UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH

Conversion of University of Maryland
Harford Memorial Hospital to a Freestanding Medical Facility
Matter No. 17-12-004

Responses to Additional Information Questions Dated March 22, 2019 and Revised Additional Information Question #5 dated March 27, 2019

Project Description

1. **In your project description (p. 12) you refer to the project schedule being incorporated by reference. Please provide the information that you intended to incorporate by reference. Such information should be included in the body of the application documents so that reviewers don't have to spend time cross-referencing other documents, and instead have the necessary information readily available.**

Applicants' Response

The Applicants do not intend to incorporate any responses to State Health Plan Chapter standards by reference. The Applicants merely intend for the Commission staff to bear in mind that the Applicants' request for conversion of HMH to a freestanding medical facility is integrally related to UM UCH's CON Application to establish a forty-bed special psychiatric hospital in Aberdeen and request for exemption from CON review to merge and consolidate HMH and UCMC.

State Health Plan Standards

COMAR 10.24.19.04.A

2. **We note that we have already informed you that your submission did not provide responses for standards C. (1) through C. (3), and that you have since provided that.**

Applicants' Response

See Applicants' Responses to Additional Information Questions dated January 4, 2019.

Charity Care Policy

3. **Based on the information submitted, it is not possible to determine whether your charity care policy is in compliance with the "Determination of Probable Eligibility" subpart of this standard (COMAR 10.24.19.04(C)(5)(a)(i)). Describe how this determination is made, and what information is required in order to convey**

probable eligibility (as contrasted with what is required to make final determination.[1]

If your review of your process and application forms do not comply with this standard, please revise it to do so.

Applicants' Response

UM UCH's charity care policy, which will be implemented at UC FMF, complies with the requirements of COMAR 10.24.10.04A(2). *See* **Exhibit 3**, UM UCH's Financial Assistance Policy. In **Exhibit 3**, UM UCH included its Financial Assistance Policy in effect at the time the Request for Exemption from CON Review was filed as well as a draft Financial Assistance Policy that was pending approval by the UM UCH Board of Directors. Subsequent to the filing of the Applicants' Request for Exemption from CON Review, UM UCH's Board formally approved of UM UCH's revised Financial Assistance Policy. A signed version of the revised financial assistance policy dated October 2018, is submitted herewith as **Exhibit 7**. Along with **Exhibit 7**, UM UCH is also enclosing its Financial Assistance Form, instructions to patients and financially responsible persons concerning completion of its Financial Assistance Application Form, a follow-up letter to patients regarding probable eligibility, and the current schedule of federal poverty levels used to make eligibility determinations.

Notices regarding UM UCH's financial assistance policy are currently posted in UM UCH's respective admissions offices, business offices, and emergency department areas. Additionally, UM UCH publishes notice annually in the Harford County Aegis in the form attached as **Exhibit 8**. Further, UM UCH's Financial Assistance Policy and related materials are available on UM UCH's website at the following URL:

https://www.umms.org/uch/patients-visitors/for-patients/financial-assistance

As set forth in UM UCH's Financial Assistance Policy, patients will be deemed presumptively eligible for financial assistance if they qualify pursuant to one or more of fourteen (14) enumerated criteria, including:

I. Active Medical Assistance pharmacy coverage
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)

[1] Note that the standard requires a two-day turnaround for a determination of probable eligibility, which allows a patient to know their likely eligibility for charity care without having to retrieve documentation that might not be readily available. As long as there is a simple procedure to assess probable eligibility, it is acceptable for the facility to require documentation prior to granting a final determination of eligibility.

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

Even if a patient does not qualify for presumptive eligibility, a probable eligibility determination may be made based on verbal or documented income levels and number of family members. Following a determination of probable eligibility, the follow-up letter enclosed with **Exhibit 7** is mailed to patients within two business days. UM UCH also reserves the right to make eligibility determinations without a formal application from its patients.

4. **You did not address the distribution of your charity care public notice (COMAR 10.24.19.04(C)(5)(a)(ii)). Please provide a copy of this public notice and describe how you will disseminate it to your service area population on an annual basis.**

Applicants' Response

See Applicants' Response to Question 3 above.

Number of Emergency Treatment Spaces

5. **The chart below reflects:**
   - **Rows 1 and 2: ACEP's prescribed number of "Total Spaces"[2] (ACEP, page 116-117) at low and high range estimates for 25,000 and 30,000 visit levels;**
   - **Row 3: the number of rooms ACEP would recommend scaled to your projected level of 27,000 visits in 2022;**
   - **Row 4: the number of rooms that you proposed for the FMF;**
   - **Row 5: the excess number of ED treatment spaces (the difference between what you proposed and the ACEP recommended number); and**
   - **Row 6: for illustration, the number of visits that would be needed to justify the number of treatment spaces proposed.**

[2] ACEP's "Total Spaces" includes "Extended Stay" treatment spaces (ACEP, p. 116 and 117). After consulting with MHCC policy staff, we concluded that the intent of the Standard is to allow applicants to include "Extended Stay" treatment spaces in their proposed number of ED treatment spaces even if the facility will have a dedicated observation unit.

		Low Range Estimate	High Range Estimate
		Total Spaces	Total Spaces
1	25,000 ED Visits	18 Spaces	20 Spaces
2	30,000 ED Visits	21 Spaces	25 Spaces
3	Spaces needed to accommodate the 27,000 visits projected for the FMF[3]	19 Spaces	22 Spaces
4	Proposed # of Total ED Spaces	25 Spaces	25 Spaces
5	Excess ED Treatment Spaces	6	3
6	ED Visits Required to Justify 25 Total ED Spaces[4]	40,000 ED Visits	30,000 ED Visits

This standard – COMAR 10.24.19.(8)(d) -- requires an applicant to "…Demonstrate that the proposed number of treatment spaces is consistent with the low range guidance [included in the most current edition of *Emergency Department Design: A Practical Guide to Planning for the Future*], unless, based on the particular characteristics of the population to be served, the applicant demonstrates the need for a greater number of treatment spaces."

Staff suggests that you reduce the number of rooms proposed, or make a compelling case for why "the particular characteristics of the population to be served…demonstrates the need for a greater number of treatment spaces." Please note that the ACEP guidelines intend for behavioral health treatment spaces to be included in the number of general treatment spaces requested; they are not extra rooms that should be "carved out" separately; i.e., behavioral health treatment spaces should be included in your proposed total ED spaces, not "add-on" spaces.

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[3] The number of ED spaces allowable for a facility with 27,000 ED visits was calculated as follows:

Low Range Estimate:
18 treatment spaces/25,000 visits = 0.00072
21 treatment spaces/30,000 visits = 0.0007
0.00071 (average of the two results above) x 27,000 visits = 19.17
Round down to 19 ED spaces
High Range Estimate:
20 treatment spaces/25,000 visits = .0008
25 treatment spaces/30,000 visits = .00083
.000815 (average of the two results above) x 27,000 visits = 22.005
Round down to 22 ED spaces

[4] ACEP designates behavioral health treatment spaces as general treatment spaces (ACEP, p. 114). As a result, a carve-out for behavioral health treatment spaces is not necessary. Behavioral health treatment spaces should be included in your requested total ED spaces

Applicants' Response

At the outset, the Applicants note that the footnote associated with the Question 5 includes a more reasoned analysis (i.e., a mathematical analysis) concerning the number of treatment spaces which are permitted by the ACEP Guide than the actual ACEP Guide. And, that is because the ACEP Guide itself is described by the author "as a starting point" for emergency department planning with "general guideline[s]" to be used for internal planning to set "preliminary benchmarks for sizing emergency departments," which can be adjusted for "each unique emergency department project" and that the size parameters are merely "estimates." *See* ACEP Guide at 106-109. Indeed, as the ACEP Guide states:

> there's no magic formula for a set number of examination rooms and square footage calculations for a certain number of patient visits. *There's no "if you see 'X' number of patients in a year, your department should be 'Y' square feet with 'Z' number of patient care spaces."* There are too many variables to consider. We can't reduce space programming to 'one size fits all. The key is for you to understand how your unique variables will affect your space need, and the biggest impact is your turnaround time for patients using examination spaces.

ACEP Guide at 106 (emphasis added).

In accordance with the ACEP Guide's instructions, UC FMF has been designed to meet the needs of the HMH's historic service area population. The proposed UC FMF includes a total of twenty-five (25) emergency department treatment spaces as follows: (1) 16 standard examination rooms; (2) 2 isolation rooms; (3) 2 resuscitation rooms; (3) 4 standard behavioral health crisis examination rooms; and (5) 1 behavioral health seclusion room that will be used for patients experiencing emotional responses that are poorly modulated and who pose a threat to themselves and others. The analysis set forth on pages 31 through 36 of the Request for Exemption from CON Review establishes that the particular characteristics from the population to be served require the number of treatment spaces proposed for UC FMF. A rigid application of the ACEP Guide's "low range" guidance, which was never intended by its author to be a canonical ceiling or floor for emergency department planning, would preclude UC FMF from having the capacity to serve the historic service area population of HMH upon conversion to a freestanding medical facility and would result in artificial barriers to timely treatment or emergency medical conditions.

The Applicants' plan for and description of its standard emergency and behavioral health crisis departments separately is fully consistent with ACEP Guide. In this regard, pages 109-112 of the ACEP Guide describe the "[f]actors that [author of the ACEP Guide suggests] will determine whether your future emergency Department will be designed in the low range or the high range." On page 111, there is a factor called "Percentage of behavioral health patients." The "low range" criterion states, "[u]nder 3% would put in the low range, and you would probably not define a specialized area in the emergency department for behavioral health patients." At the mid-range, the ACEP Guide instructs: "4% to 6% behavioral health patients would be average and you might define a few rooms as safest possible healing environmental rooms." In contrast, the "high range" criterion states: "7% or over for behavioral health would be considered high, and you might develop special areas or suites for these specialty patients."

UC FMF projects to be in the "high range" because 6.8% of HMH's historic emergency department patients experience behavioral health emergencies, and therefore, under the ACEP Guide, UC FMF should develop a special area or suite for these specialty patients.

With respect to designing behavioral health service areas, the ACEP Guide further instructs:

> The first step in identifying your physical space needs for behavioral health care is to identify the intended services and corresponding length of stay. How long will you need to hold patients after initial diagnosis and stabilization? Will you transfer patients to psychiatric inpatient floors or outpatient services within your own hospital? Or, will you be at the mercy of the receiving facilities and transport services when referring patients to appropriate outplacement locations? Review all possible operational scenarios to determine the quantity of behavioral health patient cares paces.

See ACEP Guide at 218.

In accordance with this guidance, the Applicants projected the need for behavioral health treatment bays separately (or "carved" them out) from its non-behavioral health treatment bays. Both the need assessment and the separate placement are consistent with the ACEP Guide. On the same page, the ACEP Guide states:

> The behavioral health care unit should be designed in a location with direct access from both the ambulance entrance and the walk-in entrance. The intent is to place the behavioral health care zone in an accessible area while still limiting, or eliminating, all cross-circulation with other emergency department patients.

Id.

Here, the Applicants have attempted to accomplish this through the proposed design. There is nothing in the ACEP Guide that prohibits the separation of the behavioral health zone from other treatment zones when using the capacity planning criteria.

6. Your proposed number of behavioral health treatment spaces is based on visit data from one peak hour (5:00 pm) and extrapolates that for 20 hours (p. 36 and 37). Similarly, the methodology uses the average length of stay (LOS) for this cohort and assumes that LOS for all behavioral health patients. This methodology obviously inflates the number of psychiatric/behavioral health visits that the FMF will need to accommodate. The justification and rationale for this assumption is not clear to staff reviewers.

- **a) Please explain and justify this approach.**
- **b) Please provide the actual number and average length of stay (LOS) of emergency psychiatric visits at HMH for the last three fiscal years (FYs 2016-2018).**
- **c) Recalculate the needed number of behavioral health treatment spaces based on the data provided by this broader sampling of behavioral health ED visits.**

Applicants' Response

The Applicants disagree that the methodology used to determine need for the number of behavioral health emergency treatment spaces "inflates the number of psychiatric/behavioral health visits that the FMF will need to accommodate." Rather, the methodology employed projects the peak demand for such treatment spaces so that UC FMF will be able to accommodate all patients presenting to it who are experiencing behavioral health emergencies.

The proposed five (5) behavioral health crisis treatment spaces represent a small, specialized unit. As such, the Applicants determined its was necessary to size the behavioral health crisis treatment spaces around the peak period of utilization. The Applicants extrapolated the 5:00 pm peak utilization in fiscal year 2017 to calculate a peak period adjustment that was applied to the projected bed need to ensure a sufficient number of behavioral health treatment spaces are available to meet peak demand for patients experiencing behavioral health emergencies. Overall, as a percentage of total ED visits, the number patients experiencing behavioral health emergencies at HMH has been increasing. In fiscal year 2016, 6.7% of HMH's ED visits had psychiatric diagnoses. This percent grew to 6.8% in fiscal year 2017 and 7.3% in fiscal year 2018. *See* Table 31 below.

Table 31
HMH Historical Behavioral Health Emergencies
FY2015 - FY2017

	Historical		
	FY2016	FY2017	FY2018
HMH ED Visits	29,520	28,356	26,743
HMH Psych ED Visits	1,987	1,941	1,942
Psych Visits % of Total	*6.7%*	*6.8%*	*7.3%*
HMH Psych ED Visits ALOS (hrs)	9.1	8.9	11.3

Source: HMH internal ED patient level detail data sets

Patients experiencing behavioral health emergencies are also staying in the ED longer. From fiscal year 2016 to 2018, the average length of stay associated with psychiatric ED visits increased 24%; the length of stay increased from 9.1 hours in fiscal year 2016 to 11.3 hours in fiscal year 2018. This increased length of stay reinforces the Applicants' need to plan a dedicated behavioral health unit at UC FMF and to size that unit for peak utilization. As is well documented, patients experiencing behavioral health emergencies in a general emergency department are often disruptive and bog down efficient department operations.

The Applicants acknowledges that the five behavioral health treatment spaces will not be in peak demand all of the time. Based on fiscal year 2017 experience at HMH, 13.3% of behavioral health visits occurred between the 5:00 p.m. and 6:00 p.m. hours. It is also important to note that 56.3% of HMH's behavioral health visits occurred between the hours of 12:00 p.m. and 8:00 p.m. Between these hours, UC FMF's behavioral health deparement

projects to operate at 90% of peak utilization. With a growth in psychiatric ED visits as a percentage of total ED visits and increase in the average length of stay, the Applicants strongly believe that it is important to have sufficient distinct behavioral health crisis treatment spaces to accommodate patients with psychiatric needs. As such, the Applicants request approval for five (5) behavioral health crisis treatment spaces.

Projected Percentage of Admitted Patients at UC FMF

7. **Your exemption request states that "UC FMF projects to be in the mid-range of the ACEP guide based on historic emergency department visits at HMH and projected visits to UC FMF" (p. 39 and 40) and on Table F you project that UC FMF will have approximately the same number of ED visits in its first year (FY 2022) of operation as HMH had in the last year of its operation (FY 2021). When calculating your projections, did you consider the possibility that ED volume at an FMF, which replaces an acute care hospital, might experience a decline in ED visits because both consumers and EMS personnel – expecting that a certain level of acuity would likely require admission to a hospital – might bypass an FMF and go straight to an acute care hospital?**

Applicants' Response

The Applicants have assumed that with the exception of 0.4% of historical visits that originate from northeast County and a limited number of EMS priority 1, non-stroke patients, the residents of HMH's service area will continue to come to UC FMF when experiencing emergency health conditions. These utilization projections are supported by UC FMF's plans to implement an Acute Stroke Ready Pilot and MIEMMS protocol changes allowing stable priority 2 and priority 1 stroke patients to be transported to UC FMF. The increase in accessibility to Interstate 95 rather than HMH's landlocked campus in downtown Havre de Grace is also likely to result in an increase in patient walk-ins particularly from surrounding areas, including Aberdeen, due to UC FMF being more readily accessible than HMH. Finally, UM UCH has been educating and will continue to educate the community consistently that approximately 90% of their care can be received on the UC Medical Campus at Aberdeen. The Applicants, therefore, anticipate the community will appropriately seek care at UC FMF when experiencing emergent medical conditions in the same manner as care is currently sought at HMH's emergency department. Moreover, patients experiencing emergency health conditions are unlikely to be able to self-diagnose conditions that may require an inpatient admission or to elect to bypass UC FMF in an emergency by traveling an additional 12.4 miles to UCMC, 21.8 miles to Union Hospital of Cecil county, or 23.2 miles to Franklin Square Medical Center.

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

Finally, of the 65 and older patients, 48.0% arrived to HMH's emergency department by ambulance. *See* Table 32 below.

Table 32
HMH % of Emergency Department Patients >= 65 Arriving by Ambulance
FY 2017

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

Source: UCHS Internal Utilization Report

Ambulance transport for nearly fifty percent (50%) of the aged 65 and over population, particularly EMS transport, is expected to limit any patient self-selection of the emergency department to which these patients are transported. As noted by the Commission in its February 2, 2015 Report on the Operations, Utilization, and Financial Performance of Freestanding Medical Facilities, EMS transport protocols are likely contributing factors to low utilization of existing Maryland FMFs by the population aged 65 and older. As set forth above, UC FMF projects that only a limited number of non-stroke priority 1 patients that are currently treated at HMH could not be treated at UC FMF in accordance with revised MIEMSS protocols and the pilot stroke protocol approved for UC FMF.

Number of Observation Treatment Spaces Consistent with the Needs of the Population

8. How did you arrive at your "peak utilization" levels for observation (p. 60)? What hours of the day were used? What period of time or months were used? Please provide a full explanation of your calculation of "peak utilization" and explain how it was utilized to make other projections and calculations within your request.

Applicants' Response

Because UC FMF will not have inpatient beds in which it could treat patients in outpatient observation "status," UC FMF was designed to account for peak levels of outpatient observation utilization. A detailed patient level data set of HMH observation cases for the twelve months ended August 2018 was analyzed to identify peak utilization days during the year. From this analysis, five (5) days were identified during the year that experienced a peak utilization of 38 observation patients occupying beds. This peak utilization was compared to the average daily census of 13 observation patients in fiscal year 2018 to calculate a peak period adjustment of 292% to be applied to the projected average daily census in each year. In fiscal year 2024, the average daily census associated with billed hours is projected to equal 11.1 observation patients. Applying the 292% peak utilization adjustment results in a calculation of 32 beds.

While the Applicants' observation bed need analysis projects a need for thirty-two (32) observation beds at UC FMF, the Applicants propose only twenty-four (24) observation beds. Based on 2018 experience, it is expected that observation utilization will meet or exceed UC FMF's observation capacity approximately 14% of the time. The design of the new facility, though, is expected to provide greater flexibility in managing the bed needs of observation patients. In addition, UC FMF can transfer patients to UCMC if observation beds are not available at UC FMF.

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9. The length of the observation stays projected in this proposal seems excessive. Please justify and put into context.

Applicants' Response

The Applicants disagree that the projected observation length of stay is "excessive" because the observation length of stay information presented in the Applicants' request is based upon historical data at HMH.

To project the average length of observation stays at HMH through fiscal year 2021 and at UC FMF beginning in fiscal year 2022 requires an understanding of the observation hours that can be billed and those hours that cannot be billed. Per the HSCRC Experience Report dataset, HMH reported 114,915 observation hours in fiscal year 2018 (Table 33). Included in these hours are 23,762 hours related to observation patients that were eventually admitted as inpatients and 91,153 hours for patients that remained in outpatient status (i.e., observation) for the duration of their stay. According to billing requirements for those patients that were eventually admitted as inpatients, only the observation hours that occurred prior to 12:00 a.m. of the day of admission can be billed. In other words, in HMH's actual experience in fiscal year 2018, more than 25% of all observation hours could not be billed and were not counted towards the HSCRC's Experience Report dataset total of observation hours.

During the 12 months ended August 2018, it was determined that HMH billed 135,672 observation hours, an 18% increase over the hours billed during the twelve months ended June 2018 (fiscal year 2018). In addition, there were 27,231 observation hours that could not be billed because these observation hours occurred on the same day the patient was admitted. Rather than staying in a bed an average of 1.1 days as reported in fiscal year 2018, observation patients actually stayed in beds for an equivalent of 1.5 days (Table).

Table 33
HMH's 2018 Observation ALOS

	2018		
	Inpatient	Outpatient	Total
FY2018 HSCRC Experience Report			
Cases	1,640	2,803	4,443
Hours	**23,762**	**91,153**	**114,915**
ALOS (Days)	0.6	1.4	1.1
HMH Internal Report on Observation Hours for 12 Months Ended August 2018			
Cases	1,624	2,843	4,467
Hours			
Billed	25,752	109,920	135,672
Unbilled	27,231	-	27,231
Total	**52,983**	**109,920**	**162,903**
Unbilled % of Total	*51.4%*	*0.0%*	*16.7%*
ALOS (Days)	1.4	1.6	1.5

Observation and medical patients will continue to overlap in the existing beds until a distinct observation unit is opened at UC FMF in fiscal year 2022. As such, it would be double counting to consider the full length of stay for an observation patient while also counting their inpatient days when often times the patients stay in the same bed. When a dedicated observation unit is opened, though in fiscal year 2022, the full length of stay needs to be considered when determining the required number of observation beds. Table *32* below reflects a continuation of the 1.1 day average length of stay through fiscal year 2021, but then increases it in fiscal year 2022 to reflect the amount of unbilled hours historically experienced for patients in observation. Partially offsetting the increase in length of stay for unbilled observation hours is a reduction in the length of stay at UC FMF associated with those observation cases with stays that have historically been greater than 48 hours, which patients are anticipated to be transported to UCMC.

Table 32
HMH and UC FMF Historical and Projected ALOS
FY2015 – FY2024

	Historical				Projection						% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
HMH	**1.21**	**1.20**	**1.20**	**1.08**	**1.08**	**1.08**	**1.08**				
%Change		*-0.7%*	*-0.1%*	*-10.0%*	*0.0%*	*0.0%*	*0.0%*				*-100.0%*
UC FMF								**1.25**	**1.25**	**1.25**	
%Change								*16.3%*	*0.0%*	*0.0%*	

10. On Table F you project an almost 25% increase in observation discharges and an almost 45% increase in observation patient days from the last year of HMH's operation (FY 2021) to the first year (FY 2022) of UC FMF's operation.

Applicants' Response

Submitted with **Exhibit 6** is an updated Table F that reflects the following changes to projected observation utilization:

1. A 2.4% increase in combined observation discharges at UCMC and HMH / UC FMF from 18,596 in fiscal year 2021 to 19,040 in fiscal year 2022. This increase reflects: (1) population related growth of 0.6%; and (2) 1.8% growth related to the shift of 330 observation cases from UC FMF to UCMC that are expected to last longer than 48 hours. These cases will initially be seen at UC FMF and then transferred to UCMC when it is determined that they will stay more than 48 hours. These 330 observation cases, therefore, count as observation stays at both UC FMF and UCMC. The previous projection of 5,606 observation cases at UC FMF in fiscal year 2022 has been corrected to reflect a 0.6% population growth.

2. A 47.0% increase in combined observation patient days at UCMC and HMH / UC FMF from 18,830 in fiscal year 2021 to 27,685 in fiscal year 2022. This increase reflects: (1) the 2.4% growth in observation cases as described above; and (2) a 43.6% increase in the average length of stay for the inclusion of unbilled observation hours in the determination of average length of stay. Including the unbilled observation hours at UCMC increases the average length of stay by 50% from an average of 1.0 day as reported to the HSCRC to 1.5 days that reflects the total length of stay for observation patients. At HMH / UC FMF, the inclusion of unbilled hours increase the average length of stay by 16.3% from an average of 1.1 day at HMH to 1.25 days at UC FMF.

11. The proposed number of 24 observation beds at this new FMF seems excessive considering that: a) the hospital it is replacing functions with 17 observation beds; b) the increases that you project for your observation discharges and patient days appear to be excessive; and c) your companion proposal would add a large number of observation beds at UCMC. Justify this number and discuss it in context with the UCMC project proposed in its exemption request.

Applicants' Response

The Applicants disagree that the proposed number of observation treatment beds is excessive. In fact, the Applicants project a need for thirty-two (32) observation beds at UC FMF, but only propose to construct twenty-four (24).

The growth in number of observation beds at UC FMF is a function of several factors, including: (1) the expected growth in the number of observation cases; (2) an accurate calculation of the length of stay associated with those observation cases, including unbilled hours; and (3) consideration of the need to accommodate peak utilization. Current observation billing requirements for patients that are eventually admitted severely limits the number of actual observation hours that are reported in the HSCRC Experience Report dataset. This limitation on the reporting of observation hours understates the need for observation beds when establishing a dedicated observation unit at a freestanding medical facility.

1. *HMH / UC FMF Observation Cases*

Observation cases at HMH and UC FMF are projected to increase annually with population growth. This growth is partially offset between fiscal years 2019 and 2021 by 0.25% annual reductions associated with potentially avoidable utilization. Overall, the Applicants expect that there will be a 2.9% increase in observation cases at UC FMF in fiscal year 2024 when compared with observation cases at HMH in fiscal year 2018. (Table).

Table 35
HMH and UC FMF Historical and Projected Observation Cases
FY2015 – FY2024

	Historical				Projection						% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Observation Cases											
HMH	**3,761**	**3,896**	**4,019**	**4,443**	**4,458**	**4,474**	**4,491**	**-**	**-**	**-**	
%Change	*2.3%*	*3.6%*	*3.2%*	*10.5%*	*0.3%*	*0.4%*	*0.4%*	*-100.0%*	*0.0%*	*0.0%*	*-100.0%*
UC FMF								**4,516**	**4,543**	**4,571**	
%Change									*0.6%*	*0.6%*	
Total	**3,761**	**3,896**	**4,019**	**4,443**	**4,458**	**4,474**	**4,491**	**4,516**	**4,543**	**4,571**	
%Change		*3.6%*	*3.2%*	*10.5%*	*0.3%*	*0.4%*	*0.4%*	*0.6%*	*0.6%*	*0.6%*	*2.9%*

2. *HMH / UC FMF Observation Average Length of Stay*

As noted above, to project the average length of observation stays at HMH through fiscal year 2021 and at UC FMF beginning in fiscal year 2022 requires an understanding of the observation hours that can be billed and those hours that cannot be billed. Per the HSCRC Experience Report dataset, HMH reported 114,915 observation hours in fiscal year 2018 (Table 36). Included in these hours are 23,762 hours related to observation patients that were eventually admitted as an inpatient and 91,153 hours for patients that remained in outpatient status (i.e., observation) for the duration of their stay. According to billing requirements for those patients that were eventually admitted as inpatients, only the observation hours that occurred prior to 12:00 a.m. of the day of admission can be billed; approximately 25% of all observation hours cannot be billed and are not reflected in the HSCRC data.

During the 12 months ended August 2018, it was determined that HMH billed 135,672 hours, an 18% increase over the hours billed during the twelve months ended June 2018 (fiscal year 2018). In addition, there were 27,231 hours that were not billed due to their occurrence on the day of admission. Rather than staying in a bed an average of 1.1 days as reported in fiscal year 2018, observation patients actually stayed in beds for an equivalent of 1.5 days (Table).

Table 36
HMH's 2018 Observation ALOS

	2018		
	Inpatient	Outpatient	Total
FY2018 HSCRC Experience Report			
Cases	1,640	2,803	4,443
Hours	**23,762**	**91,153**	**114,915**
ALOS (Days)	0.6	1.4	1.1
HMH Internal Report on Observation Hours for 12 Months Ended August 2018			
Cases	1,624	2,843	4,467
Hours			
Billed	25,752	109,920	135,672
Unbilled	27,231	-	27,231
Total	**52,983**	**109,920**	**162,903**
Unbilled % of Total	*51.4%*	*0.0%*	*16.7%*
ALOS (Days)	1.4	1.6	1.5

Observation and medical patients will continue to overlap in the existing beds until a distinct observation unit is opened at UC FMF in fiscal year 2022. As such, it would be double counting to consider the full length of stay for an observation patient while also counting their inpatient days when often times the patients stay in the same bed. When a dedicated observation unit is opened, though in fiscal year 2022, the full length of stay needs to be considered when determining the required number of observation beds. Table 37 presents a continuation of the 1.1 day length of stay through fiscal year 2021, but then increases it in fiscal year 2022 to reflect the unbilled hours. Partially offsetting the increase in length of stay for unbilled hours is a reduction in the length of stay at UC FMF associated with those observation cases that have historically been greater than 48 hours for which the patients will be transported to UCMC.

Table 33
HMH and UC FMF Historical and Projected ALOS
FY2015 – FY2024

	Historical				Projection						% Change
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
HMH	**1.21**	**1.20**	**1.20**	**1.08**	**1.08**	**1.08**	**1.08**				
%Change		*-0.7%*	*-0.1%*	*-10.0%*	*0.0%*	*0.0%*	*0.0%*				*-100.0%*
UC FMF								**1.25**	**1.25**	**1.25**	
%Change								*16.3%*	*0.0%*	*0.0%*	

3. <u>HMH / UC FMF Observation Bed Need</u>

Included in the projection of observation bed need is a consideration for peak utilization. A detailed patient level data set of HMH observation cases for the twelve months ended August 2018 was analyzed to identify peak utilization days during the year. From this analysis, five (5) days were identified during the year that experienced a peak utilization of 38 observation

patients in a bed. This peak utilization was compared to the average daily census of 13 observation patients in fiscal year 2018 to calculate a peak period adjustment of 292% to be applied to the projected average daily census in each year. In fiscal year 2024, the average daily census associated with billed hours is projected to equal 11.1 observation patients. Applying the 292% peak utilization adjustment results in a calculation of 32 beds.

Because the building in which the FMF will reside has a capacity limit of 24 beds, the Applicant only requests 24 of the 32 projected beds (Table).

Table 38
HMH and UC FMF Historical and Projected Observation Bed Need
FY2015 – FY2024

	Historical				Projection					
	FY2015	FY2016	FY2017	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024
Bed Need										
HMH (1)	16	16	16	16	16	16	17			
UC FMF (2)								32	32	32
Total	16	16	16	16	16	16	17	32	32	32
Bed Recommendation (3)								24	24	24

Note (1): Reflects average daily census and 80% occupancy target
Note (2): Reflects peak utilization adjusted for patients staying greater than 48 hours
Note (3): Reflects building capacity

In contrast to the observation need projections for HMH and UC FMF, for the observation bed projection at UCMC presented in the related Request for Exemption from CON Review to Merge and Consolidate HMH and UCMC, UCMC did not factor peak utilization into its projection of net observation bed need. UCMC did, however, factor in unbilled observation hours in calculating its average daily observation census and observation bed need.

Size of Observation Treatment Spaces Consistent with Licensing Standards

12. ACEP Guidelines state that [observation] rooms, furnished with standard inpatient hospital beds as you propose, will need to be larger-- 150-160 square feet (ACEP, p. 271). However, your plan would build these rooms to be between 188 and 265 square feet – 25% to 76% larger than the ACEP Guidelines specify. Please explain why.

Applicants' Response

The observation rooms at UC FMF are designed around patient and family focused. The larger square footage takes into account the anticipated extended stay of the observation patients at UC FMF. When considering the ratio of nurse to patient care in the observation units the larger room provides for the collaboration of caregiver and family care for immediate patient needs. An inpatient room size in accordance with the FGI Guidelines facilitates the family zone

and furniture for staying overnight with observation patients. At UC FMF, the observation room size provides for adjoining bathrooms (and shower units on the floor) as well as a family zone in anticipation of the patient stays up to 48 hours.

The floor plate of the building has also been designed to accommodate the space planning requirements of the specialty psychiatric hospital that will be located above UC FMF, and the shared floor plate size dictates certain space planning at UC FMF.

Utilization, Revenue, and Expense Projections

13. **Table I (p. 65) appears to include utilization projections for UC FMF only, contrary to your statement that: "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." Please provide a revised Table I that reflects the information described in your request.**

Applicants' Response

Included with **Exhibit 6** is an updated Table I that presents all utilization projections for UC FMF. Utilization projections for UCMC are presented in Table F.

14. **Similarly, Table L (p. 35) appears to just include UC FMF workforce figures for FY 2024 and does not appear to include workforce figures from HMH's emergency department in FY 2017, contrary to your statement that Table L "incorporates the workforce for HMH's emergency department in fiscal year 2017 and UC FMF in fiscal year 2024." Please provide a revised Table L that reflects the information described in your request.**

Applicants' Response

Attached as **Exhibit 6**, please see a a revised Table L that presents the workforce for the direct patient care cost centers that are located at UC FMF (in FY2024) and the associated FTEs for these services in FY 2017, with the exception of observation cost center which does not have a dedicated unit at HMH in FY 2017. These observation FTEs are included in the Med/Surg departments at HMH, which are not included within this Table L. The remainder of Table L presents the administration, direct care and support FTEs for UC FMF in fiscal year 2024.

15. **Please demonstrate that your utilization projections are consistent with observed historic trends in ED use by the population in the FMF's projected service area.**

Applicants' Response

The projections of ED utilization, as presented in Table F, reflect historic ED utilization at HMH trended to account for population growth throughout the projection period. A single exception occurs in fiscal year 2022 with the closure of HMH and shift of ED visits to UC FMF which results in a 0.4% reduction in EMS Priority Level 1 visits.

16. **Please demonstrate that your utilization projections for rate-regulated outpatient services are consistent with observed historic trends use by the population in the FMF's projected service area.**

Applicants' Response

The projections of rate regulated outpatient services, as presented in Table F, reflect historic ED utilization at HMH trended to account for population growth throughout the projection period. One exception is the assumed shift of HMH outpatient surgery in fiscal year 2022 to a freestanding ambulatory surgery center in conjunction with the merger/consolidation of HMH and UCMC and conversion of HMH to UC FMF. Another exception is the inclusion of unbilled observation hours, beginning in fiscal year 2022, in the presentation of projected observation hours.

17. **Please demonstrate that the revenue estimates for emergency services and other outpatient services are consistent with utilization projections and the most recent HSCRC payment policies for FMFs. Are your revenue estimates consistent with the trends observed by other FMFs statewide and providers of emergency services and outpatient services (hospitals) in your service area? If not, explain why your projections are different and provide justification.**

Applicants' Response

The Applicants' revenue estimates are consistent with payment policies and rates that UM UCH is negotiating with the HSCRC concerning retention of HMH's global budget. The Applicants' utilization projections are specific to UC FMF, which is replacing HMH, an existing acute general hospital serving the population of Harford and Cecil Counties. The Applicants' utilization projections may not be consistent with existing or contemplated freestanding medical facilities that service other communities or that were not created as a replacement for an acute general hospital. The Applicants understand that the HSCRC will ultimately issue an opinion to the Commission concerning its revenue estimates at UC FMF.

18. **Please describe where UM UCH is in the process of negotiations with HSCRC regarding its GBR proposal.**

Applicants' Response

On behalf of the Applicants, representatives from UM UCH recently had an initial meeting with the HSCRC on March 7, 2019. Another meeting will be scheduled in early April to review the financial projection detail supporting the GBR proposal with representatives of the HSCRC. A follow-up meeting with the HSCRC related to the GBR proposal is expected to be scheduled in late April, 2019, and it is currently expected that UM UCH will reach an agreement with the HSCRC by mid-May.

Delivery of More Efficient and Effective Health Care Services

19. **In your request (p. 74) you say, "As an initial matter, in addressing the efficiency and cost effectiveness of health care service delivery, the applicants incorporate by reference UM UCH's response to COMAR 10.24.01.08G(3)(c)…". Please provide**

the information that you intended to incorporate by reference. Such information should be included in the body of the application documents so that reviewers don't have to spend time cross-referencing other documents, and instead have the necessary information readily available.

Applicants' Response

In support of establishing that the Applicants' demonstration that the conversion of HMH to UC FMF will result in the delivery of more efficient and effective health care services, the Applicants hereby incorporate by reference UM UCH's response to COMAR 10.24.01.08G(3)(c) in its Application to establish a special psychiatric hospital, *In re Upper Chesapeake Campus at Aberdeen*, Docket No. 18-12-2436, as it relates to the planning process for the proposed project and alternatives considered.

I. Planning Process for the Proposed Project and Alternatives Considered

HMH has been serving Havre de Grace and the surrounding community with acute medical inpatient and behavioral health, outpatient, surgical, and emergency services for more than 100 years. Portions of HMH's current physical plant date to 1943 with most of the facility having been constructed between 1958 and 1972. While UM UCH has invested significant operational and capital resources over the years to renovate and maintain the facility, the physical structure of the building is well beyond its useful life, has numerous infrastructure issues, is cost prohibitive to maintain for the long-term, and would require significant capital expenditures for a partial or full renovation of the facility. Renovation and expansion opportunities are also constrained by the nine acre site in downtown Havre de Grace, which is surrounded by existing developed parcels.

Over the past decade, UM UCH has considered many alternatives to the transformation and modernization of HMH to improve access and services to the community it serves and to better serve the populations of Harford and Cecil Counties within an integrated health delivery system. The proposed project involves construction of a new specialty psychiatric hospital at the UC Medical Campus at Aberdeen. Also planned at the same time as the proposed project, UM UCH proposes to develop a freestanding medical facility on the UC Medical Campus at Aberdeen and relocate other acute inpatient services from HMH to UCMC.

The primary alternatives to the proposed project included:

1. Partial and/or full renovation and expansion of HMH;

2. Relocation of HMH's acute inpatient psychiatric beds and outpatient services to UCMC, with UM UCH developing a freestanding medical facility on the UC Medical Campus at Aberdeen. HMH would also transfer MSGA beds to UCMC; and

3. Maintaining all behavioral health services on the HMH campus and relocating emergency services to a freestanding medical facility and relocating acute inpatient and surgical services to UCMC's campus.

The following four objectives were broadly considered when evaluating each of the three alternatives. The overarching and primary objective – to maintain access to health care

services for residents of UM UCH's service area – is not listed. Alternatives that did not accomplish this overarching and primary objective, such as simply closing HMH, were rejected without further analysis.

a. Coordination of health care services across the continuum of communities served by UM UCH to improve efficiency, patient outcomes, and reduce redundancy of clinical care services;

b. Reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization;

c. Efficient use of capital expenditures; and

d. Establishment of modern, innovatively designed facilities with future expansion capability.

1. Alternative 1 - Partial and/or Full Renovation and Expansion of UM HMH

In 2006, UM UCH engaged an architect and construction management company to determine the feasibility of renovating HMH. There were several key findings from this engagement.

a. Coordination of health care services across the continuum

Coordination of care across the continuum would not be improved; it could only be maintained.

b. *Reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization*.

Under Alternative 1, total per capita health care expenditures would increase due to the need for rate increases from the HSCRC to support the capital costs and increased depreciation and interest expenses.

c. *Efficient use of capital expenditures*.

UM UCH determined renovation of HMH (Alternative 1) would not result in the efficient use of capital expenditures. First, the operating rooms and radiology suite could not be renovated, primarily due to shallow, nine foot-six inch floor-to-slab height in core which would not allow modern equipment, lighting, and HVAC. As a consequence, the operating rooms and radiology suite would need to be reconstructed elsewhere on the HMH campus, which space is limited due to existing developed parcels surrounding HMH.

The existing emergency department is obsolete and lacking patient privacy. As a result, current patient flow is inefficient. Due to HMH's existing configuration, HMH's emergency department could not be expanded absent significant relocation of other services and is further constrained by HMH's limited campus expansion possibilities.

Several parts of the building would require costly asbestos abatement in any renovation project. Further, several areas of the hospital would need to be upgraded to current life safety standards. Renovation would also require significant upgrades to the HVAC and electrical systems.

All of the acute and psychiatric beds are semi-private and many of the patient rooms have not been updated in several decades. Converting these rooms to private rooms in accordance with today's standards would be costly and require a complete bed tower renovation.

While the capital cost associated with a renovating and constructing new space at HMH varied based on the scope of construction and renovation, the cost of bringing the entire facility to modern standards is estimated to be $239.3 million (updated to a midpoint of construction in 2020). The project scope included new operating rooms, a new radiology suite, infrastructure upgrades and emergency department renovations (Table).

Table 39
Estimated HMH Renovation Costs

Description	Total (in Millions)
Bed Tower Renovations (total 107 beds):	$152.7
3rd - 4th floor for complete renovation for private rooms	
Improved and relocated Central Sterile Supply, Pharmacy, and Lab	
ED Renovation/Data Center Relocation	$5.2
New OR Suite	$16.2
New Radiology	$15.1
Critical infrastructure upgrades	$6.2
Surface Parking Addition	$0.5
Demolition	$1.2
Subtotal	$201.1
Financing Cost (19%)	$38.2
Total	$239.3

d. Modern, innovatively designed facilities with future expansion capability.

Because Alternative 1 considered renovation of the existing building, the innovation potential was limited by the existing infrastructure. Furthermore, the extensive renovation required for this alternative would have been disruptive to HMH's ability to provide patient care services during the renovation. Future expansion, though limited, would be possible on the site.

2. Alternative #2 - Relocate HMH's Acute Inpatient Psychiatric Beds and Outpatient Services and MSGA Beds to UCMC, Develop a New FMF on UCH Medical Campus at Aberdeen.

UM UCH evaluated the relocation of HMH's behavioral health services to UCMC's campus in Bel Air. UCMC would build a two-level expansion to house MSGA beds transferred from HMH. There were several key findings.

*a. **Coordination of health care services across the continuum***

Coordination of care across the continuum would not be improved through Alternative 2. UCMC's campus lacks adequate contiguous space to the inpatient psychiatric beds for existing and proposed new behavioral health outpatient programs would make the program inefficient.

b. Reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization.

Alternative 2 would increase the cost of care in the community due to the need for a rate increase from the HSCRC to support the increased capital costs and depreciation and interest expenses. Additionally, a new psychiatric unit at UCMC would not provide the Maryland health care system with cost savings.

c. Efficient use of capital expenditures.

Relocation of both acute and outpatient behavioral health services as well as MSGA services from HMH to UCMC could not be accommodated in a three-level expansion above the Kaufman Cancer Center. Rather, there would need to be two separate expansion projects at UCMC. A two-level addition above the Kaufman Cancer Center, projected to cost $78,618,810, would house observation beds as a result of MSGA beds being transferred from HMH to UCMC. A separate expansion above one of UCMC's existing patient bed towers would house acute and outpatient behavioral health services. This additional expansion is projected to cost $83 million. Finally, the development of the FMF as a stand-alone facility would cost $58,259,844 because project site costs would not be shared with another facility.

The cumulative effect of relocating inpatient MSGA beds, relocating psychiatric beds, and growing existing and needed outpatient services on UCMC's campus along with the projected volume of 13,625 behavioral health outpatient visits would trigger the need for a new

parking garage. The projected costs above do not include additional costs associated with construction of a new parking garage.

d. Modern, innovatively designed facilities with future expansion capability

The new construction at UCMC that would be required for Alternative 2 would allow for modern design. It would, however, further limit the ability to expand on the UCH campus, which is already limited.

3. Alternative #3 - Maintain All Behavioral Health Services on the HMH Campus, Relocate Emergency Service to a Free Standing FMF, and Relocate Acute Inpatient Services to UCMC's Campus.

UM UCH also evaluated maintaining all behavioral health services on the HMH campus and relocating both emergency services to a freestanding medical facility and acute inpatient and surgical services to UCMC's campus. There were several key findings.

*a. **Coordination of health care services across the continuum***

Coordination of care across the continuum would not be improved; it would only be maintained.

b. *Reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization*.

Under Alternative 3, there would be major operational cost inefficiencies created by the duplication of overhead and support services on multiple campuses and UM UCH's overall financial performance would suffer as a result of these inefficiencies. There would also be a need for ongoing and incremental capital expenditures associated with the need to maintain the aging HMH facility. Overall, these inefficiencies and costs would lead to an increase the cost of care in the community due to the need for a rate increase from the HSCRC to support the increased capital costs and associated depreciation and interest expenses.

Finally, maintaining behavioral health services at HMH would not provide Maryland health system savings.

c. Efficient use of capital expenditures.

UM UCH determined that it would be too costly to construct only a freestanding medical facility on the UCH Medical Campus at Aberdeen due to extensive site acquisition and development costs being allocated to just one service line.

Moreover, Alternative 3 would require extensive capital expenditures to renovate HMH's existing psychiatric unit and to accommodate expansion of outpatient services. Total capital expenditures were estimated to be $65.6 million at HMH, plus $58,259,844 for the freestanding medical facility to be located at the UHC Medical Campus at Havre de Grace as a stand-alone

facility, plus $78,618,810 for a two-level expansion above the Kaufman Cancer Center at UCMC to house observation beds after MSGA beds were transferred from HMH to UCMC.

d. Modern, innovatively designed facilities with future expansion capability

The freestanding medical facility would be able to be innovatively designed. Even with the significant renovation at HMH, however, any future designs would be limited by the existing infrastructure without undertaking significantly more new construction and renovations. There would be room for expansion at UCH Medical Campus at Aberdeen and, potentially, expansion capability at HMH if the vacated space at the hospital could be re-purposed (at even more cost). As said previously, however, the existing building infrastructure has outlived its useful life.

4. Alternative #4 - Relocate Psychiatric Beds into a New Special Psychiatric Hospital on the UC Medical Campus at Aberdeen, Construct a Freestanding Medical Facility on the UC Medical Campus at Aberdeen, and Relocate MSGA beds from HMH to UCMC.

UM UCH evaluated a new UC Havre de Grace Medical Campus that would include a freestanding medical facility ("FMF") and a special psychiatric hospital. There were several key findings.

*a. **Coordination of health care services across the continuum***

UM UCH determined that Alternative 4 (which includes the proposed project) will result in improved care coordination across UM UCH's service area. The new special psychiatric hospital will be centrally located within UM UCH's Service area and between the two remaining acute general hospitals in the service area – UCMC and Union Hospital. This will lead to better patient access, better service to the populations of Harford and Cecil Counties, and improve behavioral health service provider recruitment and retention.

b. Reduce the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization.

A new special psychiatric hospital would provide Maryland system saving of $2.8 million annually due to the special psychiatric hospital's reimbursement being based on the Medicare prospective payment system and a reduction in rates for Medicaid utilization. The Maryland system savings was calculated using assuming the rates that Medicare will pay UC Behavioral health will be approximately 35% below what Medicare currently pays in the current regulated settings at HMH. Potential reduction in Medicaid payments was not considered in this calculation.

Pending an agreement with the HSCRC regarding distribution of HMH's global budget revenue, an increase in rates from the HSCRC will not be required under Alternative 4, which includes the proposed project. UM Upper Chesapeake Health is negotiating with the HSCRC to reallocate revenue from HMH's global budget revenue cap to cover capital expenses and volume redistribution at UC Behavioral Health, UCMC, and UC FMF. Assuming that a sufficient

amount of HMH's global budget revenue cap is reallocated within UM UCH, UM UCH anticipates that an increase in rates will not be required under Alternative 4.

c. Efficient use of capital expenditures.

Alternative 4 provides for an efficient use of capital expenditures. The new special psychiatric hospital projected capital cost is $53,889,154.

The new FMF will cost $52,723,779. The FMF would cost approximately $6,972,020 less if built as a stand-along facility because project site work and other costs can be shared with another facility as opposed to being constructed at different times in different locations. In other words, UC FMF would cost approximately $6,972,020 more if built as a stand-alone facility.

The three-level expansion at UCMC with one floor of shell space will cost $81,789,216.

d. Modern, innovatively designed facilities with future expansion capability

Alternative 4 – which includes the proposed project – allows for both modern, innovatively designed facilities and future expansion of services. The new special psychiatric hospital will offer expanded inpatient psychiatric services including a new dedicated geriatric psychiatric unit as well as expanded and new outpatient behavioral health programs. This would include an expanded outpatient psychiatric clinic and intensive outpatient services and a new partial hospitalization program. Further, there is room for future expansion of the UC Medical Campus at Aberdeen.

With respect to the relocation of MSGA beds from HMH to UCMC, construction of one shelled floor allows for the future expansion of Kaufman Cancer Center services.

Based on these factors it was determined that a new special psychiatric hospital and freestanding medical facility at UC Medical Campus at Aberdeen was the most efficient use of capital, provided the most savings to the public and all of UCH's service area, and was able to best achieve each of UM UCH's objectives, including the overarching and primary objective of maintaining access to health care services for residents of UM UCH's service area.

Table 40 below reflects the cost estimates for each of the Alternatives considered as presented above.

Table 40
Projected Costs of Alternatives Considered

Alternatives Considered	Modified CON Page Number	Cost (Behavioral Health Only)	Cost (Obs. Only)	Cost (FMF Only)	Cost (Total)
1. Partial and/or Full Renovation and Expansion of UM HMH	52	$239.3M	N/A	N/A	$239.3M
2. Relocate UM HMH's Acute Inpatient Psychiatric Beds and Outpatient Services to UM UCMC and Maintain UHCC's Inpatient Acute Care Psychiatric Beds. New FMF on Bulle Rock Site.	53	$83M	$78.6M	$52.7M	$214.3M
3. Maintain All Behavioral Services on the UC-HMH Campus and Relocate Both Emergency Service to a Free Standing FMF and Acute Inpatient and Surgical Services to UCMC's Campus. UHCC Would Maintain Its Psychiatric Beds in Elkton, Maryland.	54	$65.6M	$78.6M	$52.7M	$196.9M
4. Construct a New Specialty Psychiatric Hospital and FMF on the Bulle Rock (now Aberdeen) Site and Relocate UHCC's Acute Inpatient Psychiatric Beds to a New Specialty Psychiatric Hospital with UHCC Maintaining Outpatient Behavioral Health Services in Elkton, Maryland.	55 & Table E	$53.9M	$81.8M (includes 1 floor of shell space)	$52.7M	$185.2M

Table 41 below summarizes how UCH evaluated the performance of each of the alternatives relative to the four objectives, scoring each in from 0-5.

Table 41
Ranking of the Alternatives

	Coordination of health care services across the continuum	Reduce the total per capita health care expenditures	Efficient use of capital expenditures	Innovatively designed facilities with future expansion capability	Total
1. Partial and/or Full Renovation and Expansion of UM HMH ($239.3M)	3	0	0	3	6
2. Relocate UM HMH's Acute Inpatient Psychiatric Beds and Outpatient Services to UM UCMC. New FMF on Aberdeen Site and Two Story Expansion at UCMC to house observation beds. ($219.8)	3	0	3	3	9
3. Maintain All Behavioral Services on the UC-HMH Campus and Relocate Both Emergency Service to a Free Standing FMF and Acute Inpatient and Surgical Services to UCMC's Campus. ($202.5M)	3	0	3	3	9
4. Construct a New Specialty Psychiatric Hospital and FMF on the Aberdeen Site and a three story addition at UCMC ($188.4M)	5	5	5	4	19

The ranking of Alternatives considered above followed more than a decade of strategic planning by UM UCH to create an optimal health care delivery system for the future health care needs of Harford and Cecil County residents. UM UCH's primary objectives in its strategic planning process included: (1) coordination of health care services across the continuum of communities served by UM UCH to improve efficiency, patient outcomes, and reduce redundancy of clinical care services; (2) reduction in the total per capita health care expenditures for service area residents by reducing unnecessary acute care hospital utilization; (3) efficient use of capital expenditures; and (4) establishment of modern, innovatively designed facilities with future expansion capability.

UM UCH's lengthy strategic planning process involved community input and engagement of a number of consultants in the fields of health care planning, architecture, and construction. The alternatives presented are by no means a definitive recitation of every option

that has been considered over course of more than a decade. As reflected on pages 49-50 of the CON Application, many options were considered to transform and modernize Harford Memorial Hospital to improve access and services to the community it serves. The Alternatives presented on pages 51-56 of the CON Application reflect, at a high level, various options that were considered with cost estimations updated to reflect the current proposed mid-point of construction in 2020.

The scoring matrix above was prepared by UM UCH's-then Chief Financial Officer, who was integrally involved in UM UCH's long term strategic planning, based on the decisions by UM UCH's strategic planning committee and its senior leadership.

Exhibits and Tables

20. On Table F you do not project an increase in "Same-Day Surgery Cases" at UCMC after the merger with HMH. Is that an oversight or do you expect that overall same day surgery across the merged facilities will decline?

Applicants' Response

The Applicants do not project an increase in "Same-Day Surgery Cases" at UCMC. However, the Applicants do anticipate that numerous same-day surgery cases will shift from HMH to UCMC upon the conversion HMH to UC FMF. The Applicants, however, also anticipate that an equivalent number of same-day surgery cases as those currently performed at HMH will shift from UCMC to an ambulatory surgical facility or multiple POSCs owned and/or controlled by UM UCH.

21. On Table B "Departmental Gross Square Feet Affected by Proposed Project" you list and total all of the square footage for ED, Observation, and Imaging units together. So that the space allocation of each of these departments can be assessed individually and footages more closely, please provide a separate Table B for each of:

- **the ED section of the FMF (including all supporting services and spaces);**
- **the Observation unit (including all supporting services and spaces);**
- **the Imaging unit (including all supporting services and spaces); and**
- **the shared spaces that support all of these units.**

Applicants' Response

The Applicants have included a revised Table B with **Exhibit 6**.

Table of Exhibits

Table of Tables

Exhibit 6

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	New Construction (General)	New Construction (Emergency Department)	New Construction (Observation)	New Construction (Imaging)	Existing To Be Renovated	Existing To Remain As Is	Total After Project Completion
Emergency Department (ED)			15,674					15,674
Imaging					8,455			8,455
Observation				11,907				11,907
Lab		1,159						1,159
Pharmacy		937						937
Administration		6,267						6,267
Behavioral Health (BH) ED Crisis Unit		3,497						3,497
Public		3,914						3,914
Maintenance		1,436						1,436
Med Gas + Body Hold		641						641
Mechanical		88						88
Public Toilets		585						585
Circulation		1,219						1,219
Receiving		103	78	59	42			281
Dietary		316	238	180	129			863
Maintenance		1,113	839	636	453			3,041
Maintnenance Staff Lounge and Lockers		134	101	76	55			366
Nursing Staff Lounge and Lockers		119	90	68	49			326
Provider Staff Lounge and Lockers		194	146	111	79			529
Provider Offices		99	75	56	40			270
Housekeeping		91	69	52	37			249
Storage		313	236	179	127			855
Mechanical		564	425	322	230			1,541
Public Dining		176	132	100	72			480
Public Toilets		61	46	35	25			168
Public Conf		153	116	88	62			419
Shared Vertical Circulation		171	129	97	69			466
Shared Exterior Walls		154	116	88	63			421
Shared Circulation		796	601	455	324			2,176
Exterior Walls		1,071						1,071
Total		25,371	19,110	14,509	10,310			69,300

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	11,671	11,948
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							4,516	4,543	4,571
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**	**30,443**	**30,832**	**31,235**
b1. ICU/CCU UCMC	814	860	842	860	879	899	1,186	1,214	1,242
b2. ICU/CCU HMH	203	179	175	179	183	187			
Total MSGA	**28,336**	**29,193**	**30,472**	**30,809**	**31,161**	**31,528**	**31,630**	**32,045**	**32,477**
c. Pediatric	94	123	108	107	106	105	104	103	102
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***	***34,407***	***34,834***	***35,277***
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***	***34,407***	***34,834***	***35,277***
2. PATIENT DAYS									
a1. General Medical/Surgical* UCMC	37,389	35,932	32,685	33,441	34,226	35,039	46,312	47,391	48,510
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							5,652	5,685	5,720
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**	**73,997**	**75,253**	**76,557**
b1. ICU/CCU UCMC	3,600	3,415	3,342	3,419	3,500	3,583	4,727	4,836	4,950
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**	**78,724**	**80,090**	**81,506**
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***	***92,927***	***94,449***	***96,028***
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***	***92,927***	***94,449***	***96,028***

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	4.1	4.1	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	2.5
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	2.5	2.5	2.5
c. Pediatric	2.5	2.7	2.2	2.2	2.3	2.4	2.4	2.4	2.4
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	2.7	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	2.7	2.7	2.7
4. NUMBER OF LICENSED BEDS									
a1. General Medical/Surgical* UCMC	128	123	112	114	117	120	159	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**	**259**	**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**	**276**	**279**	**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***	***327***	***330***	***334***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***288***	***287***	***274***	***280***	***285***	***289***	***327***	***330***	***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%	79.9%	80.0%	80.5%
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							64.5%	64.9%	65.3%
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%	78.3%	78.6%	78.8%
b1. ICU/CCU UCMC	70.5%	66.8%	65.4%	66.9%	68.5%	70.1%	76.2%	79.8%	80.2%
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%**	**78.2%**	**78.6%**	**78.9%**
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%**	**77.9%**	**78.4%**	**78.8%**
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%**	**77.9%**	**78.4%**	**78.8%**
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							4,516	4,543	4,571
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

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**
b2. Hours UC FMF							135,645	136,443	137,280
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 I. STATISTICAL PROJECTIONS - UC FMF

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*									
a2. Observation UC FMF							4,516	4,543	4,571
General MSGA & Observation							**4,516**	**4,543**	**4,571**
b. ICU/CCU									
Total MSGA							**4,516**	**4,543**	**4,571**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute							***4,516***	***4,543***	***4,571***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES							***4,516***	***4,543***	***4,571***
2. PATIENT DAYS									
a1. General Medical/Surgical*									
a2. Observation UC FMF							5,652	5,685	5,720
General MSGA & Observation							**5,652**	**5,685**	**5,720**
b. ICU/CCU									
Total MSGA							**5,652**	**5,685**	**5,720**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute							***5,652***	***5,685***	***5,720***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS							***5,652***	***5,685***	***5,720***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a1. General Medical/Surgical*									
a2. Observation UC FMF							1.25	1.25	1.25
General MSGA & Observation							1.25	1.25	1.25
b. ICU/CCU									
Total MSGA							1.25	1.25	1.25
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute							1.25	1.25	1.25
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL AVERAGE LENGTH OF STAY							1.25	1.25	1.25
4. NUMBER OF LICENSED BEDS									
a1. General Medical/Surgical*									
a2. Observation UC FMF							24	24	24
General MSGA & Observation							**24**	**24**	**24**
b. ICU/CCU									

TABLE I. STATISTICAL PROJECTIONS - UC FMF

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**
Total MSGA							**24**	**24**	**24**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute							***24***	***24***	***24***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS							***24***	***24***	***24***
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a1. General Medical/Surgical*									
a2. Observation UC FMF							64.5%	64.9%	65.3%
General MSGA & Observation							64.5%	64.9%	65.3%
b. ICU/CCU									
Total MSGA							**64.5%**	**64.9%**	**65.3%**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute							**64.5%**	**64.9%**	**65.3%**
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL OCCUPANCY %							**64.5%**	**64.9%**	**65.3%**
6. OUTPATIENT VISITS									
a. Emergency Department UC FMF (Total)							27,106	27,227	27,348
b. Same-day Surgery Cases									
c. Laboratory RVUs							1,597,178	1,618,657	1,640,932
d. Imaging RVUs							488,098	494,629	501,401
e. Other (Specify/add rows of needed)									
TOTAL OUTPATIENT VISITS							***2,112,382***	***2,140,512***	***2,169,681***
7. OBSERVATIONS**									
a1. Number of Patients UCMC									
a2. Number of Patients UC FMF							4,516	4,543	4,571
b1. Hours UCMC									
b2. Hours UC FMF							135,645	136,443	137,280

* 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

TABLE L. WORKFORCE INFORMATION

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

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table J)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Medical Staff Administration										0.5	$ 33.75
Quality & Health Information Management										3.3	$ 193.75
Fiscal Services										0.9	$ 62.34
Spirituality										0.1	$ 5.91
Patient Accounting										1.8	$ 90.23
Centralized Scheduling										1.4	$ 53.73
Admitting										7.2	$ 160.74
MIS										2.4	$ 215.00
Telecommunications										0.2	$ 16.58
Administration										0.4	$ 96.45
Safety										0.2	$ 15.55
Nursing Administration										1.6	$ 191.47
Hospital Education										1.0	$ 94.48
Quality Management										0.7	$ 53.63
Readmission										1.2	$ 94.59
Clinical Resource Management										1.0	$ 94.81
Distribution										1.2	$ 40.11
Volunteers										0.3	$ 16.03
Human Resources										0.7	$ 54.36
Healthlink										0.1	$ 4.72
Performance Improvements										0.8	$ 85.39
HC Epidemiology & Infection Control										0.2	$ 13.79
Guest Services										0.3	$ 16.17
Purchasing										0.5	$ 29.70
Risk Management										0.3	$ 27.49
General Hospital										3.3	$ 178.99
Total Administration			$ -			$ -			$ -	31.3	$ 1,939.75

TABLE L. WORKFORCE INFORMATION

Direct Care Staff *(List general categories, add rows if needed)*												
Observation	-	$ -	$ -	-		$ -				18.1	$	1,090.35
Emergency Department	53.5	75.94	4,062.02	12.4		$ 1,545.43				65.9	$	5,607.45
IV Therapy	0.6	62.28	38.01	0.1		$ 24.43				0.7	$	62.44
Pharmacy	4.7	87.90	412.70	0.5		$ 76.26				5.2	$	488.96
Respiratory Therapy	4.2	82.85	349.64	0.5		$ 11.25				4.7	$	360.88
Speech Therapy	0.1	92.60	8.36	0.0		$ 1.64				0.1	$	10.00
Physical Therapy	2.8	97.82	273.31	0.3		$ (47.68)				3.1	$	225.63
Occupational Therapy	0.9	95.60	87.00	0.1		$ 25.79				1.0	$	112.79
Radiology	14.6	67.45	987.96	1.6		$ 145.74				16.3	$	1,133.70
General Ultrasound	1.9	84.33	160.60	0.2		$ 36.91				2.1	$	197.50
Nuclear Medicine	1.6	73.34	118.95	0.2		$ 60.55				1.8	$	179.50
Cat Scan	5.3	89.24	476.22	0.6		$ 19.45				5.9	$	495.66
MRI	1.7	86.01	145.44	0.2		$ 30.11				1.9	$	175.54
Imaging Support RN	0.5	99.57	48.68	0.1		$ 7.27				0.5	$	55.95
Cardiovascular Institute	2.0	39.72	79.00	0.2		$ (0.33)				2.2	$	78.67
Cardiovascular Ultrasound	6.3	74.41	465.96	0.7		$ 67.76				6.9	$	533.72
Electroencephalography	0.2	47.00	11.48	0.0		$ 4.66				0.3	$	16.14
Laboratory	14.7	69.05	1,018.25	1.6		$ 4.60				16.3	$	1,022.85
Total Direct Care	115.7		$ 8,743.58	19.2		$ 2,013.82			$ -	153.1	$	11,847.75
Support Staff *(List general categories, add rows if needed)*												
Nutritional Services										15.6	$	595.96
Plant Operations										3.7	$	230.76
Bio Med										1.5	$	80.40
Environmental Services										10.0	$	313.67
Security										7.7	$	284.82
Print Shop										0.1	$	7.26
Total Support			$ -			$ -			$ -	38.6	$	1,512.87
REGULAR EMPLOYEES TOTAL	***115.7***		***$ 8,743.58***	***19.2***		***$ 2,013.82***			**$ -**	**223.0**	**$**	**15,300.37**

TABLE L. WORKFORCE INFORMATION

2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
											$ -
											$ -
											$ -
											$ -
Total Administration			$ -			$ -			$ -		$ -
Direct Care Staff *(List general categories, add rows if needed)*											
											$ -
											$ -
											$ -
											$ -
Total Direct Care Staff			$ -			$ -			$ -		$ -
Support Staff *(List general categories, add rows if needed)*											
											$ -
											$ -
											$ -
											$ -
Total Support Staff			$ -			$ -			$ -		$ -
CONTRACTUAL EMPLOYEES TOTAL			$ -			$ -			$ -		$ -
Benefits *(State method of calculating benefits below)* **:**											**$ 3,473.18**
22.7% of Salaries											
TOTAL COST	***115.7***		***$ 8,743.58***	***19.2***		***$ 2,013.82***	***-***		***$ -***		***$ 18,773.55***

Exhibit 7

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Upper Chesapeake Health

Subject: Financial Assistance Policy

Effective Date: 10/2018

Approved by: _____

Steve Witman, Sr. VP CFO

_____

Board of Directors

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

1. **Policy**
    a. This policy applies to the University of Maryland Upper Chesapeake Health (UM UCH) facilities to include:
        i. University of Maryland Upper Chesapeake Medical Center
        ii. University of Maryland Harford Memorial Hospital.

    UM 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 all medically necessary care will be covered based on their individual financial situation.

    b. It is the policy of UM 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. UM 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. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request and without charge, both by mail and in the emergency room and admission areas. A written estimate of total charges, excluding the emergency department, will be available to all

patients upon request. This policy, the Patient Billing and Financial Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UM UCH website (https://www.umms.org/uch/patients-visitors/for-patients/financial-assistance).

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. UM 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, UM 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 UM UCH commitment to our mission to provide healthcare to the surrounding community, UM UCH reserves the right to grant financial assistance without formal application being made by our patients.
b. Specific exclusions to coverage under the Financial Assistance Program:
    i. Physician charges are excluded from UM 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 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. Cosmetic or other non-medically necessary services

c. Patients may become ineligible for FA for the following reasons:
   i. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance programs that deny access to UM UCH due to insurance plan restrictions/limits
   ii. 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.

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, UM 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. 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. 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. For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.
c. There will be one application process for UM 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. In addition to qualifying for Financial Assistance based on income, a patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses based on the Financial Hardship criteria discussed below. 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, FA coverage is effective for:
    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
    iv. In addition, coverage will also extend to any account for which a written notice described in paragraph h (below) has not been sent or for which the deadline stated therein has not elapsed. However, UM UCH may decide to extend the FA eligibility period further into the past or the future.
f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
g. UM 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. UM 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 ECA action being taken. This written notice will indicate that Financial Assistance is available for eligible individuals, identify the ECAs that the hospital (or its collection agency, attorney or other authorized party) intends to initiate to obtain payment for the care, and state a deadline after which such ECAs may be initiated. It will also include a Patient Billing and Financial Assistance Information Sheet. In addition, the hospital will make reasonable efforts to orally communicate the availability of Financial Assistance to the patient and tell the patient how he or she may obtain assistance with the application process.

5. Financial Hardship

a. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for FA and are determined to be eligible. Medical Financial Hardship is 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 UM UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. The Financial Assistance reduction will be the balance that exceeds the 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 UM UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes. Patients determined to be eligible for Financial Hardship Assistance and granted an eligibility period extending into the future will be notified about how to apply for more generous assistance during such eligibility period.
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: 10/2018

ORIGIN DATE: 10/2010

NEXT REVIEW DATE: 10/2019

2/1/2019

% discount	MAX/MIN	Family 1	Family 2	Family 3	Family 4	Family 5	Family 6	Family 7	Family 8
Fed Pov Guideline		$12,490.00	$16,910.00	$21,330.00	$25,750.00	$30,170.00	$34,590.00	$39,010.00	$43,430.00
MHA Guidelines now at 200% of FPL									
100%	up to	$ 24,980.00	$ 33,820.00	$ 42,660.00	$ 51,500.00	$ 60,340.00	$ 69,180.00	$ 78,020.00	$ 86,860.00
90%	Min	$ 24,981.00	$ 33,821.00	$ 42,661.00	$ 51,501.00	$ 60,341.00	$ 69,181.00	$ 78,021.00	$ 86,861.00
	Max	$ 27,478.00	$ 37,202.00	$ 46,926.00	$ 56,650.00	$ 66,374.00	$ 76,098.00	$ 85,822.00	$ 95,546.00
80%	Min	$ 27,479.00	$ 37,203.00	$ 46,927.00	$ 56,651.00	$ 66,375.00	$ 76,099.00	$ 85,823.00	$ 95,547.00
	Max	$ 28,727.00	$ 38,893.00	$ 49,059.00	$ 59,225.00	$ 69,391.00	$ 79,557.00	$ 89,723.00	$ 99,889.00
70%	Min	$ 28,728.00	$ 38,894.00	$ 49,060.00	$ 59,226.00	$ 69,392.00	$ 79,558.00	$ 89,724.00	$ 99,890.00
	Max	$ 29,976.00	$ 40,584.00	$ 51,192.00	$ 61,800.00	$ 72,408.00	$ 83,016.00	$ 93,624.00	$ 104,232.00
60%	Min	$ 29,977.00	$ 40,585.00	$ 51,193.00	$ 61,801.00	$ 72,409.00	$ 83,017.00	$ 93,625.00	$ 104,233.00
	Max	$ 31,225.00	$ 42,275.00	$ 53,325.00	$ 64,375.00	$ 75,425.00	$ 86,475.00	$ 97,525.00	$ 108,575.00
50%	Min	$ 31,226.00	$ 42,276.00	$ 53,326.00	$ 64,376.00	$ 75,426.00	$ 86,476.00	$ 97,526.00	$ 108,576.00
	Max	$ 32,474.00	$ 43,966.00	$ 55,458.00	$ 66,950.00	$ 78,442.00	$ 89,934.00	$ 101,426.00	$ 112,918.00
40%	Min	$ 32,475.00	$ 43,967.00	$ 55,459.00	$ 66,951.00	$ 78,443.00	$ 89,935.00	$ 101,427.00	$ 112,919.00
	Max	$ 33,723.00	$ 45,657.00	$ 57,591.00	$ 69,525.00	$ 81,459.00	$ 93,393.00	$ 105,327.00	$ 117,261.00
30%	Min	$ 33,724.00	$ 45,658.00	$ 57,592.00	$ 69,526.00	$ 81,460.00	$ 93,394.00	$ 105,328.00	$ 117,262.00
	Max	$ 34,972.00	$ 47,348.00	$ 59,724.00	$ 72,100.00	$ 84,476.00	$ 96,852.00	$ 109,228.00	$ 121,604.00
20%	Min	$ 34,973.00	$ 47,349.00	$ 59,725.00	$ 72,101.00	$ 84,477.00	$ 96,853.00	$ 109,229.00	$ 121,605.00
	Max	$ 36,221.00	$ 49,039.00	$ 61,857.00	$ 74,675.00	$ 87,493.00	$ 100,311.00	$ 113,129.00	$ 125,947.00
10%	Min	$ 36,222.00	$ 49,040.00	$ 61,858.00	$ 74,676.00	$ 87,494.00	$ 100,312.00	$ 113,130.00	$ 125,948.00
	Max	$ 37,470.00	$ 50,730.00	$ 63,990.00	$ 77,250.00	$ 90,510.00	$ 103,770.00	$ 117,030.00	$ 130,290.00

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

UM Upper Chesapeake Health has a Financial Assistance Program based on financial need.

Please complete and return the attached form and required documents within 15 days.

This information will be held in the strictest confidence and is necessary to determine eligibility.

Within two (2) business days of receipt of the Financial Assistance Request, the hospital will make a determination of probable eligibility.

Thank you for choosing **UM Upper Chesapeake Health**

We would like to assist you with the **Financial Assistance** process. Please complete the attached form and return it to us **within 15 days** with the requested information from the list below. This information will be held in the strictest confidence and is necessary to determine eligibility. Within two (2) business days of receipt of the Financial Assistance Request, the hospital will make a determination of probable eligibility. If you are unable to provide this information within that time frame, please contact:

Financial Counselor
(443) 843-5092

In order for you to qualify for **Financial Assistance**, we are required to obtain the completed and signed application along with the following:

- **Copies of all pages of your last three (3) bank statements**
  - Must be copies of original bank statements showing bank's name and all account holders' names
  - Need copies for applicant and spouse
  - If there are deposits other than payroll, please provide an explanation
- **Copies of your last three (3) pay stubs**
  - Need copies for applicant and spouse
- **Copies of all pages of your current income tax return and W-2's**
- **Copies of any benefits you are receiving**
  - Social Security benefit letter
  - Unemployment notifications
  - Disability benefit letters
  - Proof of any public assistance
    - Food Stamps
    - WIC program
    - Primary Adult Care Program
    - Energy Assistance
    - Free or reduced lunch plans
- **If there is no income**, you will need to call me to obtain a copy of our Verification of No Income form

Please be assured that this information is necessary to determine your eligibility.

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

Maryland State Uniform Financial Assistance Application

Information About You

Name: _____ (First) (Middle Initial) (Last)

Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐ Marital Status: ☐ Single ☐ Married ☐ Separated

US Citizen: ☐ Yes ☐ No Permanent Resident: ☐ Yes ☐ No

Home Address: _____ (Street Address)
_____ (City) (State) (Zip code) (Country)

Home Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ (Area Code) ### - ####

Employer Name & Address: _____ (Employer Name)
_____ (Street Address)
_____ (City) (State) (Zip code)

Work Phone: (☐☐☐) ☐☐☐ - ☐☐☐☐ (Area Code) ### - ####

Household Members:

Name	Age	Relationship

Have you applied for Medical Assistance ☐ Yes ☐ No

If yes, what was the date you applied? ☐☐/☐☐/☐☐☐☐ *(MM/DD/YYYY)*

If yes, what was the determination?

Do you receive any type of state or county assistance? ☐ Yes ☐ No

If Yes, please attach a copy of your benefit letter as proof of this assistance.

Please return application to:
UM Upper Chesapeake Health
Patient Accounting Department
2027 Pulaski Highway, Suite 215
Havre de Grace, MD 21078

I. Family Income

List the amount of your monthly income from all sources. You may be required to supply proof of income, assets, and expenses. If you have no income, please provide a letter of support from the person providing your housing and meals. Within two (2) business days following a patient's request for Financial Assistance the hospital will make a determination of probable eligibility.

	Monthly Amount
Employment	
Retirement/pension benefits	
Social security benefits	
Public assistance benefits	
Disability benefits	
Unemployment benefits	
Veterans benefits	
Alimony	
Rental property income	
Strike benefits	
Military allotment	
Farm or self employment	
Other income source:	
Total	

II. Liquid Assets

	Current Balance
Checking account	
Savings account	
Stocks, bonds, CD, or money market	
Other accounts	
Total	

III. Other Assets

If you own any of the following items, please list the type and approximate value.

Home :	Loan Balance:			Approximate value:	
Automobile:	Make:		Year:	Approximate value:	
Additional vehicle:	Make :		Year:	Approximate value:	
Additional vehicle:	Make:		Year:	Approximate value:	
Other property:				Approximate value:	
				Total	

IV. Monthly Expenses

	Amount
Rent or Mortgage	
Utilities	
Car payment(s)	
Credit card(s)	
Car insurance	
Health insurance	
Other medical expenses	
Other expenses	
Total	

Do you have any other unpaid medical bills? ☐ Yes ☐ No

For what service? _____

If you have arranged a payment plan, what is the monthly payment? _____

If you request that the hospital extend additional financial assistance, the hospital may request additional information in order to make a supplemental determination. By signing this form, you certify that the information provided is true and agree to notify the hospital of any changes to the information provided within ten days of the change.

_____

Applicant signature *Date* *Relationship to Patient*

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

UM Harford Memorial Hospital
443-843-5000
UM Upper Chesapeake Medical Center
443-643-1000

Help for Patients to Pay Hospital Care Costs

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

PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. There may be services provided by physicians or other providers that are not covered by the **hospital's** Financial Assistance Policy. 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.
3. You will never be charged for emergency and other medically necessary care more than **amounts generally billed** to patients who are not eligible for financial assistance under the financial assistance policy. Rates are set by the State of Maryland.

HOW THE PROCESS WORKS:

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

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

HOW WE REVIEW YOUR APPLICATION:

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

1. Your income or your family's total income is at 300% or less of the federal poverty level.
2. Your income or your family's income is at 500% or less of the federal poverty level **and** your medical debt incurred at an UMMS hospital facility exceeds 25% of your family's annual household income.

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

HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out a **Financial Assistance Application Form**. (see below for website address of application form)
2. Give us all of your information to help us understand your financial situation.
3. Turn the Application Form into us.

PLEASE NOTE: The hospital must screen patients for Medicaid before giving financial help. Cosmetic and other non-medically necessary services may not be covered.

OTHER HELPFUL INFORMATION:

1. You can get a **free copy** of our Financial Assistance Policy and Application Form:
- *Online* at www.umuch.org/patients/financial-assistance
- *In person* at UM Upper Chesapeake Health, 2027 Pulaski Highway Ste 215, Havre De Grace MD 21078
- *By mail* by calling (443) 843-5092 to request a copy.

2. You can call the Financial Assistance Department at (443) 843-5092 if you have questions or need help applying.
3. The FAP, FAP application or Plain Language Summary are also available in Spanish. If you need information translated in another language, please call (443) 843-5092.

UNIVERSITY of MARYLAND
UPPER CHESAPEAKE HEALTH

UM Harford Memorial Hospital
443-843-5000
UM Upper Chesapeake Medical Center
443-643-1000

[f_Mis Current Date]

[f_Reg Guar Name Full]
[f_Reg Guarantor Address1]
[f_Reg Guarantor City], [f_Reg Guarantor State] [f_Reg Guarantor Zip]

Dear [f_Reg Guar Name Full]:

Thank you for returning your Financial Assistance application.

At this time, we have completed a preliminary review of your application and have determined that you did not return sufficient information with your application to allow us to complete the assessment of your eligibility. However, based on information we have received your eligibility for Financial Assistance is probable.

Therefore, if you would like for us to reconsider your application at this time, please return the requested information to us within **5 business days** to **University of Maryland Upper Chesapeake Health, Patient Accounting Department, 2027 Pulaski Highway, Suite 215, Havre de Grace, MD 21078.**

Missing or incomplete information: Account #: [f_Reg Account Number]

___ Three (3) most recent pay stubs
___ Three (3) most current bank statements (must be copies of original statements)
___ Explanation for deposits on bank statements
(explanations must be submitted in writing)
___ Proof of Retirement/Pension benefits
___ Proof of Social Security Income
___ Proof of Public Assistance benefits (WIC, PAC, Food Stamps, Energy Assistance)
___ Proof of Disability benefits
___ Proof of Unemployment benefits
___ Proof of Veteran's benefits
___ Proof of Alimony/Child Support
___ Most current Tax Return including W-2's
___ Verification of No Income form
___ Applicant's signature on form
___ Proof of insurance (copy of insurance card)
___ Other _____

Please feel free to contact me directly Monday through Friday at (443) 843-5092 with any questions.

If the requested information is not available, please contact our **Billing Office at 855-748-0680 within 5 business days** on Monday through Thursday from 8am to 8pm or Friday from 8am to 4:30pm to set up an acceptable payment plan. We would like to continue to work with you to clear this account as soon as possible.

Thank you for your continued cooperation.

Sincerely,

Financial Counselor

Exhibit 8

NOTICE

University of Maryland Upper Chesapeake Health maintains accessibility to all emergency and other medically-necessary services regardless of an individual's ability to pay. The hospital's financial assistance policy will consider free or discounted care for those patients who cannot pay the total cost of hospitalization due to lack of insurance coverage and/or inability to pay. For more information on our financial assistance policy for patients who qualify for help with their hospital bills, or if you require translation services to understand this policy, please call 443-843-5092 or visit us at umuch.org.

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