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November 28, 2016

By E-Mail and USPS

Patti Willis, Senior Vice President
University of Maryland Shore Regional Health
219 South Washington Street
Easton, Maryland 21601

Re: University of Maryland Shore Medical Center at Easton, Docket No. 12-20-2339

Dear Ms. Willis:

Staff has reviewed the October 11, 2016 modification of the above-referenced application filed in response to the September 30, 2016 Project Status Conference Summary that identified inconsistencies between the application as submitted in 2012 and current bed need projections. At the status conference MHCC staff also raised concerns with the size and cost of the proposed replacement hospital. Finally, staff instructed Shore to comprehensively update the application because of the length of time that has elapsed since it was submitted and its review was suspended at the applicant's request.

Staff has the following questions:

Part I: Project Description

1. Page 5 of the application states: *UM SRH also includes a network of outpatient centers offering diagnostic imaging and laboratory testing, primary care and specialty treatment, and rehabilitation services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties.* Please provide a complete listing and thorough description of these sites; a suggested table format is provided below for your convenience.

Site Name	Address	Size (SF)	Services Offered	MD Disciplines And Number Represented at Site

2. Page 13 describes an MOB to be built adjacent to the replacement hospital which will accommodate, among other services, *a full service lab that will...serve the replacement hospital (and)...other community based medical facilities...education and conference center functions.* The application states that the MOB containing this space is not part of the CON project. Please provide information on the SF of this building, and the space allotted to each function. Also, please respond to this thought: In computing SF/bed for the facility, it certainly sounds like the laboratory space, at least, should be added to the hospital SF. A laboratory is a core function of a hospital, and virtually always also serves outpatient customers.

Part II: Project Budget

3. Explain the how the Architect and Engineering fees could decrease by almost 50% from the estimated fees in the original budget, especially since the current budget includes A & E fees related to the original project design.

4. Explain the significant increase -- almost 100% -- in the estimated cost for permit fees of compared to the original budget.

5. Specify where the cost for the central utility plant is budgeted.

The instructions for the Project Budget states that the applicant must include a list of all assumptions and the applicant must specify what is included all costs and the source of the cost estimates. No such information was included in the modified application. Therefore staff has the following questions:

6. Explain how the contingency was estimated.

7. Explain a) how the gross interest during construction was estimated; and b) why there is no interest income (bond arbitrage) identified as a source of funds.

8. Explain how future inflation was estimated.

9. Break down the legal fees and non-legal consulting fees into those portions related to the CON application process and the portions attributed to other aspects of the project. Describe what the non-legal consulting fees associated with the project cover. What is the amount of both legal and non-legal fees that have been carried over from the 2012 CON application and are not useable for the current modified application?

Part IV: Consistency with Project Review Standards and General Review Criteria

COMAR 10.24.10: Acute Care Hospital Services Review Standards

Information Regarding Charges:

10. On page 22 the application states that the current list of charges will be updated quarterly; however, the information on the hospital's website was last updated June 30, 2016. Please update the charge information and insure that it is updated quarterly as required by the standard.

Identification of Bed Need

11. Explain or correct the apparent large discrepancy between the total MSGA discharges for 2015 reported on page 33 (5,314) and the total discharges reported on Table F (Exhibit 1) of 6,341 for FY 2015.

12. Regarding the recapture of the 143 discharges that are expected to make up for volume lost over the past five years due to the loss of physicians:
    a. Describe the efforts and success of recruitment efforts to replace the physicians.
    b. Provide a more detailed explanation of how the number of the discharges was estimated for each specialty.

13. Explain or correct the apparent large discrepancy between the total Pediatric discharges for 2015 reported on page 36 (133) and the total discharges reported on Table F (226) for FY 2015.

14. On page 38 there is a stated assumption that the ALOS for pediatric stays in 2024 will be the same as 2015 pediatric length of stay, which is identified as 2.48 days in Exhibit 15. However, Table F in Exhibit 1 indicates that the ALOS for Pediatric patients was 1.9 (actually 1.89) in 2015? Please explain and/or correct the projections and the affected Tables and Exhibits.

Adverse Impact:

15. Please discuss the status of the hospital's partial rate application to HSCRC and the anticipated schedule for HSCRC action.

Cost Effectiveness:

16. Although the first year of full operation of the relocated hospital appears to be 2023, the operational cost estimates and projections for alternatives presented as Tables 14 and 15 and as presented in Exhibit 16 only go through 2017. Please update these projections through the first year of full operation (through 2023) so that these projections can be compared to Table G (Exhibit 1).

17. Recent experience with hospitals that have pediatric beds and submit applications for relocation or for substantial additions/renovations to hospital EDs is that they have been incorporating the pediatric beds into the ED in combination with pediatric ED space, or into observation units. Please explain the rationale for your proposal to locate the 2 pediatric beds on an MSGA unit.

18. List and thoroughly describe each of the outpatient clinics that are included in this project, including the disciplines, target market, and expected volumes.

19. Why is the outpatient clinic space located in a building designed to more expensive hospital design standards as opposed medical office space standards?

20. On p. 50 when discussing size comparisons with other hospitals, the application states: *the new Holy Cross Germantown Hospital, the most recent approved project that has been constructed and opened, does not include any of the outpatient services to be included in the proposed replacement hospital for UMSMC E. Accordingly, outpatient service space should be excluded when comparing the two facilities.* Be specific as to what outpatient services this project includes that HC-G does not. Differentiate those outpatient services from the ones that the two hospitals would both offer. As you respond to this question, I will also refer you to a statement on p. 52, which says: *These departments have been selected for comparison as they have their own need based analysis independent of the inpatient bed need. The departments include emergency services, imaging, and surgical services. All have outpatient volumes that drive need independent of inpatient bed counts.* I will point out that *all hospitals do*; perhaps your challenge is to prove that this is disproportionately true at UMSMC.

21. On page 51 you state that the replacement hospital will function as a hub for purposes of materials management supporting other outlying facilities. Question 1 asked for a list of these outlying facilities with a description of their respective size and function. In this question, please estimate the additional space that each of those facilities will require at the central materials management hub.

22. Explain the grossing factor used in Table 17 on page 52 and in Exhibit 1, Table B. Specify the building space that is accounted for in this calculation.

23. Please provide a more thorough and/or clear explanation of this statement on p.54: *Table 19 reduces the proposed replacement hospital's total diagnostic and treatment square footage by the differential shown in Table 18, to provide a more apples-to-apples comparison of the efficiency of these two facilities' space based on the volumes of services they support.* Provide a response walking us through the comparison being made, and the rationale and/or assumptions embedded in the conclusion drawn.

24. Explain the size of the central utility plant ("CUP") designed for UMSMC at Easton. It is 22,530 SF to support a 327,000 SF facility compared to the CUP for Holy Cross Germantown – which has a 5,165 SF CUP to support a 252,941 SF facility (with 22,373 SF of shell space) -- or to the CUP planned at the replacement Washington Adventist Hospital, which will be approximately 14,000 SF to support a 468,000 SF facility (with 14,042 SF of shell space). The ratios of hospital SF to CUP SF differ greatly, with the CUP at UMSMC being relatively much larger.

25. In considering alternatives, please state if the scenarios below were considered
    a) Situating the outpatient clinics in the planned adjacent MOB rather than in the hospital building.
    b) Distributing the outpatient clinics throughout the service area, either as new facilities or as additions to the existing array of facilities previously described.

Construction of Hospital Space:

26. Regarding the costs that you have identified that not being included in the MVS calculator cost section.
    a. Since a TransVac System is a large, one-way Pneumatic tube system, please explain why there are separate estimates of the costs that should be excluded for the MVS comparison for a Pneumatic Tube System and a TransVac System?
    b. Given the fact that MVS includes a separate local cost multiplier for the Eastern Shore, please provide a detailed explanation of the labor shortages Whiting Turner has experienced on the Eastern Shore and how the costs of transporting equipment and material has affected project costs. In providing such explanations, please compare costs to national averages and provide documentation that such costs are likely to be higher than national averages.
    c. Why does the construction of a hospital in Easton need seismic protection over and above what would be included in a typical hospital in the eastern US?
    d. Why should the Minority Business Enterprise requirement add costs to the project?
    e. List what is included in the $520,000 Misc. Site "Outside the loop" expenditure.

f. Who will own the parcel that is considered outside the loop and who will financially benefit from the future development of the parcel?
g. Please provide a detailed description of the amounts spent on the 2012 project that will not be usable for the modified project.

Efficiency:

27. The response to this standard addressed the manner in which the planning and design of the replacement facility took into account operational efficiency in the nursing units, imaging, and surgery, but did not quantitatively project any measures of expected efficiency gains. Please provide metrics showing how UMSMC's staffing/unit of output is expected to be affected by the project (i.e. FTEs per discharge/admission/surgical case, imaging RVU). Was operational efficiency taken into account in the planning and design of the ED? If no, why not? If yes, please describe and quantify the expected efficiency improvements in terms of FTEs/ ED visit.

Patient Safety:

28. The modified application describes and lists a variety of so called patient safety features incorporated into the design of this project. Please provide additional information regarding the following:
    a. Explain how hospital departments are planned to allow horizontal expansion without disruption to existing services and how this relates to patient safety.
    b. What is a mobile technology dock and how does it relate to patient safety?
    c. On page 72 the application states that the building is sited and the emergency department is planned to allow for scalability in the event of contingency events. Please provide an example of a contingency event and provide a more detailed explanation of the building siting and ED design to accommodate such an event.
    d. Proposed ADA/ANSI standard upgrades.
    e. How rehab stairs at each floor will improve patient safety.

Financial Feasibility:

29. Please address each section of subpart (b) of this standard.

Emergency Department Treatment Capacity and Space

30. On page 75 the application states that the ED in the existing hospital has 32 treatment spaces. However, the supplemental survey form submitted to MHCC reported that the hospital had 34 treatment spaces on June 1, 2015 and June 1, 2016 (see attached form). Please clarify and submit a table following the same format showing the current number and proposed number of spaces by type.

COMAR 10.24.11: General Surgical Services Review Standards

31. As requested in Paragraph.06A(2)(c) please explain:
    a) Why the turnaround time ("TAT") is 36 minutes per case for both inpatient and outpatient procedures and justify the basis for this TAT.
    b) Why would the construction of six new OR suites not include steps to help reduce the TAT for cleaning and preparing these ORs?

Patient Safety

32. Please provide a response that speaks specifically to the patient safety issues addressed in the design of the surgical facilities.

COMAR 10.24.11: OBSTETRICS Services Review Standards

Need:

33. Policy 4.1(b) requires the applicant to provide information on the number of uninsured, underinsured, indigent and otherwise underserved obstetric patients in the applicant's primary service area, and an estimate of the number of women not receiving adequate prenatal care. Please address subpart b of this policy.

34. Explain or correct the apparent large discrepancy between the total Obstetric discharges for 2015 reported on page 92 (1,723) and the total discharges reported on Table F (Exhibit 1) of 995 for FY 2015. MHCC staff analysis found a total 918 discharges from service area zip codes that are almost the same as the zip codes you identified (you included zip 21619 that is not included in our list and we included zip code 21657).

35. In addition, the total OB discharges for the female population 15-44 that you report by zip code from all Maryland hospitals in Exhibit 24 is much higher than MHCC staff identified using the same HSCRC Discharge Database, 2015 total for service area of 2,717 on page 93 to our finding of 2,133. (See attached spreadsheet for the comparison for our total by zip code.)

Medicaid Access:

36. Please provide a description of the hospital's plan to assure Medical Assistance enrollees access to OB services at Memorial Easton (i.e. description of partnerships, programs, outreach).

Physical Plant Design and New Technology:

37. There is conflicting information regarding the proposed number of OB beds at the new facility. The FY 2017 version of the Annual Reports on Selected Acute Care and Special Hospitals states that Memorial Easton currently has 17 licensed OB beds and the applicant states on page 91 that this project will reduce the number of OB beds from 17 to 16. However, page 97 of the application states that the proposed facility will have three more obstetrics beds than the existing hospital. Please explain or correct this apparent discrepancy.

COMAR 10.24.09: Acute Inpatient Rehabilitation Services Review Standards

Need:

38. Please provide the assumptions used by UMSMC-E regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states used with your need projection.

COMAR 10.24.01.08G (3)Criteria for Review of Application

Need

39. Please provide additional years of the observation utilization data that is presented in Table 33, preferably so that there is a total of 5 years of actual data. This would mean providing data for FY 2012, 2013, and 2014.

Viability

40. What assumption(s) led to the projection of interest expenses of $13,219,000 in 2023 and $12,949,000 in 2024?

41. Submit a depreciation schedule that supports the project of project related depreciation of $9,064,000 in 2022 and $18,129,000 in 2023 and 2023.

42. Explain the basis of the estimate that $25 million would be raised philanthropically to help fund the project. Please provide information to support this as a reasonably achievable amount.

43. Will the source of cash be limited to Shore Health System or will it be the entire University of Maryland Medical System? Which entity will incur the debt?
    a. For whichever it is, please submit a capital finance plan that shows the use of cash and debt for all the entity's capital investments.

b. Project the financial ratios that will be evaluated by the entity that will provide the financing for the project.

Impact on Existing Providers and the Health Care Delivery System

44. Please estimate the revenue that would be lost by Anne Arundel Medical Center and by Peninsula Regional Medical Center under their current budgets and rates.

Please submit six copies of the responses to the additional information (one set of drawings and one set of requested exhibits is sufficient) requested in this letter within ten working days of receipt. Also submit the response electronically, in both Word and PDF format, to Ruby Potter (ruby.potter@maryland.gov).

All information supplementing the application must be signed by person(s) available for cross-examination on the facts set forth in the supplementary information, who shall sign a statement as follows: "I hereby declare and affirm under the penalties of perjury that the facts stated in this application and its attachments are true and correct to the best of my knowledge, information, and belief."

Please provide the requested information by December 23, 2016. If you have any questions, please call me at 410-764-5596 or Kevin McDonald at 410-764-5982.

Sincerely,

Joel S. Riklin
Program Manager

cc: Thomas C. Dame Esquire
Mallory L. Montgomery, Esquire
Andrew L. Solberg, Consultant
Fredia S. Wadley, M.D., Talbot County Health Officer
Donna Kinzer, Executive Director, HSCRC
Ben Steffen, Executive Director, MHCC
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