UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH

Conversion of University of Maryland
Harford Memorial Hospital to a Freestanding Medical Facility
Matter No. 17-12-2403

Responses to Additional Information Questions Dated September 1, 2017

Project Description

1. **The proposed FMF (page 6) is described as having 21 exam rooms and a behavioral health crisis center with four exam rooms. The floor plan drawing appears to show 29 rooms labeled as "exam rooms" and, in addition, one room labeled as "seclusion" that appears to be a type of exam room and two rooms labeled as "patient isolation rooms" that also appear to be a type of exam room. Please clarify and reconcile this floor plan with the project description.**

Applicants' Response

Enclosed as a replacement for Exhibit 2 are revised project drawings for UC FMF and UC Behavioral Health. The amended project drawings are now consistent with Table B submitted with Exhibit 1 to the Applicants' Request For Exemption from Certificate of Need Review for the Conversion of University of Maryland Harford Memorial Hospital to a Freestanding Medical Facility (the "Exemption Application") and Table B submitted as Exhibit 1 to UM Upper Chesapeake Health's Certificate of Need Application to develop a special psychiatric hospital. Table 19 below reflects the square footage of both UC FMF and UC Behavioral Health, with shared space allocated 48% to UC FMF and 52% to UC Behavioral Health. Table 19 corrects the Applicants' square footage descriptions on pages 4-5 and footnote 1 of the Exemption Application.

Table 19
Department Gross Square Footage UC FMF and UC Behavioral Health

	UC Behavioral Health	UC FMF	Total
Total Floor Plate Square Footage	78,763 (ground floor)	50,800 (first floor)	129,563
Dedicated Departmental Square Footage	53,922	49,857	103,779
Shared Space Allocation	12,918	12,866	25,784
Shared Space Allocation %	52%	48%	100%
Total Gross Departmental Square Feet consistent with Table B	66,840	62,723	129,563

The general emergency department treatment space at the UC FMF according to the current project drawings and project drawings submitted with the initial exemption request on

August 4, 2017, include a total of (21) exam rooms broken down as follows: sixteen (16) standard exam rooms; two (2) isolation exam rooms; two (2) resuscitation exam rooms; one (1) safe exam room. UC FMF also includes six (6) triage rooms. UC FMF's behavioral health crisis treatment space includes four (4) total exam rooms broken down as follows: three (3) exam rooms and one (1) seclusion room. The seclusion room in the behavioral health crisis unit will be used for patients who have emotional responses that are poorly modulated and who pose a threat to themselves or others on the unit (including staff) such that temporary seclusion provides an effective means to protect the patient and others while the patient receives medical attention.

Submitted herewith as Exhibit 8 are portions of drawing A101 (UC FMF's floor plan), which was submitted with initial and revised Exhibit 2 to the Exemption Application, with the number of treatment spaces in the emergency department, the behavioral health crisis unit, and the observation unit sequentially numbered in each respective department.

As reflected on Exhibit 8, the "Quiet Room" will be used for family consultation with the emergency department providers and/or chaplain. Also located in the emergency department is a decontamination area, a room for law enforcement, a separate room for UC FMF's security team, and offices for emergency department physicians and leadership. While not identified for in the design drawings, one of the offices in the emergency department at UC FMF will likely be used for telemedicine connection to a variety of sites.

2. **The observation suite is described as having eleven patient rooms. The floor plan drawing appears to show 11 rooms labeled as "patient rooms" and a 12th room labeled "patient isolation room," which appears to be a 12th patient room. Please clarify and reconcile this floor plan drawing with the project description.**

Applicants' Response

UC FMF's observation unit includes eleven (11) observation rooms comprised of ten (10) standard patient rooms and one (1) isolation suite. The isolation suite includes three (3) sub-rooms including a patient isolation ante room, an isolation toilet, and the actual patient isolation room. Submitted herewith as Exhibit 8 is a portion of drawing A101 (UC FMF's floor plan), reflecting the number of treatment spaces in the observation unit. The isolation suite will be utilized for patients suspected of having an active infection that requires isolation during continued testing and monitoring.

State Health Plan Standards

COMAR 10.24.19.04.C, Exemption from Certificate of Need Review to Convert a General Hospital to a Freestanding Medical Facility

C (4), Location

3. **In response to this standard, the applicants identify a 13-zip code area primary service area based on the patient origin of HMH's emergency department ("ED") patients. What is the primary service area of the converting general hospital, HMH, with respect to the patient origin of patients admitted for inpatient care?**

Applicants' Response

In fiscal year 2016, 62.0% of HMH's MSGA discharges (primary service area) came from residents of two (2) zip codes in Harford County and one (1) zip code in Cecil County as listed below in Table 20 below.

Table 20
HMH MSGA Primary Service Area Zip Codes and Discharges
FY2016

Zip Code	Community	County	Discharges	% of Discharges
21001	Aberdeen	Harford County	913	29.1%
21078	Havre De Grace	Harford County	813	25.9%
21904	Port Deposit	Cecil County	222	7.1%
	Subtotal 2016 Service Area		**1,948**	**62.0%**
	Out of Service Area		1,192	38.0%
	Total MSGA Discharges		3,140	100.0%

In fiscal year 2016, 62.7% of HMH's inpatient psychiatric discharges (primary service area) came from residents of seven (7) zip codes in Harford County as listed in Table 21 below.

Table 21
HMH Psychiatric Primary Service Area Zip Codes and Discharges
FY2016

Zip Code	Community	County	Discharges	% of Discharges
21001	Aberdeen	Harford County	193	15.7%
21040	Edgewood	Harford County	130	10.6%
21014	Bel Air	Harford County	126	10.2%
21078	Havre De Grace	Harford County	122	9.9%
21009	Abingdon	Harford County	91	7.4%
21015	Bel Air	Harford County	66	5.4%
21050	Forest Hill	Harford County	43	3.5%
	Subtotal 2016 Service Area		**771**	**62.7%**
	Out of Service Area		459	37.3%
	Total Psychiatric Discharges		1,230	100.0%

C (5), Compliance with general standards in COMAR 10.24.10.04A COMAR 10.24.10.04A (2) Charity Care Policy

4. **This standard states that, "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." Does the Financial Assistance Policy provided as Exhibit 4 comply with this requirement? If so, please identify the specific provisions of the Policy that indicate compliance.**

Applicants' Response

UM Upper Chesapeake Health's Financial Assistance Policy submitted as Exhibit 4 to the Exemption Application complies with COMAR 10.24.10.04A(2). Section 4(d) on page 6 of UM Upper Chesapeake Health's Financial Assistance Policy (Exhibit 4) provides, "[w]ithin two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, the hospital will make a determination of probable eligibility."

COMAR 10.24.10.04A (3) Quality of Care

5. **A review of the MHCC Hospital Performance Guide during the week of August 14, 2017 indicates that HMH had a "below average" score on two "Practice Pattern" quality measures, the one noted on page 15 but also on the "Contrast material (dye) used during abdominal CT scan" quality measure. Please address and document each action being taken by UM HMH to improve performance for this quality measure.**

Applicants' Response

HMH's corrective action plan for "Contrast material (dye) used during abdominal CT scan" quality measure includes the following:

Imaging

Practice patterns	Rating	Risk-Adjusted Rates
Contrast material (dye) used during abdominal CT scan	Below average	7.2%
Contrast material (dye) used during thorax CT scan	Average	0.2%
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%
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	Below average	6%

As an initial matter, though the screen shot above indicates HMH is performing below average for the State of Maryland, HMH's data compares with the average for the nation when

the filter is changed. At UM UCH the average number of patients administered contrast dye during abdominal CT scans is 3.6% and consistent with the nationwide average. Pursuant to the MHCC's quality measure definition, the denominator is very low at HMH for these type of exams resulting in a somewhat skewed "below average" quality rating.

Nevertheless, UM UCH has adopted the Choosing Wisely Campaign to limit the use of CT scans, and will be implementing clinical decision support for patients with suspected kidney stone to decrease the utilization of CT scans using contrast dye.

Regarding the use of contrast material, it is an evidenced-based practice and supported by the American College of Emergency Physicians that oral contrast is not necessary for simple uncomplicated appendicitis and especially if the patient is above a body mass index of 25. HMH has instituted this practice with General Surgery support. In addition, the same group of Emergency Physicians that would order this test most often commonly work at both UCMC and HMH, thereby enhancing compliance with this policy. Emergency department provider education and monitoring of this metric has been ongoing. Ongoing assessment of efforts to limit the use of CT with contrast dye will be reported to UM UCH's Performance Improvement Committee.

In addition, there has been initial training and implementation of a Dose Management Program at UM UCH to aid in reviewing best practice for patient exposures during advanced scans such as CT. This has been implemented in all UMMS hospitals and there will be benchmarking reports developed for the entire UMMS system.

C (8)(b), Emergency, urgent, and primary care services

6. Has Upper Chesapeake Health (UCH) gathered market intelligence on the use of the seven urgent care centers identified within 3.7 and 13.6 miles of the UCH-Havre de Grace (UCH- HG) FMF site?

Applicants' Response

UM UCH has not gathered market intelligence on the use rates of the six independent urgent care centers identified in Table 4 of the Exemption Application. UM UCH is involved in a joint venture with ChoiceOne to operate the urgent care center located in Aberdeen. Despite efforts by UM UCH to direct patients with non-emergent medical conditions to urgent care centers as more fully described in response to Question 8B below, the ChoiceOne/UM UCH urgent care center in Aberdeen has received less patient volume than the joint venture partners initially projected.

A. Is use of these centers growing and, if so, does this explain or partially explain the recent decline in hospital ED visits in the HMH ED service area?

Applicants' Response

While UM UCH does not have information on the use rates of the six independent urgent care centers identified in Table 4 of the Exemption Application, UM UCH does not attribute slight decreases in HMH's emergency department visits between fiscal years 2016 and 2017 to increased use rates at urgent care centers or a market shift of emergency department cases to

urgent care centers. Rather, UM UCH attributes slight decreases in HMH's emergency department utilization between fiscal years 2016 and 2017 to UM UCH's extensive population health efforts and initiatives, including the WATCH teams and the Comprehensive Care Center as described on pages 20-23 of the Exemption Application.

B. What assumptions were made by UCH about use of urgent care centers when developing use projections for the UCH-HG FMF?

Applicants' Response

HMH experienced an increase in emergency department visits between fiscal years 2014 and 2016, even with the presence of urgent care centers in the market. As described in the Applicants' response to Question 6A above, UM UCH attributes the slight decrease in HMH's emergency department utilization in fiscal year 2017 to extensive population health efforts and initiatives. UM UCH is not aware of the entry of new urgent care centers into the area. As such, the Applicants assume that the presence of urgent care centers will not have an impact on the projection of emergency department visits at the UC FMF.

C. What proportion of ED visits at the HMH ED occur between 8pm and 8am?

In fiscal year 2017, approximately 32% percent of HMH's emergency department visits occurred between 8 p.m. and 8 a.m. Between these hours, none of the urgent care centers identified in Table 4 of the Certificate of Exemption Application are open.

Table 22
HMH Emergency Department Visits Between 8 p.m. and 8 a.m.
FY2017

Timeframe	8 a.m. - 8 p.m.	8 p.m. - 8 a.m.	Total
Inpatient Visits	2,727	1,021	3,748
Outpatient Visits	16,666	8,062	24,728
Total Visits	19,393	9,083	28,476
% of Total	*68.1%*	*31.9%*	*100.0%*

Source: HMH FY2017 Internal Utilization

7. Do primary care physician practices not identified as urgent care centers provide an appreciable level of unscheduled, walk-in service in Harford and/or Cecil County?

Applicants' Response

In Havre de Grace, there are two (2) primary care practices that offer walk in services (Bala Family Practice and Dr. Mrowiec's practice). To the Applicants' knowledge, there are no additional primary care practices within UC FMF's proposed service area or in the Bel Air area that offer health care services to patients on an unscheduled, walk-in basis.

C (8)(d), Treatment capacity and space

8. **ED visit volume at HMH declined an estimated 6.1% between FY 2013 and FY 2017. All hospital ED visits originating in the HMH ED service area declined an estimated 4.3% over that same period. But HMH projects that the Upper Chesapeake Health-Havre de Grace (UCH-HG) FMF will experience a slightly higher visit volume in its first year of operation than the estimated 2017 volume of the HMH ED and also projects that visit volume will grow over the first three years of FMF operation.**

Applicants' Response

UC FMF is expected to continue to serve the emergent health care needs of the population in HMH's service area upon the closure of HMH. With the exception of 0.4% of historical visits that originate from northeast Cecil County and a limited number (approximately 200) of EMS priority 1, non-stroke patients, it is expected that the residents of HMH's service area will continue to come to UC FMF when experiencing emergency health conditions. Accordingly, emergency department visits at UC FMF are projected to grow annually with the service area population taking into consideration historic trends.

A. Provide an explanation of the reasoning and assumptions underlying this projection that an ED operation detached from a general hospital, the UCH-HG FMF, is likely to be more heavily utilized than recent experience of the HMH ED would suggest. Why is it not more intuitively likely that demand at the FMF will be lighter than that recently experienced by the hospital ED, given that higher acuity patients seen at the HMH ED will be redirected to hospital EDs after the conversion?

Applicants' Response

As stated above, the applicants have assumed that with the exception of 0.4% of historical visits that originate from northeast Cecil County and a limited number of EMS priority 1, non-stroke patients, the residents of HMH's service area will continue to come to UC FMF when experiencing emergency health conditions. These utilization projections are supported by UC FMF's plans to implement an Acute Stroke Ready Pilot and MIEMMS protocol changes allowing stable priority 2 and priority 1 stroke patients to be transported to UC FMF. The increase in accessibility to Interstate 95 rather than HMH's landlocked campus in downtown Havre de Grace is also likely to result in an increase in patient walk-ins particularly from surrounding areas such as Aberdeen due to UC FMF being more readily accessible than HMH. Finally, UM UCH has been educating and will continue to educate the community consistently that approximately 90% of their care can be received on the UC Medical Campus at Havre de Grace. The Applicants, therefore, anticipate the community will appropriately seek care at UC FMF when experiencing medical emergencies.

B. Will UCH encourage use of less costly urgent care centers as an alternative to the FMF for non-emergent and low acuity patients whose needs can be met at an urgent care center? If so, how will this guidance and encouragement be implemented?

Applicants' Response

UM UCH has implemented a comprehensive community educational campaign focusing on delivering "the right care at the right time and in the right setting" and has presented this patient education model in multiple community sessions and open door café sessions. UM UCH has developed an educational tool that provides specific clinical presentations that are more appropriate for the urgent care setting versus the emergency department setting. This educational information has been printed in brochures, marketing advertisements, placed on UM UCH's website and on UM UCH's electronic patient/community educational screens throughout both UCMC and HMH. Finally and as an additional educational strategy, UM UCH worked with ChoiceOne Urgent Care to develop and distribute a direct mailing to all patients who had sought care in the emergency departments of either UCMC or HMH whose low acuity care fell within the capabilities of an urgent care center. UCH has also begun to use the following graphic as part of its education efforts.

9. **Table 5 projects a total of 28,489 ED visits at HMH in FY 2017. Table 6 projects 28,245. Please clarify. Does HMH know the actual number of ED visits in FY 2017 at this time? If so, please provide.**

Applicants' Response

Table 5 presents 28,489 emergency department visits in fiscal year 2017 which was based on six (6) months of actual St. Paul Computer Center data of non-confidential patient level detail which was then annualized. Table 6 presents 28,245 emergency department visits in fiscal year 2017 which was based on HMH's internal summary utilization report that reflects six (6) months of actual patient encounters and six (6) months of projected utilization by HMH. Based on HMH's internal summary utilization report, the actual number of emergency department visits in fiscal year 2017 was 28,356. The discrepancy between Tables 5 and 6 does not impact the Applicants' emergency department treatment space need analysis as set forth in the Exemption Application.

10. **The application states that the treatment capacity and space proposed for the FMF is consistent with the ACEP Guide low range estimate of 21 treatment spaces (pages 24-26), based on an annual visit volume of 30,000 visits, and exclusion of the treatment spaces for behavioral health. However, Eme r gen c y D epartm ent Desi gn's guidance on the "Preliminary Sizing Chart" used by HMH to make this claim of consistency (page 114) defines "general or universal spaces" to include "general examination rooms, behavioral health, Ob/Gyn room (with adjacent toilets), and geriatric and pediatric spaces." It also notes that "bariatric rooms" would be included "within this designation." Thus, it would appear that exclusion of behavioral health treatment spaces as a basis for claiming consistency with the capacity guidelines is not consistent with the ACEP guidance. Please address this seeming contradiction.**

Applicants' Response

The projection of psychiatric and non-psychiatric visits at UC FMF is presented below in Table 23.

Table 23
UC FMF Projected ED Visits
FY2022 – FY2024

	Percent	Projected		
	Allocation (1)	FY2022	FY2023	FY2024
Psych	6.8%	1,968	1,977	1,986
Non-Psych	93.2%	26,795	26,914	27,033
Total	100.0%	28,763	28,891	29,019
Note (1): Percent allocation reflects FY2017 actual experience				

The Applicants provided a separate analysis for the emergency department psychiatric visits because the ACEP low range states "under 3%" of emergency department visits are psychiatric patients and, therefore, "you would probably not define a specialized area in the

emergency department for behavioral health patients." ACEP Guide at 111. Because the Applicants are planning separate psychiatric treatment space based on the needs of the particular population to be served, the Applicants excluded these treatment spaces from the ACEP low range analysis because the ACEP low range definition is inapt.

Excluding psychiatric emergency department visits, the projected emergency department treatment space need is still within the 30,000 annual visit range and, therefore, appropriate to evaluate separately given the distinct programming. The projection of 27,033 non-psychiatric emergency department visits falls between the ACEP space guidelines for 25,000 and 30,000 visits. Extrapolating between the space guidelines of 18 to 20 spaces for 25,000 visits and 21 to 25 spaces for 30,000 visits, results in an average need for 21 spaces.

Combining psychiatric and non-psychiatric visits results in a need for 25 treatment spaces and 18,259 departmental gross square feet for the emergency department, which is still within the ACEP "high range" of 25 treatment spaces and below the ACEP "high range" of 21,875 departmental gross square feet.

11. **In explaining a need for four behavioral health crisis treatment spaces, 16% of total FMF treatment capacity, HMH states that, "In fiscal years 2016 and 2017, an average of 6.8% of HMH's emergency department visits were diagnosed with a behavioral health condition. To plan for a small unit, though, it is necessary to size the behavioral health crisis treatment spaces around the peak period of utilization. In fiscal years 2016 and 2017, HMH experienced an annual peak utilization of 110 emergency psychiatric patients during the 5:00 pm hour. Extrapolating the peak period to all hours of the day yields 2,640 emergency psychiatric patients per year."**

    A. **Please clarify the meaning of "110 emergency psychiatric patients during the 5:00 pm hour." Over what period of time did HMH experience this peak demand of 110 emergency psychiatric patients and how does this period of time specifically relate to 5:00 pm?**

Applicants' Response

The 110 emergency psychiatric patients during the 5:00 p.m. hour referenced on page 26 of the Exemption Application was based on a report of the combined emergency department visits at UCMC and HMH over the fourteen (14) months from January 2016 to February 2017. A percentage of psychiatric emergency visits from this report were allocated to HMH on a pro-rated basis. Based on more recent data, HMH actually experienced an increase in the peak number of patients with 132 psychiatric emergency department arrivals during the 5:00 p.m. hour in fiscal year 2017. Thus, the behavioral health crisis need analysis presented in the Exemption Application on pages 26 through 27 actually understates the peak demand for such treatment spaces.

Table 24
HMH Peak Hour Psychiatric Emergency Department Visits
FY2017

FY2017	
Hour of Visit	5:00 P.M.
Inpatient Visits	48
Outpatient Visits	84
Total Visits	**132**

Source: HMH FY2017 internal utilization report

B. The full year extrapolation of 2,640 emergency psychiatric patients per year, offered as an adjustment of actual emergency psychiatric patients per year to account for peak demand levels, translates into an average of 9.1% of average total ED visits over the years FY 2016 and 2017 (based on the data provided in Table 6). How does this provide a basis for creating an FMF in which 16% of total treatment spaces are dedicated to behavioral health patients?

Applicants' Response

The applicants used an extrapolation at the 5:00 pm hour to ensure a sufficient number of behavioral health treatment spaces to meet peak demand for psychiatric patients who generally have longer lengths of stay. In fiscal year 2017, psychiatric patients had an average visit of 10.9 hours when seen during the 5:00 pm hour as compared to 3.3 hours for non-psychiatric patients over the course of fiscal year 2017. The four behavioral health treatment spaces will not be in peak demand all of the time. Psychiatric patients are projected to be 6.8% not 9.1% of UC FMF's emergency department visits. To meet the peak demand, though, there is a need for four (4) behavioral health treatment spaces or sixteen percent (16%) of the total twenty-five (25) of treatment spaces in the UC FMF emergency department.

12. The applicant has evaluated the proposed FMF as a high range hospital ED, based on most of the factors outlined in Emergency Department Design for such evaluation, but the discussion of this evaluation (pages 25 to 30) does not provide a clear and comprehensive basis for this evaluation. For some of these factors, this evaluation appears to be an a priori design decision based on unexplained assumptions by the applicant rather than a reasoned explanation of why the FMF must be designed or function in the manner suggested. Many of these decisions are related to the average visit time projection of over four hours. Therefore, we have the following questions:

Applicants' Response

The Applicants provided a response with data metrics for each of the sixteen (16) factors the author of the ACEP Guide uses to classify emergency departments into the low, mid, and high range tiers. This analysis is set forth at Exhibit 6 and described on page 29 of the Exemption Application. Based on the Applicants' responses to Questions 12A, 12L, 12M, and 12N, a revised Exhibit 6 is being provided to reclassify three (3) of the criteria to the ACEP "Mid Range," including the length of stay, turnaround time for diagnostic tests, and the percentage of

non-urgent patients. Even with these changes, UC FMF projects to be in the Mid to High Range according to Table 5.2 of the ACEP Guide. Of the 16 factors used by the ACEP Guide, UC FMF projects to be in the "High Range" for seven factors, in the "Mid Range" for six factors, and in the "Low Range" for only three factors.

Length of Stay

A. Why does Table 7 include UCMC data as a basis for claiming that hours per visit at the FMF will be more than four hours, on average? What is the average hours per visit at the HMH ED and why isn't this statistic the applicable data to analyze in planning the proposed FMF?

Applicants' Response

In accordance with the Applicants' response to Question 11A above, Table 7 was prepared using a report showing the combined emergency department visits at UCMC and HMH over the fourteen (14) months from January 2016 to February 2017, which reflected an average of four (4) hours per visit. A more recent report of HMH utilization in fiscal year 2017 reflects an average of 3.6 hours per emergency department visit as presented below in Table 24.

Table 25
HMH Historical Emergency Department Hours per Visit
FY2017

	FY2017
ED Visits	28,476
Average Minutes per Visit	238.48
Less: Average Minutes from Registration to ED Bay	(21.49)
Average Minutes per Visit in ED Bay	216.98
Average Hours per Visit in ED Bay	3.6

Source: UCHS Internal Utilization Report

B. Is the applicant projecting that an average visit to the proposed FMF will be four hours? How does this compare with average time per visit at other FMFs in Maryland or freestanding emergency centers in the U.S., more generally?

Applicants' Response

The proposed project is expected to continue to serve the emergent health care needs of the population in HMH's service area upon the closure of HMH. As such, it is expected the hours per visit experienced at HMH will continue at UC FMF. As described on page 26 of the Exemption Application, non-psychiatric emergency department patients at HMH stayed an average of 3.7 hours based on a pro-rated allocation of combined emergency department visits at UCMC and HMH. As reflected on Table 25 above, in fiscal year 2017, emergency department visits at HMH in fiscal year 2017 averaged 3.6 hours. UC FMF also projects that 6.8% of UC FMF emergency department visits will be patients suffering from emergency psychiatric

conditions; such patients have a much longer visits the emergency department with the average being 10.9 hours at HMH during the 5:00 pm hour. Factoring in the psychiatric patients, the average visit time is expected to average approximately four (4) hours.

The continuation of services previously provided in a hospital emergency department also limits the ability to compare UC FMF to existing Maryland FMFs. *See* the Applicants' Response to Question 12D below regarding the differences between UC FMF's design and capabilities as compared to existing Maryland FMFs.

C. Does the applicant anticipate that the average time per visit at the FMF will match the average time per visit at the HMH ED?

Applicants' Response

In short, the Applicants anticipate that the average time per visit will match the average time per visit at HMH's emergency department. *See also* Applicants' Responses to questions 12A and 12B above.

Percentage of Admitted Patients

D. Why does the applicant project that 12 to 20% of the patients seen at the FMF will be admitted to a hospital? Twelve percent of the total visits projected for FY 2022 (28,763) would be 3,452 admissions, which is 273 more admissions than the "inpatient visits" reported for the HMH ED in FY 2016. What evidence exists from the experience of existing freestanding emergency centers, in Maryland or elsewhere, to support such a projection?

Applicants' Response

The presentation of "Mid 12 to 20%" in the "Evaluation of UC FMF Bed Range" is a restatement of the ACEP Guide Table 5.2 as a "Mid Range" emergency department and based on current admission trends at HMH. As presented in the response to Question 15, the Applicants project 3,723 emergency department visits at UC FMF in fiscal year 2024 that will be admitted to UC Behavioral Health, UCMC, and other hospitals. These emergency department visits that will be admitted represent 12.8% of the total projected 29,019 emergency department visits to UC FMF in fiscal year 2024.

According to the Maryland Health Care Commission's presentation to the Maryland House Health and Government Operations Committee at a February 10, 2015 hearing, an average of 5.1% of patients treated in fiscal year 2014 at Maryland's three existing FMFs, UM Queen Anne's Emergency Center (now Shore Emergency Center at Queenstown ("UM SECQ")), Bowie Health Center, and Germantown Emergency Center, were admitted as hospital inpatients. Importantly, however, none of the existing FMFs was planned, designed, equipped, or staffed to serve as a replacement for an existing hospital emergency department. Moreover, each of these existing FMFs is limited in its capacity and ability to serve the acuity of patients currently seen at HMH. No existing FMF in Maryland has observation beds, none is accredited by the Joint Commission as an Acute Stroke Ready Hospital and only one, UM Queen Anne's Emergency Center, has an EMS base station.

Perhaps more significantly in relation to the admission rates at existing Maryland FMFs, in fiscal year 2014, MIEMSS protocols prohibited EMS providers from transporting patients who were experiencing emergency medical conditions to two of the three existing Maryland FMFs. Under MIEMSS protocols, EMS providers could only transport patients who either did not require medical attention at all or who suffered from non-emergent conditions to Bowie Health Center and Germantown Emergency Center. Under a pilot protocol applicable only to UM SECQ in fiscal year 2014, EMS providers could transport stable Priority 2 patients, defined as a patient suffering from a "less serious condition yet potentially life-threatening injury or illness, requiring emergency medical attention but not immediately endangering the patient's life," following a consultation with clinical personnel staffing the base station at UM SECQ. As a result, the number of patients suffering from actual emergency medical conditions treated at existing FMFs in Maryland in fiscal year 2014 was largely limited to walk-in patients. The low acuity of patients seen at the existing Maryland FMFs in fiscal year 2014 certainly drove the low hospital admission rate for patients treated at these facilities.

Effective July 1, 2017, MIEMSS protocols have been updated to permit EMS providers to now transport stable Priority 2 patients to all Maryland FMFs with a required medical consultation via base station communication. Assuming Maryland FMFs undertake measures to be able to safely and effectively treat stable Priority 2 EMS patients, the expansion of the MIEMSS freestanding pilot protocol to all Maryland FMFs is likely to increase the acuity of patients seen at FMFs and also increase the percentage of patients admitted for inpatient care. UC FMF is designed and will be staffed to treat such patients. Indeed, as described on page 8 of the Exemption Application, UC FMF will maintain HMH's EMS base station designation in accordance with a pilot program approved by the EMS Board to allow EMS providers to transport priority 1 stroke patients to UC FMF if a Primary Stroke or Comprehensive Stroke Center is greater than fifteen (15) additional minutes away.

UC FMF's projected number of inpatient admissions is consistent with utilization trends at HMH, adjusted to eliminate approximately 200 EMS Priority 1 patients that could not be treated at UC FMF. UC FMF's projection that in fiscal year 2024, 12.8% of emergency patients will be admitted to UC Behavioral Health, UCMC, and other hospitals is below the statewide hospital emergency department admission average of 14.8% inpatient admissions as reported by the Maryland Health Care Commission to the Maryland House Health and Government Operations Committee at the February 10, 2015 hearing.

E. Is the transport of more than nine patients per day from FMF to hospitals being factored into consideration of how development of this FMF will affect emergency transport capabilities in the area? How many patients, on average, are transported from the HMH ED to other hospitals on a daily basis? Please elaborate on this point.

Applicants' Response

Between fiscal years 2015 and 2017, there was an annual average of 1.3 daily transfers from HMH's emergency department to other hospitals.

As reflected in Table 29 provided in response to Question 15 below, in fiscal year 2022, the Applicants project that 653 emergency department patients will result in admissions to UC Behavioral Health and an additional 3,037 emergency department visits will be admitted to other hospitals. Excluding inpatient admissions to UC Behavioral Health, UC FMF is projected

to transfer 8.3 patients by ambulance per day to other facilities. In fiscal year 2024, the Applicants' project an average of 8.4 patient transfers per day to other facilities. To accommodate these projected transfers, the Applicants are actively considering a transport strategy to ensure adequate emergency transport capabilities in the area. Prior to the conversion of HMH to UC FMF, the Applicants will have a final plan for ensuring the ability to make timely ambulance transports in a safe and effective manner that will have minimal impact on the EMS system. The development of a helipad on the campus at the UC Medical Campus at Havre de Grace will eliminate ambulance transfers that currently occur at HMH for patients requiring helicopter ambulance transfers.

Patient care spaces

F. As will be noted in Table 5.2, a low range hospital ED is one that has decided to use "rapid medical evaluation areas, rapid care, and/or vertical areas to get patient assessment and advanced protocols started" thus allowing for "fewer private rooms to be designed in the overall emergency department." Why cannot an FMF that will see a higher proportion of lower acuity patients than a hospital ED be designed to move patients more rapidly through evaluation and assessment than a traditional hospital ED?

Applicants' Response

UC FMF has been designed and will be staffed to continue to serve the emergent health care needs of the population in HMH's service area upon the closure of HMH. An FMF could be developed to see a higher proportion of lower acuity patients than a hospital emergency department and designed with a minimal number of treatment spaces and reduced capabilities. Such a facility, however, would not be capable of continuing to serve the emergent health care needs of HMH's existing service area. As a consequence, other hospital emergency departments, including UCMC, would be overwhelmed with additional emergency visits necessitating additional capital projects to expand emergency department capacity at such facilities.

G. Why cannot the proposed FMF include private areas that require less space such as curtained cubicles, three-walled patient care areas, and/or patient recliners to assist in advanced protocols or nonurgent patients" as outlined in Table 5.2? Why must every patient, no matter what the emergent or urgent level of care needed, be treated in a private treatment room?

Applicants' Response

In UC FMF's emergency department space programming, the Applicants focused on patient and family experience, recognizing that negative patient satisfaction scores are generally associated with small, shared, less private care spaces. Such negative patient satisfaction scores are associated with patient confidentiality concerns as well as infection prevention considerations. The Applicants expect that patient satisfaction will be a significant factor in ensuring that the community utilizes UC FMF to its full potential.

Inner waiting and results waiting areas

H. The high range for this factor is described as, "Patients will remain in private treatment spaces for entire visit. There will be no inner waiting or results waiting spaces in the emergency department." Why is it necessary for every patient at an FMF to remain in a private treatment space for the entire visit? Why can't patients waiting for test results wait in another space, freeing up the treatment space and increasing throughput capability of the treatment spaces? Won't this help reduce the four hour or longer average visit time?

Applicants' Response

The Applicants do not agree that inner waiting or results waiting spaces in an emergency department are consistent with best practices or better outcomes. Rather, maintaining the patients in triage provides benefits with respect to patient to flow. As the acuity has risen within hospitals and emergency departments, the safety of inner waiting or results waiting spaces has been questioned.

Location of clinical decision unit (CDU) or observation space

I. The high range for this factor, which the applicant states is the apt description for the factor with respect to the proposed FMF, is described as, "Your CDU, observation, or extended stay patients will remain in the emergency department or in an adjacent care module that is part of your architectural project. You will need to add space to accommodate this volume." The low range for this factor is described as, "Your CDU/observation space will be located outside of the emergency department and is not part of your architectural project. There is, or will be, an area for CDU or observation patients in another area or on another floor. As patients are changed to observation status, they immediately leave the emergency department for another location. You will not need to accommodate this patient volume. Your emergency department can be at the lower range because you don't have to include those beds in you calculations." Specifically explain why the latter description does not apply to the proposed FMF and why the description of the high range for this factor does apply.

Applicants' Response

As reflected on Exhibit 2 to the Exemption Application (drawing A101), the observation unit at UC FMF will be adjacent to the emergency department and is part of the applicant's architectural project consistent with the ACEP Guide "high range" criteria. However, as patients are changed to observation status, they will leave the emergency department treatment space which consideration falls within the ACEP Guide "low range" criteria.

It should be noted, however, that the State Health Plan Chapter for Freestanding Medical Facilities, COMAR 10.24.17.04(c)(8)(d)(ii), requires an applicant to "demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage." Because the ACEP Guide does not contemplate an observation unit as part of the "architectural project" for an emergency

department in the "low range" and only provides for a 1.25 building gross square footage adjustment factor for a "freestanding facility," if UC FMF is classified in the low range for the "location of clinical decision unit (CDU) or observation space" criterion under Table 5.2 of the ACEP Guide, the observation unit should be excluded from the demonstration required by COMAR 10.24.17.04(c)(8)(d)(ii). As reflected in Exhibit 1, Table B, UC FMF's observation unit is 6,099 gross departmental square feet and the overall size of UC FMF's "emergency department" should be reduced by this amount if the observation unit is excluded from the emergency department.

Boarding of admitted patients

J. The high range for this factor is described as, "Emergency department patients who are admitted to the hospital will remain in the department for over 150 minutes after order to admit. This extended time will limit your ability to turn a patient care space over quickly, which means that more spaces will be needed." Why will occupancy of a treatment space for over 2.5 hours after the order to transfer the patient be a necessary way in which the FMF must function? Why can't such patients be transferred to the observation unit until all logistical requirements for transfer are completed and transfer can be implemented?

Applicants' Response

As further clarification to information provided on page 8 of the Exemption Application, the goal for optimal patient management is to achieve an average two-hour transport time for emergent, high acuity patients requiring a higher level of care. This two-hour window will start from the time a decision to admit a patient has been made and continue until the patient arrives at the receiving facility. The two-hour transport window will be accelerated for patients experiencing life threatening conditions; for example, UC FMF will have accelerated transport protocols for stroke and cardiac patients.

For non-emergent transports, a three to four-hour transport window will start from the time the receiving facility confirms bed availability. This transport time is consistent with existing patient boarding times at HMH and UCMC and will include transit time in an ambulance. UC FMF will require time to coordinate placement of most patients in an MSGA unit the receiving facility before transporting the patient. Moreover, UC FMF must still comply with the Emergency Medical Treatment and Labor Act ("EMTALA"), including the requirement to have a prepared room before transporting a patient and confirmation of acceptance from the receiving facility. *See* 42 C.F.R. §489.24(e)(2). UC FMF will not transfer patients to another emergency department unless the patient's condition requires surgery or the patient is suffering from time dependent diagnosis that requires immediate transport.

From a clinical perspective, the suggestion that UC FMF emergency department transfers should be routed through UC FMF's observation unit would not be consistent with the standard of care. The Applicants' plan is to staff the observation unit with acute care nurse practitioners under the supervision of hospitalists. Patients requiring transfer from UC FMF's emergency department for an acute inpatient admission will necessarily require a higher level of care than will be provided in UC FMF's observation unit. Therefore, it would be clinically

inappropriate to admit emergency department patients awaiting an acute inpatient admission to UC FMF's observation unit.[1]

From compliance and billing perspectives, admitting patients from the emergency department to the observation while the patient is awaiting transfer to an inpatient facility would also be inappropriate. UC FMF's observation unit will not be merely a patient holding area but rather a unit dedicated to ongoing assessment and reassessment to determine whether an inpatient admission is necessary or whether the patient can be safely discharged. Medicare guidance, which is followed by Medicaid and most commercial insurers, defines observation care as:

> a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge. Observation services are covered only when provided by the order of a physician or another individual authorized by State licensure law and hospital staff bylaws to admit patients to the hospital or to order outpatient services.

Centers for Medicare and Medicaid Services, *Medicare Claims Processing Manual*, Ch. 4 § 290.1 (Effective Date: 07-01-09) (emphasis added). Because a clinical decision to transfer emergency patients to a higher level of care will have already been made, it would not be appropriate to admit a patient awaiting such a transfer to observation status.

K. Since this is an FMF, isn't the patient simply being transferred to a hospital ED, at UCMC or some other hospital, when determined to need hospital admission? Thus, unlike ED boarding at a hospital ED, the FMF patient for which an order to admit decision has been made is not experiencing a long wait time that involves finding a vacant bed in an appropriate nursing unit of the hospital? Why can't a patient be transported more quickly, since the actual admission to a hospital bed will be taking place at the receiving hospital and not at the FMF?

Applicants' Response

See the applicants' response to Question 12(J) above.

Turnaround time for diagnostic tests

L. Why will it take more than 90 minutes to turnaround laboratory and imaging studies at the FMF? Is this the observed experience at FMFs?

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[1] In certain cases, patients already admitted to UC FMF's observation unit may require an inpatient admission. In such cases, UC FMF's observation unit staff will be supported by UC FMF emergency department physicians as needed to ensure the observation patient receives medically necessary treatment and intervention before the patient can be admitted.

Applicants' Response

The applicants' projected average imaging study turnaround time was presumed to be consistent with historical trends at HMH. In the first and second calendar quarters of 2017, 98.5% of imaging studies during the day and evening shifts had a turnaround time within 60 minutes. For overnight imaging study interpretations, 87.5 % were completed within 60 minutes during the first and second calendar quarters of 2017. For laboratory testing, in fiscal year 2017, 91% of HMH's emergency department laboratory tests had a turnaround test result within 40 minutes. Based on these figures, HMH and UC FMF are projected to be within the ACEP Guide Mid-Range for this criterion as reflected on Table 5.2 of the ACEP Guide.

Percent of Non-Urgent Patients

M. What is the basis for the projection that three percent of the ED patients visiting the proposed FMF will be patients classified as Emergency Severity Index (ESI) Level 4 and 5 (combined), as indicated in Exhibit 6? Has HMH used the ESI to classify the severity of its ED patients? If so, please provide these results.

Applicants' Response

Table 14 of the Exemption Application purported to provide HSCRC EMG Treatment Levels for emergency department visits at HMH in fiscal year 2017. Table 14 actually reported ESI Treatment Levels for emergency department visits at HMH in fiscal year 2017, and a corrected Table 14 is provided below.

Table 1
HMH FY 2017 ED Visits and Disposition

ESI Treatment Level	ED Discharges	Inpatient Admits	Observation Admits	Grand Total
1	71	105	30	206
2	2,495	1,766	1,033	5,294
3	11,001	1,788	1,503	14,292
4	7,951	90	46	8,087
5	382	1	2	385
Unclassified	208	10	7	225
	22,108	**3,760**	**2,621**	**28,489**

Based on corrected Table 14, approximately 29% of HMH's emergency department visits in fiscal year 2017 were classified as ESI level 4 and 5 combined. This percentage of non-urgent cases places HMH's emergency department within the "Mid Range" under Table 5.2 of the ACEP Guide. Exhibit 6 has been updated to reflect the reclassification under this criterion. Because UC FMF has been designed and will be staffed to continue to serve the emergent health care needs of the population in HMH's service area upon the closure of HMH, HMH's ESI levels were used to project the acuity of patients that will present for emergency care at UC FMF.

Based on the foregoing, the second paragraph on page 47 of the Exemption Application should be corrected to state:

> While there are seven (7) urgent care centers in UC FMF's service area (see Table 4 above), in fiscal year 2017, seventy-one (71%) of HMH's emergency department visits fell within an ESI Treatment Level which could not be successfully transitioned to an urgent care center (Table 14). This assumes that only patients at ESI Levels 4 and 5 who were discharged from HMH's emergency room could be transitioned to an urgent care center. The remaining 29% represent a patient population who self-selects care at a traditional emergency department rather than an urgent care center. Certainly, there are many factors that drive patient selection for site-of-service; however, one key factor is a patient's inability to discern the lowest level of care for their presenting need(s). Another factor is the limited hours of operation of urgent care centers. (*See* Table 4.)

N. With respect to Table 14, purported to classify severity of patient needs for HMH ED patients by using evaluation and management CPT codes, it appears to show that rates of inpatient admission and observation admission are inversely related to severity? Is this correct?

Applicants' Response

See the Applicants' response to Question 12M above, including the clarification of the data presented in Table 14.

Age of Patients

O. What is the basis for the projection that 22% of the FMF patients will be older than 65? This proportion appears slightly higher than the age mix of ED patients at the HMH ED in CY 2016, based on our review of the HSCRC Discharge Data Base and Outpatient Files. It is substantially higher than the percentages seen at Maryland's three existing FMFs in the 2013-2014 period reviewed in MHCC's last published report on FMF operation. Doesn't the applicant feel that elderly patients may be more disposed than younger patients, as a first option, to travel or be transported to a hospital ED, resulting in a different age mix in the patient population than that traditionally seen at HMH's ED? Isn't this what the experience of existing FMFs suggest?

Applicants' Response

In fiscal year 2017, patients 65 and older comprised 21.4% of the total number of emergency department visits to HMH.

Table 26
HMH % of Emergency Department Patients >= 65
FY 2017

FY2017	Patients >= 65	Total Visits	Patient >= 65 % of Total
ED Visits	6,097	28,502	21.4%

Source: UCHS internal utilization report

Of the 65 and older patients, 48.0% arrived to HMH's emergency department by ambulance.

Table 27
HMH % of Emergency Department Patients >= 65 Arriving by Ambulance
FY 2017

Age Group	Patient Status	Arrived by Ambulance	Total Cases	% by Ambulance
>= 65	Inpatient	1,277	1,867	68.4%
	Outpatient	1,652	4,230	39.1%
>= 65 Total		**2,929**	**6,097**	**48%**
< 65	Inpatient	663	1,893	35.0%
	Outpatient	3,295	20,512	16.1%
< 65 Total		**3,958**	**22,405**	**17.7%**
Grand Total		**6,887**	**28,502**	**24.2%**

Source: UCHS Internal Utilization Report

Ambulance transport for nearly fifty percent (50%) of the aged 65 and over population, particularly EMS transport, is expected to limit any patient self-selection of the emergency department to which these patients are transported. Moreover, it is also doubtful that any age patient, much less those aged 65 and over, would be inclined to drive past UC FMF, a full service emergency department, to another hospital further away such as UCMC (19 miles, 26 minutes), Union Hospital (17 miles, 27 minutes) or Franklin Square Medical Center (26 miles) in a health care emergency.

As noted by the Commission in its February 2, 2015 Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities, EMS transport protocols are likely contributing factors to low utilization of existing Maryland FMFs by the population aged 65 and older. As set forth in the Applicants' response to Question 12D above, UC FMF projects that only a limited number of non-stroke priority 1 patients that are currently treated at HMH could not be treated at UC FMF in accordance with revised MIEMSS protocols and the pilot stroke protocol approved for UC FMF.

Imaging Facilities

P. Are the imaging facilities being developed at the FMF dedicated to the use of FMF patients arriving for urgent and emergent care on an unscheduled basis?

Applicants' Response

The imaging unit being developed at UC FMF will be used by both UC FMF patients arriving for urgent and emergent care on an unscheduled basis and for patients at the adjacent special psychiatric hospital requiring such services. UC FMF's imaging unit will not be used for scheduled outpatient use. In fiscal year 2017, HMH outpatient emergency department utilized imaging services as presented below in Table 28. The historical relationship of imaging services to emergency department visits will continue at UC FMF with the exception of nuclear medicine.

Table 28
Imaging Services Utilized by Outpatient Emergency Department Visits
FY 2017 (1)

Service	Outpatient Utilization	% of ED Visits
Emergency Department Visits	24,412	100.0%
Radiology - Diagnostic	11,301	46.3%
CAT Scanner	5,321	21.8%
Electrocardiography	6,417	26.3%
Nuclear Medicine	344	1.4%
Magnetic Resonance Imaging	564	2.3%

Note (1): Reflects annualized 9 months (July 2016 – March 2017) of St. Paul's Non-Confidential Patient Level Data.

Q. In what sense, are "multiple imaging rooms, CT(s), mammography room(s), and a potential MRI . . . a part of" the FMF? This is the description of high range in Emergency Department Design (". . . part of. . ." the hospital ED), which is the description the applicant believes best fits the proposed FMF, based on Exhibit 6. However, the floor plan drawing shows a "diagnostic imaging suite" (so labeled as a distinct "feature" of the FMF on page 6 of the exemption request, distinct from the "emergency department" of the FMF), located adjacent to the "emergency department." Why is it inaccurate, given this facility design, to say that "imaging studies will not be performed within the department," the ACEP description of a low range hospital ED?

Applicants' Response

With respect to imaging facilities, Table 5.2 of the ACEP Guide "low range" provides, "imaging studies will not be performed within the department, so there is no need to add space for imaging rooms." At UC FMF, an imaging department is a necessary component of the facility to safely and effectively treat emergency and observation patients.

The State Health Plan Chapter for Freestanding Medical Facilities, COMAR 10.24.17.04(c)(8)(d)(ii), requires an applicant to "demonstrate that the building gross square footage is consistent with the low range guidance, unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for additional building gross square footage." Because the ACEP Guide does not contemplate an imaging unit as part of the "architectural project" for an emergency department in the "low range" and only provides for a 1.25 building gross square footage adjustment for a "freestanding facility," if UC FMF is classified in the low range for the "imaging studies" criterion under Table 5.2 of the ACEP Guide, UC FMF's imaging department and other components not contemplated by the ACEP low range should be excluded from the demonstration required by COMAR 10.24.17.04(c)(8)(d)(ii). As reflected in Exhibit 1, Table B, UC FMF's imaging department is 8,192 departmental gross departmental square feet and the overall size of UC FMF's "emergency department" should be reduced by this amount.

13. **The applicant projects that a much higher level of patient visits to the proposed FMF will result in hospital admissions (12.6% in FY 2024) than existing Maryland FMFs have historically reported (2.9% to 5.9% in 2014, as reported in MHCC's 2015 report on FMF operation). The applicant assumes that FMF visits will convert to inpatients at about the same level as ED visits at HMH convert to inpatients.**

Applicants' Response

See the Applicant's response to Question 12D above.

A. While the proposed FMF would be the first in Maryland established through conversion of a general hospital, why isn't it reasonable to expect that the service area population will adjust its care-seeking behavior in more significant ways than the assumption underlying this projection indicates, which is that no appreciable adjustment in care- seeking behavior will occur?

Applicants' Response

As stated above, the Applicants have assumed that with the exception of 0.4% of historical visits that originate from northeast Cecil County and a limited number of non-stroke priority 1 EMS cases, the residents of HMH's service area will continue to come to UC FMF when experiencing emergency health conditions. These utilization projections are supported by UC FMF's plans to implement an Acute Stroke Ready Pilot and MIEMMS protocol changes allowing stable priority 2 patient to be transported to FMFs. The increase in accessibility to Interstate 95 instead of HMH's landlocked campus in downtown Havre de Grace is also likely to result in an increase in patient walk-ins. Finally, UM UCH has been and will continue to educate the community consistently that approximately 90% of their care can be received on the UC Medical Campus at Havre de Grace. The Applicants, therefore, anticipate the community will seek care at UC FMF when experiencing medical emergencies in the same manner as care is currently sought at HMH's emergency department. Moreover, patients experiencing emergency health conditions are unlikely to be able to self-diagnose and choose to travel 19 miles and approximately 26 minutes to UCMC, 17 miles and approximately 27 minutes to Union Hospital, or 26 miles to Franklin Square Medical Center.

B. Will UCH attempt to reduce the number of patients needing transport from the FMF to hospitals for admission through education of the service area population and, if so, why won't these efforts be more successful?

Applicants' Response

The Applicants have engaged in extensive discussion with the service area community regarding the proposed capabilities of UC FMF. While UC UCH anticipates its patient education efforts will be successful, it is unlikely that patients will be able to self-diagnose all emergency medical conditions such that they will be able to determine in an emergency whether to go to a hospital or UC FMF. For example, it is unlikely that an individual or the individual's family or friend believing that the individual is suffering from a heart attack will always drive to a hospital instead of UC FMF based on education of the service area population.

C (8)(e), Observation capacity and space

14. The applicant states that it is more appropriate to project observation bed need at the proposed FMF similar to MSGA bed need (page 36) because of flaws in and a lack of direct relevance of the ACEP guidelines to a freestanding emergency center being established as a replacement of a general hospital. Table 11, in page 36, purports to show such a bed need projection based on an assumption of 70% average annual occupancy. Using the data provided in Tables 9 and 10, the following table has been developed.

	Facility	Historic (Fiscal Year)		Projected (Fiscal Year)							
		2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Observation Cases	HMH	2,887	2,664	2,669	2,473	2,277	2,283	2,290	-	-	-
	FMF	-	-	-	-	-	-	-	2,026	2,038	2,050
Average Length of Stay (Days)	HMH	1.66	1.68	1.68	1.57	1.43	1.43	1.43	-	-	-
	FMF	-	-	-	-	-	-	-	1.20	1.20	1.20
Observation Patient Days	HMH	4,792	4,476	4,484	3,883	3,256	3,265	3,275	-	-	-
	FMF	-	-	-	-	-	-	-	2,431	2,446	2,460
Average Daily Census	HMH	13.1	12.2	12.3	10.6	8.9	8.9	9.0			
	FMF								6.7	6.7	6.7
Average Annual Occupancy Rate	HMH	70%	70%	70%	70%	70%	70%	70%	-	-	-
	FMF	-	-	-	-	-	-	-	70%	70%	70%
Bed Need	HMH	18.8	17.5	17.5	15.2	12.7	12.7	12.8	-	-	-
	FMF	-	-	-	-	-	-	-	9.5	9.6	9.6

A. The bed need values in this table differ from those in Table 11. Please clarify. Are the assumptions used in the Table 11 projections misstated?

Applicants' Response

The Applicants developed the projection of observation beds at UC FMF to reflect patients that stay less than twenty-four (24) hours and those that stay between twenty-four (24) and up to forty-eight (48) hours. Of the 2,460 observation patient days presented above for fiscal year 2024, 531 are associated with patients that stay less than 24 hours and 1,929 are associated with patients that stay between 24 and 48 hours. Applying a 70% occupancy factor to the average daily censes associated with each of these categories of patients results in the

need for 3 beds for patients staying less than 24 hours and 8 beds for patients staying between 24 and 48 hours, for a total of 11 observation beds.

B. Is there substantial variation in observation length-of-stay, and an ability to predict observation length-of-stay, that would allow development of observation space that is not exclusively designed as 183 square foot rooms, exclusive of in-room toilet and bathing areas, i.e., essentially, single-occupancy hospital rooms? Is there enough variation so that a short-stay observation patient, likely to be staying for just a few hours, could be accommodated outside of what is essentially a hospital room, thus reducing the number of hospital-style rooms needed for observation?

Applicants' Response

Patients who only require care for a few hours would not likely be included in the patient population that would be cared for in the observation unit. As noted in response to Question 12J above, admission to observation status is only appropriate for monitoring and assessing patients while a decision to admit the patient for inpatient care is pending and/or it is expected that the patient's clinical condition will resolve within 48 hours following treatment.

C (8)(f), Utilization, revenue, and expense projections

15. In Table 12, the "inpatient visit" count for the proposed FMF is the same as the visit count previously "IP psych visits" in Table 6. Isn't this a large undercount of actual "inpatient visits" projected and, correspondingly, an over-count of projected FMF "outpatient visits?" Please clarify.

Applicants' Response

Starting in fiscal year 2022, patients that were previously admitted at HMH will be treated at UC FMF as outpatients and then transferred to other hospitals for inpatient admissions. In fiscal year 2022, there is a projection of 653 emergency department visits that will result in admission to UC Behavioral Health. An additional 3,037 emergency department visits will be admitted to other hospitals in fiscal year 2022 growing to 3,064 by fiscal year 2024.

Table 29
HMH and UC FMF Historical and Projected Emergency Department Visits
FY2015 – FY2024

	Historical		Projection								% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY16-FY24
Emergency Department Visits											
HMH											
Inpatient Visits	3,472	3,179	3,664	3,680	3,697	3,713	3,729	-	-	-	*-100.0%*
Outpatient Visits	25,870	26,341	24,581	24,690	24,800	24,910	25,020	-	-	-	*-100.0%*
Total	**29,342**	**29,520**	**28,245**	**28,370**	**28,496**	**28,623**	**28,750**	**-**	**-**	**-**	*-100.0%*
%Change	*2.3%*	*0.6%*	*-4.3%*	*0.4%*	*0.4%*	*0.4%*	*0.4%*	*-100.0%*	*0.0%*	*0.0%*	
UC FMF											
Outpatient Psych Visits (1)	-	-	-	-	-	-	-	653	656	659	
Outpatient Visits Admitted to Other Hospitals								3,037	3,051	3,064	
Other Outpatient Visits	-	-	-	-	-	-	-	25,073	25,184	25,296	
Total	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**28,763**	**28,891**	**29,019**	
%Change	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*100.0%*	*0.4%*	*0.4%*	
Total	29,342	29,520	28,245	28,370	28,496	28,623	28,750	28,763	28,891	29,019	*-1.7%*
%Change	*2.3%*	*0.6%*	*-4.3%*	*0.4%*	*0.4%*	*0.4%*	*0.4%*	*0.0%*	*0.4%*	*0.4%*	

Note (1): Reflects Behavioral Health patients that will be admitted to UC Behavioral Health on the UCH Medical Campus at Havre de Grace

16. The statement concerning "Laboratory and Imaging" on page 40 indicates that these facilities will be dedicated FMF facilities? Will any diagnostic and treatment services included in this Exemption from CON request and described as services of the proposed FMF be provided to non-FMF outpatients on a scheduled basis?

Applicants' Response

The imaging unit being developed at UC FMF will be used by both UC FMF patients arriving for urgent and emergent care on an unscheduled basis and for patients at the special psychiatric hospital requiring such services. UC FMF's imaging unit will not be used for scheduled outpatient use.

17. Does HMH provide all of the imaging services that will be contained in the proposed FMF "imaging department" or "imaging suite" on a dedicated basis for ED patients?

Applicants' Response

HMH provides all of the imaging services that will be contained in UC FMF's proposed imaging department. At HMH, however, such imaging services are dedicated to both inpatients and emergency department patients. *See also* Applicants' response to Question 16 above.

18. If all of the proposed imaging modalities are dedicated to patients presenting at the FMF, will they be efficiently used? Please provide examples of projected capacity use (i.e., the proportion of total service capacity projected to be used consistent with the revenue projections presented) for the following services: MRI, CT, ultrasound, and nuclear medicine imaging.

Applicants' Response

UC FMF's imaging department will be utilized for unscheduled emergent and observation cases at UC FMF and for patients at UC Behavioral Health requiring such services.

The imaging department at UC FMF will not have nuclear medicine imaging. The imaging RVU projections for fiscal years 2022, 2023, and 2024 as presented in Table F are based on a projection of comparable outpatient services at HMH and will grow with the annual increase in emergency visits and observation cases.

With respect to MRI, CT, and ultrasound, the Applicants do not project that these imaging modalities will be used as efficiently at UC FMF as they are presently used at HMH, where they serve both emergency department patients and inpatients. However, MRI, CT, and ultrasound are necessary to provide clinically appropriate care to emergency and observation patients at UC FMF. More specifically, MRI is necessary to treatment patients with Transient Ischemic Attack ("TIA") or suspected stroke. Indeed, as described in footnote 5 of the Exemption Application, MRI has been shown as superior to CT to identify acute ischemic stroke as per the AHA/ASA Guidelines in 2010 and 2013. Furthermore, as described in footnote 5 of the Exemption Application, CT and MRI are necessary at UC FMF to maintain Acute Stroke Ready Joint Commission Accreditation under the EMS pilot protocol applicable to UC FMF.

Project Budget, Table E

19. Specify the purpose of the expense at Line 2.c2 and Line 2.d2.

Applicants' Response

On Table E, Line 2.c2 totaling $143,000 includes fees for UM UCH's consultants, KPMG, LLP and Andrew Solberg, in support of filing the Exemption Application with the Maryland Health Care Commission. Line 2.d2 totaling $492,000 includes support from several vendors with pre-application tasks such as design, planning, and assessing the financial impact of this project for UM UCH. Vendors include BRG and KPMG, LLP for strategic planning, Morris Richie for architecture and engineering support, and Gallagher, Evelius & Jones, LLP for support commenting on regulation and other pre-application tasks.

Utilization, Revenue, and Expense Projections, Pages 38-46 and applicable utilization, revenue, and expense schedules

20. Tables G and H are accompanied by a statement of assumptions that, for volume projections, references Table F. However, Table F only provided use projections for the FMF while Tables G and H provide revenue and expense projections for UCMC and the FMF. Please provide a Table F-Statistical Projections that cover the entire UCH facility components (thus, UCMC and HMH during the period of FY 2015 to FY 2021) and UCMC and the UCH-HG FMF and UCH-HG psychiatric hospital during the period of FY 2022 to FY 2024. Consistent with the use projection, provide a corresponding Table G (uninflated current year dollars) and a Table H (inflated), showing historic and projected revenues and expenses for UCMC and HMH from FY 2015 to FY 2021 and projected revenue and expenses for UCMC, the UCH-HG FMF, and the UCH-HG psychiatric hospital from FY 2022 to FY 2024. Provide corresponding statements of the assumptions used in development of these tables.

Applicants' Response

Enclosed as Exhibit 9, are Tables F, G and H that cover the entire UM UCH hospital facility components, including UCMC and HMH during the period from fiscal year 2015 to fiscal year 2021 and UCMC, UC FMF, and UC Behavioral Health between fiscal years 2022 and 2024. Corresponding statements of assumptions are attached.

21. Is this proposed conversion of HMH to an FMF predicated on a global budget that will include revenue from any outpatient services other than the services provided to persons presenting at the FMF for unscheduled urgent or emergent services and the service provided to persons cared for as observation patients after assessment and treatment of their unscheduled urgent or emergency service needs?

Applicants' Response

UC FMF's financial projections are based on a global budget that includes revenue only from services provided to persons presenting at UC FMF for unscheduled urgent or emergent services and to persons cared for as observation patients after assessment and treatment of unscheduled urgent or emergency service needs.

More Efficient and Effective Delivery of Health Care Services, pages 46-48

22. From an institutional perspective, this project and the related expansion of UCMC and the consolidation of acute psychiatric hospital services currently provided at HMH and Union Hospital into a single specialty hospital, should create economies of scale in acute care hospital service delivery.

A. Please quantify the reductions in FTEs per MSGA admission and patient day achieved by transitioning from two hospitals in Harford County to one hospital.

Applicants' Response

As UM UCH consolidates from two acute hospitals to one acute hospital, efficiencies will be realized for both IP admissions and OP visits in Harford County. Because FTEs serve both inpatients and outpatients, the efficiency calculation of FTEs per adjusted average occupied bed ("AOB") is used to measure this efficiency. In the initial year of the transition, UM UCH will realize an approximate 7% efficiency gain from 4.4 FTEs in fiscal year 2021 to 4.1 FTEs per AOB in fiscal year 2022.

	FY2021	FY2022
Total FTE's	1,443	1,560
Adjusted Average Occupied Beds	329	383
FTEs Per Adjusted AOB	4.4	4.1
% Change		-6.9%

B. Please quantify the reduction in FTEs per ED visit and observation visit and observation day achieved by transitioning from two hospitals in Harford County with two EDs and two observation services to one hospital ED, one FMF, and two observation services.

Applicants' Response

A reduction in FTEs per ED visit at the FMF is not anticipated at this time. UM Upper Chesapeake Health does anticipate efficiencies in FTEs per observation visit/days. However, because HMH does not have a dedicated observation unit observation and such patients are currently dispersed throughout the facility's MSGA beds, there is not a methodology to quantify any efficiency gains at this point in time.

Public Interest, pages 48-55

23. Please provide a Table L., Work Force Information, that reflects the current work force for HMH.

Applicants' Response

Set forth in Exhibit 9 is a Table L that includes the workforce information for HMH in fiscal year 2017.

24. For comparison purposes, please provide a Table L., Work Force Information, that reflects the current FTEs dedicated to the provision of ED services at HMH. We recognize that this will require some estimation of FTEs for services such as laboratory testing and imaging that account for the use of these diagnostic services by ED patients, so please provide a statement explaining how these estimates were produced. This table is intended to provide information that can be compared with the FMF Table L provided in the exemption request, so do not include any FTEs involved in serving HMH ED patients "downstream" from the ED that would not be included in the FMF work force, i.e., surgical services or inpatient services, generally.

Applicants' Response

Set forth in Exhibit 9, is a Table L that includes the workforce for HMH's emergency department in fiscal year 2017. Included in these numbers are FTEs dedicated to the provision of ancillary services to patients when they are in the emergency department. It excludes FTEs associated with care provided to patients that came through the emergency department but were ultimately admitted or received surgical services. A methodology was devised based on the current RVU utilization of these HMH ED patients divided by the total RVU's of that specific ancillary service. This ratio was then applied to the ancillary department's total workforce to arrive at an approximate percentage of FTEs that support HMH ED patients.

Table of Exhibits

Table of Tables

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

September 18, 2017
Date

Joseph E. Hoffman, III
Executive Vice President / Chief Financial Officer and Compliance Officer
University of Maryland Upper Chesapeake Health System

#600531
011888-0023

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

September 18, 2017
Date

Robin Luxon
Vice President, Corporate Planning,
Marketing & Business Development
University of Maryland Upper
Chesapeake Health System

#600530
011888-0023

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

September 18, 2017
Date

Phillip D. Crocker
Project Manager
University of Maryland Upper Chesapeake Health System

#600530
011888-0023

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

September 18, 2017
Date

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

#600532
011888-0023

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

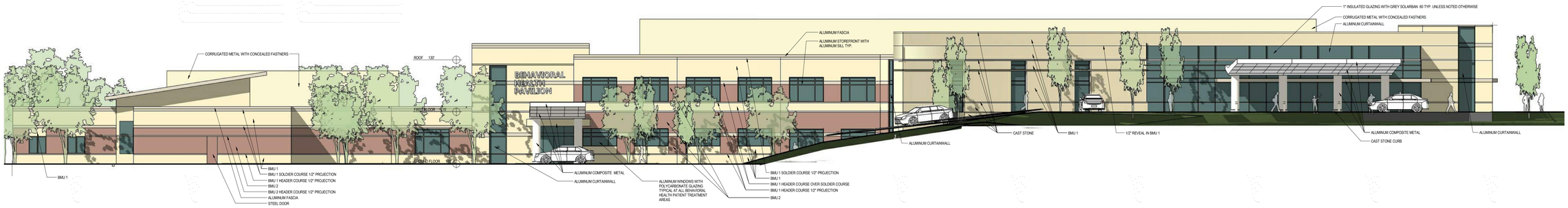
September 18, 2017
Date

Ed Anderson
Project Executive
ERDMAN

#600530
011888-0023

REVISED

EXHIBIT 2



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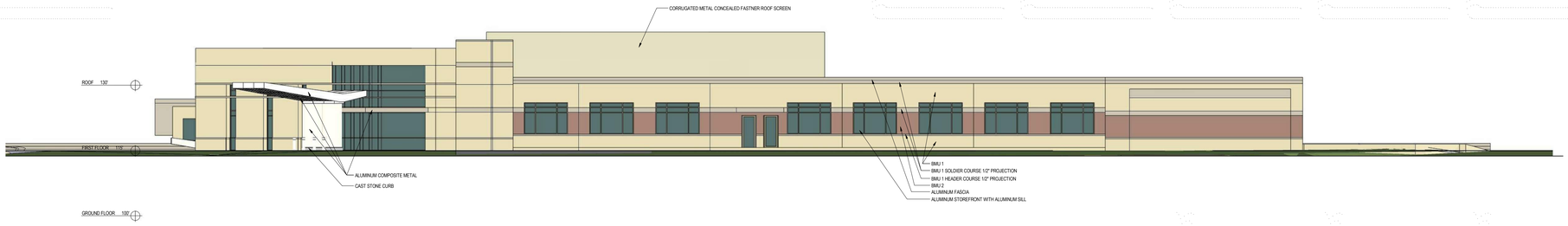

2 NORTH ELEVATION

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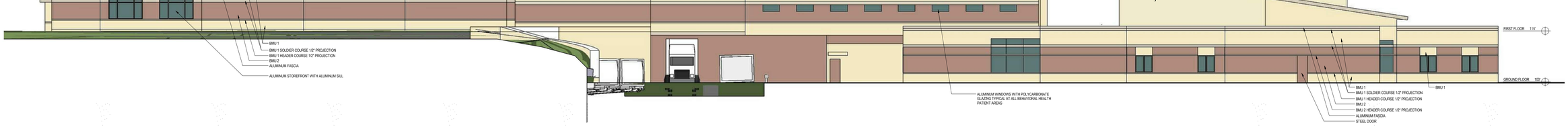

3 WEST ELEVATION

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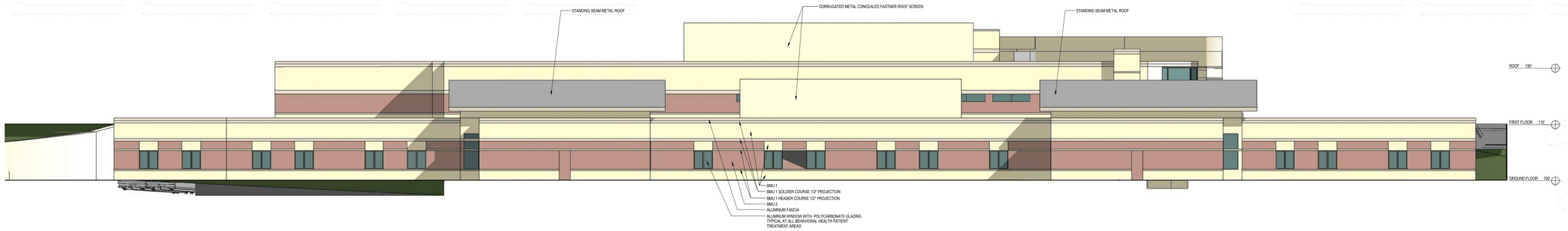

4 SOUTH ELEVATION

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FREESTANDING MEDICAL FACILITY- 49,857 SF	SHARED SERVICES- 943 SF
BEHAVIORAL HEALTH PAVILION- 53,922 SF	SHARED SERVICES- 24,841 SF

FIRST FLOOR- 50,800 GROSS SF

GROUND FLOOR- 78,763 GROSS SF

SHARED AREAS- 25,784 GROSS SF

5 STACKING DIAGRAM

SCALE: 3/32" = 1'-0"

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UNIVERSITY OF MARYLAND - UPPER CHESAPEAKE HEALTH MEDICAL CAMPUS

No.	Description	Date
13	CON SUBMITTAL	09/12/17
11	CON SUBMITTAL	07/19/17
9	DRAFT CON SUBMITTAL	06/08/17
8	SCOPE PRICING	05/15/17
4	PROJECT ANALYSIS (CON) ROUND TWO	07/31/15
3	PROJECT ANALYSIS (CON)	06/05/15

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Sheet Name
EXTERIOR ELEVATIONS

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Sheet Number
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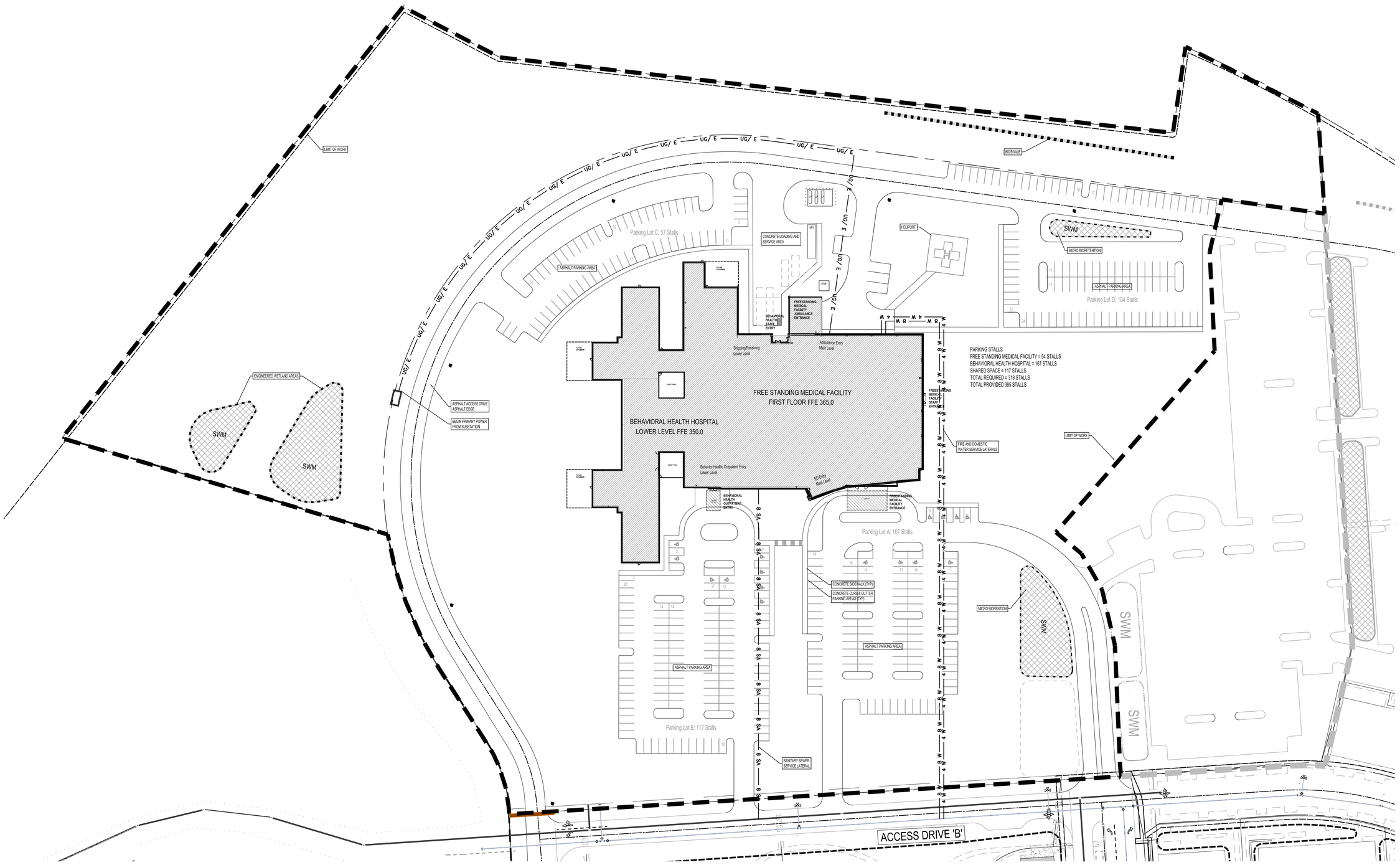
Job 628620



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ERDMAN COMPANY
One Erdman Place
Madison, Wisconsin 53717
Phone 608.410.8000 | Fax 608.410.8500

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06-08-17	DRAFT CON SUBMITTAL

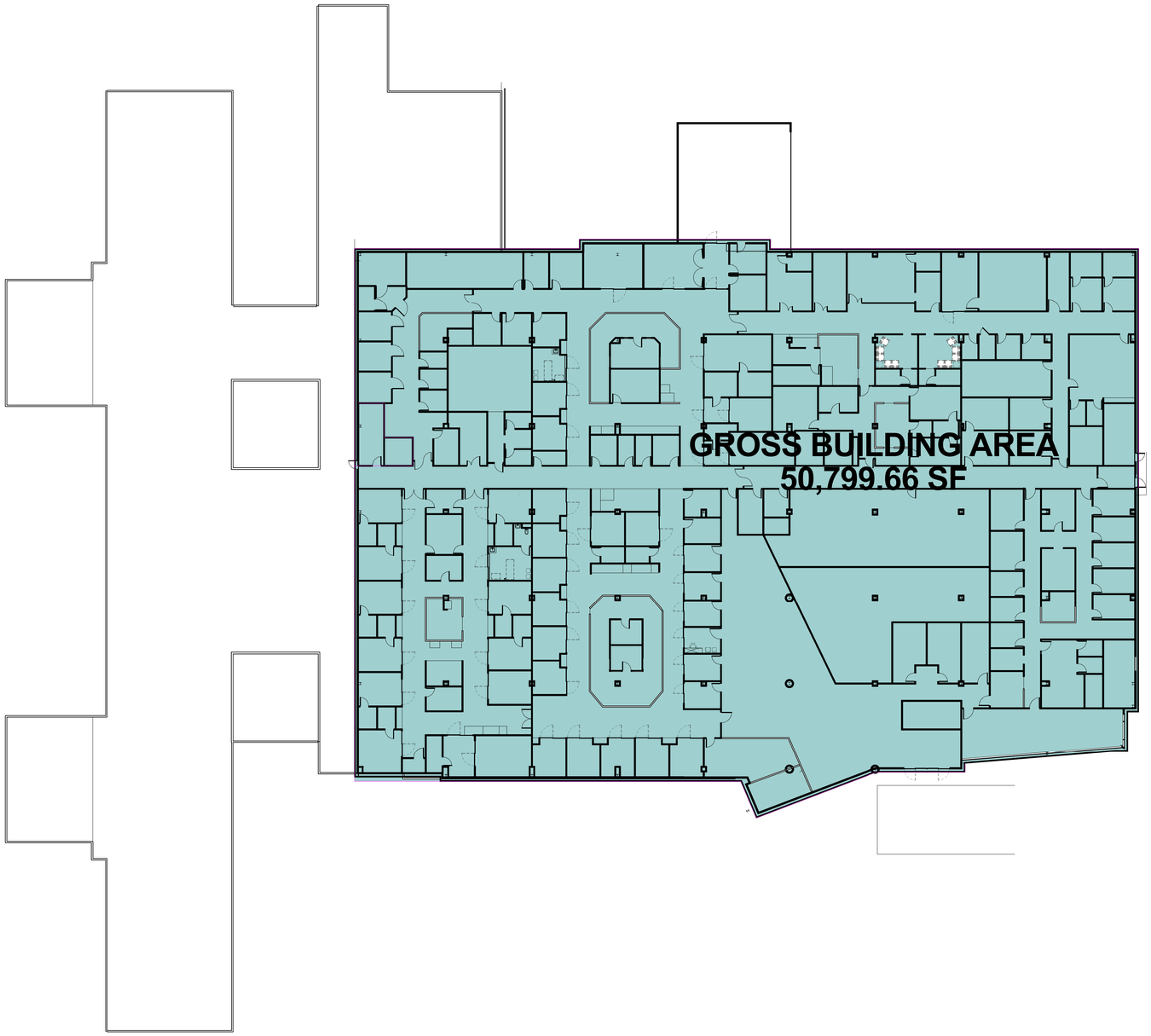
Drn: TWERNDU Chk:

Sheet Name
C101 SITE PLAN

Scale: 1" = 40'

Sheet Number
C101

HAVRE DE GRACE, MD
628620



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9	DRAFT CON SUBMITTAL	06/26/17
7	CON DRAFT DOCUMENTS	05/05/17

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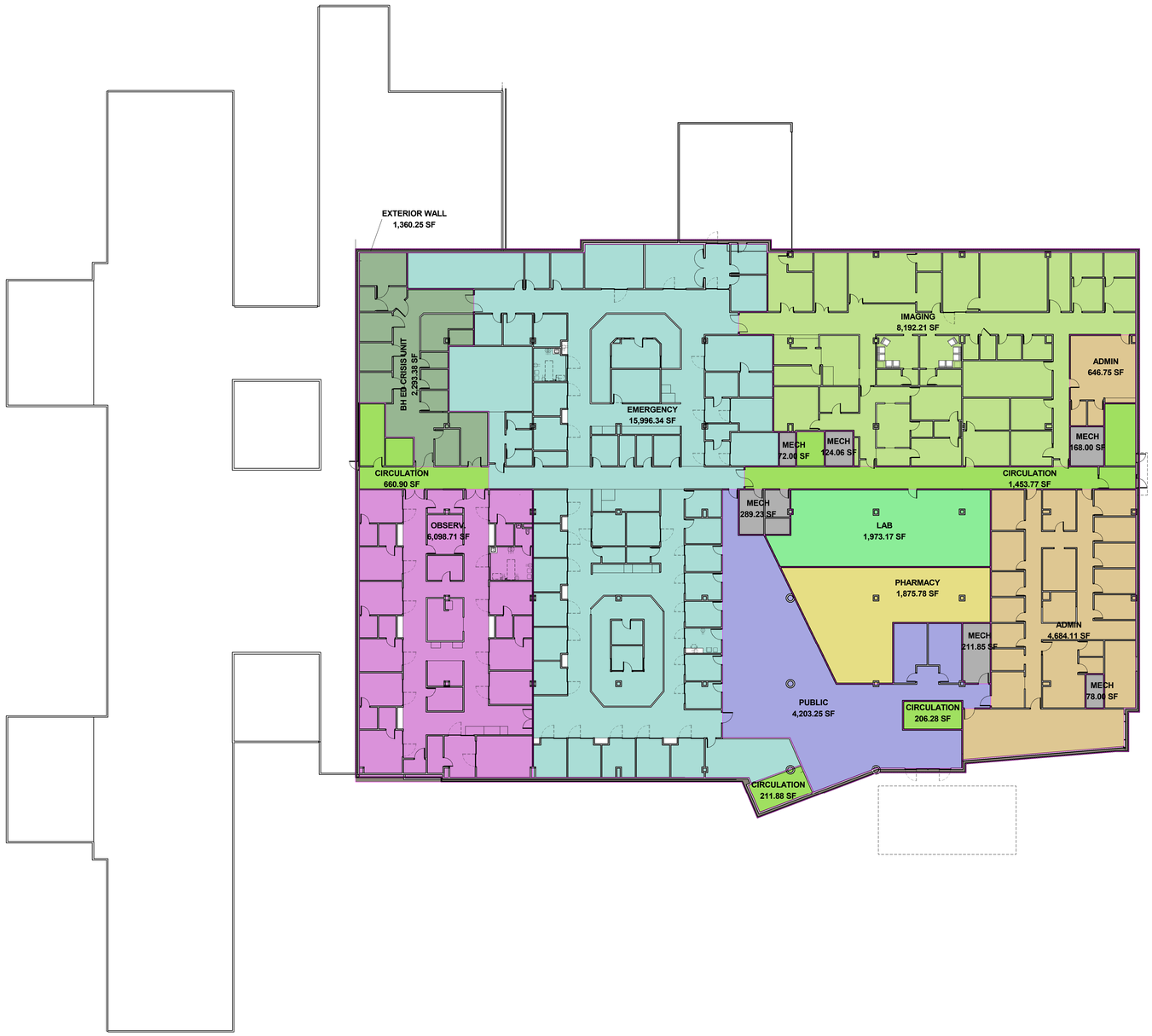
Drn: Author Chk: Checker

Sheet Name
FIRST FLOOR GROSS BUILDING AREA

Scale: **1/16" = 1'-0"**

Sheet Number
A100C

HAVRE DE GRACE, MD
Job 628620



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10	DRAFT CON SUBMITTAL	07/14/17
9	DRAFT CON SUBMITTAL	06/08/17
7	CON DRAFT DOCUMENTS	05/05/17

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Drn: Author Chk: Checker

Sheet Name

FIRST FLOOR DEPARTMENT AREA PLAN

Scale: 1/16" = 1'-0"

Sheet Number

A100B

HAVRE DE GRACE, MD
Job 628620

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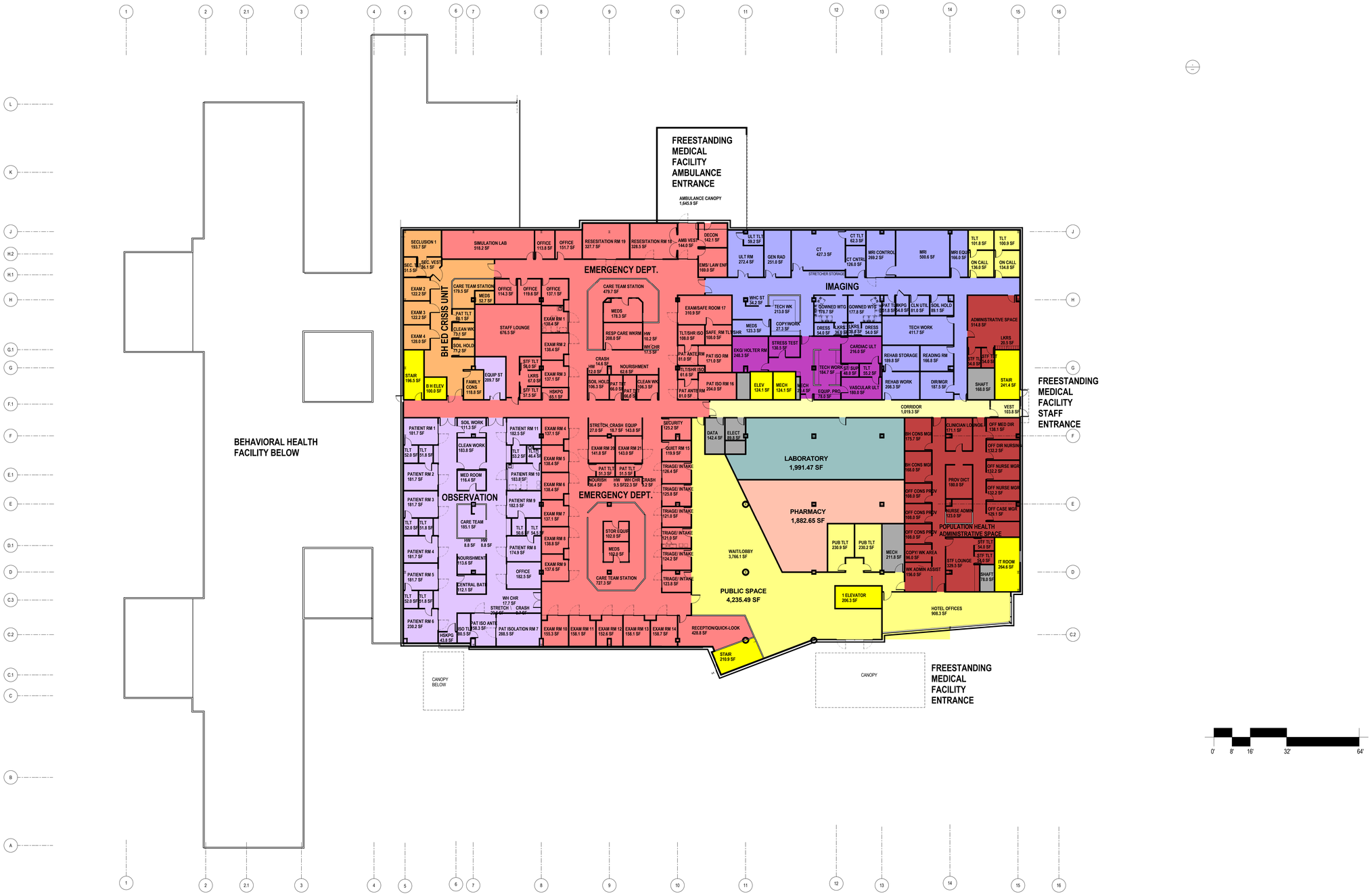

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6	PLAN TO DATE	12/30/16
5	PLAN REVIEW	7/22/16
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3	PROJECT ANALYSIS (CON)	06/05/15
2	PROGRESS PLAN	05/26/15
1	PROGRESS PLAN	05/15/15
Document Release		

Drn: BHEBERT Chk: Checker

Sheet Name
FIRST FLOOR PLAN

Scale: **1/16" = 1'-0"**

Sheet Number
A100A

HAVRE DE GRACE, MD
Job 628620

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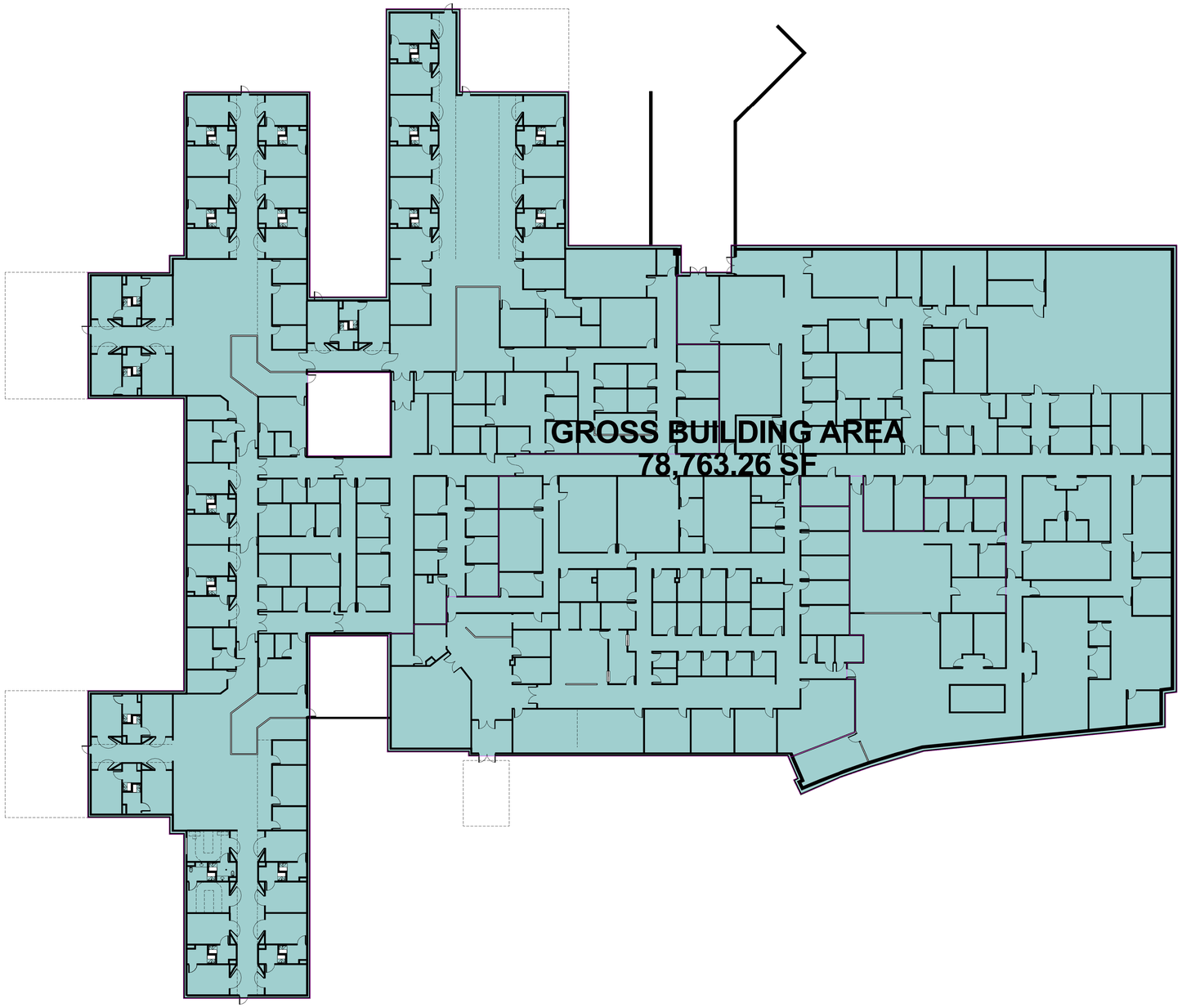

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7	CON DRAFT DOCUMENTS	05/05/17

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Sheet Name
GROUND FLOOR GROSS BUILDING AREA

Scale: **1/16" = 1'-0"**

Sheet Number
A101C

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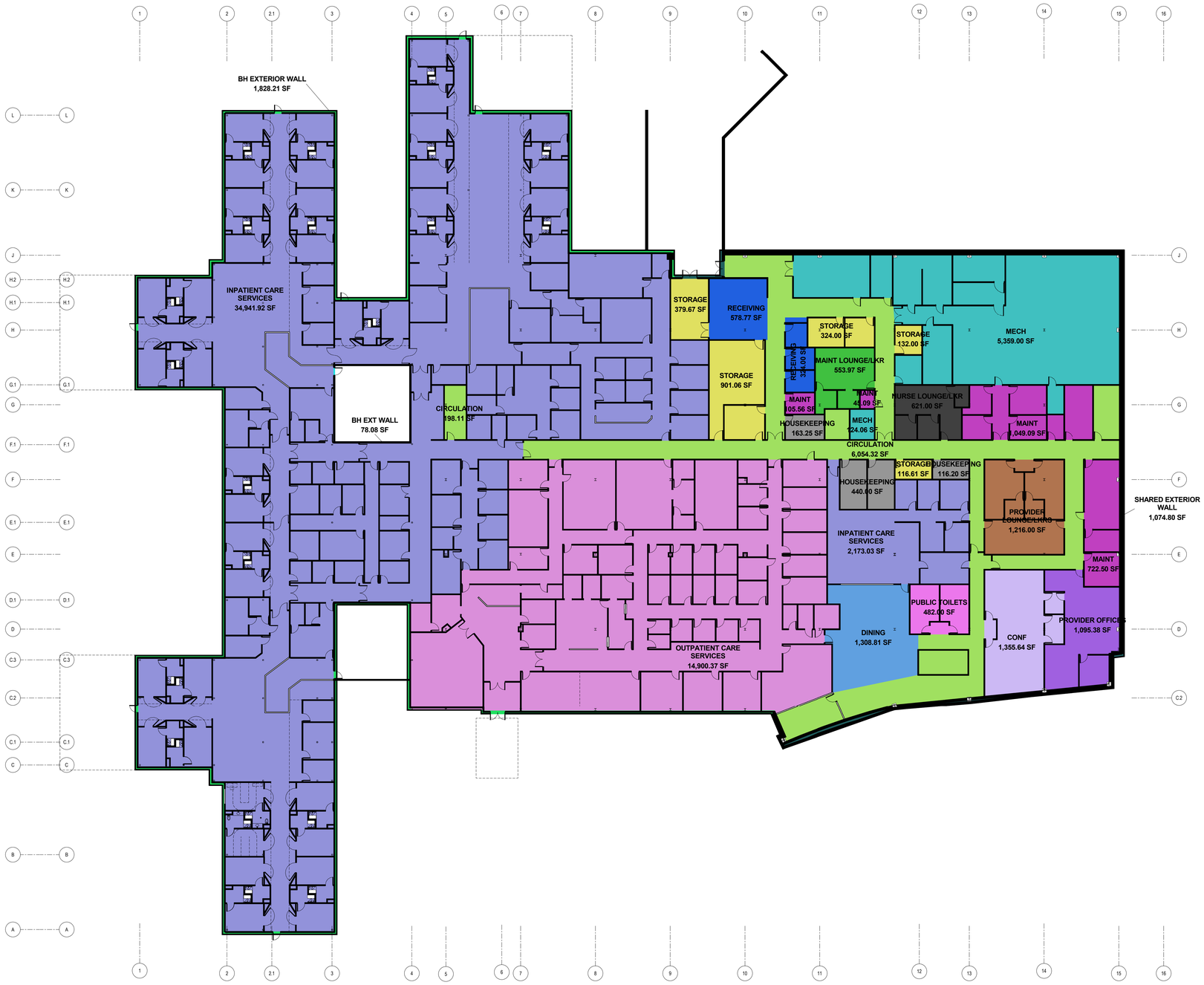

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No.	Description	Date
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11	CON SUBMITTAL	07/19/17
10	DRAFT CON SUBMITTAL	07/14/17
9	DRAFT CON SUBMITTAL	06/08/17
7	CON DRAFT DOCUMENTS	06/05/17

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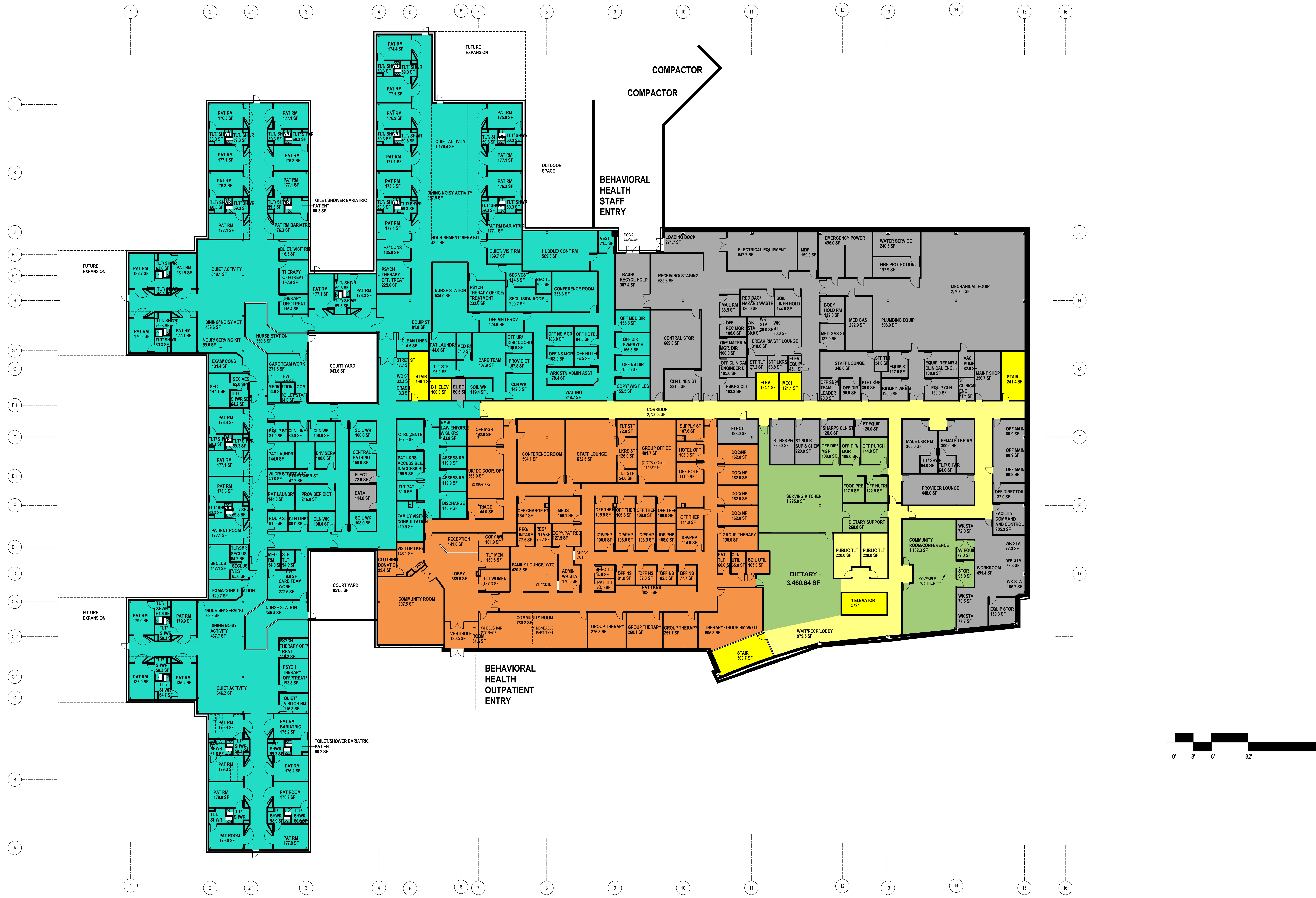
Drn: Author Chk: Checker

Sheet Name
GROUND FLOOR DEPARTMENT AREA PLAN

Scale: **1/16" = 1'-0"**

Sheet Number
A101B

HAVRE DE GRACE, MD
Job 628620



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Sheet Name
GROUND FLOOR PLAN

Scale: 1/16" = 1'-0"

Sheet Number
A101A

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EXHIBIT 6

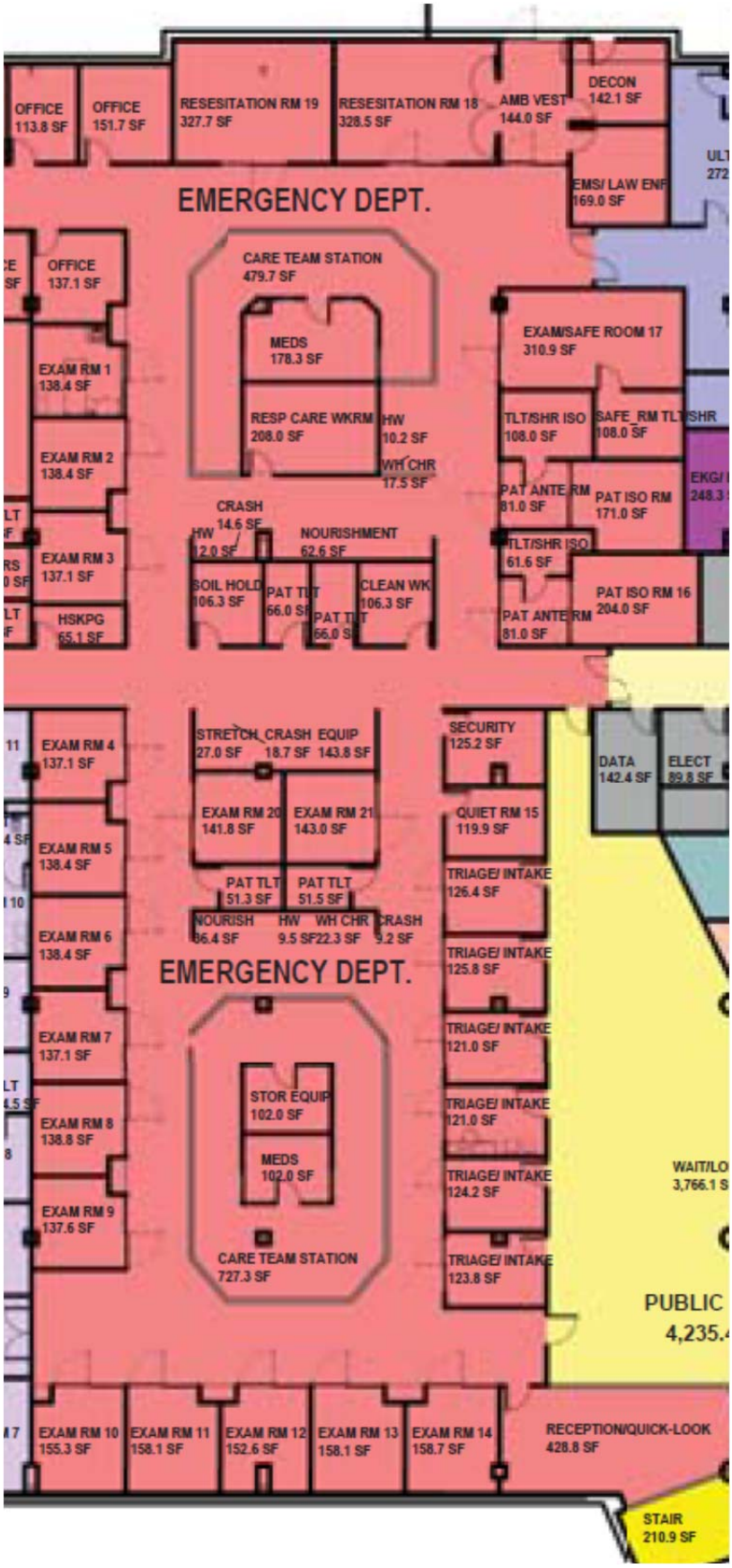
UC FMF

Evaluation of Emergency Department Bed Range

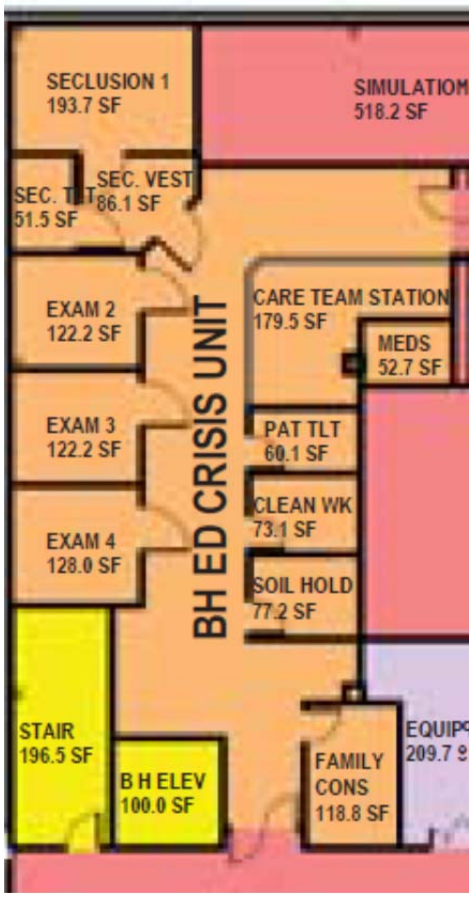
	Bed Range			Evaluation of	UC FMF Count of Low/Mid/High		
Factor	**Low**	**Medium**	**High**	**UC FMF Bed Range**	**Low**	**Medium**	**High**
Percentage of Admitted Patients	< 8%	12-20%	> 25%	Mid 12%-20%		1	
Length of Stay (LOS)	<2.25 Hours	2.5-3.75 Hours	>4 Hours	Mid (3.6 hours)		1	
Patient Care Spaces	Few	Majority	All	High (All Private)			1
Inner Waiting & Results Waiting Areas	Available	Limited	Pts. Stay in Bay	High (Stay in Bay)			1
Location of Observation Beds	Outside ED	Limited	Inside ED	High (Necessarily In)			1
Boarding of Admitted Pts.	Outside ED	Stay 90-120 Min	Stay Over 150 Min.	High (315 minutes)			1
Turnaround Time Dx Tests	<46 Minutes	60 Minutes	> 90 Minutes	Mid (60-90 minutes)		1	
Percent of Behavioral Health Patients	< 3%	4-6%	>7	Mid (6.8%)		1	
Percent of Non-Urgent Patients	>45%	25-45%	<25%	Mid (29%)		1	
Age of Patient	<10% Age 65+	<10-20% Age 65+	>20% Age 65+	High (22%)			1
Imaging within ED	None	General and CT	Extensive	High (Necessarily In)			1
Family Amenities	None	Limited Consult	Multiple Consult, Grieving	High (multiple rooms)			1
Specialty Components: Geriatrics	None	Area	Module with Support	Low (none)	1		
Specialty Components: Pediatrics	None	Area	Module with Support	Low (none)	1		
Specialty Components: Detention	None	Area	Module with Support	Low (none)	1		
Admin/Teaching Space	Minimal	Moderate	Extensive	Mid (Flight CTRL / Conf.)		1	
Count					3	6	7
% of Total					19%	38%	44%

EXHIBIT 8

UC FMF Floor Plans With Exam Rooms Numbered



UC FMF Floor Plans With Exam Rooms Numbered



UC FMF Floor Plans With Exam Rooms Numbered

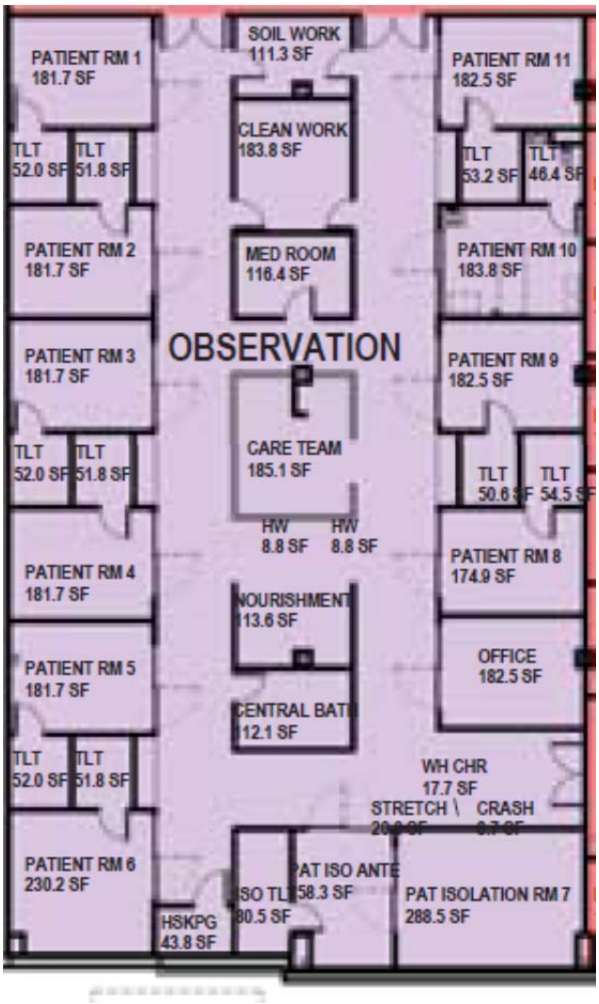


EXHIBIT 9

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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.

	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	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES										
a1. General Medical/Surgical* UCMC	8,748	9,176	9,031	9,561	10,033	10,122	10,215	13,212	13,477	13,752
a2. General Medical/Surgical* HMH	2,709	2,937	3,133	3,363	3,578	3,606	3,635			
a3. Observation UCMC	7,562	7,460	7,479	7,070	6,662	6,683	6,707	7,026	7,071	7,119
a4. Observation UC FMF								2,026	2,038	2,050
a5. Observation HMH	2,887	2,664	2,669	2,473	2,277	2,283	2,290			
General MSGA & Observation	**21,906**	**22,237**	**22,312**	**22,468**	**22,550**	**22,694**	**22,846**	**22,264**	**22,586**	**22,921**
b1. ICU/CCU UCMC	903	814	860	842	883	891	899	1,162	1,185	1,209
b2. ICU/CCU HMH	223	203	179	175	187	188	189			
Total MSGA	**23,032**	**23,254**	**23,351**	**23,485**	**23,619**	**23,773**	**23,934**	**23,426**	**23,771**	**24,130**
c. Pediatric	119	94	85	85	85	83	81	80	80	79
d. Obstetric	1,421	1,381	1,366	1,369	1,372	1,375	1,377	1,380	1,383	1,386
e1. Acute Psychiatric HMH	1,222	1,230	1,172	1,106	1,044	986	931			
e2. Acute Psychiatric UC Behavioral Health								1,567	1,576	1,586
Total Acute	***25,794***	***25,959***	***25,974***	***26,045***	***26,120***	***26,216***	***26,323***	***26,453***	***26,810***	***27,181***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***25,794***	***25,959***	***25,974***	***26,045***	***26,120***	***26,216***	***26,323***	***26,453***	***26,810***	***27,181***
2. PATIENT DAYS										
a1. General Medical/Surgical* UCMC	43,444	37,365	37,211	39,380	41,313	41,674	42,051	54,345	55,430	56,556
a2. General Medical/Surgical* HMH	11,160	11,676	14,318	15,428	16,416	16,543	16,676			
a3. Observation UCMC	11,749	11,419	11,449	10,186	8,922	8,951	8,982	9,873	9,937	10,004
a4. Observation UC FMF								2,418	2,433	2,448
a5. Observation HMH	4,779	4,488	4,497	3,874	3,250	3,259	3,268			
General MSGA & Observation	**71,132**	**64,948**	**67,475**	**68,868**	**69,901**	**70,427**	**70,977**	**66,636**	**67,800**	**69,008**
b1. ICU/CCU UCMC	3,585	3,600	3,415	3,342	3,506	3,537	3,569	4,612	4,704	4,800
b2. ICU/CCU HMH	1,382	1,515	1,496	1,465	1,559	1,571	1,584			
Total MSGA	**76,099**	**70,063**	**72,386**	**73,675**	**74,966**	**75,536**	**76,130**	**71,248**	**72,504**	**73,808**
c. Pediatric	294	256	185	185	184	180	176	175	173	171
d. Obstetric	2,919	2,806	2,776	2,781	2,787	2,793	2,799	2,805	2,810	2,816
e1. Acute Psychiatric HMH	6,869	7,502	7,148	6,747	6,722	6,700	6,326			
e2. Acute Psychiatric UC Behavioral Health								12,157	12,285	12,418
Total Acute	***86,181***	***80,627***	***82,495***	***83,388***	***84,660***	***85,209***	***85,432***	***86,384***	***87,773***	***89,214***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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.

	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	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
TOTAL PATIENT DAYS	*86,181*	*80,627*	*82,495*	*83,388*	*84,660*	*85,209*	*85,432*	*86,384*	*87,773*	*89,214*

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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.

	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	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a1. General Medical/Surgical* UCMC	5.0	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1
a2. General Medical/Surgical* HMH	4.1	4.0	4.6	4.6	4.6	4.6	4.6			
a3. Observation UCMC	1.6	1.5	1.5	1.4	1.3	1.3	1.3	1.4	1.4	1.4
a4. Observation UC FMF								1.2	1.2	1.2
a5. Observation HMH	1.7	1.7	1.7	1.6	1.4	1.4	1.4			
General MSGA & Observation	3.2	2.9	3.0	3.1	3.1	3.1	3.1	3.0	3.0	3.0
b1. ICU/CCU UCMC	4.0	4.4	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
b2. ICU/CCU HMH	6.2	7.5	8.4	8.4	8.4	8.4	8.4			
Total MSGA	3.3	3.0	3.1	3.1	3.2	3.2	3.2	3.0	3.1	3.1
c. Pediatric	2.5	2.7	2.2	2.2	2.2	2.2	2.2	2.2	2.2	2.2
d. Obstetric	2.1	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0	2.0
e1. Acute Psychiatric HMH	5.6	6.1	6.1	6.1	6.4	6.8	6.8			
e2. Acute Psychiatric UC Behavioral Health								7.8	7.8	7.8
Total Acute	3.3	3.1	3.2	3.2	3.2	3.3	3.2	3.3	3.3	3.3
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STAY	3.3	3.1	3.2	3.2	3.2	3.3	3.2	3.3	3.3	3.3
4. NUMBER OF LICENSED BEDS										
a1. General Medical/Surgical* UCMC	149	128	127	135	141	142	144	186	190	194
a2. General Medical/Surgical* HMH	37	39	48	52	56	56	57			
a3. Observation UCMC	40	39	39	35	31	31	31	34	34	34
a4. Observation UC FMF								11	11	11
a5. Observation HMH	16	15	15	13	11	11	11			
General MSGA & Observation	**242**	**221**	**230**	**235**	**239**	**240**	**243**	**231**	**235**	**239**
b1. ICU/CCU UCMC	12	12	12	11	12	12	12	16	16	16
b2. ICU/CCU HMH	6	6	6	6	6	6	6			
Total MSGA	**260**	**239**	**247**	**252**	**257**	**258**	**261**	**247**	**251**	**255**
c. Pediatric	1	1	1	1	1	1	1	1	1	1
d. Obstetric	11	10	10	10	10	10	10	10	10	10
e1. Acute Psychiatric HMH	22	24	23	22	22	22	20			
e2. Acute Psychiatric UC Behavioral Health								40	40	40
Total Acute	***294***	***274***	***281***	***285***	***290***	***291***	***292***	***298***	***302***	***306***
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***294***	***274***	***281***	***285***	***290***	***291***	***292***	***298***	***302***	***306***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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.

	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	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a1. General Medical/Surgical* UCMC	80.0%	80.2%	80.1%	80.2%	80.3%	80.4%	80.1%	80.0%	80.0%	80.0%
a2. General Medical/Surgical* HMH	82.6%	82.0%	81.7%	81.3%	80.3%	80.9%	80.2%			
a3. Observation UCMC	80.1%	80.0%	80.0%	80.0%	79.9%	79.9%	79.9%	80.0%	80.1%	79.9%
a4. Observation UC FMF								60.2%	60.6%	61.0%
a5. Observation HMH	81.8%	82.0%	82.1%	81.6%	80.9%	81.2%	81.4%			
General MSGA & Observation	80.6%	80.6%	80.6%	80.5%	80.3%	80.5%	80.2%	79.0%	79.1%	79.1%
b1. ICU/CCU UCMC	79.9%	80.2%	80.0%	80.3%	80.0%	80.8%	80.1%	80.0%	80.0%	80.2%
b2. ICU/CCU HMH	63.1%	69.2%	68.3%	66.9%	71.2%	71.7%	72.3%			
Total MSGA	**80.1%**	**80.3%**	**80.2%**	**80.1%**	**80.0%**	**80.3%**	**80.0%**	**79.1%**	**79.1%**	**79.2%**
c. Pediatric	80.5%	70.1%	50.7%	50.7%	50.5%	49.3%	48.2%	47.8%	47.4%	47.0%
d. Obstetric	72.7%	76.9%	76.0%	76.2%	76.4%	76.5%	76.7%	76.8%	77.0%	77.2%
e1. Acute Psychiatric HMH	85.5%	85.6%	85.1%	84.0%	83.7%	83.4%	86.7%			
e2. Acute Psychiatric UC Behavioral Health								83.3%	84.1%	85.1%
Total Acute	**80.3%**	**80.6%**	**80.4%**	**80.2%**	**80.1%**	**80.3%**	**80.2%**	**79.5%**	**79.6%**	**79.8%**
f. Rehabilitation										
g. Comprehensive Care										
h. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	**80.3%**	**80.6%**	**80.4%**	**80.2%**	**80.1%**	**80.3%**	**80.2%**	**79.5%**	**79.6%**	**79.8%**
6. OUTPATIENT VISITS										
a1. Emergency Department UCMC (Total)	63,155	65,251	65,026	65,415	65,805	66,199	66,594	69,455	69,869	70,287
a2. Emergency Department UC FMF (Total)								28,763	28,891	29,019
a3. Emergency Department HMH (Total)	29,342	29,520	28,245	28,370	28,496	28,623	28,750			
b1. Same-day Surgery Cases UCMC	6,034	5,890	5,678	5,621	5,652	5,685	5,719	6,174	6,211	6,249
b2. Same-day Surgery Cases HMH	1,351	1,169	1,210	1,234	1,240	1,246	1,252			
c1. Laboratory RVUs UCMC	11,579,753	11,182,649	12,048,570	11,494,331	11,994,371	12,089,088	12,187,847	15,308,251	15,567,044	15,835,413
c2. Laboratory RVUs HMH	3,020,073	2,803,257	2,695,784	2,487,416	2,575,584	2,559,873	2,546,777			
c3. Laboratory RVUs UC Behavioral Health								1,813,871	1,822,216	1,830,644
d1. Imaging RVUs UCMC	1,789,053	1,772,683	1,905,329	1,809,354	1,888,067	1,902,976	1,918,522	2,649,594	2,691,468	2,734,861
d2. Imaging RVUs HMH	613,403	590,035	615,566	582,398	603,042	599,363	596,297			
d3. Imaging RVUs UC Behavioral Health								496,726	499,044	501,386
e. Psych Emergency Department										
f1. Outpatient Psych Clinic HMH	4,856	5,052	5,646	5,759	5,874	5,992	6,111			
f2. Outpatient Psych Clinic UC Behavioral Health								6,234	6,358	6,485
g1. Intensive Outpatient Psych Program HMH	1,491	1,190	1,443	1,362	1,286	1,214	1,146			
g2. Intensive Outpatient Psych Program UC Behavioral Health								1,929	1,941	1,953
h1. Partial Hospitalization Program HMH					1,300	2,600	2,600			
h2. Partial Hospitalization Program UC Behavioral Health								3,900	5,200	5,200
TOTAL OUTPATIENT VISITS	***17,108,511***	***16,456,696***	***17,372,496***	***16,481,259***	***17,170,717***	***17,262,858***	***17,361,616***	***20,384,897***	***20,698,243***	***21,021,495***
7. OBSERVATIONS**										

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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.

	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	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
a1. Number of Patients UCMC	7,562	7,460	7,479	7,070	6,662	6,683	6,707	7,026	7,071	7,119
a2. Number of Patients UC FMF								2,026	2,038	2,050
a3. Number of Patients HMH	2,887	2,664	2,669	2,473	2,277	2,283	2,290			
b1. Hours UCMC	281,983	274,061	274,765	244,456	214,119	214,816	215,567	236,943	238,486	240,100
b2. Hours UC FMF								58,043	58,385	58,743
b3. Hours HMH	114,695	107,718	107,933	92,977	78,009	78,216	78,442			

* 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 - Entire UCH Facility Components

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.

	Two 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	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE										
a. Inpatient Services	$ 182,942	$ 183,811	$ 190,553	$ 195,419	$ 194,791	$ 195,460	$ 196,131	$ 204,042	$ 204,850	$ 205,665
b. Outpatient Services	243,927	252,316	256,945	264,030	263,175	264,111	265,051	256,363	257,344	258,329
Gross Patient Service Revenues	***$ 426,869***	***$ 436,127***	***$ 447,498***	***$ 459,449***	***$ 457,966***	***$ 459,571***	***$ 461,182***	***$ 460,406***	***$ 462,193***	***$ 463,994***
c. Allowance For Bad Debt	18,149	12,593	14,027	13,476	13,435	13,481	13,526	13,078	13,128	13,178
d. Contractual Allowance	47,778	43,703	42,404	47,587	47,433	47,599	47,767	49,836	50,036	50,239
e. Charity Care	4,877	4,894	4,988	5,084	5,071	5,087	5,103	3,891	3,904	3,918
Net Patient Services Revenue	***$ 356,065***	***$ 374,936***	***$ 386,079***	***$ 393,302***	***$ 392,027***	***$ 393,404***	***$ 394,786***	***$ 393,601***	***$ 395,125***	***$ 396,659***
f. Other Operating Revenues (Specify/add rows if needed)	8,474	5,719	5,056	4,728	4,728	4,728	4,728	3,755	3,755	3,755
NET OPERATING REVENUE	***$ 364,539***	***$ 380,655***	***$ 391,135***	***$ 398,030***	***$ 396,755***	***$ 398,132***	***$ 399,514***	***$ 397,356***	***$ 398,880***	***$ 400,414***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 154,959	$ 172,601	$ 168,907	$ 171,026	$ 172,267	$ 172,439	$ 172,394	$ 164,095	$ 164,707	$ 165,342
b. Contractual Services	10,810	13,010	14,374	14,902	14,966	14,968	14,970	13,727	13,727	13,727
c. Interest on Current Debt	7,292	8,580	10,619	9,977	10,113	9,801	9,476	9,136	8,786	8,484
d. Interest on Project Debt	-	-	-	-	-	-	-	7,804	7,658	7,506
e. Current Depreciation	20,531	18,432	21,116	22,409	21,738	21,106	21,162	21,339	22,398	23,790
f. Project Depreciation	-	-	-	-	-	-	200	7,694	7,694	7,694
g. Current Amortization	-	-	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-	-	-
i. Supplies	71,174	74,195	77,282	77,628	78,872	79,576	80,298	79,879	80,854	81,849
j. Other Expenses (Specify/add rows if needed)	56,837	56,979	63,010	68,285	68,325	68,341	68,357	68,453	68,507	68,562
TOTAL OPERATING EXPENSES	**$ 321,603**	**$ 343,797**	**$ 355,308**	**$ 364,227**	**$ 366,282**	**$ 366,231**	**$ 366,856**	**$ 372,126**	**$ 374,331**	**$ 376,954**
3. INCOME										
a. Income From Operation	**$ 42,936**	**$ 36,858**	**$ 35,827**	**$ 33,803**	**$ 30,474**	**$ 31,901**	**$ 32,659**	**$ 25,230**	**$ 24,549**	**$ 23,460**
b. Non-Operating Income	$ (10,186)	$ 1,280	$ (8,399)	$ 5,615	$ 5,615	$ 5,615	$ 5,615	$ 5,615	$ 5,615	$ 5,615
SUBTOTAL	***$ 32,750***	***$ 38,138***	***$ 27,428***	***$ 39,418***	***$ 36,089***	***$ 37,516***	***$ 38,274***	***$ 30,845***	***$ 30,164***	***$ 29,075***
c. Income Taxes										
NET INCOME (LOSS)	***$ 32,750***	***$ 38,138***	***$ 27,428***	***$ 39,418***	***$ 36,089***	***$ 37,516***	***$ 38,274***	***$ 30,845***	***$ 30,164***	***$ 29,075***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - Entire UCH Facility Components

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.

	Two 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	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	47.3%	46.9%	46.9%	46.9%	46.9%	46.9%	46.9%	45.4%	45.4%	45.4%
2) Medicaid	13.0%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	14.2%	14.2%	14.2%
3) Blue Cross	12.6%	11.2%	11.2%	11.2%	11.2%	11.2%	11.2%	11.4%	11.4%	11.4%
4) Commercial Insurance	22.2%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	24.5%	24.5%	24.5%
5) Self-pay	0.9%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.8%	0.8%	0.8%
6) Other	4.0%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days										
1) Medicare	63.6%	61.4%	61.4%	61.4%	61.4%	61.4%	61.4%	57.9%	57.9%	57.9%
2) Medicaid	11.8%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	15.8%	15.8%	15.8%
3) Blue Cross	7.1%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	7.0%	7.0%	7.0%
4) Commercial Insurance	13.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.6%	15.6%	15.6%
5) Self-pay	0.7%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%	0.5%
6) Other	3.0%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.2%	3.2%	3.2%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table G – Key Financial Projection Assumptions for UM Upper Chesapeake Medical Center (Excludes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2018 – FY2024	
2) Projection is based on the Upper Chesapeake Medical Center (UCMC) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue • Gross Charges o Update Factor	0.0% annual increase
o Demographic Adjustment	Remains constant at 0.37% per year
o Variable Cost Factor	100% variable cost factor for inpatient and outpatient
o Other	In total, $51.1 million shifting from HMH to UCMC in FY 2022 $1.8 million shifting from UCMC to unregulated ASC in FY 2022
• Revenue Deductions o Contractual Allowances	Remains constant at 10.5% of gross revenue per year
o Charity Care	Remains constant at 0.6% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Remains constant at 2.48% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue • Includes Rental Income, Cafeteria Revenue, Contributions and Other Miscellaneous Revenue	0.0% increase per year
6) Non-Operating Revenue • Investment Income	0.0% increase per year
7) Expenses • Inflation	0.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes o Salaries and Benefits	Identified at the cost center level Ranges from 0% for overhead departments to 90% for inpatient nursing units.
o Professional Fees	0% for all cost centers
o Supplies	Ranges from 0% for overhead departments to 100% for the Emergency Department and EEG
o Purchased Services	Ranges from 0% for overhead departments to 100% for inpatient nursing units.
o Other Operating Expenses	Ranges from 0% for overhead departments to 35.1% for inpatient nursing units.
• Interest Expense o Existing Debt	88% allocation in FY2018 – FY2021 and 90% allocation in FY2022 – FY2024 of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds

	- 3.6% interest on $50.0M 2011A Series bonds
o Project Debt	4.5% interest on $67.3M bonds over 30 years
• Depreciation and Amortization	Average life of 26 years on $74.4M of construction project expenditures and 10 years on routine capital expenditures
8) Routine Capital Expenditures	$7.1M in FY2018 growing to $10.2M in FY2024

Table G – Key Financial Projection Assumptions for UM Harford Memorial Hospital (Excludes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2018 – FY2021	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue • Gross Charges o Update Factor	0.0% annual increase
o Demographic Adjustment	Remains constant at 0.27% per year
o Variable Cost Factor	100% variable cost factor for inpatient and outpatient
• Revenue Deductions o Contractual Allowances	Remains constant at 12.8% of gross revenue per year
o Charity Care	Remains constant at 2.8% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Remains constant at 4.42% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue • Includes Rental Income, Cafeteria Revenue, and Other Miscellaneous Revenue	0.0% increase per year
6) Non-Operating Revenue • Investment Income	0.0% increase per year
7) Expenses • Inflation	0.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes o Salaries and Benefits	Identified at the cost center level Ranges from 0% for overhead departments to 90% for inpatient nursing units.
o Professional Fees	0% for all cost centers
o Supplies	Ranges from 0% for overhead departments to 100% for inpatient nursing units.
o Purchased Services	Ranges from 0% for overhead departments to 100% for inpatient nursing units.
o Other Operating Expenses	Ranges from 0% for overhead departments to 18.4% for inpatient nursing units.
• Interest Expense o Existing Debt	12% allocation in FY2018 – FY2021 of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Depreciation and Amortization	10 year useful life on routine capital expenditures
8) Routine Capital Expenditures	$2.5M in FY2018 reducing to $0.4M in FY2021

Table G – Key Financial Projection Assumptions for UC Behavioral Health (Excludes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2022 – FY2024	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to CON Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue • Gross Charges o Update Factor	0.0% annual increase
o Demographic Adjustment	No demographic adjustment
o Variable Cost Factor	HMH Psychiatric revenue will shift to UC Behavioral Health at a 100% variable cost factor, while revenue from UHCC will shift at 50%
o Geriatric Psychiatry Change	Geriatric Psychiatry charge per day calculated using state-wide average Geriatric Psychiatry utilization profile multiplied by projected rates
o Partial Hospitalization Psychiatry Changes	Outpatient Partial Hospitalization Psychiatry charges calculated by multiplying visits by projected PDC rate
o Other	Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2016 Psychiatric payer mix
• Revenue Deductions o Contractual Allowances	Based on FY2016 HMH Psychiatric payer mix and remains constant at 17.4% of gross revenue per year - Medicare contractual adjustments reflect an inpatient Medicare per diem rate that is 65% of the assumed charge per visit based on Sheppard Pratt average per diem - Outpatient is assumed to be the same as inpatient - Assumes Medicaid will pay HSCRC rates
o Charity Care	Based on FY2016 HMH uncompensated care and remains constant at 0.5% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Based on FY2016 HMH uncompensated care and remains constant at 3.1% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue • Cafeteria Revenue	0.0% increase per year
6) Expenses • Inflation	0.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes o Salaries and Benefits	Identified at the cost center level Ranges from 10% for overhead departments to 100% for inpatient nursing units.
o Professional Fees	0% for all cost centers except inpatient nursing (50%) and Laboratory (100%).

o Supplies	Ranges from 0% for overhead departments to 100% for the Emergency Department.
o Purchased Services	Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	Ranges from 0% for overhead departments to 50% for certain ancillary and support departments
• Other Operating Expense Adjustments	Additional adjustments totalling approximately $3.4M were made to reduce Pharmacy and other operating expenses and UCHS overhead allocations to reflect Psychiatric specific services and a smaller facility
• Interest Expense o Existing Debt	5.2% allocation of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
o Project Debt	4.5% interest on $55.4M bonds over 30 years
• Depreciation and Amortization	Average life of 26 years on $55.4M of construction project expenditures and 10 years on routine capital expenditures
7) Routine Capital Expenditures	$0.4M in FY2022, growing to $1.3M in FY2021 and $2.6M in FY2024

Table G – Key Financial Projection Assumptions for Upper Chesapeake Freestanding Medical Facility (Excludes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2022 – FY2024	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue	
• Gross Charges	
o Update Factor	0.0% annual increase
o Demographic Adjustment	Remains constant at 0.27% per year
o Variable Cost Factor	UC FMF volume shifting at 100% VCF before the addition of retained revenue for capital
o Other	Removed assessments and quality from HMH rates and changed the markup based on HMH FY2016 OP PDA payer mix and actual FY 2016/FY 2017 UCC
• Revenue Deductions	
o Contractual Allowances	Based on FY2016/FY 2017 actual contractual allowances for HMH Behavioral Health, ED, and Observation services and remains constant at 8.9% of gross revenue per year
o Charity Care	Based on FY2016/FY 2017 actual charity care for HMH Behavioral Health, ED, and Observation services and remains constant at 4.4% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Based on FY2016/FY 2017 actual bad debt for HMH Behavioral Health, ED, and Observation services and remains constant at 7.2% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue	
• Cafeteria Revenue	0.0% increase per year
6) Expenses	
• Inflation	0.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	Identified at the cost center level
o Salaries and Benefits	Ranges from 10% for overhead departments to 100% for inpatient nursing units.
o Professional Fees	0% for all cost centers except inpatient nursing (50%) and Laboratory (100%).
o Supplies	Ranges from 0% for overhead departments to 100% for the Emergency Department.
o Purchased Services	Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	Ranges from 0% for overhead departments to 50% for certain ancillary and support departments
• Other Operating Expense Adjustments	Additional adjustments totalling approximately $3.2M were made to reduce Pharmacy and other operating

	expenses and UCHS overhead allocations to reflect specific services at UC FMF and a smaller facility
• Interest Expense o Existing Debt	4.8% allocation of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
o Project Debt	4.5% interest on $51.2M bonds over 30 years
• Depreciation and Amortization	Average life of 26 years on $51.2M of construction project expenditures and 10 years on routine capital expenditures
7) Routine Capital Expenditures	$0.3M in FY2022, growing to $1.2M in FY2021 and $2.4M in FY2024

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - Entire UCH Facility Components

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.

	Two 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	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. REVENUE										
a. Inpatient Services	$ 182,942	$ 183,811	$ 190,553	$ 195,419	$ 199,409	$ 205,885	$ 212,572	$ 227,447	$ 234,692	$ 242,173
b. Outpatient Services	243,927	252,316	256,945	264,030	269,405	278,171	287,221	286,146	295,453	305,063
Gross Patient Service Revenues	***$ 426,869***	***$ 436,127***	***$ 447,498***	***$ 459,449***	***$ 468,813***	***$ 484,056***	***$ 499,793***	***$ 513,593***	***$ 530,145***	***$ 547,237***
c. Allowance For Bad Debt	18,149	12,593	14,027	13,476	13,753	14,199	14,659	14,585	15,053	15,537
d. Contractual Allowance	47,778	43,703	42,404	47,587	48,556	50,135	51,766	55,584	57,361	59,196
e. Charity Care	4,877	4,894	4,988	5,084	5,191	5,358	5,531	4,338	4,478	4,622
Net Patient Services Revenue	***$ 356,065***	***$ 374,936***	***$ 386,079***	***$ 393,302***	***$ 401,313***	***$ 414,363***	***$ 427,838***	***$ 439,086***	***$ 453,253***	***$ 467,882***
f. Other Operating Revenues (Specify/add rows if needed)	8,474	5,719	5,056	4,728	4,775	4,823	4,871	3,903	3,942	3,982
NET OPERATING REVENUE	***$ 364,539***	***$ 380,655***	***$ 391,135***	***$ 398,030***	***$ 406,088***	***$ 419,186***	***$ 432,709***	***$ 442,989***	***$ 457,195***	***$ 471,864***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 154,959	$ 172,601	$ 168,907	$ 171,026	$ 175,715	$ 179,938	$ 184,023	$ 177,525	$ 182,285	$ 187,194
b. Contractual Services	10,810	13,010	14,374	14,902	15,415	15,877	16,354	15,158	15,613	16,081
c. Interest on Current Debt	7,292	8,580	10,619	9,977	10,113	9,801	9,476	9,136	8,786	8,484
d. Interest on Project Debt	-	-	-	-	-	-	-	7,804	7,658	7,506
e. Current Depreciation	20,531	18,432	21,116	22,409	21,738	21,106	21,162	21,339	22,398	23,790
f. Project Depreciation	-	-	-	-	-	-	200	7,694	7,694	7,694
g. Current Amortization	-	-	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-	-	-
i. Supplies	71,174	74,195	77,282	77,628	82,184	86,482	91,014	94,383	99,642	105,205
j. Other Expenses (Specify/add rows if needed)	56,837	56,979	63,010	68,285	70,079	72,160	74,303	75,415	77,690	80,035
TOTAL OPERATING EXPENSES	***$ 321,603***	***$ 343,797***	***$ 355,308***	***$ 364,227***	***$ 375,245***	***$ 385,365***	***$ 396,531***	***$ 408,454***	***$ 421,766***	***$ 435,990***
3. INCOME										
a. Income From Operation	**$ 42,936**	**$ 36,858**	**$ 35,827**	**$ 33,803**	**$ 30,843**	**$ 33,821**	**$ 36,178**	**$ 34,536**	**$ 35,429**	**$ 35,874**
b. Non-Operating Income	$ (10,186)	$ 1,280	$ (8,399)	$ 5,615	$ 5,671	$ 5,728	$ 5,785	$ 5,843	$ 5,901	$ 5,960
SUBTOTAL	***$ 32,750***	***$ 38,138***	***$ 27,428***	***$ 39,418***	***$ 36,514***	***$ 39,549***	***$ 41,963***	***$ 40,379***	***$ 41,331***	***$ 41,835***
c. Income Taxes										
NET INCOME (LOSS)	***$ 32,750***	***$ 38,138***	***$ 27,428***	***$ 39,418***	***$ 36,514***	***$ 39,549***	***$ 41,963***	***$ 40,379***	***$ 41,331***	***$ 41,835***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	47.3%	46.9%	46.9%	46.9%	46.9%	46.9%	46.9%	45.4%	45.4%	45.4%
2) Medicaid	13.0%	13.5%	13.5%	13.5%	13.5%	13.5%	13.5%	14.2%	14.2%	14.2%
3) Blue Cross	12.6%	11.2%	11.2%	11.2%	11.2%	11.2%	11.2%	11.4%	11.4%	11.4%
4) Commercial Insurance	22.2%	23.9%	23.9%	23.9%	23.9%	23.9%	23.9%	24.5%	24.5%	24.5%
5) Self-pay	0.9%	0.7%	0.7%	0.7%	0.7%	0.7%	0.7%	0.8%	0.8%	0.8%
6) Other	4.0%	3.8%	3.8%	3.8%	3.8%	3.8%	3.8%	3.7%	3.7%	3.7%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - Entire UCH Facility Components

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.

	Two 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	**FY2015**	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
b. Percent of Patient Days										
Total MSGA										
1) Medicare	63.6%	61.4%	61.4%	61.4%	61.4%	61.4%	61.4%	57.9%	57.9%	57.9%
2) Medicaid	11.8%	12.9%	12.9%	12.9%	12.9%	12.9%	12.9%	15.8%	15.8%	15.8%
3) Blue Cross	7.1%	6.7%	6.7%	6.7%	6.7%	6.7%	6.7%	7.0%	7.0%	7.0%
4) Commercial Insurance	13.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.6%	15.6%	15.6%
5) Self-pay	0.7%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.5%	0.5%	0.5%
6) Other	3.0%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.2%	3.2%	3.2%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H – Key Financial Projection Assumptions for UM Upper Chesapeake Medical Center (Includes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2018 – FY2024	
2) Projection is based on the Upper Chesapeake Medical Center (UCMC) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue • Gross Charges o Update Factor	 2.38% increase in FY2019 and 2.90% annual increase from FY2020 – FY2024
o Demographic Adjustment	Remains constant at 0.37% per year
o Variable Cost Factor	100% variable cost factor for inpatient and outpatient
o Other	In total, $51.1 million shifting from HMH to UCMC in FY 2022 $1.8 million shifting from UCMC to unregulated ASC in FY 2022
• Revenue Deductions o Contractual Allowances	 Remains constant at 10.5% of gross revenue per year
o Charity Care	Remains constant at 0.6% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Remains constant at 2.48% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue • Includes Rental Income, Cafeteria Revenue, Contributions and Other Miscellaneous Revenue	1.0% increase per year
6) Non-Operating Revenue • Investment Income	 1.0% increase per year
7) Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	 2.3% increase per year 3.0% increase per year 4.3% increase per year 3.0% increase per year 2.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes o Salaries and Benefits	Identified at the cost center level Ranges from 0% for overhead departments to 90% for inpatient nursing units.
o Professional Fees	0% for all cost centers
o Supplies	Ranges from 0% for overhead departments to 100% for the Emergency Department and EEG
o Purchased Services	Ranges from 0% for overhead departments to 100% for inpatient nursing units.
o Other Operating Expenses	Ranges from 0% for overhead departments to 35.1% for inpatient nursing units.

• Interest Expense o Existing Debt	88% allocation in FY2018 – FY2021 and 90% allocation in FY2022 – FY2024 of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
o Project Debt	4.5% interest on $67.3M bonds over 30 years
• Depreciation and Amortization	Average life of 26 years on $74.4M of construction project expenditures and 10 years on routine capital expenditures
8) Routine Capital Expenditures	$7.1M in FY2018 growing to $10.2M in FY2024

Table H – Key Financial Projection Assumptions for UM Harford Memorial Hospital (Includes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2018 – FY2021	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue	
• Gross Charges	
o Update Factor	2.38% increase in FY2019 and 2.90% annual increase from FY2020 – FY2021
o Demographic Adjustment	Remains constant at 0.27% per year
o Variable Cost Factor	100% variable cost factor for inpatient and outpatient
• Revenue Deductions	
o Contractual Allowances	Remains constant at 12.8% of gross revenue per year
o Charity Care	Remains constant at 2.8% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Remains constant at 4.42% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue • Includes Rental Income, Cafeteria Revenue, and Other Miscellaneous Revenue	1.0% increase per year
6) Non-Operating Revenue • Investment Income	1.0% increase per year
7) Expenses	
• Inflation	
o Salaries and Benefits	2.3% increase per year
o Professional Fees	3.0% increase per year
o Supplies	4.3% increase per year
o Purchased Services	3.0% increase per year
o Other Operating Expenses	2.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	Identified at the cost center level
o Salaries and Benefits	Ranges from 0% for overhead departments to 90% for inpatient nursing units.
o Professional Fees	0% for all cost centers
o Supplies	Ranges from 0% for overhead departments to 100% for inpatient nursing units.
o Purchased Services	Ranges from 0% for overhead departments to 100% for inpatient nursing units.
o Other Operating Expenses	Ranges from 0% for overhead departments to 18.4% for inpatient nursing units.
• Interest Expense	
o Existing Debt	12% allocation in FY2018 – FY2021 of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds

• Depreciation and Amortization	10 year useful life on routine capital expenditures
8) Routine Capital Expenditures	$2.5M in FY2018 reducing to $0.4M in FY2021

Table H – Key Financial Projection Assumptions for UC Behavioral Health (Includes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2022 – FY2024	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to CON Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue	
• Gross Charges	
o Update Factor	1.9% annual increase
o Demographic Adjustment	No demographic adjustment
o Variable Cost Factor	HMH Psychiatric revenue will shift to UC Behavioral Health at a 100% variable cost factor, while revenue from UHCC will shift at 50%
o Geriatric Psychiatry Change	Geriatric Psychiatry charge per day calculated using state-wide average Geriatric Psychiatry utilization profile multiplied by projected rates
o Partial Hospitalization Psychiatry Changes	Outpatient Partial Hospitalization Psychiatry charges calculated by multiplying visits by projected PDC rate
o Other	Removed assessments and quality from HMH rates and changed the markup based on HMH FY2016 Psychiatric payer mix
• Revenue Deductions	
o Contractual Allowances	Based on FY2016 HMH Psychiatric payer mix and remains constant at 17.4% of gross revenue per year - Medicare contractual adjustments reflect an inpatient Medicare per diem rate that is 65% of the assumed charge per visit based on Sheppard Pratt average per diem - Outpatient is assumed to be the same as inpatient - Assumes Medicaid will pay HSCRC rates
o Charity Care	Based on FY2016 HMH uncompensated care and remains constant at 0.5% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Based on FY2016 HMH uncompensated care and remains constant at 3.1% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue	
• Cafeteria Revenue	1.0% increase per year
6) Expenses	
• Inflation	
o Salaries and Benefits	2.3% increase per year
o Professional Fees	3.0% increase per year
o Supplies	4.3% increase per year
o Purchased Services	3.0% increase per year
o Other Operating Expenses	2.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	Identified at the cost center level
o Salaries and Benefits	Ranges from 10% for overhead departments to 100% for inpatient nursing units.

o Professional Fees	0% for all cost centers except inpatient nursing (50%) and Laboratory (100%).
o Supplies	Ranges from 0% for overhead departments to 100% for the Emergency Department.
o Purchased Services	Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	Ranges from 0% for overhead departments to 50% for certain ancillary and support departments
• Other Operating Expense Adjustments	Additional adjustments totalling approximately $3.4M were made to reduce Pharmacy and other operating expenses and UCHS overhead allocations to reflect Psychiatric specific services and a smaller facility
• Interest Expense o Existing Debt	5.2% allocation of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
o Project Debt	4.5% interest on $55.4M bonds over 30 years
• Depreciation and Amortization	Average life of 26 years on $55.4M of construction project expenditures and 10 years on routine capital expenditures
7) Routine Capital Expenditures	$0.4M in FY2022, growing to $1.3M in FY2021 and $2.6M in FY2024

Table H – Key Financial Projection Assumptions for Upper Chesapeake Freestanding Medical Facility (Includes HSCRC Annual Update Factors & Expense Inflation)

1) Projection period reflects FY2022 – FY2024	
2) Projection is based on the Harford Memorial Hospital (HMH) FY2018 budget with assumptions identified below.	
3) Volumes	Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
4) Patient Revenue	
• Gross Charges	
o Update Factor	2.38% increase in FY2019 and 2.90% annual increase from FY2020 – FY2024
o Demographic Adjustment	Remains constant at 0.27% per year
o Variable Cost Factor	UC FMF volume shifting at 100% VCF before the addition of retained revenue for capital
o Other	Removed assessments and quality from HMH rates and changed the markup based on HMH FY2016 OP PDA payer mix and actual FY 2016/FY 2017 UCC
• Revenue Deductions	
o Contractual Allowances	Based on FY2016/FY 2017 actual contractual allowances for HMH Behavioral Health, ED, and Observation services and remains constant at 8.9% of gross revenue per year
o Charity Care	Based on FY2016/FY 2017 actual charity care for HMH Behavioral Health, ED, and Observation services and remains constant at 4.4% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	Based on FY2016/FY 2017 actual bad debt for HMH Behavioral Health, ED, and Observation services and remains constant at 7.2% of gross revenue per year - No overfunding or underfunding of UCC
5) Other Revenue	
• Cafeteria Revenue	1.0% increase per year
6) Expenses	
• Inflation	
o Salaries and Benefits	2.3% increase per year
o Professional Fees	3.0% increase per year
o Supplies	4.3% increase per year
o Purchased Services	3.0% increase per year
o Other Operating Expenses	2.0% increase per year
• Expense Volume Driver	Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	Identified at the cost center level
o Salaries and Benefits	Ranges from 10% for overhead departments to 100% for inpatient nursing units.
o Professional Fees	0% for all cost centers except inpatient nursing (50%) and Laboratory (100%).
o Supplies	Ranges from 0% for overhead departments to 100% for the Emergency Department.
o Purchased Services	Ranges from 0% for overhead departments to 50% for certain ancillary departments

o Other Operating Expenses	Ranges from 0% for overhead departments to 50% for certain ancillary and support departments
• Other Operating Expense Adjustments	Additional adjustments totalling approximately $3.2M were made to reduce Pharmacy and other operating expenses and UCHS overhead allocations to reflect specific services at UC FMF and a smaller facility
• Interest Expense o Existing Debt	4.8% allocation of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
o Project Debt	4.5% interest on $51.2M bonds over 30 years
• Depreciation and Amortization	Average life of 26 years on $51.2M of construction project expenditures and 10 years on routine capital expenditures
7) Routine Capital Expenditures	$0.3M in FY2022, growing to $1.2M in FY2021 and $2.4M in FY2024

TABLE L. WORKFORCE INFORMATION - UM Harford Memorial Hospital

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)*											
Medical Staff Administration	1.8	$ 58	$ 107			$0			$0	0.0	$ -
Quality & Health Information Management	14.9	$ 66	$ 988			$0			$0	0.0	$ -
Fiscal Services	3.6	$ 77	$ 276			$0			$0	0.0	$ -
Spirituality	0.3	$ 67	$ 20			$0			$0	0.0	$ -
Patient Accounting	7.4	$ 53	$ 391			$0			$0	0.0	$ -
Centralized Scheduling	5.9	$ 43	$ 252			$0			$0	0.0	$ -
Admitting	12.7	$ 44	$ 555			$0			$0	0.0	$ -
MIS	11.4	$ 83	$ 948			$0			$0	0.0	$ -
Communications	5.7	$ 34	$ 194			$0			$0	0.0	$ -
Telecommunications	0.6	$ 103	$ 65			$0			$0	0.0	$ -
Mailroom	1.2	$ 34	$ 41			$0			$0	0.0	$ -
Administration	1.2	$ 162	$ 194			$0			$0	0.0	$ -
Safety	0.6	$ 103	$ 62			$0			$0	0.0	$ -
Nursing Administration	11.0	$ 79	$ 872			$0			$0	0.0	$ -
Hospital Education	4.3	$ 109	$ 462			$0			$0	0.0	$ -
Quality Management	4.3	$ 51	$ 219			$0			$0	0.0	$ -
Readmission	3.4	$ 41	$ 140			$0			$0	0.0	$ -
Clinical Resource Management	8.1	$ 129	$ 1,053			$0			$0	0.0	$ -
Distribution	5.4	$ 35	$ 187			$0			$0	0.0	$ -
Volunteers	1.2	$ 60	$ 71			$0			$0	0.0	$ -
Human Resources	3.6	$ 69	$ 246			$0			$0	0.0	$ -
Healthlink	0.5	$ 43	$ 21			$0			$0	0.0	$ -
Business Intelligence	1.8	$ 87	$ 156			$0			$0	0.0	$ -
Performance Improvements	3.0	$ 123	$ 364			$0			$0	0.0	$ -

TABLE L. WORKFORCE INFORMATION - UM Harford Memorial Hospital

HC Epidemiology & Infection Control	1.1	$ 85	$ 94			$0			$0	0.0	$ -
Guest Services	1.0	$ 60	$ 60			$0			$0	0.0	$ -
Purchasing	2.2	$ 64	$ 140			$0			$0	0.0	$ -
Risk Management	1.2	$ 77	$ 92			$0			$0	0.0	$ -
General Hospital	(1.6)	$ 115	$ (187)			$0			$0	0.0	$ -
Total Administration	117.6		$ 8,085			$0			$0	0.0	$ -
Direct Care Staff *(List general categories, add rows if needed)*											
3 South Tele	44.1	$ 58	$ 2,571			$0			$0	0.0	$ -
ICU and CCU	38.3	$ 76	$ 2,898			$0			$0	0.0	$ -
Behavioral Health	45.0	$ 62	$ 2,784			$0			$0	0.0	$ -
Outpatient Psychiatric Clinic	11.7	$ 66	$ 773			$0			$0	0.0	$ -
Regional BHU Office	2.0	$ 87	$ 174			$0			$0	0.0	$ -
Intensive Outpatient Psychiatry	7.8	$ 68	$ 532			$0			$0	0.0	$ -
Emergency Department	53.5	$ 76	$ 4,062			$0			$0	0.0	$ -
Med/Surg 4th Tower	53.2	$ 56	$ 3,002			$0			$0	0.0	$ -
Sleep Disorder Center	4.7	$ 52	$ 243			$0			$0	0.0	$ -
Operating Room	12.2	$ 85	$ 1,038			$0			$0	0.0	$ -
Anesthesia	1.0	$ 53	$ 53			$0			$0	0.0	$ -
PACU	9.9	$ 92	$ 916			$0			$0	0.0	$ -
Bariatric	4.4	$ 66	$ 289			$0			$0	0.0	$ -
Central Supply	2.1	$ 52	$ 110			$0			$0	0.0	$ -
IV Therapy	3.1	$ 62	$ 191			$0			$0	0.0	$ -
Pharmacy	15.6	$ 88	$ 1,371			$0			$0	0.0	$ -
Anticoag Clinic	1.5	$ 137	$ 203			$0			$0	0.0	$ -
Respiratory Therapy	10.5	$ 83	$ 873			$0			$0	0.0	$ -
Speech Therapy	1.0	$ 93	$ 96			$0			$0	0.0	$ -
Physical Therapy	4.5	$ 98	$ 443			$0			$0	0.0	$ -
Occupational Therapy	2.3	$ 96	$ 222			$0			$0	0.0	$ -
Radiology	17.9	$ 67	$ 1,209			$0			$0	0.0	$ -
General Ultrasound	2.3	$ 84	$ 194			$0			$0	0.0	$ -
Nuclear Medicine	2.0	$ 73	$ 145			$0			$0	0.0	$ -
Cat Scan	6.7	$ 89	$ 599			$0			$0	0.0	$ -
MRI	2.5	$ 86	$ 212			$0			$0	0.0	$ -
Imaging Support RN	0.5	$ 100	$ 46			$0			$0	0.0	$ -
Cardiovascular Institute	2.5	$ 40	$ 100			$0			$0	0.0	$ -
Interventional Angiography	0.3	$ 784	$ 227			$0			$0	0.0	$ -
Cardiovascular Ultrasound	6.9	$ 74	$ 510			$0			$0	0.0	$ -
Electroencephalography	1.0	$ 47	$ 47			$0			$0	0.0	$ -
Stroke Center	0.6	$ 96	$ 54			$0			$0	0.0	$ -

TABLE L. WORKFORCE INFORMATION - UM Harford Memorial Hospital

Inpatient Diabetes	0.8	$	86	$	70			$0			$0	0.0	$ -
Laboratory	28.6	$	69	$	1,974			$0			$0	0.0	$ -
Total Direct Care	401.1			$	28,233			$0			$0	0.0	$ -
Support Staff *(List general categories, add rows if needed)*													
Nutritional Services	24.5	$	28	$	699			$0			$0	0.0	$ -
Plant Operations	14.2	$	57	$	810			$0			$0	0.0	$ -
Bio Med	4.0	$	52	$	206			$0			$0	0.0	$ -
Environmental Services	22.6	$	34	$	756			$0			$0	0.0	$ -
Security	16.0	$	36	$	580			$0			$0	0.0	$ -
Print Shop	0.3	$	107	$	32			$0			$0	0.0	$ -
Total Support	81.6			$	3,084			$0			$0	0.0	$ -
REGULAR EMPLOYEES TOTAL	***600.2***			$	39,401			$0			$0	0.0	$ -
2. Contractual Employees													
Administration *(List general categories, add rows if needed)*													
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
Total Administration					$0			$0			$0	0.0	$ -
Direct Care Staff *(List general categories, add rows if needed)*													
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
Total Direct Care Staff					$0			$0			$0	0.0	$ -
Support Staff *(List general categories, add rows if needed)*													
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
					$0			$0			$0	0.0	$ -
Total Support Staff					$0			$0			$0	0.0	$ -
CONTRACTUAL EMPLOYEES TOTAL					$0			$0			$0	0.0	$ -
Benefits *(State method of calculating benefits below)**:***				**$**	**9,149**								**$ -**
23.2% of Benefits													
TOTAL COST	***600.2***			***$48,550***		***0.0***		***$0***	***0.0***		***$0***		***$ -***

TABLE L. WORKFORCE INFORMATION - UM Harford Memorial Hospital Ancillary Services utilized by the ED

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*	**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)*											
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
Total Administration			$0			$0			$0	0.0	$ -
Direct Care Staff *(List general categories, add rows if needed)*											
Emergency Department	53.5	$ 76	$ 4,062			$0			$0	0.0	$ -
IV Therapy	1.2	$ 62	$ 72			$0			$0	0.0	$ -
Pharmacy	3.4	$ 88	$ 297			$0			$0	0.0	$ -
Respiratory Therapy	3.9	$ 83	$ 326			$0			$0	0.0	$ -
Speech Therapy	0.1	$ 93	$ 8			$0			$0	0.0	$ -
Physical Therapy	1.9	$ 98	$ 184			$0			$0	0.0	$ -
Occupational Therapy	0.5	$ 96	$ 49			$0			$0	0.0	$ -
Radiology	9.7	$ 67	$ 653			$0			$0	0.0	$ -
General Ultrasound	1.4	$ 84	$ 115			$0			$0	0.0	$ -
Nuclear Medicine	0.9	$ 73	$ 69			$0			$0	0.0	$ -
Cat Scan	5.2	$ 89	$ 463			$0			$0	0.0	$ -
MRI	0.9	$ 86	$ 80			$0			$0	0.0	$ -
Imaging RN	0.5	$ 100	$ 46			$0			$0	0.0	$ -
Cardiovascular Institute	1.8	$ 40	$ 73			$0			$0	0.0	$ -
Cardiovascular Ultrasound	5.9	$ 74	$ 436			$0			$0	0.0	$ -
Electroencephalography	0.2	$ 47	$ 10			$0			$0	0.0	$ -
Laboratory	6.2	$ 69	$ 429			$0			$0	0.0	$ -
Total Direct Care	97.1		$ 7,371			$0			$0	0.0	$ -
Support Staff *(List general categories, add rows if needed)*											

TABLE L. WORKFORCE INFORMATION - UM Harford Memorial Hospital Ancillary Services utilized by the ED

			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
Total Support			$0			$0			$0	0.0	$ -
REGULAR EMPLOYEES TOTAL	***97.1***		$ 7,371			$0			$0	0.0	$ -
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
Total Administration			$0			$0			$0	0.0	$ -
Direct Care Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
Total Direct Care Staff			$0			$0			$0	0.0	$ -
Support Staff *(List general categories, add rows if needed)*											
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
			$0			$0			$0	0.0	$ -
Total Support Staff			$0			$0			$0	0.0	$ -
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$ -
Benefits *(State method of calculating benefits below)* **:**			**1,711**								**$ -**
23.2% of Benefits											
TOTAL COST	***0.0***		***$9,083***	***0.0***		***$0***	***0.0***		***$0***		***$ -***