions

Elevator (If not in base)	\$0.00
Other	\$0.00
Subtotal	\$0.00

Total \$354.99

C. Multipliers

Perimeter Multiplier 0.876764891
Product \$311.24

Height Multiplier 0.98
Product \$306.47

Multi-story Multiplier 1.000
Product \$306.47

D. Sprinklers

Sprinkler Amount \$0.00
Subtotal \$306.47

E. Update/Location Multipliers

Update Multiplier 1.05 3/1 5
Product \$321.79

Location Multiplier 1.07 1/1 5
Product \$344.32

Calculated Square Foot Cost Standard **\$344.32**

VIII. The Project

A. Base Calculations	Actual	Per Sq. Foot
Building	\$2,375,878	\$135.09
Fixed Equipment	\$2,254,000	\$128.16
Site Preparation	\$0	\$0.00
Architectural Fees	\$127,460	\$7.25
Permits	\$35,600	\$2.02
Capitalized Construction Interest	\$215,980	\$12.28
Subtotal	\$5,008,918	\$284.81

MVS Benchmark	\$344.32
The Project	\$284.81
Difference	-\$59.51

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 non-hospital space shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost. In general, rate increases authorized for hospitals should not recognize the costs associated with construction of non-hospital space.

Applicant Response:

Inapplicable.

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:

ROOM/FUNCTION	NEW-ADDITIONAL		
	NSF	BEDS	SF/BED
MEDICAL/SURGICAL	12,740	30	424.7
MEDICAL/SURGICAL	11,434	24	476.4

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:

Suburban Hospital has not been designated a high-charge hospital by the Health Services Cost Review Commission, and so, is not under nor needing 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:

As outlined in the project description, based on a master planning analysis performed in 2005, Suburban is undersized by 130,000 square feet based on current building codes, industry standards and 2005 patient volumes. Suburban's volumes have only increased since 2005 exacerbating many identified space deficiencies. The proposed project is rightsizing in nature; no additional capacity is being requested. When reviewing potential stacking alternatives, a key consideration was the adjacencies of departments and benefits that can be achieved in patient safety and operational efficiencies. A broad range of departmental representation was included in the planning process to ensure the departments located in the proposed building addition optimized what could be achieved with the additional space recognizing both short term and long term needs. Once the services to be relocated were identified, the design team worked with user groups to incorporate specific design features, including elements that create desired efficiencies. The final design of operating rooms and patient care rooms will include a mock up process that will allow users to further refine the design for patient safety and operational efficiencies. The current design incorporates the following efficiencies:

- Optimally located supply and medication rooms on nursing units to minimize nurse travel
- Relocation of clinical decision unit from 6th floor to 2nd floor; again reducing the time required for patient transport
- Relocation of central transport to an area that both the existing facility and the proposed building addition will be easy to access for patient transports from nursing units to diagnostic and treatment services or from the emergency department/ trauma center to a patient room
- Relocation and renovation of the receiving department to provide optimal access to the loading dock

- Creation of a consolidated conference room area will allow media services to be more efficient rather than having conference rooms located in multiple locations throughout the hospital
- The design of the new nursing units allows for the sharing of a family area rather than dedicating separate space to each unit
- The provision of 100% medical/surgical private rooms will provide the ability to achieve high occupancy because beds in semi-private rooms will not have to be blocked for isolation patients and will eliminate multiple patient transfers between rooms due to roommate conflicts such as noise which requires nursing time to effect the moves
- The inclusion of separate elevator banks segregating patients, service and the public will provide much more efficient vertical transport through the building addition

Specific features related to the Operating Room Suite:

- Relocation of surgical suite to be adjacent to emergency department/ trauma center rather than 5 floors away, reducing the time required for patient transport between the two departments
- Due to space limitations, Suburban currently performs minor procedures such as endoscopy of a separate floor with separate pre-op and recovery staff. This service will be co-located within the operating rooms suite. This physical adjacency will provide for efficient staffing of pre and post procedure rather than maintain separate staffs.
- Locating pre-operative holding adjacent to secondary recovery eliminates the need to oversize either area to allow high demand times. The adjacency provides the ability for both areas to flex; each area has a distinctly different high times of demand. The adjacency also provides for staff to be efficiently shifted between the areas as needed especially since their designs will be similar.
- Relocating central sterile to one floor below the operating room with dedicated lifts for clean and dirty transport will allow for more efficient delivery and removal of supplies and instruments. Currently central sterile is 6 floors away from the operating rooms and relies on outdated dumbwaiter system to move materials.
- The design includes 2 consultation rooms located near the waiting room for families to receive updates on loved ones status. While Suburban currently has one consultation space, it is not in a convenient location making it inefficient for surgeons to use. The planned location will increase physician efficiency as well as enhance communication and increase patient confidentiality.
- Surgical Pathology will be relocated to the operating room suite. Currently it is located 6 floors away from surgery. Locating the service within the suite will eliminate the need for runners to transport the specimens and will foster greater and more timely communication between surgeon and pathologist.
- The design of the operating room includes efficient and effective sterile cores strategically located between two pods of operating rooms. This will allow for

better organized and readily accessible storage of supplies. The design also allows for efficient turnover of operating rooms.

- In addition to the sterile core, the operating room will have sufficient storage for equipment and less used supplies. Currently there is inadequate storage requiring equipment to be stored elsewhere in the hospital.
- The operating rooms sizes and shapes will allow for adequate storage of critical stock within the operating room minimizing the need for staff to leave while a case is being performed
- The operating rooms size and shapes allow for flexibility in the types of cases that can be performed. Suburban's flexibility is currently limited due to the small sizes and awkward shapes of many existing operating rooms. This flexibility allows Suburban to reduce its licensed capacity from 15 to 14 operating rooms. This will not result in a savings in staff as staff currently shift between rooms; it will end up generating a high utilization rate of operating rooms.
- The nursing units located within the proposed building addition will be designated primarily for surgical patients. With patient only designated elevators in the proposed project, this will provide for more efficient transfer from the operating room to the patient room.

While the efficiencies are numerous, it is hard to measure exactly what staffing savings will be achieved. With the exception of staffing efficiencies associated with not having to staff a separate pre-op and recovery for minor procedures, for the purposes of the financial projections, Suburban has maintained variable staffing ratios constant. Due to the increase in the size of the facility, there are increases in staff to support the increased square footage in areas such as environment services, clinical transport, security and plant operations. Table L (Exhibit 1L) provides workforce information.

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:

In establishing project priorities, Suburban Hospital gave significant weight to patient safety as a consideration and has continued this focus on patient safety in the design of the proposed project. All user groups include multi-disciplinary participation including clinicians, support services and advocates from Suburban's Patient and Family Advisory Committee (Exhibit 20). Suburban's patient population is largely elderly; 45% of FY14 discharges were 70 years of age or older, with 18% of total FY14 patients over 85 years of age. Given this patient population, Suburban earned NICHE (Nurses Improving Health Care for Elders) designation from the Hartford Institute of Geriatric Nursing at New York University's college of Nursing. Participation in the NICHE program allows Suburban to provide additional insight to the designers to ensure safety features are included that specifically address the needs of the older adult patient population.

There are three main areas of the proposed expansion that address patient safety: the new nursing units, the new operating room suite and the new main entrance of the hospital. Patient Safety features included in the operating room suite are described under the surgical service standards of the application (10.24.11.05.B.(6)).

At most facilities the creation of a new main entrance might be considered only aesthetic. The creation of a new main entrance in the proposed project was identified as a high priority for patient safety reasons. The new main entrance in the proposed project allows for the segregation of the majority of patient pedestrian traffic from the circulation of emergency vehicles and helicopters. The new main entrance is also much closer to the parking garage being built, providing easier and safer movement from parking to the hospital facility.

Greater improvements in patient safety are achieved on the new nursing units. The overall nursing unit design includes features that will:

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

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 ways described below.

COMMUNICATION ERRORS

Communication failures have been identified as the leading cause of medication errors, delays in treatment, and wrong-site surgeries (Source: The Joint Commission). 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.
- Private Patient rooms will eliminate the need to transfer patients between rooms due to roommate conflicts and isolation needs.
- Lean Operational planning has been integrated into the Diagnostic and Treatment platform to reduce the number of patient transfers. An example includes building the operating room suite adjacent to the emergency department/trauma center and on the same floor as radiology for ease of patient transfer.
- The proposed Nursing Unit design is based on a planning module to reduce travel distances for access to supplies and medications.

HOSPITAL ACQUIRED INFECTIONS

The prevalence of Hospital Acquired Infections (HAI) increases with the duration of hospitalization. These infections can be acquired through airborne, droplet and contact transmissions. Some of the most common organisms of HAI are resistant bacteria and *Clostridium difficile*. Hospital Acquired Infections will be reduced in the proposed design as a result of the following:

- Readily accessible positioning of sinks in patient rooms and clinical unit hallways with hand washing supplies, such as dispensers of soap and hand sanitizers
- Use of surfaces that are easily cleaned and do not collect standing water
- Use of building materials at sinks and showers that seal out water without using caulking
- Utilizing 100% fresh air systems can successfully reduce airborne infections to near zero
- Installation of air handling systems that can provide up to 6 air changes for inpatient rooms and negative pressure air flow for soiled/decontamination rooms
- Negative pressure patient rooms where needed
- Space to accommodate readily available personal protective equipment, such as gowns, gloves and masks between rooms

- Built-in design at each patient room door to display isolation signs without the need for less effective devices
- Elimination of under sink storage space

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 as close as possible to the patient; easier bathroom transfers result in fewer falls.
- 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; just a small increase in the amount of charting at bedside has been shown to decrease patient falls.
- The Nursing Unit configuration provides decentralized nursing and touch-down stations with clear lines of sight into patient rooms. This will allow greater visibility of the patient who 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.
- Use of patient alarm systems to alert nurses of movement of at risk patients.

MEDICATION ERRORS

Research has shown that Adverse Drug Events on complicated admissions can contribute to a longer length of stay. The use of CPOE and EMAR Technology will reduce the risk of medication errors:

- Eliminates confusion among drug names that sound alike
- Prompts for drug interaction, allergy, or overdose
- Associated with a reduction in prescribing errors

TRANSFERS AND HAND-OFFS

The majority of serious medical errors result from miscommunication during the transition of care between health care practitioners. Dangerous errors and missed changes in condition can occur when a patient is moved between procedural areas, transferred to different units or when care is transitioning between nurses or doctors. The solution proposed at Suburban Hospital follows:

- Expectation that transition of care will be done at the patient bedside whenever possible with participation of the patient and/or family.
- Easy access to computerized records during transition and to allow for identification of patient through barcoding.
- Comfortable patient and family seating in each room to allow the patient and family to participate fully in the planning of patient care.
- Flexible multidisciplinary work spaces provide areas for team collaboration during the work day.

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 comprehensive table of the financial projections around revenue and expense can be found in Tables G and H (Exhibit 1G and 1H). Inflation assumptions used for revenue are consistent with HSCRC Global Budget methodologies of update factor (2.4%), Population (1.07% for our service area) and Market Share (50% on volume growth above population growth). Expense inflation assumptions are based on average historical inflation rates of 2.0 - 2.5% for salaries and 2.0 - 3.0% for all other expenses. Depreciation expense is based on anticipated capital spending and asset disposals. Interest expense is at current debt assumptions.

Projections of future utilization of hospital services are based on Suburban's historical market share in our primary and secondary service areas applied to projected

service area utilization taking into account changes in population and utilization rates. COMAR10.24.01.08G(3)(b) provides a full explanation of the methodology used to project hospital volumes.

Revenue estimates are based on current allowable charge levels and incorporate the current reimbursement methodologies employed by the HSCRC. No changes in hospital charges are expected. All adjustments to revenue are expected to continue at current experience levels. Investment income is based on projected cash levels and assumes a blended earning rate of 2.5% to 3.5% based on our current investment portfolio.

Staffing and associated expenditure levels in Table L (Exhibit 1L) are based on current expenditure levels but take into account changes in utilization and the necessary increases that are responsive to the change in total square footage of the new building.

The hospital will generate excess revenues over expenses in the 2nd year following the opening of the new building. Table G (Exhibit 1G) demonstrates how this will be achieved. This assumes no performance improvement to achieve a higher operating target.

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 not applicable to the proposed project.

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

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

Applicant Response:

This standard is not applicable to the proposed project.

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:

As discussed in section 10.24.01.08G(3)(c) Cost-Effective Alternatives, during the planning for the proposed project, a priority that was identified was to provide flexibility for the future. This key priority was established based on Suburban's knowledge of the challenging zoning environment in which it exists and the significant financial costs and time associated with the zoning and appeal process. Suburban's last major clinical addition was in 1979. The proposed addition is designed to serve the physical needs of the organization for decades to come. Based on historical experience, Suburban anticipated a prolonged zoning and appeal process. Suburban therefore sought zoning approval before filing a CON application, even though zoning approval is not required before CON approval. The zoning process is not yet complete but the major challenges have been addressed.

Shell space is an important element of creating necessary flexibility. The proposed project includes shell space in three different forms:

- Newly constructed space (what is typically considered shell space),

- Space vacated by departments that will be relocated to the proposed building addition for which no specific use or renovations have been identified to date, and
- 35,212 square feet for physician office space, which is being classified as shell at this time.

Based on Table B (Exhibit 1B), below is a summary by floor of the shell space that will be available when the proposed project is complete:

Floor	Building Addition	Notes	Existing Facility (vacated & unrenovated)	Notes
Cellar/ Lower	0		8,009	
1	0		5,391	
2	35,212	Physician offices	0	
3	35,288	2 wings	0	
4	0		7,890	
5	N/A		38,718	4 wings
6	N/A		0	
Total	70,500		60,008	

The shell space on the third floor of the proposed building addition will have the same footprint as the fourth floor that will house 2 nursing units; one 24 bed unit and one 30 bed unit. Suburban anticipates that the third floor will also be used for nursing units in the future. Over the next five years, Suburban will continue to evaluate and prioritize space deficiency issues with departments not moved to the proposed building addition. It is anticipated that two other nursing units will ultimately be relocated from the existing facility to the proposed building addition. The third floor of the proposed addition was specifically selected to be shell with the anticipation that it would be less disruptive and more cost effective to build over a floor of lobby, conference rooms and physician office space than over an operational nursing unit.

As a start to the next planning process Suburban has engaged an architect to develop a master facility plan for imaging services to be performed in the next 6 months. Suburban has also begun evaluating a long term facility plan for behavioral health services. While the focus of rightsizing remaining services and functions will focus on major departments such as imaging, emergency/ trauma and laboratory, there are few existing departments that are adequately sized. Currently, there is no vacant space in the facility to provide as staging or relocation space necessary to perform construction or renovations. Having vacant space on site will allow for renovation and relocation rather than renovation in place which is inherently more expensive due the phasing required to complete even the smallest of projects. Suburban will also consider the relocation of programs back to campus that were moved offsite to accommodate the proposed project, such as human resources and training and education space. This will allow for the elimination of offsite lease expense. Applicable regulatory approval will be sought for the fit-out of the shell space that will be used for hospital services, including the submission of another Certificate of Need application, if necessary.

The physician office space is classified as shell for the purposes of the application and is not part of the performance requirements of the proposed project. In Table G (Table 1G) of the application, lease revenue at market rates is included for the physician office space as are the operating expenses associated with this space. Capital of \$1,400,000 required to provide a provision for a landlord fit out allowance is included the financial projections as well. It is assumed that the space will be leased within a year of the opening of the building addition.

COMAR 10.24.11. GENERAL SURGICAL SERVICES
.05A. GENERAL STANDARDS.

Standard .05(A)(1) – Information Regarding Charges.

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

Applicant Response:

Please see the response to COMAR 10.24.10.04A-Standard .04A (1) – Information Regarding Charges.

Standard .05(A)(2) – Charity Care Policy.

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

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

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

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

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

(c) A proposal to establish or expand an ASF for which third party reimbursement is available, shall commit to provide charitable surgical services to indigent patients that are equivalent to at least the average amount of charity care provided by ASFs in the

most recent year reported, measured as a percentage of total operating expenses. The applicant shall demonstrate that:

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

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

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

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

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

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

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

Applicant Response:

Please see the response to COMAR 10.24.10.04A-Standard .04A(2) – Charity Care Policy.

Standard .05(A)(3) – Quality of Care.

A facility providing surgical services shall provide high quality care.

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

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

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

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

(ii) Accredited by the Joint Commission, the Accreditation Association for Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, or another accreditation agency recognized by the Centers for Medicare and Medicaid as acceptable for obtaining Medicare certification.

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

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

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

Applicant Response:

Please see the response to COMAR 10.24.10.04A-Standard .04A (3) – Quality of Care.

Standard .05A(4) – Transfer Agreements.

(a) Each ASF and hospital shall have written transfer and referral agreements with hospitals capable of managing cases that exceed the capabilities of the ASF or hospital.

(b) Written transfer agreements between hospitals shall comply with the Department of Health and Mental Hygiene regulations implementing the requirements of Health-General Article §19-308.2.

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

Applicant Response:

As a member of Johns Hopkins Medicine, Suburban Hospital patients that exceed the capabilities of Suburban Hospital are transferred to Johns Hopkins Hospital in Baltimore.

COMAR 10.24.11. GENERAL SURGICAL SERVICES
.05B. Project Review Standards.

Standard .05B(1) – Service Area.

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

Applicant Response:

The proposed project includes the replacement and relocation of Suburban's existing surgical suite. Given that the proposed project is rightsizing in nature, Suburban does not anticipate a change in primary or secondary service area for surgical services. Exhibit 21 includes maps of the service areas and a listing of zip codes sorted by patient origin.

Standard .05B(2) – Need- Minimum Utilization for Establishment of a New or Replacement Facility.

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

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

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

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

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

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

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

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

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

Applicant Response:

The replacement and relocation of Suburban's operating room suite is a major component of the proposed project. Throughout this application the deficiencies of Suburban's existing operating suite and the impact of such deficiencies are fully described including:

- The inability of the building's existing structural grid to support technology-intensive space needs, such as intra-operative imaging

- Operating rooms that are too small and awkwardly shaped; significantly impacting the flexibility to schedule many specialties in multiple operating rooms reducing the ability to achieve efficient occupancy percentages
- The existing surgical suite, located on 4 separate wings, has an ineffective layout and inadequate adjacencies
- Operating rooms are located on the fifth floor, five floors away from the emergency department and trauma center and six floors from sterile processing.

When determining the number of ORs to include in the proposed project, Suburban considered volume projections for its service area and relied on the operating room optimal capacity assumptions and other guidance included in Regulation .06 of this Chapter 10.24.11.05(B). With the creation of appropriately sized operating rooms, Suburban is projecting a need for 14 operating rooms reducing capacity by one operating room. The Table 2 summarizes historical overall utilization of Suburban operating rooms.

Table 2
Historical Overall Utilization of Suburban Operating Rooms

	FY14			FY13		
	IP	OP	Total	IP	OP	Total
All Cases (Cardiac and Non-Cardiac)	4,542	3,675	8,217	4,299	3,775	8,074
Minutes	734,457	369,532	1,103,989	691,953	369,658	1,061,611
Average Minutes/Case	161.70	100.55	134.35	160.96	97.92	131.49
MSGA Discharges	11,599			11,632		
IP Surgery Cases as a % of Discharges	39.2%			37.0%		
Ratio of O/P to I/P cases		80.9%			87.8%	
I/P TSA Population	1,565,373			1,545,743		
Suburban Cases/ 1,000	2.90	2.35	5.25	2.78	2.44	5.22

Currently Suburban has 15 licensed operating rooms of which 3 are designated special purpose operating rooms (2 Cardiac and 1 Outpatient) and 12 are designated mixed use general purpose. In addition to reducing operating room capacity by one operating room, Suburban is proposing to reclassify the outpatient special purpose operating room to a mixed use general purpose operating room. Suburban is not requesting a designated special purpose operating room for its trauma service at this time. If Suburban finds that it needs an additional OR for trauma, it will apply for one in the future. Table 3 provides a summary of FY14 utilization.

Table 3
FY14 Utilization

	FY14 Inpt. Cases	FY14 Outpt. Cases	Total Cases	FY14 Inpt. Minutes	FY14 Outpt. Minutes	Clean Up Minutes @ 25/Case	Total Minutes
Cardiac	266	-	266	84,124	-	6,650	67,458
Non-Cardiac	4,276	3,675	7,951	650,333	369,532	198,775	1,218,640
General Purpose Mixed Use Minute Standard per OR @ 80% of Capacity							114,000
Calculated Room Need based on standard – FY14							10.7

Just as it currently has two ORs to accommodate its cardiac surgery program, Suburban proposes two ORs for this program in the new addition. Suburban projects future need for its non-cardiac ORs based on the projected growth in MSGA admissions from 2015-2022. Suburban has used the number of minutes per case in 2014 and has used 25 minutes per case for cleanup time. These projections are shown below. The result is that Suburban will require 12 ORs for non-Cardiac cases. When the Cardiac ORs are included, Suburban will need 14 ORs, one less OR than it currently has. Table 4 shows the calculation of need for General Purpose Mixed Use Operating Rooms in FY22.

The need projection methodology is population-based for the following reasons:

1. The number of Non-Cardiac OR Cases in 2014 was divided by the number admissions at Suburban in 2014 to obtain a ratio of surgical cases per admission.
2. This ratio was multiplied by the projected number of projected MSGA admissions at Suburban in 2022, which was population-based.

Table 4
Calculation of FY22 Need for General Purpose Mixed Use Operating Rooms

	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>	<u>2018</u>	<u>2019</u>	<u>2020</u>	<u>2021</u>	<u>2022</u>
MSGA Discharges	11,599	12,164	12,138	12,215	12,291	12,368	12,576	12,784	12,992
% of IP Non-Cardiac OR Cases of MSG Discharges	0.369	0.369	0.369	0.369	0.369	0.369	0.369	0.369	0.369
IP Non-Cardiac OR Cases	4,276	4,484	4,475	4,519	4,531	4,560	4,636	4,713	4,790
Avg IPOR Minutes	152.09	152.09	152.09	152.09	152.09	152.09	152.09	152.09	152.09
IP OR Minutes	650,333	682,025	680,535	687,366	689,152	693,471	705,133	716,794	728,455
Ratio of OP Cases to IP Cases	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86	0.86
OP Cases	3,675	3,854	3,846	3,884	3,894	3,919	3,985	4,051	4,116
Avg. OP Minutes/Case	100.55	100.55	100.55	100.55	100.55	100.55	100.55	100.55	100.55
OP Minutes	369,532	387,540	386,693	390,575	391,590	394,044	400,670	407,296	413,923
Total Cases	7,951	8,338	8,320	8,404	8,426	8,478	8,621	8,764	8,906
Turnover Minutes/case	25	25	25	25	25	25	25	25	25
Turnover Minutes	198,775	208,462	208,006	210,094	210,640	211,960	215,525	219,089	222,653
Total Minutes	1,218,640	1,278,026	1,275,234	1,288,035	1,291,382	1,299,476	1,321,327	1,343,179	1,365,031
Measure of Capacity/OR in Minutes	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000	114,000
Needed ORs	10.7	11.2	11.2	11.3	11.3	11.4	11.6	11.8	12.0

Standard .05B(3) – Need - Minimum Utilization for Expansion of An Existing Facility.

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

- (a) Demonstrate the need for each proposed additional operating room, utilizing the operating room capacity assumptions and other guidance included at Regulation .06 of this Chapter;
- (b) Demonstrate that its existing operating rooms were utilized at optimal capacity in the most recent 12-month period for which data has been reported to the Health Services Cost Review Commission or to the Maryland Health Care Commission; and
- (c) Provide a needs assessment demonstrating that each proposed operating room is likely to be utilized at optimal capacity or higher levels within three years of the completion of the additional operating room capacity. The needs assessment shall include the following:
 - (i) Historic trends in the use of surgical facilities at the existing facility;
 - (ii) Operating room time required for surgical cases historically provided at the facility by surgical specialty or operating room category; and
 - (iii) Projected cases to be performed in each proposed additional operating room.

Applicant Response:

The proposed project does not include an expansion of the number of licensed operating rooms. Due to the flexibility provided by new appropriately sized operating rooms, Suburban is reducing licensed operating rooms by one in the proposed project.

Standard .05B(4) – Design Requirements.

Floor plans submitted by an applicant must be consistent with the current FGI Guidelines.

(a) A hospital shall meet the requirements in Section 2.2 of the FGI Guidelines.

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

(c) Design features of a hospital or ASF that are at variance with the current FGI Guidelines shall be justified. The Commission may consider the opinion of staff at the Facility Guidelines Institute, which publishes the FGI Guidelines, to help determine whether the proposed variance is acceptable.

Applicant Response:

Please see Exhibit 22, which is a letter from the Architectural firm Wilmot Sanz attesting that the surgical suite meets FGI Guidelines.

Standard .05B(5) – Support Services.

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

Applicant Response:

Suburban Hospital provides laboratory, radiology, and pathology services on-site.

Standard .05B(6) – Patient Safety.

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

- (a) Document the manner in which the planning of the project took patient safety into account; and**
 - (b) Provide an analysis of patient safety features included in the design of proposed new, replacement, or renovated surgical facilities.**
-

Applicant Response:

As with the design of other areas of the hospital, the operating room suite involved multi-disciplinary team. Given the nature of the operating room suite, the group was large and included the following:

Nursing Staff (Pre-op/Post Op/ OR)
Surgeons (Variety of specialties)
Anesthesiologists
Pathologists
Radiologists
Laboratory Staff
Imaging Staff
Clinical Engineering
Environmental services
Materials Management
Patient & Family Advisory Council advocate

Part of the final design will include a physical mock-up of an operating room so that members of a larger planning team can review the work and make final adjustments to ensure the final product maximizes patient safety.

Below is a listing of patient safety features that will be included in the operating room suite of the proposed project:

- The new operating rooms in the proposed Suburban Hospital will be larger than the existing rooms and configured in a square shape to promote better access to patient for medical staff and technology.
- Standardization of the operating room configuration (size, shape and layout) will improve patient safety by standardizing work process with consistent placement of critical supplies and equipment. The space to accommodate the appropriate stock in the operating room will eliminate the need for a staff person to leave the room during a procedure creating a safer environment for the patient.

- Each operating room will be equipped with video/digital equipment (and boom technology throughout the suite), which will facilitate safe conditions and standardization.
- In the new design, monitoring equipment will be located within the OR for proper access and visibility by both the RN and anesthesiologist.
- The surgical suite will use a case cart system with a clean core design and dedicated travel paths to improve access to supplies and reduce cross traffic with patient transfer.
- The surgical suite will provide the correct ratio and location of prep and recovery areas to improve patient flow and access to the appropriate level of nursing care
- The new operating rooms will provide improved air filtration for infection control with a minimum of 25 air changes provided in a laminar flow air distribution pattern.
- Durable monolithic flooring with integral base will improve patient safety by eliminating the opportunities for contamination with damaged or degraded surfaces experienced with traditional sheet flooring alternatives
- Reducing Communication Errors – Communication failures have been identified as a cause of wrong-site surgeries. By maintaining visual connections among staff work areas the proposed design will promote communication.
- Implementing the current recommendations of the FGI Guidelines for Healthcare Construction and using inherently antimicrobial surfaces where appropriate, will limit acquired infections and improve patient safety.
- Integrating Computerized Physician Order Entry (CPOE) – CPOE technology implemented in the patient care process will improve patient safety by reducing opportunities for medication errors.
- Locating surgical pathology within the surgery suite will enhance patient safety as it will encourage timely communication between surgeon and pathologist, it will also minimize the risk of lost specimens as the need to transfer specimen via “runners” will no longer be necessary
- The inclusion of a Hybrid OR will allow certain cases that are currently performed in the interventional radiology or cath labs to be performed in the operating room suite so that if the case has a negative outcome the patient is already in an operating room and the need to transfer from another floor is eliminated.

Standard .05B(7) – Construction Costs.

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

(a) Hospital projects.

(i) The projected cost per square foot of a hospital construction or renovation project that includes surgical facilities shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

(ii) If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include:

1. The amount of the projected construction cost and associated capitalized construction cost that exceeds the Marshall Valuation Service® benchmark; and

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

(b) Ambulatory Surgical Facilities.

(i) The projected cost per square foot of an ambulatory surgical facility construction or renovation project shall be compared to the benchmark cost of good quality Class A construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors.

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

Applicant Response:

Please see the response to COMAR 10.24.10.04B-Standard .04B(7) – Construction Cost of Hospital Space.

Standard .05B(8) – Financial Feasibility.

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

(a) An applicant shall document that:

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

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

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

(iv) The facility will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years of initiating operations.

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

Applicant Response:

The proposed project's replacement surgery suite is part of a much larger building addition that provides for the rightsizing of Suburban's facility. Financial feasibility of the proposed surgery suite is incorporated in the larger proposed project's financial feasibility under 10.24.10.04(13).

Standard .05B(9) – Preference in Comparative Reviews.

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

Applicant Response:

Inapplicable.

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, Exhibit 1F 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 comprehensive planning process undertaken by Suburban Hospital in the development of the proposed project is fully described in 10.24.01.08.G(3)(c) Availability of More Cost-Effective Alternatives. The need being addressed by the proposed project is rightsizing in nature. The project will allow the organization to address multiple current and evolving code requirements, enhance patient and employee safety and provide flexibility required to address changing health care needs of the community for decades to come. Suburban is requesting no additional capacity in the proposed project. Specific facility needs being addressed include:

Increased Private Patient Rooms – Currently 50% of Suburban's medical/surgical beds

(excluding intensive and progressive care) are in semi-private rooms. Semi-private rooms fail to meet prevailing healthcare standards and practices for patient care as well as patient needs and preferences in terms of room size, patient comfort, privacy and family participation. The proposed project would allow Suburban to decant existing semi-private rooms converting the rooms to private. After completion of the proposed project, Suburban's percentage of medical/surgical private rooms will be 100%. Suburban's existing semi-private rooms range from 225 to 250 square feet, including bathrooms (some without showers). National and Maryland code requires all new medical surgical bed construction be built as private rooms. Taking into account clear floor area requirements, clearances and a patient/family centered approach, new private rooms should be a minimum of 250 square feet. Exhibit 23 is a graphic representation comparing Suburban's current typical semi-private room to a current industry standard private room. As noted above, private rooms are required by code for new construction because of the well documented patient care benefits including:

- Enhanced infection control; reduction in nosocomial infections
- Enhanced patient privacy
- Enhanced healing environment incorporating
 - Reduced noise levels
 - Increased space for family members encouraging family participation

Input on the final design of the 54 patient rooms and nursing units will include representation of multidisciplinary clinicians, as well as support services and representatives from Suburban's Patient & Family Advisory Committee (PFAC). A broad group is being utilized in an effort to ensure that the design will address the functional needs of patient and staff safety as well as providing a comfortable healing environment for both the patient and their families.

The proposed project does not include the renovation of existing semi-private rooms. Initially, these rooms will be used as private rooms with minimal changes. Existing rooms will be renovated as a part of Suburban's long term facility planning process when full nursing units are renovated. This approach provides flexibility to continually address the needs of the community Suburban serves. For example, maintaining some level of rooms with more than one head wall provides the community's care infrastructure with some surge capabilities. This need was acutely needed this past flu season when all Montgomery County hospitals were at full occupancy.

Modern Operating Room Suite Suburban's current operating room suite exists on the 5th floor on 4 different wings. In addition to the 5th floor operating room services, Suburban also houses minor procedures, such as endoscopy and ECT, and operating room administrative services on a separate floor. Built over the past 5 decades, the operating rooms lack consistent and appropriate configurations and are substantially undersized to accommodate current surgical practices. Exhibit 24 provides a visual depiction of the existing 5th floor layout. The proposed project includes the relocation of the operating room suite to the building addition's first floor which will address the following needs:

- *Inadequate adjacencies* – Located on the 5th floor, the operating room suite is 5

floors away from the emergency center/ trauma center. Minutes can be critical to the outcomes of emergency patients requiring surgery; traveling 5 floors from the ED is less than optimal. The proposed project will allow for the operating room suite to be adjacent to the ED and on the same floor as radiology. This adjacency will enhance patient outcomes. It will also enhance staff efficiencies as the time dedicated to transferring the patient from the ED to the OR will be significantly reduced.

Central processing is currently located in the basement of the existing building. This means OR instrumentation must be transported 6 floors to accommodate the needs of the operating room including unexpected emergent needs. The proposed project will accommodate a modern central sterile department a floor below the new operating room suite with dedicated clean and dirty lifts to transport case carts and necessary instrumentation. This adjacency will provide significant efficiencies as well. The need for flash sterilization equipment and space within the OR suite will be minimal as central sterile is one floor below. Staffing efficiencies will also be gained with the elimination of the extended travel currently required between floors.

- *Space Deficiencies* – The 2005 AECOM study noted that the operating room site was undersized by 60%. Exhibit 25 provides a visualization comparing a typical Suburban operating room with an industry standard operating room. Compounding the space deficiencies, many of the operating rooms are awkwardly shaped creating inconsistent configurations. Many of the operating rooms are too small or the wrong shape to support the staff and/or modern equipment required for specialized surgery, limiting the hospital's ability to maximize room utilization. Use of these operating rooms are limited in the cases that can be performed because the room cannot accommodate the necessary equipment and the staffing necessary for specific procedures.

However, it is not only the operating rooms that are undersized, each component of the operating room suite is undersized including family waiting, pre-procedure and recovery and storage. All of these space needs will be able to be addressed in the proposed project.

- *Deficient Infrastructure* – Due to the age of Suburban's facility, with the latest wing added in 1979, the existing facility is limited by outdated and inflexible infrastructure. Typical existing floor slab to floor slab heights are 10 feet and the structural grid depends on columns that are too close together. Current industry standards for floor heights for concrete framed structures range from 13'-4" to 15'-0". Exhibit 26 provides a visual depiction of the issue. Technology intensive departments, such as the operating room suite, are the most acutely impacted by the facility's infrastructure. The current facility does not provide the necessary ceiling space to accommodate current mechanical, communication and electrical systems and the structural needs of equipment to be hung from the ceiling.
- *Inefficient layout* – Having the operating rooms and necessary support functions, such as pre-procedure and recovery space, on separate wings creates inherent

logistical inefficiencies which negatively impact patient flow and staff and physician efficiencies. The space identified for the operating room suite will accommodate all of these areas in adjacent space.

On campus physician office space - Suburban is one of the few hospitals in the United States, and the only hospital in Montgomery County, that does not have a medical office building or physician offices easily accessible to the hospital. The proposed project provides 38,000 square feet that address priority needs to that will positively impact patient care and physician and staff efficiencies. Although 38,000 square feet for this purpose is considerably below the amount found in other hospitals, the limited square footage and incorporation of the physician space into the building addition was a the result of input from the community panel.

Enhancing facility/ campus circulation – The existing campus layout creates substantial pedestrian and vehicular conflicts because the main entrance is directly next to the walk in emergency department entrance and the ambulance bays which all are directly below the helipad. The proposed building addition will provide a new main entry that will serve to segregate private pedestrian traffic from emergency vehicles, both by land and air. Once completed, campus safety will be significantly enhanced by the new circulation pattern.

In addition to the physical needs of the existing facility, volume projections were performed to ensure that the proposed project was adequately sized to address the demand for services. Statistical projections are included in Table F (Exhibit 1F).

Inpatient need projections:

As a well-established provider in the market, Suburban is not proposing a change to its total inpatient primary and secondary service areas. The two service areas are determined by patient origin and account for the zip codes accounting for the top 85% of Suburban discharges. Exhibit 27 provides maps of Suburban's primary and secondary service areas, a detailed listing of the zip codes included in each service area, each zip codes' FY14 percentage of discharges and the cumulative percentage of discharges. Selected zip codes are included in the service areas even though they do not qualify in the top 85% per patient origin, but this is due to the small nature of the population of these zip codes, not their location.

Based on data provided by Truven Health Analytics, Suburban's total service area's 2014 population is over 1,565,000 and is projected to grow 6% by 2019. This growth rate is above both the state of Maryland and United States' projected growth rate (Exhibit 28). Exhibit 29 includes a demographic snapshot for the total service area, as well as both the primary and secondary service areas. In summary, the total service area population is on average affluent, racially and ethnically diverse and aging. By 2019, in addition to the growth of the population, the population 55 and over will increase as a percentage of the population increasing to 29% of the population as compared to 26% in 2014.

To calculate the future need of the service area and inpatient admissions, Suburban relied on Truven Health Analytics growth rates applied to the primary and

secondary service area demographics. Exhibit 30 provides background on the Truven Health methodology for estimating use rates. Truven Adjusted and Trended use rates were utilized as opposed to local use rates as Truven produced more conservative (lower) use rates. A comparison of the use rates is provided in Exhibit 31. Given that Suburban does not provide obstetrical services the Truven overall growth rates were adjusted to remove deliveries, obstetrical non-deliveries, newborns and neonatology. Suburban also adjusted the overall growth rate by removing behavioral health given that the growth rates for behavioral health are significantly higher than for MSGA. Separate growth rates were applied to 2014 discharges to project MSGA and Psych service area discharges. The source of base year 2014 discharges was the HSCRC for Maryland hospitals and Truven Health Analytics for Washington DC and Northern Virginia hospitals. Base year 2014 data was also utilized to calculate Suburban's MSGA and Behavioral Health market share by service area. Suburban assumed no change in market share over the projection period. Market share percentages were applied to service area projections to determine Suburban's total service discharges for 2019 through 2022. Total service area discharges were divided by 85% to reflect non service area discharges and calculate total Suburban discharges.

Patient days were projected multiplying projected discharges by Suburban's 2014 average length of stay for MSGA, Pediatrics and Psychiatry.

For Emergency Department visits, a review was performed of visits at Suburban divided by the population. An average of the past three year's utilization rate was applied to the population through 2022 to calculate projected emergency department visits. Similarly, to determine observation visits, Suburban calculated the ratio of observation visits to emergency department visits and relied on a 3 year average to project through 2022. Table 5 provides the detail of the calculation of projected emergency visits and observation visits.

Table 5

Suburban Hospital, Inc							
Total Population	Projections of ED Visits				Projections of Observation Visits		
	Service Area Population	ED Visits	ED Visits/1,000 Population		Observation Pts.	% of ED Visits	
2010	1,488,317						
2011	1,507,218	43,749	29.03	Actual	1,329	0.03	Actual
2012	1,526,359	45,048	29.51	Actual	2,461	0.05	Actual
2013	1,545,743	45,088	29.17	Actual	4,180	0.09	Actual
2014	1,565,373	43,622	27.87	Actual	5,224	0.12	Actual
2015	1,583,581	44,404	28.04	Projected	5,690	0.13	Actual
2016	1,602,001	45,431	28.36	Three year average	4,543	0.11	Three year average
2017	1,620,635	45,959	28.36		5,218	0.11	
2018	1,639,486	46,494	28.36		5,279	0.11	
2019	1,658,556	47,035	28.36		5,340	0.11	
2020	1,677,848	47,582	28.36		5,402	0.11	
2021	1,697,364	48,135	28.36		5,465	0.11	
2022	1,717,108	48,695	28.36		5,529	0.11	

Operating room cases were based on the 2014 ratio of inpatient surgery cases to MSGA discharges. Average non-cardiac inpatient minutes per case for 2014 were applied to projected cases to determine non-cardiac inpatient surgery minutes. To determine outpatient surgery cases the 2014 ratio of non-cardiac inpatient to outpatient cases was determined and applied to the projected non-cardiac inpatient surgery cases. Average outpatient minutes per case for 2014 were applied to the outpatient surgery cases to determine total outpatient surgery minutes. See 10.24.11.05B(2).

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:

Please also see the response to the State Health Plan's Acute Care Section Standard .04B(5) – Cost-Effectiveness.

As described in that response and in the Project Description, Suburban used a comprehensive approach to develop the proposed project. In 2005, Suburban engaged AECOM (Ellerbe Becket at the time), an international architecture firm specializing in healthcare, to perform a comprehensive facility master planning process. The discovery phase of the process included a thorough review including physical inspections of existing conditions, interviews with various user groups, surveys of staff and a data review of existing and projected volumes. Discovery also considered previous efforts to make space available on campus including administrative and clinical services already moved off campus, services closed because of space constraints and consideration of additional services that might be accommodated off campus. As of 2005, the following administrative and clinical services were relocated offsite from the hospital campus in ventures wholly owned or owned through a joint venture:

- Outpatient Addiction Treatment Services, including intensive day treatment

- Outpatient Imaging Services
- Radiation Oncology
- Outpatient surgery, including a freestanding surgery center and freestanding endoscopy center
- Oncology research and community services
- Laboratory draw stations
- Outpatient physical medicine
- Accounting and Patient Accounting
- Offsite parking for approximately 150 hospital employees who then take a shuttle to Suburban

As space planning benchmarks, AECOM utilized industry benchmarks that accommodate current codes and industry standards. Space deficiencies identified in the facility master planning process suggested that Suburban's entire building should be expanded by about 130,000 square feet (approximately by one third) to handle the 2005 workloads. Examples of severe deficiencies include: surgery department 60%, inpatient units 50%, interventional radiology 75%. In addition to space deficiencies, infrastructure, adjacency, and service delivery deficiencies were identified including:

- A significant lack of private patient rooms (50% of medical/surgical beds are in semi-private rooms)
- Operating rooms that are too small and awkwardly shaped; the existing surgical suite, located on 4 separate wings, has an ineffective layout and inadequate adjacencies
- A critical parking shortage
- A poor campus circulation pattern that impacts safety because there is a single point of access for emergency vehicles, pedestrians, cars and helicopters
- A lack of medical office space

Understanding that every issue cannot be resolved without relocating to a different site, AECOM established 3 categories by which to evaluate needs: Departmental/Service needs, Building Wide Component needs and Engineering Systems. Exhibit 18 includes a summary of this evaluation. Based on the evaluation AECOM determined that new construction rather than renovation, was required for the following reasons:

- The existing structural grid will not support technology-intensive spaces, such as intra-operative imaging.
- Diagnostic and Treatment spaces require large, square footprints that are not available in the existing building's geometry.
- Modern, efficient inpatient units need a larger footprint than is available in the existing wings.
- All space in the existing facility is currently being utilized. There are no additional services that could move off campus and provide sufficient space in which to accommodate renovations without sacrificing existing patient care services.

Benchmarks were then applied to projected workloads to create long term space need projections. Based on the results, AECOM performed massing studies to create options for expansion. Various design alternatives were evaluated.

To complement the AECOM study, in 2005, Suburban engaged a community panel, to provide input into Suburban's planning process to help ensure that the hospital's clinical services, outreach programs and physical facilities will be responsive to the future healthcare needs of the communities served by Suburban. The panel identified key considerations and highlighted priorities as Suburban began development of a long-range plan. The complement of the community panel was designed to gather input from the broad community that Suburban serves and included representatives from several local citizens associations, fire and rescue, business people, clergy, patients and other local healthcare professionals. Exhibit 6 includes a listing of participants. The community panel met for two years, reviewed various plans and provided valuable input as Suburban began to refine our campus enhancement effort.

Based on the deficiencies identified by AECOM and input from the community panel, Suburban's management and Board of Trustees identified the following priorities for the campus enhancement efforts:

- Private patient rooms
- State of the Art Operating Rooms
- Adequate parking for patients, physicians, employees, visitors and vendors
- Improved campus circulation
- Flexibility for the future provided by a unified campus
- Predictability for and compatibility with Suburban's surrounding neighborhood

The above priorities, along with the ability to provide physician office space, estimated project costs, phasing implications, and other factors were used to evaluate various alternatives. The response to Standard .04B(5) – Cost-Effectiveness includes a comparison of three alternatives considered and the evaluation of each based on the identified priorities and other criteria. Limited consideration was given to the potential for total relocation of the hospital to an alternative site for the following reasons:

- An assessment performed in the late 1990s found that there was limited property available that would allow Suburban to continue to serve its existing service area. The costs associated with any available properties were prohibitive and few developers were interested in the concept of a hospital being located on their land.
- Suburban's existing unique location across from NIH has fostered a research partnership that no other community hospital can provide. Providing our community access to such research is a benefit that is difficult to quantify but important for us to maintain.

Consideration was given to reducing the services Suburban provides in order to continue to provide services in the existing facility without expansion, other than the replacement of the garage. However, it was determined this alternative was only a short term solution. With the existing facility's infrastructure and grid, Suburban will not be able to incorporate advances in technology, which would impact its ability to provide high quality care in the future.

The final campus enhancement effort addresses significant campus deficiencies identified in the master planning process by upgrading hospital facilities and improving campus circulation. The proposed project is the most cost effective alternative that will allow the facility to provide high quality, cost effective care for decades to come, and also allow for flexibility to incorporate future changes without further needing significant physical expansion.

Focusing on the future, Suburban and its design team have included elements in the project that provide flexibility to accommodate cost effective decisions in the future. These elements include:

- Additional structural capacity in the footing of the building addition and space for additional elevator capacity to accommodate future vertical expansion. (Future vertical expansion will require zoning approval.)
- Additional structural capacity in one section of the operating room suite to accommodate the needs of intraoperative MRI if deemed necessary in the future.
- The proposed shell floor is planned for a level below the fit-out nursing units to avoid the inherent costs and disruption necessarily associated with building above a nursing unit when that space needs to be brought into service.
- The 24 bed nursing unit, while initially intended to serve a medical/surgical patient population, is being designed with features that will allow for a simple conversion to a more intensive level of care if the patient population and needs shifts in the future.

Standard 10.24.01.08G(3)(b) discusses the need methodology used to create the projections included in Table F (Exhibit 1F). The projections rely on use rates provided by Truven which are based on national use rates applied to the local population. As described in Exhibit 31 Truven's future use rates reflect adjustments for healthcare reform, efforts to shift services from inpatient to outpatient settings, readmission avoidance and other population health initiatives.

In order to achieve the proposed use rates Suburban has a number of initiatives supported by our Community Outreach and Care Coordination departments with the goal of reducing admissions and length of stay. Suburban's efforts also focus on providing access to care to underserved populations in order to avoid unnecessary emergency room visits and admissions. To ensure the most effective use of resources Suburban aligns health priorities with the areas of greatest identified need in the community. Working with multiple partners the ultimate goal is to build a safe and healthy community. Below are examples of these efforts:

- Nurses at four HeartWell clinics, located in Silver Spring, Gaithersburg, Wheaton and Chevy Chase, cares for an average of 927 patients per month, totaling 11,124 preventive clinic visits. The encounters include free blood pressure screenings, one-on-one counseling, disease prevention and management sessions, and small and large group educational programs.
- Montgomery Cares patients have received access to expert care from cardiologists, specialty diagnostic screenings, and open heart surgery since the inauguration of the MobileMed/NIH Heart Clinic at Suburban Hospital in 2007, totaling more than 3,700 patient visits.

- Close to 2,000 patients have access to the specialty care of endocrine diseases through the MobileMed/NIH Endocrine Clinic at Suburban Hospital that was established in July 2010. In FY14, there were 297 encounters with 146 unduplicated patients at the MobileMed/NIH Endocrine Clinic.
- To expand access to primary care and medical services for vulnerable residents, Suburban Hospital financially supports Clinica Proyecto Salud and the Holy Cross Hospital Health Center in Gaithersburg, MD by donating \$200,000 in FY14, which affords these safety net clinics the ability to extend their hours of operations and supplement additional health care providers.
- Cardiovascular outreach in Southern Maryland through the NIH Heart Center at Suburban Hospital supported nearly 600 events, engaging 11,108 individuals to improve healthy lifestyles in Prince George's, Calvert, and St. Mary's counties.
- Ongoing monthly blood pressure screenings conducted at area mall-walking programs and community centers, exercise classes and health education seminars contribute to assisting thousands of individuals to know their numbers and take better charge of their health in Montgomery and Prince George's counties.
- Provision of flu shots to more than 900 uninsured and homeless county Montgomery County residents who would otherwise not seek the vaccination helps reduce the incidence of illness in this vulnerable population.
- Handle with Care is an initiative to prevent avoidable readmissions. Through the creation of a cross continuum team, including 10 post-acute care facilities, two insurers and representation from Suburban's Patient & Family Advisory Committee, the group's focus is on creating a system for patients' smooth transitions and effective post hospitalization care.
- Suburban's Transition Guide Nurses participate in the community to share best practices and data to reduce readmissions. They are also involved internally reducing readmissions by focusing on specific strategies including early risk screening, multidisciplinary rounding, patient/ family education, Primary Care Provider contact, medication management, emergency department management

In addition, as a member of the Johns Hopkins Health System (JHHS), Suburban is actively engaged in system-wide activities designed to reduce unnecessary utilization of health care services and to ensure that care is delivered in the most appropriate setting that is cost-effective. Like hospitals across the state, JHHS is exploring regional partnerships with other hospitals and community-based organizations to expand the services available and ensure that care is timely, culturally appropriate, and effective. Suburban Hospital will continue to pursue these opportunities to learn from others, share best practices, and create partnerships to help us deliver the best care for the patient in the lowest cost setting. Our ultimate goal is to improve the health of the communities we serve, as this is the most cost-effective strategy in the long run.

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:

The financial projections submitted with the application demonstrate that the proposed project is financially viable. The proposed projections include the capital requirements for the proposed project as well as the capital requirements for Phase I of Suburban's Campus Enhancement effort. The proposed projections include a funding plan that relies on Suburban cash reserves, philanthropy and debt. To date Suburban has raised \$36 million in cash for the proposed project and has an additional \$3 million in pledges. The total goal for philanthropic funding of Suburban's Campus Enhancement effort is approximately \$75,000,000 of which approximately \$38,000,000 is designated for the proposed project. Suburban's debt will be part of a larger debt offering by Johns Hopkins Healthcare System and is assumed to be \$95,000,000 with \$69,782,482 earmarked for the proposed project. Suburban does not anticipate any difficulty with the debt financing. Exhibit 32 provides Suburban Hospital's audited financial statements for fiscal years ending June 30, 2014 and June 30, 2013. The non-hospital entity, Suburban Hospital Healthcare System, Inc. (SHHS) is consolidated into the financial statements of The Johns Hopkins Health System Corporation (JHHS). Also included in Exhibit 33 is a supplementary schedule from JHHS' 2014 audited financial statements which includes the balance sheet for SHHS. Suburban Hospital and SHHS have combined assets whose use is limited by Board of Trustees of over \$262 million. The required component of cash

for the project will be drawn on this balance. Accordingly, the cash required for the proposed project will not be an issue. Given the extended duration of the project, the financial projections also account for the timing of cash flow for the project.

Schedule L (Exhibit 1L) includes workforce information for Suburban currently, as well as the workforce impact of the proposed project. As this project is rightsizing/ replacement in nature the largest incremental staffing needs are primarily in support areas dealing with the increase in square feet. We do not anticipate recruiting challenges related to the proposed project. In fact, given that Phase I of the Campus Enhancement effort addresses Suburban's critical parking shortage, staff in support departments will no longer have to park off campus and take a shuttle extending their daily commute 30 to 45 minutes, we believe recruiting will be easier when the proposed project will be completed.

Suburban has garnered tremendous community support for the proposed project. As part of the zoning process, thousands of community members sent letters of support to local government leaders and many individuals testified on behalf of Suburban's Campus Enhancement effort in front of the regulatory agencies and Montgomery County Council. Suburban's community understands that a hospital is part of the area's infrastructure and the importance that a hospital plays in a community's overall well-being. Exhibit 34 includes more recent letters of support addressed specifically to the Maryland Health Care Commission and a copy of an editorial from the Gazette supporting the project.

The Project Description and Project Schedule included in this application outlines the phases and the proposed project timeline. Considering the duration of the proposed project, a multi-phase project is being submitted that will be procured under one construction contract. As noted in the project description, the proposed project is part of a larger campus enhancement effort; significant sitework and parking garage are under a separate contract and are currently underway. Due to the nature of the Montgomery County zoning process, details of the site plan, garage and external portion of the building addition, including connections, all were identified in the zoning approval. We have engaged the design team for the building addition, including architects, structural and MEP engineers and anticipate the final design and construction documents for the building will be completed by spring 2016 allowing Suburban to begin the proposal and negotiation process to engage and contract a construction manager fall of 2016. Having reviewed the overall campus enhancement effort with construction firms over the years and understanding where we are will the progress of the current work, Suburban is confident that the proposed project can be completed in the applicable timeframe.

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:

Suburban Hospital has been issued only one Certificate of Need since 2000: Establishment of a Cardiac Surgery and Percutaneous Coronary Intervention Program at Suburban Hospital (Docket No. 04-15-2134.)

This CON was awarded July 21, 2005. A copy of the CON is attached as Exhibit 35 and describes in detail the four conditions placed on this CON. Suburban Hospital has been and will continue to be compliant with these four conditions.

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) One the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project³;
- 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:

As Suburban's proposed project is a rightsizing of the existing facility, there should be no impact on other existing providers. In calculating future volume projections, Suburban assumed no change in market share. This is consistent with the CON application of Holy Cross Germantown (opened fall 2014), which projected no impact on Suburban. Suburban's proposed project provides no additional capacity of beds and reduces licensed operating room capacity by one room.

Suburban's proposed project includes physician office space, which is unregulated by the HSCRC, within the building addition. Suburban is one of the few hospitals in the United States that does not have a medical office building or physician offices easily accessible to the hospital. The physician office space will be utilized by specialists; Suburban is precluded by zoning conditions to lease space to family practice and primary care physicians and pediatricians. Additionally, zoning conditions require that only physicians with privileges to practice at Suburban may occupy the physician office space.

The provision of physician office space will have a positive impact on access to physicians' services and a positive impact on the response to the emergency department for consultations. Currently, specialists supporting Suburban's emergency

³ **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.**

department have private offices offsite. Given the traffic patterns in the Washington DC area, despite having an office within 10 miles of the hospital it can take 30 minutes to get to the hospital. If physicians do not need to spend time in their cars, they can see more patients, reducing wait times for patients to get appointments. From an emergency department patient perspective, if a physician has an office onsite, consultation availability will reduce the patient's length of stay and speed a decision as to admission or discharge. Exhibit 36 includes a transcript of testimony by Dr. Westerband, Suburban's Trauma Service Medical Director, provided during the zoning hearings addressing the benefits of on-campus physician office space.

The on-campus physician office space will also provide shared space to narrow the gap in availability of specialty services to the underserved. Currently Suburban coordinates and sponsors an endocrine clinic offsite for underserved patients. The service is staffed by volunteer physicians, many of who work at NIH. The plan is to relocate this clinic to the hospital campus when physician space is available. When such services are located on the Suburban campus, across the street from NIH, it will be easier to recruit volunteer physicians to support this program as well as serve in other specialty programs identified as a need in the community. Such services will also be more accessible for Suburban employees who volunteer their time in these clinics.

Overall access will also improve as a result of the increased number of private rooms. Suburban's current percentage of med/surg private rooms is 50%; this will increase to 100% when the proposed project is built. The availability of a large complement of private rooms will reduce the number of times Suburban's emergency department will need to go on ambulance diversion. Exhibit 37 is a summary of Suburban's diversion history. While Suburban makes every effort to avoid ambulance diversion, this is impossible to avoid when the emergency department is boarding patients awaiting admission and has no space to accommodate additional emergency patients. Private rooms will eliminate the need to block beds as is done currently with semi-private rooms for various reasons such as isolation needs and gender differences.

Suburban has included no increase in patient charges in Table G (Exhibit 1G) related to the proposed project. Suburban does anticipate having a positive impact on reducing overall costs to the health care system by providing a safer and more efficient facility in which to deliver health care. Limited savings related to staffing, the elimination of offsite lease expenses and the elimination of the shuttle bus service for offsite parking have been quantified for inclusion into the financial projections.

There is also a long term cost saving of the proposed project. The proposed project includes shell space, and Suburban will have access to vacated space in the existing facility, both of which will provide long term flexibility to meet future needs. Given the zoning environment in which Suburban exists, this flexibility will help avoid or postpone the need for future expansions requiring lengthy and costly zoning approval efforts. Suburban's last major clinical addition was the D wing in 1979. We anticipate it will be many decades before substantial changes to the campus will be needed once this Campus Enhancement project, including the proposed building addition, is complete.

For Affirmations, please see Exhibit 38.