GALLAGHER
EVELIUS & JONES LLP
ATTORNEYS AT LAW

July 13, 2018

VIA HAND DELIVERY

Ms. Ruby Potter
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Request for Certificate of Exemption from CON Review
Merger and Consolidation of UM SMC at Dorchester and UM SMC at Easton

Dear Ms. Potter:

On behalf of Shore Health System, Inc. *d/b/a* University of Maryland Shore Medical Center at Easton and University of Maryland Shore Medical Center at Dorchester (collectively, the "Applicant"), we are submitting six copies of its Request for Certificate of Exemption from CON Review and related exhibits, along with one set of full-size project drawings. Also enclosed is a CD containing searchable PDF files of the Request and exhibits, a Word version of the application, and native Excel spreadsheets of the MHCC tables.

I hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agencies as noted below.

Please sign and return to our waiting messenger the enclosed acknowledgment of receipt.

Sincerely,

Thomas C. Dame

Sincerely,

Mallory Regenbogen

TCD/MMR:blr
Enclosures

#633466
012516-0006

cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development
Suellen Wideman, Esq., Assistant Attorney General
William Chan, Health Policy Analyst, HSP&P/CON
Roger L. Harrell, MHA, Health Officer, Dorchester County Health Department
Scott LeRoy, MPH, MS, Health Officer, Caroline County Health Department
Fredia Wadley, MD, Health Officer, Talbot County Health Department
Pat Gainer, Acting Co-Executive Director, Maryland Emergency Medical Services Systems
Kenneth D. Kozel, President & CEO, UM Shore Regional Health
Robert Frank, Sr. Regional V.P., Operations, UM Shore Regional Health
William Huffner, M.D., Sr. V.P., Medical Affairs & Chief Medical Officer, UM Shore Regional Health
Ruth Ann Jones, Sr. V.P., Patient care Services & Chief Nursing Officer, UM Shore Regional Health
Patti Willis, Sr. V.P., Strategy & Communications, UM Shore Regional Health
JoAnne Hahey, Chief Financial officer, UM Shore Regional Health
Brian Leutner, MBA, Executive Director, UM Shore Medical Center at Dorchester
Alicia Cunningham, V.P. for Reimbursement & Revenue Advisory Services, UMMS
Michael Wood, Sr. Director of Reimbursement, UMMS
Alison Brown, Sr. V.P. & Chief Strategy Officer, UMMS
Donna Jacobs, Sr. V.P., Government, Regulatory and Community Health, UMMS
Mark L. Wasserman, Sr. V.P., External Affairs, UMMS
Kristin Jones Bryce, Vice President, External Affairs, UMMS
Megan Arthur, Senior Vice-President & General Counsel, UMMS
Sandra H. Benzer, Esq., Associate Counsel, UMMS
Brian Sturm, Senior Director, Financial and Capital Planning, UMMS
Michael Meisel, Manager, Financial and Capital Planning, UMMS
Darryl Mealy, V.P. of Construction & Facilities Planning, UMMS
Jeannette Cross, Managing Director, Berkeley Research Group, LLC
Josh Repac, Berkeley Research Group, LLC
Craig Wheeless, Director, Health Care Advisory Services, KPMG, LLP
Garo Ghazarian, KPMG, LLP
David Klahn, Vice President, HKS, Inc.
Andrew L. Solberg, A.L.S. Healthcare Consultant Services

IN THE MATTER OF	*	
	*	
THE MERGER AND CONSOLIDATION OF	*	BEFORE THE
	*	
UNIVERSITY OF MARYLAND	*	MARYLAND HEALTH CARE
	*	
SHORE MEDICAL CENTER AT DORCHESTER	*	COMMISSION
	*	
AND UNIVERSITY OF MARYLAND	*	No. _____
	*	
SHORE MEDICAL CENTER AT EASTON	*	
	*	

* * * * * * * * * * * * * *

NOTICE OF INTENT TO SEEK EXEMPTION FROM CERTIFICATE OF NEED REVIEW FOR THE MERGER AND CONSOLIDATION OF CERTAIN BEDS AND SERVICES OF UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT DORCHESTER AND UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT EASTON

Shore Health System, Inc. ("SHS"), doing business as University of Maryland Shore Medical Center at Easton ("UM SMC at Easton") and University of Maryland Shore Medical Center at Dorchester ("UM SMC at Dorchester") (collectively, the "Applicant"), by the undersigned counsel, provides notice that it is seeking approval from the Maryland Health Care Commission to merge and consolidate UM SMC at Dorchester and UM SMC at Easton by relocating UM SMC at Dorchester's inpatient services to UM SMC at Easton.

For the reasons set forth in the attached Request for Exemption, the Applicant respectfully requests that the Commission grant an exemption from Certificate of Need ("CON") review for the merger and consolidation of UM SMC at Dorchester and UM SMC at Easton and for associated capital expenditures.

Respectfully submitted,

Thomas C. Dame
Gallagher Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore MD 21201
(410) 727-7702

Mallory M. Regenbogen
Gallagher Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore MD 21201
(410) 727-7702

Attorneys for Shore Health System, Inc.

July 13, 2018

IN THE MARYLAND HEALTH CARE COMMISSION

REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW

to

Merge and Consolidate Certain Beds and Services of
University of Maryland Shore Medical Center at Dorchester and
University of Maryland Shore Medical Center at Easton

Applicant

Shore Health System, Inc.
d/b/a UM Shore Medical Center at Dorchester
and UM Shore Medical Center at Easton

July 13, 2018

TABLE OF CONTENTS

REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW
TO MERGE AND CONSOLIDATE
UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT DORCHESTER AND
UNIVERSITY OF MARYLAND SHORE MEDICAL CENTER AT EASTON

Shore Health System, Inc. ("SHS"), doing business as University of Maryland Shore Medical Center at Easton ("UM SMC at Easton") and University of Maryland Shore Medical Center at Dorchester ("UM SMC at Dorchester") (collectively, the "Applicant"), by its undersigned counsel, seeks approval from the Maryland Health Care Commission (the "Commission") to relocate medical/surgical/gynecological/addictions ("MSGA") [1] and psychiatric beds from UM SMC at Dorchester to UM SMC at Easton pursuant to a merger and consolidation of these two facilities in accordance with COMAR 10.24.01.02(A)(3)(c) and 10.24.01.04(A)(3)-(5). For the reasons set forth below, the Applicant respectfully requests that the Commission grant an exemption from Certificate of Need ("CON") Review.

BACKGROUND

UM SMC at Dorchester is an acute care hospital with 18 licensed MSGA beds and 24 licensed psychiatric beds located at 300 Byrn Street, Cambridge, Maryland 21613. UM SMC at Easton is a 104-bed licensed acute care hospital, with 79 MSGA beds, 17 obstetrics beds, and eight pediatric beds, located at 219 South Washington Street, Easton, Maryland 21601. UM SMC at Dorchester is the only acute general hospital in Dorchester County and UM SMC at Easton is the only acute general hospital in Talbot County.

[1] The Applicant uses the term "MSGA" throughout this application since it is used in the Acute Care Hospital Services State Health Plan Chapter, however, UM SMC at Dorchester does not presently have any designated gynecologic or addictions beds.

In 1996, The Memorial Hospital at Easton (now known as UM SMC at Easton) merged with Dorchester General Hospital (now known as UM SMC at Dorchester) to form SHS, a unified network of medical services with the combined resources of community hospitals, physicians, and outpatient centers. In 2006, SHS affiliated with the University of Maryland Medical System ("UMMS"), and, as of July 1, 2013, SHS joined with the University of Maryland Chester River Health System at Chestertown to become University of Maryland Shore Regional Health, Inc. ("UM SRH"), a community based, not-for-profit health system. These consolidations have permitted UM SRH and UMMS to continue their commitment to the rural five county mid-Eastern Shore of Maryland region, with expanded and improved clinical services, programs and facilities, and physician recruitment. UM SRH is the sole corporate member of SHS. UM SRH is dedicated to maintaining and improving the health of the people in the communities it serves through an integrated health delivery system that provides the highest quality of care to all.

In addition to UM SMC at Dorchester and UM SMC at Easton, UM SRH consists of: (1) UM SMC at Chestertown, a 21-bed acute care hospital, with 20 MSGA beds and one pediatric bed located at 100 Brown Street, Chestertown, Maryland 21620; (2) The Requard Rehabilitation Center, a 20-bed inpatient acute rehabilitation special hospital currently located at UM SMC at Easton; (3) UM Shore Emergency Center at Queenstown ("UM Shore EC Queenstown"), a freestanding medical facility located at 125 Shoreway Drive, Queenstown, Maryland 21658; (4) UM SRH Cancer Center and Requard Radiation Oncology Center located in Easton approximately one mile from UM SMC at Easton; (5) The Diagnostic and Imaging Center and Clark Comprehensive Breast Center located in Easton approximately one mile from UM SMC at Easton; (6) a network of diagnostic laboratory and/or imaging facilities located in Denton,

Centreville, Cambridge, and Chestertown; (7) outpatient rehabilitation centers located in Denton, Cambridge, and Easton; and (8) a regional network of employed primary care and specialty physicians and providers in all five counties of the mid-Shore region.

The existing UM SMC at Dorchester was constructed in phases between 1906 and 1960, with numerous renovations and improvements throughout the years. Although UM SRH has been committed to maintaining the facility and has undertaken capital expenditures to make infrastructure, clinical equipment, and information technology improvements, the existing physical plant has outlived its useful life. As discussed more fully herein, renovation of the facility is not cost-effective and the approximately 11 acre site on the waterfront in Cambridge is more suitable today for redevelopment benefitting the City of Cambridge and Dorchester County, and their economic development and job creation efforts. Relocation and continuation of UM SMC at Dorchester as an acute general hospital was considered, but this option was determined not to be cost effective and would be inconsistent with the direction of the State of Maryland's health care planning for hospital utilization.

The Applicant proposes to relocate 17 medical/surgical/critical care beds and 12 psychiatric beds and incorporate these beds into the existing hospital at UM SMC at Easton, approximately 15 miles away. In addition to this Request for Exemption from CON review, the Applicant has sought a Request for Exemption to convert UM SMC at Dorchester to a freestanding medical facility ("FMF") to be developed approximately one mile from the existing hospital at an easily accessible, highly visible site within Cambridge Marketplace, at the intersection of US Route 50 and Woods Road and opposite the City of Cambridge's Public Safety Center. The proposed project resulting from the conversion of UM SMC at Dorchester to

an FMF will be referred to as the "University of Maryland Shore Medical Center at Cambridge" ("UM SMC at Cambridge").

Upon conversion of UM SMC at Dorchester to an FMF, there will be loss of MSGA and psychiatric bed capacity in Dorchester County. The Commission projects a minimum need of 106 MSGA beds for Talbot and Dorchester Counties in 2025, and a maximum bed need of 137 MSGA beds. *Maryland Register*, v. 44, Issue 2 (Jan. 20, 2017). UM SMC at Easton is presently licensed for 79 MSGA beds and UM SMC at Dorchester is presently licensed for 18 MSGA beds. As discussed more fully herein, the Applicant has projected a need to relocate 17 of UM SMC at Dorchester's current licensed inventory of 18 MSGA beds to UM SMC at Easton for a combined total of 96 MSGA beds, which is less than the minimum bed need projected for Dorchester and Talbot Counties in 2025. The Applicant has also projected the need to relocate 12 of UM SMC at Dorchester's current licensed inventory of 24 adult psychiatric beds to UM SMC at Easton to ensure continued access to needed inpatient psychiatric services for residents of Dorchester, Talbot, Caroline, Kent, Queen Anne's, and Anne Arundel Counties.

To accommodate the beds to be relocated from UM SMC at Dorchester, UM SMC at Easton will renovate portions of Levels 2, 3, 4, and 5 of its existing facility. The Behavioral Health Unit will be relocated to Level 3 and the 17 additional MSGA beds will be added to existing nursing units on Levels 2, 3, and 4. In order to accommodate the relocated beds, pediatric and maternity overflow beds and rehabilitation support space will be relocated to Level 5 of the facility. The proposed renovations will be designed in accordance with applicable building codes and the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals and Outpatient Facilities 2014 Edition ("FGI Guidelines"). A more detailed

description of the project appears below and **Exhibit 2** includes the existing and proposed floor plans of the areas being renovated.

DISCUSSION

Maryland Code, Health-General § 19-120(j)(2) permits a hospital to increase the volume of one or more health care services if the proposed change: (i) is pursuant to the merger of two or more health care facilities, (ii) is not inconsistent with the State Health Plan; (iii) will result in the delivery of more effective and efficient health care services, and (iv) is in the public interest. Similarly, COMAR 10.24.01.02(A)(3)(c) provides that a CON is not required to change the bed capacity of a hospital if the change in bed capacity is "proposed pursuant to a merger or consolidation between health care facilities" and the Commission finds that the change is not inconsistent with the State Health Plan, will result in the delivery of more efficient and effective health care services, and is in the public interest. The Commission may also exempt the requirement of CON review and approval for capital expenditures, changes in bed capacity, and changes in the scope of health care services offered by a health care facility if done as part of a consolidation or merger of two hospitals. Health-General § 19-120(k)(6)(v); COMAR 10.24.01.04(A)(3)-(5).

Health-General § 19-120(a)(2) defines "consolidation" or "merger" to include "increases or decreases in bed capacity or services among the components of an organization that: (i) operates more than one health care facility[.]" "Health care facility" is defined to include a "hospital." COMAR 10.24.01.01(B)(12). "Health care service means any clinically related patient service," including a "medical service." Health-General § 19-120(a)(3)(i)-(ii). A

"medical service" includes medicine, surgery, gynecology, addictions, and psychiatry. *Id*. § 19-120(a)(5); COMAR 10.24.01.01(B)(27).

Because UM SMC at Dorchester and UM SMC at Easton are both owned and operated by SHS, the relocation of MSGA and psychiatric bed capacity from UM SMC at Dorchester to UM SMC at Easton constitutes a consolidation or merger in accordance with Health-General § 19-120(a)(2) and COMAR 10.24.01.02(A)(3)(c). Further, the proposed MSGA and psychiatric bed relocation and associated capital expenditures are not inconsistent with the State Health Plan, will result in the delivery of more efficient and effective health care services, and are in the public interest.

I. COMPREHENSIVE PROJECT DESCRIPTION

As discussed above, the proposed project is the companion to the Applicant's recently submitted request for a CON exemption for the conversion of UM SMC at Dorchester to an FMF. The project involves the relocation of 17 MSGA beds and 12 psychiatric beds from UM SMC at Dorchester to UM SMC at Easton coincident with the conversion of UM SMC at Dorchester to an FMF.[2]

The project involves incremental additions to existing patient units to accommodate the 17 MSGA beds that are planned to relocate from UM SMC at Dorchester to UM SMC at Easton. The floor plans included in **Exhibit 2** identify the current use of all rooms and configuration along with the layout of the proposed project. Some former patient rooms are no longer used as

[2] Also, on September 7, 2018, the Applicant intends to submit a CON application to replace and relocate UM SMC at Easton to a new site owned by the Applicant near the Easton Airport, approximately three miles from the existing hospital campus. The 17 MSGA beds and 12 psychiatric beds relocated from UM SMC at Dorchester will be included in the proposal to relocate UM SMC at Easton.

inpatient rooms, but could be reinstated as they still have the required plumbing and infrastructure. Other areas have been converted to a new function and configuration and will require some renovation to meet all regulatory requirements.

The Applicant proposes to relocate five MSGA beds to Level 2, seven MSGA beds to Level 3, and five MSGA beds to Level 4. The Applicant proposes to move all 12 of the relocated psychiatric beds to Level 3. Most of the displaced functions that need to be retained at the hospital will be accommodated on an existing administrative floor located on Level 2 of the Central wing. The executive administration team currently occupying the space will be relocating off site, allowing the back fill of this space for these displaced functions. As the displaced functions are generally administrative in nature, it is assumed that minimal renovation would be required to accommodate the enabling moves.

Level 2 Changes

For the five MSGA beds to be located on Level 2, there are two locations where former patient rooms are currently being used as a Sleep Room and an office. The Sleep Room is no longer required, and the office function is being accommodated in existing shared office space. The other three MSGA beds to be located on this floor will require the relocation of UM Ambulance services to the vacated central administrative area on Level 2.

Level 3 Changes

Level 3 is the location for the proposed Behavioral Health Unit, consisting of the 12 relocated psychiatric beds. This move will be accommodated by the reduction and relocation of existing pediatric beds. The census for inpatient pediatric care is very low and can be accommodated with a reduction to three beds. The Applicant plans to move these three pediatric beds to Level 5 adjacent to the existing Labor and Delivery Unit. This area is already secure and

has the staff with the required skill set to care for pediatric patients. As pediatric census is often lower than three, this also allows these beds to flex as labor and delivery ante and postpartum beds as the census on the unit fluctuates. Additional space on Level 3 is currently assigned for the Children's Advocacy Center (CAC) and the sleep laboratory. Through an agreement with the Talbot County Department of Social Services, the CAC space is utilized to provide forensic sexual assault exams to child abuse victims in order to improve community response to child abuse in Talbot, Dorchester, Queen Anne's, Kent, and Caroline counties. The CAC and sleep laboratory will be relocated to accommodate space for the 12-bed Behavioral Health Unit and its required support space and three of the seven MGSA beds to be added to Level 3. Three additional MGSA beds will be accommodated with the relocation of cardiology offices to the Level 2 Central wing administrative area. The seventh MSGA bed to be added to this floor will be accommodated by the relocation of an office at the end of the unit that currently is occupied by three employees reporting to Care Transitions to allocated space on Level 2 Central wing.

Level 4 Changes

The Applicant plans to house the remaining five relocated MGSA beds on Level 4. These beds will be located in an area that was previously used for patient rooms but was converted to a wound care center. The wound care center has been relocated off site already and the space is currently being used for administrative functions by the Care Transition Team and Clinical Information Management. The Applicant proposes to relocate these functions to the administrative space being vacated on Level 2 Central so the area can be converted back to patient rooms. The space that had been used for the hyperbaric chambers for wound care is currently functioning as rehabilitation office space and is proposed to move to Level 2 Central wing.

Level 5 Changes

Level 5 renovations, as discussed above, are planned to accommodate the relocation of three pediatric beds from the existing unit on Level 3. To enable this move, the Applicant proposes to reduce the size of the Requard Rehabilitation Unit, which is currently located adjacent to the Labor and Delivery Unit. The patient census of this unit has declined over the years.[3] The applicant proposes to reduce the rehabilitation bed count from 20 to 15 beds. This bed reduction allows for the relocation of the activity and dayroom space that currently is located outside the rehabilitation unit to be brought within the unit and provide vacated space directly adjacent to the Labor and Delivery Unit and the desired location for the pediatric beds.

Staffing for the beds planned to be moved from UM SMC at Dorchester to UM SMC at Easton will be achieved through the UM SRH transition plan for the conversion of UM SMC at Dorchester to an FMF. Staff will be moved from UM SMC at Dorchester.

Project Budget and Schedule

The total project budget is $8,517,265. The proposed project, as well as the other capital projects for which the Applicant is seeking approval from the Commission, will be funded through bonds and interest income on bond proceeds. Construction of the proposed project is projected to take approximately twelve months. The inpatient beds will not relocate from UM SMC at Dorchester until the new FMF building in Cambridge is complete and opens, which should occur by summer of 2021.

---

[3] The inpatient rehabilitation service was established as a 20-bed unit. However, the average daily census has declined in recent years to about 9.1. The census was greater when the unit opened due to a strong volume of joint replacement patients referred for inpatient rehabilitation. Today, many of these patients are treated in an outpatient setting.

The Applicant has provided project drawings at **Exhibit 2**. The Applicant has also completed hospital CON Tables A through L, which are attached as **Exhibit 1**.

II. THE RELOCATION OF MSGA BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON IS NOT INCONSISTENT WITH THE STATE HEALTH PLAN CHAPTER FOR ACUTE HOSPITAL SERVICES.

The relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is not inconsistent with the State Health Plan Chapter for Acute Hospital Services, COMAR § 10.24.10.04 (the "State Health Plan"). Because this portion of the proposed project only involves the relocation of MSGA beds, the applicants have not addressed the standards that are applicable to pediatric and obstetrics beds, emergency department expansion, and other inapplicable sections of the State Health Plan.

A. 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:

SHS's policy, implemented at both UM SMC at Dorchester and UM SMC at Easton, relating to transparency in health care pricing complies with this standard and is attached as **Exhibit 3**. The most recent list of representative charges is attached as **Exhibit 5** and can also be

found on UM SRH's website at the following link: https://www.umms.org/shore/patients-visitors/for-patients/billing-insurance.

B. Charity Care Policy

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

(a) The policy shall provide:

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

(ii) Minimum Required Notice of Charity Care Policy.

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;

2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital; and

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

(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:

SHS's financial assistance policy, implemented at both UM SMC at Easton and UM SMC at Dorchester, complies with this standard and is attached as **Exhibit 5**. The policy states that UM SMC at Easton and UM SMC at Dorchester will make a determination of probable

eligibility within two business days following a patient's request for charity care services, application for medical assistance, or both. (*See* **Exhibit 5**, p. 5).

Notices regarding the availability of financial assistance are posted in the admissions offices, the business offices, and emergency departments of the two hospitals, and notice of financial assistance is provided at admission or preadmission to each person who seeks services in the hospitals. A copy of that notice is attached as **Exhibit 6**. An annual notice regarding UM SRH's financial assistance policy is also published in the *Star Democrat, Bay Times, Times Record, Kent County News, Dorchester Star, and Record Observer*. Copies of recent newspaper notices are attached as **Exhibit 7**.

As shown in Table 1 below, neither UM SMC at Easton nor UM SMC at Dorchester are in the bottom quartile in terms of percentage of charity care to total operating expense for acute general hospitals in the State of Maryland.

Table 1
HSCRC Community Benefit Report, Data Excerpts
FY2017

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Holy Cross Hospital	$413,796,889	$31,396,990	7.59%	1st Quartile
Garrett County Hospital	$46,818,203	$2,792,419	5.96%	
St. Agnes	$433,986,000	$21,573,282	4.97%	
Doctors Community	$193,854,072	$6,756,740	3.49%	
Adventist Washington Adventist*	$219,120,045	$7,442,497	3.40%	
Western Maryland Health System	$322,835,314	$10,385,555	3.22%	
UM Prince Georges Hospital Center	$286,955,092	$9,166,191	3.19%	
Mercy Medical Center	$464,031,500	$14,411,600	3.11%	
Holy Cross Germantown	$97,124,985	$2,819,650	2.90%	
Johns Hopkins Bayview Medical Center	$613,834,000	$16,951,000	2.76%	
UM Laurel Regional Hospital	$93,884,647	$2,521,365	2.69%	
UM Midtown	$204,226,000	$5,174,000	2.53%	

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Frederick Memorial	$350,118,000	$8,081,000	2.31%	2nd Quartile
UM Harford Memorial	$84,926,000	$1,927,000	2.27%	
Atlantic General	$117,342,233	$2,569,517	2.19%	
Ft. Washington	$42,883,433	$928,769	2.17%	
UM Baltimore Washington	$334,210,000	$6,703,000	2.01%	
Calvert Hospital	$135,047,535	$2,694,783	2.00%	
Peninsula Regional	$432,141,737	$8,301,400	1.92%	
McCready	$16,564,839	$307,205	1.85%	
UM St. Joseph	$341,335,000	$6,105,000	1.79%	
UM SMC at Dorchester	$42,909,000	$647,362	1.51%	
MedStar Harbor Hospital	$187,002,302	$2,816,043	1.51%	
Meritus Medical Center	$309,163,913	$4,596,841	1.49%	3rd Quartile
UM SMC at Easton	$190,646,000	$2,786,102	1.46%	
MedStar St. Mary's Hospital	$168,757,516	$2,458,649	1.46%	
MedStar Good Samaritan	$282,735,786	$4,078,427	1.44%	
UMMC	$1,470,095,000	$20,308,000	1.38%	
Howard County Hospital	$260,413,000	$3,368,222	1.29%	
UM Charles Regional Medical Center	$117,918,178	$1,474,409	1.25%	
MedStar Southern Maryland	$243,629,886	$3,014,042	1.24%	
Lifebridge Northwest Hospital	$240,547,439	$2,734,207	1.14%	
Shady Grove*	$323,661,835	$3,646,551	1.13%	
Suburban Hospital	$283,346,000	$3,168,000	1.12%	
UM Upper Chesapeake	$284,219,000	$3,014,000	1.06%	
MedStar Franklin Square	$508,539,888	$5,147,814	1.01%	4th Quartile
MedStar Union Memorial	$443,482,532	$4,426,976	1.00%	
Johns Hopkins Hospital	$2,307,202,000	$21,697,000	0.94%	
Union Hospital of Cecil County	$157,260,383	$1,411,673	0.90%	
LifeBridge Sinai	$727,868,000	$6,526,756	0.90%	
MedStar Montgomery General	$160,725,287	$1,322,823	0.82%	
UM Shore Medical Chestertown	$46,048,000	$373,000	0.81%	
Anne Arundel Medical Center	$561,392,000	$4,450,854	0.79%	
Bon Secours	$113,068,120	$675,245	0.60%	
GBMC	$419,396,862	$2,085,315	0.50%	
Carroll Hospital Center	$197,802,000	$790,716	0.40%	
All Hospitals	**$15,292,865,451**	**$276,027,989**	**1.80%**	
Excluded:				
Levindale	$73,760,005	$1,341,932	1.82%	
UM Rehabilitation and Ortho Institute	$107,006,000	$2,271,000	2.12%	

Hospital Name	Total Hospital Operating Expense	CB Reported Charity Care	%	
Adventist Rehab of Maryland*	$43,589,181	$502,712	1.15%	
Sheppard Pratt	$221,570,405	$5,473,873	2.47%	
Adventist Behavioral Health Rockville*	$40,204,927	$1,451,432	3.61%	
Mt. Washington Pediatrics	$55,412,291	$382,465	0.69%	
* The Adventist Hospital System has requested and received permission to report their Community Benefit activities on a CY Basis. This allows them to more accurately reflect their true activities during the Community Benefit Cycle. The numbers listed in the FY 2017 Amount in Rates for Charity Care, DME, and NSPI Column as well as the Medicaid Deficit Assessments from the Inventory spreadsheets reflect the Commission's activities for FY17 and therefore will be different from the numbers reported by the Adventist Hospitals.				

Source:
http://www.hscrc.state.md.us/Documents/HSCRC_Initiatives/CommunityBenefits/CBR-FY17/FiscalYear17HCBFinancialReport20180501.xlsx

Accessed June 5, 2018.

C. 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.

(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:

UM SMC at Easton and UM SMC at Dorchester are licensed by the State of Maryland and accredited by The Joint Commission. Their licenses and accreditation certificates are attached as **Exhibit 8**. They are also in compliance with the Conditions of Participation of the Medicare and Medicaid programs.

The Commission has recognized that "subpart (b) of [COMAR 10.24.10.04(A)(3)] is essentially obsolete in that it requires an improvement plan for any measure that falls within the bottom quartile of all hospitals' reported performance on that measure as reported in the most recent Maryland [Hospital Evaluation Performance Guide], which has been reengineered with a different focus, and no longer compiles percentile standings." (*In re Dimensions Health Corporation*, Docket No. 13-16-2351, Decision p. 19 (Sept. 30, 2016)).

UM SMC at Easton scored "better than average" or "average" on 49 of the 72 quality measures. For an additional 13 quality measures, UM SMC at Easton did not have sufficient data to report. UM SMC at Easton scored "below average" on ten quality measures. **Exhibit 9** identifies those quality measures for which UM SMC at Easton scored "below average" along with the corrective action plans for these measures.

D. 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:

The State Health Plan provides that MSGA beds may be developed or put into operation only if, among other things, 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." (COMAR 10.24.10.04(B)(2)).

As an initial matter, COMAR 10.24.10.04(B)(2) is not applicable to the proposed project because the beds that the applicants proposed to relocate are already developed and have been put into operation. Nevertheless, the Applicant demonstrates compliance with standard as set forth below.

On January 20, 2017, the MHCC published the most recent MSGA bed need projection by jurisdiction in the Maryland Register (Vol. 44, Issue 2, pp. 160-162). As the majority of MSGA beds at UM SMC at Dorchester will shift to UM SMC at Easton, the projections for both Dorchester and Talbot Counties are presented below in Table 2.

Table 2
MHCC's MSGA Bed Need Projection by Jurisdiction
2025

Gross and Current Bed Need Projections for MSGA Beds: Maryland, 2025

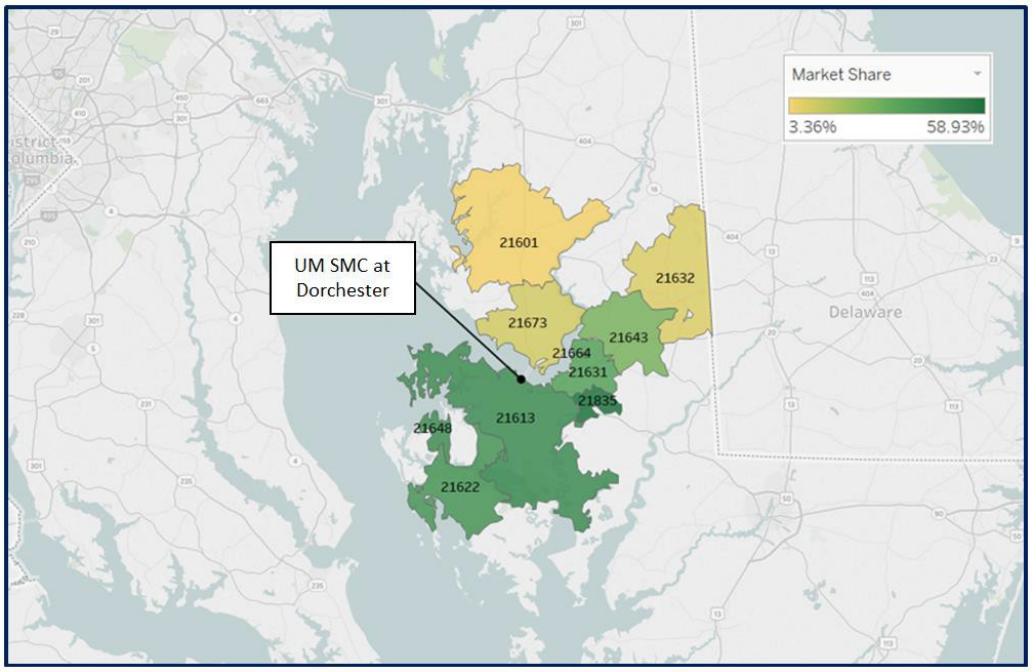
Jurisdiction	Gross Bed Need		Licensed and Approved Beds	2025 Net Bed Need	
	Minimum	Maximum		Minimum	Maximum
Dorchester	25	32	22	3	10
Talbot	81	105	87	-6	18
Combined	106	137	109	-3	28

The Applicant used the following methodology and assumptions to project the need for MSGA beds at UM SMC at Dorchester through fiscal year 2021 and at UM SMC at Easton in fiscal years 2022 through 2024 when UM SMC at Dorchester's inpatient MSGA services shift to UM SMC at Easton. The resulting projection identifies the need to shift 17 MSGA beds from UM SMC at Dorchester in Dorchester County to UM SMC at Easton in Talbot County in fiscal year 2022 when UM SMC at Dorchester is projected to close.

1. Defining UM SMC at Dorchester's MSGA Service Area

To identify the MSGA service area, discharges for UM SMC at Dorchester in fiscal year 2017 were accumulated by Zip Code for all ages. To determine the Zip Codes to be included in the service area, the Applicant identified the Zip Codes comprising the top 85% of UM SMC at Dorchester's MSGA discharges.

Figure 1
UM SMC at Dorchester MSGA Service Area
FY2017



As presented in Figure 1 above and Table 3 below, the proposed MSGA service area is defined by 10 Zip Codes that span Dorchester, Talbot, and Caroline Counties. Zip Codes are ranked from those with the highest to lowest number of discharges from UM SMC at Dorchester to identify the top 85% of total MSGA discharges.

Table 3
UM SMC at Dorchester MSGA Service Area Zip Codes and Discharges
FY2017

#	Zip Code	Community	County	Count	% of Total
1	21613	Cambridge	Dorchester	1,237	62.7%
2	21643	Hurlock	Dorchester	160	8.1%
3	21631	East New Market	Dorchester	99	5.0%
4	21664	Secretary	Dorchester	39	2.0%
5	21835	Linkwood	Dorchester	31	1.6%
6	21632	Federalsburg	Caroline	28	1.4%
7	21648	Madison	Dorchester	28	1.4%
8	21601	Easton	Talbot	29	1.5%
9	21622	Church Creek	Dorchester	25	1.3%
10	21673	Trappe	Talbot	25	1.3%
Service Area Total				**1,701**	**86.2%**
Outside of Service Area				273	13.8%
Total				**1,974**	**100.0%**

Source: St. Paul statewide non-confidential data tapes

2. Projected MSGA Service Area Population

For the Zip Codes included in UM SMC at Dorchester's projected future service area, population projections through 2023 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 0-14, 15-64, 65-74 and 75+ age cohorts. These are presented below in Table 4. The 0-14 and 15-64 age cohorts are expected to decrease from 2018 to 2023. Over the same period, the 65-74 and 75+ age cohorts are expected to grow 15.4% and 3.9%, respectively. In total, the projected population is expected to grow by 0.3% between 2018 and 2023.

Table 4
UM SMC at Dorchester's Historical and Projected MSGA Service Area Population
2010 – 2023

	Service Area Population						% Change in Population	
	2010		2018		2023			
Age Cohort	Pop	% of Total	Pop	% of Total	Pop	% of Total	2010-18	2018-23
0-14	6,493	18.7%	6,405	18.7%	6,349	18.5%	-1.4%	-0.9%
15-64	22,442	64.5%	20,925	61.0%	20,335	59.1%	-6.8%	-2.8%
65-74	3,214	9.2%	4,100	12.0%	4,732	13.8%	27.6%	15.4%
75+	2,659	7.6%	2,865	8.4%	2,976	8.7%	7.7%	3.9%
Total	34,808	100.0%	34,295	100.0%	34,392	100.0%	-1.5%	0.3%

Source: Environics Spotlight Pop-Facts Demographics by Age Race Sex

Using the compounded annual growth rates from 2018 to 2023, population projections were extrapolated through 2024 and applied to UM SMC at Dorchester's fiscal years. Table 5 below depicts the projected population for each age cohort. Led by the population over age 65, the total population is expected to grow by 0.2% from fiscal year 2017 to fiscal year 2024.

Table 5
UM SMC at Dorchester's Historical and Projected MSGA Service Area Population
FY2016 – FY2024

	Historical		Projection							% Change
Age Cohort	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
0-14	6,427	6,416	6,405	6,394	6,383	6,371	6,360	6,349	6,338	*-1.2%*
%Change		*-0.2%*	*-0.2%*	*-0.2%*	*-0.2%*	*-0.2%*	*-0.2%*	*-0.2%*	*-0.2%*	
15-64	21,294	21,109	20,925	20,806	20,687	20,569	20,452	20,335	20,219	*-4.2%*
%Change		*-0.9%*	*-0.9%*	*-0.6%*	*-0.6%*	*-0.6%*	*-0.6%*	*-0.6%*	*-0.6%*	
65-74	3,858	3,977	4,100	4,219	4,342	4,468	4,598	4,732	4,870	*22.4%*
%Change		*3.1%*	*3.1%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	
75+	2,812	2,838	2,865	2,887	2,909	2,931	2,953	2,976	2,999	*5.6%*
%Change		*0.9%*	*0.9%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	*0.8%*	
Total Service Area	34,391	34,340	34,295	34,306	34,320	34,340	34,364	34,392	34,425	*0.2%*
%Change		*-0.1%*	*-0.1%*	*0.0%*	*0.0%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	

3. MSGA Use Rates

Table 6 depicts the total use rate of MSGA discharges per 1,000 population in UM SMC at Dorchester's defined service area in fiscal years 2016 through 2018 (actual/projected). The total MSGA use rate of 99.3 discharges per 1,000 population in fiscal year 2018 represents a decline of 6.2% from fiscal year 2016.

Table 6
UM SMC at Dorchester's Historical MSGA Service Area Use Rates
FY2016 – FY2018

	Actual FY2016	Actual FY2017	Actual/ Projected FY2018
MSGA Use Rates			
Age 0-14	**18.2**	**14.7**	**12.8**
%Change		*-19.5%*	*-12.6%*
Age 15-64	**81.4**	**84.6**	**78.5**
%Change		*3.9%*	*-7.3%*
Age 65-74	**220.8**	**232.3**	**198.0**
%Change		*5.2%*	*-14.8%*
Age 75+	**333.6**	**376.3**	**303.0**
%Change		*12.8%*	*-19.5%*
Total	**105.9**	**112.8**	**99.3**
%Change		*6.5%*	*-12.0%*

While the total use rate from fiscal years 2016 and 2018 declined by 6.2%, it was separated by a 6.5% increase in fiscal year 2017.

Due to an expected reduction in potentially avoidable utilization, use rates are projected to decline by 1% at the age cohort level in fiscal year 2019. Use rates are then projected to remain constant through fiscal year 2024 by age cohort, although the total use rate will increase with the shift of population to older age cohorts with higher use rates. (Table 7).

Table 7
UM SMC at Dorchester's Historical and Projected MSGA Use Rate
FY2016 - FY2024

	Actual	Actual	Actual/ Projected	Projection						% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
MSGA Use Rates										
Age 0-14	**18.2**	**14.7**	**12.8**	**12.7**	**12.7**	**12.7**	**12.7**	**12.7**	**12.7**	
%Change		-19.5%	-12.6%	-1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*-1.0%*
Age 15-64	**81.4**	**84.6**	**78.5**	**77.7**	**77.7**	**77.7**	**77.7**	**77.7**	**77.7**	
%Change		3.9%	-7.3%	-1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*-1.0%*
Age 65-74	**220.8**	**232.3**	**198.0**	**196.1**	**196.1**	**196.1**	**196.1**	**196.1**	**196.1**	
%Change		5.2%	-14.8%	-1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*-1.0%*
Age 75+	**333.6**	**376.3**	**303.0**	**299.9**	**299.9**	**299.9**	**299.9**	**299.9**	**299.9**	
%Change		12.8%	-19.5%	-1.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*-1.0%*
Total	**105.9**	**112.8**	**99.3**	**98.8**	**99.4**	**100.0**	**100.6**	**101.2**	**101.8**	
		6.5%	-12.0%	-0.4%	0.6%	0.6%	0.6%	0.6%	0.6%	*2.6%*

4. MSGA Service Area Discharges

Based on the population and use rate assumptions described above, the total projected MSGA service area discharges are projected to increase 3.0% between fiscal years 2018 and 2024 as presented below.

Table 8
UM SMC at Dorchester's Historical and Projected MSGA Service Area Discharges
FY2016 - FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Service Area Discharges	**3,641**	**3,872**	**3,404**	**3,390**	**3,412**	**3,434**	**3,457**	**3,481**	**3,505**	*3.0%*
%Change		*6.3%*	*-12.1%*	*-0.4%*	*0.6%*	*0.6%*	*0.7%*	*0.7%*	*0.7%*	

5. UM SMC at Dorchester's MSGA Market Share

UM SMC at Dorchester's MSGA market share decreased in fiscal year 2018 after an increase in fiscal year 2017. Due to this swing, market share at UM SMC at Dorchester is projected to remain constant at the fiscal year 2018 level, by age cohort, through fiscal year 2021. Total hospital market share will increase slightly each year with the shift of population to

older age cohorts with greater market share. In fiscal year 2022, due to the conversion of UM SMC at Dorchester to an FMF and relocation of UM SMC at Dorchester's Medical/Surgical services to UM SMC at Easton, it is projected that 22.2% of UM SMC at Dorchester's MSGA cases will shift to Peninsula Regional Medical Center and Atlantic General Hospital. (Table 9).

Table 9
Projected Shift of UM SMC at Dorchester Medical and Surgical Discharges
FY2022

UM SMC at Dorchester MSGA Discharges	Projected FY2022	% of Total
Medical Discharges	1,376	92.6%
Surgical Discharges	110	7.4%
Reduction in UM SMC at Dorchester MSGA Discharges	1,486	100.0%
Shift to UM SMC at Easton	(1,155)	77.7%
Shift to Other Hospitals	(331)	22.3%
Increse at Other Hospitals	(1,486)	100.0%
Remaining UM SMC at Dorchester MSGA Discharges	-	-

This shift is based on a drive time analysis that was conducted by service line. It reflects patients who live farther from the new location of MSGA services in Easton. It is projected that this 22.3% shift to other hospitals will be comprised entirely of medical cases, while all of UM SMC at Dorchester's inpatient surgical cases are projected to transfer to UM SMC at Easton. The Applicant anticipates that all of UM SMC at Dorchester's inpatient surgical cases will be retained within SHS for the following reasons: (1) community medical staff referral patterns are not expected to change based upon change in facility location; (2) all surgical providers currently operating at UM SMC at Dorchester have privileges at UM SMC at Easton; and (3) surgical providers currently performing cases at UM SMC at Dorchester have expressed the intention to move such inpatient cases to UM SMC at Easton. A majority of the operating surgical providers

at UM SMC at Dorchester are employed by UM SRH and, therefore, the shift of surgical practice locations to other hospitals is not anticipated.

As a result of the assumptions described above, SHS's market share of the MSGA cases will decline from 36% in fiscal year 2021 to 28% in fiscal years 2022 through 2024. (Table 10).

Table 10
UM SMC at Dorchester's Historical and Projected MSGA Market Share
FY2016 - FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
UMSMCD Market Share	**40.4%**	**43.3%**	**35.9%**	**35.9%**	**36.0%**	**36.0%**	**28.0%**	**28.0%**	**28.0%**	
%Change		*7.2%*	*-17.1%*	*0.1%*	*0.1%*	*0.1%*	*-22.2%*	*0.1%*	*0.1%*	*-21.9%*

6. UM SMC at Dorchester Out-of-Service Area MSGA Discharges

UM SMC at Dorchester's out-of-service area MSGA discharges are projected to remain constant, as a percentage of service area discharges, at the age cohort level from fiscal year 2018 through the projection period. Fluctuations from year to year in this percentage are due to aging of the population into older cohorts with fewer discharges from outside the service area.

Table 11
UM SMC at Dorchester's Historical and Projected Out-of-Service Area MSGA Discharges
% of Service Area Discharges
FY2016 – FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton		
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Out-of-Service Area Discharges									
% of Service Area Discharges	18.2%	17.7%	19.5%	19.4%	19.4%	19.4%	19.3%	19.3%	19.3%

7. UM SMC at Dorchester Inpatient MSGA Discharges

Based on the assumptions described above, UM SMC at Dorchester's MSGA discharges (in Cambridge and Easton) are projected to decline from fiscal year 2017 to fiscal year 2024 by

19.7%. Much of the decline will occur in fiscal year 2022 when UM SMC at Dorchester converts to an FMF and a portion of its medical cases are projected to be lost to other hospitals.

Table 12
UM SMC at Dorchester's Historical and Projected MSGA Discharges
FY2016 – FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Inpatient Discharges										
UMSMCD	**1,738**	**1,974**	**1,460**	**1,455**	**1,465**	**1,475**	**1,155**	**1,163**	**1,172**	
%Change		*13.6%*	*-26.0%*	*-0.3%*	*0.7%*	*0.7%*	*-21.7%*	*0.7%*	*0.8%*	*-19.7%*

8. MSGA Average Length of Stay (ALOS)

The average length of stay for MSGA patients at UM SMC at Dorchester is expected to remain constant at the age cohort level from UM SMC at Dorchester's experience in fiscal year 2017.

Table 13
UM SMC at Dorchester's Historical and Projected ALOS
FY2016 – FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
ALOS - MSGA	**4.20**	**4.35**	**4.35**	**4.35**	**4.35**	**4.35**	**4.35**	**4.35**	**4.35**	
%Change		*3.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

9. MSGA Occupancy

The expected occupancy of inpatient MSGA beds at UM SMC at Dorchester for fiscal years 2016 through 2021 reflects the State Health Plan for hospitals with an average daily census of 0-49 patients. Due to the expected shift of beds to UM SMC at Easton in fiscal year 2022, the expected occupancy for fiscal year 2022 through the remainder of the projection period reflects the State Health Plan for hospitals with an average daily census of 100-299 patients as follows.

Table 14
UM SMC at Dorchester MSGA Projected Bed Occupancy

	Projected	
	Dorchester FY16-21	Easton FY22-24
Occupancy	70%	80%

10. MSGA Bed Need

Based on the assumptions presented above, the applicant has projected a need to shift 17 inpatient MSGA beds from UM SMC at Dorchester to UM SMC at Easton, beginning in fiscal year 2022 when UM SMC at Dorchester converts to an FMF.

Table 15
UM SMC at Dorchester's Historical and Projected MSGA Bed Need
FY2016 – FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
MSGA Bed Need	**29**	**34**	**25**	**25**	**25**	**25**	**17**	**17**	**17**	*-32.0%*
%Change		*17.2%*	*-26.5%*	*0.0%*	*0.0%*	*0.0%*	*-32.0%*	*0.0%*	*0.0%*	

E. The Proposed Project Will Not Have an Unwarranted Adverse Impact on Hospital Charges, Availability of Services, or Access to Services – COMAR 10.24.10.04(B)(4).

(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 State Health plan provides that 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 proposed project will not have an adverse impact on hospital charges, availability of services, or access to services. On the contrary, if the proposed project is not approved and UM SMC at Dorchester converts to a freestanding medical facility, there will be a lack of MSGA beds to meet the projected needs of UM SMC at Dorchester's service area, thereby creating a barrier to access acute inpatient services. Instead, pursuant to the merger and consolidation of UM SMC at Dorchester and UM SMC at Easton, SHS is requesting that the HSCRC approve a proposed Global Budget Revenue ("GBR") Plan that redistributes revenue among SHS's rate-regulated components, including UM SMC at Easton and the freestanding medical facility. The redistribution of SHS's GBR will provide for a revenue base to support the plans for renovation at UM SMC at Easton as well as the construction of a freestanding medical facility, UM SMC at Cambridge. By taking this approach, the HSCRC and associated parties can avoid adding additional revenue to SHS and by extension to the State's health care system.

F. The Proposed Project is the Most Cost-Effective Alternative to Continue to Provide Needed Acute Inpatient Services to the Residents of Dorchester and Talbot Counties – COMAR 10.24.10.04(B)(5).

(5) Cost-Effectiveness.

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

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

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

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

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

(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.

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

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

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

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

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

Applicant Response:

In 1904, a new hospital building was opened on the banks of the Choptank River at the current site of UM SMC at Dorchester. In 1914, a maternity wing (the "DuPont Building") was added to the hospital. Around 1931, a multi-story brick building was built on the campus for the purpose of housing nursing students of the hospital's nursing program. This building is today proximate to the current emergency room entrance, to the north east of the hospital. In 1958, a one-story brick diagnostic treatment wing was opened, which included an operating room suite. Also in the late 1950s, the dredging of the channel for the Cambridge port, resulted in spoil being placed on hospital grounds and thus increased the total acreage of the hospital campus to approximately 17 acres.

On January 6, 1967, the hospital board voted to build a new hospital. On May 25, 1969, ground broke for the new hospital building. The DuPont Building and the Diagnostic Center were incorporated into the new building, and the building was completed in 1974. In 1979, construction was completed on a 10-bed intensive care unit, a third floor operating room, and business office. After construction, Dorchester General became a licensed 135 acute bed hospital.

In the mid-1970s, two physician office buildings were constructed on Byrn Street. In 1986, Dorchester General received approval from the Health Resources Planning Commission, for the establishment of a 20-bed acute psychiatric inpatient center. Dorchester General renovated the One East patient area and converted 20 licensed MSGA beds to 20 psychiatric

beds. In accordance with the State Hospital Capacity Plan, Dorchester General de-licensed 41 acute care beds and became a 114 licensed bed hospital.

Today, UM SMC at Dorchester's licensed bed count is 42 beds. The Applicant provides this history to demonstrate that the existing hospital buildings and campus are dated and over-sized for the patient population being served. Maintaining such aged facilities to serve reduced inpatient volumes is not the most cost-effective approach, especially when UM SMC at Easton is only 15 miles away and capable of accommodating the inpatient beds needed to continue serving the residents of the service area. For this reason, the Applicant is proposing to relocate 12 psychiatric beds and 17 MSGA beds from UM SMC at Dorchester to the existing UM SMC at Easton facility. The Applicant evaluated various options for relocating the inpatient capacity of UM SMC at Dorchester before selecting the most cost-effective and practical way to relocate the beds.

The Applicant determined that there was only one practical approach for the relocation of the UM SMC at Dorchester Behavioral Health Unit. The Behavioral Health Unit needs to be located in an easily controlled and secure location with sufficient area to provide the required support and therapy spaces. Based on these requirements, there was only one practical solution available – to relocate the Behavioral Health Unit to Level 3 of the South Wing at UM SMC at Easton, which currently houses pediatric and women's health services, the Child Advocacy Center, and the Sleep Lab.

The pediatric unit has been running an average daily census of 1.6 in fiscal year 2017 and 1.7 in fiscal year 2018 and is underutilized for pediatrics. In order to make better use of the unit, female surgical patients have been admitted to this unit for more than 10 years. The average daily census for the female surgical patient population in fiscal years 2017 and 2018 was 1.9.

Occasionally the unit is used for mother/baby overflow from the birthing center. All options presented below assume that the pediatric and mother/baby overflow patients will be accommodated in three new beds that will be located in renovated space on Level 5 adjacent to the birthing center as identified on the proposed floor plans in **Exhibit 2**. The women's surgical patients will be relocated to the Level 3 East surgical unit.

Given the limited scope of the project, the Applicant determined that only two viable options exist for relocating 17 MSGA beds from UM SMC at Dorchester to UM SMC at Easton:

Option One: Conversion of an existing outpatient wing at UM SMC at Easton to a 15 bed private room Medical/Surgical Unit.

This option would require the relocation of some existing outpatient cardiovascular services, respiratory services, volunteer services, and lab services on Central Wing of Level 3 at UM SMC at Easton. Although this wing was at one time used as a patient unit, it is currently designated for business occupancy. The Applicant would relocate executive administrative offices currently located on the floor below to an offsite location and relocate all services on Level 3 Center wing to Level 2 Center wing. The vacated Level 3 wing would then require total renovation to convert to a 15 bed inpatient unit. Two additional MSGA beds would be located in former patient rooms on Level 2 East medical/surgical unit.

Although this option has the benefit of isolating all the renovation work necessary to relocate the MSGA beds to one area of the building and minimizing impact to existing units, it would require significant upgrades to the building infrastructure to allow it to be occupied again as an inpatient unit. In addition, the width of this unit is insufficient to provide sufficient space for support functions and does not meet currently regulatory requirements. It has an existing

central corridor that is 7'-6" wide, which is less than the 8'-0" width required under current regulations for a patient unit.

Option Two: Reinstatement of former patient rooms that have been converted to other functions.

This is the best option and the option being proposed, as it is the most cost effective and efficient means of relocating the MSGA beds from UM SMC at Dorchester. This option involves incremental additions to existing patient units to accommodate the 17 MSGA beds relocating from UM SMC at Dorchester to UM SMC at Easton. The floor plans included in this submission in **Exhibit 2** identify the current use of all rooms and configuration along with the proposed layout. Some of the former patient rooms that are no longer used as inpatient rooms but they can be reinstated as they still have the required plumbing and infrastructure, while other areas have been converted to a new function and configuration and will require some renovations in order to meet all regulatory requirements.

This option allows for utilization of existing unit support spaces and provides efficiency in staffing with the extra beds being absorbed into existing units and coverage by staff on that unit plus some additional staff from UM SMC at Dorchester.

The Applicant identified the following project objectives in evaluating the two options: (1) the need to provide space for the relocated inpatient beds; (2) the capital costs; (3) the need to minimize adverse impact on existing patient units; (4) operational and clinical efficiency; and (5) the need to comply with all applicable regulatory requirements. Below is the Applicant's scoring of the two options on the project objectives.

	Option 1: Conversion of Existing Outpatient Wing at UM SMC at Easton to 15-Bed MSGA Unit		Option 2: Proposed Project	
Objectives		**Score**		**Score**
Providing space for inpatient beds relocating from UM SMC at Dorchester	Space will accommodate all beds relocated from UM SMC at Dorchester	3	Space will accommodate all beds relocated from UM SMC at Dorchester	3
Capital Cost of Project	$8.6M	2	$7.6M	3
Minimizing Impact on Existing Patient Units	Minimum impact on existing inpatient units; current services and programs in that space require relocation	3	Renovations will occur on several units causing temporary disruption. Our intent with proper project planning and scheduling over time would minimize those disruptions	2
Operational / Clinical Efficiency	Given constraints on width of hallway, there are limited sight-lines and insufficient space to provide necessary support functions	1	Additional beds can be easily absorbed into existing patient units with current staffing already in place	3
Ability to Comply with Regulatory Requirements	Width of hallway is 4" less than what is currently required for an inpatient unit	1	Renovations will pose no regulatory concerns	3
Minimize Facility Considerations/ Upgrades	Significant upgrades to building infrastructure will be required to restore medical gases, fire suppression, and upgrade HVAC. Other floors will most likely require fire proofing and additional structural support.	1	Minimal infrastructure needs, as many of the spaces to be restored to an inpatient room currently have plumbing, medical gases and other infrastructure required.	2
Aggregate Score		11		16
Overall Ranking		**2**		**1**

Scoring Methodology: methodology uses a 1-3 score where 1= "objective not met" and 3= "objective completely met"

G. The Applicants Have Satisfied Their Burden of Proof Regarding Need – COMAR 10.24.10.04(B)(6).

(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 State Health provides that a hospital project shall be approved only if there is a demonstrable need. The Applicants have established need for the relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton. *See* Section II.D above.

H. The Proposed Construction Cost of Hospital Space is Reasonable and Consistent with Industry Cost Experience in Maryland – COMAR 10.24.10.04(B)(7).

(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 State Health Plan requires that the proposed cost of a hospital construction project shall be reasonable and consistent with current industry guidance in Maryland. As set forth

below, the projected construction cost per square foot for the proposed project is reasonable. The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark. Please note that this project involves renovation. Section 99, Page 1 of the MVS Guide states:

> REPAIR AND REMODEL: All costs in this manual are based on new construction. Typical repair work will run 10 to 20 higher because of restricted area, movement of materials, temporary supports, shoring, etc., and other contingencies not encountered in new construction, excluding demolition and removal.

No premium for renovation has been assumed in the following calculation for the MVS benchmark. However, the final comparison between the project costs/square foot and the benchmark should be viewed in the context of the MVS view of Repair and Remodeling costs.

I. Marshall Valuation Service
Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		6
Perimeter		358
Average Floor to Floor Height		12.0
Square Feet		14,425
f.1	Average floor Area	3,606
A. Base Costs		
	Basic Structure	$374.00
	Elimination of HVAC cost for adjustment	40.5
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$333.50
Adjustment for Departmental Differential Cost Factors		1.06
Adjusted Total Base Cost		$353.51

B. Additions		
	Elevator(If not in base)	($8.70)
	Other	$0.00
Subtotal		($8.70)
Total		$344.81
C. Multipliers		
Perimeter Multiplier		1.108272797
	Product	$382.14
Height Multiplier		1.000
	Product	$382.14
Multi-story Multiplier		1.100
	Product	$420.36
D. Sprinklers		
	Sprinkler Amount	$0.00
Subtotal		$420.36
E. Update/Location Multipliers		
Update Multiplier		1.04
	Product	$437.17
Location Multiplier		0.99
	Product	$432.80
Calculated Square Foot Cost Benchmark		**$432.80**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Med/Surg (Medical Oncology)	1,041	Inpatient Unit	1.06	1,103
Med/Surg (General)	2,048	Inpatient Unit	1.06	2,171
Behavioral Health Unit	8,310	Inpatient Unit	1.06	8,809
Med/Surg (Joint & Neuro)	1,309	Inpatient Unit	1.06	1,388
LDRP / Peds	728	Inpatient Unit	1.06	772
Med/Surg (Rehab Unit)	989	Inpatient Unit	1.06	1,048
	14,425		1.06	15,291

Cost of New Construction

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$5,058,140	$350.65
Fixed Equipment	$0	$0.00
Site Preparation	$0	$0.00
Architectural Fees	$546,949	$37.92
Permits	$10,000	$0.69
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$5,615,089	$389.26

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

B. Extraordinary Cost Adjustments

	Project Costs		**Associated Cap Interest & Finance Costs**
Demolition	$200,000	Building	$34,027
MBE Participation Cost Premium	$194,326	Building	$33,061
Total Cost Adjustments	$394,326		$67,088

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only

Capitalized Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using a Canopy as an example:

(Cost of the Canopy/Building Cost) X
(Building related Capitalized Interest and Loan Placement Fees).

Explanation of Extraordinary Costs

Below are the explanations of the Extraordinary Costs that are not specifically mentioned as not being in contained in the MVS average costs in the MVS Guide (at Section 1, Page 3) but that are specific to this project and would not be in the average cost of a hospital project.

1. Premium for Minority Business Enterprise Requirement (MBE) – UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was conservatively projected on this project to be 4% based on conversations with cost estimators.

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS benchmark.

C. Adjusted Project Cost	**Adjusted Project Costs**	**Per Square Foot**
Building	$4,663,814	$323.31
Fixed Equipment	$0	$0.00
Site Preparation	$0	$0.00
Architectural Fees	$546,949	$37.92
Permits	$10,000	$0.69
Subtotal	$5,220,763	$361.92
Capitalized Construction Interest	$466,237	$32.32
Total	$5,687,001	$394.25

Building associated Capitalized Interest and Loan Placement Fees were calculated as follows:

Hospital	New	Renovation	Total		
Building Cost	$0	$5,058,140			
Subtotal Cost (w/o Cap Interest)	$0	$5,615,089	$5,615,089		
Subtotal/Total	0.0%	100.0%	Cap Interest	Loan Placement Fees	Total
Total Project Cap Interest & Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$0	$955,319	$841,931	$113,388	$955,319
Building/Subtotal	0.0%	90.1%			
Building Cap Interest & Loan Place.	$0	$860,563			
Associated with Extraordinary Costs	$0	$394,326			
Applicable Cap Interest & Loan Place.	$0	$466,237			

As noted below, the project's cost per square foot is below the MVS benchmark.

MVS Benchmark	$432.80
The Project	$394.25
Difference	-$38.55
%	-8.91%

I. The Size of the Proposed Project's Inpatient Nursing Unit Space is Reasonable and Does not Exceed 500 Square Feet Per Bed – COMAR 10.24.10.04(B)(9).

(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 proposed project involves renovating portions of existing nursing units on Levels 2, 3, 4, and 5. To generate the nursing unit space calculation, the Applicant has included all areas within any renovated nursing unit, using the definition provided in the Acute Care Chapter of the State Health Plan. The average square feet per bed of the units that will be renovated is 372 SF/bed. The units vary from 303 SF/bed to 594 SF/bed, as indicated in Table 16 below. The labor and delivery unit has the highest SF/bed at 594 SF/bed. This is due to the additional support space required such as the nursery and the size of the private LDRP patient rooms used for deliveries. The remaining units are all below the 500 SF/bed benchmark with the medical/ surgical units significantly below this benchmark due to the quantity of existing semi-private patient rooms. A detailed analysis is included as **Exhibit 10**.

Table 16
Square Feet Per Bed Calculations for Renovated Units

Inpatient Unit Type	Location	SF	# Beds	SF/Bed
Medical / Surgical	2 South	10,907	36	303
Behavioral Health	3 East	5,729	12	477
Medical / Surgical	3 South	12,308	37	333
Medical / Surgical	4 South	8,840	26	340
Labor & Delivery / Pediatric	5 South	9,499	16	594
Totals		47,283	127	
Average SF/Bed of Renovated Units				**372**

J. The Proposed Project is Designed to Allow UM SMC at Easton to Operate Efficiently – COMAR 10.24.10.04(B)(11).

(11) Efficiency.

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

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

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

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

Applicant Response:

Please see the response to Section IV – The Relocation of Beds from UM SMC at Dorchester to UM SMC at Easton will Result in the Delivery of More Efficient and Effective Health Care Services.

K. The Design of the Project Took Patient Safety into Consideration and Includes Design Features that Enhance and Improve Patient Safety – COMAR 10.24.10.04(B)(12).

(12) Patient Safety.

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

Applicant Response:

The State Health requires that the design of a hospital project take patient safety into consideration and include design features that enhance and improve patient safety. Furthermore, a hospital proposing to replace or expand its physical plant must 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.

The relocation of 17 MSGA beds from UM SMC at Dorchester to UM SMC at Easton will not require any new construction at UM SMC at Easton's physical plant. These beds will be relocated to existing spaces within Levels 2, 3, and 4 of UM SMC at Easton, some of which will require renovations. All renovated rooms will have the same design as the existing rooms, which will provide uniformity and reduce the chance of nursing errors. Three beds to be used for pediatric patients and maternal overflow space will be relocated to Level 5 South and rehabilitation support space will be relocated to Level 5 East in order to accommodate these beds. The pediatric unit on Level 5 will be a secured unit and located adjacent to the birthing center which is also secured, which will help to maintain patient security.

The relocation of 12 psychiatric beds from UM SMC at Dorchester to UM SMC at Easton will not require expansion but will require some renovations to accommodate the inpatient acute psychiatric unit. The proposed inpatient behavioral health unit has been designed with patient and staff safety in mind. Below are some of the design considerations for the layout of the inpatient behavioral health unit:

- A Sally Port entry has been provided at the entrance for security. This controlled vestibule only allows one door at a time to be open to prevent patient elopement.
- The staff station has been located centrally to provide visibility to both corridors serving the patient rooms.
- Single patient rooms containing higher risk patients will be located with immediate visibility and access from the staff station
- The central day room and activity space has direct control and visibility from the staff station.
- A seclusion room will be located within the unit with immediate access to the activity space and visibility from the staff station.
- An enclosed and securable activity space has been provided adjacent to the open activity area to safely contain patients during any disturbance on the unit.
- A separate controlled corridor serves the staff support areas to limit patient access to non-patient care zones.

In addition to the considerations given to the layout, special design considerations will be given to injury and suicide prevention for the vulnerable population served by this unit as required per the Behavioral Health Risk Assessment portion of The Facility Guidelines Institute (FGI) guidelines for design and construction of Hospitals.

The consolidation and merger of beds from UM SMC at Dorchester to UM SMC at Easton will also enhance patient safety as well as operational efficiencies in a number of other ways, including:

- Patients will be afforded a 24/7 pharmacy service, which will enhance efficiency of delivery of medications to the patient units. UM SMC at Dorchester does not currently have an on-site pharmacy. Medications are supplied through a Pyxis machine on individual units.

- Moving UM SMC at Dorchester's ICU patients to UM SMC at Easton will provide enhanced quality and safety because UM SMC at Easton has a dedicated ICU with 10 beds and UM SMC at Dorchester has only a combined ICU/Telemetry unit. Because UM SMC at Dorchester's average ICU daily census is low, it is difficult to maintain staff competent in the care of ICU patients. With a dedicated ICU unit at UM SMC at Easton, the staff will be able to maintain proficiency and skills as ICU nurses.

- Patient safety on the MSGA units will be enhanced through the filling of staff vacancies at UM SMC at Easton with competent staff already employed by SHS, who will be relocated from UM SMC at Dorchester, thereby decreasing the use of travel staff.

- Transfer of acute care patients requiring rehabilitation services will be expedited since the acute rehabilitation unit is located within UM SMC at Easton. Currently, a patient admitted at UM SMC at Dorchester requires an interfacility transport to obtain inpatient rehabilitation services. Following consolidation, acute care patients can be taken by wheelchair or bed to the rehabilitation unit within UM SMC at Easton.

L. The Proposed Project is Financially Feasible and Will Not Jeopardize the Long-Term Financial Viability of SHS – COMAR 10.24.10.04(B)(13).

(13) Financial Feasibility.

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

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

(b) Each applicant must document that:

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

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

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

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

Applicant Response:

The State Health Plan requires that a hospital capital project be financially feasible and not jeopardize the long-term financial viability of the hospital.

Included in **Exhibit 1** are Tables F, G, and H, which provide utilization and financial projections, and a comprehensive statement of assumptions related to utilization, revenue, expenses, and financial performance for SHS, which includes UM SMC at Easton, UM SMC at Dorchester through fiscal year 2021, and UM SMC at Cambridge in fiscal years 2022 through

2024. Included in Tables I, J, and K, which are also included in **Exhibit 1**, are utilization and financial projections that include a comprehensive statement of assumptions related to utilization, revenue, expenses, and financial performance for the incremental impact of shifting MSGA and Psychiatric beds from UM SMC at Dorchester to UM SMC at Easton in fiscal years 2022 through 2024.

As presented in Tables G and H, SHS is projected to be financially viable in the long-term. As presented in Table K, the move of inpatient MSGA and Psychiatric beds from UM SMC at Dorchester to UM SMC at Easton contributes positively to SHS's long-term financial viability.

1. Projected SHS Utilization

Table F includes utilization projections that reflect both the inpatient and outpatient utilization of UM SMC at Dorchester and UM SMC at Easton, as well as outpatient emergency department visits, observation cases, and related outpatient ancillary services at UM SMC at Cambridge. Table I presents the inpatient utilization associated with the shift of beds from UM SMC at Dorchester to UM SMC at Easton.

The projected shift of inpatient MSGA and Psychiatric bed from UM SMC at Dorchester to UM SMC at Easton reflect the MSGA and Psychiatric bed need assumptions presented in sections II and III of this application. The projections of outpatient services assume the continuation of existing emergency, observation, surgery, and other ancillary services with annual population growth through fiscal year 2024.

2. Projected SHS Revenue

The presentations of projected revenue in Tables H and K reflect the utilization projections presented in Tables F and I and the 2018 regulated Global Budget Revenue ("GBR") assumptions related to update factors, demographic adjustments, revenue variability, and uncompensated care. These assumptions are included with the tables.

Also incorporated into the revenue projections and described in the list of assumptions are assumptions related to the redistribution of the GBR with the transformation of UM SMC at Dorchester to an FMF. SHS will request that the HSCRC allow SHS to retain in its GBR cap 50% of the revenue at UM SMC at Dorchester related to patients that will seek care at other providers after the closing of UM SMC at Dorchester. Keeping this revenue will allow SHS to fund the capital costs and other strategic initiatives associated with the transformation of UM SMC at Dorchester and SHS. This form of funding will have no impact on the Maryland Demonstration Model while allowing for funding of needed capital investments.

3. Projected SHS Staffing and Operating Expenses

The projection of staffing associated with the shift of inpatient MSGA and Psychiatric services from UM SMC at Dorchester to UM SMC at Easton, as presented in Table L included in **Exhibit 1**, reflects the inpatient services and utilization presented in Table I, as well as assumptions related to expense inflation, expense variability with changes in volumes and one-time adjustments to the projection of staffing and expenses when UM SMC at Dorchester converts to an FMF in fiscal year 2022. Included in the one-time adjustments to staffing and related expenses are the reduction of 113 FTEs and $8 million of salaries and benefits in fiscal year 2022 as the staff at UM SMC at Dorchester are transitioned to the proposed UM SMC at Cambridge and UM SMC at Easton (Table 17).

Table 17
Projected Reduction in Staffing and Related Salaries and Benefits
($ in thousands)

Projected FY2022						
	DGH Prior	FTEs	FTEs Retained			
Departments	to Closure	Eliminated	FMF	Easton	MOB	Total
Inpatient Units	116.6	38.9	-	77.7	-	77.7
Outpatient Units	79.8	11.8	48.5	10.1	9.4	68.0
Overhead Departments	75.4	62.7	12.7	-	-	12.7
Total FTEs	271.8	113.4	61.2	87.8	9.4	158.4
Salaries & Benefits	$ 23,583	$ 7,963	$ 5,250	$ 903	$ 9,468	$ 15,621

In addition to savings associated with salaries and benefits, there are other efficiencies, totaling $1.2 million, related to the consolidation of inpatient services at UM SMC at Easton and movement of outpatient services to the proposed UM SMC at Cambridge. Combined with reductions in salaries and benefits, there is a projected reduction of $9.1 million of operating expenses associated with the projects (Table 18).

Table 18
Projected Reduction in Operating Expenses
($ in thousands)

	Projected FY2022
Cost Savings Enabled by the Project	
Salary & Benefit Savings	$ 7,963
Utilities	698
Supplies	481
Total	$ 9,142

While the project will enable significant efficiencies in fiscal year 2022, there are new expenses that are added to the financial projection related to EPIC implementation ($5 million in fiscal year 2019), physician contracting, and other strategic initiatives (Table 19).

Table 19
Additional Fixed Costs
($ in thousands)

Additional Fixed Costs	Projected 2018	2019	2020	2021	2022	2023	2024
EPIC Go-Live & Training Costs	$ -	$ 5,000	$ -	$ -	$ -	$ -	$ -
EPIC / IT Support Costs	228	$ 388	$ 390	$ 549	$ 551	$ 551	$ 551
Community Medical Grp (revenue improvement)	(722)	(750)	(731)	(1,849)	(1,289)	(1,289)	(1,289)
Strategic Priority Operating Investments	139	800	1,970	3,108	4,247	4,247	4,247
Total	$ (355)	$ 5,438	$ 1,629	$ 1,808	$ 3,509	$ 3,509	$ 3,509

Beginning in fiscal year 2022, the retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of UM SMC at Dorchester to an FMF, will enable SHS to fund initiatives related to ambulatory and physician network development, population health initiatives, and its regional vision.

4. Projected UM SMC at Cambridge Financial Performance

As presented in Table K, the shift of MSGA and Psychiatric beds from UM SMC at Dorchester to UM SMC at Easton is projected to provide small positive financial contributions to UM SMC at Easton in fiscal years 2022 through 2024. This contribution includes the impact of depreciation and interest expense associated with the renovation of space at UM SMC at Easton. This positive contribution is included in the operating profits of SHS which are presented in Table H. As shown in Table H, SHS which includes UM SMC at Easton, UM SMC at Dorchester through fiscal year 2021, and UM SMC at Cambridge in fiscal years 2022 through 2024, will generate positive operating income throughout the projection period.

M. The Proposed Construction of Shell Space is Cost Effective – COMAR 10.24.10.04(B)(16).

(16) Shell Space.

(a) Unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective.

(b) If the proposed shell space is not supporting finished building space being constructed above the shell space, the applicant shall provide an analysis demonstrating that constructing the space in the proposed time frame has a positive net present value that:

(i) Considers the most likely use identified by the hospital for the unfinished space;

(ii) Considers the time frame projected for finishing the space; and

(iii) Demonstrates that the hospital is likely to need the space for the most likely identified use in the projected time frame.

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

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

Applicant Response:

This standard is inapplicable as the Applicant does not propose to build any shell space as part of this project.

III. THE RELOCATION OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON IS NOT INCONSISTENT WITH THE STATE HEALTH PLAN CHAPTER FOR PSYCHIATRIC SERVICES.

10.24.07 – PSYCHIATRIC SERVICES CHAPTER--APPROVAL POLICIES

Availability

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 current or recent Commission statewide child, adolescent, or adult bed need projection. Moreover, the bed need projection methodologies set forth in the State Health Plan for Psychiatric Services are outdated and obsolete. The Applicant has projected need for the relocated psychiatric beds in response to Standard 10.24.01.08G(3)(b), pp. 58-67.

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 is inapplicable; there are no delicensing requirements applicable to the proposed project.

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 inapplicable; the proposed project does not involve state hospital conversion beds.

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 1 c.

Applicant Response:

This standard is inapplicable.

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:

UM SMC at Easton is a 24/7 acute general hospital. The psychiatric services that will be provided at UM SMC at Easton will follow written procedures already implemented within UM SRH for providing psychiatric emergency inpatient services 24/7 with no special limitation for

weekend or late night shifts. These policies are specific to psychiatric services that will be provided at UMSMC-E and include:

- Behavioral Health Response Team Inquiry Calls Policy (See **Exhibit 11**)
- Admission Criteria Adult Psychiatric Inpatient (See **Exhibit 12**)
- Assessment for Admission of Patients to Inpatient Behavioral Health Unit (See **Exhibit 13**)

Each of the psychiatric protocols, policies, and procedures referenced in this section will be updated as appropriate to reflect their application to UM SMC at Easton prior to the transfer of psychiatric beds from UM SMC at Dorchester to UM SMC at Easton.

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:

UM SMC at Easton is an acute general hospital with a 32-bay emergency department, including two rooms that are designated as psychiatric holding areas for psychiatric patients awaiting disposition. The facility is designated by the Maryland Department of Health to perform evaluations of persons believed to have a mental disorder and brought to the hospital on an emergency petition.

AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

Applicant Response:

UM SMC at Easton is an acute general hospital with a 32-bay emergency department, including two rooms that are designated as psychiatric holding areas for psychiatric patients awaiting disposition. Also, the renovated inpatient behavioral health unit at UM SMC at Easton will have a designated seclusion room.

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:

The inpatient acute psychiatric program provides an array of services. The services include psychotropic medication therapy, individual therapy, group therapy, family therapy, social services, and co-occurring addictions treatment. All services are provided by dedicated staff assigned to the unit. Recreational therapy activities are provided by psychiatric technicians and by community-based providers. Social services are provided by the social worker and case management team dedicated to the behavioral health unit. Occupational and physical therapy services are provided on a consultative basis through the UM SRH Rehabilitation Department. If an inpatient behavioral health patient requires chemotherapy, UM SMC at Easton intends to transfer the patient to the MSGA inpatient unit within the facility or to the UM SRH Cancer Center in Easton to receive outpatient services.

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:

This standard is inapplicable because UM SMC at Easton does not provide inpatient child or adolescent acute psychiatric services.

AP 3c. All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicant Response:

As is the case presently at UM SMC at Dorchester, psychiatric consultation services will be provided by UM SRH's Psychiatry Department. The department will be staffed by 4.0 FTE psychiatric providers comprised of psychiatrists and mental health nurse practitioners. Services are provided 7 days per week. Additional consultation and referral services will be provided by the hospital's Behavioral Health Response Team, a group of licensed social workers and counselors who provide evaluation services and referral to patients.

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:

The Applicant proposes to relocate UM SMC at Dorchester's existing adult psychiatric inpatient beds as part of this merger and consolidation request. It is not proposing to add child or adolescent psychiatric beds as part of this request.

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:

This standard is inapplicable because the proposed project does not involve two or more age-specific psychiatric service lines.

Accessibility

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:

Once a patient has requested admission to UM SMC at Easton's behavioral health unit, the hospital will provide the following services: intake screening and admission or arrangements for transfer when a more appropriate treatment facility is indicated, and evaluation to better define the patient's psychiatric problem and to initiate emergency treatment. Currently, these functions are provided through the hospital's emergency department and psychiatry department. See **Exhibit 12** for UM SRH's Admission Criteria Adult Psychiatric Treatment Policy and **Exhibit 13** for UM SRH's Assessment for Admission of Patients to Inpatient Behavioral Health Unit, which provide more details on how these services will be provided at UM SMC at Easton.

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 use, and geriatric patients, either through direct treatment or referral.

Applicant Response:

As part of this merger and consolidation request, the Applicant is proposing to transfer UM SMC at Dorchester's general adult psychiatric unit to UM SMC at Easton. Within this general adult unit, geriatric and patients with a co-morbidity of substance use disorder will be

treated. The treatment team will consist of psychiatrists, nurses, and therapists with training and expertise in geriatrics, substance use disorder, and general psychiatry.

UM SMC at Dorchester's present behavioral health quality assurance program and program evaluation process will be implemented at UM SMC at Easton. UM SMC at Dorchester's Behavioral Health Quality Assurance policy is attached as **Exhibit 14**. UM SMC at Dorchester's treatment protocols for special behavioral health populations, including for geriatric patients and patients with a secondary diagnosis of substance use disorder, will also be implemented at UM SMC at Easton. These treatment protocols are attached as **Exhibit 15**.

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:

The Applicant does not seek a CON for new or expanded acute psychiatric services. Rather, it seeks a CON exemption to relocate the current inpatient psychiatric services from UM SMC at Dorchester to UM SMC at Easton. Nevertheless, patients will be admitted to the Behavioral Health unit regardless of their legal status. Patients are accepted for admission based on their clinical presentation and the availability of beds in the inpatient psychiatric unit. See UM SRH's Assessments for Admission of Patients to Inpatient Behavioral Health Unit provided as **Exhibit 12**.

AP 8. All acute general hospitals 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:

With the shift of cases from UM SMC at Dorchester, UM SMC at Easton intends to provide a level of uncompensated care that equals or exceeds the average uncompensated care for acute psychiatric patients in the service area.

As explained in response to COMAR 10.24.01.08G(3)(b) below, UM SMC at Easton's projected adult psychiatric service area includes Dorchester, Talbot, Caroline, Kent, Queen Anne's, and Anne Arundel Counties. The current providers of acute psychiatric services in this service area include UM SMC at Easton, UM SMC at Dorchester, Peninsula Regional Medical Center, and Atlantic General Hospital. UM SMC at Dorchester and UM SMC at Easton's percentages of uncompensated care are based on their fiscal year 2017 actual percentages of uncompensated care of 5.11% and 3.43%, respectively. This level of uncompensated care was published in the fiscal year 2017 HSCRC Annual Report of Revenue and Expenses and Volumes and reflects the level of uncompensated care for the entire hospital.

Combined with patients from UM SMC at Dorchester, UM SMC at Easton's percentage of uncompensated care is greater than the average 3.94% of uncompensated care provided by UM SMC at Easton, UM SMC at Dorchester, Peninsula Regional Medical Center, and Atlantic General, the four acute general hospitals providing psychiatric services in the health service area. (Table 20).

Table 20
Health Service Area Uncompensated Care Percent of Revenue

Hospital	FY2017 Percent UCC
UM SMC at Easton	3.43%
UM SMC at Dorchester	5.11%
SHS Average	**4.27%**
Peninsula Regional Medical Center	3.88%
Atlantic General	4.58%
Health Service Area Average	**3.94%**

Source: FY2017 HSCRC Annual Report of Revenue and Expenses and Volumes

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:

The pediatricians and the psychiatrists at UM SRH have developed treatment protocols for caring for pediatric psychiatric patients while they await transfer to another facility with pediatric inpatient bed capacity, which sometimes involves admission to a general pediatric bed. Attached as **Exhibit 16** is a decision chart and a Pediatric Behavioral Policy, which describes UM SMC at Easton's treatment protocol for pediatric psychiatric patients.

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 Standards
PBR <20	80%
20 ≤PBR <40	85%
PBR ≥40	90%

Applicant Response:

This standard is inapplicable because the proposed project does not involve expansion of existing adult care psychiatric beds.

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 is inapplicable because UM SMC at Easton is applying for an exemption to transfer existing adult psychiatric beds to another general acute care hospital.

Quality

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

Applicant Response:

The acute inpatient psychiatric services provided at UM SMC at Easton will be under the clinical supervision of a qualified psychiatrist, Dr. Eric Anderson. Dr. Anderson is the current Medical Director for the behavioral health inpatient unit of UM SMC at Dorchester as well as the Department of Psychiatry Chairperson and will continue in these roles when the behavioral health inpatient unit transfers to UM SMC at Easton. He will continue to oversee 4.0 FTE psychiatric providers comprised of psychiatrists and mental health nurse practitioners and provide clinical supervision to the nursing staff and therapists within the department. Dr. Anderson also leads training, quality improvement, and program development efforts for the Department of Psychiatry and its acute, inpatient unit.

Dr. Anderson has served as Medical Director for Shore Behavioral Health since July of 2013 and the Chairman of the Department of Psychiatry since 2017. Dr. Anderson is Board Certified in Psychiatry. He received his undergraduate degree from Iowa State University. He received his medical degree from the University of Iowa, his internship training in Family Practice at Pensacola Naval Hospital, and completed his psychiatric training at the Johns Hopkins Hospital in Baltimore. During his psychiatric residency, Dr. Anderson served as Chief Resident in Psychiatry. While in the U.S. Navy and prior to his psychiatric residency, he completed the Naval Aerospace Medicine Institute's Naval Flight Surgeon School.

Prior to coming to UM SRH, Dr. Anderson was in private practice in the Annapolis area and served as Chief Psychiatrist for Anne Arundel Medical Center. In 2011 he was named a "Top Doc." He is also an Assistant Professor for the University of Maryland's School of Medicine and a Clinical Instructor for Drexel University. He is a reviewer for a number of medical periodicals and has a lengthy list of published articles, book chapters, and interviews to his own credit. He also serves as an independent reviewer for the Maryland Board of Physicians.

Dr. Anderson directs the psychiatric care provided through UM SRH including its 24-bed, inpatient acute psychiatric unit, mental health intensive outpatient program, addictions intensive outpatient program, consultation-liaison service, and outpatient clinic. In addition to the above duties, he is a flight surgeon for the U.S. Air Force, having completed the Air Force's Flight Surgeon School. He serves as the chief flight surgeon for the 104th Fighter Squadron in Maryland's Air National Guard.

AP 12b. Staffing of acute psychiatric programs should include therapies 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:

A psychiatrist or mental health nurse practitioner is provided for each patient in the unit. Each patient is assigned to a therapist and a case manager who helps with coordination of services and referrals. See **Exhibit 17** for UM SRH's Behavioral Health Discharge Planning and Referral Policy, which provides additional information on UM SRH's Patient Care Services team, which provides referral and coordination services for patients being discharged from its behavioral health unit. The treatment program covers a seven day period. Staffing for this unit is also provided seven days per week.

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:

This standard is inapplicable because the proposed project does not involve child or adolescent psychiatric units.

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:

Attached as **Exhibit 17** is UM SRH's Behavioral Health Discharge Planning and Referral Policy, which governs discharge planning and referrals for patients being discharged from the behavioral health unit. This policy includes providing patients referrals and coordinating other services as needed, including: outpatient psychiatric treatment, community based programming, long term care, and other specialized inpatient care or referrals.

Acceptability

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:

This standard is inapplicable because UM SRH is not proposing a new or expanded program.

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 Applicant addressed the need for the proposed relocated MSGA beds in response to

COMAR 10.24.10.04(B)(2).

As for the proposed relocated psychiatric beds, the Commission has recognized that many of the standards in the State Health Plan Chapter for psychiatric Services are "out of date due to dramatic changes in use of hospital psychiatric beds (especially with respect to average length of stay) and changes in the role and scope of State psychiatric hospital facilities that have occurred since its development" and that the State Health Plan "does not have an applicable need analysis." (*In re Sheppard Pratt at Elkridge*, Docket No. 15-152367, Staff Report and Recommendation pp. 5, 13 (Sept. 20, 2016)).

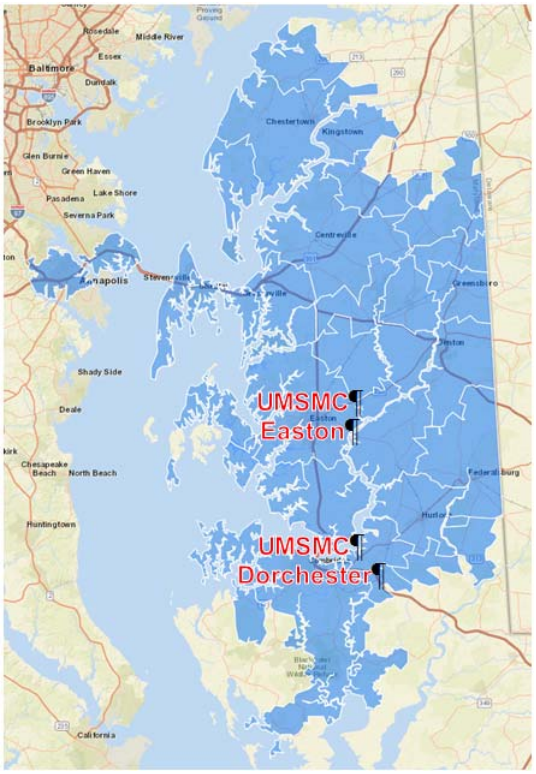
To project psychiatric bed need at UM SMC at Dorchester through fiscal year 2021 and then at UM SMC at Easton beginning in fiscal year 2022, the Applicant utilized a modified MSGA need analysis. The projected need for inpatient psychiatric beds reflect the methodology and assumptions described below.

1. *Defining UM SMC at Dorchester's Psychiatric Service Area*

To project the proposed psychiatric service area for UM SMC at Dorchester, the Applicant considered the fiscal year 2017 discharges by zip code for the adult psychiatric cohort at UM SMC at Dorchester. Child and adolescent psychiatric discharges were excluded from this analysis because UM SMC at Dorchester does not currently provide psychiatric inpatient treatment to children and adolescent patients. UM SMC at Dorchester identified the adult psychiatric service area as the zip codes that comprise the top 85% of adult psychiatric discharges at UM SMC at Dorchester.

Figure 2
UM SMC at Dorchester's Adult Psychiatric Service Area
FY2017

ZipCode	City	ZipCode	City
21613	Cambridge	21658	Queenstown
21601	Easton	21662	Royal Oak
21629	Denton	21663	Saint Michaels
21620	Chestertown	21671	Tilghman
21643	Hurlock	21623	Church Hill
21632	Federalsburg	21631	East New Market
21655	Preston	21625	Cordova
21638	Grasonville	21679	Wye Mills
21617	Centreville	21657	Queen Anne
21619	Chester	21659	Rhodesdale
21639	Greensboro	21835	Linkwood
21666	Stevensville	21626	Crapo
21660	Ridgely	21409	Annapolis
21673	Trappe	21636	Goldsboro
21661	Rock Hall	21677	Woolford
21678	Worton	21644	Ingleside
21401	Annapolis	21654	Oxford
21640	Henderson	21647	Mcdaniel
21649	Marydel	21676	Wittman



As presented in Figure 2 above and Table 21 below, UM SMC at Dorchester's proposed service area for the adult (aged 18 and over) psychiatric cohort is defined by zip codes that span Dorchester, Talbot, Caroline, Kent, Queen Anne's, and Anne Arundel Counties in Maryland. As shown in Table 21, the Zip Codes for adult psychiatric discharges from UM SMC at Dorchester are ranked from highest to lowest to identify the top 85% of total discharges.

Table 21
UM SMC at Dorchester's Adult Psychiatric Service Area
FY2017

#	Zip Code	Community	Total Discharges	Cumulative % of Discharges
1	21613	Cambridge	112	20.6%
2	21601	Easton	66	32.7%
3	21629	Denton	41	40.3%
4	21620	Chestertown	37	47.1%
5	21643	Hurlock	29	52.4%
6	21632	Federalsburg	24	56.8%
7	21655	Preston	19	60.3%
8	21638	Grasonville	14	62.9%
9	21617	Centreville	13	65.3%
10	21619	Chester	12	67.5%
11	21639	Greensboro	10	69.3%
12	21666	Stevensville	9	71.0%
13	21660	Ridgely	8	72.4%
14	21673	Trappe	8	73.9%
15	21661	Rock Hall	5	74.8%
16	21678	Worton	5	75.7%
17	21401	Annapolis	5	76.7%
18	21640	Henderson	4	77.4%
19	21649	Marydel	4	78.1%
20	21658	Queenstown	4	78.9%
21	21662	Royal Oak	4	79.6%
22	21663	Saint Michaels	4	80.3%
23	21671	Tilghman	4	81.1%
24	21623	Church Hill	3	81.6%
25	21631	East New Market	3	82.2%
26	21625	Cordova	2	82.5%
27	21679	Wye Mills	2	82.9%
28	21657	Queen Anne	2	83.3%
29	21659	Rhodesdale	2	83.6%
30	21835	Linkwood	2	84.0%
31	21626	Crapo	2	84.4%
32	21409	Annapolis	2	84.7%
33	21636	Goldsboro	1	84.9%
34	21677	Woolford	1	85.1%
35	21644	Ingleside	1	85.3%
	Other Service Area		80	85.3%
	Service Area Total		464	85.3%
	Outside of Service Area		80	100.0%
	Total		544	100.0%

Source: St. Paul statewide non-confidential data tapes

2. *Projected Adult Psychiatric Service Area Population*

Based on UM SMC at Dorchester's adult psychiatric service area, population projections through 2023 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 15-64 age cohort, the 65-74 age cohort and the 75+ age cohort, which are reflected below in Table 22. The 15-64 age cohort is expected to decline by 1.0% from 2018 to 2023, while the 65-74 age cohort is expected to grow by 17.1%, and the 75+ age cohort is expected to grow by 7.7%. Combined, the total service area population is projected to grow by 2.6% from 2018 to 2023.

Table 22
UM SMC at Dorchester's Historical and
Projected Adult Psychiatric Service Area Population
2010 – 2023

Age	Service Area Population						% Change in Population	
	2010		2018		2023			
Group	Pop	% of Total	Pop	% of Total	Pop	% of Total	2010-18	2018-23
15-64	138,490	78.7%	134,705	74.3%	133,348	71.7%	-2.7%	-1.0%
65-74	20,469	11.6%	26,864	14.8%	31,470	16.9%	31.2%	17.1%
75+	17,078	9.7%	19,676	10.9%	21,189	11.4%	15.2%	7.7%
Total	176,037	100.0%	181,245	100.0%	186,007	100.0%	3.0%	2.6%

Source: Environics Spotlight Pop-Facts Demographics by Age Race Sex

Using the compounded annual growth rate from 2018 to 2023, as set forth above in Table 22, population projections were extrapolated through 2024 and applied to UM SMC at Dorchester's fiscal years. Table 23 below depicts the projected service area population for the 15-64, 65-74, and 75+ age cohorts through 2024. Combined, the total population is expected to grow by 0.5% to 0.6% per year for a total growth of 3.2% from fiscal years 2018 to 2024.

Table 23
UM SMC at Dorchester's Historical and
Projected Adult Psychiatric Service Area Population
FY2016 - FY2024

	Actual	Actual	Actual/ Projected	Projected						% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Service Area Population										
18-64	**135,641**	**135,172**	**134,705**	**134,432**	**134,161**	**133,889**	**133,618**	**133,348**	**133,078**	*-1.2%*
65-74	**25,099**	**25,966**	**26,864**	**27,728**	**28,619**	**29,540**	**30,490**	**31,470**	**32,482**	*20.9%*
75+	**18,992**	**19,331**	**19,676**	**19,970**	**20,268**	**20,570**	**20,877**	**21,189**	**21,505**	*9.3%*
Total	**179,732**	**180,470**	**181,245**	**182,130**	**183,048**	**183,999**	**184,985**	**186,007**	**187,065**	*3.2%*
%Change		*0.4%*	*0.4%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.6%*	*0.6%*	

3. *UM SMC at Dorchester Adult Psychiatric Use Rates*

Use rates for the patient population cohorts were established based on historical trends in use rates that were calculated and projected per 1,000 population. Use rates in UM SMC at Dorchester's adult psychiatric service area declined in fiscal year 2017 and have declined year-to-date (quarters one and two) in fiscal year 2018. After experiencing these declines, future use rates are assumed to level off and remain constant, at each age cohort, with the use rates experienced in fiscal year 2018 year to date, while aging of the population will drive a lower overall use rate by fiscal year 2024, as the older two age cohorts have lower projected use rates than the younger age cohort (Table 24).

Table 24
UM SMC at Dorchester's Historical and
Projected Adult Psychiatric Use Rates
FY2016 - FY2024

	Actual	Actual	Actual/ Projected	Projected						% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Use Rate										
15-64	**5.6**	**5.1**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**	**5.2**	
%Change		-8.8%	2.5%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*
65-74	**2.7**	**2.7**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	**1.6**	
%Change		0.9%	-42.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*
75+	**2.6**	**3.9**	**2.9**	**2.9**	**2.9**	**2.9**	**2.9**	**2.9**	**2.9**	
%Change		50.4%	-24.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	*0.0%*
Total	**4.0**	**3.8**	**3.7**	**3.7**	**3.7**	**3.6**	**3.6**	**3.6**	**3.6**	
% Change		-4.8%	-4.0%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	-0.3%	*-1.6%*

4. *Adult Psychiatric Service Area Discharges*

With the growth in population and shift to older patients with lower use rates, total adult psychiatric discharges are projected to increase by 0.7% from fiscal year 2018 to 2024, a rate slower than that of total population growth (3.2%) shown above in Table 24.

Table 25
UM SMC at Dorchester's Historical and
Projected Adult Psychiatric Service Area Discharges
FY2016 – FY2024

	Actual	Actual	Actual/ Projected	Projected						% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Service Area Discharges										
15-64	**756**	**687**	**702**	**701**	**699**	**698**	**696**	**695**	**694**	***-1.2%***
%Change		***-9.1%***	***2.2%***	***-0.2%***	***-0.2%***	***-0.2%***	***-0.2%***	***-0.2%***	***-0.2%***	
65-74	**68**	**71**	**42**	**43**	**45**	**46**	**48**	**49**	**51**	***20.9%***
%Change		***4.4%***	***-40.8%***	***3.2%***	***3.2%***	***3.2%***	***3.2%***	***3.2%***	***3.2%***	
75+	**49**	**75**	**58**	**59**	**60**	**61**	**62**	**62**	**63**	***9.3%***
%Change		***53.1%***	***-22.7%***	***1.5%***	***1.5%***	***1.5%***	***1.5%***	***1.5%***	***1.5%***	
Total	**873**	**833**	**802**	**803**	**804**	**805**	**806**	**807**	**808**	***0.7%***
%Change		*-4.6%*	*-3.7%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	

5. *Adult Psychiatric Market Share*

The expected market share at UM SMC at Dorchester was calculated within the planned service area based on the number of fiscal year 2017 psychiatric discharges for the 15-64, 65-74, and 75+ age cohorts at UM SMC at Dorchester as a percentage of total adult psychiatric discharges within the service area.

While UM SMC at Dorchester's adult psychiatric market share increased in fiscal year 2017 and fiscal year 2018 year to date, it is projected to remain constant, at each age cohort, from fiscal year 2018 at UM SMC at Dorchester until the end of the projection period in fiscal year 2024 once UM SMC at Dorchester's inpatient psychiatric services have relocated to UM SMC at Easton (Table 26).

Table 26
UM SMC at Dorchester's Historical and
Projected Adult Psychiatric Market Share
FY2016 - FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Market Share										
15-64	**62.7%**	**59.8%**	**57.5%**	**57.5%**	**57.5%**	**57.5%**	**57.5%**	**57.5%**	**57.5%**	
%Change		*-4.6%*	*-3.8%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
65-74	**54.4%**	**52.1%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	**71.4%**	
%Change		*-4.2%*	*37.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
75+	**18.4%**	**21.3%**	**31.0%**	**31.0%**	**31.0%**	**31.0%**	**31.0%**	**31.0%**	**31.0%**	
%Change		*16.1%*	*45.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

6. *Out-of-Service Area Adult Psychiatric Discharges*

UM SMC at Dorchester's out-of-service area adult psychiatric discharges declined in fiscal year 2017 as a percentage of total discharges, but then increased in fiscal year 2018 year to date. Out-of-service area discharges are expected to remain constant, at each age cohort, at the 2018 level through fiscal year 2024 (Table 27).

Table 27
UM SMC at Dorchester's Out-of-Service Area Adult Psychiatric Discharges
% of Service Area Discharges
FY2016 - FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Out-of-Service Area Discharges % of Service Area Discharges										
15-64	**26.2%**	**18.7%**	**24.3%**	**24.3%**	**24.3%**	**24.3%**	**24.3%**	**24.3%**	**24.3%**	
%Change		*-28.4%*	*29.5%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
65-74	**10.8%**	**5.4%**	**20.0%**	**20.0%**	**20.0%**	**20.0%**	**20.0%**	**20.0%**	**20.0%**	
%Change		*-50.0%*	*270.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
75+	**0.0%**	**6.3%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	
%Change		*0.0%*	*-100.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

7. *Inpatient Adult Psychiatric Discharges*

In fiscal year 2017, the adult psychiatric discharges at UM SMC at Dorchester declined by 16.0%, but then increased by 2.2% in fiscal year 2018 year to date. Based on the assumptions presented above, adult psychiatric discharges are projected to grow by 0.1% per year between fiscal years 2018 and 2024, due primarily to population growth. Total adult psychiatric discharges are projected to increase by 0.6% between fiscal years 2018 and 2024 (Table 28).

Table 28
UM SMC at Dorchester's Historical and
Projected Adult Psychiatric Inpatient Discharges
FY2016 – FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Inpatient Discharges	**648**	**544**	**556**	**556**	**557**	**557**	**558**	**558**	**559**	*0.6%*
% Change		*-16.0%*	*2.2%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	*0.1%*	

8. *UM SMC at Dorchester Adult Psychiatric Average Length of Stay*

While the average length of stay ("ALOS") of adult psychiatric patients at UM SMC at Dorchester increased to 7.2 days in fiscal year 2017, it is expected to return to the fiscal year 2016 level through additional case management initiatives. This ALOS is projected to continue at UM SMC at Easton, beginning in fiscal year 2022, when UM SMC at Dorchester's inpatient adult psychiatric services will move to UM SMC at Easton. The ALOS will remain constant, at the age cohort level, through the end of the projection period (Table 29).

Table 29
UM SMC at Dorchester's Historical and Projected Adult Psychiatric ALOS
FY2016 – FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
ALOS (days)	**6.82**	**7.20**	**6.82**	**6.82**	**6.82**	**6.82**	**6.82**	**6.82**	**6.82**	*0.0%*
% Change		*5.6%*	*-5.3%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

9. *UM SMC at Easton Psychiatric Occupancy*

The adult psychiatric inpatient bed occupancy at both UM SMC at Dorchester and UM SMC at Easton was conservatively projected at 85% which is consistent with the outdated State Health Plan for Psychiatric Services, COMAR 10.24.07 (Need Projection Methodology (A)(7)), and much higher than the jurisdictional minimum occupancy standard of 70% applicable to MSGA beds with an average daily census of between 0-49 inpatients.

10. *UM SMC at Easton Psychiatric Bed Need*

Based on the assumptions presented above, the applicant has projected a need to relocate 12 adult psychiatric inpatient beds from UM SMC at Dorchester to UM SMC at Easton, beginning in fiscal year 2022 as demonstrated in Table 30.

Table 30
UM SMC at Dorchester's Historical and Projected Adult Psychiatric Bed Need
FY2016 – FY2024

	Actual	Actual	Actual/ Projected	Projected at Dorchester			Projected at Easton			% Change
	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Bed Need	**14**	**13**	**12**	**12**	**12**	**12**	**12**	**12**	**12**	*0.0%*
% Change		*-7.1%*	*-7.7%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	

IV. THE RELOCATION OF BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON WILL RESULT IN THE DELIVERY OF MORE EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES.

Finally, the Applicants have determined that the relocation of UM SMC at Dorchester's MSGA and psychiatric beds to UM SMC at Easton will result in more efficient and effective delivery of health care services.

A number of operational efficiencies will result from the relocation of MSGA and psychiatric beds from UM SMC at Dorchester to UM SMC at Easton, some of which are described in Section II.K above, the response to COMAR 10.24.10.04(B)(12) – Patient Safety. In addition, the following operational efficiencies will result from the consolidation inpatient beds from UM SMC at Dorchester to UM SMC at Easton:

- Relocation of the behavioral health unit to a unit that is right-sized to serve the reduced average daily census of behavioral health patients that are currently being served at UM SMC at Dorchester will result in operational efficiencies.
- Minimum staffing patterns for the MSGA units, which often have a low census but have to maintain minimum staffing patterns, will no longer be of concern, thereby increasing efficiency. The neuro 10 bed unit will be combined with the joint center 10 bed unit and the beds from UM SMC at Dorchester to create a 26-bed unit. This will increase efficiency of the combined unit and eliminate the need for minimum staffing patterns on the small, separate 10 bed units that currently exist.
- The consolidation of inpatient services to UM SMC at Easton will provide better access to vascular services (PICCs and midlines) because the vascular access team (IV Team) is based at UM SMC at Easton. Travel time to UM SMC at Dorchester will be obviated.

As discussed in Section II.L.3, consolidating UM SMC at Dorchester's inpatient services at UM SMC at Easton and moving UM SMC at Dorchester's outpatient services to the proposed UM SMC at Cambridge will result in a reduction of 113 FTEs and produce $9.1 million of operating expense efficiencies through reductions in salaries and other operating expenses. These efficiencies are summarized in Tables 17 and 18 above and the staffing reductions are shown in **Exhibit 1**, Table L.

V. THE RELOCATION OF MSGA BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON IS IN THE PUBLIC INTEREST.

Upon the proposed conversion of UM SMC at Dorchester to an FMF, it will be necessary to relocate MSGA and psychiatric beds to UM SMC at Easton in order to continue providing adequate access to these services for residents of the service area. Accordingly, the proposed consolidation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is necessary *in conjunction* with the conversion of UM SMC at Dorchester to an FMF and are in the public interest based on an assessment of the long-term viability of UM SMC at Dorchester as a general hospital through addressing such matters as: (i) trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends; (ii) the financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals; (iii) the age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant; (iv) the availability of alternative sources for acute care inpatient services; (v) the adequacy and appropriateness of the hospital's transition plan; and (vi) an assessment of the parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

The relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is in the public interest with respect to each of these criteria based on the analyses presented below.

A. The Relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is in the Public Interest Based on UM SMC at Dorchester's Inpatient Utilization for the Previous Five Years in the Context of Statewide Trends.

Table 31 presents a 15.7% decline in UM SMC at Dorchester's inpatient admissions between fiscal years 2014 and 2018. This decline is almost twice the 8.2% reduction experienced statewide.

Table 31
Comparison of Historical Admissions to Statewide Trends
FY2013 – FY2018

	Admissions					% Change
	FY2014	FY2015	FY2016	FY2017	FY2018 (1)	FY14-FY18
UM SMC at Dorchester	2,408	2,606	2,404	2,524	2,030	-15.7%
Statewide	602,547	583,885	569,994	564,644	553,340	-8.2%

Note (1): FY2018 results are annualized based on the first nine months of the fiscal year.
Source: HSCRC Experience Reports, rate center ADM

The decreasing number of admissions at UM SMC at Dorchester has created a financial hardship for the hospital with the cost of maintaining the hospital infrastructure, in addition to its declining financial margin. The declining margin is demonstrated in Section IV.B below. Continuing to operate UM SMC at Dorchester with reduced volumes is not in the public interest. Relocation of UM SMC at Dorchester's inpatient beds to UM SMC at Easton beds is in the public interest because it will provide continued access to MSGA and psychiatric services for residents of the UM SMC at Dorchester service area, yet provide these services in a more cost effective and efficient manner.

B. The Relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is in the Public Interest Based on UM SMC at Dorchester's Financial Performance Over the Past Five Years and in the Context of the Statewide Financial Performance of Maryland Hospitals.

As presented in Table 32, UM SMC at Dorchester generated operating margins ranging from 12.9% in fiscal year 2013 to 1.7% in fiscal year 2017. The most recent year's operating margin of 1.7% is below the statewide average of 2.8%.

Table 32
Comparison of Operating Margins to Statewide Financial Performance
FY2013 – FY2017

	Operating Margin (1)					Change
	FY2013	FY2014	FY2015	FY2016	FY2017	FY13 - FY17
UM SMC at Dorchester	12.9%	14.0%	14.3%	11.1%	1.7%	-86.9%
Statewide RE Schedule	1.3%	3.1%	3.7%	3.3%	2.8%	161.5%

Note (1): Includes both regulated and unregulated financial results.
Source: Annual Filing RE Schedule

The continued decline in operating margin at UM SMC Dorchester is not in the public interest. Relocating UM SMC at Dorchester's inpatient services to UM SMC at Easton is in the public interest because it will result in improved and sustainable financial performance by SHS.

C. The Relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is in the Public Interest Based on the Age of UM SMC at Dorchester's Physical Plant Relative to Other Maryland Hospitals and the Investment Required to Maintain and Modernize the Physical

UM SMC at Dorchester was constructed in three different phases, the oldest of which dates to at least 1914. The core of the existing building was completed in 1974. In 1992, building and grounds renovations included expansion and renovation of the emergency room, and cosmetic improvements of parts of the ground floor, including a new mammography area.

However, the hospital was originally built on that site more than 100 years ago, and parts of the original hospital structure are incorporated into the current hospital.

As presented in Table 33, the average age of UM SMC at Dorchester's physical plant was 14.4 years in fiscal year 2016. This compares to the Maryland statewide average of 10.2 years. In a publication by Moody's Investors Service, dated August 21, 2017, the median average age of plant for hospitals that it rates is 11.2 years. The Maryland statewide average is less than the Moody's median while UM SMC at Dorchester is greater. Due to the removal of the H1 schedule from the HSCRC Annual Filing, average plant age information is not available for the state for fiscal year 2017.

Table 33
Comparison of Average Age of Plant to Statewide Trends
FY2012 – FY2016

	Average Age of Plant (years)				
	2012	2013	2014	2015	2016
UM SMC at Dorchester	15.7	14.4	15.4	15.8	14.4
Statewide Average	9.0	9.1	10.0	10.0	10.2

Source: Annual Filings. This information was not reported in FY2017 filings.

For UM SMC at Dorchester to achieve the statewide average it would require approximately $32 million in capital expenditures to modernize its physical plant. This estimate of capital expenditures reflects the level of investment in assets with a 25-year useful life that would be required to increase annual depreciation expense to achieve a 10.2 year average age of plant.

This investment is supported by a study that UM SMC at Dorchester conducted to assess the capital investments that would be required to improve the UM SMC at Dorchester facilities.

This study found that a minimum of $37 million would be required to improve the following aspects of the existing facility:

- Brick and stucco veneer replacement
- Roof replacement
- Window replacement
- Emergency power generator and utility transformer replacement
- Air handling unit replacement (original building systems)
- Hot and chilled water system replacement
- Fire pump and sprinkler replacement
- Medical gas / vacuum system replacement
- American Disabilities Act upgrades
- Department renovations
    - Emergency
    - Cardiology
    - Radiology
    - Administration (walls cracking)
- Telephone system replacement

In addition, the existing UM SMC at Dorchester facility is comprised of approximately 199,000 net square feet which will require almost three times as much annual expense to continue to operate the existing plant versus the smaller proposed FMF facility with approximately 42,000 square feet. Spending this amount of money to modernize and maintain an aged facility is not in the public interest, especially when UM SMC at Easton is located only 15 miles away and has the space to accommodate the inpatient services needed to meet the community's needs. Rather, moving UM SMC at Dorchester's outpatient services to the proposed UM SMC at Cambridge and investing $8.5 million to renovate space at UM SMC at

Easton to consolidate the inpatient services currently provided at UM SMC at Dorchester is in the public interest.

D. The Relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is in the Public Interest Taking into Consideration the Alternative Sources for Acute Care Inpatient and Outpatient Services That Will no Longer be Provided on the Campus After Conversion to a Freestanding Medical Facility.

The Applicant requests an exemption from CON review to merge and consolidate UM SMC at Dorchester's inpatient services with UM SMC at Easton in order to ensure continued access to these services for residents currently served by UM SMC at Dorchester. All of the psychiatric discharges at UM SMC at Dorchester are expected to shift to UM SMC at Easton. UM SMC at Dorchester is proposing to transfer 12 psychiatric beds to UM SMC at Easton to accommodate these psychiatric patients.

While the majority of UM SMC at Dorchester's MSGA discharges will shift to UM SMC at Easton, the Applicant is projecting that in fiscal year 2022, 22.3% of UM SMC at Dorchester's medical discharges will move to other service area hospitals as presented in Table 34 below. UM SMC at Dorchester is proposing to transfer 17 MSGA beds to UM SMC at Easton to accommodate medical-surgical patients that do not move to other service area hospitals.

Table 34
Projected Shift of UM SMC at Dorchester
Medical and Surgical Discharges
FY2022

UM SMC at Dorchester MSGA Discharges	Projected FY2022	% of Total
Medical Discharges	1,376	92.6%
Surgical Discharges	110	7.4%
Reduction in UM SMC at Dorchester MSGA Discharges	1,486	100.0%
Shift to UM SMC at Easton	(1,155)	77.7%
Shift to Other Hospitals	(331)	22.3%
Increse at Other Hospitals	(1,486)	100.0%
Remaining UM SMC at Dorchester MSGA Discharges	-	-

The MSGA service area for UM SMC at Dorchester is defined as the set of zip codes from which 85% of UM SMC at Dorchester's medical-surgical admissions originate, as presented in Figure 1 and in Table 3. As shown in Table 35 below, while UM SMC at Dorchester had the largest market share in its service area in fiscal year 2017, UM SMC at Easton also had significant market share at 29.2% (Table 35). Peninsula Regional Medical Center had an 8.8% market share and is expected to receive some of UM SMC at Dorchester's medical discharges when it converts to an FMF.

Table 35
UM SMC at Dorchester Inpatient Discharge Market Share
In Inpatient MSGA Service Area
FY2017

Hospital Name	MSGA Discharges	Market Share
UM SMC at Dorchester	1,701	43.9%
UM SMC at Easton	1,131	29.2%
Peninsula Regional Medical Center	339	8.8%
University of Maryland Medical Center	250	6.5%
The Johns Hopkins Hospital	119	3.1%
Anne Arundel Medical Center	75	1.9%
Other hospitals with <100 admissions	257	6.6%
Total Service Area Inpatient Admissions	3,872	100.0%

Source: St. Pauls Non-Confidential Data Tapes

As Table 35 shows, UM SMC at Easton is already a dominant provider of medical-surgical services to residents residing in UM SMC at Dorchester's service area. It is in the public interest to allow UM SMC at Dorchester to consolidate inpatient services at UM SMC at Easton to ensure continued access to these necessary services by residents of its service area.

All outpatient services that are currently provided on the UM SMC at Dorchester campus will continue to be available to the community on the proposed UM SMC at Cambridge campus at Cambridge Marketplace.

E. The Relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is in the Public Interest Taking into Consideration the Adequacy and Appropriateness of UM SRH's Transition Plan.

UM SMC at Dorchester is part of UM SRH, the region's premier provider of coordinated health care services, inpatient and ambulatory, in the five counties of Maryland's mid-Shore region. UM SRH is a proud member of UMMS. The mission of UM SRH is ***Creating Healthier Communities Together***, a reflection of its dedication and commitment to work with community

partners, including physicians, other providers, and health and social services collaborators, to improve the health status of people who live and work in Maryland's mid-Shore region. UM SRH's vision is to be the region's leader in patient centered health care. In a rural and often economically disadvantaged region such as the mid-Shore, with a population of approximately 175,000 people spread out over nearly 2,000 square miles, the challenges of health care delivery and access are significant. In addition, rural health care providers have challenges with recruiting and retaining physicians and other clinicians and obtaining sufficient reimbursement to cover their costs. These issues are not new to the region or its primary health care system, UM SRH.

In addition to these challenges related to rural health care delivery, the landscape of health care delivery is changing across the nation and in Maryland. Health care delivery is shifting from hospital-centric care to patient- and people-centric care, with a focus on wellness, preventive care, primary care, and diagnostics. Health care planning and resource allocation has focused on planning delivery sites that are more accessible to residents. Patients have become "consumers" of health care and are defining their needs from their own perspectives. The 2016 UM SRH Community Health Needs Assessment shows a consumer-defined need in the mid-Shore region for access to outpatient services, primary care, and specialists to support prevention and management of chronic disease, including behavioral health and addiction services. Communities also define safety net needs related to urgent care and emergency medical care, which will continue to be important to citizens' health and well-being.

UM SRH's goal, in response to the Community Health Needs Assessment and its strategic planning work, is to address each of the consumer-defined needs in concert with the information gathered from UM SRH physicians, community partners, and UMMS. UM SRH's

plan for conversion of UM SMC at Dorchester to a freestanding medical facility, a facility that provides 24/7 emergency services as well as diagnostic, imaging and lab services, and observation services, is the result of input from hundreds of patients, providers, community partners and leadership, obtained over more than two years of study and planning.

The transition plan for UM SMC at Dorchester began as early as 2015, as part of UM SRH's regional plan to transform health care. In the first year of its new strategic plan, the UM SRH Board of Directors and its planning committee launched a Strategic Services Delivery Workgroup and subsequently, a Strategic Service Delivery Council. Both groups engaged physicians, providers, leadership, management, community health care partners, and elected officials in a review of regional health care needs as well as national and state trends in health care. The Service Delivery Council then assembled into five subcouncils, each chaired by a dyad of management and physician leaders and comprised of internal and external stakeholders in the fields of primary care, specialty care, surgical care, behavioral health, and oncology. The resulting recommendations were compiled by the Service Delivery Council, recommended for adoption by the UM SRH Board Strategic Planning Committee, and approved by the UM SRH Board and UMMS in 2016. This Strategic Service Delivery Plan, which defined needs and services at appropriate levels and facility types throughout the region, was then widely shared with community leaders, organizations, citizens, and elected officials.

The Strategic Service Delivery Plan envisioned that the Maryland General Assembly would allow hospitals to convert to an FMF, and a new statutory and regulatory framework would be implemented to govern hospitals converting to FMFs. UMMS and UM SRH participated in commenting on the legislation and regulations that would make hospital conversions to FMFs possible in Maryland. As the Strategic Service Delivery Plan was being

communicated and legislation was moving ahead, UM SRH continued the discussions it had already begun with its physician leaders in Dorchester County regarding the possibility of converting the aged hospital in Dorchester to an FMF. With physician support for the concept, including the relocation of inpatient beds to nearby UM SMC at Easton, just 15 miles away, UM SRH expanded the discussion to include the local public health officer, emergency medical services ("EMS"), local and state elected officials, and ultimately, to the full community in a series of community listening sessions during 2017. With overwhelmingly positive feedback from all of these sources, the Boards of UMMS and UM SRH approved moving forward with the detailed plan development for the conversion of UM SMC at Dorchester to an FMF in Cambridge with an adjacent medical pavilion with a complement of ambulatory services.

During late 2017 and early 2018, detailed planning work began on a location for the new medical campus, on facility design and site planning, services identification, budget and financing, and on early transition planning for three essential areas: (1) the plan to transition acute care services previously provided at UM SMC at Dorchester and the related transportation impact; (2) the plan to transition, retrain, and place employees of UM SMC at Dorchester; and (3) the plan for the existing UM SMC at Dorchester physical plant and site. Although the proposed conversion and transition are not scheduled to occur until 2021, there has been steady focus and measurable accomplishment on the transition planning and the steps needed to bring it to fruition by 2021.

1. Plan for Transitioning of Acute Care Services Previously Provided at UM SMC at Dorchester

The projected timeline for transitioning acute care services presently provided at UM SMC at Dorchester will depend upon several milestones, in particular the regulatory approval of

the plan to convert UM SMC at Dorchester to an FMF, to be called UM SMC at Cambridge. In conjunction with the conversion, and as described fully herein, UM SRH is seeking to move 17 inpatient MSGA beds and 12 inpatient psychiatric beds from UM SMC at Dorchester to UM SMC at Easton in order to ensure adequate access to these services for residents of the service area. UM SRH estimates that regulatory approval for conversion and transfer of these beds could take approximately six months, with groundbreaking occurring once all approvals have been finalized and permits obtained. If approved, construction for the FMF and adjacent medical pavilion, which will be called the UM Shore Medical Pavilion at Cambridge and at the inpatient facility at Easton to accommodate the inpatient medical/surgical and behavioral health beds that will be transferred from UM SMC at Dorchester to UM SMC at Easton is anticipated to take approximately 16 months. The projected opening of the FMF and transfer of beds to UM SMC at Easton is by the summer of 2021.

UM SMC at Dorchester will continue providing the full complement of services that it provides today until the conversion occurs. Upon approval and conversion, a portion of UM SMC at Dorchester's inpatients beds will be moved to UM SMC at Easton and UM SMC at Cambridge will open on a new campus conveniently located approximately one mile from the existing UM SMC at Dorchester site at the intersection of US Route 50 and Woods Road in Cambridge. The proposed UM SMC at Cambridge will provide 24/7 emergency services and be staffed by board certified University of Maryland Emergency Medicine physicians and advanced practice providers that will serve patients of all ages. The proposed UM SMC at Cambridge will continue to accept and care for all EMS priority levels as defined by established protocols and will continue to communicate as a base station with EMS providers to coordinate care that is appropriate for patients' needs and in their best interests. The proposed FMF will also continue

to provide the necessary diagnostic testing, including imaging and laboratory services, and will provide short-term observation services for the management of certain types of patients who do not meet inpatient criteria. Telemedicine consultations for behavioral health and other specialty services are currently provided for in all of UM SRH's emergency departments and will continue at the proposed UM SMC at Cambridge.

Patients who present at UM SMC at Cambridge and are assessed to be in need of inpatient medical, surgical, or critical care will, subject to the patient's expressed preferences, be transferred to UM SMC at Easton. These patients will be stabilized at UM SMC at Cambridge by emergency physicians and clinical staff and the interfacility call system will be initiated to establish physician to physician communication and to coordinate acceptance and transport of the patient to UM SMC at Easton, another UMMS inpatient facility, or a facility which the patient chooses or meets the patient's specific needs. Because it currently operates three hospitals and an FMF in Queenstown across a wide geography and in relative isolation from the rest of the State and because UM SMC at Easton is already a regional hub for certain inpatient services such as PCI, stroke, obstetrics, pediatrics and acute rehabilitation, UM SRH already has a well-defined and regularly monitored plan for transports in place and will continue to monitor and refine it as needed.

UM SMC at Easton will complete its renovations for the relocation of MSGA and psychiatric beds from UM SMC at Dorchester, the beds will be operational, and staff transitions will be complete at the time of the conversion to make the transition as seamless as possible.

Patients who arrive at UM SMC at Cambridge in need of behavioral health services will continue to receive the same emergency assessment and care as are presently provided at UM SMC at Dorchester, including assessment by the Behavioral Health Response Team ("BHRT")

and consultation with psychiatrists and clinicians via telemedicine where appropriate. The FMF will have an intensive outpatient behavioral health program for adult patients and additional outpatient behavioral health services will be located in the adjacent UM SMP at Cambridge. Patients who need adult inpatient behavioral health services will, appropriate to their needs and preferences, be transferred to the inpatient adult behavioral health unit which is being relocated from UM SMC at Dorchester to UM SMC at Easton. The inpatient behavioral health unit at UM SMC at Dorchester is a regional service at present and when the unit is relocated to UM SMC at Easton it will be sized appropriately to continue to meet the inpatient behavioral health beds needs of adult patients from around the region.

2. Transportation Planning

Transportation to and from emergency services, both in FMFs and hospitals is a critical component of successful transition planning and ultimately, to the transformation of health care delivery that provides efficient and effective care with optimal outcomes. To this end, UM SRH has had a unique opportunity to work on effective regional transportation, in particular, providing interfacility hospital-to-hospital transports for more than 20 years for patients in need of regional specialty services and providing FMF-to-hospital transports for more than eight years for patients seen at the UM Shore EC at Queenstown in need of inpatient or other specialty services.

For nearly a decade, UM SRH has had a continuing and effective contractual relationship with the region's predominant provider of interfacility ground medical transportation services, Best Care Ambulance, Inc. ("Best Care"). Best Care has base sites located throughout the region from which it deploys EMT-staffed, licensed ambulances for transports between UM SRH

hospital emergency departments and FMF and outside the region to facilities of a patient's choice or facilities with specialty services. The interfacility transport services provided by Best Care under its contract with UMMS and UM SRH are already regional. Best Care's operational and quality metrics are reviewed quarterly as part of the UM SRH Interfacility Transport Committee, which includes representatives of nursing, critical care, and emergency medicine clinicians, Maryland ExpressCare, and leadership from Best Care. UMMS and UM SRH's discussions with Best Care are ongoing as regional programs expand and the conversion of UM SMC at Dorchester to an FMF brings opportunities for further collaboration and expanded services. UMMS and UM SRH intend to amend their contract with Best Care, as needed, to accommodate the needs for additional interfacility transports.

UM SRH is also participating in discussions with UMMS and its ExpressCare service to facilitate transfers and admissions via a central access center within the UMMS system and elsewhere as appropriate, to provide ambulance services for basic life support ("BLS"), advanced life support ("ALS"), and critical care patient transportation for UM SRH patients through Maryland ExpressCare or a licensed vendor ambulance service, 24 hours per day, seven days per week. ExpressCare, already in use on the mid-Shore and contractually supported by Best Care, will undergo further UMMS refinements and ultimately will provide a coordinating center for all transports, including those by helicopter, which are currently coordinated by UMMS or other receiving institution. A modern helipad is located at each of UM SRH's hospitals and the proposed UM SMC at Cambridge will also have a helipad adjacent to the FMF that will be used for air transports.

3. Plan for Job Retraining and Placement of UM SMC at Dorchester Employees

The wellbeing and future of the UM SRH team members working at UM SMC at Dorchester has been a focus since the beginning discussions regarding the conversion of the hospital to an FMF. As UM SRH has fine-tuned its projected future patient volumes and staffing needs, it has developed a clearer picture of the staffing resources that will be needed at the FMF and adjacent medical pavilion in Cambridge, as well as in connection with the inpatient beds being transferred to UM SMC at Easton. Clinical staffing at the FMF will likely be similar to the current UM SMC at Dorchester emergency department. UM SRH also anticipates transferring clinical and support staff to cover the acute inpatient services being transferred from UM SMC at Dorchester to UM SMC at Easton, but there will be some overlap with existing staff at Easton.

To address the very specific assessment of staffing needs and plans necessary to adapt through reassignment and training for new jobs, UM SRH has formed a Workforce Transition and Development Task Force (the "Task Force") whose efforts will get underway in the second half of calendar year 2018 and will continue through 2021. The Task Force will involve a collaborative process and perspective from across multiple disciplines, including nursing, providers, clinical and ancillary support, facility management, human resources, and local community training and education resources. The Task Force's first priority will be to determine the total workforce needs and appropriate placements at the proposed UM SMC at Cambridge, the adjacent medical pavilion, and UM SMC at Easton in 2021 based on current UM SMC at Dorchester staff, taking into consideration retirements and anticipated attrition over the next three year period. The Task Force will next review options and make recommendations regarding alternative placements within UM SRH and UMMS for any displaced employees, as

well as identify training options and match employees with resources in the event of displacement. The Task Force will keep UM SMC at Dorchester team members well-informed throughout its process by engaging them early on in discussions and working with them throughout the transition process.

Once the Task Force has refined its projections and identified the appropriate team members needed for the FMF, adjacent medical pavilion, and acute services that will be transitioning to UM SMC at Easton, as well as the needs within the full UM SRH system, focused outreach efforts will be made with each team member regarding the transition plan and options. UM SRH Human Resources representatives will meet and work one-on-one with employees to provide information about resources and opportunities available to them. The top priority will be to match team members with employment opportunities; consideration will be given to placement within the employee's current county of work, to the extent options match need. UM SRH will also provide training, career shadow days, and other resources to help staff transition to new roles. In addition, UM SRH plans to provide a link to other position vacancies within the UMMS system to connect those staff members who would prefer to transfer to another UMMS facility with additional job opportunities. By identifying open positions and offering additional training, UM SRH is hopeful that it will be able to place all staff within UM SRH or UMMS, should employees elect to stay within the system. UM SRH will also work with local workforce development services to link displaced staff or staff members who want to pursue other opportunities with resources regarding other job opportunities in the community.

UM SRH leadership has worked over the years to build meaningful relationships with community partners, such as Chesapeake College, the Eastern Shore Area Health Education Center, and regional economic and workforce development offices. These relationships will help

UM SRH and its team members understand their options for learning new skills to expand their job placement opportunities, if they choose to do so. Preliminary discussions have been held with these community resources and they will participate in the Task Force's discussions and decisions. Job fairs, onsite career training, and certification courses are among the options UM SRH will evaluate as part of the workforce transition plan, which will evolve over the next three years.

4. Plan for the Existing UM SMC at Dorchester Plant and Site

Once the FMF building is complete, emergency and ancillary services will relocate to the FMF on the new campus in Cambridge along with outpatient services that will relocate to the medical pavilion. At that time, UM SRH intends to relocate the inpatient beds from UM SMC at Dorchester to UM SMC at Easton. The existing hospital building in Cambridge is planned for decommissioning and demolition and the site will be vacated in order to sell it for redevelopment in support of the Cambridge/Dorchester County Waterfront Development vision, advancing economic development in the city, county, and the region. Dorchester County, the City of Cambridge, and UM SRH have signed a Letter of Intent to outline the future property sale of the existing UM SMC at Dorchester site to the newly incorporated body, Cambridge Waterfront Development, Inc. ("CWDI") in order to include the hospital property in a waterfront development project that will enhance destination recreation, job creation, and commerce in Cambridge, its port, and Dorchester County.

F. The Relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is in the Public Interest Based on an Assessment of SHS's Projected Financial Performance.

The operating profits of UM SMC at Easton will benefit from a positive financial contribution from the shift of inpatient beds from UM SMC at Dorchester. As shown in

Table H, SHS which includes UM SMC at Easton, UM SMC at Dorchester through fiscal year 2021 and UM SMC at Cambridge in fiscal year 2022 through 2024 will generate positive operating income throughout the projection period.

CONCLUSION

For all of the reasons set forth above, the Applicant respectfully requests that the Commission authorize the merger and consolidation of MSGA and psychiatric beds from UM SMC at Dorchester to UM SMC at Easton and associated capital expenditures.

Table of Exhibits

Table of Tables

Table of Figures

Figure	Description

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

7/2/18
Date

Kenneth D. Kozel
President & CEO
UM Shore Regional Health

#632159
012516-0006

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

6/27/2018
Date

Robert Frank, MBA
Senior Regional Vice President,
Operations
UM Shore Regional Health

#632157
012516-0006

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

June 27 2018
Date

William Huffner, M.D., MBA,
FACEP, FACHE
Senior Vice President, Medical Affairs
and Chief Medical Officer
UM Shore Regional Health

#632155
012516-0006

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

6/27/2018
Date

Ruth Ann Jones
Ruth Ann Jones, Ed.D., MSN, RN, NEA-BC
Senior Vice President, Patient Care Services and Chief Nursing Officer
UM Shore Regional Health

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

June 28, 2018
Date

Patti K. Willis
Patti Willis
Senior Vice President, Strategy & Communications
UM Shore Regional Health

#569256
012516-0003

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

6/27/18
Date

JoAnne Hahey
Chief Financial Officer
UM Shore Regional Health

#632160
012516-0006

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

6/29/18
Date

Darryl Mealy
Vice President of Construction and
Facilities Planning
University of Maryland Medical System

#632162
012516-0006

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

JUNE 27th, 2018
Date

David Klahn
Vice President
HKS, Inc.

#632164
012516-0006

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

6/27/18
Date

Andrew L. Solberg
A.L.S. Healthcare Consultant Services

#632153
012516-0006

EXHIBIT 1

Name of Applicant:	Shore Health System, Inc. d/b/a University of Maryland Shore Medical Center at Easton and University of Maryland Shore Medical Center at Dorchester
Date of Submission:	13-Jul-18

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

Table Number	Table Title	Instructions
Table A	**Physical Bed Capacity Before and After Project**	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	**Departmental Gross Square Feet**	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	**Construction Characteristics**	All applicants proposing new construction or renovation must complete Table C.
Table D	**Site and Offsite Costs Included and Excluded in Marshall Valuation Costs**	All applicants proposing new construction or renovation must complete Table D.
Table E	**Project Budget**	All applicants, regardless of project type or scope, must complete Table E.
Table F	**Statistical Projections - Entire Facility**	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	**Revenues & Expenses, Uninflated - Entire Facility**	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	**Revenues & Expenses, Inflated - Entire Facility**	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	**Statistical Projections - New Facility or Service**	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	**Revenues & Expenses, Uninflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	**Revenues & Expenses, Inflated - New Facility or Service**	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	**Work Force Information**	All applicants, regardless of project type or scope, must complete Table L.

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2018	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity				
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							**ACUTE CARE**						
General Medical/ Surgical*		69					**General Medical/ Surgical***				0	0	
MedSurg	2 East		19	6	25	31	MedSurg	2 East	24	6	30	36	
Surgical/Medical	3 East		10	10	20	30	Surgical/Medical	3 East	17	10	27	37	
Neuro	4 East		5	3	8	11	Neuro	4 East	5	3	8	11	
							Med Surg	4 East	5	0	5	5	
Joint	2 East/South		6	2	8	10	Joint	2 East/South	6	2	8	10	
Telemetry	4 South		20	4	24	28	Telemetry	4 South	20	4	24	28	
Resp/Cardio	3 Center		3	4	7	11	Resp/Cardio	3 Center	3	4	7	11	
							Pediatics	5 South	3	0	3	3	
Renal	2 South		5	0	5	5	Renal	2 South	5	0	5	5	
SUBTOTAL Gen. Med/Surg*		**69**	**68**	**29**	**97**	**126**	**SUBTOTAL Gen. Med/Surg***		**88**	**29**	**117**	**146**	
ICU/CCU		**10**	10	0	10	10	**ICU/CCU**		10	0	10	10	
Other *(Specify/add rows as needed)*					0	0					0	0	
TOTAL MSGA		**79**	**78**	**29**	**107**	**136**	**TOTAL MSGA**		**98**	**29**	**127**	**156**	
Obstetrics		**17**			0	0	**Obstetrics**				0	0	
5 East (LDRP)	Birthing Center 5E		10	0	10	10	5 East (LDRP)	Birthing Center 5E	10	0	10	10	
Antepartum	Birthing Center 5E		3	0	3	3	Antepartum	Birthing Center 5E	3	0	3	3	
OR 5 East	Birthing Center 5E		1	0	1	1	OR 5 East	Birthing Center 5E	1	0	1	1	
PACU 5 East	Birthing Center 5E		1	0	1	1	PACU 5 East	Birthing Center 5E	1	0	1	1	
Triage 5 East	Birthing Center 5E		3	0	3	3	Triage 5 East	Birthing Center 5E	3	0	3	3	
Pediatrics	3rd Floor South	**8**	4	5	9	14	**Pediatrics**	3rd Floor South	0	0	0	0	
Psychiatric					0	0	**Psychiatric**	3rd Floor South	4	4	8	12	
TOTAL ACUTE		**104**	**100**	**34**	**134**	**168**	**TOTAL ACUTE**		**120**	**33**	**153**	**186**	
NON-ACUTE CARE							**NON-ACUTE CARE**						
Dedicated Observation**					0	0	**Dedicated Observation****			**0**	0	0	
Rehabilitation	5 South	**20**	4	8	12	20	**Rehabilitation**	5 South	5	5	10	15	
Comprehensive Care					0	0	**Comprehensive Care**				0	0	
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*			**0**	0	0	
Sleep Lab	3 South		4	0	4	4	Sleep Lab		0	**0**	0	0	
										0	0	0	
TOTAL NON-ACUTE		**20**	**8**	**8**	**16**	**24**	**TOTAL NON-ACUTE**		**5**	**5**	**10**	**15**	
HOSPITAL TOTAL		**124**	**108**	**42**	**150**	**192**	**HOSPITAL TOTAL**		**125**	**38**	**163**	**201**	

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the "Observation Center". Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION: Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Med/Surg (Medical Oncology)	15,184	0	1,041	14,814	15,855
Med/Surg (General)	15,300	0	2,048	15,046	17,094
Behavioral Health Unit	10,815	0	8,310	0	8,310
Med/Surg (Joint & Neuro)	12,160	0	1,309	12,160	13,469
LDRP / Peds	13,015	0	728	13,015	13,743
Med/Surg (Rehab Unit)	11,438	0	989	9,669	10,658
Total	77,912	0	14,425	64,704	79,129

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION : If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☐	☐
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☐	☐
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Basement		0
First Floor		0
Second Floor		1,041
Third Floor		10,358
Fourth Floor		1,309
Fifth Floor		1,717
Total Area		14,425
Average Square Feet		**3,606**
Perimeter in Linear Feet	**Linear Feet**	
Basement		0
First Floor		0
Second Floor		208
Third Floor		621
Fourth Floor		261
Fifth Floor		343
Total Linear Feet		**1,433**
Average Linear Feet		**358**
Wall Height (floor to eaves)	**Feet**	
Basement		N/A
First Floor		N/A
Second Floor		12
Third Floor		12
Fourth Floor		12
Fifth Floor		12
Average Wall Height		
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger		Existing
Freight		Existing
Sprinklers	**Square Feet Covered**	
Wet System		Existing
Dry System		Existing
Other	**Describe Type**	
Type of HVAC System for proposed project	Existing	
Type of Exterior Walls for proposed project	Existing	

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS		
INSTRUCTION : If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.		
	NEW CONSTRUCTION COSTS	**RENOVATION COSTS**
SITE PREPARATION COSTS		
Normal Site Preparation		
Utilities from Structure to Lot Line		
Subtotal included in Marshall Valuation Costs		
Site Demolition Costs		
Storm Drains		
Rough Grading		
Hillside Foundation		
Paving		
Exterior Signs		
Landscaping		
Walls		
Yard Lighting		
Other *(Specify/add rows if needed)*		
Sediment Control & Stabilization		
Helipad		
Water		
Sewer		
Premium for Minority Business Enterprise Requirement		
Outside the Loop		
Subtotal On-Site excluded from Marshall Valuation Costs	**$0**	**$0**
OFFSITE COSTS		
Roads		
Utilities		

TABLE E. PROJECT BUDGET

INSTRUCTION : Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. See additional instruction in the column to the right of the table.

NOTE : Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. Land Purchase			**$0**
b. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
c. Renovations			
(1) Building	$5,058,140		$5,058,140
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees	$546,949		$546,949
(4) Permits (Building, Utilities, Etc.)	$10,000		$10,000
SUBTOTAL	**$5,615,089**	**$0**	**$5,615,089**
d. Other Capital Costs			
(1) Movable Equipment	$563,590		$563,590
(2) Contingency Allowance	$557,996		$557,996
(3) Gross interest during construction period	$841,931		$841,931
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$1,963,517***	***$0***	**$1,963,517**
TOTAL CURRENT CAPITAL COSTS	**$7,578,606**	**$0**	**$7,578,606**
e. Inflation Allowance	$198,325		$198,325
TOTAL CAPITAL COSTS	**$7,776,931**	**$0**	**$7,776,931**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$113,388**		$113,388
b. Bond Discount			$0
c. Legal Fees	**$45,000**		$45,000
d. Non-Legal Consultant Fees	**$20,000**		$20,000
e. Liquidation of Existing Debt			$0
f. Debt Service Reserve Fund	**$561,946**		$561,946
g. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$740,334***	***$0***	**$740,334**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$8,517,265***	***$0***	***$8,517,265***
B. Sources of Funds			
1. Cash			$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds	**$8,419,317**		$8,419,317
4. Interest Income from bond proceeds listed in #3	**$97,948**		$97,948
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$8,517,265***	***$0***	**$8,517,265**
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - SHORE HEALTH SYSTEM

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. DISCHARGES									
a. General Medical/Surgical*	8,011	8,234	7,266	7,294	7,339	7,385	7,110	7,157	7,206
b. ICU/CCU	236	254	224	225	227	228	220	221	223
Total MSGA	**8,247**	**8,488**	**7,490**	**7,520**	**7,565**	**7,613**	**7,330**	**7,379**	**7,429**
c. Pediatric	125	106	62	62	61	61	60	60	60
d. Obstetric	1,050	1,057	1,174	1,202	1,230	1,259	1,289	1,319	1,350
e. Acute Psychiatric	648	544	556	556	557	557	558	558	559
Total Acute	***10,070***	***10,195***	***9,282***	***9,339***	***9,413***	***9,490***	***9,237***	***9,316***	***9,398***
f. Rehabilitation	344	357	346	350	355	360	364	369	374
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	***10,414***	***10,552***	***9,628***	***9,690***	***9,768***	***9,849***	***9,602***	***9,686***	***9,772***
2. PATIENT DAYS									
a. General Medical/Surgical*	35,447	37,297	31,378	30,689	30,085	29,503	27,538	26,989	26,394
b. ICU/CCU	2,107	2,047	1,753	1,710	1,671	1,632	1,558	1,522	1,483
Total MSGA	**37,554**	**39,344**	**33,132**	**32,400**	**31,756**	**31,135**	**29,097**	**28,511**	**27,878**
c. Pediatric	292	245	152	151	150	149	148	147	146
d. Obstetric	2,513	2,570	2,888	2,956	3,026	3,097	3,170	3,245	3,322
e. Acute Psychiatric	4,417	3,917	3,790	3,793	3,796	3,799	3,803	3,807	3,811
Total Acute	***44,776***	***46,076***	***39,961***	***39,300***	***38,728***	***38,180***	***36,218***	***35,710***	***35,156***
f. Rehabilitation	3,567	3,394	3,632	3,679	3,727	3,776	3,827	3,878	3,930
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	***48,343***	***49,470***	***43,593***	***42,979***	***42,455***	***41,956***	***40,045***	***39,588***	***39,086***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	4.4	4.5	4.3	4.2	4.1	4.0	3.9	3.8	3.7
b. ICU/CCU	8.9	8.1	7.8	7.6	7.4	7.2	7.1	6.9	6.7
Total MSGA	4.6	4.6	4.4	4.3	4.2	4.1	4.0	3.9	3.8
c. Pediatric	2.3	2.3	2.5	2.5	2.5	2.5	2.5	2.5	2.5
d. Obstetric	2.4	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.5
e. Acute Psychiatric	6.8	7.2	6.8	6.8	6.8	6.8	6.8	6.8	6.8
Total Acute	4.4	4.5	4.3	4.2	4.1	4.0	3.9	3.8	3.7
f. Rehabilitation	10.4	9.5	10.5	10.5	10.5	10.5	10.5	10.5	10.5
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	4.6	4.7	4.5	4.4	4.3	4.3	4.2	4.1	4.0

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - SHORE HEALTH SYSTEM

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*	94	94	94	98	96	94	88	86	84
b. ICU/CCU	16	16	16	16	16	16	11	11	11
Total MSGA	**110**	**110**	**110**	**114**	**112**	**110**	**99**	**97**	**95**
c. Pediatric	8	8	8	1	1	1	1	1	1
d. Obstetric	17	17	17	12	12	12	12	13	13
e. Acute Psychiatric	24	24	24	12	12	12	12	12	12
Total Acute	***159***	***159***	***159***	***139***	***137***	***135***	***125***	***123***	***121***
f. Rehabilitation	20	20	20	13	14	14	14	14	14
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***179***	***179***	***179***	***152***	***150***	***148***	***139***	***137***	***135***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	103.3%	108.7%	91.5%	85.6%	85.9%	86.3%	85.3%	85.7%	86.1%
b. ICU/CCU	36.1%	35.0%	30.0%	29.3%	28.6%	28.0%	38.8%	37.9%	36.9%
Total MSGA	**93.5%**	**98.0%**	**82.5%**	**77.7%**	**77.7%**	**77.8%**	**80.2%**	**80.3%**	**80.4%**
c. Pediatric	10.0%	8.4%	5.2%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
d. Obstetric	40.5%	41.4%	46.5%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
e. Acute Psychiatric	50.4%	44.7%	43.3%	86.6%	86.7%	86.7%	86.8%	86.9%	87.0%
Total Acute	**77.2%**	**79.4%**	**68.9%**	**77.6%**	**77.7%**	**77.7%**	**79.6%**	**79.7%**	**79.7%**
f. Rehabilitation	48.9%	46.5%	49.8%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**74.0%**	**75.7%**	**66.7%**	**77.4%**	**77.4%**	**77.5%**	**79.1%**	**79.2%**	**79.2%**
6. OUTPATIENT VISITS									
a. Emergency Department (IP and OP)	72,661	67,955	68,071	68,186	68,309	68,440	68,579	68,726	68,881
b. Same-day Surgery OP Visits	3,329	3,333	3,338	3,343	3,349	3,355	2,886	2,892	2,900
c. Laboratory OP RVUs	4,401,015	4,271,265	4,276,814	4,282,371	4,288,548	4,295,359	4,271,304	4,279,408	4,288,193
d. Imaging OP RVUs	776,132	768,199	769,179	770,160	771,252	772,458	767,808	769,245	770,805
e. MRI OP RVUs	29,250	26,290	26,316	26,342	26,372	26,406	12,697	12,727	12,759
TOTAL OUTPATIENT VISITS	***5,282,387***	***5,137,042***	***5,143,717***	***5,150,403***	***5,157,830***	***5,166,018***	***5,123,273***	***5,132,998***	***5,143,537***
7. OBSERVATIONS**									
a. Number of Patients	2,071	2,476	2,480	2,484	2,489	2,494	2,499	2,504	2,510
b. Hours	81,332	110,662	107,830	108,013	108,208	108,414	108,634	108,866	109,111

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Most Recent Years (Actual)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 131,796	$ 129,172	130,886	130,886	130,886	133,362	133,362	133,362
b. Outpatient Services	177,167	185,931	181,525	181,525	181,525	176,830	176,830	176,830
Gross Patient Service Revenues	***308,963***	***315,103***	***312,411***	***312,411***	***312,411***	***310,192***	***310,192***	***310,192***
c. Allowance For Bad Debt	-	7,126	7,772	7,646	7,523	7,115	6,997	6,883
d. Contractual Allowance	67,802	58,378	56,169	58,943	60,382	62,129	63,645	65,198
e. Charity Care	-	2,770	2,789	2,736	2,685	2,583	2,534	2,486
Net Patient Services Revenue	***241,161***	***246,829***	***245,680***	***243,085***	***241,821***	***238,365***	***237,015***	***235,625***
f. Other Operating Revenues (Specify/add rows if needed)	4,576	4,305	4,367	4,367	4,367	4,032	4,032	4,032
NET OPERATING REVENUE	***$ 245,737***	***$ 251,134***	***$ 250,047***	***$ 247,452***	***$ 246,188***	***$ 242,397***	***$ 241,047***	***$ 239,657***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 120,913	$ 112,640	$ 113,646	$ 113,526	$ 113,417	$ 107,520	$ 108,240	$ 108,980
b. Professional Fees	11,137	11,707	11,707	11,707	11,707	11,605	11,595	11,585
c. Interest on Current Debt	2,983	3,602	4,004	3,955	3,907	3,859	3,812	3,765
d1. Interest on Project Debt - FMF	-	-	-	-	-	2,090	2,054	2,016
d2. Interest on Project Debt - Easton	-	-	-	-	-	424	417	409
e. Current Depreciation	17,976	18,269	19,215	18,711	17,292	13,889	12,800	11,735
f1. Project Depreciation - FMF	-	-	-	-	-	1,780	1,816	1,852
f2. Project Depreciation - Easton	-	-	-	-	-	330	330	330
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	38,148	38,533	38,475	38,739	39,012	37,962	38,231	38,509
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	42,398	44,163	43,711	43,887	44,068	53,042	53,264	53,490
k. Fixed Cost Additions	-	-	5,438	1,629	1,808	3,509	3,509	3,509
TOTAL OPERATING EXPENSES	**$ 233,555**	**$ 228,914**	**$ 236,195**	**$ 232,155**	**$ 231,211**	**$ 236,011**	**$ 236,067**	**$ 236,180**
3. INCOME								
a. Income From Operation	**$ 12,182**	**$ 22,220**	**$ 13,852**	**$ 15,297**	**$ 14,977**	**$ 6,386**	**$ 4,980**	**$ 3,477**
b. Non-Operating Income								
SUBTOTAL	***$ 12,182***	***$ 22,220***	***$ 13,852***	***$ 15,297***	***$ 14,977***	***$ 6,386***	***$ 4,980***	***$ 3,477***
c. Income Taxes								
NET INCOME (LOSS)	***$ 12,182***	***$ 22,220***	***$ 13,852***	***$ 15,297***	***$ 14,977***	***$ 6,386***	***$ 4,980***	***$ 3,477***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Most Recent Years (Actual)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
4) Commercial Insurance	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
5) Self-pay	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
6) Other	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
1) Medicare	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%
4) Commercial Insurance	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
5) Self-pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
6) Other	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G –
Key Financial Projection Assumptions for UM Shore Health System
(Does not include HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the UM Shore Health System (SHS) FY2017 actual financial performance with assumptions identified below. SHS includes Memorial Hospital at Easton, Dorchester General Hospital and Queen Anne's Emergency Center.	
Projection period reflects FY2018 – FY2024	
Volumes	- Refer to historical and projected utilization in Table F
Patient Revenue • Gross Charges	
o Update Factor	- 0.00% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.00% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.00% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with outpatient services shifted to the FMF and inpatient services shifted to Easton in FY2022 - 50% variable cost factor associated with the loss of volumes to other providers
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $4.3M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense - Remainder of SHS's Retained Revenue will be apportioned to Memorial Hospital of Easton to cover its depreciation and interest expense associated with renovations and to fund ambulatory and physician network development and population health initiatives
• Revenue Deductions	- Continuation of 2017 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments, UCC pool receipts) as percentages of gross revenue
Other Operating Revenue	- Remains constant from FY2018 with the exception of a loss of other operating revenue at FMF in FY2022
Expenses	
• Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 0.0% weighted average annual increase that reflects the following: - 0.0% - 0.0% - 0.0% - 0.0% - 0.0%
• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	 - 80% - 0% - 80% - 50% - 0%

• Building Related Operating Expense	- Incremental building operating costs (utilities, housekeeping, maintenance, security) calculated for the FMF's new square feet
• Interest Expense o Existing Debt	- Continued amortization of existing debt and related interest expense
o Project Debt	- Amortization of the following debt issuance over 30 years at 5.0% • $42.0M for construction of the new FMF • $8.4M for renovations at Easton • $33.1M for construction of a new MOB
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment - 7 year useful life for routine capital expenditures
• Additional Incremental Expenses	- New expenses related to EPIC implementation ($5 million in fiscal year 2019), physician contracting and other strategic initiatives as follows: • $5.4M in FY2019 • $1.6M in FY2020 • $1.8M in FY2021 • $3.5M in FY2022-FY2024 - The retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of Dorchester to an FMF, will enable SHS to fund $8.2M of initiatives related to ambulatory and physician network development and population health initiatives.

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Most Recent Year (Actual)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 131,796	$ 129,172	$ 134,080	$ 137,351	$ 140,703	$ 146,863	$ 150,446	$ 154,117
b. Outpatient Services	177,167	185,931	185,954	190,491	195,139	194,731	199,482	204,349
Gross Patient Service Revenues	***308,963***	***315,103***	***320,034***	***327,843***	***335,842***	***341,593***	***349,928***	***358,466***
c. Allowance For Bad Debt	-	7,126	7,962	8,024	8,088	7,835	7,894	7,954
d. Contractual Allowance	67,802	58,378	57,540	58,943	60,382	62,129	63,645	65,198
e. Charity Care	-	2,770	2,858	2,872	2,886	2,845	2,859	2,873
Net Patient Services Revenue	***241,161***	***246,829***	***251,675***	***258,003***	***264,487***	***268,784***	***275,530***	***282,441***
f. Other Operating Revenues (Specify/add rows if needed)	4,576	4,305	4,367	4,367	4,367	4,032	4,032	4,032
NET OPERATING REVENUE	***$ 245,737***	***$ 251,134***	***$ 256,042***	***$ 262,370***	***$ 268,854***	***$ 272,816***	***$ 279,562***	***$ 286,473***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 120,913	$ 112,640	$ 116,260	$ 118,809	$ 121,424	$ 117,759	$ 121,273	$ 124,911
b. Professional Fees	11,137	11,707	12,011	12,324	12,644	12,860	13,183	13,514
c. Interest on Current Debt	2,983	3,602	4,004	3,955	3,907	3,859	3,812	3,765
d1. Interest on Project Debt - FMF	-	-	-	-	-	2,090	2,054	2,016
d2. Interest on Project Debt - Easton	-	-	-	-	-	424	417	409
e. Current Depreciation	17,976	18,269	19,215	18,711	17,292	13,889	12,800	11,735
f1. Project Depreciation - FMF	-	-	-	-	-	1,780	1,816	1,852
f2. Project Depreciation - Easton	-	-	-	-	-	330	330	330
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	38,148	38,533	39,629	41,099	42,629	42,726	44,321	45,982
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	42,398	44,163	44,585	45,660	46,765	57,414	58,807	60,238
k. Fixed Cost Additions	-	-	5,438	1,629	1,808	3,509	3,509	3,509
TOTAL OPERATING EXPENSES	**$ 233,555**	**$ 228,914**	**$ 241,142**	**$ 242,186**	**$ 246,470**	**$ 256,641**	**$ 262,321**	**$ 268,261**
3. INCOME								
a. Income From Operation	**$ 12,182**	**$ 22,220**	**$ 14,900**	**$ 20,184**	**$ 22,384**	**$ 16,175**	**$ 17,241**	**$ 18,212**
b. Non-Operating Income								
SUBTOTAL	***$ 12,182***	***$ 22,220***	***$ 14,900***	***$ 20,184***	***$ 22,384***	***$ 16,175***	***$ 17,241***	***$ 18,212***
c. Income Taxes								
NET INCOME (LOSS)	***$ 12,182***	***$ 22,220***	***$ 14,900***	***$ 20,184***	***$ 22,384***	***$ 16,175***	***$ 17,241***	***$ 18,212***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Most Recent Year (Actual)	Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.					
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%	53.7%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%	7.8%
4) Commercial Insurance	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
5) Self-pay	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
6) Other	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
Total MSGA								
1) Medicare	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%	62.0%
2) Medicaid	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%	21.1%
3) Blue Cross	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%	5.6%
4) Commercial Insurance	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
5) Self-pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
6) Other	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H –
Key Financial Projection Assumptions for UM Shore Health System
(Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the UM Shore Health System (SHS) FY2017 actual financial performance with assumptions identified below. SHS includes Memorial Hospital at Easton, Dorchester General Hospital and Queen Anne's Emergency Center.	
Projection period reflects FY2018 – FY2024	
Volumes	- Refer to historical and projected utilization in Table F
Patient Revenue • Gross Charges	
o Update Factor	- 2.0% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.29% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.15% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with outpatient services shifted to the FMF and inpatient services shifted to Easton in FY2022 - 50% variable cost factor associated with the loss of volumes to other providers
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $4.3M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense - Remainder of SHS's Retained Revenue will be apportioned to Memorial Hospital of Easton to cover its depreciation and interest expense associated with renovations and to fund ambulatory and physician network development and population health initiatives
• Revenue Deductions	- Continuation of 2017 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments, UCC pool receipts) as percentages of gross revenue
Other Operating Revenue	- Remains constant from FY2018 with the exception of a loss of other operating revenue at FMF in FY2022
Expenses	
• Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 2.5% weighted average annual increase that reflects the following: - 2.25% - 2.75% - 3.0% - 2.8% - 2.0%

• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	 - 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- Incremental building operating costs (utilities, housekeeping, maintenance, security) calculated for the FMF's new square feet
• Interest Expense o Existing Debt o Project Debt	- Continued amortization of existing debt and related interest expense - Amortization of the following debt issuance over 30 years at 5.0% • $42.0M for construction of the new FMF • $8.4M for renovations at Easton • $33.1M for construction of a new MOB
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment - 7 year useful life for routine capital expenditures
• Additional Incremental Expenses	- New expenses related to EPIC implementation ($5 million in fiscal year 2019), physician contracting and other strategic initiatives as follows: • $5.4M in FY2019 • $1.6M in FY2020 • $1.8M in FY2021 • $3.5M in FY2022-FY2024 - The retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of Dorchester to an FMF, will enable SHS to fund $8.2M of initiatives related to ambulatory and physician network development and population health initiatives.

TABLE I. STATISTICAL PROJECTIONS - SHIFT OF MSGA AND PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. DISCHARGES									
a. General Medical/Surgical*							1,121	1,130	1,138
b. ICU/CCU							33	34	34
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**1,155**	**1,163**	**1,172**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							558	558	559
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***1,712***	***1,722***	***1,731***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	***0***	***0***	***0***	***0***	***0***	***0***	***1,712***	***1,722***	***1,731***
2. PATIENT DAYS									
a. General Medical/Surgical*							4,897	4,933	4,971
b. ICU/CCU							129	130	131
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**5,026**	**5,063**	**5,102**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							3,803	3,807	3,811
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***8,829***	***8,870***	***8,913***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	***0***	***0***	***0***	***0***	***0***	***0***	***8,829***	***8,870***	***8,913***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	0.0	0.0	0.0	0.0	0.0	0.0	4.4	4.4	4.4
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0	3.9	3.9	3.9
Total MSGA	0.0	0.0	0.0	0.0	0.0	0.0	4.4	4.4	4.4
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0	6.8	6.8	6.8
Total Acute	0.0	0.0	0.0	0.0	0.0	0.0	5.2	5.2	5.1

TABLE I. STATISTICAL PROJECTIONS - SHIFT OF MSGA AND PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
f. Rehabilitation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	0.0	0.0	0.0	0.0	0.0	0.0	5.2	5.2	5.1
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*							16	16	16
b. ICU/CCU							1	1	1
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**17**	**17**	**17**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							12	12	12
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***29***	***29***	***29***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***0***	***0***	***0***	***0***	***0***	***0***	***29***	***29***	***29***
5. OCCUPANCY PERCENTAGE ****IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	83.9%	84.5%	85.1%
b. ICU/CCU	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	35.3%	35.6%	35.9%
Total MSGA	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**81.0%**	**81.6%**	**82.2%**
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	86.8%	86.9%	87.0%
Total Acute	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**83.4%**	**83.8%**	**84.2%**
f. Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**83.4%**	**83.8%**	**84.2%**

TABLE I. STATISTICAL PROJECTIONS - SHIFT OF MSGA AND PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
6. OUTPATIENT VISITS									
a. Emergency Department (IP and OP)									
b. Same-day Surgery									
c. Laboratory									
d. Imaging									
e. Other (Specify/add rows of needed)									
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**									
a. Number of Patients									
b. Hours									

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - SHIFT OF MSGA AND PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE							
a. Inpatient Services					$ 28,757	$ 28,757	$ 28,757
b. Outpatient Services					-	-	-
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***	***28,757***	***28,757***	***28,757***
c. Allowance For Bad Debt					1,127	1,127	1,127
d. Contractual Allowance					3,048	3,048	3,048
e. Charity Care					352	352	352
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***	***24,230***	***24,230***	***24,230***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ 24,230***	***$ 24,230***	***$ 24,230***
2. EXPENSES							
a. Salaries & Wages (including benefits)					$ 7,505	$ 7,505	$ 7,505
b. Professional Fees					1,167	1,167	1,167
c. Interest on Current Debt					-	-	-
d. Interest on Project Debt					424	417	409
e. Current Depreciation					-	-	-
f. Project Depreciation					323	323	323
g. Current Amortization					-	-	-
h. Project Amortization					-	-	-
i. Supplies					989	994	1,000
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)					13,980	14,036	14,094
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ 24,388***	***$ 24,442***	***$ 24,498***
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ (158)**	**$ (212)**	**$ (267)**
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ (158)***	***$ (212)***	***$ (267)***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ (158)***	***$ (212)***	***$ (267)***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - SHIFT OF MSGA AND PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare					61.8%	61.8%	61.8%
2) Medicaid					24.7%	24.7%	24.7%
3) Blue Cross					3.9%	3.9%	3.9%
4) Commercial Insurance					6.6%	6.6%	6.6%
5) Self-pay					0.9%	0.9%	0.9%
6) Other					2.2%	2.2%	2.2%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days							
Total MSGA							
1) Medicare					58.4%	58.4%	58.4%
2) Medicaid					28.0%	28.0%	28.0%
3) Blue Cross					4.0%	4.0%	4.0%
4) Commercial Insurance					6.8%	6.8%	6.8%
5) Self-pay					0.9%	0.9%	0.9%
6) Other					1.9%	1.9%	1.9%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table J – Key Financial Projection Assumptions for Shift of MSGA and Psychiatric beds from UM SMC at Dorchester to UM SMC at Easton (Does not include HSCRC Annual Update Factors & Expense Inflation)

Projection is based on UM Shore Medical Center at Dorchester FY2017 actual financial performance of its inpatient services with assumptions identified below.	
Projection period reflects FY2018 – FY2024	
Volumes	- Refer to historical and projected utilization in Table I and Sections H and I related to the methodology, assumptions and projections of MSGA and Psychiatric Volumes
Patient Revenue • Gross Charges o Update Factor	- 0.00% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.00% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.00% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with regulated inpatient services shifted from Dorchester General Hospital to the SMC at Easton in FY2022
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $0.83M of SHS's Retained Revenue will be apportioned to the SMC at Easton to cover its depreciation and interest expense related to the transfer of IP beds. - An additional $8.4M of SHS's Retained Revenue will be apportioned to UM SMC at Easton to fund ambulatory and physician network development and population health initiatives
• Revenue Deductions	- Continuation of 2017 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue - Historical UCC pool receipts for inpatient services at Dorchester General Hospital are carried forward when the inpatient beds transfer to UM SMC at Easton.
Other Operating Revenue	- Historical other operating revenue at Dorchester General Hospital is eliminated beginning in FY2022
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 0.0% weighted average annual increase that reflects the following: - 0.0% - 0.0% - 0.0% - 0.0% - 0.0%
• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	- 80% - 0% - 80% - 50% - 0%

• Building Related Operating Expense	- As UM SMC at Easton is an existing facility and this project will not add square feet to the facility, no incremental building operating costs (utilities, housekeeping, maintenance, security) are included
• Interest Expense	- Amortization of $8.5M for renovations to accommodate the IP beds over 30 years at 5.0%
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment
• Additional Incremental Expenses	- The retention of 50% of revenue associated with patients that will seek care at other providers following the merger and consolidation of Dorchester, will enable SHS to fund $8.2M of initiatives related to ambulatory and physician network development and population health initiatives.

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - SHIFT OF MSGA AND PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE							
a. Inpatient Services	$ -	$ -	$ -	$ -	$ 32,102	$ 32,885	$ 33,688
b. Outpatient Services	-	-	-	-	-	-	-
Gross Patient Service Revenues	**-**	**-**	**-**	**-**	***32,102***	***32,885***	***33,688***
c. Allowance For Bad Debt	-	-	-	-	1,258	1,289	1,320
d. Contractual Allowance	-	-	-	-	3,408	3,491	3,576
e. Charity Care	-	-	-	-	393	402	412
Net Patient Services Revenue	**-**	**-**	**-**	**-**	***27,044***	***27,704***	***28,380***
f. Other Operating Revenues (Specify/add rows of needed)	-	-	-	-	-	-	-
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ 27,044***	***$ 27,704***	***$ 28,380***
2. EXPENSES							
a. Salaries & Wages (including benefits)	-	-	-	-	$ 8,449	$ 8,639	$ 8,833
b. Professional Fees	-	-	-	-	1,311	1,341	1,371
c. Interest on Current Debt	-	-	-	-	-	-	-
d. Interest on Project Debt	-	-	-	-	424	417	409
e. Current Depreciation	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	323	323	323
g. Current Amortization	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	1,121	1,155	1,189
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	-	-	-	-	15,224	15,583	15,950
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ 26,853***	***$ 27,457***	***$ 28,076***
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ 191**	**$ 247**	**$ 304**
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ 191***	***$ 247***	***$ 304***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ 191***	***$ 247***	***$ 304***

4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare					61.8%	61.8%	61.8%
2) Medicaid					24.7%	24.7%	24.7%
3) Blue Cross					3.9%	3.9%	3.9%
4) Commercial Insurance					6.6%	6.6%	6.6%
5) Self-pay					0.9%	0.9%	0.9%
6) Other					2.2%	2.2%	2.2%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days							
1) Medicare					58.4%	58.4%	58.4%
2) Medicaid					28.0%	28.0%	28.0%
3) Blue Cross					4.0%	4.0%	4.0%
4) Commercial Insurance					6.8%	6.8%	6.8%
5) Self-pay					0.9%	0.9%	0.9%
6) Other					1.9%	1.9%	1.9%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table K – Key Financial Projection Assumptions for Shift of MSGA and Psychiatric beds from UM SMC at Dorchester to UM SMC at Easton (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on UM Shore Medical Center at Dorchester FY2017 actual financial performance of its inpatient services with assumptions identified below.	
Projection period reflects FY2018 – FY2024	
Volumes	- Refer to historical and projected utilization in Table I and Sections H and I related to the methodology, assumptions and projections of MSGA and Psychiatric Volumes
Patient Revenue • Gross Charges o Update Factor	- 2.0% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.29% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.15% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with regulated inpatient services shifted from Dorchester General Hospital to the SMC at Easton in FY2022
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $0.83M of SHS's Retained Revenue will be apportioned to the SMC at Easton to cover its depreciation and interest expense related to the transfer of IP beds. - An additional $9.7M of SHS's Retained Revenue will be apportioned to UM SMC at Easton to fund ambulatory and physician network development and population health initiatives
• Revenue Deductions	- Continuation of 2017 deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue - Historical UCC pool receipts for inpatient services at Dorchester General Hospital are carried forward when the inpatient beds transfer to UM SMC at Easton.
Other Operating Revenue	- Historical other operating revenue at Dorchester General Hospital is eliminated beginning in FY2022
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 2.5% weighted average annual increase that reflects the following: - 2.25% - 2.75% - 3.0% - 2.8% - 2.0%

• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	- 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- As UM SMC at Easton is an existing facility and this project will not add square feet to the facility, no incremental building operating costs (utilities, housekeeping, maintenance, security) are included
• Interest Expense	- Amortization of $8.5M for renovations to accommodate the IP beds over 30 years at 5.0%
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment
• Additional Incremental Expenses	- The retention of 50% of revenue associated with patients that will seek care at other providers following the merger and consolidation of Dorchester, will enable SHS to fund $8.2M of initiatives related to ambulatory and physician network development and population health initiatives.

TABLE L. WORKFORCE INFORMATION - SHIFT OF MSGA AND PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration			$ -			$ -			$ -	-	$ -
Direct Care Staff *(List general categories, add rows if needed)*											
2 Multi Spec Care			$ -			$ -			$ -	12.20	$ 804,979
Intensive Care			-			-			-	25.29	1,761,073
Behavioral Health Care			-			-			-	28.90	1,800,464
Laboratory Svcs			-			-			-	4.19	277,342
Respiratory Svcs			-			-			-	2.24	187,991
Emergency			-			-			-	0.80	54,074
Rehab Svcs Phys Ther			-			-			-	3.27	208,415
Clinic Pert Team			-			-			-	0.01	853
Rehab Svcs Occup Ther			-			-			-	0.80	53,488
Ss Endoscopy Svcs			-			-			-	0.03	2,468
Ambulatory Care Sdc			-			-			-	0.00	21
Sbh Partial Hosp Program			-			-			-	2.10	145,285
Clinic Pert Team			-			-			-	2.49	179,626
MRI			-			-			-	1.62	100,903
Employee Health			-			-			-	2.96	207,264
Reg Sleep Disorder Ctr			-			-			-	0.97	78,752
Total Direct Care			$ -			$ -			$ -	87.9	$ 5,862,998
Support Staff *(List general categories, add rows if needed)*											
Total Support			$ -			$ -			$ -	-	$ -
REGULAR EMPLOYEES TOTAL			$ -			$ -			$ -	87.9	$ 5,862,998

TABLE L. WORKFORCE INFORMATION - SHIFT OF MSGA AND PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT EASTON

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G.

	CURRENT ENTIRE FACILITY			***PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)***			***PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) ****	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration			$ -			$ -			$ -	-	$ -
Direct Care Staff *(List general categories, add rows if needed)*											
Total Direct Care Staff			$ -			$ -			$ -	-	$ -
Support Staff *(List general categories, add rows if needed)*											
Total Support Staff			$ -			$ -			$ -	-	$ -
CONTRACTUAL EMPLOYEES TOTAL			$ -			$ -			$ -	-	$ -
Benefits *(State method of calculating benefits below)**:***											$ 1,641,639
28% of Salaries											
TOTAL COST	**-**		***$ -***	**-**		***$ -***	**-**		***$ -***		***$ 7,504,637***

EXHIBIT 2

1 Level 02 - Existing

1/16" = 1'-0"

2 Level 02 - Proposed

1/16" = 1'-0"

5 NEW PRIVATE MED/SURG PATIENT ROOMS ON LEVEL 2 SOUTH

LOCATION OF NEW MED/SURG PATIENT ROOMS

LOCATION OF NEW INPATIENT BEHAVIORAL HEALTH UNIT

RECONFIGURED UNIT SUPPORT SPACES

LOCATION OF RELOCATED PEDIATRIC PATIENT ROOMS

UNIT BOUNDARY

HKS

ARCHITECT
HKS, INC.
2100 EAST CARY STREET, SUITE 100
RICHMOND, VA 23223

UM Shore Medical Center at Easton

INTERIM REVIEW ONLY
These documents are incomplete, and are released for interim review only and are not intended for regulatory approval,

permit, or construction purposes.

Architect: XXXXXX
Arch. Reg. No.: XXXX
Date: XX/XX/XXXX

KEY PLAN

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.006

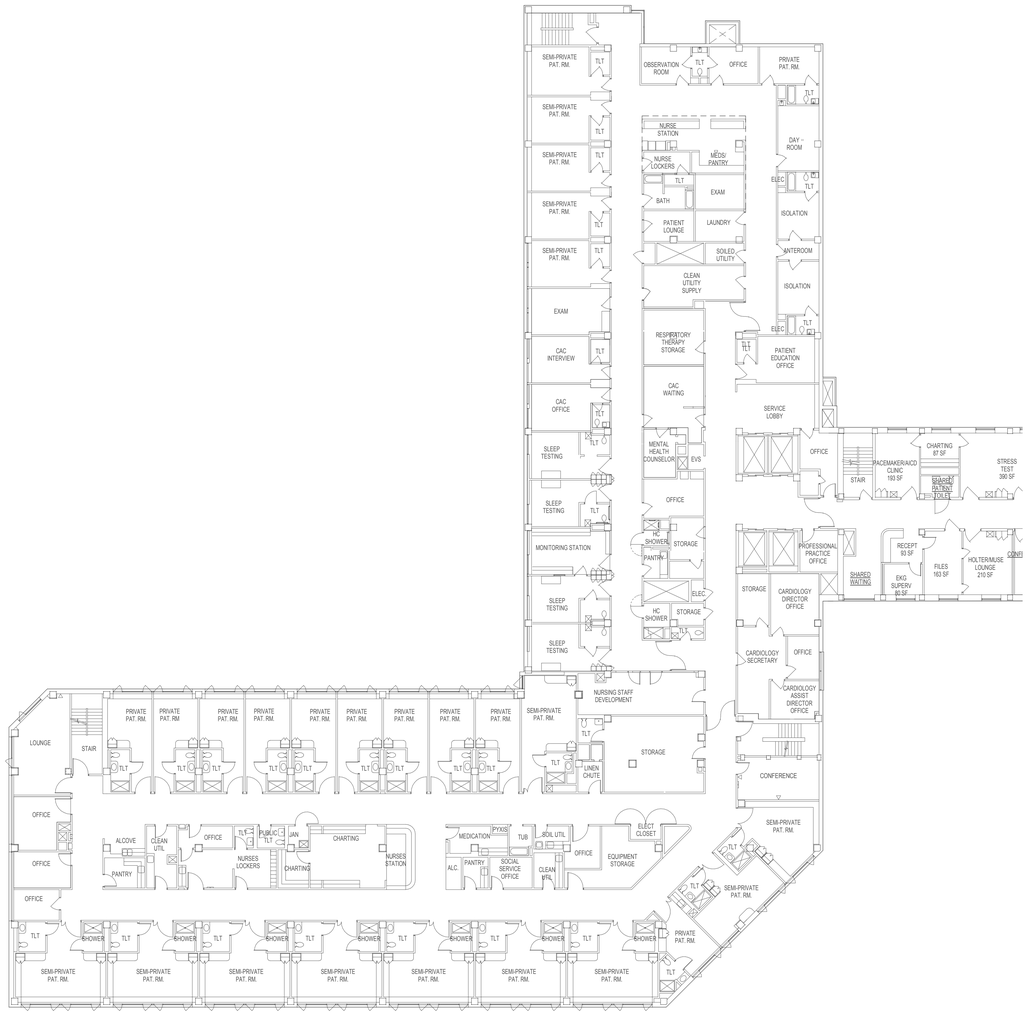
DATE
July 09, 2018

ISSUE
COE Submission

SHEET TITLE
LEVEL 02 - FLOOR PLAN

SHEET NO.
A1.02

PLOT DATE: 7/2/2018 3:47:34 PM TEMPLATE VERSION: 3.0.0.20170623



1 Level 03 - Exisiting
1/16" = 1'-0"

2 Level 03 - Proposed
1/16" = 1'-0"

7 NEW PRIVATE MED/SURG PATIENT ROOMS ON LEVEL 3 SOUTH
NEW 12 BED INPATIENT BEHAVIORAL HEALTH UNIT ON LEVEL 3 EAST

LOCATION OF NEW MED/SURG PATIENT ROOMS

LOCATION OF NEW INPATIENT BEHAVIORAL HEALTH UNIT

RECONFIGURED UNIT SUPPORT SPACES

LOCATION OF RELOCATED PEDIATRIC PATIENT ROOMS

UNIT BOUNDARY

HKS

ARCHITECT
HKS, INC.
2100 EAST CARY STREET, SUITE 100
RICHMOND, VA 23223

UM Shore Medical Center at Easton

INTERIM REVIEW ONLY
These documents are incomplete, and are released for interim review only and are not intended for regulatory approval,

permit, or construction purposes.

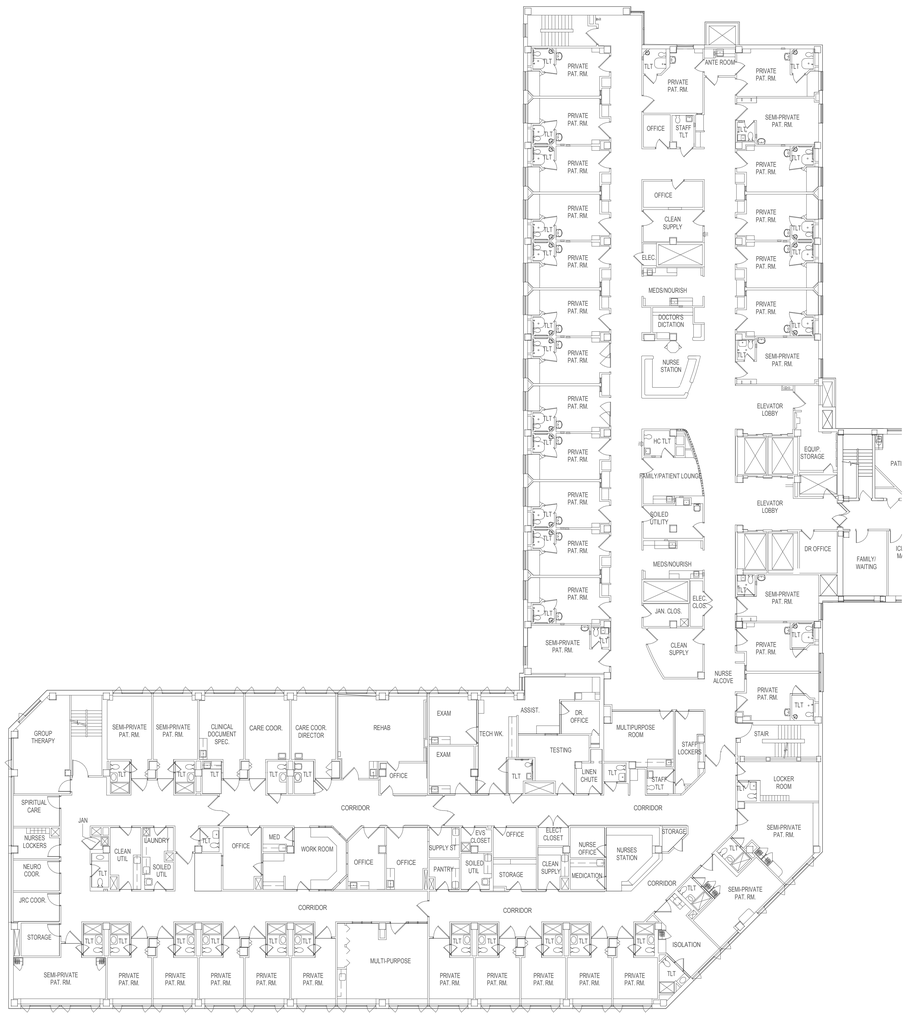
Architect: XXXXXX
Arch. Reg. No.: XXXX
Date: XX/XX/XXXX

KEY PLAN

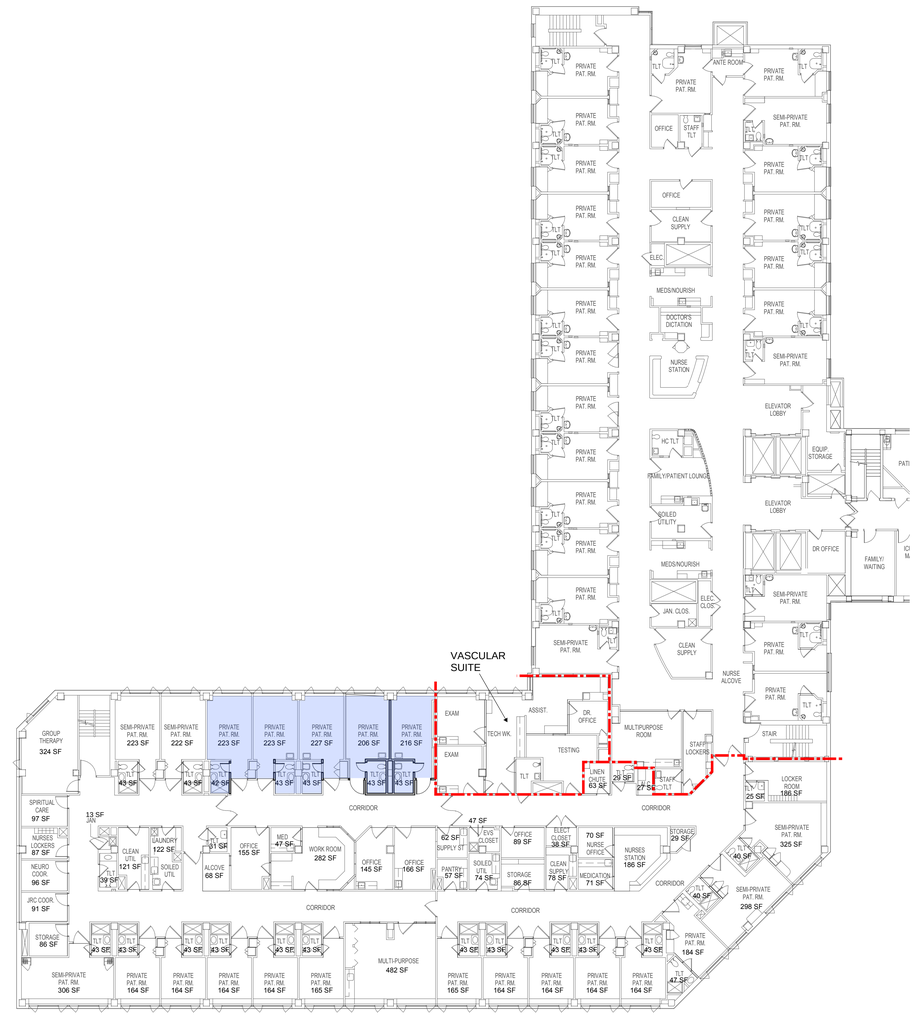
REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.006
DATE
July 09, 2018
ISSUE
COE Submission
SHEET TITLE
LEVEL 03 - FLOOR PLAN
SHEET NO.
A1.03

PLOT DATE: 7/2/2018 3:48:10 PM TEMPLATE VERSION: 3.0.0.20170623



1 Level 04 - Exisiting
1/16" = 1'-0"



2 Level 04 - Proposed
1/16" = 1'-0"

5 NEW PRIVATE MED/SURG PATIENT ROOMS ON LEVEL 4 SOUTH
LEVEL 4 EAST TO REMAIN AS EXISTING

LOCATION OF NEW MED/SURG PATIENT ROOMS

LOCATION OF NEW INPATIENT BEHAVIORAL HEALTH UNIT

RECONFIGURED UNIT SUPPORT SPACES

LOCATION OF RELOCATED PEDIATRIC PATIENT ROOMS

UNIT BOUNDARY

HKS

ARCHITECT
HKS, INC.
2100 EAST CARY STREET, SUITE 100
RICHMOND, VA 23223

UM Shore Medical Center at Easton

INTERIM REVIEW ONLY
These documents are incomplete, and are released for interim review only and are not intended for regulatory approval, permit, or construction purposes.
Architect: XXXXXX
Arch. Reg. No.: XXXX
Date: XX/XX/XXXX

KEY PLAN

REVISION
NO. DESCRIPTION DATE

HKS PROJECT NUMBER
19782.006
DATE
July 09, 2018
ISSUE
COE Submission

SHEET TITLE
LEVEL 04 - FLOOR PLAN

SHEET NO.
A1.04

PLOT DATE: 7/2/2018 3:51:09 PM TEMPLATE VERSION: 3.0.0.20170623

1 Level 05 - Existing

1/16" = 1'-0"

2 Level 05 - Proposed

1/16" = 1'-0"

3 RELOCATED PEDIATRIC BEDS ON LEVEL 5 SOUTH
RELOCATION OF REHAB SUPPORT SPACE ON LEVEL 5 EAST

- LOCATION OF NEW MED/SURG PATIENT ROOMS
- LOCATION OF NEW INPATIENT BEHAVIORAL HEALTH UNIT
- RECONFIGURED UNIT SUPPORT SPACES
- LOCATION OF RELOCATED PEDIATRIC PATIENT ROOMS
- UNIT BOUNDARY

PLOT DATE: 7/2/2018 4:14:09 PM TEMPLATE VERSION: 3.0 (3.0_20170623)

HKS

ARCHITECT
HKS, INC.
2100 EAST CARY STREET, SUITE 100
RICHMOND, VA 23223

UM Shore Medical Center at Easton

INTERIM REVIEW ONLY
These documents are incomplete, and are released for interim review only and are not intended for regulatory approval, permit, or construction purposes.
Architect: XXXXXX
Arch. Reg. No.: XXXX
Date: XX/XX/XXXX

KEY PLAN

REVISION NO. | DESCRIPTION | DATE

HKS PROJECT NUMBER
19782.006
DATE
July 09, 2018
ISSUE
COE Submission

SHEET TITLE
LEVEL 05 - FLOOR PLAN

SHEET NO.
A1.05

EXHIBIT 3

SHORE HEALTH UNIVERSITY OF MARYLAND MEDICAL SYSTEM	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-66
		REVISED:	11/12
	PUBLIC DISCLOSURE OF CHARGES	PAGE #:	1 of 2
		SUPERSEDES	09/12

CROSS REFERENCE

Administrative Policy LD-34: Financial Assistance

SCOPE

This policy applies to Shore Health System ("SHS") acute care hospitals located in the State of Maryland; Memorial Hospital at Easton and Dorchester General Hospital.

PURPOSE

To provide financial information to the communities we serve, the public and individual patients and payors with regard to the charges related to the services we provide.

BENEFITS

Increase awareness of the cost of hospital care and make information available to the public to improve care decision making, planning and patient satisfaction.

1.0 POLICY

Information regarding hospital services and charges shall be made available to the public. A representative list of services and charges shall be made available to the public in written form at the hospital(s) and via the SHS website. Individual patients or their designated payor representative may request an estimate of charges for a specific procedure or service. This policy applies to all patients, regardless of race, creed, gender, age, national origin or financial status. Printed public notification regarding the program will be made quarterly.

2.0 PROCEDURE

2.1 For the provision of information to the public concerning charges for services, a representative list of services and charges will be available to the public in written form at the hospital and also via the SHS website. The information will be updated ***quarterly*** and average actual charges will be consistent with hospital rates as approved by the Maryland Health Services Cost Review Commission (HSCRC). The Patient Financial Services Department shall be responsible for ensuring the information's accuracy and updating it on a regular basis. The Patient Financial Services Department shall be responsible for ensuring that the written information is available to the public at the hospitals. The Corporate Communications Department will ensure that the information is available to the public on the SHS website.

2.2 Individuals or their payor representative may make a request for an estimate of charges for any scheduled or non-scheduled diagnostic test or service. Requests for an estimate of charges are handled by the Financial Counselors in the Patient Financial Services Department and/or Schedulers in Community-Wide Scheduling.

2.3 The Patient Financial Services Department is responsible for ensuring that appropriate training and orientation is provided to their staff related to charge estimates and the CDM alpha-browse/estimator tool. Requirements for the Financial Counselors and Schedulers training to ensure that inquiries regarding charges for its services are appropriately handled include education on all necessary estimator tools both during their initial training and on annual job competencies.

Gerard M. Walsh, Chief Operating Officer

Effective	09/12
Revised	11/12 (Minor Editorial Revision)
Approved	Walter Zajac, Sr. Vice President / CFO

EXHIBIT 4

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

APR DRG	Shore Medical Center at Dorchester - Medical/Surgical Cases	Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
133	PULMONARY EDEMA & RESPIRATORY FAILURE	$ 2,549	$ 53,089	$ 14,919
194	HEART FAILURE	$ 2,079	$ 79,064	$ 11,737
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	$ 2,404	$ 23,043	$ 8,235
720	SEPTICEMIA & DISSEMINATED INFECTIONS	$ 3,937	$ 46,618	$ 16,397
140	CHRONIC OBSTRUCTIVE PULMONARY DISEASE	$ 3,047	$ 34,160	$ 11,028
139	OTHER PNEUMONIA	$ 4,716	$ 28,065	$ 10,631
249	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	$ 2,799	$ 33,272	$ 7,066
463	KIDNEY & URINARY TRACT INFECTIONS	$ 3,659	$ 47,725	$ 9,814
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	$ 3,819	$ 31,263	$ 11,685
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	$ 3,282	$ 21,762	$ 9,537

APR DRG	Shore Medical Center at Dorchester - Psychiatric Cases			
753	BIPOLAR DISORDERS	$ 1,272	$ 75,636	$ 8,488
754	DEPRESSION EXCEPT MAJOR DEPRESSIVE DISORDER	$ 2,998	$ 26,041	$ 7,322
750	SCHIZOPHRENIA	$ 1,486	$ 85,778	$ 10,812
751	MAJOR DEPRESSIVE DISORDERS & OTHER/UNSPECIFIED PSYCHOSES	$ 1,272	$ 76,045	$ 9,994
755	ADJUSTMENT DISORDERS & NEUROSES EXCEPT DEPRESSIVE DIAGNOSES	$ 1,272	$ 90,121	$ 7,885
756	ACUTE ANXIETY & DELIRIUM STATES	$ 2,810	$ 16,393	$ 6,997
775	ALCOHOL ABUSE & DEPENDENCE	$ 1,259	$ 20,019	$ 9,424
758	CHILDHOOD BEHAVIORAL DISORDERS	$ 2,268	$ 11,777	$ 6,009
757	ORGANIC MENTAL HEALTH DISTURBANCES	$ 3,875	$ 31,308	$ 13,156
773	OPIOID ABUSE & DEPENDENCE	$ 1,259	$ 16,657	$ 6,769

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

APR DRG	Shore Medical Center at Easton - Medical/Surgical Cases	Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
133	PULMONARY EDEMA & RESPIRATORY FAILURE	$ 2,867	$ 122,936	$ 15,199
302	KNEE JOINT REPLACEMENT	$ 9,336	$ 45,162	$ 17,443
301	HIP JOINT REPLACEMENT	$ 8,308	$ 46,171	$ 17,522
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	$ 2,226	$ 59,404	$ 7,558
720	SEPTICEMIA & DISSEMINATED INFECTIONS	$ 2,198	$ 121,572	$ 18,531
194	HEART FAILURE	$ 2,573	$ 39,229	$ 9,259
139	OTHER PNEUMONIA	$ 2,056	$ 48,943	$ 10,793
45	CVA & PRECEREBRAL OCCLUSION W INFARCT	$ 3,403	$ 159,693	$ 15,527
304	DORSAL & LUMBAR FUSION PROC EXCEPT FOR CURVATURE OF BACK	$ 16,754	$ 64,276	$ 31,118
253	OTHER & UNSPECIFIED GASTROINTESTINAL HEMORRHAGE	$ 3,813	$ 37,502	$ 10,183
APR DRG	**Shore Medical Center at Easton - Pediatric Cases**			
139	OTHER PNEUMONIA	$ 2,177	$ 14,173	$ 6,591
141	ASTHMA	$ 3,575	$ 16,635	$ 7,320
225	APPENDECTOMY	$ 6,790	$ 16,233	$ 10,211
138	BRONCHIOLITIS & RSV PNEUMONIA	$ 3,957	$ 12,261	$ 8,097
463	KIDNEY & URINARY TRACT INFECTIONS	$ 4,514	$ 13,336	$ 7,069
249	NON-BACTERIAL GASTROENTERITIS, NAUSEA & VOMITING	$ 3,112	$ 8,314	$ 5,380
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	$ 4,981	$ 16,631	$ 8,579
51	VIRAL MENINGITIS	$ 6,506	$ 8,112	$ 7,309
143	OTHER RESPIRATORY DIAGNOSES EXCEPT SIGNS, SYMPTOMS & MINOR DIAGNOSES	$ 2,839	$ 8,854	$ 5,846
144	RESPIRATORY SIGNS, SYMPTOMS & MINOR DIAGNOSES	$ 3,686	$ 6,508	$ 5,097

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

		Charge Range		
		Minimum	Maximum	Estimated Average Charge
APR DRG	**Shore Medical Center at Easton - Obstetric Cases**			
560	VAGINAL DELIVERY	$ 1,754	$ 16,631	$ 8,411
540	CESAREAN DELIVERY	$ 3,926	$ 21,536	$ 10,411
566	OTHER ANTEPARTUM DIAGNOSES	$ 1,510	$ 22,444	$ 5,155
561	POSTPARTUM & POST ABORTION DIAGNOSES W/O PROCEDURE	$ 1,775	$ 18,474	$ 5,771
542	VAGINAL DELIVERY W COMPLICATING PROCEDURES EXC STERILIZATION &/OR D&C	$ 6,986	$ 17,219	$ 10,531
541	VAGINAL DELIVERY W STERILIZATION &/OR D&C	$ 6,419	$ 16,826	$ 11,474
544	D&C, ASPIRATION CURETTAGE OR HYSTEROTOMY FOR OBSTETRIC DIAGNOSES	$ 5,981	$ 14,220	$ 9,869
APR DRG	**Shore Medical Center at Easton - Rehabilitation Cases**			
860	REHABILITATION	$ 1,855	$ 124,986	$ 23,172

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Estimated Charges for Inpatient Admissions

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

APR DRG	Shore Medical Center at Chestertown - Medical/Surgical Cases	Charge Range Minimum	Charge Range Maximum	Estimated Average Charge
133	PULMONARY EDEMA & RESPIRATORY FAILURE	$ 3,211	$ 48,781	$ 14,053
720	SEPTICEMIA & DISSEMINATED INFECTIONS	$ 4,256	$ 70,942	$ 18,384
201	CARDIAC ARRHYTHMIA & CONDUCTION DISORDERS	$ 3,060	$ 30,132	$ 8,754
463	KIDNEY & URINARY TRACT INFECTIONS	$ 3,217	$ 59,985	$ 11,705
194	HEART FAILURE	$ 3,094	$ 39,302	$ 10,972
139	OTHER PNEUMONIA	$ 3,042	$ 70,103	$ 10,959
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	$ 3,328	$ 22,836	$ 9,409
302	KNEE JOINT REPLACEMENT	$ 19,280	$ 77,213	$ 41,288
420	DIABETES	$ 2,693	$ 39,629	$ 9,080
663	OTHER ANEMIA & DISORDERS OF BLOOD & BLOOD-FORMING ORGANS	$ 3,027	$ 40,607	$ 10,737

Estimated Charges for Common Inpatient Procedures

ICD-10 Code	Procedure	Charge Range		Estimated Average Charge
		Minimum	Maximum	
Shore Medical Center at Dorchester				
HZ2ZZZZ	Detoxification Services for Substance Abuse Treatment	$ 2,121	$ 26,041	$ 9,421
30233N1	Transfusion of Nonautologous Red Blood Cells into Peripheral Vein, Percutaneous Approach	$ 3,408	$ 139,858	$ 17,861
5A09357	Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure	$ 3,276	$ 55,467	$ 13,968
5A1D60Z	Performance of Urinary Filtration, Multiple	$ 6,807	$ 79,064	$ 19,040
0FT44ZZ	Resection of Gallbladder, Percutaneous Endoscopic Approach	$ 9,135	$ 31,718	$ 17,373
0BH17EZ	Insertion of Endotracheal Airway into Trachea, Via Natural or Artificial Opening	$ 4,891	$ 128,863	$ 28,716
5A09457	Assistance with Respiratory Ventilation, 24-96 Consecutive Hours, Continuous Positive Airway Pressure	$ 5,181	$ 28,113	$ 13,462
5A1D00Z	Performance of Urinary Filtration, Single	$ 4,170	$ 13,062	$ 7,183
02HV33Z	Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach	$ 8,255	$ 39,014	$ 19,672
05HB33Z	Insertion of Infusion Device into Right Basilic Vein, Percutaneous Approach	$ 10,922	$ 40,387	$ 21,342
Shore Medical Center at Easton				
3E0234Z	Introduction of Serum, Toxoid and Vaccine into Muscle, Percutaneous Approach	$ 693	$ 26,289	$ 2,475
10E0XZZ	Delivery of Products of Conception, External Approach	$ 1,754	$ 16,826	$ 8,417
10D00Z1	Extraction of Products of Conception, Low Cervical, Open Approach	$ 3,926	$ 21,536	$ 10,390
0VTTXZZ	Resection of Prepuce, External Approach	$ 1,045	$ 13,644	$ 2,660
5A09357	Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure	$ 1,575	$ 122,975	$ 15,107
30233N1	Transfusion of Nonautologous Red Blood Cells into Peripheral Vein, Percutaneous Approach	$ 1,937	$ 71,435	$ 13,339
0SRC0J9	Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach	$ 11,351	$ 51,275	$ 17,025
0SRD0J9	Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach	$ 11,189	$ 45,162	$ 17,305
4A023N7	Measurement of Cardiac Sampling and Pressure, Left Heart, Percutaneous Approach	$ 3,606	$ 71,702	$ 13,769
HZ2ZZZZ	Detoxification Services for Substance Abuse Treatment	$ 2,013	$ 36,715	$ 9,299
Shore Medical Center at Chestertown				
5A09357	Assistance with Respiratory Ventilation, Less than 24 Consecutive Hours, Continuous Positive Airway Pressure	$ 3,800	$ 70,103	$ 14,999
30233N1	Transfusion of Nonautologous Red Blood Cells into Peripheral Vein, Percutaneous Approach	$ 3,037	$ 157,275	$ 18,356
02HV33Z	Insertion of Infusion Device into Superior Vena Cava, Percutaneous Approach	$ 4,256	$ 51,683	$ 17,427
0FT44ZZ	Resection of Gallbladder, Percutaneous Endoscopic Approach	$ 9,482	$ 32,694	$ 15,557
0SRC0J9	Replacement of Right Knee Joint with Synthetic Substitute, Cemented, Open Approach	$ 19,280	$ 69,039	$ 41,009
5A09457	Assistance with Respiratory Ventilation, 24-96 Consecutive Hours, Continuous Positive Airway Pressure	$ 5,931	$ 70,942	$ 22,189
0D9670Z	Drainage of Stomach with Drainage Device, Via Natural or Artificial Opening	$ 5,847	$ 97,036	$ 17,114
0SRD0J9	Replacement of Left Knee Joint with Synthetic Substitute, Cemented, Open Approach	$ 22,586	$ 71,746	$ 39,635
0DB78ZX	Excision of Stomach, Pylorus, Via Natural or Artificial Opening Endoscopic, Diagnostic	$ 4,203	$ 45,103	$ 11,388
0DJ08ZZ	Inspection of Upper Intestinal Tract, Via Natural or Artificial Opening Endoscopic	$ 3,419	$ 53,660	$ 13,409

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT EASTON
Estimated Charges for Common Ancillary Services

LABORATORY

Procedure	Estimated Charge
Complete cbc w/auto diff wbc	$ 20.15
Comprehen metabolic panel	$ 50.52
Assay of troponin quant	$ 66.67
Assay of magnesium	$ 12.15
Urinalysis auto w/scope	$ 18.61
Assay of ck (cpk)	$ 13.59
Creatine mb fraction	$ 34.42
Prothrombin time	$ 16.11
Urinalysis auto w/o scope	$ 8.01
Metabolic panel total ca	$ 22.26
Thromboplastin time partial	$ 16.16
Reagent strip/blood glucose	$ 16.77
Assay of lipase	$ 16.14
Urine pregnancy test	$ 20.05
Urine culture/colony count	$ 40.16
Drug Screen	$ 62.81
Assay thyroid stim hormone	$ 30.98
Assay of amylase	$ 12.08
Tissue exam by pathologist	$ 222.69
Assay of natriuretic peptide	$ 60.57
Blood typing serologic abo	$ 8.06
Blood typing serologic rh(d)	$ 8.06
Blood culture for bacteria	$ 130.03
Rbc antibody screen	$ 24.14
Influenza assay w/optic	$ 109.88

RADIOLOGY

Procedure	Estimated Charge
Ct head/brain w/o dye	$ 97.05
Ct abd & pelv w/contrast	$ 321.07
Ct abd & pelvis w/o contrast	$ 259.13
Ct angiography chest	$ 441.28
Ct neck spine w/o dye	$ 128.97
Mri brain stem w/o & w/dye	$ 1,146.50
Mri brain stem w/o dye	$ 620.81
Mri lumbar spine w/o dye	$ 639.22
Mri abdomen w/o & w/dye	$ 2,197.51
Mri neck spine w/o dye	$ 631.84
Us guide vascular access	$ 63.23
Ob us < 14 wks single fetus	$ 498.19
Us exam pelvic complete	$ 502.23
Us exam abdom complete	$ 558.52
Transvaginal us non-ob	$ 498.84
Chest x-ray 2vw frontal&latl	$ 140.35
Chest x-ray 1 view frontal	$ 96.43
X-ray exam of knee 3	$ 147.14
X-ray exam of hand	$ 145.04
X-ray exam l-2 spine 4/>vws	$ 278.03
Ntsty modul rad tx dlvr smpl	$ 881.08
Ntsty modul rad tx dlvr cplx	$ 864.95
Radiation treatment delivery	$ 595.88
Guidance for radiaj tx dlvr	$ 155.82
Radiation physics consult	$ 162.35

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT EASTON
Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY

Procedure	Charge Range		Average Estimated Charge
	Minimum	**Maximum**	
Fetal non-stress test	$ 1,050	$ 3,109	$ 1,287
Egd biopsy single/multiple	$ 742	$ 19,779	$ 2,989
Therapeutic procd strg endur	$ 4,463	$ 20,486	$ 10,432
Hysteroscopy biopsy	$ 1,897	$ 8,656	$ 3,169
Fna w/image	$ 935	$ 2,330	$ 1,221
Insert tunneled cv cath	$ 1,942	$ 7,819	$ 3,929
Colpopexy intraperitoneal	$ 8,490	$ 18,574	$ 11,942
Ra tracer id of sentinl node	$ 5,480	$ 16,915	$ 10,492
Insert mesh/pelvic flr addon	$ 6,835	$ 18,574	$ 11,768
Repair bladder defect	$ 6,661	$ 17,937	$ 11,314

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT DORCHESTER
Estimated Charges for Common Ancillary Services

LABORATORY

Procedure	Estimated Charge
Complete cbc w/auto diff wbc	$ 27.41
Comprehen metabolic panel	$ 64.72
Assay of troponin quant	$ 82.20
Assay of magnesium	$ 16.55
Urinalysis auto w/scope	$ 24.57
Assay of ck (cpk)	$ 18.33
Urinalysis auto w/o scope	$ 10.95
Prothrombin time	$ 21.80
Metabolic panel total ca	$ 30.48
Assay thyroid stim hormone	$ 40.89
Creatine mb fraction	$ 45.07
Assay of lipase	$ 22.01
Lipid panel	$ 51.92
Thromboplastin time partial	$ 21.91
Reagent strip/blood glucose	$ 20.84
Urine pregnancy test	$ 27.46
Drug Screen	$ 82.31
Urine culture/colony count	$ 54.64
Culture screen only	$ 55.26
Vitamin d 25 hydroxy	$ 41.09
Glycosylated hemoglobin test	$ 54.70
Assay of natriuretic peptide	$ 82.28
Influenza assay w/optic	$ 142.96
Assay of amylase	$ 16.24
Assay of creatinine	$ 5.45

RADIOLOGY

Procedure	Estimated Charge
Ct head/brain w/o dye	$ 79.47
Ct abd & pelv w/contrast	$ 240.52
Ct abd & pelvis w/o contrast	$ 141.16
Ct thorax w/o dye	$ 131.53
Ct thorax w/dye	$ 167.41
Mri lumbar spine w/o dye	$ 679.58
Mri brain stem w/o & w/dye	$ 1,240.23
Mri neck spine w/o dye	$ 691.36
Mri brain stem w/o dye	$ 728.13
Mri jnt of lwr extre w/o dye	$ 890.74
Us exam abdom complete	$ 451.79
Us exam abdo back wall comp	$ 436.91
Ultrasound breast limited	$ 350.78
Us exam pelvic complete	$ 413.69
Us exam of head and neck	$ 429.58
Chest x-ray 2vw frontal&latl	$ 102.39
Radiologic examination, chest 2 views	$ 103.29
X-ray exam of foot	$ 127.88
X-ray exam l-2 spine 4/>vws	$ 189.58
X-ray exam of knee 3	$ 145.09
X-ray exam of shoulder	$ 108.23
Chest x-ray 1 view frontal	$ 77.52
X-ray exam of ankle	$ 119.81
X-ray exam of hand	$ 123.93
X-ray exam hip uni 2-3 views	$ 156.84

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT DORCHESTER
Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY

	Charge Range		
Procedure	**Minimum**	**Maximum**	**Average Estimated Charge**
Therapeutic procd strg endur	$ 7,686	$ 18,742	$ 11,385
Laparoscopic cholecystectomy	$ 6,913	$ 13,131	$ 10,931
Abd paracentesis w/imaging	$ 1,302	$ 2,754	$ 2,157
Prp i/hern init reduc >5 yr	$ 5,248	$ 15,417	$ 7,423
Rpr umbil hern reduc > 5 yr	$ 4,070	$ 12,180	$ 7,088
Egd biopsy single/multiple	$ 1,653	$ 13,799	$ 3,899
Repair of hammertoe	$ 2,967	$ 9,028	$ 5,852
Rpr ventral hern init reduc	$ 6,457	$ 15,417	$ 10,346
Colonoscopy w/lesion removal	$ 2,042	$ 4,039	$ 3,290
Colonoscopy and biopsy	$ 1,786	$ 4,039	$ 3,192

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT CHESTERTOWN
Estimated Charges for Common Ancillary Services

LABORATORY

Procedure	Estimated Charge
Complete cbc w/auto diff wbc	$ 26.14
Comprehen metabolic panel	$ 58.79
Assay thyroid stim hormone	$ 39.10
Lipid panel	$ 49.23
Metabolic panel total ca	$ 29.18
Urinalysis auto w/scope	$ 23.35
Prothrombin time	$ 20.21
Assay of troponin quant	$ 82.67
Urinalysis auto w/o scope	$ 10.28
Urine culture/colony count	$ 51.40
Glycosylated hemoglobin test	$ 51.96
Reagent strip/blood glucose	$ 17.70
Assay of ck (cpk)	$ 17.44
Assay of lipase	$ 20.60
Thromboplastin time partial	$ 20.71
Assay of magnesium	$ 15.41
Creatine mb fraction	$ 45.90
Urine pregnancy test	$ 26.02
Influenza assay w/optic	$ 121.23
Vitamin d 25 hydroxy	$ 38.63
Strep a ag ia	$ 64.55
Culture screen only	$ 51.06
Culture aerobic identify	$ 27.90
Tissue exam by pathologist	$ 196.50
Drug Screen	$ 77.71

RADIOLOGY

Procedure	Estimated Charge
Ct head/brain w/o dye	$ 136.60
Ct abd & pelv w/contrast	$ 410.11
Ct abd & pelvis w/o contrast	$ 239.83
Ct thorax w/o dye	$ 220.50
Ct angiography chest	$ 437.93
Mri lumbar spine w/o dye	$ 689.25
Mri brain stem w/o dye	$ 715.44
Mri neck spine w/o dye	$ 678.45
Mri jnt of lwr extre w/o dye	$ 875.23
Mri joint upr extrem w/o dye	$ 892.40
Breast tomosynthesis bi	$ 140.78
Us exam pelvic complete	$ 504.93
Us exam of head and neck	$ 522.68
Ultrasound breast limited	$ 423.49
Transvaginal us non-ob	$ 580.15
Chest x-ray 2vw frontal&latl	$ 125.27
Radiologic examination, chest 2 views	$ 122.71
X-ray exam of foot	$ 149.90
Screening mammography, bilateral (2-view study (	$ 684.67
X-ray exam of knee 3	$ 182.00
X-ray exam l-2 spine 4/>vws	$ 232.06
X-ray exam of ankle	$ 145.72
X-ray exam of shoulder	$ 137.64
Dxa bone density axial	$ 221.17
X-ray exam hip uni 2-3 views	$ 192.84

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

SHORE MEDICAL CENTER AT CHESTERTOWN
Estimated Charges for Common Outpatient Procedures

OUTPATIENT SURGERY	Charge Range		
Procedure	**Minimum**	**Maximum**	**Average Estimated Charge**
Colonoscopy w/ablation	$ 1,407	$ 3,689	$ 2,218
Egd biopsy single/multiple	$ 1,158	$ 11,471	$ 2,411
Colorectal scrn; hi risk ind	$ 1,079	$ 4,803	$ 1,857
Egd diagnostic brush wash	$ 702	$ 11,768	$ 2,280
Therapeutic procd strg endur	$ 9,309	$ 20,706	$ 14,690
Colon ca scrn not hi rsk ind	$ 1,560	$ 2,560	$ 1,828
Diagnostic colonoscopy	$ 1,313	$ 2,983	$ 1,900
Colonoscopy and biopsy	$ 1,699	$ 3,178	$ 2,305
Colonoscopy w/lesion removal	$ 2,198	$ 4,131	$ 2,663
Prp i/hern init reduc >5 yr	$ 3,919	$ 8,206	$ 5,617

EXHIBIT 5

University of Maryland Medical Center University of Maryland Medical Center Midtown Campus University of Maryland Rehabilitation & Orthopaedic Institute University of Maryland St. Joseph Medical Center University of Maryland Baltimore Washington Medical Center University of Maryland Shore Medical Center at Chestertown University of Maryland Shore Medical Center at Dorchester University of Maryland Shore Medical Center at Easton	**The University of Maryland Medical System** **Central Business Office** **Policy & Procedure**	*Policy #:*	TBD
		Effective Date:	09/01/2017
	Subject: **FINANCIAL ASSISTANCE**	*Page #:*	1 of 11
		Supersedes:	07-01-2017

POLICY

This policy applies to The University of Maryland Medical System (UMMS) following entities:

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)
- University of Maryland Shore Medical Center at Chestertown (UMSMCC)
- University of Maryland Shore Medical Center at Dorchester (UMSMCD)
- University of Maryland Shore Medical Center at Easton (UMSME)

UMMS is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

It is the policy of the UMMS Entities to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

UMMS Entities will publish the availability of Financial Assistance on a yearly basis in their local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients to patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request.

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be

offered to patients whose accounts are with a collection agency and may apply only to those accounts on which a judgment has not been granted.

UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

University of Maryland St. Joseph Medical Center (UMSJMC) adopted this policy effective June 1, 2013.

University of Maryland Medical Center Midtown Campus (MTC) adopted this policy effective September 22, 2014.

University of Maryland Baltimore Washington Medical Center (UMBWMC) adopted this policy effective July 1, 2016.

University of Maryland Shore Medical Center at Chestertown (UMSMCC) adopted this policy effective September 1, 2017.

University of Maryland Shore Medical Center at Dorchester (UMSMCD) adopted this policy effective September 1, 2017.

University of Maryland Shore Medical Center at Easton (UMSMCE) adopted this policy effective September 1, 2017.

PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Specific exclusions to coverage under the Financial Assistance program include the following:

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services)
2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance Program.

a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.

3. Unpaid balances resulting from cosmetic or other non-medically necessary services
4. Patient convenience items
5. Patient meals and lodging
6. Physician charges related to the date of service are excluded from UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

Patients may be ineligible for Financial Assistance for the following reasons:

1. Refusal to provide requested documentation or provide incomplete information.
2. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
3. Failure to pay co-payments as required by the Financial Assistance Program.
4. Failure to keep current on existing payment arrangements with UMMS.
5. Failure to make appropriate arrangements on past payment obligations owed to UMMS (including those patients who were referred to an outside collection agency for a previous debt).
6. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
7. Refusal to divulge information pertaining to a pending legal liability claim
8. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care

Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

Coverage amounts will be calculated based upon 200-300% of income as defined by Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care.

Presumptive Financial Assistance

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. SLMB coverage
c. PAC coverage
d. Homelessness
e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
f. Medical Assistance spend down amounts
g. Eligibility for other state or local assistance programs
h. Patient is deceased with no known estate
i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
j. Non-US Citizens deemed non-compliant
k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)
m. Bankruptcy, by law, as mandated by the federal courts
n. St. Clare Outreach Program eligible patients
o. UMSJMC Maternity Program eligible patients

p. UMSJMC Hernia Program eligible patients

Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

a. Purely elective procedures (example – Cosmetic) are not covered under the program.

b. Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive financial assistance program until the Maryland Medicaid Psych program has been billed.

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.
2. Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.
   d. Upon receipt of the patient's application, they will have thirty (30) days to submit the required documentation to be considered for eligibility. If no data is received within the 30 days, a denial letter will be sent notifying that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The Financial

Assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.

e. 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.

3. There will be one application process for UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:

   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...

   b. A copy of their most recent pay stubs (if employed) or other evidence of income.

   c. A Medical Assistance Notice of Determination (if applicable).

   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

A written request for missing information will be sent to the patient. Oral submission of needed information will be accepted, where appropriate.

4. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.

   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.

      i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.
      ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
         (1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

6. Once a patient is approved for Financial Assistance, Financial Assistance coverage may be effective for the month of determination, up to 3 years prior, and up to six (6) calendar months in to the future. However, there are no limitations on the Financial Assistance eligibility period. Each eligibility period will be determined on a case-by-case basis. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

   Extraordinary Collection Actions (ECAs) may be taken on accounts that have not been disputed or are not on a payment arrangement. Except in exceptional circumstances, these actions will occur no earlier than 120 days from submission of first bill to the patient and will be preceded by notice 30 days prior to commencement of the action. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

   i) Garnishments may be applied to these patients if awarded judgment.

   ii) A lien will be placed by the Court on primary residences within Baltimore City. The facility will not pursue foreclosure of a primary residence but may maintain our position as a secured creditor if a property is otherwise foreclosed upon.

   iii) Closed account balances that appear on a credit report or referred for judgment/garnishment may be reopened should the patient contact the facility regarding the balance report. Payment will be expected from the patient to resolve any credit issues, until the facility deems the balance should remain written off.

7. If a patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.
8. A letter of final determination will be submitted to each patient who has formally submitted an application.
9. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds may be issued back to the patient for credit balances, due to patient payments, resulted from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.
10. Patients who have access to other medical care (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.

11. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.
12. The Financial Assistance Program will accept all other University of Maryland Medical System hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.
13. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
14. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

The amount of uninsured medical costs incurred at either, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE will be considered in determining a patient's eligibility for the Financial Assistance Program. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for Financial Assistance.

Medical Financial Hardship Assistance is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy, but for whom:

1) Their medical debt incurred at our either UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship; and
2) who meet the income standards for this level of Assistance.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE will grant the reduction in charges that are most favorable to the patient.

Financial Hardship is defined as facility charges incurred here at either UMMC, MTC, UMROI, UMSJMC and UMBWMC for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.

Medical Debt is defined as out of pocket expenses for the facility charges incurred here at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective starting the month of the first qualifying date of service and up to the following twelve (12) calendar months from the application evaluation completion date. Each patient will be evaluated on a case-by-case basis for the eligibility time frame according to their spell of illness/episode of care. It will cover the patient and the immediate family members living in the household for the approved reduced cost and eligibility period for medically necessary treatment. Coverage shall not apply to elective or cosmetic procedures. However, the patient or guarantor must notify the hospital of their eligibility at the time of registration or admission. In order to continue in the program after the expiration of each eligibility approval period, each patient must reapply to be reconsidered. In addition, patients who have been approved for the program must inform the hospitals of any changes in income, assets, expenses, or family (household) status within 30 days of such change(s).

All other eligibility, ineligibility, and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance criteria, unless otherwise stated above.

Appeals

- Patients whose financial assistance applications are denied have the option to appeal the decision.
- Appeals can be initiated verbally or written.
- Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
- Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.
- If the first level of appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
- The escalation can progress up to the Chief Financial Officer who will render a final decision.
- A letter of final determination will be submitted to each patient who has formally submitted an appeal.

Judgments

If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, and UMSMCE shall seek to vacate the judgment and/or strike the adverse credit information.

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

MD DHMH 2017 Income Elig Limit Guidelines		Income Level Up to 200% Pt Resp 0%	S L I D I N G S C A L E	Income Level Pt Resp 10%	Income Level Pt Resp 20%	Income Level Pt Resp 30%	Income Level Pt Resp 40%	Income Level Pt Resp 50%	Income Level Pt Resp 60%	Income Level Pt Resp 70%	Income Level Pt Resp 80%	Income Level Pt Resp 90%
HH	**100% MD DHMH**	**100% Charity**		**90% Charity**	**80% Charity**	**70% Charity**	**60% Charity**	**50% Charity**	**40% Charity**	**30% Charity**	**20% Charity**	**10% Charity**
Size	Max	**Max**		Max	Max	Max	Max	Max	Max	Max	Max	Max
1	**$16,643**	**$33,286**		$34,430	$36,615	$38,279	$39,943	$41,608	$43,272	$44,936	$46,600	$49,928
2	**$22,411**	**$44,822**		$47,063	$49,304	$51,545	$53,786	$56,028	$58,269	$60,510	$62,751	$67,232
3	**$28,180**	**$56,360**		$59,178	$61,996	$64,814	$67,632	$70,450	$73,268	$76,086	$78,904	$84,539
4	**$33,948**	**$67,896**		$71,291	$74,686	$78,080	$81,475	$84,870	$88,265	$91,660	$95,054	$101,843
5	**$39,716**	**$79,432**		$83,404	$87,375	$91,347	$95,318	$99,290	$103,262	$107,233	$111,205	$119,147
6	**$45,485**	**$90,970**		$95,519	$100,067	$104,616	$109,164	$113,713	$118,261	$122,810	$127,358	$136,454
7	**$51,253**	**$102,506**		$107,631	$112,757	$117,882	$123,007	$128,133	$133,258	$138,383	$143,508	$153,758
8	**$57,022**	**$114,044**		$119,746	$125,448	$131,151	$136,853	$142,555	$148,257	$153,959	$159,662	$171,065

Effective 7/1/17

EXHIBIT 6

Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of your care from our hospital, you may be able to get **free** or **lower cost** services.

PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. Services provided by physicians or other providers may not be covered by the hospital Financial Assistance Policy. You can call (800) 876-3364 ext 8619 if you have questions.

HOW THE PROCESS WORKS:

When you become a patient, we ask if you have any health insurance. We will not charge you more for hospital services than we charge people with health insurance. The hospital will:

1. Give you information about our financial assistance policy or
2. Offer you help with a counselor who will help you with the application.

HOW WE REVIEW YOUR APPLICATION:

The hospital will look at your ability to pay for care. We look at your income and family size. You may receive free or lower costs of care if:

1. Your income or your family's total income is low for the area where you live, or
2. Your income falls below the federal poverty level if you had to pay for the full cost of your hospital care, minus any health insurance payments.

PLEASE NOTE: If you are able to get financial help, we will tell you how much you can get. If you are not able to get financial help, we will tell you why not.

HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out a Financial Assistance Application Form.
2. Give us all of your information to help us understand your financial situation.
3. Turn the Application Form into us.

PLEASE NOTE: The hospital must screen patients for Medicaid before giving financial help.

OTHER HELPFUL INFORMATION:

1. You can get a free copy of our Financial Assistance Policy and Application Form:
   - Online at: UMShoreregional.org/patients/financial-assistance
   - In person at the Financial Assistance Department - Shore Health System, 29515 Canvasback Drive Easton MD 21601
   - By mail: call(800) 876-3364 ext 8619 to request a copy
2. You can call the Financial Assistance Office if you have questions or need help applying. You can also call if you need help in another language. Call: (800) 876-3364 ext 8619

UNIVERSITY of MARYLAND
SHORE REGIONAL HEALTH

Ayuda para que los Pacientes Paguen los Costos de Atención Hospitalaria

Si no puede afrontar todos los costos de la atención que recibió del hospital o una parte de ellos, es posible que reciba servicios gratuitos o a un costo reducido.

TENGA EN CUENTA LO SIGUIENTE:

1. Brindamos tratamiento a todos los pacientes que necesitan atención de urgencia, independientemente de lo que puedan pagar.
2. Es posible que los servicios brindados por los médicos u otros prestadores no estén cubiertos por la Política de Asistencia Financiera del hospital. Puede llamar al (800) 876-3364 ext. 8619 si tiene dudas.

CÓMO FUNCIONA EL PROCESO:

Cuando usted se convierte en nuestro paciente, le preguntaremos si tiene seguro médico. No le cobraremos más por los servicios hospitalarios que lo que les cobramos a las personas con seguro médico. El hospital hará lo siguiente:

1. Le brindará información acerca de nuestra Política de Asistencia Financiera o
2. Le ofrecerá ayuda por medio de un asesor que lo asistirá con la solicitud.

CÓMO REVISAR SU SOLICITUD:

El hospital evaluará su capacidad para pagar por la atención. Tendremos en cuenta sus ingreso y el tamaño de su familia. Es posible que reciba atención gratuita o a un costo reducido en los siguientes casos:

1. Sus ingresos o los ingresos totales de su familia son bajos para la zona en donde vive, o
2. Sus ingresos caerían por debajo del índice federal de pobreza si tuviera que pagar los costos totales de su atención hospitalaria, menos cualquier costo relacionado con el seguro médico.

TENGA EN CUENTA LO SIGUIENTE: Si usted puede obtener asistencia financiera, le informaremos el monto que puede recibir. Si usted no puede obtener asistencia financiera, le informaremos los motivos de la decisión.

CÓMO SOLICITAR ASISTENCIA FINANCIERA:

1. Complete un Formulario de Solicitud de Asistencia Financiera.
2. Brinde su información para ayudarnos a conocer su situación financiera.
3. Envíenos el Formulario de Solicitud.

TENGA EN CUENTA LO SIGUIENTE: El hospital podrá evaluar a los pacientes para determinar si son elegibles para Medicaid antes de otorgarles asistencia financiera.

OTRA INFORMACIÓN ÚTIL:

1. Puede obtener una copia gratuita de nuestra Política de Asistencia Financiera y del Formulario de Solicitud de las siguientes formas:
    - En línea en (to be added by Communications)
    - En persona en el Departamento de Asistencia Financiera - Shore Health System 29515 Canvasback Drive Easton MD 21601
    - Por correo postal llame al (800) 876-3364 ext. 8619 para solicitar una copia.
2. Puede llamar a la Oficina de Asistencia Financiera si tiene preguntas o necesita ayuda para presentar una solicitud. También puede llamarnos si necesita ayuda para recibir información en otro idioma. Llame al: (800) 876-3364 ext. 8619

EXHIBIT 7

May 10, 2018

PROOF OF PUBLICATION

University of Maryland
Shore Regional Health
Account 520158

Creative: "Financial Assistance"—Ad #2781833 & 2782024

Ad Size: 6 Col x 6—black/white

Publications and Run Dates:

Star Democrat – Wednesday, May 2, 2018
Bay Times – Wednesday, May 2, 2018
Times Record – Wednesday, May 2, 2018
Kent County News – Thursday, May 3, 2018
Record Observer – Friday, May 4, 2018
Dorchester Star – Friday May 4, 2018

Total Cost: $866.72

PO#: BL1784794BT

Art Crofoot
Publisher – APG Media
301-848-0175
acrofoot@chespub.com

Hostile language and the way things ought to be

MARK SHIELDS

It's an established American tradition to call people what they wish to be called. That's why after he converted religions, nearly everyone — except a few die-hard bigots — called the heavyweight champion Muhammad Ali instead of Cassius Clay. Marion Morrison chose to become John Wayne. Ilyena Lydia Vasilievna Mironov would later become Dame Helen Mirren, and Caryn Johnson would achieve fame and fortune as Whoopi Goldberg.

But some Republicans, included among them the current GOP president, regularly choose to ignore this national custom by refusing to address or refer to their political adversaries as belonging to — what it has been almost universally called since 1828 — the Democratic Party. Instead, by deliberately dropping the last two letters and ungrammatically substituting an adjective for a noun, some partisans seek to disparage the party of Thomas Jefferson and Andrew Jackson.

Recently, Marc Short, the presidential assistant with the challenging responsibility of managing this White House's relations with the House and the Senate, was interviewed one-on-one on PBS NewsHour by Amna Nawaz. Facing an election year in which the Republican congressional majority is clearly threatened, Short insisted on referring to the presidencies of Bill Clinton and Barack Obama as "Democrat administrations." President Trump had tweeted late last year about getting "no Democrat votes" in the Senate for his budget plan and the "Wacky Congresswoman" who was "killing the "Democrat Party" — a term which is harsher to the ear than the more melodic "Democratic" and supposedly robs the Democrats of all popular identification with the appealing virtues of social equality and anti-snobbishness.

Ever since Wisconsin's redbaiting — and, eventually, censured — Joseph R. McCarthy popularized the epithet "Democrat Party," conservative partisans have mostly employed it publicly as a sort of secret verbal handshake to prove one's GOP credentials while disparaging the other guys.

There have been happy exceptions. In 2008, the year Republicans nominated Arizona Sen. and maverick John McCain, the Party platform committee voted down a proposal to call the opposition the "Democrat Party" in the platform. Then-Mississippi Gov. and committee Chairman Haley Barbour explained, "We probably should use what the actual name is," a position endorsed by one Indiana committee member who argued, "We should afford them the respect they are entitled and call them by their legal name."

Just as most Irish-Americans reject being called "micks," and Catholics don't like to be referred to as adherents of the "Church of Rome" any more than Jewish Americans appreciate being told they are "of the Hebrew persuasion," members of the Democratic Party do not like to be told they belong to the "Democrat Party."

If the Republicans are sincerely interested in winning in 2020, for what would be only the second time having a majority of the national vote in the last eight presidential elections, they — and their leader, President Donald J. Trump — could begin by calling their fellow Americans across the aisle members of the Democratic Party. Sometimes it's not just how you say it; it really is what you say.

To find out more about Mark Shields and read his past columns, visit the Creators Syndicate webpage at www.creators.com.

Time to stop the abusers

JENNIFER RUBIN

It's quite difficult to write about the White House Correspondents' Association dinner when you think the worst kind of journalism is about journalists' reaction to a party thrown for journalists to honor journalists (and raise money). Let's get a few things out of the way:

I've never liked these soirees, which convey a false and inappropriate chumminess between reporters and the people they cover. I was in favor of dumping the thing years ago; I'm delighted if others now agree.

In an era when the media has been labeled the enemy of the people — and Republican officeholders agree — there certainly is no need to yuk it up with those contemptuous of the First Amendment. Doing so conveys that their crusade against the media is not a serious matter.

Sarah Huckabee Sanders was insulted for lying, not for her looks. The point of the jokes in question was her disdain for the truth, not her eye makeup. ("She burns facts, and then she uses the ash to create a perfect smoky eye.")

President Donald Trump is certainly meaner, more vulgar and more inappropriate than Michelle Wolf. And let's not forget that Wolf is a comedian, not a reporter, and has no obligation to uphold any social or professional standards that would apply to the media. (By definition, comedians flout standards of social and professional restraint.) Still, the media should have more dignity than the president (a low bar) and is going to be held responsible for the words of its featured guest.

The White House Correspondents' Association leadership is sadly misguided if it thinks the purpose of the evening is to "offer a unifying message about our shared commitment to a vigorous and free press while honoring civility." The media may uphold those values, but the administration so obviously does not, so this statement suggests either a stunning degree of obliviousness or a propensity to adhere to phony "balance." (Trump says the sky is pink with purple spots; others think it is blue.)

You don't need a self-indulgent, extravagant party to raise money for journalism scholarships. A credit card or checkbook is sufficient.

Now that we have this out of the way, we have a few ideas about what can be done going forward.

First, cut out the on-camera White House news conferences. To be clear, Sanders repeatedly misleads or innocently offers misleading information (on every upcoming firing/resignation, for one thing, and even on what the president did and did not say). Putting her on live TV to tell falsehoods is not news. It is enabling the destruction of objective truth. The media surely should get the White House position or response on matters on which it reports. ("The White House denied that H.R. McMaster would be leaving, but it has made similar statements regarding other officials who were then promptly fired.") However, this does not require a televised event in which the press secretary shows sullen contempt for the media as an institution and evidences no shame in dissembling.

Second, because of the propensity of this administration to lie about easily ascertained facts and events in the works, virtually every utterance from an administration figure should be couched as "the White House claimed" or "the White House argued." Virtually nothing can or should be taken at face value. When the White House repeats a falsehood after being shown incontrovertible evidence that it is a falsehood, the honest term is "lying."

Third, instead of a glitzy affair, the media and the country would benefit from an annual lunch to highlight the latest Freedom House report on press freedom. In addition to foreign abuses, the media, regardless of who is in power, should review the current administration's attacks on the free press and efforts to limit access. Rather than a third-rate comedian, the host might be *The Washington Post's* Jason Rezaian, who was held captive in Iran from July 2014 to January 2016; the parents of Daniel Pearl, the *Wall Street Journal* reporter beheaded by Islamist terrorists; or members of the punk-feminist band Pussy Riot, who were imprisoned by Russia. Media freedom isn't a joke these days, and if the media does not take it seriously, who will?

Democrats and the trap of Trump impeachment

BYRON YORK

George W. Bush was in terrible political shape in the spring of 2006. The Iraq war was going disastrously, and voters were tired of the president, whose job approval rating in the RealClearPolitics average of polls was around 35 percent. (Bush's disapproval rating was around 60 percent.) The upcoming November '06 midterms were shaping up as a debacle for Republicans, who seemed likely to lose control of both houses of Congress.

Things were so bad that a part of the Democratic base looked toward the midterms openly hoping to impeach Bush on the charge that he had lied the country into war. One leader of that movement was Rep. John Conyers, who stood to become chairman of the House Judiciary Committee if Democrats won. Conyers' committee would originate articles of impeachment.

The problem, for Democrats, was voters. Now matter how much they wanted to make changes on Capitol Hill, and no matter how much they disapproved of Bush, they didn't want to impeach the president. Democratic candidates were stuck between their anti-Bush base and the larger electorate.

The impeachment talk was so worrisome to party leaders that Rep. Nancy Pelosi, who stood to become speaker if Democrats won the House, told her conference in May 2006 that "impeachment is off the table."

Pelosi would repeat that at various times during the campaign, and in November, on the day after Democrats won a smashing victory and she was poised to become speaker, she said in her first news conference, "Democrats are not about getting even; Democrats are about getting results. I have said before and I say again, impeachment is off the table."

Indeed, impeachment was off the table, as Bush served his last two years with a Democratic House and Senate. And then Democrats won everything in 2008.

Now, it is again spring in a midterm year, and there is again talk of impeaching a Republican president if Democrats win the House. Pelosi is still around and hopes to become speaker again. What's not clear is whether her 2006 impeachment strategy will work with today's Democratic party.

In a new Quinnipiac poll, 71 percent of Democrats say they would like to see President Trump impeached if Democrats win the House. Just 21 percent oppose the idea, while 8 percent aren't sure. By way of contrast, 38 percent of independents support impeachment, while 54 percent oppose.

So where does that leave Pelosi and other Democratic leaders? Her instincts are as cautious as they were in 2006 — and at this moment, Trump's job approval rating in the RealClearPolitics average, around 42 percent, is higher than Bush's was when Pelosi declared Bush impeachment off the table.

But 71 percent — those Democrats who want to see Trump impeached — is a big number. It suggests that Pelosi, or whoever leads House Democrats if the party wins in November, might not be able to overrule the base and simply declare impeachment a non-starter.

"Many Democrats in D.C. don't want to move forward on impeachment and think they can avoid it," tweeted *National Review's* Ramesh Ponnuru recently, after release of the Quinnipiac results. "I suspect they're wrong."

While Republicans have plenty of problems of their own, they are keenly aware of the Democrats' impeachment dilemma. And GOP strategists want to use that dilemma to make Democrats more uncomfortable and to juice up the Republican base. The argument to Republican and independent voters is easy: The economy is strong, Trump is enacting a conservative wish list, America is showing strength abroad — and all Democrats want to do is impeach the president.

"It's a base motivator," says a GOP strategist working to keep control of Congress. "We have to remind (voters) that the things Democrats want to do are not mainstream. There are a lot of Americans who can't stand Trump, but they don't think he should be impeached."

The president himself is already raising the specter of his own impeachment as a way to fire up GOP voters. "We have to keep the House, because if we listen to Maxine Waters, she's going around saying, 'We will impeach him,'" Trump said April 28 at a campaign-style rally in Washington, Mich.

Of course, there's a huge wild card in any discussion of Trump, the midterms and impeachment, and that is what happens in the Russia investigation. If some new, devastating evidence comes to light from special counsel Robert Mueller, the entire dynamic could change, and Trump could lose some support in the GOP and find himself in real danger of impeachment.

But all those Democrats are ready to impeach Trump right now. They don't need any new revelations. Unless something big changes, they could be a bigger problem for their own leadership than for the president.

Byron York is chief political correspondent for The Washington Examiner.

Final lane opened on Severn River Bridge

ANNAPOLIS — Governor Larry Hogan Monday, April 30, announced the opening of the fourth eastbound lane on the US 50 Bridge over the Severn River, a full month ahead of schedule. The completion of this construction project is a major transportation milestone that will reduce congestion for hundreds of thousands of Anne Arundel County residents and visitors who travel over the Severn River Bridge in Annapolis each year. The governor was joined by Anne Arundel County Executive Steve Schuh, House Speaker Mike Busch, House Minority Leader Nic Kipke, and other local elected officials for the announcement.

"For far too long, this stretch of Route 50 has been a serious bottleneck that was a constant headache for many Marylanders, as well as commuters and vacationers trying to reach the Eastern Shore," said Hogan. "I am pleased that with the opening today, we have successfully completed this project a full month ahead of schedule, and just in time for summer. Motorists will now enjoy a safer, more efficient ride through Annapolis and to the Eastern Shore."

The project shifted the existing median barrier and restriped the lanes to provide seven through-travel lanes — four lanes on US 50 east, three lanes on US 50 west — from Rowe Boulevard across the Severn River to the MD 2/MD 450 interchange. The fourth lane was originally scheduled for completion by Memorial Day weekend.

"Part of a $3.7 billion construction program statewide, the Severn River Bridge project represents our dedicated approach to delivering solutions and keeping Maryland open for business," said MDOT SHA Administrator Greg Slater. "It is important to note that the collaboration and cooperation with our contractor allowed us to deliver this fourth lane early and get people over the bridge safely and with less delay."

Construction began just after Labor Day in 2017. As part of the construction, crews shifted the median barrier and reduced its width from three to two feet and connected what was originally two structures to create space for the additional lane. The contractor, Joseph B. Fay Construction Inc. of Glen Burnie, will complete additional work on the shoulders, guardrails, roadway signage, and surrounding areas through the summer. The eastbound fourth lane will remain open uninterrupted for daytime travel, however, nighttime lane closures will continue as needed on weeknights between 7 p.m. and 5 a.m. Sunday through Thursday.

The average daily traffic on this section of US 50 is 126,000 vehicles per day, with that number ballooning to more than 145,000 on a typical summer Friday.

Twilley celebrates 40 years with Shore United Bank

RALPH TWILLEY

STEVENSVILLE — Shore United Bank, a member of Shore Bancshares community of companies, has recognized Ralph Twilley for his 40 years of dedicated service.

Twilley started his career with Centreville National Bank in February 1978. Twilley joined the lending team as a loan officer and continues to serve the community through his lending expertise today.

Currently, Twilley is a vice president, commercial lender, focusing on meeting customers personal and commercial lending needs. His office is at the branch in Stevensville.

Twilley graduated from Salisbury State College in 2005 with a bachelor's degree in business administration. He completed Maryland Bankers School in 1982. With the goal of continuing his education, he graduated from the Maryland Executive School of Banking in 2007.

"Ralph is an exceptional member of the lending team. His knowledge and experience are an asset to the loan process for all his customers. We are fortunate to have Ralph on our team for the past 40 years," said Heather Bacher, market manager of Shore United Bank.

Twilley currently serves as a board member for the Queen Anne's County Chamber of Commerce and Mid-Shore Pro Bono. He is a past board member for the Queen Anne's County Little League, the Queen Anne's County Free Library, and the Centreville United Methodist Church.

Meetings scheduled on Bay Crossing Study

BALTIMORE — As part of the Chesapeake Bay Crossing Study: Tier I NEPA (Bay Crossing Study), the Maryland Transportation Authority will host a series of public meetings to provide all interested parties an update on the project. At the meetings, attendees will have the opportunity to learn about the project's purpose and need, scoping activities and public comments received to date, the environmental review process and the alternative cooridor development and screening process.

The purpose of the Bay Crossing Study is to consider corridors for providing additional traffic capacity and access across the Chesapeake Bay to improve mobility, travel reliability and safety at the existing Bay Bridge, while considering financial viability and environmental responsibility. The range of corridors will not be presented at these meetings.

Staff will be available to answer questions. No formal presentation will be given, and the same information will be provided at each meeting. All meeting materials will be available at baycrossingstudy.com to view prior to the meetings and for those who choose not to attend in person. Comments may be provided at the meetings, online or by email or U.S. Mail.

All meetings will be held from 6 to 8 p.m. on the following dates:

- Tuesday, May 8, Calvert High School, 600 Dares Beach Road, Prince Frederick, MD 20678.
- Wednesday, May 9, Broadneck High School, 1265 Green Holly Dr., Arnold, MD 21409.
- Thursday, May 10, Kent County Middle School, 402 E. Campus Ave., Chestertown, MD 21620.
- Wednesday. May 16, Middle River Middle School, 800 Middle River Road, Middle River, MD 21220.
- Thursday, May 17, Cambridge-South Dorchester High School, 2475 Cambridge Beltway, Cambridge, MD 21613.
- Tuesday, May 22, Chesapeake College, 1000 College Circle, Wye Mills, MD 21679.

Locations will be accessible to individuals with disabilities. Individuals who require auxiliary aids should contact MDTA at 410-537-10000 (711 for Maryland Relay) no later than three days before the date they wish to attend.

KERRIGAN

From Page 5

the journey, which he estimates will take them through as many as 13 states. "So we figure it'll be about a 32-day trip."

The pair will traverse several mountain ranges, ride past the Grand Canyon, cross the Great Plains, and go over the 2,320-mile-long Mississippi River. And they'll be filming and broadcasting their progress as they go.

But why go on such a grueling journey?

"I was one of the lucky ones," Kerrigan said, referring to the lifesaving heart transplant he received just before Christmas, 2013. "But other people aren't so lucky."

Around 20 people in the U.S. die every day due to a lack of a suitable organ transplant, Kerrigan said. "And my number one thing to do on this trip is to get that number down."

His goal is to raise $100,000 in donations for the United Network for Organ Sharing (UNOS), a nonprofit that operates the only organ procurement and transportation network, or OPTN, in the U.S.

"They're working on a system that will allow people to get matched with organ donations a lot faster," Kerrigan said, mentioning that nearly 115,000 people nationwide currently wait for an organ donor. "All the money — 100 percent — goes into new program they're starting that helps people find their organs faster."

That's not the only thing Kerrigan intends to do.

"That's one reason that we're doing it, and another reason we're doing it is, I'm filming a documentary about it," the 2016 St. Michaels High graduate said. "We're working with some people from a group called Rusted Rooster Media to get the whole thing produced."

Kerrigan said he got the idea a few months back. "My story's a good story," he said, "but to just tell my story over and over, well, that would get boring.

"So, eventually, what I want to do is have an outdoors TV show," Kerrigan said. "But in it, I want to take some other people who've faced adversity and have them tell their stories.

"People have beaten cancer. There are wounded warriors who have stories to tell," Kerrigan added. "I want more people to learn how to conquer adversity. ... Everyone needs to know there's always hope."

The beginnings of the cross-country fundraiser idea came to Kerrigan a few months back.

"At that point, it had been a year and a half since I had ridden a bike," he recalled. "And my stamina isn't what it used to be. So it's taken some work."

Receiving a new heart means several significant changes in life, and lifestyle, Kerrigan explained.

"My stamina, as I said, isn't what it was," he said, adding the anti-rejection medications any organ recipient must take suppress the recipient's natural immune system. "I can't swim in the (Chesapeake) Bay anymore. I can't eat raw food anymore. Everything has to be well-done.

"When I get sick, I stay sick a lot longer," Kerrigan said. "A three-day cold for other people becomes a month-long cold for me. So, I have to avoid germy things, getting too dirty, and if there are a lot of sick people around, I have to be away from that."

Despite such concerns, Kerrigan said, he "never lets it get in my way."

By doing this, Kerrigan added, "I want to put myself through the test, to show people you can go through adversity, and it shouldn't slow you down."

The idea, which came to him during mid-winter, was an instant plan for Kerrigan and Kinney. "We wanted to do it as soon as I mentioned it," Kerrigan said. "We decided to do it before we even knew anything about it, about what it would involve."

But why riding a bike? Why not a walk, which would still test one's stamina, or some other mode of travel?

"I just want to experience new places, and that's the fastest way to do it," Kerrigan said, "and the most physically demanding, rather than taking five months to do it like walking would."

Over the last several weeks, the plan has begun to take shape. Friday, the duo received several thousand flyers to hand out, soliciting donations. Kerrigan's page on the Everyday Hero website set up for donors, https://give.everydayhero.com/us/brandon-kerrigan, has already received more than $2,000.

Kerrigan's training over the past few weeks has been intense. Bike rides of up to 90 miles a day, combined with regular trips to work out at Hearthstone Health and Fitness in Easton, have helped his endurance and strength increase drastically.

"My legs have doubled in size from where they were," Kerrigan said.

The plan for the actual ride, Kerrigan said, consists of two planned 4-hour sessions each day, one in the morning, and another after lunchtime.

The two will take turns in the lead, Kerrigan said. "We'll draft one another when we can, when we need to, and we'll alternate."

But the terrain across the United States isn't very much like Delmarva; the average elevation of land is over 1,000 feet above sea level. Kerrigan and Kinney will go through the Sierra Nevada, Rocky, Ozark, and Appalachian Mountains along the way.

How does one train on an area as flat as Delmarva for all the elevation changes?

Planning and pushing, Kerrigan said. To compensate for the increases in elevation, which can be "as much as 800 feet in one day," he said. "I get on the StairMaster at Hearthstone with 50 pounds on my back — and I just walk up the stairs for as long as I can."

How much of an interruption of one's life is such an undertaking?

"I was at West Virginia University, and pursuing my dream in outdoor television," Kerrigan said. "So that's where I am right now, but right in the middle of living it."

The planned documentary, produced with help from Rusted Rooster Media, is part of a campaign called "Be Alive," Kerrigan said.

"We've been packing, preparing, for a month now," Kerrigan said. "There's a lot to think about, what to take, what you'll need. ... We plan on camping most of the time."

As is often the case, one journey, Kerrigan said, might lead to another in the future. "If I can do this, I think I can do almost anything."

"I've got a lot of support from (sponsorship help by Easton Cycle and Sport) friends, family, and community," Kerrigan said, "and I've got that mindset. So I'm hoping for success."

"I'm really looking forward to it all," he added. "If this is successful maybe I'll climb Mount Kilimanjaro (in Tanzania, Africa), or something like that."

More information about Kerrigan and Kinney's plan can be found on the Pray for Brandon page on Facebook, which can be found at https://www.facebook.com/groups/710061975687200/about/.

Kerrigan's progress can be followed on Instagram at: brandon__kerrigan (two underscores).

For more information about the United Network for Organ Sharing, visit www.unos.org.

Follow me on Twitter: @SDBaysideSports.

Jury finds teen innocent in alleged sexual assault

By TRISH MCGEE
pmcgee@thekentcountynews.com

CHESTERTOWN — A Kent County jury of nine men and three women found a Baltimore teenager not guilty of all charges related to an alleged sexual assault at Washington College in September 2016 that resulted in his dismissal from the college.

Jurors deliberated for about an hour and a half April 26 before acquitting Fope Moses Fadojutimi, 18, of second-degree rape, second- and fourth-degree sex offenses, and second-degree assault.

Fadojutimi was the only defense witness. He testified that all the sexual contact he had with his accuser was consensual.

The *Kent County News* does not name survivors of alleged sexual assault.

The woman in this case was a classmate of Fadojutimi's. She told the jury that he sexually assaulted her in her dorm room in the early morning of Sept. 7, 2016.

She acknowledged that they had a "romantic encounter" a couple of days earlier when she allowed him to sleep in the extra bed in her room; that they had exchanged numerous text messages, some of which laid out boundaries moving forward in their relationship; and that she let him into her room at about 1 a.m. Sept. 7.

In direct testimony that lasted nearly an hour, the woman told the jurors that Fadojutimi sexually assaulted her.

Initially she did not protest, she said, because she "felt frozen."

"I knew that I wanted to say something, but I couldn't," the woman testified. She said she was afraid and "the fear put me in a state where I couldn't move, I couldn't say anything."

At some point her "reactions kicked in," she testified, and she was able to tell Fadojutimi, "This is not what I want. I want you to stop."

"I told him 'no' more than five times and tried to push him off me," the woman testified. She said she tried to scoot up in her bed to get away from him, but that he overpowered her.

Afterward, Fadojutimi kissed her on her forehead and left her dorm room.

Several students saw Fadojutimi walking down the hallway; two of them came into the woman's room to ask what had happened.

She quickly sent them away without telling them anything, the woman said.

Almost immediately, she sent Fadojutimi a text message that said, "I let it get too far. I had to stop it."

She testified that she sent the text message, which was read aloud, to protect herself and "to settle him down some."

"I didn't know what he was capable of. ... I took false responsibility for what had happened. ... I was in a frantic state," she told the jury. "He had just seen two people walk into my room, and I didn't know what he was thinking."

She was worried about retaliation, said told prosecutor G. Robert Mowell.

"I wanted to cover and make sure I was safe in it," she said when asked what was the purpose of the text message.

"Were you the one who let it get to far?" Mowell asked.

"No," the woman answered.

After sending the text message, the woman testified that she called her closest friend on campus to say that she had been sexually assaulted. She also called the college's office of public safety and a rape hotline.

She sought out counseling services on campus and talked to the college's Title IX coordinator, Candace Wannamaker, who oversees all complaints of sexual violence.

The woman said she continues to receive counseling and takes medication after being diagnosed with post traumatic stress disorder and an anxiety disorder.

She said she doesn't sleep much.

Still a student at Washington College, she has made changes that include making sure people call before she allows them in her room. She also has a single-occupancy room with only one bed.

The woman did not report the alleged sexual assault to the Chestertown Police Department until May 2017.

The CPD served Fadojutimi with an arrest warrant on June 12. Fadojutimi, accompanied by an attorney, came to the police station to be served the warrant.

Under questioning by Mowell, the woman said she delayed in reporting to police because of "fear."

She said she ultimately came forward because "I was tired of him having the satisfaction of me keeping quiet about this."

Sobbing, she identified Fadojutimi in court as the man who allegedly sexually assaulted her.

Under cross-examination by defense attorney George Oswinkle, the woman acknowledged that Fadojutimi that did not threaten her in any way, that she did not protest and that she did not call for help.

But, she said, "letting him in (the room) is not an invitation to rape."

Wannamaker, who testified for the defense, was recognized by the court as an expert in traumatic stress.

She said she has seen the student "hundreds of hours" since the incident and that the student has reacted to trauma in various stages — including the freeze and function modes.

Wannamaker said she encouraged the student on several occasions to report the allegations to police.

In his defense, Fadojutimi said he and the student had consensual sex. "Everything seemed copacetic," he said.

"When she said she doesn't want to to do this anymore, I stopped, gave her a kiss on the forehead, said good night and left," he testified.

In his closing argument, Mowell portrayed rape as a crime of secrecy. "Most of the time the only two people who know what happened are the defendant and the victim."

Two conflicting stories were presented in court. He asked the jury to chose to believe the story that made the most sense.

Oswinkle argued that there was no threat, no coercion and no force, therefore there was no rape.

"People on both sides made bad decisions, but it does not constitute a crime," he said.

After receiving instructions from Circuit Court Judge J. Frederick Price, the jurors were sent out to deliberate at 5:45 p.m.

They sent a note to the judge at 6:40 p.m. asking for a better understanding of second-degree assault, and were brought back into the courtroom so Price could re-instruct them on the elements of the offense.

The jury returned at 7:07 p.m. with not guilty verdicts on all accounts.

This was the second trial in as many months for Fadojutimi, who was accused of another sexual assault on campus in September 2016. He was found not guilty of second-degree rape, second-degree sex offense and second-degree assault.

He is awaiting sentencing on conviction of a misdemeanor charge of fourth-degree sex offense. The maximum penalty is one year in jail and a $1,000 fine.

Fadojutimi was 17 at the time of the alleged offenses but was charged as an adult.

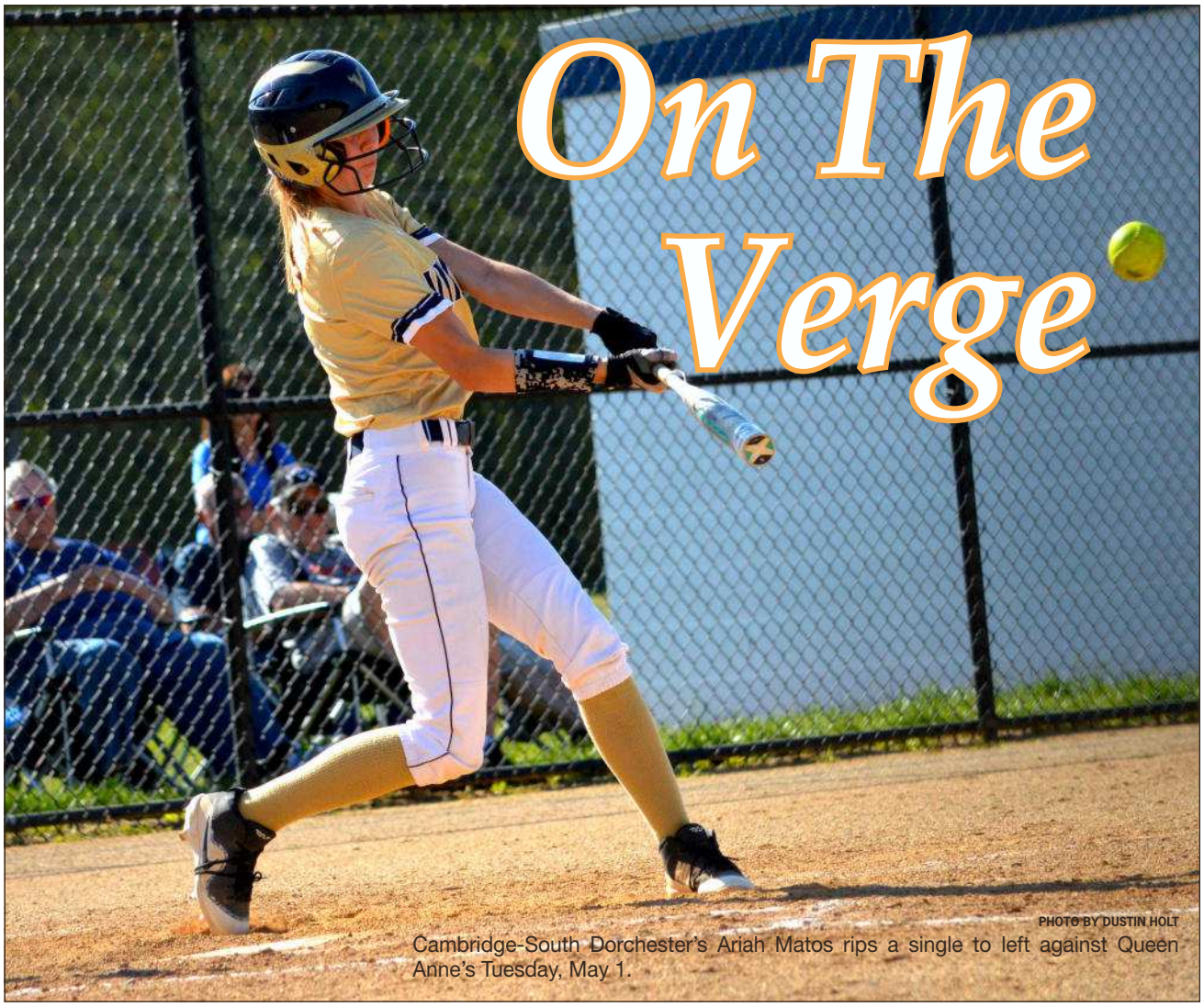


PHOTO BY DUSTIN HOLT

Cambridge-South Dorchester's Ariah Matos rips a single to left against Queen Anne's Tuesday, May 1.

Pleasants fans 14 as C-SD moves one win from first division crown

By DAVID INSLEY
dinsley@stardem.com

CAMBRIDGE — With the North Bayside title race going down to the wire, Cambridge-South Dorchester High's softball team found itself trailing early Tuesday against Queen Anne's County.

"We opened up hitting, putting the ball into play," Lions head coach Kim Rementer-Betts said. "But then, they came back on us, and we kind of got off our game.

"She (C-SD pitcher Madison Pleasants) struck out seven or eight of us in a row at one point, and that's unlike us," Rementer-Betts said. "And it spiraled on us. And then they started beating themselves up about it."

Despite the early deficit, the Vikings put together a 10-hit attack and took advantage of seven Lions errors en route to a 9-2 victory that kept them in contention for their first North Bayside softball title in school history.

Cambridge-SD (14-2 overall, 6-1 North Bayside) inched closer to idle St. Michaels (12-4, 7-1) and can clinch the division crown on Friday if it defeats Easton in a game that will be picked up in the top of the eighth inning with the Vikings holding a 4-3 lead with two on and no outs. Cambridge-SD defeated St. Michaels in their second meeting of the season and would clinch the title via tiebreaker. Should the Vikings lose to Easton on Friday, St. Michaels would win the division.

"Today was big, obviously, it was big," C-SD head coach Kareem Otey said after her team stretched its winning streak to eight. "I think this year, one of the things that we've done well is answer back when someone scores. We're able to battle back."

See **VIKINGS**
Page 13

NEWS IN BRIEF

Incendiary device leads to fire in Church Hill

CHURCH HILL — An incendiary device — more commonly known as a Molotov cocktail — was thrown Tuesday, May 1, into the front yard of a Church Hill home, the state fire marshal's office said.

The fire at 305 Oakmont Ave. was reported about 10:34 p.m. by homeowners Michael and Darlene Kuechler, according to a press release from the Office of the State Fire Marshal.

Firefighters from the Church Hill Volunteer Fire Department responded and placed the fire under control. The fire burned vegetation only.

Anyone with information regarding this fire is asked to contact the state fire marshal's office at 410-822-7609.

Cocaine recovered in elementary school zone

SUDLERSVILLE — School officials contacted the Queen Anne's Sheriff's Office on Wednesday, April 25 when a woman not on the approved school contact list attempted to pick up a child from Sudlersville Elementary School.

According to the report from the sheriff's office, deputies responded to the school in reference to a disturbance. Upon their arrival, the deputies made contact with school officials who asked police to have a male removed from the property, police said. The female, Melissa Markow of Chestertown, had attempted with Chris Markow to pick up a child from the school prior to dismissal and their erratic behavior alerted school employees to contact the sheriff's office.

Further investigation by the deputies led to the recovery of suspected crack cocaine and drug paraphernalia from a vehicle. Melissa Markow — who witnesses observed originally in the vehicle — had left the scene, but returned and was placed under arrest.

Markow, 27, of 8306 Beaver Court, Chestertown, is charged with possession of crack cocaine and possession of paraphernalia.

She was ordered held without bail.

Deputies were unable to locate Chris Markow after the suspected narcotics was located.

PHOTO BY DANIEL MCCREARY

Saturday Sunset near Centreville

On Saturday evening, April 28, Centreville resident and amateur photographer Daniel McCreary captured rain clouds approaching during sunset. The result is a photograph that captures the arrival of spring to rural Queen Anne's County.

EXHIBIT 8

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No 20-003

Issued to:

University Of Maryland Shore Medical Center At Easton
219 South Washington Street
Easton, MD 21601

Type of Facility: Acute General Hospital
Special Hospital - Rehabilitation with 20beds

Date Issued: December 18, 2015

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: March 18, 2019

Patricia Tomaka May MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 09-002

Issued to:

University Of Maryland Shore Medical Center At Dorchester
300 Bryn Street
Cambridge, MD 21613

Type of Facility: Acute General Hospital

Date Issued: December 18, 2015

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Expiration Date: March 18, 2019

Patricia Tomsho May MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

The Joint Commission

March 8, 2016

Re: # 6276
CCN: #210037
Program: Hospital
Accreditation Expiration Date: December 19, 2018

Kenneth D. Kozel
President and Chief Executive Officer
Shore Regional Health
219 S. Washington St
Easton, Maryland 21601

Dear Mr. Kozel:

This letter confirms that your December 15, 2015 - December 18, 2015 unannounced full resurvey was conducted for the purposes of assessing compliance with the Medicare conditions for hospitals through The Joint Commission's deemed status survey process.

Based upon the submission of your evidence of standards compliance on February 29, 2016 and the successful on-site unannounced Medicare Deficiency Follow-up event conducted on January 26, 2016, the areas of deficiency listed below have been removed. The Joint Commission is granting your organization an accreditation decision of Accredited with an effective date of December 19, 2015. We congratulate you on your effective resolution of these deficiencies.

§482.12 Governing Body
§482.13 Patient's Rights
§482.41 Physical Environment
§482.42 Infection Control
§482.51 Surgical Services

The Joint Commission is also recommending your organization for continued Medicare certification effective December 19, 2015. Please note that the Centers for Medicare and Medicaid Services (CMS) Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Your organization is encouraged to share a copy of this Medicare recommendation letter with your State Survey Agency.

This recommendation applies to the following locations:

Chesapeake Cardiology Cardiovascular Diagnostic Laboratory
522 Idlewild Ave, Easton, MD, 21601

Queen Anne's Emergency Center
d/b/a Univ of Maryland Shore Emergency Center at Queenstown
115 Shoreway Dr., Queenstown, MD, 21658

The Joint Commission

Shore Health System, Inc
d/b/a Univ of Maryland Shore Medical Center at Easton
219 South Washington Street, Easton, MD, 21601-2491

Shore Health System, Inc
d/b/a Univ of Maryland Shore Medical Center at Dorchester
300 Byrn Street, Cambridge, MD, 21613

Shore Medical Pavilion
d/b/a University of Maryland Shore Medical Pavilion at Queenstown
125 Shoreway Dr, Queenstown, MD, 21658

Univ of Maryland Shore Reg Health Diag and Imaging Center
838 S. 5th Avenue, Denton, MD, 21629

Univ of Maryland Shore Reg Health Diag and Imaging Center
10 Martin Court, Easton, MD, 21601

Univ of Maryland Shore Regional Health Integrative Medicine
607 Dutchmans Lane, Suite B, Easton, MD, 21601

University of Maryland Shore Regional Health Cancer Center
509 Idlewild Avenue, Easton, MD, 21601-2491

Please be assured that The Joint Commission will keep the report confidential, except as required by law or court order. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G. Pelletier, RN, MS
Chief Operating Officer
Division of Accreditation and Certification Operations

cc: CMS/Central Office/Survey & Certification Group/Division of Acute Care Services
CMS/Regional Office 3 /Survey and Certification Staff

The Joint Commission

March 8, 2016

Kenneth D. Kozel, MBA, FACHE
President and Chief Executive Officer
Shore Regional Health
219 S. Washington St
Easton, MD 21601

Joint Commission ID #: 6276
Program: Behavioral Health Care Accreditation
Accreditation Activity: 45-day Evidence of Standards Compliance
Accreditation Activity Completed: 03/08/2016

Dear Mr. Kozel:

The Joint Commission would like to thank your organization for participating in the accreditation process. This process is designed to help your organization continuously provide safe, high-quality care, treatment, and services by identifying opportunities for improvement in your processes and helping you follow through on and implement these improvements. We encourage you to use the accreditation process as a continuous standards compliance and operational improvement tool.

The Joint Commission is granting your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

- Comprehensive Accreditation Manual for Behavioral Health Care

This accreditation cycle is effective beginning December 18, 2015. The Joint Commission reserves the right to shorten or lengthen the duration of the cycle; however, the certificate and cycle are customarily valid for up to 36 months.

Please visit Quality Check® on The Joint Commission web site for updated information related to your accreditation decision.

We encourage you to share this accreditation decision with your organization's appropriate staff, leadership, and governing body. You may also want to inform the state or regional regulatory services, and the public you serve of your organization's accreditation decision.

Please be assured that The Joint Commission will keep the report confidential, except as required by law. To ensure that The Joint Commission's information about your organization is always accurate and current, our policy requires that you inform us of any changes in the name or ownership of your organization or the health care services you provide.

Sincerely,

Mark Pelletier

Mark G.Pelletier, RN, MS

Chief Operating Officer

Division of Accreditation and Certification Operations

EXHIBIT 9

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030
Date Accessed: 3/18/2018

Ratings for Health Conditions and Topics
Ratings shown here are compared to State Average

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
COPD-Chronic Obstructive Pulmonary Disease				
	Results of Care			
1	Dying within 30-days after getting care in the hospital for chronic obstructive pulmonary disease (COPD)	Average	8.9 (7.2 - 11.0)	
2	Returning to the hospital after getting care for chronic obstructive pulmonary disease (COPD)	Average	19.6 (17.4 - 22.0)	
Childbirth				
	Practice Patterns			
3	Percentage of births (deliveries) that are C-sections	Better than average	26.0773 (23.2168, 28.9379)	
4	How often babies in the hospital are delivered vaginally when the mother previously delivered by cesarean section (no complications)	Below average	1.7391 (0.0000, 4.1284)	Vaginal birth after cesarean section is not programmatically allowed at UM SRH due to a lack of ability to meet American College of Obstetricians and Gynecologists' guidelines for this type of program, which include having anesthesia and pediatric services available 24/7, in-house.
5	How often babies in the hospital are delivered using cesarean section when this is the mother's first birth.	Better than average	15.5696 (13.0413, 18.0979)	
6	How often babies are born vaginally when the mother has had a C-section in the past (includes complications)	Below average	2.3810 (0.0000, 5.0430)	See explanation to measure number 4 above.
7	Newborn deliveries scheduled 1-3 weeks earlier than medically necessary	Better than average	0%	
Combined Quality and Safety Ratings				
	Deaths			

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030
Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
8	Patients who died in the hospital after having one of six common conditions.	Average	1.0017 (0.8008, 1.2026)	
	Patient Safety			
9	How well this hospital keeps patients safe based on eleven patient safety problems	Average	0.8646 (0.5349, 1.1944)	
Consumer Ratings				
	Communication			
10	How often did nurses always communicate well with patients?	Better than average	79%	
11	How often did doctors always communicate well with patients?	Average	78%	
12	How often did staff always explain about medicines before giving them to patients?	Below average		The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) are of high priority for UM SRH, and this issue is addressed in the UM SRH Strategic Plan and Annual Operating Plan for FY 2018 under Patient Experience: Empowering Meaningful Care Relationships. UM SRH's goals are to: 1. Ensure each owner understands the Press Ganey (PG) reports and her/his area's performance. 2. Support each owner in identifying priorities and specific actions to address patients' feedback/opinions of their care experience. 3. Support each owner in balancing global priorities (nurse communication, physician communication, and environment—cleanliness & quietness) with individual area priorities. 4. Support each owner in action planning and execution of actions that will enable sustainable improvement. In addition to the emphases on HCAHPS, in January 2017 UM Shore Medical Center at Easton's Pharmacy Department increased clinical pharmacist presence on inpatient units. In addition, in November 2017, UM SRH's Patient Experience Director worked with its clinical managers and directors to build "push" reports for each department, including the Pharmacy Department and Senior Leadership Team. The HCAHPS score on "Communication and Medicines" is trending up from 54.8 in Q1 of 2016 to 77.1 in Q3 of 2017.
13	Were patients always given information about what to do during their recovery at home?	Below average	84%	In addition to the emphasis on HCAHPS, Easton and the other campuses throughout implemented a new leader rounding format around June 2017 that is standardized across units. At the same time, UM SRH implemented Care Transition Rounds (CTR) to address discharge planning. Additionally, in October 2017, UM SRH hired a full complement of Transitional Nurse Navigators (TNNs) to follow high risk patients throughout the continuum of care.

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
14	How well do patients understand their care when they leave the hospital?	Below average	46%	The HCAHPS score for communication on recovery is trending up from 86.5 in Q1 of 2016 to 89.2 in Q3 of 2017. HCAHPS are of high priority for UM SRH and is addressed in the UM SRH Strategic Plan and Annual Operating Plan for FY 18. Specifically, a Care Coordination Action Plan was developed to address this measure. In addition, as discussed in response to measure number 13, UM SRH has implemented CTRs to address discharge planning and hired TNNs to follow high risk patients throughout the continuum of care. The HCAHPS score for this measure is trending up from 47.4 in Q1 of 2016 to 66.9 in Q3 of 2017.
	Environment			
15	How often were the patients' rooms and bathrooms always kept clean?	Better than average	73%	
16	How often did patients always receive help quickly from hospital staff?	Better than average	67%	
17	How often was patients' pain always well-controlled?	Better than average	68%	
18	How often was the area around patients' rooms always kept quiet at night?	Below average	49%	The Patient Experience Committee has been working with departments and units throughout the organization. A Quietness Campaign was implemented from January through March 2017, which included initiatives to reduce noise: wheels were replaced on carts, new dietary carts were purchased, Quietness signs were posted in hallways and elevators, quiet hours were established on units and within departments, individual units and departments developed action plans to address specifics issues within their own areas. Scores from Press Ganey are monitored monthly and individual reports are pushed out to units and departments. The HCAHPS score on Quietness at night is trending up from 39.1 in Q1 of 2016 to 56.4 in Q3 of 2017.
	Satisfaction Overall			
19	How do patients rate the hospital overall?	Below average	60%	As discussed in response to measure number 12, HCAHPS are of high priority for UM SRH and is addressed in the UM SRH Strategic Plan and Annual Operating Plan for FY 18. A number of new initiatives have been implemented to improve patient experience and satisfaction, including: 1. HEART – Service Excellence and Service Recovery (implemented early 2017). This is a program from Cleveland Clinic that helps UM SRH employees understand their role in creating a positive patient experience and establish and sustain a culture of service excellence by empowering employees to interact with patients, visitors, and each other in a caring and compassionate way.
20	Would patients recommend the hospital to friends and family?	Below Average	58%	

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030
Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
				2. Executive rounds (implemented June 2016). This is a tool that allows UM SRH senior leaders to engage executives with frontline staff and demonstrate that the organization is committed to solving issues and improving experiences of patients and customers. 3. Cleanliness Focus (implemented August 2016). UM SRH implemented this initiative to improve patients' perception of cleanliness and to understand best practices to help patients heal by managing their perception of cleanliness. 4. Admission Rounds (implemented March 2017). UM SRH implemented this initiative to raise the visibility and engagement of nurse leaders and increase interaction with patients by welcoming newly admitted patients to the unit and introducing leaders in order for patient and family to have appropriate contacts if they have issues or concerns. Since implementation of these various initiatives, patient complaints and grievances have been trending down from 216 in Q1 or 2017 to 109 in Q3 of 2017. In addition, the HCAHPS score on Rate the Hospital have been trending up from 60.8 in Q1 2016 to 73.2 in Q3 of 2017.
	Wait Times			
21	How long patients spent in the emergency department before leaving for their hospital room	Better than average	365 minutes	
22	How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room	Better than average	119 minutes	
23	How long patients spent in the emergency department before being sent home	Better than average	136 minutes	
24	How long patients spent in the emergency department before they were seen by a healthcare professional	Better than average	24 minutes	
25	How long patients who came to the emergency department with broken bones had to wait before receiving pain medication.	Better than average	60 minutes	

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
26	Patients who left the emergency department without being seen	Better than average	2%	
Flu Prevention				
	Protecting Patients			
27	Patients in the hospital who got the flu vaccine if they were likely to get flu	Average	99%	
Heart Attach and Chest Pain				
	Recommended Care - Outpatient			
28	How long patients with chest pain or possible heart attack waited to be transferred to another hospital for a procedure	Average	57 minutes	
29	Patients with a heart attack who received aspirin on arrival to the hospital	Average	98%	
30	How long patients who come to the hospital with chest pain or possible heart attack waited to get a test that detects heart damage after a heart attack	Average	7 minutes	
	Results of Care			
31	How often patients die in the hospital after heart attack	Average	3.1761 (0.0000, 8.7247)	
32	Dying within 30-days after getting care in the hospital for a heart attack	Average	14.1 (11.2 - 17.5)	
33	Returning to the hospital after getting care for a heart attack	Average	16.5 (13.7 - 19.4)	
Heart Failure				
	Results of Care			
34	How often patients die in the hospital after heart failure	Average	3.3636 (1.4480, 5.2792)	
35	Dying within 30-days after getting care in the hospital for heart failure	Average	11.8 (9.9 - 14.1)	

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
36	Returning to the hospital after getting care for heart failure	Average	19.7 (17.5 - 22.0)	
Heart Surgeries and Procedures				
37	Recommended Care How often the hospital uses a procedure to find blocked blood vessels in the heart on both sides of the heart instead of on only one side.	Average	6.4516 (0.3364, 12.5668)	
	Results of Care			
38	Death rate for CABG	Not enough data to report		
39	Rate of unplanned readmission for CABG	Not enough data to report		
Hip or Knee Replacement Surgery				
	Results of Care			
40	Returning to the hospital after getting hip or knee replacement surgery	Average	4.1 (3.1 - 5.4)	
41	Complications after hip or knee replacement surgery	Average	2.6 (1.8 - 3.8)	
Imaging				
	Practice Patterns			
42.	Patients who come to the hospital with low back pain who had an MRI without trying recommended treatments first, such as physical therapy (If a number is high, it may mean the facility is doing too many unnecessary MRIs for low back pain.)	Below average	40.40%	UM SRH is implementing processes in imaging department and working with the physicians to ensure use of best practices. Education will be provided utilizing evidence-based practices on the current recommendations prior to performing the MRI. The initial education will be provided by July 2018 and possibly a second round will be planned in a year if improvements are not seen on this measure. UM SRH intends to see significant improvements in the next 24 months.
43	Contrast material (dye) used during abdominal CT scan	Below average	7%	UM SRH is working with imaging and radiologists to utilize evidence-based best practices. CTs both prior to and after the administration of intravenous contrast are not routinely performed at UM SRH. Those cases are limited to CT urograms and categorization of abdominal masses to limit radiation doses to the patient. Evidence-based methods for evaluation of other modalities will be used. Best practice guidelines such as the American College of

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
				Radiology (ACR) appropriateness criteria will be utilized to educate providers and referring physicians, and, where appropriate, UM SRH will change its protocols. UM SRH intends to see significant improvements in the next 24 months.
44	Contrast material (dye) used during thorax CT scan	Average	.20%	
45	Patients who had a low-risk surgery and received a heart-related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition	Average	4.70%	
46	Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	Average	1.70%	
Patient Safety				
	Results of Care - Complications			
47	How often the hospital accidentally makes a hole in a patient's lung	Average	0.2768 (0.0000, 0.9592)	
48	How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery or procedure	Average	1.3970 (0.0000, 2.9947)	
49	Number of patients who get a blood transfusion and have a problem or reaction to the blood they get	Not enough data to report		
50	Returning to the hospital for any unplanned reason within 30 days after being discharged	Average	15.1 (14.4 - 15.9)	
51	Patients who developed a blood clot while in the hospital and did not get treatment that could have prevented it	Not enough data to report		
52	Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	Not enough data to report		
	Results of Care - Deaths			

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
53	How often patients die in the hospital after bleeding from stomach or intestines	Average	1.3736 (0.0000, 3.7735)	
54	How often patients die in the hospital after fractured hip	Average	2.5229 (0.0000, 5.2932)	
55	How often patients die in the hospital while getting care for a condition that rarely results in death	Average	0.0000 (0.0000, 0.8581)	
Pneumonia				
	Results of Care - Deaths			
56	How often patients die in the hospital while getting care for pneumonia	Average	5.4022 (3.0753, 7.7290)	
57	Dying within 30-days after getting care in the hospital for pneumonia	Average	16.7 (14.6 - 19.1)	
58	Returning to the hospital after getting care for pneumonia	Average	17.1 (14.9 - 19.4)	
Stroke				
	Results of Care			
59	How often patients who came in after having stroke subsequently died in the hospital.	Average	7.1496 (3.6067, 10.6925)	
60	Death rate for stroke patients	Average	15.3(12.8, 18.4)	
61	Rate of unplanned readmission for stroke patients	Average	13.1(10.8, 15.7)	

	Practice Patterns			
62	Number of surgeries to remove part of the esophagus	Not enough data to report	-	
63	Number of surgeries to remove part of the	Not enough	-	

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
	pancreas	data to report		
64	Number of surgeries to fix the artery that carries blood to the lower body when it gets too large	Not enough data to report	-	
	Results of Care - Deaths			
65	How often patients die in the hospital during or after surgery on the esophagus	Not enough data to report	-	
66	How often patients die in the hospital during or after pancreas surgery	Not enough data to report	-	
67	How often patients die in the hospital during or after a surgery to fix the artery that carries blood to the lower body when it gets too large	Not enough data to report	-	
Surgical Patient Safety				
	Results of Care			
68	How often surgical patients die in the hospital because a serious condition was not identified and treated	Average	157.2296 (10.9910, 303.4683)	
69	How often patients in the hospital had to use a breathing machine after surgery because they could not breathe on their own	Average	0.0000 (0.0000, 7.5667)	
70	How often patients in the hospital get a blood clot in the lung or leg vein after surgery	Average	5.5409 (2.1535, 8.9282)	
71	How often patients accidentally get cut or have a hole poked in an organ that was not part of the surgery or procedure	Average	1.3970 (0.0000, 2.9947)	
72	Number of times a medical tool was accidentally left in a patient's body during surgery or procedure	Not enough data to report		

UM Shore Medical Center at Easton
Quality Measures Exhibit

https://healthcarequality.mhcc.maryland.gov/MarylandHospitalCompare/index.html#/professional/quality-ratings/profile/13030

Date Accessed: 3/18/2018

Measure Number	Indicator	Rating	Risk-Adjusted Rates	Comments / Plan of Correction
Healthcare Associated Infections (HAI)				
	Surgical Site Infections (SSI)	Same		
	Central Line-Associated Blood Stream Infections (CLABSI)	Not enough data to calculate		
	Health Care Worker Vaccinations (HCW)	Better than average		
	Clostridium Difficile Infections (CDI)	Same		
	Methicillin-Resistant Staphylococcus Aureus Infections (MRSA)	Same		
	Catheter-Associated Urinary Tract Infections (CAUTI)	Same		

EXHIBIT 10

Inpatient Nursing Unit Space Tabulation:

The tables below show the calculation for the net areas of the various inpatient nursing units being renovated.

Level 2 South - Med/Surg (36 beds)

Room / Function	Quantity	NSF	Total NSF
Private Patient Room	1	132	132
Private Patient Room	1	140	140
Private Patient Room	2	152	304
Private Patient Room	14	166	2,324
Private Patient Room	2	222	444
Private Patient Room	1	164	164
Private Patient Room	1	206	206
Private Patient Room	1	210	210
Private Patient Room	1	191	191
Semi-Private Patient Room	6	222	1,332
Ante Room	1	182	182
Patient Toilet Room	24	36	864
Patient Toilet Room	1	31	31
Patient Toilet Room	1	48	48
Patient Toilet Room	2	35	70
Patient Toilet Room	1	42	42
Staff Station	1	347	347
Staff Station	1	371	371
Patient Education	1	249	249
Family Lounge / Waiting	1	296	296
Lockers	1	115	115
Storage/Files	1	150	150
Palliative Care	1	225	225
Office	1	103	103
Office	1	107	107
Office	1	191	191
Linen	1	67	67
Equip Storage	1	184	184
Storage	1	44	44
Toilet	1	43	43
Toilet	1	25	25
Toilet	1	27	27
Soiled Utility	1	104	104
Closet	2	9	18

Alcove	3	19	57
Pantry	1	96	96
Bath	1	31	31
Toilet	1	32	32
Janitor	1	34	34
Storage	1	138	138
Office	1	88	88
Alcove	1	14	14
Supply	1	129	129
Staff Lounge	1	289	289
Toilet	1	32	32
Pantry	1	96	96
Soiled Utility	1	105	105
Toilet	1	27	27
Conference	1	317	317
Alcove	24	3	72
Total Net Area			10,907
Total # Beds			36
SF / Bed			**303**

Level 3 East - Behavioral Health (12 beds)

Room / Function	Quantity	NSF	Total NSF
Private Patient Room	1	151	151
Private Patient Room	1	132	132
Private Patient Room	1	147	147
Private Patient Room	1	211	211
Semi-Private Patient Room	4	203	812
Patient Toilet	1	42	42
Patient Toilet	2	41	82
Patient Toilet	5	30	150
Staff Station	1	174	174
Medications	1	121	121
Seclusion Room	1	81	81
Seclusion Toilet	1	37	37
Ante Room	1	59	59
Storage	1	53	53
Day Room / Dining	1	501	501
Group Therapy	1	225	225

Quiet / Visitor Room	1	99	99
Soiled Hold	1	55	55
Clean Supply	1	256	256
Closet	1	17	17
Patient Shower	2	64	128
Treatment / Exam	1	242	242
Therapist	1	123	123
Staff Toilet	1	30	30
Staff Toilet	1	28	28
Consult / Provider	1	203	203
Consult / Provider	1	206	206
Staff Toilet	1	41	41
Treatment Planning	1	303	303
Assistant Workroom	1	206	206
Office	1	91	91
Office	1	129	129
Office	1	112	112
Laundry	1	111	111
Sally Port	1	135	135
Staff Toilet	1	30	30
Staff Lounge	1	206	206
Total Net Area			5,729
Total # Beds			12
SF / Bed			**477**

Level 3 South - Med/Surg (37 beds)

Room / Function	Quantity	NSF	Total NSF
Private Patient Room	1	201	201
Private Patient Room	1	210	210
Private Patient Room	1	191	191
Private Patient Room	1	184	184
Private Patient Room	1	180	180
Private Patient Room	8	223	1,784
Private Patient Room	1	221	221
Private Patient Room	1	199	199
Private Patient Room	2	195	390
Semi-Private Patient Room	1	294	294
Semi-Private Patient Room	1	298	298

Semi-Private Patient Room	7	373	2,611
Semi-Private Patient Room	1	340	340
Patient Toilet	1	46	46
Patient Toilet	2	35	70
Patient Toilet	2	40	80
Patient Toilet	1	47	47
Patient Shower	7	39	273
Patient Toilet	7	54	378
Patient Toilet	1	74	74
Patient Toilet	9	55	495
Patient Toilet	1	34	34
Patient Toilet	3	41	123
Alcove	1	5	5
Alcove	1	17	17
HC Shower	1	57	57
Storage	1	50	50
Toilet	1	26	26
Satelite Staff Station	1	165	165
Charting / Workroom	1	177	177
Storage	1	502	502
Toilet	1	41	41
Linen	1	50	50
Equip. Storage	1	227	227
Office	1	92	92
Soiled	1	52	52
Clean	1	70	70
Tub	1	44	44
Pyxis Alcove	1	10	10
Office S.S.	1	89	89
Pantry	1	53	53
Alcove	1	34	34
Medications	1	99	99
Staff Station	1	128	128
Charting	1	310	310
Charting	1	79	79
Janitor Closet	1	29	29
Toilet (public)	1	41	41
Toilet (staff)	1	29	29
Lockers	1	252	252
Office	1	77	77
Clean Utility	1	120	120

Pantry	1	83	83
Alcove	1	78	78
Office	1	95	95
Storage	1	62	62
Lounge	1	342	342
Total Net Area			12,308
Total # Beds			37
SF / Bed			**333**

Level 4 South - Med/Surg (26 beds)

Room / Function	Quantity	NSF	Total NSF
Private Patient Room	1	184	184
Private Patient Room	8	164	1,312
Private Patient Room	2	165	330
Private Patient Room	2	223	446
Private Patient Room	1	227	227
Private Patient Room	1	206	206
Private Patient Room	1	216	216
Semi-Private Patient Room	1	325	325
Semi-Private Patient Room	1	298	298
Semi-Private Patient Room	1	306	306
Semi-Private Patient Room	1	223	223
Semi-Private Patient Room	1	222	222
Patient Toilet	2	40	80
Patient Toilet	1	47	47
Patient Toilet	17	43	731
Patient Toilet	1	42	42
Staff Station	1	200	200
Staff Lockers	1	186	186
Staff Toilet	1	25	25
Storage	1	29	29
Multi-Purpose	1	482	482
Storage	1	86	86
Office	1	91	91
Office	1	96	96
Lockers	1	87	87
Office	1	97	97
Group Therapy	1	324	324

Toilet	1	39	39
Janitor	1	13	13
Clean Supply	1	121	121
Laundry / Soiled	1	122	122
Toilet	1	31	31
Alcove	1	68	68
Office	1	155	155
Medication	1	47	47
Workroom	1	282	282
Office	1	145	145
Office	1	166	166
Supply Storage	1	62	62
Pantry	1	57	57
EVS	1	47	47
Soiled	1	74	74
Office	1	89	89
Storage	1	86	86
Clean Supply	1	78	78
Office	1	70	70
Medication	1	71	71
Alcove	1	27	27
Linen	1	63	63
Toilet	1	29	29
Total Net Area			8,840
Total # Beds			26
SF / Bed			**340**

Level 5 South - Labor & Delivery / Peds (16 beds)

Room / Function	Quantity	NSF	Total NSF
LDRP	1	262	262
LDRP	1	310	310
LDRP	2	311	622
LDRP	1	308	308
LDRP	1	322	322
LDRP	1	317	317
LDRP	1	324	324
LDRP	1	321	321
LDRP	1	362	362

Private Pat. Rm (Antepartum)	1	205	205
Private Pat. Rm (Antepartum)	1	211	211
Private Pat. Rm (Antepartum)	1	182	182
Ante Room	1	38	38
Private Pat.t Rm (Peds)	1	202	202
Private Pat.t Rm (Peds)	1	205	205
Private Pat.t Rm (Peds)	1	180	180
Patient Bathroom	2	76	152
Patient Bathroom	3	81	243
Patient Bathroom	1	82	82
Patient Bathroom	1	83	83
Patient Bathroom	2	74	148
Patient Bathroom	1	75	75
Patient Toilet	1	46	46
Patient Toilet	1	36	36
Patient Toilet	1	35	35
Patient Toilet	1	44	44
Patient Toilet	1	47	47
Patient Toilet	1	43	43
Family Waiting	1	386	386
Office - Case Management	1	70	70
Alcove	1	5	5
Alcove	1	17	17
Staff Lounge	1	279	279
Lockers (Women)	1	332	332
Lockers (Men)	1	139	139
EVS	1	40	40
On-Call	1	100	100
On-Call	2	93	186
Office	1	75	75
Office	1	110	110
Office	1	99	99
Office	1	92	92
Store Room	1	125	125
Soiled	1	114	114
Clean Supply	1	100	100
Clean Supply	1	135	135
Nourishment	1	102	102
EVS	1	50	50
Conference	1	274	274
Staff toilet	1	55	55

Medication	1	41	41
Staff Station	1	406	406
Work room	1	135	135
Nursery	1	608	608
Consult	1	19	19
Total Net Area			9,499
Total # Beds			16
SF / Bed			**594**

Note: Area for Unit excludes 'C' Section Suite and Triage area.

EXHIBIT 11

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES BEHAVIORAL HEALTH RESPONSE TEAM	POLICY NO:	
		REVIEWED:	03/16
UM SMC at Dorchester and Easton	INQUIRY CALLS	PAGE #:	1 of 2
		SUPERSEDES	04/11

PURPOSE: To define an inquiry call and outline the procedure for handling an inquiry call.

SCOPE: BHRT, Medical Staff: Emergency Department (ED) and Behavioral Health

DEFINITION:

1.0 An inquiry call is any call in which a prospective patient, family member/ significant other, health care professional, Medical Director or attending psychiatrist:

1.1 Seeks information about the program.

1.2 Requests information about admission for a particular individual.

1.3 Calls to admit a patient.

POLICY:

1.0 Inquiry calls will be routed to the Behavioral Health Response Team (BHRT) Clinician in a timely fashion.

PROCEDURE:

1.0 The BHRT Clinician will utilize the Electronic Request Log to elicit sufficient data to make an initial assessment to the caller's needs.

2.0 When sufficient information has been taken, the staff member will develop a plan with the caller ensuring appropriate access to needed treatment as follows:

2.1 Crisis and/or imminent danger

2.1.1 Call 911 or send to the nearest ED immediately to see a BHRT Clinician.

2.2 Appropriate for admission to Inpatient

2.2.1 Contact on-call physician and unit; proceed with admission process.

2.3 Appropriate for referral

2.3.1 Refer to another inpatient or outpatient program following procedure.

Policy	
Effective	1992
Revised/ Reviewed	03/16; 04/11; 01/07; 02/06; 01/05; 0/03; 04/02; 04/01; 04/00; 10/97
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team
SPIRIT Form	Jackie Weston 03/11/16

REFERENCE:

EXHIBIT 12

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES INPATIENT PROGRAM	POLICY NO:	
		REVIEWED:	08/17
UM SMC at Dorchester	ADMISSION CRITERIA ADULT PSYCHIATRIC INPATIENT	PAGE #:	1 of 4
		SUPERSEDES	10/15

CROSS REFERENCES:
1. Administrative Policy PE-07-Admission of Patients to Inpatient Behavioral Health
2. Administrative Policy TX-11-Stabilization of Patients Presenting for Emergency Medical Treatment

PURPOSE: To establish the criteria and process for admission to the Shore Behavioral Health (SBH) Services Adult Psychiatric Program for patients 18 years and older.

SCOPE: MD, RN, LPN

POLICY

1.0 The SBH Medical Director or designee will review admission inquiries and approve all potential patients for admission.

2.0 All patients admitted from the emergency department, transferred from within the hospital, or transferred from another facility will be medically stable prior to acceptance.

2.1 The SBH Medical Director, or designee, will evaluate the medical appropriateness of all potential patients.

3.0 The individual must have a mental disorder which is susceptible to care or treatment and must satisfy one of the following clinical criteria for admission:

3.1 Imminent risk for self-injury, with an inability to guarantee safety, as manifested by any one of the following:

3.1.1 Recent, serious, and dangerous suicide attempt, indicated by degree of lethal intent, impulsivity, and/or concurrent intoxication, including an inability to reliably contract for safety.

3.1.2 Current suicidal ideation with intent, realistic plan, or available means that is severe and dangerous.

3.1.3 Recent self-mutilation that is severe and dangerous.

3.1.4 Recent verbalization or behavior indicating high risk for severe injury to self.

3.2 Imminent risk for injury to others as manifested by any of the following:

3.2.1 Active plan, means, and lethal intent to seriously injure other(s).

3.2.2 Recent assaultive behaviors that indicate a high risk for recurrent and serious injury to other(s).

3.2.3 Recent and serious physically destructive acts that indicate a high risk for recurrence and serious injury to others.

3.3 Failure of outpatient services to stabilize psychiatric symptoms.

3.4 Acute and serious deterioration from the patient's baseline ability to fulfill age-appropriate responsibilities in one or more of the following areas:

3.4.1 Education

3.4.2 Vocation

3.4.3 Family; and/or

3.4.4 Social/peer relations to the extent that behavior is so disordered, disorganized or bizarre that it would be unsafe for the patient to be treated in a lesser level of care.

3.4.5 An ability to attend to their basic activities of daily living which may include hygiene, nutrition, and rest as a result of their mental illness.

3.5 Imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric symptom(s) manifested by either:

3.5.1 Signs, symptoms, and behaviors that interfere with diagnosis or treatment of a serious and acute medical illness requiring inpatient medical services.

3.5.2 A need for acute psychiatric interventions with a high probability of serious and acute deterioration of general medical and/or mental health.

4.0 Patients ineligible for admission include the following:

4.1 Persons able to receive treatment in a less restrictive environment.

4.2 Persons with a primary diagnosis of alcoholism or substance abuse with no primary mood, anxiety or psychotic symptoms.

4.3 Individuals in police custody.

4.4 Patients whose cognitive impairment would prevent them from participating and benefiting from psychotherapy and can be placed in a more appropriate program.

4.5 Individuals whose relative or significant other is already a patient on the inpatient unit and where admission of this patient would not be therapeutic.

4.6 Patients whose primary insurance does not include Shore Health System and there is bed availability within their provider network and the patient consents to transfer.

4.7 Patients in imminent risk of Delirium Tremens.

4.8 Patients who require treatments that are not offered at our facility, including but not limited to ECT or Medical Detoxification requiring IV treatment.

5.0 Information regarding reasons for ineligibility for treatment at SBH will be provided to the referring health care provider.

6.0 Patients may be transferred to another facility for treatment if:

6.1 Patient or patient's power of attorney requests transfer.

6.2 Treatment team recommends that the patient's treatment would have greater therapeutic benefit if patient is transferred to a specialty program.

Policy	
Effective	1992
Revised/ Reviewed	08/17; 10/15; 07/14; 09/10; 03/08; 02/06; 01/05; 08/03; 05/02; 07/99; 10/97
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team
SPIRIT Form	John Mistrangelo 10/26/15

REFERENCE:

1. American Psychiatric Nurses Association (2014). Psychiatric Mental Health Nursing: Scope and Standards of Practice.
2. State of Maryland –Department of Health and Mental Hygiene Application for Voluntary Admission (2014)
3. State of Maryland –Department of Health and Mental Hygiene Application for Involuntary Admission (2014)

EXHIBIT 13

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	PE-07
		REVISED:	02/18
	ASSESSMENT FOR ADMISSION OF PATIENTS TO INPATIENT BEHAVIORAL HEALTH UNIT	PAGE #:	1 of 5
		SUPERSEDES	09/15

CROSS REFERENCE:

Shore Behavioral Health Policy: Admission Criteria Adult Behavioral Health Inpatient Unit

POLICY:

To ***establish*** that all patients who present for psychiatric care from internal or external sources are processed in compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA).

Individuals with emergency psychiatric conditions are screened and stabilized regardless of the following, including but not limited to, diagnosis, financial status, race, color, national origin and/or disability.

Shore Regional Health strives to meet the behavioral health needs of patients in its primary, five county service area comprised of Talbot, Dorchester, Queen Anne's, Kent, and Caroline counties. This goal can best be achieved through collaboration and planning that engages our healthcare partners in the community to improve access, quality of care, and efficiency of care. Distance from referral sources can compromise the ability to provide quality, coordinated care. It is a factor that must be taken into consideration when evaluating external referrals for admission.

Sources of requests for admission:

- Shore Regional Health Emergency Services, University of Maryland Shore Medical Center at Dorchester (UMSMC at Dorchester), University of Maryland Shore Medical Center at Easton (UMSMC at Easton), University of Maryland Shore Medical Center at Chestertown (UMSMC at Chestertown, and Shore Emergency Center Queenstown.
- Psychiatric Consultation/Behavioral Health Response Team (BHRT) Consultation
- External emergency rooms and facilities

DEFINITIONS OF BEHAVIORAL HEALTH UNIT ADMISSIONS STATUS:

1. Completely Open (CO): Open bed, no milieu conditions to consider, no additional documentation required.

2. Partially Open (PO): Strategic admission of patients based on patient presentation/symptoms due to unit milieu conditions or staffing;

documentation required. Only patients presenting to a Shore Regional emergency facility will be considered for admission to provide the opportunity for a full and complete assessment of the patient in order to evaluate the inpatient unit's ability to safely accommodate the patient.

Examples of factors impacting unit ability to accept admissions include, but are not limited to:

a. Violence on unit.
b. Number of special observations.
c. Staffing required for 1:1 observation.
d. Presence of patients who have propensity for sexual acting out.
e. Victims of sexual abuse.
f. Gender.
g. Gender identity issues.

3. Not Open (NO): Bed(s) closed for infection control, beds filled to capacity or facility condition (i.e., flood, renovation, plumbing problem); documentation required.

1.0 PROCEDURE

1.1 The Charge Nurse acts as the primary point of communication regarding the Unit's admission status.

1.2 When on duty, the Administrative Supervisor shall be consulted regarding unit conditions and resource requirements that might avert an alteration of the Unit's admission status.

1.3 At other times, the Department Manager will be consulted regarding unit conditions and resource requirements that might avert an alteration of the unit's admission status.

1.4 Decisions to alter the admission status of the inpatient unit shall be made by the Medical Director and Director, or designee(s).

1.5 The Charge Nurse will communicate changes in census and capacity to Behavioral Health Response Team (BHRT) staff.

1.6 Notification will be made using a capacity alert.

1.7 All requests for admission to the Behavioral Health Inpatient Unit will be routed to the Behavioral Health Response Team (BHRT).

1.8 BHRT staff will record requests for admission on the electronic Admission Log. Unit conditions impacting admission capability will be noted.

1.9 Once medically stable, including a blood alcohol level <100, BHRT staff will gather information necessary to evaluate the patient for admission and provide that information, along with the units current admission status, to:

1.9.1 The psychiatrist on–call, if the request is from an external agency or an inpatient unit at a Shore Regional Health Hospital.

1.9.2 The Emergency Services Licensed Independent Practitioner if the patient is receiving care in Shore Health Emergency Services.

1.10 The psychiatrist/nurse practitioner (provider) on-call is responsible for ensuring that all patients accepted for admission on the inpatient unit meet clinical admission criteria. It is the provider's decision whether or not the unit is able to provide care for the patient based on the status of the unit (CO, PO, NO).

1.11 The provider's disposition decision and the rationale for it will be documented in the Admission Log by the BHRT Evaluator.

1.12 If the patient is being referred from an external source and meets the clinical admission criteria, but the unit admission status prevents the acceptance of the patient, the referring facility will be informed of a projected admission date if it is anticipated the unit admission status will change due to discharges.

1.13 If the patient is referred from internal sources and meets the clinical admission criteria but the unit admission status prevents acceptance of the patient OR the patient does not meet the admission criteria, the Care Coordination Department staff of the patient's current inpatient unit will pursue transfer to an appropriate facility. BHRT Staff may serve as a resource for the Care Coordination Department staff.

1.14 If transfer to another facility cannot be arranged within 24 hours, BHRT staff will notify the psychiatrist on-call, Behavioral Health Manager, Director or designee.

1.15 The Behavioral Health Manager or designee will arrange for the BHRT staff to conduct reassessments of the patient in collaboration with the psychiatrist, provide treatment interventions to stabilize the patient and will document the reassessments and therapeutic interventions.

1.16 For patients who remain in the Emergency Department for 24 or more hours from arrival awaiting an appropriate disposition, the Medical Director of Behavioral Health or his/her designee will confer with the treating Emergency Services Physician to ensure appropriate care from a behavioral health perspective.

1.17 The Behavioral Health Manager and Director will assist in the formulation and implementation of this plan and ensure its communication to appropriate Emergency Department and Supervisory leadership.

2.0 PRIORITIZATION OF REQUESTS FOR ADMISSION

2.1 Admission requests will be processed in chronological order from the entries on the Behavioral Health Admission Log.

2.2 Emergency Department requests will be prioritized over patients who are already in a bed on an inpatient unit.

2.3 The Behavioral Health Medical Director or designee will be contacted for all requests for clinical prioritization that necessitate deviation from the chronological order. Rationale for clinical prioritization will be documented on the Admission Log by BHRT staff with the name of the authorizing provider.

3.0 QUALITY REVIEW

3.1 The following cases will be reviewed to determine whether or not patients have been managed in compliance with established policy:

3.1.1 Patients transferred to other facilities

3.1.2 Requests for admission from remote facilities that were declined.

3.1.3 Patients being treated by SRH Emergency Services who were not relocated to the Behavioral Health Inpatient Unit within 24 hours of admission.

3.2 On a monthly basis, the data from the case reviews will be aggregated and evaluated by the Manager, Medical Director, and Director of Shore Behavioral Health.

3.3 A quarterly report, including total volume, number of transfers from other facilities and within SRH, and resolution of pending cases, will be communicated to the Behavioral Health Leadership Council and to the Performance Management Committee.

Effective	10/10
Approved	Medical Director, Shore Behavioral Health
Approved	Christopher J. Parker, RN, Sr. Vice President/CNO
Revised	09/11
Approved	Medical Executive Committee: 09/08/11
Revised	02/12
Approved	UMMS Legal Department
Approved	Linda Pittman, Director, Corporate Compliance
Revised	09/15
Revised	2/18
Approved	Linda Pittman, Director, Corporate Compliance
Approved	Eric Anderson, MD, Medical Director Shore Behavioral Health
Approved	Ruth Ann Jones, RN, Senior Vice President; Chief Nursing Officer
Approved	Diane Walbridge, RN, Director , Acute and Emergency Nursing
Approved	Tammy Curry, Regulatory Compliance
Approved	Heather Joyce-Byers, Risk Management
Approved	UMMS Legal Department
Policy Owner	John Mistrangelo, Program Director, Shore Behavioral Health

EXHIBIT 14

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES INPATIENT PROGRAM	POLICY NO:	NA
		REVIEWED:	04/18
UM SMC at Dorchester	SHORE BEHAVIORAL HEALTH QUALITY ASSURANCE	PAGE #:	1 of 2
		SUPERSEDES	NA

PURPOSE: To establish a separate Quality Assurance Program that encompasses the behavioral health services of Shore Regional Health.

SCOPE: All Shore Behavioral Health Personnel

DEFINITIONS:

Quality Assurance: This is an activity that involves the survey of treatment activities and the collection of observations and data on that treatment activity to be analyzed to identify issues impacting the provision of patient care. Information is used to develop new and or improved treatment processes.

Data: Numbers, measurements, and observations of treatment and operational processes.

Analysis: The use of statistical tools, graphic illustration, or written report to describe, compare, and contrast data within programs, year-to-year, or against local, regional, or national benchmarking.

BACKGROUND:

Shore Behavioral Health (SBH) provides acute, inpatient psychiatric services on its general adult psychiatric program. Typically, the patient population is comprised of adults age 18 and older. All are patients that are deemed to benefit from a variety of therapies including milieu, group, individual, family, and psychotropic medication.

POLICY:

1.0 Data will be collected, analyzed and reported on a monthly basis.

2.0 Data review will be conducted as a part of the monthly leadership meeting.

3.0 Results will be reported to Shore Regional Health Performance Management Committee.

4.0 Data results will be made available to staff and providers.

5.0 Data will be used to evaluate the effectiveness of the program's treatment and to formulate changes in procedures.

6.0 Each fiscal year population specific treatment issues will be identified and prioritized for the development of an improvement plan.

PROCESS:

1.0 Program managers for inpatient, Intensive Outpatient, Behavioral Health Response Team and Substance Misuse Program will submit their prior month data to the Leadership Council by the time of the scheduled Council meeting.

2.0 Review and discussion of Quality Assurance data shall be a standing item on the Leadership Council Agenda.

3.0 Results from Quality Assurance improvement initiatives shall be reported on a monthly basis.

4.0 Data collected and improvement activity progress reported shall be documented as a part of the Leadership Council's monthly meeting minutes.

Policy	
Effective	04/18
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

REFERENCE:

EXHIBIT 15

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES	POLICY NO:	
		REVIEWED:	
UM SMC at Dorchester	Special Behavioral Health Population Treatment Protocols	PAGE #:	
		SUPERSEDES	

PURPOSE: To establish any special procedure necessary for the safe management and treatment of special behavioral health populations.

SCOPE: All Shore Behavioral Health Personnel

POLICY:

1.0 Definitions:

Special Behavioral Health Population: Patients with characteristics and or diagnoses that place them outside of the typical patient group admitted and treated on the Shore Behavioral Health Inpatient Psychiatric Unit.

Medically Compromised Patients: Patients whose ability to engage in activities of daily living may be impaired because of medical condition.

Geriatric: Patients above the age of 65.

Intellectual Disability: Patients whose registration, retention, and or processing of sensory inputs has been undeveloped, disrupted, deteriorated, or damaged.

2.0 Background:

Shore Behavioral Health (SBH) Inpatient Psychiatric Unit is focused on the treatment of the general, adult psychiatric population. Typical diagnosis include affective disorders, psychosis, bipolar illness, and suicidality. Patient ages range from 18 years and greater. Patients are able to effectively participate in group, individual, and milieu therapy. Patients may have some minor medical conditions. They may have a secondary co-occurring, substance misuse conditions

3.0 Policy

3.1 SBH makes adjustments in its care and treatment to meet the special population needs of its patients so long as the efficacy of treatment and the safety of care is not unduly compromised.

4.0 Guidance for Specialty Populations

4.1 Patients with Medical Complications

4.1.1 Admissions Considerations

4.1.1.1 No IV pumps

4.1.1.2 No room isolation cases

4.1.1.3 No bed bound patient

4.1.2 Room Assignment
- **4.1.2.1** Patients will be placed in one of two medical rooms within close proximity of nurse's station.

4.1.3 Alternative treatment
- **4.1.3.1** Patients will be transferred to medical service
- **4.1.3.2** Follow-up to be provided by consulting psychiatrist with assistance from Behavioral Health Response Team (BHRT).

4.1.4 Related Policies

4.2 Geriatric Patients

4.2.1 Admissions Considerations
- **4.2.1.1** No limitation on admission if patient can participate and benefit from milieu setting and treatment.
- **4.2.1.2** Hospitalist consult is recommended
- **4.2.1.3** Fall risk assessment and precautions to be implemented

4.2.2 Room Assignment
- **4.2.2.1** Consider placement close to nurse's station.
- **4.2.2.2** Consider single room as appropriate

4.3 Intellectual Disability

4.3.1 Admissions considerations
- **4.3.1.1** No limitation if patient is able to participate and benefit from milieu setting and treatment.
- **4.3.1.2** Physical acting out behavior will need to be closely evaluated for impact on milieu and safety of other patients.

4.3.2 Room Assignment
- **4.3.2.1** Consider single room to decrease stimulation
- **4.3.2.2** Proximity to nursing station should also be considered depending on patient's presentation.

4.4 Child and Adolescent Patients

4.4.1 Admission Considerations
- **4.4.1.1** Patients under 18 years of age will not be admitted
- **4.4.1.2** Patients may be evaluated for admission to the Pediatric Unit with follow-up by psychiatry and Behavioral Health Response Team.
- **4.4.1.3** Patients not appropriate for the above option will be transferred to an available bed in a child/adolescent psychiatric unit at another hospital.

4.5 Co-occurring Substance Use Disorder

4.5.1 Admission Considerations
- **4.5.1.1** Patients with a psychiatric diagnosis as well as a co-occurring substance use disorder are appropriate for admission.
- **4.5.1.2** Medical detox is not provided on the inpatient psychiatric unit.

4.5.2 Treatment Considerations
- **4.5.2.1** The unit provides a daily, specialized Substance Use Disorder related group.

4.5.2.2 Patients are assigned to a therapist with experience working with this population

4.6 Pregnant Patients

4.6.1 Admission Considerations

4.6.1.1 Refer to Behavioral Health Admissions Policy

4.6.1.2 Certain limitations apply as specified in the Admissions Policy.

4.6.1.3 Commitment from Obstetrics to consult on case during treatment is a requirement for admission.

Policy	
Effective	
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

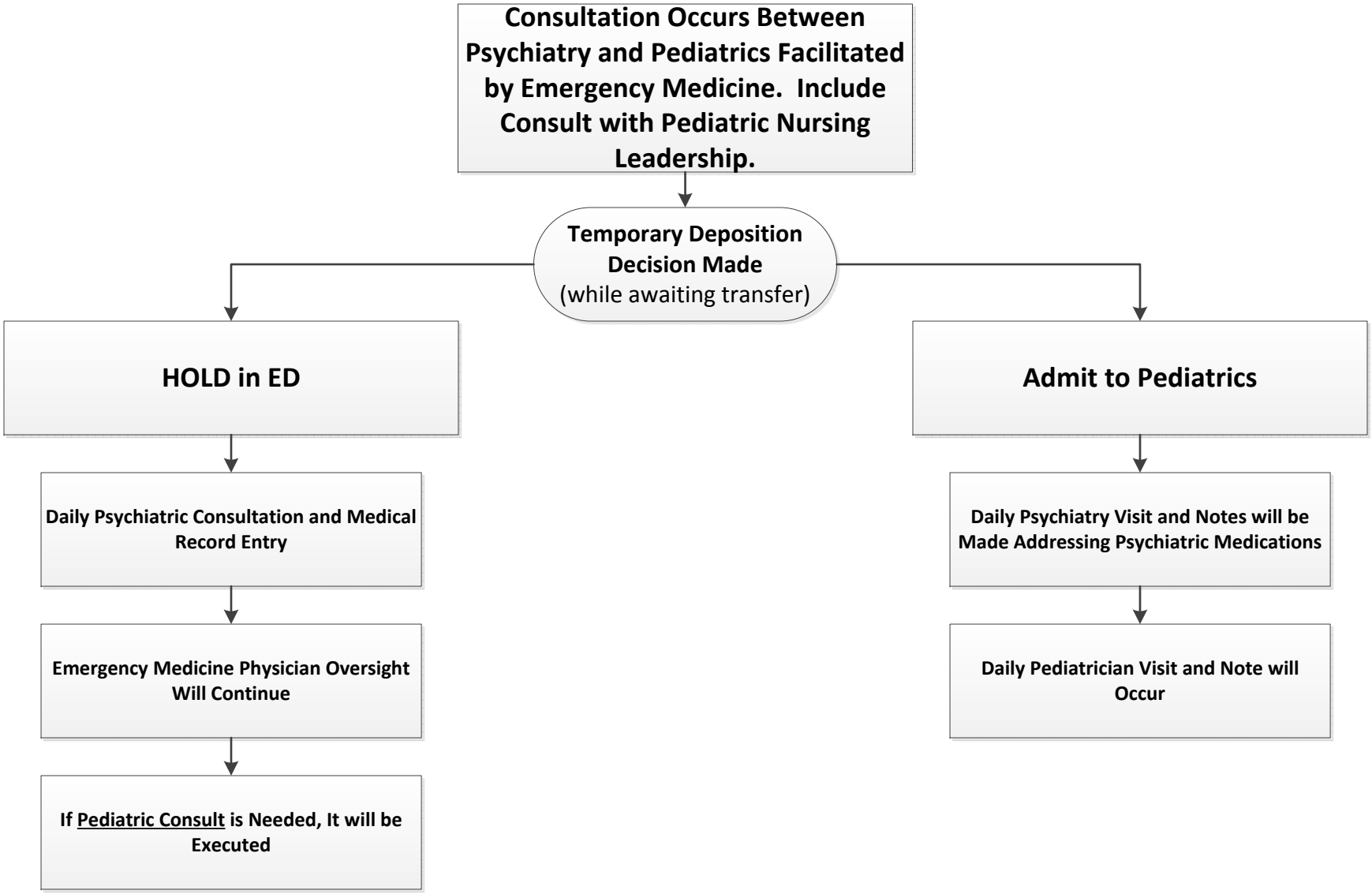
REFERENCE: Behavioral Health Admissions Policy

EXHIBIT 16

Collaborative Decision Process for Pediatric Psychiatric Patients

Conditions:

* Age <18 (Hospitalists only admit age ≥18)
* Inpatient psychiatric care needs can not be met/ are not readily available via transfer
* "Readily available" is case dependent and related to patients needs and his or her ability to tolerate ED Hold until accepted elsewhere



* **Emergency Medicine and Pediatric Nursing Education will be Required**
* **Case Management will Prioritize the Care for Transfer**

DRAFT 1.0

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES	POLICY NO:	
		REVIEWED:	
UM SMC at Dorchester	Pediatric Behavioral Health Care	PAGE #:	
		SUPERSEDES	

PURPOSE: To establish a process through which pediatric behavioral health services may be provided on an emergent basis to patients awaiting a pediatric behavioral health inpatient bed..

SCOPE: All Shore Behavioral Health Personnel

POLICY:

1.0 Background:

Shore Behavioral Health (SBH) does not provide inpatient pediatric behavioral health treatment. Pediatric patients are evaluated in Shore Regional Health's emergency facilities and in patient hospitalization may be recommended as a course of treatment. At times there is no availability of pediatric behavioral health inpatient beds. Patients then remain in the emergency department setting while they await an available bed.

2.0 Policy

2.1 Shore Behavioral Health provides alternative behavioral health care to patients awaiting placement in a pediatric behavioral health bed in another facility.

3.0 Process

3.1 In situations where inpatient behavioral health care is not available within a reasonable amount of time (typically under 24 hours) there are two potential options. These are continued care in the Emergency Department or transfer to the Hospital's Pediatric Unit with consultation from the Behavioral Health physician staff.

3.1.1 The attending emergency department physician may request a consultation at any time from Shore Behavioral Health for treatment recommendations that are appropriate for implementation while the patient remains under the care of the emergency department.

3.1.2 Patients may be considered for transfer to the Hospital's inpatient pediatric unit. This is a joint decision made by the admitting pediatrician in consultation with the consulting psychiatrist.

3.1.3 In either 4.1.1 or 4.1.2 patients will receive daily psychiatry visits with documentation in the medical record.

3.1.4 Daily supportive therapy visits will be provided in either instance by a member of the Behavioral Health Response Team.

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES	POLICY NO:	
		REVIEWED:	
UM SMC at Dorchester	Pediatric Behavioral Health Care	PAGE #:	
		SUPERSEDES	

Policy	
Effective	
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

REFERENCE:

EXHIBIT 17

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES INPATIENT PROGRAM	POLICY NO:	NA
		REVIEWED:	04/18
UM SMC at Dorchester	SHORE BEHAVIORAL HEALTH DISCHARGE PLANNING AND REFERRAL	PAGE #:	1 of 2
		SUPERSEDES	NA

PURPOSE: To establish the process for planning and coordination of services between patients who are admitted to the Shore Behavioral Health (SBH) Services Adult Psychiatric Program and other community based services, facilities, or resources.

DEFINITIONS:

Patient Care Services (PCS): Patient Care Services is the group within Shore Behavioral Health (SBH) that provides discharge planning, referral, and placement services for patients referred to Shore Behavioral Health for psychiatric care.

Community Based Aftercare Services: Community based services include clinics, provider offices, specialty programs, intensive outpatient treatment, residential programs, and mobile treatment services.

Specialized Inpatient Care: Limited specialty, inpatient programs are available. These include Addictions Rehabilitation, Geriatric Inpatient Units, and Dementia Care Inpatient and Residential programs.

Discharge Plan: This is a plan jointly developed by the patient, their provider, and other members of the treatment team. It provides the patient with information regarding their illness and its treatment. Self-help strategies, appointments for follow-up services and medication instructions are all part of the discharge plan.

POLICY:

1.0 Background: Shore Behavioral Health's (SBH) first obligation to all patients is caring for their mental health and medical needs.

1.1 Patients referred to the Hospital for treatment often require services post discharge or may at the time of referral require services not provided directly by the Hospital.

1.2 The Patient Care Services Team on the Acute Inpatient Psychiatric Unit provides referral and coordination of services. These services may include outpatient psychiatric treatment; community based programming, long term care, other specialized inpatient care and medical referrals, as needed.

2.0 Assessment. Information regarding discharge needs is typically incorporated into the Psychosocial Assessment.

2.1 The assessment delineates patient strengths and weaknesses as well as available supports and resources.

2.2 Information obtained in the psychosocial assessment is used to formulate the patient's discharge plans.

2.3 The PCS team works with the patient and treatment team to prepare them for discharge.

3.0 Discharge Plan

The PCS team will work with the patient to develop a plan to increase the likelihood of treatment success and to deal effectively with issues that might jeopardize successful transition to the community.

3.1 Discharge plans will be developed through a combination of individual and group interactions.

3.2 Copies of the plan will be sent to community based providers under continuity of care provisions.

Policy	
Effective	04/18
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

REFERENCE: