March 1, 2018

Via E-mail and USPS

Mr. Kevin McDonald
Chief, Certificate of Need
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: MedStar Franklin Square Liver Transplant Service-Matter # 17-03-2406

Dear Mr. McDonald:

This letter is written in response to the questions raised, on behalf of the Maryland Health Care Commission (MHCC), in your letter of December 26, 2017 regarding MedStar Health's application to initiate liver transplantation services at MedStar Franklin Square Medical Center (MFSMC). We have undertaken substantial effort in answering the questions as factually and comprehensively as possible. While you will note redundancy in some responses, we understand that the questions likely originated from several reviewers, and in order to ensure no misunderstandings or incomplete responses, some repetition seemed necessary.

Responses are provided ***in blue*** below in the format presented originally by the MHCC.

On behalf of MedStar Health, thank you for the opportunity to respond to the MHCC. Should you have any questions regarding this matter, feel free to contact me at (410) 772 - 6689.

Sincerely,

Patricia Cameron
Director, Regulatory Affairs

cc: Gregory Branch, MD, Health Officer, Baltimore County
Paul Parker, Director, Center for Health Care Facilities Development
Samuel E. Moskowitz, President, MedStar Franklin Square Medical Center
Anne P. Weiland, VP, MedStar Health
M. Joy Drass, MD, EVP and Chief Operating Officer, MedStar Health

LIST OF FIGURES
Liver Transplant Completeness Question Responses

FIGURE PAGE

INTRODUCTION

The State Health Plan has acknowledged the large gap between the supply and demand of donor organs that exists on national as well as state levels. MedStar Health believes that the proposed MFSMC program, a collaboration with the MedStar Georgetown Transplant Institute (MGTI), can increase the supply of donor organs for patients in the LLF OPO. As cited throughout the Certificate of Need Application and the responses to Completeness Questions that follow, MGTI's history of innovation, research, surgical expertise and demonstrated superior clinical outcomes is carried out in a context of offering patients all available options for transplantation.

MGTI is a national leader in specific areas of innovation that include novel surgical approaches to expand the utilization of single organs among multiple recipients and, importantly, judicious consideration of higher risk donors in appropriate recipients to improve long-term survival. MGTI is confident in its ability to increase the number of minorities served, as demonstrated in the data provided herein.

***Note**: New figure numbers have been assigned to the graphics provided in these responses. Where a specific graphic from the application is pasted into the response without a Figure number, the Figure number from the application is provided in a black, underlined font, e.g. "Figure 8 (page 47 in the application) pasted below".*

BEGINNING OF RESPONSES TO COMPLETENESS QUESTIONS

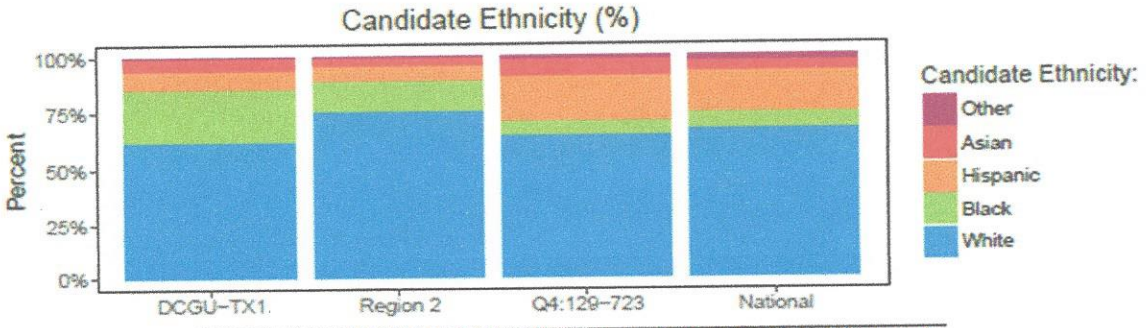
PART I – PROJECT IDENTIFICATION AND GENERAL INFORMATION

1. Please provide the data (and sources) to back up several statements made in the opening description of the project. Specifically:

a) MGTI's level of achievement in evaluating and transplanting minority populations exceeds both local and national benchmarks (p.4).

Figure 1 (SRTR report October 2017) shows the total percentages of minority populations listed for transplant "CANDIDATE Ethnicity" demonstrating that DCGUH (MGTI) listed a higher percentage of minorities than both Region 2 and national averages, clearly summarized in the small table below each graphic DCGU (MGTI) is circled in BLUE; Region 2 in GREEN; National (U.S.) in RED.

FIGURE 1: CANDIDATE ETHNICITY: DCGUH (MGTI) vs. REGION 2 vs. NATIONAL AVERAGE (08.16 – 07.17)



	DCGU-TX1	Region 2	Q4:129-723	National
White	62.65	76.49	65.03	67.78
Black	23.35	13.59	7.13	7.83
Hispanic	8.17	6.35	19.90	17.66
Asian	5.45	3.29	6.49	5.10
Other	0.39	0.28	1.45	1.62
Total	100.00	100.00	100.00	100.00

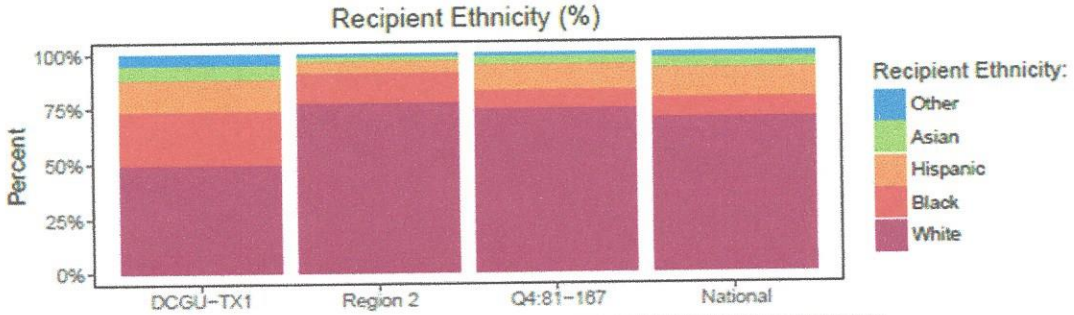
Figure 2 displays the distribution of age and ethnicity for all liver candidates waiting on September 30, 2017. While 53.33% of candidates waiting nationally were 50-64, 24.05% were 65+ years old. Overall, White candidates were the majority, followed by Hispanic, Black, and Asian candidates. Nationally, Other ethnic groups accounted for 1.62% of the waiting list.

MINORITY POPULATION EVALUATED AND LISTED FOR TRANSPLANT

DCGU (MGTI) = 37.36 %
Region 2 = 23.51 %
National = 32.21 %

Figure 2 (SRTR report October 2017) shows the total percentages of minority populations TRANSPLANTED "Recipient Ethnicity" demonstrating that DCGUH (MGTI) transplanted a higher percentage of minorities than both Region 2 and national averages, clearly summarized in the small table below each graphic DCGU (MGTI) is circled in BLUE; Region 2 in GREEN; National (U.S.) in RED.

FIGURE 2: RECIPIENT ETHNICITY: DCGUH (MGTI) vs. REGION 2 vs. NATIONAL AVERAGE (08.16 – 07.17)



	DCGU-TX1	Region 2	Q4:81-167	National
White	50.47	78.27	74.96	71.23
Black	24.30	13.55	8.55	8.39
Hispanic	14.02	5.25	11.48	14.32
Asian	6.54	2.20	4.01	4.41
Other	4.67	0.73	1.00	1.65
Total	100.00	100.00	100.00	100.00

Figure 2 displays the distribution of age and ethnicity for all recipients of liver transplants performed between August 1, 2016 and July 31, 2017. While 50.81% liver transplants nationally were performed on recipients ages 50-64, 20.50% were performed on recipients 65+ years old. Overall, the majority of liver transplants were performed on White recipients, followed by Hispanic, Black, and Asian recipients. Other ethnic recipients accounted for 1.65% of liver transplants.

MINORITY POPULATION TRANSPLANTED

DCGU (MGTI) = 49.53 %
Region 2 = 21.73 %
National = 25.04 %

Figure 3, sourced from unos.org, compares minority candidates wait-listed (left graphic) and transplanted (right graphic) at MGTI (DCGU) with the two Baltimore centers. Note that the percentage of <u>non-minority</u> candidates and recipients, shown in the purple-shaded section of each bar, is much lower at MedStar Georgetown (MGTI).

<u>FIGURE 3</u>: MINORITY CANDIDATES vs. TRANSPLANTS: MGUH vs. JHH vs. UMMS (2016 – 2017)

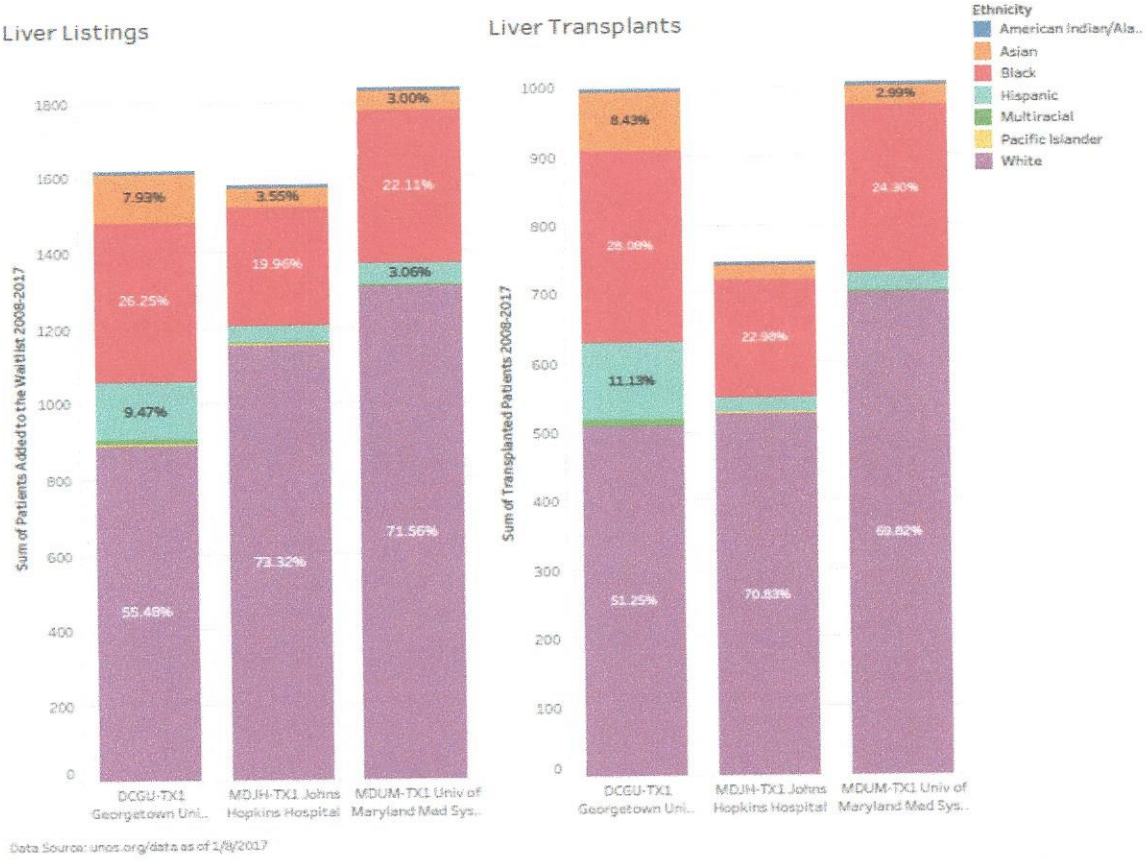


Figure 4 shows the relative minority distributions for Washington and Baltimore. It should be noted that despite Baltimore having a larger minority population, particularly Black/African American, than the District of Columbia, minority patients listed and transplanted in Washington, at MGTI, surpass those of either Baltimore center.

FIGURE 4: MINORITY DISTRIBUTION: WASHINGTON, DC AND BALTIMORE, MD (2018)

Washington , DC

Population By Races

Race	Population	% of Total
Total Population	601,723	100
Black or African American	305,125	50
White	231,471	38
Hispanic or Latino	54,749	9
Some Other Race	24,374	4
Asian	21,056	3
Two or More Races	17,316	2
American Indian	2,079	Below 1%
Three or more races	2,043	Below 1%
Native Hawaiian Pacific Islander	302	Below 1%

Source: https://suburbanstats.org/population
(powered by US Census Bureau Data)

Baltimore, MD

Population By Races

Race	Population	% of Total
Total Population	620,961	100
Black or African American	395,781	63
White	183,830	29
Hispanic or Latino	25,960	4
Asian	14,548	2
Two or More Races	12,955	2
Some Other Race	11,303	1
American Indian	2,270	Below 1%
Three or more races	1,402	Below 1%
Native Hawaiian Pacific Islander	274	Below 1%

b) The cost structure at MFSMC is significantly lower than either existing transplant center in Baltimore (p.5).

Figure 5 (Figures 3 and 4 in application) sourced from HSCRC abstract tapes demonstrate that MFSMC is significantly lower in charge by ECMAD and per case comparison to Johns Hopkins and UMMS as well as state averages.

FIGURE 5 ***(Figures 3 and 4, page 65 in Application)*****: CHARGE COMPARISONS: MFSMC vs. UMMS vs. JOHNS HOPKINS**

Figure 3. Average Charge per ECMAD Comparison

Provider	Charge Per ECMAD	% Higher Than MFSMC
UMMS	$19,544	49.2%
Johns Hopkins	$16,640	27.0%
State Average	$14,196	8.4%
MFSMC	$13,099	--

Source: HSCRC Abstract Tapes for 6 month period from October 2015 to March 2016.

Figure 4. Average Charge per Case Comparison

Provider	Average Charge per Liver Transplant	% Higher Than MFSMC
Johns Hopkins	$230,871	55.1%
UMMS	$198,464	33.3%
MFSMC	$148,848	--

Source: HSCRC Abstract Tapes for 9 month period from July 2016 to March 2017.

Inherent to the cost-effectiveness strategy underlying the proposal for MFSMC is the ability to obviate excessive overhead costs. This is made possible by utilizing the fixed staffing resources available at MGTI, i.e., there is no need to replicate existing central functions that include: data measurement and analytics; regulatory reporting requirements; information systems customized to transplantation; training; scheduling; transportation; and senior program management. Full-time equivalent (FTE) personnel are predominantly a variable staffing expense that ties to volume. In all cases, we are able to limit the FTE requirements based on integration with the central functions available at MGTI as shown in the financial and workforce tables attached to this document.

Overall projected savings to the Maryland health system are provided in the response to Question 23, that asks for "expected benefits over a 5-year period".

c) End-stage renal failure is among the leading causes of death and disability in the nation (p.6).

Source:
These statements are sourced by the Centers for Disease Control as well as the United States Renal Data System (USRDS):
https://www.cdc.gove/nchs/fastats/leading-causes-of-death.htm

d) Most liver transplant programs exist in association with a kidney program, since a stand-alone liver transplant program is not able to manage this population of patients, who require transfer to another center (p.7).

Nationally, there are 141 centers performing liver transplants that are CMS certified and approved by UNOS; only two (2) liver transplant centers nationally do not have a kidney transplant program (these two centers average only 23 liver transplant procedures annually). Since 1988, 8019 combined liver-kidney transplants have been performed nationally
Source: https://www.unos.org/

e) The percentage of MGTI liver transplant candidates from the waiting list receiving transplants is double the national average at 45.4 while centers in the LLF DSA have an average transplant rate of 36.6 (p.13).

Source: http://srtr.org. Figures 6a (MGTI), 6b (UMMS), and 6c (JHH), below show MGTI as having the lowest median time to transplant of the 3 centers. MGTI median time to transplant is 8.2 months versus UMMS at 14 months and JHM "not observed", meaning (as defined in the footnote under the table) that 50% of candidates have not received transplants due to long waiting times, death on the list or other factors.

FIGURE 6a: MEDIAN TIME TO TRANSPLANT: MGUH (01.16 – 10.31.17)

SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS

Georgetown University Medical Center
Center Code: DCGU
Transplant Program (Organ): Liver
Release Date: January 5, 2018
Based on Data Available: October 31, 2017

SRTR Program-Specific Report
Feedback?: SRTR@SRTR.org
1.877.970.SRTR (7787)
http://www.srtr.org

B. Waiting List Information

Table B9. Time to transplant for waiting list candidates*
Candidates registered on the waiting list between 07/01/2011 and 12/31/2016

	Months to Transplant**			
Percentile	Center	OPO/DSA	Region	U.S.
5th	0.2	0.2	0.2	0.2
10th	0.5	0.5	0.4	0.3
25th	1.9	1.9	3.1	2.2
50th (median time to transplant)	8.2	8.2	17.1	13.5
75th	Not Observed	Not Observed	Not Observed	Not Observed

* If cells contain "Not Observed" fewer than that percentile of patients had recieved a transplant. For example, the 50th percentile of time to transplant is the time when 50% of candidates have received transplants. If waiting times are long,then the 50th percentile may not be observed during the follow-up period for this table. Also, if more than 50% of candidates are removed from the list due to death or other reasons before receiving transplants, then the 50th percentile of time to tranplant will not be observed.

** Censored on 06/30/2017. Calculated as the months after listing, during which the corresponding percent of all patients initially listed had recieved a transplant.

FIGURE 6b: MEDIAN TIME TO TRANSPLANT: UMMS (01.16 – 10.31.17)

SRTR SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS

University of Maryland Medical System
Center Code: MDUM
Transplant Program (Organ): Liver
Release Date: January 5, 2018
Based on Data Available: October 31, 2017

SRTR Program-Specific Report
Feedback?: SRTR@SRTR.org
1.877.970.SRTR (7787)
http://www.srtr.org

B. Waiting List Information

Table B9. Time to transplant for waiting list candidates*
Candidates registered on the waiting list between 07/01/2011 and 12/31/2016

	Months to Transplant**			
Percentile	Center	OPO/DSA	Region	U.S.
5th	0.1	0.1	0.2	0.2
10th	0.2	0.3	0.4	0.3
25th	1.4	2.9	3.1	2.2
50th (median time to transplant)	14.0	22.9	17.1	13.5
75th	Not Observed	Not Observed	Not Observed	Not Observed

* If cells contain "Not Observed" fewer than that percentile of patients had recieved a transplant. For example, the 50th percentile of time to transplant is the time when 50% of candidates have received transplants. If waiting times are long,then the 50th percentile may not be observed during the follow-up period for this table. Also, if more than 50% of candidates are removed from the list due to death or other reasons before receiving transplants, then the 50th percentile of time to tranplant will not be observed.

** Censored on 06/30/2017. Calculated as the months after listing, during which the corresponding percent of all patients initially listed had recieved a transplant.

FIGURE 6c: MEDIAN TIME TO TRANSPLANT: JHH (01.16 – 10.31.17)

SRTR SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS

Johns Hopkins Hospital
Center Code: MDJH
Transplant Program (Organ): Liver
Release Date: January 5, 2018
Based on Data Available: October 31, 2017

SRTR Program-Specific Report
Feedback?: SRTR@SRTR.org
1.877.970.SRTR (7787)
http://www.srtr.org

B. Waiting List Information

Table B9. Time to transplant for waiting list candidates*
Candidates registered on the waiting list between 07/01/2011 and 12/31/2016

	Months to Transplant**			
Percentile	Center	OPO/DSA	Region	U.S.
5th	0.3	0.1	0.2	0.2
10th	0.7	0.3	0.4	0.3
25th	5.0	2.9	3.1	2.2
50th (median time to transplant)	Not Observed	22.9	17.1	13.5
75th	Not Observed	Not Observed	Not Observed	Not Observed

* If cells contain "Not Observed" fewer than that percentile of patients had recieved a transplant. For example, the 50th percentile of time to transplant is the time when 50% of candidates have received transplants. If waiting times are long,then the 50th percentile may not be observed during the follow-up period for this table. Also, if more than 50% of candidates are removed from the list due to death or other reasons before receiving transplants, then the 50th percentile of time to tranplant will not be observed.

** Censored on 06/30/2017. Calculated as the months after listing, during which the corresponding percent of all patients initially listed had recieved a transplant.

2. On pp. 8 and 9, the application describes MedStar's participation in insurance markets, its assumption of risk, and its related interest in fostering population health. *("MedStar's plan to locate kidney and liver transplant services at MFSMC furthers its commitment to managing population health, as it assures better access to needed services for the nearly 250,000 covered lives MedStar manages.")* Please discuss the relationship between MedStar's insurance initiatives and the proposed transplant projects.

MedStar Health embraces the concept of a "distributed care delivery network", meaning making safe, effective care available close to home wherever possible. In the context of the insurance plans owned by MedStar, we believe it central to our mission to deliver our transplantation services more conveniently to the populations that we manage – at the lowest cost possible. To the extent that we are able to provide a full complement of services within our own provider network, individuals benefit from lower out-of-pocket expenses such as co-payments and deductibles. Importantly, care is delivered effectively and efficiently such that duplication and redundancies are obviated. Those cost savings accrue to the benefit of the health care system overall.

3. Provide some specificity to the broad statement on p. 16 that "*Integrated resources, well-suited facilities and applied technology enable MFSMC to extend the expertise of MGTI to the Baltimore region.*"

A. Rather than recreate an identical de novo transplantation service environment at MFSMC to that which exists in Washington with MGTI, MedStar Health plans to centralize certain functions in Washington that are staffed and functioning smoothly. For example:

- ***All data analysis and reporting from MFSMC will be integrated into the processes in place at MGUH/MGTI through the team of individuals dedicated there. This centralized function, Quality Assessment and Performance Improvement (QAPI) will serve the transplant program at MFSMC, working in collaboration with local hospital quality assessment and management activities.***
  - ***Likewise, senior oversight of the program will be shared with the transplant leadership team at MGTI, reducing overhead at MFSMC.***
  - ***Training and education, development of new innovations in technology (e.g. telehealth), physician scheduling, deployment and review will all be centralized at MGTI, avoiding unnecessary redundancies.***
  - ***All transportation services for patients would be coordinated through MedStar Transport, the entity that manages triage and transfer of patients– as well as organ procurement- throughout the region and beyond.***

The maintenance of these functions at MGTI significantly lowers the overhead costs for the new program at MFSMC.

B. Sophisticated tertiary services and well-trained providers at MFSMC permit almost immediate implementation of transplant services on-site at the facility. As noted in the application, very little additional capital equipment will be necessary since most required items are available currently. Critical care, emergency and all ancillary services such as radiology, anesthesiology and pathology exist at an advanced level to support the transplant operation.

C. Both pre-transplant and post-transplant care protocols, as well as best practices, currently utilized at MGTI, will be shared with the transplant program at MFSMC. These will include, but are not limited to,:

- ***liver transplant candidate workup,***
- ***waitlist management practices,***
- ***ongoing care and follow-up for patients on the waitlist and,***
- ***post-transplant infectious and immuno-suppression protocols.***
- ***a robust teleconferencing system allows for seamless and effective sharing of information between sites both during planned weekly conferences, and on-demand at the point of care. MGTI also has new video point of care available for referring***

physicians, i.e., any physician can contact a physician on the transplant team via a hand-held device for referral, consultation or other patient-related questions. This particular application is extremely innovative in the current environment of care.

D. Finally, note that in 2017 MFSMC admitted approximately 200 patients with advanced liver disease, many of whom had to be transferred in order to receive a more complex level of care. MFSMC has had an MGTI transplant hepatologist on-site twice weekly for the last year and in January 2018, made the position full time due to increased demand for consultative services. His role, in collaboration with an advanced practice clinician, is to daily manage the inpatient census patients with advanced liver disease, engage in consultation with referring providers, and make prompt and appropriate patient disposition. In many cases, treatment now can be managed on-site at MFSMC.

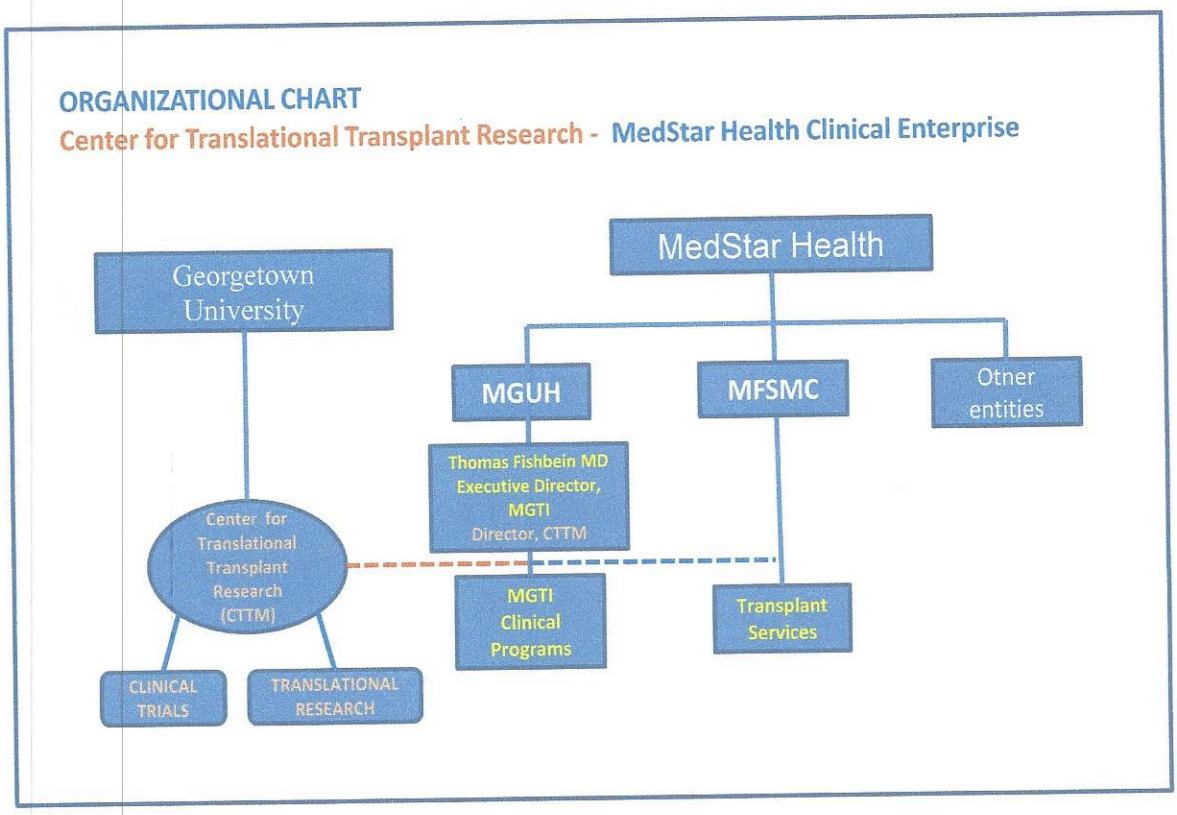
4. Will the proposed liver transplant program treat adults only?

Yes, the program anticipates transplanting adults only. However, MGTI's deep experience and expertise in transplanting pediatric patients will be a valuable asset in terms of managing in the adult population at MFSMC. Responses to Questions 20, 21, 22 elaborate on the highly-effective clinical relationship between pediatric and adult transplant programs in terms of optimizing the distribution of donor organs as efficiently and successfully as possible.

5. Please provide an organizational chart that shows (a) where the proposed transplant program falls within the structure of MedStar Franklin Square Medical Center and (b) its relationship with the MedStar Georgetown Transplant Institute (MGTI) and the Center for Translational Transplant Medicine CTTM).

Figure 7 presents an abbreviated Organizational Chart showing the relationship between CTTM, within Georgetown University's research arm and the clinical enterprises at MGTI and MFSMC. Dr. Thomas Fishbein, a full Professor of Surgery at Georgetown University, directs clinical as well as research programs, the latter falling organizationally under the University, while the former are owned and operated by MedStar Georgetown University Hospital. Dr. Fishbein also will direct all advanced liver disease and clinical transplantation activities at MFSMC.

FIGURE 7: ORGANIZATIONAL CHART FOR CTTM-MGUH-MFSMC



6. Please elaborate on and explain with specificity the "services required for referral, triage, evaluation, and listing of transplant candidates" and the "follow up services required for the long-term maintenance of patient and organ health after transplantation" that the application states have been extended to Franklin Square by MGTI. A)What are these services? B)Will MFSMC be assessed or charged for them?

A. The current organization of transplantation services at MFSMC includes both outpatient and inpatient care venues. As described earlier in this document, because of increased demand for evaluation and follow up for advanced liver disease patients in the outpatient setting, as well as the growing need for availability of 24/7 inpatient consultation, effective January 1, 2018 a full-time transplant hepatologist was deployed on-site at MFSMC (an increase from two days per week). Together with a dedicated full-time nurse practitioner, he oversees a transplant hepatology subspecialty service on-site. This team is responsible for evaluating patients in the advanced liver disease outpatient clinic as well as providing consultation, management and follow up for inpatients at MFSMC. Specific to the inpatient setting, this physician-nurse practitioner team consults on every patient admitted with advanced liver disease, and assumes the management and disposition of those patients admitted with decompensated liver failure. This team rounds daily, develops assessment and treatment plans and oversees imaging, treatment and ongoing

management at MFSMC. Where appropriate based on need, patients are transferred to MGTI for more comprehensive care that cannot be handled in the absence of the full capabilities of a transplant facility.

Inpatients that can be managed in place at MFSMC, who are determined to be candidates for transplantation, follow the established pathway that is outlined in the following paragraphs. Through MGTI, referral evaluation, listing, transplantation and follow up follow a continuum of care that is managed by a multi-disciplinary team of professionals that includes nurse coordinators, advanced practitioners, social workers and nutritionists, in addition to resident and attending physicians. In addition, patients are supported by patient navigators, nursing services, financial counseling, pharmacy services, psycho-social services, medical technology and physical rehabilitation. Additional medical specialty consultants are made available as needed.

Each stage of the continuum of care is touched by a number of these personnel and services as follows:

Referral: The referral is taken by several individuals who handle scheduling of the candidate at one of the several sites available in the community or at hospitals. Candidates scheduled to be seen at MFSMC will be assessed by the on-site team referenced above.

Formal Evaluation: At the time of formal evaluation for transplantation, comprehensive intake including medical history is taken by a transplant coordinator, who continues to follow the patient through the continuum. The transplant hepatologist examines the patient candidate and determines whether transplantation is a feasible option. A social worker and nutritionist interview the candidate relative to family support, psychological and physical readiness to undergo the procedure, and ability to comply with the life-long follow up regimen required after transplantation. Based on the preliminary evaluation, if the patient is deemed a potential candidate, s/he moves forward to review by the Transplant Candidate Review Committee (i.e., listing committee).

Waiting List: If approved as a candidate for transplantation, the patient is placed on the official UNOS waiting list that is specific to each hospital transplant program. Re-evaluation takes place periodically, according to protocol, in order to confirm candidacy and readiness for the procedure.

Transplantation: Coordination of organ matching through the UNOS registry takes place in collaboration with the local organ bank (WRTC or another depending on organ source).

An important caveat: Aside from the routine blood group/MELD score matching process administered by UNOS, key to assuring the most successful long-term outcome possible for each recipient is the judicious appraisal of the individual characteristics of the donor (e.g., age, co-existing disease, general health). Appropriately and cautiously matching the donor-recipient pair on this basis is a "risk-benefit" exercise that

requires detailed knowledge of the recipient candidate with concurrent meticulous assessment of the donor. Simply accepting any organ that presents as a blood-type match, without regard to this additional level of scrutiny does not serve the recipient well. A conscientious program that approaches the process judiciously will "pass" on a donor that is not clinically complementary with the recipient, rather than accept an organ that may not achieve a best possible outcome merely to tally an additional transplant. For these reasons, considering "donor acceptance rates" without regard to assessing outcomes measures does not appreciate the interdependency of these metrics.

Examples: A 70 year old recipient candidate with liver cancer, but no systemic disease or liver damage, can be cured with a liver transplant. This candidate is next on the list to receive an organ. A "marginal"organ from an 80 year old donor, that is, one that is functionally less robust, presents for transplant. This organ likely would be deemed acceptable for this particular recipient because he is in a similar age group and is relatively healthy (other than the liver tumor). Cured of his liver cancer, he will recover well and the organ is likely serve him for his remaining life – a positive outcome.

Alternatively, this particular organ would not be an acceptable match for a 35 year old recipient candidate with advanced liver failure and hepato-renal syndrome who is on a ventilator in the ICU. This second candidate is in a debilitated, near death state and would have an unfavorable outcome without the receipt of a younger, healthy donor organ that can sustain his improvement and serve him long-term.

Once the full matching process – involving UNOS matching in addition to the local team's appraisal of the donor-recipient pair - has been completed and the donor organ accepted, the recipient is called for transplant and the procedure performed.

Follow up: Follow-up care begins immediately at the point of discharge, with patients returning at regularly-defined intervals for evaluation and laboratory analysis as predetermined by program protocol.

Patients are followed over their lifetime by the MGTI transplant team.

B. All payors, including governmental and commercial, reimburse facilities and professionals for these services. The "organ acquisition" portion (which includes the evaluation and associated ancillary costs, the organ itself and registration with UNOS) is a "pass-through" cost reimbursed directly from Medicare, paid in addition to the DRG assigned for the procedure. As well, acquisition costs are considered in the payment methodology employed by the large commercial managed care organizations (MCOs) and are included in the global payment made at the time of transplant. If the patient does not go forward to transplant, these costs are reimbursed separately by the MCOs. All of the costs specific to organ acquisition services are incorporated in the facility cost report and

reimbursed, as appropriate, through a process that the Medicare program has employed for decades.

Again, as there is no major shift or increase in resources needed due to the collaboration with MGTI.

PART II – PROJECT BUDGET

7. Please show the Source of Funds for the $75,800 in moveable equipment for the liver transplant program.

The MedStar Health Capital Budget for the relevant year of program start-up will serve as the funding source.

PART IV – CRITERIA
STATE HEALTH PLAN

General Standards

Charity Care Policy

8. For each of the following subparts of this standard, please provide the quote from the policy that meets each provision, and in what section of the policy it can be found.

The following quotes are taken from the MedStar Health Financial Assistance Policy, which was submitted as Attachment 3 of the MedStar Franklin Square Medical Center's CON application submitted August 11, 2017.
10.24.01.04A(2) (2) Charity Care Policy.
Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. See Figure 8 that follows.

FIGURE 8: CHARITY CARE POLICY: MFSMC

	Quote from the policy	Section citation
(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.	*MedStar will provide a financial assistance probable and likely eligibility determination to the patient within two business days from receipt of the initial financial assistance application.*	*Responsibilities, 2.*
	Quote from the policy	*Section citation*
(ii) Minimum Required Notice of Charity Care Policy.		
Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis.	*MedStar Health will provide public notices yearly in local newspapers serving the hospital's target population.*	*Responsibilities, 1.5*
Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.	*Providing notification and information about the MedStar Financial Assistance Policy by: Displaying MedStar Financial Assistance Policy information at all hospital registration points.*	*Responsibilities, 1.4.3*
Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.	*Providing notification and information about the MedStar Financial Assistance Policy by: Offering copies as part of all registration or discharges processes, and answering questions on how to apply for assistance.*	*Responsibilities, 1.4.1*

9. Franklin Square provided a strong explanation in response to subparagraph (b), which states:

A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

However the response did not use the most recently available HSCRC community benefit data. Please review that data and provide a response as to whether the hospital provided the appropriate level of charity care to the service area population during FY 2016. Note: if the situation and explanation are the same, the applicant may answer simply by providing updated comparisons of its charity care to the peer group and briefly referencing and summarizing the earlier response.

Figure 9 enumerates the actual costs associated with charity care provided through MFSMC.

FIGURE 9 ***(Figure 5, page 33 in Application)*****: MFSMC CHARITY CARE ACTUAL DOLLARS AND PERCENTAGES (FY11 – 16)**

(MFSMC provides Figure 5 below, updated to include FY16 data.)

Updated Figure 5
MFSMC Charity Care
Dollars of Charity Care Provided & Ranking Among Maryland Hospitals
FY11-FY16

	FY11	FY12	FY13	FY14	FY15	FY16
Charity Care $	$10,808,600	$12,654,205	14,943,857	$13,581,700	$6,028,378	$5,147,191
% Charity Care of TE*	2.63%	2.90%	3.30%	2.90%	1.24%	1.00%
Maryland Quartile Rank	3rd	3rd	3rd	3rd	4th	4th

Source: http://hscrc.maryland.gov/init_cb.cfm
*TE = Total Operating Expenses

MFSMC is committed to providing charity care and is currently developing a plan of action to verify that it is meeting the needs of the uninsured or under-insured members of its community, and will make adjustments to its charity care processes and practices based on the results of this evaluation.

Quality of Care

10. Staff notes that subpart (b) of this standard has become outdated, as currently written; however, quality is still of great import to the MHCC, so we will ask the applicant to adapt its response to MHCC's current reporting. There is still a Maryland Hospital Performance Evaluation Guide ("HPEG"), in the hospital consumer guide component of the MHCC web site, and a set of "quality measures" are included as a component of that guide. Currently, there are 37 "quality measures" listed in the HPEG derived from the CMS Process Measures file for the fiscal year that ended on March 31, 2016 and the CMS Outcome Measures file for Mortality and Readmission for the fiscal year that ended June 30, 2014. Performance for most of these measures (32 of the 37) is now reported comparatively – i.e., "Below Average," "Average," or "Better than Average." Please identify any "below average" rating for MedStar Franklin Square, and discuss any actions taken to upgrade that item.

Below are the three quality measures reported in the hospital consumer guide component of the MHCC web site in which MFSMC scored below the Maryland hospital average in CY16: 1) Emergency Department Wait Times; 2) Flu Prevention; 3) Heart Attack and Chest Pain. A brief explanation of the steps the hospital is taking to improve performance in these areas is provided.

1) Emergency Department Wait Times:

In April-May of 2017, MFSMC launched several new initiatives focused on reducing volume and wait times in its Emergency Department. These initiatives included the creation of a FastER to treat low acuity injuries and conditions, a Vertical Patient Protocol for treating patients with an Emergency Severity Index (ESI) of "3" in the ED waiting areas rather than waiting for an available bed for treatment, and a Post-Medical Screening Exam protocol for assessing and referring patients for same-day appointments with specialists and primary care physicians. The list below summarizes other steps the hospital has taken to improve through put in its ED and reduce ED wait times.

- ***First Look RN – an RN stationed in the waiting room to triage patient and move those patients needing immediate care to the treatment area.***
- ***ESI Training – Standardization of triage training and scoring, to better align patient needs to available resources.***
- ***Improved Coaching and Training of ED Staff– Since a high proportion of ED nurses are recent graduates with less than a one year of experience, MFSMC developed a scheduling model where experienced nurses work alongside more novice staff to coach, monitor, and help improve practice.***

- ***Use of inpatient nurses to care for ED boarders (ED patients awaiting admission to the hospital's inpatient service) to free up ED nurses to care for ED patients, opening up more ED capacity.***
- ***Work with hospitalists to expedite the admission process for ED patients who are being admitted. This also frees up ED resources to more quickly move patients from waiting to treatment areas.***

2) Flu Prevention:

MFSMC has created an order set in its EMR to prompt staff at the time of admission to determine patients' flu vaccine status and to deliver the vaccine if the patient has not been vaccinated. During the hospital stay, nurse leaders review patient flu vaccine status daily. MFSMC has also implemented several checks in its EHR to remind nurses to screen and vaccinate eligible patients during their stay, including at the time of discharge.

3) Heart Attack and Chest Pain

Heart attack patients who received aspirin at arrival in FY17 was at 100%. Chest pain patients who received aspirin at arrival in FY17 was at 98%, both above the National Average of 97%. Chest pain patients arriving by ambulance now have electrocardiogram (ECG) performed in the ambulance triage area. RNs stationed in the waiting room triage patients and move those patients needing ECG tests to the testing area. ED Physicians interpret the ECGs immediately and triage patients accordingly when abnormalities are found.

Project Review Standards- State Health Plan

Need and Access

11. Please provide the source for the data in Figure 11 (p. 48) and Figure 12 (p.52).

Both figures are sourced from the Scientific Registry of Transplant Recipients (srtr): http://www.srtr.org. The release dates of each report are noted within the graphic.

12. On p. 55 the application raises the theme of the "geographical challenge" some patients may face. Please provide a breakdown on the county of origin for the 40 liver and 129 kidney patients on MGTI's waiting list "from Maryland counties that orient to Baltimore." Is this waiting list maintained by the LLF OPO or by MedStar Health?

Transplant waiting lists are maintained by each hospital program within the designated organ procurement organization (OPO), i.e., each transplant hospital within LLF and WRTC maintains an individual list. The list is dynamic, meaning the numbers of patients listed at any given time will vary depending on patient readiness and status (determined by MELD score).

MFSMC expects to primarily serve residents of Central Maryland (Baltimore City/County, Anne Arundel County, Carroll County, Harford County, and Howard County) and Frederick County. This geography includes the service areas of the four Baltimore MedStar Hospitals (MedStar Franklin Square, MedStar Good Samaritan, MedStar Harbor, and MedStar Union Memorial) and the locations of MedStar Advanced Kidney and Liver Disease Clinics (Baltimore County, Anne Arundel County, Frederick County, Prince George's, Calvert, Charles and St. Mary's counties).

If the MFSMC program is approved, all patients residing in the service areas outlined above will be offered immediate double-listing with the MFSMC program. Figure 10 shows a sample of patients by zip code origin.

FIGURE 10: MGTI WAIT-LISTED PATIENTS FROM BALTIMORE REGION: Origin by zip code

Pt City	Pt State	Pt Zip	Pt City	Pt State	Pt Zip
ESSEX	MD	21221	BALTIMORE	MD	21206
GWYNN OAK	MD	21207	GWYNN OAK	MD	21207
ROSEDALE	MD	21237	GWYNN OAK	MD	21207
BALTIMORE	MD	21218	PIKESVILLE	MD	21208
BALTIMORE	MD	21217	BALTIMORE	MD	21209
BALTIMORE	MD	21209	BALTIMORE	MD	21211
FELTON	PA	17322	BALTIMORE	MD	21212
YEADON	PA	19050	BALTIMORE	MD	21214
YEADON	PA	19050	BALTIMORE	MD	21217
TEMPLE HILLS	MD	20748	BALTIMORE	MD	21218
ABINGDON	MD	21009	SPARROWS POINT	MD	21219
BALDWIN	MD	21013	MIDDLE RIVER	MD	21220
BEL AIR	MD	21014	ESSEX	MD	21221
BEL AIR	MD	21015	DUNDALK	MD	21222
EDGEWOOD	MD	21040	BALTIMORE	MD	21224
FALLSTON	MD	21047	BROOKLYN	MD	21225
FOREST HILL	MD	21050	BALTIMORE	MD	21229
GLEN BURNIE	MD	21060	BALTIMORE	MD	21230
JOPPA	MD	21085	BALTIMORE	MD	21231
KINGSVILLE	MD	21087	PARKVILLE	MD	21234
LUTHERVILLE TIMONIUM	MD	21093	NOTTINGHAM	MD	21236
PERRY HALL	MD	21128	ROSEDALE	MD	21237
REISTERSTOWN	MD	21136	BALTIMORE	MD	21239
SEVERNA PARK	MD	21146	GLENWOOD	MD	21738
STREET	MD	21154	SYKESVILLE	MD	21784
WESTMINISTER	MD	21157	WEST	MD	21794

			FRIENDSHIP		
WHITE MARSH	MD	21162	CONOWINGO	MD	21918
TOWSON	MD	21204			

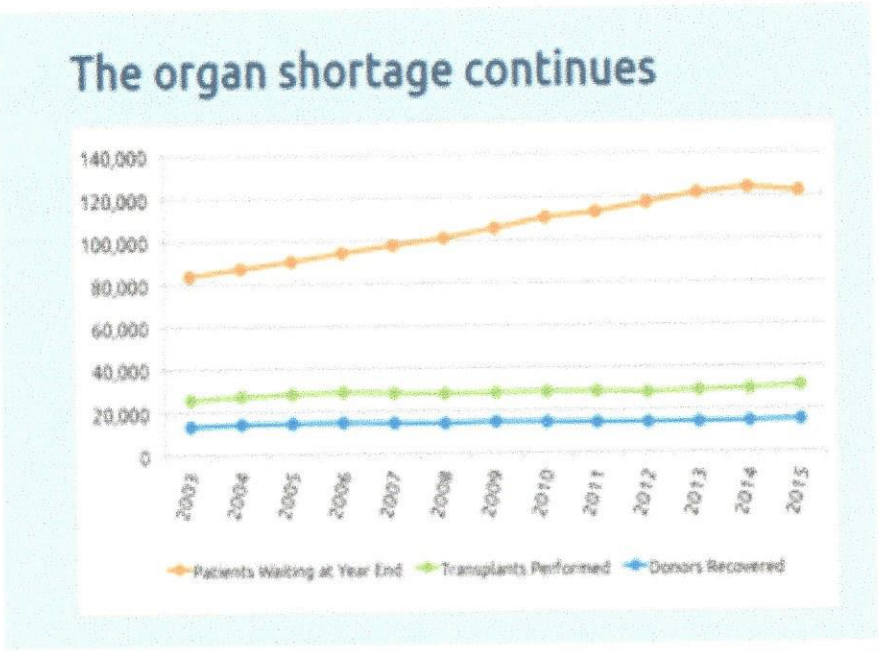
13. Despite professing not to be making its case on barriers to access (p.63), the applicant speaks to geographical challenges among members of the target market as a project justification. This seems to ignore the policy that regionalization for such highly-specialized services is appropriate and desirable.[1] (Note: An applicant that seeks to justify the need for additional organ transplantation services on the basis of barriers to access shall:
    a) Present evidence to demonstrate that barriers to access exist, based on studies or validated sources of information, and
    b) Present a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing each barrier identified, whether the plan is feasible, and whether member of the communities affected by the project support the plan.

a) The comparison of access to liver transplantation is variable based on a number of factors including physical access but, most importantly, organ availability, which represents the fundamental "barrier" to access.[1] Figure 11 demonstrates the enormous variance between patients listed for transplantation and those actually transplanted, both on national and local (Maryland) levels. The variance is due to the established fact that an inadequate number of donor organs are available relative to the many patients in need. MGTI's experience with innovative approaches to expand the available donor pool will be extended to the Baltimore region.

[1] Note that the State health Plan (COMAR 10.24.15) states: "For specialized services, the public is best served if a limited number of general hospitals provide specialized services to a substantial population base. This pattern promotes high quality care and an efficient scale of operation. As discussed later, higher volume organ transplant programs are often associated with better patient outcomes."

FIGURE 11: ORGAN SUPPLY vs. DEMAND (National)

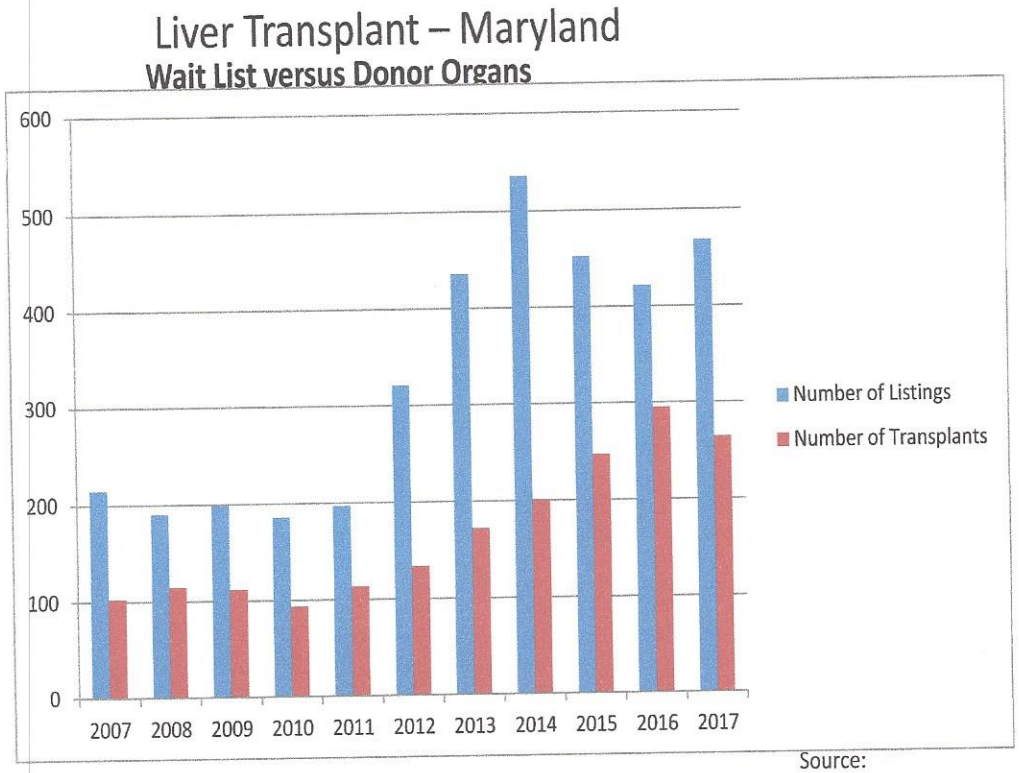
National Data on Organ Supply v. Demand by Calendar Year



Source: https://optn.transplant.hrsa.gov/news/organ-shortage-continues-to-grow/

Clearly the growing candidate waiting list far exceeds the numbers of transplants of any kind performed in the United States. Figure 12, below, shows the same scenario relative to the state of Maryland.

FIGURE 12: ORGAN SUPPLY vs. DEMAND (Maryland)



Source:
OPTN, 2017

Because of the scarcity of the resource, access to organs is largely is driven by liver allocation policy, which is determined ultimately by UNOS. Policy changes have been made by UNOS from time to time as the organization strives to give those patients with the most acute need more immediate access to the very limited organ reserve. The most recent change in liver allocation was finalized at the end of calendar year 2017 and is expected to be implemented formally and fully in the summer of 2018. While the new proposal does not redraw existing donor service areas or regional boundaries, it does, provide greater allocation priority to candidates listed at hospitals within 150 nautical miles of the donor hospital, regardless of the donor service area or region where these nearby candidates are located. In this way, the new policy is expected to provide earlier access to available livers for candidates with greater medical priority that live outside, but nearby, existing regional boundaries.

b) SRTR data show that MGTI makes effective use of as many available organs as possible through managing its wait-list carefully, matching recipient candidates and donors judiciously, and applying advanced innovative surgical techniques to address the organ shortage. MedStar Health believes that it has provided evidence that the MGTI expertise and experience can be extended to MFSMC safely and cost-effectively for the benefit of Marylanders. We have also provided evidence, through letters of support and through graphical representation of the

trend in referrals, that members of the community are fully-supportive of the addition of a MedStar transplant program at MFSMC, in collaboration with MGTI.

14. Following up on the issue of geographical access, staff notes that the applicant neglected to respond to subpart (d) of this standard which is:

> *Travel to an organ transplant center located in a health planning region other than where the organ transplant recipient resides is not, in and of itself, considered a barrier to access, if the drive time in less than three hours one-way.*

Please describe why travel from Baltimore to Washington, DC, or receiving this service at another Baltimore location is a challenge to access.

Travel to and from the transplant center in Washington, DC is not an insurmountable challenge, although can pose more significant inconvenience for minority populations that have less access to transportation, funding sources, family resources and more. Although MGTI has worked to mitigate these issues through creating funded transportation alternatives and focusing on social support for these patients, the ongoing follow up required before and after a major transplantation procedure can be onerous for individuals with resource and time constraints. Unlike other complex and more "curable" surgical procedures such as hip replacement, lifelong follow up is required for recipients of organ transplants primarily due to the sequelae of immunosuppressive treatment regimens.

Importantly also, patients will require the services of local providers including primary care physicians, specialist consultants, rehabilitation therapists and on occasion, emergency services. Patients are served well to remain in one system of care so as to maintain continuity among providers familiar with their care and the system of care. Because medical record systems still lack integration across divergent systems of care under different ownership, it is especially important that the caregiver community be able to communicate with one another as effectively and as efficiently as possible. MedStar has made positive inroads in this area.

Perhaps more importantly, MedStar Health believes that the major benefit of a program at MFSMC, in collaboration with MGTI, to be afforded to Marylanders is the addition of sophisticated expertise in donor organ utilization to augment the number of organs available for transplantation of those on the liver waiting-list, as will be explained further in responses to Questions 20, 21 and 22.

15. Please compare the access to liver transplant services enjoyed by the target population to national benchmarks.

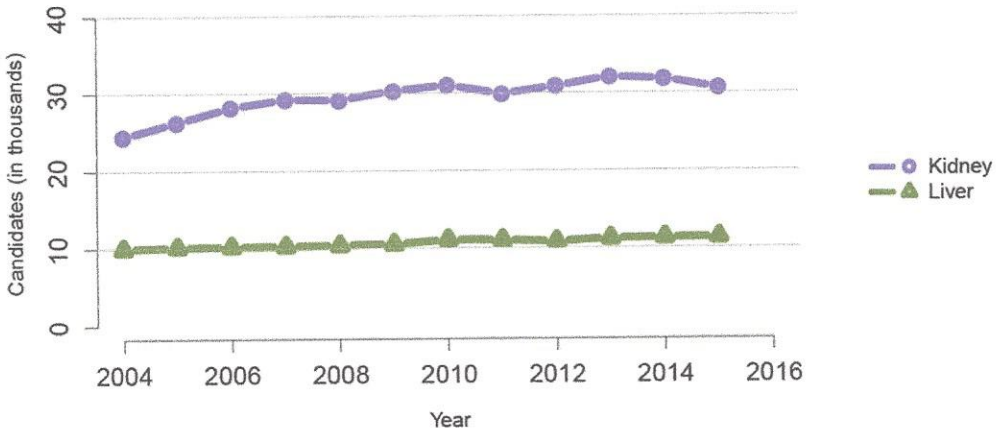
The following graphics, Figures 13 -17, all demonstrate clearly that the primary issue affecting access to transplantation is donor organ availability. Despite much effort on the part of many and various local and national organizations, organ availability has not changed over time.

The following graphics show: 1) national waiting list trend over time (Figure 13); 2) trend in the number of transplantation procedures over time (Figure 14); 3) death rate versus number of organ donors generated in the LLF OPO (Figure 15); 4) national wait list vs. transplant procedures across all organ types (Figure 16); 5) liver transplant waiting list vs. transplants performed in Maryland (Figure 17).

Access to organs. Again, because of the scarcity of the resource, access is driven by liver allocation policy, and changes have been made by UNOS from time to time as the organization strives to give those patients with the most acute need more immediate access to the very limited organ resource. The most recent change in liver allocation was finalized at the end of calendar year 2017 and will be implemented in the summer of 2018. The new proposal does not redraw existing donor service areas or regional boundaries. It does, however, provide greater allocation priority to candidates listed at hospitals within 150 nautical miles of the donor hospital, regardless of the donor service area or region where these nearby candidates are located. In this way, it provides earlier access to available livers for candidates at a greater medical priority level who are outside, but nearby to, existing regional boundaries.

FIGURE 13: NATIONAL TRANSPLANTATION WAITING LIST TREND (2004-2016)

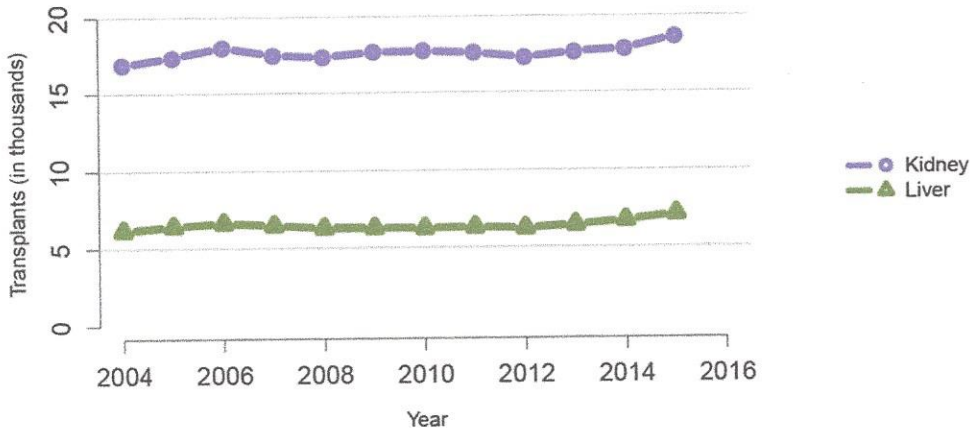
OPTN/SRTR 2015 Annual Data Report: Introduction



American Journal of Transplantation
pages 11-20, 3 JAN 2017 DOI: 10.1111/ajt.14123
http://onlinelibrary.wiley.com/doi/10.1111/ajt.14123/full#ajt14123-fig-0003

FIGURE 14: NATIONAL TREND IN TRANSPLANTATION PROCEDURES (2004-2016)

OPTN/SRTR 2015 Annual Data Report: Introduction



American Journal of Transplantation
pages 11-20, 3 JAN 2017 DOI: 10.1111/ajt.14123
http://onlinelibrary.wiley.com/doi/10.1111/ajt.14123/full#ajt14123-fig-0005

FIGURE 15: DEATH RATE vs. ORGAN DONATIONS– LLF

(January 2018)

SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS

The Living Legacy Foundation of Maryland

OPO Code: MDPC
Public Report Release: January 05, 2018
Based on Data as of: October 31, 2017

SRTR OPO-Specific Report
Feedback?: SRTR@SRTR.org
1.877.970.SRTR (7787)
http://www.srtr.org

B. US Population Density, Deaths, Death Rates, and Donations

Table B1. Measures of donation rate*, 07/01/2016 to 06/30/2017

		National		
	MDPC	Min.	Average	Max.
Eligible Deaths	220	43	195.17	570
Deceased Donors (All)	176	35	175.93	567
Deceased Donors Meeting Eligibility Criteria	155	29	137.71	428
Observed Donation Rate Per 100 Eligible Deaths	70.5	53.3	70.6	88.9
Expected Donation Rate Per 100 Eligible Deaths	67.2			
Standardized Donation Rate Ratio (95% CI)	1.05 (0.95,1.14)			
P Value	0.306			

*The donation rate is calculated as the number of deceased donors meeting eligibility criteria per 100 eligible deaths.

Figure B4. Standardized donation rate ratios (observed/expected), 07/01/2016 to 06/30/2017

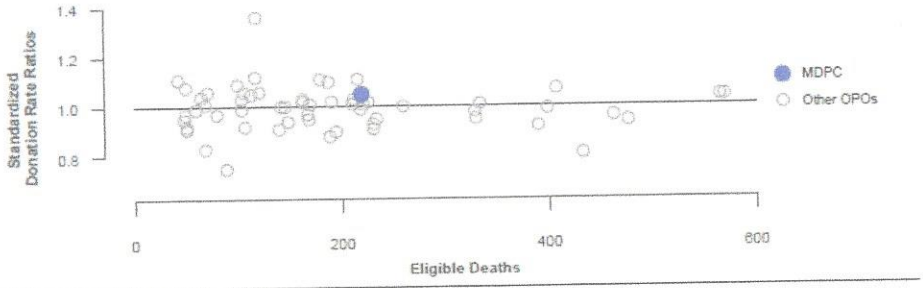
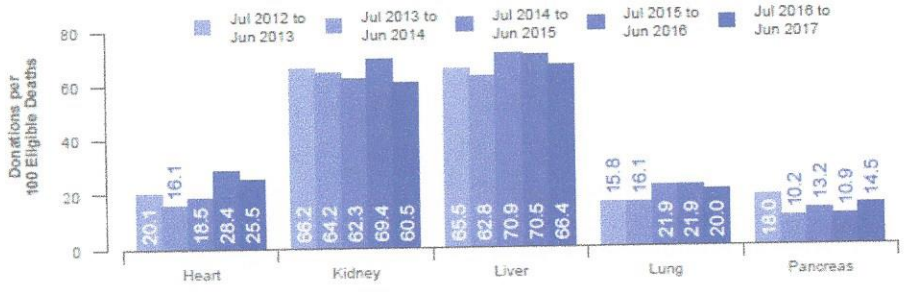


Figure B5. Donations per 100 eligible deaths, 07/01/2012 to 06/30/2017



The data reported here were prepared by the Scientific Registry of Transplant Recipients (SRTR) under contract with the Health Resources and Services Administration (HRSA).

Page: 8

FIGURE 16: NATIONAL WAITLIST BY ORGAN vs.. TRANSPLANTS PERFORMED (CY 2017)

Waiting list candidates as of today 9:51am

All ♦	115,257
Kidney	95,613
Pancreas	910
Kidney/Pancreas	1,692
Liver	13,898
Intestine	257
Heart	3,924
Lung	1,365
Heart/Lung	43

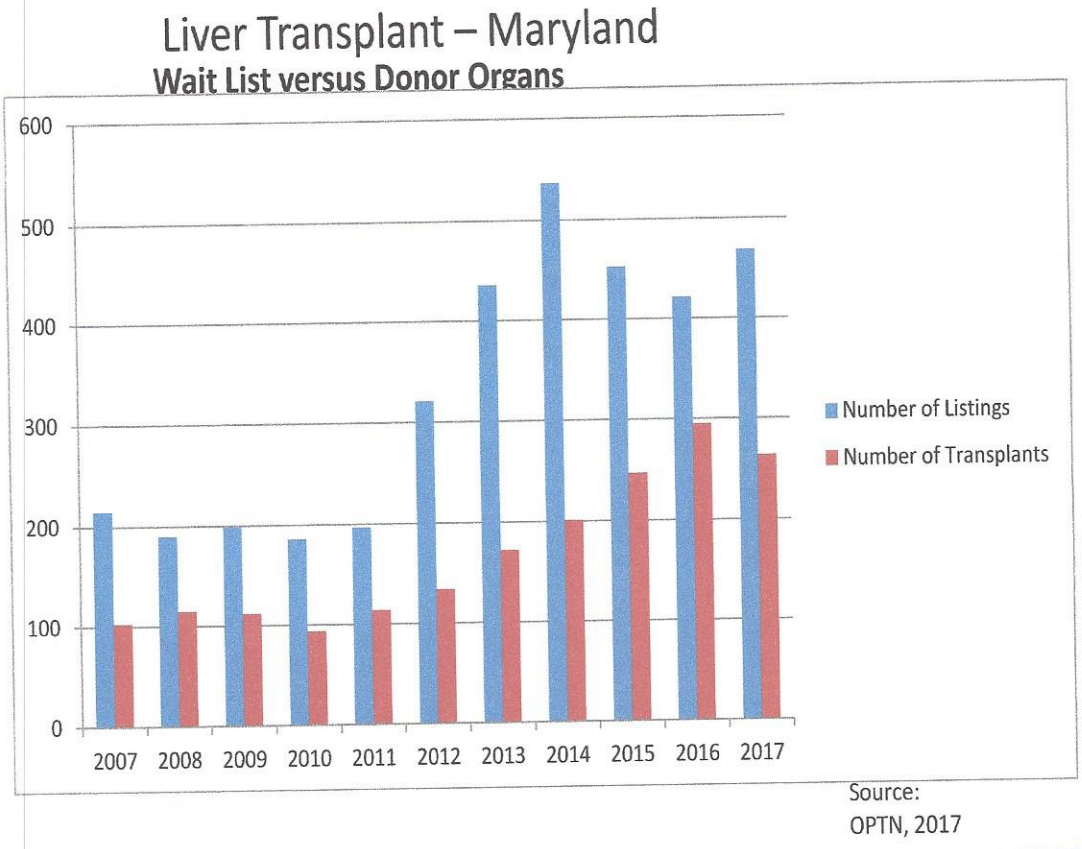
♦ *All candidates will be less than the sum due to candidates waiting for multiple organs*

Transplants performed January - December 2017

Total	34,772
Deceased Donor	28,587
Living Donor	6,185

Based on OPTN data as of 01/15/2018

FIGURE 17: LIVER WAIT LIST (Maryland) vs. DONOR ORGANS (2017)



There are no "national benchmarks" that cite the appropriate number of programs for any population base.

16. Staff does not comprehend the point made in this statement made on p. 56, speaking to the potential for volume shifts:

> *MFSMC has estimated the shift in volume from the current centers based on the number of MedStar patients referred either to JHH or UMMS for advanced liver disease evaluation. These FY15 and FY16 referrals to JHH and UMMS are estimates since referrals outside the MedStar System for these procedures were not part of the data maintained by MFSMC.*

The statement seems to say that the impact shown was based on actual "MedStar patients" referred to JHH and UMMS, but then references "estimates since referrals outside the MedStar System for these procedures were not part of the data maintained by MFSMC." These statements seem to contradict each other, which I am sure is not your intent.

MFSMC has projected the shift in volume from the current centers based on an estimate of the number of MedStar patients referred either to JHH or UMMS for advanced liver disease evaluation. The number of FYI5 and FYI6 referrals to JHH and UMMS are estimates since referrals outside the MedStar System for these evaluations were not part of the data maintained by MFSMC. The estimate was based on the knowledge of the MFSMC gastroenterology program leadership regarding these referrals.

Minimum Volume Requirements

17. The applicant failed to respond to the acknowledgements required under part (b) of this standard.

Regarding: page 59 Minimum Volume Standards.

Applicant acknowledges that if its application for a Certificate of Need is approved, it will close the program if: (i) the service is unable to sustain the minimum annual case volume for any two consecutive years and cannot 1. Provide an acceptable explanation as to why it failed to maintain the minimum case volume; and 2. To develop a credible plan for achieving the minimum annual threshold case volume that is approved; or (ii) the program fails to achieve the minimum annual case volume by a deadline established by the Commission as a result of the program's failure to achieve the minimum annual case volume requirements.

18. The application speaks to MGTI's decision to establish an Advanced Liver Disease Center at MFSMC. How many patients have been referred for liver transplants by the Advanced Liver Disease Center since its establishment?

Figure 18 shows the trend in outpatients seen at the Advanced Liver Disease Center at MFSMC, annualized through 2018.

FIGURE 18: MFSMC OUTPATIENT VOLUME

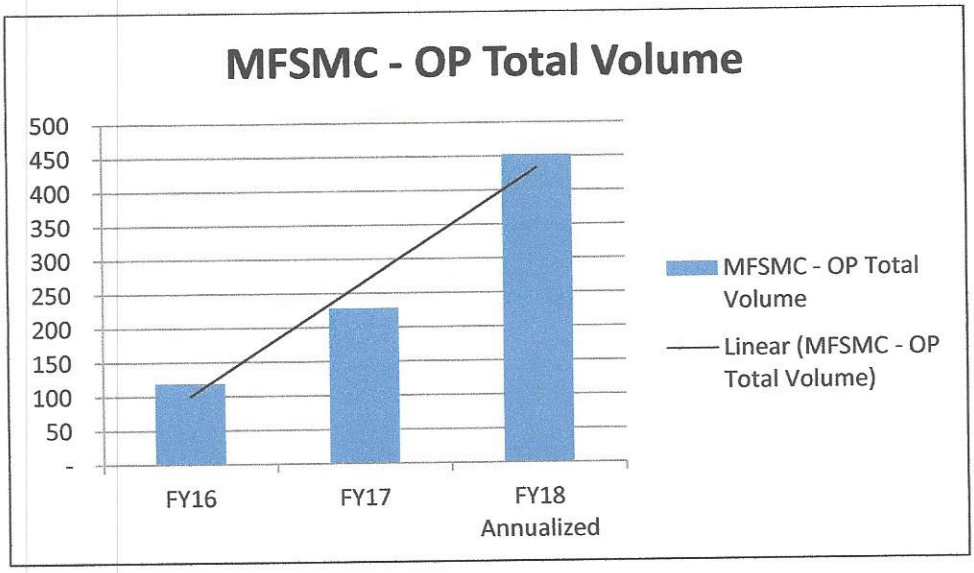
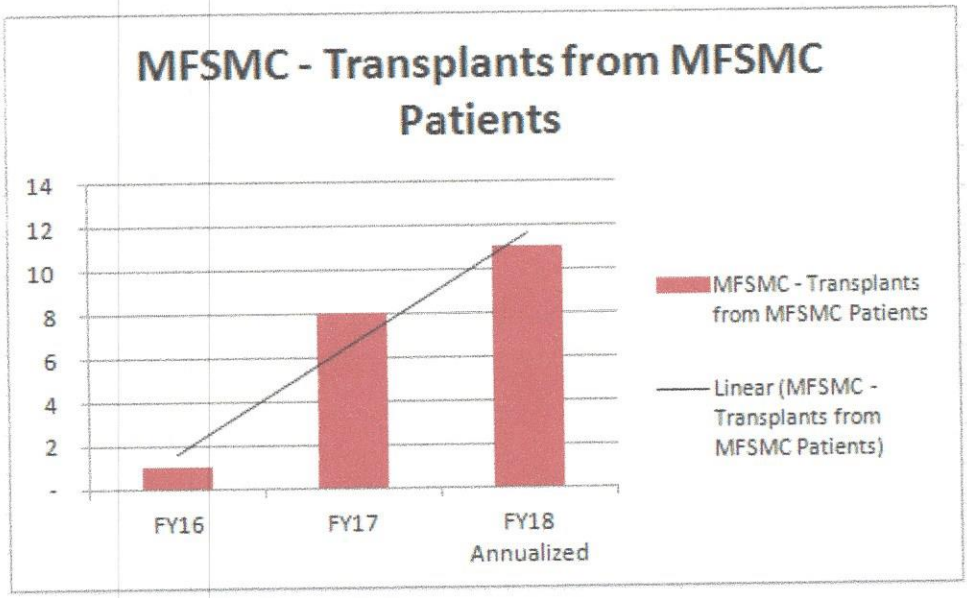


Figure 19 shows the number of patients seen at the Advanced Liver Disease Center who were transplanted since July 2017 (n=11), annualized through June 2018. Dr. Thomas Faust, a transplant hepatologist, oversees this operation.

FIGURE 19: MFSMC TRANSPLANT VOLUME



19. Figure 17 *[in the application]* projects that the program will perform 10, 14, and 30 liver transplants for FY19 through FY21; what is the basis for those projections?

Medical and administrative staff reviewed the possible volume trajectory over three years in the context of several factors including:

1) Patient safety: MGTI will carefully select patients during the first years of the program to ensure the best possible outcome after transplantation. Any patient deemed at high risk will be transferred to MGTI while the program evolves experience at MFSMC;
2) Minimum volume requirements: CMS certification requires that a new program meet a minimum volume threshold of procedures performed in order to be eligible for certification (and payment by the Medicare and Medicaid program). MGTI is aware of the need to meet the minimal requirements prior to growing extensively;
3) Minimum volume thresholds required for certification by national managed care organizations' (MCOs) Centers of Excellence (COEs) for liver transplantation programs: MCO COEs likewise have minimum volume requirements as well as minimum time frames for a program to be operational before patients will be approved for referral (and payment);
4) Community and physician outreach activities targeted toward building referral relationships: as the community becomes familiar and comfortable with the program we expect volumes to grow, while cognizant that the

growth will be incremental initially. On these bases, conservative volume projections were established.
5) MFSMC is seeing steady growth in the number of patient referrals to MGTI for transplantation since a hepatologist was deployed on-site.

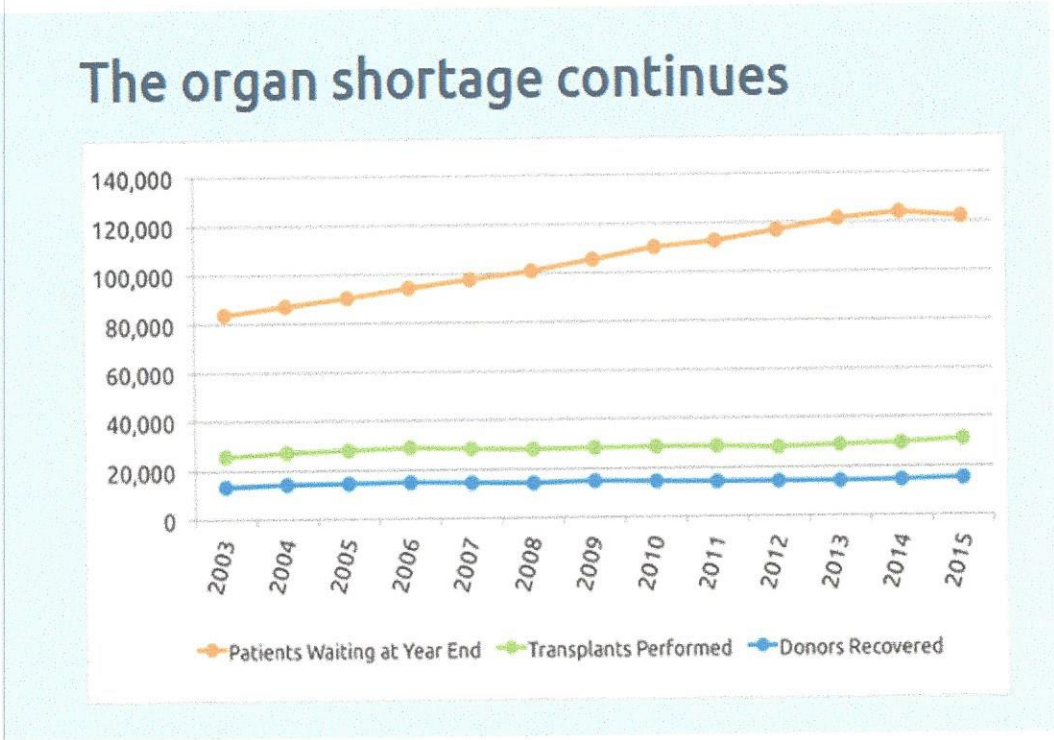
Cost Effectiveness

20. The applicant has asserted that it offers innovative surgical approaches that existing programs are not, but has not provided an analysis of whether and why existing programs cannot meet the need for the organ transplant service for the proposed population to be served, as called for in part (a) of this standard. Presenting a case that you can do more does not speak to the inability of existing programs to meet current need. It is entirely possible that your techniques indeed can offer the potential to increase output – and it can be equally true that existing programs are meeting needs. The applicant's challenge here is to show unmet need for liver transplants.

The ability to meet the need for the number of patients requiring transplantation of any organ is driven by the availability of organs– widely acknowledged to be inadequate to meet the need. No program is "meeting the need" as shown in Figure 20 below. MedStar Health believes that its level of sophistication in applying advanced innovative techniques such as "split liver" procedures that permit transplantation of more than one individual with a single donor organ, augment the available donor organ pool. Other strategies, outlined below the graphic in Figure 20 also contribute substantially to increasing the number of organs available for transplantation.

FIGURE 20: NATIONAL DATA ON ORGAN SUPPLY VS. DEMAND BY CALENDAR YEAR (2003 – 2015)

National Data on Organ Supply v. Demand by Calendar Year



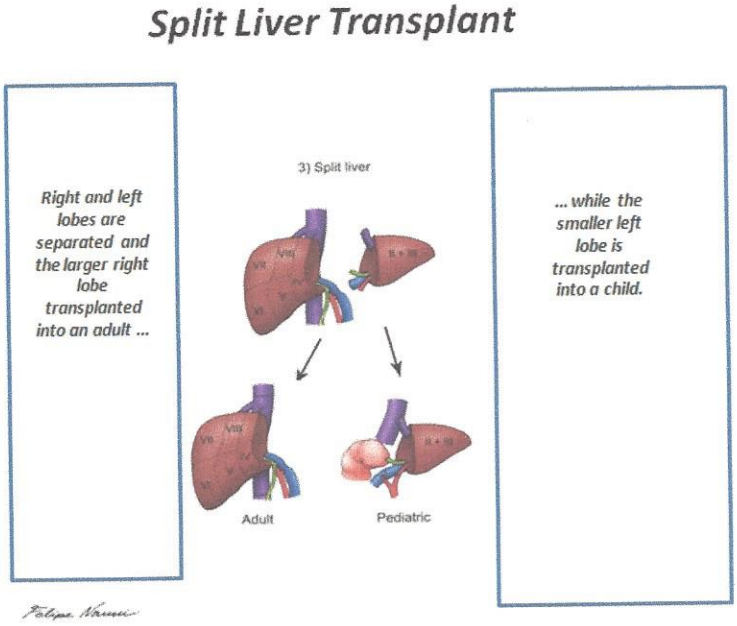
Source: https://optn.transplant.hrsa.gov/need-continues-to-grow/

As has been stated, the MedStar Health program at MGTI has made successful inroads in addressing need in certain patient populations by:

- ***creating protocols to lessen the waiting times for transplantation,***
- ***by forwarding new, advanced techniques such as "split liver" transplantation to make a greater number of transplants possible with fewer organs,***
- ***by being attentive to the special needs of the minority population (see graphics under Question 35) and,***
- ***by judiciously matching donor and recipient characteristics so as to utilize every organ, even those that are imperfect.***

Split Liver Transplantation. In this procedure, the largest segments of the liver are separated and the segmented lobes are then transplanted into two individual recipients; typically the smaller segment going to the smaller recipient (i.e., a child or small adult) while the larger to an adult. Figure 21 is a depiction of the procedure.

FIGURE 21 *(Figure 8, page 47 application)*: **SPLIT LIVER PROCEDURE DIAGRAM**



Specific to split liver procedures performed at MFSMC, the extensive experience with pediatric transplantation at MGTI, will enable adult patients at MFSMC to have access to the larger right lobe of donor organs where the smaller lobe has been used in a child or small adult. Only programs experienced with splitting livers are capable of using one organ in two (or three in the case of split domino) recipients. For example, if a liver becomes available for the highest-ranked candidate on the waiting list, who happens to be a child or small adult that can only accommodate a portion of a full organ because of size, the surgeon at MGTI will evaluate whether there is another patient for whom the larger portion of the organ can be used. Because the surgeon has knowledge of the liver anatomy (e.g., size, blood vessel distribution) of every recipient candidate on the waiting list, he can appropriately divide the organ in a manner that is both beneficial – and safe – for both recipients and that, importantly, will result in an optimal outcome for each. Programs not experienced with splitting livers may discard the portion of the organ not used in the smaller recipient. As neither existing program in the Baltimore region is experienced in split liver transplantation, the scenario described – one that provides two or three recipients with organs - does not occur.

Waiting Time to Transplant. Notable also, is the fact that MGTI has the shortest waiting time to transplant, as shown on page 12 of the application and below in Figure 22.

FIGURE 22 *(page 12 application)*: **TIME TO TRANSPLANT: MGUH vs. JHH VS. UMMS**

TIME TO TRANSPLANT
(Months waiting on list)

SRTR April 2017	MGTI	JHH	UMMS
25th percentile	1.7	5.9	1.5
50th percentile	7.8	Not observed *	14.0

** "Not observed" means that less than that percentile of patients had received a transplant, e.g., more than 50% of patients waiting have not received a transplant during the follow up period or were removed because of death or other reasons. (Source: SRTR April 2017). In other words, the wait time is so long, it cannot be quantified further here.*

We believe that the MGTI successes in addressing "need", as described in the application and summarized above, can be implemented at MFSMC so as to expand the opportunity for more Maryland patients to receive viable organ transplants.

21. Your response to part (a) of this standard refers to "innovative surgical approaches (that) offer additional options to patients that existing programs cannot serve." Reiterate what these "innovative surgical techniques" are, and how they create ability to meet needs others are unable to meet.

As described in the response to Question 20, split liver and split domino liver transplant are innovative techniques pioneered at MGTI by Dr. Thomas Fishbein that effectively expand the utilization of an individual donor organ to more than one recipient. In other words, through these procedures, the available organ, divided into segments, can be effectively transplanted into more than one recipient. These procedures are not performed in the Baltimore programs currently. For reference, the following article Elsabbagh, AM, Williams, C, Girlanda, R, Hawksworth, J, Kroemer, A, Matsumoto, CS, Fishbein, TM. The impact of intercenter sharing on the outcomes of pediatric split liver transplantation. Clin. Transplant. 2017 Dec; 31(12). The article demonstrates that split liver allows expansion of the pool of organs available for transplant when performed by the same team. As has been commented, once the program at MFSMC is established, all patients will be offered double-listing at both LLF and WRTC. Effectively then, donor livers presenting to either OPO that are deemed suitable for splitting, can be very efficiently allocated to more patients on the waiting list, rather than jeopardizing discard of a portion of the liver by a program that is not experienced with this procedure. Obviously, the process

requires very sound judgment and extensive experience – qualities inherent to the MGTI team.

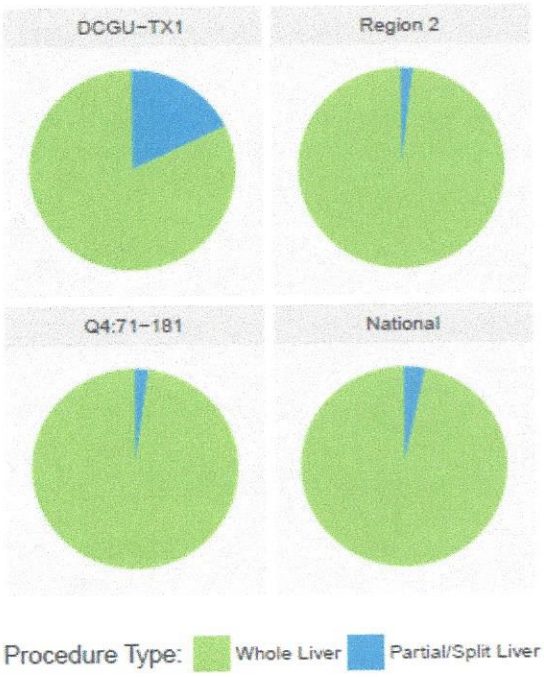
The rate of split liver transplants at MGTI is far greater than the national average among liver transplant programs as depicted in the graphic below that shows the percentage of all liver transplant procedures that were split liver procedures performed at MGTI versus Region 2 and nationally. As Figure 23 below indicates, in CY2016 17.98% of liver transplants at MGTI were split liver transplants compared to only 2.09% in our Region 2 and 3.49% nationally. MGTI's expertise in split-liver transplants enables it to make a significant contribution to the supply of donor organs and will be available immediately at MFSMC.

FIGURE 23 ***(Figure 9, page 48 application)*****: WHOLE (Green) vs. SPLIT LIVER (Blue) PROCEDURES: MGUH VS. REGION 2 vs. NATION**

Benchmark Report | Liver

DCGU-TX1 April 2017

Figure 11. Procedure Type as of April 7, 2017



Procedure Type (%)

	DCGU-TX1	Region 2	Q4:71-181	National
Whole Liver	82.02	97.91	97.76	96.51
Partial/Split Liver	17.98	2.09	2.24	3.49
Total	100.00	100.00	100.00	100.00

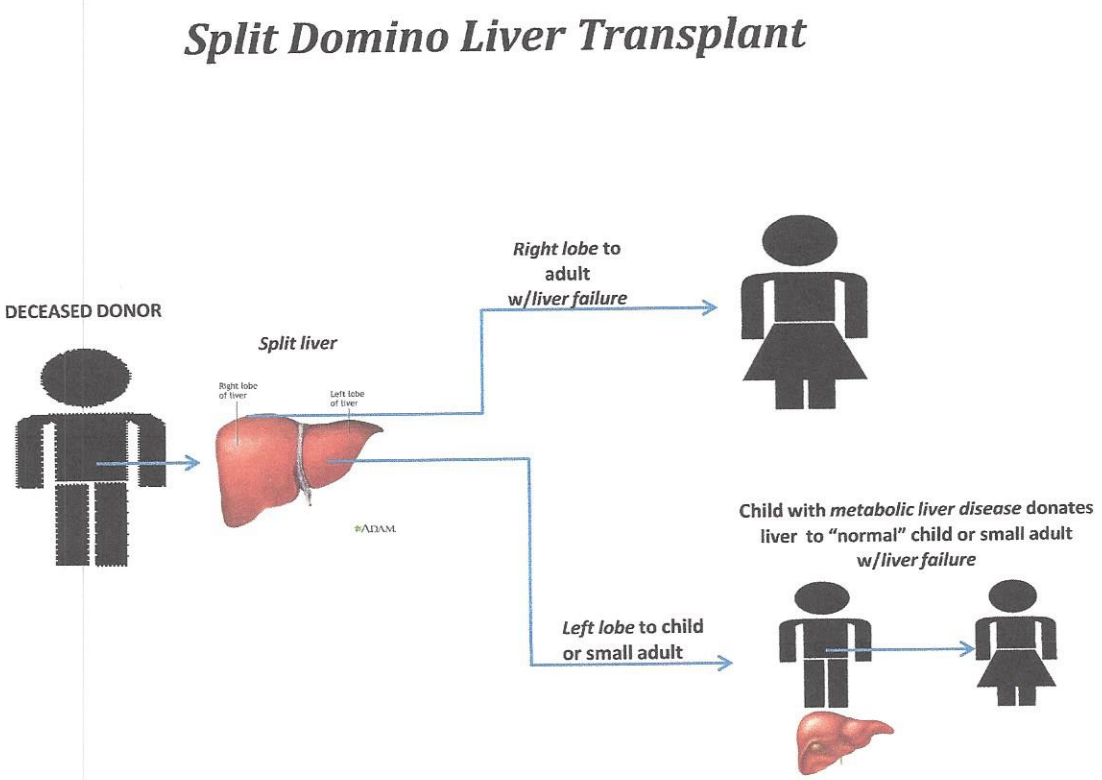
Figure 11 shows the distribution of procedure type for deceased donor liver transplants between January 1, 2016 and December 31, 2016. Nationally, most procedures were Whole Liver (96.51%).

Source**: *http://www.srtr.org. Note that "DCGU-TX1" refers to the MedStar Georgetown Transplant Institute.***

Split Domino Liver Transplantation**. *Domino Liver Transplantation is another original approach for expanding available organs to more individuals in need. In this procedure, a single organ from a deceased donor is segmented; the larger right lobe is transplanted into an adult recipient with liver failure while the smaller left lobe is placed in a child who needs a transplant because of genetic metabolic disease. The affected child's liver is then transplanted into a patient without the abnormal genetic defect with a successful outcome. This domino effect enables one donor***

liver to provide life saving organ access to three people. Larger children and adults can also participate in these stepped down donation processes by donating their livers at the time of transplant to another adult; GUH has performed many adult domino transplants. Figure 24 provides a graphical representation.

FIGURE 24 *(Figure 11, page 50 application)*: **SPLIT DOMINO LIVER DIAGRAM**

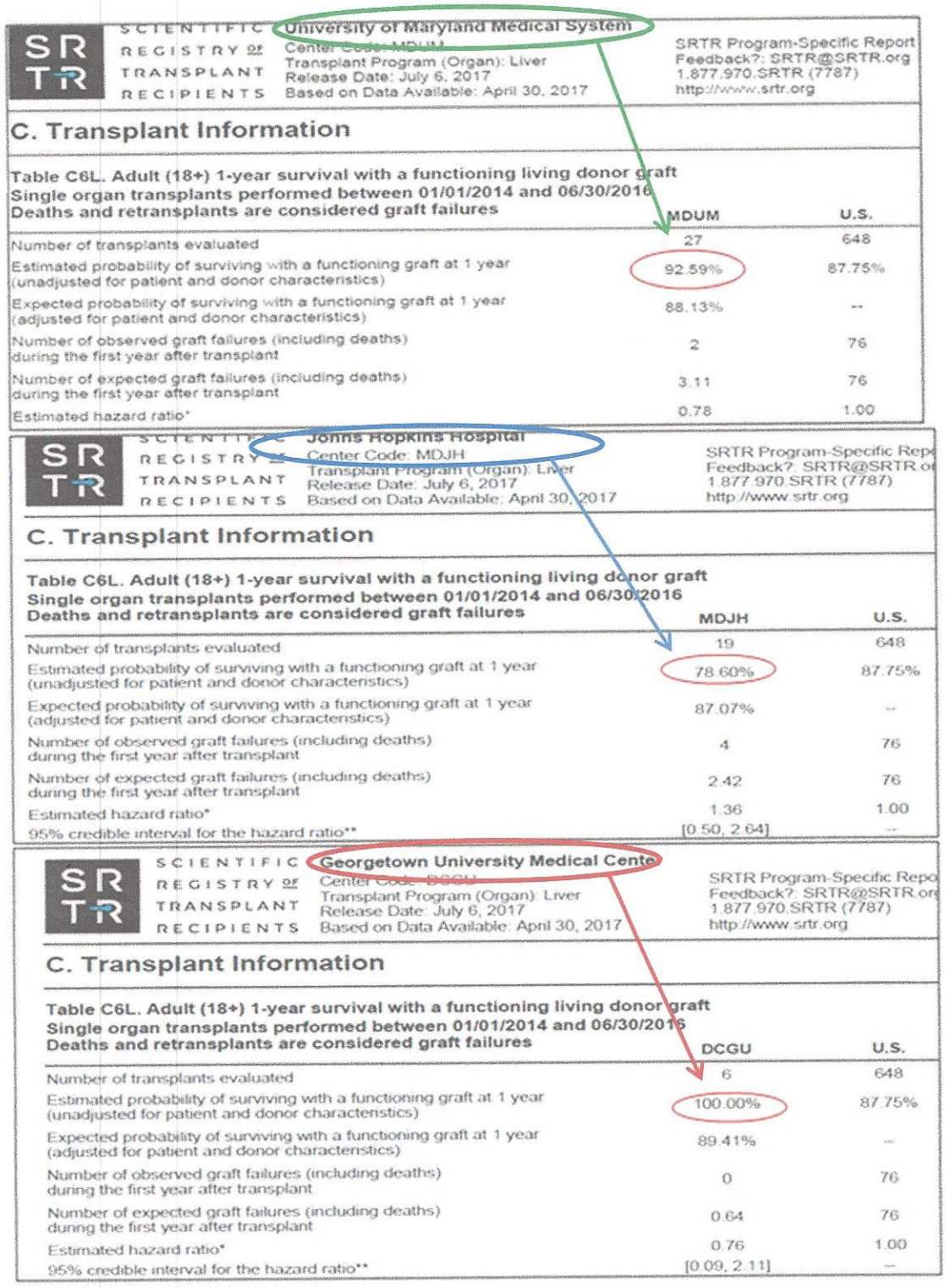


MGTI has successful experience with this technique and together with split liver procedures will enable the program at MFSMC to increase the supply of deceased donor organs in the region. The link below is to an article published in the Washington Post (attached) in 2015 that provides "real life" examples of the tremendous benefit of this procedure:
https://www.washingtonpost.com/national/health-science/how-rare-maple-syrup-urine-disease-led-to-transplants-and-saved-lives/2015/03/30/b39329c6-ce46-11e4-8a46-b1dc9be5a8ff_story.html?utm_term=.55519b015b3c

Living Donor Transplantation. MFSMC will offer living donor transplantation, initially through MGTI, and over time, on-site (MGTI is currently recruiting an additional surgeon experienced in living donor procedures to augment surgical strength in this area). Because the liver

has the unique ability to regenerate to full size over time after removal of a segment, living donor transplantation has become a viable option for individuals who have a relative or friend who is a suitable match and is willing to donate part of his or her organ. MGTI has 100% patient and graft survival for its living donor transplant procedures in a context of an "expected probability of survival" in the Baltimore region of 89.41%, and a national average of 87.75% (SRTR April 2017). See survival data related to living donor transplantation for the three centers in the Baltimore-Washington area pictured below in Figure 25.

FIGURE 25 *(Figure 12, page 52 in application)*: LIVING DONOR LIVER TRANSPLANT SURVIVAL COMPARISON



SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS
University of Maryland Medical System
Center Code: MDUM
Transplant Program (Organ): Liver
Release Date: July 6, 2017
Based on Data Available: April 30, 2017
SRTR Program-Specific Report
Feedback?: SRTR@SRTR.org
1.877.970.SRTR (7787)
http://www.srtr.org

C. Transplant Information

Table C6L. Adult (18+) 1-year survival with a functioning living donor graft
Single organ transplants performed between 01/01/2014 and 06/30/2016
Deaths and retransplants are considered graft failures

	MDUM	U.S.
Number of transplants evaluated	27	648
Estimated probability of surviving with a functioning graft at 1 year (unadjusted for patient and donor characteristics)	92.59%	87.75%
Expected probability of surviving with a functioning graft at 1 year (adjusted for patient and donor characteristics)	88.13%	--
Number of observed graft failures (including deaths) during the first year after transplant	2	76
Number of expected graft failures (including deaths) during the first year after transplant	3.11	76
Estimated hazard ratio*	0.78	1.00

SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS
Johns Hopkins Hospital
Center Code: MDJH
Transplant Program (Organ): Liver
Release Date: July 6, 2017
Based on Data Available: April 30, 2017
SRTR Program-Specific Report
Feedback?: SRTR@SRTR.org
1.877.970.SRTR (7787)
http://www.srtr.org

C. Transplant Information

Table C6L. Adult (18+) 1-year survival with a functioning living donor graft
Single organ transplants performed between 01/01/2014 and 06/30/2016
Deaths and retransplants are considered graft failures

	MDJH	U.S.
Number of transplants evaluated	19	648
Estimated probability of surviving with a functioning graft at 1 year (unadjusted for patient and donor characteristics)	78.60%	87.75%
Expected probability of surviving with a functioning graft at 1 year (adjusted for patient and donor characteristics)	87.07%	--
Number of observed graft failures (including deaths) during the first year after transplant	4	76
Number of expected graft failures (including deaths) during the first year after transplant	2.42	76
Estimated hazard ratio*	1.36	1.00
95% credible interval for the hazard ratio**	[0.50, 2.64]	--

SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS
Georgetown University Medical Center
Center Code: DCGU
Transplant Program (Organ): Liver
Release Date: July 6, 2017
Based on Data Available: April 30, 2017
SRTR Program-Specific Report
Feedback?: SRTR@SRTR.org
1.877.970.SRTR (7787)
http://www.srtr.org

C. Transplant Information

Table C6L. Adult (18+) 1-year survival with a functioning living donor graft
Single organ transplants performed between 01/01/2014 and 06/30/2016
Deaths and retransplants are considered graft failures

	DCGU	U.S.
Number of transplants evaluated	6	648
Estimated probability of surviving with a functioning graft at 1 year (unadjusted for patient and donor characteristics)	100.00%	87.75%
Expected probability of surviving with a functioning graft at 1 year (adjusted for patient and donor characteristics)	89.41%	--
Number of observed graft failures (including deaths) during the first year after transplant	0	76
Number of expected graft failures (including deaths) during the first year after transplant	0.64	76
Estimated hazard ratio*	0.76	1.00
95% credible interval for the hazard ratio**	[0.09, 2.11]	--

Transferrable expertise. ***MGTI has extensive experience in transplanting pediatric patients (MGTI is the second largest pediatric liver and largest***

small bowel program in the country), a relatively far more complex subset population than adults. Again, in terms of expertise in managing complex patients (combined organ transplants in adults and children and innovative split liver procedures), MGTI outperforms the Baltimore area regional and national norms.

22. Please respond to part (b) of this standard describing the "added benefit(s)" with specificity rather than with a broad cross-reference to other parts of the application.

Specific areas of added benefits include the following: MFSMC operating charges are lower than either JHM or UMMS by 27% and 49% respectively (Average charge per ECMAD comparison) and by 55% and 33% respectively (Average charge per case comparison). Source: HSCRC Abstract Tapes.

- *Because of its affiliation with the well-established MedStar Georgetown Transplant Institute (MGTI), the program at MFSMC will enjoy certain efficiencies in operation secondary to integration with the larger operation (data analysis, quality management administrative oversight) and thus operate at lower overhead than either JHM or UMMS programs while also being advantaged programmatically by the academic research platform upon which MGTI operates.*
- *Transferrable expertise. Deep experience with transplanting complicated patients, including the most complicated – pediatric – cases, means that the MGTI program at MFSMC will be comfortable and successful with managing any clinical situation that presents, from simple to complex.*
- *Referring gastroenterologists and internists in the community are highly supportive of the addition of the MGTI program (see letters of support); they have expressed that they view the program as providing a level of commitment to long-term patient management that is missing among providers currently.*
- *Enabling patients to stay within the MedStar system of care locally, for all associated medical issues, saves the healthcare system– and the patient– dollars, through strict utilization management, effective transitions in care, risk and illness stratification and care coordination overall.*

23. Part (c) of this standard asks the applicant to quantify the expected benefits over a five-year period. Please explicitly do so.

A. The benefits listed in Question 22 will be magnified over time.

B. Relative to actual cost savings, MFSMC believes that its lower cost environment of care, collaboration with MGTI toward keeping fixed costs at a minimum and judicious patient selection, particularly at program initiation, will result in substantial savings to the system that will accrue over time as volume builds.

C. Finally, there are certain avoidable costs that can benefit the system as a result of additional transplants performed at MFSMC. Patients with costly advanced liver diseases that include cancers, viral disease,

cirrhoses and their clinical sequelae are obviated with transplantation. Although it is difficult to quantify precisely the associated savings, the literature indicates that these are significant.

Source: Hospitalizations and costs associated with Hepatitis C and Advanced Liver disease continue to increase. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2014.0096

Impact

24. Please respond to each subpart of this standard in turn. As stated in this letter's opening, cross-referencing other parts of the application, at least without very specific reference, leaves too much risk that your point may be missed or misconstrued.

a) Regarding: volume impact on existing programs: Figure 26 shows that JHM and UMMS volumes both substantially exceed the MHCC thresholds and migration of a few cases to the MFSMC program will have an immaterial impact on those programmatic volumes.

FIGURE 26 *(Figure 14, page 56 in application)*: LIVER TRANSPLANT VOLUME IMPACT: UMMS and JHH

Liver Transplants
University of Maryland/Johns Hopkins
Actual Adult Volume to Minimum Annual Case Volume Standard

		UMMS					JHH				
Metric	Minimum Volume	CY12	CY13	CY14	CY15	CY16	CY12	CY13	CY14	CY15	CY16
Liver	12	86	90	115	146	169	41	79	84	95	122
Variance from Min.	-	74	78	103	134	157	29	67	72	83	110
% Variance from Min.	-	617%	650%	858%	1117%	1308%	242%	558%	600%	692%	917%

Source: https://optn.transplant.hrsa.gov/data/view-data-reports/state-data/

b) Regarding: the financial impact on existing programs: MedStar's intention is not to create a negative impact on any existing program, but rather to improve upon the number of transplants performed overall. Under this scenario, we would expect that the existing programs would be able to replace the small number of cases with additional transplant volume.

c) Regarding the adverse impact on access, quality or outcomes of other programs: It is inconceivable that the MFSMC program would have any negative impact on these areas. Since each transplant program operates independently in terms of operational and clinical management, each is responsible for maintaining its own standards and protocols.

(d) (i) Regarding the estimated volume migration from existing programs: MFSMC migration estimates are presented in the following

table, Figure 27. It shows the current state of referrals from the Baltimore region to local programs (first row) and to MGTI in Washington (second) row on the left side under grey-shaded columns. The columns on the right estimate the change in those referrals to local programs and MGTI in Washington as the MFSMC program evolves.

FIGURE 27 *(Figure 15, page 57 in application)*: **LIVER TRANSPLANT VOLUME SHIFTS: JHH/UMMS**

Projected Liver Transplant Volume Shift
MedStar Health & JHH/UMMS
FY15-FY21 Projected

Metric	Actual[1] FY15	Actual[1] FY16	Annualized FY17	Proj. FY18	Program Years FY19	FY20	FY21
Referrals to JHH and UMMS	9	10	5	2	0	0	0
Referrals to MGTI (Washington, DC)	3	3	6	12	5	2	2

[1]FY15-FY16 referral to JHH and UMMS are estimates
Source: MGTI Internal Data, MFSMC estimates for referrals to JHH/UMMS for FY15 and FY16
Note: Data compiled before full-year FY17 actual data available

(d) (ii) Regarding the impact on access for the population within a 3-hour drive: Access will be improved for individuals across the state of Maryland as they will have access to another program closer to the communities in which they reside, in particular, one that provides for additional expertise in organ acquisition and distribution, i.e., advanced procedural skill and judicious attention to matching individual patient characteristics.. MedStar's outreach sites in Frederick, MFSMC and Annapolis are all experiencing growth in the volume of patient visits as patients access these sites (see graphic under Q. 27). The program at MFSMC provides another direct link to transplantation services within the same system of care.

(d) (iii) Regarding the impact on quality of care for population within a 3-hour drive: The same quality of care will be provided at MFSMC as is provided currently at MGTI in Washington as the same standards, protocols, systems of care and monitoring will be applied.

The following narrative and graphic taken from the SRTR web site explain CMS's newest 5-tier ranking system for quality. The 5-tier ranking system was implemented in order to enable prospective patients to better discrimate among program quality.

Source: https: srtr.org. Understanding SRTR's Outcome Assessment
Summarizing transplant program performance using a 5-tier system; A Guide for Patients

Quoted from the SRTR website:

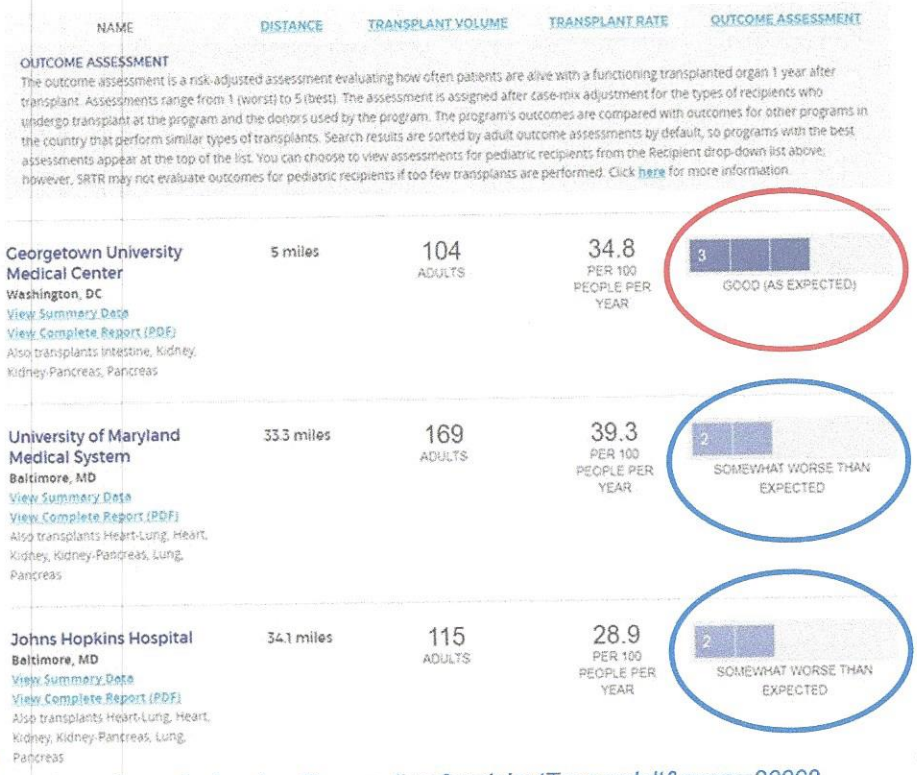
"While considering guidance from the Agency for Healthcare Research and Quality (AHRQ), we developed the 5-tiered outcome assessment system to make it easier for the general public to understand and compare the outcomes of different transplant programs. This is in alignment with the reporting requirements of the OPTN Final Rule, which states that OPTN and SRTR, as appropriate, shall 'Make available to the public timely and accurate program-specific information on the performance of transplant programs. This shall include free dissemination over the Internet, and shall be presented, explained, and organized as necessary to understand, interpret, and use the information accurately and efficiently'. *(OPTN Final Rule 121.11(b)(iv)).* ***Further in fulfillment of the Final Rule, the SRTR contractor must identify transplant programs and organ procurement organizations with better or worse outcomes (SRTR Task 3.9.1)." Figure 28 below shows the ranking system across all organ transplant types.***

FIGURE 28: NUMBERS OF ADULT TRANSPLANT PROGRAMS IN EACH OF THE 5-TIER ASSESMENT SYSTEM CATEGORIES

Transplant Type	Tier 1 (Worse than Expected)	Tier 2 (Somewhat Worse than Expected)	Tier 3 (Good, As Expected)	Tier 4 (Somewhat Better than Expected)	Tier 5 (Better than Expected)
Heart	8	16	44	47	8
Kidney	12	52	78	61	30
Liver	5	32	40	37	10
Lung	3	17	22	20	5

Figure 29 shows actual tier rankings for MGTI at Georgetown University Hospital (3/5: Good, As Expected) versus UMMS (2/5: Somewhat worse than expected) versus JHH (2/5: Somewhat worse than expected).

FIGURE 29: TIER-RANKINGS: MGUH vs. UMMS vs. JHH



NAME	DISTANCE	TRANSPLANT VOLUME	TRANSPLANT RATE	OUTCOME ASSESSMENT

OUTCOME ASSESSMENT
The outcome assessment is a risk-adjusted assessment evaluating how often patients are alive with a functioning transplanted organ 1 year after transplant. Assessments range from 1 (worst) to 5 (best). The assessment is assigned after case-mix adjustment for the types of recipients who undergo transplant at the program and the donors used by the program. The program's outcomes are compared with outcomes for other programs in the country that perform similar types of transplants. Search results are sorted by adult outcome assessments by default, so programs with the best assessments appear at the top of the list. You can choose to view assessments for pediatric recipients from the Recipient drop-down list above; however, SRTR may not evaluate outcomes for pediatric recipients if too few transplants are performed. Click here for more information.

Georgetown University Medical Center Washington, DC View Summary Data View Complete Report (PDF) Also transplants Intestine, Kidney, Kidney-Pancreas, Pancreas	5 miles	104 ADULTS	34.8 PER 100 PEOPLE PER YEAR	3 GOOD (AS EXPECTED)
University of Maryland Medical System Baltimore, MD View Summary Data View Complete Report (PDF) Also transplants Heart-Lung, Heart, Kidney, Kidney-Pancreas, Lung, Pancreas	33.3 miles	169 ADULTS	39.3 PER 100 PEOPLE PER YEAR	2 SOMEWHAT WORSE THAN EXPECTED
Johns Hopkins Hospital Baltimore, MD View Summary Data View Complete Report (PDF) Also transplants Heart-Lung, Heart, Kidney, Kidney-Pancreas, Lung, Pancreas	34.1 miles	115 ADULTS	28.9 PER 100 PEOPLE PER YEAR	2 SOMEWHAT WORSE THAN EXPECTED

Source http://beta.srtr.org/transplantcenters/?organ=liver&recipientType=adult&query=20002

(e) MFSMC agrees that if a transplant service of the same organ type has been designated as member not in good standing by the Organ Transplant and Procurement Network, then the potential adverse impacts of the proposed new or relocated organ transplant service on such a program may be disregarded, at the discretion of the Commission.

25. Given the applicant's estimate that only a small number of its prospective cases will be drawn from existing providers, please discuss whether the patients projected to be served are patients who are currently leaving the area, patients who are not currently receiving transplants, etc.

MGTI is performing liver transplants currently on Baltimore area residents that could be performed at MFSMC. Moreover, MGTI is seeing a growth in patients wait-listed and transplanted since its initiation of seven outreach sites including those in Frederick, Annapolis and especially at its hospital outreach sites at MedStar MFSMC since offering and advanced liver disease center on-site. The service expanded effective January 1st and more patients have been listed and transplanted as a result of the

increased availability of outpatient services as well as the inception of an inpatient consult service.

By expanding the donor pool through the methods described earlier, the new program will make a positive impact on the community, moving more patients to successful outcome after transplantation. MedStar has also heard directly from gastroenterologists in the community that they support and welcome MedStar Health as a provider of these services locally. They have told us that they are often burdened with the long-term management of these patients, a responsibility which they do feel is neither appropriate nor comfortable since they do not have advanced training in transplantation or immuno-suppression management. MGTI takes very seriously its long-term commitment to the patients that it transplants and although welcomes participation in care by community physicians, never wishes to abrogate ultimate responsibility for the long-term success of both the patient and his/her graft.

26. If a) an average liver transplant charge per case at Johns Hopkins Hospital is $230,871, and is $198,464 at UMMS; and b) MFSMC projects an annual ten-case decline from each of the two Baltimore centers, then JHH and UMMS would lose at least $2,308,710 and $1,984,640 respectively in liver transplant revenues (not including any lost revenue from kidney transplants, should that application be approved). Does MFSMC mean to say that that revenue decline would not have an adverse impact on the financial viability of either JHH's or UMMS' existing kidney and liver transplant programs?

Regarding the financial impact on existing programs, MedStar's intention is not to impact negatively any existing program, but rather to improve upon the number of transplants performed overall. Under that scenario, we would expect that the existing programs would be able to replace the small number of cases with additional transplant volume.

Health Promotion and Disease Prevention

27. Providing some quantification of the work and results of the seven transplant outreach clinics referenced in the application would strengthen MHCC's understanding of these efforts. Once again, the cross-reference to another standard leaves too much opportunity for misunderstandings; in addition, that standard addresses a totally different topic (need).

Figure 30 shows 1) the growth in visit volume to MedStar's transplant program outreach sites in Baltimore, Annapolis and Frederick locations since their inception Local physicians in these areas have been extremely receptive to the closer evaluation and follow up venue for their patients, which is convenient for both and enables frequent, face-to-face communication between transplant and referring hepatologists.

Outpatient volumes in the Advanced Liver Disease Clinic expanded by over 100% between FY 2016 and 2017 and are expected to exceed these numbers by year-end 2018.

The inception of the inpatient consultation service on January 1, 2018, was compelled by demand from local physicians to have these patients cared for at MFSMC rather than transferred. Consultations have been growing steadily as have referrals for evaluation, including transplantation. Cases transplanted at MGTI this fiscal year are growing steady also as noted in Figure 19, page 36 of this document.

FIGURE 30: MEDSTAR HEALTH TRANSPLANT OUTREACH SITES BALTIMORE REGION: VOLUME (2014 – 2017)

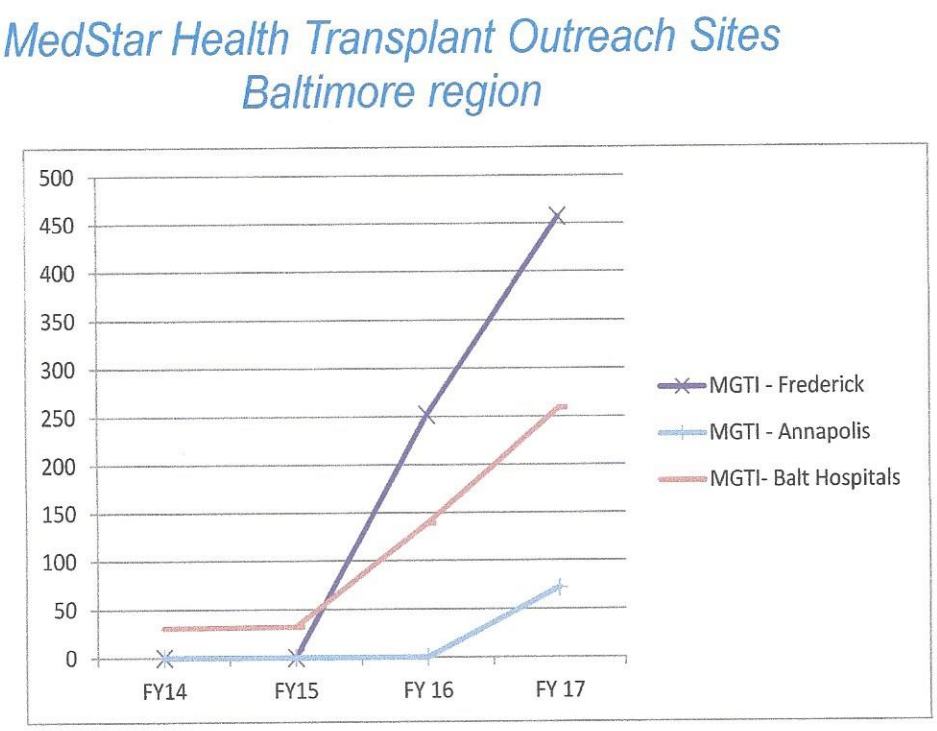


Figure 31 shows actual volumes across all outreach centers.

FIGURE 31: MGTI OUTREACH SITES ACTUAL VOLUMES (FY 14 – FY 17)
Actual volumes (FY 14 – FY 17):

		FY 14	FY 15	FY 16	FY 17
MGTI - WHC		2679	2682	3014	3398
MGTI - Frederick		0	0	252	457
MGTI - MFSMC		0	13	119	240
MGTI - Annapolis		0	0	0	72

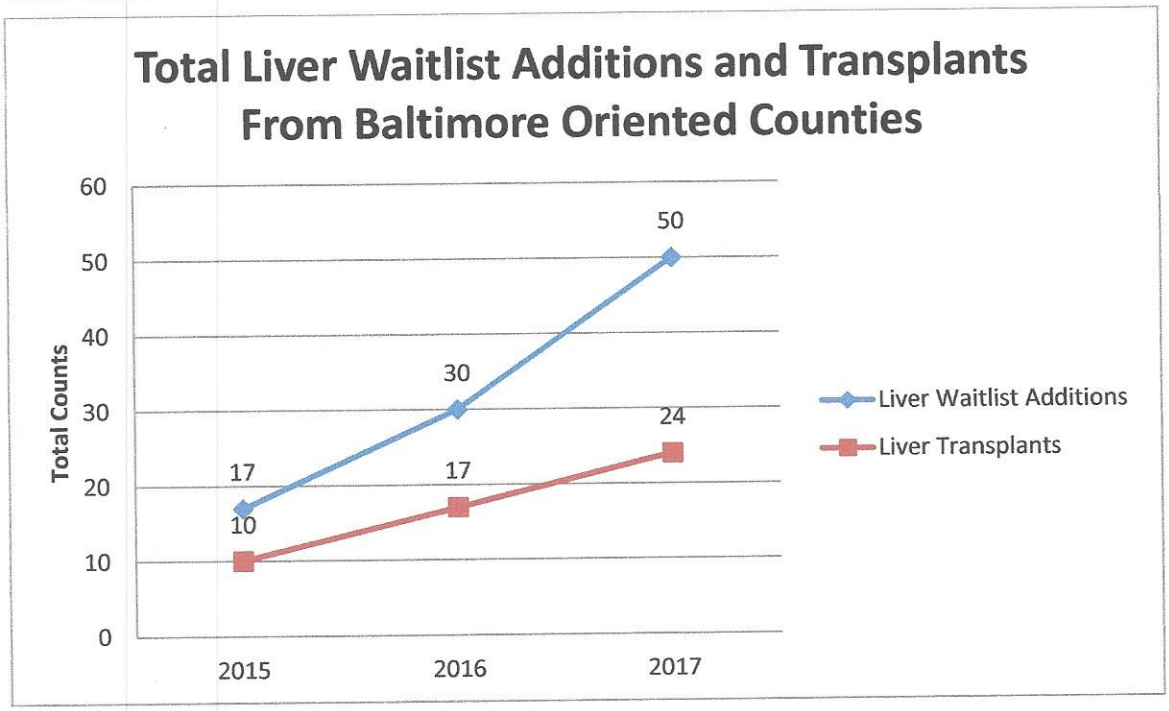
NEED

28. MedStar's summation of its "need case" on p. 73 speaks to its innovation, clinical research, success in reaching minority populations, potentially lower costs, and focus on population health. While these are valid points for an applicant to make somewhere in its application, they do not speak to subjects that the NEED criterion asks an applicant to address. As required by this criterion please:
    a) Define the existing and/or intended service area population. The applicant should clearly identify the proposed service population for the liver transplant program.

    MFSMC expects to primarily serve residents of Central Maryland (Baltimore City/County, Anne Arundel County, Carroll County, Harford County, and Howard County) and Frederick County. This geography includes the service areas of the four Baltimore MedStar Hospitals (MedStar Franklin Square, MedStar Good Samaritan, MedStar Harbor, and MedStar Union Memorial) and the locations of MedStar Advanced Kidney and Liver Disease Clinics (Baltimore County, Anne Arundel, Frederick, Howard, Prince George's, Calvert, Charles and St. Mary's counties). MedStar believes that more patients from these counties will receive liver transplants as a result of MGTI innovation and advanced surgical techniques that will augment the pool or available organs.

Figure 32 shows the 3-year trend in patients residing in Baltimore region added to the MGTI waiting list or transplanted there. While patients can continue to travel to Washington for the services desired at that site, MedStar Health proposes to provide for care closer to home.

FIGURE 32: *MGTI WAIT LIST ADDITIONS: BALTIMORE COUNTIES*



Source: Internal MedStar database: Anne Arundel, Baltimore, Calvert, Carroll, Charles, Frederick Harford, Howard, St. Mary's Counties and Baltimore City.

b) Provide an analysis of need for the project that is: population-based; applies utilization rates based on historic trends and expected future changes to those trends; and demonstrates the needs of the population served or to be served by the proposed liver transplant program.

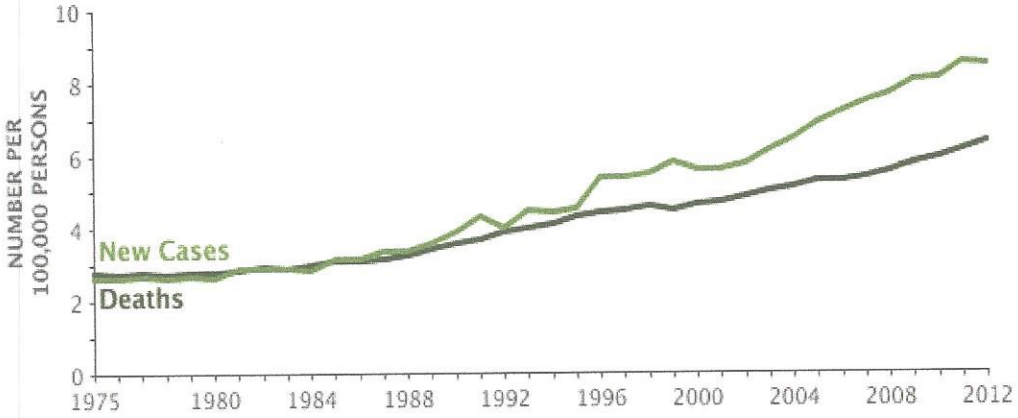
Liver Disease:

It is estimated that in the US, 3.9M people have chronic Hepatitis C Virus (HCV) and 1.2M have chronic Hepatitis B Virus (HBV), disease which drive the rise of liver cancer. The incidence rate for 2014 was 0.7 cases per 100,000 populations, an increase from 2010-12. An estimate 30,500 new infections of HCV occurred in 2014. In 2014, nearly 20,000 deaths resulted from HCV. The incidence of liver cancer has continued to rise. In the US, there were 35,660 new cases of liver cancer in 2015. Between 2003 and 2013, liver cancer incidence rates have increase 725 and deaths have increased at the highest rate of any cancer. Furthermore, rates of nonalcoholic fatty liver disease (NASH) and resultant liver cancer continue to also rise exponentially. It is estimated that by 2030, incidence of decompensated cirrhosis and liver cancer due to this disease will increase

by 168% and 137% respectively. Figure 33 shows the trend in liver disease over time.

Source:
*These statements are sourced by the Centers for Disease Control and well as the United States Renal Data System *USRDS): https://www.cdc.gove/nchs/fastats/leading-causes-of-death.htm*

FIGURE 33: GROWTH IN LIVER DISEASE PER POPULATION



https://www.cdc.gov/hepatitis/hcv/hcvfaq.htm#section1
http://seer.cancer.gov/statfacts/html/livibd.html
Annual Report to the Nation on the Status of Cancer. March 9, 2016
DOI: 10.1002/cncr.29936

c) Describe how the applicant considered the unmet needs of the population to be served in arriving at a determination that the proposed project is needed.

Again, "need" in this population is evident, based on the disparity between available donor organs and recipient candidates awaiting transplant, as the overall underlying disease prevalence. The ability to meet the need is based on organ availability – and the ability of a program to innovate solutions to the shortage. Insofar as MGTI has been successful in terms of surgical approaches and innovations described throughout the application, and in response to these completeness questions, believe that these capabilities can be transferred to the Baltimore region with more patients wait-listed, more organs made available for transplant and ultimately great benefit to that population.

29. Explain a) why a "population health focus" requires that a highly specialized – and rare – surgical procedure must be "a part of the system of care, convenient to patients' homes and families is integral to the successful management of the population's health," (p.73) rather than one that can be referred to nearby centers, especially in the context of a national policy (and State Health Plan) that regionalizes organ transplant services, and b) why MedStar's offering of just such a service barely an hour's travel time from FSMC fails to fill that "requirement."

a) Part of successful population health management involves the integration of all facets of an individual's health, that is, biological, social and psychological factors that influence recovery from acute illness, compliance with health care regimens and maintenance of behaviors that favor long-term excellent health. A "home base" for all aspects of individual healthcare provides a number of tangible benefits that include a familiar environment of care; an habitual cadre of providers; available family and other supportive "human" resources and relief from the anxiety of the cost and effort involved in travel superimposed on an already stressful situation. Unlike certain procedures that are virtually "curative" such as hip replacement, transplantation procedures require a lifelong commitment to follow up– both on the part of the provider as well as the patient. In order to assure the most favorable long-term outcome, the care of a liver transplant patient is the responsibility of the transplant center for life.

b) While the "requirement" is filled based on the 3-hour rule, taken as a whole we believe that patients and families accrue even greater benefit from having more expertise in organ utilization in even closer proximity to their own community and its providers for their care. To that purpose, the Advanced Liver Disease program at MFSMC is already providing care for patients with chronic illness who require the specialized expertise of a transplant hepatologist. Dr. Thomas Faust provides full-time rounding and consultation services on-site; these patients are further benefitting by extending the continuum of care and allowing them to enjoy the ongoing care of a familiar hepatologist in the peri- and post-transplant periods. Integrating their medical care with a full range of transplantation options in one setting is ideal.

AVAILABILITY OF MORE COST-EFFECTIVE ALTERNATIVES

30. Please articulate very plainly what the goals and objectives of this proposal are.

MedStar Health believes that the reputation of its transplantation program at MGTI speaks for itself relative to the benefit that it has brought to the Washington community in terms of innovation – particularly in the area of augmentation of organs available for transplantation, excellence in quality, attention to communication and flexibility in operation – all attributes that it proposes to extend to the Baltimore region. MedStar's desire to create a kidney transplant program adjunctively with the liver transplant program, is

driven by the clinical imperative to support the 10-15% of patients with advanced liver disease who need a simultaneous kidney transplant.

We also are confident in our ability to meet the needs of the minority population more completely, based on the experience in the District of Columbia. Finally, we feel strongly that we can make a meaningful impact on logistical issues facing individuals who need the long-term multi-specialty care that characterizes transplantation services by creating a high quality, attentive program that meets insurance considerations while situating in-network services closer to home, family, work and community providers.

Individual patients, as well as their community providers, have expressed enthusiasm for having MedStar Health as an available transplant option in the Baltimore region based on the quality and delivery of services, reputation of our physicians and attention to communication and follow up.

31. In light of the policy of regionalizing organ transplant services, and the prevalence of electronic medical records, please explain why utilizing the existing programs in Baltimore results in "critical components in the delivery of high quality care (being) compromised or lost altogether" if a kidney/***liver*** transplant patient leaves the MedStar system for this care.

While the Chesapeake Regional Information System for Patients (CRISP) has been a successful innovation augmenting communication between providers and institutions that are under different employment and use various electronic medical records systems, its utility is still limited. The data set of information that can be communicated over the health information exchange (HIE) portal is very basic. For example, the current data set includes: reason for admission, medications, allergies and a few documents, but not a <u>full</u> medical record. Hence, a patient admitted to a facility unrelated to the procedure is disadvantaged by being managed by a team that lacks familiarity with the important details of the patient's medical history and ongoing clinical management strategy. For patients with complicated medical problems who have undergone complex procedures, a large realm of information is needed to properly care for the patient. CRISP cannot provide information at that level of specificity. Having access to data in "real time" is valuable to clinicians.

32. In rejecting the alternative of referring patients to MGTI, the applicant cites "geographic(al) challenges for many MedStar Health transplant patients who live in the Baltimore area that can have an impact on their continuity of care" as a reason to reject that alternative.

    a) Please quantify that assertion; i.e., how many liver transplant patients rejected a referral to MGTI in each of the last three years?

    We are not able to quantify precisely the number of patients who might have refused referral to MGTI in Washington.

    b) Justify a selected alternative that seems to ignore the policy of regionalizing such highly-specialized services, which sets a three-hour travel benchmark, and a State

Health Plan that states: *Travel to an organ transplant center located in a health planning region other than where the organ transplant recipient resides is not, in and of itself, considered a barrier to access, if the drive time in less than three hours one-way.*

MedStar Health does not dispute the 3-hour rule, however, we believe that patients and families accrue even greater benefit from having more expertise in organ utilization and distribution across two OPOs and in closer proximity to their support systems.

The Advanced Liver Disease program at MFSMC is already providing care for patients with chronic illness who require the specialized expertise of a transplant hepatologist. Dr. Thomas Faust provides full-time rounding and consultation services on-site; these patients are further benefitting by extending the continuum of care and allowing them to enjoy the ongoing care of a familiar hepatologist in the peri- and post-transplant periods. Integration with full transplantation capabilities is the logical next step in maintaining the continuum of care on-site.

As noted in responses throughout these Completeness Questions, the program at MFSMC, in collaboration with MGTI, will augment the availability of organs due to MGTI's demonstrated innovation experience, research platform and advanced surgical approaches. In doing so, the end result will be that more Marylanders will receive an organ transplant.

VIABILITY OF THE PROPOSAL

Note: questions in the TABLES section below will ask for separate tables for each of MFSMC organ transplant applications.

33. The discussion of volume assumptions states that "Liver transplant volumes were based on the current experience of the MGTI clinic at MFSMC and in discussions with community gastroenterologists." Please be specific in quantifying those findings from both the clinics' records and gastroenterology discussions.

Below are data regarding the current volumes at the Advanced Liver Disease Center at MFSMC:

Figure 34 shows the trend in outpatient volume through the Advanced Liver Disease Center annualized through 2018.

FIGURE 34: MFSMC PATIENTS REFERRED/EVAL/LISTED/TRANSPLANTED

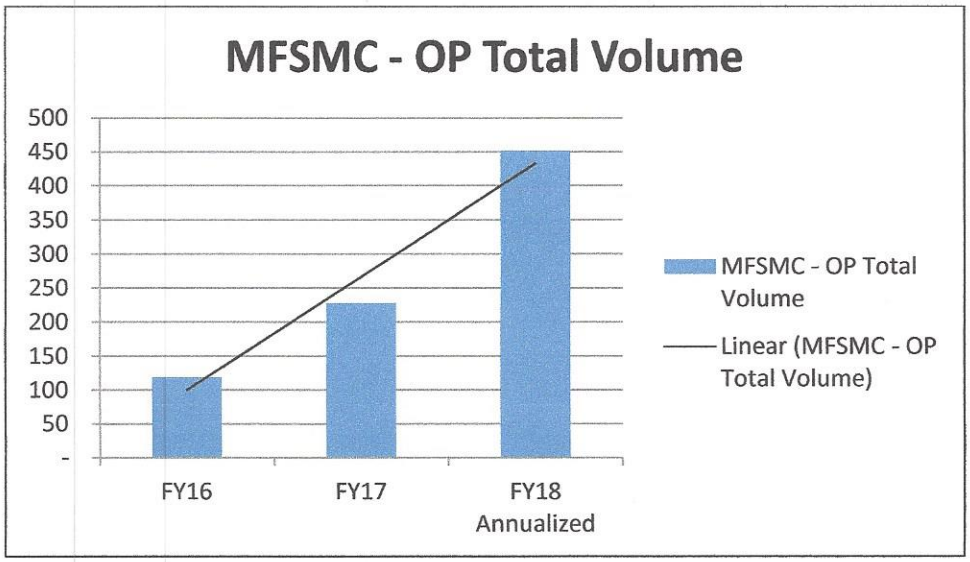
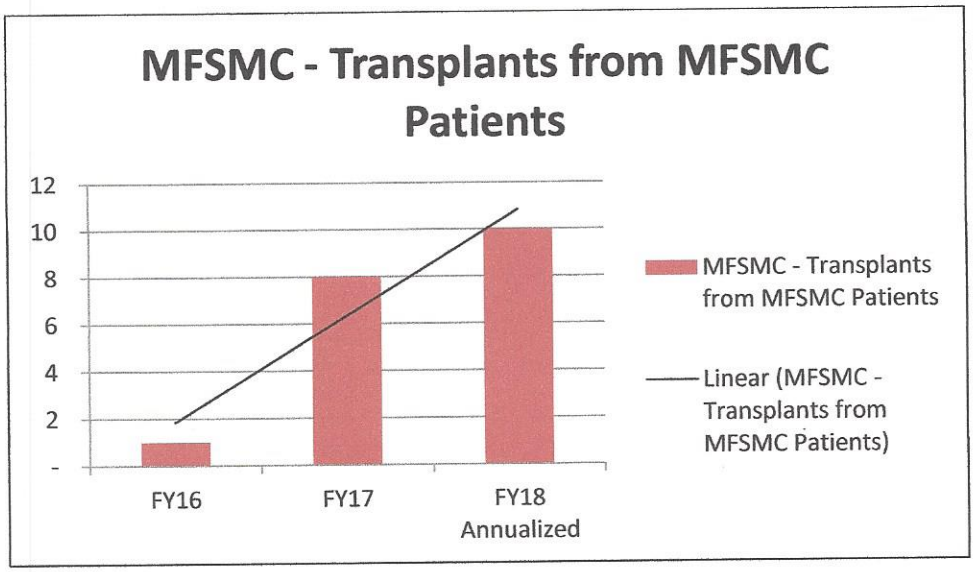


Figure 35 shows the trend in patients transplanted from the Advanced Liver Disease Center to date. Fiscal year 2018, beginning in July 2017 is annualized through June 2018.

FIGURE 35: MFSMC APPOINTMENY BY REASON



Discharge data from MFSMC show that over the past year approximately 200 patients were discharged with a primary liver diagnosis.

Gastroenterology Support. As part of the process to evaluate the feasibility of a liver transplant program at MFSMC, discussions were had with existing gastroenterology groups in Baltimore and surrounding areas, Prince Georges County, Anne Arundel County, and Frederick County. The vast majority of referring gastroenterologists looked favorably upon the establishment of a MedStar liver transplant program in Baltimore. The letters of support included with the original application provide confirmation.

IMPACT

34. Summarize the impact on the existing Baltimore liver transplant programs in terms of volume and revenue. References back to other parts of the application without being specific as to where such information can be found leaves open too much possibility for misinterpretation.

FIGURE 36 *(Figure 14, page 56 in application)*: LIVER TRANSPLANT VOLUMES: UMMS/JHH

Liver Transplants
University of Maryland/Johns Hopkins
Actual Adult Volume to Minimum Annual Case Volume Standard

Metric	Minimum Volume	UMMS					JHH				
		CY12	CY13	CY14	CY15	CY16	CY12	CY13	CY14	CY15	CY16
Liver	12	86	90	115	146	169	41	79	84	95	122
Variance from Min.	-	74	78	103	134	157	29	67	72	83	110
% Variance from Min.	-	617%	650%	858%	1117%	1308%	242%	558%	600%	692%	917%

Source: https://optn.transplant.hrsa.gov/data/view-data-reports/state-data/

Regarding volume impact shown in Figure 36: Both existing Baltimore programs far exceed the volume threshold set forth by the MHCC as demonstrated in the table that follows. We do not estimate a material impact on either through the establishment of the MedStar program at MFSMC.

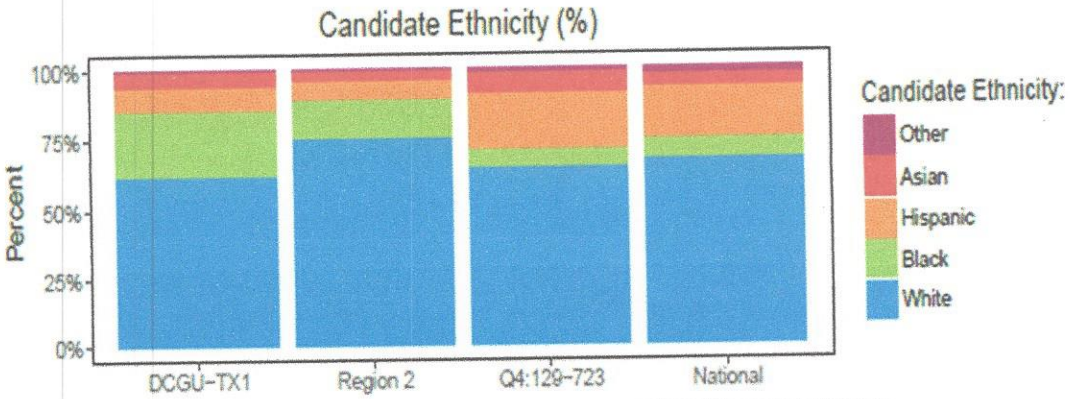
Regarding the financial impact on existing programs, MedStar's intention is not to impact any existing program negatively, but rather to improve upon the number of transplants performed overall. Under that scenario, we would expect that the existing programs would be able to replace to small number of cases with additional transplant volume.

35. Document the statement made on p.86 that "minorities in Baltimore receive transplants at lower rates than non-minorities." Note that stating numbers in absolute terms is not the same as documenting "rates" of service.

Figures 37 and 38, sourced from SRTR reports (October 2017) demonstrate that DCGU (MGTI) both evaluates (Figure 38) and transplants (Figure 39) minority candidates for liver transplant in percentages that exceed both regional and national norms.

DCGU (MGTI) is circled in BLUE; Region 2 in GREEN; National (U.S.) in RED.

FIGURE 37: LIVER TRANSPLANT CANDIDATE ETHNICITY



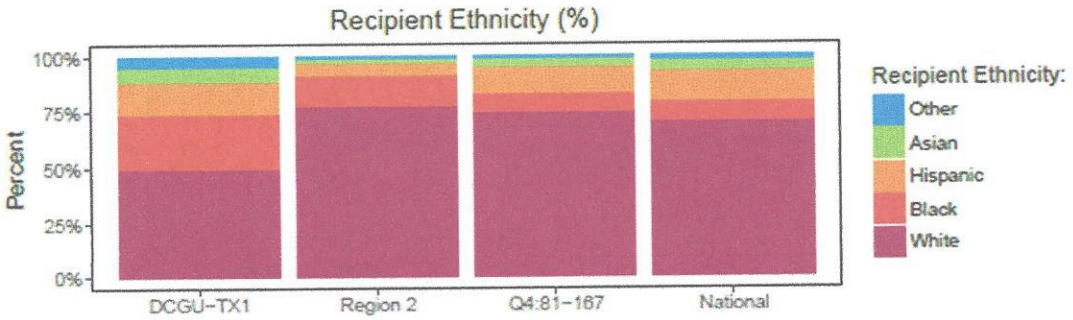
	DCGU-TX1	Region 2	Q4:129-723	National
White	62.65	76.40	65.03	67.78
Black	23.35	13.59	7.13	7.83
Hispanic	8.17	6.35	19.90	17.66
Asian	5.45	3.29	6.49	5.10
Other	0.39	0.28	1.45	1.62
Total	100.00	100.00	100.00	100.00

Figure 2 displays the distribution of age and ethnicity for all liver candidates waiting on September 30, 2017. While 53.33% of candidates waiting nationally were 50-64, 24.05% were 65+ years old. Overall, White candidates were the majority, followed by Hispanic, Black, and Asian candidates. Nationally, Other ethnic groups accounted for 1.62% of the waiting list.

MINORITY POPULATION EVALUATED AND LISTED FOR TRANSPLANT

DCGU (MGTI) = 37.36 %
Region 2 = 23.51 %
National = 32.21 %

FIGURE 38: LIVER TRANSPLANT RECIPIENT ETHNICITY



	DCGU-TX1	Region 2	Q4:81-167	National
White	50.47	78.27	74.96	71.23
Black	24.30	13.55	8.55	8.39
Hispanic	14.02	5.25	11.48	14.32
Asian	6.54	2.20	4.01	4.41
Other	4.67	0.73	1.00	1.65
Total	100.00	100.00	100.00	100.00

Figure 2 displays the distribution of age and ethnicity for all recipients of liver transplants performed between August 1, 2016 and July 31, 2017. While 50.81% liver transplants nationally were performed on recipients ages 50-64, 20.50% were performed on recipients 65+ years old. Overall, the majority of liver transplants were performed on White recipients, followed by Hispanic, Black, and Asian recipients. Other ethnic recipients accounted for 1.65% of liver transplants.

MINORITY POPULATION TRANSPLANTED

DCGU (MGTI) = 49.53 %
Region 2 = 21.73 %
National = 25.04 %

Figure 39 shows the minority distributions for the cities of Washington, DC and Baltimore, MD. As demonstrated in the previous graphics, despite Baltimore having a greater minority population, particularly Black/African American, than the District of Columbia, minority patients listed and transplanted in Washington, at MGTI surpass those of either Baltimore center.

FIGURE 39: MINORITY POPULATION DENSITY: WASHINGTON DC, AND BALTIMORE, MD

Washington , DC

Population By Races

Race	Population	% of Total
Total Population	601,723	100
Black or African American	305,125	50
White	231,471	38
Hispanic or Latino	54,749	9
Some Other Race	24,374	4
Asian	21,056	3
Two or More Races	17,316	2
American Indian	2,079	Below 1%
Three or more races	2,043	Below 1%
Native Hawaiian Pacific Islander	302	Below 1%

Source: https://suburbanstats.org/population
(powered by US Census Bureau Data)

Baltimore, MD

Population By Races

Race	Population	% of Total
Total Population	620,961	100
Black or African American	395,781	63
White	183,830	29
Hispanic or Latino	25,960	4
Asian	14,548	2
Two or More Races	12,955	2
Some Other Race	11,303	1
American Indian	2,270	Below 1%
Three or more races	1,402	Below 1%
Native Hawaiian Pacific Islander	274	Below 1%

As the applicant is an existing hospital, please follow the instructions to provide a summary description of the impact of the proposed project on costs and charges of the applicant hospital, consistent with the information provided in the application's tables package. Please submit an electronic version of the excel tables package. ***PROVIDED***

36. Submit financial and workforce tables that are limited to the addition of a liver transplant program (contrasted with the tables provided, which include both the proposed liver and kidney transplant programs).

Financial and workforce tables are provided as a separate attachment to this document.

37. Explain the relationship between outpatient visits and transplants (as shown on table I).

MedStar Health has estimated the proposed number of transplant procedures based on the methodology described in the response to Question 19. Following confirmation by MHCC of the validity of adding additional "halo effect" type admission and outpatient volume to the financial analysis, MedStar reassessed its position regarding non-transplant admissions and outpatient visits. In order to most accurately approximate the case mix and volume expectations for the initial clinical program experience at MFSMC, the following methodology was used:

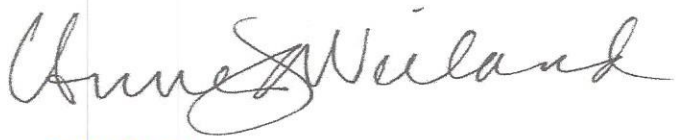
- ***A subset of actual patients undergoing liver transplant at MGTI for the most recent year was assessed, Patients with a lower length of stay and without co-morbid diagnoses and combined procedures, e.g. multi-organ transplant, were selected as a proxy for the lower acuity type of admission expected during initiation of the new program at MFSMC.***
- ***Charges associated with this subset of admissions were then adjusted to closely approximate the MFSMC-Maryland rates.***
- ***Pre-transplant and post-transplant admissions and outpatient visits were matched to actual patients transplanted (the same subset), by establishing a window prior to, and following, the transplant procedure for each patient.***
- ***Since it is expected that additional admissions will be generated for related medical conditions, based on the availability of liver transplant expertise – the so-called "halo-effect", inpatient and outpatient data were assessed in addition. Actual MGTI data regarding admissions and outpatient visits, i.e., patients admitted for management of chronic liver disease and/or undergoing associated ancillary diagnostic and therapeutic procedures on an outpatient basis at MGUH, were analyzed using specifically-related ICD-9 diagnosis and procedure coding methodology.***
- ***Again, revenues and expenses for these patient encounters were converted to MFSMC rates using historic pro-rata experience. Non-transplant variable expense estimates were based on MGUH costs and were incorporated into MFSMC variable expense rates via a blended rate.***

Additional patients resulted in an increased multiple of ≈2.9x non-transplant discharges per liver transplant discharge. The charges and costs are significantly higher than the previously identified volumes, supported by the actual diagnostic and procedural coding for these patients.

- *Under the assumption that additional admissions (and visits) will be generated for related medical conditions, based on the availability of liver transplant expertise – the so-called "halo effect", additional inpatient and outpatient data were assessed. Actual MGTI patients with specifically-related ICD-9 diagnosis and procedure codes were identified as comprising this additional subgroup.*
- *Characteristics of this more acutely-ill group of both inpatients and outpatients differ from the relatively healthier baseline group both in volume and intensity, i.e., the length of stay ranges 0-98 days with a mean of 10 and median of 6. The majority of diagnoses were for liver cell carcinoma, liver cirrhosis with ascites, viral hepatitis and portal hypertension in addition to other miscellaneous diagnoses, many in combination.*
- *Almost 30% had outpatient interventional radiologic procedures, 20% had MRI and 20% oncologic treatment a greater number than found in the baseline group.*

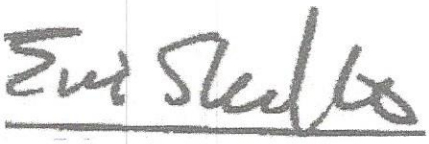
END OF RESPONSES TO COMPLETENESS QUESTIONS

"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."



Anne P. Weiland,
Vice President, MedStar Health
on behalf of MedStar Health

"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."



Eric R. Slechter,
Director, Strategic and Business Planning, MFSMC

on behalf of MedStar Health

Attachment 11: MFSMC Financial Projection Assumptions *Updated for Completeness Submission*

MedStar Franklin Square Entire Facility Assumptions:

FY17 was updated for actual performance for the Fiscal Year Ended June 30, 2017

Revenues (FY18-21)

A. *In addition to annual inflation adjustments for facility and professional service charges, the revenue projections assume incremental facility revenue to cover capital costs (depreciation and interest) related to a recently issued certificate of need for a surgical facility modernization project.*

B. Contractual, bad debt, and charity care relatively constant as a % of gross revenues.

C. Other operating revenue: FY18-FY19 includes a reduction of 6.4% in FY18 and a reduction of 2.9% in FY19 due to the decline in meaningful use revenue.

Expenses (FY18-21)

D. Expense growth based on varying levels of expense inflation with management initiatives meant to ensure MFSMC is ability to maintain a level of profitability.

Transplant Program:

Program is expected to "go live" by the start of FY2019

Revenues

A. Transplant Program Revenues: Beginning in FY19, kidney and liver project revenue projections assumed $148,848 Per Liver Transplant and $87,203 per Kidney Transplant which is 75% of comparable academic center charges

B. Inpatient Non-Transplant Discharges: Non-Transplant revenues are based on patient activity expected to occur at MFSMC as a direct result of the transplant programs for pre and post admissions and "halo" volume expectations as a result of having additional clinical expertise to treat complex patients. Rates based on MFSMC revenue per discharge expectations.

C. Ancillary Transplant Program Revenues: Ancillary outpatient revenues are based on patient activity expected to occur in MFSMC as a direct result of the transplant programs and are derived from MGUH experience and procedural pre and post operation testing. Rates based on MFSMC revenue per transplant/non-transplant discharge expectations.

D. Professional Fee Transplant Program Revenues: Professional fee revenue driven off the expectation of employed physician and actual MGUH experience for entire transplant program to arrive at a per transplant estimate of professional revenues and estimates of Hospitalist professional fee revenue for non-transplant discharges.

Expenses

A. FTE Requirements: Please see Workforce Tab L for specific FTE requirements related to the program.

B. Transplant variable expenses relate to organ acquisition, supplies, purchased services, drugs, and variable salary and wages based on current experience at MGUH

C. Non-Transplant variable expenses (inpatient and outpatient activity) relate to supplies, purchased services, drugs, and variable salary and wages based on current experience at MGUH for similar population set.

Expense reductions and savings initiatives

The projections include savings meant to counteract inflationary pressures. The savings will result from a MedStar Health-wide performance and operational excellence initiative that will enable and accelerate MFSMC's ability to optimally deliver efficient and effective, high quality patient care at a high value to our patients and the Maryland's Healthcare System. The initiative is focusing on the following:

A. Improved performance through enhanced clinical productivity

B. Reducing 20 FTEs, about $2M in salary expenses resulting from the consolidation of the current two separate OR suites into one facility

C. Creation of greater enterprise-wide synergies in the oversight of our employed provider network

D. Improving the process of care as it relates to length-of-stay management across the continuum of care and management of observation status patients

Table Number	Table Title	Instructions
Table A	Physical Bed Capacity Before and After Project	All applicants whose project impacts any nursing unit, regardless of project type or scope, must complete Table A.
Table B	Departmental Gross Square Feet	All applicants, regardless of project type or scope, must complete Table B for all departments and functional areas affected by the proposed project.
Table C	Construction Characteristics	All applicants proposing new construction or renovation must complete Table C.
Table D	Site and Offsite Costs Included and Excluded in Marshall Valuation Costs	All applicants proposing new construction or renovation must complete Table D.
Table E	Project Budget	All applicants, regardless of project type or scope, must complete Table E.
Table F	Statistical Projections - Entire Facility	Existing facility applicants must complete Table F. All applicants who complete this table must also complete Tables G and H.
Table G	Revenues & Expenses, Uninflated - Entire Facility	Existing facility applicants must complete Table G. The projected revenues and expenses in Table G should be consistent with the volume projections in Table F.
Table H	Revenues & Expenses, Inflated - Entire Facility	Existing facility applicants must complete Table H. The projected revenues and expenses in H should be consistent with the projections in Tables F and G.
Table I	Statistical Projections - New Facility or Service	Applicants who propose to establish a new facility, existing facility applicants who propose a new service, and applicants who are directed by MHCC staff must complete Table I. All applicants who complete this table must also complete Tables J and K.
Table J	Revenues & Expenses, Uninflated - New Facility or Service	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant who completes a Table I must complete Table J. The projected revenues and expenses in Table J should be consistent with the volume projections in Table I.
Table K	Revenues & Expenses, Inflated - New Facility or Service	Applicants who propose to establish a new facility and existing facility applicants who propose a new service and any other applicant that completes a Table I must complete Table K. The projected revenues and expenses in Table K should be consistent with the projections in Tables I and J.
Table L	Work Force Information	All applicants, regardless of project type or scope, must complete Table L.

TABLE E. PROJECT BUDGET

INSTRUCTION: Estimates for Capital Costs (1.a-e), Financing Costs and Other Cash Requirements (2.a-g), and Working Capital Startup Costs (3) must reflect current costs as of the date of application and include all costs for construction and renovation. Explain the basis for construction cost estimates, renovation cost estimates, contingencies, interest during construction period, and inflation in an attachment to the application. See additional instruction in the column to the right of the table.

NOTE: Inflation should only be included in the Inflation allowance line A.1.e. The value of donated land for the project should be included on Line A.1.a as a use of funds and on line B.8 as a source of funds

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
b. Renovations			
(1) Building			$0
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees			$0
(4) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
c. Other Capital Costs			
(1) Movable Equipment	$75,800		$75,800
(2) Contingency Allowance			$0
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$75,800***	***$0***	***$75,800***
TOTAL CURRENT CAPITAL COSTS	**$75,800**	**$0**	**$75,800**
d. *Land Purchase*			
e. Inflation Allowance			$0
TOTAL CAPITAL COSTS	**$75,800**	**$0**	**$75,800**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c. Legal Fees (CON)			$0
d. Legal Fees (Other)			$0
e. Non-Legal Consultant Fees (CON application related - specify what it is and why it is needed for the CON)			$0
f. Non-Legal Consultant Fees (Other)			$0
g. Liquidation of Existing Debt			$0
H. Debt Service Reserve Fund			$0
i. Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$0***	***$0***	***$0***
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$75,800***	***$0***	***$75,800***
B. Sources of Funds			
1. Cash	$75,800		$75,800
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS			**$0**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

* Describe the terms of the lease(s) below, including information on the fair market value of the item(s), and the number of years, annual cost, and the interest rate for the lease.

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 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	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
1. DISCHARGES							
a. General Medical/Surgical*	14,076	14,045	14,877	14,058	14,030	14,115	14,193
b. ICU	1,276	1,198	1,175	1,180	1,185	1,185	1,185
Total MSGA	**15,352**	**15,243**	**16,052**	**15,238**	**15,215**	**15,300**	**15,378**
c. Pediatric	481	280	250	270	280	275	275
d. Obstetric	3,203	2,955	2,798	2,964	2,964	2,964	2,964
e. Acute Psychiatric[1]	2,205	2,255	2,183	2,260	2,260	2,265	2,250
Total Acute	***21,241***	***20,733***	***21,283***	***20,732***	***20,719***	***20,804***	***20,867***
f. Rehabilitation	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0
TOTAL DISCHARGES	***21,241***	***20,733***	***21,283***	***20,732***	***20,719***	***20,804***	***20,867***
2. PATIENT DAYS							
a. General Medical/Surgical*	63,789	64,513	65,460	56,926	54,070	51,327	49,753
b. ICU	7,725	7,066	7,050	6,962	6,992	6,992	6,992
Total MSGA	**71,514**	**71,579**	**72,510**	**63,888**	**61,062**	**58,319**	**56,745**
c. Pediatric	1,195	720	551	720	720	720	720
d. Obstetric	7,984	7,262	6,766	7,196	6,910	6,620	6,437
e. Acute Psychiatric	12,649	12,750	11,292	12,805	12,805	12,805	12,805
Total Acute	***93,342***	***92,311***	***91,119***	***84,609***	***81,497***	***78,464***	***76,707***
f. Rehabilitation	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0
TOTAL PATIENT DAYS	***93,342***	***92,311***	***91,119***	***84,609***	***81,497***	***78,464***	***76,707***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)							
a. General Medical/Surgical*	4.5	4.6	4.4	4.0	3.9	3.6	3.5

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 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	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
b. ICU	6.1	5.9	6.0	5.9	5.9	5.9	5.9
Total MSGA	4.7	4.7	4.5	4.2	4.0	3.8	3.7
c. Pediatric	2.5	2.6	2.2	2.3	2.3	2.3	2.3
d. Obstetric	2.5	2.5	2.4	2.4	2.3	2.2	2.2
e. Acute Psychiatric	5.7	5.7	5.2	5.3	5.3	5.3	5.3
Total Acute	4.4	4.5	4.3	4.1	3.9	3.8	3.7
f. Rehabilitation	-	-	-	-	-	-	-

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 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	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
g. Comprehensive Care	-	-	-	-	-	-	-
h. Other (Specify/add rows of needed)	-	-	-	-	-	-	-
TOTAL AVERAGE LENGTH OF STAY	**4.4**	**4.5**	**4.3**	**4.1**	**3.9**	**3.8**	**3.7**
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*	240	251	240	240	240	240	240
b. ICU/CCU	28	27	27	27	27	27	27
Total MSGA	**268**	**278**	**267**	**267**	**267**	**267**	**267**
c. Pediatric	9	9	9	9	9	9	9
d. Obstetric	37	37	37	37	37	37	37
e. Acute Psychiatric	40	40	40	40	40	40	40
Total Acute	***354***	***364***	***353***	***353***	***353***	***353***	***353***
f. Rehabilitation	0	0	0	0	0	0	0
g. Comprehensive Care	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0
TOTAL LICENSED BEDS	***354***	***364***	***353***	***353***	***353***	***353***	***353***
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	72.8%	70.2%	74.7%	65.0%	61.7%	58.4%	56.8%
b. ICU	75.6%	71.5%	71.5%	70.6%	70.9%	70.8%	70.9%
Total MSGA	**73.1%**	**70.3%**	**74.4%**	**65.6%**	**62.7%**	**59.7%**	**58.2%**
c. Pediatric	36.4%	21.9%	16.8%	21.9%	21.9%	21.9%	21.9%
d. Obstetric	59.1%	53.6%	50.1%	53.3%	51.2%	48.9%	47.7%

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 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	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
e. Acute Psychiatric	86.6%	87.1%	77.3%	87.7%	87.7%	87.5%	87.7%
Total Acute	**72.2%**	**69.3%**	**70.7%**	**65.7%**	**63.3%**	**60.7%**	**59.5%**
f. Rehabilitation	-	-	-	-	-	-	-
g. Comprehensive Care	-	-	-	-	-	-	-
h. Other (Specify/add rows of needed)	-	-	-	-	-	-	-
TOTAL OCCUPANCY %	**72.2%**	**69.5%**	**70.7%**	**65.7%**	**63.3%**	**60.7%**	**59.5%**

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 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	**FY15**	**FY16**	**FY17**	**FY18**	**FY19**	**FY20**	**FY21**
6. OUTPATIENT VISITS							
a. Emergency Department[2]	86,609	78,770	71,487	72,200	71,000	70,500	70,000
b. Same-day Surgery[3]	13,352	12,965	12,280	13,857	14,296	14,407	14,488
c. Laboratory[4]							
d. Imaging[4]							
e. Other (Specify/add rows of needed)[5]	340,800	330,748	306,263	273,480	283,962	286,104	292,577
TOTAL OUTPATIENT VISITS	***440,761***	***422,483***	***390,030***	***359,537***	***369,258***	***371,011***	***377,065***
7. OBSERVATIONS**							
a. Number of Patients	10,699	10,419	8,886	9,800	9,750	9,700	9,650
b. Hours	487,874	466,110	340,910	387,100	385,125	383,150	381,175

* 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.

***Fluctuations in categorizing of patients originating in the ED between Inpatient and Observation status accounts for the large FY16-FY17 variance.

[1]Includes only those patients discharged from MFSMC's Psychiatric Unit. Some patients cared for on medical floors are discharged with Psychiatric MS-DRGs. These patient are not included in this count. They are included in the General Medical/Surgical count.

[2]Excludes ED pateint visits that resulted in an admission.

[3]This data represents all MFSMC patient visits with a Same Day Surgery Code, including endoscopy, interventional pain, etc. Some of these cases do not take place in MFSMC's ORs and so are not included in the OR Need calulation.

[4]MFSMC accounts for Imaging and Laboratory volume in Relative Value Units (RVUs) not patient visits. For consistency in the summing of outpatient visits, MFSMC is not including the RVUs here. MFSMC will forward the Commission staff the appropriate RVU data at the staff's request.

[5]Includes clinic visits, physician office visits, etc.

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year (Actual)	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**			
1. REVENUE										
a. Inpatient Services	$ 342,280	$ 349,256	$ 352,651	$ 347,948	$ 348,631	$ 355,283	$ 359,877			
b. Outpatient Services	$ 321,486	$ 343,454	$ 343,652	$ 365,075	$ 369,409	$ 373,414	$ 376,298			
Gross Patient Service Revenues	***$ 663,766***	***$ 692,710***	***$ 696,304***	***$ 713,022***	***$ 718,040***	***$ 728,696***	***$ 736,176***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 18,511	$ 26,600	$ 21,919	$ 27,068	$ 27,190	$ 27,636	$ 27,923			
d. Contractual Allowance	$ 149,425	$ 153,170	$ 151,745	$ 154,794	$ 156,408	$ 158,109	$ 159,989			
e. Charity Care	$ 2,956	$ 6,765	$ 6,354	$ 6,520	$ 6,503	$ 6,610	$ 6,682			
Net Patient Services Revenue	***$ 492,874***	***$ 506,175***	***$ 516,286***	***$ 524,641***	***$ 527,939***	***$ 536,341***	***$ 541,581***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 12,281	$ 13,273	$ 13,875	$ 11,800	$ 11,933	$ 11,813	$ 11,818			
NET OPERATING REVENUE	***$ 505,155***	***$ 519,448***	***$ 530,161***	***$ 536,440***	***$ 539,872***	***$ 548,153***	***$ 553,399***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 258,764	$ 272,890	$ 277,836	$ 274,989	$ 269,079	$ 266,609	$ 258,572			
b. Contractual Services	$ 4,704									
c. Interest on Current Debt	$ 8,916	$ 7,671	$ 7,824	$ 7,789	$ 7,775	$ 8,938	$ 9,138			
d. Interest on Project Debt	$ -									
e. Current Depreciation	$ 24,281	$ 22,855	$ 22,526	$ 22,814	$ 22,817	$ 22,821	$ 23,621			
f. Project Depreciation	$ -				$ 4	$ 8	$ 8			
g. Current Amortization	$ -									
h. Project Amortization	$ -									
i. Supplies	$ 75,260	$ 75,283	$ 77,519	$ 76,673	$ 75,250	$ 74,419	$ 74,479			
j. Other Expenses (Specify/add rows if needed)	$ 71,457	$ 82,737	$ 87,410	$ 93,789	$ 96,255	$ 98,360	$ 101,035			
k. Purchased Services	$ 44,339	$ 46,921	$ 35,435	$ 35,799	$ 34,526	$ 34,320	$ 34,199			
TOTAL OPERATING EXPENSES	***$ 487,721***	***$ 508,357***	***$ 508,549***	***$ 511,853***	***$ 505,706***	***$ 505,475***	***$ 501,051***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	***$ 17,434***	***$ 11,091***	***$ 21,611***	***$ 24,588***	***$ 34,166***	***$ 42,678***	***$ 52,348***	***$ -***	***$ -***	***$ -***
b. Non-Operating Income	$ 37	$ (201)								
SUBTOTAL	***$ 17,471***	***$ 10,890***	***$ 21,611***	***$ 24,588***	***$ 34,166***	***$ 42,678***	***$ 52,348***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 17,471***	***$ 10,890***	***$ 21,611***	***$ 24,588***	***$ 34,166***	***$ 42,678***	***$ 52,348***	***$ -***	***$ -***	***$ -***

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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. Specify the sources of non-operating income. See additional instruction in the column to the right of the table.

	Two Most Recent Years (Actual)		Current Year (Actual)	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2015	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021			
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	43.1%	43.8%	44.5%	44.5%	44.5%	44.5%	44.5%			
2) Medicaid	25.5%	24.9%	25.4%	25.4%	25.4%	25.4%	25.4%			
3) Blue Cross	10.3%	9.4%	9.3%	9.3%	9.3%	9.3%	9.3%			
4) Commercial Insurance	8.6%	8.5%	7.9%	7.9%	7.9%	7.9%	7.9%			
5) Self-pay	3.7%	3.5%	2.7%	2.7%	2.7%	2.7%	2.7%			
6) Other	8.8%	9.9%	10.2%	10.2%	10.2%	10.2%	10.2%			
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*
b. Percent of Equivalent Inpatient Days										
1) Medicare	43.1%	43.8%	44.5%	44.5%	44.5%	44.5%	44.5%			
2) Medicaid	25.5%	24.9%	25.4%	25.4%	25.4%	25.4%	25.4%			
3) Blue Cross	10.3%	9.4%	9.3%	9.3%	9.3%	9.3%	9.3%			
4) Commercial Insurance	8.6%	8.5%	7.9%	7.9%	7.9%	7.9%	7.9%			
5) Self-pay	3.7%	3.5%	2.7%	2.7%	2.7%	2.7%	2.7%			
6) Other	8.8%	9.9%	10.2%	10.2%	10.2%	10.2%	10.2%			
TOTAL	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*100.0%*	*0.0%*	*0.0%*	*0.0%*

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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 (Actual)	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**			
1. REVENUE										
a. Inpatient Services	$ 342,280	$ 349,256	$ 352,651	$ 350,981	$ 355,622	$ 370,348	$ 381,002			
b. Outpatient Services	$ 321,486	$ 343,454	$ 343,652	$ 369,799	$ 375,454	$ 381,664	$ 387,863			
Gross Patient Service Revenues	***$ 663,766***	***$ 692,710***	***$ 696,304***	***$ 720,780***	***$ 731,076***	***$ 752,012***	***$ 768,865***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 18,511	$ 26,600	$ 21,919	$ 27,331	$ 27,722	$ 28,448	$ 29,025			
d. Contractual Allowance	$ 149,425	$ 153,170	$ 151,745	$ 154,672	$ 156,130	$ 157,637	$ 159,237			
e. Charity Care	$ 2,956	$ 6,765	$ 6,354	$ 6,591	$ 6,648	$ 6,831	$ 6,983			
Net Patient Services Revenue	***$ 492,874***	***$ 506,175***	***$ 516,286***	***$ 532,186***	***$ 540,576***	***$ 559,096***	***$ 573,620***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows if needed)	$ 12,281	$ 13,273	$ 13,875	$ 11,800	$ 11,933	$ 11,813	$ 11,818			
NET OPERATING REVENUE	***$ 505,155***	***$ 519,448***	***$ 530,161***	***$ 543,986***	***$ 552,509***	***$ 570,909***	***$ 585,438***	***$ -***	***$ -***	***$ -***
2. EXPENSES										
a. Salaries & Wages (including benefits)	$ 258,764	$ 272,890	$ 277,836	$ 284,743	$ 288,332	$ 296,821	$ 298,514			
b. Contractual Services	$ 4,704									
c. Interest on Current Debt	$ 8,916	$ 7,671	$ 7,824	$ 7,789	$ 7,775	$ 8,938	$ 9,138			
d. Interest on Project Debt	$ -									
e. Current Depreciation	$ 24,281	$ 22,855	$ 22,526	$ 22,814	$ 22,817	$ 22,821	$ 23,621			
f. Project Depreciation	$ -				$ 4	$ 8	$ 8			
g. Current Amortization	$ -									
h. Project Amortization	$ -									
i. Supplies	$ 75,260	$ 75,283	$ 77,519	$ 80,269	$ 82,596	$ 85,693	$ 89,991			
j. Other Expenses (Specify/add rows if needed)	$ 71,457	$ 82,737	$ 87,410	$ 96,758	$ 102,395	$ 107,784	$ 113,878			
k. Purchased Services	$ 44,339	$ 46,921	$ 35,435	$ 36,401	$ 35,710	$ 36,104	$ 36,606			
TOTAL OPERATING EXPENSES	***$ 487,721***	***$ 508,357***	***$ 508,549***	***$ 528,774***	***$ 539,629***	***$ 558,168***	***$ 571,755***	***$ -***	***$ -***	***$ -***
3. INCOME										
a. Income From Operation	***$ 17,434***	***$ 11,091***	***$ 21,611***	***$ 15,212***	***$ 12,880***	***$ 12,740***	***$ 13,683***	***$ -***	***$ -***	***$ -***
b. Non-Operating Income	$ 39	$ (201)								
SUBTOTAL	***$ 17,473***	***$ 10,890***	***$ 21,611***	***$ 15,212***	***$ 12,880***	***$ 12,740***	***$ 13,683***	***$ -***	***$ -***	***$ -***
c. Income Taxes										
NET INCOME (LOSS)	***$ 17,473***	***$ 10,890***	***$ 21,611***	***$ 15,212***	***$ 12,880***	***$ 12,740***	***$ 13,683***	***$ -***	***$ -***	***$ -***
4. PATIENT MIX										
a. Percent of Total Revenue										
1) Medicare	43.1%	43.8%	44.5%	44.5%	44.5%	44.5%	44.5%			
2) Medicaid	25.5%	24.9%	25.4%	25.4%	25.4%	25.4%	25.4%			
3) Blue Cross	10.3%	9.4%	9.3%	9.3%	9.3%	9.3%	9.3%			
4) Commercial Insurance	8.6%	8.5%	7.9%	7.9%	7.9%	7.9%	7.9%			
5) Self-pay	3.7%	3.5%	2.7%	2.7%	2.7%	2.7%	2.7%			
6) Other	8.8%	9.9%	10.2%	10.2%	10.2%	10.2%	10.2%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table H should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table F. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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 (Actual)	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2015**	**FY 2016**	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**			
b. Percent of Equivalent Inpatient Days										
Total MSGA										
1) Medicare	43.1%	43.8%	44.5%	44.5%	44.5%	44.5%	44.5%			
2) Medicaid	25.5%	24.9%	25.4%	25.4%	25.4%	25.4%	25.4%			
3) Blue Cross	10.3%	9.4%	9.3%	9.3%	9.3%	9.3%	9.3%			
4) Commercial Insurance	8.6%	8.5%	7.9%	7.9%	7.9%	7.9%	7.9%			
5) Self-pay	3.7%	3.5%	2.7%	2.7%	2.7%	2.7%	2.7%			
6) Other	8.8%	9.9%	10.2%	10.2%	10.2%	10.2%	10.2%			
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (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.

	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 J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**				
1. DISCHARGES							
a. Liver Transplants	10	14	30				
b. Non-Transplants	29	41	87				
b. ICU/CCU							
Total MSGA	**39**	**55**	**117**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***39***	***55***	***117***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL DISCHARGES	***39***	***55***	***117***	***0***	***0***	***0***	***0***
2. PATIENT DAYS							
a. Liver Transplants	90	126	289				
b. Non-Tansplants	146	205	439				
b. ICU/CCU							
Total MSGA	**236**	**331**	**727.5**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***236***	***331***	***728***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL PATIENT DAYS	***236***	***331***	***728***	***0***	***0***	***0***	***0***
3. AVERAGE LENGTH OF STAY							
a. Liver Transplants	9.0	9.0	9.6	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. Non-Tansplants	5.0	5.0	5.6	#REF!	#REF!	#REF!	#REF!
C. ICU/CCU							
Total MSGA	6.1	6.1	6.2	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	6.1	6.1	6.2	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL AVERAGE LENGTH OF STAY	6.1	6.1	6.2	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

TABLE I. STATISTICAL PROJECTIONS - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (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.

	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 J and K.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**				
4. NUMBER OF LICENSED BEDS							
a. General Medical/Surgical*							
b. ICU/CCU							
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric							
d. Obstetric							
e. Acute Psychiatric							
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***0***
f. Rehabilitation							
g. Comprehensive Care							
h. Other (Specify/add rows of needed)							
TOTAL LICENSED BEDS							
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*							
a. General Medical/Surgical*	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
b. ICU/CCU	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!	#REF!
Total MSGA	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
c. Pediatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
d. Obstetric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
e. Acute Psychiatric	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Total Acute	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
f. Rehabilitation	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
g. Comprehensive Care	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
h. Other (Specify/add rows of needed)	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**
6. OUTPATIENT VISITS							
a. Emergency Department							
b. Same-day Surgery							
c. Laboratory							
d. Imaging							
e. Other (Specify/add rows of needed)	2,746	3,819	7,475				
TOTAL OUTPATIENT VISITS	***2,746***	***3,819***	***7,475***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**							
a. Number of Patients							
b. Hours							

*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.

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**				
1. REVENUE							
a. Inpatient Services	$ 2,021	$ 3,481	$ 7,528				
b. Outpatient Services	$ 1,403	$ 1,990	$ 4,276				
Gross Patient Service Revenues	***$ 3,424***	***$ 5,471***	***$ 11,804***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 115	$ 185	$ 395				
d. Contractual Allowance	$ 368	$ 591	$ 1,343				
e. Charity Care	$ 30	$ 47	$ 104				
Net Patient Services Revenue	***$ 2,911***	***$ 4,648***	***$ 9,962***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ 2,911***	***$ 4,648***	***$ 9,962***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 2,458	$ 3,395	$ 3,932				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 4	$ 8	$ 8				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 563	$ 788	$ 1,731				
j. Other Expenses (Specify)	$ 428	$ 600	$ 1,316				
k. Purchased Services	$ 79	$ 111	$ 243				
TOTAL OPERATING EXPENSES	***$ 3,532***	***$ 4,902***	***$ 7,230***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (621)**	**$ (253)**	**$ 2,731**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (621)***	***$ (253)***	***$ 2,731***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (621)***	***$ (253)***	***$ 2,731***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	28.6%	46.2%	41.9%				
2) Medicaid	42.9%	25.3%	25.3%				
3) Blue Cross	18.6%	17.7%	20.8%				
4) Commercial Insurance	10.0%	10.8%	12.0%				
5) Self-pay							
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare	28.6%	46.2%	41.9%				
2) Medicaid	42.9%	25.3%	25.3%				
3) Blue Cross	18.6%	17.7%	20.8%				
4) Commercial Insurance	10.0%	10.8%	12.0%				
5) Self-pay							
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**				
1. REVENUE							
a. Inpatient Services	$ 2,021	$ 3,502	$ 7,618				
b. Outpatient Services	$ 1,403	$ 2,009	$ 4,356				
Gross Patient Service Revenues	***$ 3,424***	***$ 5,511***	***$ 11,974***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 115	$ 187	$ 401				
d. Contractual Allowance	$ 368	$ 558	$ 1,205				
e. Charity Care	$ 30	$ 47	$ 106				
Net Patient Services Revenue	***$ 2,911***	***$ 4,719***	***$ 10,263***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 2,911***	***$ 4,719***	***$ 10,263***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 2,458	$ 3,504	$ 4,186				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 4	$ 8	$ 8				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 563	$ 817	$ 1,861				
j. Other Expenses (Specify/add rows of needed)	$ 428	$ 612	$ 1,368				
k. Purchased Services	$ 79	$ 113	$ 253				
TOTAL OPERATING EXPENSES	***$ 3,532***	***$ 5,054***	***$ 7,675***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ (621)**	**$ (335)**	**$ 2,587**	**$ -**	**$ -**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ (621)***	***$ (335)***	***$ 2,587***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (621)***	***$ (335)***	***$ 2,587***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	FY 2019	FY 2020	FY 2021				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	28.6%	46.2%	41.9%				
2) Medicaid	42.9%	25.3%	25.3%				
3) Blue Cross	18.6%	17.7%	20.8%				
4) Commercial Insurance	10.0%	10.8%	12.0%				
5) Self-pay							
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	28.6%	46.2%	41.9%				
2) Medicaid	42.9%	25.3%	25.3%				
3) Blue Cross	18.6%	17.7%	20.8%				
4) Commercial Insurance	10.0%	10.8%	12.0%				
5) Self-pay							
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

TABLE L. WORKFORCE INFORMATION

INSTRUCTION: List the facility's existing staffing and changes required by this project. Include all major job categories under each heading provided in the table. The number of Full Time Equivalents (FTEs) should be calculated on the basis of 2,080 paid hours per year equals one FTE. In an attachment to the application, explain any factor used in converting paid hours to worked hours. Please ensure that the projections in this table are consistent with expenses provided in uninflated projections in Tables F and G. See additional instruction in the column to the right of the table.

	CURRENT ENTIRE FACILITY			PROJECTED CHANGES AS A RESULT OF THE PROPOSED PROJECT THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			OTHER EXPECTED CHANGES IN OPERATIONS THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS)			PROJECTED ENTIRE FACILITY THROUGH THE LAST YEAR OF PROJECTION (CURRENT DOLLARS) *	
Job Category	**Current Year FTEs**	**Average Salary per FTE**	**Current Year Total Cost**	**FTEs**	**Average Salary per FTE**	**Total Cost** *(should be consistent with projections in Table G, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table G)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Office/Clerical	233.6	$47,908	$11,193,150	4.5	$78,049	$351,220	-19.0	$47,908	-$912,305	219.1	$10,632,064
Management	103.1	$226,573	$23,350,567				-13.0	$226,573	-$2,949,652	90.0	$20,400,914
Total Administration	336.7	$102,595	$34,543,716	4.5	$78,049	$351,220	-32.1	$120,454	-$3,861,958	309.1	$31,032,979
Direct Care Staff *(List general categories, add rows if needed)*											
RN	776.1	$100,880	$78,294,967	7.0	$90,138	$630,969	-61.6	$100,880	-$6,212,836	721.5	$72,713,100
Care Associates	238.4	$42,278	$10,080,005				-19.5	$42,278	-$823,999	218.9	$9,256,006
Physicians	157.2	$425,455	$66,864,467	4.0	$381,250	$1,525,000	-12.0	$350,000	-$4,206,427	149.1	$64,183,040
Intern/Residents	84.8	$83,283	$7,064,917				0.0	$83,283	$0	84.8	$7,064,917
Other Direct Care	132.6	$111,023	$14,716,099	1.0	$54,579	$54,579	-12.1	$122,721	-$1,479,633	121.5	$13,291,046
Total Direct Care	1389.1	$127,437	$177,020,456	12.0	$184,212	$2,210,548	-105.2	$120,996	-$12,722,894	1295.9	$166,508,109
Support Staff *(List general categories, add rows if needed)*											
Technologists	198.2	$78,169	$15,494,683				-15.7	$78,169	-$1,224,374	182.6	$14,270,309
Medical Assistants	73.0	$43,637	$3,186,359	1.0	$45,427	$45,427	-5.5	$43,637	-$242,009	68.5	$2,989,777
Clinical Pharmacist	30.9	$156,550	$4,840,530				-2.5	$156,550	-$387,894	28.4	$4,452,636
Other Support Staff	67.1	$171,617	$11,508,667	5.0	$79,033	$395,166	-5.2	$171,617	-$887,780	66.9	$11,016,054
Service/Trade	233.5	$41,169	$9,614,529				-18.7	$41,169	-$768,483	214.9	$8,846,046
Other Non Patient Care	385.8	$56,064	$21,626,692				-35.0	$61,971	-$2,171,023	350.7	$19,455,669
Total Support	988.5	$67,042	$66,271,459	6.0	$73,432	$440,593	-82.6	$68,818	-$5,681,563	912.0	$61,030,489
REGULAR EMPLOYEES TOTAL	***2714.3***	***$102,360***	**$277,835,631**	***22.5***		**$3,002,361**	***-219.8***	***$101,316***	**-$22,266,415**	**2517.0**	**$258,571,577**
2. Contractual Employees											

TABLE L. WORKFORCE INFORMATION

Administration *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Administration			$0			$0			$0	0.0	$0
Direct Care Staff *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Direct Care Staff			$0			$0			$0	0.0	$0
Support Staff *(List general categories, add rows if needed)*										
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
			$0			$0			$0	0.0	$0
Total Support Staff			$0			$0			$0	0.0	$0
CONTRACTUAL EMPLOYEES TOTAL			$0			$0			$0	0.0	$0
Benefits *(State method of calculating benefits below)* **:**										
TOTAL COST	***2714.3***		***$277,835,631***	***22.5***		***$3,002,361***	***-219.8***		***-$22,266,415***		***$258,571,577***

TABLE M. (AD-HOC) REVENUES & EXPENSES, INFLATED - CONSOLIDATED LIVER AND KIDNEY NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**				
1. REVENUE							
a. Inpatient Services	$ 2,909	$ 6,024	$ 12,286				
b. Outpatient Services	$ 1,924	$ 3,164	$ 6,482				
Gross Patient Service Revenues	***$ 4,834***	***$ 9,188***	***$ 18,769***	***$ -***	***$ -***	***$ -***	***$ -***
c. Allowance For Bad Debt	$ 164	$ 312	$ 632				
d. Contractual Allowance	$ 548	$ 972	$ 1,963				
e. Charity Care	$ 43	$ 79	$ 167				
Net Patient Services Revenue	***$ 4,079***	***$ 7,825***	***$ 16,006***	***$ -***	***$ -***	***$ -***	***$ -***
f. Other Operating Revenues (Specify/add rows of needed)							
NET OPERATING REVENUE	***$ 4,079***	***$ 7,825***	***$ 16,006***	***$ -***	***$ -***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)	$ 2,468	$ 4,171	$ 5,429				
b. Contractual Services							
c. Interest on Current Debt							
d. Interest on Project Debt							
e. Current Depreciation							
f. Project Depreciation	$ 4	$ 8	$ 8				
g. Current Amortization							
h. Project Amortization							
i. Supplies	$ 755	$ 1,246	$ 2,683				
j. Other Expenses (Specify/add rows of needed)	$ 770	$ 1,308	$ 2,691				
k. Purchased Services	$ 145	$ 253	$ 483				
TOTAL OPERATING EXPENSES	***$ 4,142***	***$ 6,986***	***$ 11,294***	***$ -***	***$ -***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	***$ (62)***	***$ 839***	***$ 4,712***	***$ -***	***$ -***	***$ -***	***$ -***
b. Non-Operating Income							
SUBTOTAL	***$ (62)***	***$ 839***	***$ 4,712***	***$ -***	***$ -***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ (62)***	***$ 839***	***$ 4,712***	***$ -***	***$ -***	***$ -***	***$ -***

TABLE M. (AD-HOC) REVENUES & EXPENSES, INFLATED - CONSOLIDATED LIVER AND KIDNEY NEW FACILITY OR SERVICE

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). 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.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2019**	**FY 2020**	**FY 2021**				
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare	28.6%	46.2%	41.9%				
2) Medicaid	42.9%	25.3%	25.3%				
3) Blue Cross	18.6%	17.7%	20.8%				
4) Commercial Insurance	10.0%	10.8%	12.0%				
5) Self-pay							
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
1) Medicare	28.6%	46.2%	41.9%				
2) Medicaid	42.9%	25.3%	25.3%				
3) Blue Cross	18.6%	17.7%	20.8%				
4) Commercial Insurance	10.0%	10.8%	12.0%				
5) Self-pay							
6) Other							
TOTAL	***100.0%***	***100.0%***	***100.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***