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December 5, 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 Second Set of Completeness and Additional Information Questions Dated November 16, 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: James L. Thompson, Esq., Counsel for Queen Anne's County
Amy C. H. Grasso, Esq., Counsel for Queen Anne's County
John C. Craig, County Manager, Talbot County
Michael Pullen, Esq., County Attorney, Talbot County
Marta D. Harting, Esq., Counsel for 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, Sr. VP, Business Development and System Strategies, UMMS
Dana Farrakhan, Sr. VP, Business Development and System Strategies, UMMS
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
Jack C. Tranter, Esq.

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ACKNOWLEDGMENT OF RECEIPT

This will acknowledge receipt of ten ~~bound~~ copies of the "Responses to Second Set of Completeness and Additional Information Questions Dated November 16, 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: Andrea Allen
On behalf of the
Maryland Health Care Commission

Date: December 5, 2012

Memorial Hospital at Easton
Matter No. 12-20-2339
Responses to Second Set of Completeness and Additional Information Questions
Dated November 16, 2012

Acute Care Hospital Services State Health Plan Chapter Standards

1. **As you will note, Question 1b requested that Memorial Hospital of Easton ("MHE") complete a spreadsheet detailing the actual physical bed capacity before and after project completion. The October 24, 2012 response does not appear to include this spreadsheet. The spreadsheet details the existing and proposed private and semi- private rooms and bed capacity by location and service. Please complete the spreadsheet, which is attached to this letter.**

In a telephone conversation on November 19, 2012 between MHE's consultant, Mr. Andrew Solberg, and Joel Riklin of the MHCC Staff, Mr. Riklin acknowledged that MHE submitted a version of the requested Physical Bed Chart as Exhibit 21 to the CON application and stated that MHE need not submit it in response to this question.

2. **The response to Question 2f provided the departmental square footage for each clinical service in the existing building and in the proposed facility in Exhibit 24. Thank you for providing this information that should prove helpful. Please provide the following clarifications:**

   a. **Question 2f asked for the total square footage of the existing physical plant comparable to the total square footage of the new facility as reported on Chart 1 (300,678 sq. ft. for Tower 1 and 58,250 for Tower 2). Please try to provide total square footage information for the existing facility(s) that is comparable to these numbers or the sum of these numbers.**
   b. **In addition, in Exhibit 24, three departments are followed by "footnote" like numbers that are not explained. Please explain these numbers.**
   c. **For a number of departments the area square footage is reported with a dash line in the existing column or the proposed column. Please explain what these dashes mean and in the case of the proposed facility, if they mean that such spaces (clinics) will not exist, explain what will happen to the services currently provided in these areas.**

a. MHE provided the comparison of departmental gross square feet in the format set forth in Exhibit 24 so that the MHCC could compare the size of the existing and proposed departments. Exhibit 24 excludes the square footage for Interdepartmental Circulation, Mechanical/Electrical Space, IT Infrastructure related space, and Exterior Wall Width. At the time, MHE could not locate data on these components for the existing building, and could not provide a complete building gross square feet number, comparable to the information requested in Chart 1. MHE has now been able to locate this information. The comparison of building gross square feet is as follows:

	Existing	**Proposed (incl. Towers 1 & 2)**
Total	395,831	358,928
First Floor	219,204	131,082
Second Floor	55,279	97,770
Third Floor	42,263	40,921
Fourth Floor	42,263	34,222
Fifth Floor	36,823	32,035
Sixth Floor		18,222
Penthouse		4,676

Exhibit 35 includes floor-by-floor detail of the existing building.[1]

b. The footnotes for Exhibit 24 are as follows:

1 Existing service is currently located off site, not within the hospital
2 Existing SF for EVS/Linen includes Facilities Management, BioMed, and Security
3 Proposed to be included in off-site Specialty Clinic.

[1] To avoid confusion, exhibits and tables in these responses are numbered sequentially following the last-numbered items in the Responses to Completeness and Additional Questions Dated September 25, 2012."

c. The dashes in Exhibit 24 do, indeed, mean that the services do not currently exist in the existing hospital or the proposed new hospital (as applicable). The services that are not proposed for the new hospital (Breast Center, Coumadin(Anti-Thrombosis Clinic), Sleep Disorders Center, Specialty Clinic, and National Wound Healing Center) will be provided off-site in one of SHS's other ambulatory centers.

3. The response to Question 5 states that "interest income was inadvertently excluded as a source of funds in the Application and is now included in a revised project budget." The response also explains that interest income is calculated assuming a 1.0% interest earned on the investment of funds from the sale of bonds during construction over an 18-month draw, the majority of which will occur within 12 months. Please explain how these assumptions were applied to arrive at the estimated interest income of $1.4 million. Submit all calculations.

The calculation of interest income is provided below. The calculation of $1,359,068 was rounded up to $1,400,000.

Total Borrowing: $242,771,216
Interest earning %: 1.00% annually

Period	Project Spending	Remaining Balance	Interest Earnings
0	$0	$242,771,216	
1	20,000,000	222,771,216	$202,309
2	20,000,000	202,771,216	185,643
3	25,000,000	177,771,216	168,976
4	25,000,000	152,771,216	148,143
5	25,000,000	127,771,216	127,309
6	20,000,000	107,771,216	106,476
7	20,000,000	87,771,216	89,809
8	15,000,000	72,771,216	73,143
9	15,000,000	57,771,216	60,643
10	10,000,000	47,771,216	48,143
11	10,000,000	37,771,216	39,809
12	10,000,000	27,771,216	31,476
13	5,000,000	22,771,216	23,143

14	5,000,000	17,771,216	18,976	
15	5,000,000	12,771,216	14,809	
16	5,000,000	7,771,216	10,643	
17	4,000,000	3,771,216	6,476	
18	3,771,216	0	3,143	
	$242,771,216		$1,359,068	Interest Earnings Estimate

4. Regarding the response to Question 8, the policy on the Information Regarding Charges (Exhibit 26) still does not make it clear that the charge information will be updated at least quarterly as required by part (b) of the definition. The policy states that the charges will be updated on a regular basis. Please revise the policy accordingly.

Please see Exhibit 36, which includes a revised policy on Public Disclosure of Patient Charges. This policy states that the information will be updated quarterly.

5. Regarding the response to Question 10a (table on page 15), reconcile the total square footage reported for the existing site (300,390) and the proposed site (321,990) with the total existing DGSF (276,701) and proposed DGSF (280,935) reported in Exhibit 24, provided in response to completeness question 2f. For the proposed total square footage, also reconcile it with Application Chart 1 total of 352,928 square feet (300,678 for Tower 1 and 58,250 for Tower 2).

The discussion and table on pages 13-15 of the Responses to Completeness Questions Dated September 25, 2012 (the "First Completeness Responses") relates to an existing campus alternative that was considered and analyzed in 2005, before the existing facility was expanded in connection with the Emergency Room project. Thus, the reference to 300,390 total square footage on the existing site presented on page 15 reflected the square footage of the existing in 2005, before the last expansion. The 321,990 square feet shown on page 15 of the First Completeness Responses does not refer to the site proposed in the present Application, but reflects the space for the expansion that MHE considered in 2005 for the existing site. (*See* the column heading on the table on page 15.)

The 276,701 DGSF at the existing site shown on Exhibit 24 included only the square footage for the departments shown on that table and did not include any space for Interdepartmental Circulation, Mechanical/Electrical space, IT Infrastructure space, or Exterior Wall width. (*See* response to question 2a above.) To make the table in Exhibit 24 an "apples to apples" comparison (and because MHE assumed that the MHCC was interested principally in the comparative size of the existing and proposed departments), MHE showed only the department sizes in the proposed new hospital and did not include the space for Interdepartmental Circulation, Mechanical/Electrical space, IT Infrastructure space, or Exterior Wall width. The total square footage for the departments on the list for the proposed hospital was 280,935 DGSF.

The 352,926 total building square feet shown in Chart 1 for the proposed new hospital includes the square footage for Interdepartmental Circulation, Mechanical/Electrical space, IT Infrastructure space, and Exterior Wall Width.

6. In responding to Question 10c, MHE states that there is currently nowhere in the existing facility to clean and store large pieces of equipment, to store beds, and to store vendor deliveries and that such space would typically be co-located with Materials Management or Environmental Services. However, Exhibit 24 does not report Environmental Services space and indicates that Materials Management space will decrease from 6,530 to 5,606 DGSF. Please explain this apparent inconsistency.

The Environmental Services ("EVS"), Linen, and Facilities Management areas are located adjacent to each other on the first floor and are both indicated in Exhibit 24. The square footages allocated for the existing space included hallways where materials, equipment, and beds are stored currently. Also, as Footnote 2 explains, the existing EVS square footage includes space for other services. Further, many of the existing areas are scattered throughout the facility, including miscellaneous office work spaces,

not in a consolidated location. Supplies, equipment, and materials are stored in a variety of surplus spaces, creating space and functional inefficiencies. The new floor plan configuration has designated areas for all support services, including employee locker rooms, EVS, Linen, Facilities Management, and Materials Management/ Receiving dock spaces. Thus, while the proposed overall square footage for these functions is smaller than the existing space, the proposed space configuration will be much more efficient.

7. The response to Question 10d indicates that the on-site alternative cost estimate was generated in 2005 while the costs of the proposed project and the other relocation alternative were estimated in 2007. The response also indicates that the estimated cost of the on-site alternative does not include the cost of renovating Dorchester General Hospital ("DGH"), implying that the cost estimates of the two relocation alternatives (i.e., the proposed project and the Northern Talbot County site) do include such renovation costs. Please update the cost of the on-site alternative and the relocation alternative to be comparable to the project cost estimate included in the Application, specifying the inflation assumptions and the reasons for making such assumptions. In other words, if the cost estimates for the proposed project and the Northern Talbot County site alternative include renovation costs for DGH, please exclude such costs from the updated cost estimates. Also include separate cost estimates for the development of the desired off-campus ambulatory care facilities under the proposed project and each alternative. If MHE considers the desirability of each off-campus ambulatory care facilities to differ for each alternative, please explain the reasons.

As indicated in the Application and in Response 10d of the First Completeness Responses, the alternatives to the proposed project were developed in 2005 and 2007. Many of the assumptions that supported those models have changed since that time. For example, the hospitalization rates in the service area in 2005 and 2007 were much greater than the present rates. Population projections generated by the Maryland Department of Planning for the service area were also greater, because they were

generated before the recession and the housing slump, which still affect the service area. Because of the timing, construction costs were significantly greater than the current market costs and were assumed to be inflating at a very rapid rate. Also, subsequent to the creation of these original models MHE has become part of the Total Patient Revenue (TPR) program.

Given that all of these assumptions made in 2005 and 2007 are no longer accurate and are inconsistent with the assumptions of the proposed project, the resultant capital projects could not be compared. To make them comparable to respond to MHCC's inquiries, MHE is now updating the models to use the same assumptions as used in the proposed project. Specifically, in updating the models MHE assumed the following:

a. Patient volumes are equivalent across all relocation alternatives.

b. Square footage of the facilities in each of the relocation alternatives will be equivalent to the square footage of the proposed project.

c. New construction costs, per square foot, are the same across all relocation alternatives to be equal to the new construction costs of the proposed project.

d. The implementation timetables of each alternative are the same as the timetable in the Application for the proposed project, so the project costs for each alternative are inflated for 27 months using the same MHCC inflation index.

e. Because the costs for the renovation of Dorchester General Hospital are not included in the proposed project, these costs are excluded from all of the alternatives.

f. The ambulatory care facilities that were included in several of the original alternative models have all been constructed or developed in the intervening years. The project costs of these ambulatory care facilities are omitted from each of the alternatives, as is the case for the proposed project.

g. The cost of the on-campus alternative was generated in 2005 as a master plan development of the MHE campus. The costs of this alternative included

new construction, renovation, and infrastructure replacement. Those costs were inflated out over the duration of the master plan implementation (10 to 20 years). To make the on-campus alternative comparable to the proposed project, inflation factors were eliminated and replaced with a single inflation rate to bring the 2005 costs to 2012 standards. To do this, the *Engineering News-Record* (ENR) construction cost indices (CCI) for 2005 and 2012 were compared. The average CCI for the U.S. in 2005 was 7446. By 2012 the CCI had increased to an average of 9292, or a 24.8% increase. This increase represents the inflation in construction costs to be applied to the 2005 master plan for MHE.

h. The cost of the on-campus alternative also included estimates for contingencies, fees, permits, furniture and equipment as a percentage of construction cost. These same percentages are assumed to apply to the updated construction costs.

The three alternatives to be compared to the proposed project are as follows:

a. On-site alternative. Under this alternative, all MHE services would remain at 219 South Washington Street in Easton. A new intensive care unit would be constructed above the Emergency Department. A five-story elevator core would be developed to connect the Emergency Department, the new ICU and the remainder of the existing hospital. A connector would be constructed at the second through fifth floor levels. Renovation includes space in the first floor for Radiology, and offices on the third and fourth floors. Infrastructure improvements include air handling system improvements, chiller replacements, new summer boiler and new emergency generator.

b. Relocation to a new site within Easton. As stated in the Application, MHE owns a 60-acre parcel of land in southwestern Easton, on the Easton Bypass (Route 322) at Oxford Road. The new hospital facility in this alternative would be sized exactly the same as the proposed project. There would be no land acquisition costs associated with this alternative. Because there are utility services available on Route 322, MHE would not be partially responsible for extending water and electrical services to the site, as is the case in the proposed project. All other project costs of this alternative would be the same as described in the proposed project.

c. Relocation to a new site in Northern Talbot County. In this alternative, MHE planned to acquire a 90-acre parcel of land on the southeast corner of the intersection of Maryland Routes 50 and 404. The cost of land acquisition is included in the cost of the alternative. The hospital facility in this alternative would be substantially the same as the proposed project. There are no utilities available currently to serve this site. MHE assumes that electric service would have to be extended from Wye Mills and that wells would have to be dug on the property to provide water. A sewage treatment plant to

serve the new facility would also have to be developed on the property. All other project costs of this alternative would be the same as has been described in the proposed project.

d. The proposed project, as described in the Application.

The resultant project cost comparisons of the three alternatives to the proposed project are presented in the following table.

Table 30
Project Cost Comparisons

	Remain at 219 S. Washington	Relocate to New Site in Easton (Bypass at Oxford Road)	Relocate to New Site in Northern Talbot County (Route 50 at 404)	Proposed Project
New Construction	$ 6,379,776	$ 125,193,045	$ 125,193,045	$ 125,193,045
Fixed Equipment (not in building)	$ 20,779,574	$ -	$ -	$ -
Renovation	$ 6,191,827	$ -	$ -	$ -
Land	$ -	$ -	$ 7,150,000	$ 2,000,000
Site Development	$ -	$ 31,929,484	$ 40,915,484	$ 36,015,484
A/E Fees	$ 5,002,677	$ 17,400,000	$ 17,400,000	$ 17,400,000
Permits	$ -	$ 4,107,718	$ 4,107,718	$ 4,107,718
Major Moveable Equipment	$ 8,337,794	$ 22,000,000	$ 22,000,000	$ 22,000,000
Minor Moveable Equipment	$ -	$ 4,100,000	$ 4,100,000	$ 4,100,000
Contingencies	$ 3,335,118	$ 7,000,000	$ 7,000,000	$ 7,000,000
IT etc.	$ -	$ 18,200,000	$ 18,200,000	$ 18,200,000
Inflation cost	$ 364,947	$ 4,561,181	$ 4,822,039	$ 4,679,795
Capitalized Construction Interest	$ 5,278,167	$ 24,259,218	$ 25,961,677	$ 24,901,333
Total Project Capital Costs	$ 55,669,880	$ 258,750,646	$ 276,849,963	$ 265,597,375

Notes: In the on-campus alternative A/E fees and permits, combined, were estimated at 15% of construction, fixed equipment and renovation costs.
In the on-campus alternative major and minor equipment costs, combined, were estimated at 25% of construction, fixed equipment and renovation costs.
In the on-campus alternative contingency costs were estimated at 10% of construction, fixed equipment and renovation costs.

Although the on-site alternative is the least costly, it still left unresolved all of the issues identified in the First Completeness Responses.

8. Regarding the response to Question 10f, please provide a copy of the questions asked of the physicians and a summary of the responses to each question. In addition, specify the number of physicians interviewed and the number of physicians that care for patients at the hospital.

Unfortunately, in the normal course of business, MHE purged any record of the specific questions asked of the physicians and any written summary of their responses. The interviews were conducted in the summer of 2005 by a representative of TriBrook Healthcare Consultants ("THC"), a consulting firm engaged by SHS in connection with the affiliation with the University of Maryland Medical System. THC was subsequently dissolved and all records related to this question have been purged. Interviews were scheduled with physician members of the Strategic Planning Committee and the Medical Executive Committee. In 2005, a total of 27 physicians on these committees were invited to participate in an interview with THC.

Mr. Douglas Rich, formerly of THC, conducted the interviews and recalls that the physicians were asked to discuss several topics. The first topic was their willingness and/or concerns with an affiliation between SHS and UMMS. The majority of physicians indicated that they were favorably disposed to an affiliation between the two organizations. They indicated that there was already a strong relationship between the SHS physicians and many of the specialists at UMMS and at the University of Maryland School of Medicine. They expressed their views that an affiliation with UMMS, as an academic medical center, would enhance the reputation of SHS. Some of the physicians also expressed concern about the ability of UMMS to handle any increase in referrals from SHS.

The interviewees were also asked to discuss their perceptions of building a new regional medical center to replace MHE. The majority of these physicians supported the concept of building a replacement facility. They indicated that the existing hospital was too small and crowded, that the nursing units were cramped and had a worn

appearance, and that there was no way to separate public traffic from patient and staff traffic.

As for the potential location of the new facility, there was some divergence of opinion among the interviewees. Several physicians suggested that the new facility should be located mid-way between Easton and Cambridge so that both MHE and DGH could be closed. The physicians who primarily practiced at DGH did not want to see DGH close, and suggested that the new hospital should be built to the north of Easton to capture growth in the northern parts of the market. Many of the physicians who practiced in Easton, especially those who owned their own medical office buildings, expressed concern about potential locations for the new hospital that they perceived as being too far from their offices in Easton. The closer the new hospital was to their offices, the easier it would be for them to provide coverage.

Finally, the interviewees were asked to discuss their perception of the needs for more physicians in the service area and any issues they perceived relative to the recruitment of new physicians. The physicians believed there was a need for more primary care physicians in the service area. They cited the long waits that their patients experienced in getting an appointment with a primary care physician. They also indicated that many of the primary care physicians had closed their practices to new patients or to patients who did not have commercial insurance. In addition to primary care physicians, the interviewees also mentioned selected medical and surgical specialties that were underrepresented in the service area.

When asked what impediments existed to recruiting new physicians to the service area, the interviewees mentioned several issues. They mentioned that

reimbursement paid to physicians in the service area was 10 to 15 percent lower than what they could expect on the "western side of the Bay Bridge." Only physicians who are interested in the "Eastern Shore lifestyle" were likely to be successfully recruited to the service area. They also mentioned that the current hospital facilities in Easton and Cambridge detracted from the recruitment effort. MHE and DGH presented a poor image of SHS and, from their perception, no amount of remodeling would be able to offset cramped and poor layout of these facilities. The interviewees believed that a new regional medical center would be very beneficial to the recruitment of new physicians. Finally, some of the interviewees mentioned that the private practice of medicine in the service area would deter candidate physicians, most of whom they believed were looking for employment situations.

The 27 physicians invited to participate in these interviews represented 12 percent of the 220 physicians who then practiced at MHE and/or DGH. There were a total of 331 physicians practicing in the service area at the time, but the remaining physicians were affiliated with other hospitals or did not have any hospital privileges.

THC was unable to schedule any interviews with physicians who were not aligned with SHS. It should be noted that concurrently with the interviews being conducted by THC, SHS had commissioned the Katz Consulting Group to prepare a Medical Staff Development Plan. As part of their engagement, Katz interviewed 24 physicians and received written surveys from 67 physicians on the SHS medical staff. Katz did not ask any questions related to the condition of the current hospitals. Their other findings were consistent with the interviews by THC.

Obstetric ("OB") Services State Health Plan Chapter Standards

9. With respect to the responses to Standard (2), Demonstration of Compliance with all Essential Requirements of the Maryland Perinatal System Standard, please provide the following additional information and clarifications with respect to the Hospital's self-assessment of MHE' s Level 1 perinatal service, performed in October 2011:

a. **Regarding standard 1.1 the assessment indicates no Board of Directors resolution but full Board support. Please explain how the Board of Directors expresses its full support and submit available documentary evidence of such support.**

b. **The Hospital's response indicated that the service did not meet three of the essential standards for a Level 1 program at the time of the self-assessment. The response also identified the corrective actions taken. While the corrective actions taken with regard to standards 6.8 and 6.13 appear to establish compliance, it is not clear how the corrective action described with respect to standard 4.4 satisfies the standard. Standard 4.4 requires a hospital without a physician board-certified in maternal-fetal medicine on the medical staff to have a written agreement with a consultant who is board certified or an active candidate for board-certification to be available 24 hours a day. Your response clearly states that there is no formal written contract, but that SHS is a member of UMMS, which now provides consultation. Please explain how this arrangement satisfies the requirement that such a physician is available 24 hours a day and submit documentation of any agreement covering the provision of such services.**

c. **Note that the Commission's OB plan standard refers to the most current version of the Maryland Perinatal System Standard, which was revised in July 2012. This revision has one essential standard for Level 1 programs not included in the Hospital's self assessment. Standard 13.7 has been added. Standard 13.7 states that "the hospital shall have a policy to eliminate deliveries by induction of labor or by cesarean section prior to 39 weeks gestation without a medical indication. The hospital shall have a systematic internal review process to evaluate any occurrences and a plan for corrective action." Does MHE have such a policy and review process?**

a. The Board's support is reflected in a November 16, 2011 resolution, which states "Shore Health System agrees to meet the Maryland Department of Health and Mental Hygiene Perinatal System Standards for its Birthing Center and Level 1 Nursery that have been established by the Maryland Institute for Emergency

Medical Services Systems." A copy of the resolution is attached as Exhibit 37. MHE apologizes for not having submitted it previously.

b. Standard 4.4 is satisfied by a written letter agreement from Christopher R. Harman, M.D., Professor and Interim Chair, Obstetrics, Gynecology and Reproductive Sciences, Director, Maternal/Fetal Medicine, and Director, Center for Advanced Fetal Care. The agreement confirms that "the University of Maryland Medical Center (UMMC) Department of Obstetrics, Gynecology and Reproductive Sciences through its division of Maternal/Fetal Medicine maintains the availability of a board-certified MFM physician 24 hours a day, and agrees to provide MFM consultation as needed to the providers of the MHE Birthing Center 24 hours a day." A copy of the agreement is attached as Exhibit 38.

c. MHE does have a policy and a process to monitor deliveries by induction of labor or by cesarean section prior to 39 weeks gestation without a medical indication. MHE meets this new Perinatal System standard.

10. The response to Obstetric Plan chapter Standard (6), Physical Plant Design and New Technology, refers to the response to Standard (12) of the Acute Care Hospital Services chapter, Patient Safety, included in the original application. Please specify what portions of the response to the Patient Safety standard of the Acute Care Hospital Services chapter also apply to the proposed relocated OB service and identify any unique aspects of the physical plant design and technology of the OB service not addressed in response to the Patient Safety standard.

As is the case with the rest of the new facility, the Birthing Center at the proposed new hospital is designed with patient and staff safety as a core design element. This commitment to safety begins with the organization of the facility with clear separation of public and staff/service corridors to improve patient privacy, and staff efficiency.

Eliminating all semi-private rooms will help reduce medication errors and infections. Also, the proposed facility will feature standardized patient care areas in both the patient units as well as in the surgical suite. The units themselves are designed to be as efficient as possible, with key supplies located to minimize staff travel distances by as much as 30% over their existing facilities. This includes placing nurse servers outside of each two patient rooms. Locating computers in patient rooms, as well as charting between the rooms, will facilitate safe delivery of medications allowing for bedside barcode checking of medications, as well as great visibility the patients by staff. The proposed facility will have fewer Birthing Center beds than in the existing hospital, which will consolidate and centralize resources, minimize staff travel distances, and open up visibility of patients, while controlling noise in the units.

Patient handling and movement is also a key aspect of patient and staff safety, as the elevators are centralized to minimize patient transport distances. The elevators for the Birthing Center allow direct access from the OR and ED.

In the diagnostic areas, the invasive procedure rooms are all located together and convenient to patient prep and recovery. The Birthing Center's Cesarean Section Rooms are all standardized, designed with input from the Director of Surgical Services and Anesthesia. To help relieve patient and family stress, the facility will feature embedded way finding for patients and family. Public areas, both circulation and waiting, will be oriented to the exterior with views of parking areas. This minimizes the distances patients have to travel, and helps alleviate congestion and confusion within staff/service only areas.

In the Birthing Center (as in the rest of the proposed hospital), patient privacy is a key factor in safety. As part of the planning process, acoustical design is an increased consideration and now required by the 2010 guidelines. As such, materials and finishes are being selected that not only soften footfalls to reduce strain on staff, but also to help absorb noise. Also, all rooms in the Birthing Center, and throughout the facility, will be private.

The greater floor to floor height in the proposed facility will accommodate larger technologies. The first two floor plates feature a regular grid that allows for adaptability over time to new modalities and services.

Some of the other features that improve patient safety in the Birthing Center include:

- Co-location of related support functions to maximize efficiency
- Universal patient room design
- Dedicated trauma and Birthing Center Elevator for patient transfers in emergencies
- Storage alcoves on the Birthing Center for wheel chairs and stretchers
- NICU – Level I Nursery
- Directed traffic flow into building (main entrance) past security
- Automation of technology and patient records
- Upgrade to ADA/ANSI standards
- Reduced patient transfer distances (surgery to short stay recovery, ED to ICU, ED to helipad, nursery/LDRP to helipad, etc.)
- Appropriate number of prep/recovery bays
- Increased telemetry capability
- Direct access from C-section to nursery/NICU
- Charting/observation at each patient room
- Airborne infection isolation rooms on every patient unit
- Appropriate number of triage bays
- Dedicated bathrooms in triage
- Locked unit with an infant security system
- Separate lactation room
- Separated special care nursery and isolation nursery rooms
- Special OR lights in all triage rooms
- Dedicated medication/clean supply room

Other Review Criteria

11. Regarding the response to Question 21g, explain the difference in the projected gross patient services revenues between the original Table 3 and Exhibit 32 for years 2014 ($188,470,949 vs. $187,024,249) and 2015 ($190,748,565 vs. $187,831,440).

The original Table 3 submitted with the Application shows projected gross patient services revenues of $188,470,949 for FY 2014 and $190,748,565 for FY 2015. This revenue projection includes the assumption that the HSCRC will approve the request to change the annual TPR population and aging adjustment formula from 25% of the increase to 70% of the increase. The gross patient services revenue included in Exhibit 32 of $187,024,249 for FY 2014 and $187,831,440 for FY 2015 is based on the current annual TPR population and aging formula of 25% of the increase.

Additional Questions

As agreed in discussions with MHCC Staff, MHE will provide responses to the questions seeking clarifications and additional information (questions 1-5 on pages 4-6 of the November 16, 2012 letter) at a later 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 12.4.12

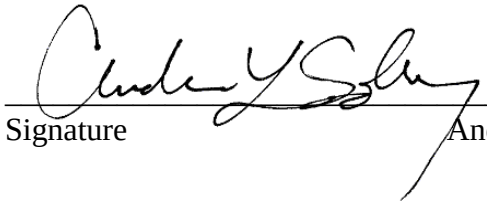
Signature Anthony Kelly Date

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 Michael L. Silgen

12-4-2012
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 W. Solberg Date 12/4/12

EXHIBITS

35. Existing Building Gross Square Feet By Floor

36. Revised Public Disclosure of Charges Policy

37. Board Resolution on Meeting Perinatal System Standards

38. Written Agreement from UMMC to Provide Board-Certified MFM Consultation 24 Hours/Day

Exhibit 35
Existing Building Gross Square Feet By Floor

Floor	Department	EXISTING Dept. Area SF
1	Emergency Department	21,220
	Imaging	16,465
	Admitting/Registration	3,410
	Lobby	1,400
	EVS/Linen2	9,295
	Facilities Management2	-
	Food & Nutrition	10,320
	Materials Management/Receiving Dock	6,530
	Breast Center	1,725
	Coumadin(Anti-Thrombosis Clinic)	925
	Specialty Clinic	1,570
	Central Plant	16,917
	Interventional Suite: Surgery & Cath Lab	20,265
	Prep/Stage II/Recovery	14,425
	Chapel/Pastoral Care	160
	Pharmacy	4,570
	Sterile Processing	4,600
	Outpatient Lab Draw	400
	Auxiliary	805
	Education Center & Medical Library	5,405
	Gift Shop	1,185
	Security2	-
	Behavioral Health	1,110
	Cardio Fitness & Wellness	2,685
	Infusion Center	1,725
	UMMS Diabetes Center	4,225
	Pain Management Center	2,318
	Clinical Laboratory	9,885
	Pre-Anesthesia Testing	1,010
	CIM/Medical Staff/Quality Team	6,160
	Human Resources	795
	Interdepartmental Circulation, Mech/Elec, IT, Exterior Wall	47,699
	Subtotal	219,204
2	Information Technology	3,005
	Inpatient Dialysis	2,410

Floor	Department	EXISTING Dept. Area SF
	Executive Administration	5,250
	Medical Staff Lounge	1,675
	Allied Health	9,920
	Medical	14,830
	CIM/Medical Staff/Quality Team	6,160
	Interdepartmental Circulation, Mech/Elec, IT, Exterior Wall	12,029
	Subtotal	55,279
3	Cardiopulmonary/Vascular: Non-Invasive	6,065
	Sleep Disorders Center	2,230
	Pediatrics	6,025
	Shared Support - Medical/Surgical	560
	Respiratory Therapy	565
	Surgical	14,705
	Nursing Administration	1,835
	Child Advocacy Center	1,310
	Hospitalist Suite	528
	Interdepartmental Circulation, Mech/Elec, IT, Exterior Wall	8,440
	Subtotal	42,263
4	National Wound Healing Center	3,160
	Neuro/Joint Center	9,980
	Intensive Care	6,505
	Telemetry	12,665
	Interdepartmental Circulation, Mech/Elec, IT, Exterior Wall	9,953
	Subtotal	42,263
5	Perinatal - LDRP	16,070
	Requard Center	12,740
	Interdepartmental Circulation, Mech/Elec, IT, Exterior Wall	8,013
	Subtotal	36,823
	Total	395,831

1 Existing located Offsite – Please Note: In this table, only onsite services are shown.

2 Existing SF for EVS/Linen includes Facilities Management, BioMed, and Security

Exhibit 36

Revised Public Disclosure of Charges Policy

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 quarterly 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 37

Board Resolution on Meeting Perinatal System Standards

MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE PERINATAL SYSTEM STANDARDS FOR THE BIRTHING CENTER AND THE LEVEL ONE NURSERY

I hereby certify that a meeting, duly called, of the Board of Directors of Shore Health System, a Maryland Corporation (the "Corporation") held on the 16th day of November, 2011, at which said meeting a quorum was present and acting throughout, the following preamble and resolution was adopted and ever since has been and now is in full force and effect:

RESOLVED, that Shore Health System agrees to meet the Maryland Department of Health and Mental Hygiene Perinatal System Standards for its Birthing Center and Level I Nursery that have been established by the Maryland Institute for Emergency Medical Services Systems.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of said Corporation this 16th day of November 2011.

John Dillon, Chair

Kenneth D. Kozel, President and CEO

Myron Szczukowski, MD, Chief of Medical Staff

Stuart Bounds, Secretary

Exhibit 38

Written Agreement from UMMC to Provide
Board-Certified MFM Consultation 24 Hours/Day

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

CHRIS HARMAN, MD
Professor and Interim Chair

Department of Obstetrics, Gynecology and Reproductive Sciences

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Baltimore, MD 21201
410 328 5966 | 410 328 2849 FAX
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www.medschool.umaryland.edu

November 26, 2012

Michael C. Tooke, M.D.
Sr. VP & Chief Medical Officer
Shore Health/University of Maryland Medical System
219 S. Washington Street
Easton, MD 21061

Dear Dr. Tooke:

Memorial Hospital at Easton (MHE) is a member hospital of the University of Maryland Medical System. Included in the services it provides to the Midshore community is a Level 1 Birthing Center. The Medical Staff of MHE does not include a physician board-certified in maternal-fetal medicine (MFM).

This letter confirms that the University of Maryland Medical Center (UMMC) Department of Obstetrics, Gynecology and Reproductive Sciences through its division of Maternal and Fetal Medicine maintains the availability of a board-certified MFM physician 24 hours a day, and agrees to provide MFM consultation as needed to the providers of the MHE Birthing Center 24 hours a day. The Division is internationally recognized or its expertise in fetal medicine and excellence in care for both the fetus and mother. We are dedicated to providing quality MFM care through our partnership with the premier community hospitals of UMMS, through consultation, the Center for Advanced Fetal Care and the Maternity Express Care system.

This written agreement between UMMC and MHE is intended to fulfill Section 4.4 of the Maryland Perinatal System Standards.

Sincerely,

Chris Harman

Christopher R. Harman, M.D.
Professor and Interim Chair, Department of Obstetrics, Gynecology & Reproductive Sciences
Director, Division of Maternal and Fetal Medicine
Director, Center for Advanced Fetal Care

CRH/smf