RESPONSES TO MHCC COMPLETENESS QUESTIONS
CALVERT MEMORIAL HOSPITAL – MATTER NO. 15-04-2370

PARTS I-III, PROJECT DESCRIPTION, PROJECT BUDGET, APPLICANT HISTORY, STATEMENT OF RESPONSIBILITY, AUTHORIZATION AND RELEASE OF INFORMATION, AND SIGNATURE

1. Please reconcile the "total current project costs" figure of $49,622,779 on page 13 with the "total current capital costs" figure of $49,533,751 in Table E. Please reconcile the "total project costs (escalated)" figure of $51, 583,166 on page 13 with the "total capital costs" figure of $51,494,138 in Table E.

Applicant Response:

The table found on p. 13 showing the Project Cost Estimates is incorrect. Please substitute the corrected table shown below, which reconciles the estimates to those shown on TABLE E.

Category	Cost	Assumptions (% of Current Project Costs)	Assumptions (Interest Rates/Year)
Pre-Construction Costs	**$160,000**	**0.32%**	
Construction Costs	**$29,404,739**	**59.36%**	
Equipment and Furnishings	**$8,240,788**	**16.64%**	
Consultants	**$3,113,127**	**6.29%**	
Inspections/Permits	**$883,754**	**1.78%**	
Contingencies	**$7,731,343**	**15.61%**	
TOTAL Current Project Costs	***$49,533,751***	***100%***	
Escalation	**$1,960,387**	**N/A**	**2015: 3%; 2016: 3%**
TOTAL Project Costs (Escalated)	***$51,494,138***		

Source: CMH.

2. Please specify the amount of space to be demolished by departmental/functional area, as described on page 2 of Exhibit 1.

Applicant Response:

We estimate that approximately 10,225 SF of demolition on the first floor of the existing hospital facility in the follow departments/functional areas: Cardiac and Pulmonary Rehab – 1,600 SF, Gift Shop/Chapel – 1,075 SF, Lobby – 3,175 SF, and Administration/Medical Staff Offices – 4,375 SF.

3. Table B identifies the total departmental gross square feet (DGSF) affected by this project after project completion as 80,580. However, summing this last column of Table B appears to result in a total of 80,590 DGSF. Please confirm that this latter figure is correct or provide a revised Table B.

Applicant Response:

We have reviewed and double-checked the computations presented on TABLE B., and believe that the 80,580 is the correct estimate for the total DGSF affected by the Project.

4. Please provide a signed Part IV affirmation and declaration (Page 5).

Applicant Response:

Please find a signed Part IV affirmation and declaration page at Exhibit 1.

5. Please describe how CMH provides pediatric inpatient care with one licensed bed being allocated to this service.

Applicant Response:

Calvert Memorial Hospital provides pediatric inpatient care to patients admitted to the hospital who are 17 years of age and under. The hospital has on staff board-certified pediatric hospitalists who specialize in the care of children who are admitted to the hospital. They are fully trained in pediatrics with an emphasis on the care of acutely ill children. They are on hand, twenty-four hours a day, seven days a week, and are available anywhere in the hospital when a child needs care. They work with families, nursing staff, other doctors and the child's primary care physician to coordinate care. The historical and projected average daily census for inpatient pediatric patients is less than one. For the most recent final fiscal year (FY 2015) the average daily census was 0.81. The first quarter of the current fiscal year (FY 2016) is 0.61. Therefore, of the total licensed beds as calculated by the Office of Health Care Quality and Maryland Heath Care Commission, the hospital designated one licensed bed for pediatric acute services. Exhibit 2 is the Acute General Hospital Licensed Bed Designation: FY 2016 from the Office of Health Care Quality and Maryland Heath Care Commission.

PART IV-CONSISTENCY WITH GENERAL REVIEW CRITERIA (COMAR 10.24.01.08G(3))

STATE HEALTH PLAN CRITERION

Information Regarding Charges

6. Please respond to this standard.

Applicant Response:

The Public Notification of Common Services and Charges policy has been approved. Please see Exhibit 3. The Representative List of Service and Charges will be available for the public in written form at the Hospital, and has been placed on the Hospital's internet web site: http://www.calverthospital.org/body.cfm?id=1411

Charity Care Policy

7. Please respond to this standard. Please assure that the response provides specific information about the application and eligibility determination process for financial assistance and the determination of probable eligibility for assistance.

   Applicant Response:

   Exhibit 4 contains the updated charity care policy that is fully responsive to the requirements of this standard.

Cost-Effectiveness

8. In the discussion of alternatives considered (pages 36 to 39), there is no specificity on the cost of alternatives, although this is cited as a basis for rejection, and little specificity on time requirements. Please provide a discussion of alternatives that is more in line with the quantification outlined in Part (a) of the standard.

Applicant Response:

Three alternatives to the proposed project were considered and evaluated for cost-effectiveness by CMH management prior to submitting this CON Application: TCU Relocation and Expansion, All MSGA Bed Replacement, and Complete Hospital Replacement.

The capital cost of relocating the existing TCU unit would have required two capital expenditures: one for the relocation and replacement of 18 beds to another health care facility, and the second to renovate the existing space for private MSGA patient rooms in the Hospital itself. Given the occupancy of existing SNF facilities in the immediate Prince Frederick area, we assumed that new construction would be required at a cost of several million dollars, assuming that such a project could actually be implemented in a timely manner. Subsequent renovation costs in the Hospital for the to-be-vacated TCU unit (15 rooms; 20 beds) would have cost far less. We concluded that in the absence of an available space to continue the TCU service at an alternative location, any capital expenditure costs for relocation and renovations would exceed the benefits of leaving the unit exactly where it is, and building the additional space for MSGA private rooms in new construction.

An All MSGA Bed Replacement Project would have required significantly more new construction than has been proposed in the Project, and fewer renovations. Hence, such a project would have been more costly if only because the cost of renovating existing space at CMH is considerably less expensive than the cost of new construction.

As noted in the MVS computations on pages 44 – 48 of the CON Application, the MVS Cost Standard for new hospital construction is $406.81 per square ft. For hospital

renovations, the standard is $364.27, 10% less. Each of the two new 20-bed nursing units in the new construction were designed at approximately 396.75 NSF/bed; 700 DGSF/bed. Assuming that all of the 77 of the licensed general MSGA beds would be replaced in new construction under this alternative, the construction costs alone for this alternative would have been $21.9 Million, only $2 Million less than the new construction cost estimate proposed for the entire three story project, $23.9 Million, which includes additional outpatient treatment areas for medical oncology, additional administrative/medical staff space, and a larger lobby in addition to the construction of two new 20-bed general medical/surgical nursing units. Under these specific cost estimates, the decision to make use of renovated existing space in the Hospital was considered more cost-effective than a complete bed replacement project.

Finally, while no cost estimates were specifically considered for a completely new replacement hospital facility for CMH, management was aware of the proposed enormous capital costs of two Maryland hospital replacement projects currently under CON review. In comparing the cost/bed of the CMH project to the cost/bed for the replacement hospital projects under CON review, we confirmed that the proposed new construction/renovation alternative selected by CMH is approximately 40% to 75% less than the cost/bed proposed for the those two projects, confirming the determination that a complete replacement hospital project for CMH was unaffordable.

9. Please define and describe the nursing unit support services (page 32)…."The hospital is currently using 5 of the existing 53 general M/S patient rooms for required nursing unit support services."

Applicant Response:

At CMH, "nursing unit support services" are defined as those functions and activities necessary to carry out the treatment objectives for each patient. On the 2nd floor, 5 of the existing 53 patient rooms are currently being utilized as follows:

Available Rooms	Semi-Private	Private	Current Use
1	X		Pyxis Med Station
2	X		Storage
3	X		Training
4		X	Nurse Office
5		X	Nurse Office

Source: CMH.

Burden of Proof Regarding Need

10. Between FY 2014 and FY 2015, CMH experienced declining demand for almost all of the services itemized in Table F. What accounted for this decline and how does the answer to this question relate to the projection that demand for most services is being projected to increase, beginning in FY 2016? Has CMH lost market share? Is it projecting recapturing lost market share or increasing market share within its service area as a basis for growth in demand?

Applicant Response:

Shown below are the changes in market share, FY 2009 through first quarter of FY 2016:

Calvert Health System
Calvert Memorial Hospital
Tradition. Quality. Progress.

Calvert Market Share in Service Area defined in CON
Years are in FY. 2016 only contains Q1 data.

	2009	2010	2011	2012	2013	2014	2015	2016
Medsurg								
Calvert	5,686	5,328	5,035	4,971	4,610	3,544	3,435	817
Other Hospitals	6,864	6,515	6,159	6,300	6,100	5,838	5,613	1,503
Grand Total	12,550	11,843	11,194	11,271	10,710	9,382	9,048	2,320
Calvert Market Share	**45.3%**	**45.0%**	**45.0%**	**44.1%**	**43.0%**	**37.8%**	**38.0%**	**35.2%**
Change in Market Share		-0.7%	0.0%	-1.9%	-2.4%	-12.2%	0.5%	-7.2%
Obstetrics								
Calvert	826	801	841	829	781	696	648	167
Other Hospitals	1,233	1,182	1,204	1,219	1,195	1,213	1,326	353
Grand Total	2,059	1,983	2,045	2,048	1,976	1,909	1,974	520
Calvert Market Share	**40.1%**	**40.4%**	**41.1%**	**40.5%**	**39.5%**	**36.5%**	**32.8%**	**32.1%**
Change in Market Share		0.7%	1.8%	-1.6%	-2.4%	-7.8%	-10.0%	-2.2%
Pediatrics								
Calvert	299	285	222	191	168	85	120	23
Other Hospitals	334	264	252	254	234	150	171	38
Grand Total	633	549	474	445	402	235	291	61
Calvert Market Share	**47.2%**	**51.9%**	**46.8%**	**42.9%**	**41.8%**	**36.2%**	**41.2%**	**37.7%**
Change in Market Share		9.9%	-9.8%	-8.4%	-2.6%	-13.4%	14.0%	-8.6%
Psychiatric								
Calvert	385	403	423	423	417	423	392	84
Other Hospitals	263	313	353	336	419	414	404	114
Grand Total	648	716	776	759	836	837	796	198
Calvert Market Share	**59.4%**	**56.3%**	**54.5%**	**55.7%**	**49.9%**	**50.5%**	**49.2%**	**42.4%**
Change in Market Share		-5.3%	-3.2%	2.2%	-10.5%	1.3%	-2.6%	-13.9%

Source: Maryland Inpatient Discharge Abstract.

CMH has seen changes in its market share as it is calculated by inpatient admissions for two primary reasons:

I) There has been some reduction in market share as it relates to a few select business lines – a) obstetrics, b) orthopedics and c) surgical care. The market share reductions are due to increased competition in our MSA for obstetrics and orthopedics. The competition is from hospitals that share secondary service areas with CMH. The decrease in surgical market share is due to some turnover related to our general surgeons which occurred in FY 2013. We are currently rebuilding that part of our business and expect to recapture much of that market share.

II) The more impactful change to our market share numbers is not really a change in market share but a change in utilization. When we moved to the Total Patient Revenue (TPR) reimbursement structure in FY 2011[1], the Hospital was incentivized to reduce hospital utilization since we were now globally capped for all regulated services. This means that our new goal is to reduce hospital episodes of care and invest in keeping our community healthy. The HSCRC as well as the TPR hospitals knew that this shift in incentives would result in a "perceived" reduction in market share since the result of these initiatives would be to reduce admissions – and the typical method of measuring hospital market share is by admissions. Comments on perceived reduction in market share were actually built into our original TPR agreement because this was anticipated.

The perceived changes in Calvert's market share are primarily due to decreased inpatient utilization that is a result of reduced utilization of the Hospital by our community. Consequently, we have seen inpatient use rates for our community decrease throughout this same time period which is the goal of TPR and the new Maryland Waiver. As we continue down the path of population health, we will see use rates decrease to a lesser degree as we get most of the unnecessary hospital

[1] CMH was on the TPR during the 1990s, and was placed on the charge/case methodology in the early 2000s, and went back on the TPR in FY 2011.

utilization out and our opportunity diminishes. From that point on, we expect to see utilization increase as demographic changes continue to impact our community.

11. Why is it necessary to have 91 MSGA beds for a projected average daily census (combined MSGA, pediatric, and surgical observation census) of 46.6 patients, an overall projected average annual occupancy rate of only 51% in 2022? Setting aside licensure considerations and focusing only on physical bed capacity, even if we assume that the objective is to never use MSGA rooms for more than one patient, an effective physical capacity of 76 beds (based on 76 rooms), this still means operating this effective bed capacity at an average annual occupancy of only 61% in 2022. The SHP assumes that a 70% average annual occupancy rate for an MSGA ADC of this size is adequate. In FY2015, on how many days did CMH experience a combined MSGA, pediatric, and surgical observation census that would justify this number of beds?

Applicant Response:

In FY 2015, CMH experienced a combined MSGA, pediatric and surgical observation census of 46 or more patients on 97 days. In our view, all of the licensed beds at CMH were justified for the number of patients who were treated at CMH in FY 2015, consistent with Maryland law and regulation.

This Application does not propose that CMH operate 91 MSGA beds, its current and future physical bed capacity, nor is it required to justify 91 physical beds that could be accommodated in the facility. The effective MSGA bed capacity of CMH, that is, the number of MSGA beds that are actually staffed and operating is determined exclusively by the patient census of the hospital, and includes both inpatients and outpatients. The determination as to how many patient rooms will be occupied and therefore will need to be staffed will not change after the Project is completed and the 26 net additional private patient rooms at CMH become available for occupancy. The fact is that the Hospital currently has a physical bed capacity of 91 hospital beds, and after the project is completed, the Hospital will continue to have the physical capacity for 91 hospital beds. Therefore, the bed capacity of the Hospital is not changing.

We would respectfully suggest that "setting aside licensing considerations and focusing only on physical bed capacity" is not relevant to the computation of hospital bed need and occupancy rates. Specifically, the State Health Plan need methodology for MSGA beds, as set forth at COMAR 10.24.10, defines capacity as the number of licensed and CON-approved beds in Maryland hospitals, not the maximum number of

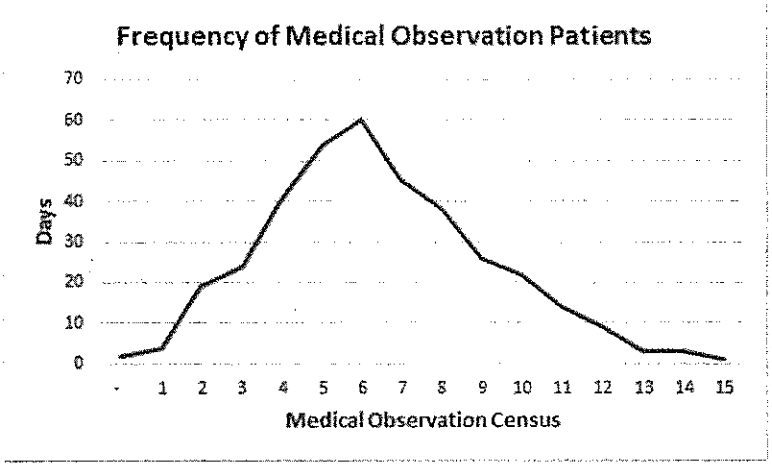
beds that could be physically set up in those hospitals without significant renovations. (See COMAR 10.24.10.05 F. (4) (d).

The 62 licensed MSGA beds at CMH is projected to remain unchanged between FY 2016 and FY 2022. The projected occupancy rate of the 62 licensed MSGA beds in FY 2022 is 72.1%, above the 70% occupancy rate applicable to CMH.

12. Why is it necessary to operate dedicated medical observation beds at an average annual occupancy rate of 46%, especially in light of the large surge capacity (see previous question) being planned for admitted and surgical observation patients, which should allow for overflow of observation patients on the vast majority of days? Please provide information on the fluctuation of observation patient census that justifies this low occupancy rate target.

Applicant Response:

In its CON Application, at Exhibit 7, CMH provided a daily census report by service for FY 2015, including Medical Observation Visits. Our review of these data indicated a significant daily census fluctuation, from 0 to 14 outpatients, with an Average Daily Census of 6.41. These data are shown below:



Source: CMH.

Because the actual medical observation census is determined by random patient visits to the CMH Emergency Department and their subsequent assignment to observation status by members of the CMH medical staff, we utilized a methodology for providing a sufficient number of dedicated observation unit beds to meet the projected need in 2022. This methodology is found in the footnote on p. 33 of the CON Application, and approximates the mathematical model represented by the Poisson distribution: # of beds needed at 99% availability = ADC + 2.33*(Sq. Root ADC). For the projected ADC of 8.3 medical observation patients in 2022 (CON Application, p. 72), the methodology yields a need for 16 beds, two fewer than 18

beds proposed for this unit. In light of the growth of medical observation patients and outpatient visits at CMH, the actual fluctuation in patient census, and the reasonable costs of renovating an existing general medical/surgical MSGA unit on the third floor for the dedicated outpatient unit, we believe that the 46% occupancy rate target for 2022 is reasonable and justified.

Efficiency

13. Provide the basis for the statement that "CMH is currently an efficient hospital" Provide quantitative measures of efficiency demonstrating that CMH is demonstrably efficient when compared with similar Maryland hospitals.

Applicant Response:

One measure of a Maryland hospital's efficiency is its position on the HSCRC Reasonableness of Charges (ROC) Comparison by Peer Groups. It is our understanding that the most recently published ROC Comparison was distributed to the public in 2011[2].

Calvert Memorial Hospital is shown with a ROC position of -3.81%, meaning that CMH's charges were 3.81% below its peer group average. This ROC position confirms CMH as being an efficient hospital. See Exhibit 4.

[2] There have been ROC calculations prepared by the HSCRC staff after 2011, but those calculations were for specific rate setting matters for selected hospitals, and an overall updated summary for all Maryland hospitals has not been published and distributed to date.

14. Cancer treatment is being expanded through this project. Provide the specific analysis and demonstration required by Parts (a) through (c) of this standard for infusion therapy services.

Applicant Response:

The objective of relocating the existing medical infusion therapy unit of the Hospital, and increase its floor space, is not to specifically change its operational efficiency. The modest growth in utilization of the unit may result in improved operational efficiency but that is by no means the reason for the relocation. Hospital management will continue to monitor volumes, expenses and outcomes of this service for changes in operational efficiency (as is the case for every CMH service to be affected by this Project) following completion of the unit's relocation.

The cancer treatment medical infusion therapy area in the proposed addition has been designed to improve the experience and support the healing process for patients undergoing treatment for extended periods of time. This is accomplished with the introduction of natural light, views to the outdoors, options for additional patient privacy and an increase in the area allocated for patient care. To meet the current space requirements (70-80 SF per patient) in the Guidelines for Hospital and Outpatient Facilities (2014 edition)[3], the square footage allocated per patient had to be significantly increased beyond what was available in the current Infusion area. Even accounting for the modest growth in future utilization, these design changes are not anticipated to provide any significant increases or reductions in the expanded unit's operational efficiency.

[3] **Paragraph 2.2-3.12.2.2 on p. 205.**

15. The primary objective of this project, creating more private rooms, should enable CMH to operate at a higher average rate of bed occupancy. CMH is also concentrating most of its observation patients on a dedicated observation unit. Why don't these changes allow for reductions in direct care staff that would translate into lower unit cost of producing patient days and observation days?

Applicant Response:

As is the case with the relocation of the existing outpatient infusion center of CMH, the primary objective of the Project is not to achieve measurable operational efficiencies, and reductions in direct care staff, which if achieved, would translate into lower unit cost of producing inpatient medical/surgical patient days and observation days. In our view, the management of operational efficiencies at CMH requires ongoing assessments of multiple factors that go into providing the best patient experience possible, not the least of which is the ability to use available space, manpower and technology resources efficiently and effectively. It is possible that CMH may be able to reduce direct care staff and achieve lower unit costs and higher occupancy. These opportunities will be maximized in the future following completion of the project. Nevertheless, we have not included such reductions in the projections, as they are highly speculative and at this point non-quantifiable.

Creating additional patient rooms for medical/surgical inpatients and observation patients is but one element to the process of delivering high quality care consistent with the best practices in the hospital industry. Thus, our primary objective in implementing this project is to keep CMH "state of the art" and compliant with updated hospital Guidelines with respect to its facilities.

Patient Safety

16. On page 57, it is stated that, "The nursing units have been designed to maximize staffing efficiency." Presumably, this represents an improvement over the design of CMH's existing nursing units. Again, why don't these design improvements allow for reductions in direct care staff that would translate into lower unit cost for patient days and observation days that would translate into reductions in direct care staff?

Applicant Response:

Private patient rooms are required in contemporary hospital design. The move towards private rooms and the provision of appropriately sized support spaces required for contemporary health care have increased the total square footage of the average nursing units in Maryland hospitals. For example, the CON-Approved and recently completed Holy Cross 4th floor medical/surgical nursing unit in the new patient tower is 24,890 SF and houses 30 patient beds (Docket No. 08-15-2287). The gross SF/bed for the typical Holy Cross medical/surgical floor is 829 SF/bed. The existing CMH 2nd floor medical/surgical unit is 21,384 SF with a physical capacity for 50 beds. The gross SF/bed for the existing CMH 2nd floor is 355 sf/bed. The Holy Cross medical/surgical patient floor has 57.2% more SF/bed to provide the space required for private nursing units with appropriately sized support space.

The proposed patient tower design and the renovations to the existing patient tower have been carefully designed to mitigate the operational impact of this increased square footage on the staffing requirements for the nursing units and to maximize the time spent by staff in direct patient care. The locations of team stations and access points for required support spaces were designed to maximize patient safety and staff efficiency in the nursing units. As stated in response to Question 15 above, CMH management will be monitoring operational efficiency before and after the completion of the Project, and will assess all opportunities to reduce direct care staff consistent with providing high quality patient care services in the affected nursing units.

Financial Feasibility

17. Please provide the first quarter use statistics for CMH to supplement the discussion of utilization projections on pages 63-66.

Applicant Response:

We have prepared an updated and supplemental TABLE F. which provides the first quarter use statistics for CMH. This is found at Exhibit 5.

VIABILITY OF THE PROPOSAL CRITERION

18. How much of the $5 million in charitable contributions anticipated to be used as a funding source for this project has been raised?

Applicant Response:

CMH has not formally commenced its Capital Campaign for the Project, which is scheduled for Spring, 2016, and thus no portion of the anticipated $5 Million in charitable contributions has been raised to date.

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Responses to the Commission's request for additional information (Letter McDonald to Teague, October 29, 2015) are true and correct to the best of my knowledge, information, and belief.

Robert Hoots VP of Finance & CFO — 11-18-15

Name and Title — Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Responses to the Commission's request for additional information (Letter McDonald to Teague, October 29, 2015) are true and correct to the best of my knowledge, information, and belief.

Name and Title

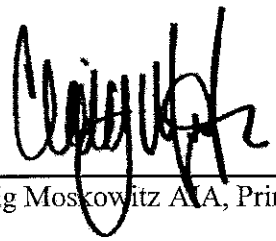
Director of Financial Planning & Reimbursement

11-17-2015

Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Responses to the Commission's request for additional information (Letter McDonald to Teague, October 29, 2015) are true and correct to the best of my knowledge, information, and belief.



Craig Moskowitz AIA, Principal

November 17, 2015
Date

AFFIRMATION

I hereby declare and affirm under the penalties of perjury that the facts stated in the Responses to the Commission's request for additional information (Letter McDonald to Teague, October 29, 2015) are true and correct to the best of my knowledge, information, and belief.

RT Coughlin
Name and Title

11/10/15
Date

EXHIBIT 1

One or more persons shall be officially authorized in writing by the applicant to sign for and act for the applicant for the project which is the subject of this application. Copies of this authorization shall be attached to the application. The undersigned is the owner(s), or Board-designated official of the applicant regarding the project proposed in the application.

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

10/7/2015
Date

Signature of Owner or Board-designated Official

President and CEO
Position/Title

Dean A. Teague
Printed Name

EXHIBIT 2

Acute General Hospital Licensed Bed Designation: FY 2016

Office of Health Care Quality and Maryland Health Care Commission

Hospital Name: *Calvert Memorial Hospital*

License Number: *04-001*

A. LICENSED ACUTE CARE BEDS SUBJECT TO DESIGNATION PROCEDURE

Service Category:	Designation of Beds
MEDICAL/SURGICAL/GYNECOLOGICAL/ADDICTIONS (MSGA)	
Medical-Surgical Acute	36
Gynecologic	0
Addictions	0
Definitive Observation/Stepdown	21
Medical Surgical Intensive Care	4
Medical Cardiac Critical Care	0
Burn Critical Care (HSCRC-designated service only)	0
Shock Trauma (HSCRC-designated service only)	0
Oncology (HSCRC-designated service only)	0
Total Medical/Surgical/Gynecological/Addictions (MSGA)	61
OBSTETRIC	6
PEDIATRIC	
Pediatric Acute	1
Pediatric Intensive Care	0
Total Pediatric	1
PSYCHIATRIC	
Acute Psychiatric-Adult	9
Acute Psychiatric-Child (MHCC-designated service only)	0
Acute Psychiatric-Adolescent (MHCC-designated service only)	0
Acute Psychiatric-Geriatric (MHCC-designated service only)	0
Acute Psychiatric-Intensive Care	0
Total Acute Psychiatric	9
TOTAL: CURRENT LICENSED ACUTE CARE BED CAPACITY	77

B. INVENTORY OF OTHER BEDS

BASSINETS	
Newborn Nursery	12
Premature Nursery (HSCRC-designated service only)	0
Neonatal Intensive Care Unit (NICU)	0
Total Newborn Services (Bassinets)	12
SPECIAL HOSPITAL SERVICES	
Acute Rehabilitation-Comprehensive Inpatient	0
Acute Rehabilitation-Brain Injury	0
Acute Rehabilitation-Spinal Cord Injury	0
Acute Rehabilitation-Stroke Specialty Programs	0
Acute Rehabilitation-Pediatrics	0
Chronic Care	0
Total Special Hospital Services	0
NON ACUTE SERVICES	
Comprehensive Care	18
Comprehensive - Special Care Certified	0
Intermediate Care Facility (ICF)	0
Residential Treatment Center (RTC)	0
Total Non Acute Care Services	18

Approved: _____ (DHMH)

Date Issued: July 1, 2015 Expiration Date: June 30, 2016

cc: Health Services Cost Review Commission

ACHI- revised 6/28/2012

OFFICE OF HEALTH CARE QUALITY

Application for Temporary Adjustment
Acute General Hospital Annual Licensed Bed Designation FY 2016

Hospital Name: *Calvert Memorial Hospital*

Service Category(ies) to be Adjusted:	Current Licensed Bed Designation	Requested Temporary Adjusted Designation
Medical/Surgical/Gynecologic/Addictions	61	
Obstetric	6	
Pediatric	1	
Acute Psychiatric	9	
Total	77	

Effective Dates: _____ _____
(Beginning) (Ending)

Reason for temporary adjustment: _____

_____

Instructions:

(1) Submit this form only when an increase in the total licensed capacity is necessary. Do not submit this form if the total number of licensed beds will not change.

(2) When a temporary adjustment in total licensed beds is necessary to adequately meet demand for services, write or type in the total number of beds to be temporarily licensed in each service category.

(3) Fill in the effective date(s) of the change. The effective date may be one to seven days as needed. If the conditions requiring the increase last longer than seven days, a new temporary adjustment must be requested.

(4) This form must be submitted to the Office of Health Care Quality within five (5) business days of any change. In addition, the hospital must report to the HSCRC in its monthly statistical report the number of days in the month the hospital exceeded its licensed bed capacity, and the number of beds that were in excess on each of those days.

VERIFICATION OF BED BREAKDOWN BY HOSPITAL CEO/PRESIDENT:

I hereby declare and affirm that the facts stated in this application are true and correct to the best of my knowledge, information and belief.

Signed: _____ CEO _____ 7/6/2015
(CEO or President) (Date)

Approved: _____ _____
(DHMH) (Effective Date)

Send to : Renee Webster, Assistant Director, Office of Health Care Quality, Spring Grove Hospital Center, Bland Bryant Building, 55 Wade Avenue, Baltimore, MD 21228; fax 410-402-8167; phone 410-402-8016.

cc: Health Services Cost Review Commission

EXHIBIT 3

CALVERT MEMORIAL HOSPITAL
PRINCE FREDERICK, MARYLAND 20678

Policy: Public Notification of Common Services and Charges
Policy #: GA-162
Category: ☐ Clinical ☑ Non-Clinical
Review Responsibility:
Effective Date: 10/01/15
Reviewed/Revised:
Associated Medical Record Documents:

The policies set forth do not establish a standard of care to be followed in every case. It is recognized that each case is different and those individuals involved in providing health care are expected to use their clinical judgment in determining what is in the best interests of the patient, based on the circumstances existing at the time. It is impossible to anticipate all possible situations that may exist and to prepare policies for each. Accordingly, these policies should be considered to be guidelines to be consulted for guidance with the understanding that departures from them may be required at times.

I. PURPOSE:

To establish a provision of information to the public concerning average charges for common services available per COMAR 10.24.10.

The process of providing average charges for common services to the public will ensure that the public has an estimate of charges for services available in written form at the hospital as well as on the hospital's website.

II. SCOPE:

All clinical staff and Revenue Cycle to include Patient Access Service Center, Registration, and Patient Financial Services

III. DEFINITIONS:

AMA: American Medical Association
Average Charge per Case: Total charges divided by total cases
Average Length of Stay: Total patient days divided by total cases
COMAR: Code of Maryland Regulations
CPT: the "Physicians' Current Procedural Terminology" developed by the AMA
DRG: Diagnosis- Related Group

IV. POLICY STATEMENT:

A. The hospital will maintain a Representative List of Services and Charges that is readily available to the public in written form at the hospital and on the hospital's internet web site. Each quarter, the hospital inpatient and outpatient services volume will be reviewed. For inpatient services, the top 10 DRGs will be reported by service line; for outpatient services, the top 10 CPT codes will be reported by service line, and will be uploaded to the hospitals internet.

1. Inpatient Average Charges: The average charge per case for the ten most frequently occurring inpatient diagnoses (determined by DRG) for service lines in each of the following:
    a. Medical-Surgical
    b. Psychiatry
    c. Obstetrics
    d. Newborn
    e. Pediatrics

2. Outpatient Average Charges: The average charge per case for the top ten most frequently occurring outpatient procedures (defined by CPT codes) for services in each of the following:
    a. Surgery
    b. Diagnostic Radiology
    c. Nuclear Medicine
    d. Cat Scan (CT)
    e. Magnetic Resonance Imaging (MRI)
    f. Laboratory Services

B. Procedures for promptly responding to individual requests for current charges for specific services/procedures:
    1. The Patient Access Service Center (PASC) will utilize the patient estimator file to calculate the average charge.
    2. If the average charge cannot be calculated by the patient estimator file, the Revenue & Reimbursement Analyst will determine the estimate.

C. Requirements for staff training to ensure that inquiries regarding charges for its services are handled appropriately:
    Registration staff will be informed of this policy as well as notified each quarter of the updated average charge per case calculations.

President & CEO

Vice President Finance & CFO

EXHIBIT 4

CALVERT MEMORIAL HOSPITAL
PRINCE FREDERICK, MARYLAND 20678

POLICY AND PROCEDURE: BD 9 EFFECTIVE: 6/27/88

FINANCIAL ASSISTANCE

I. PURPOSE

The purpose of this policy is to determine when financial assistance will be offered to a patient based upon the patient's ability to obtain assistance through state and local agencies and the patient's ability to pay. This policy will assist Calvert Memorial Hospital in managing its resources responsibly and ensure that it provides the appropriate level of financial assistance to the greatest number of persons in need.

II. SCOPE

This policy applies to all patients of Calvert Memorial Hospital for all medically necessary services ordered by a physician.

III. POLICY

Calvert Memorial Hospital is committed to providing financial assistance to persons who have healthcare 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. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, Calvert Memorial Hospital strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Financial Assistance is not considered to be a substitute for personal responsibility. Patients are expected to cooperate with Calvert Memorial Hospital's procedures for obtaining financial assistance or other forms of payment or assistance, and to contribute to the cost of their care based upon their individual ability to pay. 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, for their overall personal health, and for the protection of their individual assets.

In order to manage its resources responsibility and to allow Calvert Memorial Hospital to provide the appropriate level of assistance to the greatest number of persons in need, the Board of Directors establishes the following guidelines for the provision of financial assistance.

IV. DEFINITIONS:

For the purpose of this policy, the terms below are defined as follows:

Charity Care: Healthcare services that have or will be provided but are never expected to result in cash inflows. Charity care results from the Hospital's Financial Assistance Policy to provide healthcare services free or at a discount to individuals who meet the established criteria.

Family: Using the United States Census Bureau's definition, a group of two or more people who reside together and who are related by birth, marriage, or adoption. According to the Internal Revenue Service rules, if the patient claims someone as a dependent on their individual income tax return, they may be considered a dependent for purposes of the provision of financial assistance.

Family Income: Family Income is determined using the Census Bureau definition, which uses the following income when computing federal poverty guidelines:

- Includes earnings, unemployment compensation, workers' compensation, Social Security, Supplemental Security Income, public assistance, veterans' payments, survivor benefits, pension or retirement income, interest, dividends, rents, royalties, income from estates, trusts, educational assistance, alimony, child support, assistance from outside the household, and other miscellaneous sources;
- Noncash benefits (such as food stamps and housing subsidies) do not count;
- Determined on a before-tax basis;
- Excludes capital gains or losses; and
- If a person lives with a family, includes the income of all family members (Non-relatives, such as housemates, do not count).

Uninsured: The patient has no level of insurance or third party assistance to assist with meeting his/her payment obligations.

Underinsured: The patient has some level of insurance or third party assistance but still has out-of-pocket expenses that exceed his/her financial abilities.

V. PROCEDURES

A. **Services Eligible Under this Policy:** For purposes of this policy, financial assistance or "charity" refers to healthcare services provided without charge or at a discount to qualifying patients. The following healthcare services are eligible for financial assistance:

1. Emergency medical service provided in an emergency room setting;

2. Services for a condition which, if not promptly treated, would lead to an adverse change in the health status of an individual;
3. Non-elective services provided in response to life-threatening circumstances in a non-emergency room setting; and
4. Medically necessary services, evaluated on a case-by-case basis, at Calvert Memorial Hospital's discretion.

B. Eligibility for Financial Assistance ("Charity Care"): Eligibility for financial assistance will be considered for those individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need in accordance with this Policy. The granting of financial assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation. The hospital will make a determination of probable eligibility within 2 business days following a patient's request for charity care services, application for medical assistance, or both. Patients with insurance are eligible to receive financial assistance for deductibles, co-insurance, or co-payment responsibilities as long as they demonstrate financial need that meet the policy requirements as outlined in this Policy.

C. Determination of Financial Need:

1. Financial need will be determined in accordance with procedures that involve an individual assessment of financial need; and may
   a. Include an application process, in which the patient or the patient's guarantor are required to cooperate and supply personal, financial and other information and documentation relevant to making a determination of financial need. The application form is the Maryland State Uniform Financial Assistance Application.
   b. Include the use of external publically available data sources that provide information on a patient's or a patient's guarantor's ability to pay (such as credit scoring);
   c. Include reasonable efforts by Calvert Memorial Hospital to explore appropriate alternative sources of payment and coverage from public and private payment programs;
   d. Take into account the patient's available assets, and all other financial resources available to the patient; and
   e. Include a review of the patient's outstanding accounts receivable for prior services rendered and the patient's payment history.

2. It is preferred but not required that a request for financial assistance and a determination of financial need occur prior to rendering of services. However, the determination may be done at any point in the collection cycle. The need for payment assistance shall be re-evaluated at each subsequent time of services if the last financial evaluation was completed more than six months prior, or at any time additional information relevant to the eligibility of the patient for financial assistance becomes known.

3. The Financial Advocate or designee shall attempt to interview all identified self-pay inpatients. The Financial Advocate shall make an initial assessment of eligibility for public/private assistance, or if it is determined that the patient would not meet the criteria for public assistance and the patient has a financial need, then financial assistance may be considered.

4. If a patient may potentially meet criteria to obtain assistance with their medical bills through appropriate agencies, the patient has the following responsibilities:

   1) Apply for assistance.
   2) Keep all necessary appointments.
   3) Provide the appropriate agency with all required documentation.
   4) Patients should simultaneously apply for any need base program that can potentially provide financial sponsorship.

5. Patients must provide all required documentation to support their Financial Assistance Application in order to prove financial need. Exhibit A displays the list of documentation to support the determination of need for financial assistance. Patients requesting financial assistance may be required to consent to release of the patient's credit report to validate financial need. The Financial Advocate should review the completed financial assistance application and complete a checklist of required information and forward this documentation request to the patient. The hospital encourages the financial assistance applicant to provide all requested supporting documentation to prove financial need within ten business days of completing the Financial Assistance Application; otherwise, normal collection processes will be followed. In general, Calvert Memorial Hospital will use the patient's three most current months of income to determine annual income.

6. Patients are not eligible for the financial assistance program if: a) they refuse to provide the required documentation or provide

incomplete information; b) the patient refuses to be screened for other assistance programs even though it is likely that they would be covered by other assistance programs, and c) the patient falsifies the financial assistance application.

7. Upon receipt of the financial assistance application, along with all required documentation, the Financial Advocate will review the completed application against the following financial assistance guidelines:

   a. If the patient is over the income scale, the patient is not eligible for financial assistance and the account should be referred to the Supervisor of Financial Services, although the account should be reviewed to determine if it would potentially qualify under the catastrophic illness or medical indigence exception to this Policy's income levels. A letter will be sent to all patients who fail to meet the financial assistance guidelines explaining why they failed to meet the guidelines along with an invitation to establish a payment plan for the medical bill.

   b. If the patient is under scale but has net assets of $14,000 or greater, then the request for charity will be reviewed on an individual basis by the Manager of Financial Services to determine if financial assistance will be provided. The patient may be required to spend down to $14,000 of net assets in order to qualify for financial assistance.

   c. Once the patient has provided the required documentation to prove financial need, the Financial Advocate should review and evaluate the financial assistance application against the above guidelines and make a determination whether to request approval or to deny the application. If the Financial Advocate or designee believes the application meets the above guidelines, the Financial Advocate should sign the application on the line: "Request for Approval of the Financial Assistance Application" and forward the completed application and all supporting documentation to the following individuals as appropriate:

      i. Manager or Director of Financial Services (up to $3,000)
      ii. Vice President of Finance ($3,001 to $9,999)
      iii. Vice President of Finance & President & CEO ($10,000 and over)

   Once administrative approval of the charity adjustment is obtained, the approved application and all supporting documentation are

forwarded to the Manager of Financial Services who makes the actual adjustment. Patients will receive written notification when the application is approved, denied, or pended for additional documentation.

8. Calvert Memorial Hospital's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly and Calvert Memorial Hospital shall notify the patient or applicant in writing once a determination has been made on a financial assistance application.

D. Presumptive Financial Assistance Eligibility: There are instances when a patient may appear eligible for financial assistance discounts, but there is no financial assistance form on file due to a lack of supporting documentation. 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, Calvert Memorial Hospital could use outside agencies in determining estimate income amounts for the basis of determining financial assistance eligibility and potential discount amounts. Once determined, due to the inherent nature of the presumed circumstances, the only discount that can be granted is a 100% write-off of the account balance. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

1. State-funded prescription programs;
2. Homeless or received care from a homeless shelter;
3. Participation in Women, Infants and Children programs (WIC);
4. Food stamp eligibility;
5. Subsidized school lunch program eligibility;
6. Eligibility for other state or local assistance programs that are unfunded (e.g. Medicaid spend-down);
7. Low income/subsidized housing is provided as a valid address;
8. Patient is deceased with no known estate; and
9. Patient is active with any need base programs where the financial requirements regarding the federal poverty level match or exceed Calvert Memorial Hospital's Financial Policy income thresholds

E. Patient Financial Assistance Guidelines: Services eligible under this Policy will be made available to the patient on a sliding fee scale, in accordance with financial need, as determined in reference to Federal Poverty Levels (FPL) in effect at the time of determination, as follows:

1. Patients whose family income is at or below 200% of the FPL are eligible to receive free care;
2. Patients whose family income is above 200% but not more than 300% of the FPL are eligible to receive services on a sliding fee scale (i.e. percentage of charges discount);
3. Patients whose family income exceeds 300% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of Calvert Memorial Hospital. Typically, in these cases the outstanding medical bill is subtracted from the estimated annual income to determine a spend down amount that meets a corresponding financial assistance discount level.

F. Communication of the Financial Assistance Program to Patients and the Public: Notification about the availability of financial assistance from Calvert Memorial Hospital, which shall include a contact number, shall be disseminated by Calvert Memorial Hospital by various means, which shall include, but are not limited to, the publication of notices in patient bills, the Emergency Department, Urgent Care Centers, admitting and registration departments, and patient financial services offices. The hospital provides annual notice of its charity care policy in a newspaper of general circulation in the hospital's service area, in languages spoken by the population serviced by the hospital. Information shall also be included on the hospital's website and in the Patient Handbook. In addition, notification of the Hospital's financial assistance program is also provided to each patient through an information sheet provided each patient at the time of registration. Such information shall be provided in the primary languages spoken by the population serviced by Calvert Memorial Hospital. Referral of patients for financial assistance may be made by any member of the Calvert Memorial Hospital staff or medical staff, including physicians, nurses, financial counselors, social workers, case managers, and chaplains. A request for financial assistance may be made by the patient or a family member, close friend, or associate of the patient, subject to applicable privacy laws.

G. Patients Qualifying for Assistance Unable to Pay Insurance Premiums may be referred to the Calvert Memorial Hospital Foundation for potential programs that sponsor payment of premiums for indigent guarantors on a case by case basis. The Foundation will determine any eligibility requirements for grants, matching the patient's needs with the appropriate program. Sponsorship for premium payments includes COBRA, Affordable Care Act and specific programs tailored to specific health care specialties to assist patients with financing the cost of their care.

H. **Relationship to Collection Policies:** Calvert Memorial Hospital's management shall develop policies and procedures for internal and external collection practices that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from Calvert Memorial Hospital, and a patient's good faith effort to comply with his or her payment agreements with Calvert Memorial Hospital. For patients who are cooperating with applying and qualifying for either Medical Assistance or financial assistance, Calvert Memorial Hospital will not send unpaid bills to outside collection agencies and will cease all collection activities.

I. **Regulatory Requirements:** In implementing this Policy, Calvert Memorial Hospital shall comply with all federal, state, and local laws, rules, and regulations that may apply to activities conducted pursuant to this Policy.

APPROVED:

Henry Trentman

Henry Trentman, Chairman Board of Directors

Dean Teague, President & CEO

Robert Kertis, Vice President of Finance

Original: 6/27/88
Reviewed/Revised **7/93; 6/96, 4/99, 8/02; 8/03; 10/04; 1/08; 8/09; 4/11; 4/14; 11/15**

Exhibit A

Documentation Requirements

Verification of Income:

- Copy of last year's Federal Tax Return
- Copies of last three (3) pay stubs
- Copy of latest W (2) form
- Written verification of wages from employer
- Copy of Social Security award letter
- Copy of Unemployment Compensation payments
- Pension income
- Alimony/Child Support payments
- Dividend, Interest, and Rental Income
- Business income or self employment income
- Written verification from a governmental agency attesting to the patient's income status
- Copy of last year's Federal Tax Return
- Copy of last two bank statements

Size of family unit:

- Copy of last year's Federal Tax Return
- Letter from school

Patient should list on the financial assistance application all assets including:

- Real property (house, land, etc.)
- Personal property (automobile, motorcycle, boat, etc.)
- Financial assets (checking, savings, money market, CDs, etc.)

Patient should list on the financial assistance application all significant liabilities:

- Mortgage
- Car loan
- Credit card debt
- Personal loan

EXHIBIT 5

Summary of 2011 Maryland Hospitals' Reasonableness of Charges Comparison by Peer Groups

HOSPID	HOSPITAL NAME	ROC POSITION
PEER GROUP 1		-2.71%
210043	Baltimore Washington Medical Center	2.24%
210015	Franklin Square Hospital Center	-1.40%
210056	Good Samaritan Hospital	-1.41%
210044	Greater Baltimore Medical Center	-1.90%
210004	Holy Cross Hospital	-0.86%
210058	James Lawrence Kernan Hospital	3.65%
210011	St. Agnes Hospital	0.07%
210022	Suburban Hospital	4.41%
PEER GROUP 2		-1.86%
210023	Anne Arundel Medical Center	-0.69%
210061	Atlantic General Hospital	4.64%
210039	Calvert Memorial Hospital	-3.81%
210033	Carroll Hospital Center	-2.48%
210030	Chester River Hospital Center	7.92%
210035	Civista Medical Center	-0.56%

210051	Doctors Community Hospital	4.48%
210010	Dorchester General Hospital	-4.42%
210060	Fort Washington Medical Center	-3.79%
210005	Frederick Memorial Hospital	-3.51%
210017	Garrett County Memorial Hospital	-6.58%
210006	Harford Memorial Hospital	3.27%
210048	Howard County General Hospital	-1.91%
210055	Laurel Regional Hospital	7.75%
210045	McCready Memorial Hospital	53.05%
210037	Memorial Hospital at Easton	-3.00%
210018	Montgomery General Hospital	4.64%
210040	Northwest Hospital Center	4.26%
210019	Peninsula Regional Medical Center	-2.24%
210057	Shady Grove Adventist Hospital	-0.92%
210054	Southern Maryland Hospital Center	1.77%
210007	St. Joseph Medical Center	1.69%
210028	St. Mary's Hospital	3.23%
210032	Union of Cecil	-2.98%
210049	Upper Chesapeake Medical Center	-3.01%
210016	Washington Adventist Hospital	6.41%
210001	Washington County Hospital	-8.64%
210027	Western Maryland Regional Medical Center	2.97%
PEER GROUP 4		1.29%
210013	Bon Secours Hospital	5.36%
210034	Harbor Hospital Center	-4.99%

210029	Johns Hopkins Bayview Medical Center	-5.09%
210038	Maryland General Hospital	-2.06%
210008	Mercy Medical Center	0.36%
210003	Prince Georges Hospital Center	8.76%
210012	Sinai Hospital	1.83%
210024	Union Memorial Hospital	-0.35%
PEER GROUP 5		5.08%
910029	Johns Hopkins Bayview Medical Center	-8.52%
210009	Johns Hopkins Hospital	3.95%
910008	Mercy Medical Center	-3.26%
910003	Prince Georges Hospital Center	4.83%
910012	Sinai Hospital	-1.84%
910024	Union Memorial Hospital	-3.94%
210002	University of Maryland Hospital	2.74%

EXHIBIT 6

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). For sections 4 & 5, the number of beds and occupancy percentage should be reported on the basis of licensed beds. In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year Projected	Current Year Actual	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.					
Indicate CY or FY	**FY 2014**	**FY 2015**	**FY 2016**	**FY 16 - Q1**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**
1. DISCHARGES										
a. General Medical/Surgical*	3,918	3,464	3,570	838	3,565	3,585	3,606	3,626	3,647	3,668
b. ICU/CCU	269	324	328	72	335	337	339	341	343	345
Total MSGA	**4,187**	**3,788**	**3,898**	**910**	**3,920**	**3,943**	**3,965**	**3,988**	**4,011**	**4,034**
c. Pediatric	83	109	106	22	105	103	102	101	100	99
d. Obstetric	796	738	766	182	764	762	760	759	757	755
e. Acute Psychiatric	690	654	677	119	681	685	689	693	697	701
Total Acute	***5,756***	***5,289***	***5,447***	***1,233***	***5,470***	***5,493***	***5,517***	***5,540***	***5,564***	***5,588***
f. Rehabilitation										
g. Comprehensive Care	321	322	330	75	330	330	330	330	330	330
h. Other (Specify/add rows of needed)										
TOTAL DISCHARGES	***6,077***	***5,611***	***5,777***	***1,308***	***5,800***	***5,823***	***5,847***	***5,870***	***5,894***	***5,918***
2. PATIENT DAYS										
a. General Medical/Surgical*	15,052	13,193	14,673	3,409	14,649	14,733	14,818	14,903	14,988	15,074
b. ICU/CCU	1,131	1,218	1,232	299	1,261	1,268	1,276	1,283	1,290	1,298
Total MSGA	**16,183**	**14,411**	**15,905**	**3,708**	**15,910**	**16,001**	**16,093**	**16,186**	**16,279**	**16,372**
c. Pediatric	198	295	272	56	269	265	262	259	256	253
d. Obstetric	2,008	1,772	2,018	433	2,013	2,008	2,003	1,998	1,993	1,989

e. Acute Psychiatric	3,283	3,105	3,326	642	3,345	3,364	3,384	3,403	3,423	3,442
Total Acute	***21,672***	***19,583***	***21,521***	***4,839***	***21,537***	***21,639***	***21,742***	***21,846***	***21,951***	***22,056***
f. Rehabilitation										
g. Comprehensive Care	4,635	4,517	4,729	1,163	4,723	4,724	4,725	4,726	4,727	4,728
h. Other (Specify/add rows of needed)										
TOTAL PATIENT DAYS	***26,307***	***24,100***	***26,250***	***6,002***	***26,260***	***26,363***	***26,467***	***26,572***	***26,678***	***26,784***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)										
a. General Medical/Surgical*	3.8	3.8	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1
b. ICU/CCU	4.2	3.8	3.8	4.2	3.8	3.8	3.8	3.8	3.8	3.8
Total MSGA	3.9	3.8	4.1	4.1	4.1	4.1	4.1	4.1	4.1	4.1
c. Pediatric	2.4	2.7	2.6	2.5	2.6	2.6	2.6	2.6	2.6	2.6
d. Obstetric	2.5	2.4	2.6	2.4	2.6	2.6	2.6	2.6	2.6	2.6
e. Acute Psychiatric	4.8	4.7	4.9	5.4	4.9	4.9	4.9	4.9	4.9	4.9
Total Acute	3.8	3.7	4.0	3.9	4.0	4.0	4.0	4.0	4.0	4.0
f. Rehabilitation										
g. Comprehensive Care	14.4	14.0	14.3	15.5	14.3	14.3	14.3	14.3	14.3	14.3

h. Other (Specify/add rows of needed)										
TOTAL AVERAGE LENGTH OF STA	4.33	4.30	4.54	4.59	4.53	4.53	4.53	4.53	4.53	4.53
4. NUMBER OF LICENSED BEDS										
a. General Medical/Surgical*	67	61	58	58	57	57	57	57	57	57
b. ICU/CCU	5	5	5	5	5	5	5	5	5	5
Total MSGA	**72**	**66**	**63**	**63**	**62**	**62**	**62**	**62**	**62**	**62**
c. Pediatric	1	1	1	1	1	1	1	1	1	1
d. Obstetric	8	7	7	7	8	8	8	8	8	8
e. Acute Psychiatric	11	11	12	12	12	12	12	12	12	12
Total Acute	***92***	***85***	***83***	***83***	***83***	***83***	***83***	***83***	***83***	***83***
f. Rehabilitation										
g. Comprehensive Care	18	18	18	18	19	20	21	22	23	24
h. Other (Specify/add rows of needed)										
TOTAL LICENSED BEDS	***110***	***103***	***101***	***101***	***102***	***103***	***104***	***105***	***106***	***107***
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*										
a. General Medical/Surgical*	61.5%	59.3%	69.1%	64.6%	70.2%	70.6%	71.0%	71.4%	71.8%	72.3%
b. ICU/CCU	62.0%	66.7%	67.3%	65.7%	68.9%	69.3%	69.7%	70.1%	70.5%	70.9%
Total MSGA	**61.6%**	**59.8%**	**69.0%**	**64.7%**	**70.1%**	**70.5%**	**70.9%**	**71.3%**	**71.7%**	**72.1%**

c. Pediatric	54.2%	80.8%	74.3%	61.5%	73.4%	72.5%	71.6%	70.8%	69.9%	69.1%
d. Obstetric	68.8%	69.4%	78.8%	68.0%	68.8%	68.6%	68.4%	68.3%	68.1%	67.9%
e. Acute Psychiatric	81.8%	77.3%	75.7%	58.8%	76.2%	76.6%	77.0%	77.5%	77.9%	78.4%
Total Acute	**64.5%**	**63.1%**	**70.8%**	**64.1%**	**70.9%**	**71.2%**	**71.6%**	**71.9%**	**72.3%**	**72.6%**
f. Rehabilitation										
g. Comprehensive Care	70.5%	68.8%	71.8%	71.0%	67.9%	64.5%	61.5%	58.7%	56.2%	53.8%
h. Other (Specify/add rows of needed)										
TOTAL OCCUPANCY %	**65.5%**	**64.1%**	**71.0%**	**65.3%**	**70.3%**	**69.9%**	**69.5%**	**69.1%**	**68.8%**	**68.4%**
6. OUTPATIENT VISITS										
a. Emergency Department	35,635	38,555	38,763	9,929	39,762	40,787	41,838	42,917	44,023	45,158
b1. Same-day Surgery - Main OR	3,835	3,369	3,268	803	3,491	3,491	3,491	3,491	3,491	3,491
b2. Endoscopy Center	3,423	3,190	3,131	824	3,248	3,248	3,248	3,248	3,248	3,248
b3. Pain Management Center	1,176	1,125	1,125	298	1,142	1,142	1,142	1,142	1,142	1,142
c. Laboratory	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
d. Imaging	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
e. Infusion Therapy	5,426	4,960	5,053	1,147	5,183	5,317	5,454	5,594	5,739	5,887

TOTAL OUTPATIENT VISITS	***49,495***	***51,199***	***51,340***	***13,001***	***52,826***	***53,984***	***55,173***	***56,392***	***57,642***	***58,925***
7. OBSERVATIONS**										
a. Number of Cases - Medical Obs	1,663	2,319	2,435	650	2,527	2,624	2,723	2,827	2,934	3,046
b. Hours - Medical Obs	40,111	58,359	59,900	18,377	62,176	64,539	66,991	69,537	72,179	74,922
c. Number of Cases - Surgical Obs	252	343	360	90	369	379	389	399	409	419
d. Hours - Surgical Obs	5,796	7,889	8,280	2,070	8,493	8,712	8,937	9,167	9,404	9,646

* Include beds dedicated to gynecology and addictions, if separate for acute psychiatric unit.

** Services included in the reporting of the "Observation Center", direct expenses incurred in providing bedside care to observation patients; furnished by the hospital on the hospital's premises, including use of a bed and periodic monitoring by the hospital's nursing or other staff, in order to determine the need for a possible admission to the hospitals as an inpatient. Such services must be ordered and documented in writing, given by a medical practitioner; may or may not be provided in a distinct area of the hospital.

*** Based on actual licensed beds for FY 2014 and FY 2015; Based on projected patient days for FY 2016 through FY 2022.

CORRECTION PAGES

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7. TYPE OF PROJECT

The following list includes all project categories that require a CON under Maryland law. Please mark all that apply.

If approved, this CON would result in:

(1)	A new health care facility built, developed, or established	☐
(2)	An existing health care facility moved to another site	☐
(3)	A change in the bed capacity of a health care facility	☐
(4)	A change in the type or scope of any health care service offered by a health care facility	☐
(5)	A health care facility making a capital expenditure that exceeds the current threshold for capital expenditures found at: http://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_threshold_20140301.pdf	X

8. PROJECT DESCRIPTION

A. Executive Summary of the Project: The purpose of this BRIEF executive summary is to convey to the reader a holistic understanding of the proposed project: what it is; why you need/want to do it; and what it will cost. A one-page response will suffice. Please include:

(1) Brief description of the project – what the applicant proposes to do;
(2) Rationale for the project – the need and/or business case for the proposed project;
(3) Cost – the total cost of implementing the proposed project; and
(4) Master Facility Plans – how the proposed project fits in long term plans.

Calvert Memorial Hospital ("CMH") seeks approval for the capital expenditures related to construction of a 43,575 DGSF three story addition to the existing hospital's physical plant. The two main objectives of the project are to expand the number of private patient rooms in the hospital from 64 to 108 (See TABLE A), and to create an 18-room dedicated outpatient observation unit by renovating an existing 31-bed MSGA nursing unit. The proposed building addition is replacement in nature as the acute inpatient physical bed capacity of CMH's 120 beds will not increase. The project also involves 32,910 DGSF of renovations to the existing facility to address connections to the new addition, and reprogramming existing MSGA patient rooms to alternative uses, e.g., staff support, administration, and outpatient services.

COMAR 10.24.10 ACUTE CARE CHAPTER
COMAR 10.24.10.04B. PROJECT REVIEW STANDARDS
Standard .04B(1) – Geographic Accessibility.

A new acute care general hospital or an acute care general hospital being replaced on a new site shall be located to optimize accessibility in terms of travel time for its likely service area population. Optimal travel time for general medical/surgical, intensive/critical care and pediatric services shall be within 30 minutes under normal driving conditions for 90 percent of the population in its likely service area.

Applicant Response:

The proposed project does not involve a new hospital or an existing hospital being relocated to a new site. Also, all of the identified services are already within 30 minutes under normal driving conditions for 90% of the residents of Calvert Memorial Hospital's service area. This Standard is not applicable.

necessary to meet the projected need in FY 2022. This assumes that current patterns of demand will continue: that patients identified by CMH physicians for medical observation in the Hospital's Emergency Department will be transferred to the 18-bed dedicated observation unit on the Hospital's third floor. This unit will occupy 11,245 DGSF as shown on TABLE B. The projected average occupancy of that unit is projected be approximately 46%. Given that the average daily census of medical observation patients at CMH ranged from 0 to 14 in FY 2015[7], that the average length of stay is approximately one day, that demand for observation services is not scheduled, and is projected to grow 3.8% annually through FY 2022, we believe that the projected 46% occupancy for the 18-bed dedicated observation unit is reasonable.

Projections of outpatient observation visits have been provided on TABLE F.

2. Outpatient Infusion Services

CMH currently operates a small outpatient infusion therapy service located on the first floor of the Hospital. Approximately 5,000 infusion therapy visits are projected in FY 2016, largely for the administration of chemotherapy to cancer patients. The current location of the Hospital's Infusion Center is sub-optimal, as it does not provide sufficient space for patients, visitors, and clinical staff during periods of high utilization. In addition, the space is not provided with natural light. CMH is projecting that the number of outpatient visits to the Center will increase to 5,887 in FY 2022. To address the needs of the current Center, and to provide additional space, it will be relocated to a larger space on the Hospital's first floor in the new patient tower proposed for this Project. The specific square footage will increase from 2.990 to 5,000 DGSF is shown on TABLE B. This additional space, which will overlook the Hospital's outdoor Healing Garden, will provide patients and their families with a more comfortable and comforting setting for successful therapies.

7 See Exhibit 7.