1. Please provide a corrected Table B footnoted to explain any apparent discrepancies:

    a. Submit a revised Table B insuring that the total square footage after project completion equals the amount of space to be added in new construction plus the amount of space to be renovated plus the amount of space that will remain as is.

Applicant Response:

Exhibit 45 includes a corrected Table B. Also, Exhibit 46 includes a corrected Table C. As the corrections affected the MVS analysis for Renovation, a corrected MVS analysis for Renovation is included in Exhibit 47.

1. Please provide a corrected Table B footnoted to explain any apparent discrepancies:

    b. Correct or explain why the 3rd floor shell space reported on the table (35,184) does not match the response to question 1 (35,288).

Applicant Response:

The figure included in question 1 is incorrect it should be 35,184. The figure is also incorrect on page 68 of the original application. Please note that the correct figure was used in the MVS analysis for new construction.

1. Please provide a corrected Table B footnoted to explain any apparent discrepancies:

    c. Note that on the Revised Table B submitted on July 2, 2015 the To Remain AS Is column sums to 410,333 not 410,489 and the Total After Project Completion column sums to 724,643 not 724,799. Please correct or explain these discrepancies.

Applicant Response:

Enclosed Table B (Exhibit 45) corrects this issue. The July 2 version submitted for our review and discussion inadvertently included a hidden line.

2. Will the medical office space proposed in the project be built to hospital code? If so:

    a. Please provide a rough estimate of the incremental expense.

Applicant Response:

Occupancy type, number of stories, floor area, and construction type are the four basic variables that need to be considered when designing any building. Under the applicable building code the physician offices is considered a Business occupancy, while the hospital related uses are considered an Institutional occupancy. Where a building has only one occupancy type the design is straight forward, but ours is a mixed occupancy building. As such the building code requires that individual design choices for the building structure, enclosure and infrastructure comply with the most stringent requirement dictated by any one of the multiple occupancies. Hence, the shell will be constructed to Hospital code.

The arrangement of the fitout, such as corridor widths, is not required to follow the most stringent requirement rule but rather recognizes the point specific use. Construction elements related to fitout of the medical office space have no practical impact.

In sum, the shell will be constructed to Hospital code, but the fitout will not.

Suburban theoretically estimates that incremental expense is $2,613,079. Suburban arrived at this estimate by comparing the calculated Marshall Valuation Service (MVS) benchmarks for Hospitals and Medical Office Buildings, adjusted for only the general and local update factors. As Suburban is not fitting out the office space, and as the MVS Departmental Cost Differential factor for unassigned space is 0.5, Suburban assumed that half of the benchmark reflects the cost of the shell. The full calculation is provided below:

Type		**MOB**	**Hosp**
Construction Quality/Class		Good/A	Good/A
Basic Structure		$222.78	$354.99
Update Multiplier		1.05	1.05
	Product	$233.92	$372.74
Location Multiplier		1.07	1.07
	Product	$250.29	$398.83
Shell Component Only		$125.15	$199.42
Cost Differential/SF			$74.27
Square Feet			35,184
Estimated Cost Differential			$2,613,079

This is an imprecise measure but offers a general idea of the potential scope of the incremental expense.

2. Will the medical office space proposed in the project be built to hospital code? If so:
    b. Please justify this decision in light of the additional expense driven by that code level.

Applicant Response:

As noted in 10.24.01.08 (b) Need, incorporation of the physician office space into the hospital building was the recommendation of the community panel and part of the zoning process. Physician office space on the campus was identified as a high priority during the planning process. Given the nature and location of the campus, and in light of the arduous and contentious zoning process, building a separate Medical Office Building on the Suburban campus is not feasible or acceptable to the neighborhood. Creating physician office space within the hospital building is the only way to achieve the goal of physician office space on campus. One of the advantages gained by Suburban, though, is flexibility for the future. As planned, hospital departments will be on the floors above and the floors below the physician office space. If needs change and it is determined that the additional space is needed for a hospital purpose, the space can be re-purposed easily from a building code perspective. Given that Suburban will not be able or allowed to make any external additions to the building for decades to come, this kind of flexibility has a value. To Suburban, this solution best meets near-term needs but offers valuable flexibility for the future and is worth the incremental expense.

3. Regarding the response to **Financial Feasibility** Question 10b, please provide the following clarifications:

    a. Submit supplemental tables to support the gross patient revenue projections found in Table G (uninflated) and Table H (inflated) for years 2015 through 2022). See the attached form for possible format.

Applicant Response:

Enclosed in Exhibit 48 are the requested supplemental tables.

3. Regarding the response to **Financial Feasibility** Question 10b, please provide the following clarifications:

    b. Explain the basis for projecting an annual update factor of 2.4%.

Applicant Response:

The assumption of a 2.4% annual update factor is based on the 2.41% global budget revenues adjustment for inflation / policy adjustments that is presented in the HSCRC Update Factors for Recommendations for FY2015, dated June 11, 2014 (Exhibit 49). This assumption is confirmed by the 2.40% global budget revenues adjustment for inflation / policy adjustments that is presented in the HSCRC Draft Update Factors Recommendations for FY2016, dated May 13, 2015 (Exhibit 50).

3. Regarding the response to **Financial Feasibility** Question 10b, please provide the following clarifications:

    c. Has a population adjustment of 1.07% been used for each year? If, yes, what is the basis for projecting this percent going forward through 2022?

Applicant Response:

Yes, a population adjustment of 1.07% has been used for each year in the projection period. This assumption is based on the Suburban Hospital Population and Demographic Adjustment Volume Allowance for 2015 that is presented in the HSCRC's letter to Hospital CFOs on June 30, 2014 (Exhibit 51). Because the annual population adjustment is age and PAU adjusted and these factors are not know in future years, there was not a basis for projecting different annual population adjustments into the future.

3. Regarding the response to **Financial Feasibility** Question 10b, please provide the following clarifications:

    d. Reconcile the market share adjustment described on page 121 with the statement in response to the Impact criterion on page 102 of the April 10, 2015 application that Suburban assumed no change in market share and the discussions to date related to HSCRC's development of its market share adjustment methodology.

Applicant Response:

The HSCRC under Global Budget Revenue (GBR) models now refers to market share adjustment as market shift adjustment (MSA) to differentiate it from typical market share calculations.

The specific purpose of MSAs is to provide a criteria for increasing or decreasing the approved regulated revenue of Maryland hospitals operating under Global Budget Revenue (GBR) rate arrangements to ensure that revenue is appropriately reallocated when shifts in patient volumes occur between hospitals[1]. The MSAs reflect shifts in patient volumes independent of general volume changes in the market.

MSA's are based on service lines as defined by HSCRC for all zip codes, and excludes any PAU and is one of the tools necessary to account for changes in utilization levels and patterns. The defined geographic location is at a zip code level for each service line independent of whether the zip code falls in a hospital's service area.

The current algorithm developed to calculate the MSA compares the growth in volumes at hospitals with utilization increases to the decline in volumes at hospitals with lower utilizations. Adjustments are capped at the lesser of the growth for volume gainers or decline for volume losses[1] (Exhibit 52).

Under GBR, even if a hospital's market share is constant, a hospital will likely have changes in revenues related to market shift based on above methodology. The CON response assumes that Suburban's market share remains constant as overall market volumes grow, the market shift revenue adjustment assumes some of the volume growth is from desirable utilization change accompanied by corresponding decline in utilization in other hospitals.

In the CON submission, Market Shift is calculated as follows:

A.) Estimate the volume increase beyond the population adjusted (1.07%) volume increase for market shift

[1] Global Budget Revenue Contracts Market Shift Adjustments Draft Technical Report, May 2015

a. For FY 2021, Suburban estimates a 1.7% increase in volumes compared to prior FY due to the new building and OR opening.

b. The market shift is estimated to be 1.7% - 1.07% = 0.63%

B.) Multiply 50% of market shift (to account for 50% VCF) to prior year GBR

a. 0.5 x 0.63% x prior year GBR

The above calculation is consistent with current HSCRC market shift calculation methodology, with an assumption that all of the market shift estimated is attributed to Suburban with corresponding decrease in market shift from other Maryland hospitals.

For Affirmations, please see Exhibit 53.