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ATTORNEYS AT LAW

January 2, 2020

VIA EMAIL & HAND DELIVERY

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

Re: *Modified Request for Certificate of Exemption from CON Review – Merger and Consolidation of UM Harford Memorial Hospital, Inc., and UM Upper Chesapeake Medical Center, Inc. – Matter No. 17-12-EX0003 – Applicants' Responses to Requests for Additional Information Dated December 16, 2019*

Dear Ms. Potter:

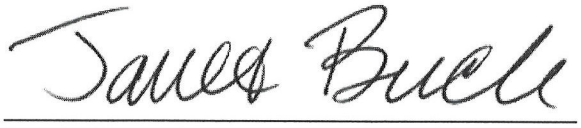
On behalf of University of Maryland Upper Chesapeake Medical Center ("UCMC") and University of Maryland Harford Memorial Hospital ("HMH"), as joint applicants, enclosed please UCMC's and HMH's responses to the Commission's Requests for Additional Information dated December 16, 2019, along with related exhibits. Native Excel spreadsheets of the MHCC CON Tables and a Word version of the responses will be sent via email.

The Applicants note their responses to questions 4, 5, and 6 refer to a number of embedded tables. The Applicants would welcome an opportunity to meet with the Commission staff to address any questions concerning these tables and any additional questions the Commission staff may have concerning the responses to the completeness questions or responses to requests for additional information filed in response to any of the three pending CON and CON exemption filings in an effort to expedite the Commission staff's review.

Please contact me if you have any questions. Please sign and return to our waiting messenger the enclosed acknowledgment of receipt.

#688525

Respectfully submitted,



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Enclosures

cc: Ben Steffen, Executive Director, Maryland Health Care Commission
Paul Parker, Director, Center for Health Care Facilities Planning and Development
Kevin McDonald, Chief, Certificate of Need Program
Suellen Wideman, Esq., Assitant Attorney General
Lyle E. Sheldon, President and Chief Executive Officer, FACHE
UM Upper Chesapeake Health System, Inc.
Steve Witman, SeniorVice President and Chief Financial Officer, UM UCHS
Robin Luxon, Vice President, Corporate Planning, Marketing and Business Development, UM UCHS
Aaron Rabinowitz, Vice President and General Counsel, UM UCHS
Andrew L. Solberg, A.L.S. Healthcare Consultant Services

UNIVERSITY OF MARYLAND UPPER CHESAPEAKE HEALTH

Merger and Consolidation of UM Upper Chesapeake Medical Center and UM Harford Memorial Hospital
Matter No. 17-12-003

Responses to Additional Information Questions Dated December 16, 2019

Applicants' Responses to Additional Information Requests Dated December 16, 2019

Charity Care

1. **Based on staff review of the Charity Care policy submitted, the UCHS charity care policy is ambiguous with regard to its compliance with the "Determination of Probable Eligibility" subpart of this standard, because it states that bank statements or other types of documentation "may be required" in order to render a "Determination of Probable Eligibility". Charity care policy and/or procedures that require documentation for a determination of probable eligibility will not pass muster with this standard.[1] Please amend your policy and any related documents or forms to comply with this portion of the standard.**

   See the attached guidance for applicants and staff, which is meant to clarify the requirements.

Applicant's response: The University of Maryland Medical System's ("UMMS") Central Business Office issued a Financial Assistance Policy and Procedure applicable to all of UMMS' acute hospital facilities. A copy of the UMMS Financial Assistance Policy and Procedure as updated on September 18, 2019 is attached as **Exhibit 8**. University of Maryland Upper Chesapeake Health System ("UM UCH") adopted an earlier iteration of UMMS' Financial Assistance Policy and Procedure on July 1, 2019. As set forth on pages 6 through 8 of UMMS Financial Assistance Policy and Procedure, a determination of probable eligibility will be made within two business days and documentation is not required to obtain a determination of probable

[1] Requiring a completed application with documentation does not comply with this standard, which is intended to ensure that a procedure is in place to inform a potential charity/reduced fee care recipient of his/her probable eligibility within two business days of initial inquiry or application for Medicaid based on a simple and expeditious process.

A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible. But the policy must include the more easily navigated determination of probable eligibility.

eligibility. The relevant language is quoted in the Table below in response to Request 2. Also attached as **Exhibit 9** is UM UCH's Financial Assistance Program Application form.

As set forth in **Exhibit 8** and quoted in the Table below in response to Request 2, a completed financial assistance application form is not required in order to obtain a determination of probable eligibility. Instead, designated staff at UM UCH facilities, including UCMC and HMH, consult with patients via phone or in person to determine if the patient meets financial assistance criteria based on family size and income. A completed financial assistance application form with supporting documentation is only required for a final determination of eligibility. **Exhibit 8**, page 8, Procedures, Section 2(a)-(e).

2. **Please complete the table below so that MHCC staff can confirm compliance with each section of the charity care standard. For each of the following subparts of this standard, quote the language from the policy that meets each provision, and give a citation to the section of the policy where that language can be can be found.**

Applicant's response:

Standard	Quote from the policy	Section citation
10.24.19.04C Charity Care Policy. Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. (a) The policy shall provide:		
(i) Determination of Probable Eligibility. Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.	"Presumptive Financial Assistance Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include: a. Active Medical Assistance pharmacy coverage	**Exhibit 8** Page 6 (Presumptive Eligibility)

	b. Specified Low Income Medicare (SLMB) coverage c. Primary Adult Care (PAC) coverage d. Homelessness e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs f. Medical Assistance spend down amounts g. Eligibility for other state or local assistance programs h. Patient is deceased with no known estate i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program j. Non-US Citizens deemed non-compliant k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID) m. Bankruptcy, by law, as mandated by the federal courts n. St. Clare Outreach Program eligible patients o. UMSJMC Maternity Program eligible patients p. UMSJMC Hernia Program eligible patients" * * * "2. When possible effort will be made to provide financial clearance prior to date of service. **Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance**. a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage. b. Preliminary data will be entered into a third party data exchange system to determine probabl[e] eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility. c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. **Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both**." (emphasis added).	**Exhibit 8** Page 8 Procedures Section 2.a.-c.
(ii) Minimum Required Notice of Charity Care Policy.		

1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;	See response to COMAR 10.24.19.04C(a)(ii)(2) and (ii)(3) below.	
2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.	"The University of Maryland Medical System ("UMMS") is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation. It is the policy of the UMMS hospitals to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications. **UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any) and admissions areas, as well as the Billing Office. Notice of availability will also be sent to the patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge, and it (along with this policy and the Financial Assistance Application) will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas**. This policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org)." The financial assistance policy is also posted on UM UCH's website on a page dedicated to financial assistance at the link provided below: https://www.umms.org/uch/patients-visitors/for-patients/financial-assistance	**Exhibit 8** Page 2
3.Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.	"Individual notice regarding the hospital's Financial Assistance Policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital."	**Exhibit 8** Procedures Section 2.g.

Observation and Inpatient Bed Need

At our meeting of June 25, 2019 MHCC staff presented data showing that HMH and UCMC were extreme outliers in their use of Observation status, both in the number of patients admitted to Observation and in length of stay.

In its modified exemption request, UCHS UCHS responded to this critique with an internal review of its utilization processes, described as follows: "[our] clinical staff has considered implementation of clinical practices…[Using] enhanced case management, utilization review, and triage evaluation processes, UM UCH estimates that it may be able to slightly reduce its observation utilization through either direct patient discharges or transitions of care to other outpatient departments or providers [and] that through implementation of such clinical practices, approximately 34% of historic observation cases that lasted 24 or more hours will result in direct inpatient admissions from the emergency department at UCMC and from the proposed freestanding medical facility in Aberdeen."

However, the following questions remain:

3. **On pages 14-15 of the modified exemption request you state that *"with the shift of observation patients from HMH to UC FMF, it is expected that approximately 400 patients that stay greater than 48 hours at UC FMF will be transferred to UCMC. Approximately one-half of those transfers will become observation patients at UCMC,"* i.e., about 200 patients who have spent more than two days in observation at the FMF will be transferred to observation status at UCMC.**

    a) **If their status has not yet been determined, why are they moved at all? Why not let them continue in observation at the FMF?**

Applicant's response: While Department of Health regulations do not presently address the length of observation stays in freestanding medical facilities, the Applicants projections anticipate that such stays would not last for longer than 48 hours. To this end, the fiscal policy note to Senate Bill 707/House Bill 1350 (2016), which made certain changes to the MARYLAND CODE, HEALTH-GENERAL ARTICLE to permit observation stays at freestanding medical facilities stated, "In addition to ED and ED-related services, freestanding medical facilities established from the conversion of a licensed general hospital could also provide (and be paid HSCRC-regulated rates for) outpatient services and **observation stays (a stay generally lasting no more than 48 hours that is provided as an outpatient service to allow testing and medical evaluation of a patient's condition)**." Department of Legislative Services, Maryland General Assembly Senate Bill 707, Fiscal Policy Note (2016 Session) (emphasis added).

b) Is it intended that the clinical changes that you describe will be put in place at UCMC to improve the processing of observation patients also be implemented at the FMF?

Applicant's response: The enhanced case management, utilization review, and triage evaluation processes will be implemented at UC FMF.

4. In FY2024 in Table F, you project 15,984 observation stays, and 15,864 MedSurg discharges, a ratio of 1.01. This is still far above the statewide average (CY2017) of 0.40. What factors explain this high ratio remaining for UM UCHS?

Applicant's response: As an initial matter, as presented in question 4, the Commission staff's comparison of UM UCH's observation cases per medical surgical discharges to the statewide average is imperfect. The Applicants' projection of 15,984 observation cases at UM UCH locations in fiscal year 2024 as presented in **Table F** includes both observation patients who are discharged as outpatients and observation patients that are ultimately admitted as inpatients. In contrast, the Commission staff's calculation of the statewide average ratio of observation cases to inpatient discharges in Calendar Year 2017 includes only observation patients who are discharged as outpatients and excludes observation patients that are subsequently admitted to inpatient status.

To confirm the Commission staff's calculation of observation cases to medical surgical discharges, UM UCH obtained utilization data from the HSCRC Experience Reports for acute hospitals as found on the HSCRC website for the OBV, MSG, DEF, MIS and CCU rate centers. Based on this utilization data, UM UCH calculated the statewide average ratios of observation cases per medical surgical discharges for observation patients that were both discharged as outpatients and subsequently admitted to inpatient status. As presented in **Table 20** below, the statewide ratio of observation patients who were discharged as outpatients equaled 0.41 in fiscal year 2017.[2] This ratio, though, excludes observation patients who were subsequently admitted to inpatient status. Including observation patients who were subsequently admitted to inpatient status results in a total statewide ratio of 0.57 observation cases per medical surgical discharge.

[2] UM UCH recognizes that the Commission staff's calculation of observation cases to MSGA discharges as set forth in question 4 is for calendar year 2017. As would be expected, the fiscal year ratio is largely the same as the calendar year calculation.

Table 20
Calculation of Statewide Observation Cases per Medical Surgical Discharge
Actual FY2017

	Patient Disposition		
	Inpatient Admission	Outpatient Discharge	Total
Observation Cases	90,963	236,704	327,667
Medical Surgical Discharges	574,993	574,993	574,993
Ratio of Observation Cases to Medical Surgical Discharges	0.16	0.41	0.57

Source: FY2017 HSCRC Experience Reports

Included in the Applicants' fiscal year 2024 projection of 15,984 observation cases are 7,000 observation cases that are expected to be converted to inpatient admissions and 8,984 observation cases where the patient will be discharged as an outpatient. Using the Commission staff's calculated statewide average ratio of observation cases that will be discharged as outpatients to medical surgical discharges at UM UCH in fiscal year 2024 results in a ratio of only 0.57. *See* **Table 21** below. This figure is much closer to the statewide ratio of 0.41.

Table 21
Calculation of UM UCH Projected Observation Cases per Medical Surgical Discharge
FY2024

	Patient Disposition		
	Inpatient Admission	Outpatient Discharge	Total
Observation Cases	7,000	8,984	15,984
Medical Surgical Discharges	15,864	15,864	15,864
Ratio of Observation Cases to Medical Surgical Discharges	0.44	0.57	1.01

Moreover, the Applicants believe that it is more appropriate to compare UM UCH's utilization to that of its identified peer group rather than every hospital in the state. As such, the Applicants analyzed UM UCH's ratio of observation cases per medical surgical discharge in fiscal year 2018 to its identified peer group. In fiscal year 2018, UM UCH experienced 18,373 observation cases. Of these cases, 11,620 of observation patients were discharged as outpatients. *See* **Table 22** below.

Table 22
UM UCH Observation Cases
Actual FY2018

	Patient Disposition		
	Inpatient Admission	Outpatient Discharge	Total
UCMC	5,113	8,817	13,930
HMH	1,640	2,803	4,443
Total	6,753	11,620	18,373

Source: FY2018 HSCRC Annual Filings

Using the Commission staff's ratio that only includes observation patients that are discharged as outpatients, the Applicants compared UM UCH's ratio of observation cases per medical surgical discharge to those of its peer group in fiscal year 2018. As presented in **Table 23** below, UM UCH experienced a ratio 0.96 observation cases per medical surgical discharge. The weighted average ratio of observation cases per medical surgical discharge for the peer group was 0.48 in fiscal year 2018.

Applying Applicants' projected reduction in observation cases, beginning in fiscal year 2020, along with the projected increase in medical surgical discharges at UM UCH reduces UM UCH's ratio of observation cases per medical surgical discharge to 0.56, a 42% reduction from fiscal year 2018. While still higher than the peer group weighted average of 0.48, it is comparable to the ratio of 0.55 that was experienced by UM BWMC in fiscal year 2018.

Table 23
Comparison of Outpatient Observation Cases per Medical Surgical Discharge
FY2018

	Outpatient Observation Cases (1)	Inpatient MedSurg Discharges	Observation Cases per Discharge
UCHS			
UM Upper Chesapeake Medical Center	8,817	8,862	0.99
UM Harford Memorial Hospital	2,803	3,196	0.88
UCHS Combined	11,620	12,058	**0.96**
Peer Group			
UM Baltimore Washington Medical Center	7,698	13,979	0.55
Howard County General Hospital	5,963	11,372	0.52
MedStar Franklin Square	7,668	16,615	0.46
Carroll Hospital Center	3,612	8,287	0.44
UM St. Joseph Medical Center	4,216	11,565	0.36
Peer Group Weighted Average			**0.48**
Impact of UCHS Achieving Targeted Conversion of Observation Cases to Inpatient Admissions and Updating for FY2019 MedSurg Utilization			
UCHS Change			
UM Upper Chesapeake Medical Center	(2,496)	2,680	
% Reduction	*-28.3%*	*30.2%*	
UM Harford Memorial Hospital	(808)	-	
% Reduction	*-28.8%*	*0.0%*	
UCHS Combined	(3,304)	2,680	
% Reduction	*-28.4%*	*22.2%*	
Pro Forma Observation Cases			
UM Upper Chesapeake Medical Center	6,321	11,542	0.55
UM Harford Memorial Hospital	1,995	3,196	0.62
UCHS Combined	8,316	14,738	**0.56**

Note (1): Includes Observation patients that are discharged as outpatients. Excludes Observation patients that are admitted to inpatient status.
Source: FY2018 HSCRC Annual Filing

Additional measures to compare UM UCH's outpatient observation and inpatient medical surgical utilization to that of its peer group are ratios of outpatient observation cases per ED visit, inpatient medical surgical discharges per ED visit, and combined outpatient observation cases and inpatient medical surgical discharges per ED visit. Key observations from **Tables 24**, **25**, and **26** below include:

- UM UCH's historical ratio of outpatient observation cases per ED visit has been greater than that of its peer group.

- UM UCH's historical ratio of inpatient medical surgical discharges per ED visit has been less than that of its peer group.
- Combined, UM UCH's historical ratio of outpatient observation cases and inpatient medical surgical discharges is equal to that of its peer group.
- Applying the Applicants' projected reduction in observation cases beginning in fiscal year 2020, along with the corresponding increase in medical surgical discharges, results in ratios that are comparable to the peer group weighted average ratios.

As reflected in **Table 24** below, UM UCH experienced a ratio of 0.13 outpatient observation cases per ED visit. This ratio compares to the peer group weighted average of 0.09. Applying the Applicants' projected reduction in observation cases, beginning in fiscal year 2020, to UM UCH's actual utilization in fiscal year 2018 reduces UM UCH's ratio of observation cases per ED visit to 0.09. With these changes, UM UCH's ratio will equal that of the peer group.

Table 24
Comparison of Outpatient Observation Cases per ED Visit
FY2018

	Outpatient Observation Cases (1)	Emergency Department Vists	OBV Cases per ED Visit
UCHS			
UM Upper Chesapeake Medical Center	8,817	60,928	0.14
UM Harford Memorial Hospital	2,803	26,743	0.10
UCHS Combined	11,620	87,671	**0.13**
Peer Group			
UM St. Joseph Medical Center	4,216	45,512	0.09
UM Baltimore Washington Medical Center	7,698	84,775	0.09
MedStar Franklin Square	7,668	85,810	0.09
Howard County General Hospital	5,963	78,049	0.08
Carroll Hospital Center	3,612	48,024	0.08
Peer Group Weighted Average			**0.09**
Impact of UCHS Achieving Targeted Reductions in Observation Utilization			
UCHS Reduction			
UM Upper Chesapeake Medical Center	(2,496)		
% Reduction	*-28.3%*		
UM Harford Memorial Hospital	(808)		
% Reduction	*-28.8%*		
UCHS Combined	(3,304)		
% Reduction	*-28.4%*		
Pro Forma Observation Cases			
UM Upper Chesapeake Medical Center	6,321	60,928	0.10
UM Harford Memorial Hospital	1,995	26,743	0.07
UCHS Combined	8,316	87,671	**0.09**

Note (1): Excludes Observation patients that are admitted as inpatients
Source: FY2018 HSCRC Annual Filing

As presented in **Table 25** below, in fiscal year 2018, UM UCH experienced a ratio of 0.14 inpatient medical surgical discharges per ED visit. This ratio compares to the peer group weighted average of 0.19. Thus, as noted above, UM UCH's ratio of medical surgical discharges per ED visit is below the peer group weighted average, and indeed, such ratio is at or below each hospital in the peer group. Applying the Applicants' projected reduction in observation cases, beginning in fiscal year 2020, along with the resulting increase in medical surgical discharges, to UM UCH's actual utilization in fiscal year 2018 increases UM UCH's ratio of medical surgical discharges per ED visit to 0.17. While still below the peer group weighted average, these changes will cause UM UCH's ratio to be greater than or equal to three of the five peer group hospitals.

Table 25
Comparison of Medical Surgical Discharges per ED Visit
FY2018

	Inpatient MedSurg Discharges	Emergency Department Vists	MedSurg Discharges per ED Visit
UCHS			
UM Upper Chesapeake Medical Center	8,862	60,928	0.15
UM Harford Memorial Hospital	3,196	26,743	0.12
UCHS Combined	12,058	87,671	**0.14**
Peer Group			
UM St. Joseph Medical Center	11,565	45,512	0.25
MedStar Franklin Square	16,615	85,810	0.19
Carroll Hospital Center	8,287	48,024	0.17
UM Baltimore Washington Medical Center	13,979	84,775	0.16
Howard County General Hospital	11,372	78,049	0.15
Peer Group Weighted Average			**0.19**
Impact of UCHS Achieving Targeted Conversion of Observation Cases to Inpatient Admissions and Updating for FY2019 MedSurg Utilization			
UCHS Change			
UM Upper Chesapeake Medical Center	2,680		
% Reduction	*30.2%*		
UM Harford Memorial Hospital	-		
% Reduction	*0.0%*		
UCHS Combined	2,680		
% Reduction	*22.2%*		
Pro Forma Observation Cases			
UM Upper Chesapeake Medical Center	11,542	60,928	0.19
UM Harford Memorial Hospital	3,196	26,743	0.12
UCHS Combined	14,738	87,671	**0.17**

Source: FY2018 HSCRC Annual Filing

As presented in **Table 26** below, UM UCH experienced a combined ratio of 0.27 outpatient observation patients discharged as outpatients and medical surgical discharges per ED visit. This ratio equals the weighted average of its peer group. Applying the Applicants' projected reduction in observation cases, beginning in fiscal year 2020, along with the resulting increase in medical surgical discharges, to UM UCH's actual utilization in fiscal year 2018 reduces UM UCH's ratio of outpatient observation cases and inpatient medical surgical discharges per ED visit to 0.26 which is less than the peer group weighted average. *See* **Table 26** below.

Table 26
Comparison of Outpatient Observation Cases and Inpatient Medical Surgical Discharges per ED Visit
FY2018

	Outpatient Observation Cases (1)	Inpatient MedSurg Discharges	Total	Emergency Department Vists	OBV Cases & MS Discharges per ED Visit
UCHS					
UM Upper Chesapeake Medical Center	8,817	8,862	17,679	60,928	0.29
UM Harford Memorial Hospital	2,803	3,196	5,999	26,743	0.22
UCHS Combined	11,620	12,058	23,678	87,671	**0.27**
Peer Group					
UM St. Joseph Medical Center	4,216	11,565	15,781	45,512	0.35
MedStar Franklin Square	7,668	16,615	24,283	85,810	0.28
UM Baltimore Washington Medical Center	7,698	13,979	21,677	84,775	0.26
Carroll Hospital Center	3,612	8,287	11,899	48,024	0.25
Howard County General Hospital	5,963	11,372	17,335	78,049	0.22
Peer Group Weighted Average					**0.27**
Impact of UCHS Achieving Targeted Conversion of Observation Cases to Inpatient Admissions and Updating for FY2019 MedSurg Utilization					
UCHS Change					
UM Upper Chesapeake Medical Center	(2,496)	2,680	184		
% Reduction	*-28.3%*	*30.2%*	*1.0%*		
UM Harford Memorial Hospital	(808)	-	(808)		
% Reduction	*-28.8%*	*0.0%*	*-13.5%*		
UCHS Combined	(3,304)	2,680	(624)		
% Reduction	*-28.4%*	*22.2%*	*-2.6%*		
Pro Forma Observation Cases					
UM Upper Chesapeake Medical Center	6,321	11,542	17,863	60,928	0.29
UM Harford Memorial Hospital	1,995	3,196	5,191	26,743	0.19
UCHS Combined	8,316	14,738	23,054	87,671	**0.26**

Note (1): Excludes Observation patients that are admitted as inpatients
Source: FY2018 HSCRC Annual Filing

5. Provide a more detailed plan to attack this apparent overuse problem that offers a realistic expectation that the observation use rate will come into closer alignment with other UMMS peers and the state average.

Applicant's response: UM UCH disagrees with the characterization of observation utilization at HMH and UCMC as "apparent overuse." UM UCH analyzes its patient population as a whole, not based on the insurance designation of "observation" or "inpatient." This is because the Health Service Cost Review Commission, the Centers for Medicare and Medicaid Services ("CMS"), and other payers have created a distinction between potentially avoidable utilization and cases that are appropriate for the acute care setting. As reflected above in **Tables 23** and **24** above, UM UCH acknowledges that its observation case per medical service discharge and observation case per ED visit exceeds that of its peer group. However, as shown in **Table 25**, UM UCH's medical surgical discharge per ED visit is below the peer group weighted average and is equal to or below each hospital in the peer group. Moreover, as demonstrated by **Table 26**, the combined

ratio of observation and medical surgical discharges at UM UCH equals the weighted average of the peer group.

Indeed, as reflected in **Table 27** below, UM UCH experienced a combined ratio of 0.78 billed observation and medical surgical patient days per ED visit in fiscal year 2018. This ratio compares to a weighted average of 0.88 patients days per ED visit for the peer group. UM UCH's combined ratio of billed observation and medical surgical patient days per ED visit is 0.10 patient days less than the weighted average of the peer group (**Table 27**).

Table 27
Comparison of Observation and Medical Surgical Patient Days per ED Visit
FY2018

	Total Observation Pat Days (1)	Inpatient MedSurg Pat Days	Total	Emergency Department Visits	Total Patient Days per ED Visit		
					Observation (1)	MedSurg	Total
UCHS							
UM Upper Chesapeake Medical Center	13,841	36,048	49,889	60,928	0.23	0.59	0.82
UM Harford Memorial Hospital	4,788	13,783	18,571	26,743	0.18	0.52	0.69
UCHS Combined	**18,629**	**49,831**	**68,460**	**87,671**	**0.21**	**0.57**	**0.78**
% of Total	27.2%	72.8%	100.0%		27.2%	72.8%	100.0%
Peer Group							
UM Baltimore Washington Medical Center	9,231	63,321	72,552	84,775	0.11	0.75	0.86
Howard County General Hospital	8,277	49,219	57,496	78,049	0.11	0.63	0.74
MedStar Franklin Square	10,499	72,170	82,669	85,810	0.12	0.84	0.96
Carroll Hospital Center	4,736	34,188	38,924	48,024	0.10	0.71	0.81
UM St. Joseph Medical Center	5,035	45,747	50,782	45,512	0.11	1.01	1.12
Peer Group	**37,778**	**264,645**	**302,423**	**342,170**	**0.11**	**0.77**	**0.88**
% of Total	12.5%	87.5%	100.0%		12.5%	87.5%	100.0%
UCHS ALOS Variance from Peer Group Average					**0.10**	**(0.20)**	**(0.10)**

Note (1): Reflects total billed Observation hours
Source: FY2018 HSCRC Annual Filing

The above tables indicate that UM UCH is not "overusing" observation status, but is instead merely managing its patients requiring acute hospital care in an alternative setting than members of its peer group, which setting is still appropriate and safe for the patient. To this end, whether to admit a patient or place a patient in observation status is based on a clinical judgment as to whether a patient will require hospital care over the span of two midnights. CMS defines an inpatient as follows:

> An inpatient is a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services (see §10.2 below). **Generally, a patient is considered an inpatient if formally admitted as inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights** and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.
>
> The physician or other practitioner responsible for a patient's care at the hospital is also responsible for deciding whether the patient should be admitted as an inpatient. **Physicians should use the expectation of the patient to require hospital care**

> **that spans at least two midnights period as a benchmark, i.e., they should order admission for patients who are expected to require a hospital stay that crosses two midnights and the medical record supports that reasonable expectation**. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient's medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital's by-laws and admissions policies, and the relative appropriateness of treatment in each setting.

CMS, Medicare Benefit Manual Chapter 1, § 10 (effective, Jan. 1, 2016) (emphasis added).

Conversely, Medicare guidance, which is followed by Medicaid and most commercial insurers, defines observation care as:

> a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. Observation services are commonly ordered for patients who present to the emergency department and who then require a significant period of treatment or monitoring in order to make a decision concerning their admission or discharge.

CMS, Medicare Claims Processing Manual, Ch. 4 § 290.1 (effective July1 , 2009).

Thus, differences in inpatient and observation utilization between hospitals not only reflect patient visit volumes, patient acuity, and population health, but also individual clinician judgment based on expectation as to whether a given patient will require hospital care that spans two midnights.

Since filing its Modified Request for Exemption from CON Review on November 21, 2018 and based on discussions with Commission staff, UM UCH's clinical staff considered implementation of clinical practices that could better align UM UCH's observation use rates with an identified peer group of hospitals. Through enhanced case management, utilization review, and triage evaluation processes, UM UCH estimates that it may be able to reduce its observation utilization through either direct patient discharges or transitions of care to other outpatient departments or providers.

More specifically, UM UCH's areas of focus continue to be multi-pronged and demonstrate a commitment to delivering the right care in the right setting. Initiatives include the following: working with our community primary care practices to help coordinate care, embedding behavioral health evaluators into primary care practices, providing case management support via initiatives led by UM UCH's Chief Technology Officer such as delivery of information to providers regarding the overall performance of their patient panels upon ED, hospital admission, and observation utilization rates. Medical staff leadership is also emphasizing adherence to ED clinical pathways with a focus on decreasing clinical variation while, at the same time, promoting evidence based practice to either safely discharge patients from the ED with the appropriate level of follow-up care or making the clinical decision regarding the need for an observation stay or an inpatient admission. Additionally, there is a continued focus on monitoring adherence to observation protocols and order sets with the goal of decreasing clinical variation and ultimately decreasing observation cases length of stay. UM UCH is further engaged in education of hospitalist providers to more appropriately place patients in an inpatient status versus an observation status using specific diagnoses driven protocols with the support of UM UCH's utilization review team providing additional guidance to the clinical team. Lastly, UMMS is developing system wide initiatives focused on sepsis, congestive heart failure, chronic obstructive pulmonary disease, colo-rectal surgery and acute respiratory failure – all of these clinical pathways will address the entire continuum of care and are anticipated to bolster current protocols and clinical pathways.

6. Why does the UCHS need to replace HMH's total of 51 med/surg inpatient beds with 59 observation beds and 33 inpatient beds, a "swap" of 51 beds for 92 beds?

Applicant's response: The premise of question 6 is fundamentally flawed. The question fails to consider that observation patients at both HMH and UCMC currently reside in existing physical beds at both facilities. The question further fails to consider the need for inpatient beds due to the implementation of clinical practice changes that are projected to result in approximately 34% of historic observation cases in excess of 24 hours at both HMH and UCMC being converted to inpatient admissions. The total of 51 licensed medical surgical inpatient beds at HMH in fiscal year 2018 does not take into consideration that there was also a need for 16 observation beds and 6 ICU beds at HMH in fiscal year 2018, for a total of 73 combined observation and MSGA beds in fiscal year 2018. *See* **Table 28** below. In calendar year 2018, the average daily census at HMH for inpatient, ICU, observation patients, and patients remaining in the emergency department for greater than four hours waiting for a bed was 60. At an assumed 80% occupancy, that census would drive a need for 75 combined observation and MSGA beds. Comparing a historical count of medical surgical beds that excludes observation beds to a projection of beds that includes observation beds is misleading.

As presented in **Table 28**, there is actually a projected reduction of seven (7) beds in the combined number of medical surgical and observation beds from fiscal year 2018 to fiscal year 2024.

Table 28
Projection of Medical Surgical and Observation Beds
FY2018 - FY2024

	Actual FY2018	Actual FY2019	Projected for Fiscal Years FY2020	FY2021	FY2022	FY2023	FY2024	Change FY'18-FY'24
UCMC MedSurg and Observation Beds			(1) (2)	(3)	(4)			
General MedSurg (5) (6)	146	124	135	144	185	190	195	49
ICU (5)	14	14	14	14	17	17	17	3
Total MedSurg	160	138	149	158	202	207	212	52
Observation	48	48	52	42	44	45	45	(3)
Total MedSurg & Observation	208	186	201	200	246	252	257	49
HMH & Aberdeen MedSurg and Observation Beds								
General MedSurg (5)	51	48	45	46				(51)
ICU (5)	6	6	6	6				(6)
Total MedSurg	57	54	51	52	-	-	-	(57)
Observation - HMH	16	16	17	14	-	-	-	(16)
Observation - Aberdeen	-	-	-	-	17	17	17	17
Total Observation	16	16	17	14	17	17	17	1
Total MedSurg & Observation	73	70	68	66	17	17	17	(56)
Total MedSurg and Observation Beds								
General MedSurg (5) (6)	197	172	180	190	185	190	195	(2)
ICU	20	20	20	20	17	17	17	(3)
Total MedSurg	217	192	200	210	202	207	212	(5)
Observation	64	64	69	56	61	62	62	(2)
Total MedSurg & Observation	281	256	269	266	263	269	274	(7)

Note (1): Reflects unbilled hours of observation stays based on billing regulations and timely clinical interventions to eliminate unbillable hours
Note (2): UCMC and HMH begin to shift Observation cases to Inpatient admissions beginning in January 2020 (6 months of fiscal year)
Note (3): UCMC and HMH continue to shift Observation cases to Inpatient admissions (full year impact)
Note (4): HMH closes and shifts both Inpatient admissions and Observation cases greater 48 hours to UCMC
Note (5): Reflects licensed beds in FY2018-FY2020 as presented in MHCC Licensed Acute Bed reports
Note (6): Excludes 1 Pediatric bed

In fiscal year 2021, there is a projected need for 52 medical surgical beds at HMH, inclusive of 46 general medical surgical and 6 intensive care beds. Additionally, there is a need for 14 observation beds, for a total projected need for 66 MSGA and observation beds at HMH in fiscal year 2021.

In fiscal year 2022, HMH will close and 39 or 75% of its MSGA discharges and associated inpatient beds will be shifted to UCMC of which 36 will be general medical surgical patients and 3 will be intensive care beds. In addition, population growth into age cohorts with higher utilization rates drives a need for 5 additional beds for a total increase of 44 medical surgical beds from 158 medical surgical beds in fiscal year 2021 to 202 medical surgical beds in fiscal year 2022. This increase, though, is offset by the reduction of 52 medical surgical beds at HMH for a net reduction of eight (8) medical surgical beds from a UCMC / HMH combined total of 210 medical surgical beds in fiscal year 2021 to 202 medical surgical beds in fiscal year 2022.

With the closing of HMH in fiscal year 2022, it is anticipated that observation cases at HMH will be shifted to the FMF at Aberdeen. While there is a need for 14 observation beds at HMH in fiscal year 2021, there is a need for 17 observation beds at the FMF in fiscal year 2022. This increase of three (3) observations beds is driven by the inclusion of non-billable hours for observation patients at the FMF that are projected to ultimately require admission to UCMC.

Without inpatient medical surgical beds at the FMF, these non-billable hours for observation patients that are admitted need to be taken into consideration when determining the required number of observation beds.

Combined with a population driven growth of two (2) observation beds at UCMC, there is an expected increase of five (5) observation beds from 56 observation beds at UCMC and HMH in fiscal year 2021 to 61 observation beds at UCMC and the FMF in fiscal year 2022.

Combining an eight (8) bed reduction in medical surgical beds from fiscal year 2021 to 2022 with a five (5) bed increase in observation beds results in a net reduction of three (3) MSGA and observation beds from 266 beds at UCMC and HMH in fiscal year 2021 to 263 beds at UCMC and the FMF in fiscal year 2022. When comparing fiscal year 2018 MSGA and observation beds to those projected in fiscal year 2024, there is an expected net reduction of seven (7) beds.

Construction Costs and Cost Effective Alternatives

7. On Table E, the Project Budget please define the line item called *Escalation* (listed as $4.8 million). Also describe any assumptions and the calculations related to that item as well as the line items *Gross Interest during construction* ($6.6 million) and *Inflation Allowance* ($2.2 million).

Applicant's response:

Gross Interest

On the project budget, **Table E**, "gross interest during construction" is associated with debt the Applicants expect to issue in fiscal year 2020 to fund the project costs over an approximate two-year construction period. Interest expense incurred on this debt during the construction period is capitalized and added to the cost of the project. The interest expense will accrue at 4.5% a year on the outstanding loan balance.

Escalation

The inclusion of Escalation as a cost item in the Project Budget was an error, though the dollars associated should remain in the project budget. UM UCH has revised the Project Budget and pro-rated the dollars in the Escalation line to Building in both New Construction and Renovation. The Total Capital Costs and Total Project Costs do not change. A revised Project Budget is attached as **Replacement Exhibit 1**.

UM UCH recognizes that this change requires a revised MVS analysis. This is attached as **Exhibit 9**. The revised MVS analysis also reflects updates the MVS has made to Section 15 and to various updates. Further, since some Extraordinary Cost factors (such as the Premium for Minority Business Enterprise Requirement) are based on percentages of the Building budget line, these have also changed, since the amount in the Building line has changed. The Gross Interest and Financing Costs that should be included in the MVS analysis have also changed as a result of

the change in the Building costs (though the total Gross Interest and Financing Costs do not change. In addition, UM UCH has revised the Departmental Square Footage Differential factor in the MVS analysis to reflect the information that the MHCC has requested in question 9.

Inflation

Inflation was calculated using the IHS Markit in the Healthcare Cost Review Building Cost Index that is posted on the MHCC website at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/con_capital_cost_index_20190820.pdf .

Original Costing Date	19.2				
Midpoint of Construction	21.2				
Step 1	2019.3	%MOVAVG	1.6	1.016	*A*
Step 2	2019.2	%MOVAVG	1.7	1.017	*B*
	2019.2	CIS Proxy	1		*C*
Step 3	2020.1	CIS Proxy	1		*D*
D/C				1	*E*
*A * B * E*				**1.033272**	.033272

The resulting inflation percentage, 3.3272%, was then applied to the Total Current Capital Costs ($51,599,983 for the Hospital Building). $51,599,983 x 0.033272 = $2,159,699.

8. It appears that the "12,000 sq. ft. on the existing Hospital Garden (Ground) Level will be renovated to expand support services and the food services department (kitchen)" described on pp. 3 and 4 of the exemption request is not reflected on Table B or C. Please submit corrected tables including it.

Applicant's response: Revised **Tables B** and **C** are submitted herewith as **Replacement Exhibit 1**.

9. **On p. 31, under the table for departmental differential, you identify Food Service & EVS Expansion as one single department containing 8,960 BGSF and having a cost factor of 1.2. Please provide a breakdown of the total space by its expected utilization in the table below (Add additional services if applicable):**

Applicant's response: The 8,960 BGSF included under Food Service & EVS Expansion includes the following:

Department/Service	Square Footage	Cost Factor
Dietary	870	1.52
Dining Room	1,550	0.95
EVS	2,990	0.7
Facilities	2,100	0.96
Security	1,450	0.96
Total	8,960	

10. **Option 2 discussed in this proposal would locate the additional inpatient and/or observation beds in the Ambulatory Care Center ("ACC"), which is connected to the hospital, and replace the ambulatory care space with a new medical office building. The applicant states that the ACC space can accommodate 54 to 60 inpatient beds, and the cost of this option was estimated at $38.1 million. Given that it has more than enough space to accommodate the 33 psychiatric beds planned for the Aberdeen site – which is projected to cost far more to build (nearly $63 million) – why was this option not considered as an alternative to the proposed Aberdeen behavioral health proposal?**

Applicant's response: The premise of question 10 is erroneous; the Commission staff is comparing what would be one line item of a project budget with an entire, completed project budget for the proposed special psychiatric hospital in Aberdeen.

As noted on page 27 of the Modified Exemption Request, the costs reflected in **Table 19** of the Modified Exemption Request reflect building construction and renovation costs only. The costs reflected on **Table 19** do not include equipment, architectural and engineering fees, permits, interest, technology systems, furniture, finance costs, or any other line items on the project budget table. To this end, **Table 19** states that the costs associated with Option 1A, the proposed expansion above the Kaufman Caner Center, would be $37 million. The actual construction and renovation costs in the current project budget are $36,598,123. And, while the construction and renovation costs of the current project budget are approximately $36.6 million, the entire project budget is $84,406,807. *See* **Exhibit 1**, **Table E** (Project Budget).

In comparison to Option 2 in the Modified Exemption Request, new construction and renovation costs for the proposed special psychiatric hospital in Aberdeen amount to only $25.7 million, while the entire project budget for that project is approximately $62 million. Nevertheless, construction and renovation costs associated with the special psychiatric hospital in Aberdeen are one-third (1/3rd) less than the construction costs associated with Option 2 discussed on page 26 of the Modified Exemption Request.

In accordance with instructions from the Commission's Executive Director, UM UCH presented an additional alternative in its Modified CON Application to establish a special psychiatric hospital in Aberdeen that presented the best alterative associated with locating inpatient and outpatient psychiatric services on UCMC's campus. UM UCH went to significant effort to develop a project budget and financial projections for such an alternative, which was presented as Alternative 2.a. in its Modified CON Application. *See In re: Upper Chesapeake Campus at Aberdeen*, Modified CON Application, Docket No. 18-12-2436 at 57-59 (Oct. 21, 2019). The construction costs alone associated with Alternative 2.a. were $42 million, slightly less than Option 2 presented in the Modified Exemption Request. However, the project budget for that Alternative 2.a. ultimately totaled $93.6 million, without additional necessary campus improvements. *See In re: Upper Chesapeake Campus at Aberdeen*, Modified CON Application, Docket No. 18-12-2436 at **Exhibit 14** (Oct. 21, 2019). In total, the impact of relocating both MSGA and psychiatric beds to UCMC's campus along with a projected shift of 13,625 behavioral health outpatient visits would give require an additional $60 million in campus improvement and relocation costs in addition to the $93.6 million project budget, for a total of $153.6 million.

In sum, Option 2 in Modified Exemption Request only presents projected construction and renovation costs. Because it is not a viable or realistic alternative to UM UCH's proposal to develop a special psychiatric hospital in Aberdeen, it was not presented in UM UCH's Modified CON Application of October 21, 2019 based on guidance from the Commission's Executive Director.

Application Table Package

11. As per our earlier conversation, there has been several iterations of various application tables submitted over the course of this review, as they were corrected or enhanced with additional information. So that reviewers can be certain they are examining the final version, please submit a complete and final set.

Applicant's response: A consolidated set of CON Tables is submitted as **Replacement Exhibit 1**, which includes updated **Tables B**, **C**, and **E**, as well as **Table F,** which includes the combined statistical projections for UCMC, UC FMF, and UC Behavioral Health.

Table of Exhibits

Table of Tables

I hereby declare and affirm under the penalties of perjury that the facts stated in HMH's and UCMC's Responses to Additional Information Requests dated December 16, 2019 are true and correct to the best of my knowledge, information, and belief.

January 2, 2020
Date

Lyle E. Sheldon
President and Chief Executive Officer
University of Maryland Upper
Chesapeake Health System

I hereby declare and affirm under the penalties of perjury that the facts stated in HMH's and UCMC's Responses to Additional Information Requests dated December 16, 2019 are true and correct to the best of my knowledge, information, and belief.

1/2/20
Date

Robin Luxon

Robin Luxon
Senior Vice President, Corporate Planning, Marketing & Business Development
University of Maryland Upper Chesapeake Health System

I hereby declare and affirm under the penalties of perjury that the facts stated in HMH's and UCMC's Responses to Additional Information Requests dated December 16, 2019 are true and correct to the best of my knowledge, information, and belief.

1-2-2020
Date

Amale Obeid
Director of Planning and Business Development
University of Maryland Upper Chesapeake Health System

I hereby declare and affirm under the penalties of perjury that the facts stated in HMH's and UCMC's Responses to Additional Information Requests dated December 16, 2019 are true and correct to the best of my knowledge, information, and belief.

1/2/2020
Date

Stephen Witman
Senior Vice President, Chief Financial Officer
University of Maryland Upper Chesapeake Health System

I hereby declare and affirm under the penalties of perjury that the facts stated in HMH's and UCMC's Responses to Additional Information Requests dated December 16, 2019 are true and correct to the best of my knowledge, information, and belief.

1/2/2020
Date

Phillip D. Crocker
Project Manager
University of Maryland Upper
Chesapeake Health System

#600548
011888-0023

I hereby declare and affirm under the penalties of perjury that the facts stated in HMH's and UCMC's Responses to Additional Information Requests dated December 16, 2019 are true and correct to the best of my knowledge, information, and belief.

1/2/20
Date

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

#600532
011888-0023

I hereby declare and affirm under the penalties of perjury that the facts stated in HMH's and UCMC's Responses to Additional Information Requests dated December 16, 2019 are true and correct to the best of my knowledge, information, and belief.

January 2, 2020
Date

Matthew W. Franklin, AIA, CDT
Principal | Project Manager
HKS Inc.

EXHIBIT 1

TABLE A. PHYSICAL BED CAPACITY BEFORE AND AFTER PROJECT

INSTRUCTIONS: 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. NOTE: Physical capacity is the total number of beds that could be physically set up in space without significant renovations. This should be the maximum operating capacity under normal, non-emergency circumstances and is a physical count of bed capacity, rather than a measure of staffing capacity. A room with two headwalls and two sets of gasses should be counted as having capacity for two beds, even if it is typically set up and operated with only one bed. A room with one headwall and one set of gasses is counted as a private room, even if it is large enough from a square footage perspective to be used as a semi-private room, since renovation/construction would be required to convert it to semi-private use. If the hospital operates patient rooms that contain no headwalls or a single headwall, but are normally used to accommodate one or more than one patient (e.g., for psychiatric patients), the physical capacity of such rooms should be counted as they are currently used.

Before the Project							After Project Completion						
Hospital Service	Location (Floor/ Wing)*	Licensed Beds: 7/1/2018	Based on Physical Capacity				Hospital Service	Location (Floor/ Wing)*	Based on Physical Capacity				
			Room Count			Bed Count			Room Count			Bed Count	
			Private	Semi-Private	Total Rooms	Physical Capacity			Private	Semi-Private	Total Rooms	Physical Capacity	
ACUTE CARE							**ACUTE CARE**						
General Medical/ Surgical*	1 West	23	25	1	26	27	**General Medical/ Surgical***	1 West	25	1	26	27	
	2 West	17	13	8	21	29		2 West	13	8	21	29	
	2 East	24	25	0	25	25		2 East	25	0	25	25	
	3 West	19	15	8	23	31		3 West	15	8	23	31	
	3 East	36	31	8	39	47		3 East	31	8	39	47	
	IMC	6	0	3	3	6		IMC	0	3	3	6	
								5 West	30	0	30	30	
SUBTOTAL Gen. Med/Surg*		**125**	**109**	**28**	**137**	**165**	**SUBTOTAL Gen. Med/Surg***		**139**	**28**	**167**	**195**	
ICU/CCU	2 East	**13**	14	0	14	14	**ICU/CCU**	2 East	14	0	14	14	
								IMC	3	0	3	3	
Other *(Specify/add rows as needed)*					0	0					0	0	
TOTAL MSGA		**138**	**123**	**28**	**151**	**179**	**TOTAL MSGA**		**132**	**28**	**184**	**212**	
Obstetrics	1 East	**10**	14	0	14	14	**Obstetrics**	1 East	14	0	14	14	
Pediatrics	1 East	**1**	9	0	9	9	**Pediatrics**	1 East	9	0	9	9	
Psychiatric					0	0	**Psychiatric**				0	0	
TOTAL ACUTE		**149**	**146**	**28**	**174**	**202**	**TOTAL ACUTE**		**155**	**28**	**207**	**235**	
NON-ACUTE CARE							**NON-ACUTE CARE**						
Dedicated Observation**		**0**	0	**0**	0	0	**Dedicated Observation****	CDU***	0	**0**	0	0	
					0	0		4 West	0	**21**	21	42	
Other *(Specify/add rows as needed)*					0	0	**Other** *(Specify/add rows as needed)*				0	0	
TOTAL NON-ACUTE							**TOTAL NON-ACUTE**		**0**	**21**	**21**	**42**	
HOSPITAL TOTAL		**149**	**146**	**28**	**174**	**202**	**HOSPITAL TOTAL**		**155**	**49**	**228**	**277**	

* 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.

*** The CDU or Clinical Decision Unit is a single room with 10 beds located near the Emergency Department which presently serves as UCMC's dedicated observation unit.

TABLE B. DEPARTMENTAL GROSS SQUARE FEET AFFECTED BY PROPOSED PROJECT

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

DEPARTMENT/FUNCTIONAL AREA	DEPARTMENTAL GROSS SQUARE FEET				
	Current	To be Added Thru New Construction	To Be Renovated	To Remain As Is	Total After Project Completion
Med / Surg Patient Unit Level 5		26,290			26,290
Observation Unit Level 4		26,290			26,290
Food Service & EVS Expansion		8,960			8,960
Food Service & Support Services Renov.			12,000		12,000
Shell Space Level 3		26,290			26,290
Central Utility Plant			8,300		8,300
Existing Cancer Center		1,020	494		1,514
					0
					0
					0
					0
					0
					0
					0
					0
Total	0	88,850	20,794	0	109,644

TABLE C. CONSTRUCTION CHARACTERISTICS

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

	NEW CONSTRUCTION	RENOVATION
BASE BUILDING CHARACTERISTICS	**Check if applicable**	
Class of Construction (for renovations the class of the building being renovated)*		
Class A	☑	☑
Class B	☐	☐
Class C	☐	☐
Class D	☐	☐
Type of Construction/Renovation*		
Low	☐	☐
Average	☐	☐
Good	☑	☑
Excellent	☐	☐
Number of Stories	3	2

*As defined by Marshall Valuation Service

PROJECT SPACE	**List Number of Feet, if applicable**	
Total Square Footage	**88,850**	**20,794**
Ground Floor	8,960	12,000
First Floor	510	494
Second Floor	510	
Third Floor	26,290	
Fourth Floor	26,290	
Fifth Floor	26,290	
Central Utility Plant		8,300
Average Square Feet	**14,808**	**6,931**
Perimeter in Linear Feet	**Linear Feet**	
Ground Floor	436	395
First Floor	94	135
Second Floor	94	
Third Floor	776	
Fourth Floor	776	
Fifth Floor	776	
Central Utility Plant		371
Total Linear Feet	**2,952**	**901**
Average Linear Feet	**492**	**451**
Wall Height (floor to eaves)	**Feet**	
Ground Floor	16	16
First Floor	16	16
Second Floor	16	16
Third Floor	16	
Fourth Floor	16	
Fifth Floor	19	
Central Utility Plant		16
Average Wall Height	**17**	**16**
OTHER COMPONENTS		
Elevators	**List Number**	
Passenger	3	
Freight	2	
Sprinklers	**Square Feet Covered**	
Wet System	88,850	20,794
Dry System		
Other	**Describe Type**	
Type of HVAC System for proposed project	Excellent Grade - Forced Air: VAV / Constant Volume, Digitally Controlled	
Type of Exterior Walls for proposed project	Glass Curtain Wall, Brick Veneer, Metal Panels	

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

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

	NEW CONSTRUCTION COSTS	RENOVATION COSTS
SITE PREPARATION COSTS		
Normal Site Preparation	$236,492	$0
Utilities from Structure to Lot Line	$0	$0
Subtotal included in Marshall Valuation Costs	**$236,492**	**$0**
Site Demolition Costs	**$0**	**$0**
Storm Drains	**$0**	**$0**
Rough Grading	**$0**	**$0**
Hillside Foundation	**$0**	**$0**
Paving	**$0**	**$0**
Exterior Signs	**$0**	**$0**
Landscaping	$0	$0
Walls	$0	$0
Yard Lighting	$0	$0
Premium for Minority Business Enterprise Requirement	$9,854	$0
Subtotal On-Site excluded from Marshall Valuation Costs	**$9,854**	**$0**
OFFSITE COSTS		
Roads	$0	$0
Utilities	$0	$0
Jurisdictional Hook-up Fees	$0	$0
Other *(Specify/add rows if needed)*	$0	$0
Subtotal Off-Site excluded from Marshall Valuation Costs	**$0**	**$0**
TOTAL Estimated On-Site and Off-Site Costs not included in Marshall Valuation Costs	**$9,854**	**$0**
TOTAL Site and Off-Site Costs included and excluded from Marshall Valuation Service*	**$246,346**	**$0**
BUILDING COSTS		
Normal Building Costs	$22,764,385	$1,583,895
Subtotal included in Marshall Valuation Costs	$22,764,385	**$1,583,895**
Complexity Premium	$3,594,605	
Demolition	$1,085,820	
2/5 HVAC System	$3,055,552	
OVHD Bridges	$2,535,000	
Pneumatic tube	$466,440	
Signage	$132,454	
Elevator Premium	$873,950	
Premium for Minority Business Enterprise Requirement	$1,437,842	
Subtotal Building Costs excluded from Marshall Valuation Costs	**$13,181,662**	**$0**
TOTAL Building Costs included and excluded from Marshall Valuation Service*	**$35,946,047**	**$1,583,895**
A&E COSTS		
Normal A&E Costs	$4,628,765	$219,817
Subtotal included in Marshall Valuation Costs	**$4,628,765**	**$219,817**
Subtotal A&E Costs excluded from Marshall Valuation Costs	**$0**	**$0**
TOTAL A&E Costs included and excluded from Marshall Valuation Service*	**$4,628,765**	**$219,817**
PERMIT COSTS		
Normal Permit Costs	$2,320,586	$104,675
Subtotal included in Marshall Valuation Costs	**$2,320,586**	**$104,675**
Jurisdictional Hook-up Fees	$0	$0
Impact Fees	$0	$0
Subtotal Permit Costs excluded from Marshall Valuation Costs	**$0**	**$0**
TOTAL Permit Costs included and excluded from Marshall Valuation Service*	**$2,320,586**	**$104,675**

TABLE E. PROJECT BUDGET

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

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

		Hospital Building	Central Plant	Total
A.	**USE OF FUNDS**			
1.	**CAPITAL COSTS**			
a.	**New Construction**			
(1)	Building	$39,639,186	$0	$39,639,186
(2)	Fixed Equipment	$0	$0	$0
(3)	Site and Infrastructure	$246,346	$0	$246,346
(4)	Architect/Engineering Fees	$4,628,765	$0	$4,628,765
(5)	Permits & Inspections (Building, Utilities, Etc.)	$2,320,586	$0	$2,320,586
	SUBTOTAL	**$46,834,883**	**$0**	**$46,834,883**
b.	**Renovations**			
(1)	Building	$718,615	$2,133,565	$2,852,180
(2)	Fixed Equipment (not included in construction)	$0	$4,736,462	$4,736,462
(3)	Architect/Engineering Fees	$80,228	$219,817	$300,045
(4)	Permits (Building, Utilities, Etc.)	$38,204	$104,675	$142,879
	SUBTOTAL	**$837,047**	**$7,194,519**	**$8,031,566**
c.	**Other Capital Costs**			
(1)	Movable Equipment	$2,520,000	$0	$2,520,000
(2)	Owner Contingency Allowance	$4,511,181	$607,722	$5,118,903
(3)	Gross interest during construction period	$6,566,503	$878,128	$7,444,631
(4)	Technology / Information Systems	$2,000,000	$0	$2,000,000
(4)	Furniture / Artwork / Signage	$1,340,790	$0	$1,340,790
(4)	Food Service Equipment	$300,000	$0	$300,000
(4)	Other *(Specify/add rows if needed)*	$0	$0	$0
	SUBTOTAL	***$17,238,474***	***$1,485,850***	**$18,724,324**
	TOTAL CURRENT CAPITAL COSTS	**$64,910,404**	**$8,680,369**	**$73,590,773**
d.	***Land Purchase***			
e.	**Inflation Allowance**	$2,159,699	$288,813	$2,448,512
	TOTAL CAPITAL COSTS	**$67,070,103**	**$8,969,183**	**$76,039,286**
2.	**Financing Cost and Other Cash Requirements**			
a.	**Loan Placement Fees**	**$626,233**	**$83,745**	$709,979
b.	**Bond Discount**			$0

c.	**Legal Fees (CON)**	**$110,322**		$110,322
d.	**Legal Fees (Other)**	**$227,508**		$227,508
e.	**Non-Legal Consultant Fees (CON application related - specify what it is and why it is needed for the CON)**	**$884,309**		$884,309
f.	**Non-Legal Consultant Fees (Other)**	**$1,181,081**		$1,181,081
g.	**Liquidation of Existing Debt**			$0
H.	**Debt Service Reserve Fund**	**$4,634,551**	**$619,771**	$5,254,322
i.	**Other *(Specify/add rows if needed)***			$0
	SUBTOTAL	***$7,664,005***	***$703,517***	**$8,367,521**
3.	**Working Capital Startup Costs**			$0
	TOTAL USES OF FUNDS	***$74,734,108***	***$9,672,699***	***$84,406,807***
B.	**Sources of Funds**			
1.	**Cash**			$0
2.	**Philanthropy (to date and expected)**			$0
3.	**Authorized Bonds**	$73,238,943	$9,479,183	$82,718,126
4.	**Interest Income from bond proceeds listed in #3**	$1,495,164	$193,516	$1,688,681
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	***$74,734,108***	***$9,672,699***	**$84,406,807**
		Hospital Building	***Central Plant***	***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 (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. DISCHARGES								
a1. General Medical/Surgical* UCMC	8,974	8,061	8,489	9,262	10,643	13,718	14,039	14,371
a2. General Medical/Surgical* HMH	3,034	3,021	2,870	3,143	3,634			
a3. Observation UCMC	12,127	13,930	13,985	13,273	11,786	12,060	12,139	12,221
a4. Observation HMH	4,019	4,443	4,458	4,210	3,697			
a5. Observation UC FMF						3,718	3,740	3,763
General MSGA & Observation	**28,154**	**29,455**	**29,802**	**29,888**	**29,759**	**29,496**	**29,917**	**30,355**
b1. ICU/CCU UCMC	860	842	887	966	1,109	1,425	1,458	1,492
b2. ICU/CCU HMH	179	175	166	182	211			
Total MSGA	**29,193**	**30,472**	**30,855**	**31,036**	**31,078**	**30,922**	**31,375**	**31,847**
c. Pediatric	123	108	114	113	112	111	110	109
d. Obstetric	1,366	1,296	1,345	1,348	1,351	1,354	1,356	1,359
e1. Acute Psychiatric HMH	1,233	1,195	1,185	1,191	1,197			
e2. Acute Psychiatric UC Behavioral Health						1,313	1,320	1,328
Total Acute	***31,915***	***33,071***	***33,499***	***33,688***	***33,738***	***33,699***	***34,162***	***34,643***
f. Rehabilitation								
g. Comprehensive Care								
h. Other (Specify/add rows of needed)								
TOTAL DISCHARGES	***31,915***	***33,071***	***33,499***	***33,688***	***33,738***	***33,699***	***34,162***	***34,643***
2. PATIENT DAYS								
a1. General Medical/Surgical* UCMC	35,932	32,776	35,685	37,903	41,614	53,418	54,724	56,077
a2. General Medical/Surgical* HMH	13,246	12,318	11,513	12,255	13,508			
a3. Observation UCMC	13,243	13,841	13,890	15,066	12,147	12,805	12,888	12,975
a4. Observation HMH	4,813	4,788	4,802	5,101	4,109	-		
a5. Observation UC FMF						4,298	4,324	4,350
General MSGA & Observation	**67,234**	**63,723**	**65,890**	**70,325**	**71,378**	**70,521**	**71,936**	**73,402**
b1. ICU/CCU UCMC	3,415	3,342	3,639	3,865	4,243	5,438	5,570	5,707
b2. ICU/CCU HMH	1,496	1,465	1,370	1,458	1,607			
Total MSGA	**72,145**	**68,530**	**70,898**	**75,648**	**77,228**	**75,959**	**77,506**	**79,108**
c. Pediatric	335	234	247	271	297	294	292	289
d. Obstetric	2,776	2,512	2,607	2,613	2,618	2,623	2,629	2,634
e1. Acute Psychiatric HMH	7,486	7,737	7,735	7,993	8,057			
e2. Acute Psychiatric UC Behavioral Health						9,358	9,445	9,535
Total Acute	***82,741***	***79,013***	***81,487***	***86,525***	***88,200***	***88,235***	***89,871***	***91,567***
f. Rehabilitation								
g. Comprehensive Care								
h. Other (Specify/add rows of needed)								
TOTAL PATIENT DAYS	***82,741***	***79,013***	***81,487***	***86,525***	***88,200***	***88,235***	***89,871***	***91,567***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
3. AVERAGE LENGTH OF STAY (patient days divided by discharges)								
a1. General Medical/Surgical* UCMC	4.0	4.1	4.2	4.1	3.9	3.9	3.9	3.9
a2. General Medical/Surgical* HMH	4.4	4.1	4.0	3.9	3.7			
a3. Observation UCMC	1.1	1.0	1.0	1.1	1.0	1.1	1.1	1.1
a4. Observation HMH	1.2	1.1	1.1	1.2	1.1			
a5. Observation UC FMF						1.2	1.2	1.2
General MSGA & Observation	**2.4**	**2.2**	**2.2**	**2.4**	**2.4**	**2.4**	**2.4**	**2.4**
b1. ICU/CCU UCMC	4.0	4.0	4.1	4.0	3.8	3.8	3.8	3.8
b2. ICU/CCU HMH	8.4	8.4	8.3	8.0	7.6			
Total MSGA	**2.5**	**2.2**	**2.3**	**2.4**	**2.5**	**2.5**	**2.5**	**2.5**
c. Pediatric	2.7	2.2	2.2	2.4	2.7	2.7	2.7	2.7
d. Obstetric	2.0	1.9	1.9	1.9	1.9	1.9	1.9	1.9
e1. Acute Psychiatric HMH	6.1	6.5	6.5	6.7	6.7			
e2. Acute Psychiatric UC Behavioral Health						7.1	7.2	7.2
Total Acute	**2.6**	**2.4**	**2.4**	**2.6**	**2.6**	**2.6**	**2.6**	**2.6**
f. Rehabilitation								
g. Comprehensive Care								
h. Other (Specify/add rows of needed)								
TOTAL AVERAGE LENGTH OF STAY	**2.6**	**2.4**	**2.4**	**2.6**	**2.6**	**2.6**	**2.6**	**2.6**
4. NUMBER OF LICENSED BEDS								
a1. General Medical/Surgical* UCMC	145	146	124	135	143	185	190	195
a2. General Medical/Surgical* HMH	53	51	48	45	46			
a3. Observation UCMC	-	-	-	-	-	-	-	-
a4. Observation HMH	-	-	-	-	-			
a5. Observation UC FMF						-	-	-
General MSGA & Observation	**198**	**197**	**172**	**180**	**189**	**185**	**190**	**195**
b1. ICU/CCU UCMC	14	14	14	14	14	17	17	17
b2. ICU/CCU HMH	6	6	6	6	6			
Total MSGA	**218**	**217**	**192**	**200**	**209**	**202**	**207**	**212**
c. Pediatric	1	1	1	2	1	1	1	1
d. Obstetric	10	10	10	10	10	10	10	10
e1. Acute Psychiatric HMH	26	29	28	31	28			
e2. Acute Psychiatric UC Behavioral Health						32	33	33
Total Acute	***255***	***257***	***231***	***243***	***248***	***245***	***251***	***256***
f. Rehabilitation								
g. Comprehensive Care								
h. Other (Specify/add rows of needed)								
TOTAL LICENSED BEDS	***255***	***257***	***231***	***243***	***248***	***245***	***251***	***256***

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
5. OCCUPANCY PERCENTAGE **IMPORTANT NOTE:* *Leap year formulas should be changed by applicant to reflect 366 days per year.*								
a1. General Medical/Surgical* UCMC	67.9%	61.5%	78.8%	76.9%	79.5%	79.1%	78.9%	78.7%
a2. General Medical/Surgical* HMH	68.5%	66.2%	65.7%	74.6%	80.5%	-	-	-
a3. Observation UCMC	-	-	-	-	-	-	-	-
a4. Observation HMH	-	-	-	-	-	-	-	-
a5. Observation UC FMF	-	-	-	-	-	-	-	-
General MSGA & Observation	**93.0%**	**88.6%**	**105.0%**	**107.0%**	**103.3%**	**104.4%**	**103.7%**	**103.1%**
b1. ICU/CCU UCMC	66.8%	65.4%	71.2%	75.6%	83.0%	87.6%	89.8%	92.0%
b2. ICU/CCU HMH	68.3%	66.9%	62.5%	66.6%	73.4%	-	-	-
Total MSGA	**90.7%**	**86.5%**	**101.2%**	**103.6%**	**101.0%**	**103.0%**	**102.6%**	**102.2%**
c. Pediatric	91.8%	64.1%	67.7%	37.1%	81.4%	80.7%	80.0%	79.3%
d. Obstetric	76.0%	68.8%	71.4%	71.6%	71.7%	71.9%	72.0%	72.2%
e1. Acute Psychiatric HMH	78.9%	73.1%	75.7%	70.6%	78.8%	-	-	-
e2. Acute Psychiatric UC Behavioral Health	-	-	-	-	-	80.1%	78.4%	80.0%
Total Acute	**88.9%**	**84.2%**	**96.6%**	**97.6%**	**97.3%**	**98.6%**	**98.1%**	**98.1%**
f. Rehabilitation	-	-	-	-	-	-	-	-
g. Comprehensive Care	-	-	-	-	-	-	-	-
h. Other (Specify/add rows of needed)	-	-	-	-	-	-	-	-
TOTAL OCCUPANCY %	**88.9%**	**84.2%**	**96.6%**	**97.6%**	**97.3%**	**98.6%**	**98.1%**	**98.1%**

TABLE F. STATISTICAL PROJECTIONS - ENTIRE FACILITY (UCMC + UC FMF + HMH + UC BEHAVIORAL HEALTH + OBSERVATION)

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Include additional years, if needed in order to be consistent with Tables G and H.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
6. OUTPATIENT VISITS								
a1. Emergency Department UCMC (Total)	64,502	61,445	61,812	62,181	62,553	63,041	63,418	63,797
a2. Emergency Department UC FMF (Total)						27,106	27,227	27,348
a3. Emergency Department HMH (Total)	28,356	26,743	26,862	26,981	27,101			
b1. Same-day Surgery Cases UCMC	5,678	5,621	5,652	5,685	5,719	5,753	5,791	5,830
b2. Same-day Surgery Cases HMH	1,210	1,234	1,240	1,246	1,252			
c1. Laboratory RVUs UCMC	12,048,570	11,494,331	10,945,039	11,228,867	11,453,817	14,992,238	15,285,725	15,589,881
c2. Laboratory RVUs HMH	2,695,784	2,487,416	2,554,276	2,599,157	2,645,591			
c3. Laboratory RVUs UC Behavioral Health						207,012	209,796	212,683
d1. Imaging RVUs UCMC	1,905,329	1,809,354	1,722,888	1,767,567	1,802,977	2,596,651	2,646,000	2,697,143
d2. Imaging RVUs HMH	615,566	582,398	598,053	608,561	619,433			
d3. Imaging RVUs UC Behavioral Health						7,624	7,727	7,833
e. Psych Emergency Department								
f1. Outpatient Psych Clinic HMH	5,646	5,759	5,874	5,992	6,111			
f2. Outpatient Psych Clinic UC Behavioral Health						6,234	6,358	6,485
g1. Intensive Outpatient Psych Program HMH	1,502	970	971	1,125	1,147			
g2. Intensive Outpatient Psych Program UC Behavioral Health						1,170	1,194	1,217
h1. Partial Hospitalization Program HMH			-	-	-			
h2. Partial Hospitalization Program UC Behavioral Health						1,300	2,600	2,600
TOTAL OUTPATIENT VISITS	***17,372,142***	***16,475,271***	***15,922,667***	***16,307,362***	***16,625,702***	***17,908,130***	***18,255,835***	***18,614,818***
7. OBSERVATIONS**								
a1. Number of Patients UCMC	12,127	13,930	13,985	13,273	11,786	12,060	12,139	12,221
a2. Number of Patients UC FMF						3,718	3,740	3,763
a3. Number of Patients HMH	4,019	4,443	4,458	4,210	3,697			
b1. Hours UCMC	317,843	332,191	333,349	361,576	291,518	307,315	309,316	311,409
b2. Hours HMH	115,522	114,915	115,254	122,426	98,617			
b2. Hours UC FMF						103,160	103,767	104,404

* 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 - UPPER CHESAPEAKE HEALTH SYSTEM

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Gross patient services revenue	540,220	558,961	537,398	552,005	556,761	553,413	555,699	558,002
Gross Patient Service Revenues	***$ 540,220***	***$ 558,961***	***$ 537,398***	***$ 552,005***	***$ 556,761***	***$ 553,413***	***$ 555,699***	***$ 558,002***
c. Allowance For Bad Debt	14,027	14,080	14,227	14,663	14,701	14,130	14,199	14,268
d. Contractual Allowance	75,402	85,596	93,596	90,221	92,040	97,840	98,106	98,375
e. Charity Care	14,970	14,471	6,513	14,002	14,039	12,313	12,377	12,441
Net Patient Services Revenue	***$ 435,821***	***$ 444,814***	***$ 423,062***	***$ 433,119***	***$ 435,981***	***$ 429,129***	***$ 431,017***	***$ 432,918***
f. Other Operating Revenues (Specify/add rows if needed)	271	3,093	3,255	5,867	5,867	5,756	5,756	5,756
NET OPERATING REVENUE	***$ 436,092***	***$ 447,908***	***$ 426,317***	***$ 438,986***	***$ 441,848***	***$ 434,884***	***$ 436,772***	***$ 438,674***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 244,970	$ 234,694	$ 245,975	262,625	$ 257,893	$ 252,291	$ 252,155	$ 252,707
b. Contractual Services	13,253	10,071	10,029	11,839	11,987	11,013	11,155	11,295
c. Interest on Current Debt	8,150	9,808	9,523	9,271	8,963	8,643	8,313	8,030
d. Interest on Project Debt	-	-	-	-	-	9,600	9,421	9,234
e. Current Depreciation	22,137	22,922	23,591	22,755	23,518	23,042	23,979	24,980
f. Project Depreciation	-	-	-	-	-	8,127	8,127	8,127
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	83,351	84,045	64,830	65,492	67,218	66,250	67,149	68,074
j. Other Expenses (Specify/add rows if needed)	58,623	65,064	55,238	62,328	59,666	51,981	51,611	51,065
TOTAL OPERATING EXPENSES	**$ 430,484**	**$ 426,605**	**$ 409,186**	**$ 434,309**	**$ 429,246**	**$ 430,948**	**$ 431,911**	**$ 433,512**
3. INCOME								
a. Income From Operation	**$ 5,608**	**$ 21,303**	**$ 17,132**	**$ 4,677**	**$ 12,602**	**$ 3,937**	**$ 4,861**	**$ 5,162**
b. Non-Operating Income	18,640	17,578	10,085	8,180	7,273	8,299	8,563	8,982
SUBTOTAL	***$ 24,248***	***$ 38,881***	***$ 27,217***	***$ 12,858***	***$ 19,875***	***$ 12,235***	***$ 13,424***	***$ 14,143***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 24,248***	***$ 38,881***	***$ 27,217***	***$ 12,858***	***$ 19,875***	***$ 12,235***	***$ 13,424***	***$ 14,143***

TABLE G. REVENUES & EXPENSES, UNINFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
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	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
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 Upper Chesapeake Health System (Excludes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Health System FY2019 cost center level projections and high level FY2020 budget, including Upper Chesapeake Medical Center, Harford Memorial Hospital, Upper Chesapeake Medical Services, Upper Chesapeake Health System (Parent entity) and several other entities with assumptions	
Projection period reflects FY2021 – FY2024	
Volumes	- Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- Based on each entity's FY2020 budget operating results.
o Demographic and Other Rate Adjustment	- Based on each entity's FY2020 budget operating results.
o Variable Cost Factor	- Based on each entity's FY2020 budget operating results.
• Revenue Deductions	
o Contractual Allowances	- Based on each entity's FY2020 budget operating results.
o Charity Care	- Based on each entity's FY2020 budget operating results.
o Allowance for Bad Debt	- Based on each entity's FY2020 budget operating results.
Other Revenue	- Based on each entity's FY2020 budget operating results.
Expenses	
• Inflation	- 0.0% increase per year
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 Volume Driver	- For the hospital entities, identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%)
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Beginning in FY2019 and F2020, UCHS includes 340B savings (at UCMC) offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos), which leads to a transition to UMMS Shared Services beginning in FY2020. - Beginning in FY2021 a $0.9M performance improvement plan is assumed at UCMC, growing to $7.2M in FY2022 ($5.9M at UCMC, $0.2M at UCMS and $1.1M at AMC Specialty Psych Hospital) when HMH closes and the Project opens. An incremental performance improvement of $1.5M per year is assumed throughout the projection period.
• Interest Expense – Existing Debt	- Continued amortization of existing debt and related interest expense: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – New Debt (Project Related)	- 4.5% interest on $214.4M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $196.3M (less land and debt service reserve fund) of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- $135.0M in routine capital over the projection period with another $47.4M of other strategic capital projects (none are related to this Project)

TABLE H. REVENUES & EXPENSES, INFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. GROSS REVENUE								
a. Gross Patient Service Revenues	$ 540,220	$ 558,961	$ 537,398	$ 565,253	$ 583,806	$ 594,222	$ 610,997	$ 628,254
Gross Patient Service Revenues	***540,220***	***$ 558,961***	***$ 537,398***	***$ 565,253***	***$ 583,806***	***$ 594,222***	***$ 610,997***	***$ 628,254***
b. Allowance For Bad Debt	$ 14,027	$ 14,080	$ 14,227	$ 15,015	$ 15,415	$ 15,172	$ 15,612	$ 16,064
c. Contractual Allowance	75,402	85,596	93,596	92,386	96,511	105,055	107,869	110,760
d. Charity Care	14,970	14,471	6,513	14,338	14,721	13,221	13,609	14,008
Net Patient Services Revenue	***435,821***	***$ 444,814***	***$ 423,062***	***$ 443,514***	***$ 457,159***	***$ 460,773***	***$ 473,908***	***$ 487,422***
e. Other Operating Revenues (Specify/add rows if needed)	271	3,093	3,255	5,926	5,985	5,930	5,989	6,049
NET OPERATING REVENUE	***436,092***	***$ 447,908***	***$ 426,317***	***$ 449,440***	***$ 463,144***	***$ 466,703***	***$ 479,897***	***$ 493,472***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 244,970	$ 234,694	$ 245,975	$ 268,665	$ 269,892	$ 270,102	$ 276,166	$ 283,136
b. Contractual Services	13,253	10,071	10,029	12,194	12,717	12,034	12,555	13,094
c. Interest on Current Debt	8,150	9,808	9,523	9,271	8,963	8,643	8,313	8,030
d. Interest on Project Debt						9,600	9,421	9,234
e. Current Depreciation	22,137	22,922	23,591	22,755	23,518	23,042	23,979	24,980
f. Project Depreciation						8,127	8,127	8,127
g. Current Amortization								
h. Project Amortization								
i. Supplies	83,351	84,045	64,830	67,457	71,312	72,393	75,577	78,917
j. Other Expenses (Specify/add rows if needed)	58,623	65,064	55,238	63,575	62,077	55,163	55,866	56,380
TOTAL OPERATING EXPENSES	***$ 430,484***	***$ 426,605***	***$ 409,186***	***$ 443,916***	***$ 448,480***	***$ 459,105***	***$ 470,004***	***$ 481,898***
3. INCOME								
a. Income From Operation	**$ 5,608**	**$ 21,303**	**$ 17,132**	**$ 5,524**	**$ 14,664**	**$ 7,598**	**$ 9,893**	**$ 11,574**
b. Non-Operating Income	18,640	17,578	10,085	8,344	7,567	8,806	9,269	9,916
SUBTOTAL	***$ 24,248***	***$ 38,881***	***$ 27,217***	***$ 13,868***	***$ 22,231***	***$ 16,405***	***$ 19,162***	***$ 21,490***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 24,248***	***$ 38,881***	***$ 27,217***	***$ 13,868***	***$ 22,231***	***$ 16,405***	***$ 19,162***	***$ 21,490***

TABLE H. REVENUES & EXPENSES, INFLATED - UPPER CHESAPEAKE HEALTH SYSTEM

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.

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses				
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 Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
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	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
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 Upper Chesapeake Health System (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Health System FY2019 cost center level projections and high level FY2020 budget, including Upper Chesapeake Medical Center, Harford Memorial Hospital, Upper Chesapeake Medical Services, Upper Chesapeake Health System (Parent entity) and several other entities with assumptions identified below.

Projection period reflects FY2021 – FY2024

Volumes	- Refer to CON Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- Based on each entity's FY2020 budget operating results.
o Demographic and Other Rate Adjustment	- Based on each entity's FY2020 budget operating results.
o Variable Cost Factor	- Based on each entity's FY2020 budget operating results.
• Revenue Deductions	
o Contractual Allowances	- Based on each entity's FY2020 budget operating results.
o Charity Care	- Based on each entity's FY2020 budget operating results.
o Allowance for Bad Debt	- Based on each entity's FY2020 budget operating results.
Other Revenue	
Other Revenue	- Based on each entity's FY2020 budget operating results.
Expenses	
• Inflation	
o Salaries and Benefits	- 2.3%
o Professional Fees	- 3.0%
o Supplies	- 3.0%
o Purchased Services	- 3.0%
o Other Operating Expenses	- 2.0%
• Expense Volume Driver	- For the hospital entities, identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%)
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Beginning in FY2019 and F2020, UCHS includes 340B savings (at UCMC) offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos) which leads to a transition to UMMS Shared Services beginning in FY2020. - Beginning in FY2021 a $0.9M performance improvement plan is assumed at UCMC, growing to $7.2M in FY2022 ($5.9M at UCMC, $0.2M at UCMS and $1.1M at AMC Specialty Psych Hospital) when HMH closes and the Project opens. An incremental performance improvement of $1.5M per year is assumed throughout the projection period.
• Interest Expense – Existing Debt	- Continued amortization of existing debt and related interest expense: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt	- 4.5% interest on $214.4M bonds over 30 years
• Depreciation and Amortization	- Average life of 26 years on $196.3M (less land and debt service reserve fund) of construction project expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures	- $135.0M in routine capital over the projection period with another $47.4M of other strategic capital projects (none are related to this Project)

TABLE J. REVENUES & EXPENSES, INFLATED - UCMC + UC FMF

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 138,399	$ 137,865	$ 133,667	$ 183,024	$ 201,829	$ 241,951	$ 246,947	$ 249,452
b. Outpatient Services	203,683	213,836	186,794	149,525	132,911	175,720	174,517	175,839
Gross Patient Service Revenues	***$ 342,082***	***$ 351,701***	***$ 320,461***	***$ 332,549***	***$ 334,740***	***$ 417,671***	***$ 421,464***	***$ 425,291***
c. Allowance For Bad Debt	9,525	9,336	8,850	9,411	9,473	13,314	13,435	13,556
d. Contractual Allowance	24,266	27,429	31,341	31,179	31,385	40,476	40,843	41,213
e. Charity Care	11,457	11,807	5,127	10,793	10,864	12,459	12,572	12,687
Net Patient Services Revenue	***$ 296,834***	***$ 303,129***	***$ 275,142***	***$ 281,166***	***$ 283,018***	***$ 351,422***	***$ 354,614***	***$ 357,835***
f. Other Operating Revenues (Specify/add rows if needed)	3,937	3,725	4,327	3,988	3,948	4,133	4,092	4,052
NET OPERATING REVENUE	***$ 300,771***	***$ 306,854***	***$ 279,469***	***$ 285,153***	***$ 286,966***	***$ 355,554***	***$ 358,706***	***$ 361,887***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 140,964	$ 123,635	$ 128,391	$ 138,441	$ 133,955	$ 168,895	$ 168,998	$ 169,737
b. Contractual Services	10,016	10,588	10,932	11,903	11,903	14,611	14,611	14,611
c. Interest on Current Debt	6,901	8,816	8,404	8,182	7,911	8,201	7,888	7,619
d. Interest on Project Debt	-	-	-	-	-	6,590	6,467	6,338
e. Current Depreciation	16,311	17,452	18,204	18,060	19,017	21,876	22,717	23,508
f. Project Depreciation	-	-	-	-	-	5,637	5,672	5,779
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	67,028	66,837	47,413	46,021	47,314	53,895	54,569	55,266
j. Other Expenses (Specify/add rows if needed)	42,999	44,932	35,203	43,325	40,371	51,772	51,439	51,047
TOTAL OPERATING EXPENSES	**$ 284,219**	**$ 272,260**	**$ 248,547**	**$ 265,930**	**$ 260,471**	**$ 331,476**	**$ 332,362**	**$ 333,907**
3. INCOME								
a. Income From Operation	**$ 16,552**	**$ 34,594**	**$ 30,923**	**$ 19,223**	**$ 26,495**	**$ 24,078**	**$ 26,344**	**$ 27,980**
b. Non-Operating Income	-	-	-	-	-	-	-	-
SUBTOTAL	***$ 16,552***	***$ 34,594***	***$ 30,923***	***$ 19,223***	***$ 26,495***	***$ 24,078***	***$ 26,344***	***$ 27,980***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 16,552***	***$ 34,594***	***$ 30,923***	***$ 19,223***	***$ 26,495***	***$ 24,078***	***$ 26,344***	***$ 27,980***

TABLE J. REVENUES & EXPENSES, INFLATED - UCMC + UC FMF

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
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	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table J – Key Financial Projection Assumptions for the UM Upper Chesapeake Medical Center & Free Standing Medical Facility (Excludes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Medical Center (UCMC) and Harford Memorial Hospital (HMH) FY2019 cost center level projections and high level FY2020 budget results with assumptions identified below	
Projection period reflects FY2021 – FY2024	
Volumes	- Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- 0.00% annual increase
o Demographic and Other Rate Adjustment	- Remains constant at 0.43% per year
o Variable Cost Factor	- UC HMH volume shifting at 100% VCF before the addition of retained revenue for capital
o Other (FMF)	- Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2018 OP PDA payer mix and actual FY2018 UCC
• Revenue Deductions (UCMC)	
o Contractual Allowances	- Remains constant at 9.4% of gross revenue per year
o Charity Care	- Remains constant at 3.2% of gross revenue per year with no overfunding or underfunding of UCC
o Allowance for Bad Debt	- Remains constant at 2.8% of gross revenue per year with no overfunding or underfunding of UCC
• Revenue Deductions (FMF)	
o Contractual Allowances	- Based on FY2018 HMH actual contractual allowances for HMH Behavioral Health, ED, and Observation Services and remains constant at 8.9% of gross revenue per year
o Charity Care	- Based on FY2018 actual charity care for HMH Behavioral Health, ED, and Observation Services and remains constant at 4.4% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	- Based on FY2018 actual bad debt for HMH Behavioral Health, ED, and Observation services and remains constant at 7.2% of gross revenue per year - No overfunding or underfunding of UCC
Other Revenue	
o Cafeteria Revenue and Other Operating Revenue	- 0.0% increase per year
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 Volume Driver	- Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%)
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Beginning in FY2019 and FY2020, includes 340B savings (at UCMC) offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos), which leads to a transition to UMMS Shared Services beginning in FY2020. - Beginning in FY2021, a performance improvement plan is included at UCMC totaling $0.9M, growing to $5.9M in FY2022 when HMH closes and the Project opens. An incremental performance improvement of $1.1M per year is assumed throughout the projection period
• Interest Expense – Existing Debt	- 95% allocation of the following UCHS debt: - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
• Interest Expense – Project Debt (UCMC)	- 4.5% interest on $82.9M bonds over 30 years
• Interest Expense – Project Debt (FMF)	- 4.5% interest on $64.3M bonds over 30 years
• Depreciation and Amortization (UCMC)	- Average life of 26 years on $73.5M of construction project (less debt service reserve fund) expenditures and 10 years on routine capital expenditures
• Depreciation and Amortization (FMF)	- Average life of 26 years on $51.9M of construction project (less land and debt service reserve fund) expenditures and 10 years on routine capital expenditures
Routine Capital Expenditures (UCMC)	- $108.8M in routine capital over the projection period with another $47.4M of other strategic capital projects (none are related to this Project)
Routine Capital Expenditures (FMF)	- $0.3M in FY2022, growing to $1.1M in FY2023 and $1.8M in FY2024

TABLE K. REVENUES & EXPENSES, INFLATED - UCMC + UC FMF

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
1. REVENUE								
a. Inpatient Services	$ 138,399	$ 137,865	$ 133,667	$ 186,685	$ 209,983	$ 256,761	$ 267,304	$ 275,416
b. Outpatient Services	203,683	213,836	186,794	152,516	138,281	186,475	188,902	194,140
Gross Patient Service Revenues	***$ 342,082***	***$ 351,701***	***$ 320,461***	***$ 339,200***	***$ 348,264***	***$ 443,236***	***$ 456,206***	***$ 469,556***
c. Allowance For Bad Debt	9,525	9,336	8,850	9,600	9,856	14,129	14,542	14,967
d. Contractual Allowance	24,266	27,429	31,341	31,803	32,653	42,954	44,210	45,503
e. Charity Care	11,457	11,807	5,127	11,009	11,303	13,221	13,609	14,008
Net Patient Services Revenue	***$ 296,834***	***$ 303,129***	***$ 275,142***	***$ 286,789***	***$ 294,452***	***$ 372,932***	***$ 383,845***	***$ 395,079***
f. Other Operating Revenues (Specify/add rows if needed)	3,937	3,725	4,327	4,067	4,108	4,386	4,429	4,474
NET OPERATING REVENUE	***$ 300,771***	***$ 306,854***	***$ 279,469***	***$ 290,856***	***$ 298,560***	***$ 377,317***	***$ 388,275***	***$ 399,552***
2. EXPENSES								
a. Salaries & Wages (including benefits)	$ 140,964	$ 123,635	$ 128,391	$ 141,625	$ 140,188	$ 180,819	$ 185,091	$ 190,176
b. Contractual Services	10,016	10,588	10,932	12,260	12,628	15,966	16,445	16,938
c. Interest on Current Debt	6,901	8,816	8,404	8,182	7,911	8,201	7,888	7,619
d. Interest on Project Debt	-	-	-	-	-	6,590	6,467	6,338
e. Current Depreciation	16,311	17,452	18,204	18,060	19,017	21,876	22,717	23,508
f. Project Depreciation	-	-	-	-	-	5,637	5,672	5,779
g. Current Amortization	-	-	-	-	-	-	-	-
h. Project Amortization	-	-	-	-	-	-	-	-
i. Supplies	67,028	66,837	47,413	47,401	50,195	58,893	61,418	64,069
j. Other Expenses (Specify/add rows if needed)	42,999	44,932	35,203	44,191	42,002	54,941	55,680	56,360
TOTAL OPERATING EXPENSES	***$ 284,219***	***$ 272,260***	***$ 248,547***	***$ 271,718***	***$ 271,941***	***$ 352,922***	***$ 361,377***	***$ 370,788***
3. INCOME								
a. Income From Operation	**$ 16,552**	**$ 34,594**	**$ 30,923**	**$ 19,138**	**$ 26,619**	**$ 24,396**	**$ 26,898**	**$ 28,764**
b. Non-Operating Income	-	-	-	-	-	-	-	-
SUBTOTAL	***$ 16,552***	***$ 34,594***	***$ 30,923***	***$ 19,138***	***$ 26,619***	***$ 24,396***	***$ 26,898***	***$ 28,764***
c. Income Taxes	-	-	-	-	-	-	-	-
NET INCOME (LOSS)	***$ 16,552***	***$ 34,594***	***$ 30,923***	***$ 19,138***	***$ 26,619***	***$ 24,396***	***$ 26,898***	***$ 28,764***

TABLE K. REVENUES & EXPENSES, INFLATED - UCMC + UC FMF

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

	Two Most Recent Years (Actual)		Current Year Projected	Projected Years (ending at least two years after project completion and full occupancy) Add columns if needed in order to document that the hospital will generate excess revenues over total expenses consistent with the Financial Feasibility standard.				
Indicate CY or FY	**FY 2017**	**FY 2018**	**FY 2019**	**FY 2020**	**FY 2021**	**FY 2022**	**FY 2023**	**FY 2024**
4. PATIENT MIX								
a. Percent of Total Revenue								
1) Medicare	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%	47.1%
2) Medicaid	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%	11.5%
3) Blue Cross	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%	11.8%
4) Commercial Insurance	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%	25.4%
5) Self-pay	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%	0.6%
6) Other	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%
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	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%	9.5%
3) Blue Cross	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%	7.2%
4) Commercial Insurance	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%	16.3%
5) Self-pay	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%	0.4%
6) Other	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%	3.3%
TOTAL	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***	***100.0%***

Table K – Key Financial Projection Assumptions for the UM Upper Chesapeake Medical Center & Free Standing Medical Facility (Includes HSCRC Annual Update Factors & Expense Inflation)

Projection is based on the Upper Chesapeake Medical Center (UCMC) and Harford Memorial Hospital (HMH) FY2019 cost center level projections and high level FY2020 budge results with assumptions identified below.	
Projection period reflects FY2021 – FY2024	
Volumes	- Refer to COE Table F, including assumptions, and Need Assessment section of the application for volume methodology and assumptions
Patient Revenue	
• Gross Charges	
o Update Factor	- 2.1% annual increase in FY2021, 2.3% annual increase in FY2022 and 2.50% annual increase in FY2023 & FY2024
o Demographic and Other Rate Adjustment	- Remains constant at 0.43% per year
o Variable Cost Factor	- UC FMF volume shifting at 100% VCF before the addition of retained revenue for capital
o Other (FMF)	- Removed assessments and quality from HMH rates and changed the mark-up based on HMH FY2018 OP PDA payer mix and actual FY2018 UCC
• Revenue Deductions (UCMC)	
o Contractual Allowances	- Remains constant at 9.4% of gross revenue per yea
o Charity Care	- Remains constant at 3.2% of gross revenue per year with no overfunding or underfunding of UCC
o Allowance for Bad Debt	- Remains constant at 2.8% of gross revenue per year with no overfunding or underfunding of UCC
• Revenue Deductions (FMF)	
o Contractual Allowances	- Based on FY2018 HMH actual contractual allowances for HMH Behavioral Health, ED, and Observation Service and remains constant at 8.9% of gross revenue per year
o Charity Care	- Based on FY2018 actual charity care for HMH Behavioral Health, ED, and Observation Services and remains constant at 4.4% of gross revenue per year - No overfunding or underfunding of UCC
o Allowance for Bad Debt	- Based on FY2018 actual bad debt for HMH Behavioral Health, ED, and Observation services and remains constant at 7.2% of gross revenue per year - No overfunding or underfunding of UCC
Other Revenue	
o Cafeteria Revenue and Other Operating	- 1.0% increase per year
Expenses	
• Inflation	
o Salaries and Benefits	- 2.3%
o Professional Fees	- 3.0%
o Supplies	- 3.0%
o Purchased Services	- 3.0%
o Other Operating Expenses	- 2.0%
• Expense Volume Driver	- Identified at the cost center level and varies based on cost center level statistics and key volume drivers.
• Expense Variability with Volume Changes	
o Salaries and Benefits	- Ranges from 10% for overhead departments to 100% for inpatient nursing units
o Professional Fees	- 0% for all cost centers except inpatient nursing (50%) and Laboratory (100%)
o Supplies & Drugs	- Ranges from 0% for overhead departments to 100% for the Emergency Department
o Purchased Services	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
o Other Operating Expenses	- Ranges from 0% for overhead departments to 50% for certain ancillary departments
• Other Operating Expenses	- Beginning in FY2019 and FY2020, includes 340B savings (at UCMC) offset by the increased cost of the implementation of the following systems: electronic medical records (EPIC), human resource module (Lawson), and time and attendance system (Kronos), which leads to a transition to UMMS Shared Services beginning in FY2020. - Beginning in FY2021, a performance improvement plan is included at UCMC totaling $0.9M, growing to $5.9M in FY2022 when HMH closes and the Project opens. An incremental performance improvement of $1.1M per year is assumed throughout the projection period
• Interest Expense – Existing Debt	- 95% allocation of the following UCHS debt - 5.76% interest on $55.3M 2008C Series bonds - 5.76% interest on $118.5M 2011 B&C Series bonds - 3.6% interest on $50.0M 2011A Series bonds
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EXHIBIT 8

<table>
<tr><td rowspan="4"> 
University of Maryland Medical Center
University of Maryland Medical Center Midtown Campus
University of Maryland Rehabilitation & Orthopaedic Institute
University of Maryland St. Joseph Medical Center
University of Maryland Baltimore Washington Medical Center
University of Maryland Shore Medical Center at Chestertown
University of Maryland Shore Medical Center at Dorchester
University of Maryland Shore Medical Center at Easton
University of Maryland Charles Regional Medical Center
University of Maryland Upper Chesapeake Health
University of Maryland Capital Region Health</td><td rowspan="2">The University of Maryland Medical System
Central Business Office
Policy & Procedure</td><td>Policy #:</td><td>TBD</td></tr>
<tr><td>Effective Date:</td><td>09/18/2019</td></tr>
<tr><td colspan="2"></td><td></td></tr>
<tr><td rowspan="2"><u>Subject:</u>
FINANCIAL ASSISTANCE</td><td>Page #:</td><td>1 of 15</td></tr>
<tr><td>Supersedes:</td><td>07/01/2019</td></tr>
</table>

POLICY

This policy applies to the following hospital facilities of the University of Maryland Medical System (“UMMS hospitals”):

- University of Maryland Medical Center (UMMC)
- University of Maryland Medical Center Midtown Campus (MTC)
- University of Maryland Rehabilitation & Orthopaedic Institute (UMROI)
- University of Maryland St. Joseph Medical Center (UMSJMC)
- University of Maryland Baltimore Washington Medical Center (UMBWMC)
- University of Maryland Shore Medical Center at Chestertown (UMSMCC)
- University of Maryland Shore Medical Center at Dorchester (UMSMCD)
- University of Maryland Shore Medical Center at Easton (UMSME)
- University of Maryland Charles Regional Medical Center (UMCRMC)
- University of Maryland Upper Chesapeake Health (UCHS)
- University of Maryland Capital Region Health (UM Capital)

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

It is the policy of the UMMS hospitals to provide Financial Assistance based on indigence or high medical expenses for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance should be made, the criteria for eligibility, and the steps for processing applications.

UMMS will post notices of financial assistance availability in each UMMS hospital's emergency room (if any) and admissions areas, as well as the Billing Office. Notice of availability will also be sent to the patient with patient bills. Signage in key patient access areas will be made available. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge, and it (along with this policy and the Financial Assistance Application) will be available to all patients upon request and without charge, both by mail and in the emergency room (if any) and admissions areas. This policy, the Patient Billing and Financial Assistance Information Sheet, and the Financial Assistance Application will also be conspicuously posted on the UMMS website (www.umms.org).

Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This should include a review of the patient's existing medical expenses and obligations (including any accounts having gone to bad debt except those accounts that have gone to lawsuit and a judgment has been obtained) and any projected medical expenses. Financial Assistance Applications may be offered to patients whose accounts are with a collection agency.

UMMS retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay. For emergent/urgent services, applications to the Financial Clearance Program will be completed, received, and evaluated retrospectively and will not delay patients from receiving care.

This policy was adopted for University of Maryland St. Joseph Medical Center (UMSJMC) effective June 1, 2013.

This policy was adopted for University of Maryland Medical Center Midtown Campus (MTC) effective September 22, 2014.

This policy was adopted for University of Maryland Baltimore Washington Medical Center (UMBWMC) effective July 1, 2016.

This policy was adopted for University of Maryland Shore Medical Center at Chestertown (UMSMCC) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Dorchester (UMSMCD) effective September 1, 2017.

This policy was adopted for University of Maryland Shore Medical Center at Easton (UMSMCE) effective September 1, 2017.

This policy was adopted for University of Maryland Charles Regional Medical Center (UMCRMC) effective December 2, 2018.

This policy was adopted for University of Maryland Upper Chesapeake Health (UCHS) effective July 1, 2019

This policy was adopted for University of Maryland Capital Region Health (UM Capital) effective September 18, 2019

PROGRAM ELIGIBILITY

Consistent with their mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital hospitals strive to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

Specific exclusions to coverage under the Financial Assistance Program:

The Financial Assistance Program generally applies to all emergency and other medically necessary care provided by each UMMS hospital, as well as certain entities related to such hospitals listed in Attachment B. However, the Financial Assistance Program does not apply to any of the following:

1. Services provided by healthcare providers not affiliated with UMMS hospitals (e.g., durable medical equipment, home health services).
2. Patients whose insurance program or policy denies coverage for services by their insurance company (e.g., HMO, PPO, or Workers Compensation), are not eligible for the Financial Assistance Program.
   a. Generally, the Financial Assistance Program is not available to cover services that are denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications.
3. Cosmetic or other non-medically necessary services.
4. Patient convenience items.
5. Patient meals and lodging.
6. Physician charges related to the date of service are excluded from this UMMS financial assistance policy. Patients who wish to pursue financial assistance for physician-related bills must contact the physician directly.
   a. A list of providers, other than the UMMS hospital itself, delivering medically necessary care in each UMMS hospital that specifies which such as providers are not covered by this policy (as well as certain such providers that are covered) may be obtained on the website of each UMMS Entity.

Patients may be ineligible for Financial Assistance for the following reasons:

1. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, or other insurance programs that deny access to the Medical Center due to insurance plan restrictions/limits.
2. Refusal to be screened for other assistance programs prior to submitting an application to the Financial Clearance Program.
3. Refusal to divulge information pertaining to a pending legal liability claim.
4. Foreign-nationals traveling to the United States seeking elective, non-emergent medical care.

Patients who become ineligible for the program will be required to pay any open balances and may be submitted to a bad debt service if the balance remains unpaid in the agreed upon time periods.

Unless they meet Presumptive Financial Assistance Eligibility criteria, patients shall be required to submit a complete Financial Assistance Application (with all required information and documentation) and determined to be eligible for financial assistance in order to obtain financial assistance. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application before receiving non-emergency medical care unless they meet Presumptive Financial Assistance Eligibility criteria. If the patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor/Coordinator and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.

Those with income up to 200% of Maryland State Department of Health and Mental Hygiene Medical Assistance Planning Administration Income Eligibility Limits for a Reduced Cost of Care (“MD DHMH”) are eligible for free care. Those between 200% to 300% of MD DHMH are eligible for discounts on a sliding scale, as set forth in Attachment A.

Presumptive Financial Assistance

Patients may also be considered for Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. There is adequate information provided by the patient or through other sources, which provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, UMMS reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100% write-off of the account balance. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:

a. Active Medical Assistance pharmacy coverage
b. Specified Low Income Medicare (SLMB) coverage
c. Primary Adult Care (PAC) coverage
d. Homelessness
e. Medical Assistance and Medicaid Managed Care patients for services provided in the ER beyond the coverage of these programs
f. Medical Assistance spend down amounts
g. Eligibility for other state or local assistance programs
h. Patient is deceased with no known estate

i. Patients that are determined to meet eligibility criteria established under former State Only Medical Assistance Program

j. Non-US Citizens deemed non-compliant

k. Non-Eligible Medical Assistance services for Medical Assistance eligible patients

l. Unidentified patients (Doe accounts that we have exhausted all efforts to locate and/or ID)

m. Bankruptcy, by law, as mandated by the federal courts

n. St. Clare Outreach Program eligible patients

o. UMSJMC Maternity Program eligible patients

p. UMSJMC Hernia Program eligible patients

Specific services or criteria that are ineligible for Presumptive Financial Assistance include:

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

PROCEDURES

1. There are designated persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Patient Financial Receivable Coordinators, Customer Service Representatives, etc.

2. When possible effort will be made to provide financial clearance prior to date of service. Where possible, designated staff will consult via phone or meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   a. Staff will complete an eligibility check with the Medicaid program for Self Pay patients to verify whether the patient has current coverage.
   b. Preliminary data will be entered into a third party data exchange system to determine probably eligibility. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility.
   c. Applications initiated by the patient will be tracked, worked and eligibility determined within the third party data and workflow tool. A letter of final determination will be submitted to each patient that has formally requested financial assistance. Determination of Probable Eligibility will be provided within two business days following a patient's request for charity care services, application for medical assistance, or both.
   d. If a patient submits a Financial Assistance Application without the information or documentation required for a final determination of eligibility, a written request for the missing information or documentation will be sent to the patient. This written request will also contain the contact information (including telephone number and physical location) of the office or department that can provide information about the Financial Assistance Program and assistance with the application process.
   e. The patient will have thirty (30) days from the date this written request is provided to submit the required information or documentation to be considered for eligibility. If no data is received within the 30 days, a letter will be sent notifying the patient that the case is now closed for lack of the required documentation. The patient may re-apply to the program and initiate a new case by submitting the missing information or documentation 30 days after the date of the written request for missing information/documentation.
   f. For any episode of care, the Financial Assistance Application process will be open up to at least 240 days after the first post-discharge patient bill for the care is sent.

g. Individual notice regarding the hospital's Financial Assistance Policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.

3. There will be one application process for UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital. The patient is required to provide a completed Financial Assistance Application orally or in writing. In addition, the following may be required:

   a. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy spouse's tax return); proof of disability income (if applicable), proof of social security income (if applicable). If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc ...

   b. A copy of their most recent pay stubs (if employed) or other evidence of income.

   c. A Medical Assistance Notice of Determination (if applicable).

   d. Copy of their Mortgage or Rent bill (if applicable), or written documentation of their current living/housing situation.

If a patient submits both a copy of their most recent Federal Income Tax Return and a copy of their most recent pay stubs (or other evidence of income), and only one of the two documents indicates eligibility for financial assistance, the most recent document will dictate eligibility. Oral submission of needed information will be accepted, where appropriate.

4. In addition to qualifying for Financial Assistance based on income, a patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive medical expenses based on the Financial Hardship criteria discussed below. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Patient Financial Services Department for final determination of eligibility based on UMMS guidelines.

   a. If the patient's application for Financial Assistance is determined to be complete and appropriate, the Financial Coordinator will recommend the patient's level of eligibility and forward for a second and final approval.

i) If the patient does qualify for Financial Assistance, the Financial Coordinator will notify clinical staff who may then schedule the patient for the appropriate hospital-based service.

ii) If the patient does not qualify for Financial Assistance, the Financial Coordinator will notify the clinical staff of the determination and the non-emergent/urgent hospital-based services will not be scheduled.

(1) A decision that the patient may not be scheduled for hospital-based, non-emergent/urgent services may be reconsidered by the Financial Clearance Executive Committee, upon the request of a Clinical Chair.

5. Once a patient is approved for Financial Assistance, Financial Assistance coverage is effective for the month of determination and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Assistance eligibility period further into the past or the future on a case-by-case basis. If additional healthcare services are provided beyond the eligibility period, patients must reapply to the program for clearance. In addition, changes to the patient's income, assets, expenses or family status are expected to be communicated to the Financial Assistance Program Department. All Extraordinary Collections Action activities, as defined below, will be terminated once the patient is approved for financial assistance and all the patient responsible balances are paid.

6. Account balances that have not been paid may be transferred to Bad Debt (deemed uncompensated care) and referred to an outside collection agency or to the UMMS hospital's attorney for legal and/or collection activity. Collection activities taken on behalf of the hospital by a collection agency or the hospital's attorney may include the following Extraordinary Collection Actions (ECAs):

a. Reporting adverse information about the individual to consumer credit reporting agencies or credit bureaus.

b. Commencing a civil action against the individual.

c. Placing a lien on an individual's property. A lien will be placed by the Court on primary residences within Baltimore City. The hospital will not pursue foreclosure of a primary residence but my maintain its position as a secured creditor if a property is otherwise foreclosed upon.

d. Attaching or seizing an individual's bank account or any other personal property.

e. Garnishing an individual's wage.

7. ECAs may be taken on accounts that have not been disputed or are not on a payment arrangement. ECAs will occur no earlier than 120 days from submission of first post-discharge bill to the patient and will be preceded by a written notice 30 days prior to commencement of the ECA. This written notice will indicate that financial assistance is available for eligible individuals, identify the ECAs that the hospital (or its collection agency, attorney, or other authorized party) intends to obtain payment for the care, and state a deadline after which such ECAs may be initiated. It will also include a Patient Billing and Financial Assistance Information Sheet. In addition, the hospital will make reasonable efforts to orally communicate the availability of financial assistance to the patient and tell the patient how he or she may obtain assistance with the application process. A presumptive eligibility review will occur prior to any ECA being taken. Finally, no ECA will be initiated until approval has been obtained from the CBO Revenue Cycle.

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

9. A letter of final determination will be submitted to each patient who has formally submitted an application. The letter will notify the patient in writing of the eligibility determination (including, if applicable, the assistance for which the individual is eligible) and the basis for the determination. If the patient is determined to be eligible for assistance other than free care, the patient will also be provided with a billing statement that indicates the amount the patient owes for the care after financial assistance is applied.

10. Refund decisions are based on when the patient was determined unable to pay compared to when the patient payments were made. Refunds will be issued back to the patient for credit balances, due to patient payments, resulting from approved financial assistance on considered balance(s). Payments received for care rendered during the financial assistance eligibility window will be refunded, if the amount exceeds the patient's determined responsibility by $5.00 or more.

11. If a patient is determined to be eligible for financial assistance, the hospital (and/or its collection agency or attorney) will take all reasonably available measures to reverse any ECAs taken against the patient to obtain payment for care rendered during the financial assistance eligibility window. Such reasonably available measures will include measures to vacate any judgment against the patient, lift levies or liens on the patient's property, and remove from the patient's credit report any adverse information that was reported to a consumer reporting agency or credit bureau.
12. Patients who have access to other medical coverage (e.g., primary and secondary insurance coverage or a required service provider, also known as a carve-out), must utilize and exhaust their network benefits before applying for the Financial Assistance Program.
13. The Financial Assistance Program will accept the Faculty Physicians, Inc.'s (FPI) completed financial assistance applications in determining eligibility for the UMMS Financial Assistance program. This includes accepting FPI's application requirements.
14. The Financial Assistance Program will accept all other UMMS hospital's completed financial assistance applications in determining eligibility for the program. This includes accepting each facility's application format.
15. The Financial Assistance Program does not cover Supervised Living Accommodations and meals while a patient is in the Day Program.
16. Where there is a compelling educational and/or humanitarian benefit, Clinical staff may request that the Financial Clearance Executive Committee consider exceptions to the Financial Assistance Program guidelines, on a case-by-case basis, for Financial Assistance approval.
    a. Faculty requesting Financial Clearance/Assistance on an exception basis must submit appropriate justification to the Financial Clearance Executive Committee in advance of the patient receiving services.
    b. The Chief Medical Officer will notify the attending physician and the Financial Assistance staff of the Financial Clearance Executive Committee determination.

Financial Hardship

The amount of uninsured medical costs incurred at either, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will be considered in determining a patient's eligibility for the Financial Assistance Program. The following guidelines are outlined as a separate, supplemental determination of Financial Assistance, known as Financial Hardship. Financial Hardship will be offered to all patients who apply for Financial Assistance and are determined to be eligible.

Medical Financial Hardship Assistance is available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy, but for whom:

1) Their medical debt incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital exceeds 25% of the Family Annual Household Income, which is creating Medical Financial Hardship.

For the patients who are eligible for both, the Reduced Cost Care under the primary Financial Assistance criteria and also under the Financial Hardship Assistance criteria, UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital will grant the reduction in charges, which is balance owed that is greater than 25% of the total annual household income.

Financial Hardship is defined as facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and UM Capital for medically necessary treatment by a family household over a twelve (12) month period that exceeds 25% of that family's annual income.

Medical Debt is defined as out of pocket expenses for the facility charges incurred at UMMC, MTC, UMROI, UMSJMC, UMBWMC, UMSMCC, UMSMCD, UMSMCE, UMCRMC, UCHS, and/or UM Capital for medically necessary treatment.

Once a patient is approved for Financial Hardship Assistance, coverage will be effective for the month of the first qualifying date of service and a year prior to the determination. However, an UMMS hospital may decide to extend the Financial Hardship eligibility period further into the past or the future on a case-by-case basis according to their spell of illness/episode of care. It will cover the patient and the eligible family members living in the household for the approved reduced cost and eligibility period for medically necessary care.

All other eligibility, ineligibility, and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance criteria, unless otherwise stated above.

Appeals

- Patients whose financial assistance applications are denied have the option to appeal the decision.
- Appeals can be initiated verbally or written.
- Patients are encouraged to submit additional supporting documentation justifying why the denial should be overturned.
- Appeals are documented within the third party data and workflow tool. They are then reviewed by the next level of management above the representative who denied the original application.
- If the first level of appeal does not result in the denial being overturned, patients have the option of escalating to the next level of management for additional reconsideration.
- The escalation can progress up to the Chief Financial Officer who will render a final decision.
- A letter of final determination will be submitted to each patient who has formally submitted an appeal.

ATTACHMENT A

Sliding Scale – Reduced Cost of Care

MD DHMH 2019 Income Elig Limit Guidelines		Income Level Up to 200% Pt Resp 0%	S L I D	Income Level Pt Resp 10%	Income Level Pt Resp 20%	Income Level Pt Resp 30%	Income Level Pt Resp 40%	Income Level Pt Resp 50%	Income Level Pt Resp 60%	Income Level Pt Resp 70%	Income Level Pt Resp 80%	Income Level Pt Resp 90%
HH	**100% MD DHMH**	**100% Charity**		**90% Charity**	**80% Charity**	**70% Charity**	**60% Charity**	**50% Charity**	**40% Charity**	**30% Charity**	**20% Charity**	**10% Charity**
Size	Max	**Max**		Max	Max	Max	Max	Max	Max	Max	Max	Max
1	**$17,244**	**$34,488**	**N**	$36,212	$37,937	$39,661	$41,386	$43,110	$44,834	$46,559	$48,283	$51,731
2	**$23,364**	**$46,728**	**G**	$49,064	$51,401	$53,737	$56,074	$58,410	$60,746	$63,083	$65,419	$70,091
3	**$29,448**	**$58,896**		$61,841	$64,786	$67,730	$70,675	$73,620	$76,565	$79,510	$82,454	$88,343
4	**$35,532**	**$71,064**	**S**	$74,617	$78,170	$81,724	$85,277	$88,830	$92,383	$95,936	$99,490	$106,595
5	**$41,652**	**$83,304**	**C**	$87,469	$91,634	$95,800	$99,965	$104,130	$108,295	$112,460	$116,626	$124,955
6	**$47,748**	**$95,496**	**A**	$100,271	$105,046	$109,820	$114,595	$119,370	$124,145	$128,920	$133,694	$143,243

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

Effective 7/1/19

EXHIBIT 9

Standard .04B(7) – Construction Cost of Hospital Space

(a) The cost per square foot of hospital construction projects shall be no greater than the cost of good quality Class A hospital construction given in the Marshall and Swift Valuation Quarterly, updated to the nearest quarter using the Marshall and Swift update multipliers, and adjusted as shown in the Marshall and Swift guide as necessary for terrain of the site, number of levels, geographic locality, and other listed factors.

(b) Each Certificate of Need applicant proposing costs per square foot above the limitations set forth in the Marshall and Swift Guide must demonstrate that the higher costs are reasonable.

The following compares the project costs to the Marshall Valuation Service ("MVS") benchmark.

I. Marshall Valuation Service
Valuation Benchmark

Type		Hospital
Construction Quality/Class		Good/A
Stories		6
Perimeter		492
Average Floor to Floor Height		16.8
Square Feet		88,850
f.1	Average floor Area	14,808
A. Base Costs		
	Basic Structure	$398.00
	Elimination of HVAC cost for adjustment	0
	HVAC Add-on for Mild Climate	0
	HVAC Add-on for Extreme Climate	0
Total Base Cost		$398.00
Adjustment for Departmental Differential Cost Factors		0.88
Adjusted Total Base Cost		$350.09
B. Additions		
	Elevator (If not in base)	$0.00
	Other	$0.00

Subtotal		$0.00
Total		$350.09
C. Multipliers		
Perimeter Multiplier		0.931774667
	Product	$326.21
Height Multiplier		1.11
	Product	$362.15
Multi-story Multiplier		1.010
	Product	$365.77
D. Sprinklers		
	Sprinkler Amount	$3.08
Subtotal		$368.84
E. Update/Location Multipliers		
Update Multiplier		1.02
	Product	$376.22
Location Multipier		1.01
	Product	$379.98
Calculated Square Foot Cost Standard		**$379.98**

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

Department/Function	BGSF	MVS Department Name	MVS Differential Cost Factor	Cost Factor X SF
ACUTE PATIENT CARE				
Med / Surg Patient Unit Level 5	26,290	Inpatient Unit	1.06	27,867
Observation Unit Level 4	26,290	Inpatient Unit	1.06	27,867
Dietary	870	Dietary	1.52	1,322
Dining Room	1,550	Dining Room	0.95	1,473
EVS	2,990	Mechnical Equipment and	0.7	2,093

		Shops		
Facilities	2,100	Offices	0.96	2,016
Security	1,450	Offices	0.96	1,392
Shell Space Level 3	26,290	Unnasigned Space	0.5	13,145
Existing Cancer Center	1,020	Outpatient Department	0.96	979
TOTAL	88,850		0.87962746	78,155

Cost of New Construction

A. Base Calculations	**Actual**	**Per Sq. Foot**
Building	$39,639,186	$446.14
Fixed Equipment	$0	$0.00
Site Preparation	$246,346	$2.77
Architectural Fees	$4,628,765	$52.10
Permits	$2,320,586	$26.12
Capitalized Construction Interest	Calculated Below	Calculated Below
Subtotal	$46,834,883	$527.12

However, as related below, this project includes expenditures for items not included in the MVS average.

B. Extraordinary Cost Adjustments

	Project Costs		**Associated Cap Interest & Financing**
Complexity Premium	$3,963,919	Building	$719,274
Demolition	$1,085,820	Building	$197,028
2/5 HVAC System	$3,055,552	Building	$554,446
OVHD Bridges	$2,535,000	Building	$459,989
Pneumatic tube	$466,440	Building	$84,638
Signage	$132,454	Building	$24,034
Elevator Premium	$850,375	Building	$154,305
Premium for Minority Business Enterprise Requirement	$1,585,567	Building	$287,709
Premium for Minority Business Enterprise Requirement	$9,854	Site	
Total Cost Adjustments	$13,684,981		$2,481,423

Associated Capitalized Interest and Loan Placement Fees should be excluded from the comparison for those items which are also excluded from the comparison. Since

only Capitalized Interest and Loan Placement fees relating to the Building costs are included in the MVS analysis, we have only eliminated them for the Extraordinary Costs that are in the Building cost item. This was calculated as follows, using a Canopy as an example:

(Cost of the Canopy/Building Cost) X (Building related Capitalized Interest and Loan Placement Fees).

Explanation of Extraordinary Costs

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

1. Complexity Premium - The complexity and necessary logistics of the project has a profound impact on the cost of construction. The project is bordered by a major road artery within 30 feet of the building footprint on the west, a road artery within 50 feet of the south elevation which is also the sole access point to the building's parking garage. On the north elevation, there is a direct attachment to the hospital and no setback from the main and sole loading dock and Central Utility Plant on the east elevation. These constraints require extraordinary methods of construction, safety, access for patients, guests and employees that will ultimately reduce construction productivity. The limited access requires a specialized tower crane that will be interior to the existing building, extreme measures to provide safe access of patients, guests and employee in to and around the building site. The limited area around the building requires off-site staging and material storage which add logistic costs from the remote staging area and scheduling demands for delivery of materials to the construction site. The tower crane as the sole source of delivery of materials into the project along with an exterior elevator system for construction staff to reach the upper floors limit material and manpower into and out of the construction floors 3, 4 and 5.

The construction activity will occur immediately above the Cancer Center and immediately adjacent to the Main Hospital, specifically three (3) floors of in-patient rooms to the east and two floors of outpatient Cancer patients directly below the construction site. These constraints require additional consideration for noise, safety and the general need to maintain ongoing operations and respect our patient experience.

2. 2/5 HVAC System - With the elimination of the existing rooftop units new services must now be provided by the Central Utility Plant (CUP) and on the roof of the new expansion for the existing two floors plus the additional three floors. The combined total demand required for this five (5) story building requires relocation of existing chillers to accommodate the installation of new two (2) chillers, replacement of the existing Cooling Tower which is not expandable to meet the current demand, replacement of one (1) boiler of our existing three (3) boilers to provide the required

redundancy, the replacement of the existing fire pump and an increase in the sprinkler supply lines for the additional water flow requirements and finally the addition of a Fire Command Center because the addition of the three floors classifies the building as "High Rise". In essence, we are providing new mechanical systems for 2/5 of the ultimate build-out of the five story building and additional support services required by the NFPA.

3. OVHD Bridges - This expansion requires the construction of two enclosed access bridges to the main hospital that will connect on existing Main Hospital patient floors two and three. These connections require modifications to the main hospital at the connection points. For efficiency, the design contemplates shared structural components gained with a stacked design. Adding to the complex logistics of this project, this connector bridge construction will occur adjacent to occupied patient units and above the busy hospital loading dock.

4. Pneumatic tube - The hospitals existing pneumatic tube system will be extended to the new facility and will utilize the bridge connection to connect to the new floors.

5. Elevator Premium - The construction of new elevator systems and the extension of the existing elevator shafts to the new floors will impact patient access and will require overnight construction activity so as not to impact the Cancer Center outpatient experience during normal business hours. Only the premium over the anticipated MVS cost is included as an Extraordinary Cost. This was calculated as follows:

Elevator Cost in Budget			$1,234,038
MVS Costs			
$112,000	per Elevator	2 Elevators	$224,000
$9,050	per Stop	16 Stops	$144,800
	Subtotal:		$368,800
	Location Multplier		1.01
			$372,488
	Update Multiplier		1.02
	Final MVS Cost		$383,663
Premium			$850,375

6. Premium for Minority Business Enterprise Requirement – UMMS projects include a premium for Minority Business Enterprises that would not be in the average cost of hospital construction. This premium was conservatively projected to be 4%. UMMS consulted with its cost estimators/construction managers on the impact on project budgets of targeting 25% inclusion of MBE subcontractors or suppliers as part of its projects, and their conservative estimate is that it adds 3-4% to the costs, compared to projects that do not include MBE subcontractors or suppliers. This

estimate has been confirmed through UMMS' experience with past construction jobs. UMMS now uses this percentage in all of its construction cost estimates.

Eliminating all of the extraordinary costs reduces the project costs that should be compared to the MVS benchmark.

C. Adjusted Project Cost		**Per Square Foot**
Building	$25,964,059	$292.22
Fixed Equipment	$0	$0.00
Site Preparation	$236,492	$2.66
Architectural Fees	$4,628,765	$52.10
Permits	$2,320,586	$26.12
Subtotal	$33,149,902	$373.10
Capitalized Construction Interest	$3,606,224	$36.71
Total	$36,756,126	$374.16

Building associated Capitalized Interest and Loan Placement Fees were calculated as follows:

Hospital	New	Renovation	Total		
Building Cost	$39,639,186				
Subtotal Cost (w/o Cap Interest)	$46,834,883		$46,834,883		
Subtotal/Total	100.0%	0.0%	Net Interest	Financing	Total
Total Project Cap Interest & Financing [(Subtotal Cost/Total Cost) X Total Cap Interest]	$7,192,736	$0	$6,566,503	$626,233	$7,192,736
Building/Subtotal	84.6%				
Building Cap Interest&Financing	$6,087,647				
Associated with Extraordinary Costs	$2,481,423				
Applicable Cap Interest & Loan Place.	$3,606,224				

As noted below, the project's cost per square foot is consistent with the MVS benchmark.

MVS Benchmark	$379.98
The Project	$374.16
Difference	-$5.82
	-1.53%