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MEMORANDUM

TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: 10/16/2018

SUBJECT: University of Maryland St. Joseph Square Medical Center
Docket No. 18-03- 2415

Enclosed is the staff report and recommendation for a Certificate of Need ("CON") application filed by University of Maryland St. Joseph Medical Center ("SJMC").

SJMC proposes to replace and consolidate its current surgical facilities, which it describes as outdated. This project will renovate and replace the hospital's 15 mixed use general operating rooms ("ORs") and support areas -- which are currently located in two separate areas on the ground floor of the hospital -- with a surgical suite consisting of 11 general ORs and one hybrid special purpose OR. The project will also renovate and replace the hospital's four cardiac special purpose ORs and its cardiac procedure suite.

The primary objectives of the proposed project are to modernize SJMC's outdated surgical facilities (with an average age of 27 years) and its cardiac procedure facilities, and consolidate services to gain efficiency. Most of SJMC's existing surgical facilities do not meet the current industry standard of 600 square feet ("SF") of clear floor area, and the cardiac procedure labs are far smaller than the current industry standard of 400 SF of clear floor area.

The total project cost is estimated to be $60,000,000. SJMC anticipates funding the project with $20,000,000 in fundraising and $40,000,000 in cash ($30.3 million from operations and $9.7 million from an escrow fund).

SJMC is not seeking an adjustment of its global budget revenue, but the project requires Certificate of Need ("CON") approval because it involves an estimated capital expenditure that exceeds the current threshold for hospital capital expenditures, and SJMC did not exercise its ability to implement the project without CON approval because it wished to preserve the ability to request an adjustment of its global budget revenue at a future date.

Commission staff analyzed the proposed project's compliance with the applicable State Health Plan standards and the other applicable CON review criteria at COMAR 10.24.01.08 and recommends that the project be APPROVED, with the following condition:

> 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 COMAR 10.24.10.04B(9) or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

IN THE MATTER OF	*	
	*	**BEFORE THE**
UNIVERSITY OF MARYLAND	*	
	*	**MARYLAND HEALTH**
ST. JOSEPH MEDICAL CENTER	*	
	*	**CARE COMMISSION**
Docket No. 18-03-2415	*	
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Staff Report and Recommendation

October 16, 2018

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I. INTRODUCTION

A. The Applicant

The University of Maryland St. Joseph Medical Center, LLC ("SJMC") is a 218-bed general hospital located at 7601 Osler Drive in Towson (Baltimore County). SJMC is owned and operated by the University of Maryland Medical System. SJMC serves inpatients requiring general medical/surgical, obstetric, pediatric, cardiac surgery, and acute psychiatric services.

B. Background and Project Description

SJMC proposes to replace and consolidate its current perioperative services facilities, including its operating rooms ("ORs"), cardiac catheterization laboratories (including electrophysiology and interventional radiology laboratories), sterile processing department, and support spaces. The project will also reconfigure the way in which cardiac surgery patients recover from surgery in critical care beds. The primary objectives of the proposed project are to modernize outdated surgical and cardiac catheterization facilities and consolidate services in ways intended to enhance efficiency.

SJMC reported in its June 2017 Annual Report to the Maryland Health Care Commission ("MHCC") that its OR inventory includes:15 mixed-use, general purpose operating rooms; four mixed-use, special purpose operating rooms; and two dedicated cesarean section operating rooms, a total of 21 ORs.[2] (DI #10, p. 2). However, these numbers do not reflect the hospital's current operational inventory.[3] SJMC's existing surgical facilities have an average age of 27 years, and most of the ORs have less than 600 square feet ("SF") of clear floor area, a dimension cited by the applicant as an industry standard. The cardiac catheterization laboratory spaces are less than 400 SF in size, again cited as undersized by current industry standards and are not located in a single place within the hospital, which is noted as inefficient.

SJMC reported that its existing complement of laboratories used in diagnostic imaging and testing and in interventional procedures, includes five cardiac catheterization laboratories ("cardiac cath labs"), one electrophysiology ("EP") laboratory, and one interventional radiology ("IR") laboratory. (DI #3, p. 5). The applicant also reported that it currently has nine cardiac care unit beds ("CCU beds"), a specialized type of intensive care or critical care bed in which vital functions are continuously monitored and patients are closely observed. (DI #3, Exh. 1, Table A).

Implementation of the project will be phased and will include both new construction and renovation of existing space with a combined total of 87,490 SF. It will create newly configured spaces within the hospital. The first will be a cardiac-focused suite with two cardiac operating rooms, four cardiac cath labs, a CCU with six intensive care patient rooms, and related support

[2] A "mixed-use" operating room is used in the performance of both inpatient and outpatient surgical cases. The "special purpose" ORs at SJMC are used for cardiovascular surgery.

[3] Several SJMC ORs were taken out of service because of water damage sustained in May 2016. Only 17 ORs are currently in service: 12 mixed-use, general purpose ORs; three special purpose ORs (one "hybrid" OR designed for certain types of cardiovascular cases and two other conventional cardiac ORs), and two labor and delivery Ors. (DI #10, p. 3, Table 22).

space. The second will be a surgical suite containing 11 mixed-use, general purpose operating rooms (six are currently in the process of being renovated under a determination of coverage issued in August 2016) and one special purpose hybrid operating room (renovated under a determination of coverage issued in June 2016). Finally, a new sterile processing suite will be established.

Upon completion of the renovation projects presented to MHCC in 2016 that were determined not to require CON review and approval, SJMC will see a net reduction of one operating room in its current operational OR capacity (a mixed-use general purpose OR). three cardiac cath labs, and three CSU rooms. (DI #3, p. 3-4). The total ORs that will be in service upon completion of these projects include: 11 Mixed Use General Purpose ORs; three Special Purpose ORs (one Hybrid and two Cardiac); and two Labor and Delivery ORs. See Table I-1 below. (DI #10, p. 3, Table 22).

Table I-1: Existing and Proposed Capacities
University of Maryland St. Joseph Medical Center

Operating Rooms	ORs in Service Prior to Water Incursion Incident	ORs in Service	ORs in Service Post-Project
Mixed-use general purpose	15	12	11
Special purpose	4	3	3
Labor & delivery (C-section)	2	2	2
Total	21	17	16
Cardiac Procedure Labs	**Cardiac Labs in Service**	**Cardiac Labs in Service Post-Project**	
Cardiac Cath Labs	5	2	
EP Labs	1	1	
IR Labs	1	1	
Cardiac Care Unit	**Beds Currently in Service**	**Beds in Service Post-Project**	
CCU Beds	9	6	

DI #10, Table 22, p. 3; DI #3, p. 5; DI #3 Exh. 1, Table A

This project only requires CON review and approval because of the size of the expenditure. The project does not include any addition of beds or operating rooms that would trigger the need for review. As such, it is only being reviewed by MHCC because SJMC has opted to not "take the pledge," which would obviate the need for this project review. This would require the hospital to obtain a determination of coverage from MHCC based on its "pledge" to the Health Services Cost Review Commission ("HSCRC") that the hospital does not require a total cumulative increase in patient charges or hospital rates over the lifetime of the project that exceeds $1,500,000 for the capital costs associated with the project. SJMC wants a CON for this project to preserve its ability to seek an increase in patient charges related to the capital expenditure that will exceed $1,500,000 over the lifetime of the project. It states that it is not seeking such an increase at this time.

The proposed project has an estimated cost of $60 million, of which an estimated $36.8 million is allocated for renovations and about $615,000 for new construction. Other capital costs (i.e., equipment, project management expense, contingency allowance) amount to $17.4 million. Approximately $2.4 million is allocated for financing costs and other cash requirements, and just under $2.9 million is allocated as an inflation allowance. The anticipated sources of funds for this project include $40 million in cash ($30.3 million from operations and $9.7 million from an escrow fund reserved and earmarked for capital projects when University of Maryland Medical System acquired SJMC), and philanthropic donations of $20 million. (DI #3, p. 3-4 and DI #10, Exh. 23, Table E).

C. Summary of Staff Recommendation

For reasons detailed in the summary below, staff recommends that the Commission APPROVE the application subject to the following condition:

> 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 COMAR 10.24.10.04B(9) or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

Criteria/Standard	Conclusions
Need and Capacity	The project will not add surgical services capacity to the hospital or health system, but will modernize and consolidate the surgical facilities that are now outdated and poorly integrated. It will reduce the OR inventory from 17 to 16 and make the OR and support space more operationally efficient.
Cost Effectiveness	The applicant outlined its goals and described alternatives it considered. The two alternatives presented by the applicant both combined significant expansion via new construction with renovation, and both were deemed cost prohibitive. In addition, neither alternative met all of the project's goals. The applicant demonstrated that renovating in-place best addresses the goals it established. Chief among these goals is modernization of some of its facilities and improving operational efficiency. Staff concludes that the applicant demonstrated that its proposed project is the most cost effective option to meet these project objectives.
Efficiency	The project will reduce expenses for maintaining unnecessary OR capacity, pre-operative and post-anesthesia care units, and laboratory space that are unnecessarily duplicative. The project is projected to result in a reduction of 20.7 full time-equivalent (FTE) staff positions, which translates to a projected savings of $2 million annually.
Financial Feasibility and Viability	Cash is anticipated to cover two-thirds of the project's cost with philanthropy expected to cover the balance. SJMC has demonstrated that it has the equity and fund-raising capability to fund the project as proposed. Its utilization projections and revenue and expense assumptions are reasonable. SJMC has been in communication with HSCRC staff and is not seeking a rate increase associated with this project at this time.
Construction Cost	Using the Marshall Valuation Service methodology, staff concluded that the estimated project cost is comfortably below the calculated benchmark for new construction.
Impact	The proposed project modernizes and "right-sizes" an existing hospital's surgical, cardiac catheterization, and coronary care unit facilities. It will bring SJMC's operative facilities in alignment with contemporary design standards. It should not have an appreciable impact on costs or charges or other hospitals. It will benefit patients and physicians using these affected facilities and services at SJMC.

II. PROCEDURAL HISTORY

A. Review of the Record

Please see Appendix 1, Record of the Review.

B. Interested Parties in the Review

There are no interested parties in this review.

C. Local Government Review and Comment

No comments were received from local government entities.

D. Community Support

Twenty letters of support were received from several public servants and elected officials, and civic, business, and religious leaders, from the Maryland Department of Commerce, the Archdiocese of Baltimore, and the Towson Chamber of Commerce. Letters also came from persons affiliated in a variety of ways with SJMC and UMMS. (DI #3, Exh. 19).

III. REVIEW AND ANALYSIS

The Commission is required to make its decision in accordance with the general Certificate of Need review criteria at COMAR 10.24.01.08G(3) (a) through (f). The first of these six general criteria requires the Commission to consider and evaluate this application according to all relevant State Health Plan ("SHP") standards and policies. The State Health Plan chapters that apply are COMAR 10.24.10, Acute Care Hospital Services, and COMAR 10.24.11, General Surgical Services.

A. The State Health Plan

COMAR 10.24.01.08G(3)(a) - State Health Plan.
An application for a Certificate of Need shall be evaluated according to all relevant State Health Plan standards, policies, and criteria.

COMAR 10.24.10 - State Health Plan for Facilities and Services: Acute Care Hospital Services

COMAR 10.24.10.04A - General Standards.

.04A(1) <u>Information Regarding Charges.</u>
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.

In its application, SJMC stated that the current list of representative services and charges is readily available to the public, both in written form at SJMC and on the Hospital's website. (DI #3, p. 20). Staff subsequently verified that the SJMC website includes a page titled "Charge Estimator" with a working link to a PDF that includes a list of representative charges. The web page was updated in August 2018.[4] The applicant included a copy of its recently updated and approved policy regarding the provision of information to the public concerning charges for its services in its application. (DI #3, Exh. 8).

SJMC stated that requests for an estimate of charges are handled by the Financial Counselors in the Patient Billing Department. SJMC also stated that The Patient Access Department is responsible for ensuring the appropriate training and orientation is provided to the staff. (DI #3, Exh.7).

.04A(2) <u>Charity Care Policy.</u>
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

[4] https://www.umms.org/sjmc/-/media/files/um-sjmc/patients-and-visitors/for-patients/financial-assistance/estimated-charges-2018.pdf?upd=20180809210645&la=en&hash=B6BE2C81E650147D29D0490FFDE98B70A1E1905E
SJMC states that the Finance Department will update this list on a quarterly basis, consistent with COMAR 10.24.10.06B(29).

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.

SJMC stated that it provides medical services to all patients regardless of their ability to pay and provided relevant sections of its Financial Assistance Policy. (DI #3, Exh. 9). The policy that the applicant provided specifically states that SJMC will make a determination of probable eligibility within two business days following a patient's request for charity care services, application for medical assistance, or both. (DI #3, p. 21).

Additionally, the University of Maryland Medical System's policy states that SJMC will provide public notices yearly in local newspapers serving the hospital's target population. (DI #3, p. 21, Exh. 11, p. 1). SJMC included a copy of its Financial Assistance Policy Notice (DI #3, Exh. 10), which is posted at patient registration locations, the billing department, the emergency department, in other key patient access areas, and on SJMC's website.[5] This notice is provided to patients at all registration areas and at the time of admission. (DI #3, p. 21).

(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.

According to figures reported by SJMC from HSCRC's FY 2016 Community Benefit Report, SJMC's level of charity care fell within the third quartile of all hospitals in 2016, ranking 33rd among 46 Maryland hospitals. (DI # 3, p. 22-23). Staff's review of the HSCRC FY 2017 Community Benefit Report showed that its ranking had moved up to 23rd, putting it at the median of Maryland hospitals in 2017.

Staff recommends that the Commission find that this standard has been satisfied.

.04A(3) <u>Quality of Care.</u>
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.

[5] https://www.umms.org/sjmc/-/media/files/umms/patients-and-visitors/umms-cbo-fa-pol-proc-manual-eff-sept-1-2017.pdf?la=en&upd=20171230142852&hash=E054B02FA942F26C448D20C78310EB8212A44557

The applicant documented its licensure status with the Maryland Department of Health, Joint Commission accreditation, and compliance with the conditions of participation of the Medicare and Medicaid programs. (DI #3, Att. 12 and 13).

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

SJMC provided its quality performance data. These measures include Serious Safety Events, Acute Care Core Measures, and Patient and Employee Safety Measures. (DI #3, Exh. 14;. https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/hcfs_con_st_joseph.aspx).

Staff notes that the wording of Paragraph (b) of this standard is somewhat outdated, in that the Maryland Hospital Performance Evaluation Guide ("HPEG") has been redesigned and is now a component of the Maryland Health Care Quality Reports ("Quality Reports") website. The Quality Reports website brings together the Commission's consumer guides on hospitals, long term care facilities and health plans to create a comprehensive consumer resource. The number and types of quality measures used to compare and evaluate hospital performance have expanded substantially during the eight years since this standard was adopted. Many of the original measures have been retired over the years. In addition, the display format for the measure results in the new Quality Reports website no longer consists of a set of measure values that conform with the format of this standard, in which each measure is scored as a compliance percentage.

Currently, there are over 70 hospital quality measures listed in Quality Reports. These measures are updated quarterly and were most recently updated in July 2018. Many performance measures are displayed in a comparative context, with ratings of "Below Average," "Average," "Better than Average," or "Not enough data to report." SJMC had sufficient data to be rated on 67 of 78 measures. SJMC scored "Better than Average" on 28 measures, "Average" on 34, and "Below Average" on five. Of those five measures, four were related to emergency department ("ED") wait times, patient flow, and through-put, and one was related to the stroke death rate. In response the rating, SJMC reports that it has created a committee that is working to improve the five components that make up the patient flow metric. The hospital plans to initiate projects that will streamline its ED processes.

The stroke death rate measure refers to how often patients who came to the hospital after experiencing a stroke subsequently died in the hospital. SJMC responds to this rating by stating that core measures for stroke care will be incorporated into the ongoing professional practice evaluations of its physicians. SJMC states that it will implement work groups to address speed of care and begin tele-stroke communication with University of Maryland Medical Center for acute stroke patients. (DI #10, p. 9).

COMAR 10.24.10.04B Project Review Standards

.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.

The project does not propose establishment of a new acute care general hospital or the relocation and replacement of an acute care general hospital on a new site. This standard is not applicable to this proposed project.

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

This project does not involve an increase in bed capacity. This standard is not applicable.

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

The applicant does not seek to establish a new pediatric unit. This standard is not applicable.

.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

SJMC is not seeking an extraordinary adjustment to its Global Budget Revenue at this time that would account for the higher depreciation expenses that will result from this project.

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

SJMC states that it is replacing operating rooms and related services based on the projected need of the residents of its service area. SJMC projects an FY 2025 need for 11.3 general operating rooms and two cardiac operating rooms.[6] In this CON application SJMC seeks to replace five general operating rooms (to contribute to a total of 11 general operating rooms, six of which are being renovated under a separate August 2016 determination of non-coverage) and two cardiac operating rooms. The applicant submitted recent and projected surgical case volume for the hospital as evidence that this reduction in operating rooms will not inappropriately diminish the availability or accessibility to care. (DI #10, p. 17, Table 27; DI #3, p. 54-59).

SJMC is projecting a 15.5% decline in inpatient surgical case volume from FY 2018 to FY 2019, followed by a rebound of two to five percent per year from FY 2019 through FY 2025. The applicant projects a six percent increase in outpatient cases from FY 2018 to 2019 and projects a one to two percent increase in such cases per year from FY 2019 through FY 2025. (DI #12, p. 8, Table 30; DI #12, p. 9, Table 34). SJMC attributes a projected decline of 100 low acuity inpatient surgical cases and 558 outpatient surgical cases by FY 2025 to a combination of patient preference for Ambulatory Surgery Centers and pressure from insurers. (DI #3, p. 56). Statewide, hospital OR use has declined in recent years.[7] Considering these trends, staff concludes that the proposed reduction of operating rooms at SJMC would be unlikely to materially diminish the availability and accessibility to surgical services for the patient population.

Staff concludes that the proposed project complies with this standard and will not have an unwarranted adverse impact on charges for, availability of, or access to services.

.04B(5) <u>Cost-Effectiveness</u>

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

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

(i) To the extent possible, quantify the level of effectiveness of each alternative in achieving each primary objective;
(ii) Detail the capital and operational cost estimates and projections developed by the hospital for each alternative; and
(iii) Explain the basis for choosing the proposed project and rejecting alternative approaches to achieving the project's objectives.

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

[6] In order to determine the number of operating rooms, SJMC forecasted OR hour demand and utilized the State Health Plan's assumption that optimal capacity per hospital mixed-use OR is 1,900 hours per room per year. (DI #3, p. 58).
[7] MHCC's Annual Survey of Ambulatory Surgical Facilities and HSCRC's Discharge Data Base.

project's objectives.

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

(i) That it has considered, at a minimum, the two alternative project sites located within a Priority Funding Area that provide the most optimal geographic accessibility to the population in its likely service area, as defined in Project Review Standard (1);
(ii) That it has quantified, to the extent possible, the level of effectiveness, in terms of achieving primary project objectives, of implementing the proposed project at each alternative project site and at the proposed project site;
(ii) 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
(iii) That the proposed project site is superior, in terms of cost-effectiveness, to the alternative project sites located within a Priority Funding Area.

SJMC identified the following project goals:

1. Modernize surgical and procedural suites so that all spaces are in compliance with appropriate codes and meet industry standards;
2. Support SJMC's move towards Integrated Practice Units ("IPUs") that allow for co-located centers of excellence based around patient disease states;
3. Improve infection control by providing appropriate flow of patients and materials;
4. Reuse existing hospital infrastructure;
5. Improve operational efficiency; and
6. Achieve all programmatic elements within SJMC's $60,000,000 budget target.

(DI #3, pp. 30-32).

The applicant developed and evaluated three alternatives: (1) a complete renovation in place; (2) a combination of expansion and renovation; and (3) an addition that would allow consolidation of SJMC's perioperative services. Table II-1 presents the applicant's description of each alternative and the applicant's statements with respect to how the alternative project plan aligns with the project's goals.

Table II-1: Comparison of Alternatives

Option/Description	Cost	Ability to Meet Project Goals
Option 1: Renovate approximately 87,500 SF of existing surgical, cardiac cath lab, pre-operative, post-operative, and related support spaces in their present locations. • Renovate approximately 22,000 SF of cardiac related spaces (two cardiac cath labs, one EP lab, one IR Lab, and two cardiac ORs, post-open-heart patient care spaces, and related support spaces) on the west side of the hospital. • Renovate the existing post-cardiac surgery unit, reducing it from nine beds to six beds. • Surgery-related spaces would remain on the east side of the hospital, including six existing and five renovated general operating rooms and surgical prep and recovery. • Relocate the Sterile Processing Department to the first floor to provide appropriately sized, consolidated space adjacent to the warehouse and loading dock. Add a new clean elevator and soiled lift to provide access to the surgical floor.	$60 million	This alternative achieves all project goals within the $60 million budget.
Option 2: Combination of expansion and renovation. Add approximately 32,000 SF of new construction on two floors for the surgical department, and renovate approximately 57,000 SF. • Renovate approximately 22,000 SF of cardiac related spaces (two cardiac cath labs, one EP lab, one IR Lab, and two cardiac ORs, post-open-heart patient care spaces, and related support spaces) on the west side of the hospital. • Renovate the existing post-cardiac surgery unit, reducing it from nine beds to six beds. • Build a new, 32,000 SF, two-story, above-grade ambulatory care pavilion with five ORs, associated prep and recovery, public lobby, and support space. This surgical environment would be separate from the remaining existing operating rooms. • Renovate approximately 24,000 SF of existing surgery related spaces on the east side of the hospital, including six existing general operating rooms. • Renovate existing surgical prep and recovery, staff support, and circulation. • Renovate approximately 11,000 SF of space on the first floor in order to relocate the Sterile Processing Department to provide appropriately sized, consolidated space adjacent to the warehouse and loading dock. Add a new clean elevator and soiled lift to provide access to the surgical floor.	$65 million	• Will not meet the goal to improve infection control because the surgical pavilion in this alternative could not be connected with the existing ORs, making it difficult to transport supplies, staff, and patients between the two. • It will not meet the goal of using existing hospital infrastructure because the project relies on 32,000 SF of expansion space, while vacating 16,500 SF of existing program space and leaving it vacant at the end of the project. • It will not meet the goal of improving operational efficiency because this alternative separates surgical environments and puts them on two different floors in different areas of the hospital, which does not allow for surgical services to support each other or easily transfer patients. • The cost exceeds SJMC's $60 million budget

<u>Option 3: Consolidate perioperative services.</u> Add approximately 65,400 SF of new construction on two floors for the surgical department, and renovate approximately 45,200 SF. • Locate new ORs and procedural spaces (two cardiac operating rooms, five new general operating rooms, two cardiac cath labs, one EP lab, and one IR lab) in new construction on the ground floor. • Build a new loading dock, warehouse, and Sterile Processing Department in new construction on the second floor. • Renovate a nine bed post-cardiac surgery care unit and relocate it to the existing fourth floor critical care unit. • Renovate surgical patient prep and recovery and support spaces on the east side of the hospital adjacent to the current operating rooms.	$80 million	• It will not meet Goal 2 to support SJMC's move towards Integrated Practice Units, which allow for co-located centers based around patient disease states, because the project combines surgical with cardiac spaces and combines post-cardiac-surgery patients with general critical care patients. • It will not meet the goal of using existing hospital infrastructure because the project relies on an expansion of 65,400 SF, while vacating 23,200 SF of existing program space and leaving it vacant at the end of the project. • This alternative will not meet the goal of improving operational efficiency because it combines unrelated surgical and procedural types. This creates potential for confusion and does not support the Integrated Practice Unit staffing mode. It also creates a larger single surgical environment, causing further travel distances for staff and patients. • The cost exceeds SJMC's $60 million budget.

Source: DI #3, Exh. 15.

The applicant summarized its bases for selection of Option 1, stating that this option provides the proper physical environment for surgical and procedural spaces, maintains the operational concept of Integrated Practice Units ("IPUs") with areas focused on cardiac or surgical centers of excellence, keeps post-cardiac-surgery patients close to specialized cardiac staff in the critical post-surgical hours, creates no significant new hospital space, and re-uses existing infrastructure wherever possible. This option also improves operational efficiency by supporting the operational concept of IPUs, focusing the staff within smaller overall footprints. Option One, the proposed project, has the lowest estimated cost.

Staff concludes that the applicant provided details on its decision-making process and alternatives, and recommends a finding that the project meets this standard.

.04B <u>(6) Burden of Proof Regarding Need</u>

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.

SJMC seeks to replace and modernize OR facilities that are out of date, and undersized by today's standards. Staff concludes that SJMC demonstrated need for its proposed project, based on its historic trends and projected future use. While addressing the need for modernization, the project will actually reduce the number of ORs.

.04B(7) <u>Construction Cost of Hospital Space</u>

The proposed cost of a hospital construction project shall be reasonable and consistent with current industry cost experience in Maryland. The projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Paragraph (a) of this standard requires a comparison of the project's estimated construction cost with an index cost derived from the Marshall Valuation Service ("MVS") guide. To complete this comparison, an MVS benchmark cost is developed for new construction based on the relevant construction characteristics of the proposed project. The MVS cost data include the base cost-per-square-foot for new construction by type and quality of construction for a wide variety of building uses including outpatient surgical centers. The MVS guide also includes a variety of adjustment factors, including adjustments of the base costs to the costs for the latest month, the locality of the construction project, as well as factors for the number of building stories, the height per story, the shape of the building (such as the relationship of floor area to perimeter), and departmental use of space. The MVS guide identifies costs that should not be included in the

MVS calculations. These exclusions include costs for buying or assembling land, making improvements to the land, costs related to land planning, discounts or bonuses paid for through financing, yard improvements, costs for off-site work, furnishings and fixtures, marketing costs, and funds set aside for general contingency reserves.[7]

Both SJMC and MHCC staff performed independent analyses comparing the applicant's estimated project cost to the MVS benchmark calculated for the proposed project. (*See* Appendix 2). The project will include 81,174 SF of renovation and a small amount of new construction (316 SF), consisting of an addition to the outside of the building for a service elevator that will connect the ground and first floors on the north-east side of the facility. The renovations will occur from the ground floor to the third floor within SJMC existing perioperative space. The MVS methodology is designed for the evaluation and comparison of new construction costs. For this reason, it is often the case that the MVS benchmarks are much higher than the costs estimated by applicants for projects that largely involve renovation. Because new construction accounts for less than one percent of the total space involved in this project, SJMC and MHCC staff each calculated the adjusted project cost per SF by combining the actual costs of renovations with the new construction costs. Using this approach, both SJMC and MHCC calculated an adjusted project cost of $427.21 per SF

The applicant and MHCC staff arrived at different MVS benchmark values. SJMC calculated an estimated benchmark cost of $611.28 per SF, whereas staff arrived at a value of $623.91 per SF. The difference between the two benchmark values is $12.63 per SF, a difference of about 2%. While both used the MVS methodology, the difference in the benchmark values is primarily due to three factors. MHCC staff utilized an updated value for the Multi-story Multiplier and the Current Cost multiplier, and calculated a different amount on the estimated costs for installing a wet sprinkler system.[8]

With an estimated construction cost of $427.21 per SF, both SJMC and MHCC staff found the estimated cost to be well below (43 to 46%) the respective benchmark calculations. Thus, the project complies with this standard.

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

The project does not involve changes to non-hospital space. This standard is not applicable.

.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

[7] Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2016).
[8] Please see Appendix 2 for further details on these differences.

on the excess space.

SJMC intends to renovate its existing cardiac surgery unit ("CSU") on the ground floor to downsize the unit from nine to six beds, which will result in an overall reduction in operating expenses. Once renovated, the CSU will provide 532 square feet per bed, slightly exceeding the 500 feet/bed standard. This is because the number of beds in the unit will be reduced but support space will not be reduced. In addition, the CSU is located in a uniquely shaped area of the building which results in atypical room shapes in this unit, which contributes to the higher space per bed ratio. (DI #3, p. 37).

Staff concludes that the applicant has explained its deviation from the 500 SF per bed benchmark. Nonetheless, staff recommends that, if this project is approved, such approval should include this condition:

> 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 COMAR 10.24.10.04B(9) or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

.04B(10) <u>Rate Reduction Agreement</u>

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.

This standard is no longer applicable because the rate reduction agreements referenced by the standard have been replaced by the Global Budget revenue model. Staff will consider the ongoing validity and/or revision of this standard in its next iteration of COMAR 10.24.10, the Acute Care Hospital Services Chapter of the State Health Plan.

.04B(11) <u>Efficiency</u>

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.

SJMC described eight features of the project that it expects will enhance operational efficiency. They are:

- A reduction in general OR inventory from 15 to 11 rooms, and corresponding reduction in operating expenses;
- A reduction in cardiac/interventional radiology lab inventory from seven total labs in three separate locations to four total labs in a single location, with corresponding reduction in operating expenses;
- Consolidation of cardiac interventional services into one common corridor sterile area, eliminating inefficiencies in patient transport and in the need to stock two separate procedural areas;
- Consolidation of the two separate Post Anesthesia Care Units (PACUs) into a single Phase 1 PACU, allowing for cross-training staff to reduce the inefficiency associated with staffing and stocking two separate units;
- Consolidation of Phase 2 recovery with patient prep area into a single swing unit, permitting cross-training staff to reduce inefficiencies in staffing and stocking two separate units;
- Inclusion of dedicated orthopedic physical therapy space within the Phase 2 recovery area to provide appropriate patient training before discharge. This should reduce the amount of post-discharge care required and reduce the likelihood of post-surgical re-admission;
- Consolidation of the hospital's sterile processing and sterile supply storage from three locations into one location located immediately adjacent to the loading dock and main warehouse. This will reduce handling time; and
- A reduction in the hospital's critical care bed count from 37 to 34 critical care beds, with corresponding reduction in operating expenses. (DI #3, pp. 38-39).

SJMC projects that these operational efficiencies will allow a staff reduction of 20.7 surgical staff FTEs[9] resulting in an annual expense savings of $2,000,000. The staff reduction results in a projected 27.6% increase in productivity per surgical FTE (60.2 cases/FTE vs. 76.8 cases/FTE), as depicted in Table II- 2 below.

[9] FTE reductions include 6.8 surgery service FTEs, 3.6 anesthesiology FTEs, 5.0 post-anesthesia care unit FTEs, and 5.3 cardiac cath lab FTEs.

Table II-2: Current and Projected Surgical and Cardiac Services Staffing, ORs, and OR Use
University of Maryland St. Joseph Medical Center

	FY 2017	FY 2025
Number of ORs	21	16
Projected Surgical Cases	9,317	10,293
FTEs[10]	154.8	134.1
Surgical Cases/FTE	60.2	76.8

Source: DI #3, Table 18, p. 57; DI #3, Exhibit 1, Table L; DI #10, p. 15.

Staff concludes that the applicant has detailed projected efficiencies resulting in significant annual savings due primarily to staffing efficiencies and, for this reason, concludes that the applicant has met this 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.

SJMC states that patient safety was an important consideration in the planning and design of the proposed project. The application included an exhaustive list of project features mostly related to enhancing infection control and appropriate room size and design. (DI #3, p.42).

Staff concludes that the applicant provided evidence that it considered patient safety issues in the design of the project, and recommends a finding that the applicant has met this 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.

SJMC states that its projections were derived from its FY 2018 budget. SJMC's key financial assumptions included revenue assumptions with: (1) a 2% annual revenue update factor; (2) contractual allowances equivalent to 5.4% of total revenue; (3) charity care equivalent to 1.3% of total revenue; and (4) bad debt equivalent to 2.6% of total revenue

SJMC's expense assumptions are: (1) salary expenses will be reduced based on the

[10] These FTEs include OR staff, surgical pre-admission staff, anesthesiology staff, post-anesthesia care unit staff, cardiac cath lab staff, cardiac cath prep and recovery staff, surgical prep staff, and surgical pathology staff.

projected reduction in FTEs; and (2) inflation assumptions for other expense categories range between 2 to 3% per annum. (DI #10, Exh. 21, Table H).

(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.

For the hospital as a whole, selected historical and projected volume, revenue and expenses are shown in Table II-3 below. SJMC projects about growth of about four percent in patient days and one percent in outpatient case volume for the entire projected time period (FY 2019 through FY 2024). (DI #10, Exh. 21, Table H). Uninflated patient services revenue is projected to increase at around this same rate. Uninflated operating expenses are projected to decline from FY 2019 to FY 2024 due to a hospital-wide reduction in FTEs and efficiency improvements. Overall, SJMC projected revenues to exceed expenses for the hospital and its projections are, as a whole, in line with FY 2016 and FY 2017 performance data.

Table II- 3: Selected Current (FY 2016 - FY 2017) and Projected (FY 2018 – FY 2024) Utilization and Financial (Current Year Dollars) Statistics
University of Maryland St. Joseph Medical Center, All Operations

	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Inpatient Days	60,756	57,429	57,390	55,161	55,855	56,565	56,870	57,187	57,516
Annual Change		-5.5%	0.0%	-3.9%	1.3%	1.3%	0.5%	0.6%	0.6%
Outpatient Visits	40,652	40,301	40,661	40,910	41,025	41,142	41,201	41,262	41,326
Annual Change		-0.9%	0.9%	0.6%	0.3%	0.3%	0.1%	0.1%%	0.2%
Patient Services Revenue (Uninflated)	$554,994	$565,905	$588,946	$586,038	$590,924	$590,970	$589,714	$589,750	$589,788
Annual Change		2%	4.1%	-0.5%	0.8%	0.0%	-0.2%	0.0%	0.0%
Total Operating Expenses (Uninflated)	$412,698	$423,986	$432,933	$426,109	$425,865	$425,904	$424,847	$427,644	$427,676
Annual Change		2.7%	2.1%	-1.6%	-0.1%	0.0%	-0.2%	0.7%	0.0%
Staffing/ Contractual Expenses (Uninflated)	$291,498	$298,102	$308,071	$299,449	$298,758	$298,427	$298,383	$300,300	$300,157
Annual Change		2.3%	3.3%	-2.8%	-0.2%	-0.1%	0.0%	0.6%	0.0%
% of Operating Expenses	70.6%	70.3%	71.2%	70.3%	70.2%	70.1%	70.2%	70.2%	70.2%
Net Income (Uninflated)	$1,577	$848	$5,182	$9,491	$13,966	$13,967	$13,935	$11,169	$11,169
Net Income (Inflated)	$1,577	$848	$5,182	$9,691	$14,539	$14,836	$15,102	$15,497	$15,815

Source: DI #10, Exh. 21, Table F; DI #10, Exh. 25, Table G.

Staff recommends that the Commission find that the project is financially feasible, will not jeopardize the long-term financial viability of the hospital, and, thus, that the applicant has met this standard.

.04B(14) Emergency Department Treatment Capacity and Space
.04B(15) Emergency Department Expansion

Neither of these standards is applicable. The project does not involve changes to SJMC's emergency department.

.04B(16) Shell Space

The project does not include construction of shell space. This standard is not applicable.

COMAR 10.24.11 State Health Plan for Facilities and Services: General Surgical Services

10.24.11.05A General Standards.

COMAR 10.24.11, the General Surgical Services Chapter of the SHP, guides CON reviews involving non-specialized surgical facilities and services. Hospital applicants are required to address all standards applicable to their proposed project in both the acute care hospital services and the general surgical services chapters of the SHP; however, COMAR 10.24.11 states that: "A hospital is not required to address standards in this Chapter that are completely addressed in its responses to the standards in COMAR 10.24.10."

SJMC currently has 21 ORs in its inventory, with 17 currently in service. Twelve rooms are mixed-use general purpose ORs, two are cardiac special purpose ORs, two labor and delivery ORs, and one OR is a hybrid special purpose room. The proposed project would replace existing surgical services facilities and relocate them within a consolidated general surgery suite. The new general surgical services suite will consist of 11 mixed-use general purpose ORs (six will be renovated under a separate project for which SJMC previously received a determination of coverage), and one hybrid OR (renovated under a separate project for which SJMC previously received a determination of coverage).

The standards in the General Surgical Services Chapter, COMAR 10.24.11, that duplicate standards in the previously discussed Acute Care Hospital Services Chapter, COMAR 10.24.10, are addressed in the preceding section of this report:

COMAR 10.24.10.04A(1) Information Regarding Charges;[11]
COMAR 10.24.10.04A(2) Charity Care Policy;[12]
COMAR 10.24.10.04A(3) Quality of Care;[13]
COMAR 10.24.10.04B(7) Construction Costs;[14]
COMAR 10.24.10.04B(12) Patient Safety;[15] and
COMAR 10.24.10.04B(13) Financial Feasibility.[16]

The analysis of the above standards, completed in discussion of the Acute Care Hospital Services Chapter will not be repeated in the discussion of comparable standards in the Surgical Services Chapter.

.05A(2) Information Regarding Procedure Volume.

A hospital, physician outpatient surgery center, or ASF shall provide to the public upon inquiry information concerning the volume of specific surgical procedures performed at the location

[11] See discussion, *supra*, at p. 4.
[12] See discussion, *supra*, at p. 5.
[13] See discussion, *supra*, at p. 6.
[14] See discussion, *supra*, at p. 13.
[15] See discussion, *supra*, at p. 17.
[16] See discussion, *supra*, at p. 17.

where an individual has inquired. A hospital, POSC, or ASF shall provide the requested information on surgical procedure volume for the most recent 12 months available, updated at least annually.

SJMC provided a supplemental affirmation that stated that

> UM SJMC will provide to the public, upon inquiry, information concerning the volume of specific surgical procedures performed at the location where an individual has inquired. UM SJMC will provide the requested information on surgical procedure volume for the most recent 12 months available, updated at least annually.
> (DI #20).

SJMC's response shows compliance with the standard.

.05A(5) 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.

SJMC provided its Transfer of Patients agreement with University of Maryland Medical Center. (DI #3, Exh. 17). Staff concludes that the standard is met.

10.24.11.05B Project Review Standards.

.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.

The applicant is not proposing a new hospital or expansion of OR capacity. This standard is not applicable to this proposed project.

.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:

(a) Demonstrate the need for the number of operating rooms proposed for the facility,

consistent with the operating room capacity assumptions and other guidance included in Regulation .07 of this chapter.

(b) 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 initiation of surgical services at the proposed facility, consistent with Regulation .07 of this chapter.

(c) 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 hospitals' likely service area population;

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

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

(d) 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.

SJMC is not proposing the establishment of a new hospital or ambulatory surgical facility or the replacement of an existing hospital or ambulatory surgical facility. Therefore, this standard is not applicable to this project, which involves replacement of the SJMC surgical facilities. As addressed elsewhere in this staff report, SJMC developed a forecast of demand for surgical services based on an 85% relevance service area for the hospital and recent trends in use of OR capacity. It used assumptions about OR capacity in the Surgical Services Chapter to translate its demand forecast into a projection of need for ORs and is proposing a project that will reduce total OR capacity at SJMC from 17 to 16.

.05B(3) <u>Need - Minimum Utilization for Expansion of An Existing Facility.</u>

The applicant is not proposing to expand its number of operating rooms. This subsection of the standard is not applicable to this proposed project.

.05B(4) Design Requirements
.05B(5) Support Services.

Among the remaining applicable standards are two that prescribe policies, facility features, and/or service requirements that an applicant must meet or agree to meet prior to first use. These are: Standard .05B(4) Design Requirements; and Standard .05B(5) Support Services. Staff has reviewed the CON application and confirmed that the applicant provided information and affirmations that demonstrate the proposed project complies with these standards.[17]

Regarding design requirements, the applicant submitted a letter from its architectural firm stating that the project complies with the applicable design requirements in Section 2.2 of the FGI Guidelines, which are incorporated by reference in the Acute Hospital Services Chapter. (DI #3, Exh. 18). Regarding support services, SJMC provides laboratory, radiology, and pathology services as part of its normal clinical operations. (DI #3, p. 61).

.05B(9) Impact.

The applicant is not seeking to establish a new ambulatory surgical facility.

.05(10) Preference in Comparative Reviews

This CON application is not part of a comparative review.

COMAR 10.24.01.08G(3) – Remaining CON Review Criteria

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

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

SJMC's rationale for this project is to replace and modernize OR facilities that are out of date, and undersized by today's standards. Staff concludes that SJMC demonstrated need for its proposed project, based on the applicant's historic trends and projected future use. While addressing the need for modernization, the project will actually reduce the number of ORs.

Staff concludes that SJMC has demonstrated the need for the proposed project by its service area population.

[17] The text of these standards, as well as the location within the application where compliance is documented, is attached as Appendix 3.

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

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

Staff has previously discussed the applicable cost effectiveness standard in COMAR 10.24.10.04B(5), and recommended that the Commission finding that the project is consistent with that standard based on the applicant's demonstration that the proposed project to renovate several operating rooms in-place was cost-effective, compared to the alternatives considered by the applicant. In a project such as this, which seeks to renovate and replace existing operating rooms and facilities, it is not meaningful to compare the cost-effectiveness of the project with the provision of the services in alternative existing facilities.

Staff concludes that the applicant has demonstrated that the project is a cost-effective approach to modernizing its surgical services department and consolidating its cardiac services.

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

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

Availability of resources necessary to implement the project.

The estimated cost of the project is $60 million, itemized in Table 14 below. SJMC proposes to fund this expense with over $39.7 million in cash reserves and escrow funds; and $20 million in philanthropic contributions. The applicant reported that the proposed project enjoys strong community support, as shown by numerous support letters submitted with its CON application. (DI #3, p. 68 and Exh. 19).

Table 14 : SJMC Project Budget

Use of Funds	Total
1. Capital Costs	
a. New Construction	
Building	$213,175
Site and Infrastructure	351,760
Architect/Engineering Fees	47,455
Permits (Building, Utilities, etc.)	3,000
Subtotal	$615,390
b. Renovations	
Building	$30,967,646
Architect/Engineering Fees	5,746,321
Permits (Building, Utilities, etc.)	47,000

Subtotal	$36,760,967
d. Other Capital Costs	
Movable Equipment	$11,630,000
Contingency Allowance	3,679,709
Other (Project Management, Enabling Relocations)	2,050,000
Subtotal	$17,359,709
Total Current Capital Costs	$54,736,066
e. Inflation Allowance	2,878,934
Total Capital Costs	$57,615,000
2. Financing Cost and Other Cash Requirements	
CON Application Assistance	$886,000
Non-CON Consulting Fees	1,499,000
Subtotal	$2,385,000
TOTAL USES OF FUNDS	**$60,000,000**
Sources of Funds	
Cash	$30,258,480
Philanthropy	20,000,000
Escrow Funds	9,741,520
TOTAL SOURCE OF FUNDS	**$60,000,000**

Source: DI #10, Exh. 23, Table E.

Availability of resources necessary to sustain the project.

The applicant projects that the hospital will generate excess revenue over expenses in every projected year, beginning with the current year, FY 2019. SJMC generated excess revenue in the two most recent historic years and projected excess revenue over expenses in fiscal year 2018. (DI # 10, Exh. 25). SJMC's global budgeted revenue will not be increased to support this project.

Table 15, below, shows SJMC's actual and projected revenues and expenses for FY 2016 through FY 2025.

Table 15: SJMC Revenue & Expense Statement, Uninflated - Entire Facility, FY 2016 thru FY 2025

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE									
a. Inpatient Services	$ 243,145	$ 243,412	$ 249,556	$ 245,592	$ 251,262	$ 251,300	$ 250,228	$ 250,258	$ 250,
b. Outpatient Services	$ 311,849	$ 322,493	$ 339,390	$ 340,447	$ 339,662	$ 339,669	$ 339,486	$ 339,492	$ 339,
Gross Patient Service Revenues	**$ 554,994**	**$ 565,905**	**$ 588,946**	**$ 586,038**	**$ 590,924**	**$ 590,970**	**$ 589,714**	**$ 589,750**	**$ 589,**
c. Allowance For Bad Debt	$ 21,673	$ 13,646	$ 14,328	$ 14,233	$ 14,393	$ 14,394	$ 14,353	$ 14,354	$ 14,
d. Contractual Allowance	$ 120,243	$ 125,132	$ 136,702	$ 133,632	$ 134,057	$ 134,061	$ 133,952	$ 133,956	$ 133,
e. Charity Care	$ 3,803	$ 6,458	$ 5,702	$ 8,474	$ 8,543	$ 8,544	$ 8,528	$ 8,528	$ 8,
Net Patient Services Revenue	**$ 409,275**	**$ 420,669**	**$ 432,214**	**$ 429,699**	**$ 433,930**	**$ 433,970**	**$ 432,881**	**$ 432,912**	**$ 432,**
f. Other Operating Revenues (Specify/add rows if needed)	$ 6,839	$ 4,750	$ 5,106	$ 5,106	$ 5,106	$ 5,106	$ 5,106	$ 5,106	$ 5,
NET OPERATING REVENUE	**$ 416,114**	**$ 425,419**	**$ 437,320**	**$ 434,805**	**$ 439,036**	**$ 439,076**	**$ 437,987**	**$ 438,018**	**$ 438,**
2. EXPENSES									
a. Salaries & Wages (including benefits)	$ 195,905	$ 198,026	$ 203,855	$ 198,068	$ 197,865	$ 198,104	$ 198,404	$ 200,015	$ 200,
b. Contractual Services	$ 95,593	$ 100,076	$ 104,216	$ 101,381	$ 100,893	$ 100,323	$ 99,979	$ 100,285	$ 100,
c. Interest on Current Debt	$ 12,982	$ 12,841	$ 12,055	$ 13,543	$ 13,153	$ 12,838	$ 12,508	$ 12,186	$ 11,
d. Interest on Project Debt	-	-	-	-	-	-	-	-	
e. Current Depreciation	$ 17,598	$ 19,716	$ 21,539	$ 21,920	$ 22,783	$ 23,031	$ 21,841	$ 20,420	$ 19,
f. Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,500	$ 3,
g. Current Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$
h. Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$
i. Supplies	$ 81,820	$ 82,507	$ 84,337	$ 84,464	$ 84,450	$ 84,862	$ 85,339	$ 86,385	$ 86,
j. Other Expenses (Specify/add rows if needed)	$ 8,800	$ 10,820	$ 6,931	$ 6,734	$ 6,722	$ 6,747	$ 6,777	$ 6,851	$ 6,
TOTAL OPERATING EXPENSES	**$ 412,698**	**$ 423,986**	**$ 432,933**	**$ 426,109**	**$ 425,865**	**$ 425,904**	**$ 424,847**	**$ 427,644**	**$ 427,**
3. INCOME									
a. Income From Operation	**$ 3,416**	**$ 1,433**	**$ 4,387**	**$ 8,696**	**$ 13,171**	**$ 13,172**	**$ 13,140**	**$ 10,374**	**$ 10,**
b. Non-Operating Income	$ (1,839)	$ (585)	$ 795	$ 795	$ 795	$ 795	$ 795	$ 795	$
NET INCOME (LOSS)	**$ 1,577**	**$ 848**	**$ 5,182**	**$ 9,491**	**$ 13,966**	**$ 13,967**	**$ 13,935**	**$ 11,169**	**$ 11,**

Source: University of Maryland St. Joseph Medical Center CON Application, DI #10, Exhibit 25, Table G

Staff conclusion regarding this criterion.

The applicant has demonstrated that it has the resources to implement this project and that its assumptions made with respect to utilization, revenues, and expenses in modeling performance and impact of the project are reasonable. Staff concludes that the project is financially feasible and will be viable.

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

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

The applicant has not applied for or been issued a CON since 2002. This criterion is not applicable to this proposed project.

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

An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the service area, 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.

Impact on Existing Providers

The applicant's proposed project is a replacement of its existing surgical services, cardiac catheterization ("cath.") and coronary care unit facilities. It reduces the number of ORs, cardiac cath labs, and intensive care beds at the hospital. SJMC anticipates no impact on the volume of services provided by other existing health care providers, on the costs of those services, or on access to those services. (DI #3, p. 71). The applicant is not requesting adjustment of its revenue budget to account for project costs at this time but is keeping this option open by seeking CON approval of this project.

Impact on Geographic and Demographic Access to Services

Because the surgical facilities will remain on the same hospital campus, there should be no negative impact on geographic or other forms of access to the affected services at SJMC. The service capacity reductions are in line with changing patterns of use. The project will improve availability of more appropriately equipped rooms for certain surgical procedures at SJMC through updating the facility to accommodate modern surgical technology.

Impact on Costs and Charges of Other Providers, and on costs to the Health Care Delivery System

Because the hospital is not expanding its service capacity and is designing its renovated facilities to more closely align with expected demand, it anticipates no impact on the volume of services provided by other existing health care providers. While its capital costs will increase, operating costs are projected to decline for the surgical program due to the more efficient staffing pattern that the renovated facilities will make possible.

Staff recommends that the Commission find that this project's impact on the health care delivery system is positive.

III. SUMMARY AND STAFF RECOMMENDATION

Based on its review and analysis of SJMC's Certificate of Need application, Commission staff recommends that the Commission find that the proposed capital project complies with the applicable State Health Plan standards, that it is needed, that it is a cost-effective alternative, that it is viable, and that it will not have a negative impact on service accessibility, on costs and charges or other providers, or on the health care delivery system..

Accordingly, Staff recommends that the application of University of Maryland St. Joseph Medical Center for a Certificate of Need to modernize and reconfigure its surgical, cardiac catheterization, and coronary care unit facilities through renovation of approximately 88,000 square feet of existing space and new construction of approximately 300 square feet, at an approved capital cost of $60,000,000, be **APPROVED** with the following condition:

> 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 COMAR 10.24.10.04B(9) or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

IN THE MATTER OF	*	
	*	**BEFORE THE**
UNIVERSITY OF MARYLAND	*	
	*	**MARYLAND HEALTH**
ST. JOSEPH MEDICAL CENTER	*	
	*	**CARE COMMISSION**
Docket No. 18-03-2415	*	
	*	

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FINAL ORDER

Based on the analysis and conclusions in the Staff Report and Recommendation, it is this 16th day of October 2018, by a majority of the Maryland Health Care Commission, **ORDERED**:

The application for a Certificate of Need by University of Maryland St. Joseph Medical Center for a project that will modernize and reconfigure its surgical, cardiac catheterization, and coronary care unit facilities, at an estimated project cost of $60,000,000, be **APPROVED,** subject to the following condition:

> 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 COMAR 10.24.10.04B(9) or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1

Record of the Review

RECORD OF THE REVIEW

Docket Item #	Description	Date
1	Commission staff acknowledges receipt of letter of intent.	12/8/2017
2	Commission staff receives letters of Support from Thomas Biddison, III, David Marks, and Mark Shulman, DDS.	Various Dates
3	St. Joseph Medical Center submits Certificate of Need application (with large construction floor plans).	2/2/2018
4	Commission staff acknowledges receipt of CON application for completeness review.	2/6/2018
5	Commission staff requests to publish notice of receipt of application in the *Baltimore Sun* newspaper.	2/6/2018
6	Commission staff requests to publish notice of receipt of application in the *Maryland Register*.	2/6/2018
7	Commission staff receives notice of receipt of the published application in the *Baltimore Sun* newspaper.	2.19/2018
8	Commission staff requests responses to completeness questions.	3/27/2018
9	St. Joseph Medical Center requests extension to file completeness questions until 4/17/2018.	4/9/2018
10	St. Joseph Medical Center submits responses to completeness questions.	4/16/2018
11	Commission staff requests second round of completeness questions.	4/25/2018
12	St. Joseph Medical Center submits second round of completeness question.	5/7/2018
13	Commission staff informs applicant that formal start of the review of the CON application will be 5/25/2018.	5/11/2018
14	Commission staff requests to publish notice of formal start of review in the *Baltimore Sun* newspaper.	5/11/2018
15	Commission staff requests to publish notice of formal start of review in the *Maryland Register*.	5/11/2018
16	Commission staff sends to Local Health Planning Organizations a form requesting their comments.	5/11/2018
17	Commission staff receives confirmation of notice as published in the *Baltimore Sun* newspaper.	5/25/2018
18	Commission staff requests that the Health Service Cost Review Commission provide comments on the project.	7/27/2018
19	St. Joseph submits summary of operating room cases.	9/28/2018
20	St. Joseph sends email confirming adherence to COMAR 10.24.11.05.A.(2).	10/5/2018

APPENDIX 2

Marshall Valuation Service Analysis

Marshall Valuation Service Analysis

The Marshall Valuation System – what it is, how it works

In order to compare the cost of a proposed construction project to that of similar projects as part of a cost-effectiveness analysis, a benchmark cost is typically developed using the Marshall Valuation Service ("MVS"). MVS cost data includes the base cost per square foot for new construction by type and quality of construction for a wide variety of building uses.

The base cost reported in the MVS guide are based on the actual final costs to the owner and include all material and labor costs, contractor overhead and profit, average architect and engineering fees, nominal building permit costs, and processing fees or service charges and normal interest on building funds during construction. It also includes: normal site preparation costs including grading and excavation for foundations and backfill for the structure; and utilities from the lot line to the structure figured for typical setbacks.

The MVS costs do not include costs of buying or assembling land, piling or hillside foundations (these can be priced separately), furnishings and fixtures not found in a general contract, general contingency set aside for some unknown future event such as anticipated labor and material cost increases. Also not included in the base MVS costs are site improvements such as signs, landscaping, paving, walls, and site lighting. Offsite costs such as roads, utilities, and jurisdictional hook-up fees are also excluded from the base costs.[18]

MVS allows staff to develop a benchmark cost using the relevant construction characteristics of the proposed project and the calculator section of the MVS guide. In developing the MVS benchmark costs, the base costs are adjusted for a variety of factors (e.g., an add-on for sprinkler systems, the presence or absence of elevators, number of building stories, the height per story, and the shape of the building. The base cost is also adjusted to the latest month and the locality of the construction project.)

Calculating the Adjusted Project Cost in this Application

The Commission uses the MVS benchmark value to evaluate the appropriateness of costs of new construction for a project. With regard to the SJMC project, the new construction portion of this project (316 SF) will construct an addition to the outside of the building for a service elevator that will connect the ground and first floors on the north-east side of the facility. The remaining 87,174 SF will consist of renovations to certain areas located in the perioperative services areas located from the ground floor to the third floor within SJMC. Conversely, the MVS methodology does not offer comparable data for use on renovation projects; thus any effort to compare proposed renovation costs to this MVS benchmark does not produce as reliable a measure on the reasonableness and consistency of construction costs as when new construction costs are used alone. In many situations, the MVS benchmarks are much higher than the costs estimated by applicants for the renovation portion of projects.

With the new construction (316 SF) only about 0.3% of the total project (87,490 SF), SJMC

[18] Marshall Valuation Service Guidelines, Section 1, p. 3 (January 2016).

and MHCC staff each calculated the adjusted project cost per SF by combining the actual costs of renovating 87,174 SF and the new construction of 316 SF, excluding those costs categorized as not included with this MVS methodology in the introduction above. Table 16 below shows the calculation of the adjusted project cost made by the applicant and by MHCC.

Table 16: Comparison of UM-SJMC's With MHCC Staff's Marshall Valuation Service Benchmark

	New Construction/ Renovations	
Building	$	31,532,481
Architectural /Engineering Fees	$	5,793,776
Permits	$	50,000
Subtotal	**$**	**37,376,257**
Project Costs for MVS Comparison	**$**	**37,376,257**
Total Square Footage of Construction		87,490
Adjusted Project Cost Per SF	**$**	**427.21**
MHCC Adj. MVS Cost/Square Foot	**$**	**623.91**
Over(Under)	**$**	**(196,70)**
Over(Under) Costs	**$**	**(17,209,588)**

Source: DI #3, pp. 33-36; DI #10, Question #11, pp. 11-12 and Exhibit 23, Table E; and MHCC Staff calculations.

SJMC and MHCC did not differ in calculating the adjusted project cost used for the MVS comparison ($427.21 per SF).

Developing an MVS Benchmark for This Project

SJMC and MHCC both used the MVS methodology to calculate the benchmark value for this project. The applicant calculated the MVS benchmark to be $611.28 per SF for good quality Class A construction for the perioperative services project. (DI #3, p. 36).

SJMC used the following assumptions for its MVS benchmark, which can be viewed in Table 17 below:

1. SJMC states "the project consists entirely of renovation, except for small elevator shaft… and did not separate the cost of the new construction from the much larger renovation." (DI #3, p. 34)
2. MVS reports that a base cost for good quality Class A construction for a general hospital at $374.00 per SF (the most current value reported by MVS as of November 2017).
3. Since the majority of the project will be in space for the surgical operating suite, the applicant calculated the departmental cost differential to be 1.54, which takes into account that the level of construction is more expensive for this department as compared with the average cost per SF for work in such areas as administrative space or adjunct services such as laboratories or pharmacy.
4. SJMC performed calculations for the perimeter multiplier (relationship of floor space to perimeter), the average floor height multiplier, and the cost for installation of a wet sprinkler system, and the values for the current and local cost multipliers.

5. While the applicant originally submitted a multi-story multiplier of 1.015 (DI #3, p. 35), the applicant corrected and adjusted this value to 1.005. (DI #10, Question #11, p. 12).

Table 17 Marshall Valuation Services Benchmark - SJMC and MHCC Staff's Calculations

	UMSJMC Calculations	MHCC Calculations
Class	**A**	**A**
Quality	**Good**	**Good**
Type Structure	**Hospital**	**Hospital**
Floors	**4**	**4**
Total Construction Area Square Footage	**87,490**	**87,490**
Average Area per Floor	**21,873**	**21,873**
Total Perimeter	**4,815**	**4,815**
Average Perimeter	**1,204**	**1,204**
Weighted Average Wall Height	**12.8**	**12.7**
Base Cost	**$ 374.00**	**$ 374.00**
Adjustment for Differential Cost By Department	**1.54**	**1.54**
Gross Base Cost	**$ 576.71**	**$ 576.71**
Perimeter Multiplier	**0.989**	**0.989**
Height Multiplier	**1.02**	**1.02**
Multi-story Multiplier	**1.005**	**1.000**
Multipliers	**1.014**	**1.005**
Refined Square Foot Cost	**$ 584.60**	$ 579.46
Sprinkler Add-on	**$ 2.95**	$ 3.09
Adjusted Refined Square Foot cost	**$ 587.55**	$ 582.55
Current Cost Modifier	**1.02**	1.05
Local Multiplier	**1.02**	1.02
CC & Local Multipliers	**1.04**	1.07
MVS Building Cost Per Square Foot	**$ 611.28**	$ 623.91
Building Square Footage	**87,490**	**87,490**
MVS Building Costs	**$ 53,481,177**	$ 54,585,845
Final MVS Cost Per Square Foot	**$ 611.28**	$ **623.91**

Source: Di #3, pp. 33-36;DI #10, Question #11, pp. 11-12.

MHCC staff calculated an MVS benchmark of $623.91 per SF. The following are the assumptions staff used to arrive at this value:

1. Staff used the same base cost of $374.00 per SF reported by MVS.
2. Staff's calculations for the departmental differential, perimeter multiplier, and the height multiplier were in agreement with the applicant.
3. The applicant utilized a multi-story multiplier of 1.005 based on the assumption the four stories for this project "multiplies the number of floors above the third floor by .005." (DI #10, Question #11, p. 12). SJMC misapplied this .005 factor; the MVS guide states "add

.5% for each story, over three, above ground, to all base costs.[19]" Since the project includes renovations to the ground floor and for floors one through three only and does not include any floors above this level, staff used a multi-story multiplier of 1.000.

4. Both the applicant and staff utilized the most recent cost estimates reported by MVS for installing a wet sprinkler system. Through interpolation, staff arrived at a cost of $3.09 per SF. While staff applied the projected costs for installation of a system between 75,000 – 100,000 SF, the applicant incorrectly applied the costs for a sprinkler system between 100,000 – 125,000 SF.
5. While the applicant and MHCC used the same local multiplier, staff used the September 2018 value (1.05) for the current cost multiplier.

The difference in the MVS benchmark values calculated by the applicant and MHCC staff is $12.63 per SF, about 2.0% difference. The major reason for staff's higher benchmark is the higher cost estimate for the installation of the wet sprinkler system and the use of the more recent value for the current cost multiplier, which more than offset the higher multi-story multiplier used by SJMC.

Comparing Estimated Project to the MVS Benchmark

The MVS analysis finds the estimated project cost of $427.21 per SF to be well below the MVS benchmark calculated by either SJMC (-43.1%) or MHCC (-46.0%).

Table 18: Comparison of Adjusted Project Cost as Calculated with the MVS Benchmark

	SJMC Calculation	MHCC Calculation
Adjusted Project Cost per SF	$427.21	$427.21
SJMC and MHCC Calculated MVS Benchmark Cost per SF	$611.28	$623.91
Total Over(Under) MVS Benchmark	($184.07)	($196.70)
Over(Under)%	-43.1%	-46.0%

[19] Marshall & Swift Marshall Valuation Service, Section 15, page 18.

APPENDIX 3

Excerpted CON Standards for General Surgical Services

Excerpted CON standards for General Surgical Services
From State Health Plan Chapter 10.24.11

Each of these standards prescribes policies, services, staffing, or facility features necessary for CON approval that MHCC staff have determined the applicant has met. Bolding added for emphasis. Also included are references to where in the application or completeness correspondence the documentation can be found.

STANDARD	**APPLICATION REFERENCE (Docket Item #)**
10.24.11.05B(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. (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.	DI #3, Exh. 18.
10.24.11.05B(5) Support Services. Each applicant shall agree to provide as needed, either directly or through contractual agreements, laboratory, radiology, and pathology services.	DI #3, p. 61.