Peninsula Regional Medical Center

Application for a Certificate of Need

March 9, 2018

Development of 15 New Child & Adolescent Psychiatric Beds

100 East Carroll Street • Salisbury, MD 21801
www.peninsula.org

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For internal staff use

MARYLAND
HEALTH
CARE
COMMISSION

_____
MATTER/DOCKET NO.
_____
DATE DOCKETED

HOSPITAL
APPLICATION FOR CERTIFICATE OF NEED

PART I - PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. FACILITY

Name of Facility: **Peninsula Regional Medical Center**

Address:

100 East Carroll Street	Salisbury	21801	Wicomico
Street	City	Zip	County

Name of Owner (if differs from applicant):
Steven Leonard, MBA, FACHE, President/CEO

2. OWNER

Name of owner: N/A

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

Legal Name of Project Applicant
Peninsula Regional Medical Center

Address:

100 East Carroll Street	Salisbury	21801	Maryland	Wicomico
Street	City	Zip	State	County

Telephone: 410-543-6400

Name of Owner/Chief Executive: Steven Leonard, MBA, FACHE, President/CEO

4. NAME OF LICENSEE OR PROPOSED LICENSEE, if different from applicant:
N/A

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

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

A.	Governmental	☐	
B.	Corporation		
	(1) Non-profit	☒	
	(2) For-profit	☐	
	(3) Close	☐	State & date of incorporation MD June 10, 1897
C.	Partnership		
	General	☐	
	Limited	☐	
	Limited liability partnership	☐	
	Limited liability limited partnership	☐	
	Other (Specify):		
D.	Limited Liability Company	☐	
E.	Other (Specify):		
	To be formed:	☐	
	Existing:	☒	

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

A. Lead or primary contact:

Name and Title: Christopher C. Hall Vice President/Chief Business Officer

Mailing Address:

100 East Carroll Street	Salisbury	21801	Maryland
Street	City	Zip	State

Telephone: 410-543-7256

E-mail Address (required): Chris.Hall@peninsula.org

Fax: 410-543-7144

B. Additional or alternate contact:

Name and Title: Tim Feist Vice President Ambulatory Services

Mailing Address:

100 East Carroll Street	Salisbury	21801	Maryland
Street	City	Zip	State

Telephone: 410-543-7118

E-mail Address (required): Tim.Feist@peninsula.org

Fax: 410-543-7144

7. TYPE OF PROJECT

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

If approved, this CON would result in:

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

8. PROJECT DESCRIPTION

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

(1) Brief description of the project – what the applicant proposes to do;

Applicant Response

Peninsula Regional Medical Center ("PRMC") seeks approval for the establishment of a 15-bed inpatient psychiatric unit for treatment of children and adolescents. The main objective of the project is to address the needs of the residents of the lower Eastern Shore and neighboring communities for these acute care hospital services.

The PRMC will add 15 acute care hospital beds to its license and incur capital and operating expenses related to the initiation of new health care services, including the addition of full-time employees. PRMC reserves the right to seek from the Health Services Cost Review Commission (HSCRC) future additional rate charging authority to help fund this project, and has projected in this CON application additional future regulated revenue to assure PRMC's and this project's financial success.

(2) Rationale for the project – the need and/or business case for the proposed project;

Applicant Response

PRMC is the largest hospital on Maryland's Eastern Shore and is headquartered in Salisbury, Maryland. As the region's tertiary referral center, there is no inpatient

psychiatric bed capacity for children and adolescents. As discussed below, children and adolescent residents of the region utilize the services of both private freestanding psychiatric hospitals and acute care general hospitals located on the Western Shore of Maryland, and in the neighboring State of Delaware. The continued utilization of these out-of-area providers is considered suboptimal by the leadership of PRMC, and the supporters in the community for this project. Community stakeholders and a community health needs assessment (CHNA) have identified mental health services as a significant need for the region. Both the FY 2013 and 2016 CHNA identified the concerns for mental health in the region. Nine out of twelve individuals interviewed during the CHNA engagement specifically brought up mental health and repeatedly it was discussed as a growing issue and concern around the lack of resources and services available. See Attachment 1 for a copy of the FY 2013 and the FY2016 CHNAs. This project seeks to improve accessibility for future children and adolescents of the region by establishing a 15-bed inpatient psychiatric unit on PRMC's campus, complementing the services currently and historically provided to adult psychiatric patients. The project is a financially viable alternative to the status quo practices of referring and transferring children and adolescents out of the community to existing hospital inpatient units elsewhere. To ensure that sufficient resources are made available to its new patients at PRMC, a rate adjustment will be needed.

(3) Cost – the total cost of implementing the proposed project; and

Applicant Response

The total cost of implementing the proposed renovation project is estimated at $8.5 Million.

(4) Master Facility Plans – how the proposed project fits in long term plans.

Applicant Response

In 2016, Peninsula Regional Medical Center completed a Master Facility Plan that anticipates all the inpatient nursing units will be housed in the four most recently built towers located on the PRMC campus: the Layfield Tower, the South Tower, the East Tower and the West Tower. The proposed location of the new 15-bed Child and Adolescent Psychiatric Unit in the South Tower, adjacent to the existing 13-bed adult inpatient psychiatric unit, located on the third floor, is consistent with the Master Facility plan.

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

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

Applicant Response

See Attachment 2 for a complete project description.

This application provides for a new department of approximately 9,410 sf of renovated space, to house a Child and Adolescent Psychiatry Unit of fifteen (15) beds. Renovation work will be completed in two overlapping phases. The first phase will require the installation of a Rooftop Air Handling Unit to service the four floors in the South Tower, floors two (2) through five (5). The first floor contains our operating suite and is served by an independent air handling system, therefore, service is not required in this project.

The new Rooftop Air Handling Unit, including vertical risers enclosed in a chase, providing supply and return air to the existing floors, will be new construction to replace existing systems serving these individual floors. The existing air handling units serving these floors will be removed to provide for additional and improved program space for the Child and Adolescent Psychiatry program.

As this new unit is connected to the existing air distribution systems, the existing Mechanical Equipment Room, 1,374 sf, will be demolished for renovation for the new Child & Adolescent Psychiatry Unit. The demolition of this Mechanical Equipment Room allows for expanded program space for patient care. The space (of 3,893 sf) where the new child and adolescent psychiatry until will be located is currently being utilized for office space for Hospitalists. They will be relocated to an adjacent, partially vacant wing under this project. Approximately 1,746 sf is currently used for temporary Nursing Training space. This area will relocate to the same 4 East wing as construction commences. The remaining corridor system of 2,400 sf will be re-assigned and distributed for program space within the Child & Adolescent Psychiatry Unit.

Basic building utilities will be provided from the existing Physical Plant with the exception of the heating, ventilating and air conditioning which will be provided by the new Rooftop Air Handling

System. Plumbing systems, fire and life safety, normal and emergency power, voice and data systems will be extended from existing points within the south tower and connected to the services for the new Child & Adolescent Psychiatry Unit. All utility services exist within the existing hospital building and will be re-distributed for the renovated Child & Adolescent Psychiatry Unit.

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

9. CURRENT PHYSICAL CAPACITY AND PROPOSED CHANGES

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

Applicant Response

See Attachment 3 for TABLE PACKAGE for Table A: the bed capacity worksheet within the CON table package.

10. REQUIRED APPROVALS AND SITE CONTROL

A. Site size: 31 acres

B. Have all necessary State and local land use approvals, including zoning, for the project as proposed been obtained? YES_____ NO _____ (If NO, describe below the current status and timetable for receiving necessary approvals.)

Applicant Response

No change in zoning is required. The proposed renovations comply with local zoning codes in effect.

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

(1) Owned by: Peninsula Regional Medical Center
Please provide a copy of the deed.

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

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

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

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

11. PROJECT SCHEDULE

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

	Proposed Project Timeline	
Single Phase Project		
Obligation of 51% of capital expenditure from CON approval date	N/A	months
Initiation of Construction within 4 months of the effective date of a binding construction contract, if construction project	N/A	months
Completion of project from capital obligation or purchase order, as applicable	N/A	months
Multi-Phase Project for an existing health care facility (Add rows as needed under this section)		
One Construction Contract	12	months
Obligation of not less than 51% of capital expenditure up to 12 months from CON approval, as documented by a binding construction contract.	6	months
Initiation of Construction within 4 months of the effective date of the binding construction contract.	2	months
Completion of 1st Phase of Construction within 24 months of the effective date of the binding construction contract	4	months
Fill out the following section for each phase. (Add rows as needed)		
Completion of each subsequent phase within 24 months of completion of each previous phase	7	months
Multiple Construction Contracts for an existing health care facility (Add rows as needed under this section)		
Obligation of not less than 51% of capital expenditure for the 1st Phase within 12 months of the CON approval date	N/A	months
Initiation of Construction on Phase 1 within 4 months of the effective date of the binding construction contract for Phase 1	N/A	months
Completion of Phase 1 within 24 months of the effective date of the binding construction contract.	N/A	months
To Be Completed for each subsequent Phase of Construction		
Obligation of not less than 51% of each subsequent phase of construction within 12 months after completion of immediately preceding phase	N/A	months
Initiation of Construction on each phase within 4 months of the effective date of binding construction contract for that phase	N/A	months
Completion of each phase within 24 months of the effective date of binding construction contract for that phase	N/A	months

12. PROJECT DRAWINGS

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

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

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

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

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

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

Applicant Response

Please see Attachment 4 for Project Drawings**.**

13. FEATURES OF PROJECT CONSTRUCTION

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

Applicant Response

Please see Attachment 3 TABLE PACKAGE for Tables C & D**.**

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

Applicant Response

Water: The renovation project utilizes the existing water service within the hospital. No new service is required. The hospital is currently served via 2 potable water sources on individual meters serving the hospital complex. All buildings and systems are integrated for support and redundancy. Potable water is also available via outlets located on each level served by a well water system approved for potable use. As a note, an independent

system of wells is utilized for water support for our mechanical systems providing heating and air conditioning.

Electricity: The renovation project utilizes the existing power service within the hospital. No new service is required. Electricity is provided by Delmarva Power & Light via a 25,000 volt service with independent service feeds into a single primary switchgear. This service provides power to the entire complex as well. Emergency Generators are connected to the entire hospital electrical distribution system to provide back-up power, within ten (10) seconds as required by code, in the event of primary power failure. Also, supplemental normal power is provided via a Combined Heat and Power Plant operated by Unison Energy for Peninsula Regional Medical Center on our Property. This system provides 3.2 megawatts of electricity for our use independent of Delmarva Power & Light. This system also provides five hundred thousand (500,000) btuh of thermal energy in heat recovery from the generators for our power plants' use. Uninterruptible Power is provided by a centralized redundant UPS system and network distributed throughout the complex in all areas of all floors.

Sewage: The renovation project utilizes the existing sewage service within the hospital. No new service is required. The hospital is serviced by three individual sanitary sewer mains and connected risers throughout the complex.

Telephone: The renovation project utilizes the existing voice and data communication systems within the hospital. No new service is required. Our distribution network is supported by a primary computer center and a secondary center with full redundant capability. Our telephone system is a Virtual Private Network with components served by cloud storage.

Others: This unit will not require medical gases, though they are available in the distribution network throughout the complex in every area of every floor.

PART II - PROJECT BUDGET

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

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

Applicant Response

Please see Attachment 3 TABLE PACKAGE for Table E.

All estimates of the cost of the project assume current market conditions for hospital renovation, new construction and equipment. PRMC has utilized the expertise of in-house personnel with years of experience in the maintenance and repair of existing hospital plant resources of multiple vintages. When necessary, in-house experts have consulted with outside experts in architecture and design, engineering, construction cost estimating and project management. The project budget was developed with the assistance of Roland Binker, Associate Vice President and architect in charge from Callison/RTKL, Inc, Tim Edmondson, Project Manager, Whiting Turner Contracting Company and Tom Anderson, Executive Director for Facilities and Property Management of Peninsula Regional Medical Center. Roland Binker developed the project program, from data collected with Katherine Smith and Dr. William Cerrato of the PRMC Behavioral Health Department. This program data was developed into the Unit's floor plan. (See Attachment 4)

(A.1.a.(2) Fixed Equipment: Mechanical cost data for the Rooftop Air Handling Unit, was developed from similar historical data from both Whiting Turner and PRMC for similar project scope and air handling unit configuration.

(A.1.b.(1) Building: The Project Cost for the renovation of existing space was based on unit cost data acquired from the Whiting Turner historical data on construction of Psychiatric Inpatient Units.

(A.1.b.(3) Architect/Engineering Fees: Fee was developed as a percentage of total building renovation cost of twelve (12%) percent plus contingency.

(A.1.b.(4) Permits : This fee was calculated based on an average of three (3%) cost for permit review and issuance.

(A.1.c.(1) Movable Equipment: Other related costs such as Information Technology, Fixtures, Furnishings and Equipment were generated from historical data of similar projects completed by PRMC during the past five (5) years.

(A.1.c.(2) Contingency Allowance: This cost was calculated based on fifteen (15%) average historical contingency for PRMC projects.

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

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

   Steven Leonard, MBA, FACHE
   President/CEO
   Peninsula Regional Medical Center
   100 East Carroll Street
   Salisbury, MD 21801

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

   No

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

   No

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

   No

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

No

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

March 9, 2018
Date

Signature of Owner or Board-designated Official

President/CEO
Position/Title

Steven Leonard, MBA, FACHE
Printed Name

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

RESOLUTION OF THE BOARD OF TRUSTEES OF PENINSULA REGIONAL MEDICAL CENTER

WHEREAS, Peninsula Regional Medical Center (the "Medical Center") strives to improve the health of the communities it serves; and

WHEREAS, the Medical Center currently provides Inpatient, Intensive Outpatient, Partial Hospitalization Program Services and a fully staffed and secured 24/7 Behavioral Assessment Unit in the Emergency Department to the adult population; and Outpatient Services and a fully staffed and secured 24/7 Behavioral Assessment Unit in the Emergency Department for the child and adolescent population; and

WHEREAS, the most recent Community Health Needs Assessment has identified a need for Behavioral Health and Service providers; and

WHEREAS, services are extremely scarce on Maryland's Eastern Shore for the provision of Child and Adolescent Behavioral Health Services; and

WHEREAS, Peninsula Regional Medical Center is proposing to establish a new 15 bed Inpatient Child and Adolescent Behavioral Health Unit; and

WHEREAS, the Medical Center is applying to the Maryland Health Care Commission for a Certificate of Need; and

WHEREAS, the Medical Center filed a Letter of Intent on January 5, 2018 to apply to the Maryland Health Care Commission for a Certificate of Need.

IT IS NOW THEREFORE,

RESOLVED that the Board of Trustees of Peninsula Regional Medical Center acknowledge the need for Acute Inpatient Child and Adolescent Behavioral Health Services; and

RESOLVED that the Board of Trustees of Peninsula Regional Medical Center authorize the Medical Center to apply to the Maryland Health Care Commission for a Certificate of Need; and

RESOLVED that the Board of Trustees hereby empower the President/CEO and Executive Staff to utilize the resources of Peninsula Regional Medical Center and hereby endorse the Medical Center's Application for a Certificate of Need for the development of a new 15 bed Inpatient Child and Adolescent Behavioral Health Unit.

I HEREBY CERTIFY that the above is a true and exact copy of a Resolution duly moved, seconded and adopted at the regularly scheduled meeting of the Board of Trustees of Peninsula Regional Medical Center, held on February 1, 2018 for which notice had been properly given, and at which a quorum was present and voting.

Ryan McLaughlin, Secretary
Board of Trustees

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

INSTRUCTION: Each applicant must respond to all criteria included in COMAR 0.24.01.08G(3), listed below.

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

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

10.24.01.08G(3)(a). <u>The State Health Plan</u>.

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

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

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

COMAR 10.24.10 (ACUTE CARE HOSPITAL SERVICES CHAPTER)

.04 Standards

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

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

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

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

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

Applicant Response

Peninsula Regional Medical Center maintains a written policy regarding hospital charges. This policy is found at Attachment 6 and outlines PRMC's procedure for providing a representative list of services and charges; procedures for responding to individual requests and requirements for staff training to inquiries.

A list of representative changes is made available in written form, upon request or on our website by accessing https://www.peninsula.org/sites/default/files/average_charge_summary_website_qe_09-30-17.pdf

(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.

Applicant Response

PRMC maintains a written policy (See Attachment 7) for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. On page 3 under (c), of PRMC's policy titled *Uncompensated Care / Financial Assistance,* provides that preliminary eligibility will be made within 2 business days of receipt of a completed application.

(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.

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

Applicant Response

The written policy and related documentation at Attachment 8 provides multiple methods for distributing notice of information regarding our charity care policy. These include a phone number to call free of charge, postings in registration areas, the PRMC website, summary of the policy in the admission packet, and an annual notification in a local newspaper.

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

Applicant Response

As found on page 45 of the most recent report, *Maryland Hospital Community Benefit Report: FY2016 – Appendix F. FY 2016 Community Benefit Analysis* PRMC's total community benefit as a percent of total

operating expenses was 10.7%. This represented a total of $43,315,440 provided in community benefit. (See Attachment 9 for a copy of the report). PRMC's 10.7% was ranked as the 16th largest provider of community benefits out of the 52 facilities listed. The State's average total community benefit as a percent of total operating expenses was 9.5%.

(3) Quality of Care.
An acute care hospital shall provide high quality care.

(a) Each hospital shall document that it is:

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

(ii) Accredited by the Joint Commission; and

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

Applicant Response

Peninsula Regional Medical Center complies with all applicable federal, state and local health and safety regulations. Peninsula Regional Medical Center is licensed by the Maryland Department of Health and Mental Hygiene, is accredited by the Joint Commission, and is in compliance with the conditions of participation of the Medicare and Medicaid Programs. Documentation of PRMC's license and accreditation is found at Attachment 10.

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

Applicant Response

Quality is an important corner stone and recently, CMS has awarded Peninsula Regional Medical Center Five (5) stars for quality outcomes. The Maryland Health Care Commission has adopted new measures for the Maryland Hospital Evaluation Performance Guide, the standard as written is no longer applicable. The current Report accessed on March 6, 2018 at (https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13016) does not report quality measures that indicate a particular hospital's relative scores in quartiles, and one cannot determine with any precision if a hospital has reached a level of 90% compliance. The scoring format for the current Guide shows a hospital's rating in three categories, i.e,

"below average," "average," or "better than average," and its risk-adjusted rate.

As shown in Attachment 11, we have charted the current quality measures for PRMC, and the actions that PRMC is taking to improve its "below average" scores. Of the 68 measures applicable to Peninsula Regional Medical Center, only 7 were below the state average.

1. How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)

   As a framework for a woman-centered model of care, Peninsula Regional and obstetrician physician providers support VBAC (Vaginal Birth after Cesarean) in discussion with the patient. To improve the overall health outcomes for both mother and baby, a set of guidelines are emphasized to help sort out the complexities of birth after a cesarean. Factors for consideration in discussion with the patient for informed decision making include i.e. maternal age, BMI, previous spontaneous labor, prior vaginal birth, hypertension, shoulder dystocia, increased estimated baby weigh, short inter-pregnancy interval, preeclampsia, ethnicity, and type of uterine incision.

2. How often babies are born vaginally when the mother has had a C-section in the past (includes complications)

   A team centered approach is key as the obstetrician, nursing staff and patient review and discuss their options alternately weighing the benefits and risks (*C-section charts are used to determine if they are a potential candidate).* If the patient decides that they would like to trial labor, there is a consent that they have to sign noting all of the risks, including uterine rupture. If the baby is in vertex position and there are no maternal complications on admission to Labor and Delivery, the mother begins her trial of labor. The ultimate goal is to prevent the first C-section to reduce morbidity and mortality. The obstetricians have stated that they review the repeat. Providing clarity through education to patients is a cornerstone of Peninsula Regional's OB program with a message that having a vaginal birth after a C- section can be a safe choice for most women.

3. Patients in the hospital who got the flu vaccine if they were likely to get the flu

   Peninsula Regional maintains an Immunization team comprised of a multidisciplinary team across clinical, pharmacy, and administrative functions. The team has in place the following action plan:

   a) developed and shared with staff a Flu vaccine information and MAR documentation tips with one point lessons.
   b) improving the screening process within the EPIC electronic medical record so accurate counts

of patients who are likely to get the flu and have not received/refuse the vaccine are properly documented.

c) a manager report was created to real time visibility on patients.
d) conducting education sessions on proper vaccination protocols across the entire medical staff.
e) evaluating evidence based best practices and working with IT to implement decision support and hard stops to ensure vaccinations are addressed.

4. How often patients die in the hospital during or after pancreas surgery

In the past year Peninsula Regional has had a very low volume (8) of pancreatic surgery cases. Several were "Whipples" which have poor outcomes and prognosis. By the time these patients have surgery they are typically in Stage 4 and the probability for a good outcome is diminished.

Peninsula Regional continues to emphasize through its community health and wellness initiatives that early detection is key and that early screening methods are especially important. A blood test that identifies a specific substance in the blood that is highly indicative of cancer, such as the PSA test for prostate cancer is important. Unfortunately, pancreatic cancer is diagnosed primarily through the use of CT and MRI and currently there is no standard diagnostic tool or established early detection method for pancreatic cancer. *(Pancreatic Cancer Action Network)*

Peninsula Regional will share these outcomes with our Oncologists as we do with most all of these cases and continue to develop the most efficacious and quality driven plan for pancreatic surgery.

5. How often did doctors always communicate well with patients?

PRMC has implemented multidisciplinary rounds with our patients on each of the medical and surgical floors. This entails the entire care team (doctors, nurses, patient care managers, and ancillary as appropriate) having a discussion about each patient together so that the team is aligned on the plan for the day. Then the provider (physician or APP) provides that communication to the patient. From that plan, the nurses document on the patient's white board, the key goals for the day related to the plan as well as the anticipated discharge dates so the family members can be prepared ahead of time for discharge. This action item came initially from the Service Excellence team, but then we formed a Discharge Team who found that the existing rounds were not occurring regularly, so they have implemented it with a new focus and will be monitoring compliance.

6. How often was the area around patients' rooms always kept quiet at night?

   PRMC has developed a team around this who identified that "noise at night" included visual noise of lights along with sound. This team implemented standard work for noise at night which included offering the patients eye shields, tea or water, and ear plugs. They also shut the patient's door (if the patient agrees to do so). PCU and ICU have implemented "quiet times" during the day when they turn the lights down and ask that visitors and personnel avoid interrupting the patient's rest during these times. Lastly, the Clinical Quality Specialists for the maternity unit did a DMAIC project on nightly interruptions and they were able to modify their care processes so that interruptions in the new mother's sleep were reduced through the night.

   Hospital-wide, a change in visitor policy has been implemented. Visiting hours are 8:00 a.m. to 8:00 p.m. and patients and guests are asked to silence their cell phones after 8:00 p.m.

7. How long patients who came to the emergency department with broken bones had to wait before receiving pain medication?

   In an effort to improve the arrival time to medication time for patients with bone fractures presenting to the ED, PRMC has implemented the following initiatives:

   - Collected a comprehensive list of patients that were coded as having a bone fracture and presenting through the ED.
   - Identified ED providers to determine trends and provide additional education as appropriate.
   - Further analyzed the data to determine the time intervals where we were deficient and the time in which most patients received their medications (ie: 15-30 min after arrival, 30-45 minutes etc.)
   - Identified which patients arrived by EMS and were medicated prior to arrival by EMS that impacted the measure by showing a longer time between arrival to medication.

   This measure continues to be monitored and a standing agenda item at our fragility fracture team monthly meeting

PRMC is consistent with the intent of this standard.

B. Project Review Standards

The standards in this section are intended to guide reviews of Certificate of Need applications and exemption requests involving acute hospital facilities and services. An applicant for a Certificate of Need must address, and its proposed projects will be evaluated for compliance with, all applicable review standards. An applicant for a Certificate of Need exemption must address, and its proposed project will be evaluated for consistency with, all applicable review standards.

(1) Geographic Accessibility.

A new acute care general hospital or an acute care general hospital being replaced

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

Applicant Response

The proposed project does not involve a new hospital or an existing hospital being relocated to a new site. The inpatient psychiatric hospital services to be provided at PRMC for children and adolescents are not included among the services which shall be within 30 minutes under normal driving conditions for 90 percent of the population in PRMC's service area. This Standard is not applicable.

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

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

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

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

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

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

Applicant Response

PRMC is not proposing to add MSGA or Pediatric hospital beds as part of this project. All of the beds in the unit will be designated as acute care hospital psychiatric beds. Therefore, this standard does not apply.

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

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

(a) The hospital is located more than 30 minutes travel time under normal driving conditions from a hospital with a pediatric unit; or

(b) The hospital is the sole provider of acute care general hospital services in its jurisdiction.

Applicant Response

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

(4) Adverse Impact.

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

(a) If the hospital is seeking an increase in rates from the Health Services Cost Review Commission to account for the increase in capital costs associated with the proposed project and the hospital has a fully-adjusted Charge Per Case that exceeds the fully adjusted average Charge Per Case for its peer group, the hospital must document that its Debt to Capitalization ratio is below the average ratio for its peer group. In addition, if the project involves replacement of physical plant assets, the hospital must document that the age of the physical plant assets being replaced exceed the Average Age of Plant for its peer group or otherwise demonstrate why the physical plant assets require replacement in order to achieve the primary objectives of the project; and

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

Applicant Response

The Applicant notes neither section (a) nor (b) is applicable to this Project. The charge per case methodology is not applicable to hospitals operating under the Global Budgeted Revenue system. The proposed project to be undertaken by PRMC will not have an unwarranted adverse impact on hospital charges, availability of services, or access to services. The financial assumptions supporting TABLE G. assume a rate increase related to the costs of the proposed project. The magnitude of that rate increase will be determined in consultation with the Health Services Cost Review Commission.

The proposed Project is to establish and operate an inpatient psychiatric unit for children and adolescents and to renovate a wing located in an existing building on the PRMC campus to house this unit.

The project does not eliminate any services. The proposed Project will improve access for indigent and or uninsured patients living in the proposed service area of the PRMC.

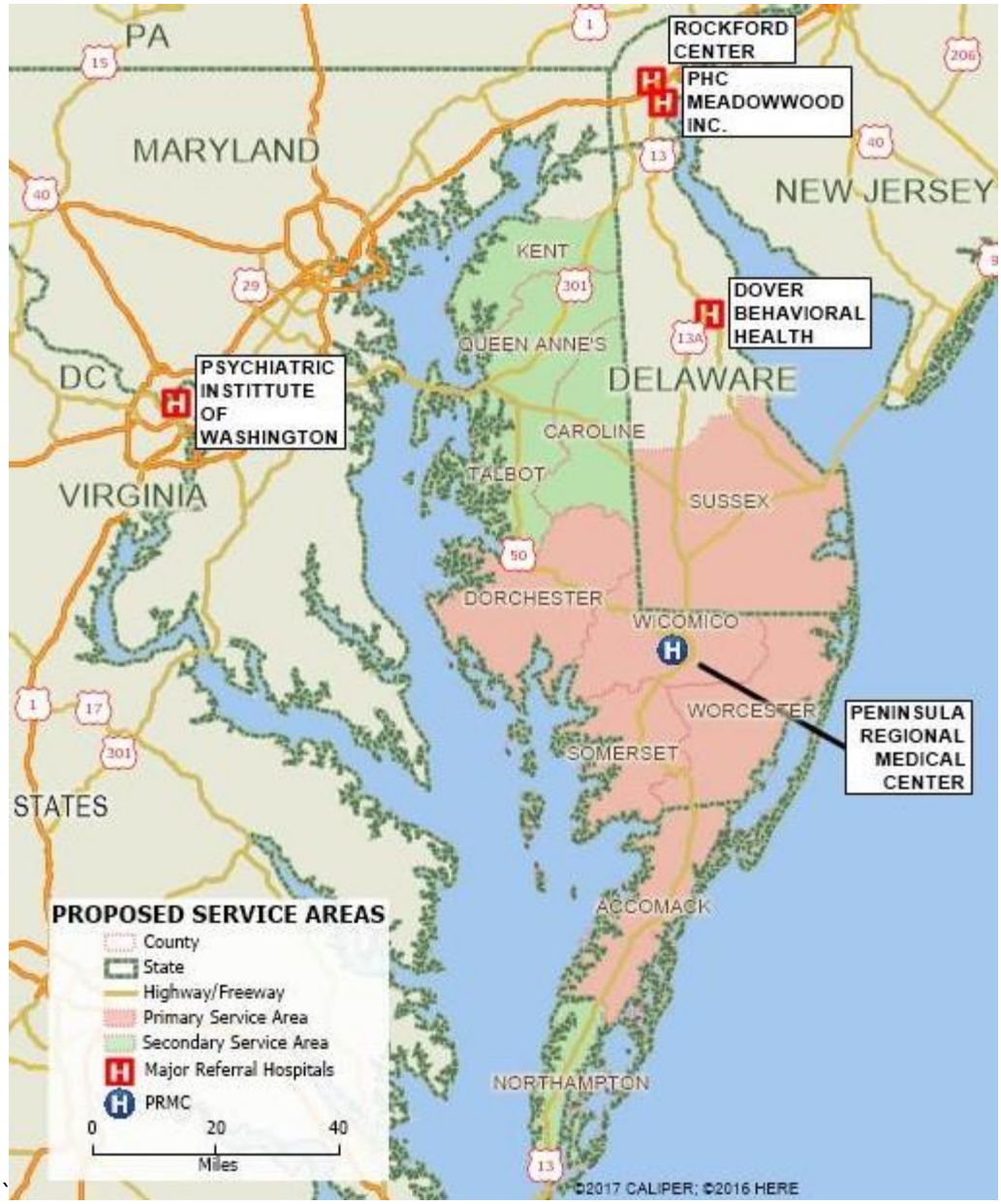
In the past, and currently, children and adolescents who are identified as requiring inpatient hospital psychiatric admission utilize hospitals located outside the lower Eastern Shore region, including hospitals on Maryland's Western Shore, in Washington, D.C. and in Delaware.

PRMC has maintained records of children and adolescents who have presented for psychiatric care in its Emergency Room, and have been transferred to out-of-area hospitals for admission.

The data derived from these records are presented and discussed under (6) Burden of Proof Regarding Need.

It is anticipated that the proposed inpatient hospital unit at PRMC for children and adolescents will significantly diminish if not eliminate the number of referrals and transfers that will be made to these out-of-area hospital providers. And because these young patients are chronically mentally ill, their psychiatric care will be ongoing, and involve multiple outpatient care providers in the primary and secondary service areas of PRMC. (See MAP 1 below)

We also anticipate that referrals and direct admits to the PRMC psychiatric unit by community providers will increase, as the inpatient hospital service's reputation for excellence, quality care, and good outcomes becomes well-established, particularly among behavioral health professionals, pediatricians and other primary care practitioners. The projections of hospital admissions, patient days and bed occupancy for the proposed 15-bed unit are shown at TABLE I. Statistical Projections – New Facility or Service, Attachment 3.



(5) Cost-Effectiveness.

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

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

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

Applicant Response

PRMC management considered and rejected two alternatives to the proposed project: 1) Do Nothing, and continue to refer children and adolescents (C&A) to out-of-area hospitals for acute inpatient

treatment or 2) establish its inpatient unit by relocating PRMC's existing Special Care Nursery (SCN) from its current location, renovating existing vacant space in the Hospital for a new SCN, and the renovating the space vacated by the relocated SCN for the 15-bed inpatient C&A psychiatric unit. PRMC management did not consider the alternative of building a freestanding psychiatric hospital in light of the available space on the PRMC campus. As discussed below, the chosen alternative is the most cost-effective alternative in comparison to the rejected alternatives.

The primary objectives to be achieved with this project are to:

1. enhance access to care for children and adolescent residing on the Lower Eastern Shore, including those resident of Maryland, Delaware and Virginia.
2. strengthen the established network of outpatient service providers currently serving the community, and
3. eliminate the delays and barriers associated with transferring children and adolescents who present with acute psychiatric conditions at the PRMC Emergency Department and require hospitalization.
4. replace the hospital inpatient treatment capacity once provided on the Lower Eastern Shore at the Adventist HealthCare Health and Wellness Hospital.
5. establish inpatient psychiatric services for children and adolescents to complement the existing inpatient service for adults

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

Applicant Response

The capital cost estimates for the project considered and rejected are approximately $9.1 Million in comparison to the $8.5 Million project proposed in this Application.

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

Applicant Response

The rejected alternative of relocating PRMC's SCN would have delivered the same level of effectiveness. The basis for choosing the proposed project and rejecting the alternative project was the comparative capital cost savings of the proposed project.

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

Applicant Response

There were two alternatives that were considered by PRMC management, and both were practical approaches that provided an on-site location for the inpatient service, made use of available space without significant new construction, and were well integrated into PRMC's existing clinical programs. The distinguishing feature between the two alternatives was the capital cost estimates.

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

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

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

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

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

Applicant Response

This standard does not apply to this project.

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

Applicant Response

The purpose of the proposed project is to increase the availability and accessibility of inpatient hospital psychiatric care to the residents of the PRMC service area. Historically, the utilization of inpatient hospital services for the treatment of psychiatric disorders by children and adolescents has been largely seen in

Maryland hospitals located outside the Eastern Shore. This pattern of outmigration is one measure of the ineffectiveness of the health care system.

We have examined the available data to determine if the utilization of inpatient hospital services among children and adolescents on the Lower Eastern Shore is lower than the utilization of these same services by the Maryland population as a whole. At this time, because the discharge data sources only include Maryland hospitals, and not hospitals located in neighboring Delaware, estimating the service population's overall discharge rate is difficult because the Delaware hospitals do not report inpatient utilization publicly, and the service population of PRMC includes residents of Sussex County, Delaware, multiple Maryland counties, and two Virginia Eastern Shore counties.
For this reason, there is no way to accurately measure historical comparative utilization, and determine with precision if there is a difference in utilization rates

Our view is that any potential "gap" in utilization between the overall Maryland population and the population of the Lower Eastern Shore region could be a measure of unmet need. By increasing the availability and accessibility of these services over time, we fully expect the utilization of the proposed unit at PRMC could increase the discharge rate of residents of the PRMC service area for these services in Maryland hospitals, and therefore shrink the gap between what is needed and what has actually been provided to these residents in the past. Nevertheless, the historical utilization data does indicate sufficient volumes of care to address future patient care needs that have gone unaddressed at PRMC.

The need for these hospital services is addressed through the utilization of the proposed unit to be located in a vacant portion of an existing wing of a building located on the PRMC campus which will undergo significant renovations. The need to provide a dedicated space for inpatient beds for children and adolescents at PRMC has emerged as a planning priority on the lower Eastern Shore following the closure of the Adventist HealthCare Health and Wellness Hospital. This project for the proposed unit continues the development of the campus as a site for cost-effective and accessible inpatient hospital services.

In order to provide a sufficient number of rooms and beds for children and adolescents needing inpatient hospital psychiatric services, PRMC conducted a review of available utilization data for residents of the service area.

First, PRMC reviewed its own data to measure the numbers and types of patients served at PRMC that could benefit from the proposed unit. Currently, children and adolescent patients with mental health

disorders and treatment needs present in the PRMC Emergency Department. For children and adolescents who have required immediate admission to an inpatient psychiatric unit, referrals to an existing hospital unit that is willing and able to take a new patient has become increasingly difficult. This frequently results in patients “boarding” in the PRMC Emergency Department, many of whom are in crisis, and cannot be safely discharged into the community.

A review of the most current data from the PRMC indicates that between 2014 and 2017, 153 patients between the ages of 5 and 17 who presented at the PRMC Emergency Department and required admission for psychiatric treatment, were transferred to multiple hospitals in Maryland, Washington, D.C. and Delaware. (See Attachment 12). This pattern of utilization is an indication of unmet need, an accessibility barrier, and a measure of the ineffectiveness of the health care system. The proposed 15-bed inpatient unit will address these identified service needs.

Second, PRMC reviewed the most current data to determine the existing numbers of hospital discharges and patient days of care provided to residents of the service area, ages 5-17, in 2010 through 2017, the most recent Calendar Years for which data is available for both Maryland hospitals. These data indicated that on average there were over 370 discharges per year, over 3,400 patient days, and an average daily census of between 9 and 10 children and adolescent patients. As discussed above, these data are for Maryland hospitals only, and do not include any resident migration to non-Maryland hospitals. (See Attachment 13)

Discharges and Patient Days			12-month period ending 2 quarter								
Behavioral Health: Ages 5-17											
PSA Dorch, Somerset, Sussex DE, Wicomico, Worcester, Accomack											
			2010	2011	2012	2013	2014	2015	2016	Total	Average
MD Acute General		Discharges	9	6	11	14	10	13	5	68	10
		Pt. Days	134	14	68	112	86	112	22	548	78
		ALOS	14.89	2.33	6.18	8.00	8.60	8.62	4.40	8.06	8.06
PSA Dorch, Somerset, Sussex DE, Wicomico, Worcester, Accomack											
MD Psych Hospitals			2010	2011	2012	2013	2014	2015	2016	Total	Average
		Discharges	264	276	302	230	252	212	191	1727	247
		Pt. Days	2934	2122	2551	2092	2347	2025	2017	16088	2,298
		ALOS	11.11	7.69	8.45	9.10	9.31	9.55	10.56	9.32	9.32
PSA TOTAL											
ALL MD Hospitals			2010	2011	2012	2013	2014	2015	2016	Total	Average
		Discharges	273	282	313	244	262	225	196	1795	256
		Pt. Days	3068	2136	2619	2204	2433	2137	2039	16636	2,377
		ALOS	11.24	7.57	8.37	9.03	9.29	9.50	10.40	9.27	9.27
SSA Northampton VA, Kent, Caroline, QA, Talbot											
MD Acute General			2010	2011	2012	2013	2014	2015	2016	Total	Average
			10	6	14	16	11	18	10	85	12
			41	25	69	142	82	114	51	524	75
			4.10	4.17	4.93	8.88	7.45	6.33	5.10	6.16	6.16
SSA Northampton VA, Kent, Caroline, QA, Talbot											
MD Psych Hospitals			2010	2011	2012	2013	2014	2015	2016	Total	Average
		Discharges	124	113	112	81	74	104	126	734	105
		Pt. Days	1343	872	981	807	796	995	1255	7049	1,007
		ALOS	10.83	7.72	8.76	9.96	10.76	9.57	9.96	9.60	9.60
SSA TOTAL											
ALL MD Hospitals			2010	2011	2012	2013	2014	2015	2016	Total	Average
		Discharges	134	119	126	97	85	122	136	819	117
		Pt. Days	1384	897	1050	949	878	1109	1306	7573	1,082
		ALOS	10.33	7.54	8.33	9.78	10.33	9.09	9.60	9.25	9.25
SSA+PSA TOTAL											
ALL MD Hospitals			2010	2011	2012	2013	2014	2015	2016	Total	Average
		Discharges	407	401	439	341	347	347	332		373
		Pt. Days	4,452	3,033	3,669	3,153	3,311	3,246	3,345		3,458
		ALOS	10.94	7.56	8.36	9.25	9.54	9.35	10.08		9.26

With respect to the demand for these proposed inpatient services at PRMC, given the likelihood that the C&A Psych Unit will not address all of the needs of the PRMC service area residents, and the potential for some double-counting among the discharges reported by Maryland hospitals and the estimated the number of patients transferred from the PRMC Emergency Room to Delaware hospitals, our best estimate of the total bed need at PRMC for the C&A Psych Unit, is based on the following assumptions:

1. PRMC will achieve a 75% Maryland hospital market share among the PSA residents for PRMC's C&A Psych Unit discharges, and 35% Maryland hospital market share among the SSA residents. The remainder will continue to be admitted to other hospitals outside the Lower Eastern Shore region.
2. 100% of the estimated number patients transferred from the PRMC emergency room to other hospitals, including Delaware hospitals, will be admitted to the C&A Psych Unit.
3. The ALOS of the C&A Psych Unit will be 9.26 days; the same ALOS reported by Maryland hospitals for behavioral health patients age 0-17 residing in the PSA and SSA during 2010 – 2016 periods.
4. 15% of the total C&A Psych Unit admissions will be residents from outside the PSA and SSA.

The statistical demand estimates for the proposed unit currently are shown below:

TABLE 3. Bed Need Estimates for C&A Pyschiatric Service at PRMC

Service Area	ADC	@ 99% Availablity	@ 71.4% Occupancy
PSA	4.88		
SSA	1.04		
PSA+SSA	5.92	12	8
Outside	1.28		
Transfers	1.33		
TOTAL	8.53	15	12

We anticipate by FY 2023, the total average daily census will increase from 8.53 to 9.47 during the "ramp up" period for the new service:

	FY 2020	FY 2021	FY 2022	FY 2023
Discharges	100	225	335	373
Patient Days	926	2,084	3,102	3,458
Average Daily Census	2.54	5.69	8.50	9.47
Beds	15	15	15	15
Occupancy Rate	16.91%	37.96%	56.66%	63.16%

(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 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.

Applicant Response

The renovations to be undertaken will involve the two existing wings located in the East Tower and the South Tower on the PRMC campus. The estimated cost of the project is approximately $8.5 Million, of which $6.4 Million are for renovations and fixed equipment. The project will take between six and twelve months to complete prior to occupancy and first use.

On a square footage basis, these renovation construction costs estimates are well below the costs of new hospital construction estimated by the Marshall and Swift Valuation (MVS) Quarterly. For example, the MVS standards estimated for recently approved new construction projects for Maryland hospitals has been well over $300 per BGSF.

Because the estimated costs per square foot for renovation proposed for the project are below the limitations set forth in the MVS Guide, the Project is consistent with this Standard. No shell space will be created in this Project. Shown below and at Attachment 5 are the cost calculations for the project:

Calculator Method

Renovations+ Air Handler Rooftop Construction

MVS Base Square Foot Cost*	$374.00
Heating Cooling Ventilation	0
Elevator Deduction	-$8.51
TOTAL	$365.49
Multipliers	
Number of Stories	N/A
Height per Story	
Floor Area Perimeter Multiplier	0.94
Combined	0.94

Refined Square Foot Cost	$343.56
Current Cost Multiplier	1.01
Local Multiplier	0.99
Final Square Foot Cost	$343.53
Project Area Allocation (Square Feet)*****	19,395
MVS Cost Standard**	$6,662,691.50
PRMC Cost Estimate***	$5,447,325.00
Difference (Savings)	-$1,215,366.50

*Class A, Good "General Hospital" Construction
**Costs Estimated as of 1/2018
***Excudes Movable Equipment
****See TABLE E. Project Budget – Attachment 3
*****See TABLE B. Dept. Gross Sq. Ft. – Attachment 3

(8) Construction Cost of Non-Hospital Space.

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

Applicant Response

This standard is inapplicable because the Project does not involve the 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.

Applicant Response

The space planned for the psychiatric unit to be addressed in this project is 391 NSF/bed, less than 500 square feet per bed. Therefore, the project is consistent with the 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.

Applicant Response

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

(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

Applicant Response

The proposed inpatient unit will be housing a new service, not replacing or expanding an existing service. The planning and design of the project did not include any specific efficiency improvements with respect to the inpatient psychiatric treatment of children and adolescents. The availability of the unit on the PRMC campus is likely to improve the efficiency of admissions, particularly for patients who currently must be transferred to another hospital from the Emergency Department. Because the 15-bed unit will be located adjacent to but separate from the existing 13-bed unit for adult, the renovation floor plan provides for 629 NSF of shared space.

(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

Applicant Response

The project does not replace or expand existing diagnostic or treatment facilities, but rather makes productive use of existing renovated space to provide a new program and inpatient unit on the PRMC campus.

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

Applicant Response

PRMC is currently an efficient hospital and will remain an efficient hospital following completion of the project. To the extent possible, the planning and design of the project in an existing hospital building took potential efficiency improvements into account, but these cannot be quantified in a manner that would clearly demonstrate significant cost savings, when the operational and capital costs of the improved space, additional personnel and other needed resources proposed for the unit is taken into account as well.

Because PRMC will become a larger hospital, with additional available square footage in its physical plant for patient care being made available for a new patient care service, PRMC's operational expenses will increase with respect to heating and cooling, maintenance, housekeeping, and other "overhead" expenses. Additional FTEs will be added to the hospital's existing employees increasing hospital costs and requiring additional revenues as shown on TABLE L. WORKFORCE, found at Attachment 3.

At the same time, the inability to provide an inpatient psychiatric service for children and adolescents on the existing PRMC campus, including nine additional patient rooms for the 15 beds, demonstrate a lack of alternatives for efficiently providing needed the inpatient care days being proposed. As a result of these deficiencies, the hospital cannot address patient needs efficiently and must "board" mentally ill patients in its Emergency Department awaiting transfers to other facilities, depend on treatment services obtained from an multiple out-of-area hospitals, manage transfers and admissions to other hospitals and service providers of patients who require inpatient services, and increase the rate of re-admissions for lack of continuity of care. All of these limitations at PRMC add to the costs of care.

In our view, incurring the additional expenses associated with supporting the increased number of patients who will benefit from the proposed unit on the PRMC campus, will be balanced with the possible improvements in operational efficiency and improvements in the overall patient care experience at PRMC.

In review of the building design, the team wanted to address the following key precepts in the discussions:

- Highest and best use of site
- Long term facility use and renewal

- Functional zoning within the campus
- Patterns for traffic, parking, and way-finding
- Patterns of organization and development of internal circulation and movement
- Phasing of development
- Integration with themed and natural elements
- Space available when and where it needs to be
- Strategic plan for clinical growth within the built environment
- Dynamic integration of clinical services, operational enhancements and calculated growth layouts
- Efficient special use to maximize patient safety, minimize steps for clinical staff, and allow for the highest efficient use of space.

The project reflects the following factors:

- The net to gross ratio is at a reasonable floor efficiency factor for the renovated space.
- The unit consists of a 15-bed nursing unit, public spaces, support spaces and office spaces.
- The unit is approximately 391 NSF, (See Attachment 14) and is therefore under the 500 NSF requirement. (See Attachment 4 for the floor plan of the proposed unit).
- Portions of the unit are separated to provide distinct treatment spaces for children and adolescent patients.
- The remaining 5,376 SF is to be used for offices, circulation and support spaces.
- The unit design allows for the separation of the children and adolescents.
- The layout of the bed unit is in a triangular-shape due to the existing building configuration. While somewhat of a challenge, this plan provides for a centralized nursing station between the Children's area and Adolescent area for segregated observation and control. This also allows the group areas to be located proximal to the associated groups living spaces. Staff and support spaces are arranged to buffer the entrance and visitors waiting areas from the patient care area for optimal use of space.
- The unit allows for security and protection of patients due to the entry portal (Sally port) extending from the entry of the South wing with an extended corridor to the Child and Adolescent inpatient space with an additional controlled entry point. PRMC maintains a card access control system which employs proximity access control in our staff and employees identification badge. Each Identification badge is individually programmed for access based on

the areas they work or are required to provide service. The associated locking systems provide magnetic locking for higher levels of control and security.

- PRMC also maintains a full time Protection Services department staffed with licensed Special Police officers who provide continuous rotating patrols throughout all areas of the building, including the new Child and Adolescent Psychiatric Inpatient Unit. These officers are trained for interaction with all patients, visitors and employee needs.

(12) Safety.

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

Applicant Response

Patient safety is always at the forefront of the design of any patient unit. With respect to an inpatient psychiatric unit, in additional to normal patient safety issues, protecting patients from hurting themselves or the staff is critical. Considerations given to the design of PRMC's inpatient unit for children and adolescents include:

- Line of sight from a central, caregiver work area that allows a single staff member to view central corridors that provide entry into the unit, patient rooms and other patient areas to track the movement of patients. Alcoves, cross corridors, etc. that would allow a patient to hide, and attack staff or cause harm to themselves have been eliminated from the design.
- From the central nursing station, other key areas including the required dayroom can also be monitored.
- The level of patient safety design required for each of the spaces within the unit will be based on the generally accepted three zone (high, medium and low) risk analysis to establish the parameters for the extent of patient safety required. As an example, the patient room and bathroom is a very high risk zone as the patient will be alone in that space. On the other hand, staff offices are considered a low risk as patients will not be in the space unattended.
- Ligature proofing the patient room will be a major focus, eliminating any possible means for patients to hang or harm themselves.
- The design will incorporate recommendations from the New York State Office of Mental Health, Patient Safety Standards, Materials and Systems Guidelines. This document is generally used on a

national level due to its comprehensiveness in analyzing and recommending a wide range of products and systems appropriate for use in mental health facilities.

- Staff safety will also be provided to the extent possible utilizing duress alarms and safe rooms that a staff member can escape to if they lose control of a patient and are in danger. A safety program will be further developed by PRMC.
- Furniture, Fixtures and Equipment will be utilized that are specifically designed to create a calm, safe environment for the patient while providing the necessary safety features specifically designed to address the needs of the behavioral health patient.
- Finally, although patient and staff safety cannot be compromised, the design of the unit will incorporate colors, materials, daylight and other means to create a non-institutional environment.

(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.

Applicant Response

A comprehensive statement of assumptions is included in Attachment 3, Complete TABLE package, which includes projected Revenue and Expenses (TABLES G. and H.), financial assumptions, and Work Force Information (TABLE L.)

The chart on the following page outlines the assumptions used for Revenues and Expenses.

Peninsula Regional Medical Center
Summary of Inflation Assumptions
FY 2019 Model

file: PRMC Model assumptions.xls

	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023
Inflation Update Factor I/P	2.00%	2.50%	2.50%	2.50%	2.50%
Inflation Update Factor O/P-Regulated	2.00%	2.50%	2.50%	2.50%	2.50%
Inflation Update Factor O/P-Unregulated	1.00%	1.00%	1.00%	1.00%	1.00%
Inflation factor Salaries	2.50%	2.50%	2.50%	2.50%	2.50%
Inflation factor Temp Labor	2.50%	2.50%	2.50%	2.50%	2.50%
Inflation factor Supplies	2.75%	2.75%	2.75%	2.75%	2.75%
Weighted volume factor	100.00%	100.00%	100.00%	100.00%	100.00%
Impact to supplies if Volume increases	75% of Increase	75% of Increase	75% of Increase	75% of Increase	75% of Increase
Impact to supplies if Volume decreases	60% of Decrease	60% of Decrease	60% of Decrease	60% of Decrease	60% of Decrease

(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;

Applicant Response

The utilization projections shown on Attachment 3, TABLE I. are based on the historic utilization of service among residents of the PRMC service area population. (See Attachment 13 for the data showing historic utilization of Maryland hospitals for the inpatient psychiatric services provided to children and adolescents.)

(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;

Applicant Response

All revenue estimates are based on current charge levels. Allowances, bad debt and provision for charity

care are based on PRMC's adult psychiatric service line. Additionally, allowances were forecasted higher than the adult population in anticipation of denials related to the age cohort of the proposed service.

(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

Applicant Response

Staff and overall expense projections are consistent with those experienced at PRMC.

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

Applicant Response

PRMC is anticipated to generate excess revenues over total expenses if utilization forecasts for the proposed service are achieved. (See Attachment 3)

(14) Emergency Department Treatment Capacity and Space.

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

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

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

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

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

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

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

Applicant Response

N/A

(15) Emergency Department Expansion.

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

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

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

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

Applicant Response

N/A

(16) Shell Space.

Unfinished hospital space for which there is no immediate need or use, known as "shell space," shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective. If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that considers the most likely use identified by the hospital for the unfinished space and the time frame projected for finishing the space. The applicant shall demonstrate that the hospital is likely to need the space for the most likely identified use in the projected time frame.

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

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

Applicant Response

N/A

10.24.01.08G(3)(b). Need.

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

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

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

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

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

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

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

Applicant Response

The need for the proposed project is demonstrated by the numbers of residents of the Lower Eastern Shore in Maryland, Virginia and Delaware between the ages of 5 and 17 who require acute hospital treatment in a safe and secure psychiatric unit. These residents comprise the primary and secondary service areas of the proposed service.

The estimates and projections of the proposed service area population whose residents will benefit from the availability and future utilization of these services at PRMC are shown below:

Primary Service Area Counties	Year	5-9	10-14	15-17	All Age Cohorts		Secondary Service Area Counties	Year	5-9	10-14	15-17	All Age Cohorts		Total PSA + SSA
	2015							**2015**						
Dorchester		2,055	1,963	1,010	**5,028**		Caroline		2,371	2,498	1,223	**6,092**		
Somerset		1,133	1,221	1,331	**3,685**		Kent		987	973	758	**2,718**		
Wicomico		6,349	6,412	5,262	**18,023**		Queen Anne's		3,009	3,408	1,822	**8,239**		
Worcester		2,412	2,818	1,558	**6,788**		Talbot		1,987	2,175	1,089	**5,251**		
Sussex, Delaware		12,187	11,553	6,653	**30,393**		Northampton, Va.		407	322	203	**932**		
Accomack, Va		923	1,015	526	**2,464**		**TOTAL**		**8,761**	**9,376**	**5,096**	**23,233**		**89,614**
TOTAL		**25,059**	**24,982**	**16,340**	**66,381**			**2020**						
	2020						Caroline		2,063	2,657	1,418	**6,138**		
Dorchester		1,975	2,234	1,199	**5,408**		Kent		898	1,030	893	**2,821**		
Somerset		1,069	1,188	1,529	**3,786**		Queen Anne's		2,704	3,226	1,905	**7,835**		
Wicomico		5,706	6,592	5,486	**17,784**		Talbot		1,856	2,132	1,232	**5,220**		
Worcester		2,284	2,843	1,658	**6,785**		Northampton, Va.		595	654	350	**1,599**		
Sussex, Delaware		11,902	12,648	7,105	**31,655**		**TOTAL**		**8,116**	**9,699**	**5,798**	**23,613**		**93,891**
Accomack, Va		1,852	1,921	1,085	**4,858**			**2030**						
TOTAL		**24,788**	**27,426**	**18,064**	**70,278**		Caroline		2,503	2,448	1,388	**6,339**		
	2030						Kent		844	907	800	**2,551**		
							Queen Anne's		3,201	3,077	1,649	**7,927**		
Dorchester		2,073	2,154	1,252	**5,479**		Talbot		2,038	2,047	1,117	**5,202**		
Somerset		1,348	1,278	1,390	**4,016**		Northampton, Va.		556	606	313	**1,475**		
Wicomico		6,921	6,554	5,122	**18,597**		**TOTAL**		**9,142**	**9,085**	**5,267**	**23,494**		**94,329**
Worcester		2,602	2,905	1,660	**7,167**									
Sussex, Delaware		11,906	12,132	7,432	**31,470**									
Accomack, Va		1,585	1,631	890	**4,106**									
TOTAL		**26,435**	**26,654**	**17,746**	**70,835**									

Source: Maryland Department of Planning.
Source: Delaware Population Consortium.
Source (Virginia): 2015 Estimates, United States Census Bureau; 2020 and 2030 Projections,
Demographics Research Group, Weldon Cooper Center for Public Service, June 2017.

As discussed under State Health Plan Standard (6) Burden of Proof Regarding Need, utilization statistics for this population for hospital admissions for inpatient psychiatric services indicate that most pediatric patients are treated at private, freestanding psychiatric hospitals, and at acute care general hospitals outside the Maryland counties of the Lower Eastern Shore. In addition, pediatric patients who present at PRMC Emergency Department are transferred in most cases to Delaware hospitals. Because Delaware hospitals do not report their utilization statistics publicly, computations of comparative use rates of the service area population cannot be made. We have assumed that average annual number of hospital discharges reported for the period 2010 – 2017 among service area residents will remain constant through FY 2023 for this patient population, or increase slightly as the referral patterns for this regional service show a preference among community providers and patients to use the services of PRMC as a more accessible alternative.

With respect to the demand for these proposed inpatient services at PRMC, given the likelihood that the C&A Psych Unit will not address all of the needs of the PRMC service area residents, and the potential for some double-counting among the discharges reported by Maryland hospitals and the estimated the number of patients transferred from the PRMC Emergency Room to Delaware hospitals, our best estimate of the total bed need at PRMC for the C&A Psych Unit, is based on the following assumptions:

1. PRMC will achieve a 75% Maryland hospital market share among the PSA residents for PRMC's C&A Psych Unit discharges, and 35% Maryland hospital market share among the SSA residents. The remainder will continue to be admitted to other hospitals outside the Lower Eastern Shore region.
2. 100% of the estimated number patients transferred from the PRMC emergency room to other hospitals, including Delaware hospitals, will be admitted to the C&A Psych Unit.
3. The ALOS of the C&A Psych Unit will be 9.26 days; the same ALOS reported by Maryland hospitals for behavioral health patients age 0-17 residing in the PSA and SSA during 2010 – 2017 periods.
4. 15% of the total C&A Psych Unit admissions will be residents from outside the PSA and SSA.

The statistical demand projections for the proposed unit are shown at Attachment 3, TABLE I.

10.24.01.08G(3)(c). <u>Availability of More Cost-Effective Alternatives</u>.

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

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

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

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

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

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

Applicant Response

PRMC management considered and rejected two alternatives to the proposed project: 1) Do Nothing, and continue to refer children and adolescents (C&A) to out-of-area hospitals for acute inpatient treatment or 2) establish its inpatient unit by relocating PRMC's existing Special Care Nursery (SCN) from its current location, renovating existing vacant space in the Hospital for a new SCN, and the renovating the space vacated by the relocated SCN for the 15-bed inpatient C&A psychiatric unit. As discussed below, the chosen alternative is the most cost-effective alternative in comparison to the proposed alternative.

The primary objectives to be achieved with this project are to:

1. enhance access to care for children and adolescent residing on the Lower Eastern Shore,
2. strengthen the established network of outpatient service providers currently serving the community, and
3. eliminate the delays and barriers associated with transferring children and adolescents who present with acute psychiatric conditions at the PRMC Emergency Department and require hospitalization.

Currently, there are no inpatient psychiatric units or programs located on Maryland's Eastern Shore, and children and adolescents who need inpatient psychiatric services have been referred to Maryland hospitals outside the service area of PRMC, or to hospitals located in Delaware. At times, transferring children and adolescents to out-of-area hospitals for acute inpatient admission has involved multiple delays and difficulties, particularly in the PRMC Emergency Department. Because PRMC is a tertiary care facility offering the full range of hospital services on the Delmarva Peninsula, and has historically only provided inpatient mental health services to adults, it is only logical that its inpatient services be expanded to address the mental health needs of children and adolescents as well. The proposed unit will address this gap in service availability and accessibility.

While the lower Eastern Shore is served by a network of existing outpatient mental health providers, there remains a significant gap in the availability and accessibility of inpatient hospital services for children and adolescents. These gaps have become increasingly apparent as the data showing historical utilization indicate that these needed services have been provided in hospitals located on Maryland's Western Shore and in Delaware hospitals. Hospital management, in responding to the needs of the community, determined that continued outmigration of lower Eastern Shore residents was a sub-optimal result for these patients and their families. The communities of the Lower Eastern Shore have come to depend on the resources of PRMC for almost all other pediatric hospital specialty services, including pediatric medical and surgical services. From a "population health" perspective, PRMC is the one

institution that has taken on the responsibility of providing needed institutional health care services to the poor and rural residents of the region. For this reason, the initiation and operation of a regional inpatient acute psychiatric unit at the Eastern Shore's pre-eminent tertiary care hospital would be consistent with its goals and objectives of addressing the full-range of specialized inpatient services for children and adolescents.

As discussed under **10.24.01.08G(3)(d). Viability of the Proposal,** providers of outpatient mental health services for children and adolescents have endorsed this project, acknowledge its contribution to strengthening the network of mental health providers on the Lower Eastern Shore, and see the benefits of its accessibility and utilization for their clients and patients.
In order to accomplish these objectives, PRMC proposes to renovate and upgrade sufficiently large and medically appropriate space for the 15-bed unit in the South Tower on the PRMC campus.

First, 8,038 DGSF of vacant and currently unoccupied space located on the fourth floor of the PRMC East Tower will be renovated to provide office and support space for clinical personnel and nurse training programs. (See Attachment 4). These PRMC offices and training programs will be relocated to the fourth floor of the East Tower to free up space for the proposed 15-bed inpatient unit.

Second, once vacated, 9,983 DGSF of existing floor space on the third floor of PRMC's South Tower will be renovated, including a mechanical equipment room which currently houses obsolete air handling equipment. To replace this equipment, and free up additional floor space for the proposed unit, PRMC proposes to install a new air handling system, whose rooftop footprint will require 1,374 DGSF of new construction. The new air handling system and replacement ductwork will serve the second through the fifth floors of the entire South Tower, including the third floor where the new 15-bed inpatient unit will be located.

Approximately, 9,412 DGSF of the renovated space on the third floor will be dedicated to the proposed 15-bed children and adolescent unit, and 571 DGSF of space will be shared between the C&A unit and the existing 13-bed adjacent adult inpatient psychiatric unit. Thus, the total amount of new construction and renovation in both hospital locations is approximately 19,395 (8,038+9,412+571+1374=19,395) DGSF in both locations. 8,400 DGSF of the existing adult inpatient psychiatric unit will remain "as is." As shown on Table E. Project Budget, under Attachment 3, the total capital cost of the project is approximately $8.5M, of which $2M is for purchase and installation of the new air handler.

This plan for renovation and new construction was selected following a careful review of the physical space requirements of the proposed 15-bed inpatient psychiatric unit, the availability of suitable existing clinical space on the campus of PRMC, and cost of renovations. At no time was any consideration given to locating the unit at an off-site location requiring new and expensive hospital construction. No estimates of the capital costs for building a freestanding psychiatric hospital were prepared in comparison to the more cost-effective alternatives considered for locating the unit on the existing PRMC campus.

The alternative to the proposed project that was considered and rejected by PRMC management was to locate the proposed 15-bed inpatient unit on the fourth floor of the PRMC East Tower in space that is currently occupied by the Hospital's Special Care Nursery (SCN). This plan would have required three steps. First, 8,038 DGSF vacant and unoccupied space would be renovated for the SCN. Second, the entire SCN would then be relocated "across the hall" to the newly renovated space. Third, the space currently occupied by the SCN would be renovated for the 15-bed inpatient psychiatric unit for children and adolescents. The renovation cost of this plan was estimated to be $9.15 Million.

PRMC management reviewed this plan, and additional renovations necessary to correct a rainwater seepage problem in the East Tower, and determined that the three-step renovation plan envisioned in this alternative was not as cost-effective as the selected alternative plan. The additional capital cost of this alternative plan was simply excessive in comparison to the proposed plan.

The proposed floor plans and drawings showing the rejected alternative project is the last page within Attachment 4.

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

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

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

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

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

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

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

Applicant Response

1. See Attachment 3 PRMC's TABLE PACKAGE.
2. The proposed Project enjoys strong community support, as demonstrated by the many letters of support included in Attachment 20.
3. The performance requirements for this project are found at 10. PROJECT SCHEDULE. This will be a multi-phased project, under a single construction contract. PRMC does not anticipate any delays in implementation of the project and will meet the applicable performance requirements. PRMC is considering developing design documents for all phases of the renovations in anticipation of CON approval by the end of CY 2018. There will be no delays in obtaining sufficient financial support to obtain and obligate the budgeted funds for this Project. The fundraising campaign to support this project has commitments of $2 Million and a second phase of the campaign to reach a total of $4 Million will commence immediately upon CON approval, if not beforehand.
4. Please find at Attachment 15 a copy of the audited financial statements for the past two years for all entities and the parent company.

10.24.01.08G(3)(e). <u>Compliance with Conditions of Previous Certificates of Need</u>.

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

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

Applicant Response

Peninsula Regional Medical Center is in compliance with all conditions applied to previous Certificate of Need. Please see Attachment 16 for a list of projects.

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

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

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

a) On the volume of service provided by all other existing health care providers that are likely to experience some impact as a result of this project[1];

Applicant Response

It is anticipated that the proposed inpatient hospital unit at PRMC for children and adolescents will significantly diminish if not eliminate the number of referrals and transfers that will be made to out-of-area hospital providers, including some Maryland and Delaware hospitals. And because these young patients are chronically mentally ill, their psychiatric care will be ongoing, and involve multiple outpatient care providers in the primary and secondary service areas of PRMC.

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

Applicant Response

We also anticipate that referrals and direct admits to the PRMC psychiatric unit by community providers will increase, as the inpatient hospital service's reputation for excellence, quality care, and good outcomes becomes well-established, particularly among behavioral health professionals, pediatricians and other primary care practitioners in the Lower Eastern Shore region. The projections of hospital admissions, patient days and bed occupancy for the proposed 15-bed unit are shown at TABLE I. Statistical Projections – New Facility or Service, Attachment 3.

c) On costs to the health care delivery system.

Applicant Response

We assume that the overall costs to the health care system will not change as a result of implementing this project. Because the proposed unit will be rate-regulated, revenues for the proposed services will be

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

included in the GBR approved by the HSCRC in the future. Discussions with the HSCRC staff regarding any adjustment to PRMC's GBR will be ongoing during the course of this CON application's review **.**

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

Applicant Response

In summary, the market share of PRMC relative to other hospitals located out of State and out of the Region is likely to increase commensurate with the improved access to and utilization of behavioral health services provided to child and adolescent residents of the Lower Eastern Shore Region.

COMAR 10.24.07 (Psychiatric Services Chapter)

Standard AP 1a

The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

Applicant Response

There is no published bed need projection in effect for child and adolescent psychiatric beds, and the need projection methodology of the State Health Plan is recognized as obsolete. For this reason, PRMC has prepared a needs assessment for its proposed 15-bed child and adolescent inpatient unit based on its review of utilization data of Maryland and District of Columbia hospitals by residents of the hospital's service area. This needs assessment shows that children and adolescent residents of the service area migrate to distant hospitals well in excess of travel times and distances applicable to residents of more populated urban and suburban communities in Maryland.

In addition, the discharge rates of these residents for the services being proposed indicates a gap in utilization between expected and actual utilization, an unmet need, that PRMC proposes to address. The needs assessment calls for reducing the "outmigration" to out-of-area Maryland, Delaware and District of Columbia hospitals. The projected discharges and patient days for the proposed 15-bed unit are expected to result in an occupancy rate which assures each patient in need access to services.

Please refer to the Applicant's Response to COMAR 10.24.01.08G(3)(b) for the Applicants complete response to AP 1a.

Standard AP 1b

A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

Applicant Response

This standard does not apply because there are no delicensing requirements in effect.

Standard AP 1c

The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

(i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;

(ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;

(iii) that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and

(iv) that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant.

Applicant Response

This standard is not applicable because this project does not involve the addition of hospital conversion beds.

Standard AP 1d

Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need", as defined, who sign a written agreement with the Mental Hygiene administration as described in part (i) and (iii) of Standard AP 1c.

Applicant Response

This standard does not apply to this project because this application is not being reviewed comparatively with another application.

Standard AP 2a

All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.

Applicant Response

PRMC has develop written procedures for providing psychiatric emergency treatment 24 hours a day, 7 days a week with no exceptions. These procedures are found at Attachment 17.

Standard AP 2b

Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

Applicant Response

PRMC's child and adolescent inpatient psychiatric unit will be an emergency facility designated by the DHMH to perform evaluations as specified in the standard. The unit will be locked for the treatment of involuntary patients.

Standard AP 2c

Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

Applicant Response

PRMC's Emergency Rooms has emergency holding bed capabilities and a seclusion room. In addition, the child and adolescent inpatient unit will have a seclusion room available. See Attachment 18 for Policy: Restraints/Seclusion/Alternative to Restraints for PRMC Administration Policy Manual.

Standard AP 3a

Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response

PRMC's child and adolescent acute inpatient services will include services required by this standard.

Standard AP 3b

In addition to the services mandated in Standard 3a, inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Applicant Response

In addition to the proposed 15-bed acute psychiatric unit for children and adolescents addressed in this application at this time, PRMC provides child and adolescent psychiatric services on an outpatient basis. These include outpatient clinical programs located on the PRMC campus. PRMC will provide a multidisciplinary treatment team. Children and adolescent age groups will each have their own separate physician environment space to meet treatment needs.

Standard AP 3c

All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicant Response

PRMC will provide psychiatric consultation services as a component of its proposed 15-bed child and adolescents inpatient psychiatric unit.

Standard AP 4a

A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Applicant Response

PRMC is proposing one unit with 2 separate and distinct spaces for the treatment of psychiatric patients. Six patient rooms in the adolescent space comprised of 10 beds and 3 rooms in the child space comprised of 5 beds. No bed conversions are being contemplated at this time, and PRMC recognizes that such a bed conversion would require a separate Certificate of Need.

Standard AP 4b

Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

Applicant Response

A distinction is being made between the adolescent (13 and over) and the child (12 and under) patient groups. The physical spaces are completely separate from each patient group. Clinical programming will be consistent with the standard for both patient groups.

Accessibility

Standard AP 5

Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

- **(i) intake screening and admission;**
- **(ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or**
- **(iii) necessary evaluation to define the patient's psychiatric problem and/or**
- **(iv) emergency treatment.**

Applicant Response

PRMC will make available all of the services required by this standard as applicable to the operation of an inpatient acute psychiatric unit for children and adolescents.

Standard AP 6

All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations, including children, adolescents, patients with secondary diagnosis of substance abuse, and geriatric patients, either through direct treatment or referral.

Applicant Response

PRMC intends to provide inpatient psychiatric services to children and adolescents in a separately designated unit from its existing inpatient unit for adults. The existing quality assurance programs of PRMC, program evaluations and treatment protocols in effect at the Hospital and applicable to the existing services to be provided, will be expanded to include those pertinent to the proposed inpatient unit.

Standard AP 7

An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

Applicant Response

PRMC proposes to admit patients without regard to their legal status.

Standard AP 8

All acute general and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12-month period.

Applicant Response

PRMC expects that the level of uncompensated care for children and adolescent psychiatric inpatients will be substantially equivalent to that experienced at the hospital for its existing inpatient pediatric services. PRMC will provide a percentage of uncompensated care for child and adolescent psychiatric patients tied to the percentage of additional gross patient revenue approved for this new service by the Health Services Cost Review Commission (HSCRC). We anticipate that the percentage approved for the proposed unit will be consistent with the average level of uncompensated care of all hospitals in Maryland which provide similar services.

Standard AP 9

If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric

bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

Applicant Response

This standard does not apply to this project because the proposed inpatient unit is for children and adolescents.

Cost

Standard AP 10
Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.

Psychiatric Bed Range (PBR)	Occupancy Standard
PBR<20	80%
20 ≤ PBR < 40	85%
PBR > 40	90%

Applicant Response

This standard does not apply because the proposed project is not an expansion of an existing child and adolescent acute psychiatric unit.

Standard AP 11
Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (≤ 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Applicant Response

The standard does not apply because PRMC is applying to develop and operate a 15-bed acute psychiatric unit to be located in a general acute care hospital. The age-adjusted average total cost for an acute (<30 days) psychiatric admission at PRMC will be comparable to the age-adjusted average total cost for an admission to other acute care general hospitals that provide similar services.

Quality

Standard AP 12a
Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicant Response

The inpatient psychiatric services provided to children and adolescents at PRMC will be under the clinical supervision of a qualified psychiatrist who will serve as its Medical Director. Please find attached at Attachment 19 a copy of Dr. Cerrato's CV.

Standard AP 12b
Staffing of acute inpatient psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven-day per week treatment program.

Applicant Response

The staffing plan for the PRMC inpatient unit for children and adolescents is shown on TABLE L., Attachment 3, which includes all of the regular and contracted employees for the unit that will be open and available seven days per week and on weekends. After-care coordinators will ensure that patients who are discharged without a private therapist will be given referrals for follow-up treatment. Group and individual therapy will be provided seven days per week on the unit.

Standard AP 12c
Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Applicant Response

All clinical staff will be licensed professionals who have training and experience in working with the acuity needs of the respective populations

Continuity

Standard AP 13
Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicant Response

PRMC will develop written policies governing discharge planning and referrals between its program for child and adolescent inpatient psychiatric treatment and a full range of other services, including inpatient, outpatient, long term care, aftercare treatment programs, and alternative treatment programs.

The continuum of care envisioned at PRMC will include outpatient services for children and adolescents. Other services needed by PRMC's patients may be made available through referrals.

Acceptability

Standard AP 14
Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);
(ii) the local community mental health center(s);
(iii) the Department of Health and Mental Hygiene; and
(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Applicant Response

Please find attached at Attachment 20 letters of acknowledgement and support.

AFFIRMATION

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

[signature]	3-02-2018
Name	Date

AFFIRMATION

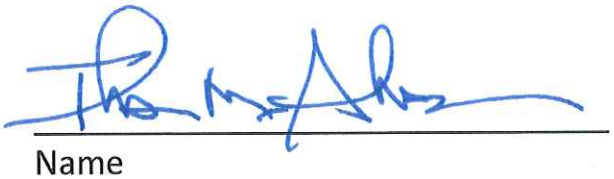
I hereby declare and affirm under the penalties of perjury that the facts stated in the foregoing Certificate of Need Application and its attachments are true and correct to the best of my knowledge, information and belief.

Jonathan L. Tutchell — Name

3/9/2018 — Date

AFFIRMATION

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



Name

3-9-2018

Date

AFFIRMATION

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

Roland M. Sinha — Name

MARCH 9, 2018 — Date

AFFIRMATION

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

RT Coughlin
Name

3/9/18
Date

AFFIRMATION

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

Name

3/9/2018
Date

AFFIRMATION

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

Henry Myco

Name

3/09/2018

Date

AFFIRMATION

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

Name

3.9.18

Date