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MEMORANDUM

TO: Commissioners

FROM: Kevin R. McDonald
Chief, Certificate of Need

DATE: April 15, 2021

SUBJECT: Adventist HealthCare Shady Grove Medical Center
Addition of Six-Story Patient Tower, Docket No. 20-15-2443

Enclosed is the staff report and recommendation regarding a Certificate of Need (CON) application filed by Adventist HealthCare Shady Grove Medical Center for a major expansion and renovation of its facility. The proposed project would add a six-floor patient care tower with 150,352 square-feet (SF) of inpatient service space, and renovation of 25,696 SF of existing hospital building space.

The project is not intended to add to the number of beds in operation, or introduce new facilities or services at SGMC. It is planned and designed to modernize the existing facilities and services. The objectives for this project are to: create more private patient rooms; modernize and expand its ED, ICU, and observation units; and improve and add space to improve clinical workflow and operational efficiency.

The proposed project will: add three floors of medical/surgical/ gynecological/addictions (MSGA) beds in single-occupancy patient rooms; create an enlarged emergency department, with private, enclosed treatment spaces; right-size the intensive care unit and locate all critical care units in a central location above the emergency room; and relocate the Clinical Decision Unit (observation beds), Emergency Psychiatric Treatment Unit, Cardiovascular Interventional Radiology services. In addition, the facility's helipad – currently located between the ambulance driveway, pedestrian walkways, and a parking lot – to the roof of the new tower.

The total project cost is estimated at just over $180 million consisting of approximately $103.3 million for new construction, $9.7 million for renovation, a contingency allowance of $12.8 million, and an inflation allowance of $14.7 million. AHC plans to fund the proposed

project with a $154 million tax-exempt municipal bond issue, about $10 million in cash, and $16.0 million in philanthropic donations. The applicant expects to complete the project in two phases scheduled over 66 months (projected completion in August, 2026).

Staff recommends that the Commission **APPROVE** the project based on staff's conclusion that the proposed project complies with the applicable standards in COMAR 10.24.10, Acute Care Hospital Services chapter of the State Health Plan (SHP), and with the Certificate of Need review criteria at COMAR 10.24.01.08G(3)(a)-(f). Staff recommends that the following conditions be incorporated into the approval.

1. Prior to its request for first use approval, Adventist HealthCare Shady Grove Medical Center shall identify bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan shall specifically address the hospital's assessment of the need for surge bed capacity and its plan to maintain and deploy adequate surge capacity when needed.

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $21,226,090, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

IN THE MATTER OF	*	
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ADVENTIST HEALTHCARE	*	**BEFORE THE**
	*	
SHADY GROVE	*	
	*	**MARYLAND HEALTH**
MEDICAL CENTER	*	
	*	
	*	**CARE COMMISSION**
Docket No. 20-15-2443	*	
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Staff Report and Recommendation

April 15, 2021

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I. INTRODUCTION

A. The Applicant

Adventist HealthCare Shady Grove Medical Center (SGMC or Shady Grove), the applicant, is part of Adventist HealthCare, Inc. (AHC), a faith-based, not for profit health system that is based in Montgomery County. AHC operates health care facilities and programs in the state that include three general acute care hospitals, special rehabilitation hospitals, hospital and outpatient mental health services, a freestanding medical facility, urgent care centers, home health agency services, physician networks, and imaging centers.[1] AHC's three general hospitals are: SGMC, a 329-bed facility located in Rockville (Montgomery); AHC White Oak Medical Center, a 178-bed hospital in Silver Spring (Montgomery); and the 28-bed AHC Fort Washington Medical Center in Fort Washington (Prince George's).[2] SGMC is the second largest general hospital in Montgomery County, by licensed acute care bed capacity, and the eighth largest hospital in Maryland.

B. The Project

The project proposed in this Certificate of Need (CON) application is a major expansion and renovation of AHC Shady Grove Medical Center located at 9901 Medical Center Drive, in Rockville. SGMC proposes to add a six-floor patient care tower with 150,352 square-feet (SF) of inpatient service space, and to renovate 25,696 SF of the existing hospital building space. The applicant states that the main hospital building is more than 40 years old, has an insufficient number of private inpatient rooms, an aging and undersized emergency department (ED) and intensive care unit, and a physical layout that does not support efficient operation. SGMC states that these factors have led to patient dissatisfaction, difficulty with patient privacy and HIPAA compliance, and inefficiencies for patients and staff. (DI #2, p. 4).

The project is not intended to add to the number of beds the hospital routinely places into operation and does not introduce new facilities or services. It is planned and designed to modernize the existing facilities and services. The applicant states that the main elements of the project are as follows:

- Private Rooms for MSGA beds
  The new tower will add three floors of medical/surgical/gynecological/addictions (MSGA or general medical surgical) beds, all in single-occupancy patient rooms. A unit on the third-floor level will hold 26 intensive care unit (ICU) beds, replacing the existing 26-bed ICU with a larger space. The fourth floor will house a 24-bed progressive care unit (PCU), for inpatients stepping down from intensive care. The fifth floor will house 24 general

[1] Further information is available at: About Us | Adventist HealthCare | Maryland.

[2] The licensed acute care bed numbers provided are the total beds licensed for use in FY 2020, which became effective on July 1, 2019. Licensed bed capacity was not updated for FY2021, by order of the Maryland Health Department. The Commission issued Emergency Certificates of Need during the state of emergency declared by Governor Hogan on March 5, 2020 that permit a hospital to operate bed capacity beyond its licensed bed inventory during the pandemic.

medical surgical beds. SGMC proposes to convert 20 existing semi-private rooms to private rooms, housing general medical surgical beds.

- Right-sizing ICU rooms and vertically stacking all critical care units in a central location above the emergency room, to improve clinical efficiency
  The applicant states that the existing Progressive Care and ICU Units are older and undersized. The proposed project will relocate both of these units in the new tower space above the replacement ED. This design vertically stacks these critical care units above the emergency room, shortening the transfer distance between units for patients. The applicant also notes that the new ICU location will enable more efficient transport to and from the surgical suite. (DI #2, p. 6).

- Creation of an enlarged ED, with private, enclosed treatment spaces
  The project will relocate the "main" ED to the second/main level of the new tower, adjacent to the existing ED, portions of which will be renovated to house ED treatment rooms for special populations, i.e., separate adult and pediatric emergency psychiatric treatment units, a dedicated pediatric emergency room, and a forensic medical unit for acutely injured victims of sexual and other assaults. The current ED exists in space that falls short of the American College of Emergency Physicians (ACEP) standards, and its layout lacks privacy. Its 69 treatment bays are separated only by curtains. (DI #2, p. 4). The renovated and expanded ED will continue to feature 69 treatment rooms. (DI #10, pp. 1-2). The applicant states that the relocation will also promote efficiency, as departments with interrelated services will be adjacent to one another.

- Relocation of the Clinical Decision Unit (CDU)
  The 18-bed dedicated observation unit, known as the clinical decision unit (CDU), will be relocated from its current space, which houses nine semi-private rooms, to the space that will be vacated by the existing ED and renovated in a project phase following completion of the tower addition. The new CDU will house 20 beds in private rooms. The applicant states that the current CDU is not in a desirable location and its future use as non-clinical space will be determined through a master planning process which is currently ongoing. (DI #10, pp. 1-2).

- Relocation of the Emergency Psychiatric Treatment Unit (EPTU)
  The adult Emergency Psychiatric Treatment Unit (EPTU) will be relocated closer to the main ED in order to reduce patient travel from the ambulance and/or police arrival space so as to avoid the patient having to travel through the main ED risking disruption and possibly compromising the patient's privacy. The existing space will be vacated and used for storage. (DI #10, pp. 1-2). The Pediatric ED and Pediatric EPTU (PEPTU) will remain in place and are not in the scope of this project. (DI #10, pp. 1-2).

- Relocation of perioperative services
  The hospital states that its Cardiovascular Interventional Radiology (CVIR) services are not located adjacent to related service lines, requiring patients to be transported long distances to receive care. The project will relocate the CVIR program to the new patient tower, where it will be immediately adjacent to the existing Surgery Department and Peri-

Operative services. It will be one level below the new ED, directly connected by a one-stop elevator ride. (DI #10, p. 12).

- Relocation of the helipad for enhanced safety and efficiency
  The current helipad is located between the ambulance driveway, pedestrian walkways, and a parking lot. A patient must be transported through weather conditions to the front door of the ED. (DI #10, p. 13). The project will relocate the helipad to the rooftop of the new tower, eliminating the need for the hospital to halt foot and vehicular traffic around the ED when the helicopters arrive and depart. (DI #2, p. 7).

The proposed six-story new patient tower, located immediately east of the existing hospital, will include one floor below grade and five above-grade. The programming in the new tower is shown in the chart below. (DI #2, p. 6).

Table I-1: Programming By Level of the Proposed New Tower, SGMC

Level	Description
1	Cardiovascular Interventional Radiology (CVIR) Suite, mechanical systems
2	Main lobby entrance, ED, courtyard
3	ICU (26 beds)
4	Progressive Care Unit (24 beds)
5	Medical/Surgical Unit (24 beds)
6	Mechanical support
Roof	Helipad and elevator lobby

The project also includes an upgrade to the Central Utility Plant (CUP), which is required to provide heated and chilled water to the hospital that is necessary to support the added space of the new bed tower. Since the CUP is located off campus, the applicant will require routing these services via conduits back to the existing building and new patient tower. (DI #10, pp. 3-4).

The total project cost is estimated at just over $180 million, consisting of approximately $103.3 million for new construction, $9.7 million for renovation, a contingency allowance of $12.8 million, and an inflation allowance of $14.7 million. The complete project budget estimate is attached as Appendix 5. SGMC plans to fund the proposed project with a $154 million tax-exempt municipal bond issue, approximately $10 million in cash, and $16.0 million in philanthropic donations. (DI #18, Exh. 46, Table E–Project Budget). The applicant expects to complete the project in two phases scheduled over 66 months (projected completion in August 2026), including six months of final design and planning. Phase 1, construction of the patient tower, is expected to take 36 months. Phase 2 – renovation of the existing facility, is expected to be completed in 24 months. (DI #10, p. 3 and Exh. 29).

C. Staff Recommendation

Staff recommends approval of the project based on its conclusion that the proposed project complies with the applicable State Health Plan standards, and that the applicant demonstrated the need for the project, its cost effectiveness, and its viability. Staff also concludes that the project will not have an adverse impact on other providers or the health care delivery system, will improve access for patients, and create opportunities for more efficient operation of the hospital. Staff recommends that the following conditions be included in any CON awarded by the Commission:

1. Prior to its request for first use approval, Adventist HealthCare Shady Grove Medical Center shall identify bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan shall specifically address the hospital's assessment of the need for surge bed capacity and its plan to maintain and deploy adequate surge capacity when needed.

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $21,226,090, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

II. PROCEDURAL HISTORY

A. Record of the Review

See Appendix 1, Record of the Review.

B. Interested Parties

There are no interested parties in this review.

C. Local Government Review and Comment

No comments were received from any local governmental body.

D. Community Support

SGMC provided letters of support for the project from the medical community, elected officials, and other members of the community. (DI #2, Exh. 6, Exh. 7, and Exh. 8. These letters came from the following individuals:

- Congressman David Trone;
- Maryland State Senators Nancy J. King, Brian J. Feldman, Craig Zucker, and Cheryl C. Kagan;
- Maryland Delegates Bonnie Cullison, Kirill Reznik, Kathleen M Dumais, David Fraser-Hidalgo, Lily Qi, Marc Korman, Kumar Barve, Jim Gilchrist, and Julie Palakovich Carr;
- Sidney A. Katz, then-President, Montgomery County Council;
- Jud Ashman, Mayor, Gaithersburg;
- Marilyn Balcombe, President & CEO, Gaithersburg-Germantown Chamber of Commerce;
- Marji Graf, President & CEO, Rockville Chamber of Commerce;

- Peter Lowet, Executive Director, Mobile Medical Care, Inc.;
- Leslie Graham, President & CEO, Primary Care Coalition;
- Agnes Saenz, Executive Director, Mansfield Kaseman Health Clinic;
- Mark Foraker, Executive Director of Mercy Health Clinic;
- Gustavo Torres, Executive Director, CASA;[3]
- Scott E. Goldstein, Fire Chief, Montgomery County Fire & Rescue Service;
- Thomas Manion, Director, Montgomery County Family Justice Center; and
- A. Thomas Grazio, Director, Tree House.[4]

E. Comments

Holy Cross Health provided a written comment on the proposed project that is briefly discussed in this report, p. 12, note 8.

III. STAFF 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. For this project, the applicable SHP regulations for acute hospital services are found at COMAR 10.24.10 (Acute Hospital Chapter).

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 10.24.10.04A — General Standards.

(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;

[3]Advocacy organization supporting the Latino and immigrant community in Maryland, Pennsylvania, and Virginia; further information available at: https://wearecasa.org/who-we-are/

[4] A multidisciplinary team dedicated to reducing trauma and promoting healing for child and adolescent victims of sexual abuse, physical abuse, and neglect; further information available at: https://treehousemd.org/.

SGMC provided a copy of AHC's Public Disclosure of Charges Policy in its CON application. The policy states that "information regarding hospital services and charges shall be made available [to] the public. A representative list of services and charges shall be made available to the public in written form at the hospital(s) and via the AHC website." (DI #2, Exh. 11, p. 1). The link for the hospital charges at AHC Shady Grove Medical Center is: https://www.adventisthealthcare.com/app/files/public/450e8e2a-f6ce-4709-9531-942c5ad92549/SGMC-Billing-HospitalCharges.pdf.

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

AHC's Public Disclosure of Charges Policy states that "requests for an estimate of charges are handled by the Financial Counselors and/or Schedulers in the Patient Access Department at each Hospital." (DI #2, Exh. 11, p. 2). The AHC website states that "patients may request an estimate of charges for a specific procedure by calling the Patient Access Department at 240-826-6162."

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

The Public Disclosure of Charges Policy tasks an AHC hospital's Patient Access Department with ensuring that appropriate training and orientation is provided to staff who respond to inquiries related to charge estimates, including "education on all necessary estimator tools both during their initial training and on annual job competencies." (DI #2, Exh. 11, p. 2).

Staff concludes that SGMC meets this standard.

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

(a) The policy shall provide:

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

SGMC provided a copy of AHC's Financial Assistance Policy (DI #10, Exh. 31) and Financial Assistance Application. (DI #2, Exh. 15 and 16). The applicant's policy on Determination of Probable Financial Assistance Eligibility Workflow states that the hospital's Patient Access Team requests information on family size, family income, and Medicaid status, and uses this information to making the required determination of probable eligibility, which the Financial Assistance Policy states "will be communicated to the patient within 2 business days of the request for assistance." (DI #10, Exh. 31, p. 8; Exh. 34, p. 1).

(ii) Minimum Required Notice of Charity Care Policy.

1. **Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;**
2. **Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and**
3. **Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.**

Public notice of the financial assistance policy appears on the AHC website[5] and is printed annually in both *The Washington Post* and *El Tiempo Latino*. (DI #3, p.53; Exh. 17, 18). The applicant also provided a copy of a Plain Language Summary of the Financial Assistance Policy in its CON application. (DI #10, Exh. 33). SGMC states that a notice regarding the charity care policy is posted in the hospital's admissions office, the business office, and the emergency department. (DI #2, p. 53). The applicant states that it will provide notice of the charity care policy to each person seeking services in the hospital at the time of admission or preadmission. (DI #2, p.53).

(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.

SGMC does not fall in the bottom quartile for all Maryland acute care hospitals for charity care provision as reported in the updated *Maryland Hospital Community Benefit Report*,[6] updated by the Health Services Cost Review Commission (HSCRC) for FY 2019. (DI #2, p.54). For FY 2019, the HSCRC reported that SGMC provided charity care with an estimated value equivalent to 1.5% of total operating expense, which placed the medical center in the third quartile for all Maryland general hospitals when ranked by this level of charity care provision.

Staff concludes that SGMC has met the charity care standard.

(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] Located at https://www.adventisthealthcare.com/patients-visitors/billing-financial/assistance/.

[6] The report is located on p. 45 at: https://hscrc.maryland.gov/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY19/FY%202019%20Community%20Benefit%20Report%20FINAL.pdf.

SGMC provided a copy of its license by the Maryland Department of Health and documentation of its Joint Commission accreditation (effective September 28, 2019 with accreditation valid for up to 36 months). (DI #2, Exh. 20, 21) It also documented compliance with all Medicare and Medicaid conditions of participation. (DI #2, Exh. 22).

(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.

Staff notes that Paragraph (b) of this standard, as currently written, has become outdated in the last decade. Although there is still a Maryland Hospital Performance Evaluation Guide (HPEG), which is the hospital consumer guide component of the MHCC website, the format has changed since this standard was written. While quality measures remain a component of that guide, it has been substantially expanded to include many more measures of hospital quality and performance. Moreover, the specific format of the quality measure component of the HPEG 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 that can be ranked by quartile. The performance for most of the expanded number of quality measures is now in a comparative context, expressed as "Below Average, Average, or Better than Average." To comply with the spirit of this standard, applicants are asked to identify any "below average" rating and discuss their approach to upgrading performance.

SGMC was ranked "Below Average" for ten of the 61 Quality Measures in the most recent Maryland Hospital Performance Evaluation Guide.[7] The applicant provided an action plan "to effect change" for each of these ten "Below Average" quality measures. (DI #2, p. 57). This information is contained in Appendix 3.

Staff concludes that the applicant has provided documentation that its license is in good standing, that it has achieved Joint Commission accreditation, and is in good standing with the Medicare and Medicaid programs. It submitted a performance improvement plan for each of the ten "Below Average" HPEG quality measures. Staff recommends that the Commission find that the applicant complies with this standard.

COMAR 10.24.10.04B-Project Review Standards

(1) <u>Geographic Accessibility</u>

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….

[7] Located at: https://www.marylandqmdc.org/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/12987.

As this project does not propose establishment of a new general hospital or relocation and replacement of a general hospital, this standard does not apply.

(2) <u>Identification of Bed Need and Addition of Beds</u>

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

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

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

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

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

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

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

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

The applicant initially responded that the standard does not apply because "Shady Grove does not propose the addition of any MSGA or pediatric beds." (DI #2, p. 59). Staff pointed out that, although the applicant states its intent not to operate more beds than it currently operates, it will be adding significant physical bed capacity. Subsequent information provided by the applicant shows that SGMC will be adding patient rooms accommodating 74 additional MSGA beds. Offsetting the addition of bed capacity in the project, SGMC proposes that:

- 20 existing semi-private rooms will be converted to single occupancy rooms;
- 13 semi-private rooms will be converted to single occupancy to support future renovation projects. It is intended that these rooms will not be in regular use, rather they will only be used as "reserve" capacity when needed as other units within the hospital are renovated; and
- 63 beds in 50 rooms will be taken off-line.

Table III-1 SGMC: Current and Proposed Acute Care Bed Configuration

	Licensed Beds	Current Physical Bed Capacity		Physical Bed Capacity After Project Completion		Maximum Operational Bed Complement After Project Completion*	
		Rooms	**Beds**	**Rooms**	**Beds**	**Rooms**	**Beds**
General Medical/Surgical	134	166	199	214	247	166	166
ICU/CCU	22	26	26	52	52	26	26
Total MSGA	**156**	**192**	**225**	**266**	**299**	**192**	**192**
Pediatric	10	17	25	17	25	17	25
Obstetric	46	48	48	48	48	48	48
Psychiatric	117	81	156	81	156	81	156
Total Acute Care	**329**	**338**	**454**	**412**	**528**	**338**	**421**

Source: DI #28.
*Licensed bed capacity is the limitation on operational bed capacity. Thus, the maximum physical bed capacity available to be set up and staffed cannot exceed licensed bed capacity, unless approval is obtained from MDH to exceed this licensed bed capacity on a temporary basis.

SGMC states that it is not proposing to increase the number of MSGA beds in Montgomery County, the planning region used by the Commission to project need for MSGA beds. The Commission's most recent such projection for MSGA beds, published in the *Maryland Register* on January 20, 2017, shows a minimum net bed need of -286 and a maximum net bed need of 15 by 2025 for Montgomery County. (DI #2, pp. 22, 23). The applicant states that the beds taken offline "will sit empty and exist only as potential surge capacity if needed. Ultimately, all of these units will be renovated and converted into alternative uses as part of future projects, at which time the headwalls will be removed." (DI #28).

Staff recommends that this project be approved despite the addition of physical bed capacity over and above the maximum need projection based on staff's belief that modernization of the nursing units at SGMC is needed and because SGMC is adding bed capacity in order to make modernization of fairly dated nursing units (40 years old) achievable on a more efficient basis, with minimal disruption of operations, and less risk that bed supply shortages will occur during the modernization process. This approach to allowing increases in physical bed capacity to better achieve modernization objectives has been widely used by MHCC in the past, in response to the design standard of single occupancy patient rooms established in the last 20 years and the demand by hospitals for more patient rooms and substantially more space per room. In this case, the hospital has sufficient rooms that are old and small, but they are difficult to upgrade and, thus, additional space is the key problem being addressed. Staff recommends that the following condition be attached to any approval given to this project:

> Prior to its request for first use approval, Adventist HealthCare Shady Grove Medical Center shall identify bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan shall specifically address the hospital's assessment of the need for surge bed capacity and its plan to maintain and deploy adequate surge capacity when needed.

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

An acute care general hospital may establish a new pediatric service only if….

This standard is not applicable because this proposed project does not propose establishment of a new pediatric unit.

(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

This standard was written prior to the 2014 change in Maryland's hospital payment model. HSCRC no longer uses a "Reasonableness of Charges" (ROC) analysis comparing adjusted charges per case within hospital peer groups as a basis for identifying high charge hospitals for remedial action. The basis for hospital revenue regulation has shifted from charges per case to a global budget revenue model.

While not assuming a rate increase in its revenue projections for this proposed project, SGMC states that it reserves the right to file a partial rate application for capital to fund the costs associated with the project, noting that,

> [i]f the hospital elects to pursue an increase in rates with the HSCRC to fund the incremental depreciation and interest costs of the project, it will be in accordance with the HSCRC's methodology for a partial rate application for capital. (DI #2, p. 60).

When asked by staff "under what circumstances or conditions will Shady Grove discuss with HSCRC the potential of renegotiating an increase in reimbursement rates," the applicant stated that it:

> will evaluate its eligibility for a potential rate adjustment for capital under the HSCRC's capital policy. If a determination is made that Shady Grove is eligible to receive a capital adjustment, the hospital will file for a partial rate application for capital. (DI #10, p. 11).

Staff recommends[8] that the Commission find that SGMC's project, as modeled, satisfies this standard.

(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.

The applicant states that the proposed project does not seek to downsize, eliminate, or diminish the availability or accessibility of services in this service area. Staff agrees and concludes that this part of the standard is not applicable.

(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.

The applicant's objectives for this project are:

- Creation of more private patient rooms;
- Modernization and expansion of its ED, ICU, and observation units; and
- Improvements and additional space needed to improve clinical workflow and operational efficiency.

(DI #2, pp. 64).

[8] Holy Cross Health, which operates two general hospitals in Montgomery County, did not seek interested party status in this review pursuant to COMAR 10.24.01.08F. Nonetheless, on March 29, 2021, it filed comments urging the MHCC "to find that SGMC is not eligible for a future rate increase on account of the substantial capital costs of the project." (DI #22). Staff notes that SGMC is not seeking a rate increase at this time and that, under such circumstances, the MHCC has historically found that an applicant's reservation of the right to seek a rate increase is not violative of this standard.

The applicant states that its executive team considered how to address these objectives with a focus on cost-effective, value-based care. SGMC notes that its team laid out the following considerations against which it measured the merits of alternative approaches:

- Clinical patient experience;
- Financial considerations;
- Hospital operations; and
- Impact for the community.

The applicant describes consideration of three options, one of which is not actually an alternative. (DI #2, pp. 65-67). This "do nothing" option does not address the stated project objectives, which do not include avoiding any capital improvements. Only one legitimate alternative to the proposed project was described, the "vertical expansion" option of adding three floors above the hospital's original four-story patient tower, resulting in all-private, inpatient rooms. This option had an estimated construction cost of $89,300,000. (The chosen alternative is labeled as the "New Tower + Renovation" alternative.)

SGMC observed that when the hospital was initially constructed approximately 40 years ago, the structural design of the original building anticipated that three floors could be added to the four-story structure. Subsequent changes in the structural code (most notably the International Building Code's wind and seismic load requirements) make this "vertical expansion" option expensive and disruptive to current operations, as it would necessitate a multi-phased construction approach that would require the hospital to shut down sections of the existing building (including beds) as the structure was reinforced, floor by floor.

SGMC states that such an effort would impose a disruptive burden on existing operations, would create infection control risks for patients during construction, and would significantly extend the construction schedule. This option, while yielding private rooms, would not include a renovation or upgrade of the ED, or ICU.

The chosen "New Tower + Renovation" project plan addresses SGMC's objective of modernizing the ED and ICU space and allows all departments to relate to one another in more effective ways, while also fully addressing the objectives for upgrading general MSGA bed capacity.

This option is estimated to have a higher construction cost than the more limited alternative plan considered by the applicant, $97 million, which is not surprising given its more expansive construction elements. As noted, SGMC projects an ability to implement the project without capital cost-related adjustments in what it projects to be the arc of its regulated revenue into the future. Thus, SGMC is expressing confidence that the more expensive project is affordable.

While there is some immediate impact to operations, the interference with ongoing activities is less than the Vertical Expansion option and, according to SGMC, it provides the greatest enhancement of the care experience for patients through private rooms and modernized ICU and ED space. It also provides the best option for future surge capacity needs with private rooms and right-sized clinical space.

This is the only part of this standard applicable to this project. Staff recommends that the Commission find that SGMC has complied with the standard, identifying the project objectives and explaining the way in which it chose the project plan described in the application.

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

The proposed project does not involve a limited objective, thus, Paragraph (b) of the standard is not applicable.

(c) An applicant proposing establishment of a new hospital or relocation of an existing hospital to a new site….

Since the applicant does not seek to establish a new hospital or relocate the existing hospital to a new location, Paragraph (c) of the standard is not applicable. As previously noted, staff concludes that the applicant has met the requirements of this standard.

(6) Burden of Proof Regarding Need

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

See the discussion under the Need criterion, COMAR 10.24.01.08G(3)(b).[9] Commission staff recommends that the Commission find that SGMC meets the burden of proof regarding need for its proposed project.

(7) Construction Cost of Hospital Space

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

[9] See pages 27-29, *infra.*

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.

This standard requires a comparison of the project's estimated construction cost, adjusted for specific construction characteristics of the proposed project, with a benchmark, or expected cost, derived using the cost-estimating methodology provided by the Marshall Valuation Service (MVS). Theoretically, the cost per SF arrived at by using this methodology reflects what a building of the type and quality described should cost to construct. The purpose of this standard is to exclude any excess costs from any future rate increase to cover the cost of the project. The MVS methodology includes a variety of adjustment factors related to the specific characteristics of the project, *e.g.*, timing of the project, the locality, the number of stories, height per story, shape of the building (*e.g.*, the relationship of floor size to perimeter), and departmental use of space. Appendix 4 provides a detailed explanation of the methodology laid out in the MVS guide and how it is used to derive a benchmark value that can be used to assess the appropriateness of new construction costs in a proposed project.

SGMC and MHCC staff each calculated the MVS benchmark and the estimated allowable new construction cost for the 150,352 SF six-story patient tower. The applicant arrived at a benchmark value of $450.11 per SF and an estimated allowable new construction cost of $486.59 per SF. MHCC staff arrived at a slightly lower benchmark value of $432.89 per SF, and a higher estimated allowable new construction cost of $535.06 per SF. [10]

The next step in the methodology is to compare the estimated allowable new construction cost with the MVS benchmark values (calculation shown in Appendix 4, Table 2). In this proposed project the total estimated allowable cost of new construction ($535.06 per SF) exceeds the MVS benchmark value ($432.89 per SF) by $102.17 per SF (23.6%). Accordingly, if SGMC were to seek a future rate increase related to the capital cost of the new patient tower, the standard requires that any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount by which the projected construction cost exceeds the MVS benchmark (and those portions of the contingency and inflation allowances, and the capitalized construction interest expenditure) that are based on the excess construction cost of the $21,226,091. This excess cost calculation is shown immediately below.

[10] As explained in Appendix 4, the differing benchmarks calculated by SGMC and MHCC staff are attributable to differences in when the analyses were performed, and in the assumptions used by the applicant and Commission staff for the MVS benchmark calculations. The respective calculations made by the applicant and Commission staff for allowable new construction costs measured against the MVS benchmark can be found in Appendix 4, Table 2.

MHCC Staff Calculation of Excess Cost

Construction cost exceeding benchmark ($102.16 x 148,176 SF)	$15,137,923
The portion of future inflation that should be excluded ($13,799,530 x 23.6 %)	$3,256,689
The portion of the contingencies that should be excluded ($11,997,789 x 23.6 %)	$2,831,478
Total to be excluded from any rate increase proposed by the hospital related to the capital cost of the project	**$21,226,090**

Based on this analysis, staff recommends that, if the Commission approves SGMC's application, the Certificate of Need should include the following condition:

> Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $21,226,090, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

(8) Construction Cost of Non-Hospital Space

The proposed construction costs of non-hospital space shall be reasonable and in line with current industry cost experience…

This standard is not applicable as the project does not include construction of non-hospital space.

(9) Inpatient Nursing Unit Space

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

SGMC provided information showing that, when considering "Inpatient Unit Program Space," each of the nursing units being constructed to support 74 inpatients on three floors of the new tower are sized so that the amount of SF per bed is within the limitation of this standard. (DI #2, pp. 73-74).

Table III-2: Square Feet per Bed
Three New Proposed Patient Units at SGMC

Unit Name	Unit Description	Beds	Unit Size (SF)	SF per Bed
Floor 3	ICU/CCU	26	12,927	497
Floor 4	Progressive Care Unit	24	11,992	499
Floor 5	Medical Surgical Unit	24	11,992	499

The applicant states that the space for each inpatient room includes patient rooms, family space and support space within the given unit, and does not include circulation (building and intradepartmental space, horizontal and vertical), interior walls, structural columns, exterior envelope, mechanical and electrical support (shafts, closets, chases). (DI #10, p. 12).

Staff concludes that the applicant complies with this standard.

(10) Rate Reduction Agreement

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

This standard is no longer applicable[11] because HSCRC has replaced the rate reduction agreements referenced by this standard with a Global Budget Revenue (GBR) model which may be subject to adjustments in GBR updates for inefficient hospitals, a policy currently under development by HSCRC.

(11) Efficiency

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

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

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

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

[11] Commission staff will consider the ongoing validity and/or revision of this standard in its next update of the Acute Hospital Chapter.

SGMC projects that patient volumes will grow very marginally. The purpose of this project is not to accommodate increasing volume, but to modernize the hospital to better serve its current and future patient volume and improve efficiency of operations. Accordingly, the applicant states that the Shady Grove design team consistently incorporated performance features into the design of the new addition and renovation in order to enhance operational efficiency. A summary follows. (DI #2, pp. 74-75).

- Departments with interrelated services will be located adjacent to one another. As described earlier the proposed project will relocate both the PCU and the ICU units to the new patient tower, sited above the new emergency department, and Cardiovascular Interventional Radiology would be relocated to the new patient tower, where it will be immediately below the ED and adjacent to the existing Surgery Department and Peri-Operative services. This location will also allow support functions to be shared between the surgery and CVIR services;

- The main public and service elevator banks will be centrally located between the new addition and the existing Hospital;

- Levels 1 through 4 of the new addition will have a direct connection to the existing hospital, optimizing the flow between departments and greater efficiency for staff and patients;

- Separate entrances for the ED patients and hospital visitors will improve patient safety, security, wayfinding and the overall visitor experience;

- Nursing unit layouts featuring decentralized team stations and optimally located clinical support areas will minimize nurse travel distance, promoting efficiency by reducing the time staff waits in line for medications and supplies. The unit layout will allow staff to perform bedside documentation in patient rooms, as opposed to using workstations on wheels, reducing the time staff spends in motion as well. The applicant states that these time-saving features will enable staff to have more time to spend in providing care. (DI #10, pp. 13-14);

- Relocation of the helipad from an exterior location on the hospital site to the roof. The new indoor travel path will now be a direct elevator ride to the roof. This will be a major improvement over the current travel path which requires the patient to be transported through the front door of the ED and outside through weather conditions. (DI #10, pp. 13-14).

The applicant was asked to justify a staffing increase of 49 FTEs given that projected volume growth is marginal. The applicant explained that most of the increase was required to support the added scope and square footage of a new patient tower (37.4 of the 48.8 FTE increase is support staff and 9.4 is nursing staff). The applicant also stated that the staff addition will be offset "through the various efficiencies gained throughout the hospital as a result of the project." (DI # 10, pp. 13, 14; DI #13, p. 1).

To quantify this assertion, the applicant compared its current productivity and staffing metrics to future projections to illustrate improvements it expects from the proposed project. The applicant calculated the total full time-equivalent (FTE) staff per adjusted occupied bed at SGMC currently, and as projected for CY 2026.[12] This calculation is shown in Table III-3 below. Assuming that the hospital will see an increase of 13 adjusted occupied beds between 2020 and 2026, SGMC projects an ability to very slightly reduce FTE staff per adjusted occupied bed, from 4.38 in CY 2020 to 4.36 in CY 2026.

Table III-3: FTE Staff per Adjusted Occupied Bed, 2020 and Projected 2026, SGMC

	CY 2020	CY 202626
Patient Days	111,572	114,044
Inpatient Revenue	$282,671,660	$344,301,092
Outpatient Revenue	$197,120,936	$240,098,188
Equivalent Patient Days[13]	189,377	193,572
Adjusted Occupied Bed	517.4	530.3
Total FTEs*	2,263.9	2,311.9
Total FTEs per Adjusted Occupied Bed	4.38	4.36

* 114 FTEs in CY 20, and 53 in CY 26 are contract labor. That number was higher than average in CY 20 as a result of COVID pandemic need for additional staff. (DI #13, p.1; DI #10, pp. 13-14).

Staff notes that this slight gain in CY 2026 is most likely overstated, because the CY 2020 staffing was boosted by the staffing demands of COVID emergency. For example, the applicant states that the number of contractual staff will decline from 114.0 in CY 20 to 53.7 FTEs in CY 26, a decline of about 60 FTEs (some of whom it projects to convert to employed FTEs in future years). If, for example, 30 of those FTEs were "COVID-created," the total FTEs per adjusted occupied bed would be 4.32 in CY 2020.

Staff concludes that the applicant has designed the project in a way that offers substantive opportunities for more efficient use of staff, and that the projected measurements of efficiency at worst show a "break-even." Thus, staff recommends that the Commission find that this standard is met.

(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

[12] The applicant explains the projected staffing changes at SGMC from CY2020 TO CY 2026 as follows:

- The number of contractual staff declines from 114.0 to 53.7 FTEs as the ramp-up to meet the COVID pandemic is relaxed; and
- The increase of 59.5 FTEs in CY 2026 is the net result of: (1) conversion of contract labor hired during the COVID-19 response to employed staff; (2) addition of 48.8 FTEs required to service the new space; (3) the projected increases in volumes over that time; and (4) efficiencies gained over time related to process improvement and optimizing patient flow and care. (DI #10, p. 30).

[13] Equivalent Patient Days is a function of (patient days x inpatient revenue) + outpatient revenue, with the sum divided by inpatient revenue. Thus, it is a metric of hospital use that combines inpatient and outpatient service use.

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.

Shady Grove cited several examples of how the elements and design features of the proposed project will enhance patient safety. Table III-4 below lists each feature and describes its expected safety benefits for both the patient and the staff.

Table III-4: Patient Safety Description and Benefits

Project element or design feature	Safety benefit
All MSGA, ICU, and ED rooms in the facility will become private rooms.	• Eliminates infection risks inherent in semi-private rooms occupied by two patients. • Private rooms improve patient privacy. • Handwashing sinks for staff and visitors further reduce the risk of infection to patients. • All private rooms will impact the footprint of the departments, and space per patient will increase, but this is mitigated by including decentralized workstations outside of the patient room and wall mounted bedside documentation stations. • Multiple units from the existing, aged hospital building will close, vacating undersized patient rooms, shared toilets, and shared patient showers.
Private patient toilets adjacent to the private patient rooms.	• Proximity of the washroom to the patient's bed and appropriate lighting levels reduces fall risks for the patient. • Shady Grove has established a standard for inpatient rooms under construction which includes, when possible, outboard (window wall) toilet/shower rooms to improve the staff's line of sight from the corridor (fall risk reduction).
Wall-mounted equipment (e.g. documentation stations) in the patient room.	• Minimal equipment around the bed promotes fewer obstacles for patients to navigate in the room, reducing patient fall risk. • Access to medical records and medication bar coding at the patients' bedside can reduce errors.
The nursing unit design decentralizes caregivers and supplies.	• Corridor and bedside documentation improve line of sight to patients • Decentralized supply and medication rooms reduce travel paths for staff, reducing fatigue and increasing staff efficiency.
Decontamination, ambulance and walk-in entrances are separated at the ED.	• A designated decontamination entry isolates and extracts potential contaminants before they can enter the ED. • Separate ambulance and walk-in entrances reduce congestion in the ED and provides more efficient patient travel in emergent situations.
Emergency Psychiatric Treatment Unit is secure and separate from the Main ED treatment rooms. It is located in close proximity to the ambulance entrance.	• Travel distance and contact with other patient treatment spaces is minimized. • The direct route, bypassing the Main ED, allows for more secure and safe patient transport from police or EMS units.

Updated and improved interior finishes.	• Thresholds at doors and between different flooring types will be seamless, and finishes that are easily cleaned and maintained will reduce risk of hospital-acquired infections.

Source; DI #10, pp. 14-16.

Staff concludes that the safety enhancements provided meet the standard and will improve patient safety at SGMC's new patient tower.

(13) Financial Feasibility

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

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

(b) Each applicant must document that:

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

The applicant provided staffing and other expense assumptions with its Revenue and Expense Tables, stating that the utilization projections for SGMC were based on "historical trends in the utilization of these services by the service area population of the hospital and were comparable with the experience of other hospitals in Montgomery County and across the State of Maryland." (DI #2, p. 78). The hospital based future utilization projections in the new patient tower on estimated population growth of the service area population. It assumed a Global Budget Revenue (GBR) based on its FY 2020 rates carried forward. (DI #2, Exh. 9 and pp. 78-79). (DI #2, Exh. 1, Tables G and H).

Staff concludes that SGMC provided its assumptions as required by Paragraph (a) of the standard, and that its utilization projections are aligned with historic trends, meeting the requirements of Subparagraph (b)(i) of the standard.

(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;

The applicant states that the revenue estimates "are based on allowable charges and incorporate the reimbursement methodologies under the HSCRC's Global Budget Revenue Model for Shady Grove." (DI #2, p. 81). SGMC notes that, since it assumed only population growth, it did not include any positive adjustments for market share in its projections. Staff concludes that the applicant has met the requirements of Subparagraph (b)(ii) of the standard.

(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

The applicant states that its staffing and expense estimates are based on historical levels, with SGMC "normalizing" staffing and expenses to levels seen prior to the onset of COVID -19. (DI #2, p. 81). Projections include the adjustments for increases in staff necessary to support the added square footage of the new patient tower when it is completed in 2024, and an annual inflation rate projection of 2-3% for the period FY 2021 through FY 2026.

Staff concludes that UMMC has met the requirements of Subparagraph (b)(iii) of the standard.

(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.

Table III-5 below excerpts key actual and projected utilization and financial statistics from the application. SGMC has recently experienced healthy bottom lines. The margin is projected to be positive through CY 2026, though much diminished after the project comes on line.

Table III-5: Selected Actual and Projected Utilization and Financial Statistics, CY 2018 to CY 2026

	Actual		Projected						
	2018	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
Discharges									
Acute	19,556	18,799	18,202	19,027	19,202	19,369	19,533	19,692	19,845
Observation	7,406	7,626	5,476	7,694	7,755	7,817	7,880	7,943	8,006
Acute Care Bed Occupancy	69.4%	69.1%	75.2%	76.3%	76.4%	76.5%	76.4%	76.7%	76.7%
Revenue and Expense ($000's)									
Net Patient Revenue	$433,121	$446,903	$467,546	$468,207	$468,207	$468,207	$465,407	$465,407	$465,407
Total Operating expenses	$412,593	$423,863	$443,291	$443,405	$442,937	$442,267	$452,278	$456,262	$455,987
Income from Operations	$20,528	$23,0404	$24,254	$24,8026	$25,270	$25,940	$13,129	$9,145	$9,420
Non-Operating Income	$775	$6,302	$1,566	$3,322	$3,322	$3,322	$3,322	$3,322	$3,322
Net Income	$ 21,303	$ 29,341	$ 25,820	$ 28,123	$ 28,592	$ 29,261	$ 16,450	$ 12,467	$12,742

Source: DI #2, Exh. 1, Tables F and G.
Note: financial projections are uninflated.

Staff concludes that the application projects a positive operating margin, consistent with Subparagraph (b)(iv) of the standard.

In its review of the application, HSCRC staff found that SGMC's gross revenue projections were reasonable and conservative and expense projections "appear reasonable on their face." It concluded that implied income demonstrated "that the operations can sustain the ongoing costs of the project." HSCRC staff also found, in reviewing the project funding plan, that the applicant provided evidence "of the where-with-all to initially finance and subsequently afford and service the project without violating established debt covenants" and that the project "appears to be financially feasible."

In summary, staff concludes that the applicant, consistent with the standard, has employed realistic assumptions, based on its historic utilization trends and staffing patterns, for its financial projections and that its project is financially feasible. HSCRC staff validated these conclusions.

(14) <u>Emergency Department Treatment Capacity and Space</u>

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

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

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

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

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

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

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

As explained earlier in the project description, *supra*, p. 1-3, the project will replace and relocate the "main" ED to the new tower, adjacent to the existing ED, portions of which will be renovated to house ED treatment rooms for special populations, i.e., separate adult and pediatric

emergency psychiatric treatment units, a dedicated pediatric emergency room, and a forensic medical unit for acutely injured victims of sexual and other assaults.

The replacement ED will be located on the ground level of the new patient tower. While there will be a significant increase in square footage, the applicant's total number of ED treatment spaces will remain the same. Currently, Shady Grove's ED has 69 treatment spaces, including 58 general use treatment spaces and 11 behavioral health evaluation rooms. The proposed ED will contain the same number of total treatment spaces but slightly alter this mix: two general use treatment spaces will be converted to behavioral health treatment spaces, decreasing the total number of general use treatment spaces from 58 to 56 and increasing the total number of behavioral health treatment spaces from 11 to 13. SGMC has the largest complement of acute psychiatric beds operated within a general hospital setting in Maryland.

Classification as Low-Range or High Range

The State Health Plan has incorporated by reference the American College of Emergency Physicians (ACEP) publication *Emergency Department Design: A Practical Guide to Planning for the Future,* commonly referred to as the "ACEP Guide." As explained in the Staff Report regarding the request for an CON Exemption to convert the University of Maryland Laurel Regional Hospital to a Freestanding Medical Facility (Docket No. 18-16-EX002, September 20, 2018, p. 22),

> The guidelines set forth estimates of the number of treatment spaces and the departmental space appropriate for a range of projected annual ED visit volumes for EDs with low to high range operating characteristics. The position of an ED on the low to high range operational spectrum is determined on the basis of 16 factors such as percentage of admitted patients, length of stay in the ED, location of observation space, percentage of behavioral health patients, percentage of non-urgent patients, and age of patients, as well as the presence of specialty units within the ED. If an ED ranks high on more of the factors, space and treatment capacity should be planned for the number of treatment spaces and square footage called for in the high range estimate for a given volume. If an ED ranks on the low range for more factors, the low range guidance should apply. The guidelines also identify medium measures for each factor but not space and the number of treatment spaces. If the facility ranks in the mid-range for more factors the number of treatment space and the amount of space should fall in between the low and high range.

The applicant states that SGMC's ED qualifies as a "High Range" facility because the facility's characteristics, features, and patients match closest to the "High Range" of ACEP's parameters. Table III-6 shows how the SGMC ED matches up with an abridged version of the ACEP guidelines for a "High Range" facility.

Table III-6: SGMC Position on Applicability of the ACEP High Range Facility Parameters

High Range Parameter	SGMC (Yes or No Response)
ALOS for all ED patients >3.5 hours	Yes
Observation/evaluation beds will be located within the ED	Yes
Time to admit >90 minutes after disposition	No
Average turnaround time for diagnostic test results in >60 minutes	Yes
More than 23% of patients are admitted to the Hospital	No
Need for offices or teaching spaces, such as a university teaching hospital	Yes
Imaging studies are performed within the department	Yes
Specialty components or departments (pediatric ED, large number of psychiatric patients)	Yes
Flight/trauma services support areas included	No
High Range Classification - Total (Yes/No)	Six of ten parameters rated as within High Range

(DI #3, p. 84).

Projected ED Volume

Shady Grove projected the number of ED visits in future years of operation based on historic data and the overall population growth rate of its service area. It reports that it has the second busiest ED in Montgomery County and the 12th busiest in Maryland, averaging 65,000 to 69,000 patient visits per year in recent years. It projects modest growth over the next six years, reaching 71,321 visits by 2026. (DI #3, Exh. 1, Table F).

ACEP Guidance: Number of Treatment Spaces and Overall Space

As shown in the table below, ACEP suggests a maximum of 56 ED treatment spaces for a "High Range" ED with an approximate annual volume of 70,000 visits. ACEP also suggests that such a facility should occupy 46,200 departmental gross SF for internal renovations and 57,750 building gross SF for newly constructed or freestanding EDs.[14] (ACEP Guide, p. 117).

[14] The variance is explained by the fact that in the case of an internal renovation the existing structure already accounts for the extra square footage required for walls, elevator shafts, utilities, etc., while they must be accounted for in a newly constructed or freestanding facility.

Table III-7: ACEP Recommendations for Sizing an Emergency Room

Annual ED Visits	High Range ED			
	Total Treatment Spaces	Annual Visits per Treatment Space	Departmental Gross Square Feet (Renovation)	Building Gross Square Feet (New ED)
50,000	40	1,250	34,000	42,500
55,000	44	1,250	37,400	46,750
60,000	47	1,277	38,775	48,469
65,000	52	1,250	42,900	53,625
70,000	56	1,250	46,200	57,750
75,000	60	1250	48,800	60,000

Source: ACEP Guide, p. 117.

The existing Shady Grove ED is just under 35,000 SF, about 75% of the recommended minimum size for an ED with its visit volume, although its 69 treatment spaces exceed the ACEP recommendation by over 20 percent. The proposed ED will continue to include 69 treatment spaces, and will create a 49,436 SF ED. That new ED will be comprised of 29,000 SF of new construction and approximately 11,600 SF of renovated space, with approximately 8,800 SF remaining as is. (DI #3, Exh. 1, Table B).

Staff notes that, although ED wait times are not directly addressed in the Acute Hospital Chapter,[15] the Commission is well aware that the average time from ED arrival to ED departure in Maryland is approximately 120 minutes longer than the national average.[16] This is a cause for concern among Maryland residents. The applicant acknowledged this issue, stating that AHC's senior executives are committed to improvement of patient throughput and considered improved patient flow in designing its new ED space. (DI #3, pp. 4, 82-87).

Staff concludes that Shady Grove's proposed ED space meets this standard. Its total SF is in line with ACEP recommendations. While its number of treatment spaces exceeds ACEP's recommended number, there are several factors that mitigate this. First, it has a large inpatient psychiatric program and, thus, its maintenance of several rooms dedicated to adult and child behavioral health patients is prudent. It is also Montgomery County's designated Sexual Assault Forensic Examination hospital and operates the only forensic examination unit in the county. Finally, Shady Grove is the closest hospital to the Montgomery County Detention Center and served over 1,100 inmates in 2020. These populations require additional security and confidentiality precautions.

(15) Emergency Department Expansion

This standard is only applicable to projects proposing additional ED treatment capacity. As noted, this project will create a replacement ED adjacent to and incorporating part of the existing ED, expanding ED space but not adding treatment spaces.

[15] ED wait times are indirectly addressed by the Acute Hospital Chapter's use of the ACEP ED planning guidelines.

[16] Source: https://healthcarequality.mhcc.maryland.gov/Article/View/7834a19c-25bd-4334-a5d5-71901b54aac6.

(16) Shell Space

This standard is not applicable since the project does not involve the use of either shell space or unfinished hospital space.

B. Need

COMAR 10.24.01.08G (3)(b) 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.

As presented by SGMC, this project is not driven by a need to increase the capacity of its services. Rather, it is a function of the facility's age and need for modernization. Shady Grove states that the project will address several significant deficiencies and bring the facility up to current practice standards and consumer expectations. Among those deficiencies are:

- Semi-private patient rooms;
- The ED is undersized and lacking privacy;
- The ICU is undersized; and
- The current layout of the hospital lacks efficient adjacencies of treatment spaces.

The project will allow the hospital to provide all MSGA and observation patients with a private room, enhancing patient privacy and reducing the risk of infection, and also will create room-style rather than curtained bay-style treatment spaces in its ED. It will also rationalize the location of departments creating adjacencies that will improve efficiency and optimize clinical workflows. The main elements of the project and the need for them are discussed below.

Making all inpatient room private rooms

Sixty-six of 225 the hospital's MSGA beds are currently located in semi-private rooms. SGMC states that semi-private inpatient rooms impede the efficient throughput of patients, make infection control more challenging, and create challenges when dealing with confidential patient information.

The project will enable SGMC to place all of its inpatient medical/surgical beds in private rooms. SGMC states that this will improve privacy for patients and family members, bolster infection control capabilities, reduce noise levels, and provide a clearer, more efficient line of sight to each patient. Clinical staff will benefit from an improved workflow design and a layout that moves them closer to their supplies, workspaces, and patient rooms. (DI #2, p. 4).

Rightsizing the aging and undersized ED

The SGMC Emergency Department serves about 70,000 patients a year. (DI# 2, p. 4). The existing facility includes 69 treatment spaces within just under 35,000 SF. The applicant states

that its existing ED treatment bays are separated only by curtains, and the square footage falls considerably short of ACEP's guidance for ED planning.

The applicant states that its ED has not had a significant renovation for 30 years, and that it needs to be upgraded, both to support the range of services it provides and to increase its capacity to meet the needs of a growing service area population. In addition, Shady Grove points out that it has significantly expanded its focus on behavioral health services since the current ED was established.

The proposed project would renovate 11,635 SF of ED space and add about 29,000 SF, expanding the ED to 49,435 SF to accommodate the same number of treatment rooms.

The 69 treatment rooms will include:

- An Adult Emergency Psychiatric Treatment Unit (8 rooms) which complements Shady Grove's large inpatient psychiatric program.

- A Pediatric Emergency Psychiatric Treatment Unit (5 rooms) to provide for pediatric psychiatric treatment and stabilization. Shady Grove states that this patient population often has protracted lengths of stay because the disposition options are limited. This population also places high demands on staff and requires separation from the main pediatric ED population for safety reasons.

- A dedicated Pediatric Emergency Room (18 treatment spaces) within the broader ED.

In addition, the ED serves as a Forensic Medical Unit for acutely injured victims of sexual and other assaults. According to SGMC this is the only such service in Montgomery County, and saw 1,157 patients in 2020. The Shady Grove ED also serves inmates from the Montgomery County Detention Center, 150 of whom were treated in 2020.

The applicant states that the design of the new and renovated space will create separate pathways for behavioral health, pediatric, and other emergency patients. (DI # 2, pp. 81-88).

Right-sizing the ICU

The 26-bed ICU currently occupies about 11,700 SF. It will be relocated and expanded to about 18,800 SF. The applicant points out that today's standard of care requires more space to accommodate modern technology and equipment, and that regulations and consumer expectations also require enhanced patient privacy.

The existing progressive care unit will be relocated to the new tower, being sited one floor above the ICU. It will transition from a combination of private and semi-private rooms to an all-private, 24-bed unit, growing from 9,535 SF to 17,239 SF.

Creating a more efficient layout and set of adjacencies

SGMC states that its incremental expansion over four decades has resulted in an inefficient layout of services within the hospital. It states that some units are not located adjacent to related service lines, requiring patients to be transported some distance within the hospital to receive care. SGMC offers the example of Cardiovascular Interventional Radiology (CVIR) patients, who must be "transported across the hospital from prep and recovery perioperative services to the CVIR interventional laboratories on the opposite side of the building." (DI #2, p. 4). The design of the new tower will "stack" the ICU, progressive care unit, and a new medical-surgical unit above the CVIR and Emergency Department. The applicant maintains that stacking these units in a central location maximizes efficiency by reducing the need to transfer patients longer distances between services. (DI #2, p. 6).

Clinical Decision Unit (Observation)

The hospital's current CDU contains 18-beds in nine rooms. The proposed project would replace it with 20 beds in private rooms, which the applicant asserts will reduce infection risks. The CDU will also have closer proximity to the Emergency Department, thus minimizing travel distance and contact with other patient treatment spaces and facilitating patient transition from the ED to inpatient care or observation status.

The number of observation patients increased substantially (52% increase in patients and a 70% increase in observation days) between 2015 and 2019 before plummeting in 2020, the first year of the pandemic. The applicant projects continued modest growth and points out that not all observation patients will be placed in the new CDU. At an 80% average annual occupancy rate, the projected utilization shows a need for well over the proposed 20 dedicated observation beds.

Table III-8: Use of Observation Status at SGMC, 2015-2019, and Projected Use of Observation Status at SGMC, 2020-2023

Observation Use Metric	Actual, CY					Projected, CY			
	2015	2016	2017	2018	2019	2020	2021	2022	2023
Patients	5,030	4,962	5,711	7,406	7,626	5,476	7,694	7,755	7,817
Days	5,153	5,151	5,959	8,261	8,760	7,045	9,029	9,101	9,174

DI #2, pp. 36, 37 and Table F).

Staff concludes that the applicant has shown a need for modernization and reconfiguration of SGMC and that the mix of new construction and renovation proposed appropriately addresses this need. Staff recommends that the Commission find that the applicant has demonstrated the need for the project.

C. Availability of More Cost-Effective Alternatives

COMAR 10.24.01.08G(3)(c) The Commission shall compare the cost effectiveness of the proposed project with the cost effectiveness of providing the service through alternative existing facilities, or alternative facilities which have submitted a competitive application as part of a comparative review.

See COMAR 10.24.10.04(B)(5), the *Cost Effectiveness* project review standard (*supra*, p. 12-14) applicable to this project addressed earlier in this report, for a discussion of the project's goals and considered alternatives. This criterion also requires the applicant to discuss the alternative of the services being provided through existing facilities.

The alternative of services being provided through existing facilities.

By its nature, the project, which does not introduce new services and does not expand existing capacities,[17] is difficult to conceive as a project whose objectives could be met by other hospitals. SGMC states that this alternative would fail to address the challenges that it seeks to meet with this project. It would fail to:

- Eliminate semi-private patient, emergency, and observation rooms;
- Provide an updated ICU and the achievement of clinical efficiencies through care unit consolidation within the new patient tower;
- Provide a modern ED that would promote clinical efficiency, safety, and a better patient experience;
- Provide adequate space for observation beds for the increasing numbers of observation patients seen at Shady Grove; and
- Provide a safe CVIR located adjacent to pre-op, surgery, and recovery areas. DI #2, p. 40).

The alternative of services being provided through population-health initiatives that would avoid or lessen hospital admissions was also addressed by the applicant. SGMC states that, as part of AHC, it participates in many population health initiatives that seek to avoid or reduce unnecessary hospital admissions. The applicant states that a key part of AHC's Population Health strategy is maintaining an effective Care Navigation department, whose core purpose is to navigate patients through "an integrated and aligned network of post-acute services, helping to minimize the cost of care and maximize the patient experience and quality of life." SGAH notes AHC's multiple strategies that it states support care navigation and mitigate the need for acute care hospitalization and rehospitalization. (DI # 2, pp. 40-43).

Staff notes that licensed non-psychiatric acute care bed capacity at SGMC declined from 339 beds in FY 2012 to 212 beds in FY 2020, a 37% decline over that eight-year period, primarily reflecting the shrinking average daily census of MSGA patients. Further, SGMC's licensed bed capacity included psychiatric beds for the first time in FY 2020, as a result of the consolidation of SGMC and a special psychiatric hospital operated by AHC adjacent to the SGMC campus.

Staff concludes that the applicant has addressed important cost and effectiveness questions, the alternatives for addressing the project objectives, and the basis for its project choices, consistent with this criterion.

[17] As noted, the projected expansion of physical bed capacity at SGMC is a result of designing and implementing a project that will eliminate the need for use of semi-private room accommodations for MSGA patients and modernize patient rooms, rather than establish more beds. The net increase in physical bed capacity will be reduced over time during a post-project period in which plans for reusing former patient room space will be finalized and implemented. See staff's recommended condition 1.

D. Viability of the Proposal

COMAR 10.24.01.08G(3)(d) 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 to Implement the Proposed Project

The total estimated cost of the project is $180,011,369. (DI #10, Exh. 30, Table E). A copy of the Project Budget is included in Appendix 5. The applicant plans to fund the project cost with approximately $154.0 million in a tax-exempt bond financing that it states "will be secured pursuant to the Amended and Restated Master Trust Indenture dated as of February 1, 2003." (DI #2, pp. 44-45). The applicant states that AHC has a long history of working with Ziegler Healthcare Investment Banking and will do so with this debt issue. The applicant plans to utilize a traditional tax-exempt municipal bond financing with a term of 30 years and an interest rate assumption of about 4.5%. It describes this assumption as conservative given that it is higher than current market rates, implying some cushion if rates should move higher. (DI #10, pp. 5-6).

SGMC will finance the remaining cost of the project with about $10 million in cash and short-term investments (DI #10, p. 5), and through a $16 million philanthropic campaign. The applicant states that this fundraising campaign has just begun, and that the applicant will work with a consultant to kick-off this campaign in 2021. While the applicant does not expect any problems in meeting this goal, SGMC states it will cover any shortfalls from its operating funds. (DI #10, pp. 4-5).

SGMC states that while it currently has not filed an application with the Health Services Cost Review Commission for a rate adjustment, it reserves the right to file a partial rate application for capital to fund the capital costs of the project. (DI #2, p. 60; DI #10, p. 11).

Availability of Resources to Sustain the Proposed Project

As discussed earlier under the *Financial Feasibility* project review standard[18] of the Acute Hospital Chapter, Shady Grove has outlined the assumptions used in its financial performance projections, consistent with that standard, it has a recent history of healthy operating margins, and projected positive margins of reduced size, as project expenses are paid. HSCRC staff's review was positive.

HSCRC Opinion

As is standard practice in a hospital CON review, Commission staff sought an opinion regarding the financial feasibility and viability of the project from HSCRC staff, which performed a review of the financial projections in the SGMC CON application and subsequent filings and followed up with questions directed to the applicant.

[18] See discussion at p. 21-23, *supra*.

HSCRC wrote to MHCC staff with the opinion that: "SGMC and AHC have the needed resources to finance the project, and SGMC's operations can be expected to sustain the project. Based upon staff's review of the information presented, the HSCRC believes that the SGMC patient tower project appears to be financially feasible." (DI #20, pp. 2-3). HSCRC staff's opinion is attached as Appendix 6.

Community Support

AHC received a number of letters from local government and community leaders who submitted comments as detailed under Community Support, *supra*, pp. 4-5.

Summary

Staff concludes that the applicant has proposed a project that can be implemented with resources that should be available to SGMC and AHC and that the ongoing viability of SGMC is sustainable if the project is implemented and used in a manner projected by the applicant.

E. Compliance with Conditions of Previous Certificates of Need

COMAR 10.24.01.08G(3)(e) 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 states that the following Certificates of Need have been issued since 2000 to Adventist HealthCare, Inc., and that AHC has complied with and met the conditions for each project to date:

- Certificate of Need issued in February 2003 to relocate and consolidate 15 of the 20 comprehensive care beds operated at Care-Link at Washington Adventist Hospital with an existing 82 bed complement at Fairland Nursing and Rehabilitation Center, expanding that facility's bed capacity to 97 beds. The applicant relinquished the remaining five beds.

- Certificate of Need issued in June 2003 for 22 rehabilitation beds.

- Certificate of Need issued in February 2005 for a project to expand the patient tower at Shady Grove Adventist Hospital.

- Certificate of Need issued in November 2005 to Washington Adventist Hospital to establish the Washington Adventist Surgery Center. The CON was relinquished in August 2006.

- Certificate of Need issued in December 2015 to relocate Washington Adventist Hospital from Takoma Park to White Oak in Silver Spring (Docket No. 13-15-2349).

- Certificate of Need issued in January 2019 to expand home health agency services into Frederick County using its existing Rockville branch office (Docket No. 17-R2-2397).

- Certificate of Need issued in March 2019 to Adventist Rehabilitation Hospital of Maryland for the relocation of 42 inpatient rehabilitation beds to an expansion within the general hospital being constructed in Silver Spring as a replacement of Washington Adventist Hospital (Docket No: 18-15-2428). Construction is currently ongoing.

- Emergency Certificate of Need issued in April 2020 to White Oak Medical Center to establish additional inpatient bed capacity (63 MSGA beds at a temporary remote location on the former Washington Adventist Hospital campus). Beds located at the site: 42 beds in a space that is currently licensed as a special rehabilitation hospital and 21 beds in rooms in a former MSGA unit on the 5th floor. This CON was superseded by the Emergency CON for the Alternate Care Site on May 20, 2020, listed below.

- Emergency Certificate of Need issued in April 2020 to White Oak Medical Center to establish additional inpatient bed capacity consisting of 23 MSGA beds that are in existing, nonclinical spaces located on floors 2, 3, 4, 5, 6 and 7.

- Emergency Certificate of Need issued in April 2020 to Fort Washington Medical Center to establish additional inpatient bed capacity consisting of 10 MSGA beds to be located in a temporary field hospital inpatient unit at the hospital.

- Emergency Certificate of Need issued in April 2020 to Fort Washington Medical Center to establish additional inpatient bed capacity consisting of 20 MSGA beds to be located in two temporary field hospital inpatient units at the hospital.

- Emergency Certificate of Need issued in April 2020 to Fort Washington Medical Center to establish additional inpatient bed capacity consisting of 16 ICU beds to be located in two temporary modular buildings at the hospital.

- Emergency Certificate of Need issued in May 2020 to White Oak Medical Center to establish additional inpatient bed capacity consisting of 200 MSGA beds as an Alternate Care Site in a temporary remote location on the first through fifth floors and the lower level of the former Washington Adventist Hospital. The construction of the Alternate Care Site space was overseen by the Department of General Services, in coordination with White Oak Medical Center, and the cost of the project will be borne by the State of Maryland. The site currently has all 200 beds with 54 operational. The site is normally staffed to serve 18 beds but can quickly ramp up to staff 54 beds in 1-2 days and the full 200 beds in 6-7 days. Since opening in May 2020, approximately 70 patients have been admitted. (DI #3, p. 47-49).

Staff concludes that the applicant has demonstrated compliance with all terms and conditions of each previous Certificate of Need granted to the applicant.

F. Impact

COMAR 10.24.01.08G(3)(f) Impact on Existing Providers and the Health Care Delivery System. An applicant shall provide information and analysis with respect to the impact of the proposed project on existing health care providers in the health planning region, including the impact on geographic and demographic access to services, on occupancy, on costs and charges of other providers, and on costs to the health care delivery system.

Impact on Other Providers

SGMC states that the proposed project should not have any material impact on other existing health care providers, noting that it has assumed that its market share of MSGA services will effectively remain the same. It is not proposing to increase the number of MSGA beds it operates, which, at a maximum is a function of licensed bed capacity and changes in its census. The same services currently provided at SGMC will be provided post-project but in larger and more functional spaces. It does not expect a significant change in referral patterns by physicians practicing at other hospitals in its service area to result from this project.

SGMC projects growth in inpatient, emergency, and outpatient services use, linking this to anticipated population growth and aging of its service area population. In its forecast model, the adult population growth is projected to be partially offset by projected declines in discharge rates per 1,000 population and average lengths of stay. (DI #3, pp. 49-50). These are reasonable assumptions within the range of recent experience.

Impact on access to health care services, system costs, and costs and charges of other providers

The applicant stated that despite the fact that this project will not result in an increase in licensed MSGA beds or a change in the location from which Shady Grove offers services, it will enhance access because:

- The reconfigured ED will improve throughput, resulting in reduced wait times, greater privacy, and a shorter length of stay;
- The relocation of the observation unit to a space with improved adjacencies will enable a quicker transition of patients from the ED to an observation setting, which should ultimately provide the patients with more privacy and better outcomes; and
- The transition to all-private MSGA rooms will enhance its population's ability to access inpatient care because all-private rooms will eliminate the limitations associated with semi-private rooms (i.e., lack of ability to provide patients with infection control and/or gender matching) and allow the hospital to fully utilize its licensed bed capacity. (DI #3, p. 50).

Impact on costs to the health care delivery system

SGMC states that it is not seeking a rate increase and no increase related to the project is reflected in the applicant's projections of future revenues and expenses, although it states that it

reserves the right to seek an increase in rates for capital funding for this project in the future. (DI #3, p. 50, Exh. 1, Tables G-H).

Staff concludes that the proposed new patient tower will not have a negative impact on existing providers, will have a positive impact on the availability and accessibility of SGMC's hospital services, and will not have a significant negative impact on costs to the health care system. Therefore, it recommends that the Commission find the likely impact of this project to be primarily positive. The incremental increase in charges that may result from this project would be a negative impact for payers, but modernization of the hospital is timely and provides benefits for users of the hospital over a period of decades that are likely to warrant the price increase.

IV. SUMMARY AND STAFF RECOMMENDATION

This proposed project by AHC Shady Grove Medical Center to add a patient tower to is based on a need to modernize the facility, bringing it up to current standards and consumer expectations by converting all patient rooms to private rooms and providing more space and more privacy for inpatients, Emergency Department patients, and observation patients.

Staff concludes that the proposed project complies with the applicable State Health Plan standards, that it is needed, that it is a cost-effective alternative for meeting the need, that it is viable, and that it will not have a negative impact on service accessibility, on costs and charges of other providers, or on the health care delivery system. Accordingly, staff recommends that the Commission **APPROVE** the proposed SGMC modernization project with the following conditions:

1. Prior to its request for first use approval, Adventist HealthCare Shady Grove Medical Center shall identify bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan shall specifically address the hospital's assessment of the need for surge bed capacity and its plan to maintain and deploy adequate surge capacity when needed.

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $21,226,090, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

IN THE MATTER OF	*	
	*	
ADVENTIST HEALTHCARE	*	**BEFORE THE**
	*	
SHADY GROVE	*	
	*	**MARYLAND HEALTH**
MEDICAL CENTER	*	
	*	
	*	**CARE COMMISSION**
Docket No. 20-15-2443	*	
	*	

*** ***

FINAL ORDER

Based on the analysis and conclusions in the Staff Report and Recommendation, it is, this 15th day of April 2021:

ORDERED, that the application for a Certificate of Need by Adventist HealthCare Shady Grove Medical Center for a project that will modernize the hospital, adding 74 MSGA beds at an estimated project cost of $180,011,359 be **APPROVED,** subject to the following conditions:

1. Prior to its request for first use approval, Adventist HealthCare Shady Grove Medical Center shall identify bed capacity it will retain in operational status, the physical bed capacity it will repurpose but retain as physical bed capacity, and the physical bed capacity it will eliminate. This plan shall specifically address the hospital's assessment of the need for surge bed capacity and its plan to maintain and deploy adequate surge capacity when needed.

2. Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $21,226,090, which includes the estimated new construction costs that exceed the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

MARYLAND HEALTH CARE COMMISSION

MARYLAND HEALTH CARE COMMISSION

APPENDIX 1: Record of the Review

Docket Item #	Description	Date
1	Commission staff acknowledged receipt of Adventist HealthCare Shady Grove Medical Center's letter of intent to file a Certificate of Need application.	8/17/2020
2	Howard L. Sollins, Esq., Baker Donelson, submitted a Certificate of Need application on behalf of Adventist HealthCare Shady Grove Medical Center proposing the development of a new six-story patient tower connected to the existing hospital located in Rockville, Maryland. (Matter No. 20-15-2443)	10/9/2020
3	Andrew R. Nicklas, Director – Government Relations & Deputy General Counsel, submitted on behalf of Adventist HealthCare Shady Grove Medical Center, a PowerPoint presentation from 10/14/2020 meeting with Commission staff	10/14/2020
4	Commission staff acknowledges receipt of CON application.	10/15/2020
5	Commission staff requested publication of notification of receipt of the Adventist HealthCare Shady Grove Medical Center's application in the *Washington Times.*	10/15/2020
6	Commission staff requested publication of notification of receipt of the Adventist HealthCare Shady Grove Medical Center's application in the *Maryland Register*.	10/15/2020
7	Commission staff requested publication of notification of receipt of the Adventist HealthCare Shady Grove Medical Center's proposal in the *Washington Times.*	10/19/2020
8	Following completeness review, Commission staff found the application incomplete, and requested additional information.	11/4/2020
9	Commission staff sent request to HSCRC for an opinion on the financial feasibility of AHC SGMC's CON application.	11/6/2020
10	Via email, Andrew R. Nicklas requested and Commission staff granted an extension until 12/11/2020 to file completeness responses.	11/18/2020
11	Commission staff received responses to the request for additional information.	12/11/2020
12	Commission staff requested information in response to Health Services Cost Review Commission staff's review of the application	12/23/2020
13	Commission staff sent a second-round of completeness questions.	1/8/2021
14	Commission staff received responses to the second-round request for additional information.	1/29/2021
15	Commission staff notified Adventist HealthCare Shady Grove Medical Center that its application would be docketed for formal review as of February 26, 2021.	2/11/2021
16	Commission received a copy of the notice of formal start of review as published in *Washington Times.*	2/11/2021

17	Commission staff requested publication of the notice of formal start of review in the *Maryland Register*	2/11/2021
18	Commission staff sent a form requesting comments from Montgomery County Department of Health.	2/12/2021
19	Commission staff received information in response to HSCRC's request for additional information.	3/4/2021
20	Commission staff received memo from HSCRC in response to Commission staff's request for an opinion on financial feasibility of AHC SGMC's CON application.	3/23/2021
21	Via email, Commission staff requested that SGMC provide additional information regarding the emergency department.	3/24/2021
22	Kristin Feliciano, Holy Cross Health, submitted comments noting that Holy Cross Health does not oppose the proposed project, but requesting that the Commission find that SGMC is not eligible to request a future rate increase from HSCRC based on the capital costs of the project.	3/29/2021
23	Via email, Commission staff requested that SGMC provide additional information regarding the ICU beds.	3/29/2021
24	Via email, Commission staff notified applicant to expect questions regarding the emergency department.	3/30/2021
25	Via email, Commission staff suggested the applicant review the staff reports for Greater Baltimore Medical Center and Suburban Hospital for their response to physical bed count.	3/30/2021
26	Via email, Andrew R. Nicklas submitted an updated Table A. Physical Bed Capacity.	3/31/2021
27	Via email, Kristin Feliciano, Holy Cross Health, informed Commission and HSCRC staff that it disagrees with the MHCC description of the Holy Cross Health's comment.	4/1/2021
28	Via email, Andrew R. Nicklas submitted a revised Table A for bed capacity and response regarding the emergency department	4/2/2021
29	Via email, Andrew R. Nicklas submitted the breakdown of the ED beds for the proposed project.	4/5/2021

MARYLAND HEALTH CARE COMMISSION

APPENDIX 2:

Project Floor Plans

MARYLAND HEALTH CARE COMMISSION

APPENDIX 3:

Shady Grove Medical Center

"Below Average" Quality Measures

And Initiatives for Improvement

Summary of Hospital Information: Adventist HealthCare Shady Grove Medical Center			
Practice Patterns	**Rating**	**Risk-Adjusted Rates**	**Initiatives to Effect Change**
Childbirth			
Percentage of births (deliveries) that are C-sections	Below average	29.4438	Use of "peanut balls" for positioning moms, frequent position changes and wireless monitoring for laboring mom.
How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	Below average	15.2632	Use of "peanut balls" for positioning moms, frequent position changes and wireless monitoring for laboring mom.
Communication			
How often did nurses always communicate well with patients?	Below average	74%	Focus on purposeful hourly rounding nurses as well as AIDET (Acknowledge, Introduce, Duration, Explanation, Thank You)
How often did doctors always communicate well with patients?	Below average	74%	Initiation of scheduled daily rounding with nurses at the patient bedside started in September 2020
How often did staff always explain about medicines before giving them to patients?	Below average	54%	Development of packet of frequently seen medication for easy reference education. Partner with pharmacy to identify frequently used medication. Information is located on laminated cards for easy access education
How well do patients understand their care when they leave the hospital?	Below average	47%	Increased emphasis on discharge education and planning delivered by the nurses, physicians and care navigation team. Education starts at the point of admission. Updated process started September 2020.
Environment			
How often were the patients' rooms and bathrooms always kept clean?	Below average	67%	Validate cleaning procedures followed and perform enhanced inspections
How often did patients always receive help quickly from hospital staff?	Below average	53%	Develop strategic team for responsiveness and revise model of care to include care team of 2 RNs and 1 CNA. This allows more extensive coverage of patient call lights. Update nurse call system to include voicera integration.
How often was the area around patients' rooms always kept quiet at night?	Below average	54%	Institute quiet time, lower unit lights to promote and serve as a reminder to implement a quiet environment, reminders to staff to minimize noise
Patient Safety			
Results of Care - Complications			
Percentage of patients who received appropriate care for severe sepsis and septic shock	Below average	49	Institution of Modifiable Early Warning Score (MEWS) to help identify change in patient condition signaling possible sepsis. Completion of SEP-1 bundle with case review for misses.

DI #2, p. 57.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 4:

Marshall Valuation Service Review

Marshall Valuation Service Review

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.[19]

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.)

This standard requires a comparison of the project's estimated construction cost, adjusted for specific construction characteristics of the proposed project, with a benchmark, or expected cost, derived using the cost-estimating methodology provided by the Marshall Valuation Service (MVS). Theoretically, the cost per SF arrived at by using this methodology reflects what a building of the type and quality described should cost to construct. The purpose of this standard is to exclude any excess costs from any future rate increase to cover the cost of the project. The MVS methodology includes a variety of adjustment factors related to the specific characteristics of the project, *e.g.*, timing of the project, the locality, the number of stories, height per story, shape of the building (*e.g.*, the relationship of floor size to perimeter), and departmental use of space. Appendix 4 provides a detailed explanation of the methodology laid out in the MVS guide and how it is used to derive a benchmark value that can be used to assess the appropriateness of new construction costs in a proposed project.

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

AHC and MHCC staff each calculated the MVS benchmark and the estimated allowable new construction cost for the 150,352 SF six-story patient tower. AHC arrived at a benchmark value of $450.11 per SF and an estimated allowable new construction cost of $486.59 per SF. MHCC staff arrived at a slightly lower benchmark value of $432.89 per SF, and a higher estimated allowable new construction cost of $535.06 per SF. [20]

The next step in the methodology is to compare the estimated allowable new construction cost with the MVS benchmark values (calculation shown in Appendix 4, Table 2). In this proposed project the total estimated allowable cost of new construction ($535.06 per SF) exceeds the MVS benchmark value ($432.89 per SF) by $102.17 per SF (23.6%). Accordingly, if AHC were to seek a future rate increase related to the capital cost of the new patient tower, the standard requires that any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount by which the projected construction cost exceeds the MVS benchmark (and those portions of the contingency and inflation allowances, and the capitalized construction interest expenditure) that are based on the excess construction cost of the $21,226,091. This excess cost calculation is shown immediately below.

MHCC Staff Calculation of Excess Cost

Construction cost exceeding benchmark ($102.16 x 148,176 SF)	$15,137,923
The portion of future inflation that should be excluded ($13,799,530 x 23.6 %)	$3,256,689
The portion of the contingencies that should be excluded ($11,997,789 x 23.6 %)	$2,831,478
Total to be excluded from any rate increase proposed by the hospital related to the capital cost of the project	**$21,226,091**

Based on this analysis, staff recommends that, if the Commission approves the project, approval should be accompanied by the following condition, in accordance with the standard:

> Any future change to the financing of this project involving adjustments in rates set by the Health Services Cost Review Commission must exclude $21,226,091. This figure includes the estimated new construction costs that exceeds the Marshall Valuation Service guideline cost and portions of the contingency allowance and inflation allowance that are based on the excess construction cost.

[20] As explained in Appendix 4, the differing benchmarks calculated by AHC and MHCC staff are attributable to differences in when the analyses were performed, and in the assumptions used by the applicant and Commission staff for the MVS benchmark calculations. The respective calculations made by the applicant and Commission staff for allowable new construction costs measured against the MVS benchmark can be found in Appendix 4, Table 2.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 5:

Project Budget

PROJECT BUDGET

	Hospital Building	***CUP Upgrade***	***Total***
USE OF FUNDS			
New Construction			
Building	$73,458,451	$6,752,441	$80,210,892
Fixed Equipment	$3,525,375	$301,922	$3,827,297
Site and Infrastructure	$10,150,141	$408,005	$10,558,146
Architect/Engineering Fees	$5,856,282	$501,546	$6,357,828
Permits (Building, Utilities, Etc.)	$2,158,953	$184,898	$2,343,851
SUBTOTAL	**$95,149,202**	**$8,148,812**	**$103,298,014**
Renovations			
Building	$8,840,236	$0	$8,840,236
Architect/Engineering Fees	$656,620	$0	$656,620
Permits (Building, Utilities, Etc.)	$242,067	$0	$242,067
SUBTOTAL	**$9,738,923**	**$0**	**$9,738,923**
Other Capital Costs			
Movable Equipment	$3,629,400	$200,000	$3,829,400
Contingency Allowance	$11,997,789	$849,381	$12,847,170
Gross interest during construction period	$13,653,795	$957,801	$14,611,596
a. Furniture	$2,367,000	$25,000	$2,392,000
b. Interior & Exterior Signage	$723,400	$15,000	$738,400
c. IS/Comm	$6,615,000	$50,000	$6,665,000
d. Security system	$1,250,000	$15,000	$1,265,000
e. Relocation expense	$315,600	$15,000	$330,600
f. Certifications, inspections, etc.	$189,360	$25,000	$214,360
SUBTOTAL	***$40,741,344***	***$2,152,182***	**$42,893,526**
TOTAL CURRENT CAPITAL COSTS	**$145,629,469**	**$10,300,994**	**$155,930,463**
Inflation Allowance	$13,799,530	$882,804	$14,682,334
TOTAL CAPITAL COSTS	**$159,428,999**	**$11,183,798**	**$170,612,797**
Financing Cost and Other Cash Requirements			
Loan Placement Fees	**$1,798,990**	**$126,197**	$1,925,187
Debt Service Reserve Fund	**$6,986,996**	**$486,379**	$7,473,375
SUBTOTAL	***$8,785,986***	***$612,576***	**$9,398,562**
TOTAL USES OF FUNDS	***$168,214,985***	***$11,796,374***	***$180,011,359***
SOURCES OF FUNDS			
Cash	$9,337,090	$659,269	$9,996,359
Philanthropy	$14,958,694	$1,041,306	$16,000,000
Authorized Bonds	$143,919,200	$10,095,800	$154,015,000
TOTAL SOURCES OF FUNDS	***$168,214,984***	***$11,796,375***	**$180,011,359**

Source: DI #10, Exh. 30, Table E.

MARYLAND HEALTH CARE COMMISSION

APPENDIX 6:

Health Services Cost Review Commission
Staff's Review and Opinion

maryland
health services
cost review commission

MEMORANDUM

TO: Kevin McDonald, Chief, CON, MHCC
William Chan, Program Manager, CON, MHCC

FROM: Katie Wunderlich, Executive Director, HSCRC
Jerry Schmith, Director, Revenue & Regulation Compliance, HSCRC

DATE: March 23, 2021

RE: Adventist Health Shady Grove Medical Center (SGMC)
Patient Tower Addition
Docket No. 20-15-2443

****

This memo is in response to your request dated November 6, 2020. Shady Grove Medical Center (SGMC) has submitted a Certificate of Need (CON) application dated October 9, 2020 proposing a capital expenditure of approximately $180 million to construct a six-story addition to the east of the existing hospital and adjacent to the existing parking garage. You have requested that the staff of HSCRC review the financial projections provided in the CON application and subsequent filings, and advise MHCC as to any questions we would like answered before offering our opinion, and then also to advise MHCC of our opinion on the general financial feasibility of the proposed project. MHCC staff believes that the utilization projections presented in the CON application are reasonable, and has asked HSCRC staff to assume that SGMC will achieve the projected utilization volumes.

BACKGROUND

As you have described it, the project will consist of approximately 150,352 square feet (SF) of new construction and about 25,656 SF of renovation. The applicant will complete the proposed project in 60 months, in two phases after signing the construction contract. Phase one includes constructing the new patient tower and will require an extended period of 36 months for completion. Phase two includes renovating the current ED space and the areas on each floor that will connect to the new patient tower, which will be completed over a 24-month period. The main features of the project are:

- Vertical stacking of clinical units to maximize clinical efficiency
- Adding 48 private medical surgical rooms and converting the remaining inpatient semi-private rooms to all private medical/surgical rooms
- Relocation and replacement of the emergency department
- Replacement of the existing 18-bed semi-private Clinical Decision Unit (CDU) (a.k.a. observation) with a new 20-bed private room CDU
- Replacing the 26 ICU beds/rooms with a new, appropriately sized unit
- Relocation of the Cardiovascular and Interventional Radiology (CVIR) unit to space adjacent to the perioperative services
- Relocation of the helipad to the roof of the new addition

THE PROJECT

The total cost of the project is approximately $180 million, with about $168.2 million for the new construction and renovations for the patient tower and about $11.8 million for an upgrade to the central utility plant. Costs are distributed as follows: $113 million for construction and renovations; $42.9 million for movable equipment, contingency allowance, and gross interest during construction; $14.7 million for inflation allowance; and

$9.4 million for financing costs and debt service reserve fund. SGMC plans to finance the project with $10 million in cash; $16 million in philanthropic gifts; and $154 million in authorized bonds.

HSCRC REVIEW, DISCUSSION, and OPINION

HSCRC staff has reviewed the following: 1) the CON application dated October 9, 2020, 2) the subsequent Completeness Responses dated December 10, 2020, January 29, 2021, and March 4, 2021. Consistent with your request, we compiled and shared with you our initial review questions, which were then forwarded to the applicant on December 23, 2020, and for which responses were received March 4, 2021.

Upon review of the planning information included in the CON, it was noted that the tower construction is to begin around September 2021 and is to conclude around August 2024, while the renovation of existing space is to begin immediately following the construction period and to conclude around August of 2026. Upon review of the statistical and financial information provided in the CON, it was noted that P&L projections were presented through CY 2026, and we requested that such projections be extended though CY 2028 so as to conclude two years after the project completion and full occupancy. Such changes were addressed by the applicant in their March 4th response.

We reviewed the projected P&L and noted that gross revenues grew by an average rate of 2.3%, which when compared to recent history of GBR growth at 2.6%, appears to be a fairly reasonable and conservative assumption. The projected P&L reflects contra-revenues at the rate of 17.2% of gross revenues, which when compared to recent history (17.4%) appears fairly reasonable given no material changes in projected patient mix or payer mix. Operating expenses as a percent of net revenues average 94.8% for projected years prior to CY 2024 (the first year of project expenses and debt service) and equal that of 2019 actual. They then grow to an average of 97.1% of net revenues after CY 2023, with the greatest contributor to growth being interest on new debt and depreciation on new assets; such projected measures appear reasonable on their face.

Upon review of the projected P&L it was noted that interest expense on project debt was presented as being flat for each year following the initial borrowing, and was set at an amount approximate to the first year's amortization. For purposes of evaluation, we prepared a pro forma presentation of the projected P&L amending the annual interest expense on project debt so as to more closely reflect the planned amortization of a bond at 4.5% interest with a 30-year term. Based upon review of the projected P&L (as amended pro forma for declining interest on project debt), the Operating Margin averages 5.2% of net revenues prior to CY 2024 (the first year of project expenses and debt service) (or $24.4 million per year) and then averages 2.9% of net revenues after CY 2023 (or $15.3 million per year). It should be noted that on the second full year of operations following the completion of construction and renovations (CY 2028), Operating Margin is projected to reach 3.3% of net revenues (or $18 million). This is evidence that the operations can sustain the ongoing costs of the project.

Although the P&L projections were prepared without any assumed increase to its GBR beyond the annual update for inflation, it is noted that according to page 60 the CON, the applicant reserves the right to file for a partial rate application in the pursuit of funds to enhance its GBR for the incremental capital related operating costs associated with this project. Additionally, it is noted that according to page 11 of the responses dated December 11, 2020, the applicant intends to file a partial rate application for any capital for which it is eligible. As of the date of the CON submission, the applicant believes it may be eligible for a $7.1 million positive adjustment to its GBR.

According to page 44 of the CON, the applicant intends to pursue traditional tax-exempt bond financing for this project, and as per the Master Trust Indenture such debt is to be serviced by the "Obligated Group" which for purposes of this review is fairly well represent by Adventist HealthCare, Inc. (AHC) consolidated. Accordingly, the historic and projected balance sheet resources and financial ratios referenced in the CON and the Responses are those of the consolidated entity. Although the consolidated balance sheet projections and related ratios conclude with CY 2025, such are deemed sufficient for providing evidence of the where-with-all to initially finance and subsequently afford and service the project without violating established debt covenants. Days cash on hand averages 128 days post borrowing as compared to the base covenant of 70 days. The debt service coverage ratio averages 2.25 post borrowing as compared to the base covenant of 1.25. The ratio of liabilities to unrestricted net assets averages 1.88 post borrowing as compared to the base of 2.5.

The project budget calls for $10 million in cash financing, and the consolidated balance sheet reflects an average $330 million in cash and liquid investments post borrowing. The project budget also calls for $16 million in philanthropic gift financing, and the CON Responses dated December 11th indicated that the first $1 million is in hand, and the campaigns to secure pledges are underway in 2021.

Collectively, therefore, it is apparent that SGMC and AHC have the needed resources to finance the project, and SGMC's operations can be expected to sustain the project. Based upon staff's review of the information presented, the HSCRC believes that the SGMC patient tower project appears to be financially feasible.