GALLAGHER
GALLAGHER EVELIUS & JONES
ATTORNEYS AT LAW

November 4, 2019

VIA EMAIL & U.S. MAIL

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

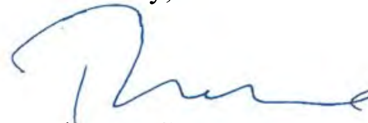
Re: Merger and Consolidation of
University of Maryland Shore Medical Center at Dorchester and
University of Maryland Shore Medical Center at Chestertown
Request for Exemption from Certificate of Need Review /
Request to Modify Existing Exemption from Certificate of Need Review

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 four copies of their response to the additional information questions dated October 11 and October 18, 2019. Please note that the completeness questions dated October 11, 2019 had two number 17s so we have renumbered them as 17A and 17B. A WORD version and the EXCEL file will be provided under separate cover.

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

Sincerely,



Thomas C. Dame

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Enclosures

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cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development
Suellen Wideman, Esq., Assistant Attorney General
Jeanne Marie Gawel, Program Manager
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
Craig Wheeless, KPMG, LLC, Director, Health Care Advisory Services
Andrew L. Solberg, A.L.S. Healthcare Consultant Services

University of Maryland Shore Medical Center at Dorchester and University of Maryland Shore Medical Center at Chestertown Request for Exemption Acute Adult Psychiatric Services

Responses to Additional Information Questions Dated October 11, 2019 and October 18, 2019

October 11, 2019 Questions

1. **Please provide a revised Table L that delineates in more detail the position descriptions of the 26.9 full-time equivalent direct care staff needed to implement the project. Identify the positions and the average salary for each position.**

Applicant Response

Attached as **Exhibit 10** please find an updated MHCC Table Set with a revised Table L showing the direct care FTEs needed to implement the project. Table L includes staffing for both the inpatient and outpatient behavioral health services to be provided at UM SMC at Chestertown.

2. **Provide a discussion of the staffing plan for this project, including the likelihood of retaining existing psychiatric service staff and medical direction, as well as a discussion of the recruitment and retention challenges and how they will be overcome.**

Applicant Response

It is difficult to know with certainty what percentage of UM SRH's existing behavioral health staff will choose to move to Chestertown should the inpatient program relocate there. Dr. Anderson has resigned and UM SRH is currently recruiting for the Medical Director and two open nursing positions, but there have been no other resignations to date. UM SRH cannot recruit for positions that are presently filled.

The recruitment and retention of psychiatric physicians and advance practice providers (e.g., nurse practitioners (NPs) and physician assistants (PAs)) in Maryland and particularly on the Eastern Shore is challenging due to a multitude of issues, including geography, salaries, and the paucity of potential recruits. However, UM SRH is committed to using all available tools to establish and maintain an excellent team of providers. Based on UM SMC at Chestertown's recruitment and retention trends, UM SRH is confident it will be able to staff the inpatient psychiatric unit to meet patient care needs. UM SMC at Chestertown currently has only one full-time nursing position open and has successfully recruited for open positions in the past. It also has a low turnover rate of 7.8% and is not currently relying on any temporary staffing.

To overcome any recruitment and retention challenges, UM SRH has engaged a search firm to recruit a new psychiatric medical director and will use the same process for other open behavioral health staff positions. Temporary staffing and premium recruitment and retention offers may also be utilized as needed. In addition, UM SRH intends to make available cross training opportunities for its existing staff interested in behavioral health in anticipation of the

expansion of outpatient behavioral health services and any turnover that may result from the relocation of the inpatient unit to Chestertown.

CONSISTENCY WITH STATE HEALTH PLAN

3. AP 1a, Bed Need

The analysis appears to project that a psychiatric unit at Chestertown will achieve a psychiatric hospital market share in its projected service area of 68% while the unit at Cambridge has only achieved an actual psychiatric hospital market share of 48% in its actual service area.

a. What are the fundamental differences in the characteristics of the projected service area and its relationship to Chestertown and/or the characteristics of the competition in the projected service area compared to those of the actual UM SMC at Dorchester in its actual service area that would support this assumption that a program located at Chestertown would achieve a higher market share?

Applicant Response

The service areas for UM SMC at Chestertown and UM SMC at Dorchester are comparable. As presented in Tables 8, 9, and 11 in the Exemption request and reproduced below for convenience, they both encompass zip codes in Dorchester, Talbot, Caroline, Queen Anne's, and Kent counties. Tables 10 and 12 from the Exemption request are also reproduced below for convenience.

There are two key points to consider when evaluating the projected market share for UM SMC at Chestertown:

1. The methodology utilized to project the market share was developed by the Maryland Health Care Commission (MHCC) staff in its review of the CON application for the relocation of Washington Adventist Hospital (Docket No. 09-15-2295) (Proposed Decision, pp. 157-162). This methodology was introduced by Commissioner Barbara McLean in the decision by the MHCC to approve the application. The same approach was used by Dimensions Health System and was accepted by the Commission in presenting the need for inpatient services for the relocation of Prince George's Hospital Center (Docket No. 13-16-2351).

2. While the service area for UM SMC at Dorchester in fiscal year 2018 included three Wicomico county zip codes (20801 Salisbury, 20804 Salisbury and 21837 Mardela Springs), they are excluded from the service area for UM SMC at Chestertown because of their close proximity to Peninsula Regional Medical Center ("PRMC"), which also provides inpatient psychiatric services. If these three zip codes, in which UM SMC at Dorchester only captured market shares in fiscal year 2018 of 8.5%, 5.2% and 10.0%, respectively (Table 8), were excluded from the service area for UM SMC at Dorchester, the resulting market share would have equaled 74.1%. This is higher than the projected market share of 67.9% for UM SMC at Chestertown shown in Tables 11 and 12.

Using the methodology used in prior CON applications, including for Washington Adventist Hospital and Prince George's Hospital Center, the Applicants calculated the historical market

share by zip code and proximity to UM SMC at Dorchester and then applied it to zip codes of comparable proximity to UM SMC at Chestertown.

Using fiscal year 2018 data, the Applicants calculated the historic market share for each zip code in UM SMC at Dorchester's service area and assigned a proximity ranking. As presented in *Table 8*, a weighted average of the zip code market shares in each proximity grouping was then calculated along with a total service area market share of 47.7%.

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* below, 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 an assumption regarding the introduction of the 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, the applicants note 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 key 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 resulting market share of 67.9%, as presented in *Table 11*, remains relatively constant through fiscal year 2024 even though 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

b. Can the service area market share experience of similarly-sized general hospital psychiatric units in Maryland be shown to support the market share assumptions being made in this request for exemption from Certificate of Need?

Applicant Response

Market share experience of psychiatric units cannot be generalized across programs based on size alone. The program's proximity to other providers, proximity to patients, size, and occupancy levels, are just a few of the characteristics that can impact a program's market share and no two programs share the same characteristics.

As explained in response 3(a) above, the Applicants developed the projected market share for UM SMC at Chestertown using the approach developed by Commissioner McLean and accepted by the Commission, which takes into account the UM SMC at Dorchester program's existing market share and adjusts for proximity to patients and other providers (i.e., PRMC and AAMC) in the projected service area. As discussed above, UM SRH also took into account the occupancy of the Delaware facilities. The projected market share for UM SMC at Chestertown is specific to UM SMC at Dorchester's historical experience, rural location, and proximity to few alternative providers.

With a focus on other rural geographies, the Applicants were able to identify three hospitals with psychiatric units with market share experience that support the market share assumed for UM SMC at Chestertown. These hospitals include Western Maryland Health System, Meritus Medical Center, and Peninsula Regional Medical Center. The definition of service areas, by zip code, and calculation of inpatient psychiatric market share for each of these hospitals in fiscal year 2018 is presented in **Exhibit 11** and summarized below in Table 18. The inpatient psychiatric market shares for these three hospitals range from 65.0% at Meritus Medical Center to 94.4% at Western Maryland Health System. Each of these examples support the 67.9% market share projected for UM SMC at Chestertown.

Table 18
Inpatient Psychiatric Market Share
of Select Hospitals in Rural Geographies
FY2018

Hosptial	Hospital Discharges	Service Area Discharges	Hospital Market Share
Western Maryland Health System	780	826	94.4%
Meritus Medical Center	885	1,362	65.0%
Peninsula Regional Medical Center	589	783	75.2%

Source: Maryland non-confidential data set

It is worth noting that while the service area for UM SMC at Dorchester in fiscal year 2018 included three Wicomico county zip codes (20801 Salisbury, 20804 Salisbury and 21837 Mardela Springs), they are excluded from the service area for UM SMC at Chestertown because of their close proximity to PRMC, which also provides inpatient psychiatric services. If these three zip codes in which UM SMC at Dorchester only captured market shares in fiscal year 2018 of 8.5%, 5.2% and 10.0%, respectively (Table 8), were excluded from the service area for UM SMC at Dorchester, the resulting market share would have equaled 74.1%. This is higher than the projected market share of 67.9% for UM SMC at Chestertown shown in Tables 11 and 12.

4. **Do the Delaware Certificate of Public Review (CPR) applications referenced on page 14 identify the service areas of the Delaware hospitals listed in Table 10? If so, do these hospitals draw patients from the Mid-Shore jurisdictions? Please provide information on this patient origin data if available. If not, does the applicant have information on patient origin of any of these hospitals? If so, please provide this information.**

Applicant Response

As noted in the Exemption request, 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* is reproduced below for convenience).

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

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The Delaware applicants present very limited market analyses with no identification of patients' origin counties or zip codes. The Applicants inquired of the Delaware Health Information Network ("DHIN") about the ability to obtain patient level detail associated with these facilities. Representatives from DHIN provided a cost estimate to purchase the data, which the Applicants determined to be cost prohibitive.

In an attempt to gather some information on Maryland residents utilizing Delaware hospitals for inpatient psychiatric services, data on Medicare Fee-for-Service recipients was obtained for residents of Caroline, Dorchester, Kent, Queen Anne's, and Talbot counties. In calendar year 2018, 224 Medicare recipients in these Maryland counties received inpatient psychiatric care. Of those patients, 18 or 8.0% of them received care at Delaware hospitals (Table 19).

Table 19
CY2018 Medicare Patients
Utilization of Inpatient Psychiatric Programs

	Patient Residence						
Hospital(s)	Caroline	Dorchester	Kent	Queen Anne's	Talbot	Total	% of Total
UM Shore Health	24	48	15	16	29	132	58.9%
Other UMMS Hospitals	1	5	4	0	1	11	4.9%
Sheppard Pratt Hospital	2	0	3	6	2	13	5.8%
Other Maryland Hospitals	4	10	2	9	9	34	15.2%
Delaware	7	1	9	1	0	18	8.0%
Other States	5	4	1	2	4	16	7.1%
Total	43	68	34	34	45	224	100.0%

Source: CY2018 MedPar data, includes Medicare FFS patients only
Note: Psychiatric DRGs are defined as MS-DRGs 876, 880 - 887

In fiscal year 2018, UM SMC at Dorchester provided inpatient psychiatric care to five patients who reside in Delaware. These Delaware zip codes fall outside of UM SMC at Dorchester's inpatient psychiatric service area. Similarly, the zip codes for the 18 Maryland Medicare patients that received inpatient psychiatric care at hospitals in Delaware are likely outside of the service areas for those Delaware hospitals. In addition, 16 or 7.1% of the Maryland Medicare patients received inpatient psychiatric care at hospitals outside of Maryland and Delaware. The zip codes for these Maryland Medicare patients are likely outside of the service areas for these other out of state hospitals.

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. Thus, they have very limited capacity to draw patients from UM SMC at Chestertown's service area. The Applicants do not expect that UM SMC at Chestertown will compete with the inpatient psychiatric programs in Delaware.

5. **On a related note, the applicants state (p. 15) that they "do not expect that UM SMC at Chestertown will compete with the inpatient psychiatric programs in Delaware," because the CPR applications include "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." The exemption request seems to assume that the Delaware facilities' projections do not include Maryland patients. Is that indeed your assumption, and if so, have you verified that assumption?**

Applicant Response

The Applicants assume that the Delaware facilities provide some inpatient psychiatric care to Maryland patients. As described in response to Question 4 above, the CPR applications do not clearly define service areas or provide patient origin data. They also reference projections of 90% to 100% occupancy. Based on these facts, the Applicants assume that the zip codes from which Delaware hospitals may draw Maryland patients are outside of the service areas for those hospitals and, therefore, the number of inpatient psychiatric patients coming to those facilities from Maryland is limited.

6. **In a series of tables beginning on page 6 the exemption request discusses continued access to psychiatric services, comparing drive times to UM SMC at Dorchester and UM SMC at Chestertown. For ease of analysis and comparison of alternatives please combine that information as shown in the chart below.**

Applicant Response

Using the template chart, the Applicants present the distance in miles from each zip code in UM SMC at Chestertown's service area to UM SMC at Dorchester, UM SMC at Easton, and UM SMC at Chestertown in Table 20 below.

Table 20
Distance (miles) from Each Zip Code in UM SMC at Chestertown Service Area to UM SMC at Dorchester, UM SMC at Easton, and UM SMC at Chestertown

#	Zip Code	Community	County	Distance (miles) to:		
				UM SMC Dorchester	UM SMC Easton	UM SMC Chestertown
1	21601	Easton	Talbot County	15.4	0.4	36.1
2	21610	Betterton	Kent County	65.0	50.0	12.3
3	21613	Cambridge	Dorchester County	1.1	16.0	52.2
4	21617	Centreville	Queen Anne's County	35.0	20.0	17.1
5	21619	Chester	Queen Anne's County	43.3	27.0	34.3
6	21620	Chestertown	Kent County	53.4	39.0	3.1
7	21623	Church Hill	Queen Anne's County	42.0	27.0	11.5
8	21625	Cordova	Talbot County	23.8	9.1	30.9
9	21628	Crumpton	Queen Anne's County	53.0	38.0	10.1
10	21629	Denton	Caroline County	33.5	20.0	34.6
11	21631	East New Market	Dorchester County	7.8	22.0	58.3
12	21632	Federalsburg	Caroline County	22.9	20.0	47.0
13	21635	Galena	Kent County	60.0	46.0	16.3
14	21636	Goldsboro	Caroline County	43.1	28.0	22.5
15	21638	Grasonville	Queen Anne's County	37.5	23.0	29.8
16	21639	Greensboro	Caroline County	7.8	24.0	29.6
17	21640	Henderson	Caroline County	44.8	30.0	18.6
18	21641	Hillsboro	Caroline County	29.0	14.0	29.0
19	21643	Hurlock	Dorchester County	16.1	19.0	53.3
20	21645	Kennedyville	Kent County	60.0	45.0	10.3
21	21649	Marydel	Caroline County	53.8	39.0	19.2
22	21651	Millington	Queen Anne's County	60.0	45.0	17.0
23	21652	Neavitt	Talbot County	36.0	21.0	55.5
24	21653	Newcomb	Talbot County	22.0	7.1	41.6
25	21654	Oxford	Talbot County	14.3	7.7	44.5
26	21655	Preston	Caroline County	20.5	10.0	13.6
27	21657	Queen Anne	Queen Anne's County	30.6	16.0	24.0
28	21658	Queenstown	Queen Anne's County	34.0	19.0	28.1
29	21659	Rhodesdale	Dorchester County	18.6	24.0	59.8
30	21660	Ridgely	Caroline County	34.0	19.0	24.1
31	21661	Rock Hall	Kent County	67.1	54.0	17.7
32	21663	Saint Michaels	Talbot County	26.4	12.0	46.1
33	21667	Still Pond	Kent County	63.0	48.0	10.5
34	21668	Sudlersville	Queen Anne's County	51.0	36.0	13.3
35	21673	Trappe	Talbot County	5.9	13.0	46.2
36	21677	Woolford	Dorchester County	10.0	24.0	60.4
37	21678	Worton	Kent County	63.5	51.0	12.6
38	21679	Wye Mills	Talbot County	28.0	13.0	27.1
39	21869	Vienna	Dorchester County	14.7	30.0	65.2
40	21912	Warwick	Cecil County	70.0	55.0	24.9
41	21915	Chesapeake City	Cecil County	76.0	61.0	30.2
42	21919	Earleville	Cecil County	68.0	53.0	22.2

Source: Distance is determined using GoogleMaps

7. **Did Shore consider the possibility of market shift to Peninsula Regional, whose adult behavioral health unit is considerably closer to several towns in the service area? For example, travel distances and times featured in the table immediately below show the trip from Cambridge to Salisbury to be much shorter than the trip to Chestertown, as is the trip from Hurlock (this list is not exhaustive, but an example). Please defend the position that the market share decline projected is realistic and not overly optimistic.**

	Service area discharges	Proximity to Chestertown (Mi./mins.)	Proximity to Salisbury	Mkt share at Cambridge	Projected Mkt share at Chestertown
Cambridge	148	52/70	32/39	86.5	66.7
Easton	81	38/51	37/55	79.0	65.7
Chestertown	43	--	83/104	65.1	86.5
Hurlock	38	54/69	29/36	75.4	66.7
Federalsburg	31	48/64	30/43	70.7	45.9

Applicant Response

Yes, the Applicants did consider the shift of market share to PRMC. In determining the appropriate zip codes to include in UM SMC at Chestertown's service area, it was determined that three zip codes in Wicomico county (20801 Salisbury, 20804 Salisbury, and 21837 Mardela Springs) should be excluded from the service area even though, in fiscal year 2018, they were included in UM SMC at Dorchester's service area. These particular zip codes were excluded because of their close proximity to PRMC, which also has an inpatient psychiatric unit. Notably, patients in these zip codes are seeking care at UM SMC at Dorchester today, in part due to the high occupancy levels at PRMC, even though PRMC is located closer to them. Accordingly, the Applicants did not think it was realistic to assume that PRMC would capture the entire market share in a particular zip codes based on proximity alone, since proximity is clearly not the only factor influencing Dorchester's market share today. As noted above, if UM SMC at Dorchester were to exclude these three Wicomico county zip codes from its service area with market shares of 8.5%, 5.2% and 10.0%, respectively, in fiscal year 2018, UM SMC at Dorchester's service area market share would equal 74.1%.

In addition, the table presented above, as prepared by the MHCC staff, correctly displays the way in which the proximity to UM SMC at Dorchester versus UM SMC at Chestertown is taken into account in the calculation of market share by zip code. As the distance to Cambridge, Easton, Hurlock, and Federalsburg is increased as inpatient psychiatric beds are moved from Cambridge to Chestertown, the market share is reduced. As the distance to inpatient psychiatric beds in Chestertown is reduced, the market share is increased.

8. **AP 2a, Written Procedures for 24/7 treatment: Staff does not find any reference in the submitted policies stating that admissions and assessments are provided on a 24/7 basis. Please affirm an intention to comply with this requirement.**

Applicant Response

The Applicants intend to update the applicable policies to include a statement that psychiatric inpatient admissions and assessments will be provided 24 hours a day, seven days a week at UM SMC at Chestertown, as is the case today at UM SMC at Dorchester.

9. AP 3c, Psychiatric consultation services: Shore states that consultative services will be provided by University of Maryland ("UM") Shore Regional Health's Psychiatry Department by 4.0 FTE psychiatric providers.

a. What is the primary – i.e., "home base" -- location of these practitioners?

Applicant Response

The primary office location of the psychiatrists and mental health nurse practitioners caring for patients in Chestertown will be in Chestertown. With respect to psychiatric consultation services, UM SRH's current policies generally require practitioners who are on call to be located within a 30 minute response time of their home base practice location in case they are required to respond to an urgent request for consult to see a patient in need. In recognition of the challenges of practitioner recruitment, practice sizes, and the advent of telehealth capabilities, this policy was recently amended to provide additional latitude while ensuring that patient care needs are met. Many specialties are able to meet patient care needs from a distance, particularly those that are amenable to telehealth use, such as psychiatry. UM SRH's goal is to recruit and retain providers who will become part of the communities they serve.

b. Provide the job description responsibilities of these consultants.

Applicant Response

Attached as **Exhibit 12** are job descriptions for UM SRH's Behavioral Health Medical Director, employed physicians, physician assistants, and nurse practitioners.

10. AP 7, Denial of Admissions: Describe the use of the psychiatric program at UM SMC at Dorchester for involuntary admissions. Will the proposed program at UM SMC at Chestertown accept involuntary admissions? If so, will the unit be designed with security features related to acceptance of involuntary admissions?

Applicant Response

Yes, the proposed program at UM SMC at Chestertown will accept involuntary psychiatric admissions, just as the UM SMC at Dorchester program does today. At UM SMC at Dorchester today, patients in need of psychiatric care are evaluated in the emergency department. If inpatient care is required and the patient does not agree with the admission, two physicians, one physician and one psychologist, or one physician and one psychiatric NP must certify that the patient must be admitted involuntarily. If the patient is referred for involuntary admission to UM SMC at Dorchester, the patient is placed on observation status in the psychiatric unit and is evaluated by a psychiatrist within 24 hours of the initial confinement to determine if the individual should be discharged, voluntarily admitted, or involuntarily admitted following a hearing with an administrative law judge. This procedure is consistent with the requirements provided by Maryland

Code, Health-General §§ 10-613 and 10-620 *et seq.* and COMAR 10.21.01 *et seq.* and is the same process that will be implemented in Chestertown.

UM SMC at Dorchester, UM SMC at Chestertown, and UM SMC at Easton currently accept emergency petition patients and will continue to do so upon relocation of the inpatient psychiatric program to Chestertown. A physician will examine an emergency petition patient within six hours of the patient's arrival at an UM SRH emergency department to determine whether the patient meets the requirements for involuntary admission.

The design of the proposed psychiatric unit at Chestertown will be consistent with the Facility Guidelines Institute's Guidelines for Design and Construction of Hospitals, Section 2.5. The design will include perimeter locking and a sally port at the entrance to accommodate patients admitted involuntarily.

11. AP 8, Uncompensated Care: Will the level of uncompensated psychiatric service projected to be provided at UM Shore Medical Center ("SMC") at Chestertown be equivalent to that provided at UM SMC at Dorchester? Please provide detail.

Applicant Response

Yes, the Applicants anticipate that the same level of uncompensated psychiatric care that is provided today by UM SMC at Dorchester will be provided at UM SMC at Chestertown because largely the same patient population will be served by the relocated inpatient psychiatric beds. The Applicants are unable to break out psychiatric uncompensated care from overall levels of uncompensated care, which is why the amounts of uncompensated care for all hospital services are presented in Table 17 of the Exemption request on page 24. In fiscal year 2018, UM SMC at Dorchester and UM SMC at Chestertown experienced uncompensated care of 5.60% and 5.25%, respectively, as a percentage of revenue.

MORE EFFICIENT AND EFFECTIVE HEALTH CARE DELIVERY

12. Please specifically state the ways in which the effectiveness of psychiatric hospital services will improve if the services are provided at UM SMC at Chestertown rather than UM SMC at Easton.

Applicant Response

The Applicants expect that the proposed relocation of the inpatient psychiatric program to UM SMC at Chestertown paired with the expansion of outpatient behavioral health services in Kent County and Talbot County will improve the overall delivery of psychiatric services in the region. The proposed changes are also expected to stimulate development of 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 and as well as partnerships with these programs. In addition, the inpatient psychiatric services provided at UM SMC at Chestertown will be just as effective as those provided at UM SMC at Dorchester today and will potentially improve service delivery over the previously proposed Easton location. The UM SMC at Chestertown facility will provide a permanent home for these services, whereas, if the psychiatric beds are relocated to the existing hospital in Easton, the unit will only be temporary and the unit will need to be relocated when the proposed replacement hospital opens.

The CON exemption standard requires that the project "[w]ill result in more efficient and effective delivery of *health care services*[.]" COMAR 10.24.01.04B(6) (emphasis added). As the Applicants note on page 28 of the Exemption request, the proposed relocation of the inpatient psychiatric beds to Chestertown will result in improvements in efficiency and effectiveness of UM SRH's overall delivery of health care to the Mid-Shore by creating cost efficiencies for the new proposed regional medical center in Easton. In addition, the relocation will improve the financial outlook for UM SMC at Chestertown by improving utilization of fixed costs by spreading the cost of numerous support services, such as food and nutrition, housekeeping, facilities, medical information services, and care transition, over a broader patient and provider base.

13. Please describe and quantify the costs that will be avoided if psychiatric hospital services are provided at:

a. UM SMC at Chestertown rather than UM SMC at Easton, other than the cost of including a psychiatric unit at a relocated Easton hospital.

b. Easton rather than UM SMC at Chestertown.

Please be sure to include transportation and transfer costs associated with service provision at the alternative sites.

After this exercise, please place this cost analysis in the context of a demonstration that the proposed project will improve the efficiency of the health care delivery system. State all assumptions supporting this cost analysis.

Applicant Response

The direct patient care costs of providing psychiatric hospital services at UM SMC at Chestertown versus UM SMC at Easton are projected to be the same. In addition to those direct patient care costs are transportation related costs. In the letter from Dr. Eric L. Anderson to the MHCC, dated September 12, 2019, Dr. Anderson states "[t]ransfer of mental health patients will add a significant expense[.]" The Applicants do not agree with Dr. Anderson's assertion. There are two types of transportation costs to the Applicants associated with psychiatric services: (1) interfacility transport of behavioral health patients requiring inpatient care who are coming from UM SRH's emergency departments and the Emergency Center at Queenstown, when the patient's insurance does not cover this cost; and (2) transportation assistance upon discharge for patients in need.

The Applicants considered two factors when comparing the difference in projected transportation costs related to interfacility transports of behavioral health patients from UM SRH's emergency departments and the Emergency Center at Queenstown to UM SMC at Easton and UM SMC at Chestertown, as follows:

- Mileage
- Number of transports

Included in **Exhibit 13** are analyses that identify the closest UM SRH emergency department or emergency center to each zip code in the psychiatric service areas for UM SMC at Easton and UM SMC at Chestertown. Also included in the exhibit is an identification of the miles

and resulting transport cost from that closest emergency department or emergency center to both UM SMC at Easton and UM SMC at Chestertown. Included in this analysis is an assumption that a patient seeking care will go to the closest emergency department. Those requiring admission will then be transported from that emergency department or emergency center to either UM SMC at Easton or UM SMC at Chestertown depending on where the psychiatric beds are located. As presented in **Exhibit 13**, the analysis of miles and resulting cost of transports to Easton total $64,458. The analysis of miles and resulting cost of transports to Chestertown total $149,078. Driven by the increase in mileage, the resulting cost of transports to Chestertown totaling $149,078 is $84,620 greater than the $64,458 cost of transports to Easton.

While the increase in mileage will drive an increase in transportation costs, the number of transports that will be required to travel to UM SMC at Chestertown is projected to be less than those required to travel to UM SMC at Easton (*see* **Exhibit 13**). This reduction in transports is driven by a reduction in the projected number of psychiatric discharges at UM SMC at Chestertown versus discharges at UM SMC at Easton. The reduction in discharges at UM SMC at Chestertown is based on the assumption that psychiatric patients in Wicomico County who are closer to Salisbury, Maryland will seek care at Peninsula Regional Medical Center. Combining out-of-service area discharges (15% of total discharges) with the service area discharges, as presented in Table 11, there are 493 projected psychiatric discharges at UM SMC at Chestertown versus 556 projected discharges at UM SMC Easton (service area discharges as presented in Table 8 plus out-of-service area discharges that equal 15% of the total discharges). The reduction of 63 psychiatric discharges at Chestertown would result in an equal reduction in the number of transports. At an average cost of $273 per transport, excluding mileage and based on historical experience at UM SMC at Dorchester, the reduction in the number of transports would result in a $17,199 reduction in transportation costs to UM SMC at Chestertown versus UM SMC at Easton.

Driven predominantly by the increase in mileage, the net impact on transportation costs associated with the two factors (mileage = increase of $84,620, number of transports = reduction of $17,199) to UM SMC at Chestertown is $67,421 more than the transportation costs to UM SMC at Easton.

A similar increase in cost of transportation assistance to patients in need upon discharge is also assumed in relation to the increase in mileage but reduction in psychiatric discharges at UM SMC at Chestertown. In fiscal year 2019, UM SMC at Dorchester incurred $6,730 in taxi vouchers for 100 behavioral health related patients. There is not sufficient information, though, to determine the zip code origin of these patients and how their transportation costs may change in relation to mileage. With the reduction in psychiatric discharges at UMC SMC at Dorchester, it is expected that the number of patients in need of transport upon discharge will also be decreased but mileage would potentially increase. The Applicants expect that transportation assistance that is provided to patients in need upon discharge could increase slightly but, like UM SMC at Dorchester's historical taxi voucher costs, will continue to be a nominal cost.

The Applicants do not believe that the small increase in transportation costs at UM SMC at Chestertown will have any meaningful impact on the overall efficiency of the health care delivery system for inpatient psychiatric services.

14. Will the unit cost of psychiatric admissions or patient days be lower at UM SMC at Chestertown than at the relocated UM SMC at Easton? If so, please explain the basis for the lower cost.

Applicant Response

The variable cost per admission and patient day is the same regardless of the facility in which the psychiatric inpatient unit is located. However, movement of the unit to the Chestertown hospital better utilizes the fixed costs at that location.

15. The exemption request states that there is "a special transportation grant serving the regional needs of families and patients during the inpatient admission" supported by the Chester River Health Foundation. Please describe:

a. The Chester River Health Foundation;

Applicant Response

The Chester River Health Foundation is the non-profit charitable organization reponsible for soliciting and distributing charitable gifts that enable, enhance and support vital patient care equipment and services at UM Shore Medical Center at Chestertown. It is governed by a community-based, volunteer Board of Directors. One hundred percent (100%) of the funds raised by the Foundation are used to support the community.

Since its inception in 1993, first as a department of the hospital and then incorporated as a 501(c)(3) not for profit organization in 2005, the Foundation has received more than $23 million of community and grant support, which serves the health and healing needs of the people served by the hopsital.

b. Its mission; and

Applicant Response

UM Chester River Health Foundation's mission is to raise funds that steward and enhance healthcare excellence for the people who live in or visit the communities served by UM Shore Medical Center at Chestertown, thus supporting the regional mission of "Creating Healthier Communities Together."

Its vision is for the community is to embrace, universally, UM Shore Medical Center at Chestertown as an excellent and a vital healthcare resource, and make the Foundation a high philanthropic priority in the community.

c. Its resources.

Applicant Response

As of September 30, 2019, the UM Chester River Health Foundation's total net assets are approximately $6.7 million.

16. Does the proposed operating budget include transportation costs associated with:

a. "patient transports from regional emergency departments provided by the health system through contractual interfacility transport services, not

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jurisdictional EMS, for behavioral health patients admitted from regional UM SRH emergency departments" (p. 30)?

Applicant Response

Yes, the proposed operating budget includes transportation costs associated with interfacility transports. These costs are based on the historical experience at UM SMC at Dorchester and the projected costs at UM SMC at Easton. The Applicants considered two factors when comparing the difference in projected transportation costs related to interfacility transports of behavioral health patients from UM SRH's emergency departments and the Emergency Center at Queenstown to UM SMC at Easton and UM SMC at Chestertown, as follows:

- Mileage
- Number of transports

Included in **Exhibit 13** are analyses that identify the closest UM SRH emergency department or emergency center to each zip code in the psychiatric service areas for UM SMC at Easton and UM SMC at Chestertown. Also included in the exhibit is an identification of the miles and resulting transport cost from that closest emergency department or emergency center to both UM SMC at Easton and UM SMC at Chestertown. Included in this analysis is an assumption that a patient seeking care will go to the closest emergency department. Those requiring admission will then be transported from that emergency department or emergency center to either UM SMC at Easton or UM SMC at Chestertown depending on where the psychiatric beds are located. As presented in **Exhibit 13**, the analysis of miles and resulting cost of transports to Easton total $64,458. The analysis of miles and resulting cost of transports to Chestertown total $149,078. Driven by the increase in mileage, the resulting cost of transports to Chestertown totaling $149,078 is $84,620 greater than the $64,458 cost of transports to Easton.

While the increase in mileage will drive an increase in transportation costs, the number of transports that will be required to travel to UM SMC at Chestertown is projected to be less than those required to travel to UM SMC at Easton (*see* **Exhibit 13**). This reduction in transports is driven by a reduction in the projected number of psychiatric discharges at UM SMC at Chestertown versus discharges at UM SMC at Easton. The reduction in discharges at UM SMC at Chestertown is based on the assumption that psychiatric patients in Wicomico County who are closer to Salisbury, Maryland will seek care at Peninsula Regional Medical Center. Combining out-of-service area discharges (15% of total discharges) with the service area discharges, as presented in Table 11, there are 493 projected psychiatric discharges at UM SMC at Chestertown versus 556 projected discharges at UM SMC Easton (service area discharges as presented in Table 8 plus out-of-service area discharges that equal 15% of the total discharges). The reduction of 63 psychiatric discharges at Chestertown would result in an equal reduction in the number of transports. At an average cost of $273 per transport, excluding mileage and based on historical experience at UM SMC at Dorchester, the reduction in the number of transports would result in a $17,199 reduction in transportation costs to UM SMC at Chestertown versus UM SMC at Easton.

Driven predominantly by the increase in mileage, the net impact on transportation costs associated with the two factors (mileage = increase of $84,620, number of transports = reduction of $17,199) to UM SMC at Chestertown are projected to be $67,421 more than the transportation costs to UM SMC at Easton. The "Other Expenses" category in Tables G, H, J, and K of **Exhibit**

10 have been updated to reflect an additional $67,421 of interfacility transport fees beginning in fiscal year 2022.

b. Family transportation for care participation and coordination?

A line item for those costs do not appear on Tables H or J. What are those costs and what assumptions are tied to those estimates? If needed, submit corrected Tables H and J including those costs.

Applicant Response

The proposed operating budget does not include transportation costs for families. The Chester River Health Foundation has expressed a willingness to provide a special transportation grant for family members that are in need.

THE PUBLIC INTEREST

17A. MHCC staff has received a number of comments in opposition to the proposed project in recent weeks, including comments from the current behavioral health staff at UM SMC at Dorchester. (The material received to date is attached.) MHCC staff would like Shore's rebuttal of the following points made by commenters.

a. Locating the behavioral health program in Easton optimizes the ability to consolidate and centralize resources for more efficient use.

Applicant Response

UM SRH is a rural health care delivery system serving approximately 175,000 people spread over nearly 2,000 square miles in Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties. Consolidation and centralization of resources is not always possible or optimal for patient care in this type of regional service area as it can create health care access issues. Patients often prefer to seek care closer to home and that becomes difficult if all health care providers are centralized in a single area. For this reason, UM SRH has focused its efforts on developing a broad network of primary and specialty providers that provide coverage across its broad service area. While there are many challenges to rural health care delivery, including operating low-volume, resource intensive hospitals, UM SRH seeks to create efficiencies where it can, while also providing adequate access to primary and specialist care, which are essential to improve the health and wellness of the entire population it serves.

Although many of UM SRH's specialty services are located in Easton, historically, behavioral health services have been in Dorchester and have operated as largely a self-contained unit. Although patients served in the behavioral health unit sometimes have co-occurring medical needs, these needs are often met by hospitalists at the facility. As explained in response 17(A)(b) below, patients currently served in the UM SMC at Dorchester psychiatric unit are rarely transferred to another acute facility for other medical needs. UM SRH expects that the same will be true of the patients served in the UM SMC at Chestertown unit, which is why UM SRH determined that this unit could be relocated without creating care delivery issues for patients served by this program.

b. **An Easton location has the benefit of a more proximal location for necessary medical services and a wider array of community services that a patient may need.**

Applicant Response

Psychiatric inpatients at UM SMC at Chestertown with co-occurring medical conditions will receive medical care from an internist or hospitalist as part of their course of treatment. In addition, these patients will be referred to UM SRH's network of primary care physicians or outpatient medical services as needed as part of their discharge planning. Table 21 below shows the Discharge Disposition of UM SMC at Dorchester psychiatric patients in calendar year 2018. The majority of psychiatric patients served by the UM SMC at Dorchester inpatient program were discharged to home (86%) and only two percent of patients were transferred to another acute care hospital for other medical needs. UM SRH anticipates that patients served by the relocated psychiatric program in Chestertown would have a similar profile. The majority of the psychiatric patients' needs would be met by the inpatient psychiatric program and other outpatient services, and a very small number of patients would need to be transferred to Easton or another acute care facility for other medical needs.

Table 21
UM SMC at Dorchester
Psychiatric Patient Discharge Disposition
CY2018

Discharge Disposition	Cases	% of Total
Home	517	86%
Left Against Medical Advice	27	4%
Unknown	22	4%
Acute Care	10 (1)	2%
SNF	9	1%
Psych Hosp	4	1%
Rehab Hosp	4	1%
Home Health	3	0%
Detention or Correctional Facility	3	0%
Unknown	2	0%
Nursing Home	2	0%
Other	1	0%
Total	604	100%

Source: CY2018 HSCRC Statewide abstract data, Psychiatric and substance abuse services lines

Note (1): One patient was transferred to Dorchester and one to Easton. The remaining receiving hospitals were not identified.

Patients generally seek community services in their community, so the broad array of community services in Easton may benefit patients living in that area but may not be utilized by

patients in more distant portions of the Mid-Shore region. Discharge planners in the proposed UM SMC at Chestertown psychiatric unit will connect patients with applicable community support services. UM SRH and its community partners also anticipate that the relocated inpatient program will spur development of additional community services in the Chestertown area, as discussed in response 17A(c) below.

c. An Easton location will provide greater opportunities for partnering with other persons and organizations to improve behavioral health services.

Applicant Response

It is understood in the behavioral health community in the Mid-Shore region that outpatient care is the greatest community need on the continuum of care for behavioral health. UM SRH's community partners throughout the five county region, including the health departments and regional service providers, work on this issue continually. No single location in the five county region has optimal availability of community based services; rather, all communities would benefit from expanded availability of outpatient behavioral health care.

When this proposed project was still in its early conceptual planning stages, UM SRH began discussions with more than a dozen regional behavioral health organizations, under the umbrella of the State's core services agency for behavioral health, Mid Shore Behavioral Health, Inc. The issues and questions raised during those discussions informed UM SRH's development and planning for the project, including issues related to transportation, access, outpatient services and staffing, which have been raised by others. UM SRH identified each of these issues in its Exemption application and described how it plans to address these issues.

The key to successful long-term treatment for behavioral health needs is the availability of a continuum of services. UM SRH is committed to working with its community partners to enhance and expand these community based services to ensure comprehensive behavioral health care across the continuum of care, including all facets of outpatient care. As a key part of UM SRH's role in care delivery, it is committed to the expansion of outpatient behavioral health services that are currently offered in Cambridge to two additional locations in Easton and Chestertown in conjunction with the relocation of the inpatient beds to Chestertown.

17B. The claim is made that about 84% of patients seen by the emergency behavioral health response team were from the Easton or Cambridge areas in the ten-month span of July 2018 to April 2019. Therefore, the proposed location of the behavioral health unit in Chestertown will "take away centralized mental health services from the population density where the need is the greatest to an area remote from said population." Please address this concern.

Applicant Response

The relocation of the inpatient psychiatric unit will not "take away centralized mental health services from the population density where the need is the greatest," as inpatient psychiatric services are only one component of mental health services and these services will still be available to the UM SRH service area when the unit relocates. Emergent and outpatient behavioral health services are decentralized today and will continue to be available to patients throughout the service area. As Dr. Anderson's statistics regarding the UM SRH Behavioral Health Response Team ("BHRT") indicate, patients seek emergent behavioral health services

across UM SRH's service area today at the various UM SRH emergency departments in Easton, Cambridge, and Chestertown and at the UM Shore Emergency Center in Queenstown. These services are decentralized and broadly available throughout the service area today, and UM SRH anticipates that patients will continue to seek emergent behavioral health services at its facilities in the same manner as they are doing today once the inpatient unit relocates. As Dr. Anderson's statistics also indicate, the majority of behavioral health patients who seek emergent care at UM SRH facilities are treated and discharged to their community. For any emergent behavioral health patients who require inpatient psychiatric care, UM SRH will provide transport to UM SMC at Chestertown or another appropriate inpatient facility, in the same manner as patients are transported to UM SMC at Dorchester or another inpatient facility today. When behavioral health patients are discharged from an UM SRH emergency department, the UM Shore Emergency Center at Queenstown, or the inpatient psychiatric unit at UM SMC at Chestertown, they will be referred to appropriate outpatient services, which are also dispersed throughout the UM SRH service area today and UM SRH plans to expand the availability in conjunction with the relocation of the inpatient unit. Accordingly, the relocation of the inpatient unit to UM SMC at Chestertown will not remove centralized mental health services from the population density where they are needed, as patients can continue to seek emergent care in the same manner as they do today, will be transported to the inpatient unit in Chestertown if inpatient care is required, and will have expanded access to outpatient services upon discharge.

18. The assertion is made that the "community resources for psychiatric follow-up and housing are lacking in the Chestertown area," implying that such resources are more plentiful in Easton. Please comment.

Applicant Response

There is very little difference in the availability of such community resources from county to county or between Easton and Chestertown. (See Mid Shore Behavioral Health, *2019 Resource Guide Public Behavioral Health Services in Caroline, Dorchester, Kent, Queen Anne's, and Talbot Counties of Maryland*, available at https://www.midshorebehavioralhealth.org/resources-links). As noted in the response to Question 17B above, no single location in the five county region has optimal availability of community based services, and all communities would benefit from expanded availability of outpatient behavioral health care. The Applicants anticipate that their proposed expansion of outpatient behavioral health services in conjunction with the relocation of inpatient psychiatric beds to Chestertown will help to spread community resources more broadly in the region. Greater dispersal of community resources throughout the Mid-Shore will be beneficial for patient care, given that discharged psychiatric patients generally return to the communities from which they originated. Patients' needs will be better served if wraparound services and the continuum of care programs are located in or closer to their communities, rather than consolidated in a single location.

Because Chestertown was, until very recently (2010), the home of Upper Shore Community Mental Health Center, a State mental health hospital, and is the home of a State inpatient substance use disorder facility (the Whitsitt Center), Chestertown and its citizens and agencies are accustomed to fostering a number of outpatient and support services that benefit and serve behavioral health patients who reside in the area. Chestertown is a hub of such supportive programs for the northern end of the Mid-Shore Region, including therapists, counselors, social workers and clinics to transitional care homes, homeless shelters, food banks, soup kitchens and other support services.

19. The comments indicate that ambulance transport of mental health patients who need restraints is a safety issue especially when the trip will be over an hour long. Please address this concern.

Applicant Response

Today, UM SRH routinely and safely transports behavioral health patients varying distances, including trips of more than an hour, without incident. These trips include transports within UM SRH, for example, from UM SMC at Chestertown to UM SMC at Dorchester (approximately 52 miles) and transports of behavioral health patients to more distant psychiatric facilities such as University of Maryland Medical Center (approximately 83 miles) and Sheppard Pratt (approximately 101 miles). UM SRH and its interfacility transport providers have protocols in place to address safety issues during these transports.

20. The comments indicate that key medical staff are unwilling to staff a relocated behavioral health unit. How can this consequence of relocation be consistent with a finding that the project is in the public interest?

Applicant Response

Please see the response to Question 2 above, which explains the Applicants' plans for recruitment and retention of key behavioral health staff. Based on these plans, the Applicants fully expect to be able to staff the relocated psychiatric unit to meet patient care needs.

21. This proposal, if executed, will likely result in creating "winners" and losers." Thus the calculation of whether it is in the public interest needs to weigh the benefits realized by the winners against the harm suffered by the losers, to arrive at a finding regarding which choice provides the greatest good for the greatest number of people.

Considering the population of the five-county service area of Shore Health, please discuss the relative weight that can be reasonably assigned to the public interest of a) communities that will benefit from the proposed relocation in comparison to; b) communities that obtain no direct benefit from the relocation and will experience longer travel times to the site of service.

Applicant Response

UM SRH has been diligent in evaluating alternatives and developing the proposed project, which, aims to meet two important regional health care needs: 1) providing continued access to the full continuum of behavioral health services for the Mid-Shore region, and 2) improving the financial outlook for UM SMC at Chestertown, which provides essential access to a multitude of medical services for residents of Kent County and northern Queen Anne's County. Neither this project, nor any other proposals considered by UM SRH that modify UM SRH's current service delivery model seek to position communities or specific populations as "winners" and "losers;" rather, they are aimed at improving overall health and wellness for the population it serves in a care delivery environment that presents many challenges. The UM SRH Board of Directors has weighed the benefits and possible challenges associated with the proposed relocation of the inpatient behavioral health unit to Chestertown. The UM SRH Board stands firm in its approval of the proposed relocation due to the intended benefits it will have for behavioral health patients

in the region, as well as for citizens of Kent and northern Queen Anne's County. Some of the key public interest considerations related to this project are as follows:

1. **The relocation of 12 inpatient psychiatric beds to Chestertown from Cambridge will not diminish the availability of inpatient psychiatric services.**

   Although the proposed psychiatric service area for the UM SMC at Chestertown program will shift slightly to the north of UM SMC at Dorchester's current psychiatric service area, the relocated program is projected to have roughly the same number of discharges and need for 12 psychiatric beds in fiscal year 2022.

   UM SRH anticipates that patients with emergent behavioral health needs will continue to be evaluated and treated in its emergency departments and freestanding medical facilities as is done today, and those patients in need of inpatient psychiatric care will be transferred to UM SMC at Chestertown or another appropriate inpatient psychiatric facility.

2. **The relocation of 12 inpatient psychiatric beds to Chestertown will improve the projected financial performance of UM SMC at Chestertown, a hospital which provides critical access to patients in Kent and northern Queen Anne's county.**

   The population of Kent and northern Queen Anne's County is approximately 22,000. Each year, many of these citizens rely upon the hospital for emergent, inpatient, outpatient, and surgical services. In fiscal year 2019 alone, UM SMC at Chestertown had more than 700 inpatient admissions, 13,800 emergency department visits, 450 observation visits, and 2,300 surgical cases. This does not include the numerous other outpatient services it provided such as lab, imaging, primary and specialty care visits, and clinic visits. Socio-economic indicators show that the population in this very rural area is economically and educationally vulnerable. From the standpoint of population health and critical access needs, the continued availability of inpatient hospital services in Chestertown benefits a significant number of people in this area. The relocation of psychiatric beds to UM SMC at Chestertown will provide additional patients and revenue that will support the essential services this hospital provides the community.

3. **Transportation for behavioral health patients to and from Chestertown will not pose any greater challenge than the current situation.**

   Today, the majority of behavioral health patients arrive at the UM SRH emergency departments or the UM Emergency Center at Queenstown through their own means, or by EMS or law enforcement transport. Patients are evaluated and stabilized and if an inpatient psychiatric admission is warranted, patients are then transported by UM SRH's contractual ambulance service directly to the UM SMC at Dorchester inpatient unit or another appropriate inpatient psychiatric facility. UM SRH covers the cost of these transports beyond any insurance payments. Upon discharge, if the patient does not have transportation, a taxi or other private transportation is arranged and paid for by UM SRH.

   The Applicants anticipate that transportation will work in the exact same manner when the inpatient psychiatric program relocates to Chestertown. In the current system, behavioral health patients are transported varying distances to reach UM SMC at Dorchester or another inpatient unit. In the proposed system, the same will be true. Some patients transport times will increase with the relocation, but others will decrease.

4. **Transportation for families to participate in behavioral health patients' care presents the same challenge regardless of the location of the behavioral health unit, but the proposed relocation will provide additional grant funding from the Chester River Foundation to support family transportation needs.**

   UM SRH recognizes the importance of family and caregiver participation in behavioral health patients' care. Transportation for families of behavioral health patients is a challenge today. The Chester River Health Foundation has expressed a willingness to make available a special transportation grant to support family transportation to and from Chestertown, which will be a likely benefit of the relocation.

5. **UM SRH is proposing to expand access to outpatient behavioral health services in conjunction with the relocation of the behavioral health unit, which will enhance continuity of care for behavioral health patients in the region.**

   The key to comprehensive treatment for behavioral health needs is patient access to the full continuum of behavioral health services. UM SRH is committed to expanding the outpatient behavioral health services that are currently offered in Cambridge, Denton, and Queenstown to two additional locations in Easton and Chestertown in conjunction with the relocation of the inpatient beds to Chestertown. UM SRH will also partner with the region's behavioral health providers to ensure comprehensive behavioral health care across the continuum of care, including all facets of outpatient care.

October 18, 2019 Questions

1. **How will it be possible to continue to provide the services in Cambridge if the bulk of the behavioral health providers are located with the inpatient facility in Chestertown?**

Applicant Response

UM SRH is committed to providing continued, robust outpatient psychiatric care. UM SRH's behavioral health providers with outpatient patient care responsibilities will be caring for patients in various communities served by UM SRH in collaboration with UM SRH's existing outpatient behavioral health care partners. UM SRH anticipates that it may use a rotational schedule for its behavioral health outpatient providers and potentially telehealth consults in order to provide access to services across its service area. UM SRH currently uses a rotational schedule and telehealth consults for other outpatient specialty care in its services area and this approach has been successful in making care accessible to patients closer to their communities. Psychiatric care across the continuum from inpatient to outpatient care will be successful with collaboration of both inpatient and outpatient providers.

2. **How many additional staff - and filling what positions - will be required to expand behavioral health outpatient coverage into the northern portion of Queen Anne's County and the eastern and southern areas of Caroline County?**

Applicant Response

As the new outpatient programs are expanded, UM SRH will develop staffing plans and begin recruitment of additional staff. UM SRH will also explore other means to meet the needs of these communities, including new technology and telehealth opportunities as well as collaboration with community partners.

3. Please describe which entity(s) in the SRH corporate structure will house the behavioral health providers that will be deployed throughout Shore's service area.

Applicant Response

Psychiatric care across the continuum from inpatient to outpatient care will be successful with collaboration of UM SRH's inpatient and outpatient behavioral health providers. A range of outpatient behavioral health providers, including physicians, psychologists, advanced practice providers, licensed counselors and social workers will be employed by the University of Maryland Community Medical Group, Inc. *d/b/a* Shore Medical Group, contracted with UM SRH, or provided by community partners of UM SRH.

Table of Exhibits

Exhibit	Description
10	MHCC Tables and Assumptions
11	Other Hospitals' Psychiatric Market Share
12	Job Descriptions for UM SRH's Behavioral Health Medical Director, Employed Physicians, Physician Assistants, and Nurse Practitioners
13	Projected Miles and Cost for Interfacility Transports

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	Description

Table 8 UM SMC at Dorchester Service Area Market Share – FY2019 3

Table 9 - UM SMC at Chestertown Service Area Market Share 4

Table 10 - Delaware Psychiatric Facilities with Recent CPR Applications 5, 8

Table 11 - UM SMC at Chestertown Service Area Market Share - Pro Forma 2018 6

Table 12 - UM SMC at Chestertown's Projected Adult Psychiatric Market Share - FY2018-FY2024 7

Table 18 Inpatient Psychiatric Market Share of Select Hospitals in Rural Geographies FY2018 8

Table 19 CY2018 Medicare Patients Utilization of Inpatient Psychiatric Programs 9

Table 20 Distance (miles) from Each Zip Code in UM SMC at Chestertown Service Area to UM SMC at Dorchester, UM SMC at Easton, and UM SMC at Chestertown 11

Table 21 UM SMC at Dorchester Psychiatric Patient Discharge Disposition CY2018 20

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

October 30, 2019
Date

Kenneth D. Kozel
President & CEO
UM Shore Regional Health

#632159
012516-0006

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

October 30, 2019
Date

JoAnne Hahey
Chief Financial Officer
UM Shore Regional Health

#632160
012516-0006

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October 30, 2019
Date

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 Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

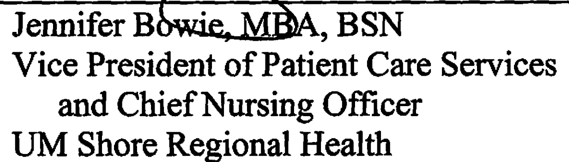
October 30, 2019
Date

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 Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

October 30, 2019
Date

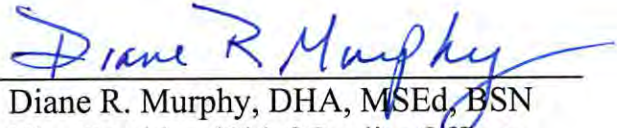


Jennifer Bowie, MBA, BSN
Vice President of Patient Care Services
and Chief Nursing Officer
UM Shore Regional Health

#680549
012516-0006

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

October 30, 2019
Date

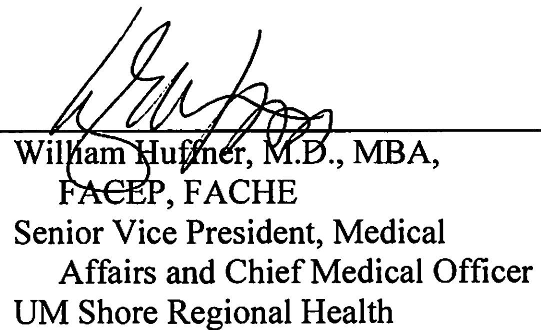


Diane R. Murphy, DHA, MSEd, BSN
Vice President/Chief Quality Officer
UM Shore Regional Health

#680550
012516-0006

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

October 30, 2019
Date

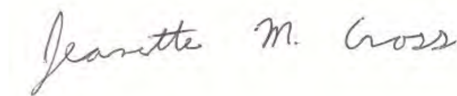


William Huffner, M.D., MBA, FACEP, FACHE
Senior Vice President, Medical Affairs and Chief Medical Officer
UM Shore Regional Health

#632155
012516-0006

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

October 30, 2019

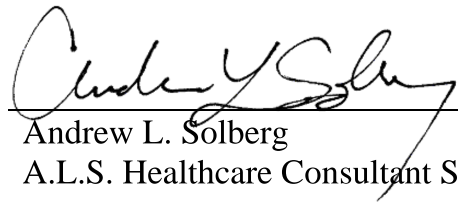


Date

Jeanette Cross
Managing Director
Berkeley Research Group, LLC

#680543
012516-0006

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.



October 30, 2019
Date

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

#632153
012516-0006

I hereby declare and affirm under the penalties of perjury that the facts stated in this Response to Additional Information Questions dated October 11, 2019 and October 18, 2019 and its attachments are true and correct to the best of my knowledge, information, and belief.

October 30, 2019
Date

David Watts
Architect
Marshall Craft Associates

#673932
012516-0006

EXHIBIT 10

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:	Based on Physical Capacity				Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity			
			Room Count			Bed Count			Room Count			Bed Count
		7/1/2019_	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	75,260	75,462	75,669
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**	**$ 290,643**	**$ 290,800**	**$ 291,021**
3. INCOME								
a. Income From Operation	**$ 18,348**	**$ 31,796**	**$ 5,442**	**$ 9,610**	**$ 10,007**	**$ (13)**	**$ (308)**	**$ (663)**
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**	**$ 2,694**	**$ 2,399**	**$ 2,044**
c. Income Taxes								
NET INCOME (LOSS)	**$ 27,507**	**$ 39,809**	**$ 8,149**	**$ 12,317**	**$ 12,714**	**$ 2,694**	**$ 2,399**	**$ 2,044**

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
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)

<table>
<tr><td colspan="2">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 servcies regulated by the HSCRC.</td></tr>
<tr><td colspan="2">Projection period reflects FY2019 – FY2024 for SHS and FY2020 - FY2024 for Chestertown</td></tr>
<tr><td>Volumes</td><td>- Refer to historical and projected utilization in Table F</td></tr>
<tr><td>Patient Revenue
• Gross Charges
o Update Factor
o Demographic Adjustment
o Other Rate Adjustments
o Variable Cost Factor

o Redistribution of Dorchester General Hospital Revenue

• Revenue Deductions</td><td>- 0.00% annual increase in FY2019 – FY2024
- 0.00% annual increase in FY2019 – FY2024
- 0.00% annual increase in FY2019 – FY2024 based on historical experience
- 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
- 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
- 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</td></tr>
<tr><td>Other Operating Revenue</td><td>Remains constant from FY2018 for SHS and FY2020 budget for Chestertown</td></tr>
</table>

Expenses	
• Inflation	- 0.0% weighted average annual increase that reflects the following:
o Salaries and Benefits	- 0.0%
o Professional Fees	- 0.0%
o Supplies	- 0.0%
o Purchased Services	- 0.0%
o Other Operating Expenses	- 0.0%
• Expense Variability with Volume Changes	
o Salaries and Benefits	- 80%
o Professional Fees	- 0%
o Supplies & Drugs	- 80%
o Purchased Services	- 50%
o Other Operating Expenses	- 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	81,464	83,316	85,216
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**	**$ 315,803**	**$ 322,782**	**$ 330,054**
3. INCOME								
a. Income From Operation	**$ 18,348**	**$ 31,796**	**$ 6,436**	**$ 11,631**	**$ 13,051**	**$ 3,722**	**$ 4,257**	**$ 4,683**
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***	***$ 6,594***	***$ 7,187***	***$ 7,672***
c. Income Taxes								
NET INCOME (LOSS)	***$ 27,507***	***$ 39,809***	***$ 9,143***	***$ 14,392***	***$ 15,868***	***$ 6,594***	***$ 7,187***	***$ 7,672***

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**
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 servcies 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	- 2.5% weighted average annual increase that reflects the following:

◦ Salaries and Benefits ◦ Professional Fees ◦ Supplies ◦ Purchased Services ◦ Other Operating Expenses	- 2.25% - 2.75% - 3.0% - 2.8% - 2.0%
• Expense Variability with Volume Changes ◦ Salaries and Benefits ◦ Professional Fees ◦ Supplies & Drugs ◦ Purchased Services ◦ 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	
◦ Existing Debt	- Continued amortization of existing debt and related interest expense
◦ 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)					845	845	845
TOTAL OPERATING EXPENSES	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,521**	**$ 3,521**	**$ 3,521**
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ 379**	**$ 379**	**$ 379**
b. Non-Operating Income							
SUBTOTAL	***$ -***	***$ -***	***$ -***	***$ -***	***$ 379***	***$ 379***	***$ 379***
c. Income Taxes							
NET INCOME (LOSS)	***$ -***	***$ -***	***$ -***	***$ -***	***$ 379***	***$ 379***	***$ 379***

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	- 0.00% annual increase in FY2020 – FY2024
o Demographic Adjustment	- 0.00% annual increase in FY2020 – FY2024
o Other Rate Adjustments	- 0.00% annual increase in FY2020 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with regulated inpatient psych services shifted from Dorchester General Hospital to the SMC at Chestertown in FY2022
• Revenue Deductions	- 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	- 0.0% weighted average annual increase that reflects the following:
o Salaries and Benefits	- 0.0%
o Professional Fees	- 0.0%
o Supplies	- 0.0%
o Purchased Services	- 0.0%
o Other Operating Expenses	- 0.0%
• Expense Variability with Volume Changes	
o Salaries and Benefits	- 80%
o Professional Fees	- 0%
o Supplies & Drugs	- 80%
o Purchased Services	- 50%
o Other Operating Expenses	- 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 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	-	-	-	-	848	865	883
TOTAL OPERATING EXPENSES	**$ -**	**$ -**	**$ -**	**$ -**	**$ 3,676**	**$ 3,757**	**$ 3,841**
3. INCOME							
a. Income From Operation	**$ -**	**$ -**	**$ -**	**$ -**	**$ 601**	**$ 623**	**$ 647**
b. Non-Operating Income							
SUBTOTAL	*$ -*	*$ -*	*$ -*	*$ -*	*$ 601*	*$ 623*	*$ 647*
c. Income Taxes							
NET INCOME (LOSS)	*$ -*	*$ -*	*$ -*	*$ -*	*$ 601*	*$ 623*	*$ 647*

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	- 2.0% annual increase in FY2020 – FY2024
o Demographic Adjustment	- 0.29% annual increase in FY2020 – FY2024
o Other Rate Adjustments	- 0.15% annual increase in FY2020 – FY2024 based on historical experience
o Variable Cost Factor	- 100% variable cost factor associated with regulated inpatient psych services shifted from Dorchester General Hospital to the SMC at Chestertown in FY2022
• Revenue Deductions	- 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	- 2.5% weighted average annual increase that reflects the following:
o Salaries and Benefits	- 2.25%
o Professional Fees	- 2.25%
o Supplies	- 3.00%
o Purchased Services	- 2.80%
o Other Operating Expenses	- 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 includec
• 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**	**Average Salary per FTE**	**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)*												
Mental Health Therapist - Behavioral Health			-			-			-	2.0	$ 67,049	$ 134,098
Social Worker										1.0	59,261	59,261
BH Case Specialist										2.0	63,748	127,497
Nursing Tech										8.1	36,537	295,949
LPN										0.5	69,838	34,919
Manager										1.0	98,718	98,718
Registered Nurse - Behavioral Health										9.0	80,000	719,997
Clinical Nurse Coordinator										1.0	105,533	105,533
Behavioral Health Program Manager										1.0	78,878	78,878
Mental Health Therapist - Partial Hospitalization										1.0	63,835	63,835
Registered Nurse - Partial Hospitalization			-			-			-	0.2	83,595	12,539
Total Direct Care			$ -			$ -			$ -	26.8		$ 1,731,225
Support Staff *(List general categories, add rows if needed)*												
Total Support			$ -			$ -			$ -	-		$ -
REGULAR EMPLOYEES TOTAL			$ -			$ -			$ -	26.8		$ 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 11

Western Maryland
Inpatient Psychiactric Service Area and Market Share
FY2018

#	Zip Code	Psych Discharges	% of Total	Cumulative % of Total
1	21502	481	52.7%	52.7%
2	21532	93	10.2%	62.9%
3	26726	48	5.3%	68.1%
4	26753	25	2.7%	70.9%
5	21550	23	2.5%	73.4%
6	21562	18	2.0%	75.4%
7	21545	17	1.9%	77.2%
8	21539	16	1.8%	79.0%
9	26757	14	1.5%	80.5%
10	21520	10	1.1%	81.6%
11	21555	10	1.1%	82.7%
12	21501	9	1.0%	83.7%
13	21536	9	1.0%	84.7%
14	21541	7	0.8%	85.4%
	Service Area Total	**780**	**85.4%**	**85.4%**
	Out of Service Area	133	14.6%	14.6%
	Total	**913**	**100.0%**	**100.0%**

Service Area Discharges	826
Western MD Market Share	94.4%

Definition of Psych Services: Cases assigned MDC 19
Source: Discharges are based on statewide non-confidential data tapes

Meritus Medical Center

Inpatient Psychiactric Service Area and Market Share

FY2018

#	Zip Code	Psych Discharges	% of Total	Cumulative % of Total
1	21740	572	55.2%	55.2%
2	21742	123	11.9%	67.0%
3	21713	41	4.0%	71.0%
4	21795	29	2.8%	73.8%
5	21722	28	2.7%	76.5%
6	21750	17	1.6%	78.1%
7	21783	14	1.4%	79.5%
8	21741	10	1.0%	80.4%
9	21767	10	1.0%	81.4%
10	17268	7	0.7%	82.1%
11	21756	7	0.7%	82.7%
12	25419	7	0.7%	83.4%
13	21550	5	0.5%	83.9%
14	21701	5	0.5%	84.4%
15	25401	5	0.5%	84.9%
16	25404	5	0.5%	85.3%
	Service Area Total	**885**	**85.3%**	**85.3%**
	Out of Service Area	152	14.7%	14.7%
	Total	**1,037**	**100.0%**	**100.0%**
Service Area Discharges		1,362		
Meritus Market Share		65.0%		

Definition of Psych Services: Cases assigned MDC 19

Source: Discharges are based on statewide non-confidential data tapes

Peninsula Regional Medical Center

Inpatient Psychiactric Service Area and Market Share

FY2018

#	Zip Code	Psych Discharges	% of Total	Cumulative % of Total
1	21804	153	22.1%	22.1%
2	21801	140	20.2%	42.3%
3	21811	59	8.5%	50.9%
4	21853	34	4.9%	55.8%
5	21826	24	3.5%	59.2%
6	21842	20	2.9%	62.1%
7	21851	20	2.9%	65.0%
8	21863	20	2.9%	67.9%
9	21875	19	2.7%	70.7%
10	21817	16	2.3%	73.0%
11	21850	16	2.3%	75.3%
12	21830	10	1.4%	76.7%
13	21871	9	1.3%	78.0%
14	19966	8	1.2%	79.2%
15	21874	7	1.0%	80.2%
16	19940	6	0.9%	81.1%
17	21822	6	0.9%	81.9%
18	21837	6	0.9%	82.8%
19	21838	6	0.9%	83.7%
20	19956	5	0.7%	84.4%
21	21813	5	0.7%	85.1%
	Service Area Total	**589**	**85.1%**	**85.1%**
	Out of Service Area	103	14.9%	14.9%
	Total	**692**	**100.0%**	**100.0%**

Service Area Discharges	783
PRMC Market Share	75.2%

Definition of Psych Services: Cases assigned MDC 19
Source: Discharges are based on statewide non-confidential data tapes

EXHIBIT 12

University of Maryland Shore Medical Group

Job Description

<u>Physician Position Description</u>

I. **Overview**

Physician shall assist with the medical and administrative management and development of Hospital and the individual department. Physician agrees to apply him/herself diligently to the development of the Hospital's medical department and to perform in a manner which shall warrant the respect and trust of patients, peers and other health care professionals.

II. **Primary Medical Responsibilities**

A. Unless otherwise approved by the Hospital and the department, Physician shall provide full-time direct medical services, including the examination and care for patients seeking treatment at the office and on hospital rounds. Full time is defined as not less than 40 hours of direct patient appointments and general rounds per week. The physician also takes call and, therefore, the average number of hours will be above 40 hours per week. Furthermore, if the patient volume is sufficient, it is the option of the physician to work more than 40 hours per week. It will generally be assumed that 40 hours per week equals 5 full work days. The Hospital may allow a physician who is especially productive and efficient to work fewer hours.

B. Physician shall provide on-call coverage for the department's patients, which shall be allocated in a fair and equitable manner among the physicians.

C. Provide for and maintain full and complete records of all services performed for patients at the department in accordance with the standards established by the Hospital in consultation with the Physician.

D. Promote the written goals and objectives of the Hospital and the department.

E. Participate in a quality assurance program of the department.

III. **Primary Administrative Responsibilities**

Physician shall cooperate with and assist administration in carrying out the following administrative responsibilities.

A. Supervise the administrative responsibilities of all non-physician employees of the department in consultation with the Medical Director and the Chief Medical Officer

B. Assure department compliance with applicable policies of the Hospital, including but not limited to, personnel actions, payroll, orientation and training, charity care, accounts payable, coding, billing and claims processing.

C. Assure appropriate staffing of department.

D. Assure Department compliance with applicable local, state and federal guidelines such as OSHA, CLIA and wage and labor regulations.

E. Assure department compliance with payer department requirements.

F. Develop and maintain department budgets in consultation with the Chief Medical Officer. Participate in reporting of expenses and budget reconciliation in consultation with the Hospital finance consultants and the Chief Medical Officer.

G. Develop and update department policies and procedures in accordance with the Hospital's policy and other applicable guidelines and regulations.

H. Appropriately manage security, property, equipment, grounds and repairs as applicable to rental and other agreement.

IV. **Human Relations**

A. Apply tact and diplomacy personally and foster it in all employees of the Hospital.

B. Apply a helpful, courteous attitude that fosters good patient relations, a positive image, and ensures acceptance of the Hospital in the community.

V. **Department Development**

A. Participate in department development activities such as community speaking, volunteerism and service projects to increase physician visibility in the community.

B. Cooperate with administration in development of adjustments to business approach such as altered department style, scheduling changes and varied department emphasis to improve productivity and patient satisfaction with Physician and the Hospital.

C. Participate in disease management programs to improve efficiency and effectiveness of medical department.

UNIVERSITY of MARYLAND
COMMUNITY MEDICAL GROUP

JOB DESCRIPTION

JOB TITLE:	PHYSICIAN ASSISTANT	GRADE:	117
FLSA STATUS:	EXEMPT	JOB CODE:	368501
DEPARTMENT:	UMCMG	LOCATION:	UMCMG
PREVIOUS TITLE:	NEW	DATE CREATED:	4/1/15
REPORTS TO:	LEAD PA or COLLABORATING PHYSICIAN	DATE REVIEWED:	9/2015

I. General Summary

Provides an advanced level of comprehensive health care to a specific patient population in collaboration with medical staff. Follows established applicable nursing and medical standards, procedures and practices, and gives specific patient care directions to nursing and other support staff. Patients served include adolescent through adult-older adult.

II. Principal Responsibilities and Tasks

The following statements are intended to describe the general nature and level of work being performed by people assigned to this classification. These are not to be construed as an exhaustive list of all job duties performed by personnel so classified.

1. Performs medical examinations and evaluations, diagnoses, treatment, follow-up, consultations and health education appropriate for the patient's age and situation.
2. Obtains patient histories and develops patient care charges, ensuring completeness and accuracy of documentation.
3. Orders, obtains and interprets appropriate diagnostic tests.
4. Designs, orders and documents appropriate treatment plans/plans of care including prescriptions of medications based on a comprehensive review of HPI and diagnostic results.
5. Communicates plan of care with appropriate providers including the collaborative physician, the primary care provider, the referring provider, the nursing staff, and the case manager.
6. Communicates plan of care with the patients and family members. Provides patient and family instruction related to the plan of care, disease process, new treatment plans, and medication regimens.
7. Provides medical care for ill and injured patients in accordance with accepted standards of care.
8. Provides health education to patients and families as required and appropriate.
9. Documents medical findings and care provided in the patient's clinical record, including information of laboratory and radiographic studies.
10. Teaches health maintenance procedures and provides educational resources to patients as needed.
11. Collaborates with physician or other health care team members regarding patients' health needs, outcomes and effectiveness of care plan.
12. Initiates appropriate contact with other health care providers as required.
13. Maintains the privacy and security of all confidential and protected health information. Uses and discloses only that information which is necessary to perform the function of the job.

III. Education and Experience

1. Graduation from a Physician Assistant educational program approved by the State Board of Licensing or found by the Board to be substantially equivalent to the programs in Maryland required.
2. Current state licensure as a Physician Assistant required.
3. Experience as a Physician Assistant preferred, not required.
4. Current BLS certification or obtained prior to providing direct patient care is required.
5. DEA and CDS eligible.

IV. Knowledge, Skills and Abilities

1. Ability to demonstrate knowledge and skills necessary to provide care appropriate to the patient population(s) served. Ability to demonstrate knowledge of the principles of growth and development over the life span and possesses the ability to assess data reflective of the patient's requirements relative to his or her population-specific and age specific needs.
2. Highly effective verbal and written communication skills are required to interact with patient families, departmental units, medical and nursing staff on all essential matters. Demonstrated/documented effective interpersonal skills.
3. Maintains updated hospital safety and other mandatory training.
4. Updated immunizations as recommended per practice area.

V. Patient Safety

Ensures patient safety in the performance of job functions and through participation in hospital, department or unit patient safety initiatives.

1. Takes action to correct observed risks to patient safety.
2. Reports adverse events and near misses to appropriate management authority.
3. Implements policies, procedure, and standards consistently in the performance of assigned duties.
4. Develops effective working relationships and maintains good communication with other team members.
5. Identifies possible risks in processes, procedures, devices and communicates the same to those in charge.

Physical Requirements & Working Conditions required to perform the essential functions of the Job

Job Title:	PHYSICIAN ASSISTANT	Job Code:	368501	Completed By:	MC
Department:	UMCMG	Date:	4/1/15	Manager Job Title:	

This form is designed to identify the physical demands **essential** to perform the job; the equipment and tools used; and the working conditions. All requirements are subject to possible modification to reasonably accommodate individuals with disabilities. See following page for physical descriptors.

PHYSICAL REQUIREMENTS

Check only the boxes which reflect what are essential to perform the physical requirements of the job. If the position does not require the physical demand, leave blank.

Physical Demand	Rarely	Occasional ly	Frequently	Constantly
Walking			X	
Sitting		X		
Standing		X		
Reclining		X		
Carrying			X	
Climbing	X			
Balancing		X		
Stooping/ Bending		X		
Kneeling		X		
Crouching		X		

Physical Demand	Rarely	Occasionally	Frequently	Constantly
Crawling	X			
Reaching			X	
Handling			X	
Fingering			X	
Feeling		X		
Talking			X	
Hearing			X	
Tasting	X			
Smelling	X			
Driving	X			

Check columns and **specify max lbs of force** required.

		Maximum Lbs	Rarely	Occasionally	Frequently	Constantly
Lifting	Exertion of force required when participating in patient care	25		X		
	Exertion of force required when moving an object	25		X		
Pushing	Exertion of force required to move an object	25		X		
Pulling	Exertion of force required to move an object	25		X		

Check the **vision** requirements for the job

Near Acuity	X
Far Acuity	X
Depth Perception	X

Field of Vision	X
Color Vision	

EQUIPMENT AND TOOLS

Check the items required to perform the essential functions of the job

Standard Office Equipment (e.g. computer, telephone)	X
Power Tools (e.g. saw, drill, hammer)	
Vehicles (please specify)	

Medical Instruments/Equipments (e.g. syringe, forceps, needles, sterilizing aids, catheters, lab tools).	X
Other Equipment (please specify)	

WORKING CONDITIONS

Check all that apply

Standard Office Environment	X
Laboratory Environment	X
Weekend, shift work, on call, holidays and overtime	X
Patients with tendencies for violent outbursts	X
Close quarters, crawl spaces, shafts, small enclosed rooms, narrow isles or passageways.	

Wet and/or Humid Conditions	
Extreme temperatures (hot or cold)	
Inclement Weather	
Noise / Vibration	

Potential Exposures

Bodily Fluids	X
Infectious Diseases	X
Blood	X
Hazardous Drugs/Medications	X

Potential Hazards

Mechanical	
Electrical	
Chemical	
Burns (e.g. kitchen)	
Radiation/Radioactive Material	

Atmospheric Conditions

Fumes/Gases	
Dust	
Poor Ventilation	

Please detail any additional physical demands or working conditions essential to the job:

SHORE HEALTH SYSTEM

JOB TITLE:	NURSE PRACTITIONER	**GRADE:**	117
FLSA STATUS:	EXEMPT	**JOB CODE:**	8691
DEPARTMENT:	SRH	**LOCATION:**	SRH
PREVIOUS TITLE:	NEW	**DATE CREATED:**	4/1/15
REPORTS TO:	LEAD NP or COLLABORATING PHYSCIAN	**DATE REVIEWED:**	9/15

I. General Summary

Under limited supervision, provides an advanced level of comprehensive health care to a specific patient population in collaboration with medical staff. Follows established applicable nursing and medical standards, procedures and practices, and gives specific patient care directions to nursing and other support staff.

II. Principal Responsibilities and Tasks

The following statements are intended to describe the general nature and level of work being performed by people assigned to this classification. These are not to be construed as an exhaustive list of all job duties performed by personnel so classified.

1. Performs medical examinations and evaluations, diagnoses, treatment, follow-up, consultations and health education appropriate for the patient's age and situation.
2. Obtains patient histories and develops patient care charges, ensuring completeness and accuracy of documentation.
3. Orders, obtains and interprets appropriate diagnostic tests.
4. Designs, orders and documents appropriate treatment plans/plans of care including prescriptions of medications based on a comprehensive review of HPI and diagnostic results.
5. Communicates plan of care with appropriate providers including the collaborative physician, the primary care provider, the referring provider, the nursing staff, and the case manager.
6. Communicates plan of care with the patients and family members. Provides patient and family instruction related to the plan of care, disease process, new treatment plans, and medication regimens.
7. Provides medical care for ill and injured patients in accordance with accepted standards of care.
8. Provides health education to patients and families as required and appropriate.
9. Documents medical findings and care provided in the patient's clinical record, including information of laboratory and radiographic studies.
10. Teaches health maintenance procedures and provides educational resources to patients as needed.
11. Collaborates with physician or other health care team members regarding patients' health needs, outcomes and effectiveness of care plan.
12. Initiates appropriate contact with other health care providers as required.
13. Maintains the privacy and security of all confidential and protected health information. Uses and discloses only that information which is necessary to perform the function of the job.

III. Education and Experience

1. Master of Science degree with completion of an accredited Nurse Practitioner Program required.
2. Current state licensure as a Nurse Practitioner required.
3. Current state licensure as a Registered Nurse required.
4. Current BLS certification or obtained prior to providing direct patient care is required.
5. Experience preferred, not required.
6. DEA and CDS eligible.

IV. Knowledge, Skills and Abilities

1. Ability to demonstrate knowledge and skills necessary to provide care appropriate to the patient population(s) served. Ability to demonstrate knowledge of the principles of growth and development over the life span and possesses the ability to assess data reflective of the patient's requirements relative to his or her population-specific and age specific needs.
2. Highly effective verbal and written communication skills are required to interact with patient families, departmental units, medical and nursing staff on all essential matters. Demonstrated/documented effective interpersonal skills.
3. Maintains updated hospital safety and other mandatory training.
4. Updated immunizations as recommended per practice area.

V. Patient Safety

Ensures patient safety in the performance of job functions and through participation in hospital, department or unit patient safety initiatives.

1. Takes action to correct observed risks to patient safety
2. Reports adverse events and near misses to appropriate management authority.
3. Identifies possible risks in processes, procedures, devices and communicates the same to those in charge.

APPROVED BY: ______________________________ ________
Department Head Date

______________________________ ________
Human Resources Date

Note:

This job description is based on an evaluation of the position at the time this description was written. This job description will change from time to time as tasks, organization, and technology change. Accordingly, the employer reserves the right to revise all or any part of this job description and the essential functions of the job and to add or eliminate essential functions of any position. Designation of any job duty as an "essential function" is not intended as an assurance or guarantee that an employee has any right to perform the particular job duty, except as required by the employer. This is not a contract of employment.

This position requires a person who exhibits a positive attitude, excellent communication skills, the ability to work productively under stress, and who displays a professional demeanor and is able to prioritize workloads. Must be willing to travel between facilities.

I have read and understand the above.

____
Employee Signature and Date

____
Supervisor Signature and Date

Shore Regional Health

Shore Behavioral Health

Position Title:

Medical Director, Shore Behavioral Health

Specific Duties. The following is a description of the physician's role and responsibility as Medical Director of Shore Behavioral Health, the Unit and associated programs. Physician shall have duties which shall include, but not be limited to the following (the following services shall be collectively referred to herein as the "Administrative Services"):

a. Program Administration – Provide program administration and oversight services regarding Unit policies, practices, development, compliance, or performance improvement. Meet with Department Director (who may include other staff as appropriate) at least once per week, or more often if needed, to discuss Unit needs. Participate in the Behavioral Health Leadership Council.
b. Program Consultation – Provide program consultation for problematic Unit issues or the clinical care of other physician's patients.
c. Program Issues – Assist in resolving Unit issues as requested specifically by the Department Director or senior Hospital administration. Responds promptly to solve medical or administrative issues (no longer than 24 hours or first working day for less urgent problems).
d. Training and Supervision – Provide training and, supervision, and consultation to program psychiatrists and staff. (consultation that is directly related to a specific patients care is not considered administrative time) In-service training for Unit staff shall be provided at least once each quarter (for example, 4-5 times per year) on topics relevant to the needs of staff as determined in consultation with the Department Director and /or senior Hospital administration.
e. Recruitment – Provide assistance in recruiting and interviewing potential key staff.
f. Medical Record Reviews – Provide medical record reviews of other practitioner's documentation regarding compliance with Hospital policies and procedures and appropriateness of admissions and continued stay of patients.
g. Hospital Staff – Proactively arrange meeting with the Senior Medical Officer of the Hospital to assure Hospital's ongoing medical staff supervision of the Unit. Actively visit and maintain relationships with other physicians on the Hospital staff and coordinate behavioral health services with other areas of the Hospital.

h. Quality Assurance – Lead Unit and Behavioral Health Provider staff quality assurance/performance improvement activities, and continually work with the active provider staff as needed to assure quality care, as well as timely and accurate completion of medical records.
i. Education – Participate in educational programs conducted by the Hospital Medical Staff.
j. Coverage – Arrange Unit clinical coverage at all times by competent, clinically privileged physicians or nurse practitioners for ongoing patient care and clinically emergent situations.
k. Compliance – Work with the Department Director and Manager to ensure that the Unit and associated programs meet all Joint Commission, federal, and state/local laws, regulations, and accreditation standards.
l. Community Representation – Engage with community groups on issues relating to behavioral and mental health. Provide related commentary and education as appropriate to community members and organizations.

EXHIBIT 13

UM Shore Medical Center at Easton
Projected Miles and Cost from Closest ED to UM SMC at Easton, by Dorchester Service Area Zip Code
FY2018

#	Zip Code	Community	County	FY2018 Service Area Discharges	Miles from Zip Code to Closest ED				Additional Miles from ED to Easton		Increase in Cost (1)
					UM SMC at Dorchester	UM SMC at Easton	Emer Ctr Queenstown	UM SMC at Chestertown	Miles Per Discharge	Total Miles for All Discharges	
1	21601	Easton	Talbot County	64	15.4	0.4	19.8	36.1	-	-	$ -
2	21613	Cambridge	Dorchester County	128	1.1	16.0	35.7	52.2	14.9	1,907.2	17,108
3	21617	Centreville	Queen Anne's County	19	35.0	20.0	9.6	17.1	20.3	385.7	3,460
4	21619	Chester	Queen Anne's County	11	43.3	27.0	7.3	34.3	20.3	223.3	2,003
5	21620	Chestertown	Kent County	28	53.4	39.0	29.8	3.1	38.2	1,069.6	9,594
6	21625	Cordova	Talbot County	5	23.8	9.1	15.9	30.9	-	-	-
7	21629	Denton	Caroline County	31	33.5	20.0	24.3	34.6	-	-	-
8	21631	East New Market	Dorchester County	12	7.8	22.0	41.9	58.3	14.9	178.8	1,604
9	21632	Federalsburg	Caroline County	24	22.9	20.0	36.3	47.0	-	-	-
10	21636	Goldsboro	Caroline County	1	43.1	28.0	26.5	22.5	38.2	38.2	343
11	21638	Grasonville	Queen Anne's County	7	37.5	23.0	2.7	29.8	20.3	142.1	1,275
12	21639	Greensboro	Caroline County	14	7.8	24.0	25.0	29.6	14.9	208.6	1,871
13	21640	Henderson	Caroline County	5	44.8	30.0	26.1	18.6	38.2	191.0	1,713
14	21643	Hurlock	Dorchester County	30	16.1	19.0	36.0	53.3	14.9	447.0	4,010
15	21649	Marydel	Caroline County	2	53.8	39.0	28.5	19.2	38.2	76.4	685
16	21654	Oxford	Talbot County	3	14.3	7.7	28.2	44.5	-	-	-
17	21655	Preston	Caroline County	11	20.5	10.0	27.3	13.6	-	-	-
18	21657	Queen Anne	Queen Anne's County	2	30.6	16.0	15.8	24.0	20.3	40.6	364
19	21658	Queenstown	Queen Anne's County	4	34.0	19.0	7.4	28.1	20.3	81.2	728
20	21659	Rhodesdale	Dorchester County	1	18.6	24.0	48.2	59.8	14.9	14.9	134
21	21660	Ridgely	Caroline County	6	34.0	19.0	20.0	24.1	-	-	-
22	21661	Rock Hall	Kent County	5	67.1	54.0	43.9	17.7	38.2	191.0	1,713
23	21663	Saint Michaels	Talbot County	9	26.4	12.0	29.8	46.1	-	-	-
24	21666	Stevensville	Queen Anne's County	11	48.1	33.0	13.2	40.0	20.3	223.3	2,003
25	21673	Trappe	Talbot County	7	5.9	13.0	33.3	46.2	14.9	104.3	936
26	21678	Worton	Kent County	4	63.5	51.0	31.9	12.6	38.2	152.8	1,371
27	21801	Salisbury	Wicomico County	16	28.9	43.0	63.1	81.0	14.9	238.4	2,138
28	21804	Salisbury	Wicomico County	10	40.3	54.0	74.2	92.0	14.9	149.0	1,337
29	21837	Mardela Springs	Wicomico County	1	20.4	35.0	54.7	73.0	14.9	14.9	134
30	21869	Vienna	Dorchester County	2	14.7	30.0	49.7	65.2	14.9	29.8	267
Subtotal Service Area				473						6,108.1	$ 54,790
Out of Servicea Area @ 15% of Total				83						1,077.9	9,669
Total				556						7,186.0	$ 64,458

Dorchester County	173			2,578	$ 23,122
Talbot County	88			104	936
Caroline County	94			514	4,612
Queen Anne's County	54			1,096	9,833
Kent County	37			1,413	12,678
Wicomico County	27			402	3,609
Subtotal Service Area	473			6,108.1	$ 54,790
Out of Servicea Area @ 15% of Total	83			1,077.9	9,669
Total	556			7,186.0	$ 64,458

- Closest ED to zip code

Note (1): Reflects number of discharges x additional miles @ $ 8.97 per mile

Source: Distance in miles is determined using GoogleMaps

UM Shore Medical Center at Chestertown
Projected Miles and Cost from Closest ED to UM SMC at Chestertown, by Chestertown Service Area Zip Code
FY2018

#	Zip Code	Community	County	FY2018 Service Area Discharges	Miles from Zip Code to Closest ED				Additional Miles from ED to Chestertown		Increase in Cost (1)
					UM SMC at Dorchester	UM SMC at Easton	Emer Ctr Queenstown	UM SMC at Chestertown	Miles Per Discharge	Total Miles for All Discharges	
1	21601	Easton	Talbot County	53	15.4	0.4	19.8	36.1	38.2	2,017.0	$ 18,092
2	21610	Betterton	Kent County	3	65.0	50.0	39.5	12.3	-	-	-
3	21613	Cambridge	Dorchester County	98	1.1	16.0	35.7	52.2	50.9	4,981.8	44,686
4	21617	Centreville	Queen Anne's County	16	35.0	20.0	9.6	17.1	27.6	445.9	3,999
5	21619	Chester	Queen Anne's County	13	43.3	27.0	7.3	34.3	27.6	359.8	3,228
6	21620	Chestertown	Kent County	37	53.4	39.0	29.8	3.1	-	-	-
7	21623	Church Hill	Queen Anne's County	2	42.0	27.0	16.5	11.5	-	-	-
8	21625	Cordova	Talbot County	4	23.8	9.1	15.9	30.9	38.2	149.4	1,340
9	21628	Crumpton	Queen Anne's County	2	53.0	38.0	27.2	10.1	-	-	-
10	21629	Denton	Caroline County	27	33.5	20.0	24.3	34.6	38.2	1,020.9	9,158
11	21631	East New Market	Dorchester County	9	7.8	22.0	41.9	58.3	50.9	471.2	4,227
12	21632	Federalsburg	Caroline County	14	22.9	20.0	36.3	47.0	38.2	539.2	4,837
13	21635	Galena	Kent County	3	60.0	46.0	34.8	16.3	-	-	-
14	21636	Goldsboro	Caroline County	1	43.1	28.0	26.5	22.5	-	-	-
15	21638	Grasonville	Queen Anne's County	11	37.5	23.0	2.7	29.8	27.6	315.4	2,829
16	21639	Greensboro	Caroline County	15	7.8	24.0	25.0	29.6	50.9	772.5	6,929
17	21640	Henderson	Caroline County	5	44.8	30.0	26.1	18.6	-	-	-
18	21641	Hillsboro	Caroline County	1	29.0	14.0	15.5	29.0	38.2	34.1	306
19	21643	Hurlock	Dorchester County	25	16.1	19.0	36.0	53.3	50.9	1,279.1	11,474
20	21645	Kennedyville	Kent County	3	60.0	45.0	34.4	10.3	-	-	-
21	21649	Marydel	Caroline County	1	53.8	39.0	28.5	19.2	-	-	-
22	21651	Millington	Queen Anne's County	2	60.0	45.0	33.6	17.0	-	-	-
23	21652	Neavitt	Talbot County	1	36.0	21.0	39.2	55.5	38.2	25.3	227
25	21653	Newcomb	Talbot County	0	22.0	7.1	25.3	41.6	38.2	17.4	156
24	21654	Oxford	Talbot County	1	14.3	7.7	28.2	44.5	38.2	52.2	468
26	21655	Preston	Caroline County	11	20.5	10.0	27.3	13.6	38.2	416.8	3,739
27	21657	Queen Anne	Queen Anne's County	2	30.6	16.0	15.8	24.0	27.6	46.4	417
28	21658	Queenstown	Queen Anne's County	7	34.0	19.0	7.4	28.1	27.6	197.1	1,768
29	21659	Rhodesdale	Dorchester County	5	18.6	24.0	48.2	59.8	50.9	235.6	2,114
30	21660	Ridgely	Caroline County	6	34.0	19.0	20.0	24.1	38.2	214.3	1,922
31	21661	Rock Hall	Kent County	5	67.1	54.0	43.9	17.7	-	-	-
32	21663	Saint Michaels	Talbot County	5	26.4	12.0	29.8	46.1	38.2	173.9	1,560
33	21667	Still Pond	Kent County	1	63.0	48.0	40.8	10.5	-	-	-
34	21668	Sudlersville	Queen Anne's County	2	51.0	36.0	25.6	13.3	-	-	-
35	21673	Trappe	Talbot County	5	5.9	13.0	33.3	46.2	50.9	231.8	2,079
36	21677	Woolford	Dorchester County	1	10.0	24.0	44.1	60.4	50.9	35.0	314
37	21678	Worton	Kent County	6	63.5	51.0	31.9	12.6	-	-	-
38	21679	Wye Mills	Talbot County	1	28.0	13.0	10.5	27.1	27.6	24.6	221
39	21869	Vienna	Dorchester County	1	14.7	30.0	49.7	65.2	50.9	69.9	627
40	21912	Warwick	Cecil County	1	70.0	55.0	44.0	24.9	-	-	-
41	21915	Chesapeake City	Cecil County	3	76.0	61.0	50.7	30.2	-	-	-
42	21919	Earleville	Cecil County	10	68.0	53.0	42.7	22.2	-	-	-
Subtotal Service Area				419						14,126.7	$ 126,717
Out of Servicea Area @ 15% of Total				74						2,492.9	22,362
Total				493						16,619.6	$ 149,078

Dorchester County	139			7,072.6	$ 63,441
Talbot County	69			2,691.6	24,143
Caroline County	82			2,997.9	26,891
Queen Anne's County	58			1,364.7	12,241
Kent County	58			-	-
Cecil County	14			-	-
Subtotal Service Area	419			14,126.7	$ 126,717
Out of Servicea Area @ 15% of Total	74			2,492.9	22,362
Total	493			16,619.6	$ 149,078

- Closest ED to zip code
Note (1): Reflects number of discharges x additional miles @ $ 8.97 per mile
Source: Distance in miles is determined using GoogleMaps