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January 18, 2013

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

VIA HAND DELIVERY

Re: Replacement of Memorial Hospital at Easton
Matter No. 12-20-2339

Dear Ms. Potter:

Enclosed are ten copies of the "Responses to Second Set of Additional Information Questions Dated 11/16/2012 and 12/21/2012" with respect to the CON Application of Shore Health Systems, Inc. to relocate Memorial Hospital at Easton.

Please sign and return to our waiting messenger the enclosed acknowledgment of receipt. Thank you for your assistance.

Sincerely,

Thomas C. Dame

TCD:blr
Enclosures
cc: Joel Riklin, Acting Chief, Certificate of Need Division
James L. Thompson, Esq., Counsel for Queen Anne's County
Amy C. H. Grasso, Esq., Counsel for Queen Anne's County
Kathleen H. Foster, R.N., Talbot County Health Department
John C. Craig, County Manager, Talbot County
Michael Pullen, Esq., County Attorney, Talbot County
Marta D. Harting, Esq., Counsel for Talbot County
Howard L. Sollins, Esq., Counsel to Caroline County
Kenneth D. Kozel, FACHE, CEO, Shore Health System
Michael Silgen, Vice President, Strategic Planning & Marketing, Shore Health System
Anthony J. Kelly, AIA, PE, LEED AP
Robert A Chrencik, President and CEO, UMMS
Alison G. Brown, Sr. VP, Business Development and System Strategies, UMMS
Dana Farrakhan, Sr. VP, Business Development and System Strategies, UMMS
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Jack C. Tranter, Esq.

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ACKNOWLEDGMENT OF RECEIPT

This will acknowledge receipt of ten bound copies of the "Responses to Second Set of Additional Information Questions Dated 11/16/2012 and 12/21/2012" with respect to the CON Application of Shore Health Systems, Inc. to relocate Memorial Hospital at Easton (Matter No. 12-20-2339).

_____
Signature

Printed Name: _____
On behalf of the
Maryland Health Care Commission

Date: January 18, 2013

452729

Memorial Hospital at Easton
Matter No. 12-20-2339
Responses to Second Set of Additional Information Questions
Dated 11/16/2012 and 12/21/2012

<u>Responses to Additional Information Questions Dated November 16, 2012</u>

1. **The Cost Effectiveness standard requires applicants to identify the primary objectives of the proposed project and to consider at least two alternatives for achieving the objectives. The application identified four primary objectives (pages 57 to 58) and the proposed project and two alternatives for achieving these objectives, one involving changes on the existing site and one involving an alternative site for relocation. The application reported how each alternative was ranked against each objective. While this analysis indicates that all three alternatives received a *top* ranking in terms of meeting the primary objectives of the space needs of a growing population and of the space needs of senior citizens, the response to completeness Question 10, especially parts (c) and (d), indicates that many of the existing physical plant deficiencies would not be corrected by the on-site alternative, Commission staff is uncertain if an on-site alternative could be described that maximizes the correction of these deficiencies, especially the lack of adequate private rooms. If so, that is the alternative that should be analyzed in responding to this Standard. Commission staff suggests that such an alternative could include construction of parking garage space and significant new hospital space either on top of an existing building, if possible, or in place of existing surface parking. The new hospital space should be able to accommodate significant portions of the patient care space, especially inpatient bed space. If MHE has concluded that such an alternative is not physically possible or approvable by local government, supporting facts and documentation must be provided. (Please review Additional Completeness Question 7 above, which asks for an updated cost estimate of the on-site alternative that is more comparable to the proposed project budget estimate in the Application. This Additional Information question asks MHE to reconsider the scope of the on-site alternative to assure that that best alternative can be considered in this review. If, in responding to this question, the scope of the on-site alternative is expanded, please provide a cost estimate for this expanded on-site alternative as well.)**

As discussed in the Application, the project to replace and relocate MHE is intended to serve the health care needs of the people living in a region comprised of five counties: Talbot County, Caroline County, Dorchester County, Queen Anne's County, and Kent County (the "Mid-Shore Region"). The population of the Mid-Shore Region is

growing, and the aging population is growing disproportionately. Based on data collected in the planning process, SHS concluded that a shortage of primary care and specialist physicians in the Mid-Shore Region is a significant health problem for the region. Thus, the primary objectives of the project focus on the need to serve a growing aging population and the need to recruit physicians to the region. *See* Application, at 57-58.

In the early stages of the planning process (circa 2005), SHS included the redevelopment of the existing MHE campus (and the redevelopment of DGH's campus) as an alternative to be considered, although SHS noted in the Application that the redevelopment of the existing site would not resolve the significant current space problems at MHE as well as the other two alternatives and the financial performance of SHS would suffer as a result of the redevelopment of the existing site. *See* Application, at 71-72.

Upon further consideration and analysis, SHS has now concluded that the redevelopment of the existing MHE site is not a viable alternative because redeveloping MHE in downtown Easton will not achieve the primary objectives of the project and it is extremely unlikely that MHE could obtain the necessary local land use approvals to undertake a large-scale renovation and redevelopment project at the existing site.

As discussed in the Responses to Completeness Questions, the renovation of the existing MHE site was planned as a relatively modest project, including 21,600 square feet of new construction and 19,500 square feet of renovation, without expanding the existing footprint of the facility. *See* Responses to September 25, 2012 Completeness Questions, at 13-14, Exhibit 28. The existing site alternative, as

planned, would not have solved most of the deficiencies in the existing facility. *Id.* at 15-22.

To Address the Deficiencies Through an Existing Facility Redevelopment, the Scope of the On-Site Project Must be Much Larger Than Described in the Application and Would Require Horizontal Expansion.

To achieve the primary objectives and solve the deficiencies present in the existing site, the scope of the proposed redevelopment of the existing site would have to be much larger and involve the expansion of the footprint of the existing facility. In particular, to include adequate private rooms for inpatient services in the hospital, the facility would have to be expanded beyond the current footprint because the existing structure cannot support the addition of floors of new construction. *See* January 17, 2013 Letter of Anthony J. Kelly, AIA, PE, LEED AP (attached as **Exhibit 39**). Also, among other required improvements, the existing site project would need a parking deck structure to accommodate the parking needs for visitors, staff, and patients. The existing site is small and is immediately surrounded by a dense residential neighborhood.

Even if these improvements could be made, the location of the redeveloped facility in downtown Easton would not provide acceptable ease of access for the residents of the Mid-Shore Region outside of Easton, consistent with the intent to provide a regional medical center for the Mid-Shore Region. As discussed in earlier submissions, the interviews of Mid-Shore Region residents and physicians revealed that some regard the existing facility as inaccessible and difficult to find. *See* Responses to September 25, 2012 Completeness Questions, at 23 – 24.

Local Government Approvals Would be Extremely Difficult to Obtain for a Large-Scale Redevelopment of the Existing Facility.

Redevelopment of the existing site to provide a facility that would address the deficiencies of the existing facility and be comparable to the proposed project would be extremely difficult, if possible at all, considering applicable zoning, property constraints, and political and neighborhood challenges. Even if possible, based upon space and zoning constraints, the on-site redevelopment would not accommodate future expansion of the hospital or expansion or consolidation of other medical services provided by SHS.

The existing facility is located in what is otherwise a single-family residential neighborhood. Also, the Town of Easton's "Old Easton" Historic District borders MHE's property on the east and the north (along Washington Street and Biery Street), and a portion of MHE's property – currently used as a surface parking lot – is within the Historic District. The Town of Easton's Historic Districts Boundaries Map (with the MHE property highlighted in red) is attached as **Exhibit 40**.

Efforts to develop a replacement regional hospital on the existing site would require reconfiguration and improvement of existing parking limitations, which would necessitate construction of structured parking. As explained by Town Planner, Lynn Thomas, in his January 17, 2013 letter (attached as **Exhibit 41**), zoning setbacks, open space requirements and other bulk regulations present very significant obstacles for construction of a replacement hospital on the existing site. Among other applicable standards noted by Mr. Thomas, the property is subject to a 200 foot setback and a 50-foot height restriction. The existing buildings already exceed these standards. Thus, the standards would have to be modified for the redevelopment project to be approved. Also, MHE currently falls below the common open space requirement and nearly

exceeds the lot coverage limitation; however, any expansion will cause MHE to exceed each of those standards, requiring modification of the standards. The extent of waivers and modifications that would be required to develop the existing site would severely complicate the land use and political approval processes.

With the exception of incidental landscaping areas, the existing site is occupied by structures and surface parking. Attached as **Exhibit 42** is an aerial photo that illustrates the boundaries of the portion of the MHE property within the Historic District and the very small area of the site that complies with the 200-foot setback from residentially zoned property that would apply to wholesale redevelopment of the MHE property.

MHE's development on the portion of its property within the Historic District (the surface parking lot bounded by S. Washington, Biery, Vine, and West Streets) would require additional approvals from the Easton Historic District Commission in the form of a "Certificate of Appropriateness." The Historic District Commission is charged with, among other responsibilities, evaluating applications for rehabilitation and new construction projects within the Historic District in order to preserve the rich historical and architectural heritage of Easton. A copy of the New Construction Guidelines (the "Guidelines") that would apply to the Historic District Commission's consideration of the construction of new structures on MHE's surface parking lot is attached as **Exhibit 43**. As noted in the Guidelines, "[t]he key to the design of a new building or addition that enhances the existing environment is its compatibility with neighboring buildings and landscapes. Given that MHE's proposed new construction would involve parking structures and/or modern hospital building structures, and especially considering the

scale, proportion, massing, and height of such structures, it is unlikely that the Historic District Commission would find the proposed new construction to be approvable under the Guidelines.

Both the zoning approval process before the Planning Commission and Town Council and the Historic District Commission approval process involve public meetings or hearings and participation by neighbors and Town residents. Based upon MHE's recent experience with a much smaller development project, MHE expects that a proposal to undertake a large-scale redevelopment of this property as a regional hospital would draw substantial community interest that would materially influence the required legislative and administrative approvals. Indeed, Easton's Town Planner predicts that the project "would seem likely to generate a tremendous amount of neighborhood opposition." Exhibit 41, at 2.

MHE's expansion of its Emergency Department in 2002 (the "ED Project") generated significant community interest and involvement. Due to the lack of adequate space for expansion of the building and required parking, SHS and its design team evaluated the possibility of constructing structured parking as part of the ED Project. Based on informal discussions in the community and reasonably anticipated opposition and political challenges, construction of structured parking was not pursued. In order to secure adequate space for the project, SHS successfully petitioned the Easton Town Council to close and abandon Adkins Avenue, a public street that separated the hospital building from a partial block of single-family lots owned by MHE.

The Town's action was aggressively challenged by the South Easton Neighborhood Association, Inc. ("SENA"), based on its concerns about the expansion of

the facility and potential impacts to the surrounding community. The litigation related to the ED Project finally was resolved by the Maryland Court of Appeals in June 2005, resulting in considerable delay. *South Easton Neighborhood Assoc. v. Town of Easton*, 387 Md. 468 (2005). A comparable or greater level of community involvement would be triggered by construction of a replacement hospital on the existing site, a much larger project than the ED Project. SENA, nearby residents, and other community members would almost certainly oppose development of a new hospital and parking garage(s) on the existing site.

While noting that he cannot *definitively* state that a new redeveloped hospital could or could not be built on the existing site, Easton Town Planner Lynn Thomas advises "it would be extremely difficult to do so from a practical, technical, and political point of view." Upon consideration of the high likelihood that a redevelopment project on the existing site of MHE would not be approved and, even if approved, still would not meet the primary objectives of the project, SHS has concluded that the existing site alternative (Alternative 1 in the Application) should not be included among the viable alternatives considered in the CON review.

2. Clearly identify any differences in the expected time for project construction of the proposed project and the two alternative projects, including phasing of the current campus alternative requested in #1 above and the time required to obtain local approvals such as land use and site plan approval and account for the impact of such time frame differences on project cost.

The Application for the proposed project identifies a three year construction time frame, to begin within three months of project approval (see page 5 of the Application).

The alternative to build a replacement facility at Route 322 and Oxford Road in Easton is assumed to have the same three year construction time frame. There would

be no additional time required to receive local approvals such as land use and site plan approval. Because the time frames would be the same as for the proposed project, there would be no impact on project costs.

The alternative to build a replacement facility at Routes 50 and 404 in Northern Talbot County is also assumed to have the same three year construction period. When this alternative was developed in 2005 and redeveloped in 2007, it was assumed that it would require an additional two years to receive local approvals. At the time the alternative was made public in 2006, there was strong community opposition to moving the hospital from Easton. If SHS had proceeded with this alternative, it was assumed that the Town of Easton and Talbot County likely would have used available legal strategies to prevent the project from proceeding in that location. However, SHS expected that local approvals eventually would be attained and the project would proceed toward MHCC approval. Because these obstacles were known as early as 2006, it was assumed for the purposes of the Application that local approval would have been sought and achieved prior to 2012. Therefore, the time frame for this alternative has no impact on project cost, as compared to the proposed project.

The alternative to build out the current campus at 219 South Washington Street has been withdrawn from consideration. As discussed in Response to Question 1 above, MHE does not regard the existing site alternative to be viable.

3. Prepare revised revenue and expense projections for each alternative (update Application Tables 10, 12, and 14 and add projected revenues and expenses). Clearly specify all assumptions, especially differences in revenue assumptions and fixed/variable expense assumptions. Patient volume assumptions including changes in market share that support the expense assumptions and revenue assumptions, if appropriate, must be clearly identified and explained.

Exhibit 44 includes the revised Application Tables 10, 12, and 14. **Exhibit 45** includes revised revenue and expense projections for each alternative, including the assumptions.

4. Prepare a ranking of the alternatives that more completely accounts for desired project objectives such as percentage of private rooms, improvements in location, layout, and adequacy of departmental space, etc. Consider including cost and financial feasibility in such rankings.

A revised ranking of the three alternatives and the proposed project are presented in the following table.

Objectives	Relocate to New Site in Easton (Bypass at Oxford Road)	Relocate to New Site in Northern Talbot County (Route 50 at 404)	Proposed Project
Needs of Growing Population			
BGSF as % of Required	1	1	1
% Private Beds	1	1	1
Inter-Department Layout	1	1	1
Intra-Department Layout	1	1	1
Needs of Senior Citizens			
Campus/Building Wayfinding	1	1	1
Improve Access for All Citizens			
Aggregate Drive Times	3	2	1
Ease of Access by Employees	1	3	1
Ease of EMS Access	3	2	1
Enhance Physician Recruitment			
New v. Renovation Facility	1	1	1
Capital Cost			
Lowest Capital Cost	1	3	2
Philanthropic Support	2	3	1
Aggregate Score	16	19	12
Overall Ranking	**2**	**3**	**1**

1 = Best
2 = 2nd Best
3 = Worst

5. **The Financial Feasibility standard of the Acute Care Hospital Services chapter of the SHP states that "a hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital." It requires, among other things, that revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital. It also requires that "staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital ... " It finally requires that "the hospital will generate excess revenues over total expenses (including debt service expenses and plant and equipment depreciation), if utilization forecasts are achieved for the specific services affected by the project within five years or less of initiating operations . . . ." Your response to this standard in the application pointed to Table 3 and the projected excess of revenues and expenses in both the first year (2016) and 2017 (first full year after initiating operations). While this would appear to demonstrate consistency with the standard, the revenue projections included both a rate adjustment for capital yet to be approved by HSCRC and an estimate for the population adjustment to be given to MHE as a TPR hospital in lieu of increases for volume and inflation. Since these revenue projections are not based on current charge levels, Commission staff requested that you submit an alternative Table 3 with no revenue increase associated with the proposed project (completeness Question 21g), which you did as Exhibit 32 of the responses to the completeness questions. However, this forecast, which continues to include the population adjustment but not the rate adjustment for capital, did not show that the Hospital will generate excess revenues over expenses for the years included in the forecast. Therefore, please expand the projections to as much as five years after the project is scheduled to be completed to determine if the standard could be met under such revenue assumptions and submit the projections along with assumptions. In addition, explain why you think the original Table 3 was the appropriate test of financial feasibility with respect to this standard given that the standard specifies that revenues and expenses be based on current levels experienced by the hospital.**

First, SHS must clarify its Response to Completeness Question 21g, which incorporated Exhibit 32. The original Table 3 in the CON application included both an increase to the population adjustment and a rate adjustment for capital. Exhibit 32 reflected the HSCRC's <u>current</u> methodology for the TPR population adjustment and excluded a rate adjustment for capital. Exhibit 32 did not include an increase to the population adjustment over and above the current TPR population adjustment to which

MHE is entitled under its current HSCRC rate agreement. MHE's request for an adjustment to the TPR includes both an increase in the capital component and an increase in the population adjustment.

Without an increase to the population adjustment and a rate adjustment for capital, MHE is not projected to "breakeven" within five years of the completion of the project (i.e., before at least 2022). The primary reason for this is that, under the TPR methodology, a hospital is not able to cover the incremental cost of capital with increased revenue from additional volumes. Historically, this has been the way that hospitals under the HSCRC's Charge Per Case "CPC" methodology have justified the feasibility of similar capital projects. Under the TPR methodology, the only way that hospitals could remain profitable under a replacement hospital project scenario would be to reduce their expense base equal to the cost of the incremental capital. During periods of volume growth, this is a challenge because increased volumes lead to increased variable expenses, which in the case of MHE, averages 70% of volume increases for non-capital expenses.

Aside from the HSCRC's update factor, a TPR hospital's only opportunity to increase revenue is via the TPR age-adjusted population adjustment. The TPR adjustment is equal to 25% of the age-adjusted population growth for its service area. Under TPR, when a hospital's volumes increase, the hospital would have to reduce its variable expense base to cost in order to address the 75% "gap" between actual volume growth and the 25% amount put into its rates. MHE's service area is projected to have moderate growth over the next ten years, related to population and use rates based on the projected aging population. The increase in volumes expected from projected

growth in population and use rates would require a significant expense reduction, which would not be possible, given the current and expected staffing levels necessary to meet this volume increase. The proposed capital and TPR rate adjustments would allow the project to achieve a financial "breakeven" during the five year time horizon.

The original Table 3 was the appropriate test of financial feasibility with respect to this standard because of the nature of MHE's service area and current rate structure. MHE's service area is expected to have moderate growth in population and use rates, and MHE does not believe that the current methodology to calculate the TPR population adjustment accurately reflects the variable cost growth as it relates to population and use rate growth. As a result, MHE chose to use an alternative TPR population adjustment that more closely reflects the variable cost change in relation to population and use rate changes.

Responses to Additional Information Questions Dated December 21, 2012

1. **In responding to Question 5 you indicate that the total building square feet reported in Chart I (Application, p. 8) is 352,926 square feet. The total square footage reported in Chart 1 is 300,678 for Tower .1 and 58,250 for Tower 2 for a total of 358,928. also the number reported in your response to Question 2a. Please confirm that the 358,928 is the correct total square footage of the proposed project or correct your December 5, 2012 response to Question 2a accordingly.**

The reference to 352,926 in the Response to Completeness Question 5 dated November 16, 2012 is in error. Likely, it results from two typographical errors.

The last sentence in the original wording of Question 5 states:

> "For the proposed total square footage, also reconcile it with Application Chart 1 total of 352,928 square feet (300,678 for Tower I and 58,250 for Tower 2)."

The reference to 352,928 in the question was probably a typographical error. It should have been (as you state in this question) 358,928.

MHE compounded the error by attempting to quote the 352,928 from the question but erroneously inserted a “6” for the final “8” in the number.

The total number of square feet in the proposed project is 358,928.

	Total SF
Tower 1	300,678
Tower 2	58,250
TOTAL	358,928

2. The response to Question 8 references interviews and a survey conducted by Katz Consulting Group ('Katz") in addition to interviews conducted by TriBrook Healthcare Consultants ("THC"). The response indicates that Katz did not ask questions related to the condition of the current hospitals and that the other findings were consistent with the interviews by THC. Please detail how the findings of the Katz study were consistent with the findings of the THC interviews.

The TriBrook Healthcare Consultants interview responses were categorized into three areas: attitude toward an affiliation between Shore Health and UMMS; attitude toward a new regional medical center; and perceived need for physician recruitment. The following excerpts, taken from a presentation and report submitted by the Katz Consulting Group, summarize the findings from the interviews and survey that they conducted in 2005:

- “Many primary care physicians practice in the Service Area only to fulfill obligations under NHSC Scholarship and Loan Repayment Programs and leave when they are met.”
- “Physician reimbursement rates are 10-15% lower in the 5-County area than on the Western Shore.”
- “Area physicians are believed to be seeing fewer patients than their counterparts in metropolitan areas.”

- “38% [of survey respondents] reported not accepting a specific insurance.”
- “61% [of survey respondents] reported that MHE does not have enough primary care physicians to meet community needs.”
- 71% [of survey respondents] reported needing to refer to specialists outside of the 5-County area.

Based on their research, the Katz study found that there was a deficit of 87 physicians in the Mid-Shore Region as of 2005. By 2010, Katz expected that deficit to increase to 136 physicians due to population growth and attrition among current physicians.

EXHIBITS

39. January 17, 2013 letter of Anthony J. Kelly

40. The Town of Easton Historic Districts Boundaries Map (MHE property highlighted in red)

41. January 17, 2013 letter of Town Planner Lynn Thomas

42. Aerial photo illustrating boundaries of the portion of MHE property within the Historic District

43. New Construction Guidelines applicable to Historic District Commission consideration of construction of new structures on MHE surface parking lot

44. Revised Application Tables 10, 12, and 14

45. Revised revenue and expense projections for each alternative, (with assumptions)

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

Anthony J. Kelly / alb — 1/17/13

Signature Anthony J. Kelly Date

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

_____		January 17, 2013
Signature	Douglas R. Rich	Date

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

Signature Michael L. Silgen

Date 1-17-2013

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

Signature Andrew L. Solberg

1/18/13
Date

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

Signature Walter Zajac Date 1/18/13

SHORE HEALTH SYSTEM
UNIVERSITY OF MARYLAND MEDICAL SYSTEM

219 South Washington Street
Easton, Maryland 21601
410.822.1000
www.shorehealth.org

Administration

January 17, 2013

Mr. Thomas C. Dame
Gallagher Evelius & Jones LLP
Park Charles - Suite 400
218 North Charles Street
Baltimore, Maryland 21201

RE: Expansion of Memorial Hospital at Easton on Existing Site

Dear Mr. Dame:

As you know, I am the Project Director for the proposed project to replace and relocate Memorial Hospital at Easton (MHE). I write to address your inquiry concerning the possibility of expanding facilities on the existing site and whether the existing buildings can support floors of new construction, *i.e.*, vertical expansion.

If MHE were to attempt to replace its facilities on the existing site, it would require a substantial expansion of the existing hospital's footprint. The construction of modern patient units could not be accomplished by building vertically on top of the existing buildings. The existing buildings were not constructed with the strength to support additional floors, and the hospital's infrastructure would not be able to handle it. Consequently, any additional patient areas or parking decks would have to involve horizontal expansion, expanding the existing footprint.

Sincerely,

Anthony J. Kelly

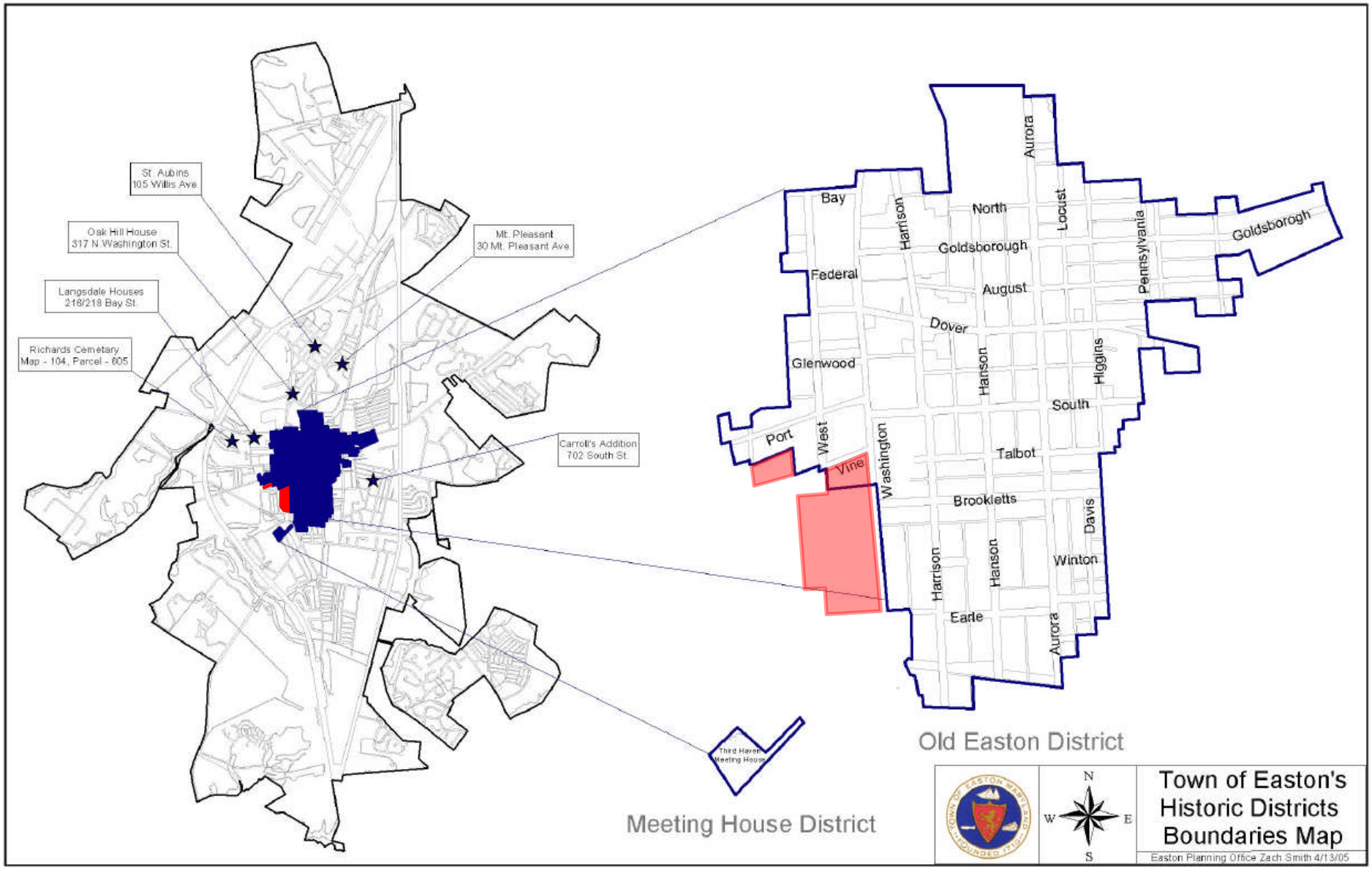
Anthony J. Kelly AIA, PE, LEED AP
Project Director - Regional Medical Center
Shore Health System

EXHIBIT
39

EXHIBIT 40

Town of Easton Historic Districts Map

Memorial Hospital at Easton Highlighted In Red



January 17, 2013

Paul Parker
Chief, Hospital Services Planning & Policy
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Parker:

I am writing this letter with regards to the proposed relocation of Memorial Hospital at Easton in my capacity as Easton's Town Planner. Specifically, I have been asked to comment on the likelihood of approval of a plan to further develop the existing hospital site at 219 South Washington Street, Easton, MD.

The current hospital site is zoned Planned Healthcare. This is a floating zone that was applied, upon its creation, to a number of properties in Easton, including the hospital. Its purpose is to provide for the planned and orderly development of major medical-related uses. It has become the primary vehicle through which retirement communities, nursing homes, and medical office parks, among other uses, are approved in Easton.

Because this zoning classification was assigned to the hospital property after it was substantially developed, there are a number of prescribed development standards with which the current facility does not comply. While not an exhaustive list, these include maximum height limitations (50'), common open space requirements (20% minimum), and special setbacks of the principal structure (200') and parking lots (50') from residentially zoned properties. A redevelopment project for the existing site would be required to submit its application under the current zoning provisions.

Without receiving and reviewing a specific application for the site, I cannot provide a specific planning staff opinion on a redevelopment project, but do have some general observations. 219 South Washington Street is a very constrained site, completely surrounded by an existing road network and residentially-zoned property, some of which is also within Easton's Historic District. It is hard, if not impossible, to imagine how the site might be redeveloped in such a way that it does not move further away from compliance with the applicable zoning standards.

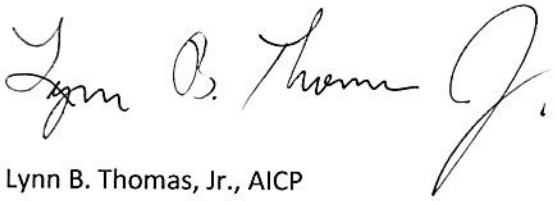
Recent applications to intensify the use at this site have been met with increasing neighborhood opposition. The most recent application for the expansion of the emergency room was opposed by the

EXHIBIT
41

local neighborhood association and ended up in litigation for several years. The level of intensification that would be necessary to replicate the kinds of new, regional-scale hospital services contemplated at the proposed site at MD Rt. 662 and US Route 50, would seem very likely to generate a tremendous amount of neighborhood opposition. There also does not seem to be the opportunity at the existing site for the expansion of medical services that is planned for the new location. Thus, absent a very large scale purchase of surrounding properties (which could be problematic politically and logistically in and of itself), it seems extremely unlikely that a redeveloped hospital could be designed for the 219 South Washington Street site in a way which would pass political and technical (i.e. regulatory compliance) muster. Furthermore, this is to say nothing of the practical operational difficulties that would be inherent in trying to run a hospital while at the same time redeveloping it. Finally, it would obviously not allow for the consolidation of operations that the hospital envisions as critical to their goal of becoming a more truly regional-scale facility for the Middle Eastern Shore, nor provide a more accessible location for the region being served.

In conclusion, while I cannot in good faith definitively state that a new redeveloped hospital could or could not be built at the site of the present facility, I think that it would be extremely difficult to do so from a practical, technical and political point of view. I trust this letter is sufficient for your needs. If you should have any additional questions, please do not hesitate to contact me at (410) 822-1943 or via e-mail at lbthomas@town-eastonmd.com.

Sincerely,



Lynn B. Thomas, Jr., AICP

Town Planner

Memorial Hospital at Easton

219 S. Washington Street, Easton, MD

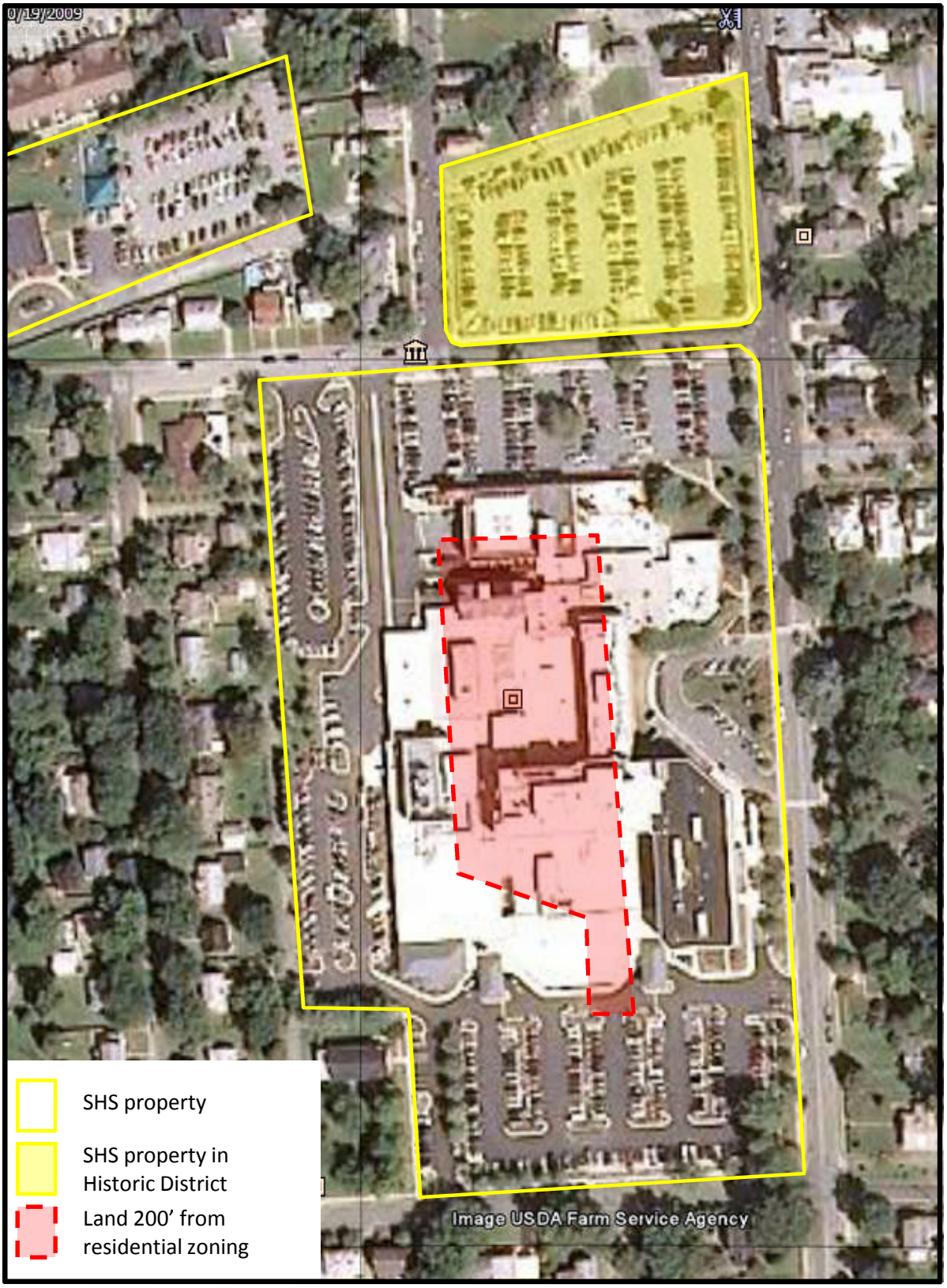


EXHIBIT 42

NEW CONSTRUCTION

EXHIBIT
43

NEW CONSTRUCTION

New construction in Easton's historic districts consists of additions to existing buildings as well as entirely new buildings. The design of new buildings and additions is critical to preserving the character of the districts. They should contribute to that character by respecting the location, design, materials and other character-defining elements of the existing historic buildings, as well as respecting the character of the landscape and other important features of the residential and commercial areas in which they are located. Additions and new buildings should be compatible with the existing environment without exactly duplicating existing buildings.

The key to the design of a new building or addition that enhances the existing environment is its compatibility with neighboring buildings and landscapes. Compatibility may be achieved in many ways. It is based on an understanding of the character-defining elements of the existing buildings, landscape, and other features of the districts. Typically, this understanding involves an analysis of how the design principles discussed below are used in the existing buildings and landscapes, and interpreting them in today's design philosophies, materials and construction techniques. To the maximum extent possible construction plans should preserve the existing historic landscape and natural features of the property.

Compatibility does not mean exact duplication. The addition or new building should be seen as a product of its own time. To reproduce an historic building, or to exactly copy a style of the past, will create a false sense of history. Rather an addition or new building should seek to show the districts' future evolution just as the existing buildings show their past development. In short, a new building or addition should be a good neighbor, changing the fabric of the districts for the better.

DESIGN PRINCIPLES FOR ADDITIONS AND NEW BUILDINGS

Designing a new building or addition that contributes to, rather than detracts from, the character of the historic districts should begin with an analysis of the character-defining features of existing historic buildings and landscapes in its immediate neighborhood. Typically these character-defining features include: setback, orientation, scale, proportion, rhythm, massing, height, materials, color, roof shape, details and orientation. In the residential areas, the location and design of landscape features, such as plants, trees, fences, sidewalks and driveways also significantly contributes to their character.

Setback

A building's setback is the distance it is located inside the property lines. Many commercial buildings have no setbacks on the front or side façades, and only a small setback at the rear façade. On the other hand most residential, institutional and religious buildings in the historic districts are free standing with setbacks on all four sides.

The location of a new building should respect the established setbacks of historic buildings on a street. Typically this means that commercial buildings in the commercial areas should have no setbacks on the front or side property lines. In the case of most of the residential areas, the front faced should align with the buildings on the street, and typically be centered between the side property lines.

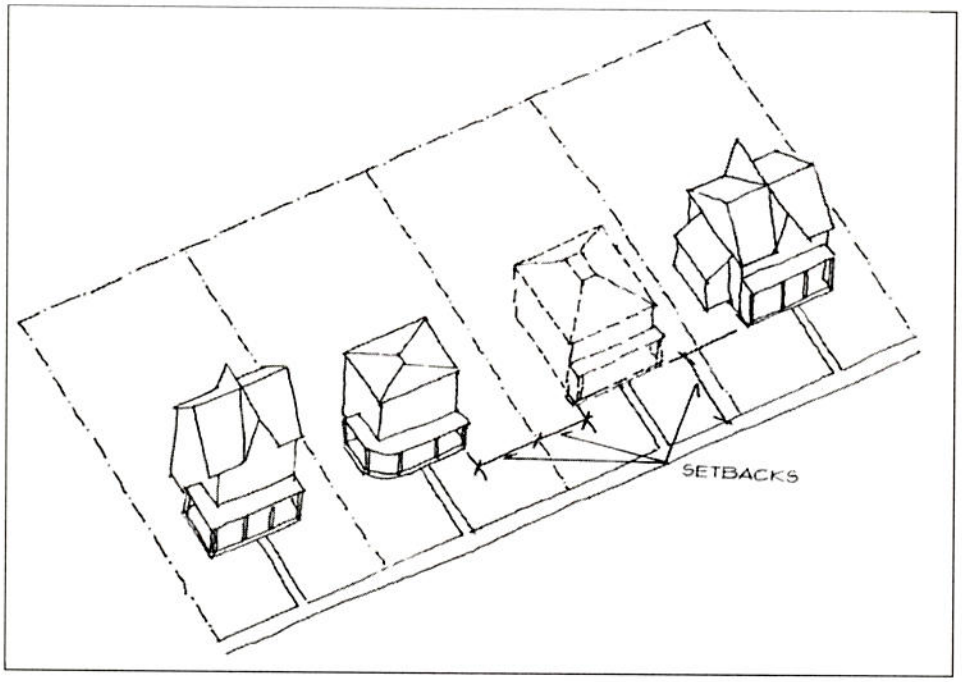
Additions to historic buildings should respect the front property line setback of the existing building, either by aligning with the front façade or being recessed behind it. If possible, additions should be attached to the rear façade

Recommended

- The setbacks of a new building should be compatible with its neighbors.
- Additions to free standing buildings should be setback behind the front façade if possible.
- In most cases, the front façade of a side addition to zero lot line, party wall buildings should align with the front façade of the existing building.

Not Recommended

- Locating the front façade of an addition to a free standing building closer to the street than the front façade of the building to which it is attached.
- Locating the front façade of a new building or side addition in the commercial areas so that it fails to align with the front façades of buildings in the block.



Orientation

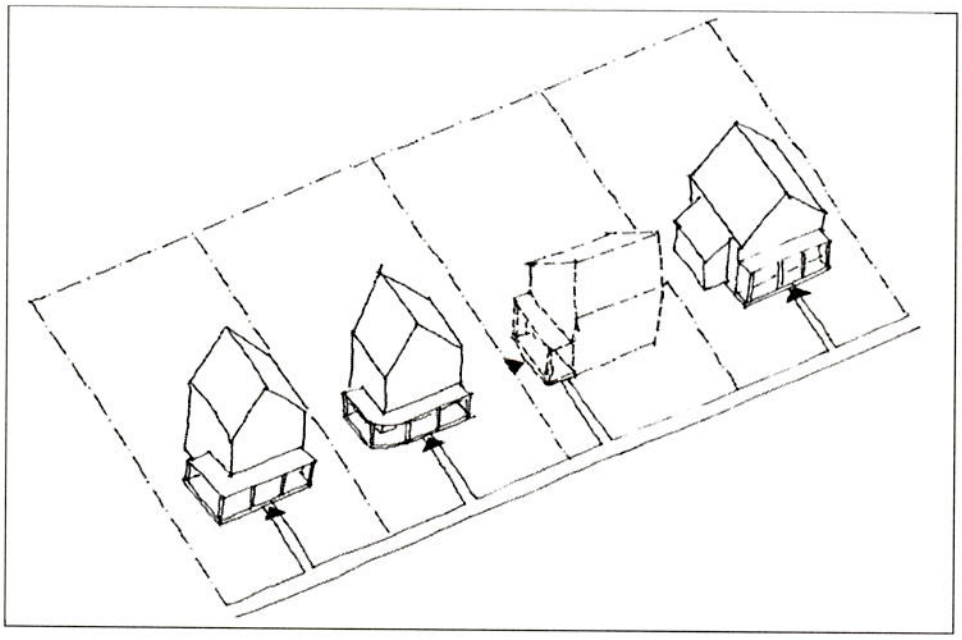
Orientation is the direction a building faces the street. Most historic residential and commercial buildings face a street, with their principal entrance in full view. Sometimes a building is oriented to a side yard or placed at an angle to a street. A new building should respect the primary orientation of its neighbors. An addition to an historic building should typically maintain the same orientation as the building to which it is attached.

Recommended

- Orienting a new building so that it is compatible with the neighboring buildings.
- Orienting an addition so that it is compatible with the orientation of the building to which it is attached.

Not Recommended

- Dramatically changing the orientation of a new building or addition.



Scale

Scale is the relative or apparent size of a building in relation to its neighbors. Scale is also the relative or apparent size of building elements, such as windows, doors, cornices, and other features, to each other and to the building. Most buildings are designed to be of human scale; that is, they appear to be of a size appropriate for human occupancy and use. Other buildings are designed to be of monumental scale, giving them prominence and symbolic importance. Typically monumental scale is associated with governmental and religious buildings.

Human or monumental scale can be achieved in many ways. For example, windows, doors, cornices and other elements can be enlarged to impart a sense of monumentality or designed to be human in scale. Façades can be heavily rusticated, contributing to a sense of monumentality, or of plainer treatment, making the building appear human in scale.

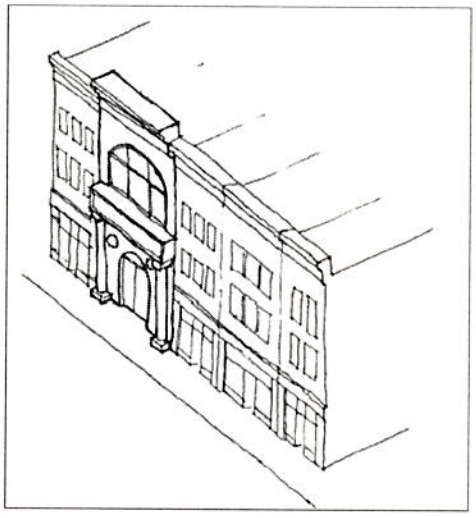
The scale of a new building should generally respect the prevailing scale of its neighbors. In a few cases, a new building's use and symbolic importance may make it appropriate for its scale to differ from that of its neighbors. The scale of an addition to an historic building should respect the scale of the building to which it is attached.

Recommended

- The scale of an addition should be compatible to the scale of the building to which it is attached.
- The scale of a new building should be compatible to the scale of its neighbors.

Not Recommended

- Drastically changing the scale of an addition or new building.



Proportion

Proportion is the relation of dimensions of components of a building to each other and to the elevation of a building. Often proportions are expressed as mathematical ratios, drawn from the architectural theories of ancient Greece and Renaissance Italy. For example, many historic buildings designed in the Classical Revival style use mathematical proportions to locate and size windows, doors, columns, cornices, and other building elements. The façades of a new building should respect the existing proportions of neighboring buildings. The façades of an addition should respect those of the building to which it is attached.

Recommended

- The proportions of a façade of a new building should be compatible with the façades of its neighbors.
- The proportions of a façade of an addition should be compatible to the façade of the building to which it is attached.

Not Recommended

- Dramatically changing the proportion of an addition or new building.

Rhythm

The spacing and repetition of building façade elements, such as storefronts, windows, doors, belt courses, and the like, give an elevation its rhythm. The space between free standing buildings, or lack of space between most commercial and other party wall buildings in Easton, as well as the height of roofs, cornices, towers, and other roof projections establishes the rhythm of a street. New buildings should respect the rhythm of its neighbors as well as the rhythm of the street. An addition to existing buildings should respect the rhythm of the building to which it is attached.

Recommended

- The rhythm of a façade of a new building should be compatible with the façades of its neighbors.
- The rhythm of a façade of an addition should be compatible to the façade of the building to which it is attached.

Not Recommended

- Drastically changing the rhythm of the façade on an addition or new building.

Massing

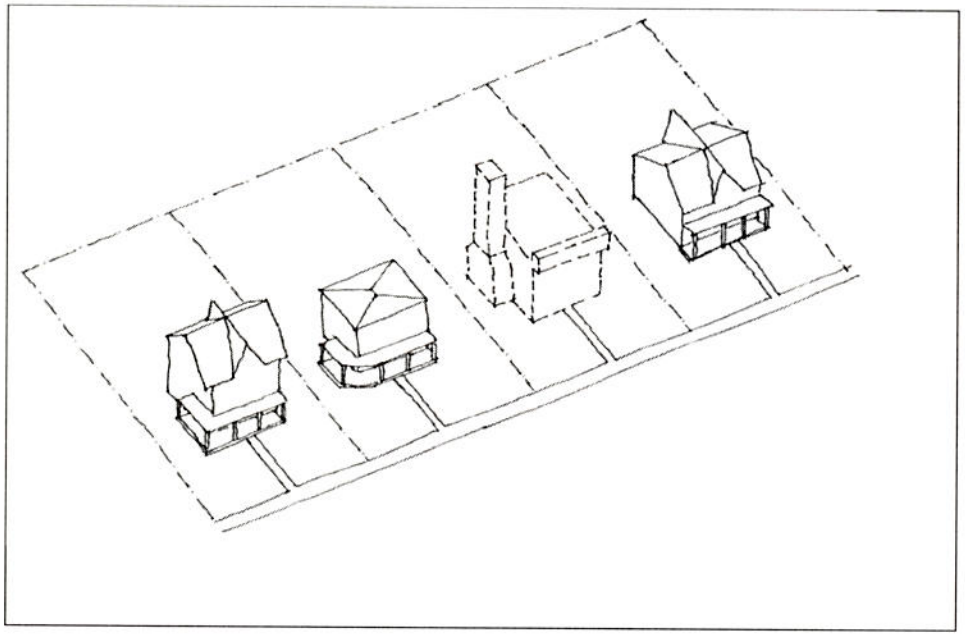
A building's massing is derived from the articulation of its façade through the use of dormers, towers, bays, porches, steps and other projections. These projections contribute significantly to the character of a street. A new building should respect the massing of neighboring historic buildings. An addition should respect the massing of the building to which it is attached.

Recommended

- The massing of a façade of a new building should be compatible with the façades of its neighbors.
- The massing of a façade of an addition should be compatible to the façade of the building to which it is attached.

Not Recommended

- Drastically changing the massing of the façade an addition or new building.



Height

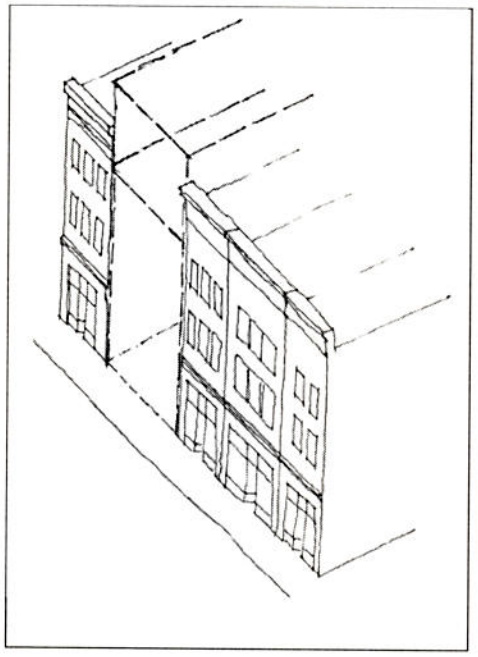
The height of walls, cornices, and roof ridges as well as the heights of bays, chimneys, and towers contributes to the character of existing buildings and districts. While new buildings or additions do not necessarily need to be exactly the same height as its neighbors or the building to which it is attached, they should be designed to respect existing building heights.

Recommended

- The height of the front façade of a new building in the commercial areas should be compatible with the front façades of its neighbors.
- The height of the front façade of an addition in the commercial areas should be compatible to the front façade of the building to which it is attached. Taller additions should be located so they are not visible when viewing the principal façades.
- The height of a new building should be within ten percent of the height of surrounding buildings.
- The height of all façades of new buildings or additions in the residential areas should be compatible with its neighbors or the building to which it is attached.

Not Recommended

- Designing one-story buildings in the downtown commercial area.
- Adding new floors to existing buildings.
- Removing floors from existing buildings.



Materials

The materials used for walls, sloped roofs and visible elements of historic buildings should be respected in the design of a new building or addition. In some districts, where all the buildings on a street use a limited number of exterior materials, the new building should probably use the same or similar material. On streets where buildings have diverse exterior materials, a wider range of material options for a new building is possible. Additions to existing buildings should use the same or similar material to the building to which it is attached.

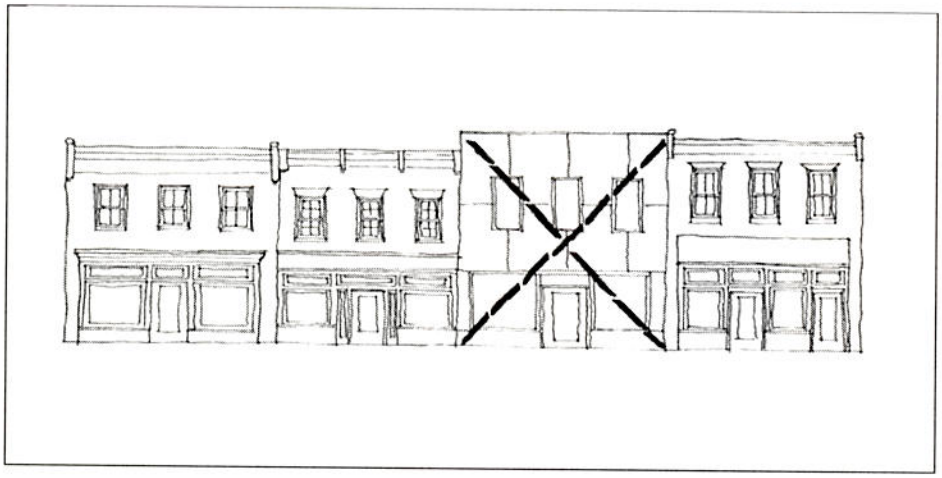
The size, texture, surface finish, and other defining characteristics of exterior materials are as important as the type of material. For example in a street of red brick façades, a new building constructed of glazed white brick would probably not be compatible.

Recommended

- Exterior materials of a new buildings or addition should be compatible with surrounding buildings or the building to which it is attached.

Not Recommended

- Introducing dramatically different exterior materials for a new building or addition.



Roof Shape

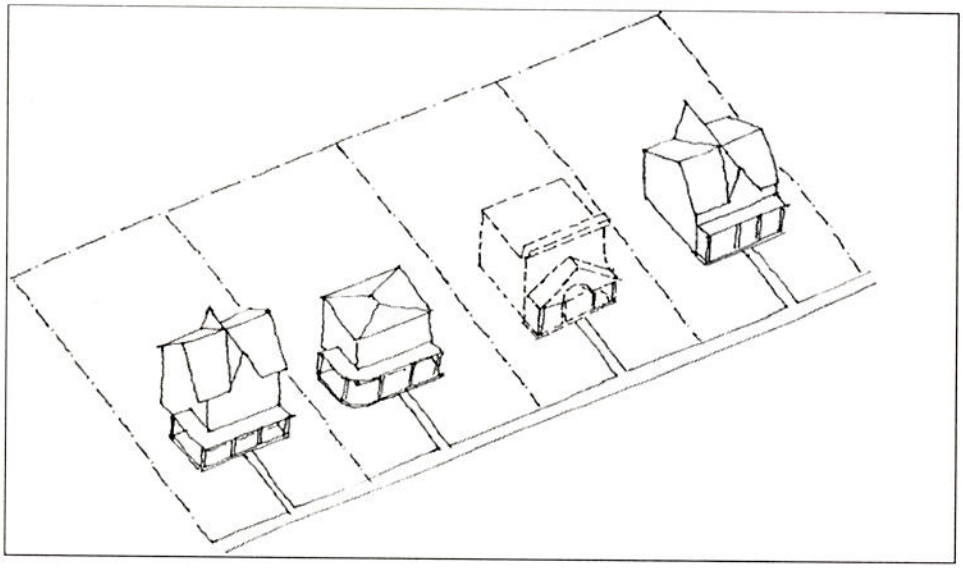
The roof shape of a new building should respect that of its neighbors. For example, in a street of buildings where gable end roofs predominate, introducing a different roof shape, such as a flat roof with an elaborate cornice would probably be not be in keeping with the existing character of the street. The roof shape of an addition should complement the shape of the roof of the building to which it is attached.

Recommended

- The roof shape of a new building should be compatible with those of neighboring buildings.
- The roof shape of an addition should be compatible with the roof shape of the building to which it is attached.

Not Recommended

- Introducing dramatically different roof shapes for a new building or addition



Details and Ornamentation

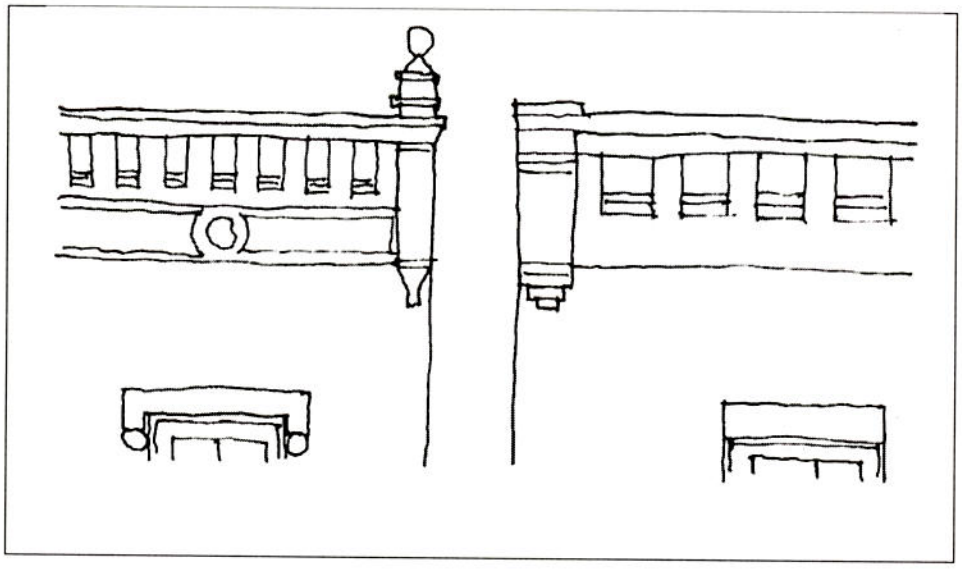
Many historic buildings in Easton contain elaborate details and ornamentation. A new building should consider the amount, location and elaborateness of details and ornamentation on neighboring buildings in its design. Existing details and ornamentation may be used as the basis for those on a new building, but they usually should not be copied exactly. Details and ornamentation on additions should complement, but not copy, that of the building to which it is attached.

Recommended

- The details and ornamentation of a new building should be compatible with those of neighboring buildings.
- The details and ornamentation of an addition should be compatible with those of the building to which it is attached.

Not Recommended

- Introducing dramatically different details and ornamentation on a new building or addition.
- Exactly copying details and ornamentation from existing buildings for a new building or addition.



Color

Closely related to the materials selected for a new building is its color. Sometimes, the color is derived from the material itself, such as in the case of unpainted brick, stone, terra cotta, slate, asphalt shingle, copper, lead and other materials. In other cases, color is applied to materials by painting or staining. This is typically the case for wood, stucco, some metals, and sometimes concrete. The colors of a new building should be compatible with those of surrounding buildings. The colors of an addition should complement those of the building to which it is attached. Inappropriately intense or overly vibrant color schemes are not recommended. Typically no more than three colors should be used on a new building. Residents, property owners or contractors are encouraged to consider the Historic District Commission a resource for assistance on issues of appropriate color and material selections during the planning phase of any project.

Recommended

- Using compatible exterior colors for a new building or addition.

Not Recommended

- Using incompatible exterior colors for a new building or addition.
- Using more than three exterior colors for a new building or addition

Landscape Features

Yards, plants, trees, fences, garden walls, sidewalks, driveways and other landscape features are important character-defining elements of many of Easton's residential areas. A new building or addition should respect the existing character-defining landscape features of the property on which it is located. The landscape design of a new building should be compatible with the landscape designs of neighboring properties

Recommended

- Designing compatible landscaping for a new building's property.

Not Recommended

- Unnecessarily removing character-defining landscape to construct a new building or addition.
- Designing an incompatible landscape for a new building or addition.

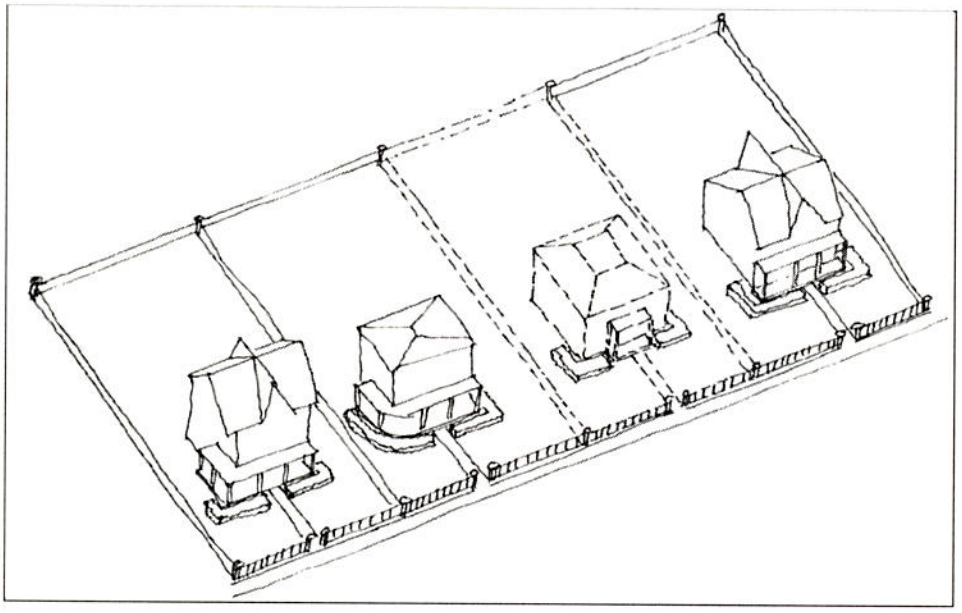


Exhibit 44

Revised Tables 10, 12, and 14

Revised Table 10
Key Financial Indicators - Alternative 1: No Move
(Dollars in Thousands)

	Historical			Projected				
	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Operating Revenue	$157,772	$155,330	$161,534	$163,622	$165,564	$167,531	$171,543	$175,609
Operating Expenses	$152,400	$144,273	$149,837	$161,848	$161,768	$161,702	$163,737	$167,601
Operating Income	$5,372	$11,057	$11,696	$1,773	$3,795	$5,828	$7,805	$8,008
Excess of Revenue Over Expense	$9,912	$19,017	$10,860	$8,989	$10,050	$12,409	$14,769	$15,358
Cash (1)	$16,945	$14,465	$26,190	$20,297	$25,367	$36,278	$50,365	$66,308
Long Term Debt (1)	$89,966	$87,728	$85,712	$84,135	$130,798	$128,762	$126,162	$122,954
Net Assets (1)	$155,118	$179,887	$186,207	$197,391	$197,391	$208,027	$221,821	$236,508
Total Capitalization (1)	$134,814	$155,506	$160,571	$165,296	$161,832	$170,814	$182,920	$195,885
Operating Margin	3.40%	7.12%	7.24%	1.08%	2.29%	3.48%	4.55%	4.56%
Excess Margin	6.28%	12.24%	6.72%	5.49%	6.07%	7.41%	8.61%	8.75%
Debt Service Coverage (1)	5.81	7.93	4.00	3.72	3.91	4.31	4.22	3.82
Days Cash on Hand (1)	151.7	177.2	181.0	172.0	165.4	182.6	204.6	227.8
Debt to Capitalization (1)	36.71%	32.78%	31.52%	29.70%	39.85%	38.23%	36.26%	34.21%

Note (1): Based on consolidated financial statements.

Revised Table 12
Key Financial Indicators - Alternative 2: Relocate to Easton
(Dollars in Thousands)

	Historical			Projected				
	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Operating Revenue	$157,772	$155,330	$161,534	$163,622	$165,564	$167,531	$178,202	$189,018
Operating Expenses	$152,400	$144,273	$149,837	$161,848	$208,508	$155,889	$168,690	$179,939
Operating Income	$5,372	$11,057	$11,696	$1,773	-$42,945	$11,642	$9,512	$9,079
Excess of Revenue Over Expense	$9,912	$19,017	$10,860	$8,989	-$36,516	$18,599	$16,540	$16,161
Cash (1)	$9,970,106	$9,967,626	$9,979,350	$9,973,457	$9,949,482	$9,960,492	$9,975,173	$9,993,062
Long Term Debt (1)	$89,966	$87,728	$85,712	$84,135	$309,075	$296,039	$280,637	$273,709
Net Assets (1)	$155,118	$179,887	$186,207	$159,325	$159,325	$187,152	$213,716	$229,206
Total Capitalization (1)	$134,814	$155,506	$160,571	$165,296	$123,767	$149,939	$174,815	$188,583
Operating Margin	3.40%	7.12%	7.24%	1.08%	-25.94%	6.95%	5.34%	4.80%
Excess Margin	6.28%	12.24%	6.72%	5.49%	-22.06%	11.10%	9.28%	8.55%
Debt Service Coverage (1)	5.81	7.93	4.00	3.72	3.93	4.31	2.73	2.29
Days Cash on Hand (1)	17869.9	17015.8	16097.7	14888.1	14666.8	14574.1	14200.8	13927.8
Debt to Capitalization (1)	36.71%	32.78%	31.52%	29.70%	65.99%	61.27%	56.77%	54.42%

Note (1): Based on consolidated financial statements.

Revised Table 14
Key Financial Indicators - Alternative 3: Relocate to Talbot
(Dollars in Thousands)

	Historical			Projected				
	2010	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**
Operating Revenue	$157,772	$155,330	$161,534	$163,622	$165,564	$167,531	$178,727	$190,075
Operating Expenses	$152,400	$144,273	$149,837	$161,848	$208,144	$155,525	$169,289	$180,891
Operating Income	$5,372	$11,057	$11,696	$1,773	-$42,581	$12,005	$9,438	$9,184
Excess of Revenue Over Expense	$9,912	$19,017	$10,860	$8,989	-$36,546	$18,487	$16,225	$16,330
Cash (1)	$16,945	$14,465	$26,190	$20,297	$3,061	$13,581	$27,960	$45,684
Long Term Debt (1)	$89,966	$87,728	$85,712	$84,135	$328,557	$315,521	$299,931	$292,615
Net Assets (1)	$155,118	$179,887	$186,207	$159,412	$159,412	$187,244	$213,611	$229,387
Total Capitalization (1)	$134,814	$155,506	$160,571	$165,296	$123,854	$150,031	$174,710	$188,765
Operating Margin	3.40%	7.12%	7.24%	1.08%	-25.72%	7.17%	5.28%	4.83%
Excess Margin	6.28%	12.24%	6.72%	5.49%	-22.07%	11.04%	9.08%	8.59%
Debt Service Coverage (1)	5.81	7.93	4.00	3.72	3.87	4.23	2.57	2.22
Days Cash on Hand (1)	151.7	177.2	181.0	172.0	132.8	149.6	167.9	191.2
Debt to Capitalization (1)	36.71%	32.78%	31.52%	29.70%	67.33%	62.76%	58.40%	56.06%

Note (1): Based on consolidated financial statements.

Exhibit 45

Revenue and Expense Tables for Each Alternative

(With Assumptions)

Alternative 1
Redeveloping the Existing Campus

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
1. Revenue		SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE
a. Inpatient Services	$ 95,278,600							
b. Outpatient Services	65,490,600							
c. Gross Patient Services Revenues	160,769,200	173,497,318	184,253,259	186,220,528	188,470,949	190,748,565	195,383,263	200,080,533
d. Allowance for Bad debt	4,236,594	5,391,828	7,101,833	8,021,144	8,118,785	8,217,096	8,413,817	8,613,188
e. Contractual Allowance	16,378,961	18,633,681	21,768,847	22,001,273	22,267,152	22,536,244	23,083,816	23,638,781
f. Charity Care	2,739,281	3,674,124	2,924,725	3,348,098	3,390,605	3,432,152	3,507,067	3,582,977
g. Net Patient Services Revenue	137,414,364	145,797,685	152,457,854	152,850,013	154,694,407	156,563,073	160,378,563	164,245,587
h. Other Operating Revenues (Specify)	1,806,811	4,140,354	1,973,877	2,750,365	2,750,365	2,750,365	2,750,365	2,750,365
i. Net Operating Revenues	139,221,175	149,938,039	154,431,731	155,600,378	157,444,772	159,313,438	163,128,928	166,995,952

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
2. Expenses								
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	$ 71,411,890	$ 74,253,305	$ 74,204,911	$ 80,557,061	$ 81,088,310	$ 81,628,524	$ 82,643,145	$ 83,299,524
b. Contractual Services	24,456,064	24,608,309	26,679,222	28,588,038	29,284,784	29,486,272	29,564,519	29,681,102
c. Interest on Current Debt	2,186,211	2,778,462	3,616,202	4,114,645	3,537,700	3,432,358	3,325,967	3,208,819
d. Interest on Project Debt	-	-	-				743,407	2,027,317
e. Current Depreciation	11,944,011	10,750,217	10,246,329	11,296,978	10,883,672	10,660,494	11,381,557	12,874,407
f. Project Depreciation								
g. Current Amortization								
h. Project Amortization								
i. Supplies	23,190,072	26,490,957	27,988,639	29,270,553	28,854,957	28,277,541	27,665,033	27,897,003
j. Other Expenses (Impairment Loss)					-			
k. Total Operating Expenses	133,188,248	138,881,250	142,735,303	153,827,275	153,649,423	153,485,189	155,323,628	158,988,172
3. Income								
a. Income from Operation	6,032,927	11,056,789	11,696,428	1,773,103	3,795,349	5,828,249	7,805,300	8,007,780
b. Non-Operating Income	8,472,033	7,960,026	(836,760)	7,215,807	6,254,292	6,580,729	6,963,855	7,350,066
c. Subtotal	14,504,960	19,016,814	10,859,668	8,988,910	10,049,641	12,408,978	14,769,155	15,357,846
d. Income Taxes								
e. Net Income (Loss)	$ 14,504,960	$ 19,016,814	$ 10,859,668	$ 8,988,910	$ 10,049,641	$ 12,408,978	$ 14,769,155	$ 15,357,846

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
4. Patient Mix:								
A. Percent of Total Revenue								
1) Medicare	48.8%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%
2) Medicaid	15.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%
3) Blue Cross	14.9%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
4) Commercial Insurance	16.6%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self Pay	3.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)								
1) Medicare	48.8%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%
2) Medicaid	15.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%
3) Blue Cross	14.9%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
4) Commercial Insurance	16.6%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self Pay	3.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

NOTE: Memorial Hospital Easton is a TPR hospital. TPR does not distinguish between Inpatient and Outpatient

Alternative 2
Relocation to a New Site in Easton

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
1. Revenue		SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE
a. Inpatient Services	$ 95,278,600							
b. Outpatient Services	65,490,600							
c. Gross Patient Services Revenues	160,769,200	173,497,318	184,253,259	186,220,528	188,470,949	190,748,565	203,063,697	215,545,093
d. Allowance for Bad debt	4,236,594	5,391,828	7,101,833	8,021,144	8,118,785	8,217,096	8,736,098	9,262,101
e. Contractual Allowance	16,378,961	18,633,681	21,768,847	22,001,273	22,267,152	22,536,244	23,991,231	25,465,863
f. Charity Care	2,739,281	3,674,124	2,924,725	3,348,098	3,390,605	3,432,152	3,620,473	3,811,320
g. Net Patient Services Revenue	137,414,364	145,797,685	152,457,854	152,850,013	154,694,407	156,563,073	166,715,895	177,005,809
h. Other Operating Revenues (Specify)	1,806,811	4,140,354	1,973,877	2,750,365	2,750,365	2,750,365	2,750,365	2,750,365
i. Net Operating Revenues	139,221,175	149,938,039	154,431,731	155,600,378	157,444,772	159,313,438	169,466,260	179,756,174

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
2. Expenses								
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	$ 71,411,890	$ 74,253,305	$ 74,204,911	$ 80,557,061	$ 81,088,310	$ 81,628,524	$ 82,642,978	$ 83,299,031
b. Contractual Services	24,456,064	24,608,309	26,679,222	28,588,038	29,284,784	29,486,272	30,856,985	29,867,232
c. Interest on Current Debt	2,186,211	2,778,462	3,616,202	4,114,645	3,537,700	3,432,358	3,325,967	3,208,819
d. Interest on Project Debt	-						4,898,996	9,816,856
e. Current Depreciation	11,944,011	10,750,217	10,246,329	11,296,978	10,954,180	4,846,890	10,564,326	16,587,969
f. Project Depreciation								
g. Current Amortization								
h. Project Amortization								
i. Supplies	23,190,072	26,490,957	27,988,639	29,270,553	28,854,957	28,277,541	27,664,979	27,896,846
j. Other Expenses (Impairment Loss)					46,669,784			
k. Total Operating Expenses	133,188,248	138,881,250	142,735,303	153,827,275	200,389,715	147,671,585	159,954,231	170,676,753
3. Income								
a. Income from Operation	6,032,927	11,056,789	11,696,428	1,773,103	(42,944,943)	11,641,853	9,512,029	9,079,421
b. Non-Operating Income	8,472,033	7,960,026	(836,760)	7,215,807	6,429,269	6,956,961	7,027,694	7,081,204
c. Subtotal	14,504,960	19,016,814	10,859,668	8,988,910	(36,515,674)	18,598,814	16,539,723	16,160,625
d. Income Taxes								
e. Net Income (Loss)	$ 14,504,960	$ 19,016,814	$ 10,859,668	$ 8,988,910	$ (36,515,674)	$ 18,598,814	$ 16,539,723	$ 16,160,625

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
4. Patient Mix:								
A. Percent of Total Revenue								
1) Medicare	48.8%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%
2) Medicaid	15.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%
3) Blue Cross	14.9%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
4) Commercial Insurance	16.6%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self Pay	3.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)								
1) Medicare	48.8%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%
2) Medicaid	15.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%
3) Blue Cross	14.9%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
4) Commercial Insurance	16.6%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self Pay	3.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

NOTE: Memorial Hospital Easton is a TPR hospital. TPR does not distinguish between Inpatient and Outpatient

Alternative 3
Relocation to a New Site in Northern Talbot County

TABLE 3: REVENUES AND EXPENSES - ENTIRE FACILITY (including proposed project)

	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
1. Revenue		SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE	SEE NOTE
a. Inpatient Services	$ 95,278,600							
b. Outpatient Services	65,490,600							
c. Gross Patient Services Revenues	160,769,200	173,497,318	184,253,259	186,220,528	188,470,949	190,748,565	203,669,231	216,764,335
d. Allowance for Bad debt	4,236,594	5,391,828	7,101,833	8,021,144	8,118,785	8,217,096	8,761,507	9,313,261
e. Contractual Allowance	16,378,961	18,633,681	21,768,847	22,001,273	22,267,152	22,536,244	24,062,773	25,609,912
f. Charity Care	2,739,281	3,674,124	2,924,725	3,348,098	3,390,605	3,432,152	3,629,414	3,829,323
g. Net Patient Services Revenue	137,414,364	145,797,685	152,457,854	152,850,013	154,694,407	156,563,073	167,215,537	178,011,839
h. Other Operating Revenues (Specify)	1,806,811	4,140,354	1,973,877	2,750,365	2,750,365	2,750,365	2,750,365	2,750,365
i. Net Operating Revenues	139,221,175	149,938,039	154,431,731	155,600,378	157,444,772	159,313,438	169,965,902	180,762,204

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
2. Expenses								
a. Salaries, Wages. And Professional Fees, (including fringe benefits)	$ 71,411,890	$ 74,253,305	$ 74,204,911	$ 80,557,061	$ 81,088,310	$ 81,628,524	$ 82,642,966	$ 83,298,994
b. Contractual Services	24,456,064	24,608,309	26,679,222	28,588,038	29,284,784	29,486,272	30,864,275	29,881,908
c. Interest on Current Debt	2,186,211	2,778,462	3,616,202	4,114,645	3,537,700	3,432,358	3,325,967	3,208,819
d. Interest on Project Debt							5,609,805	10,629,344
e. Current Depreciation	11,944,011	10,750,217	10,246,329	11,296,978	10,589,961	4,483,242	10,419,665	16,662,294
f. Project Depreciation								
g. Current Amortization								
h. Project Amortization								
i. Supplies	23,190,072	26,490,957	27,988,639	29,270,553	28,854,957	28,277,541	27,664,974	27,896,834
j. Other Expenses (Impairment Loss)					46,669,784			
k. Total Operating Expenses	133,188,248	138,881,250	142,735,303	153,827,275	200,025,496	147,307,937	160,527,652	171,578,193
3. Income								
a. Income from Operation	6,032,927	11,056,789	11,696,428	1,773,103	(42,580,724)	12,005,501	9,438,250	9,184,011
b. Non-Operating Income	8,472,033	7,960,026	(836,760)	7,215,807	6,034,374	6,481,722	6,786,664	7,146,148
c. Subtotal	14,504,960	19,016,814	10,859,668	8,988,910	(36,546,350)	18,487,223	16,224,914	16,330,159
d. Income Taxes								
e. Net Income (Loss)	$ 14,504,960	$ 19,016,814	$ 10,859,668	$ 8,988,910	$ (36,546,350)	$ 18,487,223	$ 16,224,914	$ 16,330,159

Table 3 cont.	Two Most Recent Actual Years		Current Year Projected	Projected Years (ending with first year at full utilization)				
Fiscal Year	2010	2011	2012	2013	2014	2015	2016	2017
4. Patient Mix:								
A. Percent of Total Revenue								
1) Medicare	48.8%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%
2) Medicaid	15.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%
3) Blue Cross	14.9%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
4) Commercial Insurance	16.6%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self Pay	3.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
B. Percent of Patient Days\Visits\Procedures (as applicable)								
1) Medicare	48.8%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%	51.3%
2) Medicaid	15.9%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%	15.3%
3) Blue Cross	14.9%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%	14.7%
4) Commercial Insurance	16.6%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self Pay	3.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%	4.8%
6) Other (Managed care)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
7) Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

NOTE: Memorial Hospital Easton is a TPR hospital. TPR does not distinguish between Inpatient and Outpatient

Assumptions

Alternative 1

Volume And Revenue

	Actual	Actual	Budget	Projected			
	2011	2012	2013	2014	2015	2016	2017
VOLUMES							
Inpatient Admissions							
Existing Services	9,919	8,872	8,628	8,680	8,732	8,784	8,872
Rehab	599	445	459	459	459	459	459
UMMS Add'l Cases	-	-	-	-	-	-	-
Other Cases	-	-	-	-	-	-	-
Subtotal: Inpatient Admissions	10,518	9,317	9,087	9,139	9,191	9,243	9,331
% Growth	-2.9%	-11.4%	-2.5%	0.6%	0.6%	0.6%	1.0%
Emergency room Visits	35,104	36,737	37,264	37,799	38,341	38,891	39,449
% Growth	14.9%	4.7%	1.4%	1.4%	1.4%	1.4%	1.4%
Other Regulated Outpatient % Growth	0.0%	16.5%	1.0%	1.8%	1.8%	1.9%	1.9%
Unregulated Outpatient % Growth	5.8%	10.7%	9.3%	1.6%	1.3%	1.1%	1.1%
EIPAs	21,621	21,713	19,490	19,664	19,877	20,087	20,336
% Growth	-1.0%	0.4%	-10.2%	0.9%	1.1%	1.1%	1.2%
CASEMIX							
Increase in existing cases	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Increase for all cases - Rehab & UMMS Cases	8.74%	6.47%	14.14%	0.37%	-0.09%	-0.09%	-0.09%
RATES							
Inpatient:							
Expense Inflation				0.00%	0.00%	0.00%	0.00%
HSCRC Shortfall				0.00%	0.00%	0.00%	0.00%
Update				-	-	-	-
Scaling				-	-	-	-
Increase in CPC for OP and ER				0.00%	0.00%	0.00%	0.00%
Increase in Case Mix (Existing Cases)				0.00%	0.00%	0.00%	0.00%
CMI Governor				0.00%	0.00%	0.00%	0.00%
Increase in CPC for CMI				0.00%	0.00%	0.00%	0.00%

Increase in CPC				0.00%	0.00%	0.00%	0.00%
Partial Capital Amount in Rates				$ -	$ -	$ 2,032,012	$ 4,064,023
Emergency Department:							
Update				0.00%	0.00%	0.00%	0.00%
Scaling				0.00%	0.00%	0.00%	0.00%
Increase in rates				0.00%	0.00%	0.00%	0.00%
Other Regulated Outpatient:							
Update				0.00%	0.00%	0.00%	0.00%
Scaling				0.00%	0.00%	0.00%	0.00%
Increase in rates				0.00%	0.00%	0.00%	0.00%
Unregulated Services				0.00%	0.00%	0.00%	0.00%
TPR Rev Adj for Age-Adjusted Population Growth				1.21%	1.21%	1.35%	1.35%
CONTR. ALLOWS. (% OF GROSS REV)							
Regulated	10.74%	11.81%	11.81%	11.81%	11.81%	11.81%	11.81%
Unregulated	57.85%	58.11%	47.60%	47.60%	47.60%	47.60%	47.60%
Charity Care	2.05%	1.52%	1.70%	1.70%	1.70%	1.70%	1.70%
OTHER OPER. REVENUE GROWTH (%)				0.0%	0.0%	0.0%	0.0%

Note 1 : Partial Rate Application

Expense Assumptions

	Actual	Actual	Budget				Projected
	2011	2012	2013	2014	2015	2016	2017
OPERATING EXPENSES							
Expense Inflation Assumptions							
Salaries & Benefits				0.00%	0.00%	0.00%	0.00%
Professional Fees				0.00%	0.00%	0.00%	0.00%
Hospital-Based Physicians				0.00%	0.00%	0.00%	0.00%
Purchased Services				0.00%	0.00%	0.00%	0.00%
Insurance				0.00%	0.00%	0.00%	0.00%
Supplies				0.00%	0.00%	0.00%	0.00%
Drugs				0.00%	0.00%	0.00%	0.00%
Weighted Average				0.00%	0.00%	0.00%	0.00%

Expense Variability with Volume

Salaries (FTEs per AOB)				70.0%	70.0%	70.0%	70.0%
Professional Fees (Fixed)				-	-	-	-
Hospital-Based Physicians (EIPAs)				70.0%	70.0%	70.0%	70.0%
Purchased Services (EIPAs)				70.0%	70.0%	70.0%	70.0%
Supplies (% variable with EIPAs)				70.0%	70.0%	70.0%	70.0%
Drugs (% variable with EIPAs)				70.0%	70.0%	70.0%	70.0%
Fringe Benefits as % of Salaries	29.0%	29.2%	31.7%	31.7%	31.7%	31.7%	31.7%

Expense Variability with CMI

Salaries & Benefits				70.0%	70.0%	70.0%	70.0%
Professional Fees				-	-	-	-
Hospital-Based Physicians				70.0%	70.0%	70.0%	70.0%
Purchased Services				70.0%	70.0%	70.0%	70.0%
Supplies				70.0%	70.0%	70.0%	70.0%
Drugs				70.0%	70.0%	70.0%	70.0%

Additional IP Rehab Expense ($K)

Professional Fees	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchased Services	-	-	-	-	-	-	-
Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-
	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Additional Expense ($K)

Salaries & Benefits	$ -	$ -	$ -	$ -	$ -	$ 360,243	$ 360,243
Physician Acquisition Costs	-	-	-	-	-	-	-
Purchased Services	-	-	-	-	-	(152,721)	(152,721)
Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-
Total	$ -	$ -	$ -	$ -	$ -	$ 207,522	$ 207,522
Actual->	6.43%	6.57%	3.30%	4.23%	5.31%	6.26%	6.26%
Cap->	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%

Efficiency Factor [1]

Salaries & Benefits	-	-	-	-	-	-	-
Professional Fees	-	-	-	-	-	-	-
Hospital-Based Physicians	-	-	-	-	-	-	-
Purchased Services	-	-	-	-	-	-	-

Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-

Note 1: Efficiency Factor has cumulative effect in future years

Bad Debt as a % of Gross Revenue	3.09%	3.81%	4.20%	4.20%	4.20%	4.20%	4.20%

Other Assumptions

	2011	2012	2013	2014	2015	2016	2017
NON-OPERATING REVENUE							
Return on Board Designated Assets	66.44%	-3.31%	9.91%	2.00%	2.00%	2.00%	2.00%
Return on Cash & Cash Equiv	49.26%	-1.08%	-3.38%	2.00%	2.00%	2.00%	2.00%
ROUTINE CAPITAL	$ 19,844,656	$ 24,072,402	$ 5,027,551	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,300,000
FUNDRAISING ($K)	$ -	$ -	$ -	$ -	$ -	$ -	$ -
UMMS CONTRIBUTION ($K)	$ -	$ -	$ -	$ (10,000,000)	$ -	$ -	$ -

Volume Reduction Factor		100%	100%
		15%	

Assumptions

Alternative 2

Volume and Revenue Assumptions

	Actual	Actual	Budget	Projected			
	2011	2012	2013	2014	2015	2016	2017
VOLUMES							
Inpatient Admissions							
Existing Services	9,919	8,872	8,628	8,680	8,732	8,784	8,872
Rehab	599	445	459	459	459	459	459
UMMS Add'l Cases	-	-	-	-	-	-	-
Other Cases	-	-	-	-	-	-	-
Subtotal: Inpatient Admissions	10,518	9,317	9,087	9,139	9,191	9,243	9,331
% Growth	-2.9%	-11.4%	-2.5%	0.6%	0.6%	0.6%	1.0%
Emergency room Visits	35,104	36,737	37,264	37,799	38,341	38,891	39,449
% Growth	14.9%	4.7%	1.4%	1.4%	1.4%	1.4%	1.4%
Other Regulated Outpatient % Growth	0.0%	16.5%	1.0%	1.8%	1.8%	1.9%	1.9%
Unregulated Outpatient % Growth	5.8%	10.7%	9.3%	1.6%	1.3%	1.1%	1.1%
EIPAs	21,621	21,713	19,490	19,664	19,877	20,087	20,336
% Growth	-1.0%	0.4%	-10.2%	0.9%	1.1%	1.1%	1.2%
CASEMIX							
Increase in existing cases	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Increase for all cases - Rehab & UMMS Cases	8.74%	6.47%	14.14%	0.37%	-0.09%	-0.09%	-0.09%
RATES							
Inpatient:							
Expense Inflation				0.00%	0.00%	0.00%	0.00%
HSCRC Shortfall				0.00%	0.00%	0.00%	0.00%
Update				-	-	-	-
Scaling				-	-	-	-
Increase in CPC for OP and ER				0.00%	0.00%	0.00%	0.00%
Increase in Case Mix (Existing Cases)				0.00%	0.00%	0.00%	0.00%
CMI Governor				0.00%	0.00%	0.00%	0.00%
Increase in CPC for CMI				0.00%	0.00%	0.00%	0.00%

Increase in CPC				0.00%	0.00%	0.00%	0.00%
Partial Capital Amount in Rates				$ -	$ -	$ 9,610,135	$ 19,220,271
Emergency Department:							
Update				0.00%	0.00%	0.00%	0.00%
Scaling				0.00%	0.00%	0.00%	0.00%
Increase in rates				0.00%	0.00%	0.00%	0.00%
Other Regulated Outpatient:							
Update				0.00%	0.00%	0.00%	0.00%
Scaling				0.00%	0.00%	0.00%	0.00%
Increase in rates				0.00%	0.00%	0.00%	0.00%
Unregulated Services				0.00%	0.00%	0.00%	0.00%
TPR Rev Adj for Age-Adjusted Population Growth				1.21%	1.21%	1.35%	1.35%
CONTR. ALLOWS. (% OF GROSS REV)							
Regulated	10.74%	11.81%	11.81%	11.81%	11.81%	11.81%	11.81%
Unregulated	57.85%	58.11%	47.60%	47.60%	47.60%	47.60%	47.60%
Charity Care	2.05%	1.52%	1.70%	1.70%	1.70%	1.70%	1.70%
OTHER OPER. REVENUE GROWTH (%)				0.0%	0.0%	0.0%	0.0%

Note 1 : Partial Rate Application

Expense Assumptions

	Actual	Actual	Budget	Projected			
	2011	2012	2013	2014	2015	2016	2017
OPERATING EXPENSES							
Expense Inflation Assumptions							
Salaries & Benefits				0.00%	0.00%	0.00%	0.00%
Professional Fees				0.00%	0.00%	0.00%	0.00%
Hospital-Based Physicians				0.00%	0.00%	0.00%	0.00%
Purchased Services				0.00%	0.00%	0.00%	0.00%
Insurance				0.00%	0.00%	0.00%	0.00%
Supplies				0.00%	0.00%	0.00%	0.00%
Drugs				0.00%	0.00%	0.00%	0.00%
Weighted Average				0.00%	0.00%	0.00%	0.00%

Expense Variability with Volume

Salaries (FTEs per AOB)				70.0%	70.0%	70.0%	70.0%
Professional Fees (Fixed)				-	-	-	-
Hospital-Based Physicians (EIPAs)				70.0%	70.0%	70.0%	70.0%
Purchased Services (EIPAs)				70.0%	70.0%	70.0%	70.0%
Supplies (% variable with EIPAs)				70.0%	70.0%	70.0%	70.0%
Drugs (% variable with EIPAs)				70.0%	70.0%	70.0%	70.0%
Fringe Benefits as % of Salaries	29.0%	29.2%	31.7%	31.7%	31.7%	31.7%	31.7%

Expense Variability with CMI

Salaries & Benefits				70.0%	70.0%	70.0%	70.0%
Professional Fees				-	-	-	-
Hospital-Based Physicians				70.0%	70.0%	70.0%	70.0%
Purchased Services				70.0%	70.0%	70.0%	70.0%
Supplies				70.0%	70.0%	70.0%	70.0%
Drugs				70.0%	70.0%	70.0%	70.0%

Additional IP Rehab Expense ($K)

Professional Fees	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchased Services	-	-	-	-	-	-	-
Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-
	$ -	$ -	$ -	$ -	$ -	$ -	$ -

Additional Expense ($K)

Salaries & Benefits	$ -	$ -	$ -	$ -	$ -	$ 360,243	$ 360,243
Physician Acquisition Costs	-	-	-	-	-	-	-
Purchased Services	-	-	-	-	-	(152,721)	(152,721)
Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-
Total	$ -	$ -	$ -	$ -	$ -	$ 207,522	$ 207,522
Actual->	6.43%	6.57%	3.30%	-20.54%	8.54%	7.04%	6.48%
Cap->	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%

Efficiency Factor [1]

Salaries & Benefits	-	-	-	-	-	-	-
Professional Fees	-	-	-	-	-	-	-
Hospital-Based Physicians	-	-	-	-	-	-	-
Purchased Services	-	-	-	-	-	-	-

Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-

Note 1: Efficiency Factor has cumulative effect in future years

Bad Debt as a % of Gross Revenue	3.09%	3.81%	4.20%	4.20%	4.20%	4.20%	4.20%

Other Assumptions

	2011	2012	2013	2014	2015	2016	2017
NON-OPERATING REVENUE							
Return on Board Designated Assets	66.44%	-3.31%	9.91%	2.00%	2.00%	2.00%	2.00%
Return on Cash & Cash Equiv	34.17%	-0.74%	-2.56%	2.00%	2.00%	2.00%	2.00%
ROUTINE CAPITAL	$ 19,844,656	$ 24,072,402	$ 5,027,551	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,300,000
FUNDRAISING ($K)	$ -	$ -	$ -	$ 8,500,000	$ 11,000,000	$ 11,000,000	$ -
UMMS CONTRIBUTION ($K)	$ -	$ -	$ -	$ (10,000,000)	$ -	$ -	$ -

Volume Reduction Factor	100%	100%
	15%	

Assumptions

Alternative 3

Volume and Revenue Assumptions

Fiscal Years 2011 - 2020

	Actual	Actual	Budget	Projected			
	2011	2012	2013	2014	2015	2016	2017
VOLUMES							
Inpatient Admissions							
Existing Services	9,919	8,872	8,628	8,680	8,732	8,784	8,872
Rehab	599	445	459	459	459	459	459
UMMS Add'l Cases	-	-	-	-	-	-	-
Other Cases	-	-	-	-	-	-	-
Subtotal: Inpatient Admissions	10,518	9,317	9,087	9,139	9,191	9,243	9,331
% Growth	-2.9%	-11.4%	-2.5%	0.6%	0.6%	0.6%	1.0%
Emergency room Visits	35,104	36,737	37,264	37,799	38,341	38,891	39,449
% Growth	14.9%	4.7%	1.4%	1.4%	1.4%	1.4%	1.4%
Other Regulated Outpatient % Growth	0.0%	16.5%	1.0%	1.8%	1.8%	1.9%	1.9%
Unregulated Outpatient % Growth	5.8%	10.7%	9.3%	1.6%	1.3%	1.1%	1.1%
EIPAs	21,621	21,713	19,490	19,664	19,877	20,087	20,336
% Growth	-1.0%	0.4%	-10.2%	0.9%	1.1%	1.1%	1.2%
CASEMIX							
Increase in existing cases	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Increase for all cases - Rehab & UMMS Cases	8.74%	6.47%	14.14%	0.37%	-0.09%	-0.09%	-0.09%
RATES							
Inpatient:							
Expense Inflation				0.00%	0.00%	0.00%	0.00%
HSCRC Shortfall				0.00%	0.00%	0.00%	0.00%
Update				-	-	-	-
Scaling				-	-	-	-
Increase in CPC for OP and ER				0.00%	0.00%	0.00%	0.00%
Increase in Case Mix (Existing Cases)				0.00%	0.00%	0.00%	0.00%

CMI Governor				0.00%	0.00%	0.00%	0.00%
Increase in CPC for CMI				0.00%	0.00%	0.00%	0.00%
Increase in CPC				0.00%	0.00%	0.00%	0.00%
Partial Capital Amount in Rates				$ -	$ -	$ 10,207,603	$ 20,415,205
Emergency Department:							
Update				0.00%	0.00%	0.00%	0.00%
Scaling				0.00%	0.00%	0.00%	0.00%
Increase in rates				0.00%	0.00%	0.00%	0.00%
Other Regulated Outpatient:							
Update				0.00%	0.00%	0.00%	0.00%
Scaling				0.00%	0.00%	0.00%	0.00%
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Charity Care	2.05%	1.52%	1.70%	1.70%	1.70%	1.70%	1.70%
OTHER OPER. REVENUE GROWTH (%)				0.0%	0.0%	0.0%	0.0%

Note 1 : Partial Rate Application

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Expense Inflation Assumptions							
Salaries & Benefits				0.00%	0.00%	0.00%	0.00%
Professional Fees				0.00%	0.00%	0.00%	0.00%
Hospital-Based Physicians				0.00%	0.00%	0.00%	0.00%
Purchased Services				0.00%	0.00%	0.00%	0.00%
Insurance				0.00%	0.00%	0.00%	0.00%

Supplies				0.00%	0.00%	0.00%	0.00%
Drugs				0.00%	0.00%	0.00%	0.00%
Weighted Average				0.00%	0.00%	0.00%	0.00%
Expense Variability with Volume							
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Expense Variability with CMI							
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Professional Fees				-	-	-	-
Hospital-Based Physicians				70.0%	70.0%	70.0%	70.0%
Purchased Services				70.0%	70.0%	70.0%	70.0%
Supplies				70.0%	70.0%	70.0%	70.0%
Drugs				70.0%	70.0%	70.0%	70.0%
Additional IP Rehab Expense ($K)							
Professional Fees	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Purchased Services	-	-	-	-	-	-	-
Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-
	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Additional Expense ($K)							
Salaries & Benefits	$ -	$ -	$ -	$ -	$ -	$ 360,243	$ 360,243
Physician Acquisition Costs	-	-	-	-	-	-	-
Purchased Services	-	-	-	-	-	(152,721)	(152,721)
Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-
Total	$ -	$ -	$ -	$ -	$ -	$ 207,522	$ 207,522
Actual->	6.43%	6.57%	3.30%	-20.33%	8.74%	7.00%	6.51%
Cap->	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%	4.00%
Efficiency Factor [1]							
Salaries & Benefits	-	-	-	-	-	-	-

Professional Fees	-	-	-	-	-	-	-
Hospital-Based Physicians	-	-	-	-	-	-	-
Purchased Services	-	-	-	-	-	-	-
Supplies	-	-	-	-	-	-	-
Drugs	-	-	-	-	-	-	-

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Return on Cash & Cash Equiv	49.26%	-1.08%	-3.38%	2.00%	2.00%	2.00%	2.00%
ROUTINE CAPITAL	$ 19,844,656	$ 24,072,402	$ (2,122,449)	$ 10,000,000	$ 10,000,000	$ 10,000,000	$ 10,300,000
FUNDRAISING ($K)	$ -	$ -	$ -	$ 8,500,000	$ 11,000,000	$ 11,000,000	$ -
UMMS CONTRIBUTION ($K)	$ -	$ -	$ -	$ (10,000,000)	$ -	$ -	$ -

Volume Reduction Factor	100%	100%
	15%	