UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

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November 21, 2018

VIA EMAIL & HAND DELIVERY

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

Re: Modified Request for Certificate of Exemption from CON Review – Merger and Consolidation of UM Harford Memorial Hospital, Inc., and UM Upper Chesapeake Medical Center, Inc.

Dear Ms. Potter:

On behalf of University of Maryland Upper Chesapeake Medical Center and University of Maryland Harford Memorial Hospital, as joint applicants, we are submitting four copies of a modified request for exemption from Certificate of Need review and related exhibits. One set of full-size sets of project drawings will be provided at a later date. Also enclosed is a CD containing searchable PDF files of the application and exhibits, a WORD version of the application, and native Excel spreadsheets of the MHCC tables.

If you have questions about the information provided above, please contact UM Upper Chesapeake Health System's legal counsel at your convenience:

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Gallagher, Evelius & Jones LLP
218 North Charles Street, Suite 400
Baltimore, Maryland 21201
410-347-1353
jbuck@gejlaw.com

#646407
011888-0023

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

Sincerely,

Lyle E. Sheldon FACHE,
President and Chief Executive Officer
UM Upper Chesapeake Health System, Inc.

Enclosures

cc: Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assitant Attorney General
Steve Witman, SeniorVice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Vice President and General Counsel, UM UCHS
Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer University of Maryland Medical System
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
James Buck, Gallagher, Evelius & Jones LLP

IN THE MATTER OF THE MERGER	*	
AND CONSOLIDATION OF	*	BEFORE THE
UNIVERSITY OF MARYLAND UPPER	*	MARYLAND HEALTH CARE
CHESAPEAKE MEDICAL CENTER	*	COMMISSION
AND HARFORD MEMORIAL HOSPITAL	*	

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

MODIFIED REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW
MERGER AND CONSOLIDATION OF HARFORD MEMORIAL HOSPITAL
AND UPPER CHESAPEAKE MEDICAL CENTER

University of Maryland Upper Chesapeake Medical Center, Inc. ("UCMC") and Harford Memorial, Inc. ("HMH"), by their undersigned counsel, seek approval from the Maryland Health Care Commission (the "Commission") to relocate MSGA beds from HMH to UCMC and to construct a three story addition to UCMC pursuant to a merger and consolidation of these two facilities in accordance with COMAR 10.24.01.02(A)(3)(c) and 10.24.01.04(A)(4)-(5). For the reasons set forth more fully below, UCMC and HMH respectfully request that the Commission grant an exemption from Certificate of Need ("CON") Review.

BACKGROUND

HMH is an acute care hospital with fifty-four (54) licensed MSGA beds and twenty-eight (28) licensed psychiatric beds located in Havre de Grace. UCMC is a 149-bed licensed acute care hospital, with 138 MSGA beds, 10 obstetrics beds, and 1 pediatric bed located in Bel Air. HMH and UCMC are the sole acute general hospitals located in Harford County. Both HMH and UCMC are owned and operated by the University of Maryland Upper Chesapeake Health ("UM UCH"), a community based, not-for-profit health system. UM UCH is dedicated to

maintaining and improving the health of the people in the communities it serves through an integrated health delivery system that provides the highest quality of care to all. UM UCHS has been affiliated with the University of Maryland Medical System ("UMMS") since 2009, and in late 2013, UM UCHS formally merged into UMMS in order to continue its commitment to the growing northeast Maryland area with expanded clinical services, programs and facilities, and physician recruitment. In addition to HMH and UCMC, UM UCH consists of the: (1) Patricia D. and M. Scot Kaufman Cancer Center (an affiliate of the University of Maryland Marlene and Stewart Greenebaum Cancer Center) located on the campus of UCMC; (2) the Klein Ambulatory Care Center located on the campus of UCMC; (3) the Senator Bob Hooper House, a residential hospice facility in Forest Hill; and (4) Upper Chesapeake Medical Services, a physician practice group.

HMH was constructed in phases between 1943 and 1972. Although UM UCH has been committed to maintaining the facility and has undertaken capital expenditures to make infrastructure, clinical equipment, and information technology improvements, the existing physical plant has outlived its useful life. Renovation of the facility is not cost-effective and the nine (9) acre site in downtown Havre de Grace is surrounded by existing developed parcels, limiting a practical opportunity for renovation or expansion. Consistent with local and national healthcare trends and to best promote access to convenient and quality care for the population it serves, UM UCHS proposes to transition portions of HMH to a multi-service facility to be located on an approximate 35.63 acre property known as the Upper Chesapeake Health Medical Campus at Aberdeen ("UC Medical Campus at Aberdeen"), four and four-fifths (4.8) miles from the existing HMH campus and conveniently located near Interstate 95. Contemporaneous with this Request for Exemption from CON review, HMH and UCMC, as joint applicants, have

sought a Request for Exemption to convert HMH to a freestanding medical facility to be located on the UC Medical Campus at Aberdeen, and UM UCH has filed a CON Application to establish a forty-bed (40) bed special psychiatric hospital which will be connected to and located above the freestanding medical facility.

Upon conversion of HMH to a freestanding medical facility, there will be loss of medical/surgical/gynecological/addictions ("MSGA") bed capacity in Harford County. The Commission projects a minimum need of 168 MSGA beds for Harford County in 2025 and a maximum MSGA bed need of 223. Maryland Register, v. 44, Issue 2 (Jan. 20, 2017). UCMC is presently licensed for only 138 MSGA beds – less than the Commission's projected minimum need. Thus, upon conversion of HMH to a freestanding medical facility, Harford County will clearly have a need for additional MSGA beds and also a need for a substantially increased number of dedicated observation beds as a result of ongoing changes to clinical intervention protocols to reduce avoidable utilization, and to decrease lengths of stay, readmissions, and the total cost of care. As discussed more fully herein, in fiscal year 2024, following the conversion of HMH to a freestanding medical facility, the Applicants have projected a need for UCMC to have 182 MSGA beds and 77 observation beds in two dedicated units housed on two floors above the Kaufman Cancer Center. This represents a net decrease of 10 MSGA beds between the current combined licensed bed capacity of UCMC and HMH and a net 67 bed increase in the number of dedicated observation beds at the two existing facilities combined. However, the net increase in observation capacity does not account for MSGA used presently at both UCMC and HMH for patients in observation status or for time patients spend in observation after 12:00 a.m. on the day they are admitted as inpatients.

UCMC proposes to transfer all existing MSGA bed capacity from HMH to UCMC when HMH converts to a freestanding medical facility, which is projected to occur in fiscal year 2022, up to a maximum of 182 beds at UCMC. UCMC will house the MSGA beds to be transferred from HMH through existing physical bed capacity that is presently used for both inpatients and observation patients. UCMC also proposes to construct a three-story, 78,870 square foot addition above the Kaufman Cancer Center to house two dedicated observation units on the fourth and fifth floors consisting of seventy-seven (77) observation beds. Because the Kaufman Cancer Center was designed to accommodate vertical expansion and is one of the final locations on the UCMC campus that is capable of being developed, UCMC also proposes to construct one floor of shell space to accommodate future growth of the Kaufman Cancer Center's diagnostic and treatment services and/or additional future inpatient or observation needs. The proposed addition has been designed in accordance with applicable building codes and the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals and Outpatient Facilities 2018 Edition ("FGI Guidelines"). A more detailed description of the project is provided below.

DISCUSSION

MARYLAND CODE, HEALTH-GENERAL §§ 19-120(j) permits a hospital to increase the volume of an existing health care service if the proposed change: (i) is pursuant to the merger of two or more health care facilities, (ii) is not inconsistent with the State Health Plan; (iii) will result in the delivery of more effective and efficient service, and (iv) is in the public interest. Similarly, COMAR 10.24.01.02(A)(3)(c) provides that a CON is not required to change the bed capacity of a hospital if the change in bed capacity is "proposed pursuant to a merger or consolidation between health care facilities" and the Commission finds that the change is not

inconsistent with the State Health Plan, will result in the delivery of more efficient and effective health care services, and is in the public interest. The Commission may also exempt the requirement of CON review and approval for capital expenditures and changes in the scope of health care services offered by a health care facility if done as part of a consolidation or merger of two hospitals. HEALTH-GENERAL § 19-120(k)(6)(v); COMAR 10.24.01.04(A)(4)-(5).

HEALTH-GENERAL § 19-120(a)(1)(2) defines "consolidation" or "merger" to include "increases or decreases in bed capacity or services among the components of an organization that: (i) operates more than one health care facility[.]" "Health care facility" is defined to include a "hospital." COMAR 10.24.01.01(B)(12). "Health care service means any clinically related patient service," including a "medical service." HEALTH-GENERAL § 19-120(a)(3)(i)-(ii). In turn, a "medical service" includes "medicine, surgery, gynecology, addictions." *Id.* § 19-120(a)(5); COMAR 10.24.01.01(B)(27).

Because UCMC and HMH are both owned and operated by UM UCH, the relocation of MSGA bed capacity from HMH to UCMC constitutes a consolidation or merger in accordance with HEALTH-GENERAL § 19-120(a)(1)(2) and COMAR 10.24.01.02(A)(3)(c). Further, the proposed MSGA bed relocation and associated capital expenditures are not inconsistent with the State Health Plan, will result in the delivery of more efficient and effective health care services, and are in the public interest.

I. COMPREHENSIVE PROJECT DESCRIPTION

As noted above, UCMC proposes to house MSGA beds to be transferred from HMH through existing physical bed capacity that is presently used for both inpatients and observation

patients. No new construction is contemplated at UCMC to house the MSGA beds transferred from HMH.

UCMC proposes to house patients placed in observation through two floors of new construction above the Kaufman Cancer Center as well as one floor of shell space. The existing Kaufman Cancer Center was constructed in 2011. It occupies two stories above the garden level parking garage but was designed to accommodate an additional three floors of vertical expansion. The proposed expansion project will provide 26,290 square of additional space on each of three floors. Level 3, the first floor of new construction will be constructed as shell space, with a horizontal connection to UCMC's existing top floor (the existing hospital is a total of three stories above the garden level). Levels 4 and 5 of the new construction will house two new dedicated observation units consisting of a total of seventy-seven (77) beds. More specifically, Level 4 will house a forty-one (41) bed dedicated observation unit consisting of twenty (20) semi-private rooms and one (1) private room. Level 5 will house eighteen (18) semi-private rooms as well as office space. Each of the semi-private rooms will have a private en suite toilet/shower rooms – one for each observation bed/patient.

To support the additional beds, 1,993 square feet on the existing Garden Level will be renovated to expand the food services department and environmental services. To separate traffic flows to and from the observation units from traffic flows to and from the existing Kaufman Cancer Center at the existing public elevator bank, a new and separate 238 square foot public elevator and lobby will be established. Further, a 512 square foot addition on Level 1 will relocate toilets currently at the location of the proposed new lobby. An equal addition on Level 2 will provide additional toilets needed to support existing outpatient services on Level 2.

To accommodate the increased mechanical and electrical loads required by the proposed building expansion, modifications to the existing free-standing central utility plant will be necessary. Two 550-ton electric centrifugal chillers and associated pumps will be installed to meet the increased loads and provide redundancy in case of a chiller failure. The existing cooling towers, currently located within an enclosure on grade, will be replaced with four 625-ton units to serve the expanded chiller plant.

The existing high pressure steam boilers in the central plant will remain, with heating for the new vertical addition to be provided by the existing steam converters in the existing Kaufman Cancer Center mechanical equipment room, and new, gas-fired condensing hot water boilers, that will be located in the existing mechanical equipment room, to back-feed the existing Kaufman Cancer Center. The existing fire pump and controller will be replaced with a higher-pressure pump, to meet the higher pressure demands at the tops of the standpipes.

Existing site electrical utilities (normal power from BGE) are adequate for the proposed expansion. The natural gas service to the Central Utility Plant will require an upgrade to accommodate the increased load for the new hot water boilers and gas fired humidifiers in the building. As part of this project, UM UCH will be extending a second source of domestic water to the Central Utility Plant from the existing main in MacPhail Road. All other utilities are currently sufficient to service this addition.

The total project budget is $81,789,216. The proposed project and as well as the other capital projects for which UM UCH and its constituent hospitals have sought approval from the Commission will be funded through a combination of $200.0 million in tax exempt bonds and $3.7 million of interest earned on bond proceeds. The bonds are anticipated to be issued in fiscal year 2020 through the University of Maryland Medical System.

Construction of the proposed project is projected to take approximately 18 months but will not open until HMH is converted to a freestanding medical facility which is projected to take place in 2022. UCMC has provided project drawings at **Exhibit 2**. UCMC has also completed hospital CON **Tables A**, **B**, **C**, **D**, **E**, **I, J**, and **K**, which are related to the proposed project, as well as the projected utilization and financial performance of UCMC, inclusive of the UC FMF which becomes a department of UCMC beginning in fiscal year 2022. These tables are included with **Exhibit 1**. **Table I** includes utilization projections that reflect both the inpatient and outpatient utilization of UCMC and outpatient emergency department visits, observation cases, and related outpatient ancillary services at UC FMF. Also enclosed with **Exhibit 1** are **Tables F**, **G**, and **H** that cover the entire utilization and financial performance of all 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. The financial projection assumptions related to revenue, expenses and financial performance underlying **Tables G**, **H**, **J,** and **K** are also provided with **Exhibit 1**.

II. THE RELOCATION OF MSGA BEDS FROM HMH TO UCMC IS NOT INCONSISTENT WITH THE STATE HEALTH PLAN CHAPTER FOR ACUTE HOSPITAL SERVICES.

The relocation of MSGA beds from HMH to UCMC is not inconsistent with the State Health Plan Chapter for Acute Hospital Services, COMAR § 10.24.10.04 (the "State Health Plan"). Because the proposed project only involves the relocation of MSGA beds, the applicants have not addressed State Health Plan Chapters applicable to pediatric and obstetrics beds, emergency department expansion, and other inapplicable sections of the State Health Plan.

A. Information Regarding Charges

UM UCH's policy relating to transparency in health care pricing complies with this COMAR 10.24.10.04(A)(1), and attached as **Exhibit 3**. This policy is currently implemented at both UCMC and HMH.

B. Charity Care Policy

UM UCH's financial assistance policy, implemented at both UCMC and HMH, complies with COMAR 10.24.10.04(A)(2) and is attached as **Exhibit 4**.

C. Quality of Care

UCMC complies with requirements issued by Maryland Department of Health (formerly the Department of Health and Mental Hygiene) for licensure, is accredited by the Joint Commission, and complies and will continue to comply with all conditions of participation in the Medicare and Medicaid programs.

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

UCMC ranked "better than average" or "average" on fifty (50) of the seventy-two (72) quality measures. For an additional eleven (11) quality measures, UCMC did not have sufficient data to report. UCMC ranked "below average" on only eleven (11) quality measures. Table 1

below, identifies those quality measures for which UCMC was ranked "below average" along with UCMC's corrective action plan:

Table 1
Below-Average Quality Measures and Corrective Action

Quality Measure	Corrective Action Plan
COPD- Chronic Obstructive Pulmonary Disease	
Dying within 30-days after getting care in the hospital for chronic obstructive pulmonary disease (COPD).	As a part of UCMC's Patient and Family Centered Care Oversight Council, a multi-disciplinary COPD Workgroup has been created to focus on transitions of care. There are various scopes of work being implemented by the workgroup. The development of new pathway and order sets are in progress to reduce clinical variation in the COPD management. In addition, UCMC is working to increase patient education through video and pulmonary consults as needed.
Communication	
How often did doctors always communicate well with patients?	UCMC's Patient Experience Plan includes several strategies to improve physician communication including: language of caring education, direct observations of physician interactions with patients, and structured bedside rounding with physicians and nurses to communicate each patient's plan of care and to answer patient questions.
Were patients always given information about what to do during their recovery at home?	UCMC's Patient Experience Committee as well as the Transition of Care Committee work plans include revision of patient discharge educational materials and the implementation of a new interactive patient engagement system to include patient specific education plans, patient portal registration, and an extensive library of education videos.
Environment	
How often was patients' pain always well-controlled?	UM UCH's Pain Management Steering Committee work plan includes several strategies for improving pain management including pain medication reassessment monitoring, RN education, designated pain management RN specialist and palliative care

Quality Measure	Corrective Action Plan
	program. UCMC has also included pain assessment during hourly care rounds and shift hand-off communication.
How often was the area around patients' rooms always kept quiet at night?	UCMC is implementing several strategies to reduce noise including noise stoplights at nurses station to increase staff awareness of noise levels, reducing noise from delivery carts by changing cart wheels, reducing deliveries during night hours ,and implementing "quiet times" at designated times to promote uninterrupted rest.
Wait Times	
How long patients spent in the emergency department before being sent home? How long patients spent in the emergency department before they were seen by a healthcare professional?	In furtherance of UM UCH's fiscal year 2019 strategic objective for efficient care, a process improvement team has been charged to review Emergency Department ("ED") throughput and efficiency. Specifically, the work group will utilize the organization's IMPRV methodology to improve the ED's average length of stay and the times from "door to doctor." Executive oversight for this initiative will be driven through the Patient & Family Centered Care Oversight Committee and performance improvements will be monitored through a system-wide scorecard.
Heart Attack and Chest Pain	
Patients with heart attack who received aspirin on arrival to the hospital.	UCMC is actively developing a plan to ensure that all patients with heart attack receive aspirin on arrival to the hospital.
Practice Patterns	
Patients who came to the hospital for a scan of their brain and also got a scan of their sinuses.	During FY18, three new CT scanners were installed within UCH (2 at UCMC and one at HMH). All three new scanners have the newest software and X-ray tube technology assuring low dose CT scans. A dose monitoring software, Radimetrics, was also purchased to monitor patient exposures during the CT scans allowing UCH to benchmark and watch for any outliers or trends with dose. During calendar year 2018, January through October measuring period, zero patients underwent CT of the sinus when ordered for a CT of the brain.
Results of Care - Death	

Quality Measure	Corrective Action Plan
How often patients die in the hospital after bleeding from stomach or intestines.	All-cause mortality is an area of focus on UCMC's fiscal year 2019 Operating Plan. It also constitutes 15% of its Quality Based Reimbursement. A multidisciplinary project team has been deployed to determine both clinical interventions and documentation optimization to better understand the root causes driving any below average performance In addition, under the Safety domain, potentially preventable complications are being tracked, evaluated, and preventive efforts focused on opportunities for improvement.
How often patients die in the hospital after fractured hip.	UM UCH implemented a Geriatric Hip Fracture Program in April 2017. The primary focus of the program is to improve clinical care for acute hip fractures seen at UM UCMC and UM HMH. Following implementation of the program, there has been a decreases in average length of stay, time from admission to surgery, 30 day readmission rates, and 1 year all-cause mortality. In addition, the Geriatric Hip Fracture program has implemented a process to identify patients with an increased risk of a large bone fracture to provide preventative care coordination.

D. Identification of Bed Need and Addition of Beds

The State Health Plan provides that MSGA beds may be developed or put into operation only if, among other things, the "proposed additional beds exceed the minimum jurisdictional bed need projection but do not exceed the maximum jurisdictional bed need projection adopted by the Commission and calculated using the bed need projection methodology in Regulation .05 of this Chapter and the applicant can demonstrate need at the applicant hospital for bed capacity that exceeds the minimum jurisdictional bed need projection." COMAR 10.24.10.04(B)(2).

As an initial matter, COMAR 10.24.10.04(B)(2) is not applicable to the proposed project because the beds that the applicants proposes to relocate are already developed and have been

put into operation. Nevertheless, the applicants demonstrate compliance with standard as set forth below.

On January 20, 2017, the MHCC published the most recent MSGA bed need projection by jurisdiction in the Maryland Register (Vol. 44, Issue 2, pp. 160-162). Table 2 shows the MSGA projections for Harford County.

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

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

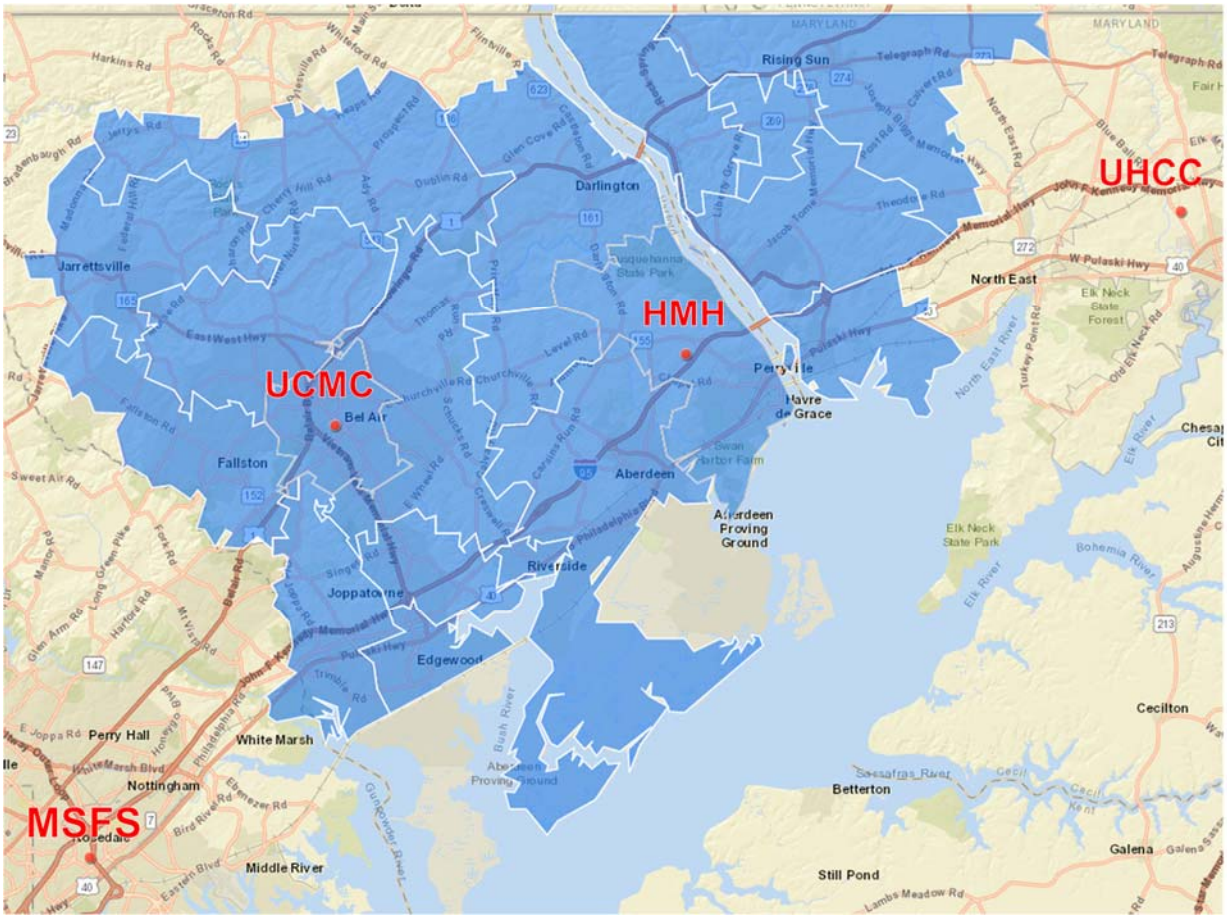
Jurisdiction	Gross Bed Need		Licensed and Approved Beds	2025 Net Bed Need	
	Minimum	Maximum		Minimum	Maximum
Harford	168	223	218	-50	5

The proposed project will result in 182 MSGA beds in Harford County which includes 165 general MSGA beds and 17 intensive care ("ICU") beds. The applicants used the following methodology and assumptions to project the need for these beds at UCMC.

1. Defining UCMC's MSGA Service Area

To identify the MSGA service area for UCMC that also serves MSGA patients currently treated at HMH, the applicants combined fiscal year 2017 UCMC and HMH discharges by zip code for all ages. To determine the zip codes to be included in the service area, the applicants identified the zip codes that comprised the top 85% of UCMC's and HMH's combined MSGA discharges.

Figure 1
UCMC and HMH Combined MSGA Service Area
FY2017



As presented in the Figure 1 above and Table 3 below, the proposed service area for all MSGA discharges is defined by eighteen (18) zip codes that span Harford and Cecil Counties. Zip codes are ranked from those with the highest to lowest combined discharges between UCMC and HMH to identify the top 85% of total discharges.

Table 3
UCMC / HMH MSGA Service Area (All Ages) Zip Codes and Discharges
FY2017

#	Zip Code	Community	County	2017 MSGA Discharges UCMC	HMH	Total	Cumulative % of Discharges
1	21014	Bel Air	Harford County	1,604	50	1,654	12.6%
2	21001	Aberdeen	Harford County	630	971	1,601	24.7%
3	21078	Havre De Grace	Harford County	346	771	1,117	33.2%
4	21040	Edgewood	Harford County	996	81	1,077	41.4%
5	21009	Abingdon	Harford County	975	43	1,018	49.1%
6	21015	Bel Air	Harford County	919	33	952	56.3%
7	21050	Forest Hill	Harford County	634	30	664	61.4%
8	21085	Joppa	Harford County	600	17	617	66.1%
9	21047	Fallston	Harford County	402	5	407	69.1%
10	21904	Port Deposit	Cecil County	87	224	311	71.5%
11	21903	Perryville	Cecil County	75	214	289	73.7%
12	21154	Street	Harford County	256	23	279	75.8%
13	21084	Jarrettsville	Harford County	262	9	271	77.9%
14	21034	Darlington	Harford County	171	36	207	79.5%
15	21918	Conowingo	Cecil County	106	100	206	81.0%
16	21017	Belcamp	Harford County	165	30	195	82.5%
17	21911	Rising Sun	Cecil County	83	92	175	83.8%
18	21028	Churchville	Harford County	113	35	148	85.0%
		Subtotal 2017 Service Area		**8,424**	**2,764**	**11,188**	
		Out of Service Area		1,533	449	1,982	15.0%
		Total MSGA Discharges		9,957	3,213	13,170	100.0%

Source: St. Paul's Inpatient Abstract Data Tapes

2. Projected MSGA Service Area Population

For the zip codes included in UCMC's projected future service area, population projections through 2021 were obtained from Nielsen Claritas for the 0-14, 15-64, 65-74 and 75+ age cohorts. These are presented below in Table 4. The 0-14 age cohort is expected to decrease from 2016 to 2021, while the 15-64 age cohort is expected to remain constant. Over the same period only the 65-74 and 75+ age cohorts are expected to grow 24.2% and 15.1%, respectively. In total, the projected population is expected to grow by 2.4% between 2016 and 2021.

Table 4
UCMC / HMH Historical and Projected MSGA Service Area Population
2010 – 2021

	Service Area Population						% Change in Population	
	2010		2016		2021			
Age Cohort	Pop	% of Total	Pop	% of Total	Pop	% of Total	2010-16	2016-21
75+	14,064	5.4%	16,600	6.2%	19,106	7.0%	18.0%	15.1%
65-74	18,302	7.0%	25,306	9.5%	31,437	11.5%	38.3%	24.2%
15-64	175,504	67.4%	177,315	66.4%	177,380	64.8%	1.0%	0.0%
0-14	52,689	20.2%	47,910	17.9%	45,679	16.7%	-9.1%	-4.7%
Total	260,559	100.0%	267,131	100.0%	273,601	100.0%	2.5%	2.4%

Source: Nielsen Claritas Pop-Facts Demographics by Age Race Sex

Using the compounded annual growth rates from 2016 to 2021, as set forth in Table 4, population projections were extrapolated through 2024 and applied to UCMC's fiscal years. Table 5 below depicts the projected population for each age cohort. Led by the population over age 65, the total population is expected to grow by 3.8% from fiscal year 2017 to fiscal year 2024.

Table 5
UCMC / HMH Estimated and Projected MSGA Service Area Population
FY2015 – FY
2024

	Historical			Projection							% Change
Age Cohort	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
0-14	48,675	47,910	47,455	47,005	46,559	46,116	45,679	45,245	44,815	44,390	*-6.5%*
%Change	*-1.6%*	*-1.6%*	*-0.9%*	*-0.9%*	*-0.9%*	*-0.9%*	*-0.9%*	*-0.9%*	*-0.9%*	*-0.9%*	
15-64	177,012	177,315	177,328	177,341	177,354	177,367	177,380	177,392	177,405	177,418	*0.1%*
%Change	*0.2%*	*0.2%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	
65-74	23,975	25,306	26,428	27,600	28,824	30,102	31,437	32,831	34,287	35,807	*35.5%*
%Change	*5.5%*	*5.5%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	*4.4%*	
75+	16,148	16,600	17,073	17,560	18,061	18,576	19,106	19,651	20,211	20,787	*21.8%*
%Change	*2.8%*	*2.8%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	*2.9%*	
Total Service Area	265,810	267,131	268,285	269,506	270,797	272,161	273,601	275,119	276,719	278,403	*3.8%*
%Change	0.5%	*0.5%*	*0.4%*	*0.5%*	*0.5%*	*0.5%*	*0.5%*	*0.6%*	*0.6%*	*0.6%*	

3. MSGA Use Rates

Table 6 depicts the total use rate of MSGA discharges per 1,000 population in the combined UCMC / HMH defined service area in fiscal years 2015 through 2017. The total MSGA use rate of 73.9 discharges per 1,000 population in fiscal year 2017 is the same as the aggregate use rate for all age cohorts that was experienced in fiscal year 2015. While the use rates for the under age 65 and 75 and over age cohorts declined, the aggregate use rate remained the same due to a slight increase in the use rate for the 65-74 age cohort which experienced the greatest increase in population (Table 6).

Table 6
UCMC / HMH Historical MSGA Service Area Total Use Rate
FY2015 – FY2016

	Historical		
	FY2015	FY2016	FY2017
MSGA Use Rates			
Age 0-14	**13.7**	**13.2**	**13.0**
%Change	*-17.1%*	*-3.4%*	*-1.6%*
Age 15-64	**51.1**	**51.3**	**51.2**
%Change	*-10.3%*	*0.4%*	*-0.2%*
Age 65-74	**180.9**	**174.5**	**175.3**
%Change	*-6.4%*	*-3.6%*	*0.4%*
Age 75+	**347.2**	**338.2**	**322.0**
%Change	*-3.6%*	*-2.6%*	*-4.8%*
Total	**73.9**	**74.0**	**73.9**
%Change	*-6.5%*	*0.1%*	*-0.1%*

While the aggregate use rates from fiscal year 2015 to 2017 remained relatively constant, UCMC and HMH experienced reductions in inpatient discharges from fiscal year 2017 to 2018. This decline in discharges which is calculated as a 4.6% reduction in use rates reflects deliberate reductions in potentially avoidable utilization ("PAU") by UCMC and HMH, as well as shifts of

inpatients to the lowest cost setting of care. This reduction is reflected in an increase in observation patients at UCMC and HMH in fiscal year 2019.

After the initiatives to reduce discharges in fiscal year 2018, UCMC and HMH expect that use rates will level off at the age cohort level. However, due to the aging of the population and to an increase in age cohorts with higher use rates, the aggregate use rate is expected to increase by 1.3% to 1.4% a year in fiscal year 2019 through 2024 with the exception of fiscal year 2022. With the shift of observation patients from HMH to UC FMF in fiscal year 2022, it is expected that, based on historical utilization, approximately 700 patients that stay greater than 48 hours will be transferred to UCMC. Approximately one-half of those transfers will be admitted as inpatients at UCMC. These admissions of observation patients will increase the discharge use rate in the service area by an additional 1.5%.

As presented in Table 7, the discharge use rates for the combined UCMC / HMH service area are expected to decline by age cohort, but with the aging of the population to age cohorts with higher use rates, the aggregate use rate is expected to increase 5.1% from fiscal year 2017 to 2024.

Table 7
UCMC / HMH Historical and Projected MSGA Use Rate
FY2015 - FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
MSGA Use Rates											
Age 0-14	**13.7**	**13.2**	**13.0**	**12.7**	**12.7**	**12.7**	**12.7**	**12.8**	**12.8**	**12.8**	
% Change	*-17.1%*	*-3.4%*	*-1.6%*	*-2.4%*	*0.0%*	*0.0%*	*0.0%*	*0.5%*	*0.0%*	*0.0%*	*-1.9%*
Age 15-64	**51.1**	**51.3**	**51.2**	**48.5**	**48.5**	**48.5**	**48.5**	**49.1**	**49.1**	**49.1**	
% Change	*-10.3%*	*0.4%*	*-0.2%*	*-5.2%*	*0.0%*	*0.0%*	*0.0%*	*1.3%*	*0.0%*	*0.0%*	*-4.0%*
Age 65-74	**180.9**	**174.5**	**175.3**	**164.5**	**164.5**	**164.5**	**164.5**	**167.1**	**167.1**	**167.1**	
% Change	*-6.4%*	*-3.6%*	*0.4%*	*-6.2%*	*0.0%*	*0.0%*	*0.0%*	*1.6%*	*0.0%*	*0.0%*	*-4.6%*
Age 75+	**347.2**	**338.2**	**322.0**	**299.2**	**299.2**	**299.2**	**299.2**	**304.9**	**304.9**	**304.9**	
% Change	*-3.6%*	*-2.6%*	*-4.8%*	*-7.1%*	*0.0%*	*0.0%*	*0.0%*	*1.9%*	*0.0%*	*0.0%*	*-5.3%*
Total	**73.9**	**74.0**	**73.9**	**70.5**	**71.4**	**72.4**	**73.4**	**75.5**	**76.6**	**77.6**	
% Change	*-6.5%*	*0.1%*	*-0.1%*	*-4.6%*	*1.3%*	*1.3%*	*1.4%*	*2.9%*	*1.4%*	*1.4%*	*5.1%*

4. MSGA Service Area Discharges

Combined with population growth, the total projected MSGA service area discharges are projected to increase 9.0% between fiscal year 2017 and fiscal year 2024 as presented below (Table 8).

Table 8
UCMC / HMH Historical and Projected MSGA Service Area Discharges
FY2015 - FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Service Area Discharges	**19,650**	**19,758**	**19,821**	**18,994**	**19,341**	**19,700**	**20,073**	**20,775**	**21,184**	**21,609**	*9.0%*
%Change	*-6.1%*	*0.5%*	*0.3%*	*-4.2%*	*1.8%*	*1.9%*	*1.9%*	*3.5%*	*2.0%*	*2.0%*	

5. UCMC MSGA Market Share

When HMH is projected to convert to a freestanding medical facility and cease inpatient services in fiscal year 2022, its acute inpatient services will necessarily shift to other local providers based on a drive time analysis that was conducted by service line. The applicants anticipate, though, that all of HMH's surgical cases will be retained within UM UCH for the following reasons: (1) community medical staff referral patterns are not anticipated to change based upon change in facility location; (2) all surgical providers currently operating at HMH have privileges at UCMC; and (3) surgical providers currently performing cases at HMH have expressed the intent to move such cases to UCMC. A majority of the operating surgical providers at HMH are employed by UM UCH and, therefore, the shift of surgical practice locations to other hospitals is not anticipated. In addition, UM UCH and the applicants are not anticipating a change in the primary care provider base other than the primary care recruitment that UM UCH is leading in conjunction with community and employed primary care providers.

As a result of the foregoing, the applicant projects that 74.4% of HMH's acute medical and surgical cases will shift to UCMC and 25.6% will shift to other facilities (Table 9).

Table 9
Shift of HMH MSGA Discharges
FY2022

HMH MSGA Discharges	Projected FY2022	% of HMH Discharges
Medical Discharges	3,009	86.2%
Surgical Discharges	481	13.8%
HMH MSGA Discharges	3,490	100.0%
Transfer to UCMC	(2,595)	-74.4%
Transfer to UHCC	(762)	-21.8%
Transfer to Other Hospitals	(132)	-3.8%
Transfer of HMH MSGA Discharges	(3,490)	-100%

UCMC's MSGA market share of 44.2% in fiscal year 2017 is the same as was experienced in fiscal year 2015. UCMC did experience a reduction, though, in service area market share in fscal year 2018 with the reduction in PAUs and shift of inpatient services to the outpatient setting. UCMC assumes that market share will then remain constant at the age cohort level, but will increase slightly each year, in aggregate, through fiscal year 2021 with the aging of the population into age cohorts with greater market share. In fiscal year 2022, UCMC's market share is projected to increase 27.8% with the shift of cases from HMH and admission of observation patients transferred from the UC FMF. (Table 10).

Table 10
UCMC's Historical and Projected MSGA Market Share
FY2015 - FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
UCMC Market Share	**44.2%**	**44.9%**	**44.2%**	**41.7%**	**41.8%**	**41.9%**	**42.0%**	**53.8%**	**53.9%**	**54.0%**	
%Change	*-2.0%*	*1.4%*	*-1.5%*	*-5.7%*	*0.3%*	*0.3%*	*0.3%*	*27.8%*	*0.2%*	*0.2%*	*22.1%*

a) UCMC Out-of-Service Area MSGA Discharges

UCMC's out-of-service area MSGA discharges are projected to equal 17.4% of its in-service area discharges as experienced in fiscal year 2017 (Table 11).

Table 11
UCMC's Historical and Projected Out-of-Service Area MSGA Discharges
% of Service Area Discharges
FY2015 – FY2024

	Historical			Projection						
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Out-of-Service Area Discharges	16.0%	16.8%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%	17.4%

6. UCMC Inpatient MSGA Discharges

Based on the assumptions listed above, UCMC's MSGA discharges are projected to increase from fiscal year 2017 to fiscal year 2024 by 33.2% (Table 12).

Table 12
UCMC's Historical and Projected Inpatient MSGA Discharges
FY2015 – FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Inpatient Discharges											
UCMC	**9,682**	**9,990**	**9,957**	**9,011**	**9,208**	**9,412**	**9,624**	**12,694**	**12,976**	**13,267**	
%Change		*3.2%*	*-0.3%*	*-9.5%*	*2.2%*	*2.2%*	*2.2%*	*31.9%*	*2.2%*	*2.2%*	*33.2%*

7. MSGA Average Length of Stay (ALOS)

The average length of stay for MSGA patients at UCMC is expected to remain constant at 4.0 days based on UCMC's 2017 actual experience even with the shift of observation cases with stays greater than 48 hours to the inpatient setting (Table 13).

Table 13
UCMC's Historical and Projected ALOS
FY2015 – FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
ALOS - MSGA	**4.4**	**4.1**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	**4.0**	
%Change		*-6.8%*	*-2.4%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*

8. MSGA Occupancy

The expected occupancy of inpatient MSGA beds at UCMC reflects the State Health Plan for hospitals with an average daily census of 100-299 patients as follows (Table 14).

Table 14
UCMC MSGA Projected Bed Occupancy

	Projected Occupancy
UCMC - MSGA	80%

9. MSGA Bed Need

Based on the assumptions presented above, the applicant projects a need for 182 inpatient MSGA and one pediatric bed at UCMC in fiscal year 2024 (Table 15). The pediatric bed is included in the MSGA bed need in Table 15.

Table 15
UCMC's Historical and Projected MSGA Bed Need
FY2015 – FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
MSGA Bed Need	**146**	**141**	**136**	**124**	**127**	**130**	**133**	**175**	**179**	**183**	*34.6%*
%Change		*-3.4%*	*-3.5%*	*-8.8%*	*2.4%*	*2.4%*	*2.3%*	*31.6%*	*2.3%*	*2.2%*	

Based on UCMC's allocation of MSGA patient days in fiscal year 2017, the fiscal year 2024 projected MSGA beds at UCMC are split between 165 general MSGA and 17 ICU beds as well as one (1) pediatric bed as presented in Table 16.

Table 16
UCMC's Historical and Projected MSGA Bed Need
FY2015 – FY2024

UCMC
MSGA Bed Need
FY2015 - FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
MSGA Bed Need											
General MSGA	**131**	**126**	**121**	**109**	**112**	**115**	**118**	**157**	**161**	**165**	*36.4%*
ICU/CCU	**14**	**14**	**14**	**14**	**14**	**14**	**14**	**17**	**17**	**17**	*21.4%*
Pediatric	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	**1**	*0.0%*
Total	**146**	**141**	**136**	**124**	**127**	**130**	**133**	**175**	**179**	**183**	*34.6%*
%Change		*-3.4%*	*-3.5%*	*-8.8%*	*2.4%*	*2.4%*	*2.3%*	*31.6%*	*2.3%*	*2.2%*	

10. Observation Cases

In addition to the need for MSGA beds, UCH also evaluated the demand for observation beds. The number of observation cases at UCMC increased 10.6% from fiscal year 2015 to 2017 (Table 17).

Table 17
UCMC Historical Observation Cases
FY2015 – FY2017

	Historical			% Change
	FY2015	FY2016	FY2017	FY15-FY17
Observation Cases				
UCMC	**10,963**	**11,409**	**12,127**	*10.6%*
%Change		*4.1%*	*6.3%*	

Consistent with the reduction in discharges related to inpatient PAUs and a shift of inpatient services to the outpatient setting, the volume of observation cases at UCMC in fiscal year 2018 increased an additional 14.9%. This observation utilization is expected to grow with population in fiscal year 2019 through 2021 offset partially by an assumed 0.25% annual reduction for observation PAUs. In fiscal year 2022, with the shift of observation patients from

HMH to UC FMF, it is expected that, based on historical utilization, approximately 700 patients that stay greater than 48 hours will be transferred to UCMC. Approximately one-half of those transfers will become observation patients at UCMC. This addition results in a 3.0% increase in cases in fiscal year 2022 followed by population increases in fiscal years 2023 and 2024. Between fiscal year 2017 and 2024, the observation cases at UCMC are expected to increase 21.4% (Table 18).

Table 18
UCMC's Historical and Projected Observation Cases
FY2015 – FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Observation Cases	**10,963**	**11,409**	**12,127**	**13,930**	**13,985**	**14,043**	**14,106**	**14,523**	**14,618**	**14,717**	
%Change		*4.1%*	*6.3%*	*14.9%*	*0.4%*	*0.4%*	*0.4%*	*3.0%*	*0.7%*	*0.7%*	*21.4%*

11. Observation Average Length of Stay

Determining the average length of stay to apply to the observation patients at UCMC before and after the construction projects requires an understanding of the observation hours that can be billed and those hours that are not billed. Per the HSCRC Experience Report dataset, UCMC reported 332,191 observation hours in fiscal year 2018. Included in these hours are 61,276 hours related to observation patients that were eventually admitted as inpatients and 270,915 hours for patients that remained in outpatient status their entire stay. According to billing requirements for those patients that were eventually admitted, only those observation hours that occurred prior to 12:00 am of the day of admission can be billed. This billing requirement severely limits the number of incurred observation hours that are actually reported.

During the 12 months ended August 2018, it was determined that UCMC billed 408,805 hours, a 23% increase over the hours billed during the twelve months ended June 2018 (fiscal

year 2018). In addition, there were 82,808 hours that were not billed due to their occurrence on the day of admission. Rather than staying in a bed an average of 1.0 day as reported, observation patients are actually staying in beds an equivalent of 1.4 days (Table 19).

Table 19
UCMC's 2018 Observation ALOS

	2018		
	Inpatient	Outpatient	Total
FY2018 HSCRC Experience Report			
Cases	5,113	8,817	13,930
Hours	**61,276**	**270,915**	**332,191**
ALOS (Days)	0.5	1.3	1.0
UCHS Internal Report on Observiation Hours for 12 Months Ended August 2018			
Cases	5,408	8,768	14,176
Hours			
Billed	75,740	333,065	408,805
Unbilled	82,808	-	82,808
Total	**158,548**	**333,065**	**491,613**
Unbilled % of Total	*52.2%*	*0.0%*	*16.8%*
ALOS (Days)	1.2	1.6	1.4

Observation and medical patients will continue to overlap in the existing beds until distinct observation units are opened in fiscal year 2022. As such, it would be double counting to consider the full length of stay as an observation patient along with counting inpatient days when often times the patients stay in the same bed. When the dedicated observation units are opened, though in fiscal year 2022, the full length of stay needs to be considered when determining the required number of observation beds. Table 20 presents a continuation of the 1.0 day length of stay through fiscal year 2021, but then increases in fiscal year 2022 to 1.5 days

which also takes into account the addition of observation cases with longer lengths of stay that will be transferred from the UC FMF beginning in fiscal year 2022.

Table 20
UCMC's Historical and Projected Observation ALOS
FY2015 – FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
ALOS - Observation	**1.0**	**1.1**	**1.1**	**1.0**	**1.0**	**1.0**	**1.0**	**1.5**	**1.5**	**1.5**	*36.4%*
%Change		*10.0%*	*0.0%*	*-9.1%*	*0.0%*	*0.0%*	*0.0%*	*50.0%*	*0.0%*	*0.0%*	

12. Observation Bed Need

The applicants used the State Health Plan occupancy rate of 80% to project the number of observation beds at UCMC. Based on the assumptions presented above, there is a projected need for 77 observation beds at UCMC in fiscal year 2024 to accommodate the full stay of observation patients in a dedicated unit (Table 21).

Table 21
UCMC's Historical and Projected Observation Bed Need
FY2015 – FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Observation Bed Need	**38**	**42**	**46**	**48**	**48**	**48**	**48**	**76**	**76**	**77**	*67.4%*
%Change		*10.5%*	*9.5%*	*4.3%*	*0.0%*	*0.0%*	*0.0%*	*58.3%*	*0.0%*	*1.3%*	

13. Total Inpatient Discharges and Observation Cases

Combining MSGA discharges with observation cases, the total number of patients occupying beds at UCMC is expected to increase 26.7% between fiscal years 2017 and 2024, with almost 28,000 patients occupying beds in fiscal year 2024 (Table 22).

Table 22
UCMC Historical and Projected MSGA Discharges and Observation Cases
FY2015 – FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
IP Discharges + Observation Cases											
UCMC - Inpatient MSGA	**9,682**	**9,990**	**9,957**	**9,011**	**9,208**	**9,412**	**9,624**	**12,694**	**12,976**	**13,267**	*33.2%*
%Change		*3.2%*	*-0.3%*	*-9.5%*	*2.2%*	*2.2%*	*2.2%*	*31.9%*	*2.2%*	*2.2%*	
UCMC - Observation	**10,963**	**11,409**	**12,127**	**13,930**	**13,985**	**14,043**	**14,106**	**14,523**	**14,618**	**14,717**	*21.4%*
%Change		*4.1%*	*6.3%*	*14.9%*	*0.4%*	*0.4%*	*0.4%*	*3.0%*	*0.7%*	*0.7%*	
Total	**20,645**	**21,399**	**22,084**	**22,941**	**23,193**	**23,456**	**23,729**	**27,218**	**27,594**	**27,984**	*26.7%*
%Change		*3.7%*	*3.2%*	*3.9%*	*1.1%*	*1.1%*	*1.2%*	*14.7%*	*1.4%*	*1.4%*	

These patients are projected to need a total of 182 MSGA beds, 77 observation beds, and one (1) pediatric bed for a total of 260 beds in fiscal year 2024 (Table 23). The single pediatric bed is included in the MSGA Bed Need in Table 23.

Table 23
UCMC's Historical and Projected Bed Need
FY2015 – FY2024

	Historical			Projection							% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY17-FY24
Bed Need											
MSGA Bed Need	**146**	**141**	**136**	**124**	**127**	**130**	**133**	**175**	**179**	**183**	*34.6%*
%Change		*-3.4%*	*-3.5%*	*-8.8%*	*2.4%*	*2.4%*	*2.3%*	*31.6%*	*2.3%*	*2.2%*	
Observation Bed Need	**38**	**42**	**46**	**48**	**48**	**48**	**48**	**76**	**76**	**77**	*67.4%*
%Change		*10.5%*	*9.5%*	*4.3%*	*0.0%*	*0.0%*	*0.0%*	*58.3%*	*0.0%*	*1.3%*	
Total	**184**	**183**	**182**	**172**	**175**	**178**	**181**	**251**	**255**	**260**	*42.9%*

The applicant has, demonstrated need for the relocation of beds from HMH to UCMC.

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

The State Health plan provides that a capital project undertaken by a hospital shall not have an unwarranted adverse impact on hospital charges, availability of services, or access to services.

The proposed project will not have an adverse impact on hospital charges, availability of services, or access to services. On the contrary, if the proposed project is not approved and HMH converts to a freestanding medical facility, there will be a lack of MSGA beds and observation bed capacity in Harford County to meet the projected needs of UCMC's projected service area, thereby erecting an access barrier to acute inpatient and hospital observation services. Instead, pursuant to the merger and consolidation of UCMC and HMH, UM UCH has requested that the HSCRC approve a proposed Global Budget Revenue ("GBR") Plan that will provide for a revenue base to support UCH's plans for the proposed expansion at UCMC as well as the construction of a special psychiatric hospital and freestanding medical facility at UC Medical Campus at Aberdeen. UM UCH is requesting that the HSCRC work with UM UCH to develop and implement a new GBR Plan that redistributes and redeploys revenue among UM UCH's rate-regulated components, including UCMC, the freestanding medical facility, and the special psychiatric hospital. The redeployment of UM UCH's GBR revenue can largely pay for the financing costs of the proposed expansion at UCMC as well as the new special psychiatric hospital and freestanding medical facility. By taking this approach, the HSCRC and associated parties can avoid adding additional revenue to UM UCH and by extension to the State's health care system.

E. The Proposed Project is the Most Cost-Effective Alternative to Continue to Provide Needed Acute Inpatient Services to the Residents of Harford County – COMAR 10.24.10.04(B)(5).

Before deciding on the proposed project, UCMC evaluated and studied various options to expand inpatient capacity on its campus. Ultimately, the proposed project was determined to be the most cost-effective alternative.

1. Option One – A Two Floor Vertical Expansion of the Cancer Center

The Kaufman Cancer Center was designed for 3 stories of vertical expansion. The floorplate (26,000 BGSF) is capable of supporting up to 21 semi-patient rooms with private en suite toilet/shower rooms. A 2-story expansion would provide up to 84 semi-private rooms.

Essential components of this option include replacing 2 existing chillers, 3 existing cooling towers and 2 existing boilers with larger units, replacing the existing fire pump, and a new emergency power feeder from the central plant as well as renovations to include a Fire Command Center to accommodate the new designation as a high-rise building.

The Kaufman Cancer Center, moreover, is the most recent addition to the UCMC campus and is most likely to meet current seismic codes. It was also planned to become a high-rise and, therefore, the conversion accommodations are already in place. Structural stub-ups exist and rooftop mechanical equipment is disposable and was planned to be replaced.

1A. The Proposed Project - Option One-A – A Three Floor Vertical Expansion of the Cancer Center

Option 1.A., the proposed project, included a 3-story expansion above the Kaufman Cancer Center, with one floor constructed as shell space in addition to the patient rooms described in Option 1 above.

2. Option Two - Renovation of Levels 3 and 4 of the Ambulatory Care Center (ACC)

The Ambulatory Care Center ("ACC") was built in 1998 and was not designed for vertical expansion, but is connected to the main hospital and has a floorplate (24,000 BGSF) capable of supporting up to 30 single-patient rooms with private en-suite toilet/shower rooms (approximately 300 square feet each). A two-level renovation project would provide up to 60

private patient rooms. Additional floors could be renovated in the future if additional beds are needed.

Essential components of this alternative include construction of a new medical office building ("MOB") to accommodate the existing tenants on the 3rd and 4th floors of the ACC, conversion of plenum air return system to ducted system, new sanitary risers, new medical gas risers, and new emergency power feeder from the central plant.

Additional potential (recommended) components of this option include renovations to the existing structure to provide a second patient/service elevator and relocation of an electrical/data room to maximize the number of inpatient rooms.

3. Option Three - One floor vertical expansion of the Main Hospital towers and the ED/bed tower addition to the east

UCMC's main hospital bed towers were constructed in 1998 and the emergency department/bed tower addition, constructed in 2005, were each designed for one story of vertical expansion and the floorplate of the two combined, 47,000 building gross square feet, is capable of supporting up to 60 single-patient rooms with private en suite toilet/shower rooms (approximately 250 square feet each).

Essential components of this option include relocation of 3 penthouses, structural re-analysis for seismic compliance with current building codes, phased construction (including temporary air handling units with resulting increases in construction duration), replacing 1 chiller and 2 cooling towers with larger units, replacing the existing fire pump to meet the high-rise code, a new emergency power feeder from the central plant, and replacement of all rooftop fans, lightning protection, etc.

4. Option Four - One floor vertical expansion of main hospital bed towers

The main hospital bed towers constructed in 1998 were designed for one story of vertical expansion and have a 38,000 building gross square foot floorplate capable of supporting up to 44 single-patient rooms with private en suite toilet/shower rooms (approximately 250 square feet each).

Essential components of this alternative include relocation of 3 penthouses, structural re-analysis for seismic compliance with current building codes, phased construction (including temporary air handling units with resulting increases in construction duration), replacing 1 chiller and 2 cooling towers with larger units, replacing the existing fire pump to meet the high-rise code, new emergency power feeder from the central plant, and replacement of all rooftop fans, lightning protection, etc.

5. Option Five - One floor vertical expansion of the main hospital diagnostic and treatment core.

UCMC's main hospital diagnostic and treatment core was built in 1998 and designed for one story of vertical expansion. It has a floorplate for expansion of 24,600 building gross square feet and is capable of supporting up to 30 single-patient rooms with private en-suite toilet/shower rooms (approximately 300 square feet each).

Essential components of this alternative include renovation of existing Level 1 space to provide two new stairs, relocation of surgical air handler and MRI chillers, structural re-analysis for seismic compliance with current building codes, new sanitary piping in ceilings of surgery suite, removal and relocation of three existing air handling units, phased construction (including temporary air handling units with resulting increases in construction duration), replacing one

chiller and two cooling towers with larger units, new emergency power feeder from the central plant, and replacement of all rooftop fans, lightning protection, etc.

6. Analysis of Options

Upon review of the costs and benefits of the available options, Option 1A provides the most viable and cost-effective solution. Option 1A provides the optimal number of beds to meet the projected need – seventy-seven total observation beds– at the optimal patient room size and at the lowest cost per bed. Option 1A also provides efficient and effective flexibility for future expansion of either inpatient needs or oncology diagnostic and treatment services. In addition to the benefits listed above, Option 1A provides adequate space to expand a number of the semi-private rooms to serve as semi-private observation rooms in a manner that is cost effective, space efficient, and focused on patient and staff safety.

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

The State Health provides that a hospital project shall be approved only if there is a demonstrable need. UCMC and HMH have established need for the relocation of MSGA beds from HMH to UCMC and creation of a dedicated observation unit at UCMC. *See* Section II.D above.

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

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

Marshall Valuation Service
Valuation Benchmark

Type	Hospital

Construction Quality/Class		Good/A
Stories		6
Perimeter		492
Average Floor to Floor Height		16.8
Square Feet		85,591
f.1	Average floor Area	14,265
A. Base Costs		
	Basic Structure	$365.78
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$365.78
Adjustment for Departmental Differential Cost Factors		0.89
Adjusted Total Base Cost		$324.37
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00
Subtotal		$0.00
Total		$324.37
C. Multipliers		
Perimeter Multiplier		0.934990213
	Product	$303.28
Height Multiplier		1.11
	Product	$336.91
Multi-story Multiplier		1.010
	Product	$340.28
D. Sprinklers		
	Sprinkler Amount	$3.01
Subtotal		$343.29

E. Update/Location Multipliers

Update Multiplier	1.07
Product	$367.32
Location Multiplier	1.01
Product	$370.99
Calculated Square Foot Cost Standard	**$370.99**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Med / Surg Patient Unit Level 5	26,290	Inpatient Unit	1.06	27,867
Observation Unit Level 4	26,290	Inpatient Unit	1.06	27,867
Food Service & EVS Expansion	5,697	Inpatient Unit	1.06	6,039
Shell Space Level 3	26,290	Unassigned Space	0.5	13,145
Existing Cancer Center	1,024	Outpatient Department	0.96	983
TOTAL	85,591		0.88679487	75,902

Cost of New Construction

A. Base Calculations	Actual	Per Sq. Foot
Building	$36,829,575	$430.30
Fixed Equipment	$0	$0.00
Site Preparation	$234,705	$2.74
Architectural Fees	$4,628,765	$54.08
Permits	$2,204,173	$25.75
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$43,897,218	$512.87

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

B. Extraordinary Cost Adjustments

	Project Costs		Associated Cap Interest & Financing
Complexity Premium	$3,682,957	Building	$693,954
Demolition	$1,085,820	Building	$204,593
2/5 HVAC System	$3,055,552	Building	$575,736
OVHD Bridges	$2,535,000	Building	$477,652
Pneumatic tube	$466,440	Building	$87,888
Signage	$132,454	Building	$24,957
Elevator Premium	$870,349	Building	$163,994
Premium for Minority Business Enterprise Requirement	$1,473,183	Building	$277,581
Premium for Minority Business Enterprise Requirement	$9,388	Site	
Total Cost Adjustments	$13,311,143		$2,506,356

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since only Capitalized Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using the Canopy as an example: (Cost of the Canopy/Building Cost) X (Building related Capitalized Interest and Loan Placement Fees).

1. Explanation of Extraordinary Costs

Below are the explanations of the Extraordinary Costs that are not specifically mentioned as not being in contained in the MVS average costs in the MVS Guide (at Section 1, Page 3) but

that are specific to this project and would not be in the average cost of a hospital project.

1. Complexity Premium - The complexity and necessary logistics of the project has a profound impact on the cost of construction. The project is bordered by a major road artery within 30 feet of the building footprint on the west, a road artery within 50 feet of the south elevation which is also the sole access point to the building's parking garage. On the north elevation, there is a direct attachment to the hospital and no setback from the main and sole loading dock and Central Utility Plant on the east elevation. These constraints require extraordinary methods of construction, safety, access for patients, guests and employees that will ultimately reduce construction productivity. The limited access requires a specialized tower crane that will be interior to the existing building, extreme measures to provide safe access of patients, guests and employee in to and around the building site. The limited area around the building requires off-site staging and material storage which add logistic costs from the remote staging area and scheduling demands for delivery of materials to the construction site. The tower crane as the sole source of delivery of materials into the project along with an exterior elevator system for construction staff to reach the upper floors limit material and manpower into and out of the construction floors 3, 4 and 5.

The construction activity will occur immediately above the Cancer Center and immediately adjacent to the Main Hospital, specifically three (3) floors of in-patient rooms to the east and two floors of outpatient Cancer patients directly below the construction site. These constraints require additional consideration for noise, safety and the general need to maintain ongoing operations and respect our patient experience.

2. 2/5 HVAC System - With the elimination of the existing rooftop units new services must now be provided by the Central Utility Plant (CUP) and on the roof of the new expansion

for the existing two floors plus the additional three floors. The combined total demand required for this five (5) story building requires relocation of existing chillers to accommodate the installation of new two (2) chillers, replacement of the existing Cooling Tower which is not expandable to meet the current demand, replacement of one (1) boiler of our existing three (3) boilers to provide the required redundancy, the replacement of the existing fire pump and an increase in the sprinkler supply lines for the additional water flow requirements and finally the addition of a Fire Command Center because the addition of the three floors classifies the building as "High Rise". In essence, we are providing new mechanical systems for 2/5 of the ultimate build-out of the five story building and additional support services required by the NFPA.

3. OVHD Bridges - This expansion requires the construction of two enclosed access bridges to the main hospital that will connect on existing Main Hospital patient floors two and three. These connections require modifications to the main hospital at the connection points. For efficiency, the design contemplates shared structural components gained with a stacked design. Adding to the complex logistics of this project, this connector bridge construction will occur adjacent to occupied patient units and above the busy hospital loading dock.

4. Pneumatic tube - The hospitals existing pneumatic tube system will be extended to the new facility and will utilize the bridge connection to connect to the new floors.

5. Elevator Premium - The construction of new elevator systems and the extension of the existing elevator shafts to the new floors will impact patient access and will require overnight construction activity so as not to impact the Cancer Center outpatient experience during normal business hours. Only the premium over the anticipated MVS cost is included as an Extraordinary Cost. This was calculated as follows:

Elevator Cost in Budget			$1,234,038
MVS Costs			
$106,000	per Elevator	2 Elevators	$212,000
$8,600	per Stop	16 Stops	$137,600
	Subtotal:		$349,600
	Location Multiplier		1.01
			$353,096
	Update Multiplier		1.07
	Final MVS Cost		$363,689
Premium			$870,349

6. Premium for Minority Business Enterprise Requirement – UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was conservatively projected to be 4%. UMMS consulted with its cost estimators/construction managers on the impact on project budgets of targeting 25% inclusion of MBE subcontractors or suppliers as part of its projects, and their conservative estimate is that it adds 3-4% to the costs, compared to projects that do not include MBE subcontractors or suppliers. This estimate has been confirmed through UMMS' experience with past construction jobs. UMMS now uses this percentage in all of its construction cost estimates.

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

C. Adjusted Project Cost		**Per Square Foot**
Building	$23,527,819	$274.89
Fixed Equipment	$0	$0.00
Site Preparation	$225,317	$2.63
Architectural Fees	$4,628,765	$54.08
Permits	$2,204,173	$25.75
Subtotal	$30,586,074	$357.35
Capitalized Construction Interest	$3,315,885	$34.91

Total	$33,901,960	$356.95

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

Hospital	New	Renovation	Total		
Building Cost	$36,829,575				
Subtotal Cost (w/o Cap Interest)	$43,897,218		$43,897,218		
Subtotal/Total	100.0%	0.0%	Net Interest	Financing	Total
Total Project Cap Interest &Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$6,939,537	$0	$6,335,348	$604,189	$6,939,537
Building/Subtotal	83.9%				
Building Cap Interest & Financing	$5,822,241				
Associated with Extraordinary Costs	$2,506,356				
Applicable Cap Interest & Loan Place.	$3,315,885				

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

MVS Benchmark	$370.99
The Project	$356.95
Difference	-$14.04
	-3.78%

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

The State Health Plan requires that space built for inpatient nursing units that exceeds reasonable space standards per bed for the type of unit being developed shall not be recognized in a rate adjustment. Additionally, the State Health Plan provides that if the inpatient unit program space per bed of a new or modified inpatient nursing unit exceeds 500 square feet per bed, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost for the space that exceeds the per bed

square footage limitation or those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess space.

As explained above, UCMC proposes to house all MSGA beds to be transferred from HMH through existing physical bed capacity that is presently used for both inpatients and observation patients. No new construction is contemplated at UCMC to house the MSGA beds transferred from HMH.

I. The Proposed Project is Designed to Allow UCMC to Operate Efficiently – COMAR 10.24.10.04(B)(11).

The relocation of MSGA beds from HMH to UCMC does not require replacement or expansion of any diagnostic or treatment facilities on its campus. However, there is a need to expand non-clinical support services such as with dietary, environmental, and security services.

Additionally, as described above, a key component of the proposed project is the establishment of two dedicated observation units at UCMC. The relocation of MSGA beds from HMH to UCMC will allow UCMC to more effectively distribute patients who are in an observation status to the two dedicated observation units. Currently, with the exception of a 10 bed CDU, UCMC has its observation patient population scattered throughout all of its medical surgical units. This geographic dispersion of observation patients does not support optimum patient management as it relates to focused attention on timely diagnostic treatment. However, a clinical practice model that incorporates a dedicated observation unit provides a setting for focused attention to lower acuity patients from admission to the observation unit through discharge, thereby minimizing unnecessary testing and ultimately reducing lengths of stay. By establishing a dedicated observation unit clinical model, with the appropriate staffing matrix to

support short lengths of stay and therefore rapid turnover of patients on the unit, UCMC expects that the enhanced efficiencies will ultimately support enhanced clinical outcomes as well as positively impact overall patient experience.

The following summary provides an overview of the clinical, safety, and efficiency factors supporting UCMC's plans for a dedicated observation unit, including enhanced security benefits, enhanced room design to support high quality clinical practice (i.e. medication administration delivery system), and enhanced the patient and family experience:

- Infection Prevention & Control:
  - Provision of individual toilets and showers reduces the incidence of infections
  - Physical separation within the semi-private rooms to enhance infection prevention
- Fall Prevention:
  - Due to the configuration of the rooms staff can see the entire patient room from entry
  - Space design supports area for family attendance providing added support to the patient who may be at risk for falls
  - Room design provides for a clear path of travel within the room reducing obstacles likely to cause falls
  - Bathrooms are configured in close proximity to the head wall decreasing distance patient needs to ambulate to the bathroom reducing likelihood of falls
  - Room design includes continuous handrails from the head of the bed to the toilet room reducing the likelihood of falls
  - Toilets and showers were designed to minimize fall risk
- Operational Efficiencies:
  - Clear path of travel within the room for efficient patient transfers and transports
  - Design allows for adequate space at each patient zone for mobile lift equipment when needed
  - Design allows staff visibility of the entire room
- Patient Care/Clinical practice enhancements:
  - Standardized head wall provides clear individual patient zone
  - Design provides a physical, visual, and auditory separation between patients enhancing clinical practice (medication zones)

- Patient & Family Experience:
  - The design of the zoned semi-private rooms provides a physical, visual and auditory separation between patients enhancing the individual patient/family experience.
  - Room design allows for a patient's significant other to stay in a recliner chair during their short stay providing additional support the patient may need thereby enhancing their short stay observation experience.

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

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

The design of the proposed project took patient safety into consideration and includes design features, including a dedicate observation unit, that will enhance and improve patient safety. See the applicants' response to COMAR 10.24.10.04(B)(11) above.

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

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

As presented in Table 24, UCMC is projected to generate positive operating income in each year of the projection period. With limited additional overhead costs added to UCMC with the expansion of its facilities, the addition of beds will have a positive financial contribution to the hospital beginning in fiscal year 2022.

Table 24
UCMC Historic and Projected Operating Income
FY2015 – FY2024

UCMC + UC FMF
Financial Performance
FY2017 - FY2024

	Historical		Projection ($ in millions)					
	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Revenue	**$ 300.8**	**$ 306.9**	**$ 280.7**	**$ 282.7**	**$ 290.2**	**$ 368.6**	**$ 379.3**	**$ 390.3**
Expenses	**284.2**	**272.3**	**248.5**	**255.5**	**260.0**	**343.5**	**351.6**	**360.8**
Operating Income	**$ 16.6**	**$ 34.6**	**$ 32.1**	**$ 27.2**	**$ 30.2**	**$ 25.0**	**$ 27.6**	**$ 29.4**

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

The State Health Plan requires that unfinished hospital shell space for which there is no immediate need or use shall not be built unless the applicant can demonstrate that construction of the shell space is cost effective. Shell space being constructed on lower floors of a building addition that supports finished building space on upper floors does not require a net present value analysis. Applicants must provide information on the cost, the most likely uses, and the likely time frame for using such shell space. Finally, the State Health Plan provides that the cost of shell space included in an approved project and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the construction cost of the shell space will be excluded from consideration in any rate adjustment by the HSCRC.

The proposed project includes construction of 26,290 square feet of shell space on the third floor of the proposed addition above the Kaufman Cancer Center. The shell space on this floor will support finished building space on upper floors. The estimated cost of constructing the shell space as part of this proposed project is $3,170,406 and will accommodate growth for the

Kaufman Cancer Center's diagnostic and treatment services and/or additional future inpatient needs within the next three years.

Providing this shell floor directly above the Kaufman Cancer Center will allow for future expansion with limited impact to the daily operations of the Kaufman Cancer Center including mitigation of construction noise, leaks, and HVAC outages. If the shell space was not constructed during this planned expansion and UCMC required to construct an additional floor in the near future, the following impacts would be anticipated:

- Relocation of mechanical equipment would be needed;
- Replacement of roof screens would be needed;
- A new crane location would be needed due to inability to use the existing shaft; As an alternative, the loading dock would need to be used for a new crane location which would require a temporary location of hospital's loading dock;
- Another replacement roof would be needed;
- Disruption of occupied space would impact end users in inpatient units;
- There would be an extended schedule for fit out for the developed space that would be subject to existing patient census;
- New air handling units would be needed as UCMC could not shut down existing air handling units to add another floor; and
- A detrimental impact on everyday hospital operations and patient/visitor experience.

The addition of shell space now is reasonable to limit disruption of the Kaufman Cancer Center's operations, to allow for future expansion, and is cost effective.

III. THE RELOCATION OF MSGA BEDS FROM HMH TO UCMC WILL RESULT IN THE DELIVERY OF MORE EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES.

Finally, UM UCH and the applicants have determined that the relocation of HMH's MSGA beds to UCMC will result in more efficient and effective services. The establishment of a dedicated observation unit will not only improve the efficiency of the care for patients with short stays, it will improve operational efficiencies overall within the system. As previously noted, observation stay patients are dispersed across all MSGA units and patients are frequently

transferred between beds and between different nursing units, in order to accommodate the needs of the acute, inpatient medical surgical patient population. It is anticipated that the level of patient transfers between units and patient rooms would be significantly reduced with the implementation of a dedicated observation unit. Reducing patient transfer activity will directly impact operational and staffing efficiencies within the nursing, ancillary, and support services teams. Centralizing observation patients on one dedicated unit will also allow for the centralization of the inpatient acute care patient population appropriately on the medical surgical units. This model of care will support optimal staffing patterns, allowing for all staff to function at their highest, appropriate level.

Moreover, the project will achieve cost efficiencies over the long term. As is the case with many aging hospitals that were built over the span of several decades, HMH is not constructed to current best practices and energy codes. The cost, timing, and disruption to ongoing healthcare operation, compounded by numerous physical constraints make the replacement of the facility a more cost effective alternative. The following is a partial list of mechanical, electrical, and plumbing infrastructure inefficiencies at HMH that will be remediated by the relocation of acute MSGA inpatient services from HMH to UCMC under the proposed project:

a) HMH's building envelope was not constructed to meet current R-values required by code. (Roof insulation, wall insulation, below grade foundation insulation, single pane windows). The proposed project will allow for required insulation R-values in the roof, walls and ceiling, with exterior glazing to be low E with double pane glazing.
b) HMH has inefficient hospital boilers, while the proposed project will have higher efficiency units.
c) HMH currently uses water cooled cooling towers whereas the proposed project will use air cooled chillers.

d) HMH uses two-pipe heating and cooling systems while the proposed project will include a system that more accurately provides desired patient care temperatures.

e) HMH has a dedicated split system cooling and other condensing units that provide cool air without monitoring, whereas the proposed project will utilize centralized cooling systems that can be more accurately programmed and monitored for usage.

f) HMH's plumbing fixtures are outdated and the proposed project will have lower flow heads and fixtures that require less consumption of water.

g) HMH has inefficient lighting fixtures and ballasts while the proposed project will use higher efficiency fluorescent fixtures and/or LED fixtures.

h) HMH's light fixtures are currently on timers or manual switches but the proposed project will have modern occupancy sensors that turn lights off when spaces sit idle.

For all of the reasons above, the proposed project satisfies this standard.

IV. THE RELOCATION OF MSGA BEDS FROM HMH TO UCMC IS IN THE PUBLIC INTEREST.

The proposed project is part of UM UCH's vision to create an optimal integrated health delivery system for the residents it services by providing care for patients in the right setting at the right time, at the lowest cost. The geographic proximity of Harford and Cecil Counties provide opportunities for a regionally integrated care network which facilitates coordination of healthcare throughout the services areas of the combined health systems. Ultimately, it is the goal of UCH to enhance the care delivery model by building contemporary state-of-the-art facilities which not only addresses the recognized needs for acute inpatient and behavioral health needs within its community, but which also offer services that continue to deliver consistent high quality patient outcomes and maximizes financial, operational and provider efficiencies.

The major goals of a regionally integrated care network include:

- Clinical and program development and Population Health collaboration;
- Facilitated coordination of healthcare throughout the services areas of the existing health systems and hospitals;
- When appropriate shared, physician recruitment activities; and

- Programs to improve administrative efficiency, including, but not limited to, cost efficiency and cost savings.

Key aspects to the regionally integrated care network plan include the transition of HMH from an acute care general hospital to a freestanding medical facility. Following this conversion, there will be a reduction in MSGA beds in Harford County, which will require the proposed expansion of UCMC. As noted above, the Commission projects a minimum need for 168 MSGA beds in Harford County in 2025 and a maximum bed need of 223. Maryland Register v. 44, Issue 2 (Jan. 20, 2017). UCMC is presently licensed for only 138 MSGA beds. Accordingly, upon conversion of HMH to a freestanding medical facility, Harford County will have fewer MSGA beds that the Commission's projected need. The proposed project ensures that the residents of UCH's service area will have continued access to acute hospital services which is clearly in the public interest.

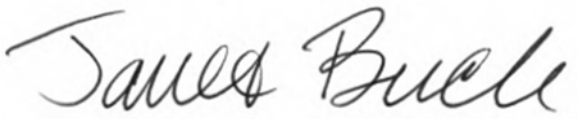
In addition to HMH's inpatient medical surgical beds, its inpatient psychiatric beds will also be transitioned to a new special psychiatric hospital located at UC Medical Campus at Aberdeen. These inpatient psychiatric services will be aligned with a robust array of outpatient behavioral health services. This regional approach to the delivery of health care services provides greater access to health care services with improved geographic distribution across the two counties.

The proposed project is, therefore, is in the public interest.

CONCLUSION

For all of the reasons set forth above, HMH and UCMC respectfully request that the Commission authorize the relocation of MSGA beds from HMH to UCMC and associated capital expenditures pursuant to a merger and consolidation of these two acute general hospitals.

Respectfully submitted,



James C. Buck
Gallagher, Evelius & Jones LLP
218 N. Charles Street, Suite 400
Baltimore, Maryland 21201

Counsel for UM Upper Chesapeake Medical Center, Inc. and UM Harford Memorial Hospital, Inc.

November 21, 2018

Table of Exhibits

Exhibit / Description
1. MHCC Tables
2. Project drawings
3. Policy Regarding Charges
4. Financial Assistance Policy

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Table 4	UCMC / HMH Historical and Projected MSGA Service Area Population 2010 – 2021
Table 5	UCMC / HMH Estimated and Projected MSGA Service Area Population FY2015 – FY 2024
Table 6	UCMC / HMH Historical MSGA Service Area Total Use Rate FY2015 – FY2016
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Table 10	UCMC's Historical and Projected MSGA Market Share FY2015 - FY2024
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Table 12	UCMC's Historical and Projected Inpatient MSGA Discharges FY2015 – FY2024
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Table 15	UCMC's Historical and Projected MSGA Bed Need FY2015 – FY2024
Table 16	UCMC's Historical and Projected MSGA Bed Need FY2015 – FY2024
Table 17	UCMC Historical Observation Cases FY2015 – FY2017
Table 18	UCMC's Historical and Projected Observation Cases FY2015 – FY2024
Table 19	UCMC's 2018 Observation ALOS
Table 20	UCMC's Historical and Projected Observation ALOS FY2015 – FY2024
Table 21	UCMC's Historical and Projected Observation Bed Need FY2015 – FY2024
Table 22	UCMC Historical and Projected MSGA Discharges and Observation Cases FY2015 – FY2024
Table 23	UCMC's Historical and Projected Bed Need FY2015 – FY2024
Table 24	UCMC Historic and Projected Operating Income FY2015 – FY2024

Table of Figures

Figure	Description
Figure 1	UCMC and HMH Combined MSGA Service Area FY2017

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.

November 19, 2018
Date

Lyle E. Sheldon
President and Chief Executive Officer
University of Maryland Upper
Chesapeake Health System

#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.

November 19, 2018
Date

Stephen Witman
Senior Vice President, Chief Financial Officer
University of Maryland Upper Chesapeake Health System

#646235
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.

November 19, 2018
Date

Robin Luxon
Senior 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.

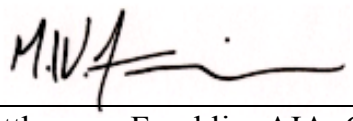
November 19, 2018
Date

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

#600548
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.

November 19, 2018
Date



Matthew w. Franklin, AIA, CDT
Vice President | Project Manager
HKS

#600688
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.

November 19, 2018
Date

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

#600532
011888-0023

EXHIBIT 1

Name of Applicant: _____

Date of Submission: _____

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

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

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

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

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2018	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							ACUTE CARE					
General Medical/ Surgical*	1 West	23	25	1	26	27	General Medical/ Surgical*	1 West	25	1	26	27
	2 West	17	13	8	21	29		2 West	13	8	21	29
	2 East	24	25	0	25	25		2 East	25	0	25	25
	3 West	19	15	8	23	31		3 West	15	8	23	31
	3 East	36	31	8	39	47		3 East	31	8	39	47
	IMC	6	0	3	3	6		1 East	6	0	6	6
SUBTOTAL Gen. Med/Surg*		125	109	28	137	165	SUBTOTAL Gen. Med/Surg*		115	25	140	165
ICU/CCU	2 East	13	14	0	14	14	ICU/CCU	2 East	14	0	14	14
								IMC	3	0	3	3
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA		138	123	28	151	179	TOTAL MSGA		132	25	157	182
Obstetrics	1 East	10	14	0	14	14	Obstetrics	1 East	14	0	14	14
Pediatrics	1 East	1	9	0	9	9	Pediatrics	1 East	3	0	3	3
Psychiatric					0	0	Psychiatric				0	0
TOTAL ACUTE		149	146	28	174	202	TOTAL ACUTE		149	25	174	199
NON-ACUTE CARE							NON-ACUTE CARE					
Dedicated Observation**	CDU***	0	10	0	10	10	Dedicated Observation**	CDU***	0	0	0	0
					0	0		4 West	1	20	21	41
					0	0		5 West	0	18	18	36
Other *(Specify/add rows as needed)*					0	0	Other *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE							TOTAL NON-ACUTE		1	38	39	77
HOSPITAL TOTAL		149	156	28	184	212	HOSPITAL TOTAL		150	63	213	276

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

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

*** The CDU or Clinical Decision Unit is a single room with 10 beds located near the Emergency Department which presently serves as UCMC's dedicated observation unit.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Med / Surg Patient Unit Level 5		26,290			26,290
Observation Unit Level 4		26,290			26,290
Food Service & EVS Expansion		5,697	1,993		7,690
Shell Space Level 3		26,290			26,290
Central Utility Plant			8,300		8,300
Existing Cancer Center		1,024	494		1,518
					0
					0
					0
					0
					0
					0
					0
					0
					0
Total	0	85,591	10,787	0	

TABLE C. CONSTRUCTION CHARACTERISTICS

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

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☑
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☑
Excellent	☐	☐
Number of Stories	3	2

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**85,591**	**10,787**
Ground Floor	5,697	1,993
First Floor	512	494
Second Floor	512	
Third Floor	26,290	
Fourth Floor	26,290	
Fifth Floor	26,290	
Central Utility Plant		8,300
Average Square Feet	**14,265**	**3,596**
Perimeter in Linear Feet	**Linear Feet**	
Ground Floor	436	395
First Floor	94	135
Second Floor	94	
Third Floor	776	
Fourth Floor	776	
Fifth Floor	776	
Central Utility Plant		371
Total Linear Feet	**2,952**	**901**
Average Linear Feet	**492**	**451**
Wall Height (floor to eaves)	**Feet**	
Ground Floor	16	16
First Floor	16	16
Second Floor	16	
Third Floor	16	
Fourth Floor	16	
Fifth Floor	19	
Central Utility Plant		16
Average Wall Height	**16**	**12**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	3	
Freight	2	
Sprinklers	**Square Feet Covered**	
Wet System	85,591	10,787
Dry System		

Other	Describe Type
Type of HVAC System for proposed project	Excellent Grade - Forced Air: VAV / Constant Volume, Digitally Controlled
Type of Exterior Walls for proposed project	Glass Curtain Wall, Brick Veneer, Metal Panels

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$225,317	$0
Utilities from Structure to Lot Line	$0	$0
Subtotal included in Marshall Valuation Costs	**$225,317**	**$0**
Site Demolition Costs	**$0**	**$0**
Storm Drains	**$0**	**$0**
Rough Grading	**$0**	**$0**
Hillside Foundation	**$0**	**$0**
Paving	**$0**	**$0**
Exterior Signs	**$0**	**$0**
Landscaping	$0	$0
Walls	$0	$0
Yard Lighting	$0	$0
Premium for Minority Business Enterprise Requirement	$9,388	$0
Subtotal On-Site excluded from Marshall Valuation Costs	**$9,388**	**$0**
OFFSITE COSTS		
Roads	$0	$0
Utilities	$0	$0
Jurisdictional Hook-up Fees	$0	$0
Other *(Specify/add rows if needed)*	$0	$0
Subtotal Off-Site excluded from Marshall Valuation Costs	**$0**	**$0**
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$9,388**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$234,705**	**$0**
BUILDING COSTS		
Normal Building Costs	$23,527,819	$0
Subtotal included in Marshall Valuation Costs	$23,527,819	$0
Complexity Premium	$3,682,957	
Demolition	$1,085,820	
2/5 HVAC System	$3,055,552	
OVHD Bridges	$2,535,000	
Pneumatic tube	$466,440	
Signage	$132,454	
Elevator Premium	$870,349	
Premium for Minority Business Enterprise Requirement	$1,473,183	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$13,301,755**	**$0**
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$36,829,575**	**$0**
A&E COSTS		
Normal A&E Costs	$4,628,765	
Subtotal included in Marshall Valuation Costs	**$4,628,765**	**$0**
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	**$0**
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$4,628,765**	**$0**
PERMIT COSTS		
Normal Permit Costs	$2,204,173	$0
Subtotal included in Marshall Valuation Costs	**$2,204,173**	**$0**
	$0	$0
	$0	$0
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$0**	**$0**
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$2,204,173**	**$0**

TABLE E. PROJECT BUDGET

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

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

	Hospital Building	Central Plant	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building	$36,829,575	$5,074,711	$41,904,286
(2) Fixed Equipment	$0	$0	$0
(3) Site and Infrastructure	$234,705	$0	$234,705
(4) Architect/Engineering Fees	$4,628,765	$0	$4,628,765
(5) Permits & Inspections (Building, Utilities, Etc.)	$2,204,173	$0	$2,204,173
SUBTOTAL	**$43,897,218**	**$5,074,711**	**$48,971,929**
b. Renovations			
(1) Building	$764,076	$2,093,491	$2,857,567
(2) Fixed Equipment (not included in construction)	$0	$0	$0
(3) Architect/Engineering Fees	$80,228	$219,817	$300,045
(4) Permits (Building, Utilities, Etc.)	$38,204	$104,675	$142,879
SUBTOTAL	**$882,508**	**$2,417,983**	**$3,300,491**
c. Other Capital Costs			
(1) Movable Equipment	$5,197,500	$0	$5,197,500
(2) Owner Contingency Allowance	$2,989,997	$357,722	$3,347,719
(3) Gross interest during construction period	$6,335,348.17	$878,413	$7,213,761
(4) Technology / Information Systems	$2,000,000	$0	$2,000,000
(4) Furniture / Artwork / Signage	$1,340,790	$0	$1,340,790
(4) Food Service Equipment	$300,000	$0	$300,000
(4) Other *(Specify/add rows if needed)*	$0	$0	$0
SUBTOTAL	***$18,163,635***	***$1,236,135***	**$19,399,770**
TOTAL CURRENT CAPITAL COSTS	**$62,943,361**	**$8,728,829**	**$71,672,190**
d. *Land Purchase*			
e. Inflation Allowance	$1,700,281	$234,187	$1,934,467
TOTAL CAPITAL COSTS	**$64,643,641**	**$8,963,016**	**$73,606,657**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees	**$604,189**	**$83,772**	$687,961
b. Bond Discount			$0
c. Legal Fees (CON)	**$110,322**		$110,322
d. Legal Fees (Other)	**$227,508**		$227,508
e. Non-Legal Consultant Fees (CON application related - specify what it is and why it is needed for the CON)	**$884,309**		$884,309
f. Non-Legal Consultant Fees (Other)	**$1,181,081**		$1,181,081
g. Liquidation of Existing Debt			$0
H. Debt Service Reserve Fund	**$4,471,405**	**$619,972**	$5,091,377
i. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$7,478,814***	***$703,745***	**$8,182,559**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$72,122,455***	***$9,666,761***	***$81,789,216***
B. Sources of Funds			
1. Cash			$0
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds	$70,679,541	$9,473,363	$80,152,904
4. Interest Income from bond proceeds listed in #3	$1,442,914	$193,398	$1,636,312
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$72,122,455***	***$9,666,761***	**$81,789,216**
	Hospital Building	***Central Plant***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (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 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES									
a1. General Medical/Surgical* UCMC	9,082	8,974	8,061	8,241	8,427	8,619	11,404	11,660	11,925
a2. General Medical/Surgical* HMH	2,931	3,034	3,021	3,087	3,155	3,226			
a3. Observation UCMC	11,410	12,127	13,930	13,985	14,043	14,106	14,523	14,618	14,717
a4. Observation UC FMF							5,606	5,606	5,606
a5. Observation HMH	3,896	4,019	4,443	4,458	4,474	4,491			
General MSGA & Observation	**27,319**	**28,154**	**29,455**	**29,770**	**30,099**	**30,442**	**31,534**	**31,884**	**32,249**
b1. ICU/CCU UCMC	814	860	842	860	879	899	1,186	1,212	1,240
b2. ICU/CCU HMH	203	179	175	179	183	187			
Total MSGA	**28,336**	**29,193**	**30,472**	**30,809**	**31,161**	**31,528**	**32,720**	**33,097**	**33,488**
c. Pediatric	94	123	108	107	106	105	121	120	119
d. Obstetric	1,381	1,366	1,296	1,299	1,301	1,304	1,307	1,310	1,312
e1. Acute Psychiatric HMH	1,236	1,233	1,195	1,201	1,207	1,213			
e2. Acute Psychiatric UC Behavioral Health							1,367	1,375	1,385
Total Acute	***31,047***	***31,915***	***33,071***	***33,416***	***33,776***	***34,150***	***35,514***	***35,902***	***36,304***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	***31,047***	***31,915***	***33,071***	***33,416***	***33,776***	***34,150***	***35,514***	***35,902***	***36,304***
2. PATIENT DAYS									
a1. General Medical/Surgical* UCMC	37,389	35,932	32,685	33,441	34,226	35,039	46,125	47,215	48,346
a2. General Medical/Surgical* HMH	13,472	13,246	12,318	12,601	12,896	13,201			
a3. Observation UCMC	12,169	13,243	13,841	13,890	13,941	13,996	22,033	22,177	22,327
a4. Observation UC FMF							7,008	7,008	7,008
a5. Observation HMH	4,670	4,813	4,788	4,802	4,818	4,834	-		
General MSGA & Observation	**67,700**	**67,234**	**63,631**	**64,734**	**65,881**	**67,070**	**75,166**	**76,400**	**77,681**
b1. ICU/CCU UCMC	3,600	3,415	3,342	3,419	3,500	3,583	4,708	4,818	4,933
b2. ICU/CCU HMH	1,515	1,496	1,465	1,499	1,534	1,571			
Total MSGA	**72,815**	**72,145**	**68,439**	**69,653**	**70,914**	**72,224**	**79,874**	**81,219**	**82,614**
c. Pediatric	232	335	234	232	245	251	249	246	244
d. Obstetric	2,806	2,776	2,512	2,517	2,522	2,528	2,533	2,538	2,544
e1. Acute Psychiatric HMH	7,502	7,486	7,737	8,138	8,542	8,609			
e2. Acute Psychiatric UC Behavioral Health							11,421	11,574	11,734
Total Acute	***83,355***	***82,741***	***78,922***	***80,541***	***82,224***	***83,612***	***94,076***	***95,578***	***97,135***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	***83,355***	***82,741***	***78,922***	***80,541***	***82,224***	***83,612***	***94,076***	***95,578***	***97,135***

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 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	4.1	4.0	4.1	4.1	4.1	4.1	4.0	4.0	4.1
a2. General Medical/Surgical* HMH	4.6	4.4	4.1	4.1	4.1	4.1			
a3. Observation UCMC	1.1	1.1	1.0	1.0	1.0	1.0	1.5	1.5	1.5
a4. Observation UC FMF							1.25	1.25	1.25
a5. Observation HMH	1.2	1.2	1.1	1.1	1.1	1.1			
General MSGA & Observation	2.5	2.4	2.2	2.2	2.2	2.2	2.4	2.4	2.4
b1. ICU/CCU UCMC	4.4	4.0	4.0	4.0	4.0	4.0	4.0	4.0	4.0
b2. ICU/CCU HMH	7.5	8.4	8.4	8.4	8.4	8.4			
Total MSGA	2.6	2.5	2.2	2.3	2.3	2.3	2.4	2.5	2.5
c. Pediatric	2.5	2.7	2.2	2.2	2.3	2.4	2.1	2.1	2.1
d. Obstetric	2.0	2.0	1.9	1.9	1.9	1.9	1.9	1.9	1.9
e1. Acute Psychiatric HMH	6.1	6.1	6.5	6.8	7.1	7.1			
e2. Acute Psychiatric UC Behavioral Health							8.4	8.4	8.5
Total Acute	2.7	2.6	2.4	2.4	2.4	2.4	2.6	2.7	2.7
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL AVERAGE LENGTH OF STAY	2.7	2.6	2.4	2.4	2.4	2.4	2.6	2.7	2.7
4. NUMBER OF LICENSED BEDS									
a1. General Medical/Surgical* UCMC	128	123	112	114	117	120	158	162	165
a2. General Medical/Surgical* HMH	45	44	41	42	43	44			
a3. Observation UCMC	42	46	48	48	48	48	76	76	77
a4. Observation UC FMF							24	24	24
a5. Observation HMH	16	17	16	16	17	17			
General MSGA & Observation	**231**	**230**	**217**	**221**	**225**	**228**	**258**	**262**	**266**
b1. ICU/CCU UCMC	14	14	14	14	14	14	17	17	17
b2. ICU/CCU HMH	6	6	6	6	6	7			
Total MSGA	**251**	**250**	**237**	**241**	**245**	**249**	**275**	**278**	**283**
c. Pediatric	1	1	1	1	1	1	1	1	1
d. Obstetric	10	10	10	10	10	10	10	10	10
e1. Acute Psychiatric HMH	26	26	26	28	29	29			
e2. Acute Psychiatric UC Behavioral Health							40	40	40
Total Acute	***288***	***287***	***274***	***280***	***285***	***289***	***326***	***329***	***334***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***288***	***287***	***274***	***280***	***285***	***289***	***326***	***329***	***334***

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 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	80.2%	79.8%	80.2%	80.2%	80.1%	80.1%	80.0%	80.1%	80.2%
a2. General Medical/Surgical* HMH	82.0%	82.5%	82.3%	82.2%	82.2%	82.2%			
a3. Observation UCMC	79.4%	78.9%	79.0%	79.3%	79.6%	79.9%	79.4%	79.9%	79.4%
a4. Observation UC FMF							80.0%	80.0%	80.0%
a5. Observation HMH	80.0%	79.9%	80.0%	80.2%	80.0%	79.8%			
General MSGA & Observation	80.4%	80.2%	80.3%	80.4%	80.4%	80.5%	79.9%	80.0%	80.0%
b1. ICU/CCU UCMC	70.5%	66.8%	65.4%	66.9%	68.5%	70.1%	75.9%	80.0%	80.0%
b2. ICU/CCU HMH	69.2%	68.3%	66.9%	68.5%	70.0%	61.5%			
Total MSGA	**79.6%**	**79.1%**	**79.1%**	**79.3%**	**79.5%**	**79.3%**	**79.6%**	**80.0%**	**80.0%**
c. Pediatric	63.6%	91.8%	64.1%	63.6%	67.1%	68.7%	68.1%	67.5%	66.9%
d. Obstetric	76.9%	76.0%	68.8%	69.0%	69.1%	69.3%	69.4%	69.5%	69.7%
e1. Acute Psychiatric HMH	79.1%	78.9%	81.5%	79.6%	80.7%	81.3%			
e2. Acute Psychiatric UC Behavioral Health							78.2%	79.3%	80.4%
Total Acute	**79.4%**	**79.0%**	**78.9%**	**78.9%**	**79.2%**	**79.2%**	**79.1%**	**79.6%**	**79.7%**
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL OCCUPANCY %	**79.4%**	**79.0%**	**78.9%**	**78.9%**	**79.2%**	**79.2%**	**79.1%**	**79.6%**	**79.7%**
6. OUTPATIENT VISITS									
a1. Emergency Department UCMC (Total)	65,251	64,502	61,445	61,812	62,181	62,553	63,041	63,418	63,797
a2. Emergency Department UC FMF (Total)							27,106	27,227	27,348
a3. Emergency Department HMH (Total)	29,520	28,356	26,743	26,862	26,981	27,101			
b1. Same-day Surgery Cases UCMC	5,890	5,678	5,621	5,652	5,685	5,719	5,753	5,791	5,830
b2. Same-day Surgery Cases HMH	1,169	1,210	1,234	1,240	1,246	1,252			
c1. Laboratory RVUs UCMC	11,182,649	12,048,570	11,494,331	10,945,039	11,228,867	11,453,817	14,782,750	15,082,236	15,392,589
c2. Laboratory RVUs HMH	2,803,257	2,695,784	2,487,416	2,554,276	2,599,157	2,645,591			
c3. Laboratory RVUs UC Behavioral Health							1,804,190	1,828,452	1,853,615
d1. Imaging RVUs UCMC	1,772,683	1,905,329	1,809,354	1,722,888	1,767,567	1,802,977	2,326,993	2,374,136	2,422,989
d2. Imaging RVUs HMH	590,035	615,566	582,398	598,053	608,561	619,433			
d3. Imaging RVUs UC Behavioral Health							495,722	502,356	509,234
e. Psych Emergency Department									
f1. Outpatient Psych Clinic HMH	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	1,190	1,443	1,362	1,286	1,214	1,146			
g2. Intensive Outpatient Psych Program UC Behavioral Health							1,593	1,625	1,658
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	***16,456,696***	***17,372,083***	***16,475,662***	***15,924,282***	***16,310,051***	***16,628,300***	***19,517,282***	***19,896,799***	***20,288,744***
7. OBSERVATIONS**									
a1. Number of Patients UCMC	11,410	12,127	13,930	13,985	14,043	14,106	14,523	14,618	14,717
a2. Number of Patients UC FMF							5,606	5,606	5,606
a3. Number of Patients HMH	3,896	4,019	4,443	4,458	4,474	4,491			
b1. Hours UCMC	292,060	317,843	332,191	333,349	334,589	335,915	528,801	532,243	535,846
b2. Hours UC FMF							168,192	168,192	168,192
b3. Hours HMH	112,075	115,522	114,915	115,254	115,620	116,014			

* 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

TABLE G. REVENUES & EXPENSES, UNINFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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

	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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Gross patient services revenue	540,220	558,961	538,479	536,269	537,497	537,055	539,283	541,526
Gross Patient Service Revenues	***$ 540,220***	***$ 558,961***	***$ 538,479***	***$ 536,269***	***$ 537,497***	***$ 537,055***	***$ 539,283***	***$ 541,526***
c. Allowance For Bad Debt	14,027	14,080	14,266	14,200	14,237	13,706	13,773	13,839
d. Contractual Allowance	75,402	85,596	93,732	95,854	96,016	99,960	100,241	100,524
e. Charity Care	14,970	14,471	6,536	6,499	6,516	5,812	5,842	5,872
Net Patient Services Revenue	***$ 435,821***	***$ 444,814***	***$ 423,945***	***$ 419,716***	***$ 420,727***	***$ 417,577***	***$ 419,427***	***$ 421,291***
f. Other Operating Revenues (Specify/add rows if needed)	271	3,093	3,255	2,955	2,955	2,843	2,843	2,843
NET OPERATING REVENUE	***$ 436,092***	***$ 447,908***	***$ 427,200***	***$ 422,671***	***$ 423,682***	***$ 420,420***	***$ 422,271***	***$ 424,134***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 244,970	$ 234,694	$ 246,185	247,564	$ 247,714	$ 243,607	$ 243,542	$ 244,210
b. Contractual Services	13,253	10,071	10,029	10,180	10,328	8,558	8,700	8,840
c. Interest on Current Debt	8,150	9,808	9,523	9,271	8,964	8,643	8,313	8,030
d. Interest on Project Debt	-	-	-	-	-	8,961	8,794	8,619
e. Current Depreciation	22,137	22,922	23,591	22,634	23,518	23,042	23,979	24,980
f. Project Depreciation	-	-	-	-	-	7,438	7,438	7,438
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	83,351	84,045	64,830	66,164	67,476	66,901	67,795	68,717
j. Other Expenses (Specify/add rows if needed)	58,623	65,064	55,238	54,902	52,043	49,875	49,329	48,821
TOTAL OPERATING EXPENSES	***$ 430,484***	***$ 426,605***	***$ 409,396***	***$ 410,714***	***$ 410,043***	***$ 417,024***	***$ 417,890***	***$ 419,655***
3. INCOME								
a. Income From Operation	**$ 5,608**	**$ 21,303**	**$ 17,804**	**$ 11,957**	**$ 13,640**	**$ 3,396**	**$ 4,381**	**$ 4,480**
b. Non-Operating Income	18,640	17,578	10,085	8,487	7,815	9,075	9,513	10,135
SUBTOTAL	***$ 24,248***	***$ 38,881***	***$ 27,889***	***$ 20,443***	***$ 21,455***	***$ 12,471***	***$ 13,893***	***$ 14,615***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 24,248***	***$ 38,881***	***$ 27,889***	***$ 20,443***	***$ 21,455***	***$ 12,471***	***$ 13,893***	***$ 14,615***

TABLE G. REVENUES & EXPENSES, UNINFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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

	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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
Total MSGA								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

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

Projection is based on the Upper Chesapeake Health System FY2019 projected results, including Upper Chesapeake Medical Center, Harford Memorial Hospital, Upper Chesapeake Medical Services, Upper Chesapeake Health System (Parent entity) and several other entities that comprise the majority of UCHS with assumptions identified below.	
Projection period reflects FY2019 – FY2024	
Volumes	- Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- Based on each entity's FY2019 projected operating results. Removed where appropriate
o Demographic and Other Rate Adjustment	- Based on each entity's FY2019 projected operating results.
o Variable Cost Factor	- Based on each entity's FY2019 projected operating results.
• Revenue Deductions	
o Contractual Allowances	- Based on each entity's FY2019 projected operating results.
o Charity Care	- Based on each entity's FY2019 projected operating results.
o Allowance for Bad Debt	- Based on each entity's FY2019 projected operating results.
Other Revenue	- Based on each entity's FY2019 projected operating results.
Expenses	
• Inflation	- 0.0% increase per year
o Salaries and Benefits	- 0.0%
o Professional Fees	- 0.0%
o Supplies	- 0.0%
o Purchased Services	- 0.0%
o Other Operating Expenses	- 0.0%
• Expense Volume Driver	- For the hospital entities, 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	- 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 & Drugs	- 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 departments
• Other Operating Expenses	- Beginning in FY2019 and F2020, 340B savings is assumed at UCMC, however the savings is offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos). - At UCMC beginning in FY2019, a $3.6M performance improvement plan is assumed with an incremental $900k of performance improvement per year assumed throughout the projection period. - At Upper Chesapeake Medical Services (physicians) a $72k performance improvement plan is assumed beginning in FY2019, increasing to a $766k cumulative performance improvement plan by FY2024.
• Interest Expense – Existing Debt	- Continued amortization of existing debt and related interest expense: - 4.75% interest on $55.3M 2008C Series bonds - 4.75% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – New Debt (Project Related)	- 4.5% interest on $200.0M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $183M (less land and debt service reserve fund) of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- Total $146.5M of routine and other (non project related) capital spend over the projection period.

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. GROSS REVENUE								
a. Gross Patient Service Revenues	$ 540,220	$558,961	$ 538,479	$549,140	$563,606	$576,659	$592,947	$609,704
Gross Patient Service Revenues	***540,220***	***$ 558,961***	***$ 538,479***	***$ 549,140***	***$ 563,606***	***$ 576,659***	***$ 592,947***	***$ 609,704***
b. Allowance For Bad Debt	$ 14,027	$ 14,080	$ 14,266	$ 14,541	$ 14,928	$ 14,717	$ 15,143	$ 15,582
c. Contractual Allowance	75,402	85,596	93,732	98,154	100,681	107,331	110,216	113,180
d. Charity Care	14,970	14,471	6,536	6,655	6,833	6,240	6,423	6,611
Net Patient Services Revenue	***435,821***	***$ 444,814***	***$ 423,945***	***$ 429,789***	***$ 441,164***	***$ 448,370***	***$ 461,165***	***$ 474,331***
e. Other Operating Revenues (Specify/add rows if needed)	271	3,093	3,255	2,985	3,014	2,929	2,959	2,988
NET OPERATING REVENUE	***436,092***	***$ 447,908***	***$ 427,200***	***$ 432,774***	***$ 444,179***	***$ 451,299***	***$ 464,124***	***$ 477,320***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 244,970	$ 234,694	$ 246,185	$ 253,258	$ 259,240	$ 260,805	$ 266,732	$ 273,616
b. Contractual Services	13,253	10,071	10,029	10,485	10,957	9,352	9,792	10,248
c. Interest on Current Debt	8,150	9,808	9,523	9,271	8,964	8,643	8,313	8,030
d. Interest on Project Debt						8,961	8,794	8,619
e. Current Depreciation	22,137	22,922	23,591	22,634	23,518	23,042	23,979	24,980
f. Project Depreciation						7,438	7,438	7,438
g. Current Amortization								
h. Project Amortization								
i. Supplies	83,351	84,045	64,830	68,149	71,585	73,104	76,304	79,662
j. Other Expenses (Specify/add rows if needed)	58,623	65,064	55,238	56,000	54,146	52,927	53,395	53,903
TOTAL OPERATING EXPENSES	***$ 430,484***	***$ 426,605***	***$ 409,396***	***$ 419,796***	***$ 428,409***	***$ 444,272***	***$ 454,748***	***$ 466,495***
3. INCOME								
a. Income From Operation	***$ 5,608***	***$ 21,303***	***$ 17,804***	***$ 12,977***	***$ 15,769***	***$ 7,027***	***$ 9,376***	***$ 10,825***
b. Non-Operating Income	18,640	17,578	10,085	8,487	7,815	9,075	9,513	10,135
SUBTOTAL	***$ 24,248***	***$ 38,881***	***$ 27,889***	***$ 21,464***	***$ 23,585***	***$ 16,102***	***$ 18,889***	***$ 20,960***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 24,248***	***$ 38,881***	***$ 27,889***	***$ 21,464***	***$ 23,585***	***$ 16,102***	***$ 18,889***	***$ 20,960***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

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

Projection is based on the Upper Chesapeake Health System FY2019 projected results, including Upper Chesapeake Medical Center, Harford Memorial Hospital, Upper Chesapeake Medical Services, Upper Chesapeake Health System (Parent entity) and several other entities that comprise the majority of UCHS with assumptions identified below.

Projection period reflects FY2020 – FY2024

Volumes	- Refer to CON Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- Based on each entity's FY2019 projected operating results.
o Demographic and Other Rate Adjustment	- Based on each entity's FY2019 projected operating results.
o Variable Cost Factor	- Based on each entity's FY2019 projected operating results.
• Revenue Deductions	
o Contractual Allowances	- Based on each entity's FY2019 projected operating results.
o Charity Care	- Based on each entity's FY2019 projected operating results.
o Allowance for Bad Debt	- Based on each entity's FY2019 projected operating results.
Other Revenue	
Other Revenue	- Based on each entity's FY2019 projected operating results.
Expenses	
• Inflation	
o Salaries and Benefits	- 2.3%
o Professional Fees	- 3.0%
o Supplies	- 3.0%
o Purchased Services	- 3.0%
o Other Operating Expenses	- 2.0%
• Expense Volume Driver	- For the hospital entities, 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	- 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 & Drugs	- 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 departments
• Other Operating Expenses	- Beginning in FY2019 and F2020, 340B savings is assumed at UCMC, however the savings is offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos). - At UCMC beginning in FY2019, a $3.6M performance improvement plan is assumed with an incremental $900k of performance improvement per year assumed throughout the projection period. - At Upper Chesapeake Medical Services (physicians) a $72k performance improvement plan is assumed beginning in FY2019, increasing to a $766k cumulative performance improvement plan by FY2024.
• Interest Expense – Existing Debt	- Continued amortization of existing debt and related interest expense: - 4.75% interest on $55.3M 2008C Series bonds - 4.75% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt	- 4.5% interest on $200.0M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $183M (less land and debt service reserve fund) of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- Total $146.5M of routine and other (non project related) capital spend over the projection period.

TABLE I. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + FMF & 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 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES									
a1. General Medical/Surgical*	9,082	8,974	8,061	8,241	8,427	8,619	11,404	11,660	11,925
a2. Observation UCMC	11,410	12,127	13,930	13,985	14,043	14,106	14,523	14,618	14,717
a3. Observation UC FMF	-	-	-	-	-	-	5,606	5,606	5,606
General MSGA & Observation	**20,492**	**21,101**	**21,991**	**22,225**	**22,470**	**22,725**	**31,534**	**31,884**	**32,249**
b. ICU/CCU	814	860	842	860	879	899	1,186	1,212	1,240
Total MSGA	**21,306**	**21,961**	**22,833**	**23,086**	**23,349**	**23,624**	**32,720**	**33,097**	**33,488**
c. Pediatric	94	123	108	107	106	105	121	120	119
d. Obstetric	1,381	1,366	1,296	1,299	1,301	1,304	1,307	1,310	1,312
e. Acute Psychiatric									
Total Acute	***22,781***	***23,450***	***24,237***	***24,492***	***24,757***	***25,034***	***34,148***	***34,526***	***34,919***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	***22,781***	***23,450***	***24,237***	***24,492***	***24,757***	***25,034***	***34,148***	***34,526***	***34,919***
2. PATIENT DAYS									
a1. General Medical/Surgical*	37,389	35,932	32,685	33,441	34,226	35,039	46,125	47,215	48,346
a2. Observation UCMC	12,169	13,243	13,841	13,890	13,941	13,996	22,033	22,177	22,327
a3. Observation UC FMF	-	-	-	-	-	-	7,008	7,008	7,008
General MSGA & Observation	**49,558**	**49,175**	**46,526**	**47,331**	**48,167**	**49,035**	**75,166**	**76,400**	**77,681**
b. ICU/CCU	3,600	3,415	3,342	3,506	3,500	3,583	4,708	4,818	4,933
Total MSGA	**53,158**	**52,590**	**49,868**	**50,837**	**51,666**	**52,618**	**79,874**	**81,219**	**82,614**
c. Pediatric	232	335	234	232	245	251	249	246	244
d. Obstetric	2,806	2,776	2,512	2,517	2,522	2,528	2,533	2,538	2,544
e. Acute Psychiatric									
Total Acute	***56,196***	***55,701***	***52,614***	***53,587***	***54,434***	***55,396***	***82,656***	***84,004***	***85,401***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	***56,196***	***55,701***	***52,614***	***53,587***	***54,434***	***55,396***	***82,656***	***84,004***	***85,401***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a1. General Medical/Surgical*	4.1	4.0	4.1	4.1	4.1	4.1	4.0	4.0	4.1
a2. Observation UCMC	1.1	1.1	1.0	1.0	1.0	1.0	1.5	1.5	1.5
a3. Observation UC FMF	-	-	-	-	-	-	1.3	1.3	1.3
General MSGA & Observation	2.4	2.3	2.1	2.1	2.1	2.2	2.4	2.4	2.4
b. ICU/CCU	4.4	4.0	4.0	4.1	4.0	4.0	4.0	4.0	4.0
Total MSGA	2.5	2.4	2.2	2.2	2.2	2.2	2.4	2.5	2.5
c. Pediatric	2.5	2.7	2.2	2.2	2.3	2.4	2.1	2.1	2.1
d. Obstetric	2.0	2.0	1.9	1.9	1.9	1.9	1.9	1.9	1.9
e. Acute Psychiatric									
Total Acute	2.5	2.4	2.2	2.2	2.2	2.2	2.4	2.4	2.4
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL AVERAGE LENGTH OF STAY	2.5	2.4	2.2	2.2	2.2	2.2	2.4	2.4	2.4
4. NUMBER OF LICENSED BEDS									
a1. General Medical/Surgical*	128	123	112	114	117	120	158	162	165
a2. Observation UCMC	42	46	48	48	48	48	76	76	77
a3. Observation UC FMF	-	-	-	-	-	-	24	24	24
General MSGA & Observation	**170**	**169**	**160**	**162**	**165**	**168**	**258**	**262**	**266**

TABLE I. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + FMF & 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 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
b. ICU/CCU	14	14	14	14	14	14	17	17	17
Total MSGA	**184**	**183**	**174**	**176**	**179**	**182**	**275**	**278**	**283**
c. Pediatric	1	1	1	1	1	1	1	1	1
d. Obstetric	10	10	10	10	10	10	10	10	10
e. Acute Psychiatric									
Total Acute	***195***	***194***	***185***	***187***	***190***	***193***	***286***	***289***	***294***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***195***	***194***	***185***	***187***	***190***	***193***	***286***	***289***	***294***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE: Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a1. General Medical/Surgical*	80.2%	79.8%	80.2%	80.4%	80.1%	80.1%	80.0%	80.1%	80.2%
a2. Observation UCMC	79.4%	78.9%	79.0%	79.3%	79.6%	79.9%	79.4%	79.9%	79.4%
a3. Observation UC FMF	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	80.0%	80.0%	80.0%
General MSGA & Observation	80.0%	79.6%	79.9%	80.0%	80.0%	80.1%	79.9%	80.0%	80.0%
b. ICU/CCU	70.5%	66.8%	65.4%	68.6%	68.5%	70.1%	75.9%	80.0%	80.0%
Total MSGA	**79.3%**	**78.6%**	**78.7%**	**79.1%**	**79.1%**	**79.3%**	**79.6%**	**80.0%**	**80.0%**
c. Pediatric	63.6%	91.8%	64.1%	63.6%	67.1%	68.7%	68.1%	67.5%	66.9%
d. Obstetric	76.9%	76.0%	68.8%	69.0%	69.1%	69.3%	69.4%	69.5%	69.7%
e. Acute Psychiatric									
Total Acute	**79.1%**	**78.5%**	**78.1%**	**78.5%**	**78.5%**	**78.7%**	**79.2%**	**79.6%**	**79.6%**
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL OCCUPANCY %	**79.1%**	**78.5%**	**78.1%**	**78.5%**	**78.5%**	**78.7%**	**79.2%**	**79.6%**	**79.6%**
6. OUTPATIENT VISITS									
a1. Emergency Department UCMC (Total)	65,251	64,502	61,445	61,812	62,181	62,553	63,041	63,418	63,797
a2. Emergency Department UC FMF (Total)	-	-	-	-	-	-	27,106	27,227	27,348
b. Same-day Surgery Cases	5,890	5,678	5,621	5,652	5,685	5,719	5,753	5,791	5,830
c. Laboratory RVUs	11,182,649	12,048,570	11,494,331	10,945,039	11,228,867	11,453,817	14,782,750	15,082,236	15,392,589
d. Imaging RVUs	1,772,683	1,905,329	1,809,354	1,722,888	1,767,567	1,802,977	2,326,993	2,374,136	2,422,989
e. Other (Specify/add rows of needed)									
TOTAL OUTPATIENT VISITS	***13,026,473***	***14,024,078***	***13,370,751***	***12,735,391***	***13,064,300***	***13,325,066***	***17,205,644***	***17,552,808***	***17,912,552***
7. OBSERVATIONS**									
a1. Number of Patients UCMC	11,410	12,127	13,930	13,985	14,043	14,106	14,523	14,618	14,717
a2. Number of Patients UC FMF	-	-	-	-	-	-	5,606	5,606	5,606
b1. Hours UCMC	292,060	317,843	332,191	333,349	334,589	335,915	528,801	532,243	535,846
b2. Hours UC FMF	-	-	-	-	-	-	168,192	168,192	168,192

* 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 H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 138,399	$ 137,865	$ 135,067	$ 133,824	$ 134,703	$ 167,930	$ 169,461	$ 171,006
b. Outpatient Services	203,683	213,836	186,794	187,026	188,261	237,667	239,819	241,990
Gross Patient Service Revenues	***$ 342,082***	***$ 351,701***	***$ 321,861***	***$ 320,850***	***$ 322,964***	***$ 405,597***	***$ 409,280***	***$ 412,997***
c. Allowance For Bad Debt	9,525	9,336	8,889	8,861	8,919	12,910	13,026	13,144
d. Contractual Allowance	24,266	27,429	31,478	33,689	33,911	43,642	44,038	44,437
e. Charity Care	11,457	11,807	5,150	5,134	5,167	5,880	5,934	5,988
Net Patient Services Revenue	***$ 296,834***	***$ 303,129***	***$ 276,344***	***$ 273,167***	***$ 274,967***	***$ 343,165***	***$ 346,282***	***$ 349,427***
f. Other Operating Revenues (Specify/add rows if needed)	3,937	3,725	4,327	3,988	3,948	4,128	4,088	4,048
NET OPERATING REVENUE	***$ 300,771***	***$ 306,854***	***$ 280,671***	***$ 277,154***	***$ 278,915***	***$ 347,293***	***$ 350,370***	***$ 353,475***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 140,964	$ 123,635	$ 128,391	$ 129,760	$ 129,975	$ 165,228	$ 165,349	$ 166,154
b. Contractual Services	10,016	10,588	10,932	10,932	10,932	12,542	12,542	12,542
c. Interest on Current Debt	6,901	8,816	8,404	8,182	7,911	8,201	7,888	7,619
d. Interest on Project Debt	-	-	-	-	-	6,218	6,102	5,981
e. Current Depreciation	16,311	17,452	18,204	18,060	19,017	24,758	25,600	26,391
f. Project Depreciation	-	-	-	-	-	2,321	2,357	2,464
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	67,028	66,837	47,413	48,431	49,452	56,320	57,023	57,749
j. Other Expenses (Specify/add rows if needed)	42,999	44,932	35,203	34,683	31,675	46,993	46,468	45,957
TOTAL OPERATING EXPENSES	***$ 284,219***	***$ 272,260***	***$ 248,547***	***$ 250,047***	***$ 248,962***	***$ 322,583***	***$ 323,328***	***$ 324,858***
3. INCOME								
a. Income From Operation	**$ 16,552**	**$ 34,594**	**$ 32,125**	**$ 27,107**	**$ 29,953**	**$ 24,710**	**$ 27,042**	**$ 28,617**
b. Non-Operating Income								
SUBTOTAL	***$ 16,552***	***$ 34,594***	***$ 32,125***	***$ 27,107***	***$ 29,953***	***$ 24,710***	***$ 27,042***	***$ 28,617***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 16,552***	***$ 34,594***	***$ 32,125***	***$ 27,107***	***$ 29,953***	***$ 24,710***	***$ 27,042***	***$ 28,617***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
Total MSGA								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table J – Key Financial Projection Assumptions for the UM Upper Chesapeake Medical Center & Free Standing Medical Facility (Does not include HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Medical Center (UCMC) and Harford Memorial Hospital (HMH) FY2019 projected results with assumptions identified below.	
Projection period reflects FY2019 – FY2024	
Volumes	- Refer to COE Table I, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- 0.00% annual increase
o Demographic and Other Rate Adjustment	- Remains constant at 0.43% per year
o Variable Cost Factor	- UC HMH volume shifting at 100% VCF before the addition of retained revenue for capital
o Other (FMF)	- Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2016 OP PDA payer mix and actual FY2016/FY2017 UCC
• Revenue Deductions (UCMC)	
o Contractual Allowances	- Remains constant at 9.78% of gross revenue per year
o Charity Care	- Remains constant at 1.6% of gross revenue per year with no overfunding or underfunding of UCC
o Allowance for Bad Debt	- Remains constant at 2.76% of gross revenue per year with no overfunding or underfunding of UCC
• Revenue Deductions (FMF)	
o Contractual Allowances	- Based on FY2018 HMH 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 FY2018 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 FY2018 actual bad debt for HMH Behavioral Health, ED, and Observation services and remains constant at 7.25% of gross revenue per year - No overfunding or underfunding of UCC
Other Revenue	
o Cafeteria Revenue and Other Operating Revenue	- 0.0% increase per year
Expenses • Inflation	- 0.0% weighted average annual increase that reflects the following:
o Salaries and Benefits	- 0.0%
o Professional Fees	- 0.0%
o Supplies	- 0.0%
o Purchased Services	- 0.0%
o Other Operating Expenses	- 0.0%
• 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	- 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 & Drugs	- 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 departments
• Other Operating Expenses	- Beginning in FY2019 and FY2020, includes 340B savings (at UCMC) offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos), which leads to a transition to UMMS Shared Services beginning in FY2020. - Beginning in FY2019, a performance improvement plan is included totaling $3.6M with an incremental $900k of performance improvement per year assumed throughout the projection period.

• Interest Expense – Existing Debt	- 90% allocation of the following UCHS debt: - 4.75% interest on $55.3M 2008C Series bonds - 4.75% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt (UCMC)	- 4.5% interest on $80.1M bonds over 30 years
• Interest Expense – Project Debt (FMF)	- 4.5% interest on $51.8M bonds over 30 years
• Depreciation and Amortization (UCMC)	- Average life of 26 years on $75.M of construction project (debt service reserve fund is not depreciated) expenditures and 10 years on routine capital expenditures
• Depreciation and Amortization (FMF)	- Average life of 26 years on $46.3M of construction project (debt service reserve fund and land are not depreciated) expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures (UCMC)	- $108M in routine capital over the projection period with another $47M of other strategic capital projects (not related to this Project)
Routine Capital Expenditures (FMF)	- $0.3M in FY2022, growing to $1.2M in FY2023 and $2.4M in FY2024

TABLE K. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 138,399	$ 137,865	$ 135,067	$ 136,500	$ 140,145	$ 178,209	$ 183,430	$ 188,805
b. Outpatient Services	203,683	213,836	186,794	190,767	195,867	252,214	259,588	267,177
Gross Patient Service Revenues	***$ 342,082***	***$ 351,701***	***$ 321,861***	***$ 327,267***	***$ 336,012***	***$ 430,423***	***$ 443,018***	***$ 455,982***
c. Allowance For Bad Debt	9,525	9,336	8,889	9,038	9,279	13,700	14,100	14,512
d. Contractual Allowance	24,266	27,429	31,478	34,363	35,281	46,313	47,668	49,062
e. Charity Care	11,457	11,807	5,150	5,236	5,376	6,240	6,423	6,611
Net Patient Services Revenue	***$ 296,834***	***$ 303,129***	***$ 276,344***	***$ 278,630***	***$ 286,075***	***$ 364,169***	***$ 374,827***	***$ 385,796***
f. Other Operating Revenues (Specify/add rows if needed)	3,937	3,725	4,327	4,067	4,108	4,381	4,425	4,469
NET OPERATING REVENUE	***$ 300,771***	***$ 306,854***	***$ 280,671***	***$ 282,697***	***$ 290,183***	***$ 368,550***	***$ 379,251***	***$ 390,265***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 140,964	$ 123,635	$ 128,391	$ 132,744	$ 136,023	$ 176,893	$ 181,094	$ 186,161
b. Contractual Services	10,016	10,588	10,932	11,260	11,598	13,705	14,116	14,540
c. Interest on Current Debt	6,901	8,816	8,404	8,182	7,911	8,201	7,888	7,619
d. Interest on Project Debt	-	-	-	-	-	6,218	6,102	5,981
e. Current Depreciation	16,311	17,452	18,204	18,060	19,017	24,758	25,600	26,391
f. Project Depreciation	-	-	-	-	-	2,321	2,357	2,464
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	67,028	66,837	47,413	49,884	52,464	61,543	64,179	66,947
j. Other Expenses (Specify/add rows if needed)	42,999	44,932	35,203	35,377	32,955	49,870	50,298	50,740
TOTAL OPERATING EXPENSES	***$ 284,219***	***$ 272,260***	***$ 248,547***	***$ 255,506***	***$ 259,967***	***$ 343,509***	***$ 351,634***	***$ 360,843***
3. INCOME								
a. Income From Operation	**$ 16,552**	**$ 34,594**	**$ 32,125**	**$ 27,191**	**$ 30,216**	**$ 25,041**	**$ 27,617**	**$ 29,421**
b. Non-Operating Income								
SUBTOTAL	***$ 16,552***	***$ 34,594***	***$ 32,125***	***$ 27,191***	***$ 30,216***	***$ 25,041***	***$ 27,617***	***$ 29,421***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 16,552***	***$ 34,594***	***$ 32,125***	***$ 27,191***	***$ 30,216***	***$ 25,041***	***$ 27,617***	***$ 29,421***

TABLE K. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
Total MSGA								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table K – Key Financial Projection Assumptions for the UM Upper Chesapeake Medical Center and Free Standing Medical Facility (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Medical Center (UCMC) and Harford Memorial Hospital (HMH) FY2019 projected results with assumptions identified below.	
Projection period reflects FY2019 – FY2024	
Volumes	- Refer to COE Table I, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- 2.1% annual increase in FY2021, 2.3% annual increase in FY2022 and 2.50% annual increase in FY2023 & FY2024
o Demographic and Other Rate Adjustment	- Remains constant at 0.43% per year
o Variable Cost Factor	- UC FMF volume shifting at 100% VCF before the addition of retained revenue for capital
o Other (FMF)	- Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2016 OP PDA payer mix and actual FY2016/FY2017 UCC
• Revenue Deductions (UCMC)	
o Contractual Allowances	- Remains constant at 9.78% of gross revenue per year
o Charity Care	- Remains constant at 1.6% of gross revenue per year with no overfunding or underfunding of UCC
o Allowance for Bad Debt	- Remains constant at 2.76% of gross revenue per year with no overfunding or underfunding of UCC
• Revenue Deductions (FMF)	
o Contractual Allowances	- Based on FY2018 HMH 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 FY2018 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 FY2018 actual bad debt for HMH Behavioral Health, ED, and Observation services and remains constant at 7.25% of gross revenue per year - No overfunding or underfunding of UCC
Other Revenue	
o Cafeteria Revenue and Other	- 1.0% increase per year
Expenses	
• Inflation	
o Salaries and Benefits	- 2.3%
o Professional Fees	- 3.0%
o Supplies	- 3.0%
o Purchased Services	- 3.0%
o Other Operating Expenses	- 2.0%
• 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	- 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 & Drugs	- 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 departments

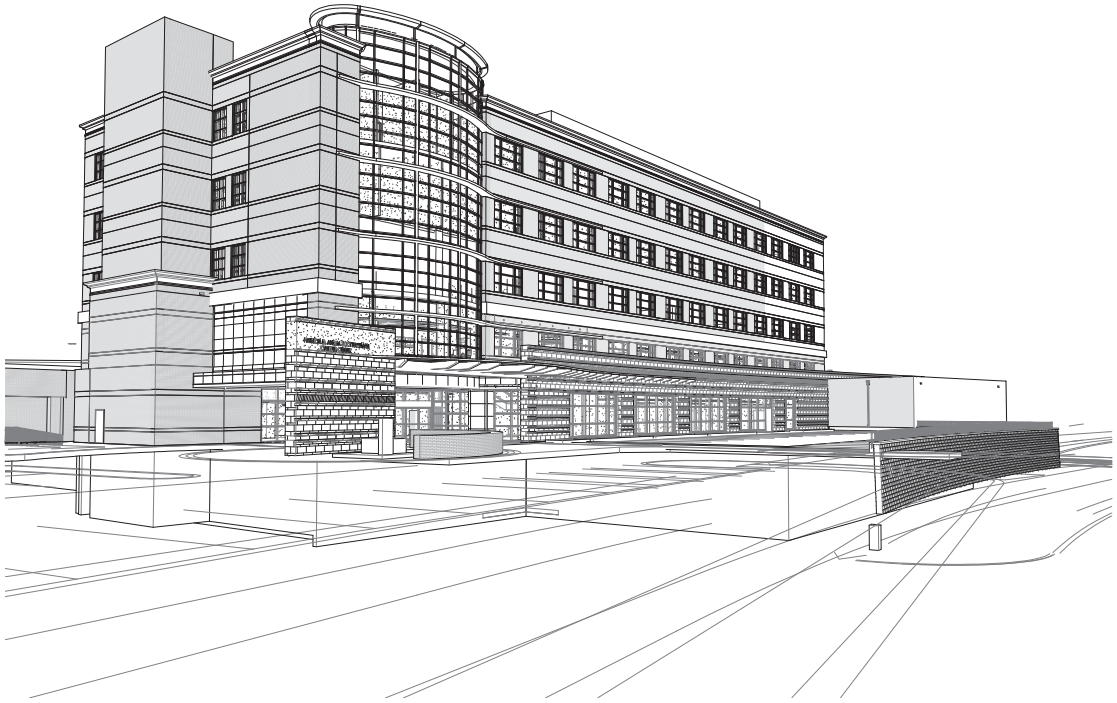
• Other Operating Expenses	- Beginning in FY2019 and FY2020, includes 340B savings (at UCMC) offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos) which leads to a transition to UMMS Shared Services beginning in FY20. - Beginning in FY2019, a performance improvement plan is included totaling $3.6M with an incremental $900k of performance improvement per year assumed throughout the projection period.
• Interest Expense – Existing Debt	- 90% allocation of the following UCHS debt: - 4.75% interest on $55.3M 2008C Series bonds - 4.75% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt (UCMC)	- 4.5% interest on $80.1M bonds over 30 years
• Interest Expense – Project Debt (FMF)	- 4.5% interest on $51.8M bonds over 30 years
• Depreciation and Amortization (UCMC)	- Average life of 26 years on $75.M of construction project (debt service reserve fund is not depreciated) expenditures and 10 years on routine capital expenditures
• Depreciation and Amortization (FMF)	- Average life of 26 years on $46.3M of construction project (debt service reserve fund and land are not depreciated) expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures (UCMC)	- $108M in routine capital over the projection period with another $47M of other strategic capital projects (none are related to this Project)
Routine Capital Expenditures (FMF)	- $0.3M in FY2022, growing to $1.2M in FY2023 and $2.4M in FY2024

EXHIBIT 2

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

HKS

BED EXPANSION BEL AIR, MARYLAND



OWNER
UPPER CHESAPEAKE HEALTH
520 UPPER CHESAPEAKE DRIVE
BEL AIR, MARYLAND 21014

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

MEP ENGINEER
LEACH WALLACE ASSOCIATES, INC.
6522 MEADOWRIDGE ROAD
ELKRIDGE, MARYLAND 21075

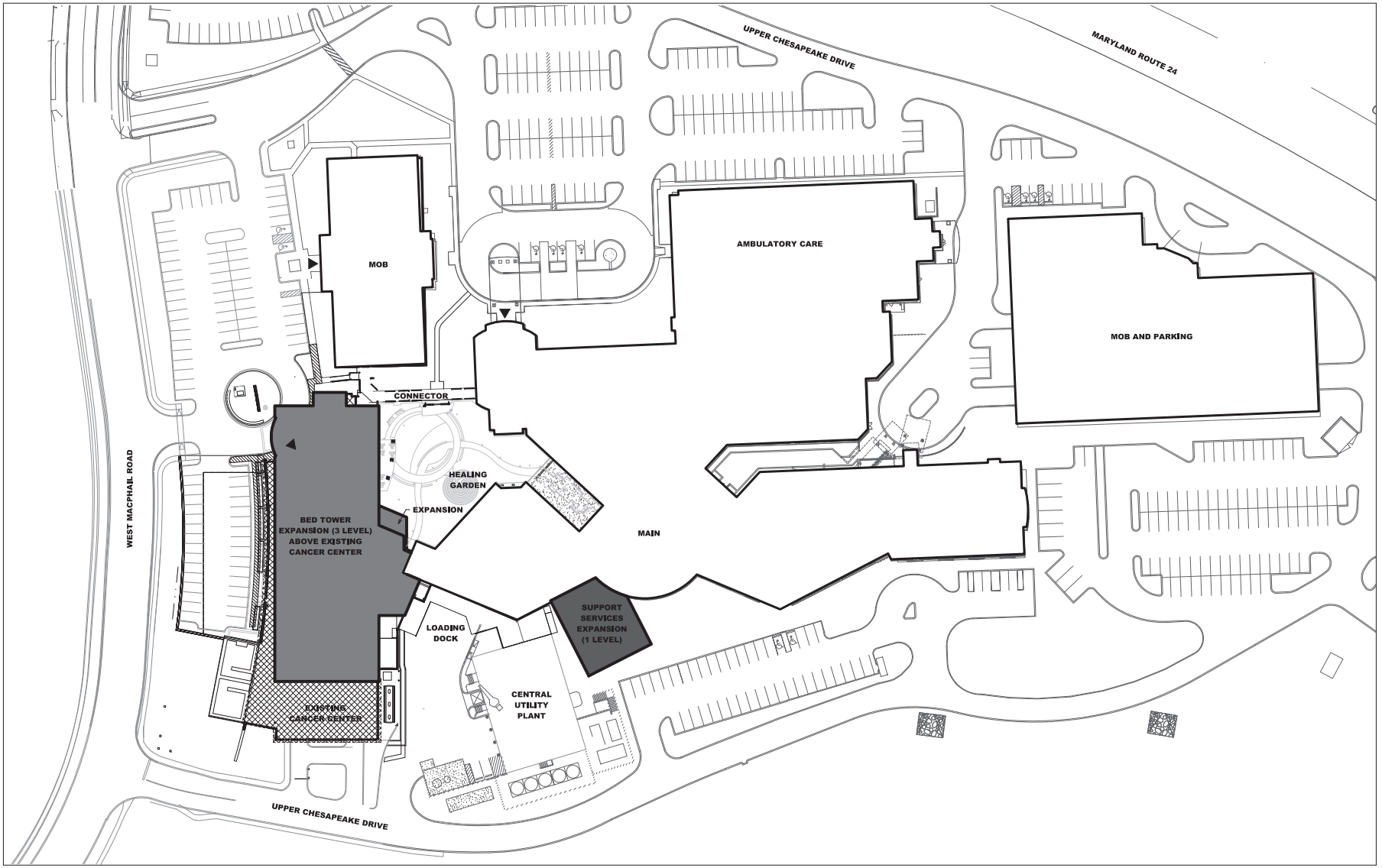
CERTIFICATE OF NEED SUBMISSION

OCTOBER 26, 2018

30% SCHEMATIC DESIGN

HKS # - 18931.008

PLOT DATE: 10/22/2018 2:21:25 PM



A0-01

SITE PLAN - PROPOSED

UCMC BED EXPANSION

BEL AIR, MARYLAND

OCTOBER 26, 2018 18931.008

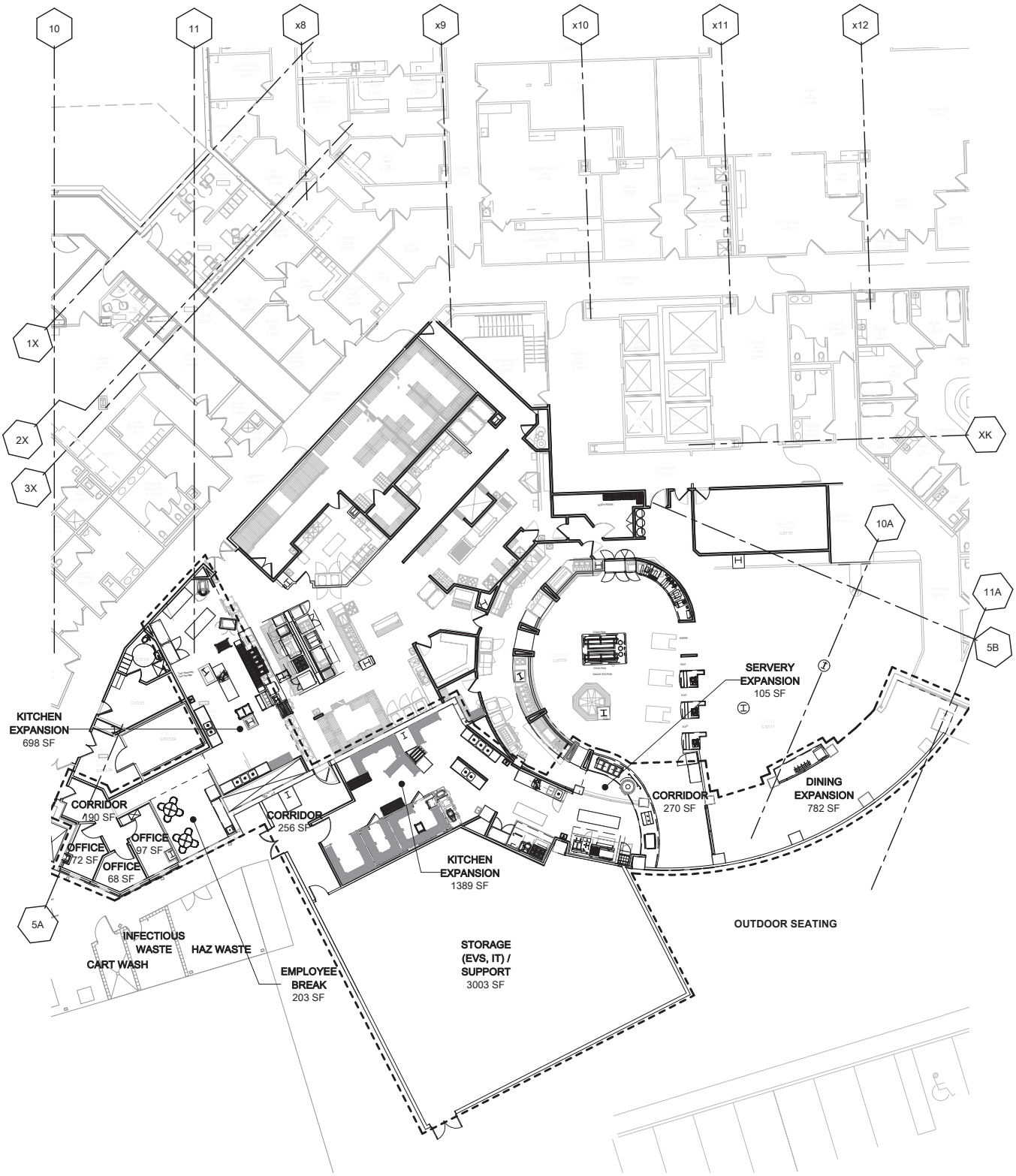
HKS

UCMC BED EXPANSION

BEL AIR, MARYLAND

EXISTING GARDEN LEVEL 0 10 20 FT

A-00 OCTOBER 26, 2018 18931.008

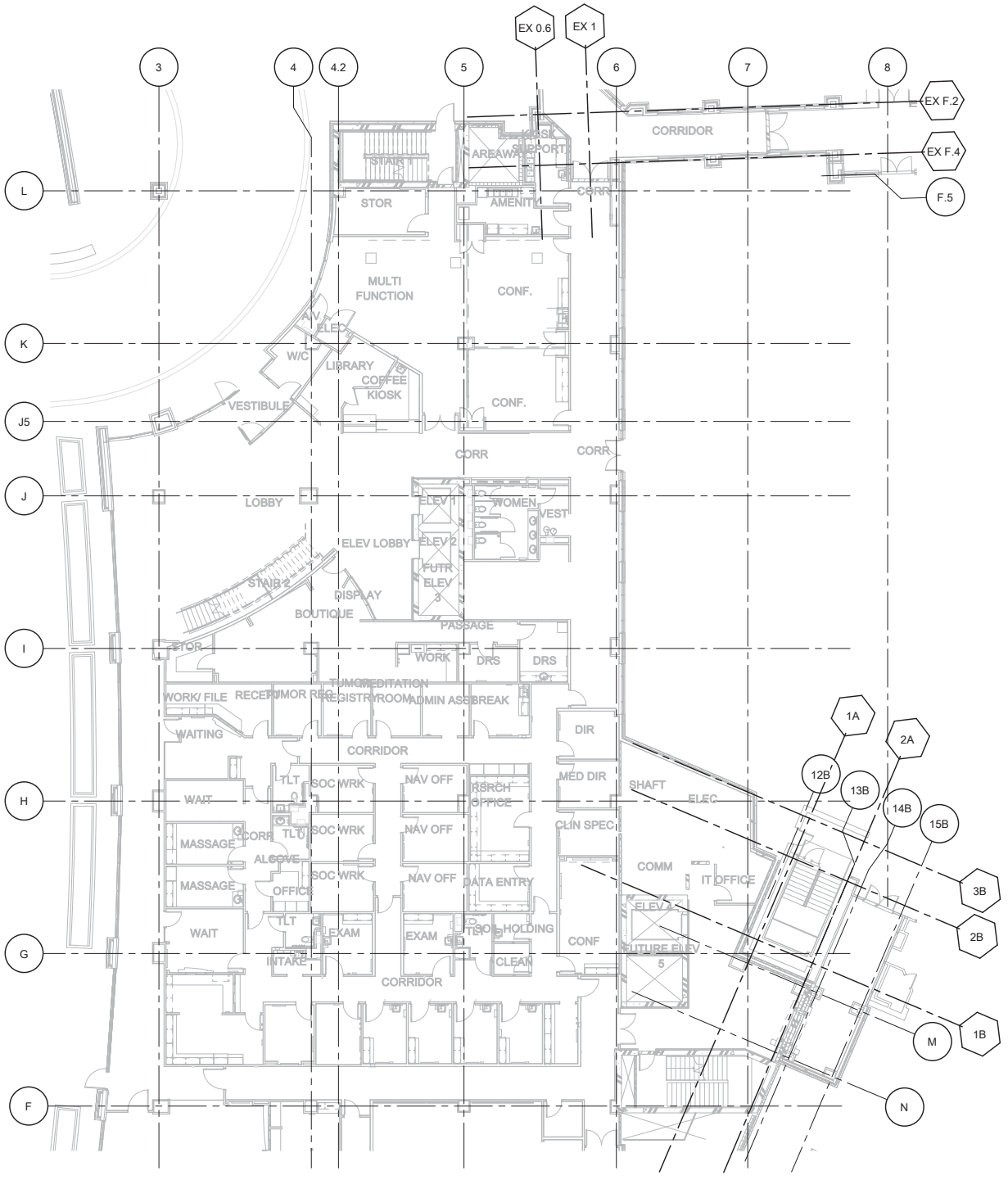


UCMC BED EXPANSION

BEL AIR, MARYLAND

PROPOSED GARDEN LEVEL 0 10 20 FT

A-00.1 OCTOBER 26, 2018 18931.008



UCMC BED EXPANSION

BEL AIR, MARYLAND

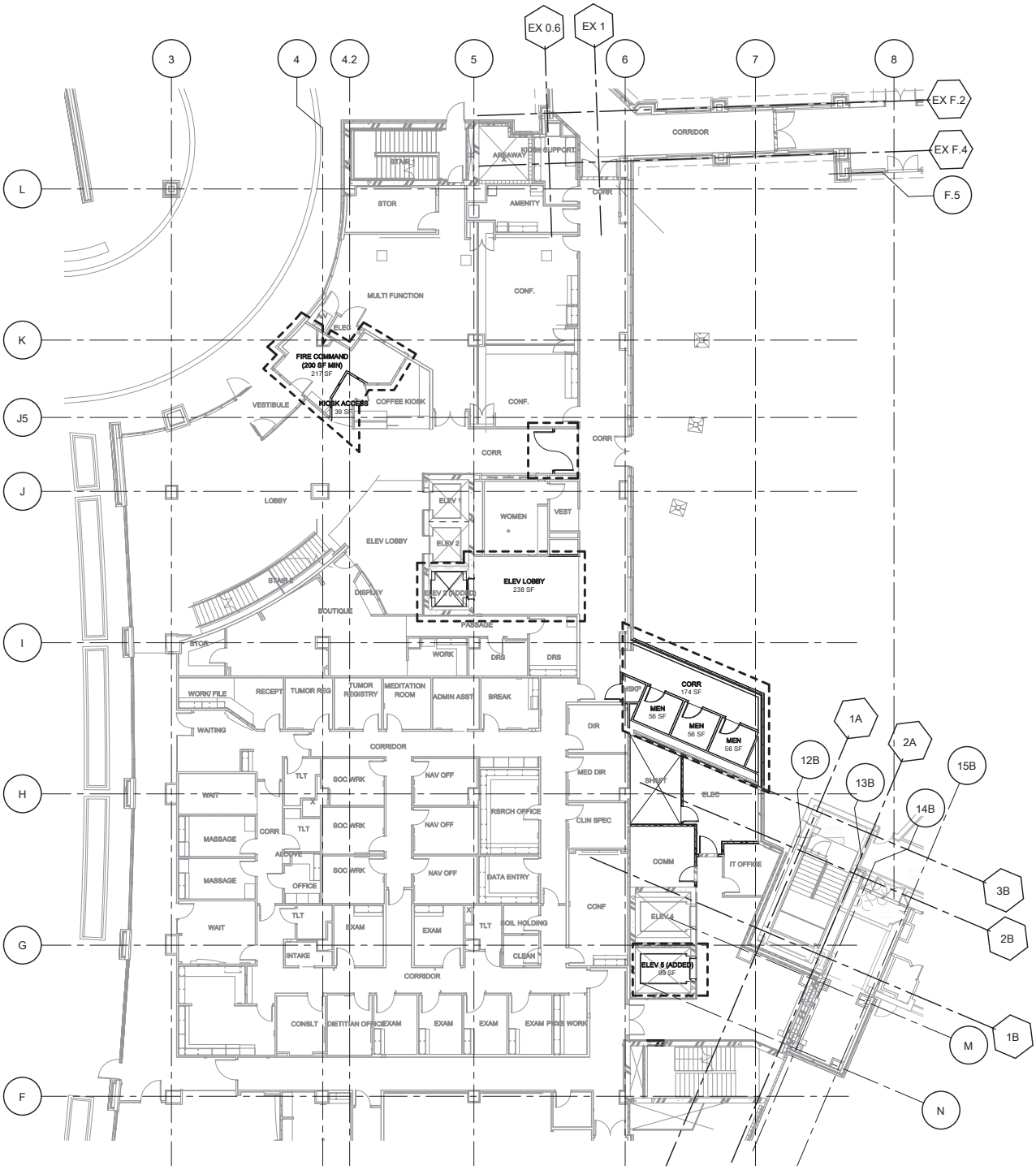
EXISTING LEVEL 01

0 10 20 FT

A-01 OCTOBER 26, 2018 18931.008

THE FIRE COMMAND CENTER SHALL COMPLY WITH NFPA 72 AND SHALL CONTAIN THE FOLLOWING FEATURES:

1. THE EMERGENCY VOICE/ALARM COMMUNICATION SYSTEM CONTROL UNIT.
2. THE FIRE DEPARTMENT COMMUNICATIONS SYSTEM.
3. FIRE DETECTION AND ALARM SYSTEM ANNUNCIATOR.
4. ANNUNCIATOR UNIT VISUALLY INDICATING THE LOCATION OF THE ELEVATORS AND WHETHER THEY ARE OPERATIONAL.
5. STATUS INDICATORS AND CONTROLS FOR AIR DISTRIBUTION SYSTEMS.
6. THE FIRE FIGHTER'S CONTROL PANEL REQUIRED BY SECTION 909.16 FOR SMOKE CONTROL SYSTEMS INSTALLED IN THE BUILDING.
7. CONTROLS FOR UNLOCKING STAIRWAY DOORS SIMULTANEOUSLY.
8. SPRINKLER VALVE AND WATERFLOW DETECTOR DISPLAY PANELS.
9. EMERGENCY AND STANDY POWER STATUS INDICATORS.
10. A TELEPHONE FOR FIRE DEPARTMENT USE WITH CONTROLLED ACCESS TO THE PUBLIC TELEPHONE SYSTEM.
11. FIRE PUMP STATUS INDICATORS.
12. SCHEMATIC BUILDING PLANS INDICATING THE TYPICAL FLOOR PLAN AND DETAILING THE BUILDING CORE, MEANS OF EGRESS, FIRE PROTECTION SYSTEMS, FIRE-FIGHTING EQUIPMENT AND FIRE DEPARTMENT ACCESS AND THE LOCATION OF FIRE WALLS, FIRE BARRIERS, FIRE PARTITIONS, SMOKE BARRIERS AND SMOKE PARTITIONS.
13. WORK TABLE.
14. GENERATOR SUPERVISION DEVICES, MANUAL START AND TRANSFER FEATURES.
15. PUBLIC ADDRESS SYTEM, WHERE SPECIFICALLY REQUIRED BY OTHER SECTIONS OF THIS CODE.
16. ELEVATOR FIRE RECALL SWITCH IN ACCORDANCE WITH ASME A17.1.
17. ELEVATOR EMERGENCY OR STANDBY POWER SELECTOR SWITCH(ES), WHERE EMERGENCY OR STANDBY POWER IS PROVIDED.



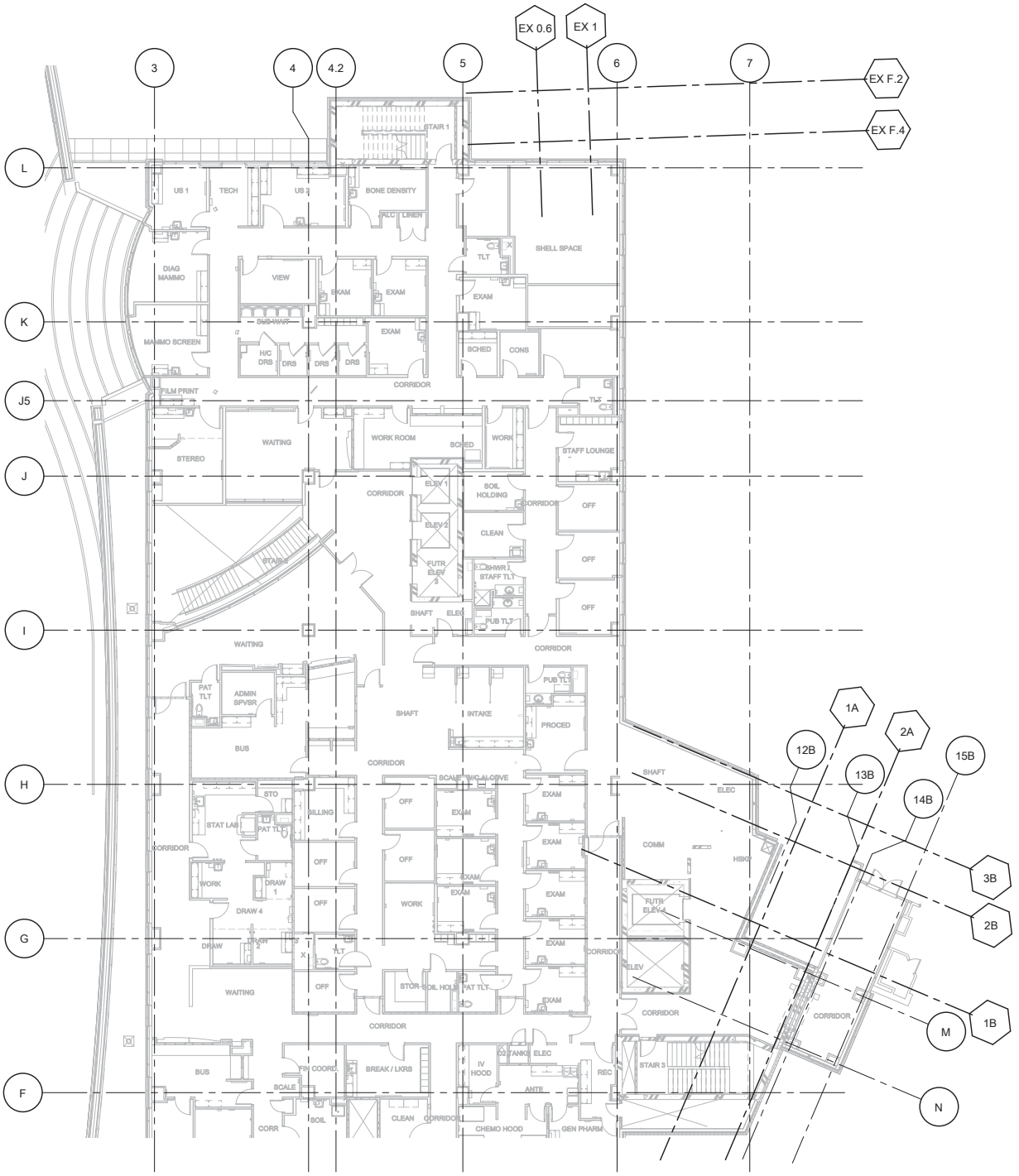
UCMC BED EXPANSION

BEL AIR, MARYLAND

PROPOSED LEVEL 01

0 10 20 FT

A-01.1 OCTOBER 26, 2018 18931.008



UCMC BED EXPANSION

BEL AIR, MARYLAND

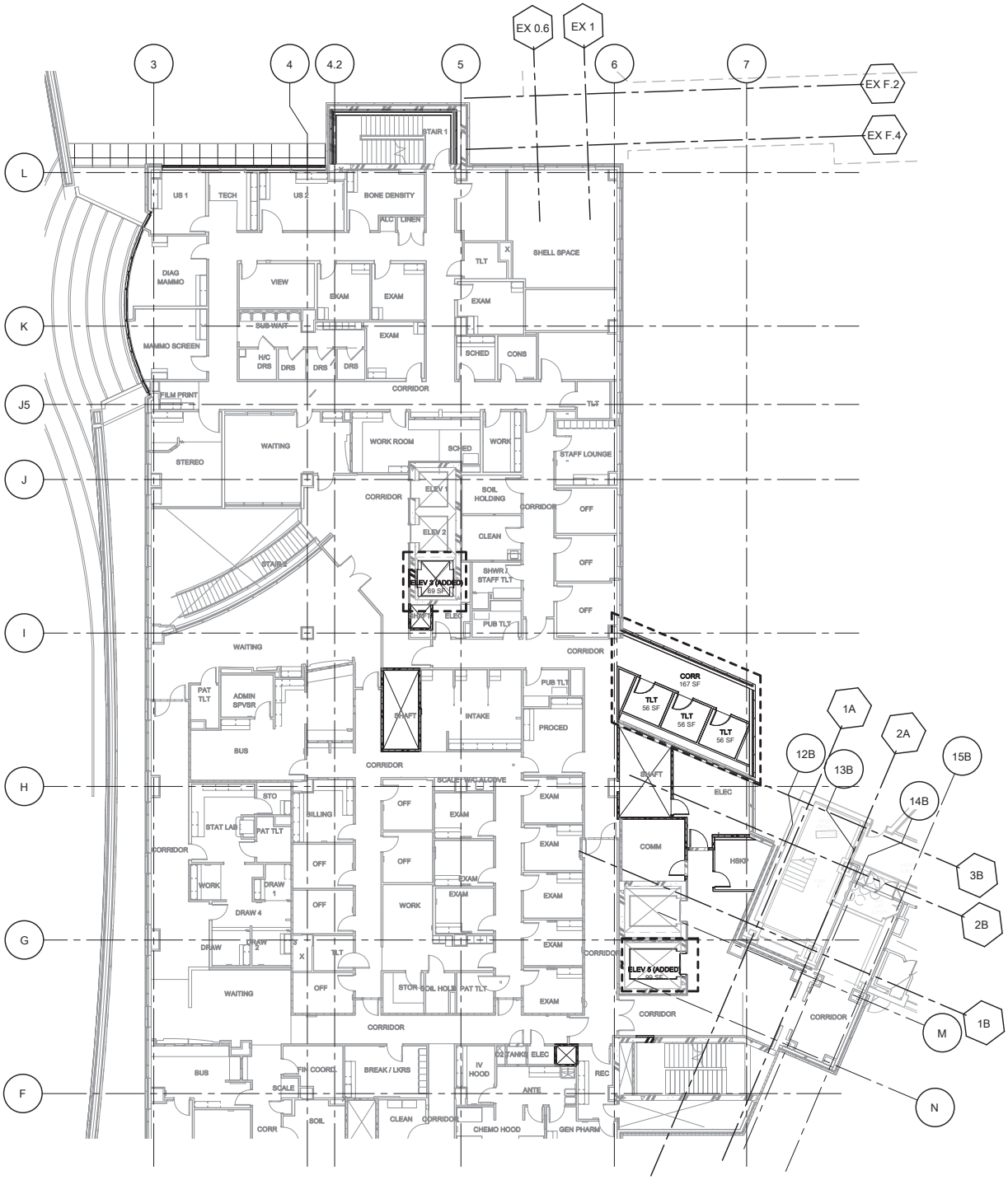
EXISTING LEVEL 02

A-02

0 10 20 FT

OCTOBER 26, 2018

18931.008



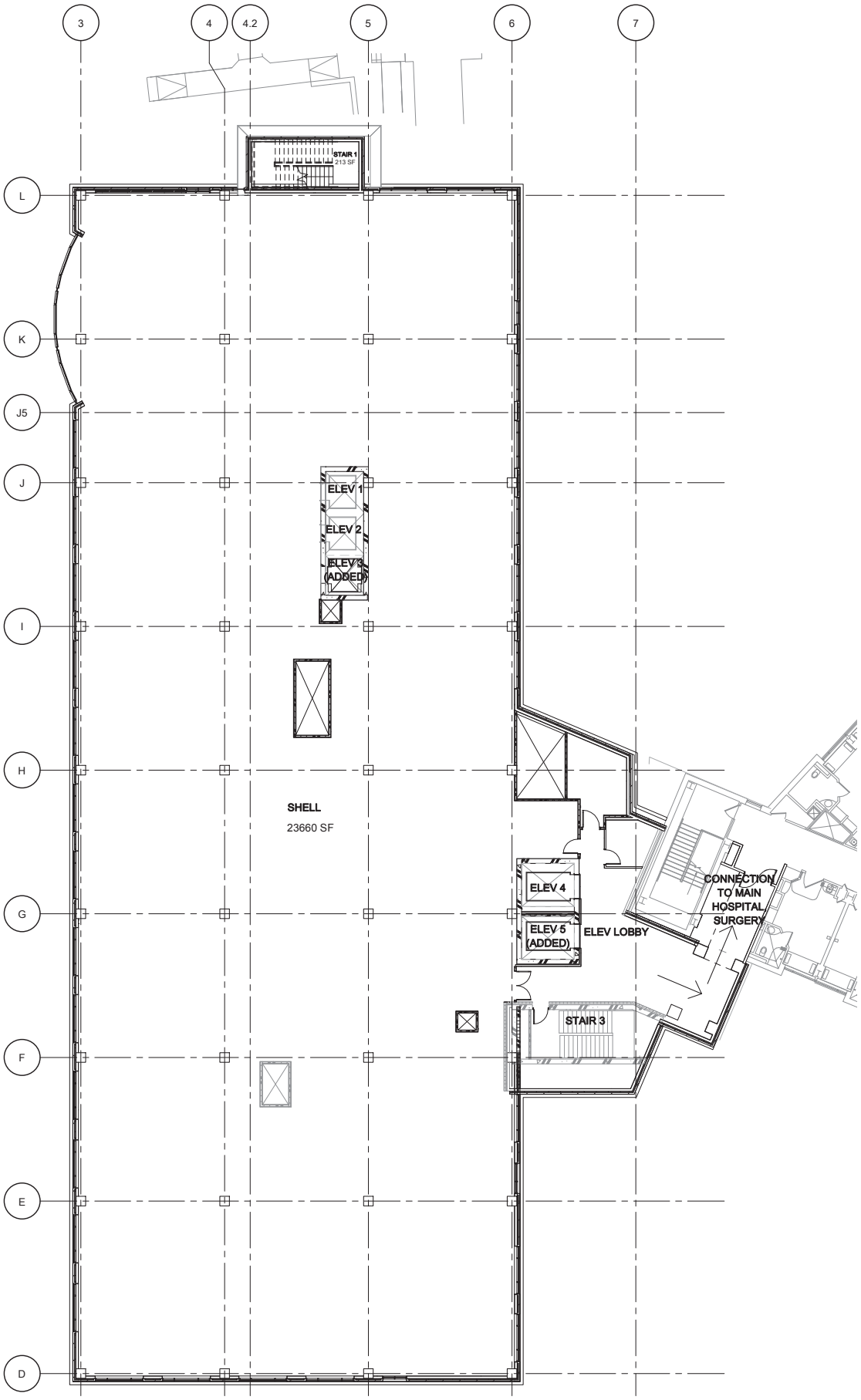
UCMC BED EXPANSION

BEL AIR, MARYLAND

PROPOSED LEVEL 02

0 10 20 FT

A-02.1 OCTOBER 26, 2018 18931.008

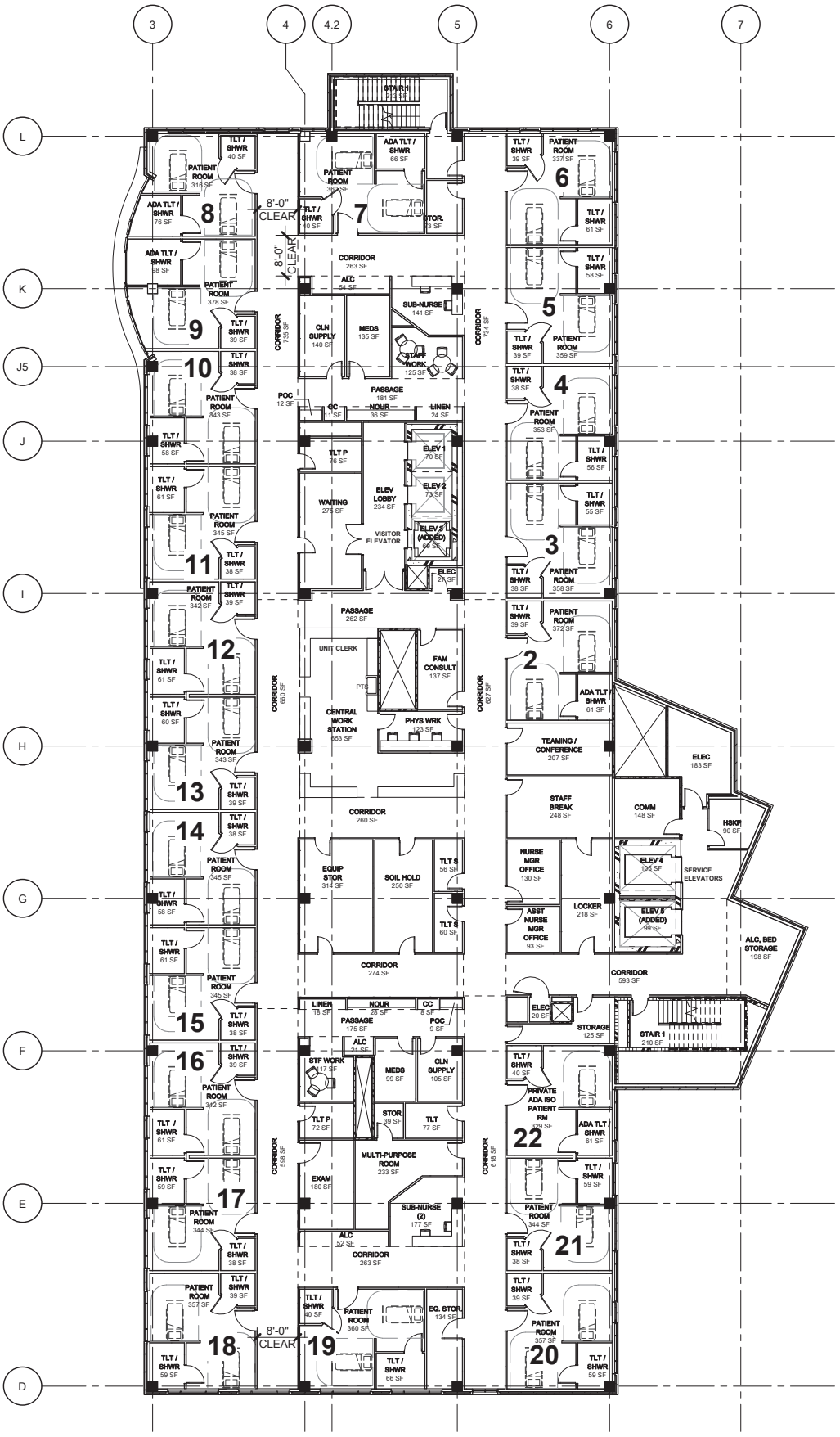


UCMC BED EXPANSION

BEL AIR, MARYLAND

LEVEL 03 - SHELL FLOOR 0 10 20 FT

A-03 OCTOBER 26, 2018 18931.008



20 SEMI-PRIVATE + 1 PRIVATE ISO OBSERVATION ROOM
41 TOTAL OBSERVATION BEDS

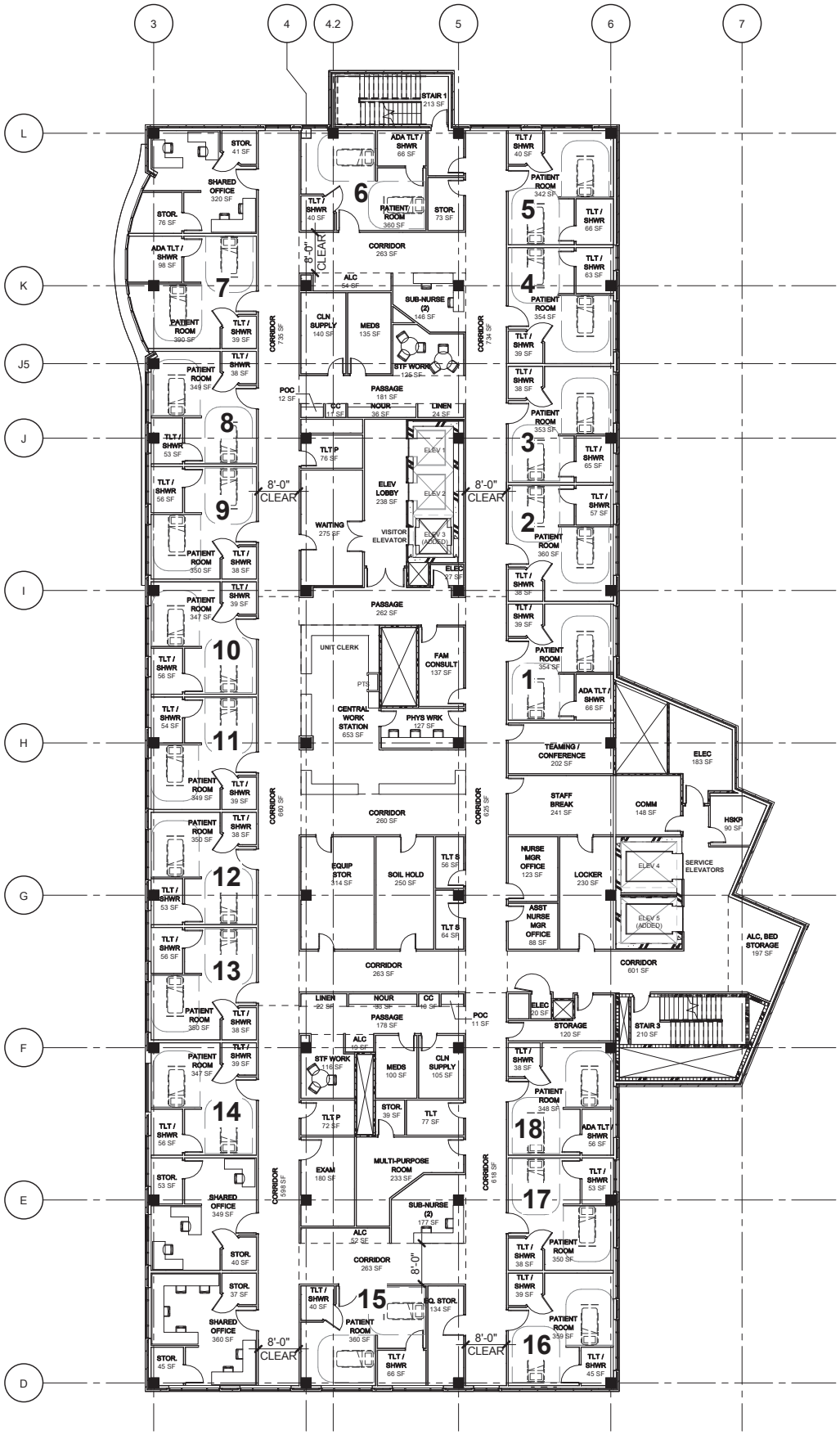
UCMC BED EXPANSION

BEL AIR, MARYLAND

LEVEL 04 - BED FLOOR

0 10 20 FT

A-04 OCTOBER 26, 2018 18931.008



18 SEMI-PRIVATE ROOMS
36 TOTAL OBSERVATION BEDS

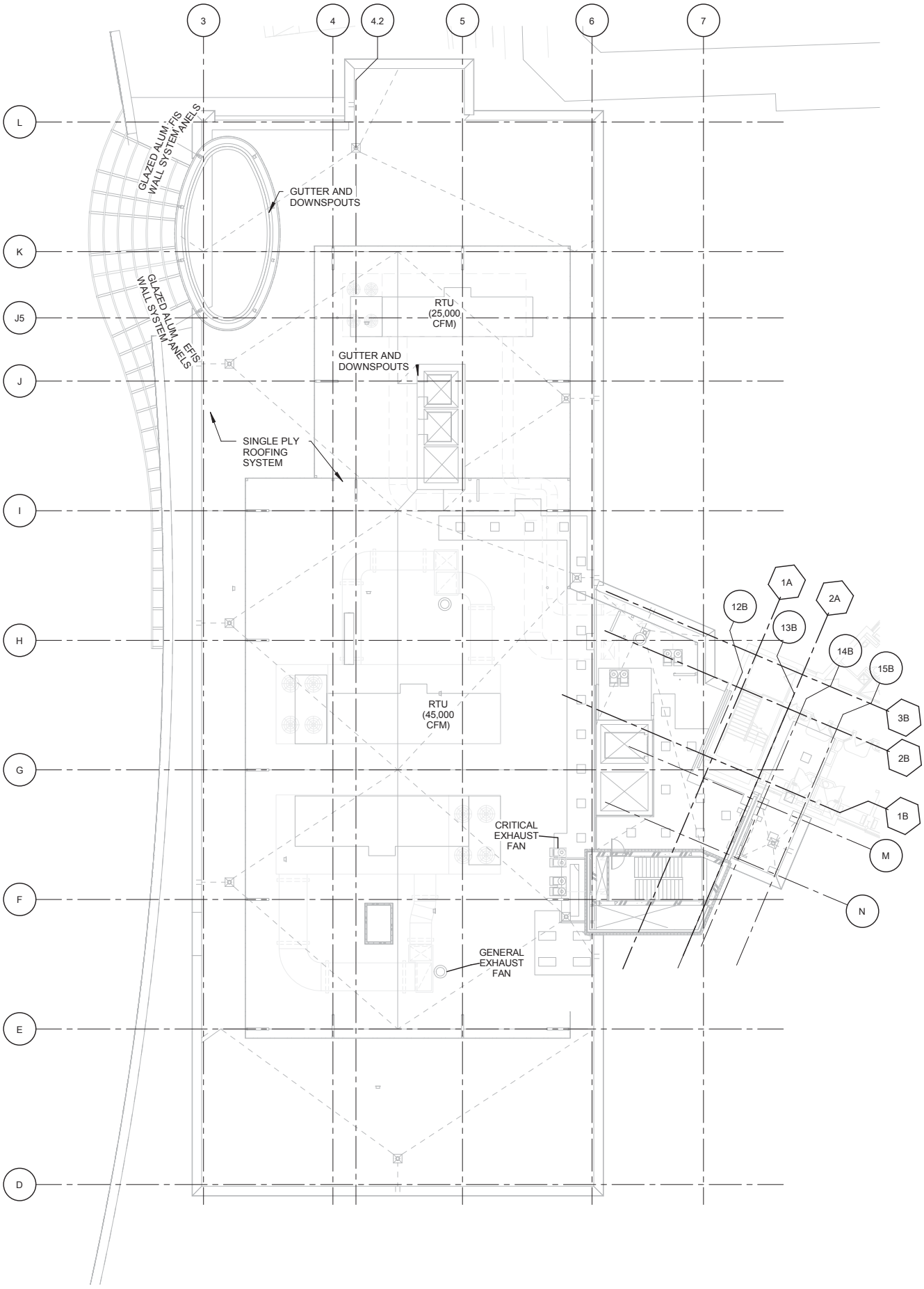
UCMC BED EXPANSION

BEL AIR, MARYLAND

LEVEL 05 - BED FLOOR

0 10 20 FT

A-05 OCTOBER 26, 2018 18931.008



UCMC BED EXPANSION

BEL AIR, MARYLAND

EXISTING ROOF LEVEL

0 10 20 FT

A-06 OCTOBER 26, 2018 18931.008

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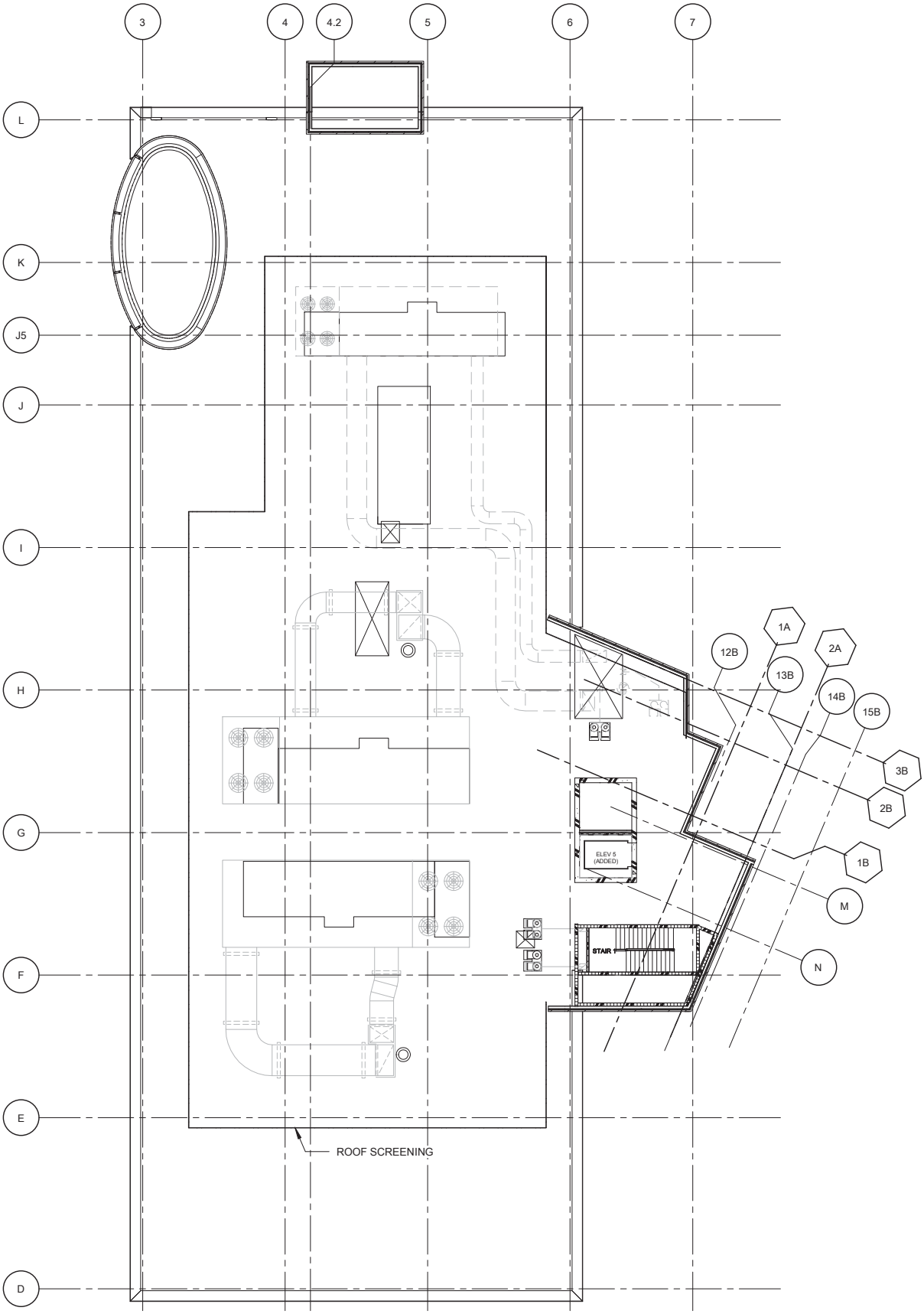


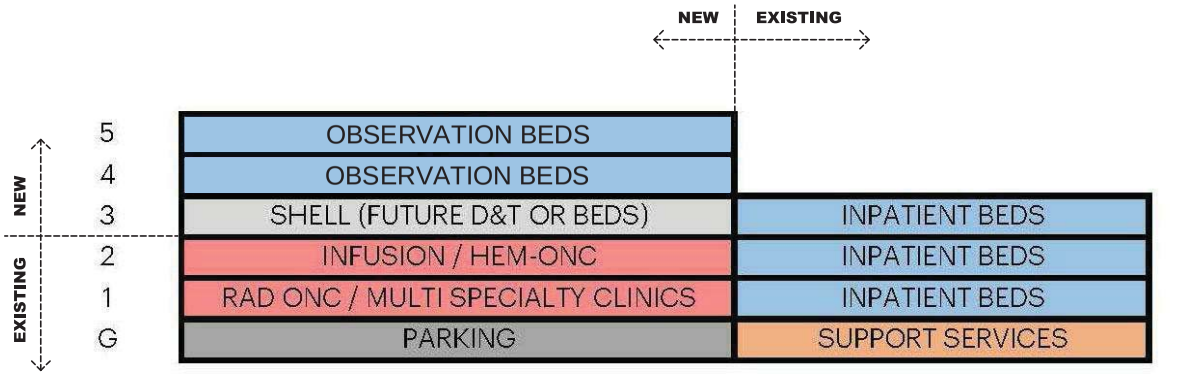
UCMC BED EXPANSION

BEL AIR, MARYLAND

PROPOSED ROOF LEVEL

0 10 20 FT

A-06.1 OCTOBER 26, 2018 18931.008



01 STACKING DIAGRAM
NT

A2-05

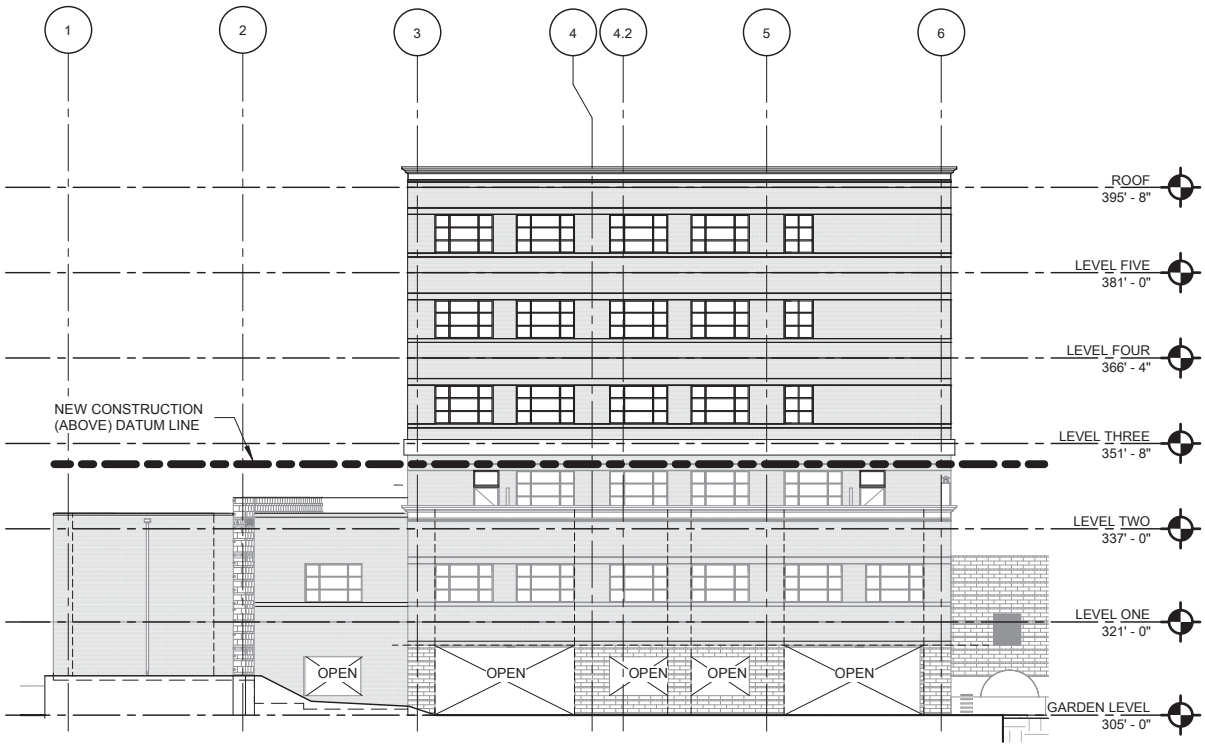
STACKING DIAGRAMS

UCMC BED EXPANSION

BEL AIR, MARYLAND

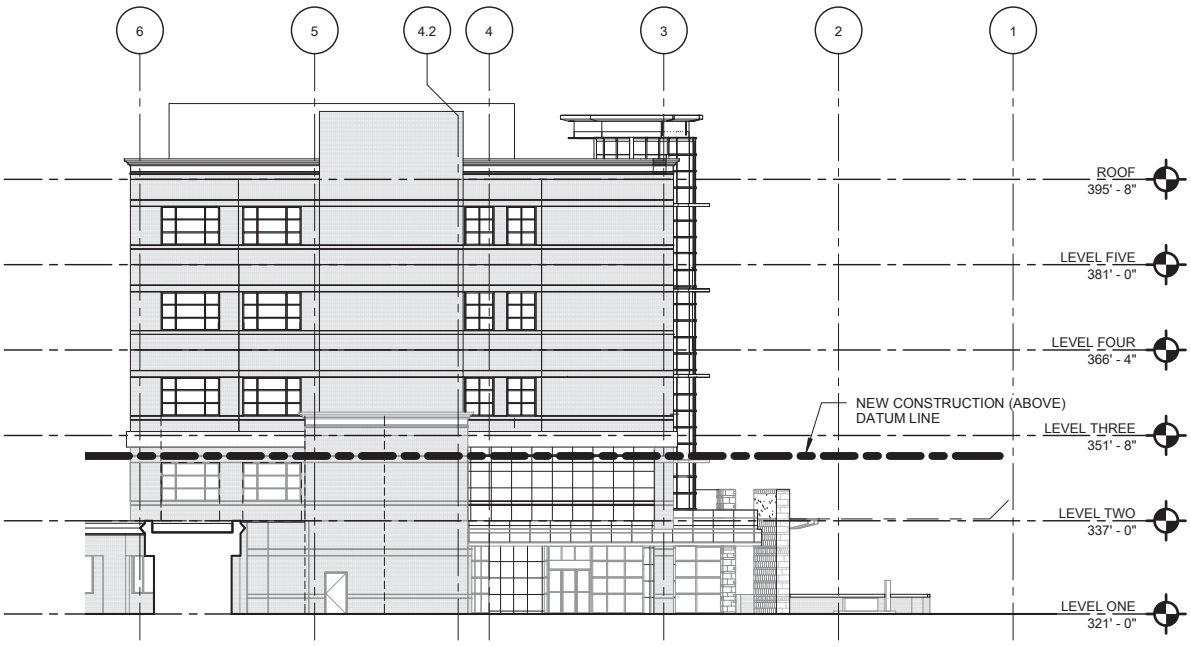
OCTOBER 26, 2018 18931.008

HKS



02 SOUTH ELEVATION

3/64" = 1'-0"



01 NORTH ELEVATION

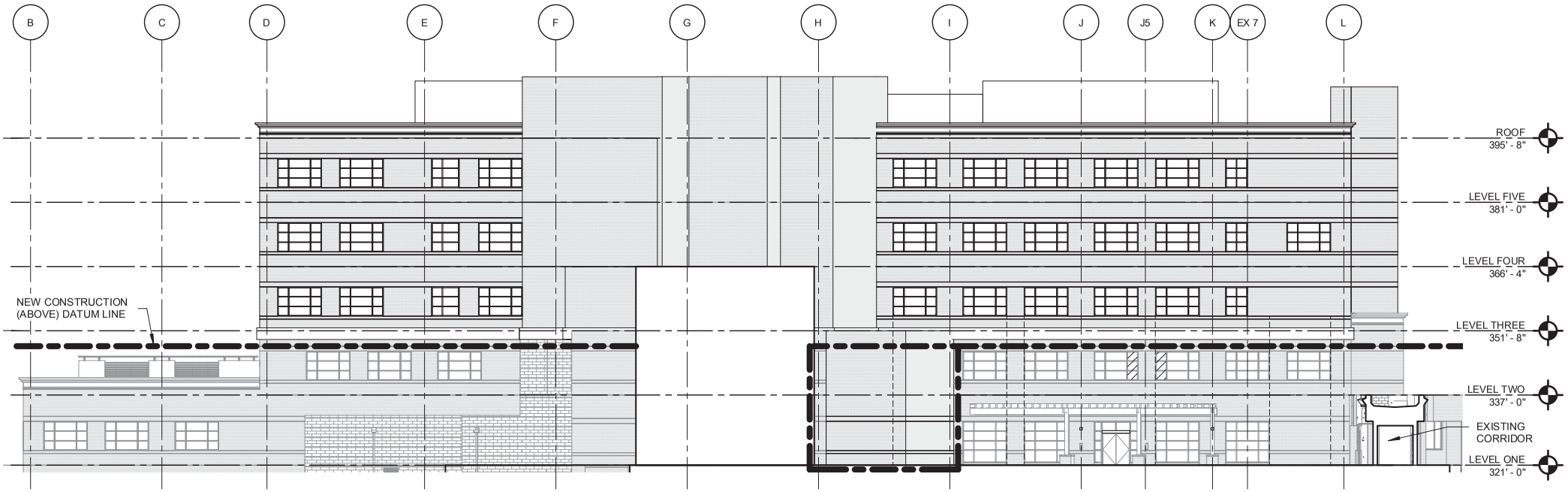
3/64" = 1'-0"

UCMC BED EXPANSION

BEL AIR, MARYLAND

NORTH & SOUTH ELEV.

A-10 OCTOBER 26, 2018 18931.008



01 EAST ELEVATION

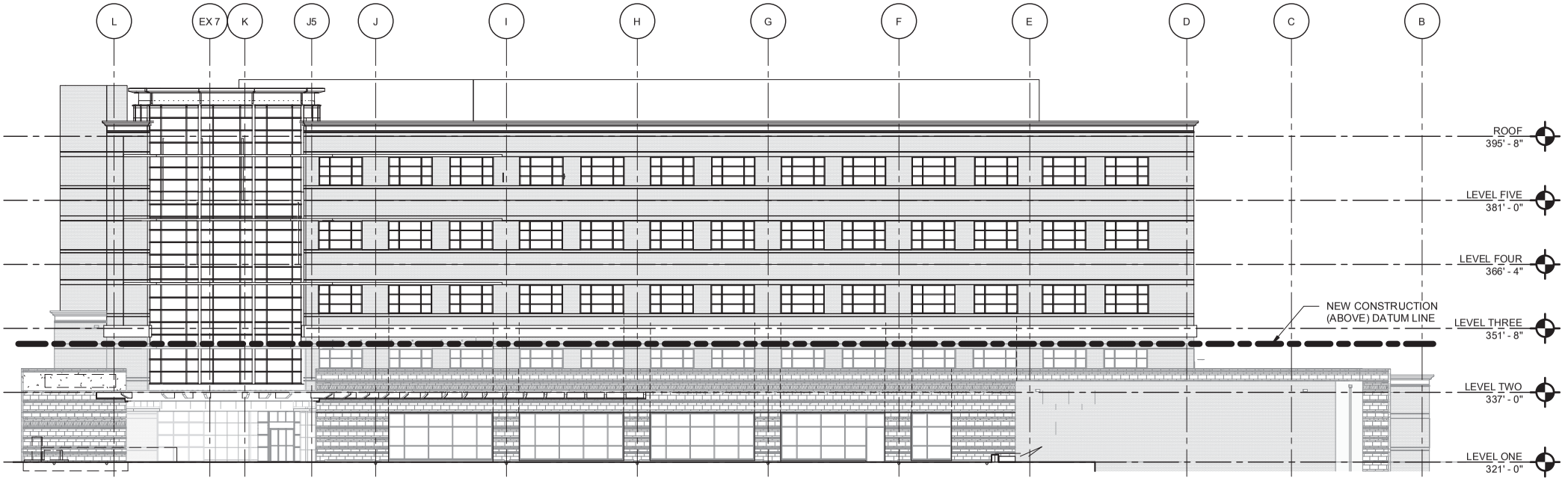
3/64" = 1'-0"

UCMC BED EXPANSION

BEL AIR, MARYLAND

EAST ELEVATION

A-11 OCTOBER 26, 2018 18931.008



01 WEST ELEVATION

3/64" = 1'-0"

UCMC BED EXPANSION

BEL AIR, MARYLAND

WEST ELEVATION

A-12 OCTOBER 26, 2018 18931.008

HKS

A2-07

PERSPECTIVE VIEW - ENTRANCE

UCMC BED EXPANSION

BEL AIR, MARYLAND

OCTOBER 26, 2018 18931.008

HKS

A2-08

PERSPECTIVE VIEW - NORTH VIEW

UCMC BED EXPANSION

BEL AIR, MARYLAND

OCTOBER 26, 2018 18931.008

HKS

A2-09

PERSPECTIVE VIEW - AERIAL VIEW

UCMC BED EXPANSION

BEL AIR, MARYLAND

OCTOBER 26, 2018 18931.008

HKS

EXHIBIT 3

Upper Chesapeake Health

Subject: Estimate of Charges

Origin Date: 1/7/11

Approved by: _____

Craig Willig, Vice President of Finance

To provide for transparency in health care pricing

Policy

Upper Chesapeake Health (UCH) shall publicly disclose, on a continuous basis, price estimates for such items, products, services, or procedures in accordance with current Legislation.

Manner of Disclosure

- Shall be made in an open and conspicuous manner;
- Shall be made available at the point of service, in print, and on the Internet; and
- UCH provides estimated charges for the most commonly used inpatient, outpatient, and ancillary services. The information is reviewed semi-annually by the Director of Reimbursement and updated when appropriate.

The amounts are estimates of charges for hospital procedures and services only.

Procedures

UCH promptly responds to individual requests for current charges for specific services/procedures.

- Patients seeking estimates of procedures/services that are not listed on the UCH Common Procedure chart will be encouraged to call the Cashier (443-643-1663).
- The UM Upper Chesapeake Health website will include a listing of current rates for common services; to be updated semi-annually
- If the Cashier is unable to provide the estimate, the Director of Reimbursement will be consulted.
- An estimate will be provided within three business days of receiving the request.

All Patient Accounting, Patient Access, Guest Services, and Administrative Personnel are knowledgeable of the process for providing estimates of charges.

DEVELOPER:

Patient Access, UCH

Reviewed / Revised: 7/1/17

ORIGIN DATE: 1/2011

NEXT REVIEW DATE: 7/2018

EXHIBIT 4

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 01/2013

Approved by: _____

Joseph E. Hoffman, Sr. VP CFO

_____

Board of Directors

To provide financial relief to patients unable to meet their financial obligation to Upper Chesapeake Health.

1. **Policy**
    a. This policy applies to Upper Chesapeake Health (UCH). UCH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
    b. It is the policy of UCH to provide Financial Assistance (FA) based on indigence or high medical expenses (Medical Financial Hardship program) for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for FA should be made, the criteria for eligibility, and the steps for processing applications.
    c. UCH will post notices of availability at appropriate intake locations as well as the Patient Accounting Office. Notice of availability will also be sent to patients on patient bills. Signs will be posted in key patient access areas. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request. A written estimate of total charges, excluding the emergency department, will be available to all patients upon request.
    d. FA may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include a

review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.

e. Payments made for care received during the financial assistance eligibility window that exceed the patients determined responsibility will be refunded if that amount exceeds $5.00
    i. Collector notes, and any other relevant information, are deliberated as part of the final refund decision; in general refunds are issued based on when the patient was determined unable to pay compared to when the payments were made
    ii. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for a refund
f. UCH retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services or diagnosed-cancer care will be treated regardless of their ability to pay, except as noted under 2. d. iv. below.

2. Program Eligibility

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the UCH commitment to our mission to provide healthcare to the surrounding community, UCH reserves the right to grant financial assistance without formal application being made by our patients.
b. Specific exclusions to coverage under the FA program include the following:
    i. Physician charges are excluded from UCH's FA policy. Patients who wish to pursue FA for physician related bills must contact the physician directly
    ii. Generally, the FA program is not available to cover services that are 100% denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications
    iii. Unpaid balances resulting from cosmetic or other non-medically necessary services
c. Patients may become ineligible for FA for the following reasons:
    i. Refusal to provide requested documentation or provide incomplete information

ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance programs that deny access to UCH due to insurance plan restrictions/limits
iii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program

d. Determination for Financial Assistance eligibility will be based on assets, income, and family size. Please note the following:
   i. Liquid assets greater than $15,000 for individuals, and $25,000 for families will disqualify the patient for 100% assistance.
   ii. Equity of $150,000 in a primary residence will be excluded from the calculation for determination of financial assistance; and
   iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans will not be used for determination of financial assistance.
   iv. Non-citizens/non-residents of the United States may only qualify for Financial Assistance under these circumstances: 1. an initial visit for emergency care or 2. if qualified for presumptive Medical Assistance upon inpatient admission or prior to outpatient treatments for cancer care, and only after a determination by the Financial Counselor/Director of Patient Accounting and/or V.P. of Finance. See the Upper Chesapeake Health Self Pay Billing policy for criteria for beginning outpatient cancer care for these patients.

e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a FA application unless they meet Presumptive FA (see section 3 below) eligibility criteria. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
f. Free medically necessary care will be awarded to patients with family income at or below 200 percent of the Federal Poverty Level (FPL).
g. Reduced-cost, medically necessary care will be awarded to low-income patients with family income between 200 and 300 percent of the FPL

h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.
i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor. Payment plans are available to uninsured patients with family income between 200 to 500 FPL.

3. Presumptive Financial Assistance

a. Patients may also be considered for Presumptive Financial Assistance eligibility with proof of enrollment in one of the programs listed below. There are instances when a patient may appear eligible for FA, but there is no FA form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patent with FA. In the event there is no evidence to support a patient's eligibility for FA, UCH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100-percent write-off of the account balance. Presumptive FA eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
    i. Active Medical Assistance pharmacy coverage
    ii. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
    iii. Primary Adult Care coverage (PAC)
    iv. Homelessness
    v. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
    vi. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
    vii. Participation in Women, Infants and Children Program (WIC)
    viii. Supplemental Nutritional Assistance Program (SNAP)
    ix. Eligibility for other state or local assistance programs
    x. Deceased with no known estate
    xi. Determined to meet eligibility criteria established under former State Only Medical Assistance Program
    xii. Households with children in the free or reduced lunch program
    xiii. Low-income household Energy Assistance Program

xiv. Self-Administered Drugs (in the outpatient environment only)
xv. Medical Assistance Spenddown amounts

b. Specific services or criteria that are ineligible for Presumptive FA include:
   i. Purely elective procedures (e.g. cosmetic procedures) are not covered under the program
   ii. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
   i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
   ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
   iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.
c. There will be one application process for UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
   ii. Proof of disability income (if applicable)
   iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
   iv. A Medical Assistance Notice of Determination (if applicable)
   v. Proof of U.S. citizenship or lawful permanent residence status (green card)
   vi. Reasonable proof of other declared expenses may be taken in to consideration

vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
viii. A Verification of No Income Letter (if there is no evidence of income)
ix. Three most recent bank statements

Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

d. A patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses. Within 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. Completed applications will be forwarded to the Manager of Patient Accounting who will determine approval for adjustments up to $10,000. Adjustments of $10,000 or greater will be forwarded to the V.P. of Finance for an additional approval.
e. Once a patient is approved for FA, eligibility will be extended to the following accounts:
    i. All accounts in an FB (Final Billed) status
    ii. All accounts in a BD (Bad Debt) status that were transferred within one year of the service date of the oldest FB account being adjusted using the current application
    iii. All future visits within 6 months of the application date
f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
g. UCH does not report debts owed to credit reporting agencies.
h. In rare cases, accounts may warrant Extraordinary Collection Actions (ECAs). Once an account has met the following criteria, the account is closed by the collection agency as "uncollectible" and forwarded back to Patient Accounting for review to establish grounds for legal action. UCH reserves the right to place a lien on a patient's income, residence and/or automobile. This only occurs after all efforts to resolve the debt have been exhausted.

    Criteria:

    i. The debt is valid
    ii. The account is equal to or greater than 120 days old
    iii. Patient refuses to acknowledge the debt
    iv. Upon review and investigation, we have determined liquid assets are available (checking, savings, stocks, bonds or money market accounts)

v. The VP of Finance must authorize legal action

Action will be preceded by notice 30 days prior to commencement. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

5. Financial Hardship

a. Financial Hardship is a separate, supplemental determination of Financial Assistance and may be available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy
b. Financial Hardship Assistance is defined as facility charges incurred at UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. Family annual income must be less than 500% of the Federal Poverty Limit
c. Once a patient is approved for Financial Hardship Assistance, coverage may be effective starting with the first qualifying date of service and the following twelve (12) months
d. Financial Hardship Assistance may cover the patient and the immediate family members living in the same household. Each family member may be approved for the reduced cost and eligibility period for medically necessary treatment.
e. Coverage will not apply to elective or cosmetic procedures.
f. In order to continue in the program after the expiration of an eligibility period, each patient (family member) must reapply to be considered.
g. Patients who have been approved for the program should inform UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes
h. All other eligibility, ineligibility and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance, unless otherwise stated

DEVELOPER:

Patient Financial Counselor, UCH

Reviewed / Revised: 04/2016

ORIGIN DATE: 10/2010

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 03//2018

Approved by: _____

Steve Witman, Sr. VP CFO

_____

Board of Directors

To provide financial relief to patients unable to meet their financial obligation to Upper Chesapeake Health.

1. **Policy**
    a. This policy applies to Upper Chesapeake Health (UCH). UCH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
    b. It is the policy of UCH to provide Financial Assistance (FA) based on indigence or high medical expenses (Medical Financial Hardship program) for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for FA should be made, the criteria for eligibility, and the steps for processing applications.
    c. UCH will post notices of availability at appropriate intake locations as well as the Patient Accounting Office. Notice of availability will also be sent to patients on patient bills. Signs will be posted in key patient access areas. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request. A written estimate of total charges, excluding the emergency department, will be available to all patients upon request.
    d. FA may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include a

review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.

e. Payments made for care received during the financial assistance eligibility window that exceed the patients determined responsibility will be refunded if that amount exceeds $5.00
    i. Collector notes, and any other relevant information, are deliberated as part of the final refund decision; in general refunds are issued based on when the patient was determined unable to pay compared to when the payments were made
    ii. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for a refund
f. UCH retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services or diagnosed-cancer care will be treated regardless of their ability to pay, except as noted under 2. d. iv. below.

2. Program Eligibility

a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the UCH commitment to our mission to provide healthcare to the surrounding community, UCH reserves the right to grant financial assistance without formal application being made by our patients.
b. Specific exclusions to coverage under the FA program include the following:
    i. Physician charges are excluded from UCH's FA policy. Patients who wish to pursue FA for physician related bills must contact the physician directly. For a list of physicians providing emergency and other medically necessary care in the hospital facility, whose services are not covered under this policy, please visit our website or contact our Financial Assistance Department at (443) 843-5092.
    ii. Generally, the FA program is not available to cover services that are 100% denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications
    iii. Unpaid balances resulting from cosmetic or other non-medically necessary services

c. Patients may become ineligible for FA for the following reasons:
    i. Refusal to provide requested documentation or provide incomplete information
    ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance programs that deny access to UCH due to insurance plan restrictions/limits
    iii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program
d. Determination for Financial Assistance eligibility will be based on assets, income, and family size. Please note the following:
    i. Liquid assets greater than $15,000 for individuals, and $25,000 for families will disqualify the patient for 100% assistance.
    ii. Equity of $150,000 in a primary residence will be excluded from the calculation for determination of financial assistance; and
    iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans will not be used for determination of financial assistance.
    iv. Non-citizens/non-residents of the United States may only qualify for Financial Assistance under these circumstances: 1. an initial visit for emergency care or 2. if qualified for presumptive Medical Assistance upon inpatient admission or prior to outpatient treatments for cancer care, and only after a determination by the Financial Counselor/Director of Patient Accounting and/or V.P. of Finance. See the Upper Chesapeake Health Self Pay Billing policy for criteria for beginning outpatient cancer care for these patients.
e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a FA application unless they meet Presumptive FA (see section 3 below) eligibility criteria. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
f. Free medically necessary care will be awarded to patients with family income at or below 200 percent of the Federal Poverty Level (FPL).

g. Reduced-cost, medically necessary care will be awarded to low-income patients with family income between 200 and 300 percent of the FPL
h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.
i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor. Payment plans are available to uninsured patients with family income between 200% to 500% of the FPL.

3. Presumptive Financial Assistance

a. Patients may also be considered for Presumptive Financial Assistance eligibility with proof of enrollment in one of the programs listed below. There are instances when a patient may appear eligible for FA, but there is no FA form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patent with FA. In the event there is no evidence to support a patient's eligibility for FA, UCH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100-percent write-off of the account balance. Presumptive FA eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
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    ii. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
    iii. Homelessness
    iv. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
    v. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
    vi. Participation in Women, Infants and Children Program (WIC)
    vii. Supplemental Nutritional Assistance Program (SNAP)
    viii. Eligibility for other state or local assistance programs
    ix. Deceased with no known estate
    x. Determined to meet eligibility criteria established under former State Only Medical Assistance Program
    xi. Households with children in the free or reduced lunch program

xii. Low-income household Energy Assistance Program
xiii. Self-Administered Drugs (in the outpatient environment only)
xiv. Medical Assistance Spenddown amounts

b. Specific services or criteria that are ineligible for Presumptive FA include:
   i. Purely elective procedures (e.g. cosmetic procedures) are not covered under the program
   ii. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
   i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
   ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
   iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to. The financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill is sent.
c. There will be one application process for UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
   i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
   ii. Proof of disability income (if applicable)
   iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
   iv. A Medical Assistance Notice of Determination (if applicable)
   v. Proof of U.S. citizenship or lawful permanent residence status (green card)

vi. Reasonable proof of other declared expenses may be taken in to consideration
vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
viii. A Verification of No Income Letter (if there is no evidence of income)
ix. Three most recent bank statements

Written request for missing information will be sent to the patient. Where appropriate, oral submission of needed information will be accepted.

d. A patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses. Within 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. Completed applications will be forwarded to the Manager of Patient Accounting who will determine approval for adjustments up to $10,000. Adjustments of $10,000 or greater will be forwarded to the Director of Patient Financial Services and the V.P. of Finance for an additional approval.
e. Once a patient is approved for FA, eligibility will be extended to the following accounts:
    i. All accounts in an AR (Accounts Receivable) status
    ii. All accounts in a BD (Bad Debt) status that were transferred within one year of the service date of the oldest AR account being adjusted using the current application
    iii. All future visits within 6 months of the application date
f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
g. UCH does not report debts owed to credit reporting agencies.
h. In rare cases, accounts may warrant Extraordinary Collection Actions (ECAs). Once an account has met the following criteria, the account is closed by the collection agency as "uncollectible" and forwarded back to Patient Accounting for review to establish grounds for legal action. UCH reserves the right to place a lien on a patient's income, residence and/or automobile. This only occurs after all efforts to resolve the debt have been exhausted.

    Criteria:

    i. The debt is valid
    ii. The account is equal to or greater than 120 days old
    iii. Patient refuses to acknowledge the debt

iv. Upon review and investigation, we have determined liquid assets are available (checking, savings, stocks, bonds or money market accounts)
v. The VP of Finance must authorize legal action

Action will be preceded by notice 30 days prior to commencement. Availability of financial assistance will be communicated to the patient and a presumptive eligibility review will occur prior to any action being taken.

5. Financial Hardship

a. Financial Hardship is a separate, supplemental determination of Financial Assistance and may be available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy
b. Financial Hardship Assistance is defined as facility charges incurred at UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. Family annual income must be less than 500% of the Federal Poverty Limit
c. Once a patient is approved for Financial Hardship Assistance, coverage may be effective starting with the first qualifying date of service and the following twelve (12) months
d. Financial Hardship Assistance may cover the patient and the immediate family members living in the same household. Each family member may be approved for the reduced cost and eligibility period for medically necessary treatment.
e. Coverage will not apply to elective or cosmetic procedures.
f. In order to continue in the program after the expiration of an eligibility period, each patient (family member) must reapply to be considered.
g. Patients who have been approved for the program should inform UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes
h. All other eligibility, ineligibility and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance, unless otherwise stated
i. See Attachment A for the sliding scale reduced cost of care.

6. Amounts Generally Billed

a. An individual who is eligible for assistance under this policy for emergency or other medically necessary care will never be charged more than the amounts generally billed (AGB) to an individual who is not eligible for

assistance. The charges to which a discount will apply are set by the State of Maryland's rate regulation agency (HSCRC) and are the same for all payers (i.e. commercial insurers, Medicare, Medicaid or self-pay).

Reviewed / Revised: 03/2018

ORIGIN DATE: 10/2010

NEXT REVIEW DATE: 03/2019

1/23/2018

% discount	MAX/MIN	Family 1	Family 2	Family 3	Family 4	Family 5	Family 6	Family 7	Family 8
Fed Pov Guideline		$12,140.00	$16,460.00	$20,780.00	$25,100.00	$29,420.00	$33,740.00	$38,060.00	$42,380.00
MHA Guidelines now at 200% of FPL									
100%	up to	$ 24,280.00	$ 32,920.00	$ 41,560.00	$ 50,200.00	$ 58,840.00	$ 67,480.00	$ 76,120.00	$ 84,760.00
90%	Min	$ 24,281.00	$ 32,921.00	$ 41,561.00	$ 50,201.00	$ 58,841.00	$ 67,481.00	$ 76,121.00	$ 84,761.00
	Max	$ 26,708.00	$ 36,212.00	$ 45,716.00	$ 55,220.00	$ 64,724.00	$ 74,228.00	$ 83,732.00	$ 93,236.00
80%	Min	$ 26,709.00	$ 36,213.00	$ 45,717.00	$ 55,221.00	$ 64,725.00	$ 74,229.00	$ 83,733.00	$ 93,237.00
	Max	$ 27,922.00	$ 37,858.00	$ 47,794.00	$ 57,730.00	$ 67,666.00	$ 77,602.00	$ 87,538.00	$ 97,474.00
70%	Min	$ 27,923.00	$ 37,859.00	$ 47,795.00	$ 57,731.00	$ 67,667.00	$ 77,603.00	$ 87,539.00	$ 97,475.00
	Max	$ 29,136.00	$ 39,504.00	$ 49,872.00	$ 60,240.00	$ 70,608.00	$ 80,976.00	$ 91,344.00	$ 101,712.00
60%	Min	$ 29,137.00	$ 39,505.00	$ 49,873.00	$ 60,241.00	$ 70,609.00	$ 80,977.00	$ 91,345.00	$ 101,713.00
	Max	$ 30,350.00	$ 41,150.00	$ 51,950.00	$ 62,750.00	$ 73,550.00	$ 84,350.00	$ 95,150.00	$ 105,950.00
50%	Min	$ 30,351.00	$ 41,151.00	$ 51,951.00	$ 62,751.00	$ 73,551.00	$ 84,351.00	$ 95,151.00	$ 105,951.00
	Max	$ 31,564.00	$ 42,796.00	$ 54,028.00	$ 65,260.00	$ 76,492.00	$ 87,724.00	$ 98,956.00	$ 110,188.00
40%	Min	$ 31,565.00	$ 42,797.00	$ 54,029.00	$ 65,261.00	$ 76,493.00	$ 87,725.00	$ 98,957.00	$ 110,189.00
	Max	$ 32,778.00	$ 44,442.00	$ 56,106.00	$ 67,770.00	$ 79,434.00	$ 91,098.00	$ 102,762.00	$ 114,426.00
30%	Min	$ 32,779.00	$ 44,443.00	$ 56,107.00	$ 67,771.00	$ 79,435.00	$ 91,099.00	$ 102,763.00	$ 114,427.00
	Max	$ 33,992.00	$ 46,088.00	$ 58,184.00	$ 70,280.00	$ 82,376.00	$ 94,472.00	$ 106,568.00	$ 118,664.00
20%	Min	$ 33,993.00	$ 46,089.00	$ 58,185.00	$ 70,281.00	$ 82,377.00	$ 94,473.00	$ 106,569.00	$ 118,665.00
	Max	$ 35,206.00	$ 47,734.00	$ 60,262.00	$ 72,790.00	$ 85,318.00	$ 97,846.00	$ 110,374.00	$ 122,902.00
10%	Min	$ 35,207.00	$ 47,735.00	$ 60,263.00	$ 72,791.00	$ 85,319.00	$ 97,847.00	$ 110,375.00	$ 122,903.00
	Max	$ 36,420.00	$ 49,380.00	$ 62,340.00	$ 75,300.00	$ 88,260.00	$ 101,220.00	$ 114,180.00	$ 127,140.00