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October 24, 2012

VIA HAND DELIVERY

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

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

Dear Ms. Potter:

Enclosed are ten copies of the "Responses to Completeness and Additional Information Questions Dated September 25, 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: Kathleen H. Foster, R.N., Health Officer, Talbot 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, Senior Vice President, Business Development and System Strategies, UMMS
Dana Farrakhan, Senior Vice President, Business Development and System Strategies, UMMS
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Jack C. Tranter, Esq.

#456106
012516-0003

ACKNOWLEDGMENT OF RECEIPT

This will acknowledge receipt of ten bound copies of the "Responses to Completeness and Additional Information Questions Dated September 25, 2012" with respect to the CON Application of Shore Health Systems, Inc. to relocate Memorial Hospital at Easton (Matter No. 12-20-2339).

_____

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

Date: October 24, 2012

Memorial Hospital at Easton
Matter No. 12-20-2339

RESPONSES TO COMPLETENESS AND ADDITIONAL INFORMATION QUESTIONS DATED SEPTEMBER 25, 2012

PART I— PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. **Regarding the response to Item 9, please provide the following clarifications:**
   a. **On the physical bed capacity form, MHE indicated that there is a total capacity for 132 beds including the rehabilitation beds, but on the OHCQ and MHCC Application for Annual Licensed Bed Designation, MHE indicated that the total physical bed capacity at MHE in FY 2012 was 150 beds (this number was not provided for FY 2013). Please correct or reconcile these numbers; and**
   b. **Please complete the attached spreadsheet detailing the actual physical bed capacity before and after the project.**

MHE submitted the requested physical bed chart, included as Exhibit 21 to the CON application. In preparing the physical bed chart for this CON application, MHE staff visited each room and counted headwalls. The chart shows that there are currently 189 physical acute and rehabilitation beds (*i.e.*, headwalls for a bed) at MHE. The chart on page 3 of the CON application was completed showing licensed, not physical, beds (although the applicable column heading erroneously was labeled "Current Physical Beds"). The chart showing physical beds is presented below.

Service	Current PhysicalBeds	Beds to be Added or Reduced	Total Beds if Project is Approved
M/S/G/A	122	(40)	82
Pediatrics	14	(8)	6
Obstetrics	18	(4)	14
ICU/CCU Care	10		10
Psychiatry			
Rehabilitation	20		20
Chronic			
Other (Sleep, Renal)	5	(5)	
TOTAL BEDS	189	(57)	132

2. Regarding the project description (Item 14):

a. Please provide a map with the location for the proposed relocated MHE at the intersection of Longwoods Road and Route 50, as well as the current location in the City of Easton on South Washington Street. Please include the major roads that will provide access to the new hospital location;

b. Does the proposed project include the relocation of all the programs and services that are currently provided at the current South Washington Street location to the proposed Longwood Road location?

c. While plans for the existing site are not finalized, please discuss whether Shore Health System intends to or is considering the operation of any health programs and services at the South Washington Street location;

d. Please provide further details as to the features and functions included in the $16 million in software and related costs to implement a new electronic health record system. Will MHE implement a similar system at Dorchester General Hospital, and will this provide interoperability with the other hospitals in the University of Maryland Medical System;

e. Explain the nature of the inconvenience of driving into downtown Easton for patients. Can this inconvenience be quantified in some way?

f. Specify the total square footage of the existing physical plant in a manner comparable to the total square footage of the new facility as reported on Chart 1 (page 8);

g. Summarize the number, the type (public, patient/service, trauma) and location of elevators in the existing facility. Explain the term "stps" and the numbers accompanying its use in Chart 1 such as public - 5(18 stps); and

h. Provide the following detail for the existing MHE and the new facility:

(i) The number and type of devices in the Imaging Department;

(ii) The types of services that will be located in the Cardiopulmonary/Vascular Services program;
(iii) The number of cardiac catheterization laboratories;
(iv) The number of sterile operating rooms and non-sterile, minor procedure rooms, as well as the number of recovery beds in the Prep/Stage II Recovery area; and
(v) Will all 14 obstetric ("OB") post partum beds be in a labor/delivery/ recovery/post partum configuration?

a. Maps with the location for the proposed relocated MHE at the intersection of Longwoods Road and Route 50, and the current location in the City of Easton on South Washington Street, showing major roads are attached as Exhibit 23.[1]

b. All of the programs and services that are currently provided at the current South Washington Street location will relocate to the proposed Longwoods Road location.

c. Shore Health System currently has no plans to operate any health programs and services at the South Washington Street location.

d. The breakdown of the $16M in costs to implement a new electronic health record system include:

NetworkGear	$6,000,000
PCs	$3,600,000
Cabling	$2,000,000
AV	$400,000
Nursecall	$1,400,000
Security	$1,000,000
Phones	$400,000
Misc	$1,200,000
TOTAL	$16,000,000

[1] To avoid confusion, exhibits and tables in these responses are numbered sequentially following the last-numbered items in the original application.

The $16 million budget is to cover the infrastructure costs required to build a system that will support the necessary clinical processes. The future goal is to expand the UMMS EMR to the proposed MHE replacement hospital so that a patient's chart can be viewed across all the UMMS facilities. As the new facility is built, UMMS will evaluate the specifications of the system wide EMR system and the device selection will be made accordingly. A separate EMR implementation project will be organized to complete the integration of the UMMS EMR into both the new facility and DGH. Any hardware requirements for DGH will be part of the EMR project and not included in the $16M budget. The software components within the $16M apply to any new systems that will be implemented such as the new Nurse Call System and Security System.

e. The two most significant inconveniences in accessing downtown Easton are:

i. There are seven stop-lights between the hospital and Route 50. These traffic lights, in addition to the traffic in downtown Easton, make accessing the hospital inconvenient to many patients and visitors.

ii. Once at the hospital, there is not adequate parking. MHE actually shares part of its parking lot with a Synagogue that is on an adjacent parcel, the main entrance of which faces the parking lot. Patients, visitors, and Staff often have to park on the streets in the residential neighborhood. Consequently, because of parking meter enforcement by the Town of Easton, patients, visitors, and staff frequently receive parking tickets.

f. Exhibit 24 shows the gross square footage, by department, for clinical services in both the existing Building and the proposed facility. Exhibit 24 differs from

Chart 1 on page 8 of the Application in that it does not include space for mechanical and shafts, exterior Building walls, the power plant, and interdepartmental circulation. MHE asked its architects to provide the clinical space comparison in expectation that the Commission may request it.

g. The elevators in the existing facility are planned as follows:

- Two passenger elevators in outpatient Building running two stories (2 stops each).
- One trauma sized elevator running from the main floor up six stories of bed and surgery floors (6 stops).
- Three central core area: public elevators running up through six floors (6 stops each)
- Three central core area staff/freight elevators running up through six floors (6 stops each).

"Stps" is an abbreviation for "stops" or floors. "Public—5 (18 stps)" means that there will be five elevators making a total of 18 stops.

h. (i) The changes in radiology equipment are planned as follows:

Types of Devices	**Existing No. of Devices**	**New Facility No. of Devices**
Diagnostic Radiographic Rooms	3	2
Radiographic/Fluoroscopy	1	2
Mobile C-arm Fluoroscopy	4	4
Mobile Radiographic (portable units)	2	2
Computerized Tomography (CT)	1	2
Nuclear Gamma Camera	2	2
Magnetic Resonance Imaging (MRI)	1	1
Interventional Radiology Fluoroscopic	1	1
Diagnostic Ultrasound	2	2
Digital Mammography	1	1
Sterotactic Mammography	1	0
Computerized Radiology Readers	2	0
Picture Archieval Communications Workstations	6	6

(ii) The types of services that will be located in the Cardiopulmonary/Vascular Services program include:

Services Provided by Department of Cardiovascular & Pulmonary Services

- Non-Invasive Cardiology
  - ECG
  - Holter
  - Stress Test to include routine stress, pharmacologic stress, stress echo and nuclear stress
  - Tilt table testing
  - Cardiac Ultrasound to include transesophageal
  - To be Determined – Pacemaker/Implantable Defibrillator Clinic

- Non-Invasive Vascular Lab
  - Carotid Duplex Imaging
  - Deep Venous Imaging of Upper and Lower Extremities
  - Vessel Mapping
  - Arterial and Venous Bloodflow Studies
  - Segmental Arterial and Venous Pressures

- Neurodiagnostics
  - Basic EEG
  - EEG with Sleep
  - Auditory Evoked Potential
  - Actigraphy

- Respiratory Care
  - Pulmonary Function Testing to include complete, comprehensive studies
  - Arterial Blood Gas Analysis
  - Overnight Pulse Oximetry
  - Full range of therapeutic services
  - Mechanical Ventilation/CPAP/BiPAP
  - Bronchoscopy
  - Emergency Airway Care
  - Participation on Code Teams

- Cardiac & Pulmonary Rehab
  - Phase II Cardiac Rehab (monitored)
  - Phase III/Adult Fitness for Cardiac and Pulmonary
  - Pulmonary Rehabilitation (monitored)
  - External Counterpulsation Therapy

- Diagnostic Cardiac Cath Lab
  - Adult Diagnostic Cardiac Cath
  - Implantation Pacemakers and Defibrillators
  - Implantation of Reveal Devices
  - Outpatient Elective Cardioversion

(iii) There will be one cardiac catheterization laboratory.

(iv) There will be six sterile operating rooms and two non-sterile, minor procedure rooms. There will be 25 prep/recovery beds in the Prep/Stage II Recovery area and 10 PACU beds.

(v) All 14 obstetric ("OB") post partum beds will be in a labor/delivery/ recovery/post partum configuration.

3. Regarding Chart 1 on page 8 through 10, will the expenditures for offsite improvements (outside the loop) be allocated and charged to future developments that benefit from them? If yes, how will such allocations be made? If no, why not?

The offsite improvement expense identified in Chart 1 will not be allocated to future development on the relocated MHE campus based on UMMS internal accounting policy. The offsite improvement expense in Chart 1 was separated into "inside the loop" and "outside the loop" for the sole purpose of making an “apples to apples” comparison of costs for the Marshall Valuation Service cost analysis.

The offsite improvements or infrastructure assets as defined by GASB are those that are long-lived capital assets that normally are: (1) stationary in nature; and (2) can be preserved for a significantly greater number of years than most other capital assets. Examples of such infrastructure assets include water and sewer systems, lighting systems and electrical and gas (main lines and distribution). The infrastructure asset cost for the relocated MHE will be captured in construction-in-progress (CIP) and will be

reported as a capital fixed asset on the SHS balance sheet during the project construction period.

Once the hospital Building is substantially complete, the total cost of the infrastructure assets will be capitalized to the appropriate asset category (Land, Land improvements, Infrastructure, etc.). UMMS internal accounting policy requires the capitalization of all infrastructure assets purchased or constructed during the project construction period to be capitalized upon completion of that project regardless of the prospective benefits from that infrastructure asset.

PART II—PROJECT BUDGET

4. Explain how the $7,000,000 in contingency allowance (line 1c(3)) was estimated.

The Contingency in line 1(c)(7) was calculated as 3% of all capital cost lines in the budget (except the contingency line itself). The result ($7,010,881) was then rounded down to $7,000,000.

5. Explain how the capitalized construction interest of $24,901,333 (line 1d(1)) was calculated. Also explain why there is no interest income included in the source of funding for this project. This explanation should specify how and when the proceeds from the sale of the bonds will be disbursed.

The capitalized interest calculation was based on the following assumptions:

Total debt issuance	$242,771,000
Annual interest rate	4.25%
29 months of interest expense over the life of the project	

Interest income was inadvertently excluded as a source of funds in the Application and is now included in the capital sources in a revised project budget, which is attached as Exhibit 25. The assumption behind interest earnings is a conservative

1.0% historical investment earnings rate over an eighteen month draw of the bond proceeds of which the majority of the bond proceed are drawn within twelve months.

6. Please provide additional detail on the calculation of the inflation (line 1d(2) that shows exactly how you arrived at the budgeted amount of $4,679,795. Include an explanation of why the inflation amount covers 27 months and an explanation of what is meant by MHCC Index 11.3 - 14.4.

MHE first added the capital costs in the Building and Site Development lines of the Project budget found on page 28 of the CON application.

Building	$125,193,045
Site Development	$36,015,484
Total	$161,208,529

MHE then consulted the MHCC's IHS Global Insight in Healthcare Cost Review inflation index posted on the MHCC website at:

http://mhcc.dhmh.maryland.gov/certificateofneed/Documents/Threshold_changes9_25_12.pdf

Using the methodology that the MHCC describes on its website, MHE calculated inflation from the cost estimation date to the midpoint of construction as follows:

Cost Est Date	8/1/2012				
MidPoint	11/1/2014				
Step 1	2013.3	%MOVAVG	1.3	1.013	*A*
Step 2	2014.3	%MOVAVG	1.4	1.014	*B*
Step 3	2014.3	CIS Proxy	1.112		*C*
	2014.4	CIS Proxy	1.114		*D*
	D/C			1.001798561	*E*
	*A * B * E*			**1.02902945**	

Finally, MHE multiplied the Building and Site Development cost total calculated above times the calculated inflation rate.

Total	$161,208,529
Inflation Rate	0.02902945
Inflation	$4,679,795

The reference to “11.3—14.4” on the inflation line should have read “12.3—14.4.” It refers to the year and the quarter for which the costs were estimated and the midpoint of construction. For example, the costs were estimated in August 2012. Using the parlance of the Commission’s methodology on its web site, August 2012 (which is in the third quarter of 2012) is referred to as “2012.3”

7. **Explain how the estimated cost for loan placement fees, bond discount, and debt service reserve fund were calculated.**

The loan placement and bond discount assumptions are based on the recent UMMS Series 2010 bond issuance in which loan placement and bond discount fees were approximately 0.7% of the total bond issuance. The debt service reserve fund is based on the maximum principal payment due over the 30 year life of the bond repayment period. Please refer to Question No. 5 for the assumptions for the bonds.

PART III—CONSISTENCY WITH GENERAL REVIEW CRITERIA AT COMAR 10.24.01.08G(3)

8. **The response to COMAR 10.24.10.04A(1), Information Regarding Charges does not satisfy the requirements of the standard. Specifically the list of charges submitted with the application and available on the Hospital's website is not completely consistent with the definition of a representative list as specified in the definition section of the Acute Care Hospital Services chapter (COMAR 10.24.10.06)(29). The definition requires that at a minimum the list contain "the average charge per case for the ten most frequently occurring inpatient diagnoses (determined by diagnosis-related group or "DRG") for discharged medical/surgical patients, and also for discharged obstetric patients, discharged pediatric patients, and discharged acute psychiatric patients, if the hospital operates an inpatient unit for any of these latter three services. The list submitted with the application and available on the website contains the charges for a total of 12 inpatient procedures that are not identified with a particular inpatient service. Therefore, you will need to revise the charge information available in written form at the Hospital and on the Hospital's website. The charge information must include, at a minimum, for inpatients the average charge**

per case for the 10 most frequently occurring diagnoses for discharged medical/surgical patients, the 10 most frequently occurring diagnoses for discharged obstetric patients, and the 10 most frequently occurring diagnoses for discharged pediatric patients, all as determined by DRG. The written policy should also be revised to make it clear that the list of charges will be updated at least quarterly as required by part (b) of the definition. It will be necessary for MHE to make these changes prior to the docketing of this application.

MHE has revised the inpatient charge information posted on its website to comply with the standard. They are also presented below. Please note that when MHE obtained the data for the MHA product line defined as Obstetrics in St. Paul's SNAPSHOT software for FY 2012, only 9 DRG's appeared on the report.

DRG	Charge Range		Estimated
	Minimum	Maximum	Average Charge
Medical/Surgical Cases			
470 - MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	$9,674	$44,874	$16,620
392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	$1,403	$30,840	$7,798
690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	$2,497	$33,957	$8,514
190 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W MCC	$2,788	$36,989	$11,062
292 - HEART FAILURE & SHOCK W CC	$2,419	$51,166	$9,732
603 - CELLULITIS W/O MCC	$1,400	$30,618	$7,942
194 - SIMPLE PNEUMONIA & PLEURISY W CC	$2,639	$31,381	$8,839
291 - HEART FAILURE & SHOCK W MCC	$3,125	$67,419	$14,095
191 - CHRONIC OBSTRUCTIVE PULMONARY DISEASE W CC	$2,439	$34,537	$9,858
065 - INTRACRANIAL HEMORRHAGE OR CEREBRAL INFARCTION W CC	$2,099	$43,342	$10,182
Pediatric Cases			
203 - BRONCHITIS & ASTHMA W/O CC/MCC	$2,170	$14,411	$8,019
202 - BRONCHITIS & ASTHMA W CC/MCC	$3,003	$26,166	$10,809
194 - SIMPLE PNEUMONIA & PLEURISY W CC	$1,930	$24,753	$10,330
195 - SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	$2,239	$14,707	$8,660
603 - CELLULITIS W/O MCC	$2,040	$13,337	$7,031
690 - KIDNEY & URINARY TRACT INFECTIONS W/O MCC	$2,497	$9,424	$5,537
193 - SIMPLE PNEUMONIA & PLEURISY W MCC	$7,388	$18,758	$11,816

DRG	Charge Range		Estimated
	Minimum	Maximum	Average Charge
392 - ESOPHAGITIS, GASTROENT & MISC DIGEST DISORDERS W/O MCC	$1,363	$8,842	$5,955
864 - FEVER	$1,574	$11,203	$8,032
153 - OTITIS MEDIA & URI W/O MCC	$1,166	$27,128	$8,328
Obstetric Cases			
775 - VAGINAL DELIVERY W/O COMPLICATING DIAGNOSES	$1,543	$14,959	$6,554
766 - CESAREAN SECTION W/O CC/MCC	$3,257	$15,801	$8,466
774 - VAGINAL DELIVERY W COMPLICATING DIAGNOSES	$2,816	$15,059	$7,255
765 - CESAREAN SECTION W CC/MCC	$2,798	$20,597	$9,615
781 - OTHER ANTEPARTUM DIAGNOSES W MEDICAL COMPLICATIONS	$1,631	$44,513	$8,374
776 - POSTPARTUM & POST ABORTION DIAGNOSES W/O O.R. PROCEDURE	$1,985	$10,485	$6,034
777 - ECTOPIC PREGNANCY	$9,615	$9,615	$9,615
769 - POSTPARTUM & POST ABORTION DIAGNOSES W O.R. PROCEDURE	$11,867	$15,313	$13,591
782 - OTHER ANTEPARTUM DIAGNOSES W/O MEDICAL COMPLICATIONS	$1,141	$7,245	$6,980

The revised written policy is attached as Exhibit 26.

9. The Charity Care Policy, COMAR 10.24.10.04A(2), requires that a determination of probable eligibility be made within two business days following a patient's request for charity care. MHE's charity care policy addresses this requirement in section 9.4 on page eight of the nine page policy at the end of a paragraph that includes as the second sentence the statement that "once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for determination of final eligibility based on SHS guidelines." One of the objectives of this standard is to require that patients seeking charity care be informed of probable eligibility at the earliest possible time. Satisfying the standard requirement for a determination of probable eligibility will require separation of the probable determination process from the final determination process in order to make it clear that the probable determination does not require submission of a complete application.

A revised Charity Care Policy is attached as Exhibit 27.

10. Regarding COMAR 10.24.1 O.04B(5), Cost Effectiveness, please provide the following information:

a. Provide a detailed description of the existing campus alternative specifying the amount of new construction and renovation in square feet, the changes in bed capacity and mixes of private and semi-private rooms and the changes in capacity and space allocated to each department;

b. Submit a site plan of the existing site indicating the location of physical plant expansion(s) that were part of the on-site-alternative. What is the size of the existing site?

c. Identify the degree to which the on-site alternative (Alternative 1) would solve the concerns expressed about the existing physical plant, especially as detailed in the project description (pages 20 through 24);

d. Compare the estimated cost of $38,888,000 for the on-site alternative to the cost of the proposed alternative;

e. Explain why, after a major on-site improvement project, "way-finding" would still rank as poor, as specified in Table 9 on page 61;

f. Explain why the on-site alternative ranks so low in terms of enhancing physician recruitment,

g. Why are patient volumes expected to grow faster under the Easton relocation alternative (Alternative 2) and even faster under the northern Talbot County alternative (Alternative 3) than the on-site alternative (Alternative 1)? To the extent such differences in expected growth are associated with the development of new ambulatory care centers (one if the hospital is relocated in Easton, two if it is relocated to northern Talbot County.and none with the on-site alternative), why wouldn't the same ambulatory care centers be developed with each alternative?

h. Provide a more detailed explanation of the projected high level of ongoing capital budgeting for replacement equipment ($8 million under Alternative 1 and $7 million under Alternatives 2 and 3); and

i. Explain why SHS assumed pursuit of the northern Talbot County site would be delayed two years, as stated on page 74.

a. The existing campus alternative was developed in conjunction with planning the construction project that created a new Emergency Department and Outpatient Center from the hospital's approved Certificate of Need in 2005. Once that construction project was completed, the footprint of the hospital could not change further because of space limitations. The existing campus alternative assumed that a

16-bed ICU would be constructed above the Emergency Department, along with a 5-stop elevator tower and connectors to the existing hospital on levels 2 through 5. The existing campus alternative also contemplated renovation of the Imaging Department to provide two CT rooms, a catheterization lab, consult room, and inpatient holding. The vacated cardiopulmonary space on 3-North ICU space on 4-North would be renovated as offices for Nursing Administration, Education, Professional Practice, Corporate Compliance, Chaplain and Foundation, along with support space for Respiratory. The remainder of the capital budget for the existing campus alternative was devoted to infrastructure replacement and improvement. Chillers 1, 2, and 3 would be replaced, as would the air systems for the center, south, and east buildings. A new summer boiler would be installed, and the emergency generator would be replaced. Excluding the new Emergency Department and Outpatient Center (which were assumed to remain), the existing campus alternative included 21,600 square feet of new construction and 19,500 square feet of renovation. At the time the existing campus alternative was developed, MHE had a licensed capacity of 137 acute care beds. The existing campus alternative proposed to add 8 ICU beds to increase the ICU bed complement from 8 beds to 16 beds. All other inpatient units were to remain unchanged. There would be no change in the private to semi-private room mix in any of the inpatient units. The total square footage for the hospital would increase from 300,390 to 321,990., which broke down as follows:

PROGRAM REQUIREMENTS	EXISTING at Existing Site	PROPOSED at Existing Site	
	Dept. Gross SF	Dept. Gross SF	Differential (Required Additional Area)
Functional Grouping			
Outpatient Programs	37,078	37,108	**30**
Inpatient Programs	82,287	82,287	**0**
General Services	19,767	19,767	**0**
Operations	31,719	31,719	**0**
Ancillary Services	43,810	51,010	**7,200**
Allied Health Center	11,883	11,883	**0**
Imaging	21,727	21,727	**0**
Surgical Services	24,791	24,791	**0**
Critical Care	27,328	35,400	**8,072**
Available Space	0	6,298	**6,298**
Total Square Footage	**300,390**	**321,990**	**21,600**

b. A site plan of the existing site is attached as Exhibit 28. The size of the site is approximately 12.9 acres.

c. Alternative 1 solved very few of the concerns with the existing site. Specific to the concerns identified on pages 20 through 24 of the CON application:

- Location and accessibility of supplies – not addressed. The current location of the loading docks and Materials Management Department on the first floor is at great distance from both the clinical departments on the first floor and from the main elevator core. Distribution of supplies to clinical departments is slow because of the distance and is exacerbated by competition for the main elevators from other support departments. It was not possible to relocate the loading docks and the Materials Management Department to a more central location on the first floor due to space limitations of the site.
- Inordinate staff time for supply and inventory ordering – not addressed. Supply and inventory ordering is encumbered by significant amounts of manual work. While an automated system could have resolved some of the problems, the storage spaces of departments throughout the hospitals were too dispersed to support efficient use of an automated system.
- General lack of storage – not addressed. Although many of the departments in the existing Building are larger than their planned counterparts in the proposed project, the existing spaces are much less efficient because of layout, room sizes and corridor configurations. Many of the existing departments have inadequate space available for storage in spite of their large square footage.

- Elevator size and location – partially addressed with new elevator tower. This alternative proposed a new elevator tower near the southwest corner of the facility. While this elevator tower would presumably resolve issues related to the transport of Emergency Department patients to inpatient floors, they would not be of significant value in improving elevator use by the support departments (Materials Management, Linen Services, Dietary and Central Sterile Supply) because of the distance and the need of these departments to penetrate the Emergency Department in order to use the new elevator tower.
- Equipment cleaning and storage – not addressed. Employees noted that there is nowhere in the facility to clean and store large pieces of equipment. Typically this space would be collocated with Materials Management or Environmental Services. Both of these departments are on the first floor of the existing hospital and have no room to expand into adjacent space to provide for equipment cleaning and storage. Expanding into new construction was precluded because of a lack of adequate space on the site.
- Size of clean and soiled utility rooms – not addressed. As above, many of the existing clinical departments are larger than their counterparts in the proposed project, but the space is very inefficient. The size of the clean and soiled utility rooms could not be increased because of the layout of the departments. Much of the space is consumed by corridors and patient rooms that are sized for semiprivate use.
- Par level inventory management – not addressed. Par level inventory management is dependent on well-controlled, centralized storage spaces in the clinical departments. Because of the space shortages noted above, there is no centralized space for supplies so inventory tends to get horded throughout the department. It was not possible to provide centralized supply storage in the existing clinical departments.
- No elevator near the Emergency Department – addressed. Alternative 1 provided an elevator tower within the Emergency Department that connected it to all inpatient floors.
- Bed storage in the Emergency Department – not addressed. The configuration of the existing site forced the design of the Emergency Department to be long and narrow. Although the square footage of the existing department is greater than its counterpart in the proposed project, the existing department uses more space for corridors. There was no way to expand the department to provide adequate bed storage space because of site constraints.
- Location of PTS station at nurses' station in the Emergency Department – not addressed. The design of nurse's station in the existing facility is constrained by the location of structural columns. It would not be possible to relocate the PTS station without complete relocation of the nurse's station. Again, expansion of the department is not possible due to site constraints.

- Location and accessibility of supplies in Emergency Department – not addressed. The design of the department was a function of site constraints, creating a long and narrow configuration. It was not possible to relocate the supply storage area to make it more accessible to all clinical spaces.
- Location of patient care equipment – not addressed. Because of the general lack of storage space noted above, patient equipment is scattered throughout the department. It was not possible to provide the desired space without expanding the department which, in turn was not possible due to site constraints.
- Size of soiled utility rooms in Emergency Department – not addressed. Because of the general lack of storage space noted above, the soiled utility room is too small to support its intended function. It was not possible to provide the desired space without expanding the department which, in turn was not possible due to site constraints.
- Environmental Services storage in Emergency Department – not addressed. Because of the general lack of storage space noted above, Environmental Services has only a small space in the department. It was not possible to provide the desired space without expanding the department which, in turn was not possible due to site constraints.
- Storage space for dietary carts in Emergency Department – not addressed. Because of the general lack of storage space noted above, dietary carts are frequently left in the corridors and patient trays are left at the nurse's station counters. It was not possible to provide the desired space without expanding the department which, in turn was not possible due to site constraints.
- Long waits for Dietary for elevators – partially addressed with new elevator tower. The planned elevator tower in the Emergency Department was expected to reduce some of the load on the existing elevators. However, as noted previously, the new elevators are too far away, so the Dietary Department would continue to use the existing elevators. Most other support departments would similarly use these elevators, causing ongoing queuing problems and long delays.
- Elevator size for Imaging – partially addressed with new elevator tower. The new elevators in the Emergency Department would be sized to support transporting patients in beds. If the existing elevators need to be used for patient transport, the problems would remain.
- Size of clean and soiled utility rooms for Infection Control – not addressed. Although many of the inpatient units in the existing Building are larger than their planned counterparts in the proposed project, the existing spaces are much less efficient because of layout, room sizes and corridor configurations. Many of the existing inpatient units have inadequate space available for adequately sized clean and soiled utility rooms in spite of their large square footage.

- Need for all single-patient rooms for Infection Control – not addressed. Although many of the inpatient units in the existing Building are larger than their planned counterparts in the proposed project, the existing patient rooms are sized for semiprivate use. Converting these rooms to private use would not provide a sufficient number of rooms to meet the projected bed needs.
- Location of isolation supply carts for Infection Control – not addressed. Although many of the inpatient units in the existing Building are larger than their planned counterparts in the proposed project, the existing spaces are much less efficient because of layout, room sizes and corridor configurations. Many of the existing departments have inadequate space available for storage of isolation carts in spite of their large square footage.
- Separation of clean and soiled rooms for Infection Control – not addressed. Although many of the inpatient units in the existing Building are larger than their planned counterparts in the proposed project, the existing spaces are much less efficient because of layout, room sizes and corridor configurations. Many of the existing departments have inadequate space available to separate the clean utility rooms from the soiled rooms in spite of their large square footage.
- Placement of sinks in patient rooms for Infection Control – not addressed. The location of the sinks in existing patient rooms is dictated by the plumbing stacks of the existing buildings. It is not possible to move the sink locations without changing the plumbing stacks which would be both costly and disruptive to ongoing operations.
- Need for more negative pressure isolation rooms for Infection Control – not addressed. Adding more negative pressure isolation rooms is not possible in the existing buildings due to the constraints of the air handling systems in the existing buildings.
- Bed storage – not addressed. Typically bed storage space would be co-located with Materials Management or Environmental Services. Both of these departments are on the first floor of the existing hospital and have no room to expand into adjacent space to provide for bed cleaning and storage. Expanding into new construction was precluded because of a lack of adequate space on the site.
- Vendor/supplier delivery storage – not addressed. Vendor delivery storage is constrained by the number of loading docks and the size/configuration of the Materials Management Department. The current location of the loading docks and Materials Management Department on the first floor. It was not possible to expand or relocate the loading docks and the Materials Management Department on the first floor due to space limitations of the site.
- Size of sinks – not addressed. The size of sinks was not included in Alternative 1, but could have been accommodated by increasing the capital budget.

- Location of warehouse relative to clinical functions – not addressed. The current location of the warehouse is in the Materials Management Department on the first floor, near the northwestern corner of the site. The department is at great distance from both the clinical departments on the first floor and from the main elevator core. Distribution of supplies to clinical departments is slow because of the distance and is exacerbated by competition for the main elevators from other support departments. It was not possible to relocate the loading docks and the Materials Management Department to a more central location on the first floor due to space limitations of the site.
- Areas on inpatient units for supply and equipment storage – not addressed. Although many of the inpatient units in the existing Building are larger than their planned counterparts in the proposed project, the existing spaces are much less efficient because of layout, room sizes and corridor configurations. Many of the existing departments have inadequate space available for supply and equipment storage in spite of their large square footage.
- General concern with storage space – not addressed. Storage space is at a premium throughout the existing hospital. Largely due to the inefficient configuration of many departments, it was not possible to add storage space without adding new construction. New construction was in turn precluded due to the size and configuration of the site.
- Nursing time needed to locate, clean and store equipment – not addressed. As indicated previously, most clinical departments lack adequate space to store both supplies and large pieces of equipment. As a result, equipment is often scattered around the department. The nursing staff consumes valuable time tracking down the location of needed equipment and subsequently finding places to clean and store them once they have been used.
- Size of elevators for transporting patients – partially addressed with new elevator tower. The new elevators in the Emergency Department would be sized to support transporting patients in beds. If the existing elevators need to be used for patient transport, the problems would remain.
- Layout of the Clinical Laboratory – not addressed. The clinical laboratory is located on the first floor and is surrounded by other clinical departments. It was not possible to renovate or expand the Clinical Laboratory in place and there was nowhere else to move in in existing space. New construction was precluded because of the constraints of the site size and configuration.
- Inconsistent linen storage on the floors – not addressed. As has been noted previously, storage space is at a premium throughout the existing hospital. Largely due to the inefficient configuration of many departments, it was not possible to add storage space without adding new construction. New construction was in turn precluded due to the size and configuration of the site.
- Correction of loading dock, receiving and storage deficiencies – not addressed. The existing loading dock lacks enough loading bays and space to receive

incoming and outgoing shipments. The area could not be expanded because of the constraints of the surrounding departments. The area also could not be relocated elsewhere on the campus due to the size and configuration of the site.

- Location of pallet racking – not addressed. Pallet racking is currently performed in undesirable locations but cannot be moved due to space and site constraints.
- Locations of emergency supplies – not addressed. Emergency supplies are currently stored both on- and off-campus. It would be preferable to store all these emergency supplies on campus but there is insufficient space on the existing site to accommodate their space requirements.
- Need for IT storage room – not addressed. As has been noted previously, storage space is at a premium throughout the existing hospital. Providing additional storage space for the IT department was not possible without adding new construction. New construction was in turn precluded due to the size and configuration of the site.
- Location of the cylinder farm on the loading dock – not addressed. Gas cylinders are stored on and adjacent to the loading bays and are exposed to the elements. Ideally, they should be stored inside a Building or at least under cover. The existing loading dock lacks enough loading bays and space to receive incoming and outgoing shipments. The area could not be expanded because of the constraints of the surrounding departments. The area also could not be relocated elsewhere on the campus due to the size and configuration of the site.
- Site traffic issues with refilling bulk gas tanks – not addressed. The bulk gas tanks are located adjacent to the loading docks. Refilling of the tanks cannot be scheduled and the gas trucks block the loading bays in order to access the tanks, thus precluding other deliveries. The loading docks could not be reconfigured nor expanded to allow for concurrent deliveries because of the constraints of the surrounding departments. The loading docks also could not be relocated elsewhere on the campus due to the size and configuration of the site.
- No Central Supply for Outpatient Services and Surgery – not addressed. As has been noted previously, storage space is at a premium throughout the existing hospital. Providing additional storage space for Outpatient Services and Surgical Suite was not possible without adding new construction. New construction was in turn precluded due to the size and configuration of the site.
- Size of elevators for Outpatient Services and Surgery – partially addressed with new elevator tower. The new elevator tower in Alternative 1 was intended to allow for patient transport between the Emergency Department and upper levels of the building. Outpatient Services and Surgery would have access to these elevators, but only by passing through clinical areas of the Emergency Department, which was considered undesirable.

- Size and location of pneumatic tube stations for Pharmacy – not addressed. The size and location of the pneumatic tube stations for pharmacy could not be modified because of limitations of the existing Building configuration.
- Location of Plant Operations maintenance area – not addressed. The maintenance area is adjacent to the loading docks and Materials Management Department. The area needs more space for equipment and supply storage, but there is no room for expansion.
- Bio-Medical Services storage – not addressed. As has been noted previously, storage space is at a premium throughout the existing hospital. Bio-Medical Services is responsible for over 2,500 pieces of equipment that are located throughout the hospital. There is no space to provide additional storage space in the Bio-Medical Service, itself, without adding new construction. New construction was in turn precluded due to the size and configuration of the site.
- Location of outpatient Respiratory Services on 3rd and 4th floors – not addressed. It would be preferable to locate all outpatient services on the first floor. There was no room to accommodate outpatient Respiratory Services within the space available in the first floor Outpatient Center.
- Pneumatic tube station for Respiratory Services – not addressed. There is no pneumatic tube station in Respiratory Services or in the Cath Lab. It was not possible to add tube stations in these locations due to limitation of the system and the configuration of the existing buildings.
- Use of elevators for Respiratory Services – partially addressed with new elevator tower. The new elevator tower in Alternative 1 was intended to allow for patient transport between the Emergency Department and upper levels of the building. Respiratory Services would have access to these elevators, but only by passing through clinical areas of the Emergency Department, which was considered undesirable.
- Respiratory Services contact with EVS – not addressed. This issue pertained to the size of the soiled utility rooms which are too small to clean ventilators. As has been stated previously, there is no space in the existing hospital to accommodate larger soiled utility rooms.
- Cart washing in Sterile Processing – not addressed. This issue could have been addressed in Alternative 1 by replacing the existing cart washing equipment with a new model that has faster throughput. This equipment was not included in the capital budget for Alternative 1.
- Equipment storage in Surgery – not addressed. As has been noted previously, storage space is at a premium throughout the existing hospital. Largely due to the inefficient configuration of many departments, it was not possible to add storage space without adding new construction. New construction was in turn precluded due to the size and configuration of the site.

- Impact of storage issues on double well sinks in Sterile Processing – not addressed. One of the double sinks is blocked by storage of supplies and equipment. As has been noted previously, storage space is at a premium throughout the existing hospital. Largely due to the inefficient configuration of many departments, it was not possible to add storage space without adding new construction. New construction was in turn precluded due to the size and configuration of the site.

d. The $38.9 million estimated cost for the on-site alternative excluded many of the factors included in the financial analyses of each of the other alternatives. For example, the estimated cost for the on-site alternative does not include the $57 million included in each of the other alternatives for the renovation of DGH. The on-going capital expenditures incurred by SHS are also not included in this cost estimate, but were included in the financial analysis of this alternative. Also, the on-site alternative cost estimate was generated in 2005. The proposed project alternative costs were estimated in 2007, after significant inflation occurred in construction costs.

Perhaps most significantly, the cost estimation for the on-site alternative provided for the correction of only the most important deficiencies of the hospital. The budget provided for the replacement of the outdated air handling, chiller and emergency power systems. The budget also provided for the development of a new ICU and some renovation to the Imaging department. All else was to remain unchanged. In particular, the on-site alternative did not correct any of the following deficiencies:

- Location in a densely-populated residential neighborhood
- Insufficient number of parking spaces
- Improved, but still deficient site access
- Poor layouts of the surgical suite, imaging and laboratory
- Location of outpatient services above the first floor
- Lack of adequate private rooms for inpatient services.

e. There were several factors that lead to the poor ranking for way-finding in Alternative 1. The existing main lobby entrance and public elevators locations were not changed in this alternative. Finding the elevators from the main lobby entrance has been a frequent complaint of both patients and visitors. For a patient or visitor to move from either the main lobby entrance or the outpatient center entrance to Imaging, Surgery or Laboratory on the first floor required several corridor changes, all of which can be confusing to patients and visitors. Alternative 1 also left outpatient services on the second through fifth floors of the hospital.

f. The low ranking for enhanced physician recruitment at the on-site alternative was based on interviews with existing physicians in the community. They indicated that a renovated hospital will not be as attractive to prospective physician recruits as a new hospital. Presumably the lower appeal is a function of the confusing corridor systems and the spread of outpatient functions on all floors of the building. Also, the on-site alternative made no provision for the renovation or expansion of the surgical suite, which would impact its appeal to prospective surgeons. The interviewees also commented that the existing site is located on a residential street in the heart of Easton and therefore is not easily accessible from the major roads in Talbot County. Alternatives 2 and 3 were both to be developed on greenfield sites adjacent to major roads and would eliminate these concerns. The three alternatives were ranked as 1, 2 or 3 for each of the criteria. A ranking of 1 equals “best,” while 2 equals “second” and 3 equals “third.” The ranking of each alternative therefore was relative to the other alternatives, as opposed to an absolute scale. Therefore the “new hospital” Alternatives

(2 and 3) were determined to be superior to the "renovated" Alternative (1). They were each given a score of 1 while the on-site alternative was given a score of 3.

g. Volume growth projections were a function of population growth and market share changes. The volume projections assumed that improving the access of the project would make it more appealing to the residents of Queen Anne's County. Queen Anne's County has the largest population in the service area and is the fastest growing county in the service area. Moving the hospital to the northern part of Talbot County would have resulted in a greater market share in Queen Anne's County and would have the greatest impact on the volume projections.

The existing, on-site alternative (Alternative 1) is removed from the major roads of Talbot County (Routes 50 and 322) and is accessed from residential streets within the City. Interviews and surveys with residents of Queen Anne's County indicated that they regarded the existing campus as difficult to find. Because of these issues, the volume projections assumed the least increase in market share from Queen Anne's County residents.

Alternative 2 would have been more easily accessible because it was located on Route 322 and was proximate to Route 50. As a result, volume projections were higher because market share was increased over Alternative 1. It was also assumed that the new facility associated with Alternative 2 would have a "halo" effect in attracting new patients through higher market share penetrations.

Alternative 3 in northern Talbot County was not only adjacent to major roads (Routes 50 and 404), but was also closer to Queen Anne's County residents.

The market share increase in Queen Anne's County for this alternative was highest because the proximity, easy access and the halo effect of the new facility.

Although the new ambulatory care centers were not included in the capital costs of each of alternatives, it was assumed that SHS would have identical physician recruitment targets for all three alternatives. It was the physician recruitment targets, coupled with the accessibility, proximity and halo of the proposed sites that drove the volume projections, as opposed to the ambulatory care centers themselves.

h. One reason why the routine capital is so high in all three scenarios is because, as an UMMS hospital, MHE pays its portion of "system capital projects," which amounts to approximately $3 million per year. Under any of the alternatives, MHE would still pay for that portion of capital. The actual routine capital MHE would spend on SHS facilities, after adjusting for "system capital" is approximately $4-5 million. In a typical year, without a new facility or major renovations, MHE would spend approximately $6-8 million. Another reason MHE would still spend funds on routine capital is to furnish all of the offsite facilities and DGH with replacement equipment, because they would not be impacted by any of these alternatives.

i. The northern Talbot County site was opposed by both the Town of Easton and the Talbot County Commissioners. In light of this opposition, it was assumed that an additional two years of appeals by the Town and the County would be consumed before the project would be able to commence.

11. Regarding the response to COMAR 10.24.10.04B(7), Hospital Construction Cost, it appears that the inside-the-loop costs identified on page 91 were treated as extraordinary costs and removed from the project costs for comparison to the Marshall Valuation Service ("MVS') benchmark. However, the reason why these costs are not included in the MVS

benchmark are not explained on pages 91 and 92. Please explain why the costs identified on the top of page 91 are considered to be extraordinary costs for purposes of comparison with the MVS benchmark, given that the MVS costs include the cost of utilities from the property line to the building.

The reference to the costs on page 91 being "Inside the Loop" is error. The list is a continuation of the costs listed on the previous page (page 90), all outside the loop. The costs identified on page 91 all describe costs of bringing utilities to the border of the inside loop. Utility cost from the border of the inside loop (or what MHE considers the hospital's property line) to the Building were not treated as extraordinary costs. Exhibit 29 is a replacement page 91.

12. **Regarding the response to Standard B(14), Emergency Department Treatment Capacity and Space, while MHE may not be proposing an expansion of treatment capacity, the proposed emergency department will be in new space. Therefore; its treatment capacity and space must be evaluated with respect to the most recent edition of Emergency Department Design: A Practical Guide to Planning for the Future as required by this standard. (Commission staff notes that this has been done under the need criterion.)**

MHE acknowledges that the MHCC Staff considers Standard B(14) to be applicable. Since the MHCC Staff recognized that MHE provided the comparison of the proposed square footage and number of treatment bays under the discussion of Need on pages 130-134 of the Application, MHE hereby incorporates pages 130-134 in response to Standard B(14).

13. **Regarding the response to Standard B(16), Shell Space, since the proposed shell space supports upper floors, your response must address part (c) as follows:**

    a. **Please specify the additional square footage of each shell space area;**

b. Please specify the most likely use of each area and the likely time frame for using the space. The time frame projected should be accompanied by an explanation of why you expect to use the space as contemplated in the time frame specified; and

c. Please specify the cost of constructing each shelled area and the practicality and cost of redesigning the Building to eliminate such areas.

On pages 6 and 106 of the Application, MHE identified the shell space. Presented below are those areas, the square footage of each and the cost of constructing each shelled area.

2 ICU shelled rooms	654 SF	$119,600
1 Neuro shelled room	269 SF	$59,800
1 Joint shelled room	269 SF	$59,800
6 Rehab shelled rooms	1,669 SF	$358,880
Unassigned space	2,385 SF	$379,040

At this time, the shelled room areas are truly "unassigned." MHE would review the potential use of the space based upon census after opening. If use of the space for patient rooms is not warranted under the licensing law ("140% rule") for the acute care rooms, or under the lesser of 10 beds or 40% waiver rules in the CON regulations pertaining to the rehabilitation beds, these rooms will likely be converted to office or storage space. Likely, these decisions will be made in 2018, after the first year of full operation.

The 2,385 square footage of shell space on the second floor are located in two separate areas, one of which has 1,552 square feet and the other 833 square feet. Again, these areas remain unassigned, and a decision will not likely be made of their use until 2018, or thereafter.

It is simply not practical to redesign the Building to eliminate the shell space. There are, in total, 5,246 square feet of shell space spread throughout Building 1, as

described above. The areas are above and below functional areas, not shell space. There are 300,678 total square feet in Building 1. The shell space comprises only 1.74% of the total square footage of the building. (5,246/300,678 = .0174) Eliminating the shell space would require the total redesign of the Building because of the functional areas above and below the shelled areas (which cannot be rendered smaller, themselves). It would simply be too costly to redesign the entire building, which is why MHE did not do so prior to submission of the Application.

Obstetrics Plan

It appears that in responding to the Obstetric Plan chapter, the latest version of the plan chapter was not used. The result is that some of the current standards were not addressed and others were addressed out of order. Note that the current plan includes 15 standards. However, because you are proposing the relocation of an existing service, not a new service, you only need to address standards (1) through (6) and standard (15).

With respect to the Charity Care Policy standard, which has been revised in the current plan chapter, but is still standard (3), please document how MHE's charity care policy is consistent with the standard. Explanations with references to documents submitted in response to the Acute Care Hospital Services chapter charity care standard are acceptable where the standards are consistent.

Please see Exhibit 30.

Acute Rehabilitation Plan

14. **Concerning the response to the Transfer and Referral Agreements standard, please provide the following clarifications:**

    a. **Identify the types of rehabilitation cases that exceed MHE's capabilities and the facilities to which such cases are transferred. Specify the number of such cases that have been transferred to each facility in the last three years; and**
    b. **Identify the other facilities and agencies to which patients are transferred for rehabilitation that could have been provided in MHE's acute medical rehabilitation unit.**

a. Transfers that exceed the Requard unit's capabilities fall into two categories: (1) patients whose acute care needs exceed the rehabilitation unit's capabilities and so must be transferred to an acute care service and (2) patients whose rehabilitation needs exceed the Requard unit's capabilities and so must be transferred to another rehabilitation facility (such as new acute traumatic brain injury, new quadriplegics, new paraplegics, and multiple traumas with multiple weight bearing limitations). The number of transfers for FY 2010 – 2012 are shown in Table 30.

TABLE 30
Patients Transferred Due to Exceeding the Requard Unit's Capabilities
2010 – 2012

Types of Cases	FY2010	FY2011	FY2012
Acute Care Transfers (discharged from Rehab)	53	46	31
Specialized Rehab/Care (admitted to Rehab then transferred)	0	1	0

Source of Data: UDS Pro I IRF PAI Data base

1. Acute Care Hospitals to which patients were transferred for acute care:
    a. Memorial Hospital of Easton
    b. Dorchester General Hospital
    c. University of Maryland Medical Center
    d. Johns Hopkins Hospital

2. Acute Rehabilitation Hospitals to which patients were transferred for rehabilitation:
    a. Kernan Orthopedics and Rehabilitation Hospital (Baltimore, MD)

b. Some cases could have been provided at MHE Acute Rehab (i.e. evidenced medical necessity for acute rehab) but were referred elsewhere because of

bed availability issues, patient/caregiver choice, and/or health plan/payer barriers. Examples include:

1. Acute Rehab Hospitals
    a. Healthsouth Chesapeake Rehabilitation Hospital (Salisbury, MD)
    b. Kernan Orthopedics and Rehabilitation Hospital (Baltimore, MD)

2. Skilled Nursing Facilities
    a. Genesis (Easton, Cambridge, Centreville, MD)
    b. William Hill Manor (Easton, MD)
    c. Mallard Bay (Cambridge, MD)
    d. Envoy Nursing and Rehab (Denton, MD)
    e. Caroline Nursing and Rehab (Denton, MD)

Need Criterion, 10.24.01.08G(3)(b)

15. Regarding the need for the number of obstetric post partum beds proposed, please provide the following information:

a. Explain why an average length of stay ("ALOS") of 2.26 days was used to calculate need, as presented on page 127, when the OB ALOS reported in 2010 and 2011 was 2.21 days and the ALOS projected for 2012 is 2.16 days; and
b. Regarding the assumption that obstetric bed utilization will be distributed in a cumulative normal distribution, discuss and justify the continued validity of this approach, given the growing ability to manage patient census (because of caesarean section deliveries and induction of labor). Also address the appropriateness of using specific minimum occupancy rates, such as those used for pediatric beds.

The calculations of need were performed independently of the development of Table 1 (Statistical Projections). For purposes of calculating need for OB beds, MHE's Planning Department aggregated data on admissions and patient days by Zip Code for FY 2011 and calculated an ALOS of 2.26 days. When MHE's Finance Department later prepared Table 1, it calculated that the 2011 ALOS was 2.21 and it projected that the ALOS for 2012 would be 2.16. The discrepancies in these calculations are very small. Applying the three ALOS to the Admissions projection from Table 21 on pages 126-127

of the Application shows that the difference is less than one bed. Regardless of which estimates are used, MHE believes that these data show that 14 beds would still be needed in 2017. While the projection of using and ALOS of 2.16 days results in a need for 13.00 beds, a small error in projecting an ALOS five years hence would leave MHE with an inadequate number of beds on peak days.

Admissions	1,163	1,163	1,163
ALOS	2.26	2.21	2.16
Pt. Days	2,623	2,570.23	2,512.08
ADC	7.19	7.04	6.88
Sq.Rt ADC	2.68	2.65	2.62
2.33XSqRt	6.25	6.18	6.11
Beds	13.43	13.22	13.00

The Commission should continue to use the distribution approach for projecting OB beds because, in fact, there continues to be significant variation in the average daily census both by day and season. Table 31 shows the variation for OB inpatient services at MHE for FY 2011. There is a 105% difference between the high and the low census. [(136.8%/66.8%)-1 = 1.048]. Further, these figures are averages, themselves. That is, the number for Sundays (July-September) does not reflect the variation within that range. MHE believes that it must continue to use the distribution approach to projecting bed need in order to have adequate beds to accommodate peaks in admissions.

Table 31
Percent Over and Under the Average Daily Census By Day and Quarter
OB—FY 2011

	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Total
Sunday	84.0%	78.6%	66.8%	76.5%	76%
Monday	86.2%	86.2%	86.2%	85.1%	86%
Tuesday	106.7%	95.9%	113.1%	99.1%	104%
Wednesday	120.7%	100.2%	108.8%	103.4%	108%
Thursday	127.1%	120.7%	107.7%	115.3%	118%

	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Total
Friday	136.8%	123.9%	101.3%	103.4%	116%
Saturday	101.3%	98.0%	77.6%	89.4%	92%
TOTAL	109%	101%	94%	96%	100%

Given the continuing variability in census, MHE does not see any reason to use a specific minimum occupancy. The goal should still be to assure that there is a bed available. Using the formula that MHE used accomplishes this.

16. **Regarding the need for acute medical rehabilitation beds, please address the following:**

    a. **Why is Table 23 on page 129 labeled as 2018 and 2020 when the projected days are for 2017? and**
    b. **Why is an MHE market share of 78% used to calculate need when the narrative (page 129, 3rd paragraph) indicates that the market share for CY 2011 was 74%?**

These were both typographical errors. Table 23 should have been labeled 2017. MHE's market share is 78.4%, shown on Table 23. It was incorrectly cited as 74% in the text. A revised page 129 is included as Exhibit 31.

17. **Regarding the need for emergency department treatment spaces, please respond to the following:**

    a. **On the Maryland Health Care Commission's Supplemental Survey of Emergency Department Treatment Capacity, MHE reported a total of 34 treatment spaces as of June 1, 2012, but the tables on pages 104 and 130 of the application appear to indicate that the total is currently 32 and the proposed capacity is also 32 spaces, including three pediatric treatment spaces. Please reconcile or explain this apparent discrepancy.**
    b. **Specify the location of the rapid diagnostic and other triage spaces on the project drawings.**

When MHE completed the Maryland Health Care Commission's Supplemental Survey of Emergency Department Treatment Capacity, it incorrectly included the two triage desks listed on pages 104 and 130 of the CON application as treatment spaces.

These are not treatment areas and should not be counted as such. Therefore, MHE has 32 treatment bays.

Figure 1 below shows the architectural drawing for the first floor of Building 1. One can see that the Emergency/Express Care Department is located on the right hand side of the building. Figure 2 shows an enlargement, and identifies where the Triage and Rapid Diagnostic areas are located.

Figure 1
First Floor of Building 1

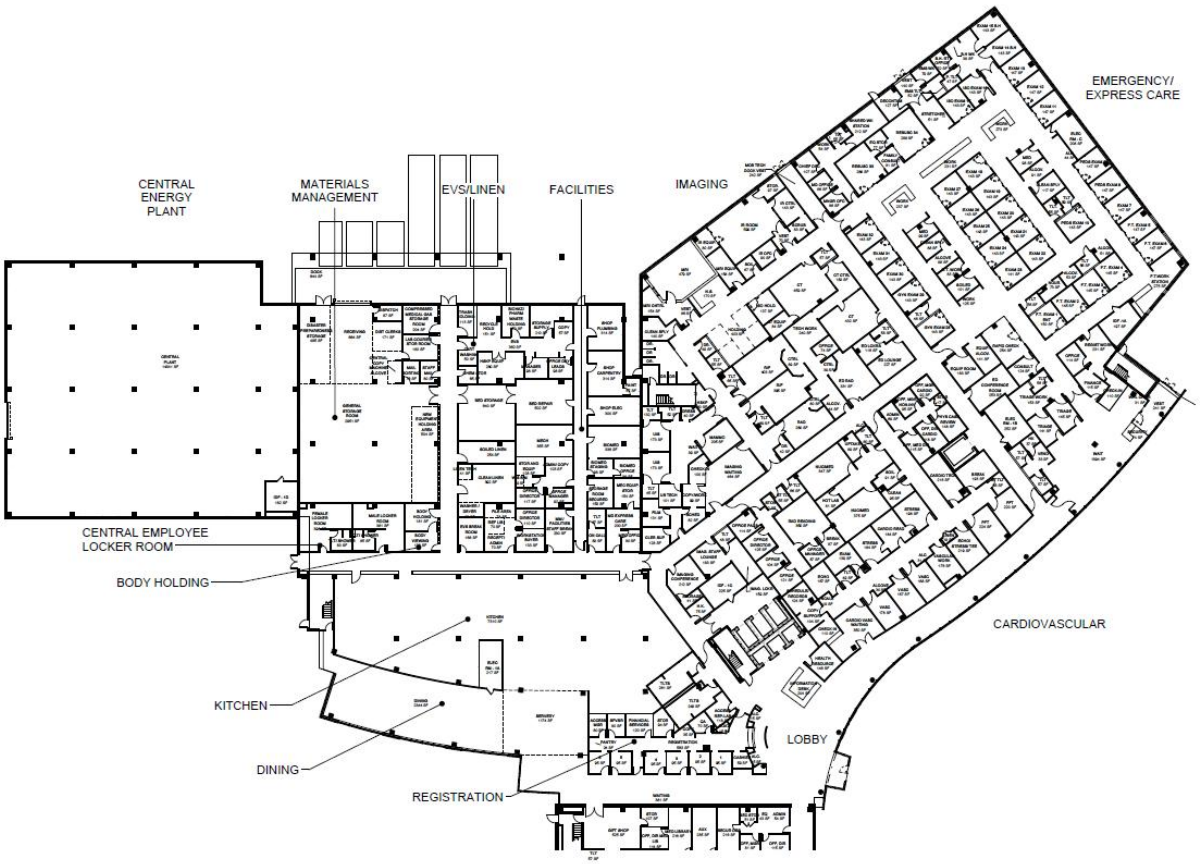
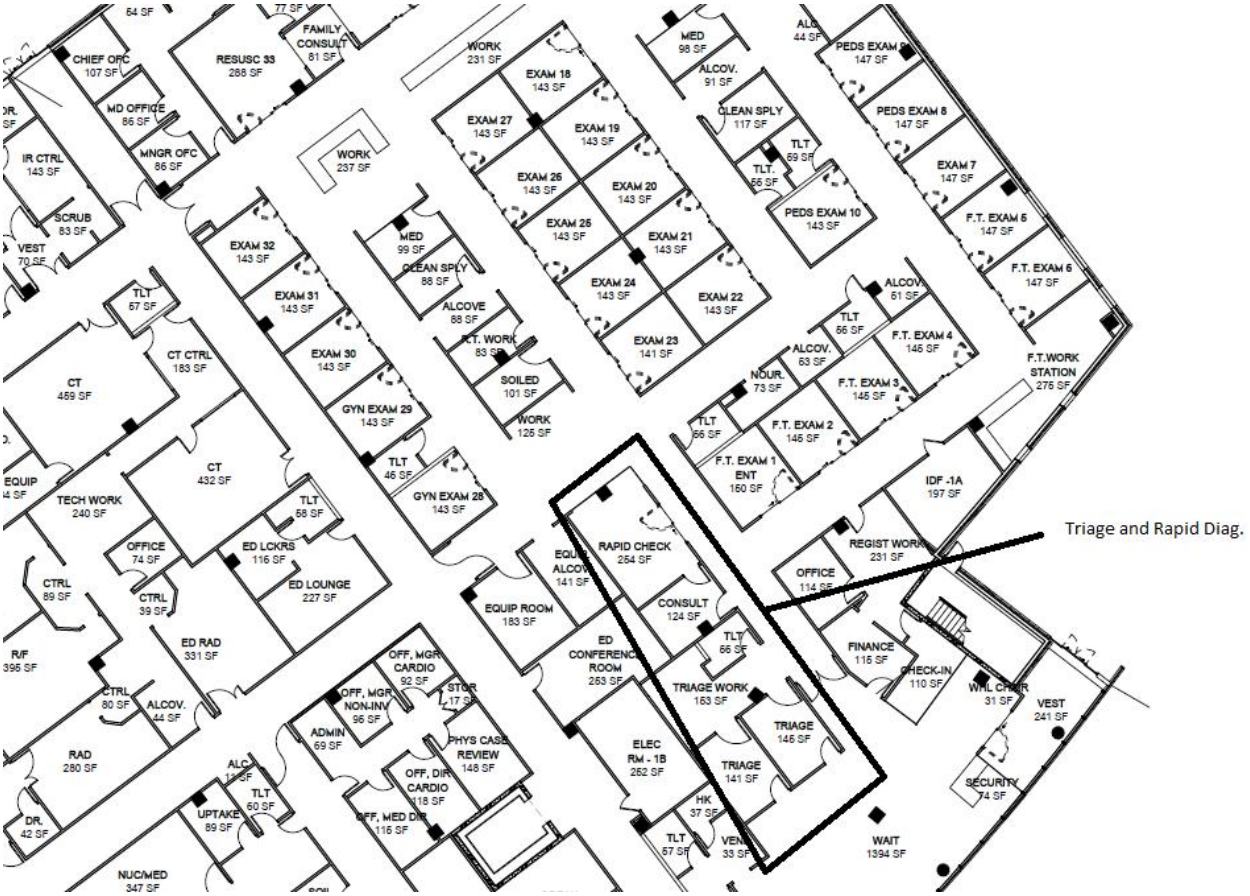


Figure 2
Triage and Rapid Diagnostic Areas



18. Regarding the need for operating rooms, please provide the following information:

a. Submit a more detailed description of the need methodology that was used including submission of the calculation of the compound annual growth rate from 2008 to 2012 and the projections forward through 2020;

b. Why do the plans for the replacement hospital appear to call for six ORs when you are projecting the need for eight ORs in 2016 when the replacement hospital would be expected to open based on the current criteria for optimal utilization of 97,920 minutes per year for each OR?

c. How would additional OR capacity be added when it is needed?

Below, is a reproduction of Table 27 that can be found on page 135 of the Application in the discussion of need for ORs.

CON Application Table 27
Historical OR Volumes
MHE
2008-2012

	Cases			Minutes			Cleanup Minutes	Total	% of Capacity
	Inpt.	Outpt.	Total	Inpt.	Outpt.	Total	37.8	Minutes	122,400
2008	1,304	2,677	3,981	159,280	182,440	341,720	135,354	477,074	65.0%
2009	1,667	3,331	4,998	204,612	234,088	438,700	169,932	608,632	82.9%
2010	1,623	3,280	4,903	196,131	221,792	417,923	166,702	584,625	79.6%
2011	1,551	3,601	5,152	193,140	253,729	446,869	175,168	622,037	84.7%
2012	1,359	3,371	4,730	173,989	265,773	439,762	160,820	600,582	81.8%

MHE used the following formula to calculate the compound average growth rate ("CAGR") for admissions 2008 and 2012 separately for inpatient and outpatient cases.

Inpatient Cases: +((1,359/1,304)^(1/4))-1 = 0.010381688

Outpatient Cases: +((3,371/2,677)^(1/4))-1 = 0.059321033

MHE next multiplied the CAGR for inpatient and outpatient cases by the number of 2012 cases and added the product to the number of 2012 cases to obtain the projected 2013 cases.

Inpatient Cases: 1,359 X 0.010381688 = 14.01
1,359 + 14.01 = 1,373 cases in 2013

Outpatient Cases: 3,371 X 0.059321033 = 199.97
3,371 + 199.97 = 3,571 cases in 2013

(These projections for 2013 can be found on Table 29 on page 137 of the CON application.)

MHE then performed the same calculation, applying the CAGR to the 2013 projected cases to obtain 2014 projections, and so on through 2020.

MHE applied the average minutes per case for FY 2012 (128.03 for inpatient and 78.84 for outpatient) to the cases from 2013 through 2020. The clean-up time calculation is discussed fully on page 135.

Finally, MHE divided the total number of minutes by the current SHP measure of optimal capacity per OR (97,920 minutes).

MHE planned for only six operating rooms because of budgetary limitations at this time. In addition, MHE was concerned that it would be subject to the new OR measure of optimal capacity (114,000 minutes per OR), which the Commission recently adopted at its October 18, 2012 meeting. Applying that measure, MHE would need only six ORs in 2017. Together, these issues led management to decide to propose six ORs at this time and seek regulatory approval for additional ORs sometime in the future as needed.

Either of the two equipment storage areas could be converted into ORs at some future date. While this would lead to storage problems, MHE will determine a solution at that time.

Availability of More Cost-Effective Alternatives

19. Please compare the cost-effectiveness of providing the services affected by the proposed project with the cost effectiveness of providing the services at alternative existing facilities.

First, one must consider which other hospitals are available for residents of the MHE Service Area. Table 32 shows the market share of hospitals in each of the five counties in FY 2012. As Table 32 shows, only MHE, DGH, Chester River Hospital ("CRH"), and Anne Arundel Medical Center ("AAMC") serve more than 10% of the admissions from any one of the five counties.

Table 32
Percent Market Share
By Hospital
Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties
FY 2012

	Market Share %				
Provider	**Caroline**	**Dorchester**	**Kent**	**Queen Anne's**	**Talbot**
Memorial at Easton	66.16%	30.45%	5.61%	20.95%	73.26%
Anne Arundel Medical Center	7.08%	1.95%	6.24%	46.47%	4.35%
Chester River Hospital	3.75%	0.00%	63.32%	9.53%	0.06%
Dorchester General	3.73%	44.72%	1.96%	1.74%	3.90%
University of Maryland	7.98%	6.75%	9.19%	8.15%	8.61%
Johns Hopkins	3.02%	2.94%	3.22%	3.40%	2.58%
Peninsula Regional	2.59%	9.10%	0.57%	0.53%	1.38%
Subtotal	94.32%	95.91%	90.11%	90.77%	94.14%
All Other Hospitals	5.68%	4.09%	9.89%	9.23%	5.86%
TOTAL	100.00%	100.00%	100.00%	100.00%	100.00%

Figure 3 shows the location of each of these hospitals in comparison to the five county area.

Figure 3

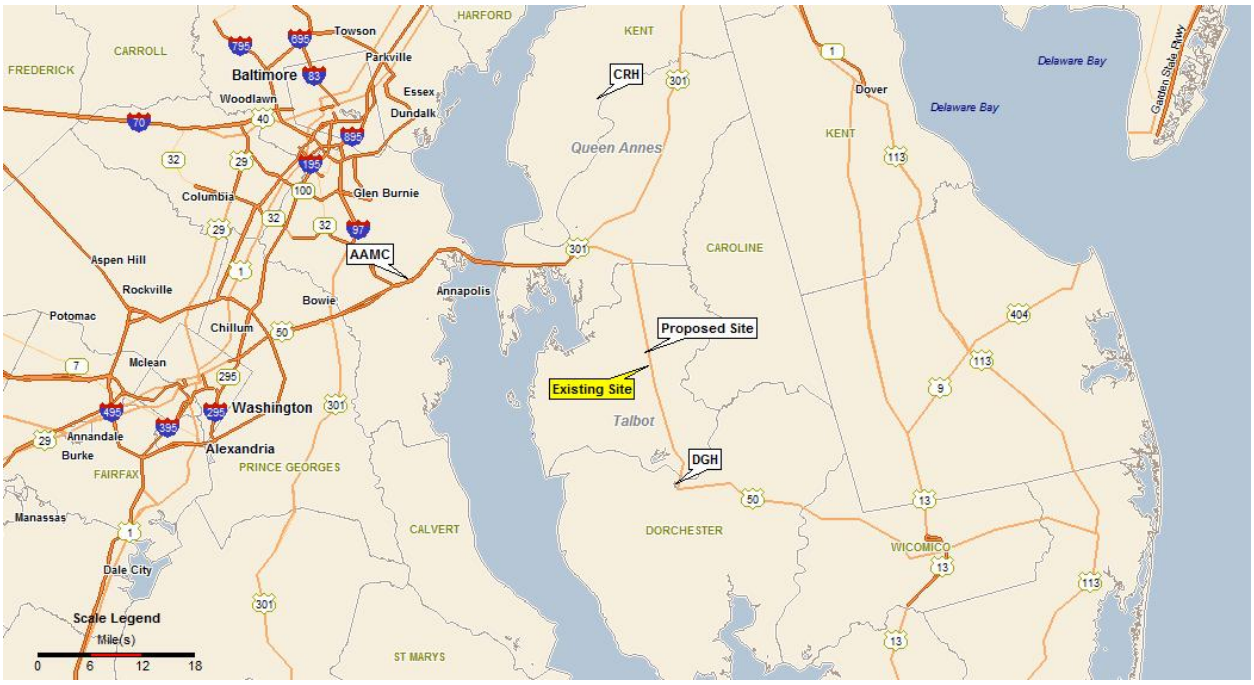


Table 33 shows the driving distance (miles) and driving time (minutes) from the site that Google designates to identify a county as point of departure to each of the four hospitals. These were determined by entering the county name in Google Maps and obtaining driving directions to each of the hospitals. The shortest driving distance and lowest driving times are identified by a box. One can see that the proposed MHE site has the shortest driving distance and driving time for Caroline, Queen Anne's, and Talbot Counties.

Table 33
Driving Distance (Miles) and Driving Time (Minutes)
Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties
To AAMC, DGH, CRH, and the Proposed MHE Site

	Miles					Minutes				
	Caroline	**Dorchester**	**Kent**	**Queen Anne's**	**Talbot**	**Caroline**	**Dorchester**	**Kent**	**Queen Anne's**	**Talbot**
DGH	32.2	15.2	56.5	36.7	18.5	44	26	87	50	26
CRH	28.2	67	6.4	20.5	39	47	93	19	37	62
AAMC	42.1	72	52.2	27	44.2	60	89	80	37	60
MHE	17.8	35.3	38.6	18.8	5.8	32	48	68	31	17

Furthermore, only DGH has expenses per Equivalent Inpatient Admission ("EIPA") that are lower than those proposed at the new facility, even when the capital costs are included. Table 34 compares the existing operating expenses, Case Mix Index, EIPAs, and CMI Adjusted Expense per EIPA at DGH, CRH, AAMC to those projected for the proposed MHE replacement. It shows that CRH is considerably higher and AAMC is slightly higher than MHE.

Table 34
Existing Operating Expenses, Case Mix Index, EIPAs, and
CMI Adjusted Expense per EIPA
DGE, CRH, AAMC, and
The Projected Measures at the Proposed MHE Replacement

	Current Cost [1]			New Facility [2]
	DGH	CRH	AAMC	MHE
Total Operating Expenses [3]	$46,139,659	$52,881,000	$404,474,300	$197,354,280
CMI	0.854866	0.835229	0.902474	0.898588
EIPAs	6,068	5,376	41,168	20,336
CMI Adjusted Expense per EIPA	$8,894	$11,777	$10,887	$10,800

Note (1): Figures for MHE, DGH, and CRH taken from current FY13 Budget. Figures for AAMC taken from most recent data available: FY11 Annual Filing.

Note (2): Figures for New Facility found using projected expenses for FY17. These numbers are not adjusted for inflation.

Note (3): Total operating expenses include regulated and unregulated expenses.

In addition, given current volumes, there would not be adequate beds available at the other hospitals to serve the patients treated at MHE. Table 35 shows that there would only be room for approximately half of the current MHE volumes at the other hospitals.

Table 35
Current Volumes, Available Capacity
DGH, CRH, and AAMC

CAPACITY	Current Occupancy [1]				New Facility
	MHE	DGH	CRH	AAMC	MHE
Admissions	9,087	2,913	2,451	25,287	9,331
Patient Days	34,424	13,652	10,077	96,092	35,348
Occupied Beds	94.31	37.40	27.61	263.27	96.84
Licensed Beds	112	46	42	354	112
Bed Capacity at 85% Occupancy	95.20	39.10	35.70	300.90	95.20
Current Bed Capacity	0.89	1.70	8.09	37.63	(1.64)

Current Remaining Bed Capacity Among DGH, CRH, & AAMC	47.42
MHE Occupied Beds	94.31
Over / (Under)	(46.89)

Note (1): Figures for MHE, DGH, and CRH taken from current FY13 Budget. Figures for AAMC taken from most recent data available: FY11 Annual Filing.

DGH is located in Cambridge, Maryland. DGH is licensed for 46 acute care beds (30 MSGA and 16 Psychiatric). It currently does not have obstetrical, pediatric, or rehabilitation services. As shown above DGH does not have the ability to absorb the volumes projected by MHE in 2017 (a total of 35,260 patient days) without substantial expansion. DGH has an old physical plant, itself, and additional expansion would either require substantial renovation or a replacement facility which would be larger than the proposed MHE project (since it would be serving its current volumes and those of MHE).

As Table 35 shows, DGH has a substantial market share in only Dorchester County. Not surprisingly, as it is located in the southernmost county in the five county service area, it has the shortest driving distance and time of the four hospitals only for residents of Dorchester County.

CRH is located in Chestertown, Maryland. CRH is licensed for 42 acute care beds (41 MSGA and 1 Pediatric). It currently does not have obstetrical and rehabilitation services. Like DGH, CRH does not have the ability to absorb the volumes projected by MHE in 2017 without substantial expansion. CRH also has an old physical plant, and additional expansion would either require substantial renovation or a replacement facility which would be larger than the proposed MHE project.

As Table 35 shows, CRH has a substantial market share only in Kent County. Not surprisingly, as it is located in the northernmost county in the five county service area, it has the shortest driving distance and time of the four hospitals only for residents of Kent County.

AAMC is located in Annapolis, Maryland, on the other side of the Chesapeake Bay. AAMC is licensed for 380 acute care beds (312 MSGA, 60 OB, and 8 Pediatric). It currently does not have acute rehabilitation services. AAMC recently completed an expansion project. MHE does not believe that it would be able to absorb the volumes projected by MHE in 2017 without substantial expansion.

As Table 35 shows, AAMC has a substantial market share only in Queen Anne's County. Not surprisingly, as it is located across the Chesapeake Bay, it has the longest driving distance and time of the four hospitals for residents of every one of the five counties in MHE's service area.

In comparison, MHE is proposed to be located in the middle of the five county service area, still in Easton, but on Route 50, outside of the downtown area. MHE already has substantial market share in every county but Kent County. The proposed location for MHE makes it the closest hospital for Caroline, Queen Anne's, and Talbot Counties.

If the services provided by MHE were to be provided by one or a combination of the other hospitals, there would have to be an alternative expansion project at one or more hospitals to accommodate MHE's volumes. Drive times would be longer, and costs would not be lower. Further, Talbot County would be left without a hospital. As

the most central hospital in the mid shore area, it makes sense that MHE be a regional medical center.

Viability of the Proposal, 10.24.01.08G(3)(d)

20. Regarding the response to the Viability criterion:

a. Please provide the Audited Financial Statement for the year ending June 30, 2012 with the response to this letter or as soon as it becomes available;
b. Specify the source of the cash contribution and document the current or expected availability of these funds;
c. Specify the expected terms (interest rate(s), years, etc.) of the proposed bond financing;
d. Document the likelihood of raising the $28 million in philanthropic funding for the proposed project. Document the experience of MHE and/or Shore Health System in fundraising; and
e. Identify the type of state grant or appropriation that is expected to supply $2.5 million of the required project funding.

a. The Audited Financial Statement for FY 2012 is not yet complete. MHE will forward it to the MHCC as soon as it becomes available, which likely will be in November, 2012.

b. The cash contribution is approximately $10 million. Of that amount $8 million will be funded by SHS operating funds, and $2 million will be funded from UMMS for the purchase of the land . As of June 30, 2012, $5 million of the SHS amount had been expended on the project as pre-development costs. The balance of the operating fund for SHS is shown on the audited statements as cash. The balance of $3 million has been accounted for in the fiscal year 2013 capital budget.

c. The amount of the proposed bond financing is $242,771,216, with an interest rate of 4.25% for 30 years. The construction period is 29 months.

d. The Memorial Hospital Foundation has engaged Ghiorsi & Sorrenti to conduct a feasibility study for the capital campaign. The results are expected in January of 2013. Any shortfall in the capital campaign projection of $28 million would be covered by funds in the investment portfolio of the Memorial Hospital Foundation/Shore Health System. The last major capital campaign was the 1989 construction capital campaign. The total goal was $7.5 million and the final contributions totalled $7.6 million.

e. The $2.5 million state grant in the proposed project reflects funds from the State of Maryland for the widening of Route 50 at the new entrance to the hospital.

21. Regarding the response to the Viability criterion, please provide the following clarifications and additional information regarding the availability of financial resources to sustain the project:

a. Provide a detailed description of the calculation of the gross patient revenues as they appear in Table 3 including a detailed explanation of how current rates account for capital cost; how rates would change as a result of the rate increase MHE is requesting; and how the increase in rates is reflected, if it is, in the gross patient revenue projections of Table 3;

b. Specify your assumptions with respect to the projection of allowances for bad debt, contractual allowances and charity care and explain how contractual allowances are calculated given the Total Patient Revenue method or rate regulation being used by MHE;

c. Specify the sources of the non-operating revenue reported in Table 3;

d. Explain the $46,669,784 in other expenses that are only reported for FY 2014;

e. Explain why supply expenses are projected to decline from 2013 through 2016;

f. Explain why current depreciation is reported in 2016 and 2017 after the hospital relocates; and

g. Submit a Table 3 with no increase in rates (revenue") associated with the proposed project.

a. The detail for how gross patient revenues were calculated are as follows:

GROSS PATIENT REVENUE	2013	2014	2015	2016	2017
Beginning TPR Cap	$184,253,259	$186,220,528	$188,470,949	$190,748,565	$203,306,578
Budgeted Adjustments to FY2013 Cap [(1)]	$1,967,269	$0	$0	$0	$0
Partial Rate Application	$0	$0	$0	$9,849,781	$9,849,781
TPR Cap Before Adjustments	$186,220,528	$186,220,528	$188,470,949	$200,598,346	$213,156,358
Population Adjustment	---	1.21%	1.21%	1.35%	1.35%
Gross Regulated Patient Revenue	$186,220,528	$188,470,949	$190,748,565	$203,306,578	$216,034,133
As Presented in Table 3 of CON	$186,220,528	$188,470,949	$190,748,565	$203,306,578	$216,034,133

PARTIAL RATE APPLICATION (DETAIL)	
Incremental Rate Increase	
Depreciation	$10,495,895
Interest	$10,141,642
Total Capital Expenses	$20,637,537
Partial Capital %	$1
Markup	$1
Capital Increase in Rates	$19,699,561
Partial Rate Application Applied to 2016	$9,849,781
Partial Rate Application Applied to 2017	$9,849,781
Total Partial Rate Application as Presented in Table 3 of CON	$19,699,561

Note (1): Includes update factor, population adjustment, and increases in HSCRC pass-thrus.

b. MHE's assumptions with respect to the projection of allowances for bad debt, contractual allowances, charity care, and contractual allowances are as follows:

BAD DEBT	2013	2014	2015	2016	2017
Total Bad Debt Expense [(1)]					
Regulated and Unregulated Gross Patient Revenue	$226,750,780	$229,629,605	$232,443,372	$245,440,331	$258,611,657
% of Gross Patient Revenue	4.20%	4.20%	4.20%	4.20%	4.20%
Bad Debt Expense	$9,514,750	$9,635,549	$9,753,619	$10,298,987	$10,851,673
Unregulated Bad Debt Expense					
Total Bad Debt Expense per Annual Filing	$6,395,833				
Unregulated Bad Debt Expense per Annual Filing	$1,004,005				
Unregulated % of Total	$0				
Bad Debt Expense [(2)]	$1,493,606				

BAD DEBT	2013	2014	2015	2016	2017
Unregulated Gross Patient Revenue	$40,530,252	$41,158,656	$41,694,807	$42,133,753	$42,577,524
% of Gross Patient Revenue	3.69%	3.69%	3.69%	3.69%	3.69%
Bad Debt Expense [3]	$1,493,606	$1,516,764	$1,536,522	$1,552,698	$1,569,052
Regulated Bad Debt Expense					
Bad Debt Expense [4]	$8,021,144	$8,118,785	$8,217,096	$8,746,289	$9,282,621
As Presented in Table 3 of CON	$8,021,144	$8,118,785	$8,217,096	$8,746,289	$9,282,621

Note (1): The budgeted total bad debt expense as a percent of total gross revenue for 2013 was determined and that ratio was held constant throughout the projection.
Note (2): Unregulated bad debt expense as a percent of total bad debt expense from the most recent annual filing (FY2011) was applied to budgeted total bad debt expense in 2013.
Note (3): The 2013 unregulated bad debt expense as a percent of unregulated gross patient revenue was applied to 2014 and throughout the projection period.
Note (4): Regulated bad debt was calculated by first calculating the total bad debt amount, regulated and unregulated, and then subtracting out unregulated bad debt.

CONTRACTUAL ALLOWANCES	2013	2014	2015	2016	2017
Gross Regulated Patient Revenue	$186,220,528	$188,470,949	$190,748,565	$203,306,578	$216,034,133
% of Gross Regulated Patient Revenue	11.81%	11.81%	11.81%	11.81%	11.81%
Regulated Contractual Allowances [1]	$22,001,273	$22,267,152	$22,536,244	$24,019,927	$25,523,641
As Presented in Table 3 of CON	$22,001,273	$22,267,152	$22,536,244	$24,019,927	$25,523,641

Note (1): The percentage of regulated contractual allowances to gross regulated patient revenue was determined per the budget and that ratio was then applied to 2014 and held constant throughout the projection.

CHARITY CARE	2013	2014	2015	2016	2017
Total Charity Care Expense [1]					
Regulated and Unregulated Gross Patient Revenue	$226,750,780	$229,629,605	$232,443,372	$245,440,331	$258,611,657
% of Gross Patient Revenue	1.70%	1.70%	1.70%	1.70%	1.70%
Charity Care Expense	$3,862,184	$3,911,218	$3,959,144	$4,180,518	$4,404,861
Unregulated Charity Care Expense [2]					
Total Charity Care Expense per Annual Filing	$4,889,038				
Unregulated Charity Care Expense per Annual Filing	650,768				
Unregulated % of Total	13.31%	13.31%	13.31%	13.31%	13.31%
Charity Care Expense	$514,086	$520,613	$526,992	$556,459	$586,320
Regulated Charity Care Expense [3]					
Charity Care Expense	$3,348,098	$3,390,605	$3,432,152	$3,624,059	$3,818,541
As Presented in Table 3 of CON	$3,348,098	$3,390,605	$3,432,152	$3,624,059	$3,818,541

Note (1): The budgeted total charity care expense as a percent of total gross revenue for 2013 was determined and that ratio was held constant throughout the projection.
Note (2): Unregulated charity care expense as a percentage of total charity care expense from the most recent annual filing (FY2011) was applied to 2013 and throughout the projection period.
Note (3): Regulated charity care was calculated by first calculating the total charity care amount, regulated and unregulated, and then subtracting out unregulated charity care.

c. Non-operating revenue reported on Table 3 includes investment income on cash and cash equivalents, investment income on Board Designated Assets, and profits/losses related to unregulated services.

d. The $46,669,784 in other expenses for FY2014 is an impairment loss on the old hospital in the year construction begins.

e. Supply expenses are projected to decline due to the initiatives of the UMMS Supply Chain process. The savings incorporated into the financial projections are as follows; FY 2013 $1.1m , FY 2014 $1m, FY 2015 $1.2m, and FY 2016 $1.2m. For FY 2012, the Supply Chain initiatives savings exceeded their targets. The savings are a result of price savings through bid processes and standardization of products.

f. The current depreciation that is reported in FY 2016 and later years is related to MHE's offsite facilities, which are not affected by the project. The offsite facilities include the Cancer Center, Ambulatory Surgery Center, and several diagnostic centers. These centers will continue to operate when the new facility is opened.

g. A version of Table 3 with no increase in rates (revenue) associated with the proposed project is attached as Exhibit 32.

Impact on Existing Providers, 10.24.01.08G(3)(f)

22. In responding to this criterion you state that the project will have no negative effect on other providers. However, the criterion requires that the applicant provide information and analysis with respect to the impact (not necessarily negative) of the proposed project on existing health care providers in the service area. Please respond to this requirement with analysis of such impacts especially given the response to the cost effectiveness standard stating that MHE expects its service volume to grow faster under the proposed alternative than under the on-site alternative. Submit the analysis supporting the view that this growth will or will not have an impact on other providers.

There are several reasons why this project should not have any impact on other providers, negative or positive. As explained in the Application, MHE participates in the HSCRC's "Total Patient Revenue" ("TPR") hospital initiative. Under this rate system, the HSCRC provides assurance of a certain amount of revenue each year, independent of the number of patients treated and the amount of services, either inpatient or outpatient, provided to these patients. If volumes go down, MHE has to increase prices, and if volumes go up, MHE has to decrease prices. Volume will not drive net revenue, only expenses will do so. Consequently, MHE has no incentive to seek market share from other hospitals.

Hence, MHE was very conservative in its projections of growth. On CON Formset Table 1 (Statistical Projections - Entire Facility, pages 139-141), MHE projected actual declines in MSGA admissions in between 2010 and 2017. Some of this expectation is because of a substantial conversion of one day ALOS admissions to observation. Another explanation for the negative projection is the incentive that MHE has to avoid admissions and treat people on an outpatient basis when medically safe and appropriate, consistent with the HSCRC's TPR initiative.

Table 36
Projected Changes in Admission
MHE
2010 - 2017

	2010	2017	Annual % Change
MSGA	7,111	5,950	-2.51%
Intensive Care	360	326	-1.41%
Total MSGA	7,471	6,276	-2.46%
OB	1,145	1,162	0.21%

Source: MHE CON Application Table 1, P. 139

However, population in the five county area is projected to continue to grow. MDP projects that, between 2010 and 2020, the 15-64 age group of the five counties will grow by 0.3% per year. Further, the 64+ age group is projected to grow by 2.8% per year. Consequently, MHE is projecting that it will not experience admission growth over that time period that matches population growth. The highest population growth will be in Queen Anne's County. MHE believes that AAMC's market share will not be reduced in Queen Anne's County because MHE has no incentive to do so.

Table 37
Population
Ages 15-64 and 65+
Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties
2010 and 2020

	2010 15-64	2020 15-64	Annual % Change	2010 65+	2020 65+	Annual % Change	2010 15+	2020 15+	Annual % Change
Caroline	21,767	22,976	0.5%	4,413	5,434	2.1%	26,180	28,410	0.8%
Dorchester	21,053	21,428	0.2%	5,771	7,126	2.1%	26,824	28,554	0.6%
Kent	12,874	12,660	-0.2%	4,397	5,899	3.0%	17,271	18,559	0.7%
Queen Anne's	31,385	33,592	0.7%	7,141	10,176	3.6%	38,526	43,768	1.3%
Talbot	22,811	22,778	0.0%	8,958	11,839	2.8%	31,769	34,617	0.9%
Total	109,890	113,434	0.3%	30,680	40,474	2.8%	140,570	153,908	0.9%

Source: MDP, 2012

23. Regarding Table 5, Manpower, please correct or explain the following apparent discrepancies:

a. Under Total Direct Care, you report an addition of 25.3 FTEs, but your Table indicates an addition of only 24.6 FTEs.

b. Using the number of additional FTEs reported in Table 5, staff calculates, using the total number of FTEs projected for FY 2017 and the average projected salary of employees after the implementation of the project as:

	Reported Table 5	Calculated
Total Administration	**$17,948,125**	**$17,944,320.50**
Total Direct Care	**$58,213,945**	**$58,156,712.80**
Total Support	**$7,136,946**	**$7,139,122.30**
Total	**$83,299,016**	**$83,240,355.60**

If a correction is made to the total, please revise Table 3 accordingly.

The differences in both sections 23a and 23b that Staff calculated were due to rounding in a number of steps in the model used by MHE. A revised Table 5 that reconciles the rounding issue is included in Exhibit 33. The total ($83,299,016) does not change, and there is no need to revise Table 3 for this issue.

24. It will be necessary to provide a Table 3 that includes inflation in revenues and expenses for HSCRC's review and comment on the financial feasibility of this project. Provide an accompanying comprehensive statement of assumptions with all alternative Table 3s provided.

MHE has already begun discussions with the HSCRC about this project and is in the process of preparing the material for the HSCRC in the manner in which HSCRC Staff requests it. When MHE submits the material to the HSCRC, it will also provide a copy to the MHCC.

EXHIBITS

23. Maps Showing Major Roads at Proposed Site and The Current Location

24. Departmental Gross Square Feet For Clinical Services In Both The Existing Building And The Proposed Facility

25. Revised Project Budget

26. Revised Policy on Information on Charges

27. Revised Charity Care Policy

28. Existing Site Plan

29. Replacement Page 91

30. Revised Responses to Obstetrical Standards

31. Replacement Page 129

32. Table 3 without a Rate Increase

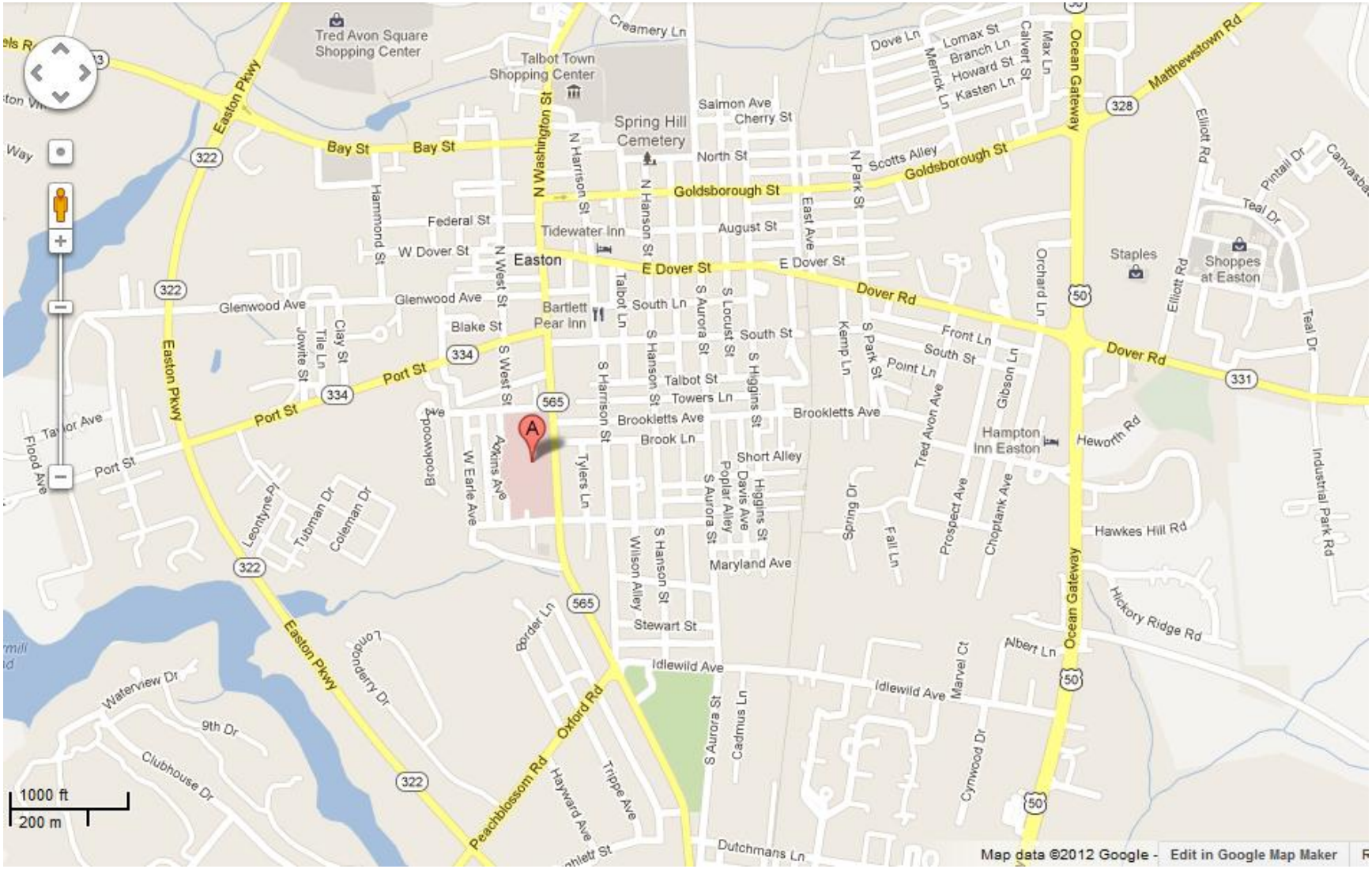
33. Corrected Table 5

34. Affirmations

EXHIBIT 23

Maps Showing Major Roads Proposed Site and Current Location

Existing Site Map with Roads



Proposed Site Map with Roads

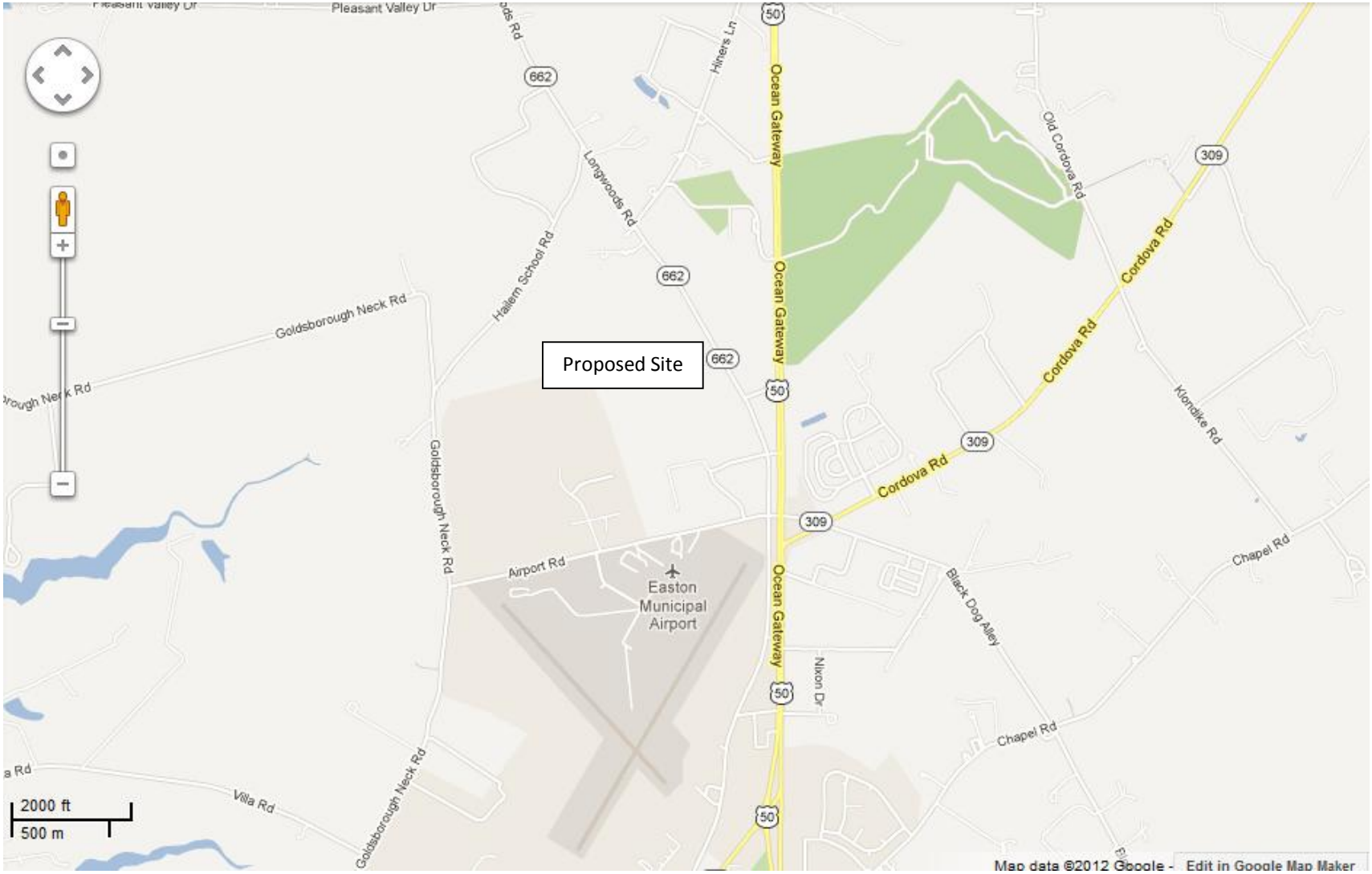


EXHIBIT 24

Departmental Gross Square Feet For Clinical Services
In Both The Existing Building And The Proposed Facility

EXHIBIT 24

Departmental Gross Square Feet For Clinical Services
In Both Existing Building And Proposed Facility

Department	EXISTING Dept. Area SF	PROPOSED Dept. Area SF
Diagnostic & Treatment		
Cardiopulmonary/Vascular: Non-Invasive	6,065	5,026
Emergency Department	21,220	19,394
Imaging	16,465	17,179
Maryland Express Care	-	644
Subtotal DGSF	***43,750***	***42,243***
Administrative & Public Services		
Admitting/Registration	3,410	2,097
Lobby	1,400	2,116
Subtotal DGSF	***4,810***	***4,213***
Support Services		
Body Holding	-	342
Central Employee Locker Room	-	1,039
EVS/Linen[2]	9,295	3,986
Facilities Management[2]	-	4,189
Food & Nutrition	10,320	10,953
Materials Management/Receiving Dock	6,530	5,606
Subtotal DGSF	***26,145***	***26,115***
Clinics		
Breast Center	1,725	-
Coumadin(Anti-Thrombosis Clinic)[3]	925	-
Sleep Disorders Center	2,230	-
Specialty Clinic	1,570	-
National Wound Healing Center	3,160	-
Subtotal DGSF	***9,610***	***-***
Inpatient		
Pediatrics	6,025	5,682
Observation	-	1,929
Subtotal DGSF	***6,025***	***7,611***

Department	EXISTING Dept. Area SF	PROPOSED Dept. Area SF
Diagnostic & Treatment		
Interventional Suite: Surgery & Cath Lab	20,265	24,472
Prep/Stage II/Recovery	14,425	9,055
Subtotal DGSF	***34,690***	***33,527***
Administrative & Public Services		
Chapel/Pastoral Care	160	559
Information Technology	3,005	2,659
Nurse Staffing	-	645
Subtotal DGSF	***3,165***	***3,863***
Support Services		
Pharmacy	4,570	4,033
Sterile Processing	4,600	6,109
Subtotal DGSF	***9,170***	***10,142***
Inpatient		
Medical	14,830	13,207
Shared Support - Medical/Surgical	560	-
Perinatal – LDRP	16,070	22,351
Subtotal DGSF	***31,460***	***35,558***
Inpatient		
Neuro/Joint Center	9,980	12,782
Requard Center	12,740	15,974
Subtotal DGSF	***22,720***	***28,756***
Inpatient		
Intensive Care	6,505	9,918
Telemetry	12,665	12,722
Subtotal DGSF	***19,170***	***22,640***
Diagnostic & Treatment		
Respiratory Therapy	565	1,621
Inpatient Dialysis	2,410	2,157
Subtotal DGSF	***2,975***	***3,778***

Department	EXISTING Dept. Area SF	PROPOSED Dept. Area SF
Inpatient		
Surgical	14,705	15,153
Subtotal DGSF	***14,705***	***15,153***
Diagnostic & Treatment		
Outpatient Lab Draw	400	698
Subtotal DGSF	***400***	***698***
Administrative & Public Services		
Auxiliary	805	250
Education Center & Medical Library	5,405	5,941
Gift Shop	1,185	676
Nursing Administration	1,835	1,176
Switch Board	-	124
Subtotal DGSF	***9,230***	***8,167***
Support Services		
Security[2]	-	733
Subtotal DGSF	***-***	***733***
Clinics		
Behavioral Health	1,110	730
Cardio Fitness & Wellness	2,685	3,367
Child Advocacy Center	1,310	1,372
Infusion Center	1,725	2,273
UMMS Diabetes Center	4,225	3,158
Pain Management Center	2,318	2,728
Shared Waiting Area	-	572
Subtotal DGSF	***13,373***	***14,200***
Diagnostic & Treatment		
Clinical Laboratory	9,885	9,917
Anatomic Pathology[1]	-	2,036
Pre-Anesthesia Testing	1,010	1,030
Subtotal DGSF	***10,895***	***12,983***

Department	EXISTING Dept. Area SF	PROPOSED Dept. Area SF
Administrative & Public Services		
CIM/Medical Staff/Quality Team	6,160	4,580
Executive Administration	5,250	4,663
Hospitalist Suite	528	502
Human Resources	795	1,072
Medical Staff Lounge	1,675	471
Subtotal DGSF	***14,408***	***11,288***
Subtotal DGSF	***276,701***	***280,935***

EXHIBIT 25

Revised Project Budget

EXHIBIT 25

Revised Project Budget

1.	**Capital Costs:**			
a.	**New Construction**			
	(1)	Building		$125,193,045
	(2)	Fixed Equipment (not in Building)		
	(3)	Land Purchase		$2,000,000
	(4)	Site Development		$36,015,484
	(5)	Architect/Engineering Fees		$17,400,000
	(6)	Permits (Building, Utilities, Etc.)		$4,107,718
			SUBTOTAL	$184,716,247
b.	**Renovations**			
	(1)	Building		$0
	(2)	Fixed Equipment (not included in construction		$0
	(3)	Architect/Engineering Fees		$0
	(4)	Permits (Building, Utilities, Etc.)		$0
			SUBTOTAL	$0
c.	**Other Capital Costs**			
	(1)	Major Movable Equipment		$22,000,000
	(2)	Minor Movable Equipment		$4,100,000
	(3)	Kitchen / Servery Equipment		
	(4)	Building / Wayfinding Signage		
	(5)	BR Insurance / Commissioning		
	(6)	Relocation Expenses		
	(7)	Contingencies		$7,000,000
	(8)	Other (Specify) IT/Integration/Communications/ Commissioning		$18,200,000
			SUBTOTAL	$51,300,000
		TOTAL CURRENT CAPITAL COSTS (a - c)		$236,016,247
d.	**Non-Current Capital Costs**			
	(1)	Inflation 27 mos. at MHCC Index 12.3 - 14.4		$4,679,795
	(2)	Capitalized Construction Interest		$24,901,333
		TOTAL PROPOSED CAPITAL COSTS (a - e)		$265,597,375
2.	**Financing Cost and Other Cash Requirements:**			
a.	Loan Placement Fees			$600,000
b.	Bond Discount			$970,000
c.	Legal Fees, Printing, etc.			$700,000

d.	Consultant Fees	
	CON Application Assistance	$100,000
	Other (Accounting)	$300,000
e.	Liquidation of Existing Debt	$0
f.	Debt Service Reserve Fund	$14,973,000
g.	Principal Amortization	
	Reserve Fund	$0
h.	Other	$0
	TOTAL (a - h)	$17,643,000
3.	**Working Capital Startup Costs**	
	TOTAL USES OF FUNDS (1 - 3)	$283,240,375
B.	**Sources of Funds for Project:**	
1.	Cash	$8,569,159
2.	Pledges: Gross less allowance for uncollectable = Net	
3.	Gift, bequests	
4.	Interest income (gross)	$1,400,000
5.	Authorized Bonds	$242,771,216
6.	Mortgage	
7.	Working capital loans	
8.	Grants or Appropriation	
	(a) Federal	
	(b) State	$2,500,000
	(c) Local	
9.	Other (Specify) Fundraising $28M	$28,000,000
	TOTAL SOURCES OF FUNDS (1 - 9)	$283,240,375

EXHIBIT 26

Revised Policy on Information on Charges

SHORE HEALTH UNIVERSITY OF MARYLAND MEDICAL SYSTEM	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-66
		EFFECTIVE:	09/12
	PUBLIC DISCLOSURE OF CHARGES	PAGE #:	1 of 2
		SUPERSEDES	N/A

CROSS REFERENCE

Administrative Policy LD-34: Financial Assistance

SCOPE

This policy applies to Shore Health System ("SHS") acute care hospitals located in the State of Maryland; Memorial Hospital at Easton and Dorchester General Hospital.

PURPOSE

To provide financial information to the communities we serve, the public and individual patients and payors with regard to the charges related to the services we provide.

BENEFITS

Increase awareness of the cost of hospital care and make information available to the public to improve care decision making, planning and patient satisfaction.

1.0 POLICY

Information regarding hospital services and charges shall be made available to the public. A representative list of services and charges shall be made available to the public in written form at the hospital(s) and via the SHS website. Individual patients or their designated payor representative may request an estimate of charges for a specific procedure or service. This policy applies to all patients, regardless of race, creed, gender, age, national origin or financial status. Printed public notification regarding the program will be made quarterly.

2.0 PROCEDURE

2.1 For the provision of information to the public concerning charges for services, a representative list of services and charges will be available to the public in written form at the hospital and also via the SHS website. The information will be updated regularly and average actual charges will be consistent with hospital rates as approved by the Maryland Health Services Cost Review Commission (HSCRC). The Patient Financial Services Department shall be responsible for ensuring the information's accuracy and updating it on a regular basis. The Patient Financial Services Department shall be responsible for ensuring that the written information is available to the public at the hospitals. The Corporate Communications Department will ensure that the information is available to the public on the SHS website.

2.2 Individuals or their payor representative may make a request for an estimate of charges for any scheduled or non-scheduled diagnostic test or service. Requests for an estimate of charges are handled by the Financial Counselors in the Patient Financial Services Department and/or Schedulers in Community-Wide Scheduling.

2.3 The Patient Financial Services Department is responsible for ensuring that appropriate training and orientation is provided to their staff related to charge estimates and the CDM alpha-browse/estimator tool. Requirements for the Financial Counselors and Schedulers training to ensure that inquiries regarding charges for its services are appropriately handled include education on all necessary estimator tools both during their initial training and on annual job competencies.

Gerard M. Walsh, Chief Operating Officer

Effective	09/12
Approved	Walter Zajac, Sr. Vice President / CFO

EXHIBIT 27

Revised Charity Care Policy

SHORE HEALTH SYSTEM UNIVERSITY OF MARYLAND MEDICAL SYSTEM	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	LD-34
		REVISED:	8/12
	FINANCIAL ASSISTANCE	PAGE #:	1 of 9
		SUPERSEDES	2/11

1.0 POLICY

1.1 This policy applies to Shore Health System ("SHS"). Shore Health System is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay for medically necessary care based on their individual financial situation. The hospitals covered by this policy include:

- The Memorial Hospital at Easton
- Dorchester General Hospital

1.2 It is the policy of SHS to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility and the steps for processing applications.

1.3 SHS will publish the availability of Financial Assistance on a yearly basis in the local newspapers and will post notices of availability at appropriate intake locations as well as the Billing Office. Notice of availability will also be sent to patients on patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided to patients receiving inpatient services with their Summary Bill and made available to all patients upon request.

1.4 Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include the patient's existing medical expenses, including any accounts having gone to bad debt, as well as projected medical expenses.

1.5 SHS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent services, applications to the Financial Assistance Program will be completed, received and evaluated retrospectively and will not delay patients from receiving care.

2.0 PROGRAM ELIGIBILITY

2.1 Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who are poor, SHS strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further SHS commitment to our mission to provide healthcare to those residing in the neighborhoods surrounding our hospital, SHS reserves the right to grant Financial Assistance without formal application being made by our patients. The zip codes for the SHS primary service area are included in ***Attachment A***. Additionally, patients residing outside of our primary service area may receive Financial Assistance on a one-time basis for a specific episode of care.

2.2 Specific exclusions to coverage under the Financial Assistance program include the following:

2.2.1 Services provided by healthcare providers not affiliated with SHS (e.g., home health services).

2.2.2 Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, Workers Compensation or Medicaid), are not eligible for the Financial Assistance Program. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made considering medical and programmatic implications.

2.2.3 Unpaid balances resulting from cosmetic or other non-medically necessary services.

2.2.4 Patient convenience items.

2.2.5 Patient meals and lodging.

2.2.6 Physician charges related to the date of service are excluded from SHS' Financial Assistance Policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.

2.3 Patients may become ineligible for Financial Assistance for the following reasons:

2.3.1 Refusal to provide requested documentation or providing incomplete information.

2.3.2 Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid or other insurance programs that deny access to SHS due to insurance plan restrictions/limits.

2.3.3 Failure to pay co-payments as required by the Financial Assistance Program.

2.3.4 Failure to keep current on existing payment arrangements with SHS.

2.3.5 Failure to make appropriate arrangements on past payment obligations owed to SHS (including those patients who were referred to an outside collection agency for a previous debt).

2.3.6 Refusal to be screened or apply for other assistance programs prior to submitting an application to the Financial Assistance Program.

2.4 Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

2.5 Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application unless they meet Presumptive Financial Assistance eligibility criteria (See Section 3 below). If patient qualifies for COBRA coverage, patient's financial

ability to pay COBRA insurance premiums shall be reviewed by appropriate personnel and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services and for their overall personal health.

2.6 Coverage amounts will be calculated based upon 200-300% of income as defined by federal poverty guidelines and follows the sliding scale included in ***Attachment B***.

3.0 PRESUMPTIVE FINANCIAL ASSISTANCE

3.1 Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for Financial Assistance, but there is no Financial Assistance form and/or supporting documentation on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with Financial Assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, SHS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining Financial Assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only Financial Assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

3.1.1 Active Medical Assistance pharmacy coverage.

3.1.2 Qualified Medicare Beneficiary ("QMB") coverage (covers Medicare deductibles) and Special Low Income Medicare Beneficiary ("SLMB") coverage (covers Medicare Part B premiums).

3.1.3 Primary Adult Care ("PAC") coverage.

3.1.4 Homelessness.

3.1.5 Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs.

3.1.6 Maryland Public Health System Emergency Petition patients.

3.1.7 Participation in Women, Infants and Children Programs ("WIC").

3.1.8 Food Stamp eligibility.

3.1.9 Eligibility for other state or local assistance programs.

3.1.10 Patient is deceased with no known estate.

3.1.11 Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program.

3.2 Patients who present to the Outpatient Emergency Department but are not admitted as inpatients and who reside in the hospitals' primary service area may not need to complete a Financial Assistance Application but may be granted presumptive Financial Assistance based upon the following criteria:

3.2.1 Reside in primary service area (address has been verified).

3.2.2 Lack health insurance coverage.

3.2.3 Not enrolled in Medical Assistance for date of service.

3.2.4 Indicate an inability to pay for their care.

3.2.5 Financial Assistance granted for these Emergency Department visits shall be effective for the specific date of service and shall not extend for a six (6) month period.

3.3 Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

3.3.1 Purely elective procedures (e.g., cosmetic procedures) are not covered under the program.

3.3.2 Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered under the presumptive Financial Assistance Program until the Maryland Medicaid Psych Program has been billed.

3.3.3 Qualifying Non-U.S. citizens are to be processed for reimbursement through the Federal Program for Undocumented Alien Funding for Emergency Care (a.k.a. Section 1011) prior to financial assistance consideration.

4.0 MEDICAL HARDSHIP

4.1 Patients falling outside of conventional income or Presumptive Financial Assistance criteria are potentially eligible for bill reduction through the Medical Hardship program. Uninsured Medical Hardship criteria is State defined as:

4.1.1 Combined household income less than 500% of federal poverty guidelines.

4.1.2 Having incurred collective family hospital medical debt at SHS exceeding 25% of the combined household income during a 12 month period. The 12 month period begins with the date the Medical Hardship application was submitted.

4.1.3 The medical debt excludes co-payments, co-insurance and deductibles.

4.2 Patient Balance after Insurance
SHS applies the State established income, medical debt and time frame criteria to patient balance after insurance applications.

4.3 Coverage amounts will be calculated based upon 0 - 500% of income as defined by federal poverty guidelines and follow the sliding scale included in **Attachment B.**

4.4 If determined eligible, patients and their immediate family are certified for a 12-month period effective with the date on which the reduced cost medically necessary care was initially received.

4.5 Individual patient situation consideration:

4.5.1 SHS reserves the right to consider individual patient and family financial situation to grant reduced cost care in excess of State established criteria.

4.5.2 The eligibility duration and discount amount is patient-situation specific.

4.5.3 Patient balance after insurance accounts may be eligible for consideration.

4.5.4 Cases falling into this category require management level review and approval.

4.6 In situations where a patient is eligible for both Medical Hardship and the standard Financial Assistance Programs, SHS is to apply the greater of the two discounts.

4.7 Patient is required to notify SHS of their potential eligibility for this component of the Financial Assistance Program.

5.0 ASSET CONSIDERATION

5.1 Assets are generally not considered as part of Financial Assistance eligibility determination unless they are deemed substantial enough to cover all or part of the patient responsibility without causing undue hardship. Individual patient financial situation such as the ability to replenish the asset and future income potential are taken into consideration whenever assets are reviewed.

5.2 Under current legislation, the following assets are exempt from consideration:

5.2.1 The first $10,000 of monetary assets for individuals and the first $25,000 of monetary assets for families.

5.2.2 Up to $150,000 in primary residence equity.

5.2.3 Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans.

Generally this consists of plans that are tax exempt and/or have penalties for early withdrawal.

6.0 APPEALS

6.1 Patients whose financial assistance applications are denied have the option to appeal the decision.

6.2 Appeals can be initiated verbally or written.

6.3 Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

6.4 Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.

6.5 If the first level appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.

6.6 The escalation can progress up to the Chief Financial Officer who will render a final decision.

6.7 A letter of final determination will be submitted to each patient who has formally submitted an appeal.

7.0 PATIENT REFUND

7.1 Patients applying for Financial Assistance up to 2 years after the service date who have made account payment(s) greater than $25 are eligible for refund consideration.

7.2 Collector notes, and any other relevant information, are deliberated as part of the final refund decision. In general, refunds are issued based on when the patient was determined unable to pay compared to when the payments were made.

7.3 Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for refund.

8.0 JUDGEMENTS

If a patient is later found to be eligible for Financial Assistance after a judgment has been obtained or the debt submitted to a credit reporting agency, SHS shall seek to vacate the judgment and/or strike the adverse credit information.

9.0 PROCEDURES

9.1 Each Service Access area will designate a trained person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Customer Service, etc.

9.2 Every possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.

9.2.1 Staff will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage.

9.2.2 Preliminary data will be entered into a third party data exchange system to determine probable eligibility. To facilitate this process each applicant must provide information about family size and income (as defined by Medicaid regulations). To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.

9.2.3 SHS will not require documentation beyond that necessary to validate the information on the Maryland State Uniform Financial Assistance Application.

9.2.4 Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance.

9.2.5 Patients will have thirty (30) days to submit required documentation to be considered for eligibility. If no data is received within 20 days, a reminder letter will be sent notifying that the case will be closed for inactivity and the account referred to bad debt collection services if no further communication or data is received from the patient. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to.

9.3 In addition to a completed Maryland State Uniform Financial Assistance Application, patients may be required to submit:

9.3.1 A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations); proof of disability income (if applicable).

9.3.2 A copy of their most recent pay stubs (if employed), other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations or documentation of how they are paying for living expenses.

9.3.3 Proof of Social Security income (if applicable).

9.3.4 A Medical Assistance Notice of Determination (if applicable).

9.3.5 Proof of U.S. citizenship or lawful permanent residence status (green card).

9.3.6 Reasonable proof of other declared expenses.

9.3.7 If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.

9.4 Determination of Probable Eligibility will be made within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.

9.5 A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses. Once a patient has submitted all the required information, appropriate personnel will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on SHS guidelines. If the patient's application for Financial Assistance is determined to be complete and appropriate, appropriate personnel will recommend the patient's level of eligibility.

9.5.1 If the patient does qualify for financial clearance, appropriate personnel will notify the treating department who may then schedule the patient for the appropriate service.

9.5.2 If the patient does not qualify for financial clearance, appropriate personnel will notify the clinical staff of the determination and the non-emergent/urgent services will not be scheduled. A decision that the patient may not be scheduled for non-emergent/urgent services may be reconsidered upon request.

9.6 Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. With the exception of Presumptive Financial Assistance cases which are date of service specific eligible and Medical Hardship who have twelve (12) calendar months of eligibility. If additional healthcare services are provided beyond the approval period, patients must reapply to the program for clearance.

9.7 The following may result in the reconsideration of Financial Assistance approval:

9.7.1 Post-approval discovery of an ability to pay.

9.7.2 Changes to the patient's income, assets, expenses or family status which are expected to be communicated to SHS.

9.8 SHS will track patients with 6 or 12 month certification periods utilizing either eligibility coverage cards and/or a unique insurance plan code(s). However, it is ultimately the responsibility of the

patient or guarantor to advise of their eligibility status for the program at the time of registration or upon receiving a statement.

9.9 If patient is determined to be ineligible, all efforts to collect co-pays, deductibles or a percentage of the expected balance for the service will be made prior to the date of service or may be scheduled for collection on the date of service.

_____
Gerard M. Walsh, Chief Operating Officer

Effective	10/05
Approved	Shore Health System Board of Directors: 06/22/05
Revised	07/10 (Minor Changes)
Revised	02/11
Submitted	Walter Zajac, Sr. Vice President/CFO
	Samuel Harris, Director Patient Financial Services
Approved	SHS Board of Directors:

ATTACHMENTS:

- Attachment A - Zip Codes for Coverage Areas
- Attachment B - Sliding Scale

EXHIBIT 28

Existing Site Plan

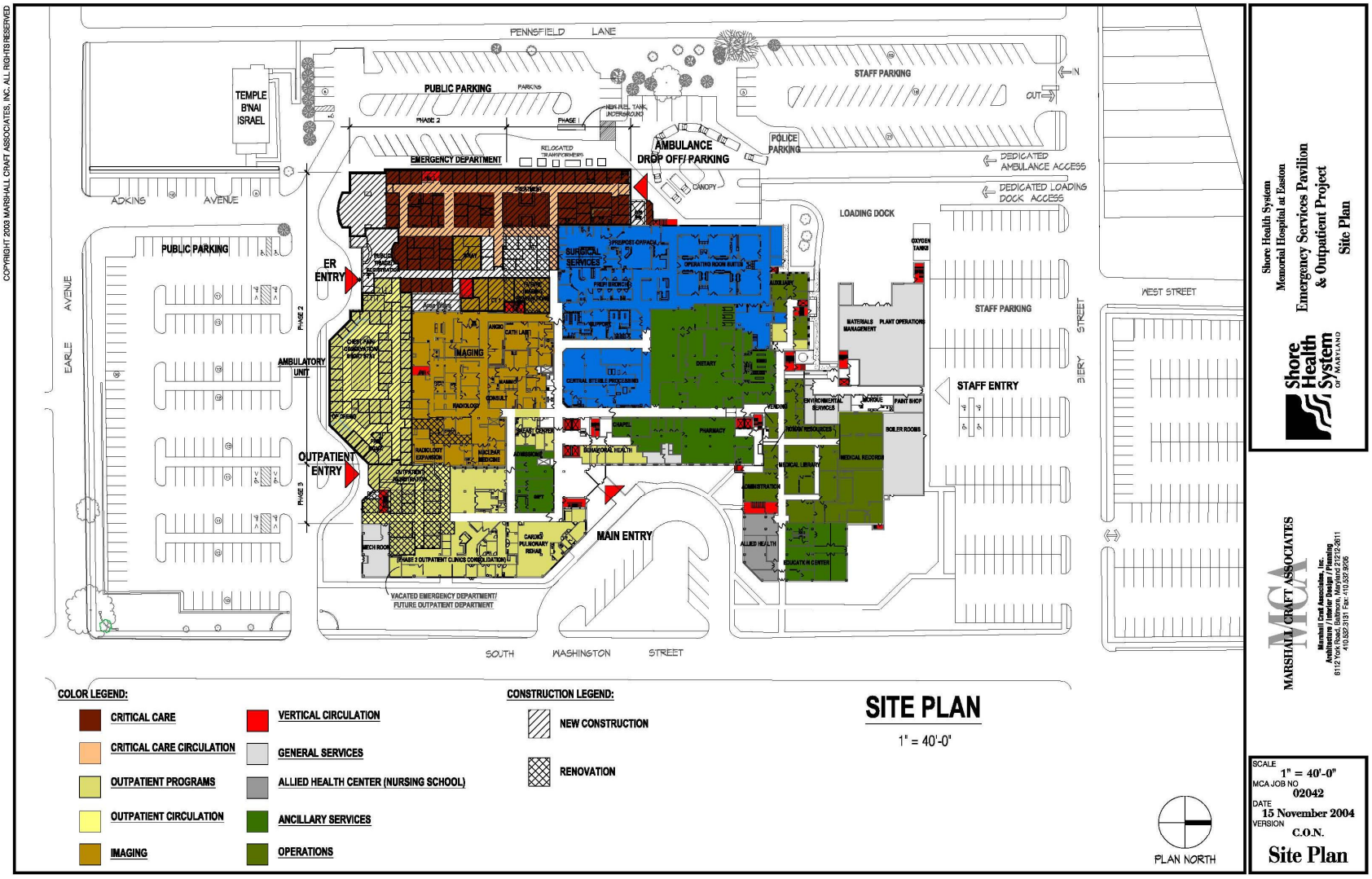


EXHIBIT 28

Existing Site Plan

EXHIBIT 29

Replacement Page 91

Water	$1,125,436	Site
Sewer	$677,278	Site
Gas	$244,420	Site
Electrical Ductbanks & Raceways	$2,887,287	Site
Communication Cabling - Verizon, etc.	$1,125,478	Site
Upsize Pump Station - 327 - 900 EDU's	$1,531,200	Site
Upsize Forcemain - 8" - 12"	$2,717,312	Site
SHS Share of Electrical Extension - Looped 25kV Feeder from Sub 2 & Sub 3	$3,397,000	Site
SHS Share of Gas Extension to RMC Building Site	$689,000	Site
MAN Loop Feed	$106,500	Site
Other County Charges	$1,580,380	Site
Total Cost Adjustments	$57,215,447	

Explanation of Extraordinary Costs

- Demolition - The project requires a small amount of demolition. These costs are specifically excluded from the Marshall & Swift Valuation base square foot cost for a Class A - Good General Hospital per Section 1, page 3 of the Marshall Valuation Service.

- Premium for Labor Shortages/Remote Location on Eastern Shore Projects – Whiting Turner, the cost estimator on this project, has included a 7.5% premium (based on Building Costs) due to labor shortages and costs of transporting equipment and construction materials that they have experienced on the Eastern Shore. Please see **Exhibit 12** which includes a letter from Whiting Turner attesting to the need for this premium. In Section 99, Page 1, MVS recognizes the potential for a 2%-10% premium for Abnormal Shortages and for a 5%-15% for Remote Areas.

- LEED Silver Premium - Whiting Turner has included a 4% premium (based on Building Costs only) due to constructing this Building to LEED Silver standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.

- Seismic Costs - Whiting Turner has included a 2% premium (based on Building Costs only) due to constructing this Building to the necessity of Building in seismic protection factors. The potential for a 2%-5% premium is recognized by MVS in Section 99, Page 1.

- Signs, Canopy, Jurisdictional Hook-up Fees, Impact Fees, Paving and Roads, Storm Drains, Rough Grading, Landscaping, and Sediment Control & Stabilization – These costs are specifically excluded from the Marshall & Swift Valuation base

EXHIBIT 30

OB Standards

.04 Review Standards

(1) Need. All applicants must quantify the need for the number of beds to be assigned to the obstetric service, consistent with the approach outlined in Policy 4.1. Applicants for a new perinatal service must address Policy 4.1.

MHE is proposing to reduce its number of Obstetrical ("OB") beds from its current 17 beds to 14.

There is a need for 14 OB beds. Table 21shows the number of OB admissions at MHE by Zip Code in CY 2011 in MHE's PSA and SSA. Table 21 also shows the female population age 15-44 in 2011 (interpolated from the difference between 2000 and 2012 using the CAGR) and the resultant use rate per 1,000 population. MHE then applied that use rate multiplied by the projected 2017 female 15-44 population to calculate the projected number of admissions from each Zip Code in the PSA and SSA. MHE projects 1,163 OB admissions in 2017. MHE then multiplied the estimated admissions by the CY 2011 OB average length of stay of 2.26 days to project 2,623 patient days. Therefore the Average Daily Census ("ADC") in 2017 will be 7.19 (2,623/365=7.19). MHE used the following methodology to project bed need:

$$ADC + 2.33(\sqrt{ADC}) = \text{Bed Need}^2$$

$$7.19 + 2.33(\sqrt{7.19}) = 13.4 \text{ Beds}$$

[2] This formula has been used by the Commission and other health planning agencies to assure that there will be an available bed for OB patients 99 percent of the time

Table 21
OB Admissions, Female Age 15-44 Population,
And Projected 2017 OB Bed Need

Zip Code	Admissions #	Admissions %	2011 Pop Female 15-44	Adm/1,000	2017 Pop Female 15-44	2017 Adm
Primary Service Area						
21601	221		3,869	57	3,949	226
21629	105		1,793	59	1,773	104
21613	204		3,221	63	3,096	196
21655	61		956	64	889	57
21632	69		1,298	53	1,249	66
21617	32		1,870	17	2,028	35
21639	65		945	69	922	63
Subtotal	757	64.2%	13,952	54	13,906	747
Secondary Service Area						
21663	19		422	45	409	18
21660	34		754	45	754	34
21643	54		1,200	45	1,214	55
21625	16		464	34	461	16
21673	33		532	62	517	32
21638	11		833	13	841	11
21666	7		2,220	3	2,145	7
21658	6		598	10	586	6
21671	7		104	67	90	6
21619	8		1,102	7	1,083	8
21654	7		142	49	131	6
Subtotal	202	17.1%	8,370	24	8,231	199
PSA&SSA	959	81.3%				946
All Other Zip Codes	220	18.7%				217
Total	1,179	1.0000				1,163
					ALOS	2.26
					Pt. Days	2,623
					ADC	7.19

(2) The Maryland Perinatal System Standards. Each applicant shall demonstrate the ability of the proposed obstetric program and nursery to comply with all essential requirements of the most current version of Maryland's Perinatal System Standards, as defined in the perinatal standards, for either a Level I or Level II perinatal center:

MHE currently has a Level I nursery, as will the proposed replacement facility. Exhibit 15 to the CON application is a self-assessment (provided by the Maryland Department of Health and Mental Hygiene) that MHE performed in October 2011 as part of its designation evaluation. It shows that MHE met all of the perinatal standards for Level I with the exception of the following:

4.4 For a hospital without a physician board-certified in maternal-fetal medicine on the medical staff, there is a written agreement with a consultant who is board-certified or an active candidate for board-certification in maternal-fetal medicine to be available 24 hours a day.

After the self-assessment, MHE took steps to assure that this (and other standards) are met. The obstetricians at MHE have relationships with various facilities based on their preferences. While there is no formal written contract, Maternal – Fetal conferences are held monthly at SHS by a Maternal – Fetal Medicine physician from John Hopkins. Also, SHS is a member of UMMS, which now provides consultation.

6.8 The hospital shall have an International Board Certified Lactation Consultant on full-time staff who shall have programmatic responsibility for lactation support services which shall include education and training of additional hospital staff members in order to ensure availability seven days per week of dedicated lactation support.

Currently, there is a full-time Board Certified Lactation Consultant who provides education and training of additional hospital staff members. In addition, SHS is a member of UMMS, which now provides consultation.

6.13 The hospital shall have genetic diagnostic and counseling services or written consultation and referral agreements for these services in place.

SHS is a member of UMMS, which now provides consultation.

MHE is now in compliance with all of the Level I standards.

(3) Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for uninsured and under-insured patients to promote access to obstetric services regardless of an. individual's ability to pay.

(a) The policy shall include provisions for, at a minimum, the following:

(i) annual notice by a method of dissemination appropriate to the hospital's patient population (for example, radio, television, newspaper);

(ii) posted notices in the. admissions office, business office and emergency areas within the hospital;

(iii) individual notice provided to each person who seeks services in the hospital at the time of community outreach efforts, prenatal services, preadmission, or admission, and

(iv) within two business days following a patient's initial request for charity care services, application for medical assistance, or both, the-facility must make a determination of probable eligibility.

(b) Public notice and-information regarding a hospital's charity care policy shall be in a format understandable by the target population.

As related above, the replacement hospital's charity care policy will be consistent with these requirements. Please see Exhibit 5.

(4) Medicaid Access. Each applicant shall provide a plan describing how the applicant will assure access to hospital obstetric services for Medical Assistance enrollees, including:

(a) an estimate of the number of Medical Assistance enrollees in its primary service area, and the number of physicians that have or will have admitting privileges to provide obstetric or pediatric services for women and infants who participate in the Medical Assistance program.

MHE provides care to all individuals, regardless of ability to pay or who their payors

are. According to Maryland Department of Health and Mental Hygiene's Maryland Medicaid eHealth Statistics there were an average of 6,151 Medicaid enrollees in Talbot County in FY 2012 (http://www.chpdm-ehealth.org/mco/mco-enrollment_action.cfm). The website provides data for each month in the fiscal year. MHE averaged the monthly data.

All of the obstetricians and pediatricians with privileges at MHE participate in the Medical Assistance Program. There are nine obstetricians and thirteen pediatricians.

(5) Staffing. Each applicant shall provide information on the proposed staffing, associated number and type of FTEs, projected expenses per FTE category and total expenses, for labor and delivery, post partum, nursery services, and other related services, including nurse staffing, non-nurse staffing and physician coverage, at year three and at maximum projected volumes; if applicable, current staffing and expenses should also be included.

Staffing at third-year projected volumes is estimated to be:

Employee Category	FTE	FTE Replacement Factor	Total Expense	Comments
Staff Nurse (RN)	24.6	18.6%	$3,070,347	All RNs are cross-trained to L&D, Nursery, Post-partum, and outpatient testing/triage. This is an LDRP unit.
Per diem RN	4.575			These are the replacement factor FTEs
Clinical Coordinators	2.4			
Nurse Practitioner	0			
Surgical Technician (ST)	4.2	14.28%	$258,959	
Per Diem ST	0.6			These are the replacement factor FTEs
Nurse Manager	1.0		$124,237	Includes benefits
Unit Secretary (US)	2.8	3.6%	$107,266	
Per diem US	0.1			These are the replacement factor FTEs

Lactation Consultant	1.0		$92,674	
Midwife	2			Not a part of the nursing staff. Credentialed through the Medical staff office and employed by private physician practices.
Overtime			$34,161	All employee categories
On-Call			$12,302	All employee categories
TOTAL	41.775		$3,699,946	Midwives not included in total

(6) Physical Plant Design and New Technology. All applicants must describe the features of new construction or renovation that are expected to contribute to improvements in patient safety and/or quality of care, and describe expected benefits.

Please see the response to Standard 10.24.10.04B(12) (Patient Safety) on pages 99-102 of the Application, which is incorporated herein by reference.

(7) Nursery. An applicant for a new perinatal service shall demonstrate that the level of perinatal care, including newborn nursery services, will be consistent with the needs of the applicant's proposed service area.

Inapplicable

(8) Community Benefit Plan. Each applicant proposing to establish a new perinatal service will develop and submit a Community Benefit Plan addressing and quantifying the unmet community needs in obstetric and perinatal care within the applicant's anticipated service area population, This Plan should include an outreach program component, and should provide a detailed description of the manner in which the proposed perinatal service will meet these needs, and the resources required, At a minimum, the Community Benefit Plan must include:

(a) a needs assessment related to obstetric and nursery services for the proposed program's service area population, including a description of the manner in which the proposed perinatal service will satisfy unmet needs identified in the needs assessment,

(b) measurable and time-limited goals and objectives for health status improvements pursuant to which the Plan can be evaluated; and

(c) information on the structure, staffing and funding of the Plan;

(d) documentation of community support and involvement in program planning for the Plan by other agencies, organizations or institutions which win be involved, directly or indirectly, with the Plan;

(e) an implementation scheme for the Community Benefit Plan.

(f) Applicants must commit to implementation of the Community Benefit Plan and continuing commitment to the Plan as a condition of Commission approval, and as an ongoing condition of providing obstetric services.

(g) Applicants must agree to submit an Annual Report to the Commission which will include:

(i) an evaluation of the achievement of the goals and objectives of the Community Benefit Plan; and

(ii) information on staffing levels and the total costs of any programs implemented as part of the Community Benefit Plan.

Inapplicable

(9) Source of Patients. An applicant for a new obstetric service shall demonstrate that the majority of its patients will come from its primary service area.

Inapplicable

(10) Non-metropolitan Jurisdictions. A proposed obstetrics program in non-metropolitan jurisdictions, as defined in the chapter, shall demonstrate that physicians with admitting privileges to provide obstetric services have offices for patient visits within the primary service area of the hospital.

Inapplicable

(11) Designated Bed Capacity. An applicant for a new obstetric service shall designate a number of the beds from within the hospital's licensed acute care beds that will comprise the proposed obstetric program.

Inapplicable

(12) Minimum Volume.

(a) An applicant for a new obstetrics program must be able to demonstrate to the Commission's satisfaction that the proposed program can achieve a minimum volume of 1,000 admissions annually in metropolitan jurisdictions, or 500 cases annually in non-metropolitan jurisdictions, within 36 months of initiation of the program.

(b) As a condition of approval; the applicant shall accept a requirement that it will dose the obstetric program, and its authority to operate will be revoked, if:

(i) it fails to meet the minimum annual volume for any 24 consecutive month period, and

(ii) it fails to provide good cause for its failure to attain the minimum volume, and a feasible corrective action plan for how it will achieve the minimum volume within a two year period.

Inapplicable

(13) Impact on the Health Care System.

(a) An application for a new perinatal program will he approved only if its likely impact on the volumes of obstetric discharges at any existing obstetric program, after the three year start-up period, will not exceed 20 percent of an existing program's current or projected volume.

(b) When determining whether to approve an application for an obstetrics program, the Commission will consider whether an existing program's payer mix of obstetrics patients will significantly change as a. result of the proposed program, and the existing program will have to care for a disproportionate share of the indigent obstetrics patients in its service area; and

(c) When determining whether to approve an application for an obstetrics program the Commission will also consider the impact on a hospital with an existing program that has undertaken a capital expenditure project for which it has pledged pursuant to H-G Article § 19·120(k) not to increase rates for that project, so long as the pledge was based, at least in part, on assumptions about obstetric volumes.

(d) The Commission may consider evidence:

(i) from an applicant as to why rules (a) through (e) should not apply to the applicant, or;

(ii) from a very low volume program (fewer than 500 annual obstetric discharges) as to why a lower volume impact should apply.

Inapplicable

(14) Financial Feasibility. Hospitals applying for a Level I or II perinatal program must clearly demonstrate that the hospital has the financial and non-financial resources necessary to implement the project, and that the average charge per admission for new perinatal programs will be less than the current statewide average charge for Level I and Level II perinatal programs. When determining whether to approve an application for an obstetric program, the Commission will consider the following:

(a) The applicant's projected sources of funds to meet the program s total expenses for the first three years of operation,

(b) the proposed unit rates and/or average charge per case for the perinatal services;

(c) evidence that the perinatal service will be financially feasible at the projected volumes and at the minimum volume standards in this Plan, and

(d) the written opinions or recommendations of the HSCRC.

Inapplicable

(15) Outreach Program. Each applicant with an existing perinatal service shall document an outreach program for obstetric patients in its service area who may

not have adequate prenatal care, and provide hospital services to treat those patients. The program shall address adequate prenatal care, prevention of low birth weight and infant mortality, and shall target the uninsured, under-insured, and indigent patients in the hospital's primary service area, as defined in COMAR 10.24.01.01.B

MHE works closely with many partners. Entry into the healthcare system occurs through many referral sources. The hospitals (including DGH and Chester River), the County Health Departments, Community Centers, local physicians, schools, social services agencies, and other organizations in the five counties identify women who need prenatal care, prevention of low birth weight and infant mortality, and uninsured, under-insured, and indigent patients. Of course, families may refer women who think that they may be pregnant and people refer themselves for services.

MHE's program accommodates referrals for obstetric and gynecologic care for underserved women in all five counties from any of these sources.

In addition, MHE offers dozens of classes in the community, including:

Planning for baby's arrival - Take A Childbirth Education Class
Labor and delivery – Lamaze
Successful Breastfeeding
Health & Wellness Classes.
Labor & Delivery Class
Childbirth Class
Classes and Support Groups Focus on Managing Diabetes
Pneumonia - Antibiotic and Antiviral Drug Classes
Mindfulness-Based Stress Reduction
Blood Pressure Screenings
Breast Cancer Screenings
Cancer Support Groups
Pregnancy and Infant Loss
New Mom, New Baby & Infant Safety
Big Brother & Big Sister
Infant CPR
Labor & Delivery I, II, III
Stroke Survivor Support Group

Us Too Prostate Support Group
Shore Kids Camp
Overcoming Your Fear of Flying
Look Good…Feel Better
Shore Kids Camp
Safe Sitter Class
Breast cancer – Chemotherapy

There is no financial barrier to attend these classes, as there is no charge for any participant.

Many of these entities identify people who need medical care (not only women who need prenatal care) by an informal referral by a family member. In terms of prenatal care, whenever a woman in need of medical care is identified, either by a Health Department, social service agency, school, at an MHE class, or other source, the woman is referred to the Local Health Department which evaluates the situation to assure that the family has all the resources it needs (not only regarding the pregnancy). Working with the Health Department, MHE assigns the woman to one of the seven MHE Obstetricians, and she is then a patient of that Obstetrician. No women are turned away. Every woman who needs an obstetrician becomes a private patient of an MHE Obstetrician.

As Table 19 shows, MHE's OB service area has a lower percentage of births that had "Late or No Prenatal Care" compared to the state of Maryland, as a whole. Also, the MHE OB service area had a significantly higher percent of births that had "First Trimester Prenatal Care" than did the state as a whole.

Table 19
Births with "Late or No Prenatal Care" and "1st Trimester Prenatal Care"
Queen Anne's, Kent, Caroline, Talbot, and Dorchester Counties
CY 2010

	Total Births	Late or No Prenatal Care		1st Trimester Prenatal Care	
		#	%	#	%
Kent	166	8		126	
Queen Anne's	487	15		408	
Caroline	432	25		321	
Talbot	357	17		282	
Dorchester	381	26		278	
Total	1,823	91	5.0%	1,415	77.6%
Maryland	73,783	4,668	6.3%	41,999	56.9%

Source: Maryland Vital Statistics Annual Report 2010
http://dhmh.maryland.gov/vsa/Documents/10annual.pdf

EXHIBIT 31

Replacement Page 129

In CY 2011, there were 652 rehabilitation admissions in the five county region (to any Maryland provider). This is projected to grow to 771 in 2018 and 810 in 2020.

MHE applied the 2011 average length of stay at the Requard Center to calculate the total number of expected patient days. MHE then divided the expected patient days by 365 to obtain the average daily census and divided the result by 85% occupancy to obtain the projected number of needed beds. Based on these calculations, there will be 22.5 rehabilitation beds needed to serve the five county area in 2018 and 23.7 in 2020.

In CY 2011, the Requard Center had a 78.4% market share in the five county region. Furthermore, in FY 2012, the Requard Center experienced a 16.16% decline in admissions due to changes it made to its admission criteria. MHE believes that this reduction will continue into the future. (MHE has to make the adjustment in this way because MHE used 2011 data for its need calculations. Comparable 2012 data are not yet available.) When both factors are taken into account, the Requard Center would need 14.46 beds in 2017. MHE believes that these projections demonstrate that the proposed reduction to 14 beds is needed and is reasonable.

Table 23
Summary Calculations of Rehabilitation Bed Need
Talbot, Dorchester, Caroline Queen Anne, and Kent Counties
2017

Age Cohorts:	15-24	25-34	35-44	45-54	55-64	65-74	75+	Total
2011 Total	3	11	14	48	101	173	302	652
2011 ALOS	7.33	14.71	10.33	9.04	8.88	9.19	8.86	
2017 Total	5.77	11.54	15.09	41.37	80.95	199.93	398.10	752.74
2017 Pt. Days	42.28	169.86	155.92	374.03	718.94	1,837.47	3,528.83	6,827.33
							ADC	18.71
							MHE Mkt Shr	78.4%
							2012 Adj.	83.8%

EXHIBIT 32

Table 3 with No Rate Increase

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	187,024,249	187,831,440	188,737,108	189,647,142
d. Allowance for Bad debt	4,236,594	5,391,828	7,101,833	8,021,144	8,058,080	8,094,690	8,134,936	8,175,390
e. Contractual Allowance	16,378,961	18,633,681	21,768,847	22,001,273	22,096,229	22,191,596	22,298,597	22,406,115
f. Charity Care	2,739,281	3,674,124	2,924,725	3,348,098	3,369,244	3,389,079	3,408,933	3,428,923
g. Net Patient Services Revenue	137,414,364	145,797,685	152,457,854	152,850,013	153,500,696	154,156,075	154,894,642	155,636,714
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	156,251,061	156,906,440	157,645,007	158,387,079

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	$ 82,642,973	$ 83,299,016
b. Contractual Services	24,456,064	24,608,309	26,679,222	28,588,038	29,267,357	29,451,133	30,684,762	29,556,319
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	-	-	-				5,170,889	10,124,579
e. Current Depreciation	11,944,011	10,750,217	10,246,329	11,296,978	10,755,019	4,639,046	5,205,469	6,078,099
f. Project Depreciation							5,247,948	10,495,895
g. Current Amortization								
h. Project Amortization					97,900	106,800	106,800	106,800
i. Supplies	23,190,072	26,490,957	27,988,639	29,270,553	28,854,957	28,277,541	27,664,977	27,896,842
j. Other Expenses (Impairment Loss)					46,669,784			
k. Total Operating Expenses	133,188,248	138,881,250	142,735,303	153,827,275	200,271,027	147,535,402	160,049,785	170,766,369
3. Income								
a. Income from Operation	6,032,927	11,056,789	11,696,428	1,773,103	(44,019,966)	9,371,038	(2,404,778)	(12,379,290)
b. Non-Operating Income	8,472,033	7,960,026	(836,760)	7,215,807	5,956,177	6,311,673	6,495,644	6,544,494
c. Subtotal	14,504,960	19,016,814	10,859,668	8,988,910	(38,063,789)	15,682,711	4,090,866	(5,834,796)
d. Income Taxes								
e. Net Income (Loss)	$ 14,504,960	$ 19,016,814	$ 10,859,668	$ 8,988,910	$ (38,063,789)	$ 15,682,711	$ 4,090,866	$ (5,834,796)

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

EXHIBIT 33

Corrected Table 5

Table 5 Manpower Information

Position Title	Current FTE's (FY 13 Budget)	Change In FTE's (2017 Projected)	Average Salary (@ 2080 Hrs)	Contractual Employee	Total Cost
Administration:					
Health Information Management					
Records Coordinator	20.00	0.50	47,967	Employee	983,324
Coder	11.00	0.30	65,446	Employee	739,540
Patient Accounting					
Account Representative	45.40	1.10	46,609	Employee	2,167,319
Scheduling					
Scheduler	24.60	0.60	44,938	Employee	1,132,438
Admitting					
Coordinator	1.20	0.00	111,934	Employee	134,321
Nursing Administration					
Coordinator	4.70	0.10	131,844	Employee	632,851
Other	1.00	0.00	39,206	Employee	39,206
Clinical Resource Management					
Case Manager	9.90	0.20	88,289	Employee	891,719
Social Worker	4.50	0.10	61,772	Employee	284,151
Human Resources					
Recruiter	1.80	0.00	72,861	Employee	131,150
Purchasing					
Buying Agent	1.40	0.00	51,599	Employee	72,239
Other					
Child Care Center	8.20	0.20	40,373	Employee	339,133
Management and Administrative Services	105.70	2.60	95,558	Employee	10,348,931
Physician Stipend				Contractual	48,000
Total Administration	**239.40**	**5.70**	**898,396**		**17,944,321**
Direct Care					
MedSurg and ICU Nursing Floors					
Tech	57.50	1.90	41,187	Employee	2,446,508
RN	156.00	5.30	102,767	Employee	16,576,317
Other	26.30	0.90	41,076	Employee	1,117,267
Physician Subsidy				Contractual	1,075,586
Physician Stipend				Contractual	339,000
Acute Rehab Nursing					

Tech	1.80	0.00	38,798	Employee	69,836
RN	11.70	0.00	101,857	Employee	1,191,727
Other	8.10	0.00	57,618	Employee	466,706
Physician Stipend				Contractual	50,000
Emergency Department					
Tech	15.50	0.90	41,118	Employee	674,335
RN	39.70	2.20	99,095	Employee	4,152,081
Other	5.90	0.30	45,703	Employee	283,359
Physician Subsidy				Contractual	1,051,000
Operating Room					
Tech	12.10	0.50	54,452	Employee	686,095
RN	29.80	1.30	97,463	Employee	3,031,099
Other	11.70	0.50	52,168	Employee	636,450
Physician Stipend				Contractual	24,000
Anesthesiology					
Other	1.00	0.10	43,996	Employee	48,396
Physician Subsidy				Contractual	1,100,000
Physician Stipend				Contractual	45,000
PACU					
RN	6.90	0.30	93,478	Employee	673,042
Sleep Center					
Tech	3.50	0.20	110,887	Employee	410,282
Other	1.00	0.10	40,991	Employee	45,090
Physician Stipend				Contractual	4,000
IV Therapy					
RN	4.70	0.20	98,377	Employee	482,047
Other	2.00	0.10	46,312	Employee	97,255
Pharmacy					
Pharmacist	12.00	0.50	151,169	Employee	1,889,613
Tech	13.20	0.60	38,848	Employee	536,102
Respiratory					
Tech	14.70	0.70	95,924	Employee	1,477,230
Other	1.00	0.10	52,733	Employee	58,006
Physician Stipend				Contractual	10,800
Speech Therapy					
Pathologist	2.20	0.10	104,523	Employee	240,403
Physical Therapy					
Therapist/Aide	15.30	0.70	80,884	Employee	1,294,144
Other	1.00	0.00	51,908	Employee	51,908
Physician Stipend				Contractual	12,000
Occupational Therapy					
Therapist/Aide	5.60	0.30	90,301	Employee	532,776
Radiology					

Tech	14.60	0.60	76,372	Employee	1,160,854
Other	14.50	0.60	48,925	Employee	738,768
Physician Stipend				Contractual	200,000
Ultrasound					
Sonographer	1.00	0.00	72,428	Employee	72,428
Nuclear Medicine					
Tech	2.00	0.10	128,467	Employee	269,781
CAT Scan					
Tech	1.90	0.10	100,283	Employee	200,566
RN	1.00	0.00	105,669	Employee	105,669
Radiology Interventional					
RN	1.10	0.00	108,267	Employee	119,094
Tech	2.50	0.10	103,492	Employee	269,079
MRI					
Tech	1.70	0.10	100,645	Employee	181,161
EKG					
Tech	3.60	0.20	37,367	Employee	141,995
Other	0.50	0.00	48,771	Employee	24,386
Cardio Ultrasound					
Tech	2.50	0.10	94,616	Employee	246,002
Diabetes Center					
RN	1.60	0.10	93,214	Employee	158,464
Tech	1.00	0.00	52,561	Employee	52,561
Other	2.00	0.10	41,798	Employee	87,776
EEG					
Tech	0.50	0.00	87,053	Employee	43,527
Lab					
Tech	53.10	2.30	76,980	Employee	4,264,692
Other	5.20	0.20	43,204	Employee	233,302
Physician Stipend				Contractual	313,000
Radiation Therapy					
RN	1.90	0.10	103,263	Employee	206,526
Tech	13.80	0.60	114,141	Employee	1,643,630
Other	6.50	0.30	45,498	Employee	309,386
Outpatient Chemotherapy					
RN	4.00	0.20	93,959	Employee	394,628
Other	1.00	0.00	46,450	Employee	46,450
Physician Stipend				Contractual	302,000
Cardiac Cath Lab					
RN	3.00	0.10	88,748	Employee	275,119
Tech	2.00	0.10	98,787	Employee	207,453
Outpatient Vascular Lab					
Tech	3.00	0.10	109,220	Employee	338,582

Other	1.00	0.00	37,180	Employee	37,180
Physician Stipend				Contractual	2,400
Outpatient Clinics					
RN	9.80	0.50	108,954	Employee	1,122,226
Tech	8.50	0.40	72,178	Employee	642,384
Other	4.10	0.20	47,552	Employee	204,474
Physician Stipend				Contractual	24,354
Outpatient Cardiac Rehab Services					
RN	2.00	0.10	107,448	Employee	225,641
Tech	2.00	0.10	78,226	Employee	164,275
Other	0.50	0.00	42,569	Employee	21,285
Ambulance Services					
RN	2.80	0.10	98,214	Employee	284,821
Total Direct Care	**636.40**	**25.30**	**4,586,132**		**58,215,373**
Support :					
Central Sterile					
Tech	8.10	0.40	48,023	Employee	408,196
Other	1.00	0.00	37,283	Employee	37,283
Food & Nutrition					
Other	35.90	1.20	38,544	Employee	1,429,982
Plant Operations					
Mechanic	18.50	0.80	65,528	Employee	1,264,690
Other	1.00	0.00	53,762	Employee	53,762
Environmental Services					
Aide	47.50	1.60	39,333	Employee	1,931,250
Security					
Officer	10.50	0.50	51,606	Employee	567,666
Hospital Education					
Educator	11.90	0.50	87,135	Employee	1,080,474
Other	1.40	0.10	50,981	Employee	76,472
Distribution					
Clerk	7.00	0.30	39,664	Employee	289,547
Total Support	142.80	5.40	511,859		**7,139,322**
TOTAL REPORT					**83,299,016**

Fringe Benefits % 31.7%

EXHIBIT 34

Affirmations

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

Signature

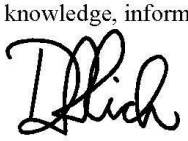
10/22/12
Date

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

Anthony Kelly
Signature | Anthony Kelly

10.23.12
Date

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



October 22, 2012

Signature Douglas R. Rich

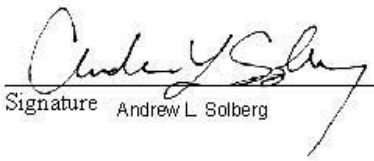
Date

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

Michael L. Silgen 10-22-18

Signature Michael L. Silgen Date

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

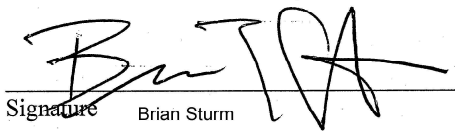


Signature Andrew L. Solberg

10/22/12

Date

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



Signature Brian Sturm

10/22/12

Date

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

Signature Walter Zojac

Date 10/22/12