GALLAGHER
GALLAGHER EVELIUS & JONES
ATTORNEYS AT LAW

Thomas C. Dame
Direct Dial: 410.347.1331
tdame@gejlaw.com

September 6, 2019

VIA HAND DELIVERY

Ms. Ruby Potter
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Merger and Consolidation of
University of Maryland Shore Medical Center at Dorchester and
University of Maryland Shore Medical Center at Chestertown
Request for Exemption from Certificate of Need Review / Request to
Modify Existing Exemption from Certificate of Need Review

Dear Ms. Potter:

On behalf of Shore Health System, Inc. ("SHS"), doing business as University of Maryland Shore Medical Center at Easton ("UM SMC at Easton") and University of Maryland Shore Medical Center at Dorchester ("UM SMC at Dorchester"), and University of Maryland Shore Regional Health, Inc. ("UM SRH"), doing business as University of Maryland Shore Medical Center at Chestertown ("UM SMC at Chestertown") (collectively, the "Applicants"), enclosed are six copies of its Request for Exemption from CON Review and Request to Modify Existing Exemption from Certificate of Need Review. Also enclosed is a CD containing searchable PDF files of the Request and exhibits, a Word version of the application, and native Excel spreadsheets of the MHCC tables.

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

Please sign and return to our waiting messenger the enclosed acknowledgment of receipt.

Sincerely,

Thomas C. Dame

TCD:blr
Enclosures

#674787
012516-0006

cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development
Suellen Wideman, Esq., Assistant Attorney General
Roger L. Harrell, MHA, Health Officer, Dorchester County Health Department
Scott LeRoy, MPH, MS, Health Officer, Caroline County Health Department
Bill Webb, MPH, Health Officer, Kent County Health Department
Joseph A. Ciotola, Jr., M.D., Health Officer, Queen Anne's County Health Department
Fredia Wadley, MD, Health Officer, Talbot County Health Department
Kenneth D. Kozel, President & CEO, UM Shore Regional Health
Robert Frank, Sr. Regional V.P., Operations, UM Shore Regional Health
William Huffner, M.D., Sr. V.P., Medical Affairs & Chief Medical Officer, UM Shore Regional Health
Patti Willis, Sr. V.P., Strategy & Communications, UM Shore Regional Health
JoAnne Hahey, Chief Financial officer, UM Shore Regional Health
Donna Jacobs, Sr. V.P., Government, Regulatory and Community Health, UMMS
Sandra H. Benzer, Esq., Associate Counsel, UMMS
Brian Sturm, Senior Director, Financial and Capital Planning, UMMS
Darryl Mealy, V.P. of Construction & Facilities Planning, UMMS
Andrew L. Solberg, A.L.S. Healthcare Consultant Services

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Thomas C. Dame
Direct Dial: 410.347.1331
tdame@gejlaw.com

September 6, 2019

VIA HAND DELIVERY

Ben Steffen
ben.steffen@maryland.gov
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Merger and Consolidation of
University of Maryland Shore Medical Center at Dorchester and
University of Maryland Shore Medical Center at Chestertown
Request for Exemption from Certificate of Need Review / Request to
Modify Existing Exemption from Certificate of Need Review

Dear Mr. Steffen:

I write on behalf of Shore Health System, Inc. ("SHS") and University of Maryland Shore Regional Health, Inc. ("UM SRH"). SHS doing business as University of Maryland Shore Medical Center at Easton ("UM SMC at Easton") and University of Maryland Shore Medical Center at Dorchester ("UM SMC at Dorchester"), and UM SRH doing business as University of Maryland Shore Medical Center at Chestertown ("UM SMC at Chestertown") (collectively, the "Applicants"), hereby provide notice that they seek approval from the Maryland Health Care Commission to merge and consolidate UM SMC at Dorchester and UM SMC at Chestertown by relocating UM SMC at Dorchester's inpatient psychiatric services to UM SMC at Chestertown. Provided the Commission approves the request, SHS also seeks to modify the existing exemption from Certificate of Need ("CON") review for the relocation of beds and services from UM SMC at Dorchester to UM SMC at Easton.

For the reasons set forth in the enclosed Request for Exemption from Certificate of Need Review and Request to Modify Existing Exemption from Certificate of Need Review, the Applicants respectfully request that the Commission grant: (1) an exemption from CON review for the merger and consolidation of UM SMC at Dorchester and UM SMC at Chestertown and for associated capital expenditures through the relocation of inpatient psychiatric services; and (2) a modification of the existing CON exemption to remove inpatient psychiatric services and associated capital expenditures from the existing exemption approval.

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012516-0006

Thank you for your consideration of these matters.

Sincerely,

Thomas C. Dame

TCD:blr
Enclosures
cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development
Suellen Wideman, Esq., Assistant Attorney General
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Andrew L. Solberg, A.L.S. Healthcare Consultant Services

IN THE MARYLAND HEALTH CARE COMMISSION

REQUEST FOR EXEMPTION
FROM CERTIFICATE OF NEED REVIEW AND REQUEST TO MODIFY
EXISTING EXEMPTION FROM CERTIFICATE OF NEED REVIEW

to

(1) Merge and consolidate inpatient psychiatric services of University of Maryland Shore Medical Center at Dorchester and University of Maryland Shore Medical Center at Chestertown; and

(2) modify the existing Certificate of Need exemption to remove inpatient psychiatric services and associated capital expenditures from the relocation of inpatient services from University of Maryland Shore Medical Center at Dorchester to University of Maryland Shore Medical Center at Easton

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Applicants

Shore Health System, Inc.
d/b/a UM Shore Medical Center at Dorchester
and UM Shore Medical Center at Easton

and

University of Maryland Shore Regional Health, Inc.
d/b/a UM Shore Medical Center at Chestertown

September 6, 2019

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012516-0006

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REQUEST FOR EXEMPTION FROM
CERTIFICATE OF NEED REVIEW AND
REQUEST TO MODIFY EXISTING EXEMPTION FROM
CERTIFICATE OF NEED REVIEW

Shore Health System, Inc. ("SHS"), doing business as University of Maryland Shore Medical Center at Easton ("UM SMC at Easton") and University of Maryland Shore Medical Center at Dorchester ("UM SMC at Dorchester"), and University of Maryland Shore Regional Health, Inc. ("UM SRH"), doing business as University of Maryland Shore Medical Center at Chestertown ("UM SMC at Chestertown") (collectively, the "Applicants"), by the undersigned counsel, request approval from the Maryland Health Care Commission to relocate inpatient psychiatric beds and services from UM SMC at Dorchester to UM SMC at Chestertown pursuant to a merger and consolidation of these two facilities in accordance with COMAR 10.24.01.02(A)(3)(c) and 10.24.01.04(A)(3)-(4).

Provided the Commission approves the exemption request, SHS also seeks to modify the existing exemption from Certificate of Need ("CON") review granted on April 18, 2019 for the relocation of beds and services from UM SMC at Dorchester to UM SMC at Easton to remove inpatient psychiatric beds and services and associated costs from the existing exemption approval.

BACKGROUND

UM SMC at Dorchester is an acute care hospital with 18 licensed MSGA beds and 16 licensed psychiatric beds located at 300 Byrn Street, Cambridge, Maryland 21613. UM SMC at Easton is a 97 bed licensed acute care hospital, with 79 MSGA beds, 13 obstetrics beds, and five pediatric beds, located at 219 South Washington Street, Easton, Maryland 21601. UM SMC at Dorchester is the only acute general hospital in Dorchester County and UM SMC at Easton is the only acute general hospital in Talbot County. UM SMC at Chestertown is an acute care hospital with 12 licensed MSGA beds located at 100 Brown Street, Chestertown, Maryland 21620. UM SMC at Chestertown is the only acute general hospital located in Kent County.

In 1996, The Memorial Hospital at Easton (now known as UM SMC at Easton) merged with Dorchester General Hospital (now known as UM SMC at Dorchester) to form SHS, a unified network of medical services with the combined resources of community hospitals, physicians, and outpatient centers. In 2006, SHS affiliated with the University of Maryland Medical System ("UMMS"), and, as of July 1, 2013, SHS joined with the University of Maryland Chester River Health System at Chestertown to become University of Maryland Shore Regional Health, Inc. ("UM SRH"), a community based, not-for-profit health system. These consolidations have permitted UM SRH and UMMS to continue a strong commitment to the rural five county mid-Eastern Shore of Maryland region, with expanded and improved clinical services, programs and facilities, and physician recruitment. UM SRH is the sole corporate member of SHS and also trades as UM SMC at Chestertown. UM SRH is dedicated to maintaining and improving the health of the people in the communities it serves through an integrated health delivery system that provides the highest quality of care to all.

In addition to UM SMC at Dorchester, UM SMC at Easton, and UM SMC at Chestertown, UM SRH consists of:

(1) The Requard Rehabilitation Center, a 20-bed inpatient acute rehabilitation special hospital located at UM SMC at Easton;

(2) UM Shore Emergency Center at Queenstown ("UM Shore EC Queenstown"), a freestanding medical facility located at 125 Shoreway Drive, Queenstown, Maryland 21658;

(3) UM SRH Cancer Center and Requard Radiation Oncology Center located in Easton approximately one mile from UM SMC at Easton;

(4) The Diagnostic and Imaging Center and Clark Comprehensive Breast Center located in Easton approximately one mile from UM SMC at Easton;

(5) A network of diagnostic laboratory and imaging facilities located in Denton, Centreville, Cambridge, Chestertown, and Queenstown;

(6) Outpatient rehabilitation centers located in Denton, Cambridge, Queenstown, and Easton; and

(7) A regional network of employed primary care and specialty physicians and providers in all five counties of the mid-Shore region.

The existing UM SMC at Dorchester was constructed in phases between 1906 and 1960, with numerous renovations and improvements throughout the years. Although UM SRH has been committed to maintaining the facility and has undertaken capital expenditures to make infrastructure, clinical equipment, and information technology improvements, the existing physical plant has outlived its useful life.

On April 18, 2019, the Commission approved two separate exemptions from CON review. First, the Commission approved an exemption to convert UM SMC at Dorchester to a freestanding medical facility to be developed approximately one mile from the existing hospital (the "FMF Exemption"). Second, the Commission approved an exemption to relocate 17 MSGA beds and 12 psychiatric beds from UM SMC at Dorchester to UM SMC at Easton (the "Dorchester-Easton Exemption").

The Applicants now propose to relocate 12 psychiatric beds and services and incorporate the beds into the existing hospital, in renovated space for that purpose, at UM SMC at Chestertown, approximately 50 miles away from Cambridge, rather than locating the psychiatric beds at UM SMC at Easton as the Commission previously approved in the Dorchester-Easton Exemption. The Applicants determined to seek this change in order to support the future viability of UM SMC at Chestertown to continue to provide inpatient services for residents in UM SMC at Chestertown's service area. Also, if approved, the change in service configuration will produce capital cost savings of approximately $4.3 million as compared to the approved project set forth in the Dorchester-Easton Exemption because it will not be necessary to include an inpatient behavioral health unit in the proposed new hospital in Easton.

The proposed renovations at UM SMC at Chestertown will be designed in accordance with applicable building codes and the Facilities Guidelines Institute, Guidelines for Design and Construction of Hospitals and Outpatient Facilities 2014 Edition ("FGI Guidelines"). A more

detailed description of the project appears below and **Exhibit 2** includes the existing and proposed floor plans of the areas being renovated.

DISCUSSION

Maryland Code, Health-General § 19-120(j)(2) permits a hospital to increase the volume of one or more health care services if the proposed change: (i) is pursuant to the 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. The Commission may also exempt the requirement of CON review and approval for capital expenditures, changes in bed capacity, and changes in the scope of health care services offered by a health care facility if done as part of a consolidation or merger of two hospitals. Health-General § 19-120(k)(6)(v); COMAR 10.24.01.04(A)(3)-(5).

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 medicine, surgery, gynecology, addictions, and psychiatry. *Id*. § 19-120(a)(5); COMAR 10.24.01.01(B)(27).

Because UM SMC at Dorchester and UM SMC at Chestertown are both affiliated with UM SRH, the relocation of psychiatric bed capacity from UM SMC at Dorchester to UM SMC at Chestertown 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 psychiatric 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.

I. REQUEST FOR EXEMPTION FROM CON REVIEW

A. PROJECT DESCRIPTION

The proposed project described below supplements and accompanies the Commission's approval of the FMF Exemption and the Dorchester-Easton Exemption. The project involves the relocation of 12 psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown coincident with the conversion of UM SMC at Dorchester to an FMF.[1]

[1] Also, on September 7, 2018, SHS submitted a CON application to replace and relocate UM SMC at Easton to a new site owned by the Applicant near the Easton Airport, approximately three miles from the existing hospital campus. The 17 MSGA beds and 12 psychiatric beds relocated from UM SMC at Dorchester are included in the proposal to relocate UM SMC at Easton. If the Commission approves this CON exemption request, SHS will modify the CON application to remove the behavioral health unit from the proposed new hospital in Easton.

The proposed relocation supports the need for a modern, state of the art health care facility for inpatient behavioral health and related services and supports the strategic community health improvement goals of expanded access to care that is efficient and effective and is in the public interest. It will also contribute to a sustainable future for inpatient care at UM SMC at Chestertown to continue to meet the needs of the population in the northern portion of UM SRH's regional service area, while expanding access to outpatient services such as intensive outpatient programs and bridge clinics, which will be co-located with the inpatient unit and provided by UM SRH. In addition, the location of an acute behavioral health unit in Chestertown will promote beneficial collaborations with the A.F. Whitsitt Center, a 24-bed intermediate care, addictions treatment, and co-occurring disorders facility in Chestertown.

The project involves renovations to an existing patient unit in UM SMC at Chestertown to accommodate the 12 behavioral health beds that are planned to relocate from UM SMC at Dorchester and related enabling moves. The space for the relocated beds is located on the third floor. The space is currently available as an inpatient unit and, therefore, it is already configured for inpatient care and is under- or un-utilized, currently making it inefficient from a facility and resource standpoint. Renovations will be largely focused upon preparing the unit specifically for behavioral health inpatient care. The floor plans included in **Exhibit 2** identify the current use of all rooms and configuration along with the layout of the proposed project to meet all regulatory requirements.

B. PROJECT BUDGET AND TIMETABLE

The total project budget is $4,946,810. The proposed project is expected to be funded through board-designated funds.

Assuming the Commission approves this request for CON exemption, the project is estimated to proceed on the following timeline:

- Projected approval – December 2019
- Design completion – June 2020
- Award of construction contract – September 2020
- Completion of construction – April 2021

The inpatient beds will not relocate from UM SMC at Dorchester until the new FMF building in Cambridge is complete and opens, which should occur by summer of 2021.

Project drawings are attached as **Exhibit 2**. The Applicants have also completed hospital CON Tables A and E through L, which are attached as **Exhibit 1**.

C. IDENTIFICATION OF OUTSTANDING PUBLIC BODY OBLIGATIONS

The University of Maryland Medical System Corporation ("UMMS") and several of its subsidiaries, including the entities that own and operate UM SMC at Chestertown and UM SMC at Dorchester (collectively, the "UMMS Obligated Group"), have issued long term public and private placement bond debt through the Maryland Health and Higher Educational Facilities Authority. Each of the UMMS Obligated Group members are jointly and severally liable for the outstanding bond debt.

D. THE RELOCATION OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN IS NOT INCONSISTENT WITH THE STATE HEALTH PLAN CHAPTER FOR PSYCHIATRIC SERVICES.

10.24.07 – PSYCHIATRIC SERVICES CHAPTER--APPROVAL POLICIES

Availability

AP 1a. The projected maximum bed need for child, adolescent, and adult acute psychiatric beds is calculated using the Commission's statewide child, adolescent, and adult acute psychiatric bed need projection methodologies specified in this section of the State Health Plan. Applicants for Certificates of Need must state how many child, adolescent, and adult acute psychiatric beds they are applying for in each of the following categories: net acute psychiatric bed need, and/or state hospital conversion bed need.

Applicant Response:

There is no current or recent Commission statewide child, adolescent, or adult bed need projection. Moreover, the bed need projection methodologies set forth in the State Health Plan for Psychiatric Services are outdated and obsolete.

For FY2020 UM SMC at Dorchester is licensed to operate 16 psychiatric beds. The Applicants propose to relocate and license 12 inpatient psychiatric beds at UM SMC at Chestertown beginning in FY2022, and relinquish the remaining four beds. In determining the need for these beds at UM SMC at Chestertown, the Applicants considered the State Health Plan for psychiatric services. The Commission has recognized that many of the standards in the State Health Plan Chapter for psychiatric services are "out of date due to dramatic changes in the use of hospital psychiatric beds (especially with respect to average length of stay) and changes in the role and scope of State psychiatric hospital facilities that have occurred since its development" and that the State Health Plan "does not have an applicable need analysis." (*In re Sheppard Pratt at Elkridge*, Docket No. 15-152367, Staff Report and Recommendation pp. 5, 13 (Sept. 20, 2016)).[2]

[2] One outcome of the Commission's 2018 Task Force on the Modernization of CON Regulation was the recent formation of a workgroup to study the State Health Plan chapter for psychiatric services and recommend changes to the chapter, which is largely out-of-date. With regard to applicants demonstrating need for inpatient services, the Commission staff recommended that need for additional capacity should be based on existing service areas and market share analysis, rather than the current health service regions. *See* Summary of Standards for Psychiatric Service Standards and MHCC Staff Recommendations (https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/Psych%20work%20group/Appendix%20A%20Summary%20Standards_20170617.pdf).

To project psychiatric bed need at UM SMC at Chestertown beginning in fiscal year 2022, the Applicants utilized a modified MSGA need analysis. The projected need for inpatient psychiatric beds reflects the methodology and assumptions described below.

1. Defining UM SMC at Dorchester and UM SMC at Chestertown's Psychiatric Service Areas

To determine the proposed psychiatric service area for UM SMC at Chestertown, the Applicants first considered the service area for UM SMC at Dorchester based on fiscal year 2018 discharges by zip code for the adult (age 18 and older) psychiatric cohort. Child and adolescent psychiatric discharges were excluded from this analysis because UM SMC at Dorchester does not currently provide inpatient psychiatric treatment to children and adolescent patients and these services will not be provided at UM SMC at Chestertown. The Applicants identified the adult psychiatric service area as the zip codes that comprise the top 85% of adult psychiatric discharges in FY 2018 at UM SMC at Dorchester. As presented in Table 1 below, UM SMC at Dorchester's service area for the adult psychiatric cohort is defined by zip codes that span Dorchester, Talbot, Caroline, Kent, Queen Anne's and Wicomico counties in Maryland.

Table 1
UM SMC at Dorchester's Adult Psychiatric Service Area
FY2018

#	Zip Code	Community	County	Total Discharges	% of Total	Cumulative % of Discharges
1	21613	Cambridge	Dorchester County	128	23.0%	23.0%
2	21601	Easton	Talbot County	64	11.5%	34.5%
3	21629	Denton	Caroline County	31	5.6%	40.1%
4	21643	Hurlock	Dorchester County	30	5.4%	45.5%
5	21620	Chestertown	Kent County	28	5.0%	50.5%
6	21632	Federalsburg	Caroline County	24	4.3%	54.9%
7	21617	Centreville	Queen Anne's County	19	3.4%	58.3%
8	21801	Salisbury	Wicomico County	16	2.9%	61.2%
9	21639	Greensboro	Caroline County	14	2.5%	63.7%
10	21631	East New Market	Dorchester County	12	2.2%	65.8%
11	21619	Chester	Queen Anne's County	11	2.0%	67.8%
12	21655	Preston	Caroline County	11	2.0%	69.8%
13	21666	Stevensville	Queen Anne's County	11	2.0%	71.8%
14	21804	Salisbury	Wicomico County	10	1.8%	73.6%
15	21663	Saint Michaels	Talbot County	9	1.6%	75.2%
16	21638	Grasonville	Queen Anne's County	7	1.3%	76.4%
17	21673	Trappe	Talbot County	7	1.3%	77.7%
18	21660	Ridgely	Caroline County	6	1.1%	78.8%
19	21625	Cordova	Talbot County	5	0.9%	79.7%
20	21640	Henderson	Caroline County	5	0.9%	80.6%
21	21661	Rock Hall	Kent County	5	0.9%	81.5%
22	21658	Queenstown	Queen Anne's County	4	0.7%	82.2%
23	21678	Worton	Kent County	4	0.7%	82.9%
25	21654	Oxford	Talbot County	3	0.5%	83.5%
24	21649	Marydel	Caroline County	2	0.4%	83.8%
26	21657	Queen Anne	Queen Anne's County	2	0.4%	84.2%
27	21869	Vienna	Dorchester County	2	0.4%	84.5%
28	21636	Goldsboro	Caroline County	1	0.2%	84.7%
29	21659	Rhodesdale	Dorchester County	1	0.2%	84.9%
30	21837	Mardela Springs	Wicomico County	1	0.2%	85.1%
	Service Area Total			**473**	**85.1%**	**85.1%**
	Outside of Service Area			83	14.9%	100.0%
	Total			**556**	**100.0%**	**100.0%**

Source: St. Paul statewide non-confidential data tapes

To define the service area for UM SMC at Chestertown, the Applicants reviewed the methodology first outlined in Commissioner Barbara McLean's proposed decision on the 2009 CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (Proposed Decision, pp. 157-162). The same approach was used in several subsequent CON reviews, including by Dimensions Health System in presenting need for inpatient services for the relocation of Prince George's Hospital Center (Docket 13-16-2351). Utilizing a similar methodology, the Applicants determined the drive time from UM SMC at Dorchester to each zip code in UM SMC at Dorchester's service area. The zip codes in UM SMC at Dorchester's service area were then sorted by proximity to UM SMC at Dorchester and ranked by groupings of similar drive times. These groupings of zip codes included 0-4 miles, 5-9 miles to UM SMC at Dorchester, 10-14 miles, 15-19 miles, 20-24 miles, 25-29 miles, 30-39 miles, 40-49 miles, 50-59 miles and 60-69 miles. These groupings of 5 and 10 miles reflect zip codes with similar distance and market share. Additional rankings were included in the 25-30 mile grouping and the 40-50 mile grouping to distinguish between those zip codes that are north of UM SMC at Dorchester and those that are southeast of UM SMC at Dorchester.

Table 2
Grouping and Ranking of Zip Codes in UM SMC at Dorchester's Service Area

#	Zip Code	Community	County	Distance to UM SMC Dorchester (Miles)	Zip Code Rank
1	21613	Cambridge	Dorchester County	1.1	1
2	21673	Trappe	Talbot County	5.9	2
3	21639	Greensboro	Caroline County	7.8	2
4	21631	East New Market	Dorchester County	7.8	2
5	21654	Oxford	Talbot County	14.3	3
6	21869	Vienna	Dorchester County	14.7	3
7	21601	Easton	Talbot County	15.4	4
8	21643	Hurlock	Dorchester County	16.1	4
9	21659	Rhodesdale	Dorchester County	18.6	4
10	21837	Mardela Springs	Wicomico County	20.4	5
11	21655	Preston	Caroline County	20.5	5
12	21632	Federalsburg	Caroline County	22.9	5
13	21625	Cordova	Talbot County	23.8	5
14	21663	Saint Michaels	Talbot County	26.4	6
15	21801	Salisbury	Wicomico County	28.9	7
16	21657	Queen Anne	Queen Anne's County	30.6	8
17	21629	Denton	Caroline County	33.5	8
18	21660	Ridgely	Caroline County	34.0	8
19	21658	Queenstown	Queen Anne's County	34.0	8
20	21617	Centreville	Queen Anne's County	35.0	8
21	21638	Grasonville	Queen Anne's County	37.5	8
22	21804	Salisbury	Wicomico County	40.3	9
23	21636	Goldsboro	Caroline County	43.1	10
25	21619	Chester	Queen Anne's County	43.3	10
24	21640	Henderson	Caroline County	44.8	10
26	21666	Stevensville	Queen Anne's County	48.1	10
27	21620	Chestertown	Kent County	53.4	11
28	21649	Marydel	Caroline County	53.8	11
29	21678	Worton	Kent County	63.5	12
30	21661	Rock Hall	Kent County	67.1	12
	Service Area Total				

Source: Distance is determined using GoogleMaps

These groupings and rankings of zip codes were then applied to the zip codes around UM SMC at Chestertown to determine the adult psychiatric service area for UM SMC at Chestertown as presented in Table 3.

Table 3
Definition of UM SMC at Chestertown's Adult Psychiatric Service Area

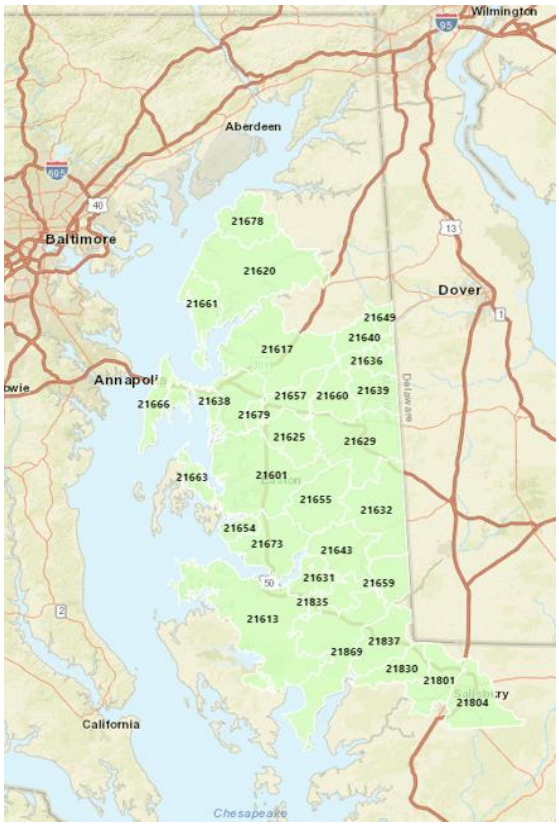
#	Zip Code	Community	County	Distance to UM SMC Chestertown (Miles)	Zip Code Rank
1	21620	Chestertown	Kent County	3.1	1
2	21628	Crumpton	Queen Anne's County	10.1	3
3	21645	Kennedyville	Kent County	10.3	3
4	21667	Still Pond	Kent County	10.5	3
5	21623	Church Hill	Queen Anne's County	11.5	3
6	21610	Betterton	Kent County	12.3	3
7	21678	Worton	Kent County	12.6	3
8	21668	Sudlersville	Queen Anne's County	13.3	3
9	21655	Preston	Caroline County	13.6	3
10	21635	Galena	Kent County	16.3	4
11	21651	Millington	Queen Anne's County	17.0	4
12	21617	Centreville	Queen Anne's County	17.1	4
13	21661	Rock Hall	Kent County	17.7	4
14	21640	Henderson	Caroline County	18.6	4
15	21649	Marydel	Caroline County	19.2	4
16	21919	Earleville	Cecil County	22.2	5
17	21636	Goldsboro	Caroline County	22.5	5
18	21657	Queen Anne	Queen Anne's County	24.0	5
19	21660	Ridgely	Caroline County	24.1	5
20	21912	Warwick	Cecil County	24.9	5
21	21679	Wye Mills	Talbot County	27.1	6
22	21658	Queenstown	Queen Anne's County	28.1	6
23	21641	Hillsboro	Caroline County	29.0	6
24	21639	Greensboro	Caroline County	29.6	6
25	21638	Grasonville	Queen Anne's County	29.8	6
26	21915	Chesapeake City	Cecil County	30.2	8
27	21625	Cordova	Talbot County	30.9	8
28	21619	Chester	Queen Anne's County	34.3	8
29	21629	Denton	Caroline County	34.6	8
30	21601	Easton	Talbot County	36.1	8
31	21653	Newcomb	Talbot County	41.6	10
32	21654	Oxford	Talbot County	44.5	10
33	21663	Saint Michaels	Talbot County	46.1	10
34	21673	Trappe	Talbot County	46.2	10
35	21632	Federalsburg	Caroline County	47.0	10
36	21613	Cambridge	Dorchester County	52.2	11
37	21643	Hurlock	Dorchester County	53.3	11
38	21652	Neavitt	Talbot County	55.5	11
39	21631	East New Market	Dorchester County	58.3	11
40	21659	Rhodesdale	Dorchester County	59.8	11
41	21677	Woolford	Dorchester County	60.4	12
42	21869	Vienna	Dorchester County	65.2	12

Source: Distance is determined using GoogleMaps

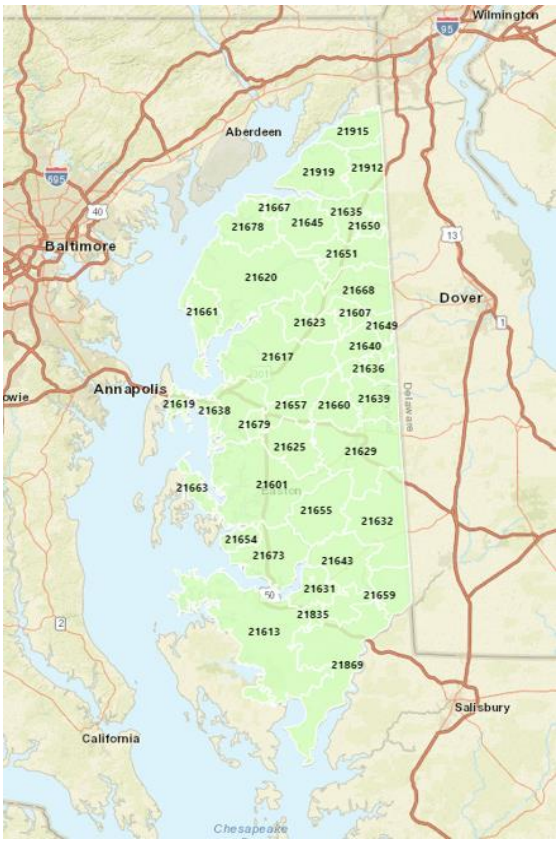
As presented in Figure 1, the resulting definition of UM SMC at Chestertown's adult psychiatric service area represents a shift of zip codes from Wicomico County in the southeast portion of UM SMC at Dorchester's service area to zip codes in Cecil County that are north of UM SMC at Chestertown.

Figure 1
Adult Psychiatric Service Areas

UM SMC at Dorchester



UM SMC at Chestertown



2. *Projected UM SMC at Chestertown Adult Psychiatric Service Area Population*

Using the projected adult psychiatric service area definition for UM SMC at Chestertown, population projections for the zip codes in the projected service area through 2024 were obtained from Environics Spotlight (formerly Nielsen Claritas) for the 18-64 and 65+ age cohorts, and are reflected below in Table 4. The 18-64 age cohort is expected to decline by 1.8% from 2019 to 2024, while the 65+ age cohort is expected to grow by 12.0%. Combined, the total adult service area population is projected to grow by 2.1% from 2019 to 2024.

Table 4
UM SMC at Chestertown's Historical and
Projected Adult Psychiatric Service Area Population
2010 – 2024

Age Group	Service Area Population 2010 Pop	2010 % of Total	2019 Pop	2019 % of Total	2024 Pop	2024 % of Total	% Change in Population 2010-19	2019-24
18-64	96,971	77.0%	92,905	72.0%	91,252	69.3%	-4.2%	-1.8%
65+	29,005	23.0%	36,152	28.0%	40,506	30.7%	24.6%	12.0%
Total	**125,976**	**100.0%**	**129,057**	**100.0%**	**131,758**	**100.0%**	**2.4%**	**2.1%**

Source: Environics Spotlight Pop-Facts Demographics by Age Race Sex

Using the compounded annual growth rates from 2010 to 2019 and 2019 to 2024, as set forth above in Table 4, population projections were interpolated for each year in between and applied to the projected fiscal years for UM SMC at Chestertown. Table 5 below depicts the projected service area population for the 18-64 and 65+ age cohorts through 2024. Combined, the total population is expected to grow approximately 0.4% per year for a total growth of 2.4% from fiscal years 2018 to 2024.

Table 5
UM SMC at Chestertown's Historical and
Projected Adult Psychiatric Service Area Population
FY2018 - FY2024

Age Group	Historical FY2018	Projected FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	% Change FY18-FY24
18-64	93,348	92,905	92,572	92,240	91,910	91,580	91,252	*-2.2%*
65+	35,278	36,152	36,984	37,834	38,705	39,595	40,506	*14.8%*
Total	**128,626**	**129,057**	**129,556**	**130,075**	**130,614**	**131,175**	**131,758**	***2.4%***
%Change		*0.3%*	*0.4%*	*0.4%*	*0.4%*	*0.4%*	*0.4%*	

3. <u>UM SMC at Chestertown Adult Psychiatric Service Area Use Rates</u>

Use rates, by age cohort, were established based on the fiscal year 2018 Maryland hospital discharges per 1,000 population for residents of UM SMC at Chestertown's projected adult psychiatric service area. Consistent with historical trends, the psychiatric use rates, by age cohort, are projected to decline by 1.0% in fiscal year 2019. Driven by current market demands for psychiatric services, though, the inpatient use rates, by age cohort, are projected to level off in fiscal year 2020 and then remain constant. As the 65+ age cohort has lower use rates, the aging of the population will drive a 3.5% reduction in the overall use rate by fiscal year 2024 (Table 6).

Table 6
UM SMC at Chestertown's Historical and
Projected Adult Psychiatric Use Rates
FY2018 - FY2024

	Actual	Projected						% Change
	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Use Rate								
18-64	**5.8**	**5.7**	**5.7**	**5.7**	**5.7**	**5.7**	**5.7**	
%Change		*-1.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.0%*
65+	**2.2**	**2.2**	**2.2**	**2.2**	**2.2**	**2.2**	**2.2**	
%Change		*-1.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.0%*
Total	**4.8**	**4.7**	**4.7**	**4.7**	**4.7**	**4.7**	**4.6**	
% Change		*-1.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*-3.5%*

Source: Historical use rates are calculated based on discharge data obtained from the Maryland State non-confidential patient level data set

4. *Adult Psychiatric Service Area Discharges*

While the population is projected to grow 0.4% a year, that growth is offset by declining use rates as the population shifts to older patients with lower use rates. As such, service area discharges are projected to remain constant at 610 discharges throughout the projection period (Table 7).

Table 7
UM SMC at Chestertown's Historical and
Projected Adult Psychiatric Service Area Discharges
FY2018 – FY2024

	Actual	Projected						% Change
	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Service Area Discharges								
18-64	**540**	**532**	**530**	**528**	**526**	**524**	**523**	
%Change		*-1.5%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*-0.4%*	*-3.2%*
65+	**77**	**78**	**80**	**82**	**84**	**86**	**88**	
%Change		*1.5%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*2.3%*	*13.7%*
Total	**617**	**610**	**610**	**610**	**610**	**610**	**610**	
%Change		*-1.1%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*-1.1%*

Source: Historical discharges were obtained from the Maryland State non-confidential patient level data set

5. *Adult Psychiatric Market Share*

To determine UM SMC at Chestertown's expected market share of service area discharges, the Applicants again applied the methodology introduced in Commissioner Barbara McLean's proposed decision on the CON application for the relocation of Washington Adventist

Hospital (Docket No. 09-15-2295) (Proposed Decision, pp. 157-162). This methodology determines expected market share at the zip code level. UM SMC at Chestertown's expected market share, by zip code, is based on UM SMC at Dorchester's average market share for zip codes of similar proximity groupings and rank.

Using fiscal year 2018 data, the market share was calculated for each zip code in UM SMC at Dorchester's service area. As presented in Table 8, a weighted average of the zip code market shares in each proximity grouping was then calculated.

Table 8
UM SMC at Dorchester Service Area Market Share
FY2018

#	Zip Code	Community	County	Total Discharges	Distance to UM SMC Dorchester (Miles)	Zip Code Rank	Service Area Discharges	Market Share	Weighted Market Share by Rank
1	21613	Cambridge	Dorchester County	128	1.1	1	148	86.5%	86.5%
2	21673	Trappe	Talbot County	7	5.9	2	10	70.0%	
3	21639	Greensboro	Caroline County	14	7.8	2	17	82.4%	80.5%
4	21631	East New Market	Dorchester County	12	7.8	2	14	85.7%	
5	21654	Oxford	Talbot County	3	14.3	3	3	100.0%	100.0%
6	21869	Vienna	Dorchester County	2	14.7	3	2	100.0%	
7	21601	Easton	Talbot County	64	15.4	4	81	79.0%	
8	21643	Hurlock	Dorchester County	30	16.1	4	38	78.9%	75.4%
9	21659	Rhodesdale	Dorchester County	1	18.6	4	7	14.3%	
10	21837	Mardela Springs	Wicomico County	1	20.4	5	10	10.0%	
11	21655	Preston	Caroline County	11	20.5	5	11	100.0%	70.7%
12	21632	Federalsburg	Caroline County	24	22.9	5	31	77.4%	
13	21625	Cordova	Talbot County	5	23.8	5	6	83.3%	
14	21663	Saint Michaels	Talbot County	9	26.4	6	10	90.0%	90.0%
15	21801	Salisbury	Wicomico County	16	28.9	7	188	8.5%	8.5%
16	21657	Queen Anne	Queen Anne's County	2	30.6	8	3	66.7%	
17	21629	Denton	Caroline County	31	33.5	8	41	75.6%	
18	21660	Ridgely	Caroline County	6	34.0	8	8	75.0%	65.7%
19	21658	Queenstown	Queen Anne's County	4	34.0	8	10	40.0%	
20	21617	Centreville	Queen Anne's County	19	35.0	8	27	70.4%	
21	21638	Grasonville	Queen Anne's County	7	37.5	8	16	43.8%	
22	21804	Salisbury	Wicomico County	10	40.3	9	191	5.2%	5.2%
23	21636	Goldsboro	Caroline County	1	43.1	10	2	50.0%	
25	21619	Chester	Queen Anne's County	11	43.3	10	25	44.0%	45.9%
24	21640	Henderson	Caroline County	5	44.8	10	7	71.4%	
26	21666	Stevensville	Queen Anne's County	11	48.1	10	27	40.7%	
27	21620	Chestertown	Kent County	28	53.4	11	43	65.1%	66.7%
28	21649	Marydel	Caroline County	2	53.8	11	2	100.0%	
29	21678	Worton	Kent County	4	63.5	12	6	66.7%	69.2%
30	21661	Rock Hall	Kent County	5	67.1	12	7	71.4%	
Service Area Total				**473**			**991**	**47.7%**	

Source: Discharges are based on St. Paul statewide non-confidential data tapes
Source: Distance is determined using GoogleMaps

As presented in Table 9, UM SMC at Dorchester's average market share for each proximity grouping was then applied to each zip code in the comparable proximity groupings for UM SMC at Chestertown.

Table 9
UM SMC at Chestertown Service Area Market Share

#	Zip Code	Community	County	Distance to UM SMC Chestertown (Miles)	Zip Code Rank	Weighted Market Share by Rank
1	21620	Chestertown	Kent County	3.1	1	86.5%
2	21628	Crumpton	Queen Anne's County	10.1	3	100.0%
3	21645	Kennedyville	Kent County	10.3	3	100.0%
4	21667	Still Pond	Kent County	10.5	3	100.0%
5	21623	Church Hill	Queen Anne's County	11.5	3	100.0%
6	21610	Betterton	Kent County	12.3	3	100.0%
7	21678	Worton	Kent County	12.6	3	100.0%
8	21668	Sudlersville	Queen Anne's County	13.3	3	100.0%
9	21655	Preston	Caroline County	13.6	3	100.0%
10	21635	Galena	Kent County	16.3	4	75.4%
11	21651	Millington	Queen Anne's County	17.0	4	75.4%
12	21617	Centreville	Queen Anne's County	17.1	4	75.4%
13	21661	Rock Hall	Kent County	17.7	4	75.4%
14	21640	Henderson	Caroline County	18.6	4	75.4%
15	21649	Marydel	Caroline County	19.2	4	75.4%
16	21919	Earleville	Cecil County	22.2	5	70.7%
17	21636	Goldsboro	Caroline County	22.5	5	70.7%
18	21657	Queen Anne	Queen Anne's County	24.0	5	70.7%
19	21660	Ridgely	Caroline County	24.1	5	70.7%
20	21912	Warwick	Cecil County	24.9	5	70.7%
21	21679	Wye Mills	Talbot County	27.1	6	90.0%
22	21658	Queenstown	Queen Anne's County	28.1	6	90.0%
23	21641	Hillsboro	Caroline County	29.0	6	90.0%
24	21639	Greensboro	Caroline County	29.6	6	90.0%
25	21638	Grasonville	Queen Anne's County	29.8	6	90.0%
26	21915	Chesapeake City	Cecil County	30.2	8	65.7%
27	21625	Cordova	Talbot County	30.9	8	65.7%
28	21619	Chester	Queen Anne's County	34.3	8	65.7%
29	21629	Denton	Caroline County	34.6	8	65.7%
30	21601	Easton	Talbot County	36.1	8	65.7%
31	21653	Newcomb	Talbot County	41.6	10	45.9%
32	21654	Oxford	Talbot County	44.5	10	45.9%
33	21663	Saint Michaels	Talbot County	46.1	10	45.9%
34	21673	Trappe	Talbot County	46.2	10	45.9%
35	21632	Federalsburg	Caroline County	47.0	10	45.9%
36	21613	Cambridge	Dorchester County	52.2	11	66.7%
37	21643	Hurlock	Dorchester County	53.3	11	66.7%
38	21652	Neavitt	Talbot County	55.5	11	66.7%
39	21631	East New Market	Dorchester County	58.3	11	66.7%
40	21659	Rhodesdale	Dorchester County	59.8	11	66.7%
41	21677	Woolford	Dorchester County	60.4	12	69.2%
42	21869	Vienna	Dorchester County	65.2	12	69.2%

Source: Distance is determined using GoogleMaps

Applying these market shares to the projected service area discharges, by zip code, results in an initial projection of service area psychiatric discharges at UM SMC at Chestertown. Capturing this market share begins in fiscal year 2022 when the psychiatric beds are moved to UM SMC at Chestertown.

Layered onto this initial projection of market share is the introduction of a new inpatient psychiatric facility to be provided near Annapolis by Anne Arundel Medical Center ("AAMC"), known as the Anne Arundel Medical Center Mental Health Hospital. The Commission approved the CON application for this new 16-bed facility in April 2018 (Docket No. 16-02-2375). With the

introduction of this facility, AAMC projects it will capture 20% of the psychiatric patients who reside in Queen Anne's County. While the Applicants do not agree with AAMC's market share projection, for purposes of this need analysis only, the Applicants assume conservatively that AAMC's projection will prove correct.

While AAMC may draw psychiatric patients from UM SMC at Chestertown' service area, the Applicants do not expect that UM SMC at Chestertown will compete with the inpatient psychiatric programs in Delaware. Since 2015, the Delaware Health Resources Board has reviewed five Certificate of Public Review ("CPR") applications from healthcare providers seeking to expand their inpatient psychiatric service offerings (Table 10).

Table 10
Delaware Psychiatric Facilities with Recent CPR Applications

Facility Name	Distance from UM Shore – Chestertown
MeadowWood Behavioral Health (2019, 2018)	44.1 miles
Dover Behavioral Health (2017)	38.6 miles
Christiana Care – Wilmington (2017)	55.1 miles
SUN Behavioral Health (2015)	60.7 miles

In each of the CPR applications, there are noted shortages in the availability of inpatient psychiatric services. Three of the five applications included projections of 90% to 100% occupancy. As such, they do not have the capacity to draw patients from UM SMC at Chestertown's service area.

Considering these competitor related assumptions, Table 11 presents the assumption of market share capture by AAMC combined with the initial projection of market share based on UM SMC at Dorchester's historical experience and fiscal year 2018 discharge data to calculate an expected market share for UM SMC at Chestertown if the psychiatric beds were moved to its location in fiscal year 2018.

Table 11
UM SMC at Chestertown Service Area Market Share
Pro Forma 2018

#	Zip Code	Community	County	Psychiatric Service Area Discharges	Zip Code Rank	Weighted Market Share by Rank	UM SMC Chestertown Discharges	AAMC Market Share Adjustment [1]	Adjusted Discharges	Adjusted Market Share
1	21620	Chestertown	Kent County	43	1	86.5%	36.9		36.9	86.5%
2	21628	Crumpton	Queen Anne's County	3	3	100.0%	3.0	-20.0%	2.4	80.0%
3	21645	Kennedyville	Kent County	3	3	100.0%	3.0		3.0	100.0%
4	21667	Still Pond	Kent County	1	3	100.0%	1.0		1.0	100.0%
5	21623	Church Hill	Queen Anne's County	3	3	100.0%	3.0	-20.0%	2.4	80.0%
6	21610	Betterton	Kent County	3	3	100.0%	3.0		3.0	100.0%
7	21678	Worton	Kent County	6	3	100.0%	6.0		6.0	100.0%
8	21668	Sudlersville	Queen Anne's County	2	3	100.0%	2.0	-20.0%	1.6	80.0%
9	21655	Preston	Caroline County	11	3	100.0%	10.9		10.9	100.0%
10	21635	Galena	Kent County	4	4	75.4%	3.0		3.0	75.4%
11	21651	Millington	Queen Anne's County	3	4	75.4%	2.2	-20.0%	1.8	60.3%
12	21617	Centreville	Queen Anne's County	27	4	75.4%	20.2	-20.0%	16.2	60.3%
13	21661	Rock Hall	Kent County	7	4	75.4%	5.2		5.2	75.4%
14	21640	Henderson	Caroline County	7	4	75.4%	5.2		5.2	75.4%
15	21649	Marydel	Caroline County	2	4	75.4%	1.5		1.5	75.4%
16	21919	Earleville	Cecil County	14	5	70.7%	9.8		9.8	70.7%
17	21636	Goldsboro	Caroline County	2	5	70.7%	1.4		1.4	70.7%
18	21657	Queen Anne	Queen Anne's County	3	5	70.7%	2.1	-20.0%	1.7	56.6%
19	21660	Ridgely	Caroline County	8	5	70.7%	5.6		5.6	70.7%
20	21912	Warwick	Cecil County	2	5	70.7%	1.4		1.4	70.7%
21	21679	Wye Mills	Talbot County	1	6	90.0%	0.9		0.9	90.0%
22	21658	Queenstown	Queen Anne's County	10	6	90.0%	8.9	-20.0%	7.1	72.0%
23	21641	Hillsboro	Caroline County	1	6	90.0%	0.9		0.9	90.0%
24	21639	Greensboro	Caroline County	17	6	90.0%	15.2		15.2	90.0%
25	21638	Grasonville	Queen Anne's County	16	6	90.0%	14.3	-20.0%	11.4	72.0%
26	21915	Chesapeake City	Cecil County	4	8	65.7%	2.6		2.6	65.7%
27	21625	Cordova	Talbot County	6	8	65.7%	3.9		3.9	65.7%
28	21619	Chester	Queen Anne's County	25	8	65.7%	16.3	-20.0%	13.0	52.6%
29	21629	Denton	Caroline County	41	8	65.7%	26.7		26.7	65.7%
30	21601	Easton	Talbot County	80	8	65.7%	52.8		52.8	65.7%
31	21653	Newcomb	Talbot County	1	10	45.9%	0.5		0.5	45.9%
32	21654	Oxford	Talbot County	3	10	45.9%	1.4		1.4	45.9%
33	21663	Saint Michaels	Talbot County	10	10	45.9%	4.6		4.6	45.9%
34	21673	Trappe	Talbot County	10	10	45.9%	4.6		4.6	45.9%
35	21632	Federalsburg	Caroline County	31	10	45.9%	14.1		14.1	45.9%
36	21613	Cambridge	Dorchester County	147	11	66.7%	97.9		97.9	66.7%
37	21643	Hurlock	Dorchester County	38	11	66.7%	25.1		25.1	66.7%
38	21652	Neavitt	Talbot County	1	11	66.7%	0.7		0.7	66.7%
39	21631	East New Market	Dorchester County	14	11	66.7%	9.3		9.3	66.7%
40	21659	Rhodesdale	Dorchester County	7	11	66.7%	4.6		4.6	66.7%
41	21677	Woolford	Dorchester County	1	12	69.2%	0.7		0.7	69.2%
42	21869	Vienna	Dorchester County	2	12	69.2%	1.4		1.4	69.2%
	Service Area Total			**617**		**70.3%**	**434**		**419**	**67.9%**

Note (1): Reflects AAMC assumption that it will capture 20% of the market share of IP Psych discharges in Queen Anne's County

Source: Discharges are based on St. Paul statewide non-confidential data tapes
Source: Distance is determined using GoogleMaps

The adjusted market share of 67.9%, as presented in Table 11, is projected to decline slightly from fiscal year 2018 to 2024 as the population ages and UM SMC at Chestertown is expected to have a lower market share of psychiatric patients who are 65 and older than it will have for patients younger than the age of 65. When the psychiatric beds open at UM SMC at Chestertown in fiscal year 2022, UM SMC at Chestertown's market share of adult psychiatric patients throughout its expected service area is projected to equal 67.8% (Table 12).

Table 12
UM SMC at Chestertown's
Projected Adult Psychiatric Market Share
FY2018 - FY2024

	Actual	Projected						% Change
	FY2018	FY2019	FY2020	FY2021	FY2022	FY2023	FY2024	FY18-FY24
Market Share								
18-64	**69.6%**	**69.6%**	**69.6%**	**69.6%**	**69.6%**	**69.6%**	**69.6%**	
%Change		*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
65+	**56.5%**	**56.5%**	**56.5%**	**56.5%**	**56.5%**	**56.5%**	**56.5%**	
%Change		*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*	*0.0%*
Total	**67.9%**	**67.9%**	**67.9%**	**67.8%**	**67.8%**	**67.7%**	**67.7%**	
%Change		*-0.1%*	*-0.1%*	*-0.1%*	*-0.1%*	*-0.1%*	*-0.1%*	*-0.4%*

Source: Historical market shares are calculated based on discharge data obtained from the Maryalnd State non-confidential patient level data set

6. <u>UM SMC at Chestertown Discharges from the Service Area</u>

Driven by the aging of the population with lower use rates and market share, the projection of service area adult psychiatric discharges at UM SMC at Chestertown is projected to equal 413 discharges in fiscal year 2022 when the adult psychiatric beds open at UM SMC at Chestertown.

Table 13
UM SMC at Chestertown's
Projected Adult Psychiatric Discharges from the Service Area
FY2022 - FY2024

	Projected			% Change
	FY2022	FY2023	FY2024	FY22-FY24
UM SMC at Chestertown Service Area Discharges				
18-64	**366**	**365**	**364**	
%Change		*-0.3%*	*-0.3%*	*-0.5%*
65+	**47**	**48**	**49**	
%Change		*2.1%*	*2.1%*	*4.3%*
Total	**413**	**413**	**413**	
%Change		*0.0%*	*0.0%*	*0.0%*

7. <u>Out-of-Service Area Adult Psychiatric Discharges</u>

Out-of-service area adult psychiatric discharges are projected to equal 15% of the total adult psychiatric discharges at UM SMC at Chestertown.

8. Inpatient Adult Psychiatric Discharges at UM SMC at Chestertown

Combining discharges from outside of the service area with those within the service area results in a projection of adult psychiatric discharges at UM SMC at Chestertown that will remain relatively constant at 486 discharges in fiscal year 2022 when the psychiatric beds open at UM SMC at Chestertown (Table 14).

Table 14
UM SMC at Chestertown
Projected Adult Psychiatric Inpatient Discharges
FY2022 – FY2024

	Projected			% Change
	FY2022	FY2023	FY2024	FY22-FY24
UM SMC at Chestertown				
Total Psychiatric Discharges	**486**	**486**	**486**	
% Change		*0.0%*	*0.0%*	*0.0%*

9. UM SMC at Chestertown Adult Psychiatric Average Length of Stay

The average length of stay ("ALOS") of adult psychiatric patients at UM SMC at Chestertown is expected to remain constant at 7.0 days based on UM SMC at Dorchester's historical experience (Table 15).

Table 15
UM SMC at Dorchester
Historical Average Length of Stay

	Historical		
	FY2016	FY2017	FY2018
IP Psychiatric ALOS	**6.95**	**7.48**	**6.98**
% Change		*7.5%*	*-6.7%*

10. UM SMC at Chestertown Adult Psychiatric Occupancy

The adult psychiatric inpatient bed occupancy is projected at 80% which is consistent with the outdated State Health Plan for psychiatric services, COMAR 10.24.07, for psychiatric units with fewer than 20 beds (Need Projection Methodology (A)(7)).

11. UM SMC at Easton Chestertown Adult Psychiatric Bed Need

Applying the average length of stay to the projected discharges results in a projection of psychiatric patient days. Dividing the patient days by 365 days a year results in an average daily census (ADC) of 9.3 patients. Applying the occupancy assumption of 80% to the projected ADC results in a projected need to relocate twelve (12) adult psychiatric inpatient beds from

UM SMC at Dorchester to UM SMC at Chestertown beginning in fiscal year 2022 as demonstrated in Table 16.

Table 16
UM SMC at Dorchester and UM SMC at Chestertown
Projected Adult Psychiatric Bed Need
FY2022 – FY2024

	Projected			% Change
	FY2022	FY2023	FY2024	FY22-FY24
Discharges	**486**	**486**	**486**	
% Change		*0.0%*	*0.0%*	*0.0%*
Average Length of Stay	**7.0**	**7.0**	**7.0**	
% Change		*0.0%*	*0.0%*	*0.0%*
Patient Days	**3,402**	**3,402**	**3,402**	
% Change		*0.0%*	*0.0%*	*0.0%*
Average Daily Census	**9.3**	**9.3**	**9.3**	
% Change		*0.0%*	*0.0%*	*0.0%*
Occupancy	**80%**	**80%**	**80%**	
% Change		*0.0%*	*0.0%*	*0.0%*
Bed Need	**12**	**12**	**12**	
% Change		*0.0%*	*0.0%*	*0.0%*

AP 1b. A Certificate of Need applicant must document that it has complied with any delicensing requirements in the State Health Plan or in the Hospital Capacity Plan before its application will be considered.

Applicant Response:

This standard is inapplicable; there are no delicensing requirements applicable to the proposed project.

AP 1c. The Commission will not docket a Certificate of Need application for the "state hospital conversion bed need" as defined, unless the applicant documents written agreements with the Mental Hygiene Administration. The written agreements between the applicant and the Mental Hygiene Administration will specify:

(i) the applicant's agreement to screen, evaluate, diagnose and treat patients who would otherwise be admitted to state psychiatric hospitals. These patients will include: the uninsured and underinsured, involuntary, Medicaid and Medicare recipients;

(ii) that an equal or greater number of operating beds in state facilities which would have served acute psychiatric patients residing in the jurisdiction of the applicant hospital will be closed and delicensed, when the beds for the former state patients become operational;

(iii) that all patients seeking admission to the applicant's facility will be admitted to the applicant's facility and not be transferred to the state psychiatric hospital unless the applicant documents that the patient cannot be treated in its facility; and

(iv) that the applicant and the Mental Hygiene (MHA) Administration will be responsible for assuring financial viability of the services, including the payment of bad debt by DHMH as specified in the written agreement between MHA and the applicant.

Applicant Response:

This standard is inapplicable; the proposed project does not involve state hospital conversion beds.

AP 1d. Preference will be given to Certificate of Need applicants applying for the "net adjusted acute psychiatric bed need," as defined, who sign a written agreement with the Mental Hygiene Administration as described in part (i) and (iii) of Standard AP 1 c.

Applicant Response:

This standard is inapplicable.

AP 2a. All acute general hospitals with psychiatric units must have written procedures for providing psychiatric emergency inpatient treatment 24 hours a day, 7 days a week with no special limitation for weekends or late night shifts.

Applicant Response:

UM SMC at Chestertown is a 24/7 acute general hospital. The psychiatric services that will be provided at UM SMC at Chestertown will follow written procedures already implemented within UM SRH for providing psychiatric emergency inpatient services 24/7 with no special limitation for weekend or late night shifts. These policies are specific to psychiatric services that will be provided at UM SMC at Chestertown and include:

- Behavioral Health Response Team Inquiry Calls Policy (See **Exhibit 3**)

- Admission Criteria Adult Psychiatric Inpatient (See **Exhibit 4**)
- Assessment for Admission of Patients to Inpatient Behavioral Health Unit (See **Exhibit 5**)

Each of the psychiatric protocols, policies, and procedures referenced in this section will be updated as appropriate to reflect their application to UM SMC at Chestertown prior to the transfer of psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown.

AP 2b. Any acute general hospital containing an identifiable psychiatric unit must be an emergency facility, designated by the Department of Health and Mental Hygiene to perform evaluations of persons believed to have a mental disorder and brought in on emergency petition.

Applicant Response:

UM SMC at Chestertown is an acute general hospital with a 16-bay emergency department, including one room that is designated as a psychiatric holding area for psychiatric patients awaiting disposition. The facility is designated by the Maryland Department of Health to perform evaluations of persons believed to have a mental disorder and brought to the hospital on an emergency petition.

AP 2c. Acute general hospitals with psychiatric units must have emergency holding bed capabilities and a seclusion room.

Applicant Response:

UM SMC at Chestertown is an acute general hospital with a 16-bay emergency department, including one room that is designated as a psychiatric holding area for psychiatric patients awaiting disposition. Also, the renovated inpatient behavioral health unit at UM SMC at Chestertown will have a designated seclusion room.

AP 3a. Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response:

The inpatient acute psychiatric program provides an array of services. The services include psychotropic medication therapy, individual therapy, group therapy, family therapy, social services, and co-occurring addictions treatment. All services are provided by dedicated staff assigned to the unit. Recreational therapy activities are provided by psychiatric technicians and by community-based providers. Social services are provided by the social worker and case

management team dedicated to the behavioral health unit. Occupational and physical therapy services are provided on a consultative basis through the UM SRH Rehabilitation Department. If an inpatient behavioral health patient requires chemotherapy and continues to require inpatient care the patient would be transferred to the UM SMC at Easton inpatient unit for chemotherapy. If the patient is ready for discharge the patient will be referred to the UM SMC at Chestertown outpatient infusion center or to the UM SRH Cancer Center in Easton to receive outpatient services.

AP 3b. In addition to the services mandated in Standard 3a., inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Applicant Response:

This standard is inapplicable because UM SMC at Chestertown does not provide inpatient child or adolescent acute psychiatric services.

AP 3c. All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicant Response:

As is the case presently at UM SMC at Dorchester, psychiatric consultation services will be provided by UM SRH's Psychiatry Department. The department will be staffed by 4.0 FTE psychiatric providers comprised of psychiatrists and mental health nurse practitioners. Services are provided seven days per week. Additional consultation and referral services will be provided by the hospital's Behavioral Health Response Team, a group of licensed social workers and counselors who provide evaluation services and referral to patients.

AP 4a. A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

Applicant Response:

The Applicants propose to relocate UM SMC at Dorchester's existing adult psychiatric inpatient beds as part of this merger and consolidation request. They are not proposing to add child or adolescent psychiatric beds as part of this request.

AP 4b. Certificate of Need applicants proposing to provide two or more age specific acute psychiatric services must provide that physical separations and clinical/programmatic distinctions are made between the patient groups.

Applicant Response:

This standard is inapplicable because the proposed project does not involve two or more age-specific psychiatric service lines.

Accessibility

AP 5. Once a patient has requested admission to an acute psychiatric inpatient facility, the following services must be made available:

(i) intake screening and admission;

(ii) arrangements for transfer to a more appropriate facility for care if medically indicated; or

(iii) necessary evaluation to define the patient's psychiatric problem and/or

(iv) emergency treatment.

Applicant Response:

Once a patient has requested admission to UM SMC at Chestertown's behavioral health unit, the hospital will provide the following services: intake screening and admission or arrangements for transfer when a more appropriate treatment facility is indicated, and evaluation to better define the patient's psychiatric problem and to initiate emergency treatment. Currently, these functions are provided through the hospital's emergency department and psychiatry department. See **Exhibit 4** for UM SRH's Admission Criteria Adult Psychiatric Treatment Policy and **Exhibit 5** for UM SRH's Assessment for Admission of Patients to Inpatient Behavioral Health Unit, which provide more details on how these services will be provided at UM SMC at Chestertown.

AP 6. All hospitals providing care in designated psychiatric units must have separate written quality assurance programs, program evaluations and treatment protocols for special populations including: children, adolescents, patients with secondary diagnosis of substance use, and geriatric patients, either through direct treatment or referral.

Applicant Response:

As part of this merger and consolidation request, the Applicants are proposing to transfer UM SMC at Dorchester's general adult psychiatric unit to UM SMC at Chestertown. Within this general adult unit, geriatric and patients with a co-morbidity of substance use disorder will be treated. The treatment team will consist of psychiatrists, nurses, and therapists with training and expertise in geriatrics, substance use disorder, and general psychiatry.

UM SMC at Dorchester's present behavioral health quality assurance program and program evaluation process will be implemented at UM SMC at Chestertown. UM SMC at Dorchester's Behavioral Health Quality Assurance policy is attached as **Exhibit 6**. UM SMC at Dorchester's treatment protocols for special behavioral health populations, including for geriatric patients and patients with a secondary diagnosis of substance use disorder, will also be implemented at UM SMC at Chestertown. These treatment protocols are attached as **Exhibit 7.**

AP 7. An acute general or private psychiatric hospital applying for a Certificate of Need for new or expanded acute psychiatric services may not deny admission to a designated psychiatric unit solely on the basis of the patient's legal status rather than clinical criteria.

Applicant Response:

The Applicants do not seek a CON for new or expanded acute psychiatric services. Rather, they seek a CON exemption to relocate the current inpatient psychiatric services from UM SMC at Dorchester to UM SMC at Chestertown. Nevertheless, patients will be admitted to the Behavioral Health unit regardless of their legal status. Patients are accepted for admission based on their clinical presentation and the availability of beds in the inpatient psychiatric unit. See UM SRH's Assessments for Admission of Patients to Inpatient Behavioral Health Unit provided as **Exhibit 5**.

AP 8. All acute general hospitals and private freestanding psychiatric hospitals must provide a percentage of uncompensated care for acute psychiatric patients which is equal to the average level of uncompensated care provided by all acute general hospitals located in the health service area where the hospital is located, based on data available from the Health Services Cost Review Commission for the most recent 12 month period.

Applicant Response:

With the shift of cases from UM SMC at Dorchester, UM SMC at Chestertown intends to provide a level of uncompensated care that exceeds the average uncompensated care for acute general hospitals in the Eastern Shore health service area.

As presented in the State Health Plan for Psychiatric Services (COMAR 10.24.07), there are five health service areas in the State of Maryland. UM SMC at Chestertown is located in the health service area of the Eastern Shore which covers Dorchester, Talbot, Caroline, Kent, Queen Anne's, Cecil, Wicomico, Somerset and Worcester Counties. The acute general hospitals in this health service area include UM SMC at Dorchester, UM SMC at Chestertown, UM SMC at Easton, Peninsula Regional Medical Center, Atlantic General Hospital and Union Hospital of Cecil County. As published in the FY2018 HSCRC Annual Report of Revenue and Expenses and Volumes, UM SMC at Dorchester and UM SMC at Chestertown experienced uncompensated care of 5.60% and 5.25%, respectively, as a percentage of revenue.

The combined uncompensated care percentage of 5.41% for UM SMC at Dorchester and UM SMC at Chestertown is greater than the average 4.25% of uncompensated care provided by UM SMC at Dorchester, UM SMC at Chestertown, UM SMC at Easton, Peninsula Regional Medical Center, Atlantic General Hospital and Union Hospital of Cecil County, the six acute general hospitals in the health service area.[3] (Table 17).

Table 17
Health Service Area Uncompensated Care Percent of Revenue

Hospital	FY2018 UCC %
UM SMC at Dorchester	5.60%
UM SMC at Chestertown	5.25%
SHS Average	**5.41%**
UM SMC at Easton	3.59%
Peninsual Regional Medical Center	3.49%
Atlantic General Hospital	4.95%
Union Hospital of Cecil County	5.89%
Health Service Area Average	**4.25%**

Source: FY2018 HSCRC Annual Report of Revenue and Expenses and Volumes

[3] The Applicants did not include Edward W. McCready Memorial Hospital in Table 17 because McCready Hospital is seeking a CON exemption to convert the hospital to an FMF.

AP 9. If there are no child acute psychiatric beds available within a 45 minute travel time under normal road conditions, then an acute child psychiatric patient may be admitted, if appropriate, to a general pediatric bed. These hospitals must develop appropriate treatment protocols to ensure a therapeutically safe environment for those child psychiatric patients treated in general pediatric beds.

Applicant Response:

The pediatricians and the psychiatrists at UM SRH have developed treatment protocols for caring for pediatric psychiatric patients while they await transfer to another facility with pediatric inpatient bed capacity, which sometimes involves admission to a general pediatric bed. If pediatric patients are evaluated at UM SMC at Chestertown and are determined to be safely admitted to the UM SRH pediatric unit, the patients would be transferred to UM SMC at Easton Pediatric unit. Attached as **Exhibit 8** is a decision chart and a Pediatric Behavioral Policy, which describes the treatment protocol for pediatric psychiatric patients.

AP 10. Expansion of existing adult acute psychiatric bed capacity will not be approved in any hospital that has a psychiatric unit that does not meet the following occupancy standards for two consecutive years prior to formal submission of the application.

Psychiatric Bed Range (PBR)	Occupancy Standards
PBR <20	80%
20 ≤PBR <40	85%
PBR ≥40	90%

Applicant Response:

This standard is inapplicable because the proposed project does not involve expansion of existing adult care psychiatric beds.

AP 11. Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (≤ 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Applicant Response:

The standard is inapplicable because UM SMC at Chestertown is applying for an exemption to transfer existing adult psychiatric beds to another general acute care hospital.

Quality

AP 12a. Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicant Response:

The inpatient psychiatric services to be provided at UM SMC at Chestertown will be under the supervision of a qualified psychiatrist.

AP 12b. Staffing of acute psychiatric programs should include therapies for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven day per week treatment program.

Applicant Response:

The staffing models in the relocated inpatient psychiatric unit would remain the same as the models in the unit at UM SMC at Dorchester.

A psychiatrist or mental health nurse practitioner is provided for each patient in the unit. Each patient is assigned to a therapist and a case manager who helps with coordination of services and referrals. See **Exhibit 9** for UM SRH's Behavioral Health Discharge Planning and Referral Policy, which provides additional information on the required Patient Care Services team, which provides referral and coordination services for patients being discharged from its behavioral health unit.

The treatment programs cover a seven day period. Staffing for this unit is also provided seven days per week.

AP 12c. Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Applicant Response:

This standard is inapplicable because the proposed project does not involve child or adolescent psychiatric units.

AP 13. Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicant Response:

Attached as **Exhibit 9** is UM SRH's Behavioral Health Discharge Planning and Referral Policy, which governs discharge planning and referrals for patients being discharged from the behavioral health unit. This policy includes providing patients referrals and coordinating other services as needed, including: outpatient psychiatric treatment, community based programming, long term care, and other specialized inpatient care or referrals.

Acceptability

AP 14. Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);

(ii) the local community mental health center(s);

(iii) the Department of Health and Mental Hygiene; and

(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Applicant Response:

This standard is inapplicable because UM SRH is not proposing a new or expanded program.

E. THE RELOCATION OF INPATIENT PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN WILL RESULT IN THE DELIVERY OF MORE EFFICIENT AND EFFECTIVE HEALTH CARE SERVICES.

The relocation of UM SMC at Dorchester's psychiatric beds to UM SMC at Chestertown will result in more efficient and effective delivery of health care services.

Operational efficiencies will result from the relocation of psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown because altering the behavioral health unit to a unit that is right-sized to serve the reduced average daily census of behavioral health patients that are currently being served at UM SMC at Dorchester will result in operational efficiencies.

Consolidating UM SMC at Dorchester's inpatient services at UM SMC at Easton and UM SMC at Chestertown, as well as moving UM SMC at Dorchester's outpatient services to the proposed UM SMC at Cambridge, will result in the same staffing efficiencies that were projected in connection with the Dorchester-Easton Exemption.

As part of the proposed relocation of inpatient services to UM SMC at Chestertown, important outpatient behavioral health services provided by UM SRH, such as the intensive outpatient program and the bridge clinic will continue to be located in Dorchester County and will be expanded to Kent County and Talbot county, thereby increasing access to these important services to additional locations, to help successfully transition discharged behavioral health patients back to their families, communities and services located close to their homes. The expansion of UM SRH outpatient behavioral health services to new locations, along with the location of services to the northern segment of UM SRH's service area in Chestertown, will expand behavioral health outpatient coverage for the region, including for residents in the northern portion of Queen Anne's County as well as the eastern and southern areas of Caroline County.

Additionally, the relocation of inpatient behavioral health services and the expansion of intensive outpatient and bridge clinic services throughout the entire region will stimulate the development of related collaborative programs, such as outpatient therapy centers, clinics and providers, school based programs, primary care provider integration, public health initiatives, transitional housing and services for the homeless. Discussions with agencies, organizations and primary care providers, conducted as part of UM SRH 2016 Service Delivery Plan, indicate that this array of community services and their integration into the coordinated care of behavioral health patients—whether discharged from an inpatient facility or not—is far more important to successful treatment than the location of an inpatient facility.

Transportation for inpatients and families will support the relocated service, with patient transports from regional emergency departments provided by the health system through contractual interfacility transport services, not jurisdictional EMS, for behavioral health patients admitted from regional UM SRH emergency departments. Family transportation for care participation and coordination will be coordinated by the care transitions team, taking advantage of resources including vouchers for private transportation, public transportation, volunteer transportation services and with the stated financial support from the Chester River Health Foundation for a special transportation grant serving the regional needs of families and patients during the inpatient admission. This is especially important as a previously identified need regardless of the inpatient location.

Further, the relocation of behavioral health inpatient beds to Chestertown supports progress on plans for a proposed new regional medical center in Easton by reducing costs of the project through relocation of the behavioral health unit from the facility. The need to replace the aged hospital on Washington Street in Easton has been well-documented and has been a part of the health system's service delivery planning for more than eight years.

F. THE RELOCATION OF INPATIENT PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN IS IN THE PUBLIC INTEREST.

Upon the proposed conversion of UM SMC at Dorchester to an FMF, it will be necessary to relocate MSGA and psychiatric beds in order to continue providing adequate access to these

services for residents of the service area. Accordingly, as SHS demonstrated previously in connection with the FMF Exemption and the Dorchester-Easton Exemption, the proposed consolidation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton and the psychiatric beds to UM SMC at Chestertown is necessary *in conjunction* with the conversion of UM SMC at Dorchester to an FMF and are in the public interest based on an assessment of the long-term viability of UM SMC at Dorchester as a general hospital through addressing such matters as: (i) trends in the hospital's inpatient utilization for the previous five years in the context of statewide trends; (ii) the financial performance of the hospital over the past five years and in the context of the statewide financial performance of Maryland hospitals; (iii) the age of the physical plant relative to other Maryland hospitals and the investment required to maintain and modernize the physical plant; (iv) the availability of alternative sources for acute care inpatient services; (v) the adequacy and appropriateness of the hospital's transition plan; and (vi) an assessment of the parent hospital's projected financial performance or the projected financial performance of the parent hospital and other health care facilities that share a global budget with the parent hospital.

Moreover, the relocation of psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown is in the public interest based on the considerations discussed below. The Applicants will provide letters of support from affected parties at a later date.

1. *The Relocation of Psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown is in the Public Interest Based on the Need to Support the Continued Viability of UM SMC at Chestertown.*

The relocation of the UM SMC at Dorchester inpatient psychiatric beds to Chestertown is in the public interest because it will support the continued viability of UM SMC at Chestertown as an important health care facility serving residents in the northern portion of the mid-Shore region. In the UM SRH Service Delivery Planning Process (2016), the Rural Study White Paper (2017), the Community Health Needs Assessment (2019), and the Strategic Planning Medical Staff Survey (2019), the access to inpatient beds for specific lengths of stay at the hospital in Chestertown was deemed to be necessary and strategically important for the health status of Kent and Queen Anne's counties' populations and to the communities there, which are extremely rural and economically vulnerable.

Also, Chestertown is home to a large retirement population as a destination for retirement from outside the region. It has several independent nursing homes as well as a large and successful Continuing Care Retirement Community, which has grown up and prospered as a result of being close to the available inpatient hospital. As the only acute general hospital in the State of Maryland that is more than 35 miles from the nearest hospital,[4] UM SMC at Chestertown would qualify as a critical access hospital in states where that designation is recognized. The hospital is critical to delivering needed health care in Kent County and the rural region, as well as to supporting the seasonal health care needs brought by Washington College, by tourism and by the agricultural industry. UM SMC at Chestertown is among the top three employers in Kent County, a county with few employment opportunities. With the well documented impact of economic wellbeing upon individual health, the impact of the hospital as an inpatient facility cannot be minimized.

[4] McCready Hospital in Somerset County is seeking a CON exemption to convert the hospital to an FMF.

Additionally, the relocation of inpatient behavioral health beds to UM SMC at Chestertown is projected to create additional positive net income of approximately one million dollars annually to support UM SRH regional health care services. The additional bed supply and related revenue will positively affect the cost effective continuation of support services necessary to an inpatient facility, such as food and nutrition services, housekeeping, facilities, medical information services, care transition, across a broader base of patients throughout the hospital.

2. *The Relocation of Psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown is in the Public Interest Based on the Capital Expenditure Savings that will be Realized.*

Implementing the Dorchester-Easton Exemption likely will require moving the inpatient behavioral health unit twice – once to the existing UM SMC at Easton hospital facility and then again when UM SMC at Easton is replaced and relocated pursuant to a pending CON application. Relocating inpatient behavioral health services to UM SMC at Chestertown, rather than to UM SMC at Easton (as approved in the Dorchester-Easton Exemption), will create capital cost savings of approximately $4.3 million in capital costs by avoiding adding these costs to the proposed new hospital in Easton. UM SRH estimates that eliminating the inpatient behavioral health unit from the proposed hospital will save $4.3 million.

3. *The Relocation of Psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown is in the Public Interest Taking into Consideration the Alternative Sources for Inpatient Psychiatric Services That Will no Longer be Provided at UM SMC at Dorchester After Conversion to a Freestanding Medical Facility.*

The Applicants request an exemption from CON review to merge and consolidate UM SMC at Dorchester's psychiatric inpatient services with UM SMC at Chestertown in order to ensure continued access to these services for residents currently served by UM SMC at Dorchester. As shown in the Applicants' need analysis above, most of the inpatient psychiatric discharges at UM SMC at Dorchester are expected to shift to UM SMC at Chestertown. The Applicants are proposing to transfer 12 psychiatric beds to UM SMC at Chestertown to accommodate these psychiatric patients.

4. *Plan for Transitioning of Acute Care Services Previously Provided at UM SMC at Dorchester*

Renovations for the relocation of MSGA and psychiatric beds from UM SMC at Dorchester, the beds will be operational, and staff transitions will be complete at the time of the conversion of UM SMC Dorchester to an FMF in 2021 to make a seamless transition.

Patients who arrive at UM SMC at Cambridge in need of behavioral health services will continue to receive the same emergency assessment and care as are presently provided at UM SMC at Dorchester, including assessment by the Behavioral Health Response Team ("BHRT") and consultation with psychiatrists and clinicians, via telemedicine where appropriate. The FMF will have an intensive outpatient behavioral health program for adult patients and additional outpatient behavioral health services will be located in the UM SMP at Cambridge. Patients who need adult inpatient behavioral health services will, appropriate to their needs and preferences, be transferred to the inpatient adult behavioral health unit at UM SMC at Chestertown.

5. *The Relocation of MSGA beds from UM SMC at Dorchester to UM SMC at Easton is in the Public Interest Based on an Assessment of SHS's Projected Financial Performance.*

The operating profits of UM SMC at Chestertown will benefit from a positive financial contribution from the shift of inpatient beds from UM SMC at Dorchester. As shown in Table H, the UM SRH hospitals, which includes UM SMC at Chestertown, UM SMC at Easton, UM SMC at Dorchester through fiscal year 2021 and UM SMC at Cambridge in fiscal year 2022 through 2024, will generate positive operating income throughout the entire projection period.

II. REQUEST TO MODIFY THE EXISTING DORCHESTER-EASTON EXEMPTION

Provided the Commission approves the Applicants' request for exemption from CON review to relocate 12 psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown, as set forth above, SHS requests that the Commission also modify the existing Dorchester-Easton Exemption to remove the relocation of 12 psychiatric beds from that approval, leaving only the relocation of 17 MSGA beds.

If the modification is approved, minimal capital expenditures will be needed at UM SMC at Easton. The configuration of the physical space of the hospital will remain as it exists today, and UM SMC at Easton will simply upgrade some rooms to activate existing physical beds. The total cost of these upgrades is estimated not to exceed $500,000.

CONCLUSION

For all of the reasons set forth above, the Applicant respectfully requests that the Commission: (1) authorize the merger and consolidation inpatient psychiatric beds from UM SMC at Dorchester to UM SMC at Chestertown and associated capital expenditures; and (2) modify the existing Dorchester-Easton Exemption to remove the relocation of 12 psychiatric beds and the associated capital costs.

Table of Exhibits

Table of Tables

Table of Figures

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

September 3, 2019
Date

Robert Frank, MBA
Senior Regional Vice President,
Operations
UM Shore Regional Health

#632157
012516-0006

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

September 3, 2019
Date

Patti L. Willis

Patti Willis
Senior Vice President, Strategy & Communications
UM Shore Regional Health

#632158
012516-0006

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

September 3, 2019
Date

Ruth Ann Jones

Ruth Ann Jones, Ed.D., MSN, RN, NEA-BC
Senior Vice President, Patient Care Services and Chief Nursing Officer
UM Shore Regional Health

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

September 3, 2019
Date

JoAnne Hahey
Chief Financial Officer
UM Shore Regional Health

#632160
012516-0006

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

September 3, 2019
Date

Darryl Mealy
Vice President of Construction and
Facilities Planning
University of Maryland Medical System

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

September 3, 2019
Date

David Watts
Architect
Marshall Craft Associates

#673932
012516-0006

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

September 3, 2019
Date

Andrew L. Solberg
A.L.S. Healthcare Consultant Services

#632153
012516-0006

EXHIBIT 1

Name of Applicant:	Shore Health System, Inc. + University of Maryland Shore Regional Health, Inc.
Date of Submission:	6-Sep-19

Applicants should follow additional instructions included at the top of each of the following worksheets. Please ensure all green fields (see above) are filled.

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

TABLE 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: 7/1/2019_	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*					0	0	**General Medical/Surgical***				0	0
	2nd Floor	8	20	4	24	28		2nd Floor	20	4	24	28
	3rd Floor	0	10	3	13	16					0	0
					0	0					0	0
					0	0					0	0
SUBTOTAL Gen. Med/Surg*		**8**	**30**	**7**	**37**	**44**	**SUBTOTAL Gen. Med/Surg***		**20**	**4**	**24**	**28**
ICU/CCU		**4**	4		4	4	**ICU/CCU**		4	0	4	4
Other *(Specify/add rows as needed)*					0	0					0	0
TOTAL MSGA		**12**	**34**	**7**	**41**	**48**	**TOTAL MSGA**		**24**	**4**	**28**	**32**
Obstetrics					0	0	**Obstetrics**				0	0
Pediatrics					0	0	**Pediatrics**				0	0
Psychiatric					0	0	**Psychiatric**	3rd Floor	12	0	12	12
TOTAL ACUTE		**12**	**34**	**7**	**41**	**48**	**TOTAL ACUTE**		**36**	**4**	**40**	**44**
NON-ACUTE CARE							**NON-ACUTE CARE**					
Dedicated Observation**					0	0	**Dedicated Observation****				0	0
Rehabilitation					0	0	**Rehabilitation**				0	0
Comprehensive Care					0	0	**Comprehensive Care**				0	0
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*				0	0
TOTAL NON-ACUTE							**TOTAL NON-ACUTE**					
HOSPITAL TOTAL		**12**	**34**	**7**	**41**	**48**	**HOSPITAL TOTAL**		**36**	**4**	**40**	**44**

* 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 E. PROJECT BUDGET

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

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

	Hospital Building	Other Structure	Total
A. USE OF FUNDS			
1. CAPITAL COSTS			
a. New Construction			
(1) Building			$0
(2) Fixed Equipment			$0
(3) Site and Infrastructure			$0
(4) Architect/Engineering Fees			$0
(5) Permits (Building, Utilities, Etc.)			$0
SUBTOTAL	**$0**	**$0**	**$0**
b. Renovations			
(1) Building	$3,200,000		$3,200,000
(2) Fixed Equipment (not included in construction)			$0
(3) Architect/Engineering Fees	$500,068		$500,068
(4) Permits (Building, Utilities, Etc.)	$9,143		$9,143
SUBTOTAL	**$3,709,211**	**$0**	**$3,709,211**
c. Other Capital Costs			
(1) Movable Equipment	$515,282		$515,282
(2) Contingency Allowance	$510,168		$510,168
(3) Gross interest during construction period			$0
(4) Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$1,025,450***	***$0***	**$1,025,450**
TOTAL CURRENT CAPITAL COSTS	**$4,734,661**	**$0**	**$4,734,661**
d. *Land Purchase*			
e. Inflation Allowance	$152,721		$152,721
TOTAL CAPITAL COSTS	**$4,887,382**	**$0**	**$4,887,382**
2. Financing Cost and Other Cash Requirements			
a. Loan Placement Fees			$0
b. Bond Discount			$0
c CON Application Assistance			
c1. Legal Fees	**$41,143**		$41,143
c2. Other (Specify/add rows if needed)	**$18,286**		$18,286
d. Non-CON Consulting Fees			
d1. Legal Fees			$0
d2. Other (Specify/add rows if needed)			$0
e. Debt Service Reserve Fund			$0
f Other *(Specify/add rows if needed)*			$0
SUBTOTAL	***$59,429***	***$0***	**$59,429**
3. Working Capital Startup Costs			$0
TOTAL USES OF FUNDS	***$4,946,810***	***$0***	***$4,946,810***
B. Sources of Funds			
1. Cash	**$4,946,810**		$4,946,810
2. Philanthropy (to date and expected)			$0
3. Authorized Bonds			$0
4. Interest Income from bond proceeds listed in #3			$0
5. Mortgage			$0
6. Working Capital Loans			$0
7. Grants or Appropriations			
a. Federal			$0
b. State			$0
c. Local			$0
8. Other *(Specify/add rows if needed)*			$0
TOTAL SOURCES OF FUNDS	***$4,946,810***		**$4,946,810**
	Hospital Building	***Other Structure***	***Total***
Annual Lease Costs (if applicable)			
1. Land			$0
2. Building			$0
3. Major Movable Equipment			$0
4. Minor Movable Equipment			$0
5. Other *(Specify/add rows if needed)*			$0

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

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - SHORE HEALTH SYSTEM

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

	Three 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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. DISCHARGES									
a. General Medical/Surgical*	9,191	9,354	7,834	7,369	7,410	7,452	7,184	7,228	7,273
b. ICU/CCU	326	495	498	484	486	487	479	480	482
Total MSGA	**9,517**	**9,849**	**8,332**	**7,853**	**7,895**	**7,939**	**7,663**	**7,708**	**7,754**
c. Pediatric	125	106	77	76	76	75	75	74	74
d. Obstetric	1,050	1,057	1,092	1,118	1,144	1,171	1,199	1,227	1,256
e. Acute Psychiatric	642	549	556	551	551	552	486	486	486
Total Acute	***11,334***	***11,561***	***10,057***	***9,598***	***9,667***	***9,738***	***9,423***	***9,496***	***9,570***
f. Rehabilitation	344	357	353	357	362	366	371	376	381
g. Comprehensive Care	0	0	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0	0
TOTAL DISCHARGES	***11,678***	***11,918***	***10,410***	***9,956***	***10,029***	***10,104***	***9,794***	***9,871***	***9,951***
2. PATIENT DAYS									
a. General Medical/Surgical*	38,131	40,394	32,426	30,160	29,700	29,878	28,696	28,876	29,063
b. ICU/CCU	2,381	2,236	1,946	1,728	1,697	1,706	1,680	1,690	1,701
Total MSGA	**40,512**	**42,630**	**34,372**	**31,888**	**31,397**	**31,585**	**30,377**	**30,567**	**30,764**
c. Pediatric	292	245	179	178	177	175	174	173	172
d. Obstetric	2,513	2,570	2,698	2,762	2,827	2,893	2,961	3,031	3,104
e. Acute Psychiatric	4,465	4,106	3,880	3,844	3,848	3,851	3,402	3,402	3,402
Total Acute	***47,782***	***49,551***	***41,129***	***38,672***	***38,248***	***38,505***	***36,914***	***37,173***	***37,441***
f. Rehabilitation	3,567	3,394	3,455	3,499	3,542	3,588	3,634	3,682	3,731
g. Comprehensive Care	0	0	0	0	0	0	0	0	0
h. Other (Specify/add rows of needed)	0	0	0	0	0	0	0	0	0
TOTAL PATIENT DAYS	***51,349***	***52,945***	***44,584***	***42,171***	***41,790***	***42,093***	***40,548***	***40,855***	***41,172***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - SHORE HEALTH SYSTEM

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

	Three 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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	4.1	4.3	4.1	4.1	4.0	4.0	4.0	4.0	4.0
b. ICU/CCU	7.3	4.5	3.9	3.6	3.5	3.5	3.5	3.5	3.5
Total MSGA	4.3	4.3	4.1	4.1	4.0	4.0	4.0	4.0	4.0
c. Pediatric	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3	2.3
d. Obstetric	2.4	2.4	2.5	2.5	2.5	2.5	2.5	2.5	2.5
e. Acute Psychiatric	7.0	7.5	7.0	7.0	7.0	7.0	7.0	7.0	7.0
Total Acute	4.2	4.3	4.1	4.0	4.0	4.0	3.9	3.9	3.9
f. Rehabilitation	10.4	9.5	9.8	9.8	9.8	9.8	9.8	9.8	9.8
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	4.4	4.4	4.3	4.2	4.2	4.2	4.1	4.1	4.1
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*	118	118	113	100	98	99	97	98	98
b. ICU/CCU	22	22	22	22	22	22	17	17	17
Total MSGA	**140**	**140**	**135**	**122**	**120**	**121**	**114**	**115**	**115**
c. Pediatric	8	8	8	1	1	1	1	1	1
d. Obstetric	17	17	17	11	11	11	12	12	12
e. Acute Psychiatric	24	24	24	12	12	12	12	12	12
Total Acute	***189***	***189***	***184***	***146***	***144***	***145***	***139***	***140***	***140***
f. Rehabilitation	20	20	20	13	13	13	13	13	14
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***209***	***209***	***204***	***159***	***157***	***158***	***152***	***153***	***154***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY - SHORE HEALTH SYSTEM

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

	Three 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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	88.5%	93.8%	78.6%	82.6%	82.8%	82.9%	80.9%	81.0%	81.0%
b. ICU/CCU	29.6%	27.8%	24.2%	21.5%	21.1%	21.3%	27.1%	27.2%	27.4%
Total MSGA	**79.3%**	**83.4%**	**69.8%**	**71.6%**	**71.5%**	**71.7%**	**72.9%**	**73.0%**	**73.1%**
c. Pediatric	10.0%	8.4%	6.1%	50.0%	50.0%	50.0%	50.0%	50.0%	50.0%
d. Obstetric	40.5%	41.4%	43.5%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%
e. Acute Psychiatric	51.0%	46.9%	44.3%	87.8%	87.8%	87.9%	77.7%	77.7%	77.7%
Total Acute	**69.3%**	**71.8%**	**61.2%**	**72.6%**	**72.6%**	**72.8%**	**72.9%**	**73.0%**	**73.1%**
f. Rehabilitation	48.9%	46.5%	47.3%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**67.3%**	**69.4%**	**59.9%**	**72.8%**	**72.8%**	**72.9%**	**73.1%**	**73.2%**	**73.3%**
6. OUTPATIENT VISITS									
a. Emergency Department (IP and OP)	87,353	82,686	96,603	96,270	96,401	96,532	96,664	96,795	96,927
b. Same-day Surgery OP Visits	6,271	5,890	5,659	5,351	5,356	5,361	5,015	5,020	5,025
c. Laboratory OP RVUs	5,844,288	5,693,445	5,476,007	5,437,549	5,444,105	5,450,671	5,457,248	5,463,835	5,470,433
d. Imaging OP RVUs	1,050,939	1,046,787	1,738,096	1,742,283	1,744,267	1,746,254	1,748,243	1,750,236	1,752,233
e. MRI OP RVUs	43,202	41,020	163,575	160,007	160,178	160,350	160,521	160,693	160,866
f. Infusion Visits	-	207	202	202	203	203	203	204	204
g. Pulmonary Rehab Visits	-	238	264	264	265	265	266	266	267
h. Cardiac Rehab Visits	-	286	392	393	393	394	394	395	396
TOTAL OUTPATIENT VISITS	***7,032,053***	***6,870,559***	***7,480,798***	***7,442,320***	***7,451,168***	***7,460,030***	***7,468,555***	***7,477,445***	***7,486,349***
7. OBSERVATIONS**									
a. Number of Patients	2,950	3,126	3,850	3,717	3,736	3,756	3,776	3,797	3,818
b. Hours	109,049	131,961	129,672	122,165	123,052	123,953	115,655	116,408	117,173

* 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 - SHORE HEALTH SYSTEM + CHESTERTOWN

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 153,847	$ 146,666	138,273	138,142	138,142	142,328	142,328	142,328
b. Outpatient Services	218,119	235,341	232,678	232,775	232,775	228,481	228,343	228,209
Gross Patient Service Revenues	**371,966**	**382,007**	**370,951**	**370,917**	**370,917**	**370,809**	**370,671**	**370,537**
c. Allowance For Bad Debt	-	10,489	10,030	9,999	9,999	10,569	10,569	10,569
d. Contractual Allowance	78,994	66,361	67,369	69,613	69,613	71,011	71,011	71,011
e. Charity Care	-	3,980	3,958	3,954	3,954	3,794	3,794	3,794
Net Patient Services Revenue	**292,972**	**301,177**	**289,594**	**287,350**	**287,350**	**285,435**	**285,298**	**285,163**
f. Other Operating Revenues (Specify/add rows if needed)	4,979	5,156	5,833	5,195	5,195	5,195	5,195	5,195
NET OPERATING REVENUE	**$ 297,951**	**$ 306,333**	**$ 295,427**	**$ 292,545**	**$ 292,545**	**$ 290,630**	**$ 290,493**	**$ 290,358**
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 139,010	$ 127,170	$ 130,463	$ 128,270	$ 128,142	$ 122,555	$ 123,268	$ 124,001
b. Professional Fees	16,919	17,785	17,946	17,416	17,416	17,100	17,090	17,080
c. Interest on Current Debt	3,135	3,740	4,171	4,141	4,098	4,048	3,998	3,949
d1. Interest on Project Debt - FMF	-	-	-	-	-	1,917	1,884	1,849
d2. Interest on Project Debt - MOB	-	-	-	-	-	1,185	1,166	1,146
d3. Interest on Project Debt - Easton	-	-	-	-	-	-	-	-
d4. Interest on Project Debt - Chestertown Psych	-	-	-	-	-	-	-	-
e. Current Depreciation	22,314	22,232	23,407	22,755	21,895	18,474	17,503	16,563
f1. Project Depreciation - FMF	-	-	-	-	-	1,812	1,848	1,885
f2. Project Depreciation - MOB	-	-	-	-	-	1,218	1,232	1,247
f3. Project Depreciation - Easton	-	-	-	-	-	21	21	21
f4. Project Depreciation - Chestertown Psych	-	-	-	-	-	220	220	220
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	44,339	44,263	43,297	43,637	43,911	43,323	43,599	43,882
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	53,886	59,346	65,263	65,088	65,268	75,198	75,400	75,607
k. Fixed Cost Additions	-	-	5,438	1,629	1,808	3,509	3,509	3,509
TOTAL OPERATING EXPENSES	**$ 279,603**	**$ 274,536**	**$ 289,985**	**$ 282,936**	**$ 282,538**	**$ 290,581**	**$ 290,738**	**$ 290,959**

TABLE G. REVENUES & EXPENSES, UNINFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM + CHESTERTOWN

INSTRUCTION: Complete this table for the entire facility, including the proposed project. Table G should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table F and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
3. INCOME								
a. Income From Operation	**$ 18,348**	**$ 31,796**	**$ 5,442**	**$ 9,610**	**$ 10,007**	**$ 49**	**$ (246)**	**$ (601)**
b. Non-Operating Income/Expense	$ 9,159	$ 8,013	$ 2,707	$ 2,707	$ 2,707	$ 2,707	$ 2,707	$ 2,707
SUBTOTAL	**$ 27,507**	**$ 39,809**	**$ 8,149**	**$ 12,317**	**$ 12,714**	**$ 2,756**	**$ 2,461**	**$ 2,106**
c. Income Taxes								
NET INCOME (LOSS)	**$ 27,507**	**$ 39,809**	**$ 8,149**	**$ 12,317**	**$ 12,714**	**$ 2,756**	**$ 2,461**	**$ 2,106**
4. PATIENT MIX								
a. Percent of Total Charges								
1) Medicare	54.7%	54.7%	54.7%	54.7%	54.7%	54.7%	54.7%	54.7%
2) Medicaid	20.6%	20.6%	20.6%	20.6%	20.6%	20.6%	20.6%	20.6%
3) Blue Cross	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%
4) Commercial Insurance	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self-pay	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
6) Other	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
TOTAL	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**
b. Percent of Patient Days								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	20.3%	20.3%	20.3%	20.3%	20.3%	20.3%	20.3%	20.3%
3) Blue Cross	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
4) Commercial Insurance	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
5) Self-pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
6) Other	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
TOTAL	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**100.0%**

Table G –
Key Financial Projection Assumptions for UM Shore Health System + Chestertown (Does not include HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the UM Shore Health System (SHS) FY2018 actual financial performance and Chestertown FY2020 budget with assumptions identified below. SHS includes Memorial Hospital at Easton, Dorchester General Hospital and Queen Anne's Emergency Center. The assumptions listed below only apply to services regulated by the HSCRC.	
Projection period reflects FY2019 – FY2024 for SHS and FY2020 - FY2024 for Chestertown	
Volumes	- Refer to historical and projected utilization in Table F
Patient Revenue • Gross Charges	
o Update Factor	- 0.00% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.00% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.00% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with outpatient services shifted to the FMF and inpatient MSG services shifted to Easton in FY2022 - 100% variable cost factor associated with regulated inpatient psych services shifted from Dorchester General Hospital to the SMC at Chestertown in FY2022 - 50% variable cost factor associated with the loss of volumes to other providers
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $4.1M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense - Remainder of SHS's Retained Revenue will be apportioned to Memorial Hospital of Easton to fund ambulatory and physician network development and population health initiatives
• Revenue Deductions	- Continuation of FY2018 for SHS and budget FY2020 for Chestertown deductions from revenue (contractual allowances, denials, charity, bad debts, assessments, UCC pool receipts) as percentages of gross revenue - Beginning in FY2022 for the services located in the FMF, deductions from revenue is based off historical actual results by service line and held constant throughout the remainder of the projection period
Other Operating Revenue	Remains constant from FY2018 for SHS and FY2020 budget for Chestertown

Expenses	
• Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 0.0% weighted average annual increase that reflects the following: - 0.0% - 0.0% - 0.0% - 0.0% - 0.0%
• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	 - 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- No incremental building operating costs (utilities, housekeeping, maintenance, security) associated with shift of psych services to Chestertown - Incremental building operating costs (utilities, housekeeping, maintenance, security) calculated for the FMF's new square feet
• Interest Expense	
o Existing Debt	- Continued amortization of existing debt and related interest expense
o Project Debt	- Amortization of the following debt issuance over 30 years at 5.0% - $38.5M for construction of the new FMF - $21.9M for construction of a new MOB
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment - 7 year useful life for routine capital expenditures
• Additional Incremental Expenses	- New expenses related to EPIC implementation ($5 million in fiscal year 2019), physician contracting and other strategic initiatives as follows: - $5.4M in FY2019 - $1.6M in FY2020 - $1.8M in FY2021 - $3.5M in FY2022 - FY2024 - The retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of Dorchester to an FMF, will enable SHS to fund $8.9M of initiatives related to ambulatory and physician network development and population health initiatives.
Non-Operating Income/Expense	- Includes $2.4M of investment income with 0.0% investment earnings rate. Non-operating expenses were not assumed over the projection period to the unpredictability of this expense

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM + CHESTERTOWN

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.

	Most Recent Year (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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 153,847	$ 146,666	$ 141,647	$ 144,966	$ 148,503	$ 156,736	$ 160,560	$ 164,478
b. Outpatient Services	218,119	235,341	238,355	244,273	250,233	251,610	257,594	263,724
Gross Patient Service Revenues	***371,966***	***382,007***	***380,003***	***389,239***	***398,736***	***408,346***	***418,155***	***428,202***
c. Allowance For Bad Debt	-	10,489	10,275	10,493	10,749	11,639	11,923	12,214
d. Contractual Allowance	78,994	66,361	69,013	73,052	74,834	78,200	80,108	82,062
e. Charity Care	-	3,980	4,055	4,150	4,251	4,178	4,280	4,384
Net Patient Services Revenue	***292,972***	***301,177***	***296,660***	***301,544***	***308,902***	***314,330***	***321,844***	***329,542***
f. Other Operating Revenues (Specify/add rows if needed)	4,979	5,156	5,833	5,195	5,195	5,195	5,195	5,195
NET OPERATING REVENUE	***$ 297,951***	***$ 306,333***	***$ 302,493***	***$ 306,739***	***$ 314,097***	***$ 319,525***	***$ 327,039***	***$ 334,737***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 139,010	$ 127,170	$ 133,464	$ 134,238	$ 137,189	$ 134,225	$ 138,111	$ 142,128
b. Professional Fees	16,919	17,785	18,413	18,334	18,810	18,949	19,430	19,924
c. Interest on Current Debt	3,135	3,740	4,171	4,141	4,098	4,048	3,998	3,949
d1. Interest on Project Debt - FMF	-	-	-	-	-	1,917	1,884	1,849
d2. Interest on Project Debt - MOB						1,185	1,166	1,146
d3. Interest on Project Debt - Easton						-	-	-
d4. Interest on Project Debt - Chestertown Psych						-	-	-
e. Current Depreciation	22,314	22,232	23,407	22,755	21,895	18,474	17,503	16,563
f1. Project Depreciation - FMF						1,812	1,848	1,885
f2. Project Depreciation - MOB						1,218	1,232	1,247
f3. Project Depreciation - Easton						21	21	21
f4. Project Depreciation - Chestertown Psych						220	220	220
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	44,339	44,263	44,596	46,294	47,983	48,761	50,543	52,398
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	53,886	59,346	66,568	67,717	69,262	81,397	83,248	85,146
k. Fixed Cost Additions	-	-	5,438	1,629	1,808	3,509	3,509	3,509
TOTAL OPERATING EXPENSES	**$ 279,603**	**$ 274,536**	**$ 296,057**	**$ 295,109**	**$ 301,046**	**$ 315,736**	**$ 322,714**	**$ 329,984**

TABLE H. REVENUES & EXPENSES, INFLATED - ENTIRE FACILITY - SHORE HEALTH SYSTEM + CHESTERTOWN

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.

	Most Recent Year (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	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
3. INCOME								
a. Income From Operation	**$ 18,348**	**$ 31,796**	**$ 6,436**	**$ 11,631**	**$ 13,051**	**$ 3,789**	**$ 4,326**	**$ 4,753**
b. Non-Operating Income/Expense	9,159	8,013	2,707	2,761	2,816	2,873	2,930	2,989
SUBTOTAL	***$ 27,507***	***$ 39,809***	***$ 9,143***	***$ 14,392***	***$ 15,868***	***$ 6,662***	***$ 7,256***	***$ 7,742***
c. Income Taxes								
NET INCOME (LOSS)	***$ 27,507***	***$ 39,809***	***$ 9,143***	***$ 14,392***	***$ 15,868***	***$ 6,662***	***$ 7,256***	***$ 7,742***
4. PATIENT MIX								
a. Percent of Total Charges								
1) Medicare	54.7%	54.7%	54.7%	54.7%	54.7%	54.7%	54.7%	54.7%
2) Medicaid	20.6%	20.6%	20.6%	20.6%	20.6%	20.6%	20.6%	20.6%
3) Blue Cross	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%	8.1%
4) Commercial Insurance	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%	13.9%
5) Self-pay	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%	1.2%
6) Other	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%	1.4%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days								
Total MSGA								
1) Medicare	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%	63.4%
2) Medicaid	20.3%	20.3%	20.3%	20.3%	20.3%	20.3%	20.3%	20.3%
3) Blue Cross	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%	5.5%
4) Commercial Insurance	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%	9.0%
5) Self-pay	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%	0.5%
6) Other	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%	1.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table H –
Key Financial Projection Assumptions for UM Shore Health System + Chestertown (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the UM Shore Health System (SHS) FY2018 actual financial performance and Chestertown FY2020 budget with assumptions identified below. SHS includes Memorial Hospital at Easton, Dorchester General Hospital and Queen Anne's Emergency Center. The assumptions listed below only apply to services regulated by the HSCRC.	
Projection period reflects FY2019 – FY2024 for SHS and FY2020 - FY2024 for Chestertown	
Volumes	- Refer to historical and projected utilization in Table F
Patient Revenue • Gross Charges	
o Update Factor	- 2.0% annual increase in FY2019 – FY2024
o Demographic Adjustment	- 0.29% annual increase in FY2019 – FY2024
o Other Rate Adjustments	- 0.15% annual increase in FY2019 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with outpatient services shifted to the FMF and inpatient MSG services shifted to Easton in FY2022 - 100% variable cost factor associated with regulated inpatient psych services shifted from Dorchester General Hospital to the SMC at Chestertown in FY2022 - 50% variable cost factor associated with the loss of volumes to other providers
o Redistribution of Dorchester General Hospital Revenue	- Shore Health System (SHS) will retain 50% of revenue related to volumes that will be lost to other providers in FY2022 (Retained Revenue) - $4.1M of SHS's Retained Revenue will be apportioned to the FMF to cover its depreciation and interest expense - Remainder of SHS's Retained Revenue will be apportioned to Memorial Hospital of Easton to fund ambulatory and physician network development and population health initiatives
• Revenue Deductions	- Continuation of FY2018 for SHS and FY2020 budget for Chestertown deductions from revenue (contractual allowances, denials, charity, bad debts, assessments, UCC pool receipts) as percentages of gross revenue - Beginning in FY2022 for the services located in the FMF, deductions from revenue is based off historical actual results by service line and held constant throughout the remainder of the projection period
Other Operating Revenue	- Remains constant from FY2018 for SHS and FY2020 budget for Chestertown

Expenses	
• Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	- 2.5% weighted average annual increase that reflects the following: - 2.25% - 2.75% - 3.0% - 2.8% - 2.0%
• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	 - 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- No incremental building operating costs (utilities, housekeeping, maintenance, security) associated with shift of psych services to Chestertown - Incremental building operating costs (utilities, housekeeping, maintenance, security) calculated for the FMF's new square feet
• Interest Expense	
o Existing Debt	- Continued amortization of existing debt and related interest expense
o Project Debt	- Amortization of the following debt issuance over 30 years at 5.0% - $38.5M for construction of the new FMF - $21.9M for construction of a new MOB
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment - 7 year useful life for routine capital expenditures
• Additional Incremental Expenses	- New expenses related to EPIC implementation ($5 million in fiscal year 2019), physician contracting and other strategic initiatives as follows: - $5.4M in FY2019 - $1.6M in FY2020 - $1.8M in FY2021 - $3.5M in FY2022 - FY2024 - The retention of 50% of revenue associated with patients that will seek care at other providers following the transformation of Dorchester to an FMF, will enable SHS to fund $10.0M of initiatives related to ambulatory and physician network development and population health initiatives.
Non-Operating Income/Expense	- Includes $2.4M of investment income with 2.0% investment earnings rate. Non-operating expenses were not assumed over the projection period to the unpredictability of this expense

TABLE I. STATISTICAL PROJECTIONS - SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN

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

	Two Most Recent Years (Actual)		Current Year Projected	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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
1. DISCHARGES									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							486	486	486
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***486***	***486***	***486***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL DISCHARGES	***0***	***0***	***0***	***0***	***0***	***0***	***486***	***486***	***486***
2. PATIENT DAYS									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							3,402	3,402	3,402
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***3,402***	***3,402***	***3,402***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL PATIENT DAYS	***0***	***0***	***0***	***0***	***0***	***0***	***3,402***	***3,402***	***3,402***

TABLE I. STATISTICAL PROJECTIONS - SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN

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

	Two Most Recent Years (Actual)		Current Year Projected	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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)									
a. General Medical/Surgical*	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
b. ICU/CCU	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total MSGA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
c. Pediatric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
d. Obstetric	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
e. Acute Psychiatric	0.0	0.0	0.0	0.0	0.0	0.0	7.0	7.0	7.0
Total Acute	0.0	0.0	0.0	0.0	0.0	0.0	7.0	7.0	7.0
f. Rehabilitation	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
g. Comprehensive Care	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
h. Other (Specify/add rows of needed)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL AVERAGE LENGTH OF STAY	0.0	0.0	0.0	0.0	0.0	0.0	7.0	7.0	7.0
4. NUMBER OF LICENSED BEDS									
a. General Medical/Surgical*									
b. ICU/CCU									
Total MSGA	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
c. Pediatric									
d. Obstetric									
e. Acute Psychiatric							12	12	12
Total Acute	***0***	***0***	***0***	***0***	***0***	***0***	***12***	***12***	***12***
f. Rehabilitation									
g. Comprehensive Care									
h. Other (Specify/add rows of needed)									
TOTAL LICENSED BEDS	***0***	***0***	***0***	***0***	***0***	***0***	***12***	***12***	***12***

TABLE I. STATISTICAL PROJECTIONS - SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN

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

	Two Most Recent Years (Actual)		Current Year Projected	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	**FY2016**	**FY2017**	**FY2018**	**FY2019**	**FY2020**	**FY2021**	**FY2022**	**FY2023**	**FY2024**
5. OCCUPANCY PERCENTAGE ***IMPORTANT NOTE:*** *Leap year formulas should be changed by applicant to reflect 366 days per year.*									
a. General Medical/Surgical*	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
b. ICU/CCU	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total MSGA	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**
c. Pediatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
d. Obstetric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
e. Acute Psychiatric	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	77.7%	77.7%	77.7%
Total Acute	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**0.0%**	**77.7%**	**77.7%**	**77.7%**
f. Rehabilitation	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
g. Comprehensive Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
h. Other (Specify/add rows of needed)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
TOTAL OCCUPANCY %	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**#DIV/0!**	**77.7%**	**77.7%**	**77.7%**
6. OUTPATIENT VISITS									
a. Emergency Department (IP and OP)									
b. Same-day Surgery									
c. Laboratory									
d. Imaging									
e. Other (Specify/add rows of needed)									
TOTAL OUTPATIENT VISITS	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***	***0***
7. OBSERVATIONS**									
a. Number of Patients									
b. Hours									

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

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

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE							
a. Inpatient Services					$ 4,819	$ 4,819	$ 4,819
b. Outpatient Services					-	-	-
Gross Patient Service Revenues	***$ -***	***$ -***	***$ -***	***$ -***	***4,819***	***4,819***	***4,819***
c. Allowance For Bad Debt					329	329	329
d. Contractual Allowance					487	487	487
e. Charity Care					103	103	103
Net Patient Services Revenue	***$ -***	***$ -***	***$ -***	***$ -***	***3,900***	***3,900***	***3,900***
f. Other Operating Revenues (Specify)							
NET OPERATING REVENUE	***$ -***	***$ -***	***$ -***	***$ -***	***$ 3,900***	***$ 3,900***	***$ 3,900***
2. EXPENSES							
a. Salaries & Wages (including benefits)					$ 2,216	$ 2,216	$ 2,216
b. Professional Fees					30	30	30
c. Interest on Current Debt					-	-	-
d. Interest on Project Debt					-	-	-
e. Current Depreciation					-	-	-
f. Project Depreciation					220	220	220
g. Current Amortization					-	-	-
h. Project Amortization					-	-	-
i. Supplies					211	211	211
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)					777	777	777
TOTAL OPERATING EXPENSES	***$ -***	***$ -***	***$ -***	***$ -***	***$ 3,454***	***$ 3,454***	***$ 3,454***
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ 446**	**$ 446**	**$ 446**
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ 446***	***$ 446***	***$ 446***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ 446***	***$ 446***	***$ 446***

TABLE J. REVENUES & EXPENSES, UNINFLATED - NEW FACILITY OR SERVICE - SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table J should reflect current dollars (no inflation). Projected revenues and expenses should be consistent with the projections in Table I and with the costs of Manpower listed in Table L. Manpower. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable. Specify the sources of non-operating income.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX							
a. Percent of Total Charges							
1) Medicare					59.4%	59.4%	59.4%
2) Medicaid					18.4%	18.4%	18.4%
3) Blue Cross					9.8%	9.8%	9.8%
4) Commercial Insurance					10.1%	10.1%	10.1%
5) Self-pay					1.0%	1.0%	1.0%
6) Other					1.3%	1.3%	1.3%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days							
Total MSGA							
1) Medicare					77.3%	77.3%	77.3%
2) Medicaid					12.1%	12.1%	12.1%
3) Blue Cross					4.5%	4.5%	4.5%
4) Commercial Insurance					4.9%	4.9%	4.9%
5) Self-pay					0.3%	0.3%	0.3%
6) Other					0.9%	0.9%	0.9%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table J – Key Financial Projection Assumptions for SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN (Does not include HSCRC Annual Update Factors & Expense Inflation)

Projection is based on UM Shore Medical Center at Dorchester FY2020 budget financial performance of its inpatient services with assumptions identified below.	
Projection period reflects FY2020 – FY2024	
Volumes	- Refer to historical and projected utilization in Table I and Sections H and I related to the methodology, assumptions and projections of Psychiatric Volumes
Patient Revenue • Gross Charges o Update Factor o Demographic Adjustment o Other Rate Adjustments o Variable Cost Factor • Revenue Deductions	 - 0.00% annual increase in FY2020 – FY2024 - 0.00% annual increase in FY2020 – FY2024 - 0.00% annual increase in FY2020 – FY2024 based on historical experience - 100% variable cost factor associated with regulated inpatient psych services shifted from Dorchester General Hospital to the SMC at Chestertown in FY2022 - Continuation of FY2020 budget deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue - Historical UCC pool receipts for inpatient services at Dorchester General Hospital are carried forward when the inpatient beds transfer to UM SMC at Chestertown
Other Operating Revenue	- Historical other operating revenue at Dorchester General Hospital is eliminated beginning in FY2022
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses • Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses • Building Related Operating Expense • Interest Expense • Depreciation and Amortization	 - 0.0% weighted average annual increase that reflects the following: - 0.0% - 0.0% - 0.0% - 0.0% - 0.0% - 80% - 0% - 80% - 50% - 0% - As UM SMC at Chestertown is an existing facility and this project will not add square feet to the facility, no incremental building operating costs (utilities, housekeeping, maintenance, security) are included - No interest expense is expected to occur as this $4.9M project will be funded 100% by Shore Health System operating cash. - 30 year useful life for new construction and renovations - 7 year useful life for new equipment

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE							
a. Inpatient Services	$ -	$ -	$ -	$ -	$ 5,296	$ 5,425	$ 5,557
b. Outpatient Services	-	-	-	-	-	-	-
Gross Patient Service Revenues	**-**	**-**	**-**	**-**	***5,296***	***5,425***	***5,557***
c. Allowance For Bad Debt	-	-	-	-	369	378	388
d. Contractual Allowance	-	-	-	-	535	548	561
e. Charity Care	-	-	-	-	115	118	121
Net Patient Services Revenue	**-**	**-**	**-**	**-**	***4,276***	***4,381***	***4,488***
f. Other Operating Revenues (Specify/add rows of needed)	-	-	-	-	-	-	-
NET OPERATING REVENUE	**$ -**	**$ -**	**$ -**	**$ -**	***$ 4,276***	***$ 4,381***	***$ 4,488***
2. EXPENSES							
a. Salaries & Wages (including benefits)	-	-	-	-	$ 2,317	$ 2,369	$ 2,422
b. Professional Fees	-	-	-	-	30	30	31
c. Interest on Current Debt	-	-	-	-	-	-	-
d. Interest on Project Debt	-	-	-	-	-	-	-
e. Current Depreciation	-	-	-	-	-	-	-
f. Project Depreciation	-	-	-	-	220	220	220
g. Current Amortization	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-
i. Supplies	-	-	-	-	261	273	284
j. Other Expenses (Purchased Services, Other Expense and Overhead & Shared Services)	-	-	-	-	780	797	813
TOTAL OPERATING EXPENSES	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,609**	**$ 3,689**	**$ 3,771**
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ 668**	**$ 692**	**$ 716**
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ 668***	***$ 692***	***$ 716***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ 668***	***$ 692***	***$ 716***

TABLE K. REVENUES & EXPENSES, INFLATED - NEW FACILITY OR SERVICE - SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN

INSTRUCTION: After consulting with Commission Staff, complete this table for the new facility or service (the proposed project). Table K should reflect inflation. Projected revenues and expenses should be consistent with the projections in Table I. Indicate on the table if the reporting period is Calendar Year (CY) or Fiscal Year (FY). In an attachment to the application, provide an explanation or basis for the projections and specify all assumptions used. Applicants must explain why the assumptions are reasonable.

	Projected Years (ending at least two years after project completion and full occupancy) Add years, if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.						
Indicate CY or FY	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX							
a. Percent of Total Charges							
1) Medicare					59.4%	59.4%	59.4%
2) Medicaid					18.4%	18.4%	18.4%
3) Blue Cross					9.8%	9.8%	9.8%
4) Commercial Insurance					10.1%	10.1%	10.1%
5) Self-pay					1.0%	1.0%	1.0%
6) Other					1.3%	1.3%	1.3%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***
b. Percent of Patient Days							
1) Medicare					77.3%	77.3%	77.3%
2) Medicaid					12.1%	12.1%	12.1%
3) Blue Cross					4.5%	4.5%	4.5%
4) Commercial Insurance					4.9%	4.9%	4.9%
5) Self-pay					0.3%	0.3%	0.3%
6) Other					0.9%	0.9%	0.9%
TOTAL	***0.0%***	***0.0%***	***0.0%***	***0.0%***	***100.0%***	***100.0%***	***100.0%***

Table K – Key Financial Projection Assumptions for SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on UM Shore Medical Center at Dorchester FY2020 budget financial performance of its inpatient services with assumptions identified below	
Projection period reflects FY2020 – FY2024	
Volumes	- Refer to historical and projected utilization in Table I and Sections H and I related to the methodology, assumptions and projections of Psychiatric Volumes
Patient Revenue • Gross Charges o Update Factor o Demographic Adjustment o Other Rate Adjustments o Variable Cost Factor • Revenue Deductions	 - 2.0% annual increase in FY2020 – FY2024 - 0.29% annual increase in FY2020 – FY2024 - 0.15% annual increase in FY2020 – FY2024 based on historical experience - 100% variable cost factor associated with regulated inpatient psych services shifted from Dorchester General Hospital to the SMC at Chestertown in FY2022 - Continuation of FY2020 budget deductions from revenue (contractual allowances, denials, charity, bad debts, assessments) as percentages of gross revenue - Historical UCC pool receipts for inpatient services at Dorchester General Hospital are carried forward when the inpatient beds transfer to UM SMC at Chestertown
Other Operating Revenue	- Historical other operating revenue at Dorchester General Hospital is eliminated beginning in FY2022
Expenses • Inflation o Salaries and Benefits o Professional Fees o Supplies o Purchased Services o Other Operating Expenses	 - 2.5% weighted average annual increase that reflects the following: - 2.25% - 2.25% - 3.00% - 2.80% - 2.00%

• Expense Variability with Volume Changes o Salaries and Benefits o Professional Fees o Supplies & Drugs o Purchased Services o Other Operating Expenses	- 80% - 0% - 80% - 50% - 0%
• Building Related Operating Expense	- As UM SMC at Chestertown is an existing facility and this project will not add square feet to the facility, no incremental building operating costs (utilities, housekeeping, maintenance, security) are included
• Interest Expense	- No interest expense is expected to occur as this $4.9M project will be funded 100% by Shore Health System operating cash
• Depreciation and Amortization	- 30 year useful life for new construction and renovations - 7 year useful life for new equipment

TABLE L. WORKFORCE INFORMATION - SHIFT OF PSYCHIATRIC BEDS FROM UM SMC AT DORCHESTER TO UM SMC AT CHESTERTOWN

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 J, if submitted).*	**FTEs**	**Average Salary per FTE**	**Total Cost**	**FTEs**	**Total Cost** *(should be consistent with projections in Table J)*
1. Regular Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration			$ -			$ -			$ -	-	$ -
Direct Care Staff *(List general categories, add rows if needed)*											
Behavioral Health Care			-			-			-	24.74	1,575,972
Sbh Partial Hosp Program			-			-			-	2.15	155,253
Total Direct Care			$ -			$ -			$ -	26.9	$ 1,731,225
Support Staff *(List general categories, add rows if needed)*											
Total Support			$ -			$ -			$ -	-	$ -
REGULAR EMPLOYEES TOTAL			$ -			$ -			$ -	26.9	$ 1,731,225
2. Contractual Employees											
Administration *(List general categories, add rows if needed)*											
Total Administration			$ -			$ -			$ -	-	$ -
Direct Care Staff *(List general categories, add rows if needed)*											
Total Direct Care Staff			$ -			$ -			$ -	-	$ -
Support Staff *(List general categories, add rows if needed)*											
Total Support Staff			$ -			$ -			$ -	-	$ -
CONTRACTUAL EMPLOYEES TOTAL			$ -			$ -			$ -	-	$ -
Benefits *(State method of calculating benefits below)* **:**											$ 484,743
28% of Salaries											
TOTAL COST	-		***$ -***	-		***$ -***	-		***$ -***		***$ 2,215,968***

EXHIBIT 2

DEPARTMENT LEGEND

- BUILDING SUPPORT
- CIRCULATION
- OFFICE
- PATIENT BEDROOM
- PATIENT TREATMENT
- STAFF SUPPORT

OVERALL RENOVATION AREA = **9526 SF**

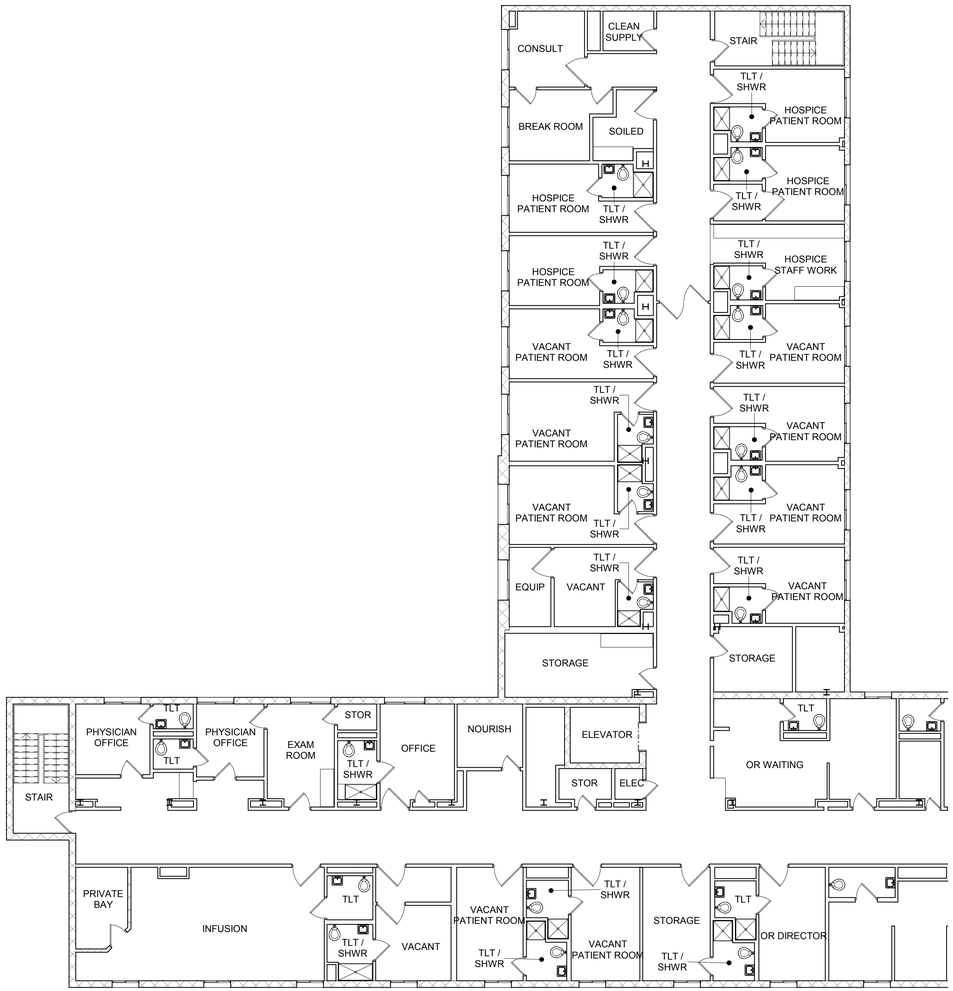
SCALE:	3/32" = 1'-0"
MCA JOB NO.	19034
PROJECT STATUS:	CON
SKETCH NO.	**A-103**

MCA | ARCHITECTURE
Architecture | Interior Design | Planning
Marshall Craft Associates, Inc.
2031 Clipper Park Road, Suite 105
Baltimore, Maryland 21211
410.532.3131 | www.mca.design

CLIENT:	UM SHORE REGIONAL HEALTH
PROJECT:	BEHAVIORAL HEALTH BED CON EXCEPTION
SHEET:	PROPOSED CONSTRUCTION PLAN
DATE:	08/07/19
COMMENTS:	

Behavioral Health Bed CON Exception

UM Shore Regional Health



1 A-103 **THIRD FLOOR - EXISTING PLAN**
SCALE: 3/32" = 1'-0"

2 A-103 **THIRD FLOOR - PROPOSED CONSTRUCTION**
SCALE: 3/32" = 1'-0"

DEPARTMENT LEGEND

- PATIENT BEDROOM
- PATIENT TREATMENT
- OFFICE
- STAFF SUPPORT
- CIRCULATION
- BUILDING SUPPORT
- NOT IN SCOPE

TOTAL RENOVATION AREA = **9526 SF**

0 4' 8' 16' 24' 32'
SCALE: 3/32" = 1'-0"

Existing & Proposed Floor Plans

08.09.2019

MCA | ARCHITECTURE®

EXHIBIT 3

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES BEHAVIORAL HEALTH RESPONSE TEAM	POLICY NO:	
		REVIEWED:	03/16
UM SMC at Dorchester and Easton	INQUIRY CALLS	PAGE #:	1 of 2
		SUPERSEDES	04/11

PURPOSE: To define an inquiry call and outline the procedure for handling an inquiry call.

SCOPE: BHRT, Medical Staff: Emergency Department (ED) and Behavioral Health

DEFINITION:

1.0 An inquiry call is any call in which a prospective patient, family member/ significant other, health care professional, Medical Director or attending psychiatrist:

1.1 Seeks information about the program.

1.2 Requests information about admission for a particular individual.

1.3 Calls to admit a patient.

POLICY:

1.0 Inquiry calls will be routed to the Behavioral Health Response Team (BHRT) Clinician in a timely fashion.

PROCEDURE:

1.0 The BHRT Clinician will utilize the Electronic Request Log to elicit sufficient data to make an initial assessment to the caller's needs.

2.0 When sufficient information has been taken, the staff member will develop a plan with the caller ensuring appropriate access to needed treatment as follows:

2.1 Crisis and/or imminent danger

2.1.1 Call 911 or send to the nearest ED immediately to see a BHRT Clinician.

2.2 Appropriate for admission to Inpatient

2.2.1 Contact on-call physician and unit; proceed with admission process.

2.3 Appropriate for referral

2.3.1 Refer to another inpatient or outpatient program following procedure.

Policy	
Effective	1992
Revised/ Reviewed	03/16; 04/11; 01/07; 02/06; 01/05; 0/03; 04/02; 04/01; 04/00; 10/97
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team
SPIRIT Form	Jackie Weston 03/11/16

REFERENCE:

EXHIBIT 4

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES INPATIENT PROGRAM	POLICY NO:	
		REVIEWED:	08/17
UM SMC at Dorchester	ADMISSION CRITERIA ADULT PSYCHIATRIC INPATIENT	PAGE #:	1 of 4
		SUPERSEDES	10/15

CROSS REFERENCES:
1. Administrative Policy PE-07-Admission of Patients to Inpatient Behavioral Health
2. Administrative Policy TX-11-Stabilization of Patients Presenting for Emergency Medical Treatment

PURPOSE: To establish the criteria and process for admission to the Shore Behavioral Health (SBH) Services Adult Psychiatric Program for patients 18 years and older.

SCOPE: MD, RN, LPN

POLICY

1.0 The SBH Medical Director or designee will review admission inquiries and approve all potential patients for admission.

2.0 All patients admitted from the emergency department, transferred from within the hospital, or transferred from another facility will be medically stable prior to acceptance.

2.1 The SBH Medical Director, or designee, will evaluate the medical appropriateness of all potential patients.

3.0 The individual must have a mental disorder which is susceptible to care or treatment and must satisfy one of the following clinical criteria for admission:

3.1 Imminent risk for self-injury, with an inability to guarantee safety, as manifested by any one of the following:

3.1.1 Recent, serious, and dangerous suicide attempt, indicated by degree of lethal intent, impulsivity, and/or concurrent intoxication, including an inability to reliably contract for safety.

3.1.2 Current suicidal ideation with intent, realistic plan, or available means that is severe and dangerous.

3.1.3 Recent self-mutilation that is severe and dangerous.

3.1.4 Recent verbalization or behavior indicating high risk for severe injury to self.

3.2 Imminent risk for injury to others as manifested by any of the following:

3.2.1 Active plan, means, and lethal intent to seriously injure other(s).

3.2.2 Recent assaultive behaviors that indicate a high risk for recurrent and serious injury to other(s).

3.2.3 Recent and serious physically destructive acts that indicate a high risk for recurrence and serious injury to others.

3.3 Failure of outpatient services to stabilize psychiatric symptoms.

3.4 Acute and serious deterioration from the patient's baseline ability to fulfill age-appropriate responsibilities in one or more of the following areas:

3.4.1 Education

3.4.2 Vocation

3.4.3 Family; and/or

3.4.4 Social/peer relations to the extent that behavior is so disordered, disorganized or bizarre that it would be unsafe for the patient to be treated in a lesser level of care.

3.4.5 An ability to attend to their basic activities of daily living which may include hygiene, nutrition, and rest as a result of their mental illness.

3.5 Imminent risk for acute medical status deterioration due to the presence and/or treatment of an active psychiatric symptom(s) manifested by either:

3.5.1 Signs, symptoms, and behaviors that interfere with diagnosis or treatment of a serious and acute medical illness requiring inpatient medical services.

3.5.2 A need for acute psychiatric interventions with a high probability of serious and acute deterioration of general medical and/or mental health.

4.0 Patients ineligible for admission include the following:

4.1 Persons able to receive treatment in a less restrictive environment.

4.2 Persons with a primary diagnosis of alcoholism or substance abuse with no primary mood, anxiety or psychotic symptoms.

4.3 Individuals in police custody.

4.4 Patients whose cognitive impairment would prevent them from participating and benefiting from psychotherapy and can be placed in a more appropriate program.

4.5 Individuals whose relative or significant other is already a patient on the inpatient unit and where admission of this patient would not be therapeutic.

4.6 Patients whose primary insurance does not include Shore Health System and there is bed availability within their provider network and the patient consents to transfer.

4.7 Patients in imminent risk of Delirium Tremens.

4.8 Patients who require treatments that are not offered at our facility, including but not limited to ECT or Medical Detoxification requiring IV treatment.

5.0 Information regarding reasons for ineligibility for treatment at SBH will be provided to the referring health care provider.

6.0 Patients may be transferred to another facility for treatment if:

6.1 Patient or patient's power of attorney requests transfer.

6.2 Treatment team recommends that the patient's treatment would have greater therapeutic benefit if patient is transferred to a specialty program.

Policy	
Effective	1992
Revised/ Reviewed	08/17; 10/15; 07/14; 09/10; 03/08; 02/06; 01/05; 08/03; 05/02; 07/99; 10/97
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team
SPIRIT Form	John Mistrangelo 10/26/15

REFERENCE:

1. American Psychiatric Nurses Association (2014). Psychiatric Mental Health Nursing: Scope and Standards of Practice.
2. State of Maryland –Department of Health and Mental Hygiene Application for Voluntary Admission (2014)
3. State of Maryland –Department of Health and Mental Hygiene Application for Involuntary Admission (2014)

EXHIBIT 5

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	ADMINISTRATIVE POLICY & PROCEDURE	POLICY NO:	PE-07
		REVISED:	02/18
	ASSESSMENT FOR ADMISSION OF PATIENTS TO INPATIENT BEHAVIORAL HEALTH UNIT	PAGE #:	1 of 5
		SUPERSEDES	09/15

CROSS REFERENCE:

Shore Behavioral Health Policy: Admission Criteria Adult Behavioral Health Inpatient Unit

POLICY:

To ***establish*** that all patients who present for psychiatric care from internal or external sources are processed in compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA).

Individuals with emergency psychiatric conditions are screened and stabilized regardless of the following, including but not limited to, diagnosis, financial status, race, color, national origin and/or disability.

Shore Regional Health strives to meet the behavioral health needs of patients in its primary, five county service area comprised of Talbot, Dorchester, Queen Anne's, Kent, and Caroline counties. This goal can best be achieved through collaboration and planning that engages our healthcare partners in the community to improve access, quality of care, and efficiency of care. Distance from referral sources can compromise the ability to provide quality, coordinated care. It is a factor that must be taken into consideration when evaluating external referrals for admission.

Sources of requests for admission:

- Shore Regional Health Emergency Services, University of Maryland Shore Medical Center at Dorchester (UMSMC at Dorchester), University of Maryland Shore Medical Center at Easton (UMSMC at Easton), University of Maryland Shore Medical Center at Chestertown (UMSMC at Chestertown, and Shore Emergency Center Queenstown.
- Psychiatric Consultation/Behavioral Health Response Team (BHRT) Consultation
- External emergency rooms and facilities

DEFINITIONS OF BEHAVIORAL HEALTH UNIT ADMISSIONS STATUS:

1. Completely Open (CO): Open bed, no milieu conditions to consider, no additional documentation required.

2. Partially Open (PO): Strategic admission of patients based on patient presentation/symptoms due to unit milieu conditions or staffing;

documentation required. Only patients presenting to a Shore Regional emergency facility will be considered for admission to provide the opportunity for a full and complete assessment of the patient in order to evaluate the inpatient unit's ability to safely accommodate the patient.

Examples of factors impacting unit ability to accept admissions include, but are not limited to:

a. Violence on unit.
b. Number of special observations.
c. Staffing required for 1:1 observation.
d. Presence of patients who have propensity for sexual acting out.
e. Victims of sexual abuse.
f. Gender.
g. Gender identity issues.

3. Not Open (NO): Bed(s) closed for infection control, beds filled to capacity or facility condition (i.e., flood, renovation, plumbing problem); documentation required.

1.0 PROCEDURE

1.1 The Charge Nurse acts as the primary point of communication regarding the Unit's admission status.

1.2 When on duty, the Administrative Supervisor shall be consulted regarding unit conditions and resource requirements that might avert an alteration of the Unit's admission status.

1.3 At other times, the Department Manager will be consulted regarding unit conditions and resource requirements that might avert an alteration of the unit's admission status.

1.4 Decisions to alter the admission status of the inpatient unit shall be made by the Medical Director and Director, or designee(s).

1.5 The Charge Nurse will communicate changes in census and capacity to Behavioral Health Response Team (BHRT) staff.

1.6 Notification will be made using a capacity alert.

1.7 All requests for admission to the Behavioral Health Inpatient Unit will be routed to the Behavioral Health Response Team (BHRT).

1.8 BHRT staff will record requests for admission on the electronic Admission Log. Unit conditions impacting admission capability will be noted.

1.9 Once medically stable, including a blood alcohol level <100, BHRT staff will gather information necessary to evaluate the patient for admission and provide that information, along with the units current admission status, to:

1.9.1 The psychiatrist on–call, if the request is from an external agency or an inpatient unit at a Shore Regional Health Hospital.

1.9.2 The Emergency Services Licensed Independent Practitioner if the patient is receiving care in Shore Health Emergency Services.

1.10 The psychiatrist/nurse practitioner (provider) on-call is responsible for ensuring that all patients accepted for admission on the inpatient unit meet clinical admission criteria. It is the provider's decision whether or not the unit is able to provide care for the patient based on the status of the unit (CO, PO, NO).

1.11 The provider's disposition decision and the rationale for it will be documented in the Admission Log by the BHRT Evaluator.

1.12 If the patient is being referred from an external source and meets the clinical admission criteria, but the unit admission status prevents the acceptance of the patient, the referring facility will be informed of a projected admission date if it is anticipated the unit admission status will change due to discharges.

1.13 If the patient is referred from internal sources and meets the clinical admission criteria but the unit admission status prevents acceptance of the patient OR the patient does not meet the admission criteria, the Care Coordination Department staff of the patient's current inpatient unit will pursue transfer to an appropriate facility. BHRT Staff may serve as a resource for the Care Coordination Department staff.

1.14 If transfer to another facility cannot be arranged within 24 hours, BHRT staff will notify the psychiatrist on-call, Behavioral Health Manager, Director or designee.

1.15 The Behavioral Health Manager or designee will arrange for the BHRT staff to conduct reassessments of the patient in collaboration with the psychiatrist, provide treatment interventions to stabilize the patient and will document the reassessments and therapeutic interventions.

1.16 For patients who remain in the Emergency Department for 24 or more hours from arrival awaiting an appropriate disposition, the Medical Director of Behavioral Health or his/her designee will confer with the treating Emergency Services Physician to ensure appropriate care from a behavioral health perspective.

1.17 The Behavioral Health Manager and Director will assist in the formulation and implementation of this plan and ensure its communication to appropriate Emergency Department and Supervisory leadership.

2.0 PRIORITIZATION OF REQUESTS FOR ADMISSION

2.1 Admission requests will be processed in chronological order from the entries on the Behavioral Health Admission Log.

2.2 Emergency Department requests will be prioritized over patients who are already in a bed on an inpatient unit.

2.3 The Behavioral Health Medical Director or designee will be contacted for all requests for clinical prioritization that necessitate deviation from the chronological order. Rationale for clinical prioritization will be documented on the Admission Log by BHRT staff with the name of the authorizing provider.

3.0 QUALITY REVIEW

3.1 The following cases will be reviewed to determine whether or not patients have been managed in compliance with established policy:

3.1.1 Patients transferred to other facilities

3.1.2 Requests for admission from remote facilities that were declined.

3.1.3 Patients being treated by SRH Emergency Services who were not relocated to the Behavioral Health Inpatient Unit within 24 hours of admission.

3.2 On a monthly basis, the data from the case reviews will be aggregated and evaluated by the Manager, Medical Director, and Director of Shore Behavioral Health.

3.3 A quarterly report, including total volume, number of transfers from other facilities and within SRH, and resolution of pending cases, will be communicated to the Behavioral Health Leadership Council and to the Performance Management Committee.

Effective	10/10
Approved	Medical Director, Shore Behavioral Health
Approved	Christopher J. Parker, RN, Sr. Vice President/CNO
Revised	09/11
Approved	Medical Executive Committee: 09/08/11
Revised	02/12
Approved	UMMS Legal Department
Approved	Linda Pittman, Director, Corporate Compliance
Revised	09/15
Revised	2/18
Approved	Linda Pittman, Director, Corporate Compliance
Approved	Eric Anderson, MD, Medical Director Shore Behavioral Health
Approved	Ruth Ann Jones, RN, Senior Vice President; Chief Nursing Officer
Approved	Diane Walbridge, RN, Director , Acute and Emergency Nursing
Approved	Tammy Curry, Regulatory Compliance
Approved	Heather Joyce-Byers, Risk Management
Approved	UMMS Legal Department
Policy Owner	John Mistrangelo, Program Director, Shore Behavioral Health

EXHIBIT 6

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES INPATIENT PROGRAM	POLICY NO:	NA
		REVIEWED:	04/18
UM SMC at Dorchester	SHORE BEHAVIORAL HEALTH QUALITY ASSURANCE	PAGE #:	1 of 2
		SUPERSEDES	NA

PURPOSE: To establish a separate Quality Assurance Program that encompasses the behavioral health services of Shore Regional Health.

SCOPE: All Shore Behavioral Health Personnel

DEFINITIONS:

Quality Assurance: This is an activity that involves the survey of treatment activities and the collection of observations and data on that treatment activity to be analyzed to identify issues impacting the provision of patient care. Information is used to develop new and or improved treatment processes.

Data: Numbers, measurements, and observations of treatment and operational processes.

Analysis: The use of statistical tools, graphic illustration, or written report to describe, compare, and contrast data within programs, year-to-year, or against local, regional, or national benchmarking.

BACKGROUND:

Shore Behavioral Health (SBH) provides acute, inpatient psychiatric services on its general adult psychiatric program. Typically, the patient population is comprised of adults age 18 and older. All are patients that are deemed to benefit from a variety of therapies including milieu, group, individual, family, and psychotropic medication.

POLICY:

1.0 Data will be collected, analyzed and reported on a monthly basis.

2.0 Data review will be conducted as a part of the monthly leadership meeting.

3.0 Results will be reported to Shore Regional Health Performance Management Committee.

4.0 Data results will be made available to staff and providers.

5.0 Data will be used to evaluate the effectiveness of the program's treatment and to formulate changes in procedures.

6.0 Each fiscal year population specific treatment issues will be identified and prioritized for the development of an improvement plan.

PROCESS:

1.0 Program managers for inpatient, Intensive Outpatient, Behavioral Health Response Team and Substance Misuse Program will submit their prior month data to the Leadership Council by the time of the scheduled Council meeting.

2.0 Review and discussion of Quality Assurance data shall be a standing item on the Leadership Council Agenda.

3.0 Results from Quality Assurance improvement initiatives shall be reported on a monthly basis.

4.0 Data collected and improvement activity progress reported shall be documented as a part of the Leadership Council's monthly meeting minutes.

Policy	
Effective	04/18
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

REFERENCE:

EXHIBIT 7

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES	POLICY NO:	
		REVIEWED:	
UM SMC at Dorchester	Special Behavioral Health Population Treatment Protocols	PAGE #:	
		SUPERSEDES	

PURPOSE: To establish any special procedure necessary for the safe management and treatment of special behavioral health populations.

SCOPE: All Shore Behavioral Health Personnel

POLICY:

1.0 Definitions:

Special Behavioral Health Population: Patients with characteristics and or diagnoses that place them outside of the typical patient group admitted and treated on the Shore Behavioral Health Inpatient Psychiatric Unit.

Medically Compromised Patients: Patients whose ability to engage in activities of daily living may be impaired because of medical condition.

Geriatric: Patients above the age of 65.

Intellectual Disability: Patients whose registration, retention, and or processing of sensory inputs has been undeveloped, disrupted, deteriorated, or damaged.

2.0 Background:

Shore Behavioral Health (SBH) Inpatient Psychiatric Unit is focused on the treatment of the general, adult psychiatric population. Typical diagnosis include affective disorders, psychosis, bipolar illness, and suicidality. Patient ages range from 18 years and greater. Patients are able to effectively participate in group, individual, and milieu therapy. Patients may have some minor medical conditions. They may have a secondary co-occurring, substance misuse conditions

3.0 Policy

3.1 SBH makes adjustments in its care and treatment to meet the special population needs of its patients so long as the efficacy of treatment and the safety of care is not unduly compromised.

4.0 Guidance for Specialty Populations

4.1 Patients with Medical Complications

4.1.1 Admissions Considerations

4.1.1.1 No IV pumps

4.1.1.2 No room isolation cases

4.1.1.3 No bed bound patient

4.1.2 Room Assignment
- **4.1.2.1** Patients will be placed in one of two medical rooms within close proximity of nurse's station.

4.1.3 Alternative treatment
- **4.1.3.1** Patients will be transferred to medical service
- **4.1.3.2** Follow-up to be provided by consulting psychiatrist with assistance from Behavioral Health Response Team (BHRT).

4.1.4 Related Policies

4.2 Geriatric Patients

4.2.1 Admissions Considerations
- **4.2.1.1** No limitation on admission if patient can participate and benefit from milieu setting and treatment.
- **4.2.1.2** Hospitalist consult is recommended
- **4.2.1.3** Fall risk assessment and precautions to be implemented

4.2.2 Room Assignment
- **4.2.2.1** Consider placement close to nurse's station.
- **4.2.2.2** Consider single room as appropriate

4.3 Intellectual Disability

4.3.1 Admissions considerations
- **4.3.1.1** No limitation if patient is able to participate and benefit from milieu setting and treatment.
- **4.3.1.2** Physical acting out behavior will need to be closely evaluated for impact on milieu and safety of other patients.

4.3.2 Room Assignment
- **4.3.2.1** Consider single room to decrease stimulation
- **4.3.2.2** Proximity to nursing station should also be considered depending on patient's presentation.

4.4 Child and Adolescent Patients

4.4.1 Admission Considerations
- **4.4.1.1** Patients under 18 years of age will not be admitted
- **4.4.1.2** Patients may be evaluated for admission to the Pediatric Unit with follow-up by psychiatry and Behavioral Health Response Team.
- **4.4.1.3** Patients not appropriate for the above option will be transferred to an available bed in a child/adolescent psychiatric unit at another hospital.

4.5 Co-occurring Substance Use Disorder

4.5.1 Admission Considerations
- **4.5.1.1** Patients with a psychiatric diagnosis as well as a co-occurring substance use disorder are appropriate for admission.
- **4.5.1.2** Medical detox is not provided on the inpatient psychiatric unit.

4.5.2 Treatment Considerations
- **4.5.2.1** The unit provides a daily, specialized Substance Use Disorder related group.

4.5.2.2 Patients are assigned to a therapist with experience working with this population

4.6 Pregnant Patients

4.6.1 Admission Considerations

4.6.1.1 Refer to Behavioral Health Admissions Policy

4.6.1.2 Certain limitations apply as specified in the Admissions Policy.

4.6.1.3 Commitment from Obstetrics to consult on case during treatment is a requirement for admission.

Policy	
Effective	
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

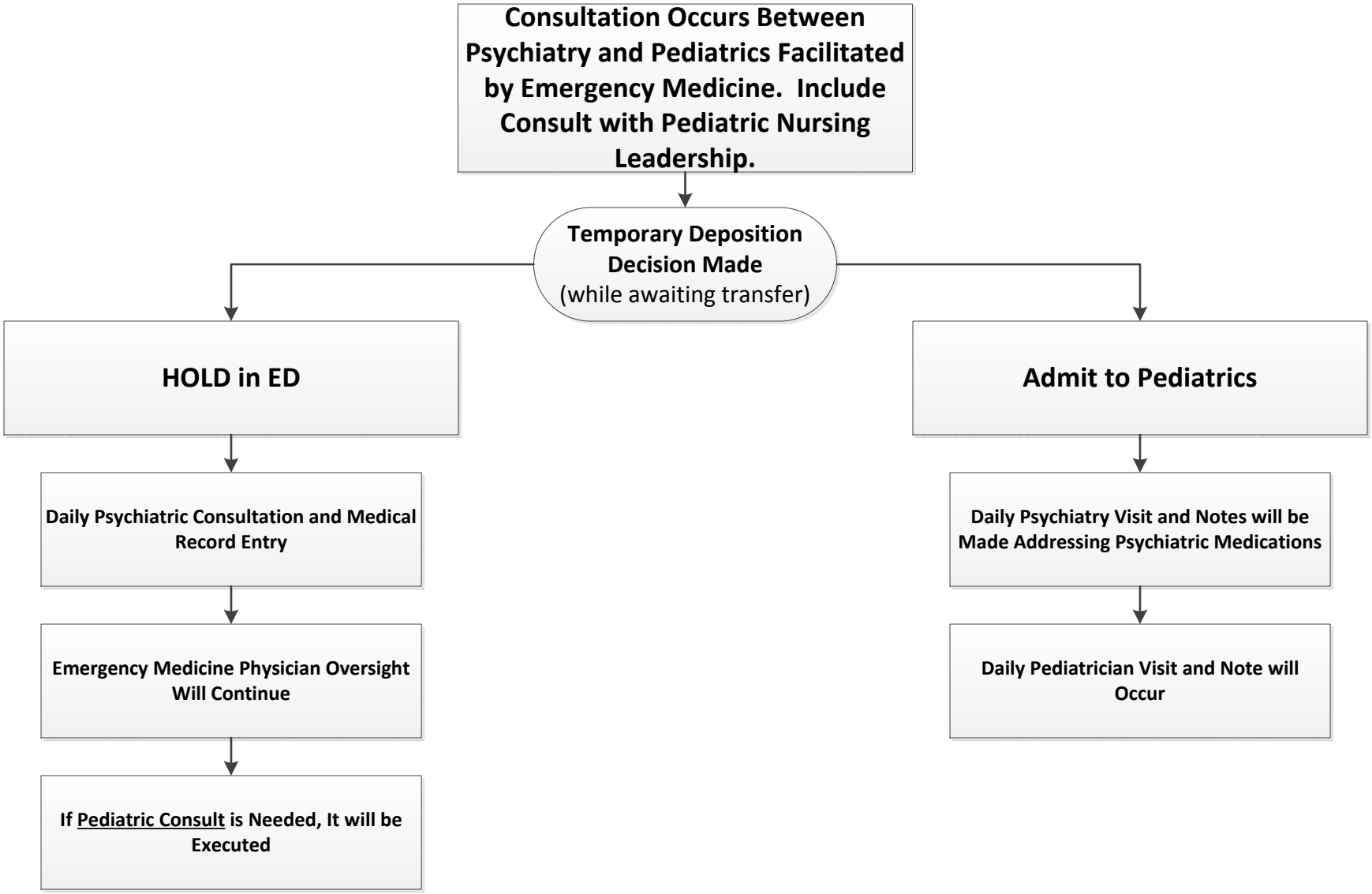
REFERENCE: Behavioral Health Admissions Policy

EXHIBIT 8

Collaborative Decision Process for Pediatric Psychiatric Patients

Conditions:

* Age <18 (Hospitalists only admit age ≥18)
* Inpatient psychiatric care needs can not be met/ are not readily available via transfer
* "Readily available" is case dependent and related to patients needs and his or her ability to tolerate ED Hold until accepted elsewhere



* **Emergency Medicine and Pediatric Nursing Education will be Required**
* **Case Management will Prioritize the Care for Transfer**

DRAFT 1.0

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES	POLICY NO:	
		REVIEWED:	
UM SMC at Dorchester	Pediatric Behavioral Health Care	PAGE #:	
		SUPERSEDES	

PURPOSE: To establish a process through which pediatric behavioral health services may be provided on an emergent basis to patients awaiting a pediatric behavioral health inpatient bed..

SCOPE: All Shore Behavioral Health Personnel

POLICY:

1.0 Background:

Shore Behavioral Health (SBH) does not provide inpatient pediatric behavioral health treatment. Pediatric patients are evaluated in Shore Regional Health's emergency facilities and in patient hospitalization may be recommended as a course of treatment. At times there is no availability of pediatric behavioral health inpatient beds. Patients then remain in the emergency department setting while they await an available bed.

2.0 Policy

2.1 Shore Behavioral Health provides alternative behavioral health care to patients awaiting placement in a pediatric behavioral health bed in another facility.

3.0 Process

3.1 In situations where inpatient behavioral health care is not available within a reasonable amount of time (typically under 24 hours) there are two potential options. These are continued care in the Emergency Department or transfer to the Hospital's Pediatric Unit with consultation from the Behavioral Health physician staff.

3.1.1 The attending emergency department physician may request a consultation at any time from Shore Behavioral Health for treatment recommendations that are appropriate for implementation while the patient remains under the care of the emergency department.

3.1.2 Patients may be considered for transfer to the Hospital's inpatient pediatric unit. This is a joint decision made by the admitting pediatrician in consultation with the consulting psychiatrist.

3.1.3 In either 4.1.1 or 4.1.2 patients will receive daily psychiatry visits with documentation in the medical record.

3.1.4 Daily supportive therapy visits will be provided in either instance by a member of the Behavioral Health Response Team.

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES	POLICY NO:	
		REVIEWED:	
UM SMC at Dorchester	Pediatric Behavioral Health Care	PAGE #:	
		SUPERSEDES	

Policy	
Effective	
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

REFERENCE:

EXHIBIT 9

UNIVERSITY of MARYLAND SHORE REGIONAL HEALTH	SHORE BEHAVIORAL HEALTH SERVICES INPATIENT PROGRAM	POLICY NO:	NA
		REVIEWED:	04/18
UM SMC at Dorchester	SHORE BEHAVIORAL HEALTH DISCHARGE PLANNING AND REFERRAL	PAGE #:	1 of 2
		SUPERSEDES	NA

PURPOSE: To establish the process for planning and coordination of services between patients who are admitted to the Shore Behavioral Health (SBH) Services Adult Psychiatric Program and other community based services, facilities, or resources.

DEFINITIONS:

Patient Care Services (PCS): Patient Care Services is the group within Shore Behavioral Health (SBH) that provides discharge planning, referral, and placement services for patients referred to Shore Behavioral Health for psychiatric care.

Community Based Aftercare Services: Community based services include clinics, provider offices, specialty programs, intensive outpatient treatment, residential programs, and mobile treatment services.

Specialized Inpatient Care: Limited specialty, inpatient programs are available. These include Addictions Rehabilitation, Geriatric Inpatient Units, and Dementia Care Inpatient and Residential programs.

Discharge Plan: This is a plan jointly developed by the patient, their provider, and other members of the treatment team. It provides the patient with information regarding their illness and its treatment. Self-help strategies, appointments for follow-up services and medication instructions are all part of the discharge plan.

POLICY:

1.0 Background: Shore Behavioral Health's (SBH) first obligation to all patients is caring for their mental health and medical needs.

1.1 Patients referred to the Hospital for treatment often require services post discharge or may at the time of referral require services not provided directly by the Hospital.

1.2 The Patient Care Services Team on the Acute Inpatient Psychiatric Unit provides referral and coordination of services. These services may include outpatient psychiatric treatment; community based programming, long term care, other specialized inpatient care and medical referrals, as needed.

2.0 Assessment. Information regarding discharge needs is typically incorporated into the Psychosocial Assessment.

2.1 The assessment delineates patient strengths and weaknesses as well as available supports and resources.

2.2 Information obtained in the psychosocial assessment is used to formulate the patient's discharge plans.

2.3 The PCS team works with the patient and treatment team to prepare them for discharge.

3.0 Discharge Plan

The PCS team will work with the patient to develop a plan to increase the likelihood of treatment success and to deal effectively with issues that might jeopardize successful transition to the community.

3.1 Discharge plans will be developed through a combination of individual and group interactions.

3.2 Copies of the plan will be sent to community based providers under continuity of care provisions.

Policy	
Effective	04/18
Revised/ Reviewed	
Policy Owner	Shore Behavioral Health Leadership Team
Approved by:	Shore Behavioral Health Leadership Team

REFERENCE: