

March 2, 2018

VIA EMAIL & FIRST CLASS MAIL

Ms. Ruby Potter
ruby.potter@maryland.gov
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Request for Exemption from Certificate of Need Review
Merger and Consolidation of Harford Memorial Hospital
and Upper Chesapeake Medical Center

Dear Ms. Potter:

On behalf of UM Harford Memorial Hospital and UM Upper Chesapeake Medical Center, we are submitting four copies of the Applicants' Responses to Additional Information Questions Dated December 29, 2017 in the above-referenced matter. A WORD version will be forwarded in a separate email.

In Good Health,



Lyle E. Sheldon FACHE,
President and Chief Executive Officer
UM Upper Chesapeake Health System, Inc.

Enclosures

CC by email:

Ben Steffen, Executive Director, Maryland Health Care Commission
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assistant Attorney General
Joseph E. Hoffman III, Executive Vice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business
Development, UM UCHS

#620684
011888-0023

Ms. Ruby Potter
March 2, 2018
Page 2

Aaron Rabinowitz, Esq., Vice President and General Counsel, UM UCHS
Alison G. Brown, MPH, Senior Vice President and Chief Strategy Officer
University of Maryland Medical System
Russell Moy, M.D., Acting Health Officer, Harford County
Andrew L. Solberg, A.L.S. Healthcare Consultant Services
James Buck, Gallagher, Evelius & Jones LLP

**UNIVERSITY OF MARYLAND UPPER CHESAPEAKE MEDICAL CENTER AND
UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL**

**Request For Exemption From Certificate of Need Review
Merger and Consolidation of Harford Memorial Hospital and
Upper Chesapeake Medical Center**

Responses to Additional Information Questions Dated December 29, 2017

STATE HEALTH PLAN STANDARDS

Bed Need

1. A reduction in observation patient discharges of approximately 11% and a reduction in observation patient length of stay of 0.2 days (13.3%) was projected for University of Maryland Upper Chesapeake Medical Center (“UCMC”) between FY 2017 and FY 2019. This projection reflects the discussion of high use of observation status at UCMC on pages 16 and 17 of the request:
 - A. Does experience to date indicate that UCMC is on track for achieving the projected reductions?

Applicant Response

In its Request for Exemption from CON Review (the “Exemption Request”), UCMC projected an 11 percent reduction in observation discharges between fiscal years 2017 and 2019 and a 12.4 percent reduction in average length of stay for observation patients during this period. See Exemption Request at Tables 22 and 24. While experience to date indicates HMH has been successful in its efforts to convert observation cases longer than 48 hours to the inpatient setting, at least for the first six months of fiscal year 2018, experience indicates that UCMC is not on track to achieve the projected conversions to inpatient status or observation length of stay reductions.

UCMC attributes this unexpected experience in converting observation stays lasting longer than 48 hours to inpatient admissions and reducing observation lengths of stay primarily to the implementation of a clinical decision unit (“CDU”) in UCMC’s emergency department beginning in July 2017. As implemented at UCMC, this CDU is more enhanced than a typical observation unit and includes additional case management resources; there is an elevated priority for ancillary testing, 24/7 coverage by nurse practitioners, and regularly timed specialty consults. Emphasis is placed on caring for patients in the CDU beyond the four walls of the hospital. The goal of CDU attending physicians is to develop an acceptable discharge plan for patients within 24 hours. If patients are unable to be safely discharged with an acceptable plan to improve their health, the patient is transferred to a floor as an inpatient or placed in observation status.

Given that the impact of the CDU is limited to six months’ of data, UCMC is continuing to evaluate the aggregate impact on its projections in the Exemption Request. UCMC expects to have determined the impact on or before April 30, 2018.

- B. What proportion of the reduction in observation patients is projected to result from admission of short-stay patients who, in recent years, had been served as relatively longer-stay observation patients?

In its Exemption Request, UCMC projected to reduce observation utilization due to potentially avoidable utilizations (“PAUs”) and high utilization. UCMC projected a reduction in observation cases by shifting 60% of patients with a length of stay greater than two days to the inpatient setting. As presented in Table 27, these patients account for 88.2% and 91.7% of the total projected reduction at UCMC and HMH, respectively.

Table 27
Upper Chesapeake Health System
Projected Reduction in Observation Cases at UCMC and HMH
FY2016 – FY2021

| | <u>UCMC</u> | <u>HMH</u> |
|---|----------------------|----------------------|
| PAU Reduction - OBV Cases ⁽¹⁾ | 89 | 31 |
| Reduction of OBV Cases > 2 Days | <u>664</u> | <u>343</u> |
| Total Reduction | <u><u>753</u></u> | <u><u>374</u></u> |
| <i><u>% of Total Reduction</u></i> | | |
| PAU Reduction - OBV Cases | 11.8% | 8.3% |
| Reduction of OBV Cases > 2 Days | <u>88.2%</u> | <u>91.7%</u> |
| Total Reduction | <u><u>100.0%</u></u> | <u><u>100.0%</u></u> |

Note (1): Projected 1.25% decrease in observation cases from FY2017 - FY2021

2. Given that the project will establish the first dedicated observation unit at UCMC, how many bed days for existing general medical/surgical beds will be freed up for use by admitted patients after the observation unit goes into operation?

As presented in Table 28, UCMC projected to reduce observation bed days by 2,437 days between fiscal years 2016 and 2021, while HMH projected to reduce observation bed days by 1,220 days. As identified above, 88.2% and 91.7% of these bed days were projected to shift from observation status to inpatient admissions. As a result, the reduction in observation bed days would not free up medical surgical beds.

Table 28
 Upper Chesapeake Health System
 Projected Observation Bed Days FY 2016 and FY 2021
 FY2016 – FY2021

| | Observation Bed Days | |
|-----------|----------------------|--------------|
| | UCMC | HMH |
| FY2016 | 11,419 | 4,488 |
| FY2021 | 8,982 | 3,268 |
| Reduction | <u>2,437</u> | <u>1,220</u> |

- From Table F, Exhibit 9 of the response to completeness questions on the other exemption request on file from Upper Chesapeake Health, we see that UCMC projects 11[,]449 observation patient days in FY 2017, presumably all of which are being accommodated in general medical/surgical patient rooms. We also see that University of Maryland Harford Memorial Hospital (“HMH”) is projected to experience 14,318 general medical/surgical patient days in FY 2017, only 2,869 more patient days than the observation patient day total at UCMC, representing an average daily census of just 7.9 patients. Given that all of the observation patient days currently experienced at UCMC will be eliminated from the general medical/surgical nursing units at UCMC, why is it necessary to construct an additional 41 general medical/surgical patient rooms at UCMC to accommodate general medical/surgical patient census that will transfer from HMH to UCMC after the conversion of HMH to a freestanding medical facility (“FMF”)?

Applicant Response

As an initial matter, while the proposed project involves construction of 41 additional MSGA rooms, as reflected on footnote 1 on page 5 of the Exemption Request and Exhibit 1, Table A, under the proposed project, a total of only 31 MSGA beds would be added to UCMC upon the conversion of HMH to a freestanding medical facility. UCMC proposed to convert 10 existing semi-private rooms to private rooms.

With that being said, the question presupposes that fiscal year 2017 population metrics and age cohorts, inpatient days at HMH, and observation days at UCMC will remain static through fiscal year 2022 when the proposed conversion of HMH to a freestanding medical facility is contemplated. As reflected in Exemption Request, Exhibit 9, Table F to the Request for Exemption from CON Review to Convert HMH to a freestanding medical facility, and the response to Question 4 below, UCMC projected increases in inpatient utilization between fiscal years 2016 and 2021 at HMH and UCMC primarily associated with an increase of the age 65+ cohort which historically has had higher utilization rates and the projected shift of observation cases with stays longer than 48 hours to the inpatient setting.

4. Related to Question 3, we also see from the same Table F, Exhibit 9, that general medical/surgical discharges at UCMC are projected to increase by 12% between FY 2016 and FY 2021, the last year before HMH converts to an FMF, with a corresponding increase of 13% in general medical/surgical patient days at UCMC over the same period, resulting from a 1% increase in average length of stay (“ALOS”). In contrast, general medical/surgical discharges at HMH are projected to increase 24% between FY 2016 and FY 2021 and, remarkably, general medical/surgical patient days are projected to increase 43% over this same period, due to an increase in ALOS for such patients of 15% at HMH. The historic context for these projections are, based on MHCC analysis of the HSCRC discharge data base, a decline of 33% in medical/surgical/gynecological/ addictions (“MSGA”) discharges at HMH in the ten year period of CY 2006 to CY 2016 and a 7% decline in MSGA discharges at UCMC over the same period.

- A. How can these projections be viewed as credible in light of the recent history of medical/surgical bed demand at Harford County hospitals?

The projected increase in utilization at UCMC and HMH between fiscal years 2016 and 2021 was primarily due to the shift of the population to the age 65+ cohort with higher utilization rates and the projected shift of observation cases with a length of stay greater than 48 hours days to the inpatient setting. As presented in Table 29 below, the age 65+ age cohort is expected to grow in the service area population by 20.9% at UCMC and 21.2% at HMH, respectively based on historic utilization. As a result, discharges were projected to grow by 13.4% at UCMC and 20.1% at HMH, respectively. As projected discharges in the age 65+ patient population grow, the number of patient days was also projected to grow. Patients in the age 65+ cohort at UCMC have an average length of stay of 4.22 days compared to 5.19 days at HMH. In addition to the increase in the age of the patient population, observation cases were projected to decline between fiscal years 2016 and 2021 by 10.1% at UCMC and 14.0% at HMH, which based on the projected shift of observation patients with a length of stay greater than 48 hours to the inpatient setting.

Table 29
Upper Chesapeake Health System
Projected Utilization Changes
FY2016 – FY2021

| <u>UCMC</u> | <u>FY2016</u> | <u>FY2021</u> | <u>% Change</u> |
|--|---------------|---------------|-----------------|
| Population - Age 65+ | 38,811 | 46,933 | 20.9% |
| Med/Surg Discharges - Age 65+ | 6,039 | 6,847 | 13.4% |
| Total Med/Surg Discharges - All Ages | 10,084 | 11,195 | 11.0% |
| Average Med/Surg Length of Stay - All Ages | 4.09 | 4.10 | 0.4% |
| OBV Cases | 7,460 | 6,707 | -10.1% |
| OBV Cases % of Total Med/Surg Discharges | 74.0% | 59.9% | -14.1% |
| <u>HMH</u> | | | |
| Population - Age 65+ | 21,868 | 26,494 | 21.2% |
| Med/Surg Discharges - Age 65+ | 1,782 | 2,141 | 20.1% |
| Total Med/Surg Discharges - All Ages | 3,140 | 3,824 | 21.8% |
| Average Med/Surg Length of Stay - All Ages | 4.91 | 4.81 | -2.0% |
| OBV Cases | 2,664 | 2,290 | -14.0% |
| OBV Cases % of Total Med/Surg Discharges | 84.8% | 59.9% | -25.0% |

Sources:

- St. Paul's Statewide Non-confidential Discharge Database
- Spotlight (formerly Claritas) Population Data

B. How does the applicant explain the contrast in projections of general medical/surgical bed demand and ALOS between UCMC and HMH for the period FY 2016 and FY 2021?

When comparing fiscal year 2016 to fiscal year 2021 projections of UCMC to HMH, the difference lies in the shift of observation cases greater than 48 hours as presented in Table 29 above, as well as the difference in the average length of stay (“ALOS”) of the 65+ age cohort. The projected shift of observation cases greater than 48 hours to the inpatient setting would reduce UCMC observation cases as a percentage of total MSGA discharges by 14.1% and 25.0% at HMH, a difference of 10.9%. With a projected greater shift of observation cases greater than 48 hours to the inpatient setting at HMH than at UCMC, the projected discharges at HMH would increase more than at UCMC. Length of stay of the 65+ age cohort was also a factor. Patients who are admitted as inpatients at UCMC stay on average 4.22 days compared to 5.19 days at HMH. HMH’s ALOS is 23% greater than that at UCMC.

COSTS AND EFFECTIVENESS

5. No cost estimates are provided for the five alternative approaches to expansion of UCMC described on pages 28 to 31 of the request. But the applicant's "analysis" of the options refers to a "review of the cost and benefits of the available options."

Provide a more comprehensive discussion of the "costs and benefits" of the alternative considered than the single paragraph on page 31. Explicitly discuss the effectiveness of each alternative in terms of the project's key objective – providing the likely additional space needed to provide the inpatient services that will no longer be available at HMH after its conversion to an FMF. (Secondary "benefits" can be assessed and appropriately considered within the context of "cost/effectiveness" in reaching final conclusions, but the initial assessment should compare and contrast the particular effectiveness of providing more bed space, given that this is essentially the only need directly addressed by the chosen Option 1A, with respect to the conversion of HMH.)

Applicant Response

For each of the alternatives described on pages 28 to 31 of the Exemption Request, UCMC's architectural and construction consultants provided preliminary estimates solely of building construction costs. Based on these estimates, Options 1 and 1A were clearly determined to be the most cost-effective alternatives to provide the requisite space to house the number of beds projected to be needed upon the anticipated closure of HMH in fiscal year 2022. Ultimately, UCMC chose option 1A because it also provided shell space for potential expansion at UCMC's campus.

As set forth in the need analysis on pages 11 through 26 of the Exemption Request, UCMC projected a need for 202 MSGA beds and 34 observation beds in fiscal year 2022.

Option 1, considered a two story expansion above the Kaufman Cancer Center, with each floor being 26,000 building gross square feet ("BGSF") for a total of 52,000 BGSF. Option 1 did not include construction of a third floor of shell space as does Option 1A. Initial construction cost estimates for Option 1 were \$25.8 million or approximately \$430 per bed assuming construction of 60 private rooms. Ultimately, more detailed construction costs as set forth in the Exemption Application for Option 1 were determined to equal approximately \$27 million.¹ While Option 1 would have provided adequate space to house the number of beds projected to be needed at UCMC in fiscal year 2022, it provided no opportunity for additional expansion on the UCMC campus.

Option 1A, the proposed project, includes Option 1 coupled with a single floor of shell space directly above the existing Kaufman Cancer Center that UCMC anticipates using for

¹ The \$27 million figure subtracts the estimated cost for construction of an additional level of shell space, \$3,170,406, from the Project Budget, Table E, Line A.1.a.(1) of Exhibit 1, which reflects total new construction costs.

expansion of the Kaufman Cancer Center's diagnostic and treatment services and/or future inpatient needs. Initial cost estimates for construction of the shell space were estimated to be \$4.2 million, however, as set forth in the Exemption Request these construction costs were ultimately determined to be approximately \$3.17 million. As further described on pages 43 and 44 of the Exemption Request, construction of the shell space as part of the proposed project is cost effective, reasonable to include as part of the proposed project to limit disruption to the future operations of the Kaufman Cancer Center, and consistent with COMAR 10.24.10.04(B)(16).

Option 2 contemplated renovation of two levels of the Ambulatory Care Center ("ACC") on UCMC's campus. The floor plate of the ACC is 24,000 BGSF and, therefore, a two level renovation could have provided 48,000 BGSF of space for construction of between 54 and 60 private rooms. While Option 2 could have provided the necessary space to house the number of beds projected to be needed in fiscal year 2022, preliminary construction cost estimates for the renovation were \$30.9 million or \$542 per bed, assuming a total 57 beds. As a result, Option 2 was determined not to be as cost effective as Options 1 and 1A and was therefore rejected.

Option 3 examined a one story vertical expansion of each of UCMC's main hospital bed towers and the ED/bed tower. The combined vertical expansion would have created an additional 47,000 BGSF, sufficient to house 60 private patient rooms with each being 250 square feet. Estimated construction costs were \$37.7 million or approximately \$640 per bed (assuming 60 beds). This option was also rejected because it was not as cost effective as Options 1 and 1A.

Option 4 considered a one story vertical expansion of each of UCMC's main hospital bed towers but not the ED/bed tower. Combined, the vertical expansion would have created an additional 38,000 BGSF capable of housing 40 to 44 private rooms, each being 250 square feet. The estimated construction cost for Option 4 was \$27.7 million or approximately \$693 per bed assuming only 40 beds. Given the significant increase in cost per bed over Options 1 and 1A, Option 4 too was rejected as not cost-effective. Moreover, Option 4 failed to provide the requisite space for the number of beds projected to be needed by UCMC in fiscal year 2022.

Finally, Option 5 evaluated a one story vertical expansion above the main hospital diagnostic and treatment core, which would have created an additional 24,600 BGSF capable of housing up to 30 single patient rooms, with each room being approximately 300 square feet. Construction costs associated with Option 5 were estimated to be \$21 million or \$700 per bed. Option 5 was rejected because it failed to provide requisite space to house the number of beds projected to be needed by UCMC in fiscal year 2022 and also because the cost per bed significantly exceeded Options 1 and 1A which will yield significantly more space at a reduced cost per bed.

As described in the Exemption Request, Options 1 and 1A provide the most viable and cost-effective solution to providing the additional space needed to provide the inpatient services that will no longer be available at HMM after its conversion to an FMF. Option 1A also provides efficient and effective flexibility for future expansion of either inpatient needs or oncology diagnostic and treatment services.

6. The other exemption request states that “the existing (HMH) physical plant has outlived its useful life” and “renovation of the facility (HMH) is not cost effective” and notes the “practical” limitations for any expansion of the existing HMH campus. It also states that relocation and replacement of HMH was “considered but determined not to be cost effective and was viewed unfavorably by the Commission Staff and the staff of the Health Services Cost Review Commission.”

However, neither exemption request provides a substantive discussion of this threshold issue. (The other request notes that “approximately \$100 million” would be required to modernize the HMH physical plan to achieve the statewide average age of plant.) As an issue pertinent to both exemption requests and as a useful addition to the record, please provide a broader perspective on the alternative of maintaining a second general hospital operation in Havre de Grace area, which would obviate the need for this project and involve a substantially different development plan for the Bulle Rock site involving relocation and replacement of HMH. Provide a perspective on the cost estimates and feasibility assessment developed by Upper Chesapeake Health in reaching a decision that continued operation of a second general hospital in Harford County was not cost effective and/or financially feasible.

Applicant Response

HMH has been serving Havre de Grace and the surrounding community with acute medical inpatient and behavioral health, outpatient, surgical, and emergency services for more than 100 years. Portions of HMH’s current physical plant date to 1943 with most of the facility having been constructed between 1958 and 1972. While UM UCH has invested significant operational and capital resources over the years to renovate and maintain the facility, the physical structure of the building is well beyond its useful life, has numerous infrastructure issues, is cost prohibitive to maintain for the long-term, and would require significant capital expenditures for a partial or full renovation of the facility. Renovation and expansion opportunities are also constrained by the nine acre site in downtown Havre de Grace, which is surrounded by existing developed parcels.

Over the past decade, UM UCH has considered many alternatives to the transformation and modernization of HMH to improve access and services to the community it serves and to better serve the populations of Harford and Cecil Counties within an integrated health delivery system. In 2006, UM UCH engaged an architect and construction management company to determine the feasibility of renovating HMH. There were several key findings from this engagement. UM UCH determined renovation of HMH would not result in the efficient use of capital expenditures. First, the operating rooms and radiology suite could not be renovated, primarily due to shallow, nine foot-six inch floor-to-slab height in core which would not allow modern equipment, lighting, and HVAC. As a consequence, the operating rooms and radiology suite would need to be reconstructed elsewhere on the HMH campus, which space is limited due to existing developed parcels surrounding HMH.

The existing emergency department is obsolete and lacking patient privacy. As a result, current patient flow is inefficient. Due to HMH’s existing configuration, HMH’s emergency department could not be expanded absent significant relocation of other services and is further constrained by HMH’s limited campus expansion possibilities.

Several parts of the building would require costly asbestos abatement in any renovation project. Further, several areas of the hospital would need to be upgraded to current life safety standards. Renovation would also require significant upgrades to the HVAC and electrical systems.

All of the acute and psychiatric beds are semi-private and many of the patient rooms have not been updated in several decades. Converting these rooms to private rooms in accordance with today's standards would be costly and require a complete bed tower renovation.

While the capital cost associated with a renovating and constructing new space at HMH varied based on the scope of construction and renovation, the cost of bringing the entire facility to modern standards is estimated to be \$239.3 million (updated to a midpoint of construction in 2020). See Table 30 below. The project scope included new operating rooms, a new radiology suite, infrastructure upgrades and emergency department renovations.

**Table 30
Estimated HMH Renovation Costs**

| Description | Total (in Millions) |
|--|---------------------|
| Bed Tower Renovations (total 107 beds): | \$152.7 |
| 3rd - 4th floor for complete renovation for private rooms | |
| Improved and relocated Central Sterile Supply, Pharmacy, and Lab | |
| ED Renovation/Data Center Relocation | \$5.2 |
| New OR Suite | \$16.2 |
| New Radiology | \$15.1 |
| Critical infrastructure upgrades | \$6.2 |
| Surface Parking Addition | \$0.5 |
| Demolition | \$1.2 |
| Subtotal | \$201.1 |
| Financing Cost (19%) | \$38.2 |
| Total | \$239.3 |

Moreover, undertaking an expansive renovation of HMH would cause total per capita health care expenditures to increase due to the need for rate increases from the HSCRC to support the capital costs and increased depreciation and interest expenses. Further, the extensive renovation required for renovation of HMH would be disruptive to HMH's ability to provide patient care services during the renovation. UM UCH determined that renovation of HMH would not be cost effective.

UM UCH also engaged architectural and construction consultants to evaluate the costs associated with construction of a replacement acute general hospital to be located on the UC Medical Campus at Havre de Grace. A number of different scenarios were considered, including an eighty-four (84) bed hospital with sixty (60) MSGA beds and twenty-four (24) psychiatric beds. Preliminary assessments regarding the cost to construct an acute general hospital with sixty (60) MSGA beds and twenty-four (24) psychiatric beds escalated to the mid-point of calendar year 2021, including finance costs, was projected to be \$274,975,146 as reflected in Table 31 below.

Table 31
Projected Costs of an 84 Bed Replacement Hospital (60 MSGA / 24 Psych Beds)
Inflated Through Mid-Point of Calendar Year 2021

| | |
|---|----------------------|
| SITE ASSESSMENT COSTS | \$700,384 |
| DESIGN AND CONSULTANTS | \$18,209,973 |
| CONSTRUCTION | \$140,076,718 |
| <i>Hospital Sitework & Construction</i> | <i>\$111,984,539</i> |
| <i>Off-Site Road & Utility Improvements</i> | <i>\$14,324,861</i> |
| <i>Construction Escalation</i> | <i>\$13,767,318</i> |
| EQUIPMENT AND FURNISHINGS | \$44,863,429 |
| <i>Medical Equipment</i> | <i>\$26,481,968</i> |
| <i>Technology Equipment/Systems</i> | <i>\$9,942,170</i> |
| <i>Food Service Equipment</i> | <i>\$1,405,048</i> |
| <i>Furniture/Artwork</i> | <i>\$2,840,620</i> |
| <i>Signage/Graphics/Wayfinding</i> | <i>\$710,155</i> |
| <i>Equipment & Furnishings Escalation</i> | <i>\$3,212,793</i> |
| FEES, TESTING, INSPECTIONS & ADMIN. | \$7,003,836 |
| FINANCE COSTS | \$53,578,088 |
| CONTINGENY | \$10,542,716 |
| <i>Owner Contingency (5% of Total Costs)</i> | <i>\$10,542,716</i> |
| TOTAL | \$274,975,146 |

The study by architectural and construction consultants also projected the costs to construct an acute general hospital with only sixty (60) MSGA. Preliminary assessments

regarding the cost to construct such a hospital escalated to the mid-point of calendar year 2021 were \$250,224,112 as reflected on Table 32 below.

Table 32
 Projected Costs of a 60 Bed Replacement Hospital
 Inflated Through Mid-Point of Calendar Year 2021

| | |
|---|----------------------|
| SITE ASSESSMENT COSTS | \$631,444 |
| DESIGN AND CONSULTANTS | \$16,417,522 |
| CONSTRUCTION | \$126,288,630 |
| <i>Hospital Sitework & Construction</i> | <i>\$99,551,601</i> |
| <i>Off-Site Road & Utility Improvements</i> | <i>\$14,324,861</i> |
| <i>Construction Escalation</i> | <i>\$12,412,168</i> |
| EQUIPMENT AND FURNISHINGS | \$42,222,914 |
| <i>Medical Equipment</i> | <i>\$25,810,001</i> |
| <i>Technology Equipment/Systems</i> | <i>\$8,491,661</i> |
| <i>Food Service Equipment</i> | <i>\$1,405,048</i> |
| <i>Furniture/Artwork</i> | <i>\$2,426,189</i> |
| <i>Signage/Graphics/Wayfinding</i> | <i>\$606,547</i> |
| <i>Equipment & Furnishings Escalation</i> | <i>\$3,019,291</i> |
| FEES, TESTING, INSPECTIONS & ADMIN. | \$6,314,431 |
| FINANCE COSTS | \$48,755,423 |
| CONTINGENY | \$9,593,748 |
| <i>Owner Contingency (5% of Total Costs)</i> | <i>\$9,593,748</i> |
| TOTAL | \$250,224,112 |

Based on these projected costs estimates, UM UCH determined that a replacement hospital would not be cost effective and would result in an increase of total per capita health care expenditures due to the need for rate increases from the Health Services Costs Review Commission (“HSCRC”) to support the capital costs and increased depreciation and interest expenses. Further, as noted in the Commission’s question and in the Exemption Request, in discussions with staff from the Maryland Health Care Commission and the HSCRC, it was made clear to UM UCH that neither agency would support a proposed replacement hospital at the UC Medical Campus at Havre de Grace.

Ultimately, UM UCH determined that a new special psychiatric hospital and freestanding medical facility at the UC Medical Campus at Havre de Grace and consolidation of MSGA beds

at UCMC provided the most efficient use of capital, the most savings to the public for the Havre de Grace Community and all of UCH's service area, and was able to best achieve each of UM UCH's objectives, including the overarching and primary objective of maintaining access to health care services for residents of UM UCH's service area.

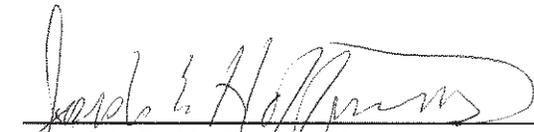
Table of Tables

| Table | Description |
|--------------|---|
| 27 | Projected Reduction in Observation Cases at UCMC and HMH |
| 28 | Projected Observation Bed Days FY 2016 and FY 2021 |
| 29 | Projected Utilization Changes FY 2016 and FY 2021 |
| 30 | Estimated HMH Renovation Costs |
| 31 | Projected Costs of an 84 Bed Replacement Hospital (60 MSGA / 24 Psych Beds) |
| 32 | Projected Costs of a 60 Bed Replacement Hospital |

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.

March 2, 2018

Date



Joseph E. Hoffman, III
Executive Vice President / Chief
Financial Officer and Compliance
Officer
University of Maryland Upper
Chesapeake Health System