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ATTORNEYS AT LAW

December 29, 2023

VIA EMAIL & HAND DELIVERY

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

Re: James Lawrence Kernan Hospital, Inc. *d/b/a* University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, LLC
Request for Exemption from Certificate of Need to Merge and Consolidate Portions of University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center

Dear Ms. Potter:

On behalf of the applicants James Lawrence Kernan Hospital, Inc. *d/b/a* University of Maryland Rehabilitation and Orthopaedic Institute ("UMROI") and University of Maryland Medical Center, LLC ("UMMC"), we are submitting an electronic version, via email and four (4) hard copies of their Request for Exemption from Certificate of Need Review and related exhibits. We will be providing a WORD version of the application, and an EXCEL file of the MHCC tables under separate email.

We hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agency as noted below.

If you have questions about the information provided above, please contact us at your convenience.

Very truly yours,

Ella R. Aiken, Esq.

Alison B. Lutich, Esq.

cc: Ben Steffen, Executive Director, MHCC

#863780
006551-0232

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IN THE MARYLAND HEALTH CARE COMMISSION

REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW
TO MERGE AND CONSOLIDATE PORTIONS OF
UNIVERSITY OF MARYLAND REHABILITATION AND ORTHOPAEDIC INSTITUTE AND UNIVERSITY OF MARYLAND MEDICAL CENTER

Applicants

James Lawrence Kernan Hospital, Inc.
d/b/a University of Maryland Rehabilitation and Orthopaedic Institute

and

University of Maryland Medical Center, LLC

December 29, 2023

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REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW
TO MERGE AND CONSOLIDATE PORTIONS OF
UNIVERSITY OF MARYLAND REHABILITATION AND ORTHOPAEDIC INSTITUTE AND
UNIVERSITY OF MARYLAND MEDICAL CENTER

James Lawrence Kernan Hospital, Inc., d/b/a University of Maryland Rehabilitation and Orthopaedic Institute ("UMROI") and University of Maryland Medical Center, LLC ("UMMC"), (collectively, the "Applicants"), both hospitals within the University of Maryland Medical System, Inc. ("UMMS"), by their undersigned counsel and pursuant to COMAR 10.24.01.02(A)(3)(c), COMAR 10.24.01.04(A)(3)-(4), and Md. Code Health-General Article § 19-120(k)(6)(v), hereby provide notice to the Maryland Health Care Commission (the "Commission") of the relocation of certain acute inpatient rehabilitation and chronic care beds from UMROI to UMMC pursuant to a merger and consolidation within UMMS of these two facilities (the "Project"). For the reasons set forth below, the Applicants respectfully request that the Commission find that the project is exempt from Certificate of Need ("CON") review.

BACKGROUND

UMMC is a 710-licensed bed facility, with 579 MSGA beds, 30 obstetric beds, 59 pediatric beds, and 42 acute psychiatric beds. UMMC is located at 22 S. Greene St., Baltimore, MD 21201. UMROI is an acute care hospital with five licensed MSGA beds, 88 licensed acute inpatient rehabilitation beds, 40 chronic care beds, and 16 dually-licensed acute inpatient rehabilitation/ chronic care beds. UMROI is located at 2200 Kernan Drive, Baltimore, MD 21207.

A. University of Maryland Medical Center

UMMC is one of Maryland's two large academic medical centers, and was established in 1823 in close collaboration with the first public medical school in the nation. Located on the west side of downtown Baltimore, UMMC provides highly specialized tertiary and quaternary care for the entire state and region. It includes the 710-bed Downtown Baltimore campus and the 116-bed Midtown campus one mile north. UMMC provides a broad range of inpatient and outpatient services and functions as a teaching hospital.

The Downtown Campus is home to the Marlene and Stewart Greenebaum Comprehensive Cancer Center ("GCCC"), the R Adams Cowley Shock Trauma Center ("STC") the University of Maryland Hospital Children's Hospital as well as other noted clinical programs such as organ transplantation, neurosciences, heart, and vascular. STC is one of the highest volume trauma centers in the nation, and is the world leader in trauma care and research and training. It is the heart of Maryland's model emergency medical services system. The Marlene and Stewart Greenebaum Comprehensive Cancer Center is an NCI-designated comprehensive cancer center and one of only 53 top cancer treatment and research centers in the U.S. Construction on the new home for the GCCC, the Leonard Stoler Center for Advanced Medicine, is currently underway (the "Stoler Center"). The Stoler Center will provide state-of-the-art inpatient and outpatient cancer treatment services.

B. University of Maryland Rehabilitation and Orthopaedic Institute

UMROI has been serving the Baltimore community for over 120 years as a provider of orthopedic surgery and is the largest inpatient rehabilitation hospital and provider of rehabilitation services in the State of Maryland. Since its inception as the "Hospital for Crippled and Deformed Children" in 1895, the hospital has continued to evolve to meet the needs of Marylanders. The original hospital facility was located at 6 West 20th Street in Baltimore, MD, where it operated as a free orthopaedic hospital for children. In its early years, the hospital expanded to multiple buildings due to overcrowding, resulting in a small complex.

Shortly thereafter, Mr. James Lawrence Kernan, a theater owner, showman, and philanthropist, purchased Radnor Park, an old Victorian mansion located at the northeast corner of the intersection of Forest Park Avenue and Windsor Mill Road near Dickeyville, MD. Mr. Kernan deeded this property to the hospital to serve as a new site. After converting the mansion into a working hospital, the facility was renamed the James Lawrence Kernan Hospital and Industrial School of Maryland for Crippled Children, Inc. ("JL Kernan Hospital") in 1911. In 1926, a new, modern hospital was constructed on the Radnor Park site and the existing mansion was remodeled for administrative use.

Throughout the years, JL Kernan Hospital expanded to provide services for adults, in addition to children. In 1986, the University of Maryland Medical System purchased the former JL Kernan Hospital. Three years later, the State of Maryland selected UMROI as one of only five centers throughout the state with licensed rehabilitation beds. In 1996, the former Montebello State Chronic Disease Hospital merged with JL Kernan Hospital. Through the merger, which combined JL Kernan Hospital's nearly 100-year legacy of orthopedic medical and surgical excellence with Montebello's history of chronic disease care and rehabilitation, the institutions opened as the William Donald Shaefer Rehabilitation Center: the premier rehab center in Maryland.

Today, UMROI's programs are primarily aligned around orthopedics and neurology, with both inpatient and outpatient supporting services. In addition, UMROI provides a dental clinic for general dentistry and special needs children and young adults. UMROI has earned Commission on Accreditation of Rehabilitation Facility (CARF) accreditation for Brain Injury, Spinal Cord System of Care, Comprehensive Integrated Inpatient Rehabilitation, and Stroke Specialty Programs.

C. The University of Maryland Medical System

UMMS is dedicated to providing quality health care through a market-responsive regional system composed of a world-class academic medical center and partnerships with the University of Maryland School of Medicine and premier community and specialty hospitals.

Over the last 28 years, UMMS has grown significantly to become a multi-hospital, Maryland-based health care delivery system. The medical system includes 13 acute care facilities and 150+ ambulatory and physician practice sites that are located throughout Maryland. UMMS' impact on the health and well-being of Marylanders is significant by any measure. It is the largest health system serving the State of Maryland, comprising 25% of hospital care in Maryland. UMMS also provides more than $460 million in community benefits each year. These community services include medical education, subsidized programs, community funding, civic involvement, community service programs, and charity care.

UMMS now looks to lead the evolution of post-acute care throughout its system and the State. UMMS is strategically focused on developing a full post-acute care continuum for the citizens of Maryland and the patients it serves. UMMS' post-acute care initiatives include both community-based and facility-based levels of care. In its community-based approach, UMMS has built over 26 outpatient therapy locations. It has also entered into partnerships with two large home health providers in an effort to improve access to home health and align its clinical programs with appropriate post-discharge care options. In its facility-based approach, UMMS seeks to advance and realign portions of its acute inpatient rehabilitation and chronic care services through the project.

D. The Project

The Applicants propose to merge and consolidate elements of the world-class rehabilitation services now offered at UMROI in northwest Baltimore City to the UMMC campus in downtown Baltimore. The relocation of UMROI's TBI and SCI acute inpatient service lines, along with associated chronic care beds, will better align these services with the care delivered at the world-renowned R Adams Cowley Shock Trauma Center and at UMMC more broadly. As a result, the project will enhance patient safety and quality of care, enhance access to care, improve the overall efficiency of care provided to TBI and SCI patients across the continuum of care, and provide numerous clinical benefits as demonstrated throughout this request.

Specifically, the Applicants propose to relocate 25 acute inpatient rehabilitation TBI beds, 18 acute inpatient rehabilitation SCI beds, five chronic care beds, and ten dually-licensed acute inpatient rehabilitation and chronic care beds from UMROI to UMMC. These beds will accommodate patients recovering from traumatic brain injuries and spinal cord injuries, as well as medically-complex comprehensive medical rehabilitation ("CMR") patients requiring acute inpatient rehabilitation services. Such medically-complex patients will include patients with multiple comorbidities, transplant patients, and oncology patients, many of whom cannot currently be accommodated at the UMROI campus.

The project will bring together UMMS' world-class trauma care and high-quality acute and chronic rehabilitation services to the same campus, allowing for improved quality and efficiency in the delivery of health care services.

UMMC plans to accommodate the relocated services in both renovated space and new construction. As a result of the spacing needs for these services, UMMC also plans to relocate certain existing services to new construction and renovated space within the hospital. The relocation of these other beds will allow UMMC to make improvements in patient care and efficiency for the internally relocated services.

DISCUSSION

Maryland Code, Health-General § 19-120(k)(6)(v) permits a health care facility to make a capital expenditure, change the bed capacity, or change the scope of health care services offered by a health care facility if the proposed change: (i) is pursuant to the consolidation or merger of two or more health care facilities, (ii) is not inconsistent with the State Health Plan; (iii) will result in the delivery of more effective and efficient health care services, and (iv) is in the public interest. Similarly, COMAR 10.24.01.02(A)(3)(c) provides that a CON is not required to change the bed capacity of a hospital if the change in bed capacity is "proposed pursuant to a merger or consolidation between health care facilities" and the Commission finds that the

change is not inconsistent with the State Health Plan, will result in the delivery of more efficient and effective health care services, and is in the public interest.

Health-General § 19-120(a)(2) defines "consolidation" or "merger" to include "increases or decreases in bed capacity or services among the components of an organization that: (i) operates more than one health care facility[.]" "Health care facility" is defined to include a "hospital." COMAR 10.24.01.01(B)(12). "Health care service means any clinically related patient service," including a "medical service." Health-General § 19-120(a)(3)(i)-(ii). A "medical service" includes chronic care and rehabilitation. *Id*. § 19-120(a)(6); COMAR 10.24.01.01(B)(27).

Because UMROI and UMMC are both hospitals within the UMMS merged asset system, the relocation of acute inpatient rehabilitation and chronic care bed capacity from UMROI to UMMC constitutes a consolidation or merger in accordance with Health-General § 19-120(a)(2) and COMAR 10.24.01.02(A)(3)(c). Further, the proposed acute inpatient rehabilitation and chronic care bed relocation and associated capital expenditures are not inconsistent with the State Health Plan, will result in the delivery of more efficient and effective health care services, and are in the public interest. The project therefore qualifies for exemption from CON review.

I. REQUEST FOR EXEMPTION FROM CON REVIEW

A. PROJECT CONSTRUCTION, TIMELINE, DESIGN AND DESCRIPTION

Aligning the post-acute TBI and SCI programs currently offered at UMROI with the world-class trauma care offered at UMMC will provide a number of benefits to patients, as demonstrated in detail in the response to the Effective and Efficient Delivery of Health Care Services standard. The relocated programs will continue to deliver high quality care in a convenient location, located on the same campus as necessary ancillary services for these highly-complex patient populations.

1. Proposed Project Construction and Timeline

The project will involve the construction of four additional floors on top of the Stoler Center for Advanced Medicine (the "Stoler Center"), which is currently under construction on the UMMC campus, and the renovation of certain existing space in UMMC's north hospital tower (the "North Hospital"). Due to the needs of the TBI and SCI patient population, the relocated rehab and chronic care beds and related support from UMROI require a greater footprint than the Stoler Center floors. Thus, the units will occupy two floors of the Stoler Center as well as a portion of existing space in the North Hospital, which UMMC will renovate to accommodate the services. Building additional floors on top of the Stoler Center to house the rehab and chronic beds will result in the loss of windows for a number of existing patient rooms in the North Hospital. The non-rehabilitation floors UMMC proposes to add on top of the Stoler Center will be used to accommodate existing UMMC medicine and psychiatry beds that must be relocated to preserve access to natural light, in accordance with Facilities Guidelines Institute ("FGI") guidelines.

The selection of the Stoler Center as the site for the relocated beds offers a number of practical benefits in the construction process. Because the first nine floors of the Stoler Center are currently under construction, the proposed project can be completed on a shorter schedule than would be possible with an undeveloped site or a site requiring demolition. Due to the

increasing costs of construction and major equipment, saving time on project development will result in significant savings on escalation costs.

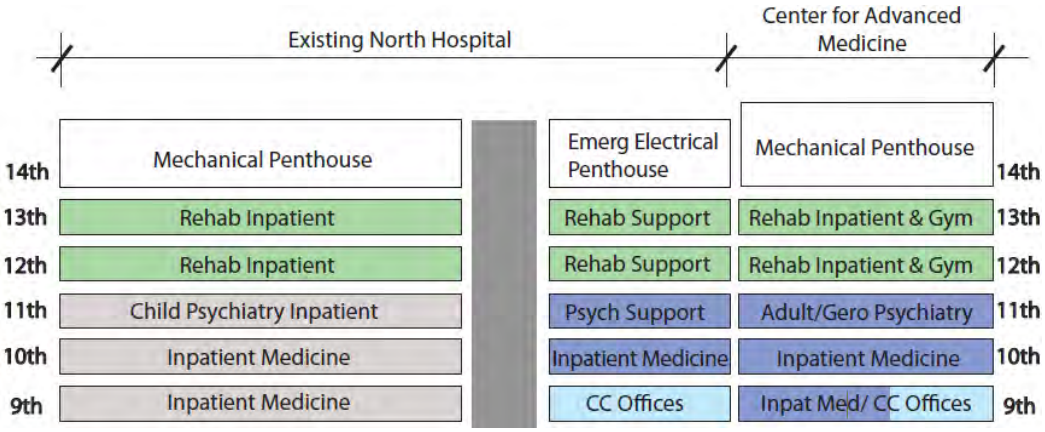
Aligning the timeline of the project with the construction of the Stoler Center will also result in cost savings based on magnitudes of scale. The initial nine-story design of the Stoler Center required deep foundations and already accounted for an additional three stories to be added in the future. Because the cost for deep foundations was already included in the original Stoler Center project, costs for deep foundations do not need to be included in the current project. Additionally, because the Stoler Center construction has already begun, the Applicants will not incur separate mobilization costs for subcontractors while the building shell for both projects is completed simultaneously. The Applicants will save on cost per square foot for concrete, curtainwall, roofing, and other materials by purchasing these materials at a higher volume to complete the full 14-story building.

Finally, the Applicants will save significantly by constructing four additional floors at this time, while the Stoler Center is currently under construction, rather than adding these floors at a later date. If the Applicants were to wait to construct the new floors on the Stoler Center to accommodate the TBI and SCI programs until after the first nine stories are complete, the cost to add the floors would nearly double. This significant cost increase is due to a number of factors, including, for example, the cost of a crane delivery and monthly rental expense. Additionally, due to industry standards and guidelines, facilities cannot engage in construction over an occupied floor. As a result, to add these floors at a later date, UMMS would need to vacate full floors to begin the construction, resulting in serious disruption to patient care, decreased patient volumes, and lower revenues. Moving ahead with the relocation of the TBI and SCI beds at this time is therefore the most cost-effective approach.

2. Project Design

The floor plans included in **Exhibit 2** and the following excerpt from the stacking diagram, **Exhibit 3**, present the layout of the proposed project.

Figure 1
Stacking Diagram Excerpt



	Services to be relocated from UMROI pursuant to proposed Exemption project
	Services to be relocated from UMMC North Hospital pursuant to proposed Exemption project
	Services subject to existing CON for Cancer Center Project

Note: **Exhibit 3** includes a complete stacking diagram for floors 0-14, and a before stacking diagram of the North Hospital.

The project will involve adding four floors of occupiable space to the top of the Stoler Center. Specifically, the project will involve adding Floors 10, 11, 12, and 13 as occupiable space. The mechanical penthouse originally planned for Floors 9/10 of the Stoler Center will be moved to the top of the building to become the 14th floor mechanical penthouse, as locating a mechanical penthouse on a top floor improves efficiency. This will also align the Stoler Center mechanical penthouse with the existing mechanical penthouse for the North Hospital. Floor 9 will be fitted out as occupiable space.[1] The beds relocating from UMROI to UMMC will occupy the 12th and 13th floors as new construction, as well as portions of the existing 12th and 13th floors of UMMC's North Hospital, which will be renovated to accommodate the relocated services. The proposed project will be designed in accordance with applicable building codes and the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals and Outpatient Facilities ("FGI Guidelines").

The Applicants considered a number of factors unique to the acute inpatient rehabilitation population in determining that a four-story addition to the Stoler Center best addresses the project goals and design requirements. In the process of developing an appropriate configuration for rehabilitation services within the new Stoler Center tower, the Applicants determined that the ideal layout for delivering care to patients is to have the cohorts (SCI or TBI) together on the same floor with their own gym space, day, and dining spaces. FGI guidelines require locating day rooms and dining spaces on the same floor. Further, moving

[1] Because these changes to Floor 9 impact the construction plans for the approved CON for the Stoler Center, UMMC will be submitting a project change request related to the Stoler Center in early January, 2024 to discuss and request approval of those changes.

patients up and down elevators to reach the gym presents safety risk for patients and inefficiency for staff. For TBI patients in particular, who require a locked unit because of flight risk and the risk of harming themselves or staff, moving patients multiple times a day in an elevator exposes patients and staff to potential for significant harm. As a result, the Applicants determined that each cohort must be located on their own floor with dedicated support services and gym space.

The floorplate of the Stoler Center tower can only hold 22 beds on each floor, with no additional space for a gym, day space or dining space. The Applicants thus determined that existing adjacent space within the North Hospital must be used for the rehabilitation service lines. The gym space required for patients with life-altering TBI and SCI conditions also significantly exceeds FGI minimums. In the initial planning efforts, the Applicants attempted to develop a functional diagram using only the east wing of North Hospital, where the new building connects to the old. However, this footprint was not adequate from a workflow or staffing ratio perspective, and did not leave enough space for support.

Ultimately, the Applicants determined that the only appropriate design that adequately addresses all of the inpatient rehabilitation program goals and unique constraints requires using all of the North Hospital's existing footprint on levels 12 and 13 as part of the acute inpatient rehabilitation units. Housing rehab services on Floors 12 and 13 will result in ideal workflow improvements because existing medicine inpatient beds on Floor 13 will be moved to Floor 10, where other medicine beds already exist. Similarly, moving the Adult and Geriatric Psychiatry beds, currently located on Floor 12, to align with the recently renovated Child Psychiatry Unit on Floor 11 will allow Floor 11 to become a fully locked down psychiatry floor. The colocation of psychiatry services all on one floor may also allow for a portion of the east wing to function as a swing space for special activities for any of the psychiatry patient groups.

The Applicants provide details of the design and layout of each floor involved in the project below.

A. Floors 9, 10, and 11

The non-rehabilitation floors will include:

- Floor 9: 16-bed medicine unit, comprised of all private patient rooms;
- Floor 10: 22-bed medicine unit, comprised of all private patient rooms;
- Floor 11: 22-bed adult and geriatric psychiatry unit, comprised of all private patient rooms and located adjacent to the existing child psychiatry unit in the North Hospital, which was recently renovated.

Expanding the Stoler Center from a nine-story building to a 13-story building, plus mechanical penthouse, will block existing windows along the east face of the North Hospital. The loss of windows will affect 27 existing patient beds located on floors 10 and above in the North Hospital, which will no longer meet FGI guidelines for access to natural light. As a result, these 27 beds may no longer be used as inpatient beds.

The rehab and chronic beds together with support services, such as a gym fit out with highly specialized equipment for rehab patients, require a larger footprint than the planned Stoler Center. Applicants will thus renovate the adjacent space of Floor 12 and Floor 13 of the North Hospital to accommodate the rehabilitation and chronic care programs. This renovation results in a loss of 26 psychiatry beds on Floor 12 and 27 medicine beds on Floor 13. To

replace the existing UMMC medicine and psychiatry beds whose windows will be blocked or that will be lost as a result of the renovations to Floors 12 and 13, the Applicants propose to fit out Floor 9 and construct new Floors 10 and 11 on top of the Stoler Center.

The loss of beds and need to relocate them elsewhere within the hospital provides UMMC with the opportunity to convert many of the impacted beds from semi-private rooms to private rooms. This will promote patient safety and enhance patient experience. *See* Responses to COMAR 10.24.09.04B(1) – Access and COMAR 10.24.09.04B(4) – Patient Safety. Through the construction of Floors 9 and 10 and the associated relocation of medicine beds to those floors, UMMC will transition from having 45 private medicine beds and 46 semi-private medicine beds to having 93 private rooms and only ten remaining semi-private beds in five remaining semi-private rooms. The newly constructed medicine floors will also ensure sufficient support space exists to advance UMMC's academic mission, representing an improvement over the existing medicine units in the North Hospital.

The project also provides UMMC the opportunity to locate adult and geriatric psychiatry services adjacent to the existing child psychiatry unit, allowing for one full locked floor that will house all psychiatry services at UMMC. Locating all psychiatry services on the same floor will provide efficiencies in operations. The child/adolescent psychiatry patients and adult/geriatric psychiatry patients will be treated in two distinct therapeutic areas on the unit. The unit will be designed to allow the clinical team to section off space to establish safe environments for frail geriatric patients, similar to the ways in which the clinical team separates functionally developed children from one another in the child and adolescent unit.

Currently, all of UMMC's 26 adult and geriatric psychiatry rooms are located in former medicine rooms and most are semi-private. The construction of the new Floor 11 and reallocation of psychiatry beds will result in the elimination of all semi-private adult and geriatric psychiatry patient rooms at UMMC, and UMMC will transition to having 20 private adult and geriatric psychiatry rooms. While the project will result in the loss of six physical beds, the improvements to patient safety and throughput that private psychiatry beds will afford represents a significant improvement over the existing facility layout.

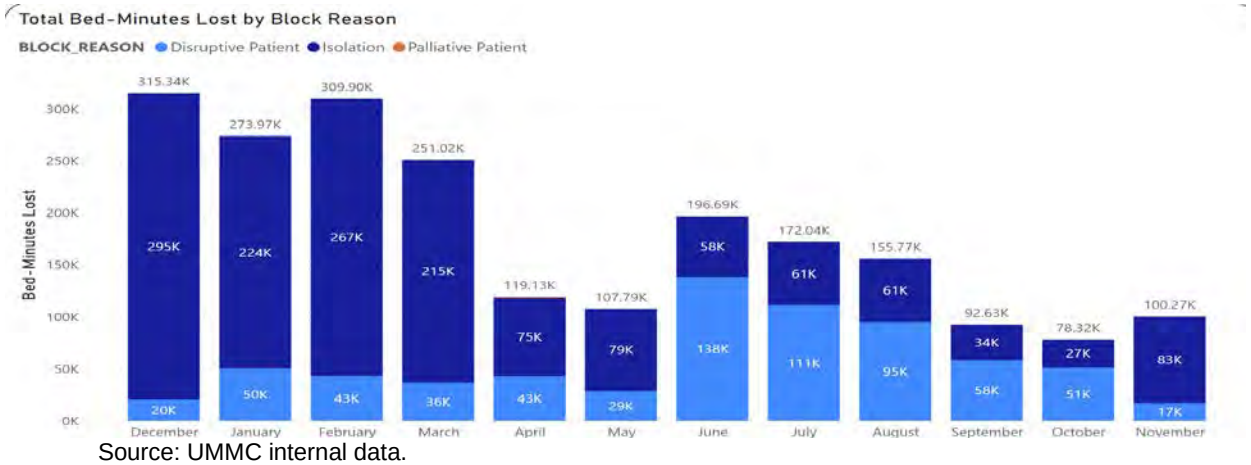
Semi-private rooms, particularly for the psychiatric patient population, present a number of challenges to optimal patient flow. Patients must be cohorted by gender and placement depends on the patient's age and diagnosis. There are many circumstances where a patient cannot be cohorted with another patient in a semi-private room. For example, disruptive patients who, due to behaviors associated with their psychiatric illness, would present a threat to the safety and well-being of another patient placed in the same room cannot be left unobserved with other patients in a semi-private room. This includes patients exhibiting hypersexual behaviors, aggressive or violent impulsive behaviors (including those specifically towards particular ethnic groups or genders), and behaviors associated with gross lack of hygiene. Patients who are admitted to the inpatient psychiatric unit with an infection requiring isolation and precautions to prevent spread to other patients also cannot be cohorted with other patients in a semi-private room. This includes patients with MRSA who also have open and draining wounds, and patients requiring droplet precautions due to respiratory illness.

When disruptive patients or patients requiring isolation are admitted to the inpatient psychiatric unit in a semi-private room, UMMC must "block" the second bed in the room, meaning it is not available for use by other patients. From December 2022 to November 2023, UMMC placed a total of 349 blocks on beds due to patients who could not be cohorted with another patient in the semi-private room. As demonstrated in Figure 2 below, these blocks

resulted in a total of 2.17 million bed minutes lost, for a total of 1,507 bed days lost. By replacing its semi-private adult and geriatric psych rooms with all private rooms, UMMC will significantly improve the number of lost bed days because it will no longer face the same level of cohorting challenges with disruptive and infectious patients that it does today.

Figure 2
Adult and Geriatric Inpatient Psychiatric Unit Semi-Private Beds Blocked
December 2022 – November 2023

Blocks: 349	Total Block Time (mins.): 2.17M	Avg. Block Time (mins): 6.23K



Source: UMMC internal data.

All of the new psychiatry rooms will be designed and constructed specifically to accommodate the unique needs of psychiatric patients. The current inpatient psychiatric units were originally designed to be inpatient med/surg units and have been adapted to be safe for the psychiatric patient population. The initial adaptations occurred decades ago when the inpatient adult and geriatric units were moved to these areas from the old psychiatric building adjacent to STC, and the move was intended to be temporary. Over time, the units have been renovated for patient safety, with some renovations addressing the clinical team's ability to deliver optimal therapeutic care. The physical environment, however, which is a critical component of psychiatric care, has not been fully addressed for the best possible therapeutic value. As a result, the current adult and geriatric psychiatric units maintain an institutional feel due to the emphasis on safety. Through the project, the Applicants will have the opportunity to address patient safety as well as design an optimal therapeutic environment for psychiatric care on the new Floor 11, where the existing adult and geriatric psychiatric beds will be relocated.

Finally, by co-locating the adult and geriatric psychiatry beds on the same floor as child and adolescent psychiatry beds, UMMC will gain additional flexibility to accommodate fluctuations in patient volumes, thereby resulting in improved operational efficiency and patient flow.

B. <u>Floors 12 and 13: Acute Inpatient Rehabilitation and Chronic Care</u>

The Applicants propose to relocate a total of 58 beds from UMROI to UMMC. To accommodate the relocated beds, UMMC will create two new 29-bed units on Floors 12 and 13. The new units will be a combination of new construction and renovation of existing space in the North Hospital.

To optimize patient and staff safety, the Applicants determined that both new construction and renovation of existing space are necessary to accommodate the relocated beds. Floor 13 will hold 25 acute inpatient rehab TBI beds along with three chronic beds and one dually-licensed acute inpatient rehabilitation and chronic care bed to provide flexibility depending on patient census. TBI patients present high flight and wander risks and pose a high risk of harm to themselves and staff. As a result, these patients must be cohorted on a locked unit. To minimize flight and wander risk, TBI patients should have access to necessary services within the locked unit and avoid traveling to other areas of the facility by elevator. This unit will thus include all TBI patient rooms, the TBI rehab gym, and support space. Floor 12 will comprise the spinal cord injury unit. To ensure flexibility and efficiency for this patient population, the floor will include 18 acute inpatient rehab SCI beds along with two chronic beds and nine dually-licensed beds located adjacent to the SCI rehab gym.

TBI and SCI patients have unique, highly-specialized needs due to the life-altering nature of their injuries. Accordingly, rehab gyms designed for these patient populations must be larger than typical inpatient rehabilitation therapy gyms. See response to COMAR 10.24.09.04B(5) – Patient Safety. Gyms should also be located close to patient rooms and on the same floor, to avoid unnecessary transports. Due to these requirements, the Applicants determined that both new and existing space would be necessary to accommodate TBI and SCI patients on single units. Each new unit will include 29 private inpatient beds, day and dining space, multi-purpose space, a large gym, and all associated support and office space, ensuring that the patients may access all necessary components of their care on one single floor.

C. Floor 14 Mechanical Penthouse

The Floor 14 mechanical penthouse will include the mechanical elements previously planned for Floors 9/10 of the Stoler Center in the nine-story building design. UMMS has found that locating the mechanical space on a top floor improves efficiency. Further efficiency will be gained by locating the mechanical space adjacent to the 14th floor mechanical space of the existing North Hospital.

3. Change in Bed Capacity at each Affected Facility

As a result of the merger and consolidation of acute inpatient rehabilitation and chronic care beds from UMROI to UMMC, a total of 43 acute inpatient rehabilitation, five chronic care, and ten dually-licensed acute inpatient rehabilitation and chronic care beds will be removed from UMROI and relocated to UMMC.

Changes to the bed capacity at UMMC are reflected in **Exhibit 1,** Table A. As demonstrated therein and in Section I.A.2.A above, UMMC currently has 45 private medicine beds in 45 private rooms and 46 semi-private medicine beds in 23 semi-private rooms. As a result of the project, UMMC will transition to having 93 private beds in 93 private rooms and only ten semi-private medicine beds in five semi-private rooms. The project will result in a net gain of 48 private medicine beds at UMMC that are currently semi-private. These changes are due to the need to relocate medicine beds whose windows will be blocked by the addition of new floors on the Stoler Center and to the renovation of space on Floors 12 and 13 of the North Hospital to accommodate rehab services.

The transition to private medicine rooms will be accomplished, in part, by converting and relocating all of UMMC's 26 semi-private adult and geriatric psychiatry rooms to 20 private

rooms. The project will result in the loss of six physical adult/geriatric psychiatry beds, but will significantly improve the patient experience, as discussed in more detail above. Project drawings are attached as **Exhibit 2.** The Applicants have also completed hospital CON Tables, which are attached as **Exhibit 1.**

B. PROJECT BUDGET AND TIMETABLE

The total project budget is $207,315,000. The proposed project is expected to be funded through bonds, interest on bond proceeds, and state funding.

As background context, consistent with its approved CON, as modified, UMMC anticipates that the Phase 1 work for the approved Stoler Center CON, which includes new construction plus renovation of the first-floor lobby, remains on track for completion in early 2026. The Phase 2 work, which includes the renovation scope on levels 5, 7, 8, & 9 is anticipated to be complete in late 2026.

Applicants anticipate that the completion of construction for the additional four floors plus mechanical penthouse, as well as the fit out of Floors 9 through 11, will be completed and ready to open together with the approved relocated GCCC in the new Stoler Center. Applicants anticipate that the fit-out of Floors 12 and 13 and the renovations of the North Hospital Floors 12 and 13 to accommodate the relocated acute inpatient rehabilitation and chronic care units will take an additional 12 months. The Applicants anticipate completing Floors 12-13 in the second half of 2027.

Assuming the Commission finds that this project is exempt from CON review, the project is estimated to proceed on the following timeline:

- Projected determination of exemption from CON review – April 2024
- Award of construction contract – April 2024 (Immediately following finding of exemption from CON review)
- Completion of construction – New Construction in Spring/Summer 2026; Renovation Summer 2027
- Opening of relocated beds from UMROI – Summer 2027

The Applicants note that the projected determination of exemption from CON review timeline is a significant component of the cost-effectiveness of this project, as Applicants seek to take advantage of the existing ongoing construction of the Stoler Center, including by taking advantage of the existing delivery and use of heavy equipment, planned patient flow disruptions, and changed traffic patterns. Delay in the initiation of construction for the proposed project past April 2024 may increase project costs by approximately one million dollars monthly. Initiation of the proposed project after completion of the existing CON project for the Stoler Center would likely increase costs for this project by approximately 150%.

C. IDENTIFICATION OF OUTSTANDING PUBLIC BODY OBLIGATIONS

A portion of the proceeds of the following bond issues currently outstanding for the benefit of the UMMS Obligated Group are allocable to UMROI: Series 2021A, Series 2020D, and Series 2017B. The Applicants do not anticipate that the project will have any adverse effect

on the UMMS Obligated Group's ability to pay the outstanding debt associated with these bond issues.

D. THE MERGER AND CONSOLIDATION OF THE BEDS FROM UMROI TO UMMC WILL RESULT IN THE DELIVERY OF MORE EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES.

Applicant Response:

The merger and consolidation of UMROI's acute inpatient rehabilitation beds, chronic care beds, and dually licensed acute inpatient rehabilitation and chronic care beds to UMMC will result in more efficient and effective delivery of health care services.

1. The project will result in more efficient and effective clinical care for patients.

The co-location of acute inpatient rehabilitation and chronic care services for TBI, SCI, and highly complex comprehensive medical rehabilitation patients with the trauma care and other services currently provided at UMMC's downtown campus will improve the patient experience in a number of ways.

Access to Full Spectrum of Services on One Campus

The newly constructed rehabilitation and chronic units will allow for a more efficient transition for patients from critical care to step-down care, as the full continuum of services will exist on the same campus. As a result of the project, patients will have access to the vast majority of their medical needs in one place, eliminating the need for transports to step-down chronic or rehab care from trauma and the need for transfers back and forth from UMMC for complex patients requiring services not offered at the existing UMROI campus.

TBI and SCI patients often have complex medical needs requiring ongoing care even after discharge from an acute care setting. Many TBI, SCI, and chronic patients receiving post-trauma care at UMROI still require regular follow-up appointments with their trauma care team. For example, TBI and SCI patients typically have an initial follow-up appointment within four weeks of discharge from trauma, which often includes a follow-up head or spine CT scan in addition to the clinic visit. Others have ongoing medical needs that require appointments for services not currently available on the UMROI campus. To attend their follow-up appointments or receive ongoing services, these patients must be transported from UMROI to UMMC for care either by ambulance or by wheelchair van. Those patients who require imaging as part of these visits must first receive their imaging tests and wait for the results before attending their appointment, requiring them to wait on-site at UMMC, sometimes for long periods of time. By co-locating TBI and SCI rehab and chronic care downtown, these patients will have the ability to attend their follow-up appointments and receive other medical services needed to address their complex needs in a timely manner without requiring a transport, including:

- Radiology: MRI/Nuclear Medicine
- Interventional Radiology: Central Line Insertion for Hemo-Dialysis or long-term infusions
- Specialty CT Studies
- Peg tube insertion: Nutrition for patients who cannot eat
- GI Studies

- Nuclear Medicine
- Orthopedics
- Plastics
- Oncology
- Cardiology

Co-locating TBI and SCI rehabilitation services with UMMC's acute and trauma care services at the downtown campus will not only improve patient experience by avoiding the inconvenience of a transport, but it will also help avoid disruption to the patient's treatment plan. CMS regulations require all acute inpatient rehabilitation facilities to provide a minimum of three hours of therapy a day, five days per week, for each patient. When patients must be transported to UMMC to obtain medical services not currently available on the UMROI campus, the time associated with the transport takes away from available therapy hours. While the mileage involved in a round trip transport from UMROI to UMMC is less than fifteen miles, the time required to attend the appointment often averages four hours and at times far exceeds that.

Most patient transports from UMROI to UMMC take place by ambulance. Ambulance companies have experienced significant staffing challenges as a result of the COVID-19 pandemic, which often results in delayed scheduling of return transports. Patients requiring ambulance transport for an outpatient clinic appointment also have lower priority than emergent patient transports, making the availability of an ambulance more uncertain. Difficulty obtaining timely transport is prevalent. During the eight-month period from March 1, 2023 through November 30, 2023, UMROI had 393 ambulance round trips scheduled for patients across all of its programs. Of those, 93 were late and 89 were cancelled outright, meaning only slightly over half of all scheduled trips occurred on time.

When ambulances are late in picking patients up at UMROI to begin the transport to UMMC, patients often arrive late to their scheduled clinic appointment. Late arrivals disrupt the UMMC clinical schedule and sometimes result in the patient's appointment being cancelled altogether. Not only does the cancelled appointment negatively impact the patient by delaying access to outpatient services, but it also results in lost productivity and revenue at UMMC, given that the appointment could have been filled by another patient requiring such services.

Even when a patient's transport is on-time in delivering the patient to their UMMC visit, patients often experience delays for return transport to UMROI. This can result in patients waiting at UMMC after their specialty appointment has ended for hours before return transport arrives, at times interfering with the patient's ability to receive services that day at UMROI. By relocating TBI and SCI units from UMROI to UMMC, transfers will be avoided and patients will receive their required three hours of therapy even on days when they require additional non-rehabilitation related services. This will mitigate disruption to patients' rehabilitation process and will assist in optimizing some patient's length of stay.

Difficulties arranging timely ambulance transport also affect the ability of patients to access rehabilitation services most efficiently once the trauma team has approved the patient for discharge. On average, it takes seven hours from the time a patient receives a bed assignment at UMROI for acute inpatient rehabilitation services to the time the patient is actually admitted to UMROI. This delay is attributable to the time required to arrange transportation for the patient and will be fully avoided by co-locating rehab services at UMMC, thereby eliminating the need to transport patients at discharge. As a result, patients will have fewer avoidable acute care days and missed therapy days will be reduced.

Reducing the need for transports from UMROI to UMMC and back will also improve efficiency from a staffing perspective. Due to the severity of their conditions, patients require a staff member to accompany them for the duration of their transport, appointment, waiting time, and return transport. A staff member must accompany a patient at all times throughout this process. To ensure adequate staffing, UMROI must add additional staff members to the patient schedule to account for those who must travel offsite with patients. UMROI, however, is not immune to the staffing shortage challenges that have affected most health care providers since the onset of the COVID-19 pandemic. When UMROI does not have enough staff members to fully staff its patient floors and to accompany patients offsite for outpatient appointments, it must run with fewer clinical staff on the floors while others travel with patients to UMMC. By eliminating the need for these transports, UMROI will improve staffing efficiency overall.

Finally, trauma patients such as TBI and SCI patients may experience reduced stress during their transition to post-acute care by stepping down to a lower level of care on the same campus. The process to transition a patient from critical care to the step-down unit can be difficult. TBI and SCI patients often experience fear when moving away from the trauma care team that may have saved their life. UMMC's providers make every effort to educate patients that the transition to a lower level of care is a positive step in a patient's recovery and signals that the patient is getting better. Patients may feel more comfortable transitioning their care on the same campus, where the trauma care team that initially provided care remains close by.

Reduced Transport Costs

Reducing the number of patient transports required between UMROI and UMMC will reduce operational expenses. During fiscal year 2023, UMROI's TBI and SCI patients required 183 round trip transfers to UMMC for ancillary services. Patients cannot be transported unattended. As a result, a patient care tech accompanies each patient during their transport, off-site appointment, waiting time, and return transport. The average patient care tech hourly rate is $20.91. Assuming an average total off-site visit time of 4 hours, UMROI's fiscal year 2023 round trip transfers cost approximately $15,306 in staff time. These costs will be eliminated by relocating the services from UMROI to UMMC.

Additionally, in fiscal year 2023, the average round-trip cost for a wheelchair van transport was $113. Ambulance transports cost significantly more, with a base rate of $600 plus additional fees based on mileage in fiscal year 2023. Patients often bear the burden of these transport costs, which are charged to their insurance and for which they may owe deductibles or copays. Reducing the number of transports required would therefore directly lower the financial impact on patients of receiving acute inpatient rehabilitation or chronic care services. If a patient's insurance does not cover a transport, the cost is billed to UMROI, which covers the charge instead. Assuming (based on UMROI's experience) that 20% of patient transports are made by wheelchair van and 80% are made by ambulance, the annual cost incurred by UMROI for patient transports from UMROI to UMMC that were not covered by patient insurance was approximately $95,000 based on the number of round trip transports in fiscal year 2023. Transportation costs have increased for fiscal year 2024, with current wheelchair van transports costing $270 and ambulance transport costing approximately $800. With these increased costs, UMROI will incur over $131,000 in transport costs in fiscal year 2024, based on fiscal year 2023 transport volumes. This figure does not include costs that patients or their insurance companies pay for transports. Reducing required transports will improve the total cost of care by eliminating these costs for the Applicants and patients.

Access to Rehabilitation and Chronic Services for Cancer Patients

The project will enable additional patient populations to access acute inpatient rehabilitation services who currently cannot be admitted to UMROI's existing campus due to their unique needs. UMROI cannot currently accept patients receiving chemotherapy or radiation for cancer care for acute inpatient rehabilitation services because such patients require frequent cancer treatments and cannot be transported back and forth from UMROI to UMMC so often. As a result, these patients currently remain in acute care hospital beds even when they may be medically stable enough to tolerate acute inpatient rehabilitation services and would benefit from such services. The newly constructed UMMC units, however, will have the capabilities to accommodate this complex patient population. By co-locating acute inpatient rehabilitation services with the specialized cancer services that the Stoler Center will offer, cancer patients will no longer face delays in accessing rehabilitation services.

2. The merger and consolidation of beds from UMROI to UMMC will result in operational efficiencies and cost savings.

Relocating UMROI's TBI and SCI units in close proximity to UMMC's acute care and trauma care units will improve throughput at UMMC and enhance efficiency of care delivery in a number of ways.

Improved Patient Flow

Currently, patients ready to step down from acute care at UMMC to acute inpatient rehabilitation or chronic care must be transferred to a different facility, such as UMROI, to receive such care. UMMC's care management team arranges all transports for patients discharged from the acute care units to UMROI for post-acute care. This process not only requires staff time, but it also results in delays in patient discharges, which disrupts patient flow at UMMC overall.

The post-acute team responsible for evaluating all patient referrals to UMROI and coordinating their discharge operates out of UMMC. Before a patient may be discharged from UMMC to UMROI, the post-acute team must confirm the patient's medical readiness for discharge. Significant staff resources will be conserved by co-locating the post-acute care programs with acute and trauma care on the UMMC campus. Medically screening patients and determining their medical readiness for referral and admission to UMROI requires significant time and effort of the post-acute care team. Typically, the patient's trauma care team orders the patient's discharge but the post-acute care team must evaluate the patient's medical stability and confirm the patient is appropriate for transport to UMROI. The post-acute care team takes a conservative approach to determining medical readiness for post-trauma patients due to the severity and complexity of their conditions. By relocating rehabilitation and chronic care beds to UMMC, the post-acute care team will have immediate access to the trauma team members to follow-up if the patient's medical stability requires evaluation. In the event that patients require evaluation with their trauma team after admission to rehab, co-locating the services on the same campus will also mitigate the need to transport patients back to UMMC for re-evaluation. As a result, the trauma team may have greater ability to sign off on a patient's medical stability for acute inpatient rehabilitation services sooner due to the immediate availability of acute resources without the need for transport of the patient.

Once a patient referral to UMROI has been confirmed as appropriate, UMMC's care management team coordinates patient transportation to UMROI via an electronic platform called Ryde Central. This process causes avoidable delays in discharging patients from UMMC, as transports are not always immediately available and the process requires significant case manager involvement. Transportation for patients is insurance-dependent, so the care management team must coordinate with payers prior to arranging medical transport for a discharged patient. The patient's case manager handles all aspects of communication with patients, their caretakers, and the treatment teams at both UMMC and UMROI throughout the discharge and transportation process. After requesting transportation, it takes between 20 minutes to two days to receive confirmation of the scheduled transport. Case managers are responsible for keeping patients and their interdisciplinary team updated on all stages of the discharge process throughout this time.

The delay in available vehicles slows the discharge process overall. In fiscal year 2023, UMMC experienced 40 patient days' worth of avoidable delays in patient discharges due to medical transportation wait times. By relocating rehabilitation and chronic care beds to the UMMC downtown campus, TBI and SCI patients will no longer require transportation to UMROI for post-acute care. Eliminating the need to arrange transportation for these patients will result in a decrease in avoidable discharge delays. This will, in turn, improve patient flow at UMMC by freeing up acute care beds more efficiently because patients may transition to post-acute care more quickly.

Improved Patient Rooms

All patient rooms on the new UMMC rehabilitation and chronic care units will be private rooms. Private rooms provide a number of clinically significant benefits to patients in rehabilitation and are considered the best practice for this patient population. *See* Response to COMAR 10.24.12.04B(1) – Access. For patients receiving acute inpatient rehabilitation services, the primary focus is fostering independence of self-care after a recent traumatic or medical event. Having a private room preserves patient privacy and dignity while patients re-learn how to manage their self-care, mobility, and medical management. While receiving acute inpatient rehabilitation services, patients receive at least three hours of therapy per day. To ensure patients can meaningfully participate in this intensive therapy schedule, patients must have restful sleep. Private rooms facilitate the rest and recovery needed for patients to best engage in their daily therapy regimen.

Private rooms also enable family members to better engage in the rehabilitation process by enabling early and unrestricted caregiver involvement. Dedicated space for each patient allows family members to provide psycho-social support as well as to begin learning patient-specific care needs early in the rehabilitation stay. In turn, family members have multiple opportunities to learn and practice care, which may improve patient progress post-discharge.

In addition to having all single-occupancy rooms, each patient room will come equipped with ceiling lifts to efficiently and safely care for patients. At the existing UMROI campus, only one TBI room and only half of the SCI patient rooms include ceiling lifts to assist with patient transfers. Equipping all patient rooms with ceiling lifts will assist patients with movement within their room, including transitioning to the bathroom. Ceiling lifts will reduce the number of staff members needed for patient transfers, which will allow for improved patient and staff safety.

Efficient Unit Design

The acute inpatient rehabilitation and chronic care floors the Applicants propose to add on top of the Stoler Center will be designed and constructed to maximize efficiency in care delivery. The floors will be designed to the latest codes and standards and will include all private patient rooms. Compared to the existing UMROI facility, the floors that will hold the relocated beds will have an improved layout designed to facilitate efficient, high quality patient care. The new units will be structured in neighborhoods, which will optimize room workflow for staff, patients, and family. The neighborhood design will also allow for efficient staffing throughout the day. The gym and dining rooms will be located within the borders of the unit, minimizing the time it takes for patients to reach key services and improving patient safety. *See also* Response to COMAR 10.24.12.04B(5) – Safety.

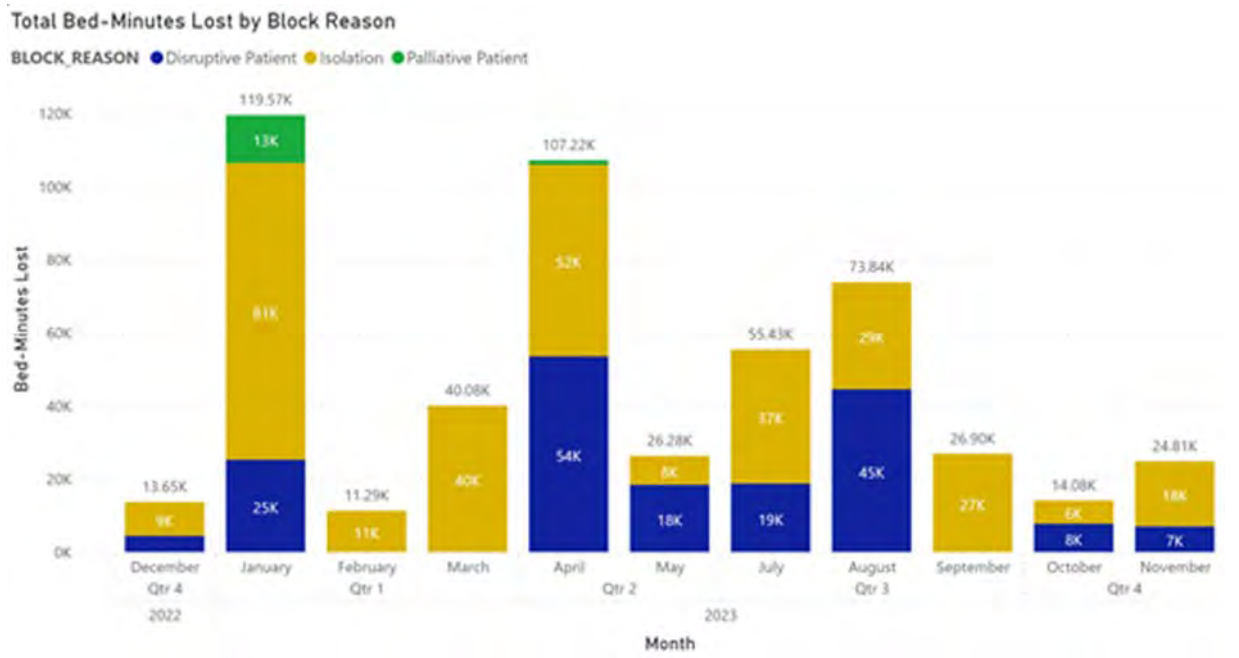
3. The project will result in improved patient flow throughout UMMC due to the increase in private medicine and adult and geriatric psychiatry rooms.

As discussed in Section I.A.2, Project Description, above, UMMC currently must block beds in semi-private adult and geriatric psychiatry rooms when disruptive or infectious patients are admitted and cannot be cohorted with another patient. In the period between December 2022 through November 2023, these semi-private psychiatric bed blocks resulted in a total of 2.17M lost bed minutes, for a total of 1,507 lost bed-days. The new adult and geriatric psychiatry unit to be constructed on Floor 11 will have all private rooms, thereby significantly reducing the number of lost patient days due to blocked beds.

UMMC faces similar challenges with optimal capacity and patient flow with its semi-private medicine beds. From December 2022 through November 2023, UMMC was forced to block 89 beds from admissions in semi-private rooms due to disruptive patients, patients requiring isolation and in limited circumstances, patients receiving palliative care. These blocked beds resulted in a total of 356 lost bed days. Figure 3 below demonstrates UMMC's blocked medicine beds.

Figure 3
UMMC Semi-Private Medicine Beds Blocked
December 2022 – November 2023

Blocks:	Total Block Time (mins.):	Avg. Block Time (mins):
89	513.13K	5.77K



Source: UMMC internal data.

Through the build-out of the new medicine units on Floors 9-11, UMMC will more than double its number of private medicine rooms. UMMC will reduce the 46 semi-private rooms it currently has to ten. Conversion to private rooms will reduce the frequency with which UMMC must block beds for admissions. As a result, UMMC will improve access to inpatient care through more efficient utilization of bed capacity.

E. THE MERGER AND CONSOLIDATION OF THE BEDS IS NOT INCONSISTENT WITH THE STATE HEALTH PLAN.

The relocation of acute inpatient rehabilitation beds and chronic care beds from UMROI to UMMC is not inconsistent with the State Health Plan Chapters for Acute Inpatient Rehabilitation Services, COMAR 10.24.09.04 and Special Hospital- Chronic Care Services, COMAR 10.24.08.03 (the "State Health Plan.").

**COMAR 10.24.09. Specialized Health Care Services —
Acute Inpatient Rehabilitation Services**

Standard .04A. – General Review Standards.

(1) Charity Care Policy.

(a) Each hospital and freestanding acute inpatient rehabilitation provider shall have a written policy for the provision of charity care that ensures access to services regardless of an individual's ability to pay and shall provide acute inpatient rehabilitation services on a charitable basis to qualified persons consistent with this policy. The policy shall have the following provisions:

(i) Determination of Eligibility for Charity Care. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the facility shall make a determination of probable eligibility.

(ii) Notice of Charity Care Policy. Public notice and information regarding the facility's charity care policy shall be disseminated, on an annual basis, through methods designed to best reach the facility's service area population and in a format understandable by the service area population. Notices regarding the facility's charity care policy shall be posted in the registration area and business office of the facility. Prior to a patient's admission, facilities should address any financial concerns of patients, and individual notice regarding the facility's charity care policy shall be provided.

(iii) Criteria for Eligibility. A hospital shall comply with applicable State statutes and HSCRC regulations regarding financial assistance policies and charity care eligibility. A hospital that is not subject to HSCRC regulations regarding financial assistance policies shall at a minimum include the following eligibility criteria in its charity care policies. Persons with family income below 100 percent of the current federal poverty guideline who have no health insurance coverage and are not eligible for any public program providing coverage for medical expenses shall be eligible for services free of charge. At a minimum, persons with family income above 100 percent of the federal poverty guideline but below 200 percent of the federal poverty guideline shall be eligible for services at a discounted charge, based on a sliding scale of discounts for family income bands. A health maintenance organization, acting as both the insurer and provider of health care services for members, shall have a financial assistance policy for its members that is consistent with the minimum eligibility criteria for charity care required of hospitals that are not subject to HSCRC regulations regarding financial assistance policies.

Applicant Response:

UMMC provides care to all patients regardless of the ability to pay. A copy of the hospital's Financial Assistance Policy is attached as **Exhibit 4.** Notices regarding the availability of charity care at the hospital are posted in the admissions office, business office, and emergency department. A copy of that notice is attached as **Exhibit 5.** Public notice is provided through publication on UMMC's website at: https://www.umms.org/ummc/patients-visitors/for-patients/financial-assistance, where the public may also access information about the application process. Each patient or patient representative is advised of UMMC's charity care policy at the time of admission or outpatient registration. The hospital's Financial Assistance Policy specifically states that it will make a determination of probable eligibility within two (2) business days following a patient's request for charity care services, application for medical assistance, or both. Financial counselors are available to assist individuals to prepare and file all documents required to seek charity care at the hospital.

(b) 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 HSCRC Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Applicant Response:

The most recent Community Benefit Report on the Health Services Cost Review Commission website is from FY 2022. As shown in Table 1 below, UMMC fell within the fourth quartile in FY 2022, with charity care comprising 1.13% of its total operating expenses.

Table 1
Maryland Hospitals Charity Care as a Percentage of Total Operating Expenses
Fiscal Year 2022

Hospital Name	Total Hospital Operating Expense	CB Charity Care Reported	% Charity Care	
Holy Cross Hospital	$523,163,323	$32,744,408	6.26%	Quartile 1
GRMC, Inc., DBA Garrett Regional Medical Ctr.	$63,270,654	$2,860,842	4.52%	
UPMC Western Maryland	$346,075,327	$13,988,602	4.04%	
Adventist HealthCare White Oak Medical Center	$316,057,692	$11,912,201	3.77%	
Mercy Medical Center	$549,134,673	$20,692,798	3.77%	
Doctors Community Hospital	$243,435,000	$8,470,800	3.48%	
Saint Agnes Healthcare, Inc.	$506,146,000	$16,175,690	3.20%	
Johns Hopkins Bayview Medical Center	$773,596,000	$23,211,000	3.00%	
MedStar Harbor Hospital	$218,397,738	$6,380,276	2.92%	
Univ. of Maryland Capital Region Health	$365,558,000	$10,414,000	2.85%	
MedStar Southern Maryland Hospital Center	$297,984,021	$8,131,773	2.73%	

TidalHealth Peninsula Regional	$445,496,000	$11,921,900	2.68%	Quartile 2
MedStar Montgomery Medical Center	$205,575,926	$5,332,559	2.59%	
Holy Cross Germantown Hospital	$134,492,223	$3,275,651	2.44%	
Univ. of Maryland Shore Medical Center at Chestertown	$44,681,000	$1,084,000	2.43%	
MedStar Good Samaritan Hospital	$311,646,463	$7,212,228	2.31%	
Adventist HealthCare Shady Grove Medical Center	$429,916,114	$9,523,791	2.22%	
Meritus Medical Center	$478,452,262	$10,003,851	2.09%	
MedStar St. Mary's Hospital	$189,706,615	$3,911,833	2.06%	
Frederick Health Hospital	$408,396,000	$8,370,062	2.05%	
MedStar Franklin Square Medical Center	$669,486,011	$13,546,067	2.02%	
CalvertHealth Medical Center	$146,404,724	$2,799,501	1.91%	
Univ. of Maryland Shore Medical Center at Easton	$231,740,000	$4,379,000	1.89%	Quartile 3
Suburban Hospital	$359,685,000	$6,501,000	1.81%	
Howard County General Hospital	$323,918,000	$5,553,000	1.71%	
MedStar Union Memorial Hospital	$500,756,162	$7,871,609	1.57%	
Northwest Hospital Center, Inc.	$305,327,335	$4,603,315	1.51%	
Johns Hopkins Hospital	$2,920,138,000	$43,952,000	1.51%	
Univ. of Maryland Upper Chesapeake Medical Center	$300,645,000	$4,448,000	1.48%	
Univ. of Maryland Medical Center Midtown Campus	$267,139,000	$3,907,000	1.46%	
Univ. of Maryland Baltimore Washington Medical Center	$445,181,000	$6,170,000	1.39%	
Univ. of Maryland Shore Medical Center at Dorchester	$28,191,000	$386,000	1.37%	
Univ. of Maryland St. Joseph Medical Center	$383,026,000	$4,848,000	1.27%	
Sinai Hospital of Baltimore, Inc.	$912,336,095	$11,488,577	1.26%	Quartile 4
Univ. of Maryland Harford Memorial Hospital	$105,601,000	$1,298,000	1.23%	
Univ. of Maryland Charles Regional Medical Center	$153,803,523	$1,849,670	1.20%	
ChristianaCare, Union Hospital	$201,277,425	$2,395,905	1.19%	
Carroll Hospital Center	$269,285,583	$3,120,445	1.16%	
Univ. of Maryland Medical Center	$1,954,590,000	$22,001,000	1.13%	
Atlantic General Hospital	$154,127,092	$1,620,972	1.05%	
Adventist HealthCare Fort Washington Medical Center	$61,599,333	$613,543	1.00%	
Univ. of Maryland Rehabilitation & Orthopaedic Institute	$115,219,000	$1,023,000	0.89%	
Anne Arundel Medical Center	$672,800,000	$4,976,327	0.74%	
Greater Baltimore Medical Center	$605,730,943	$2,773,030	0.46%	
Grace Medical Center	$43,098,140	$166,170	0.39%	

Source: Maryland Health Services Cost Review Commission Maryland Hospital Community Benefit Report: FY 2022, https://hscrc.maryland.gov/Documents/CommBen/FY%202022%20Final%20State%20Reports/HCB%20FY22%20Statewide%20Report%20Final%209-27-23.pdf

Despite falling in the bottom quartile, UMMC's level of charity care is appropriate to the needs of its service area population, as described more fully below.

One factor that may explain UMMC's position in the charity care rankings is UMMC's success in enrolling uninsured individuals in Maryland's Medical Assistance program, which in turn reduces the population of patients in need of charity care. As demonstrated in Table 2 below, Baltimore City has the highest percentage of its population enrolled in Medicaid of all jurisdictions in the state. As of calendar year 2019, 36.3% of Baltimore City residents were Medicaid enrollees, compared with 19.8% statewide.

Table 2
Medicaid Enrollment as a Percent of Population
Maryland Jurisdictions
2019

	Medicaid Enrollment	Total Pop	Percent
County	**June, 2019**	**2019**	**2019**
Allegany	17,710	71,048	24.9%
Anne Arundel	83,204	578,793	14.4%
Baltimore City	217,731	599,097	36.3%
Baltimore County	171,621	829,800	20.7%
Calvert	12,363	92,767	13.3%
Caroline	10,322	33,501	30.8%
Carroll	19,237	168,709	11.4%
Cecil	22,781	102,957	22.1%
Charles	27,960	162,730	17.2%
Dorchester	10,771	32,133	33.5%
Frederick	35,264	260,636	13.5%
Garrett	6,944	29,197	23.8%
Harford	38,750	256,123	15.1%
Howard	38,543	324,982	11.9%
Kent	4,178	19,677	21.2%
Montgomery	158,456	1,048,001	15.1%
Prince George's	203,774	910,107	22.4%
Queen Anne's	7,199	50,331	14.3%
Somerset	7,341	25,746	28.5%
St. Mary's	19,660	114,344	17.2%
Talbot	7,198	37,561	19.2%
Washington	37,220	151,439	24.6%
Wicomico	29,623	103,745	28.6%
Worcester	11,338	52,278	21.7%
Total	1,199,188	6,055,704	19.8%

Sources: Medicaid Enrollment: md-medicaid.org/mco/index.cfm
Population: planning.maryland.gov/MSDC/Documents/popproj/TotalPop-Race-Age-Gender.xlsx, 2019
Population interpolated between 2015 and 2020 populations using the Compound Average Growth Rate between those two years.

UMMC has a robust process in place to evaluate all uninsured patients who are treated at the hospital for their eligibility in Medical Assistance. UMMC offers eligible patients assistance with the enrollment process, which enables more patients to obtain coverage for their treatment. By enrolling more patients in Maryland Medical Assistance, the population of uninsured patients treated at UMMC decreases. As a result, the population of individuals eligible for charity care may be less than at other facilities in the state, as demonstrated in Table 3, which shows the percentage of self-pay patients and Medicaid-pending patients UMMC treats each year.

Table 3
Percentage of UMMC Self-Pay and Medicaid-Pending Patients
FY 2019 – FY 2024 (Year-to-Date)

FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024 YTD
0.9%	0.9%	1.0%	1.7%	1.9%	2.1%

Source: UMMC internal data.

Moreover, UMMC's charity care as reported in Table 1 above understates the full amount of free or uncompensated care UMMC provides to patients. To be eligible for charity care, patients must provide a complete financial assistance application. If patients start, but do not complete, a financial assistance application and are unresponsive to requests to provide outstanding information, UMMC is unable to confirm the patient's qualifications for charity care and the patient's application often must be denied. In fiscal year 2022, UMMC awarded free or reduced care to approximately 60% of the patients whose accounts were evaluated for eligibility for financial assistance. The vast majority of the denials (70%) were for patients who either failed to complete the full financial assistance process or who were non-compliant with requests for necessary documentation. The remaining denials were primarily due to patients not meeting UMMC's eligibility criteria for free or reduced cost care as set forth in the UMMC Financial Assistance Policy.

Many patients who submit incomplete financial assistance applications may still lack the financial resources to pay for their care. In these circumstances, UMMC often writes off the care provided to such patients as "bad debt," and the care is not captured as "charity care." If the free or uncompensated care that UMMC provides to such patients, many of whom could demonstrate financial need, were included as "charity care," UMMC's charity care amounts as reflected in the Community Benefit Report would be even higher. Table 4 below shows UMMC's combined charity care and bad debt as a percentage of total operating expenses in FY 2021 and FY 2022.

Table 4
UMMC's Charity Care and Bad Debt as a Percentage of Total Operating Expenses
FY 2021 and FY 2022

Year	Charity Care & Bad Debt	Total Expenses	% Total UCC to Total Expenses
FY 2021	70,528,914	1,867,360,000	3.78%
FY 2022	66,859,362	1,954,590,000	3.42%

Sources: HSCRC Community Benefit Report FY 2021 and FY 2022; HSCRC Final Hospital Financial Condition Report FY 2022.

Charity care and uncompensated care are not the only measures of the how a hospital is appropriately serving its community, including underserved groups. A hospital's contributions to the community may also be measured by total community benefit spending overall. The HSCRC Community Benefits Report cited above shows that UMMC's community benefit expense as a percentage of its total operating expense was 13.71% in FY 2022. This percentage is the sixth highest of all the acute care hospitals in the state.

UMMC's investments in the community are also illustrated by the programs it has implemented to address needs identified through its Community Health Needs Assessment ("CHNA"). UMMC most recently conducted a CHNA in 2021. The Executive Summary discussing the CHNA is available on UMMC's website at https://www.umms.org/ummc/community/needs-assessment. In response to the CHNA, UMMC prepared an implementation plan setting forth goals to address between fiscal years 2022 through 2024, which is attached hereto as **Exhibit 6**. The goals identified in the implementation plan not only address the community's top clinical needs, but they also recognize the importance of addressing social determinants of health including employment and career opportunities, neighborhood safety and violence prevention, and affordable housing and homelessness. UMMC has initiated community outreach and engagement programs aimed at addressing these social determinants of health, which disproportionately affect its lower income patients. Some of UMMC's community health outreach and engagement programs include:

- Community Health Education and Engagement: UMMC has initiated and supported community health programs that focus on preventive care, health education, and wellness initiatives. The hospital actively engages with the community through outreach events, health fairs, and partnerships with local organizations. Collaborations with community groups, schools, and businesses strengthen the hospital's ties with the community. UMMC anchors its mission in the community to improve overall health, as well as foster a sense of shared responsibility for community well-being. Community outreach programs and health screenings organized in the community have a positive impact on public health, reducing the overall burden on healthcare services.

- Career Academy: Unemployment, as well as the need for a living wage, is a major obstacle for many West Baltimore City residents. UMMC serves as a training hub for future healthcare providers, offering internships, free career training, and continuing education programs. These educational initiatives enhance the skills of healthcare professionals but also contribute to the intellectual and professional growth of the community and non-physician provider supply. The UMMC partnership creates job opportunities for healthcare professionals from the community through its Career Academy. Employment opportunities contribute to the economic stability of the community, reducing unemployment rates and fostering financial independence among residents, both of which have contributed to health disparities in West Baltimore. Newly trained employees will also be deployed in their communities to promote population health.

- Violence/Trauma Prevention Programs and Outreach: The Violence Prevention Program aims to decrease the occurrence and severity of repeat violent injuries and criminal activities among residents of Baltimore City and its surrounding areas. The program provides services that help individuals improve their strengths, develop conflict-resolution skills, and build relationships within the community.

- Safe Kids Buckle Up & Safe Kids Baltimore: Research has shown that proper installation of car safety seats and correct usage of seat belts can significantly reduce car-related fatalities and serious injuries. This community program aims to prevent unintentional childhood injuries in Baltimore City by promoting safety awareness that focuses on avoiding dangerous situations and implementing injury-prevention strategies. The program includes an annual poster contest, safety fairs, and regular child safety seat checks.

- Breath Mobile: The University of Maryland Children's Hospital has introduced Breathmobile, a custom-built pediatric asthma and allergy clinic that travels to over two dozen schools to provide ongoing care to children. The clinic, staffed by a team of healthcare professionals, aims to keep children healthy and in school rather than in the emergency room.

(c) A proposal to establish or expand an acute inpatient rehabilitation hospital or subunit, for which third party reimbursement is available, and which is not subject to HSCRC regulations regarding financial assistance policies, shall commit to provide charitable rehabilitation services to eligible patients, based on its charity care policy, which shall meet the minimum requirements in .04A(1)(a) of this Chapter. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

Applicant Response:

Not applicable. All acute inpatient rehabilitation services relocated to UMMC will be subject to rate regulation by the HSCRC and will be covered by UMMC's hospital Financial Assistance Policy which, as demonstrated above, complies with HSCRC regulations.

(d) A health maintenance organization, acting as both the insurer and provider of health care services for members, if applying for a CON for a project that involves acute inpatient rehabilitation services, shall commit to provide charitable services to indigent patients. Charitable services may be rehabilitative or non-rehabilitative and may include a charitable program that subsidizes health plan coverage. At a minimum, the amount of charitable services provided as a percentage of total operating expenses for the health maintenance organization will be equivalent to the average amount of charity care provided statewide by acute general hospitals, measured as a percentage of total expenses, in the most recent year reported. The applicant shall demonstrate that:

(i) Its track record in the provision of charitable health care facility services supports the credibility of its commitment; and

(ii) It has a specific plan for achieving the level of charitable care provision to which it is committed.

(iii) If the health maintenance organization's track record is not consistent with the expected level for the population in the proposed service area, the applicant shall demonstrate that the historic level of charity care was appropriate to the needs of the population in the proposed service area.

Applicant Response:

Not applicable.

(2) Quality of Care.

A provider of acute inpatient rehabilitation services shall provide high quality care.

(a) Each hospital shall document that it is:

(i) Licensed, in good standing, by the Maryland Department of Health and Mental Hygiene.

(ii) Accredited by the Commission for Accreditation of Rehabilitation Facilities.

(iii) In compliance with the conditions of participation of the Medicare and Medicaid programs.

Applicant Response:

UMMC is licensed by the State of Maryland. A copy of its hospital license is attached hereto as **Exhibit 7**.

UMMC will pursue accreditation from the Commission for Accreditation of Rehabilitation Facilities ("CARF"), including sub-specialty accreditations for inpatient medical rehabilitation for comprehensive integrated rehabilitation program, spinal cord specialty program, and brain injury specialty program for children, adolescents, and adults. To obtain CARF accreditation, applicants must collect data for six months after opening, at which time applicants must schedule a site survey. UMMC will contact its CARF representative to schedule the site survey after six months of operations.

UMMC is in compliance with the Conditions of Participation of the Medicare and Medicaid programs.

(b) An applicant that currently provides acute inpatient rehabilitation services that is seeking to establish a new location or expand services shall report on all quality measures required by federal regulations or State agencies, including information on how the applicant compares to other

Maryland acute inpatient rehabilitation providers. An applicant shall be required to meet quality of care standards or demonstrate progress towards reaching these standards that is acceptable to the Commission, before receiving a CON.

Applicant Response:

Not applicable. The Applicants are not proposing to establish a new location or expand services, but rather propose to relocate existing inpatient rehabilitation beds from UMROI to UMMC.

(c) An applicant that does not currently provide inpatient rehabilitation services that is seeking to establish an inpatient rehabilitation unit within an acute care hospital or an inpatient rehabilitation specialty hospital shall demonstrate through reporting on quality measures that it provides high quality health care compared to other Maryland providers that provide similar services or, if applicable, nationally.

Applicant Response:

Not applicable. The Applicants propose to relocate existing acute inpatient rehabilitation beds from one facility to another within the same merged asset system. Nevertheless, UMROI has a proven history of delivering high quality rehabilitation care that results in good patient outcomes. The programs the Applicants propose to relocate to UMMC will continue to deliver high quality care, as the programs will remain under the same programmatic leadership.

As demonstrated in the UMROI Program Reports for TBI, SCI, and complex medical rehabilitation attached hereto as **Exhibit 8**, UMROI's case mix index is much higher than the regional and national averages due to the highly medically complex patients it serves. Approximately 58% of its SCI patients and 60% of its TBI patients require rehabilitation care due to a traumatic injury, compared with only 23% of SCI and 31% of TBI rehabilitation patients nationally. UMROI earns high marks across the board in patient quality and satisfaction in its treatment of these complex patients, and the vast majority are successfully discharged home following their treatment. UMROI also exceeds expectations in the functional outcomes its patients achieve, including for change in self-care and mobility and functional efficiency for its SCI and medically-complex patients. While the functional outcome targets are risk-adjusted, such targets do not fully account for the complexity of UMROI's TBI patients. UMROI has the only secured TBI unit in the state, allowing it to treat more behaviorally complex patients who often have serious cognitive impairments. As a result, UMROI's performance compared with other rehabilitation providers for TBI patients is not accurately captured and is better measured by focusing on the high patient satisfaction marks it has earned.

The Applicants expect to continue to build upon the strong patient outcomes UMROI currently achieves once the beds are relocated to UMMC, where patients will have access to the full spectrum of services necessary to continue their post-trauma recovery on one campus.

Standard .04B. – Project Review Standards.

In addition to these standards, an acute general hospital applicant shall address all applicable standards in COMAR 10.24.10 that are not duplicated in this Chapter. These standards apply to applicants seeking to provide comprehensive acute rehabilitation services or both comprehensive acute rehabilitation services and specialized acute rehabilitation services to adult or pediatric patients.

(1) Access

A new or relocated acute rehabilitation hospital or subunit shall be located to optimize accessibility for its likely service area population. An applicant that seeks to justify the need for a project on the basis of barriers to access shall present evidence to demonstrate that barriers to access exist for the population in the service area of the proposed project, based on studies or other validated sources of information. In addition, an applicant must demonstrate that it has developed a credible plan to address those barriers. The credibility of the applicant's plan will be evaluated based on whether research studies or empirical evidence from comparable projects support the proposed plan as a mechanism for addressing the barrier(s) identified, whether the plan is financially feasible and whether members of the communities affected by the project support the plan.

Applicant Response:

The proposed project will address existing barriers to access to care including (1) the use of semi-private rooms and (2) the need to transport patients from UMROI's campus to UMMC for specialty ancillary services and physician subspecialties.

1) The availability of all private rooms will improve access.

The proposed project will consist of all private rooms with private baths, thus addressing the existing access barrier to care by enabling UMMC to admit patients in need in a timely manner regardless of the demographics and medical condition of its patient population at that time.

Currently, the vast majority (approximately 88%) of UMROI's rehab and chronic care beds are in semi-private rooms. The use of semi-private rooms too often limits access to services because UMROI must consider current and to-be-admitted patient's gender, medical condition, complexities and co-morbidities, mental status, and the need for isolation before a patient in need of UMROI's intensive rehabilitative and restorative services can be admitted.

Any delay in discharging a patient from a general acute care hospital who is in need of intensive rehabilitative services unnecessarily increases the patient's length of stay in the general acute care hospital, negatively impacting both the patient awaiting discharge to UMROI

and the patient in need of the occupied general acute care hospital bed. In those instances, the patient's physical and mental condition declines while awaiting discharge to the physician-prescribed intensive inpatient rehab care, negatively impacting the patient's short-term and sometimes long-term recovery and quality of care.

As detailed below, 126 patients' admissions have been delayed to UMROI's TBI, SCI, and CMR programs in the most recent fiscal year (July 1, 2022 – June 30, 2023) for a total 390 days. The 390 days that patients were delayed admission to UMROI's programs not only negatively impacted UMROI's patients (and families), but also patients who were in need of the occupied general acute care hospital bed.

Table 5
Delays in UMROI Patient Admissions
Because of the Lack of a Private Bed, FY23

Patient Type	Avg. Delay (Days)	No. of Patients	Total Patient Days Delayed Admission
Spinal Cord Injury	5*	75	279
Traumatic Brain Injury	3	30	90
Medically-Complex CMR	1	21	21
Total	**3.1**	**126**	**390**

Source: UMROI internal data.
*Note: of the 75 spinal cord injury patient admissions delayed to UMROI, 51 waited an average of five days for an available bed; 24 patients waited an average of one day for medical transport.

As a result of both the physical limitations imposed by the current facility and the interplay with the existing patient population, many semi-private rooms are often only able to accommodate one patient, thus limiting the total number of beds that the Applicants are able to utilize and resulting in a barrier to access which will be remedied by the proposed project. The lack of private rooms and isolation rooms created additional challenges during the COVID-19 pandemic, making it difficult to implement necessary social-distancing.

Moreover, the healthcare industry's move to private rooms across care settings supports the need for the construction of private rooms by the Applicants. Private rooms are most often constructed in new facilities because, for example, the use of semi-private rooms increases the risk of spreading infectious diseases and does not promote patient privacy or family participation in patient care. Moreover, shared rooms negatively impact patients' ability to fully rest and relax during the day and sleep through the night, which is important for optimal recovery for all patients, including UMROI's rehabilitation patients.

The Facility Guidelines Institute ("FGI") of the American Institute of Architects ("AIA"), which the Commission expressly considers in some State Health Plan chapters, has specified since 2006 that single-bed rooms should be the standard in new construction. As noted in the 2006 Guidelines:

> Perhaps the most widely anticipated change in the text in the General Hospitals chapter (now Chapter 2.1) is the change in room capacity in medical/surgical (including postpartum) units. *The 2006 edition specifies that the single-bed room*

is the minimum standard in new construction. Approval of a two-bed arrangement is still permitted if a facility's functional program demonstrates it is necessary. In addition, when an organization undertakes a major renovation, the patient room bed compliment is permitted to remain the same. [Emphasis added.] [2]

A number of studies further document the benefits of private rooms, some of which are referenced below.

Do Cost Savings From Reductions in Nosocomial Infections Justify Additional Costs of Single-Bed Rooms in Intensive Care Units? A Simulation Case Study; Hessam Sadatsafavi, PhD, Bahar Niknejad, MD, Rana Zadeh, PhD, Mohsen Sadatsafavi, MD, PhD; Journal of Critical Care, 2015, *available at* http://dx.doi.org/10.1016/j.jcrc.2015.10.010

> "Conclusions: This case study shows that although single-patient rooms are more costly to build and operate, they can result in substantial savings compared to open-bay rooms by avoiding costs associated with nosocomial infections."

Single-Patient Rooms for Safe Patient-Centered Hospitals; Michael E. Detsky, MD, Edward Etchells, MD, MSc, JAMA, August 27, 2008.

> The physician authors highlight the benefits of private rooms when it comes to safety, dignity, privacy and ensuring patient-centered care. The benefits of facility design in reinforcing patient safety, including the ability to clean and decontaminate a private room compared to the challenges associated with the same activities in a partially occupied semi-private room, are discussed.

The Use of Single Patient Rooms versus Multiple Occupancy Rooms in Acute Care Environments; Habib Chaudhury, PhD, Atiya Mahmood, PhD, Maria Valente of Simon Fraser University, Vancouver, BC, Canada, 2004.

> This study's comprehensive and extensive review of existing literature identifies a number of clinically beneficial outcomes associated with private rooms including enhanced infection control, the ability to isolate patients who are contagious or may be a high-risk for infection. The study also highlights improved communication between patients, family members and providers, which is critical in the inpatient rehabilitation setting where family members actively participate in the patient's recovery, rehabilitation, and discharge planning.
>
> This study also identifies other beneficial characteristics of private patient rooms that enhance the patient healing environment. These characteristics include increased patient privacy, noise reduction, fewer sleep disturbances, and an overall increase in patient satisfaction. In sum, the study showed that a patient's sense of control of their environment in a private room results in a significant reduction in overall stress during their stay.

The Role of the Physical Environment in the Hospital of the 21st Century: A Once-in-a-Lifetime Opportunity; Roger Ulrich of Texas A&M University and Craig Zimring of the

[2] 2006 Guidelines for Design and Construction of Health Care Facilities, The Facility Guidelines Institute of the American Institute of Architects, available at https://www.fgiguidelines.org/wp-content/uploads/2016/07/2006guidelines.pdf.

Georgia Institute of Technology and reported to The Center for Health Design; September 2004

> "To summarize briefly, there is a convincing pattern of evidence across many studies indicating that single-bed rooms lower nosocomial infection rates. Singles appear to limit person-to-person and person-surface-person spread of infection in part because they are far easier to decontaminate thoroughly than multibed rooms after patients are discharged. Also, single rooms with a conveniently located sink or alcohol-gel dispenser in each room may heighten hand washing compliance compared to multibed rooms with few sinks. Finally, single rooms are clearly superior to multi-bed rooms with respect to reducing airborne transmission of pathogens."

2) The ability to provide ancillary services on the same campus will improve access to care.

The proposed relocation of the highly-specialized UMROI programs to UMMC's campus will provide on-site access to a vast array of subspecialists and services, thus eliminating the disruptive medical transport of patients from one campus to another. The result will be enhanced quality and continuity of care as well as increased access to on-site specialty services. *See also* response to More Effective and Efficient Delivery of Health Care Services standard.

The need to transport patients from UMROI's campus to UMMC for access to specialty ancillary services and physician subspecialty providers who practice at UMMC is an existing barrier to access to care. During the most recent fiscal year (July 1, 2022 – June 30, 2023), UMROI TBI and SCI patients alone required 366 one-way medical transports (183 round trips) to receive specialized services on a comprehensive general acute care hospital campus, most often at UMMC.

By co-locating TBI, SCI, and the most medically-complex acute CMR patients on the UMMC campus with its quaternary care and subspecialty services, patients will have timely access to needed services and subspecialty providers (such as physicians and care coordinators) who practice at UMMC. UMMC's vast array of physician subspecialties such as Neuro-Hospitalists, Neuro-Intensivists, Brain Tumor Neurosurgery, Brain Tumor Neuro-Oncology, Spine Neurosurgery, and Physiatry will be able to care for TBI and SCI patients without the need for the patient to be transported between campuses. Similarly, a wide array of physician specialists will be able to care for medically-complex CMR patients, such as transplant and oncology patients, without the need for medical transport.

Not only do medical transports delay rehab patients' timely access to needed services and providers on the UMMC campus, but medical transport from UMROI to UMMC also results in a disruption of the rehab patient's time in therapy. Ultimately, this increases the patient's length of stay in the rehab program because the patient has to "make up" the lost therapy time spent receiving services at another hospital campus.

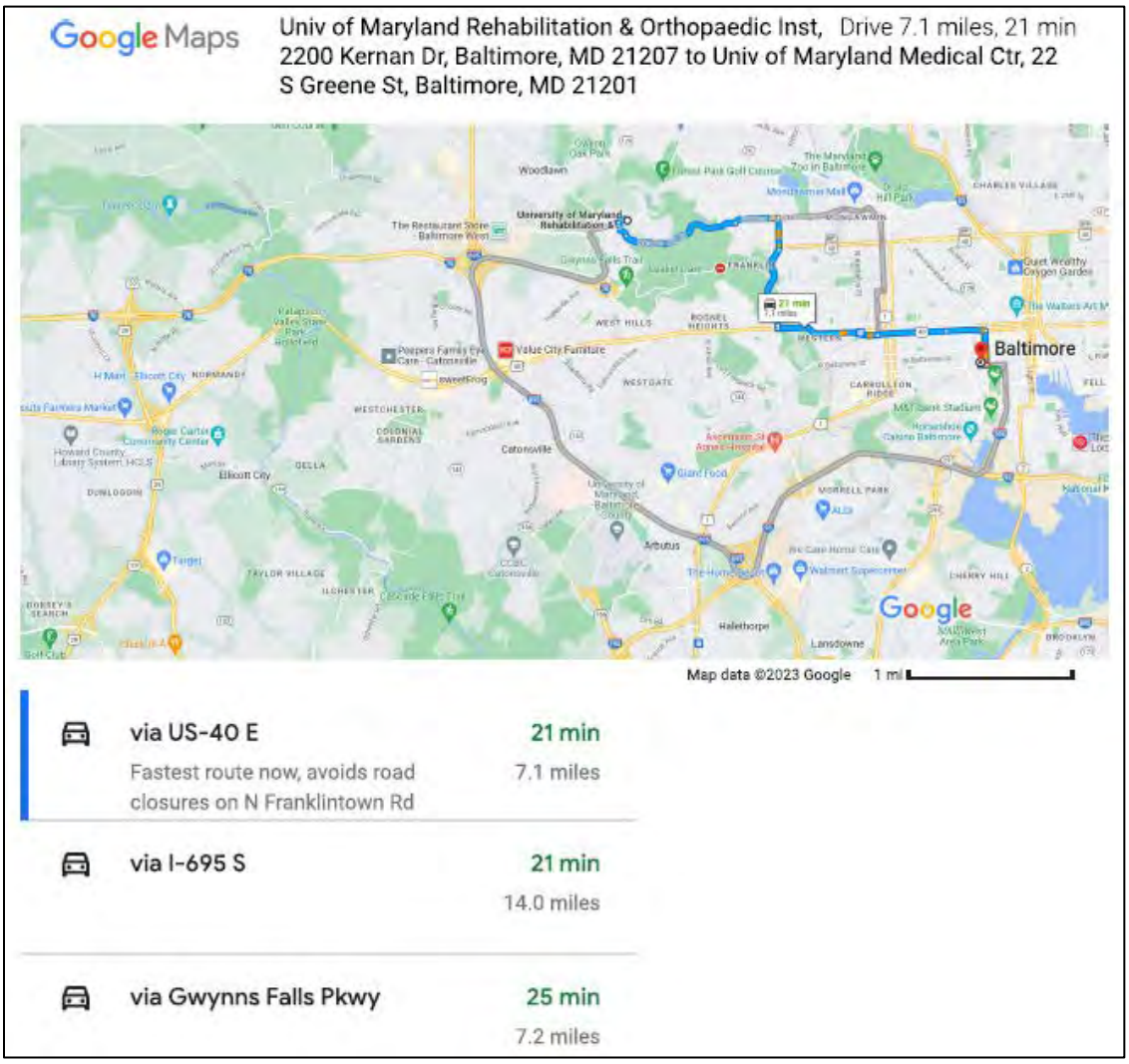
The need for medical transport disrupts and negatively impacts not only rehab patients, but also other UMROI patients as well because each transport requires a staff member such as a Certified Nursing Assistant (CNA) or Patient Care Tech to travel with the patient to and from the UMMC campus and remain with that patient during his/her time on the UMMC campus. Thus, UMROI must either call-in additional staff members to cover for the staff who is caring for the patient on the medical transport, which is an additional cost of care, or, if additional staff is

unavailable at that time, UMROI's remaining on-campus staff cares for the patients remaining on campus with one fewer staff member. Neither scenario is optimal for patients or staff.

The project will also improve patients' ability to access acute inpatient rehabilitation services as soon as they are ready for discharge from acute care without the need to coordinate ambulance transport from UMMC to UMROI. Currently, patients face routine delays when waiting for initial transport at discharge to UMROI due to staffing shortages amongst ambulance providers and because medically stable patients ready for discharge to post-acute care are lower priority for ambulance transport than emergency calls. Many scheduled transports get delayed or cancelled, resulting in patients remaining in their acute beds despite having been cleared for discharge to acute inpatient rehabilitation. This delay not only results in avoidable days in acute care beds, but it also deprives patients of the opportunity to begin their rehabilitation services once medically cleared to do so. By relocating the TBI, SCI, and certain medically-complex CMR patients to UMMC, such patients will no longer need to wait for an available ambulance transport to begin receiving their post-acute care. *See also* Response to More Effective and Efficient Delivery of Health Care Services.

In addition to addressing the identified barriers to access that exist for the Applicants' patients, the proposed relocation will ensure continued geographic accessibility for service area patients to TBI, SCI, and medically-complex CMR care programs by relocating those services only a short distance from their current location. As shown in Figure 4 below, the UMROI and UMMC campuses are in close proximity, separated by only approximately seven (7) driving miles and 21 minutes. Thus, the relocation of the services from UMROI to the UMMC campus will continue to be geographically accessible to the vast majority of the Applicants' patients.

Figure 4
Proposed Relocation of Specialized Adult Inpatient Rehabiliation Programs is Close to Existing UMROI Location, Thus Patients will Continue to have Access to Services



Source: Google Maps, Sept. 19, 2023 at 12:12pm.

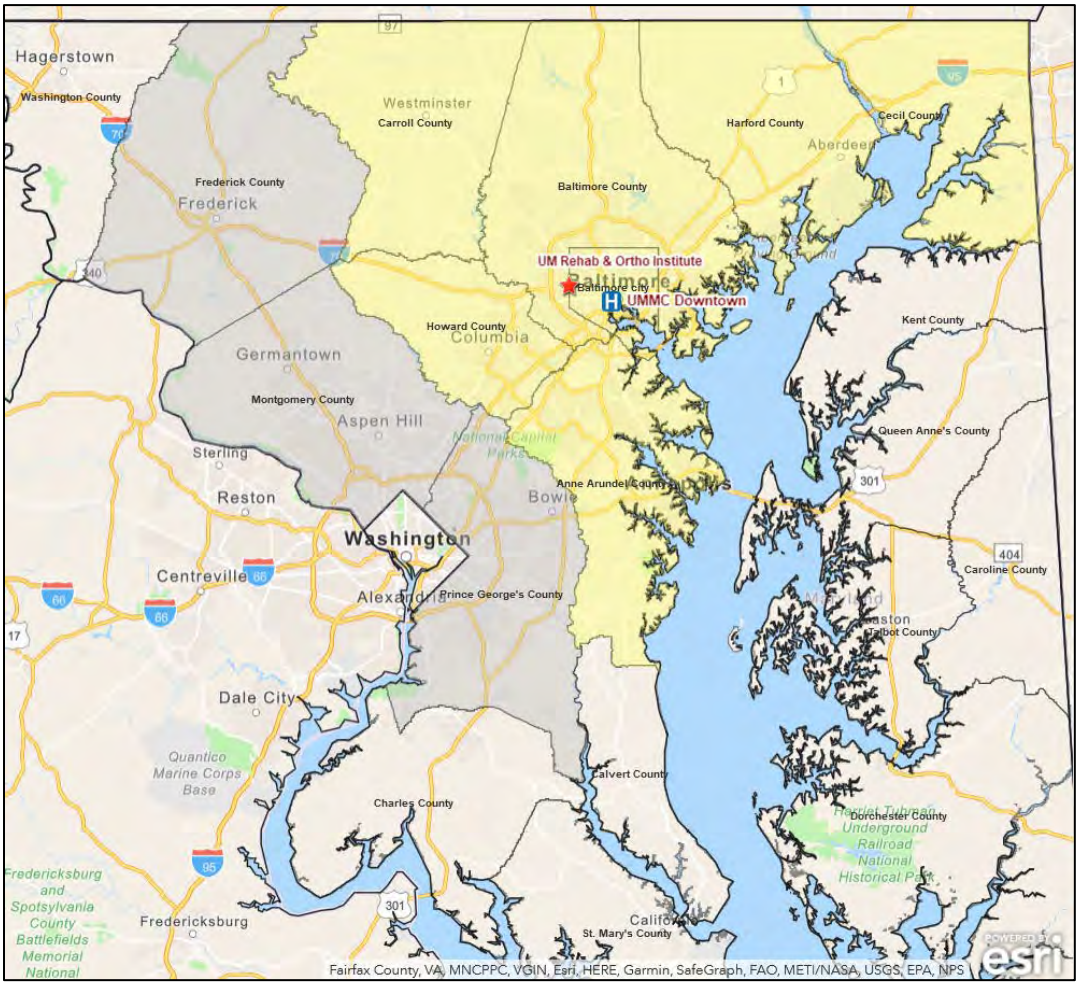
The following table demonstrates that the programs proposed to be relocated will continue to be geographically proximate to the vast majority of UMROI's patient population. As shown, more than 90% of UMROI's Maryland patients in the identified programs reside in the Central Planning Region or the three counties contiguous to that Region (*i.e.*, Frederick, Montgomery, and Prince George's counties). For ease of reference, a map showing the proximity of the current and proposed locations of the programs to the majority of UMROI's service area population follows the table.

Table 6
UMROI FY23 Inpatient Origin for Adult Specialized Programs Proposed to be Relocated to UMMC

Counties	TBI Program	SCI Program	CMR Program
Central Planning Region	79.1%	78.2%	80.9%
Contiguous to Central	13.5%	12.0%	11.2%
Combined	92.6%	90.2%	92.1%

Source: UMROI internal data. FY23 is July 1, 2022 – June 30, 2023.
Notes: percentages are based on Maryland residents, excluding out-of-state patients

Figure 5
The Vast Majority of UMROI Patients Reside in Relatively Close Proximity to UMMC, and will have Continued Geographic Accessibility to UMROI's Programs



Source: ArcGIS.

Central Planning Region

Counties Contiguous to Central Planning Region

(2) Need.

A project shall be approved only if a net need for adult acute rehabilitation beds is identified by the need methodology in Section .05 in the applicable health planning region (HPR) or if the applicant meets the applicable standards below. The burden of demonstrating need rests with the applicant.

(a) An application proposing to establish or expand adult acute inpatient rehabilitation services in a jurisdiction that is directly contiguous to another health planning region may be evaluated based on the need in contiguous regions or states based on patterns of cross-regional or cross-state migration.

Applicant Response:

Because the project does not seek to add beds to the region and the beds are part of a merged asset system, the numeric need methodology is not applicable to this project. Nevertheless, the Applicants have provided the following information in support of the need for the relocated beds.

UMROI's patient origin has remained consistent year-over-year, reflecting relatively consistent patient migration and physician referral patterns. Thus, the Applicants anticipate that the patient origin for the programs relocating will remain unchanged and to the extent that patients currently travel from outside the health planning region now, they will continue to do so in the future. While STC serves as the statewide referral resource, the vast majority of patients in the TBI and SCI programs reside in the Central Planning Region. The same is true for medically-complex CMR patients.

Table 7 *UMROI Inpatient Origin by County, FY23*			
County	**TBI**	**SCI**	**CMR**
Central Planning Region			
Anne Arundel County	18.2%	15.4%	27.4%
Baltimore city	20.9%	24.4%	17.6%
Baltimore County	16.2%	19.7%	18.9%
Carroll County	3.7%	6.0%	4.8%
Cecil County	1.4%	2.1%	0.4%
Harford County	7.1%	8.1%	4.0%
Howard County	11.5%	2.6%	7.7%
Subtotal, Planning Region	***79.1%***	***78.2%***	***80.9%***
Contiguous Counties			
Frederick County	3.7%	4.3%	2.9%
Montgomery County	4.1%	2.6%	3.1%
Prince George's County	5.7%	5.1%	5.1%
Subtotal, Contiguous	***13.5%***	***12.0%***	***11.2%***
Combined Areas	**92.6%**	**90.2%**	**92.1%**

Source: UMROI internal data. FY23 is July 1, 2022 – June 30, 2023.
Notes: percentages are based on Maryland residents, excluding out-of-state patients.

(b) For all proposed projects, an applicant shall explicitly address how its assumptions regarding future in-migration and out-migration patterns among Maryland health planning regions and bordering states affect its need projection.

Applicant Response:

Because UMROI's in-migration and out-migration patterns have been consistent year-over-year, the Applicants expect that the current in-migration and out-migration patterns among UMROI's current Maryland patients will continue in the future at UMMC, mirroring the patient origin shown in Table 7 above. Similarly, the Applicants expect that the historical in-state migration patterns to the relocated programs will continue in the future as they have in the past. These patterns for fiscal year 2023 are presented in Table 8 below.

Table 8 UMROI Inpatient Origin by State, FY23			
State or District	**TBI**	**SCI**	**CMR**
Maryland	92.8%	94.7%	94.9%
Pennsylvania	1.6%	0.4%	0.3%
Virginia	0.6%	0.8%	0.3%
West Virginia	0.3%	1.2%	0.5%
Delaware	0.6%	0.0%	0.5%
Washington D.C.	0.0%	0.4%	0.7%
All Other	4.1%	2.4%	2.6%
Total	100.0%	100.0%	100.0%

Source: UMROI internal data. FY23 is July 1, 2022 – June 30, 2023.
Notes: numbers may not sum exactly due to rounding.

The Applicants therefore assume that there will be no material change in future in-migration and out-migration patterns among Maryland health planning regions and bordering states that will affect their need projection.

(c) If the maximum projected bed need range for an HPR includes an adjustment to account for out-migration of patients that exceeds 50 percent of acute rehabilitation discharges for residents of the HPR, an applicant proposing to meet the need for additional bed capacity above the minimum projected need, shall identify reasons why the existing out-migration pattern is attributable to access barriers and demonstrate a credible plan for addressing the access barriers identified.

Applicant Response:

Not applicable.

(d) An applicant proposing to establish or expand adult acute rehabilitation beds that is not consistent with the projected net need in .05 in the applicable health planning region shall demonstrate the following:

(i) The project credibly addresses identified barriers to access; and

(ii) The applicant's projection of need for adult acute rehabilitation beds explicitly accounts for patients who are likely to seek specialized acute rehabilitation services at other facilities due to their age or their special rehabilitative and medical needs. At a minimum, an applicant shall specifically account for patients with a spine or brain injury and pediatric patients; and

(iii) The applicant's projection of need for adult acute rehabilitation beds accounts for in-migration and out-migration patterns among Maryland health planning regions and bordering states.

Applicant Response:

Not applicable.

(e) An applicant that proposes a specialized program for pediatric patients, patients with brain injuries, or patients with spinal cord injuries shall submit explanations of all assumptions used to justify its projection of need.

Applicant Response:

The Applicants propose to relocate specialized programs for patients with brain injuries and spinal cord injuries. While these programs already exist and will simply be relocated from one facility within a merged asset system to another, the Applicants nevertheless address need.

1. Programmatic Need for TBI, SCI, and Medically-Complex CMR Beds

The need for the proposed relocation of 58 beds from UMROI to the UMMC campus is demonstrated by UMROI's historical utilization of beds, taking into consideration the seasonal fluctuations in certain services (particularly in the TBI and SCI programs), and the Commission's 80% target optimal occupancy rate for acute inpatient rehabilitation beds.

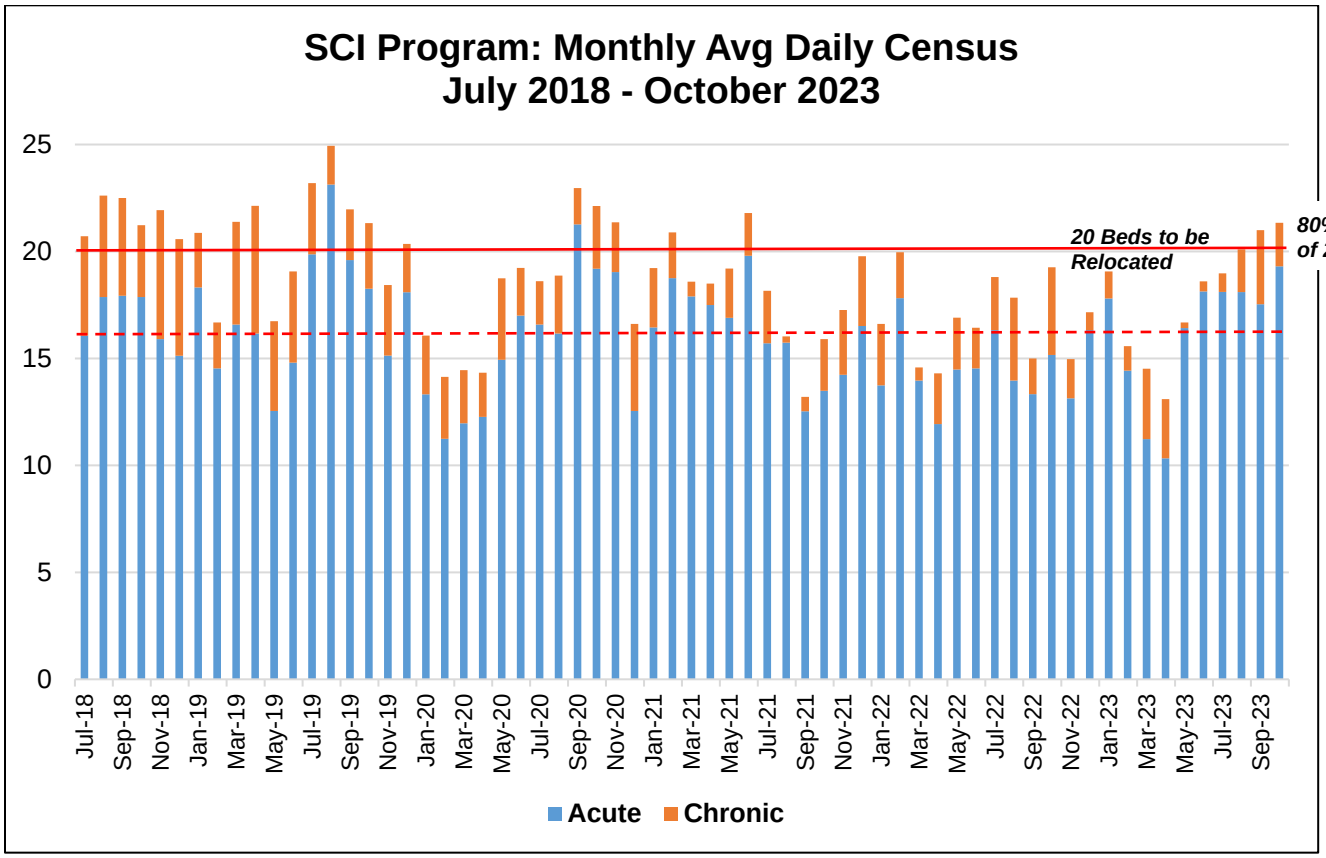
The proposed relocation of 58 beds ensures that the Applicants will have sufficient capacity to care for TBI and SCI acute and chronic patients during the busy summer months and flexibility to care for the most medically-complex acute CMR patients during winter months when TBI and SCI admissions are typically lower. The type of medically-complex CMR patients who will most benefit from the beds that the Applicants propose to relocate to UMMC are patients with multiple comorbidities, transplant patients, and oncology patients.

Patients with a TBI, SCI, or medically-complex CMR condition have unique physical and cognitive needs, whether those patients are acute or chronic. Though the following data distinguishes the acute patients from chronic patients in each program, patients with the identified medical conditions benefit from colocation on the same unit served by the same highly-specialized and uniquely-trained staff members and their specialized and programmatically-focused equipment and technology.

Between July 1, 2018 and October 31, 2023, UMROI's SCI and TBI programs' acute care patients' monthly average daily census ("ADC") often met or exceeded the Commission's optimal 80% occupancy rate (illustrated by the red dashed lines in the figures below). In addition, UMROI's programs care for chronic SCI and TBI patients, as illustrated by the orange portion of each monthly average census data point/bar in the figures below. The Applicants propose to relocate chronic care and dually-licensed beds to ensure that chronic and acute

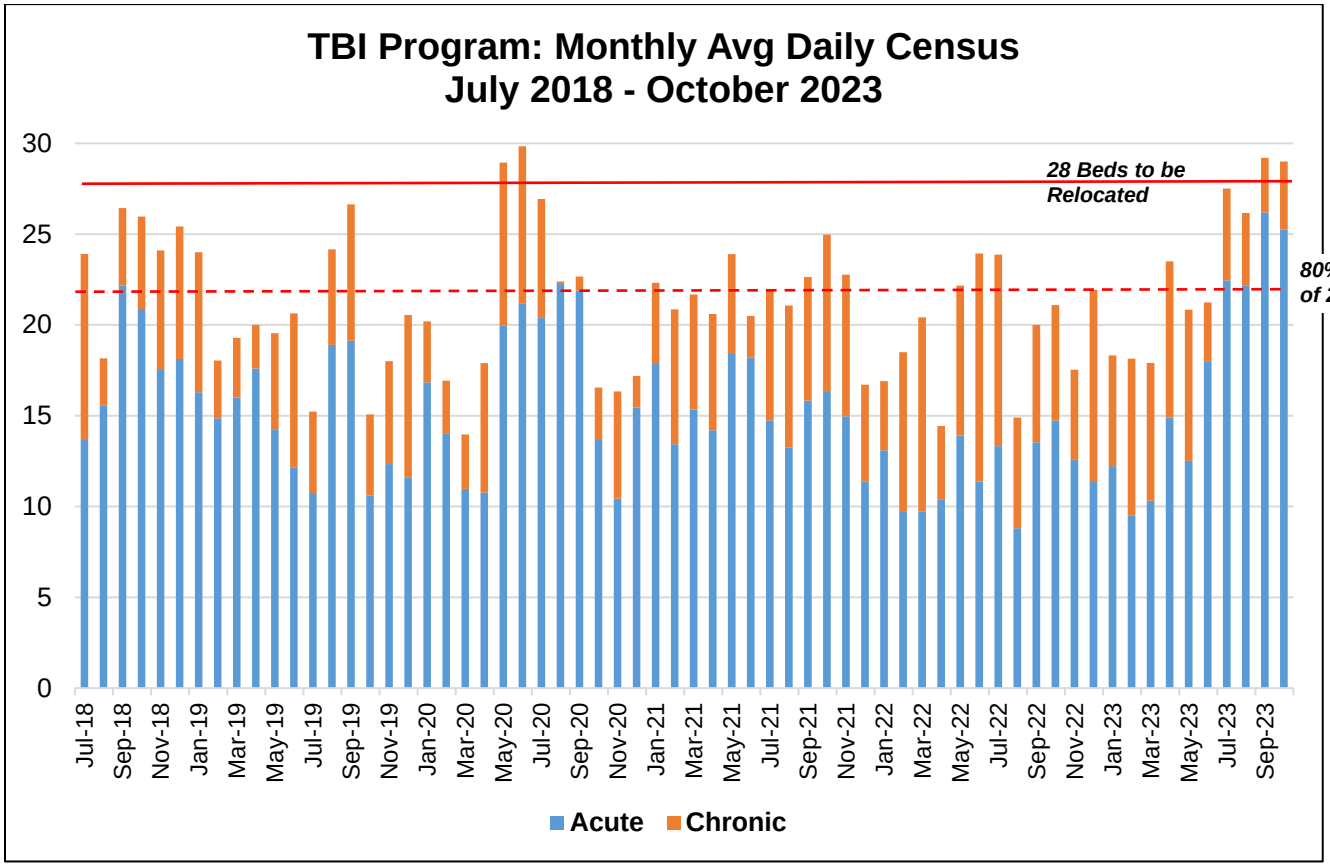
patients' needs can be met in a timely manner and in the most efficient and high-quality setting, by combining chronic and acute care beds in the same specialty units.

Figure 6
SCI Program: Monthly Average Daily Census July 2018 – October 2023



Source: UMROI internal data.

Figure 7
TBI Program: Monthly Average Daily Census July 2018 – October 2023



Source: UMROI internal data.

COVID-19 impacted each of the programs for which beds will be relocated from UMROI to UMMC, causing volumes to temporarily decline. UMROI's most recent fiscal year-to-date data shows a recovery of volumes across all of its programs. The Applicants therefore expect that the volume this fiscal year-to-date (since July 1, 2023) is the best indicator of need for the relocated programs in the future, as discussed below.

In addition to TBI and SCI patients, the Applicants propose to treat certain medically-complex CMR patients at UMMC. These medically-complex patients will include certain patients currently treated at UMROI, such as post-transplant patients, some oncology patients, and patients with mulitple comorbidities. These patients would benefit from being on the campus of UMMC because of the proximity to the quaternary care and subspecialty services (*e.g.*, physicians and care coordinators).

Currently, UMROI may only accommodate a subset of the medically-complex CMR patients that will be treated in the new acute inpatient rehabilitation units at UMMC because UMROI cannot accommodate patients undergoing chemotherapy and radiation. Due to the colocation of the rehabilitation units with UMMC's Cancer Center on the downtown campus, UMMC will be able to treat oncology patients in the new acute inpatient rehabilitation units.

The Applicants project that an average daily census of 12 medically-complex CMR patients will be treated in the UMMC acute inpatient rehabilitation units. This average daily

census projection takes into account both patients currently treated at UMROI and oncology patients treated at UMMC who are unable to access acute inpatient rehabilitation services at UMROI. Based on a manual chart review by the Medical Director of UMROI of medically-complex patients currently accommodated at UMROI, the Applicants determined that an average of eight medically-complex patients each day would be treated in the UMMC acute inpatient rehabilitation beds because such patients require significant medication management, infusions, blood product transfusions, and nursing care. The remaining four patients will be oncology patients who currently cannot be transferred to UMROI for rehabilitation services due to their ongoing chemotherapy or radiation who, as a result of the project, will have access to acute inpatient rehabilitation on the same campus where they receive their cancer treatment.

2. Need for Beds to Preserve Optimal Flexibility for Patient Care

To optimize flexibility and enable the Applicants to accommodate patients most in need of acute inpatient rehabilitation and chronic care services on the same campus as acute trauma care, the Applicants propose to relocate ten dually-licensed chronic care and acute inpatient rehabilitation beds. The breakdown of beds the Applicants propose to relocate from UMROI to UMMC to allow the Applicants to tailor treatment to patients as needed depending on seasonal volume fluctuations is demonstrated in Table 9 below.

Table 9
Distribution of Beds Relocated to UMMC

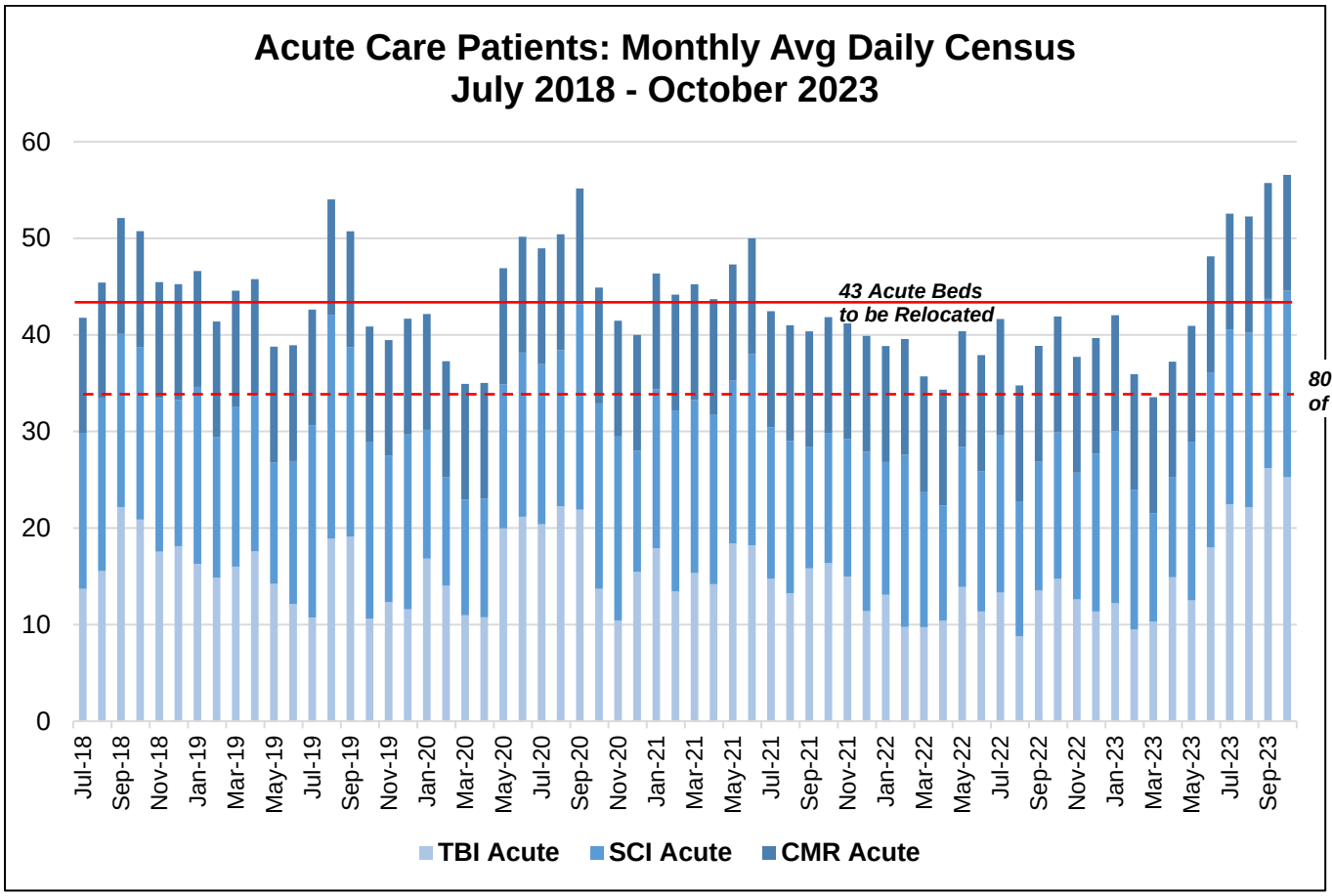
Bed Type	No. of Beds
Traumatic Brain Injury: Acute Rehab	25
Spinal Cord Injury: Acute Rehab	18
Dually-Licensed Rehab and Chronic	10
Chronic Care	5
Total	**58**

Note: Need for chronic care beds is addressed in response to COMAR 10.24.08.03A.

As demonstrated in Figure 6 and Figure 7 above, the volume of TBI and SCI patients varies seasonally, peaking in the summer months when trauma events occur most frequently. The Applicants propose to relocate 58 total beds from UMROI to UMMC to ensure sufficient capacity exists to accommodate TBI and SCI patients during peak seasonal months. During periods when TBI and SCI patient volumes are lower, the Applicants will accommodate additional medically-complex CMR patients in the available beds.

The Applicants propose to relocate 43 acute inpatient rehabilitation beds, which will accommodate TBI, SCI, and medically-complex CMR patients. UMROI's historical experience supports the need for these 43 beds Figure 8 below shows the historical average daily census of UMROI's TBI and SCI acute inpatient rehabilitation patients, along with the medically-complex CMR patients that the Applicants will treat at UMMC as a result of the project. Based on this historical experience, the Applicants will consistently meet the Commission's occupancy expectation and are likely to exceed the occupancy expectation during the seasonal volume peaks.

Figure 8
UMROI Acute Care Patients: Monthly Average Daily Census July 2018 – October 2023



Source: UMROI internal data.
Note: Because only a subset of UMROI's existing CMR patient population will be treated at UMMC and certain patients to be accommodated at UMMC are oncology patients who cannot currently be accommodated at UMROI, the "CMR Acute" portion of the bars are held constant at 12 to represent the Applicants' assumption of an ADC of 12 for medically-complex CMR patients to be treated at UMMC.

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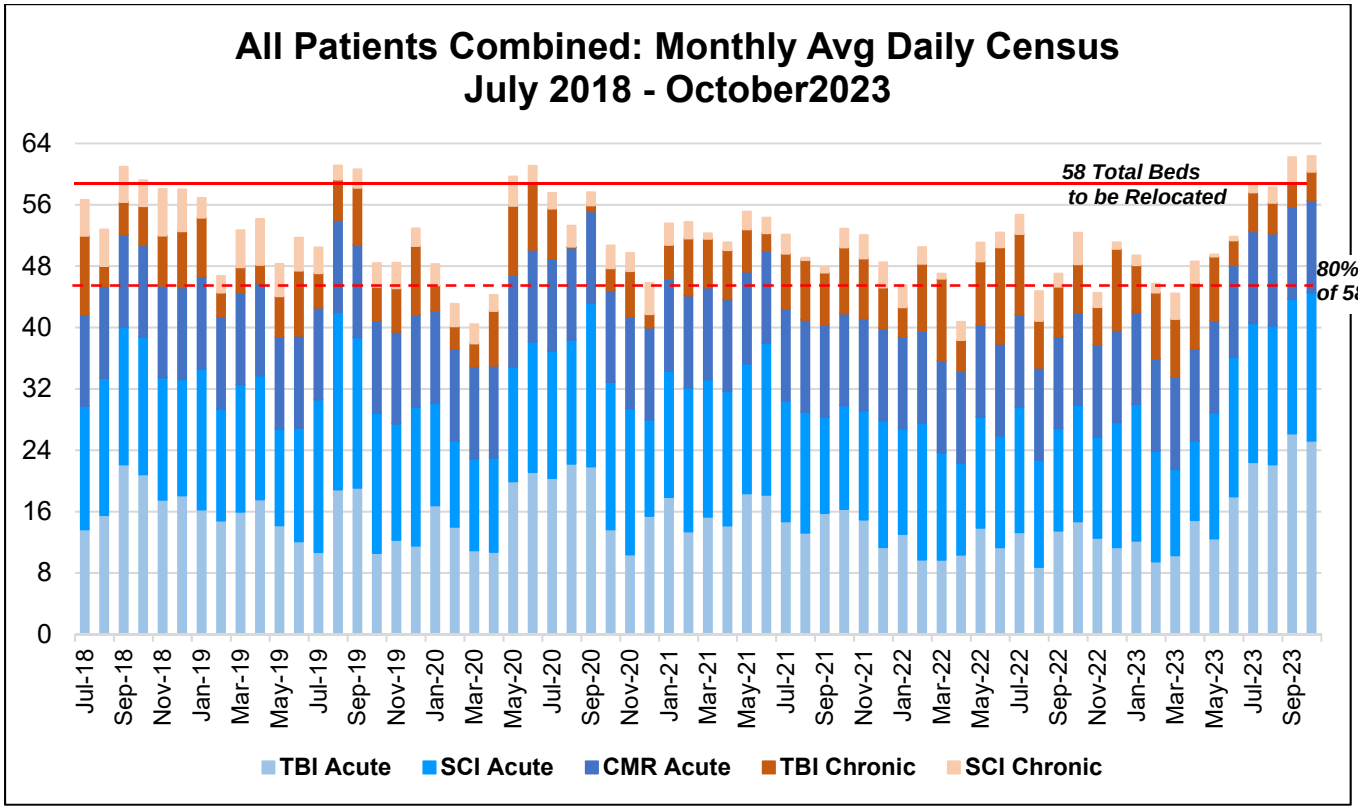
UMROI's historical data regarding average daily census of chronic care patients further demonstrates the need to relocate five chronic care beds from UMROI to UMMC and ten dually-licensed chronic care and acute inpatient rehabilitation beds to provide flexibility for seasonal volume variations. The need for chronic care beds is discussed in response to COMAR 10.24.08.03 – Need.

Altogether, UMROI's historical experience demonstrates the need for the 58 beds the Applicants propose to relocate to UMMC:

Figure 9
All Patients Combined: Monthly Avg Daily Census



Source: UMROI internal data.
Note: Chronic care bed need addressed in response to COMAR 10.24.08.03A.

Figures 7, 8 and 9 indicate that UMROI's historical experience over the past five years supports the relocation of 58 beds to accommodate the patient population the Applicants will treat at UMMC. In addition, data from fiscal year 2024 to-date indicates recovery from the impact of COVID-19 and further supports the need for 58 total beds. The following table provides a comparison of UMROI's most recent fiscal-year-to-date ADC compared to the number of TBI and SCI beds proposed to be relocated for each program. In addition to the TBI and SCI beds, the Applicants will relocate ten dually-licensed acute inpatient rehabilitation and chronic care beds to help address seasonal volume peaks and to account for medically-complex CMR patients.

Table 10 *Average Daily Census by Program and Beds Proposed for Each, FYTD24*						
	July	**Aug.**	**Sept.**	**Oct.**	**4-month Avg.**	**Beds to be Relocated**
TBI (Traumatic Brain Injury)	**27.51**	**26.16**	**29.20**	**29.00**	**27.97**	**--**
Acute Rehab	22.45	22.16	26.20	25.26	24.02	**25**
Chronic Rehab	5.06	4.00	3.00	3.74	3.95	**3**
SCI (Spinal Cord Injury)	**18.98**	**20.10**	**21.00**	**21.34**	**20.36**	**--**
Acute Rehab	18.11	18.10	17.53	19.31	18.26	**18**
Chronic Rehab	0.87	2.00	3.47	2.03	2.09	**2**
TBI and SCI Bed Need	**46.49**	**46.26**	**50.2**	**50.34**	**48.32**	**48**

Source: UMROI internal data.
Note: UMROI FY24 began July 1, 2023.

(f) An applicant that proposes to add additional acute rehabilitation beds or establish a new health care facility that provides acute inpatient rehabilitation services cannot propose that the beds will be dually licensed for another service, such as chronic care.

Applicant Response:

Not applicable. Applicants do not propose to add acute rehabilitation beds or establish a new facility. Applicants propose to relocate existing acute inpatient rehabilitation beds from UMROI to UMMC. While Applicants propose to move certain dually-licensed rehab and chronic care beds, all such beds are already in existence and no new beds are requested.

(3) Impact

A project shall not have an unwarranted adverse impact on the cost of hospital services or the financial viability of an existing provider of acute inpatient rehabilitation services. A project also shall not have an unwarranted adverse impact on the availability of services, access to services, or the quality of services. Each applicant must provide documentation and analysis that supports:

(a) Its estimate of the impact of the proposed project on patient volume, average length of stay, and case mix, at other acute inpatient rehabilitation providers;

Applicant Response:

Applicants do not expect the proposed project to have any impact on patient volume, average length of stay, and/or case mix at other acute inpatient rehabilitation providers because the project proposes to simply relocate existing highly-utilized rehab programs from UMROI to UMMC to enhance quality and continuity of care for the Applicants' existing patient population. Admissions for these services are highly referral-based, and the new location is just seven miles away and still within Baltimore City.

UMROI's admissions by referral sources have been consistent year-over-year, thus the Applicants expect patients to continue to come from its existing referral sources. As shown below, the vast majority of UMROI patient admissions are for patients referred from within the UMMS system, a trend that Applicants expect to continue following implementation of the project.

Table 11
UMROI Admissions by Referral Source, FY23

Health System	TBI	SCI	CMR
UMMS	84.0%	72.5%	80.1%
Non-UMMS	16.0%	27.5%	19.9%
Total	100%	100%	100%

Source: UMROI internal data.

(b) Its estimate of any reduction in the availability or accessibility of a facility or service that will likely result from the project, including access for patients who are indigent or uninsured or who are eligible for charity care, based on the affected acute rehabilitation provider's charity care policies that meet the minimum requirements in .04A(1)(a) of this Chapter;

Applicant Response:

There will be no change in the availability or accessibility of services to any patient population, including those who are indigent, uninsured, or eligible for charity care, based on the relocation of UMROI's highly-utilized services from its current location to the quaternary campus of UMMC. Rather, access to the highly-specialized subspecialty services for all patients, including indigent, uninsured, and charity patients, will be enhanced by the co-located services of UMROI and UMMC.

(c) Its estimate of any reduction in the quality of care at other providers that will likely be affected by the project; and

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Applicant Response:

The proposed relocation of select UMROI services to UMMC will have no impact on the quality of care at other providers. Because the relocation from UMROI to UMMC includes specific, specialized service lines, the other service lines that will remain at UMROI will not be materially impacted.

(d) Its estimate of any reduction in the ability of affected providers to maintain the specialized staff necessary to provide acute inpatient rehabilitation services.

Applicant Response:

The relocation of existing services from UMROI to UMMC will not affect any provider's ability to maintain the specialized staff necessary to provide acute inpatient rehabilitation services because UMROI plans to transfer FTEs from its current staffing plan to UMMC for the relocated inpatient rehabilitation services. The remaining FTEs at UMROI will be sufficient to care for patients in the programs that will not be relocated as part of the project.

(4) Construction Costs.

(a) The proposed construction costs for the project shall be reasonable and consistent with current industry and cost experience in Maryland.

(b) For a hospital that is rate-regulated by the Health Services Cost Review Commission, the projected cost per square foot of a hospital construction project or renovation project shall be compared to the benchmark cost of good quality Class A hospital construction given in the Marshall Valuation Service® guide, updated using Marshall Valuation Service® update multipliers, and adjusted as shown in the Marshall Valuation Service® guide as necessary for site terrain, number of building levels, geographic locality, and other listed factors. If the projected cost per square foot exceeds the Marshall Valuation Service® benchmark cost, any rate increase proposed by the hospital related to the capital cost of the project shall not include the amount of the projected construction cost that exceeds the Marshall Valuation Service® benchmark and those portions of the contingency allowance, inflation allowance, and capitalized construction interest expenditure that are based on the excess construction cost.

Applicant Response:

The proposed construction costs for the project are reasonable and consistent with current industry and cost experience in Maryland, as demonstrated by the following comparison of the hospital construction Project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service
Valuation Benchmark – New Hospital Construction

	MVS Reference	
Type		Hospital
Construction Quality/Class		Good/A
Stories		6
Perimeter		588
Average Floor to Floor Height		13.5
Square Feet		107,246
Average Floor Area		17,874
A. Base Costs		
Basic Structure (MVS November 2023 Update)	15-24	$560.00
Elimination of HVAC Cost for Adjustment	15-25	0.00
HVAC Add-On for Mild Climate	15-25	0.00
HVAC Add-On for Extreme Climate	15-25	0.00
Total Base Cost		$560.00
Adjustment for Departmental Differential Cost Factors	87-8	0.9828
Adjusted Total Base Cost		$550.37
B. Additions		
Elevator (if not in base)	15-36	$0.00
Other	15-25	0.00
Subtotal		$0.00
Total		$550.37
C. Multipliers		
Perimeter Multiplier	15-38	0.93091
Product		$512.35
Height Multiplier	15-38	1.0343
Product		$529.93
Multi-story Multiplier	15-25	1.055
Product		$559.08
D. Sprinklers		

Sprinkler Amount (MVS November 2023 Update)	15-37	$4.25
Subtotal		$563.34

E. Update/Location Multipliers

Update Multiplier (MVS November 2023 Update)	99-3	1.01
Product		$568.97
Location Multiplier	99-8	0.99
Product		$563.28

MVS Cost per Square Foot Benchmark **$563.28**

The MVS estimate for this project is impacted by the Adjustment for Departmental Differential Cost Factor. In Section 87 on page 8 of the Valuation Service, MVS provides the cost differential by department compared to the average cost for an entire hospital. The calculation of the average factor is shown below.

Table 12
Calculation of Average Cost Factor

Department/ Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Adult/Geriatric Psych Inpatient	17,357	Inpatient Unit	1.06	18,398
Lobby	8,735	Public Space	0.8	6,988
Medical/Surgery Inpatient	28,850	Inpatient Unit	1.06	30,581
Mechanical/Electrical	6,019	Mechanical Equipment & Shop	0.7	4,213
SCI Rehab	16,996	Inpatient Unit	1.06	18,016
TBI Rehab	16,902	Inpatient Unit	1.06	17,916
Shared Staff Support & Public Circulation	6,187	Public Space	0.8	4,950
Mechanical/Penthouse	6,200	Mechanical Equipment & Shop	0.7	4,340
Total	107,246		0.9828	105,402

II. Cost of New Construction

A. Project Costs

Table 13
MVS Analysis Project Costs

	Construction	Per Sq. Foot
Building	$69,183,536	$645.09
Fixed Equipment	11,996,000	111.85
Site Preparation	2,296,914	21.42
Architectural Fees	7,340,800	68.45
Permits	50,000	0.47
Subtotal	90,867,250	847.28
Loan Placement Fees	708,090	6.60
Capitalized Construction Interest	5,388,716	50.25
Total	**$96,964,056**	**$904.13**

However, as discussed below, this project includes expenditures for items not included in the MVS average. As this project consists of the build out of four floors on top of the ten floors associated with the UMMC nine-story Cancer Center project, many of the project cost adjustments are calculated at 40% of the cost adjustment included in the Cancer Center MVS analysis for nine floors plus the mechanical penthouse. Other project cost adjustments are calculated at the same percent of Site Preparation or Building costs as were assumed in the Cancer Center MVS analysis. Other project cost adjustments are described following the table below.

B. MVS Extraordinary Project Cost Adjustments

Table 14
MVS Extraordinary Project Cost Adjustments

Extraordinary Cost Adjustments	Cancer Center (CC) Project Cost Adjustments	Rehab Project			Project Component	Assumption
		Cost Adjustments	Allocated Loan Placement Fees	Allocated Capitalized Interest		
Site Demolition Costs	$1,782,000	$ -	$ -	$ -	Site	Included in CC budget
Storm Drains	2,250,000	210,000	2,080	15,831	Site	Increased piping sizes, install included in CC budget
Rough Grading	825,000	-	-	-	Site	Included in CC budget
Paving	600,000	-	-	-	Site	Included in CC budget
Deep Foundation	4,155,000	1,650,500	16,350	124,427	Site	Additional CFAs required
Yard Lighting	592,500	-	-	-	Site	Included in CC budget

Dewatering	120,000	-	-	-	Site	Included in CC budget
Sediment Control & Stabilization	120,000	-	-	-	Site	Included in CC budget
Premium for Constrained Site	872,716	114,846	1,138	8,658	Site	5% of site preparation for constrained site
Underground utility work for Foundations / Total Shoring for excavation	2,376,000	-	-	-	Site	Included in CC budget
Premium for Prevailing Wage	1,745,432	229,691	2,275	17,316	Site	10% of site preparation for prevailing wage
Premium for Minority Business Enterprise Requirement	698,173	91,877	910	6,926	Site	4% of site preparation for MBE requirement
Canopy	7,125,000	-	-	-	Building	Included in CC budget
Pneumatic Tube System	1,125,000	450,000	4,458	33,924	Building	40% of CC budget for 4 additional floors on top of 10 floors
Deep trusses on Levels 3 & 4 to allow building to span over drive up	3,564,000	-	-	-	Building	Included in CC budget
Infection Prevention	1,500,000	600,000	5,944	45,232	Building	40% of CC budget for 4 additional floors on top of 10 floors
Asbestos abatement	750,000	300,000	2,972	22,616	Building	40% of CC budget for 4 additional floors on top of 10 floors
Adjacent Occupants Premium	1,500,000	600,000	5,944	45,232	Building	40% of CC budget for 4 additional floors on top of 10 floors
Temporary entrance and logistics associated with entrance closure	2,800,000	-	-	-	Building	Included in CC budget
Structured Floor with Soffit under 3rd Level in lieu of Slab on Grade	7,125,000	-	-	-	Building	Included in CC budget
Premium for Constrained Site	8,058,934	3,459,177	34,267	260,778	Building	5% of building cost for constrained site
Level 4 Temporary MEP Piping Offset to allow access in 4th Floor Ceiling	8,496,000	-	-	-	Building	Included in CC budget
Retro Fit Two New Elevators, Shafts and Pits into the existing Medical Tower	6,363,000	-	-	-	Building	Included in CC budget
Premium for LEED Silver Construction	6,447,147	2,767,341	27,413	208,622	Building	4% of building cost for LEED Silver construction standards
Premium for Prevailing Wage	16,117,868	6,918,354	68,534	521,556	Building	10% of building cost for prevailing wage
Premium for Minority Business Enterprise Requirement	6,447,147	2,767,341	27,413	208,622	Building	4% of building cost for MBE requirement
Vertical Flooded Heating Hot Water Plant Upgrade	-	3,150,000	31,204	237,470	Building	Not Included in MVS base cost
Fire Pump with Express Riser & Electrical Feeder	-	1,209,000	11,976	91,143	Building	Not Included in MVS base cost
Tier 4 Generators (Qty 3)	-	6,000,000	59,436	452,324	Building	Not Included in MVS base cost
Cistern Within Building for Storm Water Retention	-	889,000	8,806	67,019	Building	Not Included in MVS base cost
Penthouse Exterior - Fully Clad on 4 sides	-	1,376,000	13,631	103,733	Building	Not Included in MVS base cost
Penthouse Roof Screenwall	-	459,364	4,550	34,630	Building	Not Included in MVS base cost
Total Cost Adjustments	$93,555,917	$33,242,491	$329,302	$2,506,061		
% of Site Preparation & Bldg. Costs	52.4%	46.5%	46.5%	46.5%		

Explanation of Extraordinary Costs

Below are the explanations of the Extraordinary Costs that are not specifically mentioned as not included in the MVS average costs in the MVS Guide (at Section 1, Page 3) but that are specific to this project and would not be in the average cost of a hospital project.

Premium for Constrained Site

The site for the new building is quite constrained in a dense downtown block, directly next to an existing operating hospital building on the west side, Baltimore Street on the North side, Greene Street on the east side, and other existing hospital buildings on the south side. Building on this site will require close coordination with adjacent occupants and premiums for overtime to shorten the duration of work to reduce operational impacts and night / weekend work throughout the project. UMMC has included a 5% premium in the Site Preparation and Building costs due to the constrained site.

Premium for LEED Silver Construction

UMMC has included a 4% premium in Building Costs due to constructing this building to LEED Silver standards. The potential for a 0%-7% premium is recognized by MVS in Section 99, Page 1.

Premium for Paying Prevailing Wage

Because State funds will be used to construct the building, UMMC's contractors will have to pay "prevailing" wages, rather than "scale." For a previous project, UMMC's consultant telephoned Marshall and Swift's Technical Assistance staff on 9/27/13 and asked John Thompson whether this would constitute a premium over the average cost per square foot presented in the MVS, even when adjusted for update and local multipliers. Mr. Thompson stated that paying prevailing wage would definitely be a premium over the average. He stated that he had previously been an electrician and, on buildings on which he was paid scale, the pay was approximately $11/hour. However, on projects on which he was paid prevailing wage, he was paid approximately $32/hour. The consultant searched for an average premium to use as the basis for the assumption that the difference between scale and prevailing wages are treated as premium. The Maryland Department of Legislative Services Office of Policy Analysis issued a report on March 25, 2014 that found that in cases of available "side by side" bid comparisons with prevailing wage requirements and without prevailing wage requirements, on average bids with prevailing wages came in at 10% higher.[3] UMMC assumes the premium will be 10%. Because prevailing wage will have to be paid for both site preparation and construction, UMMC has applied it to both.

Premium for Minority Business Enterprise Requirement

UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was projected to be 4%. UMMS consulted with its cost estimators/construction managers on the impact on project budgets of targeting 25% inclusion of MBE subcontractors or suppliers as part of its project. The cost estimators and construction managers conservatively estimate that achieving MBE goals adds 3% to 4% to the project costs, compared to projects that do not include MBE subcontractors or suppliers. This estimate has been confirmed through UMMC and UMMS' experience with past

[3] Maryland Department of Legislative Services Office of Policy Analysis, Task Force to Study the Applicability of the Maryland Prevailing Wage Law (Annapolis, MD, March 25, 2014), p. 5

construction jobs. UMMS and UMMC now use this percentage in all of their construction cost estimates.

Pneumatic Tube System

UMMC uses a pneumatic tube system to transport medications and lab samples throughout the complex. The four additional floors in the building will include tube stations on every clinical floor connecting back to the existing system and allowing for movement of these items to and from any point on campus. Extensive coordination, design, and fabrication / installation work will be required to implement the system.

Infection Prevention

Working in an occupied hospital requires rigorous infection control requirements to ensure dust does not impact adjacent patient care areas. These requirements include, but are not limited to, containment around the site perimeter, mechanical devices to vent the contaminated air outside the building, and protective coverings to be worn by all workers during construction.

Asbestos abatement

Given the age of the building in which renovations are required, UMMC anticipates needing to abate multiple building elements within the site. These elements could include piping insulation, structure fire-proofing, and under-floor adhesive materials.

Adjacent Occupants Premium

Connecting a new tower to an existing operating medical facility with ongoing adjacent inpatient services involves complex phasing and congested areas. Given that all materials cannot be stored on-site and delivery of materials will have to be phased without affecting adjacent services, UMMC has included a premium for off-site storage and delivery.

Vertical Flooded Heat Exchanger

The nine-floor design of the UMMC Cancer Center project did not trigger the need to replace the existing heating hot water plant at UMMC. Adding the loads of the four additional floors through the current project will require additional heating hot water load, triggering replacement of the facility's aged system. UMMC will install a new technology called a vertical flooded heat exchanger, which is a more efficient system than currently exists. The replacement of these components will also add resilience to the rest of the campus.

Fire Pump with Express Riser

The existing fire protection system does not have enough pressure to serve Floors 10-14. An additional dedicated fire pump with express riser to serve Floors 10-14 is required. An independent feeder from BGE may also be required to feed the fire pump.

Tier 4 Diesel Generators (Quantity of 3)

The nine-story UMMC Cancer Center project did not trigger the need to add generator capacity to the campus. Existing generators, despite their age, were able to carry that capacity. The addition of four floors requires more capacity than can be handled with existing equipment. This project proposes replacing three 1500KV generators with three 2000KV

generators. There is not a good location to add an additional generator within the complex that allows for connection to the paralleling gear, and the existing generators are aged and need to be replaced. It is more cost effective to replace and enlarge the existing generators in their current location. Doing this also improves the resiliency of the UMMC downtown campus. The generators will be able pick up emergency load throughout the downtown campus.

Additionally, by purchasing Tier 4 generators, UMMC can more effectively respond to BGE's requests for load reduction during code red heat days - helping reduce the risk of a utility brown out or black out. Tier 4 generators are more costly than Tier 2 (standard). They also have significantly lower carbon emissions than standard diesel generators.

Cistern within Adjacent Building

The original plan for the Cancer Center project was to have a green roof to meet the storm water requirements. However, by adding the four stories, the roof of the tower is now full of additional mechanical equipment, exhaust and relief fans. There is no room left for a green roof. This project plans to add a rainwater cistern system at the roof level, tapping into an existing unused cistern within an adjacent building.

Mechanical Penthouse Fully Clad on Four Sides

The mechanical penthouse design for the nine-story Cancer Center was adjacent to the existing building, and therefore only three sides needed to be clad. With this project, the penthouse is now located above the existing building and will require cladding on the fourth face. Additionally, the double height space is taller than originally planned none-story Cancer Center.

Mechanical Penthouse Roof Screenwall

The mechanical penthouse cladding will extend 42" above the roof to hide all of the mechanical equipment and provide fall protection. This was not originally the plan for the nine-story Cancer Center.

Loan Placement Fees and Capitalized Interest on Extraordinary Costs

Loan Placement Fees and Gross Interest associated with the Authorized Bonds that are shown on the project budget are related to the entire costs of the hospital building. The costs associated with this line item also apply to the extraordinary costs. Because Interest Income is earned on the bonds during construction, the Interest Income is netted against the Gross Interest and referred to as Capitalized Interest. Because Loan Placement Fees and Capitalized Interest are considered in the MVS analysis, it is appropriate to adjust these costs in relation to the Site Preparation and Building cost adjustments.

The Loan Placement Fees and Capitalized Interest associated with the Site Preparation and Building cost adjustments are calculated as follows:

Table 15
Loan Placement and Capitalized Interest Associated with Site Preparation and Building Costs

Hospital	Construction	Renovation (1)	Total
Project Cost (excluding Cap Interest and Loan Placement Fees)	$90,867,250	$100,083,750	$190,951,000
% of Total Project Costs	47.6%	52.4%	100.0%
Allocation of Debt	$70,791,380	$77,971,620	$148,763,000
Allocation of Gross Interest	$7,078,995	$7,797,005	$14,876,000
Allocation of Interest Income	-$1,690,279	-$1,861,721	-$3,552,000
Allocation of Capitalized Interest	$5,388,716	$5,935,284	$11,324,000
Allocation of Loan Placement Fees	$708,090	$779,910	$1,488.000
Site Prep & Bldg. Cost Adjustments @ of Total Site & Bldg. Costs	46.5%	-	-
Cap Interest Associated with Extraordinary Costs	$2,506,061	-	-
Loan Placement Fees Associated with Extraordinary Costs	$329,302	-	-

Eliminating all of the extraordinary costs enables the project costs to be compared to the MVS benchmark.

Table 16
Project Costs Compared to MVS Benchmark

C. Adjusted Project Cost	Construction	Per Square Foot
Building	$38,237,959	$356.54
Fixed Equipment	11,996,000	111.85
Site Preparation	0	0.00
Architectural Fees	7,340,800	68.45
Permits	50,000	0.47
Subtotal	57,624,759	537.31
Loan Placement Fees	378,788	3.53
Capitalized Construction Interest	2,882,655	26.88
Total	**$60,886,202**	**$567.72**

As presented below, the adjusted project cost per square foot is within 1% of the MVS benchmark.[4]

[4] In recent reviews, Commission Staff have added Contingency and Inflation to the costs being compared to the MVS benchmark. Historically, Contingency and Inflation costs were not included in the comparison. UMMC believes that Contingency costs should not be included because they may not be

Table 17
Project Costs within 1% of the MVS Benchmark

Source of Cost	Per Square Foot
MVS Benchmark	$563.28
Adjusted Project Cost	$567.72
$ Difference	$4.44
% Difference	0.79%

(5) Safety.

The design of a hospital project shall take patient safety into consideration and shall include design features that enhance and improve patient safety.

Applicant Response:

The relocated acute inpatient rehabilitation and chronic care bed units at UMMC will be designed to current building codes and standards and with the goal of optimizing patient safety. All patient rooms in the units will be fully-private rooms, which will improve patient safety in a number of ways. Private rooms decrease the risk of infection, both due to the ability to isolate patients who are contagious or at high risk of infections and to efficiently decontaminate and clean the room as compared with a multi-occupancy room. *See* Response to COMAR 10.24.12.04B(1) – Access. Private rooms also decrease the risk of medication errors and testing on the incorrect patient. Finally, private rooms allow patients an ideal environment to rest and recover from the intensive therapy schedule that is required in acute inpatient rehabilitation. The ability to fully rest during the day and sleep through the night is important for optimal recovery and contributes to overall patient safety.

The design of the units and private rooms will also reduce patient safety risks. Ceiling tracking systems will be installed in all patient rooms and bathrooms to provide safe lifting and movement from patient beds to bathrooms and doorways. These systems will allow staff to immediately access necessary mechanical lift devices, thereby increasing compliance with use of safety equipment and decreasing the number of transfers necessary. This positively impacts

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spent. If the inclusion of Contingency in the comparison causes an applicant to exceed the MVS benchmark, a condition is imposed by the Commission that the HSCRC should take a related amount out of the rates that the HSCRC approves for the project. However, if in building the project, an applicant subsequently does not need to spend the Contingency, the condition is not revised or removed. This combined with the contingent nature of this budget item favors not including it in the comparison. Like Contingency costs, the Commission Staff have only recently begun considering Inflation in the MVS comparison in the last few years. Inflation is calculated through the midpoint of construction, reflecting future costs per square foot, while the MVS benchmark reflects current costs. Thus, including inflation results in an unfair comparison. However, should Commission Staff include Contingency and/or Inflation in its consideration of the comparison, certainly the percentage of Contingency and/or Inflation associated with Extraordinary Costs (which are, themselves, excluded from the comparison) should not be included.

both patient and staff safety. Universal installation of the ceiling lift systems also represents an improvement from the current UMROI campus, where only a subset of patient rooms (and no bathrooms) include this feature. The patient rooms will also accommodate teleport devices, which increase access to remote patient safety monitoring capabilities.

Unit design and location will also promote patient safety by taking the unique needs of TBI and SCI patient populations into consideration. The TBI unit will be contained on one floor in one cohesive locked unit. TBI patients present a high wander and flight risk, and are at higher risk of harm to self and staff. Locating these patients on a single floor in a locked unit will promote patient safety by reducing the risk of wandering. All TBI services will be accessible on the unit without the need to transport patients by elevator, which will also contribute to patient safety and reduce flight risk. Similarly, the SCI unit will be located on one floor, enabling patients to access dining, therapy, gym, and support services without the need to travel by elevator. Each floor will have two smoke compartment zones to minimize transfers off the floor for patients who smoke. These zones will be equipped with a smoke control system that helps exhaust smoke off the floor through a fire vent that also keeps smoke out of neighboring floors. These unit designs reduce the risk of injury associated with distances patients must travel from their rooms to access therapy spaces and other services.

Each floor will have a large, dedicated rehabilitation gym. The gyms will be sized to accommodate the necessary equipment for intensive acute inpatient rehabilitation therapies and will also include vector track systems to assist with patient gait training in a safe manor. Each gym will be outfitted with patient lift systems to maximize safety for patients and staff. The gyms will include space for multiple treads, enabling more than one patient to engage in wheelchair mobility skill training at a time – a necessary feature for TBI and SCI patient populations that have high rates of non-manual wheelchair usage. These gyms will represent an improvement over the existing facility, which does not accommodate as many non-manual wheelchairs at once and has other significant limitations due to age. As a result, some wheelchair mobility skill training must be conducted outside at the existing facility. By constructing large rehab gyms on each floor of the rehabilitation units at UMMC, patients will have access the full spectrum of therapies without needing to travel off the floor, thereby optimizing patient safety.

Finally, the relocation of the beds from UMROI to UMMC will enable patients who require certain services not currently available at the UMROI campus to access that care in a timely manner on the same campus as their rehabilitation treatment. For example, patients will have access to radiology services including MRI and nuclear medicine; interventional radiology including central line insertion for hemo-dialysis or long-term infusions; specialty CT studies; peg tube insertion to provide nutrition for patients who cannot eat; lab; and GI studies. For post-trauma and medically-complex patients, having access to advanced imaging and 24-hour laboratory services will enable patients to access specialty services at any time. The units at UMMC will also accommodate immune-suppressed oncology patients due to the availability of private rooms. Because patients will have access to these specialty services on the UMMC campus, patients will avoid transfers and eliminate delays in their care, which ultimately promotes their safety.

(6) Financial Feasibility.

A hospital capital project shall be financially feasible and shall not jeopardize the long-term financial viability of the hospital.

(a) Financial projections filed as part of a hospital CON application must be accompanied by a statement containing each assumption used to develop the projections.

Please see **Exhibit 1,** hospital tables.

(b) Each applicant must document that:

(i) Utilization projections are consistent with observed historic trends in the use of the applicable service(s) by the service area population of the hospital or State Health Plan need projections, if relevant;

(ii) Revenue estimates are consistent with utilization projections and are based on current charge levels, rates of reimbursement, contractual adjustments and discounts, bad debt, and charity care provision, as experienced by the applicant hospital or, if a new hospital, the recent experience of other similar hospitals;

(iii) Staffing and overall expense projections are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by the applicant hospital, or if a new hospital, the recent experience of other similar hospitals; and

(iv) The hospital will generate excess revenues over total expense (including debt service expenses and plant and equipment depreciation), if the applicant's utilization forecast is achieved for the specific services affected by the project within five years or less of initiating operations with the exception that a hospital proposing an acute inpatient rehabilitation unit that does not generate excess revenues over total expenses, even if utilization forecasts are achieved for the services affected by the project, may demonstrate that the hospital's overall financial performance will be positive.

Applicant Response:

The proposed project will be financially feasible. The financial feasibility of the project is based on the following assumptions:

(a) Utilization projections that are consistent with observed historic trends for the existing services at UMMC and the relocated services from UMROI, with approximately 2% volume growth. **Exhibit 1**, Tables I, F.

(b) Revenue estimates that are consistent with utilization projections and are based on current Global Budget Revenue (GBR), rates of reimbursement, contractual adjustments and discounts, bad debt, charity care provision,

and ongoing negotiations with the HSCRC as to the GBR revenue that will shift from UMROI to UMMC. **Exhibit 1**, Tables G, H, J, and K.

(c) Staffing and overall expense projections that are consistent with utilization projections and are based on current expenditure levels and reasonably anticipated future staffing levels as experienced by UMMC, with input from UMROI as to staffing requirements for the relocated services. **Exhibit 1**, Table L.

(d) Depreciation, interest, and other operating costs associated with the new building and renovated space. **Exhibit 1**, Tables G, H, J, and K.

As Tables G and H demonstrate, UMMC will generate excess revenues over total expenses (including debt expenses and depreciation).

(7) Minimum Size Requirements.

(a) A proposed acute inpatient rehabilitation unit in a hospital shall contain a minimum of 10 beds and shall be projected to maintain an average daily census consistent with the minimal occupancy standard in this Chapter within three years.

Applicant Response:

The inpatient rehabilitation unit will contain 43 acute inpatient rehabilitation beds and ten dually-licensed acute inpatient rehabilitation and chronic care beds, thereby satisfying the minimum size requirements for a hospital unit. As demonstrated in **Exhibit 1**, Table G, the Applicants project an average occupancy of over 90%, which far exceeds the minimum 80% occupancy for acute inpatient rehabilitation units of 50-99 beds set forth in the COMAR 10.24.09.05D(5)(a).

(b) A proposed acute inpatient rehabilitation specialty hospital shall contain a minimum of 30 beds and shall be projected to maintain within three years an average daily census consistent with the minimum occupancy standard in this Chapter.

Applicant Response:

Not applicable.

(8) Transfer and Referral Agreements.

Each applicant shall provide documentation prior to licensure that the facility will have written transfer and referral agreements with facilities, agencies, and organizations that:

(a) Are capable of managing cases that exceed its own capabilities; and

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Applicant Response:

The Applicants currently provide the highest level of acute inpatient rehabilitation services to patients with the most severe medical needs in the State at UMROI. The Applicants will relocate the programs serving the most complex patients to UMMC as a result of the project. As a result, there are no acute inpatient rehabilitation patients who will exceed the rehabilitation care capabilities of the Applicants. Patients admitted to the UMMC inpatient rehabilitation unit but who exceed the unit's level of care capabilities will be transferred to UMMC's acute care units or to other acute care facilities within the UMMS system in the event UMMC lacks capacity for such patients.

(b) Provide alternative treatment programs appropriate to the needs of the persons it serves.

Applicant Response:

The Applicants have referral relationships in place with a number of organizations that provide alternative treatment programs appropriate to the needs of patients served who do not have new (if the patients are at UMMC) or continued (if at UMROI) acute inpatient rehabilitation needs or due to payor restrictions. These patients may be referred, for example, to:

- Home Health Agencies (such as Amedisys Home Health, Centerwell Home Health, Bayada Home Health Care, VNA of Maryland, All about Home Care, PB Home Health, Homecall, Medstar Health VNA)
- Skilled Nursing Facilities (such as Westgate Hills Rehab and Healthcare-Marquis, Future care, Lorien Bulle Rock, Citizens Care & Rehabilitation Center, Sterling Care Riverside, and Autumn Lake Healthcare)

(9) Preference in Comparative Reviews.

In the case of a comparative review of applications in which all standards have been met by all applicants, the Commission will give preference to the applicant that COMAR 10.24.09 Supplement 1 13 offers the best balance between program effectiveness and costs to the health care system as a whole.

Applicant Response:

Not applicable.

COMAR 10.24.08 - Special Hospital –
Chronic Services

Standard .03A – Project Review Standards

(1) Need.

An applicant shall quantitatively demonstrate the specific unmet needs it proposes to meet in its service area, by number of patients, principal and additional diagnoses, and expected length of stay.

Applicant Response:

The Applicants propose to relocate five existing chronic care beds from UMROI to UMMC. The need for these five beds is supported by UMROI's historic experience and takes into consideration historic ALOS and ADC of TBI and SCI chronic care patients.

The historic ALOS for UMROI's chronic TBI and SCI patient populations is set forth in Table 18 below.

Table 18
***UMROI Chronic Care Patients' Average Length of Stay*[5]**

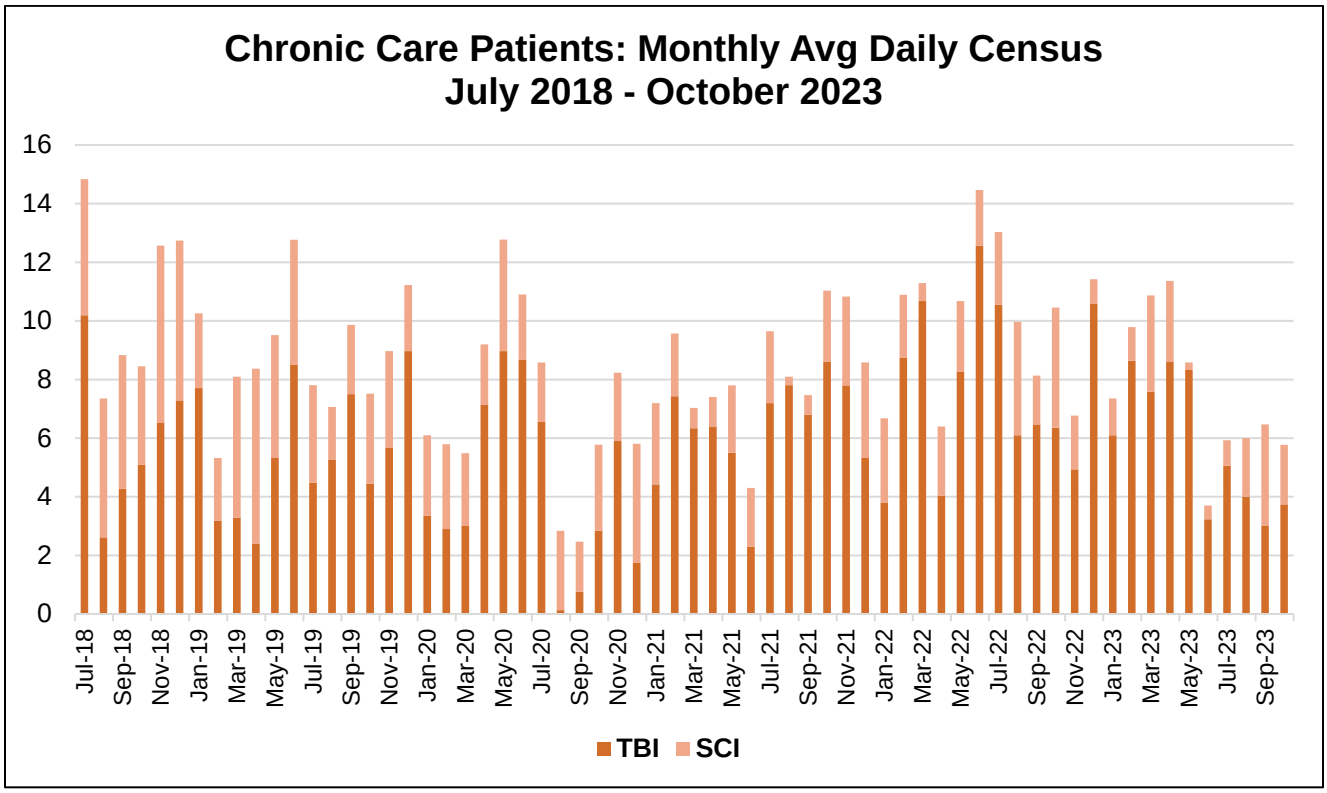
Program	FY19	FY20	FY21	FY22	FY23	FYTD24
TBI	25.50	23.91	22.98	30.35	44.25*	35.29
SCI	26.59	23.10	27.79	24.87	23.17	25.05

Source: UMROI internal data.
Notes: Fiscal Year data are for July 1 through June 30 of each year, with exception of FYTD24 which is for the time period July 1, 2023 – October 2023.
*Data anomaly due to the inclusion of all patients in the calculation, including several patients with atypically high length of stay.

UMROI's historic ADC of SCI and TBI chronic care patients is demonstrated in Figure 10 below.

[5] Table I projects a combined ALOS for TBI and SCI chronic patients of 28.5. This projected ALOS represents the average across both categories of chronic patients combined, regardless of specific diagnosis.

Figure 10
UMROI Chronic Care Patients: Monthly Average Daily Census July 2018 – October 2023



Source: UMROI internal data.

Based on UMROI's historic ALOS and ADC, the following table shows the projected ADC and ALOS for each patient population to be served in the relocated beds.

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Table 19
Chronic Care Patient Utilization, Project Year 1

		ADC	ALOS	Admissions
TBI				
	Rehab	17.80	19.00	342
	Chronic	5.50	30.00	67
TBI Total		**23.30**	**20.80**	**409**
SCI				
	Rehab	15.30	27.00	207
	Chronic	2.00	25.00	29
SCI Total		**17.30**	**26.75**	**236**
Complex CMR				
	Rehab	**12.00**	**15.00**	**292**
Total		**52.60**	**20.49**	**937**

(2) Financial Access.

An applicant shall agree to accept patients whose primary payer source is Medicare and Medicaid.

Applicant Response:

The Applicant agrees to accept patients whose primary payer source is Medicare or Medicaid.

(3) Facility Occupancy.

An applicant shall propose to serve and maintain at least an 85 percent average annual occupancy level.

Applicant Response:

As demonstrated in **Exhibit 1**, Table I, the Applicants propose to maintain chronic care occupancy levels above 85% annually.

(4) Jurisdictional Occupancy.

(a) The Commission may approve a Certificate of Need application for a new chronic hospital or a new chronic hospital service at an existing health care facility only if every chronic hospital in the jurisdiction has maintained, on average, an 85 percent or higher occupancy level, for the most recent fiscal year, as shown in the Chronic Hospital Occupancy Report published by the Commission in the Maryland Register. Each December, the Commission will issue a report on chronic hospital occupancy.

Applicant Response:

Not applicable. The Applicants do not propose to create a new chronic hospital or expand chronic care services, but rather seek only to relocate existing chronic beds from UMROI to UMMC.

(b) The applicant may show evidence why this standard should not apply.

Applicant Response:

Not applicable.

(5) Financial Viability.

Any applicant proposing to develop a new chronic hospital or a new chronic hospital service at an existing health care facility must demonstrate that it can meet the Medicare Conditions of Participation as a Long-Term Care Hospital consistent with 42 CFR Part 412.

Applicant Response:

Not applicable; the Applicants do not propose to develop a new chronic hospital service but rather propose to relocate existing chronic care beds from UMROI to UMMC. Nevertheless, the Applicants can demonstrate compliance with the requirements of 42 C.F.R. § 412.23 regarding Long-term care hospitals. UMMC participates in the Medicare program as a hospital and as demonstrated in **Exhibit 1**, Table I, the Applicants project an average length of stay of 28.5 days for chronic care patients, which exceeds the 25-day minimum to qualify as a Long-term care hospital pursuant to the Medicare regulations.

(6) Expansion.

(a) The Commission may approve a chronic hospital for expansion only if all of its beds are available for use and it has been operating at 85 percent or higher average occupancy for the two most recent fiscal years, as shown in the Commission's Chronic Hospital Occupancy Report.

(b) An applicant may show evidence why this standard should not apply.

Applicant Response:

Not applicable; the Applicants are not proposing to expand chronic hospital bed capacity.

F. THE MERGER AND CONSOLDIATION OF THE BEDS FROM UMROI TO UMMC IS IN THE PUBLIC INTEREST.

Applicant Response:

As demonstrated throughout this request, the relocation of acute inpatient rehabilitation, chronic care, and dually-licensed acute inpatient rehabilitation and chronic care beds from UMROI to UMMC will advance the public interest in a number of ways. Aligning the highly-specialized TBI and SCI programs with the world-class trauma care provided at the UMMC downtown campus will result in better patient care and improved patient experience. The project will also enable oncology patients who are medically cleared for acute inpatient rehabilitation services and who would benefit from such care to access acute inpatient rehabilitation services despite active chemo or radiation treatment all on the same campus. Patients will have access to a wide range of ancillary services and specialty providers on the same campus, allowing for a seamless transition through the continuum of care without the need for time consuming, inconvenient, and costly transfers. The reduction of transports will not only reduce costs for patients, but will also reduce costs to the health care system overall.

As a result of the project, patients will have improved access to acute inpatient rehabilitation, chronic, psychiatric, and medicine services in fully private patient rooms. This will enhance patient experience and promote optimal recovery. The higher complement of private rooms will also improve operational efficiency and patient throughput at UMMC's downtown campus.

This project, which represents a more efficient model of care delivery that improves patient safety, experience, and clinical outcomes while reducing costs to the health care system overall advances the public interest. The Applicants, therefore, respectfully request that the Commission find that the project is exempt from CON review.

INDEX OF EXHIBITS

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Figures **Description**

I hereby declare and affirm under the penalties of perjury that the facts stated in the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center and its attachments are true and correct to the best of my knowledge, information, and belief.

December 29, 2023

Date

DocuSigned by:
Dana Farraklan
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Dana Farraknan, Ph.D., MHS, FACHE
Senior Vice President, Strategy,
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December 29, 2023
Date

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Heather Beauchamp
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Heather Beauchamp, MSN, RN, LSSBB
Chief Nursing Officer, Vice President
Patient Care Services
University of Maryland Rehabilitation &
Orthopaedic Institute

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December 29, 2023
Date

DocuSigned by:
Jon Burns
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Jon P. Burns
Senior Vice President & Chief
Administrative Officer
University of Maryland Medical System

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December 29, 2023

Date

DocuSigned by:
Julie Nemens
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Julie Nemens, RN, MSN
Chief Administrative Officer & Senior Vice President
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December 29, 2023
Date

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Krishnaj Gourab
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Krishnaj Gourab, M.D.
Vice President & Chief Medical Officer
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December 29, 2023
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DocuSigned by:
Kristie Snedeker
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Kristie Snedeker, DPT
Vice President
UM R Adams Cowley Shock Trauma Center

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Linda Whitmore
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Linda Whitmore
Director of Project Development
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December 29, 2023
Date

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Lori Patria
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Lori Patria, M.S.
Director of Rehabilitation Services
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December 29, 2023
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Lucas Sater
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December 29, 2023
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Marina Bogin
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Marina Bogin, MBA
Vice President of Financial Services,
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December 29, 2023

Date

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Marty Chafin
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Marty Chafin, FACHE
President
Chafin Consulting Group, NE

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December 29, 2023
Date

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Scott Tinsley-Hall
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Scott Tinsley-Hall
Senior Director, Strategic Planning
University of Maryland Medical Center

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December 29, 2023
Date

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Brian Sturm
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Brian Sturm
Vice President, Corporate Decision Support & Capital Planning
University of Maryland Medical System

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December 29, 2023
Date

DocuSigned by:
Daniel Shelly
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Daniel Shelly
Vice President of Operations
University of Maryland Rehabilitation & Orthopaedic Institute

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December 29, 2023

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Laura Kautz
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Laura Kautz, RA
Director of Planning, Design & Development
University of Maryland Medical System

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December 29, 2023
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DocuSigned by:
Craig Wheeless
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Craig Wheeless, CHFP

EXHIBIT 1

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.
NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/Wing)*	Licensed Beds: July 1, 2023	Based on Physical Capacity				Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity
ACUTE CARE							**ACUTE CARE**					
General Medical/Surgical*	CS Telemetry, Acute 11E, Acute 10E, Med Telemetry 13 E/W, Medical IMC, Neurocare Step Down, Neurocare Acute, Vascular PCU, Transplant Gudelsky, Acute W5, Surgical IMC	262	152	40	192	232	**General Medical/Surgical***	CS Telemetry, Acute 10E, Medical IMC, Neurocare Step Down, Neurocare Acute, Vascular PCU, Transplant Gudelsky, Acute W5, Surgical IMC, N8W, N9W, CAM 9 Acute Med, CAM 10 Acute Med	200	22	222	244
SUBTOTAL Gen. Med/Surg*		**262**	**152**	**40**	**192**	**232**	**SUBTOTAL Gen. Med/Surg***		**200**	**22**	**222**	**244**
Medical Surgical Intensive Care	Neurocare ICU, Cardiac Surgery ICU, Medical ICU, Surgical ICU	99	101	2	103	105		Neurocare ICU, Cardiac Surgery ICU, Medical ICU, Surgical ICU	101	2	103	105
Medical Cardiac Critical Care	Cardiac Care Unit, Cardiac Progressive Care Unit	41	41	0	41	41		Cardiac Care Unit, Cardiac Progressive Care Unit	41	0	41	41
Oncology	Gudelsky BMT C9W, Medical Oncology N8W & N9W	62	52	0	52	52		CAM 6 Med Onc, CAM 7 Med Onc, CAM 9 BMT	62	0	62	62

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.
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Before the Project							After Project Completion						
Hospital Service	Location (Floor/Wing)*	Licensed Beds: July 1, 2023	Based on Physical Capacity: Room Count: Private	Room Count: Semi-Private	Room Count: Total Rooms	Bed Count: Physical Capacity	Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity: Room Count: Private	Room Count: Semi-Private	Room Count: Total Rooms	Bed Count: Physical Capacity
Shock Trauma	Neurotrauma IMC, Neurotrauma CC, Multitrauma IMC-5, Multitrauma CC, Multitrauma IMC-6, Multitrauma Acute Care, Ortho Acute	115	110	2	112	114		Neurotrauma IMC, Neurotrauma CC, Multitrauma IMC-5, Multitrauma CC, Multitrauma IMC-6, Multitrauma Acute Care, Ortho Acute	110	2	112	114
TOTAL MSGA		**579**	**456**	**44**	**500**	**544**	**TOTAL MSGA**		**514**	**26**	**540**	**566**
Obstetrics	Inpatient Perinatal - N6	30	22	4	26	30	**Obstetrics**	Inpatient Perinatal - N6	22	4	26	30
Pediatrics	PPCU, PICU	59	37	11	48	59	**Pediatrics**	PPCU, PICU	37	11	48	59
Psychiatric	Adult N12W, Geriatric N12E, Child and Adolescent N11W	42	10	17	27	44	**Psychiatric**	11E and CAM 11 Adult/Geri Psych, Child and Adolescent N11W	34	2	36	38
TOTAL ACUTE		**710**	**525**	**76**	**601**	**677**	**TOTAL ACUTE**		**607**	**43**	**650**	**693**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**		10	6	2	8	10	**Dedicated Observation****		6	2	8	10
Newborn Nursery		24	24	0	24	24	**Newborn Nursery**		24	0	24	24
Neonatal Intensive Care Unit		52	52	0	52	52	**Neonatal Intensive Care Unit**		52	0	52	52
Acute Rehabilitation					0	0	**Acute Rehabilitation**	12 E/W and CAM 12, 13 E/W and CAM 13	43	0	43	43
Comprehensive Care					0	0	**Comprehensive Care**				0	0
Other: Chronic Care Beds					0	0	**Other: Chronic Care Beds**	12 E/W and CAM 12, 13 E/W and CAM 13	5		5	5
Other: Dually-licensed Chronic/Rehab					0	0	**Other: Dually-licensed Chronic/Rehab**	12 E/W and CAM 12, 13 E/W and CAM 13	10		10	10
TOTAL NON-ACUTE		**76**	**82**	**2**	**84**	**86**	**TOTAL NON-ACUTE**		**140**	**2**	**142**	**144**
HOSPITAL TOTAL		**786**	**607**	**78**	**685**	**763**	**HOSPITAL TOTAL**		**747**	**45**	**792**	**837**

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTION: Identify the location of each nursing unit (add or delete rows if necessary) and specify the room and bed count before and after the project in accordance with the definition of physical capacity noted below. Applicants should add columns and recalculate formulas to address rooms with 3 and 4 bed capacity. See additional instruction in the column to the right of the table.
NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/Wing)*	Licensed Beds: July 1, 2023	Based on Physical Capacity				Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity

* Include beds dedicated to gynecology and addictions, if unit(s) is separate for acute psychiatric unit

** Include services included in the reporting of the "Observation Center". Service furnished by the hospital on the hospital's promise, including use of a bed and periodic monitoring by the hospital's nursing or other staff, which are reasonable and necessary to determine the need for a possible admission to the hospital as an inpatient; Must be ordered and documented in writing, given by a medical practitioner.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

INSTRUCTION : Add or delete rows if necessary. See additional instruction in the column to the right of the table.

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
ADULT/GERIATRIC PSYCH INPATIENT		17,357	8,513		25,870
LOBBY		8,735	8,377		17,112
MEDICAL/SURGERY INPATIENT		28,850	0		28,850
MECHANICAL/ELECTRICAL		6,019	3,581		9,600
SCI REHAB		16,996	17,131		34,127
TBI REHAB		16,902	17,738		34,640
SHARED STAFF SUPPORT & PUBLIC CIRCULATION		6,187	7,959		14,146
MECHANICAL PENTHOUSE		6,200	0		6,200
					0
Total		107,246	63,299		170,545

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☑
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☑
Excellent	☐	☐
Number of Stories		

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**Total Square Feet**	
Ground Floor	0	0
First Floor	0	0
Second Floor	0	0
Third Floor	0	0
Fourth Floor	0	0
Fifth Floor	0	0
SixthFloor	0	0
Seventh Floor	0	0
Eighth Floor	0	0
Ninth Floor	12,186	0
Tenth Floor	22,215	1,005
Eleventh Floor	22,215	12,132
Twelveth Floor	22,215	25,125
Thirteenth Floor	22,215	25,037
Fourteenth Floor	6,200	0
Total	107,246	63,299
Average Square Feet	**17,874**	**10,550**
Perimeter in Linear Feet	**Linear Feet**	
Ground Floor	0	0
First Floor	0	0
Second Floor	0	0
Third Floor	0	0
Fourth Floor	0	0
Fifth Floor	0	0
SixthFloor	0	0
Seventh Floor	0	0
Eighth Floor	0	0
Ninth Floor	312	0
Tenth Floor	628	0
Eleventh Floor	628	132
Twelveth Floor	628	349
Thirteenth Floor	628	349
Fourteenth Floor	703	0
Total Linear Feet	**3,527**	**830**

TABLE C. CONSTRUCTION CHARACTERISTICS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table C for each structure.

	NEW CONSTRUCTION	RENOVATION
Average Linear Feet	**588**	**138**
Wall Height (floor to eaves)	**Feet**	
Ground Floor		
First Floor		
Second Floor		
Third Floor		
Fourth Floor		
Fifth Floor		
SixthFloor		
Seventh Floor		
Eighth Floor		
Ninth Floor	12'-6"	12'-6"
Tenth Floor	12'-6"	12'-6"
Eleventh Floor	12'-6"	12'-6"
Twelveth Floor	12'-6"	12'-6"
Thirteenth Floor	12'-6"	12'-6"
Fourteenth Floor	29'-8"	29'-8"
Average Wall Height	**13'-6"**	**13'-6"**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	2	
Freight (Hospital)	2	
	Square Feet Covered	
Wet System Fully Sprinklered -Preaction in main electrical rooms.	107,246	63,299
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	The HVAC system is a fully ducted Variable Air Volume system with air handling units on level 9. Chilled water and heating water is provided from the existing central utility plant	
Type of Exterior Walls for proposed project	Curtain Wall System with glass and spandrel panels on the east, south & north facades. Terracotta with windows on the west facade. Curtainwall and Metal panel clading on the penthouse.	

TABLE D. ONSITE AND OFFSITE COSTS INCLUDED AND EXCLUDED IN MARSHALL VALUATION COSTS

INSTRUCTION: If project includes non-hospital space structures (e.g., parking garges, medical office buildings, or energy plants), complete an additional Table D for each structure.

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$0	
Other		
Subtotal included in Marshall Valuation Costs	**0**	**-**
Storm Drains	210,000	
Deep Foundation	1,650,500	
Premium for Constrained Site	114,846	
Premium for Prevailing Wage	229,691	
Premium for Minority Business Enterprise Requirement	91,877	
Subtotal On-Site excluded from Marshall Valuation Costs	**2,296,914**	
OFFSITE COSTS		
Roads		
Utilities		
Jurisdictional Hook-up Fees		
Other		
Subtotal Off-Site excluded from Marshall Valuation Costs	**-**	**-**
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**2,296,914**	**-**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$2,296,914**	**$0**
BUILDING COSTS		
Normal Building Costs	$38,237,959	
Subtotal included in Marshall Valuation Costs	**38,237,959**	**-**
Pneumatic Tube System	450,000	
Infection Prevention	600,000	
Asbestos abatement	300,000	

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
Adjacent Occupants Premium	600,000	
Premium for Constrained Site	3,459,177	
Premium for LEED Silver Construction	2,767,341	
Premium for Prevailing Wage	6,918,354	
Premium for Minority Business Enterprise Requirement	2,767,341	
Vertical Flooded Heating Hot Water Plant Upgrade	3,150,000	
Fire Pump with Express Riser & Electrical Feeder	1,209,000	
(Qty 3) Tier 4 Generators	6,000,000	
Cistern Within Building for Storm Water Retention	889,000	
Penthouse Exterior - Fully Clad on 4 sides	1,376,000	
Penthouse Roof Screenwall	459,364	
Subtotal Building Costs excluded from Marshall Valuation Costs	**30,945,577**	**-**
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$69,183,536**	**$0**
A&E COSTS		
Normal A&E Costs	$7,340,800	
Subtotal included in Marshall Valuation Costs	**7,340,800**	**-**
A&E Costs Excluded from Marshall Valuation Costs		
Subtotal A&E Costs excluded from Marshall Valuation Costs	**-**	**-**
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$7,340,800**	**$0**
PERMIT COSTS		
Normal Permit Costs	$50,000	
Subtotal included in Marshall Valuation Costs	**50,000**	**-**
Permit Costs Excluded from Marshall Valuation Costs		
Subtotal Permit Costs excluded from Marshall Valuation Costs	**-**	**-**
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$50,000**	**$0**

TABLE E. PROJECT BUDGET		
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.		
	Hospital Building	
A. USE OF FUNDS		
1. CAPITAL COSTS		
a. New Construction		
(1) Building	$	71,480,450
(2) Fixed Equipment	$	11,996,000
(3) Site and Infrastructure	$	-
(4) Architect/Engineering Fees	$	7,340,800
(5) Permits (Building, Utilities, Etc.)	$	50,000
SUBTOTAL	**$**	**90,867,250**
b. Renovations		
(1) Building	$	40,950,000
(2) Fixed Equipment (not included in construction)	$	8,000,000
(3) Architect/Engineering Fees	$	4,893,600
(4) Permits (Building, Utilities, Etc.)	$	44,000
SUBTOTAL	**$**	**53,887,600**
c. Other Capital Costs		
(1) Movable Equipment	$	22,296,200
(2) Contingency Allowance	$	10,611,800
(3) Gross interest during construction period	$	14,876,000
(4) Other (Specify/add rows if needed)		
SUBTOTAL	**$**	**47,784,000**
TOTAL CURRENT CAPITAL COSTS	**$**	**192,538,850**
d. Land Purchase		
e. Inflation Allowance	$	10,678,800
TOTAL CAPITAL COSTS	**$**	**203,217,650**
2. Financing Cost and Other Cash Requirements		
a. Loan Placement Fees	$	1,488,000
b. Bond Discount	$	-
c CON Application Assistance	$	125,750
c1. Legal Fees	$	-
c2. Other (Accounting, Architectural, Planning)	$	-
d. Non-CON Consulting Fees	$	-
d1. Legal Fees	$	185,000
d2. Other (third party peer review of documents; third party testing & scheduling, curtain wall testing)	$	335,000
e. Debt Service Reserve Fund	$	-
f Other (Specify/add rows if needed)	$	1,963,600
SUBTOTAL	**$**	**4,097,350**
3. Working Capital Startup Costs		
TOTAL USES OF FUNDS	**$**	**207,315,000**
B. Sources of Funds		
1. Cash		
2. Philanthropy (to date and expected)	$	-
3. Authorized Bonds	$	148,763,000
4. Interest Income from bond proceeds listed in #3	$	3,552,000
5. Mortgage		
6. Working Capital Loans		
7. Grants or Appropriations		
a. Federal		

	b. State	$ 55,000,000
	c. Local	
8.	**Other (Cash Flow from Operations)**	$ -
	TOTAL SOURCES OF FUNDS	**$ 207,315,000**
		Hospital Building
Annual Lease Costs (if applicable)		
1.	**Land**	
2.	**Building**	
3.	**Major Movable Equipment**	
4.	**Minor Movable Equipment**	
5.	**Other (Specify/add rows if needed)**	

* 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.

Note 1: There is no "other structure" for this project. That column has been removed.

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.

	Two Most Recent Years (Actual)		Current Year Projected	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	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**	**FY29**
1. DISCHARGES									
a. General Medical/Surgical*	17,610	15,877	15,434	15,627	15,627	15,649	15,671	15,693	15,715
b. ICU/CCU	2,817	3,019	3,382	3,424	3,424	3,424	3,424	3,424	3,424
Total MSGA	***20,427***	***18,896***	***18,816***	***19,052***	***19,052***	***19,074***	***19,096***	***19,118***	***19,140***
c. Pediatric	1,687	1,943	2,134	2,134	2,134	2,134	2,134	2,134	2,134
d. Obstetric	3,173	3,166	3,438	3,438	3,438	3,438	3,438	3,438	3,438
e. Acute Psychiatric	665	632	550	600	600	600	600	600	600
Total Acute	***25,952***	***24,637***	***24,938***	***25,224***	***25,224***	***25,246***	***25,268***	***25,290***	***25,320***
f. Rehabilitation							841	856	872
g. Comprehensive Care									
h. Other - Chronis							96	98	100
TOTAL DISCHARGES	***25,952***	***24,637***	***24,938***	***25,224***	***25,224***	***25,246***	***26,109***	***26,146***	***26,192***
2. PATIENT DAYS									
a. General Medical/Surgical*	121,364	106,502	105,575	106,634	106,634	107,141	108,293	109,446	109,600
b. ICU/CCU	67,084	72,453	70,796	71,506	71,506	71,506	71,506	71,506	71,506
Total MSGA	***188,448***	***178,955***	***176,371***	***178,140***	***178,140***	***178,647***	***179,799***	***180,952***	***181,106***
c. Pediatric	7,085	6,942	7,296	7,296	7,296	7,296	7,296	7,296	7,296
d. Obstetric	7,470	7,965	8,080	8,080	8,080	8,080	8,080	8,080	8,080
e. Acute Psychiatric	7,768	9,332	9,101	9,926	9,926	9,926	9,926	9,926	9,926
Total Acute	***210,771***	***203,194***	***200,848***	***203,443***	***203,443***	***203,949***	***205,102***	***206,254***	***206,408***
f. Rehabilitation							16,462	16,772	17,081
g. Comprehensive Care									
Other - Chronis							2,738	2,792	2,848
TOTAL PATIENT DAYS	***210,771***	***203,194***	***200,848***	***203,443***	***203,443***	***203,949***	***221,563***	***223,026***	***223,489***
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	6.9	6.7	6.8	6.8	6.8	6.8	6.9	7.0	7.0
b. ICU/CCU	23.8	24.0	20.9	20.9	20.9	20.9	20.9	20.9	20.9
Total MSGA	***9.2***	***9.5***	***9.4***	***9.4***	***9.4***	***9.4***	***9.4***	***9.5***	***9.5***
c. Pediatric	4.2	3.6	3.4	3.4	3.4	3.4	3.4	3.4	3.4
d. Obstetric	2.4	2.5	2.4	2.4	2.4	2.4	2.4	2.4	2.4
e. Acute Psychiatric	11.7	14.8	16.5	16.5	16.5	16.5	16.5	16.5	16.5
Total Acute	***8.1***	***8.2***	***8.1***	***8.1***	***8.1***	***8.1***	***8.1***	***8.2***	***8.2***
f. Rehabilitation							19.6	19.6	19.6
g. Comprehensive Care									
Other - Chronis							28.5	28.5	28.5
TOTAL AVERAGE LENGTH OF STAY	8.1	8.2	8.1	8.1	8.1	8.1	8.5	8.5	8.5
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*	392	392	392	392	392	392	392	392	392
b. ICU/CCU	239	239	239	239	239	239	239	239	239
Total MSGA	**631**	**631**	**631**	**631**	**631**	**631**	**631**	**631**	**631**
c. Pediatric	44	44	44	44	44	44	44	44	44
d. Obstetric	34	34	34	34	34	34	34	34	34
e. Acute Psychiatric	42	42	42	42	42	42	42	42	42
Total Acute	***751***	***751***	***751***	***751***	***751***	***751***	***751***	***751***	***751***
f. Rehabilitation							50	50	50
g. Comprehensive Care									
Other - Chronis							8	8	8
TOTAL LICENSED BEDS	***751***	***751***	***751***	***751***	***751***	***751***	***801***	***801***	***801***
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:** Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	84.8%	74.4%	73.8%	74.5%	74.5%	74.9%	75.7%	76.5%	76.6%
b. ICU/CCU	76.9%	83.1%	81.2%	82.0%	82.0%	82.0%	82.0%	82.0%	82.0%
Total MSGA	***81.8%***	***77.7%***	***76.6%***	***77.3%***	***77.3%***	***77.6%***	***78.1%***	***78.6%***	***78.6%***
c. Pediatric	44.1%	43.2%	45.4%	45.4%	45.4%	45.4%	45.4%	45.4%	45.4%
d. Obstetric	60.2%	64.2%	65.1%	65.1%	65.1%	65.1%	65.1%	65.1%	65.1%
e. Acute Psychiatric	50.7%	60.9%	59.4%	64.8%	64.8%	64.8%	64.8%	64.8%	64.8%
Total Acute	***76.9%***	***74.1%***	***73.3%***	***74.2%***	***74.2%***	***74.4%***	***74.8%***	***75.2%***	***75.3%***
f. Rehabilitation							90.2%	91.9%	93.6%
g. Comprehensive Care									
Other - Chronis							93.8%	95.6%	97.5%
TOTAL OCCUPANCY %	***76.9%***	***74.1%***	***73.3%***	***74.2%***	***74.2%***	***74.4%***	***75.8%***	***76.3%***	***76.4%***
6. OUTPATIENT VISITS									
a. Emergency Department	33,089	36,359	38,855	38,855	38,855	38,855	38,855	38,855	38,855
b. Same-day Surgery	15,354	15,622	15,726	15,726	15,726	15,726	15,726	15,726	15,726
c. Laboratory	Included in Item "e"								
d. Imaging									
e. Clinic Visits / Other Ancillary	228,779	228,665	221,628	221,628	221,628	226,528	229,376	232,223	235,105
TOTAL OUTPATIENT VISITS	***277,222***	***280,646***	***276,208***	***276,208***	***276,208***	***281,108***	***283,956***	***286,803***	***289,686***
7. OBSERVATIONS**									
a. Number of Patients	3,756	3,821	3,636	3,636	3,636	3,636	3,636	3,636	3,636
b. Hours	113,088	138,102	123,889	123,889	123,889	123,889	123,889	123,889	123,889

* 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 G. REVENUES & EXPENSES, UNINFLATED - 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.

	Two Most Recent Years (Actual)		Current Year Projected	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	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**	**FY29**
1. REVENUE									
a. Inpatient Services	$1,405,371	$1,431,200	$1,471,160	$ 1,432,600	$ 1,434,650	$ 1,440,117	$ 1,525,447	$ 1,531,971	$ 1,536,455
b. Outpatient Services	616,878	666,749	672,830	663,815	664,765	667,298	669,831	672,681	674,581
Gross Patient Service Revenues	***$2,022,249***	***$2,097,949***	***$2,143,989***	***$2,096,415***	***$2,099,415***	***$2,107,415***	***$ 2,195,278***	***$ 2,204,652***	***$ 2,211,036***
c. Allowance For Bad Debt	$ 49,246	$ 51,392	$ 51,929	$ 50,777	$ 50,850	$ 51,043	$ 53,381	$ 53,608	$ 53,763
d. Contractual Allowance	195,934	223,069	225,401	239,464	239,807	240,720	250,694	251,722	252,407
e. Charity Care	20,877	21,746	21,973	21,486	21,516	21,598	22,497	22,593	22,658
Net Patient Services Revenue	***$ 1,756,192***	***$ 1,801,742***	***$ 1,844,686***	***$ 1,784,688***	***$ 1,787,242***	***$ 1,794,052***	***$ 1,868,706***	***$ 1,876,729***	***$ 1,882,208***
f. Other Operating Revenues (Specify/add rows if needed)	$ 205,193	$ 219,353	$ 247,431	$ 214,431	$ 214,431	$ 219,431	$ 223,431	$ 226,431	$ 228,431
NET OPERATING REVENUE	***$ 1,961,385***	***$ 2,021,095***	***$ 2,092,116***	***$ 1,999,119***	***$ 2,001,672***	***$ 2,013,483***	***$ 2,092,137***	***$ 2,103,160***	***$ 2,110,639***
2. EXPENSES									
a. Salaries & Wages (including benefits)	$ 732,429	$ 785,407	$ 786,433	$ 739,633	$ 727,933	$ 738,463	$ 761,623	$ 764,430	$ 764,648
b. Contractual Services	511,461	524,206	554,444	551,944	552,944	554,978	569,043	570,632	570,702
c. Interest on Current Debt	24,523	21,080	20,782	22,398	21,944	21,966	21,499	21,030	20,690
d. Interest on Project Debt	-	-	-	-	-	7,990	$ 15,608	$ 15,456	$ 15,296
e. Current Depreciation	94,920	95,624	94,246	92,928	95,170	94,218	93,276	92,343	90,506
f. Project Depreciation	-	-	-	-	-	13,673	25,491	25,491	25,491
g. Current Amortization	-	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-	-
i. Supplies	468,374	477,808	502,651	492,701	496,901	500,909	506,139	508,909	510,059
j. Other Expenses (Utilities / Insurance)	46,792	51,517	55,431	55,708	55,708	55,708	55,708	55,708	55,708
TOTAL OPERATING EXPENSES	***$ 1,878,499***	***$ 1,955,642***	***$ 2,013,987***	***$ 1,955,312***	***$ 1,950,600***	***$ 1,985,960***	***$ 2,048,387***	***$ 2,053,999***	***$ 2,053,100***
3. INCOME									
a. Income From Operation	**$ 82,886**	**$ 65,453**	**$ 78,129**	**$ 43,807**	**$ 51,073**	**$ 27,523**	**$ 43,750**	**$ 49,161**	**$ 57,539**
b. Non-Operating Income	$ 57,183	$ (47,869)							
SUBTOTAL	***$ 140,069***	***$ 17,584***	***$ 78,129***	***$ 43,807***	***$ 51,073***	***$ 27,523***	***$ 43,750***	***$ 49,161***	***$ 57,539***
c. Income Taxes	$ -	$ -							
NET INCOME (LOSS)	***$ 140,069***	***$ 17,584***	***$ 78,129***	***$ 43,807***	***$ 51,073***	***$ 27,523***	***$ 43,750***	***$ 49,161***	***$ 57,539***
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare	35.9%	36.8%	37.3%	37.5%	37.7%	37.9%	38.1%	38.3%	38.4%
2) Medicaid	28.4%	28.0%	27.1%	27.1%	27.1%	27.1%	27.0%	26.9%	26.8%
3) Blue Cross	15.8%	16.1%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%
4) Commercial Insurance	15.5%	14.4%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%
5) Self-pay	0.9%	1.2%	1.4%	1.4%	1.3%	1.2%	1.2%	1.2%	1.2%
6) Other	3.6%	3.6%	4.1%	4.0%	3.9%	3.8%	3.7%	3.6%	3.6%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

TABLE G. REVENUES & EXPENSES, UNINFLATED - 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.

	Two Most Recent Years (Actual)		Current Year Projected	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	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**	**FY29**
b. Percent of Equivalent Inpatient Days									
Total MSGA									
1) Medicare									
2) Medicaid									
3) Blue Cross									
4) Commercial Insurance									
5) Self-pay									
6) Other									
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***		***0.0%***	***0.0%***

UMMC does not track payer's by patient days

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.

	Two Most Recent Years (Actual)		Current Year Projected	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	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**	**FY29**
1. REVENUE									
a. Inpatient Services	$1,405,371	$1,431,200	$1,471,160	$1,461,252	$1,508,706	$1,561,403	$1,704,233	$1,765,756	$1,827,138
b. Outpatient Services	616,878	666,749	672,830	$677,091	$699,080	$723,498	$748,758	$775,254	$801,544
Gross Patient Service Revenues	***$2,022,249***	***$2,097,949***	***$2,143,989***	***$2,138,343***	***$2,207,786***	***$2,284,902***	***$2,452,991***	***$2,541,010***	***$2,628,683***
c. Allowance For Bad Debt	$ 49,246	$ 51,392	$ 51,929	$ 51,792	$ 53,474	$ 55,342	$ 59,159	$ 61,283	$ 63,398
d. Contractual Allowance	195,934	223,069	225,401	224,807	232,108	240,215	254,620	263,368	272,048
e. Charity Care	20,877	21,746	21,973	21,915	22,627	23,418	24,835	25,725	26,611
Net Patient Services Revenue	***$ 1,756,192***	***$ 1,801,742***	***$ 1,844,686***	***$ 1,839,828***	***$ 1,899,577***	***$ 1,965,926***	***$ 2,114,377***	***$ 2,190,635***	***$ 2,266,626***
f. Other Operating Revenues (Specify/add rows if needed)	$ 205,193	$ 219,353	$ 247,431	$ 218,719	$ 225,499	$ 237,911	$ 249,758	$ 260,958	$ 271,424
NET OPERATING REVENUE	***$ 1,961,385***	***$ 2,021,095***	***$ 2,092,116***	***$2,058,547***	***$2,125,076***	***$2,203,837***	***$ 2,364,135***	***$ 2,451,593***	***$ 2,538,049***
2. EXPENSES									
a. Salaries & Wages (including benefits)	$ 732,429	$ 785,407	$ 786,433	$ 765,520	$ 776,013	$ 810,856	$ 860,582	$ 888,990	$ 915,241
b. Contractual Services	511,461	524,206	554,444	$ 568,502	$ 583,771	$ 600,566	$ 630,974	$ 648,211	$ 664,154
c. Interest on Current Debt	24,523	21,080	20,782	22,398	21,944	21,966	21,499	21,030	20,690
d. Interest on Project Debt	-	-	-	-	-	7,990	15,608	15,456	15,296
e. Current Depreciation	94,920	95,624	94,246	92,928	95,170	94,218	93,276	92,343	90,506
f. Project Depreciation	-	-	-	-	-	13,673	25,491	25,491	25,491
g. Current Amortization	-	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-	-
i. Supplies	468,374	477,808	502,651	$ 514,872	$ 541,330	$ 568,889	$ 599,078	$ 627,865	$ 655,937
j. Other Expenses (Utilities / Insurance)	46,792	51,517	55,431	$ 57,379	$ 58,908	$ 60,478	$ 62,090	$ 63,745	$ 65,444
TOTAL OPERATING EXPENSES	**$ 1,878,499**	**$ 1,955,642**	**$ 2,013,987**	**$ 2,021,600**	**$ 2,077,136**	**$ 2,176,690**	**$ 2,308,597**	**$ 2,383,131**	**$ 2,452,759**
3. INCOME									
a. Income From Operation	**$ 82,886**	**$ 65,453**	**$ 78,129**	**$ 36,947**	**$ 47,940**	**$ 27,147**	**$ 55,538**	**$ 68,462**	**$ 85,290**
b. Non-Operating Income	$ 57,183	$ (47,869)	$ -						
SUBTOTAL	***$ 140,069***	***$ 17,584***	***$ 78,129***	***$ 36,947***	***$ 47,940***	***$ 27,147***	***$ 55,538***	***$ 68,462***	***$ 85,290***
c. Income Taxes	$ -	$ -	$ -						
NET INCOME (LOSS)	***$ 140,069***	***$ 17,584***	***$ 78,129***	***$ 36,947***	***$ 47,940***	***$ 27,147***	***$ 55,538***	***$ 68,462***	***$ 85,290***
4. PATIENT MIX									
a. Percent of Total Revenue									
1) Medicare	35.9%	36.8%	37.3%	37.5%	37.7%	37.9%	38.1%	38.3%	38.4%
2) Medicaid	28.4%	28.0%	27.1%	27.1%	27.1%	27.1%	27.0%	26.9%	26.8%
3) Blue Cross	15.8%	16.1%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%	16.0%
4) Commercial Insurance	15.5%	14.4%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%	14.0%
5) Self-pay	0.9%	1.2%	1.4%	1.4%	1.3%	1.2%	1.2%	1.2%	1.2%
6) Other	3.6%	3.6%	4.1%	4.0%	3.9%	3.8%	3.7%	3.6%	3.6%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

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.

	Two Most Recent Years (Actual)		Current Year Projected	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	**FY21**	**FY22**	**FY23**	**FY24**	**FY25**	**FY26**	**FY27**	**FY28**	**FY29**
b. Percent of Equivalent Inpatient Days									
Total MSGA									
1) Medicare									
2) Medicaid									
3) Blue Cross									
4) Commercial Insurance									
5) Self-pay									
6) Other									
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***

UMMC does not track payer's by patient days

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.

Indicate CY or FY	FY21	FY22	FY23	FY24	FY25	FY26	FY27	FY28	FY29
1. DISCHARGES									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute									
f. Rehabilitation							841	856	872
g. Comprehensive Care									
h. Other - Chronic							96	98	100
TOTAL DISCHARGES							***937***	***954***	***972***
2. PATIENT DAYS									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute									
f. Rehabilitation							16,462	16,772	17,081
g. Comprehensive Care									
h. Other Chronic							2,738	2,792	2,848
TOTAL PATIENT DAYS							***19,199***	***19,564***	***19,929***
3. AVERAGE LENGTH OF STAY									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute									
f. Rehabilitation							19.6	19.6	19.6
g. Comprehensive Care									
h. Other - Chronic							28.5	28.5	28.5
TOTAL AVERAGE LENGTH OF STAY							20.5	20.5	20.5
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute									
f. Rehabilitation							50	50	50
g. Comprehensive Care									
h. Other - Chronic							8	8	8
TOTAL LICENSED BEDS							***58***	***58***	***58***
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA									
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric									
Total Acute									
f. Rehabilitation							90.2%	91.9%	93.6%
g. Comprehensive Care									
h. Other - Chronic							93.8%	95.6%	97.5%
TOTAL OCCUPANCY %							**90.7%**	**92.4%**	**94.1%**
6. OUTPATIENT VISITS									
a. Emergency Department									
b. Same-day Surgery									
c. Laboratory									
d. Imaging									
e. Clinic Visits / Other Ancillary									
TOTAL OUTPATIENT VISITS									
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		**FY26**	**FY27**	**FY28**	**FY29**		
1. REVENUE							
a. Inpatient Services			$ 65,765	$ 65,765	$ 65,765		
b. Outpatient Services							
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 65,765***	***$ 65,765***	***$ 65,765***	***$ -***	***$ -***
c. Allowance For Bad Debt			$ 1,644	$ 1,644	$ 1,644		
d. Contractual Allowance			$ 6,703	$ 6,703	$ 6,703		
e. Charity Care			$ 605	$ 605	$ 605		
Net Patient Services Revenue	***$ -***	***$ -***	***$ 56,813***	***$ 56,813***	***$ 56,813***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 56,813***	***$ 56,813***	***$ 56,813***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)			$ 20,726	$ 20,726	$ 20,726		
b. Contractual Services			$ 12,579	$ 12,579	$ 12,579		
c. Interest on Current Debt							
d. Interest on Project Debt			$ 7,853	$ 7,709	$ 7,559		
e. Current Depreciation							
f. Project Depreciation			$ 13,673	$ 13,673	$ 13,673		
g. Current Amortization							
h. Project Amortization							
i. Supplies			$ 1,982	$ 2,021	$ 2,062		
j. Other Expenses (Specify)							
Other Expense (Utilities)							
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ 56,813***	***$ 56,709***	***$ 56,599***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ -**		**$ 0**	**$ 104**	**$ 215**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ -***		***$ 0***	***$ 104***	***$ 215***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***		***$ 0***	***$ 104***	***$ 215***	***$ -***	***$ -***

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		**FY26**	**FY27**	**FY28**	**FY29**		
4. PATIENT MIX							
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***0.0%***	***0.0%***	***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		**FY26**	**FY27**	**FY28**	**FY29**		
1. REVENUE							
a. Inpatient Services			$ 72,073	$ 74,307	$ 76,611		
b. Outpatient Services							
Gross Patient Service Revenues	***$ -***	***$ -***	***$ 72,073***	***$ 74,307***	***$ 76,611***	***$ -***	***$ -***
c. Allowance For Bad Debt			$ 1,802	$ 1,858	$ 1,915		
d. Contractual Allowance			$ 7,344	$ 7,572	$ 7,807		
e. Charity Care			$ 663	$ 684	$ 705		
Net Patient Services Revenue	***$ -***	***$ -***	***$ 62,264***	***$ 64,194***	***$ 66,184***	***$ -***	***$ -***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ 62,264***	***$ 64,194***	***$ 66,184***	***$ -***	***$ -***
2. EXPENSES							
a. Salaries & Wages (including benefits)			$ 22,648	$ 23,327	$ 24,027		
b. Contractual Services			$ 13,745	$ 14,158	$ 14,583		
c. Interest on Current Debt							
d. Interest on Project Debt			$ 7,853	$ 7,709	$ 7,559		
e. Current Depreciation							
f. Project Depreciation			$ 13,673	$ 13,673	$ 13,673		
g. Current Amortization							
h. Project Amortization							
i. Supplies			$ 2,166	$ 2,231	$ 2,297		
j. Other Expenses (Specify)							
Other Expense (Utilities)							
TOTAL OPERATING EXPENSES	***$ -***		***$ 60,085***	***$ 61,098***	***$ 62,139***	***$ -***	***$ -***
3. INCOME							
a. Income From Operation	**$ -**		**$ 2,178**	**$ 3,096**	**$ 4,045**	**$ -**	**$ -**
b. Non-Operating Income							
SUBTOTAL	***$ -***		***$ 2,178***	***$ 3,096***	***$ 4,045***	***$ -***	***$ -***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***		***$ 2,178***	***$ 3,096***	***$ 4,045***	***$ -***	***$ -***
4. PATIENT MIX							

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		**FY26**	**FY27**	**FY28**	**FY29**		
a. Percent of Total Revenue							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***0.0%***
b. Percent of Equivalent Inpatient Days							
Total MSGA							
1) Medicare							
2) Medicaid							
3) Blue Cross							
4) Commercial Insurance							
5) Self-pay							
6) Other							
TOTAL	***0.0%***	***0.0%***	***0.0%***	***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.

	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)*											
Managers/Directors/Sr. Administrators	370.0	$120,264	$ 44,499,345	4.0	$126,125	$ 504,500	4.7	$120,264	$ 568,809	378.7	$ 45,572,655
							-		$ -		
							-		$ -		
Total Administration	370.0	$ 120,264	$ 44,499,345	4.0	$126,125	$ 504,500	4.7		$ 568,809	378.7	$ 45,572,655
Direct Care Staff *(List general categories, add rows if needed)*											
RNs	1,830.3	$104,809	$ 191,829,176	52.9	$101,069	$5,344,504	237.9	$90,380	$ 21,501,053	2,121.0	$ 218,674,732
Clinical Professionals	1,144.1	$100,888	$ 115,422,303	73.0	$77,844	$5,681,815	56.7	$118,361	$ 6,711,533	1,273.8	$ 127,815,651
Clinical Techs	593.2	$78,054	$ 46,300,430	6.4	$69,835	$446,944	27.8	$72,595	$ 2,018,111	627.4	$ 48,765,485
Non-Licensed Clinical	960.2	$42,061	$ 40,387,816	72.1	$53,177	$3,832,490	136.8	$43,269	$ 5,917,428	1,169.1	$ 50,137,735
Residents	583.0	$65,606	$ 38,248,111	0.0		$ -	7.5	$65,606	$ 495,210	590.5	$ 38,743,322
Total Direct Care	5,110.7	$ 84,565	$ 432,187,836	204.3	$ 74,903	$ 15,305,753	466.7	$ 78,515	$ 36,643,336	5,782	$ 484,136,925
Support Staff *(List general categories, add rows if needed)*											
Administrative and Clerical	508.7	$ 45,346	$ 23,066,330	5.9	$38,876	$228,200	48.8	$44,094	$ 2,152,746	563.4	$ 25,447,276
All Other Support	710.6	$ 40,135	$ 28,521,883	21.5	$43,096	$926,560	14.3	$40,135	$ 572,951	746.4	$ 30,021,394
							-		$ -		
							-		$ -		
Total Support	1,219.3	$ 42,309	$ 51,588,212	27.4	$ 42,191	$ 1,154,760	63.1	$ 43,198	$ 2,725,697	1,310	$ 55,468,670
REGULAR EMPLOYEES TOTAL	***6,700.1***	***$78,846***	***$ 528,275,394***	***235.7***	***$71,974***	**$ 16,965,013**	***534.5***	***$74,715***	**$ 39,937,843**	***7,470.3***	**$ 585,178,250**
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
							-		$ -		
							-		$ -		
							-		$ -		
							-		$ -		
Total Administration			$ -				-		$ -		
Direct Care Staff *(List general categories, add rows if needed)*											
RNs	371.1	$260,671	$ 96,729,721	1.8	$185,120	$ 333,216	(250.0)	$260,671	$ (65,167,700)	122.9	$ 31,895,236
Clinical Professionals	32.4	$218,524	$ 7,086,748			$ -	(10.0)	$218,524	$ (2,185,244)	22.4	$ 4,901,503
Clinical Techs											
Non-Licensed Clinical	276.5	$69,659	$ 19,262,823	3.2	$72,800	$ 232,960	(150.0)	$69,659	$ (10,445,614)	129.8	$ 9,050,169
Total Direct Care Staff	680.0	180,988	$ 123,079,291	5.0	113,235.2	$ 566,176	(410.0)	$ 189,774	$ (77,798,558)	275.1	$ 45,846,909
Support Staff *(List general categories, add rows if needed)*											
Administrative and Clerical	18.7	$62,815	$ 1,174,643				(4.8)	$62,815	$ (300,250)		
All Other Support	78.9	$49,799	$ 3,929,617				(9.2)	$49,799	$ (460,527)		
							-		$ -		
							-		$ -		
Total Support Staff	97.6	52,292	$ 5,104,260				(14.0)	$54,234	$ (760,777)		
CONTRACTUAL EMPLOYEES TOTAL	***777.7***	***164,835***	***$ 128,183,551***	***5.0***	***$113,235***	**$ 566,176**	***(424.0)***	***$185,290***	***$ (78,559,335)***	**275.1**	**$ 45,846,909**
Benefits *(State method of calculating benefits below)*:			**$ 117,118,655**			**$ 3,761,143**			**$ 8,854,220**		**$ 129,734,018**
22.17% of regular employee salaries											
TOTAL COST	***7,477.7***		***$ 773,577,600***	***240.7***		***$ 21,292,333***	***110.6***		***$ (29,767,272)***	***7,745.4***	***$ 760,759,176***

Assumption

	2024	2025	2026	2027	2028	2029
Assumptions to Revenue						
Inflation	2.91%	3.10%	3.10%	3.10%	3.10%	3.10%
Quality Adjustments	-0.82%	0.00%	0.00%	0.00%	0.00%	0.00%
Demographic Factor	-0.48%	0.00%	0.00%	0.00%	0.00%	0.00%
Market Shift	-0.30%	0.00%	0.00%	0.00%	0.00%	0.00%
Innovation	-0.51%	0.00%	0.00%	0.00%	0.00%	0.00%
High Cost Drug Funding	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
All Other	-1.55%	0.00%	0.00%	0.00%	0.00%	0.00%
Total	**-0.75%**	**3.10%**	**3.10%**	**3.10%**	**3.10%**	**3.10%**

	2024	2025	2026	2027	2028	2029
Assumptions to Salaries						
Inflation	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Performance Improvement [1]	($46.8M)	($11.7M)				
New Facility			**Variable w/ Volume**			

[1] Salaries in the current and prior fiscal year reflect an environment that is heavily dependent on temporary and other premium labor. This is driving up salaries due to the extremely high cost of that labor. UMMC has an action plan in place over the next two years to reduce both the hourly rate for temporary labor (anticipated softening of the market nationwide) as well as the number of premium FTEs. The reduction in FTEs is due to efficiency improvements driving down the number of FTEs needed to provide the care as well market equity salary adjustments to facilitate hiring. ***These changes drive the salaries down which is relfected in the Work Force Table under "Other Anticipated Changes".***

	2024	2025	2026	2027	2028	2029
Assumptions to Benefits	21.8%	21.8%	21.8%	21.8%	21.8%	21.8%

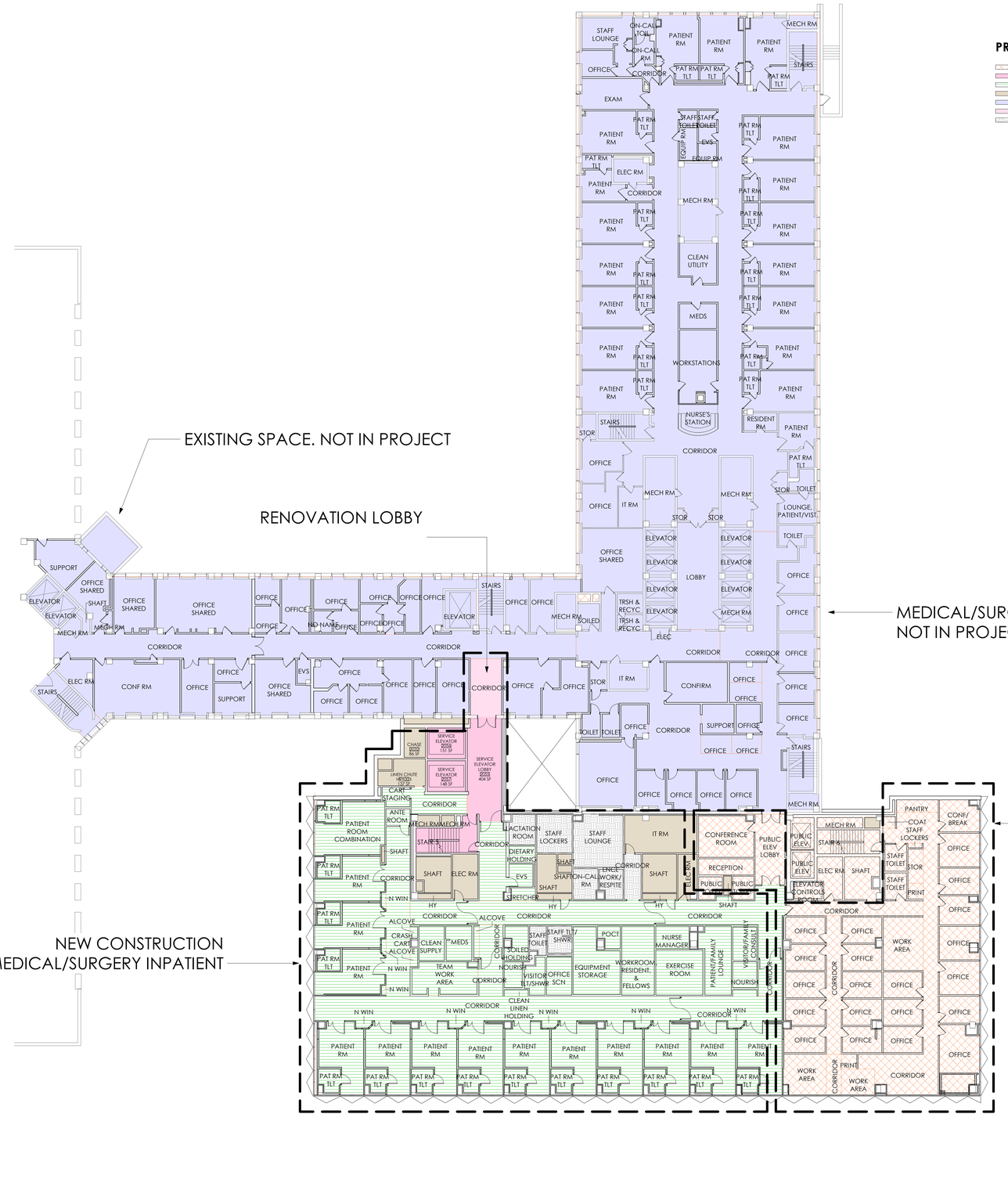
	2024	2025	2026	2027	2028	2029
Other Inflation Assumptions)						
Drugs	6.0%	6.0%	6.0%	6.0%	6.0%	6.0%
Supplies	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Purchased Services	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Physician Services	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
Insurance	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%

EXHIBIT 2

DEC
08 2023

CRGADESIGN

UNIVERSITY of MARYLAND
MEDICAL CENTER



PROJECT DEPARTMENT

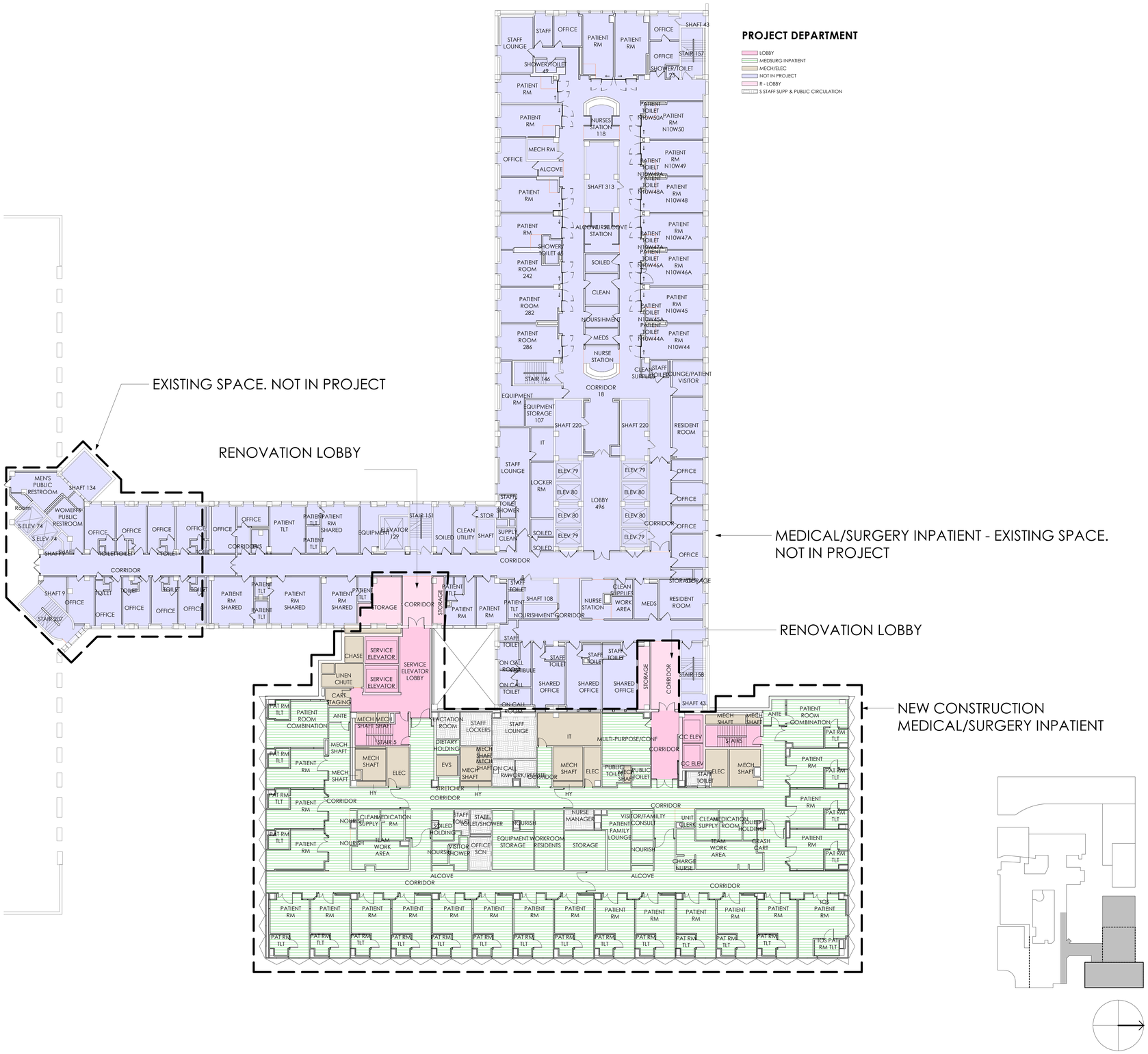
- CC ADMIN OFFICES
- LOBBY
- MEDSURG INPATIENT
- MECH/ELEC
- NOT IN PROJECT
- R - LOBBY
- S STAFF SUPP & PUBLIC CIRCULATION

1 PROJECT NEW PLAN - LEVEL 09
PR - 09 SCALE: 1/16" = 1'-0"

22.116.A

LEVEL 09
12/08/2023

CRGADESIGN



1 PROJECT NEW PLAN - LEVEL 10
PR - 10 SCALE: 1/16" = 1'-0"

22.116.A

LEVEL 10
12/08/2023

CRGADESIGN

PEDIATRIC PSYCH - EXISTING SPACE. NOT IN PROJECT

RENOVATION MECH/ELEC

RENOVATION LOBBY

RENOVATION SHARED STAFF SUP AND PUBLIC CIRC

RENOVATION PSYCH

NEW WINDOWS

EXISTING SPACE. NOT IN PROJECT

NEW CONSTRUCTION
ADULT & GERIATRIC PSYCH INPATIENT

PROJECT DEPARTMENT

- ADULT GERIATRIC PSYCH INPATIENT
- LOBBY
- MECH/ELEC
- NOT IN PROJECT
- R - ADULT GERIATRIC PSYCH INPATIENT
- R - LOBBY
- R - MECH/ELEC
- R - S STAFF SUPP & PUBLIC CIRCULATION
- S STAFF SUPP & PUBLIC CIRCULATION

1 PR - 11 PROJECT NEW PLAN - LEVEL 11
SCALE: 1/16" = 1'-0"

22.116.A

LEVEL 11
12/08/2023

CRGADESIGN

RENOVATION REHAB SCI

RENOVATION MECH/ELEC

RENOVATION LOBBY

RENOVATION
SHARED STAFF SUP AND PUBLIC CIRC

NEURO CLINICS - EXISTING
SPACE. NOT IN PROJECT

RENOVATION
SCI REHAB INPATIENT

NEW WINDOWS

NEW CONSTRUCTION
SCI REHAB INPATIENT

PROJECT DEPARTMENT

- LOBBY
- MECH/ELEC
- NOT IN PROJECT
- R - LOBBY
- R - MECH/ELEC
- R - S STAFF SUPP & PUBLIC CIRCULATION
- R - SCI REHAB
- SCI REHAB
- S STAFF SUPP & PUBLIC CIRCULATION

1 PR - 12 PROJECT NEW PLAN - LEVEL 12
SCALE: 1/16" = 1'-0"

22.116.A

LEVEL 12
12/08/2023

CRGADESIGN

1 PR - 13 PROJECT NEW PLAN - LEVEL 13
SCALE: 1/16" = 1'-0"

22.116.A
LEVEL 13
12/08/2023

CRGADESIGN

EXHIBIT 3

Before completion of Cancer Center CON Project and Proposed CON Exemption Project

Existing North Hospital

	West Wing		East Wing
14th	Mechanical Penthouse		Emerg Electrical Penthouse
13th	Medicine Inpatient		Medicine Inpat
12th	Adult Psychiatry		Gero Psych
11th	Child Psychiatry		Medicine Inpat
10th	Medicine Inpatient		Medicine Inpat
9th	Cancer Inpatient		CC Offices
8th	Cancer Inpatient		Digestive Health
7th	Peds Cath Hybrid OR/Endo/PACU		Stage 1&2 / Clinics
6th	Labor & Delivery		CAFCA
5th	Pediatrics Clinics & Support		Pediatrics
4th	NICU		NICU
3rd	EP Labs/Diagnostics		Diagnostics
2nd	Blood Bank/ Pathology		LOBBY & Cancer Center Infusion
1st	Main Pharmacy/ Cancer Center Clinics		
Ground	Materials Mgmt/ Surg Clinic		Misc Clinics
Basement	Anatomic Pathology		IT & One-Call

NORTH ELEVATORS

DROP OFF

After completion of Cancer Center CON Project and Proposed CON Exemption Project

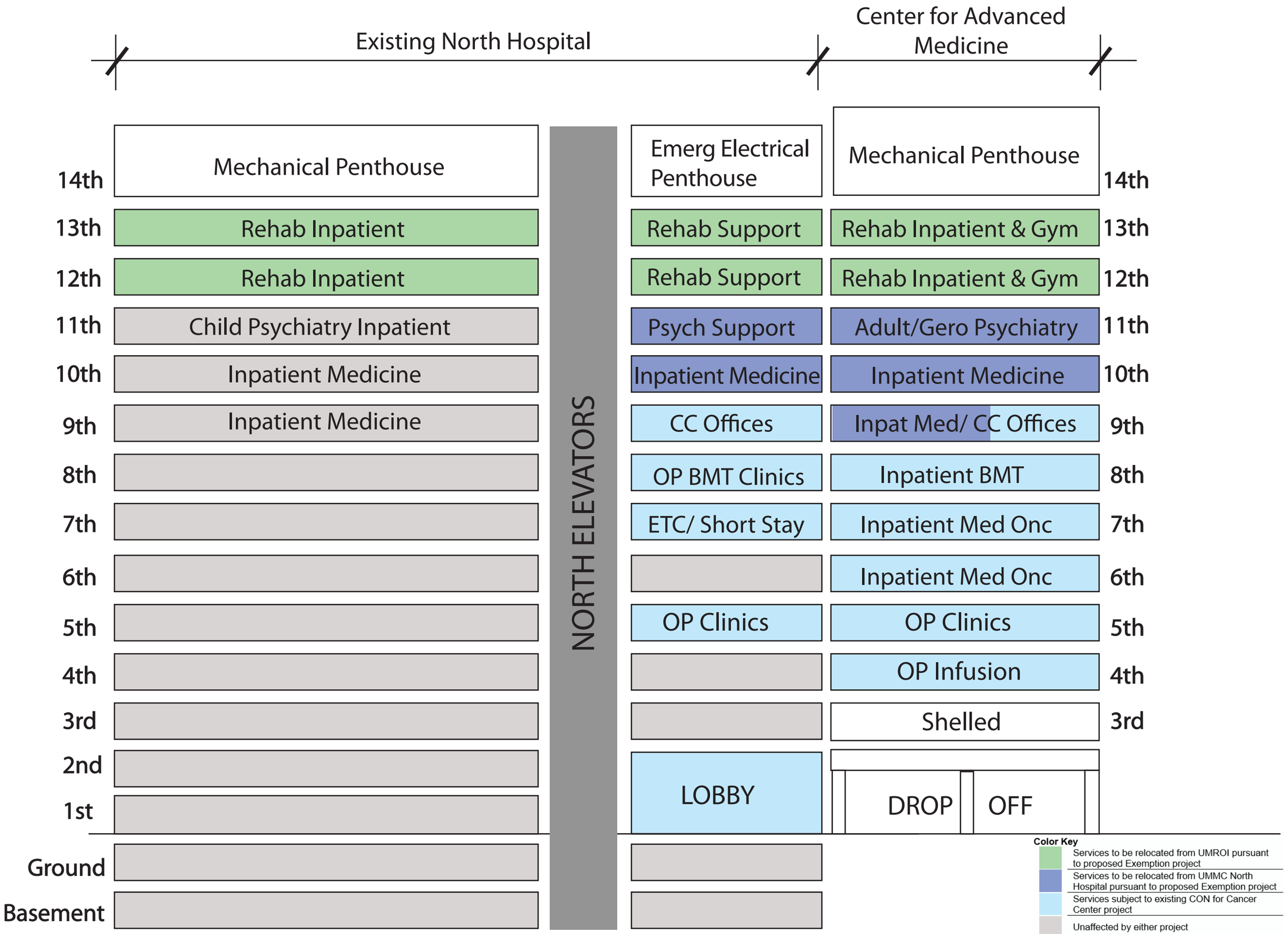


EXHIBIT 4

UNIVERSITY of MARYLAND MEDICAL SYSTEM Revenue Cycle Services	PAGE: 1 OF 14	POLICY NO: RCS - 01
	EFFECTIVE DATE: 09/18/19	REVISION DATE(S): 07/01/22
SUBJECT: UMMS Financial Assistance Policy		

KEY WORDS:
Financial Assistance, Financial Hardship, Financial Clearance, Medical Assistance

OBJECTIVE/BACKGROUND:
The purpose of the following policy statement is to describe the financial assistance application process, how applications are reviewed and determinations of eligibility are made, eligibility criteria for financial assistance programs (including presumptive eligibility and financial hardship assistance), financial clearance of patients with medically unique or humanitarian needs, how UMMS notifies patients of the availability financial assistance availability, the appeal process, and extraordinary collection actions.

APPLICABILITY:
This policy applies to all team members, vendors, and agents [volunteers, medical team members] of any of the following University of Maryland Medical System member organizations:

- University of Maryland Medical Center (UMMC)
- UM Midtown Campus (MTC)
- UM Rehabilitation & Orthopaedic Institute (UMROI)
- UM St. Joseph Medical Center (UMSJMC)
- UM Baltimore Washington Medical Center (UMBWMC)
- UM Shore Regional Health (UMSRH)
- UM Shore Medical Center at Dorchester (UMSMCD)
- UM Shore Medical Center at Easton (UMSME)
- UM Charles Regional Medical Center (UMCRMC)
- UM Upper Chesapeake Health (UCHS)
- UM Capital Region Health (UMCRH)
- UM Physician Networks (UMPN)
- UMMS Outpatient Rx Weinberg
- UMMC Pharmacy at Redwood
- UMMS Pharmacy Services
- UMMC Mid-Town Campus Pharmacy
- UMMC Pharmacy at Capital Region
- UMMC Pharmacy at Baltimore Washington

DEFINITIONS:

Federal Poverty Level	A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits.
Financial Hardship	Instances in which member organization charges incurred at UMMS member organizations for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.
MDH Limits	Refers to the income eligibility limits for reduced cost care, set by Maryland Department of Health (MDH) office of Medical Assistance Planning. The State of Maryland accepted the Federal Medicaid expansion on January 1, 2014 vs the Federal Poverty Levels, under the Affordable Care Act, which expanded the eligible income limits for Maryland Medicaid. UMMS adopted these new limits for the reduced cost care sliding scale, as set forth in Attachment A.
Medical Debt	Out-of-pocket expenses, including co-payments, coinsurance, and deductibles, incurred at UMMS member organizations for medically necessary treatment.
Presumptive Eligibility	Instances in which information provided by the patient or through other sources provides sufficient evidence that the patient is eligible for financial assistance, but there is no financial assistance form on file.

POLICY:

The University of Maryland Medical System ("UMMS") is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation.

It is the policy of the University of Maryland Medical System ("UMMS") member organizations to provide financial assistance which meets or exceeds the requirements set forth by the State of Maryland for patients who meet specified financial criteria and request such assistance.

I. **Free Care -** Those with income up to 200% of the income eligibility limits established by the Maryland Department of Health are eligible for free care.

II. **Reduced Cost Care -** Those between 200% and 300% of the income eligibility limits established by the Maryland Department of Health are eligible for discounts on a sliding scale, as set forth in Attachment A.

III. **Financial Hardship -** Those who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom their medical debt incurred at all UMMS member organizations exceeds 25% of the Family Annual Household Income, are eligible for financial hardship assistance.

Payment plans are also available to all patients. Plan terms may be modified at the request of the patient. Additional information on payment plans is available in the UMMS Payment Plan Policy. UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

PROCEDURE:

I. How To Apply for Financial Assistance

For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent. Patients may voluntarily apply for financial assistance before or after receiving healthcare services, or they may be identified as potential candidates for financial assistance during the financial clearance process or a presumptive financial assistance eligibility screening.

Financial clearance is a process that determines a patient's ability and likelihood to pay. When possible effort will be made to provide financial clearance prior to date of service. During the financial clearance process, patients who indicate they are unemployed and have no insurance coverage will be required to submit a financial assistance application before receiving non-emergency medical care (unless they meet presumptive financial assistance eligibility criteria).

There will be one application process for all UMMS member organizations. UMMS will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications (and application requirements) in determining eligibility for the UMMS Financial Assistance program. Patients are required to provide a completed financial assistance application (with all required information and documentation), unless they meet the criteria for presumptive eligibility. To facilitate this process, each applicant must provide information about

family size and income. Oral submission of needed information will be accepted, where appropriate. UMMS will provide the financial assistance application to all patients regardless of health insurance status to all patients, including uninsured patients, and the application will be readily available on the UMMS website and by request.

Supporting Documentation for Financial Assistance Applications

To help applicants complete the process, required and suggested documentation will be clearly listed on the financial assistance application, including:

- A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable).
- If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
- A copy of their most recent pay stubs (if employed) or other evidence of income.
- A Medical Assistance Notice of Determination (if applicable).
- Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.
- If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility.

Financial assistance may not be denied based on the omission of information or documentation that is not specifically required in this policy or on the financial assistance application, and UMMS reserves the right to offer financial assistance to patients that have not provided all supporting documentation.

- If a patient submits a financial assistance application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient.
- This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about financial assistance and assistance with the application process.
- The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no the information is not received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation.
- The patient may re-apply for financial assistance and initiate a new case by submitting the missing information or documentation

II. Reviewing and Determining Eligibility of Financial Assistance Applications

There are designated team members who will be responsible for taking financial assistance applications. These team members can be financial counselors, patient financial receivable coordinators, customer service representatives, or third party agencies working as an extension of the central business office. To help applicants complete the process, UMMS will provide the financial assistance application that will let them know what paperwork is required for a final determination of eligibility. Where possible, designated team

members will consult via phone or meet with patients who request financial assistance to determine if they meet preliminary criteria for assistance.

Preliminary data will be entered into a third party data exchange system which will allow the designated team member to track the application and determine eligibility for financial assistance. Designated team members will:

- Determine whether the patient has health insurance. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for financial assistance.
- If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the designated team member and recommendations shall be made to Senior Leadership.
- Complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage. To facilitate this process each applicant must provide information about family size and income.
- Determine whether the patient is presumptively eligible for free or reduced-cost care.
- Determine whether uninsured patients are eligible for public or private health insurance. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

To the extent practicable, the designated team members will offer assistance to uninsured patients if the patient chooses to apply for public or private health insurance, determine whether the patient is eligible for other public programs that may assist with health care costs, and use information available to UMMS to determine whether the patient is qualified for free or reduced-cost care under the UMMS Financial Assistance policy.

Within two business days of receipt of a patient's request for financial assistance or an application for medical assistance, UMMS must make a determination of probable eligibility. The determination of probable eligibility is subject to change, based on the receipt of supporting documentation.

If the patient's financial assistance application is determined to be complete and appropriate, the designated team member will recommend the patient's level of eligibility and forward for a second and final approval. UMMS will provide final determination the patient's eligibility within 14 days after the patient submits a completed application for financial assistance and suspend any billing or collections actions while eligibility is being determined.

If a Financial Assistance Application is Approved

Once a patient is approved for financial assistance, financial assistance coverage is effective for the month of determination and a year prior to the determination.

- A letter of final determination will be submitted to each patient who has formally requested financial assistance, which includes (if applicable): the assistance for which the individual is eligible and the basis for the determination.
- UMMS may decide to extend the financial assistance eligibility period further into the past or the future on a case-by-case basis.

- Financial assistance is generally applicable to all emergency and other medically necessary care provided by each UMMS member organization (See Exclusions for more information).
- If additional healthcare services are provided beyond the eligibility period, patients must reapply for financial assistance.
- If the patient is determined to be eligible for reduced-cost care, and has already received a statement for eligible healthcare services rendered during the financial assistance coverage period, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.
- If a patient made payments for healthcare services prior to receiving approval for financial assistance, they may be eligible for a refund. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. If the amount that the patient is determined able to pay is less than the amount of the patient payment, the resulting credit balance will be issued to the patient as a refund if the amount exceeds the patient's determined responsibility by $5.00 or more. This includes determinations of eligibility for financial assistance within 240 days after the initial bill was provided.

If there are changes to the patient's income, assets, expenses or family status, the patient is expected to notify the Financial Assistance Department at 410-821-4140. To facilitate this process, and ensure that patients have the opportunity to be re-evaluated for eligibility for financial assistance within 240 days of the initial statement, UMMS will notify patients that if their income has changed, they should contact the Financial Assistance Program Department on each statement.

If a Financial Assistance Application is Not Approved

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

- If the patient is determined to be ineligible for financial assistance, and they applied in order to obtain financial clearance for non-emergent or non-urgent hospital based services, the designated team member will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.
- A clinician may appeal this decision and request reconsideration by the Financial Clearance Executive Committee on a case-by case basis.
- For emergent or urgent services, financial assistance applications will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.
- Patients who are ineligible for financial assistance will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.
- The patient may appeal the decision, please see the Appeals section for more information.
- For any episode of care, the financial assistance application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.

III. Eligibility Criteria

UMMS will offer financial assistance when a review of a patient's individual financial circumstances has been conducted and documented. UMMS will not use a patient's citizenship or immigration status as an eligibility

requirement for financial assistance; or withhold financial assistance or deny a patient's application for financial assistance on the basis of race, color, religion, ancestry or national origin, sex, age, marital status, sexual orientation, gender identity, genetic information, or on the basis of disability.

The following criteria will be applied in assessing a patient's eligibility for financial assistance, presumptive eligibility for financial assistance, and eligibility for financial hardship assistance.

Financial Assistance Eligibility

UMMS will refer to the MDH household income thresholds to determine eligibility for financial assistance and the level of free or reduced cost care to award to eligible patients. UMMS will calculate a patient's family (household) income at time of service. To account for any changes in financial circumstance, UMMS will recalculate family (household) income within 240 days after the initial hospital bill is provided.

UMMS may consider household monetary assets in determining eligibility for free and reduced-cost care under the financial assistance policy in addition to income-based criteria. Monetary assets shall be adjusted annually for inflation in accordance with the Consumer Price Index. The following monetary assets that are convertible to cash shall be excluded:

- At a minimum, the first $10,000 of monetary assets.
- A safe harbor equity of $150,000 in a primary residence.
- Retirement assets that the Internal Revenue Service has granted preferential tax treatment as a retirement account, including deferred-compensation plans qualified under the Internal Revenue Code or nonqualified deferred-compensation plans.
- One motor vehicle used for the transportation needs of the patient or any family member of the patient;
- Any resources excluded in determining financial eligibility under the Medical Assistance Program under the Social Security Act.
- Prepaid higher education funds in a Maryland 529 Program account.

In determining the family income of a patient, UMMS shall apply a definition of household size that consists of the patient and, at a minimum, a spouse (regardless of whether the patient and spouse expect to file a joint federal or State tax return), biological children, adopted children, or stepchildren, and anyone for whom the patient claims a personal exemption in a federal or State tax return. For a patient who is a child, the household size shall consist of the child and biological parents, adopted parents, or stepparents or guardians, biological siblings, adopted siblings, or stepsiblings, and anyone for whom the patient's parents or guardians claim a personal exemption in a federal or State tax return.

Patients may be deemed ineligible for financial assistance:

- If they have insurance coverage (e.g., HMO, PPO, or Workers Compensation, Medicaid, or other insurance programs), that denies access to UMMS due to insurance plan restrictions/limits.
- If they refuse to be screened for other assistance programs prior to submitting an application for financial assistance.
- If they refuse to divulge information pertaining to a pending legal liability claim.

Financial assistance generally applies to all emergency and other medically necessary care provided by each UMMS member organization; however, the following exclusions may apply:

- Services provided by healthcare providers not affiliated with UMMS member organizations (e.g., durable medical equipment, home health services).
- Services denied by a patient's insurance program or policy (e.g., HMO, PPO, or Workers Compensation). Exceptions may be made on a case by case basis considering medical and programmatic implications.
- Cosmetic or other non-medically necessary services.
- Patient convenience items, meals, and lodging.
- Supervised Living accommodations and meals while a patient is in the Day Program.
- Third Party Liability claims (Auto Accident, Workers Compensation, Bodily Injury, or other legal claim) until all means of payment are exhausted.

Financial assistance for professional charges awarded under this policy applies to the UM Physician Network (UMPN). Patients who wish to pursue financial assistance for non-UM Physician Network charges must contact the physician or provider group directly. A list of providers delivering medically necessary care in each UMMS hospital can be obtained on the website of each UMMS entity. This list specifies which such as providers do not participate in the UMMS Financial Assistance Policy.

Presumptive Financial Assistance Eligibility

In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to determine presumptive financial assistance eligibility for all hospital accounts. To determine presumptive eligibility for financial assistance, UMMS may use outside agencies or information to estimate income which can be used to assess the patient's eligibility for financial assistance eligibility. Due to the inherent nature of presumptive circumstances, UMMS will award free care to patients deemed presumptively eligible for financial assistance. Presumptive eligibility for financial assistance shall only cover the patient's specific date of service. UM Physician Network provider groups will offer financial assistance on a physician balance based on a determination of eligibility on a hospital balance.

Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Patient currently has Medical Assistance coverage
f. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
g. Medical Assistance spend down amounts
h. Eligibility for other state or local assistance programs, such as:
    i) Supplemental Nutrition Assistance Program
    ii) State Energy Assistance Program
    iii) Special Supplemental Food Program for Women, Infants, and Children
    iv) Any other social service program as determined by MD DHMH and Health Services Cost Review Commission (HSCRC).

i. Patient is deceased with no known estate
j. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program
k. Non-US Citizens deemed non-compliant
l. Non-Eligible Medical Assistance services for Medical Assistance eligible patients
m. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)
n. Bankruptcy, by law, as mandated by the federal courts
o. Eligibility in certain UMMS clinical programs (including: St. Clare Outreach Program, UMMS Maternity Program, UMSJMC Hernia Program).

Uninsured patients seen in the Emergency Department under Emergency Petition will not be considered for presumptive financial assistance until the Maryland Medicaid Psych program has been billed.

Financial Hardship Assistance Eligibility

Financial hardship assistance is available for patients who otherwise do not qualify for financial assistance under the primary guidelines of this policy, but for whom medical debt for medically necessary treatment over a twelve (12) month period exceeds 25% of that family's annual income.

- The amount of uninsured medical costs incurred at all UMMS member organizations will be considered in determining a patient's eligibility (including any accounts having gone to bad debt, except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses.
- For the patients who are eligible for reduced-cost care under the financial assistance criteria and also meet the criteria for financial hardship assistance criteria, UMMS will grant the total eligible reduction in charges.
- To calculate household income, UMMS will use the same criteria outlined in the Financial Assistance Eligibility section of this policy to calculate assets, household income, and family size.
- Once a patient is approved for financial hardship assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. UMMS may decide to extend the financial hardship eligibility period further into the past or the future on a case-by-case basis.
- Financial hardship assistance will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care and will remain eligible for reduced-cost medically necessary care when seeking subsequent care at the same member organization during the 12–month period beginning on the date on which the reduced-cost medically necessary care was initially received. To avoid an unnecessary duplication of UMMS' determination of eligibility for free and reduced-cost care, the patient or eligible family members shall inform UMMS of the patient's or family member's eligibility for the reduced-cost medically necessary care.

All other eligibility, ineligibility, and procedures for primary financial assistance criteria apply to financial hardship assistance criteria, unless otherwise stated above.

IV. Appealing a Determination of Eligibility for Financial Assistance

Patients whose financial assistance applications are denied have the option to appeal the decision. Appeals can be initiated verbally or written. Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.

If a patient wishes to make an appeal, UMMS will:

- Notify the patient that the Health Education and Advocacy Unit is available to assist them or their authorized representative in filing and mediating a reconsideration request.
- Provide the address, phone number, facsimile number, e-mail address, mailing address, and website of the Health Education and Advocacy Unit: Office of the Attorney General, Health Education and Advocacy Unit | 200 St. Paul Place, 16th Floor, Baltimore, MD 21202 | Phone: (410) 528-1840 | Toll-free in Maryland 1-877-261-8807 | Fax: (410) 576-6571 | Email: heau@oag.state.md.us
- Document appeals within the third party data and workflow tool for review by the next level of management above the representative who denied the original application.
- Submit a letter of final determination to each patient who has formally submitted an appeal.

Provider Driven Financial Clearance and Reconsideration

Where there is a compelling educational, medical, and/or humanitarian benefit, UMMS clinical team members may request financial clearance of patients that are not otherwise able or likely to pay for their healthcare services. Clinical team members must submit appropriate justification in advance of the patient receiving services. UMMS Revenue Cycle central billing office will evaluate the patient's eligibility for Medical Assistance and financial assistance. A Financial Clearance Executive Committee at the member organization level, comprised of clinical and financial leadership, will request the information submitted by the requesting clinical and the central billing office and make the final determination on whether to grant financial clearance on a case-by-case basis.

If financially cleared, patients are still responsible to complete the financial assistance application process, and may be subject to presumptive eligibility screening, as outlined in this policy.

V. Notice of Availability of Financial Assistance

UMMS will advise patients, patient's families, and authorized representatives of the availability of financial assistance using posted notices and the Patient Billing and Financial Assistance Information Sheet. The Patient Billing and Financial Assistance Information Sheet notifies the patient of the availability of financial assistance and payment plans, includes a description of UMMS Financial Assistance Policy, explains how to apply for financial assistance, and includes a description of the patient's rights and obligations with regard to hospital billing and collection under the law.

- UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any), admissions areas, key patient access areas, and the hospital billing office. Notice of availability will also be sent to the patient with patient statements.
- The Patient Billing and Financial Assistance Information Sheet will be provided at preadmission and before discharge for each hospital encounter, with each hospital statement, and it will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.

- The Financial Assistance Policy and the Financial Assistance Application will also be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas.
- The Financial Assistance Policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Patient Billing and Financial Assistance Information Sheet Content

In addition to the content referenced above, the Patient Billing and Financial Assistance Information Sheet will include:

- The website and physical location(s) where patients can obtain copies of the financial assistance policy and financial assistance application form
- Instructions on how to obtain a free copy of the financial assistance policy and financial assistance application form by mail.
- A statement of the availability of translations of the financial assistance documents.
- Contact information for UMMS Hospital Billing Customer Service Department, which is available to assist the patient, the patient's family, or the patient's authorized representative understand their statement, understand the patient's rights and obligations regarding the statement, learn how to apply for free or reduced cost care, or learn how to apply for Maryland Medical Assistance, or any other programs that may help pay their medical bills.
- Contact information for the Maryland Medical Assistance Program.
- A notification that physician charges are not included in the hospital statement and are billed separately.
- A notification informing patients of the right to request and receive a written estimate of the total charges for hospital nonemergency services, procedures, and supplies that reasonably are expected to be provided for professional services by the hospital.
- A notification that a patients who are eligible for free or reduced care may not be charged more than AGB for emergency or other medically necessary care.
- A section that informs the patient of their ability to make a formal complaint with the HSCRC and the Office of the Attorney General of Maryland.
- A section for the patient to initial to indicate that they have been made aware of UMMS Financial Assistance Policy

The Patient Billing and Financial Assistance Information Sheet will be written in plain language, as specified by the Requirements for 501(c)(3) Hospitals Under the Affordable Care Act – Section 501(r), and will be made available in the patient's preferred language. It will also include a section that allows for patients to initial that they have been made aware of the financial assistance policy.

VI. Extraordinary Collection Actions

Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to UMMS's attorney for legal and/or collection activity. Third party agencies and/or attorneys are jointly and severally responsible for meeting the debt collection requirements listed in this policy, and in the UMMS Credits and Collections Policy. Collection activities taken on behalf of

UMMS by a collection agency or UMMS' attorney may include the following Extraordinary Collection Actions (ECAs):

- Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus. UMMS will not report adverse information to a consumer reporting agency regarding a patient who was uninsured or eligible for free or reduced-cost care at the time of service. UMMS will not report to a consumer reporting agency until at least 180 days after the initial statement was provided. Prior to reporting to a consumer reporting agency, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not report adverse information about a patient to a consumer reporting agency if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days, or if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Commencing a civil action against the individual. UMMS will not hold a spouse or another individual liable for the debt owed on a hospital bill of an individual who is at least 18 years old. UMMS will not file a civil action to collect debt until at least 180 days of after the initial bill was provided. Prior to filing the civil action, UMMS will determines whether the patient is eligible for free or reduced-cost care. UMMS will not file a civil action to collect debt if UMMS was notified in accordance with federal law by the patient or an insurance carrier that an appeal or a review of a health insurance decision is pending within the immediately preceding 60 days. UMMS will not file a civil action to collect debt if UMMS has completed a requested reconsideration of the denial of free or reduced-cost care that was appropriately completed by the patient within the immediately preceding 60 days.
- Attaching or seizing an individual's bank account or any other personal property.
- Garnishing an individual's wage. UMMS will not request a garnishment of wages or file an action that would result in an attachment of wages against a patient if the patient is eligible for free or reduced-cost care.

ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 180 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 45 days prior to commencement of the ECA. This written notice will be accompanied by an application for financial assistance (and instructions for completing the application) and a notice of availability of a payment plan to satisfy the medical debt, and the Patient Billing and Financial Assistance Information Sheet. The written notice will include the following information:

- Specified contact and procedural information.
    - The name and telephone number for UMMS,
    - The name and telephone number for the debt collector (if applicable)
    - The contact information for the UMMS Financial Assistance Department (or third party agency acting on behalf of UMMS), authorized to modify the terms of a payment plan (if applicable)
    - Telephone number and internet address of the Health Education Advocacy Unit in the Office of the Attorney General, available to assist patients experiencing medical debt.
- The amount required to satisfy the debt (including any past due payments, penalties, or fees, if applicable)

- Identification of ECAs that UMMS (or its collection agency, attorney, or other authorized party) intends to utilize in order to obtain payment for the care, and state a deadline after which such ECAs may be initiated.
- A deadline after which such ECA(s) may be initiated that is no earlier than 45 days after the date that the written notice is provided.
- A statement recommending that the patient seek debt counseling services,
- An explanation of the UMMS Financial Assistance Policy, and a notification of availability of financial assistance for eligible individuals
- And any other information as prescribed by the HSCRC

Written notice and accompanying documentation will be sent to the patient by certified mail and first class mail, in the patient's preferred language, or another language, as specified. The written notice will be in simplified language of at least 10 point type.

In addition to the written notification, UMMS (and/or its collection agency or attorney) will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the UMMS Revenue Cycle Services leadership.

If a patient is determined to be eligible for financial assistance, UMMS (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau. All ECAs will cease once the patient is approved for financial assistance and all the patient responsible balances are paid.

UMMS will not engage in the following ECAs:

- Selling debt to another party.
- Charge interest on bills incurred by patients before a court judgement is obtained
- Requesting a lien against a patient's primary residence. In some cases, Local, State, or Federal judicial protocols may mandate that a lien is placed, but UMMS will not force the sale or foreclosure of a patient's primary residence.
- Request the issuance of or take action causing a court to issue a body attachment or an arrest warrant against a patient.
- Make a claim against the estate of a deceased patient if the deceased patient was known by UMMS to be eligible for free care or if the value of the estate after tax obligations are fulfilled is less than half of the debt owned. However, UMMS may offer the family of the deceased patient the ability to apply for financial assistance.
- Require payment of medical debt prior to providing medically necessary care.

ATTACHMENTS:

ATTACHMENT A: Sliding Scale – Reduced Cost of Care

2022 Federal Poverty Limits (FPL) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$13,590	$18,310	$23,030	$27,750	$32,470	$37,190	

2022 Maryland Dept of Health (MDH) Annual Income Eligibility Limit Guidelines							
House-hold (HH) Size	1	2	3	4	5	6	See UMMS Charity Thresholds below
Income Limit (up to Max)	$18,768	$25,272	$31,800	$38,304	$44,808	$51,336	

UMMS Financial Assistance Charity Income Thresholds							
If your total annual household (HH) income level is at or below:							You are eligible for the following level of charity at UMMS:
House-hold (HH) Size	1	2	3	4	5	6	
Income Limit (up to Max)	$37,536	$50,544	$63,600	$76,608	$89,616	$102,672	**100% Charity** (Equals Up to 200% of MDH Annual Income limits)
Income Limit (up to Max)	$39,413	$53,071	$66,780	$80,438	$94,097	$107,806	**90% Charity** (Equals Up to 210% of MDH Annual Income limits)
Income Limit (up to Max)	$41,290	$55,598	$69,960	$84,269	$98,578	$112,939	80% Charity (Equals Up to 220% of MDH Annual Income limits)
Income Limit (up to Max)	$43,166	$58,126	$73,140	$88,099	$103,058	$118,073	**70% Charity** (Equals Up to 230% of MDH Annual Income limits)
Income Limit (up to Max)	$45,043	$60,653	$76,320	$91,930	$107,539	$123,206	60% Charity (Equals Up to 240% of MDH Annual Income limits)
Income Limit (up to Max)	$46,920	$63,180	$79,500	$95,760	$112,020	$128,340	**50% Charity** (Equals Up to 250% of MDH Annual Income limits)
Income Limit (up to Max)	$48,797	$65,707	$82,680	$99,590	$116,501	$133,474	40% Charity (Equals Up to 260% of MDH Annual Income limits)
Income Limit (up to Max)	$50,674	$68,234	$85,860	$103,421	$120,982	$138,607	**30% Charity** (Equals Up to 270% of MDH Annual Income limits)
Income Limit (up to Max)	$52,550	$70,762	$89,040	$107,251	$125,462	$143,741	**20% Charity** (Equals Up to 280% of MDH Annual Income limits)
Income Limit (up to Max)	$56,303	$75,815	$95,399	$114,911	$134,423	$154,007	**10% Charity** (Equals Up to 290% of MDH Annual Income limits)

*All discounts stated above shall be applied to the amount the patient is personally responsible for paying after insurance reimbursements.
*Amounts billed to patients who qualify for Reduced-Cost of Care on a sliding scale (or for Financial Hardship Assistance) will be less than the amounts generally billed to those with insurance (AGB), which in Maryland is the charge established by the Health Services Cost Review Commission (HSCRC). UMMS determines AGB by using the amount Medicare would allow for the care (including the amount the beneficiary would be personally responsible for paying, which is the HSCRC amount; this is known as the "prospective Medicare method".

Effective 7/1/22

RELATED POLICIES:
UMMS Credit & Collections Policy
UMMS Payment Plan Policy

POLICY OWNER:
UMMS Revenue Cycle Services

APPROVED:
Executive Compliance Committee Approved Initial Policy: 09/18/19
Executive Compliance Committee Approved Revisions: 10/19/2020, 11/07/22

This policy was approved by the UMMS Executive Compliance Committee (ECC) Board on October 19, 2020.
This policy was adopted for:

- UM St. Joseph Medical Center (UMSJMC) effective June 1, 2013.
- UM Midtown Campus (MTC) effective September 22, 2014.
- UM Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.
- UM Shore Regional Health (UMSRH) effective September 1, 2017.
- UM Charles Regional Medical Center (UMCRMC) effective December 2, 2018.
- UM Upper Chesapeake Health (UCHS) effective July 1, 2019
- UM Capital Region Health (UMCRH) effective September 18, 2019

EXHIBIT 5

The University of Maryland Medical Center provides healthcare services to those in need regardless of an individuals ability to pay. Care may be provided without charge, or at a reduced charge, to those who do not have insurance, Medicare/Medical Assistance coverage, and are without the means to pay. An individual's eligibility to receive care without charge, at a reduced charge, or to pay for their care over time is determined on a case by case basis. Interested parties seeking to determine a patient's eligibility should direct their inquiries to the Financial Counseling Office at (410) 821-4140.

UNIVERSITY OF MARYLAND
MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICINE

El Centro de la Universidad de Maryland da servicios de salud a personas con necesidad aunque no tengan la abilidad de pagar. Servicios pueden ser obtenidas sin ser cobradas, o a un precio reducido a esas personas sin seguro medico, sin Medicare/Medical Assistance o personas sin la abilidad de poder pagar. Las personas elegibles de poder tener servicios gratis, servicios a un predio reducido o servicios con la abilidad de poder pagar con un tiempo extendido será determinado individualmente. Personas interesadas de determinar la elegibilidad de un paciente deberia dirigir sus preguntas a la oficina de Aconsejamientos Financieros al (410) 821-4140.

UNIVERSITY OF MARYLAND
MEDICAL CENTER
UNIVERSITY OF MARYLAND MEDICINE

EXHIBIT 6

UNIVERSITY of MARYLAND MEDICAL CENTER

COMMUNITY HEALTH NEEDS ASSESSMENT

IMPLEMENTATION PLAN

FY2022-FY2024

APPROVED BY THE COMMUNITY ENGAGEMENT COMMITTEE, BOARD OF DIRECTORS • JUNE 7, 2021

IV. Selecting Priorities

Analysis of all quantitative and qualitative data described in the above section identified these top five areas of need within Baltimore City. These top priorities represent the intersection of documented unmet community health needs and the organization's key strengths and mission. These priorities were identified by the Community Health and Engagement Team and validated with the health experts from the UMB Campus Panel:

Adult Health Priorities

1. Substance Use Disorder
2. Mental Health
3. Chronic Disease Management (CVD, Diabetes, HIV)

Social Determinants of Health Priorities

1. Employment and Career Opportunities
2. Neighborhood Safety and Violence Prevention
3. Affordable Housing and /Homelessnes

In addition to identifying adult health needs and priorities, UMMC identify the unmet needs for the children within our community benefits service area. These priorities were also identified by the UMMC Community Health and Engagement Team and the Experts from the UM Children's Hospital:

Children Health Priorities

1. Mental Health (ACEs)
2. Obesity/Nutrition
3. Asthma
4. Maternal and Child Health

V. Documenting and Communicating Results

The UMMC 2022–2024 Community Health Needs Assessment process fully embraced community listening, involvement and collaboration with a broad group of community leaders, the academic community, the general public, and health experts. This report will be posted on the UMMC website under the Community Health and Engagement webpage at https://www.umms.org/ummc/community-health.

Highlights of this report will also be documented in the Community Benefits Annual Report for FY2021. Reports and data will also be shared with our community partners and community leaders as we work together to make a positive difference in our community by empowering and building healthy communities.

VI. Planning for Action and Monitoring Progress

A) PRIORITIES AND IMPLEMENTATION PLANNING

UMMC has aligned its identified community health priorities with the National and State Health Priorities. The following matrix shows the alignment of the identified priorities with each of the National and State priorities. UMMC will also track the progress with long-term outcome objectives measured through the National Prevention Strategy Priority Areas. Short-term programmatic objectives, including reach and outcome measures will be measured annually by UMMC for each priority area through the related programming. Adjustments will be made to annual plans as other issues emerge or through our annual program evaluation.

In addition to the identified strategic priorities from the CHNA, UMMC employs the following prioritization framework to address an urgent or emergent need in the community, (i.e., disaster response or infectious disease issue). The CHNA prioritized needs for the Sustained and Strategic Response Categories and the Rapid and Urgent Response Categories' needs will be determined on an as-needed basis.

UMMC will provide leadership and support in partnership with the communities we serve at a variety of response levels. Rapid and Urgent response levels will receive priority over sustained and strategic initiatives as warranted.

- **Rapid Response** - Emergency response to local, national, and international disasters, i.e., civil unrest and weather disasters (earthquake, blizzard, and terrorist attack)
- **Urgent Response** - Urgent response to episodic community needs, i.e., COVID-19 and Flu response
- **Sustained Response** - Ongoing response to long-term community needs, i.e., obesity, tobacco prevention education, health screenings, and workforce development
- **Strategic Response** - Long-term strategic leadership at legislative and corporate levels to leverage relationships to promote health-related policy or reform and build key networks

Future Community Health Needs Assessments will be conducted every three years and strategic priorities will be re-evaluated then. Programmatic evaluations will occur annually, and adjustments to programs will be as needed. All community benefits reporting will occur annually to meet state and federal reporting requirements.

B) UNMET COMMUNITY NEEDS

Several additional topic areas were identified by the Community Health and Engagement Team during the CHNA process including: Cancer, Homelessness and Transportation. While the UMMC will focus the majority of its efforts on the identified strategic priorities, we will review the complete set of needs identified in the CHNA for future collaboration and work. These areas, while still important to the health of the community, will be met through either existing clinical services and through collaboration with other health care organizations as needed. The unmet needs not addressed by this CHNA will also continue to be addressed by key Baltimore City governmental agencies and existing community-based organizations.

The UMMC identified core priorities target the intersection of the identified community needs and the organization's key strengths and mission. The following table summarizes the programs either currently in use or to be developed to address the identified health priorities.

VII. Implementation Plans FY2022-2024

UMMC Strategic Programs FY2022–2024

SHCRC Strategic Integrated Health Improvement Domain Goals	National Prevention Strategy: Priority Areas	UMMC Priorities	UMMC Strategic Community Programs
Maternal/Child Health	Reproductive and Sexual Health	Maternal and Child Health Asthma Obesity/Nutrition	B'More Health Babies Breathmobile Kids to Farmer's Market, Safe Kids (Helmets, Fire Safety, Car Seats)
Opioid Use Disorder	Mental and Emotional Well-Being Injury and Violence Free Living Preventing Drug Abuse and Excessive Alcohol Use Tobacco Free Living	Mental Health Trauma/Violence Prevention Substance Use Disorder	Mental Health Conference, MH Screenings, MHFA Violence Prevention Program, Bridge Program, PHAT, My Future, My Career Drug Facts campaign, Provider education on prescribing practices, SBIRT, Naloxone, TND
Chronic Conditions: Coordinated Care Diabetes	Healthy Eating	Cardiovascular Disease Obesity Diabetes COVID-19 Vaccine	Farmer's Market, Maryland Healthy Men Program, Mobile Market, BMI screenings, BP Screenings, DPP Program, A1C screenings, Nutrition education, Living Well workshops (HTN, Chronic Disease, Diabetes, and HIV)
	Active Living	Employment/ Career Advancement	UM Career Academy Project Search, BACH Fellows, Youthworks, NAHSE, Healthcare Career Alliance, Urban Alliance

FY2022-FY2024 Community Health Improvement Implementation Plan – Mental Health

PRIORITY AREA: Mental Health – FY2022-FY2024

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the suicide rate and reduce the emergency department visits related to mental health (Healthy People 2030: "for intentional self-harm injuries")
2. Increase the proportion of persons with co-occurring substance use disorders and mental health disorders who receive treatment for both disorders
3. Increase the proportion of adults with serious mental illness (SMI) who receive treatment

Annual Objective	Strategy	Target Population	Actions Description
Reduce the suicide rate Reduce the ED visit rate r/t mental health Increase awareness in the community of mental health Increase the number of individuals referred to appropriate mental health resources	Provide education and information and training to primary and specialty UMMC clinics about Trauma-informed care Integrating Trauma Informed Principals to Target Clinics within UMMC/S Educating community members on how to access the Mental Health System for resources and care. (SAMHSA Grant for funding if possible) Collaborating with City Police and Greater Baltimore Region Integrated Crisis System to create policies and better practices around trauma informed responses	Health care providers and staff West Baltimore Community West Baltimore Community	Using SAMHSAs principles and guidance for trauma-informed approaches, provide training to clinics and provide implementation consultation as needed Provide education and information about mental health with information on resources Provide free mental health screenings using the PHQ2 (then PHQ9 if +) tool in the community. Provide education and information about mental health with information on resources.

FY2022-2024 Community Health Improvement Implementation Plan – Substance Abuse

PRIORITY AREA: Substance Abuse

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Increase the proportion of persons who need alcohol and/or illicit drug treatment who received specialty treatment for a substance use problem in the past year
2. Reduce the proportion of persons with alcohol use disorder in the past year

Annual Objective	Strategy	Target Population	Actions Description
Reduce the Drug-induced death rate Increase early intervention, treatment, and management of substance use disorders	Provide education and information to community members on identifying substance abuse issues in the community Provide education to licensed providers on scope of opioid crisis and appropriate prescribing practices Provide education to school aged students about drug use and healthier coping mechanisms	Faith Leaders, Health Ministry Leaders, Community members in West Baltimore, Partner Schools, Parent groups Licensed, prescribing health care providers High school students (14-19 yrs.)	Develop and utilize Drug Facts campaign to educate and inform West Baltimore City residents about identification of substance abuse behavior and community resources Provide free provider education on scope of opioid crisis and relevant prescribing practices utilizing Centers for Disease Control and/or American Hospital Association best practices standards Work with commercial insurers to reduce Co-pay for Narcan Link SBIRT program to increase referrals Provide an evidence-based, interactive classroom-style, substance use prevention program that focuses on three factors that predict tobacco, alcohol, and other drug use, violence-related behaviors, and other problem behaviors among youth (14-19 yrs.)

FY2022-2024 Community Health Improvement Implementation Plan - Maternal and Child Health

PRIORITY AREA: Maternal and Child Health

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the percentage of births that are low birth weight (LBW)
2. Increase the proportion of pregnant women starting prenatal care in the 1st trimester
3. Ease the transition for families and babies to coordinated pediatric care and increase referrals to the BITP for all newborns with NAS
4. Improve outcomes for pregnancies with substance abuse complications
5. Reduce the child motor vehicle crash related deaths buy increasing Baltimore City family access to affordable car seats

Annual Objective	Strategy	Target Population	Actions Description
Increase the number of families that participate in the Safe Kids low cost program to put more children in appropriate and safe car seats	Increase awareness and participation in program through partnerships with and referrals from Midtown Peds, WIC, Healthy Start, Head Start, and BCHD programs	Baltimore City families with infants and children through 8 yrs. of age	Safe Kids Baltimore strives to reduce unintentional MVC injuries and deaths through monthly car seat check-up events (pre-COVID), education, and providing the availability of low cost ($40) car seats to families in need
Increase parent knowledge and awareness of fire safety, pedestrian safety, child passenger safety and safe sleep for infants, and wheel/helmet safety	Provide prevention education and information on the before mentioned unintentional childhood injury areas via Safe Kids Baltimore programs and events	Parents and children in Baltimore City	Safe Kids Baltimore strives to reduce unintentional childhood injuries and deaths in Baltimore City through free education and training on fire safety, pedestrian safety, child passenger safety, safe infant sleep, and wheel/bike safety
Increase the proportion of pregnant women starting prenatal care in the 1st trimester Increase the proportion and ease the transition for families and babies to coordinated pediatric care	Liaison for continuity of OB and Pediatric care for families and newborn babies Ensure each new mom is set up with a Pediatrician consult Moms-in-Training to after the child is born with incentives to attend pediatric appointments and having classes for parents on important pediatric topics, i.e., development, newborn care, feeding, immunizations, handling sick children	Women in West Baltimore Communities delivering at UMMC	Partner with Maryland-Moms-in-Training to engage community and offer free resources and education on breastfeeding

Improve outcomes for pregnancies with substance abuse complications	Address substance abuse during and after pregnancy	Women in West Baltimore Communities	Partner with UMMC in their various outreach efforts to provide free education and resources around substance abuse during pregnancy Conduct feasibility analysis of providing a follow-up program for infants experiencing NAS and their mothers. If feasible, implement program and distribute program information to community partners.
Reduce the percentage of births that are low birth weight (LBW)	Enroll pregnant women in the B'More Healthy Babies Program	Women in West Baltimore Communities	Continue support of the B'More Healthy Babies Initiatives

FY2022-2024 Community Health Improvement Implementation Plan – Chronic Disease Prevention

PRIORITY AREA: Chronic Disease – Cardiovascular Disease/Obesity

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce household food insecurity and in doing so reduce hunger
2. Reduce the proportion of adolescents (ages 12-19) with obesity
3. Age adjusted mortality rate from heart disease
4. Reduce emergency department visit rate due to hypertension
5. Increase the proportion of adults age 19 years or older who get recommended vaccines
6. Increase the proportion of people with vaccine records in an information system

Annual Objective	Strategy	Target Population	Actions Description
Increase the proportion of adults who are at a healthy weight Reduce the proportion of youth who are obese Reduce emergency department visit rate due to hypertension	Provide education and information on the importance of heart healthy lifestyle through engaging, evidence-based programs: Know Your Numbers, Hypertension Screening and Outreach Program, Living Well with Hypertension, Living Well with Chronic Disease, Maryland Healthy Men, BP Hubs	Adults and youth in Priority Targeted zip codes	Engage targeted communities on healthy lifestyles through the sponsorship or provision of: - Community-wide education - Store Tours - Cooking Classes/Demos/ Tastings - Community Screenings and Referrals (Blood pressure, BMI/Weights, and Cholesterol) - Exercise Demonstrations Provide Living Well with Hypertension class monthly to community members

			Provide *Living Well w/ Chronic Disease* workshop twice/annually Develop resource guide (pdf) to be used on website and for community events Provide info on healthy weight resources at every major outreach event: - Fall Back to Good Health - B'More Healthy Expo - Lexington Market Monthly Health Fair - Mobile Market Deploy Blood Pressure Hubs in the community in barber/ beauty shops and churches Continue the Maryland Healthy Men hypertension program with 50 men/yr
Increase the variety of fruits and vegetables to the diets of the population aged 2 yrs. and older Increase healthy food access	Through engaging, evidence-based programs: 1) Improve access to variety of fruits and vegetables: Farmer's Market, UMMC Mobile Market 2) Promote awareness of healthy ways to prepare fruits and vegetables: Kids to Farmer's Market, Fruits and Vegetables Prescription Program (pilot), Mobile Market, New Food insecurity initiatives (TBD) COVID-19 Food distribution	Adults and children	Sponsor UMMC Farmer's Market: - Maintain WIC and SNAP voucher acceptance by vendors - Pilot prescription program promoting consumption of fruits and vegetables purchased at Farmer's Market - Explore additional Farmer's market and food access options for West Baltimore - Provide educational opportunity for local school children to attend Farmer's Market as a field trip - Provide support for local legislation supporting healthy food options and access to fresh fruits and vegetables Mobile Market: - Provide access to healthy produce in West Baltimore food deserts by using Mobile Van and Hungry Harvest in West Baltimore sites weekly - Provide educational materials to encourage use and purchasing of fresh produce COVID -19 Food Distribution: - Provide meals to family in need by emergency response

Provide expanded COVID-19 immunization access for the pubic in recognized community locations as a key strategy to reduce COVID-19 related illnesses, hospitalizations, and deaths through the reduction of transmission of COVID-19 Decrease vaccination disparity among minority populations by providing access in West Baltimore neighborhoods, by partnering with trusted community organizations Create equitable access for COVID-19 immunization in underserved locations throughout West Baltimore and for identified target populations	Provide COVID-19 vaccine, education, and information to reduce COVID-19 related illnesses, hospitalizations, and deaths through the reduction of transmission of COVID-19 in vulnerable populations across Baltimore City. UMMC Mobile Vaccine Equity Clinic	Seniors, Adults and age appropriate children	Vaccine Clinic: - Create a simplified registration process for seniors and individuals with limited access/knowledge to internet access - Provide accessible vaccine clinics in high-populated neighborhoods.

FY2022-2024 Community Health Improvement Implementation Plan – HIV/HCV Prevention

PRIORITY AREA: Chronic Disease – HIV/HCV Prevention

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the incidence of HIV infection

Goals of the National HIV and AIDS Strategy (NHAS) and National Viral Hepatitis Strategic Plan:

1. Reduce new HIV/HCV infections. HP2030: 3,835 persons
2. Increase access to care and improving health outcomes for people living with HIV and HCV
3. Reducing HIV-related health disparities
4. Achieve a coordinated response to the HIV epidemic

Annual Objective	Strategy	Target Population	Actions Description
To reduce new HIV infections by increasing awareness of individuals' HIV status and their risk factors	Provision of free, POC rapid HIV testing at community sites Coordination between UMMC and UMB (JACQUES Initiative) to conduct community outreach activities in collaboration with IHV and the UMB Office of Community Engagement to provide HIV and complementary services in areas within the university's strategic area, particularly within Southwest Partnership	High-risk individuals as defined by CDC, particularly African-American, LGBTQ-identified youth living in Baltimore, sex-workers, women, Latinx, and IV drug users	Offer free HIV/ HCV education and screenings at various community sites, programs and events, including use of the UMMC Community Health Mobile Van within various West Baltimore targeted zip codes Provide pre and post HIV-test counseling-education, including information and referral to PrEP
Increasing access to care	Linkage to Care for newly identified HIV-positive and PPOOC individuals	High-risk individuals as defined by CDC, particularly African-American, LGBTQ-identified youth living in Baltimore, sex-workers, women, Latinx, and IV drug users	Provide coordination of all aspects of linkage to care (e.g. assessment, identification of barriers and strengths, insurance, and medical provider) to ensure that HIV-positive clients encountered in the community have immediate access to care, particularly through C2C (Connect to Care) at THRIVE Clinic

HTTPS://WWW.CDC.GOV/HIV/PDF/DHAP/CDC-HIV-DHAP-EXTERNAL-STRATEGIC-PLAN.PDF

FY2022-2024 Community Health Improvement Implementation Plan – Diabetes Prevention

PRIORITY AREA: Diabetes

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Increase the proportion of adults who are at a healthy weight
2. Reduce diabetes-related emergency department visits
3. Reduce household food insecurity and in doing so reduce hunger
4. Increase the proportion of persons with diagnosed diabetes who ever receive formal diabetes education

Annual Objective	Strategy	Target Population	Actions Description
Increase diabetes awareness and healthy lifestyles to prevent and manage diabetes	Engage the church in a variety of year around activities to improve health of church members living with diabetes and their families	Adults and youth in six church communities within the targeted zip code	Offer six educational workshops, then a support group 1x/month for 9 months following the workshop series Each workshop is 1-1.5 hours Content areas: Diabetes Basics, Fitness, healthy eating, Heart health, Diabetes prevention for children
Increase the proportion of adults who are at a healthy weight Provide three cohorts of DPP/annually	CDC Diabetes Prevention Program (DPP)	Adults in Priority Targeted zip codes	Offer the CDC National Diabetes Prevention Program: for people at risk with diabetes 16-week program and a monthly post core follow-up
Increase the variety of fruits and vegetables to the diets of the population aged 2 yrs. and older Increase healthy food access	Improve access to variety of fruits and vegetables Promote awareness of healthy ways to prepare fruits and vegetables	Adults and children	BDS Healthy Aging Networks Monthly series on *Fruits and Veggies Matters* with basket of produce. Cooking demo. The goal of this series is to increase intake of produce of the participants Each seminar will identify fruit and vegetables of the season and feature a recipe will be provided. The participants will be challenged to try a new fruit and or vegetable and create a new recipe.
Decrease food insecurity in the diabetes population served at UMCDE	Therapeutic Food Pantry Access	Positive screening for food insecurity while living with diabetes	Providers and MAs will screen for food insecurity at office visit If positive for food insecurity, CHW will provide a bag of food The patient will be contacted monthly for a bag of groceries

FY2022-2024 Community Health Improvement Implementation Plan – Violence Prevention

PRIORITY AREA: Violence Prevention

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the domestic violence rate
2. Reduce homicides
3. Reduce firearm-related deaths
4. Maintain the low rate of recidivism for VIP participants due to violent injury. (VIP FY17 Performance = < 1.3% ➢ 2021 Target: < 1%)

Annual Objective	Strategy	Target Population	Actions Description
Reduce the rate of recidivism due to violent injury and domestic violence	Deliver service and intervention via evidence-based, hospital-integrated programs: Violence Intervention Program and Bridge Program	Patients admitted to UM Shock Trauma Center due to violence > 15 yrs. Participants include victims of assault, intimate partner violence, gunshot wounds, and domestic violence related incidents.	**VIP** provides intense, post-discharge, trauma-informed case management services to improve health outcomes, increase pro-social and protective supports, and decrease risk for recidivism for violent injury - Violence Prevention Specialists enroll patients of violent injury at the bedside in STC and in the EDs - Community Trauma Responder provides support and resources to secondary victims and communities exposed to trauma and violence - Participants are individual therapy and peer support - Participants receive services to help with employment, housing, mental health, substance abuse, physical health, and interpersonal skills Bridge Program provides crisis intervention, safety stabilization, and targeted case management to help participants achieve goals of independence, safety, and self-sufficiency - Advocates offer 24/7 response to anyone on campus affected by IPV

			- Interventions include safety planning, ongoing therapy, and case management - Participants benefit from Court accompaniment and legal advocacy - Participants receive services to help with employment, housing, mental health, substance abuse, safety planning, and interpersonal skills
Promote primary prevention activities for risky behaviors, unhealthy relationships, and the effects of trauma in youth and youth-serving populations	Deliver workshops, presentations, lectures, guest speaking, and group facilitation to youth and youth-impacting audiences impacted by risky behavior, violence, and trauma	Youth and youth-serving individuals on campus and in the adjacent communities	Curriculum: Youth Injury and Violence Prevention
Identify underlying causes of violence and effective interventions	Publish peer-reviewed research focused on violence prevention and intervention	Violence prevention, public health, and research community	Facilitate the operations of the Violence Intervention Research Group on campus, and support efforts to move research endeavors and projects forward

MARYLAND STATE HEALTH IMPROVEMENT PROCESS WEBSITE: HTTP://SHIP.MD.NETWORKOFCARE.ORG/PH/SHIP-DETAIL.ASPX?ID=MD_SHIP12

CALCULATED FROM 342 DEATHS IN 2017 (1F)

HTTPS://WWW.HEALTHYPEOPLE.GOV/2020/DATA/MAP/4768?YEAR=2015

FY2022-2024 Community Health Improvement Implementation Plan – Local Hiring/Career Advancement

PRIORITY AREA: Local Hiring/Career Advancement

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Lay the foundation for a healthier and more vibrant community, expanding economic opportunity for residents experiencing the greatest barriers to employment
2. Prepare West Baltimore residents for high-demand jobs through training and skills development, and then provide specific entry points for those candidates
3. Connect hires, and other frontline workers, to clear pathways for career advancement within UMMC
4. Improve employee retention and job performance of entry-level workers

Annual Objective	Strategy	Target Population	Actions Description
Career Advancement	UMMC managers and supervisors have indicated the need for training for incumbent employees who may be new to the workforce or recently re-entered society Microsoft Training is technology-focused skills enhancement to train employees and community members in Word, Excel, PowerPoint, Outlook and internet research to equip them with the computer skills required in today's workplace. Training will take place as part of the Southwest Partnership grant obtained in September 2020 and continue as an Academy initiative. As we engage with the community to improve community health and wellbeing, our goal is to help build an inclusive and sustainable West Baltimore. UMMC partners with community-based workforce organizations to	The goal is to retain employees (incumbent workers) hired (1st year) through UMMC community partners West Baltimore residents hired through our Workforce Training Partnership Programs Residents with the most significant barriers to employment including underserved community members, financially fragile community members, returning citizens, recipients of government assistance	Rising Star and Career Coaching focuses on enhancing entry-level employee engagement, improving job readiness skills, reducing turnover, and increasing productivity through training, mentoring, and coaching. New hires and incumbents are coached in career pathways, professionalism, employer expectations, and overall competencies. Employees are referred from their manager or HR Business Partner and will be case managed by Career Academy staff. Pathways to Success encompasses a comprehensive review of basic adult education (GED) and college prep (ACCUPLACER) classes. The goal is to prepare individuals for the workplace and higher education by removing promotional barriers. Employees who are hired through a community partner will be evaluated and referred to appropriate classes by the Career Academy staff.

	provide youth and adults with programs that lead to employment and career advancement. Workforce goals are to build a pipeline of qualified health care workers by leveraging strategic partnerships, removing barriers, and providing advancement opportunities through talent acquisition, career advancement, workforce development, and resource provision.		
Talent Acquisition	UMMC partners with over 30 community organizations that provide various resources to assist West Baltimore residents in obtaining employment. UMMC Human Resources and the Workforce Development offices conduct resource events, informational sessions, speed interviews, and feedback to community partners from referrals made to the hospital. The goal is to hire 250 West Baltimore employees through community partners. Satellite Center support will be provided for community partners to enhance workforce development in established centers within the eight target zip codes. Those centers include the UMMC Midtown Campus Outpatient Center (scheduled to open in 2021), the UMB Community Engagement Center and McCulloh Homes (expected to open in 2021).	- Unemployed and underemployed West Baltimore Community Members - Returning Citizens and Ex-Offenders - Displaced and dislocated adults and career-switchers - Baltimore City Public High School Students/Partnership High School Students - Opportunity Youth from targeted zip codes - Local College and University students - Parents from Partnership Schools - UMMC employees seeking career advancement and upskilling opportunities	Knowledge Empowers Youth Success (K.E.Y.S.) CNA to BSN with partner high schools Edmondson Westside H.S. and Vivien T. Thomas Medical Arts Academy, students will participate in a bridge program to foster the recruitment and development of CNA students who are pursuing careers in Nursing. The Academy will work with the identified schools to recruit UMMC employees, upskill incumbent workers and expose employees to career growth opportunities in Nursing. Careers in Healthcare Pathways Training (Multi-Skilled Medical Tech, PCT, Pharm Tech, Surgical Tech, Medical Assistant) will increase the number of new hires pipelined from workforce training partners who receive credential/skilled training by enrolling 50 community members in a career in health care occupational skills training. The Career Academy will partner with schools and organizations that offer the specified occupational skills.

FY2022-2024 Community Health Improvement Implementation Plan – Pediatrics Mental Health

PRIORITY AREA: Pediatrics Mental Health

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Increase the proportion of children with mental health problems who receive treatment
2. Increase the number of children who receive preventative mental health care in schools

Annual Objective	Strategy	Target Population	Actions Description
Increase the proportion of children with mental health problems who receive treatment Increase the number of children receiving preventative mental health care in schools Increase awareness in the community of mental health	Provide education and information to community members on identifying mental health problems Increase funding to school mental health programs in partner schools and Family Connections Program Provide education and to community members	West Baltimore Youth West Baltimore	Trauma Informed-Care/ Specific Interventions. Utilizing evidence-based programs to address specific needs identified in partner schools in West Baltimore and UMMC pediatric psychiatry clinics; Family Connections Program. Co-sponsor Mental Health Conference annually for the community at large
Partner with Baltimore City Hospitals on one mental health initiative annually	Partner with the Baltimore City Trauma Informed Care Task Force	Baltimore City	Partner with the City of Baltimore Trauma Informed Care Task Force and implement recommended strategies

FY2022-2024 Community Health Improvement Implementation Plan – Pediatrics Asthma

PRIORITY AREA: Pediatrics Asthma

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce emergency department visits for children over 5 years of age with asthma

Annual Objective	Strategy	Target Population	Actions Description
Pediatrics Asthma Needs Assessment and Community Engagement	Surveys, Zoom and in person individual and focus group meetings	Asthma Caregiver/ Providers/ Community/Leaders	Obtain feedback regarding current asthma services and identify unmet needs
Reduce Asthma Hospitalizations and ED visits	UMCH Pediatric Asthma Program Team Clinical Component	Patients seen in the PED and hospital for asthma BCPS children with asthma (targeted zip codes)	Identify children in need of services through Asthma RN, review of daily Epic reports, BCHD-CAP referrals, BCPS asthma screening tool and PCP/ Community/Self-referrals Asthma RN triages patients for inpatient consults and/or outpatient specialty care through Pulm/Allergy/Breath-mobile in person and/or Telemed service
Increase Asthma Awareness and Education	UMCH Pediatric Asthma Program Team Educational Component	Children with asthma and caregivers, PCPs, trainees, BCPS school personnel and general public	Provide asthma education at appointments, "Back to school" nights and health fairs. Develop on line educational resources. Provide didactic lectures in person and by webinars Certified Asthma Educator (CAE) certification of team
Coordination with other UMMC Community Programs to provide resources to address factors impacting asthma control: - Adherence - Environmental Exposures - Obesity - Psychosocial factors - ACEs	Asthma Program RN and Social Worker BCHD-CAP program UMMC Community Program	Children and their families in need of additional Support/ Resources	Asthma Program Team Members identify need* for additional services and notify Asthma RN and/or Social Worker for assistance and referrals if indicated Asthma RN makes reminder Calls/Texts to PTs for appointments and sets up medication reminder system ("Asthma Storylines" app) *Includes screening surveys at appts for maternal depression and ACEs

FY2022-2024 Community Health Improvement Implementation Plan – Pediatrics Obesity

PRIORITY AREA: Pediatrics Obesity

Objectives Supporting SIHIS and The National Prevention Strategy:

1. Reduce the proportion of children and adolescents with obesity
2. Reduce the consumption of calories from added sugars by persons aged 2 yrs. and over
3. Eliminate very low food security among children

Annual Objective	Strategy	Target Population	Actions Description
Eliminate very low food security among children	Provide Food Pantry option to Patients and Community at Midtown, General Pediatrics Practice	Children and families in Baltimore City Children with BMI over the 95th percentile for their age	Through outreach, provide the community with resources directing them to wellness visits to see a pediatrician and upon their first visit, they will be offered a voucher to the pantry Expand these services to include the Mobile Market, which could offer fresh fruits and veggie options. Days they park at Midtown we could offer free community pediatric obesity screenings. Strengthen partnership with existing community outreach initiatives and efforts directed at addressing food insecurities
Reduce the proportion of children and adolescents with obesity Reduce the consumption of calories from added sugars by persons aged 2 yrs. and over	Provide Free Dietician and Social Work Support to increase resources in supporting a holistic approach to obesity and eliminate barriers to access	Children and families in Baltimore City Children with BMI over the 95th percentile for their age	Through outreach, provide community with meet and greets, Q&A, free screenings and direct them to visits to see a pediatrician and coordinated visit with a dietician and social worker to support their clinical outcomes Offer larger complement of services through stronger partnerships with the community, such as UMCDE by having a bridge with social work and dietician services

DOWNTOWN
22 S. Greene Street
Baltimore, MD 21201

MIDTOWN
827 Linden Avenue
Baltimore, MD 21201

EXHIBIT 7

MARYLAND Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

May 2, 2018

RECEIVED

MAY 04 2018

University of Maryland Medical Center
Executive Office

Mohan Suntha, President and CEO
University Of Maryland Medical Center
22 South Greene Street
Baltimore, MD 21201

Dear Dr. Suntha,

Based on legislation passed during the 2018 legislative session, the Office of Health Care Quality will eliminate license fees and expiration date effective July 1, 2018. Therefore, we are issuing new licenses to all facilities reflecting an effective date of July 1, 2018. Please continue to supply the findings of The Joint Commission's accreditation survey to the OHCQ at the address below:

The Hospital and HMO QA Unit
Spring Grove Center, Bland-Bryant Building
55 Wade Ave.
Catonsville, MD 21228

The Department of Health retains the authorities as specified in Health-General Article 19 and may revoke this license for failure to comply with its provisions. The license is the hospital's authority to operate an Acute General Hospital.

This license should be displayed in a conspicuous place, at or near the entrance to the hospital, plainly visible and easily read by the public.

Sincerely,

Anne Jones RN, BSN, MA
Acting Director, Hospital and HMO QA Unit

cc: Maryland Health Care Commission
Maryland Health Services Cost Review Commission
Office of Health Services
Division of Cost and Reimbursements
Ann Elliott, CareFirst Blue Cross
Baltimore City Health Department
License File

MARYLAND DEPARTMENT OF HEALTH
OFFICE OF HEALTH CARE QUALITY

SPRING GROVE CENTER
BLAND BRYANT BUILDING
55 WADE AVENUE
CATONSVILLE, MARYLAND 21228

License No. 30-068

Issued to:

University Of Maryland Medical Center
22 South Greene Street
Baltimore, MD 21201

Type of Facility: Acute General Hospital

Date Issued: July 1, 2018

Authority to operate in this State is granted to the above entity pursuant to The Health-General Article, Title 19 Section 318 Annotated Code of Maryland, 1982 Edition, and subsequent supplements and is subject to any and all statutory provisions, including all applicable rules and regulations promulgated thereunder. This document is not transferable.

Patricia Tomasko May, MD

Director

Falsification of a license shall subject the perpetrator to criminal prosecution and the imposition of civil fines.

EXHIBIT 8

UM REHABILITATION & ORTHOPAEDIC INSTITUTE

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Spinal Cord Injury Rehabilitation | 2023

NUMBER OF PATIENTS: 121

CASE MIX INDEX (CMI)

- UM Rehab & Ortho **2.1764**
- Region **1.6730**
- Nation **1.6576**

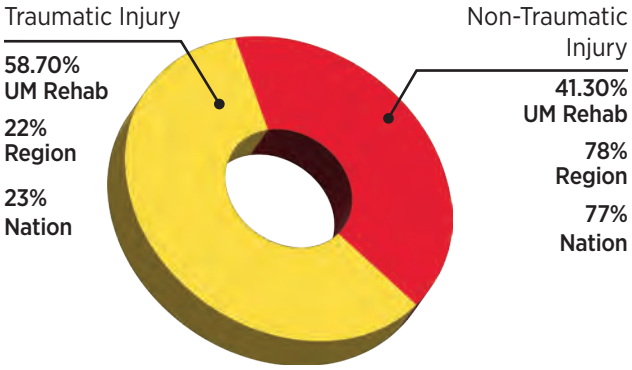
Higher number indicates increased medical complexity

AVERAGE DAYS FROM ONSET

- UM Rehab & Ortho **18.9 days**
- Region **19.3 days**
- Nation **21.1 days**

Our patients come to rehab earlier

INJURY

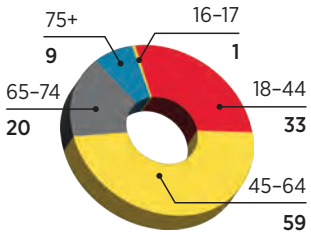


AVERAGE LENGTH OF STAY

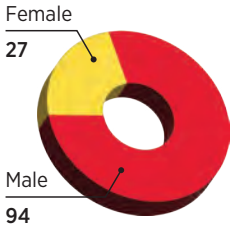
- UM Rehab & Ortho **32.1 days**
- Region* **22.3 days**
- Nation **23.4 days**

*Region: MD, WV, PA, DE & DC

AGE (Average Age: 53.1)



GENDER

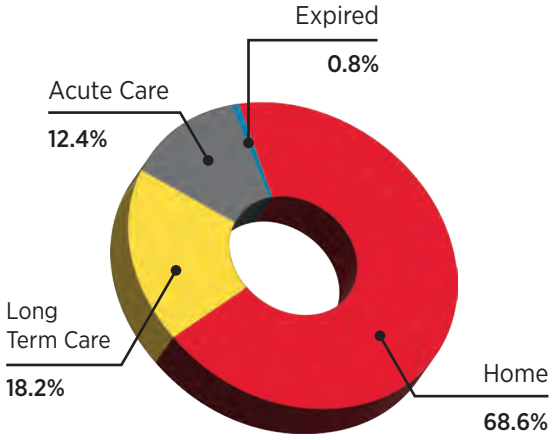


QUALITY & SATISFACTION

(Based on Press Ganey scores (0–100) | UM Rehab & Ortho mean score)

- Likelihood to Recommend **93.33**
- Overall Rating **81.25**
- Prepared to Function at Home **68.33**

DISCHARGE SETTING



FUNCTIONAL OUTCOMES

Change in Self-Care	UM Rehab & Ortho	**16.30**
	Expected Ave	**13.40**
Change in Mobility	UM Rehab & Ortho	**37.30**
	Expected Ave	**29.70**
Functional Efficiency *(higher number is better)*	UM Rehab & Ortho	**2.65**
	Expected Ave	**2.19**

Patients receive a minimum of three hours of therapy per day, five days per week and as appropriate, participate in educational sessions, support groups and recreation therapy

UM REHABILITATION & ORTHOPAEDIC INSTITUTE

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Brain Injury Rehabilitation | 2023

NUMBER OF PATIENTS: 198

CASE MIX INDEX (CMI)

UM Rehab & Ortho	1.4704
Region	1.3856
Nation	1.3685

Higher number indicates increased medical complexity

AVERAGE LENGTH OF STAY

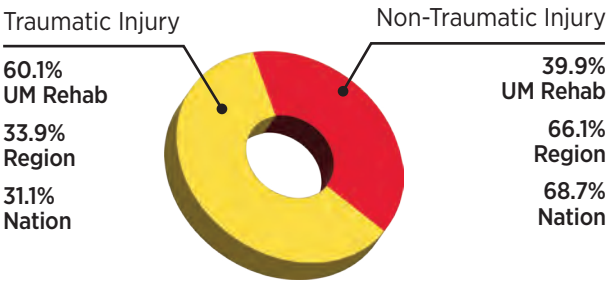
UM Rehab & Ortho	22.9 days
Region*	14.2 days
Nation	13.6 days

*Region: MD, WV, PA, DE & DC

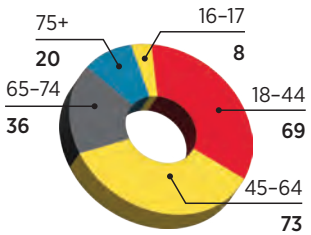
AVERAGE DAYS FROM ONSET

UM Rehab & Ortho	20
Region	15.7
Nation	15.2

INJURY



AGE (Average Age: 51.6)



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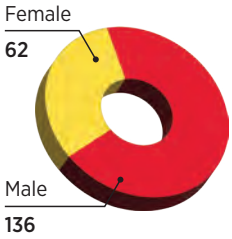
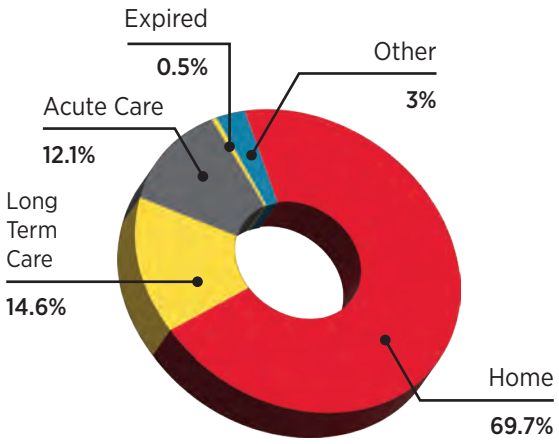


QUALITY & SATISFACTION

(Based on Press Ganey scores (0–100) | UM Rehab & Ortho mean score)

Likelihood to Recommend	83.04
Overall Rating	82.14
Prepared to Function at Home	78.85

DISCHARGE SETTING



FUNCTIONAL OUTCOMES

Change in Self-Care	UM Rehab & Ortho	11.40
	Expected Ave	13.00
Change in Mobility	UM Rehab & Ortho	26.00
	Expected Ave	29.80
Functional Efficiency *(higher number is better)*	UM Rehab & Ortho	2.45
	Expected Ave	2.97

Patients receive a minimum of three hours of therapy per day, five days per week and as appropriate, participate in educational sessions, support groups and recreation therapy

UM REHABILITATION & ORTHOPAEDIC INSTITUTE

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Medically Complex Rehabilitation | 2023

NUMBER OF PATIENTS: 165

AVERAGE DAYS FROM ONSET

- UM Rehab & Ortho **24.6**
- Region **19.1**
- Nation **18.9**

AVERAGE LENGTH OF STAY

- UM Rehab & Ortho **15 days**
- Region* **14.7 days**
- Nation **13.2 days**

*Region: MD, WV, PA, DE & DC

CASE MIX INDEX (CMI)

- UM Rehab & Ortho **1.3797**
- Region **1.2850**
- Nation **1.2829**

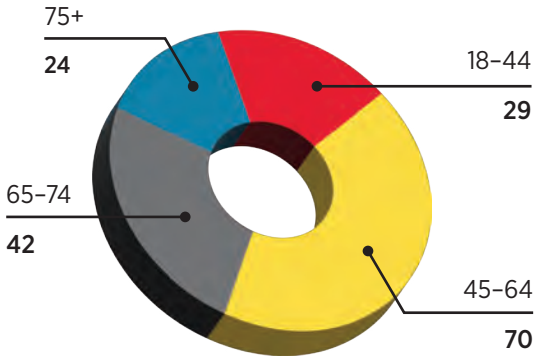
Higher number indicates increased medical complexity

QUALITY & SATISFACTION

(Based on Press Ganey scores (0–100) | UM Rehab & Ortho mean score)

- Likelihood to Recommend **87.75**
- Overall Rating **86.88**
- Prepared to Function at Home **89.11**

AGE (Average Age: 59.2)



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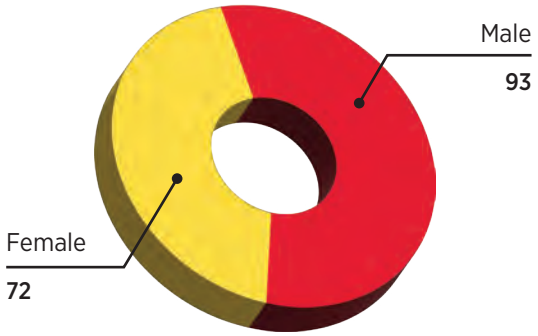
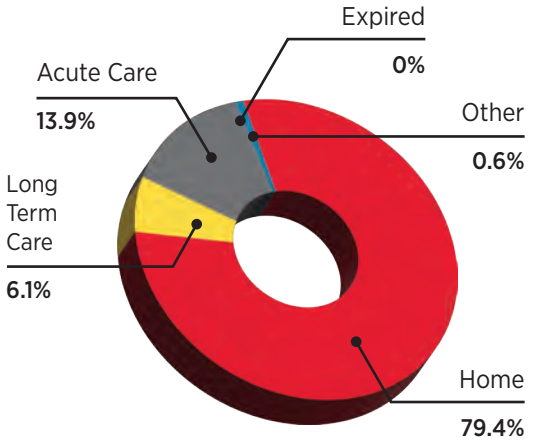


DISCHARGE SETTING



FUNCTIONAL OUTCOMES

Change in Self-Care	UM Rehab & Ortho	**15.60**
	Expected Ave	**13.90**
Change in Mobility	UM Rehab & Ortho	**35.10**
	Expected Ave	**33.50**
Functional Efficiency *(higher number is better)*	UM Rehab & Ortho	**4.30**
	Expected Ave	**3.53**

Patients receive a minimum of three hours of therapy per day, five days per week and as appropriate, participate in educational sessions, support groups and recreation therapy